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Feature Articles

Facilitators and barriers to optimal preventive service use among providers and older patients

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ABSTRACT

Preventive service use remains low among Medicare beneficiaries despite the Affordable Care Act's waiver of coinsurance. This study sought to understand barriers and facilitators to preventive service provision, access, and uptake. We used a mixed methods approach synthesizing quantitative survey and qualitative focus group data. Self-reported utilization of and factors related to preventive services were explored using quantitative data from the 2012 Medicare Current Beneficiary Survey. Qualitative data from 16 focus groups conducted in 2016 with a range of providers, health advocates, and Medicare beneficiaries explored perspectives on preventive service use. Providers indicated time and competing priorities as factors for not offering patients a full range of preventive services, while beneficiaries reported barriers related to knowledge, perception, and trust. Current healthcare reform efforts incorporating team-based care, nurses and other non-physician providers, and coordinated electronic health records could support enhanced use of preventive services if fully implemented and utilized.

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Introduction

Prevention is central to public health and health reforms, particularly the 2010 Affordable Care Act (ACA). The ACA has promoted Medicare beneficiaries' access to preventive services by removing most coinsurance for services such as obesity counseling and bone density tests (Centers for Medicare & Medicaid Services, 2016; Medicare Learning Network, 2016). However, uptake of many preventive services remains low and disparities persist.^{1,2,3,4,5} Some services, such as cancer screenings and screening and counseling for tobacco use, obesity-related behaviors, and alcohol misuse, save lives and health care costs, but only if beneficiaries use them.^{6,7,8}

There may be barriers to preventive service use other than costs. Many beneficiaries do not know or do not perceive themselves to be at risk of conditions addressed by preventive services, or they actively wish to avoid services that are inconvenient, uncomfortable, or that they believe are risky. For instance, the vast majority of adults with alcohol use disorder do not believe their drinking is a problem,⁹ some older adults decline the influenza vaccine because they believe that it

causes the flu,¹⁰ and some avoid colonoscopies because of fear of pain.¹¹ Cancer screenings can be perceived as invasive and many patients are afraid to find out the results.^{12,13} In addition, despite the documented benefits of preventive health, many primary health care providers focus their attention on addressing patient's acute or chronic conditions and have not integrated such preventive services into their standard practice and may not even offer a full array of these services.^{14,15,16,17} Primary care providers may not have the resources to provide follow-up care, further discouraging them from offering preventive services.¹⁸

Using a mixed methods approach that incorporates both quantitative survey and qualitative focus group data, this article presents both broad and deep preliminary findings from an ongoing study to assess the ACA's impact on preventive service use. Eliciting and understanding facilitators and barriers related to preventive service use is a critical step in increasing access to these services, promoting healthy behaviors, and ultimately decreasing disease burden.

Material and methods

This mixed methods study incorporates secondary data analysis of quantitative survey data and primary data collection and analysis of qualitative data through focus groups. We analyzed quantitative data from the 2012 Medicare Current Beneficiary Survey (MCBS), which includes Medicare beneficiaries' self-reported knowledge of covered

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preventive services, utilization, and reasons for not obtaining recommended services. Drawing on MCBS survey results that indicated particular gaps in patients' use of preventive services, we developed guides and conducted qualitative focus groups in 2016 to gain insight into patients' and providers' knowledge, attitudes and preferences. Quantitative survey results were synthesized with themes from the qualitative focus groups to highlight the similarities and incongruences between findings and to provide a comprehensive analysis across the two data sources.

Survey sample and methods

The MCBS, conducted by the Center for Medicare and Medicaid Services (CMS), is a continuous, rotating panel survey of a nationally representative sample of the Medicare population. The survey contains a rich set of data including beneficiary self-reported socio-demographics, health status and health behaviors, as well as utilization and access to care. More information about the survey is available on the MCBS Web site.¹⁹

Descriptive statistics were used to examine answers among Medicare beneficiary survey respondents to provide a cross-sectional analysis of recent perceptions and trends related to preventive service use after the implementation of the ACA. Survey responses for the top reasons Medicare beneficiaries did not obtain relevant cancer screenings (mammogram, Pap smear, or prostate-specific antigen [PSA]) are reported in Table 1. Self-reported utilization of preventive services ever received (bone mass test, colorectal cancer screenings, pneumonia vaccination) and those received in the year (PSA, digital rectal exam for prostate cancer, influenza vaccination, mammogram, Pap smear) are reported in Table 2. The analytic sample for this study included all community-dwelling Medicare beneficiary respondents in the 2012 Access to Care (ATC) portion of the survey among the age and gender subgroups related to coverage guidelines for each preventive service (see measure specific sample sizes and demographic restrictions in Tables 1 and 2).²⁰ All survey responses are reported as proportions (%) and were up-weighted using MCBS sample weights to be nationally representative of the Medicare population (weighted N = 46,869,319).

Focus group samples

In 2016, we convened three, in-person, provider-based focus groups at professional conferences held in Washington, D.C and hosted one virtual focus group composed of individuals who assist beneficiaries in receiving and understanding Medicare benefits. Providers were recruited through conference organizers. In two cases, researchers were able to piggyback on panels of 15 that had been assembled to discuss conference-related topics. One group consisted of physicians who served a large proportion of Medicare recipients and one was a group of mixed providers that included physicians, nurses, social workers, and pharmacists. All members of each panel consented to participate. The third group was a convenience sample of 10 physicians who served Medicare beneficiaries, most in primary

Table 2

Medicare beneficiary self-reported utilization of preventive services (%), 2012.

Receipt of Service	Weighted N	%
Ever received		
Bone mass test (female, age ≥ 65)	20,469,161	48
Colorectal cancer screening (age ≥ 50)		
Colonoscopy or sigmoidoscopy	41,420,867	72
Fecal blood test in doctor's office	6,941,950	19
Home fecal blood test	41,263,840	54
Pneumonia vaccination (all beneficiaries)	44,142,310	69
Received in last year		
Blood test (PSA) for prostate cancer (males ≥ 50)	17,472,046	67
Digital rectal exam for prostate cancer (males ≥ 50)	18,683,309	34
Influenza vaccination (all beneficiaries)	13,595,118	69
Mammogram (females age ≥ 35)	24,043,471	51
Pap smear (all females)	24,222,047	24

Source: 2012 Medicare Current Beneficiary Survey, weighted sample sizes account for age and gender restrictions as well as missing respondents.

care, and who responded to a general request from a conference organizer. One virtual focus group was held at a regular staff meeting of approximately 75 representatives who assist Medicare recipients in obtaining care and understanding their benefits. Respondents could choose to contribute responses or not. Participants across all four groups were racially diverse, served a mix of patient populations, and included those working with both private practice and managed care.

Twelve beneficiary focus groups (n = 96) were conducted in 2016 across four metropolitan areas: Baltimore, MD; Miami, FL; Memphis, TN; and New York, NY. Groups each had 8 people, all of whom were contacted through databases of people who had registered as potential focus group participants. Recruiters used purposive and quota sampling to create groups that were balanced on key demographic factors such as gender, race/ethnicity, and length of Medicare coverage. In total, 42 men and 54 women, who represented an even mixture of newer and longer-term Medicare fee-for service recipients, participated. Forty-one participants identified as white, 41 as African American, and 11 as Hispanic (three participants identified with another race ethnicity).

Focus group methods

Three researchers attended each provider focus group, one as a facilitator and two as note takers. Each session lasted approximately one hour. Using a semi-structured focus group guide, the facilitator asked participants in these groups about influences on preventive service uptake, with an emphasis on barriers and facilitators for both beneficiaries and providers. Probes asked specifically about different patient populations, strategies tried, and potential changes or interventions at both the individual and systems level.

A trained moderator led each video-recorded Medicare beneficiary session, which lasted approximately one hour. Questions in the structured focus group guide addressed participants' interactions with insurance and the health care system; their awareness and understanding of preventive services and health; the value they

Table 1

Top reasons Medicare beneficiaries do not receive cancer screenings (%), 2012.

Weighted N	Mammogram Women age ≥ 35 11,619,939	Pap smear Women (all ages) 18,196,898	Prostate-Specific Antigen Men age ≥ 50 5,558,396
Didn't know needed / Unnecessary because nothing was wrong (%)	20	18	34
Forgot / missed it / procrastinated (%)	21	11	10
Doctor didn't recommend (%)	18	28	32
Not recommended annually (%)	12	15	15

Source: 2012 Medicare Current Beneficiary Survey, weighted sample sizes account for age and gender restrictions as well as missing respondents.

assigned common services; and what they perceived as barriers to access, either for themselves or others. Although the researchers' work on public benefit programs is IRB exempt per Section 45 Code of Federal Regulations 46.101[b][5], all researchers and focus group moderators followed standard ethical protocols. These included reading a statement about the purpose of the research and the voluntary nature of participation in the focus groups before the groups began. Participants provided verbal consent and were assured that they could end participation at any time without consequence. Participant identities were kept anonymous. Permission was obtained to record the sessions.

Transcripts and notes were entered in Dedoose²¹ and were inductively analyzed using open, axial and selective coding in accordance with principles of grounded theory.²² First researchers read the full extent of data, assigning categories and making notes on key points and passages. This phase of open coding revealed many barriers and facilitators to service use, misunderstanding of services and coverage by both providers and beneficiaries, issues unique to specific services, and issues unique to either providers or beneficiaries. During the axial phase, we categorized observations under code umbrellas that covered key issues that arose, such as transportation under beneficiary barriers or time for education under provider facilitators. We then used selective coding to identify thematic codes that revealed the narrative story underlying preventive service use since the ACA was implemented, including how both beneficiaries and providers perceived services and how facilitators and barriers differed between or within groups. Final thematic codes included 7 that applied to both patients and providers, 5 that applied only to providers, and 3 that applied only to beneficiaries. Thematic codes included knowledge, time, costs or billing, workflow, alternative providers, community-based resources, trust, provider recommendations, policy, stigma, and technology (see Table 3 for complete list of thematic codes).

Results

Patient perspectives

Beneficiaries generally indicated a lack of knowledge, understanding and agreement about what constituted preventive services. Most beneficiaries identified diet and exercise, not screenings or clinical services, as “prevention.” For instance, when asked about preventive care, one beneficiary said *“I swim every day. I try to keep my sugar level down, and my salt level down.”* Many beneficiaries also perceived that health problems resulted in part from fate or divine decisions, rather than individual control. As one beneficiary observed, *“My grandparents always taught me about faith. He said ‘when it’s your time, it’s your time.’ But you’re supposed to do everything to keep yourself in shape while you’re here.”*

Beneficiaries did not perceive screening services that identified an existing problem as preventive, even if early treatment could prevent or mitigate poor health outcomes (secondary or tertiary prevention). Participants noted that screenings for alcohol misuse and depression,

tests for human immunodeficiency virus (HIV), and counseling for obesity and tobacco cessation addressed a condition already present rather than preventing it from developing. One beneficiary explained, *“It says tobacco use cessation, so that means you’re already smoking. You can’t prevent it because you’re already doing it.”* Another noted, *“If you’re not abusing alcohol or tobacco, you don’t need counseling services to help you reduce your intake. So, to me, that’s not preventive, that’s ‘help you get better.’ To me, it’s the same thing with obesity.”* Patients questioned the value of initiating screening services if they didn’t perceive themselves to have or be at risk of the problem addressed.

Additionally, beneficiaries weren’t aware that many preventive services, particularly those related to behavioral health, were available. This lack of knowledge of the availability and need of services was also reported in MCBS survey results as a prominent reason that cancer screenings were not accessed (Table 1). Beneficiaries in focus groups suggested that getting consistent information in multiple formats through multiple channels would make knowledge more accessible. This includes making information easier to find in the Medicare Handbook, receiving direct mail and email specifically on the topic, as well as providing information through senior organizations and TV advertising. Many beneficiaries expressed an interest in receiving information from one or more of these venues, but there was not a consistent preferred source cited by a majority of beneficiaries. While most beneficiaries were exposed to television advertising and received printed materials in the mail, the attention and credence they gave to each varied. Beneficiaries reported widely different interactions with technology such as internet sources or patient portals, with some beneficiaries using these as a primary source of information and others not using them at all.

In addition to lack of familiarity with available screenings, most focus group participants did not know that many preventive services were currently available at no cost to them. Similarly, less than half of survey respondents in the 2012 MCBS were aware that Medicare pays for screening tests for colorectal cancer (46%) or osteoporosis (47%). Learning that services were available without cost increased interest among many focus group participants. One participant explained, *“I knew the flu shot was free, but I didn’t know the pneumonia shot was free. That might change my mindset on whether I get it.”* Some beneficiaries insisted that there was a cost to covered preventive services; for instance, one stated that yearly increases in charges for flu shots were “a fact,” even though the influenza vaccine is fully covered. However, beneficiaries in focus groups generally did not say that costs stopped them from obtaining services, a finding consistent with MCBS survey data in which fewer than 2% of respondents cited cost as a barrier to receiving cancer screenings.

Even after learning many available services were free to them, some beneficiary focus group participants remained suspicious about hidden costs, particularly in cases when screening results could lead to diagnostic or treatment services not fully covered by Medicare. For instance, a free colonoscopy may reveal polyps that need removal and the removal procedure may have a co-payment. As one beneficiary observed, *“Where I go, you’re supposed to tell them when you make your appointment, what you’re in there for. But when I get in there and another test is run, and then when it goes through, and then you’ve got a lab that sends you a bill, and you’re going, ‘Well, I was in there for my wellness visit.’”* Beneficiaries did not trust that their providers were reliable sources of information on coverage. A beneficiary noted: *“The doctor could be really good, but sometimes because they’re so busy, they don’t even know the regulations of Medicare. The girl that does the paperwork is the one who knows. So sometimes you have to go through a different channel to figure out if it’s covered or not.”* Representatives assisting Medicare beneficiaries with health insurance coverage issues noted that they frequently encountered participants whose preventive services were billed as diagnostic, resulting in patient charges.

Table 3
Provider and beneficiary focus group themes.

	Barriers (B)	Facilitators (F)	Both B & F
Identified by Providers and Patients	Time Billing System complexity	Community-based resources	Trust Policy
Identified by Providers	Stigma Acute focus of care	Alternative providers Redesigned workflow Care teams	Technology
Identified by Patients	Lack of knowledge	Provider recommendation Technology	Cost

Regardless of whether services were free or had associated costs, beneficiaries in focus groups indicated that they were only interested in services that they or their doctor believed were needed. Many beneficiaries took the attitude, “if it ain’t broke, don’t fix it,” which led them to a preference for rejecting most preventive services. Just as focus group beneficiaries rarely reported requesting services of their own accord, and no one appeared to know the full range of available covered services, survey results revealed that between a fifth and a third of Medicare beneficiaries cited lack of agreement that they needed services or that their provider did not recommend a service as top reasons for not accessing services (Table 1).

Beneficiaries in focus groups mentioned that a handful of services, particularly cancer screenings (colorectal, breast, and cervical) and vaccinations for influenza and pneumonia were frequently brought up by their providers. Focus group participants stated that they were most likely to get these services, in addition to the Annual Wellness Visit and Welcome to Medicare Visit. In 2012, survey results show that around 70% of Medicare beneficiaries self-reported receiving the influenza vaccination, colonoscopy/sigmoidoscopy, or pneumonia vaccination, most of which aligned with what focus group participants identified as frequently provider-recommended services (Table 2).

Most beneficiaries credited providers as their main source of information. As one participant explained, “The doctor office gives you this information also. You get pamphlets at the doctor’s office for these preventive measures. You have to do your stool. You have to do this every time you go. We get those pamphlets.” However respondents did not always trust their provider’s advice, and some appeared to have a general mistrust of the medical system (Table 3). For instance, one beneficiary reported her doubts regarding the need for follow-up office visits: “The doctor just wants the office visit—he doesn’t really need to see you in three weeks. Then you get an argument.” Other barriers that beneficiaries identified were the time required to visit the doctor’s office, including the need for scheduling far in advance and long stints in the waiting room. One beneficiary noted, “Making your appointment—that’s a hassle. If you have to change your appointment—oh my god. Even getting the people on the phone, that is enough to make your blood pressure go sky-high.” Once in the appointments, beneficiaries often reported feeling rushed or not having enough time during the office visit to address all of their concerns.

Provider perspectives

Providers identified challenges that limit their willingness to offer services (see Table 3). A primary issue expressed by providers is that appointments are too short and wellness visits with a physician are overtaken by acute health issues, limiting the ability to focus on—or even address—prevention without the participation of ancillary personnel. The number of preventive services they were expected to offer in one visit was overwhelming. One physician said, “It’s impossible for one doctor to do all of these screenings, even if an appointment lasted 15 h.” Team-based care, with non-physician providers (nurses were frequently mentioned, along with social workers and community health workers) taking over some screening patient education and charting responsibilities, was identified as a primary way to gain both efficiency and higher quality care. As one respondent explained, “Doctors didn’t go to medical school to do these services. [We need] a team environment. . . The doctor needs others to help with protocols and next steps.” Another noted, “We don’t have the doctor put you on the MRI table, so why does [the primary care provider] have to put things in the right place in the computer?” Providers also noted that budget priorities tended to focus on equipment that could generate billing rather than on staffing, especially for positions or staff time not typically reimbursed by Medicare. As one physician said, “We should be

able to bill for being a primary care educator – just like when get an MRI. . . not just paying for a machine—paying for the people.”

Technology provided both opportunities and current barriers for providers. Electronic health records (EHR) that could track services across multiple venues could be used to flag providers when a relevant service could be offered; however, there was often no crossover in EHR systems among various health venues, and in some practices, not all staff have access to the EHR. One provider noted, “Things might get done, but the information is not being captured. . . If someone gets their flu vaccine at a pharmacy, do we even know? – that isn’t tracked. That’s a ding against me if the patient doesn’t tell me about it. . . We need a universal EMR [electronic medical records].”

Increasing uptake of preventive services can be important for quality improvement measurement, which may be tied to compensation, either for the physician or for a nurse or other staff member to provide the service. However some providers were frustrated that those who set policy are usually not affected by it, and thus adherence to standards for providing preventive services was particularly difficult for providers whose patients were less likely to pursue preventive care or accept care when it was offered. As one provider explained, “These people [who set Healthcare Effectiveness Data and Information Set (HEDIS) measures] don’t have contact with patients. They don’t understand you need to build the trust.” Some voiced that providers serving disenfranchised and vulnerable populations are not sufficiently included in setting policy, that policies are based on the patterns of middle-class white beneficiaries, and that some services should actually be offered at an earlier age or at greater frequency for some patients. As one provider noted, “You can’t compare urban poor with suburban rich; you need to look specifically at at-risk populations.”

Providers also cited inadequate reimbursement and referral resources, especially for behavioral health, as factors impeding their ability to offer a full array of services. Coding and billing for preventive services can be confusing and mistakes could lead to a lack of reimbursement or costs to make corrections. One respondent observed, “I see 100 patients per week. I’m out there in the trenches. You try to stick with the things you get paid for. You don’t get paid for alcohol screening.” Providers noted that positive screening results may require unanticipated time for finding referral resources, many of which were in short supply in their communities, and they were also concerned about being held liable for a bad outcome if a screening result indicated need for follow-up that wasn’t readily available, a problem commonly raised regarding mental health resources.

Providers also reported that patients were unaware of official policy recommendations and thus might take offense when offered certain screenings associated with stigma. Alcohol use, HIV testing, and obesity were identified as particularly delicate topics. As one physician explained, “I can’t tell them they are coming in for their HIV screening today—they wouldn’t come in. . . For the older Medicare population, it will come out in other ways, through other blood tests.” Providers thought that patients could feel stigmatized and that the doctor was making assumptions about them if certain tests or screenings associated with sexuality, race, or socioeconomic status were offered. Providers also reported that patients worry about having stigmatized diagnoses in their medical charts. Physicians in particular felt they were already pressed for time and could not provide the level of education and sensitivity needed to offer these services successfully.

Providers identified patient-level issues as frequent barriers to preventive service use, noting that patients often miss appointments or will not wait after appointments for tests and screens to be conducted. As one respondent observed, “We fight with patients to have tests done. Sometimes it’s a socioeconomic issue: transportation, three jobs, take care of kids, etc.” Many perceived that some patients, especially those from disadvantaged minority groups or with low levels of education, don’t trust the medical system. Providers believed that patients won’t seek care in a space or from a clinician they don’t trust,

but that patients are more likely to use services when a trusted provider recommends them. As one physician noted, “[Going to appointments] is not about insurance. . . It's distrust of the system. You would find a neighbor bringing people to [a community health] event. . . They trust their neighbor or church more than they trust their system.” Providers suggested that culturally competent nurses or community health workers would have more time for education and making patient-specific recommendations. They also suggested that education and even services themselves could be provided in venues familiar to beneficiaries, such as community centers. As one physician suggested, “We have opened up a local community center for breast cancer screening, and we had 120 people coming in, and those individuals have insurance.” Publicly accessible, community-based services can reduce confusion and wait times for patients and may mitigate transportation as well as trust barriers.

Discussion

These findings offer preliminary insight into facilitators and barriers associated with uptake of preventive services after implementation of the ACA. Knowledge and trust were the most prominent issues surrounding beneficiaries' use of preventive services. Beneficiaries were most interested in receiving services recommended by their primary care provider, whom they generally considered their main source of information. Many beneficiaries lacked individual knowledge regarding what services are available and relevant to their health. These findings were consistent across data sources, suggesting that education and recommendations from providers have the strongest potential to improve patients' knowledge and uptake of preventive services. For providers, a lack of time was the most commonly cited issue. Physicians particularly noted insufficient time to offer preventive education and recommendations, particularly when patients presented with acute or uncontrolled conditions, which are more time-sensitive and require extensive attention. Current reimbursement rates for preventive services also appeared to lead some providers to make prevention a lower priority. Furthermore, providers working to generate patient trust expressed reluctance to offer services associated with stigma or that could require a complicated referral.

Conclusions and limitations

There are a number of limitations to this study that should be noted. First, the qualitative data have not reached saturation: new themes emerged with each focus group conducted. Second, only one of the three provider focus groups included non-physician providers, such as nurses or those who might be part of an alternative workforce care team (e.g., social workers, community health workers). Third, patient focus groups were conducted in a limited number of metropolitan areas and did not include some key demographic groups (e.g., rural beneficiaries, individuals dually eligible for Medicare and Medicaid). Quantitative analyses of survey data also had a number of limitations, including the use of only one point in time, the comparison of 2012 data to more current perceptions from Medicare beneficiaries from the 2016 focus groups, and the lack of provider survey data to complement the focus group themes from providers. Despite these limitations, our findings highlight the multiple facets of preventive care provision and receipt, identifying themes related to final codes that cross both patients and providers and that highlight differences between them. A strength of this study is that, the mixed-methods design allowed focus group guides to be developed based on quantitative survey results. Results were then synthesized across data types to triangulate findings, validate concordance, and provide a richer analysis.

Our findings suggest that a multipronged approach to addressing provider and patient barriers could be an effective strategy to increase the provision and uptake of preventive services. Diverse care teams that include nurses, social workers, community health workers, and others could help build rapport, better incorporate beneficiary preferences, and provide education that enhances patient knowledge and self-advocacy. As noted elsewhere in the literature, care team members such as nurses can aid in access to or even provide many screenings or services, especially in areas of provider shortages such as behavioral health.^{23,24} Additional support or training could help all providers better approach sensitive topics such as alcohol use or obesity, and further development of referral resources, especially for behavioral health, may increase provider willingness to conduct these screenings. Many current healthcare reform efforts incorporate these and other strategies, including having nurses work at the top of their licenses and using non-clinical physician extenders, community-based services, and incentives for preventive service use. Broader adoption and use of these and other strategies could further support and enhance use of preventive services among Medicare beneficiaries.

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Conflict of interest

None.

Disclaimer

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