AWV
Learning Lab

April 18, 2024
2:00 pm to 3:30 pm ET

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.

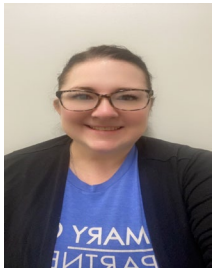
Housekeeping Items

- 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

		Speakers
2:00 pm – 2:10 pm	Learning Lab Opening Introduction	Melody Danko-Holsomback, NAACOS
2:10 pm – 2: 40 pm	Care Coordination in Primary Care	Angela Zavala DNP APRN FNP-C, Nursing Director, Megan Bjerrum, LPN Care Coordinator, and Stephanie Anderson, LPN Care Coordinator, Primary Care Partners
2:40 – 3:00 pm	The Medicare Annual Wellness Visit Opportunities	Kevin McNeill, MD, Associate Medical Director, Lehigh Valley Accountable Care Organization, and Lehigh Valley Physician Hospital Organization.
3:00 – 3:10 pm	AWVs: Oh The Possibilities	Melody Danko-Holsomback, NAACOS
3:15pm – 3:25 pm	Q and A	Attendee participation
3:25 pm - 3:30 pm	Adjourn	Melody Danko-Holsomback

Speakers

	**Angela Zavala DNP APRN FNP-C,** Nursing Director Primary Care Partners
	**Megan Bjerrum, LPN,** Care Coordinator Primary Care Partners
	**Stephanie Anderson, LPN,** Care Coordinator Primary Care Partners

Speakers

Kevin McNeill, MD
Associate Medical Director, Lehigh Valley Accountable Care Organization, and Lehigh Valley Physician Hospital Organization.

Melody Danko-Holsomback, MSN, CRNP
VP of Education, NAACOS

Care Coordination in Primary Care

OBJECTIVES

- CARE COORDINATION MODEL
- ANNUAL WELLNESS VISIT WORKFLOW AND DATA INTEGRATION FOR PATIENT PLAN OF CARE
- TRANSITION OF CARE AND CHRONIC CARE MANAGEMENT PROGRAM
- COLLABORATION OF CARE COORDINATORS WITH CARE TEAM
- OUTCOME IMPACT WITH THIS MODEL

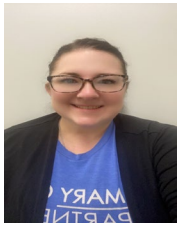
ABOUT US

- Angela Zavala DNP APRN FNP-C

Angela is a board-certified Family Nurse Practitioner by the American Academy of Nurse Practitioners. Working in healthcare for over 20 years she has experience in adult and neonatal intensive care, ambulatory surgery and primary care. She has worked as a nurse practitioner at Primary Care Partners in Lincoln, NE, for the last 5 years. In addition to her role as a clinician, she is also a member of the leadership team and serves as the Nursing Director.

- Megan Bjerrum, LPN, Care Coordinator

Megan has been an LPN since 2007. After working in long term care for 7 years made the decision to focus her nursing career on more preventative care and started working at Primary Care Partners. She has worked as a Care Coordinator for the last 5 years with the emphasis of her role being performing Annual Wellness Visits for Medicare patients.



- Stephanie Anderson, LPN, Care Coordinator

Stephanie is a Care Coordinator at Primary Care Partners and for the last 4 years has led the Chronic Care Management program for complex patients. She graduated in 2013 from Southeast Community College in Practical Nursing and is licensed in the State of Nebraska. She also has an MBA and bachelor's degree in management with certificates in sales and marketing, accounting, human resources, and office management from Peru State College.

2024: Primary Care Partners, Lincoln, NE.

- 13 providers, 5 owners
- 90% insurance payments
- Medicare patients: 4100
- 3 locations (all owned)
- 75 employees
- ACO-One Health NE

OneHealth NEBRASKA

Value of Care Coordinators

- "Care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."

GOAL:
HIGH-QUALITY
HIGH-VALUE HEALTH CARE

Care Coordination. Content last reviewed August 2018. Agency for Healthcare Research and Quality, Rockville, MD.
https://www.ahrq.gov/ncepcr/care/coordination.html

CARE COORDINATOR PRIMARY ROLES

In our Clinic:

*5 Care Coordinators

*4 CC perform AWV. Each CC manages 2-3 provider's AWV for continuity

*1 Care Coordinator Manages CCM

*TOC calls shared among the 5 CC

01

Annual Wellness Visits

02

Transition of Care

03

Chronic Care Management

ANNUAL WELLNESS VISITS

- Preventative Health Maintenance
- Risk Stratification
- Medication and Health History Reconciliation
- Functional Assessments-Fall risk, Home Safety Assessment, Memory Assessment, Barriers
- Advanced Care Planning

ANNUAL WELLNESS VISIT WORKFLOW & PREVENATIVE GUIDE

*Preparation
*Records & Documentation
*Discussion
*New orders
*Collaboration

PRIMARY CARE PARTNERS
Your Partner in Health

Todays Date:_____ Patient Name_____ DOB_____

Annual Wellness Preventive Plan

Recommendation	Who qualifies/frequency	Last Received	Due Next	N/A
Abdominal aortic aneurysm screening	Family history of abdominal aortic aneurysm or a man between age 65-75, who has smoked at least 100 cigarettes in life/once			
Alcohol misuse screening/counseling	Those who use alcohol but don't meet criteria for dependency			
Breast cancer screening	Women age 40 and older/yearly			
Dexascan/ Bone Mass	65/older with diagnoses R/T osteoporosis or estrogen Deficiency/ every 2 years			
Cardiovascular disease (lipid profile)	All/every 5 years (more frequent if abnormal)			
Cervical/vaginal cancer screening	All women/ 3-5 years			
Colorectal cancer screening	All patients age 45 and older			
Depression Screening	All/yearly			
Diabetes screening (fasting glucose)	All/2 times per year			
Diabetes screening and self-management training	Those with diabetes			
Glaucoma testing	Those at risk/yearly			
Hepatitis C screening	Those born between 1945-1965 OR prior illicit drug use, OR a blood transfusion before 1992/once			
HIV screening	Those at risk or ask for test/yearly			
Lung cancer screening (low dose CT)	Those age 55-77 who smoke (or quit in the last 15 years) and have a 20 pack-year history/yearly			
Obesity screening and counseling	Those with body mass index of 30 or more/not stated			
Prostate cancer screening	Men over 40/yearly/PSA blood test			
Influenza vaccine (flu shot)	All/yearly			
Prevnar 20 (pneumonia vaccine)	All/once 65 and over (must be given >1yr after Prevnar 13 or Pneumovax 23; if patient received complete series Prevnar 13 & Pneumovax 23 give >5yrs after series)			
Prior pneumococcal vaccination	Those under 65 with preexisting condition			
Tobacco use/ cessation	Those who smoke/varies			
Wellness visit	All with Medicare B longer than 12 months/yearly			

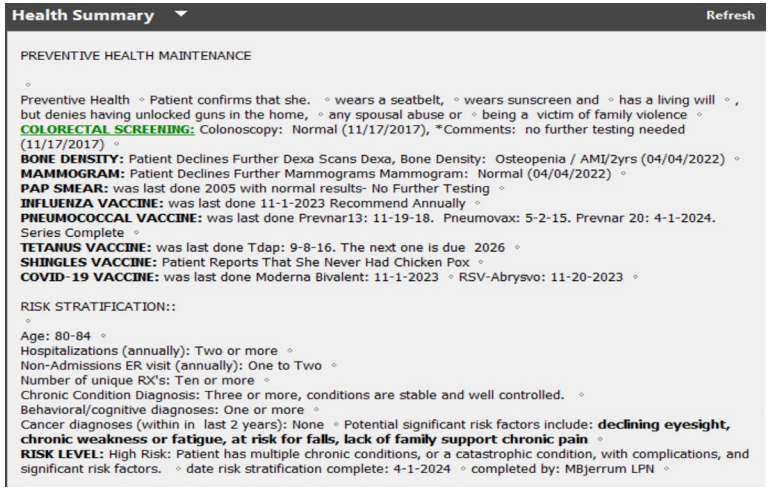
Services not covered under Part B Medicare but MAY be covered under Part D

Shingrix (2 shot series)	Varies/varies/varies			
Zostavax (shingles shot)	Varies/varies/varies			
Tdap vaccine (tetanus/diphtheria/pertussis)	Varies/varies/varies			
Td (tetanus/diphtheria) vaccine	Varies/varies/varies			
COVID series	Varies			

Updated 10/23

ANNUAL WELLNESS VISIT

HEALTH SUMMARY INTEGRATION



Health Summary Refresh

PREVENTIVE HEALTH MAINTENANCE

Preventive Health ◦ Patient confirms that she. ◦ wears a seatbelt, ◦ wears sunscreen and ◦ has a living will ◦ , but denies having unlocked guns in the home, ◦ any spousal abuse or ◦ being a victim of family violence ◦
COLORECTAL SCREENING: Colonoscopy: Normal (11/17/2017), *Comments: no further testing needed (11/17/2017) ◦
BONE DENSITY: Patient Declines Further Dexa Scans Dexa, Bone Density: Osteopenia / AMI/2yrs (04/04/2022) ◦
MAMMOGRAM: Patient Declines Further Mammograms Mammogram: Normal (04/04/2022) ◦
PAP SMEAR: was last done 2005 with normal results- No Further Testing ◦
INFLUENZA VACCINE: was last done 11-1-2023 Recommend Annually ◦
PNEUMOCOCCAL VACCINE: was last done Prevnar13: 11-19-18. Pneumovax: 5-2-15. Prevnar 20: 4-1-2024. Series Complete ◦
TETANUS VACCINE: was last done Tdap: 9-8-16. The next one is due 2026 ◦
SHINGLES VACCINE: Patient Reports That She Never Had Chicken Pox ◦
COVID-19 VACCINE: was last done Moderna Bivalent: 11-1-2023 ◦ RSV-Abrysvo: 11-20-2023 ◦

RISK STRATIFICATION::
Age: 80-84 ◦
Hospitalizations (annually): Two or more ◦
Non-Admissions ER visit (annually): One to Two ◦
Number of unique RX's: Ten or more ◦
Chronic Condition Diagnosis: Three or more, conditions are stable and well controlled. ◦
Behavioral/cognitive diagnoses: One or more ◦
Cancer diagnoses (within in last 2 years): None ◦ Potential significant risk factors include: **declining eyesight, chronic weakness or fatigue, at risk for falls, lack of family support chronic pain** ◦
RISK LEVEL: High Risk: Patient has multiple chronic conditions, or a catastrophic condition, with complications, and significant risk factors. ◦ date risk stratification complete: 4-1-2024 ◦ completed by: MBjerrum LPN ◦

WORKFLOW

- AWV occurs several days prior to the patient's annual comprehensive exam.
- CC obtains pertinent records prepares standing orders for preventative screening due to be completed
- Communication with provider prior to comp exam to close the loop on issues, barriers, gaps in care.
- AWV documents scanned and completed for provider review

TRANSITION OF CARE CALLS AND VISITS

ER VISIT

- **Contact with patient within 5 days of discharge**

Hospitalization

- **Contact with patient within 48 hours & office visit with provider to follow within 14 days of discharge**

Transition of Care

GOALS OF THE TOC

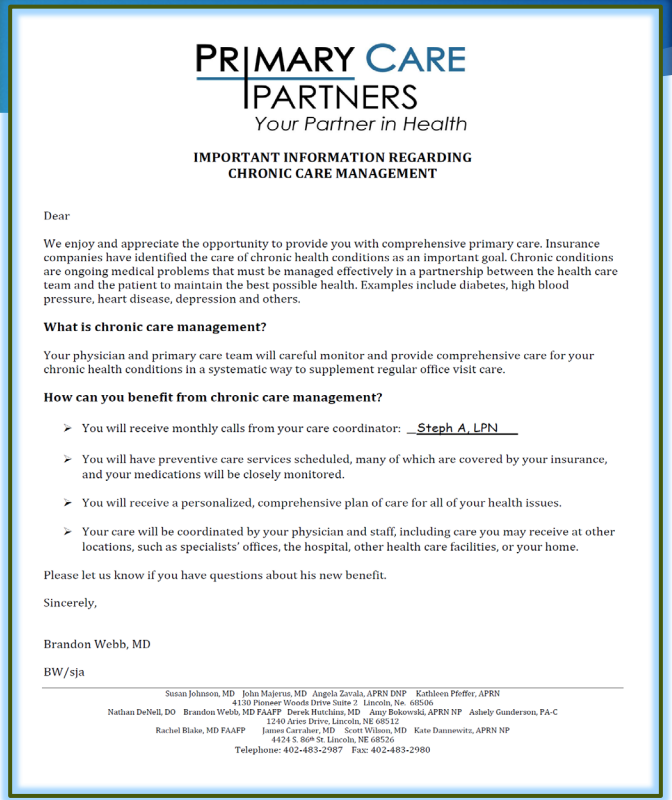
- **Medication Reconciliation**
- **Assessment of potential barriers to the plan of care from hospital**
- **Early intervention and communication with provider if potential complications**

CC: Ms. [redacted] is a 81 year old White female. she is a transition of care patient . **This will be a telephone follow up from recent hospital stay:** Information is provided by the the patient. Date of Admission was 7-15-2021, Date of Discharge was 7-16-2021. Medical problems to be addressed include Pneumonia/ weakness. The following lab tests were done: CK-MB, troponin I, CK/ Myoglobin, CBC, blood and urine culture, hepatic function panel, INR, basic metabolic panel, total T4, TSH, Lipase, Procalcitonin. The following radiology tests were done: chest CT, chest x-ray. **The following procedures were done:** EKG Current symptoms are coughing improved now just a dry cough, temp normal, tired and not sleeping well. Patient reports no questions or concerns at this time. Reviewed discharge instructions with patient/family member and questions answered. Medications reviewed and reconciled. Face to face appointment made for 7-23-2021 Symptoms started on 7-12-2021

CHRONIC CARE MANAGEMENT

HIGH RISK PATIENTS WITH MULTIPLE COMORBIDITIES

- Providers notify CCM nurse of high-risk patients
- Individualized care plan developed
- 20 minutes of time per month for patient coordination of care
- Improves treatment plan adherence and early identification of problems
- Collaboration with providers and updates with care plan and patient care needs



PRIMARY CARE PARTNERS
Your Partner in Health

IMPORTANT INFORMATION REGARDING CHRONIC CARE MANAGEMENT

Dear

We enjoy and appreciate the opportunity to provide you with comprehensive primary care. Insurance companies have identified the care of chronic health conditions as an important goal. Chronic conditions are ongoing medical problems that must be managed effectively in a partnership between the health care team and the patient to maintain the best possible health. Examples include diabetes, high blood pressure, heart disease, depression and others.

What is chronic care management?

Your physician and primary care team will careful monitor and provide comprehensive care for your chronic health conditions in a systematic way to supplement regular office visit care.

How can you benefit from chronic care management?

- You will receive monthly calls from your care coordinator: Steph A, LPN
- You will have preventive care services scheduled, many of which are covered by your insurance, and your medications will be closely monitored.
- You will receive a personalized, comprehensive plan of care for all of your health issues.
- Your care will be coordinated by your physician and staff, including care you may receive at other locations, such as specialists' offices, the hospital, other health care facilities, or your home.

Please let us know if you have questions about his new benefit.

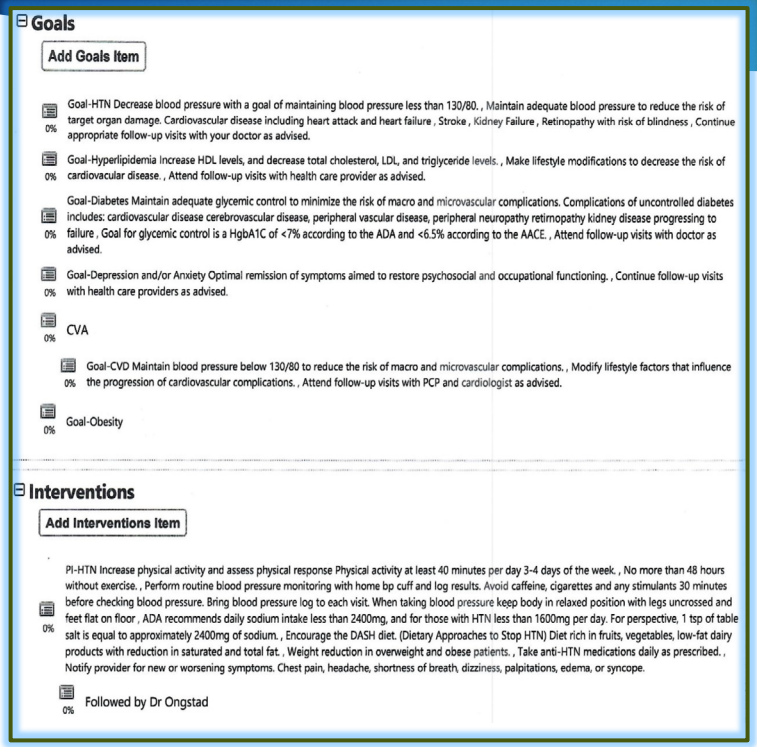
Sincerely,

Brandon Webb, MD

BW/sja

Susan Johnson, MD John Majerus, MD Angela Zavala, APRN DNP Kathleen Pfeffer, APRN
4130 Pioneer Woods Drive Suite 2 Lincoln, Ne. 68506
Nathan DeNell, DO Brandon Webb, MD FAAFP Derek Hutchins, MD Amy Bokowski, APRN NP Ashely Gunderson, PA-C
1240 Aries Drive, Lincoln, NE 68512
Rachel Blake, MD FAAFP James Carraher, MD Scott Wilson, MD Kate Dannewitz, APRN NP
4424 S. 86th St. Lincoln, NE 68526
Telephone: 402-483-2987 Fax: 402-483-2980

CCM PATIENTS



Goals

Add Goals Item

0% Goal-HTN Decrease blood pressure with a goal of maintaining blood pressure less than 130/80. , Maintain adequate blood pressure to reduce the risk of target organ damage. Cardiovascular disease including heart attack and heart failure , Stroke , Kidney Failure , Retinopathy with risk of blindness , Continue appropriate follow-up visits with your doctor as advised.

0% Goal-Hyperlipidemia Increase HDL levels, and decrease total cholesterol, LDL, and triglyceride levels. , Make lifestyle modifications to decrease the risk of cardiovacular disease. , Attend follow-up visits with health care provider as advised.

0% Goal-Diabetes Maintain adequate glycemic control to minimize the risk of macro and microvascular complications. Complications of uncontrolled diabetes includes: cardiovascular disease cerebrovascular disease, peripheral vascular disease, peripheral neuropathy retimopathy kidney disease progressing to failure , Goal for glycemic control is a HgbA1C of <7% according to the ADA and <6.5% according to the AACE. , Attend follow-up visits with doctor as advised.

0% Goal-Depression and/or Anxiety Optimal remission of symptoms aimed to restore psychosocial and occupational functioning. , Continue follow-up visits with health care providers as advised.

0% CVA

0% Goal-CVD Maintain blood pressure below 130/80 to reduce the risk of macro and microvascular complications. , Modify lifestyle factors that influence the progression of cardiovascular complications. , Attend follow-up visits with PCP and cardiologist as advised.

0% Goal-Obesity

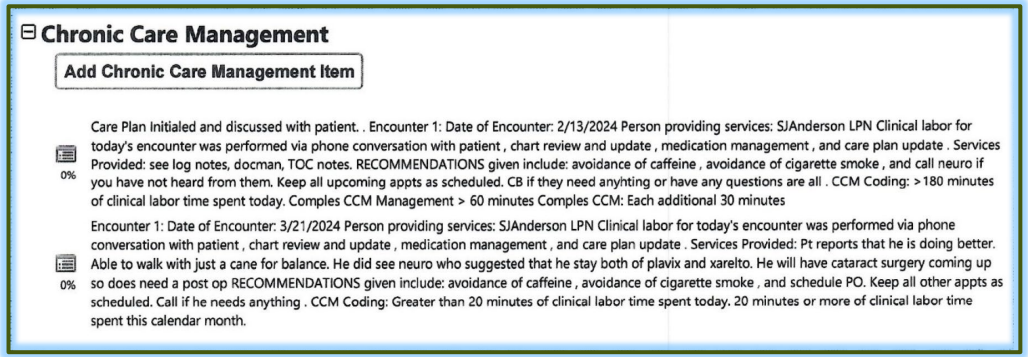
Interventions

Add Interventions Item

0% PI-HTN Increase physical activity and assess physical response Physical activity at least 40 minutes per day 3-4 days of the week. , No more than 48 hours without exercise. , Perform routine blood pressure monitoring with home bp cuff and log results. Avoid caffeine, cigarettes and any stimulants 30 minutes before checking blood pressure. Bring blood pressure log to each visit. When taking blood pressure keep body in relaxed position with legs uncrossed and feet flat on floor , ADA recommends daily sodium intake less than 2400mg, and for those with HTN less than 1600mg per day. For perspective, 1 tsp of table salt is equal to approximately 2400mg of sodium. , Encourage the DASH diet. (Dietary Approaches to Stop HTN) Diet rich in fruits, vegetables, low-fat dairy products with reduction in saturated and total fat. , Weight reduction in overweight and obese patients. , Take anti-HTN medications daily as prescribed. , Notify provider for new or worsening symptoms. Chest pain, headache, shortness of breath, dizziness, palpitations, edema, or syncope.

0% Followed by Dr Ongstad

CARE PLAN MANAGMENT



Chronic Care Management

Add Chronic Care Management Item

0% Care Plan Initialed and discussed with patient. . Encounter 1: Date of Encounter: 2/13/2024 Person providing services: SJAnderson LPN Clinical labor for today's encounter was performed via phone conversation with patient , chart review and update , medication management , and care plan update . Services Provided: see log notes, docman, TOC notes. RECOMMENDATIONS given include: avoidance of caffeine , avoidance of cigarette smoke , and call neuro if you have not heard from them. Keep all upcoming appts as scheduled. CB if they need anyhting or have any questions are all . CCM Coding: >180 minutes of clinical labor time spent today. Comples CCM Management > 60 minutes Comples CCM: Each additional 30 minutes

0% Encounter 1: Date of Encounter: 3/21/2024 Person providing services: SJAnderson LPN Clinical labor for today's encounter was performed via phone conversation with patient , chart review and update , medication management , and care plan update . Services Provided: Pt reports that he is doing better. Able to walk with just a cane for balance. He did see neuro who suggested that he stay both of plavix and xarelto. He will have cataract surgery coming up so does need a post op RECOMMENDATIONS given include: avoidance of caffeine , avoidance of cigarette smoke , and schedule PO. Keep all other appts as scheduled. Call if he needs anything . CCM Coding: Greater than 20 minutes of clinical labor time spent today. 20 minutes or more of clinical labor time spent this calendar month.

OUTCOMES

ANNUAL WELLNESS VISITS

- AS OF MARCH 2024, PCP HAD TOTAL OF 4100 MEDICARE PATIENTS
- ROLLING TOTAL OF AWV COMPLETED OVER THE LAST YEAR IS AT 76%

OUTCOMES

Pioneer Greens Clinic

Acute Hospital Utilization (AHU) – PBA*

Observed-to-Expected Ratio (Risk Adjusted)

My Practice	Change from	My Practice	All Regions
0.87	3%	0.85	0.94
2023Q3	2023Q2	2023Q2	2023Q3

Emergency Department Utilization (EDU)

Observed-to-Expected Ratio (Risk Adjusted)

My Practice	Change from	My Practice	All Regions
0.69	-4%	0.72	1.05
2023Q4	2023Q3	2023Q3	2023Q4

Total Medicare FFS Expenditures

Per Beneficiary Per Month

My Practice	Change from	My Practice	All Regions
$837	8%	$773	$885
2023Q4	2023Q3	2023Q3	2023Q4

Meadowlark Clinic

Acute Hospital Utilization (AHU) – PBA*

Observed-to-Expected Ratio (Risk Adjusted)

My Practice	Change from	My Practice	My Region
0.87	3%	0.85	0.91
2023Q3	2023Q2	2023Q2	2023Q3

Emergency Department Utilization (EDU)

Observed-to-Expected Ratio (Risk Adjusted)

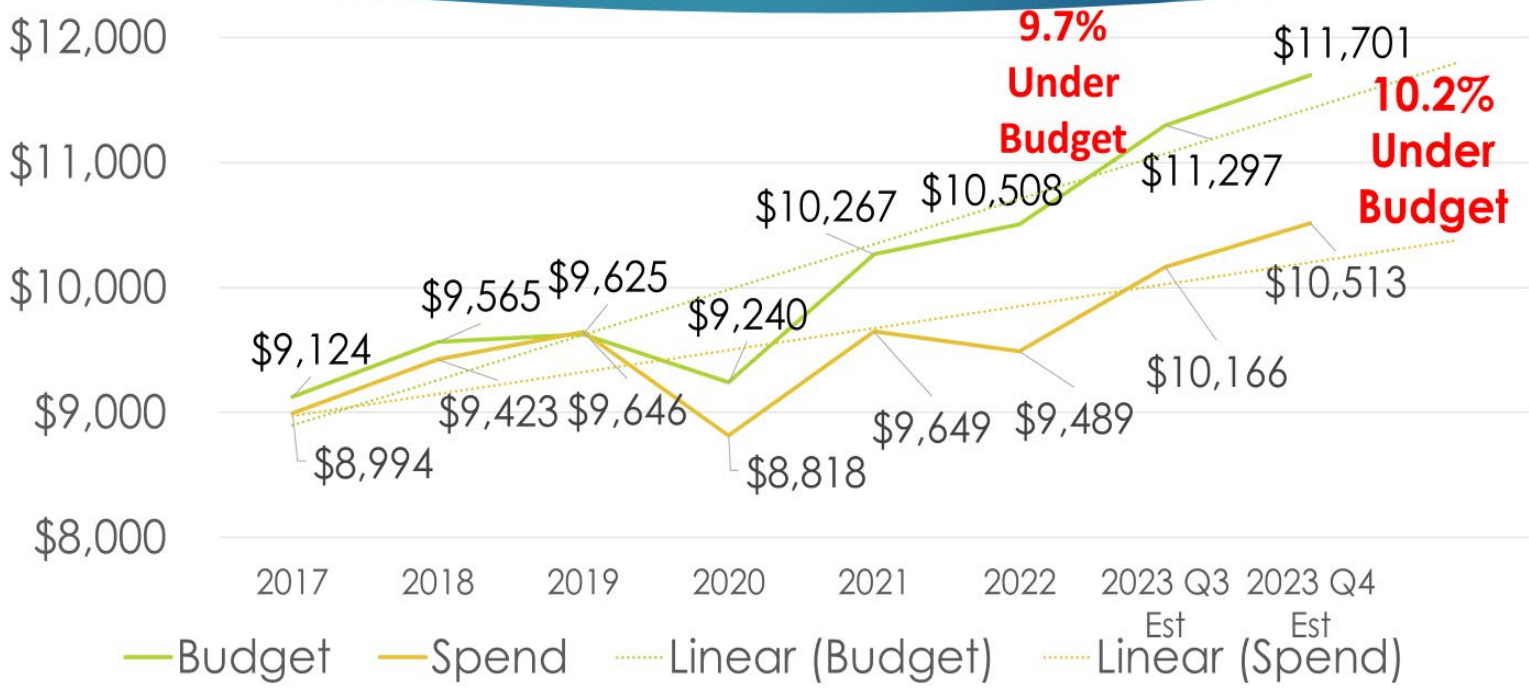
My Practice	Change from	My Practice	My Region
0.74	-6%	0.79	0.92
2023Q4	2023Q3	2023Q3	2023Q4

Total Medicare FFS Expenditures

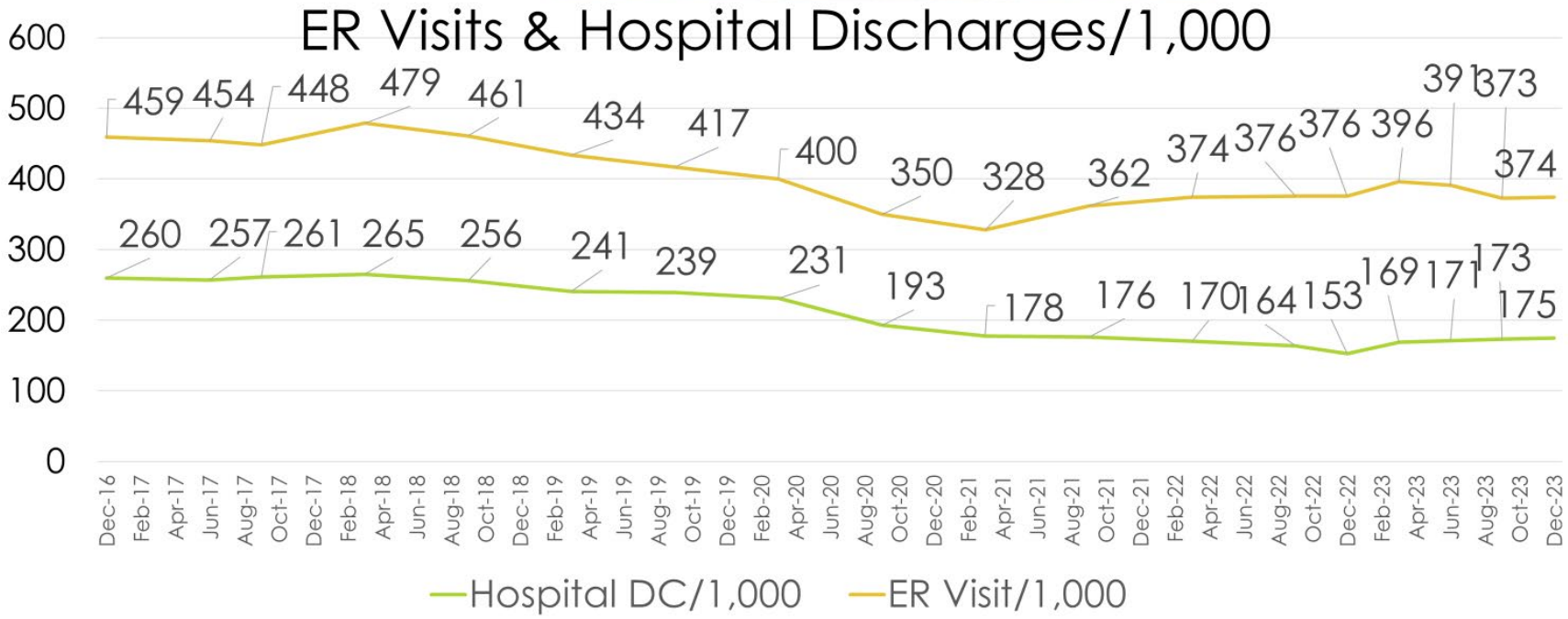
Per Beneficiary Per Month

My Practice	Change from	My Practice	My Region
$760	2%	$748	$858
2023Q4	2023Q3	2023Q3	2023Q4

OneHealth Nebraska ACO Medicare Annual Cost Per Patient



OneHealth Nebraska ACO



Collaborative Care

- Care Coordinators work with the providers to communicate concerns, barriers to care, and close gaps between the AWV and preventative exam.
- Nurse led AWV is an effective way to assist Medicare patients in meeting their preventive needs while allowing providers more time to focus on chronic and acute needs.
- Together nurses and providers can improve the quality and value of care Medicare patients receive.

Farford, B. A., Baggett, C. L., Paredes Molina, C. S., Ball, C. T., & Dover, C. M. (2021). Impact of an RN-led Medicare Annual Wellness Visit on Preventive Services in a Family Medicine Practice. *Journal of Applied Gerontology*, *40*(8), 865-871. https://doi.org/10.1177/0733464820947928


ANY QUESTIONS

The Medicare Annual Wellness Visit Opportunities

Kevin McNeill MD

Associate Medical Director LVHN ACO

Lehigh Valley Health Network

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

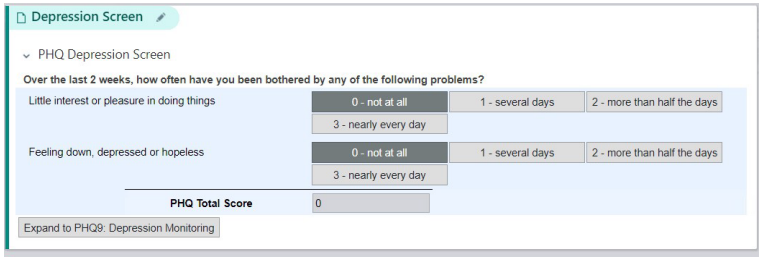
LVHN ACO's MSSP

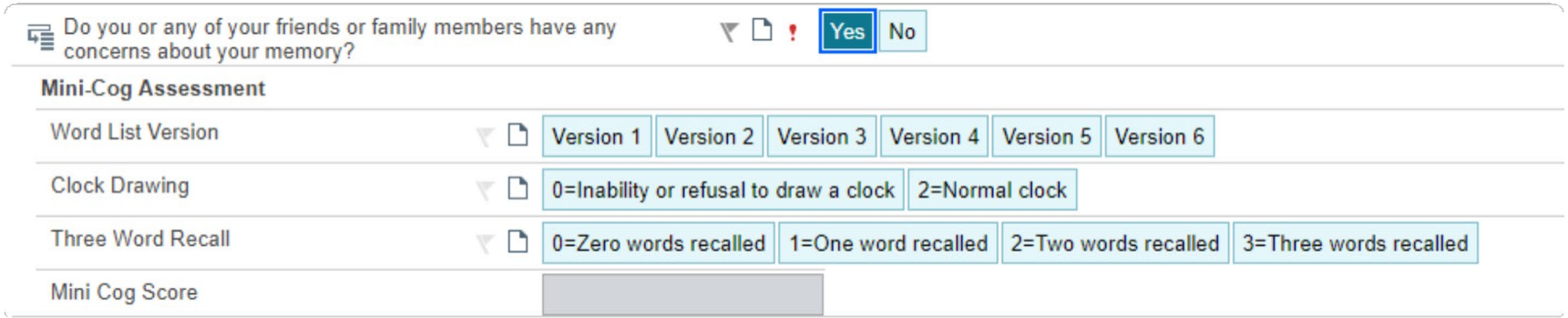
- **ACO Mission-**To foster a collaborative delivery of patient centered, high-value care to support individuals and groups in the achievement of better health and well-being
- **ACO Vision-** To elevate the health and well-being of our beneficiaries and the communities we serve
- Set up as a distinct legal entity (LLC)
- ~40,000 Medicare fee-for-service beneficiaries, attributed for 2024
- Founded in 2014, started program in 2015

Agreement Period 1 (2015-2017)	Agreement Period 2 (2018-2021)	Agreement Period 3 (2022-2026)
• Track 1 (upside only) • Earned Shared Savings • Quality above average • Philadelphia Area Wage Index (AWI) introduced	• Track 1 (upside only) • Newark AWI • AWI net worth $30M per year • MIPS increases	• Pathways to Success BASIC Track Level E • Second year in down-side risk • aAPM bonus payable in 2024

Depression is Not a Normal Part of Growing Older
https://www.cdc.gov/aging/depression

- Older adults are at increased risk.
- We know that about 80% of older adults have at least one chronic health condition, and 50% have two or more.
- Depression is more common in people who also have other illnesses (such as heart disease or cancer) or whose function becomes limited.
- Older adults are often misdiagnosed and undertreated.
- Healthcare providers may mistake an older adult's symptoms of depression as just a natural reaction to illness or the life changes that may occur as we age, and therefore not see the depression as something to be treated.
- Older adults themselves often share this belief and do not seek help because they don't understand that they could feel better with appropriate treatment.





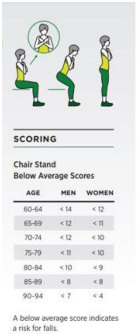
Mild Cognitive Impairment

- 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

Vaishya R, Vaish A. Falls in Older Adults are Serious. Indian J Orthop. 2020 Jan 24;54(1):69-74. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7093636/

- The falls in elderly are on rise and taking the shape of an epidemic.
- Prevention of these falls is far better than the management.
- Safe living environment of the elderly people helps in prevention of these falls.
- The management of the falls should focus on the causative factors, apart from treating the injuries caused by the falls.

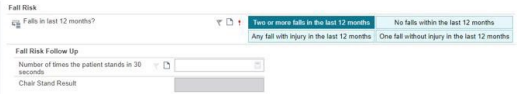


SCORING

Chair Stand
Below Average Scores

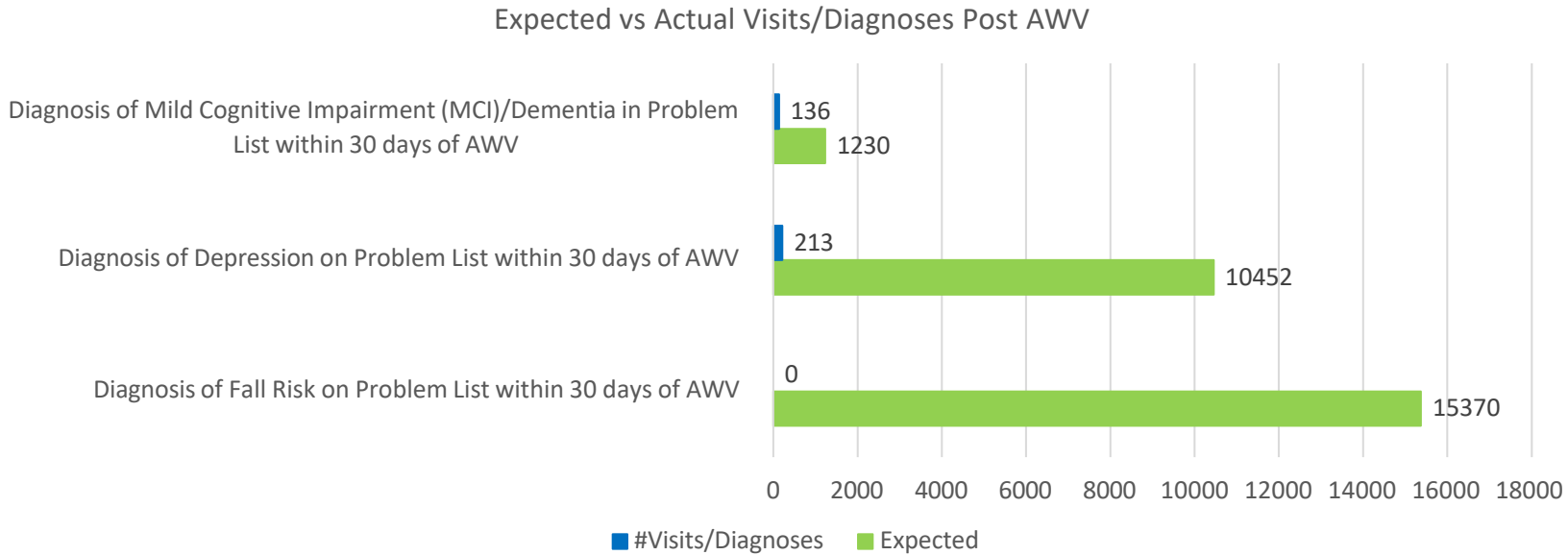
AGE	MEN	WOMEN
60-64	< 14	< 12
65-69	< 12	< 11
70-74	< 12	< 10
75-79	< 11	< 10
80-84	< 10	< 9
85-89	< 8	< 8
90-94	< 7	< 4

A below average score indicates a risk for falls.



Follow up Metrics/Opportunities Missed?

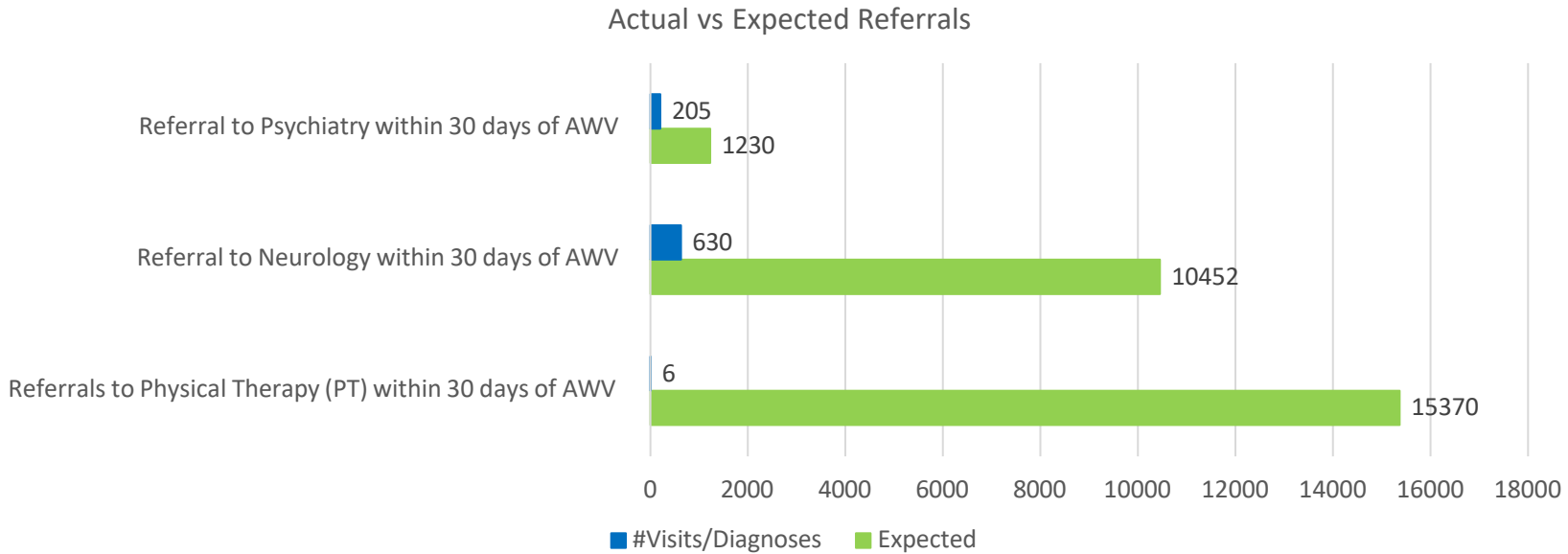
- Source of Expected: Falls - 25% of 65+ fall annually https://ncoa.org/article/get-the-facts-on-falls-prevention
  - MCI/Dementia (prevalence is 234/10,000) & Depression (prevalence is calculated from MSSP population



NOTE: Data source EPIC 1/1/22-12/31/22. Expected estimates based on condition prevalence in LVHN ACO MSSP population; 2% dementia & 17% depression.

Follow up Metrics/Opportunities Missed?

- Source of Expected: Falls - 25% of 65+ fall annually https://ncoa.org/article/get-the-facts-on-falls-prevention
  - MCI/Dementia (prevalence is 234/10,000) & Depression (prevalence is calculated from MSSP population



NOTE: Data source EPIC 1/1/22-12/31/22. Expected estimates based on condition prevalence in LVHN ACO MSSP population; 2% dementia & 17% depression.

The Growing Problem

- Research suggests that substance use disorders are on the rise among older adults in the United States.
- Eight million older Americans have a substance use or mental health condition.
- Baby boomers have different lifestyles and attitudes compared to earlier generations of older adults.
- Dealing with stressful life events can lead to risky behaviors.
  - Retirement
  - Loss of a spouse
  - Development of chronic disease

- Substance Abuse and Mental Health Services Administration. (2011). *Leading change: A plan for SAMHSA's roles and actions 2011-2014*. (HHS Publication No. SMA 11-4629). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- (Mattson, M., Lipari, R.N., Hays, C. and Van Horn, S.L. *A day in the life of older adults: Substance use facts.* The CBHSQ Report: May 11, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD).

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)?”

- Inconsistent screen prior to pilot
- With protocol in place screening was done approximately 50% of the time
- 2 PDSA cycles resulted in slight workflow changes:
- Laminated prescreen distributed by front desk
- Laminated AUDIT and DAST 10 distributed by clinical staff
- Screening test scored by clinician

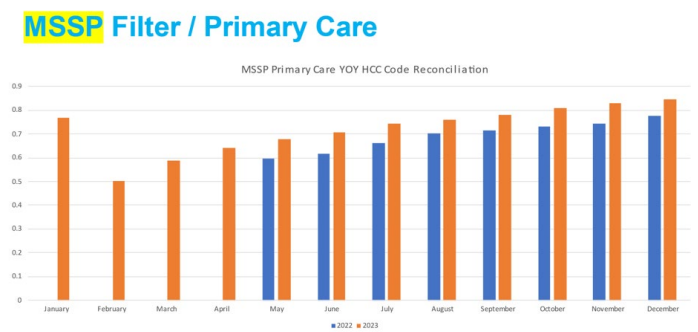
	Baseline AUDIT C & AUDIT	Baseline NIDA & DAST 10	1st intervention AUDIT C	1st intervention NIDA	1st intervention AUDIT	1st intervention DAST 10
Numerator	0	0	84	84	0	0
Denominator	144	144	110	110	110	110
Rate	0.0%	0.0%	76.4%	76.4%	0.0%	0.0%

Second intervention NIDA	Second Intervention AUDIT	Second Intervention DAST 10	Third intervention AUDIT C	Third intervention NIDA	Third Intervention AUDIT	Third Intervention DAST 10
43	0	0	42	42	0	0
78	78	78	90	90	90	90
55%	0%	0%	47%	47%	0%	0%

Coding Opportunities

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

2023 MSSP Filter / Primary Care



3M HCC Engage Clinician Metrics – Diagnostic Coding Reconciliation

Physician Leader: Dr. Jennifer Stephens

This dashboard reflects the performance of clinicians currently using the 3M HCC Engage tool to manage the capture and reconciliation of patient diagnosis codes. The performance data is calculated through the addition of applicable chronic condition codes captured during an encounter plus those dismissed (via 3M and / or the Epic BPA), compared to all the codes presented to individual clinicians (via 3M and Epic). The goal is for accurate code capture and reconciliation.

Note: It is important to first select the correct HCC specific view from the Specialty Specific HCC View filter before filtering on Practice, Department, or Provider.

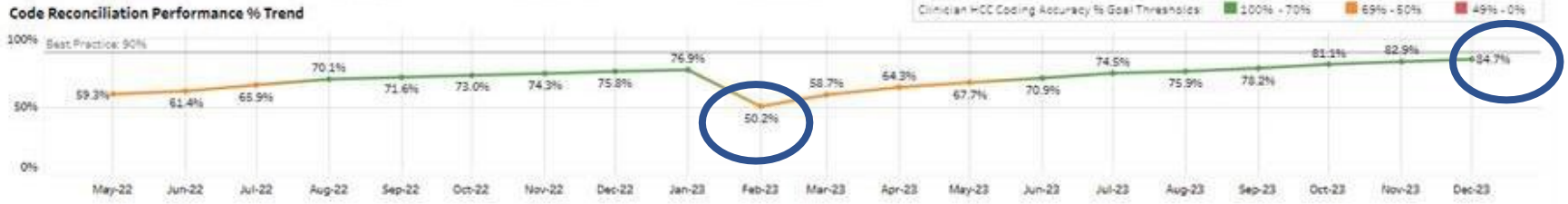
Data by Enterprise Analytics
Last Update: 01/04/2024 10:28
Data is updated weekly
Data current through 01/03/2024

Calendar Year	Month/Year	Entity	Specialty Specific HCC View	Specialty	Practice	Department	Provider	HCC Code and Name
(All)	(Multiple values)	(All)	Primary Care	(All)	(Multiple values)	(All)	(All)	(All)

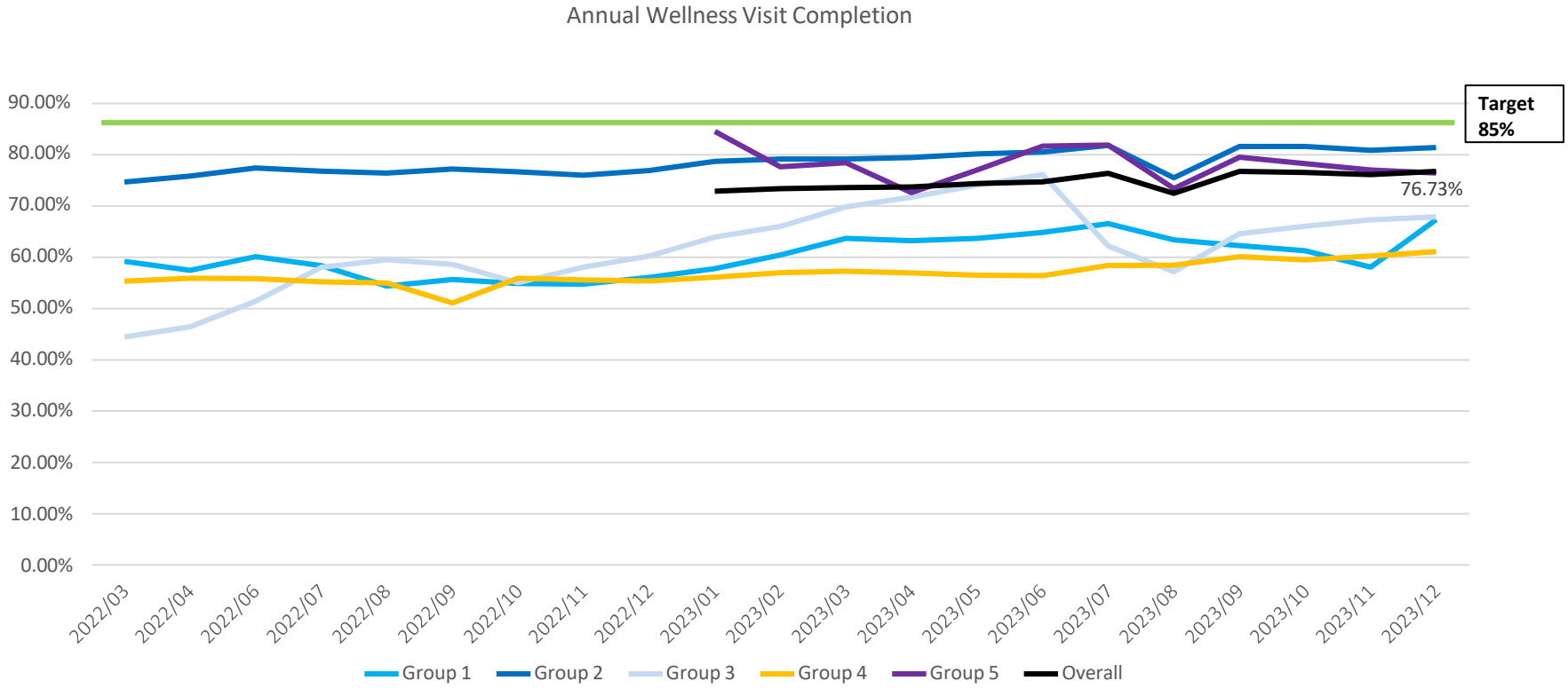
Encounter Type	Visit Type	Attributed Plan	Primary Payor	Primary Plan	3M Provider?	Has BPA Alert?	Has 3M Message?
(All)	(All)	MSSP	(All)	(All)	(All)	(All)	(All)

Code Reconciliation Performance %	Total Encounters	Total Patients	Total Encounters with BPA	Total Encounters with 3M Message	Total Encounters with 3M Message and BPA
70.7%	112,662	27,181	32,037	65,035	22,083

Code Reconciliation Performance % Trend



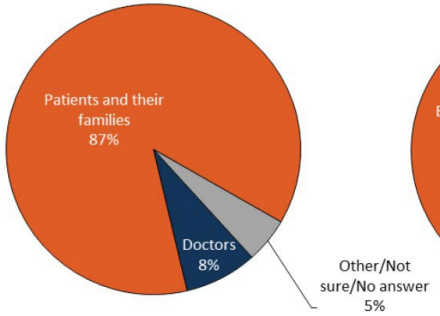
Annual Wellness Visit Trends



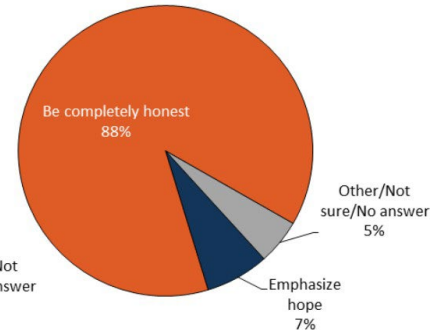
AWV Progress

Public Wants Patients/Families to Have Biggest Say in Medical Decisions, and Doctors to be Honest About Prognosis

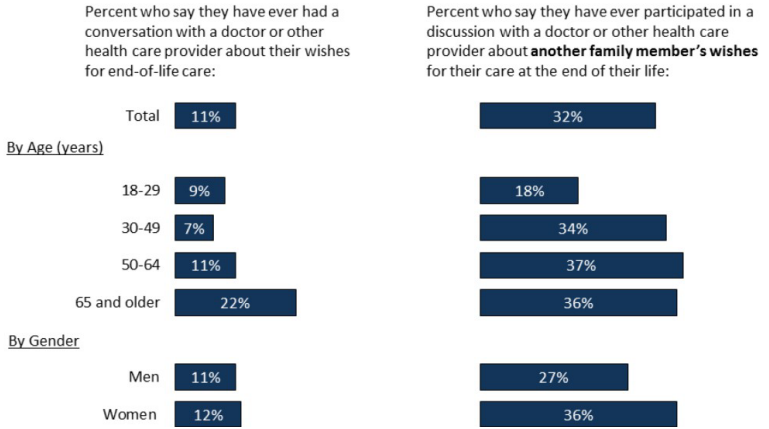
Who do you think should have the greater say in decisions about which medical treatments to pursue for seriously ill patients who are near the end of their lives?



When a patient is seriously ill, do you think it is more important for their doctors to emphasize hope, or more important for doctors to be completely honest even if there is little chance of recovery?



1 in 10 Report Discussing Their Own End-of-Life Care Wishes With a Health Care Provider



Care Wishes

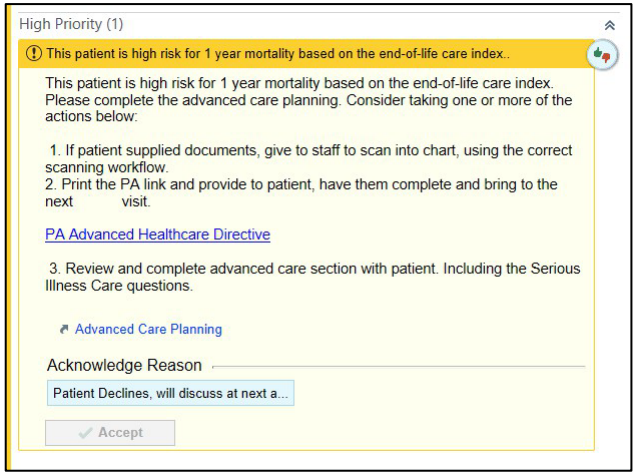
Views and Experiences with End-of-Life Medical Care in the U.S.
KFF

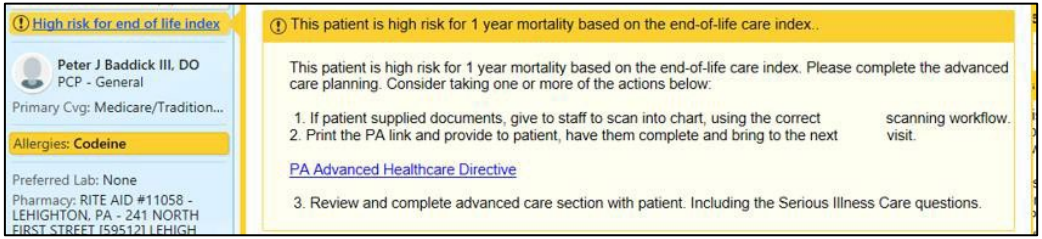
Advance Care Planning BPA

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	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.

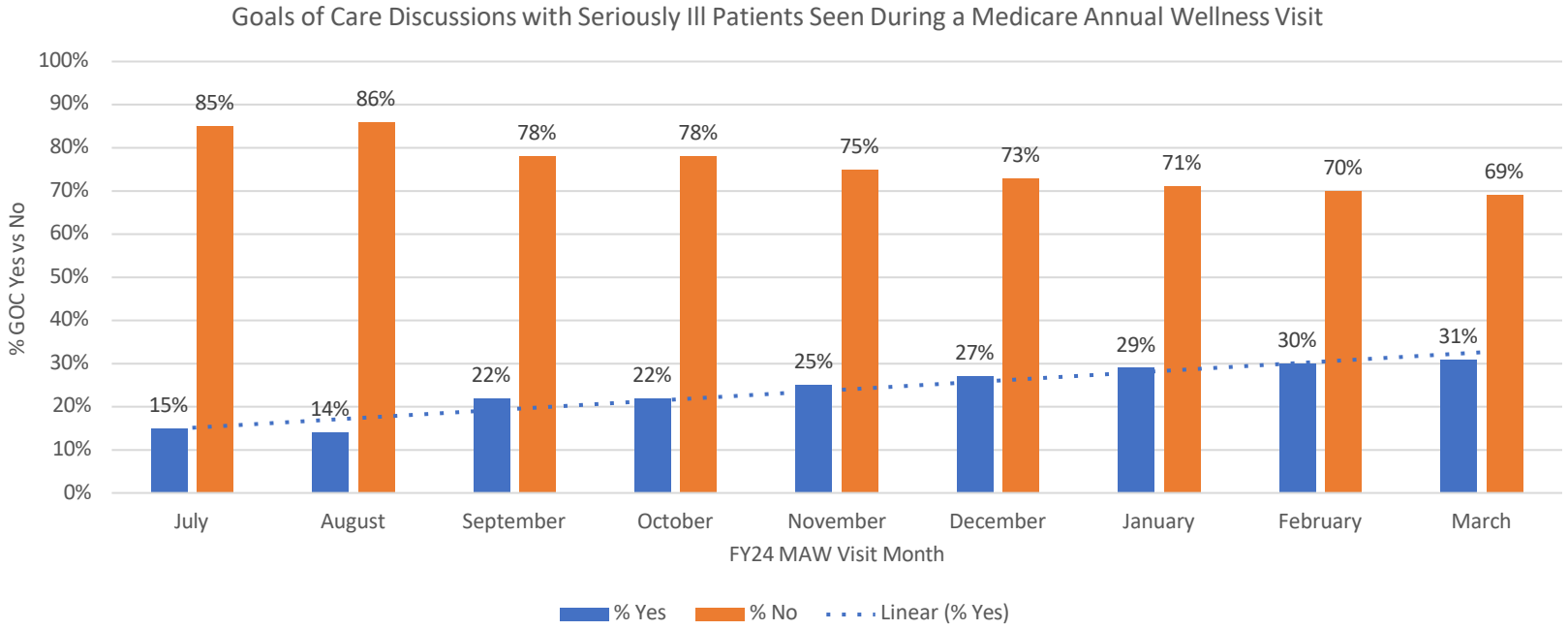
Reviewed by	MCNEILL, KEVIN A
Reviewed time	5/19/2022 1:16 PM Now

Cognitive Computing Model Brief: End of Life Care Index

The Epic EOL Index model is a logistic regression model that predicts risk of 12-month mortality.

It takes in 46 input features including demographics (e.g., age, sex, insurance status), labs (e.g., albumin, RDW), comorbidities (e.g., such as those relating to cancer, neurological diagnoses, cardiologic diagnoses, and more), and medications.

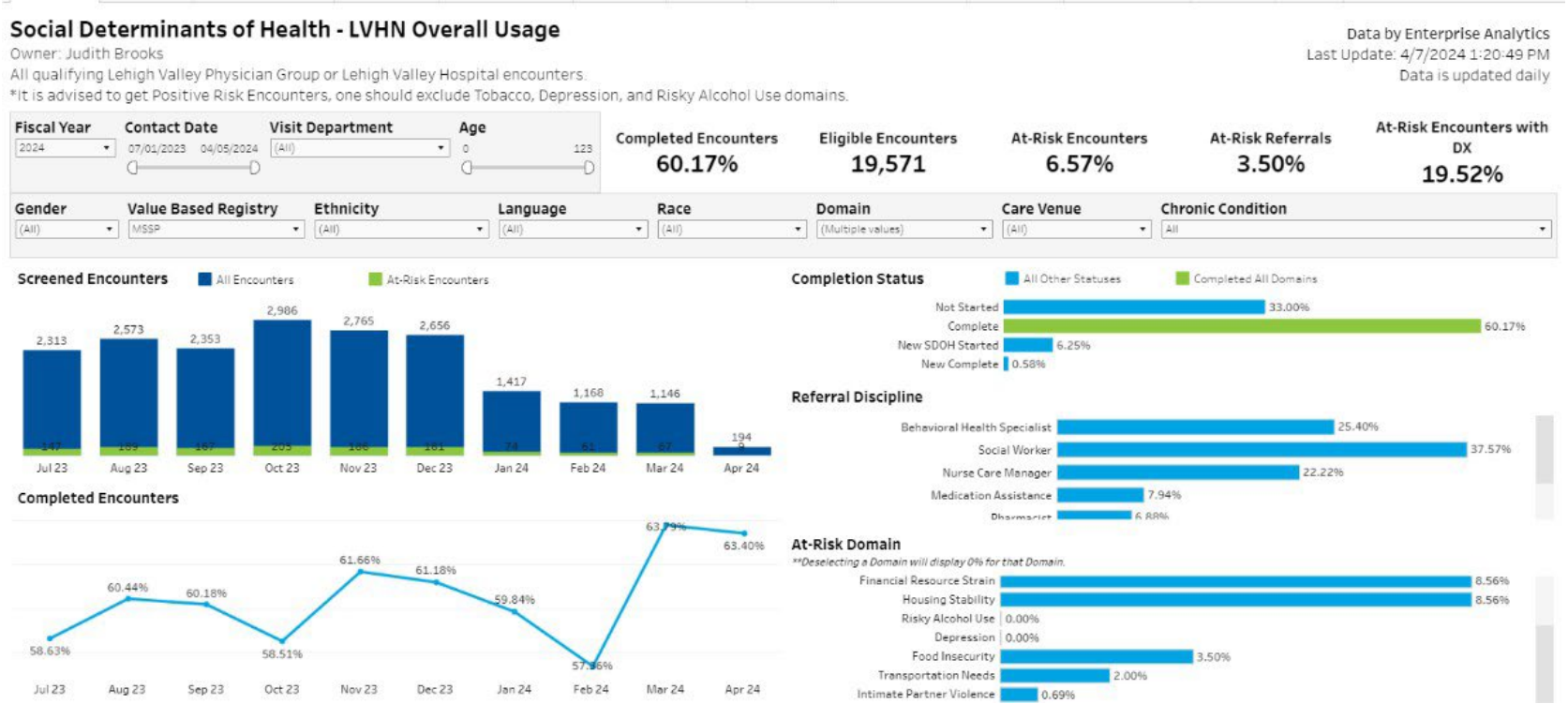
Serious Illness Conversation/GOC



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-focuses on the 5 domains for which the positive BPA fires (Food, Housing, Transportation, IPV, Financial Resource Strain).



SDOH Screening LVHN

Successes

- Standardized screening
- Number of patients screened
- Expansion of screening to IP settings
- Integrating FindHelp into the EMR

Challenges

- Tying SDOH to health outcomes or access to healthcare
- Defining “success or improvement” (ie are our interventions making a difference)
- Leveraging FindHelp to fullest potential
- Availability of/partnerships with community resources
- Lack of financial incentives (risk adjustment, FFS revenue, quality payments) to screen & address, volume of patients w “needs” based on positivity rates (sensitivity of the tool to capture patients w modifiable factors)

Summary

- An integrated approach to AWV results in strong capture rates, improved performance in population health management, and opportunities for advanced care planning.
- Opportunities abound in identifying and managing at risk patients

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Questions

AWVs: Oh The Possibilities!

- While use of AWVs is increasing, what information isn't being used in positive actions in your ACO?
- Other than quality reporting, how are abnormal values being followed up on?
- Are actionable care plans embedded in EMRs or office workflows?
- Are advanced care plans and POA information available where and when they are most needed? (the ED)
- Let's discuss what your ACO is or isn't doing and how to advance the information collected in the AWV to improve patient quality of life and care.

Contact Information

Speakers

- **Dr. Kevin McNeill:** Kevin_A.Mcneill@lvhn.org
- **Angela Zavala:** azavala@primarycarepartnersne.com

NAACOS Staff

- **Melody Danko-Holsomback:** mdholsomback@naacos.com
- **Karen Fetterolf:** kfetterolf@naacos.com

Thank you

Appendix

Session Notes

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.