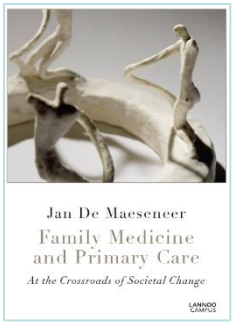
ISTITUTO SUPERIORE DI STUDI SANITARI
Giuseppe Cannarella

II Conferenza Nazionale sull'ASSISTENZA PRIMARIA 2017



DALL'OFFERTA DI SERVIZI ALL'INIZIATIVA

La partecipazione attiva di tutti gli attori

Roma, 7-9 novembre 2017
Auditorium - Centro Congressi
Università Cattolica del Sacro Cuore di Roma
Largo Francesco Vito, 1

Family Medicine and Primary Care at the Crossroads of Societal Change

Prof. Em. Jan De Maeseneer, MD, PhD
Department of Family Medicine and Primary Health Care, Ghent University, Belgium

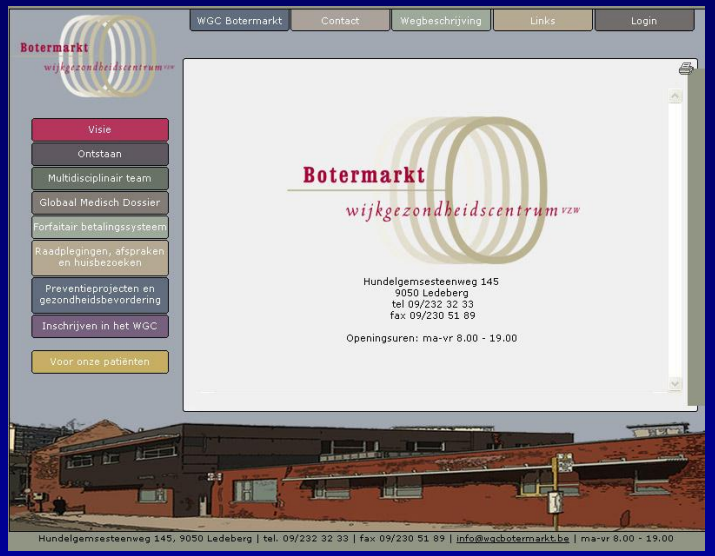
Jan De Maeseneer

Family Medicine and Primary Care

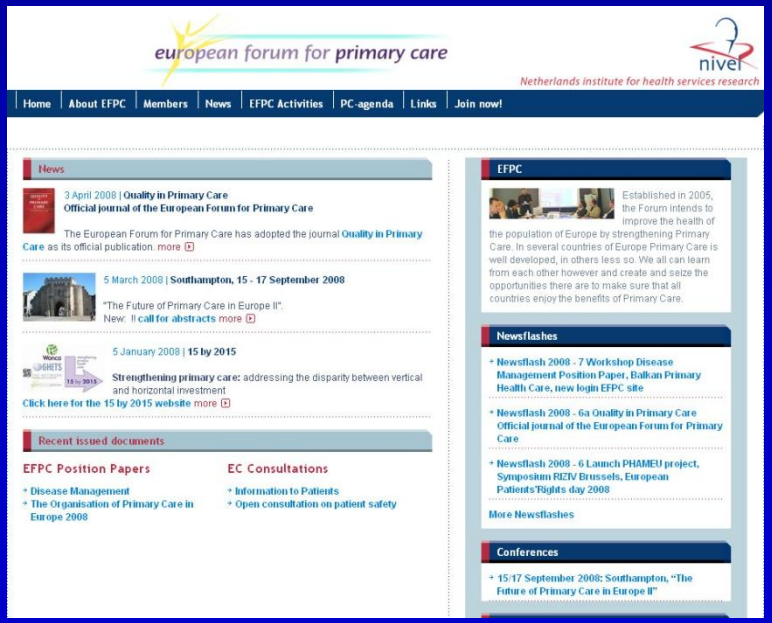
At the Crossroads of Societal Change

LANNOO CAMPUS

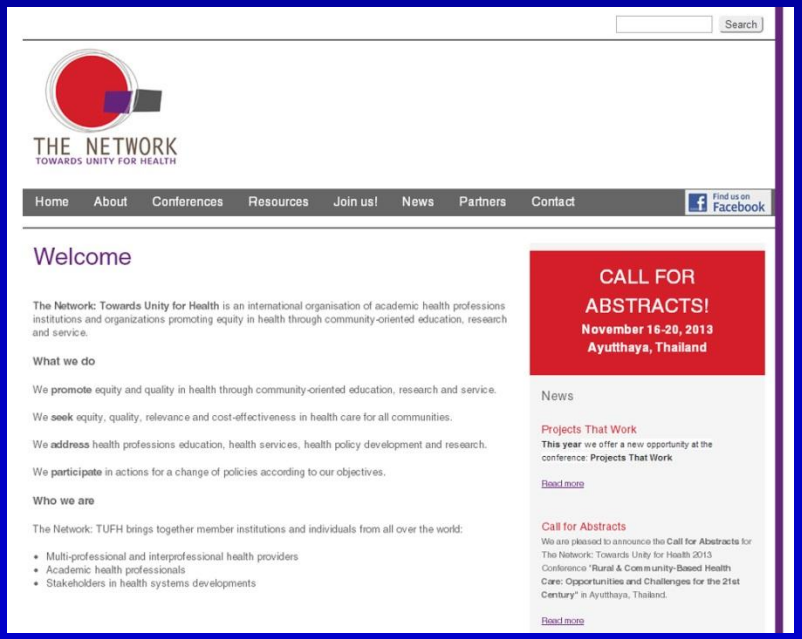
http://www.primafamed.ugent.be



http://www.wgcbotermarkt.be



http://www.euprimarycare.org



http://www.thenetworktufh.org

WGC Botermarkt | Wegbeschrijving | Links | Login

Botermarkt
wijkgezondheidscentrum

- Visie
- Ontstaan
- Multidisciplinair team
- Globaal Medisch Dossier
- Forfaitair betalingssysteem
- Raadplegingen, afspraken en huisbezoeken
- Preventieprojecten en gezondheidsbevordering
- Inschrijven in het WGC

Voor onze patiënten

Community Health Centre:

- General Practitioners; nurses; dieticians; health promotors; dentists; social workers; tabacologist;…
- 6200 patients; 95 nationalities
- Integrated needs-based mixed capitation; no co-payment
- COPC-strategy

Hundelgemsesteenweg 145, 9050 Ledeberg | tel. 09/232 32 33 | fax 09/230 51 89 | info@wgcbotermarkt.be | ma-vr 8.00 - 19.00

Family Medicine and Primary Care at the Crossroads of Societal Change

1. The changing society
2. Primary care: the challenges
3. Nano-level
4. Micro-level
5. Meso-level
6. Macro-level
7. Primary Care and Social Cohesion
8. Conclusion

The changing society

a. Demographical and epidemiological developments

b. Scientific and technological developments

c. Cultural developments

d. Socio-economical developments

e. Globalisation and “glocalisation”

‘By 2030, 70% of the world population will live in an urban context’ (Castells, 2002)
By 2100, 85%?

Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie

Summary

Background Long-term disorders are the main challenge facing health-care systems worldwide, but health systems are largely configured for individual diseases rather than multimorbidity. We examined the distribution of multimorbidity, and of comorbidity of physical and mental health disorders, in relation to age and socioeconomic deprivation.

Lancet 2012; 380: 37–43
Published Online
May 10, 2012
DOI:10.1016/S0140-

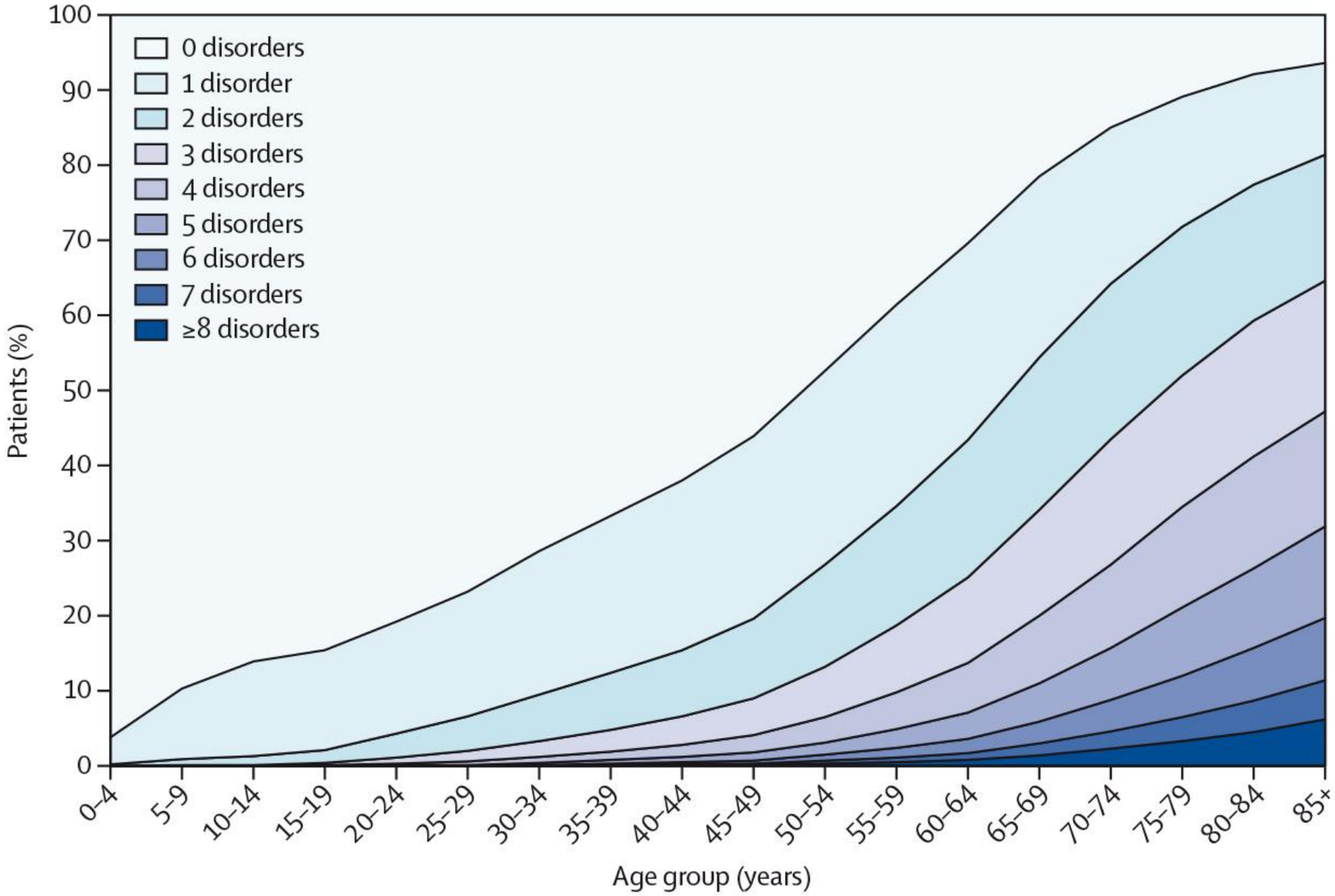


Figure 1: **Number of chronic disorders by age-group**

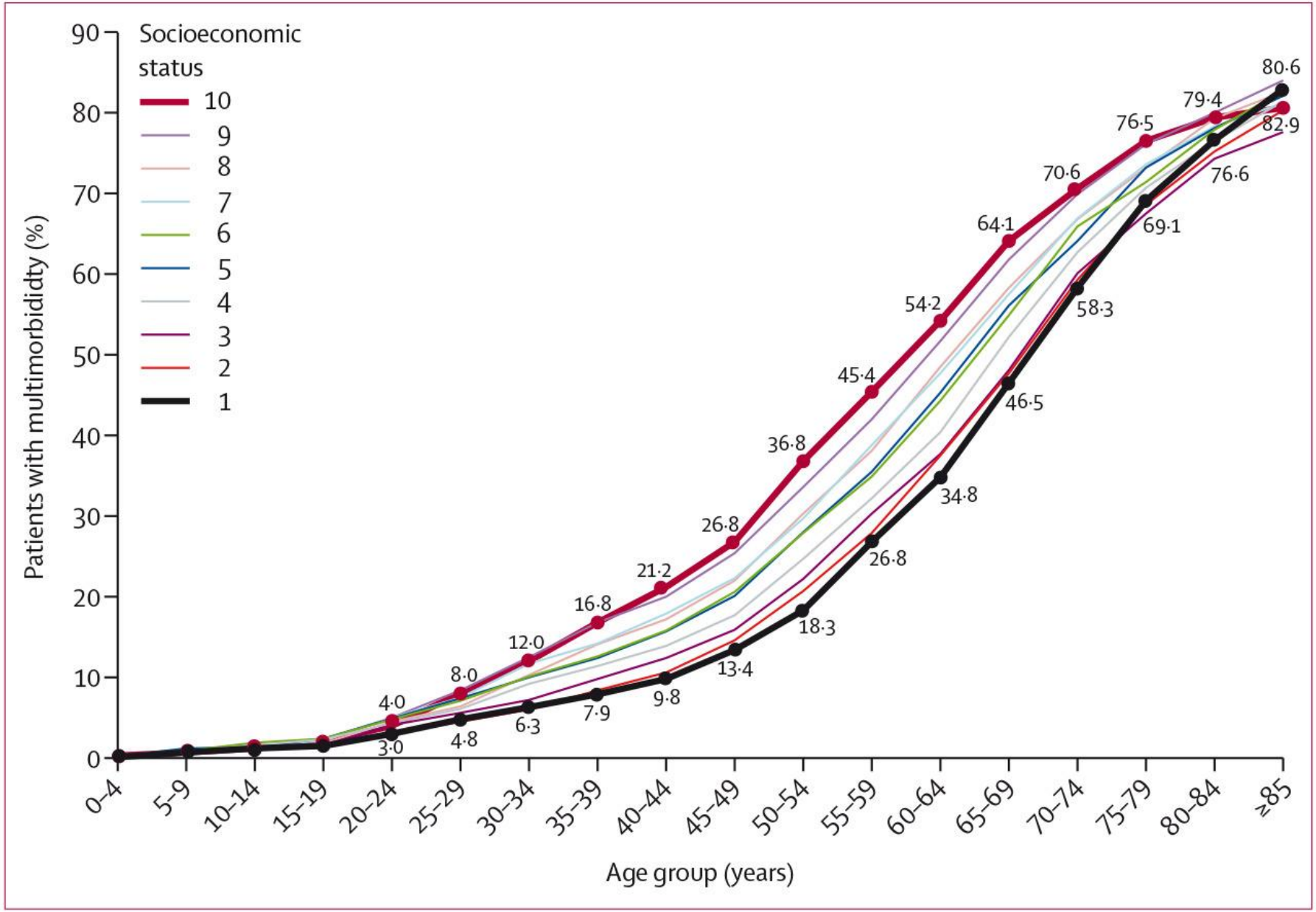


Figure 2: **Prevalence of multimorbidity by age and socioeconomic status**

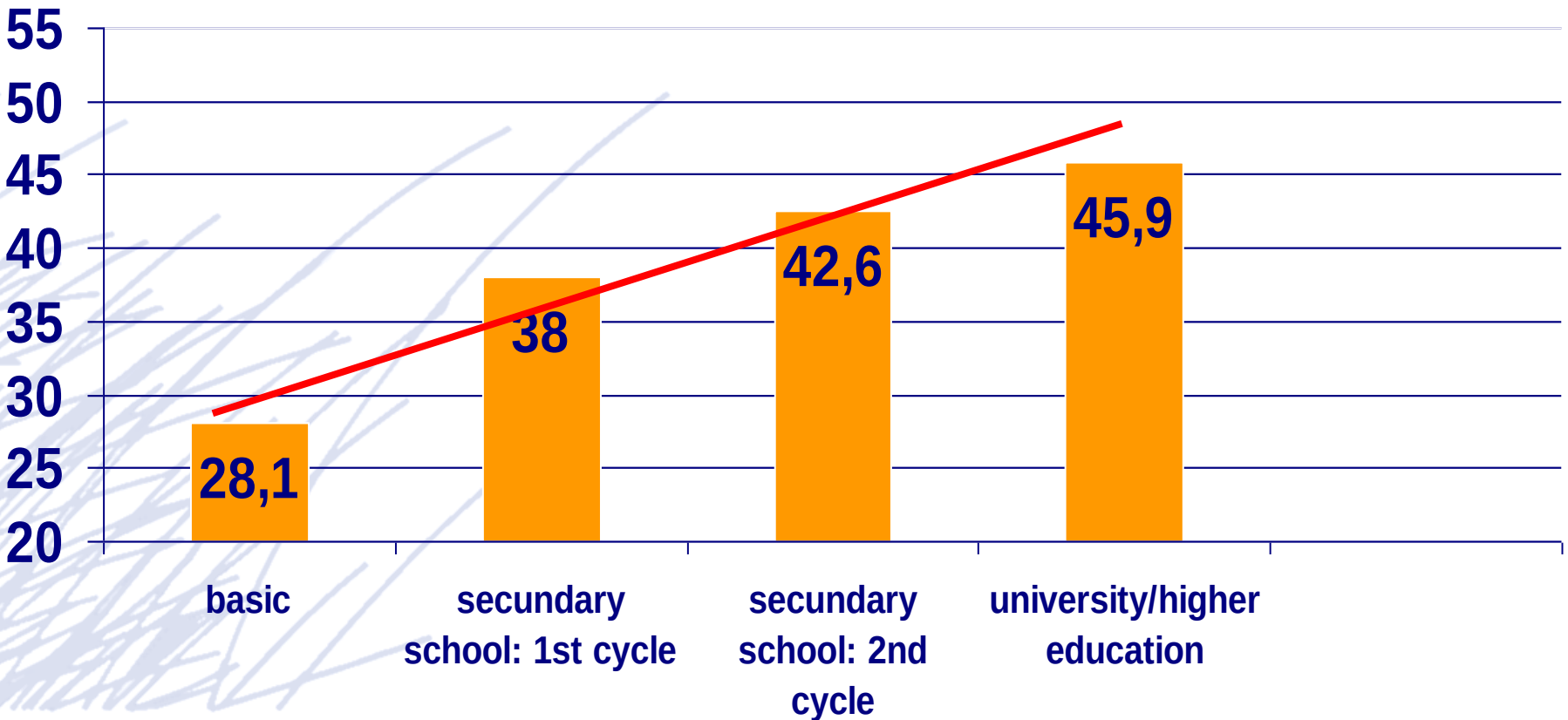
On socioeconomic status scale, 1=most affluent and 10=most deprived.

Healthy life expectancy in Belgium

(Bossuyt, et al. Public Health 2004)

Socio-economic inequalities in health

Healthy life expectancy in Belgium, 25 years, men



The changing society

a. Demographical and epidemiological developments

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e. Globalisation and “glocalisation”

‘By 2030, 70% of the world population will live in an urban context’ (Castells, 2002)
By 2100, 85%?

▶ Woensdag redde een Zweeds schip nog 439 mensen voor de Libische kust; 51 anderen waren gestorven. © AP

Boot met honderden vluchtelingen gezonken

Wonca Europe 2015 Istanbul Statement:

"*Urge governments to take action so that all people living permanently or temporarily in Europe will have access to equitable, affordable and high-quality health care services*"

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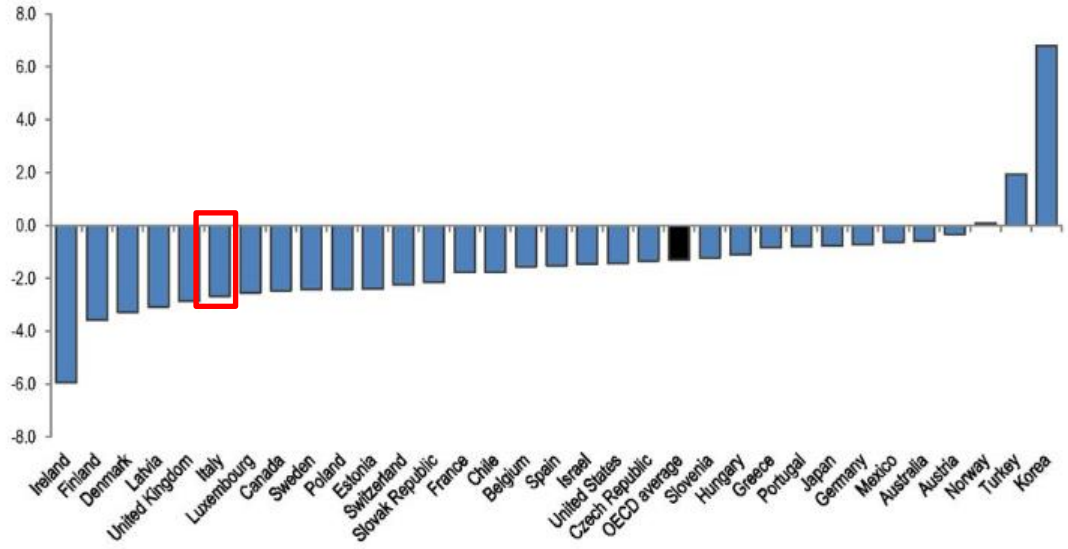
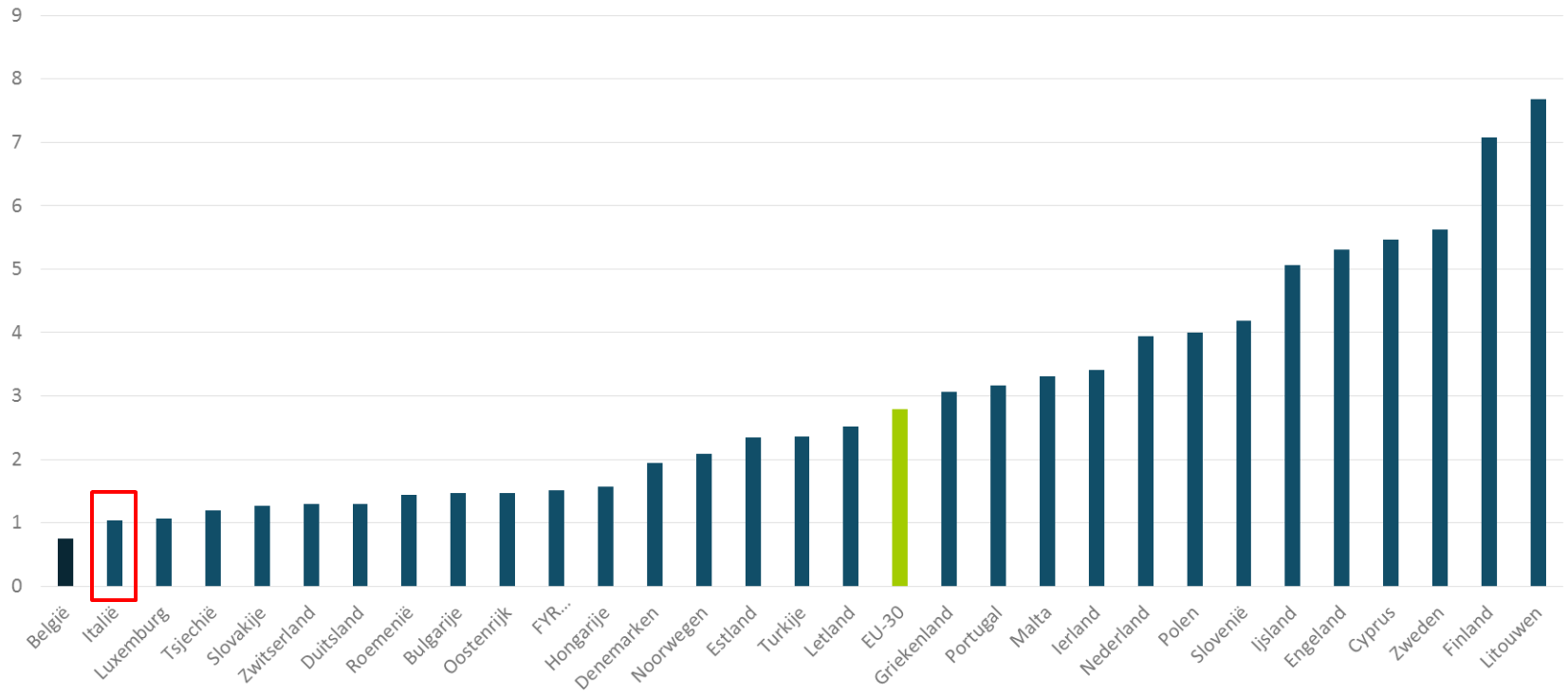
SHIFT FROM HOSPITAL TO COMMUNITY CARE

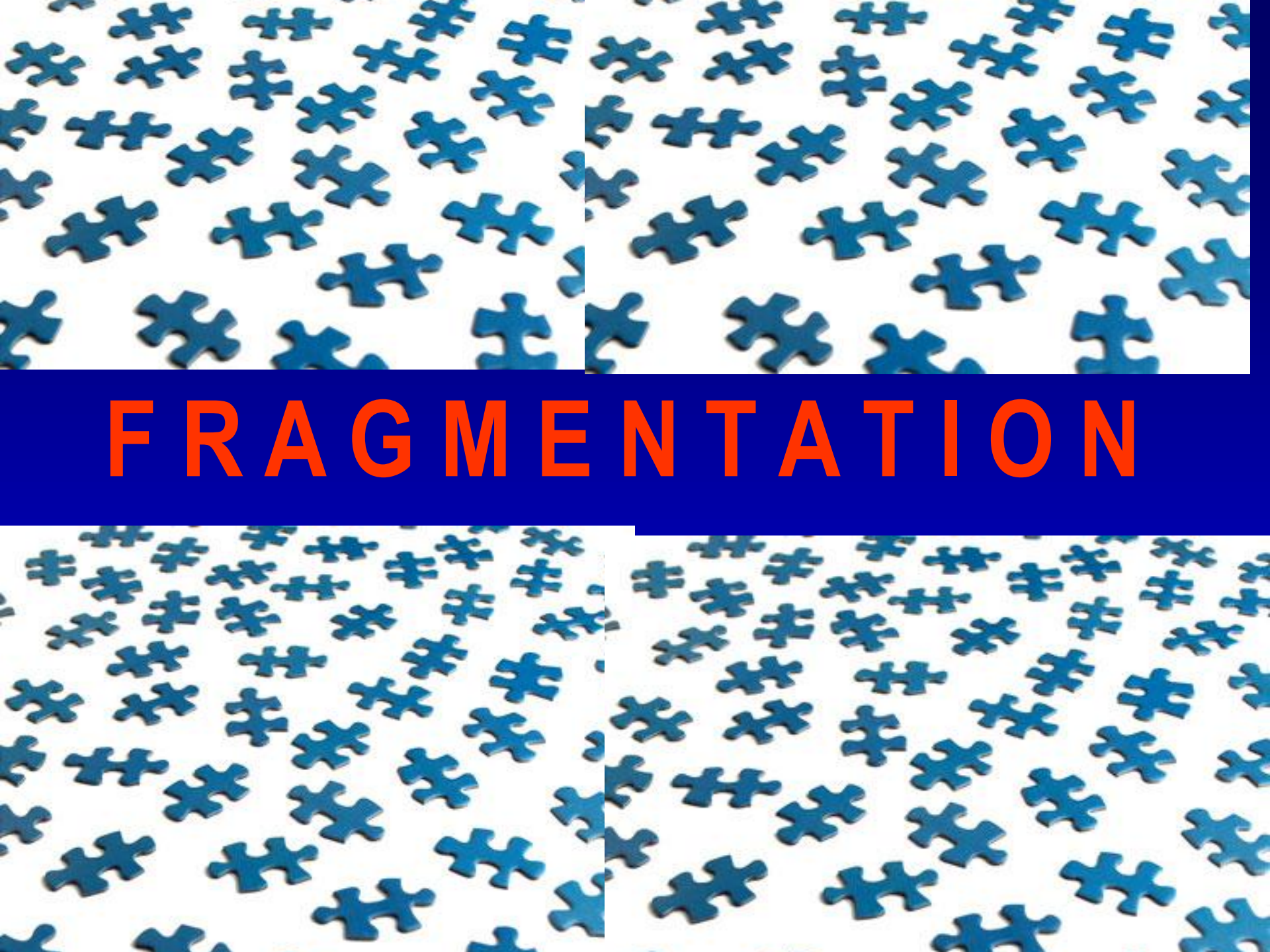
Figure 1.2. Health care is progressively shifting out of hospitals but progress in some countries is still low

Panel A. Average annual growth rate of hospital beds, 2000-14 (or nearest year)



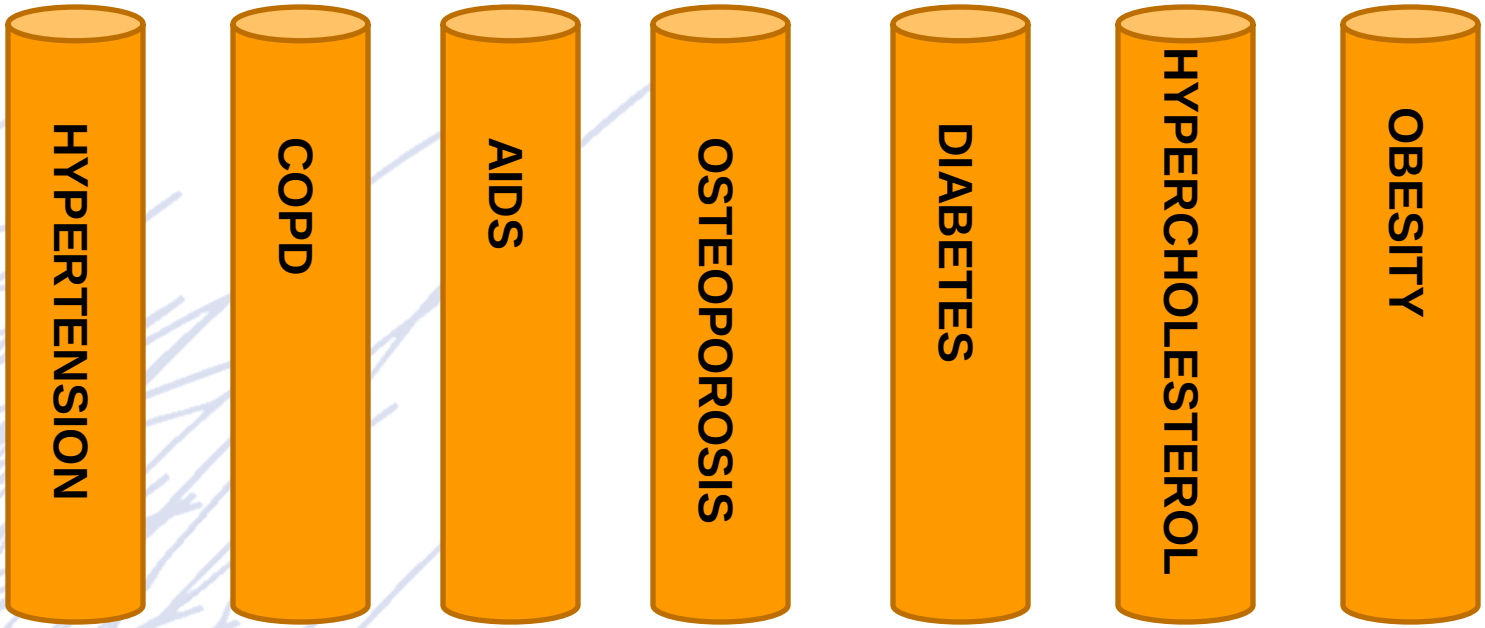
COOPERATION OF DIFFERENT HEALTH PROFESSIONALS IN THE SAME FAMILY PRACTICE (QUALICOPC, 2013)




FRAGMENTATION

Vertical Disease Oriented Approach

- Mono-disease-programs? Or…
- Integration in comprehensive PHC




1 NO POVERTY
2 ZERO HUNGER
3 GOOD HEALTH AND WELL-BEING
4 QUALITY EDUCATION
5 GENDER EQUALITY
6 CLEAN WATER AND SANITATION
7 AFFORDABLE AND CLEAN ENERGY
8 DECENT WORK AND ECONOMIC GROWTH
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
10 REDUCED INEQUALITIES
11 SUSTAINABLE CITIES AND COMMUNITIES
THE GLOBAL GOALS
For Sustainable Development
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
13 CLIMATE ACTION
14 LIFE BELOW WATER
15 LIFE ON LAND
16 PEACE AND JUSTICE STRONG INSTITUTIONS
17 PARTNERSHIPS FOR THE GOALS

Panel: Proposed Sustainable Development Goals

Goal 1
End poverty in all its forms everywhere

Goal 2
End hunger, achieve food security and improved nutrition, and promote sustainable agriculture

Goal 3
Ensure healthy lives and promote wellbeing for all at all ages

Goal 4
Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Goal 5
Achieve gender equality and empower all women and girls

Goal 6
Ensure availability and sustainable management of water and sanitation for all

Goal 7
Ensure access to affordable, reliable, sustainable, and modern energy for all

Goal 8
Promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all

Goal 9
Build resilient infrastructure, promote inclusive and sustainable industrialisation, and foster innovation

Primary health care and the Sustainable Development Goals

After the eight Millennium Development Goals that have shaped progress in the past 15 years, 17 Sustainable Development Goals (SDGs) were adopted by governments at the UN General Assembly in September, 2015. SDG3 explicitly relates to health—to "Ensure healthy lives and promote well-being for all at all ages". This goal is tr… to reproductive and … diseases, non-comm… to environmental he… health coverage (UI… tobacco control, vacc… and workforce, and g…

When supported … and with aligned e… political domains, pr… in achievement of … differences are ine… organisation of pri… resources available, … in SDG3—related t… communicable dise… multimorbidity), ad… problems—can be a… and population-based approach to primary health care.[1,2] Delivery of vaccines and drugs needs a functioning primary care system. Well integrated and prepared primary health care has a key role in health emergency responsiveness, and it is essential for the achievement of UHC equitably and cost-effectively.[3,4]

Moreover, primary health care can contribute to the achievement of many of the 16 other SDGs; for example, its role in addressing the social determinants of health was underlined in the report *Closing the Gap in a Generation*. Primary care teams worldwide can provide examples from daily practice that illustrate their contribution across the SDGs, including helping to end poverty, improve nutrition, provide health education and promote lifelong learning, empower individuals and communities to reduce inequities and promote justice, enable access to safe water and sanitation, encourage productive and sustainable employment, foster innovation, advocate for healthy and sustainable living environments, and promote peaceful communities.

*Luisa M Pettigrew, Jan De Maeseneer, Maria-Inez Padula Anderson, Akye Essuman, Michael R Kidd, Andy Haines

Department of Health Services Research and Policy (LMP), and Department of Social and Environmental Health Research (AH), Faculty of Public Health and Policy, London School of Hygiene & Tropical Medicine, London WC1 9SH, UK; Department of Family Medicine and Primary Health Care, Ghent University, Ghent, Belgium (JDM); Department of Family and Community Medicine, Rio de Janeiro State University, Rio de Janeiro, Brasil (M-IPA); Family Medicine Unit, Department of Community Health, School of Public Health, University of Ghana, Accra, Ghana (AE); and Faculty of Medicine, Nursing and Health Sciences, Flinders University, Adelaide, Australia (MRK)

luisa.pettigrew@lshtm.ac.uk

Yet investment in realising the full potential of primary health care still seems elusive to many governments, policy makers, funders, and health-care providers. Therefore, 7 years after the World Health Report and *The Lancet* Series on primary health care, and 37 years since the Alma-Ata declaration, the absence of reference … their targets … could be … and … integral to the … goal or target … do so with … factors to … care in many … the scarcity … and its … purposes".[5] … of … the agenda is … good-quality … or how to … risk repeating the failures of the past.

National governments and other stakeholders need to be ambitious in measuring progress towards delivery of primary health care that will address the SDGs. This monitoring includes the use of indicators that can capture

For **Sustainable Development Goals (SDGs)** see http://sustainabledevelopment.un.org/topics

For the **World Health Report and The Lancet Series on primary health care** see http://www.thelancet.com/series/alma-ata-rebirth-and-revision

For the report **Closing the Gap in a Generation** see http://www.who.int/social_determinants/thecommission/finalreport/en/

Photo: Sarah Errington

Expert Panel on Effective Ways of Investing in Health

European Commission

Report of the

EXPERT PANEL ON EFFECTIVE WAYS OF INVESTING IN HEALTH (EXPH)

on

Definition of a Frame of Reference in relation to Primary Care with a special emphasis on Financing Systems and Referral Systems

Health and Consumers

Opinion on Definition primary care – Definition

Core-definition

'The Expert Panel considers that primary care is the provision of universally accessible, integrated person-centered, comprehensive health and community services provided by a team of professionals accountable for addressing a large majority of personal health needs. These services are delivered in a sustained partnership with patients and informal caregivers, in the context of family and community, and play a central role in the overall coordination and continuity of people's care

The professionals active in primary care teams include, among others, dentists, dieticians, general practitioners/family physicians, midwives, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers.'

Opinion on tools and methodologies for assessing the performance of primary care

Expert Panel on effective ways of investing in health

Jan De Maeseneer
Chair of the Expert Panel

Sabina Nuti, Italy
Margareth Barry, Ireland

Brussels, 03 October 2017

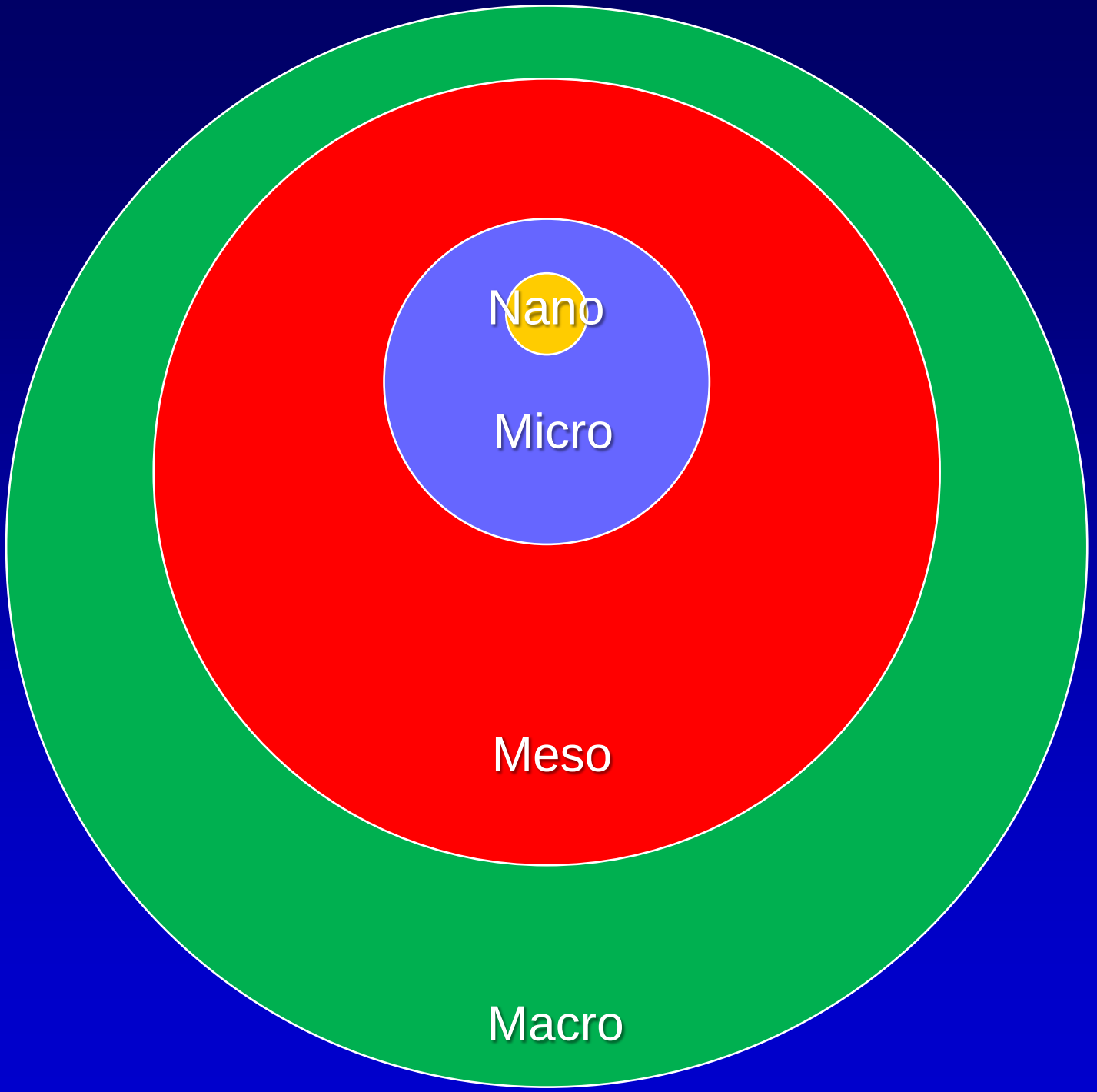
Health

Expert Panel on Investing in Health

Provides independent non-binding advice on effective ways of investing in health

Established by Commission Decision 2012/C 198/06 following the Council conclusions of June 2011 'Towards modern, responsive and sustainable health systems'; renewed in 2017.

Table 2. Examples of comparative key-indicators along its key domains	
Domains	Examples of Indicators
8) Continuity of people's care	• **Do GP-practices have a patient list system? Or another form of defined population?** • **% of patients reporting to visit their usual PC provider for their common health problems** • **% of GPs/PC Teams keeping electronic clinical records for all patient contacts routinely.** • **% of patients who are satisfied with their relation with their GP/PC provider** • **Do PC practices receive information within 24 hours about contacts that patients have with out-of-hours services?**


Nano
Micro
Meso
Macro

General structure

	Nano	Micro	Meso	Macro
Pro-active or pre-care				
RE-active care				
Chronic care				
Community/population oriented care				
PHC in Health System				

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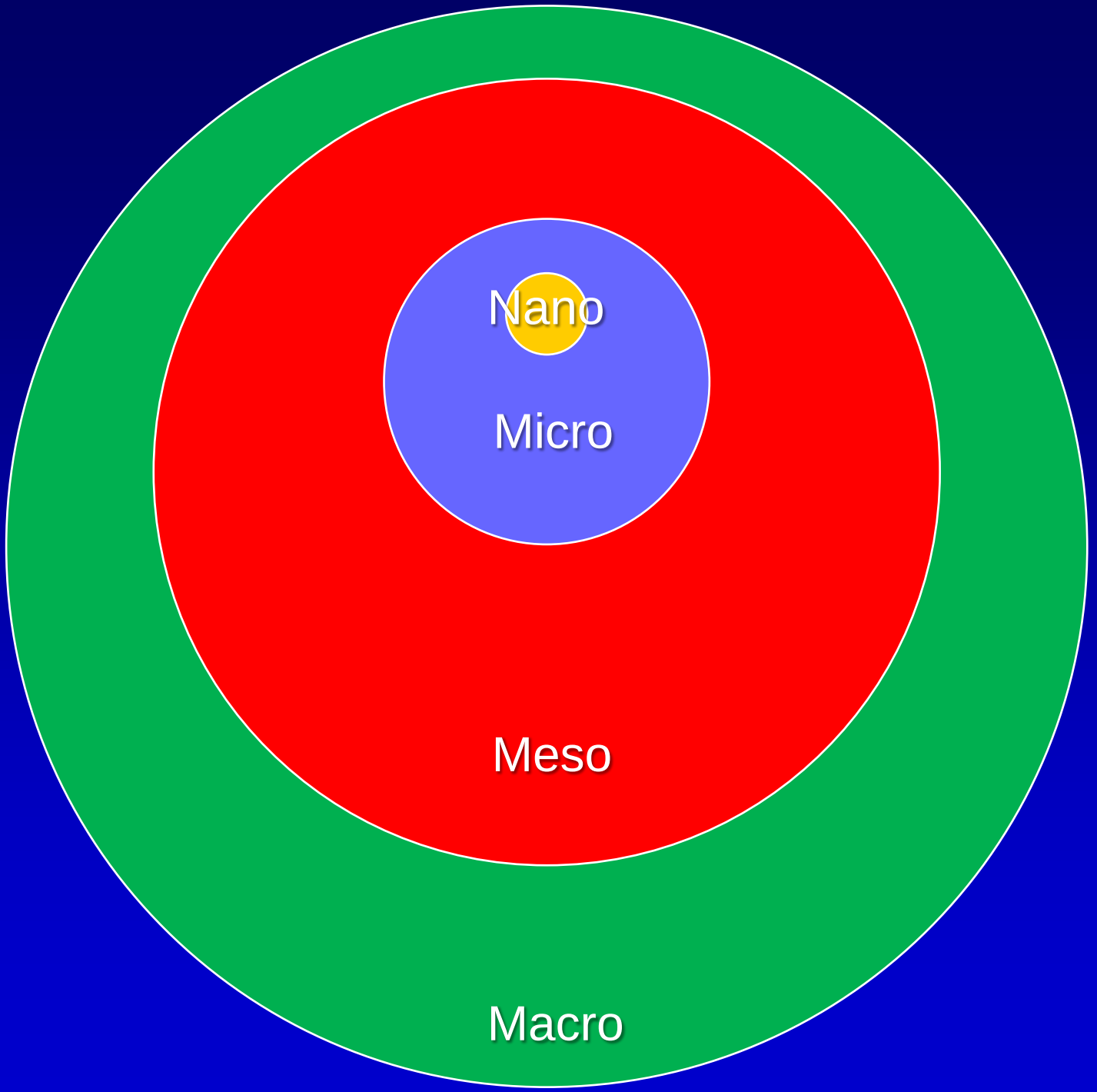
Nano
Micro
Meso
Macro

Nano-level:

The person/patient is the starting point of the process

- Active
- Informed
- Service delivery
- Multicultural

Accessibility

Equity


Commitment
Context
Cultural competence
Continuity
Cure
Care
Compassion
Cohesion
Connectedness
Cure
Continuity
Commitment
Community
Cure
Cohesion
Complexity
Context
Cultural competence
Comprehensiveness
Cost-effectiveness
Coordination
Cure
Care
Cultural competence
Context
Confidentiality
Cost-effectiveness
Complexity
Cohesion
Clinical competence

Characteristics of PHC / patient encounters

- C
- C
- C
- C
- C
- C
- C
- C
- C

Characteristics of PHC /patient encounters

- Commitment - Connectedness
- C
- C
- C
- C
- C
- C
- C

Characteristics of PHC /patient encounters

- Commitment - Connectedness
- Clinical Competence
- C
- C
- C
- C
- C
- C

Characteristics of PHC /patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- C
- C
- C
- C
- C

Characteristics of PHC /patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- C
- C
- C
- C

Characteristics of PHC /patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- C
- C
- C

Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- Complexity
- C
- C

Characteristics of PHC / patient encounters

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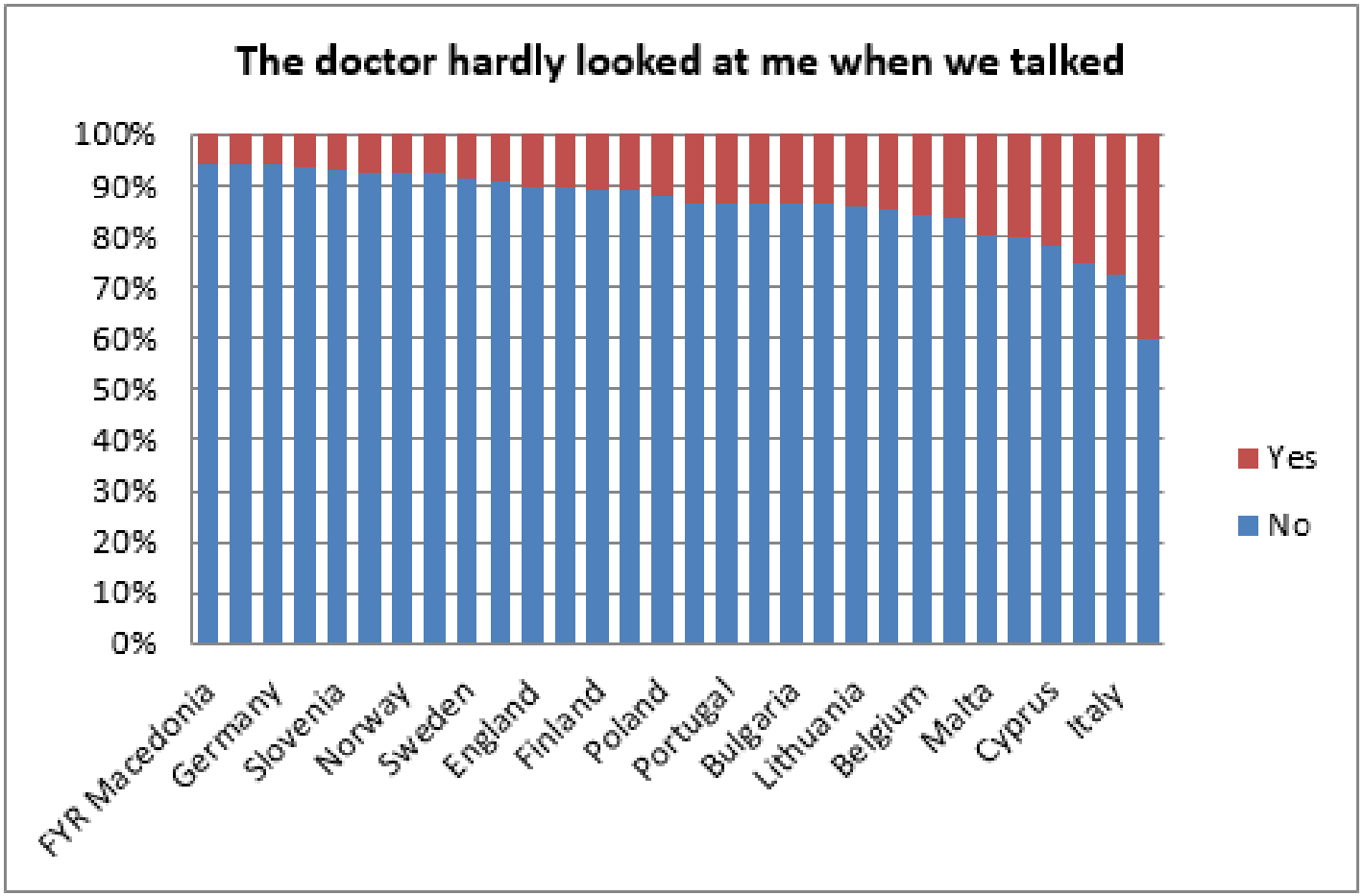
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- Complexity
- Coordination
- C

Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- Complexity
- Coordination
- Continuity

Compassion ↔ Computer

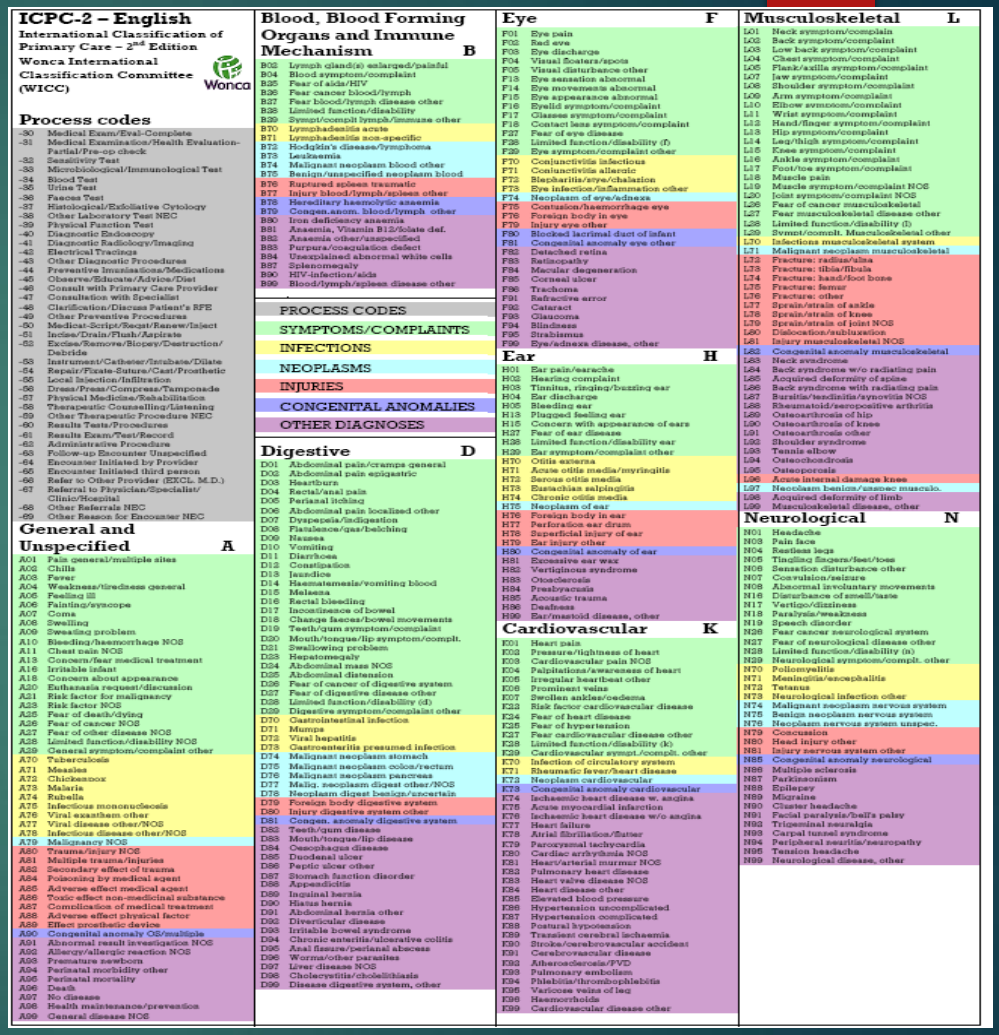


(Schäfer et al., 2011)

International Classification of Primary Care (ICPC)

Allow us to measure what is happening daily in primary care locally, nationally, globally

Primary Health Care should be documented using ICPC in patient records



ICPC-2 – English

International Classification of Primary Care – 2nd Edition

Wonca International Classification Committee (WICC)

Process codes

-30 Medical Exam/Eval-Complete
-31 Medical Examination/Health Evaluation-Partial/Pre-op check
-32 Sensitivity Test
-33 Microbiological/Immunological Test
-34 Blood Test
-35 Urine Test
-36 Faeces Test
-37 Histological/Exfoliative Cytology
-38 Other Laboratory Test NEC
-39 Physical Function Test
-40 Diagnostic Endoscopy
-41 Diagnostic Radiology/Imaging
-42 Electrical Tracings
-43 Other Diagnostic Procedures
-44 Preventive Immunisation/Medications
-45 Observe/Educate/Advice/Diet
-46 Consult with Primary Care Provider
-47 Consultation with Specialist
-48 Clarification/Discuss Patient's RFE
-49 Other Preventive Procedures
-50 Medicat-Script/Recat/Renew/Inject
-51 Incise/Drain/Flush/Aspirate
-52 Excise/Remove/Biopsy/Destruction/Debride
-53 Instrument/Catheter/Intubate/Dilate
-54 Repair/Fixate-Suture/Cast/Prosthetic
-55 Local Injection/Infiltration
-56 Dress/Press/Compress/Tamponade
-57 Physical Medicine/Rehabilitation
-58 Therapeutic Counselling/Listening
-59 Other Therapeutic Procedure NEC
-60 Results Tests/Procedures
-61 Results Exam/Test/Record
-62 Administrative Procedure
-63 Follow-up Encounter Unspecified
-64 Encounter Initiated by Provider
-65 Encounter Initiated third person
-66 Refer to Other Provider (EXCL. M.D.)
-67 Referral to Physician/Specialist/Clinic/Hospital
-68 Other Referrals NEC
-69 Other Reason for Encounter NEC

General and Unspecified A

A01 Pain general/multiple sites
A02 Chills
A03 Fever
A04 Weakness/tiredness general
A05 Feeling ill
A06 Fainting/syncope
A07 Coma
A08 Swelling
A09 Sweating problem
A10 Bleeding/haemorrhage NOS
A11 Chest pain NOS
A13 Concern/fear medical treatment
A16 Irritable infant
A18 Concern about appearance
A20 Euthanasia request/discussion
A21 Risk factor for malignancy
A23 Risk factor NOS
A25 Fear of death/dying
A26 Fear of cancer NOS
A27 Fear of other diseases NOS
A28 Limited function/disability NOS
A29 General symptom/complaint other
A70 Tuberculosis
A71 Measles
A72 Chickenpox
A73 Malaria
A74 Rubella
A75 Infectious mononucleosis
A76 Viral exanthem other
A77 Viral disease other/NOS
A78 Infectious disease other/NOS
A79 Malignancy NOS
A80 Trauma/injury NOS
A81 Multiple trauma/injuries
A82 Secondary effect of trauma
A84 Poisoning by medical agent
A85 Adverse effect medical agent
A86 Toxic effect non-medicinal substance
A87 Complication of medical treatment
A88 Adverse effect physical factor
A89 Effect prosthetic device
A90 Congenital anomaly OS/multiple
A91 Abnormal result investigation NOS
A92 Allergy/allergic reaction NOS
A93 Premature newborn
A94 Perinatal morbidity other
A95 Perinatal mortality
A96 Death
A97 No disease
A98 Health maintenance/prevention
A99 General disease NOS

Blood, Blood Forming Organs and Immune Mechanism B

B02 Lymph gland(s) enlarged/painful
B04 Blood symptom/complaint
B25 Fear of aids/HIV
B26 Fear cancer blood/lymph
B27 Fear blood/lymph disease other
B28 Limited function/disability
B29 Sympt/complt lymph/immune other
B70 Lymphadenitis acute
B71 Lymphadenitis non-specific
B72 Hodgkin's disease/lymphoma
B73 Leukaemia
B74 Malignant neoplasm blood other
B75 Benign/unspecified neoplasm blood
B76 Ruptured spleen traumatic
B77 Injury blood/lymph/spleen other
B78 Hereditary haemolytic anaemia
B79 Congen.anom. blood/lymph other
B80 Iron deficiency anaemia
B81 Anaemia, Vitamin B12/folate def.
B82 Anaemia other/unspecified
B83 Purpura/coagulation defect
B84 Unexplained abnormal white cells
B87 Splenomegaly
B90 HIV-infection/aids
B99 Blood/lymph/spleen disease other

PROCESS CODES
SYMPTOMS/COMPLAINTS
INFECTIONS
NEOPLASMS
INJURIES
CONGENITAL ANOMALIES
OTHER DIAGNOSES

Digestive D

D01 Abdominal pain/cramps general
D02 Abdominal pain epigastric
D03 Heartburn
D04 Rectal/anal pain
D05 Perianal itching
D06 Abdominal pain localised other
D07 Dyspepsia/indigestion
D08 Flatulence/gas/belching
D09 Nausea
D10 Vomiting
D11 Diarrhoea
D12 Constipation
D13 Jaundice
D14 Haematemesis/vomiting blood
D15 Melaena
D16 Rectal bleeding
D17 Incontinence of bowel
D18 Change faeces/bowel movements
D19 Teeth/gum symptom/complaint
D20 Mouth/tongue/lip symptom/complt.
D21 Swallowing problem
D23 Hepatomegaly
D24 Abdominal mass NOS
D25 Abdominal distension
D26 Fear of cancer of digestive system
D27 Fear of digestive disease other
D28 Limited function/disability (d)
D29 Digestive symptom/complaint other
D70 Gastrointestinal infection
D71 Mumps
D72 Viral hepatitis
D73 Gastroenteritis presumed infection
D74 Malignant neoplasm stomach
D75 Malignant neoplasm colon/rectum
D76 Malignant neoplasm pancreas
D77 Malig. neoplasm digest other/NOS
D78 Neoplasm digest benign/uncertain
D79 Foreign body digestive system
D80 Injury digestive system other
D81 Congen. anomaly digestive system
D82 Teeth/gum disease
D83 Mouth/tongue/lip disease
D84 Oesophagus disease
D85 Duodenal ulcer
D86 Peptic ulcer other
D87 Stomach function disorder
D88 Appendicitis
D89 Inguinal hernia
D90 Hiatus hernia
D91 Abdominal hernia other
D92 Diverticular disease
D93 Irritable bowel syndrome
D94 Chronic enteritis/ulcerative colitis
D95 Anal fissure/perianal abscess
D96 Worms/other parasites
D97 Liver disease NOS
D98 Cholecystitis/cholelithiasis
D99 Disease digestive system, other

Eye F

F01 Eye pain
F02 Red eye
F03 Eye discharge
F04 Visual floaters/spots
F05 Visual disturbance other
F13 Eye sensation abnormal
F14 Eye movements abnormal
F15 Eye appearance abnormal
F16 Eyelid symptom/complaint
F17 Glasses symptom/complaint
F18 Contact lens symptom/complaint
F27 Fear of eye disease
F28 Limited function/disability (f)
F29 Eye symptom/complaint other
F70 Conjunctivitis infectious
F71 Conjunctivitis allergic
F72 Blepharitis/stye/chalazion
F73 Eye infection/inflammation other
F74 Neoplasm of eye/adnexa
F75 Contusion/haemorrhage eye
F76 Foreign body in eye
F79 Injury eye other
F80 Blocked lacrimal duct of infant
F81 Congenital anomaly eye other
F82 Detached retina
F83 Retinopathy
F84 Macular degeneration
F85 Corneal ulcer
F86 Trachoma
F91 Refractive error
F92 Cataract
F93 Glaucoma
F94 Blindness
F95 Strabismus
F99 Eye/adnexa disease, other

Ear H

H01 Ear pain/earache
H02 Hearing complaint
H03 Tinnitus, ringing/buzzing ear
H04 Ear discharge
H05 Bleeding ear
H13 Plugged feeling ear
H15 Concern with appearance of ears
H27 Fear of ear disease
H28 Limited function/disability ear
H29 Ear symptom/complaint other
H70 Otitis externa
H71 Acute otitis media/myringitis
H72 Serous otitis media
H73 Eustachian salpingitis
H74 Chronic otitis media
H75 Neoplasm of ear
H76 Foreign body in ear
H77 Perforation ear drum
H78 Superficial injury of ear
H79 Ear injury other
H80 Congenital anomaly of ear
H81 Excessive ear wax
H82 Vertiginous syndrome
H83 Otosclerosis
H84 Presbyacusis
H85 Acoustic trauma
H86 Deafness
H99 Ear/mastoid disease, other

Cardiovascular K

K01 Heart pain
K02 Pressure/tightness of heart
K03 Cardiovascular pain NOS
K04 Palpitations/awareness of heart
K05 Irregular heartbeat other
K06 Prominent veins
K07 Swollen ankles/oedema
K22 Risk factor cardiovascular disease
K24 Fear of heart disease
K25 Fear of hypertension
K27 Fear cardiovascular disease other
K28 Limited function/disability (k)
K29 Cardiovascular sympt./complt. other
K70 Infection of circulatory system
K71 Rheumatic fever/heart disease
K72 Neoplasm cardiovascular
K73 Congenital anomaly cardiovascular
K74 Ischaemic heart disease w. angina
K75 Acute myocardial infarction
K76 Ischaemic heart disease w/o angina
K77 Heart failure
K78 Atrial fibrillation/flutter
K79 Paroxysmal tachycardia
K80 Cardiac arrhythmia NOS
K81 Heart/arterial murmur NOS
K83 Pulmonary heart disease
K84 Heart valve disease NOS
K85 Heart disease other
K86 Elevated blood pressure
K87 Hypertension uncomplicated
K88 Hypertension complicated
K89 Postural hypotension
K90 Transient cerebral ischaemia
K91 Stroke/cerebrovascular accident
K92 Cerebrovascular disease
K93 Atherosclerosis/PVD
K94 Pulmonary embolism
K95 Phlebitis/thrombophlebitis
K96 Varicose veins of leg
K97 Haemorrhoids
K99 Cardiovascular disease other

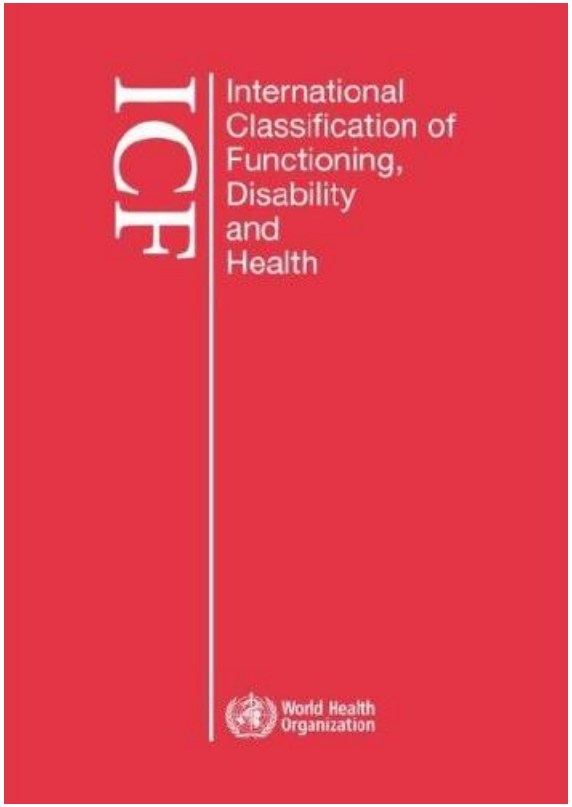
Musculoskeletal L

L01 Neck symptom/complain
L02 Back symptom/complaint
L03 Low back symptom/complaint
L04 Chest symptom/complaint
L05 Flank/axilla symptom/complaint
L07 Jaw symptom/complaint
L08 Shoulder symptom/complaint
L09 Arm symptom/complaint
L10 Elbow symptom/complaint
L11 Wrist symptom/complaint
L12 Hand/finger symptom/complaint
L13 Hip symptom/complaint
L14 Leg/thigh symptom/complaint
L15 Knee symptom/complaint
L16 Ankle symptom/complaint
L17 Foot/toe symptom/complaint
L18 Muscle pain
L19 Muscle symptom/complaint NOS
L20 Joint symptom/complaint NOS
L26 Fear of cancer musculoskeletal
L27 Fear musculoskeletal disease other
L28 Limited function/disability (l)
L29 Symptcomplt. Musculoskelesal other
L70 Infections musculoskeletal system
L71 Malignant neoplasm musculoskeletal
L72 Fracture: radius/ulna
L73 Fracture: tibia/fibula
L74 Fracture: hand/foot bone
L75 Fracture: femur
L76 Fracture: other
L77 Sprain/strain of ankle
L78 Sprain/strain of knee
L79 Sprain/strain of joint NOS
L80 Dislocation/subluxation
L81 Injury musculoskeletal NOS
L82 Congenital anomaly musculoskeletal
L83 Neck syndrome
L84 Back syndrome w/o radiating pain
L85 Acquired deformity of spine
L86 Back syndrome with radiating pain
L87 Bursitis/tendinitis/synovitis NOS
L88 Rheumatoid/seropositive arthritis
L89 Osteoarthrosis of hip
L90 Osteoarthrosis of knee
L91 Osteoarthrosis other
L92 Shoulder syndrome
L93 Tennis elbow
L94 Osteochondrosis
L95 Osteoporosis
L96 Acute internal damage knee
L97 Neoplasm benign/anatomic musculo.
L98 Acquired deformity of limb
L99 Musculoskeletal disease, other

Neurological N

N01 Headache
N03 Pain face
N04 Restless legs
N05 Tingling fingers/feet/toes
N06 Sensation disturbance other
N07 Convulsion/seizure
N08 Abnormal involuntary movements
N16 Disturbance of smell/taste
N17 Vertigo/dizziness
N18 Paralysis/weakness
N19 Speech disorder
N26 Fear cancer neurological system
N27 Fear neurological disease other
N28 Limited function/disability (n)
N29 Neurological symptcom/complt. other
N70 Poliomyelitis
N71 Meningitis/encephalitis
N72 Tetanus
N73 Neurological infection other
N74 Malignant neoplasm nervous system
N75 Benign neoplasm nervous system
N76 Neoplasm nervous system unspec.
N79 Concussion
N80 Head injury other
N81 Injury nervous system other
N85 Congenital anomaly neurological
N86 Multiple sclerosis
N87 Parkinsonism
N88 Epilepsy
N89 Migraine
N90 Cluster headache
N91 Facial paralysis/bell's palsy
N92 Trigeminal neuralgia
N93 Carpal tunnel syndrome
N94 Peripheral neuritis/neuropathy
N95 Tension headache
N99 Neurological disease, other

International Classification of Functioning



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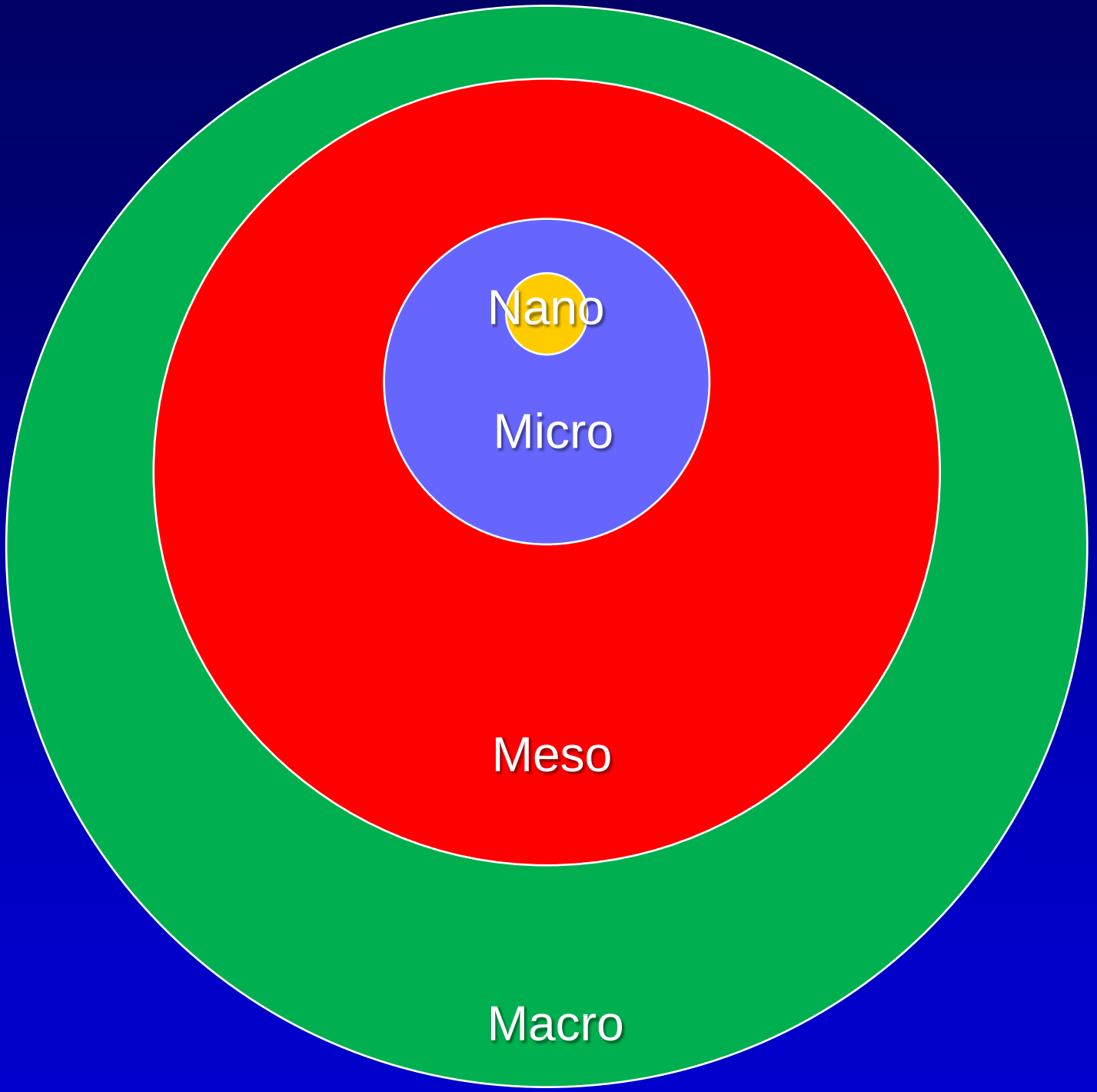
Nano
Micro
Meso
Macro

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WELCOME
to the
Community Health Centre Botermarkt

Hundelgemsesteenweg 145
9050 Ledeberg
www.wgcbotermarkt.be
Info@wgcbotermarkt.be
Tel 0032 9 232 32 33
Fax 0032 9 230 51 89

UNIVERSITEIT GENT
GHENT UNIVERSITY TEACHING PLATFORM

Wijkgezondheidscentrum
Botermarkt Ledeberg

UNIVERSITEIT
GENT

Botermarkt
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INTERDISCPLINARY TEAM

Family physicians

Nurses

Administrative staff and receptionist

Ancillary staff

Social workers

Dentists

Health promotion worker

Dietician

External health care workers: physiotherpists, psychologists,…

Community Health Center Botermarkt Ledeberg!

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Competency sharing

Care is provided by the person most equipped for the task and most knowledgeable about the subject. Disciplines share their competencies!

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Social Work

- 2 FTE social workers
- Social work in the health centre includes :
  - first intake, exploring the problem
  - information and counseling
  - advocating, mediating
  - supporting, psychosocial guidance
  - referral to specialised services
  - administrative support, application for allowances, budgetplanning
  - establishing patient centered networks of care

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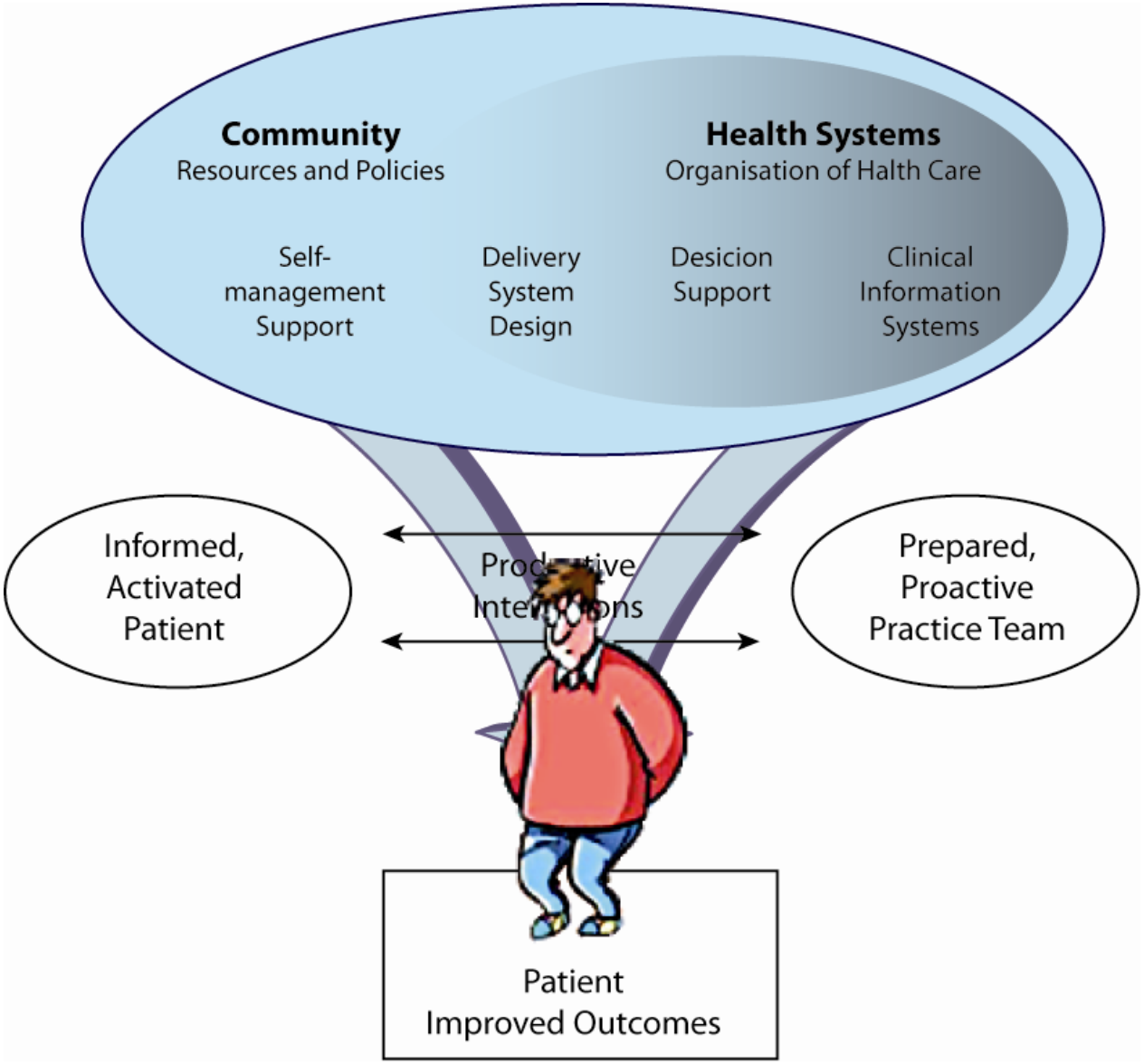
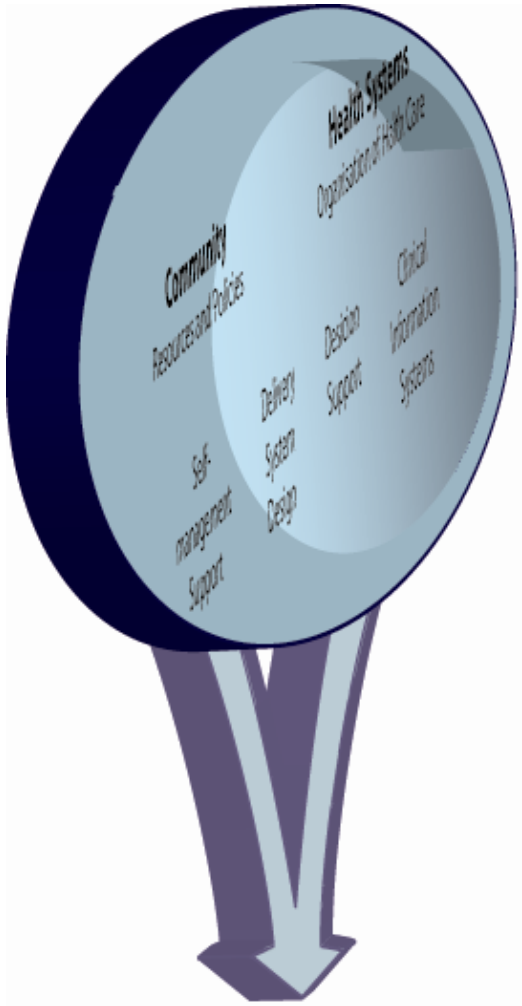
Integrated care

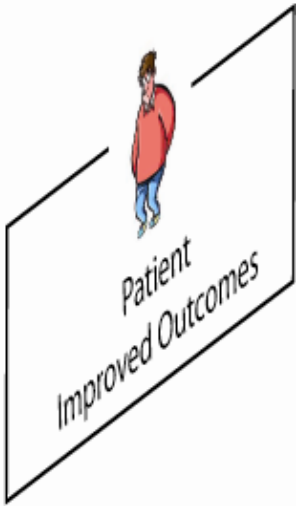
- Physical, mental, ecological and social well-being
- Taking environment/living conditions into account
- Citizen/patient in the driver's seat

Challenges in patients with multimorbidity


Community
Resources and Policies
Health Systems
Organisation of Halth Care
Self-management Support
Delivery System Design
Desicion Support
Clinical Information Systems
Informed, Activated Patient
Prepared, Proactive Practice Team
Patient Improved Outcomes

But…


Health Systems
Organisation of Patient Care
Community
Resources and Policies
Delivery System Design
Decision Support
Clinical Information Systems
Self-management Support


Patient
Improved Outcomes

Sum of the guidelines

Patient tasks

- Joint protection
- Energy conservation
- Self monitoring of blood glucose
- Exercise
  - Non weight-bearing if severe foot disease is present and weight bearing for osteoporosis
  - Aerobic exercise for 30 min on most days
  - Muscle strengthening
  - Range of motion
- Avoid environmental exposures that might exacerbate COPD
- Wear appropriate footwear
- Limit intake of alcohol
- Maintain normal body weight

R

- Physical th
- Ophtalmol
- Pulmonary

Time	Medications
7:00 AM	Ipratropium dose inhaler Alendronate 70 mg/wk
8:00 AM	Calcium 500 mg Vit D 200 IU Lisinopril 40mg Glyburide 10mg Aspirin 81mg Metformin 850 mg Naproxen 250 mg Omeprazol 20mg
1:00 PM	Ipratropium dose inhaler Calcium 500 mg Vit D 200 IU
7:00 PM	Ipratropium dose inhaler Metformin 850 mg Calcium 500 mg Vit D 200 IU Lovastatin 40 mg Naproxen 250 mg
11:00 PM	Ipratropium dose inhaler
As needed	Albuterol dose inhaler Paracetamol 1g

Clinical tasks

- Administer vaccine
  - Pneumonia
  - Influenza annually
- Check blood pressure at all clinical visits and
- sometimes at home
- Evaluate self monitoring of blood glucose
- Foot examination
- Laboratory tests
  - Microalbuminuria annually if not present
  - Creatinine and electrolytes at least 1-2 times a year
  - Cholesterol levels annually
  - Liver function biannually
  - HbA1C biannually to quarterly

Patient education

- Foot care
- Oesteoartritis
- COPD medication and delivery system training
- Diabetes

Boyd et al. JAMA, 2005

Special Article

Goal-Oriented Medical Care

James W. Mold, MD; Gregory H. Blake, MD; Lorne A. Becker, MD

ABSTRACT

The problem-oriented model upon which much of modern medical care is based has resulted in tremendous advancements in the diagnosis and treatment of many illnesses. Unfortunately, it is less well suited to the management of a number of modern health care problems, including chronic incurable illnesses, health promotion and disease prevention, and normal life events such as pregnancy, well-child care, and death and dying. It is not particularly conducive to an interdisciplinary team approach and tends to shift control of health away from the patient and toward the physician. Since when using this approach the enemies are disease and death, defeat is inevitable.

Proposed here is a goal-oriented approach that is well suited to a greater variety of health care issues, is more compatible with a team approach, and places a greater emphasis on physician-patient collaboration. Each individual is encouraged to achieve the highest possible level of health as defined by that individual. Characterized by a greater emphasis on individual strengths and resources, this approach represents a more positive approach to health care. The enemy, not disease or death but inhumanity, can almost always be averted.

(Fam Med 1991; 23:46-51)

1. There exists an ideal "health" state which each person should strive to achieve and maintain. Any significant deviation from this state represents a problem (disease, disorder, syndrome, etc.).
2. Each problem can be shown to have one or more potentially identifiable causes, the correction or removal of which will result in resolution of the problem and restoration of health.
3. Physicians, by virtue of their scientific understanding of the human organism and its afflictions, are generally the best judges of their patients' fit with or deviation from the healthy state and are in the best position to determine the causes and appropriate treatment of identified problems.
4. Patients are generally expected to concur with their physicians' assessments and comply with their advice.
5. A physician's success is measured primarily by the degree to which the patients' problems have been accurately and efficiently identified and labeled and appropriate medical techniques and technologies have been expertly applied in an effort to eradicate those problems.

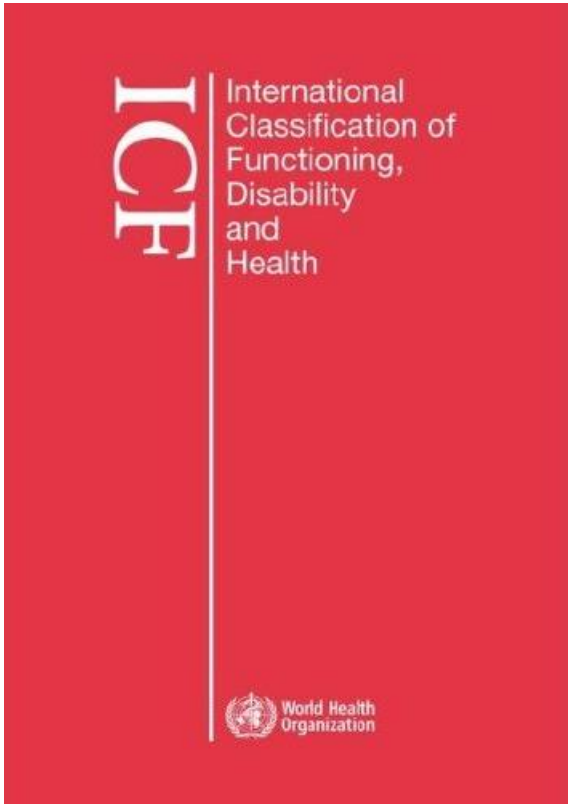
This conceptual model is ideally suited to the understanding and management of acute and curable illnesses. It has

“Problem-oriented versus goal-oriented care”

	Disease-oriented	Goal-oriented
Definition of Health	Absence of disease as defined by the health care system	Maximum desirable and achievable quality and/or quantity of life as defined by each individual

What really matters for patients is

- Functional status
- Social participation



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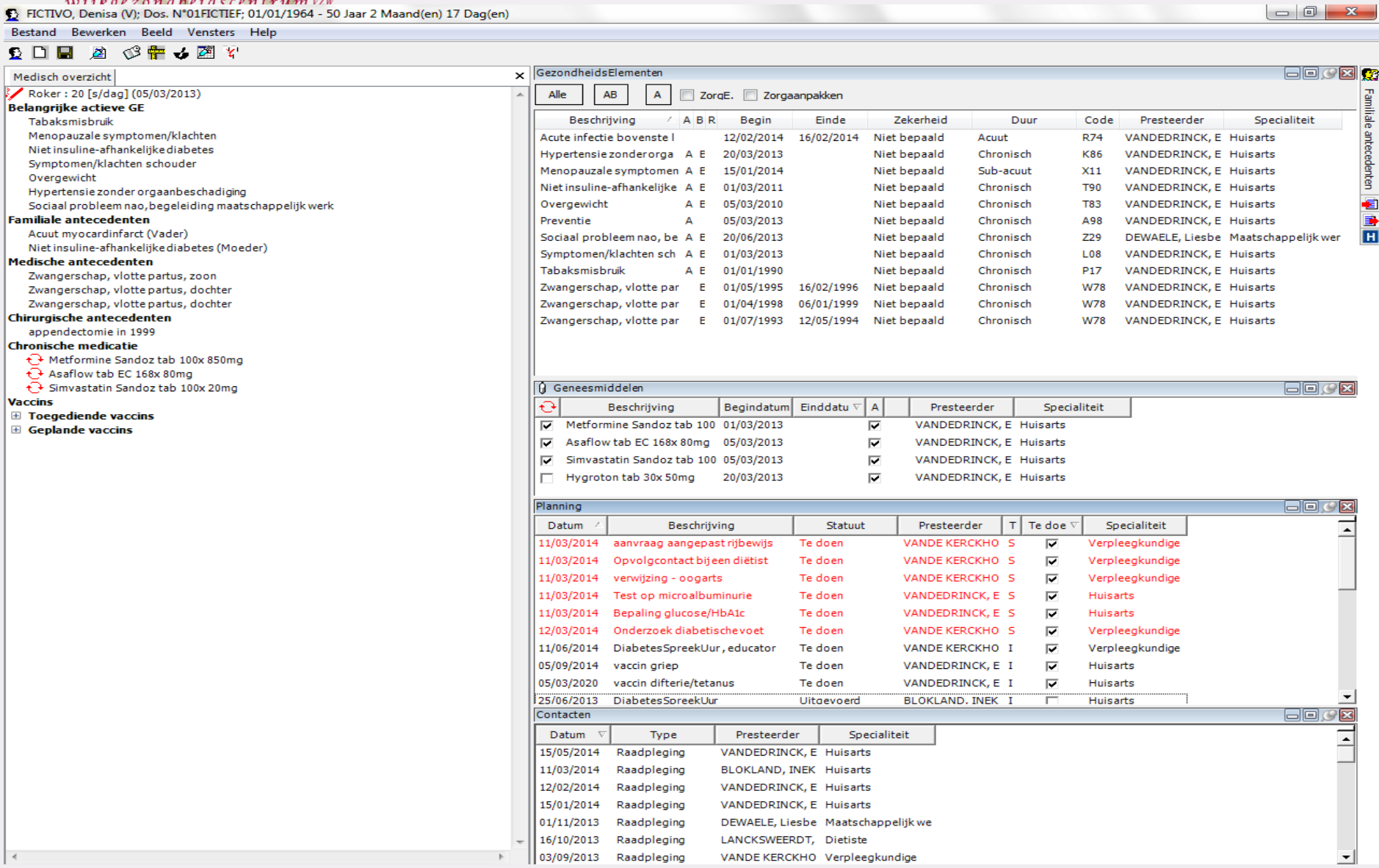
Shared Electronic Patient Record



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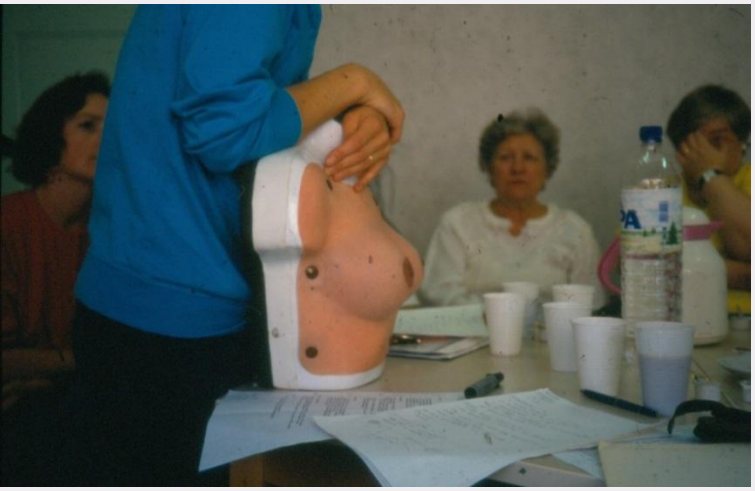
Illness prevention & Health promotion

- Individual illness prevention
- Group-based illness prevention
- Health promotion



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Diabetes Fair

- Presentation of 7 Self-care Activities, including cooking workshops & fitness classes

Involving informal care-givers!

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INTERDISCPLINARY TEAM

Family physicians

Nurses

Administrative staff and receptionist

Ancillary staff

Social workers

Dentists

Health promotion worker

Dietician

External health care workers: physiotherpists, psychologists,…

EDITORIAL

Time to Do the Right Thing: End Fee-for-Service for Primary Care

Michael K. Magill, MD

Department of Family and Preventive Medicine, University of Utah School of Medicine, Salt Lake City, Utah

Ann Fam Med 2016;14:400-401. doi: 10.1370/afm.1977.

You can always count on Americans to do the right thing - after they've tried everything else.

-Winston Churchill

Current fee-for-service (FFS) payment rates for physician visits trace to the origins of Blue Cross Blue Shield insurance in the 1930s. At that time, rates were set that paid generously for hospitalizations and for procedures, such as surgery.[1,2] Payments for so-called "cognitive services" were lower per minute of physician time. This disparity has been perpetuated since the 1980s in the calculation of rates set by the Centers for Medicare & Medicaid Services (CMS), based on "Relative Value Units," for payment of the Evaluation and Management codes most often billed by primary care physicians.[3] Despite recognition by the Medicare Payment Advisory Commission (MedPAC)[4] and others[5] of the adverse effects of inadequate payment for primary care, only limited progress has been made toward correction of the disparity. This may be due, at least in part, to treatment of total payment for physicians as a zero-

beginning in 1945[8] and expanded in the Health Maintenance Organizations (HMOs) of the 1980s and 1990s.[9] Following collapse of many of the HMOs, payers have experimented with multiple smaller changes in payment models, mostly incremental adjustments to existing FFS, perpetuating structural disadvantages for primary care.

In this issue of the *Annals*, Basu, et al report on their study in which they calculated potential effects on primary care practice costs and revenue resulting from 3 modifications of FFS payment: increased FFS, traditional FFS plus per-member per-month (PMPM), and traditional FFS plus PMPM plus pay-for-performance (P4P).[10] The authors drew on extensive published literature about how primary care practices can staff and organize to deliver patient-centered medical home (PCMH) services such as enhanced access, care management, and alternative visits, and the impact of these changes on revenue and expense within the practices. The authors created simulated models of these financial effects based on detailed profiles of patient demographics, insurance coverage, and disease burden. They conducted tens of

Belgium : Community Health Centres (3,5 % of population)

- Integrated capitation system
- Since 1982
- No cost sharing for the patient

Capitation

$$= \frac{\textit{spending in PHC in the fee–for–service system in the framework of the NIHDI}}{\textit{total number of citizens in Belgium}}$$

Stu
syst


KCE
Vergelijking van kost en kwaliteit van twee financieringssystemen voor de eerstelijnszorg in België
KCE reports 85A
Federaal Kenniscentrum voor de Gezondheidszorg
Centre fédéral d'expertise des soins de santé
2008

Study: comparison payment systems

2008: Federal Knowledge Center for Health Care

Fee-for-service ↔ Capitation

Strengths capitation system

- high degree of accessibility, especially for vulnerable groups
- no risk selection
- patients in the capitated system use:
  - less resources in the secondary care
  - less medications
- the quality of care was at least as good or better

State of the art

- In 2013 the system changed into a system
  - With its own budget
  - Needs-based distribution of resources between the community health centres

The “needs-variables”

- Demographic variables
- Social-economic variables
- Morbidity variables
- Contextual variables

- Age/sex (41 combinations)
- Widow
- Low income: < 15 000,00EUR
- Self-employed workers
- Deceased in that year
- Disability
- Urbanization index in the neighbourhood
- Medical supply index in the neighbourhood
- Handicap
- Help from public welfare centres
- Impaired functional status
- Cardiac diseases
- COPC
- Asthma
- Cystic Fibrosis
- Diabetes combined with chronic cardiac condition
- IDD
- NIDD
- Exocrine pancreatic diseases
- Psoriasis
- Rheumatoid arthritis, Crohn's disease, ulcero-hemorragic recto-colitis
- Psychosis: young adults
- Psychosis: elderly people
- Parkinson's disease
- Epilepsy
- HIV
- Chronic hepatitis B & C
- Multiple sclerosis
- Post-transplant immunosuppression
- Alzheimer
- Thyroid diseases
- Thrombosis
- Coagulation disorders
- Protected habitat

Implementation

- Based on an (electronic) “photograph” of the population on the list of the different CHC’s

  → photograph made annually

- Each CHC receives a specific “capitation” for the patients on the list

The integrated needs-based mixed capitation system:

- stimulates prevention, health promotion and self-reliance of the people,
- as there is a global payment for all disciplines, there is an incentive to task-shifting and subsidiarity,
- Prevents risk selection
- Stimulates a global approach to a broad range of problems, avoiding the fragmentation and disease-orientation

Federal Health Minister:“Budget cuts” in Community Health Centres?

- Budget cuts?
- Moratorium: no new CHCs?
- Audit
- ….?

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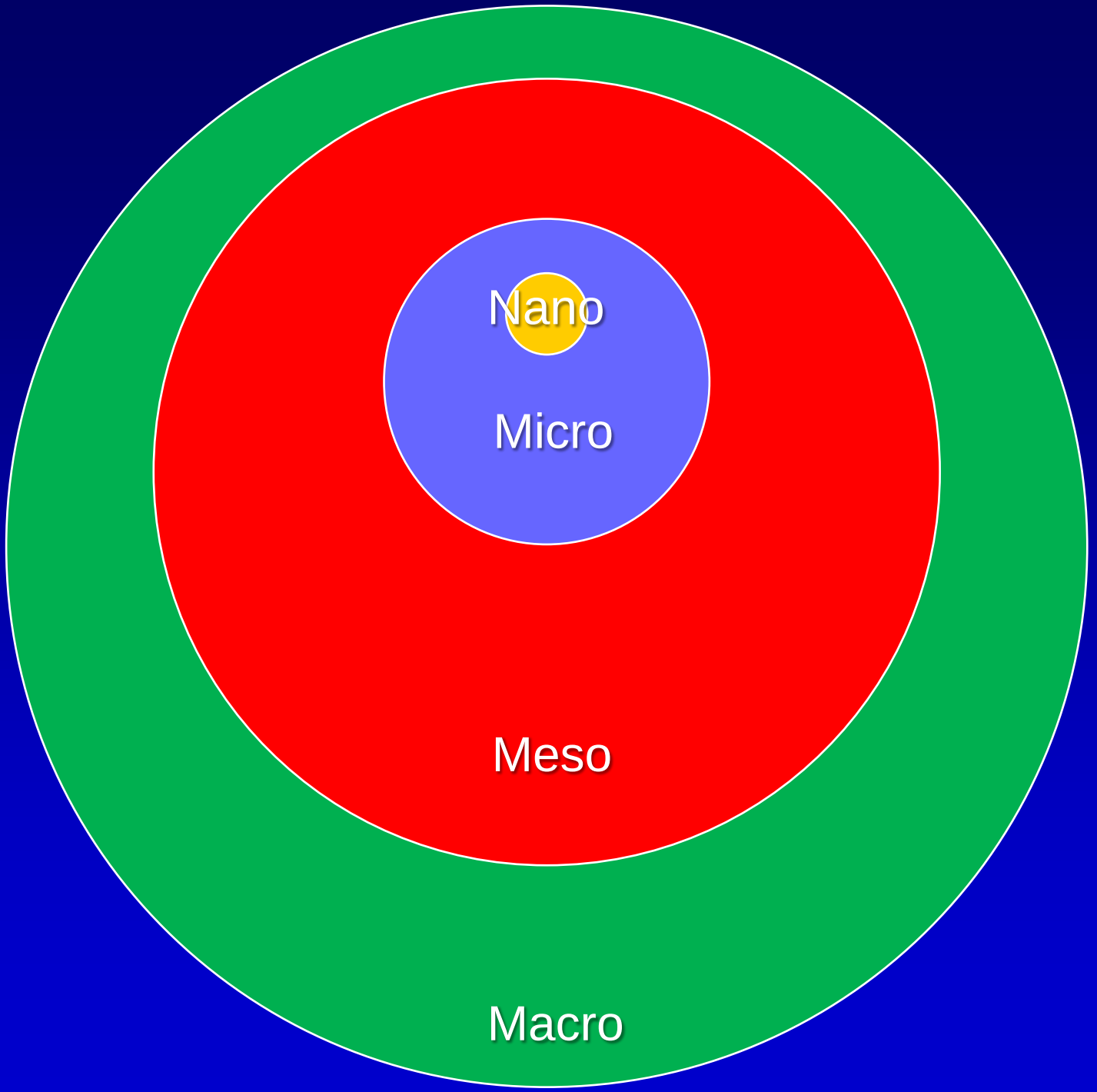
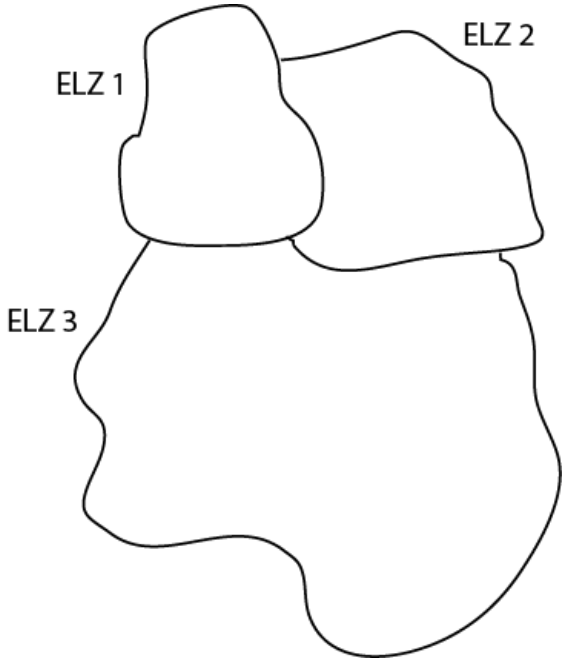

Nano
Micro
Meso
Macro

PRIMARY CARE ZONE: MESO-LEVEL: 75.000-125.000 INHABITANTS



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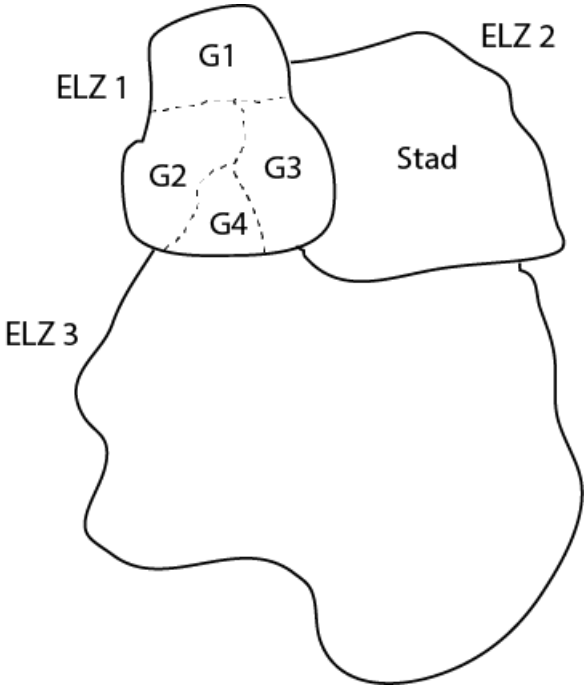
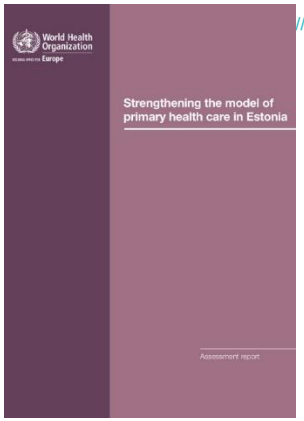


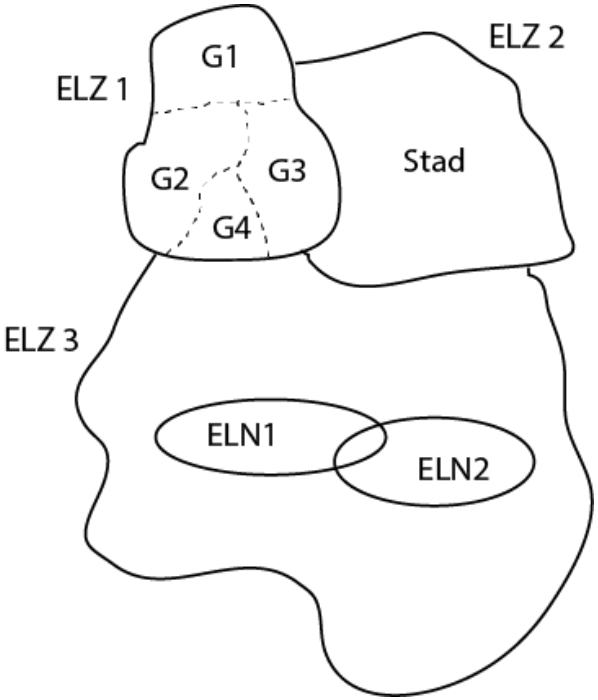
COUNCIL PRIMARY CARE ZONE: INTEGRATED IN LOCAL POLICY

PARTICIPATION OF ALL STAKEHOLDERS, INCLUDING CITIZENS

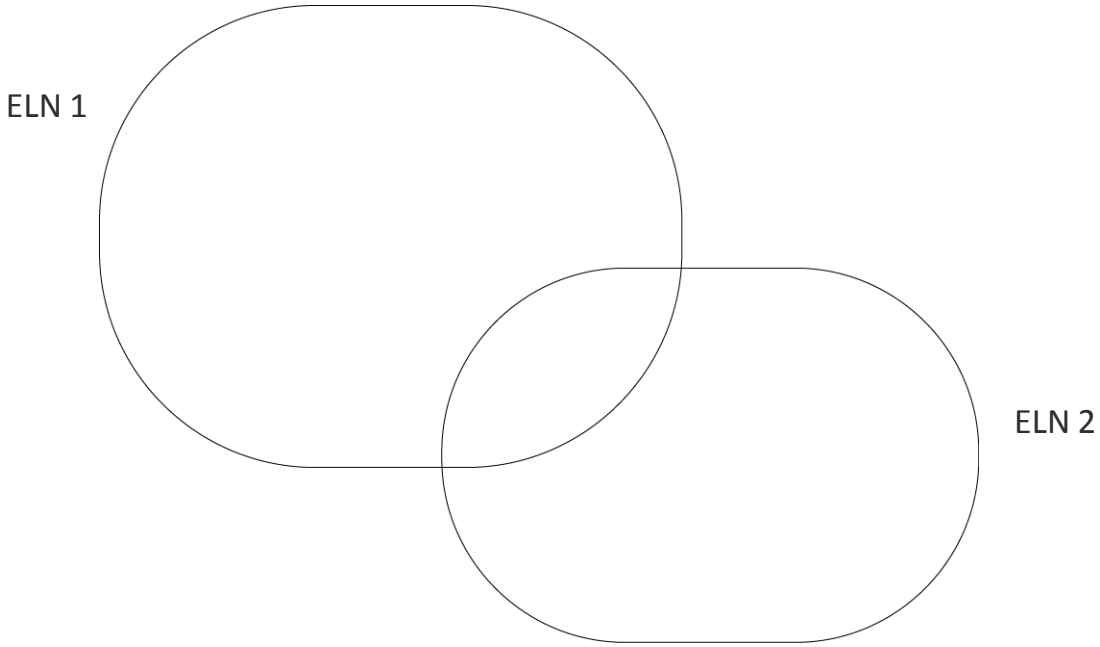


"Organizing primary care in decentralized entities, for example, primary care zones (PCZs), can contribute to the visibility of primary care. Defining the population that accesses a certain group of services and providers in primary care, can contribute to the accountability of providers in terms of outcomes, access and quality of care."

PRIMARY CARE ZONE: MESO-LEVEL: 75.000-125.000 INHABITANTS



PRIMARY CARE NETWORKS: > 5.000 INHABITANTS (RURAL AREAS) > 10.000 INHABITANTS (URBAN AREAS)



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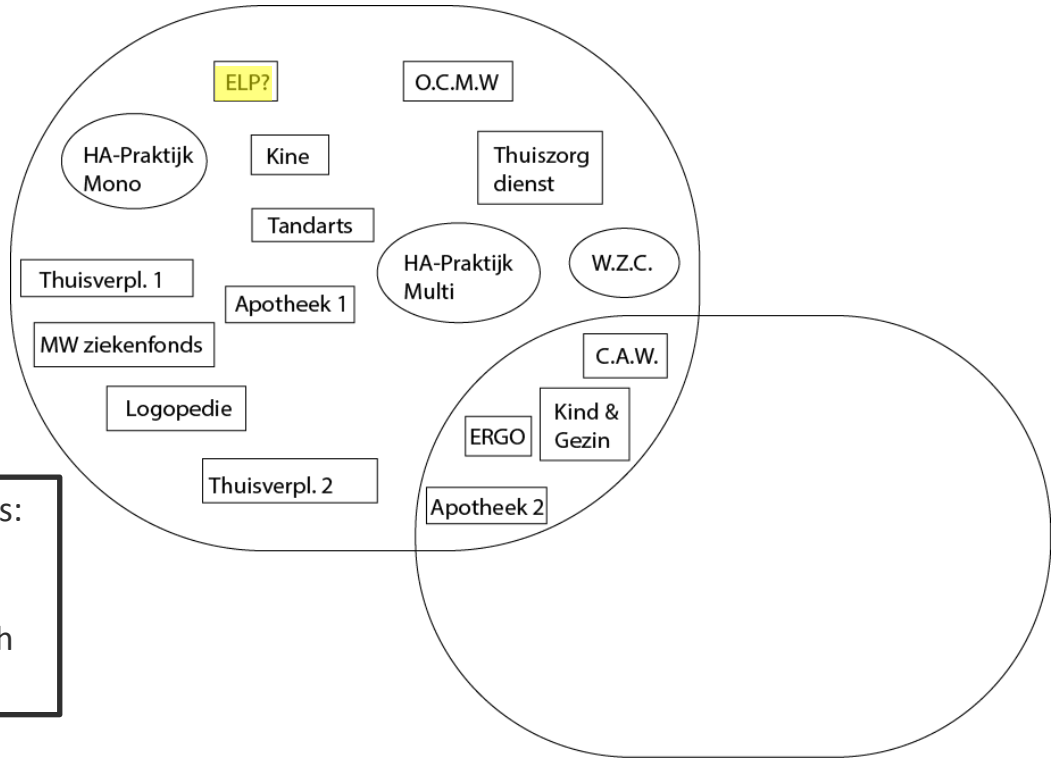

New professionals: Advanced nurse practitioners; community health workers;…

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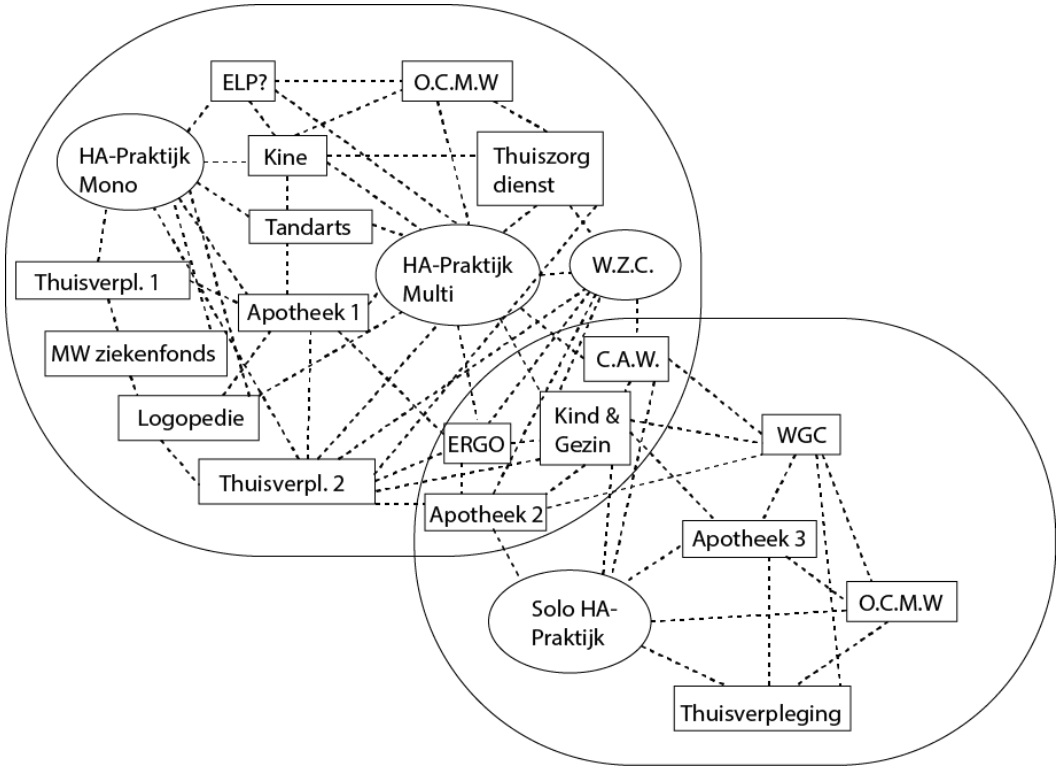
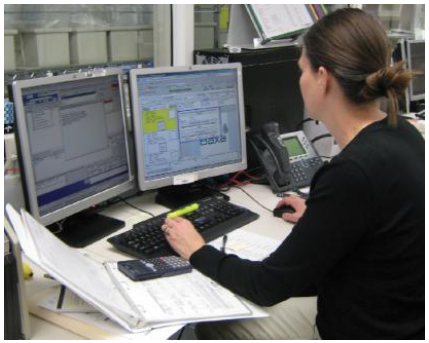


Role of the Community Pharmacist/Family Physician/Nurse….

“Pharmaceutical care”:

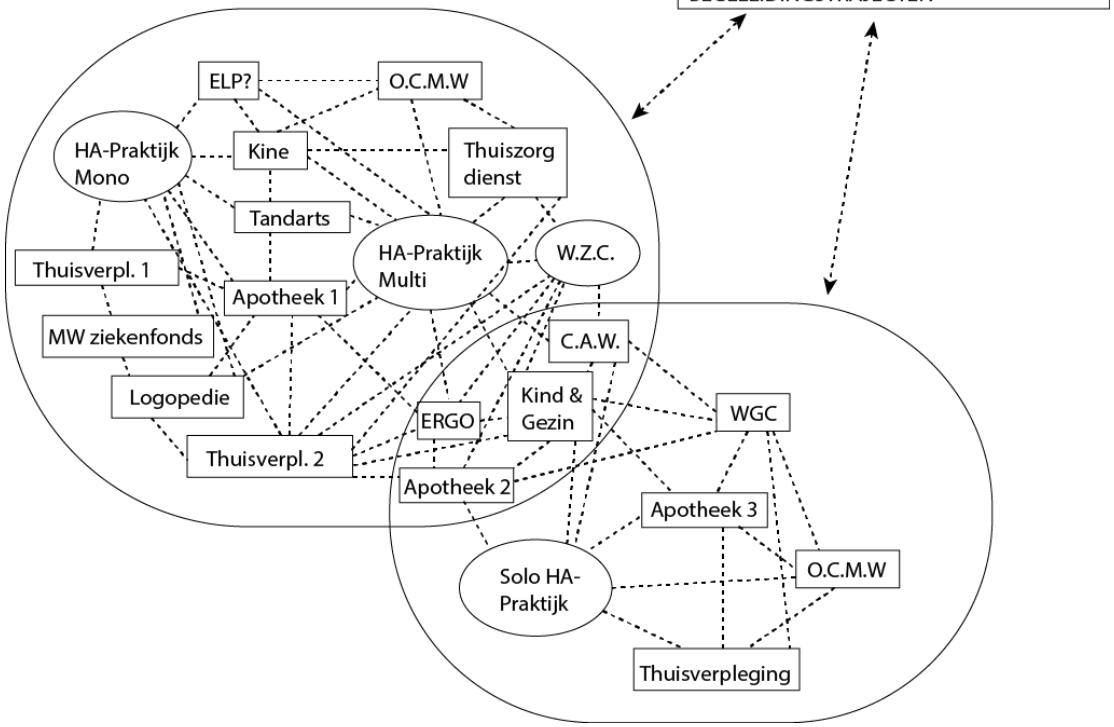


SURVEILLANCE

= Optimising therapeutical impact

- Indication appropriate?
- Contra-indications?
- Dose appropriate?
- Approprite frequency, time-schedule,…?
- Side-effects?
- Adequacy?
- Interactions?
- Adherence?

PRIMARY CARE NETWORK: > 5.000 INHABITANTS (RURAL AREAS) > 10.000 INHABITANTS (URBAN AREAS)



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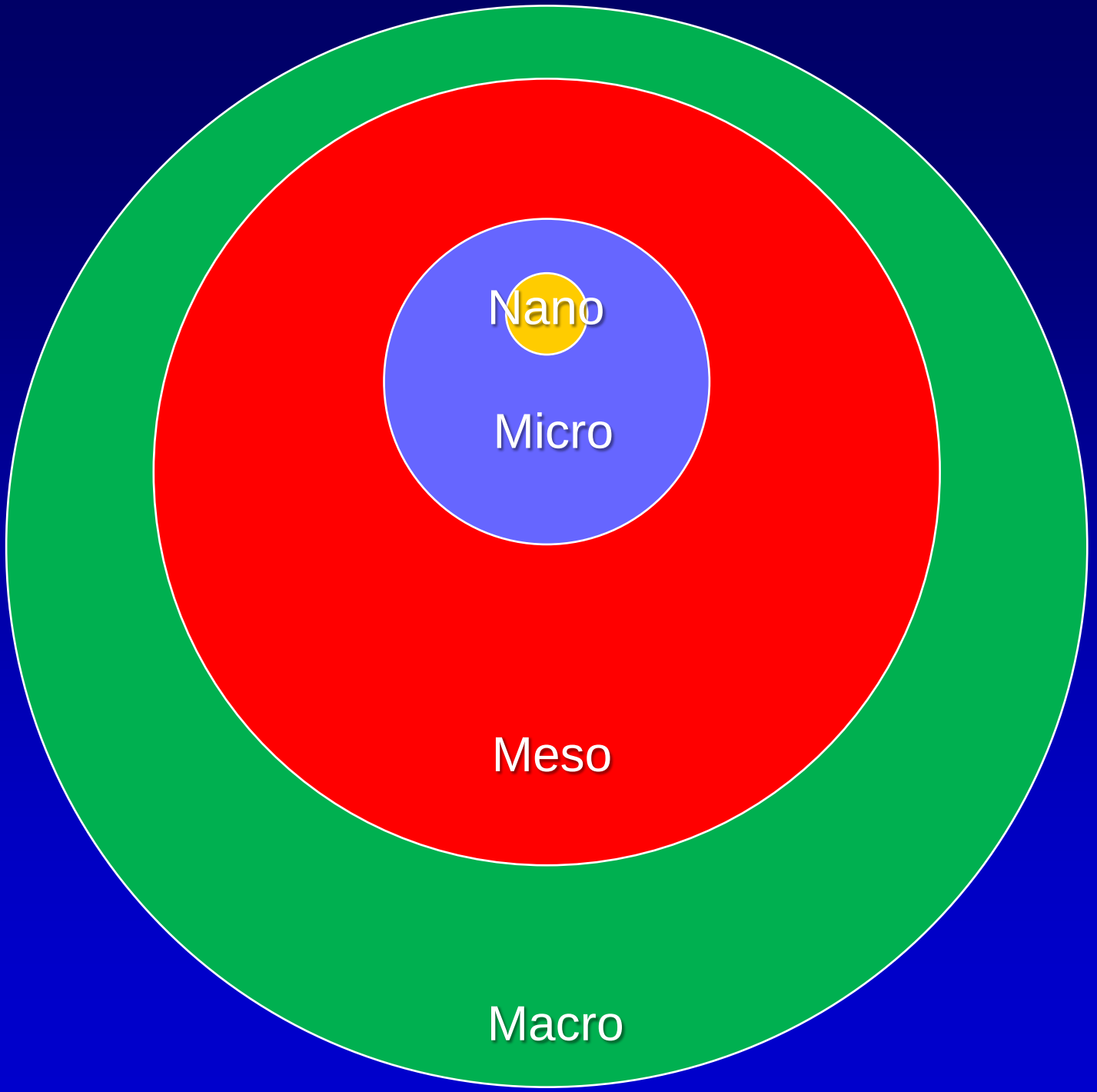
Nano
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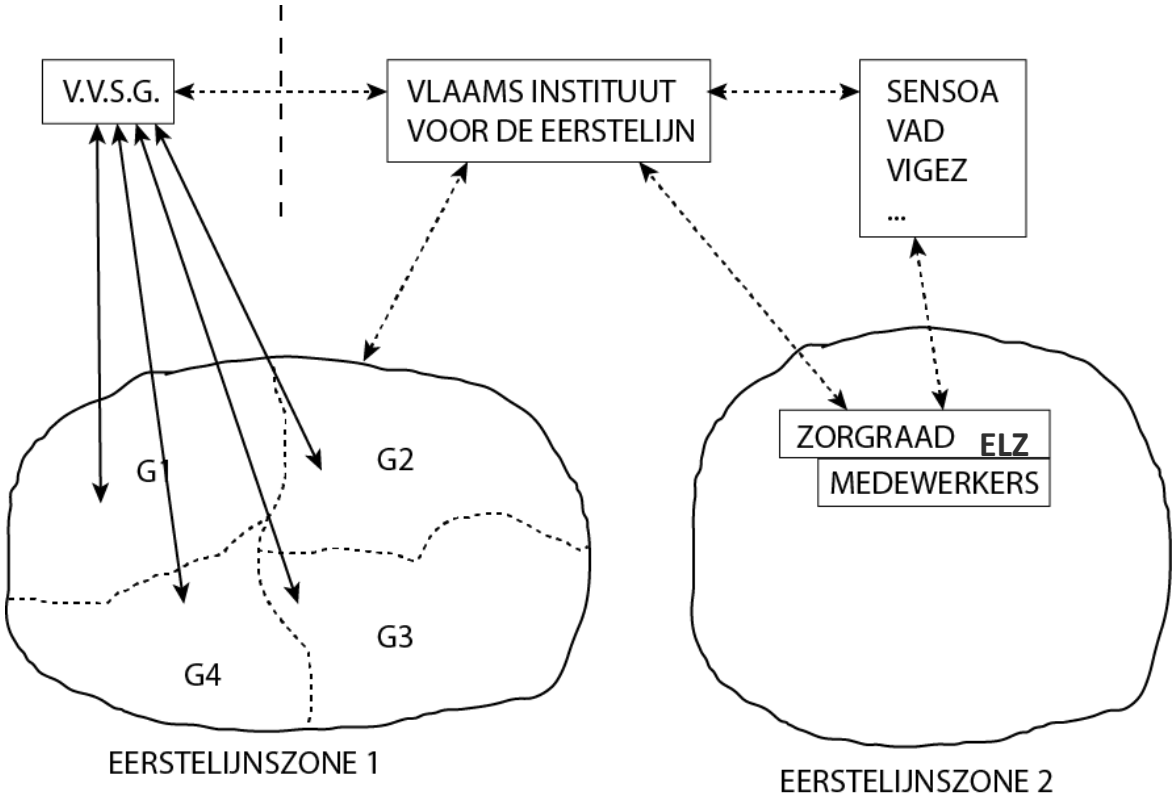
FLEMISH INSTITUTE FOR PRIMARY CARE: REGIONAL LEVEL



CHANGE…

From good care for individuals and families by committed and skilled professionals , towards integrated inter-professional accountability for a population:

“Everybody counts!”

“No one should be left behind!”

Vlaanderen
is zorg

Integration of personal and community health care

The promotion of primary health care since 1978[1] has had a profound political impact: it forced medical educators around the world to address the health needs of all people and it spurred the global recognition of family doctors as the primary medical providers of health care in the community. Yet, on the 30th anniversary of the Alma-Ata Declaration,[2] disillusionment with and failure to appreciate primary care's contribution to health persist. The missing link in the translation of the principles of Alma-Ata from idealism to practical, at the expense of population health. The challenge of this balancing act is illustrated in the interchanged use of the terms "primary care", which usually means care directed at individuals in the community, and "primary health care", which usually means a population-directed approach to health. To simplify this discussion and to reduce confusion, we will use the term "personal care" instead of "primary care" and "community-oriented primary care" (panel) instead of "primary health care".

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The Lancet 2008;372:871-2

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for primary care

Created in 2005

The main objectives

- To provide information to and share the information between the members
- Advocacy for Primary Care towards policymakers and politicians
- Membership network
- Membership is Multi-Professional (links with a large number of European professional associations)

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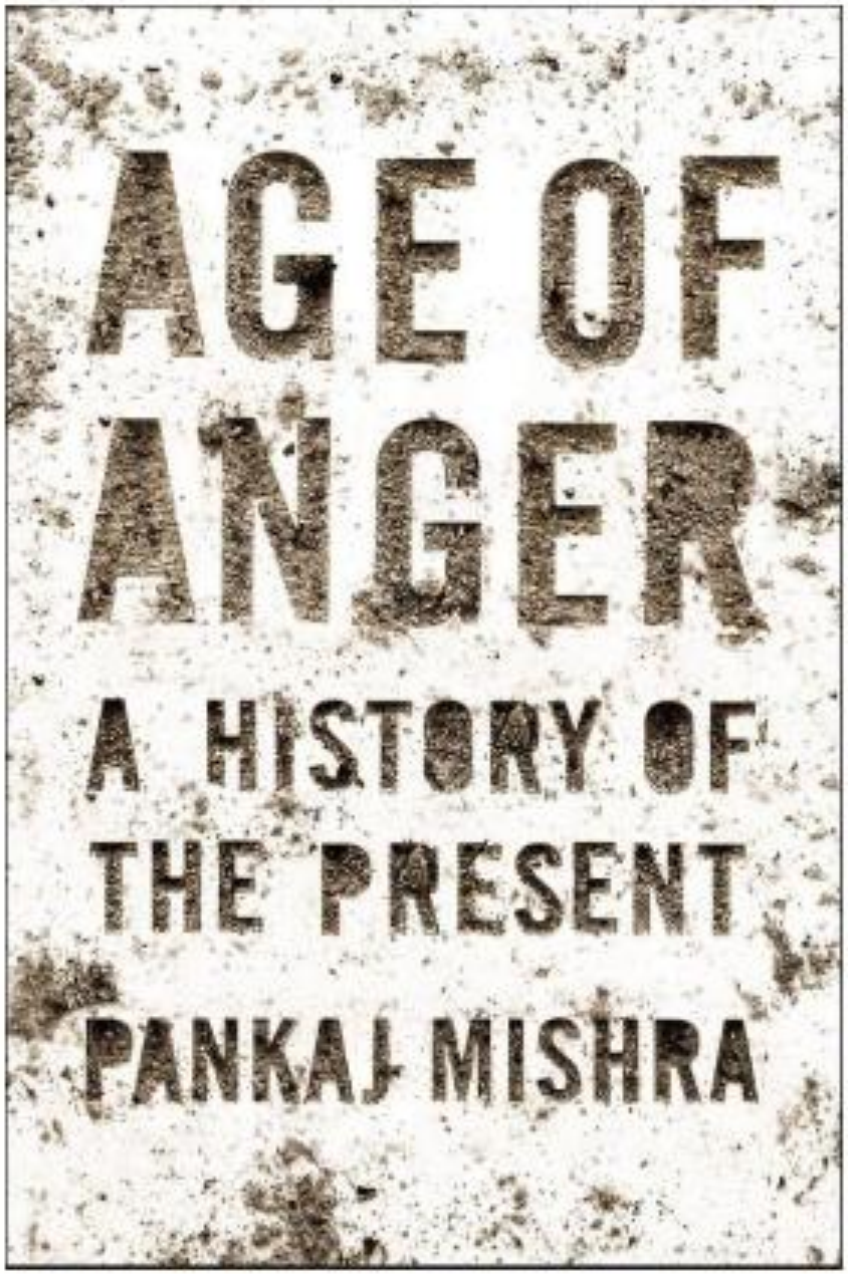
2. Primary care: the challenges
3. Nano-level
4. Micro-level
5. Meso-level
6. Macro-level
7. Primary Care and Social Cohesion
8. Conclusion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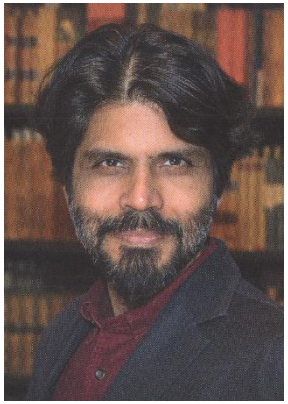

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Family Medicine and Primary Care

At the Crossroads of Societal Change

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HOW CAN FAMILY MEDICINE AND PRIMARY CARE MAKE A DIFFERENCE?

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- CONTINUITY
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- ADVOCACY
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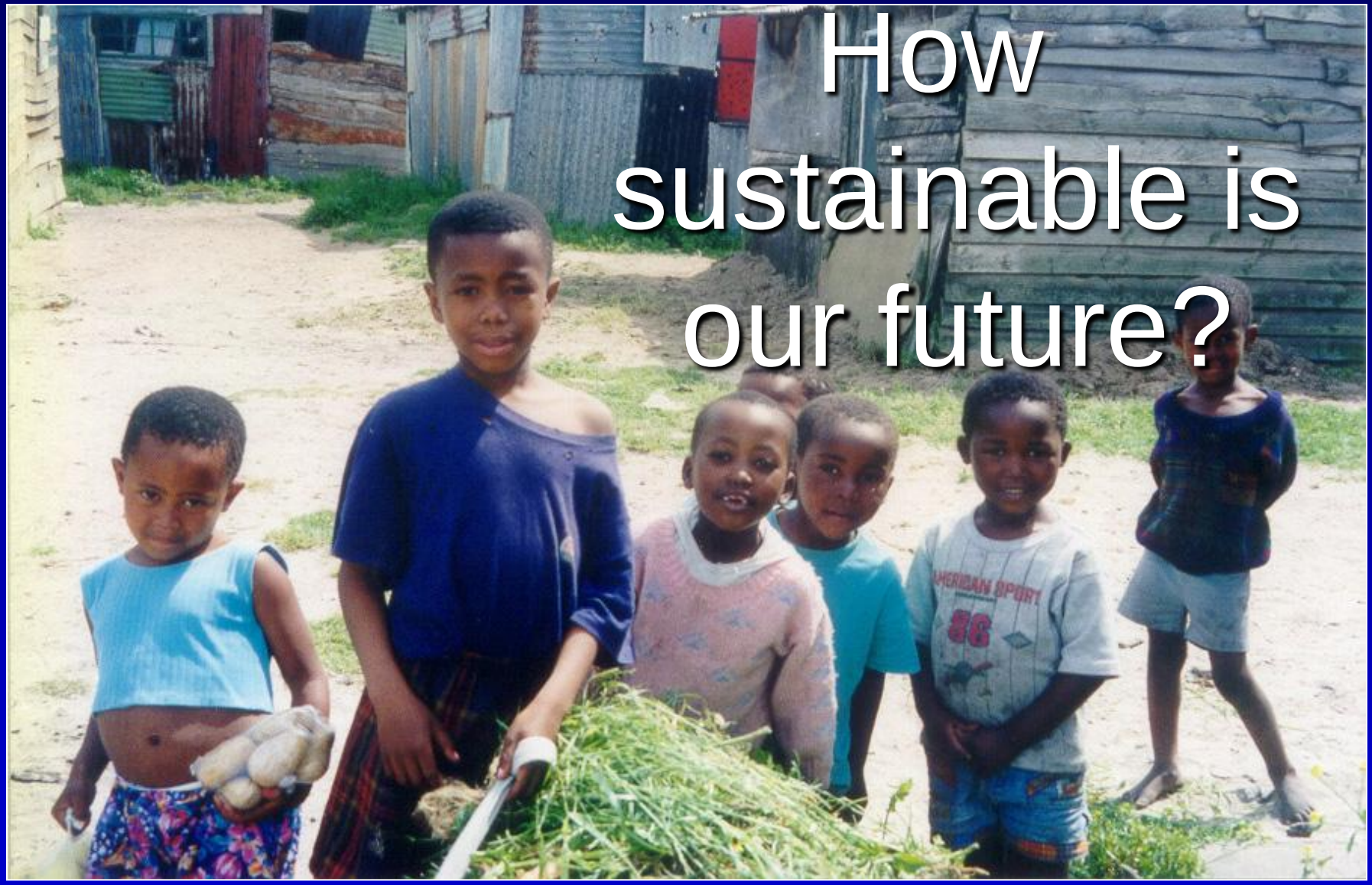

THE TIME FOR CHANGE IS NOW !

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Thank you…

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