Redesigning Primary Care Practice to Incorporate Health Behavior Change

Prescription for Health Round-2 Results

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Introduction

When Prescription for Health was conceived by the Robert Wood Johnson Foundation (the Foundation), primary care practice–based research networks (PBRNs) and their community, practice, academic, and healthcare system partners began with hard-won local knowledge.[1] They worked to integrate this with a platform of basic organizational and behavioral science research to provide a foundation on which to build a program for testing practical approaches in frontline clinical practice to help people change unhealthy behaviors. This intellectual foundation included the components of the chronic care model,[2] the 5A's model of behavioral counseling,[3] the transtheoretical model of behavior change,[4] and models of diffusion.[5] It was also apparent that the high prevalence and clustering of unhealthy behaviors within individuals and populations[6] would make addressing multiple behaviors and problems—sometimes simultaneously—a pragmatic necessity in primary care settings. It was hoped that addressing multiple behaviors would result in synergy among practice systems, patients, families, and communities, and thereby position redesigned primary care practices to contribute to decreasing premature mortality, avoidable morbidity, and escalating healthcare expenditures.[7]

After decades of limited success in incorporating health behavior issues into medical practice, a key challenge was how to engage those primary care clinicians who are in small- to medium-sized primary care practices, the dominant model of primary care delivery in the healthcare system. The strategy selected was to work with the nation's PBRNs.[8] Thirty years from their inception, approximately 100 of these networks of primary care practices were in existence, comprising mostly full-time clinicians working in their communities, asking and answering questions important to the health of their patients. Practices in these PBRNs are known to be similar to randomly chosen primary care practices[9] and to be relevant sites for research.[10] The Foundation decided to offer funding to primary care PBRNs to test their best ideas to help their patients modify their behaviors related to tobacco use, unhealthy diet, physical inactivity, and risky alcohol use. All projects were required to develop approaches capable of addressing two or more of these behaviors in the first round of Prescription for Health and all four target behaviors in the second round.

The feasibility of working with primary care practices was shown with a first round of work by 17 PBRNs that was summarized in a supplemental issue of the *Annals of Family Medicine*.[11,12] This early work confirmed that primary care practices were interested and willing to address health behavior issues when supported by grant funds and PBRN infrastructure. It established that health behavior counseling can be done in frontline primary care practices, and that doing so requires substantive practice redesign. It revealed the need and possibility of the explicit integration of primary care with public health and community resources. It also confirmed the utility and limitations of adapting existing models and theories into primary care, and that a co-evolutionary approach across projects created synergistic learning. This round of work was brief, focused on feasibility testing, and did not fund comprehensive trials. These successes inspired another round of work that is the basis for the papers[13–24] in this supplement to the *American Journal of Preventive Medicine*.

In Round 2 of Prescription for Health, ten PBRNs (five PBRNs from Round 1 and five new to the program) implemented 2-year studies that tested behavior-change counseling strategies, and again joined together with an imbedded evaluation team to learn what happened. The tested interventions included a broad mix of strategies[18] and required a spectrum of evaluative methods, including surveys, interviews, focus groups, medical record reviews, site visits, and collaborative meetings. All PBRNs collected a set of common patient-oriented measures[25] and provided systematic reports about prac-

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tice organization and function. Each network used the Reach, Efficacy/Effectiveness, Adoption, Implementation, Maintenance (RE-AIM) framework[26] to aid and guide their evaluation. They shared with the evaluation team real-time experience about their implementation processes via a secure website diary system provided by the Agency for Healthcare Research and Quality, and also reported expenditure data from a subset of their practices to estimate the expenses that practices would have to incur to implement their chosen strategy.[22]

The prevalence and fundamental role that these four unhealthy behaviors play as drivers of premature death and avoidable suffering continue to be confirmed,[27,28] making the work of Prescription for Health relevant and timely. This supplement creates an anchoring point for accessing the results of Prescription for Health. It incorporates manuscripts that report overarching conclusions derived by examining practice-based experience across PBRNs[17–22] as well as primary results from four PBRNs.[13–16]

As Prescription for Health concludes, the concept of the medical home has emerged as a cornerstone to help achieve the key policy objectives of improved quality, reduction of disparities in health and health care, and affordability of care.[29,30] This medical-home concept is modernized primary care with rich interfaces—still in development—between patients and the healthcare system. The medical home now enjoys widespread support from professional organizations, government agencies, and particularly purchasers of health care.[29,30] The emerging medical home and its architects are the likely primary targets for the results from Prescription for Health and this supplement.

The process of getting from the practice of yesterday to this practice of tomorrow is underway, and it is crucial to recognize both the need and the opportunity to incorporate health behavior counseling into the core business of the medical home. The work of Prescription for Health confirms that this requires not a few minor adjustments but the substantive redesign of how highly personalized, patient-centered care is rendered. Success may depend on adaptation to local situations.[17] It leans heavily on teamwork and new roles for office staff; on the routine, systematic assessment of health behaviors and the use of this information; on community linkages; and on robust clinical information systems[13–19]—virtually all of which not only are unsupported in the current frontline clinical environment, but also often are punished. It would be difficult to overstate how hard it is to change things at the micro level of a $2 trillion/year enterprise,[31] and also how urgent is the need for healthcare reform to make this transformative change possible and accessible to the entire population.

While much more research and development remain before widely available, high-performance frontline practice is achieved, the situation is changing. Instead of innovation being held back by a lack of knowledge and desire, now inappropriate primary care payment strategy is the key barrier. A classic chicken-and-egg problem exists: The change that is needed requires funding for acquisition and redesign, but the needed funding is conditional on the change already having been made.

Promising approaches to revising the payment systems that enable such redesigned frontline practice exist.[32,33] Approaches to the progressive, continuing improvement of practice performance exist as well.[34–36] Technology sufficient for the information and management requirements of superior frontline practice is within reach.[37] A workforce well-trained in nursing, medicine, pharmacy, mental health, and other fields exists, yearning to enter a new world of practice that makes big differences in the lives of millions of people.[38] The stunning impact of behavior on health, disease, and illness is obvious, and incorporating appropriate attention to behavior in frontline medicine is feasible and valuable, as revealed by the work of Prescription for Health. This promising set of circumstances justifies some optimism and begs for immediate further attention from government, purchasers of health care, foundations, patient-advocacy organizations, and professional societies.

The union of frontline primary care practice—the acknowledged foundation for effective health care—with the knowledge and skills from public health, decades of behavioral science research, and now practice-based research is at hand. Health behavior counseling in primary care practices is not a problem. It is a solution to some of the nation's most pressing health and healthcare problems, and it is trying to happen now.

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