From Alma Ata to Prescription for Health

Correcting 30 Years of Drift in Primary Care Prevention and Behavioral Interventions

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With the completion of the second round of the Robert Wood Johnson Foundation's Prescription for Health Program and the submission of the manuscripts for this supplement to the *American Journal of Preventive Medicine*,[1–12] we celebrated both a landmark in the renewal and development of primary care in the U.S. and the 30th anniversary of the Alma Ata declaration of WHO and UNICEF.[13] Alma Ata in 1978 made primary health care a renewed international priority. It declared a vision for primary health care that differs from what it had become internationally, just as Prescription for Health has offered evidence that a correction of the drift of primary care in the U.S. toward ever more specialized, more technologic, more expensive, more medicocentric care is possible with greater practitioner and patient participation. The concern registered at the Alma Ata conference was that primary health care was losing its way as "the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work . . . the first element of a continuing healthcare process." The Prescription for Health projects blazed a trail that we can hope will be followed by other initiatives to fulfill the Alma Ata vision of "community participation and ultimate self-reliance with individuals, families and communities assuming more responsibility for their own health."[13]

Five ways in which these papers represent a large step in this direction and a major departure from the decades of research and practice drift in primary care are: (1) the demonstration of a model of practice-based participatory research that engages practitioners and their patients in a process of identifying their particular concerns and needs, the potential solutions in their settings, and in co-learning with research experts in evaluating their progress and accomplishments in addressing their needs; (2) the demonstration of practice-based research networks that provide, in their multiplicity of settings, greater assurance of the external validity or robustness of the interventions across variable contexts; (3) examination of the ways in which practitioners adapt the prescribed interventions to fit their circumstances, and how the typical adaptations align with or depart from the theoretical constructs on which the interventions were designed; (4) an accommodation of interventions to the realities of patient lives with respect to the interaction of multiple behavioral changes required to adjust their risk profiles, and the potential synergies and economies of coordinated interventions addressing the multiple behaviors; and (5) the value of intervening and measuring change at several levels of a system of care, from the individual patient educational and behavioral level to the practitioner to the organization of the practice levels.

Besides these demonstrated reality checks in primary care research directed at behavioral changes in patients, the Prescription for Health projects have addressed several of what Barbara Starfield and her colleagues[14] have recently identified among the "challenges in setting policy for interventions" in prevention:

1. avoiding the fallacy of treating risks as independent;
2. setting priorities based on frequency of the desired outcome in populations;
3. considering when it is more efficient (and perhaps more effective and equitable) to prioritize interventions to populations, including defined populations in the clinical sector, with explicit consideration of attributable risk;
4. taking into account the patient's perspective in clinical prevention; and
5. avoiding incentives for physician activities that are measurable but of low priority for population health gain.

Besides these examples of ways in which the Prescription for Health projects have sought to correct the course of prevention "gone astray" in primary care, the project reports in this supplement to *AJPM* suggest some additional lessons to be drawn from their experience:

The ecologic imperative. The projects have recognized the necessity of looking at causes of the four risk behaviors (use of tobacco, physical inactivity, unhealthful diet, and the risky use of alcohol) beyond the individual patients themselves. They have addressed

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the influential determinants that lie in the control of the practitioners serving them, in the organizational demands influencing them, and in the home, work, and community environments into which the patients must return to adapt their behavior. Many of the tested interventions have explicitly addressed some of these behavioral determinants beyond the individual patient's motivation, in part with technologic and organizational innovations to influence the practitioners and their settings, in part by applying the RE-AIM (reach, efficacy, adoption, implementation, and maintenance) model[15] and the chronic care model[16] to assure measurement attention to the reach and effectiveness of the interventions, the organizational adoption of practices, and the practitioner implementation of those practices.[17]

The limitation of most information technologies, however, is that they have not been developed with provisions for multi-level intervention. The limitation of both models used to structure the interventions is that while they elaborate what needs to be considered in structuring and evaluating interventions, they do not provide much guidance in the process of planning them and how to integrate theories and concepts pertaining to the various levels of intervention. These limitations could be grist for the next round of research, developmental work, and evaluation of such programs. In the other commentary accompanying this set of papers, for example, Thompson[12] reflects on the history of the remarkably successful experience of developing, implementing and evaluating the Group Health Cooperative services in tobacco cessation[18] and other areas of primary and secondary prevention services.[19] One example was expanded services for prenatal developmental.[20]

The comprehensiveness imperative. The studies reported here have demonstrated in various ways that interventions addressing multiple behavioral risks must be comprehensive in their coverage of key determinants of behavioral change. Some of the interventions tested are more discrete and confined, but they are tested within the context of usual care where some of the standard provision of patient education and support lends to a comprehensive approach. What makes an intervention comprehensive? The simplest answer to that question is a combination of components to the intervention and context of its implementation and follow-up that address the three broad categories of determinants of sustained behavioral change: predisposing factors such as attitudes, beliefs, and perceptions that make a person motivated to change; enabling factors such as skills and resources that help them make the change; and reinforcing factors that reward the behavior.[21] When the tested intervention is implemented within the context of an ecologic approach, it is almost inherently more comprehensive insofar as the enabling and reinforcing functions of environments are brought to bear on supporting (enabling) and reinforcing the behavioral change.

The imperative for blending evidence-based practice with practice-based evidence. Returning to the ways the Prescription for Health projects have blazed a new trail noted at the beginning of this commentary, the one that has become increasingly recognized during the years these projects have matured is the need for participatory practice-based research. This has become salient in part because so much push had come from funding agencies and healthcare institutions for more evidence-based practice while practitioners were finding much of the evidence to miss the mark of their practice needs. The drive for increasingly tight research designs that would pass peer review and qualify the research for systematic reviews that produce evidence-based practice guidelines had produced more and more evidence that was more and more removed from the realities of practice. To achieve greater experimental control, the research had screened, blinded, and limited practitioners' and patients' choices to randomly assigned intervention arms or components to a degree that made the evidence less and less relevant to the real life of patient care and patient behavior. Such evidence is unassailable in its internal validity, but increasingly dubious in its external validity.[22] With the greater participation of practitioners in shaping the research and with more practice-based settings for the research, the Prescription for Health projects demonstrate the added value of practice-based evidence to complement evidence-based practice.

For the other Larry Green—the one who directed the National Program Office for the Robert Wood Johnson Foundation's Prescription for Health Program—this set of papers and others that will continue to flow from these projects must be a dream fulfilled. His tireless efforts on behalf of practice-based research networks in family medicine over several decades[23] have truly borne fruit that is both low hanging and worth the squeeze.

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