Addressing Multiple Behavioral Risk Factors in Primary Care

A report from two
Structured Interactive Dialogue Conferences

June 10-11, 2003 Washington, D.C.
July 9-10, 2003 Colorado Springs, CO

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Addressing Multiple Behavioral Risk Factors in Primary Care

A project of the Bayer Institute for Health Care Communication
funded by The Robert Wood Johnson Foundation

Proceedings Book For Structured Interactive Dialogues

This booklet summarizes background information, agenda, and results of the two Structured Interactive Dialogues that were held June 10 & 11, 2003 in Washington, D.C. and July 9 & 10, 2003 in Colorado Springs, CO. An Executive Summary is provided in a separate document.

The Proceedings Book and Executive Summary are for the Program Committee-- to inform their subsequent work, and for the participants-- as appreciative feedback for their help in making the meetings a success.

Contents

A project file (in a separate document) contains source documents used to create this Proceedings Book.

August, 2004

Report prepared by C.J. Peek, Ph.D., Brigid Sanner, and Michael Goldstein, M.D.

Acknowledgements

This Proceedings Book is a product of "Addressing Multiple Behavioral Risk Factors in Primary Care," a project which was launched in 2001 through a grant from The Robert Wood Johnson Foundation (RWJF) to the Bayer Institute for Health Care Communication. The project aims were to: review existing evidence regarding multiple behavioral risk factors in primary care; identify effective and promising screening, intervention and system-based strategies; and develop recommendations for research, practice and policy.

I deeply appreciate the efforts of the talented and energetic Project Planning Committee that I have had the privilege to chair: Thomas Babor, PhD, MPH; Helen Burstin, MD, MPH; Elliot Coups, PhD; Lawrence Fine, MD, DrPH; Russell Glasgow, PhD; Jessie Gruman, PhD; Susan Hassmiller, PhD, RN; John Higgins-Biddle, PhD; David Lanier, MD; Joseph Marx, BA; Judith Ockene, PhD, MEd, MA; C. Tracy Orleans, PhD; C.J. Peek, PhD; Nicolaas Pronk, PhD; Brigid McHugh Sanner; Kurt Stange, MD, PhD; and Evelyn Whitlock, MD, MPH.

Members of the Planning Committee wrote four background research papers and designed and conducted two Structured Interactive Dialogue sessions that brought together leaders from the clinical, health care system and public policy arenas to share and discuss perspectives, insights and innovative approaches for addressing multiple behavioral risk factors in primary care.

The Planning Committee also published the four background papers and a synthesis article that captured the results of this project in a special supplement of the *American Journal of Preventive Medicine* (*AJPM*, Volume 27, Supplement 2, August, 2004) along with four additional papers submitted by research groups that were working contemporaneously with the Planning Committee. I would like to thank my *AJPM* Co-Guest Editor, Susan Curry, PhD, for her sterling editorial contributions and commentary and also acknowledge the authors who contributed to the supplement, the anonymous group of *AJPM* reviewers, and Charlotte Seidman, Managing Editor, and Kevin Patrick, Editor-in Chief of AJPM, for their astute guidance and assistance.

The Planning Committee would especially like to acknowledge and thank Tracy Orleans of the RWJF for her visionary leadership and project oversight. The RWJF provided generous funding to support Planning Committee meetings, the literature reviews, the two dialogue sessions and the publication and distribution of the supplement.

The Planning Committee would also like to recognize Brigid Sanner for her superb administrative and editorial support and for her contributions to the design of the dialogue sessions; C.J. Peek, who ably facilitated the dialogues and contributed to their design; and Laurie Mansfield, who provided exceptional administrative support from the project home at the Bayer Institute. C.J. and Brigid also took lead roles in pulling together the contents of this report.

We would also like to acknowledge and thank the more than 70 clinician, health system and policy leaders who attended the dialogues and shared their wisdom, experience, ideas and passion for improving health care and enhancing our capacity to reduce the heavy burden of illness and disease caused by behavioral risk factors.

Michael G. Goldstein, MD
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August, 2004

Project Purpose and Approach

Why multiple behavior risk factor intervention is important
Smoking, risky drinking, sedentary lifestyle and unhealthy diet ("the big four") are leading causes of disease, death and loss of functioning. Research has shown that primary care clinicians can spark change in specific health risk behaviors in many patients with brief assessment, brief behavior change counseling, referral and follow-up. However, despite evidence for the efficacy of brief interventions to address health risk behaviors, rates of screening and intervention in primary care settings are low.

An important barrier to the delivery of health behavior change interventions in primary care settings is the lack of a flexible screening and intervention approach that can cut across multiple risk factors and help clinicians and patients to address health risks in an efficient and productive manner. Because researchers have, for the most part, worked in silos and have focused on single health behavior risks, the models, approaches, screening tools and intervention strategies that have evolved from "single-risk" research have missed important commonalties as well as potential opportunities for synergism and efficiency.

A unified approach that targets multiple risk behaviors and integrates assessment and treatment has important advantages, especially in the primary care setting.

- Because most patients have multiple health risks or risk behaviors, an approach that integrates assessment and intervention of multiple risk behaviors may be experienced by patients as more holistic, which in turn may promote synergistic effort across behaviors.
- From the clinician and system point of view, an approach that addresses multiple behaviors is likely to be more efficient, saving time, effort and even health care dollars.
- Primary care clinicians may be more willing to consider, adopt and implement a single approach that addresses multiple health behaviors as opposed to several distinct approaches, each targeting a single health behavior.

What an ideal approach would do. A comprehensive "cross-cutting" primary care-based behavioral risk factor approach would:

1. Address multiple behavioral risk factors and comorbidities;
2. Balance population and individual patient needs;
3. Be culturally sensitive and address the needs of diverse and disadvantaged populations;
4. Address public health as well as medical care priorities, including:
    - Encompassing the spectrum of primary, secondary and tertiary prevention, and
    - Facilitating early identification, case finding, treatment (active and maintenance) and referral;
5. Maintain efficacy while maximizing adoption, implementability and sustainability in real world settings, including:
    - Addressing patient needs, clinician needs, system/organizational needs, and community needs,

- Using a team approach that emphasizes sharing of responsibility for intervention delivery among multiple providers and disciplines, and
- Training, technical assistance, tracking systems and implementation tools necessary to effect system-level changes; and

6. Be supported by other changes such as:
   - Policy changes and financing/reimbursement solutions,
   - Accreditation and performance measures, and
   - Direct-to-consumer marketing that increases demand for widespread implementation.

Project goal:
The goal of this Robert Wood Johnson Foundation-funded project is to foster the development of flexible and efficient screening and brief intervention approaches that can be applied to multiple health risk behaviors in primary care settings.

Project objectives:
- Gather research evidence regarding epidemiology, assessment strategies, intervention approaches and translation efforts for addressing multiple behavioral risk factors in primary care;
- Identify cross-cutting models and approaches that have the potential to effectively and efficiently combine assessment and intervention strategies into a unified approach;
- Lay out steps that would facilitate widespread adoption and implementation of such a model or interventions by diverse primary care clinicians; and
- Test for support and build commitment to these approaches from stakeholders who would be key to implementing the strategies identified.

Project funding:
Project funds were provided through a grant from The Robert Wood Johnson Foundation to the Bayer Institute for Health Care Communication to review evidence, produce background papers and host meetings of clinician, health systems and health policy experts to gather knowledge, perspective, and insight regarding the challenges and opportunities for addressing multiple health risk behaviors in primary care settings.

Project approach:
The project was guided by a Planning Committee chaired by Michael Goldstein, M.D., of the Bayer Institute for Health Care Communication. The Planning Committee was made up of research and professional leaders from various disciplines and settings with long-standing knowledge and passion for research and practice in the areas of health behavior change, prevention, health services delivery and community and public health. This group was in a position to pull together research findings in health risk behavior assessment and intervention to serve as a common base of participant information.

At an initial meeting, the Planning Committee recognized the value of engaging key stakeholders (clinician leaders, health system leaders, and policy leaders) whose information, wisdom, interest, support, and mutual understanding would be necessary if multiple behavioral risk

intervention is to be implemented and sustained in real primary care settings. The basic tasks of the Planning Committee were to:

1. Create a shared base of research information on multiple behavioral risk factor intervention in the form of four background papers;
2. Hold two Structured Interactive Dialogues among clinician leaders, health systems leaders, and health policy experts to gather their interacting perspectives on multiple behavioral risk intervention in primary care settings;
3. Publish an ensemble of papers with project results, synthesis, and recommendations to clinical, health systems, and policy audiences for guiding future efforts; and
4. Write a RWJF final report and detailed proceedings book.

Project tasks and products:

1. Four background papers were written by members of the Planning Committee (with some additional co-authors) to address the following topics:

- Epidemiology of multiple behavioral risk factors in primary care populations, with a particular focus on the overlap of risks. (Fine, Philogene, Grambling, Coups, & Sinha)
- Screening issues and brief assessment tools, with particular attention to tools that perform multiple risk assessments within health care settings. (Babor, Sciamanna, & Pronk)
- Intervention strategies, with particular attention to multiple behavioral risk factor interventions and models, integration of assessment and intervention strategies, and the importance of systems that support and prompt clinicians to deliver interventions (Goldstein, Whitlock, & DePue)
- Implementation and translation of multiple health behavior interventions in real-world primary care settings, including the role of training, technical assistance, implementation tools, policy change, reimbursement, accreditation and development of performance measures. (Glasgow, Goldstein, Ockene, & Pronk)

The background papers identified the key principles that emerged from previously published review papers in these areas. This created an accessible information base for moving ahead with the Structured Interactive Dialogues among the stakeholder panels.

2. Two Structured Interactive Dialogues were held among clinician leaders, health system leaders, policy leaders to gather additional evidence and also so they could begin to "see the world through each other's eyes" regarding what it would take to value and implement multiple behavioral risk factor intervention in real primary care settings. Each dialogue session involved twelve leaders from each stakeholder group plus the project Program Committee. The first dialogue session was in Washington, D.C., in June 2003; the second in Colorado Springs, Colorado, in July. The task of the stakeholder panels was to:

- Make comments and suggestions on the key findings of the background papers;

- Reveal information about the importance, challenge and opportunity of multiple behavioral risk factor intervention in primary care, as seen by each of these stakeholders;
- Create mutual understanding of what is important to each other as stakeholders; and
- Test for interest and motivation for groups of stakeholders such as this to move forward together in implementing multiple behavioral risk factor interventions.

3. **Results and recommendations from background papers and dialogue sessions were published** in an ensemble of nine papers (see "Publications plan") in a special supplement to the *American Journal of Preventive Medicine* (Volume 27, supplement 2, August 2004). Following the second dialogue session (Colorado Springs; July, 2003) the Planning Committee met to capture major themes and results of the two meetings and make plans for revising and submitting these papers.

   These papers draw from the original background papers, learnings from the dialogue sessions and related work from other authors. They include recommendations for the development of integrated screening and brief intervention approaches for multiple behavioral risk factors in primary care settings. These papers contain practical as well as scholarly information for clinical, health system and policy audiences who will need to cooperate to implement such approaches to address multiple behavioral risk factors.

4. **Project reports captured the entire project** including its broad findings and detailed meeting contents. These were printed in hard copy and saved to data CDs for compact storage and easy electronic access for later use or adaptation of the components.

   - The *Proceedings Book* and its *Executive Summary* contain background information, agenda, and results of the structured interactive discussions. The audiences are the Program Committee-- to inform their subsequent work; the participants-- as appreciative feedback for their help in making the meetings a success; and the RWJF-- as detailed information for the RWJF final report.

     A *Project File* contains all source documents from the meetings that were used to create the Proceedings Book and RWJF Final Report.

   - The *RWJF Final Report* documents the project activities and results in a format prescribed by RWJF. The audience for the final report is RWJF and the Bayer Institute for Health Care Communication. The Proceedings Book is attached to the RWJF final report as a detailed reference. The Project File of source documents will be available from the Bayer Institute upon request.

Structured interactive dialogues

Why hold structured interactive dialogues? The Planning Committee knew that developing flexible, practical and efficient screening and bref intervention approaches for application to multiple health risk behaviors in primary care settings represents a significant shift in usual care, not only at the clinical level, but at the health systems and policy level as well.

The Planning Committee wanted its recommendations to be informed by research evidence and an understanding of how multiple behavioral risk factor intervention looks to clinician leaders, health system leaders, and policy makers. Moreover, the Planning Committee realized that these three stakeholder groups, along with patients and consumer groups, would ultimately need to understand what is important to *each other* and take cooperative effort. No single group would be able to implement multiple behavior risk factor intervention by itself. The Planning Committee wanted its recommendations to RWJF and those written in published papers to include not only evidence-based research findings, but also the perspectives of these interacting stakeholders, knowing also that productive engagement of patients and consumer stakeholders will also be needed in the end.

Purpose of the meetings: To elicit, hear and synthesize clinician, health system and health policy leaders' views and insights on the importance, challenge and opportunity for addressing multiple behavioral risk factors in primary care settings. A secondary goal was to learn from the interaction of the three leader panels and to promote enhanced understanding of what is important to each other.

The statements used to orient participants were refined between the first meeting in Washington D.C. and the second meeting in Colorado Springs as a result of lessons learned at the Washington, D.C. meeting. These are shown separately in a later section.

Participants at each meeting were organized into three "leader panels," each representing stakeholders with background and experience within 3 realms:

- Clinical practice, e.g., physicians, nurses, health psychologists, clinician educators, clinical program managers;
- Health systems, e.g., health system or insurance executives and managers;
- Health policy, e.g., government agencies, legislative bodies, or advocacy groups

In these dialogues, panels were focused primarily on the health and health care needs of adults.

The Planning Committee was invited to both meetings to fulfill these roles:

- To answer questions on background research papers
- To listen-- to see the world through the eyes of the three leader panels-- and reflect back their understanding during the meeting.
- To understand and synthesize questions from participants.
- To capture the insights from the meeting for later use in publications

The project consulting and facilitation staff was present at both meetings to

- Help plan the meetings ahead of time and prepare materials
- Set up and manage the logistics and arrangements
- Facilitate the process and capture the results

Agenda overview: Each meeting followed roughly the same agenda:

Day 1, evening; 6:00 to 8:45 p.m.

- Evening reception followed by a welcome and introduction from the Planning Committee Chair (Michael Goldstein). Participants began to get to know each other and were oriented to the program, the program binder, and what to expect during the meeting.
- Dinner with keynote presentation. Participants had the opportunity to experience and react to an energizing, visionary, or "out of the box" talk on health behavior intervention.
- Wrap-up and reminder of schedule for the next day.

Day 2, morning; 7:45 a.m. to 12:45 p.m.

- Opening remarks by the Planning Committee Chair including a recap of the evening discussion and a preview of the schedule for the day.
- Presentation and discussion of the 4 background papers, which were also provided to participants ahead of time. The Chair summarized the papers and asked participants for their questions or quick reactions. This process is described in the next section.
- Structured Interactive Dialogue #1-- Clinician leader panel: The clinician leader panel engaged in a facilitated conversation while seated around a large conference table in the middle of the room (the "fishbowl") while the other two leader panels and members of the Planning Committee listened from surrounding tables. This process was the heart of the meeting and is described in detail later.
- Structured Interactive Dialogue #2-- Health systems leader panel: Followed the same basic process as for the clinician leader panel.

Day 2, afternoon; 1:45 p.m. to 4:00 p.m.

- Structured Interactive Dialogue #3-- Health policy leader panel: Followed the same basic process as the other leader panels.
- Remarks on behalf of Robert Wood Johnson Foundation from officers of the Foundation.
- Final comments by the Planning Committee Chair, including a summary, an outline of next steps and an expression of appreciation for everyone's participation.
- Meeting evaluation and adjournment

Planning Committee and consultation / facilitation staff debriefed informally after adjournment in Washington D.C. and formally the next day after the meeting in Colorado Springs.

Presentation and discussion of background papers: Process outline

Prior to arrival at the Washington, D.C. and Colorado Springs meetings, all participants were provided with drafts of the background papers developed as part of the project (described earlier):

- Epidemiology of multiple behavioral risk factors in primary care populations;
- Screening issues and brief assessment tools;
- Brief intervention models and research evidence; and
- Implementation and translation of multiple behavioral risk factor interventions in real-world primary care settings.

The papers were intended to provide a summarized knowledge base for participants-- as understood by the researchers and scholars on the Planning Committee. Rather than serving as comprehensive systematic evidence-based reviews, the background papers focused on identifying principles that emerged from previously published review papers in these areas. Input from the meeting participants helped the Planning Committee refine the papers and identify needs not fully addressed in the drafts.

The Chair (Michael Goldstein) summarized the papers and asked participants for their questions and reactions. Prompts such as these were used to get discussion started: "From your perspective---

- what are the key principles or opportunities for action that you see in this?"
- what about this research evidence is important or not important?"
- where are there significant knowledge gaps and what other information is needed?"
- what impact does this work have on your interest or decision to implement multiple risk factor assessment in your setting?"
- what was especially interesting, surprising, valuable, missing?"

Questions were directed to the authors on the Planning Committee. The consultation and facilitation staff captured the main themes from the questions and discussion.

Structured interactive dialogues: Process outline-- This repeating 90-minute process was the heart of both meetings and was how the leader panels and the Planning Committee began to see the world through each other's eyes. The process was implemented similarly at both meetings, though there were important differences in prompt questions, to be described later. Consultation and facilitation staff took notes and recorded the conversations and questions for later use in capturing the results of the meeting. Actual instructions and orientation to participants are contained as an "annotated agenda" in the Project File. Here is the outline:

A. Discussion in the fishbowl among members of a leader panel (40 minutes)
The dialogue sessions were organized in such a way that each of the stakeholder groups (leader panels) were invited to engage in a facilitated and structured conversation while seated around a large conference table in the middle of the room while the other two stakeholder groups were instructed to listen while seated at the surrounding tables.

The group participating in the structured conversation ("in the fishbowl") was prompted to engage in a 45-minute conversation around specific questions designed to address key issues related to addressing multiple behavioral risk factor interventions in primary care and to highlight common themes and significant differences.

B. Questions of clarification from table groups around the fishbowl (35 minutes)
While the "fishbowl panel conversation" was in progress, the other two stakeholder groups at surrounding tables listened carefully to understand the other stakeholders' perspectives—to see the world through the others' eyes. Listeners were instructed not to immediately respond or argue, but rather to write down questions that were collated by Planning Committee members positioned at each table.

At the end of each 45-minute fishbowl conversation, Planning Committee members helped their table group select their most important or compelling question and pose it to the leader panel in the fishbowl. These questions were intended to clarify and seek understanding of the perspectives of those in the fishbowl panel. The Planning Committee saved all the questions in their original wording on note cards for subsequent use and documentation.

C. Reflection from Planning Committee (15 minutes)
Finally, after the fishbowl conversation and questions of understanding from the surrounding table groups, pre-selected members of the Planning Committee reflected back in summary fashion their understanding of what was said during the fishbowl conversation and in response to questions.

The fishbowl panel was provided a last chance to tweak this reflection to its satisfaction. The amended reflection was utilized by the Planning Committee to produce (see results section).

The dialogues were set-up in this particular way because each leader panel lives and works mostly in one dimension of the larger healthcare reality, yet all need to understand each other's viewpoint if they are to take positive action on multiple behavioral risk factor intervention. Just as a physical object is manufactured from at least three drawings, i.e., front view, side view, and

top view, an improved healthcare system will also need to be created from at least three "drawings"—clinical, health systems, and policy. Though the Planning Committed realized that patient and family perspectives ultimately need to be understood and appreciated as well, we elected not to include a patient panel in the dialogue sessions.

It will take all three views (clinician, systems, and policy), harmonized as dimensions of one basic design, to actually produce sustainable change. Thus, the dialogue was designed not only to yield information from the three leader panels but also to test a simplified version of a multi-dimensional learning process where listening to understand is the first key step in the process of creating a cooperative "design approach" that generates real change in our healthcare system.

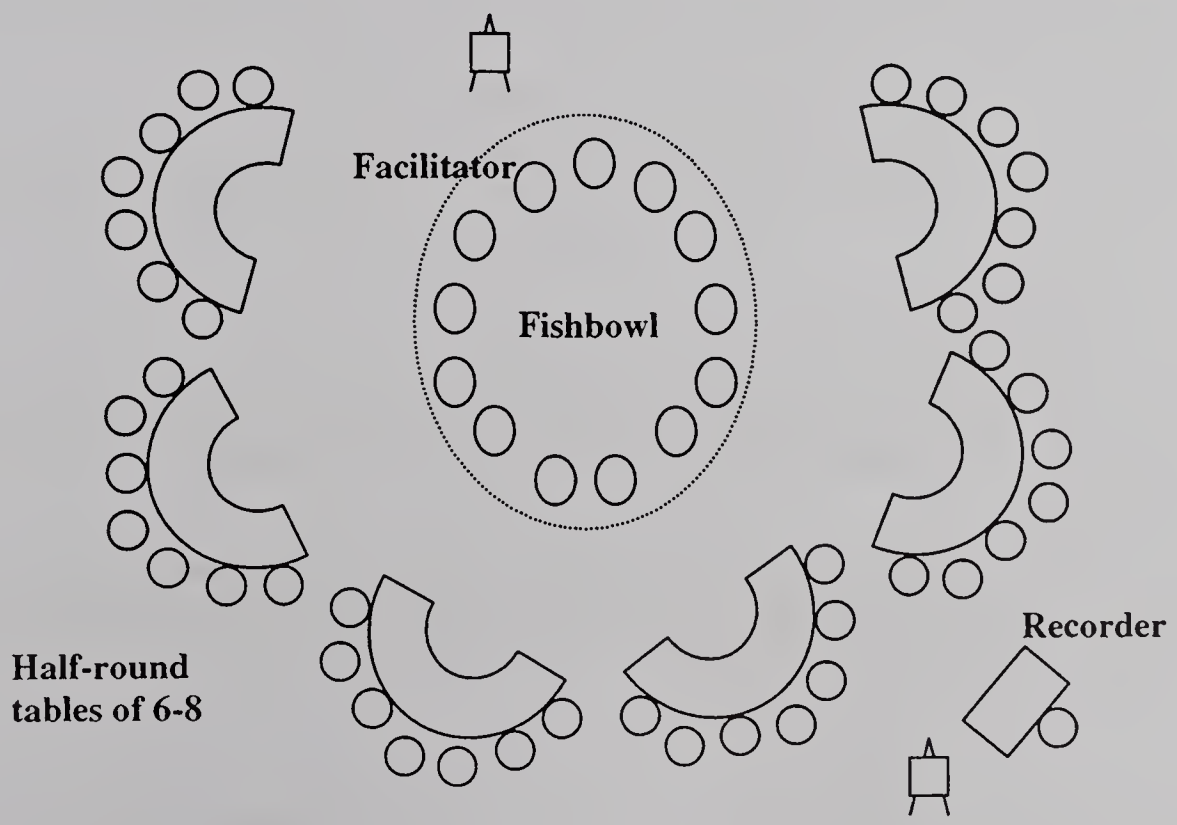
The three leader panels were drawn from populations of leaders and implementers with knowledge and experience with the practical demands of their working environments. Given how this experience is obtained, some participants on the leader panels could have spoken to more than one perspective, e.g., policy or health systems leaders who were also clinicians. The clinician, systems, and policy perspectives are best thought of as "hats" that people were asked to wear for purposes of this meeting rather than as distinct identities.

Room arrangement: At each meeting there were close to 36 participants in the three leader panels, 12 Planning Committee members and a recorder. Surrounding the fishbowl were 6-7 half-round tables of 6-8. The participants and Planning Committee members were assigned to sit in maximum-mixture table arrangements, e.g., roughly--

- 2 clinician leaders
- 2 healthcare system leaders
- 2 policy leaders
- 1 or 2 Planning Committee members

When the time for a specific fishbowl conversation arrived, a leader panel (twelve) got up from their respective tables and moved to the middle of the room to sit in the fishbowl.

To allow people to hear each other better, 4 hand microphones were available in the fishbowl and one at each of the surrounding tables. The process facilitator wore a wireless lavaliere microphone.



Differences in participant orientation and dialogue questions for the Washington, D.C. and Colorado meetings. Lessons learned at the Washington D.C. meeting led to the following two improvements at the Colorado meeting.

1. **Begin with a clearer definition and project context for multiple risk factor intervention.** Though the concept paper and background papers were supplied with the background binder, Washington, D.C. participants were unclear about what the Planning Committee and the RWJF meant by multiple risk factor intervention (MRFI) and what it wanted to learn at the meetings. The following questions were answered during the meeting.
   - Does MRFI mean the clinician and patient tackle all four risk factors at once?
   - Is the main point of the meeting to learn about health risk behavior intervention in general or more specifically about *multiple* risk behavior intervention?
   - What are the specific products of these meetings? How will our input be used?
   - What is the difference in background and role in the meeting between participants who are on the Planning Committee and those on the leader panels?

During the D.C. meeting, Tracy Orleans, an RWJF officer, clarified what RWJF meant by *multiple* risk factor intervention and what RWJF wanted to learn about it during the meetings and why. The following participant orientation was added to the introductory letter in the binder sent to the Colorado participants, and served as the basic orientation to the meeting. Including this expanded orientation in the materials and reviewing it at the start of the Colorado meeting made the task and framework clearer and generated a more focused discussion.

Participant orientation for the Colorado Springs meeting:

What RWJF means by Multiple Risk Factor Intervention:

For purposes of this meeting, multiple risk factor intervention *does not* mean that the clinician must intervene with all four health risk behaviors simultaneously-- for example to encourage a high risk patient to lose weight, increase activity, reduce risky drinking and improve dietary habits all at once.

Instead, multiple risk factor intervention means clinical teams and health systems have a practical and reliable clinical approach, system or infrastructure that allows them to effectively provide behavior change assessment and intervention for any combination of single or multiple risks that individual patients are ready to take on. Thus, we are referring to a general "platform" or system infrastructure that supports assessment and intervention at any time for of any combination of these "big four" health risk behaviors rather than fragmenting them into separate and parallel systems of assessment and intervention that become impractical to implement in fast-paced and increasingly complex primary care settings.

From a policy perspective, Multiple Risk Factor Intervention also means a health policy framework that permits and supports health system implementation of assessment and intervention for the "big four" health risk behaviors.

Purpose of the meeting:

The Planning Committee wants to hear and synthesize clinician, health system and health policy leader views and insights on the importance, challenge, and opportunity for creating integrated "platforms" of clinical method and system infrastructure to address any combination of the "big four" health risk behaviors in primary care settings.

We would like to learn what additional energy or benefit would be realized by working from an integrated approach, rather than working from separate and parallel systems aimed at separate behaviors and diseases. We would also like to learn what change concepts or approaches for addressing multiple risk behaviors work best in primary care settings.

A secondary goal is to see what can be learned from the interaction of the three leader panels and enhanced understanding of what is important to each other.

Participants and approach to the meeting

Three leader panels (clinician, health system, and health policy) are drawn from populations of leaders and innovators with direct knowledge of the practical demands and opportunities of their work environments. They will be provided with background information and engaged in structured dialogue that will enable the Planning Committee to learn from the leader panels' knowledge and experiences

The Planning Committee consists primarily of researchers drawn from various disciplines and settings with knowledge and passion for research and practice in the area of health behavior change, prevention, health services delivery, and community and public health. The Planning Committee's major roles during the meeting are to provide information and evidence about multiple risk behavior intervention in primary care; to see the world through the eyes of the three leader panels; and to gather information about what is needed to take the next steps to effectively address multiple health risk behaviors in primary care.

Products:

The Planning Committee will synthesize the insights from the meeting into a formal report for RWJF and hopefully an ensemble of published papers and recommendations that will foster the development of flexible and efficient screening and brief intervention approaches that can be applied to multiple risk behaviors in primary care settings. It is hoped that practical information will be created for clinical, health system and policy audiences. The Committee will also prepare a proceedings booklet for participants of the meetings.

2. **Change dialogue prompt questions to help panels focus on systems or platforms for *multiple* behavioral risk factor intervention.** In the Washington D.C. meeting, the prompt questions pulled for a high-level view that did not sharply focus on an "integrated platform" approach. The Washington, D.C. prompt questions assessed "importance" and "confidence", an approach developed by the proponents of Motivational Interviewing (Rollnick, Mason and Butler, 1999).

Washington D.C. prompt questions:

1. "How important is to you, in your world, that multiple risk factor interventions are implemented in primary care?"
    - What makes it important or not important?
    - What would you have to know to make it more of a priority?

2. "In your role as a [clinician, health systems expert, policy expert], how confident are you that you can deliver, influence, or support the delivery of multiple risk factor interventions in primary care?"
    - What are the biggest barriers in front of you?
    - What would make you more confident in overcoming the barriers?

The results from these questions were useful as a general assessment of perceived importance and confidence but did not sharply focus the leader panels on the issues around the use of "integrated platforms" for multiple behavioral risk factor intervention. The Planning Committee sharpened the questions for the Colorado meeting to focus on the value of integrated platforms and to pull for more concrete, direct experiences and opinions of the

members of the leader panels. For the health policy panel, the focus was on the case that would need to be made with various constituencies in the near term and longer term.

Colorado Springs prompt questions:

For clinician and health system leaders:

1. "In your role as a [clinician leader or health system leader], what additional energy or benefit would be released by working from an integrated approach to multiple health risk behaviors rather than working from separate and parallel systems aimed at separate behaviors and disease?"
    - What features or attributes would make this clearly superior to usual practice?
    - What practical virtues would influence clinicians to adopt an integrated multiple risk factor approach?"

2. "Which hypotheses and change concepts offered in the papers, from other sources, or your own experience, make good sense and will work in your setting?"
    - What change concepts or approaches have the most face validity to you, and would work in your setting?
    - Which of these can be done now? Which would take a longer-term plan of action?

For health policy leaders:

"In your role as a health policy leader, what would you need to make a convincing case for policies that support systematic health risk behavior intervention, given the many competing constituencies and priorities for effort and resources in primary care? "

- What would you need in the short term to begin making a convincing case?
- What would you need in the longer term to create a durable policy structure that supports health risk behavior intervention?

These sharpened prompt questions tapped the particular perspectives and direct experiences of the leader panels more directly and at a more specific level. The participant letters and agenda with prompt questions for each meeting are available upon request.

Participation in leader panels for the two meetings.

Washington, D.C.	June 10-11, 2003	36 Experts Assigned to Leader Panels ▪ 13 on Clinician Leader Panel ▪ 11 on Systems Leader Panel ▪ 12 on Policy Leader Panel	11 members of the Planning Committee
Colorado Springs, CO	July 9-10, 2003	35 Experts Assigned to Leader Panels ▪ 12 on Clinician Leader Panel ▪ 12 on Systems Leader Panel ▪ 11 on Policy Leader Panel	11 members of the Planning Committee

Summary of Dialogue Results
Observations and feedback on background papers
Questions and comments from participants
at both Washington D.C. and Colorado Springs meetings

Suggestions for the papers:

- Useful to have summarized multiple risk behavior interventions in one paper.
- A review of reviews depends on available reviews. The alcohol reviews are outdated.
- Incorporate stages of change in the opening "Concept Paper".
- Address different ages. Messages and tools hinge on generation and gender differences and need to be culture specific or sensitive.
- Explore the "smoking as a vital sign" literature in the assessment paper.
- Include CDC guide to community preventive services with regard to tobacco-- which did not find training alone helpful but training with systems support helpful. A 2002 Cochrane review found training helpful in changing provider behaviors, but not necessarily patient behavior.
- Can you provide the equivalent of the Framingham 10-year risk for the multiple risk factors? If I am a 20-year old male who smokes, drinks and is sedentary, what is my equivalent age in terms of life expectancy, i.e., 50 years old?
- Describe how the risk behaviors influence each other, e.g., alcohol use relates to smoking relapse, quitting smoking is related to gaining weight, and weight restricts exercise.
- Include more examples of community support services, not just healthcare services.
- Address medical education in the studies and interventions if possible.

Observations from the participants about the literature and its impact on practice:

- Look at well-implemented primary care based studies with positive outcomes and ask:
  --Are there commonalties in their intervention processes and components?
  --Can any aspects of study implementation be a guide for integration/translation?
- From the 30,000-foot view-- we are trying to get a health care system built for acute medical care to provide something else-- *behavioral* results. It is clear a new paradigm for health care delivery is needed such as prescribed by Crossing the Quality Chasm (IOM report, 2000).
- Accolades to the collaborative Chronic Care Model. But why doesn't it take off and become the system in which we take care of our patients?
- What has happened historically with MRFI concepts as pushed by HMOs as far back as 1970's?
- For impact in real world settings, it is important for clinicians and systems to have:
  --Support systems to identify the problems to be addressed and help follow-through, including getting through the discomfort of addressing alcohol and obesity;
  --Education and motivation to change;
  --Appropriate payment for this activity (pay for performance);
  --Measurement with both process and outcome measures
- Is there a role for patient incentives as well as provider and system action? For example, patient co-pay for health care based on their level of participation.
- Effective dissemination efforts employ simple messages (talking points) that champions can use.

- Effective interventions respect the context in which they take place, i.e., the tension between where the patient "is" versus where you want them to be-- and when they are ready to close that gap. Diet and exercise interventions have to move away from "prescription" to behavior change strategies. Re-train the primary care physicians and nurses on the "spectrum of change."
- We have spent a lot of time and effort with patients, physicians, and health plans trying to get them to act based on the evidence (or not act). As we develop this intervention strategy, be careful to not recommend anything not strongly supported by evidence.
- Community based interventions at school or work will anchor improved health status (diet, weight, and activity) in the population. Reinforcement and enhancement in primary care are important components but not the only relevant ones. Example: CATCH Program in school settings in New Mexico.
- Watch our for competing priorities and an attention cycle such as: a new issue comes along, word gets out, there is attention to fix it, a big push takes place, it is not easily solved, discouragement sets in, end of effort.

Cultural issues:

- Culture is everything-- family health habits, workplace policies, public areas, educational institutions, advertising/mass media, medical offices, and primary care physicians.
- The family is a learning environment. Family holds cultural transmission mechanisms. Each individual in the family is a point of entry to the entire family.
- Fitness is a lifelong process. Fitness needs to be in pre-school, K-12, college, work and development of an active lifestyle and tap into cultural values of activity. Fitness interventions should be multifaceted, multi-system: education, medicine, and workplace.
- Pay attention to cultural obstacles and skepticism about addressing risk factors in primary care as recently outlined in the British Medical Journal.
- Messages and tools need to be culturally specific or sensitive.

Risk factor assessment:

- Can weight or BMI identify those who will need a screening for multiple behavioral risk factors?
- Kristal et al. measures of dietary behavior as distinct from dietary intake are worth considering.
- If there is no consensus on the "real healthy" diet how can we make a screening tool?
- The current estimate for physical activity is misleading. Suggest using "no physical activity during last month" from the National Health Inventory Survey.
- The goal with problem drinking is not abstinence but moderate drinking.
- Surprising that alcohol and smoking are not linked as a combined risk that exceeds either.
- Add depression screening as a fifth vital sign. Depression is preventable and cognitive behavioral therapy (low intensity and self-administered) can create large public health effect. Clinical settings are part of multifaceted intervention strategy.
- The precision of evaluation and assessment tools is useful for managing population health, but does not seem as useful in the care of a specific patient.
- Genetics play an important role in BMI, blood lipids, glycosylated hemoglobin and metabolic processes. Genomics can help individuals understand what their normal body tendencies are.

Summary of Structured Interactive Dialogues

Leader panel "fishbowl" dialogue is summarized here based on reflections made by Planning Committee members immediately after each panel, enhanced by notes taken during the sessions. There was much consistency between the Washington, D.C. and Colorado Springs meetings, reflecting common themes, opportunities and challenges, although the different prompt questions at the two meetings led to some differences in focus, as previously noted. This summary does not reflect any prioritization by importance.

Summary of Clinician Leader Panels (combined)

Questions: What would make MRFI more important, give you more confidence in being able to deliver or influence it, or overcome barriers to it?

What additional energy or benefit would come from working from an *integrated* approach to *multiple* health risk behaviors rather than separate systems for separate behaviors?

1. **Clinicians value an integrated approach to health risk behavior counseling.**

   - *An integrated approach allows clinicians to improve care*; "to do the right thing" for patients; to integrate a model for managing health and preventing disease with treating illness and managing disease.
   - *An integrated approach enables clinicians and patients to look at the pros and cons of various behavior*s and facilitates joint decision-making. This makes it easier for patients to take responsibility for self-care and "contract" with their providers. Presently, patients are often confused by different providers advocating different behavior changes for different problems ("this doctor tells me this, and that doctor tells me that") and feel alone making decisions to act, if they do anything at all.
   - *An integrated approach energizes medical staff and teams* by letting them have more input and influence over how and when they engage patients. An integrated approach helps clinicians to view the broader behavioral picture and helps them to identify opportunities for synergy and teamwork.
   - *An integrated approach can streamline the process* and clarify what a clinician needs to do, and when. This approach is superior to usual care because there is so much overlap in the many guidelines, methods, and strategies for each separate health behavior.

2. **But the "locus of responsibility" for screening and behavior change is unclear.** Most clinicians would agree that screening and behavior change counseling is their responsibility, especially when a patient develops a condition such as diabetes, heart disease, or hypertension where changes in behavior can have an immediate and profound effect on health outcomes. But there is little agreement on the roles of patients, families, the community, and how various members of the care team can take on responsibility for specific tasks or roles. Clinicians are asking, "What part of this is my job? I can't do all of it"

- *Clinical practice team roles need to be defined* to make health behavior assessment and intervention workable. What specifically are clinicians (doctor, nurse practitioner, physician assistant) accountable for, and to what extent can other staff in a clinical practice assist with behavior interventions? Nurse practitioners and physician assistants are often better trained to deliver health behavior interventions.
- *Engender a view that recognizes that patients may be at various stages of readiness for* health behavior change or self-management. Patients may or may not have behavior change on their agenda when they come in. Some may not want to work on a single behavioral risk factor, let alone multiple ones. On the other hand, we may, at times underestimate patient interest in and ability to address risks as well as their willingness to use technology and other tools to connect to resources they can use. Assessing patient readiness and responding appropriately can reduce clinician frustration while permitting more effective and efficient tailoring of an intervention.
- *Think of the physician and other primary care clinicians as a "catalyst"* for influencing the patient to consider health behavior change. Physicians and other primary care clinicians might motivate and empower patients while others in the system might carry out much of the counseling and follow up with feedback loops back to the physician. Physicians can also influence practice priorities and promote clinical links to other services (e.g., dietary counseling, smoking cessation, substance abuse treatment).
- *Address the role of families in the health behaviors of individuals*, particularly for children who are developing health habits early in life.
- *Consider community roles and responsibility for supporting health behavior change.* How can community organizations, groups, schools, or public health agencies connect with and reinforce primary care interventions? How can patients get "face time" with community-based programs? Should the conversation about health behavior start in the community rather than in the clinical setting? Right now it tends to be the other way around.

3. **Clinicians want multiple risk factor intervention as part of larger change in the system of care--** as long as it is practical and doesn't make clinic life more difficult than it already is. This is a combination of effectiveness, fit within the overall time demands of primary care and addressing clinician overload and quality of life.

    - *The "system is broken" and needs a different paradigm* such as the one described in the IOM report, "Crossing the Quality Chasm". Interventions to address multiple behavioral risk factors needs to be linked to the implementation of improved office systems and the adoption of new ways to promote a team approach.
    - *The practice needs to be organized to distribute responsibility* for health behavior counseling rather than placing the burden only on an *individual clinician*. Reorganize the practice so that the clinicians don't feel health behavior change is all on their shoulders.
    - *Appreciate that health behavior intervention is experienced as "messy"* compared to "tidy" interventions such as writing a prescription or doing a Pap smear. Behavior change counseling is not so easy to "get out of the way" and can seem "vague" in terms

of goals and procedures compared to more familiar interventions. Many clinicians are not comfortable with behavior counseling.

- *Make behavioral interventions clearer and more compact so they take less clinician time*-- a solid, brief, clear, patient-centered model that the physician can follow--something that makes it easier for physicians and other clinicians to actually do in daily practice.

- *Use tools and systems to help clinicians easily implement health behavior interventions*; to know exactly what they should do at a particular point in the patient visit, and how much time needs to be allocated to that activity. Clinicians need to experience this area as systematic, "tidy", "cleaner", time-efficient, and energizing. If so, they will do health behavior intervention with more regularity and confidence. Some examples:
    - Computerized or paper tracking forms and flow sheets to ensure multiple contact points and the right intensity of monitoring
    - Making behavior goals and progress part of the medical record system
    - Health risk assessments, supported by the health system, that screen and inform clinicians and patients, and create a feedback loop across care teams and patients. These can be completed in waiting rooms, by mail, or even the internet and then integrated with other automated health information. Health assessments can also help motivate the patient.
    - Identifying people with behavioral risks who are not seeing clinicians as well as those who come in for visits.
    - Links with community resources that create confidence that, when a referral is made, there will not only be an effective intervention, but feedback about what happened once the patient leaves the clinical practice.
    - Group interventions within and outside the practice setting.

- *Look at what may need to be re-prioritized or not addressed if more time is allocated to health behavior intervention* as more and more demands are being placed on primary care practice. "Every time there is an important issue to address, it goes to the primary doctor"-- but not everything can remain a priority. Addressing all the targets listed in the US Preventive Services Task Force report is not feasible, given the time pressures in primary care.

- *Develop better methods for financial support for multiple behavior risk factor intervention*. At present, multiple risk factor programs do not support themselves. If health risk behavior intervention is to be done, financial support needs to come from the payers, health systems, government, or others. Some remarked, "If you can't bill for it, it doesn't exist."

- *Consider ways to code for self-management support* so health behavior counseling can be part of care *and* part of reimbursement, e.g. setting up separate visits or a "bundled service" that focuses on providing the counseling.

- *If it were clear that every primary care practice had to address risk behaviors*, it would help people fit it into the practice and find money for it.

- *Leaders must model health promotion in the culture of healthcare.* Clinic schedules and culture should reflect what we teach in health promotion. An emphasis on the quality of life and health behaviors of clinicians themselves may help them see the value of working on these topics with their patients. The culture of medicine and health care usually doesn't explicitly support the need for clinicians to address their own health behaviors.

4. **Incorporate behavioral counseling training in all levels of clinician training,** in early years of medical school, nursing and physician assistant school, and reinforced through residency and continuing education in actual practice environments.

   - *Clinicians want to know the evidence base for behavioral counseling and exactly what to do and how to do it.* When evidence and the procedures for behavioral intervention are clear, clinicians will do it. Include training in the 5A's as a generic approach to promote *multiple* risk behavior intervention. Train to an image of what success "looks like" for both patient and clinician.

   - *Training should take place in the context of one's specialty* and *within teams* so that the right interactions and use of systems are also supported. This training can be part of making health behavior intervention clearer and more practical and responsive to the different settings and cultural realities of both patients and clinicians.

   - *Training should allow clinicians to do it and to teach someone else*. Clinicians need to feel confident they know exactly what they should be doing and teaching

5. **Clinicians can immediately--**

   - *Endorse MRFI as "the right thing to do"* and demonstrate why. The primary clinician's role in recommending a clinical approach or system is very important.

   - *Sit down with their own systems and see what is do-able.* This won't be "one size fits all." There is a need to tailor to the needs of individual systems to make this happen.

   - *Begin using clinical tools that highlight behavioral priorities* for individual patients, e.g., patients' behavioral goals prominently identified on the charts so that clinicians can be prompted to work with them.

   - *Begin moving their practices towards a more patient-centered model* and a "practice-centered" approach to improving whole practices. Addressing multiple behavioral risk factors is an important component of such an approach.

   - *Work with the inevitable tensions in their own systems* between being able to do all these things and paying for them.

Summary of Health System Leader Panels (combined)

Questions: What would make MRFI more important, give you more confidence in being able to deliver or influence it, or overcome barriers to it?

What additional energy or benefit would come from working from an *integrated* approach to *multiple* health risk behaviors rather than separate systems for separate behaviors and diseases?

1. **Today's health system was not designed for health risk intervention.**
   - The current health care system was designed for acute, episodic care.
   - Systems, workflow, teamwork, standards, and tools will need to be updated if we expect the system to do more.
   - Healthcare is far behind the times compared to other industries.

2. **System infrastructure needs to be developed or enhanced for multiple behavioral risk factor interventions. The following system characteristics were endorsed:**
   - *Keep it simple*. If the solution appears complex, it is headed for failure.
   - *Technology* such as automated medical records, e-health, and interactive video or web-based technology can support risk behavior intervention, especially in rural settings. However, technology is expensive and the investment required needs to be recouped. Telephonic and home-based interventions may be less expensive in the long run.
   - *Standards and guidelines* providers can follow no matter which health system they are working in. Standards that cut across all systems in the community would allow providers in that community to follow a single recognized and accepted process rather than sort through a multiplicity of standards and guidelines in one community. "Standards *do* drive change" and "shared standards drive shared change." One example is joint creation and use of guidelines by multiple health systems in Minnesota, facilitated by the Institute for Clinical Systems Improvement.
   - *Show how the "Chronic Care Model",* also known as the "Planned Care Model" (Wagner et al.) *can serve as a prevention model that cuts across conditions and health behavior targets*. This is a generalizable evidence-based model that calls for platforms of operations and practice teamwork that can be implemented across multiple health systems and be acknowledged by multiple payers.
   - *Support "learning collaboratives"* where people from multiple systems work together in a disciplined process to share information and experiences and develop practical solutions that answer the question, "What can we do by Tuesday?"
   - *Practice teams must function with support structures from the larger system* to integrate and coordinate their work and connect multiple providers. The primary care clinician needs to be part of a continuum of care and an extended team, with feedback loops back to the "primary care clinician quarterback of the team".
   - *Multiple providers often need to link beyond the clinic walls*-- and beyond the traditional definition of primary care.

- *Different systems need different approaches to infrastructure*. What is helpful or possible for a large well-supported health system may not be possible or useful in a small or "underserved" system with limited resources.
- *Small or "underserved" systems may benefit from bridging to other systems*, private practices, or other service providers, e.g., employer-based or faith-based systems. Look for the overlap of agendas of these various communities.

3. **Health system improvement requires assessment data in key areas.**
   - *Know the health status of individuals* and *create population-based data sets that monitor* population *health status*. To make a difference at the population level, the system needs to find the individuals that need help. A problem in the system would show up at the population level, while improvements should be expected to have an effect at that same level.
   - *Assess the effectiveness of the interventions*. To make a difference at the individual level, systems need not only to "find patients to help, but help the patients it finds." Discover what approaches are most effective in addressing the root causes of diseases and health risks.
   - *Different systems serve different populations*. Generate knowledge about the population to permit tailored interventions *and* to help address larger needs beyond healthcare services. Create links to the community for things not traditional in the medical care world.

4. **Develop a business case for the value of multiple behavioral risk factor intervention to all stakeholders**.
   - *MRFI has to have value for each stakeholder independently.*
   - *The business case needs to be made quickly* or it will be difficult to align the stakeholders and make progress. The business case can't wait for years and years.
   - *The business case needs to address health (or quality), cost and satisfaction,* at least.
   - *Patients may need some kind of "business case" too*. What are their financial or non-financial incentives? How can care and payment systems work for measurable patient-based improvements?
   - *Recognize that high quality care does not mean the most expensive care* and that "appropriate cost", not "reduced cost", and aligns with payer and purchaser interests.
   - *Infrastructure costs need be included in the value proposition to purchasers and payers.* Otherwise there is no room for investment in infrastructure.
   - *Keeping multiple parallel systems for separate behaviors and diseases is not sustainable* in the long run. Economies of scale and consistency require integrated approaches.
   - *A major restructuring of reimbursement and systems that support primary care* activities is necessary for real change and would have to be worked out among key stakeholders.

- *Paying for performance is expected to meet clinician resistance* because of the uncertainty of getting clinical or behavioral outcomes even when you are doing the right things, because of the delay between doing something right and seeing the results, and because of the challenge in gathering data to reward clinician behaviors. Thus, it is critical to find the right balance between paying for outcomes and paying for process.

5. **Align the interests and formulate the business case for MRFI with multiple constituents.** These include purchasers (or employers), payers (or health plans), health care providers (or systems), and patients (health plan members / purchaser's employees) These stakeholders need to be involved together in creating solutions.

   - *The value of behavior change tends to require a long-range view* and is not as "exciting" as many other facets or innovations in care.
   - *Determine the values important to various stakeholders* (the "value proposition" for each). For example,
     --For employers, does MRFI result in a lower cost? Does it achieve other valuable employer outcomes?
     --For physicians, does it improve quality of care? Without taking too much time?
     --For health systems, does it improve market share? Reputation?
     --For society, does it improve health across the community?
     --For policy makers, does it give legislators a constituency that can affect policy and reimbursement?
   - *Measure the different kinds of value and frame the arguments with compelling evidence* acceptable to each audience. Some of this evidence may not be currently available and some of it may need to be gathered in non-traditional ways, e.g. community health centers gathering evidence to make a better case.
   - *Make good results and evidence much more widely known.* Show its effects (and efficiency) on a population basis. Create much better publicity for the evidence.
   - *Find ways to align values among stakeholders*, e.g., shared principles on cost, quality, and service. Patients also need to find value in health behavior intervention. None of this will take place without providers, purchasers, and patients each finding value in MRFI.
   - *Each stakeholder needs to understand* how their role fits with the others in an overall system "architecture" that helps all realize value. Though each stakeholder is like a "system within a larger system", everyone also needs to understand the larger picture and *each stakeholder needs to be accountable to other stakeholders.*

6. **Measurement enables stakeholders to become jointly accountable.** "What doesn't get measured doesn't get attention or get recorded at all". But there isn't just one measure--different measures are needed different purposes. A full set of measures can become a universal language.
   - *Measurement for accountability* or performance; meeting specified end goals.

- *Measurement for improvement*; with feedback loops for improving the processes it takes to meet end goals. Measures that support teams in cycles of feedback and improvement.
- *Measurement for payment*; reimbursement for work done.
- *Different things are important to different stakeholders.* Measurement needs to reflect the range of what is important to the full range of key stakeholders.

7. **Measurement needs to be systematic and part of how ongoing work is done.** Measurement can be part of the clinical solution rather than a cumbersome add-on. For example, automated medical records or health risk assessments (HRA's) might be used to measure health status and health status change over time as an ongoing part of the clinical system.

8. **Address morale among providers.**
   - *Providers are dealing with concern or unhappiness with increasing pressure*, need, urgency, or even "tyranny" of increasing demand for productivity. There is concern that clinicians could be expected to do more without reimbursement at a time when the expectations are already rising.
   - *Need to improve health, satisfaction and optimism among providers.* "You can't give to others what you don't have yourself."

9. **Behavior intervention models such as the 5 A's should be integrated with other things.**
   - *Integrate useful models of behavioral risk factor intervention, such as the 5A's*, into the Chronic Care or Planned Care Model, with particular attention to how systems can support clinician delivery of the 5A elements.
   - *Build behavioral risk factor intervention and models such as the 5A's into medical and other professional school* curricula and teach students early on how to do it. Also teach students about quality improvement and the role of technology and how they can support all elements of care, including behavioral risk factor intervention.

10. **Making MRFI a reality would take a plan proposed by a credible group.** Such a plan would:
    - Represent consensus among the stakeholders.
    - Include a convincing business case for all.
    - Outline key measures that align with the plan.
    - Be based on clinical data in the end.

    An example of an organization facilitating joint effort among stakeholders is the Institute for Clinical Systems Improvement (ICSI) in Minnesota

Summary of Health Policy Leader Panels (combined)

Questions: What would make MRFI more important, give you more confidence in being able to deliver or influence it, or overcome barriers to it?

What would you need in front of you to make a convincing case for policies that support systematic health risk behavior assessment and intervention, given competing constituencies and priorities for resources in primary care– in the near-term? In the longer-term?

1. **Multiple health risk intervention is not a current priority among federal policymakers.** A large "marketing" job remains to get this notion on the table. Research does not make policy, and the way we have approached making the case is not all that effective.

   - *Making the case for MRFI is challenging because health issues are traditionally presented in disease-specific or population specific "silos"*, e.g. cancer, diabetes, heart disease, kids, elderly, etc., each with an organization and constituency. Policy makers need to understand the value of *multiple* risk factor intervention to the public
   - *It can be difficult to get attention for disease prevention initiatives.* Legislators respond to crises but do not view prevention as a health crisis. "Politics and prevention are natural enemies."
   - *Multiple health behavior intervention messages could be misread as "nanny-ism"*, an intrusion into the private habits of individuals.
   - *The key stakeholders that value MRFI haven't been identified.* There is considerable work to do to create a demand and a constituency.
   - *The case for MRFI hasn't been made in terms that are influential to policymakers*, or that points clearly to where things will be in our multi-cultural society in the future. "We need to skate to where the puck is *going* to be."

2. **An influential case for multiple risk factor intervention needs to be made.** MRFI may be important, but is it important *enough*? There may be agreement that it should be done, but that doesn't put it at the top of the list for action. To make the case, answer these questions:

   - *Where is the demand?* Who wants it? What constituents want the issue addressed? What's in it for them so they want to act *together* (align themselves) rather than pursue only their own narrower interests?
   - *What are national standards in this area?*
   - *What is the evidence* that multiple behavioral risk factor interventions work?
   - *Will a healthier population decrease demand for health services?*
   - *What is the cost and potential return on investment?* Who receives that return?
   - *Where are the proven system infrastructures and tools* to support integrated health behavior interventions?
   - *What resources need to be tapped to create an overall impact,* e.g., community health workers, *promotoras*, public health agencies, advocacy groups, etc.
   - *Where can favorable health policies be built into other policies?*

3. **Develop a unified constituency around multiple risk behaviors.** Consider a comprehensive partnership, maybe an umbrella organization, so that constituents are better able to speak with a unified voice.
   - *Coalesce a unified constituency around risk behaviors, not just the resulting diseases.* Advocacy groups and funding sources are often in "silos" but can come together around behaviors not just diseases so they reinforce each other rather than compete.
   - *Create a national imperative for managing health risk behaviors.* Build the case for how critical this is and highlight the danger of letting risky behaviors go unchecked. Consider tapping into marketing and media skills that we don't normally have in health care.
   - *Integrate public support.* Emphasize that everyone - patients, providers, systems, and our society– have a stake in this and even though they "may not get all they want, they can get what they need" by rallying around this cause. Realize that different individuals and stakeholders understand health and prevention in different ways.
   - *Get multiple health behavior change on the agendas of other health and professional organizations*-- a convergence of effort. For example,
     - Work with the Society of Behavioral Medicine with its goal to help advocate for research and education in health behavior change and behavioral risk factor intervention. Work with other groups, e.g., Prescription for Health, Partnership for Prevention or others to keep health behavior intervention on the agenda. Use connections with CDC for message development on public health.
     - Perhaps this meeting can be a springboard for various organizations here to begin to build a strong coalition and a message advocating behavioral risk factor intervention.
   - *Look outside the U.S. for models or data* systems that could produce information and demonstrate results that could help move this issue forward on the policy level. Bring forward national or international evidence from trials of MRFI.

4. **Develop a business case that addresses cost-effectiveness and "human capital."**
   - *Keep the message simple.* Policymakers can make good use of simple, brief, understandable pieces that don't rely on elaborate diagrams, spreadsheets and models. Include the problem, the solutions, the evidence for the solutions, which supports it, who opposes it, and where it has been successfully tried before.
   - *Measurements need to be valid, reliable, simple, brief*, and capable of being implemented on a broad basis, perhaps even nationally at some point. Ideally, there is a single shared data set.
   - *Policymakers usually want to see near-term return on investment* or cost-effectiveness. Employers may settle for a 4-5 year timeframe. On the other hand, legislators may want to see return on investment within a year or less.
   - *Employers and payers want to play a major role* in shaping the healthcare system. They want cost control, improved quality, prevention as part of the system, patient decision-making role, evidence based medicine, clinician-patient relationships, and integrated solutions across their large, national employee or member base.

- *Show how investments result in improvements for people.* In framing public policy messages, think in terms of "human capital." Investing in behavioral interventions is an investment in people or employees or community members.
- *Set expectations that are realistic, achievable* and *have a demonstrable health benefit.* You don't need to have 90% of smokers quit to have a huge public health impact.

5. **Primary health care is only one small piece of the major environmental and cultural changes needed to effectively address multiple health behaviors.**
   - *Many factors besides medical care account for people's health behaviors*, e.g., media messages, advertising, school, work, and family environment to name a few. Thinking of primary care in that larger context, a more comprehensive package of health behavior intervention is needed that includes all of the above.
   - *There is usually a huge gap between health care settings and the community.* Connection needs to be incorporated in the groundwork for policy change. Even the success stories of healthcare / community collaboration [referring to one of the Dialogue's keynote addresses] are not the case in most of American healthcare. A similar gap exists in most places between healthcare settings and employers and worksites, and between healthcare settings and schools.
   - *Understand communities in a multi-faceted way*, e.g., the community's culture and needs, the politics of the situation, and the culture of care-- how it is delivered and the needs of the different practitioners. Build links between different kinds of agencies and health care systems that cut across worksites, schools, and other community resources.

6. **Common impressions work against MRFI in the eyes of the public and policymakers.**
   - *The idea persists that clinicians and technological medicine can fix any health problem.* Behavior change takes a long-term perspective, unlike a test or procedure. Patient and health system culture expects or prefers short term fixes to long term prevention.
   - *Behavioral intervention is seen and experienced as inexact or "messy"* compared to specific treatments such as pharmaceuticals. "The purple pill is clean and easy."
   - *Messages about how to implement and support multiple behavioral risk factor intervention may be unclear*, even while the *health messages* are very clear, e.g., "Don't smoke, eat well, exercise, drink in moderation, and you'll reduce your cancer risk by 60%"
   - *There is too wide a gap between the Planning Committee's hypotheses and its recommendations*, especially about the additional benefit that would be gained by creating the infrastructure for multiple behavioral risk factor intervention rather than incrementally adding single risk factor interventions.
   - *The business case for prevention needs to reveal benefits to companies sooner rather than later*, e.g. 4 years, not 20.
   - *In tight economic times it may be unrealistic to successfully advocate for this issue* at the national level. State and local levels may be more promising.

7. **However, there are reasons to be encouraged.**

   - *Lessons learned from the "tobacco wars"* about influencing public opinion, health systems, and policymakers *can be applied* to MRFI.
   - *There is potential for engaging the media in getting the messages across* and building demand for reducing multiple behavioral risk factor interventions. For example, a compelling case can be made to address behavioral risk factors to combat the epidemic of childhood obesity.
   - *Lessons from other parts of the world* can be applied, e.g., "promotoras" and lay health workers that don't rely on expensive technology or people to make a difference.
   - *There may be opportunities to effect change at state and local levels* when it may seem too difficult to affect national level policy, e.g., state or county health departments.

8. **Undertake demonstration projects** to illustrate successful approaches that can be duplicated and expanded. These can unify and give confidence to the constituency. "Proven successes can influence policy."

9. **Engage the media**. As noted above, the media can help make a compelling case to communicate important messages about the importance of multiple behavioral risk factor intervention.

10. **Accept that influencing policy will be complex, a long-term effort, and require thoughtful planning**. An example of a policy change is re-writing Medicare so that prevention is valued and coverage is provided for it.

    - *Both policy makers and policy shapers need to be considered.* Policymakers actually create or legislate public policy. Policy shapers influence policy through study, advocacy, or their decisions and choices made as leaders and managers. Some policymakers and policy shapers are public and some are private. "Policymaker" or "shaper" is more like a "hat" that a wide range people might wear at times rather than a smaller set of particular people.
    - *Influencing policy requires understanding many things at once:* different leverage points, different policy levels, and the different people to influence. We can't take the exact same approach to them any more than we can give exactly the same prescription to every patient or care system. Policy is complex and multi-dimensional. Reminder from Mencken: "For every complex problem there's a simple solution-- and it's wrong." We need to tailor our policy messages to our different audiences and the different things that are important to them at the time they are important.
    - *Policy and legislative attention often comes in the context of a crisis.* Accept that presently, longer-range preventive issues may not command policy and legislative attention that is focused on current crises.
    - *Consider how genomics will play a role in future health care*, and how cutting edge medicine will relate to health behaviors, particularly how health behavior can help people who are known to be at very high risk and who need to manage it for a lifetime.

Future Direction and Next Steps
Common Threads from Interactive Dialogue

Summarized from: Pronk, N., Peek, C.J., & Goldstein, M. Addressing Multiple Behavioral Risk Factors in Primary Care: A Synthesis of Current Knowledge and Stakeholder Dialogue Sessions. *American Journal of Preventive Medicine*, Volume 27, Supplement 2, August 2004.

Immediately following the Colorado Springs meeting, the Planning Committee identified common threads from Washington, D.C. and Colorado Springs dialogues. These were further developed for a "synthesis" paper from which they are summarized here.

1. **MRFI needs to be addressed among multiple health care system stakeholders.** Clinicians, health system leaders, and policymakers all feel the need to address behavioral health risk factors in primary care. But each feels that need in a different way, has a different role to play, and has a different constituency to engage in bringing it about. To ensure effective and efficient implementation of multiple risk factor interventions in primary care, appropriate roles and responsibilities need to be taken by each of the multiple stakeholders that collectively affect health care delivery.

   Stakeholders identified include patients and families across the full range of ages and development, the clinician, the health care system, and the payer and purchaser in their various forms. All play a role in shaping policy along with policy makers. The interaction among these key stakeholders emerged as a critically important aspect of addressing MRFI and takes place in the context of what matters to each, what processes and resources each has available to make or promote change, and what constituencies each needs to satisfy.

2. **MRFI represents a positive opportunity for integration in healthcare.** Leader panels were enthusiastic about MRFI as a piece of the larger task of integrating healthcare in general. They were less enthusiastic about addressing MRFI "in a silo" because without a more generalized effort towards better integration, MRFI platforms could find themselves swimming against the current of existing fragmentary methods and approaches. Citing recommendations in the Institute of Medicine's "Crossing the Quality Chasm" report, participants made connections between MRFI and implementing the Chronic Care Model. MRFI appears to generate the most interest when featured as an important player in the larger "ball game" of which it is a part—integration of health care delivery, finance and benefits.

   This generally positive view was tempered by concerns about how MRFI could be embedded into current practice settings, which are overly busy and often fragmented. In many cases, delivery systems are not currently ready or able to support changes in practice that allow MRFI implementation, although several clinicians felt that they had achieved success in their own practice settings. Overall, clinicians felt strongly that systems, infrastructure and policy changes were necessary for MRFI implementation, based on a recognition that the entire health care delivery system needs to be redesigned cooperatively with sound and interlocking clinical, systems, and policy dimensions.

3. **Measurement can be a "language" that pulls together multiple stakeholders in MRFI.** Defining a common set of agreed-upon measures for MRFI across stakeholders is a way to tease out and align what is important and feasible in various settings by those stakeholders.

Such an agreed-upon set of measures becomes a shared "language" that facilitates communication and alignment among the stakeholders. This "universal language", understood by all parties, is a principal component for successful implementation of MRFI. Panelists acknowledged that quality improvement is not achieved unless there is a means of measuring it, that payment mechanism and other incentives need to be created in the context of explicit measures, and that such measures must be consistent with the roles and responsibilities of various stakeholders. Participants also urged caution regarding setting realistic expectations for outcomes and performance.

- A realistic expectation for population outcomes depends in part upon which sub-populations are actually reached, and in what proportions.
- Outcomes and timelines used to drive improvement and accountability must be based on realistic and actionable timeframes appropriate to the particular approach employed, e.g., the 5A's.
- Measurement or payment for one action, such as outcomes or use of 5A's, shouldn't overshadow other priorities, e.g. being patient-centered and efficient.
- Measurement should minimize interference with daily practice and be woven closely into to actual workflow, becoming *part* of the work rather than a cumbersome add-on.
- Creating a fully operational system capable of reliably delivering mature clinical and financial outcomes follows a developmental path from pilot to full implementation. Realistic and escalating expectations need to be set at each developmental stage, including a stage-appropriate balance of clinical, operational, and financial expectations.

4. **Each stakeholder needs a compelling value proposition for MRFI.**
Participants identified the need to make a compelling business case or "value propositions" that directly addresses perceived needs and interests of each stakeholder group enough to actively support and participate in MRFI implementation. Five stakeholder groups were identified for whom value propositions were considered important, along with a first pass at what may be most important to them.

A. Patients and families	Function, health, and practicality in using the system
B. Physicians, other clinicians, clinic systems	Quality of care and feasibility in the clinic setting
C. Purchasers (employers or purchasing groups)	Return on investment, cost, and reduced cost trend
D. Payers (health plans or government programs)	Appropriate cost, quality of care, market share gains
E. Society (local, state or national levels)	Health status of the population at reasonable cost

While these groups may respect each other's perspectives, aspirations and felt needs, it is likely and appropriate that each is most strongly influenced by its own highest needs and wants. Results will not be achieved without alignment of all the value propositions and rationales for action.

5. **Supportive infrastructure to address MRFI is greatly needed.**
Infrastructure support consistently emerged as critical to successfully implementing MRFI in primary care, including:

   A. Information technology to identify individuals at risk, tailor messages and interventions in a variety of environments, and help individuals connect to appropriate follow-up.

   B. Evidence-based guidelines and protocols for MRFI recognized by multiple payers, care systems, and practice settings to reduce fragmentation across payers or clinicians.

   C. Shared assessment and intervention models for creating a context of meaning and common elements for MRFI across stakeholders, e.g., the Chronic Care Model and 5A's behavioral counseling approach.

   D. Operational platforms that integrate information technology, clinic systems, and intervention processes across multiple behavioral risk factors– using a single systematic operational approach rather than separate operational systems for each behavioral risk factor.

   E. Learning systems such as "collaboratives" that enable health care organizations to learn from each other and create solutions to MRFI implementation and operational challenges. Similar collaboratives have been used to improve practice in areas such as office practice redesign, improved access, and chronic care.

   F. Extended practice teams with system supports that enable coordinated operation with appropriate roles and division of labor within the larger health care system, e.g. extending the reach of the primary care clinician with health educators, counselors, dieticians, exercise physiologists, psychologists, and other health professionals in or outside the primary care clinic setting.

6. **The desire is strong to "do the right thing" for patients and populations.**
Clinicians, health system leaders and policy makers who participated in the dialogues agreed that addressing the four risk behaviors as major threats to health and quality of life is not only prudent, it's the right thing to do despite all the challenges and barriers. This desire to "do the right thing" generated energy for moving forward with MRFI and agreement that a multi-stakeholder approach to benefits, costs, methods, and evidence for MRFI is the right route to take.

   Participants saw that despite their different roles, backgrounds, language and immediate priorities and pressures, they shared the same goals and values at the highest levels of significance. That is, at the top level they were all after the same thing—best care, excellent relationships, superior design, flawless implementation, and wise use of resources. Listening to understand what was important to each other appeared to build an increasing sense of agreement and shared values.

   "Doing the right thing" also moved participants to feel a strong need to vividly articulate what MRFI would actually look like and feel like when taking place in real world clinical settings. Such a practical shared vision is part of outlining a course and obtaining commitment that results in operational reality for MRFI.

7. **Shared implementation tools, platforms and process "maps" are needed.**
Interest and willingness to act on the concept of MRFI goes nowhere without a practical vision for what needs to be created and a "road map" for getting there. While the overall "road map" needs to include policy dimensions, panelists also identified several crucial clinical and systems elements.

   First of all, participants agreed that MRFI does not mean that a primary care clinician must intervene with all four risk factors simultaneously. Rather, it means clinical teams use a practical clinical approach, supported by an integrated "platform" or system infrastructure, that can address any combination of single or multiple risks that an individual patient may be ready to take on at any given time. This contrasts with a fragmented set of separate and parallel systems of assessment and intervention for each health behavior, which was seen as impractical to implement in fast-paced and increasingly complex primary care settings.

   A practical problem with otherwise excellent single risk factor assessment and intervention approaches arises when a primary care clinic or clinician wants to implement interventions for several behavioral risk factors, e.g., smoking, diet, activity, risky drinking. For each individual risk factor, the clinic is faced with an array of separate and parallel assessment forms, algorithms, tracking tools, counseling approaches, and in some cases, separate advocates or champions within the care system. When a clinic begins to implement more and more of these, the proliferation of separate checklists and intervention resources can slow down clinic processes, confuse or discourage clinicians, and perhaps even give the entire area of behavioral risk factor intervention a bad name in the clinic. What already-pressed clinics need are fewer separate and competing pieces and more cooperating wholes. That means a "platform"– a single approach to behavioral risk factor intervention that can be applied across a number of specific risk behaviors with ingredients such as:

   - *Health Risk Appraisal (HRA) and Health Assessment (HA)* was seen as a promising way to assess multiple health risk factors in a way that can be integrated into other care processes in a variety of formats (paper, on-line, telephonic, and face-to-face).
   - *The 5A's approach to behavior change counseling* (Assess, Advise, Agree, Assist and Arrange follow-up) was seen as the most promising clinical process for fostering an integrated approach to MRFI in primary care. Evidence-based intervention elements can be delivered at various points in the care process (e.g., pre-visit, during the visit, after the visit) by various members of the clinical team (e.g. medical assistant, physician, nurse, health educator) across multiple visits or contacts.

     The primary care clinician might use data obtained from a pre-visit risk assessment (Assess) to provide a personalized motivational message tied to the patient's health concerns (Advise), encourage the patient to choose a behavioral goal and, if the patient agrees address a specific risk behavior (Agree), refer them to a system-based counseling service, staffed by a health educator or other member of the health care team (Assist and Arrange follow-up). Embedding the 5A's in an integrated system of care while distributing responsibility for delivering the 5A's across multiple team members, helps ease clinicians' concerns about the burden of addressing MRFI within the context of time-pressured primary care practice

- *Interactive technology* to move and share data and information, create feedback reports and tailored intervention options, and take the measurements important to the different stakeholders at specified points along the way.

Recommendations and Call to Action

Summarized from: Pronk, N., Peek, C.J., & Goldstein, M. Addressing Multiple Health Risk Behaviors in Primary Care: A Synthesis of Current Knowledge and Stakeholder Dialogue Sessions. *American Journal of Preventive Medicine*, Volume 27, Supplement 2, August 2004.

Recommendations:

1. **Create multiple stakeholder dialogues.** The dialogue format used in this project allowed clinicians, health system leaders and policymakers to see and hear each other's views and perspective– to see the world through each other's eyes– and understand what is important to each other. With better mutual understanding comes shared knowledge, an increased sense of the possibilities in multi-dimensional design, and motivation to open a path or create a roadmap. We recommend including a patient perspective by inviting patient stakeholders to future dialogues. Multi-dimensional approaches based on mutual understanding across stakeholders will broaden our concept of "best practices" to include the interlocking operational, business, and political processes it will take to make MRFI in primary care actually happen.

2. **Create a policy agenda organized around public "issues that matter" in MRFI.** Though all three stakeholder groups expressed the desire to "do the right thing" and support MRFI in primary care, the lack of system infrastructure and policy-level support for MRFI continue as serious barriers to implementation. There is a clear need for a compelling public campaign that addresses the concerns and needs of multiple stakeholders and constituencies. We recommend that key clinician, health system and policy level stakeholders work together to craft a compelling policy agenda for supporting MRFI in primary care and beyond. This could be accomplished with a structured interactive dialog method in conjunction with follow-up work teams. Such a policy agenda may have several aspects:

   - Encourage multiple behavior risk interventions as a health system goal coupled with development and testing of clinical, operational and financial platforms for implementation.
   - Unite behavior- or disease-specific constituencies on behalf of MRFI.
   - Mobilize public energy for policies that influence the incidence of health risk behaviors and addresses current public health concerns, perhaps building on the growing concern about the epidemic of obesity.
   - Mobilize energy among multiple stakeholders, using questions that are meaningful to them, for policies that improve feasibility for individuals, families, communities to make changes in behavioral risk factors, including development and testing of systems and platforms for MRFI in real-world settings.

3. **Support translation of research findings to practical MRFI applications.** The development of replicable, scalable (to large and small systems), and sustainable program applications is a major challenge and is urgently needed. Such applications may stem from promising efficacy research but also require testing in, and adaptation to, real-world primary care environments and marketplace dynamics.

   This requires us to think not just of unidirectional "translation" of research into practice, but of two-way "integration" of research and practice, where research is the result of the interplay of researchers, practicing clinicians, care systems leaders and policymakers from the very

beginning—when research questions are framed and experiments conceived. This is different than researchers framing clinical science questions and later involving practice and policy communities in translating the results for use in real-world settings. "Integration" of research and practice is a variation on the theme of multiple stakeholder dialogue—where everyone is involved in the basic design from the beginning. Then follow up by making what is learned accessible to the clinical, health systems, and policy communities through practice-oriented information sources, journals, conferences or other forums for exchanging what has been discovered.

4. **Initiate a series of demonstration projects around MRFI.** Bring together researchers, practitioners, care system leaders and policymakers to try systematic approaches to MRFI in real-world settings under real-world conditions. Use real world multiple stakeholder dialogue at multiple levels of the health system, including patient, physician, care team, care system, and health plan levels. Learn from the work of the Agency for Healthcare Research and Quality (AHRQ) and The Robert Wood Johnson Foundation's new translational research program, Prescription For Health, that focuses on testing innovative interventions for addressing MRFI in real-world primary care settings.

5. **Support a broader research agenda focused on multiple behavioral risk factor interventions.** Most research has addressed only single risk factors. We also need to address the following issues: profiles of multiple risk behaviors among various populations; longitudinal MRFI impact on population health status; sequencing versus simultaneous intervention across multiple risk factors; integration of health or health risk assessments as a tool within primary care settings; and practical implementation of platforms for MRFI.

A call to action:

As is so often the case, "we know more than we apply in practice." Even with unanswered questions in the research literature, we *do* know enough to act now. We know health risk behaviors are a major and growing threat—that we can do something about even if our scientific and practical knowledge is incomplete. More boldly, we know enough to begin demonstrations that allow us to learn from experience and open the two-way street between research and practice with ever-increasing confidence that what we do is making a difference– not only in health outcomes, but in clinic operations and financial sustainability.

We know that real-world demonstrations will require clinicians, health system leaders and policymakers to jointly craft workable solutions as three dimensions of one underlying design rather than to settle for acting as competing constituencies. We know enough about mobilizing interest in effective and cooperative design through multiple stakeholder dialogues to have confidence in building it into demonstration projects from the beginning.

We know that people prefer cooperative testing and problem-solving to feeling discouraged by an inability to make these changes on their own– and that discouragement, blaming, and cynicism are not "first choice" for anyone. We recommend acting on what we know now– about MRFI and about people– to let our collective knowledge and know-how spread and deepen via cycles of learning from experience in the complex real world in which we live. We recommend that action-based systematic learning start now rather than waiting for definitive answers or flawless designs that may never emerge.

Publication Plan

Following the Colorado Springs Dialogue session, the Planning Committee outlined a publication plan. Kevin Patrick, MD, Editor of the *American Journal of Preventive Medicine* (AJPM), and a participant at the second Dialogue session, invited the Planning Committee to submit the four background papers to AJPM for publication as a special supplement. A synthesis paper that summarized the background papers and the output of the Dialogues was added to the submission along with four additional relevant papers. Michael Goldstein, MD, and Susan Curry, PhD, served as Co-Guest Editors. After undergoing peer review, all 9 papers, as well as 4 invited Commentaries, were published in AJPM (Volume 27, Supplement 2, August 2004). The 9 papers are listed below:

- Prevalence of Multiple Chronic Disease Risk Factors: 2001 National Health Interview Survey (LJ Fine, GS Philogene, R Gramling, EJ Coups, & S Sinha)*
- Assessing Multiple Risk Behaviors in Primary Care: Screening Issues and Related Concepts (TF Babor, CN Sciamanna, & NP Pronk)*
- Multiple Behavioral Risk Factor Interventions in Primary Care: Summary of Research Evidence. (MG Goldstein, EP Whitlock, J DePue, & Planning Committee)*
- Translating What We Have Learned Into Practice: Principles and Hypotheses for Interventions Addressing Multiple Behaviors In Primary Care. (RE Glasgow, MG Goldstein, JK Ockene, & NP Pronk)*
- Addressing Multiple Health Risk Behaviors in Primary Care: A Synthesis of Current Knowledge and Stakeholder Dialogue Sessions. (NP Pronk, CJ Peek, & MG Goldstein)*
- Physician Screening for Multiple Behavioral Health Risk Factors (EJ Coups, A Gaba, & CT Orleans)
- Interactive Behavior Change Technology: A Partial Solution to the Competing Demands of Primary Care. (RE Glasgow, SS Bull, JD Piette, & JF Steiner)
- Meeting Recommendations for Multiple Healthy Lifestyle Factors: Prevalence, Clustering and Predictors among Adolescent, Adult and Senior Health Plan Members. (NP Pronk, LH Anderson, AL Crain, C Martinson, PJ O'Connor, NE Sherwood, & RR Whitebird)
- Multiple Risk Factor (MRF) Reduction: A Challenge for the Primary Care Setting (MC Rosal, JK Ockene, R Luckman, J Zapka, KV Goins, G Saperia, T Mason, & G Donnelly)

* These five papers were supported by a grant from The Robert Wood Johnson Foundation. The other papers were selected by the Planning Committee to provide a broader picture of multiple behavioral risk factors in primary care.

This Proceedings Book was written by CJ Peek, Brigid Sanner, and Michael Goldstein.

Participant Feedback
Meeting evaluations:
Addressing Multiple Behavioral Risk Factors in Primary Care

Washington, D.C. Meeting (June 10-11, 2003)
Colorado Springs Meeting (July 9-10, 2003)

	Washington, D.C.	Colorado Springs
Total Respondents	**23**	**24**
Clinicians	9	10
Health system experts	7	6
Health policy experts	3	6
Not indicated	4	2

Meeting evaluation questions	**Washington D.C.**	**Colorado Springs**
1. How helpful were the background papers in preparing for the meeting? 1= nothing new or useful 7= a great preparation	5.4	5.6

Washington, D.C. comments:
- Add Chronic Care Model paper
- Very helpful! Although I wish we had additional topics
- Very helpful for forming thoughts before meeting
- Succinct, easy to read, arrived in advance, relevant and a great intro and resource for the meeting.
- Very helpful for forming thoughts before meeting
- Would love to have final versions of the papers
- You need a "how to" paper written by a primary care practitioner
- Tools would have been great

Colorado Springs comments:
- Good selection. More.

2. To what extent did the keynote provoke worthwhile thoughts & reactions? 1= ho-hum 7= mind opening	4.7	5.1

Washington D.C. comments:
- Topic was very familiar to me and I have mixed opinion of collaborative and chronic care model.
- Interesting background on evolution of health clinics
- It had a great start, but the middle and end were very difficult to follow. Lost the take-home points.
- For those of us relatively uninitiated in community health centers, it was a little confusing (and too long)
- Seeing success in underserved poor populations makes a great case we can do it too!

Colorado Springs comments:
- No major new insights to me but entertaining.
- Pared things finer and finer, but nothing jumped out as actionable. Also how generalizable is Ohio data?
- The review was limited to speaker's research. A much broader review of the literature is merited
- Nothing new. Not thought provoking.
- Excellent presentation.

	Washington, D.C.	Colorado Springs
3. To what extent did you feel the other panels and the program committee heard the perspectives and priorities of your own panel? 1= I didn't feel heard 7= I think they really understand	5.7	6.2

Washington, D.C. comments:

- Summaries were helpful in acknowledging what was said.
- Great facilitation, but still I'm unclear how this will become useful.

Colorado Springs comments:

- Prevention and multiple risk factor interventions are essential elements of comprehensive health reform.
- Reflector did excellent summary.

4. To what extent do you think you heard and understood what is important to the other panels? 1= no idea 7= I think I understand	5.5	6.2

Washington, D.C. comments:

- The focus on the different perspectives was very helpful. Seeing through their lenses helps to clarify the benefits and challenges.
- Somewhat disjointed.
- I don't work at the other two levels, and don't know what some of the things they said mean.
- Health system less cohesive.
- Policy group went off track by addressing policy-maker support of multiple risk-factor approaches. The MRFI focus is on an implementation strategy that has no need for policy support. Policy needs are for support for all behavior risk factor management in primary care. Much of the discussion has been off what is really important, i.e. how we can develop practice infrastructure that works for all risk factors, not a different one for each one.

Colorado Springs comments:

- Not enough conversation on panels, too much "speechifying".
- The policy group was prone to speeches. I found the dialog more effective.

5. Overall, how much difference did this meeting make to you? 1= nothing has changed for me 7= A definite advance for me	6.3	5.4

Washington, D.C. comments:

- This has been an issue that my organization has struggled with. I now have a better knowledge of the issue, but am no closer to resolution.
- Some. I am an advocate of this topic.
- Difference with regard to what? The discussion was interesting, but it does not change my perspectives re. most desirable targets for QI. Opportunity cost may not justify focusing on MRFI.
- Although not much has changed acutely, this meeting makes a difference in that the appropriate dialogs and background work is started.
- Reassuring we are on the right track
- My clinical life is organized around this anyway.

Colorado Springs comments:

- Conflicted. I have pushed our health system about as far as it can go. It was very helpful to be here and it will allow for collaboration, which is paramount.
- A few new pearls: mostly same old same old (data is needed, integration, etc.)
- Very encouraging and confirming own risks and push in chronic disease.
- Energized!
- Hit at a good time. Our single-issue roadmaps (e.g. tobacco or breast cancer screening) are coming under fire from the delivery system. Intervention across is a good concept to help deal with it, and it is patient centered.

	Washington, D.C.	Colorado Springs
6. To what extent do you feel the meeting agenda and discussion process were well prepared and run? 1= never do it this way again 7= a pro job	6.3	6.5

Washington, D.C. comments:

- We didn't focus on the papers and feedback on their content.
- The format was great. It kept everyone involved.
- Process was different and very effective.
- Tracy Orleans' description of what was meant by multiple risk intervention would have been very helpful at the start of the meeting.
- Structure and process of meeting were excellent. Desired outcomes of meeting still a little vague to me.

Colorado Springs comments:

- Well done. I have read all papers and taken notes. Was somewhat frustrated that I only had formal time to address about one-third what I put down. Others are likely to have had similar reactions I guess.
- Fish bowl design excellent. Very good design – would have limited time of "speeches" and made more conversational.
- Not enough time for discussions and free flow of ideas.
- Incredibly productive use of time.
- Wish there was more time for networking – especially with folks from other groups.
- Not enough time to hear all viewpoints. Great meeting but felt rushed.

7. To what extent would you like to be involved in further dialog or action on this topic? 1= had enough already 7= let me at it!	6.3	6.6

Washington, D.C. comments:

- I would be very interested in any follow-up activity on this subject.
- I am interested, but not sure what else I can offer.
- Very interesting first step. Would enjoy being part of continuing evolution.
- Be glad to support, especially in the areas related to health and culture.
- We are committed to pursue these issues.
- Would very much appreciate continued involvement.
- Very interested.

Colorado Springs comments:

- This is a very important area. I and my group health colleagues would be quite interested.
- Thanks
- Would like to receive a copy of the formal paper.
- I'm very interested in this concept/problem and would like to be involved.
- I would love further opportunities to be involved in this or similar initiatives.
- This systematic evaluation will shape the future of health care. I love to participate with this cutting-edge improvement strategy.
- I would invite, if I could, key stakeholders of my organization to be involved.

Post-meeting Participant Surveys:
Addressing Multiple Behavioral Risk Factors in Primary Care

Washington, D.C. Meeting (June 10-11, 2003
Colorado Springs Meeting (July 9-10, 2003)

Respondents	Washington, D.C.	Colorado Springs
Question 1	**21** (8 clinicians, 7 systems leaders, 3 policy leaders, 3 unspecified)	**8** (panel unspecified)
Question 2	**19** (7 clinicians, 7 systems leaders, 3 policy leaders, 2 unspecified)	**8**
Question 3	(not asked)	**7**

	Washington, D.C.	Colorado Springs
1. How important is it to you, in your world, that multiple risk factor interventions are implemented in primary care? 1= not even on my radar 7= must have it!	5.9	5.0

Washington, D.C:

What makes it important or not important?

- It's where we need to go.
- Antecedent to major causes of morbidity and mortality.
- The health implications are huge in doing nothing or not enough.
- These are the precursors for 50% of early mortality and morbidity.
- Many, many of our patients and those we care for have multiple risks.
- Improving health of communities.
- Impact – patient outcomes
- Infrastructure support and money, codes.
- Reduce morbidity/mortality from chronic and/or preventable diseases.

What would you have to know to make it more of a priority?

- That it is easily incorporated in my practice – i.e., collaborative care
- Better science that brief interventions work – long-term outcome
- Supportive system
- Leadership support
- Funding
- Reimbursement
- More research to bolster message
- Successful initiatives
- Data
- Education / awareness of community

Colorado Springs:

What makes it important or not important?

- Not a priority in our health system.
- More important are cancer treatment and other disease management.
- It is important when the patient thinks it is important.
- Have not seen business case for effectiveness.
- Too many other things to do.
- The top diseases/issues are intertwined and their intervention requires it.
- Essential aspect of care
- Bringing behavioral health and increased attention to intervention for behavior change is generic to our business.
- Important for tobacco and risky alcohol.
- Whether there is demand for multiple risk factor interventions from payers, insurers and enrollees.
- We have had a number of single note successes now in primary care (smoking cessation).

What would you have to know to make it more of a priority?

- Knowledge not as much an issue as reimbursement.
- Need to have timeframe for ROI.
- Effectiveness
- Support by clinicians
- The effect on deflection of cost and to get corporate backing.
- More evidence for exercise and diet.
- Clearly articulated demand for such interventions.
- Secondary prevention (breast cancer screening) and tertiary prevention (diabetes).
- Health intervention outcomes for dietary, exercise, smoking and problem drinking alone or in combination. Could be at primary care and/or organizational levels.
- The airways are pretty crowded. A unified approach to address behavioral issues would help free them up some.

	Washington, D.C.	Colorado Springs
2. In your role as clinician, health system or policy leader, how confident are you that you can deliver, influence, or support the delivery of multiple risk factor interventions in primary care? 1= a snowball's chance 7= watch my dust!	4.6	6.0

Washington, D.C.

What are the biggest barriers in front of you?

- Time, money, infrastructure
- Time, money, tools for brief screening and interventions
- Resources, time, culture
- Time, money, "it's not my job"
- System support for clinicians (me) and the patient
- Still good idea; easy ways to evaluate our efforts
- Lack of infrastructure and organization of practice to support collaborative care; lack of performance incentives
- Funding to test interventions
- Time and cost
- Competing priorities, limited time, money, infrastructure, training of providers
- The slow process of the federal government!
- Resources/funding

What would make you more confident in overcoming the barriers?

- Access to best practice models
- Being able to conceptualize implementation of the designed tool(s)/model(s)
- Reimbursement
- Infrastructure of providers that could be referred to for these services
- Support from system
- Leadership support
- Better ideas
- Implementation of a national infrastructure
- Pay for performance
- Effective ways to impact reimbursement to policy
- MRFI would have to be part of a consensus target for QI
- Stronger access to the Hill!
- Single payer health system
- That this becomes a priority at the legislative level

Colorado Springs

What are the biggest barriers in front of you?

- It will need to be something that happens across the health care continuum before our health system will adopt this
- Time, money
- Clinician buy-in, reimbursement system, claims system
- Time and staffing
- Inertia
- Lack of compelling value proposition in light of 7-13% cost increases
- Lack of evidence for exercise and diet
- Limited ability to partner with community resources
- The usual – sick care and perceived emergency care come first. Got to measure up front for prevention to show it's a problem and then continue to measure to show you produced results.
- Single risk factor funding.
- Lack of evidence-base for some of the risk factors discussed at the meeting.

What would make you more confident in overcoming the barriers?

- It national leadership (Medicare) took this seriously
- I am well on the way. You just need to be creative and tenacious.
- Incorporation into reimbursement structure, i.e. as CPT code
- Medicare covering this
- Demonstration of ROI
- More meetings like this
- More research about how
- The solid commitment of the CEO and medical director and about $2-3 million for outmoded systems to make patient data entry health risk assessments possible and telephone and/or web based self-management support over time a reality
- Opportunities to test multiple risk factor interventions – evaluate the changes needed to integrate the interventions into systems of care.

	Washington D.C.	Colorado Springs
3. What change concepts and approaches presented or discussed at the meeting have the most relevance, validity and potential value to you? 1= a snowball's chance 7= watch my dust!	(not asked)	6.0

Washington, D.C.
(This question not asked at the Washington, D.C. meeting)

Colorado Springs
What are the biggest barriers in front of you?

- Ability to tailor models to unique local circumstances while maintaining overall integrity of model/goals.
- 5 A's are OK, but they are "what *should* be done." Need to couple this with planned care model to tell *how* it will be done.
- Collaborative approaches
- Understanding that these changes have and will make a difference
- New approach to preventive care
- Economics
- I think being able to discuss more specificity by those who have implemented
- Clinical and system change
- Improve clinician skills

What would make you more confident in overcoming the barriers?

- Need strong leadership from national perspective (Medicare)
- Opportunity to leverage more resources
- I am very interested in obesity prevention as well as activity
- I like the idea of incorporating with tobacco
- The systems that have been successful
- Instructions in brief counseling
- That I had the money to make it happen

Addressing Multiple Behavioral Risk Behavioral Risk Factors
Comments and Questions for Expert Panels

From participation in table groups or submitted on cards

Approximately 12 pages of questions and comments for the leader panels were captured from table groups at the Structured Interactive Dialogues in June 2003 in Washington D.C., and July 2003 in Colorado Springs. These are paraphrased below. Not all questions or comments were addressed by leader panels, but many responses are incorporated in the dialogue summaries. Noteworthy differences in questions or issues at the two meetings did not appear, so they were combined.

Questions and comments for Clinician Leader Panel

About how MRFI works for patients

- How receptive are patients to multiple risk factor interventions? The classic teaching is to deal with one at a time so as not to overwhelm patients or compromise the quality of counseling for any one behavior. What is the gain of "packaging" counseling in a hopefully synergistic way vs. the risk of overload or setting patient up for failure?
- Say more about how the risk behaviors influence each other: alcohol use relates to smoking relapse. Quitting smoking relates to gaining weight. Weight restricts exercise.

About the proper role of physicians and other providers

- When do we declare that multiple behavior counseling is part of the job of primary care? But what *is* the job of primary care clinicians? The whole thing – all 5 A's? Or just the initial A's? Some of the A's can be done by other clinical professionals, nurses, etc. in a team.
- In the dentistry model, most of the patients' time is spend with the hygienists. The dentist sees the patient for a few minutes only. The dentistry model is well accepted.
- What are the opportunities for communication and cooperation between the clinician, public health, and community? And for empowering each to do the part they do well? Would looking at partnerships outside the practice be a desirable and feasible possibility?
- Do most primary care providers feel comfortable referring "counseling" out or do they think it should be done as part of their job but just don't think they know how to do it well?
- Would or could clinicians give up some of what is now done in clinical visits to do MRFI?
- Are we beating a dead horse trying to get doctors to do more? Even if we pay for it?
- Have generalists and specialists splintered because of the need for a systematic approach to care of people with specific chronic diseases that generalists do not have the resources to support?

About the role of public health

- If we know that group counseling works for tobacco and diet, can we set up a public health system for referral? What should be the role of the local public health system in assisting primary care clinicians with multiple behavioral risk factors?
- Should the entire realm of behavior change health be taken out of the physicians office and be given to public health professionals or at least ancillary providers?

About the early and later training of physicians and other providers

- Is there training in behavioral intervention for MRFI such as the 5A's in residency programs? If you show students an effective approach, will they adopt it? The authoritative mentor is the physician. What do we know about faculty development for the 5 A's?

- How do we get curriculum in medical school, residency, nursing, dental, PA, NP programs to address the issues identified in the IOM report *Crossing the Quality Chasm*?
- Is it feasible for the "ordinary" primary care physician to activate and train his or her non-physician office staff to provide preventive services after physician initiation and advice?
- How do you empower professionals to be change-agents in a practice setting?

About primary care overload

- More and more is put on the shoulders of primary care where there is less time and fewer unscheduled resources. Would we do better to focus on specialty providers and systems where people are already engaged in behavior change, e.g. addictions settings, cardiac rehabilitation, rheumatology, or emergency departments?

About infrastructure and "platforms"

- What tools, resources and systems supports do providers most need to have in place to be willing to take on the multiple behavior risks? Most office infrastructures are circa 1960.
- Are there any successful MRFI models to emulate? Who has the infrastructure/skills in your practice setting to execute all of the 5 A's?
- The JCAHO has also asked for pain and domestic violence assessments. More and more assessments overwhelm the system.
- What is the likelihood of electronic medical records (EMR's) in your practice environments?

About health risk assessments and other data collection

- What is the role of health risk assessment in assessing MRFI and integrating follow-up in primary care and other provider settings, e.g. health promotion and community?
- When clinicians say it takes too long to capture data, is it taking the patients too long or the physician, or both. Isn't the time issue solved with self-administered questionnaires?
- How do you respond to a patient who walks in with a health risk appraisal feedback report?

About building a constituency and implementing MRFI

- What would a "health model" look like to patients, providers, systems, payers and policy makers?
- How would you make addressing health risk behaviors a "standard of care"?
- What is the role of patients in the behavior change process?
- We have all the 'true believers' in the collaborative model around the table. What can we learn from those experiences?
- Physicians who are "prevention zealots" seem able to provide counseling services at some level. Is there a way to make all physicians such zealots? What would it take?
- How do you respond to those who don't value MRFI?
- How do you see evidence-based medicine getting together with the imperative for patient-centered care and relationship-based medicine?

About financial models that support MRFI and build a constituency

- Can physicians reallocate resources from the payment system to try MRFI?
- The costs of doing primary care practice mean it is important to look at ROI.
- Money and time are obviously important factors affecting practice. What other important factors like performance measures or incentives are there to do risk factor assessment?
- The discussion of what the clinician needs to be patient-focused is undermined by the payers "pay for performance" strategies.

Questions and comments for Health Systems Panels

About the evidence

- Bring out the body of evidence on the effectiveness of multi-component risk reduction programs in corporate or work-site programs. Talk about cost/effectiveness of alternate approaches.
- Should we be looking at or paying for outcomes vs. process?
- Look at well-implemented primary care based studies with positive outcomes and see if there are commonalities in their intervention processes and components? Can any of the aspects of study implementation be a guide for integration translation?

About building a constituency for implementation

- If managed care is collapsing, a consumer driven system may replace it. How might that affect demand for multiple behavior change programs? What will motivate the consumer to participate in programs and pay for them?
- The public is increasingly turning to alternative medicine for assistance with prevention. They want more than one minute intervention. They want to try new ideas. Does the healthcare industry want to get wellness customers back? If so, how does this service get paid for?
- Is it possible to have shared accountability measurers for providers, payers, public entities to drive collaboration? How do you get all the payers to come together?
- Why not establish "system" level accountabilities for reimbursement eligibility vis a vis information technology, multidisciplinary teams, patient access to resources outside of clinical setting, etc.
- Given the rates of relapse associated with the four major health risk behaviors identified for the payer/health plan representatives, what information do you need from health systems and community linkages that would provide sufficient accountability for results?
- Does the healthcare industry want to address diet and physical activity as interventions to keep people well? Should it, since there is no evidence of effectiveness of interventions other than to link to community resources and public health?
- How do you incentivize and increase accountability for multi-level/multiple risk factor interventions in the type of environment where "the front line" is beaten down?
- Literature on "changing providers' behaviors" needs to be applied to "changing health systems behaviors."

About reimbursement and ROI as part of building a constituency for MRFI

- Say more about medical resistance to the "pay for performance" model? What performance do you propose to pay for? What was perceived as negative? Is it a control issue between specialists and primary care? What incentives do the local medical societies suggest?
- How do payers and others create the incentives and resources to support the infrastructure for integrated systems? What kind of payment system would support MRFI?
- How do we make the business case or communicate the value statement to payers when rates are rising, affordability is decreasing, and the payoff is in the future.
- Is three years the time-frame that employers want to see an ROI? If expenditures are sold as human capital investments, then longer time frames are acceptable (3-5 years). If they are seen as expenses then it may be one year or less.
- Payers generally have no interest in prevention.
- How does payment systems to support integrated prevention systems relate to public health and alternative medicine? What is the patient's role in payment?
- Is there any evidence that an integrated model is more efficient, produces better outcomes, or frees up physician time?

About infrastructure and system design

- If the healthcare system were to take on MRFI, where are the pressure points or leverage points? How would the system be re-tooled and re-integrated? Who has a vision for system-wide change?
- If our primary care system does not support provider counseling for MRFI, should we modify the primary care system or establish a new system to address multiple risk factors?
- Where can providers go for information about systems changes that may help them to provide multiple screening and interventions?
- If we can standardize billing forms and standardize diagnostic, evaluation & management, and procedure codes, why can't we standardize behavior assessment and give it a code and follow-up codes?
- Making MRFI codeable and billable may help document and cover the cost, but we run the risk of "medicalizing" lifestyle issues and having to conform to strict traditional medical models.
- Show examples of ways you have initiated systems supports and changes to allow a more integrated model of care in your settings, how was it supported, where you started, and how someone at a "middle level" (not the top) can initiate change? Does it have to be top-down? Can it be bottom-up?

About technology and MRFI

- How do you connect the patient to new technology?
- Less developed countries are moving directly to cellular phone technology, skipping hard-wired networks. Can we make such technology leaps in managing behavioral health risks?
- If we can solve the HIPAA privacy and security problems, would a satellite-based medical record, practice guideline, interactive knowledge management system help reduce the urban-rural disparities, and large system vs. small practice disparities?

About the role of physicians and other providers

- Is there consensus among panel members that the appropriate role of the physician is to serve as a catalyst? What do we mean by catalyst? Brief advice or counseling? Does the doctor, the most expensively trained and reimbursed professional, need to engage in counseling or should that be done primarily by others?
- Is it reasonable to suggest as a principle that delivery of counseling /treatment for multiple risk factors is best done by the primary care team (physician, nurse practitioner, etc.) but that the impetus for change must, due to the medical culture we have evolved, come initially from the physician?
- Much of the discussion centers on whether or not to have behavioral counseling in primary care or to refer out to other systems. Why not do both? Wouldn't primary care seen as part of the larger system be most effective/cost effective?
- How do behavioral health "carve outs" fit in with MRFI? Or do they?
- Given trends and opportunities, what will be the roll of primary care medicine in 20 years?

About the training and preparation of physicians and other providers

- One of the clinician concerns when you ask a question is whether you are prepared to deal with the answer. Do you have the resources to address it? If not, what resources do you need?
- Do physicians have the competence to actively deal with behavior change discussions? What in their training demonstrates this competence? How can training be enhanced?

Questions and comments for Health Policy Panels

About selecting the right policy questions and approaches

- The fundamental questions around MRFI implementation in primary care has very little to do with government or national policy. The only policy areas relevant have to do with research funding for studies of MRFI and regional or national payment policies that provide an incentive to address outcomes. Otherwise this is an implementation issue, not a policy issue.
- Because of the healthcare crisis, do you think policy makers will give very little priority to something like restructuring health care around prevention? Is this putting new awnings on the burning house?
- Is the policy issue getting policy makers on board with supporting assessment of multiple risk factors? Or are the policy issues really centered on the lack reimbursement and system support for primary care providers to be involved in/prevention and delivery system change?
- A great tragedy in the tobacco settlement and distribution is that it pitted the health prevention interests against each other in vying for funds. How do we prevent that from happening here?
- A health model is needed. The medical model needs to be replaced for population and public health.

About specific policy directions

- How can we counter the metastasis of sugar and fat in school lunches and snacks which provide profit for large corporations?
- Health policy issues should focus on reforming the delivery system to provide support to clinicians to be more effective with prevention and chronic care management.
- What would be required to change policies for reimbursement of care coordination or risk management services?
- How would you view bringing to the AMA or other groups that reach into medical care the importance of personal choices and right to live in communities that support healthy living environments, e.g., second hand smoke?
- Have Congress redefine language in Medicare (nothing about prevention in here.)

About the evidence, making the case, and "marketing" MRFI

- What do we need to do to show that MRF reduction improves outcomes?
- The impact of personal stories/experiences is sometimes bigger than researchers' evidence in passing legislation. To what degree should "stories" (personal vignettes) be included in evidence reports?
- How do we get the powerful influence of 'Madison Avenue' on our side?
- What evidence would prove "the sky is falling"? Epidemic of obesity? Diabetes rates?
- If marketing is key to shaping policy, policy changes systems, and systems change practice, who will market this issue?
- How do we increase national recognition and dissemination of "centers of excellence" for prevention?

About creating a demand and constituency for MRFI

- With multiple risks there is huge need but not a big demand. Yet marketers can generate demand for products for which there is no need. How can social marketing produce demand given the need?
- What are, if any, the common benefits and value added factors that can ensure that multiple single-focused advocates and stakeholders are aligned to promote multiple risk-factor interventions?
- If we build a better mouse trap, will the policy makers beat a path to our door?
- Will national policies and incentives to implement multiple risk behavior interventions be able to overcome local organizational or cultural barriers?
- How do you get Medicare engaged and involved in this process and pay for prevention?

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