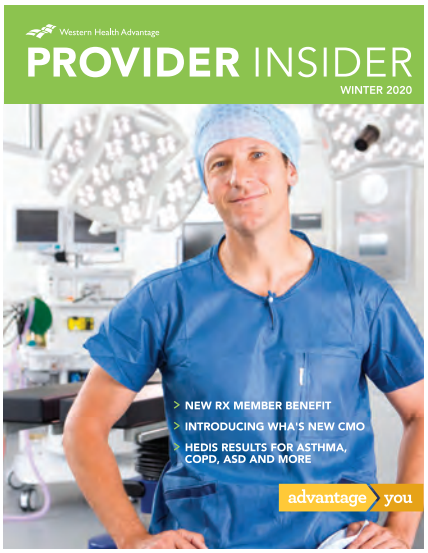
Western Health Advantage

PROVIDER INSIDER

WINTER 2020

- NEW RX MEMBER BENEFIT
- INTRODUCING WHA'S NEW CMO
- HEDIS RESULTS FOR ASTHMA, COPD, ASD AND MORE

advantage you



CMO MESSAGE

WHA Welcomes New Chief Medical Officer

A board-certified pediatrician, **Dr. Khuram Arif** practiced for 19 years. He keenly understands challenges facing physicians and advanced clinicians and the imperative of preserving the joy of practice. Dr. Arif spent a decade in physician leadership helping doctors transition from volume to value based care. Most recently he served as Chief Medical Officer at Woodland Clinic and Medical Director Managed Care at Mercy Medical Group.

Dr. Arif obtained his medical degree at Aga Khan University in Pakistan, then completed a general pediatrics residency at SUNY Brooklyn where he also served as chief resident. After a three-year stint in a federally qualified, underserved area in New Mexico he moved to Sacramento in 2005. Dr. Arif has presented on the physician and advanced practice clinician team, written about home mailing programs for colon cancer screening, and represented physicians as an expert witness to help the California Senate with healthcare lawmaking. He obtained an MBA from UC Davis in 2014, and became a Certified Physician Executive with the American Association of Physician Leadership in 2019.

Dr. Arif believes firmly in the Quadruple Aim and supports clinical provider satisfaction, patient experience improvement, the use of clinical quality metrics and value-based cost-effective care delivery.

KHURAM ARIF MD, MBA, CPE
Chief Medical Officer

PROVIDER INSIDER | WINTER 2020

KHURAM ARIF, M.D.
Chief Medical Officer

LAURA MONTEIL, R.N.
Population Health Management Manager

KAREN BENNETT
Marketing Project Manager

Provider Insider is published quarterly as a health resource exclusively for WHA health care providers. Questions and comments may be directed to WHA at the address and phone number provided. Content reviewers include physicians, nurses, other health specialists and professionals.

Western Health Advantage

2349 Gateway Oaks Drive, Suite 100
Sacramento, California 95833
916.563.2250 – 888.563.2250

westernhealth.com
twitter.com/westernhealth
facebook.com/westernhealth
mywha.org/blog

advantage you

Rx LOCKING CAP

NEW COMPLIMENTARY MEMBER BENEFIT

The opioid and other prescription medication abuse epidemic calls for solutions on many fronts, including the use of abuse-resistant packaging. For this reason, WHA is introducing the availability of a prescription locking cap product from Gatekeeper Innovation, Inc..

The Rx Locking Cap can be secured over a standard prescription bottle and cap and includes a patented 4-digit combination design. Safer Lock, a part of Gatekeeper Innovation, created the Rx Locking Cap using abuse-resistant technology designed to help prevent kids, specifically teens, from sneaking medications from family members, and deter others from unauthorized access. This includes helping protect young children and others from accidental medication poisoning or overdose.

Starting in April 2020, WHA will communicate to pharmacies that the Rx Locking Cap is available at no cost to members when they present a prescription for a Schedule II to V medication, such as an opioid. Gatekeeper Innovation will additionally provide information to the pharmacies on how to order the Rx Locking Cap. WHA will provide full pharmacy reimbursement for up to five Rx Locking Cap devices when provided to WHA members.

Using the Rx Locking Cap can help deter prescription abuse, misuse, and theft. WHA wants to help give members peace of mind with this benefit as part of our enhancements with OptumRx, knowing that easy access to unsecured medications, whether at home, carried in a purse, briefcase, backpack, or suitcase, may be less of a problem.

PATIENT SAFETY

WHA's Patient Safety Program monitoring and quality improvement activities are inclusive of all members and all practitioners at WHA's contracted medical groups/IPAs, and hospitals.

PATIENT SAFETY GOALS

WHA's Patient Safety Goals are adopted from the National Quality Forum to:

- **REDUCE** harm from inappropriate or unnecessary care
- **REDUCE** preventable hospital admissions and readmissions
- **REDUCE** the incidence of adverse healthcare associated conditions

PATIENT SAFETY ACTIVITIES

WHA's patient safety activities are directed to all members, practitioners and providers and include the following:

TO EDUCATE:

- Members, practitioners and providers regarding safe clinical practices
- PCPs regarding behavioral health conditions commonly seen in primary care practice settings

TO COMMUNICATE:

- Safety-related information to members, practitioners and providers through WHA publications, the WHA website and other media sources

TO IDENTIFY OPPORTUNITIES:

- At the practitioner office settings to improve safe practices
- At the hospital to improve patient safety practices.

TO MONITOR:

- The progress of contracted hospitals in the implementation of Leapfrog safe practices
- Findings from the CalHospitalCompare survey rating patient safety issues, patient experience and clinical quality
- Continuity and coordination of care between practitioners and between settings of care to identify issues with miscommunication or lack of communication
- The safe use of pharmaceuticals through WHA's drug recall and drug utilization review processes
- Patient safety in the behavioral health environment through analysis of quarterly and annual reports submitted by the BH-contracted vendors
- Appeals and grievances to identify patient safety and potential quality issues
- Outcomes from HEDIS® and Pay for Performance measures, which are shared with the medical groups in order to identify opportunities to improve safe clinical practices for members:
  - Reduce harm from inappropriate or unnecessary care:
    - Annual Monitoring for Patients on Persistent Medications
    - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
    - Appropriate Treatment for Children with Upper Respiratory Infection
    - Use of Imaging Studies for Low Back Pain
  - Reduce preventable hospital admissions and readmissions
    - Plan All-Cause Readmissions

TIMELY IDENTIFICATION AND FOLLOW-UP OF:

- Clinical issues through WHA's Disease Management programs, Nurse24 advice line and case management services, including complex case management

---

WHA encourages all contracted health care systems to implement Leapfrog's Never Events Policy and to report hospital safety data to Leapfrog and other publicly reported entities.

To locate publicly-reported data on health care quality and patient safety, go to:

- Leap Frog Group: leapfroggroup.org
- Hospital Compare/CMS Quality Reporting: medicare.gov/hospitalcompare/About/What-Is-HOS.html
- CalHospitalCompare: calhospitalcompare.org
- National Patient Safety Goals/The Joint Commission: jointcommission.org/standards/national-patient-safety-goals

FRAUD, WASTE, ABUSE AND PREVENTING MEDICAL IDENTITY THEFT

WHA is committed to the prevention, detection, and reduction of fraud, waste and abuse. Fraud is the No. 1 threat to the health care system, costing Americans billions of dollars each year.

Successful attacks targeting medical files and billing and insurance records have increased. Medical identity theft is an ever-present concern for health care insurers, medical/hospital groups, and individual providers. The effects of a breach can be significant, costing you and your patients time, money, and stress. More importantly, a breach causes patients to lose trust and confidence in health care providers and can result in patient safety issues.

How can you help prevent fraud, waste, and abuse while safeguarding your confidential records and your patients' protected health information? Take these proactive steps to protect yourself, your practice, and your patients.

- Actively manage your information with payers. Provide updates when opening, moving, or closing a practice location. Payers can then alert you to red flags, such as additional billings from old locations, or new locations being opened without your knowledge.
- Keep your banking information current. Banks can alert you to suspicious activity on your business account.
- Develop sound policies and procedures (P/Ps). Documents should address how to properly screen, hire and train staff on protecting medical and non-medical business records and information.
- Monitor claims, billing and compliance processes. Monitor your staff to ensure accurate claim submission/billing practices. Oversee organizations to whom you have assigned billing privileges or to whom you provide protected health information. Ensure remittance notices are backed by proper medical record documentation.
- Secure all medical information. Physically and electronically secure both hard copy and electronic medical records. Use appropriate encryption on data accessed by mobile devices.
- Control your unique medical identifiers. Investigate contractors/vendors before sharing your identifiers. Keep track of all of prescription pads and lock them up when not in use.
- Engage your patients. Advise patients to review their explanation of benefits, medical bills, and credit reports. If they see anything suspicious, advise them to report it right away.
- Invest in next-generation technology that can prevent attacks.

If you suspect medical identity theft, report it immediately to the appropriate parties, including payers, Medicare or Medi-Cal programs, or a local district attorney's office.

You can help report possible fraudulent activity by calling WHA's toll-free Fraud and Compliance Hotline at 833.310.0007 or by submitting a report online at lighthouse-services.com/westernhealth.

ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

Alcohol and other drug (AOD) dependence is common across many age groups and can be one of the most preventable health conditions. There is strong evidence that treatment for AOD dependence can improve health, productivity and social outcomes, and can save millions of dollars on health care and related costs. According to the National Institute on Drug Abuse:

- In 2016 an estimated 47.7 million Americans (14.8 percent) needed treatment for a problem related to drugs or alcohol, but only about 1.48 million people (< 10 percent) received treatment.
- In 2017 healthcare costs related to AOD were $740 billion annually.
- In 2017 more than 70,200 Americans died of drug overdoses. Out of this number 47,600 death are related to opioid use.
- In 2017 almost 74% of adults suffer from a substance use disorder.
- In 2017 tobacco on its own totaled $300 billion annually in costs related to crime and lost work productivity.
- In 2018 37% of 12th graders reported vaping, compared with 28% in 2017.

Identification of patients with alcohol and other drug (AOD) dependence is an increasing issue in primary care. The early recognition of patients with AOD issues and their timely referral to behavioral health services is a key to the most effective treatment.

HEDIS Results 2019

WHA monitors AOD treatment annually with the HEDIS measure "Initiation and Engagement of Alcohol and other Drug Dependence Treatment." This measure identifies adolescents and adults 13 years of age and older as of 12/31 of the measurement year, with a new episode of alcohol or drug dependence who received the following services:

- **Initiation of AOD Treatment:** The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- **Engagement of AOD Treatment:** The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT	WHA 2017 RATE	WHA 2018 RATE	WHA 2019 RATE	WHA NCQA PERCENTILE RANK 2019	NCQA 2019 90TH PERCENTILE RANK GOAL
Initiation of AOD Treatment	22.28%	31.99%	31.65%	10th	42.36
Engagement of AOD Treatment	5.76%	8.18%	5.67%	5th	17.07

WHA's HEDIS 2019 performance results show a priority need for improvement. The Initiation rate increased but ranks less than the NCQA 10th percentile nationally. The rate remained unchanged for engagement with additional services within 30 days in the 5th percentile.

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT BY MEDICAL GROUP

MEDICAL GROUP	POPULATION WITH AOD DIAGNOSIS	INITIATION COMPLIANCE COUNT (RATE)	ENGAGEMENT COMPLIANCE COUNT (RATE)
A	39	13 (33%)	5 (13%)
B	330	111 (34%)	20 (6%)
C	327	120 (37%)	30 (9%)
D	174	38 (22%)	8 (5%)
E	77	24 (31%)	3 (4%)
F	79	27 (10%)	2 (3%)
G	153	48 (31%)	5 (3%)
WHA Total	**1,179**	**281 (24%)**	**60 (6%)**

Identification and Treatment of Patients with AOD

There are five settings of care recognized as sources for identification of patients with AOD diagnosis: outpatient visit, emergency department visit, inpatient admission, ED visit with admission, or detox services. Patients with AOD are most frequently identified from ambulatory care, then outpatient visits, followed by ED visit only.

Early Screening & Detection of AOD Issues

Screening tools for clinicians in general medical settings include the National Institute on Drug Abuse (NIDA) Quick Screen, which allows clinicians to:

- Identify drug use early and prevent escalation to addiction.
- Increase awareness of the interaction of substance abuse with a patient's medical care, including potentially fatal drug interactions.
- Identify patients in need and refer them to specialty treatment.

Adherence to the AOD Treatment Guidelines Depends on Timely Referral

- **Initiation of AOD Treatment:** Initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- **Engagement of AOD Treatment:** Members who initiate treatment for AOD need two or more services (outpatient, inpatient and partial hospitalization) for AOD within 30 days of initiation of service.

Behavioral Health Referrals

Behavioral health (BH) and chemical dependence (CD) services are covered benefits. WHA members are allowed to self-refer for BH/CD services and the contact numbers for Magellan/HAI-CA or Optum (for UCD employees) are present on the WHA ID card. However, patients with AOD problems may not be capable of self-referral.

When you identify a patient who needs AOD treatment, you can make a referral on your patient's behalf. You can speak directly with a BH professional 24/7 if your patient or a parent is unable or reluctant to seek BH services themselves or needs assistance in knowing what to do next.

WHA members have Magellan/HAI-CA as their BH provider organization. Call 800.424.1778 then select the emergency choice to speak directly to a clinician.

References:

1) addiction.surgeongeneral.gov/surgeon-generals-report.pdf

2) cdc.gov/tobacco/data_statistics/fact_sheets/economics/econ_facts/index.htm

3) https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.pdf

4) https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

5) https://newsinhealth.nih.gov/2019/02/vaping-rises-among-teens

IMPROVING THE DIAGNOSIS AND TREATMENT OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

According to the National Heart, Lung, and Blood Institute (NHLBI), COPD is the third leading cause of death in the United States. More than 15.3 million Americans have been diagnosed with COPD, and millions more may have the disease without even knowing they have it.

COPD includes chronic bronchitis and emphysema, and is characterized by chronic airflow limitation that is not fully reversible, is usually progressive, and is associated with an abnormal inflammatory response. Spirometry testing is required to make the diagnosis of COPD, assess airflow limitation, and help in determining the severity of the disease. It can be used to monitor specific treatment steps, as well as the progression of the disease (Global Initiative for Chronic Obstructive Lung Disease - GOLD 2019).

Performance is assessed with the NCQA HEDIS measure "Use of Spirometry Testing in the Assessment and Diagnosis of COPD," which measures the percentage of members 40 years of age and older with a new diagnosis or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. WHA's provider performance with spirometry testing for COPD decreased in 2019 and ranks at NCQA 10th percentile nationally. This is a priority opportunity for improvement.

Pharmacotherapy Management

COPD symptoms range from chronic cough and sputum production to severe shortness of breath. For stable COPD, pharmacologic therapy is used to reduce symptoms, improve exercise tolerance, and reduce the frequency/severity of exacerbations. Inhaled long-acting bronchodilators are preferred and are more effective for maintained symptom relief. An inhaled corticosteroid combined with a long-acting B_2 agonist (LABA) is more effective than either individual component in patients with moderate to severe COPD. Long-term monotherapy with inhaled corticosteroids or long-term treatment with oral corticosteroids is not recommended.

An exacerbation of COPD is defined as an acute event characterized by a worsening of the patient's respiratory symptoms that is beyond the usual day-to-day variations

SPIROMETRY TESTING FOR ASSESSMENT & DIAGNOSIS OF COPD	WHA 2017 RATE	WHA 2018 RATE	WHA 2019 RATE	WHA NCQA PERCENTILE RANK 2019	NCQA 2019 90TH PERCENTILE RANK GOAL
40 year olds and older with a new diagnosis or newly active COPD	38.91%	37.34%	35.71%	10th	51.26%

and leads to a change in medication. Management of exacerbations with pharmacotherapy is an essential component, and decreasing the frequency of exacerbations may slow the progression of COPD. Studies show that inhaled bronchodilators and systemic corticosteroids are the preferred treatment for home/outpatient management of exacerbations (GOLD 2019).

Common challenges to the diagnosis and treatment of COPD include:

1. Under-diagnosis and misdiagnosis: confusion with Asthma, and Asthma-COPD Overlap Syndrome
2. Lack of spirometry/lung function testing to determine severity of the disease
3. Lack of guideline use
4. Removing or reducing triggers (e.g., smoking)
5. Medication adherence, and poor communication among treating practitioners, pharmacists, and health plans in identifying members non-compliant with medications

Given the above factors, WHA's quality improvement activities for COPD include:

1. Increasing members' awareness and knowledge about the prevention and management of COPD. November is National COPD Awareness month, and the NHLBI *COPD Learn More Breathe Better* campaign resources are available online.
2. Increasing primary care providers' knowledge of and access to current Clinical Practice Guidelines (CPGs), as they have a key role in the diagnosis and management of COPD. Practitioners can find the GOLD "Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease" (2017) CPGs at westernhealth.com.

References:

1) https://www.nhlbi.nih.gov/health/educational/copd/get-involved/COPD-national-action-plan.htm

2) https://goldcopd.org/wp-content/uploads/2018/11/GOLD-2019-POCKET-GUIDE-FINAL_WMS.pdf

3) https://www.nhlbi.nih.gov/health/educational/copd/event-listing/awareness-month/materials-resources.htm

4) *Global Initiative for Chronic Obstructive Lung Disease (GOLD) A Guide for Health Care Professionals 2019 REPORT*. https://goldcopd.org/wp-content/uploads/2018/11/GOLD-2019-v1.7-FINAL-14Nov2018-WMS.pdf

5) National Heart, Lung, and Blood Institute, *COPD: Tracking Perceptions of Individuals Affected, Their Caregivers, and the Physicians Who Diagnose and Treat Them.* https://www.nhlbi.nih.gov/health/educational/copd/health-care-professionals/COPD-Tracking-Perceptions-of-Individuals-Affected-Their-Caregivers-and-the-Physicians-Who-Diagnose-and-Treat-Them.pdf. (Retrieved October 2018)

6) https://www.medscape.org/resource/copd/cme

NEW TECHNOLOGY ASSESSMENT

While some new technologies may prove to be advantageous for our members, patient safety and "quality of care" are of primary concern. If you order a treatment or service that involves new technologies or clinical trials for your patient, it will require prior authorization by WHA.

A thorough study of the requested service is done by WHA's Medical Director to verify safety and effectiveness. The clinical information is compared against current accepted national medical practices and standards of care and new technology assessment criteria developed by Hayes, Inc.

WHA's Medical Directors may also choose to send the information to iMedecs for external review by independent board-certified specialty physicians with relevant medical expertise. WHA's Medical Directors may also use InformedDNA to provide expert review of genetic testing.

There are times when WHA's investigation reveals that the new technology under review is no longer considered experimental and so WHA may include the service as a regular plan benefit. If WHA's medical professionals decide a new technology is unproven and your request is denied, you and/or your patient may appeal the decision by contacting WHA's Member Services Department at 916.563.2250 or 888.563.2250.

MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA

In the United States, more than 25 million people have asthma; 7.7% of adults (1 in 13) and 8.4% of children (1 in 13) have asthma and it was responsible for over 3,564 deaths in 2017 (Asthma and Allergy Foundation of America). The morbidity and mortality rates continue to rise.

WHA 2019 HEDIS RESULTS

WHA annually measures and reports the percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

The 2019 Asthma Medication Management rates for 75% controller medication compliance show mixed results. For patients 5 to 64 years of age, the overall rate of compliance with controller medications decreased slightly to 43.35%, and ranks in the NCQA national 5th percentile. For children 5 to 11 years of age the rate decreased to 28.21 percentage points and the 5th percentile. For adolescents, the rate decreased slightly and dropped to less than the 5th percentile. For adults 19 to 50 years old, the rate slightly improved and remained in the 10th percentile. For seniors 65 to 85, the rate was not reported.

MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA – MEDICATION COMPLIANCE AT 75%	WHA 2016 RATE	WHA 2017 RATE	WHA 2018 RATE	WHA 2019 RATE	WHA NCQA PERCENTILE RANK 2019	NCQA 2019 90TH PERCENTILE RANK GOAL
Overall Rate for 5 to 85 year olds	37.35%	41.89%	43.75%	43.35%	5th	60.27%
Rate for 5 to 11 year olds	19.63%	23.94%	33.57%	28.21%	5th	40.05%
Rate for 12 to 18 year olds	32.98%	36.11%	29.20%	28.44%	<5th	48.08%
Rate for 19 to 50 year olds	31.96%	34.79%	38.70%	39.22%	10th	60.93%
Rate for 51 to 64 year olds	46.50%	55.00%	55.26%	55.51%	10th	69.61%
Rate for 65 to 85 year olds	61.29%	53.66%	NA	NA	NA	NA

National Heart Lung and Blood Institute/National Asthma Education and Prevention Program

Long-term control medications, including inhaled corticosteroids (ICS), inhaled long-acting bronchodilators, leukotriene modifiers, cromolyn, theophylline, and immunomodulators, are used daily to achieve and maintain control of persistent asthma. The most effective are those that attenuate the underlying inflammation characteristic of asthma. The Expert Panel defines anti-inflammatory medications as those that cause a reduction in the markers of airway inflammation in airway tissue or airway secretions (e.g., eosinophils, mast cells, activated lymphocytes, macrophages, and cytokines; or ECP and tryptase; or extravascular leakage of albumin, fibrinogen or other vascular protein).

ICS are the preferred treatment for mild persistent asthma in adults and children. Leukotriene modifiers are an alternative, although not preferred, treatment. Long-acting B_2 agonists (LABA) should only be used in combination with ICS for long-term control and prevention of symptoms in moderate or severe persistent asthma (step 3 care or higher in children ≥5 years of age and adults). There is a strong recommendation against the use of LABA as monotherapy. Of the adjunctive therapies available, long-acting B_2 agonists is the preferred therapy to combine with ICS in youths ≥12 years of age and adults. The beneficial effects of long-acting B_2 agonists in combination therapy for the great majority of patients who require more therapy than low-dose ICS alone to control asthma (i.e., require step 3 care or higher) should be weighed against the increased risk of severe exacerbations, although uncommon, associated with the daily use of long-acting B_2 agonists. The NHLBI/NAEPP guideline strongly recommends against the use of long-acting B_2 agonists for the treatment of acute symptoms or exacerbations.

References:

1) Akinbami LJ, Moorman JE, Bailey C, et al. Trends in asthma prevalence, health care use, and mortality in the United States, 2001-2010. NCHS data brief, no 94. Hyattsville, MD: National Center for Health Statistics. 2012. https://www.cdc.gov/nchs/products/databriefs/db94.htm

2) American Lung Association. 2010. Epidemiology & Statistics Unit, Research and Program Services. Asthma. (September 2010)

3) Asthma and Allergy Foundation of America. Asthma Facts and Figures. http://www.aafa.org/asthma-facts

4) National Heart Lung and Blood Institute/National Asthma Education and Prevention Program. August 2007. Measures of asthma assessment and monitoring: Expert panel report 3: guidelines for the diagnosis and management of asthma. Washington (DC): National Heart Lung and Blood Institute (NHLBI)

5) United States Environmental Protection Agency. Asthma Facts. May 2018. https://www.epa.gov/sites/production/files/2018-05/documents/asthma_fact_sheet_0.pdf

CARE & TREATMENT REVIEW

COVERAGE DECISIONS

WHA's physician reviewers make coverage decisions related to appropriateness of care and services using available medical information about the patient and criteria that are based on recognized standards of medical practice. During these reviews, Plan benefits and individual circumstances of the patient are also considered.

Financial incentives or compensation are not linked to these decisions or to the withholding of care. If you would like to learn more about WHA's management processes or receive information about the criteria or guidelines used by WHA to make care and treatment decisions, please contact WHA's Member Services Department.

UM CRITERIA

The criteria primarily used by WHA to make medical necessity decisions are MCG® (formerly known as *Milliman Care Guidelines*), Hayes, Inc.'s *New Technology Assessment & Experimental Treatment Guidelines*, *Informed DNA Genetic Testing Guidelines* and *UpToDate® Decision Support Guidelines*. If you would like to receive excerpts or copies of clinical criteria currently used by WHA to make utilization management decisions on a particular subject matter or desire information about WHA's pharmaceutical management procedures, please contact WHA at 916.563.2250 or 888.563.2250 and ask for the Clinical Resources Department.

COLORECTAL CANCER UPDATE

WHA 2019 HEDIS RESULTS

WHA's results for colorectal cancer screening for 2019 improved to 69.17% from 68.61% in 2018. WHA's percentile ranking decreased from the NCQA 67th percentile to the 50th percentile. WHA's results showed that our performance remains below the goal of 77.57%, which is the NCQA 90th percentile.

Note: The measure reflects the percentage of adults ages 50-75 who had appropriate screening for colorectal cancer for any of the four tests included in the WHA guidelines.

COLORECTAL CANCER SCREENING GUIDELINES	
Age 40 – 49	**Age 50 – 65+**
If patient is high risk*	FOBT annually and/or sigmoidoscopy every 5 years or colonoscopy every 10 years until age 75
Test Name	**Measurement Period**
FIT-DNA (Cologuard®)	Measurement year (2018) or the two years prior to the measurement year (2016-2017)
CT Colonography	Measurement year (2018) or the four years prior to the measurement year (2014-2017)

*High risk factors include but are not limited to: history of previous polyps or colorectal cancer for either the patient or close family, ulcerative colitis and/or Crohn's disease, African Americans or Jews of Eastern European descent (Ashkenazi Jews).

COLORECTAL CANCER SCREENING	WHA 2016	WHA 2017	WHA 2018	WHA 2019	WHA NCQA PERCENTILE RANK 2019	NCQA 2019 90TH PERCENTILE RANK GOAL
50 to 75 year olds who had appropriate screening	64.97%	68.68%	68.61%	69.17%	50th	77.57%

Colorectal Cancer Screening Recommendations: Recommendations are included in WHA's Preventive Health Guidelines (PHGs) and are available at **mywha.org/PHGs**. Colorectal cancer screening preventive services are covered with no share of cost; however procedures to treat any abnormalities may require a copayment, even if performed at the same time as the screening. Consult the member's Copayment Summary for more information.

Screening Reminders to WHA Members: Some of your patients may have received colorectal cancer screening reminders from WHA if our records indicate the member has not completed screening. This may prompt some questions from your patients regarding the need and types of screening methods available.

Reducing the Risk: While some studies show increased physical activity and maintaining a healthy weight may decrease the risk of colorectal cancer, evidence is less clear about other ways to prevent it. There is no consensus on the role of diet in preventing colorectal cancer.

Practice-based Interventions to Empower Patients

Doctors, nurses and other health care providers can take actions to empower patients to take charge of their health with these interventions:

- Develop systems to remind patients when they are due for regular screening.
- Use "Patient Navigators" or "Health Coaches" for those at high risk and/or needing additional support to ensure preventive screenings are done.
- Offer patients multiple screening options recommended by the U.S. Preventive Services Task Force, including home FIT Testing kits.

Note: The preferred screening test for colon cancer remains a colonoscopy as screening and diagnostic follow-up can be performed during the same examination.

RESOURCE AVAILABLE FROM THE CDC

This continuing education activity provides guidance and tools for clinicians on the optimal ways to implement screening for colorectal cancer to help ensure that patients receive maximum benefit. There are two versions of this course: one for primary care providers and one for clinicians who perform colonoscopy, nurses, and other health professionals. To view this continuing education visit: cdc.gov/cancer/colorectal/quality/index.htm for details.

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED **ADHD MEDICATION**

Attention deficit hyperactivity disorder (ADHD) is a disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. ADHD is the most common neurobehavioral health condition in childhood and the disorder can continue through adolescence into adulthood. According to a 2016 national survey, the Centers for Disease Control and Prevention (CDC) estimated 6.1 million (9.4%) of children 2-17 years of age were diagnosed with ADHD. In a 2016 parent report from Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), it was reported that about 3.8 million (62%) of children are taking medication for ADHD.

The National Institute of Mental Health states that ADHD has three subtypes: predominantly hyperactive-impulsive, predominantly inattentive, or combined hyperactive-impulsive and inattentive. Currently available treatments focus on reducing the symptoms of ADHD and improving functioning. Timely reassessment of children with newly prescribed ADHD medication is particularly important.

WHA has been monitoring "Follow-up Care for Children Prescribed ADHD Medication." This HEDIS measure determines the percentage of children 6 to 12 years of age with newly prescribed ADHD medication who had at least 3 follow-up care visits within a 10-month period, one of which was within 30 days of when the ADHD medication was first dispensed. There are two rates reported.

- **Initiation Phase (30 days):** The percentage of children 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.
- **Continuation & Maintenance Phase (9 months):** The percentage of children 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner with prescribing authority within 9 months after the initiation phase ended.

WHA's HEDIS 2019 performance results show a slight increase in the Continuation and Maintenance phase and an increase in the Initiation phase. In 2019, 47.66% of children taking ADHD medication had at least one follow-up visit within the 30-day initiation phase, increased from 38.03% the prior year. In the continuation and maintenance phase, 49.15% of the children who remained on ADHD medication had at least two follow-up visits within the next 9 months of treatment. The ranking for the Initiation Phase increased to the 75th from the 33rd percentile, while the Continuation and Maintenance Phase decreased from the 50th to the 33rd.

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION	WHA 2017	WHA 2018	WHA 2019	WHA NCQA PERCENTILE RANK 2019	NCQA 2019 90TH PERCENTILE RANK GOAL
Initiation Phase	39.61%	38.03%	47.66%	75th	52.02%
Continuation & Maintenance Phase	44.83%	48.39%	49.15%	33rd	61.59%

Clinical practice guidelines for the diagnosis and treatment of ADHD are published by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Academy of Pediatrics. The AACAP Official Action published the Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder, with: Key Points; Diagnosis and Evaluation Algorithm; Treatment Algorithm Criteria for Diagnosis; and Medication Tables.

References:

1) Centers for Disease Control and Prevention, Attention-Deficit/Hyperactivity Disorder (ADHD). https://www.cdc.gov/ncbddd/adhd/data.html

2) Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). National Resource Center on ADHD. https://chadd.org/understanding-adhd

3) National Institute of Mental Health, Attention-Deficit/Hyperactivity Disorder (ADHD). https://www.nimh.nih.gov/health/statistics/attention-deficit-hyperactivity-disorder-adhd.shtml

4) Rowland, Andrew et al. (September 2015). The Prevalence of ADHD in a Population-Based Sample. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4058092/

5) AACAP Official Action: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder. http://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/jaacap_adhd_2007.pdf

DEPRESSION MANAGEMENT

Effective Antidepressant Medication Management

PHYSICIAN-DIRECTED BH CARE REFERRALS

WHA members can self-refer for behavioral health (BH) services as long as they contact a BH provider first and obtain prior authorization. Providers can refer on patient's behalf and speak directly with a BH professional 24/7 if your patient or a parent is unable or reluctant to seek BH services themselves or needs assistance in knowing what to do next. WHA members have Magellan/HAI-CA as their BH provider organization. Call 800.424.1778 then select the emergency choice to speak directly to a clinician.

Depression is a common illness, and even those with the most severe depression can get better with treatment, usually medication and/or psychotherapy. Proper depression screening and evaluation are essential prior to prescribing an antidepressant. It's important to identify co-existing alcohol/substance abuse issues or serious medical conditions such as heart disease, diabetes, cancer, etc. Treating the depression can also improve the outcome of treating the co-condition.

WHA's performance measurement for Antidepressant Medication Management is focused on continued medication therapy. WHA annually measures effectiveness with the HEDIS measure, "Antidepressant Medication Management", which determines the percentage of members 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. This measure allows for some gaps in medication treatment. This can include wash-out period gaps to change medication or treatment gaps to refill the same medication.

ANTIDEPRESSANT MEDICATION MANAGEMENT	WHA 2017	WHA 2018	WHA 2019	WHA NCQA PERCENTILE RANK 2019	NCQA 2019 90TH PERCENTILE RANK GOAL
Acute Phase Treatment	61.31%	57.62%	61.31%	10th	78.66%
Continuation Phase	45.83%	44.02%	45.82%	10th	61.99%

There are two rates reported:

Effective Acute Phase Treatment (12 weeks)
The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days during the first 114-day period following the prescription start date. This phase allows for treatment gaps of up to a total of 30 days.

Effective Continuation Phase Treatment (6 months)
The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days during the 231-day period following the prescription start date. This phase allows for treatment gaps of up to a total of 51 days.

WHA's HEDIS 2019 performance results show a slight increase in rates for both acute phase and continuation phase treatment. While the continuation phase maintained rank at the NCQA 10th percentile nationally, the Acute Phase increased to the 10th percentile from 5th percentile. Both measures show a priority opportunity for improvement.

Barriers frequently noted in the acute phase of therapy are issues underlying the patient's medication adherence: intolerance of side effects or unmet expectations of feeling better early in therapy. Timely follow-up visits and/or telephonic outreach to re-evaluate the patient and the antidepressant therapy are essential. Most screening for depression and initiation of treatment occurs in primary care. Referral to a behavioral health specialist is an option, particularly for patients with increasing symptoms or difficulties with medication adherence.

References: Call the 24-hour, toll-free confidential National Suicide Prevention Lifeline at 1.800.273.TALK (8255) or visit suicidepreventionlifeline.org.

1) https://www.nimh.nih.gov/health/publications/depression-what-you-need-to-know/index.shtml

2) Barkil-Oteo, Andres. (2013). *Collaborative Care for Depression in Primary Care: How Psychiatry Could "Troubleshoot" Current Treatments and Practices.* Yale Journal of Biology and Medicine, 86(2), 139-46.

3) Ellis, R., Heise, B. A., & van Servellen, G. (2011). *Factors associated with antidepressant medication adherence and adherence enhancement programmes: a systematic literature review.* Mental Health in Family Medicine, 8(4), 255-71.

HOW TO SET UP A WHA PROVIDER ACCOUNT

Providers can verify their patients' past, current and future eligibility and benefits online 24/7 by signing up for a secure provider account on our portal; to do so please visit westernhealth.com/provider.

Here are the steps for setting up a secure provider account:

1. Go to westernhealth.com
2. Click on "Login" or "Register"
3. Choose the "Provider, Broker, or Employer" tab
4. Log in if an account has already been created, or click on "Sign-up for Secure Access"
5. Choose the appropriate account type from "Provider/Administrator, Medical Group, Hospital, Ancillary Facility, DME Supplier or All Other Organizational Providers/Suppliers"
6. Fill out the form – this will include the Provider Information or Organization Information based on the type of provider, whom the provider or organization is contracted with and the requests for information
7. Enter a Username for the account and select a Security Question
8. Review the Terms & Conditions of Use
9. Complete sign-up (provider will receive an email)

WHA places no limit on the number of website accounts for providers. We encourage each provider in the office to create an account so they have their own login to the portal and can use this as a resource.

Providers can also contact Change Healthcare at 877.363.3666 for real time eligibility, benefit information, claims and EFT Status.

Providers should read the valuable information provided quarterly in this *Provider Insider* magazine to find out about WHA's quality improvement, pharmaceuticals procedures and options and much more.

GUIDELINES & SCHEDULES

PRACTITIONER FEEDBACK ON HEALTH GUIDELINES

Your feedback is a key factor in ensuring the guidelines are accurate and reflect the current standards of practice within our community. Provide your comments to WHA's Chief Medical Office Khuram Arif, M.D., by emailing k.arif@westernhealth.com or calling 916.563.3186.

CLINICAL PRACTICE GUIDELINES

WHA adopts clinical guidelines developed by nationally-recognized organizations that are the basis for our Condition Management Programs. The guidelines support WHA's Asthma, Coronary Artery Disease and Diabetes Programs managed by Optum™.

The guidelines listed below were recently reviewed for updates and are accessible at mywha.org/CPGs.

Asthma: Updated

- National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. National Heart, Lung and Blood Institute, 2007
- Asthma Care Quick Reference: Diagnosing and Managing Asthma, 2012

Coronary Artery Disease

- AHA/ACC Guidelines for Secondary Prevention for Patients With Coronary and Other Atherosclerotic Vascular Disease, 2011
- Effectiveness-Based Guidelines for Cardiovascular Disease Prevention in Women, 2011

Diabetes: Updated

- ADA's Standards of Medical Care in Diabetes, 2019

IMMUNIZATION SCHEDULES

Immunization schedules can be accessed directly through the Centers for Disease Control and Prevention (CDC) website and at mywha.org/PHGS.

- Children 0-18 years
- Adults

PREVENTIVE HEALTH GUIDELINES

The following preventive health guidelines were recently updated based on the latest United States Preventive Services Task Force (USPSTF) recommendations and can be accessed at mywha.org/PHGs:

- Children Birth to 19 years
- Adults 20-65 years and older
- Perinatal

Preventive health provider tools are also available through the USPSTF website.

ADVANTAGE REFERRAL PROGRAM & STANDING REFERRAL: **THE BASICS**

ADVANTAGE REFERRAL PROGRAM

WHA members receive most medical care from their primary care physician (PCP). When specialty care is needed, PCPs are encouraged to follow their usual referral practices by sending their patients to specialists within their own affiliated medical group/IPA. However, with WHA's Advantage Referral Program, members have the option of receiving medically necessary specialty care from WHA Advantage Referral participating specialists affiliated with other WHA medical groups/IPAs.

It is important to know that all specialists in WHA's core network participate in the Advantage Referral program.

Here are important "Advantage Referral" details to remember:

- No prior authorization is required for the initial referral from the member's affiliated medical group/IPA, however, a referral and tracking number is important for billing purposes. Follow your medical group/IPA's internal procedure.
- Annual OB/gynecological or annual eye exams (if covered) are allowed under direct access regulations. No referral or authorization is required for these services by a participating provider.
- Specialists may provide routine services such as ordering lab work and plain-film x-rays without obtaining approval.
- After the PCP submits a referral to his or her affiliated medical group/IPA, the specialist of choice is notified of the number of visits and timeframe that is allowed to provide the service(s).
- The initial referral allows up to three visits with the Advantage Referral participating specialist of choice.
- Surgery, special tests, and procedures recommended by the treating specialist require prior authorization from the member's assigned medical group/IPA to ensure coverage.
- After the initial referral expires, if the member wants to continue receiving care and services from the specialist outside his or her own medical group/IPA, this must be allowed as long as medical necessity exists, prior authorization is obtained, and the specialist is still a WHA participating provider.
- Recommendations for referral to another specialist should be coordinated through the member's PCP for referral in group or to another Advantage Referral specialist if the member prefers.
- UC Davis affiliated members and their dependents do not have access to the Advantage Referral Program. These members cannot be referred to specialists outside their affiliated medical group unless the necessary service is not available in their medical group.

STANDING REFERRALS

- Allow the member access to a specialist and/or specialty care services from a provider with expertise in treating the medical condition or disease that requires ongoing monitoring
- Are for certain life-threatening, degenerative or disabling conditions or diseases requiring specialized medical care over a prolonged period of time, including HIV or AIDS
- Require a treatment plan describing the course of care/treatment to be provided by the specialist or specialty care center that should be agreed upon by the PCP, specialist and Medical Director or designee
- Allow the specialist to provide health care services to the member that are within the specialist's area of expertise and training in the same manner as the member's PCP, subject to the terms of the treatment plan
- Require that the specialist provide the PCP with regular reports on the health care provided to the member
- WHA network specialists with specific expertise in treating HIV or AIDS are noted in the Provider Directory with a special symbol next to their names

Appointment Availability SURVEY

Health plans are required by the Department of Managed Health Care's (DMHC) Timely Access to Non-Emergency Health Care Services Regulations ("Timely Access Regulations") to ensure that appointments for various types of non-emergent care are offered to members within specified timeframes, in a manner appropriate for the nature of the patient.

Each year, WHA administers the Provider Appointment Availability Survey (PAAS), using the DMHC methodology, to its network of primary, specialty, and ancillary care providers. This survey determines how many network providers in a county are compliant with the Timely Access Regulations regarding access to both urgent services and non-urgent appointments. WHA appreciates the participation of its contracted Medical Groups/IPAs.

The results of the PAAS are communicated to the Medical Groups/IPAs, along with findings specific to each group and a request for corrective action plans as applicable.

To assist providers in offering appointments to patients within the timeframes required under the Timely Access Regulations, we have included the appointment availability standards. Share this information with the appointment schedulers in your office.

TIMELY ACCESS REGULATIONS: APPOINTMENT AVAILABILITY STANDARDS	
Appointment Type	**Appointment Within**
Non-urgent appointments with Primary Care Physicians	10 business days
Non-urgent appointments with Specialist Physicians	15 business days
Urgent care appointments that do not require prior authorization	48 hours
Urgent care appointments that require prior authorization	96 hours
Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness or other health condition)	15 business days
Non-urgent appointments with a non-physician mental health care provider	10 business days

GUIDELINES FOR THE APPOINTMENT AVAILABILITY STANDARDS
Preventive Care Services and Periodic Follow Up Care: Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.
Extending Appointment Waiting Time: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.
Rescheduling Appointments: When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice.
Advanced Access: The primary care appointment availability standard listed above may be met if the primary care physician office provides "advanced access." "Advanced access" means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician's assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

PRIMARY CARE SCREENING FOR **ASD**

The American Academy of Pediatrics (AAP) has long advocated for early screening of children for Autistic Spectrum Disorder (ASD). Its current recommendations—demonstrated by the AAP/Bright Futures Preventive Guidelines—ask that PCPs screen children at 18 and 24 months during well-care visits. The CDC recommends screenings at 9, 18 and 24 or 30 months.

DMHC REQUIREMENTS

DMHC regulations require health plans to ensure medically necessary and timely screening of children for ASD. In 2018, WHA underwent a DMHC audit. Based on the results, WHA took steps to enhance its review of medical group policies/procedures (P/Ps) to ensure processes are in place for medically necessary and timely screening of children for ASD based on the AAP's and medical groups' guidelines: screening at 18, 24, or 30 months of age.

ASD SCREENING TOOLS

The CDC provides practitioners with various screening tools at https://www.cdc.gov/ncbddd/autism/hcp-screening.html, including:

- M-CHAT: Designed for parents who have children 16-30 months old to complete; commonly used by local pediatricians. The M-CHAT-R/F is the newer version of the M-CHAT screening tool and its developers (Diana Robins, PhD; Deborah Fein, PhD; and Marianne Barton, PhD) encourage the use of the newer tool as it detects more ASD cases and has less false-positives than the earlier version.
- Ages and Stages Questionnaires (ASO): Parent-completed general developmental screening tool
- Communication and Symbolic Behavior Scales: Parent-completed checklist; screens for communication and symbolic abilities
- Parents' Evaluation of Developmental Status (PEDS): Parent-interview form; screens for developmental and behavioral problems and can be used as a surveillance tool
- Screening Tool for Autism in Toddlers and Young Children (STAT): Comprehensive interactive screening tool when developmental concerns are suspected

For more information on ASD screening guidelines, visit AAP's website at aap.org or CDC's website at cdc.gov.

2019 ANNUAL REVIEW
MEDICAL RECORD DOCUMENTATION

WHA is required to establish and maintain standards for medical record documentation and management of medical records in the ambulatory setting by the State of California Department of Managed Health Care (DMHC). The WHA Medical Record Documentation standards, policy and audit procedure are based on the DMHC medical record documentation requirements. Approximately one-third of PCPs with 100 or more assigned members will be reviewed at least annually for each Medical Group/IPA.

Auto credit is now available for groups achieving NCQA Patient Centered Medical Home (PCMH) recognition and those attesting for CMS Meaningful use Stage 1 and/or 2. In addition, those practices who made investments in their infrastructure by implementing electronic health records systems are eligible for autocredit for these requirements. These practices were not asked to submit records for this review.

At least one third of PCPs with 100 or more members were reviewed for each contracted Medical Group/IPA. A sample size of 5 to 20 charts was used, depending on the number of assigned members.

WHA reviewed providers who had not yet implemented electronic health records and had not met WHA's minimum score from 2018.

MEDICAL GROUP/IPA	# MDS REVIEWED	MD WITH EHRS	NUMERATOR	#CHARTS DENOMINATOR	SCORE
Canopy Health	14	13	42	44	95%
Hill Physicians Medical Group	56	54	60	62	95%
Meritage Medical Network	33	33	40	40	100%
Mercy Medical Group	Autocredit				
UC Davis Medical Group	Autocredit				
Woodland Clinic Medical Group	Autocredit				
NorthBay Healthcare*	Autocredit				

*No contracted providers due for audit

MEDICAL RECORD DOCUMENTATION AUDIT

This year WHA's Quality Improvement licensed nurses conducted a review of primary care physician (PCP) ambulatory medical record documentation to assess the status of documentation for patients seen in 2018, based on DMHC requirements as shown below.

DMHC Documentation Standard

1. Patient name or ID present on each page
2. Consultations are documented as appropriate
3. Medication allergies and adverse drug reactions are present
4. Clinical findings and evaluation are present for every visit, including diagnoses
5. Pathology, laboratory and other reports are recorded
6. Provider is identifiable for every entry
7. Case management and/or multidisciplinary team notes are present, if applicable

Audit Findings

Four of WHA's seven Medical Groups/IPAs were awarded autocredit. The results and analysis of the medical record documentation audit are assessed by WHA's QI Committee, including results by Medical Group/IPA and by physician. The performance goal is 90% compliance to the standards. The frequency of routine, follow-up ad hoc reviews and/or corrective action plan is based on the criteria in the accompanying table.

PERFORMANCE CRITERIA AUDIT SCORES	REVIEW FREQUENCY	CORRECTIVE ACTION PLAN (CAP)
90% or above	**Every 3 years**	**None**
70 to 90%	Every year	May be required as needed, based on safety, security, grievance or continued opportunities for improvement identified
Below 70%	Every year	Required

PHARMACY UPDATE

NEW-TO-MARKET, HIGH-COST/LOW-VALUE DRUGS

Prescription drugs are often an integral part of a patient's total care but unfortunately, costs continue to dramatically increase. The cost of a single prescription for some new-to-market drugs—used to treat unique conditions—can be as high as a patient's annual income. Annual costs may be similar for some decades-old drugs that have undergone slight changes in formulation by the manufacturer, helping to extend patent life or provide a new market strategy for these "me too" products. Some manufacturers bypass the Food and Drug Administration's (FDA) New Drug Application (NDA) process to expedite their product's availability. However, the FDA often considers these "medical foods," "devices," or otherwise being non-FDA approved. Newly available "kits" and combination products are often made up of ingredients that are much less expensive when sold individually. Overall, these New-To-Market, High-Cost products do not provide a safer or more cost-effective alternative for the patient, especially for those with high copays, on deductible plans, or with cost share.

Consider the following when prescribing for your patients.

- Xyzbac is an example of a prescription dietary supplement that contains multivitamins B, C, and D, folic acid, and Coenzyme Q10 in amounts that are also available over-the-counter as other separate or combined products. Xyzbac is indicated for the dietary management of suboptimal nutritional status in patients where advanced folate supplementation is required and nutritional supplementation in physiologically stressful conditions for maintenance of good health is needed. Xyzbac offers no safety or efficacy advantage when compared to other over-the-counter separate or combined multivitamin products but comes at a monthly cost of approximately $2,000.
- Vimovo 375/20 mg and 500/20 mg delayed-release tablets (naproxen/esomeprazole magnesium) is an example of a newer combined formulation of an existing non-steroidal anti-inflammatory drug with a proton-pump inhibitor, offering no improved dosing frequency or advantage otherwise, at a much higher patient cost. Vimovo is marketed to patients as a single tablet, providing relief from Osteoarthritis or Rheumatoid Arthritis pain and inflammation while providing a reduced risk of developing stomach ulcers. Manufacturer prescribing information contains similar safety and efficacy information as that of the separate products. This includes the increased risk of bleeding, ulcers, and tears (perforations) of the esophagus, stomach, and intestines; the same as with the naproxen ingredient. Comparative studies demonstrated Vimovo had a similar or greater incidence of adverse reactions, including a higher percentage of diarrhea, and abdominal pain, when compared to generic Enteric-Coated Naproxen. Average monthly cost for Vimovo is approximately $2,900 compared to Enteric-Coated Naproxen at approximately $120 and $5 to $10 for generic naproxen film coated tablets.
- Numerous topical creams, gels, ointments, and kits are available in the market that may not be covered by most prescription plans. Some lack FDA approval as a prescription drug and are marketed with unsubstantiated claims of safety and efficacy. Others consist of combined ingredients at a much higher cost than when sold separately. Consider more cost effective alternatives before prescribing products such as Lidovix 75 mg-5% Kit (diclofenac sodium delayed-release 75 mg tablets with Lidocaine 5 % Patch Kit) or Gabacaine Pak (Gabapentin 300 mg capsules and Lidocaine Patch 5 % Therapy Pack). Lidovix has not been found by the FDA to be safe and effective and this labeling has not been approved by FDA. The cost of Lidovix and Gabacaine Pak is approximately $2,400 to $3,400 per kit, respectively. IBU 600-EZS (Ibuprofen Tab 600 mg and Swallowing Spray Kit) is another example of a special packaged Kit that contains 100 tablets of generic Ibuprofen 600 mg tablets and a 2 ounce container of a "Pill Swallowing Spray" at a cost of approximately $1,500 per kit.

PROVIDER AFTER-HOURS ACCESS, TRIAGE & SCREENING

Health plans are required by the Department of Managed Health Care's (DMHC) Timely Access Regulations to assess after-hours access, triage and/or screening in their provider networks. Health plans must ensure that after-hours triage and screening are offered within specified timeframes, in a manner appropriate for the nature of the patient's condition.

The DMHC defines "triage" or "screening" as the assessment of a patient's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a patient who may need care, for the purpose of determining the urgency of the patient's need for care. The "triage or screening waiting time" means the time waiting to speak by telephone with the qualified health professional, which shall not exceed 30 minutes.

Statewide Provider After-Hours Access Survey

Compliance is assessed by the Industry Collaborative Effort (ICE) Provider After-Hours survey, completed annually in the fall.

This statewide telephonic survey will assess the following:

1. **After-Hours Appropriate Emergency Instructions:** What would you tell a caller who states he/she is dealing with a life-threatening emergency situation (e.g., sudden onset chest pain)? For example, is the patient told to call 911 or referred to the nearest emergency room?
2. **After-Hours Access to a Clinician:** If a patient expresses an urgent need to speak with a clinician, is there a way to put them into contact with the physician, on-call physician, or a health care professional such as an advice nurse? The response should be "yes".
3. **After-Hours Provider Timeliness:** In what timeframe can patients calling after-hours expect to hear from the provider or on-call provider? For example, be connected immediately or receive a call back within 30 minutes.

WHA's After-Hours Access Standards

- Provider Telephone Access — 24 hours a day, 7 days per week
- Appropriate Emergency Instructions — 24 hours a day, 7 days per week
- Telephone Screening and Triage Wait Time — Not to exceed 30 minutes

Provider Telephone Access, Triage & Screening Guidelines

Providers should provide or arrange for the provision of 24/7 telephone access, triage or screening services. The telephone triage or screening services should be provided in a timely manner appropriate for the patient's condition, and the triage or screening wait time should not exceed 30 minutes.

Providers should maintain a procedure for triaging or screening patient telephone calls, which includes the 24/7 employment of a telephone answering machine/service/or office staff that will inform the caller:

- Regarding the length of wait for a return call from the provider (not to exceed 30 minutes); and
- How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

The provider is responsible for the actions of the office staff or answering service:

- If a patient calls after hours or on a weekend for a possible medical emergency, there should be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."
- Office staff/answering service handling patient calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the patient so that the patient can be referred to licensed staff; however, they are not permitted to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the patient, or to determine when a patient needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.
- Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a patient that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.
- The answering service as well as office staff should document all calls.

WHA's Nurse Advice Line

Additionally, WHA arranges for the provision of triage or screening services for members by telephone through a contracted nurse advice line, Optum's Nurse24. This is available 24 hours a day, 7 days a week. WHA and Optum ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and the triage or screening wait time does not exceed 30 minutes. The Nurse24 contact number is 877.793.3655.

Western Health Advantage

2349 Gateway Oaks Drive
Suite 100
Sacramento, CA 95833

916.563.2250
888.563.2250
westernhealth.com

#BDOG2020 | #whasupports

Big Day of Giving

Make a **difference.** Feel **good.** **Donate** locally.

Participate in the Sacramento region's Big Day of Giving on Thursday, May 7

Starting at midnight, a full 24 hours of giving

Choose from more than 600 local nonprofits. Share your community pride by supporting a charity or cause that is important to you.

Western Health Advantage
visit bigdayofgiving.org and sacregcf.org/BDOG
for more info and to make a donation on May 7

SACRAMENTO REGION COMMUNITY FOUNDATION

WHA is a proud sponsor of the Sacramento Region Community Foundation's 2020 Big Day of Giving