Programme Book & Information

Crosscutting Informal Care & Professional Primary Care
Latvian Society House, Riga, Latvia
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Welcome

Foreword from EFPC

Welcome to the first EFPC-conference in a Baltic state: "Cross-cutting informal care and primary care", welcome in the beautify city of Riga, and a special welcome to the young primary care experts, the brand new You&EFPC group!

These 2-days international conference unites people committed to primary care from different backgrounds: informal carers, pharmacists, patients/citizens, general practitioners/family physicians, hospitals, nurses, health insurers, policy makers in order to strengthen the bridge between professional and informal care.

Apart from technological and scientific evolutions, socio-economic developments, with and increasing social health gradient between the rich and the poor, increasing diversity in the populations we serve, there is the undeniable fact that there are more people with chronic conditions and especially with multi-morbidity, presenting multiple problems.

Health systems try to find solutions to this challenge, building health systems that are based on relevance, equity, quality, person- and people centeredness, cost-effectiveness, sustainability and innovation.

Although – at least in policy statements – everybody agrees that the patient is in "the driver's seat" in the care process, there is still a lot of "top-down" communication between providers and patients, and especially informal care givers are too often at a side-line when it comes to development of the health care system.

The Expert Panel on Effective Ways of Investing in Health (EXPH) stressed the importance of informal care givers when it defined the primary care as follows: "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." [http://ec.europa.eu/health/expert_panel/opinions/docs/001_definitionprimarycare_en.pdf]

This conference will take a closer look at how in different settings, regions and countries, informal care interacts with professional primary care, and how this interaction can be improved. Special attention will be given to deprived and vulnerable groups that very often are not supported by "informal care givers".

Important aspects when it comes to informal care giving, are related to the improvement of health literacy in society, the creation of appropriate social systems, that enable people to combine work with caring tasks, the accountability of the health system, as informal care can never be a substitute for insufficient investment in professional care.

The Riga-Conference will bring together participants, active at different levels: at the nano-level: the direct interaction between a provider, the patient and the informal care giver, the micro-level looking at how the interdisciplinary team tries to contribute to the achievements of the goals of the patient, the meso-level, in order to improve the organizational support for primary care services and the macro-level that looks at policy, financing, quality assurance, equity. At all these levels, action is needed to assure that integrated care is delivered for all those in need.
The Riga-Conference will also be a testimony of our commitment that in spite of the multiple events in the last year, inspired by violence, lack of mutual respect, conflict and "exit", the EFPC is convinced that only trust, solidarity and dialogue will remain the basis for building a sustainable and health Europe.

Prof. Jan De Maeseneer, MD, PhD.
Chairman EFPC.

Foreword by local partners

Honourable organising committee, Dear participants and guests!

I am pleased and extremely grateful that you decided to organise your conference in close collaboration with Rīga Stradiņš University here in Riga, Latvia. I would like to express my gratitude for the confidence and trust you have shown us.

Rīga Stradiņš University has seen tremendous growth in the last few years, and we are currently the leading medical and dentistry university in the Baltic States.
In the past few years we have proved ourselves as an integrated entity in the health care system on a national level, building bridges between education and healthcare. As a result, we have become leaders in the Baltic States in international student recruitment, currently having approximately 1800 international students from 20 countries studying at the RSU.
Our success story in international student recruitment and international education is accomplished due to the fact that we introduced new comprehensive teaching technologies. For example, at the end of 2013, we opened the most modern dental pre-clinic in Northern Europe serving as reference centre for others. We also continuously improve and quality and content of our study programmes. Health system governance and management is among our top priority areas. The RSU aim is to support current trends in transformation of care from silo to integrated practices, from hospital to outpatient setting and from cure to prevention. I follow the idea about aligning formal and in-formal care, the theme of today’s conference. The success lies in working together to find better solutions for our patients.

I wish you all success in acquiring creative ideas, professional contacts and the best of memories of time you spend while in Riga.

Thank you!

Toms Baumanis
Vice-Rector for Development, RSU
Conference Theme

Health systems will not automatically gravitate towards greater fairness and efficiency. This world will not become a fair place for health all by itself. Deliberate policy decisions are needed. It requires appropriate conditions at the health care system level and in actual practice to make primary care providers able and willing to take responsibility for the health of the population under their care. The EU Health Commissioner defined the challenges as follows: we need to ensure the cost-effectiveness and sustainability of health systems and call for concrete reforms to optimize the hospital sector, strengthen primary care and rationalize pharmaceutical spending.

There is a need for a policy shift from separation to integration of services in order to tackle the complex social and health problems experienced by vulnerable populations. In order to enable these people to maintain stability and encourage independency and employment, access to stable services that suit their complex needs must be ensured.

Fragmentation is often the result of organizations, professionals, caregivers and services operating independently of each other, with adverse consequences for service users. Often, a comprehensive set of changes in the health care delivery is needed to firstly improve coordination of care with a special focus on addressing the rising burden of Chronic Diseases, the ageing population and the high prevalence of comorbidity. Secondly, in acknowledging the specific needs of the individual, people centeredness and patient empowerment are key in this approach. Much of the focus on fighting fragmentation has tended to be on structures and governance. This is, however, only one aspect; process and cultural changes are likely to be at least as important. In this broader context the purpose of this conference is to identify, explore and further develop the following dimensions: 1) Commitment, 2) Cultural, 3) Coping, 4) Compassion, 5) Sustainability, 6) Participation, 7) Governance & 8) Autonomy/independence.

Integrated primary care with the involvement of the informal caregiver as a hub for person-centered health systems with ensured continuity. The conference organizers emphasize that the key players in primary care like medical doctors, nurses (general and more specialized), pharmacists, dieticians, physiotherapists and social workers will connect with informal caregivers on the above mentioned dimensions.

The limited empirical evidence-base for, and the absence of tools for, measurement and comparison of involving informal caregivers remain a significant barrier for the evaluation and implementation of these policies. The conference organizers recognize the need for comparative analysis at an international level to assist stakeholders and policymakers to prepare for future challenges. It calls upon all researchers from the different professions to share their results in providing the evidence which is needed to develop further progress and nurture the policy discussion.

The conference will provide an opportunity for the health service delivery system to interact and exchange useful information and lessons learnt. The conference will therefore build upon the individual capacities and knowledge of informal caregivers, pharmacists, patients/citizens, GPs, hospitals, nurses and health insurers, to increase their understanding. The Riga conference will 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.

Organized in collaboration with
The Scientific Committee

Prof Jan De Maeseneer
EFPC chair

Prof Peter Groenewegen
EFPC Executive Board Member

Aigars Miezitis
EFPC Advisory Board Member

Prof Arnoldas Jurgutis
Klaipeda University

Prof Sally Kendall
EFPC Advisory Board Member

Andre Biscaia
USF AN

Stecy Yghemonos
EuroCarers

Inga Millere
Riga Stradins University

Liana Deklava
Riga Stradins University

Soemitro Poerbodipoero
HvA

Charlotte Hazewinkel
EFPC WG You&EFPC

Diederik Aarendonk
EFPC coordinator

The Organizing Committee

Marianne Van Lancker
European Forum for Primary Care

Diederik Aarendonk
European Forum for Primary Care

Annelien Boutens
European Forum for Primary Care

Aigars Miezitis
Riga Stradins University

Marika Petrovica
Ministry of Health, Latvia

Daiga Behmane
Riga Stradins University

We wish you a great conference!

Using Twitter?

#EFPC2016

#primarycare

@PrimaryCare4um
Key-note Speakers

Anda Čakša – Latvian Minister of Health

When we talk about primary health care we always emphasize that it is the basis of the entire health system, refer to Alma – Ata Declaration which is no doubt very essential. However, sometimes we neglect all those little things related to the treatment, diagnosis and surgical procedures. For instance, starting with the colour of the pill, the cosiness of the hospital ward and support and compassion are also crucial factors for the patient’s fast and successful recovery.

Care, selfless work, personal interest and willingness to grow and develop are those things that give the sense of safety in healthcare. And ‘safety’ is one of the key terms in medicine. Moreover, it is very important to provide appropriate and safe treatment as well as to gain patient trust. However, nowadays due to the fast pace of life and insufficient healthcare resources sometimes we do not manage to spend enough time with our patients in order to make them feel safe, understood and heard.

For every patient it is vital to feel the engagement of healthcare staff, their understanding and warm-heartedness. Therefore, every decision and activity should contribute towards one common goal – to ensure that the patient feels better. I believe that everyone who works in healthcare should follow this commitment. Additionally, the fact that informal care is included in the agenda of healthcare professionals highlights the importance of this issue.

We have a great pleasure and honour to share Latvia’s experience of informal care. I hope that the experience gained during the visits to the healthcare institutions will give all the participants of the conference new inspiration and ideas for future professional work.

Aigars Miezitis

Mr. Aigars Miezitis (Latvian national) is a lecturer at Riga Stradins University for courses on Health Economics.

He has been a project manager in the National Health Service of Latvia with experience in health economics more than 15 years. The main areas of activities at the National Health Service include improvement of payment methods for health care services in Latvia and eHealth solutions for outpatient care.

His former positions were Head of Department at the Central Statistical bureau of Latvia, Financial director of a hospital, participation in several projects financed by PHARE, World Bank and EU.

He is the Latvian representative in the Primary Health and Prison Health expert group of Northern Dimension Partnership in Public Health and Well-being, and eHealth for Regions Network.
Jovile Vingraite

Jovile Vingraite graduated from Vilnius University Medical Faculty (Lithuania) as a pediatrician and specialized in pediatric gastroenterology. As a doctor pediatric gastroenterologist she worked in public out-patient departments in Vilnius. The work in state institutions started in 2004, in the field of control of legal trade of narcotic drugs and psychotropic substances and drug precursors. Since 2011 Jovile worked at the Vilnius Territorial Patient Fund (VTPF) being responsible for the medical part of contracts between the VTPF and health care institutions for provision of health care services and payment of their expenses from the budget of Compulsory Health Insurance Fund. At the end of 2015 she started to work at the Ministry of Health of the Republic of Lithuania, Personal Health Care Department in the fields of family medicine, infectious diseases and dermatovenereology.

Andris Bērziņš - Samaritan Association of Latvia

In 1992 Andris Bērziņš founded one of the largest non-governmental organizations in Latvia – Samaritan Association of Latvia, which has been acknowledged as the best NGO and is considered as an example of social entrepreneurship in Latvia. Nowadays Samaritan Association of Latvia employs 700 employees, has 20 departments and are proud to create and fulfil innovative projects in the field of educations, charity and social services at global level. Andris Bērziņš having 23 years of experience of NGO, created most of the LSA services, participant in several governmental and parliamentary working groups, Vice-Chairperson in Social Services Development Council in Ministry of Welfare, have an academic education in law history and economics. A. Bērziņš has a leader charisma, penchant for excellence, creativity and entrepreneurial spirit and his moto is: As long as people will need help, we will seek innovative solutions to meet their needs.

"Together we can do more or Innovative home care in rural areas, including e-solutions"

How to connect terms "long-term care" "aging society", "social innovation", "de-institutionalization" in real life with human needs? Samaritan Association of Latvia has found the answers and implementing it also in real life – creative solutions that help people and also is effective in results and costs. We have different solutions combining effectively planned human resources, e-solutions and unique innovative ideas.

Stecy Yghemonos – Executive Director of Eurocarers

Stecy Yghemonos is the Executive Director of Eurocarers, the European association working for carers. A trained journalist, Stecy is an EU policy and communication specialist. Over the last 12 years he has acted as a Project, Advocacy and Communications Director in organisations promoting and defending the reinforcement and harmonisation of domestic and foreign EU policies in the fields of press freedom, social justice, children’s rights, development, health, education and vocational training. Together with the Eurocarers Steering Committee he sets the direction of the Eurocarers network, develops and oversees the implementation of the action plan. He is also responsible for the Eurocarers secretariat in Brussels as well as for its activities in the
fields of network development, project management, fund raising, policy influencing, advocacy and communications.

The Eurocarers network brings together carers’ organisations as well as relevant research & development organisations from across Europe. Our aim is to advance the issue of informal care at both national and EU levels by:

- Raising awareness of the significant contribution made by carers to health and social care systems and the economy as a whole, and of the need to safeguard this contribution;
- Ensuring that EU and national policies take account of carers, i.e. promote social inclusion of carers, the development of support services for carers, enable them to remain active in paid employment and maintain a social life.

Eurocarers defines a ‘carer’ as a person who provides unpaid care to someone with a chronic illness, disability or other long lasting health or care need, outside of a professional or formal framework.

Abstract for Presentation
Europe’s overall increase in life expectancy and ageing demographic is generating a growing incidence of age-related diseases and demand for care.

In Europe, 80% of this care is provided by family and friends. The contribution of these informal carers clearly constitutes a great resource for our society, even if their role is not always recognised. Delivering a wide range of support services such as personal care, housekeeping, transportation, care and financial management as well as emotional support, carers often offer the most comprehensive and desirable option for people in need of care.

Caring for a loved one can be a source of great personal satisfaction but it does create its own set of challenges. If society expects informal carers to keep providing care, their vital role and contribution must be recognised and their support needs must be addressed.

This presentation will seek to provide an overview of the challenges facing carers and highlight the entry points that exist in current policy agendas to ensure carers’ role and added value is properly recognised, valued and supported.
Location

The EFPC Conference 2016 takes place at the ‘Latvian Society House’ in the city centre of Riga.

Address: Merķeļa Street 13, Riga, LV-1050
Phone: (+371) 67213204; (+371) 67222932

Travel directions

The Latvian Society House is easy to reach by foot from most of the hotels. It is located near Riga Central Station, around 450 meters away, a 6 minute walk. The map below shows the location of the conference premises.

Halls in the Latvian Society House

- Gold Hall
- White Hall
- Ligo Hall
- Club Hall
- Fireplace Hall
- Gold Hall Saloon
- Foyer 2nd floor
# Programme

## Day 1

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<th>Morning</th>
<th>Afternoon</th>
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<tr>
<td>08:00 Registration</td>
<td>13:30 5 parallel sessions, round 3 (90 minutes)</td>
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<tr>
<td></td>
<td>• 4 workshop sessions</td>
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<tr>
<td></td>
<td>• 1 research abstract session</td>
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<tr>
<td>09:00 Welcome by Toms Baumanis</td>
<td>15:00 Break, change of rooms (30 minutes)</td>
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<td></td>
<td>Coffee is served in Grand Theater Hall</td>
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<tr>
<td>09:05 Key Note Mrs Anda Čakša, Minister of Health</td>
<td>15:30 5 parallel sessions, round 4 (90 minutes)</td>
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<tr>
<td></td>
<td>• 4 workshop sessions</td>
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<tr>
<td></td>
<td>• 1 research abstract session</td>
</tr>
<tr>
<td>09:15 Key Note Mr Aigars Miezitis – Latvian primary care</td>
<td>17:00 EFPC General Assembly</td>
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<tr>
<td></td>
<td>For EFPC members only</td>
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<tr>
<td>09:30 Key Note Ms Jovile Vingraite – Lithuanian primary care</td>
<td>19:00 Dinner</td>
</tr>
<tr>
<td>09:45 7 parallel sessions, round 1 (45 minutes)</td>
<td>• Meet the Key Note</td>
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<tr>
<td></td>
<td>• 4 workshop sessions</td>
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<tr>
<td></td>
<td>• 2 policy debate sessions</td>
</tr>
<tr>
<td>10:30 Break (30 minutes)</td>
<td>Coffee is served in Foyer</td>
</tr>
<tr>
<td>11:00 5 parallel sessions, round 2 (90 minutes)</td>
<td>• 3 workshop sessions</td>
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<tr>
<td></td>
<td>• 2 research abstract session</td>
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<tr>
<td>12:30 Lunch</td>
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## Day 2

<table>
<thead>
<tr>
<th>Morning</th>
<th>Afternoon</th>
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<tbody>
<tr>
<td>09:00 Key Note Andris Bērziņš</td>
<td>13:30 5 parallel sessions, round 7 (45 minutes)</td>
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<tr>
<td></td>
<td>• 3 policy debate sessions</td>
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<tr>
<td></td>
<td>• 1 multimedia session</td>
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<td></td>
<td>• 1 workshop session</td>
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<tr>
<td>09:30 Key Note Stecy Yghemonos</td>
<td>14:15 5 parallel sessions, round 8 (90 minutes)</td>
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<tr>
<td></td>
<td>• 3 workshop sessions</td>
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<tr>
<td></td>
<td>• 1 policy debate session</td>
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<tr>
<td></td>
<td>• 1 research abstract session</td>
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<tr>
<td>10:00 Break, change of rooms (15 minutes)</td>
<td>15:45 Break, Twitter summary, change of rooms (15 minutes)</td>
</tr>
<tr>
<td></td>
<td>Coffee is served in Foyer</td>
</tr>
<tr>
<td>10:15 7 parallel sessions, round 5 (45 minutes)</td>
<td>• Meet the Key Note</td>
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<tr>
<td></td>
<td>• 3 policy debate sessions</td>
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<tr>
<td></td>
<td>• 3 workshop sessions</td>
</tr>
<tr>
<td>11:00 5 parallel sessions, round 6 (90 minutes)</td>
<td>• 4 workshop sessions</td>
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<td></td>
<td>• 1 research abstract session</td>
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<tr>
<td>12:30 Lunch</td>
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### Parallel Sessions

- **Policy debate session** / Meet the key note
- **Multimedia session**
- **Workshop session**
- **Research abstract session**

#### Parallel sessions round 1 (Day 1; 09:45 – 10:30)

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<th>Session 4</th>
<th>Session 5</th>
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<th>Session 7</th>
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<tbody>
<tr>
<td>Room</td>
<td>Gold Hall</td>
<td>White Hall</td>
<td>Ligo Hall</td>
<td>Club Hall</td>
<td>Fireplace hall</td>
<td>Gold Hall Saloon Foyer 2nd floor</td>
</tr>
<tr>
<td>Chairperson</td>
<td>Melina Raso</td>
<td>Ian Banks</td>
<td>Leo Pas</td>
<td>Timo Fischer</td>
<td>Peter Groenewegen</td>
<td>Henk Parmentier</td>
</tr>
<tr>
<td>Theme</td>
<td>Meet the key-notes (Mr Aigars Miezitis &amp; Ms Jovile Vingraite)</td>
<td>Health First Europe coalition letter to EU commissioners for community care investments</td>
<td>ECCO European Cancer Organisation: Primary Care at their 2017 Amsterdam congress</td>
<td>Stimulating Primary Care for family Violence: interdisciplinary collaboration needed (WONCA SIG)</td>
<td>The “Austrian Patient” 2.0 – The latest primary care developments in Austria</td>
<td>Policy debate session 1: Organisation of Primary Care</td>
</tr>
<tr>
<td>Abstract &amp; presenters</td>
<td>Stacy Yghemonos Diederik Aarendonk</td>
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<td>Policy debate session 2: PC &amp; Mental Health</td>
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#### Parallel sessions round 2 (Day 1; 11:00 – 12:30)

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<tbody>
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<td>Gold Hall</td>
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<td>Ligo Hall</td>
<td>Club Hall</td>
</tr>
<tr>
<td>Chairperson</td>
<td>Fieke Vrielink</td>
<td>Walter Marrocco</td>
<td>Barbara Krekels</td>
<td>Antoni Peris</td>
</tr>
<tr>
<td>Abstract &amp; presenters</td>
<td>Ivana Silva Anna Stavdal Jamie Wilkinson</td>
<td>Jan De Maeseneer</td>
<td>135 Haemel 144 Miller 148 Kontrimiene 265 Vivilaki</td>
<td>113 Hengelaar 124 Liaeen 129 Skarbaliene 146 Glenngard</td>
</tr>
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#### Parallel sessions round 3 (Day 1; 13:30 – 15:00)

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<thead>
<tr>
<th>Session 1</th>
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<tbody>
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<td>Ligo Hall</td>
<td>Club Hall</td>
</tr>
<tr>
<td>Chairperson</td>
<td>Pim de Graaf</td>
<td>Giorgio Visentin</td>
<td>Tonka Poplas Susic</td>
<td>Bettina Borisch</td>
</tr>
<tr>
<td>Theme</td>
<td>European Refugees - HUman Movement and Advisory Network (EUR-HUMAN)</td>
<td>European Medicine Agency WG (session2)</td>
<td>Alliance for Community Oriented Primary Care: Community Health Centres in Europe</td>
<td>The Global Charter for the Public’s Health of the World Federation of Public Health Associations</td>
</tr>
<tr>
<td>Abstract &amp; presenters</td>
<td>Christos Lionis Kathryn Hoffmann Imre Runik Piero Salvadori Danica Rotar Tessa van Loenen Marieke van Veldhuizen</td>
<td>Walter Marrocco Ivana Silva</td>
<td>Diederik Aarendonk</td>
<td>Jan De Maeseneer</td>
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</tbody>
</table>
### Parallel sessions round 4 (Day 1; 15:30 - 17:00)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Room</td>
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<td>White Hall</td>
<td>Ligo Hall</td>
<td>Club Hall</td>
</tr>
<tr>
<td>Chairperson</td>
<td>Kate O’Donnell</td>
<td>Brian Slater</td>
<td>Mariska Smit</td>
<td>Marije Bolt</td>
</tr>
<tr>
<td><strong>Theme</strong></td>
<td>EFPC Migrant Health WG: Supporting migrants and refugees – the role, challenges and opportunities for European primary care</td>
<td>Scottish Health Directorate: Integrating Health and Social Care Services in Scotland</td>
<td>INEEN: Developing cross-domain patient centred primary care arrangements for vulnerable patient groups: crucial topics for a dialogue</td>
<td>COTEC/ENOTHE Position Paper Occupational Therapy &amp; Primary Care</td>
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<tr>
<td><strong>Abstract &amp; presenters</strong></td>
<td>Pim de Graaf Capri Kalaca</td>
<td>Jan Beaty Herma Barnhoorn</td>
<td>Stephanie Saenger 125 Jakobsen 133 Huang 142 Schoenmakers 149 Poplas Susic</td>
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### Parallel sessions round 5 (Day 2; 10:15 – 11:00)

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<td>Chairperson</td>
<td>Tino Marti</td>
<td>Veerle Piessens</td>
<td>Christos Lionis</td>
<td>Sally Kendall</td>
<td>Mehmet Akman</td>
<td>Anna Stavdal</td>
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<tr>
<td><strong>Theme</strong></td>
<td>Meet the key-notes (Andris Berzins &amp; Stecy Yghemonos)</td>
<td>Policy debate session 3: Primary Care &amp; IT solutions</td>
<td>Flemish Community Health Centres: How to account for social factors in primary care payment?</td>
<td>The challenge and prospective in working together on adult vaccination – introducing a new EFPC Working Group</td>
<td>Making the most of your journal – Primary Health Care Research and Development</td>
<td>Policy debate session 4: Management of Chronic Diseases</td>
</tr>
<tr>
<td><strong>Abstract &amp; presenters</strong></td>
<td>257 Longman Misericordia</td>
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<td>Elena Petelos</td>
<td>Shaun Speed</td>
<td>217 Levato Tarvydiene</td>
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### Parallel sessions round 6 (Day 2; 11:00 - 12:30)

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<td>Chairperson</td>
<td>Peter Groenewegen</td>
<td>Danica Rotar</td>
<td>Dineke Smit</td>
<td>Charlotte Hazewinkel</td>
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<tr>
<td><strong>Theme</strong></td>
<td>EFPC Position Paper on Primary Care &amp; Community Participation</td>
<td>Palliative care in primary care, Position paper of EFPC</td>
<td>EFPC Mental Health WG: Mental health in primary care: when (not) to use disease-oriented guidelines</td>
<td>You&amp;EFPC: Presentation of the You&amp;EFPC Business Plan and interactive discussion on ‘How to involve Young Primary Care Experts’</td>
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### Parallel sessions round 7 (Day 2; 13:30 – 14:15)

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<td>Chairperson</td>
<td>Warren Newton</td>
<td>Antonio Verginelli</td>
<td>Annette Fagertun</td>
<td>Victoria Vivilaki</td>
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<tr>
<td>Theme</td>
<td>Policy debate session 6: Should North Carolina (USA) Professionalize Community Health Workers?</td>
<td>Policy debate session 7: Caregiver for elderly</td>
<td>Policy debate session 8: The Anti-Politics of Care</td>
<td>Multimedia session 1: Organisation of Primary Care</td>
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<tr>
<td>Abstract &amp; presenters</td>
<td>234 Newton</td>
<td>250 Verginelli</td>
<td>137 Fagertun</td>
<td>314 Essig 355 Longman</td>
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### Parallel sessions round 8 (Day 2; 14:15 – 15:45)

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<td>Chairperson</td>
<td>Montse Moharra</td>
<td>Kerstin Haemel</td>
<td>Andre Biscaia</td>
<td>Harry Longman</td>
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<tr>
<td>Theme</td>
<td>AQuAS: The ESSENCIAL Project: identifying key clinical practice actions for avoiding over diagnosis and overtreatment</td>
<td>Inter-professional healthcare centre of primary and long term care in Wolmirstedt, Germany (PORT) – A participatory concept design</td>
<td>USF-AN Portugal: Social commitment to health: citizens’ participation in primary care health services from planning to accountability, from management to informal care</td>
<td>Research workshop session 6: Patient perspective &amp; Sustainability</td>
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<tr>
<td>Abstract &amp; presenters</td>
<td>Manel Medina Caridad Almazán Johana Caro Anna García-Altes</td>
<td>Fabian Teztlaff</td>
<td>Antonio Pereira</td>
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Abstracts Workshop Sessions

Workshops round 1 – Day 1 (09:45 – 10:30)

HEALTH FIRST EUROPE COALITION LETTER TO EU COMMISSIONERS FOR COMMUNITY CARE INVESTMENTS – WHITE HALL

“Making Patient – Centered Community Care a Reality”

Authors/presenters: Melina Raso – Project manager Community Care for Health First Europe
Stecy Yghemonos - Executive Director for Eurocarers
Diederik Aarendonk – Coordinator European Forum for Primary Care

Purpose: Brainstorm session among leading advocates for health and social care policy to discuss:
• Definition of community and integrated care
• Foster coordination on social and health care
• EU Member States best practices on community care
• EU support to national policy on community care

Context: The Latvian Presidency launched in June 2015 a Declaration on “Declaration for Making Patient – Centered Community Care a Reality,” to promote the importance of patient-centered care for all citizens in Europe and encourage supporting and investing in the development of policies to improve care for patients specifically in community settings.

The declaration encourages all stakeholders to focus on supporting Member States to:
• Increase preventive care in the community
• Facilitate access to innovation for patients in the community setting
• Support training of healthcare professionals in the community
• Promote integrated care across all points of patient care
• Strengthen the governance of integrated care

In December 2015, Eurocarers, European Forum for Primary Care, European Social Network and Health First Europe, together call European Commissioners for health and food safety and employment, social affairs and inclusion, to support Member States in their efforts to make person-centred community care a reality.

Community care has the potential to support smarter spending, generate greater investment in the local communities, and reduce inequalities for citizens who want and need to access care and technologies outside of the hospital.

State of the art: In order to support sustainable healthcare and social welfare systems in Europe, the partners called upon the Commissioners to:
1. Develop a Commission Communication on Community Care
2. Ensure best practices in community care are reflected as part of the work on health systems performance assessment
3. Establish funding in the 2016 health and social affairs programmes dedicated to projects in community care
4. Consider a future joint action which addresses the diversity of issues encompassed in community care including policy, system design, innovation & value, access & reimbursement, workforce planning and quality care and standards.

The European Commission has shown a clear interest in discuss this use and a meeting has been set up on 15th September 2016.
**ECCO EUROPEAN CANCER ORGANISATION – LIGO HALL**

“Cancer and Primary Care: To Boldly Go. ECCO Conference 2017 Breaks New Ground”

**Authors/presenters:** Prof. Ian Banks - Co-Chair ECCO conference 2017

**Background:**
The story so far: Many cancers are age related. Life expectancy is increasing. Cancer survival for most cancers is significantly extending. Population demographics show a steadily aging population pyramid. Retirement age is being lifted across Europe. More people will be at work with and despite cancer. Can the secondary sector cope? What do patients want? How will primary care evolve with a cancer care focus? Will it mean HCP integrated care or fragmented chaos?

The answers to these and other questions will be discussed in the light of the ECCO (European Cancer Organisation) decision to devote one day of their 2017 conference addressing exactly these issues.

Your ears, voice and determination will be required at this presentation.

**FAMILY VIOLENCE - CLUB HALL**

Stimulating Primary Care for family Violence: interdisciplinary collaboration needed

**Presenter:** Leo Pas, MD, Academic Center General Practice Catholic University Leuven, Belgium.
Convenor of WONCA SPECIAL INTEREST GROUP ON FAMILY VIOLENCE - URL: [http://www.wonca.net/groups/SpecialInterestGroups/FamilyViolence.aspx](http://www.wonca.net/groups/SpecialInterestGroups/FamilyViolence.aspx)

**Additional contributors:** Kenkre Joyce, University of South Wales, UK
Carmen Fernandez Alonso, Valladolid, Spain
Maria Papadakaki, Crete, Greece
Lorraine Bacchus, London, UK
Pekez Pavlovski Tanja, Croatia
Pascale Franck, Provincie Antwerpen, Belgium

**Background:** Life time prevalence of intimate partner violence in Europe accounts to one in four women. Equally a high prevalence is found for Elderly and Child Abuse. Health, social and economic consequences are huge creating a burden of disease that outreaches many non-communicable diseases by a factor of two. WHO guidance indicates the need for general practitioners, nurses and midwives to prioritise health care for intimate partner violence. Several programmes for training have been developed separately. However the tight relationship to mental health problems and family violence requires a model for psychosocial counselling for all professions involved and adequate collaboration with mental health care facilities.

**Problem:** Detection and referral to specialised advocacy services are to be promoted. In urban areas indeed more facilities have been created to support victims disclosing violence. However specialised services and forensic support are not equally available in all health care settings. In some countries social services are integrated into primary care in others they work separately. International collaboration is needed to define available facilities, identify barriers to implementation and find solutions for better detection and collaborative care. Task definition and subsidiarity suffer from lacking protocols for sharing information.
Methods: In this workshop several models will be presented. Improving communication between different primary health care providers and social support services may even need more attention. Organisational, educational and ethical challenges will be discussed to answer following questions
1. How could collaborative care be organised to care for family violence taking into account the basic roles of different caregivers in primary health care?
2. How can sharing of information be conceived to promote effective care balancing between confidentiality and safety?
To inform the debate examples will be drawn from different country settings
1. Promoting midwifery and nurse care for family violence (J Kenkre, Wales, L Bacchus, England and US)
2. Multidisciplinary training and monitoring in rural areas in Spain (Carmen Fernandez Alonso and Marta Menéndez Suárez)
3. Family Justice centres as a model for stepped care (Pascale Franck, Belgium)

Conclusion: The workshop aims to achieve the development of a statement on how to improve multidisciplinary care collaboration at primary care level and with specialised services for family violence. Participants will be invited to collaborate after the meeting through their organisations and local contacts in different professional groups.

AUSTRIAN FORUM ON PRIMARY CARE – FIREPLACE HALL
The “Austrian Patient” 2.0 – The latest primary care developments in Austria

Presenters: Timo Fisscher & Kathryn Hoffmann

Purpose: One year after the workshop on the “Austrian patient” at the EFPC-Amsterdam conference we would like to present an update of the health care reform taking place focusing on a new approach to primary care in Austria.

Context: Implementation is not an easy task and the results of our efforts still fail to live up to our expectations. On the one hand, there is a small number of initiatives and projects across Austria. In some areas new multiprofessional primary care centers are being built and in other areas sickness funds and general practitioners are discussing the idea of creating primary care networks. In fact, these developments are encouraging and proof that people in the Austrian health care system adopt new ways of thinking and working together. On the other hand, important prerequisites on a system level such as legislation that ought to give way to new forms of contracting between sickness funds and doctors and new payment systems (away from fee for service) or reforms of the education of health professionals still lag behind. However, we make great efforts to promote the idea of a new approach to primary care. In 2016 there have been several initiatives to further promote primary care in Austria: The very first primary care conference primarily aiming on general practitioners and medical students took place at the Medical University of Graz in April 2016. Out of this conference the “Austrian Forum for Primary Care” was founded. In May, the European Observatory on Health Systems and Policies organized a policy dialogue on “Enhancing coordination and multi-professional working in primary care: implementing change” involving all stakeholders. In autumn of this year, the Vienna health care lectures will focus on the implementation of primary care models.

Statements for debate: In the EFPC-Riga conference we would like to discuss the latest developments in Austria with international experts. We are also hoping for some technical advice on how to build networks and what elements should be included.
Workshops round 2 – Day 1 (11:00 – 12:30)

WES/VdG ON GP CARE FOR REFUGEES – GOLD HALL
“Care without borders; health care for refugees in the Netherlands”

Presenter: Fieke Vrielink
Purpose: An overview of healthcare for refugees in the Netherlands
Context: In recent years the influx of asylum seekers and refugees has increased in the Netherlands. Refugees should all have access to affordable health care. This healthcare can be provided in an asylum seekers centre as well as in a regular GP surgery or out-of-hours service. Since Eritrean and Syrian refugees in most cases get permanent residence permit to stay in the Netherlands, every health care professional may have to deal with health care for refugees at some point.

How is health care for refugees organised in the Netherlands? What challenges do doctors face, when taking care of this special group of people? This workshop will illustrate health care from applying for asylum at an application centre till obtaining a permanent residence permit. It will also focus on differences in medical health issues, psychosocial problems and challenges in communication.

EUROPEAN MEDICINE AGENCY (EMA) WG (Session 1) – WHITE HALL
“Which concrete areas of collaboration exist between EMA and PHC/GPs?”

Presenter: Walter Marrocco (F.I.M.M.G. (Italian Federation of Family Medicine) – EFPC representative in the HCPWP-EMA)
Purpose: How to assign to drugs, an evaluation of the use in PC. The EMA GPs Working Group can be the basis to involve other HCP for this process.
Context: From the start (endpoints, comparators) to the end (cost, safety) EMA decisions are crucial for PHC and the Patients. General Practitioners play a key role in patient care; they often have the first contact with the patient and accompany them throughout the life of their condition.

State of art:
The evaluation of the experience of medications in real clinical practice, in the HTA assessment but also through data collect, by: Observational, PAS, PAES, Registries, Adaptive Path Way, Pharmacovigilance activity, etc, is important in order to continuously improve benefit-risk assessment of medicines throughout their life-cycle for a best “place in therapy”. In case of Observational Studies about the use and experience drug it could be very important organize a European sentinel practice network in PC. This way could be realized in identifying the drug of particular interest in PC and in different fases of the drug life-cycle:

- Pre-submission
- Evaluation
- Post authorization

At the same time the GPs involvement (see the recent engagement of a GPs Group in EMA: WS April 19th 2106 ) could be implemented in different fields of the EMA collaboration:

- Scientific Advice / Protocol Assitance Procedures
- Scientific Advisor
- Scientific Committe consultations
- Review of documents
- Evaluation of specific medicine
PROPOSAL FOR AN EFPC POSITION PAPER ON NEW PROFESSIONALISM – LIGO HALL

“The search for New Professionalism”

Presenters: Barbara Krekels MA (Flemish Strategic Advisory Board Welfare, Health and Family, Belgium) and Jan De Maeseneer, MD, PhD, (Hon) FRCGP.

Purpose: To define the "professional profile" that will be needed in health care and welfare in the future to respond to societal change and to explore if the actual Flemish report on 'New Professionalism' can be broadened towards a European perspective, in the format of an EFPC- Position Paper.

Context: The changing demographical, socio-economical, cultural and epidemiological context, invites Primary Care to reflect on a new profile for professionals, active in health care and welfare: the search for New Professionalism. We report how such a process actually takes place in the Flemish region in Belgium.

Methods: Presentation of the actual report on New Professionalism. The participants should read the following document before the session:

Debate on the content and views of the report. Exploration of possibilities to use this as a start for an EFPC-Position Paper.

Headlines of the report on New Professionalism: Comprehensive care and support should contribute at first to quality of life. This requires an eco-bio-psycho-social model where people value their possibility to function and their ability to participate in society. A more generalist approach is required and emphasis should be on connecting people: "Connectedness as a pre-condition for autonomy". Professionals should develop generalist competencies: enabling a professional to provide care and support, based on the general strategy, with the aim to address a broad range of unspecified health and/or well-being (related) problems. The care should focus on quality of life, on supporting self-care and care of informal care-givers, strengthening social cohesion, embracing diversity and appropriate use of technology an ICT. The care provider should focus on functioning, pay attention to what really matters for people, support autonomy through information and strengthen participation and inclusion. Finally, the solution to the challenges is not in the creation of a "super-professional", but in stimulating inter-professional cooperation in team.

Conclusion: After the session it should be clear if and how an EFPC-position paper could be produced, starting from the Flemish document on ‘New Professionalism’. Concrete commitments should be formulated.

Workshops round 3 – Day 1 (13:30 – 15:00)

EUROPEAN REFUGEES – HUMAN MOVEMENT AND ADVISORY NETWORK (EUR-HUMAN) – GOLD HALL

“Addressing health care needs of refugees/migrant and designing primary care based intervention in selected European settings: The EUR-HUMAN Project.”

Authors: Pim de Graaf, Dean Ajdukovic, Christopher Dowrick, Michel Dückers, Kathryn Hoffmann, Maria van den Muijsenbergh, Danica Rotar Pavlič, Imre Rurik, Piero Salvadori, Annelieke Drogendijk, Christos Lionis

Additional Contributors: University of Crete (Coordinator): Agapi Angelaki, Valeria Chatzea, Myron Galainanos, Antonis Koutis, Kyriakos Maltezis, Enkeleint-Aggelos Mechili, Elena Petelos, Dimitra
Sifaki Pistolla, Chrisa Tatsi, Rena Theodosaki, Victoria Vivilaki  
*Stichting Katholieke Universiteit*: Tessa van Loenen, Marijke Hofmeester,  
*University of Liverpool*: Nadja Van-Ginneken,  
*Netherlands Institute for Health Services Research*: Derek de Beurs, Tim Schoenmakers, Dinny de Bakker, Marieke van Veldhuizen,  
*Faculty of Humanities and Social Sciences Zagreb - FFZG*: Helena Bakic, Lana Pehar, Nikolina Stankovic,  
*Medizinische Universität Wien*: Elena Jirovsky, Elisabeth Sophie Mayrhuber, Werner Lagler,  
*Univerza V Ljubljani*: Alem Maksuti, Erika Zelko, Mateja, Žagar,  
*European Forum for Primary Care*: Diederik Aarendonk,  
*azienda Unità Sanitaria Locale Toscana Centro*: Laura Delli Paoli, Luca Scali, Maria José Caldés Pinilla, Nicole Mascia, Vieri Lastrucci,  
*Arq Psychotrauma Expert Group*: Juul Gouweloos, Trudy Mooren, Corné Versluis,  
*University of Debrecen*: Anna Nánási, Zoltán Jancsó, Hajnalka Tamás, László Kolozsvári, Roland Palla, Timea Ungvári,

**Purpose:** The overall aim of the EUR-HUMAN (EUropean Refugees - HUman Movement and Advisory Network (EUR-HUMAN) (Specific Call HP-HA-2015 Project Proposal number 717319), project is to enhance the capacity, knowledge and expertise of European member states who accept refugees and migrants in addressing their health needs, safeguard them from risks, while at the same time to minimize cross-border health risks. This 3rd Health Programme funded by the European Commission / Chafea is focusing on addressing both the early arrival period and longer-term settlement of refugees in European host countries. Its expected results and pilot testing of selected interventions in European settings to transfer know-how and an appraised proposal application in all EU countries, particularly those that serve as main countries of entry or reception of refugees. The workshop aims to report, both tools in assessing the refugees/migrant health care needs and as well as an operational framework for a comprehensive primary care based and integrated approach for implementation and to design effective and comprehensive primary care based interventions to address the health care needs of refugees/migrant in six European settings.

**Context:** The international refugee crisis has reached a critical point and many European countries are developing policy and plans to better define their role in supporting refugees entering Europe. Primary care and integrated approach on refugees/migrant health needs especially “on the move” are greatly warranted. Several European consortiums have been developed to apply implementation findings from earlier studies. EUR-HUMAN is implemented by a strong consortium (11 partners) and is coordinated by the Clinic of Social and Family Medicine, School of Medicine, University of Crete.

**Methods:** WP2 (coordinated by Radbouwmc University) utilized relevant methodology including Participatory and Learning Action (PLA) to introduce a democratic dialogue with national, regional and local stakeholders and as well as the refugees themselves to access their needs, wishes and preferences. PLA sessions have been carried out in seven EU countries (Greece, Croatia, Slovenia, Hungary, Italy, Austria, and the Netherlands). WP3 (coordinated by NIVEL) reviewed systematically the existing literature to identify success factors and obstacles in the implementation of tools and interventions to optimize health care for refugees and other migrants in the European context. WP5 (coordinated by University of Zagreb) was working on a report protocol for rapid assessment of mental health and psychosocial needs of refugees that would. As part of WP4, the results of the systematic review (WP3), the brokered dialogue with the stakeholders and refugees (WP2) and mental health protocol has been incorporated in an operational plan prepared by the coordinator of project (University of Crete) and this comprehensive approach was discussed in an expert panel group in Athens (June 8-9). All the
above will help in developing guidance documents/recommendations and to pilot guidance, tools and training for the provision of integrated and comprehensive person centred primary care for refugees at the intervention site in hotspots, transit centres and longer stay first reception centres (WP6 coordinated by University of Vienna). The whole process is being monitored and evaluated by WP7 (coordinated by European Forum for Primary Care). The workshop will offer insights to the UoC (overall design), WP2 (RUMC), WP3 (NIVEL), WP4 (RUMC and UoC), WP5 (FFZG), WP6 (MUW and UoC), and WP7 (EFPC).

**Findings:**

1. According to WP2, a total of 98 refugees participated in a total of 43 sessions. In addition to the sessions with refugees in Croatia, 6 PLA sessions were held with health care workers or volunteers. The main health problems mentioned by the participants were related to flight reasons (shooting and war) and the journey they had to undertake. Furthermore, the results revealed important barriers in accessing health care such as time pressure, linguistic and cultural differences, and lack of continuity of care.

2. The systematic review revealed that the collected material points at recurring success factors and implementation obstacles, linked to characteristics of health care interventions and measures, professionals, patient/refugee population, professional-patient interaction, incentives and resources, local capacity for organizational change, and social, political and legal factors. There were compared across different categories of health problems.

3. The rapid mental health assessment includes three steps: triage with the focus on recognising refugees whose functioning is severely impaired, their safety or safety of other people is endangered; screening for high risk for MH disorders that are common in the refugee populations, such as PTSD, anxiety and depression; for those who score above the cut-off on indicative trauma symptoms, immediate help based on psychological first aid principles should be provided together with referral to MH specialists for full assessment and further care. Most MH assessments tools that are used with refugees are not comprehensive, but rather assess specific experiences and/or symptoms and disorders, while only a few assess several common MH problems.

**Discussion:**

The workshop anticipates motivating the participants in an active discussion on tools to the health care needs, wishes and expectations of refugees/migrants and as well as an effective primary health care and person centered approach.

**EUROPEAN MEDICINE AGENCY (EMA) WG (Session 2) – WHITE HALL**

“Opportunity for independent research in Primary Care: cooperation between European Medicine Agency and organisations of Primary Care providers”

**Authors/presenters:** Giorgio Visentin, Ivana Silva & Walter Marrocco

**Keywords:** Primary care research, independent research, sponsorship

**Purpose:**

The aim of this session is to verify the possible cooperation between EFPC WG and EMA in primary care independent research for drugs, and to provide information on existing independent researches that can be used as example for planning new studies, mostly for countries where research capability is still poor.

During the invitational meeting in London, April 2016, between EMA and organizations of General Practitioners one of the issues was the lack of GPs participation on the research in developing new drugs. GPs declared that often the researches proposed by pharmaceutical companies have conflict of interest. It was decided that EMA and the organizations of General
Practitioners should produce a document to ask European Commission to enhance funding for independent research in Primary Care.

In this session we want to show some examples already existing of independent research in Primary care, analysing particularly good examples of funding that can be duplicated in different setting and in Countries where research capability is still poor.

An open discussion will take place to compare different experiences and provide a data base that can be used also to plan some operative cooperation among different EFPC members with the help of EMA.

ALLIANCE FOR COMMUNITY ORIENTED PRIMARE CARE (ACOPC) – LIGO HALL
“Community Health Centres in Europe”

Authors/presenters: Tonka Poplas Susič, Diederik Aarendonk

Purpose: Primary care is considered as the cheapest level of health care which solves most health problems of population. Community health Centres (CHCss) offer medical care to people living in specific geographic region, municipality/ city. Their content of acting influence important the health of population.

The purpose of the workshop is to illuminate the role of CHCs on the area of health promotion and prevention, providing curative treatment and quality of work and discuss on possible added role of CHCs that enable to employees and patients an additional context. It is also important to take into account the potential of new-coming ICT (Information and communication technology) in providing medical care and building up the network of health data. The ACOPC wants to discuss the different aspects, arriving to a list of added values to be included in forthcoming Position Paper to be published in Primary Health Care Research & Development.

Context: CHCs offer comprehensive and integrated medical care to patients on the basis of teamwork. It is very important to addressed patient needs through different aspects that all together enable providing the appropriate health care measures to the appropriate person at the appropriate time. CHCs provide medical care on different levels that are personalised approach, patients centred care, person focused care and community oriented health care. All people should have equal access to health care and the horizontal-vertical integration of different experts can define better clinical pathway for patients’ management.

On the basis of ICT, integration or/and cooperation of different CHCs is of great importance to build up the health data network that enables broader insight into health-indicators development on the international level.

CHCs have also important role in health education of employees and vocational trainees and have possibilities to set up activities that allow patients' engagement in different processes in CHCs.

State of the art: CHCs can enable the best environment for the best population health. Policies and governments have to enhance and to support them in tendency to improve the public health through improving every individual's health in accordance with quality indicators. It is important that CHCs provide data for broader health assessment and measures on international level.
THE GLOBAL CHARTER FOR THE PUBLIC’S HEALTH OF THE WORLD FEDERATION OF PUBLIC HEALTH ASSOCIATIONS – CLUB HALL

Presenters: Bettina Borisch & Jan de Maeseneer
Purpose: To introduce the main aims and visions of the Charter
Context: the Global Charter was launched at the World Health Assembly in May 2016 and received quickly very positive reactions; as an example the MoHs of the Commonwealth Nations adopted the Charter the same week.
State of the art: Working with the World Health Organization, the World Federation of Public Health associations has asked how the global public health community should position itself to influence all of the key actors across the entire spectrum of public health issues, whether in government, civil society or industry. The result is the Global Charter for the Public’s Health (The Charter) published in the European Journal of Public Health, vol 26; no 2, 2017. Recognising the need to adapt policies to differing circumstances, The Charter provides ‘a clear and flexible framework that can be applied globally and within individual countries’. It builds on a long tradition of public health thinking, from the time of The Declaration of Alma Ata through to The Ottawa Charter and the Commission into the Social Determinants of Health. Individually and collectively, these have long provided inspiration for measures to improve public health.

There have been many successes. The Global Burden of Disease studies have demonstrated health gains that few thought possible. Yet there have also been many setbacks. Too often, the public health community remains fragmented, and many governments pay little more than lip service to the commitments that they have made. This recognition provided a catalyst for the development of The Charter.

By identifying the enabling functions of ‘Governance, Advocacy, Capacity and Information’ The Charter provides the groundwork necessary to deliver the most effective public health policy and outcomes locally, nationally and internationally. The focus of many of the previous declarations and charters has been on specific issues such as health promotion or the social determinants of health. The role of The Charter is to ensure a comprehensive approach to tackle the threats to health everywhere.

The challenge that the WFPHA has set itself is to ensure that it becomes embedded in the work of as many as possible of its member public health associations and other dedicated organisations around the world, who can use it to support and advance the ambition that their political leaders have signed up to in the Sustainable Development Goals, which The Charter should be read in conjunction with. Using both as an opportunity to influence their governments. Crucially, The Charter speaks to the entire public health community, whether in policy, practice, training or research. All have a role to play. There is an enormous need to build public health capacity in many countries, to foster and sustain the next generation of public health workers, and to undertake high quality multidisciplinary research to generate the knowledge needed to inform policy. The process has commenced and needs to be extended.

Workshops round 4 – Day 1 (15:30 – 17:00)
EFPC MIGRANT HEALTH WG ON PP REFUGEE CARE – GOLD HALL
“Supporting migrants and refugees – the role, challenges and opportunities for European primary care.”

Authors/presenters: Kate O’Donnell, Diederik Aarendonk, Pim de Graaf, Cagri Kalaca and others
Purpose: Providing care for migrants and refugees continues to present challenges and opportunities for European primary care. This workshop will present the preliminary findings of an EFPC Position Paper on the role of primary care in caring for migrants and refugees.
Migration continues to be a key issue for Europe. Much attention has, rightly, been focussed on addressing the needs of recently arrived migrants in Turkey, Greece and Italy and on those travelling through eastern Europe. However, once arrived there are continuing challenges both in transit and when migrants arrive and settle in a destination country. For health care, many of these challenges present at the door of primary care.

This workshop will present the on-going work in the development of a Position Paper on Migrant Health and Primary Care. In particular, this will present an opportunity to comment on the work so far and to contribute to the development of the paper itself.

State of the art: This workshop will offer an opportunity for those involved in caring for, or planning services for, migrants in vulnerable and marginalised situations. As well as drawing on previously funded EU projects such as RESTORE, it will complement the workshop on current developments like the EUR-HUMAN project, Dutch GP trainee association (WES), etc. and present an opportunity to contribute to developing our knowledge and advocacy in this important area.

SCOTTISH HEALTH DIRECTOREATE – WHITE HALL
“Integrating Health and Social Care Services in Scotland”

Authors/Presenters: Brian Slater & Jan Beaty

Purpose/Context: The Public Bodies (Joint Working)(Scotland) Act 2014 integrated health and social care services in Scotland - This is one of the most significant care reforms since the creation of the NHS in 1948. It will enable local partnerships to deliver preventative person-centred care and came into force on 1st April 2016.

The legislation aims to
• Improve quality and consistency of care for patients, carers, service users and their families;
• provide seamless, joined up care that enables people to stay in their homes, or another homely setting, where it is safe for them to do so;
• ensure that resources are used effectively and efficiently to deliver services that meet the needs of the growing population with longer term and often complex needs, many of whom are older.

Health Boards (providing primary and secondary care) and local authorities (providing social care) delegate functions to the new integrated partnerships. The minimum scope of functions and budgets that must be integrated covered primary and community health care, social care and aspects of acute hospital care that offer the best opportunities for service redesign.

Locality planning arrangements will secure clinical and professional leadership, and the engagement of the voluntary and private sectors, in strategic service planning.

Format of Workshop: We will present Scotland’s experience – Why, how and what this means for the population of Scotland in the future including:
1. Policy Perspective: The legislative process
2. Delivery in practice: What integration means from a health-worker, carer and patient perspective
3. The Future of Primary Care – The transformation of primary care in an integrated landscape with a focus on our cluster working an multidisciplinary team approach to local need

Participants will be invited to take part in a Q&A session after the main presentation.

INEEN – LIGO HALL
“Developing cross-domain patient centred primary care arrangements for vulnerable patient groups: crucial topics for a dialogue.”

Authors/presenters: Ms. Mariska Smit, Policy Advisor InEen, Dutch association of primary health care organisations
Ms. Herma Barnhoorn, Director Primary Care Foundation EenPlus, member of InEen
Mr. Arthur Eyck, Programme Manager InEen

Purpose: Patients with multiple or complex conditions rely on care and support from multiple sources, both from professional health care providers as from informal care and support. Smooth collaboration between various health care providers and with the informal support system of patients is a precondition for effective person centred care for vulnerable patients.

Context: We will present two examples of target group based arrangements for vulnerable patients that involve cross-domain collaboration, amongst others, care for the frail elderly in a community with a high proportion of elderly. Both examples will address issues relating to the organisation of these arrangements. These issues involve as well professional as practical and organisational matters.

State of art: Smooth collaboration is not a given. Successful initiatives and failures have shown that various issues should be addressed upfront in order to establish effective and sustainable care arrangements. Issues that should be discussed with all participants are, amongst others:
• the culture and tradition of collaboration,
• communication,
• cross-domain trust,
• handling various modes of work and ways of considering patients,
• financial arrangements,
• information exchange,
• joint client records,
• individual responsibility of patients versus collective arrangements.

COTEC / ENOTHE – CLUB HALL
“Position Statement Occupational Therapy and Primary Care”

Presenters: Marije Bolt, occupational therapist, member advisory board EFPC, marijebolt@ergo-doen.nl
Stephanie Saenger, occupational therapist, president of Council of Occupational Therapists for the European Countries (COTEC), stephanie.saenger@coteceurope.eu
Rosa Baaijen

Purpose: To raise the awareness of participants about the possibilities of Occupational Therapy (OT) in Primary Care (PC) in Europe.
To present the Position Paper on OT and PC that includes:
- the contribution of OT in PC
- the state of the art of OT in PC in Europe
- examples of best practices of OT in PC in Europe

**Context:** Occupational therapists can deliver an important contribution to the primary care work force (Donnelly et al 2014). A ‘clear fit’ has been identified between the holistic, health promoting nature of OT and PC (Donnelly et al 2013). Occupational therapists recognize the importance of meaningful activity/occupation in promoting mental and physical wellbeing. They are skilled in assessing the impact of developmental, physical and mental health conditions on a person’s ability to participate in activities that are important to them, and in devising intervention plans that facilitate occupational engagement. Across Europe there are great differences in the availability of OT in primary care. In some European Countries, OT is “mainstream” in PC and every citizen has access to an occupational therapist in their community. In other countries, OT’s are mainly employed in institutions and OT is not available nor funded in PC.

The Position Statement OT and PC was written in assignment of COTEC by the Project Group OT and PC. One of the aims of this paper is to support countries to develop OT services in PC and make OT more visible, valued, available and accessible in Europe. The Project Group searched for literature and a survey has been used to gather best practices and evidence from OT all over Europe. The second draft was presented at the Joint COTEC ENOTHE congress in Galway, Ireland in June 2016. The final Position Statement will be presented to you in Riga in an interactive way. We are looking forward to meeting you in the session to exchange ideas.

**Workshops round 5 – Day 2 (10:15 – 11:00)**

**FLEMISH COMMUNITY HEALTH CENTRES (VWGC) – LIGO HALL**

“How to account for social factors in primary care payment?”

**Presenters:** Veerle Piessens, Jan De Maeseneer

**Contact:** veerle.piessens@vwgc.be

**Context:** In Belgium the majority of primary care providers (PCP) work within a fee-for-service payment system. However, 3 % of the belgian population receives care in the framework of the capitation system, mostly in multidisciplinary community health centers (CHC’s). These CHC’s serve disproportionately socially disadvantaged populations, primarily because they operate in socially deprived neighbourhoods. Additionally the capitation system increases the accessibility of primary health care, especially for socially deprived patients.

In 2013 the ‘integrated needs-based mixed capitation system’ was installed. The system calculates the capitation fee for each CHC, based on the “needs-variables” of that CHC’s population: demographic and morbidity variables, but also some contextual (urbanicity, provider density) and socioeconomic variables, like very low income, care dependency and invalidity.

Since then improvements to this system are being prepared, including exploration of the opportunities of the ACG® System. The PCP’s strongly urge that more socioeconomic variables should be included, with a greater impact.

Social disparities in health and health care resource utilization.

Many socio-economic factors are related to a higher prevalence or an earlier onset of several diseases. Although this phenomenon will be captured by a performant case-mix system, it will not compensate for less obvious effects of social deprivation. People living in socially deprived conditions, often wait longer before seeking medical advice. As a result, their diseases are often at a more advanced stage at the time of diagnosis, requiring more intensive care and leaving a less favourable prognosis.
It will also require more efforts and resources from the PCP to offer the same level of quality of care to socially disadvantaged patients, due to e.g. low language proficiency, lack of social support, homelessness, insufficient resources to buy or prepare healthy food etc. And even with all these extra efforts, it is not guaranteed that the targets for health outcomes will be met. The latter implies that in a pay-for-performance system or value-based payment system these PCP's would be penalized for not meeting the targets. However, if a society intends to reduce health disparities and subscribes the principle of proportionate universalism, it seems only fair to encourage these PCP's who serve disproportionately socially vulnerable patients, to offer high quality care by accounting for social risk factors in quality measurement and payment.

Methodology: A set of social risk factors should be identified that have an (empirical) association with health outcomes and/or health care resources. In addition, the data collection on these social risk factors has to be reliable and feasible and the risk of manipulation of the data (gaming) should be minimized. Finally, the financial incentive or adjustment in quality measurement should not have a counterproductive effect quality of care of the PCP.

The academic literature describes several social risk factors like income, education, occupation, ethnicity, language proficiency, social and instrumental support, housing quality etc. Most of these factors are probably universally applicable, but the availability of reliable data as well as the willingness to register these data may vary regionally.

Purpose: The purpose of this session on the EFPC Conference is to exchange ideas and experiences on successes, difficulties and challenges of accounting for social risk factors in the different local contexts of the participants.

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Association of Community Health Centers – Flanders - Belgium

Ghent University, Dpt. of Family Medicine and Primary Health Care

PRIMARY CARE & VACCINATION – CLUB HALL

“The challenge and prospective in working together on adult vaccination – introducing a new European Forum of Primary Care (EFPC) Working Group.”

Presenters: Christos Lionis and Elena Petelos, Faculty of Medicine, Crete, Greece

Purpose: This workshop aims to bring together stakeholders, present the overall aim and objectives of a new EFPC Working Group (WG), to highlight certain domains where joint work is anticipated.

Context: The important and critical role of general practice and primary care in disease prevention and health promotion has been widely recognised. Immunisation of both adults and children is a key health promotion activity and constitutes a public health priority. Nevertheless, immunisation of adults and control of infectious disease morbidity and mortality substantially lags behind in many European settings, including that of Greece.

Vaccination update in adults is still low in multiple settings. Current literature discusses certain determinants and contextual factors impacting upon the vaccination uptake either in regard to healthcare provider strategy and overall approach or in terms of patients and families.

Contextual and organizational issues are interrelated to social influences, disease- or vaccine-related aspects, general views of health and disease, and motivation. There are also studies identifying adult immunisation barriers, however given the low compliance of primary care workers to existing guidelines and the low adherence of patients, clients and their families to the guidance of healthcare workers requires further attention and study, as well as a dedicated initiative.
Recent socioeconomic trends (migration and refugee aspects) affecting Europe have made immunisation issues more complex and a unified public health agenda adopting a unified approach across Europe even more imperative.

Additionally, the Council of the European Union has called upon Member States to "encourage the use of alternative treatment and prevention options, including vaccines and the development and use of affordable diagnostics’ tests" as recent evidence suggests that antibiotic use can decrease in association with the initiation of immunisation programmes or increased uptake.

Multidisciplinary work between primary care physicians, community nurses, and pharmacists holds great promise, while motivational interviewing could be utilised as a vehicle of dialogue and change amongst healthcare workers and patients to facilitate further research and the implementation of relevant interventions.

The European Forum of Primary Care (EFPC) seems to be a fertile ground to promote all thoughts, ideas and research plans amongst many primary care disciplines. It can also contribute to the launch of an effort to generate a unified approach and jointly work in spreading and disseminating key messages and position papers relevant to vaccination uptake across Europe. This workshop aims to bring together stakeholders, present the overall aim and objectives of a new EFPC Working Group (WG), to highlight certain domains where joint work is anticipated.

**State of the art:** Immunization of adults and control of infectious disease morbidity and mortality substantially lags behind in many European settings. The European Forum of Primary Care seems to be a fertile ground to the launch of an effort to generate a unified approach and jointly work in spreading and disseminating key messages and position papers relevant to the vaccination uptake across Europe.

**PRIMARY HEALTH CARE RESEARCH AND DEVELOPMENT (PHCR&D) – FIREPLACE HALL**

“Making the most of your journal”

**Presenters:** Sally Kendall, Editor in Chief, PHCRD - Professor of Community Nursing and Public Health - University of Kent, UK
Shaun Speed - Senior Lecturer in Nursing - University of Manchester, UK

**Context:** In August 2015 Primary Health Care Research and Development became the official journal of EFPC. In 2016 PHCRD has successfully achieved its impact factor. The aim of EFPC and PHCRD is to bring together the research, critical dialogue and policy analysis at the heart of primary care across Europe to ensure the widest communication and engagement with these debates. How can we ensure that we bring together the membership and wider collegiate in EFPC to achieve the highest quality publications that cause the greatest impact on policy and practice in the global arena? This workshop will debate the merits and challenges for EFPC for making the most of your journal. We will explore authorship of types of papers, reviewing articles, use of social media such as Twitter, special issues, becoming an associate editor and becoming an advocate for your journal. We will listen to your ideas for development of the journal and how together we can make the greatest impact.

**Workshops round 6 – Day 2 (11:00 – 12:30)**

**EFPC POSITION PAPER ON PC & PATIENT PARTICIPATION – GOLD HALL**

**Presenters:** Peter Groenewegen, NIVEL – Netherlands Institute for Health Services Research, Utrecht, The Netherlands

**Keywords:** Community participation, patient involvement, primary care
The European Forum for Primary Care is preparing a position paper on community participation in primary care. Community participation in primary care can be understood as structured efforts to engage community members into the primary care organization in their neighbourhood. We distinguish community participation from patient participation, where the focus is on individual patients, and from participation at policy level by patient organizations.

Community participation in primary care is important, because of changing health care needs in the population and because of increased attention to health care close to home, in the residential area or neighbourhood. Community participation is also important because of the role of informal care and support for patients to enable them to continue living in their home and neighbourhood, despite illness or handicaps. Tailoring primary care to the needs of the population requires that we have insights in the needs of that population. Engaging the community might contribute to these insights.

The Position Paper preparation group has collected examples of community participation from different countries in Europe. During the workshops the results of this inventory will be discussed. Together we will try to identify good practices in community participation.

**PALLIATIVE CARE WG – WHITE HALL**

“Palliative care in primary care, Position paper of EFPC”

**Authors:** Danica Rotar

**Purpose:** To discuss the Position paper about palliative care in primary care, which was developed in workshops organised by European Forum for primary care. The key objective of this Paper is to assist practitioners, policymakers and researchers in Primary Care by providing information on health needs of palliative patients. It discusses the current context in which health care for the palliative patients functions and shows various approaches in policy, practice and research intended to improve PC for palliative patients and their families.

**Context:** Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Primary care workers value this part of their work. Most of the time, patients appreciate the contribution of the GPs, district nurses, physiotherapists, social workers, hospices and lay support, especially if they accessible, take time to listen, allow patient and carers to ventilate their feelings, and make efforts made regarding symptom relief. However, some reports from bereaved relatives suggest that palliative care is performed less well in the community than in other settings. Primary care has great potential to access and deliver effective palliative care to patients, especially home based palliative care. There is a great diversity in the extent and type of palliative care in primary care provided by European countries. More patients benefit from palliative and end-of-life care if it is delivered in the community by Primary Healthcare trams.

**State of the art:** Primary care teams can reach patients with life-threatening illnesses, start early in the course of the disease, meet physical, social, psychological and spiritual dimensions of need, provide care at home and care homes and support family members.
EFPC MENTAL HEALTH WORKGROUP – LIGO HALL

“Mental health in primary care: when (not) to use disease-orientated guidelines.”

Presenters: Dineke Smit, Philosopher of Science, PhD candidate Psychology Radboud University Nijmegen, Netherlands
Lisa Hill, MSc in Primary Care Mental Health and Doctorate in Education student, Staffs University, Advanced mental health practitioner, Worcestershire UK.
Ian Walton, General Practitioner, MSc in Primary Care Mental Health and Clinical Lead for the Sandwell Primary Care Mental Health Hub. UK

Keywords: mental health, primary care, disease-orientated guidelines

Purpose: In public health as in primary care we see a lot of patients with mental health problems. Patients present with complex needs and a mixture of health symptoms related to both their physical and their mental health.
The questions are: Do all patients need a diagnosis of a mental disorder and treatment as described in the mental disease-orientated guidelines? How do we help patients and clinicians understand this and so improve health outcomes.

Theory: To answer this question we make use of the theory of complexity thinking, including the Cynefin Framework and how this way of thinking can be translated into a model of care that meets the needs of complex patients helping us to decide when (not) to use the linear models generally used by disease orientated guidelines.

Methods: We will use anonymised case studies from different countries to look at methods and practices across Europe, looking at best practice, so we can further develop the framework.
Please contact us if you wish to bring such a case to the workshop.

Discussion: We will explain the Cynefin Framework and on the basis of several cases from different countries we will publish our outcomes on the EFPC website as an outcome from the mental health working group. Alongside a working hypotheses.

YOU&EFPC – CLUB HALL

“Involving Young Primary Care Experts in the EFPC”

Presenters: Metka Žitnik Šircelj & Charlotte Hazewinkel

Purpose: Presentation of the You&EFPC Business Plan and interactive discussion on ‘How to involve Young Primary Care Experts’

Context: The Next Generation has the future! However, at this moment we experience that there is only a limited number of organisations that offer young health care professionals a space to unify, meet and share knowledge while it is exactly these young professionals that are key to innovation, multidisciplinary collaboration, and development opportunities which are necessary condition to keep health care affordable and cost-effective. You&EFPC is a working group established by young primary care experts in Europe under the European Forum for Primary Care (EFPC) in January 2016. Our mission is to support the inclusiveness of the EFPC for young primary care students and professionals from all European countries and professions, to stimulate interaction with senior members and build capacity for solving current European primary care challenges. The You&EFPC working group already developed a Business Model supported by the EFPC Executive Board. The business model describes the added value of YOU@EFPC in comparison to other existing
network, the advantages of integrating You&EFPC into the EFPC, and the activities planned to achieve the mission.

**Format of the workshop:** During this workshop we will present you 1) What is You&EFPC and its value added, 2) Who can be part of You&EFPC, 3) How You&EFPC will be organized; 4) Which are the main activities You&EFPC planned for next year. In the second part of the workshop we will start an open discussion on the planned activities of You&EFPC in order to receive feedback and define new activities.

We would like to welcome young professionals and students to join our workshop, but all those who are young of spirit or supporting our mission are invited.

**Workshops round 7 – Day 2 (13:30 – 14:15)**

**PIE APP – WHITE HALL**

“I have an idea: share your PIE”

**Authors/presenters:** Cagri Kalaca, MD - EFPC Executive Board Member, TAHEV Member, Turkey

**Purpose:** Are you ready to be the pioneers of the online collaborative platform of your EFPC: the PIE application?

By attending this workshop you will be the initiators, architects and leaders of efpc.pietoshare.com. We will create the THEMES and TOPICS of 2016-17 and initiate this revolutionary tool that will create a multi-professional, informal learning opportunity for EFPC and primary care. If we succeed to stay together and get crowded, next year in EFPC Conference in Porto, we can have chance to create POSTERS and ORAL PRESENTATIONS with the authentic content created by PIE sharings.

SO WHAT IS “PIE”? LET’S SIMULATE:

- **Diederik Aarendonk shared a PROBLEM:**
  “Peer-to-peer learning is engaging each other’s problems, ideas and experiences. We have some opportunities to learn from our opinion leaders in a formal way. However we all have less opportunities to learn from each other, particularly from the field professionals of primary care.”

  ☑️  Yep! Big problem
  ☐  Not interested

- **Cagri Kalaca linked an IDEA for this problem:**
  “Is it possible to have an informal communication and collaboration platform to share our PROBLEMS, IDEAS and EXPERIENCES? Maybe we can use this new-generation online forum application prepared for EFPC members: efpc.pietoshare.com...”

  So we can create an effective channel which uses members’ knowledge, ideas and potential to create innovative tools and solve the community health problems; break through organizational walls and facilitating communication and collaboration; collect ideas which respond to the current challenges of community health; and discover hidden talents and create a community of innovators who are motivated to work in collaboration with other members.”

  ☑️  Wow! Brilliant idea
  ☐  Not interested
Wim Klein Nagelvoort linked an EXPERIENCE for this idea:

“We tried to use this PIE application for PRIPHECI study group. We saw that we can link and share our knowledge, creative and innovative ideas as well as good and/or bad experiences, best practices...

We experienced that we can create an informal learning opportunity from each other for our common issues... Our opinion leaders may follow, learn and contribute as well...

However more members are needed to be involved and real-life issues should be brought to attention in order to create the critical user mass.”

☑️ Aha! Great experience
☐ Not interested

Workshops round 8 – Day 2 (14:15 – 15:45)

ESSENCIAL PROJECT AQUAS – GOLD HALL

“The ESSENCIAL Project: identifying key clinical practice actions for avoiding over diagnosis and overtreatment.”

Presenters: M. Medina, C. Almazán, J. Caro, A. García-Altes & M. Moharra

Structure: The Essencial project: to explain and discuss how to approach the reduction of low value practices through the Essencial project launched in Catalonia. Currently, a total of 40 low value practices have been identified in strong collaboration with Scientific Societies. Recommendations have been elaborated to avoid low value practices, 20 out of 40 are low value practices related to prevention, diagnosis, treatment and rehabilitation procedures in primary care. These low value practices are related mainly to clinical situations of over diagnosis, over treatment and overuse. All recommendations are published in the project website. (http://www.essenciaisalut.gencat).

From the recommendations to everyday clinical practice, group work: discussion among participants to enrich interaction and exchanging knowledge about low value practices and barriers to implement recommendations and avoid low value practices. Main points of discussion will be: 1) Factors to promote or maintain low value practices in usual clinical practice or every day clinical. 2) Forseen barriers and recommendations for implementing recommendations in everyday clinical practice.

Avoiding over diagnosis and treatment: the economic perspective: to discuss aspects on the application of economics to medical practice. The application of economics to clinical practice does not necessarily mean that less should or can be spent, but rather that the use of resources might be more efficient. With this idea, the concept of opportunity cost will be presented, and the strategy of avoiding over diagnosis would be envisioned as a way to allocate resources to more effective uses, and as a way for health systems to be more efficient.

Patient empowerment in the Essencial project: to present the patient factsheet elaborated to explain why to avoid low value practices. Engaging patients in medical decision making is still today a challenge. The Essencial project with the collaboration of the Catalan Patient Advisory Council elaborates recommendations for the patients in relation to low value practices. The
fact sheets include information in a clear and understandable manner for patients. Currently, eight recommendations for patients have been prepared.

**Group work:** Different Patient paper factsheets will be distributed and discussed among participants about the content, formal structure and understandability.

**PRIMARY AND LONG TERM CARE IN WOLMIRSTEDT GERMANY (PORT) – WHITE HALL**

“Inter-professional healthcare centre of primary and long term care in Wolmirstedt (PORT) – A participatory concept design.”

**Authors:** Markus Herrmann, Fabian Tetzlaff, Yvonne Marx, Martina Schmiedhofer, Bernt-Peter Robra, Martin Stichnoth, Ulrich F. Apel, Jan Hülsemann, Kerstin Hämel

**Keywords:** Primary healthcare and long term care, inter-professional cooperation, rural practice

**Introduction and Aim:** Besides the aging of population caused by the demographic change, the number of General Practitioners in rural areas is declining due to retirement. At the same time, competencies of non-physician health care professionals are restricted. As filling the resulting gap with medical graduates and other health professionals is very difficult, this circumstance is prospectively coming to a crisis. First moves like optimizing practice processes and improving the cooperation and communication between all participants of the health care system form the base to tackle this tense situation. Joining the Institute of General Practice and Family Medicine of the Otto-von-Guericke-University and the community of Wolmirstedt as an essential part of the project, a concept that focuses on enlarged responsibilities of non-physician health care professionals, particularly on long-term domestic care, which is largely covered by the German compulsory nursing care insurance will be developed. It is also going to cover regular home visits from nurses, physicians, physician assistants, physical therapists as well as from community volunteers. The comprehensive approach of the concept focuses not only on patients’ needs for medical care, but also on social participation and empowerment. In the fragmented German health care system primary, secondary, long term and tertiary care are financed and planned separately. Therefore, patient-centered integrated health care requires a fundamental structural change to create budgets and structural incentives for population-related care for the future.

**Didactic method:** The workshop starts with an input picture presentation showing background, procedures, methods and results of the project. We give an insight into the decentralised corporatist character of the German healthcare system that has important implications for any strategy that aims at strengthening PHC. The workshop will provide opportunity to discuss our project results, to share experiences and to exchange knowledge with participants.

**USF-AN PORTUGAL CONSUMER GROUPS INVOLVEMENT – LIGO HALL**

“A social commitment to ‘health for all’: citizens’ participation in the health system, from planning to accountability, from management to informal care.”

**Authors/presenters:** André Biscaia (USF-NA – Associação Nacional de Unidades de Saúde Familiar)
Graça Silveira Machado (Ordem dos Enfermeiros)
Tiago Vieira Pinto (USF-AN/EFPC)
António Pereira (USF-AN)
Manuel Lopes (Ministério da Saúde – RNCCI)
César Fonseca (Ministério da Saúde - RNCCI)

**Purpose:** To explore the opportunities of potential cooperation between societal sectors for a social commitment to ‘health for all’, in order to empower citizens for a more efficient participation in the health system, from planning to accountability, from management to informal care. For this purpose, it seems useful to discuss how it will be possible to reach such social commitments by exploring the Portuguese case with:

- it’s 2005 primary care reform (including it’s 2016’s new cycle) in the field of:
  - health planning through commissioning of health services;
  - accountability by promoting the discussion of the services with the population;
  - management by including the local authorities in the state primary care units’ boards;
  - informal care by issuing legislation to backing it and structuring support services;
- and institutional cooperation between professionals’ associations and consumers’ association for:
  - the joint creation of Patients/Community Commissions and Citizens’ Friendship Leagues,
  - support to the development and spread of health volunteering movements,
  - support to a citizens’ active participation in Family Health Units plans and goals,
  - interaction with the national strategy for Education, Literacy and Self-care,
  - evaluation of patients’ satisfaction.

The workshop has the following design:

1. general presentation as a starting point of the discussion, followed by discussion with the audience;
2. discussion of two themes in two groups following the World Café Method (http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/):
   a) how to effectively hear the voice of the citizen in health care?
   b) participation in health care - how to support informal caregivers?
3. presentation of conclusions and discussion.

**Context:** The implementation of Family Health Units was the most significant aspect of the 2005 Portuguese Primary Care Reform and led to important health gains for the population, professionals and the health system. This reform has, since 2016, a new cycle that encompasses a strategy, shared by the Health Ministry, some of the professional’s associations and consumers’ associations, with a focus on citizens and community satisfaction and the promotion of its active participation in the health sector. Empowered citizens have better conditions to make decisions and to participate more actively in health services planning, management, evaluation and provision.

**State of the art:** The commissioning of health services aims to optimize the delivery of health care and its financing. Commissioning of health services occurs when an organisation acts on behalf of a population to decide which health services to contract, using tax funds allocated by the State according to a formula based on health needs. It entails decision-making about needs assessment, resource allocation, service purchasing, monitoring and review.
It implies a commitment and an alignment between all interested parties about the best solutions to implement and how to do it. It enables the definition, implementation and monitoring of health goals as an expression of a social commitment to health.

The commissioning of health services in the primary care sector in Portugal has been evolving in recent years, having already reached a considerable degree of sophistication, but has missed the voice of the citizen.

Evaluations of citizens’ satisfaction with the health services are nowadays a valid measure of quality of the health care and a way to make heard the voice to the citizens within the health system as are the PROMs (Patient Reported Outcome Measures) - targeted questionnaires to assess the improvement in the health of a person as he or she perceive it.

Informal care is important within the health systems. Portugal has recently issued legislation and developed support and training services to informal / family caregivers, but there is yet a long way to go.
Submitted Research, Policy Debates and Multimedia Abstracts

Abstract ID: EFPC2016111
Management of Obesity in Primary Care and Frequency of Following

Author: Prof. Dr. Selcuk Mistik - Erciyes University Medical Faculty - Turkey
Additional authors: Songul Oruc - Erciyes University Medical Faculty - Turkey
Habibe Sahin - Erciyes University Faculty of Health Sciences - Turkey
Sunay Kutuk - Erciyes University Hospitals - Turkey

Keywords: primary care, obesity, management, follow up frequency

Purpose: The aim of this study was to make obese patients lose weight and see the effect of different frequencies of patient following.
Theory: There are few studies on management strategies of obesity in primary care.
Methods: Body mass index and body fat proportion was measured by a standard device. The patients were given a diet by the dietician according to their individual properties. The patients recorded their food intake in a notebook. These were evaluated at follow up visit by a program. The required feedback was given to the patients. Daily exercise was suggested to the patients and duration of daily exercise was recorded as well. This study was funded by the Scientific Research Council of Erciyes University (ERUBAP, Project No. TTU-2015-5856).
Findings: There was decrease in the body mass index of the study groups (p<0.001). The decrease in the body mass index mean value was 0.92 in the one-week group, 0.53 in the two-week group and 0.49 in the four week group.
Discussion: Although the biggest decrease was in the one week group, there was no difference in the decrease of body mass index between the one week, two weeks and four weeks study groups.

Abstract ID: EFPC2016112
Routine use of patient reported outcome measures (PROMs) for improving treatment of common mental health disorders in adults

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Keywords: PROMs, mental health, OQ-45

Purpose: Routine outcome monitoring of common mental health disorders using PROMs has been promoted across primary care, psychological therapy and multidisciplinary mental health care settings, but is likely to be costly.
Theory: Feedback of the results of PROMs to healthcare professionals may influence them to adjust treatment or refer for alternative interventions, improving care when measured against best practice guidelines.

Methods: We conducted a systematic review for RCTs including adults with CMHDs.

Findings: 17 studies involving 8787 participants were included, two in primary care, six in psychological therapy, and nine in mental health care settings. Meta-analysis of 12 studies using OQ-45 or ORS PROMs found no significant difference in outcome between feedback and non-feedback groups (SMD -0.07, 95% C.I. -0.16 to 0.01). A post-hoc analysis of 10 studies assessing 'not-on track' participants for a good outcome found a statistically significant effect favouring the use of PROMs in this group (SMD = -0.22, 95% CI -0.35 to -0.09).

Discussion: Routine outcome monitoring may be beneficial in terms of improving outcomes for patients identified as 'not on track' for a good outcome early in treatment. However, more research of better quality is required, especially in primary care where most CMHDs are managed.

Abstract ID: EFPC2016113
Exploring the collaboration between formal and informal care from the professional perspective – a thematic synthesis

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Keywords: formal care, informal care, perspective, collaboration

Caregivers are essential team members with professionals in order to create a comprehensive and coordinated care network for the care recipient. Little is known about the collaboration between professionals and caregivers. What is known so far shows that the collaboration is not always effective. Caregivers and professionals have different backgrounds and therefore different frames of reference when it comes to providing care. Aim of this thematic synthesis was to explore the collaboration between professionals and caregivers, from the professional perspective.

A systematic search was performed in PubMed, Medline, PsychInfo, Embase, Cochrane/Central, Cinahl. Based on inclusion criteria and a quality appraisal, using CASP, N=22 were included.

The collaboration with caregivers requires a different way of working from professionals. Professionals should not only focus on caring for the client but also on supporting the caregiver. There are several dilemma’s expressed by professionals; collaboration occurs in an informal and unstructured way, and only when there is time left over from caring for a care recipient. Which is not congruent with government policy. Caregivers are less positive about the provided care then professionals and several professionals express that they are not confident and/or qualified to support caregivers and work in a partnership.

Abstract ID: EFPC2016116
FOB screening in Latvia: compliance of patients in primary care.

Author: Mrs Jekaterina Ivanova - Riga Stradins University Faculty of Medicine student, Latvia

Keywords: Colorectal cancer, FOB, screening, compliance, psychooncology, qualitative study.

Purpose: Patients’ compliance for fecal occult blood test in Latvia is only 10.9%. This research is done to study out the reasons for patients’ co-operation or unwillingness to perform the test.

Theory: Data about the FOB test ability to affect incidence and mortality of the colon cancer are contradictory. From one side regularly performed FOB test can decrease both indicators of the colon cancer, however in spite
of adequate precancerous therapy, morbidity in the population is not decreasing. The negative aspect of screening methods is psycho emotional influence, emotional consequences can be determined even many years after the test.

Methods: Randomized selection, individual interviews, qualitative research.

Findings: The total number of respondents is 30 at the age of 51 to 68 years. Reasons for the rejection were lack of time, unwillingness to see the doctor if the patient has no complaints and faithlessness to the test. Motivation to perform the test, was interest about own health and confidence to general practitioner.

Discussion: Offering people qualitative information about cancer screening, it positive and negative aspects could improve patients compliance.

Abstract ID: EFPC2016118
Primary care in Turkey in 1993 and 2012: from general physicians to family doctors

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Keywords: primary care, Turkey, family medicine, service profile

Purpose: During the past decade the healthcare system of Turkey has undergone reforms in which the reconstruction of primary care was a core element.

Theory: This study is aiming to give a historical perspective regarding the changes in Turkish primary healthcare system from the Family Doctors’ (FD) perspective.

Methods: Data, based on cross sectional questionnaire surveys among FDs from Turkey are derived from the 1993 European Task Profile study (N=199 participating FDs) and the 2012 QUALICOPC study (N=299 FDs). Comparison of two studies was based on process dimensions of primary care: continuity, access, coordination and comprehensiveness of care.

Findings: Compared to general physicians in 1993, Family doctors (FD) in 2012 reported that their involvement in treatment of chronic diseases, first contact care, antenatal and child health care increased. FDs have more contact with other primary healthcare workers but their contact with hospital consultants decreased. In 2012 FDs serve extremely high number of patients on their list and primary care teams became smaller independent units.

Discussion: The breadth of the service profile of FDs increased. However there is still room for improvement in terms of integration of health services and strengthening primary care teams.

Abstract ID: EFPC2016119
The Efficacy of patient centred Motivational Short Interviews on behavioral change: Diabetic Patients in Primary care setting

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Keywords: life style, chronic disease, short interview techniques, primary care
Purpose and theory: Although life style changes shown to be as effective as medical treatment for glycemic control of diabetic patients, adherence to exercise and dietary recommendations are still very low. This study designed for developing and testing a short interview model aiming to enhance behavioral change among type 2 diabetic patients in the primary care setting.

Methods: This study is a randomized controlled trial. The inclusion criteria were being type 2 diabetic patient at least for one year, no changes in drugs at least for three months, BMI > 25, HbA1c levels between %7-10, age of 40-65. Intervention group were invited to 3 or 4 consecutive patient centered motivation based short interviews. The primary efficacy endpoints were decrease daily calories by 300 ccal/day and increase exercise by 1300 pedometers/day. Assessments were done via daily diet diaries and daily pedometer outcomes.

Findings: Both groups (n= 84 vs 79 in intervention and control groups) were similar in terms of baseline characteristics. Short interview technique found effective for primary efficacy endpoint of increasing exercise (1300 pedometer/day; p<0.001), but not for decreasing daily calories (300 ccal/day).

Discussion: Short interview model used in this study is an effective tool for behavioral change especially when combined with externally validated measurements and could be a supportive technique for management of chronic conditions in primary care.

Abstract ID: EFPC2016120

Community-oriented primary health care in Brazil – a coming trend

Author: Prof. Dr. Kerstin Haemel - Bielefeld University, Germany
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Keywords: Brazil, Family Health Strategy, community-oriented primary care, health professions education

Purpose: The study analyzes a new approach of primary health, the Family Health Strategy (FHS), which is based on a concept of community-oriented primary care (COPC) and promoted in Brazil since the late 1990s with rapid scaling up.

Theory: The COPC concept combining public/community health care strategies and primary health care services has emerged as visionary, although rather elusive practice in many countries. The analysis of the concept and practices in Brazil discloses potentials and pitfalls.

Methods: Literature analysis and semi-structured interviews with researchers and practitioners in the field of primary care and public health; also, recorded visitations of health centers in two Brazilian regions in different stages of program implementation.

Findings: Brazil's FHS is based on strictly interdisciplinary teams working at the community clinical centers. Community health agents provide community health surveillance, health education at home and connect professional and self-care. A key element of the program is community empowerment through social participation. Success depends on 'cultural change'. Community oriented care needs a 'new generation' of health professionals. Interdisciplinary university programs, sustained further education and cooperation between universities and health centers have been promoted.

Discussion: What can other countries learn from Brazil to (re)engage COPC will be discussed.
Abstract ID: EFPC2016123
Correlation between availability of primary health care specialists and calls to the Emergency department in Latvia. Part of international study.

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Keywords: Primary health care, availability, Emergency department

Purpose: The aim of our study was to find relationship between accessibility of primary health care services and calls to the Emergency department in Latvia, to investigate the reasons for patients to visit Emergency department rather than a GP practice.

Theory: When we are doing analysis of family medicine quality an important quality criterion is availability of the primary health care specialists. Each patient who has good contact with his GP firstly contact his family doctor and only in emergency situations call for emergency medical assistance. But years 2014 data show that the number of calls to Emergency department was 436 245. From this total number one third (145668) calls could be cared out in primary health care level.

Methods: Data were collected as a part of a larger international study entitled Quality and Costs of Primary Care in Europe (QUALICOPC) that took place in 2012 and 2013. A cross-sectional survey of 1,937 patients who had just visited general practitioners in 218 family doctor practices was done. We used random sampling of GP practices in Latvia.

Findings: Some 16,9% had visited the Emergency department in the year 2013. Patients with a regular doctor who knows them personally were less likely to attend Emergency departments. The most frequent users of ED services are patients with poor health. One-third (37,2%) of all patients who visited an ED indicated that the main reason for this was that their complaint could not be treated by a GP, 9% of respondents indicated that Emergency service requires them less time, but 2,7% answered that ED provide better care than GPs.

Discussion: Great part of the patient complains could be well treated in primary health care sector.

Abstract ID: EFPC2016124
Experiences using Reablement as a tool for improving participation among elderly service recipients living at home.

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Keywords: Reablement,elderly, professional carers

Purpose: To gain knowledge regarding professional carers’ experience of using Reablement to increase participation in everyday activities in primary health-care in Norway.
Method: Qualitative study, utilising focus group discussions to collect data. 25 professional carers across two municipalities contributed to the study. The data has been analysed using Grounded Theory.

Findings: The results indicate an increased focus on ensuring participation for the service recipients. This was done through changing ways of working, such as increasing multidisciplinary teamwork and focusing on participation and enablement.

Discussion: Reablement can be a framework allowing for increased focus on participation in everyday activities. However, a shift in focus from providing care to enabling participation is necessary for this to be successful. This shift in paradigm from caring to enabling can be challenging for the professional carers.

Abstract ID: EFPC2016125

Professional carers' subjective experiences with next of kin of older adult participating in reablement in Norway

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Keywords: Elderly, professional primary care, home-based services

Purpose: The purpose of this empirical study was to provide knowledge about professional carers’ view and collaborates with next of kin to older adults who participate in everyday rehabilitation.

Methods: 49 professionals from different organisational levels were selected, allowing for differences in ages, gender, and length of working experience, and profession or education. Ten focus group discussions were performed in two municipalities. A grounded theory approach was used to analyse the data.

Results: The core category was identified as “Negation between professional careers and next of kind”. Two categories included the “professional careers’ experience of next of kin perspective” and “professional careers’ have different motives to include next of kin”.

Conclusion: To promote collaborations, the findings suggest that professional carers must extend their focus to next of kin. Professional careers should always consider how they can include next of kind without compromising older adults autonomy.

Abstract ID: EFPC2016128

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Purpose: To analyse the experiences of healthy America’s long-livers, seeking to disclose the core factors leading to health promotion in an old age.

Theory: Antonovksy’s (1987) Salutogenic model as a theory to guide informal and Professional primary care.

Methods: Participants of the qualitative study were in total 22 (14 men and 8 women) functionally healthy and cognitively intact long-livers, 90-104 year old aged at the time of in-depths interviews, living in U.S. – Chicago and its surroundings. Data was analysed by Grounded theory methodology.

Findings: The experiences of study participants show that uniting feature of the most long-livers – sense of coherence, which during the whole lives of investigated participants not from „outside“ institutional attempts, but from „inside“ motivation stimulated theirs calm,
In the Grounded theory visual scheme, raised from Salutogenic theory and study data, sense of coherence is presented as the origin of healthy long-living.

Discussion: Salutogenic model could be used as a theory to guide primary care. Informal and professional care-givers have to be acquainted theoretically and learned practically to apply Salutogenic model, which is powerful instrument promoting health in an old age.

Abstract ID: EFPC2016129
Validation of Patient Enablement Instrument (PEI) in Lithuanian general practice setting. Pilot research

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Keywords: patient empowerment, patient enablement, patient enablement instrument (PEI)

In order to provide better patient care outcomes, community-based primary care and patient-centred consultations are promoting. The ideas of patient empowerment and patient enablement are especially emphasized nowadays (Howie et al., 1998; Pawlikowska et al., 2002; Roost et al., 2015; etc.). Patient Enablement Instrument can be used to evaluate core ingredients in primary care consultations for moving beyond patient satisfaction evaluations. The aim of the present study was to examine the applicability of the Patient Enablement Instrument to the Lithuanian context. A quantitative questionnaire survey was carried out using the PEI. The subjects were patients consulting at the family doctors distributed within one municipality (Pagegiai).

Since PEI validation studies were carried out in few counties before, we had the possibility to compare some results. The research revealed pretty high patient enablement situation. In particular mean consultation duration is 20.11 minutes and is longer than the consultation duration in the UK study – which is a feature of medical consultations that is usually good for patients. The other thing that stood out is that older patients reported higher enablement. In general, the study gave good introduction into PEI validation project and revealed new ideas for further researches.

Abstract ID: EFPC2016131
Does cultural distance explain differences in health among migrants in Europe?

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Keywords: culture, health, migrants, Europe, acculturation

Purpose: Examine whether cultural distance explains (part of) the variation in migrants’ health in Europe.
Theory: Migrants are known to have worse health outcomes. Previous research has shown that acculturation is a key determinant of migrants’ health. We argue that this acculturation is more difficult when the cultural distance between migrants’ host country and their country of origin is higher. Therefore, we hypothesize that migrants’ health is negatively associated with this cultural distance.
Methods: We run multilevel regression models on data merged from two sources. Self-perceived health and control variables for social background of approximately 5,000 migrants (residing in 27 European countries, originating from more than 200 countries) are obtained from the European Social Survey. Besides, we use an
index of cultural distance based on country differences in values, norms and attitudes measured in the World Values Survey.

Findings: The higher the cultural distance, the worse the health status of migrants. This finding is driven by first generation migrants and independent of gender and socioeconomic status.

Discussion: Our results should be taken into account by (i) policymakers targeting particular minorities with their health and migration policies, and (ii) individual migrants when considering different potential host countries.

Abstract ID: EFPC2016133

Informal Care by Family Members of Persons with Spinal Cord Injury in Switzerland

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Keywords: informal care, family members, spinal cord injury, long-term caregiving

Purpose: To portray the caregiving situation by family members of persons with spinal cord injury (SCI) in Switzerland, in order to identify support measures.

Theory: This study starts with Andersen’s model of health care service utilization and applies it on analyzing utilization of supporting measures of caregivers.

Methods: Research on caregiving family members of persons with SCI is carried out with mix-method approach, consisting of a national questionnaire survey followed by a qualitative investigation of semi-structured interviews with caregivers. Development of interview is informed by findings of questionnaire survey.

Findings: Sixty-nine percent of persons with SCI receive assistance in daily activities at home, over 50 percent of whom receive assistance from family members, such as partners, parents, children etc. Predisposing characteristics are influential to their caregiving situation, as well as their decision of utilizing professional care services and support means.

Discussion: This is an ongoing PhD project of the presenting author. Preliminary results of the questionnaire survey will be presented at the workshop, along with an outline of further steps, for which expert feedback is desired.

Abstract ID: EFPC2016135

Primary care teams – an analysis of cross-professional collaboration in Slovene and Spanish health centres

Authors: Prof. Dr. Kerstin Haemel - Bielefeld University, Germany
Additional authors: Carina Voessing - Bielefeld University - Germany

Keywords: primary care teams, collaboration, teamwork

Purpose: A comparative analysis of concepts and practices of cross-professional collaboration in primary care in Slovenia and Spain.

Theory: Cross-professional collaboration is an integral part of comprehensive primary care. Given the increasing number of patients with complex needs, many countries have developed new concepts of collaboration.

Methods: Literature and document analysis, semi-structured interviews with researchers and practitioners and recorded visitations of health centres in Slovenia and Spain.
**Findings:** Both, Spain and Slovenia have extensive experience in multi-professional primary care. In Slovenia, mono-professional units had been most predominant and direct communication between different primary care/health professions was seldom. In 2010, however, an innovative care concept was initiated based on doctor-nurse tandems with roles in prevention for advanced practice nurses. This new care concept challenged conventional procedures and command structures between professionals. Spain has used multi-professional primary care teams since the 1980s. Here team members work independently while collaboration is ensured through the use of various communication channels as well as through joint interventions in complex cases. Our findings underscore that clearly defined structures, team development and team commitment are key factors in improving collaboration.

**Discussion:** Methods of cross-professional collaboration will be discussed.

**Abstract ID: EFPC2016137**

**The anti-politics of Care: re-informalization and re-familiarization in the Norwegian healthcare sector – a discourse analysis**

**Authors:** Dr. Anette Fagertun - Centre for Care Research, Bergen University College, Norway

**Keywords:** policy discourse, healthcare, re-informalization, informal care

The EFPC conference focuses on the cross cutting of informal and formal care in order to promote integration, fairness and efficiency of health systems through deliberate policy decisions. In this paper, I discuss recent ideological trends in Norwegian policy discourses that indicate a move towards both a re-informalisation and a re-familiarisation of care. From a comparative perspective, the Norwegian welfare state model provide citizens with extensive universal services and a much applied description of the model is that it is ‘de-familiarised’. Policy and reforms signal a transformation of the public sector in order to meet the challenge of the demographically graying Norwegian society. Increasingly citizens themselves, their relatives, friends and neighbours, as well as NGOs and local communities, are expected by the state to produce, and take responsibility for, care services - something that is indicative of increasing state reliance on the informal care economy. Policy discourses and interventions have real and sometimes unintended, or undeliberate, effects (Ferguson 1994). I argue that one of the ‘un-authored’ effects is a de-politicizing of care that push towards fragmentation and increasing social inequality. Policy discourses involve two contradictory processes that produce a “particular sort of state power while simultaneously exerting a powerful depoliticizing effect” (Ferguson 1994:21) which assemblage as an ‘anti-politics machine’— an anti-politics of care which might thwart fairness and integration and challenge the cultural value of equality in Norway.

**Abstract ID: EFPC201614**

**Improving self-management of cardiovascular disease in primary care**

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**Keywords:** self-management, cardiovascular disease, education, prevention

**Purpose:** The aim of our study was to ascertain the content of education for patients with cardiovascular disease (CVD) and evaluate the use of patient education for self-management support to reduce recognised risk factors for CVD progression through a family physician intervention in primary care.

**Theory:** The burden of CVD continues to escalate at significant cost to the patient and health care system. Supporting self-management in people with CVD is an important element in preventing disease progression.
Methods: Patients were identified from a patient registry and physician referrals. 426 persons responded to the questionnaire and we estimated the effectiveness of patient education. The model of care was grounded in patient education, building health literacy, and strengthening self-management. An initial holistic health assessment of current lifestyle behaviours, self-management practices, health and medication knowledge was performed as part of baseline data collection. Patient self-management was assessed at baseline, three months and six months.

Findings: The intervention resulted in improvements in biomedical and some self-management outcomes including: five year absolute CV risk, blood pressure, serum cholesterol, glycaemic control, knowledge of medications and conditions, medication adherence, and adherence to a healthy lifestyle. There was a significant change in the following self-management domains: sharing in decision making with health professionals; accessing culturally appropriate health care; attending appointments; keeping track of symptoms and early warning signs; taking action on early warning signs; managing the effects of health condition on activities of daily living; and managing the effects of condition on social life, over the course of the study.

Discussion: The outcome of this intervention indicates that a targeted self-management support program is successful in improving patient self-management and patient-centered outcomes. While there have been a growing number of efficacious pharmacological and non-pharmacological interventions for patients with CVD, their effectiveness will be limited without self-management support to assist patients in adopting behaviors that contribute to improved health. The application of targeted self-management interventions such as this model should be implemented into primary care prevention programs to delay CVD progression.

Abstract ID: EFPC2016142
Scientific foundation and evaluation of an integrated health approach in a deprived area.

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Keywords: Patient centred care, integrated care, complex health problems, deprived area

Purpose: In the deprived area Overvecht, The Netherlands, primary care providers use an integrative approach toward vulnerable citizens: Power-Care. The approach has been developed bottom-up by general practitioners. Core elements are: a holistic approach of health problems, shared responsibility of professionals and patients, self-management, and intensive cooperation with social welfare, secondary care, and other primary care professionals. Goal of the study was to search for a scientific foundation of Power-Care, and to evaluate its implementation.

Theory: The approach shares similarities with the Expanded Four Habits Model (Lundeby) and is based on the concept of positive health (Huber).

Methods: We identified core elements of Power-Care through documentation and interviews. Literature was explored to find out how the core elements could be founded by scientific evidence and theory. Finally, we studied barriers and facilitators in the implementation and application of the core elements by interviewing general practitioners, GP practice nurses, social workers and patients.

Findings: In general the elements of Power-Care are supported. Professionals were especially positive about holistic and customized care. They faced most challenges in applying elements regarding patients’ own responsibility and self-management in this specific population.

Discussion: Recommendations for integrated care in vulnerable citizens will be discussed.
Teams and Incentives the key enablers for integrated primary care?

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Keywords: Integrated care, inter-professional teams, incentive payments, general practice, outcomes

As part of its drive towards more preventative, community based care NHS England has introduced an ambitious national programme to encourage more innovative models of care. The programme seeks to test out six new models, including ‘multi-specialist community providers’ which aim to bring together a diverse range of primary and community care services. Dudley Clinical Commissioning Group (CCG) has developed a network of integrated, GP-led providers across health and social care, each working at a level of 60,000 people and reaching a total population of around 318,000 across Dudley. Key to this approach is encouraging frontline practitioners to work as “teams without walls” for the benefit of patients and taking shared mutual responsibility for delivering shared outcomes. To incentivise and support general practices to adopt this new approach a new payments framework has been introduced which seeks to increase the focus on care planning for people with long term conditions (LTCs) and include outcome measures that are the shared responsibility of primary and secondary care.

Theory: The evaluation will explore mid-range theories related to inter-professional team working and financial incentives.

Methods: The evaluation is taking a theory-based mixed methods approach. This will include observations, staff and patient interviews, surveys and analysis of secondary data related to quality, finances and performance

Findings: The 12 month evaluation began in April 2016 and by September will have emerging findings.

Registered process measures or patient reported experience measures for assessment of providers? A study of access and continuity in Swedish primary care.

Authors: Dr (PhD) Anna H Glenngård - Lund University School of Economics and Management, Sweden
Additional authors: Anders Anell - Lund University School of Economics and Management - Sweden

Keywords: process measures, PREM, accessibility, continuity, regression model, Sweden

Background/Theory: Access and continuity are important objectives in primary care and can be measured as both registered process measures and patient reported experience measures (PREM). These measures do not always converge. Patient views are affected by factors not necessarily reflecting actual access and continuity of the services provided. Results from surveys are often uncertain because of a low response rate, in particular from vulnerable groups. The quality of process measures may on the other hand be influenced by registration practices and they are often more easy to manipulate. With increased transparency and use of quality indicators for improved quality and to hold providers to account, knowledge about the pros and cons of using process measures or PREMs to assess differences in the performance across providers are important.

Purpose: To study the variation and potential conflict between process measures and PREMS when assessing access and continuity in a primary care setting in terms of a) ranking between providers, and b) whether process measures or PREMs provided more information about linkages between access and continuity and explaining variables.

Methods: Four regression models including all providers in two county councils (Region Skåne, Västra Götalandsregionen) 2012 and 2013. Two models with PREMs as dependent variables: patients views of
accessibility and continuity according to the national patient survey. Two models with registered measures as dependent variables: accessibility, defined as the proportion of patients who got an appointment with a doctor within seven days after having contacted the practice, and continuity, defined as the proportion of patients who met with the same doctor for three consecutive visits. Independent variables: characteristics of providers (five variables), location of practices (two variables) and degree of competition facing providers (two variables).

Findings: The results suggest that PREMs and registered process measures are positively correlated. Providers who perform well with respect to one measure also tend to perform well with respect to the other. Results indicate that PREMs provide more useful information than process measures when it comes to exploring factors that contribute to a variation in performance across providers.

Discussion/Conclusion: There is no obvious conflict in using both PREMs and registered process measures to assess and ultimately hold providers to account for activities related to access and continuity. As process measures are easier and quicker to collect, however, they have an administrative advantage when holding providers to account. If the purpose of comparison on the other hand is to learn and understand, PREMs should be the preferred option.

Abstract ID: EFPC2016146
Is increased standardisation in health care compatible with responsiveness towards patient’s expectations? A register based study in Swedish primary care.

Authors: Dr (PhD) Anna H Glenngård - Lund University School of Economics and Management, Sweden
Additional authors: Anders Anell - Lund University School of Economics and Management - Sweden

Keywords: Standardization, responsiveness, patients, payers, regression model, Sweden

Background/Theory: Health care providers in the 21st century face demands of increased accountability from both payers and patients. On the one hand, providers are expected to be more responsive to needs and demands from individual patients. On the other hand, payers demand adherence to evidence-based clinical guidelines and performance targets focusing on cost-effectiveness. Demands from patients calls for increased individualization of care, while demand from payers can be described as calls for compliance towards standards. Research about the outcome of these two parallel trends and how they can be combined is an interesting topic for research.

Purpose: In this study, we analyse if increased standardisation in health care is in conflict with responsiveness towards patients expectations in primary care.

Methods: Using regression analysis, we study the association between patient views on responsiveness and indicators reflecting standardisation in the form of provider’s adherence to evidence-based guidelines. The analysis is based on data from two Swedish county councils (Region Skåne, Västra Götalandsregionen) years 2012 and 2013. The results are controlled for the degree of competition facing providers and characteristics and location of providers.

Findings: Patient’s views on responsiveness were positively correlated with variables reflecting provider’s adherence to evidence-based guidelines about drug treatment to elderly and vaccination to risk groups, restrictiveness in the prescription of antibiotics and use of drug reviews. Private ownership, a high overall illness among registered individuals and a high proportion of all visits being with a doctor, were positively correlated with patient views on responsiveness. The opposite relation was found for high social deprivation among registered individuals.

Discussion/Conclusion: The results indicate that a high satisfaction among patients can be combined with at least some forms of increased standardisation in health care. We suggest that increased standardisation is not in conflict with responsiveness towards patients expectations per se. The risk of such conflicts rather depends on the type and form of standardisation that payers introduce.
Abstract ID: EFPC2016148

The relationship between explicitness of team member roles and individual, organizational and teamwork perceptions between Lithuanian general practitioners and community nurses

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Keywords: primary health care, roles and responsibilities, community nurse, general practitioner

Purpose: Identify the relationship between explicitness of team member roles and individual, organizational and teamwork perceptions between Lithuanian general practitioners (GPs) and community nurses (CNs).

Theory: Explicit roles and responsibilities are among the key features of teamwork; however little is known about how this feature affects team members’ perception of various individual, team and organizational level factors.

Methods: The study included 33 (10 large and 23 small) randomly selected primary health care centers in Kaunas, Lithuania. An anonymous questionnaire was used to conduct the 108-item survey. A total of 180 CNs and 164 GPs participated in the survey (response rate was 74.6%).

Findings: In both groups explicitness of team member roles had a beneficial relationship with perception of team and organizational environment, professional recognition, as well as with the compliance between individual and organizational orientations. Team member role explicitness also had beneficial effect on perception of professional autonomy (73.4% Vs. 55%) and burnout perception (20.6% Vs. 30.9%) as well as with time management (51.1% Vs. 38.8%), although statistically significant differences were found only among CNs.

Discussion: Increased certainty of CNs roles could have a significant impact on their individual, organizational and teamwork perceptions. Policy makers should focus more on the legal framework defining the roles and responsibilities of CNs in primary health care.

Type of presentation: oral paper.

Abstract ID: EFPC2016149

Care for medically compromised patients: a need for combining professional and informal care? A pilot study in The Community Health Centre Ljubljana

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Keywords: medically compromised patients, comprehensive care, dependent patient, chronic disease, risk factor

Purpose: To identify the needs of compromised patients at their home and to define future activities regarding professional and informal patient care.

Theory: Compromised patients, especially those with chronic diseases, are more exposed to health, social, economic and other challenges. Their management can be planned if their needs and weak points are known.

Methods: From October 2015 until February 2016, community nurses visited 1171 compromised patients at their home. Patients were screened using different tools (screening for non-communicable chronic disease, health status questionnaire, family APGAR, MORSE, daily activities assessment etc.).

Findings: Out of 1171 patients, 42.3 % had chronic disease, 50.4 % risk factors, 7.3 % were signed healthy, 12 % of patients are fragile, 7 % have social troubles and 11.5 % are dependent with basic daily activities. Family APGAR identified 112 %/2.4 % of patients with dysfunctional family /very dysfunctional families accompanied by lower score of their health assessment, increased loneliness and worse pain intensity score.
Discussion: The proportion of patients with specific needs was assessed in the region and consequently, the amount and content of care/service can be planned. Fragile patients, patients with low family APGAR score and dependent patients with their daily activities could be supported by non-professionals/informal care. Additional research is needed to confirm these results.

Abstract ID: EFPC2016151
Chronic obstructive pulmonary disease (COPD) management in primary care (PC): an experimental model of professional integration “caregiver – pc”: from preventing to diagnosis and treatment

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Keywords: integration, caregiver, primary care, prevention, diagnosis, treatment

Background: Considering that COPD prevalence is increasing worldwide and that its treatment currently allows only to control symptoms without affecting either the disease itself or the progressive decline of pulmonary function, the real goals of COPD management are: prevention (e.g. stop smoking), early diagnosis, and treatment education with adherence and correct use of devices. It is well known that the use of spirometry as a first line diagnostic test and an active integrated (general practitioners, GP, and lung specialists) approach to the patients and disease, significantly improve COPD management. DALY (Disability Adjusted Life Year) data report that COPD will become in 2020 the 5th cause among the disabling diseases, and this aspect is sufficient (along with prevention and home-treatment possibilities) to strictly involve PC area in its management, also taking into account both the economic and the managerial advantages of Caregiver participation.

Aim: To develop a Caregiver-PC integrated ideal and experimental model of COPD management, able to allow a prevention improvement (stop smoking), an early diagnosis, the therapeutic suitability, patient’s adherence with correct use of devices, and, finally, a lowering of management costs.

Study design: 1. organization of a dedicated surgery (2 hours a week) for Caregivers (patients’ relatives or carers) of patients having COPD risk factors and/or symptoms, or a COPD diagnosis. 2. Caregiver education (also using brochures and slides) about the importance of motivation counselling and lifestyle in COPD prevention and cure, as well as about COPD related risk factors and symptoms. 3. Demonstration of CAT questionnaire and of the correct use of spirometry and therapeutical devices. 4. Caregiver active involvement in patient’s follow up and relapse management.

Results: In patients with COPD risk factors, and/or symptoms or with an already established COPD diagnosis, the presence of the Caregiver (thanks to “peer education method”) should allow an easier weaning from smoking, a correct lifestyle adoption, a better willingness to undergo clinical and functional evaluations useful for an early diagnosis, and, finally, a correct therapy (doses and use of devices). All together, these results will improve COPD primary prevention, early diagnosis (case finding), therapeutic suitability (patient’s empowerment) and adherence, as well as the management of relapses and of associated diseases with a resource optimization and a lowering of management costs.

Conclusions: The Caregiver has to be integrated with an active and well defined role, together with GP, in the different disease-related diagnostic and therapeutical-welfare projects and/or Chronic Care Models in order to allow a real disease prevention, an increase of COPD diagnoses and a better therapeutical line-guided management. These goals have to be pursued because of the progressive increase in COPD prevalence (also related to ageing), the low rate of smoke-weaning before 60 years, the low rate of diagnosis that often arrives late and the high rate of inappropriate treatment (adherence, doses, use of devices, etc.), all causing suboptimal results and cost increase.
Abstract ID: EFPC2016158
The effectiveness of an educational intervention targeting community pharmacy staff

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Keywords: primary care, community pharmacy, intervention

Purpose: To improve knowledge and skills of community pharmacies employees when attending patients with hypertension, diabetes mellitus, cholesterol and pediatric skin rashes.

Theory: The community pharmacies are the effective place to implement different health education and health promotion interventions. In our health system, chronic patients go to their local pharmacy every month with electronic prescriptions, interacting with pharmacy staff which provides health advice on a regular basis. Sometimes, pharmacies also attend patients with acute, not urgent, conditions. The proximity, the accessibility and the continuity of care makes pharmacies a key element in prevention and care of patient’s ailments.

Methods: An intervention study was conducted by a general practitioner, a pediatrician and two nurses, at six of the seven community pharmacies in our area, targeting all their personnel. The intervention consisted of two one-hour sessions on hypertension combined with cholesterol, and diabetes mellitus along with pediatric skin rashes, respectively. The sessions cover the definitions of the targeted conditions, the actions to be performed for abnormal findings at the pharmacy and the proper patient counseling. A pre and post-test self-designed survey of 15-items was administered.

Findings: A total of 27 answered the questionnaire, of which 15 were pharmacists, the rest being pharmacy technicians. The mean age was 40, and 85% were women. Before the intervention, two thirds of the respondents were familiar with the abnormal values for arterial blood pressure and half knew the recommend values for cholesterol level, but their information on pre or postprandial glucose level was scarce in general. All of them were aware of the lifestyles changes recommended for patients with hypertension. After the intervention, their skills improved substantially in regards to the technique of measuring blood pressure and they were more knowledgeable about the appropriate referral of patients to the emergency department in case of abnormal findings.

Discussion: A proper assistance and counseling by the community pharmacy staff can be beneficial for both patient and health system, by reinforcing advices given in primary care clinics and reducing unnecessary emergency visits.

Abstract ID: EFPC2016163
Reducing dementia risk in mid-life: evaluating a dementia risk profiler and on-line support environment. The In-MINDD feasibility RCT

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Keywords: Dementia; Primary prevention; Risk factors; eHealth
Purpose: Dementia is a major challenge for individuals and health systems. As well as age/genetics, mid-life risk factors associated with later dementia risk include: hypertension; physical inactivity; smoking; obesity. In-MiND developed an on-line risk profiler which gave participants a Lifestyle for Brain Health (LIBRA) profile and access to health information. We aimed to assess its feasibility/acceptability in European primary care.

Theory: Normalisation Process Theory used to understand the work required to use the profiler and sustain change.

Methods: Feasibility RCT with embedded qualitative process evaluation conducted in France, Ireland, The Netherlands, Scotland. Primary outcome measure: change in “Keep It Up” LIBRA score over 6 months. Interviews with 56 participants.

Findings: 451 participants randomised: 31.1% obese; 50.0% hypertensive; 13.0% CVD diagnosis; 20% smoked; over 40.0% drank regularly. Mean LIBRA “Keep It Up” score improved slightly more in intervention arm than control arm (1.8 (SD 8.6) vs 1.1 (SD 9.7); mean difference = 0.638, p=0.638, 95% CI -1.389 to 2.664). Drinking, diet and physical activity improved more than other factors. Participants liked the profiler but lack of time to make changes was challenging.

Discussion: A digital heath intervention targeting mid-life risk factors for dementia is feasible and acceptable. Lack of statistical significance may be due to feasibility trial lacking power or to knowledge contamination in control group.

Abstract ID: EFPC2016170

Using linked person level data to examine the impact of ‘hot’ primary care on the non-elective health care system.

Purpose: Null Hypothesis: ‘Hot’ primary care confers no cost containment with regard to summed per capita costs associated with Adult Social Care, Community care, in-patient elective and non-elective care, Outpatient and A&E attendances and Out of Hours care and telecare’

Theory: Well-resourced and organisationally nuanced primary care systems (Focus on long term conditions / multi-morbidity) helps prevent illness and premature death and is associated with cost containment in the secondary/tertiary care settings1,2,3 .

Methods: We used linked data analyses covering the period April 2014 to March 2016 to calculate cumulative per capita costs at GP practice level. The care costs included adult social care, community care, non-elective acute admissions, accident and emergency first attendances, Out of Hours care and Telecare. We also calculated GP practice consultation rates (GP + Practice Nurse). These data were then compared with practice staff to population ratios to assess variance in per capita costs and association with staffing ‘intensity’ scores. Per capita costs were adjusted for deprivation using practice level deprivation (Index of Multiple Deprivation 2015). This was done to remove potential confounding in service utilisation rates and therefore cumulative costs.

Practices were then grouped using a two-step cluster technique. Post hoc ANOVA tests were conducted to assess cluster differences.

Findings: Practice size does not discriminate for cost efficiency.

Also, when practice costs were compared using FTE_1000 population ratio clusters, per capita costs gradients were accentuated with better-resourced practices generating higher mean per capita costs. Significant differences were observed between statistical cluster groups 1 and 4, with cluster 4 having a significantly lower mean per capita total and non-elective cumulative cost per patient.
Kingsnorth Medical Practice (KMP) is a statistical outlier at the low end of the cluster distribution (i.e. beyond the 95% ICL).

Despite the fact that there are highly significant variations in consultation intensity, for the majority of practices included in the analysis, there were no significant differences in cost per capita between ‘hot’ and ‘cold’ practices (notable exception was KMP). If the cost efficiencies observed in the KMP are attributable to the configuration of the practice (running ‘hot’ with notable nuances in the way business is done) — potential cost savings are likely to be highly significant if the KMP operating model were rolled out across the CCG.

Discussion: The rising tide of multi morbidity and other cost containment pressures in the UK health care system are now forcing policy makers to re-consider the role of primary care in transforming the way health care is provided in the future. The analyses presented in this paper indicate that it is not so much the staffing intensity of primary care practices that conveys cost containment gains in the non-elective sector, rather it is the way in which staffing resources are configured that makes a difference. If the model of care observed in the Kingsnorth Medical Practice were operationalised elsewhere there may be significant cost reductions in the acute care system through avoided admissions.

Abstract ID: EFPC2016217
Care coordination of complex chronic patients by family doctors: the Italian CReG program

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Keywords: care coordination, home telemonitoring, hospital-family practice integration

In 2011 Lombardia Region launched an innovative program, called CREG (chronic related groups) with the objective to promote continuity of care for chronic patients, with a proactive approach. The CREG, a sort of territorial diagnosis related group (DRG), is assigned to a CREG provider, a cooperative of family doctors (GPs), to guarantee the delivery of an established treatment plan to the chronic patients, in order to provide them with a comprehensive care, outside of the hospital.

The BuongiornoCReG program includes care coordination activities, patient education and home telemonitoring (for the more complex patients) to generate a productive interaction between the 40.000 recruited patients and GPs. The sharing and management of information was guaranteed by an IT web platform, integrated with the GPs EMR, a CRM system, a class IIa medical device home tele monitoring platform, a Service Center, all provided by the partner Telbios. The expected and already proved benefits are the reductions in avoidable or unnecessary hospitalizations, a more sustainable and optimized use of resources, and a more efficient care and effective secondary prevention at individual level. The embedded economic model, the collaboration between GPs and specialists, the deployment at large scale, make the CReG program a promising and replicable model.

Abstract ID: EFPC2016232
New Approaches in Prevention of Non-Communicable Diseases - Integration of Primary Health Care And Public Health Services in Lithuania

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Keywords: Primary health care, public health, local policy, cooperation, synergy

Purpose: To describe case from Lithuania on integration of primary health care and public health services at local and national level.

The growing prevalence of chronic non-communicable diseases (NCD), the World Health Organization encourages the countries to focus on the effectiveness of health systems so that they would give a better response to public health. Lithuania NCD prevalence is also one of the most pressing public health problems: deaths from circulatory system diseases in 2014 among women amounted to 64.9 percent and males 47 percent of all deaths. On 22nd September 2014, the Lithuanian Ministry of Health approved cardiovascular disease risk groups’ health promotion procedure, involving in its implementation national and local authorities. From 2015, around 700 risk group individuals finished this program. Started intensive work with heart disease risk group’s involved cardiologists, dieticians, physiotherapists, psychologists and public health professionals. They monitor and assess the risk of human health, teach them a healthier diet, rational move, give up bad habits, manage stress, understand their health indicators, reducing the risk of negative consequences. Risk of persons consulted in detail, and the following year valued at their lifestyle and health indicators.

This case has generated the integrated at national level formalized actions at local and municipal level between personal and public health institutions health service providers.

Statements for debate: Functional integration of public health and primary health care services (PHC) in Lithuania not so successful as it was expected. PHC providers are burden with increasing flow of patients and refer enough patients for education.

Abstract ID: EFPC2016234
Should North Carolina Professionalize Community Health Workers?

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Keywords: population health, triple aim, community health workers, professionalism, health professions education, disparities, community based education, AHECs

Purpose: U.S. Health Care reform has increased interest in improving population health, but how to do this remains unclear. Several states have developed formal programs for training community health workers (CHWs). We review a two year statewide consensus process, with attention to stakeholders, needs assessment, competencies & career ladders, public-private partnerships, financing and anticipated challenges.

Context/State of the Art: North Carolina (NC) has >10,000,000 residents and striking geographical and racial disparities. 32% of NCs population consists of underrepresented minorities whose health status makes up the bottom 1/3 of its health outcomes. NC also has dramatic economic growth, well developed universities, community colleges, and an area health educational network; its hospitals and clinicians are rapidly consolidating and payments for population health are spreading rapidly. Would a formalized CHW profession improve effectiveness of care? If so, how would it be best organized?

Debate Statements: We assume that informal CHWs benefit selected patients, communities and clinical providers. We argue:
1. CHWs want professional recognition and core competencies
2. Both private and public organizations can provide initial certification; ongoing career development needs, ongoing education and formal schooling
3. Accreditation will be more cost-effective than licensure
4. Public interest will be served by professionalizing CHWs.
Guideline for Developing Clinical Practice Guideline in Primary Care

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Keywords: Primary care; clinical practice guideline; development

To optimize patient care, clinical practice guidelines for primary care must be developed at universal standards and this must be accepted as an aspect of health policies. Before the current evidence-based guidelines were developed, guidelines based on expert opinions did exist. However, because personal views have been brought forward in these guides there have been uncertainties about which guide to use. For this reason, the Institute of Medicine published a document stating the rules an appropriate guideline should follow in the United States of America in 1990. The first national program directed to the development of clinical practice guidelines required to form the guide was launched in the 1980s in the USA, and other developed countries also started launching national programs in the 1990s. In our country, both the Ministry of Health and Non-Governmental Organizations undertake the activities towards the development of guidelines. Despite the fact that the Ministry of Health and the non-governmental organizations have developed several guidelines for many diseases and conditions, there is no organization or institution specialized in the development of guidelines in Turkey. The only reference source about developing guidelines in Turkey is the “Turkish Thoracic Society Guideline, Report and Opinion Development Directive” published by the Turkish Thoracic Society in 2007 within the context of “evidence based medicine” to promote a standard in the development of guidelines. Many countries around the world have launched national programs for the development of clinical practice guidelines. The main purpose of these programs is to facilitate the easier and more systematic development of clinical practice guidelines. Our goal in this project is to develop the “Primary Care Clinical Practice Guidelines Development Handbook” for Turkey.

Right Care strategy in a Primary Care team

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Keywords: Right Care; Prescription; Insomnia; Depression

Essencial Project, widespread in Catalunya, aims for evidence based strategies, according to Right Care philosophy, looking for reducing low value activities (both from clinic and cost effectiveness point of view). It has been developed in primary care teams and with population.
Goal: Reducing benzodiazepines’ inadequate prescription for elderly insomnia and antidepressants in mild non-complicated depression in elderly attended in Primary Care.

Methods: We develop a before and after study in a Barcelona primary care team (PCT).

Variables: 1) Long life benzodiazepines prescription in insomniac patients >= 65 y. 2) Antidepressants in initial phases of non-complicated mild depressive patients. Two training sessions were performed with de prescription guidelines and alternative treatment options.

Results: Benzodiazepines prescription was reduced in 2.5% three months after intervention (from 8.45% to 5.95%) for previously diagnosed patients. Benzodiazepines prescription was reduced in 19% for all new insomniac cases (from 67% to 48%). A 3% antidepressants prescription reduction was achieved after 3 months (from 47% to 44% post-intervention).

Discussion: Right Care strategies help reducing avoidable benzodiazepines and antidepressants prescription in primary care. It may help to reduce low value activities in primary care. Variables evaluation in the long term is required. It’s also needed training sessions to maintain or furthermore reduce low practices or prescription, sharing strategies with other care levels and integrate patients in them.

Abstract ID: EFPC2016250

Manual to support caregiver in nutrition of the elderly

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Keywords: elderly /nutrition/ caregiver/ manual

Purpose: Manual to support caregiver in nutrition of the elderly

Context: The caregiver is someone who takes care of an individual and responds to all their physical, mental and social needs. When the caregiver is a family member, they are known as a spontaneous or ‘informal’ caregiver, while a ‘formal’ caregiver is someone who assists the patient under the form of a working relationship.

The increasing aging of the population brings a change in the traditional models of care. Looking after a person with disabilities can be physically and emotionally exhausting.

A key aspect of assistance provided by caregivers is the nutrition of the elderly. It is therefore crucial to teach the caregiver how to recognize and evaluate the poor nutrition levels and how to correct cases of malnutrition.

With the objective of supporting the caregiver, in collaboration with the University of Rome "La Sapienza", we have developed a manual on the correct diet for a healthy patient.


Abstract ID: EFPC2016252

The simulation in Situ

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Keywords: In situ simulation, latent security risks, team, primary care
Purpose: This study aimed to evaluate the feasibility, and measure the impact of an “In situ interdisciplinary primary care team quality improvement simulation program.”

Context: The team in family practice often meets life-risk patients in their offices or outside. It is very important to treat them in accordance with guidelines and quality standards. An educational program “In situ simulation” has been prepared and implemented into practices. It aimed to ensure work quality and to identify potential errors and security risks in the treatment of a patient that could be avoid in advance in Community health Centre Ljubljana (CHC Ljubljana).

We describe an in situ simulation-based quality improvement program that was designed to continuously monitor the cardiac arrest response process for hazards and defects and to detect opportunities for system optimization.

From 2013 onwards continuously we organize simulations for all teams of family medicine infirmaries and paediatricians. All physicians (150) in CHC Ljubljana must be together with the entire team qualified for the implementation of the Protocol vitally threatened patient care and properly apply to all the necessary equipment and utilities. They must provide an adequate response time of team, properly apply all the necessary equipment and appropriate team cooperation and communication, also management software for the supply of vitally threatened patient.In 2015, we upgraded program with “in situ simulations”.

A total of 180 simulated unannounced cardiac arrest exercises were conducted between January 2013 and April 2016 at various locations throughout our medical center and at different times of the day. We detected several environmental, human-machine interface, culture, and policy hazards and defects.

For evaluation we used the following indicators of quality: safety, algorithm, safe defibrillation, team leadership, communication, control of the equipment.

Participants solved the life-risk problems of an virtual patient and the simulations were performed at their workplace and used their medical equipment. All simulations were carried out unannounced.

This kind of simulations can illuminate deviations, which can be developed during the patient’s treatment, in advance. In situ simulations are excellent opportunity to find out latent error (latent security risks) (LST) in treatment process.

State of the art: From January of year 2014 to April 2016 we organized 180 simulations and 6 in situ. Pre- and post-evaluation experiment of qualification, which indicates, that the level in situ simulation is bigger for 25 %. Prepared treatment protocols were excellent valued. Latent security risks, that have been identified were: problems with equipment, high stress of some participants, uncoordinated team, not to lead the process of supply vitally threatened by the doctor, too long response time, inadequate resuscitation algorithm.

Statements for debate: The use of simulation in health professional education has increased rapidly over the past 2 decades. While simulation has predominantly been used to train health professionals and students for a variety of clinically related situations, there is an increasing trend to use simulation as an assessment tool, especially for the development of technical-based skills required during clinical practice.

Abstract ID: EFPC2016253

Patient satisfaction and how it is affected by practice list size

Authors: Harry J A Longman - GP Access Ltd, United Kingdom

Keywords: practice, size, patient, satisfaction, survey

Purpose: to understand how patient satisfaction is affected by primary care unit size, in terms of registered patients.

Context: in the UK and other countries there is a policy direction to increase unit size, for assumed issues of efficiency, but evidence on the effects of this policy is lacking. Larger unit size also affects the composition and role of the primary care team, and the relationship with informal care. Smaller units tend mathematically to have greater continuity as the pool of clinicians is smaller, but we do not know how this affects informal relationships.
State of the art: we know that unit size has no measurable effect on secondary care use (see paper H Longman at EFPC Amsterdam 2015). We hear anecdotally that patients like small practices with personal relationships, but we do not know whether this can be seen in overall satisfaction ratings.

**Method:** to analyse the national Patient Experience Survey, produced annually in England over 10 years, by practice list size. 8,000 practices in size bands from 2,000 to 20,000 allow good sample sizes for retrospective analysis.

**Questions for debate:**
1. How important is patient satisfaction as a policy driver?
2. What does the data tell us about its relationship with practice size?
3. How might this affect the primary care team and informal care?
4. Does any further information emerge which is useful for system design?
5. What are the policy implications?

**Abstract ID:** EFPC2016256

**Provision of healthcare to refugees: what is the best practice?**

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**Keywords:** immigrant health, discrimination,

Immigration was a humanitarian problem for long times. But for last decade determinants of migration shifted from economic and demographic to political issues especially for millions of people who emigrated from Muslim countries due to war conditions. Turkey, Jordan and Lebanon had millions of refugees from Afghanistan, Iraq and Syria. Definition of “persons of concern” is another issue and it reflects the perspective of countries (for example in Turkey Syrian refugees are defined as “guests”) and institutions. Defining them as refugees, asylum seekers or internally displaced persons have different consequences especially for their legal status.

According to studies, health care is given as third or fifth priority of concern by Syrian migrants in Lebanon and Jordan, coming after first two major concerns: livelihood and shelter. Most of the studies on refugee health covers areas of maternal and child care, and communicable diseases. However, in concordance with demographic and epidemiologic changes of recent decades, non-communicable diseases are also becoming more prevalent among refugee populations. Although provision of strong primary care services is a promising tool for decreasing inequities in health and essential for disadvantaged groups like refugees, migrant-specific (exclusive approach) health policies seem to be a barrier for refugees to access already existing primary care services. In this policy debate session, we will present results of a pilot study exploring primary care physicians’ perceptions and attitude towards refugees in Turkey and also preliminary results of a cross-sectional survey regarding health care provided to refugees for chronic diseases.

**Discussion** will be done on these questions:

- Do we, as primary care physicians, discriminate refugees?
- Should refugees have primary health care through regular services (inclusive approach) or governments should provide special health care services to refugees (exclusive approach)?
- Does religion have any influence against care to refugees?
- How far communication problems (verbal, nonverbal and cultural) influence the healthcare given to refugees?
**Abstract ID: EFPC2016257**

How can digital channels promote access, efficiency and equality, and how are governments promoting their use?

Authors: Mr Harry J A Longman - GP Access Ltd, United Kingdom

Keywords: digital government promotion equality access

Purpose: Understand how digital channels may and may not be useful in primary care

Context: In the UK government efforts to persuade patients to interact digitally with primary care have focussed on the three functions of ordering prescriptions, booking appointments and viewing their medical record. Despite heavy investment over some years, results have been poor or at best mixed.

State of the art: we analyse results and assess why, with around 90% of the population having online access, only 3% of appointments are booked online, and only 0.6% of patients have accessed their records. Prescription booking is growing and over 10% of transactions. We relate the potential for online access to address real problems, of demand and workload, and show how this has moved over 40% of demand online in some practices, with measurable benefits in workload. Usage by informal carers as well as patients is discussed.

Questions for debate:
1. In what ways do digital channels offer most scope for solving primary care problems?
2. How are govts around Europe promoting digital channels?
3. How can digital channels help the primary care team and informal carers through improved work design?
4. Do digital channels affect equity of access and can equality be maintained or enhanced?

**Abstract ID: EFPC2016262**

The biopsychosocial vulnerability in Primary care

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Keywords: chronic disease; comorbidity; primary health care; outcome and process assessment

The need for early screening of the biopsychosocial vulnerability within primary care is clear in the literature, but there is disagreement on the definition and type of score to be used.

Health is influenced by determining not only biological, but also psychological and social. The progressive aging of the population in industrialized countries and the social changes of the last century brought the onset of new health problems and management difficulties; increasingly requires the management of chronic diseases and the progressive loss of autonomy of people who cannot have a stable social support. It seems clear that to define the vulnerability of a person we cannot simply be based on age registry, therefore it arises the need for a simple assessment tool, rapid and complete for the identification of the most vulnerable people on which to plan the most efficient use of resources.

The aims of the study are research and evaluation tools to determine the biopsychosocial vulnerability and the creation of a flow-chart for the establishment of health and socio-personalized care programs, but based on scientific evidence.

The tools found were analysed according to the following criteria: execution Simplicity, objectivity, practicality with territorial medical instruments, feasibility based on the execution time, completeness, ability to anticipate future loss of autonomy.
Abstract ID: EFPC2016264
Sharing health data among General Practitioners: the Netmedica Italia case history

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Keywords: sharing data; standardization; cloud computing; interoperability

General Practitioners (GPs) are the highest fragmented category in the public sanitary service. Here we present the case study of the Netmedica Italia (NMI) project, designed by FIMMG GPs association in Italy, that has been able, in the last 3 years, to set up one of the first GP's Healthcare Information System, connecting all the providers, and providing full access to clinical and health-related data independently from the healthcare software that generated the data itself.

This goal was achieved providing a novel technological infrastructure for data sharing based on interoperability specifications recognized at the national level for messages transmitted from GP providers to the central domain, adopting Healthcare Enterprise Integration (IHE) profiles which refer to HL7 standards.

At present, the system manages more than 3,000 GPs with about 3,500,000 patients. Hence the NMI healthcare system is a fully interoperable healthcare system connecting patients, GPs, healthcare organizations, and healthcare professionals in a large and heterogeneous territory through the implementation of data standards with a strong focus on cybersecurity. Results of the application of this scenario at a national level could have a relevant impact on the sanitary system and on GPs every day professional activities with a strong improvement of efficiency and a reduction of social costs.

Abstract ID: EFPC2016265
Propagating Keys: The role of rural midwife in advancing health promotion behavior among community-dwelling women

Authors: Dr Victoria G. Vivilaki - Midwifery Department, TEI Athens, GREECE, Greece

Keywords: health promotion, midwife, rural, community, women

Purpose: Propagating Keys is a Model of community empowerment. ‘Propagating Keys’ are the active players in the process of gaining influence over conditions that matter to people who share neighborhoods, workplaces, experiences, or concerns.

Context: This horizontal relationship between neighbors or members of a Target Group, with variables such as trust, reciprocity and civic engagement, such as voluntary organizations, clubs, classrooms, parent teacher organizations and like, are particularly important in health education interventions. This inexpensive framework focuses on individual motivational factors as determinants of the likelihood of performing a specific health behavior and can help improve collaborative partnerships for community health education interventions. It is an interactive model of community empowerment that describes reciprocal influences between personal or target group factors and environmental factors in an empowerment process.

State of the art: An example of research applying the Propagating Keys model is the study by Vivilaki et al 2005 in a rural and remote area in Crete island. This example describes a study conducted by rural midwives in order to explain the greater a rural woman’s commitment as member of the target group premised on the identity of being member of this specific group, the greater will be the salience of the identity for rural woman. Moreover, this example provides description of the phases involved in the application of the model by rural midwives, including selection of the Propagating Keys by rural health professionals, description of model component
measurement; and descriptions of analyses to explain behavior within the target group of rural women. The presented study reports on the effectiveness of a health education meeting with Propagating Keys selected from the Target Group in recruiting women by rural midwives for screening program in a primary-care setting in a rural area of Crete island.

Statements for the debate: The view that individual behavior change is the primary goal of health education presents several serious problems. Although individual behavior does contribute to health and disease, social organization is perhaps a more powerful influence. The use of behavior change as the primary tool for health education gives birth to ethical issues. Health education which seeks to change individual behavior has also failed to have a significant impact on public health. Propagating Keys are an alternative inexpensive strategy in health education for social change. The goal of this approach is to involve people in collective action to create health promoting environments and life-styles.

Abstract ID: EFPC2016267

Health care system in Slovakia - good or bad, advantages and disadvantages.

Authors: Dr. Stefan Krnac - Private GP and surgeon, Slovakia

Keywords: Health care system in Slovakia, advantages, disadvantages of care, questions and answers

Purpose: Information about health care in Slovakia - member of EU - and finding answers of how the system could be improved.

Context: The author has 3 GP private practices, one in a big town, 2 in rural areas. Within this presentation the author is finding out what are the pro’s and the cons of health care in Slovakia. Also, where are the advantages and disadvantages of the Slovakian system. At the end of the presentation there will be an answer about how the system could be made better.

Abstract ID: EFPC2016314

Can Nurse Practitioners Contribute to Transformation of the Swiss Primary Care Practice?

Authors: Dr. Stefan Essig - Institute of Primary and Community Care, Lucerne, Switzerland

Additional authors: Christoph Merlo - Institute of Primary and Community Care, Lucerne - Switzerland
Iren Bischofberger - Kalaidos University of Applied Sciences, Zurich - Switzerland
Beat Sottas - sottas formative works, Bourguillon/Fribourg - Switzerland

Keywords: Interprofessionalism, Nurse Practitioners, General Practitioners, Switzerland

Purpose: This project develops, evaluates and establishes the role of nurse practitioners (NPs) in Swiss primary care as an unprecedented innovation. It determines how task sharing with NPs as newly introduced professional actors is specified and shaped.

Context: For historic and legal reasons, primary care in Switzerland has been dominated by general practitioners (GPs) running mostly single practices. The perspective of this traditional setting does not seem to be an appealing option to a younger generation of physicians. Their main focus on acute care in education and practice barely reflects the shift towards more chronically ill patients. Accordingly, patient demands remain unmet and require a “reinvention of primary care”. NPs and their scope of practice have the potential to alleviate this unsatisfactory situation.

State of the art: As shown in an abundant international literature, there is a significant potential of tasks and procedures which do not require a physician’s education. NPs were able to complement health care teams in primary care settings, particularly for the most vulnerable, mostly elderly and disabled patients by coordinating
care, engaging in self-management, or taking over home visits and acting as a point of first contact in the community.

**Mode of presentation:** non-stop slide-show

**Abstract ID:** EFPC2016355

**Demand led system change in Northern Ireland through online and telephone channels**

**Authors:** Mr Harry J A Longman - GP Access Ltd, United Kingdom

**Keywords:** demand led telephone digital efficiency

**Purpose:** to show how a demand led system change in Northern Ireland has affected patient care and primary care efficiency.

**Context:** Northern Ireland has a strong tradition of GP led primary care, but this is under pressure because of a shortage of GPs in training and large numbers approaching retirement. Aware of this, Health and Social Care Northern Ireland (HSCNI) is supporting change within its GP practices to become demand led.

**New state of the art:** practices can respond within minutes to patient demand either through telephone or online channels. Efficiency is improved as 2/3 patients can be dealt with remotely, addressing the GP shortage both through time saved directly and the ability to use other members of the team to triage online demand.

GP can also triage to others, spreading the workload.

Further gains are in the pipeline, as some demand can be managed remotely in areas such as Fermanagh with acute GP shortages, and system wide changes follow widespread adoption of the online channel.

**A video is presented** telling the story of how the system works from the point of view of patients, GPs and other primary care staff.
Call for abstracts
Submission deadline: Sunday, 1st of May 2017

“The Citizen Voice in Primary Care: a social commitment to 'health for all'”

Main Themes: promotion of participative citizenship in healthcare; development of commissioning of services procedures oriented to quality management and care planning/care delivery integration; implementation of health adaptive policies; integration of policies and projects between the health sector and the education, work, science, environment and culture sectors.

Abstract types:

Research abstracts: These presentations will provide the results, completed or in advanced in-progress form, of original research projects. The material should not have been published elsewhere, except in preliminary form, and it should be ready for publication as a journal article. Papers related to PhD projects, either completed or in progress, are especially encouraged. The selected abstracts will be discussed within workshops that are moderated by key-experts in the specific theme.

Policy debate posters: These posters describe significant developments in policy (whether governmental, organizational, or any other) that affects primary care associated with the themes of the conference. In particularly national, regional or local policy makers are invited to provide new policy developments. Posters need clear statements for debate. All selected posters will be publically presented / defended in specific parallel sessions with a 15 minutes time-slot for each poster. These sessions are located at innovative settings, such as “debate corners”, animated by an expert facilitator.

Practice multi-media presentations: Projects and developments focusing on practice-oriented questions and reporting on recent experiences and innovations in primary care. These presentations should present case descriptions of primary care on the national, regional or local level and are presented as such, without oral explanation. The selected multi-media presentations (video’s, slide-shows, small photo exhibitions, theatre, art, etc.) will be prominently presented with non-stop shows during the conference.
The Future of Primary Care in Europe

The Citizen Voice in Primary Care
a social commitment to 'health for all'

12th EFPC conference
24/26 SEPTEMBER
PORTO 2017
http://efpc2017.pe.hu

Conference fees

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Early bird ends June 16