Development of a Protocol for Implementing the Medicare Annual Wellness Visit in a Primary Care Setting

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Development of a Protocol for Implementing the Medicare Annual Wellness Visit in a Primary Care Setting

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Dedication

This work is dedicated to God, who led me on this journey. To my parents and grandparents who have influenced and supported my career and education, I will be forever grateful for your love, support, and prayers. To my sister for the laughter and endless supply of my favorite teas. And, to my highlighter stealing, paper chewing buddy, Rascal, for lightening the mood when I needed it the most.
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Thank you to those at Kirkhof College of Nursing and the organization where my project took place who were a part of my DNP experience. Last, but not least, thank you to my family and friends for sticking by me through it all. It took a team to finish this degree, and I could not have done it alone!
Abstract

The Medicare Annual Wellness Visit (AWV) was enacted in 2011 as part of the Patient Protection and Affordable Care Act. The AWV is an opportunity to improve care delivery by encouraging use of preventive services and coordinate care for Medicare patients 65 and older who are at high risk for high usage of healthcare services. During this visit, patients are screened for common geriatric-related conditions such as depression, cognitive impairment, fall risk, and functional decline. This visit is also an opportunity to identify risk factors for chronic illness and help patients stay current on recommended screenings and vaccinations. The organization of interest is a regional healthcare system which provides primary care to Medicare patients; however, less than 5% of these patients have received an AWV. The purpose of this scholarly project is to develop a comprehensive protocol to conduct the AWV and trial the protocol for feasibility within the primary care office.

**Keywords:** Medicare Annual Wellness Visit, protocol, older adult, primary care, nursing in primary care, depression screening, functional risk screening, fall risk screening, cognitive screening
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Executive Summary

This scholarly project final report provides insight into the Medicare Annual Wellness Visit (AWV), the geriatric syndromes of depression, cognitive impairment, fall risk, and functional disability, and the Doctor of Nursing Practice Scholarly Project journey of writing a protocol for implementing the AWV in a primary care setting and trialing the protocol for feasibility. This report includes the background of the AWV, the evidence based initiative driving the project, conceptual frameworks utilized throughout the project, an assessment of the organization in which to implement the project, the project plan and outcomes, as well as implications for practice and a plan for dissemination of outcomes. The overall aim of this project is to improve care delivery to the older adult population age 65 and older by early identification of chronic disease risk factors and geriatric syndromes and early referral to community resources in order to improve quality of life and decrease healthcare costs.

Methods of evaluation include the amount of time associated with each visit, the number of updates made to the patient’s chart as a result of the AWV, and patient satisfaction with the AWV and the process to conduct the visit. The final deliverables include this scholarly report, the protocol which was updated throughout the process, and a business case for continuation of the AWV within the primary care setting. The protocol and business case can be found in the appendices.
**Introduction and Background**

In 2013, more than $2.5 trillion was spent nationwide on healthcare for older adults. These costs were attributed to patients overusing healthcare services and/or receiving duplicate services (Snyder, 2013). Screening and preventive care for the older adult population is limited at best. Use of preventive services varies across the nation, often due to “quality of health and health care across age, gender, race or ethnicity, income, education, geographic location, disability, and sexual orientation” (Centers for Disease Control and Prevention, Administration on Aging, Agency for Healthcare Research and Quality, and Centers for Medicare and Medicaid Services, [CDC, AoA, AHRQ, CMS], 2011, p. 1). Some Medicare recipients receive an excessive amount of screening services while some receive a scarce amount of services (Nicholas & Hall, 2011). While the majority of Medicare beneficiaries are seen by a physician at least six times per year, they do not receive preventive services that are recommended by the United States Preventive Services Task Force (USPSTF) (CDC, AoA, AHRQ, CMS, 2011). An increase in the availability of preventive services can lead to decreased morbidity and mortality (Krist et al., 2013) which ultimately leads to a decrease in healthcare spending.

The Affordable Care Act (ACA) was signed into law in 2010 with the aim of improving the quality of healthcare and making it affordable for all Americans. The Medicare Annual Wellness Visit (AWV), introduced as part of the ACA in 2011, is a free Medicare benefit which is a visit “that focuses on establishing and then maintaining a personalized prevention plan” (American College of Physicians [ACP], 2015, para. 1). Many aspects of health care are a part of this visit, including review of personal and family history; review of medications and current healthcare providers; vital signs, height and weight; disease risk factors and management options; and preventive screening schedule (Centers for Medicare and Medicaid Services (CMS),
During this visit, patients are screened for common geriatric-related conditions (geriatric syndromes) such as depression, cognitive impairment, fall risk, and functional decline (CMS, 2015; Snyder, 2013).

Additionally, the AWV encourages use of preventive services and coordinated care for Medicare patients 65 and older, who are at increased risk for high usage of healthcare services (CMS, 2015; Snyder, 2013). Preventive care has the potential to decrease morbidity and mortality; yet older adults use less than half of preventive services recommended (Krist et al., 2013; Nicholas & Hall, 2013). During the AWV, patients are advised regarding upcoming screenings such as colonoscopies and mammograms. In addition, they are reminded to schedule immunizations such as shingles and pneumonia vaccines (CMS, 2015). Recommendations for preventive services for older adults differ from those recommended for younger and middle-aged adults (Nicholas & Hall, 2013; Spalding & Sebesta, 2008); the AWV aims to improve delivery of preventive services specifically for older adults (Nicholas & Hall, 2013).

Advice related to improving self-care and decreasing the risk for disease or disability, including referrals to community programs, counseling, and education are discussed during the AWV (CMS, 2015). At the conclusion of the AWV, each patient is provided with a personalized plan based on what was discussed during the visit to “promote self-management and wellness” (CMS, 2015, p. 3). A schedule of routine preventive services is updated and provided as part of the personalized plan (CMS, 2015; Nicholas & Hall, 2013).

The AWV is an important component to healthcare for the Medicare population, as “older adults are at greater risk of developing conditions that affect health outcomes, quality of life, and costs of care” (May et al., 2014, p. 2415). Despite the provision for this visit by the Centers for Medicare and Medicaid Services (CMS), there has not been a significant increase in
utilization of Medicare preventive services (Jensen, Salloum, Hu, Ferdows, & Tarraf, 2015). The AWV can aid in the early detection and diagnosis of the geriatric conditions of depression, cognitive impairment, fall risk, and functional decline, and in turn, streamline use of services and decrease healthcare spending while increasing support and management of these conditions (CMS, 2015; Snyder, 2013).

The cost of undiagnosed geriatric conditions is severe. In 2009, the annual cost of treating an older adult with depression is $22,960, roughly double the healthcare costs associated with an older adult without depression. Once antidepressant therapy is initiated, the cost falls approximately 38% to $14,365 annually (National Institutes of Health, 2009). In 2016, approximately $236 billion will be spent to care for those with dementia (Alzheimer’s Association, 2016). The CDC (2015b) reported $34 billion was spent on older adults who suffered a fall. Manini (2011) reported the cost of care in 2004 for those fully disabled cost upwards of $50 thousand per year, with the cost increasing approximately 2% per year. Given that projection, in 2016, care would equal $66 thousand per year per disabled person. The use of the AWV for prevention and early detection and early intervention of geriatric syndromes has the potential to decrease Medicare spending significantly.

Since its inception in 2011, the AWV has been implemented in limited facilities across the nation. Only 32% of Medicare beneficiaries are even aware of the AWV (Thomas & Goode, 2014), which does not lead to a pressing demand for this service. Several barriers have been identified in implementation of this visit. The primary barrier is misunderstanding of the AWV. Initially, Medicare beneficiaries were informed that the AWV was a physical (Hughes, 2011), which to many means time with a provider during the appointment. However, the AWV is considered a hands-off visit, meaning unless providing the visit, the provider will not see the
patient, nor will a physical assessment be completed. The AWV visit is typically completed by a registered nurse, which has led to confusion about the visit (Cuenca, 2011). Another barrier includes the requirements of this visit. As CMS does not specify tools to use to conduct the AWV, visits have not always been completed properly causing an incomplete visit, sometimes requiring a repeat visit to ensure all documentation was completed to billing standards (Cuenca, 2011). Due to lack of guidance, the AWV has caused an increase in burden on the healthcare team, as the AWV takes longer than a typical office visit, and as a result, physician productivity decreased, as did patient satisfaction (Cuenca, 2011).

The basis of nursing is to prevent illness and promote health (American Nurses Association [ANA], 2016). Furthermore, a nurse practitioner (NP) “provides the full spectrum of health care services to include health promotion, disease prevention, health protection, anticipatory guidance, counseling, disease management, palliative, and end of life care” (National Organization of Nurse Practitioner Faculties [NONPF], 2012, p. 4). The role of nursing aligns with the premise of the AWV by identifying risk factors and chronic illnesses; assessing for depression, functional and fall risk, and cognitive impairment; and making a plan to decrease present risk factors for disease and maintain well-being in light of chronic illness. A Doctor of Nursing Practice (DNP) prepared NP receives an education in which to support “the changing demands of this nation's complex healthcare environment” via “the highest level of scientific knowledge and practice expertise to assure quality patient outcomes” (American Association of Colleges of Nursing, 2015, para. 5). Identifying imperative health care initiatives such as the AWV to support illness prevention and health promotion, and working to enact the initiatives in a high quality, evidence-based methodology, are ways a
DNP prepared provider can work to improve health care delivery and increase positive patient outcomes.

**Problem Statement**

The organization of interest is a regional healthcare system which serves western Michigan with hospitals, multiple specialty clinics, and several primary care clinics run by a physician group. The parent organization is well-known for its dedication to care of older adults, and this dedication trickles down into the work of the regional organization (Trinity Health, 2015). Approximately 23,000 Medicare patients are served in the primary care offices annually, however fewer than 5% of these patients have received the AWV (Kimberly Fry, personal communication, December 7, 2015), less than the national average of 7% (Thomas & Goode, 2014). The AWV aligns with the organization’s consumer promise “to be accessible, to listen intently, and to provide expert guidance that empowers you to take an active role in your health care decisions” (Mercy Health, 2015, para. 3).

While CMS addressed the required components to this visit, lack of a standardized procedure for healthcare facilities to implement and provide the AWV could be a reason for the low number of Medicare beneficiaries who have received this visit. Providing the primary care office(s) with a comprehensive protocol to carry out the AWV is the first step in making this visit a reality. A scholarly project entailing the creation of an efficient, evidence-based protocol to improve the delivery of the AWV within the primary care setting was proposed to help the primary care offices move forward with offering the AWV to its clients.

An assessment of the organization reveals that the senior administrators believe the AWV is an important part of the patient care experience. Furthermore, the AWV aligns with the organization’s mission to provide people-centered care and focus on care for the elderly. The
AWV is a reimbursable benefit designed to be available to every Medicare patient as a way to improve care delivery through early disease recognition and management (CMS, 2015). The purpose of this project was to develop a comprehensive protocol that all RNs, Nurse Practitioners (NPs), Physician Assistants (PAs), and physicians could reference in order to successfully complete the AWV in its entirety. This protocol was piloted to determine its effectiveness within one primary care office (the primary care office) in order to assess feasibility and patient satisfaction. A business case was developed to support the use of a dedicated member of the staff to conduct this visit.

At the time of the pilot, a gap in the care of older adults was noted throughout the organization as only 2 out of 19 offices provided the AWV, and a limited number of providers at these locations offered the visit. The AWV protocol was expected to modify current primary care practice by improving care delivery to the older adult population, as well as increasing timely access to resources. Additionally, by providing the patients who have Medicare with one of their benefits, payments from Medicare for the AWV would increase revenue.

Evidence Based Initiative

A literature search for the Medicare AWV was conducted using Pubmed, CINAHL, Cochrane Library, Science Direct, Google Scholar, as well as the Grand Valley State University Library website. The search terms included: Medicare Annual Wellness Visit, Elderly, Older Adult, Primary Care, Guidelines, and Implementation. Inclusion criteria for this search were: human studies; in the English language; from the year 2010 to present, to reflect the time period of the initiation of the Affordable Care Act (ACA) and the CMS mandate of the AWV beginning in 2011. Exclusion criteria for this search were: non-English language. This literature review returned no research studies related to the implementation of, or outcomes resulting from the
AWV. When including the grey literature, primary evidence-based guidance for this project was gathered from the CMS website, as well as published anecdotal reports of implementation of the AWV in individual practices. The Institute of Medicine (IOM) website was referenced when searching for the role of nursing in primary care. The Agency for Healthcare Research and Quality was referenced when reviewing screening guidelines.

**Implementation of the AWV into Primary Care Offices**

At the time of this pilot, the effectiveness of the implementation of the AWV into primary care practice had not been researched; thus, best practice for implementing the AWV had not been established. Approaches to implement the AWV into primary care had been published, but varied substantially from one office to another. Cuenca (2011) and Hughes (2011) explained the implementation of the AWV in a step-wise approach, starting by communicating with the patient using protocols for scheduling. During the scheduling process, the patient is made aware of the AWV, including what it is, and what it is not. Prior to the in-office visit, the patient’s history should be reviewed. Once the patient is in the office, the visit begins. The person administering the AWV will complete the Health Risk Assessment (HRA); obtain vital signs, height, weight, and BMI; and assess the patient’s cognitive ability. Then the patient is counseled on required screenings and when they are next due; risk factors for poor health outcomes and suggestions for improvement; and their personalized plan is developed. The preparation time prior to the patient’s visit is not billed for, but the in-office AWV is billed for. The provider must ensure all portions of the visit are documented to achieve a complete AWV and subsequent reimbursement. Should the provider complete a physical or manage an episodic complaint, the provider must input the correct billing code, and use a modifier to indicate the visit is separate from the AWV (Cuenca, 2011; Hughes, 2011).
Kainkaryam (2013) describes utilizing a shared medical appointment (SMA) to complete the AWV. A SMA is a group appointment made up of patients who are of similar age. This allows providers to provide the same education to the whole group, and couples can come to a medical visit together. Hartford HealthCare Medical Group gathered a team consisting of a physician, medical assistant, nurse, and behaviorist to provide the AWV in a group setting. Each member of the team has a role in the SMA. The medical assistant is responsible for documentation and set up. The nurse takes the vitals and provides immunizations if needed; the nurse also helps with room set up and patient checkout. The behaviorist reviews the paperwork from the patients, identifies risk factors, and helps with education. The physician provides group education on screening and risk factors, requests follow up visits on any positive screens, and then reconciles medications. The SMA as a method for conducting the AWV has 95% positive feedback from the patients, demonstrates a “significant financial benefit” (Kainkaryam, 2013, p. 337), and provider satisfaction. The administration of screening tools was not discussed.

Thomas and Goode (2014) detail utilizing a pharmacist to complete the visit. The AWV was initiated in response to patient demand for this benefit. A multi-disciplinary team developed a plan for implementation of the visit, which included a written protocol and modification of the electronic medical record (EMR). This visit was delegated to the pharmacist, who was an expert in medication management and immunizations. Each patient was scheduled for a 30 minute visit; appointments were scheduled once a week in an 8 hour time span. Nurses (type of nurse not identified) roomed the patient, reviewed history and took vital signs; the pharmacist carried out the rest of the visit, with a check-in by the patient’s physician at the end of the visit. The physician would then review and cosign the visit. In the 6 month period of analysis, 8.7% of eligible Medicare beneficiaries were seen. The authors reported that using a pharmacist to
conduct the AWV is a valuable resource, however, the pharmacist cannot provide the AWV independently as he/she is not a “provider” (Thomas and Goode, 2014, p. 433) with the ability to bill for services.

Similarly, Warshany, Sherrill, Cavanaugh, Ives, and Shilliday (2014) reported on the use of a pharmacist to provide the AWV. However, the pharmacist described in their report is a clinical pharmacist practitioner (CPP). A CPP is considered an advanced practice provider in North Carolina, and therefore is eligible to conduct the AWV. The clinic schedule allowed 40 minute time slots for conducting the AWV, and limited the number of AWVs to 16 per month. At the end of one year, the monthly visits were not being filled; only 4.6% of the eligible beneficiaries had scheduled and received an AWV. The CPP prepared the chart for the visit, conducted all the visits, and formulated a plan of care based on the visit. While patient satisfaction was not reported at the time of publication, the authors anticipated patient satisfaction would be high, correlating with previous reports they reviewed.

The literature revealed several methods of conducting the AWV. All articles have processes based on guidance from CMS and team development of a protocol for implementation. At the time of this pilot, outcome data were not available.

**Who Should Conduct the AWV?**

The role of nurses in primary care expanded with the implementation of the ACA. Primary care is becoming increasingly complex, requiring chronic disease management and preventing hospitalizations, and nurses are at the forefront of care coordination and quality improvement of care (Institute of Medicine (IOM), 2011). The Institute of Medicine (IOM, 2015) suggested that in order for patients to receive unique and personalized care, the way healthcare is delivered must be transformed. Initiatives identified under the ACA have stimulated
care transformation, however the role of nurses in healthcare delivery can help to expand this transformation. The IOM states “the nursing profession is making a wide-reaching impact by providing and affecting quality, patient-centered, accessible, and affordable care” (IOM, 2015, para. 4). The first key message of the IOM’s report The Future of Nursing: Leading Change, Advancing Health (2011) is that “nurses should practice to the full extent of their education and training” (p. 85).

Each member of the primary care workforce plays an integral role in the team. “Health promotion, education, and assessment are essential components of primary care that are also traditional strengths of the nursing profession; these services may be provided by either registered nurses (RNs) or advanced practice registered nurses (APRNs)” (IOM, 2011, p. 55). Keeping this in mind, the registered nurse in the primary care setting is most equipped to provide older adults with the AWV. The unique assessment skills of a registered nurse can lead to identification of “new health problems or needs” (IOM, 2011, p. 55) revealed through the AWV screening. The second component of the AWV includes individualized planning to promote well-being, which includes education on risk factors, preventive medicine, referrals to community resources, and disease management (IOM, 2011). While the advanced practice registered nurse is also in a position to conduct the AWV, the time associated with administering the AWV can interfere with other responsibilities the advanced practice registered nurse fulfills within the primary care setting.

**Implementing Change in the Primary Care Setting**

Implementing evidence-based guidelines in primary care can be challenging due to conflicting guidelines, lack of time for the provider to review the new guidelines, and difficulties in understanding the guidelines. Liddy, Blazhko, Dingwall, Singh, and Hogg (2014) explored the
barriers to implementing new care guidelines and how practice facilitation could improve this process. A practice facilitator (PF) is one who knows health care and is skilled in managing change and works with an organization to facilitate the implementation of evidence-based guidelines (Knox et al., 2011). The key barriers identified were “organizational behavior, practice accessibility, practice engagement, resistance to change, and competing priorities” (Liddy, Blazhko, Dingwall, Singh, & Hogg, 2014, p. 4). The PFs utilized “flexibility, integration, persistence, and tailoring” (p. 4) to assist with solutions to counteract the barriers identified.

Similarly, Arar et al. (2011), examined the insights of staff related to implementing change in the primary care setting. The majority of participants expressed the importance of improving patient care by “improving the process of care” (Arar et al., 2011p. 294) and “improving the patient’s involvement in his/her care” (p. 294). Despite this perceived importance, there were still reported barriers to change, including lack of acceptance of the change, personality conflicts and lack of rapport among staff, “power struggles” (Arar, 2011, p. 297), barriers related to finances and insurance, space, and lack of education.

Change processes in the primary care setting might benefit from a model of implementation. Holtrop, Potworowski, Fitzpatrick, Kowalk, and Green (2015) utilized the macrocognition framework when implementing care management into five primary care offices. This framework led to positive “behavior change and clinical improvements made by the patients” (Holtrop, Potworowski, Fitzpatrick, Kowalk, and Green, 2015, p. 6) involved in the intervention, adoption of the intervention by the majority of patients, and good implementation in two of the five clinics. The framework has multiple components: coordinating, planning, decision making, managing the unknown, monitoring and detecting, and sensemaking and planning, all of which work together to lead to successful change in primary care. The authors
suggest this framework allows for a deeper understanding of how teamwork can lead to successful practice interventions.

A longitudinal study by Morténíus, Fridlund, Marklund, Palm, and Baifi (2012) identified strategic communication, or the “purposeful use of communication by an organization to fulfill its mission” (Morténíus, Fridlund, Marklund, Palm, & Baifi, 2012, p. 131) as a key factor among primary care staff influencing willingness to change practice. Over half the participants reported a new way of thinking with the strategic thinking. Approximately one-third of participants reported making a change, or hoping to make a change to their current practice. These researchers also identified that those who had been employed with the organization longer were more resistant to change; those who could be persuaded by change were more likely to make the change.

Implementing evidence-based guidelines into primary care can be challenging. Considering the culture of the office in which the change is to be made, and tailoring the implementation process to meet the team where they are can lead to successful implementation (Liddy et al., 2014). Utilizing a team based approach and a framework for implementation can lead to further success (Holtrop et al., 2015; Arar et al., 2011). Maintaining communication at the forefront of innovation can increase the acceptance of any proposed change (Morténíus et al., 2012). Keeping these considerations in mind when introducing innovation or suggesting change in the primary care setting should increase willingness to change and increase the success of implementation.

**Geriatric Syndromes**

A separate literature search was conducted to garner in-depth information about the geriatric syndromes of depression, functional impairment, falls, and cognitive impairment, and
the screening tools used in detection of these syndromes. Pubmed, CINAHL, Cochrane Library, Science Direct, Google Scholar, as well as the Grand Valley State University Library website were used to locate this information. The search terms included: Elderly, Older Adult, Depression, Functional Ability, Falls, Cognition, Depression Screening, Functional Risk Screening, Dementia Screening, Primary Care, and Screening Tools. Inclusion criteria for this search were: human studies; in the English language; from the year 2010 to present to remain consistent with the timing of the AWV and to ensure the most up to date information was reviewed. For purposes of clarifying screening tools, studies were found outside of the 2010 to present time frame. Exclusion criteria for this search were: non-English language.

**Best Practices for AWV Assessments**

While CMS has identified the important geriatric syndromes of depression, functional impairment, falls, and cognitive impairment of importance to screen for during the AWV, it has not indicated which screening tools should be used to identify dysfunction (CMS, 2015). CMS recommends the AWV administrator “select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations” (CMS, 2015, p. 2). Multiple screening tools are available for each domain. The lack of guidance from CMS regarding screening tools for identifying fall risk and cognitive impairment has sparked the facilitation of workgroups to identify best practice in conducting these screenings. The importance of these syndromes is discussed below, followed by available screening tools for each syndrome.

**Depression.** Depression occurs in up to 20% of community dwelling older adults, and the incidence of chronic illness can increase the occurrence of depression (Centers for Disease Control and Prevention (CDC), 2015a). Additionally, up to 20% of community dwelling adults
present with symptoms of depression that go unrecognized (Magnil, Gunnarsson, & Bjorkelund, 2011; Pfoh, Mojtabai, Bailey, Weiner, & Dy, 2015). Depression in the older adult can lead to a decrease in functional ability, increased use of healthcare, and a higher rate of suicide; therefore, early diagnosis is important to decrease healthcare spending and disability as a result of depression, as well as to provide the older adult with the proper support and treatment (Pfoh et al., 2015). Despite depression screening being incorporated as a quality measure of healthcare (Pfoh et al., 2015), and the drive for standardized screening, there is still a gap in care because of a lack of quality treatment for those who have a positive screen (Almeida et al., 2012).

**Functional decline.** Functional ability is understood to be the ability of someone to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (Geron, 2002). ADLs are the basic activities one needs to complete to care for oneself, such as eating, toileting, and transferring. IADLs are more complex, yet necessary activities such as the ability to take one’s medication or complete tasks such as shopping or managing bills. The ability to complete IADLs can determine if an older adult can be self-sufficient (Geron, 2002).

Functional limitations occur in approximately 25% of older adults aged 60-69; this number increases to almost 60% in adults over 80 years of age (Holmes, Powell-Griner, Lethbridge-Cejku, & Heyman, 2009). Frailty has been found to occur in up to 40% of older adults (Pialoux, Goyard, & Lesourd, 2012). While older adults can have obvious or acute events that lead to functional decline, often the signs of decline can be subtle, requiring screening to identify these changes. The presence of chronic disease often leads to functional decline, which can manifest as disorders in mood or cognition; pain; impairment in sensory abilities; adverse drug reactions; and difficulty with gait and balance. Min and Shekelle (2012) suggest “when
multiple conditions coexist, the potential for additive or interactive effects of these health conditions is greater, further complicating determination of risk” (p. 2168).

**Fall risk.** Each year, more than 2.5 million emergency visits are related to falls; 700,000 patients are hospitalized for a fall-related injury (CDC, 2015b). The National Council on Aging (2015) reports that “falls are the leading cause of fatal and non-fatal injuries for older Americans” (para. 1). As many as 1 in 3 older adults fall each year, at worst, falls can lead to broken bones, traumatic brain injuries, fear of falling again, and death (CDC, 2015b). Additionally, falls can lead to social isolation, increased decline, and depression (National Council on Aging, 2015). Screening for falls can indicate when an older adult is at risk for falling and interventions can be taken to decrease fall risk, therefore decreasing healthcare spending and falls while improving quality of life.

**Cognition.** Dementia is a term which encompasses a decline in individuals’ memory and/or thinking. This decline leads to the inability for individuals to maintain their activities of daily life (ADLs) (Alzheimer’s Association, 2015). The Alzheimer’s Association (2015) suggest that up to half of those with Alzheimer’s disease (AD) have not been diagnosed or have not been informed of their AD diagnosis. Researchers believe that early detection of AD “will be key to preventing, slowing, and stopping Alzheimer’s disease” (Alzheimer’s Association, 2015, p. 8). Early diagnosis has the potential to improve management, decrease hospitalizations, create a provision for a long-term plan, and improve the patient’s care overall (Borson et al., 2013).

**Evidence Based Screening Tools**

There are several screening tools available to use in the assessment of depression, functional risk, falls, and cognition. The assessments vary in how they assess the syndrome of interest. A brief description of the common tools and their validity are presented in Table 1.
Recommendations, based on the evidence, for the most appropriate tool to be used during the AWV, were made.

The Patient Health Questionnaire-9 (PHQ-9) (Pfizer, n.d.) and Geriatric Depression Scale (GDS) (Yesavage et al., 1982) are two tools used in the primary care setting for assessment of depression. The PHQ-9 was developed to assess adult of any age, while the GDS was tailored to assess the population aged 65 and older. Phelan et al. (2010) compared the performance of the PHQ-9 and GDS in a sample of 71 older adults. They found that both screening tools performed similarly when using the tool to detect major depression. The authors suggest that either test could be used when screening older adults for depression in the primary care setting. As the GDS is focused on the older adult, it is suggested that this screening tool be used in the AWV.

The Health Assessment Questionnaire Disability Index (HAQ-DI) (Fries, Spitz & Young, 1982) and Katz Index of Independence in Activities of Daily Living (Katz ADL) (Katz, 1983) are two tools used for the assessment of functional ability. The HAQ-DI assesses activities of daily living (ADLs) as well as instrumental activities of daily living (IADLs) while the Katz ADL solely assesses the ability to complete ADLs. As the HAQ-DI is a more comprehensive tool which has been validated in the primary care setting, it is recommended for use during the AWV.

There are three recommended screening tools by the Panel on Prevention of Falls in Older Persons, convened by the American Geriatrics Society and British Geriatrics Society (AGS/BGS, 2011) for assessment of fall risk: the Timed Up and GO (TUG) (Podsiadlo & Richardson, 1991), the Berg Balance Scale (BBS) (Berg, Galvin, Keogh, Horgan, & Maki, 1992), and the Performance-Oriented Mobility Assessment (POMA) (Tinetti, 1986). The TUG measures functional mobility; however, multiple studies as identified by Barry, Galvin, Keogh,
Horgan, and Fahey (2014), Herman, Giladi, and Hausdorff (2011), and Schoene et al. (2013) in systematic literature reviews suggest the TUG actually is limited in its ability to predict risk for falls. The BBS solely assesses balance (Podsiadlo & Richardson, 1991) while the POMA assesses balance and gait (Tinetti, 1986). Considering the recommendations of these three tools from the AGS/BGS and results of multiple literature reviews, the most comprehensive fall risk assessment would be combined results from the TUG and POMA.

The American Geriatrics Society (2012) advises using the Mini–Mental State Examination (MMSE) (Folstein, Folstein, & McHugh, 1975), Montreal Cognitive Assessment (MOCA) (Nasreddine et al., 2005), Mini-Cog (Borson, Scanlan, Brush, Vitaliano, & Dokmak, 2000), or AD8 (Galvin et al., 2005) for cognitive screening in older adults. The AD8 has also been recommended for use by the Alzheimer’s Association (Cordell et al., 2013). The Mini-Cog is recommended for use during the AWV, due to its brief, two task administration and strongest validity. While the MOCA is the most reliable tool at present in detecting Mild Cognitive Impairment (MCI) and AD, it is composed of 30 questions, which is time consuming in an already time limited visit. It is recommended that this tool be used to further assess someone who shows evidence of cognitive impairment.

The AWV was designed to identify risk factors for or the presence of depression, functional impairment, falls, and cognitive impairment. A search of the literature identified the current tools used in screening for these geriatric conditions. A recommendation for use during the AWV was made based on the critical review of each screening tool. As one ages, “an emphasis on preservation of functionality and quality of life increasingly take precedence over simple extended biologic longevity (Nicholas & Hall, 2011, p. 5). By identifying depression, functional decline, fall risk, and cognitive impairment via the AWV, the personalized plan of
care can help the older adult preserve function and quality of life while managing risk factors/presence of illness.

**Conceptual Frameworks**

In order to create a protocol for use when conducting the AWV in the primary care office two conceptual frameworks were identified to guide this process. Conceptual frameworks are useful for guiding project design and implementation (Moran, Burson, & Conrad, 2014). The Chronic Care Model (Wagner, 1998) will be utilized to understand the phenomenon of interest (the AWV) and how to develop an effective protocol. The Plan-Do-Study-Act Model (Institute for Healthcare Improvement [IHI], 2016) will be used to guide the process of developing and revising the protocol.

**Chronic Care Model**

The Chronic Care Model (CCM), developed by E. H. Wagner in 1998 (Wielawski, 2006) “identifies and organizes the changes needed in the health care system, the practice, and the patient to improve outcomes” (Glasgow et al., 2001, p. 581). There are six tenets to this model: “community resources and policies, health care organization, self-management support, delivery system design, decision support, and clinical information systems” (Bodenheimer, Wagner, & Grumbach, 2002, p. 1776). The CCM aligns with the overarching objective of nursing care: prevention of illness and a change in health related behavior to increase health and decrease health disparities (Glasgow et al., 2001). Each of the tenets are described below. See Appendix A for a depiction of the CCM.

**Concepts of the CCM.** The concepts of the CCM are defined in Table 2. The AWV, as it fits into the CCM, is also depicted in this table. When these components work together, as they are meant to, the outcome of the CCM is “an informed, activated patient interacting with a
prepared, proactive practice team, resulting in high-quality, satisfying encounters and improved outcomes” (Bodenheimer et al., 2002, p. 1777).

**Plan-Do-Study-Act**

The Plan-Do-Study-Act (PDSA; IHI, 2016) model is a depiction of a continuous process which can be used to implement change. The four stages include making a plan for conducting change, trialing the change, assessing the results, and acting on the findings (Moule, Evans, & Pollard, 2013). This model allows for quick review and the ability to make changes while working toward the end goal of process change, so it is ideal for use in this project (Taylor et al., 2014). See Appendix B for a depiction of the Plan-Do-Study-Act Framework.

The process of PDSA starts with **Planning**. In this phase, the project manager/team must identify where improvement is necessary, what type of change is required, where to make a change to the process, how to make the change, and how to measure the effect of the change. Using this information, objectives can be identified, questions are presented, and a plan is developed to achieve the objectives and answer the questions of interest. Next, the **Do** phase begins, where the plan is enacted, results are recorded, and problems are identified. In the **Study** phase, the results of the enacted change are analyzed, which include how and to what extent the process improved; whether objectives of the change were met; whether the process was easier or more challenging with the new plan; if anything not planned for occurred, and what was learned; or if more information must be gathered. Finally, in the **Act** phase, the plan is revised based on the study results (United States Department of Health and Human Services Health Resources and Services Administration, 2011).

This project was guided by the PDSA model in a way that allowed for clear understanding of each step planned. **Plan:** A gap in care for improving identification and
management of multiple geriatric conditions in Medicare patients and the potential for improving care delivery and access to resources was noted throughout primary care offices within the organization. The project aimed to use a team-based approach to create a comprehensive protocol for completing the AWV in the primary care office after an organizational assessment revealed offering the AWV was a high priority task. Do: Using resources identified from CMS and the grey literature, a comprehensive protocol for completion of the AWV was developed. Members of the care team participated in development of the protocol to ensure its applicability within the clinic. Assistance was obtained from medical assistants, nursing staff, and the nurse practitioner at the office. Study: Feedback on the protocol was requested from the project committee members as well as the staff at the office to ensure practicality of use. Feedback from the members listed led to protocol modifications. Act: The protocol was then trialed with seven patients within this office who were eligible for the AWV. Patient satisfaction and feedback were evaluated. The protocol was modified based on patient and provider feedback. The protocol was made available to the office for use in everyday practice. A business case for performing the AWV at this location will be presented to the organization’s primary care key stakeholders.

**Need and Feasibility Assessment of Organization**

An organizational assessment was completed using Burke and Litwin’s (1992) Theory of Organizational Change and Performance, which guided the exploration of the organization. Questions were guided by the Department for International Development’s (2003) adaptation of the Burke and Litwin Model, which suggested key questions to ask during an organizational assessment. This model offers 12 variables which interact to advise the assessor of how the organization performs and where the area(s) necessary for change are located. The model shows the most powerful variable within an organization (the external environment) and relates
transformational and transactional factors as they relate to individual and organizational performance.

The transformational factors include the organization’s mission and strategy, organizational leadership, and the organizational culture. The transactional factors include the structure of the organization, the practices of management, policies and procedures (systems), individual skills, motivation, work unit climate, and the individual’s needs and values. All of these factors interact with each other and culminate in individual and organizational performance. Each of the factors in the model as they related to the practice group are presented in Appendix C. Using the information gathered during the organizational assessment and in conjunction with the factors of the organizational theory, a diagram was developed to demonstrate the internal strengths and weaknesses as well as external opportunities and threats of the intended project.

The external environment refers to the outside circumstances that influence the organization, whether positively or negatively. The factors that drive the organization forward or hold it back are part of the external environment (Burke & Litwin, 1992; Fleenor & Prince, 1997; University of Exteter, n.d.). The most prominent external factor which affected the organization is the Affordable Care Act (ACA), signed into law in 2010. The major goal of the ACA was to improve the quality of healthcare, yet make it affordable for all Americans, including the elderly. This includes preventive care at no cost to the consumer, prescriptions for the elderly at a reduced cost, improved protection of consumers against health care fraud, and improving Medicare benefits. Medicare recipients benefited from the implementation of the AWV and an increased number of covered preventive care measures such as immunizations and screenings (CMS, 2015a; United States Department of Health and Human Services, 2014). The AWV, a
component of the ACA, was an external factor affecting the organization. An additional external factor affecting the organization was the presence of two additional health systems in west Michigan. If these systems would have initiated the AWV, existing patients might have sought care outside of the organization to receive the benefit of the AWV.

*Transformational factors* include the organization’s mission and strategy, leadership, organizational culture, and individual and organizational performance (Burke & Litwin, 1992). Implementation of the AWV into practice within primary care aligned with the mission and strategy of the organization to support the elderly. The AWV paved the way for provision of high quality, comprehensive, and personalized care for the elderly, which was in alignment with the organization’s vision. By providing expert and empowering guidance via the individualized patient plan, providers administering the AWV could align their practice with the mission and vision of the organization (Mercy Health, 2015).

Senior leadership was believed to be forward thinking in their vision to drive the organization forward with initiatives to become a leader in health care. While decisions were made top down, collaboration between leadership and each primary care office occurred when implementing initiatives such as the AWV. Each office was allowed to decide whether or not to offer the AWV, which led to inconsistency in its availability. Overall, the organizational culture was supportive of the AWV.

The organization’s initial attempt at bringing the AWV into practice was not well thought out, and therefore unsuccessful. This led to negative opinions of the AWV in practice (Dr. David Blair, personal communication, December 4, 2015). There were locations interested in providing the visit, but did not know how, as well as locations that did the visit, but incorrectly. Many primary care offices within the organization had verbalized a desire to provide these visits to
their patients, but were unable to add another task to their workload (Tamara Dingeman, personal communication, October 20, 2015). With the appropriate training, and a dedicated team member to complete the AWV, providers were more comfortable with introducing this visit for their patients (Dr. Thomas Foster, personal communication, November 6, 2015).

*Transactional factors* are those factors which invoke “short-term reciprocity” (Burke & Litwin, 1992, p. 530) from members that can internally alter performance on a personal or possibly an organizational level (Burke & Litwin, 1992; Fleenor & Prince, 1997). Transactional factors include the organization’s structure, the practices of management, and policies and procedures (systems); work unit climate; task and individual skills; the individual’s needs and values; and motivation. Each primary care office had a practice leader who was responsible for developing the annual budget; maintaining staffing, including hiring and corrective action; setting clinic standards of care; and communicating with the staff and the organization leadership. Practice leaders were considered to be responsible for driving the implementation of the AWV into practice as a standard of care; however, motivation to add the AWV (another task) to daily workflow was expected to be a challenge. Encouragement and support from management, as well as improvement in quality measures and patient satisfaction as a result of the AWV can improve motivation among staff.

Each primary care office was composed of several provider teams. The model that the organization used was comprised of one physician, one APP, and either one LPN and one MA, or two MAs. This design was to ensure the team worked together consistently to establish a good working relationship, and trust among all members of the team. At the start of the project, the provider teams did not include a RN, who would be a key player in implementation of the AWV.
There was ongoing recruitment for more RNs in the clinic setting. However, the organization had been unable to fill these positions.

Physicians are hesitant to allow other office personnel to administer the AWV because of concerns about losing the relative value units (RVUs; compensation) which can be gained from these visits (National Health Policy Forum, 2015). However, working as a team to conduct the AWV and review the results would ensure the patient is cared for in an appropriate manner and that the physician receives his/her RVUs.

All of the transactional factors together culminate in the way the individual and organization performs. Many factors are included in performance, including “productivity, customer satisfaction, profit, and quality” (Burke & Litwin, 1992, p. 533). Another indicator of performance is the effort put into the outcome. Simply put, individual and organizational performance is how members and groups within the organization respond when driven by the mission, leadership, and culture (Burke & Litwin, 1992). Within the organization where the AWV pilot occurred, individuals were motivated to work with their patients to provide value-based care. Oftentimes this was challenging as patients and providers could have different visions of what their care entails. The organization was focused on patient satisfaction, reimbursement for services provided, and compliance with government mandated services. As with many organizations, financial reimbursement was the bottom line, achieved by quality of care and provided services (Dr. Kimberly Lanning, personal communication, December 30, 2015).

**SWOT Analysis**

An analysis of the Strengths, Weaknesses, Opportunities, and Threats (SWOT) (Mind Tools, 2016) associated with carrying out this project at the primary care office was completed.
A SWOT analysis of the circumstances surrounding the project is depicted in Appendix D. Components of this analysis included the strengths and weaknesses identified from within the organization, as well as opportunities and threats identified in relationship to the community.

**Strengths**

Key to the success of this project was the support achieved from leadership. As visits were already being completed within the organization, incorporating the AWV into practice in the remaining offices was vital. The organization emphasized the vision of providing people centered care, as well as care for the elderly. These visions aligned with the purposes of the AWV. Approximately 23,000 of the provider group’s patients were age 65 or older (Kimberly Fry, personal communication, December 7, 2015), ensuring there were enough patients to make this visit worthwhile. Finally, through this visit, dementia, depression, falls, and safety risk could be identified earlier, leading to improved care management and increased patient satisfaction.

**Weaknesses**

The initial implementation of the AWV was not successful at the primary care office where this project occurred because there was not a dedicated RN in the office, and a lack of perceived support for the AWV by some office physicians. The organization’s leadership was actively recruiting RNs for each location, but the interest of RNs to work in a clinic setting was lacking. Also, providers were not adequately trained to conduct this visit. This visit, if done correctly, takes longer than a typical provider appointment, presenting scheduling challenges if a provider was required to conduct this visit. In addition, there was a new EMR charting system implemented at the same time, which was expected to be overwhelming for the providers.
Opportunities

The AWV is a reimbursable visit by Medicare, expected to increase revenue for the facility. It is a longer visit than the usual 15 minute scheduled provider visit, and was likely to increase patient satisfaction. During the visit, chronic illnesses are reviewed which can lead to a higher capture rate, and more revenue. At the same time, this visit allows for capture of quality indicators, such as routine screenings like mammograms and colonoscopies. When dementia, depression, falls, or safety risk are identified earlier, patients can receive early access to services and an increased quality of life. In 2015, a total of 1534 patients who were seen at the primary care office were Medicare beneficiaries (Kimberly Fry, personal communication, December 7, 2015). If all the AWV eligible patients received an initial AWV, over $250,000 of additional revenue would be generated; a subsequent AWV would generate over $170,000 per year.

Threats

The AWV has the potential to decrease the number of patients seen in a day, because it is longer than a typical office visit. CMS continually modified the rules and requirements for this visit following its inception in 2012, which often caused confusion and missed documentation. CMS proposed the AWV, but no standardized guidelines or gold standard testing were recommended. Mechanisms for follow-up were yet to be identified, and there was limited access to AWV outcome measures. Finally, there was a lack of awareness among Medicare beneficiaries regarding the existence and purpose of this visit and their eligibility for this benefit.

Organizational Needs Identified by the Assessment and SWOT Analysis

When the Medicare AWV was introduced in 2011, the organization attempted to implement this visit into all of its 19 locations through the installation of Wellness RNs. A group of six RNs were hired to split their time between three to four clinics each. Unfortunately, the
Wellness RNs were met with adversity, and the majority of these RNs pursued other opportunities within the organization. At the time of this project, only one Wellness RN remained, and worked in just one of the other primary care clinics to provide this visit to its Medicare beneficiaries. Senior level management verbalized the need to successfully bring this valuable patient benefit to all locations. A standardized, all-inclusive written protocol for completion of the AWV, to be used in all clinic locations in the future, was an identified need to bring the concept of the AWV to reality in all the primary care clinics in west Michigan within this organization.

The CCM (Wagner, 1998) provides guidance for understanding the drive to implement the AWV for older adults. While all parts of the CCM are utilized in the application of the AWV, the most prominent component of the CCM as it relates to the AWV is the delivery system design: an effective plan to manage chronic illness in a system that focuses primarily on acute illness. The AWV is a way to identify chronic illness and risk for chronic illness through the health risk assessment and multiple screenings. Health advice and community resources are provided to help the patient prevent further risk or maintain the level of illness present.

The purpose of the developed protocol manual is to illustrate a team-based approach to provide step-by-step directions to complete the visit, and to ensure consistency and completeness in the exam, documentation, and billing. The goal of this protocol is to assist all parties who have a role in the AWV, from scheduling, to assistive personnel, to the provider, to billing. The protocol demonstrates identification of those eligible for this visit; how to contact these patients and schedule the visit; scripting for scheduling and performing the visit; step-by-step directions to complete the screening assessments; how to chart the visit in the EMR, including screen shots; how to code and bill for the visit; and other needs identified by the organization as the protocol
was developed. The baseline process flow, in the form of a short “job aid,” serves as a brief overview of how the AWV is conducted; however, detail is required to ensure the thoroughness and completeness of the visit in a location that does not currently complete the AWV. Not only was the protocol needed, it also was important to trial the procedure to ensure accuracy, consistent workflow, and successful accomplishment of all components of the AWV. Input from patients was assessed to evaluate the effectiveness of the AWV as a part of their care. Revisions were necessary to ensure thoroughness and effectiveness. A business plan was developed to communicate the need for, and most effective method of conducting the AWV at this office.

**Project Plan**

**Purpose of Project with Objectives**

This project provided the primary care office with a comprehensive protocol to use to complete the AWV for their Medicare patients. The ultimate goal of this project was to improve delivery of care to Medicare patients by earlier identification of geriatric syndromes, and referral for diagnosis and available resources. At the time of the project, this office did not provide the AWV to their Medicare patients. The objectives for this project were:

1. **Plan/Do:** To use a team-based approach to develop a comprehensive protocol for use in the primary care setting of how to conduct the AWV. This includes:
   a. Background information to inform the person providing the AWV
   b. Identification of eligible patients
   c. Contacting the patient and explaining the AWV
   d. Scheduling the patient for an appointment
   e. Steps to take prior to the AWV
   f. Day of the visit
g. Discussing findings with the patient’s provider

h. References

i. Visit flow sheet

j. Forms to reference

2. **Study:** To revise the protocol based on feedback from key stakeholders.

3. **Act:** To trial the protocol on 5-10 AWV eligible patients. The following information was collected for each visit:

   a. Total time to complete the following:
      
      i. Identifying, contacting, and scheduling the patient for the AWV

      ii. Preparing for the AWV by reviewing the EMR for information to complete the vaccination and screening portions of the HRA

      iii. Completing the AWV in the office by reviewing the HRA and updating the patient’s chart, completing the four mandatory screenings (GDS, Mini-Cog, TUG/fall risk, and functional assessment screening), goal setting, creating the personalized plan of care, and billing/coding the visit

      iv. Following up on pertinent findings with the patient’s primary care provider

   b. Amount of additional prevalent information identified via the AWV and updated in the chart, including:
      
      i. Chronic diseases

      ii. Current medications

      iii. Providers
iv. Positive screens and follow up with provider
v. Screening guidelines met/advised on

(c) Feedback from the patient, including:

i. Awareness and understanding of the AWV

ii. Convenience in scheduling

iii. How the visit could have been improved

iv. Was the visit enjoyed/not enjoyed

v. If a subsequent AWV will be scheduled

vi. Overall satisfaction

4. To disseminate the findings of this project via the Scholarly Project Final Report at the Kirkhof College of Nursing.

5. To present a business case in the form of a white paper and oral presentation, based on the findings of the protocol trial, to key stakeholders for conducting the AWV at the primary care office.

**Type of Project**

This project was the development of an evidence-based protocol for care delivery in primary care. The feasibility of the protocol was trialed on seven patients. A business plan was written to inspire clinical practice change at the primary care office.

**Setting and Resources Utilized**

This project was completed to benefit the primary care office. Input regarding the development of, and review of the protocol was solicited from members of the primary care team. Resources required for success of this project included access to the EMR in order to develop the stepwise approach to each component of the protocol, obtain screenshots of the
required charting components, and assess the tools available. The input of the office staff was valuable for developing the steps of the protocol; navigating the EMR; and helping the DNP student understand routine parts of the patient visit (patient flow). Finally, the most important resource was continued support of the project advisory team and staff at the office, especially the community project advisor for assistance navigating the EMR and obtaining essential information from the organization.

**Design for the Evidence-Based Initiative**

The protocol was developed based on the evidence-based guidelines set forth by CMS and guidance from the PDSA (IHI, 2016) model in the approach to protocol development. After shadowing the Wellness RN at another primary care office within the organization, the protocol was tailored to include the screening tools that two other primary care offices within the organization had in place for the AWV. Articles obtained from the grey literature that reported how the AWV was designed and implemented were used as references in development of this protocol. The protocol was developed in conjunction with clinic staff, in order to assure it aligned with the workflow and culture of that location. Once the protocol was written, members of the office were asked for their feedback and the protocol was revised.

The protocol was then trialed by the DNP student with seven patients who are eligible for the AWV to assess how the written protocol represented the reality of the conducted visit. The protocol was updated based on information learned during the visit, as well as patient feedback. A business plan to make the case for conducting the AWV with a dedicated RN was developed and for presentation to senior leadership at the organization. See Appendix E for a diagram illustrating the flow of the project.
Participants and Recruitment

Participants involved in this project included the student, her scholarly project advisory team, and staff at the primary care office. Feedback was obtained from the two RN case managers, three MAs, and one NP. While physician feedback was requested, it was not received, likely due to competing interests and concurrent time off while the project was being implemented.

Initially, the DNP student estimated conducting the AWV with 5-10 patients would be sufficient to ensure a mix of patients and adequate feedback on the process. A total of 10 patients were contacted to schedule the AWV. The patients were contacted in person during their scheduled office visit and via phone after being suggested by their primary care physician. Each potential patient received a verbal explanation of the AWV, time and appointment requirements, and was allowed to ask questions. If the participant was interested in scheduling an appointment, he/she was scheduled for a two hour time period based on availability within a one week period. The patients were scheduled and received an automated reminder phone call for their appointment time the day prior to the AWV.

Measurement: Sources of Data and Tools

The sources of data for the protocol part of this project included the project advisory committee and the staff at the primary care office. The DNP student engaged in verbal discussion with the staff to ensure ease of use, applicability to the office, clarification of questions, and for solicitation of suggestions for improvement. The questions discussed with the staff are included in Appendix F.

The sources of data for the trial part of this project were received from the patients seen for an AWV. Prior to the AWV, data were obtained from background factors obtained during the
process of trialing the protocol. First, a record of time was collected which included the time required for each step of the visit. The specific time inquiries are listed in Appendix G. In addition, the following data were collected: 1) patient age; 2) patient gender; 3) pre/post AWV number of chronic illnesses on the chart; 4) medication type and dose accuracy pre/post AWV; 5) current health care providers listed on the chart pre/post AWV; 6) the number of “positive” (indicating a problem) health screens from the AWV; 7) the follow-up plan from the AWV; and 8) the number of health care guidelines (such as mammograms and other screenings) met prior to and after the AWV. These data are listed in Appendix H. Finally, the patients were asked several questions in order to assess satisfaction and garner feedback. The questions were delivered in the form of a survey. No identifying information was asked on the survey. The response forms were collected in envelopes sealed by the patients, which were opened after 4 patients had their visits in order to maintain anonymity. The last 3 response forms were opened after the DNP student completed the final visit. The response forms were used to modify the protocol for upcoming visits. The survey questions are included in Appendix I. These data will be used in presenting the business plan to the organization.

Steps for Implementation of Project, Including Timeline

The initial step for this project was to read the available literature to learn and understand the AWV. Based on the literature review, and collaboration with staff at the primary care office, the comprehensive protocol for conducting the AWV was written, ensuring that all components of the AWV as mandated by CMS were included. This was completed in March 2016. The project proposal defense occurred in mid-March 2016. The project was submitted to the Institutional Review Boards (IRB) at both Grand Valley State University and the organization for review of the intended project and its anticipated outcomes. The protocol was submitted to
key stakeholders at the office for feedback. Patients were contacted at the end of March to schedule the AWV. Patients were seen in early April 2016. Data were analyzed in mid-April 2016 and prepared for inclusion in the Scholarly Project final report, which was completed at the beginning of May 2016. At that time, the final report was presented to the Kirkhof College of Nursing community. A meeting was scheduled with senior leadership at the organization in May 2016, to present the business plan for a dedicated RN to conduct the AWV at the primary care office.

**Budget Reconciliation**

The annual salary of a full time RN with benefits in 2015 was $75,933 (personal communication, Benefits Administrator, March 9, 2016). The cost of a computer for use by the RN is estimated at $2,000; additional monthly costs, made up of computer software, workspace, utilities, and supplies (paper, envelopes, postage) are estimated at $300/month. It is estimated that the first four weeks of employment will be general orientation, with an additional 2 weeks of time needed to schedule and prepare upcoming visits; no visits are anticipated for the first six weeks of employment. The projection is the RN will start with 5 visits per week (weeks 7-10), increase to 10 visits per week one month later (weeks 11-14), and then, by week 15 of employment, conduct 15 visits per week. With this plan, one RN can see 41% of the Medicare patients who are seen at this office per year. The return on investment for the Initial AWV comes in week 28 (Figure 1). The second year, if all visits are Subsequent AWVs, the monthly net return is +$631.20.

The protocol was the outcome of this scholarly project and thus does not have to be included in the budget, although there may need to be some revisions as the protocol is implemented using the PDSA cycle. The protocol implementation was billed for by the DNP
student’s preceptor. The DNP student piloted the protocol with seven patients. The cost to the office for the seven patients was included as part of the preceptor’s salary. Approximately $1,169 was billed for reimbursement.

**Ethics and Human Subjects Protection**

This project was submitted for review to the Grand Valley State University IRB. The Grand Valley State University deemed this project “not research.” See Appendix J for the letter of determination from Grand Valley State University. This project was also submitted to the organization’s IRB. The organization deemed this project “not considered human subjects research,” but “a clinical quality improvement measurement.” See Appendix K for the Notice of Clinical Quality Improvement Measurement Designation.

**Project Outcomes**

**Results of Project Implementation**

**The AWV protocol.** A comprehensive protocol for conducting the AWV was written in collaboration with the MAs, RNs, and NP at the primary care office. Understanding the CCM (Wagner, 1998) as it relates to the importance of chronic care management within the primary care setting, the best evidence-based tools were used for screening for geriatric syndromes in order to provide early referral for community resources. The design of the protocol included utilization of the EMR to ensure the patient was at the center of the AWV. Using the PDSA cycle (IHI, 2016), the protocol was reviewed and revised for feasibility and trialed with Medicare patients who were eligible for receiving the AWV. Overall, the protocol was easy to read and follow. The only feedback received was to enlarge the screenshots so they would be easier to see.
A total of 10 patients were contacted regarding the AWV. The patients were contacted in person at an existing appointment or on the phone. These were the only methods of contacting and informing the patients of the AWV.

Seven patients were interested and scheduled their Initial AWV. The three patients who declined the AWV had very different reasons for not participating. One patient was not interested because only wanted to see the physician for his medical needs, despite the reinforcement that the RN would communicate directly with his physician. Another patient felt she was too healthy to need the AWV, and reported “I don’t know what you can do for me” and declined the offer to establish a prevention plan for staying healthy. Finally, the last patient did not want to come back to the office until it was necessary to see the provider.

**AWV outcomes.** Of the seven patients scheduled, all came to their appointments and completed the AWV. Four females (57%) and three males (43%) participated. The age of the patients ranged from 70 – 80 years, with a mean age of 74.29 years. Two couples came together for their AWV.

The initial step of the AWV is for the nurse to review the patients’ personal histories and medications, as well as their current list of healthcare providers (CMS, 2015). The patients who participated in the AWV had an average of 15 chronic conditions recorded in their charts. As a result of the HRA, an average of six chronic illnesses was identified per patient that was not already part of the patient’s EMR. These chronic illnesses were updated in their charts and provided a more accurate record of the patients’ health history (Figure 2).

As a result of the medication review, two of the seven patients were found to have complete and correct medication lists in the EMR. Additions and/or modifications of medication lists were required for five patients. Three patients required 3-4 (M = 3.67) medication additions
to their charts. Three patients’ existing medication administration frequencies were also updated. A range of 2-14 (M = 8.67) medications were updated for these patients (Figure 3). The list of providers was also inaccurate on all of the patients’ records. An average of four providers per patient was added to the EMR as a result of the pilot AWV (Figure 4).

An important part of the AWV is the development of a preventive screening schedule to maintain the patients’ health and facilitate collaboration between the patient and the healthcare team in order to set health care goals (CMS, 2015). The CCM (Wagner, 1998) proposes that when patients are informed and activated and work with a proactive healthcare team, productive interactions occur, and patients have improved outcomes. All patients over 65 should have the following vaccines: influenza, pneumovax 23, zostavax, and tDap (Agency for Healthcare Research and Quality [AHRQ], 2014). In addition, it is recommended that patients receive the following tests: a colonoscopy every 10 years, a serum fasting glucose every three years unless abnormal, and lipids every 5 years unless abnormal. Male patients who have ever smoked should have a one-time abdominal ultrasound to screen for an abdominal aortic aneurysm between the ages of 65 and 75. Female patients should have a mammogram every two years until the age of 75; and after the age of 65, the pelvic exam and PAP are not indicated unless the patient is at high risk. Additionally, patients with diabetes should receive a foot exam and routine checks of their Hemoglobin A1C (AHRQ, 2014). At present, for male patients without diabetes, there are 4 recommended screenings; for female patients without diabetes, there are five recommended screenings. For male patients with diabetes, there are six recommended screenings; for female patients with diabetes, there are seven recommended screenings. See Table 3 for the current screening recommendations from the Agency for Healthcare Research and Quality (AHRQ; 2014).
In the AWV pilot, most patients were up to date on their screenings. One abdominal ultrasound was suggested for a male with a history of smoking and one colonoscopy was recommended but refused (Figure 5). In the health counseling section of the AWV, an average of one goal was set per patient for achieving health, which included goals around increasing exercise and weight loss.

The results of the geriatric screenings during the AWV showed that all of the patients were at low risk for having depression. None of the patients demonstrated risk for functional disability. Three patients were positive for cognitive impairment; one had a known history of dementia but two had no previously identified cognitive disorders. The provider for the other two patients was notified, and he indicated that he would further assess the issue in a follow up visit that was already scheduled. Two patients were positive for a risk for falls. One patient was scheduled for home physical therapy to assess and treat balance and gait. The other patient was presently working with physical therapy. Thus, the most significant findings from the screenings were that two patients who had no history of cognitive impairment were identified as having a risk for cognitive problems.

Two incidental findings occurred during the AWV. One patient had been seen for back pain in the primary care office, and reported during the visit that her pain was not getting better. Further assessment revealed a history of lower back pain with surgical intervention. Through the counseling as part of the AWV, the patient decided on her own that it was time for her to return to her back specialist for further assessment. In addition, another patient, 80 years old, reported a history of breast cancer which had been diagnosed only through her yearly mammogram. This important information would have been missed had the HRA, as part of the AWV, not been completed with the patient.
**Time to conduct the AWV.** The time taken to prepare for and conduct the AWV by the DNP student was recorded. It took a range of 45-55 minutes ($M = 49$) to identify, contact, schedule, and prepare the paperwork for the AWV, which included a chart review for incomplete quality measures (Figure 6). Of the 49 minutes spent, it took an average of 24 minutes to review the chart. All patients were scheduled for a 2-hour office appointment with the DNP student in order to ensure the AWV could be completed in its entirety. While the length of the appointment could vary based on the complexity of responses on the HRA or the amount of conversation that occurred during the visit, the time to administer the AWV ranged from 70-125 minutes ($M = 97$ minutes) (Figure 7). When the couples had their AWV appointments consecutively, the second person’s AWV took 10-15 minutes less than the first person’s, likely due to similar responses on the review of social history. This indicates that as the nurse gets to know the patients, the visit time may decrease. The combined visit ranged from 115-179 minutes ($M = 148$ minutes) (Figure 8). It should be noted that the pilot was done by the DNP student who had advanced education in assessment, data collection, and protocol implementation. The time may differ when it is conducted by an office RN or case manager. However, administering the AWV is well within the scope of practice for an RN, and with time and practice, efficiency and expertise should be developed.

**Patient satisfaction.** Finally, patient satisfaction was assessed via an anonymous survey (Appendix I). While all patients completed the survey, only five of the seven (71%) patients completed the survey in its entirety. None of the patients reported knowing what the AWV was prior to scheduling the appointment. All patients reported that they understood what the AWV was from the phone discussion. The patients reported that the visit was easy to schedule. When asked what the patients enjoyed or did not enjoy about the AWV, patients cited the visit as being
informative and enjoyable. One patient wrote that she was helped to “face the fact that I need to
do something about my back pain.” Of the seven patients who completed the visit, all indicated
that they planned to schedule a subsequent AWV in 12 months. The overall response to the visit
was positive, with high satisfaction indicated.

Overall, the added benefits of the AWV outweighed the time involved with preparing and
conducting the visit. The patients enjoyed the opportunity to sit down with a RN and plan ways
to maintain their health. Of the three patients who screened positive for a geriatric syndrome, all
expressed relief at the identification of the disease and were appreciative for the opportunity for
follow up with their provider.

Implications for Practice Discussion

Summary of important successes/difficulties encountered

Successes. This project was successful in that it is was a well-planned project which has helped the primary care office take a step toward bridging a gap in care of the older adult. It
demonstrated the need for a dedicated RN to conduct the AWV. The chart review and update
during the AWV provided a more comprehensive and accurate picture of patient health, which
might have been lost with the implementation of the new EMR at the organization. For example,
one patient had a history of breast cancer and required yearly mammograms. This information
did not merge from the old to the new EMR, and easily could have been lost if the chart review
had not been completed.

The AWV was well received by the patients who attended the visit. The patients reported
feeling informed about their health and the plan for maintaining wellness in the future. Those
who were positive for geriatric syndromes were appreciative of the help offered to them.
The protocol was developed by a team of MAs and nurses at the primary care office. It was revised to ensure ease of use within this office. Additionally, this project assisted the office in generating revenue, and provided data to support the need for hiring more RNs in the primary care setting.

**Difficulties.** There were many challenges throughout the project, the most prominent being lack of a standardized process in the literature for completing the AWV. The best practices had to be identified by the DNP student and compiled within a protocol. Throughout the scholarly project process, the lack of understanding by some of the stakeholders of the AWV and CMS required components was evident. This likely was the cause of lack of buy-in from providers and staff in a prior attempt by the office to initiate the visits.

At the office of interest, the lack of a dedicated RN to provide the AWV left a gap in the ability to consistently provide the AWV. Similarly, there was a lack of a consistent space to provide the visit; the location moved with each visit that was provided. The previous unsuccessful attempt at implementing the AWV left providers wary of attempting to re-launch the visit. Another significant challenge to the project was the implementation of a new EMR just prior to implementing the AWV pilot. This required extra time of the DNP student to learn and navigate patient records. Lastly, the vision of senior leadership is not always aligned with the priorities of the primary care offices. Oftentimes initiatives are communicated to the clinical level, yet each office is responsible for carrying them out in its own way. Due to competing demands within the primary care environment, such as the changing healthcare landscape and required healthcare initiatives, the AWV had not been made a priority within this office.
Project strengths/weaknesses/sustainability

**Strengths.** This was an evidence based, quality improvement project which was designed with input from staff at the primary care office. The protocol assures that the guidelines set forth by CMS are adhered to and that best practice for older adults is evident through the AWV. The protocol was piloted on a small scale and was tailored to meet the culture of the office. This project also demonstrated the cost effectiveness of using a RN to provide the unique and personalized care (IOM, 2015) required for the AWV. By integrating a RN into primary care with the role of providing the AWV, RNs will be able to “practice to the full extent of their education and training” (IOM, 2011, p. 85).

This project, in accordance with the interest of senior leadership at the organization, helped the primary care office to begin offering the AWV to its Medicare patients. This further aligns the office with the organization’s vision to care for the elderly in a way that is a Medicare benefit for the patient. The AWV, if conducted properly, has the potential to increase office revenue and decrease Medicare spending by providing preventative care, diagnosing problems earlier than routine care, and empowering patients to set healthcare goals. In the small pilot study, the AWV in this setting resulted in an increased capture rate of chronic illness and quality indicators within the patients’ charts. The use of an RN to complete the AWV provided high patient satisfaction and led to earlier identification of patients with depression, cognitive impairment, fall risk, and loss of functional ability. Patients were linked with community resources, and through goal setting, were empowered to be more responsible for their health. Several patients commented that the AWV was informative and were looking forward to a visit next year to continue improving their health.
Weaknesses. As the primary care office did not routinely conduct the AWV, patients were unaware of this benefit and were hesitant to schedule an appointment. A previously unsuccessful attempt at implementing the AWV made providers hesitant to recommend or complete this visit. Similarly, it was not feasible for providers to provide the AWV, as it would decrease their number of visits per day. While there are RNs employed at this office, their jobs are care management, and they state they cannot commit to administering the AWV. The transition to the new EMR had been more of a challenge than anticipated, which led to increased charting times and longer appointments. While most of the screening tools could be completed within the EMR, the Mini-Cog required completion on paper, which was then filed to be scanned into the chart. This could lead to a delay in the ability of the provider to review the cognitive screening results from the AWV. There continued to be a lack of outcomes documented as related to the AWV, especially at the organization, which made it difficult for staff to appreciate the impact the visit is having on Medicare patients and their healthcare in other venues.

Sustainability. At the time this report is being finalized, there was not a RN in the office to provide the AWV. Sustainability is at risk until a RN is hired to continue the work of this scholarly project. A business case for implementing the AWV was developed (Appendix L) which shows that the return on investment of hiring RNs to conduct the visit is positive in terms of revenue and projected patient outcomes. Thus, the sustainability of the project depends upon the willingness and ability of the office to hire appropriate staff to conduct the visits, because the workload of the staff does not allow for the visits to be incorporated into the current work flow. It is not known whether the office intends to hire staff to implement the AWV, as there are varying levels of support for the AWV at the office.
While this protocol was written for the primary care office, it is the intent of the DNP student that it will be able to be used system-wide. The nurse practitioner for the primary care office, who has been an advocate of the AWV, has agreed to be the expert of the AWV protocol and assist with training new RNs to become competent in administering the AWV. The DNP student will be available as well for issues of clarification and support.

**Recommendations for Future Practice**

This project provided beginning work for a standardized method of completing the Medicare AWV throughout the organization. Many lessons were learned from the development of the protocol, trialing the protocol with a small number of patients, and working with a new EMR. Future plans for furthering this work include:

- Another DNP (student or graduate) identifying the next steps to increase the frequency of AWVs administered in the primary care office.
- Considering alternative methods of informing the patient of the AWV.
- Working with the EMR developers to create a Mini-Cog template in which the screening drop down would include the test in which the patient could complete on the touch screen laptops the staff utilize.
  - Considering use of a tablet with drawing capacity for conducting the AWV.
- Working with the EMR developers to develop an automatic note to provider when screenings identify a finding outside of the normal range.
- Considering the most appropriate methods to train and evaluate effectiveness of training for RNs who are conducting the AWV.
  - Planning length of time appropriate for training.
  - Analyzing role of media in effective training, i.e. video modules.
Planning frequency of re-evaluation to ensure fidelity among those conducting the AWV.

- Utilizing RN student nurses in their community health or leadership rotations to conduct the AWV. Working with student nurses would provide an example of the role of the RN in primary care.
- Meeting with providers about the AWV. Solicit ideas for improvement as more patients receive the visit.
- Publication of results to inform future practice.
- Collaboration with the billing department and EMR to generate CPT codes which will allow for data that can be queried.
- Collaboration with PhD colleagues to create a longitudinal study in which to assess outcomes in those who have an AWV, compared to those who do not.

Relation to other evidence/healthcare trends

The existing literature is limited in documenting the effectiveness of the implementation of the AWV into primary care. Therefore, the outcomes produced for this project cannot be compared to data from other sites. The project utilized a combination of anecdotal reports, combined with the guidelines set forth by CMS, so it was truly a reflection of the available literature to date.

As the limited literature suggested, the AWV was slow to be implemented as routine practice. The practice at the organization was consistent with the literature. Thomas and Goode (2014) found that 32% of Medicare beneficiaries knew about the AWV; of the 10 patients contacted for this project, none reported they knew what the AWV was. Hughes (2011) posits that the main reason for the lack of AWV implementation is that patients misunderstand the
purpose of the AWV, thinking it is an annual physical rather than a visit with an RN. Knowing this, in the current project, purposeful intent was taken to clearly identify the AWV as a visit with a RN and a physical examination would not take place.

The AWV can be conducted by several members of the healthcare team. Despite this, the IOM recommends that RNs be present in the primary care setting. The RN possesses a unique set of assessment skills which can lead to precise identification of healthcare issues. As the basis of nursing is health promotion. The RN is suited to work with patients to set goals and make a plan for maintaining current health and preventing identified risk factors from developing into chronic illness. At the time of the trial, the organization was utilizing a RN to provide the AWV in another site, which aligned with the IOM’s recommendation for utilizing RNs in the workplace.

Limitations

The limitations of this project were few, but significant in nature. The lack of literature related to the AWV led to a gap in identifying the state of this Medicare benefit. While grey literature and anecdotal reports helped provide information for the development of the protocol, in-depth assessment of the cost effectiveness and patient benefit related to the AWV is not available to further inform practice.

This project was trialed on a small population of patients at the primary care office who were identified as “good candidates” by their provider. The results found during this project can be used to guide further work on the AWV, but cannot be generalized to the office as a whole or to other practices within the organization. Further work with the protocol and AWVs in this office is suggested to ensure the utility of this work.

Transition to the new EMR was a challenge. It is unknown whether the transition to the new EMR resulted in identification of a greater number of needed chart updates due to data that
had not been transferred from the old EMR to the new EMR. It was noted that the patients with high numbers of chronic conditions entered at time of the AWV saw their provider more frequently than those with lower numbers, which could influence the amount of information in the chart. However, the AWV remains important to review and update the patient chart on an annual basis.

Another limitation was the perceived lack of provider support for the AWV. Providers have verbalized they feel the AWV is not useful, and therefore they do not support the provision of this in the office. Additionally, due to the lack of a RN to provide the AWV, all the AWVs were completed by the DNP student who is adept at administering the health history and screenings. Training of a RN to continue this work was not possible and it is not known whether the time for the visit and accuracy of the screenings will be similar to that of the student.

**Reflection on Enactment of DNP Essentials Competencies**

The American Associations of Colleges of Nursing (AACN, 2006) identified eight core competencies to be addressed in the Doctor of Nursing Practice (DNP) education. These competencies ensure that a nurse who achieves the DNP degree is prepared for “a variety of nursing roles” (AACN, 2006, p. 8). The competencies include *Scientific Underpinnings for Practice, Organizational and Systems Leadership for Quality Improvement and Systems Thinking, Clinical Scholarship and Analytical Methods for Evidence-Based Practice, Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care, Health Care Policy for Advocacy in Health Care, Interprofessional Collaboration for Improving Patient and Population Health Outcomes, Clinical Prevention and Population Health for Improving the Nation’s Health, and Advanced Nursing Practice* (AACN, 2006).
Through scholarly project work and immersion opportunities, the eight core competencies have been met by this DNP student in accordance with the AACN guidelines. All competencies were addressed throughout this project, however, some were enacted to a greater extent than others. The prominent competencies used were Organizational and Systems Leadership for Quality Improvement and Systems Thinking, Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care, Clinical Prevention and Population Health for Improving the Nation’s Health, and Advanced Nursing Practice.

**Organizational and Systems Leadership for Quality Improvement and Systems Thinking**

A competency essential for the success of this project was organizational and systems leadership. According to the DNP essentials (AACN, 2006), the DNP prepared APRN must carefully consider the needs and culture of an organization or community and align his or her work to help improve quality of care and promote positive health outcomes. The DNP prepared APRN must be skilled at assessing the organization, reviewing policies in place for efficacy, and develop practical solutions to achieve desired outcomes (AACN, 2006).

An important component of the current project was to conduct a system-wide assessment of the organization. As part of this assessment, a need for quality improvement was identified in regard to the AWV. In order to be successful, this student had to assure there was support by the senior leadership. In addition, the project had to align with the organization’s mission and values. To make sure that the project would be successful, it was important to assess the possible methods for carrying out the AWV and build upon them based on the culture of the immersion site. Providers at the office were interviewed about their experience with the wellness RN and
AWVs. In fact, a prior attempt at initiating the AWV at this immersion site failed likely due to a lack of understanding of the culture of the organization and support from key stakeholders.

This DNP student spent time within the organization shadowing the RN who conducts the AWV and interviewing organization members who play a role in the AWV: scheduling, billing, a previous wellness RN, and senior leadership. All expressed a need for a comprehensive and standardized protocol, and the desire to implement the AWV within all the primary care offices. Using this information and the information from the literature, the protocol was developed. It was trialed at one office for feasibility, with a long term goal of implementing this protocol throughout the organization.

**Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care**

The DNP essentials emphasize the need for the DNP prepared APRN to integrate knowledge of information systems and technology into methods to improve patient care. In this project, knowledge of and utilization of the EMR was key to the implementation. The conceptual framework of the CCM emphasizes the role of delivery system design, decision support, and clinical information systems to lead to the best care (Wagner, 1998). Thus, the DNP student had to thoughtfully consider the implementation of the AWV including how the protocol could be designed to logically flow within the new EMR. This presented challenges because the system was not fully understood by the staff. It was essential that the DNP student fully understand the functions of the new EMR and integrate the AWV into the work flow, otherwise the AWV would not be successful. The AWV protocol supported an appropriate visit flow and allowed for most aspects of the visit to be recorded in the EMR (all except the Mini-Cog assessment), whereas the previous EMR was fragmented in its ability to handle the AWV and required
scanned documents to complete the charting. In addition, the AWV protocol provides clinical support for the nurses and providers by explaining how the results of the tests should lead to further assessment. In the future, automated clinical decision support could be built into the EMR to facilitate communication of the results to the providers and tracking of the results over time.

**Clinical Prevention and Population Health for Improving the Nation’s Health**

This project closely aligns with this DNP essential which focuses on “clinical prevention and population health in developing, implementing, and evaluating interventions to address health promotion/disease prevention efforts, improve health status/access patterns, and/or address gaps in care of . . . populations” (AACN, 2006, p. 16). This student had always been interested in the older adult population, which inspired a desire to create a project that would directly affect those patients aged 65 and older. The AWV was one way to identify risk factors for chronic illness, increase access to important prevention measures such as vaccinations and screenings, and create a plan to promote health and well-being. However, there was no clear model or guideline in the literature which gave clear instructions on implementing the AWV, including which assessment tools to use and how to administer the visit. This project demonstrated the DNP prepared APRN’s unique ability to synthesize the literature, develop a protocol consistent with best practices (including the selection of screening tools), the office culture and EMR, and assess the efficacy of the protocol. Understanding geriatric syndromes and their manifestations when left untreated is imperative to addressing the gap in care that affects the older adult population. Creating a sustainable protocol that the primary care office can use to provide the AWV can help to bridge the gap in care of the older adult. Innovative care delivery via the AWV is just the beginning of finding ways to help improve quality of life and decrease
modifiable disability in older adults. Earlier disease diagnosis can increase access to resources and benefit this population.

**Advanced Nursing Practice**

This DNP competency focuses on the role of the APRN in assessing health and illness and developing interventions to support the health and well-being of the patients served. When the APRN works in tandem with patients, members of an interdisciplinary team, and the community, positive health care outcomes are possible (AACN, 2006). The role of the APRN aligns with the CCM which demonstrates that when health care delivery and community work together, they produce engaged patients and active health care teams which lead to positive interactions and positive outcomes (Wagner, 1998).

The role of the APRN is essential to care delivery in the primary care. Through “health promotion and education” (IOM, 2011, p. 55), provided through a vehicle such as the AWV, the health of older adults can be optimized. The APRN has the skillset to manage complex health issues and incorporate innovative therapies to improve healthcare outcomes. Through health promotion and goal setting, patients are engaged and empowered to take charge of their health and well-being.

**Summary**

This project was a culmination of the past four years of doctoral nursing education. I approached this project from the perspective of a DNP prepared APRN, which was evident in several ways. I chose the CCM (Wagner, 1998) and PDSA (IHI, 2016) models to influence and guide my project. I utilized Burke and Litwin’s Theory of Organizational Change and Performance to ensure my project aligned with the organization’s goals and objectives. Two complex and thorough literature reviews were undertaken to assess the state of the science and
inform my work. I was able to demonstrate leadership ability and interdisciplinary collaboration while taking a team-based approach to develop the protocol, which ensured it aligned with the culture of the office. Using the findings from my literature review, I evaluated geriatric syndrome screening tools and made evidence-based recommendations for practice. Through use of the PDSA cycle (IHI, 2016), I was able to evaluate outcomes and provide feedback to the organization through a business plan and presentation. Most importantly, I advocated for the health and well-being of older adult patients to receive one of their Medicare benefits, which ultimately has the potential to improve their quality of life.

**Dissemination of Outcomes**

The final phase of the *Development of a Protocol for Implementing the Medicare Annual Wellness Visit in a Primary Care Setting* scholarly project is the dissemination of the outcomes that were generated. As per the project plan, primary dissemination occurred through the Scholarly Project Final Report, which was presented on May 4, 2016 to the Kirkhof College of Nursing community. Members of the primary care office were invited to attend this presentation as well. The secondary dissemination of outcomes was planned for delivery on-site to the leadership at the primary care office, in a short presentation to discuss outcomes and answer questions, as well as to close the two semester practicum in which this project was completed. The DNP student’s scholarly portfolio, including the Organizational Assessment, Literature Review, White Paper, and Project Proposal will be available upon request.

The project has three physical deliverables: the scholarly project final report which will be made available through Grand Valley State University’s ScholarWorks digital repository; the Medicare Annual Wellness Protocol (Appendix M); and a business plan, which will be delivered to the senior leadership at the organization at the time of the on-site presentation. All of the
documents associated with the AWV, such as the patient letters, HRA, and the form to complete the Mini-Cog will be made available on the office network for use by the staff.

**Conclusion**

This scholarly inquiry identified a gap in care of the older adult at the organization, and this project was developed to deliver evidence-based care to increase access to resources and decrease disability in the older adult population. This scholarly project provided the primary care office with a protocol to implement the AWV. An organizational assessment of the organization indicated interest in implementing the AWV as a method of caring for the older adult population.

The CCM (Wagner, 1998) was an excellent model to inform the key principles of the AWV, combining health systems and community to interact with patients and their healthcare providers in order to improve patient outcomes. This ultimately leads to decreased healthcare spending. Using the PDSA cycle (IHI, 2016), the protocol was developed using a team-based approach ensuring that it would work with the culture of the office. The protocol was then trialed with Medicare patients eligible for the AWV to ensure the feasibility of using a RN to conduct the AWV. The protocol was revised as needed, based on the patient response to the AWV.

The implementation of the AWV demonstrated one-on-one time with a RN to review patient history, identify risk factors for disease and disability, and help the patient set goals to maintain health and wellness. Patient satisfaction was high in this small sample, and patients felt their needs were met through this visit.

Implementation of the AWV at the primary care office is just a start to provide the AWV office- and system-wide. Further work must be done to ensure sustainability and to produce outcomes, to show how the AWV affects a patient’s healthcare. It is recommended that this
clinic continue to provide the AWV via the RN case manager(s) until a dedicated RN can be hired to provide the AWV full time.
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Shumway-Cook, A., Brauer, S., & Woollacott, M. (2000). Predicting the probability for falls in


**Table 1**
*Common Screening Tools for the Geriatric Syndromes of Interest in the AWV*

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Tool</th>
<th>Type of Assessment</th>
<th>Validity</th>
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<tbody>
<tr>
<td>Depression</td>
<td>Patient Health Questionnaire-9 (PHQ-9)</td>
<td>Nine item questionnaire which can be used to screen, diagnose, monitor, and measure depression.</td>
<td>88% sensitivity and 88% specificity for detecting depression in community dwelling adults (Kroencke, Spitzer, &amp; Williams, 2001).</td>
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<td></td>
<td>Geriatric Depression Scale (GDS)</td>
<td>15-item tool which assesses life satisfaction and how the patient feels about their mental well-being</td>
<td>81.3% sensitivity and specificity of 78.4% (Mitchell, Bird, Rizzo, &amp; Meader, 2010).</td>
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<td>Functional Risk</td>
<td>Health Assessment Questionnaire Disability Index (HAQ-DI)</td>
<td>20 question assessment of functional disability: “dressing, arising, eating, walking, hygiene, reach, grip, and activities” (National Institute of Environmental Health Sciences, n.d., p. 1).</td>
<td>Unable to locate exact sensitivity and specificity. However, it was validated in primary care (Fries, Spitz, &amp; Young, 1982).</td>
</tr>
<tr>
<td>Fall Risk</td>
<td>Timed Up and Go (TUG)</td>
<td>A test to measure functional mobility in older adults.</td>
<td>Sensitivity of 87% and a specificity of 87% (Shumway-Cook, Brauer, &amp; Woollacott, 2000). Multiple reviews suggest Timed Up and Go not reliable on its own.</td>
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<tr>
<td></td>
<td>Berg Balance Scale (BBS)</td>
<td>14-item screening tool to assess balance in the older adult.</td>
<td>Sensitivity of 77% and specificity of 86% (Berg, Wood-Dauphinee, Williams, &amp; Maki, 1992).</td>
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<tr>
<td><strong>Performance-Oriented Mobility Assessment (POMA)</strong></td>
<td>A tool used to assess balance and gait. Balance is assessed in 9 questions; gait is assessed in 7 questions (Tinetti, 1986).</td>
<td>Sensitivity of 64% and a specificity of 66.1% (Faber, Bosscher, van Wieringen, 2006).</td>
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<tr>
<td><strong>Mini Mental State Examination (MMSE)</strong></td>
<td>11 questions to assess “orientation, registration, attention and calculation, recall, and language” (Kurlowicz &amp; Wallace, 1999)</td>
<td>Sensitivity of 66% and specificity of 99% (Lucas et al., 2008).</td>
<td></td>
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<tr>
<td><strong>Montreal Cognitive Assessment (MOCA)</strong></td>
<td>Assesses “attention and concentration, executive functions, memory, language, visuconstructional skills, conceptual thinking, calculations, and orientation” (Doerflinger, 2012, para. 2) in older adults.</td>
<td>Able to detect MCI with a sensitivity of 90-96% and specificity of 87%; Alzheimer’s disease was detected with a sensitivity of 100% and a specificity of 87% (Doerflinger, 2012).</td>
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<tr>
<td><strong>Mini-Cog</strong></td>
<td>Brief 2-item screening tool consisting of word recall and clock drawing (Borson et al., 2003). which can be used for older adults in primary care.</td>
<td>Sensitivity of 75% and specificity of 89% (Borson, Scanlan, Chen, &amp; Ganguli, 2003).</td>
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<tr>
<td><strong>AD-8</strong></td>
<td>An 8-item tool that was designed to use during the AWV. This tool assesses “memory, orientation, judgment, and function” (Kroencke &amp; Zweig, 2013, para. 2).</td>
<td>Sensitivity of 80% and specificity of 59% (Coats, Galvin, Morris, and Roe, 2007). Correlation (r = 0.75) with the longer neuropsychological test, the Clinical Dementia Rating Scale (Galvin &amp; Zweig, 2013).</td>
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### Table 2
*Concepts of the CCM (Bodenheimer et al., 2002; Glasgow et al., 2001)*

<table>
<thead>
<tr>
<th>CCM Concept</th>
<th>Conceptual Definition</th>
<th>How it relates to the project</th>
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<tr>
<td>Community Resources and Policies</td>
<td>A way to link patients with programs in their community for healthcare improvement.</td>
<td>The personalized prevention plan will identify resources available to assist the patient in meeting his/her healthcare goals.</td>
</tr>
<tr>
<td>Health care organization</td>
<td>Prioritizing chronic care as an important goal within the health system by visibility of leadership who support emerging goals, and rewarding those who observe the guidelines set forth to achieve the identified goals.</td>
<td>Senior management of the organization has deemed the AWV to be a priority.</td>
</tr>
<tr>
<td>Self-management support</td>
<td>Patients and their caregivers are educated on management of their chronic illness.</td>
<td>The personalized prevention plan allows the patient to have a voice in goal-setting and utilize the expertise of the RN in helping to achieve those goals whether by prevention or management of chronic illness.</td>
</tr>
<tr>
<td>Delivery-system design</td>
<td>An effective plan to manage chronic illness in a system that focuses primarily on acute illness.</td>
<td>The AWV focuses on the patient history, in order to identify risk for or the presence of chronic illness. The patient becomes a part of the plan of care in order to prevent or manage risk factors.</td>
</tr>
<tr>
<td>Decision support</td>
<td>The integration of best evidence into practice and training providers to use evidence-based procedures and protocols to ensure effective management of chronic illness.</td>
<td>The AWV is a way to improve the care of older adults, utilizing evidence-based testing in order to identify geriatric syndromes sooner and decrease present risk factors.</td>
</tr>
<tr>
<td>Clinical information systems (CIS)</td>
<td>A system that allows providers to access information about chronic illness on their patients, or the population they serve.</td>
<td>All components of the AWV are made a part of the patient’s permanent record, and queries can be run to identify the presence/prevalence of chronic illness. CIS also help to ensure screenings and immunizations are up to date.</td>
</tr>
</tbody>
</table>
**Table 3**  
*AHRQ vaccine and screening recommendations for older adults*

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>Annually</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>If over 65, once. If received vaccine more than 5 years before turning 65, 2nd one required.</td>
</tr>
<tr>
<td>Shingles (Zoster)</td>
<td>Once after age 60</td>
</tr>
<tr>
<td>Tdap</td>
<td>Once, then Td booster every 10 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screening</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Ultrasound</td>
<td>Once for men ages 65-75 years old who have ever smoked</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Every 10 years until 75, unless previous test indicates different frequency</td>
</tr>
<tr>
<td>EKG</td>
<td>As needed</td>
</tr>
<tr>
<td>Mammogram</td>
<td>Every 2 years until age 75</td>
</tr>
<tr>
<td>Pelvic Exam/PAP</td>
<td>PAP not indicated over 65 if 3 negative tests in past 10 years</td>
</tr>
<tr>
<td>A1C (for Diabetics)</td>
<td>1-2 times per year if diabetic</td>
</tr>
<tr>
<td>Fasting Glucose</td>
<td>Every 3 years if normal. Every 1-2 years if abnormal</td>
</tr>
<tr>
<td>Lipids</td>
<td>Every 5 years if normal. Every 1-2 years if presence of diabetes, cardiac disease, kidney problems, high cholesterol</td>
</tr>
</tbody>
</table>
Figure 1. Return on Investment.
Figure 2. Number of chronic illnesses recorded in the chart before and after the AWV.
Figure 3. Number of medications recorded in the chart before and after the AWV and number of medications updated as a result of the AWV.
Figure 4. Number of providers recorded in the chart before and after the AWV.
Figure 5. Number of screening recommendations met before and after the AWV.
Figure 6. Time for completion of chart review prior to AWV.
Figure 7. Time for completion of AWV in office.
Figure 8. Total time to conduct the AWV.
Appendix A

The Chronic Care Model

Community
Resources and Policies
Self-Management Support

Health Systems
Organization of Health Care
Delivery System Design
Decision Support
Clinical Information Systems

Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team

Improved Outcomes

Effective clinical practice: ECP by American College of Physicians--American Society of Internal Medicine; Alliance of Community Health Plans Reproduced with permission of AMERICAN COLLEGE OF PHYSICIANS in the format Thesis/Dissertation via Copyright Clearance Center.
Appendix B

Plan-Do-Study-Act Model

- Trial the protocol with 5-10 eligible patients
- Request feedback from members of staff at primary care office
- Using resources identified from CMS, grey literature, staff at primary care office develop comprehensive protocol for completing the AWV

- Gather feedback on visit from the patients
- Revise protocol based on feedback
- Prepare business plan based on findings

- AWV high priority task
- Identify members of the office team to collaborate with to develop the comprehensive protocol for completing the AWV

Appendix C:

Burke and Litwin Model of Change as it Applies to the Organization

[Diagram showing the Burke and Litwin Model of Change with nodes for External Environment, Leadership, Organizational Culture, Structure (Facility), Management Practices, Systems, Work Unit Climate, Task & Individual Skill, Motivation, Individual Needs and Performances, and Ind. & Org. Performance.]

Adapted from Burke & Litwin's Model of Organization Performance and Change (1992)
Appendix D

SWOT Analysis

Strengths
* Support from Leadership
* Visits already being completed in other offices
* Aligns with vision of care for the elderly
* Large Medicare base
* Early identification = improved care management and increased patient satisfaction

Weaknesses
* Previous unsuccessful attempt at implementation
* RN vacancies
* Providers not trained
* Takes longer than a typical provider visit to complete
* New EMR to learn at same time as AWV

Opportunities
* Reimbursable by Medicare/extra revenue
* Increased patient satisfaction due to longer visit with provider
* Higher capture rate of chronic illness and quality indicators
* Earlier ID of pts with dementia, depression, fall/safety risk and early referral for services

Threats
* Changing rules/requirements from CMS
* Decreased # visits/day
* Lack of standardized guidelines/tests for completing the AWV
* Lack of guidance for follow up when required
* Limited access to AWV outcomes
* Lack of community awareness of this benefit

Adapted from Mind Tools (2016).
Appendix E

Design for the Evidence Based Initiative

- **Step 1**: Take a team-based approach to create protocol for use in the primary care setting
- **Step 2**: Request feedback on revised protocol from members of the office
- **Step 3**: Revise protocol based upon feedback received
- **Step 4**: Obtain IRB determination
- **Step 5**: DNP student will trial protocol with 5-10 AWV eligible patients at the primary care office
- **Step 6**: Prepare business plan for senior leadership
- **Step 7**: Complete steps to present Final Scholarly Project Report to KCON community
- **Step 8**: Meet with senior leadership at the organization to present business plan and share findings
Appendix F

Protocol Discussion Questions

Dear Colleague at the organization,

As part of my scholarly project at Grand Valley State University, I am writing a protocol for implementation of the Medicare Annual Wellness Visit. I am requesting that you read the attached protocol and please answer the following questions regarding the protocol. I welcome any feedback you wish to share.

Thank you,
Jennifer Ohman, DNP Student

1. What is your role in this project/organization?

2. How easy is this protocol to read?
   a. No difficulty
   b. Moderate difficulty
   c. Extreme difficulty

3. How applicable is this protocol to the Southwest Office?
   a. Applicable
   b. Sort of Applicable
   c. Not at all Applicable

4. Do you feel that you would use this protocol if it was available?
   a. Yes
   b. No

5. Do you feel anything is missing from the protocol?

6. Do you have suggestions for improvement/areas that need to be clarified?
Appendix G

Time Tracker (in minutes)

<table>
<thead>
<tr>
<th>Patient</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tr>
<td>Time spent to identify eligible patients</td>
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<td>Time spent contacting patient</td>
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<td>Time spent scheduling patient</td>
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<td>Time spent preparing for AWV</td>
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<td>Time spent day of visit</td>
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<td>Time spent follow up</td>
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<td>Total patient time for visit</td>
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### Appendix H

#### Updates Made to Patient’s Chart

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<td>Age</td>
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<tr>
<td># Prevalent Chronic Diseases</td>
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<td># Chronic Diseases Identified via AWV</td>
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<td># Meds</td>
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<td># Meds Identified via AWV</td>
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<td># Providers</td>
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<tr>
<td># Providers ID’d via AWV</td>
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<td># Positive Screens</td>
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<td>Follow Up Needed (Y/N)</td>
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<td># Guidelines Met Before</td>
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<tr>
<td># Guidelines Met After AWV</td>
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</tbody>
</table>

*# Identified via AWV = Additional items ID’ed*
Appendix I

Patient Feedback Survey

Dear Patient,

Thank you for having your Medicare Annual Wellness Visit completed today. We appreciate your interest in this free Medicare benefit. Before you go, we have a few questions for you about your visit today. We appreciate your honest responses!

1. Were you aware of the Medicare Annual Wellness Visit before being contacted?

2. Did you understand the visit from your conversation on the phone? If not, what could have been clarified?

3. Was it easy to schedule your visit? If not, what could have been better?

4. What did you enjoy about the visit, if anything?

5. What did you NOT enjoy about the visit, if anything?

6. What could the nurse have done better?

7. Did anything surprise you about this visit?

8. Will you schedule another Annual Wellness Visit? Why or Why Not?

9. On a scale of 0 to 10, 0 is no satisfaction, 10 is total satisfaction, how satisfied were you with this visit?

10. Do you have any further question(s)/concern(s)?

THANK YOU FOR YOUR FEEDBACK!
Appendix J

Determination Letter from Grand Valley State University

DATE: March 17, 2016

TO: Jennifer Chman, BSN
FROM: Grand Valley State University Human Research Review Committee
STUDY TITLE: [884237-1] Development of a Protocol for Implementing the Medicare Annual Wellness Visit in a Primary Care Setting
REFERENCE #: New Project
SUBMISSION TYPE: New Project
ACTION: NOT RESEARCH
EFFECTIVE DATE: March 17, 2016
REVIEW TYPE: Administrative Review

Thank you for your submission of materials for your planned research study. It has been determined that this project:

DOES NOT meet the definition of covered human subjects research* according to current federal regulations. The project, therefore, DOES NOT require further review and approval by the HRRC.

If you have any questions, please contact the Research Protections Program at (616) 331-3197 or rpp@gvsu.edu. The office observes all university holidays, and does not process applications during exam week or between academic terms. Please include your study title and reference number in all correspondence with our office.

*Research is a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge (45 CFR 46.102 (d)).

Human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains data through intervention or interaction with the individual, or identifiable private information (45 CFR 46.102 (f)).

Scholarly activities that are not covered under the Code of Federal Regulations should not be described or referred to as research in materials to participants, sponsors or in dissemination of findings.
Appendix K

Determination Letter from The Organization

NOTICE OF CLINICAL QUALITY IMPROVEMENT MEASUREMENT DESIGNATION

To: Jennifer Ohman, RN, BSN

Re: IRB# 16-0318-6
Development of a Protocol for Implementing the Medicare Annual Wellness Visit in a Primary Care Setting

Date: March 18, 2016

This is to inform you that the Mercy Health Regional Institutional Review Board (IRB) has reviewed your proposed research project entitled "Development of a Protocol for Implementing the Medicare Annual Wellness Visit in a Primary Care Setting. The IRB has determined that your proposed project is not considered human subjects research. The purpose and objective of the proposed project meets the definition of a clinical quality improvement measurement. All publications referring to the proposed project should include the following statement:
"This project was undertaken as a Clinical Quality Improvement Initiative at Mercy Health and, as such, was not formally supervised by the Mercy Health Regional Institutional Review Board per their policies."

The IRB requests careful consideration of all future activities using the data that has been proposed to be collected and used "in order to develop a protocol for implementing the Medicare Annual Wellness Visit in a Primary Care Setting."

The IRB requests resubmission of the proposed project if there is a change in the current clinical quality improvement measurement design that includes testing hypothesis, asking a research question, following a research design or involves overriding standard clinical decision making and care.

Please feel free to contact me if you have any questions regarding this matter.

Brenda Hoffman
IRB Chairperson

Copy: File
Appendix L

Business Case Presented to the Organization

Use of a Registered Nurse to Conduct the Medicare Annual Wellness Visit

The Organization

Date: May 2016

To: Leadership, the Organization

From: Jennifer M. Ohman, DNP, RN

Medicare Annual Wellness Visit

The Medicare Annual Wellness Visit (AWV) was introduced in 2011 as part of the Patient Protection and Affordable Care Act (American College of Physicians [ACP], 2015). The AWV is an opportunity to improve care delivery by encouraging use of preventive services and care coordination for Medicare patients 65 and older who are at risk for high usage of healthcare services. During this visit, patients are screened for common geriatric-related conditions such as depression, cognitive impairment, fall risk, and functional decline. This visit is also an opportunity to identify risk factors for chronic illness and to help patients stay current on recommended screenings and vaccinations. Through the AWV, it is possible to improve care delivery to the older adult population over age 65 by early identification of chronic disease risk factors and geriatric syndromes, and by early referral to community resources in order to improve quality of life and decrease healthcare costs (CMS, 2015a; Snyder, 2013).

Why is the Medicare Annual Wellness Visit Important?

In 2013, more than $2.5 trillion was spent nationwide on healthcare for older adults. These costs were attributed to patients overusing healthcare services and/or receiving duplicate services (Snyder, 2013). Screening and preventive care in the older adult population is limited, at best. Use of preventive services varies across the nation, often due to “quality of health and health care across age, gender, race or ethnicity, income, education, geographic location, disability, and sexual orientation” (Centers for Disease Control and Prevention, Administration on Aging, Agency for Healthcare Research and Quality, and Centers for Medicare and Medicaid Services, [CDC, AoA, AHRQ, CMS]. 2011, p. 1).

Some Medicare recipients receive an excessive amount of screening services while some receive a scarce amount of services (Nicholas & Hall, 2011). While the majority of Medicare beneficiaries are seen by a physician at least six times per year, they do not receive preventive services that are recommended by the United States Preventive Services Task Force (USPSTF) (CDC, AoA, AHRQ, CMS. 2011). An increase in the availability of preventive services can lead to decreased morbidity and mortality (Krist et al., 2013) which ultimately leads to a decrease in healthcare spending. The AWV is a vehicle to streamline screening and preventive care, to ensure patients are receiving the necessary healthcare, but not in excess.

The Organization

The organization is a regional healthcare system which serves western Michigan with hospitals, multiple specialty clinics, and several primary care clinics run by a physician practice group (the primary care group). This organization is well-known for its dedication to care of older adults, and this dedication is consistent with the work of the primary care group (Trinity
Health, 2015). The primary care group serves approximately 23,000 Medicare patients annually, however fewer than 5% of these patients have received the AWV (Kimberly Fry, personal communication, December 7, 2015), less than the national average of 7% (Thomas & Goode, 2014). The AWV aligns with the organization’s consumer promise “to be accessible, to listen intently, and to provide expert guidance that empowers you to take an active role in your health care decisions” (Mercy Health, 2015, para. 3). Additionally, this is a fully covered Medicare benefit with no cost or copay to the patient.

Currently in the primary care group only 2 out of 19 offices routinely provide the AWV, and a limited number of providers at these locations offer the visit. Incorporating the AWV as a standard of care for Medicare patients will improve care delivery to older adults as well as increase timely access to resources. Additionally, by providing the patients at the primary care group who have Medicare with one of their benefits, payments from Medicare for the AWV will increase revenue.

Although the patient care benefits are sufficient enough reason to provide the AWV, there is also a strong business case for offering this service. The current reimbursement for an initial AWV is $167.12; a subsequent AWV is $112.87. If all 23,000 Medicare patients served by the physician group had an AWV, revenue generated would be between $2.5 and $3.8 million, depending on which visit was received. Even if only 50% of the Medicare patients had an AWV, the primary care group would generate approximately $1.25 million!

The Role of Registered Nurses in Primary Care

The basis of nursing is to prevent illness and promote health (American Nurses Association (ANA), 2016). The role of nurses in primary care has expanded with the implementation of the ACA. Primary care is becoming increasingly complex, requiring chronic disease management and preventing hospitalizations, and nurses are at the forefront of care coordination and quality improvement of care (Institute of Medicine (IOM), 2011).

The Institute of Medicine (IOM) suggests that in order for patients to receive unique and personalized care, the way healthcare is delivered must be transformed. Initiatives identified under the ACA have started to transform care, however nurses in healthcare systems can help to expand this transformation. The IOM states “the nursing profession is making a wide-reaching impact by providing and affecting quality, patient-centered, accessible, and affordable care” (IOM, 2015, para. 4). The first key message of the IOM’s report The Future of Nursing: Leading Change, Advancing Health (2011) is that “nurses should practice to the full extent of their education and training” (p. 65).

Why a Registered Nurse for the Annual Wellness Visit?

The role of nursing aligns with the promises of the AWV in that screening for risk factors and chronic illness, assessing for depression, functional and fall risk, and cognitive impairment is performed. A plan to decrease present risk factors for disease and maintain well-being in light of chronic illness is created. “Health promotion, education, and assessment are essential components of primary care that are also traditional strengths of the nursing profession; these services may be provided by either registered nurses (RNs) or advanced practice registered nurses (APRNs)” (IOM, 2011, p. 55). Keeping this in mind, the registered nurse in the primary
care setting is very qualified to provide older adults with the AWV. The unique assessment skills of a registered nurse can lead to identification of “new health problems or needs” (IOM, 2011, p. 55) revealed through the AWV screening.

The second component of the AWV includes individualized planning to promote well-being, which includes education regarding risk factors, preventive medicine, referrals to community resources, and disease management. While the advanced practice registered nurse or primary care physician is also in a position to conduct the AWV, it would be more cost effective to utilize RNs to their highest level of education and training to conduct the AWV. This allows the APRN or physician to review the results of the AWV screening and intervene with the appropriate medical management. This approach uses an efficient, team approach to care.

The AWV has the ability to be the platform for identifying those appropriate for chronic care management (CCM), a reimbursable service through Medicare. In 2015, CMS identified CCM as a “critical component” (CMS, 2015b, para. 1) to the provision of primary care to Medicare beneficiaries. Chronic conditions include depression, dementia, and diseases that lead to fall risk or functional decline, such as osteoporosis, heart failure, and arthritis, which can be identified via the AWV. CCM includes a “comprehensive care plan [which is] established, implemented, revised, or monitored” (CMS, 2015b, para. 3). Patients with two or more chronic conditions work with the provider for 20 minutes each month in personalized management of their chronic conditions. CCM can lead to improved health, improved individualized care, and a decrease in healthcare spending, while increasing provider reimbursement (CMS, 2015b).

Benefits of the AWV
There are many possible benefits to offering the AWV. These include: early diagnosis and follow up of geriatric syndromes, adherence to recommended screenings and immunizations, patient goal setting for health improvement, and an interdisciplinary approach to wellness.

Benefits to the organization include improved revenue from the AWV. If health conditions are identified, subsequent appointments would incur revenue. High patient satisfaction can be attained with the visits. Offering the AWV can also be a marketing tool since this is a service that is reimbursed through Medicare and its goals align with focus of care in the office.

Implementation of AWV
A pilot implementation of the AWV with seven patients aged 70 to 80 demonstrated that one-on-one time with a RN to review patient history, identify risk factors for disease and disability, and help the patient set goals to maintain health and wellness was successful. Patient satisfaction was high in this small sample, and patients felt their needs were met through this visit.

As a result of the AWV, an average of six chronic illnesses were identified per patient that were not part of the patient’s EMR, and were updated in the chart. As a result of the medication review, five of the seven patients required the addition and/or modification of medications on their lists. The list of providers was also inaccurate on all of the patients’ records. An average of four providers per patient were updated in the EMR. While administering the
screenings for the geriatric syndromes, three patients were positive for cognitive impairment; one had a known history of dementia. The provider for the other two patients was notified. They already had follow-up visits scheduled, and the provider indicated he would address the findings at their appointments. Two patients were positive for fall risk. One patient was scheduled for home physical therapy to assess and treat balance and gait. The other patient was presently working with physical therapy.

The AWV can be used to update the patient’s chart, especially in light of the new EMR and vital information that might not have transferred from the old EMR. Utilizing a RN to screen for geriatric syndromes allows for rapid assessment and skilled follow-through to connect the patient with resources to maintain well-being.

Cost Analysis
Reimbursement

In 2015, the primary care office served 1534 Medicare patients. If each patient receives an AWV, revenue would range from $173,000 to $256,000. If each of these patients received an AWV, at least two RNs could be hired full time and produce revenue by solely focusing on the work associated with the AWV. Below is listed the type of visit along with the current reimbursement rates from Medicare.

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Reimbursement</th>
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<tbody>
<tr>
<td>Initial</td>
<td>$167.12</td>
</tr>
<tr>
<td>Subsequent</td>
<td>$112.87</td>
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</table>

RN Cost

The annual salary of a full time RN with benefits in 2015 was $75,933. The cost of a computer for use by the RN is approximately $2,000; additional monthly costs, made up of computer software, workspace, utilities, and supplies (paper, envelopes, postage) are estimated at $300/month. It is estimated that the first four weeks of employment will be general orientation, with an additional 2 weeks of time needed to schedule and prepare upcoming visits; no visits are anticipated for the first six weeks of employment. The projection is the RN will start with 5 visits per week (weeks 7-10), increase to 10 visits per week one month later (weeks 11-14), and then, by week 15 of employment, conduct 15 visits per week. With this plan, one RN can see 41% of the Medicare patients.

During the pilot AWV trial, the average time to conduct the AWV was 148 minutes, with the most time consuming portion being the chart review, and the AWV itself. As the process becomes more familiar, it is anticipated that the time to conduct the visit will decrease. At present, it is feasible to do 3 AWVs per day, per office, with 1 RN.
The return on investment for the Initial AWV comes in week 28. The second year, if all visits are Subsequent AWVs, the monthly net return is +$631.20.

**Patient Satisfaction**

Of the seven patients who completed the AWV, none of the patients reported knowing what the AWV was prior to scheduling the appointment. All patients reported that they understood what the AWV was from the phone discussion. The patients reported that the visit was easy to schedule. When asked what the patients enjoyed or did not enjoy about the AWV, patients cited the visit as being informative and enjoyable. One patient wrote that she was helped to “face the fact that I need to do something about my back pain.” Of the seven patients who completed the visit, all indicated that they planned to schedule a subsequent AWV in 12 months. The overall response to the visit was positive, with high satisfaction indicated.

**Conclusion**

Through the findings of the DNP Scholarly Project *Development of a Protocol for Implementing the Medicare Annual Wellness Visit in a Primary Care Setting*, it is the recommendation of the project director to hire a dedicated RN to conduct the AWV. Evidence shows “the nursing profession is making a wide-reaching impact by providing and affecting
quality, patient-centered, accessible, and affordable care” (IOM, 2015, para. 4). The RN has a skillset including “health promotion, education, and assessment” (IOM, 2011, p. 55), which is essential to the success of the AWV.

For more Information
Please contact Jennifer Ohman at ohmanj@mail.gvsu.edu
References


Appendix M

Medicare Annual Wellness Protocol

Medicare Annual Wellness Visit Protocol

Written by Jennifer M. Ohman BSN, RN
For use in the Primary Care Setting
Doctor of Nursing Practice Scholarly Project
April 2016
Purpose

The purpose of this protocol is to guide the user in completion of all steps of the Medicare Annual Wellness Visit (AWV) as mandated by the Centers for Medicare and Medicaid Services (CMS). This protocol encompasses the following parts of the AWV: 1) Identification of eligible patients; 2) Contacting the patient and explaining the AWV; 3) Scheduling the patient for an appointment; 4) What to do prior to the AWV; 5) Day of the AWV; and 6) Discussing findings with the patient’s provider.

This protocol is organized in a step-by-step format in order to provide consistent delivery of the visit to each patient. When available, a screenshot or an example of the designated test is included for reference.

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  Health Risk Assessment
  Geriatric Depression Scale
  Mini Cog
  Timed Up and Go
Background from CMS (2015)

The following information is not office protocol, it is only for reference. The protocol begins on page 7.

Medicare covers an Annual Wellness Visit (AWV) for beneficiaries who:

- Are not within the first 12 months of their first Medicare Part B coverage period; and
- Have not received an Initial Preventive Physical Examination (“Welcome to Medicare” visit) or AWV within the past 12 months.

There are two types of AWVs: initial and subsequent.

- Initial visit: The first time a beneficiary receives an AWV.
- Subsequent visits: Any AWV occurring after the initial AWV.

In order to meet CMS requirements for this visit, the following components are required:

Initial AWV

Acquire Beneficiary Information

- Administer the Health Risk Assessment (HRA) (Form 9.1)
  - The HRA can be completed prior to visit by patient or staff
  - Consists of
    - Demographic data
    - Self-assessment of health status
    - Psychosocial risks
    - Behavioral risks
    - Activities of Daily Living (ADLs), including, but not limited to: dressing, bathing, and walking
    - Instrumental ADLs, including, but not limited to: shopping, housekeeping, managing own medications, and handling finances

- Establish a list of current providers and suppliers
  - Include current providers and suppliers regularly involved in providing medical care to the beneficiary

- Establish the beneficiary’s medical/family history
  - Medical events in the beneficiary’s parents, siblings, and children, including diseases that may be hereditary or place the beneficiary at increased risk
  - Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments
  - Use of, or exposure to, medications and supplements, including calcium and vitamins
Medicare Annual Wellness Visit

✓ Review the beneficiary’s potential risk factors for depression, including current or past experiences with depression or other mood disorders
  o Use any appropriate screening instrument for beneficiaries without a current diagnosis of depression, which you may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations
✓ Review the beneficiary's functional ability and level of safety
  o Use direct observation of the beneficiary, or select appropriate screening questions or a screening questionnaire, from various available screening questions or standardized questionnaires recognized by national professional medical organizations to assess, at a minimum, the following topics
    ▪ Ability to successfully perform ADLs
    ▪ Fall risk
    ▪ Hearing impairment
    ▪ Home safety

Begin Assessment (NOTE: the patient does not receive a head-to-toe assessment at this visit)

✓ Assess
  o Obtain the following measurements
    ▪ Height, weight, body mass index
    ▪ Blood pressure
    ▪ Other routine measurements as deemed appropriate based on medical and family history
✓ Detect any cognitive impairment the beneficiary may have
  o Assess the beneficiary’s cognitive function by direct observation, with due consideration of information obtained via beneficiary reports and concerns raised by family members, friends, caretakers, or others.

Counsel Beneficiary

✓ Establish a written screening schedule for the beneficiary, such as a checklist for the next 5 to 10 years, as appropriate
  o Base written screening schedule on:
    ▪ Age-appropriate preventive services Medicare covers
    ▪ Recommendations from the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP)
    ▪ The beneficiary’s HRA, health status, and screening history
✓ Establish a list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or underway for the beneficiary
  o Include the following
Medicare Annual Wellness Visit

- Any mental health conditions or any risk factors or conditions identified through an IPPE
- A list of treatment options and their associated risks and benefits
- Furnish personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs
  - Includes referrals to programs aimed at
    - Community-based lifestyle interventions to reduce health risks and promote self-management and wellness
    - Fall prevention
    - Nutrition
    - Physical activity
    - Tobacco-use cessation
    - Weight loss

Subsequent AWVs

**Acquire** Update of Beneficiary History

- Update HRA
  - Collects self-reported information from the beneficiary
  - You or the beneficiary can complete the update of HRA before or during the AWV encounter
  - At a minimum, addresses the following topics:
    - Demographic data
    - Self-assessment of health status
    - Psychosocial risks
    - Behavioral risks
    - ADLs, including, but not limited to: dressing, bathing, and walking
    - Instrumental ADLs, including, but not limited to: shopping, housekeeping, managing own medications, and handling finances

- Update the list of current providers and suppliers
  - Include current providers and suppliers regularly involved in providing medical care to the beneficiary

- Update the beneficiary’s medical/family history
  - At a minimum, update and document the following
    - Medical events in the beneficiary’s parents, siblings, and children, including diseases that may be hereditary or place the beneficiary at increased risk
    - Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments
    - Use of, or exposure to, medications and supplements, including calcium and vitamins.
Medicare Annual Wellness Visit

**Begin Assessment**

- **Assess**
  - Obtain the following measurements
    - Height, weight, body mass index
    - Blood pressure
    - Other routine measurements as deemed appropriate based on medical and family history
  - Detect any cognitive impairment the beneficiary may have
    - Assess the beneficiary’s cognitive function by direct observation, with due consideration of information obtained via beneficiary reports and concerns raised by family members, friends, caretakers, or others.

**Counsel Beneficiary**

- **Update the written screening schedule for the beneficiary**
  - Base written screening schedule on
    - Age-appropriate preventive services Medicare covers
    - Recommendations from the USPSTF and the ACIP
    - The beneficiary’s health status and screening history
  - Update the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway for the beneficiary
    - Include any such risk factors or conditions identified
  - Furnish personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs
    - Includes referrals to programs aimed at
      - Community-based lifestyle interventions to reduce health risks and promote self-management and wellness
      - Fall prevention
      - Nutrition
      - Physical activity
      - Tobacco-use cessation
      - Weight loss

1 Identification of Eligible Patients

Background

Eligible patients are those who are 65 or older, have Medicare, and have not had a “Welcome to Medicare” visit or an Annual Wellness Visit (AWV) in the past 12 months.

To identify eligible patients

Review provider’s schedule, looking for patients over 65 with Medicare benefits.

✓ From the athenaNet home page
  ○ Arrow forward to find date of interest
  ○ Select applicable patient to get to patient face sheet
Medicare Annual Wellness Visit

- View insurance coverage to ensure patient is a Medicare beneficiary.
- View encounters to check for previous AWV
  - If no previous AWV conducted, then patient is to receive an INITIAL AWV
  - If previous AWV conducted, then patient is to receive a SUBSEQUENT AWV

Once patient has been deemed eligible for this visit, the next step is to contact the patient and offer the AWV.
2 Contacting the Patient and Explaining the Annual Wellness Visit

Background

Once the patient is identified as eligible for the AWV, a call should be placed to the patient to explain the visit and schedule the patient to come in for the visit. Alternately, you may discuss in person with the patient while he/she is being seen during a scheduled visit with a provider. This will be your initial contact with the patient, and a chance to explain the AWV. Realize that most patients are unaware of this visit and might have questions. Allow adequate time for discussing the AWV with the patient.

It is very common that it must be explained that the AWV is NOT a visit for a physical exam, and patients should NOT expect to see a provider unless an appointment with the provider is scheduled before or after the AWV.

Contacting the patient

Once the patient is identified as eligible for the AWV, the patient must be contacted. If you are contacting via phone, the patient’s phone number can be obtained from the face sheet.
Hello Mr./Ms.,

My name is ________________, I’m a RN working with ________________ (MD/APP) at Mercy Health Physician Partners. How are you today?

I’m calling to speak with you today about the Medicare Annual Wellness Visit, a benefit you receive as a Medicare beneficiary. Are you aware of this visit?

May I tell you about it?

There is no charge for Annual Wellness Visit, as Medicare feels meeting with a nurse every year is important. This visit is not a physical examination, but a meeting with a nurse to review your medical history, review your health risk factors, and make a personalized prevention plan to optimize your health and well-being. The visit does not include a hands-on exam or any testing that your doctor may recommend, nor does it include any discussion about any new or current medical problems, conditions, or medications. Do you have any questions for me?

We can make the appointment for any time at your convenience. If you would like to be seen before your scheduled visit with your provider, we can check for availability. At your next scheduled appointment with your provider after the wellness visit, you will be able to discuss medical problems and medications. Your usual copay will apply for your visit with the provider. May I schedule you for an appointment for this free Annual Wellness Visit with the nurse?

(If the patient is not interested, reinforce that this is a visit completely covered by Medicare and is to help maintain their health. If that patient remains uninterested, thank them for their time).

After scheduling the appointment, continue:

A part of this visit is a health information form, which I would like to mail to you to fill out. This form, called a Health Risk Assessment form, will be used to review your medical history, medications, specialists you see, and ask you more questions about your health and personal history. Please fill this out as completely as you can, and bring it with you. There is a section that asks about your vaccination and screening histories. I will add that information as I am able to from your chart. We will review the answers together and I will use it to update your chart.

Thank you so much for your time, I look forward to meeting you!
Medicare Annual Wellness Visit

Frequently Asked Questions (FAQs) Answers from CMS (2015)

Is the AWV the same as a beneficiary's yearly physical?

No. The AWV is not a “routine physical checkup” that some seniors may get every year or so from their physician or other qualified non-physician practitioner. Medicare does not cover routine physical examinations.

Are clinical laboratory tests part of the AWV?

No. The AWV does not include any clinical laboratory tests, but providers may make referrals for such tests as part of the AWV, if appropriate.

Do deductibles or coinsurance/copayments apply for the AWV?

No. Medicare waives both the coinsurance or copayment and the Medicare Part B deductible for the AWV.

3 Scheduling the Patient for an Appointment

Background

The patient should be scheduled for a 60 minute nurse visit in order to ensure all parts of the visit are completed. Ideally, the patient would be scheduled immediately prior to the scheduled provider visit, but that might not be an option due to scheduling conflicts of the patient or nurse.

To schedule the visit

✓ Select quick view on patient’s face sheet
✓ Scroll to Appointments
✓ Select schedule

✓ Do not change Resource type
✓ Choose Appointment type - Initial or Subsequent Medicare 60 minutes
✓ Choose Location - MHGR_Southwest
✓ Choose type of Visit - MGHR_SW_MCRWellness
✓ Choose the date you wish for the appointment
✓ Choose time from available slots (ensure 60 minute appointment)
✓ Patient information will populate
✓ Scroll to Notes/Reason
  - Indicate Initial AWV or Subsequent AWV
✓ Scroll to Schedule Appointment and select
✓ A new screen will open, scroll to Approve and select
4 Prior to the Patient’s Visit

Health Risk Assessment

✓ The HRA should be completed by the patient prior to the patient’s visit, as it is the most time-consuming part of the visit (See Form 9.1 for HRA).
  ○ This should be mailed to patient
  ○ Fill out any information you can gather from Athena or Next Gen Database regarding immunizations and/or screenings
✓ Cover letter to send to patient (on MHPP letterhead) enclosed with HRA

Date

Dear Mr./Ms. _______

It was a pleasure speaking with you on the phone on ________ about the Medicare Annual Wellness Visit. As a reminder, there is no charge for this visit. I have enclosed the Health Risk Assessment form which we discussed during our call. Please fill out the form to the best of your ability and please bring it to your appointment. I will use this information to update your medical record.

Please bring your medication bottles to the visit, so I can ensure there are no duplicate medications and you are taking them as prescribed. If you have completed an advanced directive form, please bring that as well, so I can add that to your medical record.

I look forward to seeing you on __________ at ________ for your Medicare Annual Wellness Visit. Please call the office at 616-685-1350 if you need to cancel or reschedule this appointment.

Sincerely,

[Name, RN]
5 Day of AWV

Supplies Needed

✓ Blood pressure cuff/stethoscope
✓ Clipboard and pen for the patient
✓ Mini-Cog
✓ Computer with mouse and power cord
✓ Exam room to use

When patient has arrived

✓ Call the patient back
✓ Introduce yourself and your role
✓ State that you will be completing the AWV with the patient
✓ Obtain height/weight/temperature/pulse ox
✓ Go to exam room

Once in the exam room

✓ Offer to take coat/jacket, etc.
✓ Allow patient to get comfortable
✓ Reinforce the reason for the visit
  o This is just a reminder that the AWV is not a physical examination. I will be meeting with you today to review your history, ask you questions related to your health and well-being, and together we will establish a plan for you to maintain your health and well-being, which I will give to you at the end of your visit. If anything of concern comes up during this visit, I will speak with your provider ________________________, and he/she will follow up with you.
✓ Allow patient to ask questions
  o Do you have any questions for me before we get started?
✓ Begin assessment (following layout in Athena)
  o Chief Complaint: AWV: Initial or Subsequent, Male or Female
    ▪ Will open template for charting
  o Confirm/Update Patient Pharmacy
  o Add Members of Care Team if patient has more than PCP
Medicare Annual Wellness Visit

### Patient’s Pharmacies

**Pharmacy**

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**Add**

- Search

**Notes**

### Patient’s Care Team

**Role**

**Member**

**Primary Care Provider**

- 2373 64TH ST SW STE 1300, BYRON CENTER, MI 49315, Ph (616) 685-1350, Fax (616) 261-7191

**Add**

- Type to search

**Notes**

- Vital Signs

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### Review with Patient (from HRA)

- Clarify if Needed
  - Past Medical History

### Past Medical History

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**Add**

**Notes**

### Medications

**Renew**

**Medication**

**Sig**

**Start Date**

**Stop Date**

**Stop Reason**

**HIDE**

**Source**

**Add**

**Default Pharmacy**

**Notes**

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**Registry Status**

**Not submitted to any registries**

**Notes**
### Medicare Annual Wellness Visit

- **Family History**
- **Social History**

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<th>Social History Templates</th>
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<tr>
<td>Cardiology</td>
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<td>Tobacco Use</td>
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<tr>
<td>Type of Tobacco</td>
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<tr>
<td>Vocational Health</td>
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<tr>
<td>Wilderness Medicine</td>
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- **Surgical History**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Surgery Date</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

- **Gyn History (if Female)**
Medicare Annual Wellness Visit

- **Screening (this MUST be done in the office)**
  - Select Geriatric Depression Scale
  - Select Mini-Cog
  - Uncheck all others
  - Screening does not imply diagnosis!

- Geriatric Depression Scale (Yesavage, 1998)
  - Read the questions on the screen aloud to the patient.
  - Choose yes or no based on patient’s response and click on score-score will be generated—see Form 9.2 for more information.
  - A score of >5 indicates that further assessment is needed and should be communicated to the provider.
**Medicare Annual Wellness Visit**

---

**Geriatric Depression Scale**
Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? ● Yes ○ No
2. Have you dropped many of your activities and interests? ○ Yes ● No
3. Do you feel that your life is empty? ○ Yes ● No
4. Do you often get tense? ○ Yes ● No
5. Are you in good spirits most of the time? ○ Yes ● No
6. Are you afraid that something bad is going to happen to you? ○ Yes ● No
7. Do you feel happy most of the time? ○ Yes ● No
8. Do you often feel helpless? ○ Yes ● No
9. Do you prefer to stay at home, rather than going out and doing new things? ○ Yes ● No
10. Do you feel you have more problems with memory than most? ○ Yes ● No
11. Do you think it is wonderful to be alive now? ○ Yes ● No
12. Do you feel pretty worthless the way you are now? ○ Yes ● No
13. Do you feel full of energy? ○ Yes ● No
14. Do you feel that your situation is hopeless? ○ Yes ● No
15. Do you think that most people are better off than you are? ○ Yes ● No

**Score**

**Guidelines**

---

- **Mini-Cog (Borson, 2016)**
  - This must be done on paper; see Form 9.3
  - Score is 0-5; enter score.
  - Make a note of what patient missed in the notes field.
  - Put the patient’s name and medical record number on the paper.
  - Put completed paper in the scan box in the copy room to be scanned into chart.
  - Scores of 4 or less indicates that further assessment is needed and should be communicated to the provider.

---

- **Review of Pertinent Information**
  - Click appropriate choices based on patient’s answer
Medicare Annual Wellness Visit

- Quality Management
  - Update with information from HRA if available
- Results/Interpretations
  - If screenings not done, click X on right upper side of box to remove
    - Hearing Screening
    - Vision Screening
    - Cognitive Behavioral Rating Scale
  - You MUST do:
  - Fall Risk Assessment
    - Timed Up and Go (Form 9.4; Centers for Disease Control and Prevention, n.d.)
      o Up and go test > 12 seconds indicates that further assessment is needed and should be communicated to the provider.
    - Answer the yes/no questions
      o En bloc turning is turning on 1 foot but taking 1-2 steps to turn versus pivot turn

### Fall Risk Assessment Result

<table>
<thead>
<tr>
<th>Variable</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Risk Assessment</td>
<td></td>
</tr>
<tr>
<td>Up &amp; Go Test &gt;12 sec</td>
<td>✔️</td>
</tr>
<tr>
<td>Slow tentative pace</td>
<td>✔️</td>
</tr>
<tr>
<td>Loss of balance</td>
<td>✔️</td>
</tr>
<tr>
<td>Short strides</td>
<td>✔️</td>
</tr>
<tr>
<td>Shuffling</td>
<td>✔️</td>
</tr>
<tr>
<td>Little or no arm swing</td>
<td>✔️</td>
</tr>
<tr>
<td>Steady self on walls</td>
<td>✔️</td>
</tr>
<tr>
<td>En bloc turning</td>
<td>✔️</td>
</tr>
<tr>
<td>Not using assistive device properly</td>
<td>✔️</td>
</tr>
</tbody>
</table>

- Functional Assessment
  - 1 for independent, 0 for dependent
  - Add total points, indicate in Result Note
  - Overall score of 6 is highly independent
  - If you discussed the result with the patient, check Discussed this result/Close
Medicare Annual Wellness Visit

**FUNCTIONAL ASSESSMENT Result**

- **ADL Assessment**
  - **Bathing**
  - **Dressing**
  - **Toileting**
  - **Transfer**
  - **Continence**
  - **Feeding**
- **Total Points** (6: High, patient independent, 0: Low-patient very dependent)
- **Result**
- **Note**

- **IADL**
  - 1 for independent, 0 for dependent
  - Add total points, indicate in Result Note
  - Overall score of 8 is highly independent
  - If you discussed the result with the patient, check Discussed this result/Close

**INSTRUMENTAL ACTIVITIES OF DAILY LIVING Result**

- **Instrumental Activities of Daily Living**
  - **Ability to use telephone**
  - **Shopping**
  - **Food Preparation**
  - **Housekeeping**
  - **Laundry**
  - **Mode of Transportation**
  - **Responsibility for own medications**
  - **Ability to handle finances**

- **Notes**

- **Assessment/Plan**
  - Z00.00 will default
  - All screenings/recommendations will fall under this code
    - Delete the following by clicking the X on right hand side of screen
      - Labwork
      - Hearing Screening
Medicare Annual Wellness Visit

- Vision Screen
- Cognitive Behavioral Rating Scale
- Education/Care Instructions NOT done
- Add the following diagnoses and order tests under other
  - Screening for depression (Z13.89)
    - Geriatric Depression Screen
  - Screening for mental disorder (Z13.89)
    - Mini-Cog

### Diagnoses and Orders Detail

1. **Adult health examination**
   - ICD-10 code: Z00.00: Encounter for general adult medical examination without abnormal findings
   - Add Orders: Most Used, Order Set, Medication, Lab, Imaging, Vaccine, DME, Surgery/Px, Referral, Patient Info, Other
   - **FUNCTIONAL ASSESSMENT** Send To: +MHGR_SOUTHWEST
   - **FALL RISK ASSESSMENT** Send To: +MHGR_SOUTHWEST
   - **FALL RISK SCREENING**
   - **INSTRUMENTAL ACTIVITIES OF DAILY LIVING** Send To: +MHGR_SOUTHWEST
   - **ADVANCE DIRECTIVES: CARE INSTRUCTIONS**

2. **Depression screening**
   - ICD-10 code: Z13.89: Encounter for screening for other disorder
   - Add Orders: Most Used, Order Set, Medication, Lab, Imaging, Vaccine, DME, Surgery/Px, Referral, Patient Info, Other
   - **GERIATRIC DEPRESSION SCREEN** Alarm: 14 days

3. **Screening for mental disorders**
   - ICD-10 code: Z13.89: Encounter for screening for other disorder
   - Add Orders: Most Used, Order Set, Medication, Lab, Imaging, Vaccine, DME, Surgery/Px, Referral, Patient Info, Other
   - **MINI-COG ASSESSMENT**

- **Goal Setting**
  - Discuss goals patient would like to accomplish in next 1 year
  - In add goal box, type the first 2-3 letters of the goal to search
  - Select appropriate goal
  - Goal will populate, fill in white boxes for further detail
Patient Instructions

- Template: MAWV Male or Female
- Will populate appropriate plan/screening
- Personalized Health Plan and Screening Recommendations
  - Choose Low, Moderate, High in each category and associated recommendation
  - Enter dates of when screenings are next due
  - Advise patient that no tests have been ordered at this time, and provider will review for appropriateness and order if necessary.
- Add tickler
  - Return for Subsequent AWV Medicare 60 in 1 year

- Print Care Plan
  - Checkout
  - Start Checkout
  - Scroll Down to Letters
  - Print and Mark Notified
Medicare Annual Wellness Visit

Coding

Ensure E & M Code is one of the following

✓ G0438: Annual wellness visit; includes a personalized prevention plan of service, initial visit
✓ G0439: Annual wellness visit, includes a personalized prevention plan of service, subsequent visit

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Modifiers (Non Fee-Affecting)</th>
<th>Units</th>
<th>Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adult health examination</td>
<td></td>
<td></td>
<td>20000, 21389, 2139</td>
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<tr>
<td>Z00.00: Encounter for general adult medical examination without abnormal findings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Depression screening</td>
<td></td>
<td></td>
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<tr>
<td>Z11.89: Encounter for screening for other disorder</td>
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<td></td>
<td></td>
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<tr>
<td>3. Screening for disorder</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Z13.9: Encounter for screening, unspecified</td>
<td></td>
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</tbody>
</table>

| Services                                      |                               |      |           |
| Procedure Code                                | Code Description               |      |           |
| Ebil                                          | G0438                          | PPPS, INITIAL VISIT |           |

Billing (CMS, 2015)

The AWV must be performed by a:

✓ Physician (a doctor of medicine or osteopathy)
✓ Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist)
✓ Medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals who are working under the direct supervision of a physician (doctor of medicine or osteopathy).

6 Discuss Findings with the Patient’s Provider

As the person performing the AWV, it is your responsibility to discuss any positive/pertinent finding with the provider in charge of the patient’s care. He/she may wish to conduct additional assessment(s) to diagnose and treat the patient or refer the patient to a specialist for further workup.

To report your finding(s) to the provider, you should discuss in person to ensure the appropriate information is received.

Below is a list of the tests with their scores and indication. Should you feel there are pertinent concerns outside of these recommendations, they should be addressed with the patient’s provider.

<table>
<thead>
<tr>
<th>Test</th>
<th>Score</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Depression Scale (Greenberg, 2012)</td>
<td>0-4</td>
<td>No depression → No follow up needed</td>
</tr>
<tr>
<td></td>
<td>5-9</td>
<td>Possible depression → Follow up needed</td>
</tr>
<tr>
<td></td>
<td>10 or greater</td>
<td>Depression → Follow up needed</td>
</tr>
<tr>
<td>Mini Cog (Doerflinger, 2013)</td>
<td>3-5</td>
<td>Negative for dementia → No follow up needed</td>
</tr>
<tr>
<td></td>
<td>2 or under</td>
<td>Positive for dementia → Follow up needed</td>
</tr>
<tr>
<td>Timed Up and Go (CDC, n. d.)</td>
<td>12 seconds or greater</td>
<td>Risk for fall → Follow up needed</td>
</tr>
<tr>
<td>Activities of Daily Living (Wallace &amp; Shelkey, 2007)</td>
<td>5-6</td>
<td>Full function → No follow up needed</td>
</tr>
<tr>
<td></td>
<td>3-4</td>
<td>Moderate impairment → Follow up needed</td>
</tr>
<tr>
<td></td>
<td>0-2</td>
<td>Severe impairment → Follow up needed</td>
</tr>
<tr>
<td>Instrumental Activities of Daily Living (Graf, 2013)</td>
<td>8</td>
<td>Full function → No follow up needed</td>
</tr>
<tr>
<td></td>
<td>1-7</td>
<td>Concern for impairment → Follow up needed</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>Severe impairment → Follow up needed</td>
</tr>
</tbody>
</table>
7 References


Medicare Annual Wellness Visit

8 Visit Flow Sheet

1. Call patient from waiting room
   - Height, Weight, Temp, Pulse Ox before rooming patient
   - Take blood pressure once patient is settled in room

2. Review HRA, completed prior to visit/enter into chart as review is completed
   - Review Social History
   - Ask questions to clarify, if needed

3. Geriatric Depression Scale
   - Mini-Cog (Cognition) on Paper
   - Review of Systems
   - Quality Management
   - Fall
   - Functional Assessment (ADLs and IADLs)

4. Assessment/Plan
   - Goal Setting with Patient
   - Patient Instructions (Include screenings/immunizations that are due or upcoming)

5. Print Plan of Care
   - Set Tickler for Subsequent AWV in 1 year
   - Bill and code for visit

6. Discuss findings in person with provider
9 Forms

9.1 Health Risk Assessment
9.2 Geriatric Depression Screen
9.3 Mini Cog
9.4 Timed Up and Go
9.1 Health Risk Assessment

Past Medical History

Please circle any of the following conditions you have.

<table>
<thead>
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<th>Cardiovascular</th>
<th>Metabolic/Endocrine</th>
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<tbody>
<tr>
<td>Abdominal Aortic Aneurysm</td>
<td>Diabetes</td>
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<tr>
<td>Arrhythmia</td>
<td>Obesity</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>Hyperparathyroidism</td>
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<td>Cardiomyopathy</td>
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<td>Carotid Disease</td>
<td>Hypothyroidism</td>
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<tr>
<td>Aneurysm</td>
<td>Vitamin Deficiency</td>
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<td>Thyroid</td>
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<td>Congestive Heart Failure</td>
<td><strong>Musculoskeletal</strong></td>
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<td>Coronary Artery Disease</td>
<td>Amputation (where)</td>
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<td>Blood Clots</td>
<td>Artificial joints (where)</td>
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<td>Low Blood Pressure</td>
<td>Back Pain</td>
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<tr>
<td>High Blood Pressure</td>
<td>Fibromyalgia</td>
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<tr>
<td>High Cholesterol</td>
<td>Gout</td>
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<tr>
<td>Hypertension</td>
<td>Leg or Foot Ulcers</td>
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<tr>
<td>Myocardial Infarction (Heart Attack)</td>
<td>Osteoarthritis</td>
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<tr>
<td>Pacemaker</td>
<td>Osteoporosis/Osteopenia</td>
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<tr>
<td>Peripheral Vascular Disease</td>
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<td>Rheumatic Fever</td>
<td>Arthritis (where)</td>
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<tr>
<td>Valvular Heart Disease</td>
<td>Other Spine/Back Problems</td>
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<tr>
<td>Varicose Veins</td>
<td><strong>Neurological</strong></td>
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<tr>
<td>Other Heart Condition</td>
<td>Brain Injury</td>
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<tr>
<td><strong>Gastrointestinal</strong></td>
<td>Carpel Tunnel</td>
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<tr>
<td>Acid Reflux (GERD)</td>
<td>Cerebral Palsy</td>
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<tr>
<td>Cirrhosis</td>
<td>Encephalitis</td>
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<tr>
<td>Pancreatitis</td>
<td>Epilepsy/Seizures</td>
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<tr>
<td>Constipation</td>
<td>Head Injury/Concussion</td>
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<tr>
<td>Chron’s Disease</td>
<td>Headaches</td>
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<td>Diverticulitis</td>
<td>Migraines</td>
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<td>Liver Disease</td>
<td>Multiple Sclerosis</td>
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<td>Neuropathy</td>
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<td>Peptic Ulcer Disease</td>
<td>TIA/Stroke</td>
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<td>Hepatitis</td>
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<td>Breast Cancer</td>
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<td>Bedwetting</td>
<td>Colon Cancer</td>
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<td>Bladder or Kidney Problems</td>
<td>Lung Cancer</td>
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<td>Chronic Kidney Disease</td>
<td>Ovarian Cancer</td>
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<td>Dialysis</td>
<td>Prostate Cancer</td>
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<td>Enlarged Prostate</td>
<td>Uterine Cancer</td>
</tr>
<tr>
<td>Blood in Urine</td>
<td>Other Cancer (Type)</td>
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<tr>
<td>Incontinence</td>
<td>Ophthalmology (Please write in)</td>
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<tr>
<td>Proteinuria</td>
<td>Psychiatric</td>
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<tr>
<td>Recurrent Urinary Tract Infections</td>
<td>ADD/ADHA</td>
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<tr>
<td>Other Kidney Problems</td>
<td>Alcohol Overuse/Abuse</td>
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<td>HEENT</td>
<td>Anxiety Disorder</td>
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<td>Chronic Ear Infections</td>
<td>Autism Spectrum Disorder</td>
</tr>
<tr>
<td>Eye Injuries</td>
<td>Behavior Problems</td>
</tr>
<tr>
<td>Eye Exposure to chemicals/toxins</td>
<td>Dementia/Alzheimer’s</td>
</tr>
<tr>
<td>Wears glasses/contacts</td>
<td>Depression</td>
</tr>
<tr>
<td>Macular degeneration</td>
<td>Eating Disorder</td>
</tr>
<tr>
<td>Amblyopia (lazy eye)</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Cataracts</td>
<td>Learning Disorder</td>
</tr>
<tr>
<td>Diabetic retinopathy</td>
<td>Mental Illness</td>
</tr>
<tr>
<td>Strabismus (crossed eye)</td>
<td>Schizophrenia</td>
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<tr>
<td>Hearing Loss</td>
<td>Substance Abuse</td>
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<td>Nasal or Sinus Problems</td>
<td>Reproductive</td>
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<td>Vertigo</td>
<td>Abnormal Pap Smear</td>
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<td>Abnormal Uterine Bleeding</td>
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<td>Infertility</td>
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<td>Anticoagulation Therapy</td>
<td>PCOS</td>
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<td>Bleeding Disorder</td>
<td>Pre-Eclampsia</td>
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<td>Blood Disorders</td>
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<td>Immunologic</td>
<td>Asthma</td>
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<td>AIDS/HIV</td>
<td>Chronic Bronchitis</td>
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<td>Allergies/Hay fever</td>
<td>COPD</td>
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<td>Autoimmune Disease</td>
<td>Cystic Fibrosis</td>
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</table>
# Medicare Annual Wellness Visit

<table>
<thead>
<tr>
<th>Condition</th>
<th>Other Condition</th>
</tr>
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<tbody>
<tr>
<td>Chicken Pox</td>
<td>Emphysema</td>
</tr>
<tr>
<td>Food Allergy</td>
<td>Lung Mass</td>
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<tr>
<td>Hives</td>
<td>Sleep Apnea</td>
</tr>
<tr>
<td>Immune System Disorder</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Lupus</td>
<td>Smoker</td>
</tr>
<tr>
<td>Lyme Disease</td>
<td><strong>Other</strong></td>
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<tr>
<td>MRSA/VRE</td>
<td>Abuse/Domestic Violence</td>
</tr>
<tr>
<td>Organ Transplant</td>
<td>Anesthesia Complications</td>
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<tr>
<td><strong>Integumentary</strong></td>
<td>Birth Defects of Inherited Disease</td>
</tr>
<tr>
<td>Acne</td>
<td>Developmental Problems</td>
</tr>
<tr>
<td>Eczema</td>
<td>Frequent Falls</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>Sinus Problems</td>
</tr>
<tr>
<td></td>
<td>Appetite Change</td>
</tr>
</tbody>
</table>

## Other Physicians Seen (Eye Doctor, Specialists, etc.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone Number</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
### Medicare Annual Wellness Visit

#### Allergies

<table>
<thead>
<tr>
<th>Name of Item Allergic To</th>
<th>Reaction (Upset stomach, hives, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

#### Current Medications (please bring ALL medication bottles to visit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
### Vaccinations

<table>
<thead>
<tr>
<th>Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>Annually</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>If over 65, once. If received vaccine more than 5 years before turning 65, 2nd one required.</td>
</tr>
<tr>
<td>Shingles (Zoster)</td>
<td>Once after age 60</td>
</tr>
<tr>
<td>Tdap</td>
<td>Once, then Td booster every 10 years</td>
</tr>
</tbody>
</table>

### Family History

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Problem(s)</th>
<th>Deceased (Age), Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling (Brother/Sister)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling (Brother/Sister)</td>
<td></td>
<td></td>
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<tr>
<td>Sibling (Brother/Sister)</td>
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<td></td>
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<tr>
<td>Sibling (Brother/Sister)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling (Brother/Sister)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Medicare Annual Wellness Visit

<table>
<thead>
<tr>
<th>Relative</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Grandmother</td>
<td></td>
</tr>
<tr>
<td>Maternal Grandfather</td>
<td></td>
</tr>
<tr>
<td>Paternal Grandmother</td>
<td></td>
</tr>
<tr>
<td>Paternal Grandfather</td>
<td></td>
</tr>
</tbody>
</table>

### Surgical History

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>
### Gyn History (if Female)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LMP</td>
<td></td>
</tr>
<tr>
<td>Age at first child</td>
<td></td>
</tr>
<tr>
<td>Age at menarche</td>
<td></td>
</tr>
<tr>
<td>If post-menopausal, Age at menopause</td>
<td></td>
</tr>
<tr>
<td># Pregancies</td>
<td></td>
</tr>
<tr>
<td># Miscarriages</td>
<td></td>
</tr>
<tr>
<td># Deliveries</td>
<td></td>
</tr>
</tbody>
</table>

### Screenings

<table>
<thead>
<tr>
<th>Exams</th>
<th>Date Completed</th>
<th>How Often</th>
<th>Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Exam</td>
<td></td>
<td>6 months</td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td></td>
<td>Yearly</td>
<td></td>
</tr>
<tr>
<td>Foot exam (if Diabetic)</td>
<td></td>
<td>Yearly</td>
<td></td>
</tr>
<tr>
<td>Physical Exam</td>
<td></td>
<td>Yearly</td>
<td></td>
</tr>
<tr>
<td>Subsequent AWV</td>
<td></td>
<td>Yearly</td>
<td></td>
</tr>
<tr>
<td>Abdominal Ultrasound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Men ages 65-75 years old who have ever smoked)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone Density (Female)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EKG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic Exam/PAP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- Abdominal Ultrasound: Once
- Bone Density (Female): Bi-annually
- Colonoscopy: Every 10 years until 75, unless previous test indicates different frequency.
- EKG: As needed
- Mammogram: Every 2 years until age 75.
- Pelvic Exam/PAP: PAP not indicated over 65 if 3
### Medicare Annual Wellness Visit

<table>
<thead>
<tr>
<th></th>
<th>negative tests in past 10 years.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Labs</strong></td>
<td></td>
</tr>
<tr>
<td>A1C (for Diabetics)</td>
<td>1-2 times per year if diabetic</td>
</tr>
<tr>
<td>Fasting Glucose</td>
<td>Every 3 years if normal. Every 1-2 years if abnormal.</td>
</tr>
<tr>
<td>Lipids</td>
<td>Every 5 years if normal. Every 1-2 years if presence of diabetes, cardiac disease, kidney problems, high cholesterol</td>
</tr>
<tr>
<td>PSA (men)</td>
<td>Not required if asymptomatic</td>
</tr>
<tr>
<td>TSH</td>
<td>If disease is suspected</td>
</tr>
</tbody>
</table>
9.2 Geriatric Depression Scale

**GERIATRIC DEPRESSION SCALE (SHORT VERSION)**

<table>
<thead>
<tr>
<th>No.</th>
<th>Questions</th>
<th>Answer</th>
<th>Test Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Are you basically satisfied with your life?</td>
<td>Yes/No</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Have you dropped many of your activities or interests?</td>
<td>Yes/No</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Do you feel that your life is empty?</td>
<td>Yes/No</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Do you often get bored?</td>
<td>Yes/No</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Are you in good spirits most of the time?</td>
<td>Yes/No</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>Are you afraid that something bad is going to happen to you?</td>
<td>Yes/No</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Do you feel happy most of the time?</td>
<td>Yes/No</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>Do you feel helpless?</td>
<td>Yes/No</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>Do you prefer to stay at home, rather than go out and do things?</td>
<td>Yes/No</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>Do you feel that you have more problems with memory than most?</td>
<td>Yes/No</td>
<td>Yes</td>
</tr>
<tr>
<td>11</td>
<td>Do you think it is wonderful to be alive now?</td>
<td>Yes/No</td>
<td>No</td>
</tr>
<tr>
<td>12</td>
<td>Do you feel pretty worthless the way you are now?</td>
<td>Yes/No</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>Do you feel full of energy?</td>
<td>Yes/No</td>
<td>No</td>
</tr>
<tr>
<td>14</td>
<td>Do you feel that your situation is hopeless?</td>
<td>Yes/No</td>
<td>Yes</td>
</tr>
<tr>
<td>15</td>
<td>Do you think that most people are better off than you are?</td>
<td>Yes/No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Total Score**

*The right hand column shows test answers which are positive for depression.*

9.3 Mini-Cog

Mini-Cog™
Instructions for Administration & Scoring

ID: __________ Date: __________

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies. For repeated administrations, use of an alternative word list is recommended.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Banana</td>
<td>Leader</td>
<td>Village</td>
<td>River</td>
<td>Captain</td>
<td>Daughter</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Saason</td>
<td>Kitchen</td>
<td>Nation</td>
<td>Garden</td>
<td>Heaven</td>
</tr>
<tr>
<td>Chair</td>
<td>Saison</td>
<td>Baby</td>
<td>Finger</td>
<td>Picture</td>
<td>Mountain</td>
</tr>
</tbody>
</table>

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: _____ Person's Answers: __________________________

Scoring

| Word Recall: _____ (0-3 points) | 1 point for each word spontaneously recalled without cuing. |
| Clock Draw: _____ (0 or 2 points) | Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:20). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points. |
| Total Score: _____ (0-5 points) | Total score = Word Recall score + Clock Draw score. A cut point of ≤3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of ≤2 is recommended as it may indicate a need for further evaluation of cognitive status. |

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v. 0.1.13.15
Medicare Annual Wellness Visit

Clock Drawing

ID: __________  Date: __________

References


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9.4 Timed Up and Go

The Timed Up and Go (TUG) Test

**Purpose:** To assess mobility

**Equipment:** A stopwatch

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

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

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

**Time:** _______ seconds

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

Observe the patient’s postural stability, gait, stride length, and sway.

**Circle all that apply:** Slow tentative pace □ Loss of balance □ Short strides □ Little or no arm swing □ Steadying self on walls □ Shuffling □ En bloc turning □ Not using assistive device properly

**Notes:**

For relevant articles, go to: [www.cdc.gov/injury/STEADI](http://www.cdc.gov/injury/STEADI)