



Prevention, Health Promotion and the Practicing Healthcare Professional:

*A Policy Paper of the National
Academies of Practice*

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Executive Summary

The National Academies of Practice is an interdisciplinary nonprofit organization with membership representing ten health professions. The NAP's mission is to provide the advice of its distinguished practitioner and scholar members to health care policy makers in Congress and at all levels of government.

While we are in general support of the Health Reform bill, we are very concerned about the extent of our role as health practitioners in health promotion and prevention and the extent to which the bill does or does not recognize, define and support our role.

As background to this policy paper, the NAP studied available literature, heard from national and international speakers, solicited the views of its members, and reviewed recently-passed health reform legislation.

Our conclusions and recommendations are:

- Health promotion and prevention are important tools in fostering optimal health. However, the evidence base for “best practice” models of achieving health goals, and quantifying the results is thin.
- Many barriers impede practicing health practitioners from providing optimal prevention and health promotion services. Only some of these barriers are addressed in the current Health Reform legislation.
- Issues that require special attention are:
 - a. which health practitioners should do what and how are they to be reimbursed;
 - b. how should public health goals and health services delivery be integrated;
 - c. what training for health practitioners in prevention and health promotion is needed.
- To address these issues successfully, Health Reform legislation needs to be implemented so that it promotes:
 - a. an integrated coordinated vision and infrastructure through the National Prevention, Health Promotion and Public Health Council, an expanded and strengthened Practitioner Advisory Committee and a strong plan;
 - b. removal of specific barriers to the full participation of all practicing healthcare professionals;
 - c. sustainable and broader financing through study of both public and private sector needs with a report to Congress;
 - d. testing of many types of prevention and health promotion delivery models;
 - e. evaluation of all funded delivery models through a single entity: i.e. The Innovation Center;
 - f. development of a replication strategy for best delivery models rather than one-time projects through a redesign of the current legislative approach to administration;
 - g. development of innovative financing models to support the various prevention and health promotion delivery models;
 - h. establishment of a “continuous improvement” model through research funding for ongoing efforts to reach public health goals;
 - i. support healthcare professional workforce training in prevention, health promotion and interdisciplinary teams.

Background:

Steps to creation of the Policy Paper on Prevention and Health Promotion

Since its founding in 1981, the NAP has produced a series of policy papers on various aspects of needed health care reform. Recent papers have focused on access to care, healthcare workforce shortages, and models of accountable, coordinated health care. More information about the NAP, including its policy papers can be found at our web site, www.NAPpractice.org.

The potential role of practicing health professionals (i.e. clinicians) in achieving that goal is the focus of this policy paper. The NAP believes that achieving progress in disease prevention and health promotion is critical to the success of the healthcare reform effort. To develop the background and reach the conclusions found in this paper, the NAP has relied on three primary sources of information:

1. a review of the pertinent evidence-based peer-reviewed published articles, books and reports;
2. a Forum hosted by the NAP in Arlington, Virginia on March 19, 2010;
3. deliberations of the Forum Policy Committee informed by the literature review and proceedings of the Forum.

In addition we have integrated the very broad experience of the NAP's Distinguished Practitioners into our efforts.

The Forum, titled "Promoting Prevention and Wellness" included collaborative discussions among the NAP members and guests and presentations by four nationally-known speakers:

- **Sylvie Stachenko, MD, MSc, FCPP**, Dean of the School of Public Health, University of Alberta, Canada who shared information about the Canadian public health system and her views of what an effective comprehensive public health care system would look like;
- **Robert A. Smith, PhD.**, Senior Vice President, American Cancer Society who addressed the limits and issues in promoting prevention in clinicians' offices and discussed some possible alternative delivery systems;
- **Yvonne J. Graham, RN, BHA, MPH**, Deputy Brooklyn Borough President, New York who discussed her pioneering work as Executive Director of the Caribbean Women's Health Association and lessons learned about community models;
- **Rear Admiral Penelope Slade-Sawyer**, Deputy Asst. Secretary for Health, HHS who reviewed the Healthy People 2010 initiative and how clinicians can be involved in this master plan.

For more details about the Forum 2010 presentations, please visit the "Policy Forums" section of the NAP's web site at www.NAPpractice.org.

Prevention and health promotion

Internationally, the World Health Organization and several countries have adopted a definition of prevention and health promotion based on the Ottawa Charter and updated through a series of conferences. It encompasses all activities to “enable people to increase control over and improve their health.” As a modern public health concept, health promotion is “everyone’s business” and is used to include activities involving everything that affects personal health—the environment, culture, lifestyle, and health services—by all stakeholders and providers in government, the community, schools and the workplace. The focus of health goes beyond doctor’s offices and hospitals. As the World Health Organization and the Institute of Medicine point out, true health care must focus on the social determinants of health.

In the United States, the terminology is used more narrowly, in large part because the United States and most developed countries have fundamental differences in the way they organize and pay for healthcare. Health promotion is typically defined as those activities that encourage and support lifestyle choices that lead to the avoidance of behaviors that put a person’s health at risk. Prevention is typically used to refer to specific activities aimed at diseases. Prevention can be primary, e. g., preventing teens from smoking, or secondary e.g., providing smoking cessation classes.

Health promotion activities tend to be seen as those for which public health entities have the lead responsibility. Prevention is typically seen as the practitioner’s province, although some practitioners are also involved in health promotion activities. For example, medical directors of company wellness initiatives may also have office practices. Public health entities typically are governmental in the US, funded by tax revenue appropriations; practitioners typically are in private practice, funded through reimbursement fee schedules of the government and private insurers and patient fees.

Health promotion and disease prevention activities are usually justified in one of two ways—improved quality of life (QUALYs methodologies), or cost savings. The problem, especially in the United States, is that, when asked to justify these efforts on the basis of cost savings—“bending the curve”—few interventions, and some say none, qualify. Why? In part because of the exceedingly long time horizon required for results to occur as a result of the activities; in part because it is difficult to trace people over time. It is much easier to measure costs over the life of an individual in single payor health systems than it is in the United State’s fragmented payment system where people jump between systems. Finally, methodologies—such as Congressional Budget Office analysis used for legislative consideration of Federal proposals—usually score such activities as “costers” rather than “savers” and this often acts as a deterrent to prevention and health promotion program adoption. As one of our speakers pointed out, it is unfair to expect these activities to show cost savings when we do not have similar requirements for many other health services—lab tests, surgeries, etc—that add to, rather than subtract from costs. Nevertheless, even in the United States, some of these activities have been funded some of the time.

It is the NAP’s belief that three factors will contribute to reducing costs. They are reduction in intensity, less reliance on costly technology, and the more efficient use of healthcare providers of all disciplines. And since “an ounce of prevention is worth a pound of cure” no matter the evaluation method, the NAP endorses prevention and health promotion activities as worth the investment. We believe that prevention and health promotion interventions should be evidence-based and should use best practices to justify expenditures. We also believe that there must be an objective evaluation of programs to conserve resources. Unfortunately, as we will point out later in this paper, adequate evaluation and an evidence base is available for fewer health prevention and promotion programs than would be ideal.

What is the role of the provider in delivering prevention and health promotion services?

The past and the present

The preponderance of peer-reviewed published reports emphasizes the primary care physician's pivotal role in prevention, either providing preventive services directly or directing other healthcare professionals to do so. Past reimbursement for preventive services has supported this role almost exclusively. Forty years ago, reimbursement targeted an "annual physical examination" or "checkup" that generally included not only a physical examination but a review of health issues, some health behavior counseling, and screening tests and recommendations [Smith]. Gradually the annual physical examination and checkup fell into disrepute. Preventive care, if delivered at all, was delivered as an opportunistic event occurring during an office visit for some medical complaint or problem. Given the enormous pressure on primary care physician time [Yarnes], prevention has been poorly delivered in this model. It is estimated that less than half of US adults have received just the top 5 most important of the 23 prevention priorities recommended by the US Preventive Services Task Force [Smith]. In an effort to improve physician office-based prevention services, the Robert Wood Johnson Foundation funded the Prescription for Health Initiative that was based on changing primary care physician practices to promote health. Several reports from the project have suggested that success will depend on significant reorganization of physician offices, a difficult task to implement [Cifuentes].

To a lesser extent, the literature reports on non-physician health practitioner efforts in delivering preventive services and promoting healthy behaviors. Current trends in care by non-physician healthcare practitioners show that as such services are increasing, the physicians' role in prevention is reduced and refocused on acute and chronic disease management [Druss]. Preventive services may also be offered outside the physician's office, for example, on the telephone by nurses working as physician extenders [Marshfield Clinic] or in clinics, where advanced practice nurses manage other non-physician healthcare professionals in providing preventive and health promotion services [Blau]. The VA has a proven home-based program for veterans managed by advanced practice nurses who provide or oversee not only disease management, but also appropriate prevention services [Beales].

There are specific circumstances in which practicing non-physician healthcare practitioners routinely deliver prevention and health promotion services. Pharmacists now administer flu shots and vaccines in many communities where allowed by law. They have been active in patient education about potential drug toxicities and in preventing drug dosing mishaps. Rural clinics and clinics in disadvantaged neighborhoods have long been managed by advanced practice nurses who deliver prevention and health promotion to their patients. Dentists and pediatricians have developed joint programs to protect young teeth from cavities and decay. Perhaps best detailed are behavioral modification programs to alter unhealthy life style behaviors associated with obesity, tobacco, alcohol or drugs. These programs are typically delivered by psychologists and social workers. A significant deterrent to non-physician practicing healthcare professionals' participation is reimbursement.

While there are no doubt many other instances of preventive services and health promotion activities provided by non-physician healthcare practitioners, the peer-reviewed literature lacks details of these efforts. Many articles report single site efforts without rigorous evaluation of the results. Information from our own NAP practitioners shows they have provided a broad spectrum of prevention and health promotion services: nursing outreach programs on a wide variety of 'healthy life' topics for school-aged children, adult education programs and new mother-at-home programs to name a few; optometrists regularly screen for treatable eye diseases; podiatrists have had active campaigns on preserving foot health and prevent foot pain, and veterinarians work to identify zoonotic diseases before they afflict humans.

The pediatric model is a bright spot in prevention delivery. Pediatric preventive and health promotion services

are routinely provided during well-baby/child visits, usually by the pediatrician or by a nurse practitioner. Pediatric preventive care is coordinated, comprehensive, proactive and family-centered [Antonelli]. As such, it could serve as a successful model for the Medical Home Joint Principles of the PCMH [AAFP], chronic care settings and other venues. But the success of coordinated pediatric care is not just centered on visits to the pediatrician. Other home and community based programs, also offer significant preventive benefits, e.g., the Nurse-Family Partnership program that offers in-home visits during pregnancy and through the first two years of life, programs designed to improve parenting practices offered in home, and community based programs that coordinate early education for preschoolers that lower and prevent depression as well as rehabilitation and education for special needs children in a combined healthcare-educational program that promotes upstreaming to a higher level of function [DiCowden, Minkovits, Olds (2002), Olds (2007), Reynolds, Williams].

Summary: While a fair amount of work on prevention and a somewhat lesser amount of health promotion among practicing healthcare professionals exists, the effort is not usually coordinated, comprehensive or interdisciplinary. Historically, primary care physicians have been the major focus for preventive services; they have been unable to perform at a high standard principally due to the United States health delivery system's structure and inherent barriers. Even if these barriers (sufficient time, proper training and reimbursement) were removed, there are not enough primary care physicians to do the job.

Similarly, most health promotion activities have been uncoordinated. Apart from sporadic efforts to alter deleterious health behaviors or to promote healthy behaviors, practicing healthcare professionals have been only marginally involved in health promotion. That area has been the major focus of public health and community groups. The United States needs significant changes in the structure, organization and delivery of prevention and health promotion activities. Without change, this helter-skelter array will persist and the enormous potential to be found in combining practicing health professionals with larger efforts to address the social determinants of health will be lost. Worse still, the American public will not receive the prevention and health promotion services it needs and deserves.

The future

The future role for non-physician healthcare practitioners is far from clear as governmental programs and payors continue to highlight the physician's central role. For example, Canada's plans emphasize "Health Promotion in Primary Care," making primary care physicians once again the linchpin of the healthcare professional effort. Our own recent healthcare legislation also focuses on primary care physicians as the main source of prevention care. Medicare will now allow an annual "prevention health promotion" visit, presumably to the physician's office. What happens there - whether the physician delivers the prevention protocol or the office or other staff is organized to do so - remains unclear.

More disturbing is the absence of a national plan for including and directing practicing healthcare professionals in the practice of prevention and health promotion. Our own Healthy People 2020 does not specifically target practicing healthcare professionals in the effort to achieve the 2020 goals. Generally public health initiatives either focus on public health departments and their programs or on community-based efforts, but leave the vast majority of practicing health professionals without a clear direction or role.

A national coordinated program to involve *practicing healthcare professionals*—physicians and non-physicians alike—is needed. Such a program would ensure that each professional society focuses on recommended preventive and/or health promotion activities. It would assign responsibility for all critical activities to ensure all preventive services are performed. This does not entail a single plan or mode of delivery. One size does not fit all. Below are some examples of prevention and health promotion delivery models that should be tried and studied more fully.

Medical Home-based: If reimbursement is available to the Medical Home for delivering prevention/health promotion services, there should be no restriction on who actually performs these services. A Medical Home could offer the services by the primary care physician, by non-physician Medical Home professionals, by refer-

ral to an outside stand-alone “Prevention Center,” or by referral to different healthcare professionals. The key would be coordinating interdisciplinary services and capturing overlap, medical record data and so on.

Chronic Care Home-based: For those with multiple co-morbidities who are home-based or home-bound, receiving multiple services at outside offices is inappropriate and/or impractical. Advanced practice nurses manage many home-based programs and coordinate care both for disease amelioration and appropriate prevention services. Nurses or other healthcare personnel may deliver these services during home visits.

Health Home-based: For persons who are well or who have minimal health issues and are invested in remaining healthy, Prevention/Health Promotion Centers could provide the recommended prevention and health promotion services in a comprehensive, coordinated and interdisciplinary manner. Other “homes” could refer their patients for these services.

Workplace-based: Realizing the importance of maintaining a healthy workforce, many companies provide many prevention and/or health promotion services: on-site gyms, blood pressure checks, diet/nutrition programs (Eat Well programs). Some companies have on-site primary care facilities that can provide blood tests, mammograms and so on. Other entities provide paid time-off work so that their work staff can participate in prevention programs. The key to good prevention and health promotion care is coordination and communication with the person’s primary care providers.

Community-based: Many communities and churches actively provide prevention or health promotion activities. These may consist of Health Fairs, Visiting Nurse run programs or special prevention promotions like free skin-check. Community programs often focus on environmental or social changes to promote health such as safe exercise paths, banning junk food in schools, or statutes about smoke-free places. Practicing healthcare professionals do participate in some or all of these programs. Typically, data about specific results of prevention screening are not transmitted beyond the person receiving them.

Other Sites-based: These “homes” provide comprehensive single focus care usually for disease states but could also include site-specific prevention and health promotion activities: Dental Homes [Nowak] for those with chronic or complex developmental tooth problems; Mental Homes for patients with significant chronic mental health issues and Chronic Care Homes [Cohen]. Some diseases are so significant, that primary care is secondary to specialty care such as found in cancer centers, cardiovascular centers, diabetic centers and so on. It might be advantageous for some patients to have most of their prevention and health promotion services delivered at those sites and managed by those specialists. But for other patients, the services might be best delivered elsewhere. The system for delivery needs to be flexible enough to serve each person’s prevention and health promotion needs optimally. The key to success is the coordination and communication of prevention care with all involved healthcare providers.

Summary: The pool of potential prevention and health promotion services providers is diverse and vast. Among practicing healthcare professionals, most prevention/health promotion activities are provided by primary care physicians, advanced practice nurses and, in the last several decades, by mental health professionals. These providers’ efforts have generally not been comprehensive, coordinated or interdisciplinary in nature. The diverse models for delivery of these services presented above provide ways to tap into thousands of healthcare providers who have been left out of prevention and health promotion. The manner in which the services are delivered to an individual should be focused on that individual’s unique needs. Regardless of the model that is appropriate for that individual, the most pressing need is to have the recommended services be comprehensive and coordinated among that individual’s practicing healthcare professional providers.

Current barriers to providing comprehensive prevention and health promotion services

Although focus on the “annual check up” in primary care practitioners’ offices has long been a means for delivering opportunistic prevention care, the delivery of primary prevention and health promotion services has not been highly effective in the United States. Given the pressures of health care delivery system, there is often a lack of sufficient time for physicians to promote health. Nor are there enough primary care physicians to do the job.

Other important barriers to the active participation of all relevant health practitioners in health promotion and prevention activities include but are not limited to the following:

No consensus on who should do what, where, and with what kind of payment

As previously discussed, the primary care physician is still the central focus of legislation and thinking, even though there is and will continue to be a glaring shortage of primary care physicians. While other practicing health care professionals could help bridge the gap, the United States lacks a plan or direction for integrating these practitioners into the mandate for improving prevention and health promotion activities.

Within primary care physician circles—even those who do prevention full time within integrated healthcare systems—there is no agreement on what models of delivery are best and most effective with choices including the “opportunistic” and “carve out” among other options. While primary care physicians are specifically but irregularly paid for some prevention/health promotion activities, other health professionals are not. Few providers can afford to provide their services for free—even if they knew exactly what to do and had the time to do it.

Also, as previously discussed, while there is activity, there is no consensus on the appropriate scope of practice for all the other health professionals who could—and *given workforce shortages*—should be involved in these activities. There also is little active funded research to provide an evidence base for decisions.

No clear connection between public health goals and health services delivery

The key example of this problem is the lack of connection between the Healthy People 2020 targets and the health services delivery community [Koh]. While health departments, some health systems, providers, communities, and businesses undertake activities they believe will help achieve the targets, there is no national, regional, state or local implementation plan that accompanies the Healthy People targets. There is also insufficient guidance on “best practices” or funding to help practicing health professionals (clinicians) participate in achieving those goals.

No adequate and clear reimbursement plans

While primary care physicians are paid for some activities, others are not. Few providers can afford to provide their services for free. This situation is further complicated by a lack of clarity as to what goals must be accomplished and how much time is required.

No specific training in prevention and health promotion

With the exception of schools of medicine, nursing, dentistry, podiatry and psychology, few health professional schools teach students what to do and how to do it in this field, in large part because of the factors outlined above. Post-graduate training in prevention and health promotion is rare. There exist a few tailored pro-

grams developed by the few practitioners who specialize in these areas. Since most public health officials believe that health is more a “function of lifestyles linked to living and working conditions rather than traditional healthcare,” social determinants both inside and outside the healthcare system are key and need to be addressed. The seminal paper, ‘Eight Americans’, detailed socioeconomic determinants of health and mortality in eight subsets of the American population and emphasized the critical importance of these factors on health indicators [Murray]. The 21st century clinician needs to be aware of these determinants and to appreciate the cultural setting in which prevention and health promotion activities will occur. The cultural changes required for adoption of these principles and implementation of programs requires that training commence at the earliest possible stage in the training of healthcare practitioners.

Recommendations for the implementation of the Health Reform Bill

Overall, the NAP is pleased with the Health Reform bill's many steps of progress. However we fear that the implementation process will be lacking in a number of critical ways--ways that, if not corrected, will undermine the goal of significantly improving prevention and health promotion. We believe 5 overall areas need attention and improvement:

- Development of an integrated, coordinated vision and infrastructure
- Removal of barriers to allow full participation of all practicing health care professionals
- Creation of a sustainable and broader financing infrastructure
- Specific support for developing broadened and replicable delivery models
- Support for workforce training in delivering coordinated prevention and health promotion

Develop an integrated, coordinated vision

Health, as the NAP defines it, is "an individual's state of well being based on integration of biological, psychological and social functioning within the context of social, cultural, family, and other environmental conditions." Health promotion involves the whole person, his/her environment and lifestyle. To be successful, health promotion must involve everyone, not just practicing health professionals but also healthcare workers, community members, government, legislators, the workplace and the individual. Our society must become "prevention and health promotion conscious" the way we are becoming "green conscious." This awareness needs to start in kindergarten and proceed through the postgraduate training of all healthcare professionals, similar to that recommended by the CDC for physician training in prevention and health promotion [Koo].

As an initial step, the current gulf between public health approaches and healthcare provider approaches must end. It must be replaced with an integrated, coordinated vision, a plan, and the creation of an evidence-based "best practice"-based sustainable infrastructure to carry out initiatives aimed at achieving pre-determined goals.

For success, we must expand our vision to recognize we need a sustainable infrastructure that will provide coherent coordinated plan for both prevention and health promotion. Just as the quality improvement movement has developed an infrastructure that details what and how goals will be measured and met, efforts in prevention and health promotion need a national home.

Currently the piecemeal program we have leaves enormous gaps in delivery both in prevention (primary and secondary) of specific diseases for the individual and for society as a whole or as identifiable subgroups. If properly constituted and led, The National Prevention, Health Promotion and Public Health Council with its Practitioner Advisory Group could create the vision and basic implementation structure. The question will be the strength and vision of the leadership, and whether they see the need to bring the two sides of the equation public health and health services together, and create the infrastructure to achieve targets and goals.

We are very concerned with the limited role given practitioners in the process outlined by the Health Reform bill. The Practitioner Advisory Group is only supposed to "advise on the development of lifestyle-based chronic disease prevention and management." In fact, practitioners need to be included throughout the development and implementation of strategies. Furthermore, if the emphasis is limited to historic concepts of primary care, and if only physicians and nurses are included, the chance for a new start will have been lost. The National Council needs a broad array of advisors from ALL relevant health professions including all the professions represented by the NAP.

Recommendation: Develop a coherent coordinated plan for both prevention and health promotion and for both public health and practitioner providers. Broaden the practitioner provider category to include non-physician healthcare practitioners.

Remove the barriers to permit and encourage participation of all practicing healthcare professionals

The following is a specific list of necessary changes that must occur if the practicing provider community is to play a more active role in prevention and health promotion.

- Provide reimbursement for in-home and community based interventions that provide prevention and health promotion
- Recognize that appropriate health care providers in these various settings go beyond the traditional physician and can include many other team members of the health care workforce, including community workers all of whom must be paid
- Emphasize team work rather than the efforts of the single physician practitioner for effective health promotion and prevention
- Support training for all practicing healthcare professionals in prevention and health promotion as detailed below in section E.

Recommendations Remove barriers as listed above which discourage or prevent integration of all practicing health care practitioners in the prevention and health promotion effort.

Create sustainable and broader financing

We also are very much concerned about the financial approach taken in the Health Reform bill. Creation of the Prevention and Public Health Fund to fund prevention, wellness and public health activities including prevention research and health screenings funded by the Federal government is a great beginning idea. But will this funding be only for public health departments?

Similarly, we are pleased that some further support for primary care is included for Medicare and Medicaid programs, and that health plans will be required to provide a minimum level of coverage without cost-sharing for some preventive services. Primary care physicians, whose practices are made up of 60% or more of Medicare payments, will receive 10% incentive payments as a bonus for prevention and health promotion services. However, this does not begin until 2011. It also provides a 5% incentive payment for mental health psychotherapy services under Medicare for prevention services. However, few people go to physicians for wellness visits and the concept of psychotherapy for health rather than illness is a novel concept for most Americans.

The emphasis on primary care physicians as the principal source of prevention activity fails to recognize that even with reimbursement, there are not enough physicians nor enough physician time to carry out the required prevention activities. Reimbursement for other providers who are or can be involved in prevention and health promotion—dentists, nurses, optometrists, pharmacists, podiatrists, psychologists, social workers, veterinarians—must be provided. All these clinicians are capable of participating in the advancement of the prevention and health promotion agenda. While some might work within the Medical Home model, many work independently or in other models of care as described above. Also, if the only source of funding is taxpayer dollars and the annual appropriation process, how can long-term sustainability of the effort be guaranteed?

Recommendations Create long term and sustainable financing of health promotion and prevention in both public and private sectors, with a report to Congress on options. Broaden the reimbursement portfolio.

Support multiple types of replicable delivery models

The Health Reform bill aims to promote the conditions that will incentivize health education and health delivery systems in this country to tackle barriers to improving prevention and health promotion. There are specific

provisions to enhance the development of health teams and encourage coordinated, comprehensive focus of care on the whole person.

We are pleased that the bill calls for several types of grant or contract programs to establish a variety of models for prevention/promotion delivery. We like the components of some of the models, such as the community-based interdisciplinary, interprofessional teams. We believe these teams have promise in expanding the workforce needed for prevention and health promotion, and increasing the scope and effectiveness of interventions.

However, models for providing this care, beyond the Patient Centered Medical Home model, are yet to be developed. Specifically missing are models to assist small primary care practices that currently provide the majority of medical care in the United States transition to fuller scale models. These models could be of any type that could focus more on prevention and health promotion as well as more balanced approach to the whole person when illness does occur. Also missing is consensus on “best practices” for the rest of the conceptual models mentioned in the legislation.

More problematic is that there is no cycle envisaged for ‘program development-evaluation-improvement-replication’. At a time when we need an evidence base to support building a delivery infrastructure, the legislation merely provides funds to stimulate potential one-time projects.

Recommendations To rectify these problems, five things need to be done either within implementing agencies or as a result of new legislation.

1. **Test many types of delivery models**

While the legislation seems to assume agreement on how best to deliver prevention and health promotion services, even within the primary care community there is no such agreement. Many kinds of “homes” need to be tested for effectiveness, not just the medical home, and many kinds of approaches do also. Similarly, varying approaches to the delivery of preventive/health promotion services should be tested including the “opportunistic,” “carve out” and other approaches. Grants to establish state hubs and primary care extension need to link to all of these kinds of models, not just the traditional primary care office.

2. **Evaluate all funded delivery models in a single entity i.e. through the Innovation Center**

Unlike the Medicare legislation’s demonstrations, pilots, and Innovation Center, this section of the Health Reform bill makes no attempt to turn a large number of individual grant programs into demonstrations that can be studied, evaluated, learned from and replicated. Otherwise we cannot develop a sustainable public health/health services infrastructure for health promotion and disease prevention in this country. In our view, *models* of care to be tested under the legislation should be put under one funded “Innovation Center.” This Center should span the disciplines of public health and health services, and manage these programs so that evidence-based “best practices” can be articulated, learning can take place, and replications strategies can be developed. Evaluation must be comprehensive to include both process and outcomes. Organizational effectiveness and behavior should also be assessed.

3. **Develop a replication strategy for successful delivery models**

At the end of CMS demonstrations, successful models can in many cases become nation-wide programs because the who, what, when, how, and how paid for have all been established. The same opportunity should be offered successful prevention and promotion models or components of models.

4. **Develop innovative financing models to support delivery models**

The bill lacks the directive to study ways to finance successful models at the same time the models themselves are being funded. As a result, when the funding ends, these programs will end and what we will have learned? The “Innovation Center” outlined above could coordinate testing various funding models, including incentive and gain-sharing programs. For example gain-sharing funding could be tied to achievement of “Healthy People 2020” targets.

5. Establish a “continuous improvement” model for ongoing efforts to reach public health goals. Similar to quality improvement efforts in hospitals and health systems, government and/or foundations should fund development of one or more centers to create methodologies to establish, evaluate and improve health improvement programs at the local level. The Institute for Healthcare Quality Improvement might be one model to replicate.

Support healthcare professional workforce training in prevention and health promotion and in interdisciplinary teamwork

We believe that, for all the progress made in the Health Reform bill, more progress needs to be made in workforce training.

Overall, medical care is a relatively small contributor to the general health status of the population of the United States [McGinnis]. Based on recent public health literature and WHO studies, a case can be made for health as more a “function of lifestyles linked to living and working conditions rather than traditional healthcare.” Social determinants both inside and outside the healthcare system need to be addressed. Health promotion needs to be more community-based and must consider the cultural and socio-economic aspects of the particular area where health care is delivered. Successful programs to address some of the social determinants of health are beginning in places like the Boston Medical Center, Yonkers, New York and Chicago. They cover a wide variety of interventions that address health disparities, prevention of substance abuse, violence and crime. [Fauth, Reynolds, Williams, Zuckerman]. A workforce for the 21st century can include, but needs to go beyond, physician involvement in health promotion and prevention and also go beyond the traditional office visit with a physician.

To be effective participants in community-based interprofessional, interdisciplinary teams, all practicing professions need to be trained. Yet there is no provision to support that kind of effort. An overall plan for training is required. The plan should be developed with the participation of professional associations such as NAP and it must be adequately funded.

To maximize the number of practicing healthcare professionals contributing to the overall prevention effort, educational programs designed for each discipline are needed. They would highlight what could/should be done within their scope of practice. This set of efforts could be done in cooperation with HRSA, AHRQ, professional associations such as the NAP and promoted as an Advisory Committee project.

Healthcare practitioners need training in interdisciplinary care, not just in addressing chronic or acute care problems, but in coordinating and delivering comprehensive prevention services and participating in health promotion activities with healthcare and non-healthcare professionals and workers alike.

Specifically, workforce training should include the following:

- Recognition that appropriate health providers in these various settings go beyond the traditional physician-provided care and can include many other team members of the health care workforce, including public health workers;
- Emphasis on the importance of team work rather than the single physician practitioner for prevention and promotion services;
- Specific training in order to work effectively in teams and to meld interprofessional cultures in providing prevention/health promotion services;
- Increased emphasis on and support of education and training of future healthcare practitioners in order to effectively engage directly with community efforts in health promotion and prevention activities;

- Emphasis on health as based on an integration of biological, psychological and social functioning within the context of social, cultural, family and other environmental conditions.

Recommendation: Support the development of educational programs in prevention, health promotion, and interdisciplinary effort at the level of professional schools and post-graduate training

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