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Clinician Reflections on Promotion of Healthy Behaviors in Primary Care Practice

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Abstract

Objective—Recommendations to use integrated models for health behavior change abound, however, the translation to practice has been poor. We used stimulated reflections of primary care physicians and nurse practitioners to generate insights about current practices and opportunities for changing how health behavior advice is addressed.

Method—Twenty-one community practicing primary care clinicians invited to a nationally sponsored practice-based research network conference on promotion of healthy behaviors were asked to record aspects of health behaviors they addressed during a day of outpatient visits. In response to 8 questions, clinicians reflected insights which were then analyzed by a multidisciplinary team to identify over-arching themes.

Results—Health behavior discussions are initiated and carried out predominantly by the clinician. These discussions occur primarily during health care maintenance visits or visits in which presenting complaints or chronic illnesses can be linked to health behaviors. Clinicians' reflections on viable opportunities for change include different modes of patient education materials such as web-based materials. Suprisingly infrequent were solutions outside of the clinical encounter or strategies that engage other staff or other community partners.

Conclusion—Implementation of the integrated care model as an opportunity to enhance health promotion seems far from the current realities and future vision of even motivated network-based clinicians.

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Keywords

health promotion; primary care practice; practice patterns; practice-based research

Introduction

Health behaviors such as tobacco use, lack of exercise, poor diet and obesity are major causes of preventable morbidity and mortality.[1,2] Among adults seeking care at primary care practices, the prevalence of poor health behaviors is staggering; 97% of adults report at least one of four poor health behaviors and 80% report two or more.[3] Because each of these health behaviors is potentially modifiable, effective health behavior counseling holds great promise as a strategy to reduce disease incidence and premature mortality.[4,5] Since most individuals see a primary care physician at least once a year,[6] and often make repeat office visits,[7,8] primary care physicians are uniquely positioned to provide health behavior counseling to a majority of health care consumers.

Although evidence is building about the effectiveness of brief counseling strategies,[5,9-11] the translation to practice has been poor. Logistical problems and other priorities of a busy practice may impede even the most motivated physicians from promoting healthy behaviors.[12-14] Thus, recommendations for newer integrated models of care emphasize proactive team- and system-based approaches for prevention and chronic disease management.[15-22] Specifically, recommendations for incorporating effective health behavior change strategies into routine patient care in the primary care setting include organizational change to engage other health professionals (e.g., nurses, nutritionists, health educators) in the practice to assist with providing preventive services as well as linking patients to resources outside of the practice.[20,22,23]

The perspectives of individuals on the front lines of delivering primary care can help understand current approaches and how to better integrate effective strategies into practice. Prior studies have used surveys and focus groups to elicit beliefs and explanations about providing preventive services and health behavior counseling[24-28] and predominately have focused on identifying barriers rather than encouraging identification of potential solutions. In this study, we used stimulated reflections by primary care physicians and nurse practitioners to generate insights about current practices and opportunities for changing how health behavior advice is addressed.

Methods

On November 8-10, 2001 a conference on “Primary Care Practices Promoting Healthy Behaviors” was sponsored by the Robert Wood Johnson Foundation (RWJF) and the US Agency for Healthcare Research and Quality (AHRQ). This working meeting was designed to inform development of a new funding initiative, Prescription for Health[29] (see: http://www.prescriptionforhealth.org/) and focused on the design, implementation and evaluation of strategies for promoting health behaviors among patients seen in primary care settings.

Thirty primary care practice-based research networks (PBRNs) were invited to send participants. PBRNs are organizations of clinician practices that collectively engage in research. These networks were chosen from among those funded by AHRQ and were selected to provide diversity in types of network clinicians. Each PBRN was asked to send a clinician (physician, physician assistant, or nurse practioner) whose primary function was patient care and who had directly participated in one or more studies conducted within the PBRN. The

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conference also was attended by content experts, representatives of organizations funding health behavior change research, and other representatives from invited PBRNs including researchers, network directors and staff. Since the goal of the conference was to solicit insights from those on the front lines of delivering primary health care, each PBRN clinician was asked to complete a pre-meeting assignment designed to solicit his/her initial insights and to start a reflective process. This report focuses on the self-reflective insights recorded by the 21 PBRN clinicians that participated in the conference.

Clinician participants were asked to complete a self-reflective questionnaire for each patient seen during a half day of patient care and to have these patients complete a brief questionnaire asking what health behaviors were discussed during the visit, how the topic was intiated, what important behaviors were not addressed, and the main reason for the visit. Patients were also asked to note anything else that might have been done to motivate improvement in health behaviors. After completing this data collection, clinicians were then asked to compare their reflections of each visit with those of their patients. Clinicians were then asked to describe insights that emerged from this self-reflective exercise by answering eight questions about current approaches and processes used to provide health behavior counseling, as well as opportunities for change.

All 21 clinicians responded to all eight questions. Responses to individual questions ranged from one sentence to six sentences. On average, each clinician generated approximately 2/3 of a page of single spaced text in response to the eight questions. The richest response was 1 ½ single spaced text. Given the nature of the questions, the data are sufficiently rich to conduct the analyses.

Analysis

The three authors independently read and summarized all 21 clinician responses to the eight questions and identified initial categories for organizing the data. Then the authors met as group and read out loud and discussed each clinician response in order to develop an initial coding scheme for each question. An editing approach[30] was used to mark segments of text for the responses to each question and these segments were read again and sorted in a variety of ways to identify themes for each question. A statement representing each theme was written and rewritten until consensus was reached. The final step was to generate overarching themes by comparing insights across questions.

Findings

Clinician reflections on each of the eight questions

The themes extracted from the clinician responses for each of the questions are reported in the Table. Synthesizing the responses to the six reflective questions about how health behavior advice is accomplished in practice resulted in four overarching themes: 1) health behavior <u>assessment</u> is predominately done by the clinician, 2) health behavior <u>advice</u> is clinician delivered; internal and external referrals are infrequently used; 3) health behavior advice is provided in the context of the visit, generally health care maintenance visits, but also in illness visits when a presenting complaint or chronic illness is related to a health behavior, and 4) collaborative models of preventive service delivery are not a daily reality.

The last two questions (7 & 8) probed for perceived new opportunities for health promotion both in their practice and outside of the ambulatory visit. Clinicians responded that web-based and written patient education materials would be helpful. Using a survey or assessing smoking status or body mass index as a routine ‘vital sign’ to identify individuals at risk was suggested by a few physicians. Likewise, a few clinicians suggested opportunities for increasing health

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promotion outside of their practice by using a newsletter, referral for smoking cessation, community outreach worker or home visits. Public health campaigns using the media were seen as a way of reaching a broader audience. A few clinicians mentioned currently participating in public speaking and providing educational talks. Two clinicians provided responses suggesting engaging with another entity that could help support health promotions - a school based clinic and wishing to have access to a centralized telephone counseling system. Several clinicians identified lack of personnel and financial and time pressures that would get in the way of practice involvement in health promotion outside of the ambulatory visit. One clinician's response summed up this sentiment:

> "Our practice is so focused on the {financial} bottom line that these initiatives don't get done often enough. We need more incentives beyond just our good will to do better in these areas. There is just not enough time to figure out how to do this better." Clinician 2.

Opportunities for Change

At the conference, small group sessions were used discuss opportunities for increasing promotion of healthy behaviors in the primary care setting. Away from the day-to-day activities of providing care to patients, the small group sessions produced an environment that facilitated participants' creative idea generation. Focusing on brief interventions during teachable moments with patients and leveraging this with referral to other resources both in the practice and in the community was identified as a fundamental solution by the conference participants. While not novel for those that conduct research in this area, this idea was absent from the clinicians' initial reflective responses.

Discussion

Using clinician collected data and a reflective process focused on a day of routine patient care, this study shows that clinicians currently perceive the task of health behavior assessment and advice as sitting squarely on their shoulders. Strategies recommending the engagement of other staff and use of referrals and tools outside of the visit context are rarely employed. In fact, opportunities for change initially perceived by the clinicians emphasize patient education materials and redoubling effort on the part of the clinician. Solutions that involve activities outside of the clinical encounter such as engaging staff or community partners were rare. What is striking about these findings is that the reported approaches to health behavior advice and the perceived solutions were from a group of PBRN clinicians that were highly motivated to improve health promotion in primary care, as evidenced by their participation in a national conference on the topic.

Interestingly, away from the practice setting and among a group of peers, clinician participants generated creative strategies to improve health promotion. The solutions were in line with those proposed in the literature and included engaging other staff members[5] and linking to resources and community partners for health behavior change.[31,32] Guiding individuals to step back and reflect by creating space to share ideas with others is a common element of change models including continuous quality improvement (CQI),[33] learning collaboratives [34] and other participatory change models.[35] Creating space to facilitate reflection may be particularly important for individuals who are working in a high-productivity-driven environment. This approach could be used to develop a sense of ownership of the ideas for change and specific change strategies and subsequently may increase motivation to change.

Newer models of integrated care relevant to preventive service delivery, such as the Chronic Care Model, emphasize proactive team-based system driven approaches with core elements of utilization of clinical information systems and decision support, support for patient self-

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management, proactive identification and management of patients who are at-risk, and use of community resources.[15-21,36,37] However, these care process models have emerged and have been primarily evaluated in large closed panel health care systems.[38-41] If these team- and system-based models are to succeed,[36] much more attention must be paid to the steps needed to bridge the chasm to the current reality of the front lines of primary care. In other words, care process models must be accompanied by the development and evaluation of frameworks for *how to implement practice change*.[42-46] Further, use of community resources assumes that they are available, affordable, and accessible. Integrating utilization of community resources to support practices' health behavior change efforts will require the engagement of community partners in the practice change process.[23]

This study has some limitations. The clinician participants in the conference were selected based on participation in practice-based research networks and an interest in improving health promotion. Thus, these findings should not be generalized to other groups. While this may be viewed as a limitation, one could have expected this motivated group to be utilizing innovative strategies for integrating health behavior advice into routine patient care. The low level of utilization of team approaches and resources outside of the practice therefore, indicate that even among this motivated group the challenges outweigh the resources. Another potential limitation is that these data were collected 5 years ago. However, within our context, the prevalence of poor health behaviors remains high and little has changed in the past 5 years with regard to rates of health behavior advice.[47-49] A third limitation is that the analyses were constrained to the data generated as part of the pre-conference reflective exercise. Observation of practice processes and in-depth interviews with clinicians and other staff may have produced a greater breadth and depth of information about current approaches to health promotion.

The current context of primary care is one in which acute care accounts for the majority of primary care outpatient visits[50] and continues to shape health care service delivery and health care reimbursement. This acute care approach to seeking, delivering and reimbursing for healthcare reinforces a reactive rather than a proactive stance toward health promotion and provision of health behavior advice. In health care systems where health behavior counseling is not reimbursed[51] and therefore not emphasized, long term solutions to improving health promotion in the primary care setting will require fundamental changes in reimbursement and staffing structure and organization.[32,52]

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Table

Pattern of Clinician Responses to Questions

Question 1: "What insights do you get from looking at your visit reporting cards, you patient cards, and by comparing them for specific visits?"

1	Patient interest in health behavior advice varies - some patients seem not at all interested, while others use bring information from outside sources such as the internet to the visit.
2	Other health issues take priority over health behavior advice, particularly during acute visits. Health maintenance visits (i.e. annual exams) are seen by both clinicians and patients as the time for addressing health behaviors.

Question 2: "How does promotion of healthy habits typically occur in your practice?"

1	Health behavior advice is predominately addressed by the clinician. Some clinicians indicate that a nurse, health educator or community outreach worker help, but only with specific patients (e.g. patients with diabetes).
2	Health maintenance visits are the primary vehicle for discussing healthy behaviors.
3	Several reported things that may prompt advice: acute and chronic illness problems that could be linked to a health behavior; intake forms and flow sheets; patients that raise health behavior topics through questions, concerns, or articles. None of the clinicians reported having a systematic way of addressing health behavior advice within the practice.

Question 3: "How is promotion of healthy habits integrated with the other kinds of care that your practice provides?"

1	Clinicians use health maintenance visits as the primary time to discuss healthy behaviors.
2	Some clinicians use internal and external referrals to dieticians, nutritionists, smoking cessation counselors to aid with specific health behavior advice.

Question 4: "How does your practice ascertain patients' current health habits?"

1	Health behaviors are predominately ascertained by the clinician during the visit.
2	New patient forms and health maintenance (annual exam) forms were commonly reported as prompts to ascertain health behaviors.

Question 5: "Who is responsible for this ascertainment and for following up on health habit counseling?"

1	Predominately the clinician is responsible for ascertaining patients' current health behaviors. In 5 instances, other health professionals were listed, but only for specific services such as smoking cessation.

Question 6: "How is health habit counseling prioritized in your practice? Does your counseling target certain behaviors more than others? How do you weigh health habit counseling against other demands on time and energy of you and your staff?"

1	Health behavior discussions are overwhelmingly considered a lower priority than acute problems or complaints.
2	Health behavior topics are a higher priority when they are linked to a chronic illness, a presenting problem or when the reason for visit is health maintenance.
3	Practices prioritize health behavior topics based on individual patient characteristics or patient requests. In terms of specific health behaviors, smoking and diet were mentioned most frequently.

Question 7. "What new opportunities for promotion of healthy behaviors do you see for your practice?"

1	Many responded with alternative modes of patient education including computerized education materials, use of the internet, videos and small group education classes in the clinic.
2	Few responses (3) regarding using surveys or vital signs to identify individuals at risk.
3	Few responses (3) regarding opportunities outside the practice: newsletter, referral for smoking cessation, utilize community outreach worker and home visits.

Question 8. "What healthy habit promotion can be provided outside of the ambulatory visit, and how can this be supported by your practice?"

1	In-house patient education and use of the internet.
2	Public speaking.
3	Promoting healthy behaviors through other media, newspaper, radio, sponsoring health events.
4	Several clinicians acknowledged the complexity and barriers to addressing health promotion.
5	One clinician suggested use of a centralized telephone counseling system.

6 One clinician suggested that they had a partnership with a school-based clinic and that was a venue that could potentially support more health promotion classes.

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