NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Together, our voices elevate all.

Elevate *Learning Forum*

Annual Wellness Visits (AWVs)

March 8, 2022

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF Community Health Centers®

Packaging and implementing evidence-based transformational strategies for safety-net providers

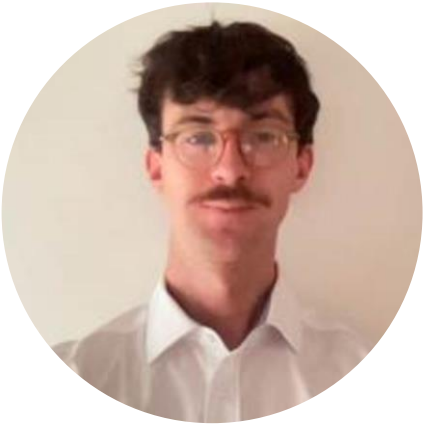
Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director,
Quality Center

Cassie Lindholm

Deputy Director,
Quality Center



Addison Gwinner

Specialist,
Quality Center

Joining Today's Call

Gervean Williams
NACHC

Lisa Messina
Messina Consulting

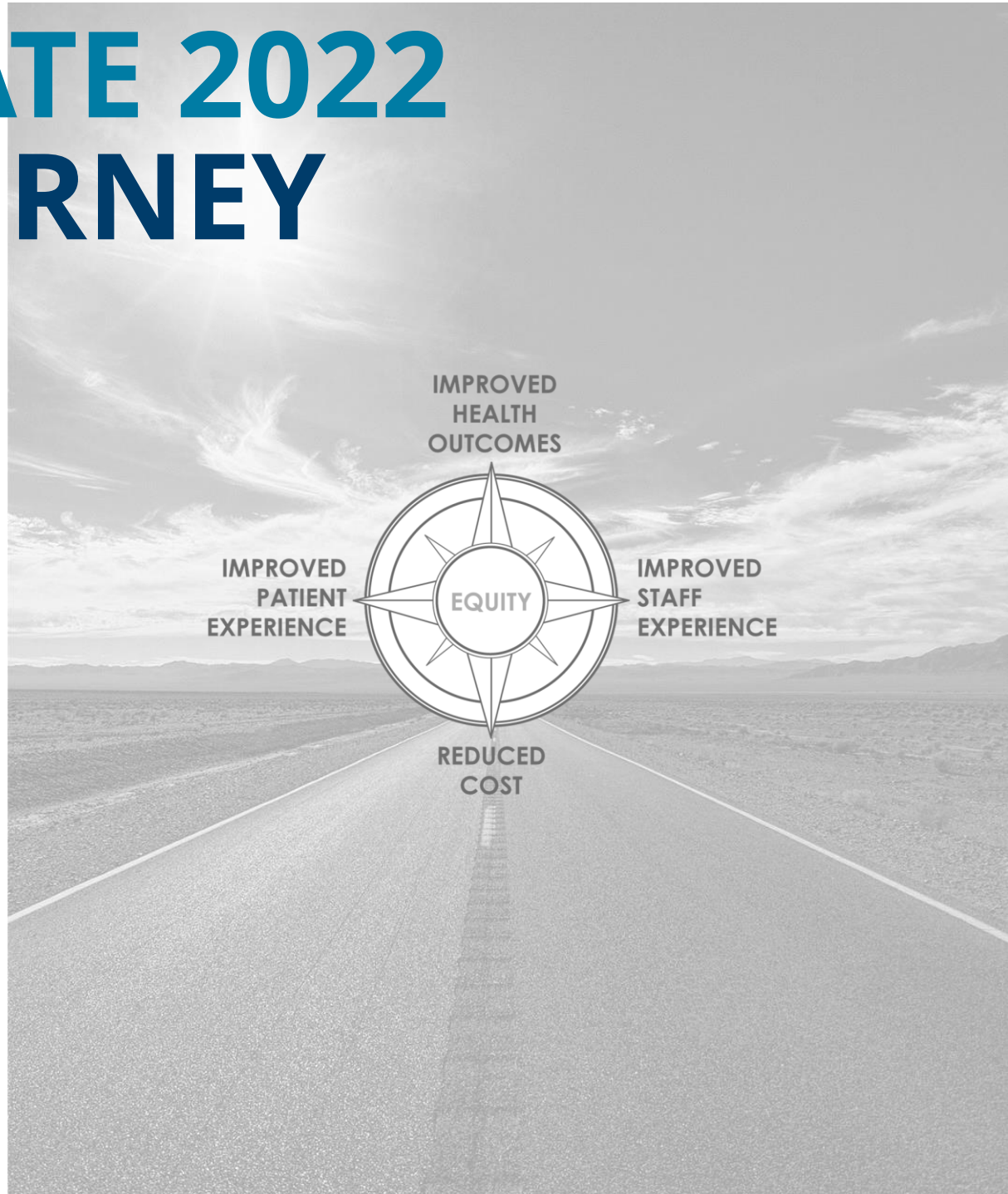
Rebekah Wallace Pardeck
Achieve Revenue

Victor Lanovych
Keystone Rural Health (PA)

Cherona Owens
Evara Health (FL)

ELEVATE 2022 JOURNEY

- Leadership
- Empanelment
- Population Health: Risk Stratification
- Care Management
- Payment
- Care Teams
- Evidence-Based Care
- Social Drivers of Health (SDOH)
- Improvement Strategy
- Workforce
- Health Information Technology
- Patients
- Partnerships
- Policy
- Cost
- Patient-Centered Medical Home



Elevate Journey…
Your Way

2nd Tuesday, monthly, 1-2 pm

Elevate Learning Forum

Learning Forum:

- Microlearning
- Field examples
- Human-centered design
- Discussion

4th Thursday, monthly, 1-2 pm

Elevate Connect

Elevate *Connect*:

- Gather with peers
- Share & exchange tools
- Discussion

Self-paced

Online Platform

Online Platform:

- Library of microlearnings
- Repository of tools & resources

Microlearning: Annual Wellness Visits

Modules	Action Steps	Resources
What? Why? How?	**STEP 1** Compile a List of Patients Eligible for an AWV **STEP 2** Outreach to Schedule AWV **STEP 3** Manage Care Team Roles & Schedule AWV **STEP 4** Conduct AWV • Health Risk Assessment (HRA), screenings, & substance use • Medical and family history • Current providers/suppliers • Preventive screening schedule • Offer Advanced Care Planning Services • Obtain measurements • Assess functional ability • Assess cognitive function • Establish a list of risk factors • Provide personalized health advice or referrals **STEP 5** Document, Code, and Bill for AWV	Payment Reimbursement Tips: Initial Preventative Physical Exam and Annual Wellness Visits CMS Medicare Wellness Visits

Annual Wellness Visits

WHAT?

WHY?

HOW?

WHAT is an Annual Wellness Visit (AWV)?

Part of Medicare's suite of "Wellness Visits"

Initial Preventive Physical Examination (IPPE)

IPPE

- Within 12 months of Medicare Part B enrollment.
- One-time benefit. "Use it or lose it"

Initial **Annual Wellness Visit (AWV)**

Initial AWV

- No longer within 12 months of enrollment **OR** 12 months after IPPE
- One lifetime benefit

Subsequent **Annual Wellness Visit (AWV)**

Subsequent AWV

- 12 months after initial AWV
- One subsequent AWV per year thereafter.

WHAT

Elements of an IPPE, Initial AWV, and Subsequent AWV

Element	Component Examples	IPPE G0402	Initial AWV G0438	Subsequent AWV G0439
Perform a Health Risk Assessment (HRA) +	Patient Self-reported information (HRA). At a minimum, collect information about demographics, health status, psychosocial risks, behavioral risks, ADLs. Consider communication options for challenged patients (i.e., non-English speaking, disabled, limited literacy)		x	Review & Update
Establish medical and social history	Medical, surgical and family histories (i.e. parents, siblings, children), hereditary conditions, allergies, injuries, current medications and supplements, diet, physical activities, alcohol, tobacco, and illegal drug use.	x	x	Update

Sample from full tool

New table that is part of NACHC's 2022 updated IPPE/AWV Reimbursement Tips that will be available by May 24, 2022.

Annual Wellness Visits

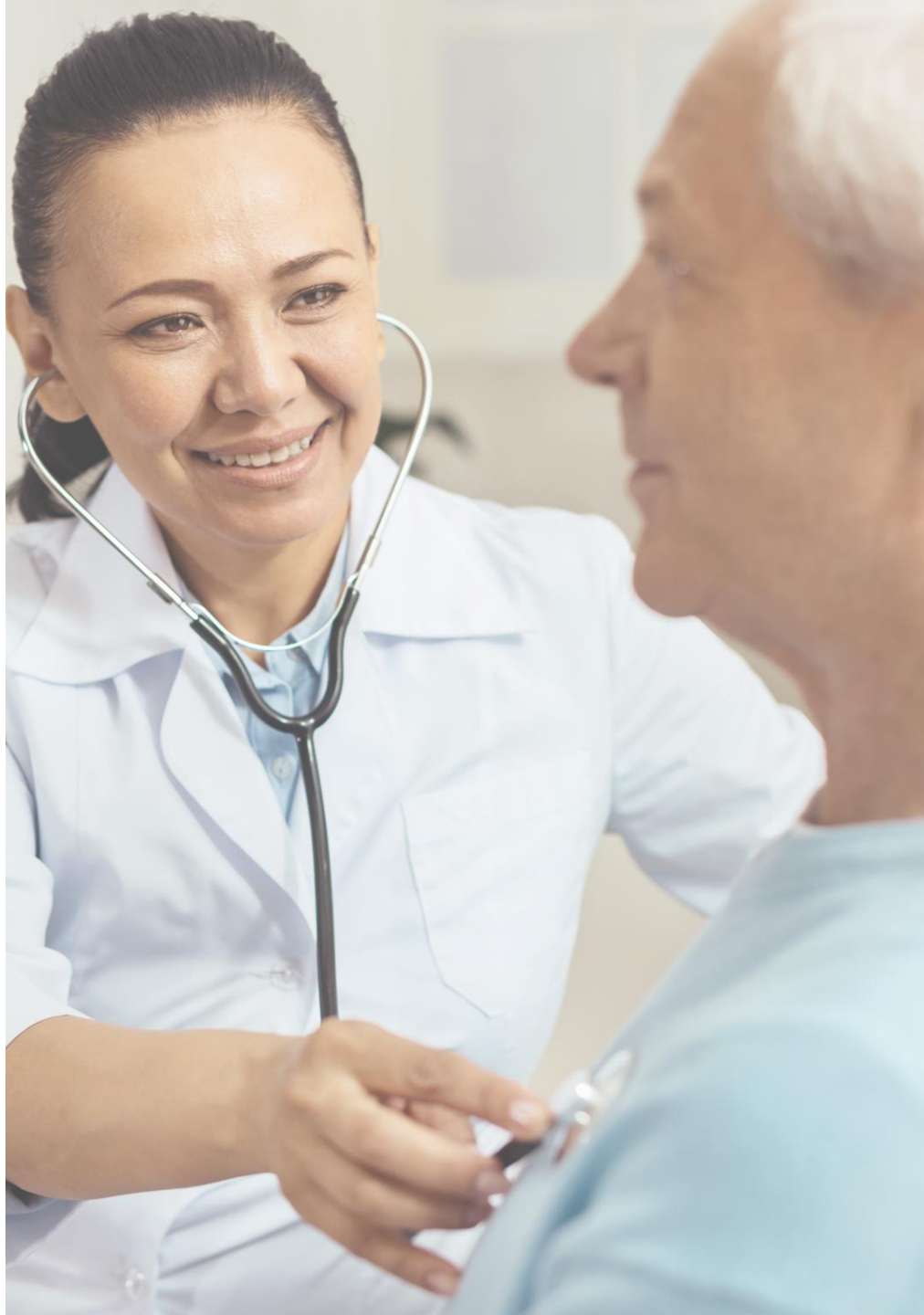
WHAT?

WHY?

HOW?

WHY
Annual Wellness Visits?

- **Contributes to quality care.** Allows providers and care teams to gain information about the patient, including medical and family history, assess health risks, and promote positive health behaviors.
- **Offers reimbursement opportunity driven by extended care team.**
- Qualifies as an **"initiating" visit for care management** if conducted in the year prior to start. Care management provides its own unique reimbursement opportunity.



Annual Wellness Visits

WHAT?

WHY?

HOW?

Step 1:
Compile a list of eligible patients

Build on your Empanelment and Risk Stratification work:

- Consider both empaneled and attributed patients

Identify patients eligible for an AWV:

Initial AWV

- No longer within 12 months of enrollment OR 12 months after IPPE
- One lifetime benefit

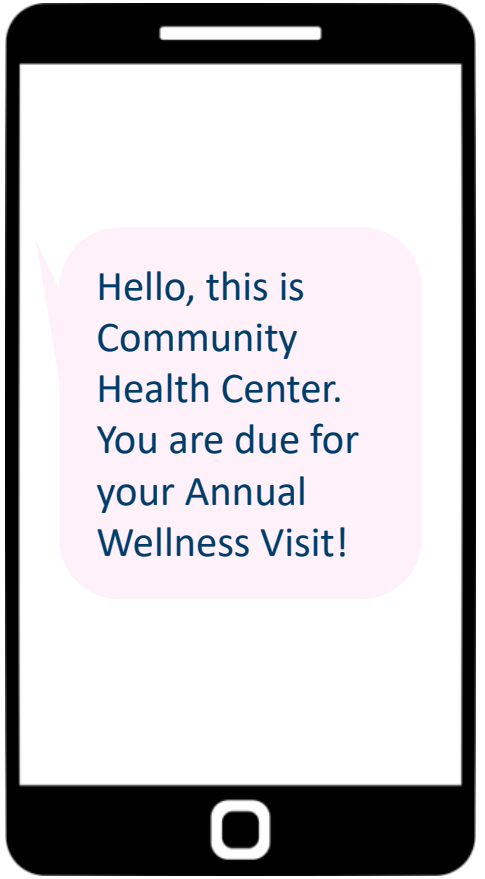
Subsequent AWV

- 12 months after initial AWV
- One subsequent AWV per year thereafter.

Step 2:
Outreach to schedule AWV appointments

Optimize the use of technology to reach out to patients and schedule appointments

- Texts
- Phone calls
- Portal messages



Step 3:
Manage Care Team Roles & Schedule AWV

- **Expanded care team roles!** Much of the AWV can be completed by MA, RN, CHW, or other care extenders
- **Focused provider role**. Only those services that can be done by an authorized provider.
- **Move much of the work of AWV outside of the provider schedule**:
  - Phone or video call before provider component of the AWV
  - Care extender meets with patient before provider visit
  - Patient-driven processes (electronic forms, kiosks) to self-complete screenings

Step 4: Conduct AWV

Meets AWV requirements for:

- ✓ Perform Health Risk Assessment
- ✓ Review patient's potential depression risk factors
- ✓ Review patient's functional level of safety
- ✓ Screen for potential SUDs

Patient completes screening questions, including:

- Patient self-assessment *(how does the patient rate their health)*
- Tobacco use screening
- Alcohol use screening
- Substance use screening
- Depression screening
- SDOH screening (PRAPARE)
- Activities of daily living (ADLs)
- Home safety

Optimize Technology and Care Team Roles!

Can be completed by MA, nurse, CHW, or other care extender

Complete prior to the visit via phone/video to reduce staff time needed during the visit

Use electronic forms for patients to self-complete

Step 4: Conduct AWV

Meets AWV requirements for:

- ✓ Establish patient's medical and family history
- ✓ Review current opioid prescriptions

Review and update the patient's history

- Medications *(including opioids and supplements)*
- Allergies
- Medical history
- Surgical history
- Hospitalizations
- Family history

Optimize Technology and Care Team Roles!

Can be completed by MA, nurse, CHW, or other care extender

Compete prior to the visit via phone/video to reduce staff time needed during the visit

Use electronic forms for patients to self-complete

Step 4: Conduct AWV

Meets AWV requirements for:

- ✓ Establish list of current providers and suppliers

Document the patient's care team members

Establish a list of current providers who provide regular care. For example:

- Medical specialty providers
- Behavioral health providers
- Dental providers
- Home health

Optimize Technology and Care Team Roles!

- Can be completed by MA, nurse, CHW, or other care extender
- Compete prior to the visit via phone/video to reduce staff time needed during the visit
- Use electronic forms for patients to self-complete
- Share with patient as part of the visit summary

Step 4: Conduct AWV

Meets AWV requirements for:

- ✓ Establish an appropriate written screening schedule

Establish a screening schedule

Establish a written screening schedule, such as a checklist, for the next 5-10 years, see Medicare Services Checklist. For example, consider:

- Colorectal cancer screening
- Breast cancer screening
- Immunizations

Optimize Technology and Care Team Roles!

Can be completed by MA, nurse, CHW, or other care extender

Compete prior to the visit via phone/video to reduce staff time needed during the visit

Share with patient as part of the visit summary

Step 4: Conduct AWV

Meets AWV requirements for:

- ✓ Provide ACP services at patient's discretion

At the patient's discretion, offer Advanced Care Planning (ACP) Services

ACP is a discussion between a care team member and the patient about:

- Preparing an advance directive in case an injury or illness prevents them from making health care decisions
- Future care decisions they might need to make
- How they can let others know about care preferences
- Caregiver identification
- Explanation of advance directives, which may involve completing standard forms

Time spent completing ACP is an additional billing opportunity!

Optimize Technology and Care Team Roles!

Can be completed by MA, nurse, CHW, or other care extender

Offering ACP is needed for AWV. *Providing* ACP can be done as a separate visit if more time is needed

If ACP is completed, share with patient as part of the visit summary

Step 4:
Conduct AWV

Meets AWV requirements for:

✓ Measure

Obtain patient measurements

- Height
- Weight
- BMI (or waist circumference)
- Blood pressure

Optimize Technology and Care Team Roles!

Can be completed by MA, nurse, CHW, or other care extender

During the COVID-19 PHE, when the visit is conducted via telehealth, document any information:

-self-reported by the patient -unable to be obtained -visually observed

Step 4: Conduct AWV

Meets AWV requirements for:

- ✓ Review patient's functional ability and level of safety

Assess functional ability

- Falls risk
- Hearing impairment

Optimize Technology and Care Team Roles!

Can be completed by MA, nurse, CHW, or other care extender

During the COVID-19 PHE, when the visit is conducted via telehealth, document any information:

-self-reported by the patient -unable to be obtained -visually observed

Step 4: Conduct AWV

Meets AWV requirements for:

- ✓ Detect any cognitive impairment

Assess cognitive function

Assess cognitive function by direct observation, considering information from the patient, family, friends, caregivers, and others.

Consider using a brief cognitive test, health disparities, chronic conditions, and other factors that contribute to increased cognitive impairment risk.

Optimize Technology and Care Team Roles!

Can be completed by MA, nurse, CHW, or other care extender

During the COVID-19 PHE, when the visit is conducted via telehealth, document information that is:

-self-reported by the patient -unable to be obtained -visually observed

Step 4: Conduct AWV

Establish a list of risk factors

Meets AWV requirements for:

- ✓ Establish list of patient risk factors and conditions where primary, secondary, or tertiary interventions are recommended or underway

Establish a list of risk factors and conditions for which various interventions are recommended or already underway. **Essentially, the patient's diagnosis list!**

Coding Tips:

Use this visit as an opportunity to update the patient's diagnosis list in the EHR. Remove any resolved or duplicate items and add **appropriate specificity** as needed

Ensure all active diagnoses are captured in the documentation of the AWV and included on the claim. This allows Medicare to appropriately risk adjust attributed members each year.

Optimize Technology and Care Team Roles!

Use this step as an opportunity for the billing provider to review visit documentation and complete visit with patient

Can be completed by MD, DO, NP, PA, CNM, CNS

Complete via telehealth (audio-only or audio and visual) or in-person

Use EHR features or code gap reports to assist with Hierarchical Condition Category (HCC) coding

Step 4: Conduct AWV

Meets AWV requirements for:

- ✓ Provide patient's personalized health advice and appropriate referrals to health education or preventive counseling services or programs

Provide personalized health advice and referrals

Provide patient with personalized health advice/referrals to health education or preventive counseling services or programs

Include community-based lifestyle interventions to reduce health risks and promote self-management and wellness:

- Fall prevention
- Nutrition
- Physical activity
- Tobacco-use cessation
- Weight loss
- Cognition

Optimize Technology and Care Team Roles!

- Can be completed by MA, nurse, CHW, or other care extender
- Complete via telehealth (audio-only or audio and visual) or in-person
- Share with patient as part of the visit summary
- If the patient qualifies for care management, perform a warm hand-off with care manager

Step 5:
Code and Bill for AWV

G0438 Annual Wellness Visit (AWV) billable after the first 12 months of Medicare Part B enrollment.

G0439 Annual Wellness Visit (AWV) subsequent visit, billable once every 12 months after the Initial AWV

FQHC bills G0468 and wellness code (above) to CMS

CMS/Medicare 2022 Fee - $241.71*

*FHQCs reimbursed the lesser of the PPS rate or their organizational charge fee for G0468

No coinsurance for IPPE or AWV

Keystone Rural Health Consortia

Victor Lanovych
Medical Director

Annual Wellness Visits

Emporium, PA

Rural

Founded 1976

7,838
Patients

2 MDs,
3 NPs, 3 PAs

WHY
Our health center started doing AWVs

- **We joined an ACO:**
  - AWV is a core metric of clinical performance in this value-based arrangement
- **We were doing much of the work - "big ticket" preventive care**
  - Did not understand the value of the AWV
  - Did not have a standard template in our EMR to properly document the AWV

Solution: Make the AWV part of the process

Keystone Rural Health Consortia, Inc.

Annual Wellness Visits

WHAT?

WHY?

HOW?

Step 1:
Compile list of patients for AWV
Build on Empanelment & Risk Stratification; use Technology

- **External partners:** Leverage Accountable Care Organization/ACO's (Aledade) online "Aledade App" to run reports and view who is due for an AWV

- **Internal staff:** Care Managers create lists weekly (especially 2nd half of the year) to review for who is due AWV
  - Use I2i to track/flag preventive care protocols, including AWVs
  - AWV status is available at-a-glance on clinical huddle sheets

Step 2:
Outreach to Schedule AWVs
Build on Empanelment & Risk Stratification; use Technology

Care Managers:

- Conduct outreach to schedule patients for AWVs
- Aggressively work the lists to capture AWV for all patients attributed to the ACO
- At time of scheduling, educate patients that AWV is separate from chronic care visit

Incentives:

- $15 gas cards provided in the past several years for an AWV

Keystone Rural Health Consortia, Inc.

Step 3:
Managing care team schedule for AWV

- The overall work of AWVs is time consuming but much of the work can be done outside of a provider visit by other members of the care team
- **40-minute slots** are built into the provider schedule template
  - However, this is not where most of the work is planned to be done
- **Template:** RN care managers put the patients on a separate AWV schedule
  - Health Risk Assessment (HRA) questions and preventive care services are discussed
  - EMR template works like a “script”

Step 3:
Managing care team schedule for AWV

- **Care Management –** *'the glue' that holds it all together*
  - The cornerstone of the Quality Program, including AWVs
  - Care Managers all RNs
  - Deep relationships with most complex patients
  - Coordinate and lead morning clinical huddles
- **Front desk –** *partners in the process*
  - Morning huddle – flag patients to be asked about their preventive care (and if they are a Medicare recipient, the AWV).
  - Created by front desk managers at each of our two sites

Keystone Rural Health Consortia, Inc.

Step 3:
Conduct AWV

RN Care Manager (30 mins)

- Health risk assessment questions and preventive care services
- Chronic care issues (non-urgent) are deflected to the schedule by care manager
- EMR template provides a “script” to complete requirements

Provider (~5 mins)

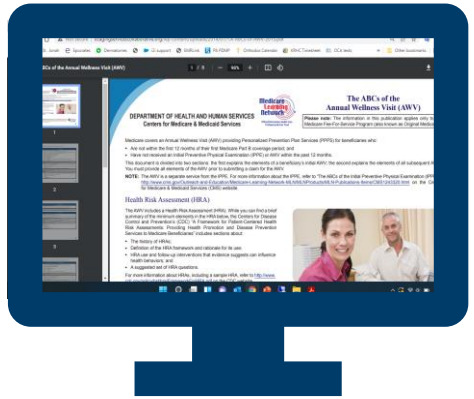
- Briefed by Care Manager (between patients)
- Performs a brief visit with the patient

Keystone Rural Health Consortia, Inc.

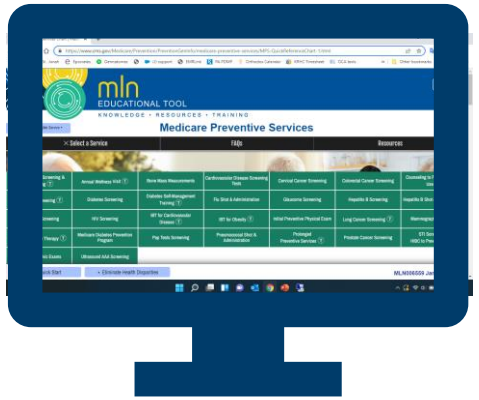
Step 4:
Documentation/Coding/Billing

Created EHR templates to properly document the AWV

- **EMR templates built in-house** (by Medical Director)
  - Our EMR: AthenaPractice
  - Our template editor: Visual Form Editor
- **Health Risk Assessment**
  - Based upon the 2014 document "The ABC's of the Annual Wellness Visit" from the Medicare Learning Network
  - Easy because its format lends itself to EMR templating
- **Preventive Services**
  - Based upon the CMS website.



Resource: The ABCs of the Annual Wellness Visit (AWV)



Resource: CMS Medicare Preventative Services website

Keystone Rural Health Consortia, Inc.

Update - Johnny A. Test -- Ofc Visit at CCHC on 2/19/2022 3:06:47 PM by Victor Lahnovych MD [Doc ID: 1807]

Summary: Medicare Annual We... | Orders | Medications | Problems | + Medication | + Problem | End...

Interactions:

Forms | Text

Forms | Add...

- Medicare Ann. Well. Risk KRI
- PHQ-9 Questionnaire
- PMH-PSH-CCC
- Family History-CCC
- Risk Factors-CCC
- Care Plan Management
- Nurse Intake-test2
- PE-CCC
- Diabetic Foot Exam KRHC
- Medicare Annual Wellness A
- Medicare Ann Well Serv KRH
- Follow up - MAW KRHC
- Capturing CPT II
- MU CORE Checklist
- Process Lab Orders

Attachments | Add...

Favorites | Add

- Blank image
- Anticoagulation Hx KRHC
- Anticoagulation Plan KRH
- Asthma O&E-HPI-CCC

HPI | Phys. Act./Nutri | ADL | **Gen. Health/Falls** | Psych | Cognitive

GENERAL HEALTH

In general, would you say your health is: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

How would you describe the condition of your mouth and teeth—including false teeth or dentures? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

How often during the past four weeks have you had the following problems?

Falling or dizzy when standing up:	Sexual problems:	Trouble eating well:	
Teeth or denture problems:	Problems using the telephone:	Tiredness or fatigue:	

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

How often do you have trouble taking medicines the way you have been told to take them?

How confident are you that you can control and manage most of your health problems?

FALLS

Have you fallen two or more times in the past year? ○ Yes ○ No

Are you afraid of falling? ○ Yes ○ No

TIMED UP AND GO

Directions: Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters or 10 feet away on the floor.

Instructions to the patient: When I say "Go," I want you to: 1. Stand up from the chair 2. Walk to the line on the floor at your normal pace 3. Turn 4. Walk back to the chair at your normal pace 5. Sit down again

On the word "Go" begin timing. Stop timing after patient has sat back down and record.

Was the patient's Timed Up & Go test unsteady or longer than 12 seconds? ○ Yes ○ No

An older adult who takes >12 seconds to complete the TUG is at high risk for falling.

Total time for Timed Up and Go Test (in seconds):

3:07 PM 2/19/2022

Ofc Visit at CCHC on 2/19/2022 3:06:47 PM by Victor Lahnovych MD [Doc ID: 1807]

Summary: Medicare Annual We... «

Orders | Medications | Problems | + Medication | + Problem | End...

Interactions:

Forms | Text

Forms | Add...

- Medicare Ann. Well. Risk KRI
- PHQ-9 Questionnaire
- PMH-PSH-CCC
- Family History-CCC
- Risk Factors-CCC
- Care Plan Management
- Nurse Intake-test2
- PE-CCC
- Diabetic Foot Exam KRHC
- Medicare Annual Wellness A
- Medicare Ann Well Serv KRH
- Follow up - MAW KRHC
- Capturing CPT II
- MU CORE Checklist
- Process Lab Orders

Attachments | Add...

Favorites | Add

- Blank image
- Anticoagulation Hx KRH
- Anticoagulation Plan KRH
- Asthma O&E-HPI-CCC

Vaccines | Screen | More Screen | Mas Screen | Services | More Serv

☐ Preventive services checklist given to patient.

VACCINES GIVEN	INDICATION	VACCINE ORDERS
☐ Pneumovax given. ☐ Prevnar given. ☐ Pneumonia vaccination up to date. ☐ Not needed pneumonia vaccination. ☐ Declined pneumonia vaccine. Click if giving.	If never immunized, give Prevnar today and Pneumovax in 1 year. If had Pneumovax after age 65 and > 1 year has passed, administer Prevnar t If had Pneumovax as an adult prior to age 65, administer Prevnar today and Pneumovax in 1 year. If had Prevnar as an adult prior to age 65, administer Pneumovax today, no further vaccination needed.	Prevnar 13: CCHC FXT RMC MNT Pneumovax 23: CCHC FXT RMC MNT
☐ Influenza vaccine given. ☐ Influenza vaccine up to date. ☐ Influenza vaccine not indicated. ☐ Influenza vaccine declined. Click if giving.	All Medicare benificiaries, once per influenza season.	Flulaval: CCHC FXT RMC MNT Fluvirin: CCHC FXT RMC MNT Fluzone: CCHC FXT RMC MNT
☐ HBV vaccine given. ☐ HBV vaccine up to date. ☐ HBV vaccine not indicated. ☐ HBV vaccine declined. Click if giving.	Give if medium/high risk: end-stage renal disease, hemophiliacs who received Factor VIII or IX concentrates, clients of institutions for the mentally retarded, persons who live in the same house as a HBV carrier, homosexual men,IV drug users.	Hepatitis B, Engerix-B Priv Hepatitis B Private (MNT)

POTENTIAL RECOMMENDATIONS NOT COVERED AS MEDICARE PART B PREVENTIVE SERVICES

These vaccines could be ordered: Varicella, Tdap or Td (every 10 years), Herpes Zoster, MMR, Meningococcal, Hep A.

(Patients should contact their Part D plan for information on preventive vaccines benefits.)

Order Vaccines

Recommendations can also be made, if appropriate, for: aspirin therapy, calcium supplementation, social services, and dietary counseling.

Prev Form (Ctrl+PgUp) | Next Form (Ctrl+PgDn)

3:08 PM
2/19/2022

Time	Provider	Resource	Type	Patient	Nickname	DOB	Age	Sex	Language	Race
PCP	NACHC Risk									
10:40 AM	Lahnovych MD, Victor	Lahnovych MD, Victor	Established Patients Over 50	[redacted]		[redacted]	66 Yrs	F	English	White
Lahnovych MD, Victor										

H L

Reason: [* Selected Program: 6 - Medical *]1 **History (12 Mo.):** No Shows: 0 Canceled: 3 Visits: 10 ER: 0 Admits: 0 **Last Visit DR:** Lahnovych MD, Victor
Month Follow Up HTN NB 1/20/22 Autoimmune arthritis

Outstanding Referrals: 8 Joint plan - labs - Ref to Rheumatology - Rheumatoid arthritis, hx bone inflammation

Last BMI: 22.41 (1/20/22) **Weight Change (6 Mo.):** -1.37 lbs **Last BP:** 138/76 (1/27/22) **Last PHQ-9:** 0 (1/20/22) **Last PHQ-2:** **Last Weight:** 143.13 (1/20/22)

Last Mammo: 11/1/2021 **Colon Cancer Screening:** 4/1/2017 Colonoscopy **Smoker:** No **Framingham Risk Factor:** 5.91%

Last 3 BP: 138/76 (1/27/22) 167/90 (1/20/22) [illegible] **Last 2 LDL:** 186 (11/2/21) 153 (6/25/19) CPT - Restart lisinopril - 1/27 BP ✓ OK

Due: Procedure / Referral: Depression Follow up Plan

Protocols: Depression Screening, Fall Risk, PCMH Data, Tetanus MMW DUE July

11:00 AM	Lahnovych MD, Victor	Lahnovych MD, Victor	Medicare Welcome to Medicare IPPE (1st 12 months)	[redacted]		[redacted]	65 Yrs	F	English	White
Lahnovych MD, Victor										

11:00 AM	Lahnovych MD, Victor	Lahnovych MD, Victor	Medicare Welcome to Medicare IPPE (1st 12 months)	[redacted]		[redacted]	65 Yrs	F	English	White
Lahnovych MD, Victor										

D H C L

Reason: [* Selected Program: 6 - Medical *] **History (12 Mo.):** No Shows: 0 Canceled: 1 Visits: 9 ER: 0 Admits: 0 **Last Visit DR:** Lahnovych MD, Victor **Outstanding Referrals:** 4
welcome to medicare 2/22 nm 12/28 DM Controlled A1c - BP Controlled

Last BMI: 30.38 (12/28/21) **Weight Change (6 Mo.):** -1 lbs **Last BP:** 110/70 (12/28/21) **Last PHQ-9:** 0 (12/28/21) **Last PHQ-2:** **Last Weight:** 188.25 (12/28/21)

Last Mammo: 10/18/2021 **Colon Cancer Screening:** 6/27/2019 FIT **Smoker:** No **Last 3 A1c:** 6.6 (12/14/21) 6.8 (9/22/21) 6.4 (6/22/21)

HCC

Last 3 BP: 110/70 (12/28/21) 130/78 (9/28/21) 134/72 (6/28/21) **Last 2 LDL:** 68 (9/22/21) 78 (3/24/21)

Due: Procedure / Referral: Depression Follow up Plan, Procedure / Referral: Fall Risk Assesment

Protocols: Depression Screening, Diab Foot Exam, Fall Risk, HIV screening, Microalbumin, PCMH Data, Urinary Incontinence Assessment, CRCS

KRHC Patient Registration Morning Huddle

Location: CCHCC

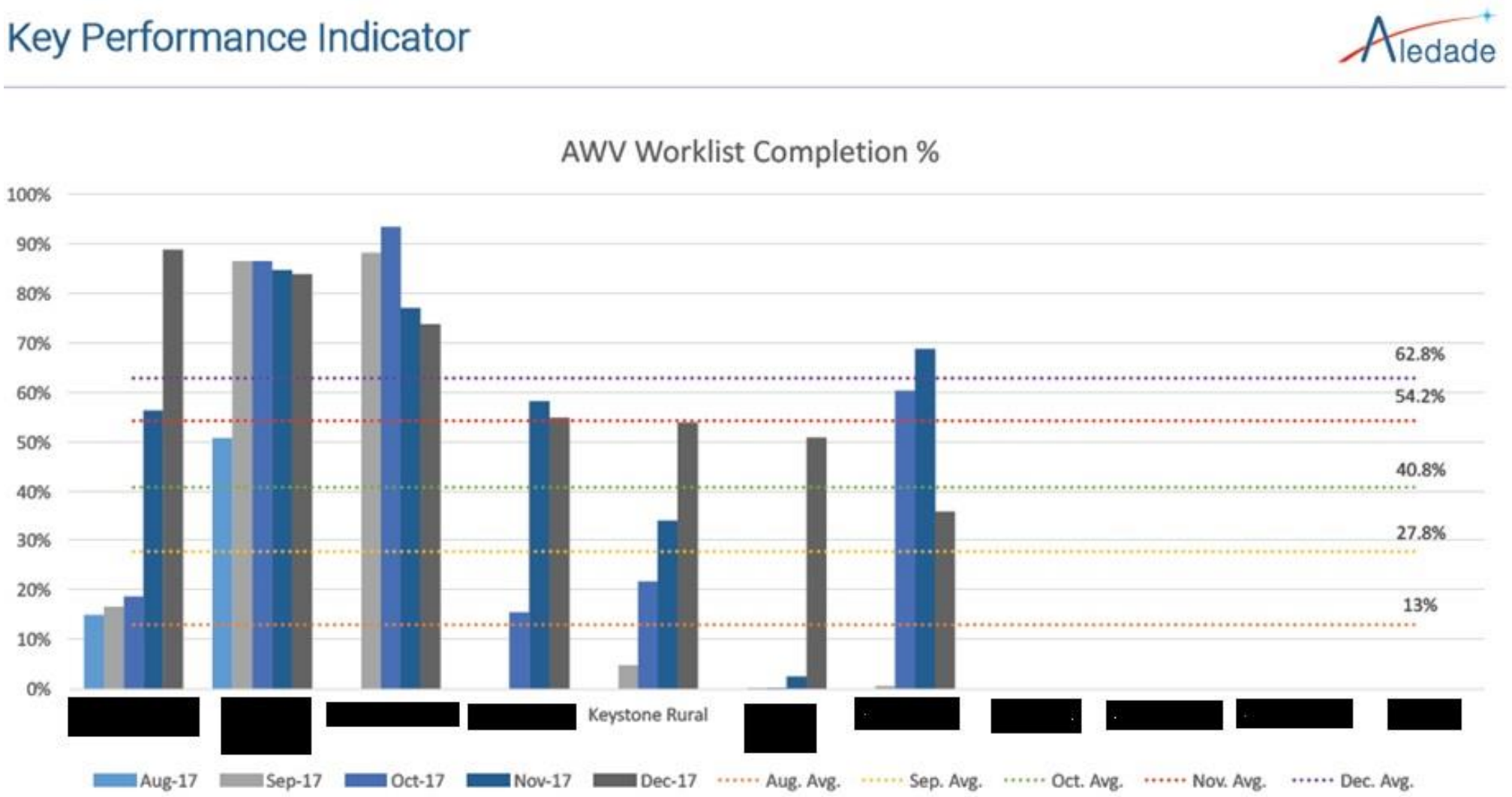
Date: 3-7-22

	Patient	New or Established	Appt Confirmed	Paper Work Current within 1 yr	Active Patient Portal	Eligible Insurance and/or Sliding Fee within date	Outstanding Patient Balance	Payment Plan	Date of Last Preventive Exam	Comments
LAUREN	[redacted]	Est.	LVM	✓	✓	(NGS) ✓	—	$15	Unknown	
		Est.	✓	✓	✓	(NGS) ✓	—	—	10/20/21	
		Est	✓	✓	✓	✓	—	—	Unknown	
		Est.	✓	no	✓	✓	—	$35.	8/28/15	needs Paperwo
		Est	✓	no	✓	✓	—	—	Unknown	needs paperwor
		Est.	✓	no	✓	✓	—	—	11/3/21	needs paperwork
		Est.	✓	no	no	✓	—	—	Unknown	needs paperwork
PATTY		Est.	✓	✓	✓	✓	—	—	10/5/21	
		Est.	no Answer	✓	✓	✓	—	—	Unknown	
		Est.	LVM	no	✓	need new Insurance info	—	?	Unknown	needs paperwo
		New	LVM	no	no	need Insurance	—	?	Unknown	needs paperwor
		Est.	✓	no	✓	✓	$70.00	$35	Unknown	needs paperwork

Annual Wellness Visits:
Now (2021) and Then (2017)

KRHC AWVs

80% (!!!!!) as of 12/31/2021



Evara Health

evara HEALTH
CARE THAT EMPOWERS

Cherona Owens
Value Based Services Supervisor

Annual Wellness Visits

- Pinellas County, FL
- Urban
- 14 locations
- Founded 1980
- 61,500 Patients
- 2,100 Medicare Patients

Annual Wellness Visits

WHAT?

WHY?

HOW?

WHY
Our health center started doing AWVs

- Evara Health began performing AWVs since their introduction by the Affordable Care Act.
- Participation in the Health Choice Care Medicare Accountable Care Organization (ACO) led us to realize that our processes supporting the AWV program must be restructured.
- In order to improve the outcome, our Value Based Services (VBS) team created new tools and protocols for the process.

evara HEALTH
CARE THAT EMPOWERS

Tracking AWVs

AWV 2022	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Totals	
Number completed in 2021	11	33	17	27	24	51	44	63	48	72	64	86	540	
Number due per the Q0 roster 794	241	263	258											
Number Scheduled	38	42											80	
Number Completed in 2022														
Totals based on Q0 roster 794	27	34											61	
YTD Percentage Q0	0.03%	0.07%												
794 Q0	70% completion													
# AWV need to complete to reach goal	556													
ACO patient engagment														
794 Q0	138	42											180	22.60%

evara HEALTH
CARE THAT EMPOWERS

Annual Wellness Visits

Step 1:

Compile list of patients for AWV

Build on Empanelment & Risk Stratification; use Technology

Eligible patients identified by:

- **Running lists**. Monthly spreadsheet generated from HCN (CLEAR), Greenway Intergy by VBS Supervisor.

- **Converting Upcoming Medicare Visits**. All Medicare appointments reviewed two days prior to appointment to evaluate for conversion to AWV (if converted, complete Health Risk Assessment (HRA) and Falls Risk at time of scheduling AWV)

- **Care Management Referrals**. Staff within Care Management Services schedule AWV (complete HRA and Falls Risk at time of scheduling AWV)

evara HEALTH
CARE THAT EMPOWERS

Sample Telephone Script: AWV

We see you have an existing appointment, and you are due for your Annual visit.

***Medicare** is very specific about what the "**Annual Wellness Visit**" offers. At the **Annual Wellness Visit**, your health care professional will talk to you about your medical history, review your risk factors, and provide a written personalized prevention plan to help keep you healthy. During this visit you will also be able to get medication refills, lab/screening orders and review any existing lab results.*

I would be glad to assist you in getting your Annual Wellness visit completed at your upcoming visit.

evara HEALTH
CARE THAT EMPOWERS

List of patients for AWV

Other data:
Patient #
Patient Name
Date of Birth
Home phone
Mobile phone

LastInPersonVisit	LastInPersonAWVDate	LastTelehealthAWVDate	NextAppt	NextApptReason	AWV Already Completed Date	AWV Already scheduled Date	Deceased / New PCP/ Pt Refused/ Covid only/	Name of New PCP	Appointment Scheduled AWV	HRA Completion Date	Falls Risk assessment completed date	Comments	UTC 1	UTC 2	UTC3	Date Letter Mailed	CM date/ Initials
12/15/2021	2/2/2021								2/1/2022 No Show	1/21/2022			3/4/22 LS	3/1/22 LS	3/3/22 LS	2/3/22 LS	
12/13/2021	2/3/2021		3/7/2022	Medicare Subsequent Wellness Visit					3/7/2022	1/11/2022							1/21/22 LS
12/31/2021	2/5/2021								3/2/22 LS	1/25/2022	1/25/2022	Daughter needs appt in March	1/21/22 LS	1/25/22 LS			1/25/22 LS
11/17/2021	2/5/2021		2/2/2022	ADULT ESTABLISHED					2/2/22 LS	1/26/22 LS			1/26/22 LS				1/26/22 LS
12/6/2021	2/24/2021								2/1/22 LS	1/26/22 LS	1/26/22 LS		1/26/22 LS	1/27/22 LS			1/26/22 LS
10/12/2021	2/5/2021				1/11/2022 Too Early				2/7/22 LS	1/10/2022	1/26/2022		1/31/22 LS	2/1/22 LS	1/28/22 LS		2/1/22 LS
7/26/2021	2/8/2021								2/17/22 LS	2/7/22 LS	2/7/22/ LS		2/14/22 LS	2/15/22 LS	2/17/22 LS	2/2/22 LS	2/17/22 LS
8/2/2021	2/22/2021								2/2/22 LS	1/31/22 LS			1/26/22 LS	1/31/22 LS			1/31/22 LS
8/17/2021	2/4/2021						AWV Done NO Code Dropped		2/16/22 LS	2/1/22 LS		Messaged Cherona Code 2-23 LS	1/26/22 LS	1/31/22 LS	2/1/22 LS		2/1/22 LS

Step 2:
Outreach to Schedule AWVs
Build on Empanelment & Risk Stratification; use Technology

- VBS Review Nurse and Case Managers conduct outreach to schedule patients for AWV (completes HRA and Falls Risk at time of scheduling)
- After-hours and weekend outreach to patients that staff have been ‘unable to reach’
- Send CareMessage reminders for patients to schedule AWV

evara HEALTH
CARE THAT EMPOWERS

Step 3:
Managing care team schedule for AWV

Daily Huddle Task Sheet reviewed with provider – includes HCC coding opportunities and Care Gaps (e.g., cancer screening) to be addressed

VBS Review Nurse/Case Manager

- Health risk assessment questions and preventive care services
- Reminder call to the patient 24 hours before appointment and document on ACO template (created internally).

Provider

- Briefed by Care Manager (between patients)
- Performs a brief visit with the patient

evara HEALTH
CARE THAT EMPOWERS

Daily Huddle Task Sheet

colorectal & cervical cancer screening

Center	Provider	Last Visit Date	Next Appt	Last AWV (EHR) In person	Last AWV (EHR) Telehealth	Patient Info
JRC	Ahmad, Akif MD	9/22/2021	2/25/2022	12/31/2020	12/31/2020	[redacted]
CLW	Bonaparte, Katina M. MD, MPH	9/13/2021	2/25/2022	9/13/2021	1/0/1900	
CLW	Bonaparte, Katina M. MD, MPH	12/7/2021	2/25/2022	12/7/2021	12/7/2021	
CLW	Bonaparte, Katina M. MD, MPH	8/31/2021	2/25/2022	8/31/2021	8/28/2020	
DUN	De La Noval, Barbara APRN	11/16/2021	2/25/2022	1/0/1900	1/0/1900	
JRC	Dziopala, Joy APRN	12/13/2021	2/25/2022	10/28/2021	10/28/2021	

AWV Elig Date	AWV Missed Opportunity?	HCC Opportunities	ACO13 Fall Risk	ACO14 Flu Immun	ACO17 Tob Screen	ACO18 De... Screen	ACO19 Colo Screen	ACO20 Breast Screen	ACO27 DM Poor Ctrl	ACO28 Htn Control	ACO40 Dep Rem	ACO42 Statin Use	# Quality Gaps
12/1/2022	No	59 - Delusional disorders		Non-Comp	Comp		Comp	Non-Comp					2
9/1/2022	No	*100 - Ischemic or Unspecified Stroke *104 - Monoplegia, Other Paralytic Syndromes		Non-Comp	Comp	Non-Comp	Comp			Non-Comp		Comp	3
12/1/2022	No			Non-Comp	Comp		Comp	Non-Comp		Non-Comp			3
8/1/2022	No	*84 - Cardio-Respiratory Failure and Shock 85 - Congestive Heart Failure 86 - Acute Myocardial Infarction *112 - Fibrosis of Lung and Other Chronic Lung Disorders *169 - Vertebral Fractures without Spinal Cord Injury											0
12/1/2022	No		Non-Comp	Comp	Comp	Non-Comp	Non-Comp						3
10/1/2022	No	2 - Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock 22 - Morbid Obesity 40 - Rheumatoid Arthritis and Inflammatory Connective Tissue Disease		Non-Comp	Comp		Comp	Comp		Non-Comp			2
10/1/2022	No	*12 - Breast, Prostate, and Other Cancers and Tumors *18 - Diabetes with Chronic Complications 23 - Other Significant Endocrine and Metabolic Disorders *48 - Coagulation Defects and Other Specified Hematological Disorders	Non-Comp	Non-Comp	Comp		Comp		Poor Control	Non-Comp		Comp	3

evara HEALTH
CARE THAT EMPOWERS

Daily Huddle Task Sheet

Daily Huddle Task Example

-ACO

HCC CODING-PLEASE ADDRESS CHF AND VASCULAR DISEASE
GAPS-FIT TEST, HTN LABS, ALCOHOL/DRUNG ABUSE SCREENING, FLU SHOT

-MEDICARE

GAPS-FIT TEST, HTN LABS, ALCOHOL/DRUNG ABUSE SCREENING, SMOKING & TOBACCO CESSATION, FLU SHOT

ACO

HCC CODING- PLEASE ADDRESS (pt will probably need another visit to address all HCC coding)
Morbid Obesity
Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
Disorders of Immunity
Congestive Heart Failure
Specified Heart Arrhythmias
Ischemic or Unspecified Stroke
Vascular Disease with Complications
Chronic Obstructive Pulmonary Disease
Chronic Ulcer of Skin, Except Pressure
GAPS-FIT TEST, HTN LABS, ALCOHOL/DRUNG ABUSE SCREENING, MAMMO, FALLS RISK, FLU SHOT

-MOLINA

GAPS-FIT TEST, NEEDS SCHEDULED FOR PHYSICAL ONSITE

SIMPLY

GAPS-FIT TEST, ALCOHOL/DRUNG ABUSE SCREENING, A1C, MAMMO, NEEDS SCHEDULED FOR PHYSICAL ONSITE

evara HEALTH
CARE THAT EMPOWERS

Step 3:
Conduct AWV

Visit Types:

- In-person clinic visit
- Video telehealth – 2 designated providers
- Audio call
- Medical Home @ Home:
  - Evara clinical team completes an office visit in the home then connects patient with a provider via video
  - Vitals, weight, BMI, HbA1c, and all screenings completed during visit

evara HEALTH
CARE THAT EMPOWERS

Ongoing Monitoring & Reporting

Weekly	Monthly	Quarterly
VBS Supervisor Review: • AWVs completion • Required documentation • Correct coding • Task Case Managers if f/u needed or member needs rescheduling **Team Review:** • Completions • Trends • Goals	**Leadership Review:** • # AWV scheduled • # AWV completed • # outreaches • Report and barriers to care • Patient engagement rate • Current AWV completion rate YTD	**VBS Supervisor Review:** • Rosters to add/remove patients from panels. • Task Case Managers to outreach and schedule IPPE/AWVs.

evara HEALTH
CARE THAT EMPOWERS

Tracking AWVs

01/31/22 8:50 AM **Appointments Reason Detail Report** Page 1

Community Health Centers of Pinellas

Selections:

Appointment Dates: From: 01/24/2022 To: 01/28/2022

Reason Codes: IMWV, CCM, TPHONE, MWVA, TELAWV, WMV, MHHES

Date	Time	Length	Chrt #	Patient	Location	Provider	Room	PLAN	RESULTS	
Reason: MWVA Medicare Subsequent Wellness V (IMW ANNUAL WELLNESS VISIT)										
01/24/2022	3:20 PM	20		[redacted]		CLW	DMS	ACO	COMPLETED	CODE DROPPED
01/26/2022	10:00 AM	20				CLW	DMS	ACO	COMPLETED	CODE DROPPED
01/27/2022	5:00 PM	20				STP	HJO	ACO	COMPLETED	CODE DROPPED
01/27/2022	10:40 AM	20				LEA	TEP	ACO	COMPLETED	CODE DROPPED
01/27/2022	10:20 AM	20				PPK	PAB	ACO	COMPLETED	CODE DROPPED
01/27/2022	10:00 AM	20				JRC	KEW	ACO	COMPLETED	CODE DROPPED
01/28/2022	10:00 AM	20				JRC	JDZ	ACO	NEEDS RESCHED	SICK VISIT
Total MWVA Appointments: 7										
Reason: WMV MediCare Welcome Wellness Visi (IMW ANNUAL WELLNESS VISIT)										
01/27/2022	2:00 PM	20		[redacted]		CHL	CLP	ACO	COMPLETED	CODE DROPPED
01/27/2022	9:30 AM	20				TSH	KET	ACO	NEEDS RESCHED	ER F/U
Total WMV Appointments: 2										
Total Appointments: 9										

9 SCHED 7 COMPLETED 2 NEEDS RESCHED

evara HEALTH

CARE THAT EMPOWERS

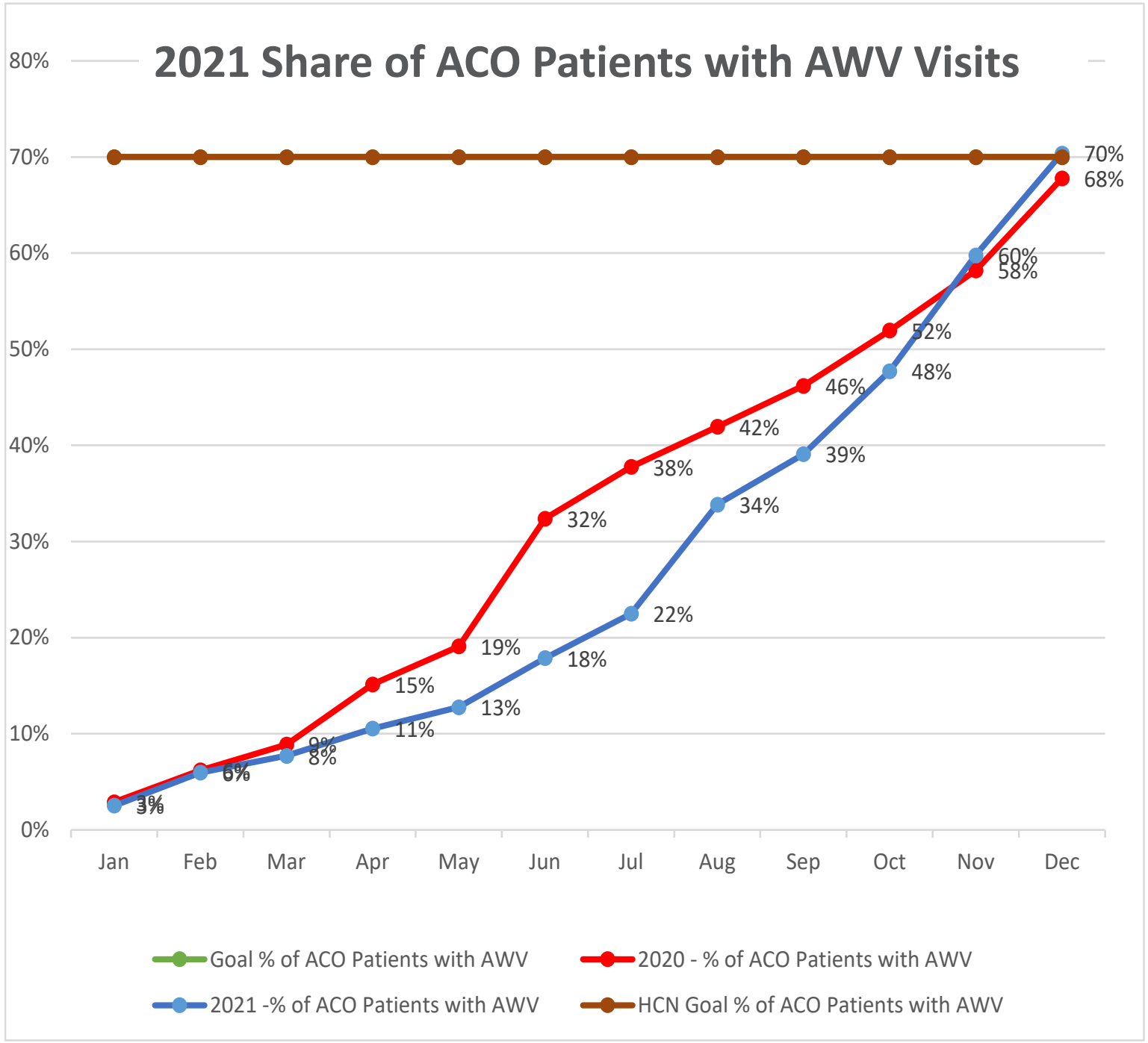
Step 4:
Documentation/Coding/Billing

- All Medicare appointments are reviewed weekly for required documentation and correct code dropped.

evara HEALTH
CARE THAT EMPOWERS

ACO Annual Wellness Visits Approach

- Establish AWV plan for the year
- Determine # of AWV to be completed to meet goal of 70%
- Track HEDIS measure monthly
- Track monthly ACO member engagement



ACO Quality Measures				
Quality Measure	HCN GOAL	HCN ACO Report 11/2019	HCN ACO Report 11/2020	HCN ACO Report 12/2021
1. Falls Risk	94%	88.2%	66.3%	91.0%
2. Tobacco Use + Cessation	90%	99.8%	88.1%	98.6%
3. Depression Screening	90%	91.9%	68.5%	91.2%
4. Colorectal Cancer Screening	68%	55.3%	43.7%	57.9%
5. Breast Screening	70%	56.8%	49.7%	48.6%
6. DM HbA1C Poor control	16.2%	18.3%	35.4%	18.9%
7. HTN <140/90	70%	73.7%	48.8%	72.5%
8. Depression Remission	20%	0.0%	0.0%	0.0%
9. Statin Therapy	90%	73.9%	74.5%	85.4%
10. Influenza Vaccine	70%	11.8%	4.3%	16.7%
11. AWV's	70%	43.5%	54.0%	67.0%

evara HEALTH

CARE THAT EMPOWERS

Thank you for allowing us to share!

Messina Consulting

Annual Wellness Visit Reimbursement

Your FQHC Base Rate Matters!

Lisa Messina

FQHC Prospective Payment System (PPS)
Base Rate as related to IPPE/AWV

- FQHCs base rate is updated each calendar year
- 2022 National FQHC PPS Base Payment Rate = $180.16

Adjustment components include:

Geographic Adjustment Factor: Locality

New Patient Adjustment: 1.3416 ($241.71)

IPPE/AWV Adjustment: 1.3416 ($241.71)

The GAF file for 2022 may be found at the bottom of the CMS FQHC webpage: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center

FQHC Prospective Payment System (PPS)
Local FQHC Rate

Step 1: Calculate the local FQHC PPS Payment

National PPS Base Rate	FQHC GAF	FQHC Adjusted PPS Base Payment
$ 180.16	Alabama = 0.946	$ 170.43
$ 180.16	Miami, FL = 1.080	$ 194.57

Step 2: Calculate IPPE, AWV, New Patient Encounter Rate

FQHC PPS Base Rate	Adjustment Factor	IPPE, AWV, New Patient Rate
$ 170.43	1.3416	$ 228.65 (Alabama)
$ 194.57	1.3416	$ 261.04 (Miami, FL)

Remember!
- Payment is based upon the lesser of the FQHC's charge or the adjusted PPS rate.
- No coinsurance for IPPE/AWV encounters.

Medicare Claims Processing Manual, Chapter 9: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

Wellness Visit Revenue

What can we expect?

ACHIEVE REVENUE
MANAGEMENT

Rebekah Wallace Pardeck, CMPE, CPC®, CPCO™

Let's Do the Math:

Health Center Scenario

Total Health Center Patients	X	Medicare Patient Percentage	=	Total Medicare Patients	X	Estimated Percent of AWVs to be completed	=	Number of AWVs Rendered	X	Payment rate (lesser of PPS rate or Health Center charge)	=	Total Revenue
42,000	X	10%	=	4,200	X	70%	=	2,940	X	$259.60	=	$763,224

Assumptions:

- Total unique health center patients for 21 providers based on patient panel of 2,000
- 10% of patients are covered by Medicare
- Anticipate 70% of eligible patients will receive AWV
- Established health center charge is $292.00
- PPS rate for health center locality is $259.60

Example for discussion purpose only

Your Turn

Total Health Center Patients	X	Medicare Patient Percentage	=	Total Medicare Patients	X	Estimated Percent of AWVs to be completed	=	Number of AWs Rendered	X	Payment rate (lesser of PPS rate or Health Center charge)	=	Total Revenue

PEER EXCHANGE

I Have Questions

I Have Tools to Share

Dr. Victor Lahnovych: Speaking about the subsequent AWVs, our providers review those, but we do not go through all chronic conditions with the patient unless a "Welcome to Medicare." I would point you to the CMS document here. Do the risk assessment and the services offered and don't focus on a lot else.
http://www.ocagingservicescollaborative.org/wp-content/uploads/2014/07/1.4-ABCs-of-AWV-2015.pdf

Additional Resources

Dr. Victor Lahnovych: Speaking about the subsequent AWVs, our providers review those, but we do not go through all chronic conditions with the patient unless a "Welcome to Medicare." I would point you to the CMS document here. Do the risk assessment and the services offered and don't focus on a lot else. http://www.ocagingservicescollaborative.org/wp-content/uploads/2014/07/1.4-ABCs-of-AWV-2015.pdf

Lisa Messina: Has a patient already had an IPPE or AWV visit? This link can be used to help you determine Medicare beneficiary eligiblity data in real-time. You can also ask your MAC. https://www.cms.gov/research-statistics-data-and-systems/cms-information-technology/hetshelp

UPCOMING EVENTS

March 2022

SUN	MON	TUE	WED	THU	FRI	SAT
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

April 2022

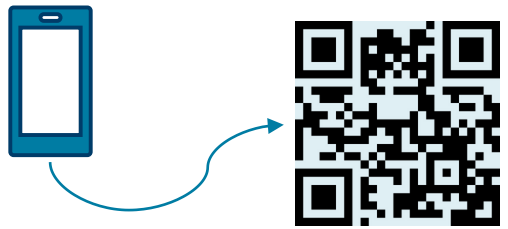
SUN	MON	TUE	WED	THU	FRI	SAT
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

24. Elevate Connect – Annual Wellness Visits

12. April Learning Forum

28. Elevate Connect

Register for Elevate 2022 to receive sign-up links for all upcoming learning forums:



NATIONAL ASSOCIATION OF Community Health Centers®

Elevate 2022 Participants:
Free Trial Opportunity

- **Free** 6-month trial
- **Free** unlimited access to recorded trainings
- **Free** Form 5A evaluation
- **Free** unlimited access to web-based platform
- **Free** unlimited access to NEW Project Management module
- **Free** unlimited access to Credentialing/Privileging module

Available for **FREE** to all health centers that complete 3+ VTF Assessments!

Missed the info session?

Access the recording on the Elevate platform

FEEDBACK

Don't forget! Let us know what you thought about today's session.

FOR MORE INFORMATION CONTACT:

qualitycenter@nachc.org

Cheryl Modica
Director, Quality Center
National Association of Community Health Centers
cmodica@nachc.org
301.310.2250

Next *Connect* Call:

March 24, 2022
1-1:45 pm ET

Next Monthly Forum Call:

April 12, 2022
1-2 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

Together, our voices elevate° all.

The Quality Center Team

Cheryl Modica, Cassie Lindholm, & Addison Gwinner

qualitycenter@nachc.org