CMS
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Case STUDY

Learning Systems
for Accountable Care Organizations

The Evolution of Annual Wellness Visits at Bellin Health Partners Next Generation Accountable Care Organization

This case study describes the strategy that Bellin Health Partners Accountable Care Organization (Bellin ACO) developed to maximize the effectiveness of annual wellness visits (AWVs). The initiative included four components: (1) structuring the care team, (2) health information technology (HIT) applications, (3) provider incentives, and (4) provider and staff communication. From 2015 to 2017, Bellin ACO increased the percentage of ACO-aligned beneficiaries who completed an AWV from 43 to 68 percent and observed that patients with AWVs showed improvements in quality and cost metrics compared with patients who did not receive an AWV. Bellin ACO's experience can be helpful for ACOs that seek to increase beneficiaries' participation in the AWV and to enhance the benefits of these visits for patient care.

BACKGROUND

Organization

Bellin Health Partners Accountable Care Organization (Bellin ACO) is part of Bellin Health Partners (Bellin), a clinically integrated network located in northeastern Wisconsin and the upper peninsula of Michigan. From 2014 to 2016, Bellin partnered with ThedaCare HealthPartners to participate in the Pioneer ACO Model. In 2017, Bellin joined the Next Generation ACO Model with a primary and specialty physician group consisting of 147 clinicians, 86 independent specialty physicians, and 22 additional nurse practitioners and physician assistants. It also includes two hospitals and a psychiatric center. As of January 2018, the ACO served about 10,000 aligned beneficiaries.

Designing the AWV initiative

In 2016, Bellin created a steering team to set the overall strategy for operating the ACO. This steering team consisted of representatives with expertise in primary care, care transitions, coding and documentation, quality improvement, care redesign, and population health. The steering team identified AWVs as an opportunity for improvement. They hypothesized that using AWVs effectively could lead to improvements in key metrics on the ACO's internal scorecard related to patients' experiences, care gaps, total cost of care, and accuracy of recorded Hierarchical Condition Category (HCC) scores. To anchor the AWV initiative, the team set a goal to increase the percentage of Next Generation ACO patients who completed an AWV from a baseline of 43 percent in 2015 to 70 percent in 2018.

Concurrent with the AWV initiative, Bellin implemented an initiative to redesign its delivery of primary care. The redesign sought to encourage team-based care and enable patients to build familiar, trusting relationships with their providers. Bellin established one or more primary care teams in each clinic that included four key staff: a primary care physician (PCP), a care team coordinator, a care team registered nurse (RN), and a patient admission representative. The AWV initiative leveraged many elements of the primary care team redesign, such as having primary care teams schedule and complete the visits. As such, the overall primary care redesign work was foundational to the success of the AWV initiative.

> *The annual wellness visit is a foundational piece for all of the redesign work. It's there to help collect the discrete data we need to understand our populations and prioritize work so that we're doing the highest impact work with our limited resources to achieve better outcomes, to achieve a better experience, and to improve the affordability of health care.*
>
> *Christopher Elfner, Director of Accountable Care*

FOUR COMPONENTS OF THE AWV STRATEGY

Figure 1 shows the four main components of Bellin's AWV initiative: structuring the care team, HIT applications, provider incentives, and communication with staff and providers. We describe each of the four components after the figure.

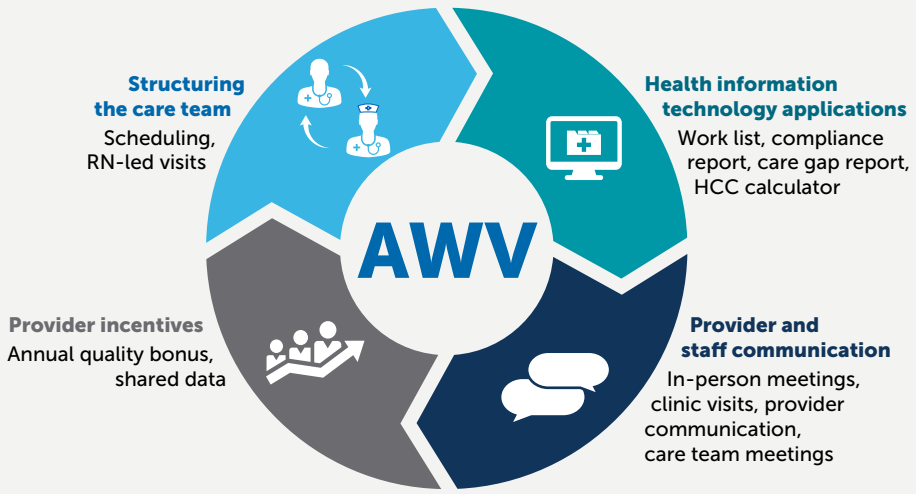
STRUCTURING THE CARE TEAM

Bellin tested multiple staffing approaches when implementing the AWV initiative. Initially, it used a centralized care management team to contact ACO-aligned beneficiaries and schedule the visits. This led to a rapid increase in the number of patients completing AWVs. After this initial success, however, Bellin's leadership recognized an opportunity to leverage new scheduling processes from the ongoing primary care team redesign initiative. Bellin decentralized the AWV scheduling process, assigning the task to the patient admission representatives, which streamlined the scheduling process and reinforced the primary care team's relationship with patients. To support patient admission representatives, Bellin created standard scripts for conversations with patients and hosted roundtable discussions to consider challenges they encountered. Leaders use the information from these discussions to develop additional training materials as appropriate.

Building on the primary care redesign effort, Bellin identified care team RNs as the appropriate providers to complete the AWVs, as it would enable RNs to practice at the top of their license. Bellin theorized that this change would increase the RNs' job satisfaction, free up PCPs to conduct other kinds of patient visits, and ultimately increase patients' access to care. Bellin completed analyses that revealed that care team RNs would have more time for AWVs if other care team members took on tasks such as completing forms or stuffing envelopes. Bellin revised the workflows of the care team staff to allow RNs to dedicate half their time to conducting visits with patient, including the AWVs. In addition, Bellin encouraged care teams to think strategically about how to use RNs to maximize patients' time in the office (for example, scheduling

Figure 1

Bellin ACO's AWV strategy



back-to-back appointments for an AWV with the RN and a physical with the PCP). Bellin provided training and coaching to support care team RNs that were new to conducting the AWVs.

HIT APPLICATIONS

Bellin's analytics team built reports and tools that support implementation of the AWV initiative, leveraging the single electronic health record (EHR) system used by the ACO's primary care clinics. The team designed these HIT applications to increase the number of patients who received AWVs and to maximize the effectiveness of those visit. For example:

- **Work lists** facilitate the AWV scheduling process by pulling data from the EHR to assign tasks to a primary care team member. Patient admission representatives receive a copy of a work list that identifies patients who are overdue or about to become due for an AWV.
- **A Medicare wellness visit compliance report** shows clinic managers which patients have scheduled and completed AWVs, as well as completed AWVs that were not billed correctly.
- **A care gap report** displays the status of key clinical and process measures within the EHR during the patient's visit. Providers use this report as a resource to review care gaps (such as outstanding diagnostic tests) or to discuss scheduling additional visits.
- **An HCC calculator** prompts providers to clarify a patient's diagnosis during the AWV, which supports the scorecard goal of increasing the accuracy of the HCC score.

Bellin held education and training sessions to help primary care clinics adopt these tools. As the implementation progressed, Bellin provided ongoing support to clinic staff to resolve technical challenges and encourage their use of the tools. For example, when introducing the care gap report, Bellin leaders held an organization-wide webinar, as well as on-site training at the clinics.

PROVIDER INCENTIVES

Bellin began using data to prioritize the AWV initiative and to create an atmosphere of healthy competition among PCPs. The ACO gives PCPs monthly data on their AWV completion rate and provides comparisons with their peers. In addition, Bellin includes a measure about AWV completion in the PCPs' annual quality bonus calculation. Although the quality bonus is a relatively small amount, Bellin believes it is an important aspect of the ACO's approach to encourage value-based care by sharing revenue with PCPs. PCPs have relayed that they appreciate that the quality bonus communicates clear priorities and goals for care.

PROVIDER AND STAFF COMMUNICATION

Bellin leadership communicated the organization-wide emphasis on AWVs to primary care team staff during in-person meetings. Bellin introduced the AWV initiative at monthly clinic manager meetings, which included staff from across the system to discuss new and ongoing organizational priorities. Based on these discussions, clinic mangers returned to their clinics to implement the AWV, provide training, and encourage engagement in the AWV effort. Bellin's leaders also traveled to many clinics to have one-on-one conversations with primary care staff about the AWV initiative, pointing to connections between the AWV effort and other organization-wide strategic initiatives.

To encourage ongoing engagement with providers and staff about the AWV initiative, Bellin looks to the HIT applications and related data analyses. Providers receive monthly data on their AWV completion rates and primary care teams display their AWV completion rates on clinic activity boards. During standing meetings, staff analyze data from the work list, Medicare wellness visit compliance report, and care gap reports to identify opportunities for continued improvement. Primary care teams consider these data in daily care team huddles to identify priorities for the day and highlight patients with AWV appointments. Larger, biweekly care team meetings provide an opportunity to reflect on the information collected during the AWV with staff from both the primary and extended care teams (such as a clinical pharmacist, diabetic educator, and case manager).

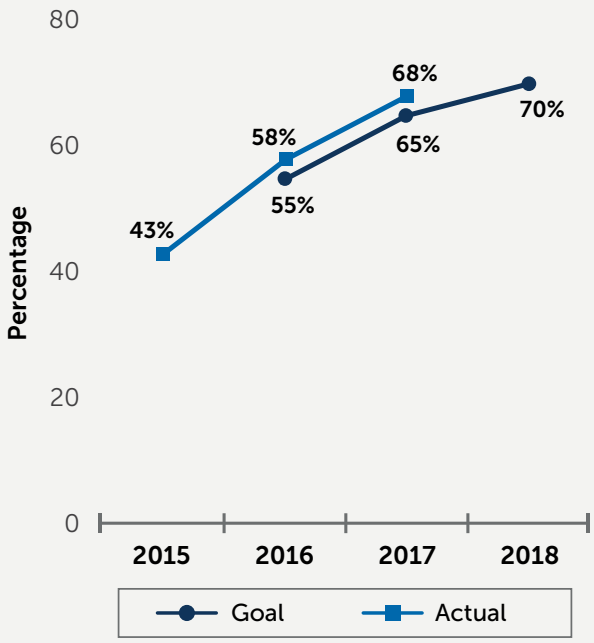
RESULTS

Bellin successfully increased the percentage of ACO-aligned beneficiaries who completed an AWV. In 2015, before the initiative began, the AWV completion rate stood at 43 percent of aligned beneficiaries. In 2016, the ACO steering team set annual goals of 55 percent in 2016, 65 percent in 2017, and 70 percent by the end of 2018. As shown in Figure 2, Bellin increased the AWV completion rate in the first two years of implementation beyond its annual goals.

In 2017, Bellin analyzed the health outcomes for beneficiaries who received an AWV in the previous year compared with those who did not. The analysis indicated that beneficiaries with an AWV in 2016 had 30 percent fewer service gaps (for example, appropriate treatment for hypertension) and were 60 percent more likely to have an advance directive on file. In addition, beneficiaries with AWVs had substantially fewer emergency room visits and lower overall health costs. Although Bellin's leaders recognize underlying patient characteristics and other factors might contribute to some of these outcomes, they are encouraged by preliminary results that suggest the AWV initiative supported improvement on relevant quality and cost metrics.

Figure 2

Percentage of ACO-aligned beneficiaries with annual AWV: Goal versus actual



Bellin has also received positive feedback on the care redesign from RNs and PCPs. Care team RNs reported increased job satisfaction and stronger patient–provider relationships as a result of the AWV initiative. They noted an increase in the quality and quantity of patients' information collected during AWVs, including related to social determinants of health. Through discussions during AWVs, the primary care team staff get to know their individual patients better and are increasingly able to identify and address overall health needs.

> *Some patients are skeptical at first … after they come in and see the care team RNs, they're very thankful because certain things they didn't realize were a health care concern were picked up during the Medicare wellness visit … having the camaraderie with that care team RN allows that trust for the care team RN to get the provider involved.*
>
> *Kathy Kerscher, Team Lead of Primary Care Operations*

REFLECTIONS AND NEXT STEPS

Bellin attributed the success of its AWV initiative to several factors. Looking back, Bellin leadership noted how integrating the AWV initiative into the overall organizational strategy raised the profile of the initiative. It helped to encourage uptake, increased the impact on care delivery, and improved the long-term sustainability of the intervention. The ACO also invested in regular communication with providers and clinic staff to emphasize culture change and highlight the value of AWVs as a strategy to provide high-value care. These communications included formal presentations, informal conversations that emphasized feedback, and data analyses and reports. Finally, Bellin noted the importance of engaging providers and clinic staff early when designing new tools and trainings to support use of AWVs to refine and encourage adoption in the care delivery environment.

In the coming years, Bellin will explore strategies to expand the scope of the AWV initiative to additional clinics and practices. In addition, Bellin is currently exploring how to systematically collect information on the social determinants of health, information that patients are more likely to share as they develop stronger relationships with their care team during the AWV. Finally, Bellin will identify strategies to provide additional tools to care team RNs in order to provide better care for beneficiaries during and after the AWVs.

ABOUT THE ACO LEARNING SYSTEMS PROJECT

This case study was prepared on behalf of CMS's Innovation Center by Natalie Graves of Mathematica Policy Research under the Learning Systems for ACOs contract (HHSM-500-2014-00034I/ HHSM-500-T0006). CMS released this case study in May 2018. We are tremendously grateful to the many staff from Bellin Health Partners for participating in this case study.

For more information, contact the ACO Learning System at ACOLearningActivities@mathematica-mpr.com.