EQuiP

European Association for Quality and Safety in General Practice/Family Medicine

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Newsletter

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Aurore Girard

28th WONCA Europe Conference, 7-10 June, 2023, Brussels, Belgium

"MAKING CHOICES IN PRIMARY CARE"



Dear Friends and Colleagues, hello to you all!

Let's start by introducing ourselves:

My name is Aurore Girard, I am the Vice-President of Société Scientifique de Médecine Générale (member of the Belgian Society for General Practitioners) and I have the privilege to chair the Host Organising Committee for the 28th WONCA Europe conference in Brussels from 7 to 10 June 2023.

My name is Ann Van den Bruel - I'm a GP in Antwerp and an Associate Professor at the KU Leuven in Belgium, and the Chair of the Scientific Committee of WONCA Europe 2023.

It is our pleasure to welcome you to the capital of more than 500 million Europeans. As the centre of European culture and institutions, Brussels has much more to offer than most people imagine. Apart from its famous chocolates and beers, there are almost 90 museums, beautiful parks, architecture, bars and much more.

Our conference theme is: 'Making choices in primary care'.

The Scientific Committee is preparing an exciting programme based on original abstracts and contributions from leading international scientific networks and special interest groups.

Coming together as a research community, WONCA 2023 will showcase cutting edge research to support primary care in Europe.

The conference will give us all a chance to meet, discuss choices and implement positive change. See you soon in Brussels!

Aurore Girard
President WONCA Europe Conference 2023

Event website: https://www.woncaeurope2023.org/

https://twitter.com/woncaeurope2023

https://www.facebook.com/WONCAEurope2023





IPCRG 7th Scientific meeting 15-16 May 2023, Munich Germany

Ee Ming Khoo **Siân Williams**

The IPCRG, a WONCA Europe Special Interest Group, is delighted to announce that the 7th IPCRG Scientific Meeting will be held in Munich, Germany, 15-16 May 2023.

The meeting will provide primary care researchers, innovators, and leaders in respiratory care the opportunity to present their research for peer review, test out new ideas for real life research, foster high quality exchange about what primary care needs to improve performance, build capacity and strengthen global research networks.

The conference programme is being built by our Research Leadership Team and other scientific colleagues, seeking ideas from our network.

The conference will take place at the Maritim Hotel, Munich, Germany.

We are working with our German Group led by Univ.-Prof. Dr. med. Antonius Schneider and are picking up the successful series of scientific meetings that took place prior to the pandemic.

The meeting will also include an optional introductory course in qualitative research as part of our drive to build research capacity in primary care. This course will have remote learning blocks before and after the meeting and will be a high quality learning opportunity for our colleagues. Please share this opportunity with early-to-mid-career researchers you work with and ask those who are to contact neil@ipcrg.org.

Abstracts

Registration and abstract submission will open on 21 December 2022, with abstract submission closing on 15 March.

We welcome abstracts on clinical research, service development/improvement, and research ideas on themes related to respiratory health, including but not limited to air quality, tobacco use and dependence, physical activity, breathlessness, cough, asthma, COPD, multi-morbidity including chronic respiratory disease, respiratory infections, COVID-19 and post-COVID syndrome.

Draft programme

The meeting has an opening and closing plenary; the rest is parallel workshops to discuss research abstracts, interspersed with refreshment breaks.

We are extremely pleased to be able to return to our normal schedule for face to face meetings and have committed to holding a Scientific Meeting in the 'odd' years when there is no IPCRG World Conference.

Put the 15th and 16th May 2023 in your diaries now!

We will keep our conference webpage updated with the latest information: https://www.ipcrg.org/Munich2023

Ee Ming Khoo
President IPCRG

Siân Williams
CEO IPCRG

Graduate program POKAL in Munich

Jonas Raub, Hannah Schillok, Dr. Kirsten Lochbühler, for the POKAL-Group (DFG-GRK 2621)
https://pokal- kolleg.de/

In 2021, the two institutes for general medicine at the Ludwig-Maximilians-University and the Technical University Munich secured funds from the German Research Foundation (DFG, DFG-GRK 2621) to establish the graduate program POKAL (predictors and clinical results in patients with depression in the general practice setting).

The objective of the program is twofold. First, it aims to improve health care for patients with depression and multimorbidity in the primary care setting. Second, it provides training in both medical practice and research in order to prepare trainees for their career as clinician scientists.

The first cohort of the program consists of 16 trainees with a diverse background ranging from general practice, to pharmacy, psychology, public health, and informatics.

Each trainee participates in a three- year program and is supervised by an experienced principal investigator (PI).

Funding is provided for at least 6 years, offering the opportunity to train a second cohort starting in 2024.

The program includes nine projects within the framework of the Chronic Care Model (CCM), each of which addresses specific challenges in primary depression care.

Particularly, they focus on the diagnosis (reliability of diagnosis, prediction models, and ignoring suicidal risks), the treatment (insufficient patient involvement, highly fragmented care, and inappropriate long-time anti-depressive medication) and the implementation of innovation (insufficient guideline adherence, use of irrelevant patient outcomes, and ignoring relevant context factors).

The first cohort of the POKAL research training group will develop and test new depression-specific diagnostic instruments (hermeneutical strategies, predicting models, screening for suicidal ideation), aspects of treatment (primary-care based psycho-education, modulating factors in depression monitoring, strategies of de-prescribing) and their implementation in primary care (guideline implementation, use of patient-assessed data, identification of relevant context factors).

Based on those results, a second cohort of trainees and their PIs will conduct two major trials to prove innovations in primary care-based diagnostics and treatment for depression.

Published article

Gensichen, J., Lukaschek, K., Jung-Sievers, C. et al. Predictors and outcomes in primary depression care (POKAL) – a research training group develops an innovative approach to collaborative care. BMC Prim. Care 23, 309 (2022).

https://doi.org/10.1186/s12875-022-01913-6

https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-022-01913-6

Audit of the Carbon Footprint of Inhalers in an Irish General Practice

S. Owens, S. Garavaglia, E. Mc Dermott, M. Baxter, K. Whately, S. Maroof
Blackrock Medical Centre, Dundalk, Co. Louth, Ireland.

Source: *Ir Med J*; Vol 114; No. 6; P393. Access here.

The climate crisis has been described by the Lancet as 'biggest global health threat of the 21st century'. There is a paradox in that the healthcare we provide may exacerbate the climate crisis; it is estimated that global healthcare has a carbon footprint that exceeds most Western countries. There is a paucity of literature showing how we can decarbonise healthcare.

The most frequently employed therapeutics for respiratory are inhalers which vary in class, use and importantly carbon footprint. Multidose Inhalers (MDIs) contain hydrofluorocarbons which have a disproportionate effect on the carbon footprint of healthcare.

The NHS estimates inhalers account for 3% of their entire carbon footprint and have identified inhaler prescribing as a target to achieve 'net zero' by 2040.

Soft Mist Inhalers (SMIs) and Dry Powder Inhalers (DPIs) do not contain hydrofluorocarbons and so have a fraction of the carbon footprint than MDIs.

The number and type of prescribed inhalers in a mixed rural urban GP practice was determined retrospectively January-June 2020.

An educational team intervention was performed aiming to switch MDIs to DPIs where appropriate, with patient counselling and consent and in line with best practice. Inhaler prescribing was re-audited July-December 2020 and the carbon equivalent difference estimated.

Over the six months of the duration of the audit a potential saving of approximately 21,448 kg of CO2 was achieved.

Targeting inhaler prescribing offers the potential to significantly improve the carbon footprint of Irish healthcare.

The carbon saved by changing MDIs to DPIs and SMIs in this audit is the equivalent of driving around the globe twice or charging almost 3 million smartphones.

DPIs and SMIs may also improve drug delivery, improve compliance, reduce waste and reduce costs associated with unscheduled care.

Targeting inhaler prescribing offers the potential to significantly improve the carbon footprint of Irish healthcare and importantly these savings will continue on into the future.

Reducing the carbon costs of inhalers offers healthcare a rare triple win; better health for the patient, better health for the planet, and monetary savings from improved disease management.

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Contacts in general practice during the COVID-19 pandemic:
a register-based study

Background
The COVID-19 pandemic has altered the provision of health care and expanded telehealth consultations.

Aim
To study the effect of the COVID-19 pandemic on contact patterns in general practice, and to identify patient groups at risk of losing care.

Design and setting
Register-based study of Danish general practice, including daytime and out-of-hours (OOH) services.

Method
All individuals residing in Denmark from 1 January 2017 to 31 October 2020 were included.

The incidence rate for six contact types in general practice and adjusted incidence rate ratio were calculated by comparing the incidence rate in the pandemic period with the adjusted expected incidence rate based on the incidence rate in the pre-pandemic period.

Results
The number of face-to-face in-clinic consultations declined during the lockdown in March 2020.

A subsequent increase in the number of clinic consultations was observed, rising to a level above that of the pre-pandemic period; this increase resulted mainly from the introduction of telehealth consultations (that is, video and extended telephone).

The number of daytime email consultations increased, whereas the number of daytime home visits decreased.

Likewise, the number of OOH telephone consultations increased, whereas the number of OOH home visits and clinic consultations decreased.

Consultation rates of patients who are vulnerable, that is, those with low education, old age, and comorbidity, were most adversely affected by the pandemic.

The most adverse impact in OOH clinic consultations was seen for children aged 0-9 years.

Conclusion
New methods are called for to ensure access to general practice for patients who are vulnerable during a pandemic.

The potential of telehealth consultations should be further investigated.

Keywords
COVID-19; general practice; health equity; primary health care; telemedicine.

Cite
Huibers L, Bech BH, Kirk UB, Kallestrup P, Vestergaard CH, Christensen MB. Contacts in general practice during the COVID-19 pandemic: a register-based study. *Br J Gen Pract.* 2022 Oct 27;72(724):e799-e808.

doi: 10.3399/BJGP.2021.0703.

SUSTAINABILITY FOR PLANETARY HEALTH:
A SEVENTH DOMAIN OF QUALITY IN PRIMARY CARE

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Abstract
Climate change is one of the biggest threats to public health. Sustainability is characterized by using resources wisely in a way that protects finite resources and the environment, and takes into account the needs of our planets' inhabitants in the future.

Sustainability in health care should be considered as a seventh domain of quality, as it can lead to improvement of patient outcomes, and more capacity for health care workers to engage in quality improvement and thereby improve the quality of care.

The carbon footprint of primary care is high, mainly due to prescribing medication, but also due to the transport of patients to hospitals and primary care services for interventions requested by family medicine.

Other causes are the transport of staff and supplies, consumables and staff involved in laboratory analysis and radiation, medical and non-medical equipment, clinical and non-clinical waste, heating and cooling systems and other activities.

Small adjustments in these areas could significantly decrease the carbon footprint of primary care practices.

The suggested steps for primary care to achieve a more sustainable practice are fostering research, raising awareness, reducing the burden on primary care, engaging in quality improvement, and leadership and advocacy.

Each individual primary care practice has the potential to be a leader and role model for sustainable health care.

With the implementation of interventions to reduce carbon footprints, primary care could set an example within the health sector and for patients.

This could significantly raise the awareness of the public about the need to take actions for a greener health system.

Source
Klemenc Ketis Z, Rochfort A. Sustainability for planetary health: a seventh domain of quality in primary care. Zdr Varst. 2022;61(4):198-200.

doi: 10.2478/sjph-2022-0026.

What role do patients prefer in medical decision-making?

a population-based nationwide cross-sectional study

Objective

To assess patients' preferred roles in healthcare-related decision-making in a representative sample of the Portuguese population.

Design

Population-based nationwide cross-sectional study.

Setting and participants

A sample of Portuguese people 20 years or older were interviewed face-to-face using a questionnaire with the Problem-Solving Decision-Making scale.

Outcomes

The primary outcome was patients' preferred role for each vignette of the problem-solving decision-making scale. Sociodemographic factors associated with the preferred roles were the secondary outcomes.

Results

599 participants (20–99 years, 53.8% women) were interviewed.Three vignettes of the Problem-Solving Decision-Making scale were compared: morbidity, mortality and quality of life.

Most patients preferred a passive role for both the problem-solving and decision-making components of the scale, particularly for the mortality vignette (66.1% in the analysis of the three vignettes), although comparatively more opted to share decision in the decision-making component.

For the quality of life vignette, a higher percentage of patients wanted a shared role (44.3%) than with the other two vignettes.

In the problem-solving component, preferences were significantly associated with area of residence ($p<0.001$) and educational level ($p=0.013$), while in the decision-making, component preferences were associated with age ($p=0.020$), educational level ($p=0.015$) and profession ($p<0.001$).

Conclusions

In this representative sample of the Portuguese mainland population, most patients preferred a practitioner-controlling role for both the problem-solving and decision-making components.

In a life-threatening situation, patients were more willing to let the doctor decide.

In contrast, in a less serious situation, there is a greater willingness to participate in decision-making.

We have found that shared decision-making is more acceptable to better-educated patients in the problem-solving component and to people who are younger, higher educated and employed, in the decision-making component.

Citation

Gregório M, Teixeira A, Henriques T, et al. What role do patients prefer in medical decision-making?: a population-based nationwide cross-sectional study. BMJ Open 2021;11:e048488.

doi: 10.1136/bmjopen-2020-048488.

61st EQuiP Assembly Meeting in Zagreb,
22-24 September 2022

During the peak times of the COVID-19 pandemic we met online, even hosting our annual spring conferences online.

On 11th & 12th March 2022, we held a two day online event for the 60 th meeting of EQuiP.

The theme was 'The Future of Primary Care: Securing & Sustaining Quality for Everyone' when we explored quality of care for patients and quality of work for primary care clinicians. Read more here: www.qualityfamilymedicine.eu

In September, the EQuiP network met in person for the first time since the pandemic, in Zagreb, Croatia.

The meeting was held in the beautiful Croatian Institute for Brain Research, School of Medicine, University of Zagreb, and was opened by representatives from University of Zagreb School of Medicine.

We solemnly paid tribute to the hard work and warm friendship of our two EQuiP colleagues who died since our last meeting, Dr Dijana Ramic Severinac, Croatia and Dr Isabelle Dupie, France. May they rest in peace. We thanked their families for sharing these two wonderful family doctors with the 'EQuiP family'.

We welcomed new members, and began with the traditional business meeting, website updates and finances.

Dr Jose Miguel Bueno Ortiz delivered a report on WONCA Europe (WE) Executive Board activities, WE newsletter, Twitter account and Facebook page. He also reported from the WONCA World Working Party on Quality and Patient Safety.

During Day 2 we had several topics. One was PRICOV19 (https://pricov19study.ugent.be/), a globally unique and ambitious research project involving 45 academic departments and national colleges from 38 countries (37 European countries and Israel).

The EQuiP members at Ghent University Belgium have gathered data on the way family medicine and primary care organised itself during COVID-19 and have already begun to publish the multiple research papers in peer-reviewed journals. Many more are on the way.

Study protocol published

Van Poel, E., Vanden Bussche, P., Klemenc-Ketis, Z. et al. How did general practices organize care during the COVID-19 pandemic: the protocol of the cross-sectional PRICOV-19 study in 38 countries. BMC Prim. Care 23, 11 (2022).
https://doi.org/10.1186/s12875-021-01587-6

We had a plenary Session on existing and new Working Groups (WGs) and Projects, Outputs, Collaborations, Teamwork, Leadership and Communications. Also, we had an offsite visit to a Croatian family practice.
We had such a productive meeting, seeking 2 workshops to submit to WONCA Europe 2023 in Brussels, and coming up with 9 finalists and had to vote on the top 2 to go forward! The others will also be prepared as specific projects or abstracts for submission.

Prof Goranka Petricek, Dr Eva Arvidsson and Dr Piet van den Bussche gave us impressive presentations and Dr Andrée Rochfort, chaired the three day meeting.

Some delegates joined us virtually at the opening session and the closing session on Day 3.

The energy and innovation among the delegates was palpable and we look forward to planning
the EQuiP Spring Conference 2023, details to follow.

Read more:

https://www.woncaeurope.org/news/view/61st-equip-assembly-meeting-in-zagreb-22-24-september-2022

Immigrant Health Experience of an Education Family Health Center in Turkey

By Ogulcan Cöme, Mehmet Yeral, Vildan Season,
Dokuz Eylul University Faculty of Medicine, Department of Family Medicine, Izmir, Turkey



The health status of the immigrant enters a new interaction process after arriving in the destination country. The immigrant needs information about the new country. The integration process that takes place after arrival in the destination country plays a key role in the health of the immigrant. Migration, which affects the society and individuals politically, socially, culturally and economically, brings health problems with it.

Especially in the 20th century, mass migration movements increased. There are approximately 1 billion immigrants in the world today. Wars have a special place in mass migrations. Migration resulting from the war primarily affects neighboring countries.

After the Syrian war, Turkey experienced an intense wave of migration. Turkey hosts the highest number of refugees; from among more than 2.18 million Syrian refugees, 267,000 live in 25 camps in 10 cities. The remaining majority live in big cities. About three out of every four Syrian refugees who are not in the camps live in a house or apartment, which is generally very crowded, with around 62% living with seven or more people. In and out of the camps, the Turkish Ministry of Health provides free health care.

Among the reasons why Syrian immigrants prefer our country more, such as the closeness of our borders, the fact that they can pass more easily, and they think that they can live in humanitarian conditions. Regardless of the reason, one of the most important problems of immigrants who have migrated to our country is their ability to receive health services.

Migration is an important social determinant of health. Each country produces new health policies for immigrants according to its own health system. These policies are closely related to the immigration policies of that country.

Turkey has been experiencing domestic migration for 40-50 years, so the health system and health workers have been able to come up with this issue over the years, but external migration has been a phenomenon for the last 15 years. The adaptation of the health system to this is still not achieved, and there are still many difficulties. The most important problems experienced in terms of Family Medicine Health Centers are communication problems and health problems that immigrants have specific to their own culture and places they live.

Turkey is a crowded country with a population of 83 million living in 81 provinces. Izmir, one of these provinces, is one of the leading cities in the Aegean Region in terms of economic, historical and socio-cultural aspects. İzmir is the third city with population density and the highest number of Syrian immigrants. It is also a developed city in terms of health and education infrastructure.

There are many well-established universities in the city. Dokuz Eylül University (DEU) is one of such universities.

DEU has many faculties and departments. Dokuz Eylul University Faculty of Medicine Department of Family Medicine provides primary health care services with its family health centers, pre- and post-graduate education in family medicine, primary care research studies. Gaziemir Education Family Medicine Health Center is one of our 6 Education Family Health Centers (EFHC) affiliated to our department and serving in different regions of İzmir. The registered population of our Family Health Center is 3820 people.

Immigrant Health Experience of an Education Family Health Center in Turkey

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At that time, Migrant Health Centers were opened in the provinces by the Ministry of Health. There were translators in these health centers. These health centers were not enough for a very large number of immigrants. They were more inclined to receive services from Family Health Centers in their area. They preferred to come to our EFHC. There was no translator for Syrian immigrants at EFHCs. We suggested that our patients bring a relative who speaks Turkish and Arabic to EFHC.

Again, some of our registered patients who speak Turkish-Arabic in the population of the region volunteered as translators at EFHC, especially during the follow-up days of pregnant women. Over time, the immigrants began to understand the Turkish language, but this time the differences in the way they expressed the disease made communication difficult.

Our physicians and assistants at EFHC began to learn about the diseases of immigrant patients and their expressions over time. As a result of the regular service to migrant patients from EFHC, they became the patients that our physicians know. More attention and efforts to develop solutions specific to them were highly appreciated by these patients. Our physicians and vocational trainees working at EFHC stated that they received high professional satisfaction from this service.

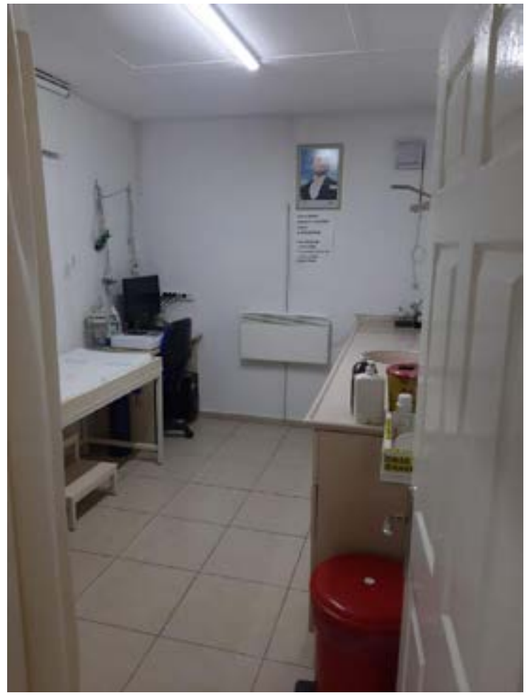


War is a public health problem with direct and indirect irreparable effects. Like deaths, injuries, illnesses. It prevents the use of limited resources for health services and destroys health services and infrastructure. The war affected not only that country but also many neighboring countries.

During the war periods, the most affected groups were children, women and the elderly. He had many conditions such as infectious diseases, psychiatric problems, violence, and worsening of chronic diseases. When Syrian immigrants came to Turkey, they came with all these health problems.

The health system of each country contains differences from each other. The health system in Syria differs from the health system in Turkey, and especially during the war period, immigrants from Syria stated that they could not access most health services in their own countries.

As a result of immigrants coming to Turkey, some of the vaccine-preventable diseases started to be observed years later. Polio, one of the diseases that has not occurred in Turkey for many years, has led to an increase in diseases such as measles and chickenpox. Problems were also experienced in terms of other respiratory and oral fecal transmitted infectious diseases. We've had similar issues with our EFHC's population and in our region.
In certain periods, we have seen increased cases of measles and chickenpox in children. The number of diarrheal diseases increased during the summer months. We encountered cases of pneumonia in infants during winter periods. We have determined that the children, babies and pregnant women of Syrian immigrant families who have just arrived in Turkey are completely unvaccinated. We struggled a lot to quickly complete their vaccinations. The low level of education and literacy also made it difficult for them to accept vaccination.



Immigrant Health Experience of an Education Family Health Center in Turkey

By Ogulcan Cöme, Mehmet Yeral, Vildan Season,
Dokuz Eylul University Faculty of Medicine, Department of Family Medicine, Izmir, Turkey

Fertility rate was very high among Syrian immigrants. They did not use modern family planning methods. The number of children at a young age was high, and the birth intervals were short. 95% of the pregnant Syrian migrant women had high-risk pregnancy. Most of them, in their countries, did not receive any health care services during their pregnancy.

Regular counseling and periodical follow-ups provided by our EFHC increased the visiting of these patients to receive preventive health services. Now, they periodically visit our EFHC for counseling of family planning and for obtaining contraceptive methods free of charge. There have been no maternal and infant deaths since they came to our region. They are also very enthusiastic about immunization and come on time and have their babies and children vaccinated. They use pregnancy and infancy supplements such as Fe and D vit by obtaining them from EFHC.

Our EFHC is in a good training practice on immigrant health in family medicine vocational training, which provides good health services to immigrants today. The health consequences of the service given are even more effective due to the fact that a special group is served.

Wars and migrations are one of the most important problems of today as well as in the past. Out-migration is a new problem in the Turkish healthcare system. In a new situation for us, we once again experienced how effective the biopsychosocial approach, which is the core concept of family medicine to health problems caused by migration, and how effective a patient-centered approach is to help people from different cultures and languages.



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