Overcoming Barriers to Preventive Care

Three articles in this issue describe strategies intended to improve provider adherence to preventive care guidelines. Batal et al.¹ demonstrate that guideline-recommended Pap smears can be provided in an urgent care setting when a pelvic exam was already being done for an acute problem. This strategy significantly enhanced the rate of Pap smears in the population of women who came to the urgent care center. How much this would increase the population-based rate of Pap smears in a managed care organization would depend on what proportion of Pap-requiring women from among that organization's "covered lives" came to an urgent care clinic for acute problems requiring a pelvic exam in a 2-year period. If the proportion was high, this strategy offers a welcome way to enable patients unaware of the importance of a Pap smear or those who don't keep appointments to get a Pap smear. If so, primary care providers and managed care organizations could improve their adherence to guidelines by employing such a strategy.

Etter et al.² describe the failure of mailing "smoker" stickers to private practitioners to improve the rate of smokers counseled to quit. The stickers were designed to be applied to records to improve identification of patients who need counseling or referral. The authors report that the intervention had worked earlier in an academic teaching practice, in which individual physicians didn't need to decide to implement it since the intervention wasn't required and nurses applied the stickers to records.

Craig et al.³ demonstrate that nonfasting results are useful for cholesterol screening, enhancing provider and patient ability to comply with guidelines by eliminating the need for the patient to come back for a separate blood test. This strategy might lead to increased screening rates by removing a barrier to patients. Although the study did not measure how much the rate of screening would be increased, it seems reasonable to conclude that a yield of equally valid results without requiring patients to return will reduce costs to patients and improve their satisfaction.

To choose interventions to improve guideline adherence and to understand whether they will succeed or fail in specific settings, it is useful to consider which types of barriers are prevalent and which barriers each intervention does or does not overcome. As primary care providers, barriers to our adherence fall into the three general areas of awareness, agreement, and ability.⁴ In turn, features of our practices and organizations, our patients and their communities can affect barriers in each of these areas. Which barriers to guideline-adherent preventive care are most prominent and how are these barriers to each intervention overcome?

In a recent review, 85 to 95% of primary care practitioners demonstrated awareness of Pap smear, smoking cessation, and cholesterol screening recommendations, if not specific guidelines delineating them.⁴ Provider agreement, however, varies depending on which preventive care

guidelines are considered. There is widespread agreement that Pap smears are useful for sexually active women. However, for smoking cessation counseling, there are significant attitudinal barriers that limit agreement with guidelines, especially in countries with higher smoking rates among physicians than the United States. Physicians who smoke are less likely to counsel smoking cessation or to refer patients to smoking cessation programs.⁵ Even more widespread is the perception that counseling and smoking cessation programs are ineffective, or have "poor outcome expectancy," and the corollary belief that practitioners waste time and energy when they counsel or refer. In a recent focus group of pediatricians at the American Academy of Pediatrics (discussing barriers to counseling parents of asthmatic children to quit smoking), one person reportedly commented that trying to get a North Carolinian to stop smoking is like trying to teach a pig to play a musical instrument as it merely annoys both you and the pig.⁶ Although interventions that would improve the national smoking cessation rate from even 3% to 5% would save many lives, physicians may not notice such a small change in their own practices and feel that interventions are ineffective. Thus, when physicians do not agree with smoking cessation guidelines, enabling interventions will fail, as Etter et al. demonstrated,² even if they worked in settings where physician agreement was less at issue. Before instituting or testing enabling measures like stickers or their high-tech equivalents (e.g., flags or prompts embedded in electronic records), it is helpful first to check on whether clinicians agree with a guideline, and if not, intervene to improve agreement instead or as well.

Barriers to cholesterol screening and Pap smears, for which both awareness and agreement are high, fall mostly into the realm of provider ability to do them. These barriers also reduce adherence to smoking cessation guidelines for physicians who are aware of and agree with recommendations. Such barriers include provider self-efficacy, skill levels, inertia, organization or practice environmental factors, and patient-based barriers. Providers' self-perceived skills play a role in all types of counseling aimed at sustained patient behavior change, including smoking cessation, diet, and exercise. Organizational barriers to provider ability include: scheduling and staffing policies creating large patient panels with inadequate time to attend to both acute and preventive care problems; absence of dedicated support staff, nurses, or specialized clinic days or sessions to schedule or provide preventive care interventions; absence of prompts or flags identifying patients who need specific preventive care interventions; and the absence of insurance or health plan coverage for preventive care. Patient factors may include: lack of understanding of the importance of specific preventive care interventions; lack of agreement that the interventions are important; dislike of certain interventions

such as pelvic exams; lack of reminders from the practice or organization; or competing priorities for their time and money.

The interventions described by all three studies in this issue focus on enabling providers to adhere to preventive care guidelines. However, they vary in their attention to provider, organizational, and patient factors affecting ability to adhere. Measuring nonfasting cholesterol mainly targets the patient barrier to returning for an additional blood test and would not address issues related to provider self-efficacy, or organizational issues affecting provider time or attention. Smoking stickers help to overcome the well-intentioned physician's lack of attention to preventive care due to a focus on chronic or acute problems, by helping clinicians recognize patients eligible for referral or counseling. Again, they would not address organizational factors that might influence provider time for referral or counseling, coverage or insurance for smoking cessation programs, or organizational barriers to putting smoking stickers on records in the first place.

For cervical cancer screening, performance of Pap smears in an urgent care setting overcomes patient and provider barriers for the segment of the population that comes in for acute treatment and needs a pelvic exam for other reasons. Hiring a dedicated nurse or physician's assistant to schedule and provide Pap smears may be more broadly applicable than doing Pap smears in urgent care. It does not depend on women presenting with an acute complaint requiring a pelvic exam, and would enhance provider ability to adhere for all women.

However, Pap screening during urgent care visits is unique among the three interventions noted because it addresses several organizational barriers. Coupling Pap smear and pelvic exam in one acute care setting only requires training of a few urgent care providers. Having a universal policy of doing Paps during acute visits eliminates the need for reminders. Coverage and administrative cost concerns are minimized by the small marginal added cost of a Pap smear when the visit and pelvic exam are already being done for other reasons. Hiring a nurse or physician's assistant would cost the provider organization more time and resources than the marginal added cost of including a Pap in a visit and a pelvic exam that are already occurring. The urgent care intervention is more feasible administratively although it may reach fewer women.

Effective interventions that enhance provider ability through increased staffing must overcome significant organizational barriers. Investigators can assist in overcoming by evaluating their relative cost-effectiveness considering both short and long term costs to and savings by payers, organizations, and the society at large.

Organizational barriers and facilitators of adherence to guidelines are often invisible to physicians. At the organizational level, what provides incentives and disincentives for enabling providers to deliver good preventive

care? It is instructive to look at the urgent-care based Pap smear as an example. Many years ago, hospitals with significant proportions of indigent care initiated programs to provide Pap smears during hospital stays because patients in these communities often did not show up for primary care visits. With the advent of DRG-based prospective payment for hospital care, many such programs were eliminated as hospitals attempted to cut costs and to reduce hospital stays under fixed payments. The urgent-care based Pap smear is a cost-effective alternative for administrators of provider group practices or managed care organizations that already have urgent care centers. What has enabled this alternative? Financial and organizational incentives to reduce costs under managed care may have promoted creation of more urgent care clinics or centers rather than emergency departments for less serious but still acute problems. These financial incentives under managed care have also stimulated creative thinking about how to provide acute and preventive care cost-effectively. In addition, quality monitoring now motivates organizations to reconsider providing preventive care in urgent, emergent, or inpatient settings. Public concern about quality under managed care has supported the National Committee on Quality Assurance (NCQA) efforts to create fledgling quality measures for HMOs that included Pap smear rates.⁷ Pap smear rates are fed back to managed care organization administrators and there is pressure for administrators to release them to the public, although not all do. In turn, payment systems requiring claims or encounter data make it easier for organizations to obtain Pap smear rates and thus make it feasible for NCQA to mandate it as a quality measure. In contrast, measures of adherence to preventive or chronic care guidelines that require new clinical data collection or patient surveys, such as examination of referral rates to smoking cessation, are relatively scarce.

Thus, to enhance our own preventive care rates, we must lobby for and otherwise promote additional legislation, public awareness, and quality monitoring efforts that will motivate our organizational administrators to spend money on cost-effective ways of making sure patients get preventive care consistent with guidelines. Investigators in this area should not only describe the effectiveness of a strategy but also its cost-effectiveness relative to other strategies counting both direct and indirect costs to the organization.

Because different barriers are present in different settings, those choosing, designing, and evaluating the impact of interventions to improve preventive care or other aspects of clinical practice should measure specific barriers, tailor interventions to them, and evaluate whether the interventions have removed the barriers they were designed to address. In addition, concerted interventions will be needed at all levels of organization, provider, and community to overcome existing barriers to preventive care. Only then will we improve our ability to implement

preventive care and other practice guidelines and thus improve patient outcomes.—**HAYA R. RUBIN, MD, PhD,**
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