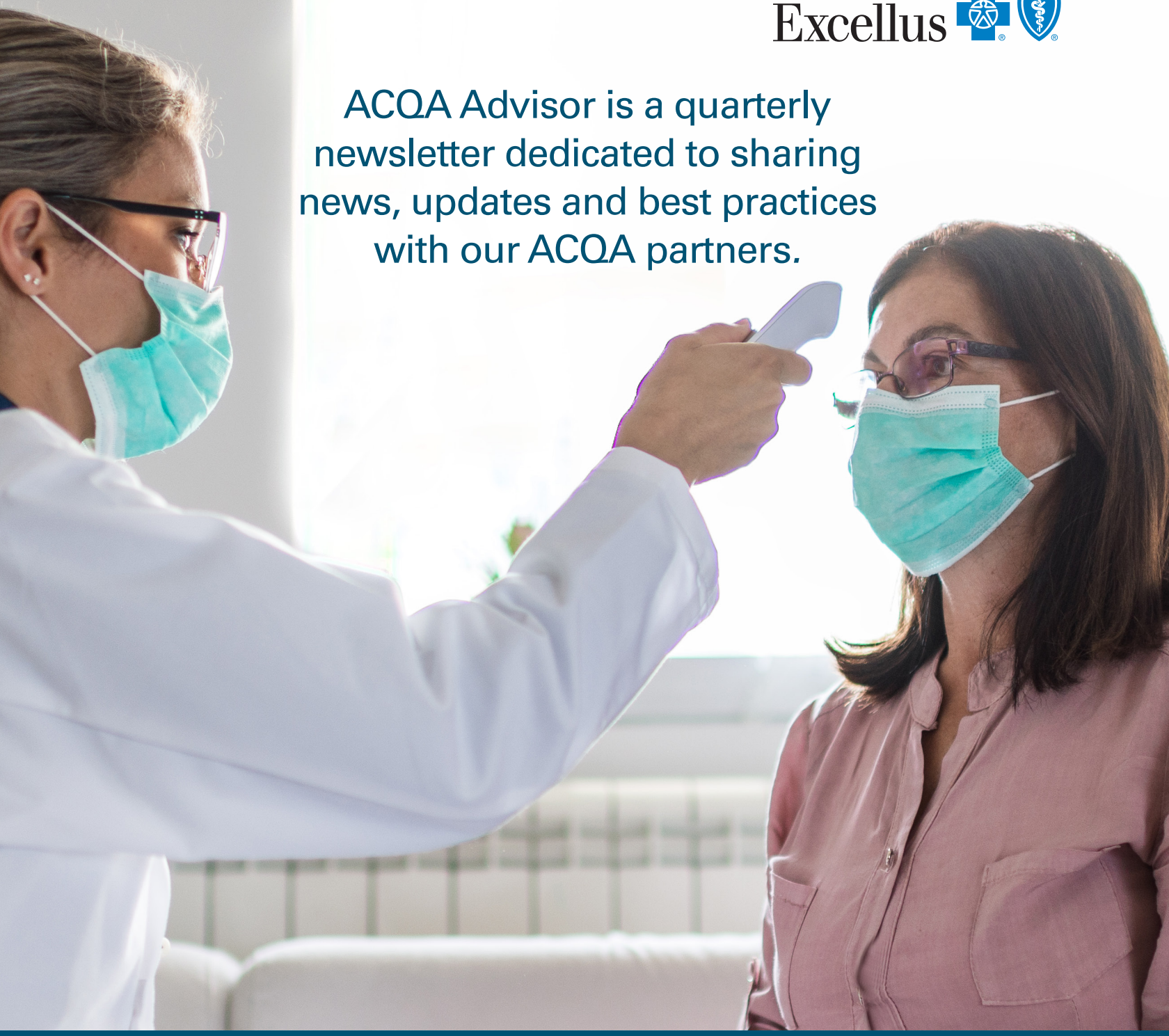
FALL 2020

ACQA ADVISOR

Excellus

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



CMO CORNER

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

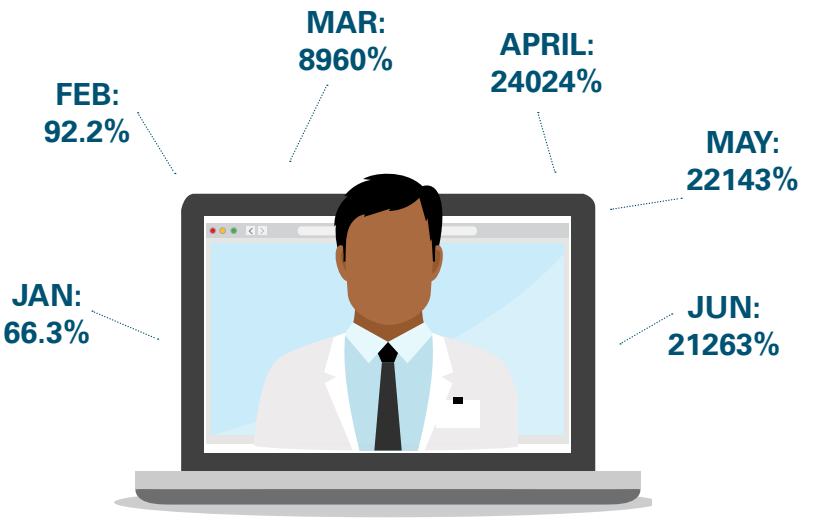
Telehealth, Preventive Care Remain Important PANDEMIC ISSUES

We have faced many challenges this year with COVID-19 being front and center. Our lives have all been affected in one way or another, both short term and likely in the foreseeable future-- an issue that was neither desired nor deserved. At Excellus BlueCross BlueShield, we witness your many efforts and remain willing to assist in the care that must continue due to this pandemic.

Telehealth remains an important aspect to the ongoing discussion in health care. Excellus BCBS continues its policies that support access, especially audio-only and e-consultations. It is my belief that while this pandemic will end, much of what we have learned regarding the best delivery of care will continue. Telehealth has gained acceptance not only from payors, but also from all of you who deliver care. Most importantly, our members, your patients, have become accustomed to the technology, with the expectation that it will continue to be a care option.

As Excellus BCBS monitors usage, special attention is being given to the quality of care that can be delivered with different technologies (i.e., phone only and physical examination). There has been much discussion nationally stemming from the concern that health care quality could be sacrificed for innovation.

Telehealth use across all lines of business increased from 2019 to 2020 by the following percentages:



While the percentage of telehealth utilization increased from January through June, the decreases in claim numbers noted in the accompanying chart (with percentage change form prior year) were observed due to combination of both telehealth and office visits from April through June.

Month	2020	2019	Change
April	375,201	591,154	-36.5%
May	443,041	602,348	-26.4%
Jun	547,984	545,020	0.5%

NOTE: MDLIVE use as a percentage of telehealth ranged between .55 and 1.28 percent from January through July.

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Other Updates:

Excellus BCBS continues to provide member messaging and education focused on the importance of reconnecting with their doctor or provider. We congratulate your efforts in keeping your office doors open. We also realize the demands placed not only on you as providers, but also your supporting personnel to ensure business operations run efficiently, albeit with different workflows in place (e.g., limits on the number of patients in office, non-allowance of significant others, waiting in car until appointment, phone check-in prior to appointment, temperature check, and of course PPE). Finally, other messaging efforts include the importance of visits for preventive care, which most often occur without cost to the member.

Finally, our value-based payment grids will change in 2021, partly due to NCQA changes to some quality measures (i.e., patients with nephropathy), but also due to state mandates and our wish to align the grids.

Binghamton Nurse Practitioner Champions end-of-Life Conversations, eMOLST

Julie Barnes, FNP, is a family medicine and primary care nurse practitioner with United Health Services (UHS) in Binghamton. Ms. Barnes began using eMOLST in Spring 2018 with the legal change to nurse practitioner scope of practice. Since then, she's initiated countless discussions for her most seriously ill and frail patients, with many others reviewed/renewed post-hospitalization or after a stay in a skilled nursing facility.

Ms. Barnes' approach to these end-of-life discussions and eMOLST completion has been straightforward:

1. Identify seriously ill or frail patients who may be appropriate for these discussions (consider the five screening questions)
2. Review information about the patient's condition, including any new details from specialists
3. Ensure the patient understands his/her health status and prognosis
4. Consider raising eMOLST in the following visit types:
   - routine office visit
   - wellness exam
   - after a specialty consult indicating they're nearing the end-stage of a chronic condition
   - after they've been to the emergency department
   - after a hospitalization or skilled nursing facility stay
   - Transitional Care Management or Chronic Care Management visit
   - a dedicated visit for advance care planning
5. Document the goals and orders in eMOLST and sign them electronically

She creates care plans to support patients' choices and follows up with them quarterly, if not more frequently, as their health status may change quickly. Some patients also reach out to her office to make eMOLST updates as they clarify goals and preferences in conversations with family. Office staff can retrieve eMOLST forms and print a copy for the patient on pink paper.

The practice uses the advance care planning CPT codes (99497 and 99498) to bill for the time that these conversations take, including when they're completed over multiple visits or using telehealth.

When the patients are seen in the hospital, eMOLST is retrievable in the emergency department and by the inpatient teams that can review goals and update the orders as needed. The changes are visible to the PCP in real time.

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"From the perspective of a PCP, I feel a responsibility and a privilege to care for people; it's my duty to ensure that all my seriously ill and frail patients are offered the opportunity to discuss eMOLST with someone that they have trusted and built a relationship with over time," according to Ms. Barnes. "My patients should not have to wait to be hospitalized in order to talk about their end-of-life preferences. There is never going to be a perfect time to have this discussion, but eMOLST is a very valuable tool to make the conversation a normal part of the care they receive. Having a plan in place is reassuring and helpful to the patients and their families; both the hospital and PCP teams benefit from having these discussions when the patients are not in crisis.

UUHS Hospitalist Director Jeffrey Gray, M.D. agrees, "In the hospital we see patients at their most vulnerable and often need to have end-of-life discussions. For those whom the illness is acute, the straightforward way we use eMOLST to document has been very useful. For those patients who come into the hospital having had this discussion with their PCP, the eMOLST system makes finding that discussion and applying those decisions very simple. No longer do we have to look through paper charts or call and fax PCPs to find this documentation, even if they're from outside our health system or outside our region. It's all at our fingertips."

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

Case Study: PCP is Trusted When Patients Face End of Life

A 66-year-old female patient from Binghamton with HTN, DM Type 2, COPD, OSA, Anasarca + SOB, recurrent right & left HF and severe valvular disease with 2010 pacemaker and 2016 ICD was cared for by Julie Barnes, FNP at United Health Services for the prior 15 years, along with a cardiac team at a large medical center elsewhere in upstate New York. Despite a long relationship with the cardiac team, they never shared the patient's worsening condition with her or her family. In Fall 2018 when the ICD was extracted and replaced the patient had no idea that she was in the end stages of her disease.

In December 2018, following the ICD replacement, Ms. Barnes broke the bad news, shared the poor prognosis and offered an end-of-life discussion. The patient and family were surprised; they were under the impression the cardiac procedure was successful and thought this meant that she would get better. Ms. Barnes helped the patient identify goals and articulate preferences and she completed the eMOLST accordingly.

In the next three months, the patient was hospitalized multiple times. eMOLST was honored, reviewed and updated by the hospital and skilled nursing facility where she received post-acute rehab, and by Ms. Barnes when the patient returned home.

When the patient was hospitalized in March 2019 she was put on a ventilator, in line with her eMOLST, and her condition worsened. Ms. Barnes remained in touch with the family and hospital team. When the trial ventilation was not returning the patient to her prior functional status, in line with her goals, the eMOLST was updated by the hospital team and the health care agent (the patient's husband). The patient was terminally extubated in accordance with her eMOLST orders.

Several months later the patient's husband expressed how thankful he was that Ms. Barnes had taken the time to have these conversations and complete the eMOLST. When the ventilator was removed, he knew it's what his wife wanted. He felt at peace knowing that her wishes were honored.

Later, Ms. Barnes reflected on this case, saying, "Given this patient's decline. I felt for sure that the cardiac team would have addressed disease trajectory, prognosis, care preferences and eMOLST, but I was mistaken. When the time came to talk about end-of-life decisions, who knew this patient best? I did. She was more comfortable discussing these issues with me. Knowing her preferences let me advocate for her and her wishes for care; eMOLST provided continuity across the multiple settings where she was seen in the final months of her life."

A Message for Primary Care Providers

Increasing Compliance with Well-Child Checks

Lisa Harris M.D.,
Chief Medical Officer, Commercial Lines of Business

COVID-19 PHE has brought significant health-care disruption for providing preventive care visits throughout our value-based arrangements. The following perspective is from Lisa Harris, M.D., chief medical officer for the Excellus BlueCross BlueShield's commercial line of business, who has provided wellness visits in under served communities.

As primary care physicians, we often struggle with finding the time to add in well-child checks. We must schedule them far in advance, and if a patient misses the appointment, it may be weeks before we can get them rescheduled.

Here are some tips that may help you to close the gap with missed well-child visits.

Assess your current process

- Does your practice use electronic medical record templates?
- What is the workflow for a well-child check (How much time does it take to get a child ready?)
- What are the roles of nursing and front-office staff?
- Are immunizations reviewed and ordered by nursing for your signature?

Identify the opportunity

- Have you reviewed the number of children with a well-child check gap?
- Can your front-office or nursing staff identify the children on your daily schedule who have a gap?
- Can you review the list weekly?

I practiced in an underserved community clinic. I began by identifying children who were present for an acute visit but needed a well-child check. I would switch the visit to a well-child check and work around the rest of the schedule. That is, I would perform the screening, history and physical and anticipatory guidance. Then I would notify nursing and the front desk staff of the change and place orders. A nurse would complete the child's biometrics while I saw another acute patient, then I completed the visit. This added about 10 minutes to my acute visit.

Of course, this created some consternation among the staff. So, what did we do to alleviate the worry?

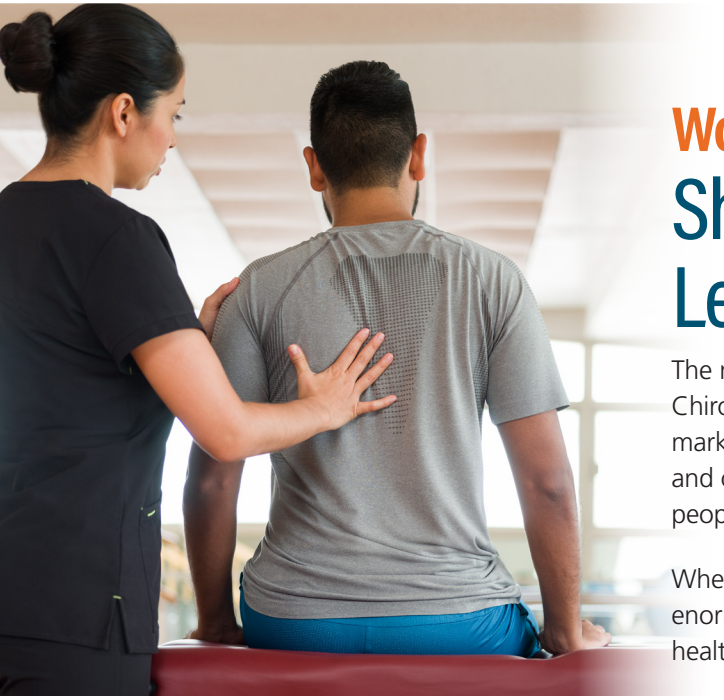
Create the vision

- Apply quality metric to close gaps.
- Explain why we need to do this.
- Explain how we can do this.
- Create a safe place for objections and concerns.
- Identify barriers and commit to creative solutions.
- Implementation does not require a separate committee and long-term strategy.

Make it happen with options

- Review the charts ahead of time and change visits to well-child checks.
- Review the chart at the time of visit, engage the parent ("I see <patient X> is missing a well-child check. We can do that today if you'd like. I expect it will only add a few minutes to the visit.")
- Create a workflow that works for all:
  - Provider begins visit and brings nursing in later for biometrics.
  - Use typical workflow and provider sees other patients while the well-child check is being prepared.
  - Create user-friendly templates.
  - Ensure that your EMR workflow is seamless:
    - Can orders be proposed?
    - Are screening tests incorporated in the EMR?
    - Is the staff flexible?
    - How much of the work can be done in advance?

With a little effort, we were able to achieve more than 90% compliance with well-child checks using this flexible model.



World Spine Day Shines Spotlight on Leading Cause of Disability

The ninth World Spine Day (WSD) coordinated by the World Federation of Chiropractic was observed on October 16. Organizations around the world marked the day by participating in activities to raise awareness of back pain and other spinal issues. These conditions, which affect an estimated 1 billion people worldwide, are the leading cause of disability.

Whether in high-income countries, where back pain afflictions result in an enormous impact on the economy, or under-served parts of the world where health care, the aims of WSD remain the same:

1. Raise awareness of spinal health and spine disorders among individuals, communities, professionals and all stakeholders associated with spine care
2. Provide a forum for ongoing discussion about the burden of spinal disorders and the sharing of best practices
3. Promote an interdisciplinary, collaborative approach to easing the burden of spinal disorders

This year's Get Back on Track theme highlights the need to lessen the impact COVID-19 has had on individuals' spine health. Due to decreases in activity caused by quarantines, working from home, and lessened social interactions, spinal disorders and back pain can naturally occur or be exacerbated.

The WSD organizing committee has provided a toolkit of resources to be used by individuals and health-care providers to support the Get Back on Track efforts, and can be found at: http://www.worldspineday.org/resources/wsd-toolkit-and-materials/

A "Straighten Up" parody presents the message in a fun way to patients: https://www.youtube.com/watch?v=q2VIom-rHi40&list=PL8HSzCvNPiszkNA48sMnwqeAOeg4MbGk_

Efforts by other organizations around the world to spread the word on WSD can be found at: http://www.worldspineday.org/

Information on the effects of back pain can be found at The Burden of Musculoskeletal Diseases in the United States website: www.boneandjointburen.com

The Health Plan has taken an active stance on supporting providers in their communication efforts with patients regarding activity maintenance during these unprecedented times to combat the impact on back pain and co-morbid conditions. The MEME well-being sharing tool, which encourages **M**indfulness, improved **E**ating habits, **M**ovement, and **E**njoyment to combat the effects of isolation and inactivity, and the two-hour Spine Pathway Training, both discussed in previous newsletter issues, are tools available to providers to have these healthful conversations with patients.

More resources on communicating information regarding back and other spinal pain can be found on the Choosing Wisely® website at: https://www.choosingwisely.org/

Since we know the health impacts on patients and the financial impact to the health care system due to back and neck pain, now is the time to continue the 2020 World Spine Day observance by starting conversations about spine health with your patients.

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2 Free CME Spine Pathway Workshops now on-line 24/7

Excellus BlueCross BlueShield is excited to announce that its nationally recognized Spine Pathway Training is now available online at your convenience! As made exceedingly clear in the World Spine Day links, the medical costs of spine care and associated disability have increased significantly over the last 30 years worldwide and regionally, with worsening outcomes. To address this issue, we have paired with Spine Care Partners, LLC, an independent company, to offer a nationally recognized educational program based on a patient-centered, evidence-based spine care pathway. The program emphasizes patient choice, education and motivation in self-care, and appropriate management at the "front end" of care. Training includes the diagnostic, treatment and communication skills required to effectively manage most patients presenting with axial and/or radicular spinal syndromes.

It's important to note, all practitioners who see patients with spine-related complaints are welcome to attend. In fact, we encourage you to attend, even if you have attended in the past, as information has been updated and condensed into a single two-hour online program available at your convenience!

Don't wait, reserve your spot today!

Register today at https://primaryspineprovider.com/excellus-bcbs-pcp-registration/

Specialty Drug Pipeline
NASH Therapy

The current rise in specialty drug expenditures continues to spark interest across many of our health systems and value-based partnerships. As we look for opportunities to tame this growing trend, a potential new blockbuster approval for NASH drug therapy may be lurking just around the corner. NASH (nonalcoholic steatohepatitis) is the most severe form of nonalcoholic fatty liver disease (NAFLD), and if left untreated can lead to liver fibrosis, cirrhosis, and possible progression to hepatocellular carcinoma and liver-related deaths.

The Significance of a NASH Drug Approval:

About 25 percent of adults in the U.S. have NAFLD, and within that population about 20 percent have NASH (about 5 percent of adults in the U.S.). Many are asymptomatic and unaware of having this disease until the later stages making it a challenge to pinpoint the true disease prevalence.[1] Common risk factors include obesity, insulin resistance, and metabolic syndrome. And as the prevalence of these key risk factors continue to grow globally, experts have become alarmed that there will also be a subsequent rise in NASH prevalence.[2] If left unmanaged, NASH could potentially become an economic burden to our health-care system in years to come.

Forecasting the Pharmaceutical Landscape:

There are currently no Food and Drug Administration-approved medications for NASH, limiting current treatment options to include lifestyle modifications and off-label drugs, such as pioglitazone and vitamin E. Several drug manufacturers have recognized this as a significant opportunity and are competing to develop the first NASH-approved drug. To date, there are seven manufacturers with drugs in phase III clinical trials. All appear to have unique mechanisms of action targeting various clinical endpoints, including steatosis and liver fibrosis improvement. However, recent analyses of trials have uncovered some disappointing results. This has resulted in approval date setbacks, speculating that launches could be delayed until next year, including obeticholic acid (Ocaliva®) – the once projected front runner to receive a 2020 approval date.[3] Drug regulators are pushing to extract more conclusive evidence from these trials around drug effectiveness, further opening speculation that combination drug therapy could be the likely approach for achieving pharmaceutical outcomes. Despite the current uncertainties and approval challenges, some experts have forecasted the NASH drug market could ultimately reach $20 billion by 2025.[5]

Keeping Ahead of the Pharmaceutical Curve:

Knowing that a NASH drug launch is likely inevitable, what can health systems and value-based partnerships do to prepare for this upcoming pharmaceutical expenditure? Unfortunately, there are still several unknown variables that exist in order to accurately predict the upcoming financial impact, most notably a lack of understanding of the true symptomatic population size and what disease stages these drugs will ultimately target to provide benefit. Additionally, drug costs can only be speculated at this time. There are a wide range of hypotheses, with some predicting annual drug costs for a single agent to be between $10,000 and $20,000 per year (and potentially higher if combination therapy is needed).[4] An opportunity to which health systems and value-based partnerships can turn their attention is focusing on robust programs that improve pre-diabetes, type-2 diabetes, obesity, and metabolic syndrome outcomes – the key risk factors for developing NAFLD and NASH. Optimizing the management of these at-risk patients ahead of advanced disease progression could pay off and help offset the costly NASH pharmaceutical expenditure that is predicted for years to come.

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