SPAIN
## Transforming primary health care during the pandemic

ACCELERATING MULTIDISCIPLINARY TEAMWORK TO ADDRESS EMERGING PRIMARY CARE NEEDS IN THREE SPANISH REGIONS

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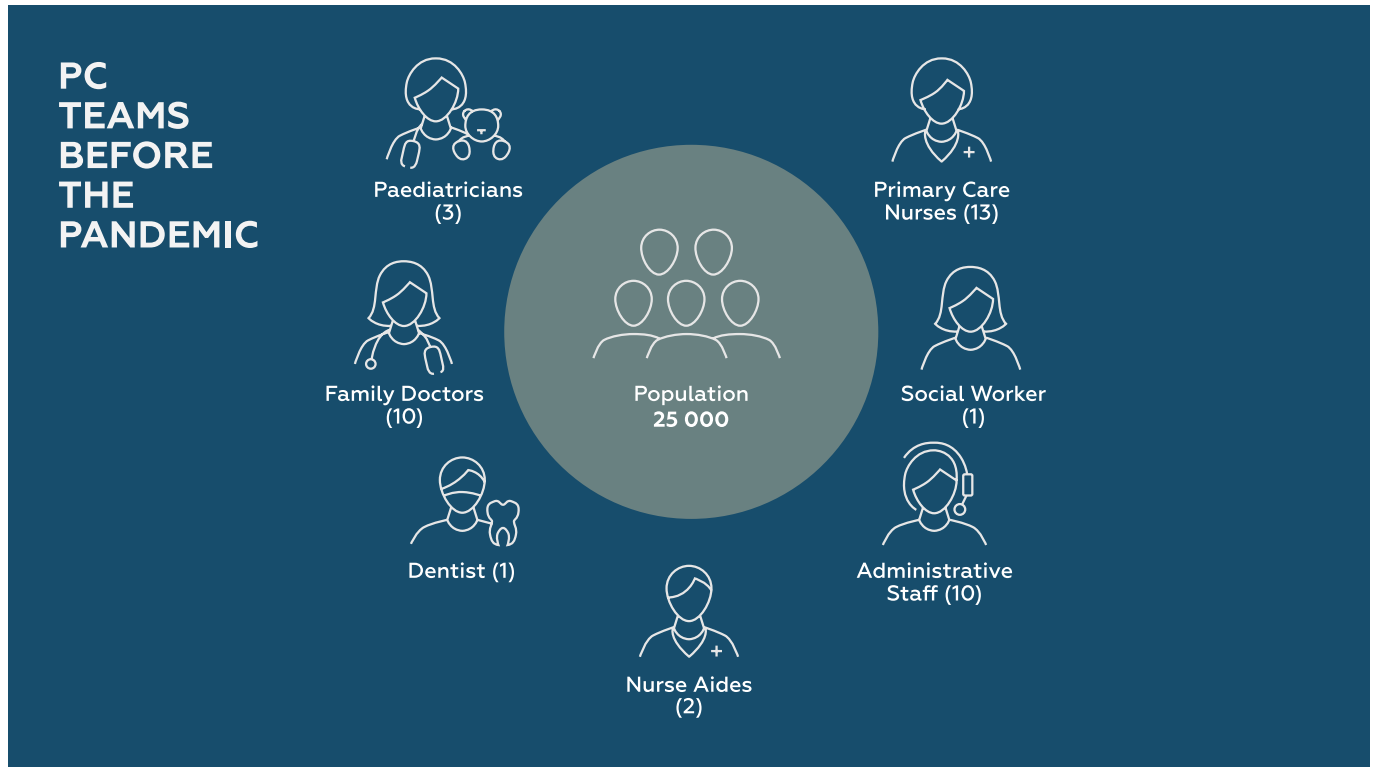
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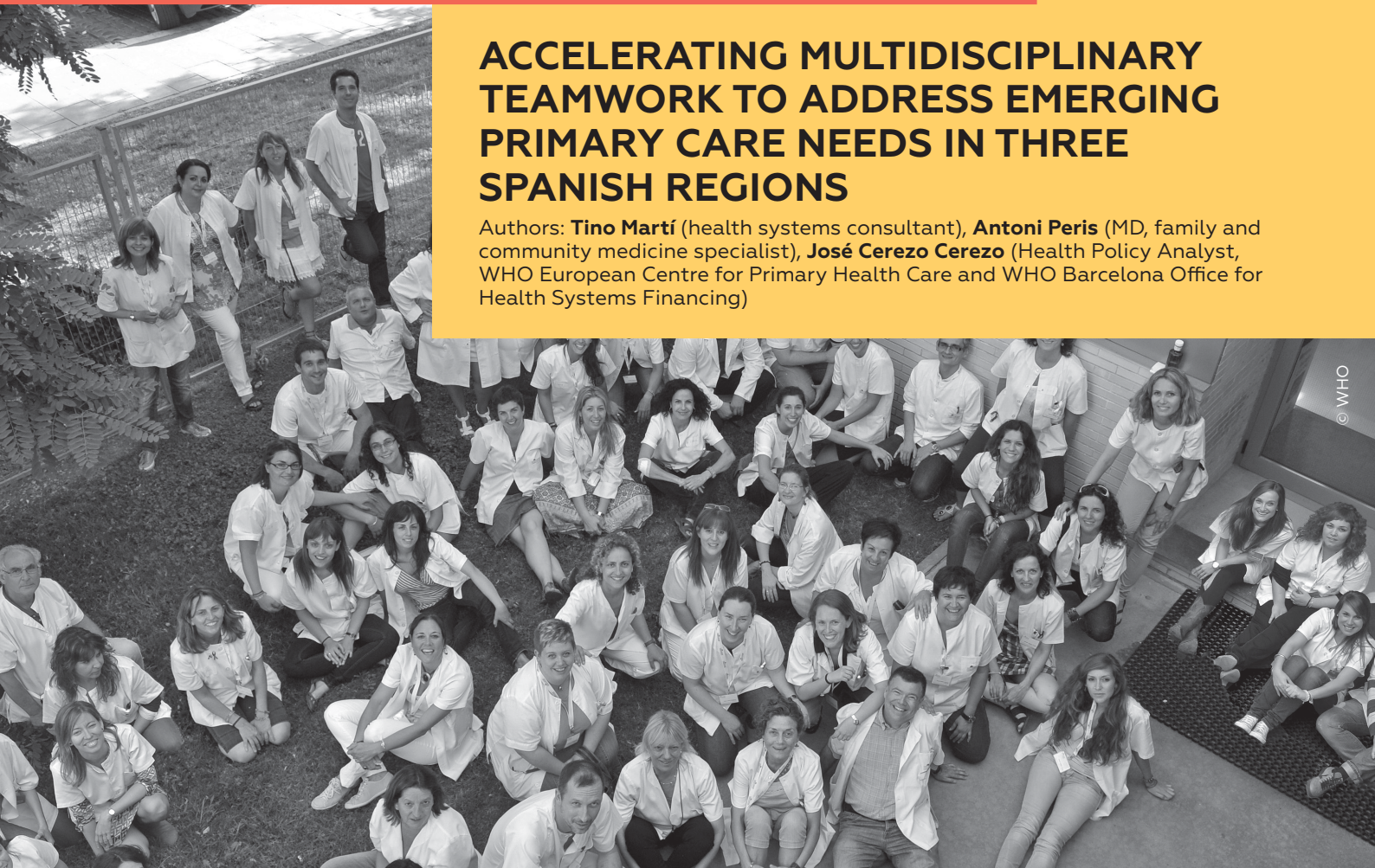
MOTIVATION

Health systems across the WHO European Region are striving to meet an unprecedented surge in health and care needs caused by the COVID-19 pandemic. Primary care is leading efforts to balance the response to COVID-19 while ensuring the continuity of essential health services. This situation, along with funding and staffing constraints, has put primary care in Spain under strain, pushing primary care teams to work differently to cope with the increased workload. Expanding the role of, and shifting and distributing tasks among, particular primary care professionals and recruiting new professional profiles have made teams work more efficiently amid extremely demanding circumstances.

The COVID-19 pandemic has exposed structural deficits in the Spanish health-care system. Newly enacted policy instruments have enabled the response of primary care — the first point of contact for more than 80% of COVID-19 patients — to evolve from an emergency-driven reaction in the first wave to a more proactive approach in successive waves. Primary care teams focused on providing face-to-face consultations only for urgent-care cases, addressing the needs of patients with all other health conditions through virtual-care delivery. Later in the pandemic, responsibility for providing clinical support to care homes and delivering the massive testing, contact-tracing and vaccination programmes fell to primary care.

PRIMARY CARE TEAMS BEFORE THE OUTBREAK

Primary health care in Spain is considered one of the strongest systems in Europe (*1*). Multidisciplinary primary care teams, underpinned by strong family medicine and advanced nursing roles, provide health promotion and preventive and curative services. Their size depends on the population served, and they are led by a doctor or a nurse from the team. Generally, teams include the health professionals displayed in Fig. 1, who share one hour a day in team activities.

Fig. 1. Composition of a primary care team for an average primary care zone

PC TEAMS BEFORE THE PANDEMIC

Paediatricians (3)

Primary Care Nurses (13)

Family Doctors (10)

Population 25 000

Social Worker (1)

Dentist (1)

Administrative Staff (10)

Nurse Aides (2)

The teams' work is supported by the primary care service network, which includes midwives and gynaecologists, physiotherapists and rehabilitation doctors, clinical psychologists and psychiatrists, and pharmacists or pharmacologists (*2*).

The Spanish Ministry of Health published the strategic framework for primary care in 2019 (*3*). The framework underlines the advanced role of nurses in chronic and home care, community health and health promotion and signposts the need for administrative staff to have a greater role in demand management. It also highlights the increased support for preventive and care services that can be provided by clinical psychologists, physiotherapists, social workers and pharmacists. Some of the transformations that were implemented swiftly during the pandemic therefore reflect previously approved national and regional strategic documents and were underpinned by the maturity of the primary health-care system.

MULTIDISCIPLINARY TEAM ADAPTATIONS TO MEET EMERGING NEEDS IN THREE SPANISH REGIONS

In Spain, regional departments of health are responsible for strategic and operational planning, resource allocation and purchasing and provision of services. This vignette describes transformations in three regions to highlight the contextual factors that determined transformational policies and implementation instruments. Since implementation varies across regions, the vignette does not necessarily reflect the transformations undertaken across the whole country.

Catalonia: strengthening primary care teams and planning the model of care transformation

To strengthen primary care beyond the COVID-19 impact, the Catalan Government released the primary health-care strengthening and transformation plan in September 2020 (*4*), securing additional funding until 2022. The plan aims to improve accessibility, responsiveness and care for chronic patients in three phases — strengthening, transformation and consolidation. The first phase ends in mid-2021, with plans to increase the primary care workforce by 17% through the recruitment of nurses, clinical assistants, social workers, administrative staff and COVID-19 managers. Services will be reorganized in the second phase, during which the priority developments are delivering home care for chronic patients, strengthening training in nursing techniques, providing mental health support, and expanding smart call systems and virtual consultations. The second phase will lead to a new model of care based on reorganization of functions and processes to reduce bureaucracy and professional burnout, and to increase accessibility. The third phase will consolidate these changes in 2022.

The pandemic has forced a swift team reconfiguration based on task-shifting, expanded roles and new team members (Fig. 2).

Task shifting: doctors handed the follow-up of patients with infectious diseases to nurses, who have trained nurse aides in technical tasks. Communication with patients that formerly was performed by health professionals is now carried out by administrative staff using reformulated patient access pathways that are agreed among the team.

Expanded roles: nurses have gained a higher degree of autonomy for following up COVID-19 and non-COVID-19 patients, increasing their work in care homes and teaming up with social workers. Nurse aides have taken up technical tasks for testing in centres and in the community, while administrative staff have increased their role in channelling demand to the right professional.

New team members: teams hired COVID-19 managers with non-health backgrounds to do community and school contact-tracing following training from nursing and administrative staff. Additional social workers strengthened the care response in relation to emerging social needs caused by economic deprivation.

Accessibility to, and the scope of, primary care services changed overnight. Primary care assumed responsibility for early diagnosis and follow-up of mild COVID-19 cases, home visits, contact-tracing and vaccination. A dual-track to non-COVID-19 patients had been set out since the first wave to ensure access and safeguard people. Doctors focused on urgent-care cases. Home visits to complex chronic patients and nurse-led virtual consultations to chronic patients soared during lockdown. In successive waves, home visits expanded to patients with all chronic conditions and face-to-face visits resumed, thanks in part to the new influx of professionals.

Fig. 2. Adaptation of primary care teams during the COVID-19 pandemic
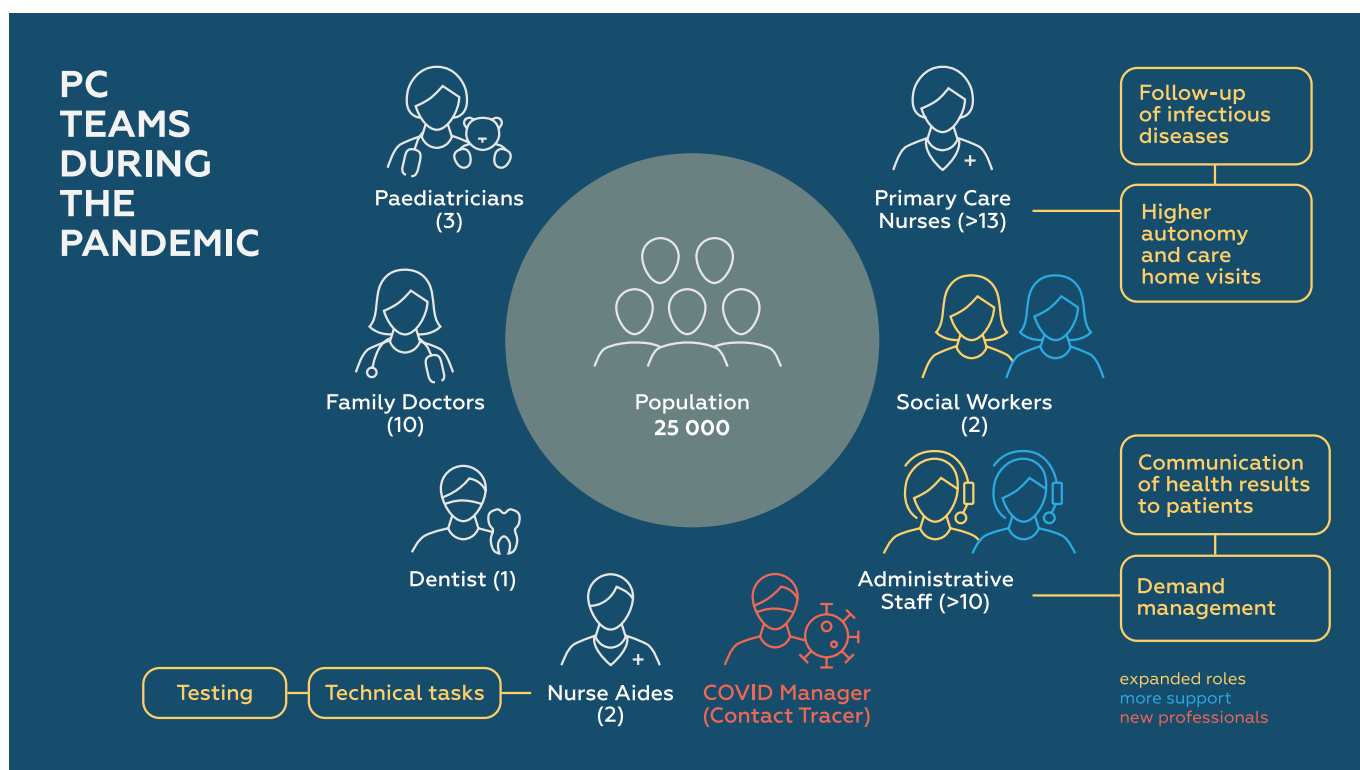
Castile and Leon: adapting teams to serve remote areas

Rurality is a critical factor for organizing primary care in Castile and Leon, the largest and most dispersed region of Spain. It has 247 primary care centres and 3665 health stations that serve 2 394 918 inhabitants scattered over 2248 municipalities (5,6). A rapid reorganization of primary care started in the autumn 2020, with the focus on rural health care. Reforms were inspired by the principles of the new model of health care in the rural environment approved in 2019 (7). Implementation relied primarily on redistributing primary care resources across the territory and promoting teamwork and professional development of primary care professionals, particularly nurses and health administrative staff. The struggle to meet the needs of COVID-19 and non-COVID-19 patients entailed a strong driving force to make advances in relation to both sets of challenges.

Administrative units were strengthened to reduce paperwork by clinical staff by shifting new tasks to administrative staff, who were supported by a specific module to collect the demand of administrative procedures and by an mHealth application (8) to help them process sick-leave receipts, medication, laboratory and vaccination reports and COVID-19 test results, preserving accessibility. The schedules of family doctors and nurses were revised in depth. This meant a big change, particularly in rural areas, where people previously had direct access to health professionals, and this enabled demand to be channelled to nurses.

The role of nurses in the proactive follow-up of patients with complex chronic conditions and multimorbidity was already standardized practice in the urban and rural areas of Castille and Leon. This has been further reinforced in rural settings during the pandemic, with nurses becoming the key professionals in delivering face-to-face and home visits to patients who need to be prioritized. A new procedure has been approved by the regional government to allow nurse prescribing. Two additional initiatives have contributed to improving the reputation of nurses within primary care teams and increasing professional satisfaction: first, the creation of a new nursing role in primary care for epidemiological surveillance and contact-tracing, working closely with public health services and capitalizing on existing public health competencies; and second, nurses have become responsible for coordinating COVID-19 immunization services (9).

The pandemic enhanced the **sense of belonging to a team**. Challenges associated with delivering care in sparsely populated rural areas undermined teamwork and left some professionals feeling isolated, even where primary care teams had been operating since 1985. The shift towards virtual consultations and concentration of activities in larger primary care centres allowed professionals to optimize the time spent on the road and had a positive team-building effect. Overall, however, the creation of COVID-19 primary care teams was a game-changer. These teams included midwives, physiotherapists, dentists and other primary care professionals whose regular activities had been disrupted by the crisis, who came together to work on solving COVID-19 related issues.

"THE PANDEMIC HAS FORCED A SWIFT TEAM RECONFIGURATION BASED ON TASK-SHIFTING, EXPANDED ROLES AND NEW TEAM MEMBERS."

Asturias: integrating primary care with mental health and long-term care

Urgent measures for strengthening teamwork and demand management were set at the beginning of the crisis in Asturias, based on the strategy for a primary care approach for 2018–2021 (*10*). Professional silos were broken down and team collaboration between doctors and nurses intensified to enable them to work more efficiently and meet the substantial surge in health and care needs. Health administrative staff expanded their role from being passive appointment dispatchers to adopting a more decisive position in managing and channelling population demand to the most adequate team members, releasing clinical staff from performing administrative work.

Health and social care teams provided proactive care in nursing homes. A standing working group involving the health and social sector ensured collaboration among integrated care teams. Coordinated by primary care nurses as case managers, the teams included geriatricians, primary care nurses and a hospital-at-home nurse who ensured continuity of care for fragile chronic patients. Based on this experience, a framework document for primary continuity of care and between primary care and long-term care is under development. It will establish a maximum number of nursing homes for which a primary care team can take responsibility, with the aim of reducing variability in access and in the quality of care delivered. The framework will include a plan to grant nursing homes access to primary care electronic medical records.

A **strong community mental health network** that brings together psychologists from primary care teams and professionals from peripheral mental health centres and social care has been of paramount importance in addressing the surge of mental health issues experienced during the pandemic. A regional programme for psychological support established a specific pathway to refer patients from primary care doctors to a specific schedule for clinical psychology. The programme envisions the incorporation of additional clinical psychologists into primary care teams based on the evolution of population mental health needs (*11*).

EARLY ACHIEVEMENTS

Regional health services have shown greater commitment towards strengthening and transforming primary care, with additional human and economic resources being delivered as part of the implementation of ad hoc or existing strategic plans.

Coordinated primary care efforts contributed substantially to deterring patients from using hospital emergency departments, mitigating the pressure on them. At the same time, primary care has shown its capacity to reconfigure rapidly to address the needs of COVID-19 and non-COVID-19 patients.

The experience of the pandemic strengthened teamworking, which helped to improve professional satisfaction in the midst of a very demanding situation. The roles of nurses and, in some cases, nurse aides expanded to provide dual-track care. Administrative staff were upgraded to health-administrative staff, providing telephone and virtual-care triage supported by local call centres with automatic caller profiling.

Digital solutions provided alternatives to face-to-face encounters, capitalizing on existing and swiftly optimized eHealth developments. Along with expanded professional roles, this allowed better demand-management based on individual needs.

Long-standing issues, such as the need for better coordination with social services and nursing homes, excessive administrative workload and the pledge for higher provider autonomy, have escalated as priorities in the political agenda.

"DIGITAL SOLUTIONS PROVIDED ALTERNATIVES TO FACE-TO-FACE ENCOUNTERS, CAPITALIZING ON EXISTING AND SWIFTLY OPTIMIZED EHEALTH DEVELOPMENTS."

SUSTAINABILITY PROSPECTS AND NEXT STEPS

Structural investments are planned to follow combined actions to strengthen primary health care. Better funding and more human resources are needed to increase the capacity of primary care networks, particularly for mental health and social care, in the coming years.

Adaptations made during the pandemic have served to test a number of innovations that combine professional roles with digitally enabled care and create more efficient administrative processes. Further efforts are needed to maximize professional competencies and make meaningful use of digital solutions.

Changes in social expectations of health services will facilitate a new approach to demand management based on needs, consolidating the wide range of nursing services, the role of health administrative staff as frontline workers and the appropriate use of digital access.

Coordination between primary care teams, public health, mental health services and social care should be further developed to face the new post-pandemic socioeconomic challenges, underlining the potential of primary care to tackle health inequity and the social determinants of health.

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LESSONS LEARNED

1. Crises are catalysers for accelerating long-standing reforms and experimenting with new models of care. Many of the transformations described were already part of national and regional strategic plans and were made possible due to the readiness and maturity of primary health care.

2. Decentralized decision-making was vital to quick adaptation to local health and social needs. Regions have adopted different strategies according to their contexts, and the composition of primary care teams has adjusted to better respond to local needs.

3. Expanded roles and task shifting among team members have supported swift adaptation. Primary care nurses and health administrative staff have shown flexibility in their roles to provide a solid team response to unplanned needs and improve demand management.

4. Multidisciplinary primary care teams contribute to better coordination and integration with other levels of care and sectors and increase professional satisfaction. Primary care teams have benefitted from strengthened links with social and mental health services. When staffed adequately, they are the cornerstone of further integration of health and social systems of care, including in nursing and care homes.

5. Countries need to account for the barriers that prevent teamwork, effective task-sharing and multidisciplinary service delivery. These include administrative and legislative barriers, unnecessary bureaucracy, reduced autonomy, unstable working conditions and lack of management skills. Regulations that enable professionals to work at the higher end of their competencies (nurse prescribing, for example) are key policy levers for effective multidisciplinary work.

6. Combined human, organizational and technological factors foster teamworking. Teams have deployed preventive measures to protect human relationships, maintain emotional stability and contain anxiety.

7. The rapid shift towards virtual consultations stresses the relevance for primary care of ensuring accessibility over immediacy. If the core values of accessibility are not looked after, however, the digital divide may favour those with less need but greater digital literacy. Monitoring the adequacy of virtual consultations is a major priority for measuring the quality of care.

8. Specialized and continuing training increases the prestige and attractiveness of primary care. The development of the family and community nursing specialty and the role of scientific societies in providing clinical updates and support documents to promote sound ethical and clinical decision-making are critical for raising capacity and prestige.

9. Sustainable transformation requires a systematic approach to cement temporary adaptations. Taking stock of successful innovations at the facility level and evaluating their impact on (and transferability to) the quality of care and professional and patient satisfaction are needed to support large-scale and enduring change.

10. A clear political commitment to primary health care must be expressed financially. Additional human and economic resources have made plans effective and readdressed chronic underfunding of primary care services. Their demonstrated efficiency should not deter further investments in addressing growing challenges brought by the health, social and economic crisis.

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ACKNOWLEDGEMENTS

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