

Primary Care Linked to Prevention

■ eAppendix Table. Disease Management and Prevention Programs in Various Countries

Country	Programs (With Some Special Features)
Austria	Disease Management Program on Diabetes Mellitus Type 2
	After pilot-phase nationwide program, to be followed by DMPs on other diseases. An evaluation program with benchmarking by a Web application involves healthcare organizations.
	A Heart for Vienna
	With a focus exclusively on CVDs, public events for information form an important part of this ongoing program.
	Vorarlberg Program
	CVD was one of several items in the program. An important aim concerning CVDs was to improve cardiovascular risk and lifestyle by education.
Belgium	National Preventive Health Checkup
	An ongoing program in which CVD is just one of several items. Education of patients is achieved by using an invitation system to promote participation.
	Herz.Leben project (Heart.Life Project)
	The program gives education to patients and provides a Train the Trainer program for health professionals with an exclusive focus on CVD.
	Cardiovascular Risk Screening in General Practice
In this ongoing program, all activities and interventions are targeted at education of healthcare professionals. GPs are taught the use of 2 tools: an algorithm as a decision aid for global risk management and a patient-communication guide.	
Finland	PreCardio
	Patients are invited for a risk assessment and tailored advice is available on a Web site. An electronic risk calculator was developed and is linked to the GP's electronic medical file, generating goals depending on the risk profile.
	Diabetes Project Leuven
	The objects of this program are (1) implementation of an evidence-based treatment protocol for diabetes type 2 patients in general practice through a multifaceted Quality Improvement Program and (2) scientific evaluation of the results. Interventions on 5 of the 6 axes of the Chronic Care Model can be distinguished. The program is meant to give a framework for diabetes care throughout the country.
Finland	North Karelia Project
	The aims of the program were to improve cardiovascular risk and lifestyle. Activities and interventions consisted of education of both the public and health professionals. Furthermore, activities were undertaken to facilitate cooperating with health organizations and with other institutions such as schools and the food industry.
	Diabetes Program 2000-10 (DEHKO)
	Activities and interventions in this nationwide program are targeted at several persons and organizations. Activities consist of education of the public and support of self-care, group counseling, and support of local groups. Activities targeted at health professionals consist of special information and education. Local authorities are influenced for social support.
Finland	Helsinki Prevention Project (HPP)
	In this program, CVD was one of several items. The aims were to improve quality of care; to implement guidelines; to share the tasks among doctors and nurses appropriately, avoiding double work; and to analyze the effect of facilitation. One aim of the project was cost containment and efficiency improvement. The main activity in the program was education. Education was targeted at patients, health visitor nurses, and GPs.

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Country	Programs (With Some Special Features)
France	Private Team Health Action (ASALEE)
	This project is about sharing tasks between GPs and nurses. Practices employ nurses; this is a new phenomenon in France. CVD is one of several items in the program.
	Escape
	The focus of the program is exclusively on CVD, aiming at improvement of cardiovascular risk, lifestyle, quality of care, and clinical performance. GPs receive detailed guidelines and a 1-day educational session about targets, therapeutic strategies, and how to manage specific preventive clinics. Patients receive education. Five cardiovascular preventive clinics for 6 patients per GP during 2 years are budgeted.
	ANCRED
	The focus of this ongoing program is on diabetes only for most networks. Some networks also focus on cardiovascular prevention. Project activities are education of patients about healthy diet, physical activity, and foot care, and education of health professionals about diabetes and lifestyle changes. Five cardiovascular preventive clinics for 6 patients per GP during 2 years are budgeted.
	Rendez-Vous Prévention
	In this program, led by a National Health Insurance health project leader, CVD is one of several items. Activities are mainly targeted at education. Each patient is offered the chance to participate in 3 workshops (3 hours each) to better understand his/her health problems, to identify risk factors, to know what foods are to be favored or avoided, to learn to plan adapted physical activity, to identify the first signs of cardiovascular complications, and to manage drugs.
	The Dinan Project
	Men from age 60-64 years and women from age 50-54 years are offered cardiovascular risk assessment by their GP. According to their risk, further activities are proposed by the GP. GPs and nurses receive education on CVD management and patient education. Physicians will be paid if they meet certain targets.
Germany	Disease Management Program
	The DMPs fit in a government strategy to strengthen the role of primary care in Germany. DMPs focus on CHD and other chronic conditions such as diabetes. Regulations and financial incentives both for GPs and patients are part of the DMPs.
	Checkup 35—Health Examination
	People age 35 years and older in statutory sickness funds are offered a CVD, diabetes, and kidney disease risk check every 2 years. Activities targeted at patients consist of education by counseling methods.
	Three-Level Strategy
	In this program CVD is one of several items. Cardiovascular risk is improved by health education on 3 levels: a GP consultation (lifestyle counseling and “prescription” of lifestyle-changing measures such as educational courses); educational group work in the practice; and educational group work at the community level (interdisciplinary cooperation).
Israel	Vita Longa
	Nurses implemented the program for secondary prevention of cardiovascular events among patients after hospitalization for a cardiovascular event. A special nurse invites patients to participate in a rehabilitation program and checks for use of preventive medications and for control of hypercholesterolemia, hypertension, and diabetes. When there is a need for a physician’s intervention, the nurse contacts the primary physician.
	Diabetes Program
	The program is exclusively targeted to diabetes and the accompanying diseases of hypertension, hypercholesterolemia, and nephropathy. Patients receive education in the program. Health professionals in the Clalit program receive computerized reminders, audit, and indicators of care. Furthermore, the infrastructure for better organization of care was improved.
	Computerized Community Cardiovascular Control (4C)
	The use of a computerized clinical decision support system will improve the performance of health professionals. Special software is attached to the medical record. When a patient’s information is incorporated, the physician will receive alerts concerning the quality of care and suggestions to improve it. A computerized case finding system was developed to identify patients at high risk for CVD.

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■ eAppendix Table. Disease Management and Prevention Programs in Various Countries (Continued)

Country	Programs (With Some Special Features)
Israel (continued)	Heart Failure Program <p>In this program patients are referred to a heart failure clinic. Education of patients by specialized nurses and quick and easy access are important features of the program. There are professional consultations (by phone, e-mail, or fax) for physicians who are taking care of heart failure patients.</p>
The Netherlands	Tailor-Made Prevention <p>All interventions were targeted at general practices. A national prevention team developed manuals for protocols, task delegation, health education materials, and information technology. District prevention teams organized informative and educational meetings. An important aspect was the contribution of prevention consultants visiting general practices and giving advice by telephone. There were financial incentives for participating GPs.</p> Familial Hypercholesterolemia <p>The Foundation for Tracing Hereditary Hypercholesterolaemia started a program with involvement of the Dutch College of GPs and the regional support structures. The aim is to have identified nationwide all patients with familial hypercholesterolemia by 2010. Several organizational changes were implemented. Regional support structures offer support to the general practices; a genetic field worker contacts identified patients and after their approval, all first-degree relatives are contacted and offered a test for diagnosis of familial hypercholesterolemia.</p> Heart Beat Limburg <p>The program focused exclusively on CVDs. Part of Heart Beat Limburg was a High Risk Project. Cardiologists, GPs, and patients were involved in this module. The most important part of the program was the community project, with 4 low socioeconomic status areas selected as special attention areas. About 100 interventions were targeted at nutrition, exercise, smoking, and lifestyle in general in the community project.</p> Vascular Risk Management <p>The funding Netherlands Heart Foundation supported the development of the multidisciplinary practice guideline on cardiovascular risk management. Because one of the main activities was education of patients and the public, a patient version of the practice guideline for cardiovascular risk management was published. A standard of care teaches patients what to expect from their healthcare provider and what is expected from the patients themselves.</p> Diabetes Program <p>The importance of this new approach followed by the Diabetes Support Service is the combination of an organization taking care of logistical aspects and patient care still being provided by the patient's own GP. The service gives information about the importance of the control system and the investigations done. Group education for patients and their family members is arranged. The service calls patients for laboratory testing and other investigations. The service has a quality control system for glucose testing devices in general practice and gives advice about these devices. General practices can receive help from a diabetes consultant. GPs receive feedback both on practice level and on patient level, and they can get treatment advice.</p>
Slovenia	Risk Factors for Noncommunicable Diseases in Adults <p>In the program CVD was one of several items. The aims of the program with respect to CVD were to improve people's lifestyle and cardiovascular risk and to increase the accessibility and volume of healthcare. Activities targeted at patients and the public consisted of education. Healthcare professionals were offered basic education about health and the prevalence and importance of risk factors. An information system enabled centralized data collection.</p> Heart Foundation Prevention Program & Study <p>With a focus exclusively on CVD, the aims were to improve the lifestyle of both patients and the public and to improve cardiovascular risk. There was a CVD prevention program all over the country for the general public, including several publications; resuscitation courses; recreational sports events; a consulting service by phone and Web; several consulting offices; food labeling (trademark "Protects Health"); and measuring people's risk factors at various public events, shopping centers, schools, and several companies.</p> Nationwide Program on Primary Prevention <p>All GPs' offices are involved and obliged to participate in this ongoing nationwide program. Healthcare professionals are offered education about health promotion and prevention. Patients are sent a screening questionnaire for basic risk assessment, followed by an invitation for a risk assessment for those with higher scores. According to the results, patients receive education about healthy lifestyles and can join workshops to modify risk factors. An information system for centralized data collection was developed and a central database of people at high risk for CVDs was built.</p>

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Country	Programs (With Some Special Features)
Spain	Intervention on CVD
	The health department created a new directorate for management and prevention of circulatory diseases including CVD in primary care with a permanent structure. Interventions in this part of the program are targeted at the diagnosis, treatment, and control of hypertension and hypercholesterolemia.
	Intervention on Diabetes Mellitus
	Interventions target the diagnosis, treatment, and control of diabetes by primary care, as well as promotion of diabetes prevention. Education and diet advice are supplied for patients and primary care professionals. Furthermore, interventions target to increase use of consensus agreements for patients who have gestational diabetes.
	Intervention on Lifestyle
	Interventions target the promotion of a healthy lifestyle in school and at work, especially for young people. Primary care professionals are encouraged to give their patients educational advice about how to lead a healthy life. Global strategies for health promotion (eg, use of mass media, neighborhood activities) are used. The Health Department develops guidelines and actions.
	Disease Management Program
	This program is a coordinated system of interventions related to health and communication with patients who have congestive heart failure. It includes a patient identification process, application of evidence-based clinical practice guidelines, collaboration models between different care providers, education for patient self-management, process and outcomes evaluation, and feedback of the information generated by the program. Initially applied to congestive heart failure, it will be extended to other conditions in which patient self-care is crucial.
Switzerland	Health Risk Assessment & Lifestyle Changes
	CVD is one of several items in the program. The aims are improvement of (1) lifestyle, (2) patient experiences, and (3) cardiovascular risk. There has been a public campaign to sensitize the public to the topic. Education of patients is part of the program. Healthcare organizations promote lifestyle changes. GPs are taught communicative skills and counseling.
	Counseling for Behavioral Change
	In this program CVD was one of several items. The activities were targeted at health professionals. The program consisted of education of physicians. Through education of physicians, education of patients was achieved.
The United Kingdom	Quality and Outcome Framework
	The program is aimed at improving quality of care and health outcomes for a number of conditions, including CVD. Prevention is predominantly secondary and tertiary rather than primary. Practices receive a financial “reward” for achieving high scores on quality indicators. The program formally provides incentives in specific areas of prevention and disease management, including coronary heart disease, hypertension, diabetes, stroke, and transient ischemic attack. Recalling patients is a central feature of United Kingdom general practice preventive care and is now incentivized in the Quality and Outcome Framework.
	National Service Framework on Coronary Heart Disease
	Education about a healthier lifestyle is targeted at the public for primary prevention and at patients with established coronary heart disease for secondary prevention. Healthcare professionals and their organizations have to meet minimum standards for the delivery of health services in England. The Healthcare Commission, which is a national health regulator, is responsible for evaluating the implementation of National Service Framework guidance.
	Primary Care Trusts “Healthy Living Programs”
	The programs, which were started in 2005 and 2006, are ongoing and nationwide. The Department of Health runs initiatives to help people quit smoking, eat better, and exercise more, as well as health screening projects and training and skills programs. Each Primary Care Trust has its own healthy living schemes.
	Heart Failure Nurse
	In this nationwide, ongoing program, multidisciplinary heart failure teams were formed by primary care trusts. There were specialist trainings for cardiac nurses. They gave education to patients as well as family members on the disease process and management and control of symptoms. Support also was provided after the diagnosis of chronic heart failure.

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■ **eAppendix Table.** Disease Management and Prevention Programs in Various Countries (*Continued*)

Country	Programs (With Some Special Features)
The United Kingdom <i>(continued)</i>	<p>Improvement Foundation</p> <p>The Improvement Foundation, involving Strategic Health Authorities and Primary Care Trusts, works nationwide with potential access for all clinicians and healthcare professionals. Several activities are targeted at the education of patients and the public, with emphasis on widening access to a healthy diet with focus on low-income groups. There also are activities targeted at education of health professionals (eg, workshops on coronary heart disease and diabetes, but also on mental health and long-term conditions).</p>
<p>CVD indicates cardiovascular disease; DMP, disease management program; GP, general practitioner.</p>	