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## Increasing Medicare Wellness Visit Participation in a Primary Care Clinic

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Increasing Medicare Wellness Visit Participation in a Primary Care Clinic

Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Nursing  
Practice at the University of Kentucky

By

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Lexington, KY

2022

## **Abstract**

**Background:** Medicare Wellness Visits (MWV) came into use in 2011 to provide Medicare patients and their providers a chance to create a 5 to 10 year plan to prevent illness, disease, and disability. These visits are often underutilized due to various barriers on both the provider and patient side.

**Purpose:** The purpose of this study is to assess provider barriers to conducting MWVs and provide an educational tool that will assist providers in increasing the number of MWVs conducted within this system.

**Design:** This is a descriptive, quasi-experimental study to assess provider barriers combined with a Quality improvement project that will focus on overcoming one of these barriers.

**Methods:** Provider barriers to MWVs were assessed via electronic survey. The educational tool, the 'Differences Between Visits' chart, was introduced to providers at a single primary care clinic within the healthcare system. Providers were educated on how to use the chart. After two months, a second survey was sent to the providers at the clinic to assess whether the chart was helpful and if providers would be willing to continue using it.

**Results:** Twelve respondents participated in the initial survey on provider barriers. Providers responded that the most important reason they did not complete MWVs was that they felt they already completed the requirements of the MWV during other visits and their patients want to discuss current health issues instead of discussing preventative measures. However, eight-three percent of the twelve respondents were somewhat or very likely to increase the number of MWVs they performed. After deployment of the 'Differences Between Visits' chart, one-hundred percent of the 4 providers who responded were satisfied with the chart and are somewhat or extremely likely to continue using the chart.

**Discussion:** In this study, providers seemed willing to improve the rate of MWVs they conducted and were receptive to the educational tool that was provided. Further research should be completed to identify strengths and weakness of the educational tool and what, if any, impact the tool has on completion of MWVs.

*Keywords:* Medicare Wellness Visit, provider barriers, patient education, educational tool, infographic, disease prevention, Geriatric, health behaviors, health education, health promotion, personalized prevention plan, primary care practices, quality improvement, Quality Caring model

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I would like to show my deep appreciation for Pam Thompson, Market Director, who provided some of the background information and statistics, as well as meeting with me on multiple occasions to answer questions.

I also wish to acknowledge the providers who participated in this research. Without their input and dedication to their patients, we would never have been able to do this research to begin with.

## **Dedication**

I would like to dedicate this study to my family and friends. Thank you all for supporting me and encouraging me to keep on going. Thank you to my husband, Julio, for allowing me space to work on my research, even when you had a lot on your plate. Thank you to my son, Julian, for providing me with comic relief. Thank you to my parents, Mark and Patti, for helping me with getting dinner on the table and taking care of the kids. Thank you to my best friends, Jennifer Noah, Shelley Larrabee, and Leah Bain for providing me with the most precious friendships I could ask for. Thank you to my friends in the program, especially Jennifer Yenke and Brittany Roher, for continually answering my questions and encouraging me to keep going.

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# **Increasing Medicare Wellness Visit Participation in a Primary Care Clinic**

## **Background and Significance**

### **Problem Statement**

According to the U.S. Census Bureau, twenty three percent of the U.S. population will be adults aged 65 years and older by 2060 (Jiang et al., 2018). Many of these adults have multiple comorbidities that can be costly to cover. In fact, an estimated 70% of illnesses and their associated costs come from life-style and vaccine preventable diseases (Farford et al., 2020). Medicare Wellness visits (MWVs) are assessments, provided free of cost to Medicare patients, that provide a way of evaluating the patient's potential health needs, including vaccinations and screenings, and creating a plan to address these needs over the next 5-10 years (Cuenca, 2019). This is a great tool to help Medicare patients focus on staying healthy as they age. MWVs can also provide an increase in revenue for the clinics and providers as incentive to focus on preventive healthcare and can improve quality measures (Cuenca, 2019). Unfortunately, research suggests that patients and providers often do not understand or see the value in completing these wellness visits (Bluestein et al., 2017; Cuenca 2019; Farford et al., 2020). Identified barriers include patient lack of knowledge of MWVs, patient lack of understanding of the purpose of the visit, provider ambivalence, complex documentation and billing, time constraints, and competing demands (Bluestein et al., 2017).

### **Context**

Medicare patients are typically adults, 65 years and older, who have applied for Medicare as a primary or supplemental insurance. Many of these patients already have multiple comorbidities that may affect their quality of life. In a disease and acute care focused healthcare system, a "hands-off" visit, like the MWV, can be difficult for patients to understand and see the

benefit in (Gardenier et al., 2019). Patients, misunderstanding the purpose of the visit, expect a physical and to be able to discuss their current health problems, acute and chronic, with their provider.

Typical primary care office visits are around 20 minutes or less, leaving little time to discuss preventive care measures (Chung et al., 2018). Providers are feeling more overwhelmed and rushed than ever due to increasingly unrealistic expectations for what they can accomplish in such a short visit (Privett & Guerrier, 2020), which leaves them less time to thoroughly educate patients on the importance of preventive care. In most clinics, there are many types of visits that a patient may experience. Most visits will be either an acute visit for sudden illnesses or injuries, a chronic visit for evaluating disease progression, or an annual physical exam to update patients on vaccinations, educate patients on a variety of topics specific to their time of life and health status, and complete recommended screenings, such as ordering a mammogram and screening for tobacco use. For Medicare patients, the annual exam is not covered, but the Medicare Wellness Visit, which focuses on developing or updating a Personalized Prevention Plan (PPP) and performing a Health Risk Assessment (HRA), is provided free of cost to Medicare recipients (Centers for Medicare & Medicaid Services: Medicare Learning Network, 2021).

According to Chung et al. (2018), older Americans are not using preventive care services at recommended rates. This means that they are not getting vaccinations and screenings to prevent disease or disability. While percentages vary throughout the research, Gardenier et al. (2019) state that only about 20% of MWVs are completed. The main benefit of the MWV is providing a clear view of the patient's and provider's healthcare goals to prevent or slow the advancing of disease and disability (Cuenca, 2019). Often times, primary care visits become sick (acute) visits, because patients have unmet needs and wish to discuss these needs with their

providers. However, without the creation of a plan, many of these needs will continue to be unmet. This may lead to worsening conditions outside the realm of the comorbidities already identified.

As with any profession, it is important that providers get compensated for the work they do. According to the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule website (2022), the current compensation for a MWV in Kentucky ranges from \$123.72 to \$135.17 per visit. Therefore, these exams are very lucrative for clinics and providers. When patients unknowingly attempt to turn their MWV into an acute or chronic visit, they are often hit with fees that they were not expecting. MWVs are provided free of charge every 12 months (Centers for Medicare & Medicaid Services: Medicare Learning Network, 2021). However, when additional issues are discussed and a physical exam is performed, providers are not paid for their services unless they code for both the MWV and the other exam they performed. When this is not adequately explained to the patient and they are not provided with the option to do both visits or come back for one, they are understandably distressed when Medicare refuses to pay for everything, and they are left paying for a physical exam.

### **Current Interventions**

There are a few strategies in the literature attempting to make sure that MWVs are completed appropriately. These range from having nurses or medical assistants doing the pre-visit planning (Cuenca, 2019) to using nurse managers and other nurses and staff to complete the entire visit (Bluestein et al., 2017). While these are excellent options, it is probably in the provider's and patient's best interest that the provider participate in at least some of the visit so that the provider and patient can have an open and ongoing relationship. Researchers have noted that providers feel that patients don't value preventive care and only wish to discuss acute issues

when they are seen (Chung et al., 2019). A good patient/provider relationship can lead to a level of trust and understanding between the patient and provider that can make suggestions for health more meaningful to the patient and has the potential to help patients make more informed decisions (Kamimura et al., 2020). However, using other staff, such as clerks, nurses, medical assistants, etc., and technology, such as online patient portals, to relay and discuss pertinent information about the purpose of the visit could be beneficial and lead to more patient satisfaction with the process (Bluestein et al., 2017).

### **Purpose/Objectives**

The purpose of this project was to assess provider barriers to completing MWVs, as well as implement and evaluate an educational tool that could be used by primary care providers within a hospital system to teach Medicare patients about the differences between MWVs and other types of primary care visits. The first objective was to assess provider barriers to completing the MWVs by providing a short survey that asked providers to rank their reasons for not conducting these visits. This information set the stage for understanding why MWVs were not being completed within this particular hospital system.

Two of the barriers that providers in the research identified were that patients did not understand the purpose of the MWV and some providers did not understand how they needed to conduct a MWV. To address these issues, the second objective was to provide a tool that assists providers with educating Medicare patients on the differences between a normal sick visit, a physical exam, and a MWV. Lastly, the third objective was to assess the usefulness and sustainability of the educational tool.

## **Theoretical/Conceptual Framework**

The Quality Caring Model (QCM) by Joanne Duffy (2013) was created with the idea that caring relationships between healthcare providers and patients can provide a positive foundation and create a sense of safety that enables advancement in attaining health goals for patients.

Kamimura et al. (2020) shared that continuity of care, part of providing caring relationships, leads to improved communication, connection, patient centeredness, a higher degree of patient health literacy, and increases in self-rated health. The purpose of using this model for providers, including APRNs, is to provide a basis for seeing patients as unique beings capable of growth and change who are worthy of a provider's time and effort.

According to Duffy and Hoskins (2003), the QCM focuses on quality healthcare through evidence-based practices, while maintaining that people are interdependent on other people. The major components of this model include structure and process. Structure is made up of each person's demographics, psychosocial, cultural, and spiritual components. These components interact to influence outcomes of care. Process is the interventions/practices providers offer. People are complex and influenced by values, perceptions, communication, transactions, roles, and stress. In order for patients to take part in the process, they must be goal-oriented. Providers are encouraged to provide caring relationships. This model also discusses independent and collaborative relationships. The independent relationship is one that focuses on the relationship between the patient and provider. This focuses on the values, attitudes, and behaviors the provider carries out. Collaborative relationships are those among team members that allow the team to fully care for the patient.

The MWV and QCM model together build and foster caring relationships, while also respecting the patient's thoughts and feelings and encouraging them to interact with healthcare

providers in informed decision-making about healthcare needs within a comfortable, stress-free environment and considering their unique social situation. The goal of this project was to help providers and patients use the MWV as a meaningful process for preventing disease and disability, as well as managing health issues.

## **Review of Literature**

### **PICOT Question and Search Methods**

Medicare Wellness visits (MWVs) give patients and providers a roadmap for health and wellness by creating a plan to prevent patient health deterioration due to preventable illnesses, injuries, or diseases. Unfortunately, providers cite numerous reasons for not completing these visits. This study intended to address this problem through creating a patient education tool to help explain the differences between a MWV and other types of primary care visits. The PICOT question guiding this study is: Among Medicare-providers in the primary care setting, can an educational tool about MWVs help providers educate their patients on the differences between a MWV and other types of visits?

Two searches were conducted using PubMed, CINAHL, and Cochrane Library. The first search used the following keywords for provider barriers: Medicare wellness visit, providers, barriers, annual wellness visit, preventive, and physical exam. This search yielded 3 articles. The second search, which focused on patient education, used the following terms: patient education, health education, visual aids, health literacy, and infographics. This search yielded 4 articles. Inclusion criteria included the years 2011 to 2021, English language, peer reviewed journals, and full text available online. Exclusion criteria included newspaper articles, books, research outside of primary care setting, or education in forms other than printed.

## **Synthesis of the Evidence**

The number of actual studies focused on provider barriers to MWVs are limited. Three of the studies found were small, descriptive studies and used a short survey of providers in two clinics (Diduk-Smith et al., 2016), a healthcare system (Bluestein et al., 2017), and a state professional organization database (Simpson et al., 2017). The three major themes that showed up within the literature were lack of time, competing agendas, and provider lack of confidence in completing the MWV or difficulty understanding the requirements (Bluestein et al., 2017; Diduk-Smith et al., 2017; Simpson et al, 2017). Simpson et al. (2017) reported the following additional barriers: office workflow issues related to integrating MWVs and patients' undervaluing preventative healthcare (2017).

The literature on the effectiveness of providing written materials specifically for increasing health education is relatively sparse. However, two meta-analyses reported written education materials could affect the outcomes of health promotion (Giguère et al., 2020; Smith et al., 2021). Researchers were unable to conclude with significant confidence that this is a beneficial way of improving patient outcomes. However, both suggest that there is a small beneficial effect (Giguère et al., 2020; Smith et al., 2021).

A third study, conducted by Garcia-Retamero & Cokely (2017), was a systematic review of the benefits of visual aids, especially for those in varying levels of numeracy and graph literacy. The authors stated that visual aids support understanding of health risks, particularly in vulnerable populations and among less skilled individuals. They went on to discuss how simple, well-designed visual aids can dramatically improve communication and comprehension. While these researchers focused more on numeracy, they did provide a set of basic guidelines for visual aids. These guidelines include keeping the information simple and focused on essentials, depict

numerical information in addition to visual aids, and effective communications anticipate user needs and skills (i.e. target groups' reading level).

A study by Jahan et al. (2021) was a cross-sectional review of health education infographics quality and usefulness. This particular study did not focus on the accuracy of the graphics, but instead focused on the perception of whether the graphic was 'high quality'. The results showed that those with less text and more images were the most effective. The quality of the infographic was also linked to whether it was easily understood. The authors encouraged infographic authors to have explicit titles, large and appropriate font, appropriate colors, clear content, and a clear, specific purpose. These qualities increased understanding and retention. Lists were found to be helpful in avoiding missed messages.

### **Gaps in Practice**

While there seems to be some certainty in the literature about provider barriers to MWVs, further research could be conducted to provide more confidence in providers opinions across different primary care clinic settings. Printed educational materials have long been used to provide patients and providers with needed information, but there is little evidence that this is a productive, impactful option. According to the literature, providers would prefer to stay away from MWVs due to its complexity and uncertainty of payment. Within the literature, there have been a handful of attempts to increase MWVs by utilizing other healthcare providers, such as nurses, medical assistants, and office staff (Cuenca et al., 2012). These attempts have been successful on a small scale, but there is room for more research and studies identifying ways to increase MWVs participation and provide more health promotion to our Medicare patients.

## **How this Proposed Solution to the Problem Addresses the Gaps**

This Quality Improvement project attempted to provide more information on specific provider barriers and how to overcome one barrier by providing education materials. This tool was used to provide a clear explanation and manage patient expectations of the MWV. By improving communication, it is this author's hope that providers and patients will have a more satisfying experience during the MWV. This project may also serve as a foundation for future QI projects aimed at increasing MWVs.

## **Methods**

### **Design**

The design of this study was a descriptive, quasi-experimental study meant to assess provider barriers combined with a Quality Improvement project that focused on overcoming one of these barriers.

### **Setting/Context**

The first part of the study was conducted across all primary care clinics within a healthcare system in Lexington, KY. The healthcare system has 135 locations across 35 Kentucky counties and includes hospitals, primary care clinics, home health agencies, etc. Their mission and vision is to "make the healing presence of God known in our world by improving the health of the people we serve", thereby creating a healthier future for all (CHI Saint Joseph Health, 2021). Their values include compassion, inclusion, integrity, excellence, and collaboration. The second part of this study took place at one of the healthcare system's primary care clinics in Lexington, KY. This project meets the mission and goals of the hospital system by attempting to improve the health of Medicare patients through the use of preventive healthcare.

## **Stakeholders**

Stakeholders include the providers, Medicare patients and their families, the hospital system leadership team, office staff, IT, and billing. Facilitators for implementing this project at the primary care clinic include an environment encouraging quality improvement, the general push for clinics to increase revenue, the presence of an easy-to-follow form for MWVs already in use, strong support from the hospital system leadership due to their focus on increasing MWVs, a supportive clinic manager, clinic providers who were willing to implement the intervention, and a clinic that sees numerous Medicare patients. Barriers to implementation include providers who are resistant to change, workflow issues, the Medicare patients' ability to understand the purpose of the visit, timing (education was provided between two major holidays), length of intervention (providers only had two months to use the chart before the post-survey), and the small number of providers at the clinic.

## **Sample**

The target population included 21 primary care providers within a Lexington hospital system, including physicians, nurse practitioners, and physician assistants, that manage Medicare patients and are English speaking/reading/writing. Exclusion criteria included anyone who was not a primary care provider of Medicare patients and did not speak/read/write in English.

## **Tools**

The 'Differences Between Visits' chart was developed by the principal investigator based on a tool already in use by the hospital system. The revised tool includes a 18 inches by 51 inches poster that provides a clear delineation between the 3 major types of visits within a primary care setting: the sick visit, an annual/physical, and a Medicare Wellness visit (MWV)

(Appendix C). The poster provides information about the components of each visit, as well as what is not included in the visit. This way, providers have a basic, easy to understand tool to help them explain visit variations to patients (Giguère et al., 2020).

## **Measurements**

Demographics (provider role, gender, race, ethnicity, and age range), were provided by the Marketing Director for the 21 primary care providers and were not included in the survey. The pre and post intervention surveys were created in Qualtrics. The pre-intervention survey contained 2 questions. Providers were asked to rank a list of barriers that was based on the barriers found in the literature. These barriers included providers already covering this information in their visits, patients preferring to discuss health issues/not wanting to discuss preventative measures, patients not knowing that MWVs exist, time constraints, complex documentation requirements, providers not knowing how to complete a MWV, or patients not caring about preventative healthcare. The pre-intervention survey also asked providers how likely they were to increase the number of MWVs they performed based on a Likert scale of 1 to 5 with 1 being ‘most important’ and 5 being ‘least important’ (Appendix B).

After providers were given two months to use the educational tool (Appendix C), a post-intervention survey was sent out (Appendix D). This survey contained three questions in Likert format and assessed the helpfulness of the tool, provider satisfaction with tool, and the likelihood that providers would continue to use the tool. Lastly, a text box was provided to share recommendations on how to improve the tool. There is no reliability or validity information associated with this survey as there are no previous studies that have validated these questions.

## **Procedures**

Providers were sent a short Qualtrics survey via email with one week to respond. The survey was deployed by the Market Director who had access to the population email addresses. The ‘Differences Between Visits’ charts were placed in each exam room or given to the provider on a laminated piece of paper during a short presentation on how to use the chart. Providers were encouraged to ask questions and were free to discuss MWVs using the chart. Two months after the ‘Differences Between Visits’ chart was implemented, the post-intervention survey was deployed by the Market Director via email. Data was collected in Qualtrics and transferred to an Excel spreadsheet and a Word document. This data is stored on a password protected computer linked to the UK server.

Institutional Review Board (IRB) approval was obtained from the University of Kentucky IRB. Letters of support were obtained from the Market Director for the healthcare system and from the Practice Manager for the clinic where the educational tool was presented. The IRB approved this study through an expedited review process due to its minimal risk to the research participants (providers and patients). All data was collected in the form of anonymous surveys or de-identified data.

## **Data Analysis**

Provider demographics were analyzed using percentages (race, gender, provider role) and mean (age). Provider barriers were analyzed using the mean of each barrier to rank the barriers from most important to least important. The likelihood of increasing MWVs and satisfaction with the ‘Differences Between Visits’ chart were analyzed using percentages. Providers were

also asked to make suggestions for how to improve the chart by writing in changes. This was analyzed by looking for themes.

## **Results**

The pre-survey was sent to a group of 21 Primary Care providers, all of whom met the inclusion criteria. Twelve providers responded to the pre-survey for a response rate of 57%. The post-survey was sent to seven providers within a single primary care clinic, all of whom had the opportunity to respond to the pre-survey. Of the seven, only four responded to the post-survey.

Of the 21 providers, the majority of providers were Caucasian (n= 18, 85.71%), with two-thirds identifying as female, and between 40 to 45 years old. There were two providers that were older than 60. See Table 1.

According to this subset of providers, the two most important barriers identified in the pre-survey were that providers already felt they were completing the requirements of the MWVs during other visits and providers feel that patients want to discuss current health issues instead of or in addition to discussing preventative measures (see Table 2). The least important issue was providers feeling they did not understand how to complete a MWV. Interestingly, in this study providers felt that the stringent documentation requirements for a MWV was relatively low (5<sup>th</sup> out of 7) on the scale of most to least important issues. Of the twelve respondents, eight-three percent (N= 10) were somewhat or very likely to increase the number of MWVs performed. Only 16.7% (N= 2) of respondents indicated that they were 'somewhat unlikely' to increase the number of MWVs.

After the intervention, one-hundred percent of providers that responded (n=4) were somewhat or extremely satisfied. All of these providers also responded that they were likely to continue using the chart as well. When queried about any changes that needed to be made to the

chart, no suggestions were offered. However, one participant suggested using the chart in a handout format to give to patients.

## **Discussion**

This study was able to gather primary care provider perspectives about barriers affecting utilization of MWVs. Following implementation of a tool to decrease the knowledge barrier of both patients and providers, the study revealed positive opinions about the tool and its usefulness in practice.

Based on the pre-survey, providers in this health care system feel that they already complete the requirements of the MWV during other visits. While this could be seen as encouraging news, there are some concerns about this mentality. One concern is that providers are attempting to fit these assessments into an already packed visit, which means that issues may not be fully explored and the education provided may not be effective due to limited time to teach. A second concern is that providers may not actually be completing all the requirements or completing them as often as necessary, even though, according to the survey, they believe they are. This affects reimbursement as all the requirements must be met before the clinic will be reimbursed for the visit. The MWV is designed to gather specific information to help providers develop a health care plan focused on the following 5 to 10 years. Gathering snippets of information in every acute care visit does not lend itself to the thoughtful planning required to develop an accurate, useful health care plan. This is a missed opportunity to provide a clearly stated plan that will be easy for patient and providers alike to follow.

The post-survey results show that 100% of the respondents ( $N=4$ ) were somewhat or extremely satisfied with the 'Differences Between Visits' chart. They also responded that they were likely to continue using the chart. This is encouraging. However, it is important to note that

these providers may have been highly motivated to respond favorably due to numerous reasons, including the hospital system's push to increase MWVs, personal beliefs about the usefulness of MWVs, extra time for visits, reimbursement rate, etc. It is also important to note that we do not know why those that did not respond did not participate in the survey. It is possible that they did not like or use the 'Differences Between Visits' chart, prefer not to do MWVs at all, or perhaps they simply forgot to respond to the survey. Unfortunately, none of the providers gave feedback that would have been helpful for revising the chart in order to make it more user-friendly.

Despite feeling like they already completed the requirements of the MWVs during other visits, the willingness to use the MWV format in future visits was encouraging. This may show that a strong focus by management has the potential to help providers change their practice for the benefit of patients and the health care system. It is possible that the presence of the chart in the exam room also helps the providers remember to discuss MWVs with their patients, because visual aids can improve communication (Garcia-Retamero & Cokely, 2017). The patients themselves may also be more likely to ask questions after noticing the chart. This means that the chart, by virtue of being visible, may help providers remember to discuss MWVs with patients even if the provider does not refer to the poster during the discussion. The literature supports visual cues as a means to enhance change (Garcia-Retamero & Cokely, 2017). The 'Differences Between Visits' chart was left with the clinic that participated in the study.

This study is ripe for continuation. Since the 'Differences Between Visits' chart is easily reproducible, the surveys are quick for providers to take and easy to collect data from, and the topic is one that affects all U.S. based primary care clinics serving Medicare patients, another researcher has the potential to take the chart to numerous other clinics and, using the pre- and post-surveys already created, can apply this study to a larger group either within the same

hospital system or in other hospital systems. By replicating this study, researchers may add to this data to get a more complete picture of the usefulness of the ‘Differences Between Visits’ chart and whether it actually helps to increase the number of MWVs scheduled and completed in primary care.

Since the ‘Differences Between Visits’ chart was left at the primary care clinic, an interesting study might also be to examine whether that particular clinic had a greater increase in MWVs compared to other primary care clinics within the same hospital system. Resurveying the providers at this clinic within a year of the initial presentation could identify whether they used the charts more frequently after the original study was completed. Data identifying how many visits the providers performed in 2021 could be compared to how many were performed in 2022 with the caveat that 2021 was considered a pandemic year where primary care visits in general were likely lower than they might have been otherwise. It would be interesting to use this second study to also identify provider characteristics of those that increased the number of MWVs they performed.

Also, this study focused on the providers and how they felt about the ‘Differences Between Visits’ chart. It would be useful to explore what patients know about MWVs and if they found the chart useful. Questions could include: Did they see the chart on the wall? What was their initial reaction to the chart? Did they find it helpful? Did their provider discuss the chart with them? Do they feel they more fully understand MWVs after reviewing the chart? What might they add/subtract to make the chart easier to read/understand? Strengths and weaknesses of the educational tool should be identified and changes made so that the tool is easy to understand for most people.

## **Implications**

The population of Medicare participants is growing annually. Due to the overwhelming number of older adults in the U.S. with life-style and vaccine preventable diseases (Farford et al., 2021), it behooves the nation as a whole to take into consideration the high cost of providing care to this population. By providing MWVs and clear plans for maintaining health, it is possible for providers in the U.S. to keep healthcare costs at a reasonable and sustainable level merely by providing education, access to certain services, and vaccinations against deadly diseases. In an overwhelmed and busy healthcare system, providing a lucrative, specified time to provide this health assessment, education, and plan can build the relationship necessary to help providers be more effective at encouraging continued health, rather than focusing on treating diseases and disabilities after they have happened.

More research is needed to explore provider barriers to MWV. In the meantime, the research that has already been completed provides researchers with a plethora of issues to solve. Further research on how to best utilize infographics and other visual aids may help to identify how best to teach certain groups of people, including those with low literacy rates. Research should also focus on how best to inform patients about what Medicare does and does not cover, encourage patient participation in MWVs, and keep patients coming back for screening and vaccinations.

This research study in particular focuses on providing education. As stated in ‘Assessment of Health Infographics in Saudi Arabia’ by Jahan et. al (2021), health education is important to health and health care. With improved understanding, patients are better able to make decisions that will affect their health. Educating Medicare patients on MWV allows them to decide whether they find value in participating in these visits. The educational tool that was

provided in this study takes this a step further by attempting to limit the burden of education that typically falls on the provider by providing a comprehensive, but simplified breakdown of typical primary care visits.

### **Limitations**

The assessment of provider barriers was limited to providers within a specific health care system in one specific city. This means that the culture within this system and city can have a heavy influence on how providers perceive barriers to MWVs. The intervention itself was also time and personnel-limited. This research project involved a small number of providers in one healthcare system in one city. Therefore, this information cannot be generalized to a larger group of providers. The barriers offered to this group of providers for identification as barriers they had encountered with implementation of MWVs in their clinic were those identified in larger studies listed in the reference section of this paper.

This hospital system is also currently working independently on increasing the number of MWVs completed in primary care. This may lead to a response bias, because providers in this system may be more motivated to work toward this goal. Providers who did not respond may not agree with the hospital system's goals or may have other reasons for not responding that have nothing to do with how they feel about MWVs.

Data collection may have been limited due to the route of delivery. Surveys were emailed to providers. Emails can be easily overlooked or ignored. Providing in-person surveys that could be completed during an in-person meeting might have been more successful at getting a response.

The poster itself may need some revisions. It uses a lot of words, which may be intimidating to some patients or may prevent those who are illiterate from interacting with the

poster at all. Providing simple pictures that represent the information provided, such as a needle to represent labs or a blood pressure cuff to represent vitals, may be more effective for this population. This may make the poster less intimidating and easier for patients to follow along when the provider is discussing the MWV. It may also make the poster smaller, which providers may prefer.

Lastly, providers are busy and tend to work long hours. They may be inundated with requests for participation in surveys and research projects. This can be stressful due to their already busy schedules. They may be more likely to only respond to research surveys that they feel strongly about. Therefore, the providers who did respond may have already been more favorable to increasing MWVs. This would skew the results in favor of the chart without providing the necessary revisions to help others better understand what the chart is attempting to convey.

### **Conclusion**

Medicare Wellness Visits are an opportunity for providers and patients to come together to create a plan to help the patient potentially live a longer, healthier life. There are several known barriers to providers completing these assessments. This study focused on assessing barriers to MWVs as identified in the literature, providing an educational tool to help providers educate Medicare patients on how MWVs are different from other visits, and assessing how satisfied providers were with the educational tool.

The two most important barriers identified were that providers felt they already completed these requirements and patients want to discuss current health issues rather than prevention. Providers responded favorably to the educational tool implemented in this study and indicated that they were willing to work on improving the number of MWVs they conduct.

Overall, though the study was small, the outcomes were encouraging. Future studies may be able to assess more thoroughly the educational tool and make changes that would potentially impact Medicare patients positively and increase primary care clinics' revenue.

By utilizing MWVs, both providers and patients have the potential to benefit. It is important for providers and patients to have an open and honest dialogue about both disease/injury related issues and preventive measures, in order to maximize personal health and live a long, healthy life. MWVs can be utilized as a potential avenue for this dialogue and have the added benefit of profiting clinics.

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## Tables

Table 1. *Provider Demographics*

Measures	Description	<i>n</i> (%)
Provider role	MD	14 (66.7%)
	APRN	5 (23.8%)
	PA	2 (9.5%)
Gender	Female	14 (66.7%)
	Male	7 (33.3%)
Race	Non-Hispanic	20 (95.2%)
	Hispanic	1 (4.8%)
Ethnicity	White	18 (85.7%)
	Black	1 (4.8%)
	Hispanic	1 (4.8%)
	Indian	0
	Native American	0
	Middle Eastern	0
	Asian	1 (4.8%)
	Other	0
Age range	30-35	3 (14.3%)
	35-40	3 (14.3%)
	40-45	4 (19.0%)
	45-50	1 (4.8%)
	50-55	3 (14.3%)
	55-60	3 (14.3%)
	60-65	1 (4.8%)
	65-70	1 (4.8%)
	70-75	1 (4.8%)
	75-80	0

Table 2. *Descriptive Summary of Pre-Survey Items (N = 12)*

Barriers*	Mean (SD) or n (%)
I already complete these requirements during other visits.	1.60 (0.97)
Patients want to discuss current health issues instead of/in addition to discussing preventative measures.	1.60 (0.52)
Patient's don't know that Medicare Wellness Visits exist.	3.60 (0.84)
Medicare Wellness Visits take too long to complete.	3.80 (1.03)
Medicare Wellness visits documentation requirements are too stringent.	5.00 (0.94)
Patients don't care about preventative healthcare.	5.60 (1.17)
I'm not sure how to complete a Medicare Wellness visit.	6.80 (0.42)

\*Ranking are in order of 1) 'most important' to 7) 'least important'

Table 3. *Descriptive Summary of Willingness to Increase Number of MWVs Performed (N= 12)*

	Frequency	Percent
Very likely	3	25%
Somewhat likely	7	58.3%
Somewhat unlikely	2	16.7%
Total	12	100%

Table 4. *Descriptive Summary of Providers that Found the ‘Difference Between Visits’ Chart Helpful in Educating Patients (N= 4)*

	Frequency	Percent
Somewhat	4	100%
Total	4	100%

Table 5. *Descriptive Summary of Measurement of Satisfaction with ‘Differences Between Visits’ Chart (N=4)*

	Frequency	Percent
Somewhat satisfied	2	50%
Extremely satisfied	2	50%
Total	4	100%

Table 6. *Descriptive Summary of How Likely Providers are to Continue Using the ‘Differences Between Visits’ chart (N=4)*

	Frequency	Percent
Somewhat satisfied	2	50%
Extremely satisfied	2	50%
Total	4	100%

## Appendix A: IRB Letter of Approval



XP Initial Review

Approval Ends:  
11/2/2022

IRB Number:  
70467

TO: Katherine Rodriguez-Guerrant, BSN  
College of Nursing  
PI phone #: 7047732574  
PI email: klbr234@uky.edu

FROM: Chairperson/Vice Chairperson  
Medical Institutional Review Board (IRB)

SUBJECT: Approval of Protocol

DATE: 11/3/2021

On 11/3/2021, the Medical Institutional Review Board approved your protocol entitled:

INCREASING MEDICARE WELLNESS VISIT PARTICIPATION IN A PRIMARY CARE CLINIC

Approval is effective from 11/3/2021 until 11/2/2022 and extends to any consent/assent form, cover letter, and/or phone script. If applicable, the IRB approved consent/assent document(s) to be used when enrolling subjects can be found on the approved application's landing page in E-IRB. [Note, subjects can only be enrolled using consent/assent forms which have a valid "IRB Approval" stamp unless special waiver has been obtained from the IRB.] Prior to the end of this period, you will be sent a Continuation Review (CR)/Annual Administrative Review (AAR) request which must be completed and submitted to the Office of Research Integrity so that the protocol can be reviewed and approved for the next period.

In implementing the research activities, you are responsible for complying with IRB decisions, conditions and requirements. The research procedures should be implemented as approved in the IRB protocol. It is the principal investigator's responsibility to ensure any changes planned for the research are submitted for review and approval by the IRB prior to implementation. Protocol changes made without prior IRB approval to eliminate apparent hazards to the subject(s) should be reported in writing immediately to the IRB. Furthermore, discontinuing a study or completion of a study is considered a change in the protocol's status and therefore the IRB should be promptly notified in writing.

For information describing investigator responsibilities after obtaining IRB approval, download and read the document "[PI Guidance to Responsibilities, Qualifications, Records and Documentation of Human Subjects Research](#)" available in the online Office of Research Integrity's [IRB Survival Handbook](#). Additional information regarding IRB review, federal regulations, and institutional policies may be found through [ORI's web site](#). If you have questions, need additional information, or would like a paper copy of the above mentioned document, contact the Office of Research Integrity at 859-257-9428.

seeblue.

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## **Appendix B: Provider Survey Questions (Qualtrics Survey)**

Instructions: The two questions provided below are in regard to provider barriers to completing Medicare Wellness visits. Answering these questions will help us to understand what you see as most important issues that prevent you and your colleagues from conducting these visits.

1. Please rank the following from most (1) to least (7) important:
  - a. I already complete these requirements during other visits.
  - b. Patients want to discuss current health issues instead of/in addition to discussing preventative measures.
  - c. Patients don't know Medicare Wellness visits exist.
  - d. Medicare Wellness visits take too long to complete.
  - e. Medicare Wellness visits documentation requirements are too stringent.
  - f. I'm not sure how to complete a Medicare Wellness visit.
  - g. Patients don't care about preventative healthcare.
  
2. How willing are you to increase the number of MWVs you perform?
  - a. Very likely
  - b. Somewhat likely
  - c. Neutral
  - d. Somewhat unlikely
  - e. Very unlikely

# Appendix C: Educational Graphic

hello there!

# Medicare Patients

Want to know what a Medicare Wellness Visit entails?

**Different kinds of Primary Care Visits:**

### Cost/Eligibility

Acute Illness	Annual Physical Exam	Medicare Wellness Exam
<p>Usually covered under Medicare Part B.</p> <p>Check your coverage to confirm.</p>	<p>Physical exam is not covered by Medicare but may be if you have Medicare Advantage.</p> <p>Check your coverage to confirm.</p>	<p>Medicare Part B covers it.</p> <p>You have had Part B for over 12 months.</p> <p>You have not received an AWP in the past 12 months.</p> <p>It is scheduled this is your "Annual Wellness Visit".</p> <p>Cannot be done year as Welcome to Medicare Visit.</p>

### First Visit

Acute Illness	Annual Physical Exam	Medicare Wellness Exam
<p><b>Vital signs</b></p> <ul style="list-style-type: none"> <li>- height, weight, BP, BMI</li> </ul> <p><b>Meet with provider for:</b></p> <ul style="list-style-type: none"> <li>- discuss symptoms of illness, injury, or concerns</li> </ul> <p><b>Physical exam:</b></p> <ul style="list-style-type: none"> <li>- related only to pertinent body systems.</li> </ul> <p><b>Health care provider will:</b></p> <ul style="list-style-type: none"> <li>- discuss what may be wrong with patient</li> <li>- give information and education related to diagnosis</li> <li>- medications</li> <li>- follow up visits</li> </ul>	<p><b>Vital signs</b></p> <p>Provider will:</p> <ul style="list-style-type: none"> <li>- perform health review assessment</li> <li>- perform a physical exam</li> <li>- discuss medical and family history</li> <li>- list current healthcare providers</li> <li>- complete screenings for:                             <ol style="list-style-type: none"> <li>1. hearing loss</li> <li>2. fall risk</li> <li>3. Cognitive impairment (dementia)</li> <li>4. depression</li> </ol> </li> <li>- develop a screening schedule, which may include:                             <ol style="list-style-type: none"> <li>1. colonoscopy</li> <li>2. mammogram</li> <li>3. bone density</li> <li>4. other screenings</li> </ol> </li> <li>- provide health counseling and referrals to community based support groups</li> <li>- discuss health with lifestyle changes, such as quitting smoking</li> </ul>	<p><b>Vital signs</b></p> <p>Provider will:</p> <ul style="list-style-type: none"> <li>- identify health risks</li> <li>- discuss your medical and family history</li> <li>- list:                             <ol style="list-style-type: none"> <li>1. current providers</li> <li>2. medical equipment suppliers</li> <li>3. medications</li> </ol> </li> <li>- complete screenings for:                             <ol style="list-style-type: none"> <li>1. hearing loss</li> <li>2. fall risk</li> <li>3. cognitive impairment (dementia)</li> <li>4. depression</li> </ol> </li> <li>- provide health advice and referrals aimed at reducing identified risks</li> <li>- discuss advanced care planning</li> <li>- create a 5-10 year personalized prevention plan to help prevent disease and disability</li> </ul>

### Subsequent Visits

Acute Illness	Annual Physical Exam	Medicare Wellness Exam
<p>If needed - vital signs will be taken again. Discuss change in symptoms with provider. Change to medication or therapy may be required.</p>	<p>Same as above every year.</p>	<p>Vital signs</p> <p>Provider will:</p> <ul style="list-style-type: none"> <li>- update questionnaire to assess health risks</li> <li>- your medical and family history</li> <li>- providers</li> <li>- medical equipment suppliers</li> <li>- medications</li> <li>- screening schedule</li> <li>- screen for cognitive issues</li> <li>- discuss health advice and referrals aimed at reducing risk and promoting wellness</li> </ul>

### Telehealth Eligible?

Acute Illness	Annual Physical Exam	Medicare Wellness Exam
<p>Maybe</p>	<p>No</p>	<p>Yes</p>

## Appendix D: Post-Survey Questions (Qualtrics Survey)

### Medicare Wellness Visit Post-survey

1. Did the ‘Differences Between Visits’ chart help you to educate patient about visit types?
  - a. Not at all
  - b. Not much
  - c. Neutral
  - d. Somewhat
  - e. Very much
2. How satisfied are you with the ‘Differences Between Visits’ chart?
  - a. Extremely dissatisfied
  - b. Somewhat dissatisfied
  - c. Neither satisfied nor dissatisfied
  - d. Somewhat satisfied
  - e. Extremely satisfied
3. How likely are you to continue using the ‘Differences Between Visits’ chart?
  - a. Extremely unlikely
  - b. Somewhat unlikely
  - c. Neither likely nor unlikely
  - d. Somewhat likely
  - e. Extremely likely
4. Please tell us what we could add or take away from the ‘‘Differences Between Visits’ chart that would make it easier for you to use.