KNOW YOUR ACO: Alabama Physician Network

In this month's edition:

APN Participants:
UAB Health System
UAB Medical West Hospital
Christ Health Center
Cahaba Medical Care

ALABAMA PHYSICIAN NETWORK

What is an ACO?

An ACO (accountable care organization) is a contract between Medicare and a network of doctors and hospitals that share responsibility for providing care to a specific population of patients. In this case, these are Medicare fee-for-service patients. Our network is a legal entity called the Alabama Physician Network, LLC (APN), and its members are UAB Health System, Medical West, Christ Health Center, and Cahaba Medical Care.

The members of an ACO are committed to improving quality care for patients while reducing costs. Doctors and hospitals in an ACO communicate with patients and with each other to help ensure that patients receive the care they need when sick and the support they need to stay healthy. Currently, APN has over 15,000 Medicare patients attributed to more than 1,500 physicians.

If the ACO achieves cost reductions and improves quality with preventive measures, the physicians in the ACO receive "shared savings" – 50% of the dollars saved by Medicare are returned to the ACO. Watch for the October newsletter for more on how savings can benefit your practice.

Risk Stratifying and Care Coordination

The Medicare patients attributed to the ACO have been risk stratified using data analytics tools that can predict the patients who need engaged and proactive care coordination. These include patients who have multiple emergency department and hospital visits with readmissions, require the most expensive medications, and show non-adherence to their medications due to cost and social issues. Through the risk stratification process, we have been able to identify the 5% of patients who account for almost 80% of the health care expenditures. APN currently utilizes five care coordinators tasked with helping ensure that high-risk patients get their meds, receive timely care, and have a team-based support system in place with their provider. We also are evaluating other forms of care coordination, with the goal of identifying patients whose risk is rising and those at risk due to social factors.

Measures & Metrics

An ACO has 31 quality measures to report to Medicare each year, and they are grouped into Clinical Quality, Claims, and Patient Experience categories.

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15 Clinical Quality Measures (Click each measure for more information)

1. Breast Cancer Screening
2. Colon Cancer Screening
3. Controlling High Blood Pressure
4. Depression Remission at 12 Months
5. Diabetes: Eye Exam
6. Diabetes: A1C Poor Control (>9%)
7. Falls: Screening for Future Fall Risk
8. IVD: Use of ASA or Antiplatelet Rx
9. Medication Reconciliation Post-Discharge
10. Pneumococcal Vaccination Status
11. BMI Screening and Follow-Up Plan
12. Influenza Immunization
13. Screening for Depression and F/U
14. Tobacco Use Screening/Intervention
15. Statin Therapy for Prevention and Treatment of CVD

8 MSSP Claims Measures (greatest opportunity for cost savings)

1. Risk-standardized, all-condition readmission (ACO-8)
2. Skilled nursing facility 30-day readmission (SNFRM) (ACO-35)
3. All-cause unplanned admission for patients with diabetes (ACO-36)
4. All-cause unplanned admissions for patients with heart failure (ACO-37)
5. All-cause unplanned admissions for patients with multiple chronic conditions (ACO-38)
6. Ambulatory-sensitive condition acute composite (AHRQ prevention quality indicator [PQI] #91) (ACO-43)
7. Use of certified EHR technology (ACO-11)
8. Use of imaging studies for lower back pain (ACO-44)

8 MSSP Patient Experience Measures (Click here to view the CAHPS Survey for ACOs)

1. Getting timely care, appointments, and information (ACO-1)
2. How well your providers communicate (ACO-2)
3. Patients' rating of providers (ACO-3)
4. Access to specialists (ACO-4)
5. Health promotion and education (ACO-5)
6. Shared decision-making (ACO-6)
7. Health status/functional status (ACO-7)
8. Stewardship of patient resources (ACO-34)

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Important Quality Measures Reminders:

1. Annual wellness visits are vital to the ACO/MSSP quality measures and historically translate to better outcomes for patients and higher quality scores.
2. Nurse should repeat blood pressure >140/90 at the end of the visit and record in EMR.
3. PHQ2 depression screening scores >2 or "Yes" should be addressed in your clinic note.
4. Send as many patients as possible to Callahan Eye Hospital Clinics for eye exams. UAB Medicine has a direct interface with Callahan's EMR and will receive all future diabetic eye exam notes directly via IMPACT.
5. Medication reconciliation for patients seen within 30 days of an inpatient stay should document the "discharge medication list," especially if the patient was at an outside hospital.

Pam Pope
Supervisor of Population Health Management

Meet the Lead Care Coordinator

Pam Pope is the supervisor of Population Health Management and works with the ACO patient population. She has over 30 years of nursing experience in both the inpatient hospital and corporate medical management settings. She is a graduate of the University of Alabama and a Certified Case Manager.

"My team's focus is proactive care coordination for the high-risk Medicare patient population. By partnering with the physician and other health care providers, we can improve the quality and efficiency of care being delivered to this patient population. By utilizing an effective health care team, we all are focused on moving toward the same goal of ensuring that patients are receiving optimal care while avoiding unnecessary duplication of services. My passion is to make a difference in these patients' lives.

My team includes both registered nurses and a social worker, and with the mix of clinical and social experience, we are able to identify and address both clinical and psychosocial issues that our patients may encounter. We work with the patients' primary care physicians and their staff to address issues or areas of concern in order to help ease the process of patient care management."

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Success Stories

Through coordinated care management, the Alabama Physician Network already is improving care and efficiency.

Case # 1:

An 82-year-old male with a history of CAD, s/p CABG, pacemaker, HTN, and a new DM diagnosis

The care coordinator telephoned the patient, and he said he was having syncopal episodes in the morning and c/o a few weeks of fatigue. The patient said that if the syncope recurred, he would go to the ED. The patient had recently started on metformin for diabetes and was not checking his blood glucose due to not having a glucometer. The patient was directed to monitor his BP and his blood glucose, the incidents were reported to his PCP, and a follow-up appointment was set. During that follow-up appointment, the BP log showed that the patient was experiencing hypotensive episodes in the morning, and his BP medication was adjusted. Also, the care coordinator was able to locate a low-cost program that provided the patient with a glucometer.

Case # 2:

A 73-year-old male with a history of lymphoma, HTN, CAD, PVD, and cellulitis

The care coordinator identified that the patient was noncompliant with his medications due to the monthly cost of $340. The care coordinator worked with the VA pharmacy to have the medications filled at the VA for a cost of just $8 per month. It was also noted during medication reconciliation that the patient had two prescriptions for Lasix and was taking both. The care coordinator reached out to the CHF clinic and his PCP to inform them, and the prescribing error was corrected.

The operationalizing of an ACO has a steep learning curve, and we are only in our first year. As we learn and grow, we will provide additional updates on our progress.