REPORT #3 CA-COVID-19-OMC

PRIMARY CARE IN THE PANDEMIC DE-ESCALATION PROCESS

Advisory Committee's 05/27/2020 report to the Spanish General Medical Council

Executive summary and key proposals

Primary care has contributed to this public health crisis with dedication, sacrifice, commitment, and a display of innovation. Furthermore, it must play an essential role in the "de-escalation" process, despite the situation of chronic abandonment; hence, incremental resources are required, particularly to take on the new tasks involved in the control of COVID-19 cases and contacts.

Proposals: In the pandemic response situation, improvement is required in five areas

1- **Prioritize the safety of the staff and patients**, with **protection** and self-protection: limiting seating capacity, and organizing and managing the exterior and interior waiting zones. Healthcare management must guarantee supplies, improve the cleaning of spaces and rooms, and enable partitions and guards when applicable. The **management of patient schedules and flows** is essential to avoid overcrowding and infections.
2- **Redesign accessibility to the Healthcare Center**, improve the Administrative Units, strengthen its staff, provide telephone lines and mobile phones, install apps, and lead flow management and distribution of attention petitions. The triage points at the entrance are essential; their design, structure, criteria, and flows, must be defined by the Team in a participatory manner.
3- **Organizational changes and professional roles:** new technological allocations (apps, email, instant messaging) are required to increase telematic connectivity legally and safely. Professionals must manage the schedules, visits spaced out, phone consultations interspersed, and delays managed using clinical criteria, with institutional support and information campaigns for the citizens.
4- **Performance of epidemiological surveillance duties**, counting with all the diagnostic means without restrictions, the information systems, and the control of cases and contacts. The Healthcare Center will be prioritized for the allocation of properly trained staff that strengthens this tracking duty.
5- **Decrease of bureaucratic burdens**, deepening the simplification experiences of work leaves, management of electronic prescription, and electronic consultations in the referral Hospital.

The **delayed agenda of Primary Care improvements must advance and be consolidated** both regarding human resources (organic staffs, strengthening of structural positions, fair internal replacement systems, etc.) and management autonomy models; advancement of the managerial image and function of the Team, including its development and professional career; and other improvements in organizations, activities, and allocations.

The Spanish Medical Colleges Organization Advisory Committee for COVID-19, is an expert panel from various professions, fields, and specializations that was launched on 21 April 2020 to advise the Spanish General Medical Council regarding several scientific, technical, and organizational issues that the pandemic causes, in order to suggest actions and generate technical reports that justify the public positioning of the Spanish General Medical Council.

Primary Care and its Community facet in the process of pandemic de-escalation; the post-COVID scenario

The Spanish General Medical Council Advisory Committee for COVID-19 has analyzed the role of **Primary Care**, with special attention to its **Community** facet in the process of the current pandemic, within the great work topics that were established according to the Spanish General Medical Council.

The contributions from experts and the donations received from the Advisory Committee's Work and Debate Forum allows the transfer of the current **Report #3 about Primary Care in the pandemic de-escalation process** to the Spanish General Medical Council and provides them with scientific-technical and professional criteria about the topic, and criteria for its eventual use in future positionings of the Spanish General Medical Council and the Local Medical Associations.

1- PREVIOUS CONSIDERATIONS

Primary Care has played and is playing an essential role in the entire approach to the current pandemic. While some autonomous Healthcare Services designed a global strategy centered almost exclusively in the hospital setting, with emphasis on the intensive care services, others tried to stop the pandemic by maintaining the presence of their Primary Care professionals in Healthcare Centers and Local Medical Offices, taking advantage of the universal coverage of the primary network, the proximity of their professionals, the capacity for early detection and progression control of the cases, and the trust and safety that it transmits to their patients.

Today it seems accepted by all the Healthcare Services that Primary Care must acquire a **major role in the de-escalation phase**, despite being in a situation of lack of resources, especially human resources (although material ones as well) due to the abandonment experienced during the last two decades.

Its professionals, who are used to work in adverse conditions, have always shown, and also during the pandemic, a commendable spirit of **sacrifice** and **collaboration** and a great **innovative capacity** for adapting the centers and their healthcare organization to a new and complex situation.

In this sense, it is also vital to continue searching for a better balance between the necessary vertical coordination (Healthcare Area Management and Hospital, Public Health Regional Ministry, Department of Health) and the indispensable **management autonomy** for each center and team that will facilitate optimizing the adjustment of the organization and activities to the needs and characteristics of their basic healthcare zone in order to be able to provide safe and quality care for the population.

Currently, although very late, Primary Care has been assigned major responsibilities, including **screening, diagnosis, treatment, and follow-up of the new cases**, as well as, in coordination with public health resources, of the **contacts**. It seems evident that the need to provide Primary Care in the very short term with new human and technological resources may adequately fulfill these objectives.

In this document, an approximation is attempted to the needs and the actions that must be implemented immediately in centers and teams with special emphasis on the necessary organizational changes to answer to the challenges posed by the pandemic. In a second section, short considerations are made about a few of the **challenges and changes** pending by Primary Care.

2- NEEDS AND ACTIONS FOR THE CURRENT DE-ESCALATION PHASE AND BEFORE A POSSIBLE SHORT TERM NEW OUTBREAK

Any proposal about the needs and actions has to be adapted to the **characteristics of each healthcare center** or local medical office. Those mentioned in this document intend to contribute ideas that can be used at different levels of management and operatives, from the healthcare area to the healthcare teams themselves.

2.1 Resources for self-protection and protection against infections

The impact of COVID-19 in Primary Care has forced us to modify substantially the healthcare provided, tending to strengthen **telematic and home care** in relation to the on-site consults. This situation should change in the following weeks in which it is foreseen that **visits** to healthcare centers and local medical offices **will increase again**.

The priority should be to guarantee the **safety** of both patients and professionals. To achieve this, it will be necessary to:

- calculate the **capacity of waiting rooms and healthcare centers** with physical and preventative distancing criteria

- and **reorganize the schedules and flows** of people in the center so that the safety criteria established are followed at all times.

By the time the max capacity of the healthcare center is reached, it is necessary to have the organizational measures in place that facilitate a **location outside** for the new patients waiting, keeping the established distancing. This situation must be avoided where possible and prioritize entering the **interior** of the facilities in safe zones for the most vulnerable patients: **elderly, patients at risk, pregnant women...**

Professionals will have to maintain the healthcare culture change that they have acquired during these months, which implies a greater involvement with each and every one of the **measures of self-protection and safety at their disposal.** Within this culture, we include the self-reliance for hand hygiene; and in the consult, the use of constant hygiene and protective measures, which could vary according to the needs and risks at any given time, and the involvement in the care of the safety of the rest of the team and patients.

Healthcare management will supervise the **supply** of individual protection equipment, hydroalcoholic gel, and other materials for the centers. The managerial structures must always be the ones to guarantee the purchase and distribution, as well as the management of the safety reserves in the storage facilities. **Records** for the entry of protection and hygiene material, and records for the exit, must be made, as well as guarantee the urgent and written communication of possible **shortages** that in case they are not addressed on time and manner, must be subject to a formal notification before the competent authorities.

Likewise, the healthcare management (or the municipalities in case it is of their competence) must guarantee the appropriate **cleaning of the Healthcare Centers** and local medical offices, increasing the **physical presence** of the cleaning staff if necessary.

According to the characteristics of the centers, the use of **partitions in the Administrative Units** must be considered, along with other elements that facilitate the best protection of patients and professionals.

2.2- Center accessibility and patient triage

Accessibility is one of the foundations of Primary Care and must be improved again after the weeks of enforced restriction that we have undergone.

Strengthen the Administrative Units

The first point is to strengthen the **Administrative Units** and the **phone lines** because they are the main ways of access to the provisions of the healthcare system, especially in emergencies like the current one.

It is vital to consider strengthening the centers with **mobile** phone terminals and **conventional** lines. It is indispensable that all the Healthcare Centers and local medical offices have smartphones and the access resources that these provide (**apps**, etc.).

The complexity of the current situation reveals the importance of **organizing in the best way possible each attention request** for Primary Care made by the population in order to decide the best moment to meet it and choose the most appropriate professional to do so.

To optimize this process, teamwork will be essential with the involvement of the professionals from the **Administrative Units** that will continue to **lead the flow of patients** and the work organization within the center.

It becomes essential for Healthcare Services **to increase the staff** in these Units, so that they are present in an adequate number in each **Healthcare Center**, also guaranteeing the coverage of their **local medical offices** according to the needs.

The telephone Exchanges for centralized calls (**Call Centers**) cannot in any case substitute the work of Administrative Units constituted by Healthcare Administrators assigned by the centers and consults, who know their population and are integrated and committed to the teams of Primary Care. The call centers can play a backup role, activating when the phone call to the Healthcare Center is not answered.

Given that it is foreseen that it will not be possible to answer all the requests for attention received during the day, their task is fundamental to **connect the patient with the correct professional at the right moment.**

Protocolized triage at the entrance

Supporting the Administrative Units with a protocolized triage table at the entrance of the healthcare center has been a practice of **proven benefit** during these weeks. Depending on the number of professionals in the team, this action proposal can be more or less possible during the entire or part of the journey.

Each team will have to decide how to implement it and place it with the patient flow of patients with a high degree of COVID suspicion as well as the rest.

With this objective, the **operative criteria for triage** in each Healthcare Center and Local Medical Office will be established and/or adapted **in a participative** and collaborative **meeting** between the representatives of all professionals of Primary Care, which will allow clarifying the **patient flow circuits**, when, how, and by whom should a patient be cared for.

2.3- Changes in the organization of activities and the roles of the professionals of the Teams

Technological allocations and institutional backup for tele-medicine

The healthcare activity in the de-escalation phase must **continue improving tele-medicine.** This implies the regular use of telephone, email, instant messaging, and videoconference. In general, it is vital to insist again on the increasingly urgent necessity to improve the **technological allocations** in this field for Healthcare Centers and local medical offices.

It is not acceptable that the **mobile phone, home computer, or Internet home line** are resources that the healthcare providers must supply; it is not acceptable either that the professionals themselves must use the #31# in order to hide their personal number during calls; all these means, together with the use of a private vehicle, must be economically covered or compensated by the healthcare services, organizing these, and providing stability and safety. The infrastructures for mobility and physical and digital accessibility are essential for Primary Care. They cannot depend on volunteerism, which is clearly abusive and takes advantage of the professionalism of doctors, nurses, and other workers in frontline healthcare.

There are **tele-medicine apps** that allow sharing reports, analytics, and medical certificates with patients. The Andalusian Health Service uses the *Mercurio* app and in Cataluña *La Meva Salut* app is used. The Healthcare Services must provide Primary Care with this class of resource, with the measures that guarantee **data protection and communication confidentiality.**

Where these tools do not exist, it will always be possible to use **email, such as an institutional personal email account**, the center's email address, or a personal account dedicated for such purpose. In these cases, the corresponding Regional Ministry must protect **its professionals** by emitting a clear directive thereon.

There are healthcare teams that are using new mobile phone lines to offer their patients the possibility of **videoconferences and instant messaging** so that they may share pictures and other information. To provide the best protection to professionals and patients it would be key for Public Health Regional Ministries to prepare a **legal framework** for this section.

Decentralized management of schedules in order to organize the demand and guarantee more safety

The design of the **new healthcare schedules** must remain in the hands of the **professionals** who best know the needs and characteristics of their patients, establishing agreed validation tools together with the healthcare management.

Each center's healthcare schedules will be modified to **space out on-site visits from patients** and avoid overcrowding of waiting rooms. This can imply organizing them in different **time slots** or interspersing them with **telephone attention time slots** in order to distance **on-site visits**.

Attention **on the same day must be guaranteed for urgent consults or** that are justified as **serious** and **delay, in their respective case, those that are not**. In this regard, the policy **guidelines** must be very clear to avoid problems of inadequate interpretation by the citizens. It would be desirable to start media **campaigns** to help citizens use healthcare services better; a simple alternative could be explanatory brochures and panels.

N**ursing homes** and institutionalized collectivities that may exist in the community continue to be the most vulnerable places in a pandemic such as the current one. We have to prioritize the **continuous phone calls or on-site coordination with such places** and establish periodic meetings between the ones in charge and the people from the Primary Care healthcare unit assigned to analyze and leave documentary evidence of the situation and the problems detected. It is important to improve the coordination with the **city councils, social services, voluntary services, and other groups** from the community to help guarantee the safety of the inhabitants and those who care for them.

2.4- How to organize the Epidemiological Surveillance

The epidemiological surveillance systems require quick diagnostic flows, information systems, and study of contacts.

1. In the case of SARS-CoV-2, **PCR analyses in sufficient number and with quick processing (24 hours)** will be required to diagnose suspicious cases with recent symptoms and **appropriate serological tests** to determine the immune status of the cases. The communication with the Lab will include symptom start dates, and the Lab shall assess the interpretation of data according to the pandemic situation.

2. **Information systems** must collect epidemiological surveillance data as they are notified and **return them to professionals dail**y.

3. The **study of contacts**, their detection, and follow-up, is a task that takes a considerable amount of professional and material resources. It is important to **analyze the specific needs in each area**, with special mention to the possible differences between urban and rural areas.

Given the heterogeneity of structures and allocations of the Public Health territorial devices, it is difficult to give general recommendations. However, their reinforcement must guarantee the capacity to support the entire network, move resources depending on the possible local outbreaks, and guarantee good coordination with other areas and subsystems, like business medicine, work health insurances, administrative mutualism, and the private sector.

Without undermining the tracking teams that can be mobilized to address outbreaks, the Primary Care Teams will have to assume an important task: diagnosing cases and investigating contacts, their confinement, and follow-up. The best coordination would be obtained through **the physical presence in each Healthcare Center** of at least **one person dedicated to the epidemiological tracing** of cases and contacts, establishing referral circuits for the Primary Care teams, and being in permanent contact with the **Epidemiological and Public Health Services**.

It is important to analyze the **training needs of these “tracers”** as well as the possible direct participation of doctors and nurses of the teams in this activity.

The most specific aspects of the work with new infections and the control of contacts, should be object of a report for a wider and more specific positioning.

2.5- How to Rationalize the bureaucratic burdens

Work leave

The enormous increase in **Occupational Disability** processes due to infection, suspicion, contact, and work risk, imply a heavy workload for many teams.

In some Autonomous Communities, **processing documentation electronically** has been achieved for some time, avoiding patients needing to go to healthcare centers to pick up their corresponding certificates. It would be desirable for this measure (proven to be possible) to be prolonged or for alternatives to be found, such as simple-to-use **informatic apps** so that citizens receive their **reports, analytics, and certificates of temporary disability**.

Electronic prescriptions

Regarding the electronic prescription systems, it has been possible to **prolong all the active prescriptions** for several months in some Autonomous Communities during the start of the epidemic, which has avoided a great number of medical consults. Generalizing this practice nationwide would seem wise.

Likewise, it is necessary to incorporate an electronic prescription for the users of the National Health System who are officials of the Administrative Mutualism (the General Spanish Civil Service Mutual Insurance Company, the General Mutual Society for the Judiciary, and the Social Institute of the Armed Forces).

It would also be necessary to electronically correct the mistakes due to mismatch in correctly prescribed medication that is impossible to provide because the patient lost a box or used medication in excess.

Another effective tool would be using an app that allows **direct, fast, simple, and safe communication with the Community Pharmacy**.

Electronic consults with the reference hospital

Facilitating and improving e-consults with reference hospitals seems like a wise course of action that can avoid inconveniences and go to the healthcare center for many patients. The system could work correctly in many territories, but it is still not an extended practice.

With **phone connection and video consults** the current system of written messages could be expanded.

3- PRIMARY CARE AFTER THE PANDEMIC

When the pandemic outbreak has been resolved, Primary Care shall be capable of incorporating the learned lessons and transforming into permanent ones the structural and organizational changes promoted during this period—that introduce significant improvements.

It is evident that the complaints being made for many years—perhaps too many—from all areas and levels of Spanish Primary Care cannot wane. Primary care still has important **resource needs**, starting with **funding**, and it requires profound changes whose description is not covered in this document.

It is necessary to insist on the funding aspect: the public healthcare expenditure (accrued) has barely surpassed in **2018** the pre-crisis number of **2009** (an increase of 0.67%); in its functional classification, the "hospital and specialized services" have grown a 12% (mainly due to the growing prices of medications) while the "primary healthcare services" show a **3.6% decrease.** This asymmetry and economic decay are incompatible with the previous normality, and much more compatible with the "new normality" advocated.

It is pertinent to **mention schematically** some of the problems that the current pandemic has placed upon the table in a very clear way and that have conditioned the progression of the Autonomous Communities during the different phases of de-escalation of the epidemic curve:

Human resources:

- **Reformulation of organic staff**, recalculating it according to quality indicators to which we have to add new ones: community health activities, demographic socioeconomical circumstances, demographic aging, nursing homes, summer population increase, etc. The **needed increase in staff allocation** must be specified according to the workloads produced by the assigned population, their characteristics, and the duties that need to be done, and this assessment of manpower assessment shall result from a planned and participative process.

- **Creation of structural employment opportunities** in the Healthcare Centers that can be filled temporarily right away and that cover the gap between yearly working days not supplied and are covered by existing staff (vacation, absences, leaves, and any decrease of manpower) as well as to compensate the **historical deficit** of human resources in Primary Care.

- When the decrease of manpower occurs, **if staff are requested to cover those substitutions in a different work schedule**, it is vital that it is made in **similar conditions to those offered in the hospital**, and not as accumulations of tasks with economic compensations clearly inferior to what is reasonable.

Management autonomy

- Delimitation of the **exclusive and shared competence areas** of the Healthcare Center (budget, staff, supplies...) that would be managed by those responsible. Selection capacity of the centers for referral and consult...

Management and professional development

- Clearly define the mechanisms for naming the manager of the Center, as well as the employment schedule and commitment required for this role.

- Consider the management role from an equivalent perspective to that of hospital service headquarters.

- Generalize the establishment and recognition for all purposes of the **professional development and career** of the team members.

- Redefine the role of nurses, adapting it to the characteristics and needs of each context and their own and delegated competencies.

Organization and activities

- Teamwork. Flexibility of professional schedules. Community activities. Attention and new technologies.

Allocations

- Means for tele-medicine. Technological resources for diagnosis and treatment. Exclusive consult for each professional.

In conclusion

Given the size of the challenges we face as a healthcare system, we will still need maximum collaboration from the professionals. It is in situations such as this one where the best values emerge.

> *"Healthcare workers are in the first line of response against the COVID-19 outbreak and, as such, are exposed to risks. The risks include exposure to pathogens, long work hours, psychological distress, fatigue, occupational exhaustion, stigma, and physical and psychological violence". (WHO, March 2020)*

The search for the greater good based on ethics and deontology must go hand in hand with the **maximum protection of the professionals and the preservation of their morale and spirit**. The coordination of all actors within healthcare, together with the political leaders and with society is a fundamental objective today.

Starting from the confidence gained when these challenges are overcome, a message of hope is sent so that, while working in true teams, Primary Care can continue providing its best qualities to the entire healthcare system and to the healthcare provided to the citizens.

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