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Annual Medicare Wellness Visit: Advanced Nurse Practitioner Perceptions and Practices

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ABSTRACT

Advanced Practice Nurses (APNs) can contribute to health prevention efforts with older adults by utilizing a health risk appraisal (HRA) during the Medicare Annual Wellness Visit. This study examined APN perceptions and practices concerning use of HRAs during Annual Wellness Visits (N = 51). Results indicate that respondents agree it is important to collaboratively identify risks and develop a personalized prevention plan, but only a small percentage (7.8%) use HRA data to do so. Reported concerns include reimbursement and time; further work on how to best integrate HRAs into APN practice to enhance prevention efforts with older adults is critical.

Keywords: health promotion, health risk appraisals, Medicare Annual Wellness Visit, nurse practitioners, older adults

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INTRODUCTION

By 2030 it is predicted that 1 out of every 5 persons in the United States will be 65 years or older.[1] As individuals live longer, the chance increases that a functional deficit, disability, or loss of independence will occur. Risky lifestyle behaviors including poor dietary habits, physical inactivity, tobacco use, obesity, and lack of preventive care frequently co-exist with other risk factors, increasing the complexity of care for this population.[2-4] Despite the existence of these factors, providers often spend more time addressing acute issues and managing chronic diseases. To help prevent disability and maintain independence of older adults, providers must complete multifactorial, interprofessional assessments while collaboratively engaging patients to support health promotion and prevention efforts.[2,5,6]

Medicare Annual Wellness Visit

The Medicare Annual Wellness Visit (AWV), covered by Medicare since 2011 with no co-pay or deductible,[6] provides an opportunity for Advanced Practice Nurses (APNs) to enhance health promotion efforts with older adults. During this visit, the provider assesses health risks, provides preventative information, and develops a personalized health promotion plan; it is not a "hands on" visit.[7] This visit, which includes coverage for several preventive services, requires completion of a health risk appraisal (HRA) to support development of the personalized prevention plan. The HRA must be completed before or during a face-to-face provider visit and should include demographic data, self-assessment of health status, psychosocial risks, behavioral risks, activities of daily living, and instrumental activities of daily living.[6-9]

Unfortunately, most of the Medicare population does not participate in the AWV.[10] In 2016, only 18.7% of Medicare Part B and Advantage program enrollees had an AWV. Even though lack of co-pays and deductibles removes a major financial barrier to patient participation,[9] a survey of Medicare recipients in 2012 indicated that 68% were unaware of the AWV benefit.[12,13] Increasing awareness and use of the AWV/HRA can engage patients more collaboratively in their care,[5] and help detect risks for falls, frailty, and cognitive decline.[3-5] Early identification of such risks supports development of interventions to improve outcomes and prevent or

delay functional disability and decline. Meaningful and informed conversations between older adults and providers can increase participation in preventive services, allowing problems to be addressed when treatment works best.[7,13]

Challenges and Barriers

Literature concerning barriers and challenges related to implementation of the AWV/HRA is limited and predominantly focused on physician perceptions and the AWV overall. Reported barriers include lack of: 1) time to complete and document visit requirements, 2) understanding of requirements, 3) a system to integrate AWV/HRAs into office workflow, and 4) a specific form for the HRA.[12-15] Challenges also exist related to physician and patient perceptions of the value of the visit. Patients report that prevention is of less importance than addressing health concerns or disease process.[15] Physicians concur, reporting that they believe patients may undervalue the visit because it does not focus on disease management.[8,12] Additionally, physicians report feeling pressured by competing demands because patients often want to discuss issues other than those covered by the AWV. These barriers and challenges impact utilization and implementation of the AWV/HRA. Research focused on implementation of the HRA aspect of the AWV, the personalized prevention plan, and the perceptions and practices of APNs related to the AWV/HRA is minimal.[12] As APNs increasingly provide care to this growing population, it is important to understand their perspectives and current practices.

METHODS

Design and Sample

This descriptive exploratory study surveyed APNs providing services to Medicare recipients. A convenience sample of 51 APNs was recruited through the university's federally qualified community health centers and a state-level professional APN organization.

Measures

The survey was developed by investigators using semi-structured interviews with currently practicing APNs, AWV/HRA guidelines, and a review of published literature. The survey contained 24 items: 15 items collected data concerning provider characteristics, practice setting, and current HRA implementation, while 9 items assessed APN perceptions of the AWV/HRA using a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree). After initial development, the survey was distributed to a known network of APNs providing services to the Medicare population and the research committee of a state-level professional APN organization to establish face validity. Only minor modifications were suggested; reviewers indicated they believed the survey would increase awareness of AWV/HRA requirements and potentially improve APN quality outcomes and chronic disease management for Medicare beneficiaries.

Procedure

Surveys were distributed from late 2016 to early 2017 at the Coalition of Advanced Practice Nurses of Indiana annual conference and online via Qualtrics. Completion of the survey implied consent. This study was deemed exempt by the University's Institutional Review Board.

RESULTS

The majority (79.6%) of participants were Family Nurse Practitioners. Most practiced in private settings (40.8%); 24.5% practiced in community-based clinics. Fifty-nine percent of participants reported being in practice for 10 years or less. In the past year, 66.4% indicated they had provided an AWV to Medicare beneficiaries. Slightly over half (56.9%) indicated awareness of the AWV/HRA requirement, with 47.1% indicating that the HRA was being administered according to the Centers for Medicare and Medicaid Services (CMS) guidelines. However, a follow-up question concerning items included in the HRA indicated that less than 10% were assessing all CMS-required items. Only 29.4% indicated that the HRA and associated data were integrated into the electronic health record system, and only 7.8% indicated that data was used to develop a personalized prevention plan. A small percentage (23.5%) reported using HRA data to support individualized health

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