



# Skill-mix innovations in primary and chronic care: Mobilising patients, peers, professionals

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## Take-home messages

1. In primary and chronic care, nurses are central to skill-mix innovations including nurse assistants, prevention and health promotion nurses, specialist nurses, chronic care nurses and prescribing nurses;
2. Most skill-mix innovations for nurses were implemented to unburden medical doctors from non-medical or simple medical routine tasks;
3. There is an emphasis on team building;
4. Non-health workers like fire-fighters, social workers, housing officers and volunteers in social services are increasingly part of skill-mix innovations.



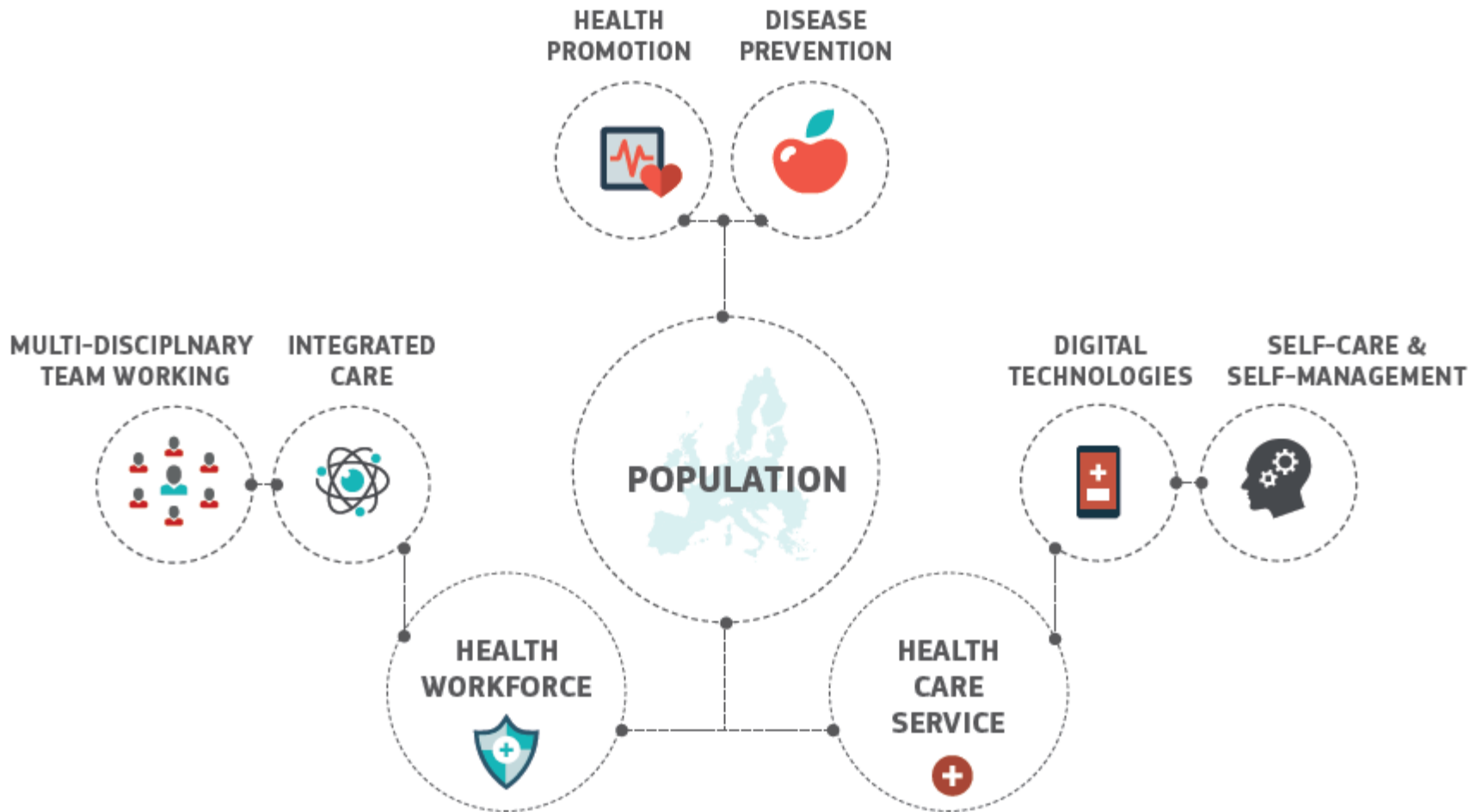
# Overview

- Background
- Skill-mix innovations
- Cross-cutting themes: periods, reform goals/strategies and implementation
- Country examples
- Conclusion



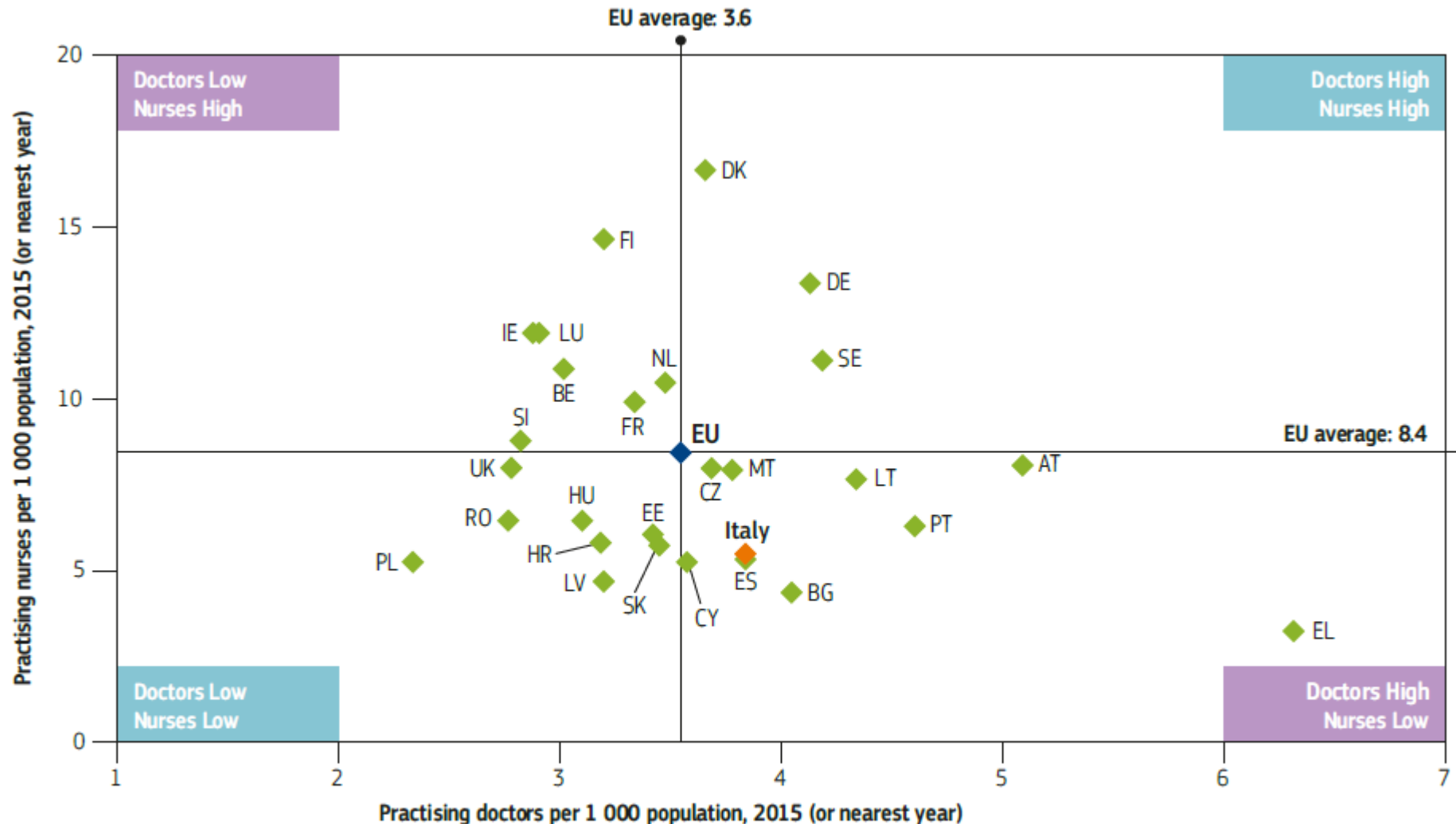
# Skill-gaps

Figure 4.2 The driving forces influencing future skills and competences





# Density of doctors and nurses



**Note:** In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

# Background: Patient, peers, professionals: skill-mix innovations for primary and chronic care.

## 17 country case studies (forthc. 2018)

### Vol I: Country case studies

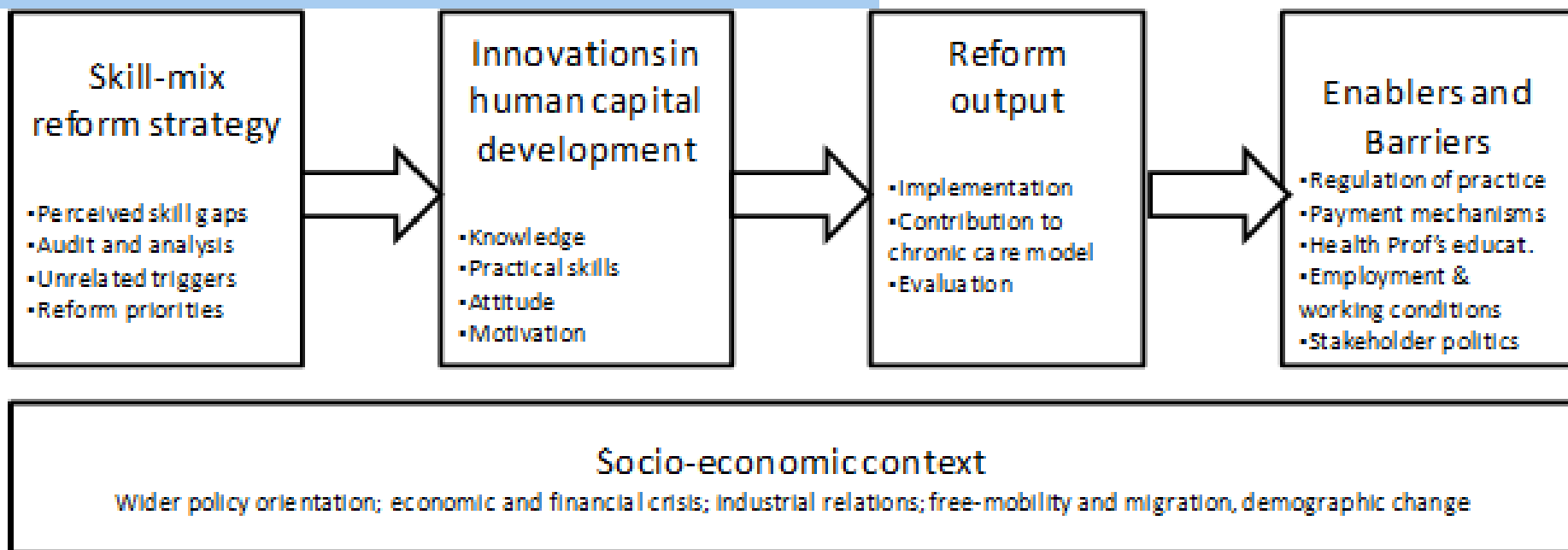
- Skill-mix

### Vol II: Innovation and implementation

- Keeping healthy / health promotion and prevention

NO

Figure 1: conceptual framework for the skill-mix study



## Box 2.2 Attributes of innovations

An innovation is an idea, practice or object that is perceived as new. An innovation is more likely to be adopted if potential adopters consider that it has the following attributes:

- **Relative advantage:** The innovation is better or more efficient than whatever is currently used.
- **Low complexity:** The innovation is simple to understand and use (or, if complex, can be broken down into simpler components).
- **Compatibility:** The innovation and its use align with prevailing values and ways of working.
- **Observability:** The effects of the innovation are easily observed and measured, and can be unambiguously attributed to it.
- **Trialability:** The innovation can be tried out on a small scale before people commit.
- **Potential for reinvention:** Users can customise the innovation to suit personal preferences and/or local circumstances.
- **Ease of use (for technologies):** The innovation is easy to use and/or comes with adequate technical support.

*Source: Adapted from Rogers [15].*

Greenhalgh 2017

## Skill-mix innovation

- An innovation in country A may be an 'old hat' in country B

Chronic care, multimorbidity, self-management

39	Home adaptation suited to patient condition and improve	Introduction of home-based care	Occupational therapist	Pilots: home-based occupational therapy in 7 of	Belgium
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Rural a/o deprived areas

74	<ul style="list-style-type: none"> <li>- Home-based care for patients over 75</li> <li>- Frailty assessment</li> <li>- Individual care plan</li> <li>- Care coordination (social, medical)</li> </ul>	Introduction of home-based care and of new task	GP, pharmacist, nurse	Nationwide: <u>PAERPA</u> programme since 2016, piloted in 2013 (nine locations in both rural and urban areas)	France
6**	<ul style="list-style-type: none"> <li>- Prevention, patient counselling (e.g. diabetes, cardiovascular risk management, COPD, dementia screening)</li> <li>- Chronic disease management</li> </ul>	Role expansion and introduction of team model	Public health nurse	Nationwide: <u>ASALÉE</u> involves ca. 2% of GPs (>1000), 300 FTE nurses, 300 000 patients	France
51**	Routine care-related tasks for chronic patients (home visits, geriatric assessments, patient education, vaccination, prevention)	Role expansion	Medical assistants, nurses	Federal States; initially especially in rural or under-served areas but has since been expanded	Germany





# Analysing the reported cases

Primary care segments	74*	Professions	74+
Keeping people healthy	10	Nurses (all sorts)	29
Acute care	30	Pharmacists	8
Chronic care, multi-morb.	26	Physiotherapists	5
Long-term and palliative care	12	(Social) care workers	4
Rural a/o deprived areas	5	Volunteers	5
		GPs	3
		Physician assistant	3
		Paramedic	3
		Oral dental Hygienist	1
		Other prof.	12

**10 x teams**



# Skill-mix policies and reforms: Periods and timing

- In virtually all countries reforms and skill mix developments 1) are ongoing, 2) seemingly with increasing activity, and 3) persist even with changing governments
- Typical period covered by case studies start in the early 2000s
- Some case studies report activities further back
  - Finland early 1990s local initiatives,
  - France 1990s mobile teams for palliative / geriatric care
  - Canada 1990s shared care family-mental health, expanded scope for physiotherapists
  - Germany 1990s long-term care insurance



## Skill-mix: Policies and reforms

- **Reform goals:** strengthening primary care; improving access; patient centeredness; cost-containment and financial sustainability; disease specific; evolution over time
- **Reform policies:** few explicit
- **Reform strategies:** top-down, bottom-up, soft tools (pilots, projects, experiments); task dumping; multitude of strategies
- **Windows of opportunity:** crisis-led; political change; market driven; transition and international technical assistance; reform of regions/decentralization; shortages (mostly doctors); new health system vision



# Eight strategic elements for implementation

1. long-term commitment
2. piece-meal approached (no overall plan or policy but incrementalism dominates)
3. creation of innovation-labs for training and delivery,
4. legal latitude and financial space for piloting innovations
5. pilot-upscale/pilot-kill mechanisms to avoid an ineffective 'pilotitis'
6. cultural conformism to appease stakeholders
7. self-induced culture change of the medical profession
8. creation of focusing events and using windows of opportunity



## Striving for integrated care and efficiency in *Finland*: country-wide and local skill mix innovations

- **Triggers:** 1990ies Shortage of MDs in primary care; cost-containment; 2000s Improvement of access; integration of care; Since 2008 cost-containment
- **Innovations:** nurse consultation/prescribing [27]; health centre chronic care nurse [45]; chronic care teams [46]; integration of care for older people [29, 47], prescribing dental hygienist [28]
- **Output:** Nurse prescribing slow uptake; many local skill-mix innovations with no systematic evaluation; 20% of closure of beds, thanks to shift to home based rehabilitation
- **Barriers:** insufficient clear instructions from MoH; insufficient fin. incentive for nurse prescribing; nurses not authorized using electronic patient record; regulatory concerns (mal-practice); pay mechanisms for doctors slow down delegation; no nurse training, no legislation for changing scope of practice
- **Enablers:** New post-grad training for nurses incl. health promotion, planning and development; uniform payment system; possibility to consult physician



## Strengthening the role of nurses in *Slovenia*: skill-mix innovation in primary and chronic care

- **Triggers:** growing chronic care burden on GPs; number of GPs lagging behind due to lower pay comp to hospital doctors
- **Innovations:** health promotion and prevention nurse in (0.5 FTE) model practice; new protocols
- **Output:** GP model practices covered 75% of all GP practices (2017), with full coverage expected by mid-2020; uptake of new care protocols; large-scale patient satisfaction survey underway
- **Barriers:** austerity slowed down spread of model practices
- **Enablers:** dialogue between GPs, nurses and MoH; gradual of new and existing nurses; GP and nurse spend at least 3 hours per week together adjusting their work; new payment model



# Skill mix innovation in the workplace and classroom in *France*: moving from task transfer to the paradigm of cooperation?

- **Triggers:** anticipated shortages of physicians; qualitative gap (intermediary role); Bologna process
- **Innovations:** Enhancement of nurse roles prevention in and chronic disease management, especially in remote or deprived areas (public health nurse – ASALÉE project) [6] collaboration and task shifts orthoptist, ophthalmologists, opticians [30, 48]; mobilizing volunteers and citizens/patients HIV-testing [4,5]; nurse coordination complex cases [50]; new task for informal carer/social carer e.s. [49] a package of home based care for patients over 75 GP, pharmacist nurse [74]
- **Output:** 2% of all GPs participate in ASALÉE ca. 300,000 patients continues; collaboration/taskshift eye care codified in 2016.
- **Enablers:** leadership; financing committee to support skill-mix; attractive employment and working conditions; from task substitution to task-enhancement; new fees for new tasks
- **Barriers:** Resistance of health professionals; fear of expenditure increase; lengthy and complex approval process changes to the scope of practice



## Take-home messages

1. In primary and chronic care, nurses are central to skill-mix innovations including nurse assistants, prevention and health promotion nurses, specialist nurses, chronic disease managing nurses; **Nursing paradox?**
2. Most skill-mix innovations were implemented to unburden medical doctors from non-medical or simple medical routine tasks;
3. There is an emphasis on team building;
4. Non-health workers like fire-fighters, social workers, housing officers and volunteers in social services are increasingly part of skill-mix innovations.





# THANK YOU

