53rd EQuiP Assembly Meeting (Bratislava, Slovakia)

- GP: Cornerstone for Health Care of Highest Quality

Hosted by Slovak Society of General Practice

Conference Themes and Topics

- The Quality of Medical Education affects the quality, safety, efficiency and effectiveness of Health Care: How to improve Teaching in Quality and Safety?
- Does eHealth improve the Quality and Safety of Care in General Practice?
- Can GPs reduce or prevent overdiagnosis and overtreatment?

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Conference Program 24 March

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

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

10:30 – 11:00 **Coffee and Tea**

11:00 – 12:15 **ORAL PRESENTATIONS *(5x 15 min.)***

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

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

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

#4 Johanna Caro (Spain):
Perceptions and opinions of healthcare professionals about low value practices

#5 Johanna Caro (Spain)
From the perspective of patients: Low-value clinical practices

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

#1 Hector Falcoff (EQuiP):
Equity of Primary Care: The EQuiP Consensus Statement

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

#3 Claire Thomas & Stuart d'Arch (VdGM):
Quality Mental Health Care in General Practice

12:15 – 13:00 **Plenary Discussion**

13:00 – 14:00 **Lunch**

14:00 – 15:00 **Closing ceremony**

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Information

General Information

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

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

Conference City
Bratislava is easy to acces either by air, car, train or Danube River cruise.

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

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

www.visitbratislava.com

Conference language
English

Currency
The currency in Slovakia is Euro (€).

Important dates

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

Abstract Submission

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

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

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

Registration

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

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

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

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

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

Fees

1 full day	
EQuiP & SSVPL Member	€150
Non member	€200
Trainee	€95
2 full days	
EQuiP & SSVPL Member	€200
Non member	€300
Trainee	€150

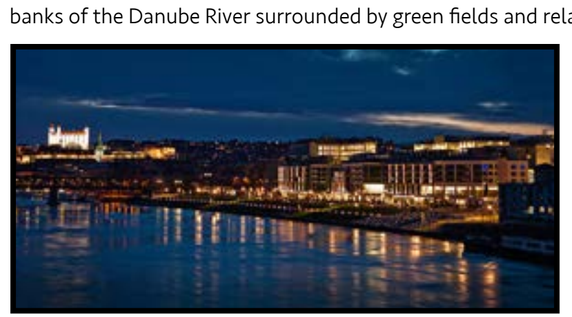
Registration fee includes scientific program, conference materials and refreshments.

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

Venue

Sheraton Bratislava Hotel
Pribinova 12
811 09 Bratislava, Slovakia

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



Hotels

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

Other recommendations

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

The EQuiP President welcomes you!

Dear Colleagues,

Dear interested Health Care Professional,

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

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

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

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

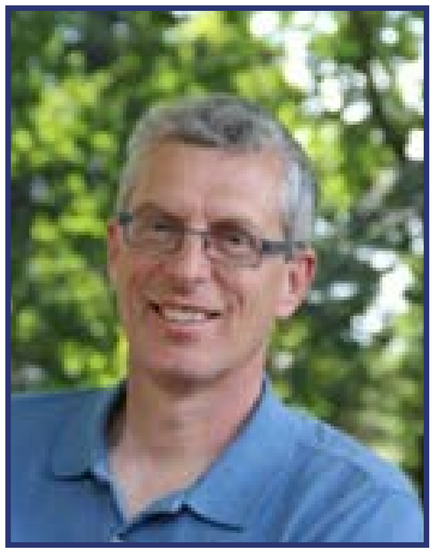
Patient safety has been the topic of the last two open EQuiP meetings and one of the main safety issues is about correct diagnosis. Not only the delay of wrong diagnosis but also and even more actual, overdiagnosis and overtreatment. We think GPs can play a major role in reducing overdiagnosis and protecting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

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

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

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

Dr. Piet Vanden Bussche, GP
EQuiP President



Dr. Piet Vanden Bussche, GP

Welcome from your Slovakian hosts!

Dear Colleagues,

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

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

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

Dr. Krnáč Štefan
Meeting President
Member of Council Slovak GP Society
Slovak national delegate in EQuiP, EFPC and EMA

Dear Colleagues,

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

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

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

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

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

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

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

Best regards

MUDr. Peter Makara, MPH.
President of SSVPL

Dr. Krnáč Štefan

MUDr. Peter Makara, MPH.

Hosted by
Slovak Society of
General Practice

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Ilkka Kunnamo

Developer of guidelines and clinical decision support, Finland

Adrian Rohrbasser

General practitioner, Switzerland EQuiP delegate, Will, Switzerland

KEYNOTE

How to teach quality and safe family medicine?

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

Zalika Klemenc-Ketiš

Short bio

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

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

Associated professor for family medicine (since 2016).

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

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

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

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

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

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

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

Research

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

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

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

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

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

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

List of publications

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

Abstract

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

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

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

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

Read more

http://equip2018.sk/keynote_speakers.php

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KEYNOTE

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

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

Jaime Correia de Sousa

Short bio

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

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

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

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

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

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

Abstract

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

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

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

Read more

http://equip2018.sk/keynote_speakers.php

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ORAL PRESENTATION

General Practitioners Education in Slovakia

Author: Prof. Peter Kalanin, MD, PhD (Slovakia)

Peter Kalanin

Education for general practitioners in Slovakia is provided by the Slovak Medical University Faculty of Medicine in Bratislava, Comenius University Jessenius Faculty of Medicine in Martin and Pavol Jozef Šafárik University Faculty of Medicine in Košice.

Pavol Jozef Šafárik University Faculty of Medicine provides education to medical students and general practitioners at General Medicine Clinic of Pavol Jozef Šafárik University Faculty of Medicine and Košice Šaca Hospital (Nemocnica Košice Šaca, a.s.) General Medicine Clinic provides undergraduate education within classes entitled "General Medicine and Professional General Medicine Practice" in the fifth and sixth year in the Slovak and English language, and since 2008 General Medicine Clinic has been providing postgraduate education for doctors within the accredited specialization programme for General Medicine programme.

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

Author: Stephanie Dowling (Ireland)
Co-Authors: Prof. Walter Cullen (University College Dublin, Ireland), Prof. Last (University College Dublin, Ireland) & Dr. Henry Finnegan (National Director of ICGP CME Ireland)

Stephanie Dowling

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

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

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

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

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

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ORAL PRESENTATION

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

Author: Esra Meltem Koç, Ministry of Health (Turkey)
Co-Authors: Hakkı Gürsöz, Mahmood Adil, Abdullah Öztürk, Dilek Tarhan, Şuule Gündüz, İbrahim Halil Kayral, Elife Dilmaç, Hüseyin Özbay, Sema Zergeroğlu, Merve Akın, Bilgehan Karadayı,Kemal Tekin, Aydın Sarı, Mustafa Said Yıldız, Bora Avcı, Hilal Aksoy

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

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

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

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

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ORAL PRESENTATION

Pre-Diabetes Network Screening and Education Program in Primary Care

Author: Giovanni Calusi, AUSL Toscana Centro (Italy)
Co-Authors: Jacopo Demurtas, Tommaso Barnini, and Alessandro Bonci

Background

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

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

Methods

Prediabetes cohort is created by screening for risk factors:
• familiarity for DM and BMI > 25,
• gestational diabetes,
• waist circumference > 102 (M) >88 (F),
• impaired fasting glucose (IFG) or impaired glucose tolerance (IGT) or unrecognized DM.

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

-General Practitioner compiles the enlisting sheet and patient account

-Patients are provided with a booklet containing educational material in paper or electronic format

-Every 4 month subjects undergone medical checkups and are requested to self-compile a SF 12 test (booklet or online)

-Annually an extended medical checkup is performed together with an SF 36 test completed by the GP

-Patients are invited to join supervised physical activity and educational advice is given periodically online or by mail

Findings

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

Conclusion

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

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ORAL PRESENTATION

Patient safety risk assessment in primary care in Hungary

Author: Eszter Pitás, Semmelweis University Health Services Management Training Centre, Budapest (Hungary)
Co-Authors: Ágnes Anita Tóth, Judit Lám, Heléna Safadi, Éva Belicza

Eszter Pitás

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

Keywords: patient safety, primary care, risk assessment

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

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

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

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

Result
Our study showed that the main identified patient safety risks in PC are:
(1) late diagnosis
(2) communication gap between specialists and general practitioners
(3) difficulty in following patient care pathways and treatments
(4) medication errors
(5) lack of professional guidelines
(6) antiquated infrastructure
(7) poor patient health literacy

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

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WORKSHOP

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

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

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

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

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

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

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

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

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

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

WORKSHOP

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

Author: Zlata Ozvacic Adzic (EQuiP, Croatia)
Co-Authors: Erika Zelko, Goranka Petricek, Zalika Klemenc-Ketis, Venija Cerovecki, Piet Vanden Bussche

Zlata Ozvacic Adzic

Background

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

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

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

Aim

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

Methods

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

Results

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

Conclusion

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

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The joy of quality indicators in small groups

WORKSHOP

Authors: Eva Arvidsson (EQuiP, Sweden) & Adrian Rohrbasser (EQuiP, Switzerland)

Eva Arvidsson

Adrian Rohrbasser

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Group discussions:

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

Reports from groups

4. Summary and conclusions

Power Point Slides
Quality indicators (Eva)
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Power Point Slides
Small Groups (Adrian)
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KEYNOTE

Health IT for empowering citizens & health professionals

Author: Ilkka Kunnamo (Finland)

Ilkka Kunnamo:

Short bio

Ilkka Kunnamo is a general practitioner in Central Finland, and Adjunct Professor of General Practice at the University of Helsinki.

He developed the idea of Evidence-Based Medicine Guidelines, a comprehensive electronic guideline database, and served as its editor-in-chief between 1988 and 2008.

He now serves as the editor-in-chief of the international version, which has been translated into 11 languages.

He has been involved in a number of projects on primary care computing, medical informatics, and the organization of primary care.

In 2002 he was the leader of the team that produced the plan for the development of a nationwide, standardized electronic health record for Finland.

Presently, he develops a comprehensive multilingual decision support service (Evidence-Based Medicine electronic Decision Support, EBMeDS, **www.ebmeds.org**) utilizing the key data sets in the health records and providing patient-specific automatic reminders, interactive algorithms, and care plans.

He has published research papers in informatics, guidelines, rheumatology, gastroenterology, sinusitis, and diabetes care.

He is a member of the international GRADE group (**www.gradeworkinggroup.org**), a founding member of the Guidelines International Network Implementation Working Group, and previous co-chair of the Multimorbidity Working Group.

He is the chair of the WONCA Informatics Working Party, and a member of the Executive Board of DynaMed Plus, EBSCO Health.

Abstract:

Empowerment of patients is a strategic goal in building health information systems. Patient-centredness requires that one patient has one record – across primary and secondary health care.

Much of the data will be recorded and used by patients and citizens themselves. Coding of patient data allows processing by computer and enables clinical decision support, precision medicine, and automation of many tasks.

The information system facilitates communication between patients and their physician, as well as within the network of professionals that create virtual teams to provide patient-centred care.

Patient empowerment is promoted through the sharing of medical knowledge, by supporting home measurements, and motivating and guiding self-care.

Safe communication via personal health records, messages, chat, and video messages enables more flexible schedules for the physician, improves continuity of care, and simultaneously reduces long hours spent in the office.

The primary care team can take care of the whole population via the information system and ensure that care can be offered equally to everyone who would benefit from health care interventions. This is enabled via patient data that can be aggregated, monitored, sorted and searched, and medical knowledge that is organized into rules that analyse the data of each patient against best available evidence.

Cross-sectional and longitudinal data from electronic health records of populations is used to create new knowledge.

More information:

WONCA Policy statement on eHealth

How to build an ideal health information system?

Presentation on clinical decision support

KEYNOTE

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

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

Harris Lygidakis

Short bio

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

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

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

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

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

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

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

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

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

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

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

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

Abstract

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

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

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

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

Read more

http://equip2018.sk/keynote_speakers.php

eHealth in Slovakia - a difficult birth

Author: Jana Bendova, general practice for adults in Velky Biel, Slovakia

Jana Bendová

Abstract

The eHealth project in Slovak Republic has been prepared since 2008. The start has been delayed several times. Finally, on the 1st January 2018 the Slovak eHealth has been born. The birth was not easy, but rather complicated with many technical and implementation problems tagged by our health minister as just 'mild labour pains'.

The State had 10 years preparation time, physicians only a few days, during Christmas season. No principle of voluntary connection, nothing but obligation to get connected for all health care providers – under threat of financial penalties and even medical licence cancellation. The functioning system has the potential to make healthcare safer, more effective and of better quality.

What is the Slovak reality at present?

Slowdown of our daily work and distraction of our attention to patient whilst turning it to our computer monitors. We have to face several challenges – eHealth started for us neither with manual, nor training, with financial costs just 'thrown on our shoulders'. The political task to launch eHealth was accomplished, however, for the price of unnecessary time and existential stress for health care providers.

Short bio

MUDr. Jana Bendová, PhD
Since 2006 I´m a full time GP in my rural solo practice in western Slovakia. Between 2010 and 2014, I was the national representative at WONCA Europe Council, EURACT and EURIPA.

Since 2014, I´m a general medicine lecturer at 2 medical faculties.
Our practice hosted in 2017 our first GP trainee, and I also completed my PhD thesis in early detection of COPD in general practice at Slovak Health University in Bratislava.

Since 2015, I study Master of Health Administration.

My favourite topics include prevention, eHealth and chronic respiratory diseases.

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

Author: Tommaso Barnini, AUSL Toscana Centro (Italy)
Co-Authors: Giovanni Calusi, Alessandro Bonci, Cosimo Capodarca, Stefano Celotto, and Jacopo Demurtas

Tommaso Barnini

Giovanni Calusi

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

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

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

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

Findings
Currently the REACT project is ongoing, with 6 months registration and over 5000 access.

Over two thirds of contacts approach the service for acute symptoms.

Top three RFEs for acute disease (reason for encounter) are:
Fever, Cough, Sore throat.

Referral rate to Emergency Department (ED) is under 7% of total access and only 3% of chronic illnesses flare up.

Half of the population declares no chronic illness.

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

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

Author: Maria José Correia, USF Oriente - Lisboa (Portugal)
Co-Authors: Nicole Marques, Francisco Sampaio, Inês Calvinho, Juliana Caçoilo, Sara Pessoa, and João Toscano Alves

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

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

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

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

Results
We gathered pre-intervention data in a total of 3.022 phone calls in twenty-seven days' time of which 26.6% were answered.

After intervention we observed a total of 3.997 phone calls in thirty-six days, of which 29,7% were answered.

The total number of answered calls was higher on post intervention period (n=1186, 29,7%), when compared to pre intervention (n=803, 26,6%), $\chi2(1)= 8.146$, $p<0.004$.

From the data, users prefer to more on Mondays (25,7%) compared to the average of the week (19,9%). They call specially between 11:00 - 14:00 (30.4%) and 14:00 -17:00 (31.3%).

The number of answered calls between 11:00 - 14:00 increased on post intervention (n=349, 28.7%) versus pre-intervention (n=218, 23.8%), $\chi2(1)= 6.298$, $p<0.012$.

In the period between 17:00 - 20:00 there was also an improvement from 30.4% to 39% of answered calls, $\chi2(1)= 8.280$, $p=0.004$.

There was not a statistically significant increase of the proportion of answered calls between 8:00-11:00 and 14:00-17:00.

Conclusion
The intervention gave way to a rise in answered phone calls, therefore improving the telephonic accessibility of the population of USFO. After statistical analysis, we observed that between 8:00-11:00 and 14:00-17:00, there is usually a bigger affluence to the USFO, which can be responsible for the non-significant increase.

In the future we hope to understand the consequences of increasing the telephonic accessibility in patient satisfaction and study other possible improvements in timeliness of answering calls and also other factors which influence USFO accessibility.

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

Author: Vildan Mevsim, Dokuz Eylul University Faculty of Medicine Department of Family Medicine (Turkey)
Co-Authors: Oguz Yilmaz and Emel Kuruoglu

Vildan Mevsim

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

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

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

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

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

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How to reduce unnecassary care?
Essencial Project in Catalonia

Author: Cari Almazán, Agency for Health Quality and Assessment of Catalonia (Spain)
Co-Authors: Johanna Caro, Montse Mias, Isabel Parada, Montse Moharra, and Toni Dedeu (on the behalf of Essential Project team)

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

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

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

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

1) Identification of low-value practices in collaboration with healthcare professionals and Medical Scientific Societies and elaboration of recommendations

2) Implementation of recommendations led by healthcare professionals and impact evaluation of these recommendations in terms of process and outcomes via quantitative and qualitative methods

3) Communication strategy to disseminate recommendations and implementation activities (web, videos, social media, infographics, training, etc) to healthcare professionals, patients and citizens.

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

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

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

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

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

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

Doctor's perspective on person-centeredness in primary care

Author: Jan van Lieshout (EQuiP, the Netherlands)
Co-Authors: Goranka Petricek, Zalika Klemenc Ketis, and Zlata Azvacic Adzic

Aims

EQuiP, Wonca Europe's network on Quality and Safety, formed a new working group on 'Person-centered Primary Care'.

Person-centeredness has been described in various models and comprises various domains. The most frequently cited model is provided by Moira Stewart et al.

They identified six interconnecting components - e.g. exploring both the disease and the illness experience, understanding the whole person, finding common ground - while other authors built upon this framework. However, a clear consensual model is currently lacking.

The aim of this workshop is to elicit the participants' views on person-centeredness and the elements relevant.

Structure

The workshop will consist of three parts:

1) Plenary (35 min)
- Presentation: Introduction on person-centered care relating to frameworks and domains, tools for measurement and its relation with outcomes of care
- Introduction to small group work

2) Discussion in small groups (40 min)
- Exchange of ideas on relevant elements of person-centeredness according to their relative importance and ways to measure

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

Conclusions

Participants will be informed on person-centered care frameworks and domains and discuss their views and experiences. This workshop will present a platform for the exchange of ideas.

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

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

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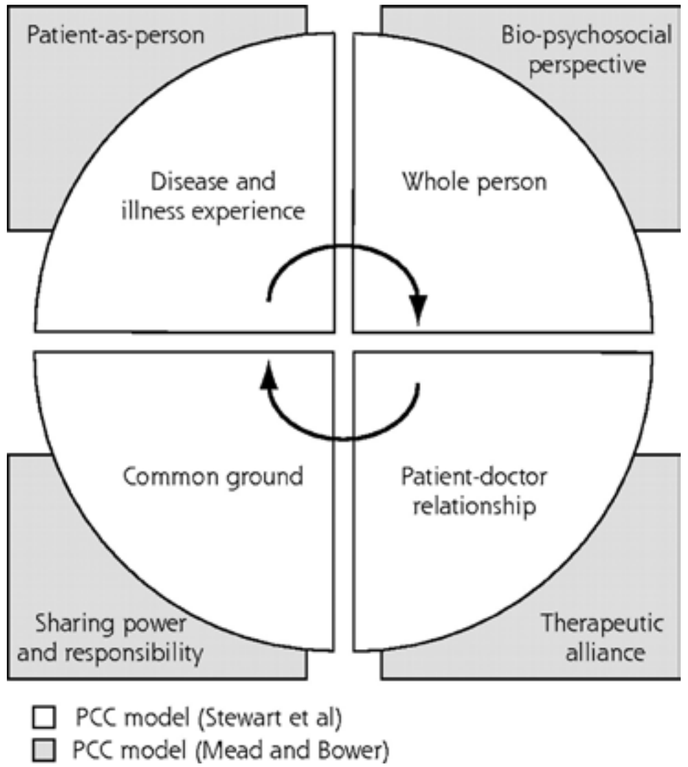

WORKSHOP

Social tools for project management and team collaboration

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

Harris Lygidakis

Background

Social media are a powerful means of communication which can support the work of health care professionals, and their communication with patients and public.

Their use has been increasing steadily globally, transforming the way that people exchange information, interact and collaborate.

At the same time, the inclusion of social networking features in project management tools hasincreased productivity and facilitate team collaboration and coordination.

New software platforms offer the possibility to set goals, plan activities, track assigned tasks, discuss, co-create and share material.

Supporting collaboration and communication can maintain the motivation of the study investigators and data collectors and support their operations throughout the project.

Aim

The aim of this workshop is to provide an overview of the available platforms for the project management, which can be employed in research.

Particular focus will be put on tools that support task-management (Trello), team communication (Slack) and social citation (Mendeley).

Practical examples will be provided and small exercises will be assigned to the participants.

Safer prescribing by medication reduction in the patient who has everything

Author: Stephanie Dowling (Ireland)
Co-Authors: Prof. Walter Cullen (University College Dublin, Ireland), Prof. Last (University College Dublin, Ireland) & Dr. Henry Finnegan (National Director of ICGP CME Ireland)
Workshop Facilitators: Dr John Bourke (GP & CME Tutor West Cork), Dr Ken Harte (GP & CME Tutor Cork), Dr Pat Harrold (GP & CME Tutor Tipperary) & Dr Henry Finnegan.

Stephanie Dowling

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

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

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

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

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

KEYNOTE

Overdiagnosis

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

John Brodersen

Short bio

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

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

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

Abstract

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

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

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

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

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

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

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

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http://equip2018.sk/keynote_speakers.php

BMJ Evidence-Based Medicine Editorial

Overdiagnosis: what it is and what it isn't
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KEYNOTE

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

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

Adrian Rohrbasser

Short bio

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

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

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

Abstract

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

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

Read more

http://equip2018.sk/keynote_speakers.php

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Growth of overdiagnosis and overtreatment as indicators of worsening healthcare

Author: Peter Lipták, MD (Slovakia)

Lipták

Abstract

Slovakia as an example of worsening health care:

1. Transfer of the place of performance of care
What can be done in the office of GP in the community to move to remoted specialists and into hospitals. What can be done in an outpatient office of a specialist to move to hospitals.

Instead of development primary care shift to secondary and hospital care.

2. Payment for inefficiency
Financial stimulation of primary care by health insurances, evaluation of effectivenessaccording to costs of individual doctors and not according to total costs spent in the healthcare scheme per patient.

The doctor is paid if he prescribes fewer medications and fewer examinations, regardless of the impact on the patient's health.

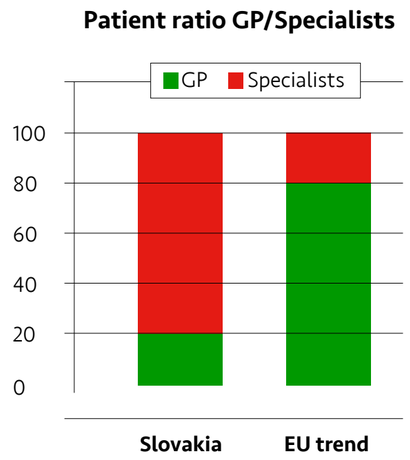
3. Blocking of competences
Administrative blocking of competences in the primary care sector, limited diagnostic and therapeutic procedures, such as limited prescribing of medicines to common chronic diseases.

4. Reduction of human resources in the primary care
Permanent deterioration in funding, mismanagement by non-systemic measures (violent eHealth, confusing examination of the deceased etc.)

5. Privatization and re-privatization
Weakening of the role of public offices of doctors and public hospitals, moving of the healthcare into private outpatients networks and private hospitals.

Targets:

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



The effect of a test ordering software intervention on the prescription of unnecessary laboratory tests
- a randomized controlled trial

Carlos Martins

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

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

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

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

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

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

Results
Comparing the monthly average number of tests prescribed before and after the software modification, from those tests that were withdrawn from the basic menu, the control group prescribed 33.8 tests per 100 consultations before and 30.8 after ($p = 0.075$); the intervention group prescribed 31.3 before and 13.9 after ($p < 0.001$).

Comparing the tests prescribed between both groups during the intervention, from those tests that were withdrawn from the basic menu, the intervention group prescribed a monthly average of 14.0 vs. 29.3 tests per 100 consultations in the control group ($p < 0.001$).

From those tests that are USPSTF's grade A and B, intervention group prescribed 66.8 vs. 74.1 tests per 100 consultations in the control group ($p = 0.070$).

From those tests categorised as USPSTF grade D, the intervention group prescribed an average of 9.8 vs. 11.8 tests per 100 consultations in the control group ($p = 0.003$).

Conclusions
Removing unnecessary tests from a quick shortcut menu of the diagnosis and laboratory tests ordering system had a significant impact and reduced unnecessary prescription of tests.

The fact that it was not possible to perform the randomization at the family physicians' level, but only of the computer servers is a limitation of our study.

Future research should assess the impact of different tests ordering systems during longer periods.

Improving anti-pneumococcal vaccination rate in diabetic patients

Author: Luís Rosális Bastos, USF Lavradio (Portugal)
Co-Authors: Mariana Guterres, António Marques Teixeira, Gisela Cravo Bessa, Punit Naguindas, and Ricardo Gouveia

Introduction

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

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

Objective

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

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

Material and methods

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

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

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

Results

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

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

Discussion

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

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

Power Point Slides (PDF)

Click the icon to access

ORAL PRESENTATION

Perceptions and opinions of healthcare professionals about low value practices

Author: Johanna Caro, Agency for Health Quality and Assessment of Catalonia (Spain)
Co-Authors: Cari Almazán, Montse Mias, Isabel Parada, Montse Moharra, and Toni Dedeu (on the behalf of Essential Project team)

Background
'Essencial Project' launched in Catalonia (March 2013) promotes the elaborations of recommendations to avoid low-value practices and its implementation in clinical practice to reduce unnecessary care.

Physicians lead the process of implementation and their involvement is crucial to the adoption of recommendations in clinical practice and the success of the project.

Objective
To explore and describe physicians' knowledge, attitudes and perceptions towards low-value practices in Primary Care.

Methods
The process of implementing recommendations stars with an anonymous online survey targeting general practitioners (GPs). The survey includes 25 questions about general awareness and understanding of concepts, perceived role, and views on driving forces and need for interventions to support change in diagnostic and prescription routines.

Survey piloted before its launch and specific strategies to maximize the response rate - user-friendly format, pre-notification and reminders - were applied. Response frequencies are calculated and correlation analyses run for pre-selected variables.

Results
Currently, 147 Primary Care Teams (PCT), which represents 52% of public PCT of Catalonia, are implementing recommendations. Up to 499 (response rate 32.1%) answered the survey.

GPs are aware of existing low value practices (64% consider them frequent and 69% identify them in their daily practice).

Reported as driving forces:
- Lack of visit time with the patient (60%)
- Clinical uncertainty (59%)
- Malpractice concern (39%)
- Patient demand (36%)

Regarding a potential solution of issues related to low-value practices, GP consider they are in the best position to approach the problem of low-value practices, follow by the Scientifics and academia.

The most effective tools to address the use of low-value practices are the need to extend visiting time, followed by measures related to the changes in the organization.

Conclusions
Low- value practices are frequent in primary care and GPs are aware of that and of existing driving forces behind these phenomena and they report solution to deal with these practices.

Physicians play a key role in these process and their views provide valuable information for better targeted policy interventions to reduce unnecessary care.

From the perspective of patients:
Low-value clinical practices

Author: Johanna Caro, Agency for Health Quality and Assessment of Catalonia (Spain)
Co-Authors: Liliana Arroyo Moliner, Hortensia Aguado & Cari Almazán
(on the behalf of Essential Project team)

Introduction

Essencial project (EP) is based on close and ongoing collaboration between scientific societies, providers and health care professionals (HCP).

EP identifies, elaborates, communicates and implements recommendations to avoid low-value clinical practices (LVCP). The previous studies carried out within the framework of the EP, confirmed the need to involve and empower patients. They are relevant decision makers in relation to their needs and demand for health services.

Before implementing any intervention at the population level, it's important to understand the perspective of them related to the unnecessary care and the strategies of effective communication.

Objective

The objective was to:

- Explore the experience of the patients attended at primary care
- Identify the profiles of patients to address the strategies
- Consensus and co-design tools and channels to achieve more effective communication

Methods

Exploratory study with a qualitative methodology has been chosen using the technique of focus groups (GF). The study was addressed to adults attended at three primary care centres (PCC) in different areas of Catalonia.

PCC have been selected because it could be possible to triangulate with the coincidences and differences of the GF. The PCC have been selected according to the location, participation in the EP and the socioeconomic index (SI).

The discussion guideline included the following topics:

- HCP visit
- Care received
- Experiences with clinical cases of unnecessary care
- Key elements of an effective communication

Results

A pilot was carried out with one GF that involve 6 people. The discussion guideline led to improvements and the results was the need to include PCC from different areas in Catalonia.

The preliminary analyses of the initial description of the PCC were:

- PCC 1 with high level of deprivation (IS=4,9)
- PCC 2 medium level of deprivation (IS=2,9)
- PCC 3 low level of deprivation (IS=1,6)

The majority of patients assigned to the PCC are between 15 and 44 year (PCC 1: 41, 5%, PCC 2: 44,2%, PCC 3: 41%). In the PCC 1 (51%) and in PCC 3 (54%) the majority are women. The population from Spain of each PCC are PCC 1: 82,3%, PCC 2: 63,2% and PCC 3: 83,4%. The results of the discussion will be present at the conference.

Conclusions

This study allows the PE to explore the perception of the patients regarding visit care, LVCP and communication strategies in the Catalan population.

The PCC have different characteristics of location, IS, and the population. The findings may help in the design of the strategy for implement interventions to patients and involve also HCP, decision makers and the organization.

Equity of Primary Care:
The EQuiP Consensus Statement

WORKSHOP

Author: Hector Falcoff (EQuiP, France)

Hector Falcoff

Background

EQuiP, the European Society for Quality and Safety in Family Practice, produced in 2017 a consensus statement entitled "Equity, an essential dimension of quality in primary care". The consensus includes 11 points that relate to practice organization, processes of care, patient's social status assessment, interprofessional collaboration, community oriented primary care, resource allocation, health professionals training on equity of care, quality improvement methods to improve equity, and the potential advocacy role of primary care professionals faced to health and health care inequities.

Aim of the Workshop

To reflect on the relevance of the consensus in the participants' countries.
To make the consensus concrete with case studies.
To understand what the consensus implies in everyday practice.

Description of the workshop

First, the core concepts related with equity will be presented.

Then the participants will get the consensus statement (double-sided A4 sheet).

They will work in small groups - and for each point they will discuss if it is clear, relevant, feasible.

In order to illustrate different points of the consensus, they will give examples of equity problems and solutions, when they exist.

They will reflect on the best strategies to disseminate the consensus in their countries.

Groups will present a summary of their reflection.
EQuiP experts will propose a synthesis.

Conclusions

We hope that participants will
1) take ownership of the consensus,
2) be motivated to bring reflection and debate to each country, and
3) try to implement some points of the consensus in their practice.

Equity Consensus Statement (PDF)

Click the icon to access the paper

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

WORKSHOP

Author: Maria Pilar Astier Peña (EQuiP, Spain), Seccion Internacional Semfyc/ Wonca Working Party on Quality and Safety
Co-Author: Jose Miguel Bueno Ortiz (EQuiP, Spain)

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

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

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

Aims
1) To present Medications without Harm Challenge

2) To describe crucial topics as transitional care, polypharmacy and high risk medications in primary care.

3) To present different tools to invite patients to use them for a safer use of medications.

4) To elaborate a plan for a safer use of medication in each participants' practice.

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

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

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

Quality Mental Health Care in General Practice:
Potential pitfalls and opportunities for success

WORKSHOP

Authors: Dr Stuart d'Arch Smith* & Dr Claire Marie Thomas**

Husband and wife team Dr Stuart d'Arch Smith, a psychiatrist, and Dr Claire Marie Thomas, a GP, will host this interactive workshop exploring what it means to provide quality mental health care in general practice, the potential pitfalls and opportunities are for maximising success.

Stuart d'Arch Smith & Claire Marie Thomas

Aim
This workshop aims to explore the full range of possibilities for improving mental health care delivery in primary care and for participants to leave with concrete actions to take home and apply.

Objectives
- To understand the burden that mental health places on the individual patient and health and social services
- To explore the notion of quality in the primary care mental health services
- To identify key quality indicators for primary care mental health services
- To analyse the strengths, weaknesses, opportunities and threats in delivering quality primary care mental health services
- For participants to develop SMART objectives to improve quality in the delivery of their local primary care mental health services

Methods
The workshop will open with a brief presentation on the importance of managing mental helath care well in general practice and the impact and opportunity costs to the individual and society of the rising burden of mental health problems.

Participant will be invited to share their experiences of managing both common mental health disorders (such as depression and anxiety) and in managing patients with more complex mental health needs.

From this sharing and exploration participants will be asked to define what they feel are key quality indicators/standards for the delivery of primary care mental health services.

We will then compare these participant defined standards with commonly recognised primary care mental health quality indicators/standards from the literature.

Returning back to group work we will ask participants to use a SWOT analysis tool to review the different quality indicators and identify strengths and weakness of their primary care systems in delivering these quality outcomes and threats and opportunities to achieving them.

Each participant will then be asked to identify 3-5 SMART objectives for improving the quality of mental health care in their practice, utilising the SWOT analysis to guide them.

Results/Conclusions
The outcomes of the working groups will be collated and reported through EQUIP and WONCA channels to provide a basic framework for addressing quality in primary care mental health.

Your Workshop Hosts
*MRCPsych MbChB
Psychiatry ST5, South London and Maudsley NHS Trust

**MRCGP DSFRH DTMH MbChB BMedSci
President, Vasco da Gama Movement
Salaried GP, Camberwell Green Surgery, London