View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by Serveur académique lausannois

Serveur Académique Lausannois SERVAL serval.unil.ch

Author Manuscript

Faculty of Biology and Medicine Publication

This paper has been peer-reviewed but does not include the final publisher proof-corrections or journal pagination.

Published in final edited form as:

Title: Involvement of family physicians in structured programs for chronic diseases or multi-morbidity in Switzerland.

Authors: Peytremann-Bridevaux I, Ebert ST, Senn N

Journal: European journal of internal medicine

Year: 2015 Mar

Issue: 26

Volume: 2

Pages: 150-1

DOI: 10.1016/j.ejim.2015.01.007

In the absence of a copyright statement, users should assume that standard copyright protection applies, unless the article contains an explicit statement to the contrary. In case of doubt, contact the journal publisher to verify the copyright status of an article.

serval
serveur académique lausannois

Unil
UNIL | Université de Lausanne
Faculty of Biology and Medicine

CHUV

European Journal of Internal Medicine 26 (2015) 150–151

Contents lists available at ScienceDirect

European Journal of Internal Medicine

journal homepage: www.elsevier.com/locate/ejim

Letter to the Editor

Involvement of family physicians in structured programs for chronic diseases or multi-morbidity in Switzerland

Keywords:
Chronic diseases
Family physicians
Structured programs

The increasing prevalence of chronic diseases and multi-morbidity [1] represents challenges for health systems worldwide. In that perspective, the current organization of healthcare delivery, fragmentation of care, limited use of evidence-based guidelines and patients' insufficient empowerment are some reasons explaining the current limited effectiveness of the management of chronically ill patients [2].

Based on theoretical models such as the Chronic Care Model (CCM), initiatives targeting improvements in the care of patients with chronic diseases have been implemented worldwide since more than a decade [3,4,5]. Their development in Switzerland, a health system where more than half of practices are still single handed [6], is only recent and infrequent [7,8].

Structured programs for patients with chronic diseases or multi-morbidity usually propose patient-centered interventions and consider an integrative multidisciplinary approach. Currently, little is known on the existence of such programs and on the role of family physicians (FPs)within these programs, in Switzerland. The objective of this study was to identify and describe current structured programs targeting chronic diseases or multi-morbidity in Switzerland. This may help in examining innovative approaches that are only developed locally but would deserve wider interest for further implementation.

We conducted a telephone-based survey between June and November 2013 and contacted systematically key institutions, informants and stakeholders nationwide and in the 26 cantons. We also contacted key informants and used the "snowball strategy" to get in touch with persons recommended by participants. To be eligible, programs needed to target adult patients with one or more chronic diseases. While patients needed to be actively involved in the programs, the latter had to be structured and represent more than usual care, not be implemented exclusively in inpatient's hospital settings and be ongoing in 2013. Programs primarily targeting rehabilitation, primary prevention, rare diseases or non-specific illnesses (e.g., palliative care) were excluded. A bilingual French–German physician researcher collected data on organizational aspects of the program and on key elements of the chronic care model, using a standardized extraction grid. Simple descriptive analyses were performed.

More than 400 persons were contacted; information was received regarding 92 programs, of which 44 met our inclusion and exclusion criteria. The top three disease categories were diabetes ($n = 15$), neuro-psychiatric disorders ($n = 10$) and COPD-asthma ($n = 6$); six programs integrated multi-morbidity. Identified programs included a small number of patients (median < 100) and the setting of the interventions was ambulatory care in most cases ($n = 32$), followed by hospitals ($n = 20$), patients' home ($n = 12$) and the community ($n = 11$). The mean number of healthcare professionals involved was three. Physicians were included in all but 4 programs. While nurses were included in 29 programs, and physiotherapists and dieticians each in 14 programs, other types of health professionals were present less frequently. The possible combination of healthcare professionals is shown in Table 1. It highlights the fact that specialist physicians were more often involved in programs than FPs (30 and 22 programs, respectively), and that nurses were more often involved than medical assistants (23 and 5 programs respectively). When present, medical assistants were systematically and exclusively associated with FPs. They were usually specially trained for the intervention consisting in patient education and support, as well as monitoring of the programs' activities; they also had a key role as program co-coordinator, assisting the FP in this task. In most of the programs in which FPs were included, their role was to inform patients about existing programs or to be a referring physician. All 44 programs considered elements of the delivery system design domain of the CCM. While 91% of the programs also included education and self-management as well as clinical information system elements, just more than half of the programs reported elements of the decision support domain, with only 10% of the programs explicitly reporting the use of evidence-based guidelines.

This study showed that structured programs for the management of chronically ill patients in Switzerland were rather comprehensive in their composition but only marginally implemented. They also highlighted the fact that FPs were less often participating in those programs than specialist physicians. Several reasons may explain the limited involvement of FPs in such programs. First, despite the high overall rating of the Swiss healthcare system [9], some consider that its primary care system presents weaknesses [10]. For example, necessary elements for a strong primary care (e.g., presence of national policies regulating the provision of primary care providers, capitation as the predominant method of remuneration, FPs as the predominant type of ambulatory care providers) are in fact lacking in Switzerland. Also, a liberal fee-for-service system such as the one in Switzerland provides little incentives to FPs to get involved in programs which may be seen just as extra workload. The recent political initiatives aiming at reinforcing primary care and shaping the healthcare workforce at a national level (i.e., improved remuneration, better academic recognition), as well as the national comprehensive healthcare strategy entitled "Health 2020" may help the development of innovative healthcare initiatives increasing both the participation and involvement of FPs and of non-physician healthcare professionals. This is particularly crucial since it is recognized that changes and innovations are more likely to happen within countries with strong primary care systems. Another reason that may explain the low participation of FPs is that most identified programs targeted single chronic diseases most often managed by specialist physicians. In fact, the role of FPs is rather limited in single disease programs compared to those targeting patients more comprehensively.

http://dx.doi.org/10.1016/j.ejim.2015.01.007
0953-6205/© 2015 European Federation of Internal Medicine. Published by Elsevier B.V. All rights reserved.

Table 1
Combination of healthcare professionals involved in the 44 programs.

Family physicians	Specialist physicians	Nurses	Medical assistants	Others	Number of programs
X			X		5
X				X	2
X		X		X	3
X	X	X			2
X	X				2
X	X	X		X	7
X	X			X	1
	X	X		X	12
	X			X	2
	X				1
	X	X			3
				X	2
		X			1
		X		X	1

The main strength of this study is that it was systematically conducted throughout Switzerland, allowing the presentation of a rather comprehensive picture. The main limitation is that even though comprehensive and having used the snowball strategy, programs may have been missed.

In conclusion, improving the management of chronically ill patients in Switzerland will not only require the further increase in supply of specific programs but also, and foremost, the rethinking of the organization, financing and coordination of the primary health care system. The latter should favor the integration of family physicians and other non-physician professionals in initiatives targeting the care of chronic patients.

Conflict of interests

The authors state that they have no conflicts of interest.

Funding statement

OBSAN (Swiss Health Observatory): Funding for data collection. N Senn is supported by an academic scholarship “bridge-relève” provided by the Leenaards Foundation. I Peytremann-Bridevaux is supported by the Swiss School of Public Health + (Assistant Professorship grant).

Acknowledgments

We thank A. Jaltier who took care of the Epidata data intput and S. Payot for the configuration of the Epidata working sheet.

References

[1] Mathers CD, Loncar D. Projections of global mortality and burden of disease from 2002 to 2030. PLoS Med 2006;3:e442.
[2] McGlyn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, et al. The quality of health care delivered to adults in the United States. N Engl J Med 2003;348:2635–45.
[3] Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. Health Aff (Millwood) 2001; 20:64–78.
[4] Martínez-González NA, Berchtold P, Ullman K, Busato A, Egger M. Integrated care programmes for adults with chronic conditions: a meta-review. Int J Qual Health Care 2014;26:561–70.
[5] Jackson GLJ, Powers BJ, Chatterjee R, Bettger JP, Kemper AR, Hasselblad V, et al. The patient-centered medical home. A systematic review. Ann Intern Med 2013;158: 169–78.
[6] Hostettler S, Laffranchi R, Kraft E. Taux d'occupation des médecins en Suisse. Bull Med Suisses 2013;50:1891–5.
[7] Berchtold P, Peytremann-Bridevaux I. Ten years of integrated care in Switzerland. Int J Integr Care 2011;11 [Spec Ed:e010].
[8] Nouveaux modèles de soins pour la médecine de recours. http://www.gdk-cds.ch/fileadmin/docs/public/gdk/Aktuelles/MMtlg/BT_Versmod_pub_20120402_f.pdf; 2012.
[9] How the U.S. health care system compares internationally. http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror.
[10] Mcinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970–1998. Health Serv Res 2003;38:831–65.

I. Peytremann-Bridevaux
Institute of Social and Preventive Medicine, CHUV, University of Lausanne, 10 route de la Corniche, 1010 Lausanne, Switzerland
Corresponding author at: IUMSP, CHUV and University of Lausanne, 10 route de la Corniche, CH-1010 Lausanne, Switzerland.
Tel.: +41 21 314 72 84.
E-mail address: Isabelle.Peytremann-Bridevaux@chuv.ch.

S.T. Ebert
N. Senn
Department of Ambulatory Care and Community Medicine, University of Lausanne, 44 rue du Bugnon, 1011 Lausanne, Switzerland

13 January 2015