

Call to Action on Making Physical Activity Assessment and Prescription a Medical Standard of Care

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Abstract

The U.S. population is plagued by physical inactivity, lack of cardiorespiratory fitness, and sedentary lifestyles, all of which are strongly associated with the emerging epidemic of chronic disease. The time is right to incorporate physical activity assessment and promotion into health care in a manner that engages clinicians and patients. In April 2015, the American College of Sports Medicine and Kaiser Permanente convened a joint consensus meeting of subject matter experts from stakeholder organizations to discuss the development and implementation of a physical activity vital sign (PAVS) to be obtained and recorded at every medical visit for every patient. This statement represents a summary of the discussion, recommendations, and next steps developed during the consensus meeting. Foremost, it is a “call to action” for current and future clinicians and the health care community to implement a PAVS in daily practice with every patient.

Introduction/Purpose

Nearly 60 years ago, President Eisenhower established the President's Council on Fitness and Sports (originally named the President's Council on Youth Fitness) in response to growing concern for the deteriorating level of American youth physical fitness. Despite this and many other national health initiatives that emphasize physical activity in both children and adults, the U.S. population is still plagued by physical inactivity, lack of cardiorespiratory fitness, and sedentary lifestyles, all of which are strongly associated with the emerging epidemic of chronic disease.

In fact, at the annual meeting of the American College of Sports Medicine in 2014, then-acting U.S. Surgeon General, Dr. Boris Lushniak, echoed research by Blair et al. stating, “Physical inactivity is the major public health issue in this country (2).” Given growing public health concern and slow progress in this area, the time is right to incorporate physical activity assessment and promotion into health care in a manner that engages both clinicians and patients.

In April 2015, the American College of Sports Medicine and Kaiser Permanente convened a joint consensus meeting to discuss how to make PA assessment and exercise prescription a standard of care, with the most important step in the process being the implementation of a physical activity vital sign (PAVS). These subject matter experts from various stakeholder organizations answered key questions related to the development and implementation of a PAVS to be obtained and recorded at every medical visit for every patient. The consensus meeting attendees endeavored to address important barriers and advocate for collaboration and unification of messaging among stakeholders, including key recommendations.

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This statement represents a summary of the discussion, recommendations, and next steps developed during the consensus meeting. Foremost, it is a “call to action” for current and future clinicians and the health care community to implement a PAVS in daily practice with every patient. It is our hope that the PAVS will be a catalyst for systemic change as part of a comprehensive transition from an emphasis on treating chronic diseases to disease prevention and a culture of health and wellness. In essence, it involves moving from our current reactive, sick-care model to proactive health care.

The Problem of Physical Inactivity

Scope and Magnitude of the Problem

There is a linear relationship between physical activity and health status, with those maintaining an active lifestyle generally being healthier and living longer (14). Individuals who are sedentary suffer greater morbidity and premature mortality. In fact, ~50% of deaths are attributed to unhealthy lifestyle behaviors such as a poor quality diet, cigarette smoking, stress, and physical inactivity (17). Global deaths per year attributed to physical inactivity may soon outpace deaths attributed to smoking (15,17), as upwards

of 90% of American adults may not meet current physical activity guidelines (25). Changing this trend will require concerted efforts by major stakeholders, including health professionals; local, state, and federal governmental agencies; health care payers; and the population as a whole.

The health care team is uniquely positioned to address the importance of a healthy lifestyle, including physical activity, in the prevention and treatment of disease and disability. Based on existing evidence, increasing physical activity is a cost-effective, first-line intervention for many chronic diseases (21). Current physical activity guidelines include a goal of ≥ 150 minutes per week of moderate intensity physical activity (7,10). Walking is often recommended as ‘the activity of choice’ for several reasons: it is accessible, low cost, and quantifiable; it is the most common adult physical activity (22); and, it imparts health benefits, is associated with reduced health care costs, and has a lower risk of untoward events than more strenuous forms of exercise (13). Although it is recognized that there are unique populations where caution must be considered when making physical activity recommendations, walking is generally considered the entry-level activity for safe and effective exercise prescription. Importantly, advice from the health

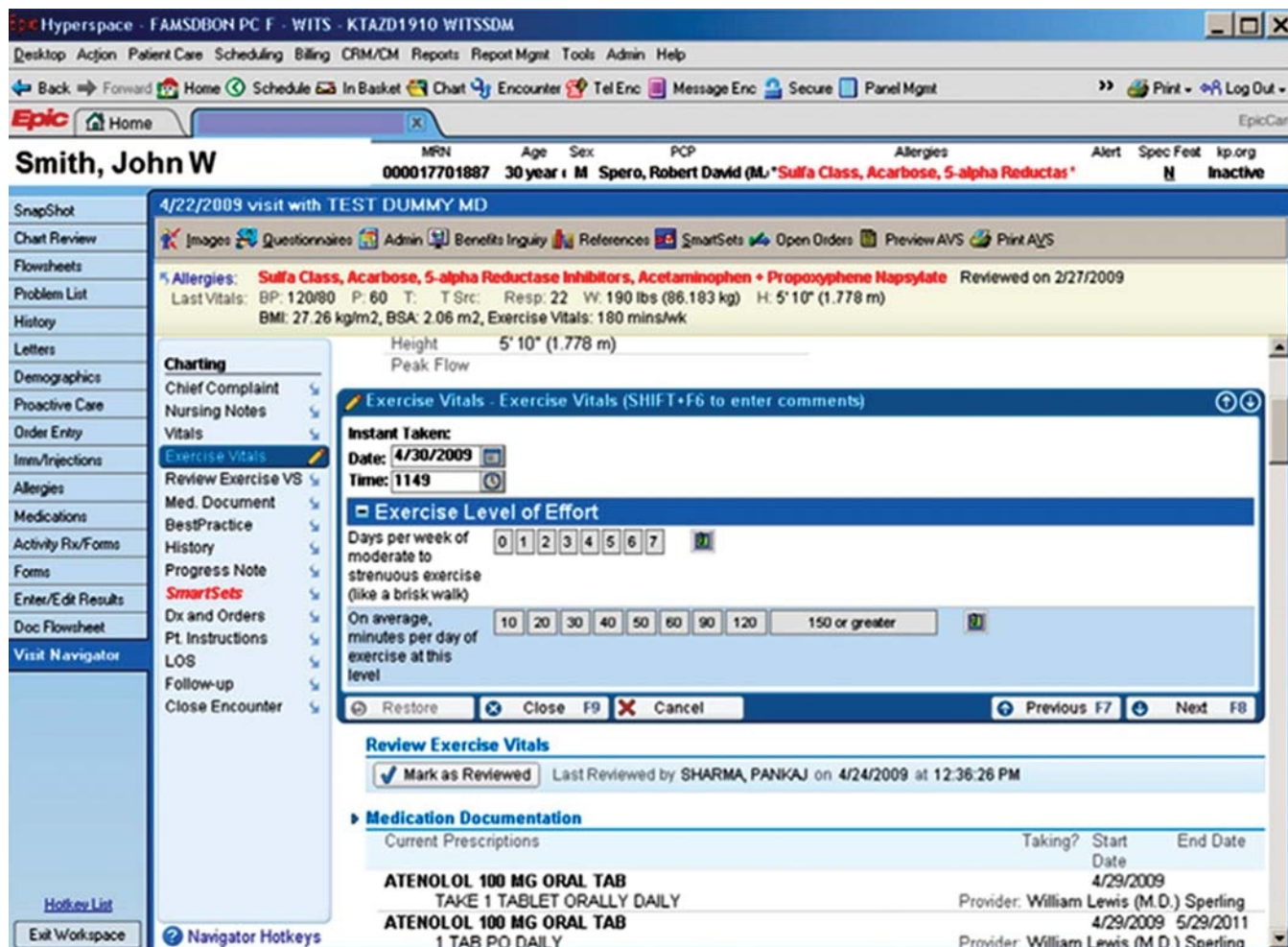


Figure 1: Exercise vital sign in Kaiser Permanente’s Epic EHR.

care team may be influential in the patient's decision-making regarding lifestyle behavior change, including exercise regimens.

Physical inactivity is a modifiable risk factor

Among the modifiable determinants of health outcomes, smoking status has been the most successfully treated, with smoking prevalence dropping from over 40% of the adult U.S. population to about 19% (3). In the U.S., physical inactivity is now the most prevalent modifiable risk factor (12). Between 6% and 10% of non-communicable disease deaths worldwide are related to physical inactivity (15). Further, physical inactivity accounts for ~9% of premature mortality (15), is linked to the diseases that place the greatest burden on health care (including coronary heart disease, breast and colon cancer, and type 2 diabetes), and may be more detrimental to health than cigarette smoking and obesity (2). Although smoking status and obesity are regularly evaluated in routine medical care, physical activity assessment has not yet held the same priority. The focus of this statement is to provide the rationale for elevating physical activity to a necessary and standardized "vital sign," and to suggest methodology for integrating the assessment and prescription of it into routine medical care.

Making the Case for the Physical Activity Vital Sign

Physical activity as a vital sign (PAVS)

What constitutes a "vital sign?" According to Medicare 1997 documentation, guidelines for evaluation and management services, the following seven items are considered vital signs: 1) sitting or standing blood pressure; 2) supine blood pressure; 3) pulse rate and regularity; 4) respiration; and 5) temperature, in addition to the anthropometric measures of 6) height; and 7) weight. In the traditional sense, vital signs are measurements that reflect basic physiologic functions and health status and are used to monitor or detect health problems. In recent years, multiple other "signs" have been proposed, that may have equally informative and important effects on health outcomes, including body mass index, smoking status, pain level, and pulse oximetry. We believe a PAVS can provide valuable insight into a patients' health status and lead to opportunities to advance a culture of wellness.

Questions remain about the best method for assessing physical activity. Self-report instruments tend to overestimate physical activity compared with objective measures (e.g., smart phone apps, accelerometers, or pedometers), but are easier to quickly institute in clinical practice. We see a PAVS as a starting point to a more accurate, quantified measure of the amount of PA a patient regularly engages in. It is unclear whether a report of physical activity over seven days or averaged over a month is more accurate, and questions remain regarding how to combine activities of different intensity into a single measurement (24). The PAVS utilized by Kaiser Permanente, Intermountain Healthcare, Greenville Health System, and others consists of obtaining the answers to two questions during each outpatient visit: 1) "On average, how many days per week do you engage in moderate to strenuous physical activity (like a brisk walk)?" and 2) "On average, how many minutes do you engage in physical

activity at this level?" The product of these answers determines the total number of minutes per week the patient performed at least moderate-intensity physical activity and the results are typically entered into the electronic health record. The PAVS is embedded alongside other relevant lifestyle information like body mass index and smoking status. For patients not meeting the recommended 150 minutes per week, providers could take the opportunity to recommend that patients increase their weekly physical activity level to this recommended amount. They also may consider asking about barriers or challenges that prevent patients from being more physically active. This allows the clinician to engage in counseling specific to the patient's individual situation and/or refer patients to resources in the community.

A study of 2.1 million adult patients from Kaiser Permanente in Southern California demonstrated that within the first year of implementation, they were able to capture a PAVS on 85% of eligible patients (5). This compares favorably with the implementation of a smoking status query (95%) recorded in an electronic health record (18). Importantly, the PAVS showed similar results to the number of minutes of exercise compared with other self-reported physical activity questionnaires, such as Behavioral Risk Factor Surveillance System (BRFSS) (50%) and the National Health and Nutrition Examination Survey (NHANES) (59.6%) (5).

When considering the case for integrating a PAVS throughout health care, it is important to recognize that successful implementation has already occurred at Kaiser Permanente, Greenville Health System in South Carolina, and Intermountain Healthcare System in Utah. These organizations have been able to manage workflows and include the measure in their electronic health record alongside other vital signs. They have accomplished this goal working alongside different health record vendors, including Epic, HELP2, and iCentra. Visual examples are included in Figures 2 and 3. Physicians can evaluate the PAVS, make time-dependent recommendations, and counsel their patients accordingly. Importantly, documenting the PAVS at Kaiser Permanente was associated with increased exercise-related progress notes, more frequent exercise counseling by physicians, and reductions in patient weight and hemoglobin A1C levels (8).

Steps for Implementation of a Uniform PAVS and Physical Activity Prescription Education

To provide beneficial patient education, our nation's health care professionals must be educated in the vital role physical activity and/or structured exercise plays in preventing, treating, and managing disease and the need to screen, motivate, and educate patients of all ages about physical activity. This requires substantive changes in health care systems and medical education (<http://www.physicalactivityplan.org/>), including integrating this information into undergraduate, graduate, and continuing medical education. This can be a challenge as today's health care curriculum rarely includes exercise or lifestyle medicine education and there are already numerous demands for specific requirements in contemporary medical education curricula.

Physical Activity Vital Sign in HELP2

1. On average, **how many days a week** do you perform physical activity or exercise?
2. On average, **how many total minutes** of physical activity or exercise do you perform on those days?
 $\text{days/week} \times \text{minutes/day} = \text{min/week (PAVS)}$
3. Describe the **intensity** of your physical activity or exercise:
light = casual walk **moderate** = brisk walk **vigorous** = jogging

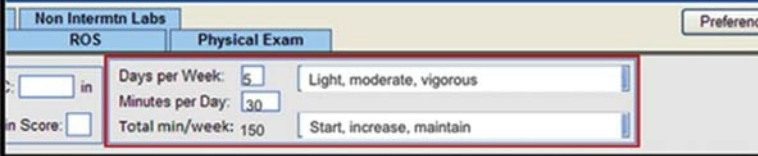


Figure 2: Intermountain Healthcare physical activity vital sign in HELP2 EHR.

Undergraduate Medical Education (Medical School)

Historically, physicians have been undertrained in medical school with regards to the health impact of physical activity. Only 6% of U.S. medical schools have core curricula on exercise guidelines, while only 10% of medical school deans believe their graduates could provide an exercise prescription for patients (6). Notably, medical students are themselves more likely to exercise, have more favorable attitudes toward physical activity and the effects of counseling, and to have improved fitness when physical activity is actively taught as part of the medical school curriculum (26). Specific medical school curricula recommendations for physical activity are shown in the Table.

At the medical school level, there are innovative curriculum, including those at the University of South Carolina at Greenville (USCSMG) and the University of Wisconsin,

where exercise and lifestyle medicine are integrated into all four years of the students' undergraduate medical education (Table). In addition to learning how exercise and physical activity prevent and treat chronic diseases from a mechanistic perspective, medical students also are encouraged to make their own lifestyle changes, including increasing physical activity. In this way, future physicians are educated to successfully integrate physical activity assessment and counseling into patient care, model these behaviors, and incorporate community resources. Although medical schools need to integrate lifestyle education into their curriculum in their own unique way, awareness and incorporation often comes first from a faculty member who champions these



Figure 3: The 5 A's to facilitate effective health behavior change counseling during a medical visit. Although more providers now perform the first 2 A's, that is, ask about the risk behavior and advise behavior change, it is the latter, less frequently performed 3 A's that have the greatest impact on healthful behavior change. Effective clinician behavior change strategies include using motivational interviewing along with rewards or incentives, asking patients to self-monitor behaviors, enhancing patients' self-efficacy (confidence), accessing social support from family and friends, and scheduling regular follow-up communications/meetings to assess progress. [Adapted from Alexander et al. (1) and Chase et al. (4)].

Table.

Recommended medical school curricula on physical activity.

- Exercise physiology
 - Structure and function of skeletal muscle
 - Cardiopulmonary and metabolic responses to physical activity
- Social and health determinants of physical activity
 - Risks of sedentary lifestyle/inactivity on cardiovascular, pulmonary, musculoskeletal and neurological systems
 - Health benefits of physical activity
 - Risks of physical activity
- Components of a physical activity history
- The components of an exercise prescription
 - Physical activity in at-risk patients (cardiac, pulmonary, etc.)
 - Physical activity guidelines in special populations
 - Pre-participation screening guidelines
- Patient education: benefits and limitations of counseling
 - Counseling to promote behavioral change
 - Methods of behavioral change counseling (e.g., motivational interviewing)
- Principles of exercise training and optimizing sport performance
- Physicians as role models

Adapted from Joy et al. (12).

initiatives. The prevailing message is that integrating health behavior information and advocacy for healthy lifestyle, especially the role of physical activity, should be a priority.

Graduate Medical Education (Residency/Fellowship)

The Accreditation Council for Graduate Medical Education sets the program requirements for residency and fellowship programs. Despite strenuous requirements about the numbers of patients to treat, and specific curricula to which a resident must be exposed during graduate medical training, in most specialties there are no current requirements that residents receive education and training in physical activity. At a few institutions, some groups have begun programs to integrate physical activity into the longitudinal curriculum. For example, University of California, Los Angeles, has a “Fit for Residents” program (<http://fitprogram.ucla.edu/body.cfm?id=60>). Other institutions, like the University of Buffalo, through their residency “Wellness Initiative” encourage residents to include physical activity in their everyday lives (<https://goo.gl/heHtGG>). Clinicians relate (unpublished data) that meeting the recommended amounts of physical activity per week is beneficial for residents, as those who reported no physical activity were three times as likely to suffer from symptoms of burnout compared to those doing regular exercise.

In addition, most patients with chronic diseases and those undergoing elective or emergent surgery demonstrate worse outcomes as a result of lower preoperative levels of physical activity and/or CRF (11,16,19,23). Therefore, we believe it is paramount that accreditation include specific educational requirements related to physical activity that mirrors and expands on the recommended medical school curriculum (Table) across all applicable hospital-based, medical, and surgical specialties. Further, the board certifying examinations for applicable specialties should reflect the importance of physical activity and other lifestyle behaviors. Finally, because the Accreditation Council remains concerned about the health and well-being of trainees, ready access to (and time for) physical activity opportunities should be a prime focus within residency programs.

Continuing Medical Education (Practicing Clinicians)

A culture of change is brought about by the education of both clinician and patient. Clinicians need to recognize the significance and benefits of physical activity so they can discuss its importance with patients at every visit. It is essential clinicians feel empowered to counsel patients on physical activity and recognize that their advice has a positive influence on their patients and health care costs.

The American Board of Medical Specialties works together with its 24 member boards to ensure physicians certified by that member board meet profession-driven standards and requirements. Its program for maintenance of certification (MOC) emphasizes ongoing professional development and assessment that is aligned with professional expectations and requirements to provide competent care. As such, the MOC process provides opportunities for physicians to receive MOC credit for incorporating the use of exercise as medicine and PAVS into their practices. Examples for achieving this could be accomplished by creating a cross-specialty Part II Self-Assessment Module, and/or a Part IV Practice

Improvement project. The MOC exam might also include specialty-specific content on the prescriptive and health benefits of physical activity.

Collaboration of Major Stakeholders

Endorsement from major medical associations

Organized medicine continues to play a strong role in the professional life of practicing physicians. Unified messaging with both specialty-specific and primary care medical associations and regional health collaboratives could pay great dividends in helping to drive the message of a PAVS. The greatest obstacle to medical society “buy-in” may be the role that some professional associations play as advocates for the physician community. Physicians continue to be frustrated by the volume of documentation and administrative burden compared to the time spent caring for patients, especially given the negligible perceived benefit of these tasks in advancing quality patient outcomes. By extension, medical societies are cautious when considering mandates that call for greater administrative burdens or workflow redesigns. Therefore, it is important to present a unified message that the benefits of obtaining a PAVS significantly outweigh the workflow changes, time constraints, and reimbursement considerations.

Another consideration for medical societies, and the individual physicians they represent, is resource allocation. At the medical society level, there is concern about choosing which of many initiatives to support and develop in terms of time, capital, and focus, because they recognize the limited number of high priority programs they can support financially and through educational initiatives. At the individual physician level, there are additional considerations related to community resource allocation. Although the evidence for the beneficial role of physical activity is clear, individual communities may have other high-priority programs, such as making sure there is access to housing and water, healthy food options, or safety from violence in the community. Physicians working in these communities will face the challenging task of engaging their patients to gain the benefits of regular physical activity, while simultaneously dealing with competing priorities.

There are compelling outcomes tied to PAVS interventions, including work done by Kaiser Permanente, Greenville Health System, and Intermountain Healthcare. These demonstration projects include easy-to-implement protocols and successful implementation strategies, but there needs to be true collaboration on messaging. This could start with convening representatives from a core group of high-priority or key stakeholder organizations representing primary care and other physicians who have heightened interest in the health outcomes tied to physical activity (e.g., cardiology, sports medicine, geriatrics) and ensuring these stakeholders have a voice in the messaging.

We create a more compelling case when the message is a simple concept that resonates with all stakeholders. The recent successful “Choosing Wisely” campaign, started by the American Board of Internal Medicine Foundation, is an example of an early success. This success was due, in large part, to the unified message from all participating member societies that promoted the rationale for avoiding wasteful,

unnecessary, or potentially harmful tests, treatments, or procedures. A key part of the success of this program was their decision to partner with Consumer Reports in an effort to engage patients. This message was easily understood by everyone involved within the clinical practice of medicine and the general community. Coordinating and unifying the medical community, medical organizations, and patients could produce a similarly successful campaign to include PAVS at every patient visit.

Aligning with Existing Initiatives

Because there is general recognition of the importance of physical activity in health promotion and disease prevention, there are a number of programs directed at increasing physical activity and functional status across the lifespan, including several that have been initiated or joined by key stakeholders. Coordinating these disparate programs with similar objectives would help achieve our goal of making a PAVS ubiquitous. A brief list includes:

- Physical Activity Guidelines for Americans
- National Physical Activity Plan
- Exercise is Medicine[®]
- President's Council on Fitness, Sports & Nutrition: Physical Activity Initiative
- Let's Move Campaign
- Comprehensive School Physical Activity Program
- National Council on Aging: Physical Activity Programs (*e.g.* Active Choices, Walk with Ease, Fit and Strong, etc.)
- Americans in Motion – Healthy Interventions
- The Institute of Medicine's Physical Activity in Youth Innovation Collaborative: "Designed to Move"
- The Every Body Walk! Initiative
- Step It Up!: Surgeon General's Call to Action to Promote Walking and Walkable Communities

Advocacy/legislation and public awareness

To successfully realize improved health outcomes by implementing the PAVS, we will ultimately have to identify appropriate ways to incentivize the end-users of health care (*i.e.*, patients). This may be accomplished through increased visibility, as with promotional campaigns such as the National Football League Play 60 program, greater emphasis on the PAVS in the scientific/clinical literature, legislation mandating daily physical activity in schools, financial incentives/penalties, or via public service announcements as we did with the hazards of smoking:

WARNING: Prolonged sitting and physical inactivity cause chronic disease and premature death.

As with other successful initiatives, effective delivery of the message is critical. Athletes and other celebrities have great credibility among their followers, especially through avenues like social media, which has the potential to reach millions of people. Patient education should include community and grassroots organizations. The Million Hearts campaign engaged churches to perform blood pressure screening, which was low cost and empowering for the

community. Direct-to-consumer education would encourage more patients to ask their physician about physical activity. Because many communities have limited access to parks or recreational facilities, and physical activity is not part of their culture, such population subsets often exhibit the highest risk for chronic disease. Accordingly, health disparities and diversity must be considered in formulating educational strategies.

Financial considerations

The PAVS will help facilitate a paradigm shift toward prevention, as opposed to the traditional singular focus on treatment of preventable diseases. This should align well with the developing Accountable Care Organization model of health care where groups are incentivized to reduce health care utilization and associated costs. One important aspect of this initiative is population health. "Hot spotting," or focusing on high utilizers of a health system, may help to identify areas of high poverty and local resources, including safe exercise locations (9). Hot spotting also helps detect fertile areas to improve health care delivery, emphasizing preventive services to reduce costs.

Third-party payers may decide to shift the cost to the patient for preventable diseases that are poorly controlled. Thus, patients may face higher monthly premiums for not receiving scheduled preventive services. In fact, some payers already offer discounts for those who demonstrate regular attendance at fitness facilities. Perhaps incentives may be provided for patients who opt for aggressive lifestyle modification as an alternative medical treatment, such as the patient with diabetes who successfully self-manages with regular exercise and weight loss instead of medication. However, it is clear that not all patients are motivated financially.

At the level of the individual physician, medical practice, and health care system, there are a variety of incentives tied to quality measures or metrics. There would likely be improved utilization of a PAVS if it were a Healthcare Effectiveness Data and Information Set (HEDIS) measure for adults or if the National Quality Forum endorsed a performance measure embracing it.

Overcoming Barriers/Dispelling Myths

Lack of skill addressing behavioral change

The United States Preventive Services Task Force has addressed behavioral counseling as it relates to lifestyle health issues suggesting that "changing the health behaviors of Americans has the greatest potential of any current approach for decreasing morbidity and mortality and for improving the quality of life across diverse populations (27)." According to the Task Force, brief interventions, centered on the same methodology as smoking cessation and designed to fit into everyday practice, have been found to elicit clinically meaningful changes in behavior (27). Like any other clinical skill, behavioral counseling techniques, such as motivational interviewing, take practice in order for the provider to become proficient. Nevertheless, even those with limited training can provide purposeful strategies and advice that may be beneficial, and should regularly refer their patients to quality community resources. In addition, physical activity is probably easier for most clinicians to

discuss with “at-risk” patients, and potentially more easily modified and impactful, than is body weight reduction. As Joy and colleagues reported, low CRF “is far more important than obesity as a cause of morbidity and mortality. In fact, obese persons who are at least moderately fit, have death rates of approximately half those of people within a normal weight range who are not fit (12).” As such, efforts to include a PAVS also should embrace basic training for the health care team related to counseling strategies to promote behavior change.

In order to effectively counsel patients on the role of physical activity in the prevention and treatment of chronic disease, some experts advise using the same strategy that has been shown to be effective in smoking cessation: the 5 A’s (Ask, Advise, Assess, Assist, and Arrange) (Fig. 3) (1,4). It is important that the treating provider first ask about the patient’s current activity level. A PAVS provides sufficient discriminative validity, can be used to counsel patients, and is associated with minimal workflow disruption (5). Therefore, routine use of a PAVS will ensure that the first “A” is completed at all patient visits.

Health Technology Problems and Solutions

There are significant technological challenges to overcome in order to successfully implement the PAVS, including the potential lack of vendor support and interoperability, the ability to use the data in a meaningful way with clinical reporting or research, and the capacity to update the measure, as technology advances (*e.g.*, physical activity tracking devices, smart phones, and applications). A commitment from health technology vendors to support this initiative and an ability to upgrade the measure in meaningful ways (*e.g.*, to directly interface smartphone motion tracking apps into the electronic health record) will help to achieve this objective. Given the high number of electronic record vendors, the most likely path to gaining this capability would be through including the PAVS as Meaningful Use certification criteria. In addition to integrating the PAVS, vendor support could include intervention toolboxes, with evidence and guideline-based clinical tools and interactive educational materials that physicians can use to facilitate behavior change in their patients.

Effective tools already exist and can be shared, as many physicians have low self-efficacy when it comes to counseling patients on behavior change. Some practices have developed a script for providers to use during their limited time with patients. Intermountain Healthcare developed a comprehensive lifestyle care process model that includes scripts for clinicians to use in promoting physical activity at the point of care.

Staffing/Time

It is crucial to build an interdisciplinary support team around the physician or other health care providers. A medical assistant can be trained to ask the PAVS (it takes less than a minute to ask and record the PAVS) and refer to local community groups, organizations, or facilities for counseling and assistance with culturally appropriate, basic physical activity information. Examples include Parks Prescription, local senior centers, community continuing education programs, regional health collaboratives, and fitness facilities. Other clinical care team members, including health coaches or

exercise physiologists, may be more accessible in urban centers, and can offer assistance. In contrast, medical practices in more rural areas may rely on community care team members and local resources to help get patients more active.

Conclusion

Clinicians have a responsibility to inform their patients of the risks of physical inactivity. Patients should understand that the benefits of moderate-to-vigorous exercise far outweigh the risks. Regular physical activity should be advocated for the prevention and first-line treatment of chronic disease. The default exercise prescription is to walk at least 30 minutes a day, 5 or more days per week, with a target of ≥ 150 minutes per week of moderate-intensity physical activity. It should be noted that any type of physical activity done at a moderate pace would count toward this weekly goal. However, when previously sedentary patients initiate an exercise program, level walking should be strongly recommended, gradually increasing the walking speed or intensity of exertion over time (2 to 3 months), provided they remain asymptomatic (20). This strategy may decrease the likelihood of injury or cardiovascular event and increase cardiorespiratory fitness. An effort also should be made to recommend activities that people enjoy and will likely continue to engage in over time.

A PAVS is reliable and feasible and has been validated against established survey tools. Furthermore, it has been successfully implemented in large-scale demonstration projects. There are readily accessible resources (professionals, patient materials, and access to adequate facilities/equipment) to implement the recommendations, avenues to re-educate practicing clinicians and health care team members, and enormous opportunities to shift the current emphasis from our reactive sick care system to one of proactive disease prevention. This statement strongly endorses the implementation of a PAVS in the medical record, to be assessed at every medical office visit. We encourage and invite the medical community and medical organizations to join us in this important population health initiative.

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