

Evvara Health



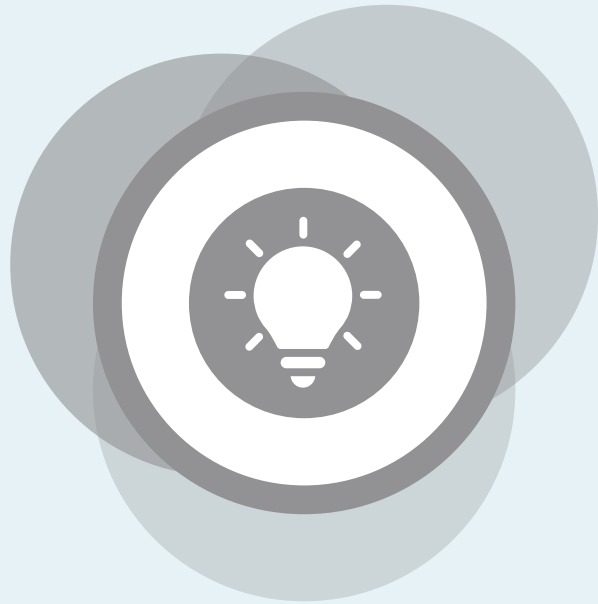
Cherona Owens
Value Based Services Supervisor

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

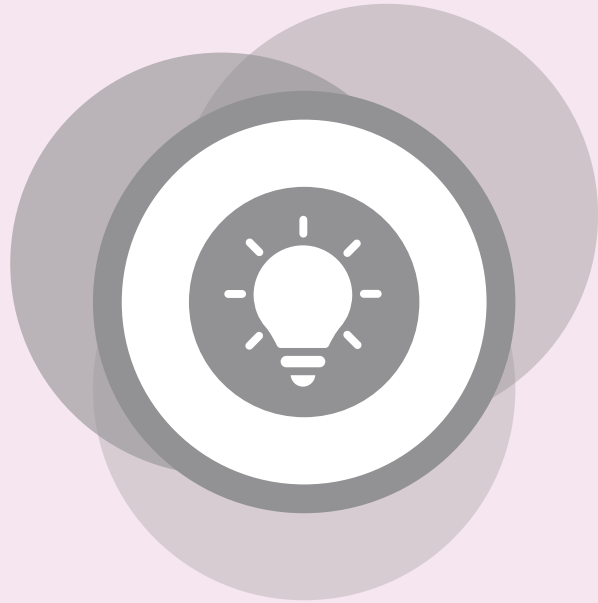
- Evara Health began performing AWVs since their introduction by the Affordable Care Act.
- Participation in the Health Choice Care Medicare Accountable Care Organization (ACO) led us to realize that our processes supporting the AWV program must be restructured.
- In order to improve the outcome, our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



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 engagement | | | | | | | | | | | | | | |
| 794 Q0 | 138 | 42 | | | | | | | | | | | 180 | 22.60% |

Annual Wellness Visits



WHAT?



WHY?



HOW?



Step 1:

Compile list of patients for AWW

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 AWW (if converted, complete Health Risk Assessment (HRA) and Falls Risk at time of scheduling AWW)
- **Care Management Referrals.** Staff within Care Management Services schedule AWW (complete HRA and Falls Risk at time of scheduling AWW)



Sample Telephone Script: AWW

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.

List of patients for AWW

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 AWW | 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 | | Message 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 AWWs

Build on Empanelment & Risk Stratification; use Technology

- VBS Review Nurse and Case Managers conduct outreach to schedule patients for AWW (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 AWW



Step 3:

Managing care team schedule for AWW

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

Daily Huddle Task Sheet

colorectal & cervical cancer screening

| Center | Provider | Last Visit Date | Next Appt | Last AWW (EHR) In person | Last AWW (EHR) Telehealth | Patient Info | AWW Elig Date | AWW 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 | |
|--------|------------------------------|-----------------|-----------|--------------------------|---------------------------|--------------|---------------|-------------------------|--|-----------------|-----------------|------------------|-----------------|-------------------|---------------------|--------------------|-------------------|---------------|------------------|----------------|---|
| JRC | Ahmad, Akif MD | 9/22/2021 | 2/25/2022 | 12/31/2020 | 12/31/2020 | | 12/1/2022 | No | 59 - Delusional disorders | | Non-Comp | Comp | | Comp | Non-Comp | | | | | 2 | |
| CLW | Bonaparte, Katina M. MD, MPH | 9/13/2021 | 2/25/2022 | 9/13/2021 | 1/0/1900 | | 9/1/2022 | No | *100 - Ischemic or Unspecified Stroke *104 - Monoplegia, Other Paralytic Syndromes | | Non-Comp | Comp | Non-Comp | Comp | | | Non-Comp | | Comp | 3 | |
| CLW | Bonaparte, Katina M. MD, MPH | 12/7/2021 | 2/25/2022 | 12/7/2021 | 12/7/2021 | | 12/1/2022 | No | | | Non-Comp | Comp | | Comp | Non-Comp | | Non-Comp | | | 3 | |
| CLW | Bonaparte, Katina M. MD, MPH | 8/31/2021 | 2/25/2022 | 8/31/2021 | 8/28/2020 | | 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 *189 - Vertebral Fractures without Spinal Cord Injury | | | | | | | | | | | 0 | |
| DUN | De La Noval, Barbara APRN | 11/16/2021 | 2/25/2022 | 1/0/1900 | 1/0/1900 | | 12/1/2022 | No | | Non-Comp | Comp | Comp | Non-Comp | Non-Comp | | | | | | 3 | |
| JRC | Dziopala, Joy APRN | 12/13/2021 | 2/25/2022 | 10/28/2021 | 10/28/2021 | | 10/1/2022 | No | 2 - Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock 22 - Morbid Obesity 40 - Rheumatoid Arthritis and Inflammatory Connective Tissue Disease *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 | Comp | | Comp | Comp | | | Non-Comp | | | 2 |
| JRC | Dziopala, Joy APRN | 12/13/2021 | 2/25/2022 | 10/28/2021 | 10/28/2021 | | 10/1/2022 | No | | Non-Comp | Non-Comp | Comp | | Comp | | Poor Control | Non-Comp | | Comp | 3 | |

Daily Huddle Task Sheet

Daily Huddle Task Example

-ACO

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

-MEDICARE

GAPS-FIT TEST, HTN LABS, ALCOHOL/DRUG 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/DRUG ABUSE SCREENING, MAMMO, FALLS RISK, FLU SHOT

-MOLINA

GAPS-FIT TEST, NEEDS SCHEDULED FOR PHYSICAL ONSITE

SIMPLY

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



Step 3: **Conduct AWW**

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



Ongoing Monitoring & Reporting

| Weekly | Monthly | Quarterly |
|--|---|---|
| <p>VBS Supervisor Review:</p> <ul style="list-style-type: none">• AWWs completion• Required documentation• Correct coding• Task Case Managers if f/u needed or member needs rescheduling <p>Team Review:</p> <ul style="list-style-type: none">• Completions• Trends• Goals | <p>Leadership Review:</p> <ul style="list-style-type: none">• # AWW scheduled• # AWW completed• # outreaches• Report and barriers to care• Patient engagement rate• Current AWW completion rate YTD | <p>VBS Supervisor Review:</p> <ul style="list-style-type: none">• Rosters to add/remove patients from panels.• Task Case Managers to outreach and schedule IPPE/AWWs. |

Tracking AWWs

01/31/22 8:50 AM

Appointments Reason Detail Report Community Health Centers of Pinellas

Page 1

Selections:

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

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

| 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 | | | | 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 | | | | 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 | |



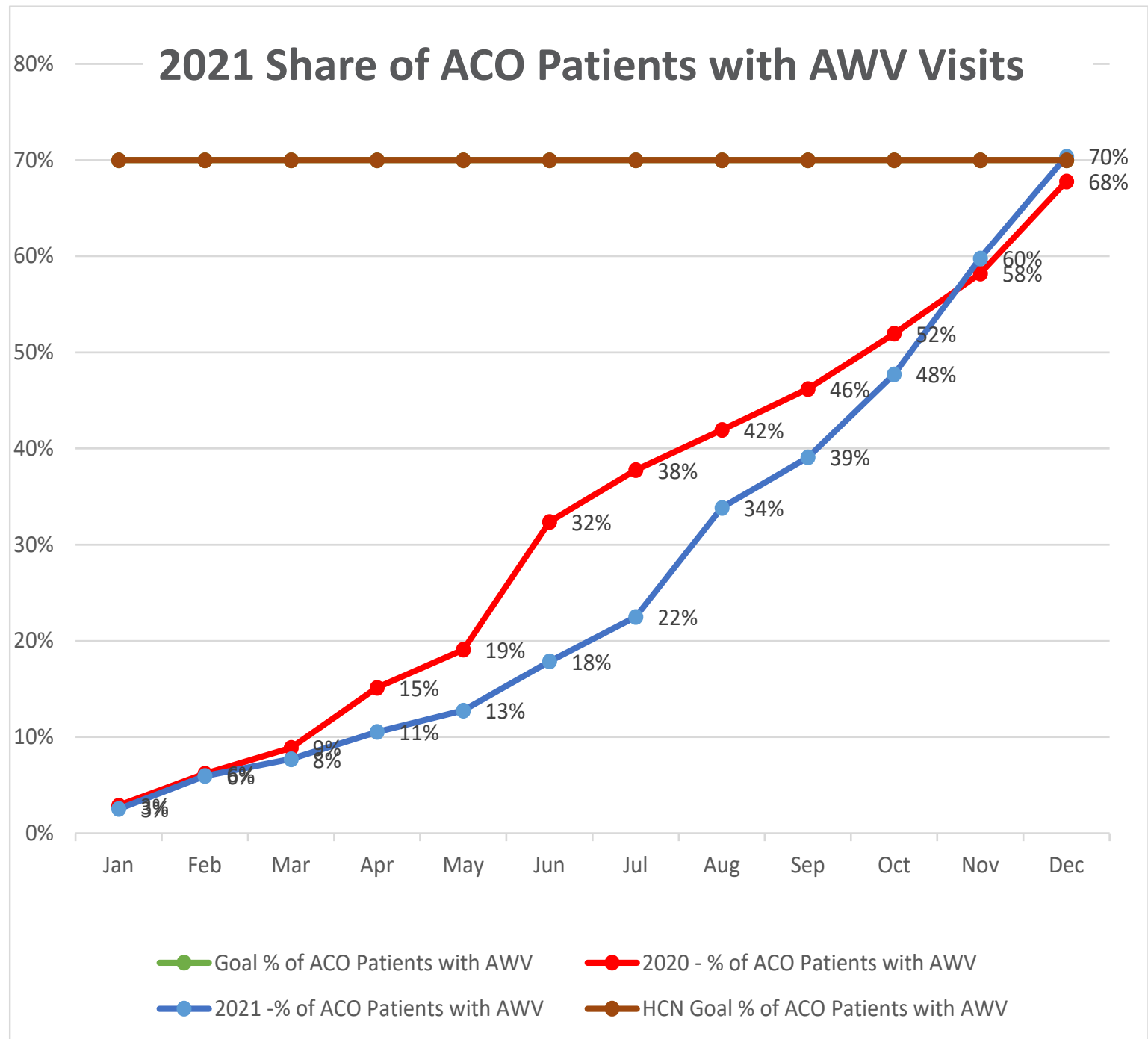
Step 4: **Documentation/Coding/Billing**

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



ACO Annual Wellness Visits Approach

- Establish AWW plan for the year
- Determine # of AWW 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. AWW's | 70% | 43.5% | 54.0% | 67.0% |

evara

HEALTH

CARE THAT EMPOWERS

Thank you for
allowing us to share!

