WINTER 2020

ACQA ADVISOR

ACQA Advisor is a quarterly newsletter dedicated to sharing news, updates and best practices with our ACQA partners.

Excellus BlueCross BlueShield
LIVE FEARLESS

CMO CORNER

Gregory G. Carnevale, M.D. M.B.A., vice president,
chief medical officer, Value-based Payments

Clinical Savings Plans are Part of SUCCESS STORY

As our Value Based Payments (VBP) team looks back on what we have accomplished this year, one new development comes to mind – implementation of many clinical savings plans. This topic is pertinent as budgets finalize and planning occurs for 2020. It should not be surprising to learn that we at Excellus BlueCross BlueShield focus annually on savings targets set by our board and finance teams. We work diligently on various initiatives and programs to help meet and, hopefully surpass, these goals.

Much like Excellus' target goals, clinical savings plans:

1. Formalize a list of cost-saving measures under way
2. Improve tracking of work being done with models calculating current savings, as well as overall predicted savings
3. Initiate conversations regarding accountability for actions taken/ not taken at year-end, and reasons for difficulties in achieving goals
4. Allow for collaboration between Excellus BCBS and our ACQAs, as well as best practice sharing between ACQAs

Plan inclusion is varied and not prescriptive. General buckets include, but are not limited to: care management outreach that promotes transitions of care and seeks to decrease readmission, as well as high-cost claimant early notification. Additionally, site-of-service work focusing on lower cost of care facilities (out-patient versus inpatient), out-of-network capture to pursue controlling costs with one's own health system, and avoidance of low-acuity emergency room visits by promoting expanded office hours and improving access to care.

You may be asking how the clinical savings plan differs from your ACQA grid and initiatives. It boils down to more of a focus on cost savings than quality. As the aforementioned examples show, these are "big-ticket" items that all of you have in common in terms of potential cost savings opportunities.

In terms of overall quality, I am happy to report that in broad terms, nearly all our ACQAs have outpaced our non-ACQAs in areas of quality, as is reported on your ACQA grids. Your providers' efforts and those of your health systems continue ton be a very positive piece of our value story. We appreciate your dedicationto achieving these results.

The accompanying graphs depict current data pertaining to three areas of quality (adolescent, diabetic, and cancer screenings) with individual metrics for each of those areas.

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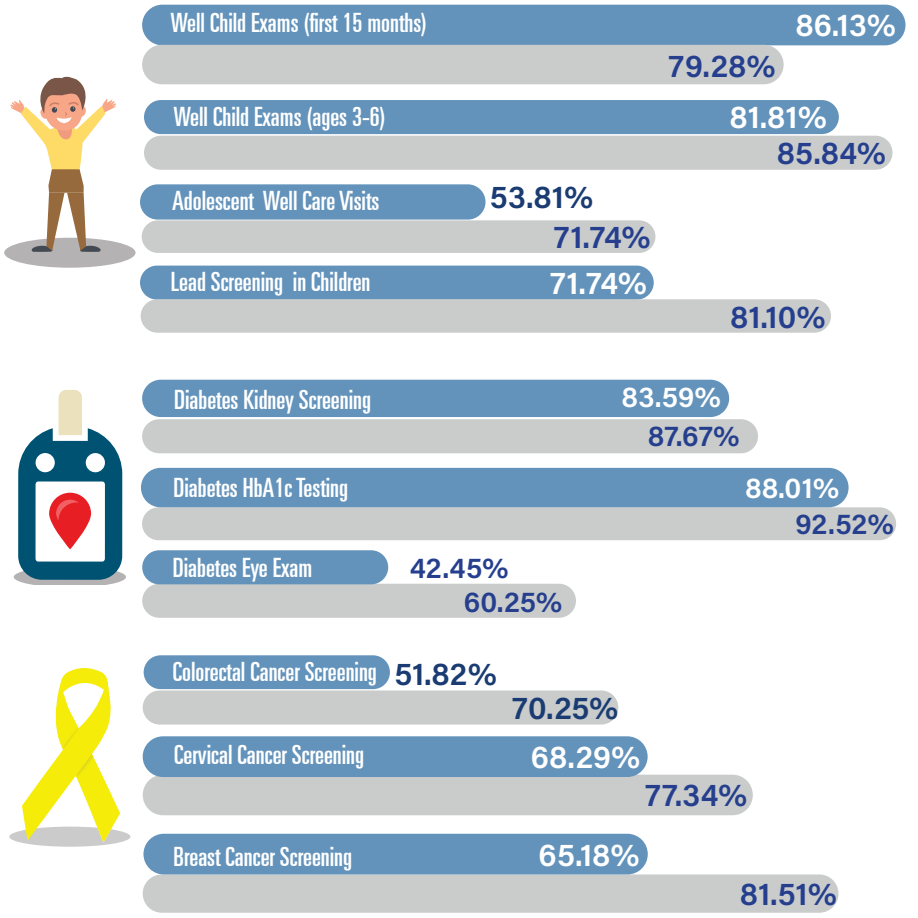
Improving Quality of Care

The accompanying graphs depict current data pertaining to three areas of quality (adolescent, diabetic, and cancer screenings) with individual metrics for each of those areas.



* Measurement period June 2018-May 2019, paid through August 2019. ACQA data includes other VBP program membership, Non-ACQA is all non-VBP members.

Our ACQA grids focus on six core measures with the goal of achieving the 90th percentile. We have seen continued quality improvement in our ACQAs over that past few years as shown in the accompanying chart, which also includes aggregated ACQA scores.

As we look to continue this value into 2020 and beyond, our VBP teams look forward to continuing our collaborative efforts to not only promote and achieve quality on the ACQA grids, but also to continue to use and expand clinical savings plans that facilitate cost reductions and gain share opportunities. Please let us know if you have any questions.

Growth in ACQA Quality Metrics

Commercial 2019 Quality Thresholds

MEASURE	90TH THRESHOLD
BREAST SCREENING	78.90%
COLO CANCER SCREENING	72.79%
DM A1C<8	66.06%
DM EYE EXAM	68.86%
HTN BP CONTROL	74.70%
DM NEPHROPATHY	92.70%

2015
12/42
Measures at 90th Percentile

2016
19/36
Measures at 90th Percentile

2017
28/42
Measures at 90th Percentile

2018
28/42
Measures at 90th Percentile

Average of five ACQAs with available reporting in 2019

Improving Chlamydia Screening Rates in Women

Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescent and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV. Screening is important because approximately 75 percent of chlamydia infections in women and 95 percent of infections in men are asymptomatic. This results in delayed medical care and treatment. Chlamydia infection also increases susceptibility to the transmission of HIV. Chlamydia is easily detected and, if identified, treatable with antibiotics.

Members May Be Excluded From The Denominator If Either Of The Following Apply:

- Evidence of a pregnancy test during the measurement year AND a prescription for isotretinoin (retinoid) on the date of the pregnancy test or six days after the pregnancy test, OR pregnancy test AND an X-ray on the date of the pregnancy test or six days after the pregnancy test.
- Members in hospice are EXCLUDED from the eligible population.

Best Practice Recommendations:

A Team Approach is a Must for Endwell Family Physicians

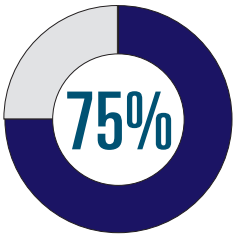
- Providers, assistants, and nurses must be comfortable explaining and discussing the topic:

✔ Use an explanation that fits your situation.

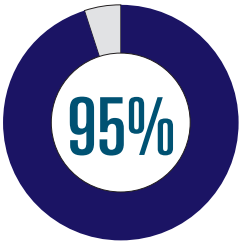
- Look at your gap reports in advance of appointments; it is much easier to discuss in person.
- Bring awareness to your local specialists and your patients of the importance (team approach).
- Don't give up, keep talking! If you miss them at an appointment, the person who reaches out should be someone with whom they are comfortable.
- If a patient will be prescribed birth control for any reason, that patient must have a chlamydia screening.

✔ Through a team approach, Endwell Family Physicians raised its chlamydia screening rates from 26 percent to 64 percent in a 16-month period.

Screening is important because approximately



of chlamydia infections in women and



of infections in men are asymptomatic.

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Implementing a universal screening protocol in a pediatric office at Cayuga Area Plan, Inc. (CAP)

- A work group was created within the pediatric office to evaluate its chlamydia screening performance and determine how to improve screening rates within the practice.
- The practice implemented a new chlamydia screening protocol for annual screening of all adolescent females age 15 and older.
- A chlamydia screening policy was adopted, and letters were sent to all parent/guardians, as well the patient.
- CAP raised its chlamydia screening rates from ***20 to 50 percent*** in a six-month period.

The Family Planning National Training Center (FPNTC) provides a complimentary toolkit to help increase chlamydia screening rates through implementation of best practice processes:

Best Practice 1:	Best Practice 2:	Best Practice 3:	Best Practice 4:
Include chlamydia screening as a part of routine clinical preventive care.	Use normalizing and opt-out language.	Use the least invasive, high-quality recommended laboratory technologies.	Use diverse payment options to reduce cost as a barrier.

Sustain and spread improvements

https://www.fpntc.org/resources/chlamydia-screening-toolkit

Simple Solution
BIG IMPACT

Using appropriate language can have a powerful impact on patients who have spine-related disorders. Minimizing patient fear, educating them on their condition, and evoking a sense of participation and control over their back pain pays huge downstream dividends for all.

Previous *ACQA Advisor* articles discussed an initiative in Rochester that encouraged, with the help of our ACQA partners, the imbedding of epidemiological frequencies of commonly seen imaging findings in MRI reports. The hypothesis was that giving patients and clinicians this data would decrease language misinterpretation and fear as well as clarify a care path.

The results are in! We studied the impact of the data-inserted MRI reports and compared the resulting spine care, analyzing both before and after intervention data in Rochester as well as the spine care trends in Syracuse, a comparable upstate city.

Use of follow-up spine imaging, spine injections and opioids diminished in members who had their first lumbar spine MRI within the last two years, resulting in an average $332 per-member/per-year savings.

Chiropractic services usage increased, demonstrating a cost-effective shift to more non-pharmaceutical, not-interventional care and overall cost savings.

Excellus BlueCross BlueShield has distributed charts with these epidemiological common imaging findings to many clinicians for use in their exam/treatment rooms. We continue to hear positive feedback from clinicians regarding the use of these charts to educate patients about their spine MRI report. The data provides more precise understanding of the findings, shifting the conversation from a pathoanatomical cause to a more accurate biopsychosocial understanding of their back disorder.

How You Can Help:

1. Assist our efforts to distribute charts in your ACQA clinicians' offices.

2. Encourage your local radiologists to insert age-appropriate templates or the entire chart into lumbar spine MRI reports. (This step may take some discussion and coordination of near simultaneous adoption by your region's radiological groups. We are here to help! Excellus BCBS can arrange consultation with the neuroradiologist who directed this initiative, if necessary.)

This no-cost initiative improves outcomes, saves primary care provider time, educates and encourages patients, and saves significant downstream costs. Widespread adoption may need the coordinated support of regional ACQAs; we can assist as needed.

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An article about this initiative and related data has been submitted to a peer-reviewed journal for publication. For a copy of the article, charts for distribution to your clinicians, or information or assistance in coordinating discussions with your regional radiologists, contact brian.justice@excellus.com.

The changes seen on an MRI report in the chart below are often normal findings for a healthy, aging spine. These findings in symptom-free patients are so common that they must be interpreted with caution and in the appropriate clinical context.

	20-30 years old	30-40 years old	40-50 years old	50-60 years old	60-70 years old	70-80 years old	80+ years old
Disc Degeneration	37%	52%	68%	80%	88%	93%	96%
Disc Signal Loss	17%	33%	54%	73%	86%	94%	97%
Disc Height Loss	24%	34%	45%	56%	67%	76%	76%
Disc Bulge	30%	40%	50%	60%	69%	77%	84%
Disc Protrusion	29%	31%	33%	36%	38%	40%	43%
Annular Fissure	19%	20%	22%	23%	25%	27%	29%
Facet Degeneration	4%	9%	18%	32%	50%	69%	83%
Spondylolisthesis	3%	5%	8%	14%	23%	35%	50%

Refrences: Brinjikj, W. Leutmer P.H.,Comstock B. Bresnahan B.W., Chen L.E., Deyo RA, Halbabi S., Turner J.A., Avins A.L., James K., Wald J.T., Kallmes D.F., AJNR 2015 April; 36(4):

Diabetes Update: An Oral GLP1 Agonist – Is it Worth the Hype?

Rybelsus® (semaglutide) has hit the market as the first oral GLP-1 agonist to treat type-2 diabetes. Ozempic®, the injectable version of semaglutide has been available for years with proven benefits in managing type-2 diabetes. In addition to Ozempic, there are several other injectable GLP-1 agonists commonly prescribed. Many who have achieved success with the GLP-1 agonist drug class may be excited about choosing an oral option over the injectable versions available currently. Awareness of the key differences between the oral and injectable formulations will be integral to successful outcomes.

Administration[1]

Rybelsus has been shown to be effective and comparable to other treatment options for type-2 diabetes. However, for Rybelsus to be effective, patients will need to be educated and motivated to take it properly. Rybelsus must be taken on an empty stomach exactly 30 minutes before the first meal, drink or medication of the day. Waiting less than 30 minutes decreases drug absorption, rendering it less effective in controlling blood glucose and A1C values.

Alternatively, waiting longer than 30 minutes could result in increased drug concentrations, putting patients at greater risk for adverse drug effects. If food has already been consumed, Rybelsus should be skipped that day, and the daily schedule resumed the next morning. These drug administration parameters could make Rybelsus an inconvenient option for many patients, especially when compared to Ozempic's once weekly dosing and injections regardless of meal schedules.

Looking Beyond Drug Cost

Rybelsus pricing is comparable to other GLP-1 Agonists, with monthly costs estimated at $772 (WAC)[6]. However, non-adherence to the rigid oral administration schedule could increase the risk of patients not receiving the full therapeutic effect, opening the door to higher overall disease management costs. Increased A1C and blood glucose levels due to medication non-adherence have been noted to contribute to total health-care costs ranging between $2,750 to $9,800 per patient per year[7]. Additionally, patients could be at risk of not hitting goals set forth by the American Diabetes Association, prompting costly unnecessary prescribing of additional diabetic agents.

Cardiovascular Considerations

With the evolution of drugs to treat diabetes, it is prudent to consider which options can provide additional cardiovascular benefit. The American Diabetes Association highlights proven diabetes drugs with cardiovascular benefit, including Ozempic, Victoza®, and Jardiance®[2]. Initial trials with Rybelsus have shown that it is superior for cardiovascular death prevention, but the same as placebo for preventing major adverse cardiovascular events (MACE)[3]. A follow-up trial is currently under way, but for now, other therapeutic options have more compelling evidence for cardiovascular benefit in diabetics.

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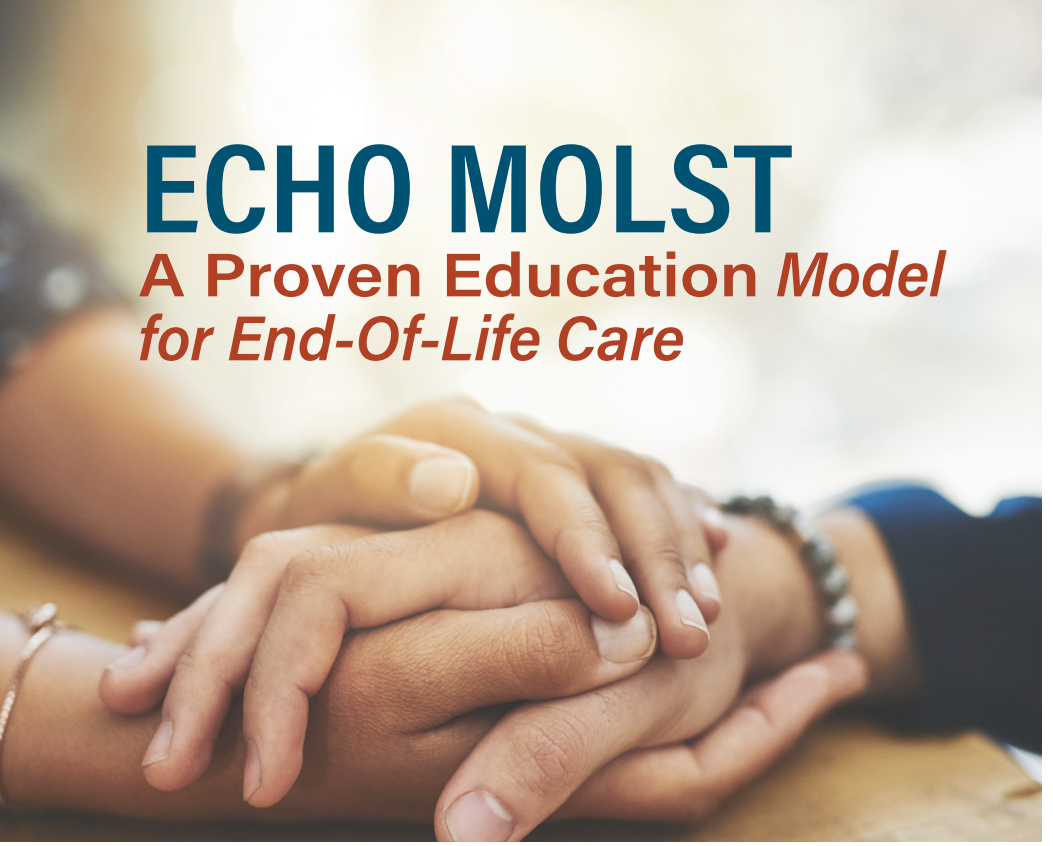
Conclusion

It has been estimated in the U.S. that the total cost attributed to diabetic medication non-adherence is more than $5 billion[7]. Complex treatment regimens are one of the several factors that can influence medication non-adherence trends[8]. When considering a GLP-1 agonist, keep in mind that the complex administration schedule associated with Rybelsus and cardiovascular benefit concerns could make it an inferior option[1] compared to other injectable GLP-1 agonist formulations.

	Ozempic (semaglutide)[4]	Rybelsus (semaglutide)[1]
Formulation	Subcutaneous once weekly injection	Once a day oral tablet
Administration	Can be taken any time of day regardless of food intake	Must be taken first thing in the morning 30 minutes before first meal, drink, or medication
Dosing	Week 1-4: 0.25mg Week 5-8: 0.5mg Can increase to 1mg	Week 1-4: 3mg Week 5-8: 7mg Can increase to 14mg *7mg and 14mg dose are therapeutically equivalent to 0.5mg of Ozempic. (There is no equivalent dose that correlates to the maximum dose of Ozempic.)
Cardiovascular Benefit compared to placebo	Superior reduction in MACE[5] Superior reduction in non-fatal stroke[5]	Superior reduction in CV death[3]
Cost for 1-month supply (WAC)[6]	$772	$772

References:

1. Rybelsus [package insert]. Bagsvaerd, Denmark. Novo Nordisk; 2019
2. Riddl M, Bakris G, Blonde L, et al. Standards of Medical Care in Diabetes 2019. American Diabetes Association. 2019 Jan; 42 (1): S1-S193.
3. Husain M, Birkenfeld A, Donsmark M, et al. Oral Semaglutide and Cardiovascular Outcomes in Patients with Type 2 Diabetes. New England Journal of Medicine. 2019 Aug; 381(9): 841-851.
4. Ozempic [package insert]. Plainsboro, NJ. Novo Nordisk; 20195.Marso S, Bain S, Consoli A, et al. Semaglutide and Cardiovascular Outcomes in Patients with Type 2 Diabetes. New England Journal of Medicine. 2016 Nov; 375(19): 1834-1844.
6. Rind D, Fazioli K, Chapman R, et al. Oral Semaglutide for Type 2 Diabetes Effectiveness and Value. Institution for Clinical and Economic Review. September 2019.
7. Cutler R, Fernandez-Limos F, Frommer M, et al. Economic impact of medication non-adherence by disease groups: a systematic review. British Medical Journal. January 2018.
8. World Health Organization. Adherence to long-term therapies: evidence for action World Health Organization. 2003. Available at: http://www.who.int/chp/knowledge/



ECHO MOLST

A Proven Education *Model for End-Of-Life Care*

There are many ways that our value-based programs address variations of care and attempt to share best practices. Extension for Community Healthcare Outcomes (ECHO) programs are an example of the ways Excellus BlueCross BlueShield works with many partner organizations and providers.

The following is a breakdown of the ECHO model, some specifics regarding ECHO MOLST, and data to prove that ECHO MOLST works as a sustainable model for educating clinicians on end-of-life care.

ECHO is an all-teach-all-learn telementoring model that uses case-based learning. Specialists and experts at a "hub" meet regularly with clinicians at "spokes" via video conferencing to support in the delivery of specialty care services. To learn more about the ECHO model and its history, visit echo.unm.edu.

The aims of ECHO MOLST are to provide sustainable MOLST education and to improve the quality of thoughtful MOLST discussions and documentation to ensure patient preferences are honored. At the end of the ECHO MOLST clinic series,attendees will learn to identify MOLST-appropriate patients, use the 8-Step MOLST Protocol and New York State Department of Health checklist to ensure accurate completion, and increase their comfort level with end-of-life conversations.

Data collected using a pre-test, post-test method from each clinic series proves that ECHO MOLST works. In the Fall 2019 series, participants' overall MOLST knowledge increased by ***16 percent***. Before the Fall 2018 clinic series, only ***34 percent*** of respondents could identify that MOLST is not an advance directive. After the clinic series, that number increased to ***72 percent***.

Similarly, the percentage of Spring 2019 participants able to interpret correctly a tough end-of-life scenario jumped from ***50 percent to 80 percent***. This is likely a direct result of learning through the case-based nature of ECHO programs. Through participation in the clinic series, attendees recognize the importance of their own advance care planning, with health care proxy completion rates among participants rising, on average, to ***22 percent***.

To date, ECHO MOLST has provided end-of-life education to ***545*** participants from ***87*** health care organizations across New York state. Furthermore, more than ***80 percent*** of participants are directly involved in patient care, suggesting that quality improvements to patient care through education are immediate. Through evaluations, we know that participants have made changes to their practices to provide their patients with higher quality end-of-life care.

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The next 8-week ECHO MOLST clinic series begins on March 4, 2020. Weekly lunch hour-video conferencing clinics begin with brief introductions and a short 15-minute didactic presentation. This is followed by a 35 to 40-minute real patient case presentation given by a "spoke" using a Q&A and discussion format. Additionally, ***free CME credits are offered to attendees***. Each ECHO MOLST clinic session has been approved for ***1.0 AMA PRA Category 1 Credit™***. For more information on ECHO MOLST, including objectives and who should attend, visit molst.org/training/echo.

MOLST
MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT
A POLST Paradigm Program

Don't miss out on this important educational opportunity! Contact Meg.Greco@Excellus.com to enroll in the next ECHO MOLST clinic series today.

Telemedicine 2020: Help Us Help YOU!

Telemedicine usage continues to grow year over year! Excellus BlueCross BlueShield has seen a 151 percent increase in behavioral health telemedicine usage and a 22 percent increase in medical telemedicine usage. More and more providers are adopting telemedicine for many reasons. Telemedicine can:

- Increase continuity of care
- Provide convenience
- Improve access to care, especially for patients in rural or under served areas
- Provide more time in person with patients who have more complex conditions
- Support patient and provider relationships
- Increase patient satisfaction

Do you offer telemedicine services or are interested in learning more about telemedicine?

The Excellus BlueCross BlueShield telemedicine team has developed a brief survey to gather information about your use of telemedicine, including technology, conditions treated, satisfaction, barriers and billing. Your responses will help us identify key areas of focus and to better serve you. We appreciate you taking the time to share your feedback.

To complete the brief survey, please click on the link below.

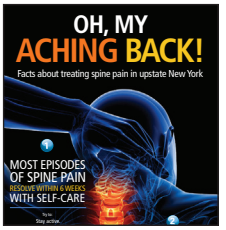
https://www.surveymonkey.com/r/ProviderTelemed

We appreciate your partnership and look forward to your feedback to better support you. If you have questions or need assistance, please contact your Provider Relations representative.

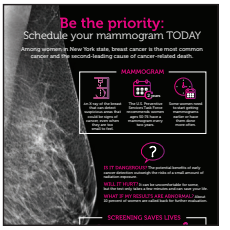
New Year, New Health Poster Inventory Guide

Our health plan creates health education posters that convey unbiased information and data about health care issues that impact upstate New York. We've put together an inventory guide to make ordering posters for your office or exam rooms even easier. To request a copy of this inventory guide or to order any of our health education posters, contact your Provider Relations representative.

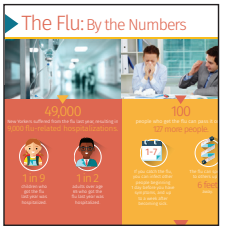
HEALTH EDUCATION POSTERS



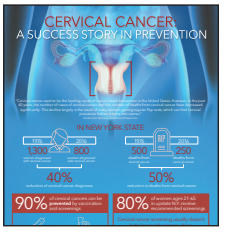
Back pain
(B-4652)



Mammography
(B-7177)

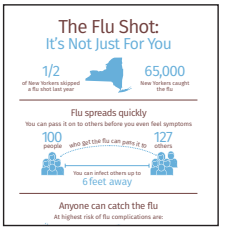


Flu by the numbers
(B-5803)

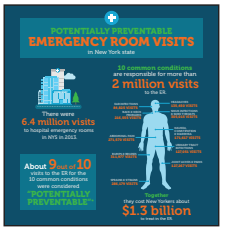


Cervical cancer
(B-5830)

Mental health
(B-5927)

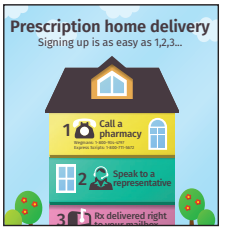


The flu shot
(B-6175)

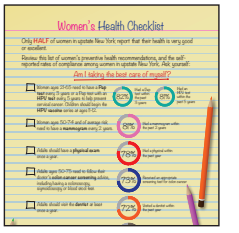


ER
(B-5434)

Skin cancer
(B-5518)



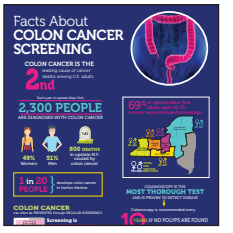
Home delivery
(B-6339)



Women's health checklist*
(B-6366)

Antibiotic
(B-5733)

Diabetes
(B-5804)



Colon cancer screening*
(B-5845)

Advance care planning
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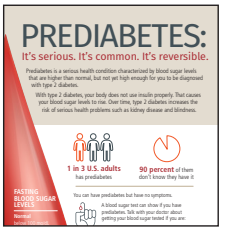
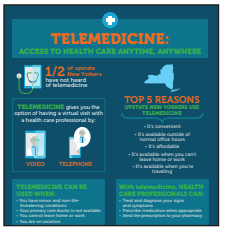


Prediabetes
(B-6963)

Asthma*
(B-6026)

Dental
(B-6438)



Telemedicine
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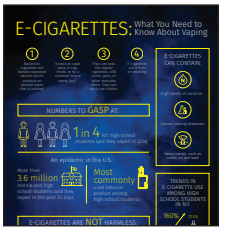

E-cigarette
(B-7068)

Falls
(B-5880)

* Also available in Spanish