



Diffusion of a Model for Addressing Behavioral Health Issues in Primary Care Practices

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INTRODUCTION

This report describes how innovative models to improve health and health care—developed with funding from the Robert Wood Johnson Foundation (RWJF)— spread and adapted and became integrated into the U.S. health care system (and also were taken up by some other countries), all without further input or influence from the Foundation.

Prescription for Health: Promoting Healthy Behaviors in Primary Care Research Networks, a \$9 million RWJF national program launched in 2002, tested the use of evidence-based models and innovative tools in primary care to counsel patients to change unhealthy behaviors related to chronic disease and death. See [Program Results](#) for a full description of the program.

When the program ended in 2008, RWJF's organizational objectives had moved in other directions, so the Foundation did not provide financial support to sustain or spread the models developed. Although relatively small by Foundation standards, "*Prescription for Health* has continued to bear fruit," according to Maribel Cifuentes, RN, deputy program director.

The Problem

Four unhealthy behaviors—tobacco use, unhealthy diet, physical inactivity, and excessive alcohol consumption—are the leading causes of preventable disease, disability, and premature death in the United States each year.¹ What's more, the "Big Four" behaviors

¹ Kvaavik E, Batty GD, Usin G, et al. "Influence of Individual and Combined Health Behaviors on Total and Cause-Specific Mortality in Men and Women." *Archives of Internal Medicine*, 170(8): 711–718, 2010.

occur in clusters: researchers found that a majority of adults reported two or more of these risk factors.²

Failure to address these behaviors is costly: spending on heart disease, diabetes, and other chronic conditions linked to them accounts for up to 70 percent of U.S. health care costs, according to the Centers for Disease Control and Prevention (CDC).

Clinicians on the front lines of health care are uniquely positioned to influence health-related behavior among their patients. Americans made more than 480 million visits to family physicians, general internists, and general pediatricians in 2002, according to the National Ambulatory Medical Care Survey.

The U.S. Preventive Services Task Force, a panel of experts supported by the Agency for Healthcare Research and Quality (AHRQ),³ issued evidence-based guidelines designed to encourage clinicians to promote healthier behaviors among their patients. However, most primary care practices lack the time, staff, practical tools, and funding to apply those interventions.

Summary of the Program⁴

The department of family medicine at the University of Colorado School of Medicine managed *Prescription for Health*, with Larry A. Green, MD, a professor of family medicine at the university and founding director of the Robert Graham Center in Washington, as director and Cifuentes as deputy director.

To engage clinicians in small- to medium-sized primary care offices, *Prescription for Health* funded 22 practice-based research networks (PBRNs), which are groups “of ambulatory practices devoted principally to the primary care of patients...PBRNs draw on the experience and insight of practicing clinicians to identify and frame research questions whose answers can improve the practice of primary care.”⁵ By investigating what can and does happen in front-line medical care, PBRNs connect research, clinical practice, and health care policy.

Prescription for Health ran from August 2002 through October 2008 in partnership with AHRQ, which, as part of its charge, has devoted funds to support the development and continued work of the nation's primary care PBRNs. AHRQ provided services to the program but no direct funding.

² Pronk NP, Peek CJ and Goldstein MG. "Addressing Multiple Behavioral Risk Factors in Primary Care: A Synthesis of Current Knowledge and Stakeholder Dialogue Sessions." *American Journal of Preventive Medicine*, 27(Suppl. 2): 4–17, 2004. Abstract available [online](#).

³ The Agency for Healthcare Research and Quality (AHRQ) is a federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care.

⁴ For a full description of the program, read [Program Results](#).

⁵ Definition from AHRQ [website](#).

Cross-Cutting Results

The national program staff and program evaluation team at the University of Medicine & Dentistry of New Jersey summarized crosscutting results in two journal supplements: *Annals of Family Medicine* (2005)⁶ and *American Journal of Preventive Medicine* (2008).⁷ Highlights include:

- **Diverse primary care practices in the 22 PBRNs deployed a wide range of tools and techniques to address multiple behavioral risk factors among their patients.** The interventions included new tools, such as personal digital assistants (PDAs), for screening patients for unhealthy behaviors; Web-based information; reminder systems, prompts, and care delivery processes to facilitate the work of the practice; links to services inside and outside primary care practices; and new and modified roles for staff.
- **To help patients change behavior, primary care practices created a “bridge” connecting them with community resources.** Practices established relationships with a small pool of community partners, created paper or electronic guides referring patients to those partners, and relied on intermediaries (called boundary spanners) to support and counsel patients and help them tap community resources.
- **The program drew from several models and strategies to guide the design of the interventions.** These included the Chronic Care Model developed by Edward H. Wagner, MD, MPH, and the 5As (Assess, Advise, Agree, Assist, and Arrange) Behavioral Change Model developed for tobacco cessation. Programmatic lessons point not only to the usefulness of these models and strategies, but also to the need to adapt and modify them based on the local experiences of those using them within the complexities of real-world settings.
- **The effectiveness of clinicians in promoting healthy behaviors and the quality of their service to patients are probably maximized when practices have systems in place to support the entire counseling sequence—all of the 5As—rather than simply components of the process.**⁸
- **“Prescription for Health took off the table the misconception that primary care practices don't care about behavior, don't want to deal with it, and are unable to support key national policy objectives, such as resolving the obesity epidemic,” according to Program Director Green.**

⁶ Cifuentes M, Fernald DH, Green LA, et al. "Prescription for Health: Changing Primary Care Practice to Foster Healthy Behaviors." *Annals of Family Medicine*, 3(Suppl. 2): S4–S11, 2005. Available [online](#).

⁷ Green LA, Cifuentes M, Glasgow RE and Stange KC. “Redesigning Primary Care Practice to Incorporate Health Behavior Change: Prescription for Health: Round-2 Results.” *American Journal of Preventive Medicine*, 35(Suppl. 5): S347–S349, 2008. Available [online](#).

⁸ Glasgow RE, Goldstein MG, Ockene JK and Pronk NP. "Translating What We Have Learned Into Practice: Principles and Hypotheses for Interventions Addressing Multiple Behaviors in Primary Care." *American Journal of Preventive Medicine*, 27(Suppl. 2): 88–101, 2004. Abstract available [online](#).

- **However, to address health-related behaviors, primary care practices had to undergo substantial redesign and incur start-up costs and continued expenses that payers do not reimburse.**

For a full description of the program and its results, see [Program Results](#).

SIGNIFICANCE OF THE PROGRAM

There is substantial medical and public health interest in targeting and alleviating unhealthy behaviors that are related to chronic disease and death.⁹ Models developed under *Prescription for Health* helped to pioneer the integration of behavioral health assessments into primary care practices in the United States. Although behavioral health assessments have yet to become commonplace in all primary practices, health systems have begun to embrace and adapt this initiative both nationally and internationally.

Prescription for Health was among the first programs to design models to help primary care physicians target multiple unhealthy behaviors at one visit. The models, designed with behavior change at their core, asked: (1) Can practice-based research networks integrate behavioral health interventions? and (2) Can primary care practices influence unhealthy behaviors?

Prescription for Health was a “start to thinking about how to redesign practice,” according to Deborah J. Cohen, PhD, program evaluator. The program helped challenge the status quo thinking about the role that primary care practices and physicians play in influencing an individual’s unhealthy behaviors.

Kurt Stange, MD, at Case Western Reserve University, the national advisory committee chair, said, “*Prescription for Health* demonstrated the potential of primary care.” By providing supporting data and outcomes to show that behavioral health intervention can be accomplished in PBRNs and primary care practices, the program helped convince physicians and health agencies that practices can be successful at integrating health behavior counseling.

According to Program Director Green, *Prescription for Health* “showed the utility, vitality, and effectiveness of PBRNs as research partners, and boosted their reputation for rigor.” During *Prescription for Health*, the prevalence of PBRNs was increasing nationally (AHRQ reports 131 active PBRNs by 2011, up from 111 in 2003¹⁰), and the program capitalized on an opportunity to leverage the power of networking PBRNs to accomplish national health objectives.

⁹ *Healthy People 2020*, the nation’s health objectives for the next decade. Available [online](#).

¹⁰ Green LA and Hickner J. “A Short History of Primary Care Practice-based Research Networks: From Concept to Essential Research Laboratories.” *Journal of the American Board of Family Medicine*, 19(1): 1–10, 2006. Available [online](#).

“[The program] proved that physicians and primary care doctors do care and can influence health behaviors” according to Cohen. Subsequently, national agencies, organizations and legislation have begun to adopt the behavioral health mantra.

PROGRAM REACH EXTENDS BEYOND RWJF FUNDING

It has been 10 years since the *Prescription for Health* initiative began. The original program innovators continue to conduct research in primary care settings across the United States, adapting models and methods that are informed by their work in *Prescription for Health*.

Researchers, primary practices, and institutions are collaborating and continuing to adapt and apply ideas used in *Prescription for Health* into national and international settings. Although problems of integration and cost continue to slow adoption of behavior change strategies by primary care practices, *Prescription for Health* provided a notable advance in knowledge.

This diffusion is happening in the following areas:

Impact on Major National Organizations and Legislation

- **Agency for Healthcare Research and Quality (AHRQ).** “AHRQ picked this [initiative] up and drove it,” according to Program Director Green. Building on the work of *Prescription for Health* and other primary care research efforts, AHRQ has teamed with RWJF and set a long-term goal of understanding whether fostering links between clinical practices and community organizations could enhance the delivery of preventive services. Because the standardized behavioral measures of the effects of these linkages in *Prescription for Health* generally failed, AHRQ is currently offering funding opportunities to both identify and understand strategies used for linking primary care practices with community resources and more accurately capture and monitor patient behaviors and assess the costs and health outcomes associated with preventive services and interventions.^{11,12}

In May 2008, AHRQ, the American Medical Association (AMA), and the Association of State and Territorial Health Officials co-sponsored a summit aimed at encouraging collaboration, coordination, and integration among health care providers and community resources. Participants included two *Prescription for Health* grantees: Virginia Ambulatory Care Outcomes Research Network and Great Lakes Research

¹¹ Etz RS, Cohen, DJ, Woolf SH, et al. “Bridging Primary Care Practices and Communities to Promote Healthy Behaviors.” *American Journal of Preventive Medicine*, 35(5): S390–S397, 2008. Abstract available [online](#).

¹² See AHRQ’s funding opportunities for PBRNs [online](#).

Into Practice Network.¹³ Recommendations from the *Prescription for Health* national program and this summit were incorporated into the most recent *Handbook of Behavioral Medicine* (“Behavioral medicine, prevention, and health reform: linking evidence-based clinical and public health strategies for health behavior change,” chapter by Ockene and Orleans, 2010).

To facilitate collaboration among summit participants and showcase their linkage projects, AHRQ created an Innovations Exchange [resource page](#). The site features information on Virginia's Electronic Linkage System (eLinkS) and the Great Lakes CHERL (Community Health Educator Referral Liaison) project. From 2009 to 2010, AHRQ, assisted by Research Triangle Institute International, identified examples of links between clinical practices and community organizations, compiled case studies of promising interventions to deliver preventive services, and sponsored another summit to develop a national strategy.

Their findings, published in *Prevention*, draw heavily from the innovations, crosscutting themes, and models developed under *Prescription for Health*. Of the 49 interventions identified in the study, 19 were *Prescription for Health* projects. (Five were from RWJF's national program *Building Community Supports for Diabetes Care*. See [Program Results](#) on the *Diabetes Initiative*.)

The report calls for further collaboration between AHRQ, other federal agencies, and foundations to strengthen evidence on linkage strategies that work, Cifuentes noted. The report also recommends evaluating their implementation, sustainability, and cost as well as any needed policy changes. AHRQ has begun funding initiatives in this arena. In 2010, the organization issued a request for proposals inviting PBRNs to develop approaches to creating and maintaining links between clinicians and communities, specifically to address obesity. Although the projects will focus on diet and physical activity, AHRQ expects PBRNs also to tackle smoking, excess drinking, and drug use, which often coexist with obesity.

- **The National Institute of Diabetes and Digestive and Kidney Diseases, the Eunice Kennedy Shriver National Institute of Child Health and Human Development, and the Office of Behavioral and Social Sciences Research** are now issuing translational research grants through applications to the National Institutes of Health (NIH) to test interventions for diabetes and obesity prevention that can be adopted and sustained in applied health care settings.
- **The Patient Protection and Affordable Care Act (ACA)** includes provisions under the concept of the primary care prevention service addressing key barriers identified by *Prescription for Health*, including the need to pay more for primary care, eliminate co-payments for preventive care, and provide more training and assistance for primary care providers.

¹³ Virginia Ambulatory Care Outcomes Research Network (grant ID#s 49060 and 53769) and Great Lakes Research Into Practice Network (grant ID#s 49049 and 53767).

The ACA authorizes a primary care extension service to help practices redesign their service models. It also authorizes a new statutory committee to study and recommend proper health professions workforce policies—presenting an important opportunity to populate primary care practices with the workforce needed. It also fully endorses interventions informed by Wagner’s Chronic Care Model, the RE-AIM evaluation framework developed by Russell Glasgow, PhD,¹⁴ and the kind of linkage between primary care-based and community-based behavioral prevention strategies that *Prescription for Health* advocated and ARHQ continues to develop.

Seeing "both a need and an opportunity to incorporate health behavior counseling into the core business of the patient-centered medical home," Program Director Green and former project leaders have shared findings from *Prescription for Health* with the Obama administration, American Cancer Society, Blue Cross Blue Shield, and other organizations.

The act also includes pilot projects designed to enhance primary care by developing "patient-centered medical homes" (also known as "advanced primary care practices"). In that model, a physician leads a medical team that coordinates all aspects of preventive, acute and chronic care for each patient, and integrates patients as active participants in their own health and well-being. (See a [brief summary](#) of the Patient Protection and Affordable Care Act.)

- **The Patient Centered Primary Care Collaborative (PCPCC).** Led by IBM, the American College of Physicians, the Academy of Family of Physicians, and other Fortune 500 employers and primary care physician organizations, the PCPCC was created in 2006 with the goal of improving the delivery of primary care in the U.S. health system. Serving as a forum for national leaders to work together, the PCPCC has developed and advocates for a patient-centered medical home (PCMH) model to deliver comprehensive primary care. According to Program Director Green, behavioral and mental health were not originally considered in the PCPCC and PCMH. Leaders who worked in *Prescription for Health* and other organizations advocated for the inclusion of behavioral and mental health at a national meeting—resulting in the creation of a PCPCC behavioral health taskforce that meets regularly. Behavioral and mental health in primary care is now established as an integral part of the PCPCC and the PCMH.
- **The Society of Behavioral Medicine and Electronic Health Records.** Electronic health records (EHRs) systems were not originally equipped to effectively measure and access behavioral health information. They generally failed to capture data reflecting crucial social and behavioral determinants of health. The failure of EHRs to capture behavioral health data was further demonstrated in *Prescription for Health*, which emphasized the importance of tracking health behaviors (for EHRs and health assessments).

¹⁴ RE-AIM is designed to assess and maximize interventions: Reach, Effectiveness, Adoption, Implementation, and Maintenance.

As a result, the Society of Behavioral Medicine developed a 2010 policy brief proposing a standardized, practical toolkit of measures for EHR inclusion.¹⁵ These measures included the standard set of self-report measures of behavioral health risk developed for the *Prescription for Health* program. “This idea has become standard in EPIC electronic health record platforms” according to Program Director Green.

Prescription for Health program consultant Russell Glasgow, PhD, deputy director of dissemination and implementation sciences at the National Cancer Institute’s Division of Cancer Control and Population Sciences, was the chief drafter of the policy brief. Other contributors from *Prescription for Health* were national advisory committee members Judith Ockene, PhD, and Kurt Stange, MD (committee chair), and Steven Woolf, MD, a principal adviser to the program director.

Accurately recording behavioral health data into EHRs opens opportunities for improving primary care. It creates the possibility of linking/referring a patient through the EHR directly to community resources. PBRNs are now using technology platforms to share information across health systems. Through EHRs, there is an opportunity for PBRNs to integrate behavioral health with other health information, community resources and health insurance coverage data in order to further research and improve access to care.

- **Health Resources and Services Administration (HRSA) and Substances and Mental Health Services Administration (SAMHSA).** *Prescription for Health* helped to foster collaboration between HRSA and SAMHSA, leading these agencies to talk at the highest levels and co-sponsor behavior change initiatives. The idea of targeting unhealthy behaviors in primary care practices gained traction in *Prescription for Health*. Behavior change and unhealthy behaviors are *fundamental* to both HRSA and SAMSHA. According to the program director, results from specific *Prescription for Health* projects showed these agencies that physicians do care about unhealthy behaviors and there are successful primary care interventions to change these behaviors and thus influence health outcomes. SAMSHA and HRSA are working together to incorporate practice assistants into mental health centers with a focus specifically on unhealthy behaviors. This effort has since been regionalized largely due to the union of these two agencies on this initiative.
- **Advancing Care Together (ACT) and the Colorado Health Foundation** are now working together on an initiative that is implementing the integration of mental health assessment along with behavioral assessment into primary care settings across the United States. “We learned how to do this from *Prescription for Health*,” said Green, who is now ACT’s program director. Funded by Colorado Health Foundation and similar to *Prescription for Health* models, ACT interventions target multiple behavioral and mental health issues at once. This program is “the strongest substantiation of the PCMH (patient-centered medical home) that I have seen” said

¹⁵ *The Public Health Need for Patient-Reported Measures and Health Behaviors in Electronic Health Records: A Policy Statement of the Society of Behavioral Medicine*, 2010. Available [online](#).

Prescription for Health's evaluator Cohen. A nationally representative steering committee selected the initial 11 ACT implementation sites in August 2011. The program launched September 2011 (see [ACT program description](#)).

The Models Spread Internationally

- **British Columbia, Canada:** In May 2011, the Ministry of Health Services of British Columbia announced the Healthy Families BC strategy and committed \$68.7 million to innovate preventive health changes in the province's health care system. The program was a partnership with the Ministry of Health's General Practice Services Committee, a joint committee focused on family physicians and community-level care. A replication of *Prescription for Health* was the first program launched in the strategy, with \$24 million going directly toward behavior change counseling targeting the Big Four unhealthy behaviors in the primary care setting.

Mirroring models and interventions developed under *Prescription for Health*, British Columbia's Healthy Families BC provides free-of-charge personal health risk assessments for physicians and patients, lifestyle support services (e.g., QuitNow smoking telephone line), and physical activity and nutrition subsidy incentives. Program services are available to patients who have the health risk factors of smoking, poor diet, lack of physical activity, and/or obesity. The program launched in June 2011.

- **Bilbao, Spain:** Since 2005, Cifuentes, the deputy program director, has provided consultation services and shared lessons learned from *Prescription for Health* with researchers and government officials from the Basque region of Spain. In 2007, the government launched a Spanish research initiative called Prescribe Vida Saludable, at four primary care sites in Bilbao. Researchers in Spain had the advantage of designing their initiative using lessons from *Prescription for Health* outcomes in the United States (e.g., linkages to community services were already in place from day one of the program launch).

In September 2010, Cifuentes participated in a three-day seminar designed to help Basque health care leaders begin the clinical phase of their systematic efforts to introduce and test behavioral health counseling strategies into primary care practice. "They wanted information on very practical lessons from *Prescription for Health*, such as working with IT tools, forming multidisciplinary teams, changing organizational cultures, and using staff in different roles," she said.

Spanish researchers in collaboration with Cifuentes have pilot tested and implemented an adapted model from *Prescription for Health* into six primary care practices as of August 2011. One of the practices is partnered with and located inside a private corporation.

Spain has a universal health care system, observes Cifuentes, so the advantages and challenges of integrating behavioral health into primary care are different from those facing U.S. providers. This Spanish initiative does not have a robust PBRN

infrastructure to rely on, for example, and no resources from private foundations such as RWJF. However, the initiative does have the advantage of a single-payer system that covers all its citizens (thus avoiding fee-for-service and access challenges faced by patients in the United States), as well as a common IT platform that allows providers throughout the Basque region to exchange information readily.

THE FUTURE

The idea at the core of *Prescription for Health*, that unhealthy behaviors matter and that it is possible to help individuals change so they make and sustain healthier choices, will continue to receive attention from national agencies and organizations. Healthy People 2020, the nation's public health objectives for the current decade focus in part on prevention of the Big Four unhealthy behaviors to reduce the prevalence of chronic disease.¹⁶

The *Prescription for Health* initiative began to answer questions about how to redesign primary care to address behavioral health. The model it developed has had a continuing impact as it has evolved, but researchers, primary care physicians, and policy-makers are still left with concerns and unanswered questions.

One concern is the cost of and difficulty of integrating behavior change into primary care. “These are serious barriers to this work being disseminated throughout the health care system and utilized for every patient,” says Thomas Bodenheimer, MD, MPH, adjunct professor at the University of California, San Francisco, School of Medicine.

One of the most prominent questions is: How can the models become more sustainable within PBRNs and primary care practices? Researchers are trying to provide answers to this question. One is Dorothy Hung, PhD, at Palo Alto Medical Foundation who received a grant award from NIH to research health behavior interventions and how practice innovations to enhance the quality and value of primary care have been disseminated. Some of her research will concentrate on *Prescription for Health* models. Hung is currently conducting model sustainability research in this area.

Areas for Model Improvement

- **Individualized adaptation.** The *Prescription for Health* innovators learned that an intervention needs to be adapted to meet the organizational capabilities and resources of the primary practice using it. This process of organizational change takes time, especially in primary practices that have few resources. “RWJF really contributed in here by allowing the projects to have localized adaptation in models,” said James Mold, MD, MPH, a former *Prescription for Health* project director. Many of the other project directors also noted that the RWJF grants allowed them the flexibility to

¹⁶ *Healthy People 2020*, the nation's health objectives for the next decade. Available [online](#).

implement interventions that required change and adaptation—as opposed to the more rigid randomized controlled trials often seen with grants from NIH.

As the evaluators Cohen et al. wrote, “. . .the need to adapt does not indicate a poor intervention or an inexperienced research team; it is a common part of the research process. It is the journey of translating evidence-based research into practice.” (“Fidelity Versus Flexibility: Translating Evidence-Based Research into Practice,” *American Journal of Preventive Medicine*, 35(Suppl. 5): S381–S389, 2008)

- **The need for change agents.** *Prescription for Health* demonstrated that physicians cannot implement organizational change for their practices alone. Practices fared best when they had help doing the organizational change work. Primary practices can receive help through health navigators or practice facilitators to assist with the integration of behavioral health assessment into primary care settings. Former Program Director Green thinks the best way to develop these change agents is through “degree and certification programs for practice facilitators and the most promising area for such training to emerge in is the county community college system.”
- **Making community linkages.** *Prescription for Health* programs failed to create sustainable linkages between primary practices and the community resources and left both researchers and physicians with two questions: Who should physicians refer patients to outside of the practice? How can communities operationalize linkages successfully? Although the linkages the projects tried to create were largely unsuccessful, the projects took a first step toward creating a web of community-based services that help people sustain healthy behaviors. Fostering stable links between those services and primary care practices “could change peoples' lives and reduce demands on the health care system,” said Steven Woolf, MD, project director for the Virginia Ambulatory Care Outcomes Research Network. However, such services “must be available, accessible, affordable, and perceived as valuable.” AHRQ is driving this work with the Community Linkages initiative.
- **Measuring costs and making the business case.** The program ended before researchers had created measures of cost- and real cost-benefits analysis in the primary care setting, although work was underway at the time of writing this report. Glasgow, at the National Cancer Institute’s Division of Cancer Control and Population Sciences, is championing measurement establishment and development in the primary care setting. More valid and reliable measures for behavioral health will provide better data and inform clinical trials.

Measures will help organizations, practices, and physicians demonstrate the cost-related savings to “make the business case” for behavioral assessment, treatment, and referral to community-based resources.

In 2010, the Great Lakes Research Into Practice Network received a \$2 million grant from the National Institute of Diabetes and Digestive and Kidney Disorders to

investigate the financial sustainability of its CHERL project.¹⁷ It also received a \$1.8 million grant from AHRQ to investigate different models of care management—an extension of the CHERL project.

Overcoming Barriers to Model Sustainability

- **Patient-Centered Medical Home (PCMH).** The Patient-Centered Primary Care Collaborative (PCPCC) has developed and advocates for the PCMH model to deliver comprehensive primary care. If the PCMH becomes a national standard in primary care, it will revolutionize how primary care and behavioral health care are delivered in the United States.
- **Payment Reform/Reimbursement.** Primary care practices cannot continue to integrate behavioral health assessments without receiving reimbursement for assessments and treatment. The payment reform necessary to support primary care practices has not been applied to behavioral health, mental health, and substance abuse. “Until there is a change in payment reform, the work of *Prescription for Health* will not come to fruition” said Green, the former program director. Provisions of the ACA begin to address payment reform in primary practice. But more payment reform is needed.

Factors that Facilitated Diffusion

Drivers of Success

- **The Need for Primary Care Practice Redesign.** Many of the project directors emphasized the urgent need for a redesign of care delivery in primary care practice as the prominent driver of integrating behavioral health care into primary care. According to project director John Wasson, MD, “the old model [of primary care] is dying and everyone is trying to reinforce it.” The spread of interest in the *Prescription for Health* models capitalized on an opportunity to challenge how primary care services are delivered.
- **Exceptional Collaboration.** Collaboration among the project directors and with the *Prescription for Health* national program staff was exceptional and far-reaching. The PBRNs were strengthened and pulled into the national scene because of their work in *Prescription for Health*. Representatives from the program’s PBRNs now sit at the table at AHRQ meetings. The PBRN directors and the national staff were able to share research findings and leverage partnerships with health agencies to influence change in primary care.

Additionally, the national staff maintained an active website after the end of the program, which kept the latest research information transparent and accessible. An

¹⁷ CHERL (Community Health Educator Referral Liaison) serves in three capacities: to support patients, to support practices, and to link to community resources. CHERL enhances the relationship between patient and primary care provider to support self-management.

active website allowed users to identify opportunities from *Prescription for Health* that might apply to their practices.

- **Learning Evaluation.** The evaluators of *Prescription for Health* developed an innovative method for the project leaders/innovators to communicate about their experiences in real time: online diaries.¹⁸ "Diary keepers" at each primary care practice wrote about their experiences on AHRQ's secure extranet site. This helped make the evaluation team a partner with the project leaders. This approach also allowed for real-time learning from the implementation and organizational changes in the primary care practices. The online diaries provided answers to the implementation question: How did change occur? Researchers were able to understand not only the outcomes, but how they were achieved, and were able to communicate about the process. "This type of evaluation was before its time in 2005; now in 2011, it is basically a standard," according to Green, the former program director. Evaluation director Cohen said *Prescription for Health* "paved the way for this kind of [evaluation] work." This method now has credence that it did not have in 2002 when the program began. "RWJF putting this on display provided a megaphone for this type of work," according to Green.

CONCLUSION

Patients and communities can be healthier, prevent chronic disease, and reduce death rates by being conscientious about their unhealthy behaviors: tobacco use, excess weight from an unhealthy diet, physical inactivity, and excessive alcohol consumption. *Prescription for Health*, a comparatively small program by RWJF standards, had an outsized impact.

Models developed under *Prescription for Health* helped to pioneer the integration of behavioral health assessments and interventions into primary care practices in the United States. Although the program's contributions make up a single factor among many that are leading the way to national changes in primary care, the models and ideas from the program continue to spread and be adapted by health systems both nationally and internationally.

Prescription for Health demonstrated that behavioral health assessment and treatment can be done in the primary care setting. Additionally, the program showed that unhealthy behaviors matter to government agencies, health providers, and insurers. The program's models are ready to be widely implemented, but continue to be stymied by a lack of understanding on how to sustain connections between primary care providers and existing community resources as well as the need for cost-benefit analyses that could lead to payment reform and reimbursement for primary practices to engage in behavioral

¹⁸ Cohen DJ, Leviton LC, Isaacson N, Tallia AF and Crabtree BF. "Online Diaries for Qualitative Evaluation." *American Journal of Evaluation*, 27(2): 163–184, 2006. Abstract available [online](#).

health interventions. Researchers and practice-based research networks need to continue to track behavioral health data and strive to better connect interventions and health outcomes.

If payment reforms cover behavioral health within primary care and the practices can build seamless linkages to community services, the future of these models and their role in fostering healthier communities is bright.

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APPENDIX

Prescription for Health Grantee Interviews

This appendix lists the individuals who received funding under the *Prescription for Health* program, directed the program and some of the projects, and were interviewed for this report.

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