POSTER ABSTRACT

Health promotion in basque local primary care centers: results from implementation strategy optimization and evaluation

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Introduction: Healthcare systems must shift focus from curative, or “sick”, care to preventative approaches intended to keep people well. In 2006, the Primary Care Research Unit of Bizkaia (in Bilbao, Spain) began a systematic action research program to investigate the effective integration of healthy lifestyle promotion into the real life, day-to-day primary health care (PHC) setting. The primary aim is the optimization of health promotion in PHC. Both quantitative and qualitative indicators are evaluated after each phase of the project in order to be able to effectively scale-up the intervention across the local PHC centers, and later generalize to other centers, in a cost-efficient and valid fashion.

Theory/Methods: The clinical intervention is based on social learning and planned behavior theories and the 5 A’s (Ask, Advise, Agree, Assist, and Arrange follow-up) intervention framework. The implementation strategy phases are based on the Medical Research Council’s evaluation framework. In the modelling phase, four PHC centers followed an implementation strategy based on a collaborative and facilitated process, and planned and designed intervention programs adapted to their specific contexts and resources. Community organizations were included in the planning. In the optimization phase – a quasi-experimental non-randomized hybrid effectiveness-implementation type II trial – the Experimental Group (EG) included four PHC centers willing to adopt health promotion and the Reference Group (RG) was three other centers. Both groups received clinical training, educational materials, and feedback, but only the EG received the collaborative modelling component of the implementation strategy.

Results: After 12 months of implementation, analysis of 17,447 PHC users ages 10-80 indicated that 46% received an assessment of physical activity, diet, and/or tobacco; 40% received personalized preventive advice, and 10% received a personalized prescription for behavior change. Preliminary results show prescription rates four times higher in EG vs. RG centers, and that, of users wanting to improve their lifestyle behaviors, those receiving a prescription were two times more likely to change their habits at six months compared to those who did not receive a prescription. Qualitative data is available from 50 professionals and 50 patients via 13 focus groups conducted by center. Analysis of barriers and facilitators related to behavior change is underway.

Discussion: Collaborative modelling involves a local champion, supported by an external facilitator from the research team, who creates a community of practice. This component is critical to successful implementation.
Conclusions: Effective implementation strategies are required to change clinical practice behaviors and impact population health.

Lessons learned: The resources required for collaborative modelling are justified by center and population outcomes. Support for the program from political stakeholders is essential.

Limitations: EG differed from RG centers in their levels commitment to adopting the clinical practice behavior. At present, results can only generalize to centers with sufficient interest in health promotion.

Suggestions for future research: Qualitative data will be analyzed using a novel analytic method (Qualitative Comparative Analysis) to determine the necessary and/or sufficient factors required for successful implementation. These conditions will help to identify other centers to be targeted for scaling-up of the optimized implementation strategy.

Keywords: Implementation science; health promotion; primary care; community involvement; mixed methods research