DEVELOPING A NURSE-LED MEDICARE ANNUAL WELLNESS VISIT PROGRAM FOR THE OUTPATIENT SETTING

by

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ABSTRACT

Chronic disease causes preventable deaths each year. The financial cost of preventable diseases continues to grow. Many evidenced-based screenings and recommendations provide ways to stop or decrease the effects of chronic diseases. The number of preventive care screenings individuals received increases when a wellness visit is provided. Yet, less than a quarter of eligible Medicare beneficiaries receive their free annual wellness visit. Low participation rates in the annual wellness visit leads to missed preventive services, increased chronic disease, and increased cost. Medical providers continue to have mixed opinions regarding the importance of the visit, leading to decreased buy-in and patient education about the visit. A nurse-led annual wellness visit program, created in an outpatient primary care setting, aims to increase awareness about the visit and increase the number of patients receiving preventive care. A multi-professional committee formed to implement and continue the program. One registered nurse was trained and piloted the program by seeing patients one day per week for their annual wellness visit and recruiting patients for the visit on another half-day. The number of people receiving the annual wellness visit will be tracked to analyze the impact of nurses recruiting and conducting the visit at an outpatient clinic. Previous programs have shown an increase in participation in the annual wellness visit and an increase in preventive services being performed.

CHAPTER ONE

INTRODUCTION

Introduction

Preventive care saves lives through early detection of disease and reducing individuals' risk for development of life-threatening conditions (Farley et al., 2010). However, only 8.0% of adults above age 34 received all evidenced-based preventive care services recommended by the U.S. Preventive Services Task Force; to improve benefit utilization, the Office of Disease Prevention and Health Promotion (n.d.) released a new goal to increase the number of adults receiving evidenced-based preventive care to 10.9% (Borsky et al., 2018). The annual wellness visit (AWV), offered to Medicare members, has been found to be an effective intervention to increase participation in all recommended preventive services (Jiang et al., 2018). Development and utilization of a nurse-led annual wellness visit program may increase utilization of preventive services and thus improve individual and healthcare organization outcomes.

Medicare exists as federally funded health insurance for all adults aged 65 and above as well as other qualifying disabilities. The percentage of the U.S. population enrolled in Medicare in 2019 was 19.1%, compared to 21.5% of Montana residents (Center for Medicaid and Medicare Services [CMS], 2020; United States Census Bureau, n.d.). Each beneficiary, or individual enrolled, qualifies for the annual wellness visit which can be performed by a provider or other qualifying healthcare worker once every 12 months (Patient Protection and Affordable Care Act, 2010). The AWV generally includes a personalized risk assessment, updates to medical history, relevant health education and evidenced-based recommendations (CMS, n.d.).

Preventive services recommended during the AWV are a cost-effective method to prevent or detect life-threatening chronic conditions earlier (Solberg et al., 2008; Haukka et al., 2011; Dabestani et al., 2019; Knudsen et al., 2016). Although recommended screenings can save money, less than 1% of Medicare expenditures are related to preventive services (National Council on Aging [NCOA], 2018). Instead, 93% of Medicare spending expenditures are related to chronic illness, with over 80% of Medicare beneficiaries have at least one chronic illness (Ward et al., 2014; Buttorff et al., 2017; NCOA, 2018). Montanans suffer from the financial and societal burdens of chronic disease as well. Annually, approximately 1,000 Montana residents under the age of 80 will die from heart disease and stroke; 200 of these are deemed preventable through tobacco cessation, lifestyle modifications, diet, and blood pressure management. (Yoon et al., 2014; Public Health in the 406, 2015).

The Patient Protection and Affordable Care Act of 2010 created the annual wellness visit as an opportunity to shift the focus of healthcare toward preventive care. However, only 25.2% of enrollees participated in an AWV during 2015 (Carter et al., 2019). Barriers to participation in the AWV include lack of benefit awareness, lack of provider buy-in to the service due to the strict requirements, and the individual complex care conditions on the initial visit (Bluestein et al., 2017; Ganguli et al., 2018).

Affordable Care Act (2010) guidelines state that a medical professional supervised by a physician may conduct the annual wellness visit. Bachelor's prepared registered nurses are uniquely prepared to provide this service, having been educated in critical thinking, health and wellness, and patient education; key skills required to provide AWVs. Nurse provision of this service is cost effective (Kubota, 2020). The limited body of research exploring the use of

Registered Nurses (RNs) to provide AWVs has consistently revealed high levels of patient and staff satisfaction (Tetuan et al., 2014; Kubota, 2020). Team-based care programs providing AWVs are also associated with improved patient participation in preventive care services as well as improved clinic financial performance (Zorek et al., 2015; Alhossan et al., 2016; Galvin et al., 2017; Woodall et al., 2017).

Based on the impact and incidence of chronic disease in the geriatric population in the United State and Montana (Buttorff et al., 2017; Public Health in the 406, 2015), preventive care provides a cost-effective method to improve healthcare outcomes. Education specific to the AWV benefits (improved outcomes, decreased cost) has the potential to entice both healthcare providers and patients alike. Therefore, developing and implementing a nurse-led Medicare annual wellness visit program provides a cost-effective method to increase the utilization of the AWV among adults 65 and older to improve preventive care participation and health outcomes.

Definitions

Medicare: a federally funded insurance company for adults aged 65 and older as well as other qualifying individuals

Medicare Annual Wellness Visit: a yearly, covered office visit designed to assess risk factors and provide individualized care planning. The visit includes:

- performing a health risk assessment
- vital sign measurement (height, weight, body mass index, and blood pressure)
- updating the current medication list
- reviewing and updating the current healthcare team

- updating medical, surgical, and family history
- performing a depression screening
- completing a cognitive function assessment
- reviewing the individual's functional status and safety
- offering advance care planning services
- providing education and referrals based on assessments done in the visit
- providing an individualized preventive screening schedule (CMS, n.d.)

Preventive services: Routine healthcare screenings, education, and exams utilized to prevent illness or detect disease earlier (healthcare.gov, n.d.).

Nurse-led: Registered nurses performing protocol-based tasks and challenges to organize medical care in an outcome driven and cost-effective way (Cullum et al., 2005).

Theoretical Framework

Peplau's Theory of Interpersonal Relationships and the Health Belief Model (HBM) were both used as the theoretical framework for this project. Peplau describes four phases of an interpersonal relationship: orientation, identification, exploitation, and resolution (Petiprin, 2020). Each phase offers nurses an opportunity to show respect and care towards individuals as the nurse plays multiple roles including stranger, teacher, resource person, counselor, surrogate, and leader (Petiprin, 2020). Peplau's theory describes the reasons nurses are trained and ready to provide the Medicare AWV. By building relationships with patients during the appointment, nurses can better understand the individual risk factors and educational needs of each person and provide individualized recommendations for each person.

The HBM offers theoretical framework for understanding the resistance or acceptance of preventive care recommendations (Simpson, 2015). This model explains each patient's willingness or apprehension to follow certain recommendations is influenced by their own perceived susceptibility and severity to the illness as well as their perceived benefits and barriers to the preventative care suggested (Champion & Skinner, 2008 pp. 47-50). Utilizing the HBM allows the nurse-led AWV program to improve and personalize education provided to individuals and increase participation in preventive care.

The team-based model also provided direction for creating diverse medical teams in primary care. Developing and utilizing nurses to their fullest capacity in the clinical setting builds upon the team-based model discussed by Mitchell et al. (2012). A high functioning team, comprised of two or more healthcare workers, collaboratively works with individuals and their caregivers/family to provide patient-centered, quality care (Mitchell et al., 2012). The cornerstones of a good team include shared goals, clear roles, mutual trust, effective communication, and measurable processes/outcomes (Mitchell et al., 2012). The team-based model creates an excellent foundation for the nurse-led AWV project as the complexity of chronic disease and preventive care continues to rise for both patients and providers. Utilizing the team approach, multiple clinics have increased their capacity to see more patients while improving patient outcomes and satisfaction (Anderson, 2013; Hopkins & Sinsky, 2014).

Research Strategy

The following PICO question was used to guide the research strategy:

If registered nurses conduct the Medicare Annual Wellness Visit for the geriatric population, will more patients receive an AWV compared to patients not offered a registered nurse-led wellness visit?

CINAL, PychInfo, and PubMed were the databases searched for peer-reviewed articles published within the past ten years using the keywords: *annual wellness visit, wellness visit, nurse, nurse-led, team-based, preventive care, and Medicare*. A total of 104 articles were found with 10 being selected based on relevance to the PICO question.

CHAPTER TWO

IDENTIFYING THE PROBLEM

Chronic Disease

In the United States, over 60% of Americans are diagnosed with at least one chronic disease (Buttorff et al., 2017). When focusing only on the geriatric population, ages 65 and older, the incidence of chronic disease soars to 81% (Buttorff et al., 2017). Chronic diseases account for 4 of the top 5 causes of death in the United States with an estimated 21%-39% of those deaths being preventable (Yoon et al., 2014). Older adults with multiple chronic conditions often report social, physical, and cognitive limitations leaving them at risk for further decline as they attempt to navigate the complex healthcare system (Buttorff et al., 2017; DuGoff, et al., 2019).

Multiple chronic conditions cause an exponential increase in Medicare spending. Annually, individuals with 0-1 chronic diseases use an average of $2,032 in healthcare spending; someone with 6 or more chronic diseases used $32,247 (CMS, 2018). A total of 17% of the Medicare beneficiaries with six or more chronic diseases required 53% of healthcare dollars in 2017, while only 1% of spending by Medicare went towards preventive care (CMS, 2018; NCOA, 2018). The cost of healthcare continues to rise, placing financial burdens on individuals, hospitals, and the U.S. government.

Montana is no exception to rising healthcare costs, both financially and in human suffering (Public Health in the 406, 2015). While the percentage of adults in Montana with chronic disease is lower than the national average, most of the state is considered rural with limited resources to combat debilitating illnesses (Koeppen, 2017; Meit et al., 2014). New cancer

cases in Montana in 2017 were 466.9 per 100,000 people, slightly higher than the national average of 438 per 100,000 people (U.S. Cancer Statistics, 2019). Montanans are less likely to receive their screening mammograms, colorectal cancer screenings or yearly influenza vaccines than the rest of the Unities States (Koeppen, 2017).

Adolescents and adults in rural areas are more likely to smoke tobacco, abuse alcohol, become obese, and be physically inactive, increasing their risk for chronic disease, heart attack, and stroke (Meit et al., 2014). Binge drinking alcohol is reported at a higher rate in rural communities than the national average of 16.9% and (Koeppen, 2017). These behaviors increase the risk of cancer, unintentional injuries, heart disease, stroke, depression, and suicide and are considered preventable with the proper interventions (Koeppen, 2017).

Suicide continues to grow in prevalence nationally and within Montana. The national suicide rate is 13.9 per 100,000 individuals with a higher rate of 16.7 per 100,000 in the elderly population of 65 and over (Rosston, 2018). Montana's rate is almost twice this at 25.9 per 100,000 (Rosston, 2018). Depression, a frequent cause of suicide, is one of the most treatable psychiatric disorders with an 86% treatment success rate (Rosston, 2018). Preventing or detecting chronic conditions earlier offers Montana an opportunity to decrease costs, save lives, and improve the quality of life for individuals in this great state.

Preventative Care through the Annual Wellness Visit

The Annual Wellness Visit, offered at no cost to Medicare beneficiaries, allows healthcare providers to do an individualized risk assessment and create a care plan based on detected risk factors (CMS, n.d.). Adults 65 and older are more likely to participate in preventive

care when it is offered during an AWV (Jiang et al., 2018). Screenings done during the AWV offer the healthcare provider conducting the visit the opportunity to provide education and make referrals to address issues that can lead to costly chronic issues, such as alcohol abuse (Solberg et al., 2008). For example, addressing alcohol use in primary care saves quality of life years at a remarkably low cost, making it one of the most cost-effective preventive measures (Solberg et al., 2008).

Elderly individuals remain at a high risk for depression and suicide, with more than half contacting their primary care provider's office within two weeks of their suicide (Rosston, 2018). Completing a depression screening is a vital component of the AWV detecting mental health concerns in the vulnerable senior population, but remains underutilized (Pfoh et al., 2015). The inclusion of this routine screening encourages the topic to be more open to discussion and accepted within the primary care office (Pfoh et al., 2015),

Other tests, such as mammograms, colonoscopies, and vaccines also prove to be cost effective ways to decrease mortality (Dabestani et al., 2019). Screening mammograms, ordered at an AWV, have decreased mortality by an estimated 16%-18% due to early detection and initiation of treatment (Haukka et al., 2011). Colorectal cancer (CRC) is slow growing but deadly without early intervention. Starting at age 50, routine colon cancer screenings reduced the risk of dying from CRC by an average of 81%-87% (Knudsen et al., 2016). Discussing the risk and benefits of the different types of CRC screenings is a part of creating an individualized preventive care plan during an AWV.

Vaccines recommended for seniors include a yearly influenza vaccine, pneumococcal vaccine, a zoster vaccine, and a tetanus booster (Norris et al., 2017). While 69% of seniors

received a yearly influenza vaccine and 63.3% received the pneumococcal, nearly one-third of this vulnerable population are missing these important vaccines (Norris, et al., 2017). Discussed and given at the AWV, these vaccines will decrease the mortality and morbidity of these diseases with cost-effectiveness (Dabestani et al., 2019).

The AWV is a well-reimbursed visit providing evidenced-based care to a vulnerable population and has been available since 2012 (CMS, n.d.). Yet, data shows only about one-fourth of the geriatric population is participating in these visits (Carter et al., 2019). Understanding barriers to getting the AWV is an important step to overcoming them.

Barriers to Receiving an Annual Wellness Visit

Patient participation in the AWV varies greatly by healthcare practices and providers (Ganguli et al., 2018). Non-white patients with multiple chronic health needs in rural areas receive fewer AWVs, likely due to the complexities of the visit requirements and limited resources within the clinics (Ganguli et al., 2018). Having an electronic health record and training staff to perform the visits correctly takes time and resources many clinics providing care to underserved populations simply do not have. While the AWV was designed to give more revenue to clinics for performing preventive care, many patients have acute needs that must be addressed and there is not time to perform the AWV (Ganguli et al., 2018).

Patients also have negative views regarding preventive care or have simply never heard of the AWV (Bluestein et al., 2017). Confusion regarding coverage of the AWV led many patients to believe their healthcare needs are not met when a physical exam is not performed (Bluestein et al., 2017). Further, providers felt they were already addressing preventive care with

their patients and thus did not recommend an appointment focused on prevention to their patients (Bluestein et al., 2018). As 90% of people who received an AWV did so because their provider recommended it, provider buy-in is an essential component of (Bluestein et al., 2017).

Previous research indicates that patients were less likely to participate in preventive care appointments if they had to pay for it "out of pocket", however, Medicare coverage of the appointment at 100% has failed to result in increased AWV utilization (Galvin et al., 2017). While financial payment for the actual visit is covered by Medicare, some preventive care is not fully covered, such as certain vaccines (Galvin et al., 2017). As a result, patient financial concerns surrounding preventive services may still limit those dependent solely upon Medicare from participating in those recommended services.

The current and forecasted primary care provider shortage serves as an additional barrier for patients receiving an AWV (Zhang et al., 2020). The increasing complexity of care for many geriatric patients, coupled with time pressures and lack of clinical support, has left many providers offering less than optimal care to complex patients (Loeb et al., 2016). Following the team-based model, building up programs and support staff offers providers additional support to meet patient needs and increase job satisfaction for health care workers (Galvin et al, 2017).

Literature Review of Team-Based AWV Programs

Based on the prevalence and cost of chronic disease, the effectiveness of preventive care, and the barriers to receiving the evidence-based AWV, developing a nurse-led AWV program following the team-based model offers an opportunity to challenge the current trends. The AWV benefit is underutilized due to lack of consumer awareness surrounding the benefit (Beran &

Craft, 2015; Bluestein et al., 2017). Healthcare provider referral for an AWV initiates the majority of this type of visit being scheduled (Bluestein et al., 2017). However, some providers report not seeing the benefit of the AWV (Beran & Craft, 2015), despite research indicating that receiving an annual wellness visit increases participation in all recommended preventive services, improving health outcomes (Jiang et al., 2018). Further research is needed to better understand negative provider beliefs towards the AWV, as they may impact provider referral for AWV (Beran & Craft, 2015).

Providers report the use of nurses or other health care providers to conduct AWVs is a good use of their skills; however, providers also assume patients would be dissatisfied with the perceived change in care (Beran & Craft, 2015). Contrary to this belief, multiple studies have confirmed excellent patient satisfaction with both nurses and pharmacists conducting the visit as patients' expectations for this visit were met with good care being provided (Zorek et al., 2015; Bluestein et al., 2017; Woodall et al., 2017). Patients reported being happy with the care they receive, feeling they were heard, had all their questions answered, and enjoyed working with multiple healthcare team members (Zorek et al., 2015).

Similar to provider referrals for AWVs, nurses recruiting and recommending the AWV provided clinics with a 300-400% increase in AWV participation over a year (Bluestein et al., 2017; Galvin et al., 2017). Using more members of the healthcare team, such as the nurse or pharmacist, to provide AWV services will result in more preventive services being utilized (Tetuan et al., 2014; Zorek et al., 2015; Alhossan et al., 2016; Galvin et al., 2017; Woodall et al., 2017). Benefits of nurse-led wellness visits have been identified. For example, nurse-led AWVs result in an increase in mammogram screening over medical providers only offering the AWV

(Tetuan et al., 2014). Larger clinics implementing both nurse and clinical pharmacist run AWV's achieved even better outcomes, with increases in medication reconciliation, pneumococcal and flu vaccine rates, CRC screening, bone density scans, mammograms, and referrals (Zorek et al., 2015; Alhossan et al., 2016; Galvin et al., 2017).

The United States health care system is making a shift in reimbursement from fee-for-service to patient-centered and quality-based outcomes (Galvin et al., 2017). With the increased participation in AWVs offered by other staff, offices are seeing increased revenue as well (Bluestein et al., 2017; Alhossan et al., 2016; Galvin et al., 2017; Zorek et al., 2015). A single clinic revising workflow and hiring no additional staff was able to increase revenue by over $27,000 in their first year offering nurse-led AWVs (Bluestein et al., 2017). Clinics hiring additional staff to accommodate the change in practice and were still able to net a significant profit (Zorek et al., 2015; Alhossan et al., 2016; Galvin et al., 2017). Future research is needed to understand the financial impact of enhanced utilization of human resources, specifically, do nurse led AWV improve health outcomes specific to chronic care and complex acute care as medical providers redirect time and effort.

The team-based approach has been shown to increase staff satisfaction (Anderson, 2013). While many studies in this literature review did not assess this phenomenon, working to the highest limit of education and skill set engages healthcare workers, a key measurement for staff satisfaction (Anderson, 2013; Galvin et al., 2017). With so many benefits to offering team-based AWVs, creating the infrastructure and workflow to provide nurse-led AWVs seems the obvious next step in many primary care settings. However, not every clinic has the resources and ability to offer the AWV in such a different capacity, potentially creating an increase in health

disparities (Ganguli et al., 2018). Ensuring the underserved populations are lifted is an important piece when rethinking team-based healthcare.

Conclusion

Chronic disease and preventable deaths are a looming and growing challenge within the United States healthcare system. Utilizing the evidenced-based AWV for seniors with increased risk for chronic conditions is an important step to control costs, both financially and in human suffering. Team-based annual wellness visits offer nurses an opportunity to work to the top of their license, educating patients and encouraging important preventive services. Providers will also be free to maximize their knowledge in treating more complex patient concerns. Increased financial reimbursement offers clinics the ability to increase much needed services and staff to better serve their communities. It is time to take this opportunity and create workflows within primary care that best serve our patients.

CHAPTER THREE

METHODS

Introduction

The Patient Care and Affordable Care Act of 2010 approved an annual wellness visit (AWV) for Medicare beneficiaries free of charge to encourage the use of preventive services in the United States. Despite the known benefits of the AWV for both patients and providers, uptake has been limited (Carter et al., 2019). Registered nurses (RNs) are uniquely qualified and approved to offer the AWV to increase the number of Medicare beneficiaries who receive the AWV and subsequently utilizing preventive services as appropriate. Stakeholder buy-in from both patients and providers continue to hinder participation in utilizing the AWV (Beran & Craft, 2015; Bluestein et al., 2017). Utilizing RNs to provide education and services supporting the AWV has the potential to improve buy-in and participation in preventive care among Medicare beneficiaries.

After completing a microsystem assessment of the Internal Medicine Clinic looking at AWV usage, many providers and patients were not utilizing the Medicare offered appointment. Nurses are already recruiting patients by sending out reminders for overdue cancer screenings and calling patients to schedule yearly appointments for refills. Opportunities were identified for RNs to both recruit and conduct the AWV offered to Medicare beneficiaries to improve preventive visit participation.

Purpose

The purpose of creating a nurse-led AWV program in the outpatient setting is to increase utilization of the Medicare annual wellness visit.

Project Development

Medicare covers specific items within the AWV and can be referenced in Appendix A. The Internal Medicine Clinic already has a health risk assessment packet sent to patients who schedule an AWV (see Appendix B). Currently, patients schedule an AWV with their primary care provider and it can be a few months wait for an appointment time. For the first phase of this project, one registered nurse (RN) will be available one day per week to see eight patients for the AWV in one-hour long appointments. Patients maintain the option of scheduling the AWV with their PCP.

The Internal Medicine Clinic serves primarily patients with chronic disease and those needing subsequent or follow-up visits for medication management and chronic disease monitoring. The nurse performing the AWV will be authorized to order appropriate lab tests based on protocols already in place for each provider (see Appendix C), and order preventive screenings as needed. The patient can get the testing completed and make an appointment with their PCP to review test results and manage chronic disease.

Provider referrals account for the majority of patients who schedule an AWV (Bluestein et al., 2017). To increase provider buy-in to the nurse-led AWV program, the nurse will attend the all-provider meeting to present the program and answer any questions. A critical component of the new program is that nurses will also have opportunity to encourage patients to schedule

the AWV; for this reason, a comprehensive program presentation will be done at the nurses' meeting as well.

A critical component of the new program will be that nurses will have AWV recruitment time scheduled into the week to call and recommend the appointment to patients, explaining the new process. The designated AWV RN will be assigned a weekly "AWV Clinical Day" for the clerical staff and nursing staff to begin scheduling the 1-hour AWV appointments. Initially, to ensure high quality documentation, the AWV RN will have a 30-minute charting period after each appointment, limiting the RN to five appointments per day for the first few weeks. However, once the RN feels more comfortable with the charting and flow of the visit, a total of eight visits will be scheduled once per week.

Target Sample

The Internal Medicine Clinic will pilot the program. Medicare beneficiaries are the target sample, generally aged 65 and older, but may also include younger patients with qualifying disabilities.

Instruments

The AWV Committee, comprised of the nursing manager, two RNs, a clerical staff member, and a medical provider, will meet to discuss project workflow and implementation. Initially, the team will meet every other week, utilizing the Plan Do Study Act (PDSA) model to implement and monitor the project. The first PDSA cycle will be specific to planning the clinical schedule for the AWV RN, scheduling the first appointments, identifying and examining relevant

project outcomes (ex. number of visits scheduled/number completed, patient satisfaction), and responding proactively to findings.

Proposed Analysis

To assess the impact of the nurse-led AWV clinic, data will initially be collected to explore the number of patients who schedule a nurse-led AWV who have never scheduled an AWV before, the total number of AWV scheduled, and patient satisfaction . One critical outcome is to explore the total number of AWVs done in clinic (by both providers and the nurse) compared to similar data from the previous cycle. Eventually outcome data will be collected preventive services AWV participants had done, such as a colonoscopy, mammogram, tobacco cessation, etc. Data will be monitored by a hospital quality analyst and evaluated by the interprofessional committee.

Clinical Nurse Leader Roles

Developing and maintaining the nurse-led AWV program utilizes multiple Clinical Nurse Leader (CNL) roles including advocacy, care coordination, team leadership, and outcomes management. The Medicare annual wellness visit has been shown to increase participation in preventive services such as breast cancer screening, colorectal screening, and fall-risk assessments (Jiang et al., 2018). Placing a CNL in the position to advocate for best-practice while implementing this program is an example of allowing the nurses on the front lines of care to offer evidenced-based care to patients.

Care coordination and team leadership will be required to organize the protocols for preventive care and referrals with the medical providers, patients, and community programs. To increase support from providers, patients, and management, collecting data on participation in both the AWV and subsequent preventive care will be crucial. A CNL is trained to gather, analyze and communicate data to stake-holders in an effective manner. Presenting information will be only part of the team management and collaboration occurring with other health professionals during the course of this program. Reviewing the progress of the program will require skills the CNL is specifically trained in by using tools to analyze financial aspects, program development, and measurable outcomes.

Medicare beneficiaries are a vulnerable population who deserve an advocate for their wellness and preventive care. The nurse-led AWV program offers the CNL an opportunity to advocate for wellness and preventive care in this population through patient and staff education. The CNL will also be advocating for RNs to work at a higher capacity of their license. Because provider buy-in is so important, finding ways to work with medical providers will increase participation in the AWV. With time dedicated to a wellness visit, the RN will then be able to spend time listening and educating patients on their specific risk factors, advocating for individualized preventive care.

Overall, the nurse-led AWV program challenges the CNL in many roles to communicate, lead, advocate, and coordinate excellent care for patients. The training and expertise of the CNL is tailor-made for this type of program and should be utilized.

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APPENDICES

APPENDIX A

MEDICARE RECOMMENDATIONS FOR ANNUAL WELLNESS VISIT

Medicare coverage for the AWV:

- Health risk assessment
- A review of medical and family history.
- Developing or updating a list of current providers and prescriptions.
- Height, weight, blood pressure, and other routine measurements.
- Detection of any cognitive impairment.
- Personalized health advice.
- A list of risk factors and treatment options for you.
- A screening schedule for appropriate preventive services.
- Advance care planning (CMC, n.d.)

APPENDIX B

HEALTH RISK ASSESSMENT FOR AWV

Health Risk Assessment – Medicare Annual Wellness Visit

Please answer these brief questions. The medical staff will review and obtain specifics during your exam. If you have completed this form previously, please note any changes.

Demographic Information

Patient Name: Last: _____ First: _____ MI: ____

DOB: _____/_____/_____ Age: _____

Appointment Date: _____/_____/_____ Reason for Visit_____

Care Teams (i.e. other providers involved in care):

Primary Care Provider: _____

Current Physicians and other Healthcare Professionals involved in your medical care:

Provider	Specialty	Provider	Specialty
1.		4.	
2.		5.	
3.		6.	

Dentist Name: _____ Dental Exam Date:_____

Eye Doctor Name: _____ Eye Exam Date:_____

☐ None

Medical Equipment Suppliers (e.g., oxygen, CPAP, wheel chair, walker, brace):

1. _____
2. _____
3. _____

☐ None

Health Maintenance:

Please indicate if you have ever had any of the following screening tests and the year completed:

Colonoscopy Date:_____ Mammogram Date:_____ Dexa Scan Date:_____

☐ None

****Please complete both sides on all pages****

Hearing/Vision:

Do you have any concerns with your hearing? ☐ Yes ☐ No

Do you have any concerns with your vision? ☐ Yes ☐ No

Risk Screenings: ***Note to clinical staff: Complete all sections in Risk Screening***

Do you have difficulty with walking, balance, climbing stairs or have you had a fall in the last 3 months? ☐ Yes ☐ No

Are you afraid of falling? ☐ Yes ☐ No

Healthcare Directives:

Do you have advance directives? ☐ Yes ☐ No

If yes, what type(s)?

☐ Living Will ☐ DNR ☐ Durable power of attorney ☐ POLST

If yes, have you provided us with a copy of those advance directives? ☐ Yes ☐ No

Have you discussed this with your Provider? ☐ Yes ☐ No

If you have not provided us with a copy, please bring a copy to your next appointment with us.

Activities of Daily Living (ADL):

Do you exercise on a regular basis? ☐ Yes ☐ No

Do you have any specific diet that you follow? ☐ Yes ☐ No

Do you have any difficulties dressing, bathing or walking? ☐ Yes ☐ No

Do you have any difficulties managing your own medications? ☐ Yes ☐ No

Do you have any problems with household chores such as shopping, housekeeping, or handling your own finances? ☐ Yes ☐ No

Do you have any concerns about safety of your home - such as stairways without handrails, bathrooms without grab bars, etc.? ☐ Yes ☐ No

How would you rate your current state of health? ☐ Excellent ☐ Good ☐ Poor

Please indicate any recent immunizations you may have had and the appropriate or known date:

Immunization	*Yes or No*	*Date*	*Date Unknown*
Tetanus/Diphtheria/Pertussis			
Influenza			
Pneumonia			
Shingles			
Other			

Social History:

Caffeine Use: ☐Yes ☐No

Alcohol Use: ☐Yes ☐No

If yes, about how many drinks per week of the following:

Glasses of wine_____ Cans of Beer_____ Shots of liquor_____

Secondary smoke exposure: ☐Yes ☐No

Tobacco Use: ☐Yes ☐No

Smoke: ☐Current daily ☐Current occasional ☐Former ☐Never

Average pack per day: _____

Smokeless Tobacco: ☐Current ☐Former ☐Never

Type: ☐Chew ☐Snuff ☐ e-Cigarette

Patient Health Questionnaire (PHQ-9):

Over the past 2 weeks, how often have you been bothered by any of the following problems?	*Not at all*	*Several Days*	*More Than Half the Days*	*Nearly Every Day*
1. Little interest or pleasure in doing things that you used to enjoy	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking slowly or the opposite being fidgety or restless	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. If you have checked any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult	Somewhat difficult	Very difficult	Extremely difficult

Thanks - you are finished!

Patient Signature: _____ Date: _____/_____/_____

Reviewed By Provider: _____ Date: _____/_____/_____

APPENDIX C

LABORATORY ORDER GUIDELINES

Guidelines for RNs ordering for yearly screening lab tests during AWV created by the AWV taskforce:

Lab Test	Diagnosis
CBC with Diff	• Anemia • History of malignancy
Comprehensive Metabolic Panel	• Yearly for prescription medication management • Hypertension • Kidney Disease • Abnormal liver enzymes
Lipid Panel	• High cholesterol
Vitamin D	• Osteoporosis • History of vitamin D deficiency
TSH	• Thyroid disease
Uric Acid	• History of gout
A1C	• Diabetes • Elevated fasting glucose
Urine Microalbumin/Creatine Ratio	• Diabetes

These are the basic guidelines and any additional testing needed or requested by the patient can be confirmed by the medical provider prior to ordering.