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Understanding the Value of the Wellness Visit: A Descriptive Study

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Abstract

Introduction: Clinical preventive services can reduce mortality and morbidity, but Americans receive only half of the recommended care. Although wellness visits protect time for clinicians to review needs and discuss care with patients, studies have not shown that having a wellness visit improves health outcomes. This study seeks to understand the types of discussions and volume of care delivered during wellness visits.

Methods: Using a sample of 1,008 patients scheduled for a wellness visit from 22 primary care clinicians across 3 states from 2018 to 2019, electronic health records were reviewed, and a subset of visits was audio recorded. The discussion and delivery of clinical preventive services, as recommended by the U.S. Preventive Services Task Force, were measured, and new diagnoses were identified from the clinical preventive services. Analyses were completed in 2020.

Results: Even though patients were up to date with 80% of the recommended clinical preventive services 3 months after the visit, only 0.5% of patients were up to date with all the recommended clinical preventive services. On average, 6.9 clinical preventive service discussions occurred

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during each wellness visit on the basis of electronic health records review, and 7.7 clinical preventive services discussions occurred on the basis of audio recordings. An average of 0.4 new diagnoses was identified, including cancer diagnoses, cardiovascular risks, and infections.

Conclusions: Wellness visits are an important time for patients and clinicians to discuss prevention strategies and to deliver recommended clinical preventive services, leading to the identification of previously unrecognized diagnoses. This will improve patients' health. Policies and incentives that promote wellness visits are important, and efforts are needed to deliver them to those most in need.

INTRODUCTION

Clinical preventive services (CPSs) improve health and reduce mortality, but Americans only receive half of the recommended CPSs.^{1,2} The Affordable Care Act introduced reimbursement for wellness visits (WVs) annually.³ The use of WVs has increased from 7% of Medicare recipients in 2011 to 20% in 2016.⁴ Although some studies have shown that patients who engage in WV are more likely to receive recommended CPSs,⁵⁻⁷ a meta-analysis of WVs did not show improvements in health outcomes.⁸

However, merely focusing on whether a WV improves health outcomes or even increases the delivery of services may miss the point. Clinicians need protected time to engage patients in health, promote healthy behaviors, and share decisions to ensure that a person's values, preferences, and needs are incorporated into care.^{9,10} Studies to date have relied on insurance claims data, which do not account for counseling and shared decision making. These discussions build relationships between clinicians and patients and foster future change to improve health.^{11,12}

This study seeks to describe the number and types of CPS discussions during WVs. The study also aims to elucidate the CPSs delivered and new diagnoses identified to understand the value of WVs.

METHODS

An electronic health record (EHR) review of 1,008 WVs was conducted, and a subset of visits was audio recorded ($n=70$) to assess what occurred during the WVs. The study was completed as part of an RCT to evaluate the use of MyHealthfinder, a web-based previsit patient education tool designed to promote shared decision making and patient engagement.^{13,14} Patients came from 22 primary care clinicians in 16 diverse practices from Virginia, West Virginia, and the District of Columbia. With a mixture of rural, suburban, and urban settings, practices included 1 solo practice, 4 private practices, 6 medical group practices, 4 health system practices, and 1 federally qualified health center. Participating clinicians enrolled approximately 40 consecutive patients scheduled for a WV with some overenrollment to account for patients potentially not showing up to an appointment. WVs included both Medicare Annual Wellness Visits and annual physical examinations for commercial insurers because a majority of practices did not differentiate between the 2 in scheduling.

Outcomes from the EHR review and audio recordings included whether CPSs, as recommended by the U.S. Preventive Services Task Force on the basis of the patient's age and sex, were discussed and delivered.¹⁵ EHR reviews were completed for all participating patients 3 months after the WV. A *discussion* was defined as any documentation of discussion in the assessment and plan, any use of billing codes that indicated a discussion or counseling, or any checkboxes that indicated a discussion if these were available in the EHR. Merely placing an order or providing a service without documentation of discussion was not counted as a discussion. Reviewers received standardized training. In total, 40% of charts were double coded by another reviewer. Disagreements were discussed with the team, and if needed, clarification was sought from the clinician. For the audio recordings, 4 patients were randomly selected from the first month of each clinicians' schedule and approached for permission to audio record the visit. Recordings were transcribed. Two reviewers documented the clinical topics and CPSs discussed from the transcripts.

For EHR reviews and audio recordings, descriptive statistics were calculated to identify the number and percentage of recommended CPSs delivered and new diagnoses resulting from the CPSs. The study was conducted between January 2018 and September 2019, with analyses completed in 2020, and was approved by the Virginia Commonwealth University IRB.

RESULTS

There were 1,008 study participants, and the mean age was 53.8 years. Of the participants, 51.7% were female and 72.4% had commercial insurance, 20.4% were Medicare insured, 3.2% had Medicaid assistance, and 4.1% were uninsured. In addition, of the participants, 12.0% were Black and 3.8% were Hispanic.

Although patients were up to date with an average of 80% of the recommended CPSs, few patients (0.5%) were up to date with all the recommended CPSs. Clinicians documented an average of 6.9 discussions (Table 1), and an average of 0.4 new diagnoses was made (Table 2). The most common discussions revolved around health behaviors (dietary counseling, exercise counseling, and obesity counseling), followed by cancer screening discussions. The most common new diagnoses were high blood pressure, elevated blood sugar, and the need for statin chemoprevention.

Of the 70 audio recordings from office visits, 11 were of poor quality and were excluded. From the remaining recordings, an average of 7.7 counseling or shared decision-making discussions for CPSs occurred, and 1.5 acute and 0.9 chronic conditions were addressed. Counseling and shared decision-making discussions often blended into acute and chronic condition discussions, making it difficult to determine the proportion of time spent on the different activities within a WV.

DISCUSSION

This study shows the breadth of issues covered during the typical WV. Audio recordings found that even more CPS discussions occurred (7.7 areas) than documented in the EHR, suggesting that clinicians may underdocument what they are actually doing with patients

in a WV. This information was not captured in previous studies that relied on insurance claims data. It suggests that WVs potentially have value beyond what is documented and that clinicians may need help or further incentives to document the work they are already doing. In addition, WVs appear to be an opportunity to identify previously unrecognized diagnoses and address both acute and chronic issues. Although recognizing that a motivating change in health behaviors may be difficult, these discussions that occur from a positive screening of CPSs in a WV could potentially be continued over future primary care visits and lead to behavioral changes that may help improve patients' health.¹¹

Attention has been drawn in recent years to burnout in primary care.^{16,17} Implementing all the recommended CPSs for patients requires clinicians' time.¹⁸ For example, 1 study estimated that it would take 7.4 hours each working day for a full-time primary care clinician to address all CPSs recommended for their patients.¹⁹ The WV addresses these time constraints by protecting time when clinicians can either directly engage patients in CPS discussions and delivery or delegate that work to other qualified health professionals. This not only encourages patients to obtain the recommended CPSs but also could reduce burnout.

A surprising finding was the number of new diagnoses made because of WVs. Resourcing and reimbursing clinicians for the asynchronous care needed to follow-up abnormal results, make new diagnoses, and get new treatments would further reduce clinician burnout and improve outcomes for patients. As such, increasing WVs could support the quadruple aim of improving health, reducing costs, improving patient experience, and increasing clinician meaning at work.²⁰

Limitations

The main limitation to this study is a potential selection bias in the sample because clinicians who agreed to participate in the RCT about a tool to promote CPSs may be more likely to engage patients in CPS discussions than the average primary care clinician. Another limitation is that EHR chart reviews may undercount the number of discussions that occur because clinicians may not document everything they discuss with the patient.

CONCLUSIONS

This study shows the value of WVs in engaging patients in discussions about a wide range of CPS issues and in identifying previously unrecognized diagnoses. Future studies could extend this work by supporting primary care clinicians in increasing the proportion of their patients who receive WVs.

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Table 1.

Documented Discussions of CPSs During Annual Wellness Examinations

CPSs	Discussion about CPS or shared decision making, n/N (%)
Total, mean (range)	6.9 (0, 13)
Cardiovascular prevention	
Statin chemoprevention	18/816 (2.2)
Abdominal aortic aneurysm screening	3/46 (6.5)
Cancer prevention	
Colorectal cancer screening	246/539 (45.6)
Lung cancer screening	15/105 (14.3)
Cervical cancer screening	149/349 (42.7)
Breast cancer screening	
Age 40–49 years	38/83 (45.8)
Age 50–75 years	159/291 (54.6)
Prostate cancer screening	94/206 (44.6)
Immunizations	
Influenza vaccination	437/1,010 (43.3)
Pneumonia vaccination	33/177 (18.6)
Shingles vaccination	110/288 (38.2)
Health behaviors	
Diet counseling	524/841 (62.3)
Exercise counseling	488/845 (57.8)
Obesity counseling	282/421 (67.0)
Tobacco use	
Counseling	43/91 (47.3)
Patients agreeing to quit	14/91 (15.4)
Unhealthy alcohol use counseling	8/23 (34.8)
Mental health	
Depression screening	373/860 (43.3)
Infection prevention	
Chlamydia screening	5/20 (25.0)
HIV screening	30/791 (4)
Hepatitis C screening	47/513 (30)
Endocrine prevention	
Diabetes screening	130/429 (30)
Osteoporosis screening	39/97 (40)

CPS, clinical preventive service.

Table 2.

New Diagnoses Identified During Wellness Examination

Overall measures	Positive screen/total patients screened (%), n/N (%)
Total diagnoses identified, mean (range)	0.4 (0, 3)
Cardiovascular prevention	
Elevated blood pressure	114/1,000 (11.4)
Need statin chemoprevention	49/816 (6.0)
Abnormal abdominal aortic aneurysm screen	0/15 (0)
Cancer prevention	
Abnormal colorectal cancer screen	20/450 (4.4)
Abnormal lung cancer screen	8/14 (57.1)
New diagnosis lung cancer	1/14 (7.1)
Abnormal cervical cancer screen	9/72 (12.5)
New diagnosis cervical cancer	0/72 (0)
Abnormal breast cancer screen	15/256 (5.9)
New diagnosis breast cancer	2/256 (0.8)
Abnormal prostate cancer screening	8/132 (6.1)
New diagnosis prostate cancer	0/132 (0)
Health behaviors	
Tobacco use identified	20/1,000 (2)
Unhealthy alcohol use identified	13/677 (1.9)
Mental health	
New diagnosis depression	7/863 (0.8)
Infection prevention	
New diagnosis chlamydia	0 (0.0)
New diagnosis HIV	1/102 (1.0)
New diagnosis hepatitis C	6/198 (3.0)
Endocrine prevention	
Elevated blood sugar	68/398 (17)
Osteopenia identified	27/77 (35)
Osteoporosis identified	5/77 (6)