AWV Learning Lab

November 16, 2023
2:00 pm to 3:30 pm ET

Staff Facilitators

Melody Danko-Holsomback, Vice President of Education, NAACOS

Melody Danko-Holsomback, MSN, CRNP is the Vice President of Education for NAACOS. She has over 12 years of population health experience and was the CAO and Director of Keystone ACO prior to her current role. She has over 30 years of experience in nursing, including positions in outpatient and inpatient care, as a CRNP healthcare provider and as an IT analysts and performance consultant.

mdholsomback@naacos.com

Emily Perron, Education Manager

Emily is the education coordinator at NAACOS where she works directly with the director of operations on tasks related to the day-to-day running of the organization and with the vice president of education on the boot camp and the two annual conferences along with overseeing marketing and registration. Before starting at NAACOS, she previously worked at Police and Firemen's Insurance Association (PFIA) in new business where she handled all incoming new life and disability insurance plans. While at PFIA, she obtained two Life Office Management Association (LOMA) certificates. She received her bachelors of science in elementary education from Liberty University.

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Learning Lab Documents

- Agenda
- Learning Lab Note Template – used to add takeaway information for future use
- Presentations by Member ACOs
- Meeting recordings and documents found on Learning Lab under Education & Events on the NAACOS website.

Housekeeping Items

- The learning lab is meant to be a classroom type of setting
- We request that participants be on camera whenever possible. This helps keep you engaged in the meeting material and place faces with names of participants.
- Questions are not only welcomed, but they are also imperative to enhance everyone's learning experience.
- We may call on you at any time for your opinion on the current topic of discussion
- Please mute your microphone when not speaking and unmute when speaking.
- Please add your First and Last Name to Zoom.

Agenda

AGENDA

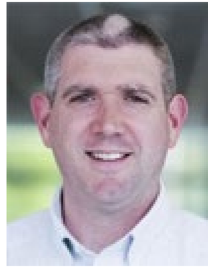
Annual Wellness Visit (AWV)
Learning Lab Virtual Series

November 16, 2023
2:00 pm – 3:30 pm

Location: Zoom Meeting **Sent to participants**

		Speakers
2:00 pm – 2:10 pm	Learning Lab Opening Introduction	Melody Danko-Holsomback, NAACOS
2:15 pm – 3:15pm	The Medicare Annual Wellness Visit The LVHN Experience	Dr. Kevin McNeill, Associate Medical Director LVHN ACO
	Walkthrough of the AWV Documentation and Considerations	CarolAnn Hudson, RN AVP, Clinical & Quality Operations, Population Health, Lifepoint Health
3:15pm – 3:25 pm	Q and A	Attendee participation
3:25 pm - 3:30 pm	Adjourn	Melody Danko-Holsomback

Introductions



Kevin McNeill, MD, Associate Medical Director LVHN ACO

Kevin McNeill, MD is an associate medical director for the Lehigh Valley Accountable Care Organization as well as the Lehigh Valley Physician Hospital Organization (LVPHO). His work with the ACO includes serving as the chair of the quality committee and assisting with operations and strategy for the MSSP population. His work with the LVPHO includes outreach and support of clinician members on population health and value-based care performance. He is a practicing family physician, faculty member of the Lehigh Valley Physician Group (LVPG) Family Medicine Residency Program and assistant clinical professor for the USF Morsani College of Medicine SELECT Program. Dr. McNeill received his MD from UMDNJ-New Jersey Medical School and completed his family medicine residency at Overlook Hospital in Summit, New Jersey.

CarolAnn Hudson, RN, AVP, Clinical & Quality Operations, Population Health, Lifepoint Health

Carol Ann Hudson is a Registered Nurse with over 30 years of experience in Informatics, Regulatory Programs, Nursing and Practice Management. She is currently employed as the Clinical Director of Population Health at Lifepoint Health. The Population Health team is responsible for Lifepoint's portfolio of Accountable Care Organizations and Clinically Integrated Networks, along with other value-based initiatives. Carol Ann brings her clinical experience to the team to help the networks, facilities and providers improve clinical health outcomes of their assigned patient populations by promoting quality, care coordination, and patient engagement. She has also assumed the primary role in projects to aid providers in risk capture spending time in the practices with a CDI team and assisting in educational presentations. Lifepoint's networks were the first to report CQM/eCQM's to CMS utilizing a registry to consolidate clinical quality data from multiple EHR's for performance year 2021.

The Medicare Annual Wellness Visit The LVHN Experience

Kevin McNeill MD

Associate Medical Director LVHN ACO

WHO WE ARE

LEHIGH VALLEY HEALTH NETWORK

- 13 HOSPITAL CAMPUSES
- 5 INSTITUTES
- 1 CHILDREN'S HOSPITAL
- 300+ PRACTICE LOCATIONS
- 9 COMMUNITY CLINICS
- 28 HEALTH CENTERS
- 20 EXPRESSCARE LOCATIONS
- 2 CHILDREN'S EXPRESSCARE LOCATIONS
- 55 REHABILITATION LOCATIONS
- 80+ TESTING AND IMAGING LOCATIONS
- 20,300+ EMPLOYEES
- 1,600+ PHYSICIANS
- 850+ ADVANCED PRACTICE CLINICIANS
- 3,700+ REGISTERED NURSES
- 72,800 ACUTE ADMISSIONS
- 235,500 ED VISITS
- 1,700+ LICENSED BEDS
- 5-TIME MAGNET® HOSPITAL

LVHN ACO's MSSP

- **ACO Mission-**To foster a collaborative delivery of patient centered, high-value care to support individuals and groups in the achievement of better health and well-being
- **ACO Vision-** To elevate the health and well-being of our beneficiaries and the communities we serve
- Set up as a distinct legal entity (LLC)
- ~40,000 Medicare fee-for-service beneficiaries, attributed for 2023
- Founded in 2014, started program in 2015

Agreement Period 1 (2015-2017)

- Track 1 (upside only)
- Earned Shared Savings
- Quality above average
- Philadelphia Area Wage Index (AWI) introduced

Agreement Period 2 (2018-2021)

- Track 1 (upside only)
- Newark AWI
- AWI net worth $30M per year
- MIPS increases

Agreement Period 3 (2022-2026)

- Pathways to Success BASIC Track Level E
- Second year in down-side risk
- aAPM bonus payable in 2024

A Brief History of the Medicare Annual Wellness Visit

- CMS Created this visit in 2011 to facilitate transition to value based care
- Serves as the wellness and prevention component of a long-term population health management strategy in the Medicare population
- The AWV is an evidence-based preventive service that focuses on disease prevention and management. Its purpose is to identify health risk factors and provide patients with a personalized prevention plan that promotes a healthier life.
- The majority of Medicare recipients aren't aware of the key preventive services and screenings covered by Medicare
- AWV provides a clinical and financial map for the patient, provider, and payer

Benefits

- Health
  - Enhanced use of Preventive Services
  - Identify candidates for wellness and prevention programs:
  - Early disease detection
  - Identify highest risk patients
- Quality
  - Quality Impact: Numerous MSSP, HEDIS and MIPS quality measures addressed
  - Care gap closure
  - Coding/RAF score
- Cost
  - At no cost to the beneficiary
  - Decreased cost of care
  - AWV reimbursement benefit
- Targeted screening
  - Opportunity for Advanced Care Planning
  - Opportunity for functional assessment
  - Opportunity for depression screening
  - Opportunity for cognitive assessment
  - Opportunity for assessment of substance use

Health Risk Assessment

HRA

- Demographic data
- Personal health history
- Self-assessed health status
- Psychosocial risk
  - Stress
  - Depression
  - Pain
  - PHQ-2
  - PHQ-9 if 2 is positive
  - Memory screening
- Behavioral risk
- Nutrition & Physical activity
- ADLs & IADLs

Health Risk Assessment

Time taken: 3/29/2023 0957 Responsible

Show Row Info Show Last Filed Value Show Details

Health Risk Assessment

Health Risk Assessment

Question	Options
In general, would you say your health is?	Excellent / Good / Fair / Poor
In a typical week, do you exercise?	Yes / No
Do you usually eat a diet that has at least 4 servings of fruit & vegetables, includes whole grain & fiber and avoids other than occasional servings of high fat foods?	Yes / No
How would you describe the condition of your mouth and teeth (including false teeth or dentures)?	Excellent / Good / Poor
In a typical week, how much alcohol do you drink?	None / One (if female) or two (if male) drink per day or less / More than one drink (if female) or two drinks (if male) per day
Do you always fasten your seat belt when you are in the car?	Yes / No
Do you know where to locate and properly use a first aid kit and fire extinguisher in case of an emergency?	Yes / No
In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?	Yes / No
In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?	Yes / No
Do you or any of your friends or family members have any concerns about your memory?	Yes / No
Do you have problems with your hearing?	Yes / No
During the last three months, have you leaked urine (even a small amount)?	Yes / No

NIDA Single Question Screening Test

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons (for example, because of the experience or feeling it caused)?

Fall Risk

Question	Options
Falls in last 12 months?	Two or more falls in the last 12 months / No falls within the last 12 months / Any fall with injury in the last 12 months / One fall without injury in the last 12 months

Restore | Close | Cancel | Previous | Next

Depression Screen

PHQ Depression Screen

Deeper Dive into the HRA

Mild Cognitive Impairment

Do you or any of your friends or family members have any concerns about your memory? Yes | No

Mini-Cog Assessment

Item	Options					
Word List Version	Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Clock Drawing	0=Inability or refusal to draw a clock	2=Normal clock				
Three Word Recall	0=Zero words recalled	1=One word recalled	2=Two words recalled	3=Three words recalled		
Mini Cog Score						

- Mild cognitive impairment (MCI) is significantly misdiagnosed in the primary care setting due to multi-dimensional frictions and barriers associated with evaluating individuals' cognitive performance.
- Sabbagh MN, Boada M, Borson S, Chilukuri M, Dubois B, Ingram J, Iwata A, Porsteinsson AP, Possin KL, Rabinovici GD, Vellas B, Chao S, Vergallo A, Hampel H. Early Detection of Mild Cognitive Impairment (MCI) in Primary Care. J Prev Alzheimers Dis. 2020;7(3):165-170. doi: 10.14283/jpad.2020.21. PMID: 32463069.

Fall Risk

SCORING

Chair Stand
Below Average Scores

AGE	MEN	WOMEN
60-64	< 14	< 12
65-69	< 12	< 11
70-74	< 12	< 10
75-79	< 11	< 10
80-84	< 10	< 9
85-89	< 8	< 8
90-94	< 7	< 4

A below average score indicates a risk for falls.

Fall Risk

Falls in last 12 months?

Two or more falls in the last 12 months	No falls within the last 12 months
Any fall with injury in the last 12 months	One fall without injury in the last 12 months

Fall Risk Follow Up

Number of times the patient stands in 30 seconds

Chair Stand Result

SUD Screening

- **SASQ**:How many times in the past year have you had X or more drinks in a day? (X = five for men; four for women)
- **NIDA Single Question**: "How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons (for example, because of the experience or feeling it caused)?"

The LVHN AWV Method

LVHN Program Elements

- ✓EMR Reports-Identifying Patients
- ✓Multidisciplinary leadership team
- ✓Training Primary Care Workforce
- ✓Dashboard reports/data transparency
- ✓EMR Template (point and click for 90% of the visit documentation)
- ✓Personalized Prevention Plan creation
- ✓Standardized order set: patient education, billing and coding automatic
- ✓Incentivized performance
- ✓Nurse led model
- ✓Coding education

Medicare Annual Wellness Visit (AWV):

Epic Reports and Suggested Outreach for Patients Overdue for a Wellness Visit

Epic Reports: Medicare Annual Wellness

Within Epic there are 3 reports related to Medicare Annual Wellness Visits. Two of these reports are Crystal Reports and the other is a workbench report.

Library

medicare annual | Search | Clear

Show templates | Collapse

LV Medicare Annual Wellness (Crystal)

Matching reports

- LV Medicare Annual Wellness All LVPG Crystal
  List of all LVPG Medicare patients along with their most recent "Medicare Annual Wellness" (G0402, G0438, G0439) charge dates.
- LV Medicare Annual Wellness by Login Department Crystal
  List of Medicare patients with a PCP in the users login department along with the patients' most recent "Medicare Annual Wellness" (G0402, G0438, G0439) charge dates.

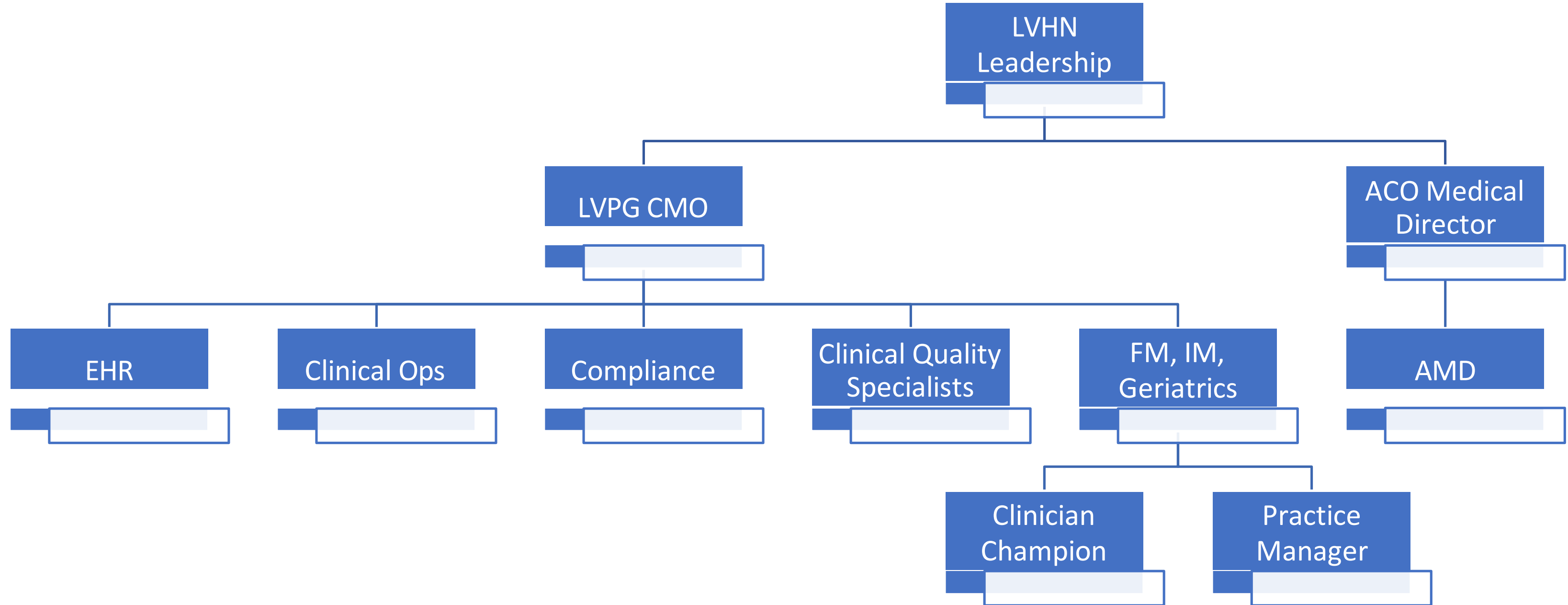
Simple Find Patients - Generic Criteria | New report

Matching reports

- LV AMB My Patients Overdue for Medicare Annual Visit | Run | Edit
  Enter the desired Health Maintenance topic on the criteria tab. This report will identify your patients that are overdue for the Health Maintenance topic you entered.

Additional reports | Details

Multidisciplinary Leadership Team



Workforce Training

Standardized Workflow

- Workflow video
- Assigning PCPs and care team members
- Scanning Advance Directives
- Clinical Staff workflow tip sheet
- Health Risk Assessment PEQ
- Update HM
- Provider ACP workflow
- Address BPAs
- Use appropriate Smart Set
  - Applicable orders based on HRA
  - LOS (billing) and Follow up from Smart Set
  - 25 modifier for E&M if applicable

Epic Tip Sheet

Medicare Annual Wellness

The following information will outline the steps necessary to complete the Medicare Annual Wellness Visits. Please click the blue hyperlinks for additional workflows/tip sheets. Also: Watch Medicare Annual Wellness Workflow Video

Try It Out

Prior to Visit:

1. Schedule for: **Welcome To Medicare Visit, Medicare Annual Wellness Visit – Initial or Medicare Annual Wellness Visit - Subsequent**
2. Provide patient (via mail or inperson) letter generated from Epic: (GEN to Patient, Welcome to Medicare).
3. Ask patient to complete that letter/form and bring to annual wellness visit. (The letter covers all 3 visits)
4. Advise patient to bring any advanced directive or living will to visit to be scanned into Epic

Front Desk Check-In

1. Update **Care Team** by right clicking on the patient in the schedule (refer to appropriate workflow for empanelment and updating PCP specialists).

*** Refer to the following tip sheet for information regarding: AssigningPCPs and Care Team Members

Dashboard Reports/Data Transparency

My Dept Preventive Health

Measure	Jan	Feb	Mar	MTD
Annual Wellness Visit - Medicare/Medicare Advantage	72.7 %	73.1 %	74.1 %	74.1 %
Adult Well Visits (45 - 64 yrs)	56.7 %	58.9 %	59.4 %	59.2 %
Colorectal Cancer Screening	69.9 %	69.9 %	70.2 %	70.0 %
Breast Cancer Screening	82.1 %	81.9 %	82.1 %	82.1 %
Cervical Cancer Screening	72.4 %	71.9 %	71.4 %	71.5 %
Influenza Vaccination Rates	57.5 %	63.1 %	67.2 %	67.6 %
Peds Influenza Vaccination Rates	32.5 %	46.1 %	56.4 %	56.8 %
Screening for Depression and Follow-Up Plan	79.1 %	80.3 %	80.6 %	80.5 %
Immunization for Adolescents	35.0 %	33.3 %	30.1 %	30.1 %

- ☑ Annual Wellness Visit - Medicare/Medicare Advantage
- ☑ Adult Well Visits (45 - 64 yrs)
- ☑ Colorectal Cancer Screening
- ☑ Breast Cancer Screening
- ☑ Cervical Cancer Screening
- ☑ Influenza Vaccination Rates
- ☑ Peds Influenza Vaccination Rates
- ☑ Screening for Depression and Follow-Up Plan
- ☑ Immunization for Adolescents

2023 ACE Value Based Measures

FAMILY MEDICINE	
1	The percentage of Medicare / Medicare Advantage patients (age ≥ 20) with an annual wellness visit in the past rolling 12 months. (CBC)
2	The percentage of patients 45–64 years of age with commercial insurance who had an ambulatory or preventative care visit during the measurement year or the two years prior to the measurement year. (HEDIS)
3	The percentage of patients 45–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, CT colonography every 5 years, FIT-DNA test every 3 years. (HEDIS)
4	The percentage of female patients, 50 through 74 years old, who had a mammogram in the last 27 months. (HEDIS)
5	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: (HEDIS) a. Women 21–64 years of age who had cervical cytology performed within the last 3 years. b. Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. c. Women 30–64 years of age who had cervical cytology / high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.
6	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. (HEDIS)
7	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Claims ONLY measure. (HEDIS)
8	The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event during the measurement year.
9	The percentage of children, 3–17 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test in the seven-day period from three days prior through three days after the diagnosis of pharyngitis. (HEDIS)
10	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.
11	The percentage of women 16–24 years of age who are identified as sexually active and who had at least one test for chlamydia during the measurement year. (HEDIS)
12	The percentage of adult patients 18–75 years of age with diabetes who had a retinal or dilated eye examination by an eye care professional in the past year, unless eye exam is normal, then an eye exam is needed every two years. (HEDIS)
13	The percentage of members 18–85 years of age with diabetes who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.
14	The percentage of patients 18–75 years of age with diabetes who had an HbA1c < 8. (HEDIS)
15	The percentage of patients 40–75 years of age who have diabetes and who do not have clinical ASCVD, who received one statin medication of any intensity during the last year. Claims ONLY measure. (HEDIS)
16	The percentage of patients with hypertension, ≥ 18–85 years old, who had their blood pressure documented in the past year as <140/90 mm Hg. (HEDIS)
17	The percentage of males 21–75 years of age and females 40–75 years of age who have clinical atherosclerotic cardiovascular disease (ASCVD) and remained on a high-intensity or moderate-intensity statin for at least 80% of the treatment period. Claims ONLY measure. (HEDIS)
18	The percentage of patients who turned 15 months old during the measurement period and had six or more well-child visits with a PCP during the first 15 months of life. (HEDIS)
19	The percentage of patients, ≥ 12 years old, screened for depression in the last year with appropriate follow-up if screening is positive. (HEDIS)

Valley Preferred
LEHIGH VALLEY HEALTH NETWORK

1

Standardized Order Set

GEN Subsequent Medicare Annual Wellness Visit

Manage User Versions

- Diagnosis
  - Screening Diagnosis — Click for more
- Billing
  - Subsequent Visit Diagnosis — Click for more
  - [x] Routine general medical examination at a health care facility [Z00.00]
  - Billing
    - [ ] Annual Wellness, Subsequent visit, Medicare [G0439]
- Labs
- Diabetic Monitoring
- Referrals
- Immunizations
- Other Preventative Care Orders
- Health Risks from HRA (Do NOT deselect any of these items, they will show up when appropriate in your note and pt instructions)
  - Personalized Prevention Plan Header
    - [x] Health Risk Assessment PI Header
  - Advance Directive
    - [x] Advance Directive (patient instructions)
- Additional SmartSet Orders
  - Search for additional SmartSet orders

You can search for an order by typing in the header of this section.

- 90% Point and Click Documentation
- Automatic coding and billing
- Referrals placed
- Education included

Personalized Prevention Plan

- Age appropriate screening
- Condition specific screening
- HRA based recommendations
- USPSTF/ACIP

PERSONALIZED PREVENTION PLAN FOR

Health Maintenance
These are your preventative care screenings with due dates:

Preventative Care Screening

	Date Due	Completion Date
Zoster Vaccine (3 of 3)	04/23/2020	2/27/2020 (Declined)
COVID-19 Vaccine (3 - Booster for Moderna series)	07/20/2021	5/25/2021
DXA scan (bone density measurement)	06/04/2022	6/4/2020
Mammogram	08/10/2023	8/10/2022
Depression Screen*	03/27/2024	3/27/2023
Fall Risk Screen	03/27/2024	3/27/2023
Medicare Annual Wellness Visit	03/27/2024	3/27/2023

ADVANCE DIRECTIVE (LIVING WILL)
We noticed that you don't have an advance directive or living will in your medical records with Lehigh Valley Health. An advance directive only takes effect when you are unable to make your own decisions regarding your health care.

If you already have an advance directive, please share a copy with us to keep in your medical record. If you would like to learn more, or are interested in obtaining an advance directive or living will, we'll be happy to assist.

Other Resources:

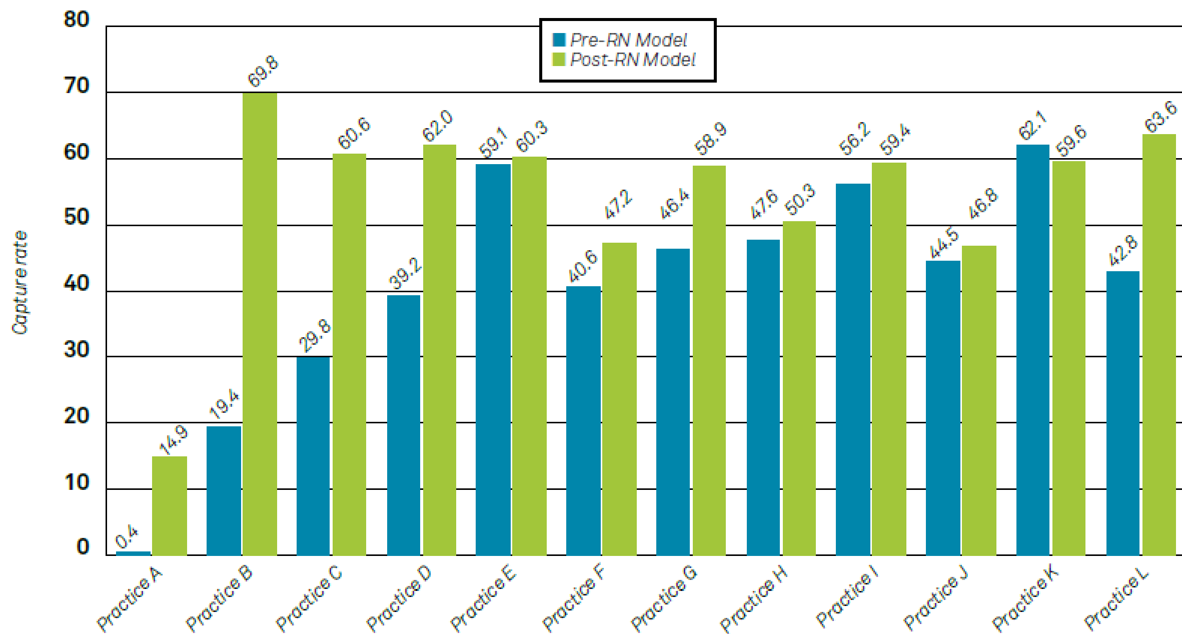
Click the link below to view the Pennsylvania Advance Health Care Directive document. You can print this document at home, complete with your family members and send back to us as an attachment in MyLVHN or bring to your next office visit. Let us know if you have any questions.

https://www.lvhn.org/sites/default/files/2019-03/PennsylvaniaAdvanceHealthCareDirectiveHandout.pdf

AWV Iterations

- Nurse Led Model
- Updates for billing compliance & CPT II codes
  - Bladder Control
  - Monitoring Physical Exercise
  - Screen for Potential Substance Use Disorders
  - Review Current Opioid Prescriptions

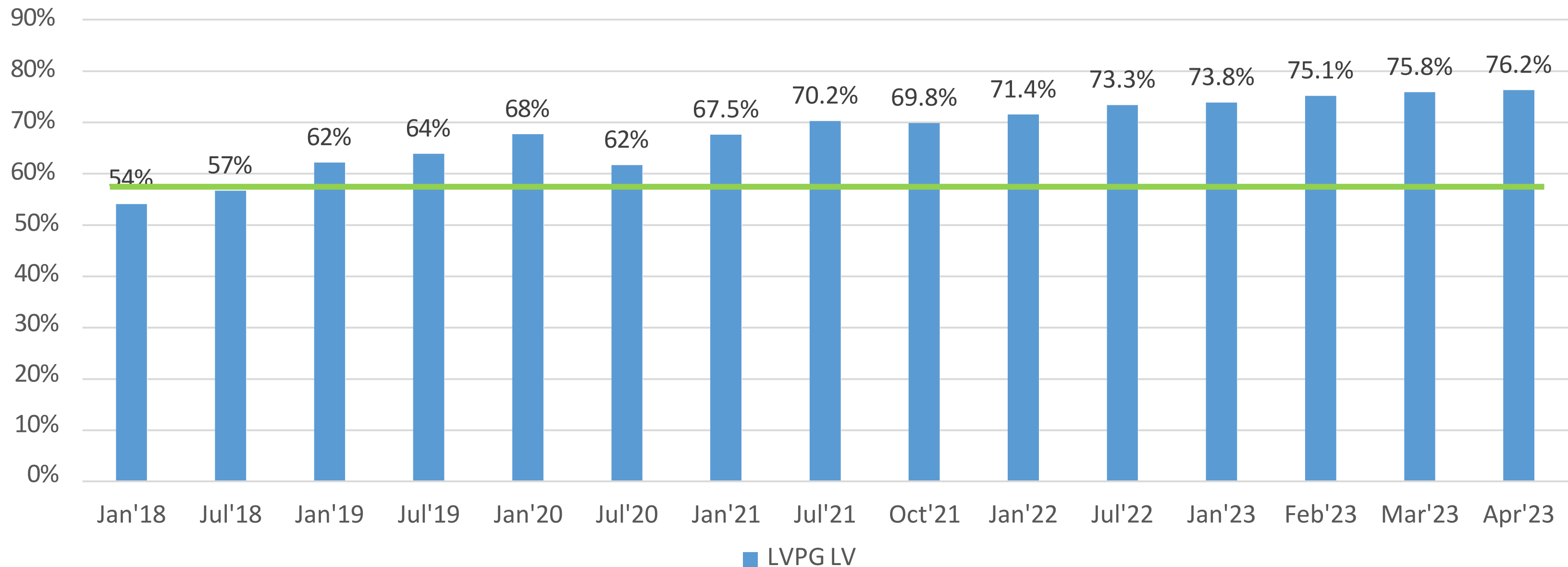
Nurse Led Model



Coding Opportunities

- AWV encounter enhances capture of clinical problems as appropriate
- Update problem list for accuracy
- HCC education
- BPA prompt
- Optimize coding

Annual Wellness Visit Trends



AWV Progression

Advance Care Planning BPA

High Priority (1)

This patient is high risk for 1 year mortality based on the end-of-life care index..

This patient is high risk for 1 year mortality based on the end-of-life care index. Please complete the advanced care planning. Consider taking one or more of the actions below:

1. If patient supplied documents, give to staff to scan into chart, using the correct scanning workflow.
2. Print the PA link and provide to patient, have them complete and bring to the next visit.

PA Advanced Healthcare Directive

3. Review and complete advanced care section with patient. Including the Serious Illness Care questions.

Advanced Care Planning

Acknowledge Reason

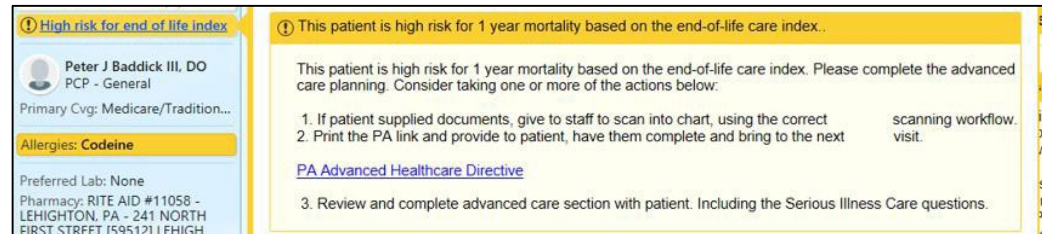
Patient Declines, will discuss at next a...

Accept

The criteria:

1. Patient is high risk based on the End-Of Life Care Index
2. Encounter is Medicare annual wellness visits
3. No documented advanced care planning in the past 1 year

Action: Recommends documentation of advanced care planning.



Advance Care Planning Status

Discussed with

- [x] Patient
- [ ] Spouse
- [ ] Parent
- [ ] Other (please specify)

ACP status

- ○ Has declined to make decisions
- ○ Has existing documents not currently in the EHR
- ○ Has existing documents reviewed in the EHR and there are no changes at this time
- ○ Has made new ACP decisions and they are noted in the EHR
- ● Is considering options

Additional notes

Advance Care Directives

Health Care Representative (Person designated by the patient verbally or in a writing other than a HC Power of Attorney or Living Will to make health care decisions for them. If the patient has not identified an individual, then next of kin.)

Scanned Document on File	Yes / No
Conversation with Patient	**Yes** / No
Comments	100%

Advanced care planning reviewed and discussed with patient. LVHN approved Pennsylvania Advance Health Care Directive form given to patient and encouraged to discuss with family or next of kin. Informed it is recommended that a completed copy be shared with PCP to update healthcare record. Pt agreed and verbalized

Health Care Agent / Durable Power of Attorney (Person designated by the patient in Health Care Power of Attorney to make health care decisions if the patient is unable to do so.)

Scanned Document on File	Yes / **No**
Conversation with	Yes / No

Goals of Care

- What is your understanding now of where you are with your illness?
- How much information about what is likely to be ahead with your illness would you like to have?
- What did you (clinician) communicate to the patient?
- If your health situation worsens, what are your most important goals?
- What are your biggest fears and worries about the future with your health?
- What abilities are so critical to your life that you cannot imagine living without them?
- If you become sicker, how much are you willing to go through for the possibility of gaining more time?
- How much does your proxy and family know about your priorities and wishes?
- What gives you strength as you think about the future with your illness?
- Based on the conversation about what's important to your patient and what is known about his/her illness, please include your recommendations.

○ Unable to complete due to advanced dementia, delirium, encephalopathy or intubation.

Reviewed by	MCNEILL, KEVIN A
Reviewed time	5/19/2022 1:16 PM Now

SDOH Screening

- The Robert Wood Johnson Foundation estimates social needs account for as much as 80% of health outcomes.
- Manatt, Phelps & Phillips, LLP. Medicaid's role in addressing social determinants of health. Robert Wood Johnson Foundation. Feb. 1, 2019. Accessed Dec. 21, 2021

SDOH Screening of MSSP Population

Social Determinants of Health - LVPG Overall Usage

Owner: Judith Brooks

All New Patient, New Patient Video Visit, New Patient/Phys/Preventative encounters within Lehigh Valley Physician Group.

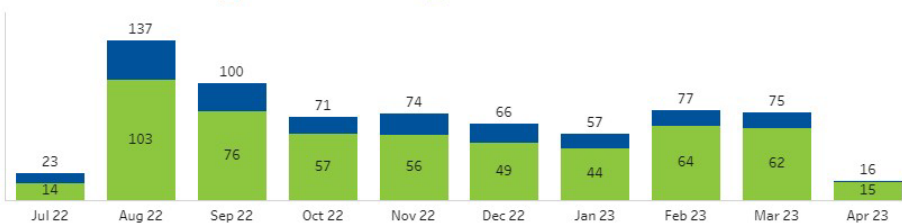
*It is advised to get Positive Risk Encounters, one should exclude Tobacco, Depression, and Risky Alcohol Use domains.

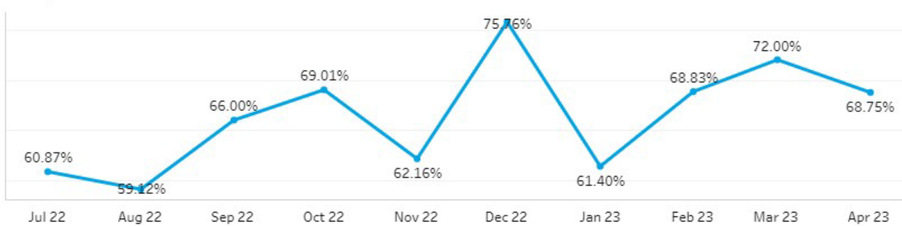
Data by Enterprise Analytics
Last Update: 4/11/2023 1:02:57 PM
Data is updated daily

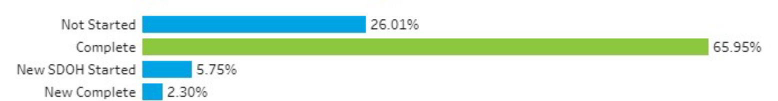
Fiscal Year	Contact Date	Visit Department	Age
2023	07/01/2022 – 04/10/2023	(All)	25 – 98

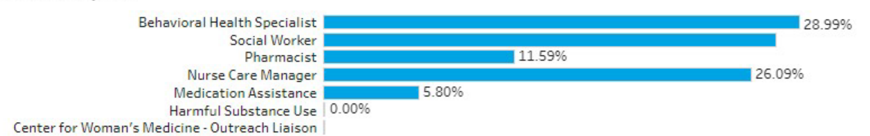
Complete Encounters	Eligible Encounters	Positive Risk Encounters	Positive Risk Referrals	Positive Risk Encounters with DX
65.95%	696	77.59%	8.89%	0.93%

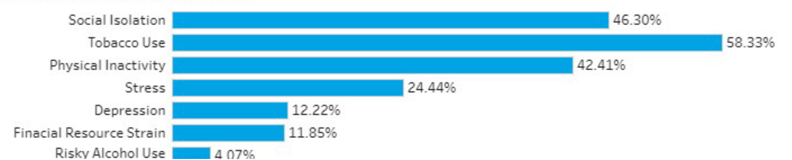
Gender	Value Based Registry	Ethnicity	Language	Race	Domain	Diagnosis	Chronic Condition
(All)	MSSP	(All)	(All)	(All)	(All)	(All)	All



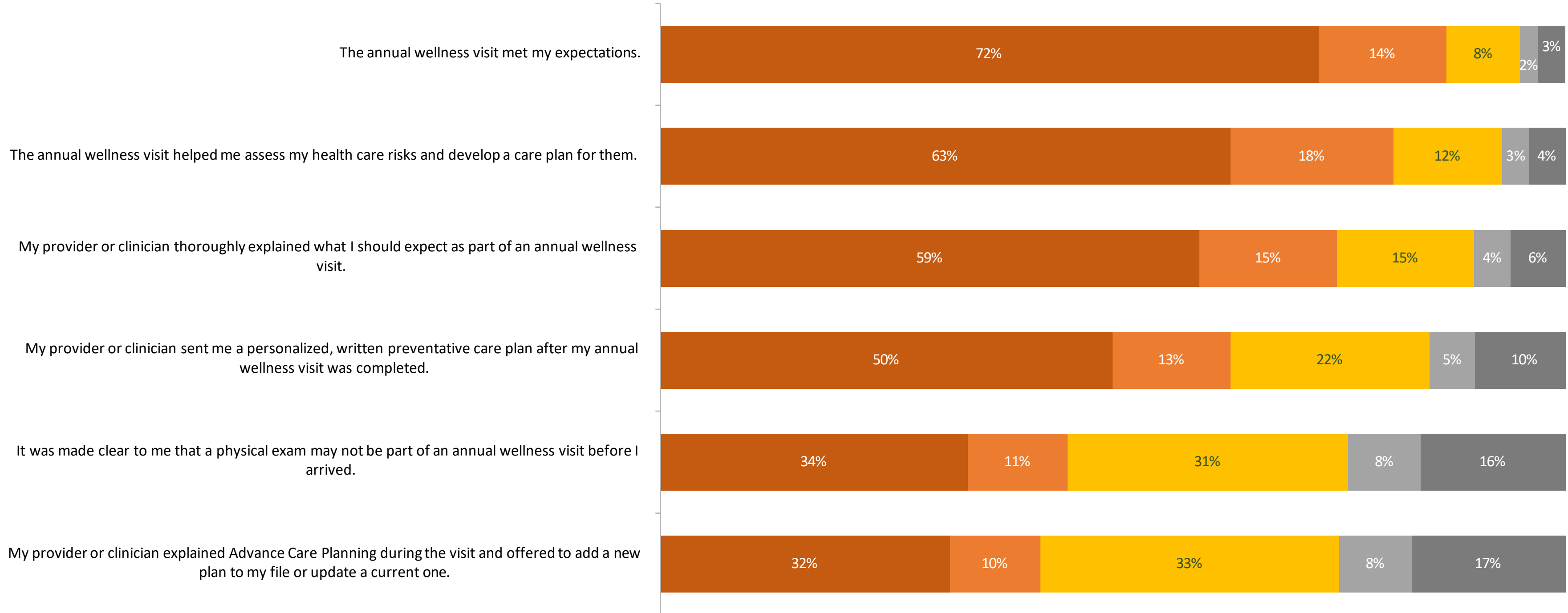








NRC Health Community Insights Study February 2023



(n=2,471)

q3 Please rate your agreement with the following statements regarding your most recent annual wellness visit through Lehigh Valley Health Network:

Challenges

- Clinician Buy In
- Scheduling
- Patient Buy In
- Modifier
- Rescheduling
- Optimal use of EMR
- Appropriate follow up
- SDOH
- GOC

Lesson Learned

- Integrated Approach
- Streamlined
- Leveraging EMR
- Data Transparency
- Monitor Performance
- Incentivize

References

1. Smartlink Health Solutions, LLC. 2018. *Path to a Healthy Annual Wellness Visit Program*. Accessed April 9, 2019 at smartlinkhealth. com/resource-center/whitepaper-path-healthy-awv/. Accessed 4/9/2019.
2. I. Ganguli, J. Souza, M. McWilliams, and A. Mehrotra. 2018. Practices Caring for the Underserved are Less Likely to Adopt Medicare's Annual Wellness Visit. *Health Affairs, 37*(2): 283–291.
3. A. Beckman, A. Becerra, A. Marcus, et al. 2019. Medicare Annual Wellness Visits Association with Healthcare Quality and Costs. *American Journal of Managed Care, 25*(3): e76–e82.
4. J.L. Colburn and S. Nothelle. 2018. Medicare Annual Wellness Visit. *Clinics in Geriatric Medicine,* 34: 1–10.
5. M. Jiang, D.R. Hughes, and W. Wang. 2018. Effect of Medicare's Annual Wellness Visit on Preventive Care for the Elderly. *Preventive Medicine,* 116: 126–133.
6. S. Snyder, S. Hazelett, K. Allen, and S. Radwany. 2012. Physician Knowledge, Attitude, and Experience with Advance Care Planning, Palliative Care, and Hospice: Results of a Primary Care Survey. *American Journal of Hospice and Palliative Medicine, 30*(5): 419–424.
7. J. Hu, G.A. Jensen, and D. Nerenz. 2015. Medicare's Annual Wellness Visit in a Large Health Care Organization: Who Is Using It? *Annals of Internal Medicine,* 163(7): 567–568.
8. T.M. Tetuan, R. Ohm, M.K. Herynk, et al. 2014. Affordable Health Care Act Annual Wellness Visits. *Journal of Nursing Administration,* 44(5): 270–275.
9. F. Camacho, N. Yao, R. Anderson. 2017. The Effectiveness of Medicare Wellness Visits in Accessing Preventive Screening. *Journal of Primary Care & Community Health,* 8(4): 247-255.
10. G.A. Jensen, R.G. Salloum, J. Hu, et al. 2015. Slow Start: Use of Preventive Services Among Seniors Following the Affordable Care Act's Enhancement of Medicare Benefits in the U.S. *Preventive Medicine,* 76: 37-42.
11. K.G. Alder. Screening for Social Determinants of Health: An Opportunity or Unreasonable Burden? *Fam Pract Manag.* 2018;25(3):3
12. J .Stephens, K.McNeill, K.Sterk, M. Crespo, K. Shaak, M. Johnson. Same Time Next Year: Capturing Preventive Care in the Annual Wellness Visit. GPJ/AMGA.ORG July/August 2020.Brief assessments and screening for geriatric conditions in older primary care patients: a pragmatic approach, Seematter-Bagnoud and Büla Public Health Reviews (2018) 39:8
13. Gill TM. Disentangling the disabling process: insights from the precipitating events project. The Gerontologist. 2014;54(4):533–49.
14. Panel on Prevention of Falls in Older Persons American Geriatric Society/British Geriatrics Society. Summary of the Updated American Geriatrics Society/British Geriatrics Society clinical practice guideline for prevention of falls in older persons. J Am Geriatr Soc. 2011;59(1):148–57.
15. Bradford A, Kunik ME, Schulz P, Williams SP, Singh H. Missed and delayed diagnosis of dementia in primary care: prevalence and contributing factors. Alzheimer Dis Assoc Disord. 2009;23(4):306–14.
16. Reed-Jones RJ, Solis GR, Lawson KA, Loya AM, Cude-Islas D, Berger CS. Vision and falls: a multidisciplinary review of the contributions of visual impairment to falls among older adults. Maturitas. 2013;75(1):22–8.
17. O'Connor E, Rossom RC, Henninger M, Groom HC, Burda BU, Henderson JT, Bigler KD, Whitlock EP. Screening for depression in adults: an updated systematic evidence review for the U.S. Preventive Services Task Force. Rockville: Agency for Healthcare Research and Quality; 2016. Contract No: No. 128

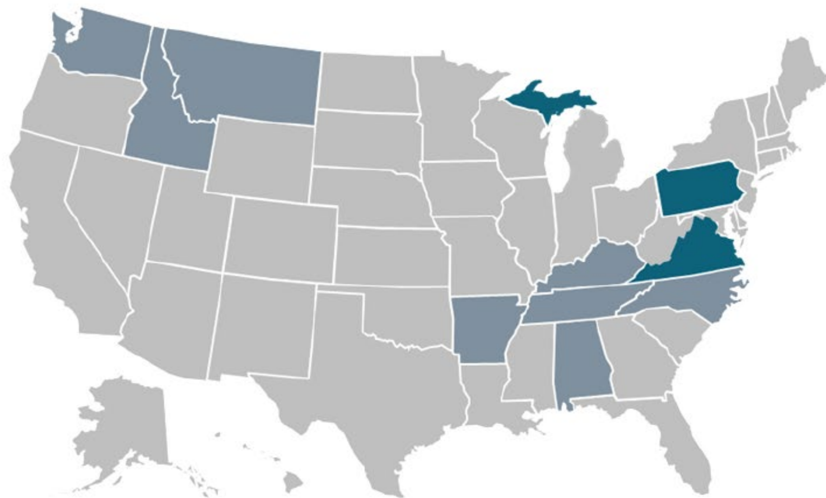
ADVANTAGEPOINT HEALTH ALLIANCE

OUR FOOTPRINT

40+ Hospitals

2300+ Providers

170,000+ Lives



8 Regional Networks

3 Legacy Networks

Blue Ridge - Virginia
Great Lakes - Michigan
Laurel Highlands - Pennsylvania

5 New Networks (2021/2022)

Commonwealth - Kentucky
Hot Springs - Arkansas
Northwest – Idaho, Montana, Washington
Tennessee Valley – Alabama, Tennessee
Western North Carolina

Intake – Reason for Visit

Annual wellness visit 60 min

Reason for Visit

Patient Preferences

Vitals

Allergies

Medications

Vaccines

Problems

Gynecological History

Obstetric History

Prep Note Prep last accessed by Carol Ann Hudson | 11-13-2023 10:10 AM

Next

Intake

Write a note to the staff member completing Intake

Exam

Write a note to the staff member completing the Exam

Reason for Visit ⊕ REASON

MAWV (LPNT)

☐ Newly referred patient, patient being referred back or new patient

NOTE

Appointment note HYPONATREMIA, HX OF FALLS MEDICARE G0439

The Reason for Visit is mapped to the Encounter Plan for the MAWV. In this case, MAWV (LPNT) is the name that pulls in the template.

ADVANTAGEPOINT HEALTH ALLIANCE Blue Ridge

Intake – Social History section

Annual wellness visit 60 min

- Reason for Visit
- Patient Preferences
- Vitals
- Allergies
- Medications
- Vaccines
- Problems
- Gynecological History
- Obstetric History
- Past Pregnancies
- Family History
- Social History

Social History ⊕ Show other specialty questions Next

Education and Occupation

Question	Answer	
What is the highest grade or level of school you have completed or the highest degree you have received?	High school gradu:	Note
Are you currently employed?	Yes / **No**	retired

Marriage and Sexuality

Question	Answer	
What is your relationship status?	Married	Note
Are you sexually active?	**Yes** / No	Note
Do you use protection during sex?	No	Note
How many children do you have?	5	Note

- Education and Occupation
- Marriage and Sexuality
- Substance Use
- Home and Environment
- Lifestyle
- Diet and Exercise
- Activities of Daily Living
- Advance Directive
- Lifepoint AWV
- PCMH

The MAWV template utilizes the standard social history sections and questions where possible

Intake – Social History section

Social History

Show other specialty questions

Next

Lifepoint AWV

Question	Response	
How would you describe the condition of your mouth and teeth—including false teeth or dentures?	Very Good	Note
In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)	0	Note
In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)	5	Note

- Education and Occupation
- Marriage and Sexuality
- Substance Use
- Home and Environment
- Lifestyle
- Diet and Exercise
- Activities of Daily Living
- Advance Directive
- **Lifepoint AWV**
- PCMH

Additional Medicare-required questions specific to the MAWV are included in a custom Social Hx section (only pulled in to the MAWV encounter

Intake – Screeners section

Annual wellness visit 60 min

Reason for Visit

Patient Preferences

Vitals

Allergies

Medications

Vaccines

Problems

Gynecological History

Screening

Next

PHQ-2/PHQ-9 × Opioid Risk × CAGE-AID × Mini-Cog × STEADI Fall Risk × AAFP Social Needs Tool ×

PHQ-2/PHQ-9

Status
Incomplete

Opioid Risk

CAGE-AID

Mini-Cog

STEADI Fall Risk

AAFP Social Needs Tool

Specific screeners are attached to the MAWV encounter plan. Practices can modify and add additional ones as needed. These are also tied to G codes for quality reporting (for MA plans) and push those codes to the claims

Epion – Pre-visit Patient Forms

A text message (or email) is pushed to the patient from Epion (3rd party tool) three days prior to the appointment. The patient can open and update demographics, insurance, and their medical information.

Medical Forms

Health History

Your health history helps us to prepare for your visit. Please review and complete this form prior to your scheduled appointment. You will be able to discuss any questions or concerns with your physician. You may update this form at any time prior to your appointment. Updates to this form will not be available to your provider until the time of your appointment.

Instructions

- When you finish updating a section, click the **Save** button.
- To go to a specific section, click the section name located to the right.
- If you have nothing to enter in a section, check **"No ..."** and click **Save**.
- If a section is already filled-out from a previous visit, check **Reviewed with no changes** and click **Save**.

Note: If your appointment is canceled, the data that you enter in this form will not be reviewed by your provider and may be discarded.

Continue

Your form is 0% complete

- Introduction
- Medications
- Allergies
- Medical History
- Family History
- Social History
- GYN History
- Surgical History

ADVANTAGEPOINT
HEALTH ALLIANCE
Blue Ridge

Epion – Pre-visit Patient Forms

Medical Forms

Health History

Social History — Updated from your medical record: 09/08/2023

Your form is 57% complete

- Introduction
- Medications ☑
- Allergies ☑
- Medical History ☑
- Family History ☑
- Social History ☐
- GYN History ☐
- Surgical History ☐

Question	Answer
Are you sexually active?	○ Yes ○ No
Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?	- Select -
Do you have a medical power of attorney?	○ Yes ○ No
Do you have an advance directive?	○ Yes ○ No
Do you or have you ever smoked tobacco?	- Select -
How much tobacco do you smoke?	- Select -
Do you or have you ever used any other forms of tobacco or nicotine?	○ Yes ○ No
How much tobacco do you chew?	- Select -
Do you or have you ever used smokeless tobacco?	- Select -
What is your level of alcohol consumption?	- Select -
How many years have you consumed alcohol?	
Do you use any illicit or recreational drugs?	○ Yes ○ No
What is your exercise level?	- Select -

☐ Reviewed with no changes

Save & Next

When the patient is checked in to the office, Epion loads the patient's answers in the various sections awaiting reconciliation by the person doing intake. When these are completed in advance, the time for Intake is greatly reduced.

ADVANTAGEPOINT HEALTH ALLIANCE Blue Ridge

Intake – Screeners section

Annual wellness visit 60 min

- Reason for Visit
- Patient Preferences
- Vitals
- Allergies
- Medications
- Vaccines
- Problems
- Gynecological History

Screening

Next

PHQ-2/PHQ-9 × Opioid Risk × CAGE-AID × Mini-Cog × STEADI Fall Risk × AAFP Social Needs Tool ×

- PHQ-2/PHQ-9
  Status
  Incomplete
- Opioid Risk
- CAGE-AID
- Mini-Cog
- STEADI Fall Risk
- AAFP Social Needs Tool

Specific screeners are attached to the MAWV encounter plan. Practices can modify and add additional ones as needed. These are also tied to G codes for quality reporting (for MA plans) and push those codes to the claims

ADVANTAGEPOINT HEALTH ALLIANCE Blue Ridge

Exam – A/P section

04-26-2023 | Annual Wellness V... | Christie Fe

Exam Prep

Review — HPI — ROS — PE — A/P ▾ – Sign-off

Done w

Assessment & Plan ⊕ DIAGNOSES & ORDERS

Sign Orders Next

Supervising Provider

2 potential diagnoses have not been added to a claim this year.

Risk score 0.428 | Gap 0.458

Prescription drug monitoring report

Misuse 800 Narcotics 652 Overdose 650 Sedatives 430 Stimulants 000

Viewed by rmarasco2 on 08/04/2021

Click here to open Risk Flyout

ADVANTAGEPOINT HEALTH ALLIANCE Blue Ridge

Risk Flyout – Add to A/P

Patient Risk

Learn more | Dismissed risk (0)

Potential Diagnoses (2) No score gap

All potential diagnoses have been documented in this encounter or submitted on a claim this year.

HCC 12: Breast, Prostate, and Other Cancers and Tumors RAF weight 0.150

ADD TO A/P

Diagnosis	Malignant tumor of breast
ICD-10	C50.111: Malignant neoplasm of central portion of right female breast
Source	CLAIM : BELL MEDICAL FAMILY PRACTICE - OFFICE 10/25/2022

HCC 35: Inflammatory Bowel Disease RAF weight 0.308

CHOOSE DIAGNOSIS

ICD-10	K50.90: Crohn's disease, unspecified, without complications
Source	CLAIM : BELL MEDICAL FAMILY PRACTICE - OFFICE 09/09/2020

Suspected Diagnoses (0)

These suspected diagnoses have not been clinically verified. They have been inferred from evidence such as labs, screenings, and prescriptions. Determine if these diagnoses are valid before documenting them.

Click here to add this specific diagnosis to the A/P section of the exam

Risk Flyout – Dismiss Dx

Patient Risk | Learn more | Dismissed risk (0)

Potential Diagnoses (1) No score gap

All potential diagnoses have been documented in this encounter or submitted on a claim this year.

HCC 8: Metastatic Cancer and Acute Leukemia RAF weight 2.659 — CHOOSE DIAGNOSIS

ICD-10 C92.60: Acute myeloid leukemia w 11q23-abnormality not achieve remis

Source MANUAL : On hospital claim in 2021 at Bell, chudson28 04/28/2023

Suspected Diagnoses (0)

Click here to Dismiss this diagnosis

JUSTIFY DISMISSAL

- disagree with diagnosis
- condition resolved
- greater specificity is appropriate
- less specificity is appropriate
- duplicate

Other

Enter justification (470 characters only)

Save

Select a reason from the list or type a reason then Save

AdvantagePoint Health Alliance Blue Ridge

Exam – Preventative Plan

Assessment & Plan ⊕ DIAGNOSES & ORDERS

1 potential diagnosis has not been added to a claim this year.

PERSONALIZED HEALTH PLAN (COPY PROVIDED TO PATIENT)

1) Vaccines:

(a) Pneumococcal Vaccine -
Type:
Last Service:
Plan:

(b) Influenza vaccine -
Last Service:
Plan:

(c) Hepatitis B vaccine -
Last Service:
Plan:

(d) Shingrix Vaccine -
Last Service:
Plan:

(e) COVID -
Last Service:
Plan:

There are two types of encounter plans (templates) for the MAWV. One includes an electronic version of the personal preventative plan that is completed in Athena and then printed at DC for the patient (provider preference).

ADVANTAGEPOINT HEALTH ALLIANCE Blue Ridge

Exam – Paper Preventative Plan

PERSONAL PREVENTIVE CARE (Female)

PATIENT NAME: ______________________ DATE: ______________

VACCINES	COVERAGE	LAST DOSE	Recommendations/Actions
Influenza	Recommended yearly (covered yearly)		
Pneumococcal	1 dose PCV15 followed by PPSV23 1 year later OR 1 dose PCV20		
PPSV 23	Recommended once over age 65 (covered once in a lifetime)		
Prevnar *(circle)* 13 15 20	Recommended once over age 65 (covered once in a lifetime)		
Shingrix (Shingles)	Optional over age 50 (covered if medically necessary) Will need to be administered by patient's pharmacy		
Tdap or Td (Tetanus)	Recommended every 10 years (covered if medically necessary)		
COVID			

SCREENINGS	COVERAGE	Last SERVICE DATE	Findings/Recommended Next Service Date
Mammogram	Recommended yearly over age 40 (covers 1 baseline age 35-39: covers yearly over age 40)		
PAP/Pelvic	Recommended age 65, once if nml (covered yearly if high risk, every 2 years if normal risk)		
Colon Cancer Screening	Recommended to start screening at 45 Colonoscopy: Every 10 years if negative Cologuard: Every 3 years if negative Fecal occult Blood card: Every year if negative		
Diabetes Screen (Fasting glucose)	Recommended once a year; if meets criteria- One of these: HTN, Hx of high BS, Hx of high cholesterol, Obesity Two of these: ≥65, overweight, FamHx DM or gestational diabetes		
Fasting Lipid	Recommended once a year; MCR will pay annually with 20% co-pay; once every 5 years MCR will cover at 100%		
Eye Care	Recommended yearly if over age 65 and diabetic. (Covered if diabetic or family history glaucoma)		
Dental Care	Regular exam and cleanings (dental care is not covered unless medically necessary)		
DEXA Scan	Recommended over age 65 (covered every 2		

Sample of Female Preventative Plan

ADVANTAGEPOINT HEALTH ALLIANCE Blue Ridge

Exam – Preventative Plan

During today's Medicare Annual Wellness Visit, the patient & I discussed/reviewed the following information:

1. Review of their medical, medication and family health history.
2. Review of their vitals, including, height, weight, blood pressure and BMI.
3. Review of their current providers & medical suppliers.
4. Discussed functional ability, home safety and screening for depression.
5. Discussed assessment of cognitive function and reviewed family or friend's comments about memory.
6. Discussed risk factors & conditions for which referrals/intervention are recommended.

I provided personalized advice or resources to help prevent disease & improve health on topics such as weight loss, physical activity, smoking cessation, advance directives/advance care planning, fall prevention and nutrition.

A written preventive screening and services plan for the patients' next 5-10 years were reviewed, given to patient, and scanned into chart.

All recommendations have been discussed thoroughly with the patient.

Next Medicare Annual Wellness Visit will be due in 1 year.

When the paper form for preventative planning is used, this language is in the encounter plan. The form is completed on paper, scanned into the encounter, and then handed to the patient to take with them.

adult health examination

Z00.00 Encounter for general adult medical examination without abnormal findings

The Z code is automatically included in the encounter plan. Additional patient educational handouts are included and can be customized by market.

preventing falls: care instructions

well visit, over 65: care instructions

advance directives: care instructions

advance care planning: care instructions

AdvantagePoint Health Alliance Blue Ridge

Upcoming Events

Virtual Affinity Groups

- **CMO and Clinical Affinity Group**
  Meets: November 28, 2023 from 3–4 pm ET.
  Participants should include CMOs, CNOs, Pop Health Officers, and others who manage patient care, and clinical care redesign, etc.
  Sign up for the Clinical Affinity Group.
- **Compliance and Legal Affinity Group**
  Meets: December 5, 2023 from 3–4 pm ET.
  Participants should include those who ACO leaders and staff members who deal with compliance documentation, operations, or events as well as those who deal with ACO contracting with payers and participants.
  Sign up for the Compliance and Legal Affinity Group.
- **Executive Affinity Group**
  Meets: December 12, 2023 from 3–4 pm ET.
  Participants should include CEOs, CFOs, Executive Directors, Chief Value Officers, and others who oversee the ACO's finances, budget, strategy, contracting, etc.
  Sign up for the Executive Affinity Group.

Learning Labs

NAACOS National Association of ACOs

Medicaid Learning Lab (Final session)

- December 1, 2023
- Register Here or locate this link on the Learning Lab website page

Upcoming Events

NAACOS National Association of ACOs

NAACOS Winter Boot Camps

- February 8-9, 2024
- Marriott Orlando Airport Lakeside, Orlando, FL
- 2 Concurrent Boot Camps
  - Clinical Operations in Care Transformation Boot Camp
  - Data and Analytics for Care Excellence Boot Camp

Register now!

Contact Information

NAACOS
National Association of ACOs

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- **Kevin McNeill, MD**, Associate Medical Director LVHN ACO, Kevin_A.Mcneill@lvhn.org
- **CarolAnn Hudson, RN,** AVP, Clinical & Quality Operations, Population Health, Lifepoint Health, CarolAnn.Hudson@LPNT.net

Appendix

Group Discussion

NAACOS
National Association of ACOs

Note Template Questions:

1. What problem does the topic address?
2. What population of patients could benefit from this?
3. What didn’t I know or haven’t thought about trying in my ACO?
4. Could any of this presentation work in your ACO or CIN?
5. If yes, how? If no, why not?

You may use this template to document notes from the presentation that you feel would be helpful in your practice.