The role of primary care in population health and prevention

WHO European Centre for Primary Health Care
Division of Health Systems and Public Health
WHO Regional Office for Europe

Spring school on whole of society approach and the role of primary health care
in populations health, prevention and intersectoral action for health equity and well-being

Ljubljana, 23-25 April 2018

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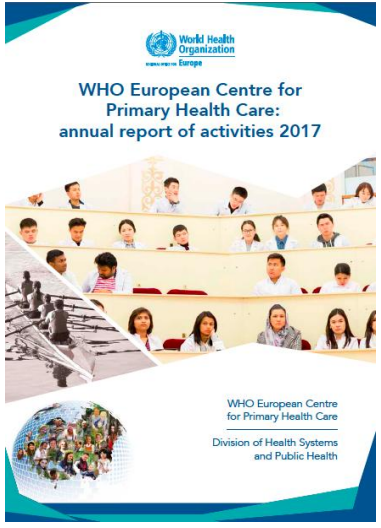
Outline

1. WHO European Centre for Primary Health Care
2. Integrated health services delivery framework
3. Primary care and population health management
4. Primary care and prevention services
5. Conclusions
6. Announcements

Policy analysis

Country support



Knowledge synthesis

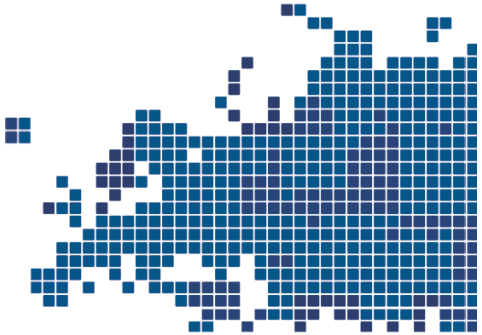
The WHO European Centre for Primary Health Care

Alliances and network

Building primary care in a changing Europe

38
Observatory Studies Series

Edited by
Dionne S. Kringos
Wienke G.W. Boerma
Allen Hutchinson
Richard B. Saltman



European Observatory on Health Systems and Policies
nivel

Dimensions of the PC structure

- Governance of PC system
- Economic conditions of PC system
- PC workforce development

Dimensions of the PC process

- Access to PC services
- Comprehensiveness of PC services
- Continuity of PC
- Coordination of PC

Dimensions of the PC outcomes

- Quality of PC
- Efficiency of PC
- Equity in health

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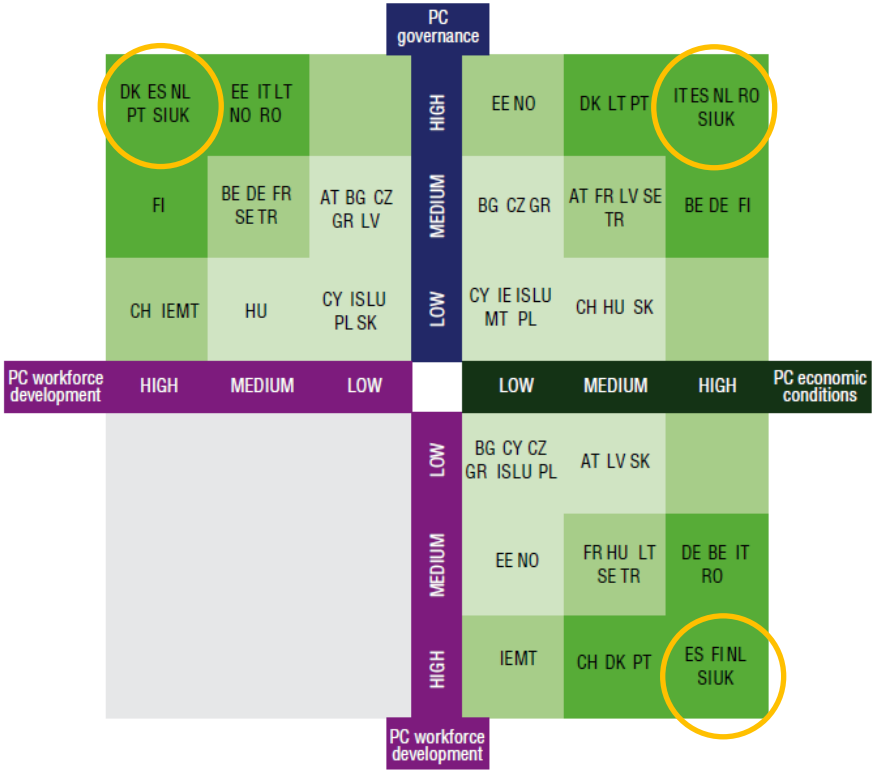

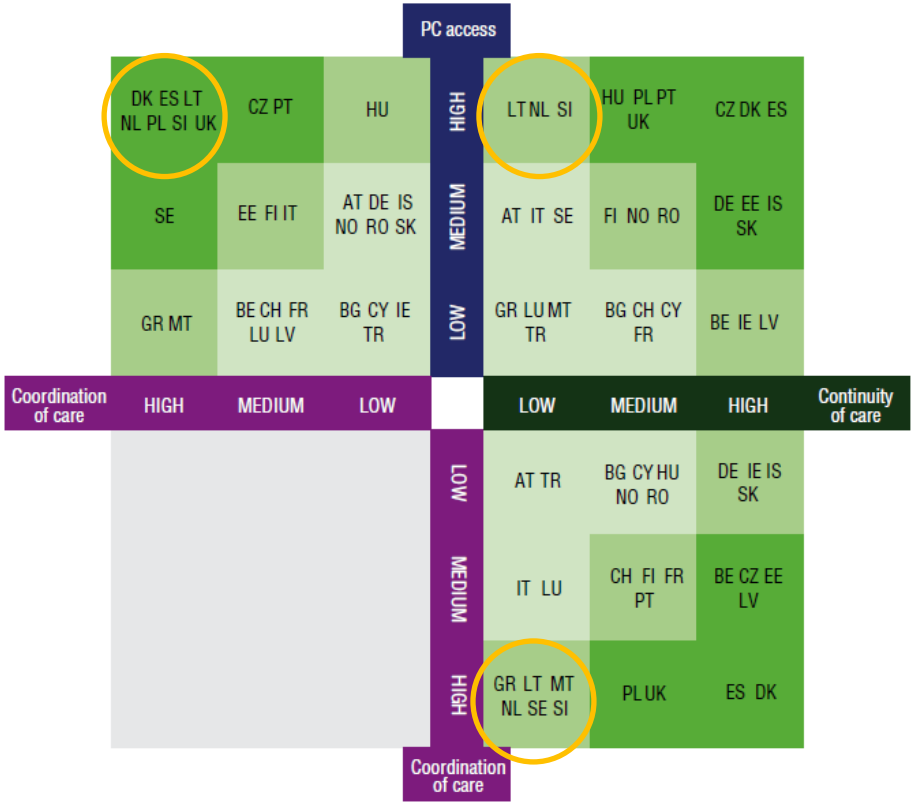

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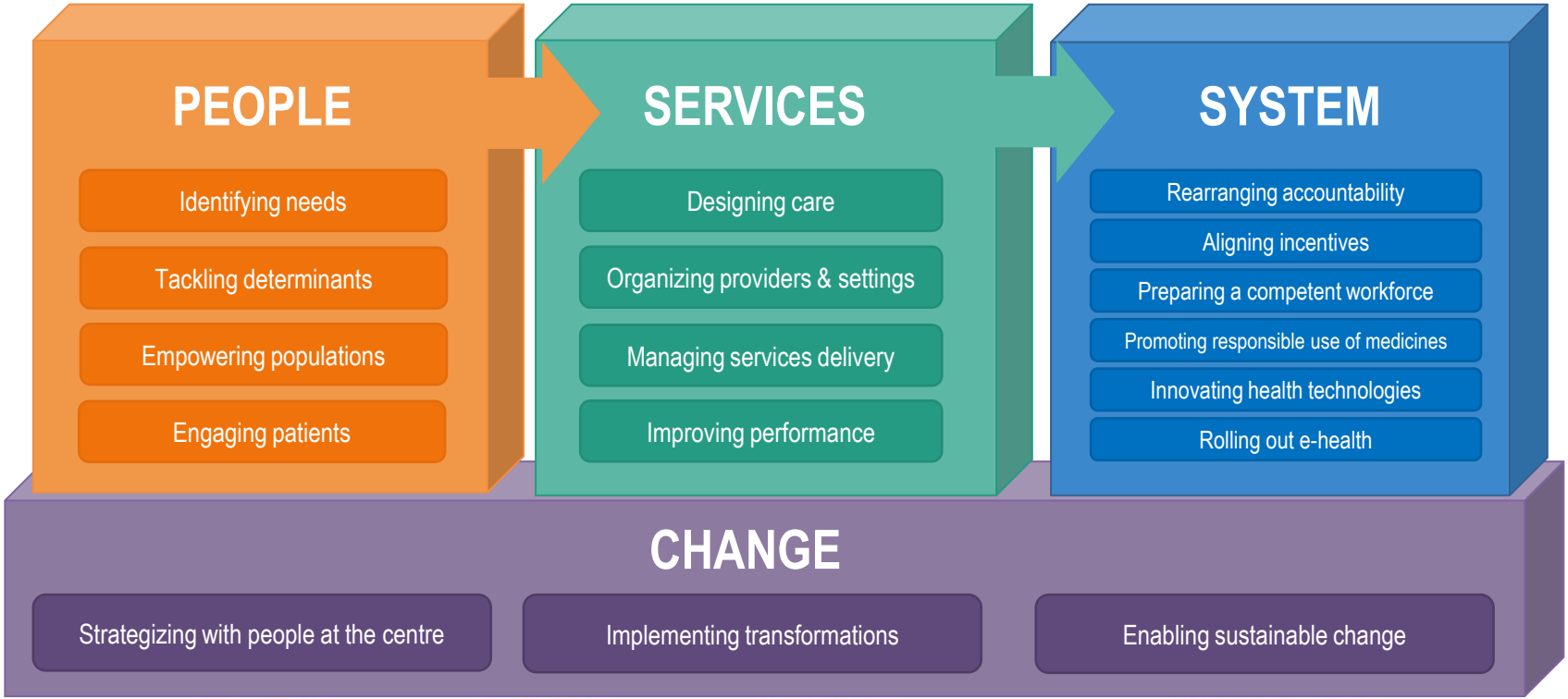
People-centred health systems and integrated health services delivery in the Region

The European Framework for Action on Integrated Health Services Delivery



Learning from practical experiences: An inventory of know-how

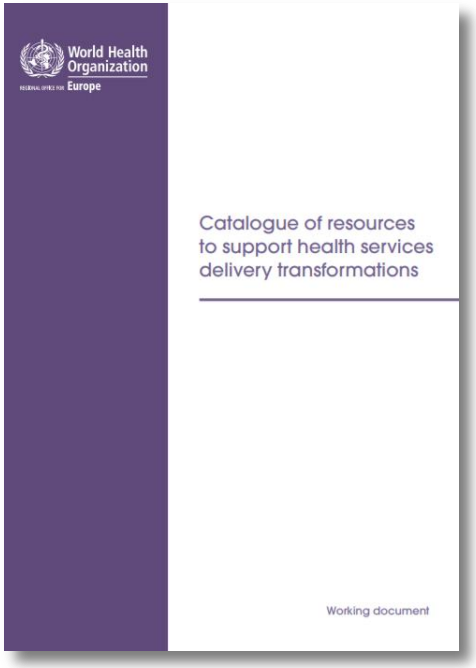
DOMAINS → AREAS → STRATEGIES → RESOURCES

PEOPLE

- Identifying health needs
- Tackling determinants
- Empowering populations
  - Protecting rights
  - Enabling informed choice
  - Enhancing health literacy
    - Health education
    - Interactive programmes
    - Support networks
    - Etc…
  - Supporting community development
- Engaging patients

Source: Retrieve from http://www.euro.who.int/__data/assets/pdf_file/0004/290443/Engaging-patients-carers-communities-provision-coordinated-integrated-health-services.pdf

Learning from practical experiences: Catalogue of resources

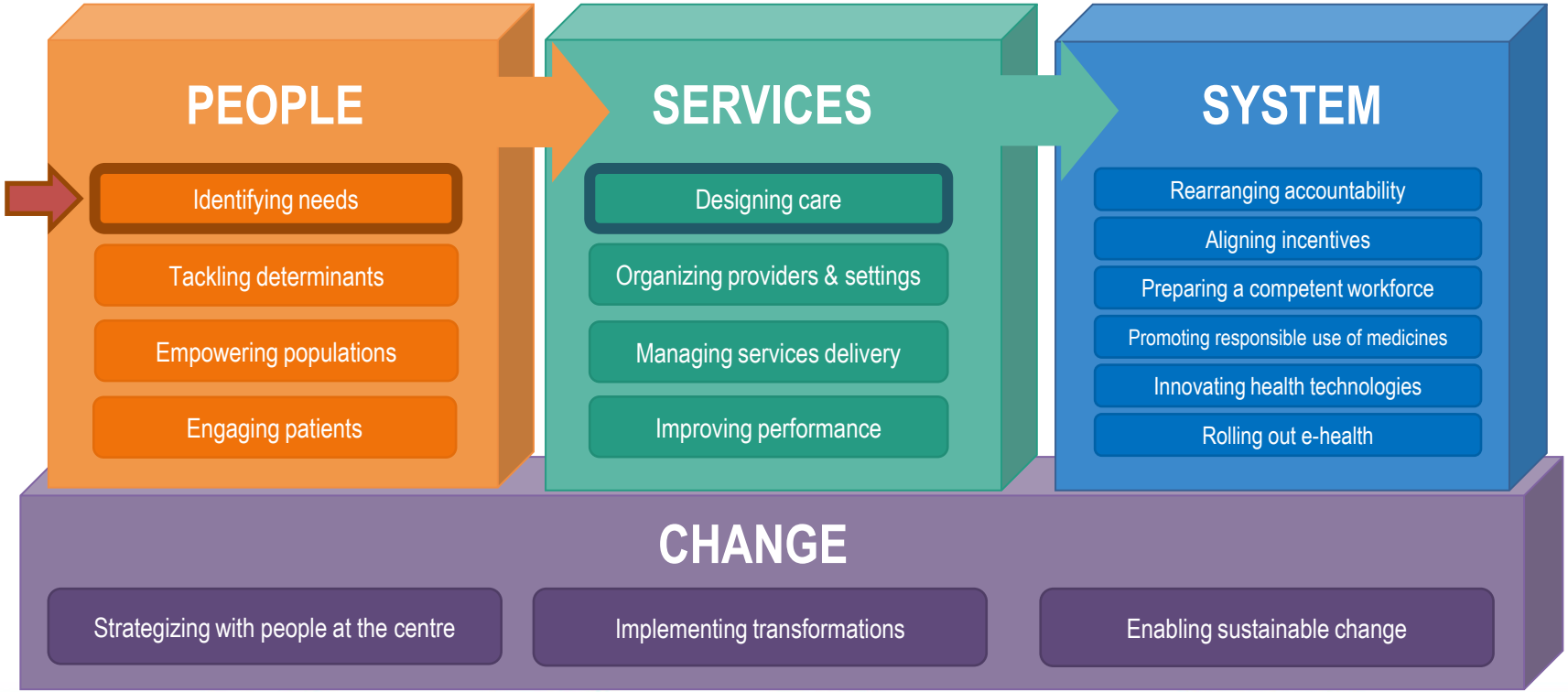


Key strategies	Examples	Resources	Type
Empowering populations			
Protecting rights and fostering shared responsibilities	Apply human rights policies to health according to internationally accepted norms	**Code of conduct for medical and health websites.** (The Health on the Net Foundation, 2014)	3.2
		Summary reflection guide on a human rights-based approach to health. (Office of the United Nations High Commissioner for Human Rights, 2015)	3.2
		A human rights-based approach to health. (Office of the United Nations High Commissioner for Human Rights, 2009)	1.5
		Charter on patient empowerment. (European Patients Forum, 2014)	3.1
	Promote the rights of patients and responsibilities of health facilities	**A declaration on the promotion of patients' rights in Europe.** (World Health Organization, 1994)	5.6
	Encourage and foster capacity for people's participation	**Citizen briefs and panel.** (McMaster Health Forum, 2014)	5.3
		Informed consent. (American Cancer Society, 2014)	6.1
		Talking with your doctor. (American Cancer Society, 2012)	6.1
	Support the co-production of health services and policies	**Experience based co-design toolkit.** (The King's Fund, 2013)	2.2
		Participation compass. (People and Participation Project, 2016)	2.2
	Train providers on the right to health	**The right to health: a toolkit for health professionals.** (British Medical Association, 2007)	2.2
	Develop health promotion activities	**The health promotion strategic framework.** (Health Service Executive, 2011)	1.1
	Support local networks	**Local involvement networks (LINks) explained.** (Department of Health, 2007)	1.5
	Monitor and evaluate the extent to which human rights are upheld	**Human rights impact assessment: a method for healthy policy making.** (MacNaughton, 2015)	4.3
Enabling informed choice	Make relevant Support patier Train providers		
Enhancing health literacy	Establish mecl organizations Introduce inter Improve patier		
Supporting the development of community health	Work with the community and support co-production Engage community development workers and encourage coalitions		

Source: Retrieve from http://www.euro.who.int/__data/assets/pdf_file/0010/317791/Catalogue-resources-support-HSD-transformations.pdf

Population health management

The European Framework for Action on Integrated Health Services Delivery



Continuum of population health management

Use of patient-level socioeconomic and geographic **data** to direct health resources and assess key population-level outcome indicators, such as life expectancy

Approach to health system **integration** and improvement

A strategy whereby population health **status** is improved by accounting for multiple determinants.

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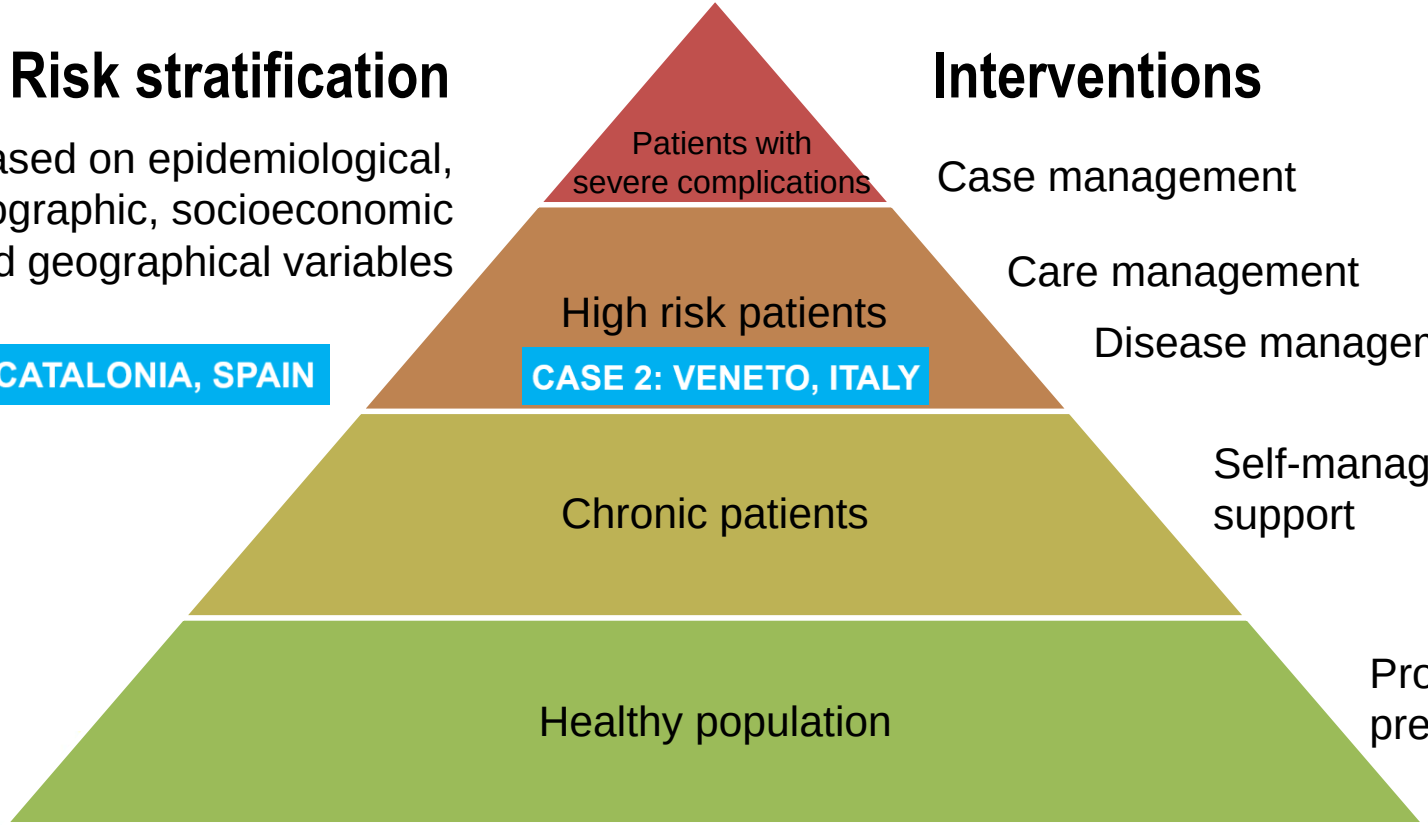
Population health management

Risk stratification

Based on epidemiological, demographic, socioeconomic and geographical variables

CASE 1: CATALONIA, SPAIN



Interventions

Case management

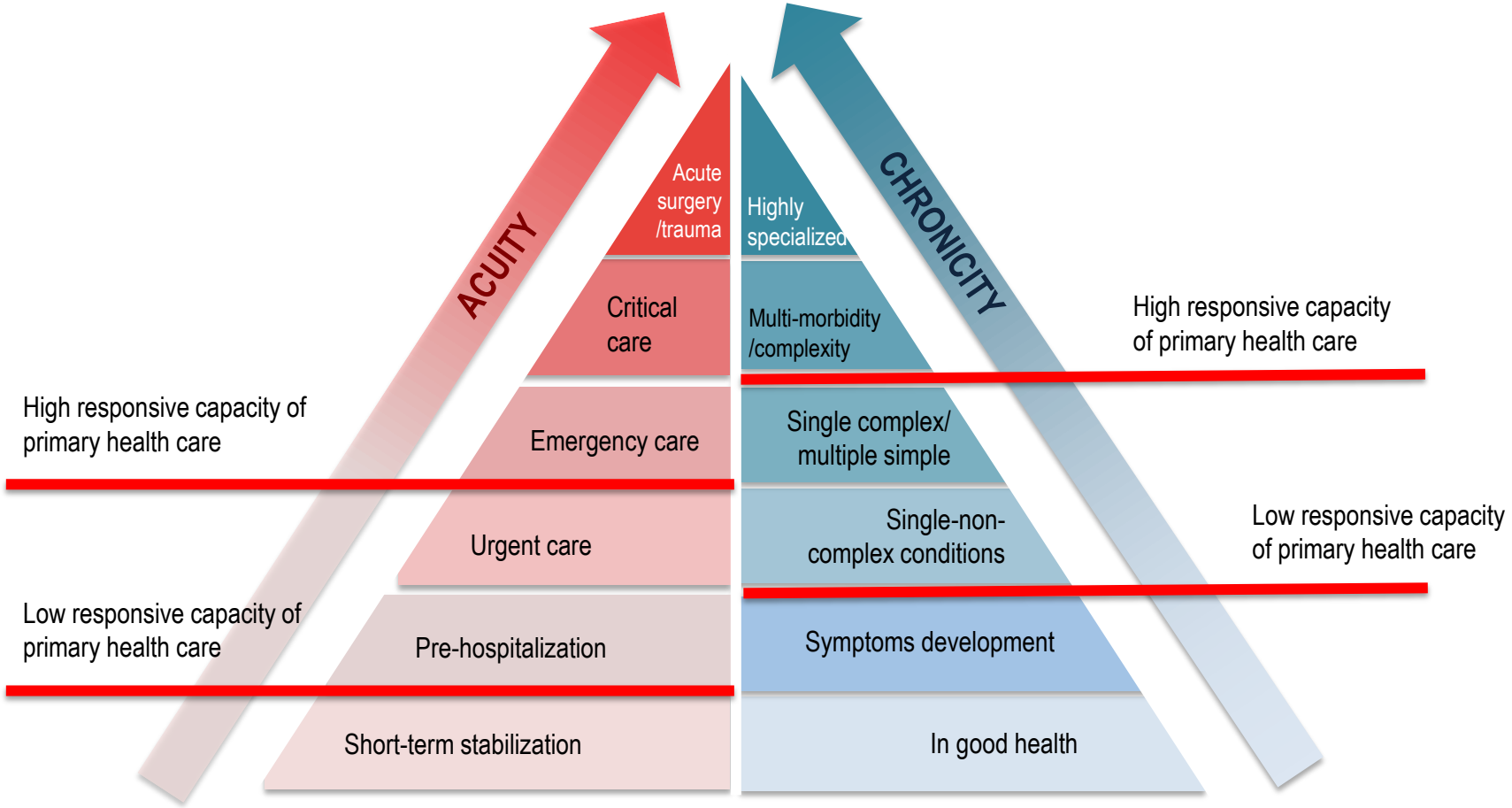
Care management

Disease management

Self-management support

Promotion and prevention

The role of primary health care in population health



CASE 1: CATALONIA, SPAIN

Population stratification: A fundamental instrument used for population health management

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Overview: chronological account of key scale-up milestones

2012

Adjusted Morbidity Groups

Development in Catalonia

Statistical validation

Strategy for approaching chronicity in the Spanish NHS

2015

National scale-up

Collaboration agreement MOH-DOH

Applied to 38 million people

In 13 out of 17 Spanish regions

2017

Multiple applications

Used in different regions for population health management, case finding, strategic purchasing…

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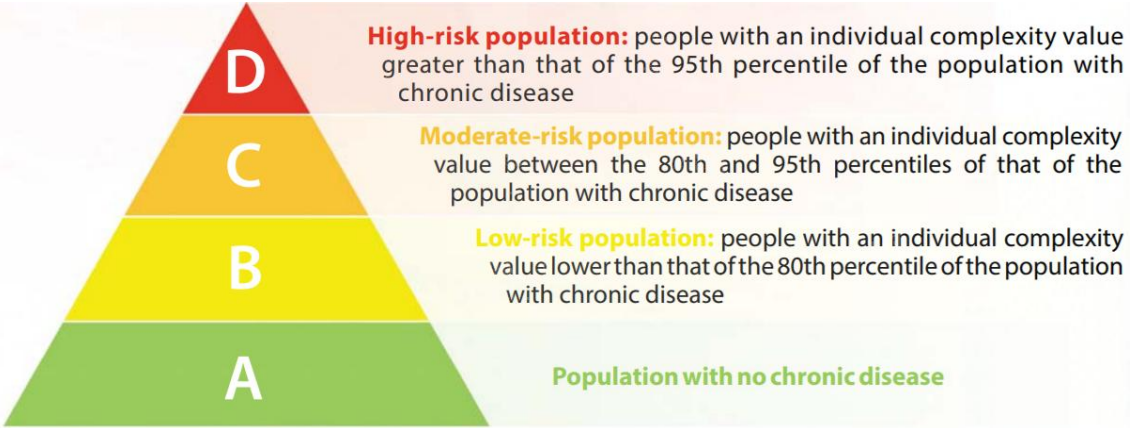
Service delivery interventions

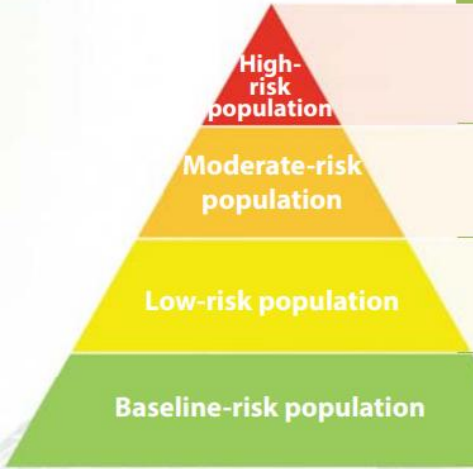
Population stratification: Adjusted Morbidity Groups (AMG)

- AMG is a tool for population grouping and risk stratification that takes into account two factors: **multimorbidity** and **complexity**
- AMG include individual clinical labels and a **complexity score**



Service delivery interventions

Population health management

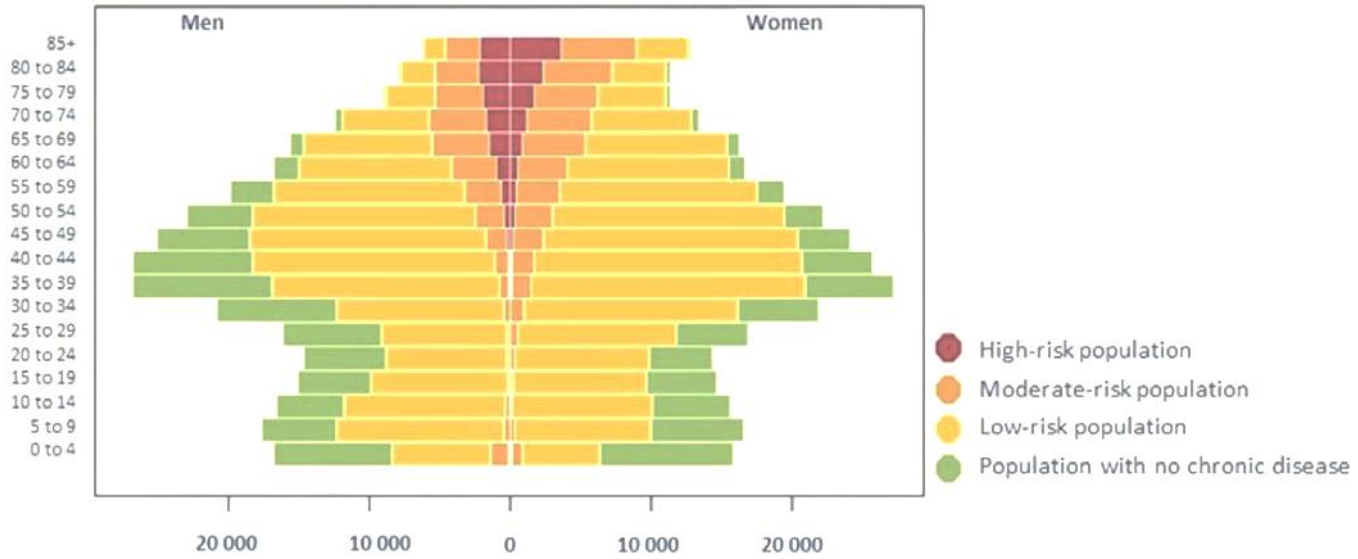


	Population (%)	Mortality rate (x 100)	Visits to primary care (mean)	Emergency admission rate (x 100)	Emergency visit rate (x 100)	Dispensed drugs (mean)	Health care expenditure (mean)
High-risk population	5	16.6	22.2	58.1	160.8	13.4	7067€
Moderate-risk population	15	1.1	12.4	7.5	72.5	8.0	2121€
Low-risk population	30	0.2	7.0	2.9	51.9	3.6	779€
Baseline-risk population	50	0.1	2.0	0.6	17.3	1.0	164€

Source: Ministerio de Sanidad, Servicios Sociales e Igualdad, 2018

Service delivery interventions

Life-course and gender distribution of health risk



Source: Ministerio de Sanidad, Servicios Sociales e Igualdad, 2018

Summary

Impact and uses of risk stratification

- Population health management and case finding
- Proactive case management of high-risk patients in primary care
- Resources, health workforce planning and strategic purchasing

Lessons learned

- ✓ **Health system transformation.** AMG can assist health systems in progressing from disease-centred to patient-centred care.
- ✓ **Proactive care**. Relevant for addressing patients with chronic comorbid conditions from both a system-wide and a clinical approach.
- ✓ **Innovation diffusion.** Nation-wide scale when there are adequate mechanisms for selecting good practices and effective collaboration agreements.

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For more information on population stratification in Spain

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GOOD PRACTICE BRIEF

POPULATION STRATIFICATION:
A fundamental instrument used for population health management in Spain

José Cerezo Cerezo[1] Carmen Arias López[2]

Motivation and summary

Changing health services from a disease-centred to a patient-centred approach was one of objectives of the Spanish Strategy for Approaching Chronicity in the National Health System (2012). A strategic priority for facilitating this transformation was considered to be identification of the health needs of every patient, so that interventions could be tailored. In the framework of the project "Stratification of the population of the National Health System", a locally developed and tested "population grouper", Adjusted Morbidity Groups (AMG), was used in the majority of the Spanish regions to stratify patients' risks according to morbidity and complexity (Ministry of Health, Social Services and Equality, 2018). Risk stratification is widely used in population health management, health service planning and clinical management.

Stratification of the health risks of people with chronic diseases has been adopted in many European countries to strengthen population health management and provide better-tailored services. Some countries have purchased or adapted existing software, and others, like Spain, have developed novel, country-specific population tools for grouping and health risk assessment (Dueñas-Espín et al., 2016; Nalin et al., 2016). These practices are aligned with the European framework for action on integrated health services delivery as one of the key strategies for moving towards people-centred health services (WHO Regional Office for Europe, 2016).

Adjusted morbidity groups

Process

AMG were set up in the Catalan Health Service by the Catalan Health Institute and the TicSalut Foundation as part of the Catalan Prevention and Chronic Care Programme. Later, the Spanish Ministry of Health, Social Services and Equality promoted two consecutive collaboration agreements with the TicSalut Foundation (Catalan Health Service), which enabled the extension of the AMG from Catalonia to the vast majority of the Spanish regions. By 2015, 38 million people had been grouped (Monterde et al., 2016; Ministry of Health, Social Services and Equality, 2018).

[1] Consultant, WHO Barcelona Office for Health Systems Strengthening, Division of Health Systems and Public Health.
[2] Technical officer of the Strategy for Addressing Chronicity in the National Health System, Subdivision of Quality and Innovation, Ministry of Health, Social Services and Equality.

Key Messages

- Risk stratification tools such as the Adjusted Morbidity groups (AMG) can assist health systems in progressing from disease-centred to patient-centred care.
- The AMG can be used to estimate current and future risks for mortality, morbidity and various indicators of health service utilization, enhancing health care management.
- The AMG are particularly relevant for addressing patients with chronic comorbid conditions from both a system-wide and a clinical approach and allow benchmarking at various levels.
- The AMG have proved to be flexible and transferable among regions.
- To develop and put into practice a tool of this nature, reliable, up-to-date, systematized, homogeneous, computerized primary health care records are indispensable.

Available at: http://www.euro.who.int/__data/assets/pdf_file/0006/364191/gpb-population-stratification-spain.pdf

CASE 2: VENETO, ITALY

Using a population risk-adjustment tool to integrate health service delivery

Acknowledgement: Dr Maria Chiara Corti. Director of Division of Epidemiology and Disease Registries, Italy

http://www.euro.who.int/__data/assets/pdf_file/0014/303026/Compendium-of-initiatives-in-the-WHO-European-Region-rev1.pdf#page=153

Context: opportunities and threats

Early 2010s

- **Multimorbidity** is the norm in the population of Veneto Region.
- Care for these peoples is **fragmented** and **expensive**
- Disease management programmes fail, when many chronic conditions are co-prevalent
- Risk stratification is a key component for **case finding** and **case-mix adjustment**.

Overview: chronological account of key scale-up milestones

2012-2013

2 Local Health Units (LHU) pilots (1m hab)

Database building

Statistical validation

Integration with GP diagnoses

2013-2014

6 LHU (2 m hab)

Retrospective analyses :

Focus on specific chronic diseases, depression, diabetes…

Hospital admission predictive modelling

ACG Interface with business intelligence systems

2015

21 LHUs (5m hab)

All LHUs are involved

Regional database is now available

Case management program in primary care

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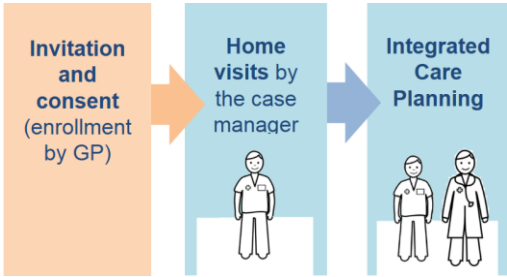
Service delivery interventions

Care and case management for Chronic Heart Failure

- Specially-trained nurses are based in GPs Medical Homes
- The nurse collaborates with 2 GPs in caring for 50-60 high-risk older patients with chronic conditions - congestive heart failure (CHF) - and complex health needs.
- Active monitoring with calls, home visits and outpatient visits.
- A lifelong partnership is developed between the patients and the nurse.
- It is NOT a “one episode” solution.



Service delivery interventions

What case managers do?

1. Assess patient needs and preferences
2. Create an evidence-based Care Guide and Action Plan
3. Monitor patients proactively and support self-management
4. Smooth transitions between sites of care and coordinate with all health care providers: from hospitals to home care and social services agencies
5. Educate and support family caregivers
6. Facilitate access to community services
7. Regularly update care and action plan with GPs.

Summary

Impact

- Significant reduced mortality for CHF hospital admissions. 51% reduction after 3 months, 40% after 6 months, 30% after 9 months and 24% after 12 months.

.

Lessons learned

✓ **Data-driven innovation.** Large data registered for administrative purposes has become a gold mine to support care integration.

✓ **Stakeholders involvement**. Valuable feedback to clinicians and health planners increases the accuracy of case finding and boosts cooperation.

✓ **Fruitful synergies**. Integrate care improved by combining efforts and integrating projects and experiences.

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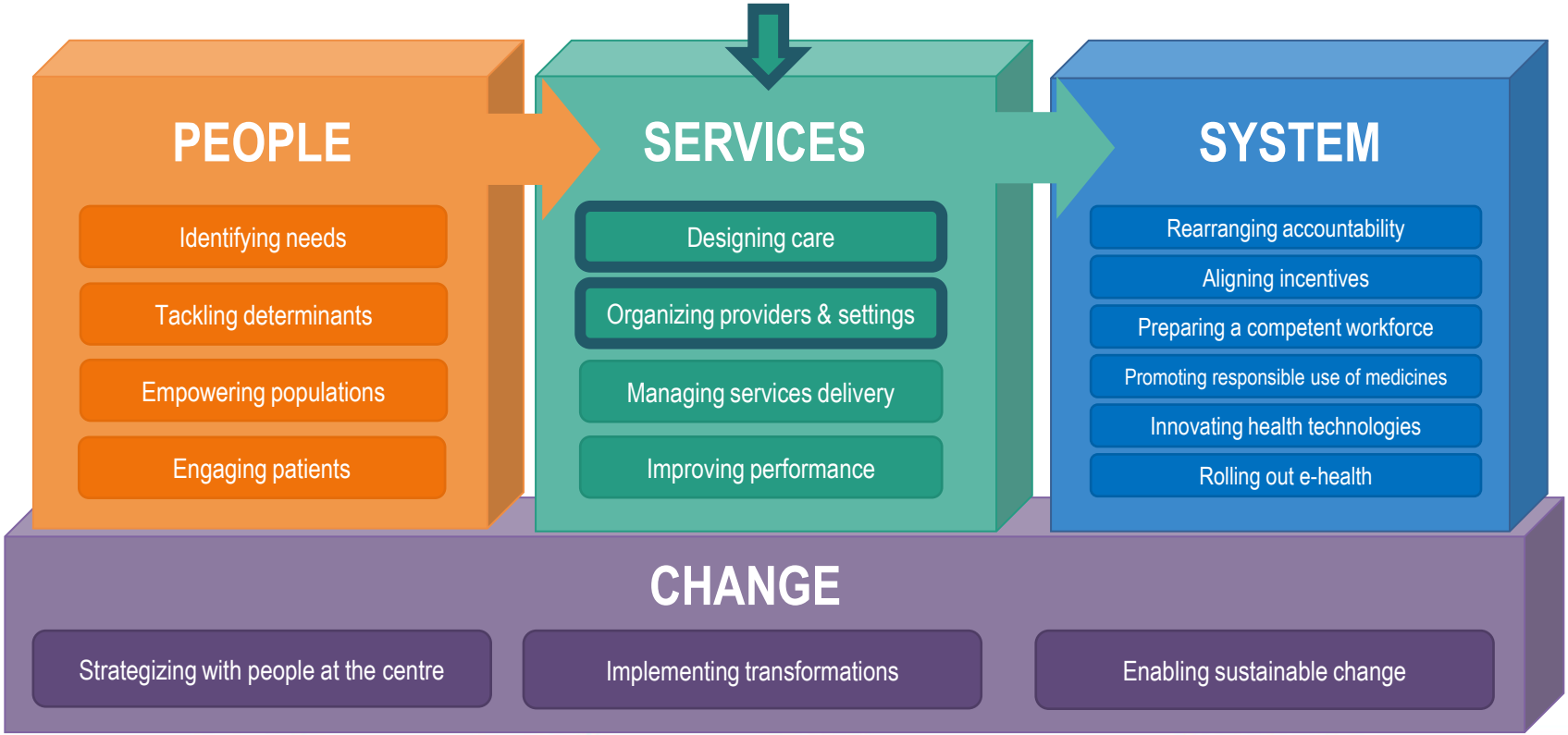
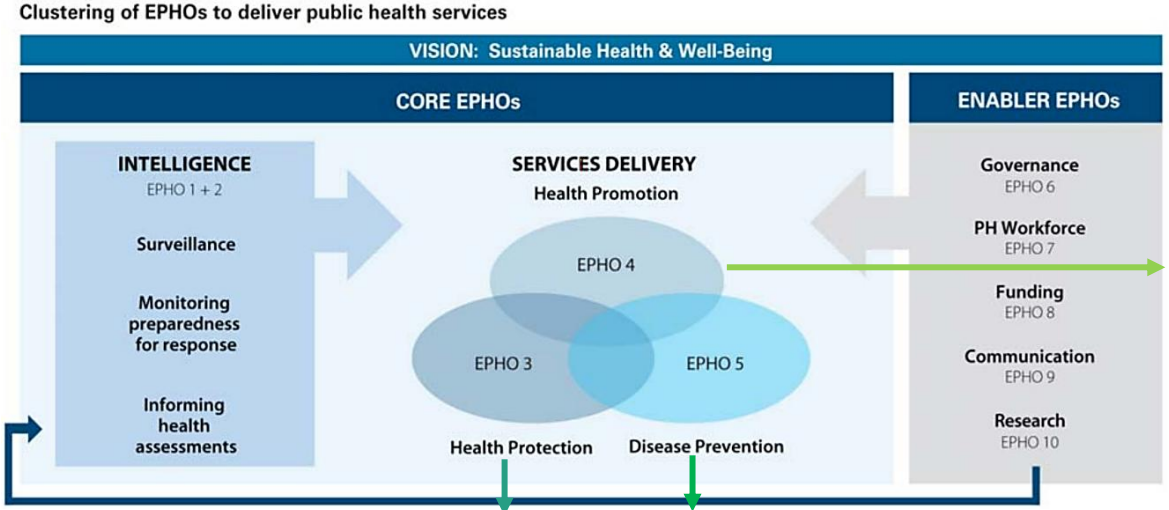
Prevention services

The European Framework for Action on Integrated Health Services Delivery



Public health and primary care

Essential Public Health Operations (EPHO)



EPHO4
Health Promotion
including action to address social determinants and health inequity

EPHO3
Health protection
including environmental occupational, food safety and others

EPHO5
Disease prevention,
including early detection of illness

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Preventive activities in primary care

Integration and coordination with public health services, specialized, inpatient and long-term care, and social services

- Health promotion and education in healthy habits
- Social assessment: vulnerable groups
- Vaccinations and
- Screening of risk factors: alcohol, smoking

- Screening of diseases: CVD, COPD, DM (retinopathy), cancers…
- Control: lipids, HBP, HbA1c…
- Health education: use of COPD inhalers…

- Home health care: case complexity assessment
- Control in at-risk population: lipids, HBP
- Health education: Expert patient programmes

- Avoid overdiagnosis and overtreatment:
- Do not do recommendations (NICE, UK; Essencial, Catalonia)
- Ex: Avoid inadequate use of PSA

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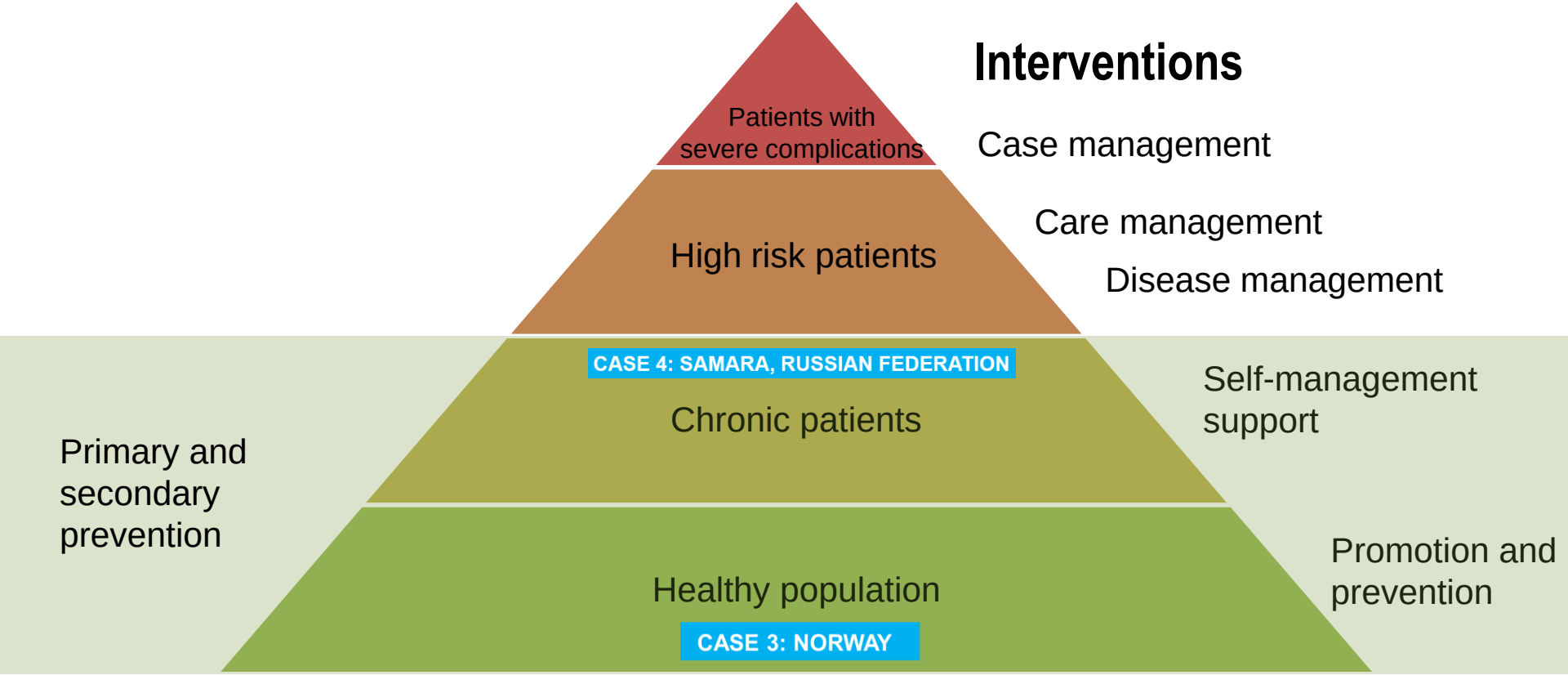
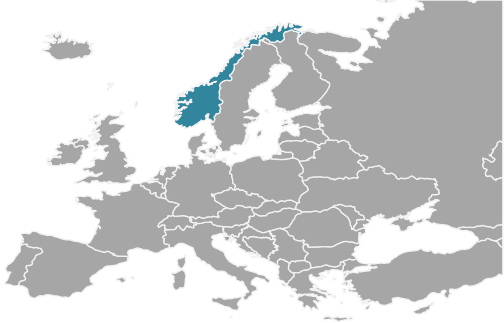
Preventive activities in primary care



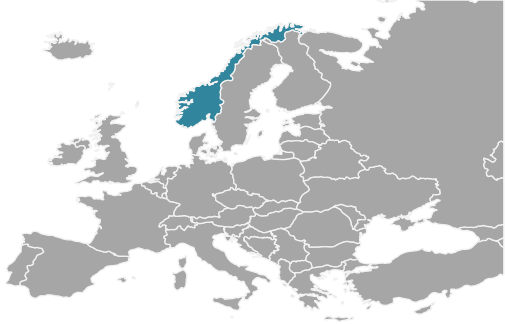
CASE 3: NORWAY



Healthy Life Centres

National rollout of Healthy Life Centres in Norway to improve population health
http://www.euro.who.int/__data/assets/pdf_file/0014/303026/Compendium-of-initiatives-in-the-WHO-European-Region-rev1.pdf#page=200

Context: opportunities and threats

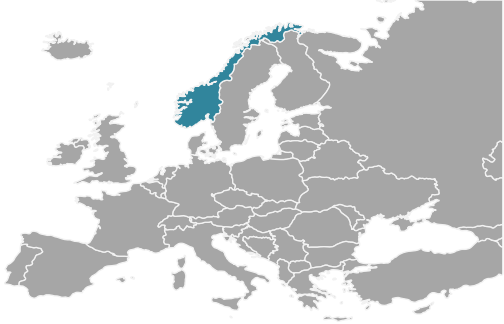


Early 2000s

Demographic	Continuous gains in life expectancy; 2012 average of 82 years at birth (relative to 77 years in European region)[1]
Epidemiological	Increasing NCDs; leading causes: CVD (33%) and cancers (27%) [percent of total deaths all ages]; increasing chronicity[2]
Socio-cultural	Poor life style choices and health behaviours (e.g. smoking; diet) a leading cause of morbidity
Economic	Rates of work absences of full-time employees highest in OECD 7% of the workforce on sick leave at any given time (x2 rate of Nordic countries)[3]
System	Reactive system to services delivery contributing to late-stage diagnosis; lack of resources (human, time) in PHC to extend promotion/prevention

1 (WHO/EURO, HFA,2014); 2 (WHO/EURO, NCD Profiles, 2014); 3 (Ringard, et al. *Health Systems in Transition Norway,* 2012) .

Overview: chronological account of key milestones



1998

Local implementation
First *Healthy Living Centre* established in Modum Kommune to address workforce absenteeism

2002

Experimentation with national interventions
Introduction of 'green prescriptions'; failed to tackle root cause of sub-optimal prevention & promotion

2004

Review and pilots
National evaluation of model; launch of 5 municipal pilots in partnership with Directorate of Health

2008

Launch of national strategy
Directorate officiates priority for municipal action to extend promotion & prevention services

2011

Resources for introducing Centres
Guidelines and supports established for introduction of Centres across municipalities

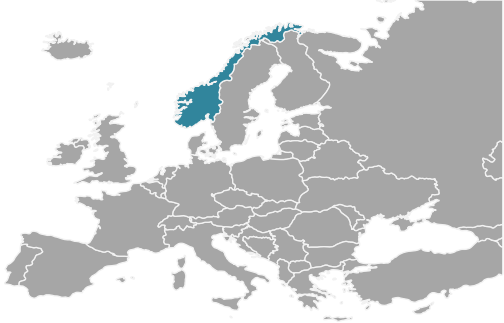
2012

Legislative change
Mandate for prevention and promotion services to be provided in all municipalities across the country

2014

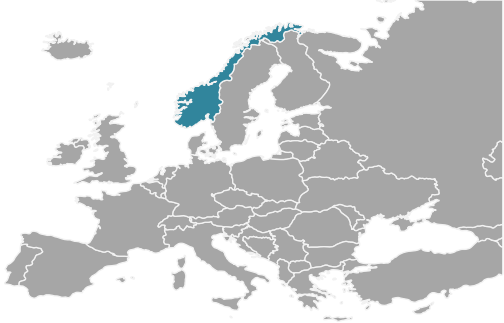
National rollout
Currently 183 *Healthy Living Centres* serving 212 of Norway's 428 municipalities

Service delivery interventions



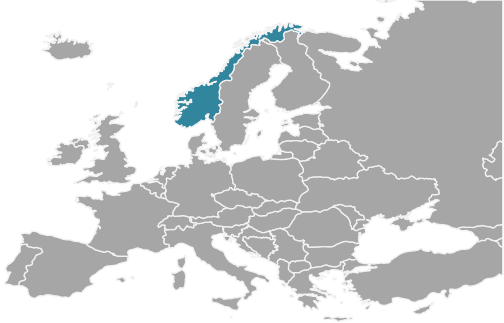
Barriers	Interventions
Lack of effective disease prevention or health promotion services	Extended continuum of services defined according to municipal needs; 12-week intensive programme
Brief, generic information for patients; limited follow-up care; unsustainable behaviour change.	Personalized care plans designed based on principles of motivational interviewing
GPs responsible for preventive care; limited time and lack of specialist training in health behaviour change	GP referral to Healthy Living Centres; multidisciplinary team of public health specialists
No dedicated resources for health promotion interventions municipally	Partnerships with public facilities to optimize resources
Gap in provider trainings to substantiate behaviour changes	Provider trainings and skill-advancement opportunities for motivating/sustaining behaviour change

Supporting system conditions



Governance	Legislation mandating universal expansion of service package across municipalities; devolved authority for municipally designed/managed services
Financing	National funds allocated by the Directorate of Health providing start-up funds to municipalities.
Information	Reporting requirements established by the Directorate of Health for regular evaluation of activities; reporting on progress

Summary



Impact

- Review of pilot sites finds follow-up for behaviour change for improved fitness to reduce weight and increase self-perceived health
- Half of participants in physical activity groups found to maintain progress one year after finishing standard 12-week programme
- 40% success rate in quitting smoking among participants in smoking cessation programme

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Lessons learned

✓ **Clear vision.** Direction given by Directorate of Health a key factor in generating national momentum for Healthy Living Centre model.

✓ **Local action.** Municipal action ensures locally designed/tailored Centres to meet community needs

CASE 4: SAMARA, RUSSIAN FEDERATION

Advancing nursing roles to improve disease prevention services

http://www.euro.who.int/__data/assets/pdf_file/0014/303026/Compendium-of-initiatives-in-the-WHO-European-Region-rev1.pdf#page=224

CASE 4: SAMARA, RUSSIAN FEDERATION

World Health Organization
REGIONAL OFFICE FOR Europe

Organisation mondiale de la Santé
BUREAU RÉGIONAL DE L' Europe

Weltgesundheitsorganisation
REGIONALBÜRO FÜR Europa

Всемирная организация здравоохранения
Европейское региональное бюро

Overview: chronological account of key milestones

1996-1997
Expand preventive health services
Conception for Development of Health Care in Samara 1996–2000
Principles of family medicine as a key goal

1998
Electronic medical record
Introduced within Polyclinic 15

1999-2004
Expansion of nursing expertise
Partnership between Polyclinic 15 and the American International Health Alliance supports the expansion of nursing expertise and scope of practice.

2006
National Priority Project - Health
launched with the aim of strengthening primary care and modernizing health facilities across the Russian Federation; Polyclinic 15 receives resources under the Project.

2012
National standards for prevention
Health Care Development Programme aligns with Polyclinic 15 standards

Present
Continued support
for strengthening of the role of nurses and expanding services delivery within Polyclinic 15.

Service delivery interventions

Barriers	Interventions
Guaranteed basic package of services; limited health promotion or disease prevention services.	Expanded services package includes health promotion, screening and disease prevention
Absence of guidelines or protocols to guide delivery of care by nurses.	Evidence-base guidelines & risk assessment tools created to assist nurses to fulfil expanded roles;
Nurses work as physician assistants w/o an independent role; physicians overburdened; paper-based records.	Shift of responsibilities from physicians to nurses; nurses assist physicians and receive patients independently; EMR enable information sharing.
Outdated infrastructure restricts effective services delivery.	Investments in EMR and a new scheduling system; medical resources updated with public & foreign funding.
Nurses lack necessary skills to take on more advanced roles; paper records inhibit timely performance assessment.	Nurses participate in additional on-the-job and ad hoc trainings to develop the skills for independent practice

Summary

Impact

- Time-efficiency gains derived from the new scheduling system and task sharing with nurses have improved access to providers for patients; physicians report having more time to spend with high-risk patients.
- The number of patients receiving health risk assessments from nurses almost tripled from 2267 in 2007 to 6675 in 2012.
- Improved screening has increased detection of diseases in less advanced stages; disease complications and need for hospitalization have reportedly declined as a result.
- Participation in health education schools increased from approximately 1000 patients in 2006 to 11 000 in 2014; schools help empower patients to improve their health and self-manage care.

Summary

Lessons learned

- ✓ **Innovation follows autonomy.** High levels of autonomy supported the development of innovative practices.
- ✓ **Upskilling nurses.** Changes to professional scope of practice helped overcome capacity barriers.
- ✓ **International support** to transfer knowledge and advance new practices
- ✓ **Continuous training**, backed by supportive legislation, helped to institutionalize new practices.
- ✓ **Patient empowerment**. Patient education was offered to help empower patients to adopt healthy lifestyles and increase self-management of care.

Take aways

- Risk stratification is an effective tool for population health management, **proactive care**, and redesign of targeted primary care interventions.
- As health is only partially produced by healthcare services, we need to encourage upstream **intersectoral action** across the government and society.
- Enhanced coordination with **public health services** and the **expanded role of nurses** makes primary care more responsive.
- Primary care has the potential of playing a much **stronger role** in disease prevention across all areas of prevention.

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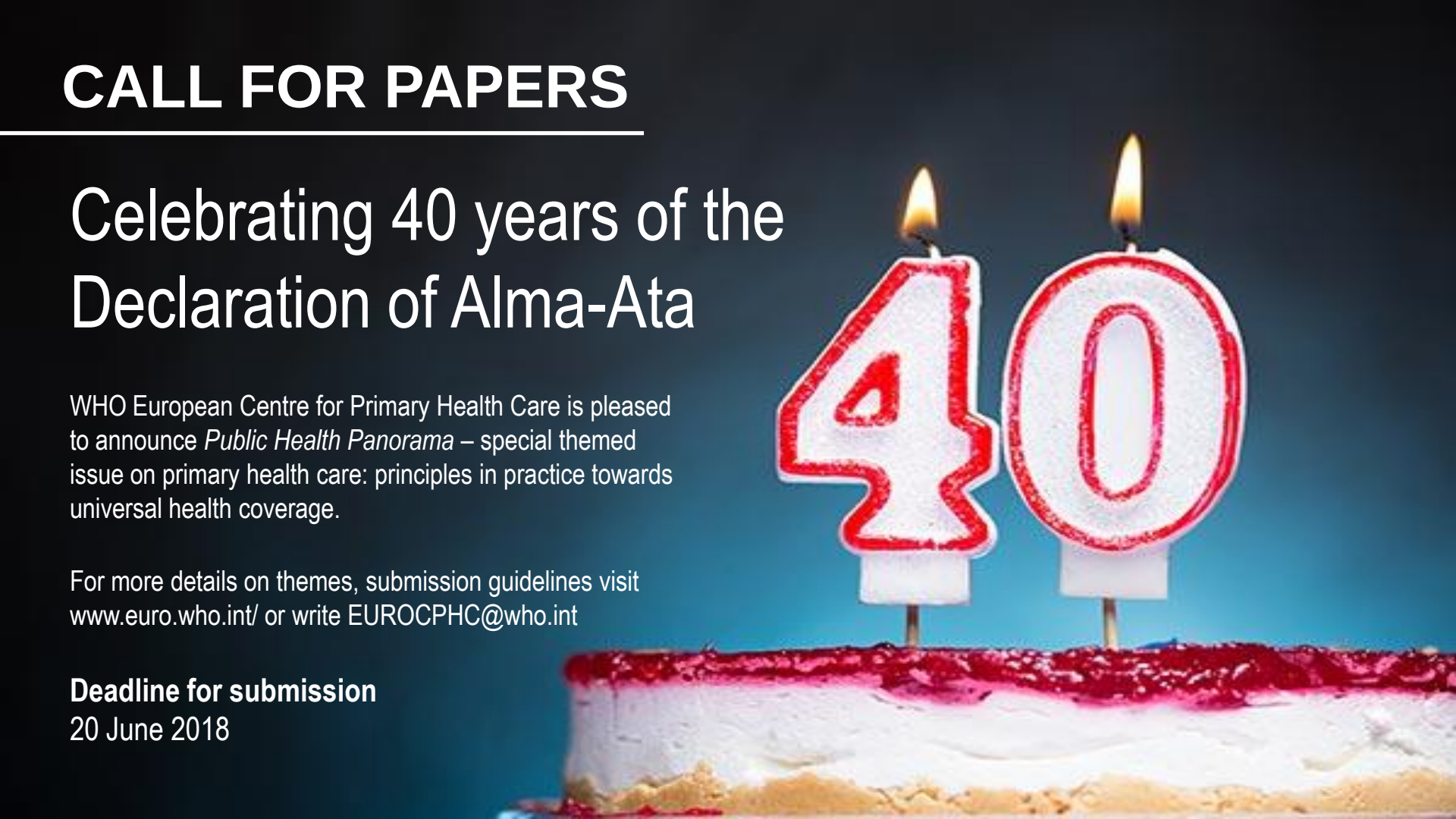
Deadline for submission
20 June 2018



European Framework for Action on
Integrated Health Services Delivery

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For more information on health services delivery at the WHO European Regional Office for Europe, visit:
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