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Increasing Adult Annual Wellness Visits

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INCREASING ADULT ANNUAL WELLNESS VISITS

by

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Presented to the Faculty of the University of the Incarnate Word
in partial fulfillment of the requirements
for the degree of

DOCTOR OF NURSING PRACTICE

UNIVERSITY OF THE INCARNATE WORD

December 2019

ACKNOWLEDGEMENTS

I would like to acknowledge my family for their unconditional support and believing in my success that is our collective success. A special acknowledgment to my mother for making the difficult choice to immigrate as a single mother so that I could have a better future. I would like to express my gratitude to my project advisor, Dr. Diana Beckmann-Mendez Ph.D., RN, FNP-BC, for her counseling, support and patience as we spent many late hours in her office working on this project. I want to thank my mentor, Mrs. Esmeralda Gill MSN, APRN, FNP-BC, for extending her time, knowledge and guidance.

Martha Caceres

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Abstract

The purpose of this quality improvement project is to increase adult annual wellness visits in a high-volume family practice clinic. The significance of an adult annual wellness exam is health maintenance, disease prevention, early disease detection, and management of chronic diseases. Approximately 133 million Americans are diagnosed with at least one chronic disease, including cancer, diabetes, and heart disease, and one in four adults are diagnosed with multiple chronic diseases (Raghupathi & Raghupathi, 2018). In 2011, the Affordable Care Act mandated insurance companies to remove deductibles for preventative health services, relieving the financial burden of out-of-pocket expenses (Borsky et al., 2018). Despite this financial relief, only 8% of adults 35 years of age and older reported receiving all of the recommended preventative health care services as of 2015 (Borsky et al., 2018). Recommended medical screenings and risk assessments are based on the U.S. Preventive Services Task Force derived from evidence-based practice. The screenings are dependent on sex, age, tobacco use, and sexual history (Owolabi & Simpson, 2012; Viera, 2018). The aim of this study was to increase the number of completed adult annual wellness visits. Interventions included staff education, implementation of a provider prompt slip to include “schedule adult annual wellness visit,” and sending electronic reminders and recalls for patients to schedule an annual wellness visit. These interventions resulted in a 28% increase in completed adult annual wellness visits. To maintain sustainability, it is crucial to have provider buy-in. Patients also expected that their provider recommend the need to complete an annual wellness visit.

Keywords: Annual wellness visit, Adult wellness visit, Preventative health care

Chronic Diseases

Chronic diseases are defined as health conditions that last a minimum of 1 year, require medical treatment, and may lead to disability (National Center for Chronic Disease Prevention and Health Promotion [NCCDPHP], 2019). Forty-five percent of Americans are diagnosed with at least one chronic disease, which include cancer, diabetes, hypertension, stroke, heart disease, respiratory diseases, arthritis, obesity, and oral diseases (Raghupathi & Raghupathi, 2018). It is estimated that approximately one in four adults has been diagnosed with more than one chronic disease (Raghupathi & Raghupathi, 2018; NCCDPHP, 2019). As of 2016, the direct health care cost of treating chronic diseases amounted to one trillion dollars (Levine, Malone, Lekiachvili & Briss, 2019). Attributing factors known to cause chronic diseases are unhealthy lifestyle choices such as tobacco use, poor diet, and lack of physical activity (Raghupathi & Raghupathi, 2018; NCCDPHP, 2019). Age is also a known risk for acquiring a chronic condition (Raghupathi & Raghupathi, 2018). It is estimated that one out of five adults will be turning 65 years old by the year 2030 (United States Census, 2018). The number of adults diagnosed with chronic diseases will continue to increase as the population continues to age. For healthcare providers, this combination of issues means an increased need for surveillance to prevent and detect health risks and chronic diseases.

As the nation continued to get more sick and national health care spending continued to rise, an intervention was formulated in 2011 with the Affordable Care Act (ACA). The ACA required some private health insurance companies and the Centers for Medicare and Medicaid Services (CMS) to cover preventative health care services (CMS, 2010). Prior to the implementation of the ACA, the financial burden, such as co-payments and deductibles, were applied to preventative health services, discouraging Americans from utilizing them (CMS, 2010).

This led to a culture of only visiting a health care provider for sick visits, and discouraged health maintenance. The ACA was an attempt by the government to manage the health care crisis by reducing health care spending and patients' financial burden.

There is a clear need for a pragmatic change in the health care delivery system. Chronic diseases are preventable and disabilities from chronic diseases can be delayed with health care initiatives, early diagnoses, and implementation of evidence-based practice disease management. Avoiding or delaying the onset of disease decreases disabilities and reduces health care spending (Levine et al., 2019).

Statement of the Problem

There is a need to establish a culture of prevention, instead of waiting to react after a disease has been detected. As of 2015, only 8% of adults 35 years of age and older reported receiving all of the recommended preventative health care services (Borsky et al., 2018). Patients tend to visit their healthcare provider when ill and neglect to take action to prevent chronic diseases. A lack of access to affordable health care, underutilization of preventive health services, and unhealthy lifestyle choices contribute to the prevalence of chronic diseases in America.

While the ACA has increased access to affordable health care, about 30 million Americans remain uninsured (United Health Foundations, 2016). Uninsured individuals are more likely to use the emergency department as their source of health care, which leads to episodic medical treatment instead of continuity of care and disease management (United Health Foundations, 2016). Compared with other states, Texas has the largest number of uninsured individuals (United Health Foundations, 2016). In fact, Texas is one of the lowest ranking states in several evidence-based interventions that improve the health of populations, including having

a designated health care provider, completing an annual dental visit, and colon-rectal cancer screenings (United Health Foundations, 2016).

Background and Significance

In 2014, of the 28 million Medicare enrollees, only 16% participated in the recommended preventative health screenings, including completing an annual wellness visit (Tao, 2018). Sociodemographic backgrounds also play a role in the utilization of preventative health care services, with reports indicating that older, sicker, African American populations underutilize preventative health care services when compared with younger, healthier, non-Hispanic Whites (Chung, Romanelli, Stults, & Luft, 2018). Individuals with higher education tend to engage in preventative care services more often.

Among adults 50 to 74 years of age, only 52% of those with less than high school education report completing the recommended colorectal cancer screening, compared with 63% of those with a high school degree, 69% with some college, and 74 % of college graduates (United Health Foundations, 2016). These statistics indicate that individuals with higher education receive preventative health care services in greater proportions, demonstrating a need for increased public health education in lower socioeconomic groups. Learning to prevent and manage chronic medical conditions can improve quality of life, reduce disabilities, and reduce healthcare spending (Raghupathi & Raghupathi 2018).

Preventative healthcare services save lives. There are three different levels of disease prevention: primary, secondary, and tertiary. In primary prevention, the disease is prevented by eliminating the cause, using vaccines and cancer screening exams (Fletcher & Fletcher, 2018). In secondary prevention, the disease is diagnosed at early stages and progression is stopped (Fletcher & Fletcher, 2018). In tertiary prevention, clinical activities are implemented to reduce

disease complications after the disease is diagnosed (Fletcher & Fletcher, 2018). It is clear that primary prevention optimizes healthcare delivery services and patient outcomes, yet there are millions of Americans that do not take advantage of preventative healthcare services (Levine et al., 2019).

The purpose of primary care providers is promoting optimum levels of care, promoting wellness, and prevention. The most thorough approach of chronic disease prevention is an annual wellness visit. An annual wellness visit has the ability to incorporate several forms of prevention with its "bundling services" property, because it is patient-centered, individualized, and prioritized depending on age and risk-appropriate recommendations (Owolabi & Simpson, 2012). In an annual wellness visit, the health care provider evaluates the need for preventative services such as vaccines, one of the most researched forms of prevention. The World Health Organization (2017) states that between 2010 and 2015, 10 million deaths from around the world have been prevented with the use of vaccines.

The effectiveness of an annual wellness visit is not only measured by an increased number of adults who complete the visit, but also by the completion of the recommended medical services. Data from 2014 estimated that 16% of Medicare beneficiaries completed an annual wellness visit, and that these individuals had higher levels of influenza vaccine administration and depression screening (Tao, 2018). This study demonstrates that small changes can make a difference.

Recommended medical screenings and risks assessments are based on recommendations of the U.S Preventive Services Task Force, which are derived from evidence-based practice. Screenings are dependent on sex, age, pregnancy status, tobacco use, and if sexually active (Owolabi & Simpson, 2012; Viera, 2018). The U.S Preventive Services Task Force (2018) has a

grading system where screenings assigned an A score are an established standard of care and known to be of benefit, while recommended services that have a B score are known to have a moderate level of benefit. The ACA based the recommended preventative health services to be offered in an annual wellness visit on these recommendations (U.S Preventive Services Task Force, 2017).

National guides are formulated to measure the effectiveness of healthcare and patient outcomes. Established by the National Committee for Quality Assurance (NCQA), the Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used to measure and evaluate facilities' effectiveness of care (NCQA, 2018). HEDIS measures the focus on prevention and medical screenings, and each measurement denotes its purpose and impact on the health of the nation. An example of this measure is the adult body mass index assessment (ABA), which explains how obesity is linked to one in five deaths in the United States (NCQA, 2018). In the form of report cards, these measures are able to maintain high standards of practice that, in turn, aim to improve general population health, prevent chronic diseases, and decrease the progression of diseases.

The annual wellness visit is a time-consuming appointment, which would concern a health care provider who depends on earnings from a full patient schedule. However, Owolabi and Simpson (2012) argue that an annual wellness visit that is coded properly can bring in 25% more revenue when compared with a problem-oriented visit. Cuenca (2012) also argues that proper utilization of the interdisciplinary team, such as nurses and medical assistants, improves patient flow in the clinic and aids in increasing revenue. The Medicare relative value unit (RVU), which is a value used to formulate revenue, was increased from 3.64 to 4.67, and average reimbursements increased from $155.89 to $224.31 (Cuenca, 2012). Coding can also

increase revenue: for example, smoking cessation counseling contains a code for providers to receive reimbursement for their time counseling the patient.

Assessment

The facility assessed for this project is located in the northwestern area of San Antonio, Texas. The estimated population for San Antonio is 1.5 million, with the three majority racial groups being 64% Hispanic/Latino, 25% White alone, and 7% African-American (City-Data, 2016). The median age for this area is 35 years of age (City-Data, 2016). The average adjusted gross income for this area is $49,000, with an average household size of 2.7 persons (City-Data, 2016). While Texas' statewide poverty level is 15.6%, San Antonio's poverty level is 19% (City-Data, 2016).

The clinic assessed is divided into four clinics. Each clinic section has its own waiting room, reception desk, and health care team, with access to each clinic via the back corridor. There are 10 exam rooms per clinic, and each area has its own nursing station. Three of the clinics offer family practice services, with patients ranging in age from 2 weeks to 97 years old. The fourth clinic offers obstetrics and gynecological services. The clinics open 5 days a week, from 8 a.m. to 5 p.m., with the first appointment scheduled for 8:30 a.m. and the last appointment at 4:30 p.m. On Thursdays, the clinics have appointments until 12:00 noon, with afternoons reserved for education, completing patient referrals, and other administrative duties.

Each clinic has a check-in area where two to three patient access representatives (PAR) work at the front desk, helping patients with paperwork and scheduling appointments. Depending on the patient volume, there can be two to three Medical Assistants (MA) in the patient care areas and one Licensed Vocational Nurse (LVN) per area, for a total of four LVNs throughout

the clinics. LVNs are in charge of their designated area. Depending on the appointment volume, there can be one MA assigned to one provider, or one MA for two providers.

This family practice clinic is a teaching facility, training family medicine residents. The clinic serves as the residents' home base for a total of 3 years. There are 28 residents—nine are in their 1st year, 11 in their 2nd year, and nine in their 3rd year—with 11 attending physicians supervising them. The residents see patients in clinics one through three, while other providers are located in section four. Section four houses the diabetic education nurse, a nurse practitioner, and the obstetric providers. On an average day there are six residents from different years, with a fluctuation with morning and afternoon clinics, meaning there can be six residents in the morning and 10 in the afternoon. The average number of attending physicians per day is five. Attending physicians also have their own workload; at times they have a full day or half-day schedule. Twice a month they have a clinic for small procedures such as toenail removals and mole removals, where the residents rotate to expand their learning experience. Residents also rotate to other clinics and specialty clinics in San Antonio.

The vastness of the clinic does not become palpable until one evaluates the number of appointments completed per year. In the last 12 months, the clinic completed 30,599 visits. These visits account for the whole patient population, birth to 97 years old (the oldest age recorded), obstetrics visits, wellness visits, and sick visits. The total number of pediatric visits, ages zero to 17 years, accounts for 8,108, while adults ages 18 years of age and over account for 22,291 visits. The average patient's age is 33 years old. Most of the visits are provided to adult patients.

Fifty-two percent of the visits are covered by government insurance policies: Medicare, Medicaid, and Tricare. Private insurance policies cover 38% of the visits, and 10% are self-pay.

This means that the majority of clinic visits are funded by government programs, and the clinic needs to maintain CMS standards of care for adequate reimbursements.

Needs for Intervention

The clinic manager stated that there were several measures they would like to improve that would increase quality measures of care, and improve patient outcomes and financial reimbursement. To evaluate their needs, Athena, an electronic health record, was used. Athena was used for all patient documentation and patient orders, and facilitated staff communication. Taking into consideration the large number of adult visits and the number of visits covered by CMS insurance policies, a low number of completed adult wellness visits was noted. The annual preventative visits were separated by the insurance policies of adult annual preventative visits and Medicare annual wellness visits, both with poor satisfaction rates— 25% and 31% respectively.

Organization's Readiness for Change

A microsystem assessment was conducted to evaluate characteristics of the clinic that were working well, and characteristics that required improvement in relation to their patient population. One of the most positive aspects of implementing a project in this facility was that it is a teaching facility. Teaching facilities have a culture of education and quality improvement. The whole clinic was receptive to answering questions about their processes. The stakeholders were the nursing staff, the medical residents, attending physicians, management, and support staff.

Project Identification

Several factors contribute to the cause of chronic diseases, including lifestyle risk behaviors and genetic predispositions (NCCDPHP, 2019). Having annual medical screening for

recommended age-appropriate health services reduce and diagnose chronic diseases at earlier stages (NCCDPHP, 2019). An annual wellness visit also targets possible co-morbidities related to current disease processes. Overall, having an annual wellness visit improves patient health outcomes.

Purpose

The purpose of this quality improvement project was to increase adult annual wellness visits. The goal was to increase health care preventative screenings as supported by HEDIS markers and multiple other measures that defined standards of care. The annual wellness visit will address age-specific healthcare recommendations including vaccines, risk assessment, and screenings.

Objectives and Anticipated Outcomes

Objective 1: By January 14, 2019, the appointment prompt slip will be updated and implemented for 100% of the patients in the clinic. The prompt slip will aid in reminding providers to have their patients schedule an annual wellness visit when the patient is in the office. The providers will also have the opportunity to educate the patients about the importance of completing an annual wellness visit.

This objective was implemented using the following interventions:

a. Educating the providers and staff members about the project and the purpose of the prompt slip. Educating providers about the importance of asking their patients to schedule an annual wellness visit.
b. Updating and distributing new prompt slip.

Objective 2: By May 10, 2019, 50% of the patients seen in the clinic that are in need of an adult annual wellness visit will have an appointment scheduled upon discharge from the

clinic. Having an annual wellness visit appointment will increase the number of patients that complete an annual wellness visit and receive the age-specific recommended health screenings.

This objective was implemented using the following interventions:

a. The prompt slips were collected for data analysis.
b. The slips were separated for the targeted population.

Objective 3: By May 10, 2019, 10% of the patients who need an annual wellness visit will receive an electronic recall/reminder. The electronic recall/reminder is meant to help patients call to schedule their annual wellness visit.

This objective was implemented using the following interventions:

a. From the list of patients that needed an annual wellness visit , electronic recall/reminders were created to have the patient call-in and schedule their annual wellness visit.
b. Monthly phone calls were made to patients from the annual wellness visit recall/reminder list asking them to schedule their annual wellness visit.

The intent in increasing annual wellness visits was to establish a clinical and patient culture of health care prevention and wellness. The anticipated outcome was that patients would continue to comply with an annual wellness visit and follow up with the recommended medical screenings. Education was a key component of wellness and the hope was that the annual wellness visits would contribute to improving patients' health initiatives. According to the CDC, diseases can be prevented with patient and health team partnership as well as adequate health screenings (2017).

Summary and Strengths of the Evidence

To address the inadequate delivery of preventive health care services a reminder/recall system should be used (Agency for Healthcare Research and Quality [AHRQ], 2018; Pich, 2019). Reminder systems notify patients of their scheduled appointment and recall systems contact patients and encourage them to schedule an appointment (AHRQ, 2018, Community Preventive Task Force, 2015; Pich, 2019). Recall and reminder systems have been shown to reduce no-show rates and increase preventative care visits (AHRQ, 2018; Pich, 2019). The reminder/recall delivery for preventative health care services is communicated in a variety of methods that include phone calls, patient portals, electronic email, text messages, letters, and postcards (AHRQ, 2018; Community Preventive Task Force, 2015; Pich, 2019). Some additional effective strategies to increase preventative services are organizational change, provider education, patient education, and provider reminders systems (AHRQ, 2018).

Most patient visits are related to acute illness, and the delivery of preventative health care services becomes a less important task (AHRQ, 2018). A provider reminder system can prompt providers at a time when they can act on it, such as when the patient is in a clinic visit, and address preventative services at every visit (AHRQ, 2018). The provider prompt can include methods such as listing services that the patient is deficient on, or have an order sheet where the provider can address the needed services. An essential strategy for implementing a provider prompt system is following an organized system that functions within the facility's framework (AHRQ, 2018). The provider prompt system can include tagged notes, cards, or stickers on the patient's chart (AHRQ, 2018). Financially, facilities can reduce cost when patients keep their appointments and reduce wasted appointment slots associated with the inefficient use of clinician and staff time (AHRQ, 2018; Community Preventive Task Force, 2015; Pich, 2019).

Method

This was a quality improvement project conducted in a family practice clinic that trains family medicine residents for 3 years. The targeted patient population were adults ages 18 to 64 years old. Completed adult annual wellness visits were monitored via the electronic health record (EHR). Provider prompt slips were implemented along with electronic reminder/recalls asking patients who needed an annual wellness visit to call-in and schedule their appointment. From the reminder/recall list, monthly phone calls were made out to patients asking them to schedule an annual wellness visit appointment.

Project Interventions

The staff received education about the process modifications of the project. The providers were informed that the clinic had poor compliance in completing adult annual wellness visits, and the project was focused on increasing these. The staff was informed of the prompt slip that included "Schedule an Adult Annual Preventative Visit," as it is worded in the EHR. The prompt slip was used to educate the providers, who were asked to fill in the slip for patients that were deficient in their annual wellness visits.

Non-medical staff, such as the PARs, were educated on the impact an annual wellness visit has on a patient's health. PARs needed to have this information to answer basic questions patients may have had. Additionally, if the PARs understood the importance of an annual wellness visit , they would be more inclined to help patients schedule the appointment. PARs were also asked to save the slips at the end of the day for data collection.

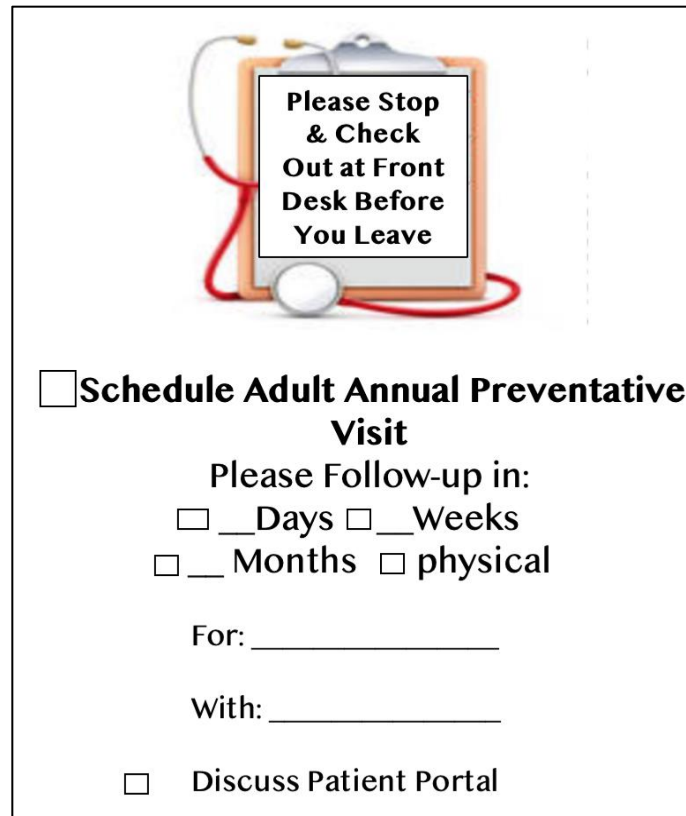

Figure 1. Provider prompt slip.

As per the clinic's practice, all of the slips had a patient label added and were managed with all of the regulations of patient confidentiality. The data that was collected from the prompt slips included whether the providers did or did not utilize the slip to have the patients schedule an annual wellness visit upon check-out. Additionally, each slip was used to evaluate if the patients, ages 18 to 64, needed an annual wellness visit. The rationale was that if the provider did not use the slip, the patient already had an annual wellness visit in the past 12 months.

Ten percent of the patients who did not have annual wellness visit in the past 12 months had a reminder/recall created, asking them to call in and schedule an annual wellness visit with their primary care provider. Depending on the communication options selected by the patient upon registering with the clinic, the reminder/recall was sent via text message, automated phone

calls, or electronic mail. The EHR has all of these components in place, so these interventions did not add additional costs to the clinic.

Setting/Population

The adult population was selected for this project due to the clinic's poor compliance in meeting the adult wellness measures. The setting was a large family practice clinic, home to a physician teaching program for family medicine residents. The residents were full-time, spent 3 years in this facility, and rotated to other facilities and specialties.

Organizational Barriers and Facilitators

A major barrier in this facility was the set up of the her, which has limited options when labeling the types of appointments scheduled. This was a barrier because the provider did not have a visual cue on the reason for patients' visits. The only option available to select when an annual wellness visit was scheduled was: "established care 30 minute." There was no option to label the appointment "adult annual wellness visit."

Another barrier in this organization was the residents' rotating schedule. As a process of their continuing education, the residents rotated through various other facilities. The continuous change in their schedules may have interfered with the residents' ability to comply with the clinic's routine and the need to meet benchmarks.

A facilitator of the organization was the resident teaching program. The facility, in general, was used to having new residents annually, and that established an environment of openness towards new team members. The residents themselves conducted research and quality improvement projects. The staff was easy to engage, helpful and available to answer questions.

There were no ethical considerations to address. This quality improvement project was assessed by the University of the Incarnate Word Institutional Review Board (IRB). After being

reviewed, the project did not meet federal regulatory requirements for human subject research and did not require additional IRB review. Additionally, all federal regulations were maintained when Protected Health Information and the Health Insurance Portability and Accountability Act information was handled.

Results

Objective 1

This objective was implemented by distributing the prompt slips to be used in the four different sections of the clinic. The slips were labeled “Schedule Adult Annual Preventative Visit,” a specific phrase that reflected the verbiage used on the EHR. This was meant to prompt the providers to educate their patient about the annual wellness visit and result in the patient scheduling an appointment upon discharge. As a result of staff education, providers stated an increased awareness of the need to educate their patients on an annual wellness visit and encourage them to schedule an appointment.

Objective 2

This objected required the PAR in the front desk to collect and save the prompt slips at the end of each day. The slips were sorted many different ways, starting with the targeted population of patients ages 18 to 64 years old, and the rest of the slips were discarded. This was followed by evaluating if the providers completed or did not complete the slip. Using the EHR, all of the slips completed and not completed were assessed to evaluate if the patient had an annual wellness visit completed in the past 12 months. This was done so that the slips of patients with a completed annual wellness visit in the past 12 months were excluded, leaving only the slips of deficient patients, those who needed an annual wellness visit.

Table 1 demonstrates the 6 weeks that the slips were collected and sorted, reflecting the deficient patients, the ones that needed an annual wellness visit. This table also demonstrates the number of deficient patient slips that were completed by a provider, where the provider asked the patient to schedule an annual wellness visit. Additionally, this table also reflects the number of annual wellness visit scheduled with the use of the completed prompt slip. The last column is the number of annual wellness visits not scheduled, even though the provider completed the prompt slip. The goal of 50% was not met; using the prompt slip, only 8% of patients completed an annual wellness visit appointment.

Objective 3

This goal was met: 10% of the patients who needed an annual wellness visit received an electronic reminder/recall. As of January 2019, 5,778 active patients needed an annual wellness visit, and the total number of recall/reminders completed was 587. Figure 1 displays the number of recall/reminders created per month, keeping in mind that only the first part of the month of May was used for data collection.

Additional factors that guided this recognition, aside from the implementation of this project, was the need to meet standards of care by auditing insurance companies, which were conducted in the month of April. Due to the upcoming evaluation and other quality improvement projects being conducted, the clinic recognized that there was a gap in their discharge instructions and follow-up care. Their phone lines were flooded with follow-up questions from patients regarding the care they received in the clinic. Examples of patient follow-up questions included those related to medication refills, specialist’s referrals, and appointments.

Table 1

Prompt Slips of the Patients Needing an Annual Wellness Visit

Weeks	Total slips of deficient patients	Slips completed	Appointments Scheduled	Appointments not scheduled
Week 1	68	5	5	0
Week 2	92	12	4	8
Week 3	167	24	12	12
Week 4	228	36	20	16
Week 5	211	38	18	20
Week 6	260	32	23	9
Totals	1026	147	82	65

Note. Table 1 demonstrates the number of deficient slips collected and completed, and if an appointment was scheduled or not.

The clinic recognized that annual wellness visits were an intervention that needed to be a staple in their care, and that completing one satisfies other health care HEDIS measures such as cancer screenings and addressing lifestyle risk assessments like smoking. In their efforts to implement lasting change and address discharge education, a new patient take-home sheet included the provider prompt slip labeled “Schedule Adult Annual Preventative Visit” and several educational points that were completed by the providers. The sheet was shown upon check-out to the PAR to schedule the appointments as directed by the provider, and the patients took it home as a reference.

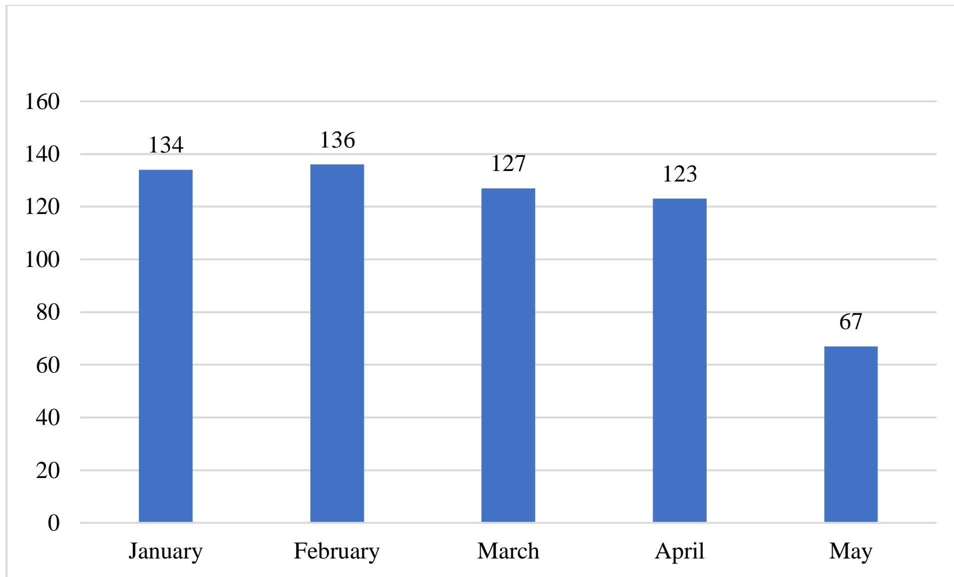

Figure 2. Number of electronic reminder/recalls. This graph displays the number of reminder/recalls built per month. The total number of reminder/recalls completed was 587.

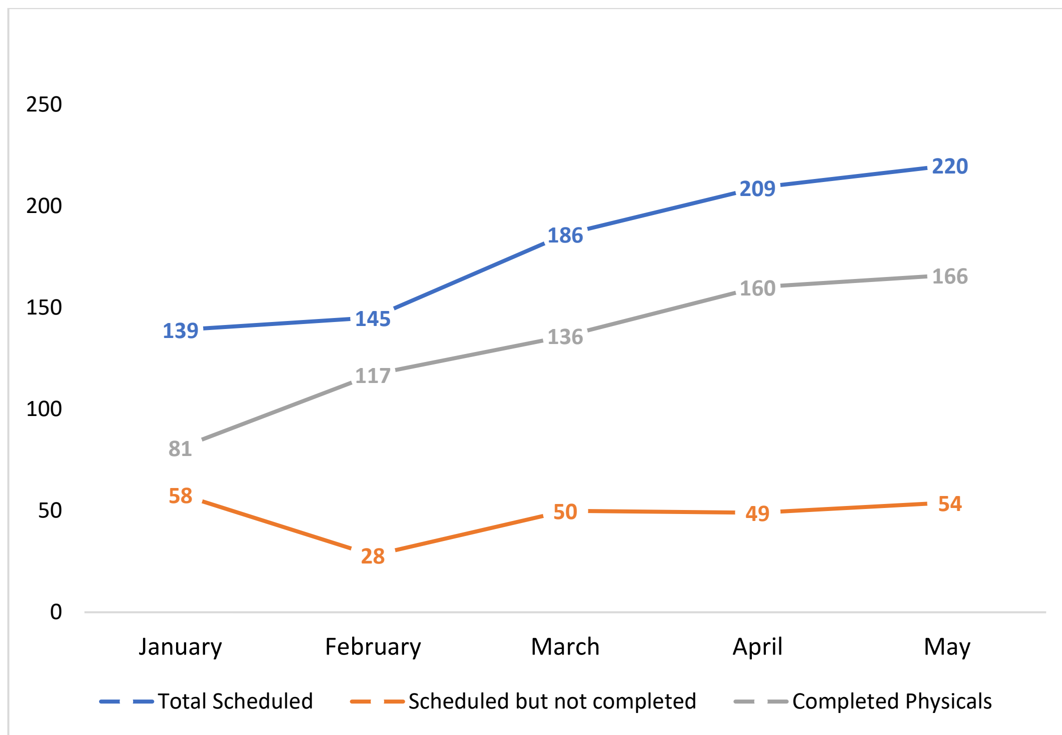

Figure 3. Number of annual adult wellness visits. This graph compared scheduled annual wellness visits with visits that are completed and not completed.

Discussion

AHRQ (2018) states that health care providers believe in the importance of preventative health care services, yet there remains a gap in the delivery of these services. The provider prompt slip is an evidence-based tool designed to shorten this gap. In the teaching facility where this quality improvement project was conducted, the prompt slip did not receive provider buy-in. About 4 weeks into the project, when there was a minimal improvement in the number of annual wellness visits scheduled with the use of the prompt slip, the providers were asked why they were not using the slip. There was an overall response from the medical residents that they felt overwhelmed with the number of quality measures that needed to be addressed per patient visit. Residents felt that it was one more step to address in their already busy routine. After implementation of the prompt slip, the providers did not agree that this was the best approach to address the education and scheduling of an annual wellness visit. Of note, there were some providers who were utilizing the prompt slip to set up an annual reminder for patients to schedule an annual wellness visit the following year.

Recall and reminder systems improve the delivery of preventative health care services, and that includes annual wellness visits (AHRQ, 2018). The different modalities of patient reminders and recalls, such as electronic email and text messages, all show effectiveness; phone calls prove to be the most effective (AHRQ, 2018). Ten percent of the patients who needed an annual wellness visit received an electronic reminder/recall sent in the modality selected by the patient when they registered in the clinic—text messages, electronic email, or automated phone calls. Additionally, from the patient recall list, live monthly phone calls were made to patients asking them to schedule their annual wellness visit. As demonstrated in *Figure 2*, there was an overall rise in the number of patients who scheduled an annual wellness visit, and the number of completed visits.

Limitations

The rotating schedule of the medical residents made it difficult to provide information and education about the project at the same time. Therefore, some residents did not have one-on-one information about the project's interventions until weeks into the project. An electronic mail for all of the providers was sent, which was necessary to communicate with providers who were working in other clinics for an extended amount of time. Additionally, the facility caps the number of 30-minute appointments to a maximum of 40 appointments monthly for established patients. This may have created a scheduling conflict for some patients.

Another limitation of the project is the staff's inability to document why an appointment was not scheduled. The EHR for this clinic still does not have a specific section for the PARs to document scheduling issues. Labels for wellness visits continue to be scheduled as "established patient 30-minute appointment." There are other types of appointments that are scheduled under the same label.

Recommendations

The clinic needs to have a specific label for annual wellness visits that would assist the staff in scheduling the annual wellness visits, and assist providers in preparing for their appointments. Due to the residents' rotating schedule, it is recommended that continuous education is provided to keep them abreast of the changes at the home-base clinic. Evidence-based practice demonstrates that completing an annual wellness visit reduces chronic health conditions (NCCDPHP, 2019; NCQA, 2018; World Health Organization, 2017). While this quality improvement project focused on adult population ages 18-64, the recommendations also apply to the pediatric population as well those 65 and older.

Implication for Practice

Patients who complete an annual wellness visit are more likely to decrease chronic disease, reduce the severity of disease with early interventions, and prevent disease with recommended medical screening and vaccinations (CDC, 2017). It is the responsibility of the clinic as a whole to continue to work on establishing a culture of health prevention. It is the responsibility of all health care providers to build rapport and educate their patients on a variety of options to decrease diseases and improve health outcomes.

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Appendix A

PATIENT INSTRUCTIONS AFTER APPOINTMENT

Your Primary Care Provider (**PCP**) is:______________________________
Return in: _____days_____weeks______months______year
Follow up: ___________________________
Annual Preventive__________________ Medicare Wellness______________

_____**Laboratory:** Please take your lab slip with you. (Quest, Labcorp, CPL)
_____**Pharmacy**: You will be picking up _______ medications today
_____**Radiology**: Please call Radiology to schedule an appointment (See Radiology Slip)
_____**Referrals**: You have been referred to______________________________*

*Routine referrals, please allow **10 business days** after your appointment for our office staff to complete. After our staff notifies you of the approved referral, **YOU are responsible for calling the specialist's office to make your appointment.**
If you have not received a call or letter from our office or the Specialist's staff in 10 days, call 210-703-9001 and ask to speak to one of our Referral Coordinators.

Medication Refills

1. Look on your prescription bottle to see whether you have remaining refills. If you do have refills, please call the pharmacy listed on the prescription bottle to request.

2. If you have NO remaining refills, please call us at 210-703-9001 to make a refill request. Provide your name, telephone number, medication name, dosage, and quantity taken. If the clinical staff or provider has any questions or concerns about the medication, he/she will call you to discuss. Otherwise, you can expect the refill to be ordered with **5 business days** and sent to your pharmacy on file.

Forms
Any forms such as: parking permits, FMLA, school or asthma action plans, etc. typically need an appointment. **You must fill out your portion of the forms before dropping off your paperwork.**
Please allow **10 business days** to have the forms completed by our staff.

Remember Medical Equipment: Walker, Incontinence supplies, Diabetes supplies need an appointment every 6 months.

Remember our Patient Portal! Log into https://622.portal.athenahealth.com

Appendix B

11/14/2018

Project Lead: Martha Caceres
Project title: Increasing Annual Wellness Visits for adults ages 18 and over in Family Practice Clinic

Martha:

Your project titled "Increasing Annual Wellness Visits for adults ages 18 and over in Family Practice Clinic" was deemed to be **Not Regulated Research**.

Your proposed project was reviewed and found to not meet federal regulatory requirements for human subject research and does not require approval via the IRB process. Please use the IRB number **NRR [18-023]** when inquiring about or referencing this determination.

No further review of the project as proposed is required. Should you determine at any point you wish to add additional elements to the project, please contact us before initiating those components, as this may impact the determination.

For information regarding the IRB or the review process, please contact me at (210) 805-5885.

Sincerely,

Ana Hagendorf, PhD, CPRA

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