“Health Promotion in the framework of Community Oriented Primary Care (COPC): from theory to practice and policy”

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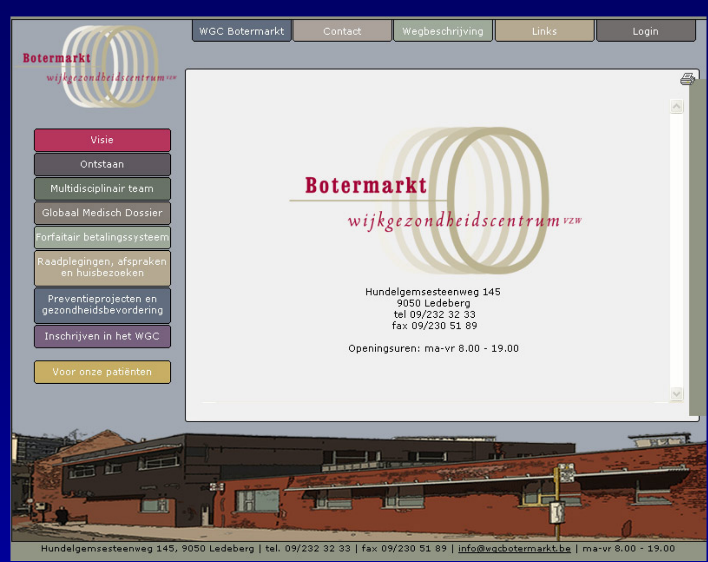
Former Secretary General The Network: Towards Unity for Health
Chairman Expert Panel on Effective Ways of Investing in Health (EC)

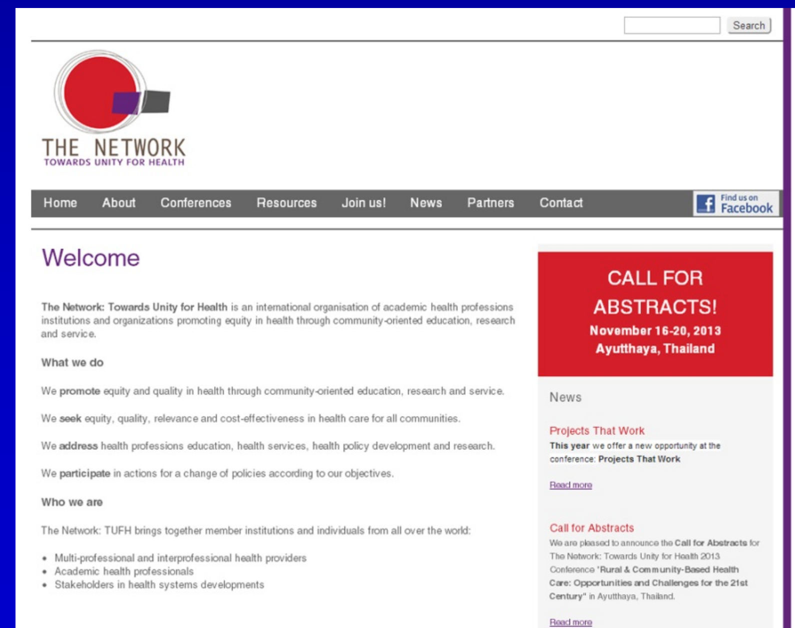
Galway, 15.06.2016

http://www.primafamed.ugent.be



http://www.wgcbotermarkt.be

http://www.euprimarycare.org



http://www.the-networktufh.org

WGC Botermarkt | Wegbeschrijving | Links | Login

Botermarkt wijkgezondheidscentrum vzw

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

Community Health Centre:

- General Practitioners; nurses; dieticians; health promotors; dentists; social workers; tabacologist;…
- 6200 patients; 90 nationalities
- Integrated needs-based mixed capitation; no co-payment
- COPC-strategy

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

How to bridge the gap between evidence and practice?

Health Promotion in the framework of COPC

1. The changing society and Sustainable Development Goals
2. Primary Care: the concepts
3. Changes in ‘pro-active or pre-care’
4. Changes in ‘chronic care’: addressing multi-morbidity
5. Changes in ‘community oriented care’
6. The health promotor as actor in the health system: “Together we change”
7. Conclusion

The changing society

a. Demographical and epidemiological developments

b. Scientific and technological developments

c. Cultural developments

d. Socio-economical developments

e. Globalisation and "glocalisation"

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

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

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

Summary

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

Lancet 2012; 380: 37–43

Published Online
May 10, 2012
DOI:10.1016/S0140-

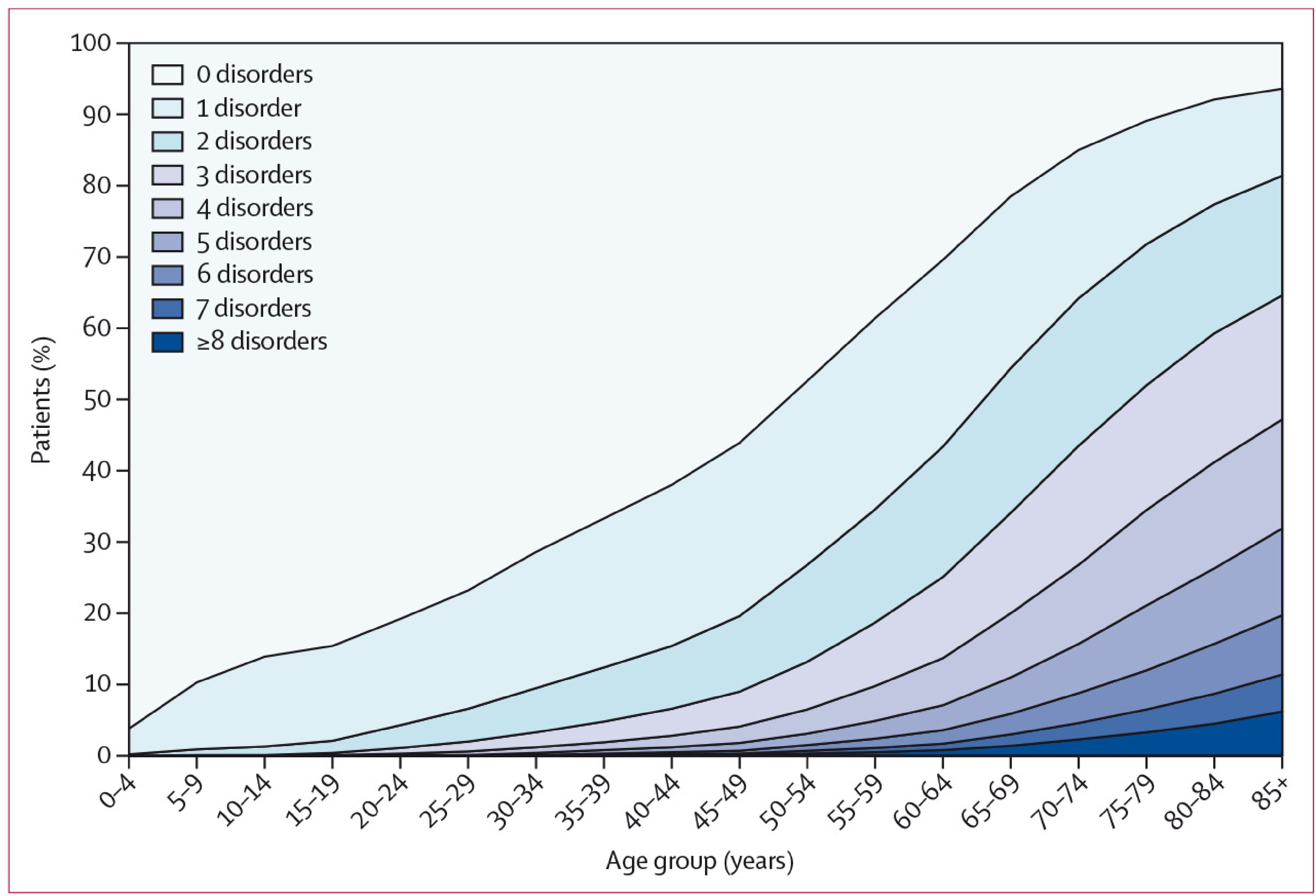


Figure 1: **Number of chronic disorders by age-group**

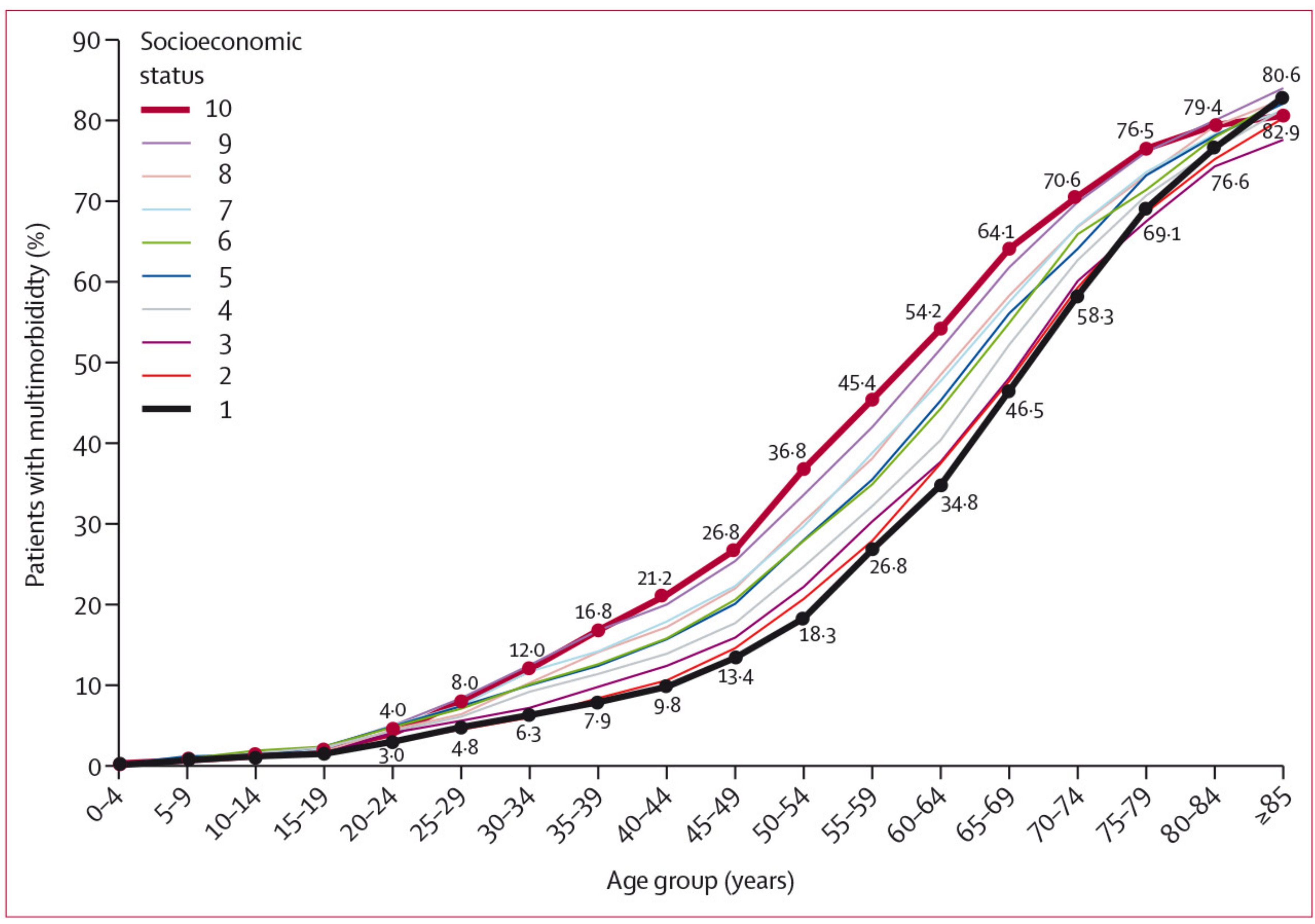


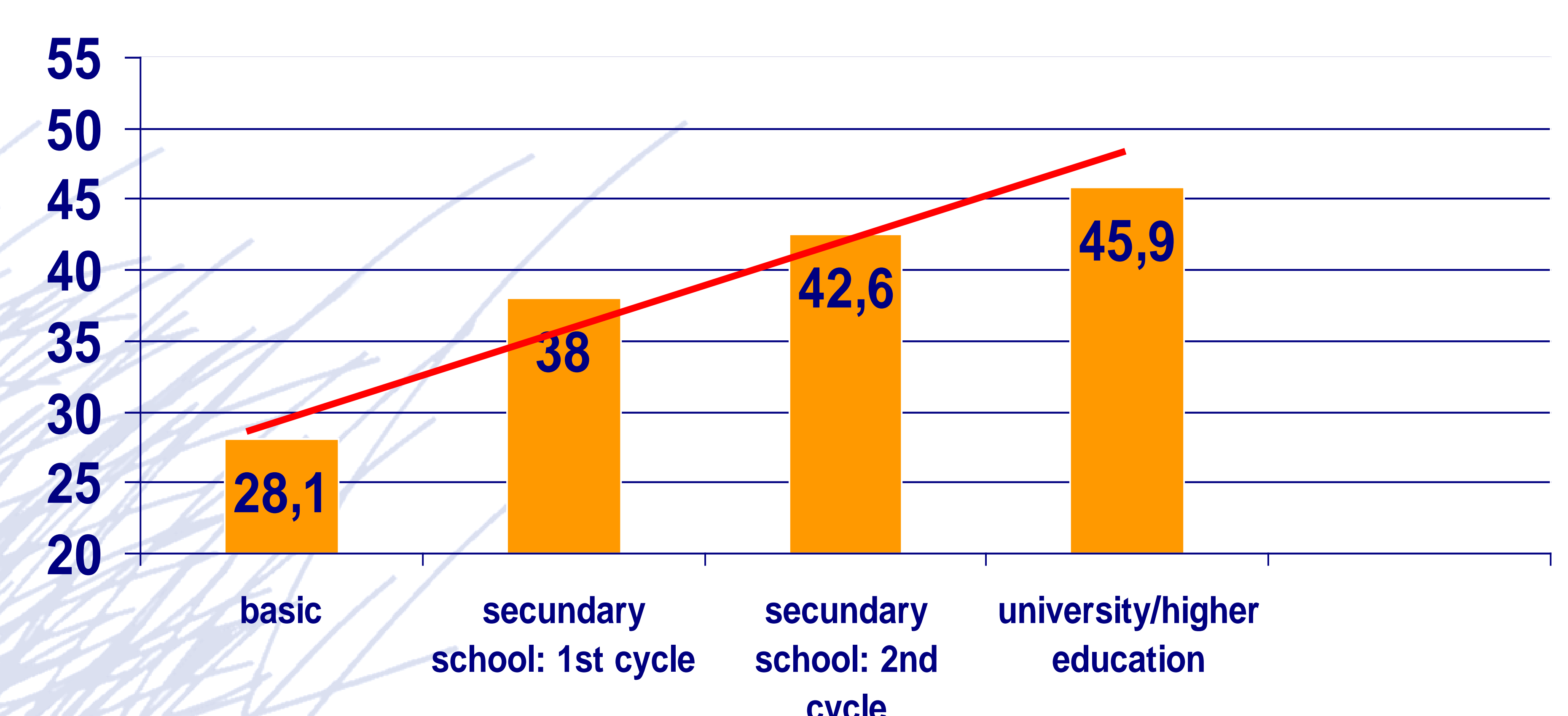
***Figure 2:* Prevalence of multimorbidity by age and socioeconomic status**

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

Healthy life expectancy in Belgium

(Bossuyt, et al. Public Health 2004)

Socio-economic inequalities in health



The changing society

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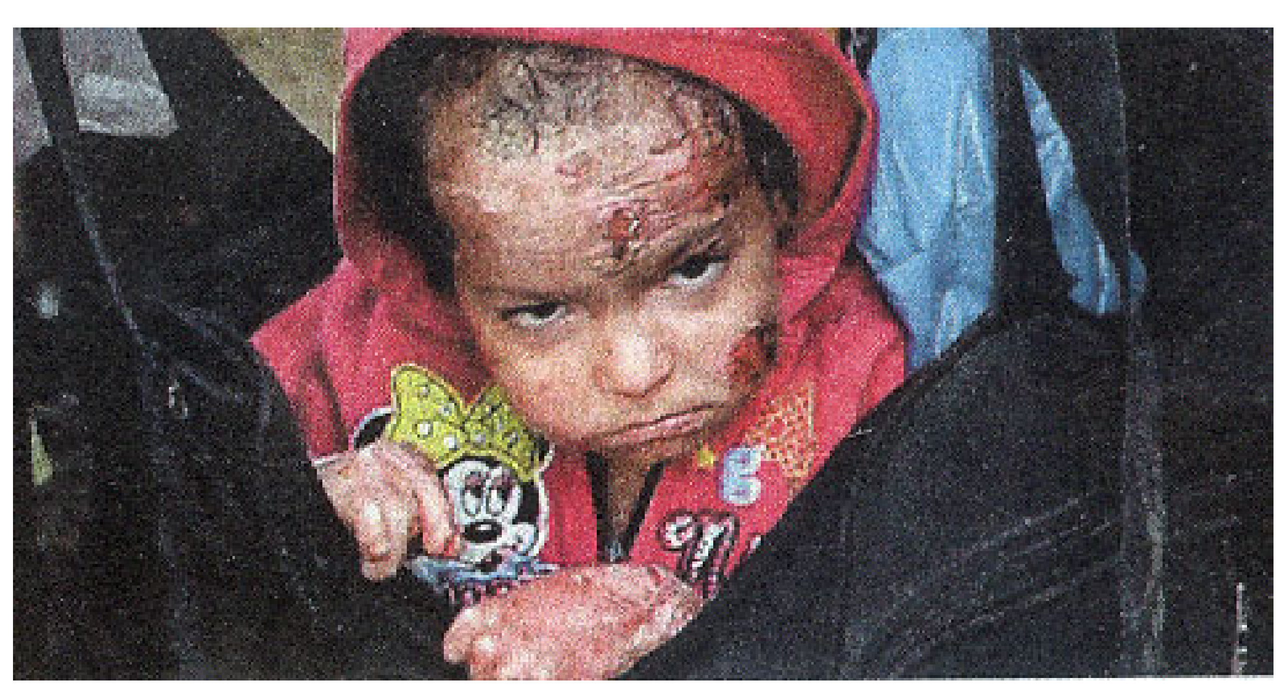
'By 2030, 70% of the world population will live in an urban context' (Castells, 2002)
By 2100, 85%?

The Long Road to a better life…

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

Boot met honderden vluchtelingen gezonken



▶ **Vluchtelingen wachten aan de Dienst Vreemdelingenzaken in Brussel om asiel aan te vragen. Iedere dag staat er zo'n 300 man.** © EPA

Wonca Europe 2015 Istanbul Statement:

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

1 NO POVERTY

2 ZERO HUNGER

3 GOOD HEALTH AND WELL-BEING

4 QUALITY EDUCATION

5 GENDER EQUALITY

6 CLEAN WATER AND SANITATION

7 AFFORDABLE AND CLEAN ENERGY

8 DECENT WORK AND ECONOMIC GROWTH

9 INDUSTRY, INNOVATION AND INFRASTRUCTURE

10 REDUCED INEQUALITIES

11 SUSTAINABLE CITIES AND COMMUNITIES

THE GLOBAL GOALS
For Sustainable Development

12 RESPONSIBLE CONSUMPTION AND PRODUCTION

13 CLIMATE ACTION

14 LIFE BELOW WATER

15 LIFE ON LAND

16 PEACE AND JUSTICE STRONG INSTITUTIONS

17 PARTNERSHIPS FOR THE GOALS

Panel: Proposed Sustainable Development Goals

Goal 1
End poverty in all its forms everywhere

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

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

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

Goal 5
Achieve gender equality and empower all women and girls

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

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

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

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

Panel: Proposed Sustainable Development Goals

Goal 10
Reduce inequality within and among countries

Goal 11
Make cities and human settlements inclusive, safe, resilient, and sustainable

Goal 12
Ensure sustainable consumption and production patterns

Goal 13
Take urgent action to combat climate change and its impacts

Goal 14
Conserve and sustainably use the oceans, seas, and marine resources for sustainable development

Goal 15
Protect, restore, and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss

Goal 16
Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable, and inclusive institutions at all levels

Goal 17
Strengthen the means of implementation and revitalise the global partnership for sustainable development

Primary health care and the Sustainable Development Goals

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

When supported
and with aligned e
political domains, p
in achievement of
differences are ine
organisation of pri
resources available,
in SDG3—related t
communicable dise
multimorbidity), ad
problems—can be a
and population-based approach to primary health care.[1-5] Delivery of vaccines and drugs needs a functioning primary care system. Well integrated and prepared primary health care has a key role in health emergency responsiveness, and it is essential for the achievement of UHC equitably and cost-effectively.[6-8]

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

Luisa M Pettigrew, Jan De Maeseneer, Maria-Inez Padula Anderson, Akye Essuman, Michael R Kidd, Andy Haines
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luisa.pettigrew@lshtm.ac.uk

Yet investment in realising the full potential of primary health care still seems elusive to many governments, policy makers, funders, and health-care providers. Therefore, 7 years after the World Health Report and *The Lancet* Series on primary health care, and 37 years since the Alma-Ata declaration, the absence of reference
d their targets
sions could be
dispensable and
velopment; or,
integral to the
a goal or target

et do so with
uting factors to
h care in many
vas "the scarcity
tation and its
-up purposes".[9]
development of
If the agenda is
th good-quality
ved, or how to
e risk repeating
the failures of the past.

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

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

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

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

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Expert Panel on Effective Ways of Investing in Health

Report of the

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

on

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

Health and Consumers

Opinion on Definition primary care – Definition

Core-definition

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

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

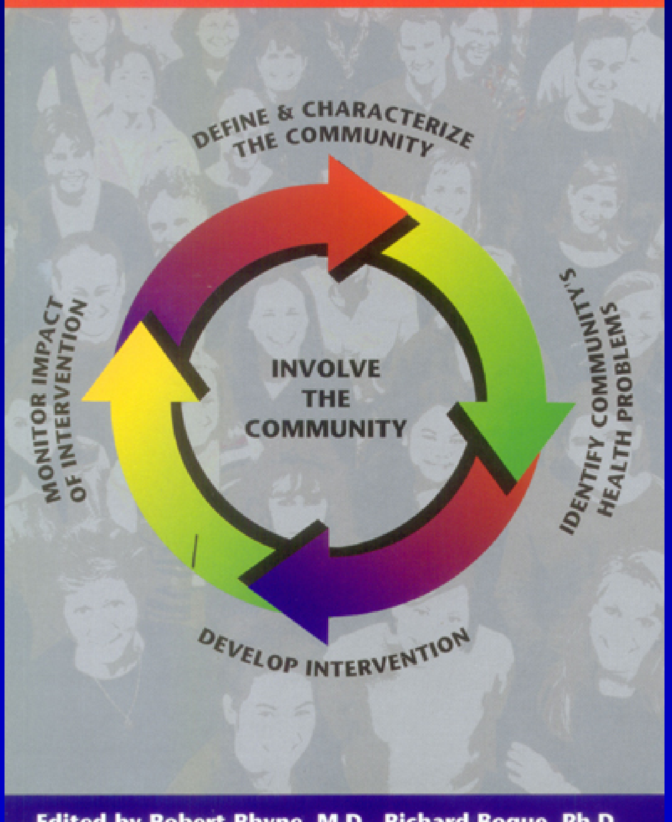
EXPERT PANEL ON EFFECTIVE WAYS OF INVESTING IN HEALTH

(EXPH)

Access to health services in the European Union

The EXPH approved this opinion at the 14th plenary meeting of 3 May 2016 after public consultation

Available since 14.06.2016 !


Community-Oriented Primary Care:
Health Care for the 21st Century
DEFINE & CHARACTERIZE THE COMMUNITY
IDENTIFY COMMUNITY'S HEALTH PROBLEMS
DEVELOP INTERVENTION
MONITOR IMPACT OF INTERVENTION
INVOLVE THE COMMUNITY
Edited by Robert Rhyne, M.D., Richard Bogue, Ph.D.,
Gary Kukulka, Ph.D., Hugh Fulmer, M.D.

Drs Sidney and Emily Kark

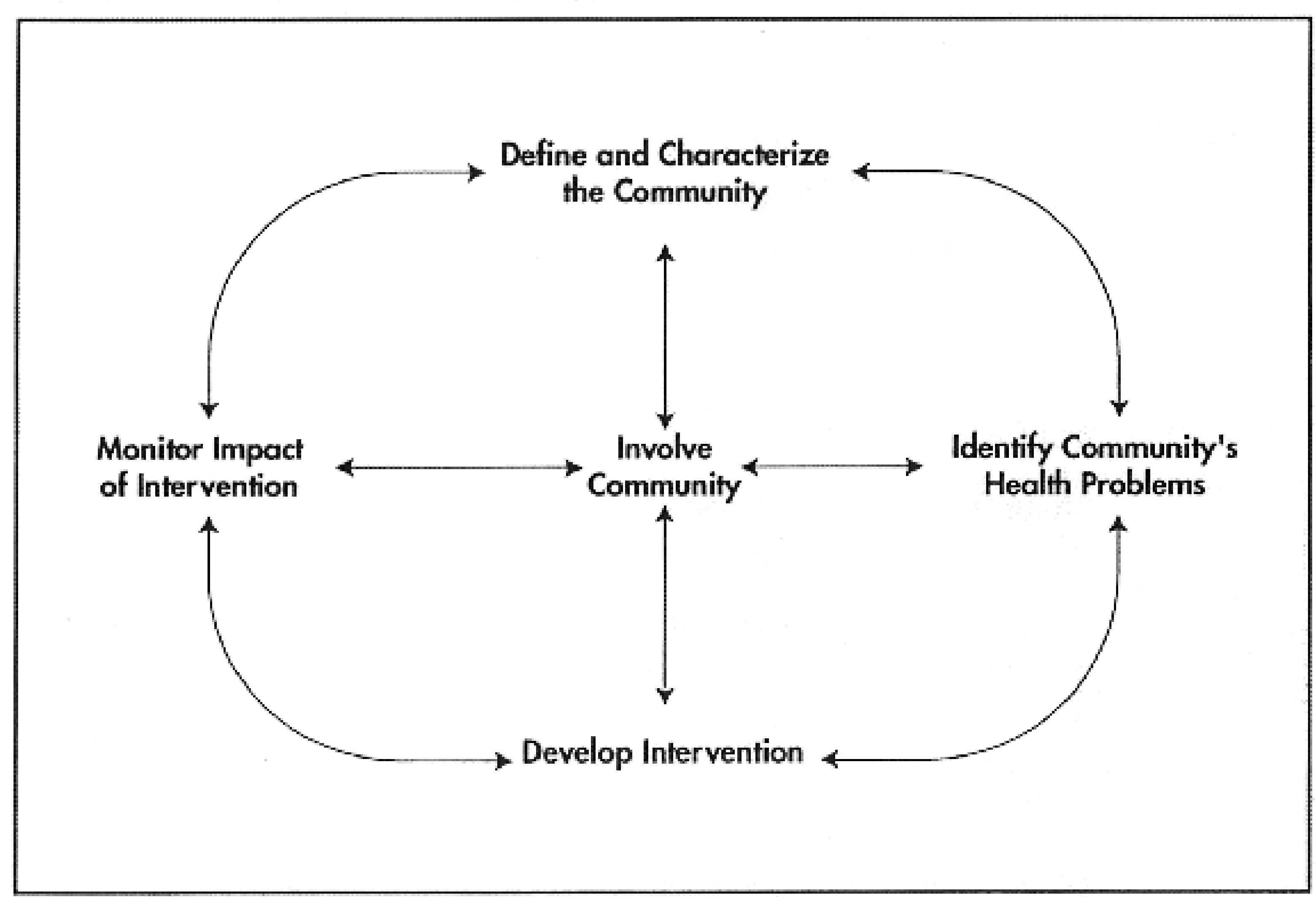


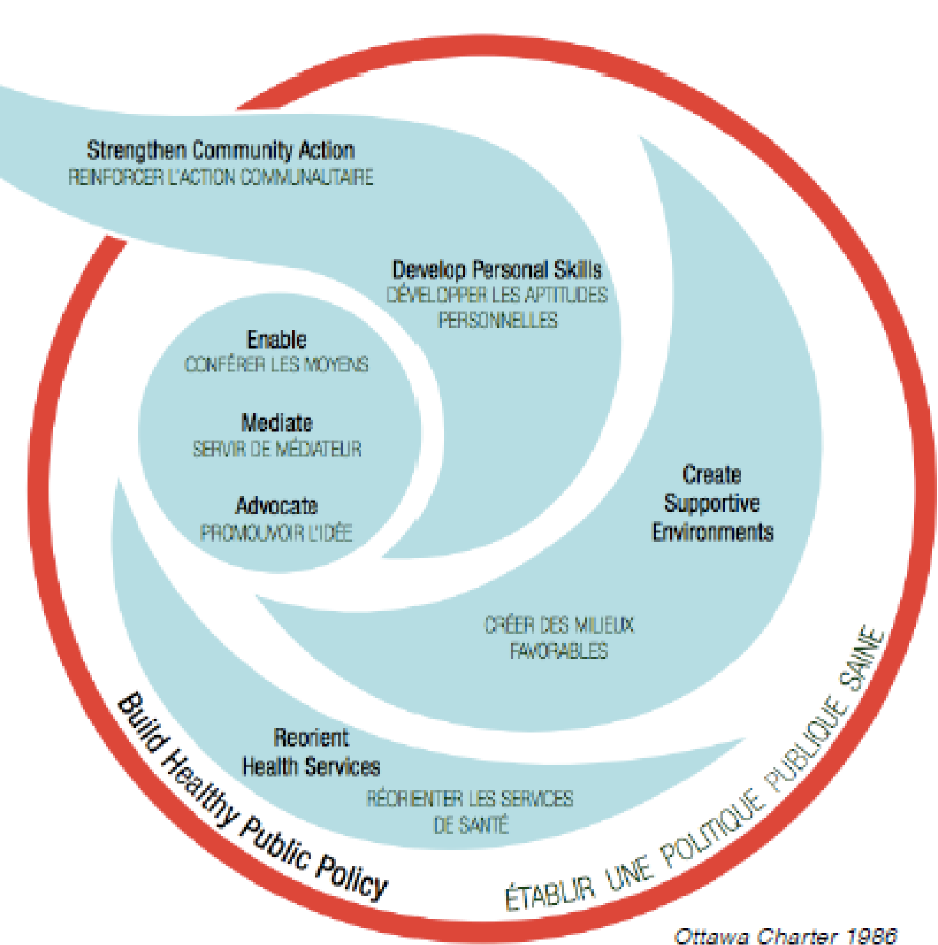
FIGURE 1.2: The COPC Process
Define and Characterize the Community
Monitor Impact of Intervention
Involve Community
Identify Community's Health Problems
Develop Intervention

COPC History

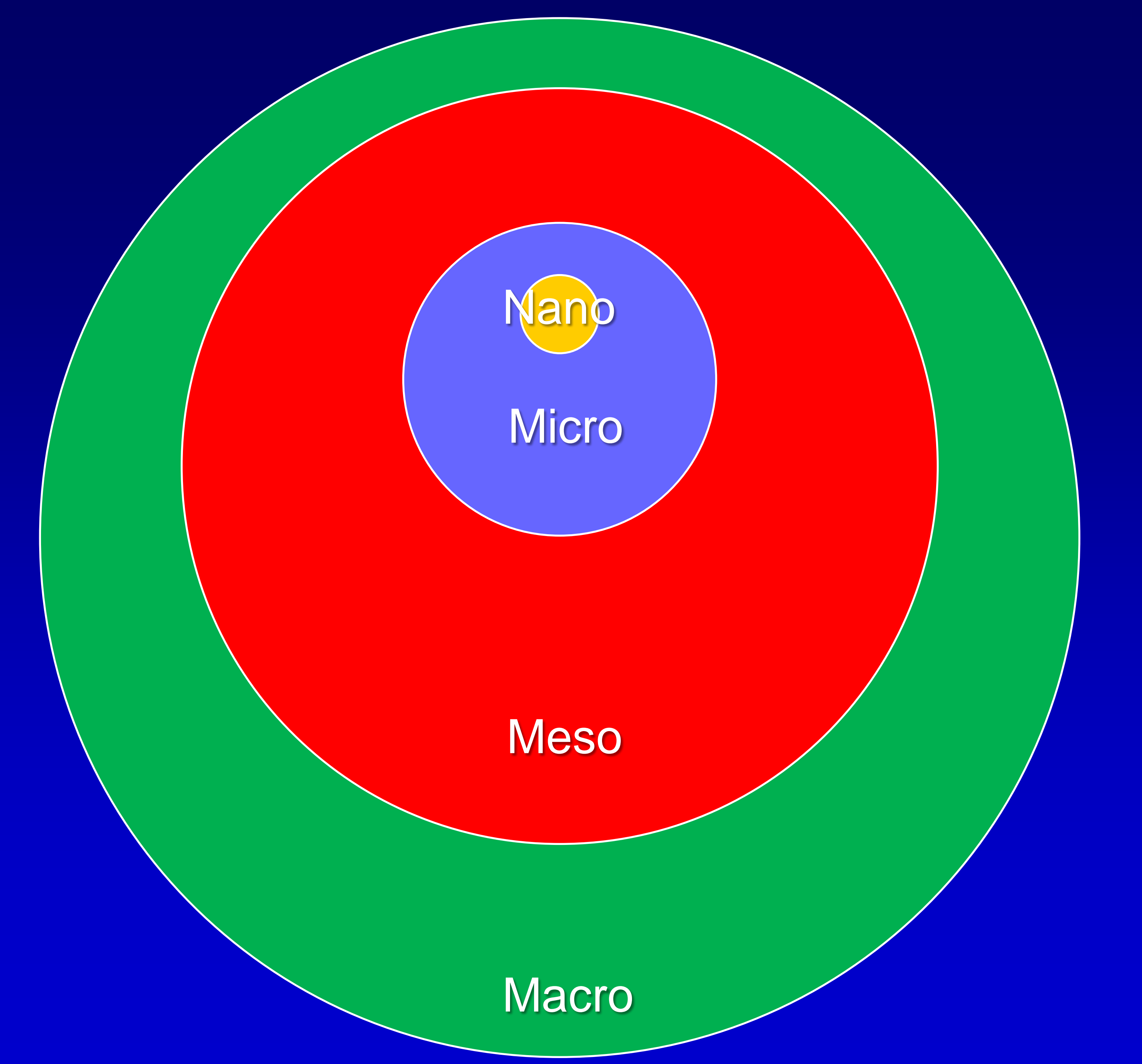
- Sidney and Emily Kark in Pholela
  - Scientific research study – proof of effectiveness of community-level engagement
  - Forerunner to ‘PHC’ and ‘DHS’
  - Conceptually started with ‘the Health Centre’
- Had massive policy impact – health systems reform, preventive and promotive health, community mobilization, Alma Ata & PHC movement

BACK TO BASICS - FACT #3

HEALTH IS CO-PRODUCED WITH PATIENTS AND COMMUNITIES



Ottawa Charter 1986


Nano
Micro
Meso
Macro

General structure

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

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Changes in ‘pro-active or pre-care’

- Nano: - health litteracy
  - empowerment
- Micro: - healthy families – relationships
  - healthy empowerment
- Meso: - healthy community / city
  - social cohesion
- Macro: - healthy environment: air, water
  - healthy economy: income inequality

Looking for upstream causes

Accident: scholar severely invalidated

Meeting: police, family physicians, schools, elderly-organisations, …

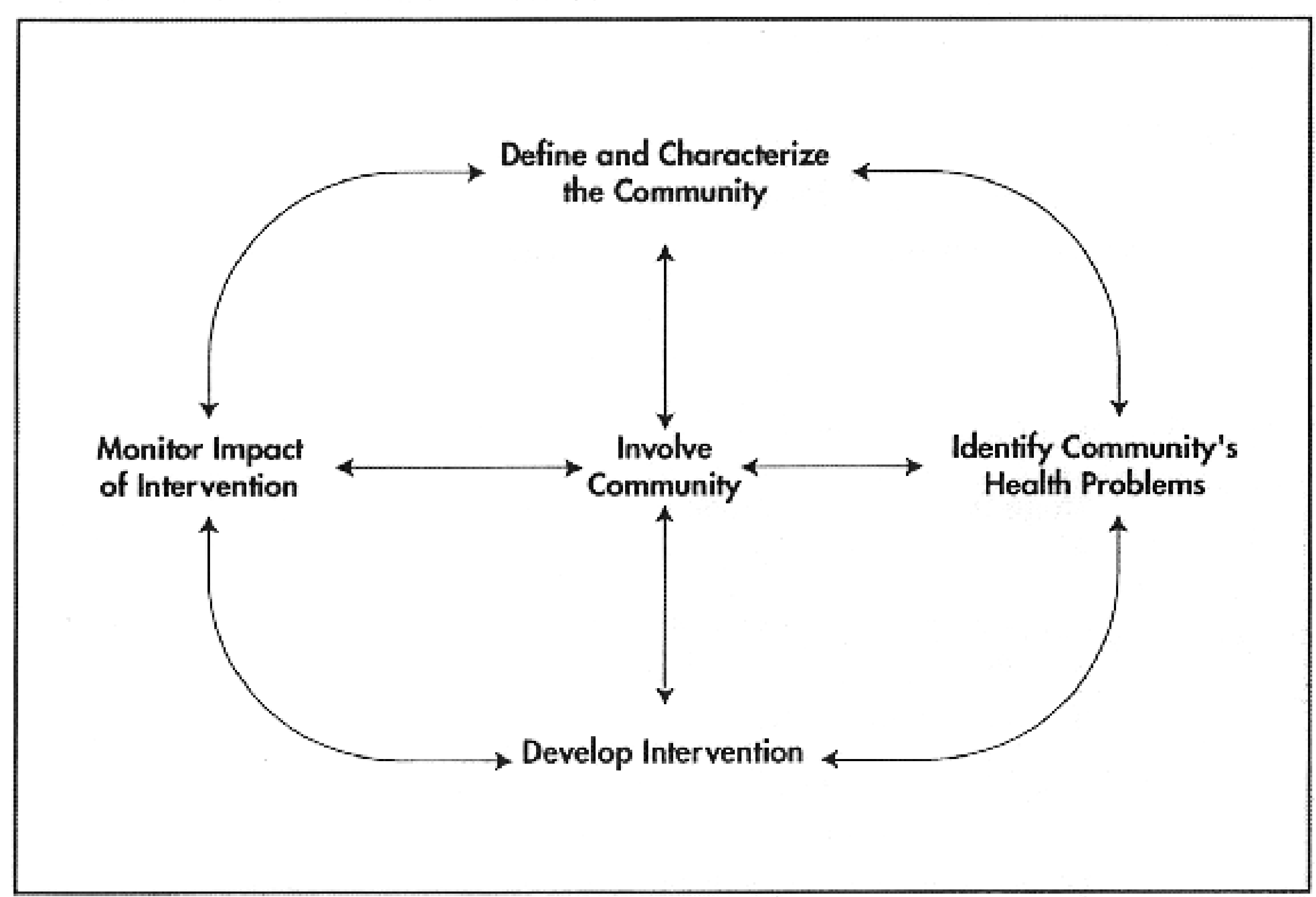
FIGURE 1.2: The COPC Process
Define and Characterize the Community
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Identify Community's Health Problems
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Intersectoral action for health: meso-level

- Platform of stakeholders (including community representatives)
- Implementing a strategy, taking different sectors on board (education, housing, work,…)

Platform of stakeholders:

- 40 to 50 people
- 3 monthly
- Exchange of information
- “Community diagnosis”

Analysis: unsafe traffic conditions for pedestrians

Formulation of proposals for improvement, involving local population

Establishment safer traffic situation

Assessment: no more severe accidents

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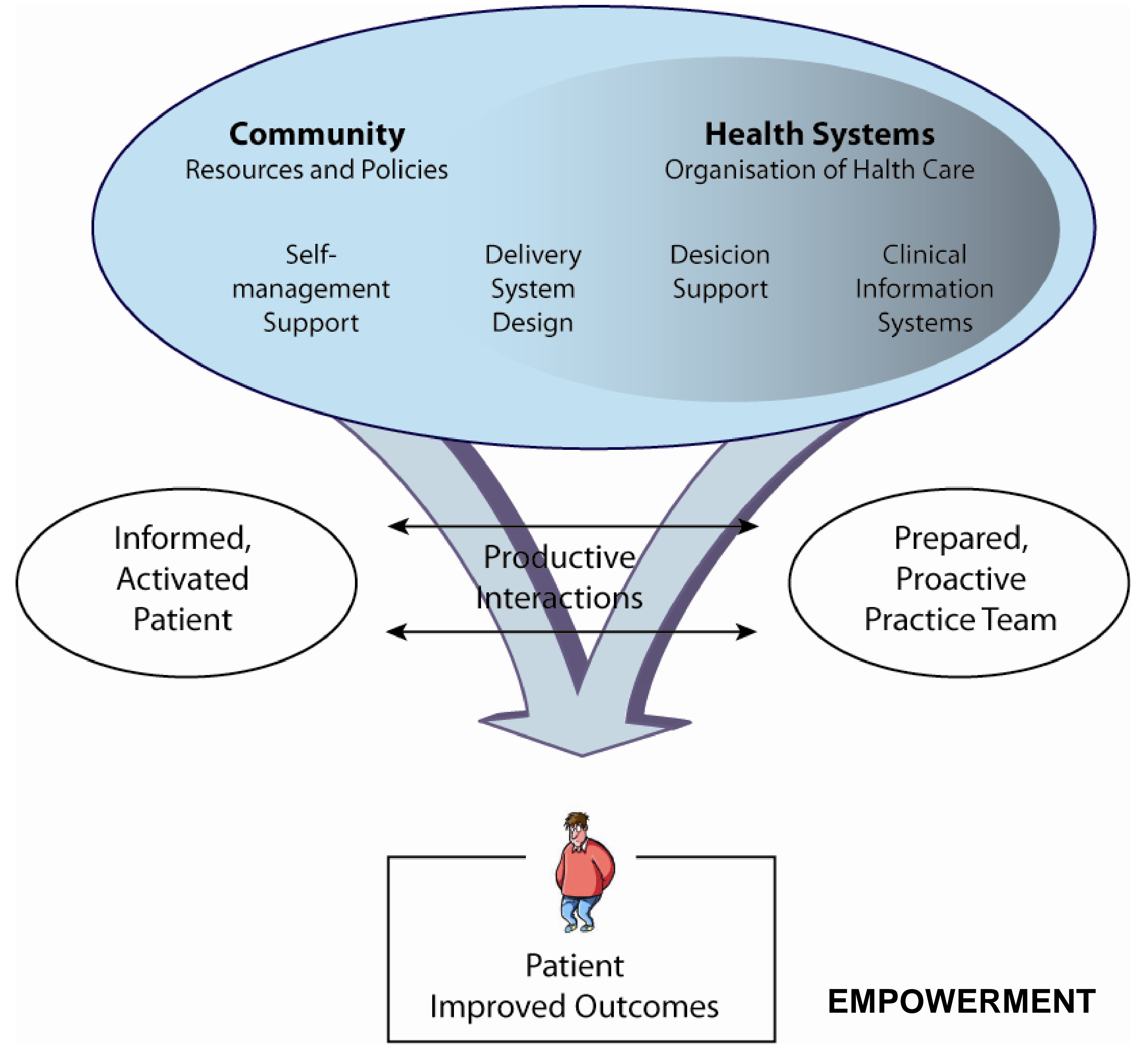
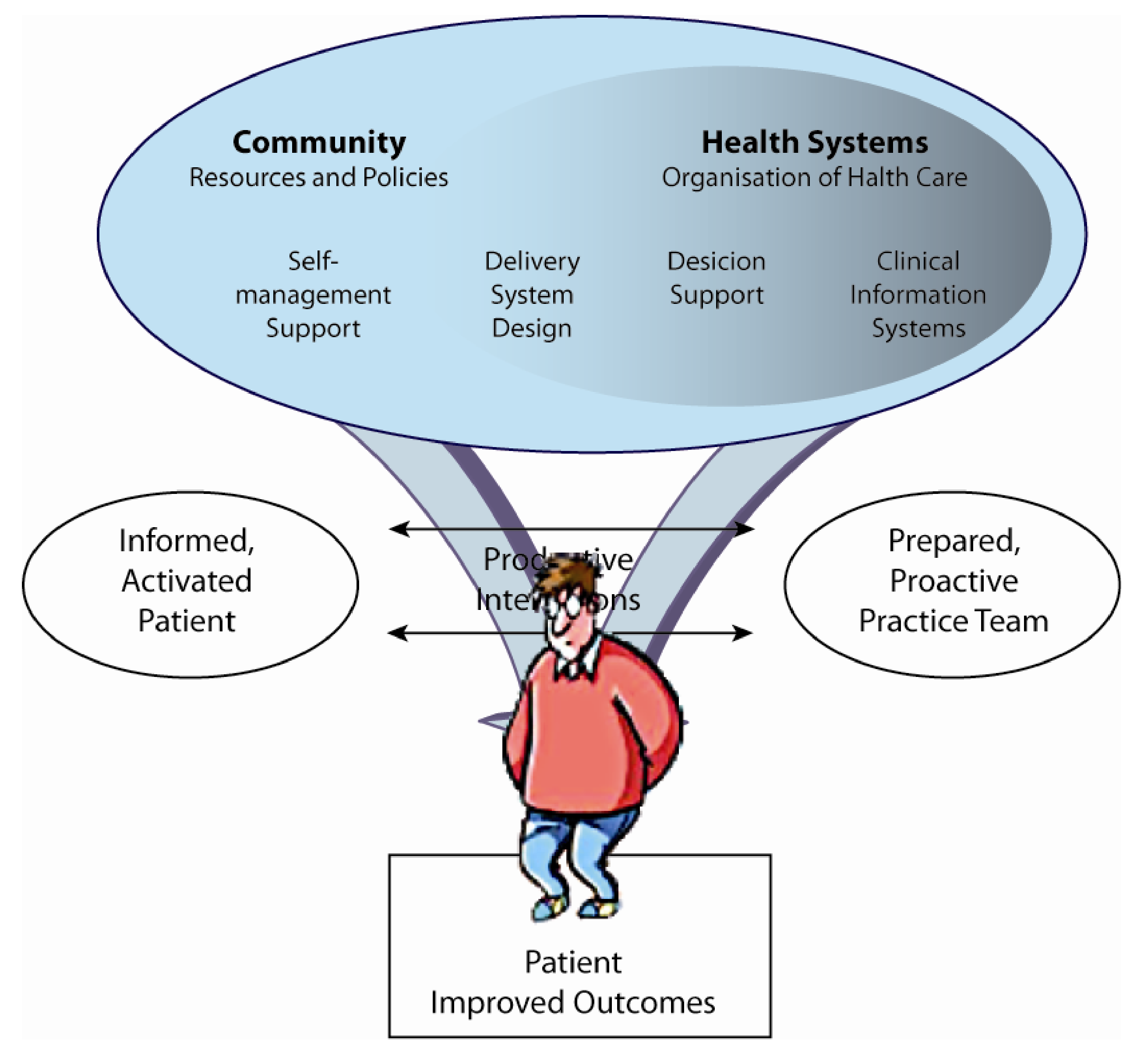
Challenges in patients with multimorbidity


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



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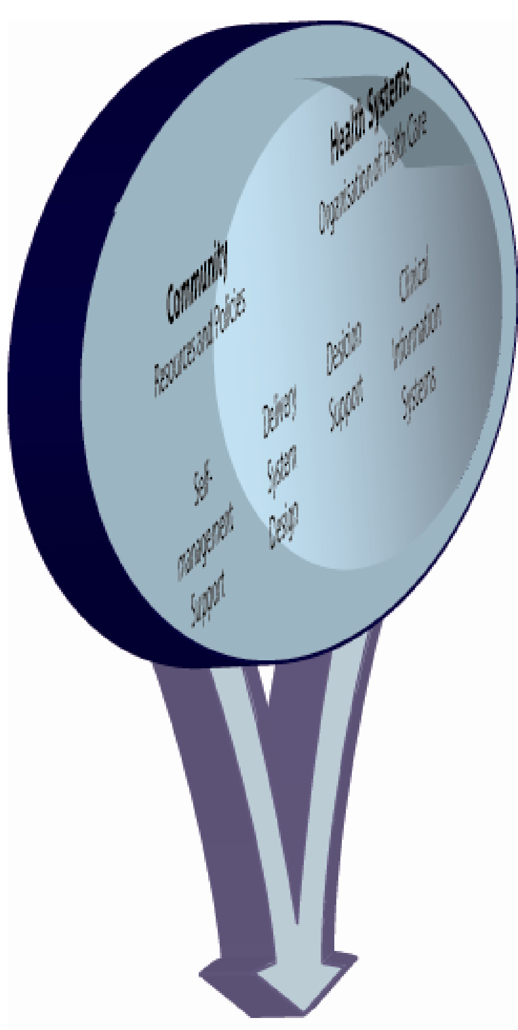
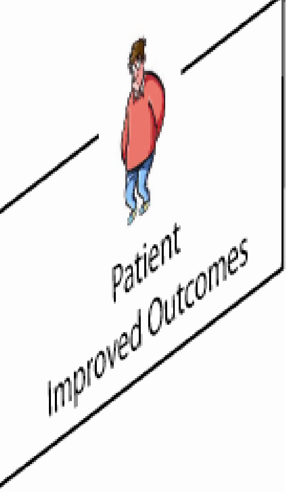
Patient
Improved Outcomes

But…





Birgitte is 75 years old. Fifteen years ago she lost her husband. She is a patient in the practice for 15 years now. During these last 15 years she has been through a laborious medical history: operation for coxarthrosis with a hip prothesis, hypertension, diabetes type 2, COPD and osteoartritis. Moreover there is osteoporosis. She lives independently at her home, with some help from her youngest daughter Elisabeth. I visit her regularly and each time she starts saying: "Doctor, you must help me". Then follows a succession of complaints and unwell feeling: sometimes it has to do with the heart, another time with the lungs, then the hip, …

Each time I suggest – according to the guidelines - all sorts of examinations that did not improve her condition. Her requests become more and more explicit, my feelings of powerlessness, insufficiency and spite, increase. Moreover, I have to cope with guidelines that are contradictory: for COPD she sometimes needs corticosteroids, which worsens her glycemic control.

The adaptation of the medication for the blood pressure (at one time too high, at another time too low), cannot meet with her approval, as does my interest in her HbA1C and lung function test-results.

After so many contacts Birgitte says: "Doctor, I want to tell you what really matters for me. On Tuesday and Thursday, I want to visit my friends in the neighbourhood and play cards with them. On Saturday, I want to go to the Supermarket with my daughter. And for the rest, I want to be left in peace, I don't want to change continually the therapy anymore, … especially not having to do this and to do that".

In the conversation that followed it became clear to me how Birgitte had formulated the goals for her life. And at the same time I felt challenged how the guidelines could contribute to the achievement of Birgittes's goals. I visit Birgitte again with pleasure ever since: I know what she wants, and how much I can (merely) contribute to her life.

Sum of the guidelines

Patient tasks

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

R

- Physical th
- Ophtalmol
- Pulmonary

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

Clinical tasks

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

Patient education

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

Boyd et al. JAMA, 2005

Special Article

Goal-Oriented Medical Care

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

Abstract

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

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

(Fam Med 1991; 23:46-51)

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

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

"Problem-oriented versus goal-oriented care"

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

“Problem-oriented versus goal-oriented care”

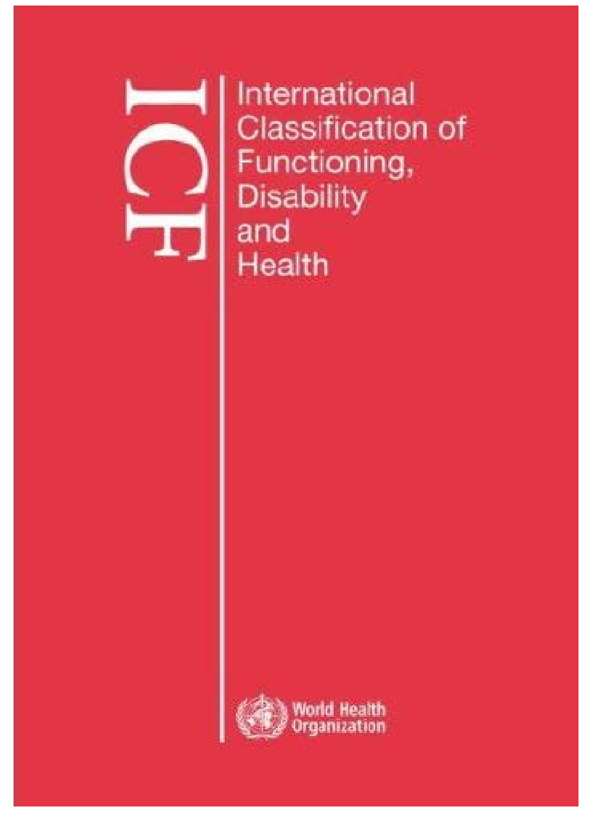
	Problem-oriented	Goal-oriented
Measures of success	Accuracy of diagnosis, appropriateness of treatment, eradication of disease, prevention of death	Achievement of individual goals

"Problem-oriented versus goal-oriented care"

	Problem-oriented	Goal-oriented
Evaluator of success	Physician	Patient

What really matters for patients is

- Functional status
- Social participation



ICF?
No thanks!
We are
too busy

Who sets the goals?

Goal-setting

- Goals change over time
- Goal-setting requires “shared decision making”
- Goals of the person should pop-up at the frontpage of the electronic Personal Health Record
- Goal-setting needs an interprofessional cooperation

FRAGMENTATION

Monthly updates online

BMJ

clinical evidence

The international source of the best available evidence for effective health care

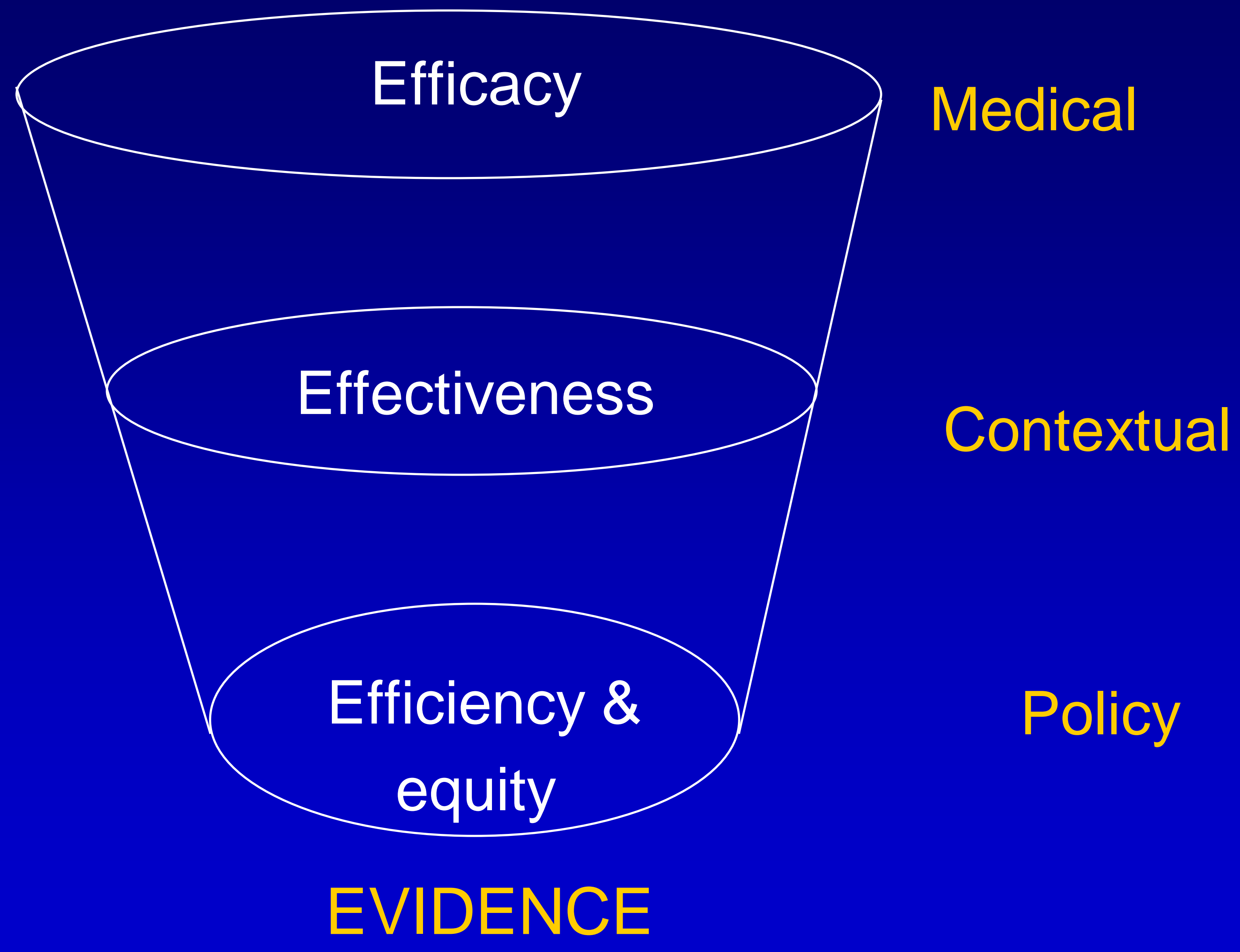
Updated and extended monthly at
www.clinicalevidence.com

11
JUNE 2004

Problems with guidelines in multimorbidity

- “Evidence” is produced in patients with 1 disease
- Guidelines may lead to contradictions (e.g. in therapy)

Quality of care



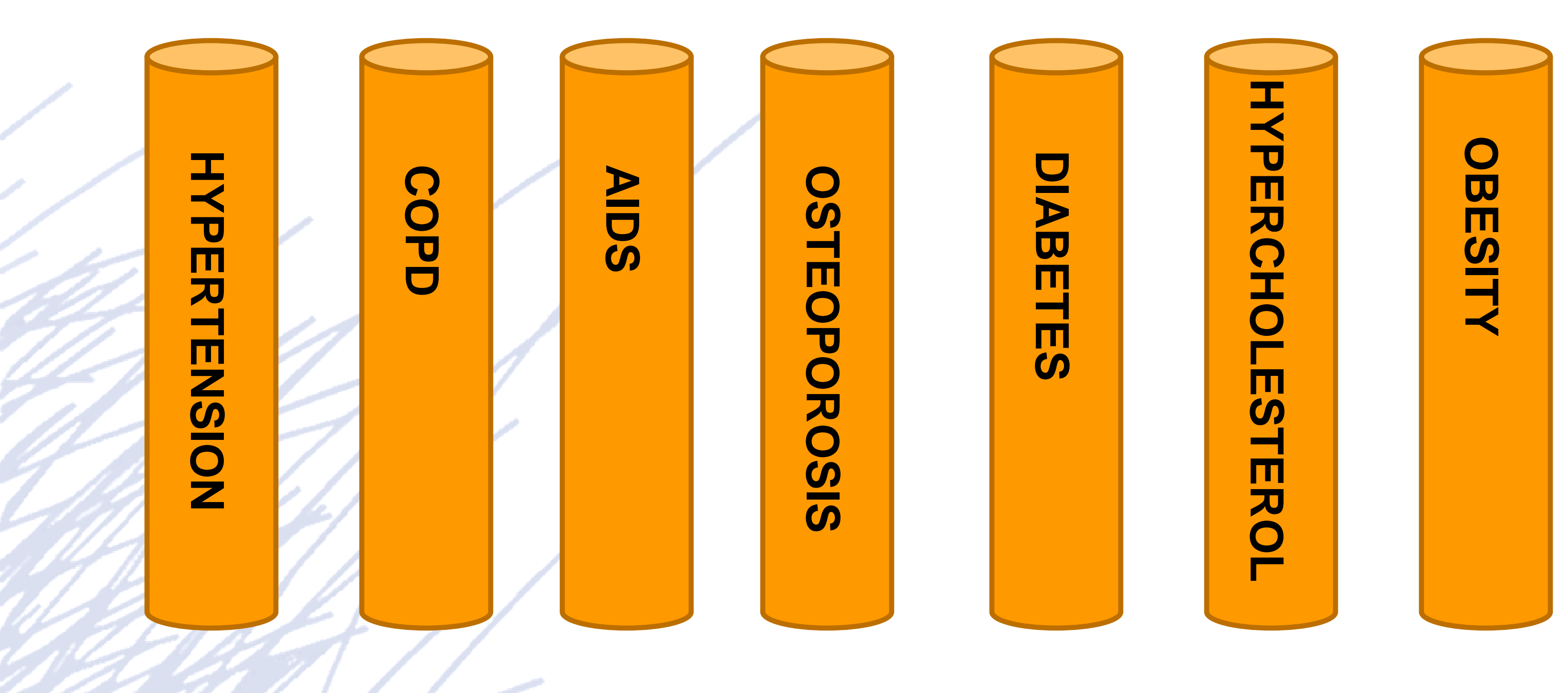
De Maeseneer J, et al. The Lancet 2003;362:1314-19

“Treat the patient”

“Treat-to-target”

Vertical Disease Oriented Approach

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



The challenge: vertical disease- oriented programs and multimorbidity

- Create duplication
- Lead to inefficient facility utilization
- May lead to gaps in patients with multiple co-morbidities
- Lead to inequity between patients

“Inequity by disease” becomes an increasing problem both in developed and developing countries

[see www.15by2015.org

Tackling NCDs: a different approach is needed

The NCD Alliance[1] aims to put non-communicable diseases (NCDs) on the global agenda to address the NCD crisis. Improving outcomes in morbidity and mortality by 2015 will clearly depend to a large extent on tackling the burden of NCDs, especially in developing countries.[2]

developed, integrated and implemented in the context of integrated primary health care".[9] Horizontal primary health care provides the opportunity for integration and addresses the problem of inequity by allowing focus on NCDs while providing access to the care of other health problems, thereby avoiding inequity by disease.[10]

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September 6, 2011
DOI:10.1016/S0140-6736(11)61135-5

Tackling NCDs: a different approach is needed

The NCD Alliance[1] aims to put non-communicable diseases (NCDs) on the global agenda to address the "NCD-crisis". Improving outcomes in morbidity and mortality by 2015 will clearly depend to a large extent on tackling the burden of NCDs, especially in developing countries.[2]

context of integrated primary health care".[9] Horizontal primary health care provides the opportunity for integration and addresses the problem of inequity by allowing focus on NCDs while providing access to the care of other health problems, thereby avoiding "inequity by disease".[10]

*Jan De Maeseneer, Richard G Roberts, Marcelo Demarzo, Iona Heath, Nelson Sewankambo, Michael R Kidd, Chris van Weel, David Egilman, Charles Boelen, Sara Willems

Faculty of Medicine and Health Sciences, Secretariat of The Network: Towards Unity For Health (JDM) and Department of Family Medicine and Primary Health Care (SW), Ghent University, Ghent, Belgium; Department of Family Medicine, University of Wisconsin School of Medicine and Public Health, Madison, WI, USA (RGR); Department of Preventive Medicine, Federal University of Sao Paolo, Sao Paulo, Brazil (MD); Royal College of General Practitioners, London, UK (IH); Makerere University College of Health Sciences, Kampala, Uganda (NS); Faculty of Health Sciences, Flinders University, Adelaide, Australia (MRK); Department of Primary and Community-Care, Radboud University Nijmegen Medical Centre, Nijmegen, The Netherlands (CvW); Department of Family Medicine, Brown University, Providence, RI, USA (DE); and Secretariat of Global Consensus for Social Accountability of Medical Schools, Sciez-sur-Léman, France (CB)

Primary Health Care and “contextual” evidence

“disease management”

↓

“person management”

Resolution WHA62.12 "Primary Health Care, including health systems strengthening"

↓

The World Health Assembly, urges member states: … (6) to encourage that vertical programmes, including disease-specific programmes, are developed, integrated and implemented in the context of integrated primary health care.

Health Promotion in the framework of COPC

1. The changing society and Sustainable Development Goals
2. Primary Care: the concepts
3. Changes in ‘pro-active or pre-care’
4. Changes in ‘chronic care’: addressing multi-morbidity
5. Changes in ‘community oriented care’
6. The health promotor as actor in the health system: “Together we change”
7. Conclusion

COPC-project: children's physical condition

- Consultation: problematic physical condition

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COPC-project: children's physical condition

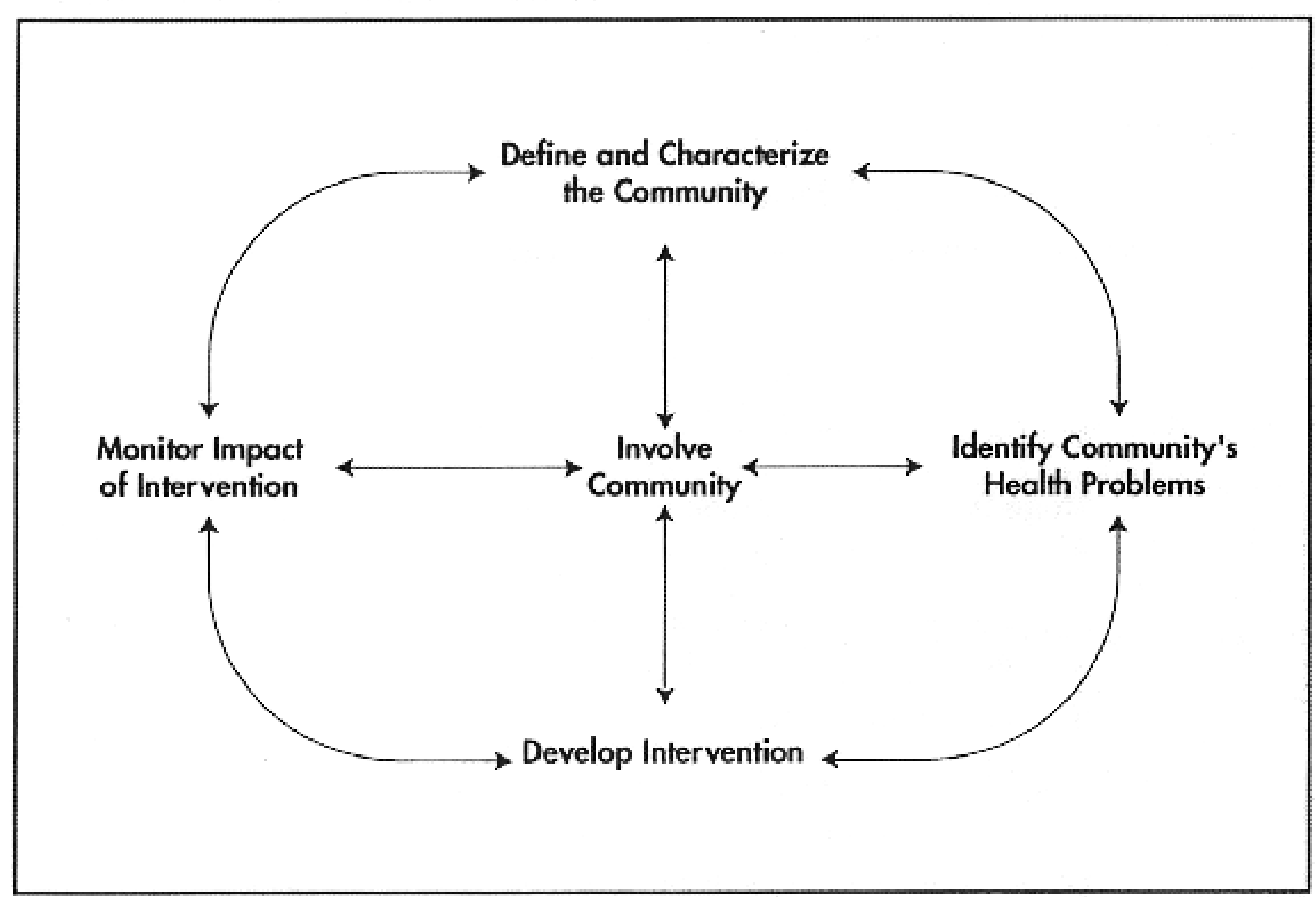
FIGURE 1.2: The COPC Process
Define and Characterize the Community
Monitor Impact of Intervention
Involve Community
Identify Community's Health Problems
Develop Intervention

COPC-project: children's physical condition

- Community diagnosis: lack of playgrounds

COPC-project: children's physical condition

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COPC-project: children’s physical condition

COPC-project: children's physical condition

WGC Botermarkt

Integration of personal and community health care

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

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The Lancet 2008;372:871-2

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Botermarkt wijkgezondheidscentrum vzw

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

Community Health Centre:

- Family Physicians; nurses; dieticians; health promotors; social workers; …
- 6200 patients; 90 nationalities
- Integrated needs based mixed capitation; no co-payment
- COPC-strategy

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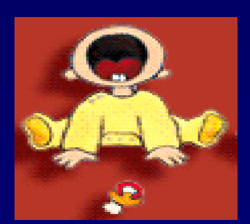
COPC-example: dental problems: periodontal disease in childhood

Risk factor for:

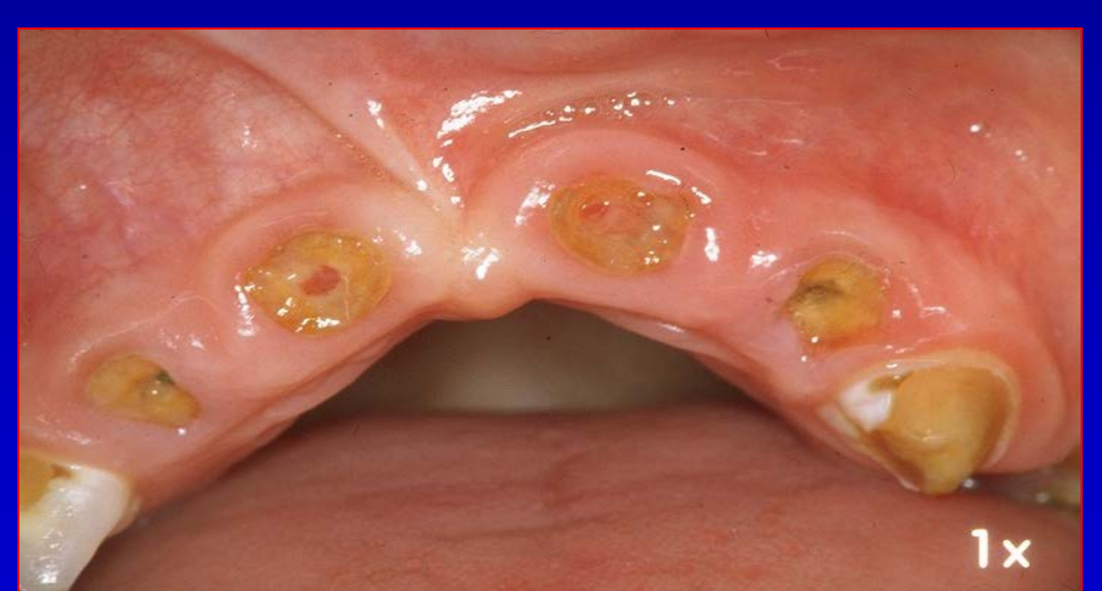
- Diabetes
- Coronary Heart Disease
- Preterm birth and low birth weight
- Osteoporosis

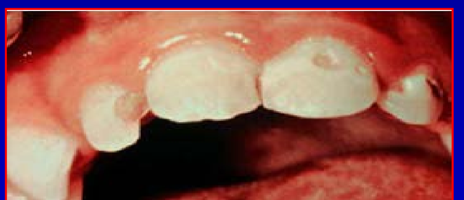


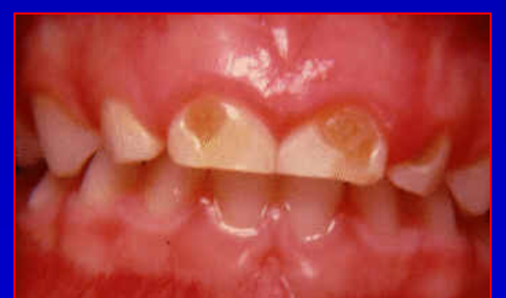
COPC-project : from individual care to community health care

Identifying health problem:

Family physicians/nurses: problematic oral condition of todlers, leading to feeding problems, crying, not sleeping,...







Project coordinated by Prof. S. Willems

COPC-project : DENTAL FITNESS

Focus Group sessions – involving the community

A dentist?
I cannot afford that.

I don't know where to find a dentist

I'm doing Fristi in his bottle to stop him cry

My child is to afraid of the dentist and to be honest, me too

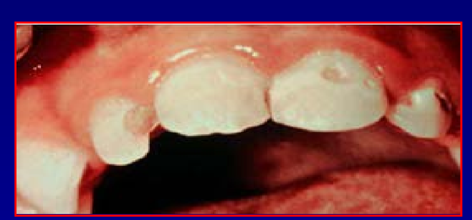
COPC-project : DENTAL FITNESS

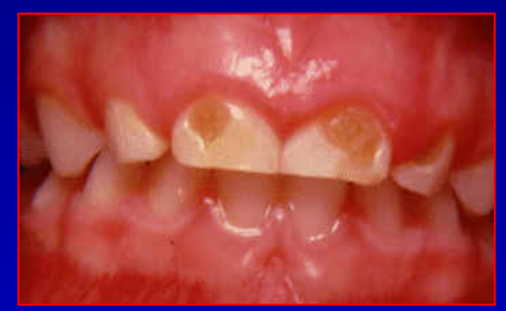
Working together with…

COPC-project : DENTAL FITNESS

Results research children 30 months old:

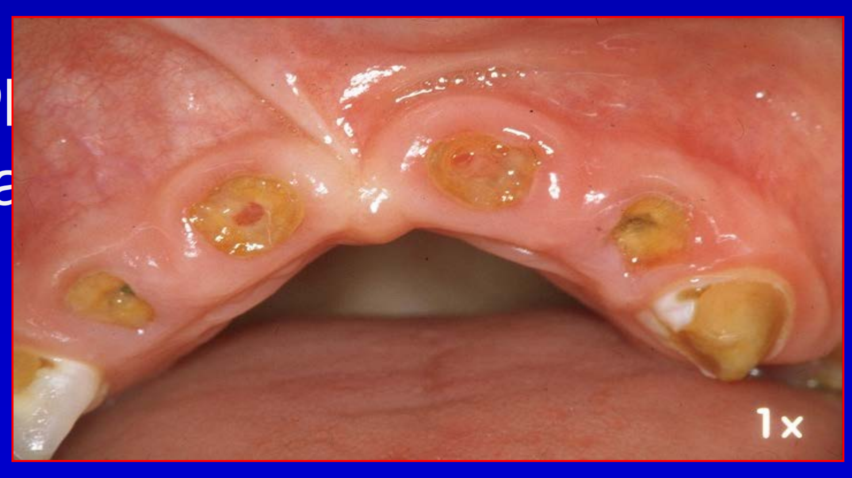
- 18,5 % early symptoms of childhood caries (7,4 % – 29,6 %)
- 100% need for treatment!





Correlation with

- deprivation
- nationality (Eastern-Europ
- no previous dentist consulta



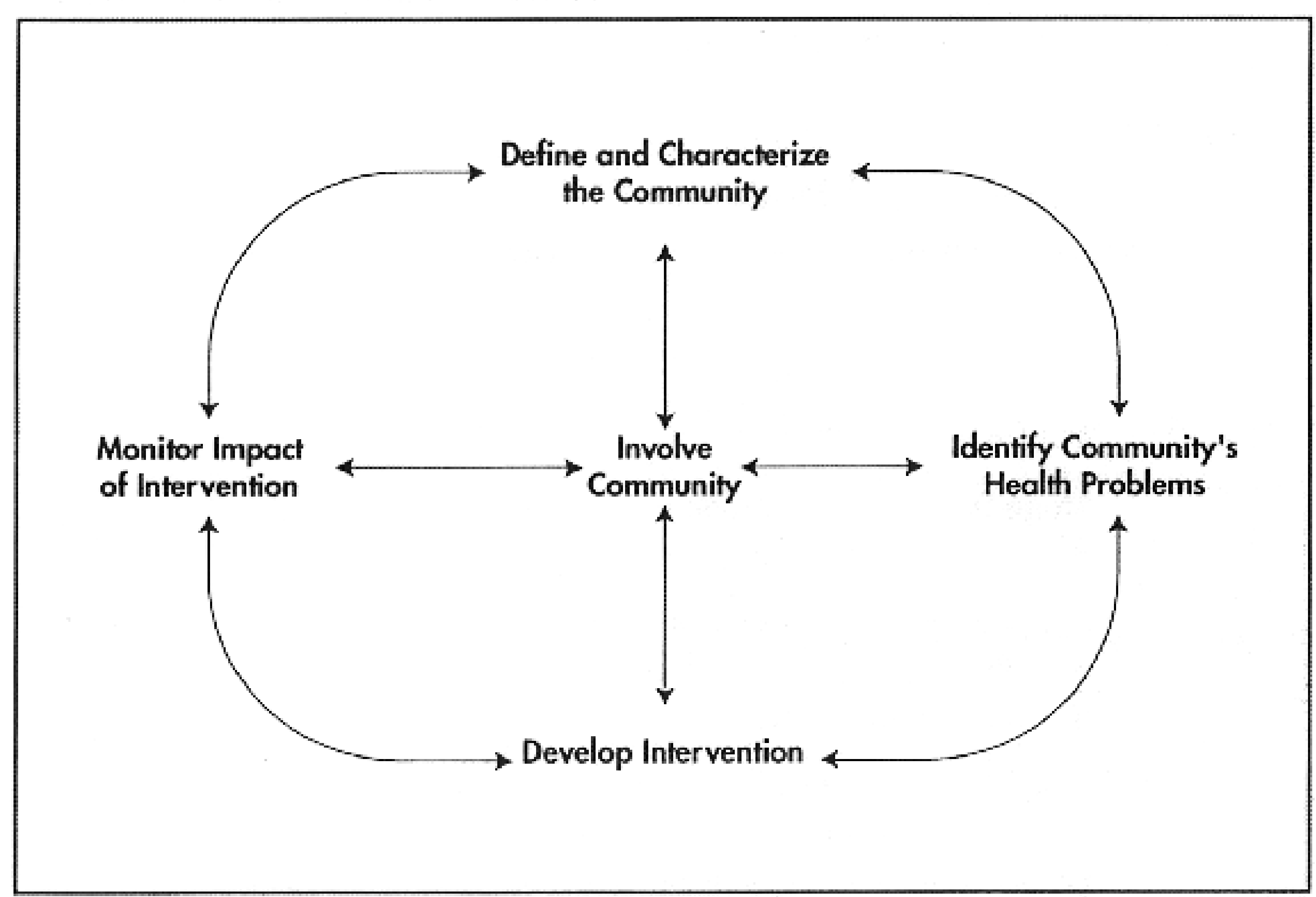


FIGURE 1.2: The COPC Process
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COPC-project : DENTAL FITNESS

Childhood caries:

- Information and Sensibilisation
  - Involving providers, social workers, parents, schools…

Strategies:

Community oriented, intersectoral, participation.

Educational platform for students in dentistry

COPC-project : DENTAL FITNESS

Accessible primary dental care

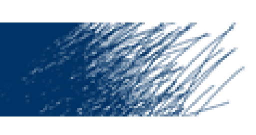
Centre for Primary Oral Health Care

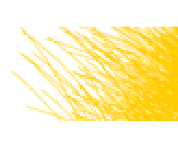
Botermarkt Ledeberg (CEMOB)

Started 01/09/2006

Towards accessible oral health care !

Ghent University





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7. Conclusion

TOGETHER WE CHANGE

Eerstelijnsgezondheidszorg: nu meer dan ooit!

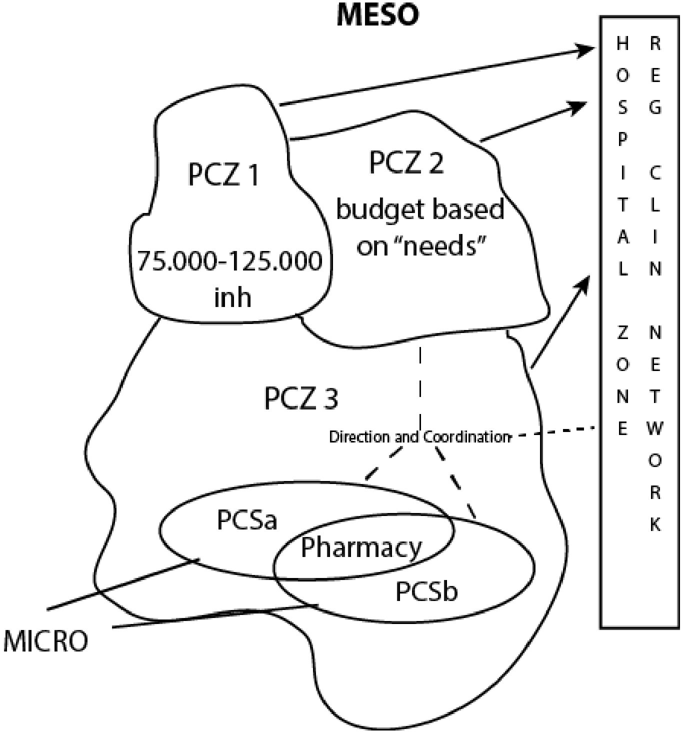
Jan De Maeseneer, Bert Aertgeerts,
Roy Remmen, Dirk Devroey

Meso-level

Primary Care Zones =

- Geographically defined areas
- 75 000 to 125 000 inhabitants
- +/- 110 zones in Belgium
- Supported by 15 to 20 hospital care zones

Figure 1: ORGANISATION PRIMARY CARE



BFR1: Budget Financial Resources PC
GWC: General Welfare Centre
PCP: Primary Care Psychologist
PCZ: PRimary Care Zone
PCS: Primary Care Services
EPR: electronic Patient Record
PCCF: Primary CAre Coordinating Function
IMC: Inter Ministerial Conference
C&F: Child and Family
HCS: Home Care Services

1 EPR

Micro-level

Every citizen registers with a family practice functioning in the framework of a primary care service

Primary Care Service

- Interprofessional (under one roof, in a network, or both)
- Composed of different primary care practices
- Direct access to primary care services

Primary Care Practice

- Operational unit
- Low treshold generalist care (health and/or welfare)
- Interprofessional approach
- Person- and population-centered

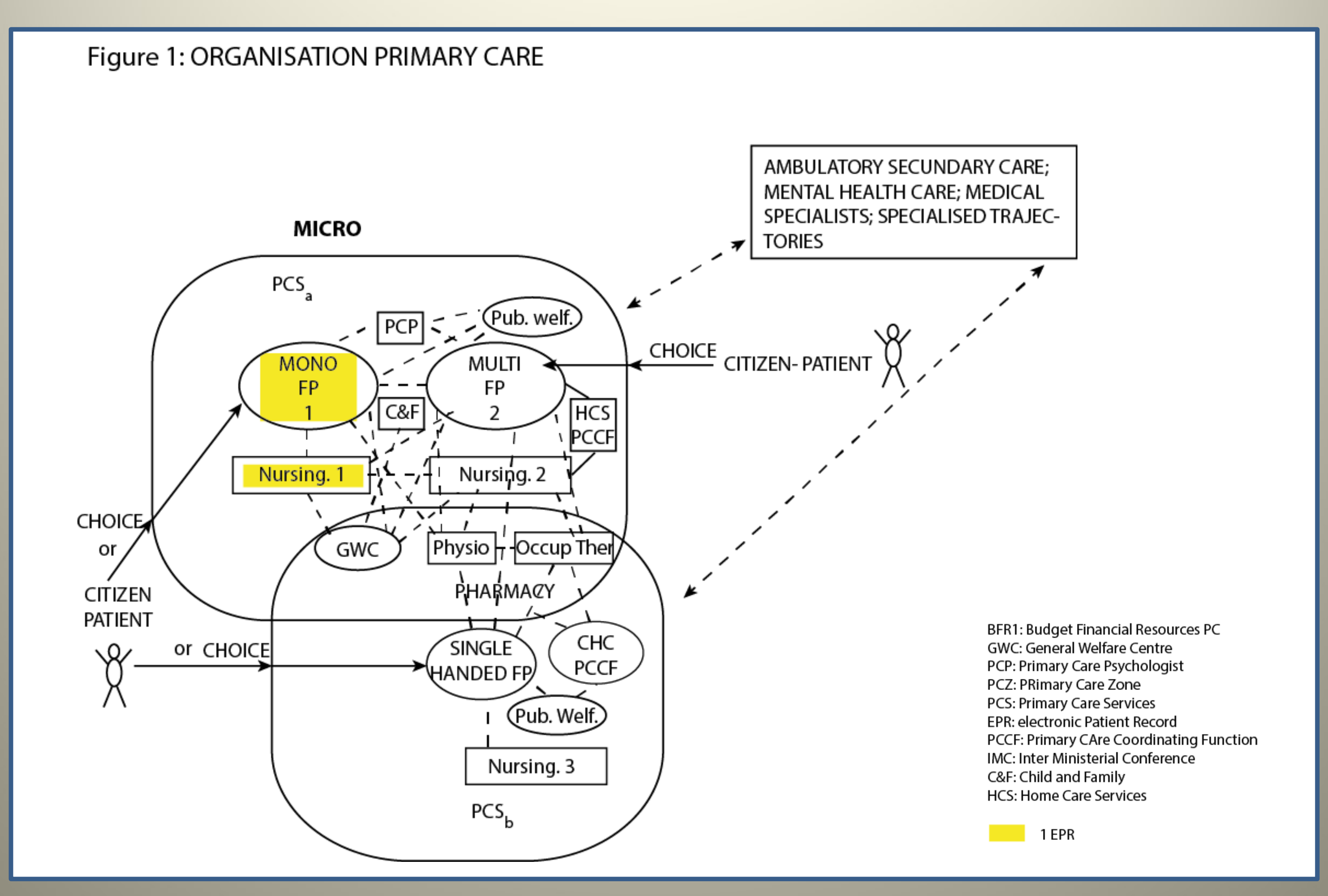


Figure 1: ORGANISATION PRIMARY CARE
MICRO
AMBULATORY SECUNDARY CARE; MENTAL HEALTH CARE; MEDICAL SPECIALISTS; SPECIALISED TRAJEC- TORIES
PCSa
PCP
Pub. welf.
MONO FP 1
MULTI FP 2
CHOICE
CITIZEN- PATIENT
C&F
HCS PCCF
Nursing. 1
Nursing. 2
CHOICE or CITIZEN PATIENT
GWC
Physio
Occup Ther
PHARMACY
or CHOICE
SINGLE HANDED FP
CHC PCCF
Pub. Welf.
Nursing. 3
PCSb
BFR1: Budget Financial Resources PC
GWC: General Welfare Centre
PCP: Primary Care Psychologist
PCZ: PRimary Care Zone
PCS: Primary Care Services
EPR: electronic Patient Record
PCCF: Primary CAre Coordinating Function
IMC: Inter Ministerial Conference
C&F: Child and Family
HCS: Home Care Services
1 EPR

Role of the health promotor

Engage in emancipatory processes of health litteracy improvement, empowerment, healthy lifestyles,
support shared decision-making, advocacy and equity in health,
signalizing upstream social determinants of health

Primary Care Service

- Interprofessional (under one roof, in a network, or both)
- Active in different primary care practices

In close cooperation with:

- Primary Care workers
- Citizens / patients
- Intersectoral action for health
- Involving new professions: **C**ommunity **H**ealth **W**orkers

WELCOME
to the
Community Health Centre Botermarkt

Hundelgemsesteenweg 145
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Forfaitair betalingssysteem
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Preventieprojecten en gezondheidsbevordering
Inschrijven in het WGC
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- COPC-strategy

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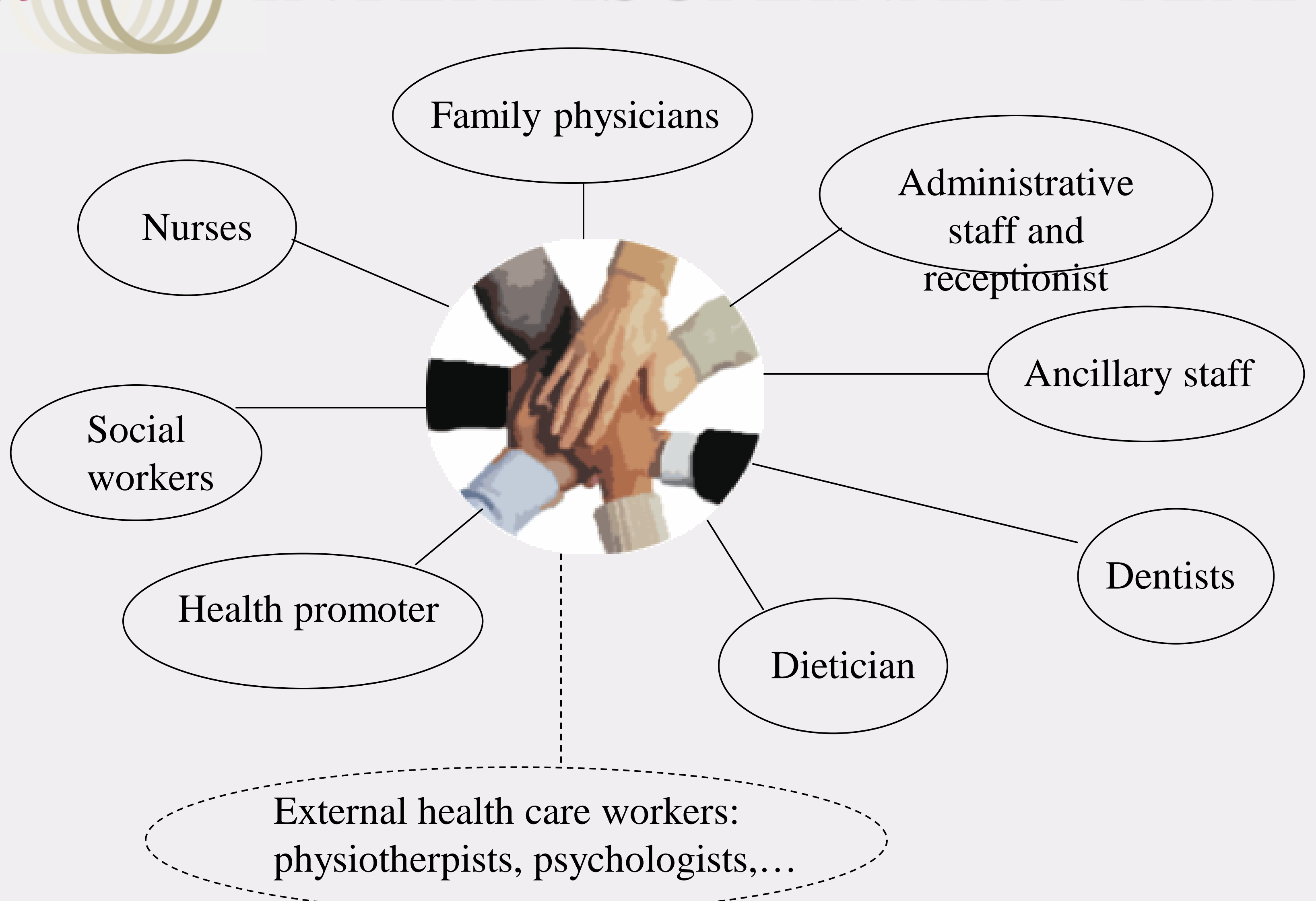
INTERDISCPLINARY TEAM

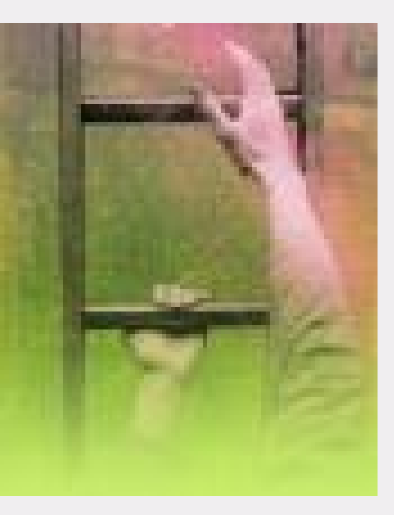


Community Health Center Botermarkt Ledeberg!

Competency sharing

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

Social Work

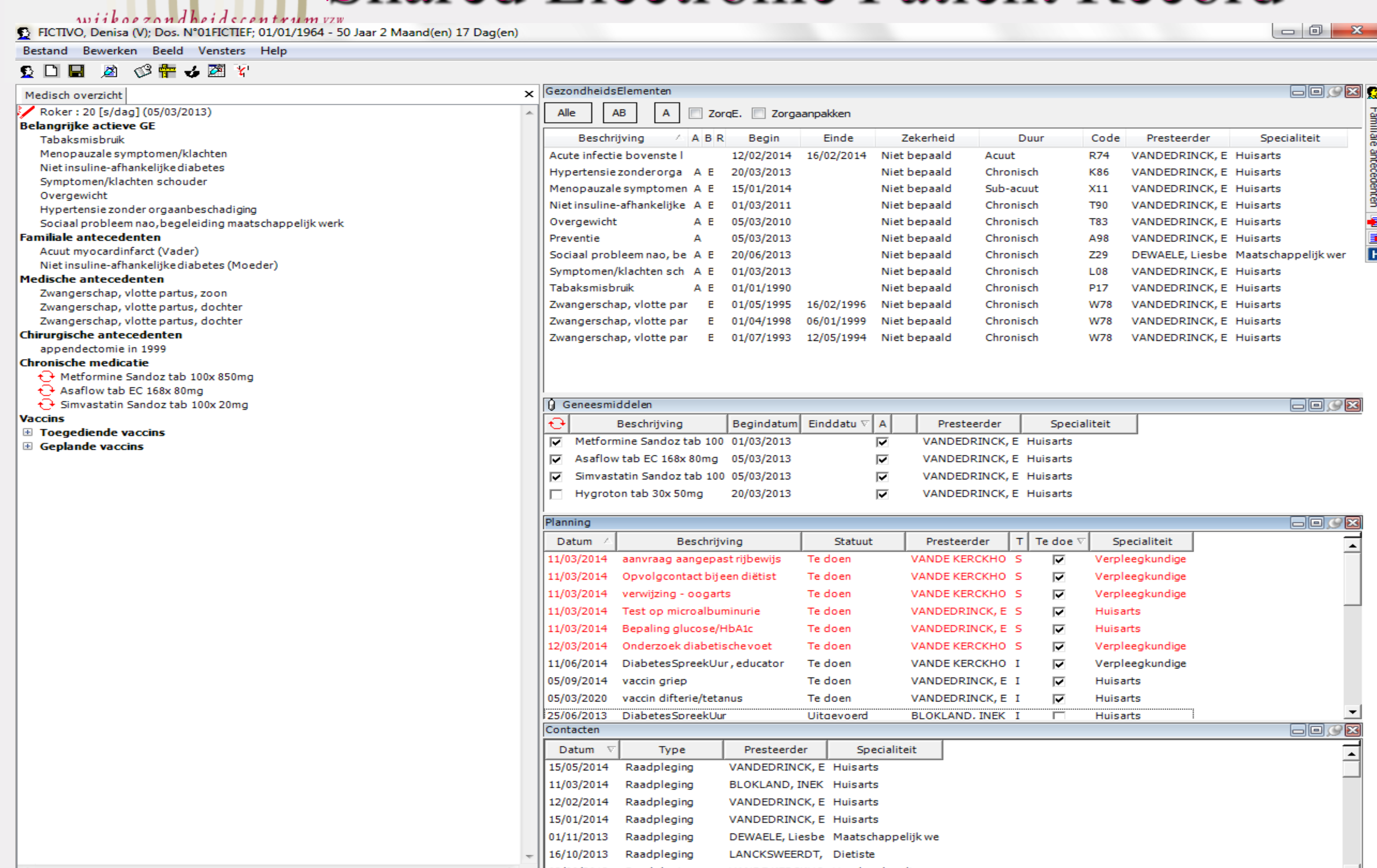


- 2 FTE social workers
- Social work in the health centre includes :
  - first intake, exploring the problem
  - information and counseling
  - advocating, mediating
  - supporting, psychosocial guidance
  - referral to specialised services
  - administrative support, application for allowances, budgetplanning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

Integrated care

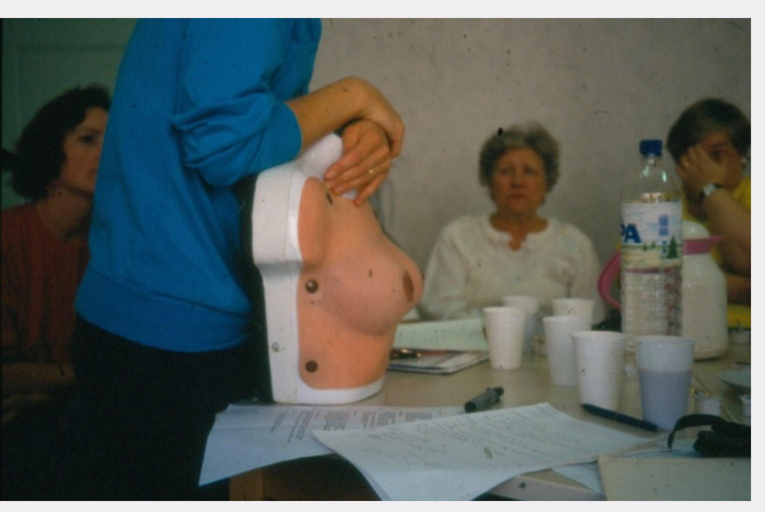
- Physical, mental, ecological and social well-being
- Taking environment/living conditions into account
- Citizen/patient in the driver's seat: empowerment, goal-setting

Shared Electronic Patient Record



Illness prevention & Health promotion

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



Diabetes Fair

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

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Community-Oriented Primary Care

The Cornerstone of Health Care Reform

Richard A. Wright, MD

The current high-cost health care delivery system, which places greater emphasis on acute hospital care than on community-based primary and preventive care, is no longer viewed by policymakers, politicians, and the American public as the ideal model for organizing and providing health care services. Americans want change; however, politicians are responding with a barrage of disjointed finance and cost-containment proposals that fail to address the organization and provision of health care services. Nevertheless, to adequately address problems of cost, access, and quality, reform proposals will need to consider delivery models that create a balance between medical care and health care, between public health and personal health services, and between curative and preventive care. The community-oriented primary care model and the discipline of community and socially responsive medicine is a process for making a health care system more rational, accountable, appropriate, and socially relevant to the public. Consequently, this model, which is now at a pivotal point in its evolution, may serve as a paradigm for reforming the organization and provision of health care services in America.

(*JAMA*. 1993;269:2544-2547)

catalyst for health care reform. While most debates have focused on financing and cost-containment options, policymakers are beginning to address issues of system design and covered services. What are the most efficient and effective models for organizing and providing health services? What are the most appropriate services to effect improvements in health status? I believe answers to these questions will resurrect interest in the basic precepts of community health and prevention, and in community-oriented primary care (COPC) as a model for organizing and providing primary and preventive services in partnership with defined communities. To this extent, the COPC model may become the cornerstone of health

Community Oriented Primary Care Interprofessional Learning Project

Ghent 2002-2016:

-one week project in ‘Health and Society’ module (BA2)

-interprofessional: nurses, medicine, midwives, occupational therapy, sociology, social pedagogy,…

Where are all the students now?
… in the Community Health Centre

Introduction to history, background and
context of the neighbourhood

preparing the patient interview
RBK

RAMMSTEIN

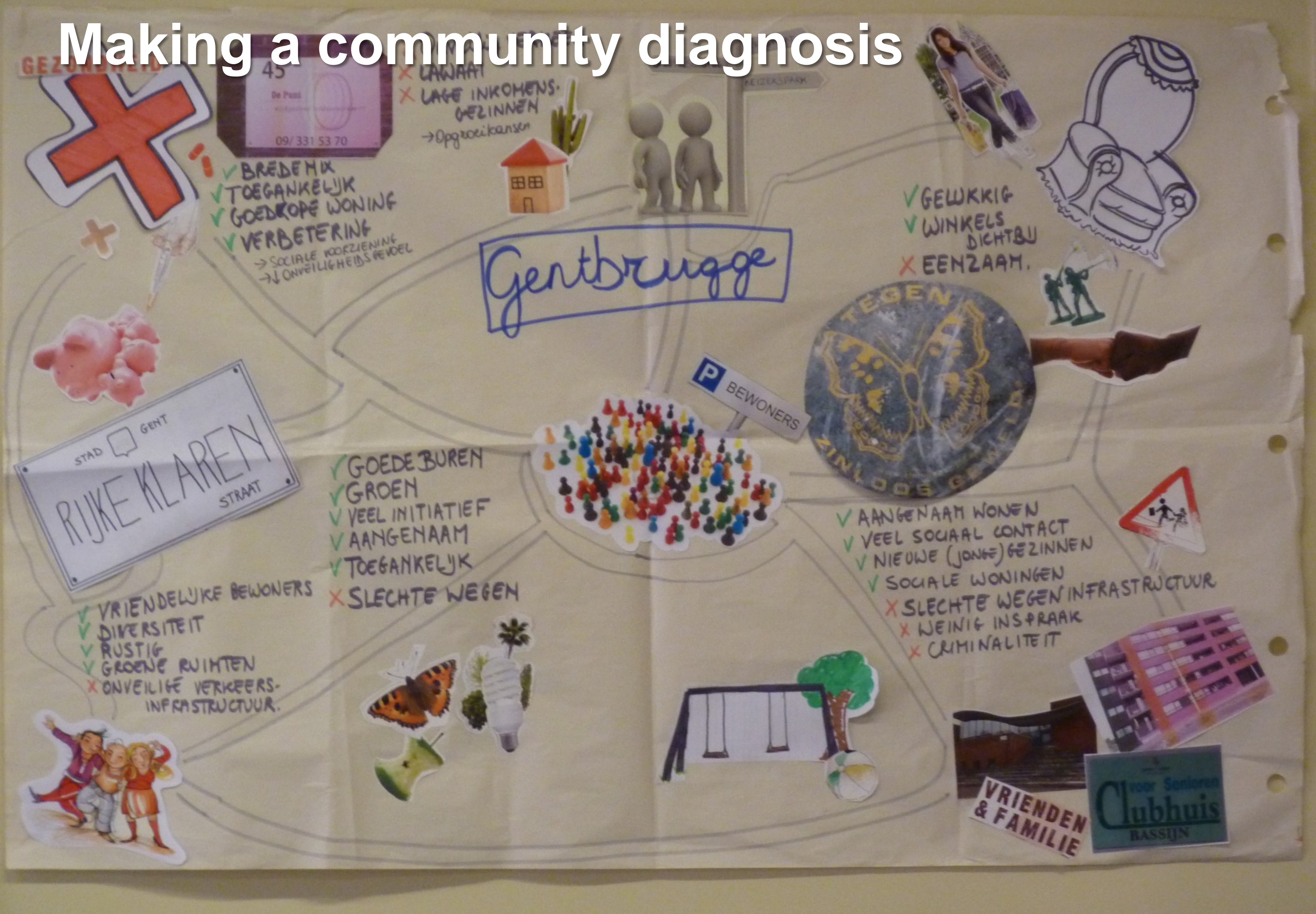
Interview with family physician

Process of data-collection in the community

Reporting experiences
PATIËNT
+ Vriendelijk, rustig, diversiteit, alles goed beschikbaar, Relatie met zorgverstrekkers
- Te weinig groen
HUISARTS
+ jong, divers, laagdrempelige zorg, interdisciplinair
- woonsituatie
APOTHEEK
+ jong, divers
- Taalbarrière, € misvatting, communicatie huisarts, niet sociaal
VERPLEEGSTER
EIGEN INDRUKKEN
weinig groen, taalbarrière
PATIËNT ID
VERLEDEN
NU
HULPVERLENERS
AALMOEZENIER
HUISARTS
M.W
Gentbrugge
RIJKE KLAREN

Interprofessional clash of cultures

Making a community diagnosis



Brainstorming for the presentation

Presentation of interventions to students and stakeholders

Politicians respond to formulated proposals for interventions

Prepare the health promotion student to
take a seat in the community platform

Vision statement

New professionalism in care and support as a task for the future

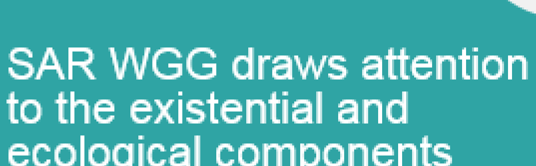
Barbara Krekels
Prof. Jan De Maeseneer

Washington, 21.04.2016

- the best possible functioning of the person with care needs in the community
- and in the ability to participate in society

ecobiopsychosociaal model

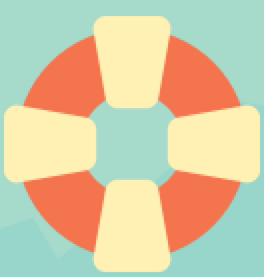
- attention to the person as a physical, psychological and social being
- attention to the person as an existential and ecological being



SAR WGG draws attention to the existential and ecological components

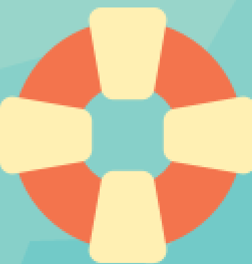
SEEKING

NEW ANSWERS



A MORE GENERALIST APPROACH NEEDED

- the demands and needs changed significantly
- the complexity is of a different order
- no standard solutions but a generalist approach required



CONNECTEDNESS AS A PRECONDITION FOR AUTONOMY

- connecting people
- necessary that a solidarity framework exists in society in which professionals and citizens can shape a care and support relationship
- the quality of living together

THE LANCET

Health professionals for a new century: transforming education to strengthen health systems in an interdependent world

Julio Frenk, Lincoln Chen*, Zulfiqar A Bhutta, Jordan Cohen, Nigel Crisp, Timothy Evans, Harvey Fineberg, Patricia Garcia, Yang Ke, Patrick Kelley, Barry Kistnasamy, Afaf Meleis, David Naylor, Ariel Pablos-Mendez, Srinath Reddy, Susan Scrimshaw, Jaime Sepulveda, David Serwadda, Huda Zurayk*

The Lancet 2010;376:1923-58

	Objectives	Outcome
Informative	Information, skills	Experts
Formative	Socialisation, values	Professionals
Transformative	Leadership attributes	Change agents

Table 3: Levels of learning

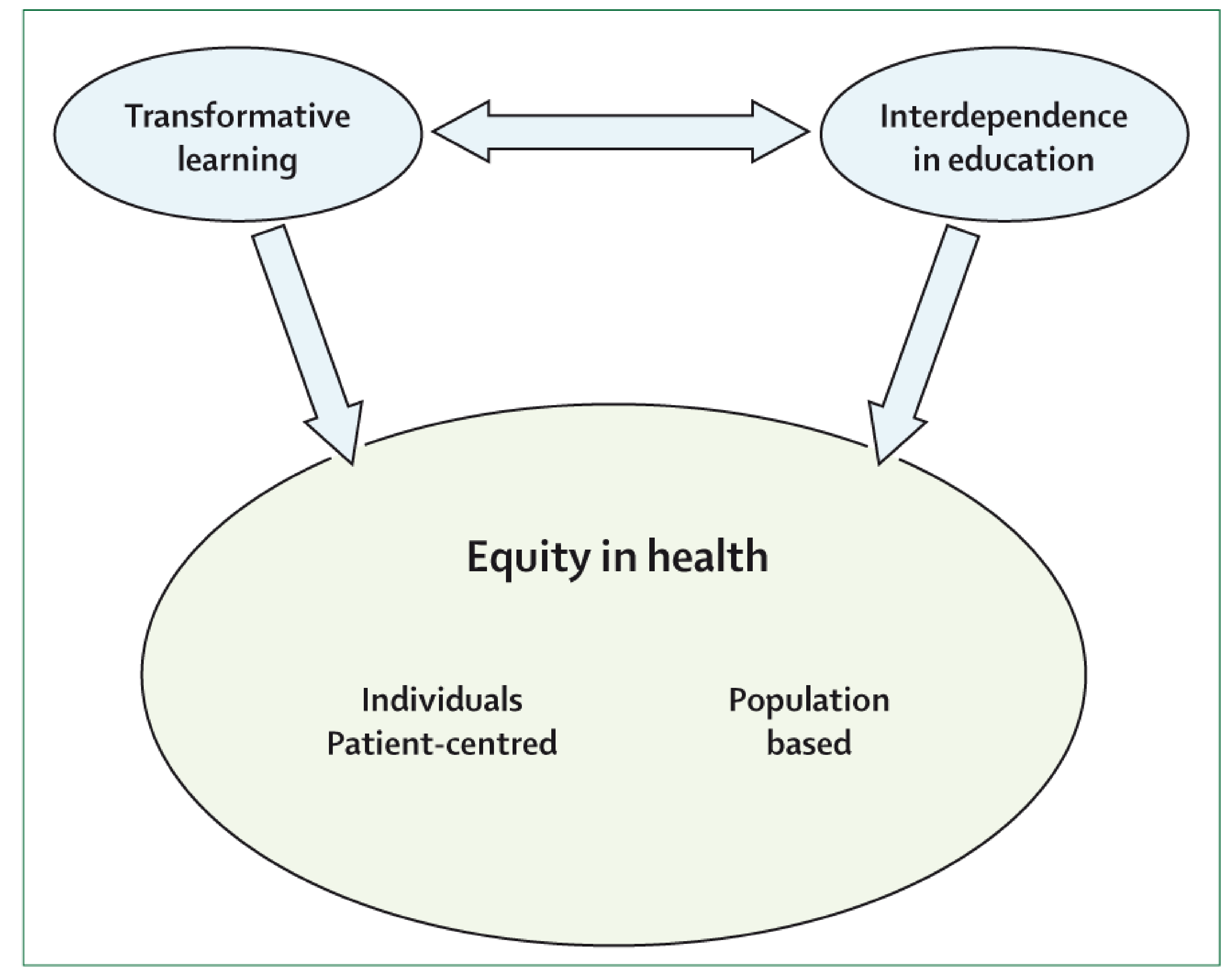


Figure 11: Vision for a new era of professional education

Definition of Social Accountability

*..the **obligation** (of medical schools) to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have the mandate to serve.*

The priority health concerns are to be identified jointly by governments, healthcare organizations, health professionals, and the public. (World Health Organization, 1995)

How to bridge the gap between evidence and practice?

- Analyze the actual situation
- Develop transformative learning
- Role of Health Promotion in Primary Care

Conclusion: changes in the role of Primary Care: actual performance and the way forward

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

D-09-02569R1

S0140-6736(09)61082-5

The role of academic health science systems in the transformation of medicine

Victor J Dzau, D Clay Ackerly, Pamela Sutton-Wallace, Michael H Merson, R Sanders Williams, K Ranga Krishnan, Robert C Taber, Robert M Califf

The challenges facing the health in communities around the world are unprecedented, and the data are all too familiar. For 5 billion people living in developing countries, environmental factors and inadequacies in hygiene, economic development, and health-care access are the main causes of shortened life expectancies. Improvements in health status, including reductions in infant mortality and declining incidence of infectious diseases, are being met by the new epidemics of obesity, diabetes mellitus, and cardiovascular disease.[1]

The system needs to overcome two distinct translational blocks or gaps in the discovery-care continuum.[11,12] The first is the gap between a scientific discovery and its clinical translation (ie, from bench to bedside); the second is the gap between expert acceptance of the application and its broad adoption in practice by local and global communities (ie, from bedside to population). AHSCs traditionally give their discoveries to industry at the first gap and to practising physicians at the second gap, thereby creating barriers and inefficiencies. We believe

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See Online/Comment DOI:10.1016/S0140-6736(09)61594-4

Duke Medicine, Durham, NC, USA (Prof V J Dzau MD, D C Ackerly MD, P Sutton-Wallace MPH, Prof M H Merson MD,

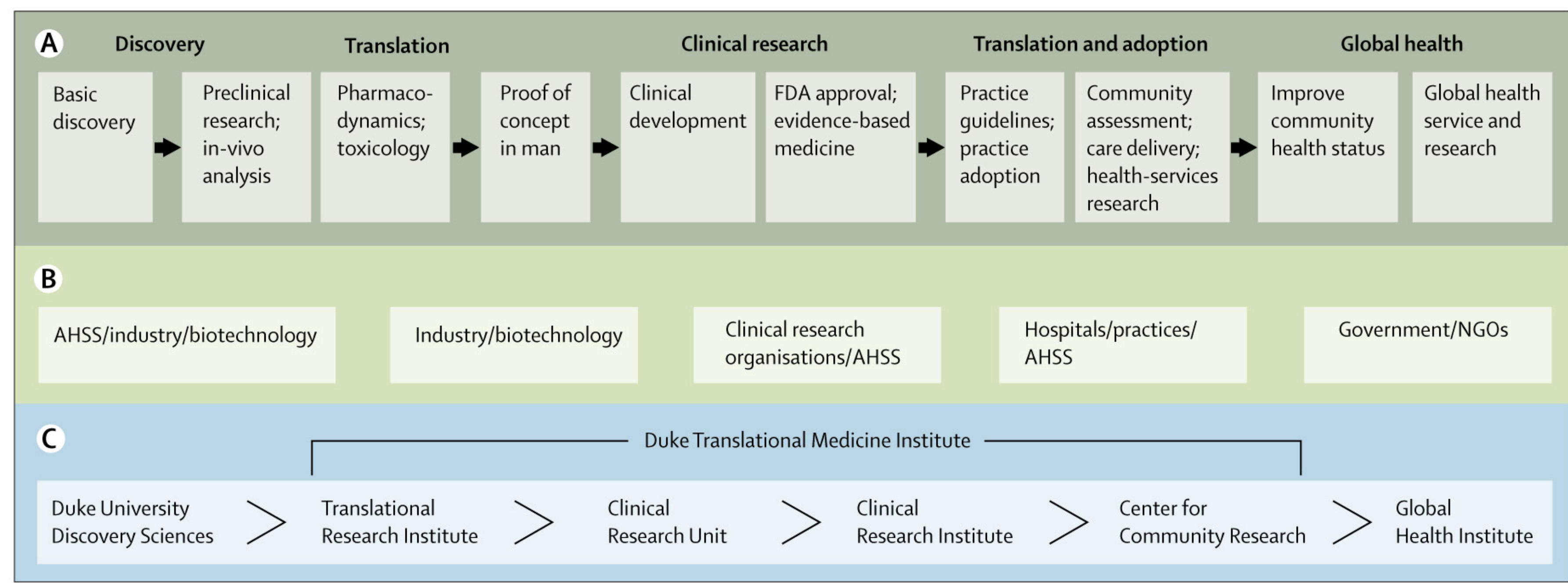


***Figure 1:* Academic health science systems as integrators**

(A) The discovery-care continuum, including discovery science, preclinical and clinical research, adoption in practice, and global uptake; (B) current fragmented organisational structure of the clinical research enterprise; (C) Duke Medicine model: a continuous, intercommunicated discovery-care model. FDA=US Food and Drug Administration. AHSS=Academic health science systems. NGOs=non-governmental organisations.

How to bridge the gap between evidence and practice in health promotion?

- More focus on contextual and policy evidence
- Focus on equity and sustainability
- Link with care-processes enables a population-health approach
- Practice COPC!
- Embrace complexity and generalism and become a change agent
- Contribute to social cohesion in a multicultural society

The Health Promotor in the PHC-team has a role to play… Now more than ever!

Never forget: the starting point are the goals of the person.

Should everybody be able to climb Diamond Hill?

RUNNING FOR…

A SUSTAINABLE FUTURE!

The Future of Primary Care in Europe

© ImantsUrtans

«Cross-cutting Informal Care & Professional Primary Care»

11th EFPC conference
5/6 SEPTEMBER
RIGA 2016

Conference fees

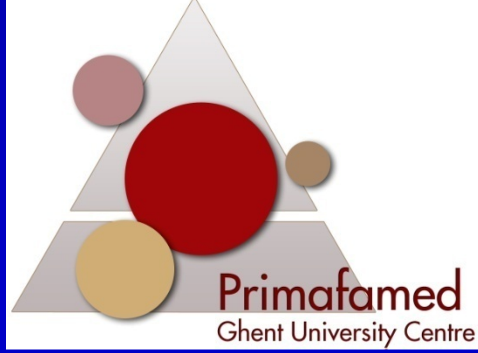
Students	€ 175
Early bird EFPC members	€ 225
Early bird Non members	€ 400
EFPC members	€ 325
Non members	€ 500
Pre-conference Sunday 4/9	+ € 100

Early bird ends June 16

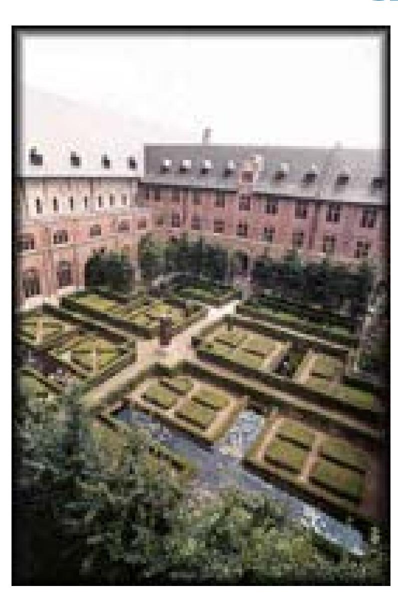
Thank you…

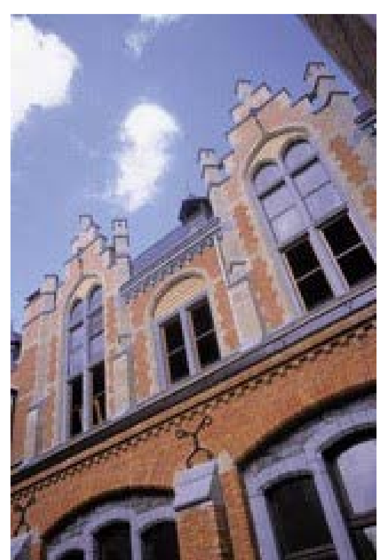
jan.demaeseneer@ugent.be

WHO Collaborating Centre on PHC



FACULTEIT GENEESKUNDE EN
GEZONDHEIDSWETENSCHAPPEN





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