Getting prepared for Interprofessional Primary Care in Switzerland

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Ongoing Transformations in medical education and health policy
To be or not GP

How many will be a GP?
- 2004: 8%
- 2005: 11%
- 2006: 9%
- 2007: 8%
- 2008: 12%

How many will be not a physician?
- 30%

How many will be a specialist?
- 63%

How many will be a geriatrician?
- 95%

One in four Europeans will be over 65 by 2030

Slow Motion Changes → new Models of Care and new Responsibilities

Demographic trends, health & social issues

Population needs & patients expectations

Resource constraints & rationalization of expenditure

Changes in clinical patterns & healthcare delivering models

- New responsibilities
- New competencies
- New abilities

Source: European Hospital and Healthcare Federation (2009), Health Professionals in Europe: New Roles, New Skills
Envisioning the Future of Health and Care

Dimensions of quality
- safe
- effective
- patient-centered
- timely
- efficient
- equitable

Additional dimensions
- continuous
- integrated
- interprofessional
  … system related

Traditional GP system
("doctor with helper-model")
= politically pushed
but: not attractive young physicians

→ *Disruptive Innovation*

but: bringing together professionals who used to co-exist in functional and structural (and mental) parallel worlds is a major issue

Case Mix Argument: «slippery slope, slow motion towards the plain of chronic diseases»

Acute care relatively less important

Enormous raise of needs:
primary care, rehab, chronic care management
pain, good end of life

Less Structured Authority:
interprofessional co-management
of complex situations
of low urgency

→ better outcomes + performance
→ higher quality of life

« caring » requires « sharing »
Physicians → Specialists

Traditional GPs → Specialist for General & Internal Medicine ≠ GPs

Room for new Provider Configurations and Arrangements

Strategic answer: add capacity, add competence
Primary care clinicians would **need 18h/day** to provide excellent care and even more hours for care coordination; and older and sicker patients require even more visits → **not a sustainable enterprise**

Paradigm shift & strategy for increasing capacity
Shift from an "I" to a “we” mindset ≠ lone-doctor-with-helpers model

“we” paradigm uses a team with a reallocation of responsibilities, not only tasks nurses, medical assistants, health educators etc. must add capacity in order to bring demand and capacity into balance.

Bodenheimer 2008

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**Strategy of Further Qualification in Nursing**

«Primary Care Home Care»

Quality of caregiving and quality of life, based on MScN

Focusing on Home Care

- Work on the Borders: Home visits with Clinical Assessment / Advanced Level Mentorship MD & Peer Mentoring
- Internationally established functions in nursing – Model NYVNS
- Intra- & interprofessional transformation

Die Pulsation liefert dem Pflegefachmann Informationen, wo genau das Zentrum des Schmerzes liegt.
New roles in nursing to meet the needs & to foster interprofessional collaboration

Starting Point
• Increase of needs among patients with long term conditions
• Traditional Education in Nursing and Medicine barely prepare for these categories of patients
• Care Industry urges to enlarge competencies for care at home

Consequences
• Kalaidos UAS Health develops curricula in Complex Care and clinical Nursing containing 900 hours of clinical training in collaboration with Nurse Practitioners from anglosaxon universities and physicians
• Content: e.g. 30 ECTS clinical assessment, management of therapies and medicines, mentorship by patients and relatives

Foundations
CanMEDS-Roles & APN-Roles (Hamric)

Need for Transformation
- recognize interrelations
- broaden competencies + reflect framing needs
- more clinical training
- joint solution finding
- health systems literacy
- attractive workplaces

Hamric, 2014
Bachelor of Science in Nursing – Acquired Competencies

- Are able to think critically, are open-minded towards new findings, and comprehend causes and effects through research
- Give room to the patient’s conditions and needs, build trust, and document results thoroughly
- Analyse patients learning needs / motivation, and find solutions together with patients/siblings
- Are able to purposely judge the patients situation by thematic classification, choose and suggest specific activities, reflect and adjust them

Master of Science in Nursing – selected competencies (work in progress)

- Initiate the development of their own professional role and of the health and social system
- Assess clinical results systematically, monitor the patient’s condition continuously, initiate examinations and treatments, evaluate them
- Are able to identify overuse, underuse, and misuse in patients with increased health risks
- Take on the lead in complex cases, give thematic guidance and integrate the perspective of care into new caregiving models and technologies
2 Mentoring Formats enhancing competencies of MScN

• Medical mentorship along the Cognitive Apprenticeship Model: Modeling-scaffolding-fading-coaching
  - Examination of the body – making a diagnosis – initiating treatments
  - Inter-professional collaboration

• Mentorship by experienced patients or relatives:
  - Reflect everyday experiences
  - Gain insight on sickness, disability and frailty of elderly

The doctor and I share our assessment results, and plan the treatment together. The patient feels comprehensively cared for and lets us know this, too. (MScN student)

My patients’ life at home is like a blackbox to me. (Senior Doctor of a University hospital)

Outcomes

• Students are able to identify patient problems relevant for their workplace (reasons - solutions):
  - pollakisuria/nocturia
  - lack of concentration
  - fear
  - adherence – non adherence

• Students find evidence-based approaches to innovative solutions

• Nursing staff are sensitized to recognize individual patients’ problem faster and to offer profound, evidence based solutions

• Nurse practitioners develop training programs, brochures, u.a. consultation by telenursing for persons in prison
Cost effects in the Netherlands

Substitution of GP by NP for out-of-hours visits
- NP needs more time & has less consultations

<table>
<thead>
<tr>
<th></th>
<th>NP</th>
<th>GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients / hour</td>
<td>2.4</td>
<td>3.1</td>
</tr>
<tr>
<td>Average duration (min)</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Costs in Euro (total)</td>
<td>38.59</td>
<td>46.17</td>
</tr>
</tbody>
</table>

- Adjusted to complexity of cases = 4.42 Euro

→ Substitution leads to cost reduction

(Van der Biezen et al.)
Observation of an NP in Primary Care

Learning in a «Shadowing» Process

A) Structured Guide on Tablet; pull-down menu selection; observation and assessment items
- objective aspects: case and setting, categorization, diagnoses ICD, description of activities and services provided
- subjective assessments, i.e. appropriateness of competences, need for support and guidance, redundant/overlapping activities, added values satisfaction of patients, relatives, NP herself, the observer, the GPs and the MPA.

B) Next Step: document reflection on learning processes along taxonomic scale

Case Mix encountered by MSc Nurse Practitioner in Primary Care

Phase I: Shadowing of 29 visits during 2 weeks, «usual business» of NP

A. Infectious & parasitic diseases
B. Blood & immune system
2. Mental & behavioural disorders
H. Eye, ear & adnexa
J. Respiratory system
L. Skin
N. Genitourinary system
1. Age

21% 31% 55% 1%
Case Mix encountered by MSc Nurse Practitioner in Primary Care

Type of competences needed according to diagnoses
Satisfaction

- Physicians perform many tasks that do not require a medical degree and could thus be delegated...

Bodenheimer Health Affairs 2008

Added values of learning acc. to Bloom et al.
reaching higher steps and peaks
acquiring more complex capabilities
Added values of learning acc. to Bloom et al. reaching higher steps and peaks acquiring more complex capabilities


Outcomes:
Transformation of Practice and Policy
Strategy of Further Qualification in Nursing «Primary Care Home Care»

Quality of caregiving and quality of life, based on MScN Focusing on Home Care

- Work on the Borders: Home visits with Clinical Assessment / Advanced Level Mentorship MD & Peer Mentoring
- Internationally established functions in nursing – Model NYVNS
- Intra- & interprofessional transformation (transgression) of borders
  - Assessment/Diagnose/Interpretation/
    Priority setting
  - Communication about Findings & Therapies with GPs, Specialists, Nursing services
  - Collaboration and Care planning
  - Case Management
- Development of Practice
  Health Policy Debate, Reimbursement
- Result: maybe Substitution of GPs more important: better access by nurse-led / nurse-enhanced Primary Care

Complexity is raising due to the chronic conditions thirst
It needs adaptive strategies – considering the needs of concerned categories

Conditions of frail elderly have to be considered in (almost) all strategies and activities
Challenges in the raising ambulatory health sector cannot be solved by GP’s alone without interprofessional collaboration – including task shifting!

Nurse practitioners in primary care are a sound and sustainable response

What are potentials for improvement in the training offered?

Conceptual and practical advice & backing