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The Annual Physical: Delivering Value

The annual primary care visit, with its many synonyms, has traditionally included a broad array of activities; including at least a detailed interim history, comprehensive physical examination, and a variable set of tests and immunizations for the purpose of health promotion and disease prevention. All of this is done because there has been, for decades, a widespread assumption that an annual visit is a worthwhile pursuit. That assumption is increasingly being called into question.[1,2] As primary care physicians, we believe that by focusing the annual visit on patient–physician dialogue and relationship building, along with evidence-based activities; patients, physicians, and health systems will accrue value from a defined annual visit.

In modern health care, the annual preventive visit is one of the few tools available to deliver value at the intersection of the myriad determinants of cost and quality for which responsibility largely rests with primary care. Managing these factors has proven beneficial in innovative health care models.[3,4] In contrast, the literature often cited to limit the annual examination[5] consists of older studies looking at a heterogeneous range of services, many of which are not supported by current guidelines. Not surprisingly, these studies have not conclusively reported lower health costs or decreased mortality. Such dated findings cannot be the basis for key decisions about whether the annual visit should be discarded or embraced.

Responsibility falls to primary care physicians to manage areas as diverse as referrals, quality measures, avoidable admissions, and the increasing burden of chronic disease. Consider the challenge posed by managing referrals; reviewing consult notes; following up on imaging, laboratory, and other results ordered in other settings (eg, emergency departments, consultants' offices, home nursing) – then being responsible for achieving high rates of chronic disease control, cancer screening, vaccination, and patient satisfaction. Primary care physicians need the time, focus, and annual frequency of patient interactions to develop relationships and craft patient-centered approaches for the multitude of issues this broad set of responsibilities entails.

Our physician group and hospital have been engaged in novel payment models with Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract and the Medicare Pioneer Accountable Care Organization initiative. Both programs include incentives for providing cost-effective care while meeting measures of health care quality for prevention and chronic disease management. In addition, overall performance is tied to patient satisfaction survey outcomes. Many of the cost and quality benchmarks achieved by our group were driven by primary care management in preventive health (including annual wellness visits), chronic disease management, and cost-effective management of outpatients (preventing avoidable emergency department visits, ambulatory sensitive admissions, inappropriate imaging studies). The annual physical examination has proven itself effective for achieving many of those performance targets that were met largely through primary care practices (Spivak B, Shein DM. MACIPA's four year experience in BC/BS AQC and three year experience in Medicare Pioneer ACO. Unpublished results, 2016).

Medicare Advantage, which is built around primary care management, also puts physicians and organizations at risk for cost and quality performance. Our internal data consistently show that physicians in practices that actively engage patients in annual visits achieve some of the highest performances on measures of both quality and cost-effectiveness. We also see a multi-year trend revealing an inverse relationship between the number of outpatient visits and inpatient admissions at the practice level (Spivak B, Shein DM. MACIPA's experience with Medicare Advantage. Unpublished results, 2016). As physicians participating in the Medicare Advantage program, we are convinced that the annual physical is a necessary component of cost-effective and high-quality care.

Calls to eliminate the annual physical examination often suggest that preventive services can be effectively delivered without the interpersonal touch of a dedicated medical visit. Additionally, many factors that add value to the annual physical are not considered in arguments to eliminate it. Episodic, problem-based visits are limited by time and patients' expectation that they focus on their agenda. This makes it difficult to layer on prevention, screening, and disease management. Consider the multitude of vaccines and screenings added in the past decade alone, many of which require specific risk review, counseling, and even signed consent. While simple, widely accepted measures

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such as flu vaccination and take-home fecal screening for colon cancer have been added successfully to episodic visits for years, consider the full range of data to be collected and considered for risk stratification and informed decision-making across multiple disease domains. Physician visits with an agenda focused on evidence-based primary care are necessary to provide the full range of individualized, guideline-driven care.

Patients also face concerns for which they may not seek medical attention due to lack of health awareness, the presence of stigma, or fear of embarrassment. Conditions ranging from depression to sexually transmitted disease are often associated with substantial barriers to seeking care. However, these issues do come to light with depression screening and sexual history updates that should be a part of the preventive visit.

The opportunity to discuss important public health issues and encourage healthy behaviors can improve personal and societal outcomes and lower health care costs. Examples include assessment and counseling on tobacco use, gun ownership and safety, domestic violence, diet, exercise, and seatbelt use. Discussion of advance directives is also better conducted at a preventive visit, rather than during an acute illness when decision-making capacity can be impaired. The annual visit also offers us a chance to address concerns from many patients who face worry or confusion due to ambiguous public health messaging, confusing product advertising, and food labeling. The ability to focus these discussions on individual patients' preferences, lifestyles, and risks is more effective than generic public health messages.

Much has been written lamenting waning physical examination skills. As medical records are increasingly populated with responses to questionnaires and surveys, a similar skill at risk for decline is medical history taking. Visits that provide adequate time for patient–doctor dialogue engender patient-centered care, build trust, and also enhance morale for physicians.[6] This necessitates a visit with the explicit goal of engaging in a conversation that captures nuance and provides opportunities for counseling by understanding the many dimensions of a patient's history, health status, and health risks. Without this, we are in danger of losing the ability to obtain, act on, and ultimately, teach, the skill of history taking via the verbal exchanges that enable communication and engender trust.

We feel that the annual visit will accrue maximum value when accompanied by a focus on the key clinical skills of history taking, physical examination, and evidence-based preventive care. Adding tests for which there is no evidence raises costs, and is not an effective mechanism for detecting asymptomatic conditions for which routine screening is not indicated. Excessive testing is a distraction that attenuates the value of the key service provided at the annual visit — the patient-doctor interaction. Primary care specialties often lament the low value given to cognitive work, yet the reflex to offer sometimes extensive testing undermines the value of the cognitive service. Expertly delivered, evidence-based cognitive skill stands on its own.

In response to support for the annual visit, primary care physicians must be knowledgeable and confident in the evidence-based care we provide, while scrupulous to avoid unnecessary testing. Nurturing the primary care relationship will also lower barriers to getting care and enable timely patient access when needed to maintain continuity, prevent avoidable emergency department visits, and avert ambulatory-sensitive hospital admissions. Therefore, we believe that the relatively small investment in the annual primary care visit reaps substantial benefits, which can be measured in avoided admissions, emergency department visits adverted, and costly illnesses prevented. Updated research and thoughtful review of the incremental impact that effective, annual primary care visits have on outcomes of value in modern health care are urgently needed before this valuable tradition is prematurely branded as "an unwise choice" and put at risk of being discarded.[7]

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