# The *Guide to Community Preventive Services* Will Be Influential in Academic Health Centers: Education, Research and Links with Practice

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"Evidence-based practice" is a term that is taking hold in medicine. When lay people hear that we intend to base our practice on evidence, they often express surprise and ask, "Well, what have you been doing up to now?" In both clinical medicine and public health, we have generally built programs and given services and advice based on individual judgments or professional consensus. We have lacked an educational commitment, a knowledge base and a practice ethic solidly grounded in research and evaluation. We have acted upon assertions, instead of rigorously-reviewed, evidence-based guidance about quality, effectiveness, cultural sensitivities and efficiency, let alone cost-effectiveness. And we have been oblivious to the heterogeneity of populations in causes of common illnesses, relevant risk factors, readiness to change behaviors or accept medical or public health interventions and financial and other practical resources to gain access to services and follow-up assessments.

During the past 20 years, the U.S. Public Health Service and the academic and practice communities in public health and preventive medicine have made important strides in overcoming this legacy. The overview article[1] of this valuable series of papers from the Task Force on Community Preventive Services makes clear that the *Guide to Community Preventive Services* is the public health companion to the *Guide to Clinical Preventive Services*.[2] The Clinical Guide is now in its third generation, and well established as a credible and useful instrument. Its content is, or should be, taught in all health profession schools. Many faculty and students are engaged in research and evaluation studies to update the underlying knowledge base for its three categories of immunizations, counseling services and screening tests. The link to the *Guide to Community Preventive Services* is clear: all of these categories of services are directed not just to individuals, but to populations of individuals, and all need coherent, effective programs on a population basis.

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The model of the Clinical Guide is important for another reason. Its findings are up for review as new knowledge is presented, and its recommendations are intended to stimulate research and evaluation that challenge those recommendations or refine them. These responses require a concerted effort from the academic community, and interest and uptake from our practice colleagues. The *American Journal of Preventive Medicine*, the *American Journal of Public Health*, the *Journal of the American Medical Association*, the *Annual Review of Public Health* and other journals have provided communication channels for the guidelines movement and for the companion training concept of core competencies.

There are other significant antecedents for the new Guide. Beginning with the Surgeon General's Report on Health Promotion and Disease Prevention in 1979,[3] we have had a sustained, influential effort to establish measurable goals and objectives under the banner of *Healthy People 2000*,[4] and now *Healthy People 2010*.[5] The Department of Health and Human Services (DHHS), Office on Disease Prevention and Health Promotion (ODPHP), led most of that time by Michael McGinnis, organized a public/private effort, with distinct emphases in various states and communities, and with support and articulation of the goals by each DHHS Secretary and Assistant Secretary for Health. The Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and other Public Health Service (PHS) agencies ensured the engagement of academics in the pursuit of Healthy People objectives by requiring specific citation of relevant objectives in appropriate research and training proposals for competitive funding. The decision of the Community Guide Task Force to utilize the McGinnis-Foege framework[6] for preventable causes of death properly emphasizes social and behavioral causal factors in health promotion, rather than disease endpoints.

Academic public health has played a complementary leadership role. Several deans of schools of public health were instrumental in gaining the Congressional mandate in 1984 for the program of Prevention Research Centers. Begun in 1986 by the CDC with just three schools of public health (North Carolina, Texas,



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and Washington), this program has expanded to nearly 20 schools of public health and a few schools of medicine, and engages faculty and students from additional health sciences schools at those institutions. Academics responded constructively to the 1988 report from the Institute of Medicine on the Future of Public Health, in which Richard Remington, Lester Breslow, and their colleagues described the "disarray" of public health in this country.[7] The Association of Schools of Public Health (ASPH), led by its executive director, Michael Gemmell, and several successive presidents, reached out to the Association of State and Territorial Health Officers, the National Association of City and County Health Officers, the Association of Teachers of Preventive Medicine and several other professional organizations (APHA, AMA, AAMC), federal agencies and foundations to form the Council on Linkages between Academic Public Health and Public Health Practice. Many schools established or enhanced programs collaborating with colleagues in practice and in other health profession fields. Faculty from various institutions also played significant roles in developing and updating community model standards[8] and in evidence-based practice centers of the Agency for Health Care Policy and Research (AHCPR). In 1997, the Robert Wood Johnson and W.K. Kellogg Foundations jointly launched Turning Point: Collaborating for a New Century in Public Health, now active in 21 states, bringing together public health, medicine, business, labor, environmental groups, agricultural and nonprofit organizations to enhance the infrastructure and the effectiveness of the public health/preventive medicine mission.[9]

International antecedents are important, too. The Lalonde Report[10] and the Canadian Task Force on the Periodic Health Examination[11] were key inputs for Healthy People and the Clinical Guide. British epidemiologist Archie Cochrane described the overwhelming, unmanageable amounts of information confronting health care professionals, consumers, researchers and policymakers, and encouraged systematic reviews of randomized controlled trials to organize evidence.[12] The Cochrane Collaboration is now active in 13 countries, including centers at Tufts, San Antonio, and University of California-San Francisco in the United States. In this era of the Internet and CD-ROM, the outputs of more than 40 review groups are widely available.[13] The Internet is the medium for a rapidly growing educational network organized by Ronald Laporte of the University of Pittsburgh School of Public Health, with course syllabi submitted by dozens of faculty to more than 700 participants in 80 countries.[14]

In developing and implementing the new Guide, it will be important to engage a broad cross-section of people in communities across the nation, as recommended by the Presidential/Congressional Commission on Risk Assessment and Risk Management for putting environmental hazards into public health context,[15] one of the three explicit categories of responsibility of the new Guide (see Zaza et al., page 27[16]). Principles and guidelines for community-based research—like those implemented at the University of Washington[17] in which we treat community organizations and individuals as true partners in the design, conduct and interpretation of studies, will facilitate real-world tests of our ideas and guidelines for community preventive services. Performance standards and cost-effectiveness analyses will be expected by all payers and by policymakers.[18] Scientific advances, especially in the emerging field of public health genetics,[19,20] need to be incorporated. And organized behavioral studies on why practitioners use or do not use guidelines will be crucial.

Many physicians who decried "cookbook medicine" have recognized that even master chefs use recipes and are accommodating themselves to physician profiling. Local review and endorsement of nationally credible guidelines can be useful.[21] At the University of Michigan Health System and Faculty Group Practice we have surveyed 191 primary care physicians for feedback on awareness, perceived usefulness, presentation and access to 15 guidelines adopted internally; scores were considered highly supportive, but we have plenty of room for improvement.

Practice variation without justification is a major criticism from employers and payers, as well as academics. Practitioners and payers risk conflict over the question of whether practice guidelines are intended to stimulate and measure improvement, or are intended to judge performance and determine payment. We believe the first is essential and the second is inevitable! Moreover, there is a problem of "dueling guidelines" and "guidelines fatigue" in the primary care clinical area which we should work to prevent in community guidelines. More than 200 guidelines have been promulgated by various organizations for the practice of primary care medicine. The cacophony and inefficiency can be illustrated by the observation that a single practitioner must comply with differences among four guidelines from different payers for routine care of asthma patients, in order to be paid by each.

Academics, practitioners, and employers should join forces to persuade payers to accept evidence-based convergence of related clinical guidelines. The same challenge should be taken up by community coalitions of the kind being developed by Turning Point and by all of us committed to productive collaborations between medicine and public health.[22,23] Such a coherent and credible process will improve the chances for increased investment in preventive medicine and public health.

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