Community-based model to Primary Health Care (PHC): a practitioner perspective

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Community-based model to PHC: a practitioner perspective

1. Introduction: Universal Health Coverage, Sustainable Development Goals and PHC

2. The Micro-level

3. The Meso-level

4. The Macro-level

5. Competencies required to function in a PHC-team

6. Health Professional Education for PHC

7. Conclusion
Nano-level:

The person is the starting point of the process

- Active
- Informed
- Service
- Multicultural

Accessibility
Equity
Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- Complexity
- Coordination
- Continuity

Compassion ↔ Computer
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1978: Declaration on PHC in Alma Ata and ....

A view of the auditorium
1978: Start of Community Health Centre Botermarkt

- **1978** family practice in poor neighbourhood
- **1980** first nurse, social worker and foundation of the community health centre, not-for-profit organisation
- **1986** interprofessional team; inter-sectoral platform for health and wellbeing
- **1995** capitation financed system
- **1996** community oriented primary care
- **2006** teaching platform Ghent University
- **Today**: 6200 citizens from 95 countries
Community Health Centre
Botermarkt Ledeberg 2006
What is a Community Health Centre?

Community-oriented primary health care organizations with several common, core attributes:

• Interprofessional, primary health care teams
• Integrate primary care services with other health services, health promotion, and social/community services
• Address social determinants of health through direct services and local partnerships
• Engage community members in identifying priorities and planning services
• Responsible for defined local population, either geographical or by population group(s)
2017 Global Survey of Community Health Centres

Responses from 448 CHCs in 24 countries

TOP PRIORITIES IDENTIFIED BY CHCs GLOBALLY

1. Improve access to appropriate health and social services for individuals/groups that are marginalized due to race, ethnicity, sexual orientation, religion, citizenship status, language or other factors

2. Provide direct services that reduce negative impacts of social determinants such as poverty, lack of housing, unemployment

3. Document evidence of health and economic impact of CHCs

4. Influence healthy public policy related to social determinants of health such as housing, food security, education, employment and income security, etc)

5. Improve collaboration and performance among interprofessional primary care teams

http://www.ifchc.org/research/2017survey
Community Health Center Botermarkt Ledeberg!
INTERDISCIPLINARY TEAM

- Family physicians
- Administrative staff and receptionist
- Ancillary staff
- Dentists
- Dietician
- Health promotion worker
- Social workers
- Nurses
- External health care workers: physiotherapists, psychologists,…
Family Physicians

• **During the day 08.00-19.00**
  - Consultations and appointments
  - Home visits (12%)

• **At night** (from 19.00 until 08.00): **24/7**
  - Organised night-duty with other GP’s in Ghent

• **During the weekend** (Friday 19.00 pm to Mo 08.00 a.m.): **24/7**
  - One “on call” GP-posts per 100,000 inhabitants in Ghent
Nursing

• Appointments
  – Immediate (walk-ins) appointments available: care substitution

• Home care for patients with mobility limitations
Nursing Responsibilities

• **Curative care**: wound care, ear irrigation, wart treatments, palliative care,…

• **Prevention**: flu vaccinations, contraceptive injection…

• **Diagnostic Procedures**: ECG, blood tests, spirometry,…

**Empowerment**: Diabetes Clinic, inhaler-training appointments
Care Substitution

Care is provided by the person most equipped for the task and most knowledgeable about the subject. Subsidiarity is the principle!
2006: Accessible Dental Care and Oral Hygiene
PATIENT, FAMILY, PHYSICIAN, NURSE, DIETICIAN, SOCIAL WORKER…:
1 ELECTRONIC PLATFORM
**Diabetes clinic: empowerment**

**Programme:**
- Contact with family physician: 1 x /year; biomedical and behavioural follow-up by the nurse: 4 x /year, following specific guidelines
- contact with dietician/diabetes educator (2 x / year)
- enabling patients to exchange experiences via group activities
- “diabetes-cooking” (3 x / year)
Diabetes Fair

- Presentation of 7 Self-care Behaviors, including cooking workshops & fitness classes
Social Work

- 2 FTE social workers
- Social work in the health centre includes:
  - first intake, exploring the problem
  - information and counseling
  - advocating, mediating
  - supporting, psychosocial guidance
  - undocumented residents
  - administrative support, application for allowances, budget-planning
  - establishing patient centered networks of care
Integrated care

- Comprehensive goal-oriented approach!
- Taking environment/context at home into account!
- Coordination by patient, informal caregivers, professional
What really matters for people is

• Functional status

• Social participation
Illness prevention & Health promotion

- Individual illness prevention
- Group-based illness prevention
- Health promotion in the community
PATIENT INVOLVEMENT IN HEALTH LITERACY PROGRAM
LEDEBERG MOVES!

Various activities

- Zumba
- Sport after school
- Learning to cycle
Local Network: Society Welfare Health

• In order to work together on a local level to tackle poverty
• 1986: first community welfare meeting in Ledeberg
• Approx 40 participants from different organisations
• Tri-monthly meetings
Local Network: Society Welfare Health

GOALS

- Coordination: City of Ghent
- Obtaining local congruence on health and welfare themes
- Signalising to policy makers
- Sharing information
- Sharing expertise
- Creating a Learning Community
Community-Oriented Primary Care: Health Care for the 21st Century

- Define & Characterize the Community
- Identify Community's Health Problems
- Develop Intervention
- Monitor Impact of Intervention
- Involve the Community

Edited by Robert Rhyne, M.D., Richard Bogue, Ph.D., Gary Kukulka, Ph.D., Hugh Fulmer, M.D.
Figure 1.2: The COPC Process

Define and Characterize the Community

Monitor Impact of Intervention

Involves Community

Identify Community's Health Problems

Develop Intervention
COPC-project: children’s physical condition

- Consultation: problematic physical condition
COPC-project: children’s physical condition

• Survey: children were two times longer in front of television and videogames, and had less physical activity compared to the flemish youngsters
COPC-project: children’s physical condition

- Community diagnosis: lack of playgrounds
COPC-project: children’s physical condition

- Intervention 1: construction of playgrounds
COPC-project: children’s physical condition

• Intervention 2: organisation of activities
COPC-project: children’s physical condition

- Evaluation:
  - ↓ street criminality
  - ↑ social cohesion
  - ↑ physical activity
Integration of personal and community health care

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

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“Organizing primary care in decentralized entities, for example, primary care zones (PCZs), can contribute to the visibility of primary care. Defining the population that accesses a certain group of services and providers in primary care, can contribute to the accountability of providers in terms of outcomes, access and quality of care.”

Everybody Counts!
No one should be left behind!
PRIMARY CARE ZONE: MESO-LEVEL: 70,000-125,000 INHABITANTS

Flemish Region of Belgium
(2018)
PRIMARY CARE NETWORKS: > 5,000 INHABITANTS (RURAL)  
> 10,000 INHABITANTS (URBAN)
CITY HEALTH COUNCIL/ PRIMARY CARE ZONE: INTEGRATION PRIMARY CARE, PUBLIC HEALTH, SOCIAL SECTOR
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FINANCIAL RESOURCES:

° INCREASE INVESTMENT IN HEALTH CARE: BY 2050 COUNTRIES SHOULD SPEND 15 % OF GDP ON HEALTH (see e.g. ABUJA DECLARATION - 2001: 15 % OF ANNUAL GOVERNMENT SPENDING IN AFRICAN COUNTRIES SHOULD GO TO HEALTH CARE )
° REDISTRIBUTHEALTH CARE RESOURCES TOWARDS PRIMARY HEALTH CARE: AT LEAST 25 % OF HEALTH CARE BUDGET SHOULD Be INVESTED IN PHC
Time to Do the Right Thing: End Fee-for-Service for Primary Care

Michael K. Magill, MD

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Current fee-for-service (FFS) payment rates for physician visits trace to the origins of Blue Cross Blue Shield insurance in the 1930s. At that time, rates were set that paid generously for hospitalizations and for procedures, such as surgery. Payments for so-called “cognitive services” were lower per minute of physician time. This disparity has been perpetuated since the 1980s in the calculation of rates set by the Centers for Medicare & Medicaid Services (CMS), based on “Relative Value Units,” for payment of the Evaluation and Management codes most often billed by primary care physicians. Despite recognition by the Medicare Payment Advisory Commission (MedPAC) and others of the adverse effects of inadequate payment for primary care, only limited progress has been made toward correction of the disparity. This may be due, at least in part, to treatment of total payment for physicians as a zero-beginning in 1945 and expanded in the Health Maintenance Organizations (HMOs) of the 1980s and 1990s.

Following collapse of many of the HMOs, payers have experimented with multiple smaller changes in payment models, mostly incremental adjustments to existing FFS, perpetuating structural disadvantages for primary care.

In this issue of the Annals, Basu, et al report on their study in which they calculated potential effects on primary care practice costs and revenue resulting from 3 modifications of FFS payment: increased FFS, traditional FFS plus per-member per-month (PMPM), and traditional FFS plus PMPM plus pay-for-performance (P4P).

The authors drew on extensive published literature about how primary care practices can staff and organize to deliver patient-centered medical home (PCMH) services such as enhanced access, care management, and alternative visits, and the impact of these changes on revenue and expense within the practices. The authors created simulated models of these financial effects based on detailed profiles of patient demographics, insurance coverage, and disease burden. They conducted tens of
The integrated needs-based mixed capitation system:

- stimulates prevention, health promotion and self-reliance of the people,
- as there is a global payment for all disciplines, there is an incentive to task-shifting and subsidiarity,
- prevents risk selection
- stimulates a global approach to a broad range of problems, avoiding the fragmentation and disease-orientation
The “needs-variables”

- Demographic variables
- Social-economic variables
- Morbidity variables
- Contextual variables
34 countries:
- 26 EU countries
- Plus Iceland, Norway, Switzerland, Turkey and FYRO Macedonia
- Canada, Australia, New Zealand

Linked survey data from:
- 7,000 Family Physicians
- 70,000 patients

Multilevel analyses
- Health care system
- Family physicians and their practice
- Patients
Community orientation of family physicians: evidence

- More community-oriented PC physicians:
  - provide a broader range of services, in particular preventive services
  - they use their medical records system more often to produce overviews of their practice population
  - List system → more community orientation
- More than average share of people from ethnic minorities in the practice area → stronger community orientation
- More than average share of socially disadvantaged people and/or ethnic minorities → broader skill mix (more different professions in the practice)
- More continuity in primary care → lower rates of avoidable diabetes-related hospitalization
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THE FIVE STAR DOCTOR

- assess and improve the quality of care
- make optimal use of new technologies
  - promote healthy lifestyles
- reconcile individual and community health requirements
  - work efficiently in teams
- leadership attributes and acts as change agent
THE LANCET

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

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

The Lancet 2010;376:1923-58
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Vision statement

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

Barbara Krekels
Prof. Jan De Maeseneer
SEEKING NEW ANSWERS

A MORE GENERALIST APPROACH NEEDED
the demands and needs changed significantly
the complexity is of a different order
no standard solutions but a generalist approach required

CONNECTEDNESS AS A PRECONDITION FOR AUTONOMY
connecting people
necessary that a solidarity framework exists in society in which professionals and citizens can shape a care and support relationship
the quality of living together
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Defined & Characterize the Community

Involve the Community

Identify Community's Health Problems

Monitor Impact of Intervention

Develop Intervention

Edited by Robert Rhyne, M.D., Richard Bogue, Ph.D., Gary Kukulka, Ph.D., Hugh Fulmer, M.D.
Visit to a family living in poverty
Exploration in the neighbourhood
Confronting experiences
Making a community diagnosis
An Interdisciplinary Community Diagnosis Experience in an Undergraduate Medical Curriculum: Development at Ghent University

Bruno Art, MD, Leen De Roo, MA, Sara Willems, MA, PhD, and Jan De Maeseneer, MD, PhD

Abstract

Since 2002, the medical curriculum at Ghent University has incorporated a community diagnosis exercise, teaming medical students with master of social work and social welfare studies students. The course focuses on the interaction between the individual and the community in matters of health and health care.

During one week, small groups of students visit patients and their caregivers in six underserved urban neighborhoods, and they combine these experiences with public health data, to develop a community diagnosis. Local family physicians and social workers monitor sessions. The course requires students to design an intervention tackling one community health issue. At the end of the course, the students present their diagnoses and interventions to community workers and policy makers who provide feedback on the results.

In the authors’ experience, medical and social work students all value the joint learning experience. The occasional culture clash is an added value. The one-week course is very intensive for students, mentors, and cooperating organizations. Although students criticize time restraints, they feel that they reach the outlined objectives, and they rate the overall experience as very positive.

The authors find that this interdisciplinary, community-oriented exercise allows students to appreciate health problems as they occur in society, giving them insight into the interaction of the local community with health and health care agencies. Combining public health data with experiences originating from a patient encounter mimics real-life primary care situations. This campus–community collaboration contributes to the social accountability of the university.

Learning from patient experiences
Students from nursing, medicine, management, health promotion
Number of graduated Family Physicians in Flanders

AT LEAST 50 % OF GRADUATES SHOULD TRAIN FOR PHC !
Graz, The Network: Towards Unity for Health conference 2011
WORLD SUMMIT ON SOCIAL ACCOUNTABILITY
In conjunction with the Annual Meeting of The Network: Towards Unity for Health (TUFH)
IMPROVING THE IMPACT OF EDUCATIONAL INSTITUTIONS ON PEOPLE’S HEALTH

8-12 April 2017 · Hammamet · Tunisia

We can’t solve the world’s health problems in silos
This summit will provide the synergy needed to make global changes together!

WHY ATTEND?
We must foster socially accountable health and educational systems to advance universal health coverage and the WHO strategy on human resources for health. These goals can be achieved if
THEnet’s Evaluation Framework for Socially Accountable Health Professional Education
- 92% of students come from Northern Ontario
  - Indigenous (7%)
  - Francophone (22%)
- 62% family medicine, mostly rural
- 69% of NOSM residents stay in Northern Ontario (22% remote rural)
- 94% NOSM MD who do residency in N Ontario stay in the region (33% in remote rural)
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Questions for Health Professional Education

- Alma Ata Declaration on PHC has been operationalised in accessible, quality community-oriented practices, putting people first, contributing to health equity.
- How to act as Socially Accountable institutions, and train and retain the appropriate PHC-workforce to be responsive to the needs of the community?
- How to train the required skills for comprehensive person- and people-centred care in the community?
Questions for Health Professional Education

• How to prepare students to be able to function in interprofessional teams with appropriate skill-mix?
• How to engage students in addressing Social Determinants of Health through inter-sectoral action?
• How to train professionals that act as health advocates and change agents in PHC?
• How to ensure care for PHC-providers with appropriate work-life balance and a sustainable commitment to communities?
Jan De Maeseneer

Family Medicine and Primary Care

At the Crossroads of Societal Change
PHC MAKES A DIFFERENCE BY CONTRIBUTING TO INTERRELATED CONNECTEDNESS AND SOCIAL COHESION
Thank you...

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Thanks for your attention…

QUESTIONS?