Prevention is a cornerstone of family medicine. Patients visit their physician to screen for illness, for counsel about risk factors and to help prevent disease. The inundation of various recommendations poses time challenges when trying to examine a patient during the annual check-up. This article examines how to put evidence-based prevention into practice.

Are preventive health recommendations applied in practice?

The Canadian and US Task Forces on Preventive Health have reviewed and graded recommendations for evidence-based prevention (see Table 1).

A standardized study involving patients sent to family practices for annual check-ups found only 41% of A/B manoeuvres were offered, and 17% of ineffective, D/E manoeuvres were offered. The study found selective offerings of “A and B manoeuvres to the exclusion of D and

Joel’s case

Joel, 55, is a middle manager at a bank. He rarely visits his doctor, but has come for a full check-up.

Joel is healthy and takes no medications. He quit smoking five years ago, after 25 years of smoking a half pack/day.

- Weight: 203 lbs
- Height: 5 ft 11 in.
- Body mass index: 28
- Blood pressure: 135/87 mmHg

Case discussion

Joel’s doctor completes the Preventive Health Table during the examination and discovers Joel does not exercise and often eats take-out food. A cholesterol profile is ordered and a stool occult blood kit is given.

The assessment reveals that Joel needs to reduce his cardiovascular risk by eating better, exercising more and losing weight. He is not interested in eating better, but may want to exercise more. He is given an exercise prescription and is scheduled to a visit two months later to review his cardiac risk status.

Table 1

Grades for preventive services recommendations

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>Good evidence for inclusion</td>
</tr>
<tr>
<td>B</td>
<td>Fair evidence for inclusion</td>
</tr>
<tr>
<td>C</td>
<td>Inconclusive (benefits vs. harms equivocal)</td>
</tr>
<tr>
<td>I</td>
<td>Insufficient evidence</td>
</tr>
<tr>
<td>D</td>
<td>Fair evidence for exclusion</td>
</tr>
<tr>
<td>E</td>
<td>Good evidence for exclusion</td>
</tr>
</tbody>
</table>
Family practices need to be organized to offer more A/B manoeuvres and fewer D/E manoeuvres.

**Putting prevention in practice: What works?**

Several interventions have been found to increase recommended interventions. A meta-analysis found that organizational changes (i.e., a planned preventive care visit) using clinics designed to deliver some screening services (i.e., the Ontario Breast Screening Program for breast cancer) or designating non-physician staff members for specific activity improved the provision of immunization and cancer screening.2

Other effective interventions included patient reminders, through letters or phone calls.2 Several jurisdictions offer physicians financial incentives for meeting targets for preventive services.

Ensuring enough family physicians are available is an effective strategy. US regions having more care provided by specialists and hospitals have less preventive services.3 In addition, patients who regularly see a family doctor are more likely to get preventive care.4

Computer-based reminder systems are very effective; a meta-analysis found that 14 out of 19 studies had positive results.5 For practices lacking an electronic medical record, chart aids, such as flow sheets, encounter forms or checklists can be helpful.
Most family physicians are very familiar with the Rourke record for well-baby visits. In one study, “the chart flow sheet was the resource that was most strongly and consistently related to preventive services provision.”

Too little time, too many things to do? Choose the “As” and “Bs” for your practice

Practising family physicians have limited time and resources available to deliver preventive services. The US Task Force on Preventive Services has stated that “services with adequate evidence of substantial to moderate net health benefit (those with "A" and "B" recommendations) ought to receive the highest priority for delivery in the primary-care setting.”

There are several chart aids available to help put the As and Bs into practice; the age-based Preventive Health Tables, the new College of Family Physicians of Canada Chart Aids or the Preventive Health Questionnaire, which patients can complete before their check-up. Table 2 provides a list of Internet addresses for downloadable charts.

How can evidence-based prevention be implemented?

A practice enlisting staff members to give patients a Prevention Kit ahead of time may work very well. This kit can include:

- the Preventive Health Questionnaire,
- a Stool Occult Blood Kit (A) for all patients age 50 or older,
- a mammogram requisition (A) for all women aged 50 to 69 or
- a urine sample for chlamydia (A) for women aged 15 to 25.

Family physicians make a difference in a patient’s use of prevention and there is evidence that no other specialty is as effective. Preventive health care truly represents family medicine at its best.

References