Executive Summary

Person-Centered Preventive Healthcare: Gathering Stakeholder Input on Evidence and Implementation

AHRQ
Agency for Healthcare Research and Quality

This document is a stand-alone executive summary of the *Person-Centered Preventive Healthcare: Gathering Stakeholder Input on Evidence and Implementation* Full Report. Prepared for AHRQ by RTI International, The Ohio State University, Kaiser Permanente Center for Health Research, and Johns Hopkins University, 2023.

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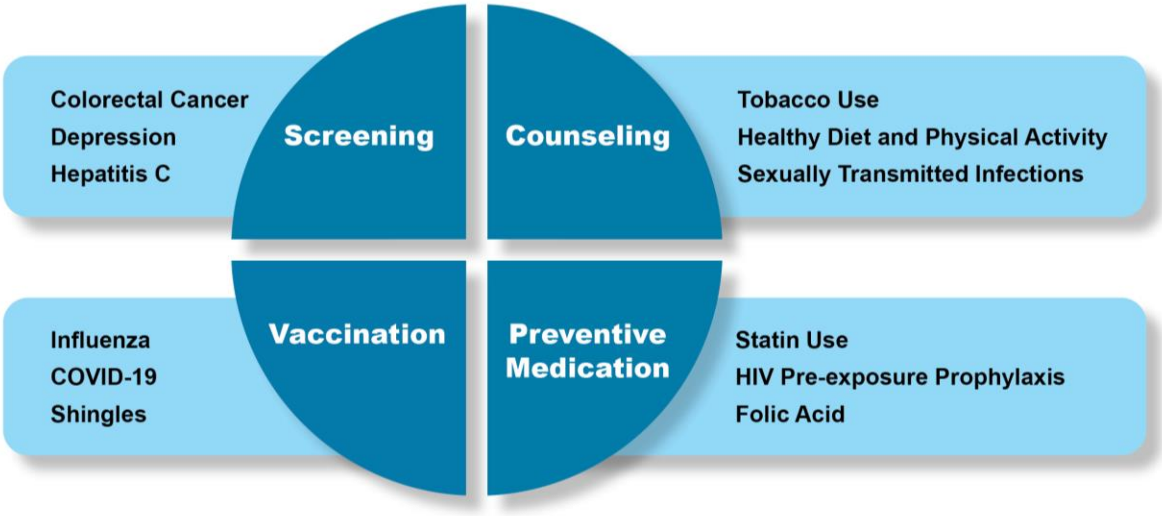
Public Availability Notice

Background

Clinical preventive services (CPS) are traditionally defined as services provided in or referred to from primary care settings to prevent future disease, detect early disease, or mitigate the impact of unhealthy behaviors on future health. They are specific services offered to most people, based on age, sex, health behaviors, or clinical risk factors. **Figure ES-1** depicts widely used categories of CPS with examples within each category.

Figure ES-1. Widely Used Categories of Clinical Preventive Services



Realizing the anticipated benefits from CPS at a population level requires widespread and equitable provision of services across all people who are candidates for these services. However, experts have documented suboptimal delivery of CPS for reasons that are multifactorial and complex and that vary according to type of service, individual factors, and system-level priorities.[1-5] Further, existing disparities in health status, disease burden, and community resources may exacerbate gaps in the equitable receipt of CPS.[5-7]

Given suboptimal and inequitable receipt of CPS among adults, the Agency for Healthcare Research and Quality (AHRQ) commissioned this project, Person-Centered Preventive Healthcare (PCPHC), to gather evidence and stakeholder input through multiple lenses to identify relevant models, strategies, resources, and opportunities to increase the use of equitable and person-centered approaches to delivering CPS. For this project, the focus was on the evidence-based preventive service recommendations relevant to adults aged 35 years and older from the U.S. Preventive Services Task Force (USPSTF)[8] and the Advisory Committee on Immunization Practices (ACIP).[9]

Methods

AHRQ identified five topic areas for this project (**Table ES-1**). We assembled teams of three to five people for each topic to conduct an environmental scan, facilitate a technical expert panel (TEP) meeting, and conduct key informant interviews (KIIs). This project was also supported by a 30-member Stakeholder Panel, which we virtually convened three times to provide guidance and feedback on findings. The Stakeholder Panel included representatives from healthcare systems, academia, public health agencies, nonprofit organizations, payers, federal agencies, and patient/consumer organizations.

Table ES-1. Topics within the Person-Centered Preventive Healthcare Project

Short Topic Title	Topic Description
Technology	Identify how technology (e.g., personal health records and patient portals, mobile device applications, telehealth, and tools for facilitating shared decision making) can be developed or implemented to deliver equitable clinical preventive services
Innovative Delivery Models	Identify emerging and innovative models, interventions, and/or programs that are implemented within healthcare organizations to ensure delivery of relevant preventive care in a way that incorporates patient values and preferences
Public Health and Community Linkages	Identify how linkages between primary care and public health or community-based organizations can be further developed and leveraged to optimize the delivery of person-centered clinical preventive services
Disparities	Identify causes of as well as person-centered strategies to mitigate health disparities related to clinical preventive services
Low-value and Harmful Services	Identify strategies for de-implementation of low-value or harmful services

For each topic, we convened a virtual TEP meeting with at least 10 experts and two patient representatives, striving for diversity with respect to discipline, race/ethnicity, geography, and organization type. We provided each TEP with an environmental scan to offer background to initiate TEP discussions. For each scan, we gathered information relevant to guiding questions and synthesized the major findings into themes with examples. We also conducted three to four KIIs for each topic, either before or after the TEP meeting. We then used inductive reasoning to identify cross-cutting themes from the TEP and KII discussions.

Results

We identified three overarching themes from across the five topics, with some overlap in themes identified from across the topics.

Transition to holistic healthcare delivery and financing models

Include community and patient voices in healthcare system design

Leverage technology to improve preventive care delivery

Transition to Holistic Healthcare Delivery and Financing Models

TEP members viewed isolated attempts to improve preventive care service delivery without addressing the larger and substantial structural barriers to providing holistic care as a missed opportunity. To deliver more person-centered preventive care, TEP members proposed transforming the current healthcare delivery system to use more holistic delivery and financing models.

Expand Perspective on Preventive Services

Some TEP and Stakeholder Panel members suggested adopting a more broad and inclusive perspective about prevention than the defined scope for the PCPHC project (i.e., USPSTF and ACIP recommendations in adults aged 35 years and older). They suggested that future work in this area may benefit from expanding the idea of prevention to encompass other areas of public health and clinical prevention and advocated for a life course approach to care.

Focus on Person-Centered Delivery

Many TEP members suggested more focus on person-centered approaches to preventive care delivery (i.e., promoting patient decision making regarding the prioritization and receipt of CPS). Some TEP members noted challenges associated with a one-size-fits-all approach to preventive care that is often driven by quality measures. They suggested that care teams incorporate patient preferences, culture, and values into all aspects of care, including but not limited to CPS.

Address Social Drivers of Health and Social Needs

TEP members described how social or economic factors—such as transportation, education, income, and housing—can impact individual health behaviors and a person's ability to engage in healthcare and healthy behaviors, including preventive care. Several TEP members suggested that although interventions with the potential to increase the receipt of CPS exist, without broader, transformative change (i.e., interventions addressing social drivers of health and social needs), the ability to impact health outcomes may be limited.

Restructure Fee-for-Service Financing Models

Restructuring current financing models could facilitate more holistic health care delivery models. TEP members described the ways in which chronic underinvestment in primary care and public health hinders equitable service provision. To accomplish changes to current financing models, TEP members underscored the importance of policy change and infrastructure investments at federal, state, and local levels to facilitate integration between primary care, public health, and community organizations.

Identify Opportunities for System Redesign

Beyond the restructuring of healthcare financing models, TEP members proposed several system-level redesign opportunities, including use of a Teaching Health Center model to train primary care providers, increased adoption of patient group models for care delivery, and the use of patient navigators. TEP members pointed to the healthcare changes implemented because of the COVID-19 pandemic, wherein services were provided outside of typical clinical spaces (e.g., telemedicine, pharmacies, urgent care). They suggested health systems could use similar approaches for the delivery of CPS.

Invest in Social and Community Infrastructure

TEP members identified the need for greater financial investment in public health, social, and community infrastructure, with the goal of enabling more partnerships and sustaining services between healthcare systems and public health and community entities. TEP members proposed infrastructure investments to expand telehealth options and phone-based services to increase access for individuals in rural areas or who are without broadband. The use of short-term grant funding versus ongoing program funding to public health and community-based organizations poses a barrier to improving community infrastructure, developing the community health worker labor force, and, most importantly, sustaining programs.

Include Community and Patient Voice in Healthcare System Design

TEP members suggested that implementing person-centered care requires shifting the focus in healthcare systems from diagnosis and treatment to meeting the broader needs of people within specific communities where they live and access healthcare. This shift aligns with the importance of understanding and considering social drivers of health and social needs and what matters most to people and their communities.

Consider Community Priorities and Context

TEP members shared that communities should be front and center of, if not leading and convening, partnerships and processes to inform healthcare models, including preventive services delivery. Trust is both critical and central to any effort to successfully engage and partner with communities to understand their priorities and important contextual considerations. TEP members discussed how funding for single disease approaches, common for preventive services, is often based on funder priorities, and community representatives are typically engaged on previously designed interventions, which may or may not reflect the actual needs and priorities of the community.

Cocreate Care Delivery and Funding Models

TEP members shared a need for system redesign using a process of cocreation with community members, patients, families, and caregivers. This process is best facilitated with an intermediary organization or an anchor institution as a convener to take on the task of listening to the community, coordinating the stakeholders, determining funding, facilitating data sharing, and providing infrastructure for smaller community-based organizations.

Design Care Delivery—Where and Who Matters

TEP members shared the importance of patients having an ongoing, trusted relationship with a primary care clinician or team. However, some TEP members prioritized having affordable services that are based in the communities where individuals live. TEP members shared that when services are offered in accessible, familiar, and comfortable settings, people can more easily receive care, and this contributes to equity-related goals. TEP members discussed the value and importance of having a healthcare workforce that reflects the community it serves, from those providing frontline services, including community health workers, to those in executive leadership positions. They emphasized the need for more community health worker training and certification programs, as well as the need for this work to be routinely reimbursable.

Engage Patients and Communities in De-Implementation Decisions

To ensure optimal care for patients and reduce waste in healthcare, experts have increasingly emphasized the need to discontinue health services that are low value (or potentially even harmful). The TEP advised that de-implementation efforts around CPS do not need to be distinct from efforts around other low-value health services. They also advised that historical dissatisfaction with and mistrust of medical authorities has generated misconceptions that equate de-implementation to rationing or withholding necessary care. TEP members shared that this mistrust could affect the physician-patient relationship and negatively impact a patient’s willingness to receive services they need, further risking inequities in access to high-value services. TEP members strongly suggested that families and communities be authentically engaged in the codesign of tools and messages related to de-implementation.

›Leverage Technology to Improve Preventive Service Delivery

TEP members offered comments about contextual and structural issues that impact how technology can be used to deliver CPS and important equity factors to consider.

Provide Technology to Support the Delivery of Preventive Services

TEP members suggested that technology can support delivery of CPS by helping individuals and clinicians realize when a given recommendation might apply, assess the risks and benefits of the CPS, or aid in the delivery of a CPS. Technology could be used to better understand what matters to patients and then help them to prioritize and personalize their preventive care. TEP members pointed to several places where technology could support closed loop communication, reinforce team-based care, and support integration across multiple sites of care.

In addition to supporting care for individual patients, technology is a tool to support population health management and facilitate CPS delivery outside of clinical settings and in the community. Despite these examples, TEP members advised that to improve equity, clinicians need more data on community context and social needs. In addition, digital standards and architecture are needed to capture and understand an individual’s preferences and values and document them in their electronic health record so that it is available to all providers across multiple entities (including public health or community organizations) that may care for the person.

TEP members described several promising uses of technology, including wearable health monitors, patient-generated data, and machine learning and artificial intelligence (AI) to curate existing data. However, TEP members noted that regulation and protections are critical to safeguard against racial, gender, and other biases that may be amplified through use of AI and machine learning on biased data. TEP members also identified a new role for digital health navigators—someone within the health system who would help to manage the potential trove of patient-generated data that results from technological advancements.

Center Equity in Use of Technology

TEP members advised that technology could exacerbate or ameliorate disparities depending on how it is used. Tools may be inaccessible to people with limited English proficiency, lower health or digital literacy, limited access to technology, or communication challenges. Furthermore, some tools may not be appropriate for a person's cultural context or may be insensitive to a person's social needs, resulting in more harm than benefit. Similarly, not all patients want to receive care through technology; therefore, providers should collect and abide by patient preferences for using technology to provide care.

Address Technology Implementation Challenges

For technology to be effectively integrated, TEP members noted that it must be linked to workflow, payment, and electronic health records. A lack of effective technology integration could create more burden for healthcare teams rather than alleviating time and resource pressures. Mobile device apps and technology tools have proliferated but often have little evidence supporting their use, are too numerous for patients or clinicians to scrutinize, and may not be free or low cost to the patient. For apps and tools developed under grant funding, sustainable business models are needed when funding ends to maintain and update hardware and software, or revise content based on changes in the clinical evidence.

Address Structural Health Information Technology Issues

TEP members identified many health IT infrastructure and data needs that while not necessarily specific to preventive services, must be addressed to improve preventive service delivery. TEP members noted the need for more real-time data sharing and solutions to navigate legal requirements around sharing patient information with public health and community organizations. Further, providers are not reimbursed for time spent dealing with technology, accessing and reviewing patient-generated health data, or supporting patients with limited digital health literacy. TEP members also highlighted that patients often need to juggle access to multiple patient/client portals, which increases burden and reduces the benefits of this technology. Further, patient data located in multiple portals is not always accessible to all involved providers. Reducing fragmentation of healthcare data from both the person and the system perspective is needed.

Discussion

Although AHRQ designed this project to collect information from five different TEPs, we heard common sentiments across the TEPs that we were able to broadly categorize into the three organizing themes discussed in the previous section. TEP members emphasized the importance of ensuring community and patient voice in the design of healthcare models intended to improve CPS delivery, but noted that such models may not be successful or sustainable in the absence of an infrastructure that supports healthcare and social needs for all. The information we gathered from the TEPs and key informants also highlighted a tension between federal agency goals of maximizing population health through the delivery of all recommended CPS to all eligible adults and the principles of person-centered care, which focus on helping people determine which CPS to receive based on their values, preferences, and personal risk factors.

Many of the comments we heard from TEP members align with the recommendations put forward in the NASEM report on High-Quality Primary Care[10] and the recently released U.S. Playbook to Address Social Determinants of Health.[11] Regardless of setting or provider, care delivery strategies must be grounded in a shared vision that is informed by current evidence and person-centeredness.

Key Recommendations

Addressing equity should be a stronger focus of integration between primary care, public health, and communities for all aspects of healthcare, including clinical preventive services.

The goal of person-centered preventive healthcare should be to help people determine which clinical preventive services to receive based on their values, preferences, and personal risk factors.

Opportunities for AHRQ

Advance digital healthcare. TEP members suggested AHRQ could consider funding projects in five areas. First, promote patient understanding of and engagement in CPS delivery through the emerging technology of AI-assisted chatbots and the vetting of health apps designed to facilitate decision making about receiving CPS and facilitate delivery of CPS where applicable. Second, embed risk assessment and tools for risk communication into electronic health records to facilitate shared decision making to determine appropriate care, including the de-implementation of low-value services. Third, develop instruments to collect standardized data related to patient values, preferences, satisfaction, and technology to facilitate the inclusion of these data into individual patient care, population health management, and a new generation of quality measures. Fourth, examine how technology can fortify healthcare systems and community linkages, including processes that best enable data sharing between these entities. Fifth, refine and evaluate a new staff role suggested by TEP members—digital health navigator.

Evolve measurement and evaluation frameworks. AHRQ could fund work into new measurement strategies and alternative evaluation frameworks for preventive service delivery, particularly through the lens of health equity. Research on person-centered delivery of preventive care requires advancing quality measurement beyond the receipt of CPS alone.

Advance person-centered care research. TEP members suggested evaluating new, person-centered models of preventive care that increase community engagement, involve family, and utilize transdisciplinary teams. The recruitment of individuals who are more representative of the race and ethnicity, disabilities, gender identity, geography, and economic diversity found in the United States is critical to generating useful person-centered care research.

Develop implementation and de-implementation research. AHRQ could consider disseminating guidance to make implementation research applicable across settings that vary with respect to available resources. There is a need for dissemination of evidence-based strategies to underresourced communities that include collaborating with community members to build the supports needed to provide services. AHRQ also has an opportunity to further the field of de-implementation research, particularly with respect to preventive services, including identifying appropriate terminology for discussing low-value care that does not alienate communities or disrupt the patient-provider relationship. Future research should carefully consider how de-implementation interacts with health equity.

Broader Opportunities

Broader opportunities include supporting collaboration and partnerships with other entities, including federal agencies, state governments, health systems, or community organizations. This may include building shared data infrastructures or playing a leading role in centering health equity.

Report Limitations

This report has several limitations. The environmental scans that we conducted to inform TEP discussions focused on U.S. settings and were not comprehensive systematic reviews of the literature. We also note that the published literature may bias toward work that receives dedicated research funding, uses specific study designs, has positive findings, or focuses on disease-specific outcomes. Although we aimed for diverse TEP membership in terms of occupation, organizational affiliation, geographic location, gender, and racial/ethnic group, the input from these TEPs and interviews cannot fully represent the diversity of opinions for clinicians, researchers, policymakers, payers, patients, or caregivers in the United States.

Conclusions

Although we identified some interventions aimed at increasing the delivery of clinical preventive services, experts stressed the need for more holistic approaches to address health disparities that include addressing social drivers of health. It is necessary to transition to holistic models of healthcare delivery and financing that incorporate community and patient voices in system design and that leverage technology-based solutions. Promoting equity requires expanding focus beyond clinical settings to encompass public health infrastructure and community engagement. Ultimately, the experts recommended that person-centered preventive care should empower patients to make informed decisions about preventive services based on their values, risks, and preferences—not apply one-size-fits-all standards. This more individualized approach tailored to individual needs and context is essential for reducing gaps in preventive services across diverse populations to maximize population health.

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