Centrul Național de Studii pentru Medicina Familiei

OPEN MEDICAL INSTITUTE
Medical Education without Borders

UNIVERSITATEA BRASOV

Brasov, Romania
July 9-10 2007

Open Medical Institute Satelit Symposium in Family Medicine

NEW OPENINGS FOR FAMILY MEDICINE IN THE WORLD

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Program

9 July 2007

8:30 - 9:00	Welcome Address: Dean Prof.Dr. Mariana Radoi Introduce Speakers, Institutions and the Open Medical Institute
9:00 - 10:00	Health Care Systems in Evolution - Prof Dr. Lloyd Michener - Duke University, USA
10:00 - 11:00	Core Competencies in Family Medicine Prof.Dr. Manfred Maier- Medical University of Vienna
11:00 - 11:30	Coffee Break
11:30 - 12:30	New Models of Education - Dr. Gwen Murphy, - Duke University, USA
12:30-14:00	LUNCH
14:00 - 14:45	Ageing of the population- are family physicians prepared to face this problem? Assoc.Prof.Dr. Mădălina Manea, Craiova Univ. of Medicine
14:45-15:30	Gastrointestinal problems in the elderly- management particularities Prof.Dr.Viorela Enachescu, Univ. Medicină Craiova
15:30-16:15	Dementias - management problems in primary care: Assoc.Prof.Dr. Victoria Burtea - Faculty of Medicine Brasov, Assist.Univ.Dr. Corneliu Mosoiu
16:15-16:45	Wrap up of the day
17:00-18:00	Practice visit in Brasov

10 July 2007

9:00 - 10:00	Requirements for Team Care . Dr. Lloyd Michener - Duke University, USA
10:00 - 11:00	Disease Registries . Prof Dr. L. Michener, Dr. G. Murphy
11:00 - 11:30	Coffee Break
11:30 - 12.30	Roundtable Discussion: The burden of chronic diseases in primary health care- the concept of the Chronic care Model Dr.L. Michener, Dr.M. Maier, Dr.G. Murphy , Dr.A. Abaitancei, Dr.C. Isar, Dr.M. Marginean
12:30 - 14:00	LUNCH
14:00 - 15:00	Chronic Care Model. Integrated Care for Diabetes type 2 Dr. Cristina Isar – National Center for Studies in Family Medicine
15:00 - 16:00	European Practice Assessment - a Tool for Improvement the Quality in Family Medicine. Dr. Marius Mărginean – National Center for Studies in Family Medicine
16:00-17:00	Patients Assess the Quality of Family Medicine Practice, Dr. Andrea Abaitancei, Dr Marius Mărginean
17:00-17:30	Certificates Awarded Closing Remarks .

Foreword

Dear colleagues,

This year's Salzburg Satellite Symposium is hosted in the space of the Romanian medical reality.

Family Medicine has a longstanding tradition in our country but considering the new reality of joining the family of the European countries, Romanian family medicine will have to face several problems.

Developing the primary care team including in it professionals like physiotherapists, community nurses, social workers, stimulating group practices, personal and practice development through well designed continuing medical education, professionalizing the departments of family medicine and primary care, including trained family physicians as resources for the training of residents and students in the vocational training and in the continuing medical education process, developing the information system, strengthening research, quality assessment are only few of the projects that will have to be completed.

Generous groups of family doctors are actively involved to raise the professional standards and to align general practice to international levels.

In this purpose the National Centre for Studies in Family Medicine (NCSFM) together with the American Austrian Foundation and the Faculty of Medicine from Braşov have initiated this meeting.

We hope this days will be an occasion of building bridges between the professionals from different countries and different continents, of communication of ideas, making new contacts and renewing the older ones.

Together with all NCSFM members, I wish you a pleasant and constructive work at this conference

Dr. Andrea Abăităncei, MD
Project coordinator

Health Systems in Evolution

Prof.Dr. Lloyd Michener, MD

Healthcare systems in the United States and around the world are evolving rapidly. In the United States, the major forces for change have been cost, access to care, and concerns about quality of care. The United States spends more than any other country on health care, and both the total spent and the amount spent per person are increasing. Most individuals are partially protected from these costs, as most US citizens' health care are paid by the government or the employer. However, those who are unemployed, who work part-time, or who are self-paid, bear the full brunt of these expenses, and often find the US health care system an ideal that is out of reach. Similarly, most US citizens are accustomed to rapid access to both primary care practitioners and specialists. The latter is likely easier in the US than other countries, as the number of specialists in the US has been increasing for decades, spurned by the growth in income and prestige. Unfortunately, despite the enormous amount spent on health care, hospitals, doctors and drugs, the morbidity and mortality of the US population is not as low as might be expected. Diseases of inactivity and obesity abound (heart disease, stroke, some cancers), as does respiratory disease (related to cigarette use) and accidents (often related to alcohol abuse). In all, the majority of disease in the United States could, at least in theory, but prevented or mitigated by programs that focus on reducing unhealthy behaviors. Providing both treatment and prevention to patients is one of the challenges of contemporary family practice.

Health care in Austria has a tradition which goes back to the 19th century. It aims at free access to essential medical care, regardless of age, social background or health status. The system is built on solidarity of all citizens, which pay an obligatory premium towards health insurance out of their income; consequently, more than 99% of the population are covered by health insurance. The first contact with the health care system usually is the General Practitioner, who refers the patient to specialists or to the hospital if necessary. The benefits of the health care system include – among others – payments for consequences of illness or for inability to work, for pre-

ventive care or consequences of motherhood; further, dental care and rehabilitative services are also included. The health insurance company covers approximately 50% of health care costs, which amount to approximately 8% of the cross-national product. Most of the costs go to the hospital sector, 26% to ambulatory care and about 15% to medications.

The Austrian Health Care System can be considered to be highly developed in terms of professionals and technical equipment; however, this does not prevent underuse, misuse or overuse of health care services, which are major causes for increasing costs. Major problems are the high number of hospitals and the high number of beds, the high frequency of consultations in health care and the high admission rate to hospitals. Therefore, ongoing reforms of the system aim to cut down the hospital sector and the number of acute care beds, to harmonize and standardize diagnostic and therapeutic procedures and to promote health care services in the ambulatory sector.

Core-Competencies in Family Medicine

Prof.Dr. Manfred Maier, MD

Family Medicine is being recognized as an increasingly important element of modern health care systems, being popular with patients able to retain a personal relationship with their doctor in the increasingly impersonal world of health care delivery and with politicians because of its inherent cost effectiveness. To address these developments, WONCA Europe published a new definition of Family Medicine. At the outsight it was recognised, that the essential elements of the discipline of General Practice/ Family Medicine needed to be identified first. The definition contains eleven characteristics, which are fundamental to the discipline and are or should be generalizeable to all health care systems, regardless of contextual differences. These were then combined with the role description of the family doctor.

Further, the core competencies required to become a skilled exponent of the discipline have been defined and explored. These core competencies are the following:

1. Primary care management – this includes the management of

primary contacts with patients dealing with unselected problems and covering the full range of health conditions

2. Person centred care- includes the ability to adopt a person centred approach in dealing with patients and problems in the context of the patients circumstances and in order to bring about an effective doctor patient relationship with respect for the patients autonomy

3. Specific problem solving skills – this includes the ability to relate specific decision making processes to the prevalence and incidence of illness in a community and to adopt appropriate working principles such as incremental diagnostic investigations or using time as a tool and to tolerate uncertainty

4. Comprehensive approach – this includes the ability to manage simultaneously multiple complaints and pathologies, both acute and chronic health problems in the individual patient and to manage and coordinate health promotion, prevention, cure, care, palliation and rehabilitation for patients.

5. Community orientation – this includes the ability to reconcile both the health needs of individual patients and the health needs of the community in which they live in balance with available resources.

Holistic approach – this includes the ability to use the bio- psychosocial model in approaching patients, taking into account cultural and existential dimensions.

In applying these competencies to teaching, learning and the practice of family medicine, it is necessary to consider contextual aspects, attitudinal aspects and scientific aspects of the discipline.

New Models of Education Summary

Gwendolyn C. Murphy RD, PhD

Introduction

This session will describe the ACGME educational competencies, appropriate methods of teaching based on the skill being taught and how to measure educational outcomes.

By the end of this session the learners will be able to:

- Choose an appropriate teaching strategy for the task
- Define and give an example of an educational outcome
- Document an outcome measure for the ACGME educational competencies

Principles of Adult Learning

Past experience is crucial in providing a framework for new learning. Therefore, finding out what your learners already know helps you provide meaningful new information in a way that the learner can comprehend. When learners are active participants, they will learn the material more thoroughly. Learners tend to do things for which they are rewarded. Thus, it is important to positively reward desirable behaviors. A combination of positive reinforcement and constructive non-threatening criticism will be most effective. Behavior specific reinforcement is most helpful. In addition, practice is an important element in gaining knowledge, skills and attitudes.

Teaching Strategies

Teaching strategies include lecture, small group seminar, patient care, demonstrations. Use of standardized patients, reading, projects or written assignments, and computer assisted learning. You want to match the teaching strategy to the type of learning you are trying to encourage.

Educational Outcomes

Just as society is moving to measuring clinical outcomes, the trend is to measure educational outcomes. Educational outcomes are the evidence that competencies are met. Competencies are the clusters of skills, abilities and knowledge that are necessary to perform a task. In the United States, the Accreditation Counsel for Graduate Medical Education (ACGME) is an accrediting body for resident education. Over the last several years, the ACGME has come up with a list of six competencies on which residents must be measured. These include: patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism, systems-based practice.

Patient Care: compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

Medical Knowledge: established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Practice-Based Learning and Improvement: involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.

Interpersonal and Communication Skills: result in effective information exchange and teaming with patients, their families, and other health professionals

Professionalism: manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-Based Practice: manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Because residents come with differing knowledge, skills, and motivation, their education needs to be individualized to meet those needs. Those who have deficiencies will need additional resources to become competent.

Evaluation

The residency program must demonstrate that it has an effective plan for assessing resident performance throughout the program and for utilizing assessment results to improve resident performance. The Evaluation Plan should:

Use dependable measures to assess residents' competence

Provide regular and timely performance feedback to residents

Use assessment results for progressive improvements in competence/perfor-mance

Program Evaluation

The program should use resident performance and outcome assessment results in their evaluation of the educational effectiveness of the residency program.

Residency Programs should use increasingly more useful, reliable, and valid methods of assessing residents' attainment of these competency-based objectives.

Some examples of assessments include 360 degree evaluation, case logs, portfolios, checklists for evaluation of performance. Oth-

ers can be found in the ACGME Toolbox of Assessment Methods http://www.acgme.org/Outcome/assess/Toolbox.pdf

The demographic phenomenon of ageing- a challenge for family practitioners from România

Mădălina Manea, MD, PHD

Age distribution is an essential parameter in analyzing the structure of a population. It is important from the perspective of the demographic analysis and also for the determination of the economic potential and the public problems health of a country. Ages pyramid is the most used graph to show the structure of a population. The urn shape shows a population with a low natality rate and an important phenomenon of ageing. This is the Romanian situation. The last census from 2002 showed the following data: 0-14 years -17,8%; 15-64 years – 68,6%; 65 and over – 13,6%. In 2005 the same structure was: 0-14 years 11,5%, 15 - 64 years 69,5%, 65 years and over – 19%. This illustrates a significant increase in the rate of older population.

Which is the impact of this change in the practice of family physicians? In order to offer an answer have studied the activity of three family medicine practices located in an urban area. I have analyzed comparatively a period of a three months in winter and summer considering the types of persons asking for medical care and their diagnosis.

This is a retrospective study. The analysis is done between the years 2002-2005. Before the obtaining of statistical data, I have organized a brainstorming meeting with those 3 doctors that offered their patients list, in order to obtain their opinions on the estimated results. The results of the brainstorming showed that all of them agree on several aspects: there is an increase in the number of elderly with multiple co morbidities, it seems to be an increased requirement for preventive services dedicated for this age group, there is an increased number of severe diseases, the family doctor activity perceive the orientation of care on age groups, there is an increased number of mental health problems in the elderly. After the statistic analysis of the records, I have remarked a good matching between the brainstorming and the data collected. The study

doesn't have external validity because of a too small pool of data but it shows the permanent changes that family doctors have to face.

In conclusion the main transitions feature of the society that we have to live has rapid changes at all levels of human existence.

Care of the elderly with digestive problems in family practice

Prof.Dr. Viorela Enachescu, Dpt. of Family Medicine, University of Medicine and Pharmacy of Craiova

Gastrointestinal problems in older people cause a great amount of anxiety, morbidity and mortality. In general, patients with these diseases present for the first time to family practitioners. The management of gastrointestinal problems is more difficult because in an older age group, functional diseases can present in the same way as organic diseases. In addition, family practitioners see a different kind of patient than speciality physicians and may not have immediate access to diagnostic investigations. The optimal cost-effective approach to the patient with uninvestigated, uncomplicated dyspepsia (defined as upper abdominal pain or discomfort) remains a topic of great controversy: an initial trial of empirical management, reserving endoscopic evaluation for patients over the age of 45-55 years (who have an increased incidence of upper gastrointestinal malignancy), patients with "alarm" symptoms (such as dysphagia, protracted vomiting, weight loss, or evidence of gastrointestinal blood loss), and patients whose symptoms do not respond to an initial trial of empirical management.

The role of the family practitioner in screening for gastrointestinal problems in asymptomatic older people is explored. In addition, how they differentiate between organic and non-organic disease and refer appropriately to secondary care is discussed. The role of family practitioners in the on-going maintenance of gastrointestinal diseases and in the management of *Helicobacter pylori* in community dwelling older people is also considered. The incidence and prevalence of most digestive diseases increase with age. Notable exceptions are intestinal infections such as gastroenteritis and appendicitis, which peak among infants and children.

Other exceptions include hemorrhoids, inflammatory bowel dis-

ease, and chronic liver disease, which occur more commonly among young and middle-aged adults. Women are more likely than men to report a digestive condition, particularly non-ulcer dyspepsia and irritable bowel syndrome (IBS). Most digestive diseases are very complex, with subtle symptoms. Because of this, patients may undergo extensive and expensive diagnostic tests. Reaching a diagnosis requires a thorough and accurate medical history and physical examination. Once complete, a doctor may recommend laboratory tests, which may include a blood test, an upper or lower GI series, an ultrasound, and endoscopic examinations of the colon, esophagus, stomach, or small intestine. For more complicated cases, a doctor may order more sophisticated tests such as a CAT (computerized axial tomography) scan or MRI.

Dementias - management problems in primary care

Assoc.Prof.Dr. Victoria Burtea - Faculty of Medicine Brasov

Dr Corneliu Mosoiu- assist univ. Faculty of Medicine Brasov

People think that dementia is an inevitable part of the ageing process, which causes forgetfulness in elderly people and it is a myth that memory loss inevitably accompanies ageing. People living with dementia is expected to increase due to population aging and it is crucial that key health professionals such as General Practitioners (GPs) are able to respond appropriately to the needs of people with dementia.

GPs are often the first point of contact for people with memory loss or for family members concerned on another person's behalf. However, there is considerable variation in GPs' access to appropriate information to assist them in this role, their skills in diagnosis, assessment and management, their involvement of carers and attention to their needs. GPs can play a major role in diagnosis and ongoing management of people with dementia, frequently providing care and support throughout the course of the disease.

Although diagnosis of dementia is often a question of clinical judgement, a thorough assessment needs to be done, as there are a number of treatable conditions and illnesses with dementia-like symptoms which need to be eliminated. It is essential that anyone showing signs of confusion should be referred by GP to a medical

specialist for a full assessment.

Possible procedures for improved care should focus on an inter-professional understanding of the importance of early decision making and care of diagnosed demented patients. We should take into account an evaluation of possible consequences in terms of treatment, care and a comprehensive diagnostic evaluation.

Care Team

Prof.Dr. Lloyd Michener, MD

Goals: At the end of this lecture, learners will understand:

the team approach for caring for a patient with chronic illness the team approach for setting up an office to care for chronic illness successful functioning of a team

Objectives: Participants will be able to:

1. Explain how a team of providers can care for patients with chronic illness

2. Recognize the value to patients of having a team approach that fits their cultural background

3. Define roles for members of the team to address different diagnoses

4. Consider case management for complex patients

5. Explain how to use the team to evaluate the care of chronic illnesses

Define how a team works together

Summary (adapted from www.improvingchroniccare.org)

A patient comes to the office with uncontrolled diabetes. She has not been in to see the doctor for 8 months. Some of her issues in caring for herself may include family stress, finances, lack of understanding her illness and treatment plan, language barriers, and trouble making appointments.

Who can participate in her care?

Patients with chronic illness have a life system that has to function in the reality of the chronic illness. The needs patients have often exceed the training of the physician. To address the many needs of patients with chronic illness, non-MD providers have a lot to offer. Such providers include: health educators, social worker, nutritionist, interpreters, appointment personnel, nurses, and pharmacists.

To first understand the patient's barriers, a detailed history can be obtained by someone other than the physician. Then an action plan can be created with the patient's input. The appropriate team members can be consulted. Since the care of chronic illness takes on cultural and social tones, there may be personnel who have a particularly good understanding of the patient's cultural norms. It would be very helpful to enlist such a person's support, no matter what their professional skills may be.

Examples of the type of care providers suited to various diagnoses include:

1. Diabetes – nutrition, pharmacist , exercise counselor/physical therapy, patient educator, Social worker, family counselor

2. Hypertenion – nutrition, pharmacist, patient educator, exercise/PT, social worker, family counselor

3. Asthma – pharmacist, patient educator, nursing

4. Congestive heart failure – exercise, patient educator, nursing

5. Arthritis – exercise, pharmacist, nursing, Physical therapist

6. Back pain – exercise, Physical Therapist, pharmacist

Respiratory illness– exercise, PT, pharmacist, patient educator

For complex patients, sometimes it is most helpful to have one person, a case manager, oversee the care and services that might benefit a patient. Often, a social worker or nurse can play this role well. It should be someone who knows local resources well. The physician should have high respect for this person to let them help make important recommendations for the patient's care.

Improving the health of people with chronic illness requires transforming a system that is essentially reactive – responding mainly when a person is sick – to one that is proactive and focused on keeping a person as healthy as possible. That requires not only

determining what care is needed, but spelling out roles and tasks for ensuring the patient gets care using structured, planned interactions. And it requires making follow-up a part of standard procedure, so patients aren't left on their own once they leave the doctor's office. It is important to assess how well the doctor's office is meeting its goals in chronic illness care. Responsibility for these tasks can come from a team within the office. The team leader should define roles and distribute tasks among team members.

The combination of expertise and experience of several individuals can produce better quality results than the individual doctor working alone (A Note on Team Process, Harvard Business School, Oct. 4, 2001). Various tasks will need attention:

- patient intake
- education
- tracking
- guidelines
- patient readable guidelines
- follow-up
- cultural sensitivity
- evaluation
- leadership

Take time to evaluate your office:

1. Who is leading or can lead a chronic care initiative?
2. Are there incentives to participate in a chronic care team approach?
3. Who can link patients to outside resources?
4. Who is culturally sensitive?
5. Who can document patients' self-management needs?
6. Who can provide self-management support?
7. Who can support evaluation and feedback efforts?
8. Who can help organize planned visits?

Who can help create a reminder system?

To form a team, a leader needs to communicate a vision to the team. The team must agree on a shared goal and agree on the methods to achieve the goal. There must be shared accountability for achieving the goal. A collaborative climate and rewards and celebrations for goals achieved are crucial. New teams go through stages of development before they learn to work well together. The leader and team members will benefit from recognizing these stages exist: forming, storming, norming, performing.

It is important to remember that in chronic illness, in particular, patients are key members of the care team. To empower patients to participate, they can be:

a. given choices,
b. have needs respected,
c. asked about setting goals,
d. notified of community resources,
e. given consideration cultural issues,
f. consulted on a plan that fit daily life,
g. encouraged to plan ahead,
h. given follow-up contact ,
i. notified of the importance of visits to other specialists like eye doctors,
j. given a log book to monitor data,
k. asked about how family, work, etc impacted caring for the illness, reminded the importance of taking care of health

Evaluating patient's satisfaction with the care could involve: a patient satisfaction questionnaire, a patient grievance committee, a special patient committees for different diagnoses, advisory committees.

Disease Registries

Lloyd Michener, MD, Gwen Murphy, PhD, RD

The world of the primary care physician is often focused on the paper record, disorganized, reactive and limited to thinking and caring for one patient at a time. The burden of chronic disease is often underestimated as patients present with acute problems rather than return visits focused on their hypertension, diabetes, or arthritis. An ideal system might provide reminders to patients and physicians, identify sub populations needing proactive case management, facilitate individual patient care planning, as well as monitor performance of the physician and the practice.

A disease registry is a list of patients and their relevant clinical data that can be sorted by a condition or set of conditions in order to improve and monitor the care of the population. A disease registry provides multiple views of clinical information including point of care, between visits and status or summary reports. Clinical care guidelines are imbedded in the registry such as frequency of A1c

testing or frequency of laboratory monitoring for hypertension.

A disease registry can be paper and pencil or electronic. The steps to getting started and the set up of a card file system will be reviewed. There are several keys to success and common mistakes that will be discussed.

At the end of the session the participant should be able to list the key functions of a disease registry, list several web sources to obtain a registry, be capable of construction a card file system, and list the factors necessary to develop and maintain a successful registry.

Roundtable Discussion:
The burden of chronic diseases in primary health care- the concept of the Chronic care Model

Dr.L. Michener, Dr.M. Maier, Dr.G. Murphy , Dr.A. Abaitancei, Dr.C. Isar, Dr.M. Marginean

Health care systems are preoccupied for the increasing burden of chronic diseases. This phenomenon is due to population ageing and the increasing prevalence of certain chronic diseases, especially the non communicable ones.

In primary care, the quality of health services offered for chronic diseases isn't satisfactory. The main cause is obvious: trying to solve the complex problem of chronic diseases with a model of care structured mainly to respond to acute health care needs.

Why do we need a different model for chronic care? Because we speak about diseases with long term evolution that require constant monitoring and systematic interventions. Because we are talking about diseases with progressive evolution that affects the person entirely- its quality of life, its family life – as well as the community. Because we talk about diseases that require team work and interdisciplinarity. Solutions are given by integrated models of care, centered on patient needs, promoting interdisciplinarity and being supported by an evidence based approach.

The Chronic Care Model, as it was conceptualised by MacColl Institute for Healthcare Innovation and the Group Health Cooperative Center for Health Studies, Seattle, offers a framework for solving the above mentioned problems.

The chronic care model - delivering care for type 2 diabetic people

Dr. Cristina Isar, vice-president of National Centre for Studies in Family Medicine

Good chronic care services are wisdom in Romania as well as for other countries in the world. For Romanian diabetes care, 2007 means the start of an important shift: from care provided mainly by diabetologists, to comprehensive care provided by GPs in collaboration with other specialists.

The National Centre for Studies in Family Medicine is one of the leading organizations in the field of primary care improvement in Romania. In the last 4 years NCSFM developed projects aiming at providing decisional support instruments for GPs and their leading organizations, in order to coagulate efforts towards family medicine improvement.

In 2006 NCSFM provided technical assistance and training in a pilot project funded by USAID - Strengthening the Quality of Primary Care. NCSFM contributed to the development of a model of delivering chronic care in primary care settings for diabetes type 2 and hypertension.

The main focus was directed towards designing a model and implementing changes at the level of GP providers. Yet, in order to assure a coherent “trip and care” of the diabetic patient within the healthcare network (of a town or district), other activities took place.

GPs were encouraged to develop individual change plans, in order to make possible the implementation of the new guideline recommendations for diabetes and hypertension. (Guidelines were elaborated in 2005, from scratch, by the NCSFM) . They were encouraged to imagine all related changes, at all levels and then to priories changes at the practice level.

We redesigned the training programs for core knowledge for GPs and their nurses, based on the guidelines recommendations and trained pilot members.

We also developed, tested and finally adopted a “combined” initial evaluation and follow up form for hypertension and diabetes.

The next step was to clarify the needs for the electronic registry in monitoring. The specifications for the adaptation of MedINS software where prepared: registering risk factors and adapting the registry for hypertension and diabetes was also planned. The specifications were used as basis for contracting Insoft Timişoara, the IT experts who developed MedINS.

GPs and nurses had to develop themselves procedures for planned visits: role and task distribution etc. The importance of supporting the patient in self-care and realistic ways to improve that aspect, were addressed.

Despite the short time for action, results showed a better care delivered by family physicians to type 2 diabetic patients, then policlinic specialists that are overwhelmed by patients.

Yet, everybody involved in the project concluded, as expected, that the implementation of the chronic care model at the level of GP cannot be separated from implementation of the model at other levels of care, including the labs.

Chronic Care Model. Integrated Care for Cardiovascular Risk Factors and Hypertension

Dr. Andrea Abaitancei, Dr. Cristina Isar

The developing countries from the eastern European block are facing today , as noticed by World Health Organisation in its 2003 report, a increased burden from non communicable disease.

Of all the non communicable diseases, cardiovascular diseases are the leading group.

Figures like this ones that announce 16,6 million of people dying each year from cardiovascular diseases all over the world, or declared spending of 169 billion EU in Europe per year for cardiovascular diseases urge for a change of policies in this direction.

Recommendations from WHO expert consensus in 2003 considering individual approaches to high risk persons are centred on primary care and emphasise the following:

- adoption of context-specific management guidelines for non communicable diseases
- sustainable, accessible and affordable supply of appropriate

medication

- a system for the consistent, high quality application of clinical guidelines and for the clinical audit of services offered.
- a system for recall of patients with diabetes and hypertension

The presentation is describing a system of identification of high cardiovascular risk persons in primary care.

The results are from a pilot project sponsored by USAID and developed in 3 counties from Romania between July 2006 and March 2007.

The system is based on a stepwise approach conducted both by the doctor and the nurse from the family practice.

It consists of a screening questionnaire, a SCORE chart test to predict risk, of enrolment in practice based education sessions for identified patients, and of putting in place a recall system for follow up for identified high risk people.

Family practitioners from the study group participated in focus sessions to identify strength and weaknesses of the programme and to adapt the program to their identified needs.

Key words: cardiovascular diseases, risk evaluation, primary care, system of screening

European Practice Assessment - a Tool for Improvement the Quality in Family Medicine.

Dr. Marius Mărginean – President of the National Center for Studies in Family Medicine

The quality in health care delivery depends mainly of two factors: a good clinical practice and the way in which the services for patients are organised and provided.

By quality management we understand the way to ensure that activities are performed as they were planned, so we can prevent problems from the very beginning by establishing attitudes and

methods which make prevention of problems possible. But for this we need to organize our practice, to have methods, to have some rules .

The objectives of EPA – European Practice Assessment Collaboration were to develop an internationally validated tool for practice assessment to offer to general practices a tool to assess and improve their quality of practice management (using feedback, benchmarks and suggestions for improvement). Also, a way for international comparisons of practice management between practices, for country - specific purposes, e.g. practice accreditation and certification. The EPA instrument was developed by EQuIP, the quality group of Wonca.

The method tries to solve the crucial paradigm between formative and summative assessment. “Formative assessment“ is primarily educational and serves quality, the “summative assessment“ is organizational, deals with standards, and is driven by equality.

The target of our organization, the National Centre for Studies in Family Medicine was to offer an overview of actual situation of Romanian medical practices and to give suggestions for improvement for specific situation, and maybe to develope an educative model. We translated and adapted the EPA indicators and the software Visotool (developed by AQUA Institute from Germany), and we prepared the practice visitors which will make the assessments. We will start the evaluation process of some GP practices and in autumn we will have a national database that could be compared with the results from other countries.

When the EPA instrument will be assessed in the Romanian reality, we will decide if it is a good model for improvement of quality in health care provided by GP practices.

Patients roles in evaluating quality of primary care

Dr. Andrea Abaitancei, Dr. Marius Mărginean

When we practice medicine we think most of the times how to reach the highest standards of care, how to be most up to date with the last techniques, but we scarcely think, neither explore, what the opinion of our patients is.

In improving the quality of health care the ultimate criterion is the extent to which health care succeeds in meeting the (subjective and objective) needs of patients.

Aspects like quality of life, the accessibility of care, the organisation of services, the attitude of care providers, and their education, communication with the patient should be explored in order to provide quality care.

This should be in the attention not only of care providers but also in the attention of policy makers. A new role of the patient in the process of health care delivery should be imagined. Seeing patients as partners and sharing the decision with them will express the natural emancipation progress that our patients are traversing.

EUROPEP is a standardised European instrument for the evaluation of patient's satisfaction in primary care.

It was developed in 8 European countries initially and is now piloted in several other eastern European countries.

The National Centre for Studies in Family Medicine is running a pilot project on practice evaluation.

The presentations is emphasising the theoretical background on evaluation of patient's satisfaction and the importance of EUROPEP.

Key words:

Patient satisfation, quality of care, EUROPEP

The American Austrian Foundation

The Foundation In Brief

Bridging The Gap Through Knowledge Transfer &

Experience Exchange In Medicine, Culture & Media

America and Austria building a better Future.

Over Two Decades of Accomplishment & Service

The American Austrian Foundation was founded in 1984 by a group of Americans and Austrians with an interest in promoting a positive relationship between the two countries.

The AAF has grown from a bilateral initiative to a multilateral, international institution, partnering with NGOs, governments and private individuals, organizing postgraduate educational programs, and providing fellowships in medicine, media and the arts. The American Austrian Foundation is a public non-profit organization incorporated under the laws of Delaware and has 501(c)(3) status with the United States Internal Revenue Service.

An Established Network of Organizations

To secure government funding, provide tax benefits to donors and facilitate program operations in Europe, a number of related foundations and institutions were established including the Salzburg Stiftung of the AAF (an Austrian non-profit foundation), the German Friends of the AAF (a German non-profit foundation), the Vienna Chapter, The Society of Friends of the AAF and the Open Medical Institute (OMI). Our combined budgets have grown from modest beginnings to $ 3 million, funded by public and private institutions and donors.

Promoting “Brain Gain”, Preventing “Brain Drain”

One of the AAF's largest programs, the Open Medical Institute is a global initiative founded by The American Austrian Foundation, Weill Cornell Medical College, NewYork-Presbyterian Hospital and the Open Society Institute. OMI's objective is to expose midcareer level, English-speaking doctors from countries in transition to Western medical knowledge and technology by offering them multiple opportunities to attend seminars and internships. This allows them to continually update their skills without emigrating from their countries, thereby preventing "brain drain" and promoting "brain gain". Faculty members come from: NewYork-Presbyterian Hospital, The Children's Hospital of Philadelphia,

Duke University Medical Center, the Hospital for Special Surgery, Memorial Sloan-Kettering Cancer Center, Cleveland Clinic, Methodist Hospital and selected European medical centers.

Over the past ten years, 800 faculty members from the United States and Europe have trained more than 8,000 physicians from 90 countries including Africa and the Middle East.

Fellows must apply and if accepted attend on full scholarships. Faculty members serve pro bono.

Schloss Arenberg

A Center of Inspiration in the Heart of Europe

Parts of Schloss Arenberg date back to the 1300s. It has been a meeting place for artists and intellectuals over the centuries. In 2001, the Salzburg Stiftung purchased it to create a permanent

home for the foundation's programs. Here physicians and artists can take time out of their busy schedules, meet, exchange knowledge and ideas, update their skills and become part of an international professional network. The Open Medical Institute's Salzburg Medical Seminars convene at Schloss Arenberg and, during the festival season, members of the world-renowned Vienna Philharmonic Orchestra conduct a children's music camp and masterclasses for young musicians, reaching out to the next generation of classical music lovers.

Colleagues Help Colleagues

The best minds in medicine, art and media share their knowledge

and skills with younger, highly qualified colleagues. When these young colleagues return home, they share their newly acquired skills, raising standards in their respective disciplines for the benefit of their societies.

Capacity Building

The AAF's network consists of over 14,000 fellows from 90 countries and regions. By using internet-based technologies, fellows can stay in touch with their mentors and each other to continually update their knowledge and skills.

Schloss Arenberg, Milton & Roslyn Wolf Park, Würth Sculpture Garden

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