

Delivering Preventive Services in the New Millennium

During the last few decades, patients and the medical community have embraced the concepts of preventive care first popularized in the 1950s by Morris F Collen, MD, and his colleagues in The Permanente Medical Group. Government-sponsored organizations in the United States,¹ Canada,² and elsewhere now publish evidence-based standards of preventive care, and research dollars flow to support the science of prevention. And why not? Both the medical community and the public believe it logical to alleviate the burdens of illness through the use of early, preclinical intervention designed to prevent or postpone disease.

In the health care industry marketplace of 2004, customers differentiate the quality of care provided by the Kaiser Permanente (KP) Medical Care Program from that of our competitors largely on the basis of how well we provide preventive services such as mammograms, Pap smears, and vaccinations. The old paradigm of symptom- and illness-driven health care is being challenged by a developing paradigm of preventive care. Doctors no longer just care for sick patients; they now must prevent illness by using an ever-expanding grab bag of preventive interventions.

Proliferation of Preventive Care Strategies

The KP administrative structure and outside organizations all have issued such a proliferation of preventive care

guidelines that primary physicians are frequently challenged to remember all the subtleties of these various tracts. Yarnall and colleagues³ estimated that if a family physician with an average case load were to implement all the currently recommended preventive care strategies for all patients seen, the physician would spend more than seven hours each day providing preventive services! How much time would that leave for acute, symptom-driven care?

Fragmentation of Preventive Services

Throughout the health care industry, various systems of “health care delivery reminders” have been implemented in an attempt to improve overworked physicians’ ability to provide timely preventive services.⁴ We at KP, both regionally and locally at the facility level, continue to develop many population-based care programs to assist physicians with certain aspects of preventive care, programs that often arise in response to an outside organization’s demand for information about that care. In general, these preventive care programs are added to departments or clinics without additional financial support.

Services in these ad hoc programs are delivered in parallel with delivery of acute care by primary physicians. However, administration of preventive care programs is often scattered among the various departments that traditionally provided care for patients with the disease targeted by that program. For ex-

ample, osteoporotic fracture prevention programs may be administered by the orthopedic department, and lipid treatment programs may be administered by the endocrinology department. Other models also exist: In our KP San Diego (KPSD) operations, care is often fragmented. Some patients receive preventive care and treatment for high cholesterol at a lipid clinic, and other patients receive this care from their primary physician. Education about blood cholesterol is provided at the lipid clinic, and medications to treat high cholesterol are often managed by primary physicians. No one entity assumes full responsibility for the care of all patients with abnormal lipid levels.

Because most preventive care programs do not assume the entire responsibility for care in their area and because no clear lines of outcome accountability exist, the primary physician is forced to act as a safety net to ensure that no preventive care activity is missed. Our medical centers have a growing conflict between delivering preventive care and providing symptom-driven care; this conflict will not be resolved by adding more decentralized, autonomous centers as pieces of the preventive care puzzle.

A Modest Proposal: Integrate Preventive Care Services

To maintain our excellence at providing preventive services, we need



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to take advantage of new technology in the workplace and to create new structures to improve our delivery of care. We must first clearly identify who will provide and manage preventive care services. Patients and health care providers should be able to easily locate who is providing preventive care. Preventive care should be consolidated under a single organizational structure, and delivery should be integrated and easy for patients to access. Preventive care should be available on demand, perhaps even without an appointment, as is described in the following example visit.

For example, a 60-year-old woman who has not seen a physician or had any health care for years and who recently joined the KP Health Plan now arrives at the KPSD Preventive Medicine Center. She completes a history form that is appropriate for her age and sex. Her history is reviewed, and with the help of a computerized medical record system, a list of needed preventive services is immediately compiled. Appropriate examinations such as Pap smear, pelvic examination, mammography, and screening laboratory tests are done. The patient also receives any immunization needed. Sigmoidoscopy is scheduled, and follow-up care arranged by a midlevel provider. If the patient is hypertensive, she is asked to obtain more blood pressure readings and is enrolled in a tracking program for hypertensive patients.

Organization of Care Delivery

All follow-up preventive care would be managed by the preventive care centers. Tasks would be done by the appropriate level of health care provider: Many preven-

tive care tasks now done by physicians would instead be done by teams of clerks, registered nurses, health educators, and midlevel providers. The physician's role would be to plan workflow policies and to provide guidance and supervision instead of the traditional one in which teams of people provide support as doctors perform these tasks.

Preventive services would thus be integrated in one setting. Because the tools that ensure successful delivery of preventive services are needed by most preventive programs, organizing these programs under one administrative structure would pool resources and allow economy of scale. A single administrative structure, whether applied regionally or locally at a facility, would improve proficiency in designing and developing these programs. A clear statement of responsibility for both components of preventive services, ie, delivery and follow-up, would eliminate political turf battles over control of programs and their resources. Programs that are currently Balkanized could be combined to more effectively deliver care. For example, one program should administer and be responsible for managing all strategies for patients who need reduction of cardiovascular risk, including delivering care for weight reduction, hypertension management, smoking cessation, and cholesterol reduction. Currently, responsibilities for each of these services often reside in separate departments.

Management Tools

We must develop tools for effective and efficient outreach and education. Many tools we already use—such as voicemail, e-mail, and surface mail—must be automated and integrated with the electronic medical record system to free phy-

sicians and their support staff from time-consuming clerical work. Automated prompts to patients should require no initiation from staff. For example, reminders to come to the preventive center for preventive services such as Pap smear and mammogram could be timed to arrive by e-mail one month before a patient's birthday each year. Automated prompts could be used to remind delinquent patients to order refills on long-term prescription medication or to have routine laboratory tests done as well as to provide follow-up for preventive care services.

With development of automated reminders must come tools for patient education. Only an educated patient population can be expected to adhere to guidelines of an ever-expanding preventive medicine program. When education and outreach are successfully implemented, a patient's lack of adherence to guidelines becomes an issue of compliance instead of an issue of miscommunication or lack of participation by the health care provider. Because providers are involved with the reminder system only after a patient fails to respond to automated contacts, more physician time can be directed to providing symptom-driven care.

Funding

These preventive care centers also need adequate funding—whether regional or local or programwide. A new initiative championed on a regional level in KP is currently given to a department to develop, often with the expectation that funding will come from existing department resources. However, this arrangement places start-up programs in competition with existing programs—a recipe for inadequate funding. Organizing centers under a single, responsible department would provide economy of scale

and the ability to manage and shift costs among preventive care programs as needs change. In addition, distributing responsibility for programs among different departments sometimes allows outdated, inefficient, or ineffective programs to continue for a variety of political—instead of medical—reasons.

Conclusion

During our 50-year history, what has truly distinguished the KP Health Care Program is its visionary commitment to preventive health care. As preventive services grow in response to discoveries in evidence-based medicine and to the demands of patients and large health care purchasers, the re-

sources required to meet these demands will inevitably rise. We must manage these resources wisely. If we take delivery of preventive care seriously, we in KP should create independent departments of preventive medicine that have full responsibility for identifying need, for providing preventive services, and for tracking outcome of services. A 15-minute appointment with a family physician will no longer suffice. ❖

References

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Effecting The Future

Knowledge and understanding of the past are essential to effecting sound administration and constructive change in the future.

— Ray Kay, founding Medical Director of the Southern California Medical Group.
This "Moment in History" quote collected by Steve Gilford, KP Historian