

Table of Contents, 1 of 2

Each keynote, Oral Presentation and Workshop is *clickable* and will take you to its own page.



Conference Information and Greetings Information

The EQuIP President welcomes you!

Welcome from your Slovakian hosts!

Organizing and Scientific Committees

Conference Program 22 March

16:00 **EQuIP Council Meeting** at Hotel Sheraton, Bratislava

19:00 **Dinner** in the city

Conference Program 23 March, Part 1

08:30 – 09:00 **Opening ceremony**

09:00 – 09:45 **Keynote: Zalika Klemenc Ketiš** (Slovenia):
Family medicine education for quality and safe family medicine practice

09:45 – 10:30 **Keynote: Jaime Correia de Sousa** (Portugal):
Teaching Future Family Doctors: How Does Vocational Training Need to Adapt?

10:30 – 11:00 **Coffee and Tea**

11:00 – 12:15 **Oral Presentations (5x 15 min.)**

#1 **Kalanin** (Slovakia):

#2 **Stephanie Dowling** (Ireland):
Continuing education for general practitioners working in rural practice; a review of the literature

#3 **Esra Meltem Koç** (Turkey):
Turkey Clinical Quality Program: The Quality Perception of Healthcare Providers, Patients and Patients' Relatives

#4 **Tommaso Barnini** (Italy):
Pre-Diabetes Network Screening and Education Program in Primary Care

#5 **Eszter Pitás** (Hungary):
Patient safety risk assessment in primary care in Hungary

11:00 – 12:15 **Workshops (3x 75 min.)**

#1 **Andrée Rochfort & Isabelle Dupie** (EQuiP):
Designing the role of the GP within integrated healthcare services 2018 and beyond

#2 **Zlata & Zalika** (EQuiP) & **Claire Thomas** (VdGM):
Using Significant Event Analysis in Teaching Quality and Safety to Family Medicine Trainees

#3 **Hector Falcoff** (EQuiP):
Quality improvement at both practice and district level

12:15 – 13:00 **Plenary Discussion**

13:00 – 14:00 **Lunch**

Conference Program 23 March, Part 2

14:00 – 14:45 **Keynote: Ilkka Kunnamo** (Finland):
Health IT for empowering citizens and health professionals

14:45 – 15:30 **Keynote: Harris Lygidakis** (Greece):
Global to local: reverse innovation & rethinking the future of health care

15:30 – 16:00 **Coffee and Tea**

16:00 – 17:15 **Oral Presentations (5x 15 min.)**

#1 **Funtal Bendova** (Slovakia):
eHealth in Slovakia - a difficult birth

#2 **Tommaso Barnini** (Italy):
REACT cooperative project (Electronic Access Register in Out-of-hours)

#3 **Maria José Correia** (Portugal):
Quality improvement project: Optimizing telephone access in a primary care health unit in Portugal

#4 **Vildan Mevsim** (Turkey):
Development of Clinical Risk Assessment Tool of Osteoporosis (OSTEORISKAPP) Using Syndromic Approach

#5 **Montse Moharra** (Spain):
Shared Decision Making in Catalonia: A new step forward in improving decision making process

16:00 – 17:15 **Workshops (3x 75 min.)**

#1 **Jan van Lieshout** (EQuiP):
Doctor's perspective on person-centeredness in primary care

#2 **Harris Lygidakis**:
Social tools for project management and team collaboration

#3 **Stephanie Dowling**:
Safer prescribing by medication reduction in the patient who has everything

17:15 – 18:00 **Plenary Discussion**

19:00 – 23:00 **Gala Dinner**

Table of Contents, 2 of 2

Each keynote, Oral Presentation and Workshop is **clickable** and will take you to its own page.



Conference Program 24 March

09:00 – 09:45 **Keynote: John Brodersen** (Denmark):
Overdiagnosis

09:45 – 10:30 **Keynote: Adrian Rohrbasser** (Switzerland):
Navigating the Sea of Overtreatment: How to Practice Informed Decision-Making in the Face of Uncertainty?

10:30 – 11:00 **Coffee and Tea**

11:00 – 12:15 **Oral Presentations (5x 15 min.)**

#1 **Peter Lipták** (Slovakia):
Growth of overdiagnosis and overtreatment as indicators of worsening healthcare

#2 **Carlos Martins** (Portugal):
The effect of a test ordering software intervention on the prescription of unnecessary laboratory tests - a RCT

#3 **Esra Meltem Koç** (Turkey):
Evaluation of clinical practice guideline quality: Comparison of two appraisal tools

#4 **Luís Rosális Bastos** (Portugal):
Improving anti-pneumococcal vaccination rate in diabetic patients

#5 **Cari Almazán** (Spain):
How to reduce unnecessary care? Essencial Project in Catalonia

11:00 – 12:15 **Workshops (3x 75 min.)**

#1 **Eva Arvidsson & Adrian Rohrbasser** (EQuIP):
The joy of quality indicators in small groups

#2 **Maria Pilar Astier Peña**:
Medication without harm: Which are the main topics in primary care?

#3 **Claire Thomas & Stuart d'Arch** (VdGM):
Mental health in general practice

12:15 – 13:00 **Plenary Discussion**

13:00 – 14:00 **Lunch**

14:00 – 15:00 **Closing ceremony**

Information



General Information

Badge

The conference badge allows access to the congress site. Participants are requested to wear the badge during the congress.

Catering

Catering (coffee break and lunch) is included in the registration fee of the meeting.

Conference City

Bratislava is easy to access either by air, car, train or Danube River cruise.

In the past, Bratislava became a significant economic, cultural and political centre of Central Europe. In the 16th Century, Bratislava was the capital and coronation town of the Hungarian Kingdom. In spite of its exciting history, Bratislava has become a modern and popular metropolis which is proved by increasing number of foreign visitors every year.

They are attracted by the cosiness and charm of the rather small city that nevertheless possesses a throbbing social life combined with the most recent trends. Palaces, modern shopping and trade centres, admirable arts of the Slovak cooks and brewers, friendly people and various international cultural events, exhibitions, and business opportunities are the reasons why it is worth of visit.

www.visitbratislava.com

Conference language

English

Currency

The currency in Slovakia is Euro (€).

Important dates

Abstract Submission Deadline:	10 January 2018
Notification of accepting abstracts:	10 February 2018
Conference dates:	23-24 March 2018

Abstract Submission

Abstracts must be submitted online by using **the abstract form**.

Abstract must be submitted in English. After submitting the abstract, author will receive a confirmation email. In case you will not receive confirmation within 24 hours, please check your spam. If you have not received any confirmation at all, please contact us at **info@equip2018.sk**

All abstracts will be reviewed by the Scientific Committee. Authors will be notified by email the 10th of February 2018.

Registration

Please fill out **the online form to register** your participation.

Upon completion of your online registration, you will be sent a confirmation by email.

If you are an EQUIP National Delegate, please contact us directly: **oninfo@equip2018.sk**

The registration fee must be paid in EUR by using bank transfer.

All cancellations should be send by email to the organiser. If notification is received 23 February 2018, a full refund - the administrative charge of EUR 30 excluded - can be made. If notification is received after this date, there will be no refund.

Fees

1 full day	
EQUIP & SSVPL Member	€150
Non member	€200
Trainee	€95

2 full days	
EQUIP & SSVPL Member	€200
Non member	€300
Trainee	€150

Registration fee includes scientific program, conference materials and refreshments.

For group registration, please consult **info@equip2018.sk**

Venue

Sheraton Bratislava Hotel
Pribinova 12
811 09 Bratislava, Slovakia

The Sheraton Bratislava Hotel is situated in Eurovea - the City Center of Bratislava, just opposite to the New Slovak National Theatre and 10 minutes walk from the historical centre. The Hotel is located on the banks of the Danube River surrounded by green fields and relaxing zone.



Hotels

- **Conference Venue (Sheraton Bratislava Hotel)**

Other recommendations

- **Radisson BLU Carlton Hotel**
- **Hotel Devín**
- **Skaritz Hotel & Residence**
- **Park Inn by Radisson**

The EQuIP President welcomes you!



Dear Colleagues,

Dear interested Health Care Professional,

As EQuIP President I want to invite you to our Annual Open Meeting. These meetings have become a very interesting moment to find inspiration, to meet interesting people and to continue our work on Quality and Safety.

It is at the same time a moment to hear from international experts the latest news about Quality. To support local initiatives and make the link between national policy and international knowledge on how to assure and promote the Quality of the work of General Practitioners, Family doctors.

Teaching about Quality has been a priority for EQuIP since 2008. A working group has been engaged in European projects to promote continuous medical education about quality in different European countries. We published a framework for local implementation of Quality in the curriculum and are working together with EURACT (the European organisation of teachers in Family Medicine) to implement it in the next years.

Electronic prescribing has been the topic of an open meeting in Estland and we had different workshops on eHealth in Wonca Europe conferences and other congresses. One of the most interesting was a workshop about patient involvement in eHealth in Copenhagen in 2016. It is good to take time to look again into this continuously changing topic and see what is happening and how the future will reshape our work and could support the quality and safety of the health care system.

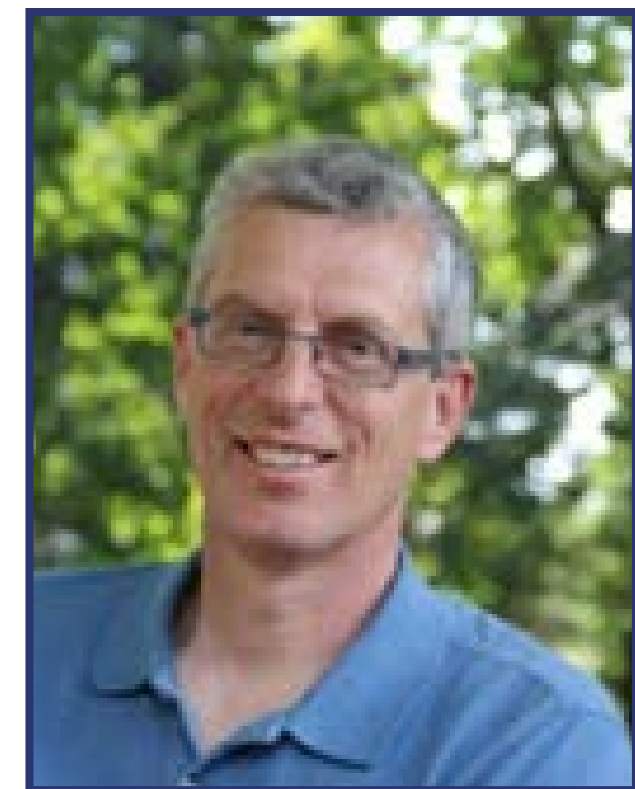
Patient safety has been the topic of the last two open EQuIP meetings and one of the main safety issues is about correct diagnosis. Not only the delay of wrong diagnosis but also and even more actual, overdiagnosis and overtreatment. We think GPs can play a major role in reducing overdiagnosis and protecting patients from harmful useless treatments.

These are the three topics chosen by our Slovak colleagues to be the subject of this conference. They have one thing in common. In all three domains GPs can make the difference and take the lead to realize safer care of high quality.

Come and tell us about your experience, come to listen to the stories of other colleagues, other countries. You will see how things are similar and different at the same time.

We really look forward to another inspiring meeting with you all.

Dr. Piet Vanden Bussche, GP
EQuIP President



Dr. Piet Vanden Bussche, GP

Welcome from your Slovakian hosts!



Dear Colleagues,

It is my pleasure to invite you to the 1st European Congress of General Practitioners that will take place here in Bratislava, Slovakia. We will welcome top experts from abroad who have long been focusing on the quality, safety, and efficiency of healthcare in all European countries.

We will have an opportunity to discuss the 3 main topics of the Congress we have chosen because of being the areas with the greatest potential for improvement in Slovakia. The first topic is education without which quality healthcare is unimaginable. The second topic is electronic healthcare (e-health) which is being prepared in Slovakia and will be launched 01/01/2018, and we believe it will bring us more benefits than problems in our everyday work. The last topic of the Congress will be an effort to demonstrate that each state with quality, efficient, and good healthcare stands on the functioning primary healthcare – that means us, general practitioners.

I am looking forward to your participation and a rich discussion about the topics mentioned that may contribute to improving the status of general practitioners in Slovakia and at the same time to improving healthcare for our patients.

Dr. Krnáč Štefan

Meeting President
Member of Council Slovak GP Society
Slovak national delegate in EQuIP, EFPC and EMA

Dear Colleagues,

As a president of SSVPL I am very glad and it is a great honour for me, for us and for Slovakia as well as pleasure to be able to organize the 53rd EQuIP Assembly Meeting, which will be held from 23 to 24 March in Bratislava, Slovakia.

It will be the first international congress of GPs for children and adults.

The program of the conference is composed of lectures to be presented by European experts and it will be enriched by a number of interesting workshops.

I would like to welcome you and thank all the lecturers who accepted and arrived from different corners of the world to share their experience and knowledge.

I would like to invite all participants, whether from abroad or from Slovakia. Do not miss this opportunity to become a member of this important event. The topics of the conference are burning and relate to each one of us. They are focused on the changes in healthcare that are taking place in our country, the issue of E-health and the competences of a general practitioner. Come to get information on how healthcare works in other EU countries.

I believe that besides the demanding program you will have the time to visit the historical centre of Bratislava and enjoy the unique atmosphere that our capital offers.

I welcome you and look forward to meeting you in March.

Best regards

MUDr. Peter Makara, MPH.

President of SSVPL



Dr. Krnáč Štefan



MUDr. Peter Makara, MPH.

Hosted by
Slovak Society of
General Practice



Organizing and Scientific Committees



Organizing Committee

Scientific Committee



Soňa Ostrovská

General practitioner,
Member of Committee
of Slovak Society of
General Practice,
Bratislava



Štefan Krnáč - Chair

General practitioner,
Slovakian EQuIP Delegate,
Slovakia



Mária Matusová

General practitioner,
Member of Committee
of Slovak Society of
General Practice,
Dunajská Streda



Eva Kačeriková



Štefan Krnáč - Chair

General practitioner,
Slovakian EQuIP Dele-
gate,
Slovakia



Mária Matusová

General practitioner,
Member of Committee
of Slovak Society of
General Practice,
Dunajská Streda



Piet Vanden Bussche

General practitioner,
President of EQuIP,
Berchem,
Belgium



Piet Vanden Bussche

General practitioner,
President of EQuIP,
Berchem,
Belgium



Peter Makara

General practitioner,
President of Slovak Society
of General Practice,
Slovakia



Ulrik Bak Kirk

The EQuIP Manager,
Denmark



Marcela Idbeková



Zalika Klemenc-Ketiš

Chair of the Department
of Family Medicine, Med-
ical Faculty, University of
Maribor, Slovenia EQuIP
delegate, WONCA Europe
EB member,
Slovenia



Ilkka Kunnamo

Developer of guidelines
and clinical decision
support,
Finland



Adrian Rohrbasser

General practitioner,
Switzerland EQuIP
delegate, Will,
Switzerland

Family medicine education for quality and safe family medicine practice

Assoc. Prof. Zalika Klemenc Ketiš, MD, PhD, GP (Slovenia):



Zalika Klemenc-Ketiš

Short bio

Chair of the Department of Family Medicine at Faculty of Medicine of University of Maribor, Slovenia (since 2015).

Family medicine specialist in Community Health Centre Ljubljana, Slovenia (since 2015).

Associated professor for family medicine (since 2016).

Chair of the Research group of the Department of Family Medicine at the Faculty of Medicine of the University of Ljubljana, Slovenia (since 2015).

Senior researcher at the Institute for the development and research in primary care at the Community Health Centre Ljubljana, Slovenia (since 2016).

Member of Scientific board for medicine at the Slovenian Research Agency (since 2015).

One of 10 members of the executive board of the European Society of Family Physicians (WONCA Europe) (since 2015). Member of the executive board of the Society for Quality and Safety in Family Medicine (EQUIP) (since 2014). This organisation stimulates the development of quality and safety in family medicine at the European level.

Member of the executive board of the Slovenian Family Medicine Society (since 2013).

Vice-president of the Professional body for family medicine of the Slovenian Physicians Society (since 2013) and member of the professional body for family medicine at the Ministry of Health (since 2016). Both bodies are involved in professional decisions at the national level and represent an advisory board.

Member of the steering committee of the project of renewing of family medicine practices in Slovenia (since 2015) run by the Ministry of Health. My field of responsibility is quality and safety assurance and improvement.

Research

From 2014 to 2017, she was the head of the Slovenian research group involved in the international research on the safety culture in out-of-hours healthcare clinics (SAFE-EUR-OOH), which was run in six European countries.

From 2015 to 2017, she participated in the international project CANCON, which involved 27 European countries. The project was aimed at developing guidelines for the quality treatment of patients with cancer at the primary level of health care.

Since 2014 she has been participating in the international PREPARE project financed by the European Commission under the FP7 program. The project is aimed at preparing European countries for the epidemics of infectious diseases.

Editorial board member of the scientific journal "Acta medico-biotechnica", which is an official scientific journal of the Faculty of Medicine, University of Maribor, Slovenia and covers the fields of medicine and bio-technique [COBISS.SI-ID 242526720].

Editorial board member of the scientific journal "Zdravstveno Varstvo" (since 2013) which is the only Slovenian journal from the fields of medicine, social sciences and humanities with an impact factor and indexed in Medline (od leta 2013) [COBISS.SI-ID 3287810].

Editorial board member of the international scientific journal "BMC Family Practice" with an impact factor of 1.7 [COBISS.SI-ID 2437652].

List of publications

<http://izumbib.izum.si/bibliografije/A20170809084419-32520.html>
<https://www.ncbi.nlm.nih.gov/pubmed/?term=klemenc-ketis>

Abstract

Family medicine has already been recognised as an independent speciality within the medical field and as such it needs appropriate education. The latter is one of the factors that ensure quality and safe family medicine practice. This involves all levels of education: undergraduate education, speciality training, and continuous professional development.

The EURACT educational agenda defines topics to be taught and teaching methods to be applied in order to provide a quality family medicine teaching. It is based on the European definition of family medicine/general practice which describes the core competencies each family medicine specialist should possess and practice when consulting with patients.

The European academic family medicine soon realised that a structured and continuous education of the family medicine teachers is necessary. Namely, a high quality of education in family medicine is maintained by professional teachers with adequate preparation in the training of future family physicians.

Recently, a system for the appraisal of teachers of family medicine/general practice has been developed by EURACT.

Read more

http://equip2018.sk/keynote_speakers.php

Teaching Future Family Doctors: *How Does Vocational Training Need to Adapt?*

Assoc. Prof. Jaime Correia de Sousa, MD, MSc, PhD, GP (Portugal):



Jaime Correia de Sousa

Short bio

Jaime Correia de Sousa is Associate Professor in the School of Medicine in the University of Minho, Portugal since 2004. Since 2008 he has been Head of the Scientific Area of Community Health.

He is the President of the International Primary Care Respiratory Group (2016-2018) and member of the Board since 2012.

He is also a practicing family physician in a group practice in Matosinhos, Porto, where he is a tutor of family medicine trainees.

He is a member of the Planning Committee of the Global Alliance against Respiratory Diseases (GARD – WHO) since July 2015.

For 25 years, from 1992 to 2016, he has participated annually as a Course Director and group coordinator in the Bled International Workshops organised by the Slovene Family Medicine Society and the Department of Family Practice, University Ljubljana & Maribor under EURACT patronage, which is aimed at training teachers in family medicine.

He has been a member of the National Committee for Good Clinical Practice at the Portuguese Health Ministry and Member of the Advisory Board of the Portuguese National Respiratory Diseases Program (PNDR) since 2013.

Abstract

The author will initially explore the shift in population health care needs in the world and consider new needs that will require family physicians to work in a different way. Working differently means that learning & teaching should be adapted in order to produce the required professionals to match patients' needs.

EURACT's Educational Agenda, the CanMeds Framework and EURACT's Performance Agenda of General Practice/Family Medicine will be very introduced as important and comprehensive references in medical education in general and family medicine.

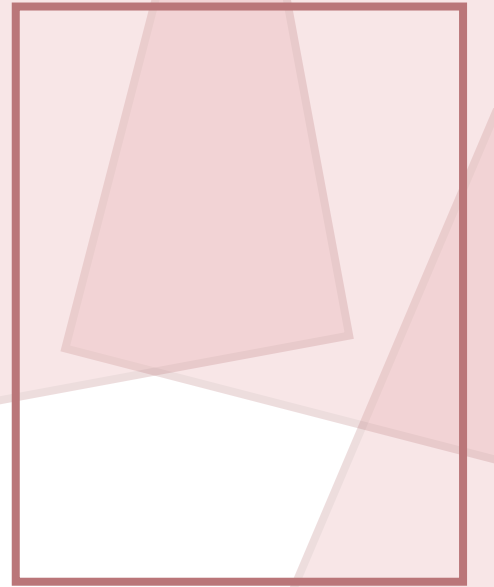
In the end of the session participants will be invited to reflect on the need for reviewing and eventually renewing EURACT's Educational Agenda.

Read more

http://equip2018.sk/keynote_speakers.php

Kalanin (Slovakia):

ORAL PRESENTATION



Kalanin

Continuing education for general practitioners working in rural practice; a review of the literature

Author: Stephanie Dowling (Ireland).

Co-Authors: Prof. Walter Cullen.



Stephanie Dowling



Background

Research evidence demonstrates that the CME/CPD (continuing medical education / continuing professional development) needs of rural physicians are unique, and professional isolation and access to CME/CPD are key factors affecting recruitment and retention. A limited number of studies have focused specifically on the effectiveness of CME/CPD programmes for rural practice.

Aims

To review the literature on CME/CPD for general practitioners (GPs) in rural areas, focussing on studies which have examined impact on doctor performance or patient outcomes.

Methods

A search of the peer-reviewed English language literature and a review of relevant grey literature (e.g. reports, conference proceedings) was conducted.

Results

We identified 19 articles that met the study inclusion criteria. The educational delivery approaches examined include regional CME/CPD small-group learning programmes, workshops and distance learning, and while the experience / satisfaction has been reported, few studies of high quality report that these approaches impact on patient care or physician performance. Distance learning programmes found it difficult to recruit doctors, two out of six studies report on self-improved knowledge or performance while no study reported measurable change in doctor performance or patient outcomes.

What your study adds to current knowledge Distance learning programmes did not have a measurable impact on doctor performance or patient outcomes among GPs who work in rural practice. More work needs to look at CME which is practical and ongoing for doctors who work rurally as these doctors have a unique set of challenges.

Turkey Clinical Quality Program; The Quality Perception of Healthcare Providers, Patients and Patients' Relatives



Author: Esra Meltem Koç, Ministry of Health (Turkey).

Co-Authors: Hakkı Gürsöz, Mahmood Adil, Abdullah Öztürk, Dilek Tarhan, Şuule Gündüz, İbrahim Halil Kayral, Elife Dilmaç, Hüseyin Özbay, Sema Zergeroğlu, Merve Akın, Bilgehan Karadayı, Kemal Tekin, Aydın Sarı, Mustafa Said Yıldız, Bora Avcı, Hilal Aksoy.

Aims

The concept of quality is used in many places today and it is desired to be realized. The aim of this study is to demonstrate how quality is perceived by patients, patients' relatives, healthcare providers and healthcare professionals in Turkey and to provide a national quality definition.

Material and Methods

The study was conducted between April 2012 and June 2012 by using survey method. The questionnaires were applied in 14 cities in Turkey. Two kinds of questionnaires were used; one for healthcare professionals and the other for patient and their relatives. Service procurement was done for the analysis of the questionnaire and the analysis report was formed.

Results

As a result of the study the clinical quality was defined as: "Providing correct diagnosis and treatment with evidence-based medicine applications, preventing mistakes, enhancement of care period, increasing patient and employee satisfaction and achieving best health outcomes". Elements of service quality were also revealed.

Conclusion

The national definition of clinical quality was made and it was used as the basis for further researches in this area.



Pre-Diabetes Network Screening and Education Program in Primary Care

Author: Tommaso Barnini, AUSL Toscana Centro (Italy).

Co-Authors: Jacopo Demurtas, Giovanni Calusi, and Alessandro Bonci.



Background

Obesity, sedentary lifestyle and Diabetes mellitus (DM) are among major health problems in developed countries. Diabetes alone affects 5.7% of the world's population.

Our project aims to screen a cohort of patients from 18 to 64 years of age for Prediabetes risk factors in order to implement a lifestyle changing program, focused on physical activity, patient empowerment and multi-disciplinary counseling through active participation.

Methods

Prediabetes cohort is created by screening for risk factors:

- familiarity for DM and BMI > 25,
- gestational diabetes,
- waist circumference > 102 (M) >88 (F),
- impaired fasting glucose (IFG) or impaired glucose tolerance (IGT) or unrecognized DM.

All subjects with at least one risk factor will be enlisted in a 2 years program in which:

- General Practitioner compiles the enlisting sheet and patient account
- Patients are provided with a booklet containing educational material in paper or electronic format
- Every 4 month subjects undergone medical checkups and are requested to self-compile a SF 12 test (booklet or online)
- Annually an extended medical checkup is performed together with an SF 36 test completed by the GP
- Patients are invited to join supervised physical activity and educational advice is given periodically online or by mail

Findings

Literature shows that lifestyle modifications could lower Diabetes incidence rates in risk subjects up to 60%. Key features to achieve these results are: frequent contacts with participants; behavioral education on self-management weight-loss strategies and physical activity; motivational campaigns, individualization of adherence strategies; tailoring of materials and strategies and an extensive network of training, feedback, and clinical support.

Conclusion

Electronic medical records nowadays could be useful to realize networks within Healthcare professionals, patients and both. Online self-management could improve patient's empowerment and adherence. Repeated brief interventions and counseling are also part of a committed initiative medicine program in Primary Care.

Patient safety risk assessment in primary care in Hungary

Author: Eszter Pitás, Semmelweis University Health Services Management Training Centre, Budapest (Hungary)

Co-Authors: Ágnes Anita Tóth, Judit Lám, Heléna Safadi, Éva Belicza



Eszter Pitás

Background

There had been no studies in the past about patient safety issues related to primary care (PC) in Hungary. Therefore it is not known which activities have significant patient safety risk in PC, and what general practitioners (GP) know about patient safety, whether they recognize errors and identify causes, or they have any skills to manage them.

Keywords: patient safety, primary care, risk assessment

Object

The aim of the study was to assess patient safety risks in Hungarian PC practices, as well as composing recommendations on managing the most important risks.

The study was funded by the Swiss-Hungarian Cooperation Program.

Methods

A questionnaire survey was conducted among family practitioners between 1st March and 30th April 2017.

The results from 209 filled out questionnaires were evaluated by statistically and synthesized with semistructured interviews of two focus group. The main results and recommendations were consulted with practitioners and representatives in a workshop.

Result

Our study showed that the main identified patient safety risks in PC are:

- (1) late diagnosis
- (2) communication gap between specialists and general practitioners
- (3) difficulty in following patient care pathways and treatments
- (4) medication errors
- (5) lack of professional guidelines
- (6) antiquated infrastructure
- (7) poor patient health literacy

Conclusion

Overall, there is poor knowledge of patient safety among GPs. The results from the questionnaire and the interviews are consistent regarding the risks and recommendations also, but wider research is necessary to formulate complex and feasible solutions.

Designing the role of the GP (general practitioner/family physician) within integrated healthcare services* 2018 and beyond



By Dr Andrée Rochfort (Ireland), Director of Quality Improvement & Doctors Health in Practice Programme & Dr Isabelle Dupie (France)

Health systems are facing multiple challenges including rising demands and rising healthcare costs and there is a need to reorganise services.

The role of the GP within primary healthcare must evolve in this environment to coordinate the increasingly complex needs of patients with longer lifespans, chronic conditions, multimorbidity, and escalating use of diagnostics, pharmaceuticals and therapies.

Patients health needs are also met by services outside the practice in primary and secondary care services. Navigating care for patients, especially those with complex needs requires appropriate coordination of services and appropriately trained and skilled professionals.

There is a need to define this emerging new role of the GP in terms of the efficient use of resources of all services while maintaining or improving the domains of quality of care (safe, timely, efficient, effective, equitable and person-centered care).

During the interactive section of this workshop delegates will discuss the role of GPs in various healthcare systems with 3 questions:

1. Which health services outside the practice are involved in the care of patients with different conditions**?
2. What are the risks associated with the interfaces between these services and the practice?
3. Participants will then consider and share examples: How could integrated care for GPs patients be improved?

***WHO definition of integrated health services:** Health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course.

**Conditions such as pregnancy, diabetes, mental health, hospital discharge in elderly, clinical emergencies.



Using Significant Event Analysis in teaching quality and safety to family medicine trainees

Author: Zlata Ozvacic Adzic (EQuIP, Croatia)

Co-Authors: Erika Zelko, Goranka Petricek, Zalika Klemenc-Ketis, Venija Cerovecki, Piet Vanden Bussche.



Zlata Ozvacic Adzic



Background

The Quality Improvement Competency Framework was developed in 2012 to help identify QI educational needs of individual GPs/FPs, but also to guide the development of postgraduate curricula for quality and safety in family medicine. The Framework consists of a list of 35 competencies organized into six domains:

- Patient Care & Safety
- Effectiveness & Efficiency
- Equity & Ethical Practice
- Methods & Tools
- Leadership & Management
- Continuing Professional Education

Each of the domains reflects an important care area in everyday family medicine (FM) practice.

Aim

The aim of this workshop is to evaluate the potential of Significant Event Analysis (SEA) as an educational tool in teaching how to deal effectively with critical incidents and medical error to family medicine trainees, one of the competencies in the Patient Care & Safety domain of the QI Competency Framework.

Methods

The workshop will consist of three parts. In the first part, the plenary presentation will be given to present the QI Competencies Framework and Significant Event Analysis protocol. The participants will then be divided into small groups with the task to use SEA on selected case scenarios. This will be followed by a plenary presentation and discussion.

Results

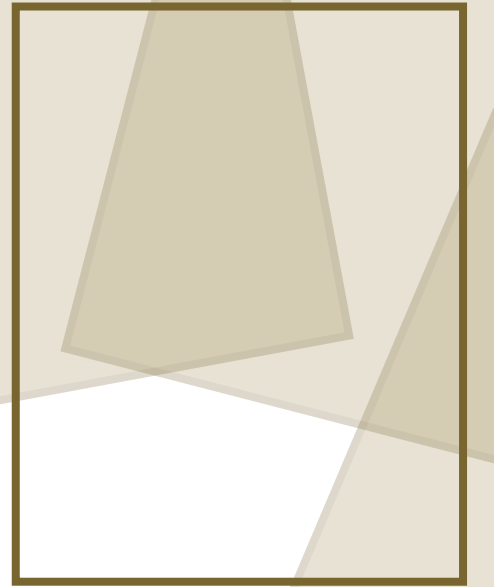
The expected results represent various experiences in using SEA method by the workshop participants and their opinion regarding SEA applicability in teaching family medicine trainees.

Conclusion

Adult learning techniques have been identified as key factors for success in delivering quality improvement and patient safety curricula, combining didactic and experiential learning. This workshop will present a platform for evaluation of a standardized QI and PS tool in terms of an educational tool in teaching quality and safety to family medicine trainees.

Quality improvement at both practice and district level

Hector Falcoff (EQuIP):



Hector Falcoff

Health IT for empowering citizens & health professionals

Ilkka Kunnamo (Finland):



Ilkka Kunnamo:

Short bio

text text text text

Abstract

text text text text

Read more

http://equip2018.sk/keynote_speakers.php

Global to local: Reverse innovation & rethinking the future of health care

Harris Lygidakis, MD, PhD student, GP (Greece):



Harris Lygidakis

Short bio

The choice of Family Medicine as my specialisation has not been a difficult one, since I have always been fascinated by the holistic approach and the patient communication in Primary Care.

My principal areas of interest comprise the non-communicable diseases, the patient quality of life, and the patient-reported outcomes, but I have also had the opportunity to study and work on lifestyle interventions and medical education.

Furthermore, I am interested in research and keen on being involved in various projects actively. For more than ten years, I have been participating in several international research projects, obtaining valuable experience as field investigator, research manager and coordinator.

Another significant part of my life involves technology. The eHealth, mobile health (mHealth), and social media revolution have been key sources of inspiration for my professional career, motivating me to explore the possibilities to improve health and healthcare through the implementation and integration of new technological tools. As such, the convergence of technology and primary care has become the main focus of my work.

I have taught in various educational sessions in primary care contexts (family medicine residency programs, continuing medical education courses), focusing on topics related to family medicine topics, clinical governance, evidence-based medicine, eHealth, ICT and social media. I have also worked in courses aiming at capacity building of the family medicine in the West Bank, and have employed methodologies from other industries and contexts, such as the Design Thinking for the needs of primary care.

For nearly 15 years, I have been participating in research, educational and advocacy working groups, and contributed to the preparation of 65 oral presentations, 21 workshops and 23 poster presentations in national and international primary care and ICT conferences (e.g. WONCA Europe, WONCA World, EGPRN, Stanford Medicine X, Medicine 2.0, Med-e-Tel, Health 2.0 etc.).

6/2016 – Present Research Unit INSIDE, University of Luxembourg
PhD Student, developing the research project: “Community- and MHealth-Based Integrated Management of Diabetes in Primary Healthcare in Rwanda” in collaboration with Aarhus University.

7/2015 – Present WONCA (World Organization of Family Doctors) Europe
Executive Board, Honorary Secretary

9/2014 – Present ISfTeH (International Society for Telemedicine and eHealth)
Social Media Working Group Leader

2007 – 2010 Diploma of Formal Qualification in General Practice / Family Medicine
Department of Health, Emilia-Romagna Region, Italy

2006 – 2007 Postgraduate Diploma (European Qualification Framework Level 7) in Alcohol-related Problems and Diseases
Faculty of Medicine, University of Florence, Italy

1998 – 2005 Integrated Bachelor’s and Master’s Degree in Medicine and Surgery, and Licence to Medical Practice
Faculty of Medicine, University of Bologna, Italy

Abstract

To attain universal health coverage, there is an urgent call to reinvent processes, advance knowledge, and tackle inequity and the high costs.

Despite the change-resistant health care culture, information technology can be the enabler of profound changes: The skyrocketing computational power, the early stages of the Internet of Things with the omnipresence of mobile devices and the ubiquitous networking, the gigantic datasets, and the new processing models and algorithms will drive transformation.

Innovation, however, requires investments in time, resources, new regulatory frameworks, task shifting and radically different approaches. The surge of technological solutions supporting the health care needs in low- and middle-income countries offer the potential to develop novel strategies in the global health landscape as well.

Identifying the common challenges in emerging and high-income countries, and accelerating the crossover, contextualization, and scaling-up of successful innovative solutions can be the answer to some of the most pressing health care challenges.

Read more

http://equip2018.sk/keynote_speakers.php

Funtal Bendova

eHealth in Slovakia - a difficult birth



Funtal Bendova

REACT cooperative project (Electronic Access Register in Out-of-hours)

Author: Tommaso Barnini, AUSL Toscana Centro (Italy).

Co-Authors: Giovanni Calusi, Alessandro Bonci, Cosimo Capodarca, Stefano Celotto, and Jacopo Demurtas.



Background

The Out-of-hours (OOH) setting provides primary care to a large part of the population in a certain area, often with poor resources, and often without communication between OOH care and in-hours care (General Practitioners, GP).

Aim

The primary aim of this registry is to analyze how different patients are managed by the service, and to evaluate what kind of symptoms/reason for encounter (RFE) represent first contact with the service.

Methods

Data will be obtained with an online multicentric survey involving 3 trusts. The items investigated will be:

- Municipality
- Day and time of access
- Age/Gender/Schooling
- Chronic diseases: (≥ 2 suggest multimorbidity)
- Home therapy: 0 to ≥ 5 (where ≥ 5 identifies polypharmacy)
- Symptoms at presentation/Reason for encounter divided in:
New/Acute illness vs. Chronic Symptoms
- Clinical Outcome: Treated/Hospitalized
- Pharmacological therapy/Prescription
- ILIs (influenza like illnesses)/ FLU vaccine status

Findings

Currently, the REACT project is ongoing, with 6 months registration and over 5000 access. Over two thirds of contacts approach the service for acute symptoms.

Top three RFEs for acute disease (reason for encounter) are: Fever, Cough, Sore throat. Referral rate to Emergency Department (ED) is under 7% of total access and only 3% of chronic illnesses flare up. Half of the population declares no chronic illness.

Conclusion

OOH service performs a significant work, avoiding inappropriate access to the EDs, the uprising request for acute care places many question about the effective organization of in-hour Primary Care towards acute illnesses.

Quality improvement project: Optimizing telephone access in a primary care health unit in Portugal



Author: Maria José Correia, USF Oriente - Lisboa (Portugal).

Co-Authors: Nicole Marques, Francisco Sampaio, Inês Calvinho, Juliana Caçoilo, Sara Pessoa, and João Toscano Alves.

Background

Accessibility is one of the dimensions of quality in health. The population and geographical location of the Unidade de Saúde Familiar Oriente (USFO) impose a greater use of the indirect forms of contact, specifically telephonic contact.

Objective

The purpose of this study was to improve the telephonic accessibility of the USFO.

Methods

We performed a non-randomized, pre-post intervention study, without control groups. The target population was composed by all the phone calls registered by the main number of the USFO, on working hours, between September and December of 2017. The intervention consisted in defining secretary schedules with dedicated hours to answering phone calls.

The data was obtained using Teltax 8® and the statistical analysis was performed with Software SPSS Statistic (v.23; IBM SPSS).

Results

We gathered pre intervention data in a total of 3022 phone calls in twenty-seven days' time of which 26.6% were answered.

After intervention we observed a total of 3997 phone calls in thirty-six days, of which 29,7% were answered.

The total number of answered calls was higher on post intervention period (n=1186, 29,7%), when compared to pre intervention (n=803, 26,6%), $\chi^2(1) = 8.146, p.$



Development of Clinical Risk Assessment Tool of Osteoporosis (OSTEORISKAPP) Using Syndromic Approach

Author: Vildan Mevsim, Dokuz Eylul University Faculty of Medicine Department of Family Medicine (Turkey)

Co-Authors: Oguz Yilmaz and Emel Kuruoglu.



Vildan Mevsim

Objective

The objective of this research is to develop a clinical risk assessment tool of osteoporosis (OSTEORISKAPP) by using syndromic approach.

Method

356 participants who are above 50 years old and applied to Radiology Laboratory of Dokuz Eylul University Faculty of Medicine are participants of study and take history and physical examination. Positive likelihood ratio, pre and post test probability, is calculated. A logistic regression analysis and a ROC analysis are made with the model constructed by these criteria.

Results

39,3% of participants is found to have osteoporosis disease 18 different clinical risk indices are diagnosed. According to likelihood ratios, 4 of these criteria are minimally effective criteria (age, first menstruation, menopause, height), 11 of them are weakly effective criteria (body pain, back, low back pain, bone fracture, cortisone use, op story in the family, mother/father's fracture with a slight trauma, mother/father suffered kyphosis, tibia shaft tenderness, BMI is 25 or below) and 3 of them are medium effective criteria (bone fracture after age of 50, vertebra spinous tenderness, dorsal kyphosis increase).

According to results of logistic regression analysis, back pain, waist pain, and usage of cortisone for more than 3 months, vertebra tenderness in physical examination, having dorsal kyphosis and being obese are turned out to be statistically significant AUC is found to be 0.948 and diagnostic test is found to have perfect distinction ability. For sensitivity, 0.386 can be used as an optimum threshold value.

Conclusions

Syndromic diagnostic criteria that will be used for screening of osteoporosis of population and that is cost effective, no need to refer, practical, reliable and has tried to be developed.

Shared Decision Making in Catalonia: a new step forward in improving decision making process

Author: Montse Moharra, AQuAS (Spain)

Co-Authors: Montse Mias, Cari Almazán, and Joan MV Pons.



Background and Aims

Over the past few decades there has been increasing interest in the concept of shared decision making.

In this context, the Catalan Patient Advisory Council was created and requested to lead a strategic plan aiming to promote patient-centered care which has been associated with improving self-management, patient satisfaction and responding to patients, families and patient associations' needs.

As part of this strategic plan, the shared decision project started by designing and developing specific patient decision aids (PDA) for shared decision making and encourage patients in discussing with their doctors reasonable treatment and decision options, including the choice to do nothing.

Method

A web based PDA was designed and elaborated with the participation of patients from the Catalan Patient Advisory Council and health care professionals representing different scientific societies.

The PDA aimed to provide patients with the best scientific evidence through the following content: Information of the health condition, appropriate options of management, pros and cons of each alternative, a test on patient's values and preferences, and frequently asked questions.

Results

Six patient decision aids are available at the moment on clinically localized prostate cancer, chronic kidney disease, abdominal aortic aneurysm, carpal tunnel syndrome and breast reconstruction after mastectomy.

All PDAs include stories of patients from the frontline, preference tests, patient resources such as video demonstration on dialysis with the final aim of helping the patient on the decision about treatment or therapeutic choice.

Conclusions

While the web based PDAs were reviewed by experts, some contents of PDAs can still remain subject of discussion since every doctor participating in the process for example the case of localized prostate cancer (nephrologist, radiotherapist or oncologist) can see the health condition from their own perspective, and all can have their own preference on presenting for instance treatment options.

However, good-shared decision making in this process should recognize the complementary areas among the experts and lead in this case to improve the quality of decisions. The shared decision project was designed to address the challenges to improving decision making process. The PDAs educate patients and emphasize the availability of multiple treatment options and the role of the patient in this process. In order to facilitate this process, it includes a test of preferences that prepares patients to discuss with their doctor their values, opinions and preferences.

All these PDAs will help to ensure that patients start being involved in the management decision making with their doctors and this might have an impact in the future in increasing patient empowerment, compliance and satisfaction and decreasing inappropriate treatments.

But there are still some challenges to cope with in the future such as the metrics needed to evaluate their impact at different levels as well as their main barriers and facilitators to overcome for its successful implementation in the decision making process. As a future action, some prioritized PDAs on primary care have been identified.

Doctor's perspective on person-centeredness in primary care

By Jan van Lieshout (EQuIP delegate from the Netherlands)



Aims and background

EQuIP has formed a new Working Group on Person-centered Primary Care.

Patient- or person-centeredness is, like generalism and continuity, a core value of primary care.

Person-centeredness has been described in various models and comprises various domains. An example of such a framework is Steward's model with 4 domains:

- Understanding the patient's experience of the illness
- Understanding the whole person
- Finding common ground
- Enhancing the patient-clinician relationship

In this workshop we will aim to elicit the participants' views on person-centeredness and the elements relevant.

Session content

1. Plenary (35 min.)

- Sharing experiences with person-centeredness in several countries (15min)
- Presentation: Introduction on person-centered care relating to frameworks and domains, tools for measurement and its relation with outcomes of care (15min)
- Introduction to small group work (5 min)

2. Discussion in small groups (40 min.)

- Exchange of ideas on relevant elements of person-centeredness with relative importance and ways to measure

3. Plenary

- Wrap up, summarize and take home messages (15 min)

Results

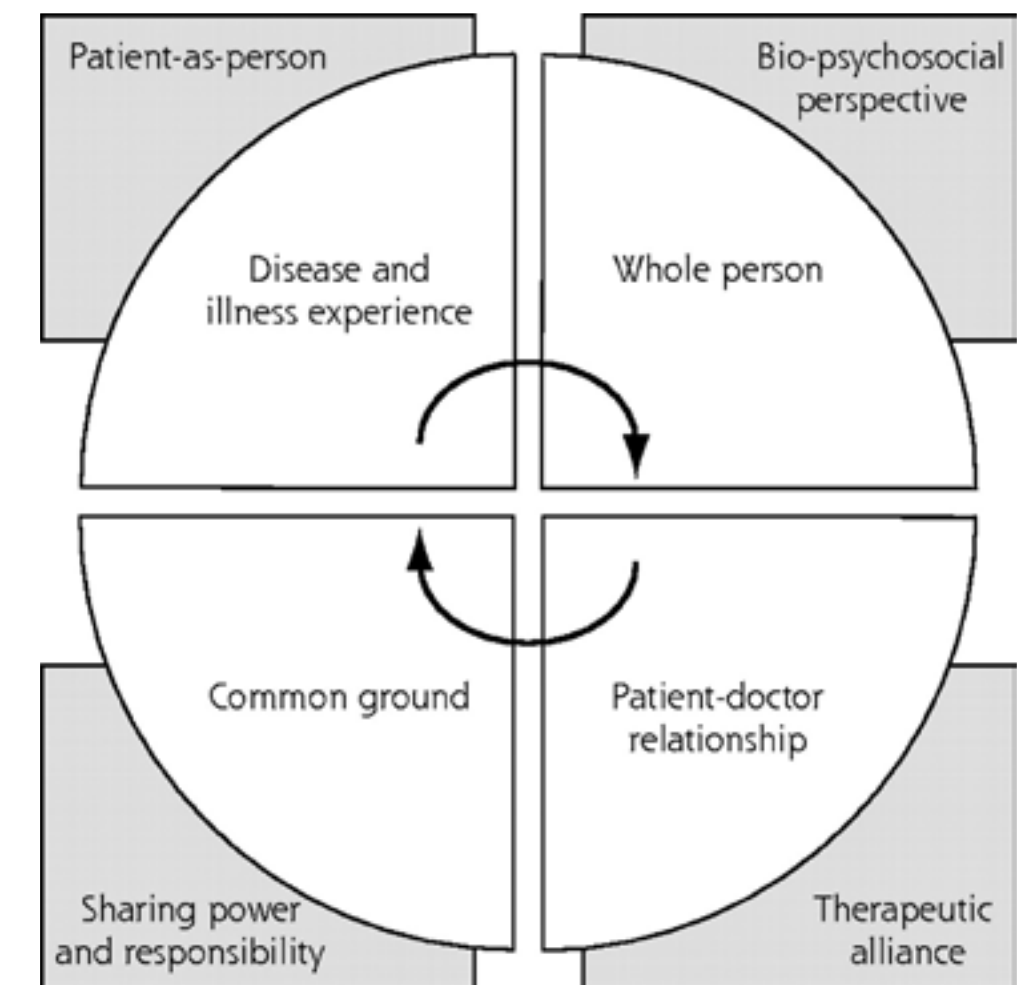
- Participants will be informed on person-centered care frameworks and domains
- Participants will discuss their views on person-centeredness and their experience with working according to the ideas of person-centered primary care.

The EQuIP Working Group will collect information from our participants on their ideas about the various elements of person-centered primary care, hoping for an audience from a variety of countries across Europe representing countries with different healthcare organizations.

Conclusion

Participants will extend their knowledge on person-centeredness and have an increased awareness of the various elements.

The EQuIP Working Group will bring forward their work taking account of the participants input.



- PCC model (Stewart et al)
- PCC model (Mead and Bower)

Social tools for project management and team collaboration

Harris Lygidakis



Harris Lygidakis

Short bio

The choice of Family Medicine as my specialisation has not been a difficult one, since I have always been fascinated by the holistic approach and the patient communication in Primary Care.

My principal areas of interest comprise the non-communicable diseases, the patient quality of life, and the patient-reported outcomes, but I have also had the opportunity to study and work on lifestyle interventions and medical education.

Furthermore, I am interested in research and keen on being involved in various projects actively. For more than ten years, I have been participating in several international research projects, obtaining valuable experience as field investigator, research manager and coordinator.

Another significant part of my life involves technology. The eHealth, mobile health (mHealth), and social media revolution have been key sources of inspiration for my professional career, motivating me to explore the possibilities to improve health and healthcare through the implementation and integration of new technological tools. As such, the convergence of technology and primary care has become the main focus of my work.

I have taught in various educational sessions in primary care contexts (family medicine residency programs, continuing medical education courses), focusing on topics related to family medicine topics, clinical governance, evidence-based medicine, eHealth, ICT and social media. I have also worked in courses aiming at capacity building of the family medicine in the West Bank, and have employed methodologies from other industries and contexts, such as the Design Thinking for the needs of primary care.

For nearly 15 years, I have been participating in research, educational and advocacy working groups, and contributed to the preparation of 65 oral presentations, 21 workshops and 23 poster presentations in national and international primary care and ICT conferences (e.g. WONCA Europe, WONCA World, EGPRN, Stanford Medicine X, Medicine 2.0, Med-e-Tel, Health 2.0 etc.).

6/2016 – Present *Research Unit INSIDE, University of Luxembourg*
PhD Student, developing the research project: “Community- and MHealth-Based Integrated Management of Diabetes in Primary Healthcare in Rwanda” in collaboration with Aarhus University.

7/2015 – Present *WONCA (World Organization of Family Doctors) Europe*
Executive Board, Honorary Secretary

9/2014 – Present *ISfTeH (International Society for Telemedicine and eHealth)*
Social Media Working Group Leader

2007 – 2010 *Diploma of Formal Qualification in General Practice / Family Medicine*
Department of Health, Emilia-Romagna Region, Italy

2006 – 2007 *Postgraduate Diploma (European Qualification Framework Level 7) in Alcohol-related Problems and Diseases*
Faculty of Medicine, University of Florence, Italy

1998 – 2005 *Integrated Bachelor’s and Master’s Degree in Medicine and Surgery, and Licence to Medical Practice*
Faculty of Medicine, University of Bologna, Italy

Abstract

To attain universal health coverage, there is an urgent call to reinvent processes, advance knowledge, and tackle inequity and the high costs.

Despite the change-resistant health care culture, information technology can be the enabler of profound changes: The skyrocketing computational power, the early stages of the Internet of Things with the omnipresence of mobile devices and the ubiquitous networking, the gigantic datasets, and the new processing models and algorithms will drive transformation.

Innovation, however, requires investments in time, resources, new regulatory frameworks, task shifting and radically different approaches. The surge of technological solutions supporting the health care needs in low- and middle-income countries offer the potential to develop novel strategies in the global health landscape as well.

Identifying the common challenges in emerging and high-income countries, and accelerating the crossover, contextualization, and scaling-up of successful innovative solutions can be the answer to some of the most pressing health care challenges.

Read more

http://equip2018.sk/keynote_speakers.php

Safer prescribing by medication reduction in the patient who has everything

Author: Stephanie Dowling (Ireland)

Co-Authors: Prof. W Cullen, Prof. Last, and Henry Finnegan.



Stephanie Dowling



Aims

To discuss safer prescribing in the elderly patient with multi-morbidity and polypharmacy.

We will also review guidelines and practical ways to help us de-prescribe in this group of patients.

Objectives

- To review the current evidence in this area and why we need to review medications in the older patient with polypharmacy and multi-morbidity.
- To review cases in general practice to highlight key learning points.
- To discuss the practical use of evidence based tools for reviewing medications in the elderly in general practice (GP).
- To discuss the problems changing prescribing in the elderly and how to overcome these in GP.
- To discuss the follow up of patients required after a medication review has occurred.

Methods

- Initial exploration of the problems for GPs in prescribing in this area.
- Case discussion.
- Resource material will be handed out for GPs to read in advance of the meeting.
- Case discussion follows and the expert resources (i.e. GPs who have read articles) will come in with any gaps in knowledge in the group.

Outcome

At the end of the session we will all be more aware of key adverse drug interactions in the care of the elderly. We will see if the use of evidence based guidelines of reviewing medication (STOPP START) is practical in general practice and what time this would require to carry out among our patients. We will discuss de-prescribing of 3 important drugs in this group of patients.

Overdiagnosis

Professor John Brodersen, MD, PhD, GP (Denmark):

KEYNOTE



John Brodersen

Short bio

John Brodersen is general practitioner with over ten years' experience in clinical practice. Dr Brodersen has a PhD in public health and psychometrics and works as a professor in the area of prevention, medical screening, evidence-based medicine and multi-morbidity at the Centre of Research and Education in General Practice, Department of Public Health, University of Copenhagen & at the Primary Health Care Research Unit, Region Zealand.

His research is focused on the balance between benefits and harms of medical prevention with a special interest in the field of development and validation of questionnaires to measure psychosocial consequences of medical screening and to measure the consequences and degree of overdiagnosis. He has employed qualitative and quantitative methods e.g. developed patient reported outcomes measures qualitatively and validated those using Item Response Theory Rasch models to objectify subjective areas like psychosocial consequences. Dr Brodersen has published widely in peer reviewed journals.

In relation to the diagnostic process in general practice plus self-testing and screening in the general population Dr. Brodersen expertise lies in areas of diagnostic test accuracy, overdiagnosis, informed consent and what the psychosocial consequences are for healthy people when they are tested. He also teaches nationally and internationally in evidence-based medicine.

Abstract

"Life can only be understood backwards; but it must be lived forwards"
- Søren Kierkegaard (Danish philosopher 1813-55)

Overdiagnosis is the diagnosis of deviations, abnormalities, risk factors and/or pathology that never in itself will: cause symptoms (applies only to risk factors and pathology), lead to morbidity or be the cause of death (1). It arises in many healthcare situations due to over-detection, over-definition and over-selling of disease (2). Treating an overdiagnosed condition (deviation, abnormality, risk factor and/or pathology) will by definition not change the patient's prognosis to the better and can therefore only be harmful (3).

At the individual level, neither we as general practitioners (GPs), nor the patient, can be sure when the patient is actually overdiagnosed. Only at the end of the individual patient's life we can for biomedical conditions be certain if our diagnosis was correct or iatrogenic. Within the area of psychosocial conditions and mental illnesses we will never get a certain answer. Therefore, the dilemmas and pitfalls in all diagnostic processes in the GPs' daily clinical patient-centred practice - with low prevalence of biomedical diseases and high prevalence of psychosocial illnesses - is so beautifully captured in the above mentioned quote of Kierkegaard.

Accordingly, the multi-billion dollar question is: How can we diminish or prevent overdiagnosis?

1: Brodersen J. How to conduct research on overdiagnosis. A keynote paper from the EGPRN May 2016, Tel Aviv. The European journal of general practice. 2017;23(1):78-82.

2: Welch HG, Schwartz L, Woloshin S. Overdiagnosed. Making People Sick in the Pursuit of Health. Boston: Beacon Press; 2011 2011.

3: Brodersen J, Schwartz LM, Woloshin S. Overdiagnosis: how cancer screening can turn indolent pathology into illness. APMIS. 2014;122(8):683-9.

Read more

http://equip2018.sk/keynote_speakers.php

Navigating the Sea of Overtreatment: *How to Practice Informed Decision-Making in the Face of Uncertainty?*



Adrian Rohrbasser, MD, MSc, GP (Switzerland):



Adrian Rohrbasser

Short bio

Adrian Rohrbasser, MSc in Evidence Based Health Care, is a general practitioner working for medbase Health Care Centres, in Eastern Switzerland. He is passionate about teaching, learning and training, which he combines with his GP work. In summer he can be found away from his books and at the top of a ladder, painting his holiday home in Sweden or hiking and fishing in the mountains.

Adrian is a member of the quality committee of the Swiss Society of General Internal Medicine and of the European Society of Quality and Safety in Family Practice. In both, he heads working groups for quality circles, promoting knowledge translation and quality improvement in primary health care.

This forms the topic of his research at the University of Oxford, Department of Continuing Education, where he is doing a DPhil in Evidence Based Health Care.

Abstract

We look at different cases and follow the courses of treatment trying to understand what happened. This talk is about underlying forces that may cause overtreatment in everyday practice.

Specialists aim to reduce uncertainty, explore possibility and marginalise error, whereas the family physician aims to accept uncertainty, explores probability and marginalises danger. To do this, treatment and care should take into account individual needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. But even though family physicians might wish to practice in a more patient centered way, testing and treating less, they work within cultural, social and regulatory frameworks which strongly discourage this. Standard guidelines for practice and treatment, financial incentives and social pressure steer us towards testing, diagnosing and treating our patient populations.

Read more

http://equip2018.sk/keynote_speakers.php

Growth of overdiagnosis and overtreatment as indicators of worsening healthcare

Author: Peter Lipták, Bratislava



Lipták

Abstract

Slovakia as an example of worsening health care:

1. Transfer of the place of performance of care

What can be done in the office of GP in the community to move to remoted specialists and into hospitals. What can be done in an outpatient office of a specialist to move to hospitals. Instead of development primary care shift to secondary and hospital care.

2. Payment for inefficiency

Financial stimulation of primary care by health insurances, evaluation of effectiveness according to costs of individual doctors and not according to total costs spent in the health care scheme per patient. The doctor is paid if he prescribes fewer medications and fewer examinations, regardless of the impact on the patient's health.

3. Blocking of competences

Administrative blocking of competences in the primary care sector, limited diagnostic and therapeutic procedures, such as limited prescribing of medicines to common chronic diseases.

4. Reduction of human resources in the primary care

Permanent deterioration in funding, mismanagement by non-systemic measures (violent e-Health, confusing examination of the deceased etc.)

5. Privatization and re-privatization

Weakening of the role of public offices of doctors and public hospitals, moving of the healthcare into private outpatients networks and private hospitals.

Target: Overdiagnosis and Overtreatment as the source of profit. Transformation of the system from the system focused on satisfying needs of people to the system focused on maximizing profit from their diseases.

The effect of a test ordering software intervention on the prescription of unnecessary laboratory tests

- a randomized controlled trial

Author: Carlos Martins, Family Medicine, Department of Community Medicine, Information and Decision in Health of the Faculty of Medicine of Porto, Porto & Centre for Health Technology and Services Research (Portugal)

Objective

The way software for electronic health records and laboratory tests ordering systems are designed may influence physicians' prescription.

A randomised controlled trial was performed to measure the impact of a diagnostic and laboratory tests ordering system software modification.

Material and Methods

Participants were family physicians working and prescribing diagnostic and laboratory tests.

The intervention group had a modified software with a basic shortcut menu changes, where some tests were withdrawn or added, and with the implementation of an evidence-based decision support based on the United States Preventive Services Task Force (USPSTF) recommendations. This intervention group was compared with usual software (control group).

The outcomes were the number of tests prescribed from those: withdrawn from the basic menu; added to the basic menu; marked with green dots (USPSTF's grade A and B); and marked with red dots (USPSTF's grade D).

Results

Comparing the monthly average number of tests prescribed before and after the software modification, from those tests that were withdrawn from the basic menu, the control group prescribed 33.8 tests per 100 consultations before and 30.8 after ($p = 0.075$); the intervention group prescribed 31.3 before and 13.9 after.



Carlos Martins

Improving anti-pneumococcal vaccination rate in diabetic patients

Author: Luís Rosális Bastos, USF Lavradio (Portugal).

Co-Authors: Mariana Guterres, António Marques Teixeira, Gisela Cravo Bessa, Punit Naguindas, and Ricardo Gouveia.



Introduction

Pneumococcal infection is an important cause of morbidity and mortality. According to WHO, it is responsible for approximately 1.6 million deaths per year worldwide. The diabetic population is considered a high-risk group for developing invasive pneumococcal disease.

Thus, the prevention of the disease is very important and can be improved through vaccination.

Objective

To improve the vaccination rate with anti-pneumococcal vaccine on a group of diabetic patient, according to indications of the Portuguese Directorate-General of Health.

Intervention period: 01/08/2017 until 31/10/2017.

Material and methods

We selected 5 healthcare centers and in each, we included all the diabetic patients above 18 years old of 2 GP regular list of patients per healthcare center and then applied the exclusion criteria.

The data regarding vaccination status was collected before and after the intervention and then analysed with Microsoft Excel.

The intervention consisted of a Microsoft Powerpoint presentation aimed at all the health care center professionals; an informative pamphlet explaining the benefits of the vaccine that was given to all diabetic patient being consulted during this period; a post-it "reminder" placed on the computer screens of all the GPs.

Results

From a total of 1528 diabetic patients, 514 (33,6%) had some consultation during the intervention period.

Overall, the vaccination rate before the intervention was 4,25% and afterwards it increased to 6,22%. The GP's list of patients with the best results resulted in an increase from 5,6% to 16%. However, in other 3 groups no increase was verified.

Discussion

Observing the vaccination rate before our intervention, it was very low, justifying the importance of our intervention. Afterwards, there was only a slight increase on the rate, with some GP's lists of patients not increasing at all.

The results of the intervention was less positive than expected. Hence we are developing a strategy to evaluate the factors that led to them both from the patients and from the healthcare professionals perspective, in order to improve the effectiveness of future interventions on this matter.

How to reduce unnecessary care?

Essencial Project in Catalonia

Author: Cari Almazán, Agency for Health Quality and Assessment of Catalonia (Spain).

Co-Authors: Johanna Caro, Montse Mias, Isabel Parada, Montse Moharra, and Toni Dedeu (on the behalf of Essential Project team).



Background

To avoid ineffective, unsafe or inappropriately used clinical practice is recognized as growing priority of healthcare systems worldwide to improve its quality of care and sustainability.

The Essential Project launched in Catalonia (March 2013) with the support of Ministry of Health and Medical Scientific Societies is aligned with International initiatives to reduce unnecessary care.

Objective

To elaborate and implement recommendations to avoid low-value clinical practices in the healthcare system of Catalonia Methods

To reach this main objective the project follows a process focus on three main activities:

- 1) Identification of low-value practices in collaboration with healthcare professionals and Medical Scientific Societies and elaboration of recommendations
- 2) Implementation of recommendations led by healthcare professionals and impact evaluation of these recommendations in terms of process and outcomes via quantitative and qualitative methods
- 3) Communication strategy to disseminate recommendations and implementation activities (web, videos, social media, infographics, training, etc) to healthcare professionals, patients and citizens.

Results

By now, 68 recommendations elaborated in collaboration with 25 Medical Scientific Societies and healthcare professionals. 40% of those recommendations are focus on Primary Care.

144 primary care teams with a coverage of around 5 million inhabitants incorporated these recommendations in their current clinical practice.

To promote the project among healthcare professionals a huge activity of meetings and presentations have been carried out, including several conferences both national and International

Conclusions

This was the first experience in Catalonia and in Spain of implementation of recommendations to avoid low value-practices. In general, the project has been widely accepted by Primary healthcare professionals.

However, the implementation of recommendations in hospitals is being a challenge for the project. Although communication has been intensive, still there is a huge proportion of healthcare professionals alongside patients that they do not know this initiative.

Therefore, further steps are to measure the impact of the project in the Catalan healthcare system, to strengthen collaborations with professionals and to promote specific communication strategies address to patients and citizens.

The joy of quality indicators in small groups

Eva Arvidsson & Adrian Rohrbasser (EQuIP):



1) MD, Specialist in Family Medicine, PhD, R&D Unit for Primary Care, Futurum, Jönköping, Sweden; Jönköping Academy for Improvements of Health and Welfare, School of Health and Welfare, Jönköping University, Jönköping, Sweden

2) The Standing Committee for Quality and Patient Safety (SFAMQ), College of General Practice, Sweden

3) European Society for Quality and Safety in Family Practice (EQuIP)

4) MD, Specialist in Family Medicine, MSc Evidence Based Health Care, Department of Continuing Education University of Oxford, medbase, Switzerland

Keywords

Quality improvement, audits, quality circles, peer small groups, indicators.

Objectives

The aims of this 90 minutes workshop are to provide participants with knowledge about quality indicators, and show them how small groups of GPs use them as a tool to mirror their practice and improve their quality of care.

Each participant will leave with updated knowledge on the use of quality indicators used in structured small group work. The ambition is also to motivate workshop attendees to take part in or even conduct a quality improvement (QI) project in their own practice.

Background

Quality indicators can be powerful tools for quality improvement. Studies have shown that we (doctors) believe that we follow guidelines to a much higher extent than we actually do. As a consequence, we need to study and scrutinize what we actually do.

Of course, many of the goals and values in primary care are very difficult to measure, e.g. ethics and humanism in consultations or if priorities are set right in everyday practice.

However, assessing the quality of care in primary health care is important for QI. Indicators can, and should, be used as starting points for discussions about the complex reality. They help us to initiate, stimulate and support local improvement work. Data for these discussions can be collected as quality indicators, data mirroring practice habits or data from other sources.

Structured small groups, also known as Peer Review Groups or Quality Circles, are small groups of health care professionals who meet to reflect and improve their standard practice. They use various didactic methods such as brain-storming and reflective thinking, and also tools for QI such as audit and feedback and therefore quality indicators or other ways of mirroring their practice.

Structured small group work (SSGW) is used for Quality Improvement in primary health care in several European countries.

Session content

1. Plenary: The basics about Structured Small Group work is shown in examples

- Knowledge of the group is more than what each participant adds
- PDSA Cycle
- Facilitator

Group discussions participants' experiences: Do you have any groups in your practice / region? What are their aims and objectives? Short reports from groups

2. Plenary: The concept of quality indicators for local improvement is introduced. Examples from Sweden (using electronic as well as paper medical records) are demonstrated.

Group discussions on participants' experiences from their own practices on quality indicators are initiated. Is this method used? Could it be? What is needed? Short reports from groups.

3. Group discussions:

- What are the next steps: If you have existing groups, can you use them for QI?
- Do you see a way of establishing small groups in your region?
- What data do you have access to: electronic medical record? Other data you can use as quality indicators? Other possibilities and opportunities?

Reports from groups

4. Summary and conclusions

Medication without harm: Which are the main topics in primary care?

Author: Maria Pilar Astier Peña, Seccion Internacional Semfyc/
Wonca Working Party on Quality and Safety (Spain)

Co-Authors: Jose Miguel Bueno Ortiz (EQuIP)



Background

The main nature of adverse events in primary is related to the use of medications. The World Health Organization has launched a new challenge to reduce adverse events concerning the use of medications along health systems in five years.

The Global Challenge involves crucial topics on the use of medications as transitional care, polypharmacy and high risk medications. The challenge considers as well to enhance patients' participation in their own safety. A tool has been developed to use in medical offices with patients: "5 Moments for medication safety".

The Wonca World Working Party on Quality and Safety is involved in this World Challenge and has a commitment to promote patient safety culture and safe practices along Wonca Events so we consider to perform this workshop to move family doctors to develop strategies with patients for a safer use of medications.

Aims

- 1) To present Medications without Harm Challenge
- 2) To describe crucial topics as transitional care, polypharmacy and high risk medications in primary care.
- 3) To present different tools to invite patients to use them for a safer use of medications.
- 4) To elaborate a plan for a safer use of medication in each participants' practice.

Methods

First part, a short theoretical introduction followed by a second part, work in small groups to prepare a checklist or plan to improve medication use in their practices and to assess the feasibility of using patients' tools for a safer use of medications.

Results

To share groups' plans on crucial topics and to give feedback on the 5 moments tools.

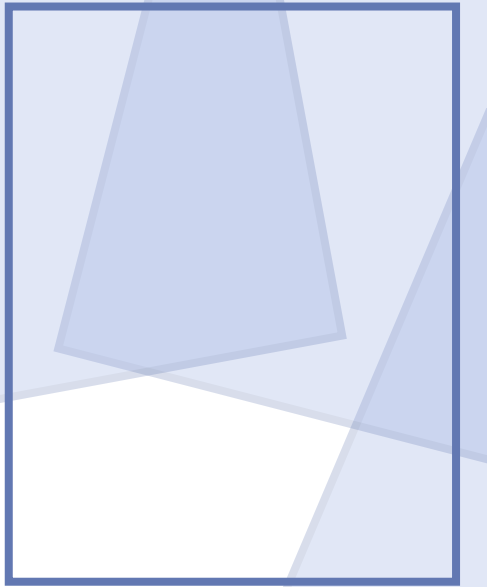
Conclusions

This workshop can be used by primary care teams to promote a safer use of medications in their practices.

Mental health in general practice

Claire Thomas & Stuart d'Arch (VdGM):

WORKSHOP



XXXXX