Facilitating the integration of prevention in primary care: a work in progress

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In this issue (page 757) we have the opportunity to read the results of a randomized controlled trial involving 46 Ontario health service organizations that evaluated a multifaceted intervention delivered by nurses trained in prevention facilitation to improve prevention in primary care.[1] For this reason alone, Jacques Lemelin and colleagues are to be congratulated. The initiative is all the more interesting given that the statistically significant results favour the intervention. The carefully done study follows in the tradition of the practice facilitator method, which, as it is applied, integrates the principles of behaviour modification and quality-assurance management among professionals.

However, although the results are statistically significant, they are quite modest and their clinical significance slight. In the intervention group of 23 practices, the overall preventive performance index (calculated as the proportion of eligible patients who received 8 recommended preventive manoeuvres less the proportion of eligible patients who received 5 inappropriate preventive manoeuvres) increased from 31.9% to 43.2%, a dissapointing absolute improvement of 11.5%. The preventive performance index for the 23 control practices remained unchanged. Certainly, any improvement in preventive behaviour by physicians is desirable and likely to lead to non-negligible effects on the scale of entire populations, but do we need to deploy such extensive means? The authors' use of specially trained nurse facilitators is undoubtedly costly, both in terms of time and money. In fact, comparable rates of effectiveness in the field of prevention have been reported with much less complex and costly interventions.[2,3]

Yet, the concept of the practice facilitator is appealing. In fact, the difficulty of introducing organizational changes in health care environments without intensive support of the change process has been established.[4,5] Unfortunately, although the results reported by Lemelin and colleagues should be catalysts for reflection on the concept, they may discourage decision-makers who are faced with the reform of primary care across Canada. There is a risk of "throwing the baby out with the bath water," so to speak.

The modest results reported by the authors should raise 2 fundamental questions. Are we using the concept of the facilitator to its full extent? Are we selecting the most meaningful outcomes? Perhaps the time has come to revisit the concept. After all, the first studies published within the framework of the Oxford Facilitator Project are over 15 years old.[6] It seems that the concept, as it is applied in its current form, has peaked in terms of effectiveness, if we are to judge from the results obtained elsewhere that are referred to by Lemelin and colleagues.

Upon reading their article, it is difficult to identify the paths to follow to improve the method. The authors have yet to publish data on the costs associated with the intervention, nor do they provide information on its acceptability by health care professionals. What is in the "black box"? Why was the difference between the 2 groups so small? Did certain players mount some resistance to the facilitators' work? Were there local champions behind changes made or the organization of specific activities in sample practices? Is a nurse the best facilitator for more "medical" (high blood pressure) or perhaps controversial (prostate cancer screening) interventions? Must the practice facilitator be an eternal "visitor," who is never fully integrated into the medical team and is interested solely in one issue? For example, McBride and colleagues[7] obtained a much larger effect than that reported to date by training a member of the team chosen by the group to be the facilitator; that person continued to assume his or her role on the team.

Indeed, we have little perspective on the facilitator method, since it has been assessed solely (or almost solely) in the field of prevention — a field that, although important, represents only a portion of the daily work performed by family physicians, especially where primary prevention is concerned. Furthermore, the physician is often the main target of the intervention. In terms of prevention, would it not be more effective and more efficient to integrate into the physician's team nurses who are capable of assuming this role in an autonomous manner?[8]

Bringing about change in primary care is exceedingly complex and requires careful development and support if it is to succeed.[9] It is time to refine the concept of the facilitator and to apply it to a different paradigm, dedicated to a genuine integration of preventive and curative care in a pri-

mary care team. The added value may be found in better integration of care (improved use of the different types of professional expertise within the primary care team), which will result in improved control of chronic diseases and greater continuity of care.

The primary care reform under way should give rise to demonstration projects that will give us the opportunity to verify these hypotheses. Lemelin and colleagues' study represents a foundation upon which we must build. Of course, research on this type of intervention will be difficult to conduct, since, to be truly useful, it will have to break away from the framework of the traditional randomized trial to focus as much on the results as on the content of the "black box." Participatory research techniques will be needed, because researchers will have to invent the model in the field, and they will be able to do so only if clinicians are invited to participate in this "work in progress."

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