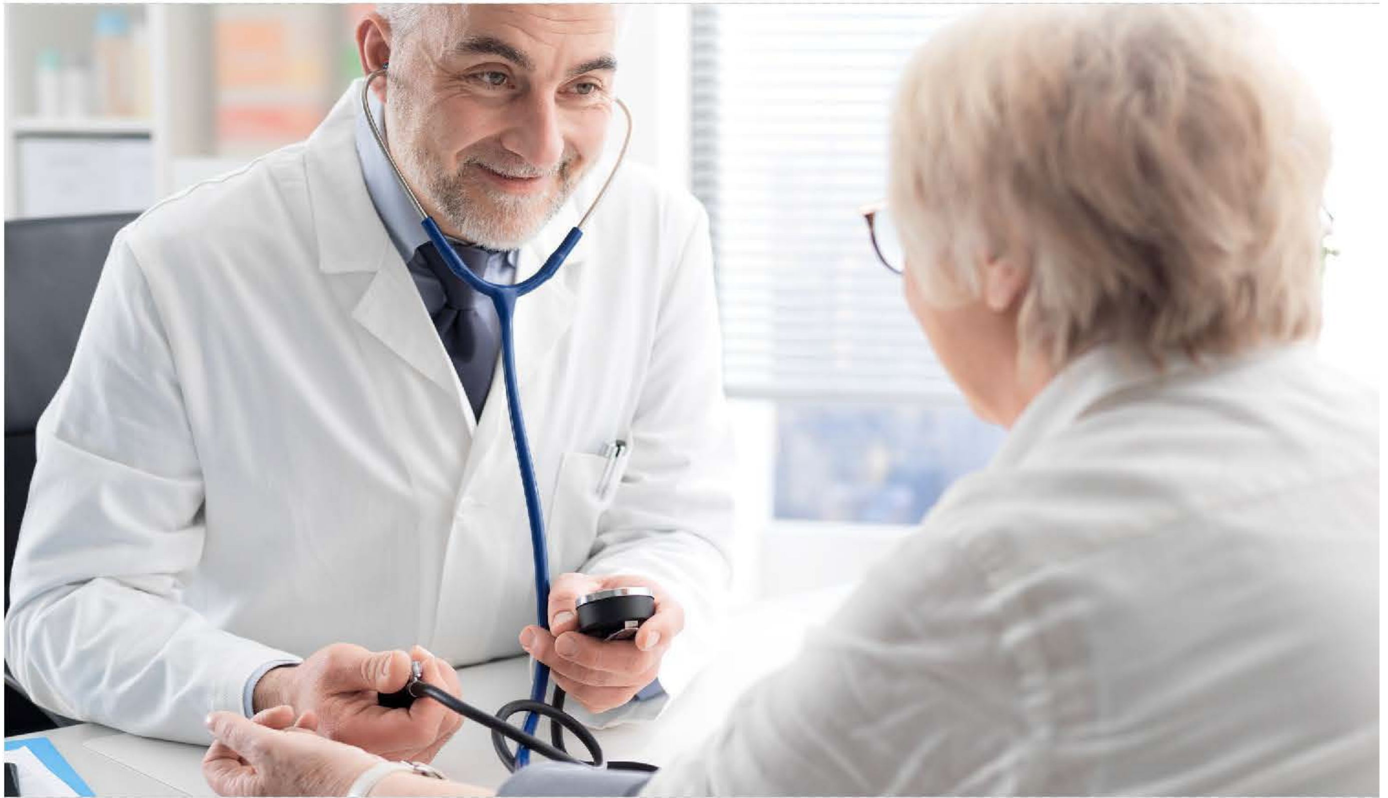

# *Yearly Visit Toolkit*

**Keeping patients healthy is the number one goal. Yearly visits allow the health care team and the patient to be proactive with the patient's health care needs.**

Bryan Health Connect ACO LLC

300 S 68th St. Pl., Ste 501
Lincoln, NE 68510
402-483-8891
bryanhealth.com/connect

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This toolkit was created to assist in establishing consistent yearly visits in your practice for all patients. The toolkit offers information on education and resources for different aspects of a yearly visit while considering various patterns of clinic workflow.

As the toolkit's intent is to have all patients' yearly visits in mind, there are specific Medicare requirements that have to be put into your workflows and practice.


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## ►Why Yearly Visits with Primary Care are Important

Keeping our patients healthy is our number one goal. Yearly visits provide the opportunity for the health care team to build a complete medical history/picture of their patients. This allows the health care team to build and strengthen their relationship with their patient. Having a yearly visit allows the health care team and the patient to be proactive with the patients' health care needs.

Yearly visits are covered by Medicare and other insurance providers and have no out-of-pocket costs to the patient. Providing yearly visits to your patients provides the opportunity for the patient to have early disease detection and prevention. Visits will assist elderly patients in staying in their homes longer and having their wishes understood and met when it comes to their needs and at end of life.

Providing yearly visits assist organizations in being successful in value-based agreements. Visits allow for providers to be successful in quality programs focused on immunizations, blood pressure, tobacco cessation, preventative services, fall assessments and medication reconciliation. The effects of a successful yearly visit program will assist in decreasing overall health care costs for the population by reducing ER visits and readmissions and reduction in duplicative services and unnecessary care.

## ►Who Can Provide an Annual Wellness Visit for Medicare

A physician, a non-physician provider and any medical professional or team member that is working under direct supervision of a physician. Special considerations if providing this service in a Rural Health Clinic or FQHC setting.

## ►Establishing AWV and Yearly Visits in Practice

**Education and Groundwork**

- Does the health care team know:
  - Key aspects of an AWV
  - The difference between Medicare and Medicare Advantage
  - The different AWV visits and requirements
  - Education and scripting to provide to patients
  - Workflows and resources for AWV
- Establish staff and provider champions to support program
- Involve scheduling, front desk, care management, staff nurse, providers, coders, HIM and IT to build a successful program

**Establish Your Why**

- Why are AWV and yearly visits important to your organization?
- Why are AWV and yearly visits important to your patients?
- Why are AWV and yearly visits important to your staff and providers?

**Establish a Benchmark**

- Total patients attributed
- Total AWVs/yearly visits completed in the last 12 months
- Percentage of completion
- Target percentage of completion each year
- Number of AWVs/yearly visits per week to reach target percentage

- Number of AWVs/yearly visits per week per provider to reach target percentage
  Example:

| Attributed Patients for Current Year | AWV/Yearly Visits Previous Year | Completion Rate Previous Year | Target Completion Rate for Current Year | Visits per Week to Reach Current Year Goal |
|---|---|---|---|---|
| | | *Total completed visits/Total Attribution* | | *(Total Attribution * Target Completion Rate)/52 weeks in the Year* |
| 1,000 | 400 | 40% | 65% | 13 |

## ►Plan for Who Will Complete Components of AWV

**Matrix for Staff Responsibilities**

| Assessment/task | MA | Nurse | Provider | Other |
|---|---|---|---|---|
| Vitals | | | | |
| Current providers and suppliers | | | | |
| Medical and family history | | | | |
| Review HRA with patient | | | | |
| Screenings<br>• Cognitive<br>• Hearing<br>• Vision | | | | |
| Assess potential risk factors<br>• Depression<br>• Fall<br>• Safety | | | | |
| Capture HRA in EMR | | | | |
| Generate preventative plan | | | | |
| Who will give to patient | | | | |

## ►Getting Patients In

**Innovative Ways to Schedule**

- Schedule next appointment during checkout
  - Nurse to schedule appointment when checking patient out
  - Nurse to direct patient to front desk to schedule next AWV/yearly visit
    - Front desk staff prepared to schedule next visits
    - Signage directing patients to front desk
- Scripting when communicating with patients for scheduling yearly visits
  - See Scripting in the Staff & Provider Resources section located on page 8
- Block off schedules for AWVs
- Scheduling done via
  - Staff
  - Phone
  - Portal
  - In-person

**Innovative Ways to Encourage Patients**

- Reminder email
  - Quick link in email to schedule visit
- Provide education on importance of yearly visits
  - Reminders and discussions at all acute visits by staff and providers
    - Messaging to educate and encourage the patient on the importance of receiving an AWV/yearly visit
  - Radio spots
  - Newspaper ads
  - Social media
  - TV advertisements in waiting areas
  - Fliers in waiting areas and exam rooms
  - Education and information at senior centers or area on aging
  - Pop-up education booths
    - Set up at facility entrance
    - Provide educational materials
    - Answer questions
    - Have the ability to schedule appointments
- Yearly postcard mailings
  - Send out during birthday month
  - Every year at the beginning of the year
  - See resource in Tools and Resources
- Encouragement by provider and rest of health care team
  - During other scheduled visits
  - Phone call reminders for patients not scheduled
- Identify patients that will be Medicare eligible in the next few months to get their initial AWV visit scheduled
  - Process for outreach established
    - Postcard mailers
    - Letters
    - Phone calls
      - Live
      - Automated
    - Portal message
- Refer to monthly AWV/HCC worklist from Bryan Health Connect for patients due for yearly visit

## ▶ Pre-Visit Planning

- Check Health Maintenance for AWV/yearly visit status
- Forms and assessments sent to patient to fill out prior
    - Fill out in waiting room on IPAD
    - Sent via patient portal
    - Paper forms mailed to home or sent with patient when scheduled
    - Information provided to patient on how to fill out paperwork
        - Why the forms and information are important
        - Contact information if they have questions or difficulty with filling out paperwork
- Identify gaps
    - Preventative screenings due
    - See Pre-Visit Planning Checklist located on page 13

## ▶ Visit

- How will AWV/yearly visit be completed?
    - In-person
    - Partial over the phone
    - Forms for patient to fill out
    - Electronically
- Preventative screenings and testing
    - Scheduled during visit or prior to visit
        - Ensure completion
        - Process for incomplete referrals
            - Patient reminders
            - Phone calls
- Advance Care Planning
- Decrease time of actual visit
    - Phone call prior to visit to do history, screenings and planning

## ▶ Action Plan

- Provide a patient with a copy of their follow-up or action plan via portal or printed copy
    - Concerns addressed during visit and a plan to address them
    - Schedule for screenings or tests
    - List of risk factors and conditions and appropriate interventions addressing them
    - Any referrals to providers or services submitted

# Coding & Billing Considerations

## ►Coding and Billing Considerations for Annual Wellness Visit

**Medicare**

- Success of coding and billing AWV in the past
    - Assessment of issues prior on barriers
        - Medicare secondary, Commercial primary
        - Commercial denies AWV and doesn't send to Medicare
- IPPE, Initial AWV, Subsequent AWV
- Rural vs Urban
    - Rural
        - Unable to bill for an E&M visit same day as AWV
        - Provider has to provide face to face encounter of AWV
        - See more resources in References located on page 20
    - Urban
        - Able to bill E&M visits 99201-99215 on same day as AWV
        - Able to have a clinician provide AWV with provider oversight
- Specifics and requirements for staff completion
- Must submit a diagnosis code when submitting AWV claim
    - No specific code required, can submit consistent with visit
    - Use Z00.00 encounter for general adult medical exam without abnormal findings if no other diagnosis code appropriate
- Co-pays for additional services provided to patients
- Able to code for Advanced Care Planning during AWV with codes 99497-99498
    - Rural unable to bill this E&M code during AWV
    - If billing Advance Care Planning outside of AWV patient will be subject to co-pays

## ►Coding and Billing Considerations for Yearly Wellness Visit

**Commercial**

- Success of coding and billing AWV in the past
    - Assessment of issues prior on barriers
        - Medicare secondary, Commercial primary
            - Commercial denies AWV and doesn't send to Medicare
            - Need to work with Commercial insurance to send AWV claim on to Medicare
- Co-pays for additional services for patients

# Staff & Provider Resources

## ►Staff Education

- **Medicare Annual Wellness Visit Webinars**
  Provides an overview and education or staff and providers about the importance of and the requirements for Medicare Annual Wellness Visits. Offered in a condensed overview and an in-depth review

- **Medicare Annual Wellness Visits-Basics**
  Handout (one-page) that provides education to staff and providers in of the requirements from Medicare for each of the Medicare Wellness Visits. AWV education resource

## ►Patient Education

- **Medicare Annual Visit**
  A one-page handout that provides a question and answer format to patients of the importance, benefits, and components of receiving their Medicare Annual Wellness Visits. Patient handout

- **Time for Your Annual Visit**
  A postcard reminder to mail out to any patient to remind them to schedule their yearly visit. Provides high-level information of the importance and components of a yearly visit. Postcard mailer

- **Annual Wellness Visit Refusal Letter**
  A letter template that can be used in an EMR or as a mailer to encourage patients that have refused or are unsure about receiving or scheduling their Medicare Annual Wellness visit. Letter

# Scripting

**All staff who interact with patients or caregivers associated with AWVs should be able to communicate these concepts**.

- (Your doctor) wants you to have this. Through wellness visits, we can help you stay healthy, prevent problems, and make sure you are up to date on screenings so we can catch any health problems you might have early.
- This is a Medicare benefit that is free to you – but only the wellness visit itself. If you need regular care in addition to the wellness visit, your usual co-pay applies.
- In a wellness care visit, we review your health, things that may be affecting your health and prevention services. We make a plan together to maintain your health and to stay current with preventive care and screenings. **Edit depending on your staffing model:** (Our nurse), under the supervision of (your doctor) may perform most, or even all, of the wellness care visit.
- There is no physical examination involved. We use information from your medical history and from a health risk assessment form that we'll ask you to fill out in advance to inform our conversation with you during this visit.
- If you happen to be ill when you have your visits scheduled, we may decide to reschedule your Wellness Visit to another day in order to focus on your more immediate health needs.

## ►Scripting for Scheduling an AWV in Certain Circumstances

- **A patient calls to reschedule or schedule a follow-up appointment**
  *I see that you have Medicare and you have not had a Medicare Wellness Visit in the past year. We are pleased to offer this Medicare free benefit called the Medicare Wellness Visit. This is a great opportunity for you and your provider to make a plan on how to stay healthy and well. During the visit your health care team will talk with you about your medical history, your current health, and your risk for certain illnesses and injuries. Before you leave, you will be given a personalized prevention plan that you and your provider think will help you stay healthy. There is no charge for the Wellness Visit. If you do have health issues that need to be addressed at the same time, you may be responsible for coinsurance and a Part B deductible would apply. What is a good day and time for you?*
- **A patient calls because of information they received about Welcome to Medicare or Annual Wellness Visit**
  *Thank you for calling. I would be happy to schedule your Medicare Wellness Visit. What is a good day and time for you?*

- **Converting routine follow-up visits to Medicare Wellness Visits**
  *Hello Mr./Mrs./Ms.______________, I see you have a follow-up appointment scheduled with Dr. __________________ on (Date) _______. Your Primary Care Provider _______________ noticed that you are due for a Medicare Wellness Visit and wanted me to share that he/she would like to see you for your yearly Wellness Visit. This is a great opportunity for you and your provider to make a plan on how to stay healthy and well. During the visit your health care team will talk with you about your medical history, your current health, and your risk for certain illnesses and injuries. Before you leave you will be given a personalized prevention plan that you and your provider think will help you stay healthy. There is no charge for this Wellness Visit. If you do have health issues that need to be addressed at the same time, you may be responsible for coinsurance and a Part B deductible would apply. Would you like me to schedule your Wellness Visit or add the visit to your upcoming appointment?*

## ►Mailers

- **Yearly visit postcard**
- **Letter for patient who has refused**

## ► Pre-Visit Planning Checklist

**Pre-visit planning checklist for opportunities to improve your patient's overall health and wellness.**

| Opportunity | Specifics and Requirements | Care Plan/Action |
| --- | --- | --- |
| Yearly Visits | ☐ Patient scheduled for yearly visit/physical-Commercial, Medicaid and Self-pay<br>☐ Annual Wellness Visit-Medicare | ☐ Schedule next yearly wellness visit/exam at this year's completion of visit and follow-up<br>☐ If unable to schedule, have a set up for a reminder to go out in advance of needed appointment |
| Immunizations | ☐ Influenza immunization (if seen between October 1 and March 31)<br>• *Exceptions*: documented allergy or patient declines<br>• *All ages > 6months*<br><br>☐ Pneumococcal – (Ages >65 unless high risk comorbid condition in 19-64 yrs old)<br><br>☐ HPV – (Ages 9-13 complete series prior to 13th birthday )<br><br>☐ TDap – (Ages 10-13 complete prior to 13th birthday. Every 10 years for adults)<br><br>☐ Meningococcal (Ages 11-13 complete prior to 13th birthday. Additional doses for patients at high risk for meningococcal disease) | ☐ Schedule next immunization If unable to do so, set up for a reminder to be sent prior to October 1<br>☐ If received doses that are not PPSV 23 schedule next does at least 8 weeks to 1 year depending on patient health status<br>☐ If patient received dose prior to 65 scheduled next dose in the next 5 years<br>☐ After 1st dose schedule next dose provide education on importance of completing<br>☐ Provide education on importance of receiving doses every 10 years<br><br>☐ Set reminder to patient to complete<br><br>☐ Assess patients for risk of disease<br><br>☐ Provide vaccination if at high risk |
| Frequent ED visits or hospitalizations | ☐ Assess for qualification for TCM visit<br><br>☐ Assessments and follow-ups to patient to provide needed services, education and resources | ☐ Refer to Care Management services<br><br>☐ Assess access to care<br><br>☐ Provide education on appropriate level of care<br><br>☐ Complete TCM visit<br><br>☐ Complete Advanced Care Planning if continued readmissions or ED |
| Blood Pressure/ Cardiovascular | ☐ Controlling high blood pressure BP < 140/90 for ages 18-85 | ☐ BP abnormal<br>• Lifestyle management<br>• Medication adjustment<br>• Pharmacy consult<br>• Care Management referral<br>• Routine follow-up scheduled until normal BP<br>☐ Advance Care Planning |

| Opportunity | Specifics and Requirements | Care Plan/Action |
|---|---|---|
| Blood Pressure/<br>Cardiovascular | ☐ Statin therapy<br>Patients 21 years and older with atherosclerotic cardiovascular disease or abnormal cholesterol screening | ☐ Abnormal cholesterol screening<br>• Lifestyle management<br>• Cardiac rehab<br>• Medication management<br>• Pharmacy consult<br>• Care management referral<br>• Routine follow-up scheduled<br>☐ Advance Care Planning |
| Diabetes | ☐ Hgb A1C | ☐ Value > than 8.0%<br>• Diabetic educator referral<br>• Pharmacy consult<br>• Lifestyle management<br>• Medication adjustment<br>• Care Management referral<br>• Routine follow-up scheduled<br>• Advance Care Planning |
| | ☐ Diabetic eye exam (Ages 18-75) | ☐ No eye exam on file<br>• Obtain current eye exam<br>• Referral to eye specialist<br>• If able, complete eye exam in clinic<br>• Provide education to patient on importance of consistent eye exams |
| | ☐ Kidney Health evaluation (Ages 18-85) | ☐ Ensure GFR and urine albumin are completed |
| | ☐ Statin therapy (Ages 40-75 patients without atherosclerotic disease) | ☐ Diabetic educator referral<br>• Pharmacy consult<br>• Lifestyle management<br>• Medication adjustment<br>• Care Management referral<br>• Routine follow-up scheduled<br>• Advance Care Planning |
| Breast Cancer Screening | ☐ Yearly mammogram (Ages 50-74) | ☐ Provide education and support to patient on importance of yearly screening<br>☐ Order mammogram and ensure completion<br>☐ Order following year's mammogram or ensure notification for reminder to schedule<br>☐ Provide written preventative screening schedule |
| Colorectal Cancer Screening | ☐ Cologuard®<br>☐ Colonoscopy<br>☐ FIT test | ☐ Provide education and support to patient on importance of screening<br>☐ Referral to appropriate screenings<br>☐ Order or set reminder for next screening<br>☐ Provide written preventative screening schedule |

| Opportunity | Specifics and Requirements | Care Plan/Action |
|---|---|---|
| Cervical Cancer Screening | ☐ Pap (Ages 21-64) | ☐ Provide education and support to patient on importance of screening<br>☐ Referral to appropriate screening<br>☐ Order or set reminder for next screening<br>☐ Provide written preventative screening schedule |
| Other Screenings | ☐ Prostate Cancer screening<br>☐ Hepatitis C and HIV<br>☐ Screening for AAA | |
| Medication Reconciliation | ☐ Review medication appropriateness and compliance | ☐ Pharmacy consult<br>☐ Care management referral<br>☐ Medication management |
| Active diagnosis reconciliation | ☐ Review active diagnosis | ☐ Document and reconcile appropriate active diagnosis |
| Health care provider list reconciliation | ☐ Review current health care providers | ☐ Update patient list of current health care team |
| Depression screening and follow-up or other mental health needs | ☐ At least yearly standardized depression screening (Ages 12 and older) (PHQ-2 or 9 for example) | ☐ Positive screening<br>• Referral to mental health provider/professional<br>• Medication management<br>• Create a mental health plan with patient<br>• Schedule follow-up after intervention to check status |
| Fall screening | ☐ At least yearly mobility assessment<br>☐ At least yearly fall risk screen | ☐ Concerns for fall and safety<br>• Home safety evaluation<br>• Care management referral<br>• Fall risk program<br>• Referral to physical therapy |
| BMI <18 or >24.9 | ☐ BMI at least yearly | ☐ Abnormal<br>• Referral to Registered Dietician or nutritional therapy and education<br>• Provider counseling<br>• Care Management referral |
| Cognitive Screening | ☐ Screening at least yearly (SLUMS or Mini-Cog, for example) | ☐ Abnormal<br>• Referral for full cognitive evaluation<br>• Care Management referral |
| Hearing Screening | ☐ Screening at least yearly | ☐ Inspection of ear canal to detect cerumen impaction<br>☐ Hearting test ordered<br>☐ Assistance with hearing device if needed |
| Vision Screening | ☐ Screening at least yearly | ☐ Ophthalmology referral |

| Opportunity | Specifics and Requirements | Care Plan/Action |
|---|---|---|
| Advance Care Planning | ☐ Advance Care Plan on file<br>☐ Discussed at least yearly | ☐ Care Management referral<br>☐ Other referral as needed |
| Substance Abuse Screening including Opioid Use | ☐ Screening at least yearly (TAPS Tool, for example) | ☐ Provider counseling<br>☐ Mental health or substance abuse Counseling referral<br>☐ Care Management referral<br>☐ Rehabilitation treatment referral<br>☐ Pain Management Care Plan |
| Bone Density Screening | ☐ Every 2 years for at risk patients | ☐ Medication treatment<br>☐ Referral to physical therapy |
| Social Determinants of Health Screening | ☐ Screening at least yearly | ☐ Care Management referral |
| Tobacco use screening and cessation | ☐ Screening at least yearly | ☐ Tobacco cessation education<br>☐ Referral to Quit Now<br>☐ Care Management referral<br>☐ Provider counseling |

## ▶ Health Risk Assessment Example

| **Physical Activity** |
|---|
| In the past 7 days, how many days did you exercise? _________ days |
| On the days when you exercised, for how long did you exercise (in minutes)? _________ minutes per day<br>☐ Does not apply |
| How intense was your exercise?<br>☐ Light (like stretching or slow walking<br>☐ Moderate (like brisk walking)<br>☐ Heavy (like jogging or swimming)<br>☐ Very heavy (like running fast or stair climbing)<br>☐ I am currently not exercising |
| **Tobacco Use** |
| In the past 30 days, have you used tobacco? Smoked:<br>☐ Yes<br>☐ No |
| Used a smokeless tobacco product?<br>☐ Yes<br>☐ No<br><br>If yes to either, would you be interested in quitting tobacco use within the next month?<br>☐ Yes<br>☐ No |
| **Alcohol Use** |
| In the past 7 days, how many days did you drink alcohol? _______ days |
| On days when you drank alcohol, how often did you have alcoholic drinks on one occasion? _________<br>(5 or more for men, 4 or more for women and those men and women 65 years old or over)<br>☐ Never<br>☐ Once during the week<br>☐ 2-3 times during the week<br>☐ More than 3 times during the week |
| Do you ever drive after drinking or ride with a driver who has been drinking?<br>☐ Yes ☐ No |
| For a patient with current opioid prescription: Review their potential opioid use disorder (OUD) factors. Evaluate their pain severity and current treatment plan. Provide information on non-opioid treatment options. Refer to a specialist as appropriate. |
| **Nutrition** |
| In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables or 1 medium piece of fruit. 1 cup = size of a baseball.<br>________ servings per day |
| In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day?<br>(1 serving = slice of 100% whole wheat bread, 1 cup of whole grain or high fiber ready-to-eat cereal, ½ cup of cook cereal such as oatmeal, or ½ cup of cooked brown rice of whole wheat pasta.) _________ servings per day |
| In the past 7 days, how many servings of fried or high fat foods did you typically eat each day?<br>(Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressing and foods made with whole milk, cream or mayonnaise) __________ servings per day |
| In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?<br>____________ Sugar-sweetened beverages consumed per day |

## Seat Belt Use

Do you always fasten your seat belt when you are in a car?

- ☐ Yes
- ☐ No

## Depression

In the past 2 weeks, how often have you felt down, depressed or hopeless?

- ☐ Almost all of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost never

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?

- ☐ Yes
- ☐ No

## Anxiety

In the past 2 weeks, how often have you felt nervous, anxious or on edge?

- ☐ Almost all of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost never

In the past 2 weeks, how often were you not able to stop worrying or control your worrying?

- ☐ Almost all of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost never

## High Stress

How often is stress a problem for you in handling such things as your health, your finances, your family or social relationships, or your work?

- ☐ Never or rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

How often do you get the social and emotional support you need?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Almost never

## Pain

In the past 7 days, how much pain have you felt?

- ☐ None
- ☐ Some
- ☐ A lot

For a patient with current opioid prescription, review their potential opioid use disorder (OUD) factors. Evaluate the pain severity and current treatment plan. Provide information on non-opioid treatment options. Refer to a specialist as appropriate.

Screen for potential substance use disorders (SUD). Review the patient’s potential risk factors for SUD and as appropriate, refer them for treatment.

## General health

In general, would you say your health is

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

How would you describe the condition of your mouth and teeth including false teeth or dentures?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

## Activities of daily living

In the past 7 days, did you need help from others to perform everyday activities such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medications?

- ☐ Yes
- ☐ No

## Sleep

Each night, how many hours of sleep do you usually get? ________ hours

Do you snore or has anyone told you that you snore?

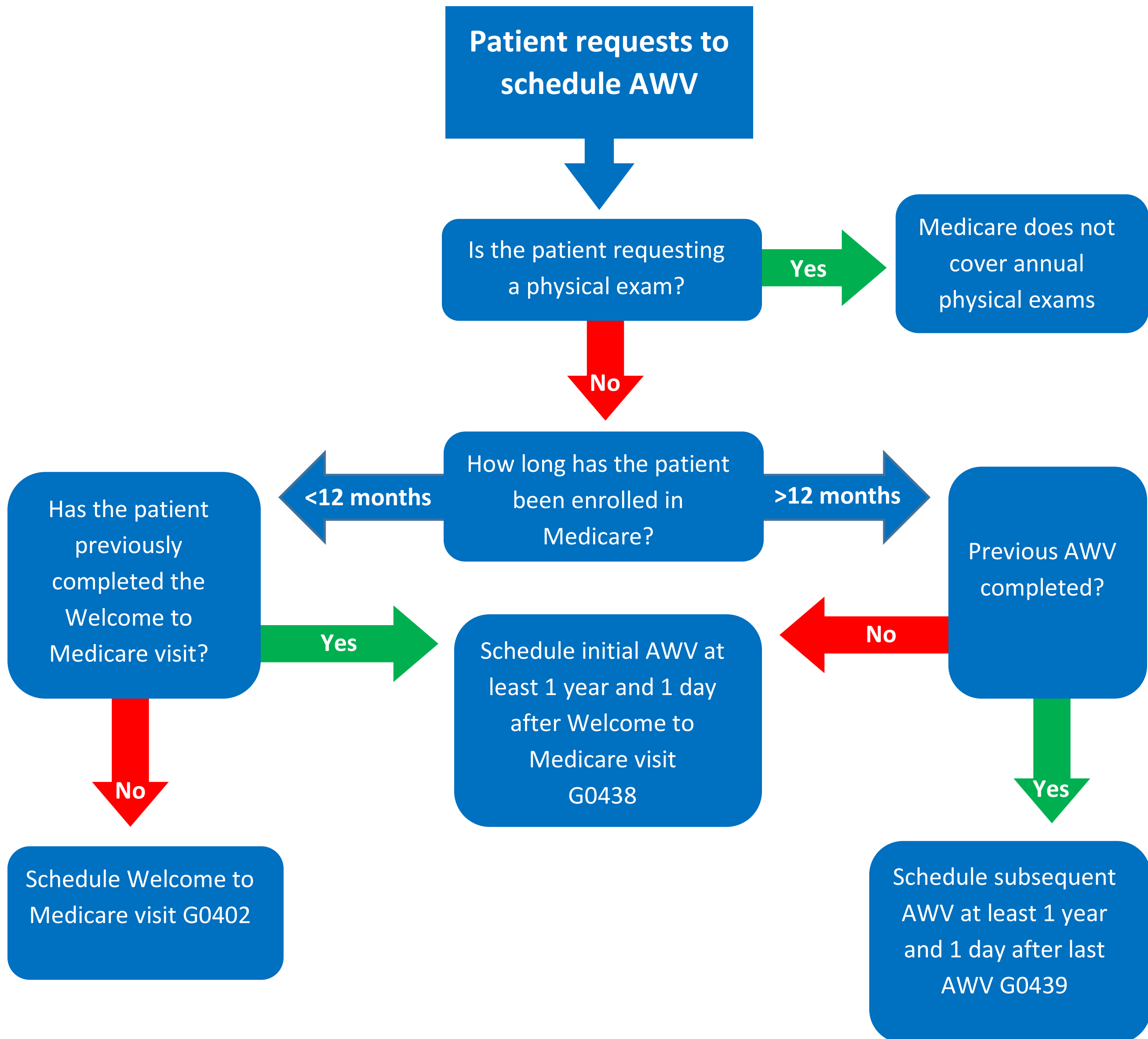
- ☐ Yes
- ☐ No

In the past 7 days, how often have you felt sleepy during the daytime?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Almost never

## ▶ Workflow for AWV Flowchart Example

## ▶Scheduling Annual Wellness Visit Flowchart Example



# AWV/Yearly Visit Process Implementation

## *Quick Guide*

### 1. EDUCATION AND GROUNDWORK

- Does the health care team know:
  - Key aspects of an AWV
  - The difference between Medicare and Medicare Advantage
  - The different AWV visits and requirements
  - Education and scripting to provide to patients
  - Providers and staff know workflows and resources for AWV
- Establish staff and provider champions to support program
- Involve scheduling, front desk, care management, staff nurse, providers, coders, HIM and IT to build a successful program

### 2. ESTABLISH YOUR WHY

- Why are AWV/yearly visits important to your organization?
- Why are AWV/yearly visits important to your patients?
- Why are AWV/yearly visits important to your staff and providers?

## 3. ESTABLISH BENCHMARKS

- Total Medicare patients attributed
- Total AWVs completed in the last 12 months
- Percentage of completion
- Target percentage of completion each year
- Number of AWVs per week to reach target percentage

| Attributed Patients for Current Year | AWV/Yearly Visits Previous Year | Completion Rate Previous Year | Target Completion Rate for Current Year | Visits per Week to Reach Current Year Goal |
|---|---|---|---|---|
| | | *Total completed visits/Total Attribution* | | *(Total Attribution * Target Completion Rate)/52 weeks in the Year* |
| | | | | |

## 4. PLAN FOR GENERATING LIST OF ELIGIBLE MEDICARE PATIENTS

- EMR list
- ACO list
- Checking eligibility

## 5. PLAN FOR SCHEDULING AWV

- Staff doing scheduling
- Phone
- Portal
- In-person
- Scripting for scheduling

## 6. PLAN FOR WHO WILL COMPLETE COMPONENTS OF AWV

**Matrix for staff responsibilities**

| Assessment/Task | MA | Nurse | Provider | Other |
|---|---|---|---|---|
| Vitals | | | | |
| Current providers and suppliers | | | | |
| Medical and family history | | | | |
| Review HRA with patient | | | | |
| Screenings<br>• Cognitive<br>• Hearing<br>• Vision | | | | |
| Assess potential risk factors<br>• Depression<br>• Fall<br>• Safety | | | | |
| Capture HRA in EMR | | | | |
| Generate preventative plan | | | | |
| Who will give to patient | | | | |

## 7. HOW WILL AWV BE COMPLETED?

- In-person
- Partial over the phone
- Forms for patient to fill out
- Electronically

## 8. HOW WILL YOU ENSURE PATIENTS ARE COMPLETING LABS AND SCREENINGS?

- Order placed during visit
- Process for incomplete referrals
  - Patient reminders
  - Phone calls
- Education and engagement for patients

## 9. CODING AND BILLING CONSIDERATIONS

- Success of coding and billing AWV in the past
    - Assessment if issues prior on barriers
        - Medicare secondary, Commercial insurance primary
            - Commercial insurance will deny
- IPPE, Initial AWV, Subsequent AWV
- Rural vs Urban
    - Physician responsibility
- Specifics and requirements for staff completion
- Co-pays for additional services for patients

## ►References

A Quality Improvement project to improve AWV completion rates

Annual Wellness Toolkit

Annual Wellness Visits - Care Management Medicare Reimbursement Strategies for Rural Providers (ruralhealthinfo.org)

Medicare Benefit Policy Manual (cms.gov)— Chapter 13 Rural Health Clinic

Annual Wellness Visits Forms and Playbook

AWV & Preventative Screenings Quick Reference Chart-Medicare

Checking Medicare Eligibility MLN Fact Sheet

## ►Contact Us

For more information or questions, contact us at 402-483-8891 or visit our website bryanhealth.org/connect