From Patient-Centered to Citizen-Centered Health Promotion

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## Role of Personal Health Behaviors

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<thead>
<tr>
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WHO Conceptual Model

“Downstream” determinants

- Access to healthy foods
- Physical activity
- Tobacco and alcohol
- Healthy housing
- Safe neighborhoods
- Clean air and water
- Safe working conditions
“Upstream determinants”

- Inadequate education
- Unemployment
- Declining income and net worth
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Role of Clinicians

Rationale for clinician involvement
• Credibility and imprimatur of advice
• Integration with primary care and medical history

Impediments
• Benefits of counseling depend on intensity
• Lack of time, skills, staff, reimbursement to offer intensive counseling and ongoing support
• Practice redesign to offer such services not feasible in typical US primary care practices
Beyond the Clinical Setting
The Problem of Silos
Silo Phenomenon

Health care providers and institutions

• Systematic identification of behaviors
• Brief advice
• Goal setting

Community resources

Intensive assistance from skilled counselors
Ongoing support
Clinical-Community Collaboration

Clinical settings

Public health and community organizations
It’s Not A New Idea
The Medicine-Public Health Divide

Efforts to establish close relations between medicine and public health date back to the 4th century B.C., when Hippocrates urged physicians to recognize the environmental, social, and behavioral determinants of disease: the air "peculiar to each particular region"; the "properties of the waters" that the inhabitants drink and use; and "the mode of life of the inhabitants, whether they are heavy drinkers, taking lunch, and inactive, or athletic, industrious, eating much and drinking little." \(^1\)\(^2\)

Rudolf Virchow (1821-1902), although considered the founder of cellular pathology, understood that the causes of premature death and disease were typically found outside the laboratory.

Should medicine ever fulfill its great ends, it must enter into the larger political and social life of our time; it must indicate the barriers which obstruct the normal completion of the life-cycle and re-

1. The diverse and dispersed health system in the United States has not provided a strong structural foundation to support cross-sectoral interactions.
2. The delivery of personal health services by public health agencies was seen by many physicians as an intrusion into the medical domain and interference with the doctor-patient relationship.
3. Rapid advances in scientific knowledge, and the development of new medical technologies and public health programs, "made each health sector feel considerably more independent, dramatically reducing their perceived need to work together."
4. The proliferation of medical specialties and the fragmentation of public health created logistical impediments to collaboration.
5. Cultural differences and growing disparities in funding between the two health sectors diminished the level of trust, respect, and communication between them.

It Has Broad Application
Applications of the Collaborative Model

• Clinical preventive services
  – Health behavior counseling
  – Screening tests, immunizations, etc.

• Chronic illness management
Provider Referrals to Community Counseling
Telephone Quitlines
A Resource for Development, Implementation, and Evaluation
Translating the Diabetes Prevention Program into the Community
The DEPLOY Pilot Study

Ronald T. Ackermann, MD, MPH, Emily A. Finch, MA, Edward Brizendine, MS, Honghong Zhou, PhD, David G. Marrero, PhD

Background: The Diabetes Prevention Program (DPP) found that an intensive lifestyle intervention can reduce the development of diabetes by more than half in adults with prediabetes, but there is little information about the feasibility of offering such an intervention in community settings. This study evaluated the delivery of a group-based DPP lifestyle intervention in partnership with the YMCA.

Methods: This pilot cluster-randomized trial was designed to compare group-based DPP lifestyle intervention delivery by the YMCA to brief counseling alone (control) in adults who attended a diabetes risk-screening event at one of two semi-urban YMCA facilities and who had a BMI $\geq$24 kg/m$^2$, $\geq$2 diabetes risk factors, and a random capillary blood glucose of 110–199 mg/dL. Multivariate regression was used to compare between-group differences in changes in body weight, blood pressures, HbA1c, total cholesterol, and HDL-cholesterol after 6 and 12 months.

Results: Among 92 participants, controls were more often women (61% vs 50%) and of nonwhite race (29% vs 7%). After 6 months, body weight decreased by 6.0% (95% CI = 4.7, 7.3) in intervention participants and 2.0% (95% CI = 0.6, 3.3) in controls ($p<0.001$; difference between groups). Intervention participants also had greater changes in total cholesterol ($-22$ mg/dL vs $+6$ mg/dL controls; $p<0.001$). These differences were sustained after 12 months, and adjustment for differences in race and gender did not alter these findings. With only two matched YMCA sites, it was not possible to adjust for potential clustering by site.

Conclusions: The YMCA may be a promising channel for wide-scale dissemination of a low-cost approach to lifestyle diabetes prevention.

Effectiveness of “Real World” Implementation of Diabetes Prevention Program

• Systematic review and meta analysis of 28 US-based studies

• Average weight change of 12 months = 4%

• “Change in weight was similar regardless of whether the intervention was delivered by clinically trained professionals or lay educators.”

Summit on Linking Clinical Practice and the Community for Health Promotion

April 30 – May 1, 2008 · Baltimore, MD

Meeting Summary
Summit on Linking Primary Care and Community Organizations for Prevention

Meeting Report

Prepared for

Therese Miller, DrPH
Lead, Prevention & Care Management Portfolio
Center for Primary Care, Prevention & Clinical Partnerships
Agency for Healthcare Research and Quality
540 Gaither Road, Room 6145
Rockville, MD 20850

Prepared by
For Further Reading

Innovation Profiles

- **Automated Clinician Prompts and Referrals Facilitate Access to Counseling Services, Leading to Positive Behavior Changes Among Patients**
- **Community Coalition Connects Medical Practices to Community Resources, Leading to Improved Asthma and Diabetes Outcomes in At-Risk Populations**
- **Community Referral Liaisons Help Patients Reduce Risky Health Behaviors, Leading to Improvements in Health Status**
- **Community Health Center-Jail Partnerships Improve Care During and After Incarceration, Reduce Jail-Based Violence and Deaths and Enhance Access to Community-Based Care**
- **Multi-Stakeholder, Community-Wide Collaborative Prevents Disease and Promotes Health**
- **Multifaceted Program That Screens for Maternal Depression, Infant Crying, and Toilet Training Enhances Ability of Pediatricians to Identify and Address Cases of Potential Child Abuse**
- **Onsite Nurses Work With Primary Care Physicians to Manage Care Across Settings, Resulting in Improved Patient Satisfaction and Lower Utilization and Costs for Chronically Ill Seniors**
- **Primary Care Managers Supported by Information Technology Systems Improve Outcomes, Reduce Costs For Patients With Complex Conditions**
- **Group-Based, Culturally Sensitive Weight-Loss Program for Families Leads to Improvements in Children’s Health-Related Behaviors and Declines in Body Mass Index**

QualityTools

- [Quitline.com](#)
- [Healthy Care for Healthy Kids Toolkit](#)
- [MD Link: Partnering Physicians with Community Organizations: A Toolkit for Physician Champions](#)

Resources

- [Connecting Those at Risk to Care: A Guide to Building a Community "HUB" to Promote a System of Collaboration, Accountability, and Improved Outcomes](#)
Joining Hands: Partnerships Between Physicians and The Community in The Delivery of Preventive Care

By Steven H. Woolf, MD, MPH
Professor of Family Medicine, Epidemiology and Community Health
Virginia Commonwealth University

Alex H. Krist, MD
Assistant Professor of Family Medicine
Virginia Commonwealth University
Community Transformation Grants

The new national health reform law, the Affordable Care Act, authorized an innovative program to help local communities address racial and ethnic health disparities and reduce chronic diseases by promoting healthy living and tackling the social and economic causes of poor health. These grants are the major provision in the law designed to address the root causes of health disparities. They provide an important opportunity to engage community members in devising solutions that improve their lives. The grants are also designed to develop community-based prevention strategies that work and can be models for other locations.

Who is eligible? State and local agencies, state and local nonprofits, national networks of community-based organizations, and Indian tribes may apply for grants. The grants will be awarded competitively, based on proposals submitted and the ability of the applicants to engage stakeholders from across the community, including those in health care and beyond. Twenty percent of the grants are reserved for rural and frontier areas.

When do the grants begin? The Obama administration plans to award grants in 2011, if Congress appropriates funding. The request for grant proposals has not yet been issued.

How much money is available? The law does not set out a specific amount for the grants. Instead, the law advises Congress to pay for the program from the Prevention and Public Health Fund also established in the law. Congress appropriated $15 billion for the Prevention Fund from 2010-2019 for a variety of prevention initiatives. Congress has taken steps toward authorizing hundreds of millions of dollars for the grants in 2011, but has not yet voted to approve the funds. Some Republicans in Congress want to eliminate the Prevention Fund, so advocacy may be needed to secure the funding. Obama administration officials say they hope to award multi-year grants.

What type of activities would be funded? Applicants must devise a plan that lays out changes in policies, programs, environment and infrastructure. Obama administration officials say all proposals should focus on reducing health disparities, as well as improving the health of everyone in the targeted communities. Specific activities suggested in the law include increasing access to nutritious foods, creating healthier school environments, encouraging physical activity, improving community safety and expanding worksite wellness programs. Administration officials say grant applicants will be asked to choose from a menu of proven strategies, but will also be allowed to try new approaches. They plan to focus on the health factors specified in the law, which include weight, nutrition, physical activity, tobacco use, emotional well-being and mental health.
<table>
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<tr>
<th>ISBN</th>
<th>Committee on Integrating Primary Care and Public Health; Board on Population Health and Public Health Practice; Institute of Medicine</th>
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<td>978-0-309-25520-2</td>
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<td>200 pages</td>
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<td>6 x 9</td>
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Challenges

• Communication and coordination
• Sustainability: the business model
• Scalability and generalizability
• Quality control and the slippery slope
• Infrastructure and logistics
• Financing
• Ownership
• Politics
A Health Care Cooperative Extension Service
Transforming Primary Care and Community Health

Kevin Grumbach, MD
James W. Mold, MD, MPH

Primary care is the essential foundation for an effective, efficient, and equitable health care system. Calls to rebuild the crumbling primary care infrastructure in the United States are reaching receptive ears, with public and private advisory groups including the Medicare Payment Advisory Commission and the National Business Group on Health recommending increased payments for primary care.1 The American Recovery and Reinvestment Act (ARRA)2 of 2009 appropriated $19 billion for the purchase of health information technology (HIT), with primary care physicians’ offices slated to be among the beneficiaries.
Deaths Prevented And Change In Health Care Costs Plus Program Spending, Three Intervention Scenarios, At Year 10 And Year 25.

Milstein B et al. Health Aff 2011;30:823-832

©2011 by Project HOPE - The People-to-People Health Foundation, Inc.
Annual Costs (Health Care And Program Spending), Three Layered Intervention Scenarios, Year 0 To Year 25.

Milstein B et al. Health Aff 2011;30:823-832
The Return on Investment for Community-Based Diabetes Prevention

• “A Nationwide Community-Based Lifestyle Program Could Delay Or Prevent Type 2 Diabetes Cases and Save $5.7 Billion in 25 Years”
• Breaks even in 14 years

From: Zhuo et al. Health Affairs 2012;31:50-60.
Socioecological Model

From: The Future of the Public's Health (IOM 2003).
Citizen-Centered Health Promotion
Building Collaborations to Facilitate Healthy Living

Steven H. Woolf, MD, MPH, Mercedes M. Dekker, MPH, Fraser Rothenberg Byrne, Wilhelmine D. Miller, PhD, MS

Abstract: Unhealthy behaviors, notably tobacco use; unhealthy diets; and inadequate physical activity are major contributors to chronic disease in the U.S. and are more prevalent among socioeconomically disadvantaged communities. The occurrence of unhealthy behaviors among communities with different physical, social, and economic resources suggest that contextual environmental factors play an important causal role. Yet health promotion interventions often are undertaken in isolation and with inadequate attention to these holistic social and economic influences on lifestyle. For example, clinicians’ advice to patients to stop smoking or lose weight can help motivate people to change behaviors, but their ability to take subsequent action can benefit from coordination with community-based and public health programs that offer intensive counseling services, and from modified environmental conditions to facilitate behavior change where people live, work, learn, and play.

Citizen-Centered Care

Community organizations

Supermarkets
Restaurants
Built environment
Retailers
Media and advertising

Health care
Public health
Worksites
Schools
About 2.3 million, or 2.2 percent, of households in the continental U.S. live more than a mile from a supermarket and do not have access to a vehicle.

“Health in All” Policies

• Transportation
• Land use
• Built environment
• Taxes
• Housing
• Agriculture
• Environmental justice
• Etc.

→ Health and illness
A comprehensive approach integrated across all initiatives.

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<th>Interventions</th>
<th>Food Industry</th>
<th>Community &amp; High Priority Populations</th>
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<td>Peer-to-peer networks and youth advocate development</td>
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<td>Multi-media campaign targets moms to prioritize FV</td>
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All foods are not created equal. Some are life-saving.
The do campaign – workplace signs

Avoid awkward silences, next time take the stairs.

Free StairMaster

Groove your body for 10 minutes 3 times a day.
Sample ads – in stores, billboards, etc.

Cancer protection. Now in a convenient package.

Fresh, frozen or dried, eat more fruits and veggies today.

EveryHelpingHelps.com

Blue Cross Blue Shield of Minnesota

Every Helping Helps
The Built Environment
From: Recasting the neighborhood. Washington Post, April 9, 2012
“The streetscape of K Street between 7th and 3rd streets is being completely rebuilt.”

From: Recasting the neighborhood. Washington Post, April 9, 2012
The Exercise Prescription

From: *Recasting the neighborhood*. Washington Post, April 9, 2012
Contact information

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