Annual Wellness Visits

Lessons learned in implementation and outreach for virtual visits

November 10, 2021
2 PM

Agenda

1. Housekeeping and Introductions
2. Presentations:
    - Virtual Annual Wellness Visits – UNC Health Alliance
    - AWV Virtual Experience - Richmond Quality ACO
    - Annual Wellness – Keystone ACO
        - Lessons Learned Through Behavioral Insights
3. Audience Q&A and follow-up

Housekeeping

NAACOS
National Association of ACOs

1. Speakers will present for around 45 minutes

2. Q&A will take the remainder of the time
   - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
   - During the Q&A session, you can use the “raise hand” feature on your dashboard to ask a live question.
3. Webinar is being recorded
   - Slides and recording will be available on the NAACOS website within 24 hours. You will receive an email when they are available.

Speakers

Stephanie Turner

Stephanie is the Healthcare System Vice President of Population Health Clinical and Support Services for UNC Health Alliance. Ms. Turner directed the expansion and transformation of UNC's embedded and centralized care management teams delivering care within ambulatory and independent practices affiliated with UNC Health Alliance. Over the past several years, her team has exceeded targets for reducing patient utilization through a variety of interventions including complex case management of the highest risk patients, a robust transitional case management program, and comprehensive care coordination services such as annual preventive visits, implementation of an integrated behavioral health model, and nutrition therapy services in primary care practices. Ms. Turner has co led a number of system wide projects including Advance Care Planning and Transitions of Care expansion. Ms. Turner earned both a Bachelor of Nursing with honors and a Master of Nursing from the University of North Carolina at Chapel Hill.

Jennifer Lui

Jennifer is the Healthcare System Director of Population Health Clinical Services for UNC Health Alliance. Ms. Lui expanded annual wellness visits, behavioral health counseling, nutritional counseling and Optometrist access and services within primary care practices. At the onset of COVID 19 she served as the Interim Executive Director of Virtual Care and was pivotal in launching virtual workflows to ensure seamless patient care. Throughout the pandemic, she redeployed many embedded care management staff to COVID 19 strategies. Ms. Lui earned a Master of Social Work and has previous experience at Blue Shield of California and Providence St Joseph Health at West Coast

Speakers

	Dr. Marianne Labarbera, MD Dr. Marianne LaBarbera is a board-certified family physician. She is the chair of the Richmond County Quality ACO and Director of Population Health at Richmond University Medical Center. After 28 years in private practice, Dr. LaBarbera joined Richmond Health Network multi-specialty group practice on Staten Island. Dr LaBarbera was President of the New York State Academy of Family Physicians and served as NY delegate to the American Academy of Family Physicians for many years.
	Jasmin A. Eversley- Danso, MS, LSSMBB Jasmin serves as the Director of Network Population Health & Clinical Informatics for the Richmond Quality ACO and Richmond Health Network in Staten Island, NY. In this role, she oversees the MSSP ACO, DSRIP/PHIP Programs, several Value Based contracts with payers, as well as all Clinical & Population Health Informatics for the network. Under her leadership, a team of nurses, analysts, and health navigators work to integrate care coordination and population health strategies within the network and community practices.
	Kaitlyn Huttman Kaitlyn is the Senior Clinical Practice Transformation Coordinator for the Keystone ACO. She serves as lead between the ACO and partner sites in the transformation to quality care. Kaitlyn played an active role in the Annual Wellness Visit project for Keystone ACO and continues to work with partners to increase compliance. She has 10 years' experience in SNF and ACO environment.

UNC HEALTH ALLIANCE
UNC HEALTH CARE

Virtual Annual Wellness Visit

Stephanie Turner, RN, MSN, FNP
Vice President, Population Health Services & Clinical Operations

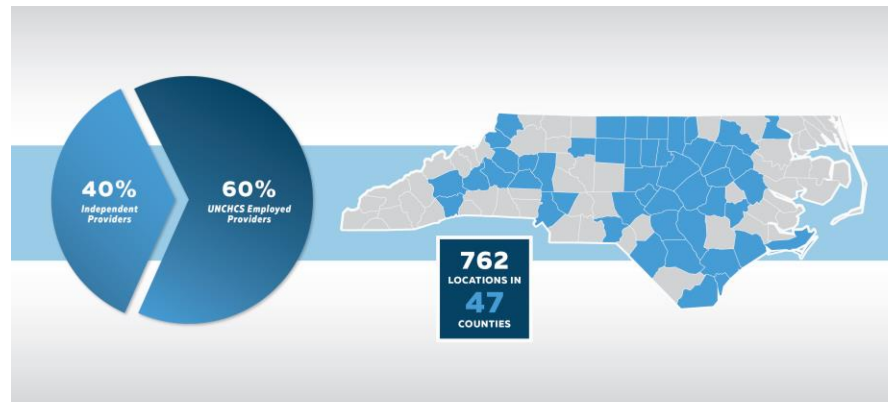
Jennifer Y. Lui, MSW, LCSW
System Director, Population Health Clinical Services – Embedded Care Management

11/10/2021

UNC HEALTH℠

UNC Health Alliance: Built on a High Value Network, Strong Foundation of Population Health Services, and Strategic Growth of Value Portfolio

UNC Health Alliance is UNC Health's statewide, physician-led, clinically integrated network and Population Health Services Organization. We are transforming healthcare delivery and payment models on behalf of more than 7,000 providers, including community-based, independent physicians along with those affiliated with UNC Health.



System-wide commitment to build population health infrastructure to support enhanced care for patients and providers

Entered into first payer arrangement for commercial and government populations, and launch journey into alternative payment models and new care delivery pathways

Strategic growth of value portfolio to include Blue Premier, the largest commercial alternative payment model in North Carolina

POPULATION HEALTH SERVICES
Clinical Services • FY21 Summary

UNC HEALTH ALLIANCE
UNC HEALTH CARE

AMBULATORY COMPLEX CASE MANAGEMENT

EXTENDED CASE MANAGEMENT

7,698 Patient served

22.79% Reduction in NGACO ED/1000 utilization

5.68% Reduction in NGACO inpatient admissions/1000

NGACO all cause readmission rate was **below the goal of 14%**

The Patient Is The Center Of Care

SHORT TRANSITIONAL CASE MANAGEMENT

30,749 Successful outreaches

For patients that were successfully contacted within 2 business days post-discharge:

13.1% Jun '21 ED rate

10.8% Jun '21 readmission rate

MEDICATION ADHERENCE

1,509 Attempted medication adherence outreaches

19 Referrals to CAMP

77 Provider contacts to help with any issues

LOCAL EMBEDDED CARE TEAM

NUTRITION SERVICES

RDs PROVIDE:

- Diabetes comprehensive care
- Goal setting
- Diabetes self-management education
- Care Coordination
- Weight management
- Medical nutrition therapy

3,524 Patients served

16,003 Services provided

4,439 Virtual nutrition visits provided

OUTCOMES

PATIENTS WITH DIABETES SEEN BY REGISTERED DIETITIANS:

- 90% Nephropathy screening completed vs. 77% Nephropathy screening completed in PCIC clinics
- 79% A1c<9% vs. 62% A1c<9% of patients seen in PCIC clinics

*Patients seen by a PHS RD have **higher compliance** across the above measures as compared to all patients in PCIC clinics*

CARE MANAGEMENT

12,211 Behavioral health services provided, virtual & face-to-face

2,906 Advance Care Planning completed

11,933 Annual Wellness Visits completed

RNs & LCSWs PROVIDE:

- Annual Wellness Visits
- Advance Care Planning
- Care coordination
- Behavioral health services by LCSWs

OUTCOMES

PATIENTS SEEN BY CARE MANAGERS:

- 85% Compliant on Colorectal Cancer Screening
- 82% Compliant on Breast Cancer Screening
- 85% Pneumo 65+
- 86% Depression Screening

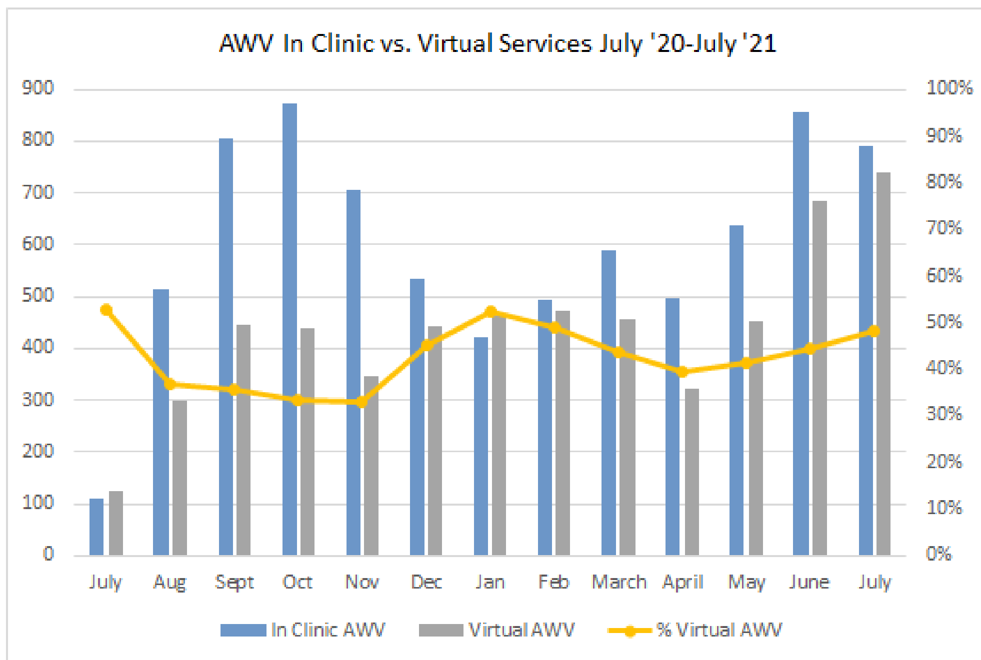
*Patients seen by a PHS Care Manager have **higher compliance** across the above measures as compared to all patients in PCIC clinics*

14,708 Patients served

27,359 Services provided

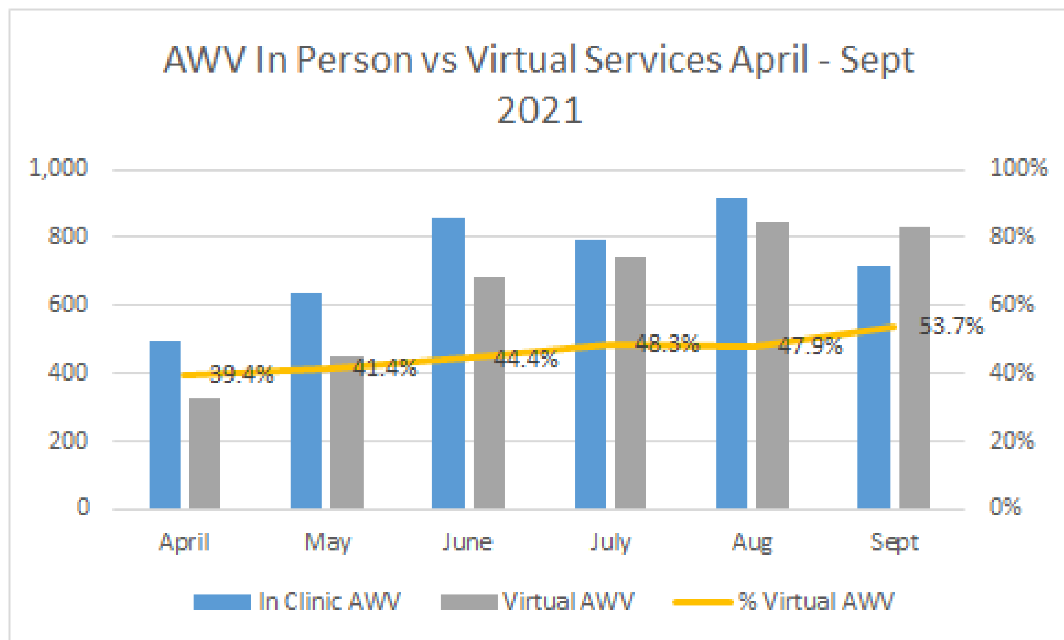
Annual Wellness Visits (AWV) - 12 Rolling Months View

On average, 42% (~ 437 per month) of Annual Virtual Visits (AWV) are now conducted virtually!



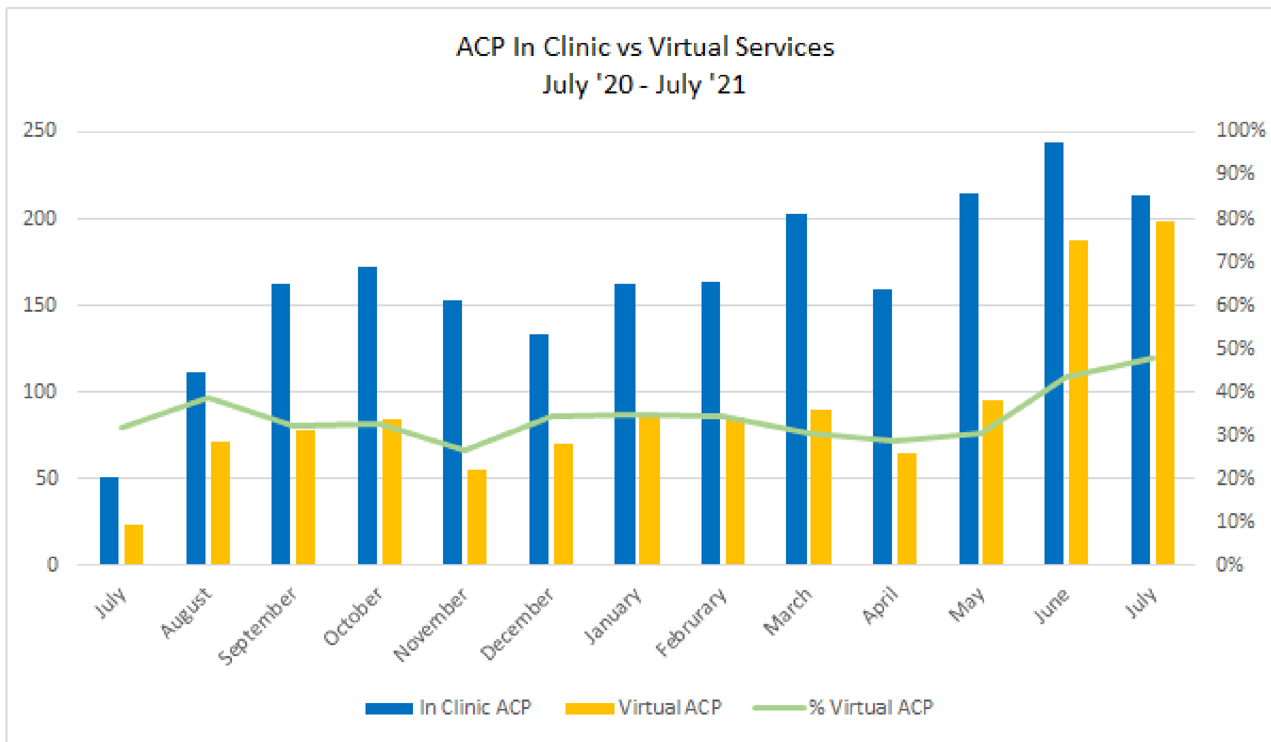
Annual Wellness Visits (AWV) - 6 Months View

Average 47% (~ 644 per month) of Annual Virtual Visits (AWV) are now conducted virtually!



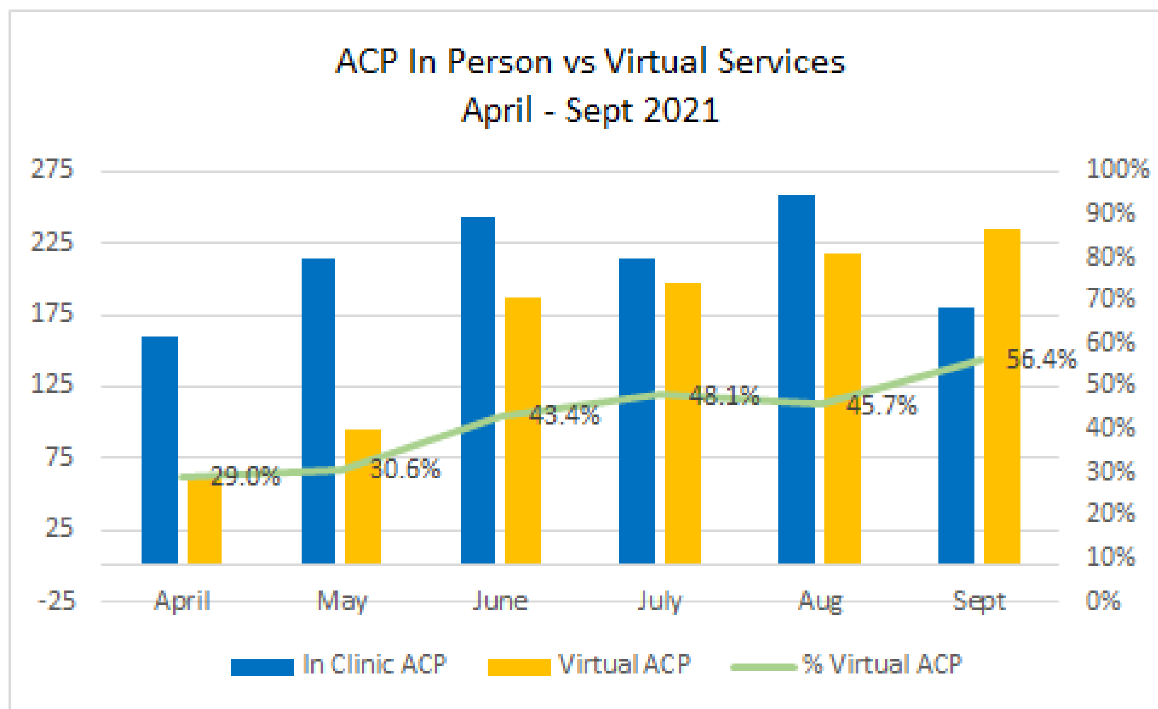
Advance Care Planning (ACP) - 12 Rolling Months View

Average 35% (~91 per month) of Advance Care Planning are now conducted virtually!



Advance Care Planning (ACP) - 6 Months View

Average 42% (~166 per month) of Advance Care Planning are now conducted virtually!



Benefit of having ACP with AWV

Educate, Communicate, and Document Patient Wishes

- ACP is a natural part of the AWV conversation
  - ACP is reviewed in *every* AWV; ACP billed when minimum time threshold is met
- No additional co-pays
- Incorporates ACP documentation in EHR
  - Opportunity to complete or update current ACP preferences and *document*
- ACP education and importance
- Resources provided to patients
- Questions answered about ACP process

Virtual AWV Implementation Experience (1 of 3)

Investigation into Virtual AWV Requirements

- **CMS guidance was vague for virtual AWV and did not address specifics such as:**
  - Vital sign requirement when patients do not have needed equipment to test
    - Initial CMS guidance: If patient unable to provide vital signs, virtual visit could not proceed
    - Subsequent CMS guidance: In the absence of vital signs, clinician to document why vital signs could not be obtained and visit could proceed
  - Screenings difficult to perform without visualization
    - Falls Screening - CDC Fall Risk Tool for phone visits or if ambulation unsafe during video visit
    - Objective measure of cognitive function (i.e., clock drawing for mini-Cog) - Short IQCODE if a phone visit and family or friend present

Virtual AWV Implementation Experience (2 of 3)

Engagement with System Stakeholders

- **EMR technology team:**
  - Created AWV visit types with access to AWV documentation flow sheets
  - Created schedule templates that optimized both virtual and in-clinic visit types
- **Compliance and Revenue teams:**
  - Ensured appropriate billing, coding, and modifiers for virtual visits
  - Proposed clear documentation to identify virtual vs in-clinic visit
- **Clinical support services team:**
  - Developed scripting specifics for virtual visits
  - Identified technology requirements for patients to complete video visit vs phone visit
  - Provided guidance on how to prepare patients for visit; obtain/provide vital signs, have paper, pencil/pen, and medications/OTCs handy
  - Created back up plans for technology failure
    - Video capture not working – convert to a phone visit
    - Inability to access AWV documentation flowsheets – work around to access and document

Virtual AWV Implementation Experience (3 of 3)

Engagement with Clinicians and Practices

- **Population Health Embedded Care Management Leaders:**
  - Collaborated with care managers, practice staff, and providers to determine escalation protocols for medical/behavioral health concerns during a virtual visit
  - Explored existing virtual visit standard work to modify for AWV workflows
  - Updated AWV standard work and checklists to include virtual visit components and requirements
  - Trained care managers on details of virtual AWV
  - Implemented virtual AWV visits slowly and met with care managers daily to trouble shoot issues/answer questions

Virtual AWV Patient Experience

Patient Centered, Increased Access to Care

- **COVID-19 and patient reception to virtual AWV:**
  - Fearful and nervous about COVID exposure
    - "I don't want to go out if I don’t have to!“
    - “My kids don't want me to go out!"
  - Feelings of isolation are common; virtual AWV allows social interaction for older populations
  - Older adults embraced FaceTime to bond with their family and friends; virtual connections thus more familiar
  - Patients are relaxed and tend to share more with HCP
  - Adult children more likely to participate
  - Patients feel connected to their doctor’s office
  - Benefits patients who have mobility issues and/or lack of transportation
- **As COVID-19 PHE diminishes many patients may still benefit from a virtual AWV**
  - Transportation, mobility, family care issues
  - Convenient and flexible

Lessons Learned

Knowledge Transfer and Learnings

- Align with existing virtual workflows to reduce re-work
- Be flexible if technology fails-use all tools available!
- Ensure virtual AWV appointment types are built to pull in specific components/requirements for AWV
  - AWV Express Lane at UNC (EPIC specific)
- The doctor is not next to you! Ensure clear communication pathways are set up for escalations (e.g., elevated blood pressure)
- Virtual AWV captured patients lost to care:
  - Wellness and preventative appointments were missed during COVID-19
  - Virtual AWV enabled access to routine visits
  - Allowed for patient education about COVID-19 vaccines, booster shots, flu vaccines, etc.
- Virtual visits usually run-on time and clinician can see the same number of patients as in person

Planning Ahead

Future State Virtual Presence

- Watching for adjustments to virtual care reimbursement as COVID-19 PHE expires
- UNC HA is committed to virtual services to promote patient access and enhance patient experience
  - Launched virtual Embedded Care Management (vECM) in July 2021 as long-term strategy
    - Services include AWV/ACP, Behavioral Health, Nutrition Services, and Care Management
    - Increases access to multidisciplinary services for smaller and newly acquired practices across UNC CINs

Thank you

RICHMOND QUALITY, LLC
RUMC AMBULATORY HEALTH NETWORK

DR. MARIANNE LABARBERA
CHIEF OF AMBULATORY POPULATION HEALTH/FAMILY MEDICINE PHYSICIAN

JASMIN EVERSLEY-DANSO, MS, LSSMBB
DIRECTOR, AMBULATORY POPULATION HEALTH & CLINICAL INFORMATICS

Bio - *Dr. Marianne LaBarbera*

Dr. Marianne LaBarbera is a board certified family physician. She is the chair of the Richmond County Quality ACO and Director of Population Health at Richmond University Medical Center. After 28 years in private practice, Dr. LaBarbera joined Richmond Health Network multi-specialty group practice on Staten Island. Dr LaBarbera was President of the New York State Academy of Family Physicians and served as NY delegate to the American Academy of Family Physicians for many years. Dr.LaBarbera is a tireless advocate for completing annual wellness visits by assisting her colleagues in utilizing a systematic and streamlined approach to identifying patient concerns and completing quality metrics which translate into more complete and comprehensive care of our Medicare patients.

RQ Richmond Quality, LLC

Bio – *Jasmin Eversley-Danso, MS*

Jasmin Eversley - Danso, MS, serves as the Director of Network Population Health & Clinical Informatics for the Richmond Quality ACO and Richmond Health Network in Staten Island, NY. In this role, she oversees the MSSP ACO, DSRIP/PHIP Programs, several Value Based contracts with payers, as well as all Clinical & Population Health Informatics for the network. Under her leadership, a team of nurses, analysts, and health navigators work to integrate care coordination and population health strategies within the network and community practices.

RQ Richmond Quality, LLC

Richmond Quality ACO

- Sponsored by Richmond University Medical Center in Staten Island NY
- Started in CMS MSSP Track 1 in 2015
- Currently serving over 6,000 Medicare beneficiaries across Staten Island

RQ Richmond Quality, LLC

Richmond Quality ACO

- Track 1- Medicare Shared Savings (MSSP), Started in 2015
- Third year (extension) of our second contract period (2018 Renewal)
- ACO state(s): Staten Island, NY
- Service area: Urban and Suburban
- Practice Led , Hospital Sponsored. [Employed vs. Voluntary Community Physicians]
- Number of practitioners: 57 providers (MD's, Dos, NPs, Pas)
- Number of assigned beneficiaries: 6,292
- 12 EHR platforms used

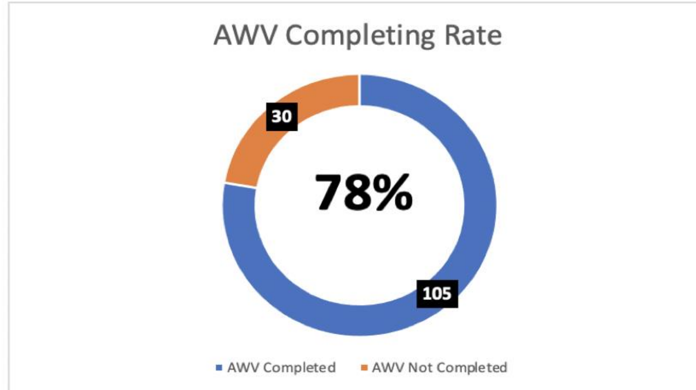
Richmond Quality, LLC

Physician Education:
IPPE vs. Physical vs. AWV

Welcome to Medicare Visit (once)	Physical Exam	AWV (yearly - preventive)
• Preventive visit • Takes place within the first 12 months of enrolling in Medicare Part B • More of a physical exam • Only offered once	• Assessment of your body's health – if you're sick or in pain • Includes bloodwork and urine sample • Includes physical examination ; lung, head, neck, abdominal & neurological exams • More extensive than an AWV	• Checks routine measurements such as height, weight, blood pressure • Create or update a personalized prevention plan • Detection of any cognitive impairment • Lists risk factors • Screening schedule/checklist • Advance care planning

Richmond Quality, LLC

Physician Engagement



YTD Progress

Metric	Num	Den	Perentage
Breast Cancer Screening	36	37	97%
Colorectal Screening	42	56	75%
Depression Screening	75	75	100%
Depression Counseling	1	1	100%
Diabetes Mellitus (A1C)	27	30	90%
Fall Screening	82	83	99%
HTN	60	64	94%
Influenza Vaccine	72	73	99%
Tobacco Screening	85	86	99%
Tobacco Counseling	7	7	100%

- Monthly e-mails sent to provider and practice manager with performance directly embedded in the body of the e-mail.
- Key senior leadership is copied for full transparency
- Monthly lists of those patients who are due for an AWV sorted by due date are sent to each office.
- Reminders at Quarterly meetings with un-blinded results displayed

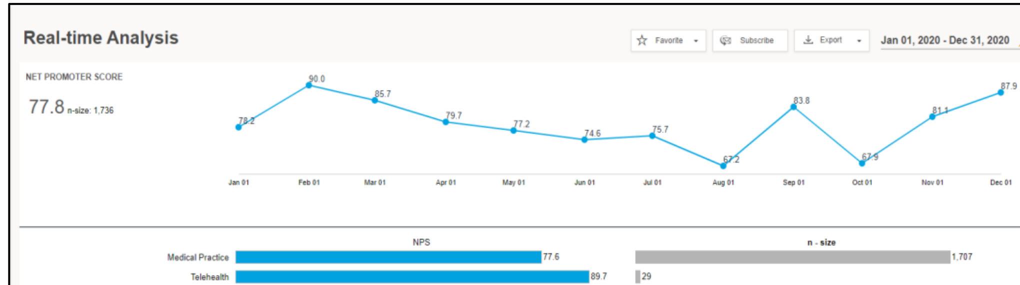
Patient Experience & Engagement

Patient Engagement

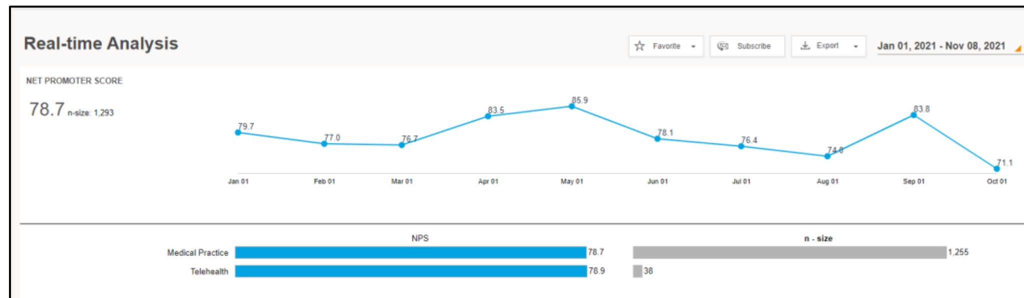
- Engaged Patients through:
  - EMR e-mail campaigns/ Patient Portal Messages
  - E-mail campaigns through Constant Contact
  - Phone Calls from the office staff
  - Phone calls from the RN Care managers

Patient Experience & Engagement

2020 Patient Experience
Office vs. Telehealth



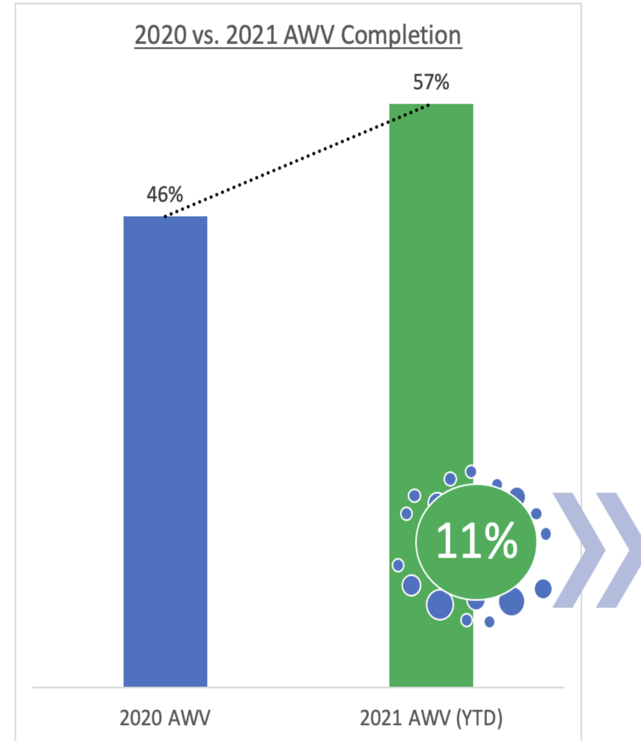
2021YTD



Richmond Quality, LLC

Richmond Quality AWV Statistics

- Thus far, we are seeing an 11% increase in AWVs between 2020 to 2021.
- Can be attributed to the promotion of the completion of virtual visits
- Active campaign to contact patients directly to come in for the visit.



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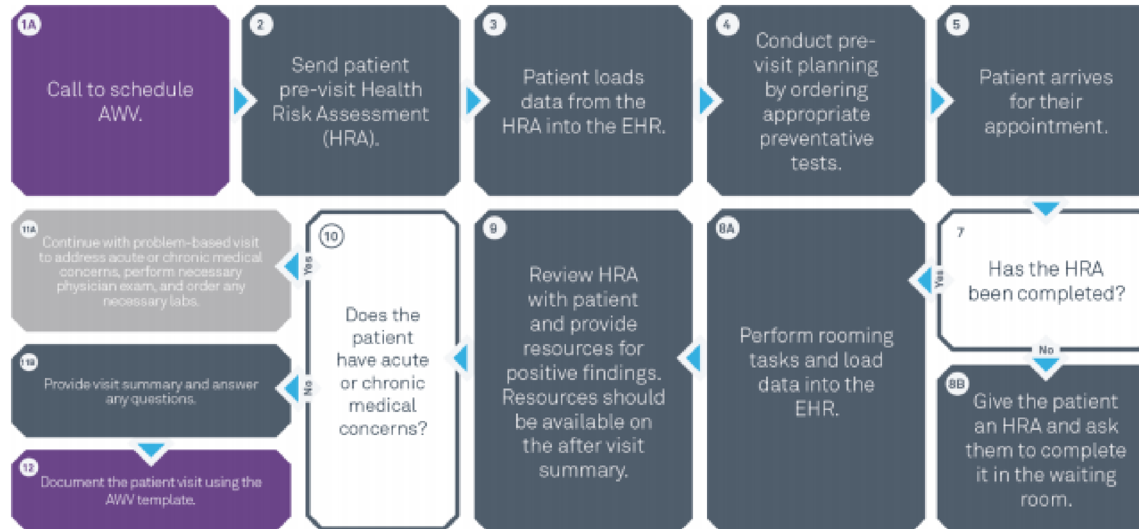
Using Telehealth to complete AWVs



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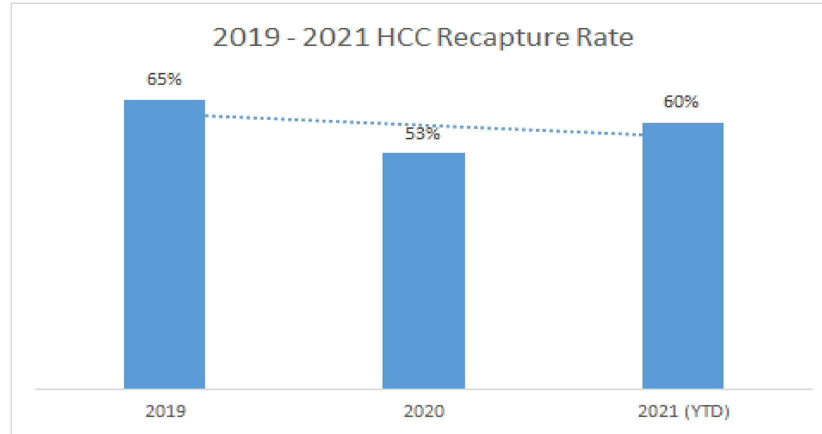
Improving HCC Coding via AWV Telehealth



Strategy:

- 2019 Aggressive strategy vs. 2020 COVID dip
- Use population health software to identify HCC codes that are presently open
- Use as a point of care tool for doctors to code during their in person or virtual visit
- Monitor closure of codes on a weekly basis

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Using Technology & Data

- In the beginning of the Pandemic we relied heavily on the data available to us to re-pivot our care management strategy
- We used our population health platform to identify high risk patients that would be severely impacted by COVID if contracted. Our RN care managers began to reach out to these patients to ensure they had everything needed for their current chronic conditions
- During this time we also identified those due for screenings and closed those gaps thru telehealth visits

Richmond Quality, LLC

Lessons Learned: Continuing beyond the PHE

- Patients are consumers and have adjusted to digital forms of care delivery
- Providers appreciate the ease of being able to complete more visits by using a combination of in person and virtual methods.
- Provider and Patient engagement is key in increasing performance
- Importance of strong nursing Care Management to fill clinical voids
- Continue to improve technology NOW that will assist

Questions?

Thank you!

Contact Information:

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Annual Wellness

Lessons Learned Through Behavioral Insights

Kaitlyn Huttman
Senior Clinical Practice Transformation Coordinator

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Geisinger

Everything we do is about caring

We care for patients.

- **10** hospital campuses
- **130** clinic sites
- **24,000** employees
- **1,800** employed physicians

We provide quality, affordable healthcare coverage.

- **More than 600,000** risk lives managed
- **48,000** contracted providers in network
- **130+** hospitals in network

We teach, research and innovate.

- **More than 600,000** risk lives managed
- **48,000** contracted providers in network
- **130+** hospitals in network

Who We Are

- Keystone Accountable Care Organization, LLC, is a collaboration between four health care systems and sponsored participants that serves Central and Northeastern PA
  - Geisinger Clinic
  - Evangelical Community Hospital
  - Wayne Memorial Hospital
  - The Wright Center for Graduate Medical Education

20 TINS

7 EMRs

70,000+ Beneficiaries

4,000+ Providers

Keystone ACO

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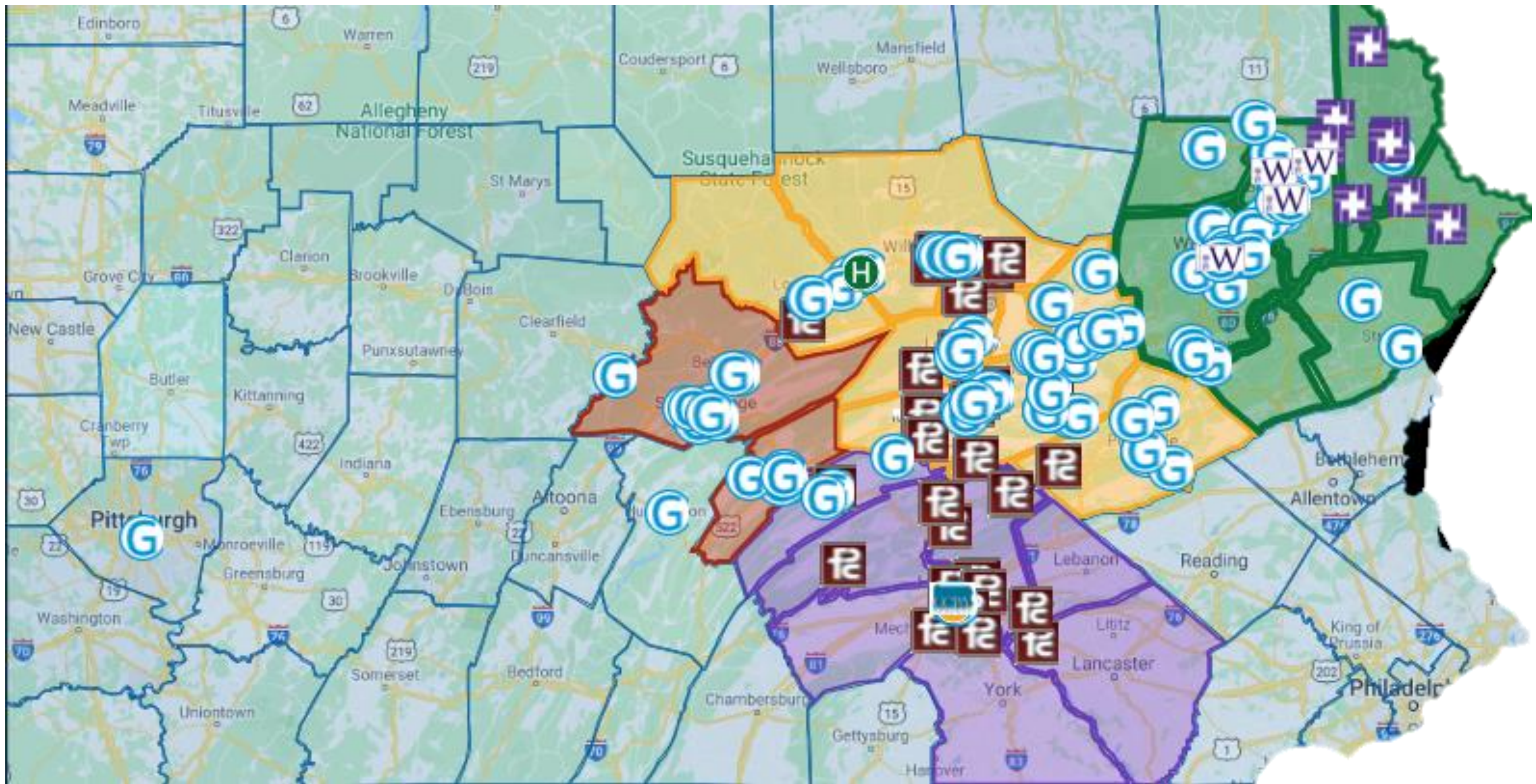

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Annual Wellness Visit

The purpose of the Medicare annual wellness exam is to develop or update your **personalized prevention plan** and perform a **health risk assessment**

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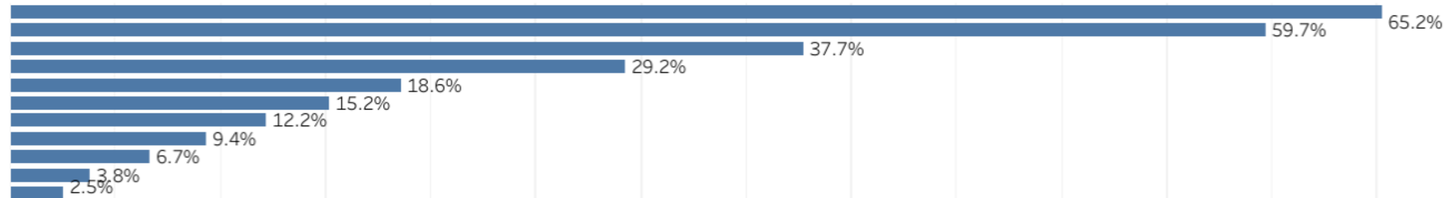
Source: Medicare.gov

Starting State

Use Available Analytics

23.4%	18,389	22,404	37,679	$6.01M
AWV Completion %	Completed AWV	Outreach - Due for AWV	Outreach - Never had AWV	AWV Opportunity



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Why Do AWVs?

- Improved Patient Outcomes
- Promote Preventive Care
- Decrease Cost of Care
- Revenue Opportunity
- Alignment of Beneficiaries
- HCC & Chronic Care Management

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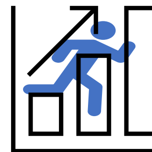
Increasing Compliance

Implementation plans may vary by ACO partner organization – Be Flexible

Beneficiary engagement – Direct contact vs targeted mailing

Creating an Education Plan for Providers



Continuous auditing

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Behavioral Insights Study

Direct Mailing

Schedule a free wellness visit to detect and prevent disease early.

Keystone ACO

Schedule a free wellness visit to detect and prevent disease early.

Keystone ACO

Schedule a free wellness visit to detect and prevent disease early.

©Marty Bucella www.martybucella.com

"Your heart, blood pressure and cholesteral are fine, but I don't like the look of those trousers."

Keystone ACO

As a Medicare beneficiary, you're eligible for a free annual wellness visit. These visits can help detect disease early so you and your doctor can take steps to keep you healthy — and possibly prevent symptoms from ever occurring. That's why it's important to schedule a visit even if you're healthy.

If you'd rather not travel to the office for your appointment, you may be able to schedule a video visit with your provider.

Call 866-230-6465 to find out more.

Keystone ACO

100 N. Academy Ave.
Danville, PA 17822-5020

Patient Population

Partner	A	B	C	D	E	F	G	H	SUM
no_contact	232	250	5348	337	410	351	1485	107	8520
nontelehealth_cartoon	232	251	5347	338	410	351	1485	107	8521
nontelehealth_photo	232	250	5348	337	409	351	1485	107	8519
phone_call	0	250	0	0	0	0	1485	107	1842
telehealth_cartoon	232	250	5348	338	410	350	0	107	7035
telehealth_photo	233	250	5348	337	409	351	0	107	7035
Sum	1161	1501	26739	1687	2048	1754	5940	642	41472

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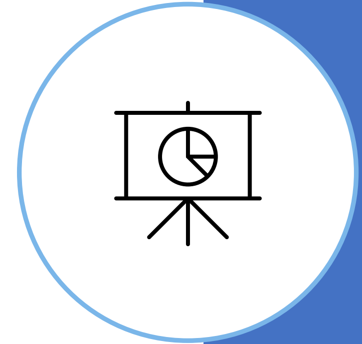
Outcomes & Lessons Learned

- Sending a postcard did **not** significantly increase appts booked.
  - Booking/completion rate did not differ among postcard types.
- Making a phone call **increased** the number of appts booked.
- Education, communication, and scripting all lead to better outcomes.
- Patients were more willing to complete and AWV if in conjunction with another appointment.



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Thank You

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Questions

Please raise you hand or place your questions in the chat. If you have questions are not answered during the live session or think of additional question you can email them to mdholsomback@naacos.com

NAACOS Resources

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AWV

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All words Any words Exact Phrase

AWV

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13 Search Results for Keyword: **AWV**

Results Per Page: 20 | Order Search Results By: Newest First

Search Only: Pages

Final NAACOS Comments on Proposed 2021 MPFS Rule

... 99495, 99496); cognitive impairment assessment and care planning (CPT code 99483); certain end-stage renal disease (ESRD) services (CPT codes 90951 through 90970); and the annual wellness visit (AWV) and ...

Quick Links

Let Your Voice be Heard!

Value Act Reintroduced

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Next Gen Saves $635M

Upcoming Events

No events

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Latest News

October

Seeking ACOs –

Annual Wellness Visits (AWV) versus GRACE-Augmented Annual Wellness Visits for Medicare ACO Beneficiaries with Complex Medical and Social Needs

- **What?** PCORI proposal to compare a structured AWV with an AWV augmented with in-home assessment and support services (GRACE model).
- **Outcomes?** Days at home, ED visits and inpatient stays.
- **Benefits?** Standardized AWV protocol, training and support in the GRACE model; financial support to off-set costs of participation, including funds for a part time site study coordinator.
- **What we ask of you?** Randomize practices; collecting patient reported outcomes, tracking home-based services, and possibly sharing claims data to monitor outcomes.
- **Interested in learning more?** Please contact Jennifer Perloff from the Institute for Accountable Care (Perloff@brandeis.edu).