MODEL PRACTICES IN FAMILY MEDICINE IN SLOVENIA
(upgrading of family medicine in Slovenia)

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Content of presentation

**Team**
- GP, nurse
- + practice nurse (0.5 FTE)
- + home care nurse (pilot project in 46 MPs in HC Lj)

**Prevention**
- Hypertension, coronary disease, diabetes, COPD, depression, benign prostatic hypertrophy, osteoporosis
- Risk factors

**Chronic Patients**
- Protocols of patients management
  (8 diseases: hypertension, coronary disease, diabetes, COPD, depression, benign prostatic hypertrophy, osteoporosis, asthma)
- Registers

**Support System**
- Project council and the National project office
- Webpage
- Unique IT support system

**Evaluation**
- Patients and staff satisfaction
- Quality indicators
Comparison between FP and FMMP

Family practice (GP+nurse)

Model practice (GP + nurse + 0.5 FTE practice nurse + home care nurse)

- CV prevention
- acute and chronic patients

- Prevention for NCD
- Practice nurse/home care nurse
- Chronic patients (protocols, registers)
- Acute illnesses
Results: preventive screening

219,228 screening tests carried out (nurses' jurisdiction)

patients regarding chronic illnesses (until the end of 2014)

Capitation in FMMPs:
802,356 patients

Chronic patients

Patients with risk factors

Healthy patients

Number of patients

<table>
<thead>
<tr>
<th>Year</th>
<th>Chronic patients</th>
<th>Patients with risk factors</th>
<th>Healthy patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>10,461</td>
<td>31,800</td>
<td>11,954</td>
</tr>
<tr>
<td>2013</td>
<td>13,410</td>
<td>44,745</td>
<td>13,648</td>
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<tr>
<td>2014</td>
<td>21,695</td>
<td>47,284</td>
<td>17,052</td>
</tr>
</tbody>
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Breakdown of chronic illnesses:

- Asthma: 2219
- COPD: 2562
- Diabetes: 8289
- Cardiovascular diseases: 12,309
- Hypertension: 15,890
- Depression: 2,701
- Coronary diseases: 825
- Osteoporosis: 734
Chronic patients: 322,494 in total in the registers (protocols)

Number of patients in registers

- Diabetes: 49,332
- Asthma: 21,469
- COPD: 11,342
- Hypertension: 166,734
- Benign prostatic hypertrophy: 19,426
- Depression: 24,375
- Coronary disease: 16,242
- Osteoporosis: 13,574
Patients in MPs

- Healthy patients: preventive screening again, determined period: 5 years.
- With risk factors: follow the risk factors, patients education and counseling.
- With chronic disease(s): putting in register(s), checking according to protocols.
Timeline of implementation of MPs

N° of MPs

N° of all FM practices

0 200 400 600 800 1000 1200


60 107 146 189 230 271 292 313 333 352 393 434 584 980

980
What we had to do?

• Nurses: additional education (8 modules for 8 chronic diseases)

• IT support (in January 2015): a unique template for gathering data (screening, checking parameters of chronic diseases, quality indicators) and reporting data monthly
The Project Council

PROJECT BOARD
Minister

COORDINATION AND MANAGEMENT OF THE GROUP
Tonka Poplas Susič

PROJECT OFFICE

GUIDELINES FOR DOCTORS
Janko Kersnik

ORGANIZATION OF WORK, EXCELLENCE CLINICS

QUALITY INDICATORS

IT SUPPORT

MODEL OF FINANCING

WEBSITE

IT group

SCREENING TESTS

EDUCATION

PROTOCOLS

Igor Švab

PROJECT DOCUMENTATION
WEBSITE: www.referencna-ambulanta.si

- prevention
- Project office
- forum
- Protocols for chronic patients
Lectures: voice, picture, ppt

KAJ ŽELIMO DOSEČI

- Manj pritožb pacientov
- Enakomerna porazdelitev delovnih obremenitev
- Načrtno vodenje bolnika
- Zmanjševanje frekvence
- ...ne pa zmanjšane dostopnosti!!!
Evaluation

• Satisfaction of patients (and staff) every year; the average score = 4.8 (out of 5)

• Validation of quality indicators: still missing
The aims of the national project FMMPs:

1. Better patient’s care now

- to unify patient’s treatment (protocols for 8 chronic diseases, quality indicators),
- to connect primary and secondary/tertiary level (guidelines for chronic diseases, protocols),
- to put more attention on prevention,
- active approach to chronic patients.

Personal management = Empowering patients
2. Better patient’s care in the future

• to interface physicians, academics and patients to perform research and development in PHC
• to adopt patient’s treatment to their specific characteristics and needs depending on the environment – flexible regulation of procedures
• to establish a tertiary family medicine institution.
MPs: an ongoing process of solution finding and consensus building

Professionals
organizations, bodies, colleagues, clinical specialist

State
politics, insurance institute (the payer), decision makers

Civil society
patients, patients associations
Our strength is in...

- our attitude and vision; our unification!
- patients that have believed in our work and entered the project with great satisfaction

We derived from:
- declarations of WHO
- scientific papers published on our topics
- pessimists who tried to diminish our strain

No policy dares to confront professionals (if proposals are evidence based and correct)
Thank you for your attention