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ACQA ADVISOR

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

Excellus

Clinical Corner

Nicholas Massa, M.D.
Interim Vice President, Medical Affairs

Now that I have had the chance to really start working with our value-based teams, it is wonderful to get to know you and to be a part of some truly collaborative relationships. But, as the COVID-19 pandemic has continued to put stress on all in the health-care system and create challenges for so many, I have had to stop at times and wonder – how important are these value-based relationships and programs right now?

The more I began to think about it, the more I realized that what we are doing is perhaps even more important and timely than we previously thought. What we have witnessed with the pandemic has exposed the vulnerability and unsustainability of the traditional fee-for-service model, and the advantages of value-based model concepts.

A colleague leading a very large health system once said, "We are in two basic businesses in health care – the business of keeping people well, and the business of taking care of them when they get sick." Health care providers can intervene at both points, and at any point in between. Sometimes it is the in-between points that can have the greatest impact. What we are often trying to do together in our ACQA relationships is to identify innovative ways to intervene at earlier stages – or even before someone becomes sick – to improve quality of care, improve outcomes, and reduce cost.

"We are in two basic businesses in health care – the business of keeping people well, and the business of taking care of them when they get sick."

In the past few years, Medicare has been moving toward value-based care, "bending the cost curve," and rewarding "quality over quantity." The hope is that, by 2025, nearly all Medicare reimbursement will be tied to value-based arrangements. The pandemic is likely to accelerate this timeline. What we do together for our communities will help better position each of you to be ready to expand these initiatives to the entire patient population you serve.

COVID-19 has created challenges we couldn't have imagined, impacting health care on so many levels. Our work in the ACQA arena is more important than ever. Let us not forget that this collaboration is truly valuable for what we are trying to accomplish together and will help us prepare for the coming landscape.

Primary Care Decisions for Acute Low Back Pain May Trigger Chronic Pain

Low back pain (LBP) is the leading cause of disability and leading cost to society[1, 2]. It typically is also the biggest health care expense of local employer groups. Primary care is widely seen as the key to efficient and effective health care in general[3], but has proven to be problematic when it comes to LBP. This has been highlighted in two prestigious journal articles published in the last few months.

Kamper et al[4], in a systematic review published in the journal **Pain**, found that only approximately 20% of primary care practitioners follow the recommended approaches of evidence-based LBP guidelines. That means four out of five patients are not getting evidence-based direction early in their care journey. There is significant opportunity in spinal care to improve outcomes and prevent harm just by adopting evidence-based care.

The clinician's early care decisions can actually trigger the evolution of chronic pain. In a groundbreaking **Journal of the American Medical Association** article published in February, Stevans et al [5] sought to identify the key factors that contribute to a patient's acute LBP becoming chronic. An assessment of more than 5,000 acute LBP primary care patients identified several factors, including smoking, obesity and depression, to be associated with transition to chronic LBP. This verified previous studies.

However, it was also found PCP care not supported by evidence-based guidelines to be an independent risk factor (i.e., controlling for smoking, obesity and depression) for transitioning from acute LBP to chronic LBP. In fact, unnecessary imaging, prescribing of opioids and early specialty referrals were the most powerful predictors of who would become a chronic back pain sufferer. The health care system is inadvertently triggering the development of chronic back pain!

The data shows that only a small number of practitioners follow evidence-based guidelines when dealing with back pain patients. And, if the practitioner's treatment approach runs contrary to recommended guidelines, not only is the patient unlikely to be helped, there is an increase in the likelihood that he/she will become a chronic LBP sufferer.

Primary care has been provided with several high-quality LBP guidelines, but evidence is clear that this is not enough to bring about improvement. What is needed is an expanded support system framed in a care pathway that includes easily applied tools and active collaboration, as is offered by the Excellus BlueCross BlueShield Spine Health Program. Our simple 2-hour evidence-based, on-line spine pathway workshop has shown to decrease inappropriate imaging, opioid use and specialist referrals while achieving high provider satisfaction scores from attendees.

To register for the pathway training, which provides 2 free CMEs, go to: https://primaryspineprovider.com/excellus-bcbs-pcp-registration/

For further information, please contact brian.justice@excellus.com

[1] Hoy D, March L, Brooks P, Blyth F, Woolf A, Bain C, et al. The global burden of low back pain: estimates from the Global Burden of Disease 2010 study. Annals of the rheumatic diseases. 2014 Jun;73(6):968-74.

[2] Dieleman JL, Cao J, Chapin A, Chen C, Li Z, Liu A, et al. US Health Care Spending by Payer and Health Condition, 1996-2016. Jama. 2020 Mar 3; 323(9):863-84.

[3] Phillips RL, Jr., Bazemore AW. Primary care and why it matters for U.S. health system reform. Health affairs. 2010 May;29(5):806-10. PubMed PMID: 20439865. eng.

[4] Kamper SJ, Logan G, Copsey B, Thompson J, Machado GC, Abdel-Shaheed C, et al. What is usual care for low back pain? A systematic review of health care provided to patients with low back pain in family practice and emergency departments. Pain. 2020 Apr;161(4):694-702.

[5] Stevans JM, Delitto A, Khoja SS, Patterson CG, Smith CN, Schneider MJ, et al. Risk Factors Associated With Transition From Acute to Chronic Low Back Pain in US Patients Seeking Primary Care. JAMA Netw Open. 2021 Feb 1;4(2):e2037371.

Consider Need for Preoperative Testing in Low-Risk Procedures

Although we are all still dealing with the COVID-19 pandemic, we continue to examine ways to address variations in care. Our research has identified variation in preoperative testing for low risk procedures. Given this fact, we want to provide the following information as food for thought prior to ordering preoperative testing.

Society of General Internal Medicine: "Don't perform routine pre-operative testing before low-risk surgical procedures."

American College of Surgeons: "Avoid admission or preoperative chest X-rays for ambulatory patients with unremarkable history and physical exam."

American Academy of Family Physicians: "Don't order annual electrocardiograms or other cardiac screening for low-risk patients without symptoms."

American Society of Anesthesiologists: "Don't obtain baseline laboratory studies in patients without significant system disease (ASAI or II), complete profiles for low-risk surgery."

American Academy of Ophthalmology: "Don't perform preoperative medical tests for eye surgery unless there are specific medical indications."

American College of Cardiology: "Avoid performing stress cardiac imaging or advanced non-invasive imaging as a preoperative assessment in patients scheduled to undergo low-risk non cardiac surgery." It was also recommended that routine electrocardiography (ECG) screening as part of preoperative or preprocedural evaluations for asymptomatic patients undergoing low-risk surgical procedures be avoided.

Excellus BlueCross BlueShield's research revealed that preoperative laboratory studies, pulmonary function tests, X-rays, electrocardiograms and other cardiac studies have been performed on patients prior to low-risk procedures. Follow-up research uncovered the following guidelines issued by various specialty societies and reported by Choosing Wisely®. These statements are intended to spark conversations between physicians and patients to ensure that the right care is delivered at the right time for the right reason.

Our claims data uncovered testing for low-risk procedures without a clear clinical indication and there was variation amongst our regional facilities. We believe that the following factors could be the probable causes of variation:

- Routine preoperative testing protocols/ facility protocols
- Preoperative standing orders versus preoperative patient-centered assessments
- Habit

As we all work together to reduce the burden on our patients and to keep health care affordable, I ask you to consider the following questions before ordering preoperative testing:

- Is this recommended evidence-based care?
- Is there a clinical rationale for testing?
- Will the test have value in the patient outcome?

Our hope is to ensure that preoperative testing is guided by the patient's medical history, physical exam findings and assessment of potential risk rather than routine protocol.

On behalf of our members, we thank you for your consideration. Please stay safe and a million thanks for everything you are doing for our members and our community during these challenging times.

Richard Vienne, DO
Senior Medical Director, WNY and Employer Group Support

Real Time Benefit Check Improves Patient, Provider Satisfaction

New medications are coming to market faster than ever and prices are continuously fluctuating. It is becoming increasingly complex and time consuming for providers to choose the most appropriate medication for their patients at the lowest cost.

Leveraging the technology of a pharmacy Real Time Benefit Check (RTBC) tool that is integrated into an electronic medical record (EMR) workflow can assist with many prescription challenges. The goal of RTBC is to provide clarity on medication costs, facilitate the prescribing process, improve health care outcomes, and, ultimately, increase both provider and patient satisfaction.

Price Transparency

Within a RTBC tool, providers can see real-time drug pricing. Out-of-pocket medication costs are available for the prescribed drug as well as for therapeutic alternatives. Providers can also see if there is a difference in medication cost depending on whether the prescription is filled at a retail or mail order pharmacy. This is especially helpful if patients are also interested in obtaining a larger quantity of medication through mail order (i.e., 90-day vs. 30-day supply) but are unsure if they can afford the larger up-front cost. These price transparency capabilities allow the most cost-effective medication to be prescribed for patients.

Electronic Prior Authorization (ePA)

Within a RTBC tool, providers can see formulary coverage and any other requirements for the medication, such as a prior authorization (PA) or a specialty pharmacy restriction. The tool can help guide the provider to choose a formulary covered medication over a non-formulary alternative. If the provider wishes to continue with prescribing the medication requiring a PA, his/her EMR system may allow for seamless submission of an electronic PA request. The fewer exchanges necessary between the provider, insurer and pharmacy throughout the prescribing process, the earlier the patient can start treatment. Having ePA available within an EMR facilitates the patient receiving the most appropriate medication as quickly as possible.

Increased Adherence

There are various reasons patients do not adhere to medications, which can increase overall health care costs drastically. Patients and prescribers often do not know the price or benefit coverage of the prescribed medication until the patient goes to the pharmacy. If a prescription is too costly, the patient may not pick it up at the pharmacy or may not take as prescribed. Also, if a patient learns the prescription is not covered by insurance or requires a prior authorization, the patient may become frustrated and forgo treatment. A RTBC with both price transparency and ePA can help avoid these situations and improve medication adherence.

This tool may be available for your EMR. Please reach out to your ACQA team for additional information.

RTBC: *Fast Facts*

Providers who report using ePA instead of fax and/or phone spend an average of **2.5 hours less per week** on prior authorization for their patients. https://www.covermymeds.com/main/pdf/cmm-scorecard-2018.pdf

71% of providers who were considered experienced users reported their patients received faster care after implementation of ePA. https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care/