KNOW YOUR ACO: Alabama Physician Network

ACO Newsletter 2019 Q2:

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- 2018 Performance
- New Lead Care Coordinator
- Success Stories

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ALABAMA PHYSICIAN NETWORK

In Focus: *Lay Navigation*

In April 2018, we hired four care coordinators to join the ACO operations team to manage the Medicare beneficiaries attributed to us. The care coordinators have focused on helping patients with rising risk scores better manage their health. They worked to ensure these patients received timely care in order to prevent expensive and unnecessary admissions, readmissions, and visits to our ED.

During the process, we realized there was a lot of work they were doing that did not require the skills of a licensed RN. To allow the current care coordinators to work at the top of their license, 3.5 lay navigators have joined the team to supplement their work.

What is lay navigation, and where is it currently being used at UAB?

- A trained, non-licensed professional who provides individualized assistance to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality health and psychosocial care
- Can be specific to disease, condition, or service
- Provide assistance in the areas of screening and testing by identifying open care gaps, obtaining records for gaps closed outside of UAB, and facilitating the scheduling of the appointment to close the gap
- Assist patients and their families in the coordination of care among providers and community resources
- Lay navigators have proven outcomes in our Oncology Care Model and in our COPD bundle.

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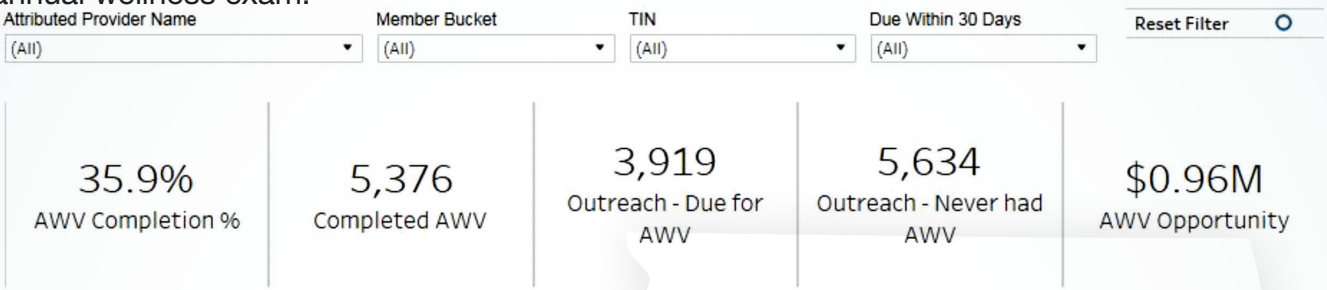
Use of Lay Navigation in the MSSP Patient Population
Use of Lay Navigation for Annual Wellness Visits
9,553 MSSP patients either have never had an annual wellness exam or are past due for their annual wellness exam.



Our strategy going forward:

- Outreach first to patients who have never had an annual wellness exam to get them scheduled.
- While speaking to patients, identify if they've had open care gaps closed outside of CIN. If so, obtain those records.
- Message provider of open gaps in care 72 hours prior to the scheduled appointment.

Use of Lay Navigation Post-ED Visit

- Approach #1: Assign 0.5 FTE lay navigator to these 115 COPD patients to perform a seven-week outreach strategy in which they will complete a dyspnea survey, COPD assessment, life space survey, anxiety and depression survey, distress assessment, and ACP survey. Also confirm date and time of next appointment and identify barriers to making that scheduled appointment.
  - 115 frequent ED utilizers with a diagnosis of COPD already have had more than $1.65 million in medical costs this performance year. Utilizing our predictive analytics, they had more than $2.32 million in potentially avoidable adverse scenario costs.
- Approach #2: All MSSP patients who visit the ED will be called the next business day, and a survey will be conducted to determine what brought them to the ED, whether they reached out to the clinic prior to going to the ED, whether new medications were prescribed, and if so, were they filled. During the call, patients also will receive a review of discharge instructions and will be asked if and when they have an appointment scheduled with their ambulatory provider.
- Approach #3: Outreach first to patients who have never had an annual wellness exam to get them scheduled. While speaking to the patients, identify if they have any open care gaps closed outside of the CIN. If so, obtain those records. Add notes in IDX to prompt MD of care gaps that need to be addressed during AWV.

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2018 Performance

CMS tracks performance on 31 measures for our ACO. Because we were in our first performance year, the only requirement was that we report on them. In 2019 and 2020 performance years, we will be held accountable for the measures listed below. We performed exceptionally well on some of them. Over the next few months, we will be communicating focus areas and strategies for improving targeted performance measures.

*The measures noted with an asterisk will not be measured in the 2019 or 2020 performance years, but we will continue to make sure that we perform well on them.

Measure Category	ACO#	Measure Name	APN 2018 Performance
Patient/ Caregiver Experience Measures (Preliminary)	ACO-1	CAHPS: Getting Timely Care, Appointments, and Information	66.90
	ACO-2	CAHPS: How Well Your Providers Communicate	85.90
	ACO-3	CAHPS: Patients' Rating of Provider	82.70
	ACO-4	CAHPS: Access to Specialists	48.90
	ACO-5	CAHPS: Health Promotion and Education	67.60
	ACO-6	CAHPS: Shared Decision Making	60.50
	ACO-34	CAHPS: Stewardship of Patient Resources*	36.80
Care Coordination/ Patient Safety Measures	ACO-12*	Medication Reconciliation	82.99
	ACO-16	Falls: Screening for Future Fall Risk	99.60
	8 additional measures to be reported when the final financial reconciliation is released from CMS.		
Preventative Health Measures	ACO-14	Preventive Care and Screening: Influenza Immunization	82.91
	ACO-15*	Pneumonia Vaccination Status for Older Adults	77.02
	ACO-16*	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	80.57
	ACO-17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	18.92
	ACO-18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	50.20
	ACO-19	Colorectal Cancer Screening	69.48
	ACO-20	Breast Cancer Screening	71.60
	ACO-42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	87.46
	ACO-27	Diabetes Mellitus: Hemoglobin A1c Poor Control	19.28
At-risk Population Measures	ACO-41*	Diabetes: Eye Exam	46.59
	ACO-28	Hypertension (HTN): Controlling High Blood Pressure	68.15
	ACO-30*	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	94.80
	ACO-40	Depression Remission	11.11

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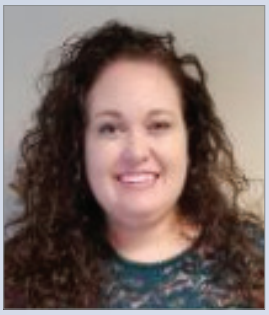

Lead Care Coordinator

Heather Thrash, RN, is a certified case manager and the supervisor of Population Health Management. She has more than 20 years of nursing experience, including government and commercial case management. Over the last year, she has worked with the ACO populations in our Selma, Montgomery, Inverness, and Whitaker clinics. "Our team collaborates with ACO patients in the office setting, hospital, and telephonically to provide education centered on self-care management, empowering our patients to know their role in health care," Thrash says. "We assist patients in setting personal goals, developing strategies, providing resources, and building problem-solving skills to gain control of their chronic diseases. The MSSP team educates our patients and their family members on chronic conditions, medications, ER vs. Urgent Care utilization, wellness screening gap closure, and social barriers to ensure efficient, quality care. We look forward to continuing to provide a collaborative effort to ensure our patients have excellent care."

Success Stories

In an effort to better coordinate care for our patients, we've developed a greater appreciation for the complexity of the issues many of them face daily. There aren't always easy solutions for these problems, but we've found that a little connection and trust go a long way. Each newsletter we try to highlight some of the successes our patients have had in their health journeys. Here are a few more:

CASE #1

58-year-old female with HTN, DM II, ESRD on HD, sarcoidosis, hyperlipidemia, hyperparathyroidism, and uterine leiomyoma

When she was first enrolled in July 2018, she was only taking her medications 4-5 times per week. Her BP was about 180/90, and her A1c was 11%. We assigned a case manager to begin working with her on education and health coaching. Here are some of the steps we took with this patient:

- Provided education via phone conversations regarding the importance of taking meds as directed and the effects of noncompliance on her organs
- Encouraged her to check blood sugar as directed and emphasized that keeping a log to review with the provider is an important part of partnering with her provider to improve her health
- Arranged an appointment with an orthopaedic specialist to evaluate her knee pain. Afterward, she started a conservative treatment.
- Reinforced education with face-to-face follow-up meetings with the case manager

As of April 2019, her BP had improved dramatically to about 130/80, and her A1c was 7.4%. Additionally, we helped make sure she received a flu vaccine, mammogram, and a colonoscopy with polypectomy.

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CASE #2
87-year-old male with HTN, CAD s/p CABG, AFib, DM II, gout, lumbar radiculopathy, PTSD, hx of CVA, dementia. S/p CABG in Jan 2019 and requires 24/7 care.

His daughter has her own medical issues and has a hard time caring for him. He also happens to be a veteran but was not using his VA benefits. We collaborated with a social worker at the VA and his daughter to start the application process for disability. He now has assistance with the cost of meds, receives disability pay including back pay, and has access to a VA home care aid. If all goes as expected, he also will be placed into a long-term VA home that should help him better manage his health.

CASE #3
68-year-old female with COPD, HTN, CKD, hypothyroidism, chronic pain in right shoulder, CAD, HLD, OA of right shoulder, smoker, AFib, anemia, SOB, hx fall, hx CABG, chronic fatigue, major depression/anxiety, pacemaker, and epilepsy

This patient previously had refused a mammogram and colonoscopy. With some education, the patient consented to a mammogram and Cologuard. During this case, the case manager discovered that the patient also was in need of a new hospital bed. We were able to coordinate a solution for this as well.