Policy Strategies for Better Integration of Education and Counseling Primary Care
Policy Strategies for Better Integration of Education and Counseling in Primary Care

One of the signature goals of the Patient Protection and Affordable Care Act (ACA) is to transform the U.S. health care system from a focus on treating the sick to a focus on keeping people healthy. An integral part of this emphasis on prevention is the requirement that all new health plans cover a defined set of preventive services without cost-sharing. Among the requirements are a set of preventive services specific to women’s health needs, including a well-woman visit. National guidelines call for education and counseling as important components of this visit, along with medical history, physical exam, age appropriate screenings, clinical tests and behavioral risk assessments.\(^1,2\)

Although there is ample evidence that providing education and counseling during routine visits improves health outcomes and is cost effective, it is not always a routine part of preventive care. The well-woman visit provides an important opportunity to improve the delivery of these services, but a number of systemic barriers remain. This paper explores those barriers and discusses policy approaches that could help ensure that education and counseling services are successfully integrated into women’s primary care.

Background: The Importance of Education and Counseling

Many of the most common causes of disease, disability and death for women in the United States are directly attributed to health risk behaviors, such as smoking tobacco, the use of alcohol or other substances, unhealthy diet, physical inactivity and other factors such as interpersonal violence and sexual assault.\(^3,4\) Behavioral counseling has proven to be effective in modifying behavior and subsequently reducing the risk of developing certain chronic illnesses.

Clinician advice targeted at lifestyle habits is associated with increased patients’ efforts to change behavior.\(^5,6\) For women, in particular, a “priming effect” results in patients being more attuned to additional information that is consistent with recommendations they have already heard from their provider.\(^7\) In addition, patient education has been shown to increase the uptake of healthy behaviors, improve medication compliance and assist with disease management.\(^8,9,10\)

Research has demonstrated that evidence-based preventive services, including education and counseling, can improve population health and quality of life, often at little cost, and should be a key element of health improvement strategies.\(^11,12,13\) Researchers have estimated that the increased use of twenty preventive services, including immunizations, screenings and counseling, would avert the loss of more than 2 million life-years annually, and, compared to 2006 utilization of these services, could save $3.7 billion.\(^14\) Most of the leading factors related to health disability in the US (including dietary risks, tobacco smoking, high body mass index, high blood pressure, high fasting plasma glucose, physical activity and alcohol use\(^15\)) can be addressed by education and counseling interventions.\(^16\)

Barriers to Education and Counseling

Although education and counseling is an important part of women’s health care, it is not yet a routine part of women’s health care. According to recent data, 81.5 percent of obstetricians/gynecologists (OBGYNs) and 73.5 percent of other primary care providers (PCPs) are not counseling their patients on obesity, exercise, diet, or tobacco use.\(^17\) Similarly, women report low rates of education and counseling services during their doctors’ visits. For example, only 31 percent of women report receiving counseling on alcohol and drug use and only 41 percent report discussing their mental health with their provider in the past year. Many documented barriers can hinder the integration and implementation of education and counseling in primary care settings, and thus account for such low numbers. These barriers fall into five major categories: time, reimbursement rates, patient perceptions, provider perceptions, and lack of training.

Time

Many PCPs struggle with lack of time when integrating counseling more fully into their practice. In fact, researchers from Duke University Medical Center found that
comprehensively providing all of the USPSTF-recommended preventive services to an average patient panel would take more than seven hours of the working day and over 1,700 hours annually.\textsuperscript{18} Having enough time with a patient is essential to providing effective preventive care, but many providers perceive time as a constraint to offering such care, particularly because brief counseling services are not separately reimbursed.\textsuperscript{19} Time constraints of the patient are another important barrier to consider when discussing education and counseling. Difficulty taking time off of work or an expectation of long wait times prevents some patients from even scheduling a well-woman visit with their provider.\textsuperscript{20}

Reimbursement
Reimbursement rates also may be a disincentive to providing education and counseling services. Many payers do not have any formal coverage policies for counseling services. In 2006, the American Society of Clinical Oncology found reimbursement to be a major barrier to the delivery of preventive cancer education. Preventive counseling was typically only reimbursed for patients with a precancerous condition or personal or family history of cancer.\textsuperscript{21} Additionally, reimbursement policies may make it harder for practices to effectively utilize mid-level providers and other non-traditional providers such as social workers and behavioral change specialists who play an important role in the delivery of education and counseling services, but who are not separately reimbursed for these services.

Patient Perceptions
Patients may not be inclined to ask for advice from their provider, even when they want to. Qualitative research has shown that patients want preventive counseling during preventive health visits, but perceive a number of barriers to asking for and receiving advice.\textsuperscript{22,23} Studies have confirmed that patients expect their providers to educate them on key behaviors including diet, exercise, and substance abuse, but may be hesitant to bring these counseling topics up themselves.\textsuperscript{24} As a result, providers may believe that there is low demand for behavioral counseling because patients may not think to ask for information on these topics, or are uncomfortable or ambivalent about requesting information on ways to improve their own health.\textsuperscript{25}

Provider perceptions
Providers’ perceptions of certain conditions as well as their perception of patients’ willingness to change may influence whether or not they provide education and counseling. According to several studies, providers often believe that behavior change is predicated on the patient’s willingness to change. In many cases, providers viewed patients as either compliant or noncompliant but did not consider issues that impacted patients’ ability to change their behavior, such as self-efficacy or personal resources.\textsuperscript{26} Providers also believed that their recommendations lacked the power to motivate the patient to change behaviors.\textsuperscript{27} These beliefs reinforce the perception of low demand for preventive counseling: patients are looking to their provider to counsel them on behavior change but providers believe patients need to express a willingness to change their behavior in order for providers’ recommendations to be effective.

Lack of effective interventions and training
In addition, some providers do not have confidence in the effectiveness of available education and counseling interventions. For example, qualitative studies of barriers to interpersonal violence (IPV) screening find that providers’ greatest concern is a lack of effective interventions for patients after they had been screened for IPV.\textsuperscript{28} Specifically, physicians described feelings of “powerlessness” in knowing how to direct patients experiencing IPV to other services or their own ability to “fix” the problem. Related to inadequate training, providers believed their inability to address IPV stemmed, in part, from their own lack of education on the issue.\textsuperscript{29} In other areas significant to women’s health, such as sexual health counseling, medical and nursing students are often taught how to initiate a topic but not how to effectively continue the conversation.\textsuperscript{30} In addition, less than one in five OB-GYN residents receive training in menopause medicine, which leaves them without the tools they need to educate patients about this life transition.\textsuperscript{31}

Policy Strategies
These systemic barriers to the increased use of education and counseling services require broad-based solutions – while individual physicians may use effective counseling techniques, and practices may reorganize to improve the availability of these services, these barriers will remain an impediment to the increased delivery of education and counseling. Strategies that address long-standing problems in our health care delivery system, such as better integration of care, increased use of mid-level health professionals, and payment reforms, would also improve the availability of education and counseling in primary care.
Integrate alternative care models in clinical settings serving predominantly low-income, minority women

Alternative care models, such as group prenatal care, have been found to improve education and counseling for women. These approaches can be applied to the well-woman visit, particularly for women who lack a regular source of care and are therefore significantly less likely to receive preventive and counseling services. The CenteringPregnancy (CP) model, which emphasizes health assessment, education, and support through group prenatal care, has served as a health system entry point for diverse groups, including low-income Latinas, adolescents, and Black women. Participants in CP pilot programs have increased health care utilization during pregnancy and the postpartum period, resulting in improved perinatal health outcomes.

The patient-centered medical home (PCMH) is another delivery system reform that offers new opportunities for specialized populations – particularly individuals with chronic illness – to receive education and counseling services in primary care settings that engage them in better managing their health. Care coordination is a particularly important element of PCMH for women. In fact, women benefit from the medical home’s assistance navigating the health care system: they remain integrated in care, are more likely to form trusting relationships with a provider, and utilize education and counseling services.

Enhance counseling instruction during clinical training and offer continuing education opportunities

Inadequate physician training and knowledge and physician attitudes towards the efficacy of education and counseling should be addressed beginning in medical school and throughout a medical career. Physicians consistently report lacking sufficient training to offer their patients motivational and educational counseling services. Not surprisingly, health professionals who receive specific, extensive, training on utilizing behavioral counseling in patient visits are more likely to provide this counseling. For example, physicians who learn about obesity counseling in school or during residency are more likely to discuss diet and exercise with their obese patients compared to those who did not receive training – and are more likely to report success in their weight counseling efforts. Overall, evidence suggests that providers who are extensively trained are more likely to educate and counsel their patients, which is related to improved patient health outcomes. In addition to emphasizing training for medical students and young professionals, continuing medical education credits for skill-building workshops on the core principles of evidence-based counseling may be helpful for mid-career professionals, particularly on women’s health issues and USPSTF-recommended preventive health services.

Case Study: Group Prenatal Care

Ludlow Street Newark Community Health Center in Newark, New Jersey began its Centering Pregnancy group prenatal care program in 2009. Over the course of 10 visits, led by a midwife, women record and report their own vital signs and then share their experiences in a facilitated group discussion. All of the women in the group sessions live at or below the poverty line, putting them at increased risk for pre-term births and low-birth weight babies. But in 2013, none of the women participating in the Centering Pregnancy program delivered preterm and nearly all had babies who were healthy weights.

Case Study: Domestic Violence Training

Continuing Medical Education courses can be effective way of providing physicians with more training inpatient education and counseling. For example, a study of California physicians who took a “Respond to Domestic Violence” online course found that the course significantly increased providers’ understanding and awareness of interpersonal violence issues. Nearly 80 percent of course participants said they would make practice changes for handling suspected interpersonal violence. On physician responded, “I thought I was aware of the general problem of IPV, but this course startled me with how much I am likely overlooking. I’ve already asked my office manager to set up an in-service for my office staff.”
Reform scope-of-practice laws

The core principles of the ACA include provision of preventive care and improved health system quality and efficiency. Mid-level practitioners (i.e., advanced practice nurses and physician assistants) are more likely to provide education and counseling services than physicians, and can thus help fulfill these objectives of the ACA. However, scope-of-practice (SOP) laws limit the effective use of the current and projected workforce. Reforming state SOP laws may help to combat inefficiencies, particularly in underserved regions. Currently, 32 states require physician involvement to diagnose, treat, or prescribe medication, with 7 of these states requiring physician oversight only for nurse practitioners’ prescribing authority. Mid-level providers are highly accepted by the majority of U.S. consumers and achieve health outcomes and quality measures equivalent to those of physicians. Improving mid-level provider’s autonomy may prove an important component of improving women’s health, and promoting education and counseling.

Broaden payers’ definitions of ‘primary care providers’ to include mid-level providers

Payers can determine which services mid-level providers are paid for, reimbursement rates, whether they are paid directly, and whether they can be designated as primary care providers and assigned their own patient panels. Stricter SOP laws are usually correlated with the level of autonomy granted to mid-level providers through public and private payers, but payers often impose additional restrictions. For example, in Arkansas and Indiana, state law restricts nurse practitioners (NPs) from practicing independently of physicians, even though they may provide essential services to their patients. In these states, Medicaid does not recognize NPs as primary care providers, and on these grounds, will not reimburse preventive services performed by NPs. In addition, many commercial health plans will not directly pay for primary care services provided by NPs. By including mid-levels in the definition of “primary care provider,” the scope and settings in which they practice can be broadened. Payer policy reforms may facilitate women receiving the care that they need, as mid-level providers are more likely to educate and counsel during the well-woman visit and work in underserved settings.

Restructure payer policies

While differing reimbursement levels do not drive providers’ willingness to counsel patients and the amount of time they spend counseling, the reimbursement structure itself does make a difference. For example, studies found no significant difference in the average length of a visit or the likelihood of patients receiving preventive health counseling when comparing safety net patients to those with private insurance. However, physicians who receive capitated or salary-based payments are more flexible in their allocation of time and have greater motivation to offer counseling on a larger number of patient health concerns than those who are reimbursed on a fee-for-service basis. Alternatively, separate payment for education and counseling services would provide greater flexibility and accountability for providing education and counseling for health care providers who are reimbursed on a fee-for-service basis.

Supplement behavioral change specialists on well-woman visit teams

Integrating behavioral health services in well-woman care helps target the underlying cause of 70 percent of primary care visits. Many primary care providers report being ill-equipped or lacking the time to address the wide range of psychosocial issues that patients present. Research suggests that primary care providers can facilitate behavioral health care. Integrated care can enhance access to this important service by making it more readily available, less stigmatized, more community-centered, and cost-effective. One promising model of integrated care includes a trained behavioral health specialist within women’s health care teams to provide education and counseling services. Behavioral health specialists are typically trained at the Master’s degree level and are qualified to treat a range of conditions commonly found in the primary care setting (e.g., depression, anxiety, relationship problems, and insomnia). Behavioral health specialists have been found to increase efficiency, increase patient and provider satisfaction, and improve co-morbid physical and mental health conditions. Co-locating, which removes geographic distance between a behavioral health specialist and the well-woman care team and improves daily interaction, increases the likelihood that women will receive education and counseling. Medicaid’s system of prospective, cost-based payment for health centers supports funding of this model.
Diabetes Educators

Education is an important part of diabetes management, but this kind of intensive education is time consuming for providers and often requires a referral for specialized outpatient education. To address these barriers, the University of Pittsburgh Diabetes Institute implemented the Chronic Care Model in several rural Pennsylvania primary care practices. This model places certified diabetes educators (CDEs) in the practices on specified days. The CDEs rotate among the 17 participating practices and provide diabetes self-management education (DSME) to patients as the point of service, so they do not require a referral outside the practice. Individuals who received the DSME saw decreases in their A1C levels as well as their LDL cholesterol levels.57

Conclusion

Patient education and counseling is an important but often underused aspect of well-woman care. Barriers such as time constraints, payment mechanisms, and patient and provider perceptions often impede the delivery of these services, but there are a number of policy solutions and other systemic approaches that could better integrate education and counseling into women’s primary care. Policies that make it easier for practices to utilize mid-level providers, rely on specialized staff such as certified educators and social workers, and spend more time with patients increase the chance that education and counseling will be delivered effectively. In addition, strategies that provide health care professionals with greater expertise and counseling skills or promote alternative delivery systems that make education and counseling a central component of their patient engagement emphasis can improve access to key education and counseling services. These changes could lead to great improvements in women’s health, which should be a key consideration for policymakers as our health care system continues its movement towards preventing disease and disability and lowering costs.
