European Forum for Primary Care
5th Biannual Conference

Twinning Population Health and Primary Care
University Pompeu Fabra, Barcelona, Spain
September 1/2, 2014
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1. Welcome
1.1. Foreword from EFPC

**Welcome to the EFPC 2014 Bi-annual conference!**

A warm welcome to the beautiful city of Barcelona for the 5th conference on the Future of Primary Health Care in Europe, this year focusing on "Twinning population health and primary care".

Primary care operates at the intersection between the health system on the one hand, and the needs of individuals, their families and communities on the other hand. So, undoubtedly, an interprofessional primary care setting is extremely well positioned in order to integrate the targets of population health with the needs of individuals: person-centered and people-centered care!

The topic will be approached from different perspectives: at the nano- and micro-level we will look at the way different professionals try to improve the health of the communities they are working with. At the meso-level, the issue of decentralization will be studied, starting from the Spanish experiences in the decentralized primary care system. At the macro-level the conference will integrate expertise of different disciplines (health economics, health financing experts, health care managers, …). Finally, we will have the opportunity to exchange the EFPC-expertise with the health system department of WHO-Geneva, looking at interprofessional collaboration and education, integration of primary care and social care, use of appropriate health technologies, shared decision making, patient empowerment,…

The conference participants will also have the opportunity to debate the recently published opinion of the Expert Panel on Effective Ways of Investing in Health (EXPH), of the European Commission: "Definition of a frame of reference in relation to primary care with a special emphasis on financing systems and referral systems".

So, as usual, an EFPC-conference with a lot of challenging interactive debates is awaiting you. Do not hesitate to give your opinion.

And... do not forget to enjoy Barcelona!

*Prof. Jan De Maeseneer, MB, Ph.D.*

*Chairman European Forum for Primary Care.*
Dear Colleagues,

It gives us great pleasure to welcome you and the European Forum for Primary Care 5th biennial conference to the University Pompeu Fabra (UPF), the Center for Research in Health Economics (CRES) and the city of Barcelona.

CRES is a research center of UPF whose mission is to offer response to our health care system most important challenges from a multidisciplinary vision around health economics, policy and management.

This congress themed “Twinning Population Health and Primary Care” will be an excellent occasion to discover how primary care is practiced in Catalonia and throughout Spain and discover its innovation frontier. It will also bring you the opportunity to exchange and network with peers in the premises of a modern and young academic institution born 24 years ago.

We look forward to welcoming clinicians, researchers, managers, academics, policy makers, and other allied health professionals with interest in the future of primary care from Europe and beyond.

Aside from the excellent scientific program, we have also prepared a social program at UPF main hall that will provide delegates an opportunity to network among colleagues while enjoying the cuisine, culture, and warm hospitality that the city of Barcelona has to offer.

We look forward to opening our doors to everyone to Barcelona for the EFPC 2014 conference!

Vicente Ortún
Antoni Peris
Local Scientific Committee

Laura Pellisé
Tino Martí
Local Organization Committee
1.3 Conference theme

The Future of Primary Healthcare in Europe (V)

“Twinning Population Health and Primary Care”

The World is changing and so are health services. Urbanization and globalization have its’ impact on what is needed from health care providers and subsequently how health care is organized. More and more cities and other local authorities become increasingly important for the health of their citizens. Important pressures are the integration of Community Care and Primary Care or in other words the connection between Public Health and care for the individual. The difficulty for local authorities is to adapt their care system to the increased needs of the individuals living within their neighbourhoods. These needs have not only increased in volume but also in complexity. An adequate monitoring system for these local authorities is needed, providing insight of the needs in terms of prevention and health promotion, reactive care including emergencies, continuity of care. Also, dealing with chronically ill mainly in the context of home care is crucial and creating equitable financing which take into account the differences between affluent and other parts within the city. Local governments need information, assistance and capacity building on how to achieve practical solutions for these major challenges which lay ahead and will become even more visible in the coming decades. The Community Oriented & Integrated Primary Care approach is a model that fits very well and tackles most of the challenges. Moreover, addressing health problems requires an inter-sector approach at the local level, integrating health and welfare sectors with housing, work, education, infrastructure etc.

The biannual conference of the European Primary Care Forum in 2014 will explore a number of critical themes for primary care. Its aim is to enable participants to identify, define and appreciate the significance of questions ranging from policy to organization, management and clinical care which are likely to determine the future of primary care in Europe. The Forum is looking to support contributions which address, in particular, issues of equitable access, cost-effectiveness, service delivery, clinical quality and the maintenance of continuity of care. Both urban and rural settings are relevant, with their differing but equally important modern pressures.

This year’s conference will look at primary care & population health from four major viewpoints:

1. Patient/Population Perspective (PP)

This view is all about creating a better care experience for the patient! We will look into topics such as patient satisfaction and patient empowerment as well as focus on specific groups such as the elderly, the world’s adolescents and minority groups such as Roma.

2. Professional Perspective (Prof)

In this perspective we look at experiences and know-how of various primary care professional associations in Europe. In addition, topics such as communication & collaboration as well as elderly and chronic care will be touched upon.
3. Systems Perspective (Syst)
The systems perspective investigates primary care systems as such by shedding a light on different country’s approaches and methods. The organization of primary care is the focus of this perspective with sub-topics such as integration of care, accountability or efficiency amongst many others.

4. Technological/Devices Perspective (Tools)
New technologies, tools and devices are the centre of attention of this perspective. We will look into quality assurance, health promotion or care registration.

EFPC’s 2014 conference in Barcelona wants to create closer connections between local authorities and Primary Care providers and analyze the different models and numerous options for improvement. We want to share knowledge and experiences to improve our daily work. We hope you will benefit from being part of the twinning exercises!

1.4 The Scientific Committee

Prof Vicente Ortun
University Pompeu Fabra

Antoni Peris
CASAP

Toni Dedeu
DHI / University of Edinburgh

Prof Cecilia Björklund
Goteborg University

Diederik Aarendonk
EFPC

Prof Peter Groenewegen
NIVEL

Prof Jan De Maeseneer
Ghent University

Aigars Miezitis
Latvian National Health Service

The Organizing Committee

Diederik Aarendonk
EFPC

Laura Pellise
Uni Pompeu Fabra

Tino Marti
CASAP

Vijoleta Gordeljevic
EFPC

We wish you a great conference
2. Key-note speakers

Prof. Vicente Ortún

Determinants of specialty choice: How to increase the attractiveness of Family Medicine

An extensive list of factors influencing specialty choice has been considered including financial remuneration, lifestyle and work hours, prestige among colleagues or the general public, research and teaching opportunities, potential for career advancement, gender, clinical clerkship experience, direct patient interaction and continuity of care, length of the residency training programs and many others. Numerous authors in many countries have lamented the shortage of primary care physicians, particularly the inadequate supply of practitioners of family and community medicine. A wide variety of corrective measures have been proposed, including changes in payment mechanisms and physician compensation, improvements in working conditions, policies to counter the low prestige of primary care medicine, and the training of non-physician practitioners as substitutes. However, there has been relatively little consideration of alternative policies focused at the critical point where medical school graduates choose residency training positions. Our objective in the presentation would be both to review what is known on how to increase the attractiveness of Family Medicine and to present research to be published that evaluates policy alternatives to the current national system for allocating residency training positions in Spain, widely known as “MIR.” We can advance one conclusion: Policies designed to increase the prestige and remuneration of practitioners of family and community medicines have the potential to be more efficient and equitable than other alternatives.

- Dean and professor of the School of Economic and Business Sciences, University Pompeu Fabra of Barcelona. Founder, former director, and member of the Center for Research in Economics and Health (CRES), University Pompeu Fabra.


- MBA by ESADE (1969), Master of Science from Purdue University (1970), BA and PhD in Economics by University of Barcelona (1990). Doctoral studies in Public Health at Johns Hopkins University and Visiting Scholar (2009) in the Department of Economics at the Massachusetts Institute of Technology (MIT).

- Business and public policy experience at regional, national and international levels.

- Former president of the Spanish Society of Public Health and Health Administration (SESPAS), former president of the Association of Health Economics (AES), former secretary of the European Public Health Association (EUPHA) and merit member of CAMFiC.
Abstract

Estonia is one of the eHealth leaders and our experience shows that in eHealth, each new service requires detailed planning and possible changing of years-long work processes. We have many examples of successful eHealth solutions in healthcare.

We have e-prescriptions, digital health record and several other projects that we have piloted. New services and functionalities are being built on the basis of the Health Information System.

However, when viewed from the inside, it often seems to us that solutions are not implemented fast enough in practice. E-health solutions are taken up slowly by doctors in their everyday work, but the need for working eHealth solutions is recognized by all parties despite occasional differences in opinion. E-health will never be complete. In addition to technological solutions what is most needed for the successful implementation of e-solutions is the cooperation and joint readiness by developers, doctors and patients. The sharing of common experiences will definitely bring it closer.
COMMUNICABLE DISEASE PREVENTION – A SHARED RESPONSIBILITY

When it comes to infectious disease, no country can afford to stand alone. The European Centre for Disease Prevention and Control (ECDC) is an EU agency set up in 2015 that has as mission to identify, assess, and communicate about current or emerging threats for human health from communicable diseases. ECDC’s activity is structured in core functions (surveillance; epidemic intelligence and response; preparedness; and scientific advice and supporting functions, training and communication being part of these). While some areas of work require in-depth epidemiological tools and approaches, in other domains cross-cutting and multi-sectorial collaboration are key, especially in communication and capacity building of public health systems in the Member States. For example in the area of vaccination, it is of utmost importance to involve the healthcare providers that are in daily contact with the population groups, especially as we see that challenges in this area still remain, measles and rubella elimination in Europe seem like a hard to achieve target by 2015. Our work in this area is based on the Council conclusions on childhood immunization (2011) and on the WHO measles and rubella elimination strategy. From this policy document, we have developed a 3 year strategy with four key areas of intervention, one of which is evidence-based communication. A communication set was developed to support the daily interactions that primary healthcare professionals have daily with parents to motivate them in vaccinating their children. The guide has been developed based on evidence from literature review, involved PHC professionals as well as the ultimate beneficiaries – parents, thus bringing innovation into designing communication tools for behaviour change especially among un- and under-vaccinated population groups. Next steps include the adaptation of the text for an e-learning session targeting
PHC, so that the content becomes widely available. In conclusion, ECDC as a technical agency in the area of prevention of communicable diseases bridge the evidence with policy and practice.

Abstract

Primary care involves a provider that who is the first contact and principal point of entry to the health care system, who provides continuing care for patients in the health care system, and who enables access to secondary or specialist care as necessary.

In the realm of maternal and newborn care, midwives have traditionally provided primary care, providing care continuously to women from early pregnancy to the end of the postpartum period (usually 6 weeks). As maternity health care systems have evolved, specialist care has taken a more prominent role, and today few models of midwifery fulfill all components of primary care. Midwifery was first regulated in Canada in 1994, providing an unique opportunity to establish the profession de novo. The resulting Canadian model of midwifery care provides an example of midwives practicing fully as primary care providers well integrated with their specialist partners. Canadian midwives are a first contact for maternity care, providing continuous care from early pregnancy through labour and birth until 6 weeks following birth. Canadian midwives are accountable for their own care and directly consult with their physician peers (in obstetrics, pediatrics, anaesthesia,

Professor Eileen Hutton, RM, PhD, is Assistant Dean in the Faculty of Health Sciences and Director of Midwifery at McMaster University in Hamilton, Ontario where she is a Professor in the Department of Obstetrics and Gynecology. In 2011 Dr. Hutton was appointed Professor of Midwifery Science at Vrije University in Amsterdam, the Netherlands where she holds a part time endowed chair position. In taking this position she is the first midwife ever to hold a professorship in the Netherlands. Her undergraduate degree is from Queen’s University School of Nursing (BNSc). Dr. Hutton is a graduate of The University of Toronto, School of Nursing (MScN) and Institute of Medical Science - Clinical Epidemiology (PhD). She held a Canadian Institutes of Health Research (CIHR) New Investigator Award (2004-2009) and was a recipient of a Michael Smith Foundation for Health Research Scholar award.

She is currently involved in four large multicentre randomised controlled trials funded by CIHR. She has expertise in clinical trial methodology, systematic review and meta-analysis, clinical epidemiology, and implementing evidence-based practice. Her particular interest is in clinical trials with a focus on normal childbirth. She has published on a variety of topics relevant to midwifery and obstetrics including twin birth, external cephalic version, late and early clamping of the umbilical cord in term neonates, vaginal birth after caesarean section, sterile water injections for labour pain relief and home birth. Dr. Hutton is a member of the CIHR Fellowship Awards Committee. She was the founding editor of The Canadian Journal of Midwifery Research and Practice, and is on the editorial board of the Journal of Obstetrics and Gynecology Canada. She is an instructor for the Society of Obstetricians and Gynaecologists of Canada (SOGC) Advances in Labour and Risk Management (ALARM) programme, both nationally and internationally, and is co-chair of the International Women’s Committee of the SOGC. She was recently awarded the inaugural Lifetime Achievement Award by the Association of Ontario Midwives.
family practice etc.) as required during the woman’s course of care, and transfer care to specialist care when this is warranted. This presentation will use the research literature to establish the importance of primary care midwifery to a maternity care system and use the Canadian midwifery model to highlight important policy decisions that promote the primary care role.

Dr. Sarah Thomson

Economic crisis, health systems and universal access to health care in Europe

The crisis has given substance to an old and often hypothetical debate about the financial sustainability of health systems in Europe. For years it was the spectre of ageing populations, cost-increasing developments in technology and changing public expectations that haunted European policy makers troubled by growth in health care spending levels. The real threat, however, came in the shape of a different triumvirate: financial crisis, sovereign debt crisis and economic crisis. After 2008, the focus of concern turned from the future to the present, from worrying about how to pay for health care in thirty years’ time to how to pay for it in the next three months.

Not all European countries were affected by the crisis. Among those that were, the degree to which the health budget suffered varied. Some countries experienced substantial and sustained falls in public spending on health; many did not. These changes and comparative differences provide a unique opportunity to observe how policy makers respond to the challenge of meeting health care needs when money is tight. In a study carried out by the World Health Organization (WHO) and the European Observatory on Health Systems, Sarah Thomson and colleagues address three questions. How have health systems in Europe responded to the crisis? How have these responses affected health system performance? And what are the implications of this experience for health systems facing economic and other forms of shock in the future? The study’s contribution is to map and analyse policy responses across Europe from late 2008 to the middle of 2013. It is the first step in a longer-term undertaking to identify those policies most likely to sustain the performance of health systems facing fiscal pressure and to gain insight into the political economy of implementing reforms in a crisis.

Since 2013, Sarah Thomson has worked as a Senior Health Financing Specialist for the WHO Regional Office for Europe and been based in the WHO Barcelona Office for Health Systems Strengthening. She is also a Senior Research Associate with the European Observatory on Health Systems and Policies, an Associate Professor in the Department of Social Policy at the London School of Economics and Political Science (LSE) and a member of the European Commission’s Expert Panel on Effective Ways of Investing in Health.

Before moving to Barcelona, Sarah was Head of the LSE Hub of the European Observatory and a Deputy Director of LSE Health. She is Associate Editor of *Health Economics, Policy and Law* (Cambridge University Press) and on the editorial board of *Health Systems and Reform* (Landes Bioscience).

Her work focuses on comparative health system policy analysis, with emphasis on health financing policy in high- and middle-income countries. Sarah has a PhD in social policy from the LSE.
Dr. Hernan Montenegro

Hernan Montenegro is currently a senior Health Systems Adviser at the World Health Organization (WHO) in Geneva, Switzerland. He holds a Medical Doctor degree from the University of Chile, a Specialist in Public Health degree from the University of Chile, and a Master in Public Health degree from the University of Johns Hopkins.

He also has two years of postgraduate training in General Surgery at the University of Chile’s Jose Joaquin Aguirre Hospital. At the beginning of his career, he served as a clinician providing primary and emergency care services to low-income population in Santiago, Chile. From 1988 to 1995, he was a professor of public health at the School of Public Health of the University of Chile.

From 1991 to 1995 he worked for the Chilean Ministry of Health, first as a Public Health Specialist, and later on, as the Head of the Health Sector Reform Project Coordination Unit. In 1996 he joined the World Bank where he became Senior Health Specialist for the Human Development Sector Management Unit, Latin America and Caribbean Region, in Washington D.C. While at the World Bank, he worked in Panama, Mexico and Brazil. In 2001 he joined PAHO/WHO as Regional Advisor on Hospital and Health Services Management, and later on from 2004 to 2007 he became Chief of the Health Services Organization Unit of PAHO/WHO in Washington, D.C.

Dr. Montenegro’s areas of expertise are health services organization, management and delivery, health systems, health sector reform, health policy, strategic planning, and project/program formulation and evaluation.

Dr. Montenegro will be interviewed by representatives of various professional associations in the Expert Panel. This session will touch upon topics ranging from inter-professional collaboration, education, over integration of primary health care and social care to the use of health technologies. Other topics might include patient empowerment and satisfaction.
3. Location

The EFPC Conference 2014 takes place on the "Citadella Campus" of the Pompeu Fabra University in Barcelona (building 40).

Address: Ramon Trias Fargas 25-27
Phone: (+34) 93 542 20 00

By public transport:

- METRO Line 4
  CIUTADELLA - VILA OLÍMPICA
- TRAM Line T4, T5
  WELLINGTON and CIUTADELLA-VILA OLÍMPICA
- BUS 10, 14, 41

3.2 Pre-conference

Address: Centre de Salut Can Bou
Avgda. Ciutat de Málaga, 18-20
08860 Castelldefels
3.3 Location maps

= Locations of parallel poster debate sessions
4. Programme

The Pre-Conference

16.00 - 19.00

**Primary Care Experience Workshop**

Your hosts are: Antoni Peris & Tino Marti

Primary Care centre CASAP in the community of Castelldefels with several sessions on

- Organizational structure CASAP
- Community involvement
- Involvement of local authorities

19.00 - 19.30

A speech by special guests Trevor Carr, CEO Community Health Australia, Damian Ferrie (Chief Executive Officer of Inner South Community Health) and Dr Ines Rio (Chair, Inner North West Melbourne Medicare Local and Head GP Liaison Unit, Royal Women’s Hospital). Subsequently a drink & dinner together with the EFPC Executive and Advisory Board

Simultaneously:

14.00 - 16.00 Executive Board meeting
16.00 - 19.00 Advisory Board meeting
14.00 - 16.00 ACOPC meeting

Day One

Morning

Chair: Henk Parmentier (GP, UK; EFPC Adv Board member)

08.00
Registration + special effects + coffee

09.15
Welcome address by local host
<table>
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<th>Time</th>
<th>Event</th>
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<tr>
<td>09.20</td>
<td>Welcome address by Prof Jan De Maeseneer, chairperson of the EFPC, including introduction to the conference themes (main hall)</td>
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<tr>
<td>09.30</td>
<td>Plenary: 1 key-note Scientific - <strong>Prof Vicente Ortun</strong>, Department of Economics and Business and Research Center on Health and Economics, University Pompeu Fabra (25 min; main hall)</td>
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</table>
| 10.00 | 8 parallel sessions, 30 min  
  - Meet the key note speaker  
  - 7 Catalan and Spanish Primary Care features  
  - Expert panel session (EXPH) with Jan de Maeseneer |
| 10.30 | Break, change of rooms (15 min), coffee is served in poster hall |
| 10.45 | Research abstract sessions (7 parallel sessions, 105 minutes), including two planned workshops. |
| 12.30 | Lunch in main hall |

### Afternoon

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| 13.30 | Balazs Hanko (Pharmacist, Hungary; EFPC Adv Board member)  
  Plenary: 1 key-note Policy & Practice - Estonia: **Dr Ivi Normet**, Deputy Secretary General of Health, Estonia presentation on ICT in Health (25 min; main hall) |
| 14.00 | Two rounds of 30 min for acquaintance with “Electronic Record Systems” with 8 Parallel sessions: 8 Case studies on Electronic Patient Records systems and related data-collection |
| 15.00 | Break, change of rooms (15 min), coffee is served in poster hall |
| 15.15 | 8 Parallel planned workshops (105 min) |
| 17.00 | EFPC General Assembly, for EFPC members only (1.5 hour) |
| 20.00 | Conference diner at the UPF main hall |
Day Two

Running the whole day: Multi Media presentations (main hall)

Morning

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<tr>
<td>Chair:</td>
<td>Victoria Vivilaki (Midwife, Greece; EFPC Adv Board member)</td>
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<tr>
<td>08.30</td>
<td>2 key-notes Scientific, Policy &amp; Practice - Prof Karl Ekdahl (ECDC) &amp; Prof Eileen Hutton (Midwife, McMaster Uni) (2 x 25 min; auditorium)</td>
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<td>09.30</td>
<td>8 parallel sessions, 30 min</td>
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<td>- Meet the key note speaker</td>
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<td>- 7 Primary Care professional European associations present themselves</td>
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<td>10.00</td>
<td>Policy poster debate sessions (11 parallel sessions, 1 hour)</td>
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<td>11.00</td>
<td>Break, change of rooms (15 min), coffee is served in poster hall</td>
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<tr>
<td>11.15</td>
<td>8 Parallel research workshops: (including abstracts; 105 minutes)</td>
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<td>13.00</td>
<td>Lunch in main hall</td>
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Afternoon

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<tr>
<td>Chair:</td>
<td>Marije Bolt (Occupational Therapist, The Netherlands; EFPC Adv Board Member)</td>
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<tr>
<td>14.00</td>
<td>1 key-note Scientific &amp; Policy – Dr Sarah Thomson (Associate Professor, London School of Economics and Political Science, Senior Health Financing Specialist, WHO Europe, Senior Research Associate, European Observatory on Health Systems and Policies) (25 min, Auditorium)</td>
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<tr>
<td>14.30</td>
<td>8 parallel sessions, 30 min</td>
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• Meet the keynote speakers
• Planned workshops

15.00
Expert Panel session (EXPH) with Sarah Thomson

15.45
Break (30 min). Coffee is served in poster hall including a speed date session with abstract authors in four corners: Patient/Population - Professional - Systems - Tools

16.15
Expert panel with representatives of professional associations interviewing Dr Hernan Montenegro, Health System Advisor WHO Geneva; (1 hour; auditorium) facilitated by Prof. Peter Groenewegen.

Topics discussed are f.e.: Inter-professional Collaboration and subsequently Education, integration of Primary Care & Social Care, use of health technologies, shared use of health records, patient empowerment, etc.

17.30
Closure

Using Twitter?

#EFPC2014
#primarycare
### 4.1 Parallel sessions

#### Spanish Sessions

7 Catalan and Spanish Primary Care features  
**Day 1**  
10.00 - 10.30

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<th>Code</th>
<th>Session 1</th>
<th>Session 2</th>
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<td>Chairpersons</td>
<td>Vicente Ortun</td>
<td>JM Picas</td>
<td>J Vidal-Alaball</td>
<td>E Sarquella</td>
<td>Isabel Casado</td>
<td>Anna Kotzeva</td>
<td>G.Barba</td>
<td>Laura Pelisse</td>
<td>Jan De Maeseneer</td>
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<td>Theme</td>
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<td>Continuity of Care</td>
<td>Community Care</td>
<td>Health and Social</td>
<td>Multi-disciplinarity</td>
<td>Appropriateness</td>
<td>Accountability</td>
<td>Efficiency</td>
<td>EXPH</td>
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**PP** = Population Health & Primary Care from a Patient/Population perspective  
**Prof** = Population Health & Primary Care from a Professional perspective  
**Syst** = Population Health & Primary Care from a Systems perspective  
**Tools** = Population Health & Primary Care from a Technological/Devices perspective
# Workshop Round 1

Research abstract sessions + planned workshops

**Day 1**
10.45 - 12.30

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<td>Jeanette Edwards</td>
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<td>Andre Vyt</td>
<td>Marije Bolt</td>
<td>Tino Marti</td>
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<td>Chronic Care Catalonia</td>
<td>Health promotion incl. new technologies</td>
<td>Population Health / Patient Satisfaction</td>
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<td>Katerina Tarasova</td>
<td>Piero Salvadori</td>
<td>Willemijn Schafer</td>
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**PP** = Population Health & Primary Care from a Patient/Population perspective  
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**Tools** = Population Health & Primary Care from a Technological/Devices perspective
Two rounds of Electronic Record Systems
Two rounds of 8 Case studies on Electronic Patient Records systems and related data–collection

Day 1
14.00–15.00

<table>
<thead>
<tr>
<th>Session 1A 14.00-14.30</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
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<td>Chair</td>
<td>Ivi Normet</td>
<td>M. Medina</td>
<td>Peter Schofield</td>
<td>Toni Dedeu</td>
<td>Jörgen Manson</td>
<td>Auke Vlonk</td>
<td>Veerle Piessens</td>
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<tr>
<td>Theme</td>
<td>Meet the keynote</td>
<td>Catalonia (M. Medina &amp; B. Miralpeix)</td>
<td>England (Lambeth DataNet)</td>
<td>Scotland (DHI / University of Edinburgh)</td>
<td>Sweden (Gothenburg Uni)</td>
<td>NL, Community Scan (Jan van Es Institute)</td>
<td>Belgium, Flemish collective registration system (VWGC)</td>
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1219 Claveria
1233 Birtwhistle
## Workshop Round II

8 planned workshops

**Day 1**

**15.15 – 17.00**

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<td>ProfWSR2-S5</td>
<td>SystWSR2-S6</td>
<td>SystWSR2-S7</td>
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<td>Dinny De Bakker</td>
<td>Henk Parmentier</td>
<td>Marc Bruijnzeels</td>
<td>Antoni Peris</td>
<td>Clive Needle</td>
<td>Peter Groenewegen</td>
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<td>Theme</td>
<td>Theatre as a tool of narrative medicine: Is there any way to use in primary care (TAHEV)</td>
<td>Care Registration within Primary Care (NIVEL)</td>
<td>Mental health EFPC WG (PRIMHE)</td>
<td>Triple Aim (JvEI)</td>
<td>Catalan scientific societies</td>
<td>Health Promotion (EuroHealthNet, ACOPC)</td>
<td>Urgent Care / Rural Health / Continuity</td>
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<td></td>
<td>Cagri Kalaca</td>
<td>Irina Stirbu-Wagner</td>
<td>Jan De Lepeleire</td>
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<td>Hubert Jamart</td>
<td>1103 Breton</td>
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<td>Jacqueline Tol</td>
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**Legend:**

- **PP** = Population Health & Primary Care from a Patient/Population perspective
- **Prof** = Population Health & Primary Care from a Professional perspective
- **Syst** = Population Health & Primary care from a Systems perspective
- **Tools** = Population Health & Primary Care from a Technological/Devices perspective
## Professional Sessions

8 Primary Care professional European associations present themselves  
**Day 2**  
9.30 –10.00

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<th>Code</th>
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<th>Session 7</th>
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<tr>
<td>SystSem-S1</td>
<td>Auditorium</td>
<td>Karl Ekdahl</td>
<td>Meet keynote</td>
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<td>COTEC/ENOTHE</td>
<td>EuroPharm Forum</td>
<td>WONCA/UEMO</td>
<td>HW4ALL &quot;Spanish Health workforce migration&quot;</td>
<td>European Midwifery Association</td>
<td>European Board for Certified Counselors (EBCC)</td>
<td>ICHPO, Allied Health Professionals</td>
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<td>EFAD (European Dietitians)</td>
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<td>European Midwifery Association</td>
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<td>HW4ALL &quot;Spanish Health workforce migration&quot;</td>
<td>European Midwifery Association</td>
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<td>European Midwifery Association</td>
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# Policy Debate Sessions PAGE I

II parallel sessions (see page I and II)

**Day 2**

10.00–11.00

Sessions 1-6

<table>
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<th>Code</th>
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<td>5</td>
<td>GF corridor-r4*</td>
<td>GF corridor-stairs**</td>
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<td>Valentina Baltag</td>
<td>David Somekh</td>
<td>Aigars Miezitis</td>
<td>Tiago Vieira Pinto</td>
<td>Katerina Venovska</td>
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* Ground Floor, corridor, next to room 4, indicated in map with ✗
** Ground Floor, corridor, next to the stairs, indicated in map with ✗
## Policy Debate Sessions PAGE II

**Sessions 7-11**  
**Day 2**  
**10.00–11.00**

<table>
<thead>
<tr>
<th>Code</th>
<th>Session 7</th>
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<th>Session 10</th>
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<td>Exhibition room, far end**</td>
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<td>Mehmet Akman</td>
<td>Henk Parmentier</td>
<td>Christos Lionis</td>
<td>Arthur Eyck</td>
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<tr>
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<td>Elderly &amp; Social care</td>
<td>Communication &amp; Integration</td>
<td>Obesity &amp; Oral Health</td>
<td>Meet the editor of BMC Fam Practice &amp; Quality in Primary Care</td>
<td>Primary Focus (ZonMW)</td>
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<td>2263 Uncu</td>
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*indicated in map with ✗

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Workshop Round III
8 research abstract sessions
Day 2
11.00–13.00

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<td>Chair</td>
<td>Marga Vintges</td>
<td>Walter Marrocco</td>
<td>Willemijn Schäfer/Wienke Boerma</td>
<td>Risto Mietunen</td>
<td>Robbert Huijsman</td>
<td>Balazs Hanko</td>
<td>Henk Parmentier</td>
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<tr>
<td>Theme</td>
<td>Roma health literacy</td>
<td>Network on PC to the European Medicine Agency (EMA)</td>
<td>Country presentations of QUALICOPC partners: Turkey, Greece, Austria, Germany, Finland</td>
<td>“Challenges and achievements in integrated care” (Union Catalan Hospitals, IHF)</td>
<td>IMPLEMENT (Achmea)</td>
<td>Palliative-/Elderly-/Chronic Care</td>
<td>Organisation of PC</td>
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# Workshop Round IV

8 sessions, planned workshops incl. multimedia sessions  
Day 2  
14.30-15.45

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<td>SystWSR4-S6</td>
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<td>Sarah Thomson</td>
<td>Kathryn Hoffman</td>
<td>Giorgio Visentin</td>
<td>Aigars Miezitis</td>
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<td>Orsi Nagy</td>
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<tr>
<td><strong>Theme</strong></td>
<td>Meet keynote</td>
<td>Multi Media session 1: Mobilization of Communities</td>
<td>Multi Media session 2: Community care</td>
<td>Multi Media session 3: Interprofessional Collaboration</td>
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<td>EIP-AHA B3 Action Group Integrated Care</td>
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<td>3104 Visentin</td>
<td>3162 Muniente Perez</td>
<td>Peter Groenewegen</td>
<td>Toni Dedeu</td>
<td>148 Asli Ocek</td>
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BMC Family Practice
Executive Editor: Magdalena Morawska

- Online submission
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- Immediate publication on acceptance
- High visibility
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*BMC Family Practice* is an open access, peer-reviewed journal that considers articles on all aspects of primary health care, including clinical management of patients, professional training, shared decision making, and the organisation and evaluation of health care in the community.

biomedcentral.com
Continuity of Care
Josep M. Picas, MD, CEO at Adaptive Health Solutions

This session will cover an overview of the most advanced projects in clinical management and integrated care as well as a description of how continuity of care is practiced in Primary care both in Spain and in Catalonia.

It will be framed by an overview of current financing, organizational and information systems aspects that influence the level of care coordination among healthcare providers.

The future of continuity of care will be tackled from a critical perspective identifying and describing the cultural, technological and structural barriers to change and improvement that innovators face.

As an illustrative case, Innspira – an innovative project to improve the care of COPD patients in coordination with hospital and social care – will be presented and discussed.

Community care in Catalonia and in Spain
Josep Vidal-Alaball, Primary Care & Public Health physician

Community care can be defined as the health of the individuals and the groups in a defined community. This is determined by the interaction of personal, family, cultural and physical factors and the socio-economic environment (determinants of health). A community health intervention is a strategy aimed to improve the health of a defined community. We want to give you a glance of a different range of community care interventions been conducted in Catalonia and in Spain at this moment. We will talk about the Programme of Community Activities in Primary Care (PACAP) and the Working Groups on Community Oriented Primary Care (APOC), the Community Health Workers project (ASACO), the Acting Together for Health network (AUPA), a project trying to facilitate access to health services for vulnerable population in Alzira and the Health Observatory of Asturias, among others. We will have some room to talk about the future of community care.

Health and Social Care
Esther Sarquella, Health and Social Care Interdepartmental Plan, Government of Catalonia

Health and social care integration is a common challenge in modern healthcare and social care systems. Although this integration improves both health and social care, it is a difficult task to get both groups to work together due to different factors. Early this year, the Government of Catalonia issued an Interdepartmental Plan to
improve the Health and Social care and interaction. The goal of this new plan is to promote and participate in the transformation of the social and health care model to achieve person-centred full integrated care.

During this session you will hear a contribution from the Catalan primary social care services about the role that should assume the community-based health and social care services to make this integrated care model a reality. It will be shown implemented cases of health and social care collaborative models in Catalonia between the basic social services and the health primary care centre in the community.

It is expected to discuss about how to define and promote collaborative environments with the workforce from all the services involved as a continued learning process; how we promote a new role from the citizens as active partners to this changing model of care; what do the primary health care expect from the primary social care sector and how it fits with the social care sector mission; which should be the common goals in this new scenario in order to move further into the bottom-up model.

Multidisciplinary teams in Primary Care: the role of nurses

Isabel Casado, Primary Care Nurse at CASAP

Primary care is a team discipline all over Spain. Since 1984 Primary Care reform, the practice of family medicine and nursing is of a collaborative nature. Within a primary care team one may find different health professions: family doctors, pediatricians, dentists, nurses (adults and children), social workers and administrative personnel.

In this session, an overview of the main dynamics within primary care teams will be covered.

A special emphasis will be on the role of nurses in Primary Care. How is defined collaboration between doctors and nurses? How nurses may advance their practice without interfering doctor’s work? And how the primary care nurse of the future will look like?

Appropriateness: The Essential Project

Anna Kotzeva, Research associate at AQuAS

The Catalan health system results are at the forefront of Europe as one of the reference systems; it is valued by users and is a major driving force for the economy of our country.

The quality of healthcare is directly related to the effectiveness and efficiency of health care services provided to achieve the maximum possible value for the resources invested.

It is shown that close to proven practices of effectiveness, there are other of little value and some where evidence states that do not add value.

Avoid the clinical practices that do not add value can help improve healthcare quality, innovation and sustainability of the health system, to the extent that frees resources that can be used for procedures that do add value in clinical practice. That is why the method for the development of this project is
explicit and transparent, with the participation of health professionals in all stages.

The **Essential project** is based on close and continued collaboration between scientific societies, health professionals, patients and the **Agency for Healthcare Quality and Evaluation of Catalonia (AQuAS)**.

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**Accountability: Results central**

Genoveva Barba, AQuAS

The Results Central measures, evaluates and disseminates health outcomes and quality achieved by different agents that make up the health system. It is a product-oriented quantitative decision making and with the ability to compare, so that it becomes a "map of results" of the health system.

The Results Central provides to get periodic knowledge of the health system, to compare between entities and to allow a systematic territorial analysis.

Each of the indicators measured are accurately defined, as well as the spatial and temporal extent is technically robust to do comparisons and analysis of trends. The indicators are grouped into areas of conceptual analysis (state of health care quality, efficiency and sustainability) and are compared according to lines of care, service delivery areas, suppliers and territories.

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**Efficiency of Primary Care**

Laura Pellisé, Director at CRES, University Pompeu Fabra

It is widely known that a strong primary care drives efficiency to the whole healthcare system.

In this session, we will go through the economics of primary care in Spain and in Catalonia. Framed by a context of a major economic downturn, it will be covered the financing of primary care services, the structural and activity costs, the configuration of human resources and value for money of the first level of care. We will also have a dynamic and historic perspective to understand how primary care has evolved in the last 30 years and which the main challenges are for the years to come.
EXPERT PANEL

The Expert Panel on Effective Ways of Investing in Health of the European Commission
Prof. Jan De Maeseneer, MD, PhD, Chair Expert Panel
Prof. Sarah Thomson, MA, PhD., Member Expert Panel

Note: This panel will take place day 1 at 10.00-10.30 with Jan De Maeseneer and on day 2 at 15.00-15.45 again with Sarah Thomson.

On the 5th of July 2012, the council of ministers invited the European Commission to support the reflection process through appropriate measures, including "by facilitating the access to informal and independent multi-sectoral expert advice". An Expert Panel on Effective Ways of Investing in Health was created (Commission Decision 2012/C 198/06). The mission of the Expert Panel was to provide the Commission upon its request to give advice on effective ways of investing in health. This advice is non-binding. In autumn 2013, an open call was launched, 420 applicants were evaluated and finally 12 members, scientists from academia, research or other scientific bodies and national administrations were selected for the period 2013-2016. The members of the Panel were officially appointed and are operating under the principles of excellence, independence, multidisciplinary approach and transparency.

Actually 3 opinions are adopted, and 1 Preliminary Opinion is under public consultation (Future EU Agenda Patient Safety/Quality of Care).

On the 15th of July 2014 the Opinion on: "Definition of a Frame of Reference in Relation to Primary Care with a Special Emphasis on Financing Systems and Referral Systems" was published, after a public consultation with input of 286 contributions, from 59 organizations.

The Opinion agrees upon the following 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 care givers, 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 other: dentists, dieticians, general practitioners/family physicians, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers".

The Opinion further focuses on referral systems, as a way to contribute to quality and cost effectiveness of care. The Opinion states clearly that primary care is the preferred entry point for problems of citizens in relation to health.

Finally, the report makes a thorough analysis of financing systems, taking into account the need for equitable access. Different payment systems are analyzed, in relation to their contribution to the strength and quality of primary care.

The Opinion finally formulates some conclusions and recommendations, including research questions and strategic direction.
Abstracts of Workshop Round I - Day 1

10.45 - 12.30

Accreditation Canada International

From knowledge to action: translating evidence acquired through the implementation of standards into better practice in primary care

Representatives: Jeanette Edwards  O.T. Reg. (MB), MHA, BOT, CHE  (Author)
Jodie Taylor, Program Manager – Program Development and Innovation
Katerina Tarasova, Director – Program Development and Innovation
Contact: JEdwards@wrha.mb.ca
Keywords: primary health care, primary health care reform, accreditation, chronic disease, evidence-based practice, knowledge transfer

Purpose:
- To gain insights through practical examples of knowledge-to-action that positively impact quality, such as chronic disease management in primary care
- To explore how evidence-based approaches in primary care can benefit the provision of care across the continuum thus contributing to addressing patient flow
- To gain an understanding of the role of the accreditation process as an effective tool for translating evidence to excellence in primary care practice

Context:
Key principles of primary care, congruent with family medicine are access, continuity and quality of care. The 3 ‘C’s, communication, convenience and continuity reinforce the importance of relational based care in primary care. These key principles support better outcomes for patients. Numerous examples such as the importance of continuity in managing chronic disease exist. Health systems are increasingly stretched to meet demands of ensuring that the right care is provided, in the right place, at the right time, and by the right provider. It is, therefore, important to find the right mechanism that will transform knowledge to action.

PRiPHECi - Primary Care and Population Health for European Cities

Pim de Graaf, MD, MPH, EFPC Board member

The Pripheci workshop brings together representatives from a number of European cities, either from the municipal council/services or from primary health services. They explore the role and activities of primary care in local public health and how collaboration can be shaped.
In May 2014, the group had a kick-off workshop and now is going to dive more deeply, in choosing specific population groups (elderly, low health-literate, other), themes (like data collection and data use, certification) and the further set up of the collaboration.
The workshop participants will be challenged to focus on those groups of the population that are most in need of seamless primary care and public health, and on results and accountability.

Cities or regions from Turkey, Italy, Slovenia, Germany, Belgium, the Netherlands and Spain are taking part in the group. Further cities or representatives from primary care are invited to join.

QUALICOPC – NIVEL
Quality and costs of primary care (QUALICOPC): from research to improvement

Stefan Gress
Peter Groenewegen
Stephanie Heinemann
Willemijn Schäfer

Purpose
The QUALICOPC project is in its final stages. The main results will become available in the next few months. During the Barcelona conference we want to discuss the implications of the research for policy and practice.

Context
QUALICOPC is an international research project, co-funded by the EU, that covers 35 countries in Europe and beyond. The project focusses on quality of care from the point of view of users of care, the quality of care processes at practice level, equity in access to care, avoidable hospitalizations and costs of care. QUALICOPC has collected data through surveys among samples of GPs and their patients. There is a large variation in primary care between countries. This variation reflects the potential of improvement of the organization of primary care. Based on the results of QUALICOPC good practices and policies will be presented.

State of the art
During the symposium we will start by setting the stage of primary care in Europe by presenting an overview of the main conclusions from the project as a whole. After that we will present the improvement potential in the area of person-centered care in the participating countries and good practices in terms of primary care policies. The improvement potential relates to issues that are important for patient-centeredness – such as providing comprehensive care – and is based on the judgments of patients. Good practices describe combinations of features of primary care policy that relate to preferred outcomes, such as timely access to primary care instead of postponing needed care or visiting an ER-department of a hospital.

Format of the symposium
We propose to have three introductory presentations (study overview, improvement potential and good practices), followed by a debate. The emphasis will be on exchanging views on the improvement of primary care based on the best available evidence and tuned to the national and local contexts.
Interprof Education (EIPEN)
Interprofessional Collaborative Education: Examples of good practice

Andre Vyt, Artevelde University College and University of Ghent, Belgium
Jan De Maeseneer, University of Ghent, Belgium
Jeffrey Allen Johnson, Associate Dean, School of Health Professions, Eastern Virginia Medical School

keywords: interprofessional education, interprofessional collaborative practice

A safe, effective, and value-driven healthcare delivery system must emphasize teams of professionals working in unison to benefit patients and improve outcomes. The WHO document Call for action (2010) and the WHO Guidelines on Transforming and scaling up health professionals’ education and training (2013) stress the need for effective implementation of collaborative practice and interprofessional education in health and social care. Students are generally educated in professional silos that provide few or no structured opportunities to interact with and learn from trainees, faculty, and practitioners in other disciplines. Accreditation requirements, substantial curricular differences, and scheduling logistics all contribute to disciplinary isolation. But also there is a need for clinical institutions and health system mechanisms to be restructured so that they can underpin interprofessional collaborative practice.

The workshop will solicit discussion on the basis of statements, available evidence, and need for further evidence. Further we will demonstrate examples of good practice from expert-institutions in Europe (UK, Sweden, Finland and Belgium). It will focus on the definition and assessment of interprofessional competences, and the development and use of learning material as it is used in Artevelde University College and University of Ghent (Belgium). The Development and implementation of IPE courses is also discussed through the presentation of the initiative of Eastern Virginia Medical School in developing a 1-credit Interprofessional Collaborative Education course for 200 students representing 6 diverse graduate level programs. It will focus on how the course will enhance education and ultimately primary care collaborative practice, using case-based learning and small groups facilitated by faculty. Participants will be able to assess their own clinical practice and/or education through the IPEQS (Interprofessional Practice & Education Quality Scales). For this they can bring their laptop or pc-tablet for online access.

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ProFound
The ProFouND project - Fall prevention among older people

Wim Rogmans is secretary general of the European Association for Injury Prevention and Safety Promotion (EuroSafe) which is based in Amsterdam, the Netherlands. EuroSafe is a network of national organisations in Europe committed to prevent accidents and the promotion of safety.
The Prevention of Falls Network for Dissemination (ProFouND) is an European Commission funded thematic network working with the European Innovation Partnership on Active and Healthy Ageing. Its aim is to bring about the dissemination and implementation of best practice in falls prevention across Europe. The main objective of ProFouND is to embed evidence based fall prevention programmes for elderly people at risk of falls by using novel ICT and effective training programmes in at least 10 countries/15 regions by 2015 to facilitate widespread implementation. ProFouND comprises 21 partners from 12 countries, with associate members from 10 countries. Through these partner organisations ProFouND wants to influence policy and to increase awareness of falls and innovative prevention programmes amongst health and social care authorities, the commercial sector, NGOs and the general public in order to disseminate the work of the network to target groups across EU.

At the workshop participants will be briefed about:
- European initiatives for promoting active and healthy ageing and falls prevention;
- Why falls matter (magnitude of the issue and societal costs)
- The difficulties of putting Falls Prevention into practice
- Products and services emanating from the ProFouND project
- Falls Prevention in Primary Care; who is involved and how can we co-operate
- Active “recovery”: experiencing an evidence based exercise programme

The workshop will offer opportunities to learn from each other through interactive discussions on key topics such as the use of assessments and guidelines, the presence of the falls prevention teaching in curricula of higher education of primary care practitioners and the need for the possible creation of an EFPC Taskforce on Falls Prevention. We invite all practitioners, researchers and teachers interested in Falls Prevention to join us in this workshop.

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**Chronic Care Catalonia**

**Chronic and Integrated Care in Catalonia: a good opportunity for positioning the Primary Health Care and community social services”**

This panel could include the following issues:

- **Contribution of the Chronic Care Program within the current Health Plan 2011-2015**
  Speaker: Mr. Joan Carles Contel. Chronic Care Program at Department of Health

- **Creating a new Integrated Care model incorporating Social services: the new Integrated Health and Social Care Plan.**
• Evaluations of the 8 earlier local “Collaborative models” between primary health care and community social services.
  Speaker: Victòria Serra. Agency of Quality Health Evaluation (AQUAS)

This panel will offer the implementation experience of the Integrated Care strategy in Catalonia based on the framework of the current Health Plan and Chronic Care Program and new initiatives launched like the “Integrated health and social care Plan”, called “Pla Interdepartamental d’Atenció i Interacció social i sanitaria” (PIAISS). These initiatives act as a very good catalyser to implement change and create a new Integrated Care scenario local level reinforcing the position of Primary Health Care and other community health and social services within this new model, substituting hospital and institutionalised oriented model by another community based system. Changes in the redesign of the model are being accompanied by other changes in instrumental areas like contractual procedures, Health Information System or ICT developments to facilitate a more collaborative work beyond the Primary Health care area. Primary care organizations, teams, clinicians and other professionals have been invited to participate in this change which is oriented toward a person-centred model.

Moderator: Tino Martí. TICSalut

5.3 Abstracts of 2 Rounds of Electronic Record Systems

Catalonia
Primary Care Health Information Systems in Catalonia

Manuel Medina, ICS & Bruna Miralpeix, TicSalut

The Institut Catala de la Salut (ICS) provides more than 80% of primary care services in Catalonia. As a result, most primary care teams use the same electronic health record (ECAP) to manage their practices. ECAP is a clinical station designed for all health professionals in primary care teams and extended primary care services such as rehabilitation, women’s health or palliative care units.

ECAP keeps record of more than 6 million citizens and allows the exploitation of health data through a customized health intelligence system called SISAP.

In order to facilitate the integration of health services, the Department of Health has developed in the last decade a set of health information systems that serves all healthcare providers. These systems are concentrated in the Shared Health Electronic Record and the Personal Health Channel. Both system will be described during the session as well as further developments that are under way.
England

Lambeth DataNet

Peter Schofield PhD, ESRC / MRC Population Health Scientist
Department of Primary Care and Public Health Sciences, Division of Health and Social Care Research, Kings College London

The Lambeth DataNet - how UK primary care data can inform service development and research

The UK National Health Service provides uniquely valuable primary care data and, in this presentation, I will discuss some of the ways in which this can be used to benefit local services. I will look at how the underlying principles of the NHS, UK national policy guidelines and national and local incentive schemes help determine the kind of data that is made available and ensure the quality of this data. Local benefits will be demonstrated using examples from a number of initiatives, focussing in particular on the Lambeth DataNet, a comprehensive collection of health records covering all (approximately 350,000) patients from one borough in South East London. I will show how this data has been used to feed back to local practices, its relevance for local health equity audits and also more general health inequalities research. Lambeth has a highly diverse population, both ethnically and economically, and is therefore ideally suited to research that helps address health inequalities. A number of recent studies will be discussed focussing on cardiovascular disease and also severe mental illness.

Scotland

Toni Dedeu

Dr. Toni Dedeu. Director of Research and Exchange Knowledge. The Digital Health Institute. Scotland

The Key Information Summary (KIS)

Since 2011 Scotland has developed a new electronic health record under the key Information Summary (KIS) Programme. Currently used by more than 60% of GP practices in Scotland. On 10 October 2013 the KIS Programme was confirmed as the winner of the “Excellence in Major Healthcare IT Development” category at the eHealth Insider Awards 2013.

The Key Information Summary (KIS) is a new electronic health record developed by NHS Scotland. KIS allows important patient information to be shared with health care professionals in unscheduled care in the NHS 24, Accident & Emergency, Scottish Ambulance Service, Out of Hours, hospital and pharmacy environments, as well as in hospices, Mental Health Units and other approved Scheduled Care Departments. With people’s permission for this information to be shared, KIS will include information on: (i) Medication; (ii) Allergies and reactions to medicines; (iii) Contact details; (iv) Care plans; (v) Next of kin and carer details; (vi) Wishes or special instructions; (vii) Self management and anticipatory care plans if a person has long term conditions. A GP can create a Key Information Summary for someone if they need one and they give consent.
Why has it been developed?

The aim of KIS is to improve the sharing of key information for patients who have long term conditions, complex care needs and mental health and/or communication issues. People could benefit from a KIS if they:

- have long term conditions (especially if they take multiple medicines and see different specialists)
- need a carer or family member to help them at home
- are likely to need care at the weekend or out of hours
- may find it difficult to speak up for themselves in an emergency (because they are unwell, or because they have a communication or memory issue, a mental health issue or learning disability).

http://www.nhs24.com/Explained/MyInfoNHS24/WhatiskIS

**Sweden**

Gothenburg University

**Jörgen Månsson**, Department of Primary Health Care, The Sahlgrenska Academy at Göteborg University

**Background:** Sweden has a unique possibility to collect population data from a national perspective. We have several large population surveys based on specialties such as orthopedics, cardiology, internal medicine, etc. with applications for primary health care, but no national based quality register for the specialty general practice/family medicine. Nearly all Primary care units are computerized and an automatic collection of information from patient records is necessary for registration of the broad information needed in general practice/family medicine compared to other specialties.

**Method:** Regional activities to set up databases with collected information of primary care parameters have started some years ago based on a nationwide program for a customer based primary care system. Q-reg PV in the western region of Sweden is the most extensive regional register with 39 quality parameters in the areas of diabetes, asthma/COPD, hypertension, ischemic heart disease, mental diseases, preventive measures, pharmaceutical therapy, patient experiences and organizational structure.

In order to create a national system we have to build a national standard for collecting data from all regional systems, synchronize the registers from other specialties in a national platform for general practice/family medicine and start a register for specific areas in primary health care.

**Results:** Until 2012, a total of 250,000 individuals have been included in Q-reg PV, of which 65,000 with diabetes, 200,000 with hypertension and 45,000 with IHD. Around 40% have more than one of these diagnoses. National strategies for launching a platform for a Primary Health Care quality register, with possibilities for research in general practice/family medicine has started. Quality indicators for areas in primary care and preventive services are defined and technical specifications are ongoing.
Discussion: Creating primary care quality registers for continuous quality monitoring and research is essential for evidence based medicine, research and development of the general practice/family medicine specialty.

The Netherlands
Jan van Es Institute

Insight in the development of supply and demand in primary healthcare

Auke Vlonk, MSc, Researcher and data analyst at the Jan van Es Institute, The Netherlands

Correspondence to: Auke Vlonk, MSc. Jan van Es Institute, Randstad 2145-a, 1314BG Almere, The Netherlands, Tel: 0031-367670360, E-mail: a.vlonk@jvei.nl

In order to reach the Triple Aim of simultaneously improving quality of care, improving population health, and reducing per capita cost, a population denominator is required. Therefore, the first step is to provide insight in the expected and actual development of a defined population in terms of demography, demand for care and costs.

Current (population) trends in the Netherlands, are e.g. the increasing prevalence of chronic diseases, the promotion of substitution of care for elderly and youth from transmural settings to municipalities, ageing and a shift from fulltime working male general practitioners to part-time working female general practitioners. These developments dramatically affect the organization of (primary) healthcare.

During the workshop a number of ways of identifying the needs and demand of a defined population in primary care settings will be shown and discussed. Results of various research projects at different geographical levels (province, municipality, (within) neighbourhoods) will be presented, mostly by means of geographical maps. The projects vary from (1) identifying risk areas at the level of a province, to (2) identifying hot spots of patient groups in urban settings and (3) providing insight in the possibilities of substitution from secondary to primary care.

These research projects have been performed by public data on demographics and demand for care for all diseases. Also data about supply of care (project 1), patients (2 and 3) and costs (3) have been used during analyses. A key aspect of all projects is to predict the situation in 5 or 10 years: e.g. which patient groups will increase, where will there be lack of supply and how can we cope with those expected developments in order to reach the Triple Aim?

Belgium

Slowly but surely: the development of an effective registration network in the Flemish community health centers

Authors: Veerle Piessens M.D., Contact: veerle.piessens@scarlet.be

The Association for Community Health Centers (ACHC) promotes the interests of and provides support to the (23) Community Health Centers in Flanders (Belgium). One of the objectives of the ACHC was to establish a collective registration system containing comparative data of patients and (healthcare) staff. Following some
false starts, the project is now up and running with only a few difficulties remaining. Every year a sectoral overview is created containing data from all patients who have visited the Community Health Centers (CHC). This data overview includes demographics (sex, age, health insurance status), healthcare consumption patterns and the personnel required to effectively meet the needs of the patients. This sectoral data overview is highly valued by the community health centers. The indicators produced are extremely useful at CHC level for internal policy reflection and care management. Further, at Association level, the structural indicators form the basis for sectoral policy.

Key success factors for the registration network include: meeting the needs of the individual health centers; clear directions on what and how to register; maximizing the use of the registration network (80% of the centers use the same registration software); investing enough time and resources; the availability of a user friendly data-extraction tool and the ability to produce thematic feedback reports.

Difficulties and threats were (and still are): moving too fast (individual centers develop at their own pace); too much decentralization of registration procedures; different registration software packages or alternative ways of registration outwith the existing software package.

Portugal Sentinel system

The information and knowledge management instruments at Portuguese primary health care level: the “ID FHU” and “Health Functional Units Sentinel Network” projects

Tiago Vieira Pinto | USF-AN (Portugal), Member of Directors Board, Coordinator of the Research and Knowledge Department | EFPC, Member of Advisory Board
André Rosa Biscaia | USF-AN (Portugal), Member of International Relations Department

Key-words: primary health care; community oriented primary care; knowledge management; information management; clinical governance; family health units.

Abstract
Community Health Centre (CHC) approach have the potential to radically improve health, health care and social wellbeing by improving individual, family and community access to health services, health outcomes and equity. The core characteristics of this model of care include a team-based approach to primary health care (PHC), a holistic approach to health and health care, an emphasis on illness prevention and mitigation, a commitment to equity and social inclusion and a strong emphasis on local, community engagement and civic participation. The recent Portuguese PHC reform implemented a new model of PHC services, coherent with the CHC concept, and it is necessary to mobilize the scientific and technological potential of Portuguese Family Health Units (FHU) to endow of intelligence this massive changing process. After been validated and contextualized, the “strategic” information produced in the clinical setting should be used to support research, surveillance and health governance. With this workshop we propose a discussion about two information management instruments which are actually being developed at Portuguese PHC level: the “ID-FHU” and the “health functional units sentinel network”. The purposes of these two complementary instruments are the retirement, transformation, loading and collection of massive and useful healthcare data produced within the clinical practice. The ID-FHU is a knowledge management tool which identifies the FHU, its performance and costs in a
multidimensional and online basis, contributing to their development and continuous quality improvement. The creation of a FHU sentinel network pretends to act as a collaborative network capable of extract, collect and share relevant amounts of clinical data useful to research and epidemiological surveillance.

5.4 Abstracts of Workshop Round II– Day I

Theatre as a tool of narrative medicine: Is there any way to use in primary care

Mehmet Akman MD, MPH, Marmara medical school department of family medicine, Istanbul Turkey, Turkish Family Medicine Foundation

Çağrı Kalaça, MD, SB Group, Istanbul Turkey, Turkish Family Medicine Foundation

Scope:
Narrative Medicine connotes a medicine practiced with narrative competence and marked with an understanding of the highly complex narrative situations among doctors, patients, colleagues, and the public. Family Physicians can define disease and illness, and manage healing process better by having a deeper understanding of individual differences, developing their thinking and language skills through arts, particularly acting in simulated environments. If it is used for educational purposes, art can have instrumental (better recognition of visual signs, developing skills to deal with uncertainty, etc) and non-instrumental (personal development, new ways of thinking beyond biomedical perspective, etc) functions.

Purpose:
General aim of this workshop is to explore possible fields in primary care where art (or theatre as a focused example) can be used as a tool to reach better outcomes, especially to enhance patient centred care in primary care settings. Theatre could be a bridge between human sciences and primary care. This workshop aims to increase the awareness about art and theatre, being a good way to understand ourselves and our patients better. During the workshop participants will have chance to share their own experiences regarding theatre and primary care.

Main topics that should be covered during workshop are:

- **Use of “art” in vocational training:** Enhancement of student well-being, improvement of clinical skills, allowance of time and space for reflection and contemplation and insight what it means to be a doctor, dealing with issues like death, dying and ethical dilemmas etc.
- **Power of Art, Abstract thinking and reflection:** using drama in primary care settings may create a stimulating environment for the primary care professionals to express their feelings and thoughts regarding different aspects of human nature and themselves in a reflective manner.
• **Art as a tool to learn how to deal with uncertainty:** Handling values rather than facts, ambivalence rather than reductionism, dealing with a world where not everything can be explained by experiments.

• **Art as a tool to empower developing a patient-centred, biopsychosocial approach.** Fine tuning biopsychosocial approach by expressing personal feelings and thoughts during drama simulations.

### Implementing the learning health care system

Robert Verheij, Di-Janne Barten, Karin Hek, Mark Nielen, Marijn Prins, Marieke Zwaanswijk, Dinny de Bakker, Irina Stirbu-Wagner, Jacqueline Tol

**Background**

As computerization of primary care facilities is rapidly increasing, a wealth of data is created in routinely recorded electronic health records (EHRs). This data can be used to create a true learning health care system, in which routinely available data are processed and analysed in order to enhance good clinical practice as well as to enable responsible decision making in health politics. This workshop focuses on how to *unleash the potential value of EHR data to create a learning health care system.*

In this workshop we will use NIVEL’s government funded Primary Care Database as an example, where routine health data from multiple primary care disciplines (GPs, out of hours services, psychologists, pharmacies, physiotherapists) pertaining to 1.2 million individual patients listed in ~400 GP practices, are linked and analyzed, thereby creating valuable information on the use of health services, quality of care and developments in public health.

This information is used for policy making by the Ministry of Health, health care insurers and professional organizations of health care providers that form the political landscape. Second, by providing valuable feedback information to participating health services that can use it in negotiations with health care insurers. And third, by making the underlying data available for secondary analyses by qualifying researchers under the condition that all research outcomes become available in the public domain.

**Learning goals**

Participants will learn how we 1) gained trust and awareness of mutual benefits in relevant parties; 2) dealt with privacy issues; 3) attained a viable governance structure, giving control to relevant parties while also allowing access to anonymized data by other parties; 4) dealt with data quality issues; 5) linked data from various primary care disciplines; 6) present relevant research outcomes in an accessible way so that they can be used for health policy; 7) provide relevant feedback information for participating health practices.
Expected impact on the participants
Participants will learn how routinely available electronic health record data can help to promote good clinical practice and to enable responsible decision making in health politics. This will help participants to develop similar initiatives in their own local/national situation.

Mental Health EFPC WG, PRIMHE

Henk Parmentier, General Practitioner UK/Netherlands, Edridge Road Community Health Centre, Croydon Board member Wonca Working Party on Mental Health

Jan De Lepeleire, MD, PhD, General Practitioner, KU Leuven - University of Leuven

Purpose: This workshop will provide you an update / state of the art concerning Mental Health in Primary Care in Europe. You will be able to envisage future developments and see how your practice/policy would be fit for these future developments

Context:
1. After the Istanbul workshop we want to further elaborate on the issue of problems and important issue in the organization of mental health care in your country. Especially the many reforms that are ongoing in different countries are of a potential high interest. What can we learn from each other and how are we tackling these problems?

2. A second, related issue, is the urgent need for research and action on the somatic health and quality of life of all those living with mental illnesses (Hermann, 2014). What are barriers and solutions for this crucial element in the organization of mental health in Europe?

3. Pharmaceutical care and (new) drugs are important. But in several countries we see an overwhelming use of psychofarmaca with a lot of important side effects and pressure on the prognosis and outcome of the patient. How are we handling psychofarmaca in daily care and what should we take into account at the primary care level?

4. DSM-V is published. Is this a workable tool in primary care or should we take another point of view? Is there an alternative for this updated classification

Format of the workshop:
In this workshop concerning Mental Health in Primary Care we want to discuss these four topics after short introductions. The changes in Mental Health care provision are compared throughout Europe, seeking the input of participants likewise the previous sessions in Istanbul and Gothenburg
Triple Aim explained
Marc Bruijnzeels
Marc Bruijnzeels, Director Jan van Es Instituut, m.bruijnzeels@jvei.nl
Marc Bruijnzeels, Randstad 2145A, 1314 BG Almere, 036 767 0360, info@jvei.nl
Keywords: Triple Aim

Most western countries, like the Netherlands, have to deal with developments like an ageing population, growing prevalence of chronic diseases, increases of prices and the progress of medical technology. Regarding those developments, it will be a great challenge to reach the Triple Aim of simultaneously improving the experienced quality of care, improving population health, and reducing per capita costs. However, recent developments in for example the United States have shown that the Triple Aim can be achieved.

Achieving the Triple Aim requires some mind shifts. First of all, the focus is on the experienced quality of care instead on cost-effectiveness. The idea is that by improving experienced quality of care also the health of a defined population will improve and costs will decrease. Secondly, the focus has to shift from disease management to wellbeing, health and happiness of the patients/population. Most care is oriented at diseases and patients with the same condition get the same intervention, while the aims, needs, underlying problems (also regarding housing, work and environment) and degree of self-reliance may differ. Interventions do not start with professionals, but with patients. Triple Aim is about ‘what matters to you’ instead of ‘what is the matter’. Thirdly, Triple Aim does not aim at the current presence of diseases only, but especially aims at predicting future risks of e.g. avoidable secondary care readmissions and excessive use of medication.

Considering the developments and shifts described above and the decentralization of elderly and youth care in the Netherlands, it is even more necessary to integrate care and wellbeing. Nowadays they are still too fragmented. This causes lack of alignment which is not effective. To find innovative and effective interventions the Triple Aim framework seems very promising. During the workshop the Triple Aim approach (7 steps) of the Jan van Es Institute will be presented. The approach will provide you with the necessary steps to reach effective and sustainable care.

Catalan Scientific Societies
Primary Care Teams in Catalonia: a view from professional societies

Dr. Antoni Peris, CEO at CASAP
Dr. Dolors Forés, President of the Catalan Society of Family Physicians - CAMFIC
Judit Bellostes, Catalan Society of Family Nursing - AIFICC
Margarida García, Catalan Social Workers Official College - COTSC
Catalonia Primary care services are organized in teams. These include diverse professionals such as clerks, family physicians, nurses, nurse aids, dentists, pediatricians and social workers. Along three decades our public health system has evolved increasing accessibility and resolution. So have professions evolved, being now responsible for new issues that had been previously developed either by hospitals or by other primary care professionals.

Primary care services rank high according to population satisfaction surveys. Nevertheless we still may improve a lot in accessibility, developing strategies linked to new techniques.

Main problems are fragmentation considering there’re parallel networks taking care of women’s health, mental health and palliative care and also a uneven budget that doesn’t acknowledge primary care developments and still favors hospital services.

The session includes short presentations of scientific societies working in primary care and an exchange of points of view with the participants to the debate.

**EuroHealthNet**

*From repair to prepare - Developing joint approaches against Health Inequalities*

Clive Needle (c.needle@eurohealthnet.eu), Policy and Advocacy Director EuroHealthNet

Hubert Jamart, Permanent politique à la Fédération des maisons médicales,
Chair of the Alliance for Community-Oriented Primary Care (ACOPC).

Europe is facing some major societal challenges. The increase in chronic diseases coupled with the ageing population, the economic crisis and persistent health inequalities demand that we reconsider the traditional boundaries of health care systems and embrace new approaches. Health and healthy behaviours are determined by a range of factors which can be personal, environmental, economic and cultural. Holistic models should therefore be explored to address the complex challenges that Europe is facing while maintaining the basic principles of equitable, accessible, and sustainable community-based health services.

The overall aim of this workshop is to present and discuss successful models of multidisciplinary health services that emphasize health promotion as well as primary care at community level, that promote patient empowerment and that take whole, as well as disease-specific approaches to the treatment and management of ill health and while addressing the underlying socio-economic conditions to disease and ill health. The aim is to investigate how such health services can be best promoted and scaled up to address more upstream determinants of health, to be more responsive to the needs of people with chronic conditions and thereby lead to lower levels of health inequalities and to cost-savings across health and social services. In addition, the workshop will present the EU policy environment for work on innovative and sustainable health systems; on improving the health of EU citizens and on enhancing people’s capacities and participation in society.

Key questions to be addressed during the workshop:

- What are the success factors and obstacles to successful community-based multidisciplinary approaches, health promotion and prevention?
- How to reach the most vulnerable people?
- How to develop the evidence base required by policy makers while working at a local level?
- What is the EU policy framework for more (cost-)effective, adequate and sustainable spending on social and health measures?
- What opportunities and challenges does this new policy framework bring about for the public health and primary care communities?

### 5.5 Abstracts Invited Professional Sessions – Day 2

#### EFAD- European Dietitians

Maria Magnusson PhD, RD specialized in Public Health, RN, Unit of Public Health Epidemiology, Institute of Medicine, Sahlgrenska Academy, University of Gothenburg and

Health Equilibrium Initiative, Angered Hospital

**Dietician’s role in Primary care and public health in Sweden**

The work of the dietitian is based on the science of nutrition and the fundamental human need for energy and nutrition. To have one’s energy and nutritional requirements fulfilled is an undisputed human right. Swedish dietitians have professional registration. The Swedish National Dietetic Association of clinical dieticians, DRF, regards Primary care (PC) as a highly important work area, from a clinical as well as a public health perspective. Competence in food and nutrition is pivotal for the treatment of many diagnoses as well as for evidence based guidelines and practice in the fields of health promotion and prevention.

The Swedish National Board of Health and Welfare has through national guidelines for methods of preventing disease provided recommendations on how to support patients to change unhealthy lifestyle habits with specific focus on four areas: unhealthy eating habits, insufficient physical activity, hazardous use of alcohol and tobacco use. From a public health perspective unhealthy eating habits are identified to be most urgent habit to address. However, unhealthy eating habits are the field, which today is least invested in. All professionals within the health care system shall, at every level, address these four lifestyle habits. In 2013 DRF established a project group working especially with this issue. There are substantial discrepancies between Swedish regions regarding their investments to make dietician’s competence obtainable to the public. The mean of the five “best” regions is 26 000 inhabitants per PC-dietician, the mean of the four at the bottom is 147 000 inhabitants per dietician (only four in this numeration since one of the five “worst” did not have any).

In Sweden, as in all of Europe, there is a considerable inequity in health. Within public health work and health care, skilled staff representing a range of competencies - including dieticians – in inter-professional teams is a necessary condition to narrow the health gap. Otherwise there is a risk of intervention generated inequalities, on top of the ones formed by other mechanisms.
The Dietitian-Nutritionist in public health Primary Care in Spain

Author: Cèlia Puig, Dietitian-Nutritionist (RD), Unit of Diabetes, Endocrinology and Nutrition (UDEN), Hospital General de Granollers, Barcelona.

The public health primary care centers are the basis of health care activities for prevention and health promotion. Most chronic diseases can be prevented and/or treated by dietary intervention involving a multidisciplinary team (doctors, nurses, pharmacists, psychologists and dietitians).

The work of the clinical dietitians complemented the function of the doctor and nurse in the assessment, treatment, follow-up and evaluation of nutrition related problems, help in the daily management of patients, reducing waiting time and improving coordination between health professionals. Therefore, an appropriate dietary intervention can lead to social and economic benefits, with a substantial reduction in healthcare costs, since dietary treatment cost is affordable and economical, so opting for inclusion of dietitians in Primary Care (PC) is an investment in health.

Health systems of many countries already include registered dietitians as agents in charge of handling dietary aspects of the population with a positive integration into interprofessional teams. But, although the importance of nutrition in PC is recognized and accepted, there are few experiences and studies in Spain that assess the dietitian’s role in this area, because the position of registered dietitians is not available on the Spanish National Health System yet. Currently, dietitians work mainly in private health, which causes inequality in health access. While the dietitian’s role in hospital is becoming regular in some Spanish regions, there are a very little dietitians in PC, which is why the General Council of Dietitians-Nutritionist of Spain is working hard for improve the dietitian’s role in public health, especially in PC. In fact, as Professional Organization of the Spanish Dietitians, has required to national and regional Ministries of Health, to establish at least one PC-Dietitian per 50 000 inhabitants.

COTEC/ENOTHE

Occupational Therapy through all levels

Marije Bolt is a member of the Advisory Board of the EFPC. She is occupational therapist and works in a private occupational therapy practice in Amsterdam, called Ergotherapiepraktijk Doen. Contact information: marijebolt@ergodoen.nl

In this parallel session the contribution of occupational therapy (OT) in primary care will be presented. In many countries OT’s work mainly in hospitals, nursing homes and rehabilitation centers. This "institutional type" of OT differs from the client centred, context based occupational therapy in primary care. In this session the benefits of OT for primary care in general will be presented and the current situation and challenges in several european countries will be discussed with the participants.

OT’s are united in Europe in ENOTHE and COTEC. The session will provide brief knowledge about how to
use these organisations if you are a practitioner, researcher or policy maker. 
So join this session, if: you are not familiar with OT or if you want to know more about OT and how OT can influence wellbeing by meaningful occupation in primary care

www.cotec-europe.org
www.enothe.eu

**EuroPharm Forum**

**Differences between efficacy and effectiveness in medication use - need for interprofessional collaboration**

Balázs Hankó PhD. vice president EuroPharm Forum

It is well known and studied that drug related problems are major challenges of health systems in many aspects. This “pharmaggedon” effect is multifactorial, including increasing Over The Counter medicine consumption, growing elderly population, low health literacy aspects, non-adherence, polypharmacy etc.

To cope with this challenge the concept of pharmaceutical care was introduced. Pharmaceutical care is the pharmacist’s contribution to the care of individuals in order to optimize medicines use and improve health outcomes. In pharmaceutical care process multidisciplinary approach is desired. Many researches and country examples showed the added value of this activity.

The workshop will highlight the core elements of interprofessional elements of pharmaceutical care, and will invite members to discuss i) different country models; ii) barriers of pharmaceutical care implementation iii) collaborative elements of health care professionals in pharmaceutical care.

**WONCA/UEMO**

**Anna Stavdal** has been a GP in Oslo, Norway for 25 years.
She is also Assistant Professor at the Department of General Practice at the University of Oslo. She has been the chair of the College of General Practice in Norway, she was the first president of Nordic Federation of General practice, and she is now the vice president of WONCA Europe. 
Zsuzsanna Farkas Pall assists in this workshop.
Zsuzsanna is a General practitioner, University assistant, Department of family medicine, Faculty of medicine and pharmacy, University of Oradea
The presentation of the GP will start with an introduction to core values and working method in general practice. We will also shed light on the differences in how general practice is carried out, depending on different factors:
What is the role of the GP in the Primary Care Team? How do external factors like working conditions, infrastructure, the character of the health care system, language and culture influence the role of the GP in different parts of Europe?
Are there significant differences between general practice in urban and rural areas within the same country?
The presentation will aim at showing general practice with concrete examples, and will have the form of dialogue between the presenters.

HW4ALL
Migration of health workers in Spain: who's going to take care of us in the future?

Carlos Mediano Ortiga, medicumundi, Coordinator in Spain "Health workers for all and all for health workers", Spain

Full contact details corresponding author(s): email: federacion2@medicusmundi.es

Keywords: Health workers, migration

Purpose: Description of migration of health workers in Spain, its consequences and solutions

Context: The critical shortage of health workers is a global problem, not only in developing countries, and we need global solutions, as the WHO Code of practice of international recruitment of health staff

State of the art: The European Commission estimates that there will be a shortage of one million health workers by 2020 in Europe. In Spain the deficit by 2025 will be a 14% of doctors.

Statements for debate: what Spain and Europe must do to face the shortage of health personnel? How can we do to implement the Code of WHO?

European Midwifery Association

Operational framework and practical implications for community midwifery of the Lancet’s Series (June 2014)

Dr Victoria Vivilaki, RM PgCert MMedSc PhD, Lecturer at Midwifery Department TEI Athens, GREECE

Franka Cadée, midwife & international policy advisor & twin2twin coordinator, Koninklijke Nederlandse Organisatie van Verloskundigen (KNOV)
The Series— that comprises four separate papers— and provides a framework for quality maternal and newborn care (QMNC) that firmly places the needs of women and their newborn infants at its centre. It is based on a definition of midwifery that takes account of skills, attitudes and behaviours rather than specific professional roles. In that context, the quality agenda for maternal and newborn health is only now slowly starting to emerge. In Netherlands and Greece, the quality of care debate has often focused on informed choice, without addressing the other aspects of quality maternal and newborn care. This has resulted in a focus being on relatively “quick fix” technical and so called “cost effective” solutions while ignoring the more difficult longer term task of building quality perinatal health that include preventive and supportive care that upholds the midwives values and attitudes required for delivering it. The discussion would be about the unexploited potential that the evidence from Series shows, for improving outcomes for women and newborn infants through collaborative practice in primary care.

European Board for Certified Councilors (EBCC)

Counseling as an element in the multidisciplinary world of the primary care- An European experience

Dr. Andreea Szilagyi, Vice President, EBCC, European Board for Certified Counselors, www.europeanbcc.eu

The presentation is focused on the counseling profession as a possible missing link in the context of the primary care multidisciplinary efforts in Europe. The author offers an introduction to the profession as well as the presentation of EBCC (European Board for Certified Counselors – www.europeanbcc.eu), which helps coordinate and foster certification, training and professional development in the region. EBCC encourages the national offices in Europe to work together to create valuable educational programs in areas of specialization such as career counseling, school counseling, mental health counseling and others that are most useful to countries’ specific needs. EBCC also supports the national offices as they work together on European and other international projects and create relationships with public and private institutions, including ministries, universities, counseling associations, businesses and other institutions interested in developing counseling programs and services. Another topic covers the main programs offered by EBCC. GCDF, as a portable certification program for career consultants - www.europeanbcc.eu/gcdf, is an option for policymakers when they are trying to develop programs that provide career development services. It is engineered to be flexible to meet country-specific needs. The MHF, with a focus on building access to community-based mental health care, was created and implemented as part of the global effort to offer first response mental health support in communities (Mental Health Facilitator www.europeanbcc.eu/mhf).

EBCC is present at the moment in Bulgaria, Cyprus, Germany, Greece, Hungary, Macedonia, Portugal and Romania, and it has as main objective to mentor national leaders, advocate for the profession, and support European countries in their efforts to develop a strong counseling profession - in a collaborative, multidisciplinary regional and global context.
ICHPO, Allied Health Professionals

Dr Jacqui Lunday Johnstone, Chief Health Professions Officer [Scotland] and ICHPO convener.

The International Chief Health Professions Officers (ICHPO) group is comprised of chief officers from government health departments across the international community, who have a policy and development role for allied health. The formation of the ICHPO group was in response to a commitment made at the 2005 AHP conference “Impacting on World health” –to establish an international network to engage and support AHPs contribution to the world health agenda and build opportunities for international collaboration.

The ICHPO now works in partnership with government health departments and allied health bodies to host an annual international conference. Conferences so far have been held in the European, North American and Pacific regions and this year’s conference will be hosted by Malaysia. The ICHPO is also working in partnership with WHO to support their disability and rehabilitation agenda and has formed strategic alliances with Handicap International and the European Forum for Primary Care.

ICHPO is seeking to grow representation across the six WHO world regions and to date member countries include: Australia, Belgium, Canada, Denmark, England, Hong Kong (SAR), Malaysia, Malta, Namibia, New Zealand, Northern Ireland, Scotland, Singapore, Slovenia, South Africa, Southern Ireland, Sweden and Wales.

5.6 Abstracts Invited Workshops– Policy Debate Session – Day 2

10.00–11.00

EFPC/ECDC

Effective primary care for Roma patients and population

Pim de Graaf, MD, MPH, EFPC Board member
Dr. Irina Dinca, Senior Expert, Public Health Capacity and Communication, European Centre for Disease Prevention and Control (ECDC)
Dr Danica Rotar, PhD, University of Ljubljana, Slovenia
Barbara Cottenie, Roma Mediator, City of Ghent
Sara Willems, University of Ghent, Belgium
Lise Hansen, University of Ghent, Belgium
Keywords: Roma, health literacy, access, primary care

This session discusses challenges and successful approaches by practitioners,
managers and policy makers to provide quality primary care to their Roma patients and communities in European countries.

For practitioners (GP’s, nurses, social workers, others), tools and policies exist to improve access to the consultation room and to develop an interaction with Roma patients that is effective in addressing the patient’s complaints. Building on the previous workshop with a role play on effective communication between care-providers and patients with low health literacy, this workshop explores further how access to health services in the community can be enhanced. Several experiences, amongst others by the WHO, will be reviewed. The perspective of Roma organizations will be presented as well. Plans and needs for further research on health needs and health services are discussed.

**WHO Geneva**

**Health for the World’s Adolescents**

Valentina Baltag, MD, MSc, PhD, Technical Officer, Adolescent Health, Department of Maternal, Newborn, Child and Adolescent Health
Cluster for Family, Women’s and Children’s Health, World Health Organization

An adolescent competent primary care workforce: challenges, opportunities and country action
What must we do to improve and maintain the health of the world’s one billion adolescents? The World Health Organization (WHO) report Health for the world’s adolescents: a second chance in the second decade, launched in May 2014, addresses that question across the broad range of health needs of people ages 10–19 years. The report highlights that progress in meeting the health-care needs of the world’s adolescents will require renewed attention to the education of primary care providers – the workforce that is central to ensuring universal health coverage for the world’s adolescents.

The presentation will focus on the current challenges and progress made in countries to improve workforce capacity to provide adolescent responsive health care services. Data from the global consultation with primary care providers for the WHO report will be presented. Based on a recent work of WHO, core competencies in adolescent health care and development in primary care settings will be outlined. Finally, actions necessary to make the transition from adolescent-friendly projects to adolescent-responsive health systems will be highlighted using the web-based report as a dynamic tool to support policy development.

**BMC Family Practice**

**Meet the editors of BMC Family Practice & Quality in Primary Care**

Christos Lionis MD PhD FRCGP(Hon), Professor of General Practice and Primary Care Head of the Clinic of Social and Family Medicine School of Medicine University of Crete
Niro Siriwardena, Professor of Primary and Prehospital Health Care and Director of Community and Health Research Unit, School of Health & Social Care, University of Lincoln

Academic peer reviewed publication is an important vehicle for presenting research and policy on future primary care. The presenters, based on their experience as researchers, reviewers and editors, discuss current processes of peer review for academic journals and discuss how authors should prepare, present and submit their work and how they should respond to reviewers and editors to maximise their chances of publication. Common pitfalls when research in primary care and family practice is reported will be highlighted by the presenters. There will also be ample opportunity for questions and answers which will make this session fully interactive for delegates.

ZonMw
Primary Focus
ZonMw, The Netherlands Organisation for Health Research and Development

Arthur Eyck MA MSc, Programme Officer Academic Collaborative Centres Public Health / Primary Focus (+eyck@zonmw.nl; 31-(0)6-46 59 19 71)
Saskia van den Toorn, Programme Officer Primary Focus (toorn@zonmw.nl; +31 70 349 52 53)

Jan Joost Meijs MD, Director of Community Health Centre De Roerdomp in Nieuwegein (The Netherlands) Karen de Groot MSc, Project Manager Primary Care, Community Health Centre De Roerdomp in Nieuwegein (The Netherlands)
Karolien van den Brekel-Dijkstra, MD, PhD; General Practitioner, Consultant Prevention, Julius Health Centers, Utrecht

As our societies change, we recognise that the traditional fragmented setup of the primary care is not really suited anymore for addressing the current and future health challenges as long term conditions, care for the frail elderly, mental health issues and care for marginal and deprived groups. Collaboration within primary care and across domain borders is considered to be crucial in addressing these challenges. In order to address these issues the Dutch Ministry of Health commissioned ZonMw, the Netherlands Organisation for Health Research and Development, to develop a programme.

The ZonMw Primary Focus programme is developed to help strengthen the organisation of primary health care through innovation and entrepreneurship. This should ensure that, in future, local care is based more on the health status and the need for care in the local population; this includes prevention and the connection with social services.
The programme should stimulate:
• further improvements in existing collaboration
• new collaboration
• enhancement of our knowledge of collaboration in primary health care (effectiveness, efficiency, genesis, preconditions)
• improved access to knowledge and experience for a broad target audience

Over the years, some 70 practice projects have experimented with a wide array of approaches to foster collaboration, accompanied with research to learn from these live experiments.

Nearing the end of the programme, we want to share and discuss experiences and insights from our programme. In order to stimulate the discussion, we will provide the opportunity for two practice projects to present their projects. Both projects have adapted a holistic approach looking at their patients in sub-urban areas. One project focuses on a more pro-active approach towards lifestyle and prevention and the other one established active links between the community health centre and social work in order to stimulate participation and well-being of their patients.

The experiences and insights of the projects will be the starting point for a discussion on ways to stimulate the development of robust and sustainable primary care arrangements that are responsive to the needs of the community, the health care provider and society as a whole.

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5.7 Abstracts of Workshop Round III- Day II

"Do I understand what you mean'

Workshop and role plays on communication skills and low health literacy with focus on Roma patients.

Marga Vintges, MD, Pharos, Centre of expertise on health disparities + a trainer/actor

Keywords: communication skills, health literacy, self-management, cross-cultural

Summary: A role play with a GP and patient-actor in a consultation room setting shows the barriers to overcome and techniques to ensure mutual trust and understanding and optimal patient comprehension. Participants will observe and discuss examples of communication between care providers and patients with low literacy.
**Background:** Limited health literacy is a challenge in all European countries. The European Health Literacy Study (2012, HLS-EU), calculated that between 25% and 50% of populations is experiencing difficulties to obtain, process and understand basic health information. Among vulnerable groups, such as low income groups this often is higher. Causes might be divers, from lack of schooling to cultural or language barriers and misunderstanding of the health care system. Low health literacy leads to poor health outcomes, due to failing compliance, bad self-management, or lack of awareness of prevention measures. Mutual understanding is a necessary tool to achieve equal health outcomes for all patients, and despite language or cultural differences, health providers must communicate in ways that all of their patients can understand.

**Network on PC to the European Medicine Agency**

Isabelle Moulon, Head of Patients and Healthcare professionals department, EMA  
Walter Marrocco, GP- Scientific Coordinator of FIMMG (Federazione Italiana Medici di Famiglia)  
Pieter van den Hombergh, Scientific lecturer at Family Medicine Training Institute, Academic Medical Centre Amsterdam

Primary Care Professionals and the European Medicines Agency have a shared goal to protect public health by using medicines rationally and safely and to achieve better health outcomes for patients and users of medicines.

**Starting points in our future collaboration are:**

1. Primary care professionals including Family Physicians are a key resource

2. Both professionals and patients benefit from safe and effective medication being integral part of a treatment plan within a personal relationship between patient and health professional.

3. There is an identified need to collect clinical practice data on medication that support regulators in improving medication safety and effectiveness. Regulators need policy research to gain a better understanding of the regulatory decisions’ impact on clinical practice

The Primary Care network will support the work of the EMA Health Care Professionals Working Party in three of its’ four main tasks:

1. Support the Agency to gain a better understanding of how medicines are being used in real clinical practice and how EU regulatory decisions impact clinical practice as well as how the Agency can best communicate with healthcare professionals to support their role in the safe and rational use of medicines;  
2. Contribute to the Agency’s scientific work intended to continuously improve benefit-risk assessment of medicines throughout their life-cycle;  
3. Enhance healthcare professionals’ organizations understanding of the mandate and work of the Agency and of the EU Regulatory Network.
The Potential areas of collaboration could be based on:

- European Network of Centres for Pharmacoepidemiology and Pharmacovigilance (ENCePP) in generating robust evidence of public health of medication.
- Practical implementation of the guideline on post-authorisation safety and efficacy studies
- Best practice regarding the education material in the context of the effectiveness of risk minimisation measures
- Impact of pharmacovigilance looking particularly at behavioural changes and health-outcomes

In this workshop, with Ms Isabel Moulon as representative of the EMA Health Care Professionals Working Party, the EMA will present both itself and its expectations towards the Primary Care professionals. Based on this introduction two EFPC members, who have been involved from the start in this collaboration, Dr Walter Marrocco and Dr Pieter van den Hombergh, will reflect on this introduction and present their view, partly also based on their experiences so far with EMA. Subsequently the audience will be invited to reflect on how to gain as much as possible from this new initiative. Ultimately this could lead to a new European Forum for Primary Care Working Group which acts as a network on Primary Care to the European Medicine Agency.

QUALICOPC
Crossing Europe: the national perspective on primary care based on an international study

Chairs of the workshop: Wienke Boerma and Willemijn Schäfer

General introduction to the workshop
The QUALICOPC (quality and costs of primary care in Europe) study is designed to compare primary care between multiple countries and evaluate the performance in terms of quality, costs and equity. To this end, surveys were held among General Practitioners and their patients in 34 countries. On the basis of this large database, comparisons are being made on the performance of primary care between countries. Moreover, national coordinators who collected data in each country, are working on more in-depth studies related to issues which are currently important in their national setting.

This workshop provides insight in the current topics which are studied in Finland, Turkey, Austria, Greece and Germany on the basis of the Qualicopc database.

Own GP for everybody – true or only a dream?
A cross-sectional study within the framework of the QUALICOPC-Finland
Elise Kosunen¹, Tuomas Koskela², Kari Mattila³
¹ Professor of General Practice; ² Senior Lecturer in General Practice; ³ Professor of General Practice (emeritus)
School of Medicine, University of Tampere

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**Background:** Primary health care in Finland has suffered from shortage of doctors. Long-term commitments to GP positions are getting rare which may deteriorate particularly care of chronic diseases.

**Aims:** We studied how many and what kind of patients have an own doctor in these days.

**Methods:** Within the QUALICOPC study in Finland, data were collected from 1196 patients in connection of their visit to a health center (index visit). A field worker of the QUALICOPC study asked patients to join the study and patients completed the questionnaires after their visit to a GP.

**Results:** Around two thirds of the patients (68.5%) reported that they have an own doctor whom they first consult when having a health problem. No significant difference was found by gender or by educational status. Percentage of those who had own doctor rose by age: among the youngest (< 30 years) the figure was 38.0 % while it was 83.4% among those aged at least 70 years. Patients with at least one chronic disease had an own doctor more often than those who had no chronic disease (71.3% vs. 62.1%, p=0.002). Of patients with chronic disease, 82.5% had reached their own doctor at the index visit. One third of those patients who described their general health status as poor, did not have an own doctor.

**Discussion:** Reports of having an own doctor were highest among those who probably were most in need, thus among the eldest patients and among those had a chronic disease. However, a remarkable proportion of population, even of those who do not feel well or have a chronic disease, do not recognize a primary care doctor of their own which may have harmful effects on their health and well-being.

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**Primary care in Turkey in terms of Coordination and Accessibility: A cross-sectional study within the framework of the QUALICOPC project**

Mehmet Akman, Sibel Kalaça, Mehmet Sargin, İlhami Ünluoğlu, Mehmet Uğurlu

**Background:** During the last decade comprehensive health reforms was conducted in Turkey including the introduction of family practitioner scheme. The aim of this analysis was to assess coordination and accessibility primary care services in Turkey after one year family practitioner scheme was introduced nationwide.

**Methods:** Within the QUALICOPC study data collection took place by using a standardized questionnaire for GPs and patients. Out of 700 contacted 300 GPs and 2623 of their patients accepted to participate. Statistical analyses included descriptive statistics.

**Results:** Female participants were 61.2% among patients and 31.8% among GPs. On average there were 3647 patients on GP patient lists. Average number of patients seen and home visits done by GPs per day were 62.0±16.0 and 3.82±6.5 respectively. Among the primary care centers, 15.1% was open at least once a week after 6 pm. 70.6% of the patients did not know how they can receive primary care service after office hours. 73.6% of the patients waited less than 15 minutes to see their GP and 88.3% of the patients reached their GPs in less than 20 minutes. 8.4% of the GPs reported that mostly patient files are send to them from the previous doctor. For referrals, 43% of the patients reported to be referred with regard to GPs decision and 38% reported their GPs inform the specialist they refer to.

**Discussion:** Accessibility of primary care services in Turkey seem to be satisfactory during office hours but insufficient after office hours. Since GPs do not have gate keeping function in Turkey, there is lack of coordination predominantly between primary and secondary care.
Primary health care teams – How prepared is Austria? A cross-sectional study within the framework of the QUALICOPC project
Kathryn Hoffmann, Katharina Süß, Manfred Maier

Background: The challenges for primary care physicians to deliver patient-centred, community-oriented, coordinated, and continuous care become more and more demanding. Primary care teams seem to be a possible answer to meet the needs of all stakeholders involved. The aim of this analysis was to assess the scope for primary health care teams in Austria.

Methods: Within the QUALICOPC study data collection took place by using a standardized questionnaire for GPs. A stratified sample of 3.050 general practitioners was invited to participate. Statistical analyses included descriptive statistics.

Results: Data from 164 out of 184 returned GP questionnaires were used for this analysis. 89.6% had a single handed-practice, 6.1% (n=10) worked together with other GPs, 2.4% (n=4) with one specialist, and 1.8% (n=3) with both. Further, GPs worked together with secretaries (93.3%; n=153), nurses (25.6%; n=42), and physiotherapists (9.1%; n=15) mainly. Seven GPs had no co-worker, 62.8% (n=103) one, 26.8% (n=44) two, 4.9% (n=8) three, and 1.2% (n=2) four. Predictors for both having a group practice (OR 7.7) and for working in a team (OR 4.2) was an age younger than 46 years, being a male (OR 2.9), and having the practice in a rural area (OR 2.5).

Discussion: The vast majority of the GPs in Austria still work in single-handed practices, however, teams consisting of one GP, a secretary at the desk and, at least, one additional primary health care professional exist in approximately 1/3 of the cases. The predominant factor for the implementation primary care teams seems to be the age of the GPs.

The Greek Primary Health Care (PHC) services: Presenting patient experiences as recorded in the QUALICOPC study.
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2 Greek Association of General Practice 3 Markopoulo Health Center, 4 Thera Health Center, 5 Litochoro Health Center, 6 Prinou Health Center, 7 Trikala Health Center, 8 Simopoulo Health Center

Background: The Clinic of Social and Family Medicine, University of Crete in cooperation with the Greek Association of General Practitioners represented Greece in the QUALICOPC project. This abstract presents the most significant results from Greece.

Study population and methods: A cross-sectional observational study with a duration of eight months was carried out from February to October 2012. Two-hundred and twenty General Practitioners (GPs) were randomly selected from all seven Greek Health Care Prefectures. Each participating GP asked nine of his/her patients to complete an anonymous questionnaire designed by the QUALICOPC partner Consortium that was translated into Greek language. The aim of this questionnaire was to elicit information regarding patients' experiences using the Greek PHC services.

Results: One thousand nine hundred and sixty four patients participated in the study (56% females, 44% males). Mean age was 52.7 ± 16 years (54.6 years in males, 51.2 in females; p<0.0001). Fifty-nine percent (n=792) reported suffering from at least one chronic illness. Twenty-one percent (n=409) described their
health status as very good, 38% (n=750) as good, 32% (n=617) as fair and 9% (n=178) as poor. Eighty-one percent of patients (n=1576) stated that they had their own personal doctor. Twenty-five percent (n=475) reported visiting or consulting a GP five times or more in the last six months, 29% (n=545) two to four times, 21% (n=405) once and 24% (n=446) none. The most frequent reason of visit to the GP was to obtain a repeat prescription (45%), followed by illness (37%), medical check-up (22%) and for a referral (11%). Regarding their latest visit to their GP, 49% of patients (n=961) stated that the GP did not have their medical records at hand during examination, 17% (n=330) that the GP did not take sufficient time, 12% (n=228) could not understand what the GP was trying to explain and 26.5% (n=524) reported not being involved in the decision making process about the treatment. Most patients (86%, n=1193) reported that they felt they could cope better with their health problems after the visit to their GP, 12% (n=235) did not feel so while 12% (n=234) were undecided.

**Conclusions:** This cross-sectional study highlighted certain issues regarding the profile of patients who visit PHC services in Greece as well as some of their recent experiences. Despite the major problems that the Greek PHC system is currently facing, most patients declare that their health needs are being met. The problems of repeated medical prescriptions and the absence of a patient health record system remain as obstacles towards a more qualitative health approach. Findings of this study could contribute towards a rational planning and restructuring of PHC services in a time when such reform is under discussion.

**Geographical Variation in GPs' Workload: A secondary analysis within the framework of the QUALICOPC project outlining the situation of General Practice in Germany**

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**Background:** Surveys among medical students and graduates reveal that working conditions in rural areas are anticipated to demand a higher workload. This presumption might be a crucial factor in the site selection of GPs, hence contribute to the rising GP shortage in rural areas. The major aim of this analysis was to assess the variation in GPs' workload between urban, mixed and rural practice location in Germany.

**Methods:** The study draws on 238 questionnaires completed by GPs in Germany in context of the QUALICOPC study. Workload is operationalized through an index containing the weekly hours of work, the scope of home and residential visits as well as on-call duties.

**Results:** Data from 211 out of 238 returned GP questionnaires were used for this analysis. GPs' workload rises with increasing rurality of practice location. In comparison to urban GPs, rural GPs worked a surplus of 7 hours/week (45 vs. 52), treated 6 patients more through home or residential visits (21 vs. 27) and had 6.5 times as many on-call duties (2 vs. 13). With regard to the indexed total workload only 13% of the urban GPs present a high workload, whereas 49% of the rural GPs do so.

**Discussion:** In addition to the practice location there are other factors influencing the total variance in GPs' workload. Nevertheless, practice location should be counted as a key criterion in site selection of GPs.
Challenges and achievements in integrated care: different healthcare providers working together

The International Hospital Federation (IHF) together with its Catalan members wants to discuss with the Forum delegates new ways of integrating care. As a follow up of previous IHF contributions to EFPC conferenced in Istanbul and Gothenburg, Dr. Risto Mietunen (IHF Board member) will chair this workshop on challenges and achievements in integrated care.

Background: The Catalan health system is a public healthcare system, funded by taxes, with universal coverage and a limited public health services portfolio. There’s a mixed healthcare providers network. Improving integration of healthcare with a shift to a patient-centered model is one of the main challenges. We will share three experiences of different models developed to improve integration, guarantee efficacy, quality and efficiency in healthcare:

A technological tools based model for integrated healthcare. Carlos Alonso. Integration is achieved, through the implementation of a patient-focused model, based on a comprehensive healthcare management strategy and a shared electronic medical record that allows integration of all levels of healthcare and allocating resources in to the more efficient place. The model ensures an overview of all the process and the continuum of care.

Functional Integration, primary care as the axis for a patient needs based healthcare organization. Anna Riera. This experience shows functional integration of healthcare services based on patients needs through a healthcare facility managed by primary care doctors, called “light” Hospital. Ambulatory specialized healthcare services, continuous healthcare services, rehabilitation and physiotherapy services are provided in this facility where all healthcare services depend on primary care doctors, who organize healthcare attention, allocate resources and manage functional dependence.

A self-management organization in Primary Healthcare, an innovative experience. Carles Brotons. We present the experience of the PHC centers managed by a group of health professionals organized themselves as a General Practitioners (GPs) association (so called Entitat de Base Associativa-EBA). They were responsible for the management of the Primary care center and providing primary healthcare services, through a contract with the Health Authority. EBAs have fully autonomy and risk sharing in managing resources. The benchmarking efficiency parameters show remarkable results. EBAs have has been a successful initiative as a model of organization.
IMPLEMENT: Implementation of Chronic Care Improvements in the EU

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Keywords: innovation, implementation, expert knowledge, chronic care

Purpose:
- Comprehend the urgency for innovation in chronic care
- Insight in drivers and barriers for implementation of innovations, from stakeholders perspectives
- Detect ‘knowledge gaps’ for implementation of innovations, building a research agenda
- Expand experts networks at the EU level

Content: Many innovators, projects and manufacturers deliver promising inventions, but a healthcare invention will only become an improvement after broad implementation resulting in actually use in a healthcare setting. However, astonishingly small numbers of innovations actually make it to the clinical practice or the patient. One reason is a lack of research that directly helps implementers overcome the challenges they face in making improvements. Another reason is that practitioners do not have the time, resources or support to successfully carry out improvements.

IMPLEMENT (http://eu-implement.eu) wants to close the ‘knowledge gaps’ to accelerate the implementation of innovations in chronic care. It’s a two-year EU FP7 project (since September 2013) to develop a Research Agenda on implementation issues and a broad EU Network. At present, a panel of experts (n=+30) is being consulted in order to determine what research is most needed to speed the implementation of different types of changes to improve chronic care. The next round consists of a broad survey amongst experts (n=+300) in the different sectors of science, government, industry and practices throughout Europe. During this EFPC-workshop, you have the opportunity to contribute to this European quest.
Inequity by disease - threat to social justice in health

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Background: "Inequity by disease" is the phenomenon whereby in a health system, people with different diagnoses, have access to diagnostic and therapeutic care packages, but are different in terms of access to services, cost-share, social support (food grants, educational grants, ...). We have seen the first presentation of "inequity by disease" in the past 20 years through the development of vertical disease-oriented programs for infectious diseases. As an example: in many African countries, people with HIV/AIDS do not have to pay for health care for that disease whereas, people with other conditions have to pay. Recently the increasing fragmented vertical approach towards chronic conditions (very often labelled as "Non communicable diseases -NCDs) have introduced "inequity by disease" in the Western world (e.g. when patients with diabetes type 2 have free consultations with the family physicians whereas this is not the case with diabetes type 1"). Apart from fragmentation of care for the individual patient, this approach also leads weakening of the health care system. In 2009, the World Health Assembly's Resolution WHA62.12 "urged member states to encourage that vertical programs, including disease-specific programs, are developed, integrated and implemented in the context of integrated primary health care".

The learning outcomes for this workshop are:

1. To explore the concept of "inequity by disease", from experiences in our own health system.
2. To increase the insight in the existing evidence on the effects of vertical disease oriented programs, compared to comprehensive primary health care approaches.
3. To understand the driving forces that conduct the verticalisation of international donor-activities and the effects of vertical disease oriented programs on local "primary" health care systems and human resources.
4. To assess the opportunities of engaging in the campaign "15by2015", with special emphasis on the approach to NCDs.

Methods: After presentation of the participants and the background a voting procedure and statements in relation to vertical and horizontal program will be developed. Some data and evidence will be confronted with the experience of the participants, that are invited to reflect in small groups on the concept of "inequity by disease" and on future strategies for the "15by2015-campaign". The workshop ends with conclusions and an action plan. In preparation of this session the participants are invited to visit the website: www.15by2015.org
Integrated Care in Primary Settings for Active and Healthy Ageing

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Dr. Toni Dedeu, Director of Research and Exchange Knowledge, DHI/University of Edinburgh

The European Innovation Partnership on Active and Healthy Ageing (EIP AHA) is a new model of cooperation to support innovation for active and healthy ageing. Launched in 2011, it is part of the Innovation Union Flagship initiative of the Europe 2020 strategy.

The EIP AHA has engaged over 3000 partners, regions, industry, research institutions, healthcare professionals and NGOs from across Europe. These partners work towards people-oriented, demand driven innovation for ageing well, which brings tangible and proven benefits to end-users, helps health and care systems to contain costs and unlocks business opportunities on European scale.

The Partnership has provided a common vision, identified key areas for action and works to find and scale up good practices:

- Action Groups – Over 300 good practices reveal a snapshot of innovative practices across the EU in 2013 in the six areas. The collections are available online.

- References Sites – 32 regions, cities, or integrated hospitals/care organisations showcasing comprehensive, innovation-based approach to active and healthy ageing and giving concrete evidence and illustrations of their impact.

Through these initiatives, partners demonstrate how the implementation of new organisational models, integrating health and care services, supported by IT systems provide more targeted, better quality of care and more efficient use of financial and human resources. Coordinating care around people’s needs can improve the treatment of chronic patients and reduce hospitalisations, in particularly in the case of multiple morbidities, which increase the risk of adverse health outcomes and poor quality of life.

The EIP is currently working on a scaling-up strategy to mobilise resources and expertise, which combined with the collection of good practices and Reference Sites experiences, will ensure the implementation of innovation solutions for active and healthy ageing on a European scale. These experiences inspire policy: they highlight new areas for policies, focusing on prevention of frailty, or managing multimorbidity; provide evidence on the efficiency of certain interventions, such as integrating care services; or highlight emerging opportunities for European industry on the silver markets.
6.0 Submitted Research, Policy Debate and Multimedia Abstracts - sorted from low to high numbers

112- D’haenens  ID:EFPC2014111

Dischargemanagement: barriers and role of nurses and midwives for ethnically and social-economical deprived patients groups

Mrs Ann Claeyss
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keywords: discharge, deprived patient groups, transmural care

Within the context of a correct use of the 1st & 2nd line health care raise questions about the “integration” of the care. Up to now very little is known about the specific needs of deprived patients during the discharge process. Does discharge needs to be organised differently for different patient groups?

The study identifies the characteristics of effective discharge management (DM), analyses the contents and organization of DM and inventarizes the patients’ experiences and needs of DM.

As the focus of the research lies on multicultural society in a metropolitan region, the view of nurses & midwives on the patient is enlarged to the “multicultural patient in a metropolitan region”.

In this study mixed methods are used, combining quantitative research (using data on patient trajectories) and qualitative research (using participant-observations, documents and interviews both from health professionals and patients).

No discipline claims the coordination of the discharge, it is organised different for specific patient groups, due to language and culture. Ethnically and socio-economic deprived patient groups receive less information. There is no clear coordination role of managing the discharge.

There need to be more attention to discharge, specifically to the preparation and communication of discharge for specific patient groups.

116- Ben Khaial  ID:EFPC2014116

Modifiable Risk Factors for Pre-Eclampsia in Pregnant Women in Benghazi, Libya

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keywords: Pre-Eclampsia- Toxemia of pregnancy- risk factors

Introduction: Pre-eclampsia (PEC) forms a worldwide problem and it is one of the most important causes of maternal morbidity and mortality. Its diagnosis and risk factors are important. A hospital based case control study was conducted in maternity hospitals of Benghazi and Ajdabia / Libya to identify and
quantify risk factors for pre-eclampsia. Methods: Case control design was adopted to include all clinically and laboratory diagnosed cases (130) of PEC and equal number of healthy controls from the same hospital matched for nationality, age and residence during the years between 2009-2014. Results: The mean age of cases and controls was 31±6.3 (18-45 years), 16% were from outside Benghazi and 84% from central Benghazi. Blood group A was the most frequent one followed by group O,B, and AB accounting for (34%,29%,24%,12 %) respectively . The most important risk factors found : living outside Benghazi compared to central Benghazi ( OR: 2.5, 95%CI: 2.1-2.9) , family history of PEC ( OR: 1.3, 95%CI: 1.1-2.3) , history of admission to ICU was significant between cases and controls ( OR: 2.4, 95%CI: 1.8-3.0), history of diabetes mellitus ( OR: 1.7, 95%CI: 1.2-1.9) , gestational diabetes ( OR: 1.9, 95%CI: 1.3-2.1),hypertension and history of previous PEC was double folds more than controls with corresponding ( OR: 2.4, 95%CI: 1.8-3.2),booking for antenatal care varied between 98.5% of cases and 100% among controls ( OR: 0.5, 95%CI: 0.4 -0.6). Spontaneous pregnancy was reported among 95.3% of cases compared to 100% controls with (OR: 0.5, 95%CI: 0.4 -0.6), planned pregnancy (OR: 0.3, 95%CI: 0.1-0.5). Urinary tract infections was also significantly high among cases compared to controls (OR: 2.2, 95%CI: 1.3-3.7). Conclusion and recommendation: Modifiable risk factors for PEC were previous history of PEC, diabetes mellitus, gestational diabetes and hypertension. Antenatal booking, planned pregnancy was a protective factor like other studies. These finding were comparable with different studies conducted in developed and developing countries. Items of antenatal care should be stressed upon for more protection and avoidance of modifiable risk factors like DM, gestational diabetes and hypertension. Further studies have to be done.

124- Sammut

The Attitudes, Knowledge and Practices of Maltese Family Doctors in Health Promotion and Disease Prevention

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keywords: Health promotion & disease prevention; attitudes, knowledge & practices; family doctors; Malta

Purpose: The study aimed to assess the knowledge, attitudes and practices of Maltese family doctors in health promotion and disease prevention. The results were compared with a similar study performed in 2000.

Theory: Family doctors are in a unique position to advocate health promotion and disease prevention, though it is known that this is not always given its due importance due to various reasons.

Methods: A validated questionnaire was sent in 2011 to all Maltese family doctors/general practitioners (GPs) and GP trainees. The results were analysed statistically. A focus group was conducted to discuss the results and develop a set of recommendations.

Findings: An improvement was seen in health promotion practice since 2000. Patients find it easier to access health promotion activities. Family doctors look after their own health better. However, they have difficulties regarding which prevention guidelines they should follow. Time constraints remain the biggest obstacle to promoting health. GPs who are involved in post-graduate teaching activities find it easier to promote health (p<0.05), while doctors working in both private and public settings find it most difficult
GPs who smoke find it harder to advise smoking cessation (p<0.05), while doctors who are obese find it more difficult to recommend exercise (p<0.05).

**Discussion:** Health promotion practice by family doctors is on the increase, yet there is clearly room for improvement. Web-based training, lectures and seminars would help family doctors to enhance their knowledge. Flyers, posters and video-clips in waiting areas could increase patient awareness of healthy lifestyles.

**Purpose and Theory**
A person-list-based family medicine model (FMM) was introduced in Turkey during healthcare reforms. Family physicians (FPs) provide individual-oriented primary care (PC) services to the patients on their lists, while community health centres (CHCs) are responsible for services at the community level. This study explores from the perspectives of physicians working in CHCs how effectively CHCs are functioning and integrating PC services.

**Methods**
This qualitative study, which reflects the views of CHC physicians, is part of a project on the assessment of the FMM. Maximum variation sampling was used and 22 CHC physicians were interviewed using a semi-structured form between February and July 2013.

**Findings**
Data analysis yielded five themes: ambiguity in the mission of CHCs, barriers to fulfillment of their functions, effects of organizational change, relationships with FPs and job satisfaction. Participants stated that CHCs are used as repositories of personnel to make up for the deficiencies of family health centres and therefore their tasks are too broad and changeable. In addition to problems such as inconvenient infrastructure, overly frequent temporary assignments and lack of in-service training, the abolition of district-oriented organization and the division of services into the individual- and community-level hamper the fulfillment of the integrative functions of CHCs. As a result of this, CHC physicians reported very low levels of job satisfaction.

**Discussion**
CHCs which are operating in a fragmented organizational structure and facing serious administration problems are not able to provide public health services or to integrate PC services effectively.
Evaluation of a Scale for the Coordination Function of Family Physicians Regarding Antenatal Care

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Keywords: coordination, antenatal care, validity, reliability, family physician

Purpose and Theory

Its cardinal functions (first-contact, longitudinality, comprehensiveness and coordination) give primary care a key position in building integrative healthcare systems. In Turkey, family physicians (FPs) provide antenatal care services with a family health worker (FHW). However, since patients are free to enter the system at any point, the question of how effectively FPs are able to coordinate services is arising. In this study, a scale was developed in order to assess the level of coordination of antenatal care services by FPs in Turkey. The aim of this presentation is to evaluate the reliability and validity of this scale.

Methods

The scale was developed in four steps. The first three steps were generation of an item pool, expert panel and pilot study. In the last step, the scale was administered to 178 women who had given birth in the last three months and lived in three suburbs of İzmir (Turkey) where the Municipality of Bornova district is providing a social service programme.

Results

Six factors emerged from the factor analysis: accessibility and comprehensiveness of FHW services, accessibility and comprehensiveness of FP services, coordination of care by FPs, coordination of care by FHWs, FPs as first point of contact and recognising determinants of health. The factors explained 65.7% of the total variance and the Cronbach alpha value was 0.903.

Discussion

The scale developed and evaluated in this study is a reliable and valid tool which can be used in the assessment of the coordination function of FPs regarding antenatal care services.

Early and menopausal weight gain, diabetes and hypertension

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Objectives: To compare data of lifelong weight gain of persons, analyzing its correlation with developed metabolic diseases, with special attention to women’s weight gain around pregnancy, delivery and menopause.

Design: Retrospective, international study. Setting: Primary care settings in Germany, Hungary, Italy, Slovakia and Ukraine.

Methods and patients: People between 60y-70y were asked to fill in a questionnaire on body weights in previous life decades and heights. Recent parameters were measured.

Measurements: Statistical analysis between the records of compared groups; diabetes, hypertension, both and free from these diseases.

Results: There were 815 participants recruited, and 286 men/447 women of them presented completely all the required data. The weight and BMI of the whole study population increased till their seventies, less after their fifties. Changes over decades were higher among patients with hypertension than within “healthy” group. Weight increase in the first decades (20-30y by men, 30-40y by women) was a significant risk factor for the development of diabetes (OR=1.49; p =0.017;95%;CI:1.07-2.08). Significantly higher weight gains were recorded in the last decade before diabetes has been diagnosed. Among patients with diabetes and hypertension, both diagnoses were set up earlier, than by patients with only one morbidity. By females, weight increases around delivery and menopause correlated significantly with higher odds for the diagnoses of diabetes and/or hypertension, without significant correlations with the numbers of children.

Conclusion: Primary care physicians are expected to observe the weight gain of their patients still in their early decades and provide intervention, if necessary.

176- Baan

Making the transition towards integrated care- the Dutch National Monitor Population Management

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keywords: population management, triple aim, integrated care, evaluation

Purpose
To present the design of the Dutch Monitor Population Management (DMPM)

Theory
Several initiatives have emerged that aim to rearrange health services and promote collaboration at regional level. The three main goals are: improving population health and quality of care and controlling health care costs (Triple Aim (TA)). The RIVM will monitor nine initiatives to get insight into the implementation process of population management (PM), and the impact of the initiatives in terms of the TA.

Methods
The DMPM contains a process and an outcome monitor. The process monitor, based on qualitative research, will focus on the organizational structure of the sites, the experiences of participants and on factors that hinder or stimulate PM. The outcome monitor will focus on measuring achievements in terms of the TA. National data sources will be used, complemented with a survey among the population in each pioneer site region.

**Findings**

Currently, the nine pioneer sites are under development. Each pioneer site includes primary care organizations, hospitals and a health insurer. The sites have defined a set of programs and interventions to achieve their goals.

**Discussion**

First results will be published early 2015, in 2018, a follow-up report will reveal the developments over time.

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### 181- Eikeleboom

**SeMaS: a tool for personalized counselling and support of self-management in primary care**

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keywords: Self-management support, Personalization, Chronic diseases, Primary care, Personalized medicine

**Purpose**

The aim of this study was to evaluate the use of the Self-Management Screening questionnaire (SeMaS) in everyday primary care for chronic patients.

**Theory**

Many self-management interventions have been developed over the last years, as patients are expected to take more control over their chronic disease. However, literature shows that the responsiveness of patients to these interventions depends on individual characteristics. The validated SeMaS questionnaire screens on individual characteristics that are important for self-management, including self-efficacy, social support, and depression.

**Methods**

Approximately 350 chronic patients of a primary care group were screened with the SeMaS. The practice nurses discussed the results of the SeMaS with the patients in the planned consults. Semi-structured interviews were held with the practice nurses for the evaluation of the application of SeMaS. The interviews were transcribed verbatim and analyzed on facilitators and barriers for the innovation on different levels of healthcare: innovation, professional, patient, social context, organization, economic and political context.

**Findings**

Facilitators were that SeMaS increased the insight in the individual characteristics (patient, professional), and provided a structure in the consult for discussing the characteristics (professional). Barriers were the
Discussion
SeMaS can help in providing personalized counselling and support for chronic patients in primary care. Identification of barriers and personalized support could help chronic patients in their self-management in daily life.

**235- Nebot Adell**
ID:EFPC2014235

**Community’s health: transforming the information into action**

Dr Carme Nebot Adell
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Key words: primary health care, community, social determinants, prevention

**Purpose:**
To develop a strategy to enhance activities oriented to community’s health

**Context:**
To promote community’s health, the board of the Muntanya-Dreta Primary Care Unit incorporates a community approach as a strategic line for Primary Care Teams (PCT) in the area (557,430 inhabitants).

First of all, a core group of family doctors and nurses working in the area were called to a brainstorming session targeted to identify the main points to be developed. Secondly, a SWOT analysis was made among 16 PCT, which showed professional motivation as the first strength (86%), knowledge teams have about the community as the first opportunity (43%); on the other hand, overload at health services was the first weakness (36%), and difficulties for community participation (43%) was the first threat.

As a result of this analysis, an educational program aimed to improve the skills of PCT was developed and implemented among 25 PCT, including two workshops, three basic level courses and two intermediated level courses, ten hours each.

**State of the art:**
A comprehensive view of health entails taking into account the social determinants of health, and pursues reducing health inequities through a multidisciplinary approach, a multisectoral action and the participation of empowered communities, as clue elements for primary care teams to move from theory into action.

**Statements for debate:**
FD can read the images
Nurse or other clinical assistant can take the pictures
The ophthalmologist will just read the images considered as pathological by the FD.

**238- Nebot Adell**
ID:EFPC2014238

**The retinal screening program for diabetic patients: what primary care can do**

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keywords: digital photography, prevention, interfaces between primary care and specialists, health information network

**Purpose:**
To improve coverage of diabetic retinopathy screening program
To improve primary care team effectiveness
To identify early signs of retinopathy and prevent blindness

**Context:** In 2012 there was 38.440 patients from diabetes in our area, 12.538 of whom were provided with a retinal photography (32.62%). From those images, 2.276 (18.15%) showed any degree of pathology. The informer of the retinal photographs by then was the ophthalmologist.
In the second half of 2013 a local working group (WG) was called to move forward the transformation of the model. The WG was compounded of family doctors and ophthalmologists, and all them agreed a new algorithm for those patients; according to the new procedure, ophthalmologists will inform only the pathologic or dodgy images. In addition, the WG approved a 20 hour training program aimed to FD, with theoretical and practical sessions; 29 FD were trained to inform retinal photographs in their Primary Care (PC) teams.
In January 2014 the new model of diabetic retinopathy screening (DRS) started in our area; the main point of this new phase is the fact that the family doctor is the controller of the process.

**State of the art:** Retinal photography is very effective to identify retinopathy in patients from diabetes. It’s recommendable to be done once the diagnosis has been made and at least every two years. The retinal photography is a non-invasive procedure to identify any retinopathy degree; images can be taken by any trained people which makes the process to be very affordable and accessible.

**Statements for debate:**
FD can read the images
Nurse or other clinical assistant can take the pictures
The ophthalmologist will just read the images considered as pathological by the FD.

**244 - Allen Johnson**
ID: EFPC2014244
Interprofessional Collaborative Education at the EVMS School of Health Professions

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**keywords:** interprofessional, interprofessional education, interprofessional collaborative practice

In growing recognition that a safe, effective, and value-driven healthcare delivery system must emphasize teams of professionals working in unison to benefit patients and improve outcomes, the School of Health Professions at Eastern Virginia Medical School is developing a 1-credit Interprofessional Collaborative Education course for the 2014-15 academic year. Approximately 200 students representing 6 diverse graduate level programs will convene for six 2-hour sessions that will include didactic learning combined with breakout sessions for 20 groups of 10 students each. This poster/policy presentation will describe
the course development process, content, learning competencies, assessment, and how the course will enhance education and ultimately primary care collaborative practice.

As with many programs hosted by academic health centers, our students are generally educated in professional silos that provide few or no structured opportunities to interact with and learn from trainees, faculty, and practitioners in other disciplines. Accreditation requirements, substantial curricular differences, and scheduling logistics all contribute to disciplinary isolation. This course will address four key competencies—values, roles, communication, teamwork—using case-based learning and small groups facilitated by faculty. Formative and summative evaluations will help assess student perceptions of each session and the overall value of the experience.

262- Fontana

Brief examination of the evolution of primary care in place in Italy and focus on the actions undertaken by the Local Health Authority (LHA) of Pavia, Lombardy Region, northern Italy

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keywords: General Practitioners, chronic patient management, primary care, Local Health Authority

Purpose
This paper briefly describes the reform that is affecting primary care in Italy and, in addition, outlines actions already in progress at the LHA of Pavia to support the changing nature of general practice in the light of the more recent legislation.

Context
In 2012, Italian Parliament approved a new healthcare reform law that, among others, redefines primary care providing for the structuring of mono-professional networks of doctors (Functional Areas of the Territory) or multi-professional structured groupings (Primary Care Complex Units - PCCU), both operating round the day.
This innovation comes at a time of simultaneous revision of the hospital network aimed at containing number of beds and redefining the role of small hospitals. These structures should treat sub-acute chronic patients, with a predominantly nursing assistance and a strong involvement of GPs.
Moreover, due to retirement, in ten years is estimated a gap of about 15,000 physicians nationwide and, in this context, implementation of professional competences and responsibilities of nurses are under discussion.

State of the art
Since 2004 LHA of Pavia has promoted the implementation of Primary Care Groups (PCGs), which resemble very closely the new PCCU. This initiative allowed LHA to verify on the field the problems related to the effective activation of multi-professional organizations and to develop some handy tips to promote a cultural shift aimed at a more advanced vision of primary care and health promotion.
**Statements for debate**

In Italy the economic crisis is affecting the financial stability of the NHS. This is generating the redefinition of the organizational model of the NHS, aimed at permanently reducing costs, while maintaining effectiveness and improving efficiency. This is the context of the reform of primary care and of the review of the hospital network aimed at developing a public health system more focused on the territory. The evolution of this scenario involves a driving role by the LHA to provide cultural development and promotion of the multi-professional associations.

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**273- Salvadori**

**Community Health Centres in the Region of Tuscany**

Dr. Piero Salvadori  
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keywords: CHC, Proactive Medicine, Chronic Care Model

**Purpose:** Tuscan region has the goal of having, at least, 120 Community Health Centres (CHCs) in the coming years. Obviously we can't have a CHC for each of the current 280 municipalities. In fact probably the larger municipalities will also have more than 1 CHC and smaller ones anyone.

**Context:** a CHC is a building with integrated health and social services. It contains, at least, the following services: family and pediatric medicine, nursing, administrative, social and specialist care: the latter through the direct presence of medical specialists or telemedicine.

**State of the art:** the CHCs open are 36. Of these, 55% are open 7 days a week, 30% for 6 days. 92% has first level diagnosis, 22% has telemedicine. 78% works with proactive medicine and chronic care model, 22% is open 24 hours a day including holidays and 20% has first aid inside.

**Statement for debate:** the increase of chronic diseases can only be faced with this type of integrated structures, in which to develop the proactive medicine and the Chronic Care Model. We need, therefore, that all countries, in opposite to an acute care hospital, develop CHCs in territory and form an alliance between CHCs.

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**299- Breton**

**Implementation of one model of centralized waiting lists for patients without family physician across province of Quebec leads to heterogeneous results**

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keywords: single point of access, family physician, relational continuity, accessibility
**Purpose:** To present the performance of 94 centralized waiting lists (CWL) for patients without family physician implemented across the province of Québec, Canada

**Context:** Nearly 29% of the Québec’s population is without a family physician. In response to this critical need, the Quebec government mandated the implementation of 94 centralized waiting lists for access to a family physician across the province.

**State of art**
We used a balanced scorecard for measuring and comparing the performance of 94 CWL. Several indicators approved by an advisory board formed by policy makers, clinicians and researchers were developed. All patients enrolled with a family physician through a CML over the last year (n=153 345 patients) were analyzed with SAS 9.3. We used ANOVA or logistic regression.

**Statement of debate**
The same innovation was implemented across the province of Quebec. Various factors at different levels explain the variations such as the leadership of family medicine in charge of CWLs, the roles of nurses working in the CWL and the dynamic of collaborations among family physicians working in the community. Linking performance outcomes to implementation characteristics offers a new reading of elements at stakes that should be considered when implementing a new prioritization system in primary health care contexts.

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**Taking Action – The Health Awareness Clinic Project in Primary Health**

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keywords: health needs assessment, health education, chronic disease, health risks

**Purpose**
Primary care has a major role to play in the prevention of chronic disease and in the prevention of risk factors. Furthermore, health professionals working in primary care are duty bound to empower clients to understand the risks that their health behaviours may be causing to their health and more so to facilitate clients through the appropriate structures to take the necessary action to address and rectify risky behaviours.

A recently introduced health awareness clinic was identified as a means to address such an unmet need in Maltese primary care. The scope of the clinic is to introduce a proactive, integrated and personalised approach towards healthier living. A review of the aim, objectives, operations and findings of such a clinic are discussed as well as a review of the client throughput and identified needs for the Mtarfa community are given.

**Context**
It is a well known fact that whilst populations of developed countries are enjoying an increasing lifespan, the morbidity rates of chronic disease are increasing. The local scenario is no different and it is also well-documented that most chronic diseases are linked to lifestyle behaviours that impinge on people’s health and wellness through the onset of chronic disease patterns or complications.

**State of the Art**
The health awareness clinic is an innovative idea of its kind in Malta in identifying persons at risk of chronic disease in an individualised manner.

343- Nieri  ID:EFPC2014343
Campaign to raise awareness of the population for the expression of willingness to donate organs after death promoted by the Department of Primary Care of the Local Health Authority of Pavia with the support of General Practitioners

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keywords: Primary Care, GPs, organ donation, LHA

Purpose
In Italy, to be a donor after death, citizens are asked to register their own will at their Local Health Authority (LHA) and these statements are recorded in the Information System of the National Transplant Center. To improve this practice LHA of Pavia decided to sensitize General Practitioners (GPs) so as to enhance their direct involvement in the collection of expressions of willingness from their patients.

Context
Until 2011 very few expressions of willingness were collected yearly in the Province of Pavia. This is probably due to the fact that, apart from few directly involved, people don't feel donation, or lack of organs, as a problem

State of the art
Since 2011 LHA designed a campaign to raise awareness of the GPs to take an active part in stimulating the decision on organ donation on the part of their patients.
An inter-institutional collaboration was set up between LHA, Hospitals, non-profit Associations and GPs. and educational interventions were specifically carried out on GPs.
From January 2014 GPs were asked for free to directly collect expressions of willingness from their patients and to transmit to LHA for registration.
Until march 2014, 64 expressions of willingness have been recorded while in the whole 2013 these were only 13.

391- Paino  ID:EFPC2014391
Wandering around: a teaching tool to approach the community

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Purpose
To present the community walk as a tool for residents of family and community medicine to assess the needs of the target community.

Context
Suburban neighborhood, low socio-economic status, with a population of 21,000, and a teaching primary healthcare center

State of the art
The community walk is a qualitative method used in the assessment of the community needs. The aim is to perceive the lifestyle and urban morphology. It is useful to generate and present information about local environment, services and infrastructure. The walk is complete by interviewing selected community leaders.

In our center, we first tested a “community walk” experience with the residents recording the walk on video. The information gathered and the conclusions were congruent with previous assessments done via traditional methods.

• Advantages: Low cost, short-time investment facilitates the detection of unexpressed needs.
• Disadvantages: bias of the observer, information might be not fully representative of the entire community.

The experience was well-received by the residents. Our plan is to use it for the first contact with the community in which residents will work during their years of training.

We think this model can be fruitfully replicated in other healthcare centres.

ID:EFPC20141103

Which organizational attributes of primary healthcare are associated with better accessibility and continuity of care?

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keywords: organizational attributes, accessibility, continuity, primary healthcare

Purpose: To analyze the relationships between various organizational attributes of primary healthcare and perceived accessibility and continuity of care

Theory: Based on Starfield’s framework (1992), several organizational attributes are related to accessibility and continuity.
Methods: Two surveys were carried out in two regions of Quebec in 2010: a postal survey among 276 responding PHC practices and a telephone survey of 9180 respondents from the general population. Data from the two surveys were linked through the respondent’s usual source of care. We based our assessment on 10 organizational attributes grouped around 3 dimensions: resources (role and function of nurses, number of information technologies, availability of a technical platform in the building, structures (sharing of clinical activities among general practitioners, collaboration with other PHC practices, collaboration with hospital), practices (extended coverage to evenings and weekends, consultation mode prevailing, scheduled length of time for consultations, systematic management of chronic disease). Multilevel linear regressions will be conducted of all organizational attributes on two dimensions of experience of care: accessibility and continuity.

Finding: We are at an advanced in-progress form. Our preliminary results from descriptive statistics show that some organizational attributes such as extended opening hours is associated with accessibility, whereas other attributes such as higher percentage of scheduled visits tends to be associated with continuity.

Discussion: The results of this study will inform decision makers about core organizational attributes likely to enhance accessibility and continuity.

1108- V.d. Berg
The relation between primary care and emergency department attendance- An international study
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keywords: emergency departements primary care access

Purpose:
1)To describe differences in emergency department(ED)-attendance between 35 countries. 2) To investigate how visiting EDs is related to patient characteristics and characteristics of primary care systems, such as access and continuity.

Theory:
Appropriate use of primary care may help to manage health problems timely so that a visit to the ED can often be avoided. Accordingly, well accessible and continuous primary care is expected to be associated with fewer ED visits.

Methods
We used survey data from 58,606 patients within 6,830 general practices. Data were collected in 31 European countries, Australia, New-Zealand and Canada within the EU-project QUALICOPC. Multilevel logistic regression analyses were used to analyze the data.

Findings
During one year, almost 30% visited an ED. Between countries, this varied between 17% and 40%. ED-visits were negatively correlated with better accessibility of primary care (e.g. nearness, availability outside office hours and home visiting). Patients with a regular (personal) doctor less frequently visit EDs.

Discussion
In some countries it may be worth it to invest in more continuous doctor-patient relationships or to
eliminate factors that hamper people to use primary care. In general, well accessible and continuous primary care seems to be able to significantly reduce emergency department use.

1112- Tol ID:EFPC20141112

Changes in health insurance reimbursement system for dietitians: effects on access and utilization of Dutch dietetic services

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keywords: Insurance, Reimbursement, Primary Health Care/utilization, dietetics

Purpose: This study examines the consequences of changing reimbursement of dietary advice on accessibility and health care utilization of dietitians.
Theory: In the Netherlands, basic health insurance cover for dietary advice fluctuated between 2011-2013. In 2011 and 2013 dietary advice was reimbursed for all patients with a medical indication by 4 and 3 hours, respectively. In 2012, 4 hours were reimbursed only for patients with a chronic condition.
Methods: This longitudinal study was based on data from 60 private dietetic practices in Dutch primary health care. Anonymous health records of patients with a consultation between 2011-2013 were extracted from electronic health records. Descriptive statistics, independent t-tests and chi-square tests were performed.
Findings: The average number of patients visiting a dietetic practice varied according with changes in reimbursement. In 2012 and 2013 significantly less overweight patients visited a dietitian compared with 2011. In 2012 patients had a significantly higher age, socio-economic status score, and more patients were treated for chronic conditions compared to 2011.
Discussion: Limiting reimbursement of dietary advice for specific patient groups results in a notable reduction of health care utilization and inequitable access. Dietetic practices experience slow, incomplete recovery, one year after expanding reimbursement for all patients.

1117- Solf Moran ID:EFPC20141117

The Gaudi’m Project

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keywords: Exercise program, Community healthcare
Purpose
To evaluate the effects in health parameters and in frequention to the healthcare center after participating in a community program based on physical exercise and health education.

Theory
The effects of physical exercise and health education sessions reflect in an improvement in biological parameters and in the capacity of self-care.

Methods
Cross-Sectional Retrospective Study.

Population: 63 patients that participated and completed the exercise program for at least one year since 2009.

Variables: Age, gender, body-mass-index (BMI), blood pressure (BP) and number of consultations (NC).

Intervention: Gaudi’m is a community program based on promoting exercise and healthy habits. The main activities are weekly group walks, health education sessions and exercise workshop conducted by two nurses and a voluntary leader that will continue the exercise.

Findings
The majority of the participants were women (96.8%), from 50-84 years old. The analysis shows no differences in BMI and NC, but it shows clinical and statistically significant differences in reduction of BP (136.7/75.6 prior and 131.3/73.2 subsequent), and even more in patients over 70 years old.

Discussion
We obtained satisfactory results in terms of BP reduction, although we expected an improvement in the other parameters. Our plan in the future is to emphasize on aspects of health education and self-care to achieve better results.

1121- Heinemann
ID:EFPC20141121
Conditions of primary care in Europe, Australia, Canada and New Zealand

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keywords: European comparative study, primary care organization, GP workload, primary care workforce, health services research

Purpose: To describe the conditions of primary care in Europe, Australia, Canada and New Zealand, grouping similar countries into clusters.

Theory: There is a large variation in the organization of primary care in Europe with respect to practice organization, practice workforce and GP workload. Primary care policymakers may be able to learn most from systems which operate under similar conditions.

Methods: We will present data from the EU co-funded QUALICOPC -study that collected information about primary care in 34 countries mainly in Europe, but also including Australia, New Zealand and Canada. The study is based on a sample of GPs in each country. The total number of GPs is approximately 6,500.
Findings: Using data from GPs, we have been able to identify three underlying factors describing the conditions for primary care in Europe: effort per patient, structure size and out-of-office duties. Four specific country clusters have become apparent. Type 1 countries, such as England and the Netherlands, typically give a high effort per patient and have an average structure size with a low amount of out-of-office duties. GPs in Type 2 countries, e.g. Germany and Austria, typically give a low effort per patient in small structures with many out-of-office duties. Type 3 and type 4 countries can be characterized by low effort per patient and large structures. However, GPs in Type 3 countries, e.g. Spain and Portugal, perform few out-of-office duties whereas GPs in Type 4 countries, e.g. Malta and Cyprus, have very many duties outside of the office.

Discussion: Although the challenges facing primary care are common to all countries, the organization of primary care shows large variation. Further analyses will show whether or not effort per patient, structure size and out-of-office duties have an effect upon patient relevant outcomes such as accessibility and quality of care.

1141- Ruikes
ID:EFPC20141141
The CareWell-primary care program for community dwelling frail elderly; results of a cluster controlled trial.

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Purpose: To investigate the effectiveness of a complex intervention targeting community-dwelling frail elders.

Theory: In our ageing society, the rising number of community-dwelling frail elders with complex health care needs demands an integrated primary health care system. Prior studies on such comprehensive chronic care models show inconclusive results. The CareWell-primary care program is a complex intervention consisting of proactive care planning, multidisciplinary team work, case management and medication review, aiming to prevent functional decline and improve quality of life.

Methods: In a one-year pragmatic cluster controlled trial, six general practices adopted the CareWell-primary care program and six control practices delivered ‘usual care’ to fifty frail elders each (70 years or above). Hierarchical mixed-effects regression models were used to study the effect on functional status, measured with the Katz-15 index, and the quality of life, measured with the EQ5D.

Findings: The CareWell-primary care program was not effective on functional status (-0.32 (95% CI -0.75;0.12), p = 0.15) or quality of life (0.04 (95% CI -0.04;0.12), p = 0.27).

Discussion: Baseline differences between the study groups, selective loss to follow up and an insufficient study period could be responsible for the lack of effect. However, the question on how primary care should be effectively transformed to face the growing ageing society remains to be answered.
Regular use of self-assessment psychological instrument for monitoring depression in frequent consultations in primary care - no improvement compared to treatment as usual

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keywords: Depression, self-assessment, psychological instrument, antidepressants, sick listing, quality of life, primary care

Purpose: To evaluate if treatment of depression in the primary care context can be improved by the use of regular monitoring of depressive symptoms in frequent consultations.
Theory: Regular use of self-assessment instruments for monitoring depression has been recommended based on the assumption that both doctor and patient knowledge on depression course and symptoms as well as detection can be highlighted and management be improved. However, these guidelines have been based largely on consensus or expert opinion.
Methods: RCT with randomization on GP level. Intervention: appointment every month for 3 months, monitoring and evaluation of symptom severity and change by MADRS-S depression scale in every consultation. Control: Treatment As Usual (TAU). Outcome: BDI-II, EQ-5D, medication, sick leave at 3 and 6 months.
Findings: 24 PCCs, 91 GPs (45 intervention/46 TAU) 258 patients (125/133) participated. 3 month follow up showed no significant differences between mean reduction of depression or increase of EQ-5D, but 6 month follow up showed significant improvement of quality of life in TAU patients compared to intervention. Use of antidepressants increased significantly more in intervention group compared to TAU group.
Discussion: Depression course was not improved although antidepressant medication increased with regular use of self-assessment instruments. Quality of life was significantly more improved in TAU group after 6 months.

1170- Murphy
ID:EFPC20141170
Ms Mary J Murphy
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keywords: obesity, primary care professionals, management

Purpose
An exploration of the factors that influence primary care professional’s perspectives of their own role and that of other primary care professionals’ roles in the primary care management of adult obesity.
Theory
A Critical Research methodology is underpinning the study and Habermas’s (1984, 1987) Theory of Communicative Action is the theoretical framework for the study.

Methods
A qualitative interpretative research method was used. In depth, face to face semi-structured interviews were completed with General Practitioners, Dieticians, Practice Nurses and Physiotherapists.

Findings
From their lifeworld perspective all primary care professional groups are supportive and expressed a desire to address obesity more effectively. There is a misfit between the directions from the system and the reality of implementing obesity management. Patients do not generally self present with obesity as a concern and it is a very sensitive issue to raise. Primary care professionals have variable levels of knowledge regarding other primary care professionals’ roles. Within the system there is an absence of dialogue among primary care professionals about the strategic management of obesity within primary care. Limited resources and current reified social structures are impeding professionals care practices.

Discussion
Those within the health care system need to engage with and facilitate a process to enable the knowledge from within the lifeworld of primary care professionals to contribute to the development of a more realistic and integrated system that enables professionals to flourish professionally and meet the needs of people with obesity.

1171- De Rosis        ID:EFPC20141171
Does e-health damage the relationship patient-general practitioner? Behaviour determinants, role of the GP and patients’ empowerment

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keywords: e-health, satisfaction, primary care, empowerment, physician–patient relationship

In the last years the debate about the patients’ empowerment is widely grown: the increasing use of the Internet for health-related purposes is expected to have behavioural consequences on both patients’ empowerment and patient-doctor relationship. The aim of the research is to investigate predictors related to e-health behavioural profile.

Statistical analyses were conducted using data collected through a validated telephone survey in Tuscany Region (Italy) to almost 5,100 citizens. Logistic regression is used to assess determinant of the Internet use purposes and citizens satisfaction and experiences with GPs.

1,158 respondents declare to use the Internet for health-related purposes. Age and education are significant determinants of e-health use. The main purposes for surfing the Internet were to deep information received during a visit and to look for a healthcare service/doctor. The majority of e-health users returned to the GP to discuss what they find on the Internet, especially if satisfaction with GP is higher in terms of the level of involvement and time of visit.

The modification of e-health related behaviours and of the relationship with the GPs appeared linked to the behaviour of the physicians and the evolution of their role in the process of patient’s empowerment.
Primary Care Centres: an analysis of a new organisational model in Italy

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keywords: Primary care centres, organisational model, primary health care, multidisciplinary team

Within the framework of the regional health services reorganisation, the Tuscany Region (Italy) have been promoting the development of a new model of primary care during the last years (2010-2013). The aim of the research is to describe the primary care centres (PCCs) pilot experiences in Tuscany Region. The traditional model of primary care, mainly based on independent practices, is not able to answer to aging population and chronic conditions. Indeed, multidisciplinary PCCs could face these challenges with a more proactive and comprehensive approach.

A web survey was conducted with the Tuscan PCCs, through a structured questionnaire and key organisational documents collection. Descriptive and cluster analysis identified different PCCs’ organisational models.
In Tuscany Region 33 PCCs are currently operating among 8 Local Health Units out of 12. In the majority of the PCCs users can find at least general practitioners, nurses, specialists and social services. However, the cluster analysis reveals a great variability in opening time, structural features, services provided, health and social professionals involved and governance.
The results allowed to identify standards useful to define a common PCCs organisational model; they supported decision makers to overcome variability and weakness of primary care and enhance its strategic function.

Co-morbidity level and consumption of out-patient health care services by population listed to different types of Primary Health Care providers of Klaipeda Region, Lithuania

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keywords: co-morbidity, out-patient health care services, primary health care

Objective of the study to describe the existing inequalities in co-morbidity level and consumption of secondary/tertiary health care by population listed to different Primary Health Care (PHC) providers (private and public; urban, rural and mixed).
Theory: Previous studies in Lithuania have indicated that up to four-fold differences exist in the consumption of out-patient secondary health care, when compared population listed to different PHC providers.
Patient's place of residence and co-morbidity level are the most important factors for determining their referral rate. The factors underlying variations in consumption of out-patient care, such as practice characteristics, to date had not been well described.

Methods: The study population included 410,000 inhabitants enlisted to 44 primary health care institutions in Klaipeda region. The necessary non-personalized population data on health care consumption in year 2009-2011 was obtained from Klaipeda Territorial Sickness Fund. Johns Hopkins ACG software have been used to group populations' distribution into six co-morbidity groups.

Findings: The study revealed existing inequalities of population co-morbidity level in Klaipeda region comparing different PHC providers (public and private PHC clinics) and according to patients' living area (urban, rural and mixed practices). The higher co-morbidity group is associated with higher needs for out-patient heath care services: high multi-morbidity group consume the main part of health care resources up to 6 times more comparing with low morbidity burden. Primary health care and secondary health care specialists in the same location are the only significant factor which through multivariate regression analysis explains differences in referral rates.

Discussion: Existing variations between PHC practices in observed-to-expected referrals, call for introduction of new quality measures, and re-consideration of age adjusted capitation based payment schemes to support better care at a community level.

1181- Liebig

Primary Palliative Care - Challenges and Resources. The Case of Switzerland

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Keywords: Primary Palliative Care, Policies, Challenges, Resources, Switzerland

Primary Palliative Care (PPC) gains increasing importance in the context of demographic ageing and the increase of chronic illnesses. This holds true also for Switzerland where a majority of people prefer community-based home care at the end of life. The study starts from the assumption that the proof and the availability of medical and other resources in the environment are important influencing factors for the quality of PPC.

Findings are based on the analysis of documents on legal regulations and guidelines, community based supply structures, financing, and training opportunities on cantonal and national level in Switzerland. In addition, they rely on expert interviews with representatives of public healthcare in three Swiss cantons (Lucerne, Ticino and Vaud), and on interviews and group discussions with 72 family doctors (FDs), experienced in palliative home care.

Results illustrate that health policies and political discourses in Switzerland do not focus on PPC yet; support structures for PPC vary strongly between Swiss cantons, and between urban and rural regions. FDs get only poor support in developing PPC competencies by education and training opportunities. Up till today the information level of FDs about laws and guidelines for decision making at the end of life seems limited. Financially palliative home care is not highly rewarded: important aspects of PPC are represented in TARMED with a very short time limit or not financed at all.

The study identifies major challenges related to the provision of palliative home care in urban and rural regions in Switzerland and provides first policy recommendations.
Effectiveness of an electronic alert integrating laboratory, clinical and population databases to improve detection and recording of diabetes mellitus - Cluster clinical trial-

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keywords: Primary Health Care, electronic health record, organizational evaluation, information systems, diabetes mellitus, alerts

PURPOSE: To evaluate effectiveness of an alert in a electronic health records (EHR) to improve recorded DM and detect unregistered or unknown. To analyze variability of prevalence and control for patient and organization factors.

METHODS: Cluster randomized trial with 705 GPs and 1 million population involved, in the public health system in Galicia (Spain). Intervention: a) detection of potential patients in laboratories databases; b) DM registered in EHR; c) eletronic alert to physicians in intervention group; d) six months later, same alert to control group to avoid inequalities between population groups .

ANALYSIS: To evaluate effectiveness by Student's t test. To assess effect size by Cohen and Hedges's d. To analyze variability: specific and adjusted rates; statistical variability and funnel plot .

RESULTS: 1) Statistical: Participation=61.5 %. No significant difference between groups; effect size < 0.10. Comparing unregistered DM, OR 1.021(95%:1,000-1, 042), meaning 1,132 patients. At baseline, 16,705 patients were refined by duplication. Among registered as DM, 10.17% patients had no A1c in the previous year. High variability with empirical Bayes statistic=0.027. 2) Organizational: EHR software changes.

DISCUSSION: EHR must not be aimed at the accumulation of data, but must extract useful information for the clinician and for system evaluation. Innovations in e-health should and can be rigorously evaluated, like any other intervention, before application . For purposes of evaluation and research, health authorities should act as guarantors of information.

Multiple professional visions and inter-professional communication at the end-of-life: challenges for Swiss family doctors

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keywords: palliative care, end-of-life, decision making, professional vision, inter-professional communication
Inter-professional collaboration is a quality indicator of end-of-life palliative care (Vyt 2008; Bandemer 2002). However, collaboration may be challenged by several obstacles, including communication problems due to the different professional visions of interlocutors (Goodwin, 1994).

The project investigates practices of decision making with a special focus on inter-professional communication between FDs, nursing home care services, ambulant nurses, specialized doctors, clinics, and hospitals. The presentation sheds light on challenges experienced by Swiss FDs, and suggests measures to improve inter-professional communication and hence the collaboration process.

Findings are based on empirical data provided by the project "Decision Making Practice at the End of Life: The Case of General Practice" (NRP67). Data have been collected by means of focus groups with 60 FDs, 60 nurses, and 60 relatives in three cantons of different language regions (LU, VD, TI). Qualitative analysis of data has been conducted according to the methodological framework of Grounded Theory (Glaser&Strauss, 1974).

Perspectives of FDs, nurses, and relatives have been triangulated, bringing to light a widely stressed need for improvement of communication flows and of communication quality.

In particular, the collaboration between hospitals and territory seems to be the most fragile loop of the network. Measures to improve would involve organizational changes informing communication flows between hospitals and territory, and training opportunities for both doctors (FDs and hospital doctors) and nurses (home care nurses and hospital nurses) aimed at developing a shared professional vision in relation to end-of-life palliative care.

1233- Birtwhistle

Linking primary care electronic health records with administrative data: Diabetes control and hospitalization and emergency room utilization

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keywords: electronic health records, primary care, data linkage, diabetes

Purpose: to link primary care electronic health records with hospitalization and emergency room visit data to assess whether people with diabetes and hemoglobin A1c levels > 8 have greater hospitalization and emergency room use than those who have A1c levels < 7.

Theory: The Canadian Primary Care Sentinel Surveillance Network (CPCSSN) extracts de-identified electronic health records every 3 months over 600,000 patients. CPCSSN has validated case definitions for 8 chronic disease including diabetes. By linking the EMR record to hospitalization and emergency room visit records we will be able to assess whether diabetes control is important in utilization of health services. This type of information can be helpful by providing information to primary care clinicians about their practice population that can be a basis for considering community interventions.

Methods: This study was done in Ontario Canada by 3 CPCSSN networks and the Institute for Clinical Evaluative Services (ICES). ICES is an entity which is entitled to hold identifiable health data. De-identified
EHR data from 100,000 patients in the CPCSSN database was sent as an encrypted file to ICES. An identification key from each practice linking the CPCSSN ID number with the patient’s health care number was sent separately. The linkage to the hospitalization and emergency room visit databases is done through the health card number and then linked back to the CPCSSN ID. Patients with diabetes will be identified to see whether they have had a hospitalization or emergency room visit, reason for hospitalization and this will be related to their diabetic control.

Findings: These will be discussed at the presentation

Discussion: Linking primary care EHR data to administrative data enriches both in order to study chronic diseases at a population level. These data linkages can a powerful method to use primary care data for public health purposes.

1241- Mashori

Mental health problems in Pakistani society as a consequence of violence and trauma

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keywords: mental health, primary care, Pakistan, health policy, conflict, post-traumatic stress disorder

Objectives
This paper discusses the increasing incidence of mental health problems in Pakistan, and specifically in the District Badin coastal Sindh, in relation to the growing insurgency and current violence in Pakistani society. The paper argues that the health care system’s response in Pakistan is not adequate to meet the current challenges and that changes in policy are needed to build mental health care services as an important component of the basic health package at primary care level in the public sector.

Method
This paper reviews the existing mental health situation in Pakistan with reference to the findings of a case study in the District Badin coastal Sindh in Pakistan. The figures presented in the case study are used to support the need for an integrated national mental health policy.

Conclusion
Mental health care needs to be incorporated as a core service in primary care and supported by specialist services. There is a strong need to provide adequate training for general practitioners and postgraduate training for mental health professionals to meet the current demands. A collaborative network between stakeholders in the public and private sector, as well as non-governmental organisations are required that promotes mental health care and advocates for changes in mental health policy.

1245- Van Loenen

What aspects of primary care contribute to avoiding hospitalizations for chronic conditions?

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keywords: Primary care, Avoidable hospitalization
Purpose: To investigate which characteristics of primary care organization influence avoidable hospitalization for chronic ACSCs by reviewing the literature and analyzing multi-country data.

Theory: Hospital admissions rates for chronic conditions are often used as indicators for the quality of primary care and are potentially avoidable by well-functioning primary care. Existing evidence about which aspects of primary care organization contribute to avoid these types of hospitalizations is inconclusive.

Methods: First, a review of literature was performed searching MEDLINE, Embase and SciSearch (January 1997 - November 2013) for publications on the relationship between avoidable hospitalization and primary care characteristics. Additionally, with use of the QUALICOPC-study, the association between several primary care characteristics and avoidable hospitalization was analyzed using data of 34 countries. The results of the review were compared to the results of the multi-country study.

Findings: The literature shows that adequate physician supply and better longitudinal continuity of care reduced avoidable hospitalizations. Furthermore, inconsistent results were found on the effectiveness of involvement in disease management programs in reducing hospitalization rates.

Discussion: The findings from the literature review suggest that strong primary care in terms of good access and longitudinal continuity reduces hospitalizations for chronic ACSCs. The comparison with the empirical data will be presented during the presentation.

1261- Tuominen ID:EFPC20141261

What is the best for the families? A comparison of two maternity and child health clinic models in Southwest Finland

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keywords: Maternal health services, Child health services, Continuity of patient care, Parents

Purpose: To clarify how organizational model of maternity and child health clinic influence parents’ service experiences, utilization of services, and maternal and perinatal health outcomes.

Theory: In Finland, primary health care for families is provided at communal maternity (MHC) and child health clinics (CHC), which are led by public health nurses (PHN) together with general practitioners. The organizational structure of MHC and CHC services varies. Clinics are maintained independently or merged with other primary health care sectors. A commonly used model is a combined MHC & CHC where the same PHN cares for a family from pregnancy until the child reaches school age.

Methods: A comparative, cross-sectional design was used. Parents from the area of Turku University Hospital evaluated the MHC and CHC services via a postal questionnaire four months (mothers N=995, fathers N=789) and eighteen months (mothers N=987, fathers N=835) postpartum. Moreover, the data of mothers (N=2741) were gathered from the Finnish Medical Birth Register. Comparisons were made between the parents who were clients of the separate MHCs and CHCs and combined MHCs & CHCs.

Findings: Parents who had used the combined MHC & CHCs evaluated several aspects of the service more positively than parents who had used the separate clinics. Home visits were more frequently provided in the combined MHCs & CHCs. There were no differences between the clients of the separate clinics and
combined MCHs & CHCs regarding the utilization of maternity care services or the explored health outcomes.

Discussion: According to our results, families clearly benefit from the combined MHC & CHC model. Moreover, we found that the equal maternal and perinatal health outcomes could be reached through both separate and combined clinic models. These findings bring novel arguments to discussion about what is the best way to organize primary maternity and child health care services.

1266- Bywood
ID:EFPC20141266
Fluctuations in non-resident populations (FIFO/DIDO) and use of rural and remote health services in Australia

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keywords: rural health; fly-in/fly-out; mining; grey nomads

Purpose: Some rural/remote areas in Australia face combined challenges of limited resources and insufficient health care workers to cope with existing demands. In some regions, the local non-resident population increases dramatically with fly-in/fly-out and drive-in/drive-out (FIFO/DIDO) mining/seasonal workers and older seasonal travellers or ‘grey nomads’. However, little is known about the extent to which these populations put pressure on local health services.

Methods: A rapid literature review was undertaken to define the size and scope of three groups (mining workers, seasonal workers and grey nomads) and investigate their impact on the use of rural health services.

Findings: Non-resident workers and grey nomads comprise over 25% of rural populations in some areas of Australia. Little empirical evidence is available on the impact of these populations on health services, although available data suggest demand is similar to that of permanent residents. Further, some data indicate that musculoskeletal injuries (mining and seasonal workers) and age-related conditions (grey nomads) are common.

Discussion:
Pressure on health services is exacerbated in some areas due to large and unpredictable fluctuations in FIFO/DIDO populations. Data on patients’ usual residence postcode could be used to quantify FIFO/DIDO populations; and inform planning and resource management in rural/remote health services.

1269- Žitnik Šircelj
ID:EFPC20141269
ROLE OF A NURSE PRACTITIONER IN MODEL FAMILY PRACTICE IN SLOVENIA AND THE SATISFACTION OF PATIENTS WITH THE NEW WORK METHOD
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Purpose: The purpose of presenting examples of good practice is to prove the importance of incorporating a nurse practitioner into family practice on the primary health care level as a form of additional help for better treatment of our patients and better and more thorough carrying out of prevention. The paper will demonstrate the importance of good preventive screening during routine check-ups performed by a nurse practitioner at a model family practice for the health of the patients.

Theory: Due to the changing needs of the population, the need for a different medical treatment of patients has arisen. Routine check-ups enable us to better control the medical condition of the population or to diagnose a disease early or perhaps even to prevent it by giving advice and taking proper measures. The main role in this process is played by a nurse practitioner, employed at a model family practice. In Slovenia model practice is a well-received innovation, especially by patients; the latter also reflect our work and good practice.

Method: A case study was used with a presentation of clinical cases and the course of treatment at a model family practice during a randomly performed routine check-up.

Findings: Patients are diagnosed with a disease much sooner, which consequently leads to a better prognosis and treatment of the disease. The individual, personal approach also increases the satisfaction of patients with the new work method and their awareness of their own actions.

Discussion: Patients are in favor of the new work method and are aware of how it benefits their health. They view the following as advantages: time of check-up, holistic approach, good traceability of patients and regular check-ups, which additionally contribute to the patients introducing and maintaining important changes to their lifestyle. Model family practice and nurse practitioners are becoming an indispensable part of the medical treatment of patients on the primary level. In addition, this work method grants autonomy to nurse practitioners.

1272- Longman

Understanding the nature of demand in general practice

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keywords: Demand, GP, data capture, acuity, urgency, continuity

Purpose: To understand in GPs view the nature of demand, by acuity, urgency, new/follow up, importance of continuity, how consultations are resolved and differences between telephone and face to face.

Theory: Better understanding of demand is fundamental to how GPs work needs to be designed, and capacity to be planned. Data underlying demand in these terms has been lacking or misleading.

Methods: Capture data online from GPs at the end of each consultation, for a sample period of one week in each study practice. Currently n = 75 practices, n = 47,000 consultations.

Findings: Higher than expected acute presentations at 60%, plus 10% acute exacerbations. Although "urgent" presentations were 25% of the total, patient need and clinical benefit are clearly linked with speed of access. Continuity is shown to be important in 45% of consultations, rising from 20% to 60% with age. Follow ups are more often resolved by telephone.

Discussion: While rapid access and continuity are both important for public health and patient satisfaction, this study highlights the clinical reasons why they should not be seen as opposed but as joint operational goals for general practice.
**1277- Van Den Hombergh**  
Investing in Primary Care, do patients value the changes? A 6 year longitudinal survey of patient experiences

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keywords: Patient experiences, Primary care, Investments in PC, Trends in patient experiences

**Purpose:** To explore the trend in patient experiences with Dutch primary care between 2007 and 2012 and how this experience is affected by patient and practice characteristics.

**Theory:** Investing in primary care is essential for a well-functioning health care system. In 2006 Dutch health care became more market oriented and insurers invested more in primary care. Practices got more nursing staff mainly for chronic care management, list size decreased, accessibility and a wider scope of diagnostic and therapeutic services were incentivized and investments were made in GP-trainers and training practices. These changes might have affected the quality of primary care form the patient perspective.

**Method:** In a survey study patient experience was measured by a validated questionnaire on the functioning of the GP and the practice. The data of 1657 practices with 2966 GPs is part of the Dutch accreditation program.

**Findings:** 78,985 patients judged the functioning of the GP, and 45,773 patients the practice. Both the overall GP and the overall practice performance scores increased with 5% between 2007 and 2012.

**Discussion:** The increased number of patients with positive evaluations of family practice may be the result of several developments since 2006. The remarkable linear improvement of all GP & practice performance scores justifies scrutinizing the underlying factors. Investing in primary care probably leads to better quality of care as appreciated by the patients.

**1284- DeClerq**  
Barriers for GP’s in West Flanders (Belgium) to refer patients to dietitians for nutritional counseling

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keywords: dietitian, primary health care, nutrition counseling, general practitioner

**Purpose:** Describing barriers that influence GP’s to refer patients who may benefit from nutritional counseling to dietitians.
**Theory:** There is growing evidence that nutrition may play an important role in aetiology and management of many chronic diseases. GP’s are at the forefront for nutritional counseling in primary health care. However there is a lack of evidence on barriers that may influence the referring behaviour of GP’s.

**Methods:** In a descriptive design 1068 GP’s and 125 dietitians were invited to complete a questionnaire related to their practices, collaboration and barriers for referring.

**Findings:** The response rate for GP’s and dietitians was 6.5% and 37.6%. Younger GP’s tended to have a positive attitude towards nutritional counseling, however this was not expressed in frequency of referring patients to dietitians. Dietitians responded that just 20% of their patients was referred by a GP. About 70% of the GP’s responded to lack knowledge and time to give nutritional counseling. The important barriers (GP response) were a lack of overview of dietitians working in the area, a lack of interest in nutritional counseling by dietitians and the costs of a dietetic counseling.

**Discussion:** These findings suggest that more research is needed so a well designed strategy can be developed to promote the profession of dietetics in primary healthcare.

1292- McKenzie  
**ID:**EFPC20141292  
**Out of hours primary care in Australia – evolution or revolution?**

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**keywords:** Out of hours care, after hours care, primary care, general practice

**Purpose:** To investigate the development of out of hours (OoH) primary care policy and service models in Australia.

**Theory:** A realist evaluation theory underpinned assessment of the impact of OoH primary health care policy reforms. A realist evaluation perspective examines not only what works, but for whom and under what circumstances. Understanding the context of reforms and the interaction of policy mechanisms with context to produce effects on consumers and providers is fundamental to identifying sustainable models of OoH care.

**Methods:** A mixed methods before and after design was used to evaluate two OoH reforms – a primary care network approach to local planning and funding and a national after hours GP telephone helpline.

**Findings:** Australia has a diverse OoH care system reflecting most European OoH models, as well as expanding corporate primary care and medical deputizing service sectors in metropolitan areas. Demand for OoH care is growing and the definition of OOH care as “urgent care that cannot wait” no longer matches consumer expectations or provider business models. Despite substantial public funding some population groups are underserved, particularly rural consumers and the elderly.

**Discussion:** OoH models have evolved rapidly in Australia but a sustainable OoH system may require a revolution in policy and funding.

1302- Mut  
**ID:**EFPC20141302  
**Obesity Case with Obstructive Sleeping Apnea Disorder**

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**Purpose:** Obstructive Sleeping Apnea (OSAS) is an important disorder among respiratory diseases in primary care. It is mostly seen together with obesity. This presentation; an OSAS case originating from obesity is presented and its importance was emphasized.

**Findings:** A seventy-seven years old female patient applied to our obesity polyclinic in 24 December 2013. She complained about shortness of breath, snoring, night sweating, insomnia and waking up tired. Moreover; she had chronic renal failure, hypertension, hyperlipidemia and type-2 diabetes. Physical examination was held; her body mass index was calculated as 43,9 kg/m2. Her chest radiography showed mediastinal enlargement, tracheal deviation to the right and increase in cardiothoracic index. She showed high blood sugar (249 mg/dl), urea (56 mg/dl), creatinin (1,4 mg/dl), uric acid (6,7 mg/dl), cholesterol (214 mg/dl) and triglyceride (235 mg/dl) levels. Other tests were usual. Blood gas parameters were PH:7,47, PCO2:47,9, PO2:66,8, HCO3:30,9 and SO2:93,3%. In the chest disease consultation; it was decided that shortness of breath was related with obesity. Giving weight and N-BPAP titration investigation was advised for the future period.

**Conclusion:** Obesity, leads many chronic diseases and causes morbidity and mortality. It is a serious health problem for primary care. It shows togetherness at approximately 70% of the OSAS cases. The examination of obese patients’ respiratory functions and sleeping mode is important due to the close relationship between obesity and OSAS.
these asylum seekers were provided to receive health service.

**Result:** Case of possible migration to the service areas of family physicians and CHC, we believe that planning fieldworks by using this model is great importance of controlling the health parameters of the service area.

**1331- Codern Bové**

**The dynamics of health in the community: a diagnostic proposal**

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- **keywords:** determinants of health, community, social structural features, health inequalities, positive and negative health processes.

The dynamics of health in a country are related to the determinants of health that exist in the different areas. Analyzing allows us to relate health problems to the different conditions in which people live. Moreover, the relationship between determinants of health and social inequalities involves identifying the macro-meso and micro social structural features that generate social action and discover to what extent these determinants influence people’s health.

The Torresana neighborhood (Terrassa-Barcelona) with 4.705 inhabitants has been studied by an interdisciplinary health team (nurses, physicians, social workers, sociologists and anthropologists). The goal was to understand the dynamics of neighborhood health and identify the positive and negative health processes. We used document analysis (official reports data about health status of community), structural and health status indicators and in-depth interviews with key informants (stakeholders and neighborhood residents). The data of morbidity of the population was obtained with help of the primary care center and Terrassa’s area of public health.

Finally, we will explain the promotion, prevention and care needs within the community and we will discuss methodological issues in the development of our community diagnosis.
Study protocol. Health Equilibrium Initiative: a public health intervention to narrow the health gap and promote a healthy weight in Swedish children

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keywords: Health equity, healthy weight, Community-based participatory research, empowerment

Purpose: Health Equilibrium Initiative (HEI) focuses on narrowing the health gap and promoting healthy weight in children. Evaluation objectives are to compare outcome between children in intervention and control areas, conduct health economic assessments (HEA) and evaluate the project processes.

Theory: HEI draws on Community-based participatory research (CBPR). Resting on principles of empowerment, CBPR has potential to narrow the health gap and raise participation rates. The Program Logic Model is based on Social Cognitive Theory and Intervention Mapping.

Methods: Primary contact groups are children in disadvantaged communities. Core efforts are to confirm and convey knowledge, elucidate and facilitate ongoing health work and support implementation of continuous health work. Anthropometry, food patterns, physical activity and belief in ability to affect health; together with learning, memory and attention assessment will be assessed in 350 children (born 2006). Examinations will be repeated after two years and form the basis of health economic analyses. Process evaluation include document analysis, key informant interviews and focus groups.

Discussion: When public health workers and researchers invite, await and include local perspectives mutual confidence and collaboration is created, forming prerequisites for complex and supportive structures. Such structures may constitute basis for sustainable health promoting programs. The HEA of this study may contribute in decision making processes.

METABOLIC SYNDROME IN NON DIABETIC POPULATION

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keywords: Metabolic Syndrome X, Prevalence, Simple Random Sampling, Primary Health Care
**Purpose:** To determine the prevalence of metabolic syndrome (MS) in a non diabetic population.

**Theory:** The prevalence of MS in non diabetic population is thought to be lower than in general population.

**Methods:** We conducted a cross-sectional study of subjects aged≥18 years randomly selected from a Primary Care Area. Patients with diabetes, gestational diabetes and other secondary diabetes were excluded. Variables recorded were age, gender, waist circumference(WC) and blood pressure(BP). A blood test with fasting plasma glucose(FPG), HDL cholesterol, triglycerides(TG) and glycohemoglobin(A1C) was also performed. MS was defined according to the National Cholesterol Education Program Adult Treatment Pannel III 2001(NCEP ATP III).

**Findings:** 282 subjects were included, 61.7% were women and 38.3% were men, mean age range 51.4 years [95%Confidence Interval(CI)49.9-52.9]. The mean ranges of MS components were: WC 94.5 cm (95%CI 93.1-95.8), systolic BP 122.5 mmHg (95%CI 120.6-124.4), diastolic BP 77.4 mmHg (95%CI 76.3-78.6), FPG 94.6 mg/dl (95%CI 93.8-95.4), HDL cholesterol 62.4 mg/dl (95%CI 60.5-64.3) and TG 102.0 mg/dl (95%CI 95.1-108.9). The prevalence of MS was 17.8% (95%CI 13.8-21.8).

**Discussion:** In our country the prevalence of MS in general population is about 17-24% and in our research this prevalence is ≈18% excluding diabetics. Our study suggests that MS is associated with diabetes but it is not a determinant factor.

1361- Sivalli Campos  
**ID:** EFPC20141361  
**Action research with nurses in Primary Health Care as an instrument for proposition emancipatory practices in health.**

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The aim of this study is to describe a process based on the methodology of critical action research, developed with primary health care (PHC) nurses. The proposal is to discuss and to propose emancipatory practices. Based on the concepts of work, health work process and health needs, we developed 7 emancipatory workshops with 12 PHC nurses of Sao Paulo, Brazil. We described the development of the workshops according to themes, objectives and strategies. Process evaluation showed that critical action research is a method that connects the disclosure of the object and its transformation. The analysis showed that object was disclosed by critically analysing current practices - mainly based on clinical knowledge, answering health needs as needs for health services and clinical care. The emancipatory proposal resulted in a pedagogical material about Home Visit. Determinants of health-disease process were emphasized expanding the understanding of health needs.
1362- Borgman  
**Women’s Sleep, Related to their Work Situation, a Comparison Between 1980 and 2005 – The Population Study of Women in Gothenburg**

Ms Anni Sofi Borgman  
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keywords: sleep, work situation, population study, public health

**Purpose**: A great part of the visits to health centers involve sleeping disturbances. Research implies that women have sleeping problems to a greater extent than men. Stress, computer use, irregular working hours are associated with sleeping problems. Women in Sweden are working to approximately the same extent as men, but in less powerful positions with lower salary. The aim of the study is to compare women’s sleep in relation to their work situation.

**Theory**: Sleep prevents stress, helps us meet stressors accordingly and is essential for good health.

**Methods**: Using the Population Study of Women in Gothenburg, a cohort comparison, of 38 year old women in the examinations 1980/81 and 2004/05 and a logistic regression analysis is done.

**Findings**: Women sleeping nine hours or more have halved in 2004/05, and those sleeping four hours or less has doubled. Moreover, there is an indicated doubled risk of experiencing inferior sleep in 2004/05 (OR 2, 31), compared with 1980/81. There is a significant association between experiencing inferior sleep and having a poor situation at work.

**Discussion**: There is a need for interventions, i.e. where people can meet and learn about sleep hygiene. These could be given at Sweden’s health centers, to enable better health for all.

1366- Peris  
**Evaluation of referrals from primary care to hospital specialists**

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keywords: referrals, primary care, specialist

**Purpose**  
Gatekeeping is one of foremost characteristics of primary care. Gatekeeping has direct repercussions on referrals to secondary care.

**Theory**  
Our team aims for a high patient resolution, employing various technical procedures and common diagnostic tests, to avoid certain referrals or to refer patients after they have been diagnosed. Despite a low number of referrals, we observed large variations in referral rates among our family physicians.

**Methods**  
We gathered, from the electronic database, all referrals made during six months in 2013. We sorted out the six most frequent specialist referrals. The referrals to be reviewed were equally distributed, as Access files, to eleven physicians that participated in the study. The files included the reason for referral and the medical history of the patient (if it was mentioned in the referral) and one question asking if the
reviewing doctor would have done the same referral, with each referral being evaluated by two doctors.

**Findings**
A total of 834 referrals corresponding to 13 doctors were evaluated. A wide variation in referrals number among doctors was noted, from 46 to 96. We analyzed the adequacy of referrals. We looked for the agreement between the two evaluators, which was reached in 621 of the cases, and out of these cases only 80 were considerate as improper.

**Discussion**
Referral rates can be lowered and we should harmonize referral criteria providing proper information to the hospital specialists.

**1369- Baba**

**ID:** EFPC20141369

**The effect of allergen-specific immunotherapy on growth rates in children**

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**keywords:** allergy, immunotherapy, children

**Purpose:** To evaluate the outcomes of specific immunotherapy on growth curves of children with allergies treated by a pediatrician in primary care.

**Theory:** Allergies are the most common chronic disease in children. Airborne allergens produce many symptoms and affect the quality of life. Immunotherapy is a well-established treatment and the only one that can modify the course of allergic diseases.

**Methods:** In the study there were included children diagnosed with allergic rhinitis, allergic conjunctivitis or mild/moderate persistent asthma produced by aeroallergens and treated with specific immunotherapy. The skin prick-test helped reach the diagnosis and determined the specific vaccine that was administered. There were excluded from the study children with mild rhinitis, intermittent or severe persistent asthma and lung diseases not related to allergies.

**Findings:** A total of 77 children were included, with ages between 4 and 14 (mean age was 13), girls being 43% of the patients. A 65.1% of the cases were diagnosed of allergic asthma, followed by 29.4% with allergic rhinitis. The mean treatment time was 1.8 years (range 0-40 months). An improvement in regards to the growth rate was noted, with a mean of 6.59% (range 0-15%) over the expected growth curves.

**Discussion:** Children suffering from allergies and treated with specific immunotherapy show an enhancement over the expected growth curves.

**1377- Björkelund**

**ID:** EFPC20141377

**Internet Cognitive Behavior Therapy in mild to moderate depression in primary care - effects on depression symptoms, pharmacological medication, sick listing, work ability and quality of life. A randomized controlled study; 3 and 6 months’ follow up**

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keywords: Depression, Internet, Cognitive Behavior Therapy, pharmacological therapy, work ability, sick listing, quality of life. Primary care

Purpose: To evaluate if treatment of depression in the primary care context can be improved by the use of internet based cognitive behavior therapy (I-CBT) compared to Treatment as Usual (TAU) with emphasis on long time (6 months) outcomes.

Theory: ICBT has shown good effects concerning treatment of depression in RCTs with participants recruited from psychiatric and psychological departments as well as (web- based) advertisements. However, few RCTs with patients from primary care centers (PCCs) have been performed.

Methods: PCCs with access to psychologists with CBT competence were offered participation. Patients diagnosed with mild-moderate depression (MINI) were randomized to ICBT or TAU. Variables measured at baseline, follow up 3 and 6 months: depressive symptoms (BDI-II, MADRS-S); medication; sick listing (days), and quality of life (EQ-5D).

Findings: Sixteen PCCs participated, 90 patients were randomized to I-CBT/ TAU. There were significant in-group reductions of depressive symptoms as well as increase of QoL in both ICBT and TAU group from baseline to 3 months follow up, but follow-up 3 and 6 months showed no significant differences between I-CBT and TAU groups concerning reduction of depressive symptoms, sick-listing frequency, or quality of life, but significant difference concerning use of antidepressant medication in the favor of the I-CBT group.

Discussion: Psychologist supported ICBT treatment in primary care patients shows at least as good effect on depressive symptoms as TAU and reduction concerning pharmacological requirements.

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1381- Dudele EFPC:ID20141381

Cost-of-illness studies of Musculoskeletal disorders as an instrument to maximise societal benefit from early interventions and coordinated health care in Latvia

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keywords: Musculoskeletal disorders, societal burden, cost-of-illness studies, early interventions, preventative health care

Purpose: To evaluate the societal burden of Musculoskeletal disorders with the aim to improve early interventions and coordination of preventative health care measures.

Theory: Early and coordinated health care interventions have been recommended as an instrument of achieving better health outcomes and efficiency in care delivery. However, these recommendations have to be based on proper analysis to understand the most effective ways and areas for interventions. Cost-of-illness studies is an instrument to evaluate the economic burden of disease, which can be used to
formulate main areas for interventions to maximise the clinical, economic and societal benefits of early intervention care.

**Methods:** Cost-of-illness model is developed to evaluate the societal burden of Musculoskeletal disorders, including direct and indirect costs for patients, health system, employers and social security system.

**Findings:** Musculoskeletal disorders is the leading cause of disability between working population in Latvia and it’s economic burden is more than 140 million EUR per year. Majority of costs are attributed to individuals (over 30%) and employers (25%), much less to the health care system – only 20%, the rest – over 15% - to the social security system. Cost analysis show the disbalance between cost distribution and certain gaps in the provision of early interventions and preventative health care services.

**Discussion:** Cost-of-illness model is an instrument to provide information for decisions to be made for economically grounded investments in health care. The study has revealed the need for better planning and coordination of early interventions and preventative measures in health system to reduce the economic burden of Musculoskeletal disorders for individuals, employers and social security system.

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1382- Agotnes

**A critical review of research on hospitalization from nursing homes; what is missing?**

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**Keywords:** Nursing Home, Long-term Care, Residential Care, Hospitalization, Literature Review

**Purpose:** “Hospitalization from nursing homes” has been a much studied topic for two decades. This emphasis can be attributed to a general consensus about the negative impact hospitalization has for those involved, both personally for the residents/patients and financially for the institutions. This article aims to critical review current research on the topic of “hospitalization from nursing homes”. Firstly, we will examine the more or less taken for granted epistemological premise within research about hospitalization. Secondly we will discuss how the research discourse treats the fundamental question resulting from such a premise: reasons for hospitalizations. Thirdly, we will examine what is missing within the research discourse about hospitalization.

**Theory:** We will understand “critical review” in accordance with Grant and Booths’ description (2009): “It goes beyond mere description of identified articles and includes a degree of analysis and conceptual innovation...A critical review provides an opportunity to “take stock” and evaluate what is of value from the previous body of work”.

**Methods:** In our review we have included 7 review articles dealing with the topic of “hospitalization from nursing homes”, 56 original research articles with “hospitalization from nursing homes” either in the title or as an important topic, and 10 articles of a more implicit relevance. The research articles are from 1993 up until current date.

**Findings:** There is a striking similarity in research design and methodology within research on hospitalization from nursing homes. Interestingly, most studies in our selection fall into the category of larger retrospective studies of actual hospitalizations, as opposed to prospective studies of potential hospitalizations.

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The similarities in approach, design and methodology, result in what we describe as “a discourse about hospitalization”. This “discourse” has its limitations and weaknesses, especially a focus on 1) how factors or conditions leading to hospitalizations are interrelated, 2) how socio-cultural conditions relate to hospitalizations and 3) potential hospitalizations rather than actual hospitalizations (leaving out half of the picture: those not hospitalized).

Discussion: In our opinion these limitations are connected to research designs (mainly retrospective), methodology (exclusively statistical) and theoretical foundation (missing altogether), resulting in a narrow approach to a subject that should be treated as multi-faceted and complex. The limitations are connected to and strengthened by a “research discourse” which seems to be taken for granted as the correct way of doing scientific work, thus enabling researchers not to see beyond the gaze of the discourse.

1383- Seghieri EFPC: ID20141383
Continuity of care and communication among general practitioners, specialists and patients in Italy

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Keywords
Continuity of care, communication, ICT, primary care, general practitioners, patients, specialists.

Comprehensiveness of information and effective communication between general practitioners (GPs) and both patients, and different care providers, is an essential requirement for the continuity of care. The aim of this study is to describe communication and networking practices in the Italian Primary Care (PC), comparing patients’ and GPs’ perceptions and identifying elements that can produce variations in the continuity and coordination of care across Italy. Statistical analyses were conducted using data collected in 2013 through the QUALICOPC survey. Comparisons between the answers of the 220 GPs and their patients, almost 10 per GP, were performed. The results showed a gap among patients’ and GPs’ perceptions of practices of communication and information sharing with other parts. Moreover, Italian GPs appeared well integrated in professional and personal networks with other GPs, but not with specialists or other care-providers like nurses or social workers, also if the computer is universally used in the Italian PC system. The informational continuity of care and the collaboration with other parts in the Italian PC might need innovation strategies both in terms of appropriate use of ICT to support the exchange of information across all level of care and in terms of behavioural and cultural approach to the collaboration among providers.
Purpose: To develop the prevention and care of chronic illnesses towards a more patient-centered approach in order to achieve greater health gain and to make health care professionals' work more meaningful and manageable.

Context: TERVEYSHYÖTYMALLI—Health Gain Model was used as a framework to enhance the management of the prevention and care of chronic diseases in Health Centers and Community by involving patients and organizations as active participants. The model is based on Chronic Care Model but it is closer to the Expanded Chronic Care Model. By applying the model, we expected to achieve better population health, healthier patients and better health outcomes for them, more satisfied patients and providers, and more cost-effective expenditure of health care resources. The most effective way to manage the current unsatisfactory situation, where patients frequently do not get the care they want or need, is to combine six interrelated system changes. In Terveyshyötymalli they include development activities in six areas: self-management support, decision support, delivery system design, clinical information systems, health care organization, and community resources.

State of the art: In the Terveyshyötymalli-project over 250 health care professionals in 61 municipalities were involved in the development activities covering ca. 1 million people. In the South-Ostrobothnia Health Care District, 14 health care professionals from Health Centers, which are the public primary health care service providers under the local government, guided development activities covering ca. 198 000 people.

The activities included evidence based self-care management support, coaching in life-style changes and structure to prepare patient-centered Health and Care Plan. The plan form was developed, nationally accepted and the digital form defined. Plan’s assessment tool was also developed. There is a dismally small number of studies related to the cost-benefits of these kind of changes. We found out, that the amount of visits to the health centers prior and one year after the Health and Care Plan was done, were significantly reduced and financial savings occurred.

Statement for debate: Patient originated centered Health and Care Plan reduces significantly patients' visits and related costs to the Health Centers.

Politic and economic concerns versus patient and physician satisfaction in new health care system in Turkey

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keywords: patient satisfaction, salary, primary care, health policy
**Purpose:** Making a critical emphasize on situation in Turkish primary care, on the basis of how paramedical concerns influence the health services. There is no “no” in clinics because of patient losing concerns.

**Context:** As the salary of a physician was correlated to the number of recorded patients, a competition started. This created a big and an endless conflict in between patient requests and physician recommendations. While some of physicians struggle against those medical and paramedical expectations, others cannot overcome the situation. Eventually extent of requests increased day by day.

**State of the art:** With the establishment of a new health care system, within the context of “family medicine”, the philosophy of economy in healthcare has also been changed. Several regulations were attempted and imposed. Family physicians have become contracted staff. The salary policy changed. Although this made most physicians more kind to patients, it also became hard for the physicians to stand against the expectations of patients. This resulted in a “patient requests oriented health care system”.

**Statements for debate:** As family physicians, we could not give negative response to control public health, so medicine usage increases, even antibiotics, so the resistance. Which should be considered income or public health?
2197- Burghout

Multidisciplinary Oncology Network in primary care in the Netherlands

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keywords: oncology care, trans mural network, quality of care, empowerment

Context: Oncology care in the Netherlands is primarily provided in hospital settings where it is very well organized. In primary care however, the care for patients with cancer is fragmented. Nevertheless many patients seek additional care that is nearby and easily accessible in primary care settings for the consequences of their medical treatment. There is also a need and desire to transfer certain parts of oncology care to the primary care setting. Above that, the concentration of oncology care in specialized hospitals implies a more important role of the primary care setting as patients do not wish to travel far for, for instance, their physiotherapy or psychosocial support.

Purpose and state of teh art:The need for a strong organization of oncology care in the primary care setting is obvious. The MuON project (Multidisciplinary Oncology Network) connects the different and relevant primary care disciplines with each other and trans mural with the professionals in hospitals. Focused on quality of the participating caregivers MuON emphasizes self-management and empowerment of cancer patients and cancer survivors.

Statement for debate: Additional care for cancer patients and cancer survivors will be best provided by highly trained professional caregivers organized in trans mural networks.

2209- Leonard

Epidemiology of Speech Disorders in Elderly Primary Care Patients and Future Directions for Primary Care Research

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keywords: speech disorder, elderly, epidemiology, primary care

Speech disorders affect elderly adults in unique ways and through many causal pathways. Such disorders pose significant threats to the quality of life of aging populations internationally. In Canada primary care is a major focus for resource utilization and first point-of-contact for most community-dwelling elderly patients. Thus primary care physicians may increasingly encounter conditions faced by elderly patients, which may be beyond their traditional scope of practice.

The epidemiology of speech disorders facing the elderly, community-based population is not well-known in the context of primary care. In Canada, referral rates to speech-language pathologists remain relatively...
low, suggesting patients with speech disorders who seek health services in primary care are diagnosed and treated within primary care clinics.

In order to begin an exploration of this population and the complexity of their interactions with the health care system, this study aims to examine the prevalence of speech disorders in elderly patients in primary care through use of a national electronic medical record database. Additionally, we will analyze treatment patterns as well as demographic characteristics related to this patient population and determine the utility and feasibility of using EMR-based data to examine conditions falling outside traditional or typical domains of primary care.

2214- Roelofs

Vulnerable citizens and their participation needs in Amsterdam

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keywords: Occupational therapy, vulnerable citizens, interview, participation, self-reliance, intervention, skills

Purpose: identify needs of immigrants, elderly, people with low income/depts and people with psychiatric problems supporting professionals like occupational therapists to prevent problems and adjust interventions and skills.

Context: In the urban area of Amsterdam a great number of citizens with a variety in background nationalities (www.zorgatlas.nl) seem to be at risk to have difficulty participating because of low income (Mani et al, 2013) and level of health literacy (Nusselder, 2012). This project is a community development project in the second year of our bachelor education in Occupational Therapy (Amsterdam School of Health Professions) a group of student performed 60+ in-depth interviews with a broad population of vulnerable citizens in Amsterdam with the objective to assess their needs and obstacles in the participation and self-reliance. Four groups were interviewed; elderly, immigrants, people with a low income and/or debts and people with psychiatric problems.

State of the art: Preliminary results show that these populations are able to report themes that are important in their daily lives. For elderly isolation and loneliness, for immigrants accessibility to health care information and communication and for the people with low income the intertwining effects of low income with productive, leisure and personal care activities

Statements for debate:
• It would be good for occupational therapists to speak more than one languages so they can easily and quickly inform immigrants and the therapist understands the problem of the client better.
• Occupational therapist in primary care should adjust there interventions / skills to avoid the problems or ascertain the problems earlier if you look at the needs of the interviewed populations.
2229- Cree

From Queue to Quality: A National Musculoskeletal (MSK) Service Re-design

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keywords: Innovation, Sustainability, Value, Quality

Purpose: The Scottish Government aims to develop innovative and sustainable MSK services, that deliver population health, appropriate access and service excellence, through National policy and local implementation. The triple aim in action.

Context: 10 million working days are lost per annum in the UK due to MSK problems. These are associated with mental health issues linking to high incapacity benefit costs as well as a personal cost. 1 in 4 consultations in General Practice are related to MSK and in Allied Health there are over 400,000 referrals per annum in Scotland. In addition current pathways are resulting in a significant number of inappropriate referrals to secondary care.

State of the Art: An innovative primary care service model being delivered through:
• Well-being and self management support – www.nhsinform.co.uk/msk/contact
• Access through both a call handler national triage model and web triage
• Efficient e health referral systems
• Sustainable clinical pathways
• Asset building through community partnerships
• Using both process and outcome data to drive improvement

Debate:
Is this model transferrable to other service pathways to support population health, cost control and experience of care?
Can we use service and patient experience data to drive excellence, performance and accountability?

2236- De Weerd

Personal health data managing population health

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keywords: primary care, new technologies, needs based population health, electronic data collection, electronic health record systems

• Purpose
Sharing ideas about current developments concerning personal health and its opportunities for population health.
• Context
Healthcare costs keep increasing, and although in many countries healthcare quality is high, the individual perceived health status and behavior is often unknown. Technology has the potential to enable a radical change. Currently, most adopted innovations are focused on process optimization and general population measures. The horizon should be broadened through technologies supporting healthy behavior and lifestyle of individuals.

• State of the art
Traditionally, personal health data are captured within primary and social care, though not integrated. Furthermore, many institutes measure population health combining these data and questionnaires, not returning this data to the individual. This strongly inhibits self-management which is the basis of the new definition: “health as the ability to adapt and self-manage”. Additionally, the influence of self-generated personal health data (via e.g. IPhone, Fitbit) is still neglected in the health system.

• Statements for debate
- Primary care should use personal health (related) data for personalizing prevention and treatment, including dynamic guidelines
- Personal health (related) data should be open for individuals (e.g. Blue button) to support them to adapt and self-manage

2240- Kiss
ID:EFPC20142240
Group Practice Pilot Project in Hungary

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keywords: group practices, public health, performance measurement, evaluation

A Hungarian pilot project, funded from the Swiss Contribution (2013-2016), was initiated to test how community-based, public health focused operation of local players could improve the performance of primary care. Our purpose is to review the implementation process, monitor how the performance changes, and provide policy recommendations.

During the pilot four group practices have been formulated in areas with high ratio of Roma population, each consisting of six GPs with their assistants and other key staff: public health coordinator, public health expert, community nurse, diabetologist, psychologist, physiotherapist, midwives, and community coordinators. The aims of the pilot project are to improve the coordination among local providers, and to improve access and decrease health inequalities, especially for the Roma population.

We have adapted the PCMonitor framework (Kringos et al., 2010) to monitor the performance of group practices. Both quantitative (central health insurance fund database, local medical IT systems, participant surveys) and qualitative methodology (semi-structured interviews) have been used to collect information. The dimensions of the PCMonitor model were found to be adequate for monitoring the performance of group practices, however, with several modifications. Preliminary results show that local management, infrastructure and competencies matter, causing a variance in how the model is implemented.
The primary care teams: facing current challenges and becoming stronger

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Purpose:
To improve primary care team effectiveness
To improve the coordination with specialists
To improve the referral profile

Context:
The Primary Care teams (PC) have experienced a remarkable decrease of its referrals to the specialists in the last five years. It might be due to a several measures taken by the board of the Catalan Institute of Health (CIH), according to the public insurer requirements. Some of these measures include, first of all, the annual agreement between the insurer and every PC team; besides that, a set of performance indicators (mainly on quality and prescription standards) settled by the CIH are monitored regularly. Lastly, several other indicators are established, according to the PC team’ specific structure, location and needs. Since 2008 the referral rates to specialists have decreased in all PC teams. For cardiology it was 4.92 per 100 patients treated while in 2013 it was 1.78; for endocrinology the rates were 2.33 and 1.10 respectively; for urology 4.53 and 2.29. A part from the measures mentioned before, other actions were taken such as setting local working groups to discuss and take consensus on clinical guides between primary care and hospital professionals. In 2014, there are more than 550 professionals working side by side on the clinical procedures between both level cares. The information system is another clue element for this change; the electronic records have been totally implemented for PC and specialists and now the connection between the different providers has reached a good implementation, 80% in Catalonia. Nowadays, the new technology is supporting a new way of connection between PC professionals and their patients: the virtual visits, which are increasing and revealing as a very helpful tool for any care team to improve their accessibility and effectiveness.

State of the art: PC effectiveness can be improved with measures as information system, clinical guidelines, and proactivity with specialists. To reach a good level of their performance, they need to be supported by the organization they belong to.

Statements for debate:
Is the referral rate a good indicator to assess the PC team effectiveness?
Benefits from working alongside the specialists can be
Mehmet Akman - University of Marmara - Turkey
Ilhami Unluoglu - University of Eskisehir Osmangazi - Turkey

keywords: Obesity, intervention, pedometer

Purpose
The aim of this presentation is to investigate pedometer usage, which has recently begun to be used as an obesity intervention in family medicine practices in Turkey. The advantages and disadvantages of this application will be explored.

Context
Obesity is a global health problem, as well as a growing problem in Turkey. According to data from the Ministry of Health, the obesity rate of individuals 19 years of age and older is 30.3%, on average. This year (2014) has been announced as the 'healthy eating and movement' year, with obesity being targeted as a major health problem. To manage this health problem, family medicine services will be utilised extensively.

State of the art
The most important goal of public health policies relating to obesity should be to increase physical activity. In studies in which pedometer use was evaluated, those using pedometers increased their physical activity and decreased their BMI. Additionally, campaigns through the mass media increase the usage of pedometers.

Statements for debate
What can be done to promote the use of pedometers? What can be the role of family physician? What methods other than pedometer are effective in the primary care setting for increasing physical activity?

2273- Longman
Pointing two directions at once: policies on Access and Continuity in the UK

Mr Harry J A Longman
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keywords: access, continuity, uk, incentives

Purpose: examine whether new policies on access and continuity in UK general practice will have the desired outcomes.

Context: patient pressure shows that it is difficult to get an appointment with a GP, in particular "my GP", as demands are rising and previous policies while stressing access have undermined continuity. The ruling party wants to "do something".

State of the art: On continuity, an incentive was introduced in April 2014 for a "named GP" for patients over age 75. On access, a £50m fund has been allocated to projects to deliver 7 day access to GPs, 12 hours per day (8am - 8pm)

Statements for debate:
1. Population Health means continuity matters to patients of all ages, more so the elderly,
2. A cutoff at 75, with no evidence, is arbitrary and therefore risky.
3. Measurement of continuity rather than bureaucratic controls and incentives would be a better policy direction
4. Access for 12 hours/7 days may reduce continuity, as the same GPs are spread more thinly.
5. For continuity, a choice of GP must be offered, only possible in limited core hours.
6. Demand out of core hours should be limited to urgent/emergency

**2276- Nebot Adell**

ID: EFPC20142276

**Integrating care: who is who in the net care?**

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**keywords:** integrated care, interfaces between primary care and specialists, working groups

**Purpose:**
To improve continuum care  
To improve the coordination with specialists  
To improve patient satisfaction

**Context:**
Some of the difficulties faced by health services when integrating processes are the diversity of suppliers, the resistance to change, the lack of clear references, the lack of instruments, different information systems, different payment systems and the lack of incentive policies favoring the integration. Having spent almost ten years from the beginning of the changes towards the integration of healthcare processes, it can be said that results are good in the provision of services. Even so it displays as a slow process. Therefore, continuing work must be considered in order to make progress in improving the continuity of care, the main aim of the transformation model. The novelty relies on two key points: the results in health and the knowledge of clinical professionals. Both are considered essential elements for the system evaluation. The mere fact of having to review jointly tackling COPD, ICC or diabetes in each one of the stages of the disease has allowed us to recognize faults, dysfunctions or duplicities. In this context it is essential to identify local leaders who can help to generate changes, establish leadership and set consensus with a variety of professionals from different providers.

**State of the art:**
The knowledge of the clinical professionals is essential to establish leadership in this process of change. The need to set up agreements between all actors from different healthcare providers implies an additional effort to decide and agree on who-does-what at the local level.

**Statements for debate:**
Are we moving forward in the right way?  
What is the role played by the University in the progress towards the integration of processes?  
Does payment system help to advance?
Purpose
The purpose of our project was to identify the communities’ needs and priorities to improve cohesion and social facilities. Subsequently the aim was to identify key-figures within the community. Using a cultural platform that lies within the community, activities fostering social cohesion and a sense of belonging were chosen to perform. The challenge and difficulty within this project was to identify a common goal within the community.

Context
The project was held over a 4-month period in a small secluded community in Amsterdam East, called Architectenbuurt. It has no resources of its own and is dependent upon surrounding communities. As a result there is little to no sense of belonging within the community. It is a diverse community with various interests and needs. The project started from a cultural platform located within the community. The owner wants to provide the community with their resources, thus enabling and empowering the community, but also creating a sense of belonging. Therefore people interested in cultural activities became the target group for this project. Six OT students were involved in this project using a community development approach.

State of the art
Using a conceptual process model (Zinkstok, 2013) for CD we continuously assessed our methods and plan. This new model gave us insight of which strategies worked and which did not.
De-institutionalization and direct responsibility of the individual for their own health is an opportunity for primary care to invest in CD projects.

Statements for debate
- Primary care should focus more on community health instead of the individual.
- Owners of primary care practices have to little knowledge of financial possibilities within community health care.

Art in medical education: Does it help for professional development?

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keywords: Medical humanities, Medical education, biopsychosocial approach
• **Purpose**
The aim of this presentation is to investigate use of arts in medical education. Possible advantages and pitfalls of this approach will be explored.

• **Context**
During the last 50 years, there has been a growing tendency in medical education to cover meta-cognitive and affective areas as well as cognitive and psycho-motor areas. The felt need for supplying education in a moral, social and cultural context has also contributed to the complex and multidimensional quality of medical curricula. Medical humanities programs, including art courses, have the valuable function of complementing biological perspective of medical education program with humanities and social science perspectives. The graduates of these programs though to be not only disease manager but also patient-carer practitioners. Such programs are being implemented at different medical schools evaluations of efficacy, however, are not found frequently in the literature. It’s important to evaluate effectiveness in order to realize suitable improvements in education programs.

• **State of the art**
Experience of art can facilitate identification and management of patient’s by stimulating insight into common patterns of response, by high-lighting individual differences and uniqueness, and, most fundamentally, by enriching the language and thinking of the practitioners. Study of humanities (arts) may not be able to make clinicians more human, but it can foster a depth of human and humane understanding, knowledge and experience. It could be especially helpful for primary care professionals while they are handling values rather than facts, ambivalence rather than reductionism, dealing with a world where not everything can be explained by experiments. On the other hand definition of final product or how to “measure” outcome seems to be the major challenges while running an art program in a medical curriculum. Besides student motivation and executive point of view of your faculty/department are other key factors for determining success of such a program.

• **Statements for debate**
• Why use the arts in Medical education?
• What could be its goals and functions in a medical school curriculum?
• Could arts help family physicians to develop attitudes and behaviour that are appropriate for biopsychosocial approach? How?
• Should art modules be a mandatory part of medical curricula or more on voluntary basis like elective courses?

2311- Calaf Moya  
ID:EFPC20142311
The development of nurse competences, the way to improve the quality of health care

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To improve the quality of health care, the pediatric nurses of our center have implemented several initiatives based on professional autonomy.

Considering the development of nurse competencies, based on health promotion and health prevention, we reorganized the patient assistance on levels, office visits and community interventions. To provide nurses with knowledge, skills and autonomy, the pediatric team developed two guidelines. One for the urgent patient demands that can be solved by the nurse and the other one for the periodic check-ups following the protocol of preventive activities and health promotion in pediatric patients. To help improve access to health services for urgent care needs and built on current protocols for diagnosis and treatment, we designed “The Nurse Interventions Guide for Health Problems, Children”, with nurses being the gatekeepers. There were selected the most common health problems that could be solved by the nurse, as well as other possible interventions for emergency care where decisions would be shared with the doctor.

To put better into practice the periodic health check-ups performed by nurses, and using the same approach, we developed “The Nurse Guide. Infant check-ups”. These regular controls are part of health care in regards to expected growth patterns of children, together with detection and evaluation of potential pathologic signs and symptoms. This initiative has improved our health care service of urgent demands and established the nurse as the reference person for the patient’s future requests.

2332- Farkas Pall  
ID:EFPC20142332

Challenges and opportunities of a national screening program from the primary care perspective

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keywords: cervical cancer screening, community involvement, education, socio-economic factors

Purpose: to explore the experience of primary care providers and patients involved in the Romanian national cervical cancer-screening program, correlated with results and design recommendations in order to avoid pitfalls and improve outcomes

Context: the incidence and mortality rates of cervical cancer in Romania are the highest in Europe. Studies were conducted and found an imminent need for prevention preceded by mapping of resources and capacity building, resulting in the launch of a national program for cervical cancer screening in 2012 coordinated by MoH.

Providers involved are GP practices, gynecology clinics, laboratories.

State of the art: Primary care providers had a well-defined role in the design of the program however not enough emphasis was put on effective communication and education in the community, leading to low participation rates especially amongst the socially underprivileged and with lower educational levels. Another major negative factor in achieving better outcomes was found reduced access to the service
locally, as high percentage of GP practices opted out of performing smear tests, the reasons of it found to be finances, lack of time allocated, shortage of trained staff.

During the program we initiated educational sessions for our patients and their representatives addressing their ideas, concerns and expectations. Special efforts were made to approach the patients with low socio-economic status and low educational levels and to find the appropriate ways of communication. We had a significant increase in the number of groups, our efforts being on the other hand jeopardized by other factors such as lack of funding, distance, fears from discrimination at secondary care levels, discontinuity.

**Statements for debate**
1. When designing a national screening program, is fundamental to set up a functional primary care network
2. Effective ways of communication and patient education in the community have to be used in order to improve outcomes
3. Continuity of the service is crucial in achieving long term, statistically significant results
4. The efficient use of existing resources is very important in addressing the needs of groups with low socio-economic status

2338- De Groote

**ID:EFPC20142338**


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On behalf of PACE - -

**keywords:** high-quality long term care, long term care facilities, palliative care, PACE, primary care

**Purpose**
In order to deliver high-quality care in long term care facilities, a further integration of palliative care, including strong links with Primary Care providers, is needed.

**Context**
Governments are struggling to provide high-quality long-term care for people with chronic advanced diseases and reduced functional and/or cognitive capacities in long term care facilities.

State of the art
PACE is a European funded project (FP7, 2014-2019) comparing the effectiveness of PAlliative Care for Elderly people in long term care facilities in Europe and aims to advise policy-makers on optimal palliative care practices. PACE compares the effectiveness of health care systems with and without formal palliative care structures in long term care facilities in 6 EU countries (BE, NL, IT, FI, PL, UK), and investigates the impact of an innovative health service intervention ‘Route to Success’ aimed at integrating palliative care in long term care facilities’ structures, on patient, family and staff outcomes and on cost-effectiveness in a
cluster controlled trial.
PACE and its’ dissemination partner EFPC will set-up a working group for Primary Care professionals in order to involve those Primary Care professionals who provide palliative care at different places and moments within care provision. First contacts with future working group members will be established.

Statements for debate
- For a higher quality of care in long term care facilities, further integration of palliative care within long-term care facilities is essential.
- Setting up a smooth collaboration between Primary Care and long term care facilities is essential to provide a higher quality of palliative care.
- Coordination of palliative care should be at long-term care facilities / Primary Care level.
- Better integration of palliative care in health care equals changes in: education and training, accessibility and (finance) structures, and investment in innovative research.

2379- Piessens  
EFPC:ID20142379
The new integrated comprehensive needs-based capitation system in Belgian Healthcare: preliminary conclusions

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In the Belgian healthcare system most health care providers are remunerated via a ‘fee-for-service’ system. However, there are also more than 130 integrated community health care centers (CHCs) in Belgium, caring for 3% of the total Belgian population. In 1982 a new financing system for primary health care was set up alongside the fee-for-service system: the integrated capitation finance system. This system is based on the average reimbursement for interventions in the primary health care system. In 2013 the old capitation system was transformed into an autonomous budgetary system with a needs-based distribution of resources between the CHCs. A yearly "photograph" of the CHC populations is now used to map the population needs (demographic, social-economic, morbidity and contextual variables) and resources are distributed according to the results of this exercise.

First findings
Despite its merits there is still room for improvement in a number of areas: the selection of data sources, the choice of variables used and the concomitant weighting procedures, the system prevents patient selection bias, but could facilitate inappropriate medication prescription, refine and improve the calculation methods to reflect even better the needs of the CHC population.

Key words: capitation-fee, needs-based, alternative financing

2380- Moosa  
EFPC:ID20142380-
“Presenting Chiawelo Community Practice in Soweto as a practical example of COPC in the NHI”

Background
The concept of Community-oriented Primary Care (COPC) started in the 1940s with a young doctor couple – Drs Sidney and Emily Kark - setting up the Pholela Community Health Centre in Bulwer, Natal. It is unfortunate that COPC seems to be poorly implemented worldwide, with high-minded theory and
impractical approaches. PHC Outreach Teams, based on Brazilian COPC experience, is a core part of PHC Re-engineering and National Health Insurance in South Africa, however implementation is poor.

Discussion
The Chiawelo Community Practice (CCP) has been implemented in Soweto using a simple framework based on the Karks, and worldwide work on COPC since:

- Community health workers, as active part of the team, developing a community diagnosis and strengthening daily interaction with the community
- Practice organization of teamwork around person, family and community, especially with strong problem-oriented record systems
- Strong structured collaboration in the health system, inter-sectorally and with community stakeholders
- Health promotion, including innovative communication

CCP covers ±10 000 population in Ward 11. The process started in January 2014 with an iterative process of CHW mapping / registration of the community; a strong person-, family- and community-centred and team-based practice integrating almost all services in the Chiawelo CHC; deep stakeholder engagement; and growing health promotion. The presentation will include the dynamics of this process, the experiences and the outputs so far, including an insightful demographic, morbidity and utilization profile of Ward 11 residents.

Conclusions
The concept of the Community Practice is allowing us to implement COPC relatively easily and transferably. CCP shows that this can be possible easily and quickly. It has already become an important focus for training and research. We see COPC as integral to building universal health coverage.

2386- Fischer ID: EFPC20142386
Breaking new grounds in Primary Care in Austria

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Keywords: Primary Care, Austria

Purpose. The new approach to primary care in Austria will be presented and chances, risks and pitfalls will be discussed.

Context. Austria’s health care system is undergoing a substantial change with the implementation of a comprehensive target control system in 2013. One of the key intentions of this reform is the increase in the levels of primary care, as in international comparison Austria performs rather poorly in the three dimensions continuity of care, coordination of care and access to primary care (Kringos, 2012). Apart from the problems in the field of primary care Austria’s system is characterized by too much use of inpatient care in hospitals (OECD, 2011).

State of the art. On 30th June 2014 the newly-created Federal Target Control Commission (in other words the governing board of the Austrian health care system) passed a concept for a multiprofessional and interdisciplinary approach to primary care in Austria. Primary care will be the first point of contact in the health care system with comprehensive services. At the same time the free access to all levels of care will not be restricted. The concept developed by a group of experts takes the know-how of certain stakeholders, represented by their professional organizations (e.g. physicians, nurses or therapists), into account. The presentation will focus on the goals of this new approach, on the functions and the involved

4 For more information see: http://www.bmg.gv.at/home/EN/Topics/Health_reform)
health professionals, as well as on the general framework for new primary care structures (e.g. concepts for patient loyalty, payment models,..).

Statements for debate. Are we really breaking new grounds in primary care and how much state of the art is being used in this new approach? Are there lessons learned from other health care systems? What kind of challenges and pitfalls will Austria face?

2388- Buysens EFPC:ID20142388
Get your teeth into it!
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Keywords: oral health, Ghent, vulnerable neighbourhoods

Purpose: the purpose of this project is to improve the oral hygiene and oral health of the population of Ghent with special attention for the vulnerable neighbourhoods situated in the 19th century belt around the city. Moreover the project aims to reduce access and oral health disparities.

Context: ‘Get your teeth into it!’ started 10 years ago out of signals from inhabitants, professionals and dentists living and working in the vulnerable neighborhoods. It started as a small project within a Community Health Centre (CHC -Wijkgezondheidscentrum). In the years following, the project has spread over the whole city of Ghent and its social vulnerable neighbourhoods. Today ‘Get your teeth into it’ is a cooperation between CHC’s, the Department of Health (city of Ghent), the university of Ghent, a professional youth welfare organization, the Flemish agency Child & Family, the 3 intercity Pupil Counselling Centers in Ghent and various organizations and dentists working in the different social vulnerable neighbourhoods.

State of the art: In this cooperation some successes were already being achieved. There is significant improvement in oral health parameters of the target group. Stumbling blocks, such as prevention materials that are not adjusted to the target group, ... and other hampering factors were observed and had to be dealt with. The poster presentation will show how the different actors cooperate and how they strengthen each other in achieving the same goal; how these organizations operate in the community and involve different actors; and what the results and stumbling blocks are of this project.

Statements: Why should we invest in prevention towards vulnerable groups who have most often a lot of oral health problems? How can city broad campaign be joined with a focus on vulnerable groups and neighbourhoods?

3104- Visentin ID:EFPC20143104
MOTIVATIONAL STRATEGY FOR DETECTING TUBERCULOSIS IN HIV POSITIVE PATIENTS
Dr. Giorgio Visentin
Csermeg, Italy
keywords: motivational education, tuberculosis prevention, HIV treatment

Background
In a recent survey in Iringa Region (Tanzania) tuberculosis screening in HIV patients resulted inefficient. The regional register showed that 0.3% of HIV positive patients was treated for TB, instead the prevalence
in these patients is supposed to be between 10 to 20 %.
There are several reasons for this result, and some of them are impossible to be solved. In this study the focus has been on nurses distraction during their daily work. A motivational approach directed to the nurses in the dispensary using a short video clip has been adopted.

Material and methods
In the VII course of the Italian school of General practice of Vicenza a script has been prepared and the students acted as actors.
The meaning is to show some ridiculous aspects of daily life in a dispensary in order to have a more critical approach in the work of the nurses.
The clip was filmed in the school and it is now distributed in the Allamanno center in Iringa.

Conclusion
As mobile telephones are distributed everywhere a clip with some educational messages may become an economic and easy way to improve the quality of the work in the countryside.

3126- Solf Moran
ID: EFPC20143126
The combined action between Public Healthcare System and Primary Healthcare

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keywords: Public healthcare system, Primary healthcare, Community healthcare

Purpose:
To present an example of conjunct work between public healthcare system (PHS) and primary healthcare (PC).

Context:
Primary healthcare center, Suburban neighborhood, 21.000 inhabitants

State of the art:
In March 2011, we started an experience of conjunct work between PC and PHS. The objectives were to optimize resources by avoiding duplicities and sharing activities. We achieved it by creating a common workspace, identifying common areas (vaccinations, community programs) and maintaining regular meetings to plan our approach. The main activities developed have been:

• Memory training workshops in participants over 65 years old: 5 editions, 19h duration each and 60 participants.
• First aid and basic CPR workshops for students in the neighborhood schools: 3 workshops, 3 hours duration each and 75 participants.
• Physical activity workshops: 2 workshops per year, 2 hour per week, 6 week duration each and 165 participants.
• Physical activity community group: 5 groups, 2 hour per week, 11 months and 80 participants.
• Conjunct scholar vaccination between PHS y PC.
• Common participation in the community plan emphasizing activities related to health promotion and health determinants.

In our opinion working together takes more time to achieve consensus, but the results obtained are more effective.

ROQUETES COMMUNITY HEALTH PLAN BOARD: A SPACE FOR NETWORKING AND PARTICIPATION

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keywords: Community health, participation, networking, community plan.

BACKGROUND:
The Board of Community Health Planning is part of the district (PCR) organizing group and commissioned to coordinate, design, program, implement and evaluate community health activities: with the programs Doing Roquetas Health (2005), Integrating Health in the Neighborhoods (2008). The Roquetas primary care center leadership has been involved and supportive from the start.

OBJECTIVES:
1. Encourage participation (institutions, services, professionals, neighbors).
2. Linking and integrating the different health programs and activities in the district and neighborhood community health programs.

MATERIAL AND METHODS:
The Board of Health is mixed: the primary care center staff (1 manager, 2 doctors, 3 nurses, 1 pediatrician, 1 clinical assistant nurse and social worker), 1 nurse from the community health staff of Barcelona’s Public Health Department, Social Services, Roquetas Public Library, the Residents Association of Roquetas, a FM Support Group, the Neighborhood Public Heath Technician, the Torrent Nursery School, and coordinated by the local Community Technician. Monthly meetings. Participatory methodology and networking. Activities for the whole population. Motor groups lead projects. Dissemination by different media. Annual budget in the PCR. Annual evaluation.

STATE OF THE MATTER:
Framework program of Community Development Plans in Catalonia.

RESULTS:

CONCLUSIONS:
Integrated sectorial work and networking. Participatory process with continuity. Process of
empowerment of the population. Satisfaction of the participants.

3167- Muniente Perez

Evaluation of The Granma’s Remedies book

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keywords: self-care, Health Community, Networking, Community Action Plan

OBJECTIVE:
1. To do an evaluation of the The Granma’s Remedies book with the following prospect.
   - Evaluate the process of creation and design of the book
   - Evaluate some of the impacts and utilisation of the book
   - Collect the no scheduled impacts of the project.

MATERIAL AND METHODS:
A support team of the commission works jointly with a internship program, to create a process of evaluation based on the needs of the group. The project is developed with the following tools: semi-structured interviews to evaluate operation for the organizational group, questionnaires to evaluate the process of participation, and surveys to evaluate the impact of the book in the neighbourhood’s population.

STATE OF THE ART
The Granma’s Remedies book is a participatory compendium of home-made remedies, that belongs to a project for community’s promotion of the self care of slight unrests, which is part of the of Healthy Habits commission. This project has not been evaluated until this research and is a part of Roquetes’ neighbourhood community planning.

RESULTS OBTAINED:
The first in depth participatory evaluation of the project

CONCLUSIONS:
The evaluation has allowed us to foster the narrative of the project and to recognise the learning process. Besides we get some results from the evaluation of: the inter-generational’ relationships, the promotion of the relational network, the creation of the self-esteem of the neighbourhood, the diffusion the learning of the elder people. Finally, we have realized that the evaluation has to be schedule from the beginning of the project.

3274- Longman

GP telephone led consulting: outcomes for a system change in an urban practice

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Purpose: Workload is a problem for UK GPs, and access is a problem for UK patients. Can a system which is GP telephone led tackle both problems?

Context: Little London is a 9,000 patient practice near the centre of Walsall, a West Midlands industrial town. Extreme pressure of patients for appointments was evidenced by queues outside the door to see a doctor.

State of the art: Patient demand is high but has stabilised as confidence grows in the rapid availability of a GP. Work is intense but in better control, as GPs are able quickly to resolve around 60% of demand by telephone, remaining patients being offered a same day face to face appointment with a GP or nurse. The presentation combines stories from patients, GPs and staff, with slides on outcomes illustrated with performance measures of response time to see a GP, continuity, and changes in volumes and patterns of demand.

3290-Vent
European Forum Primary Care Conference September 2014 Barcelona

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Keywords: Prevention, work related health, occupational therapy

Purpose: To demonstrate how occupational therapist can provide health promotion services for employees in order to support them working in a healthy condition.

Context: People in the Netherlands are expected to work longer (http://mens-samenlevening.infonu.nl/regelingen/103381-langer-werken-voor-je-pensioen.html, 2012). There is an increasing complexity in tasks to be carried out and an increasing pressure to achieve results. To put up with these challenges it's necessary to insure a healthy way of working, certainly for employees seated for many hours behind the computer. (Chris Kruiper, 2011) This topic is not only important for the employees, but as well for the employers and the health care insurances because they are facing increasing absenteeism and costs.

State of the art: Occupational therapists working in primary health care are traditionally educated to provide the best available treatment for clients experiencing problems in their daily life. However services related to health promotion in cooperation with other health care professionals will improve life style and the working situation. This can prevent future health care problems.
Which glasses do you use? A proposal of an emancipatory home visit

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keywords: Audiovisual resources. Home Visit. Nursing Primary Care. Education. Educommunication

The aim of this work is to present an audiovisual instrument constructed collectively with the pedagogical purpose of improving health workers practices in Primary Health Care (PHC). The fictional video is the result of workshops held with nurses in São Paulo, Brazil, to questioning traditional practices of PHC. The process started from the grounds of the historical-critical pedagogy, educommunication and the concepts of work, work process and health needs. We consider health needs a very complex issue and therefore they cannot be responded solely by clinical instruments. The video´s script was built based on the reports of the daily work of nurses. The process favored the critical analysis of the traditional practices of the PHC, which has been done mainly by clinical instruments focusing diseases control. The video was shot with the nurses participants of the workshops. The educational process of the audiovisual’s construction has brought to the scenario the discussion of the social determinants of the health-disease process, and therefore the proposed action were expanded to respond to the complexity of the health needs. We propose that the video is a helpfull instrument to support the discussion about the work in PHC.

Selfies & Portraits of Primary Care in Amsterdam

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keywords: multidisciplinary integrated primary care, occupational therapy (OT), client centred practice (CCP), Amsterdam

Purpose; the goal of the slide show is to give participants of the EFPC congress an impression of the day to day job of general practitioners, therapists, and nurses working in primary care in Amsterdam. Not only the "professionals" are portraited, also the daily life of the clients they visited is visualised in portraits and selfies. The slide show gives an authentic and dynamic image of primary care in Amsterdam and will hopefully enthuse the participants in Barcelona to visit the EFPC congress in 2015 in the Netherlands. Context; portraits and selfies will be made in Amsterdam in the natural environment ( home) of the people receiving primary care.
State of the Art; the portraits and selfies will be made in spring and summer 2014 by Marije Bolt and Morrin Oshea.
Role emerging placements for occupational therapy students in primary psychiatric care interventions in younger adults with psychoses (IPS)

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Keywords
occupational therapy, primary psychiatric care interventions, younger psychotic adults, (IPS) Individual Placement and Support

Purpose: Share recent experiences of placements of occupational therapy in an innovative multidisciplinary setting in psychiatric primary care from the perspectives of the professionals, educators and clients.

Context: There are several professional disciplines working in an Assertive Community Treatment (ACT) team: a psychiatrist, a physician, medical trainees, a social psychiatric nurse, a social worker, a job coach, a general nurse (and an occupational therapy student)

State of the art: IPS is an evidence-based model that puts the focus on quickly placing in regular paid work. IPS clients are first placed in a regular paid job, after which training follows on location. IPS is based on the wishes and needs of the client. There is evidence for people with a first-episode psychotic achieving to find and maintain regular jobs (Killackey, Jackson & McGorry, 2008). Also long term studies have established efficacy of IPS for people with a severe mental illness (Heslin, Howard, Leese, McCrone, Rice, Jarrett, Spokes, Huxley & Thornicroft, 2011).
Summary: TELÈMAC project (remote monitoring of Chronic patients) is an initiative whose aim is to evaluate improvement in the care of chronic patients by means of remote-monitoring devices that make it possible to monitor biomedical readings on a daily basis. The TELÈMAC project (remotemonitoring of Chronic patients) is an initiative whose aim is to evaluate improvement in the care of chronic patients by means of remote-monitoring devices that make it possible to monitor biomedical readings on a daily basis. This wealth of information allow us to anticipate changes in the state of health of the patient at an early stage and prevent potential complications in the short term. The system therefore acts in a preventive capacity and will make it possible to reduce the number of visits to the emergency department due to exacerbations and reduce the mean duration of hospitalization in these patients, as they would have to be admitted in a less severe condition.

The equipment the patients will have available in the home, based on their diseases is as follows: glucose meter, pulse oximeter, sphygmomanometer, and scales, connected using M2M technology via a tablet. The patients included in the program are chronic complex patients (CCP) or patients with advanced chronic disease (ACD) with a minimum of the following diseases: Heart Failure (HF)/Chronic Obstructive Pulmonary Disease (COPD).

Patients must also meet one of the following criteria:
- Prior admission in the previous 12 months
- Probability of admission in the next year greater than 75%

Selection of patients to be enrolled in the program also take into account social aspects such as the following:
- Degree of dependency.
- Presence of a caregiver.

So, priority is given to chronic complex and fragile patients with a high risk of exacerbation and readmission, in whom the intervention is considered to be clinically more effective.

3387-Pinto
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Practice Assistant – new practices, new roles: an emergent profession in portuguese PHC workforce

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1. The Portuguese PHC reform
PHC services of good quality are widely recognized as critical for the improvement of health care systems. This is especially important when health care systems are being challenged by aging populations, an increased prevalence of chronic diseases, complexities of team-based contemporary practice and limited funding.
Aims: Recent reforms in Portugal aimed at strengthening the role of the PHC, in order to improve quality, accessibility and efficiency. Since 2006 new policies aiming to change the organization, incentive structures and funding of the primary health care sector were designed, promoting the evolution of traditional primary health care centres (PHCCs) into a new type of organizational unit – Family Health Units (FHUs).

2. New practices, new roles
- More accessibility and efficiency, less costs
- New professional profiles

3. The Practice Assistant: an emergent profession in the Portuguese PHC workforce

Future developments: 1. Plan and execute a global program for the development of this professional group, in order to officially recognize their role and responsibilities and build a “brand”; 2. Vocational training requirements according to their professional roles; 3. Continuous education programs and projects; 4. Creation of a “Manual of the PA” which could lead to procedures uniformization in the whole country; 5. Information sharing mechanisms with information and communication technologies tools;

3389- Linnebank

The SAG (Foundation of Healthcare centres Amsterdam) explained and its innovations on involving patients/citizens in care and keeping medical records

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Keywords: Community Oriented Primary Care, Electronic Health Records, Self Management

Patient involvement

Purpose: Sharing a new approach on Community Oriented Primary Care service delivery with much patient/citizen involvement using advanced technology

Context

- The context is a network of different health care centres and social services in a new urban district coordinated to provide services and information.

- Conditions were established by health insurers for accessibility to current services delivery without financial or professional obstacles. Organising accessibility and special living conditions for particular subgroups of inhabitants. (clustered homes, assisted living)

- The main practical actions were enabling patients to make informed choices, providing guidance for patients with specific needs (e.g. mental disorders and poor social environment), organising an office of volunteers caregivers. Multi professional meetings on complex cases with the coordination of a “case manager”.

State of the art: KARIFY, connecting care. Making the future of healthcare. Patients become members. Your medical information is yours

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We hope you enjoyed the EFPC 2014

Thank you!

We are looking forward to present to you many more interesting developments in primary care at our future conferences!

Amsterdam
2015
31 August –
01 September

Riga
2016
5 September–
6 September