The new Austrian arrangements for the population based Periodic Health Examinations

An attempt to introduce EBM based preventive activities in Primary Care 2001 – 2005

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Content

- Think globally –> act locally - my slogan for today is old
- Preventive activities are embedded
- The Austrian (+German) exemption
- How change was achieved in Austria
- Future (common?) activities – going global

An old WHO slogan twisted a little summarizes the events 2001 – 2005

- Thought globally – Acted locally
  - Non-communicable diseases are „globalized“
  - Organizational arrangements to implement prevention knowledge are strictly regional
    - » Management thinking (Change Management, Quality Management) is globalized
    - » Learning from each other is easier to globalize than ever
    - » Copying complete solutions will fail to deliver change in daily primary care practice

PiCo

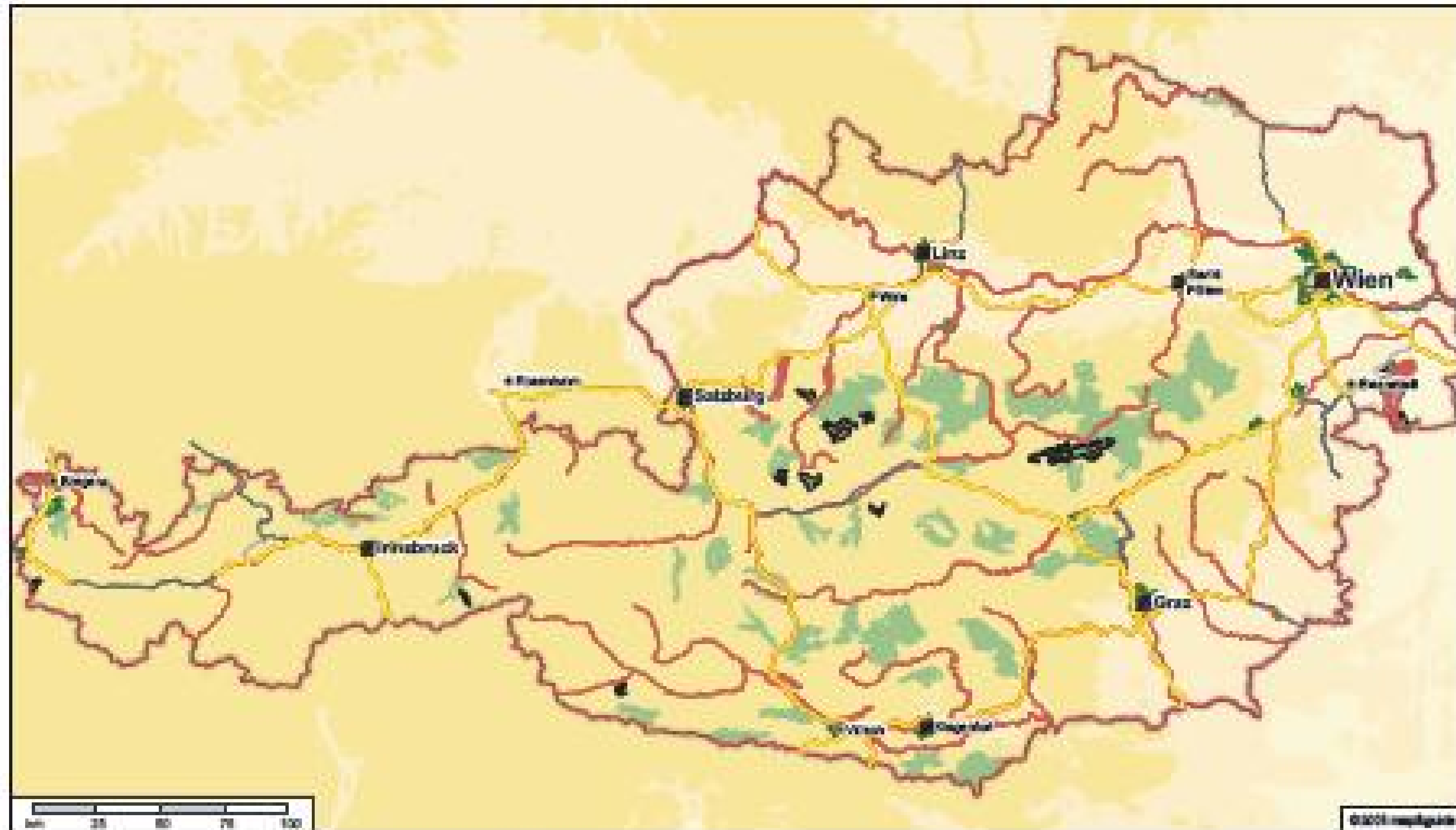
Health care system setting #1

- Austria - 1000 years old
  - Has 8 Mio inhabitants,
  - consists of 9 states,
    - » half older 500 years.

- Australia
  - 7,741,220 km² (6th)
- Austria:
  - 83,872 km² (115th)
    - » 1 % of Australian surface

- Both have universal health insurance coverage

Health care system setting #2
Austria´s 9 states organize their sozial and health services quite independently



The dawn of EBM in the 1990s made change possible

- 30 years of nationwide practice in Austria…..
  - From 1975 – 2004 a total of 13 million annual medical check-up at GPs and primary care specialists were reimbursed.
- Standardised but unspecific interventions…
  - Since 1974 fill-in forms regulated the minimal content of the free of charge annual check up in Austria.
  - Copies of the GP´s fill-in forms (results) are sent to the health insurance.
- …were replaced in 2005 by …

EBM – based recommendations.

VORSORGE-FRÜHERKENNUNGSPROGRAMM FÜR ÖSTERREICH ÜBER DIE LEBENSZEIT (INTERVALLE) BERUHEND AUF INTERNATIONALEN EVIDENZ-BASIERTEN LEITLINIEN – STAND 2005

Gesundheitsziel	Altersgruppe												
	19–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	75–79	> 80
Karzinome													
Karzinomrisikoanamnese: einmal erheben und in angemessenem Intervall aktualisieren													
Zervixkarzinom	die ersten 3 Abstriche im Abstand von 1 Jahr, wenn negativ dann alle 3 Jahre												
Mammakarzinom					zur Diskussion		< Alle 2 Jahre >						
Kolorektalkarzinom							< Jährlich Hämoccult, alle 5 Jahre Sigmoido- bzw 10 Jahre Koloneskopie[1] >						
kardiovaskuläre Erkrankungen													
kardiovaskuläre Risikoanamnese: einmal erheben und in angemessenem Intervall aktualisieren													
Rauchen	< Alle 3 Jahre >				< Alle 2 Jahre >								
Alkohol	< Alle 3 Jahre >				< Alle 2 Jahre >								
Übergewicht	< Alle 3 Jahre >				< Alle 2 Jahre >								
arterieller Blutdruck	< Alle 3 Jahre >				< Alle 2 Jahre >								
Hyperlipidämie[1]	Risikogruppenscreening				< Alle 4 Jahre >								
Typ-2-Diabetes[2]	Risikogruppenscreening							< Alle 4 (3 bis 5) Jahre >					
Anderes													
Parodontalerkrankung	< Alle 6 Jahre >												
Glaukom-Risikogruppenidentifikation[3]	Risikoanamnese: einmal erheben, in angemessenem Intervall aktualisieren												
Senium													
Hörminderung/Hörverlust										< Alle 2 Jahre >			
altersbedingte Sehschwäche										< Alle 2 Jahre >			
Glaukom-Screening im Alter[4]										Sicherung augenärztlicher Kontrolle			
Beratung													
Beratung zur körperlichen Aktivität	< Alle 6 Jahre >				< Alle 4 Jahre >								
PSA-Bestimmung	Ab 50 nach adäquater und wahrheitsgetreuer ärztlicher Aufklärung ausschließlich auf Wunsch des Screenees												

In Englisch words - EBM – based recommendations.

- Austrian prevention programme
- Health Goal --- Age group

- Carcinomas
  - » (Risk) anamnesis
  - » Cervical
  - » Mamma
  - » Colorectal
- Cardiovascular Diseases
  - » Risk anamnessis
  - » Smoking -- every 3rd year --- 2nd year
  - » Problematic Alcohol consumption
  - » Overweight
  - » Hypertonia
  - » Hyperlipidemia
  - » Typ 2 Diabetes
- Other
  - » Periodontal disease
  - » Glaucoma
- Elderly (Seniors)
  - » Hearing loss
  - » Age related vision loss
  - » Glaucoma in the elderly
- Counselling
  - » Physical acitivity
  - » PSA-measurement

14 Seite

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VORSORGE NEU Lebenszeittafel – Programmüberblick

The recommentations book is modelled after your Australian “redbook” : THANK YOU

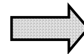
- *The first ever published evidence based guideline (“Vorsorgeuntersuchung Neu Wissenschaftliche Grundlagen”) for the Austrian Periodic Health Examination (PHE, “Vorsorgeuntersuchung Neu”)*

- 21 chapters and 201 pages were considerd to be to much for the GPs
- A short version of 48 pages, titled “Vorsorgeuntersuchung Neu”, authorized by one of the authors only was delivered free of charge to all GPs on PHE contract
  - The short version should also help the GPs to understand and complete the fill in forms correctly

- See both -> www.zaeg.at/screening

The forms controling the content of the PHE had to be invented, no model existed worldwide

- The new fill in forms are based on research, and published reports by a independent and strong “foreign” institution NIVEL from the Netherlands and an Austrian one.
- For the basic check up, two patient self-fill in forms and one Health Information Summary form (HIS), compled by the GP exist.
- The final content of the 2-page HIS was established through “political” negotiations and without careful testing its usability in daily GP practice. The final versions are forms without peronal accountable authors.



Vorsorgeuntersuchung der Österreichischen Sozialversicherung
Allgemeines Programm für Frauen und Männer

How change of daily GP prevention practice was tried to achieve in Austria

- Public Health change management models hold true
  - Cabana, Grol summarized

- Managing the change from top-down, when appropriate
  - Grimshaw reconfirmed (PPiP, 2nd ed, Table 6, p.52)

Cabana´s “barriers to change” in Primary Care delivery are approached by Grol´s perspective model

... says Houdon [3]

- Cabana´s 9 barriers[1]
  - 6 internal
  - 3 external

- Grol´s 7 professional perspectives[2]
  - 3 internal approaches
  - 4 external -”-

» [1] Cabana MD, Rushton JL, Rush AJ. Implementing practice guidelines for depression: applying a new framework to an old problem. Gen Hosp Psychiatry 2002; 24(1):35-42.

» [2] Grol R. Personal paper. Beliefs and evidence in changing clinical practice. BMJ 1997; 315(7105):418-421

» [§] Hudon E, Beaulieu MD, Roberge D. Integration of the recommendations of the Canadian Task Force on Preventive Health Care: obstacles perceived by a group of family physicians. Fam Pract 2004; 21(1):11-17.ol

Cabana´s 9 barriers to guideline implementation (=change) in Primary Care

- 6 internal
  - awareness of guideline
  - familiarity with specific component
  - agreement with the component
  - confidence in the ability to perform the guideline component (self –efficiacy)
  - belief that following the guideline will affect patient outcomes (outcome expectancy)
  - inability to overcome the inertia of previous practice

- = service providers knowledge + attidude

Cabana´s 9 barriers to implement guidelines in Primary Care

- 3 external
  - patient factors
  - environmental factors
  - guideline factors

- Grols professional perspectives address a much more broader and complex reality than Cabana´s barriers describe
  - He sees more external factors
    - » .... Thus he may see the world more with European than north-American eyes ...

Grol´s 7 professional perspectives to overcome barriers to change

- 3 internal approaches
  - the educational perspective (adult learning theories)
  - the epidemiological perspective (cognitive “reasoning” theories with interventions like evidence based guidelines and their planned dissemination)
  - marketing (social marketing theories)
- 4 external
  - Behavioral (Learning theory with interventions like audit and feedback, etc.)
  - Social Interaction (Social influence theories with interventions like peer review in local networks, etc.)
  - Organisational (Management theories with interventions like Total Quality Management, structural changes, etc.)
  - Coercive (Economic theories with interventions like laws, budgeting, accredidation, etc.)

2 of Grols 7 approaches could be used in Austria only

- 1 internal approach
  - the educational perspective (adult learning theories)
  - the epidemiological perspective (cognitive "reasoning" theories with interventions like evidence based guidelines and their planned dissemination)
  - marketing (social marketing theories)

- 1 external
  - Behavioral (Learning theory with interventions like audit and feedback, etc.)
  - Social Interaction (Social influence theories with interventions like peer review in local networks, etc.)
  - Organisational (Management theories with interventions like Total Quality Management, structural changes, etc.)
  - Coercive (Economic theories with interventions like laws, budgeting, accredidation, etc.)

Cabana´s 9 barriers only partially addressed in an unknow exent for an unknown proportion of GPs

- 2 of 6 internal barriers partially addressed
  - » awareness of guideline (short version only)
  - » familiarity with specific component
  - » agreement with the component
  - » confidence in the ability to perform the guideline component (self –efficiacy)
  - » belief that following the guideline will affect patient outcomes (outcome expectancy)
  - » inability to overcome the inertia of previous practice
- 1 of 3 external partially addressed
  - » patient factors
  - » environmental factors
  - » guideline factors

- This is my learned guess, there is little to no evidence about the distribution of physicians perspectives
- There is no evidence on a systematic approach to deal with the barriers

Managing the change 2001 - 2005

- Grimshaw reconfirmed (PPiP, 2nd ed, Table 6, p.52)
- from top-down, when appropriate

Grimshaw reconfirmed

2 interventions were performed in Austria

(PPiP, 2nd ed, Table 6, p.52)

New contract, more money (€75) act from top down

New fill in forms

Planned but not targeted to GPs and their patients

Strategy	Effectiveness	Comments
Organisational strategies (eg. clarification of roles, delegation of tasks, practice policy/standing orders, protocols, incentives)	Highly effective	Contributes to implementation of preventive interventions and helps sustain them Impact varies with area, capacity and acceptability
Reminders for the GP	Very effective Computerised	Computerised reminders have a similar impact to manual reminders. Needs to be targeted
Reminders for patients	Very effective	Needs to be targeted
Other interventions and reminders for patients	Very effective	For example, telephone, patient education, support strategies
Practice nurse interventions	Effective	Provides a clear outline of the role of the PN and gives adequate training and support
Practice co-ordinator	Effective	May be someone within the practice or external
Health summary sheet	Effective	Practice accreditation standards require a minimum number to be completed
Case note audit	Effective	Impacts particularly on prescribing and test ordering
Continuous quality improvement	Effective	Needs active GP involvement and feedback, and a supportive practice infrastructure
Clinics	Effective	More effective for conditions involving a team of health professionals and where large numbers of patients need to be seen
Feedback	Effective in some situations	Needs to be pre-negotiated and tailored. Peer comparison is useful if confidential
Practice registers	Effective in some situations	Require a computer to be most effective
Local opinion leaders	Effective in some situations	Assist in spreading information and examples
Lectures	Not effective	
Traditional CME evenings	Not effective	

Table 6. The effectiveness of implementation strategies in improving prevention

What was done at the top – systematic change management with decision makers: MOH, medical chambers, top officals in insurances

- Key change drivers
  - EBM is a principle decision makers cannot overrule easily (still they did, but only partially)
  - The global screening knowledge available now cannot easily be silenced when voiced internally, due to the ever present internet
- Main action steps
  - Representative mixed “expert groups” of GPs medical association and financers worked 150 interventions for the PHE through
  - Three final intervention lists were agreed upon:
    - » Include, Exclude, to be decided later
  - The lists were finally negotiated politically, excluding the experts and then fixed by a protocol
    - » Result: Not much change to content but
      - expansion of target ages and frequencies (annual check up can continue, but is not included in a future call – recall system)
      - Some blood and urine test remained against the evidence
      - Screening for problematic Alcohol consumption was nearly suppressed

Outcomes of the top-down change

- All states negotiated and had adopted new contracts and forms end of 2005
- In 2006 nearly 700.00 basic examinations were reimbursed again

- “the glass is half empty” view:
  - The GPs do not deliver the patient information in electronic form: less than 350 out of 700.000 HIS were handed over in 2006
  - No in depth evaluataion report ist published yet, although a qualtiy assurance and evaluation plan was commissioned and written
  - Based on personal information the completion rate of the HIS is far below 50% of reimbursed PHEs
  - No systematic link of payment to quality of HIS

Outcomes of change "the glass is half full" view

- The first EBM based official guideline has been published on a zentral website of the financers ("Wissenschaftliche Grundlagen")
- The process of judging the evidence was made transparent and public by a NGO (www.zaeg.at)
- Standards for jugding screening programmes have been published (in the MOH Public Health Journal)
- Engaged and concerned physicians have the best available absolute CVD risk assesments at their hands, none was there before
  - Translated NZ-risk tables for > 35 age
  - American heart association calculator for adults 18 -35
- Strong (subliminal) focus in whole programme on smoking cessation advice
- Periodonditis, "deliberately" neglected in Austria is now focussed
- 75 Euros (120 AUS $) pay amply for time to counsel in a country where 5 minutes is the average GP encounter time *(this personal statement is not based on evidenc)*

Future (common?) activities

- The upcomming International Austrian Screening committee
  - Sir Muir Gray will be member
  - Core working group of 2 internationally trained MPHs are home base in Austria
- Expanding service knowledge to other settings
  - AKS Vorarlberg going international (www.aks.or.at)
    - » The only population wide management of PHE integrating preventive services and health promtion in one state
    - » wants to go international, first new setting: Emirates
    - » combination of 30 years of service experience for independent (single handed) GPs with new EBM based Austrian PHE
- You are cordially invited to collaborate