Standard Work Activity Sheet		**Owner:** Ambulatory Nurses	**Rev. Date:** Jan. 2018
Step:	**Purpose:** Describes the process for conducting a Medicare Wellness Visit.	**Value Stream:** Medicare Wellness Visits	

Seq. No	Task Description:	Key Point / Image / Measure (what good looks like)	Who
1.	**Before Appointment** Provider indicates that the patient should return for a wellness visit.		Provider

2.	Assemble a "wellness visit packet" and send it to the patient at least 2 weeks prior to their appointment.	Packet should contain the following items:
		- Cover letter/explanation of visit
		  o Letter will mention that the patient will be seeing a nurse
		- Necessary paperwork
		  o Health Risk Assessment (HRA) form
		  o Confidential Communications form
		  o PCMH Agreement
		  o Advanced Directive (if patient does not already have one on file)
		  o Review of Systems (optional)
		- Medication bag
			Nurse

3.	2-3 days prior to the appointment, reach out to the patient and remind them of their appointment.	Remind the patient that they will be seeing a nurse during their visit, and that they should bring all of their paperwork and medications with them. Ask the patient if they have any questions for their provider.	Nurse
4.	**During Appointment** Patient arrives at office. All paperwork is collected, and given to the nurse to review before calling the patient back. Other electronic forms should also be signed at this time.	If the patient did not bring their paperwork with them, give them a new set of forms to complete. ALWAYS scan the patient's driver's license/ID, and insurance cards (including Part D card). **NOTE: The provider that "ordered" the wellness visit needs to be present in the office during the day of the appointment for billing purposes.**	Receptionist
5.	Patient is taken back to the exam room. During visit, the following items should be completed/reviewed and recorded: - Height, weight, blood pressure, and visual acuity - Review and update patient's surgical, medical, and social history - Update patient's "Care Team" in Epic with other providers that they are seeing - Immunizations and vaccinations - TUG test, mini-cog assessment, and PHQ 2-9 - Medication reconciliation - Health maintenance topics	Use the "LRHS AMB Welcome/Initial Medicare" or "LRHS AMB Subsequent Medicare Screening" SmartSet to document your notes in Epic. In order to drop a code for advanced care planning during the visit, your conversation needs to be at least 16 minutes long and be specific to advanced care planning.	Nurse

Seq. No	Task Description:	Key Point / Image / Measure (what good looks like)	Who
	- Health Risk Assessment form - Review/set a self-management goal - Complete Pap test and Pelvic & Breast exam (every 2 years) - Complete digital rectal exam (every 2 years) - Advanced Care Planning (optional) - Patient next steps		
6.	At the conclusion of the visit, walk the patient to the front desk to check out.	Complete a warm handoff to the receptionist/scheduler. Be sure that the patient is given a copy of their AVS, and that they either schedule their next appointment, or indicate on the AVS when their next appointment is due.	Nurse