

**BRIEF REPORT**

# A Qualitative Implementation Study to Improve Medicare Annual Wellness Visits

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**Background:** The Medicare Annual Wellness Visit (AWV) has high potential value depending on its implementation and clinical setting. We studied the perceived value of the AWV in a residency clinic providing care for underserved patients.

**Methods:** Qualitative interviews with both physicians and patients with deidentified transcription and immersion-crystallization analysis.

**Results:** Physicians and patients identified the following learning points: 1) preparing patients for the AWV; 2) aligning expectations and agenda; and 3) optimizing the value of the AWV given patients' competing demands.

**Discussion:** The Medicare AWV is a promising tool but needs thoughtful implementation to make it valuable in underserved trainee settings. (J Am Board Fam Med 2025;38:360–365.)

**Keywords:** Access to Care, Annual Wellness Visit, Geriatrics, Medicare, Qualitative Research, Resident Run Clinic, Vulnerable Populations

## Introduction

The Medicare Annual Wellness Visit (AWV) is a health maintenance visit for US Medicare recipients that focuses on topics relevant to older adults.<sup>1,2</sup> It has 4 main areas:<sup>3</sup> 1) reviewing the health history (documenting and facilitating communication with other physicians seeing the patient), 2) assessment of functional and cognitive status, using office-based screening tests, 3) patient-centered discussion of age-specific screening recommendations, and 4) discussion of advance care planning. Primary care practices have used care teams variably implementing the AWV;<sup>4–8</sup> large database analyses show benefits when

implemented,<sup>9,10</sup> though not always cost savings.<sup>11</sup> AWV uptake has been less among patients reporting lower income, and Black, and Latinx patients.<sup>12–14</sup> Even when implemented, it is unclear whether the visit is universally experienced as helpful.

In 2020, we began implementing AWVs in a busy academic family medicine clinic in the northeastern US with 2 objectives: to use the AWV to teach geriatric visits,<sup>15</sup> and to explore its implementation with patients and residents. The clinic's population is medically underserved<sup>16</sup> due to low income, limited English proficiency, limited transportation/access to health care, and low health literacy. Our research question was: What is the current patient and resident experience of the AWV and how can it be more effective?

## Methods

### Setting

The clinic physicians (10 faculty and 36 family medicine residents) serve 12,000 active patients, with 600+ visits per week, over 30,000 visits annually.

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Approximately 25% of the patients are Medicare recipients and eligible for an AWW; approximately a third have limited English proficiency, and about half report income at/below the federal poverty level. Patients have high rates of unstable housing and unmet behavioral health needs. Before the AWW, a medical assistant administers a questionnaire for health history/functional status screening; the physician uses the 30-minute AWW to review responses, discussing preventive screening, functional status, mental health, and advance care planning with the patient.

### Sample and Recruitment

The study was approved by the Kent Hospital Institutional Review Board. Residents were emailed if they had conducted one or more AWWs. For patients, a question was added to the end of the AWW questionnaire asking if they would agree to be contacted by a researcher for an interview.

### Data Collection

This was a qualitative study; family medicine resident physicians and clinic patients engaged in an individual, semistructured recorded interview with a coauthor (REG) by phone or Zoom. All interviews were professionally transcribed; for patient interviews, notes were also taken on content. Interview guides with predominantly open-ended questions were created based on the literature about AWW components and processes, and our multidisciplinary team's experience in teaching and conducting AWWs (Figure 1).

### Data Analysis

We used the immersion/crystallization method of qualitative data analysis.<sup>17</sup> Transcripts, notes, and recordings were systematically reviewed for content and themes, documenting commonalities and differences among and between residents and patients. Emerging findings were discussed by members of the faculty study team until final interpretation was achieved.

## Results

### Participants

Thirteen family medicine residents and twelve patients were interviewed (see Table 1), at which point our preliminary analyses indicated that both code and meaning saturation<sup>18</sup> had been reached.

**Table 1. Participant Characteristics**

	Number (%)
Resident characteristics	
Gender (self-disclosed)	
Man	4 (27%)
Woman	10 (67%)
Nonbinary	1 (6%)
Year in residency	
R3	8 (53%)
R2	7 (47%)
R1	0
Patient characteristics	
Gender (self-disclosed)	
Man	6 (40%)
Woman	9 (60%)
Nonbinary	0
Age	
60 or under	2 (13%)
61 to 70	6 (40%)
71 to 80	6 (40%)
Over 80	1 (7%)

### Topical Categories

Three elements emerged from data analyses regarding uptake and understanding of the AWW: 1) lack of patient preparation for the AWW, 2) agenda-setting and misalignment of expectations, and 3) appreciation of the meaning and value of the AWW to patients in light of potential competing demands.

### Lack of Patient Preparation for the AWW

There were few patient-generated requests for the AWW in the practice before their initiation. The majority of patients were called on the telephone and told they would be scheduled for an AWW as their next visit and that it would be 'like a physical.' In some cases, they were scheduled with a physician who was not their PCP. Patients had little understanding of the visit's purpose and most were unable to describe in interviews how it was different from their usual appointments. Patients demonstrated this lack of understanding by wanting to address acute issues during the visit; residents expressed frustration about keeping the patient focused on the requisite elements of the AWW.

*I noticed it was a bit different, but not that different.*  
(patient)

*The patient was not really clear why she was here.*  
(resident)

**Figure 1. Interview guide.**

<p><b>PATIENT QUESTIONS</b></p> <p><u>Intro for patient:</u> I'm going to be asking you about a particular type of visit you recently had with your primary care doctor, Dr. XXXX. I'm not asking you to evaluate your doctor, just to talk with me about this special type of visit called an Annual Wellness Visit. We're always trying to improve the care at the [clinic], so I'm looking forward to hearing your thoughts on the AWW. Participating in this interview will not affect the care you receive at the clinic in any way.</p> <ol style="list-style-type: none"> <li>1. I'll be asking you about the type of visit where before you went to the clinic for your visit with the doctor, one of the staff called to ask you a bunch of questions about exercise, your health, what other doctors you see, and other questions.             <ol style="list-style-type: none"> <li>a. What did you think about having a staff person ask you all those questions on the phone?</li> </ol> </li> <li>2. Now let's talk about the visit at the clinic that happened sometime after that telephone call.             <ol style="list-style-type: none"> <li>a. What happened during that visit?</li> <li>b. What did the doctor do?</li> <li>c. What did you and the doctor talk about?</li> <li>d. If not mentioned –                 <ol style="list-style-type: none"> <li>i. Discussed your goals for your health and your care?                     <ol style="list-style-type: none"> <li>1. End of life; advance directives</li> </ol> </li> <li>ii. Discussed medication – impact on goals, mobility, MH</li> <li>iii. Discussed MH</li> <li>iv. Discussed mobility</li> </ol> </li> </ol> </li> <li>3. How did you feel about having this type of visit with your doctor?             <ol style="list-style-type: none"> <li>a. What did you like about the AWW?</li> <li>b. What did you not like so much about the AWW?</li> <li>c. What could have made the AWW even better?</li> </ol> </li> <li>4. What makes the AWW different from other visits you've had with your primary care doctor at the clinic?</li> <li>5. Would you recommend to people you know who are on Medicare that they have an AWW with their primary care doctor? Why or why not?</li> <li>6. What else would you like to tell me about your AWW?</li> </ol>
<p><b>RESIDENT QUESTIONS</b> [relevant to this portion of the project; a few questions specific to education were omitted]</p> <p><u>Intro:</u> I'm conducting a few interviews with residents who have now conducted at least one AWW. The data is for quality improvement purposes, and I will not be reporting anything you say in connection with identifying information about you.</p> <p>Just to be certain before we start – Have you conducted any AWWs? How many?</p> <ol style="list-style-type: none"> <li>1. Before you attended the lecture, how much did you know about what is supposed to be covered in a Medicare AWW?             <ol style="list-style-type: none"> <li>a. How familiar were you with exactly how to conduct the AWW ? (probe for how to do each component, how to document, how to level the visit)</li> </ol> </li> </ol>

**Agenda-Setting**

Residents expressed chagrin when patients tried to bring up new problems or questions they wanted addressed, while trying to get through the specific agenda of the AWW. Patients were unprepared for some of the discussions, especially around goals of care or advanced care planning (ACP), and could not or would not participate fully.

*I did not give him no answers on that [ACP] because I did not have any answers. I told him I'd be thinking*

*about all that. Because that needs to be addressed, but we did not come to a conclusion while I was there.* (patient)

*I did not quite understand it so I did not know what to say. I did not know how to respond so I just did not do anything.* (patient)

Residents also reflected on the ACP discussion, sometimes characterizing the patients as not caring about the topic, but often acknowledging that the patient cared but was unprepared to engage in that discussion.

Figure 1. Continued.

2. When it came time to do your first AWW, how prepared did you feel to conduct this type of visit? Why?
3. What helped you feel prepared?
4. What could have helped make you feel more prepared?
5. Overall, how do you feel about how the visit went? Why?
6. What did you cover during the visit?
  - a. Were there components you'd hoped to cover but didn't? Why did that happen?
  - b. What difficulties, if any, did you have covering the primary parts of the AWW?
  - c. What difficulties, if any, did you have sticking to the topics and components that are officially part of the Medicare AWW, and not diverging from these to address the patient's other health issues?
7. Did the MA complete the 7 page form prior to the visit?
  - a. Did you review the form before the visit?
  - b. How did you use the information on the completed form?
  - c. What was helpful about having the form completed in advance by the MA?
  - d. What could make the form more useful for your conduct of the AWW?
  - e. What other information should be on the form?
10. Overall, in what ways would you say the AWW contributes to good patient care?
11. In what ways could the way the AWW is conducted at the FCC be improved?

*One thing I noticed with a lot of... patients in the community that we serve - that they do not have a health care proxy. They do not have a power of attorney or a living will. Their response is like, "Well, I am fine. I do not need all that." Like, "I do not need to think about what would happen if I got really sick 'cause I am feeling great." That is a part of the medical wellness visit that I think patients are not adequately—they are not necessarily prepared that they are going to have to be thinking about those questions. (resident)*

#### **Appreciation of the AWW in Light of Competing Demands**

Several patients perceived the AWW as a valuable addition to their health care. However, many were not able to understand the value of the visit, possibly due to competing priorities in their lives.

*Oh, I do not know [what we discussed], I was numb because I just lost [my] husband. (patient)*

*I could read the article [explaining the visit]... and my brain... [to] absorb it and understand it... So [I] need time. (patient)*

#### **Discussion**

The Medicare AWW has had modest uptake in primary care<sup>19</sup>; its overall benefit<sup>11</sup> is still unclear. Previous studies advocated increasing the uptake of

AWVs in underserved populations – with the implicit assumption that performing the AWW alone would be of benefit.<sup>20</sup>

However, the expressed views of patients and trainees about its meaning and utility did not support this idea in the present study. Participants reflected that the AWW was a visit that the patient had not asked for, did not really understand, and was unable to fully participate in, which diminished its effectiveness and relevance. This finding resonates with other studies suggesting that, as a 'one size fits all' approach, the AWW may not effectively address disparities.<sup>21</sup>

While the implementation experience can be variable, we were struck by the potential for competing priorities among patients experiencing life stressors other than those addressed in the AWW. This finding suggests that the elements of the AWW are sensitive to social determinants of health (SDOH), a concept that has been discussed relative to value-based care generally, but not with regard to the AWW.<sup>22</sup>

It is likely that the benefit of the AWW depends on patients' preparation and activation<sup>23–26</sup> in anticipation of the visit. While some older adults are proactive about aging, health care, and planning for medical uncertainty, others may have competing life stressors (including SDOH) such that they

cannot engage in this kind of planning without significant coaching/support from the physician. Our findings also suggest that patients less ready for the visit tended to characterize it as less valuable or helpful.

Like all health care innovations, the AWW will be revised and updated in response to feedback from patients and physician. We suggest further study regarding optimal patient involvement in the AWW, and in the meantime offer these learning points.

– **Better previsit education of target population** (not relying on written materials in English, and considering modalities broadly including videos, radio and television ads, or other forms of communication). Similar educational modalities have been used in other settings, notably to improve<sup>27</sup> chronic disease outcomes.

– **Clearly communicate the purpose of visit (during and after the experience) in a patient-centered way.** In addition consider handing out postvisit education materials or following up to emphasize important points about what was addressed.<sup>28</sup>

– **Adopt a stages-of-change model for talking about advanced care planning,** changing the goal that it could be fully addressed and acted on in a single prevention-focused visit.<sup>29</sup> This adaptation would increase the chance of a meaningful outcome.

Future study of the AWW should focus not only on improving its uptake in varied patient populations, but also on changing aspects of the way it is performed to make it a more meaningful activity, and 1 that is more responsive to social determinants of health.

To see this article online, please go to: <http://jabfm.org/content/38/2/360.full>.

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