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Re-envisioning the Annual Well-Woman Visit:

The Task Forward

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For many decades, annual cervical cancer screening has provided the foundation of well-woman visits for millions of women in the United States. Recent recommendations discouraging annual screening in most women¹ have focused attention on other important aspects of the visit. In this issue of *Obstetrics & Gynecology* (see page 697), a multidisciplinary task force reports its recommendations for the contemporary content of the examination, now a covered benefit in most private insurance and Medicaid plans.²

The Well-Woman Task Force was convened by the American College of Obstetricians and Gynecologists and included representatives from 14 subspecialty organizations. Its goal was to provide guidance not only to professional societies and the U.S. Department of Health and Human Services, but also to women and clinicians. Evidence-based recommendations by the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention, and the Institute of Medicine provided the baseline for preventive care. The final recommendations are organized by topic and stratified into four age-based groups: adolescents, reproductive-aged women, mature women, and older women.

The Well-Woman Task Force is to be commended for its comprehensive scope, yet clinicians may find the list overwhelming and difficult to navigate. A web-based application would allow busy clinicians to more easily fit recommendations to individual women. The Agency for Healthcare Research and Quality, for example, offers clinicians and patients the “Electronic Preventive Services Selector,” available on the web (<http://epss.ahrq.gov/PDA/index.jsp>) and as a free smartphone app.³ After providing patient age and a few risk factors (pregnancy, smoking, sexual activity), the selector generates a personalized list of preventive services evaluated by the U.S. Preventive Services Task Force and graded A through D based on certainty and magnitude of net benefit (benefit minus harms). A statement of insufficient evidence (an I statement) indicates that important information about benefits, harms, or benefits and harms is missing such that an evidence-based recommendation cannot be made.

The selector, for example, suggests that an average-risk, nonpregnant 41-year-old sexually active woman who does not smoke should be offered up to 20 recommended services

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(grades A and B), but a quick review shows that only three are at the highest level (grade A): screening for cervical cancer, HIV, and high blood pressure. Further, only two of the grade B recommendations may be applicable to an average-risk woman: screening for alcohol misuse and depression. These five services are all recommended by the Well-Woman Task Force and have good face validity with clinicians as being important, so it seems reasonable that these be prioritized above the others, at least at the first visit. Five recommendations are Grade C, meaning that they are reasonable to offer depending on where an individual woman places the fulcrum balancing benefits and harms. Sixteen services are boldly discouraged (grade D), and 20 are plagued by insufficient evidence (I statements). Although the recommendations of the U.S. Preventive Services Task Force are a subset of those suggested by the Well-Woman Task Force, they provide an easy starting point for clinicians interested in prioritizing evidence-based recommendations for prevention, at least until this current list can be organized similarly.

Devising a comprehensive list is an important first step, but delivering the recommended care brings a new set of challenges and opportunities. One contemporary model for care delivery mentioned by the authors is the patient-centered medical home, a way of organizing care that emphasizes coordination and communication, leading to higher quality and effectiveness, lower costs, and an improved experience for both patient and provider. The model relies on a designated physician leader committed to coordinating care among various team members. Obstetrician–gynecologists often serve this function for reproductive-aged women. The patient-centered medical home puts women front and center as active participants in their health care decisions. In fact, four recommendations by the Well-Woman Task Force call for active dialogue through the process of shared, informed decision making: beginning mammography at age 40, having a routine pelvic examination, taking medications for breast cancer prevention, and continuing colon cancer screening after age 75.

While shared, informed decision making is easy to evoke, it is challenging to implement, especially in a time-constrained visit.⁴ Clinicians and women need guidance, and professional societies can help. As much as professional societies have participated in the Choosing Wisely campaign to identify the top five low-value interventions that should be questioned,⁵ it may be an optimal time to launch a “Deciding Wisely” initiative, whereby professional societies identify the top five clinical preventive services for which shared decision making is important and recommend, or even to devise high-quality decision-assisting tools for use in clinical practice.

Re-envisioning the annual well-woman visit provides an opportunity to provide care that is evidence-based, high-value, and patient-centered. It shifts focus away from low-value interventions and toward those that are more likely to provide improved health outcomes to women. The task forward will be assuring that clinicians have the tools to easily offer and recommend these services and that women will be empowered to make health care decisions that are in line with their preferences and values.

Biography

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