

What Is the Best Approach to Annual Wellness Visits for Seniors?

Maybe it is time to change the way I do things – yet again.

The Medicare annual wellness visit (AWV) is surprisingly underused. In this issue, Daniel Bluestein, MD, and his colleagues present an interesting model for encouraging more of these exams by using nurse care managers (page 12). Whether or not you are a fan of the AWV, this raises some interesting questions.

Is an AWV performed by a registered nurse care manager likely to be as effective in screening and satisfying the patient as one performed by a physician, a nurse practitioner (NP), or a physician assistant (PA)? Should an AWV be the only annual “comprehensive” visit for seniors? Why do a number of physicians feel disdain for the AWV?

First, a little history.

The annual “physical” is a beloved 20th century invention that took hold in the 1940s.

Yet by the 1980s many prestigious medical organizations recommended scaling back the physical exam and focusing instead on preventive screening and counseling.¹ At present, the U.S. Preventive Services Task Force recommends against most routine physical examination screening of asymptomatic adults 65 and older.²

But much of the public still considers an annual physical to be good medical care, and many physicians appear to agree. I know physicians who won’t do an AWV because they feel it is inferior to the traditional preventive health visit that includes an exam (even though Medicare has never actually paid for that). Evidence-based guidelines appear to fall short of public and professional sentiment here. Perhaps the ritual of a physical exam, conveying the comfort of touch and reassuring thoroughness, helps solidify the doctor-patient relationship. The benefits of these sorts of interactions are hard to measure, but they seem pretty compelling to us clinicians as well.

I strongly support doing AWVs with all of my senior patients. A number of the components, including updating immunizations, screening for depression, hyperten-

sion, and obesity, and counseling for tobacco and alcohol use, have good evidence to support them. Doing a functional status review, screening for fall risk and cognitive abilities, and discussing advance directives also make sense to me.

Almost every senior in my practice has at least one chronic problem and takes medication for it, so I include a chronic problem review and problem-focused physical exam and explore new patient concerns with almost every AWV I do. I document and bill both an AWV and a regular evaluation and management visit, which can take up to 45 minutes each. Patients really appear to appreciate these comprehensive visits, and they pay well. But doing

more than two per four-hour session can be grueling.

Perhaps a less taxing approach would be what the article in this issue suggests: Have a nonphysician do the health risk assessment and counseling and have the physician do the “disease” stuff. I am ambivalent and feel compelled to do

both. But I am thinking maybe it is time to change the way I do things – yet again.

Please share your comments with us: How do you approach “annual visits?” Do you spend a lot of time doing screening and counseling? Do you still do an exhaustive physical exam, or is it limited? Do you address every concern a patient saves up for that special visit? What do you think about having a nurse or NP or PA doing the AWV instead of you? We look forward to hearing from you. 



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Much of the public still considers an annual physical to be good medical care.

1. Bloomfield HE, Wilt TJ. Evidence brief: role of the annual comprehensive physical examination in the asymptomatic adult. Washington, DC: U.S. Department of Veterans Affairs; 2011.

2. Published recommendations. U.S. Preventive Services Task Force web site. <http://bit.ly/2fDNQws>. Updated February 2017. Accessed Feb. 6, 2017.