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Increasing the Value of Medicare Annual Wellness Visits for Patients and Providers

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Abstract

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MS, Clemson University, 2006

BS, Lander University, 1997

Project Submitted in Partial Fulfillment

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Abstract

The Medicare Annual Wellness Visit (AWV) has been available to Medicare beneficiaries since 2005; however, most eligible individuals have not taken advantage of this benefit. The literature supports that patients are willing to schedule and complete an AWV if urged to do so by their primary care provider; however, providers are reluctant to advise patients to pursue the AWV due to the lack of perceived value and overall health benefit. The integrative theory of health behavior change was used as the theoretical framework for the project. By increasing patient self-management skills through education, engagement, and support, the project was designed to create a positive impact on the overall health of individuals eligible for the AWV, as demonstrated by evidence of a long-term decrease in chronic conditions and related complications. A retrospective chart review was conducted to evaluate the number of preventive care measures completed in 2 patient populations: those with a completed AWV in 2017, and those without a completed AWV in 2017. The number of completed preventive screenings for colon cancer, breast cancer, fall risk, and depression was as much as 41.6% higher among patients that had completed an AWV. The project's findings will be used to educate providers and patients about the usefulness of Medicare AWVs. Finally, the project findings support positive social change through enhanced patient activation in preventive health strategies.

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Section 1: Overview of the Evidence-Based Scholarly Project

Introduction

Healthcare payment models continue to shift from volume-based to more value-based methodologies. While this movement is necessary to help ensure the long-term viability and sustainability of healthcare, many organizations are struggling with the need to presently function within a fee-for-service structure while building more quality and risk-based models for the future (Centers for Medicare and Medicaid Services [CMS], 2017a). In 2016, nearly 25% of all healthcare payments were linked to alternative payment models (APMs) (CMS, 2017a). Additionally, the Department of Health and Human Services (DHHS) established a goal to move at least 50% of all Medicare payments to an APM by the end of 2018 (CMS, 2017a).

Gilbert, Goldberg, Morgan, McGrew, and Oliva (2016) discussed the need for organizations to develop holistic, population-health based systems to be poised for future success. With the predicted increase in APMs, organizations will be paid based on their ability to provide consistently high-quality services at the lowest possible cost (Gilbert et al., 2016). The authors encouraged organizations to critically assess their present capabilities as compared to the anticipated demands of future APMs (Gilbert et al., 2016). Successful healthcare organizations will be able to balance the quality, cost, and experience of patient care.

The enactment of the Patient Protection and Affordable Care Act (PPACA) in 2011 resulted in more than 20 million previously uncovered Americans now having

insurance coverage (Sundwall, 2017). Based on the latest census information (2006), only 9.1% of Americans were without healthcare coverage (Sundwall, 2017). This increase in coverage was due to several factors including Medicaid expansion, the Health Insurance Marketplace (or the Federal Exchange), and changes in private insurance (Sundwall, 2017).

Because of these changes, more emphasis was placed on chronic disease management and complication prevention. Chronic illnesses such as heart disease and diabetes accounted for 70% of the annual deaths in the United States (Wilson, 2009). Additionally, chronic diseases were associated with more than 75% of the total cost of care in the United States (Wilson, 2009). Efforts to promote chronic disease prevention or proper management were aimed to reduce these costs while maintaining or improving the quality of care provided (Wilson, 2009). Organizations that focus on chronic disease prevention will likely positively impact the overall cost, quality and experience of care.

The goal of this project was to outline a plan to positively impact the disease prevention strategy of Medicare Annual Wellness Visits (AWVs). Specifically, my aim with the project was to increase the value of Medicare AWVs for both patients and providers. This paper includes an overview of the evidence-based scholarly project, a review of the scholarly evidence, methods for accomplishing the purpose and goals of the project, project findings and recommendations, and a dissemination plan.

Problem Statement

Most providers and patients remain confused about the purpose and content of an AWV resulting in poor utilization of this preventive healthcare strategy (Gorbenko,

Metcalf, Mazumdar, & Crump, 2017). In fact, only 9 million Medicare beneficiaries participated in an AWV in 2015 (CMS, 2016). With more than 100 million lives covered by Medicare, 9 million AWVs represented a very small portion of the total population (CMS, 2015). With such limited use of the AWV benefit, the full impact of this preventive strategy is unknown.

Medicare wellness visits are not complete physical exams. Instead, the AWV is focused on health risk assessment, preventive screening, and risk mitigation (CMS, 2014). Additionally, full medication reconciliation is performed as part of this visit, and a personalized prevention plan, covering screening and testing recommendations for the next 5-10 years, is also developed (CMS, 2014).

Medicare began offering reimbursement for AWVs in 2005 in the form of "Welcome to Medicare" visits for newly-eligible Medicare Part B patients (CMS, 2015). As part of the PPACA, Medicare expanded the wellness visit offerings to include an AWV in 2011 (CMS, 2015). Anticipating a positive impact to the health of the Medicare population and a reduction in overall healthcare costs, CMS placed heavy emphasis on the provision of AWVs (CMS, 2015). Given this focus, along with the potential revenue opportunity and positive impact to population health, many organizations have established programs to encourage patients to take advantage of these covered services.

Purpose

Despite full coverage of the AWV under Medicare Part B benefits, many providers and patients have not embraced the AWV (Gorbenko et al., 2017). In fact, Jensen, Salloum, Hu, Ferdows, and Tarraf (2015) found no effect on preventive service

usage in Medicare beneficiaries after the changes in 2011. The authors noted that insurance enhancements cannot solely raise the utilization of preventive services; specifically, barriers related to provider education and behavior must be addressed in addition to these modifications to payer plans to be successful (Jensen et al., 2015).

If providers continue to have confusion related to the purpose and content of an AWV, they will waste time and money, which jeopardizes their overall efficiency and earning potential (eMDs, 2017). Also, missed preventative screenings could lead higher rates of chronic illnesses and catastrophic diseased states in this patient population (Wilson, 2009). The information gained from this project added to the body of knowledge related to AWVs, preventive health, and risk mitigation of Medicare patients.

The provision of AWVs can be an important platform for increasing preventive screenings in the Medicare population; however, the amount of literature was inadequate to provide enough evidence that an increase in AWVs equated to an increase in appropriate preventive services in this population. Provider input and engagement is critical in increasing the number of AWVs completed and the value of the AWV to patients.

Nature of the Doctoral Project

The primary sources of evidence for the doctoral project were scholarly, multidisciplinary healthcare journals. Efforts were focused on finding scientifically rigorous, peer-reviewed studies including any available meta-analyses and randomized clinical trials. Evidence was obtained through literature searches using The Cumulative Index to Nursing and Allied Health Literature (CINAHL). Additional evidence was

obtained from governmental, educational, and other reputable healthcare organizations such as CMS and the Centers for Disease Prevention and Control (CDC). This information was obtained through general internet searches.

Significance

The relatively low completion rates of AWVs in the Medicare population affects several key stakeholders including patients, providers, payers, and healthcare organizations. Additionally, the overall cost of care is impacted by preventable chronic illnesses and related complications. Finally, the overall health and well-being of our nation is affected if the population is wrought with disease and sickness.

There can be significant economic impact to organizations that increase the number of AWVs completed within their Medicare population. The average reimbursement for the initial AWV (paid once per lifetime per beneficiary) is $172, while the average reimbursement for the subsequent AWV (paid every 12 months) is approximately $111 (eMDs, 2017). In addition to the revenue potential of the AWV, there is potential downstream revenue in the referrals for preventive screenings and decreased cost per Medicare beneficiary due to early detection and treatment of disease (eMDs, 2017). As a result, providers are able to positively affect their earning potential with an increase in AWV completions.

The AWV includes several health screenings that are useful for diagnosing a variety of chronic illnesses common in senior adults (Hain, 2014). A functional, cognitive, fall risk, and depression screening are typical components of the AWV (Hain, 2014). The information gleaned from these assessments help guide treatment and

personalized prevention plan for the individual patient. Ultimately, spending per Medicare beneficiary will be reduced due to the prevention or early treatment of chronic disease.

Additionally, the AWV is an opportunity for the primary care provider and patient to connect at least annually to ensure desired health outcomes are achieved (Hain, 2014). This connection carries significant weight in the attribution model used by Medicare and other payers (CMS, 2016). This attribution will define the populations served in risk-based and other alternative payment method models.

Summary

AWVs are an emerging preventive health strategy designed to provide an opportunity for early disease detection, health education, and development of a long-term wellness plan. Eligible patients are not routinely taking advantage of this Medicare benefit due to lack of perceived value or misunderstanding of the purpose and context of the AWV. Efforts to understand the clinical impact of the AWV to increasing evidence-based preventive screenings will potentially lead to improved provider and patient engagement.

Section 2: Review of Scholarly Evidence

Concepts, Models, and Theories

Personal behaviors are strong influencers on overall health. Health risk behaviors are defined as those unhealthy behaviors that are modifiable (CDC, 2017). Poor nutrition, lack of exercise, and tobacco abuse are the primary health risk behaviors that contribute to the development of chronic illness (CDC, 2017).

Nearly 117 million people had one or more chronic condition in 2012 (CDC, 2017). In fact, one in four adults had two or more chronic conditions in 2012 (CDC, 2017). Additionally, 50% of adults did not meet physical activity recommendations in 2015 (CDC, 2017). As a result, 36% of the United States' population (or approximately 84 million people) were considered obese during the period of 2011-2014 (CDC, 2017). The high number of patients with multiple chronic conditions, lack of physical activity, and diagnosed with obesity further emphasized the need for preventive health care such as AWVs.

The integrated theory of health behavior change (ITHBC) provided the theoretical framework for this doctoral project. The ITHBC focuses on increasing patient self-management skills, as well as enhancing overall health knowledge in patients diagnosed with chronic disease or those who are considered high-risk for developing chronic disease (Ryan, 2009). Additionally, ITHBC theorists suggested that increased patient engagement and knowledge in self-regulation abilities is the "proximal outcome influencing the long-term, distal outcome of improved health status" (Ryan, 2009, p.

161). Therefore, the ITHBC was an appropriate choice for this project's theoretic framework.

The ITHBC has multiple constructs including knowledge and beliefs, self-regulation, and social facilitation (Ryan, 2009). Emphasis is placed on increasing the patient's knowledge and beliefs regarding the specific health concern (Ryan, 2009). The self-regulation concept focuses on incorporating behavior modification into lifestyle (Ryan, 2009). Finally, social facilitation highlights the need for informational, emotional, and other supports to engage patients in healthy behaviors (Ryan, 2009).

True health promotion requires behavior modification (Ryan, 2009). The anticipated immediate outcomes of this project were improved patient and provider engagement as evidenced by an increase in AWVs performed and the number of preventive screening completed. Long-term outcomes will hopefully include decreased chronic illness and their related complications over time.

Relevance to Nursing Practice

While day-to-day management of chronic conditions is the primary responsibility of the individual patient, healthcare providers must provide initial and on-going training and education regarding chronic disease self-management skills. Specifically, nurses are often tasked to support patients through care coordination, instruction, health promotion, and other activities.

Medicare AWVs are preventive medicine strategies aimed to reduce the risk of disease through early detection, education, and counseling (CMS, 2015). To strengthen the current policies related to preventive screenings and health promotion, nursing leaders

must help advocate for the value of such tools through patient and provider education, process development, and care innovation. Provider input and engagement is critical in increasing the number of AWVs completed and the value of the AWV to patients.

There is often a gap between the current evidence-based standards of care and current process (Bussières et al., 2016). This is often not necessarily due to the organization's or individual provider's unwillingness to adopt best practice standards, but more often, this is a result of multiple, competing priorities with limited human and time resources. As a nursing leader, it is imperative to help operationalize preventive medicine strategies into current workflows. Nurses must shift from the way things have always been done to care innovation and transformation. The information gathered because of this project increased the body of knowledge on this important topic and may help drive new practice guidelines related to the provision of AWVs.

Local Background and Context

The setting for this project was a multi-specialty medical group in upstate South Carolina. The medical group employs more than 400 providers including 140 primary care specialists serving in 34 locations. The project was completed within the primary care setting.

Additionally, the organization had a board-level goal to ensure at least 65% of the Medicare population has an AWV completed. All primary care providers had a portion of their compensation plan linked to their AWV performance. Additionally, the organization was in the process of adopting a Lean Management System to focus performance improvement and standardization efforts across the medical group.

Overall, organizational acceptance and support of this project was present; however, lack of a standardized process and available resources have historically caused concern amongst providers. Additionally, some providers did not clinically support the AWV due to perceived lack of value to the patient. This project aimed to determine the clinical significance of AWVs in relationship to preventive health screenings.

Role of the DNP Student

This doctoral project had several implications for the Doctor of Nursing Practice (DNP) student. In fact, the project applied to at least three of the essentials of doctoral education for advanced practice nursing cited by the American Association of Colleges of Nursing (AACN, 2006). These foundational concepts demonstrate core competencies that all doctoral candidates must possess (AACN, 2006).

The first essential competency addressed by this project was Essential I: Scientific Underpinnings for Practice (AACN, 2006). In this essential, DNP graduates integrate nursing science with evidence from other disciplines to elevate nursing practice (AACN, 2006). Additionally, DNP graduates should be able to use a science-based theory to identify a healthcare delivery issue, propose potential solutions, and evaluate outcomes of a program (AACN, 2006). The use of the ITHBC as the theoretical framework for this project's design, implementation, and evaluation served as evidence of competency for this essential skill.

The second essential competency applicable to this project was Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking (AACN, 2006). This essential requires that DNP graduates focus on the needs of target

populations by developing new care delivery models based on current evidence-based standards of care (AACN, 2006). Additionally, DNP candidates must be able to navigate organizational and political policy arenas by demonstrating strong, competent leadership to drive quality improvement (AACN, 2006). In this project, significant emphasis was given to increasing the value of an important preventive health measure to both providers and patients.

Finally, this project addressed Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice (AACN, 2006). This essential requires DNP graduates to participate in scholarly activities to solve practice problems (AACN, 2006). Specifically, a hallmark of doctorally-prepared nurses is the ability to translate research and new knowledge into practice (AACN, 2006). This project demonstrated this competency by applying the current evidence related to preventive health and wellness to a current practice problem (i.e. low utilization of AWV Medicare benefits). Additionally, the project included an evaluation of the clinical benefit to increasing the number of AWVs performed by determining the impact to preventive screening completions.

Summary

The ITHBC was an appropriate theoretic framework for this doctoral project as it aimed to increase patient education and awareness of the value of Medicare AWVs. Additionally, the impact of this project to nursing practice was significant due to nursing's role in health promotion, education of self-management skills, and care coordination across the continuum. Specifically, this project applied to the DNP role

through the translation of evidence into clinical practice, use of multidisciplinary theories, and evaluation and revision of current care delivery models.

Section 3: Approach/Methods to Accomplish Purpose and Meet Goals of the Project

Introduction

AWVs are an important healthcare benefit and preventive health tool for millions of Americans. However, many Medicare patients do not take advantage of the AWV due to misunderstanding of the purpose of the visit, confusion about insurance coverage, or lack of provider buy-in and engagement. In this section, I defined the problem further by outlining applicable sources of evidence and the project completion plan.

Practice-focused Question

The project evaluated the current healthcare practices related to the provision of AWVs. Additionally, the project helped to establish the value of the Medicare AWV for both patients and providers. Finally, the project answered the question "Do patients who receive a Medicare AWV have fewer open gaps in care (i.e. more preventive screenings/services completed) than those patients who do not receive an AWV?"

Sources of Evidence

Published Outcomes and Research

Ganguli, Souza, McWilliams, and Mehrotra (2017) noted that the majority of AWVs were performed by primary care providers (PCPs). The regional AWV rates in 2014 ranged from 3.0% (Texas) to 34.3% (Wisconsin) (Ganguli et al., 2017). From 2011 to 2014, the percentage of Medicare beneficiaries with a documented AWV increased from 7.5% to 15.6% (Ganguli et al., 2017). Several categories of patients including Caucasian race, urban location, and higher socioeconomic class were found to be more likely to receive an AWV (Ganguli et al., 2017). The authors ultimately noted that more

research is required to determine if AWVs increase preventive care and decrease risk factors in the Medicare population (Ganguli et al., 2017).

Tetuan et al. (2014) evaluated the effectiveness of an AWV clinic in improving the completion of preventive screenings such as colonoscopies and mammograms. The authors found that patients who completed an AWV were more likely to complete recommended mammogram screenings (Tetuan et al., 2014). However, no significant difference was noted in patients' adherence to colonoscopy testing (Tetual et al., 2014).

Zorek et al. (2015) found a positive correlation between interprofessional teaching in improving patients' adherence to preventive care service recommendations. Study participants were recruited based on age (66-74 years) and AWV status (no prior utilization of AWV benefits) (Zorek et al., 2015). The authors noted a 91% improvement overall in preventive service completion with the most gains noted in pneumococcal vaccination, mammography, fecal occult blood testing, and bone mineral density testing (Zorek et al., 2015).

Depression screening using a standardized tool such as the PHQ-2 is a required component of the Initial Medicare AWV (Pfoh, Mojtabai, Bailey, Weiner, & Dy, 2015). Pfoh et al. (2015) noted that there was no statistically significant difference in depression screening completion between patients receiving an AWV versus those not receiving an AWV. The authors concluded that the inclusion of depression screening in the AWV requirements was not adequate to incentivize providers to change preferred workflows and practices (Pfoh et al., 2015). Additionally, the authors called for further research to

determine and address the rationale for not utilizing the Medicare AWV benefit to its fullest extent (Pfoh et al., 2015).

Jianhui, Jensen, and Nerenz (2015) conducted a study to determine if any differences existed based on race in the percentage of Medicare beneficiaries who were utilizing their AWV benefit. Based on a sample of nearly 70,000 patients, the authors noted that the overall use of the AWV benefit rose from 2011-2014; however, the rate rose faster in white beneficiaries moving from 3.1% to 16.1% (Jianhui et al., 2015). The use of the AWV benefit during the same time for Black beneficiaries only rose from 0.6% to 8.6% (Jianhui et al., 2015).

Additionally, the authors found that the demographic of those using the AWV benefit were typically younger, male, married, white, and affluent (Jianhui et al., 2015). These individuals also had fewer chronic disease burden and had fewer primary care office visits (Jianhui et al., 2015). The authors suggested that additional research needed to be conducted in order to determine if the intended effects of the addition of these visits to the PPACA were achieved (Jianhui et al., 2015).

Patients are more likely to schedule and complete an AWV if their primary care provider or other physician recommends it (Bluestein, Diduk-Smith, Jordan, Persaud, & Hughes, 2017). Additionally, the AWV provides an opportunity to develop a personalized prevention plan as well as review and update medications, health history, and healthcare providers (Bluestein et al., 2017). The authors also noted that the AWV was a unique opportunity for providers to have proactive and coordinated discussion

which is nearly impossible to accomplish in the typical illness-focused visit (Bluestein et al., 2017).

Orom, Homish, Homish, and Underwood (2014) studied the impact of physician influence on patient choice of treatment options for prostate cancer. The authors noted that factors of the physician-patient relationship including trust, closeness, and shared decision-making were associated with greater influence (Orom et al., 2014). Ultimately, the authors identified the quality of the physician-patient relationship as an important motivator in patient adherence and adoption of a treatment plan (Orom et al., 2014).

Musich, Wang, Hawkins, and Klemes (2016) analyzed cost and usage data for patients actively engaged with a primary care provider in completing preventive health screenings. The authors noted that engaged patients demonstrated a decrease in emergency department and urgent care utilization as well as an overall reduction in healthcare spend (Musich et al., 2016). Specifically, the authors related these positive results to the ability of the primary care provider to develop a strong relationship with the patient that includes both education and encouragement (Musich et al., 2016). The development of this personalized prevention plan is a critical component of an AWV and establishes a roadmap for patient success in completing recommended health screenings and lifestyle modifications (Musich et al., 2016).

Evidence Generated for the Doctoral Project

Participants

All participants had at least one office encounter with a medical group PCP in 2017. Participants also had traditional Medicare Part B or a Medicare replacement plan

as their payer source. Additionally, participants had the AWV as a covered benefit of their plan. Finally, participants were divided into two equal groups—those who had and those who had not received a Medicare AWV in calendar year 2017. During fiscal year 2017, the medical group completed approximately 25,000 AWVs. A total sample size of 200 patient records was reviewed. Half of the records (e.g. 100) reflected patients with a documented, completed AWV while the other half consisted of patients without a documented, completed AWV.

The total number of patients that had not received an AWV in 2017 was 18,572. The total number of patients that received an AWV in 2017 was 23,760. A random sample procedure was used to identify the patients for the study. The data analyst pulled every 237th patient to be included in the sample.

Procedures

Retrospective chart reviews were completed on the sample size of patients described above with half receiving an AWV and the other half not completing an AWV during the time period. The number of preventive screenings completed was documented for each sampled patient. Specifically, the status of colorectal cancer, breast cancer, depression, and fall risk screenings was documented. Patients who did not qualify for the screening were removed from the denominator for that measure.

The U.S. Preventive Services Task Force (USPSTF) (2017) Recommendations for Primary Care Practice were used as the criteria for inclusion and exclusion from the measure denominator for breast and colorectal cancer screenings. A patient's eligibility for the specific recommendation was based upon factors such as gender, age, and past

medical history (USPSTF, 2017). The USPSTF updates its recommendations as needed to remain current with the available, relevant literature for each preventive health screening.

The USPSTF (2017) recommends screening for colorectal cancer for patients aged 50-75 years and breast cancer screening for female patients aged 50-74. Patients with a history of colorectal cancer or colectomy are excluded from the denominator for the colorectal cancer screening measure (USPSTF, 2017). Likewise, patients that have a history of a bilateral mastectomy or two unilateral mastectomies are excluded from the breast cancer screening recommendation (USPSTF, 2017).

The exclusion criteria for fall screening was limited to patients who were bed or wheelchair bound. The exclusion criteria for depression screening included a documented diagnosis of bipolar disorder or depression. No USPSTF recommendations exist for these two preventive screenings.

Protections

A retrospective review of medical records was used to obtain the necessary data for the DNP project completion. Institutional review board (IRB) approval was obtained from both Walden University and the participating organization. A limited data set with de-identified patient data was provided to the doctoral student for completion of the project. No identifiable protected health information was contained within the data set. Special care to protect human subjects was taken as evidenced by the use of de-identified data and reporting findings at an aggregate level (not the individual level).

Analysis and Synthesis

The data obtained from the retrospective chart review was analyzed to compare the raw number of applicable preventive screenings completed in the two different sample populations. Patients were selected at random for inclusion in one of the two groups based upon their AWV completion status. Patients were then categorized into eligible and ineligible groups. Both groups were further evaluated and subcategories were created. Specifically, the eligible population was sorted into two categories—preventive health screening complete and preventive health screening incomplete.

Finally, the project results were synthesized with current, available research evidence to determine the need for further exploration or expansion of the sample population. Additionally, the data and current literature was evaluated to determine if adequate evidence exists to positively relate the completion of AWVs to increased preventive health screenings.

Summary

The goal of this DNP project was to determine if a relationship exists between the completion of a Medicare AWV and increased preventive health screenings. A retrospective chart review of a sample population was used to study this potential correlation. Project findings were analyzed for applicability to current practice and need for further study.

Section 4: Findings and Recommendations

Introduction

In 2011, the CMS created the AWV in an effort to increase preventive health services for its beneficiaries (CMS, 2016). Despite this benefit, the number of AWVs completed in the Medicare patient population has not increased significantly since that time (Galvin et al., 2017). Ultimately, the addition of the AWV along with the restructuring of the benefit plan has not positively impacted the use of preventive services in Medicare patients (Galvin et al., 2017).

Through this project, I aimed to contribute to the existing literature on the subject of AWVs and preventive health screenings through the use of a retrospective limited data set. Specifically, the purpose of the project was to determine if there was a correlation between the completion of AWVs and preventive health screenings for breast cancer, colorectal cancer, fall risk, and depression. Ultimately, the ability to link the completion of the AWV to an increase in preventive health screenings could enhance the value of the preventive visit for both providers and patients.

Findings and Implications

In the sample population, the number of completed preventive screenings for colon cancer, breast cancer, fall risk, and depression was higher among patients that had completed an AWV. As shown in Table 1, preventive health screenings for these categories ranged from 76.5% (breast cancer) to 89% (depression) amongst those patients that had completed an AWV during 2017. In contrast, the number of preventive health

screenings completed in the incomplete AWV patient population ranged from 41.8% (colon cancer) to 58.3% (breast cancer) as shown in Table 2.

Table 1

AWV Completed: Number of Preventive Health Screenings

	Colon Cancer	Breast Cancer	Fall Risk	Depression
Total Population	100	100	100	100
Ineligible	38	66	0	0
Eligible	62	34	100	100
Up-to-Date	50 (80.6%)	26 (76.5%)	88 (88%)	89 (89%)
Overdue	12 (19.4%)	8 (23.5%)	12 (12%)	11 (11%)

Table 2

AWV Not Completed: Number of Preventive Health Screenings

	Colon Cancer	Breast Cancer	Fall Risk	Depression
Total Population	100	100	100	100
Ineligible	33	52	3	3
Eligible	67	48	97	97
Up-to-Date	28 (41.8%)	28 (58.3%)	45 (46.4%)	51 (52.6%)
Overdue	39 (58.2%)	20 (41.7%)	52 (53.6%)	46 (47.4%)

The difference in number of preventive screenings completed between the two patient populations is shown in Table 3. The smallest difference between the two populations was found in the breast cancer screening measure. With 76.5% completion of this preventive screening in the AWV completed population versus 58.3% in the AWV incomplete population, the delta of 18.8% was the smallest difference noted. The highest difference in the two populations was noted in the fall risk screening measure with 88% (AWV completed population) versus 46.4% (AWV incomplete population). The

difference of 41.6% was the largest difference in preventive health screenings completed amongst the two patient populations.

Table 3

Difference Between Preventive Screenings Completed in AWV Completed and AWV Incomplete Populations

	Colon Cancer	Breast Cancer	Fall Risk	Depression
AWV Completed	50 (80.6%)	26 (76.5%)	88 (88%)	89 (89%)
AWV Incomplete	28 (41.8%)	28 (58.3%)	45 (46.4%)	51 (52.6%)
Delta	38.8%	18.2%	41.6%	36.4%

The implications of this project affect individuals, communities, institutions, and the overall system of healthcare in the United States. With additional evidence supporting the positive value of completing AWVs, providers will hopefully become more engaged and proactive in promoting AWVs in their patient populations. Additionally, patients will be able to review the recommendations of their providers considering relevant evidence.

Communities will benefit from an increase in preventive health screenings and early intervention and treatment for members of the community. Hospital systems will benefit with increased revenue and improved quality scores with payers and other regulatory bodies. Finally, the overall system of healthcare in the United States will benefit as a result of an increased focus on preventive versus treatment of the sick healthcare.

Recommendations

The recommended solution to the practice problem of perceived lack of value of Medicare AWVs for both patients and providers is to begin with education to the medical

group primary care providers. The education must be evidence based and review the relevant literature and study findings. Additionally, the focus of the education should be well-rounded with emphasis on increased quality, financial implications, improved patient outcomes, and community impact.

In a recent study, Orom, Underwood, Cheng, Homish, and Scott (2018) described the impact of the patient-physician relationship in treatment plan adherence. The authors noted that the quality of the physician-patient relationship directly impacted the patient's willingness to follow physician recommendations for treatment (Orom et al., 2018). Specifically, the authors noted that strategies such as training, practice, change, and patient feedback can improve the quality of the patient-physician relationship. This project's findings and other relevant evidence coupled with the appropriate engagement with the provider and patient can result in positive implications for multiple stakeholders.

Strengths and Limitations of the Project

One strength of this doctoral project is the alignment of the project with the organization's board-approved goals. The study was intentionally designed to create local evidence to enhance the medical group leadership's understanding of the value of Medicare AWVs. Despite evidence from other health systems and providers, the medical group desired for a study to be conducted on a local level to drive education and improvement efforts.

One limitation of the project was the relatively small sample size of 200 total patients. With the strict, defined exclusion criteria applied to this project, eligible patients within the population sample were sometimes limited. Specifically, the breast

cancer screening measure only applied to female patients per the USPSTF recommendations. The eligible population in this measure was 26 in the AWV completed population and 48 in the AWV incomplete population.

Future studies should have increased sample sizes to be able to potentially correlate findings to larger, more diverse populations. Additionally, a cross-community study may provide additional insights into geographic-specific considerations or concerns. Finally, the addition of more quality metrics may be warranted to obtain a more robust picture of the impact of completed AWVs and preventive health screenings.

Summary

The number of completed preventive screenings for colon cancer, breast cancer, fall risk, and depression was up to 41.6% higher among patients that had completed an AWV. The highest difference in the two populations was noted in the fall risk screening measure with 88% (AWV completed population) versus 46.4% (AWV incomplete population). Future studies should potentially have larger sample sizes and encompass a broader geographical range; however, this project contributed to the existing body of knowledge on Medicare AWVs and preventive health screenings.

Section 5: Dissemination Plan

It is often difficult to implement evidence-based practice (EBP) change in a practice setting. Challenges vary from a perception of inadequate time to lack of supportive leadership. Hauck, Winsett, and Kuric (2013) conducted a study to determine the impact of leadership support in implementing evidence-based practice. The authors found that transformational nursing leadership was a key driver of organizational movement towards the implementation of evidence through the empowerment of nurses (Hauck et al., 2013). Specifically, the study findings noted that leadership support in the areas of strategic planning, advocacy for education, dissemination of outcomes, and mentorship were key drivers in encouraging and empowering nurses to utilize evidence-based practice techniques (Hauck et al., 2013).

Bussières et al. (2016) discussed the relationship between knowledge, research, and evidence-based practice. In their study, the authors noted that most providers supported the idea of evidence-based practice; however, there was disconnect in providers implementing evidence-based practice standards. Additionally, Bussières et al. (2016) noted that much of the gap related to application of evidence-based standards resulted from lack of broad dissemination of research findings and new knowledge.

Bearing this information in mind, I have chosen to disseminate my scholarly product via a journal article. I plan to focus on care management, primary care, and preventive health opportunities. As a nurse, I also want to target nursing journals to ensure that the new knowledge is available to other nursing professionals.

Plaisance (2003) described the process for writing for professional publications and provided tips to increase the likelihood of acceptance of an article. The time required for successful acceptance of a journal article for publication varies greatly (Plaisance, 2003). If an author ensures that he or she has the right topic, the right journal, the right information, the right words, and the right time, the ability to successfully disseminate EBP will be greatly enhanced (Plaisance, 2003).

Analysis of Self

The ability to apply current research findings into clinical practice is an essential skill for all DNP graduates. In Essential III, the AACN (2006) described this foundational behavior as "the translation of research into practice and the dissemination and integration of new knowledge" (p. 11). As a scholar-practitioner and nurse leader, I must be competent in this skill to further the professional practice of nursing, enhance patient outcomes, and maintain a spirit of continuous learning and quality improvement. Additionally, as a doctorally-prepared nurse, I must set an example to my peers and employees by supporting the creation of new nursing practice evidence as well as the translation of that evidence into practice.

Summary

This doctoral project evaluated the relationship between Medicare AWVs and preventive health screenings. The project's findings demonstrated a positive association between the two; however, additional studies with larger sample sizes and more diverse populations may be required. Ultimately, this project will be used to further educate and

motivate providers and patients to increase the number of AWVs among the Medicare population.

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