

Annual Wellness Visit Grand Rounds

Wednesday, June 28, 2017

5:00pm-6:30pm



OneCareVermont

OneCareVT.org

Welcome

Susan Shane, MD

AGENDA

#	Agenda Item	Presenter	Time
1	Welcome	Susan Shane, MD, Medical Director OneCare Vermont; Family Practice UVMHC	5:00pm-5:05pm (5 Minutes)
3	Presentations on Annual Wellness Visits	<p>1. <u>Jeremiah Eckhaus, MD, .,A.B.H.M</u> Co-Chair, Community Alliance for Health Excellence Integrative Family Medicine Montpelier/ CVMC: Presenting a case study on how AWV have been implemented in his practice. Highlighting strategies for success and how challenges were overcome. A review of staffing needs and the return on investment for adding additional staff members and training of existing staff.</p> <p>2. <u>Daniel Moran, MSN, APRN Dartmouth Internal Medicine:</u> Geriatric Workforce Enhancement Program Dartmouth Centers for Health and Aging Providing an overview of the training involved for teams implementing AWV in to practice. Brief review of what GWEP program is and the content included in “boot camp” sessions that are offered to participants.</p> <p>3. <u>Elizabeth Sheehan, RN Ottauquechee Health Center/Mt. Ascutney Hospital and Health Center:</u> Sharing on her experience of what it takes to become proficient in AWV. In the first cohort of practices to implement AWV through the GWEP; presentation will include challenges that continue in her practice, review of training and education she received to be skilled provider of AWVs.</p>	<p><u>5:05pm-6:05pm</u> 20 Minutes Each</p> <p><u>6:05pm-6:30pm</u> Q&A (25 Minutes)</p>
3		Adjournment	



Medicare Annual Wellness Visit

What is it?



- **Free** preventive care service available to Medicare beneficiaries (Affordable Care Act, 2010)
- A visit focused on prevention, safety, and coordination of care
- Different from the Welcome to Medicare Physical (IPPE)
- Does **not** include a “physical exam”

Annual Wellness Visit



Includes:

- Health Risk Assessment
- The establishment of the individual's medical and family histories and list of current providers
- Measurement of height, weight, body mass index (BMI), and blood pressure
- Screening for cognitive impairment, depression, functional ability and falls risk
- Providing a written screening schedule and list of risk factors
- Personalized health advice and referrals, as appropriate, to health education or preventive counseling services or programs



Who is eligible?

Initial Annual Wellness Visit (AWV)

- Patient has had Medicare Part B for at least 12 months
- Has not had an IPPE (“Welcome to Medicare” Physical) or has been at least 12 months since IPPE

Subsequent Annual Wellness Visit

- Has been at least 12 months since last annual wellness visit

Medicare pays for only one first AWV per beneficiary per lifetime, and pays for one subsequent AWV per year thereafter.



Medicare Annual Wellness Visit



■ OneCare Clinical Priority

- Performance rate in 2015=18.7%
- Primary or secondary prevention of chronic disease
- Identify and close gaps in care
- Align with 7 Medicare quality measures
- Maximize attribution of Medicare beneficiaries especially of “well” patients
- Opportunity for accurate coding and population risk adjustment – hierarchical condition category (HCC)
- Increased primary care revenue *

Presentation

Jeremiah Eckhaus, MD

Integrative Family Medicine-Montpelier

University of Vermont Health Network-CVMC

MEDICARE ANNUAL WELLNESS VISITS

Jeremiah Eckhaus, MD

INTEGRATIVE FAMILY MEDICINE-MONTPELIER
UNIVERSITY OF VERMONT HEALTH NETWORK-CVMC

OBJECTIVES

- Project Overview
- Implementation
- Process and Workflow
- Outcomes
 - Financial
 - Satisfaction
 - Quality
- Challenges
- Next Steps

INTEGRATIVE FAMILY MEDICINE - MONTPELIER

- About our Practice
- We serve roughly 6,000 patients in the Central Vermont area; our 65+ population is 1,062
 - Our Providers
 - 3 Family Medicine Physicians
 - 3 Family Nurse Practitioners
 - 1 Clinical Psychologist

MOTIVATING PROBLEM

- Patients are presenting for their AWV with a list of medical problems/concerns that they want us to address
- These concerns are either addressed for free, or it generates a separate visit code that is not a covered benefit for patients
- Patients are not happy about a bill (they think they are getting a free service) and it is difficult to do both the AWV and address the concerns in the scheduled time allotted (usually ½ hour to 45 minutes)
- Physicians and APPs are not happy because they don't have time or focus to cover the preventative elements of the AWV due to patient concerns / problems

PROJECT OBJECTIVES

- Improve quality of the AWV
 - Documentation, clinician job satisfaction
- Increase the number of AWVs
 - Baseline 20-40% of eligible patients had AWV in 2016
- Improve/maintain high patient satisfaction
- Free up MD time for other types of visits
- Increase the number of Medicare covered preventive screenings being completed
- Increase revenue for practice (ROI for RN AWV)

IMPLEMENTATION PROCESS

- GWEP – Geriatric Workforce Enhancement Project
 - Initial kickoff in 2/2016
 - AWV Pilot design began in 5/2016
 - AWV Pilot initiated 12/5/2016
- Education:
 - GWEP provided training
 - We created a new job description for a current RN to take this on as part of a new position—“Wellness Nurse”.
 - We created an AWV template in the EMR based on Dartmouth’s template

PROCESS

- We educated Medicare patients by sending letters explaining the new process
- We educated our staff about the new process and what the Medicare AWV is and is not
- We developed protocols for the RN related to screening lab tests, PT referrals for fall risk, etc.
- Patients have option to schedule a problem focused visit with their PCP or an AWV with the nurse
- At the AWV, the RN identifies gaps in preventative care and often a follow up appointment is scheduled with the PCP if deemed appropriate
- The RN sends PCP a note summarizing the findings at the AWV for feedback and recommendations

TYPICAL RN SUMMARY NOTE

- *No Advance Directive on file - copy given for completion
- *Labs due Lipid/CMP ordered in vv
- *former smoker US Aorta done 7/2015 and WNL
- *?Eye exam - greater than 10 years ago - referral done
- *?Dental seen last year and has upcoming appointment
- *BMI 30.33 - referral to Rebecca for weight (diet and exercise coaching)
- *PCV13 given at time of appointment
- *very little can be obtained in regards to family history; left by father and by mother and was in foster care; he is also without relationship with his own children; his English bride took the children and left the country (somewhere in Canada) when the children were young and he did not see them again until they were in their 30's and he does not have a relationship with them

RETURN ON INVESTMENT

- Average RN salary \$66,520/year
- Breakeven point for salary is 50 AWV/month or 2.5 visits per day
- Our current Medicare AWV reimbursement is \$114
- Our current reimbursement for a 99214
 - Medicare is \$85
 - Commercial is \$205
- 1 hour AWV practice net profit by provider type
 - RN \$83/hr
 - NP \$67/hr
 - MD \$24/hr
- If an MD performs two 99214s per hour and the RN does 6 AWVs per day (assuming 210 work days/yr) the average ROI could be about \$400K per year

PATIENT SATISFACTION

- “I appreciate the thoroughness of the interview and receiving a copy of all the info we went over”
- “The nurse spent a lot of time with me and was incredibly thorough, I will do this again”
- “My PCP never seems to have time to cover all of these things, I learned some new things about eating healthy with diabetes”

MD/APP SATISFACTION

- “This allows me to focus on the issues that patients have and not feel like I am missing the preventative stuff, because I know it is getting done by the nurse at the AWV”
- “I find the focused visits after the patient has had an AWV to be quite rewarding. Patients are coming in to talk about specific questions related to their Advance Directives or other issues found during their AWV, and we are able to devote the time to those things. Conversations are meaningful and less distracted by the requirements of the AWV”
- “I think it’s been positive and patients seem to like it, it frees me up to see patients for other types of visits”

IMPROVING QUALITY FOR PATIENTS

- 79 y.o. male with hx smoking, never had AAA screening despite being seen for AWV by MD 3 years ago. Screening found 4.6cm AAA, MiniCog =1 and MOCA=10,
- Wellness RN scheduled f/u with PCP and patient was diagnosed with depression, pseudodementia, started on SSRI
- Referred to vascular surgery and started surveillance for AAA

IMPROVING QUALITY FOR PATIENTS

- 74 y.o. formerly homeless female with infrequent visits to PCP, never had any preventative medical care but was referred to COA, CHT, WCMH, SASH services. She was contacted through panel management process and scheduled AWV.

IMPROVING QUALITY FOR PATIENTS

Wellness Nurse Summary Note:

- *No Advance Directive
- *No Mammo on file - ordered in vv
- *Bone Density in 2012 indicates osteopenia - ordered in vv
- *Labs done in Jan 2016 repeat ordered Lipid/CMP/Vit D/A1c - ordered in vv
- *Time Up and Go >12 referred to CVHH PT
- *Referral for Dentist - lost dentures 3 years ago and has difficulty eating since
- *Referral to CHT to assist with diet/meal planning/shopping
- *Referral for Eye Doctor - doesn't remember the last time she went - currently wearing OTC but c/o a lot of visual difficulties
- ***note multiple added DX: Gait instability, Poor Diet, Mild Depression (per PHQ-9), Teeth Missing
- ***would appreciate a chance to discuss this patient with you ***

IMPROVING QUALITY FOR PATIENTS

- Patient was reconnected with SASH and a lead care coordinator will be identified so that patient doesn't fall through the cracks
- F/U with PCP was scheduled and discovered new diagnosis of DM
- Transportation barriers identified and plan made to transfer care to a PCP office closer to where she lives in the Fall if possible

CHALLENGES

- Culture shift from the “*Annual Physical*” to “*Annual Wellness Visit*”
 - Front desk scripting and talking points
 - Scheduled follow-up with the PCP after the AWV allowed for issues to be addressed and improved patient satisfaction
 - Socialized new process with patients at other visits whenever possible
- Confusion about what is an AWV?
 - Wellness RN makes initial call to schedule the visits and answers questions
 - This increased the number of patients accepting the AWV

CHALLENGES

- Billing issues/confusion
 - First year patient is on Medicare must be an IPPE with an MD. AWV can be no sooner than 366 days from the first IPPE
 - Improved information letter with patient feedback
 - Working on a process for the practice to refer patients to a financial counselor when needed
- Updating problem list
 - RN populates diagnosis list at AWV and sends to PCP for sign off

NEXT STEPS

1. Evaluate data
 - Percent of patients with Medicare that had AWW
 - Pre/Post Intervention
2. Health Risk assessment to be completed before the visit
 - Potential time saving of 15 minutes during the visit
 - Potentially have patient complete using the patient portal
3. Panel Management to identify and recruit those in need of AWW
4. Rollout project at other practices within the network
5. Share what we've learned!

QUESTIONS??



Presentation

Daniel Moran, MSN, APRN

Dartmouth Internal Medicine

Ellen Flaherty, PhD, APRN, AGSF

Co-Director, Dartmouth Centers for Health and Aging

Medicare Annual Wellness Visit Training

Ellen Flaherty, PhD, APRN, AGSF
Co-Director, Dartmouth Centers for Health and Aging

Daniel S. Moran, MSN, APRN



Dartmouth

CENTERS FOR HEALTH AND AGING



Outline

- What is GWEP
- Transforming the Team
- Ongoing Support
- Successes
- Lessons Learned

GWEP - Making it Easy to do the Right Thing



What is GWEP

- One of 44 federally funded Geriatric Training Initiatives
- 07/01/15 – 06/30/18 \$2.5 million over 3 years
- Develop integrated geriatrics and rural primary care delivery teams that will focus on efficient and effective implementation and training in four core primary care practices:
 - Annual Wellness Visit
 - Chronic Care Management
 - Advance Care Planning
 - Dementia Care

Transforming the Team - Kickoff

Full day of in-person training

- Why Integrated Care Matters
- Partnering with Community and Social Service
- Partnering with Patients and Family
- Team Transformation
- Quality Improvement
- Best Practice in Geriatric Primary Care (a simulation)

Transforming the Team – AWW Bootcamp

Full day of in-person training:

- AWW Rules & Benefits
- Introduction to GWEP Website
- AWW Health Risk Assessment and Note Template
- AWW Video
- AWW Panel Q&A
- Learning Collaborative Orientation
- Site-Assist GWEP Implementation: Focused IT & Clinical Q&A
- Next Steps in Practice

Ongoing Support

- Elbow-to-Elbow
- Learning Collaborative
 - Regularly scheduled group video conference
 - Share relevant data
- Website
- AWW Video
- Implementation Toolkit

Elbow-to-Elbow

Onsite training

- Working with team
- Workflow development
- Electronic Medical Record usage
- Shadowing
- Mentoring

Learning Collaborative Syllabus

GWEP Learning Collaborative Syllabus

Meeting Sign-in: 11:45-12:00

Meeting Time: 12:00-1:00

Date	Phase	Topic	Content & Activities	What's Next
4/19/2017	Annual Wellness Visit	Overview of the Journey: Collaborative Learning	Introduction to Learning Collaborative Review of expectations and ground rules Monthly data expectations; updates	AWV Site Readiness
5/3/2017		Pre-Visit Site Readiness	Site Readiness Checklist Site updates, Data Dashboard and PDSA Part II	AWV Patient Readiness 1 st Monthly Data due May 31st
5/17/2017		Pre-Visit Patient Readiness	Updates, Knowledge & Skills	AWV Data Dashboard Review During the Visit
5/31/2017		Patient Readiness During the Visit	Updates, Knowledge & Skills Submit data	AWV During the Visit Data due June 28th
6/14/2017		Post- Visit	Updates, Knowledge & Skills Review May data - <i>end of AWV Phase</i>	

Website

- Designed to provide primary care practices with educational resources and important forms to conduct the AWW
 - Bootcamps, learning collaborative, abstracts
 - Pre-visit Site Readiness
 - Pre-Visit Patient Readiness
 - During the Visit
 - Post-Visit
 - Video

NNEGEC.ORG



The Northern New England Geriatric Education Center

- Home Page
- Member Login
- About Us
- About the Team
- Learning Collaborative
- Annual Wellness Visit Toolkit**
- Patient and Family Education
- Professional Education

Annual Wellness Visit Toolkit

The NNEGEC team is proud to present the Annual Wellness Visit Toolkit. This toolkit designed to provide primary care practices with educational resources and important forms to conduct the Medicare Annual Wellness Visit effectively and efficiently.

AWV Bootcamp

POST-VISIT

- Geriatric Interprofessional Team Transformation - Primary Care
- Dementia Care
- Patient and Family Education
- Professional Education
- Events
- User Registration

- GWEP Bootcamp II: Chronic Care Management**
June 28 @ 8:30 am - 4:30 pm
- Bootcamp III: Advance Care Planning**
September 12 @ 8:30 am - 4:30 pm
- Bootcamp IV: Dementia Care**
November 8 @ 8:30 am - 4:30 pm

[View All Events](#)

AWV Bootcamp & Abstracts

- AWV Rules & Benefits Presentation - [Slides](#)
- AWV HRA and Note Template Presentation - [Slides](#)
- Next Steps Presentation - [Slides](#)
- Learning Collaborative Orientation Presentation - [Slides](#)
- Abstract Poster: Implementing the nurse run AWV - [Poster](#)

PRE-VISIT SITE READINESS

- AWV - [ABCs / FAQs](#)
- Comparing Wellness Visits - [PDF](#)
- Preventive & Screening services - [Website](#)
- Practice Flow - [Checklist / Chart](#)
- Scheduler - [Training / One-Pager](#)
- HRA - [Requirement / Sample](#)
- Note - [Layout / Sample](#)
- Visit Auditing Tool - [PDF](#)
- AWV Video - [Video](#)

PRE-VISIT PATIENT READINESS

- Patient Introduction Letter - [Word](#)
- Pre-Appointment Letter - [Word](#)
- Home Safety Checklist - [PDF](#)
- How's Your Health - [Website](#)

DURING VISIT ASSESSMENTS

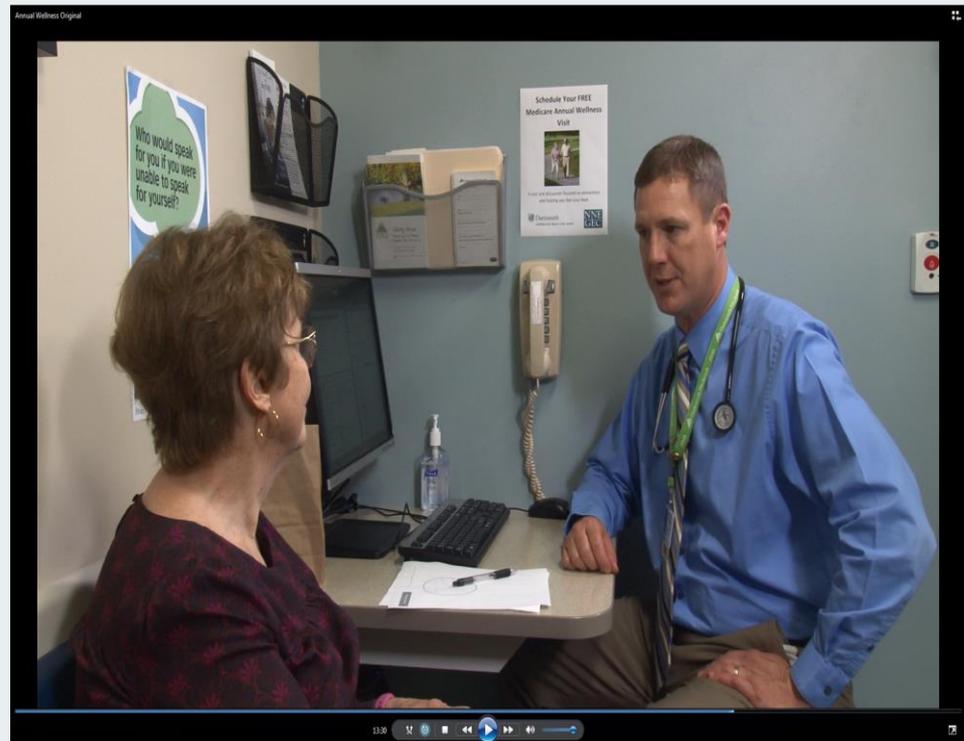
- **Depression**
 - PHQ-2 / [9](#)
- **Functional ability**
 - CDC - [STEADI / TUG](#)
 - CDC Hearing - [Website](#)
- **Measurements**
 - CDC BMI - [Website / Table](#)
- **Cognitive Impairment**
 - Alzheimer's Association - [Website / Toolkit / Algorithm / Mini Cog / Blank Clock](#)
 - MoCA®* - [Website](#)
- **Screening Schedule**
 - Preventive Plan - [Female / Male](#)

POST-VISIT

- **Health Risks**
 - Alzheimer's Association - [Website](#)
 - Curbside for Dementia - [Dementia Care Page](#)
 - Dementia, The Journey - [Patient and Family Education Page](#)
 - Dartmouth-Hitchcock ARC - [Website](#)
 - Health & Human Services - [NH / VT](#)
 - Healthy Aging (CDC) - [Website](#)
 - NCOA Falls - [Website](#)
 - Falls Prevention - [NH / VT / Stop Falls](#)
- **Psychosocial Risks**
 - Mental Health (CDC) - [Website](#)
- **Behavioral Risks**
 - Assessing and Counseling Older Drivers - [Website](#)
 - Elderly Driver Safety (DMV) - [Website](#)
 - Tobacco Prevention - [NH / VT / DH](#)
- **ADL**
- **IADLS**
 - Scams That Target Older Adults (CFPB) - [Website](#)
 - Tips to Avoid Financial Exploitation - [Website](#)
- **Medication Risks**
 - Beers Criteria - [Website / Table](#)
 - Disposal - [NH / VT](#)
- **Resources**
 - Abuse, Neglect and Exploitation - [Website / PDF](#)
 - Adult Protection - [NH / VT](#)
 - Advance Directives - [NH Website / NH Form / VT Website / VT Short Form / VT Long Form](#)
 - Elder Abuse - [Website](#)
 - Financial Protection for Older Americans - [Website / PDF](#)
 - Health Topics (NIA) - [Website](#)
 - State Offices - [NH / VT](#)
 - Support Services - [NH / VT / NE VT](#)
 - Things My Loved Ones Need to Know - [PDF](#)

AWV Video

- 18 minute video
- Demonstrating the nurse run AWV
- Reviews steps & key components
- Demonstrates cognitive and falls assessment
- Discusses After Visit Summary



Implementation Toolkit - Example of AWW Contents

- Introduction
- Implementing the AWW
 - Pre-Visit Site Readiness
 - Pre-Visit Patient Readiness
 - During the Visit
 - Post-Visit
- Key points
- References
- Tools

AWV Pre-Visit Site Readiness Check List

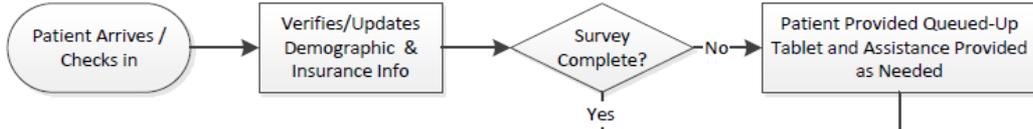
Step	Action	Date Initiated	Date Completed
1	Identify Team Members		
2	Prepare Team		
3	Educate Staff and Create Training Tools		
4	Create a workflow		
5	Create a Health Risk Assessment		
6	Create a Visit Note Template		
7	Create Auditing Tools		
8	Create a Pre-appointment Letter		
9	Set Up a Tracking System		

Medicare Annual Wellness Nurse-Run Visit Swim Lane Flow Chart

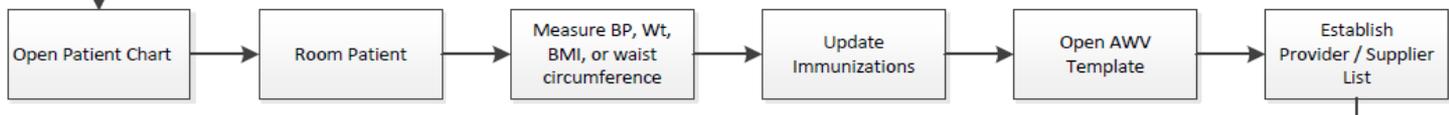
<http://nnegec.org>

Revised: 4/7/2017

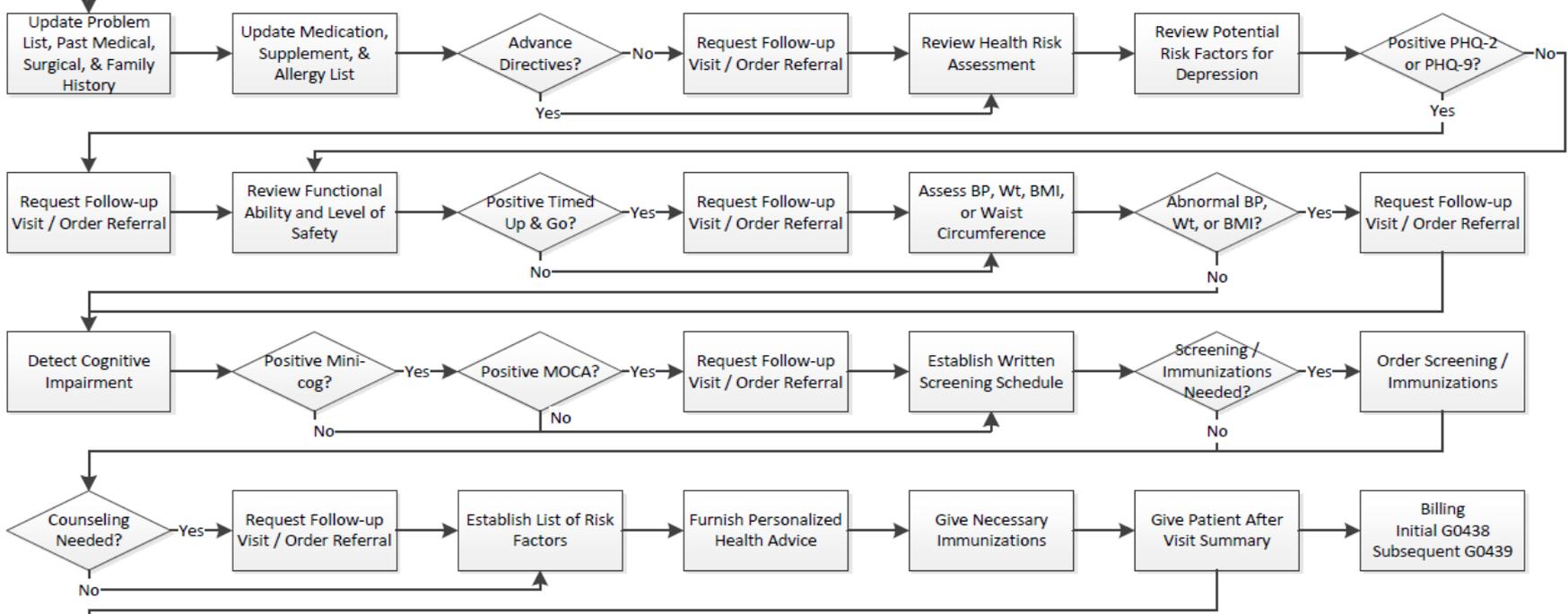
Receptionist



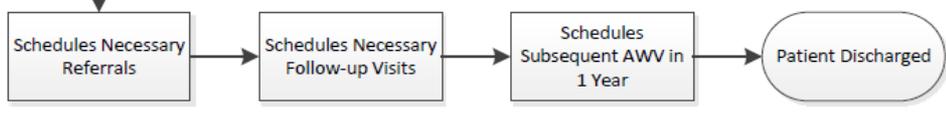
Rooming Staff



Nurse



Exit Secretary



D-H Population Health Collaboratory Implementing the Nurse Run Medicare Annual Wellness Visit

Daniel S. Moran, Linda S. Eickhoff, Timothy M. Hesselton, Lora G. Wise, Ellen Flaherty, Stephen J. Bartels

Abstract

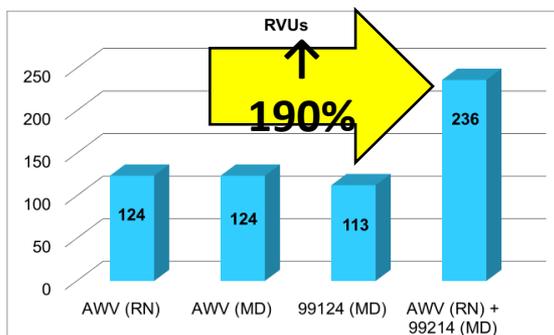
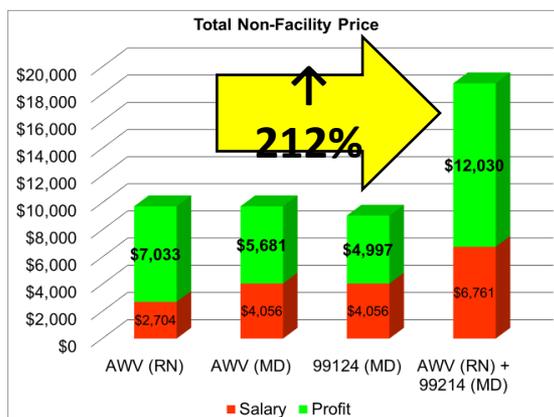
- The Medicare Annual Wellness Visit (AWV) is a free service offered to Medicare Part B beneficiaries annually to promote preventive care and reduce unnecessary utilization of health care services. [1]
- One of the most common barriers to Medicare AWVs listed by Primary Care Providers (PCPs) was the lack of time during the office visit. [2] It can be challenging and frustrating for PCPs to provide and document the extensive list of required elements in a 20 or 30 minute visit. Centers for Medicare and Medicaid Services (CMS) has made it even easier for practices to offer the service by expanding the types of professionals who can offer the AWV to include a nurse working under supervision of a physician or other licensed practitioner. [3]
- Through the Northern New England Geriatric Workforce Enhancement Program (GWEP), a cooperative agreement funded by the Health Resources and Services Administration (HRSA), we engaged six Dartmouth-Hitchcock practices and six non-Dartmouth-Hitchcock practices to implement the AWV as a nurse run visit. By implementing the nurse run AWV, a practice could increase utilization of AWV, increase employee and patient satisfaction, and increase revenue.

Introduction

- The AWV includes:
 - A Health Risk Assessment
 - The establishment of, or update to, the individual's medical and family history and list of current providers
 - Measurement of height, weight, body-mass index (BMI), and blood pressure (BP)
 - Detection of any cognitive impairment
 - Review the individual's potential (risk factors) for depression and functional ability and level of safety
 - Establishment of a written screening schedule and list of risk factors
 - Furnishing of personalized health advice and referral, as appropriate, to health education or preventive counseling services or programs
- The goal of the AWV is health promotion and disease detection, fostering the coordination of the screening and preventive services that may already be covered and paid for under Medicare Part B. [1] The AWV is not a head-to-toe physical examination.
- The AWV is well reimbursed and provides high Relative Value Units (RVU). The 2017 Medicare Non-Facility Price for Current Procedural Terminology (CPT) codes G0438 (initial AWV) and G0439 (subsequent AWV) in New Hampshire are \$177.71 (2.43 RVUs) and \$120.71 (1.5 RVUs), respectively. By comparison, the rate for CPT code 99214 (level 4, established-patient office visit) is \$120.71 (1.5 RVUs). [4] Since the nurse is working under the supervision of a physician, the reimbursement is the same.
- The Northern New England GWEP's goal was to engage nursing in the primary care of older adults allowing them to work at the top of their license.
- Our training program offered boot camps, in-person elbow-to-elbow and web-based learning collaborative sessions, and a GWEP-developed implementation guide with tool kit containing training tools, templated visit notes and patient letters, during visit assessment tools, videos, references, resources. Two cohorts engaged, one after the other, in the 12-month long training program. [5] [6]

Profit Margins / RVUs

- One site did 75 RN AWV visits in 3 months, of which 12 were Initial and 63 were Subsequent.
- Using mid-career salary of \$225,000 for a MD and \$75,000 for a RN.
- Calculating MD time for AWV and office visit (99214) at 30 minutes per visit and RN time for AWV at 60 minutes per visit.
- You would increase profit by 212% (\$6,348) and RVUs by 190% (112) by having the MD see 75 office visits (99214) and the nurse seeing 75 AWV (with the ratio of Initial and Subsequent list above) over having the MD doing the AWVs alone.**



Results

- By moving the AWV to a nurse run visit we were able to:
 - Provide the patient a free visit focused on prevention
 - Complete a comprehensive update of the Electronic Medical Record (EMR)
 - Increase the number of nurse run AWVs in all practices
 - Increase the PCP's availability for acute and chronic care of their patients
 - Increase team cohesiveness
 - Anecdotally increase nurse and PCP's satisfaction by allowing them to work at the top of their license
 - Anecdotally increase patient satisfaction by allowing the shifting of PCP visit time and focus away from prevention to pressing concerns of higher priority to the patient
 - Increase profit margins

Conclusion

- At the completion of the first cohort, we were able to identify positive benefits of the nurse run AWV to the patient, nurse, PCP and practice by transforming the culture of practices to focus more on a team approach.
- We were able to create a training program offering boot camps, elbow-to-elbow support and learning collaborative and a tool kit with multiple resources and training materials for practices to utilize and customize to fit their needs.
- As we move into cohort 2, we have identified barriers around workforce challenges, data collection and continued difficulties around educating the patient about the difference between the AWV and their yearly visit with PCP for management of their chronic medical conditions.

References

- Department of Health and Human Services Centers for Medicare and Medicaid Services. "Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)." 2 March 2016. [Online]. Available: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7079.pdf>.
- K. A. Chappell, Health Promotion in Older Adults: A Look at Medicare Annual Wellness Visits, Arizona, 2017.
- Department of Health and Human Services Centers for Medicare and Medicaid Services. "The ABC's of the Annual Wellness Visit (AWV)." January 2014. [Online]. Available: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWW_Chart_ICN905706.pdf.
- Department of Health and Human Services Centers for Medicare and Medicaid Services. "Physician Fee Schedule Search." 2017. [Online]. Available: <https://www.cms.gov/apps/physician-fee-schedule/search/research-criteria.aspx>. [Accessed 7 June 2017].
- Dartmouth Centers for Health and Aging. "The Annual Wellness Visit Toolkit." 2016. [Online]. Available: <http://nnegec.org/annual-wellness-visit-toolkit/>.
- Dartmouth Centers for Health and Aging. "The Medicare Annual Wellness Visit Video." 2017. [Online]. Available: <https://vimeo.com/217337897>.

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1QHP28718, Geriatric Workforce Enhancement Program, for \$2,534,634. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Lessons Learned

- Bringing the teams together
- Champions
- Transformation happens through
 - Collaborative learning
 - Implementation guide / Toolkit
 - Coaching and support

Questions?



Thank you

Ellen.Flaherty@Hitchcock.org

Daniel.S.Moran@Hitchcock.org



Dartmouth

CENTERS FOR HEALTH AND AGING



This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1QHP28718, Geriatric Workforce Enhancement Program, for \$2,534,634. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Presentation

Elizabeth Sheehan, RN
Ottoauguechee Health Center



THE NURSE RUN AWW

Elizabeth Sheehan, RN



Overview of the Clinic

- 6 Providers
 - 1 NP
 - 1 PA
 - 2 Pediatricians
 - 2 internists
- 6 nursing staff members
 - 3 RNS
 - 1 LPN
 - 1LNA
 - 1 CMA
- 2 Community Health Team members
- Specialists
 - Psychiatry 2 days a week
 - Podiatry 2 days a week
- Physical Therapy

My Role

Then

- Lead nurse/Admin Duties
- Walk in Triage nurse
- Phone Triage Nurse
- Prescription renewal
- Rooming patients

Now

- Lead nurse/Admin Duties
- **Annual Wellness Visits**
- Walk in Triage Nurse
- Phone Triage Nurse
- Prescription renewal
- Rooming patients

Vision for the Future

- Annual Wellness Visits
- Chronic Care management visits
 - *COPD*
 - *Hypertension*
 - *Diabetes education*

Training

- Participated in the first cohort of GWEP
 - *Boot camps*
 - *Tool kit*
- In office training with Dan Moran (see 2 do 1!)
- “Just do one already!” – a little push from our GWEP liaison Debbie.
- Continual fine tuning
- Patient input along the way

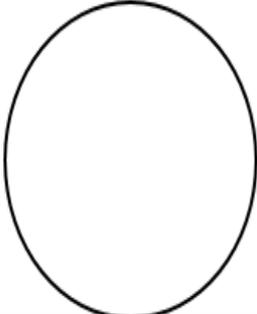
What it looks like:

- Patient is contacted via letter that they are due for their annual visit with the doctor including the AWW with the nurse.
- Patient calls, insurance is verified
- Patient is scheduled for 1 hour with the nurse and then directly after, a half hour with the provider.
- At check in patient is given a Health Risk Assessment to fill out
- Nurse sees patient
- Soft hand off to provider- noting any issues to follow up on
- Provider sees patient

The Soft Hand Off

Provider communication

<u>Outside Providers:</u>	<u>Concerns:</u>
<u>Health Maint:</u>	<u>Assessment scores:</u> PHQ- GAD- <u>Minicog:</u> SLUMS- MOCA-



Benefits

- More one on one time spent with patients talking about prevention and lifestyle-increased patient satisfaction
- More education for patients surrounding their chronic health problems and identified health and lifestyle risk factors
- Frees up providers' time to see more acute/chronic medical issues
- Allows nurses to work to the top of their license- increased staff satisfaction

Challenges-Past and Present

- PATIENT BUY-IN
- Understanding the difference between the AWW and Annual Physical
- Training for support staff
 - *Insurance questions*
 - *Scheduling*

What's Next?

- So far performed 127 AWWs, hoping for even more this year.
- In the process of a Gero Nurse Prep class to become Board Certified in Gerontology.

Questions?