Commentary

The Prescription for Health Initiative

Some Steps on the Road to Success: What Will It Take to Complete the Journey?

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The papers in this supplement to the *American Journal of Preventive Medicine*[1–11] on the Prescription for Health initiative represents a noble practice-based effort to build assessment, intervention, support, and linkages for a big four (use of tobacco, physical inactivity, unhealthy diet, and the risky use of alcohol) of behavioral issues as encountered in ten different primary care research network practices into functioning and sustained programs. Taken as a whole, the papers address various aspects of the system building that must occur to successfully address these issues in practice.

These articles use the electronic medical record (EMR) as a platform for e-links to address the issues at the point of care[2]; test the use of personal digital assistant (PDAs) for assessing health habits of teens making health visits, coupled with delivery of brief motivational interviewing interventions[3]; report that measures of health behavior can be used in practice[10]; employ rapid-cycle quality improvement and learning collaboratives[5]; describe what actually happens in "fitting" an idealized intervention into practice[6]; and examine a variety of efforts to link primary care patients to community services for the behaviors of interest.[7]

In addition, they test the concept of a community liaison to provide behavioral counseling and make linkages to community services as needed[4]; examine the costs of providing behavior change assessment and intervention in practice[11]; retrofit the components of the chronic care model (CCM) across primary care practices and examine how these correlate with patient health status[8]; and look at how systems approaches—including health risk appraisals (HRAs), registries, providing support for and linkages to behavior change services—correlate with changes in the four target behaviors of Prescription for Health Program.[9] To this reader, the bottom-line conclusion drawn from the group of papers is that the effort through community practice research networks is possibly, 25% of the way there after almost 4 years of effort.

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Why is this such a "hard slog"? The background here is that clinicians are drowning. It is estimated that a family practitioner would have to read several thousand journal articles a year to keep up with the literature,[12,13] spend 7 hours a day to deliver just the counseling messages suggested by the U.S. Preventive Services Task Force,[14] and that only about 50% of currently recommended care is actually delivered.[15] So it is critical for success in care delivery that the *right thing to do becomes the easy thing to do.* This will require acknowledging two themes that, to me, are central to the experience gained in the Prescription for Health initiative: first, the incentives for the delivery of health care are inappropriate and need realignment, and second, there is much to be learned from the application of systems thinking to service delivery from settings that are more system-like.

Theme 1: Payment needs to be aligned with the outcomes that are desired.

Fee-for-service practice is inappropriately structured (pays for discrete aliquots of care delivery, not for patient outcomes) and has the wrong incentives (forces technology and pills at the physician and the patient irrespective of benefit) for the delivery and integration of the services that are needed. Prepaid groups have different incentives—in this setting with salaried providers, and with capitation dollars paid upfront to the organization, the task becomes one of delivering the best possible care, including preventive care, at all levels and integrating it for maximal patient outcomes. In settings such as these the business case for care is better aligned with the incentives for delivery.

What about other settings with different payment mechanisms, such as salaried physicians, where the incentives for Prescription for Health may be better aligned? The New York Times[16] in reviewing the latest issue of the Dartmouth Atlas of Care on the costs of care at hospitals across the country reports that Mayo clinic doctors were the most cost effective. The Times concludes that "Mayo clinic doctors are on salary and have no financial incentive to do anything more than the patient clearly needs." Another example where providers are salaried is the Veterans Administration (VA). The VA's quality enhancement research initiative (QUERI), begun in the late 1990s provides a constructive example of implementation research targeted to

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integrating and improving the performance of the VA healthcare system.[17] This initiative is almost certainly strengthened by the fact that providers are not bound by fee-for-service considerations.

Incentives that may have applicability in some practice settings include payments for group visits. This is presently the case in the Washington State Medicaid program which pays for group visits conducted by an MD or nurse practitioner for asthma or diabetes—~$20 per patient visit four times per year. Another example is employer and health plan payment for quality care including the establishment of patient registries, provision of patient education, and the documentation of regular follow-up. And Goroll and colleagues[18] have recently described a new model, which they call *comprehensive payment* for primary care based on capitation taking into account the cost of physicians as well as the critical infrastructure necessary to deliver high quality integrated primary care. Such a remuneration system would clearly improve the chances for delivering the services targeted by Prescription for Health.

As described below, organizations with a pre-payment structure and/or salaried clinicians provide us with published experience to show *what could be*, since some of these organizations are closer to 75% of the way there on the road taken by Prescription for Health.

Theme 2: Primary care is a system and needs systems approaches to work.

McCaw and colleagues[19–21]of Kaiser Permanente Northern California have much to teach from the very successful work they have lead there, which draws more on the strength and opportunities available in the healthcare setting as a system rather than on clinician training alone for improving identification and management of domestic violence as encountered in practice.

Other successes in translating science or best-practice recommendations into programs for issues such as breast cancer screening and improving delivery of immunizations also provide important lessons about the value of practice integration and linkages at the organizational and community levels.[22–26]

The experimentally proven (23%–38% 1-year quit rates) Free and Clear, smoking-cessation program, developed at Group Health and made a fully covered service in 1993 resulted in smoking status being assessed as a vital sign at 90% of visits by 1997. The program now is an independent entity that functions across 17 states, 100 Fortune-500 companies, and at Group Health. This experience is directly applicable to all aspects of Prescription for Health.[27,28]

The focus of the VA's QUERI initiative mentioned above has been on implementation research in the context of systems-level interventions and analyses. Many of the publications from this work have appeared in the journal, Implementation Science, the name of which captures nicely much of the intent of the Prescription for Health initiative. See, for example, Smith and Barnett[29] on the role of economic analyses for interventions; Krein et al[30] evaluating the QUERI steps model for improving eye care for veterans with diabetes; Bowman et al[31] on measuring persistence of implementation effects; and the work of Goetz and colleagues[32] on implementing and evaluating a regional strategy based on a series of steps developed by QUERI and the precepts of the chronic care model to improve testing for HIV in the VA population.

From the work above and work on chronic care planning models and their potential applicability to preventive care[33–35] a picture emerges of how transformed and integrated health care looks. It is care that (is):

Employs clinical information systems to provide the data and the linkages needed for the integration of care, including patient- and population-level data, provision of reminders for practitioners and patients, identifying patient populations to be addressed with proactive care, individual patient care planning, monitoring performance of practice teams and the care system, providing a feedback loop, and facilitating community linkages as appropriate.

Evidence-based: Care in accord with the best scientific evidence.

Population-based: Care organized to reach the entire population served. Care is not dependent upon making a medical center visit but rather on what is known about the characteristics of the population and how to intervene at both the individual and population levels to prevent incident disease and manage prevalent conditions.

Multilevel: The care process involves multiple levels—the 1:1 level of care, the clinic level, the organizational level, and often the community level.

Integrated/seamless: Care that passes the we know you test.

- Don't have to tell story over and over.
- Caregiver knows *who I am* and *what I value and fear.*
- We are on the same page.
- My primary care provider is supported.

Patient-centered: Determines reason for visit, understands patient's issues, mutually agreed-upon management.

Provides self-management support: Practitioners use the 5A's: assessment, advice, agree on goals, assist, and arrange follow-up as their part of the bargain, while working through self-management support with the patient on assessment, goal setting, action planning, problem solving and follow-up.

Prospective/Hi Touch: We call you. You don't have to call us. We reach out and anticipate. Reciprocal multi-modal communication that is both prospective

and reactive. Includes phone, web, e-mail, EMR, office visits, home visits as needed, and community linkages.

Makes the right thing to do, the easy thing to do: for practitioners and for patients.

While the planning models (e.g., PRECEDE/PROCEED,[36] chronic care model[33,34]) and strategies used to evaluate program impact and translation (e.g., reach, efficacy, adoption, implementation, and maintenance [RE-AIM][37]) may vary, the overarching message of the Prescription for Health initiative is the same: there are no simple solutions to complex problems. To optimize the delivery of clinical preventive services in support of health behavior change will require fundamentally restructuring how a large portion of primary care is now paid for while at the same time acknowledging that payment must support systems capable of providing that care.

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