KNOW YOUR ACO: Alabama Physician Network

ACO Newsletter 2019 Q3:

- In Focus: ED Utilization & Navigator Update
- Beneficiary Notifications
- Shingrix Vaccine for Shingles
- Success Stories

APN Participants:

UAB Medicine
Medical West Hospital
Christ Health Center
Cahaba Medical Care

ACO Governing Board:

Chair
Tony Jones, MD
UA Health Services Foundation

ACO Executive Director
Don Lilly
UAB Health System

Secretary
Michael Moore, MD
The Healthcare Authority for Medical West

Treasurer
Bob Bourge, MD
UA Health Services Foundation

Quality Chair
Stephen Stair, MD, FACP
UAB Health System

ALABAMA PHYSICIAN NETWORK

IN FOCUS: Should I Go to the ED? Studying a Patient's Decision-Making Process

One of the metrics that we follow as part of our care guidance program for accountable care organization (ACO) patients is ED visits per 1,000 members. In the Q1 2019 report, that metric was **938/1,000** for our population. For comparison, the median for all active Medicare Shared Savings Program (MSSP) ACOs at the time of this report was 675/1,000. This metric is important to everyone; visits to the ED are stressful for patients and costly for health care systems. It is in both the patient's and our best interest if we can work to make sure that patients are being seen in the most appropriate setting, but it's easier said than done!

Guideway Care has been focused on post-ED visit outreach for more than three months, and the data collected during that time have begun to yield insights into patients' decision-making process for going to the ED.

After an ER visit, a care guide reaches out to patients to make sure they:

- Understand and are following their discharge instructions
- Have a follow-up appointment scheduled
- Are educated on using the most appropriate clinical settings

Additionally, the MSSP care coordinators receive real-time alerts when a patient checks into the ED during office hours. High risk patients are seen face to face in the ED and/or inpatient setting. These patients are evaluated for chronic disease education needs and social barriers that may lead to high utilization. MSSP care coordinators provide telephonic and face-to-face follow up in the PCP clinics to help ensure that patient-specific goals are met and resources are provided.

Our goals are to prevent patients from ending up back in the ED because they didn't follow their discharge instructions, understand how they made the decision to go to the ED, and help them with barriers or education to allow them to choose the most appropriate setting in the future.

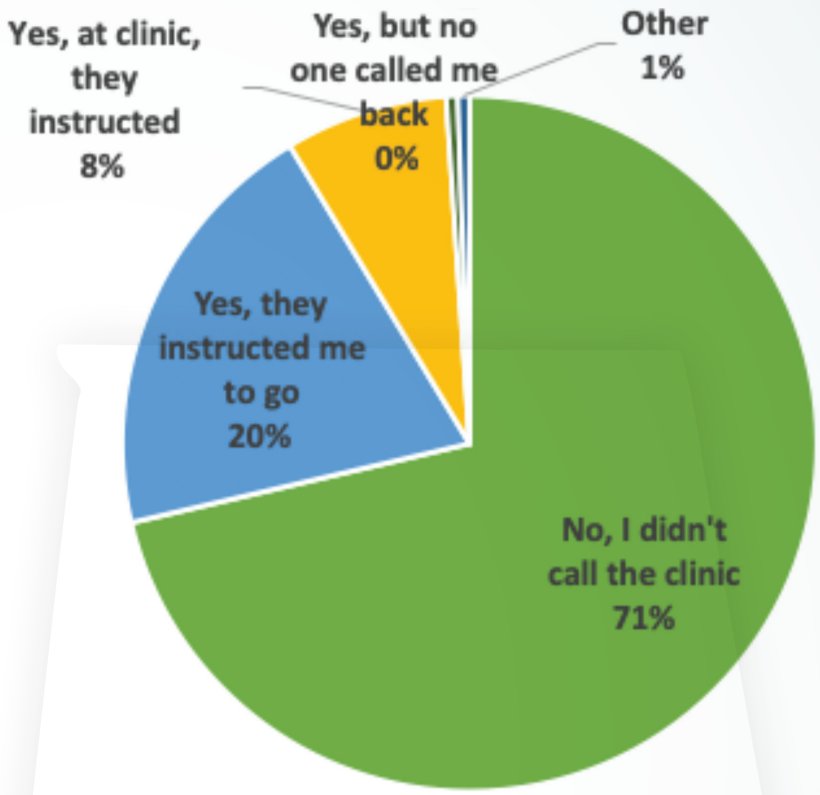
The results of the program have been very informative. In July, we surveyed 185 patients who went to the ED. **Some 46% of those visits were during office hours – that highlights an opportunity!**

KNOW YOUR ACO: Alabama Physician Network

One of the questions in the survey is, “Did you contact the clinic before going to the ED?” Out of the total respondents, 71% did not contact the clinic.

According to the same data for the 46% who went to the ED during office hours, 65% did not contact the clinic.

Our biggest challenge is also our biggest opportunity. We know that patients who did not call the clinic before going to the ED comprise the majority of ED visits, but we also know what to do to change patient behavior for the better!



We have to educate patients to address this issue. Here are some ways to do that:

- **In clinic:** You and your staff can educate patients to call the clinic before going to the ED. Talk to them about when it is appropriate to go to the ED vs. when they should come to the clinic.
- **In the ED:** Patients with a history of high utilization, chronic disease education needs, and/or social barriers are visited in the ED by the MSSP care coordinators, and they educate patients on utilization of the appropriate clinical settings.
- **After the visit:** Care guides educate patients after the visit to make sure they understand and have the contact information for both their clinic and urgent care.

Education is our starting point, but there are additional opportunities for reducing ED visits. We will explore other methods for lowering the number of unnecessary ED visits in future articles.

KNOW YOUR ACO: Alabama Physician Network

BENEFICIARY NOTIFICATIONS

CMS released new guidance on when ACO's are required to notify their beneficiaries. This, unfortunately, was designed to coincide with the newest cohort of ACOs that commenced operations on July 1, 2019. The notifications must be both in the form of a letter (physical or electronic) and in the form of a poster in each clinic of a participating provider. These communications must notify beneficiaries that:

- Their provider is participating in the Medicare Shared Savings Program.
- They have the opportunity to decline claims data sharing with our ACO – Alabama Physician Network.
- They have the ability to identify or change identification of the individual he or she designated for the purposes of voluntary alignment.

All of the new ACO's were required to comply with these requirements effective July 1, 2019 and repeat these notifications annually thereafter. All existing ACO's must have the posters in place by October 1, 2019 while the notification letters can commence January 1, 2020. We are working to comply with this regulatory requirement.

SHINGRIX VACCINE FOR SHINGLES

Two vaccines are licensed in the United States and recommended by the Advisory Committee on Immunization Practices (ACIP) to prevent shingles. Zoster vaccine live (ZVL, Zostavax) has been used since 2006. Recombinant zoster vaccine (RZV, Shingrix) has been used since 2017 and is recommended by the ACIP as the preferred shingles vaccine. Zostavax may still be used to prevent shingles in healthy adults age 60 and older. For example, you could use Zostavax if a person is allergic to Shingrix, prefers Zostavax, or requests immediate vaccination and Shingrix is not available.

The CDC recommends Shingrix (recombinant zoster vaccine) over Zostavax® (zoster vaccine live) for the prevention of herpes zoster (shingles) and related complications. It recommends two doses of Shingrix separated by 2-6 months for immunocompetent adults age 50 and older:

- Whether or not they report a prior episode of herpes zoster.
- Whether or not they report a prior dose of Zostavax.
- Who have chronic medical conditions (e.g., chronic renal failure, diabetes mellitus, rheumatoid arthritis, chronic pulmonary disease), unless a contraindication or precaution exists. Similar to Zostavax, Shingrix may be used for adults who:
  - Are taking low-dose immunosuppressive therapy.
  - Anticipate immunosuppression.
  - Have recovered from an immunocompromising illness.

- Who are getting other adult vaccines in the same doctor's visit, including those routinely recommended for adults age 50 and older, such as influenza and pneumococcal vaccines. The safety and efficacy of concomitant administration of two adjuvanted vaccines, such as Shingrix and Fluad, have not been evaluated.
- It is not necessary to screen, either verbally or by laboratory serology, for evidence of prior varicella infection.

Zostavax may still be used to prevent shingles in healthy adults age 60 and older.

Providers should know that Medicare does not cover this service under the Part A or Part B benefits. Medicare only provides coverage benefits for influenza, pneumococcal, and hepatitis B vaccinations. Therefore, patients should be given prescriptions for Shingrix or Zostavax, so they can make good decisions based on their pharmacy benefits that may or may not provide coverage. Pharmacies can give the patients cost information prior to receipt of the vaccine. If you give the vaccine in your office, be aware that patients likely will be billed for the full charge as a non-covered service.

SUCCESS STORIES

- 87-year-old female with type 2 diabetes, HTN, Stage V CKD, dementia. Patient had 2 ED visits and an inpatient admission in the last six months related to cognitive impairments, auditory hallucinations, and syncopal episodes. Patient and family visited in ED by MSSP care coordinator to discuss patient's current condition, recent DHR cases, family's ability to care for her, and their long-term care options. The family agrees to begin work with an inpatient social worker for SNF placement.

- 85-year-old male admitted for s/p one week lobectomy with wound infection and pleural effusion. MSSP care coordinator visited patient and his spouse while inpatient to discuss anticipated discharge needs. Weekly follow-up calls performed to discuss medication reconciliation, discharge instructions, wound care, and disease education. During the first week's follow-up call, the patient's spouse felt he needed to return to ED due to wound drainage. After discussion with the spouse, a call was made to the home health care nurse for wound evaluation. ED follow-up was not warranted, and the spouse felt better about the situation.

- UAB partnered with the Birmingham Fire & Rescue Service to create the Community Assistance, Referral & Education Services (CARES) program. It targets our frequent ED utilizers in a payer-agnostic fashion by providing home visits for safety, follow-up on discharge instructions, and education. We have defined frequent ED utilization as three or more visits to the ED in a rolling 30-calendar-day period. To qualify, the patient must live within the Birmingham Fire & Rescue service area, which is the Birmingham city limits. ACO patients who were enrolled in this program had a decrease from 10 to 3 visits. We look forward to additional success with this program in the future.