Ποιά πρωτοβάθμια φροντίδα υγείας χρειάζεται μια χώρα σε κρίση: διερευνώντας τα χαρακτηριστικά της στην Ελλάδα

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Τμήμα Ιατρικής, Πανεπιστήμιο Κρήτης

Ευχαριστίες

- Στη σύζυγο και τα παιδιά μου για την υπομονή τους και τη συνεχή ενθάρρυνση τους
- Στους δασκάλους μου, ανώνυμους και επώνυμους
- Στον πατέρα μου που μένει στο όνειρο μου και στους φίλους του που με δίδαξαν αρχές
- Στους ασθενείς μου που μου με πλησίασαν με αγάπη
- Στους συνεργάτες μου στο Πανεπιστήμιο

Περίγραμμα

- Η ΠΦΥ στη χώρα μας: μία ανάγνωση της βιβλιογραφίας
- Δυο κλινικά σενάρια
- Οι νέες προκλήσεις στην ΠΦΥ σήμερα(για μια νέα ΠΦΥ)
- Επίλογος

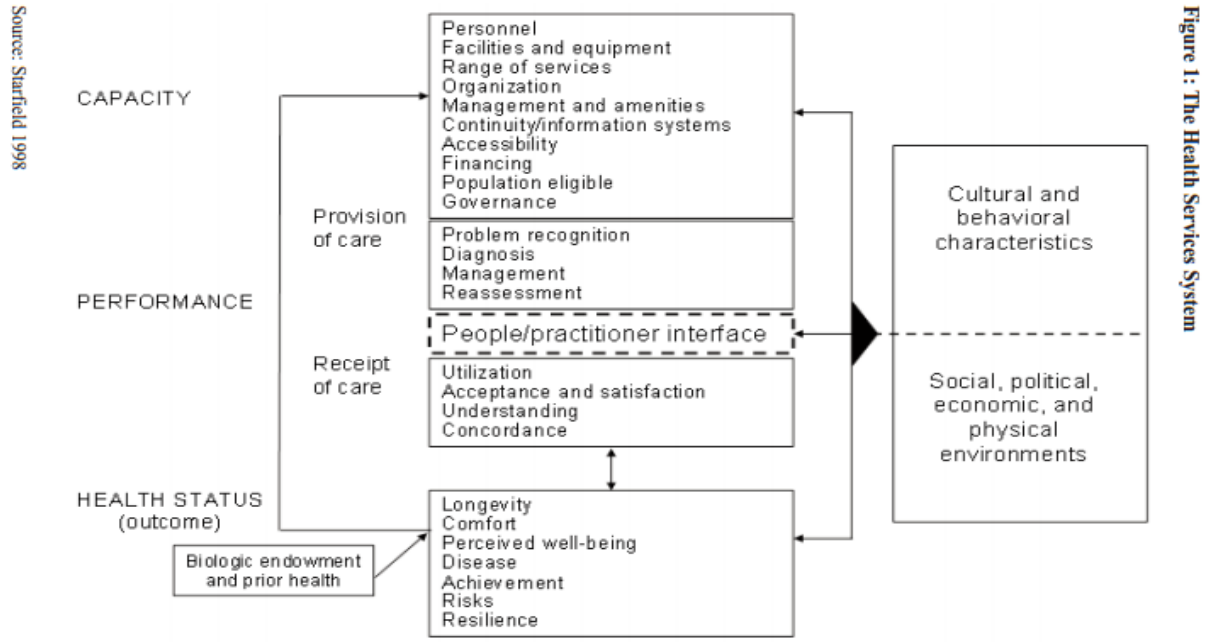
Η ΠΦΥ στη χώρα μας: μια ανάγνωση της βιβλιογραφίας

Αποτελεσματικότητα και ισότητα ως υπευθυνότητα στις ανάγκες του πληθυσμού

PRIMARY CARE AND EQUITY IN HEALTH: THE IMPORTANCE TO EFFECTIVENESS AND EQUITY OF RESPONSIVENESS TO PEOPLES' NEEDS

Barbara Starfield
Johns Hopkins University

- Σύστημα Υπηρεσιών Υγείας
- Υποδομές
- Απόδοση
- Εκβάσεις υγείας



Source: Starfield B. Humanity & Society 1998

Οι 4 διαστάσεις της διαδικασίας στην ΠΦΥ

- Πρόσβαση στις υπηρεσίες
- Ολοκλήρωση των υπηρεσιών
- Συνέχεια στη φροντίδα
- Συντονισμός στη φροντίδα

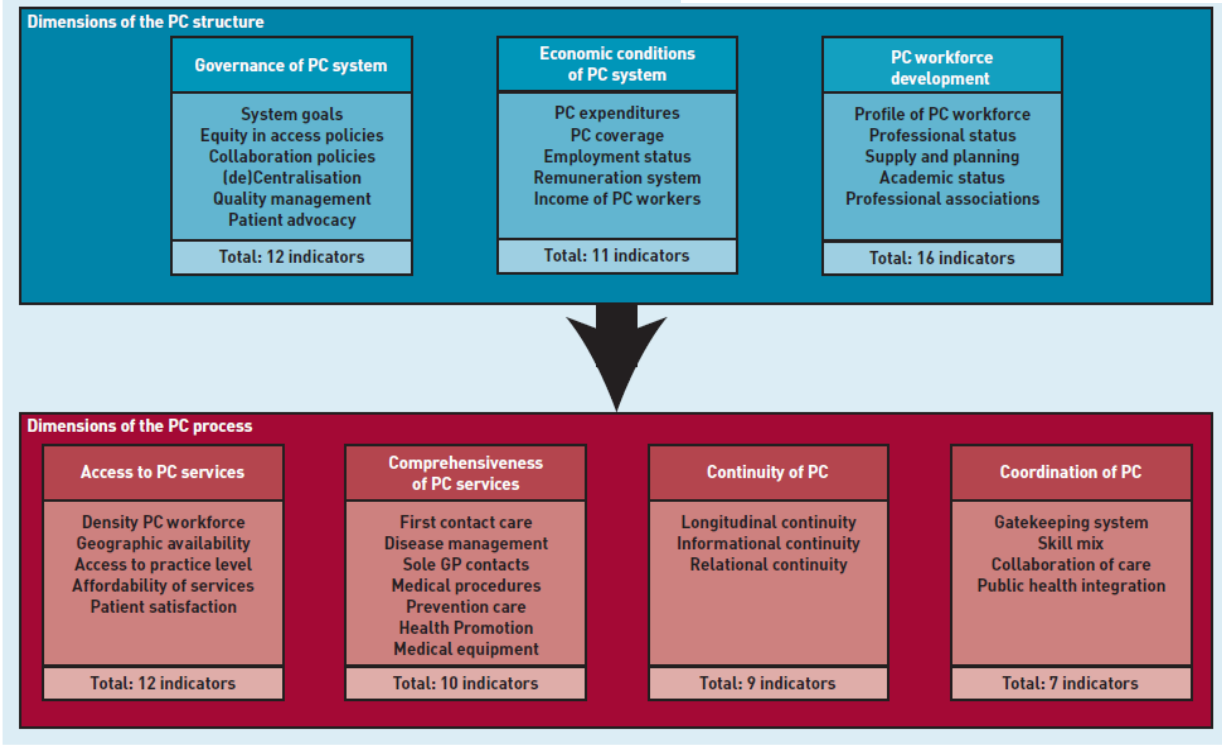
Research

Dionne Kringos, Wienke Boerma, Yann Bourgueil, Thomas Cartier, Toni Dedeu, Toralf Hasvold, Allen Hutchinson, Margus Lember, Marek Oleszczyk, Danica Rotar Pavlic, Igor Svab, Paolo Tedeschi, Stefan Wilm, Andrew Wilson, Adam Windak, Jouke Van der Zee and Peter Groenewegen

The strength of primary care in Europe:

an international comparative study

Figure 1. Primary care structure and process dimensions. PC = primary care.



Source: Kringos D. et al. British Journal of General Practice, November 2013

Τα δυνατά και αδύνατα σημεία της ΠΦΥ - Το EU-PHAMEU Project

Table 1. Availability of data on primary care indicators, by dimension and country

	Percentage of indicators (including subquestions with available data, by dimension and country)								
Country	Primary care governance (*n* = 16)	Economic conditions of primary care (*n* = 10)	Primary care workforce development (*n* = 17)	Mean %	Access to primary care (*n* = 19)	Continuity of primary care (*n* = 12)	Coordination of primary care (*n* = 9)	Comprehensiveness of primary care (*n* = 10)	Mean %
Austria	100	90	100	97	100	75	100	100	94
Belgium	100	100	100	100	100	100	100	90	98
Bulgaria	100	100	100	100	100	100	100	100	100
Cyprus	94	80	71	81	95	50	100	70	79
Czech Republic	100	100	100	100	95	75	100	100	92
Denmark	100	89	100	96	100	92	100	100	98
Estonia	100	100	100	100	100	92	100	100	98
Finland	100	89	94	94	95	92	100	100	97
France	100	100	100	100	100	92	100	100	98
Germany	100	90	100	97	100	100	100	100	100
Greece	50	70	94	71	89	67	56	70	70
Hungary	100	100	100	100	100	100	100	100	100
Iceland	75	80	100	85	84	75	78	100	84
Ireland	100	89	100	96	84	75	100	90	87
Italy	100	100	94	98	95	58	100	90	86
Latvia	100	100	100	100	95	100	100	100	99
Lithuania	100	100	100	100	100	100	100	100	100
Luxembourg	100	90	94	95	89	67	89	90	84
Malta	94	60	59	71	68	67	100	60	74
Netherlands	100	100	100	100	100	100	100	100	100
Norway	100	100	88	96	84	100	89	100	93
Poland	100	100	88	96	95	92	100	90	94
Portugal	100	89	100	96	100	100	100	100	100
Romania	100	80	100	93	95	100	89	80	91
Slovak Republic	100	100	100	100	100	100	100	100	100
Slovenia	100	100	76	92	89	100	89	100	95
Spain	100	100	94	98	89	100	100	100	97
Sweden	100	80	82	87	95	67	100	90	88
Switzerland	100	100	100	100	63	67	100	100	82
Turkey	100	60	100	87	100	100	100	90	98
UK	100	100	100	100	100	100	100	90	98
Mean %	97	91	95	—	94	87	96	94	—

Source: Kringos D. et al. British Journal of General Practice, November 2013

Αξιολόγηση της ΠΦΥ στην Ευρώπη - Η μελέτη QUALICOPC-I
(αλληλεπίδραση με ειδικούς ιατρούς - αδημοσίευτα δεδομένα)

Αλληλεπίδραση με ειδικούς ιατρούς	
Σε ποιό βαθμό χρησιμοποιείτε παραπεμπτικές επιστολές όταν παραπέμπετε ασθενείς σε ειδικό γιατρό;	
Για όλους τους ασθενείς	125 (56.8%)
Για τους περισσότερους ασθενείς	70 (31.8%)
Για ένα μικρό ποσοστό ασθενών	17 (7.7%)
Σπάνια ή ποτέ	8 (3.6%)
Σε ποιο βαθμό σας πληροφορούν οι ειδικοί ιατροί ότι ολοκλήρωσαν τη θεραπεία ή τη διαγνωστική διαδικασία των ασθενών σας;	
Σχεδόν πάντοτε	19 (8.6%)
Συνήθως	26 (11.8%)
Ορισμένες φορές	55 (25.0%)
Σπάνια ή ποτέ	120 (54.5%)
Πόσον καιρό παίρνει συνήθως έως ότου λάβετε μια σύνοψη της αναφοράς εξιτηρίου από το νοσοκομείο αφού δοθεί εξιτήριο στον ασθενή;	
1-4 ημέρες	24 (10.9%)
5-14 ημέρες	45 (20.5%)
30. μέρες	26 (11.8%)
>30 ημέρες	10 (4.5%)
Δεν λαμβάνω ποτέ ή Λαμβάνω σπάνια αναφορά εξιτηρίου	115 (52.3%)

UALICOPC
Evaluating primary care in Europe

Coordinator: Wienke Boerma PhD, NIVEL, Utrecht, the Netherlands

Αξιολόγηση της ΠΦΥ στην Ευρώπη - Η μελέτη QUALICOPC-II
(Το φάσμα των νοσημάτων-αδημοσίευτα δεδομένα)

Σε ποιο βαθμό συμμετέχετε στη θεραπεία και τη μετέπειτα παρακολούθηση (follow-up) των ασθενών σας στον πληθυσμό του ιατρείου σας με τις ακόλουθες διαγνώσεις:				
	Πάντοτε	Συνήθως	Ορισμένες φορές	Σπάνια/ποτέ
	ν(%)	ν(%)	ν(%)	ν(%)
Χρόνια βρογχίτιδα/ΧΑΠ	136 (61.8%)	69 (31.4%)	14 (6.4%)	1 (0.5%)
Χαλάζιο	51 (23.2%)	53 (24.1%)	66 (30.0%)	50 (22.7%)
Πεπτικό έλκος	104 (47.7%)	83 (37.7%)	30 (13.6%)	2 (0.9%)
Βλάβη δισκοκήλης	52 (23.6%)	88 (20.2%)	68 (30.9%)	11 (5.0%)
Συμφορητική καρδιακή ανεπάρκεια	52 (23.6%)	88 (40.0%)	68 (30.9%)	11 (5.0%)
Πνευμονία	109 (49.5%)	71 (32.3%)	37 (16.8%)	3 (1.4%)
Περιαμυγδαλικό απόστημα	69 (31.4%)	58 (26.4%)	52 (23.6%)	39 (17.9%)
Νόσο Parkinson	25 (11.4%)	63 (28.6%)	84 (38.2%)	47 (21.5%)
Τύπου-ΙΙ διαβήτη	154 (70.0%)	54 (24.5%)	10 (4.5%)	0 (0%)
Ρευματοειδή αρθρίτιδα	51 (23.4%)	55 (25.2%)	86 (39.4%)	26 (11.9%)
Κατάθλιψη	104 (47.7%)	76 (34.9%)	35 (15.9%)	3 (1.4%)
Έμφραγμα μυοκαρδίου	66 (30.1%)	81 (37.0%)	54 (24.5%)	18 (8.2%)

UALICOPC
Evaluating primary care in Europe

Coordinator: Wienke Boerma PhD, NIVEL, Utrecht, the Netherlands

Αξιολόγηση της ΠΦΥ στην Ευρώπη - Η μελέτη QUALICOPC-III
(Το φάσμα των κλινικών πρακτικών-αδημοσίευτα δεδομένα)

Σε ποιο βαθμό πραγματοποιούνται οι ακόλουθες δραστηριότητες στον πληθυσμό του ιατρείου σας από εσάς (ή το προσωπικό σας) και όχι από έναν ειδικό ιατρό;

	Πάντοτε	Συνήθως	Ορισμένες φορές	Σπάνια/ποτέ
	ν(%)	ν(%)	ν(%)	ν(%)
Διάνοιξη και ημινυχεκτομή από είσφρυση ονύχου	85 (39.0%)	58 (26.6%)	40 (18.2%)	35 (16.1%)
Αφαίρεση επιδερμοειδούς κύστης από το τριχωτό της κεφαλής	50 (22.7%)	47 (21.4%)	57 (25.9%)	65 (29.7%)
Συρραφή τραύματος	175 (79.5%)	29 (13.2%)	9 (4.1%)	7 (3.2%)
Εκτομή μυρμηγκιάς	41 (18.6%)	29 (13.2%)	47 (21.4%)	102 (4.6%)
Εισαγωγή ενδομήτριου σπειράματος	3 (1.4%)	3 (1.4%)	14 (6.4%)	198 (90.8%)
Βυθοσκόπηση	12 (5.5%)	20 (9.2%)	49 (22.5%)	137 (62.8%)
Ένεση σε άρθρωση	51 (23.6%)	26 (12.0%)	53 (24.5%)	86 (39.8%)
Δέσιμο αστραγάλου	168 (76.4%)	37 (16.9%)	20 (4.6%)	4 (1.8%)
Κρυοθεραπεία (μηρμυγκιά)	12 (5.5%)	14 (6.4%)	18 (8.3%)	174 (79.8%)
Προετοιμασία για ενδοφλέβια έγχυση	119 (54.3%)	44 (20.1%)	39 (17.7%)	17 (7.8%)

UALICOPC
Evaluating primary care in Europe

Coordinator: Wienke Boerma PhD, NIVEL, Utrecht, the Netherlands

ΠΦΥ και επαγγελματίες υγείας: Τι γνωρίζουμε;

- Αυξημένα επίπεδα επαγγελματικής εξουθένωσης στους γενικούς ιατρούς της Ελλάδας (μελέτη των 14 χωρών)
- Οι προσδοκίες και οι απόψεις των ιατρών για τη μεταρρύθμιση στην ΠΦΥ
- Οι προσδοκίες και οι εκπαιδευτικές ανάγκες των νοσηλευτών στην ΠΦΥ
- Η επίδραση της οικονομικής κρίσης (απόψεις των ιατρών ΓΙ στην αγροτική Κρήτη)
- Η κουλτούρα του compasssion στους επαγγελματίες ΠΦΥ

Soler, et al. Fam Pract 2008

Sbarouni, et al. Rural Remote Health 2012

Markaki, et al. Int Nurs Rev 2006; Markaki, et al. App Nurs Res 2009

Tsiligianni, et al. Rural Remote Health 2013

Η επίδραση της οικονομικής κρίσης στα χρόνια νοσήματα-η ανάγκη για επανεκτίμηση των αναγκών υγείας

Οι πιο συχνά αναφερόμενες ασθένειες που είχαν διαγνωστεί πριν από την κλινική επίσκεψη των ασθενών:

- Αρτηριακή Υπέρταση (19/39, 48.7%)
- Δυσλιπιδαιμία (15/39, 38.5%)
- Οστεοπόρωση (11/39, 28.2%)
- Σακχαρώδης Διαβήτης τύπου ΙΙ (8/39, 20.5%)
- Στεφανιαία Νόσος (7/39, 17.9%)

Η συνεργασία Πανεπιστημίου και τοπικών φορέων για την παροχή υπηρεσιών υγείας στους ανασφάλιστους

Quality in Primary Care 2013;21:269–73 © 2013 Radcliffe Publishing

Guest editorial

The impact of the financial crisis on the quality of care in primary care: an issue that requires a prompt attention

Christos Lionis MD PhD FRCGP(Hon)
Professor of General Practice and Primary Care, Clinic of Social and Family Medicine, School of Medicine, University of Crete, Greece

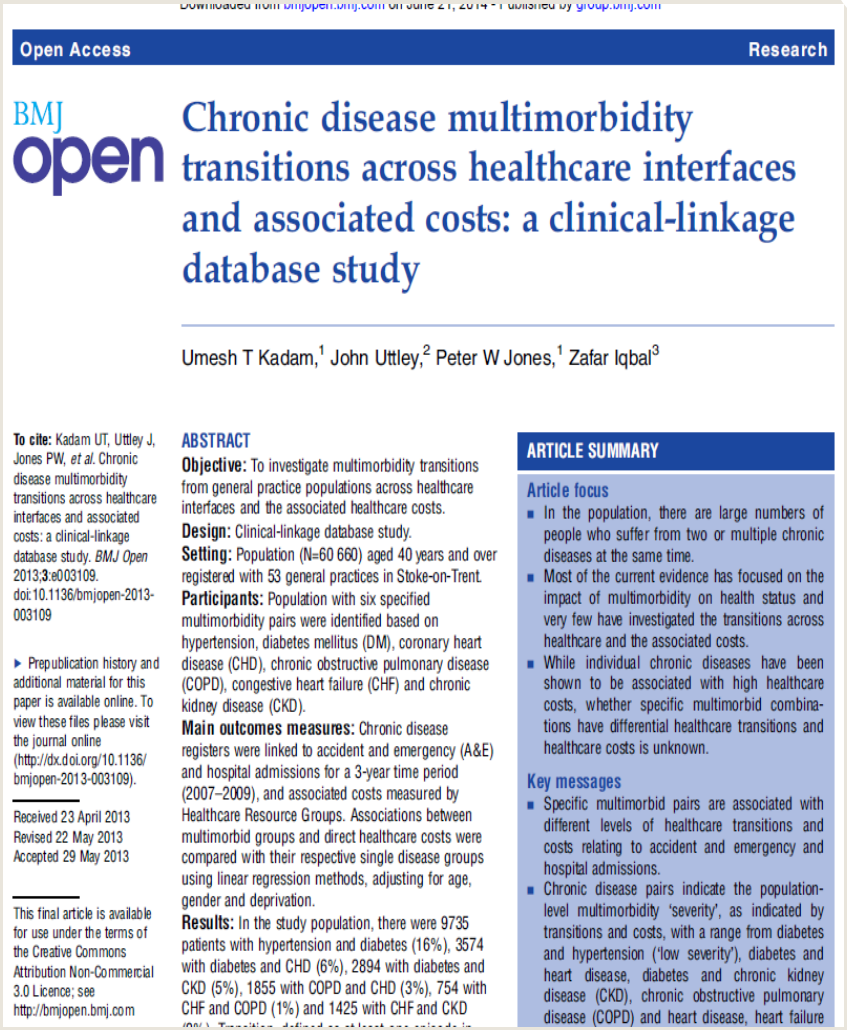
Elena Petelos BSc (Hons) MPH PhD
Research Associate, Clinic of Social and Family Medicine, School of Medicine, University of Crete, Greece and Research Fellow, Faculty of Health:, Medicine and Life Sciences and Maastricht Graduate School of Governance, University of Maastricht, the Netherlands

Δύο κλινικά σενάρια
(Οι συχνοί κλινικοί φαινότυποι)

Κλινικό σενάριο Ι (σχετικό με ερωτήματα που θα πρέπει να τεκμηριωθεί η επιστημονικότητα και η αναγκαιότητα της ΠΦΥ στην Ελλάδα)

- **Γυναίκα 37 ετών**, **άνεργη**, **με δυο παιδιά** στη δευτεροβάθμια εκπαίδευση και άνδρα υποαπασχολούμενο, ανασφάλιστο
- **Δείκτης μάζας σώματος** 33 κιλά ανά τετραγωνικό μέτρο
- **Σάκχαρο νηστείας** 105 mg/dl (μητέρα με ΣΔ τύπου ΙΙ)
- Προσέρχεται στο ιατρείο ανασφαλίστων με συμπτώματα **κατάθλιψης**.
- Χρειάζεται **φάρμακα** και **ψυχολογική** θεραπεία
- Η **παραπομπή** σε εργαστήριο για τις απαραίτητες **διαγνωστικές δοκιμασίες** αδύνατη.

Η πρόκληση της πολλαπλής νοσηρότητας στη διαχείριση των ασθενών και στη μείωση κόστους



Open Access Research

BMJ open

Chronic disease multimorbidity transitions across healthcare interfaces and associated costs: a clinical-linkage database study

Umesh T Kadam,[1] John Uttley,[2] Peter W Jones,[1] Zafar Iqbal[3]

To cite: Kadam UT, Uttley J, Jones PW, *et al*. Chronic disease multimorbidity transitions across healthcare interfaces and associated costs: a clinical-linkage database study. *BMJ Open* 2013;**3**:e003109. doi:10.1136/bmjopen-2013-003109

► Prepublication history and additional material for this paper is available online. To view these files please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2013-003109).

Received 23 April 2013
Revised 22 May 2013
Accepted 29 May 2013

ABSTRACT

Objective: To investigate multimorbidity transitions from general practice populations across healthcare interfaces and the associated healthcare costs.

Design: Clinical-linkage database study.

Setting: Population (N=60 660) aged 40 years and over registered with 53 general practices in Stoke-on-Trent.

Participants: Population with six specified multimorbidity pairs were identified based on hypertension, diabetes mellitus (DM), coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and chronic kidney disease (CKD).

Main outcomes measures: Chronic disease registers were linked to accident and emergency (A&E) and hospital admissions for a 3-year time period (2007–2009), and associated costs measured by Healthcare Resource Groups. Associations between multimorbid groups and direct healthcare costs were compared with their respective single disease groups using linear regression methods, adjusting for age, gender and deprivation.

Results: In the study population, there were 9735 patients with hypertension and diabetes (16%), 3574 with diabetes and CHD (6%), 2894 with diabetes and CKD (5%), 1855 with COPD and CHD (3%), 754 with CHF and COPD (1%) and 1425 with CHF and CKD

ARTICLE SUMMARY

Article focus

- In the population, there are large numbers of people who suffer from two or multiple chronic diseases at the same time.
- Most of the current evidence has focused on the impact of multimorbidity on health status and very few have investigated the transitions across healthcare and the associated costs.
- While individual chronic diseases have been shown to be associated with high healthcare costs, whether specific multimorbid combinations have differential healthcare transitions and healthcare costs is unknown.

Key messages

- Specific multimorbid pairs are associated with different levels of healthcare transitions and costs relating to accident and emergency and hospital admissions.
- Chronic disease pairs indicate the population-level multimorbidity 'severity', as indicated by transitions and costs, with a range from diabetes and hypertension ('low severity'), diabetes and heart disease, diabetes and chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD) and heart disease, heart failure

- Ζευγάρια χρόνιων νοσημάτων
- Βαθμολόγηση του "severity"
- Συσχέτιση φροντίδας υγείας με κόστος
- Ο συνδυασμός ΣΔ και υπέρταση "low severity"
- Ο συνδυασμός ΚΑ και ΧΑΠ ή ΚΑ και ΧΝΑ "high severity"

Source: Kadam et al, MBJ Open 2013

Η πρόκληση στην παραγγελία εργαστηριακών εξετάσεων και στην ερμηνεία των αποτελεσμάτων

ORIGINAL RESEARCH

Primary Care Physicians' Challenges in Ordering Clinical Laboratory Tests and Interpreting Results

John Hickner, MD, MSc, Pamela J. Thompson, MS, Tom Wilkinson, MPH, Paul Epner, MBA, MEd, Meghan Sheehan, MPH, Anne M. Pollock, BA, Jim Lee, MS, Christopher C. Duke, PhD, Brian R. Jackson, MD, MS, and Julie R. Taylor, PhD, MS

Background: **The number and complexity of clinical laboratory tests is rapidly expanding, presenting primary care physicians with challenges in accurately, efficiently, and safely ordering and interpreting diagnostic tests. The objective of this study was to identify challenges primary care physicians face related to diagnostic laboratory testing and solutions they believe are helpful and available to them.**

Methods: **In this study, sponsored by the Centers for Disease Control and Prevention, a random sample of general internal medicine and family medicine physicians from the American Medical Association Masterfile were surveyed in 2011.**

Results: **1768 physicians (5.6%) responded to the survey. Physicians reported ordering diagnostic laboratory tests for an average of 31.4% of patient encounters per week. They reported uncertainty about ordering tests in 14.7% and uncertainty in interpreting results in 8.3% of these diagnostic encounters. The most common problematic challenges in ordering tests were related to the cost to patients and insurance coverage restrictions. Other challenges included different names for the same test, tests not available except as part of a test panel, and different tests included in panels with the same names. The most common problematic challenges in interpreting and using test results were not receiving the results and confusing report formats. Respondents endorsed a variety of information technology and decision support solutions to improve test selection and results interpretation, but these solutions were not widely available at the time of the survey. Physicians infrequently sought assistance or consultation from laboratory professionals but valued these consultations when they occurred.**

Conclusions: **Primary care physicians routinely experience uncertainty and challenges in ordering and interpreting diagnostic laboratory tests. With more than 500 million primary care patient visits per year, the level of uncertainty reported in this study potentially affects 23 million patients per year and raises significant concerns about the safe and efficient use of laboratory testing resources. Improvement in information technology and clinical decision support systems and quick access to laboratory consultations may reduce physicians' uncertainty and mitigate these challenges. (J Am Board Fam Med 2014;27:268–274.)**

Keywords: **Diagnostic Services, Laboratories, Patient Safety, Primary Health Care**

Laboratory tests are essential tools for clinical diagnosis. Over the past 20 years, the number of laboratory tests available to clinicians has more than doubled to at least 3500 tests (ARUP Laboratories, Salt Lake City, Utah, personal communication). This complexity presents physicians with increasing challenges in accurately ordering and

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From the Department of Family Medicine, University of Illinois College of Medicine, Chicago (JH); the Centers for Disease Control and Prevention, Atlanta, GA (PJT, AMP, JRT); the Altarum Institute, Ann Arbor, MI (TW, MS, JL, CCD); Paul Epner LLC, Evanston, IL (PE); and the Department of Pathology, University of Utah, Salt Lake City (BRJ); and ARUP Laboratories, Salt Lake City, UT (BRJ).
Funding: This study was supported in part from a contract (GS-10F-0261K) funded by the Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry. OMB Control Number 0920–0893.
Conflict of interest: none declared.
Disclaimer: The findings and conclusions in this publication are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Corresponding author: John Hickner, MD, MSc, Department of Family Medicine, University of Illinois Chicago, 1919 W. Taylor, MC 663, Chicago, IL 60612 (E-mail: hickner@uic.edu).

- Οι γιατροί ΠΦΥ σπάνια έχουν υποστήριξη ή συμβουλές από τους εργαστηριακούς συναδέλφους
- Δηλώνουν αβεβαιότητα στην παραγγελία και ερμηνεία των εργαστηριακών δοκιμασιών
- Βελτιώσεις στο σύστημα της πληροφόρησης της τεχνολογίας και ανάπτυξης συστημάτων υποστήριξης της απόφασης και γρήγορη πρόσβαση σε εργαστηριακή συμβουλευτική

Source: Hickner et al, J Am Board Fam Med 2014

Η πρόκληση της συνταγογράφησης

Lionis et al. BMC Family Practice 2014, 15:34
http://www.biomedcentral.com/1471-2296/15/34

BMC Family Practice

RESEARCH ARTICLE Open Access

Irrational prescribing of over-the-counter (OTC) medicines in general practice: testing the feasibility of an educational intervention among physicians in five European countries

Christos Lionis[1*], Elena Petelos[1], Sue Shea[1], Georgia Bagiartaki[1], Ioanna G Tsiligianni[1], Apostolos Kamekis[1], Vasiliki Tsiantou[2], Maria Papadakaki[1], Athina Tatsioni[3], Joanna Moschandreas[4], Aristoula Saridaki[1], Antonios Bertsias[1,4], Tomas Faresjö[5], Åshild Faresjö[5], Luc Martinez[6,12], Dominic Agius[7], Yesim Uncu[8], George Samoutis[9], Jiri Vlcek[10], Abobakr Abasaeed[10] and Bodossakis Merkouris[11]

Abstract

Background: Irrational prescribing of over-the-counter (OTC) medicines in general practice is common in Southern Europe. Recent findings from a research project funded by the European Commission (FP7), the "OTC SOCIOMED", conducted in seven European countries, indicate that physicians in countries in the Mediterranean Europe region prescribe medicines to a higher degree in comparison to physicians in other participating European countries. In light of these findings, a feasibility study has been designed to explore the acceptance of a pilot educational intervention targeting physicians in general practice in various settings in the Mediterranean Europe region.

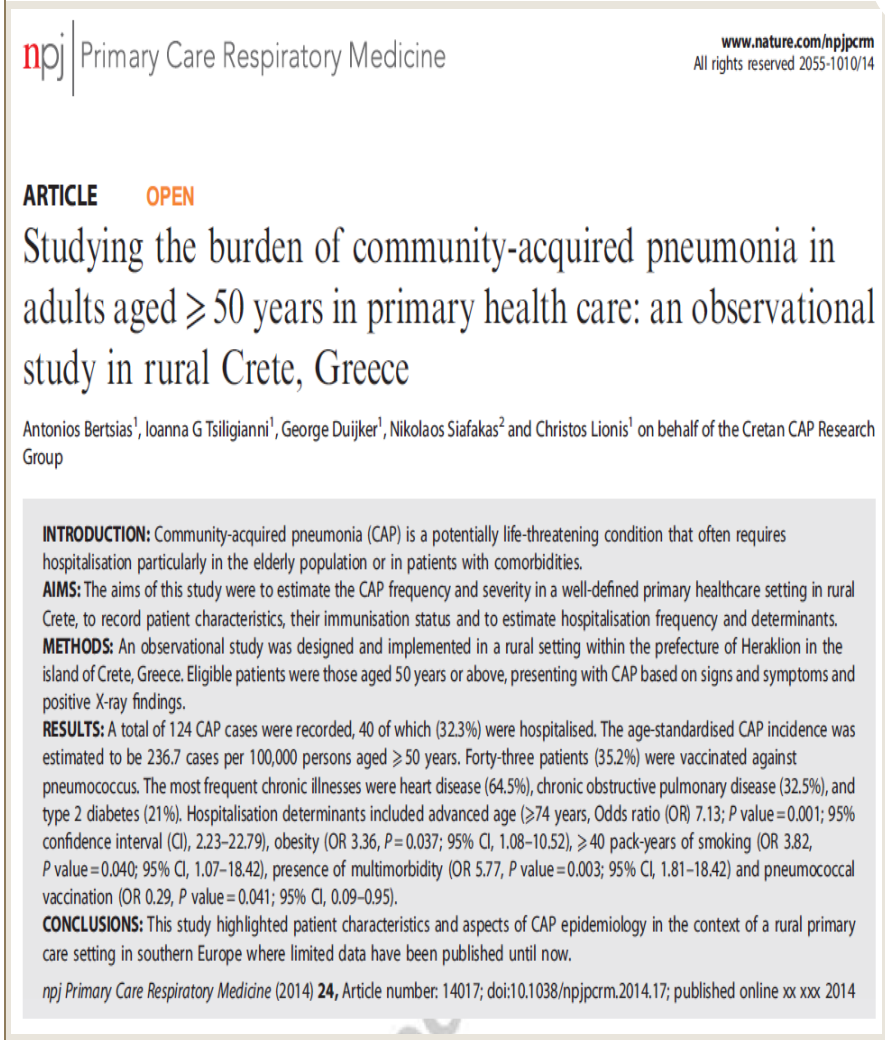
Methods: This feasibility study utilized an educational intervention was designed using the Theory of Planned Behaviour (TPB). It took place in geographically-defined primary care areas in Cyprus, France, Greece, Malta, and Turkey. General Practitioners (GPs) were recruited in each country and randomly assigned into two study groups in each of the participating countries. The intervention included a one-day intensive training programme, a poster presentation, and regular visits of trained professionals to the workplaces of participants. Reminder messages and email messages were, also, sent to participants over a 4-week period. A pre- and post-test evaluation study design with quantitative and qualitative data was employed. The primary outcome of this feasibility pilot intervention was to reduce GPs' intention to provide medicines following the educational intervention, and its secondary outcomes included a reduction of prescribed medicines following the intervention, as well as an assessment of its practicality and acceptance by the participating GPs.

Results: Median intention scores in the intervention groups were reduced, following the educational intervention, in comparison to the control group. Descriptive analysis of related questions indicated a high overall acceptance and perceived practicality of the intervention programme by GPs, with median scores above 5 on a 7-point

- Μια δοκιμή ελέγχων εφικτότητας και αποδοχής μιας παρέμβασης στην Κρήτη
- Εντατική εκπαίδευση μιας μέρας
- Υπενθυμίσεις μέσω ανάρτησης τηλεφώνου και posters

Source: Lionis, et al, BMC Fam Pract 2014

Η πρόκληση της διαχείρισης των κοινών προβλημάτων στην ΠΦΥ στη μείωση των παραπομπών στο νοσοκομείο και στη μείωση του κόστους - Το έλλειμμα στην πρόληψη



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ARTICLE OPEN

Studying the burden of community-acquired pneumonia in adults aged ⩾ 50 years in primary health care: an observational study in rural Crete, Greece

Antonios Bertsias[1], Ioanna G Tsiligianni[1], George Duijker[1], Nikolaos Siafakas[2] and Christos Lionis[1] on behalf of the Cretan CAP Research Group

INTRODUCTION: Community-acquired pneumonia (CAP) is a potentially life-threatening condition that often requires hospitalisation particularly in the elderly population or in patients with comorbidities.
AIMS: The aims of this study were to estimate the CAP frequency and severity in a well-defined primary healthcare setting in rural Crete, to record patient characteristics, their immunisation status and to estimate hospitalisation frequency and determinants.
METHODS: An observational study was designed and implemented in a rural setting within the prefecture of Heraklion in the island of Crete, Greece. Eligible patients were those aged 50 years or above, presenting with CAP based on signs and symptoms and positive X-ray findings.
RESULTS: A total of 124 CAP cases were recorded, 40 of which (32.3%) were hospitalised. The age-standardised CAP incidence was estimated to be 236.7 cases per 100,000 persons aged ⩾ 50 years. Forty-three patients (35.2%) were vaccinated against pneumococcus. The most frequent chronic illnesses were heart disease (64.5%), chronic obstructive pulmonary disease (32.5%), and type 2 diabetes (21%). Hospitalisation determinants included advanced age (⩾74 years, Odds ratio (OR) 7.13; *P* value = 0.001; 95% confidence interval (CI), 2.23–22.79), obesity (OR 3.36, *P* = 0.037; 95% CI, 1.08–10.52), ⩾ 40 pack-years of smoking (OR 3.82, *P* value = 0.040; 95% CI, 1.07–18.42), presence of multimorbidity (OR 5.77, *P* value = 0.003; 95% CI, 1.81–18.42) and pneumococcal vaccination (OR 0.29, *P* value = 0.041; 95% CI, 0.09–0.95).
CONCLUSIONS: This study highlighted patient characteristics and aspects of CAP epidemiology in the context of a rural primary care setting in southern Europe where limited data have been published until now.

npj Primary Care Respiratory Medicine (2014) **24,** Article number: 14017; doi:10.1038/npjpcrm.2014.17; published online xx xxx 2014

- Η ανάγκη εστίασης σε νοσήματα - καταστάσεις υγείας που «χάνουν» οι υπηρεσίες ΠΦΥ
- Η εκτίμηση του κόστους που συνεπάγεται
- Η πνευμονία της κοινότητας ως παράδειγμα
- Πότε παραπέμπουμε;
- Η χρήση εργαλείων και κριτηρίων παραπομπής (CURB-65)

Source: Bertsias, et al, npj Primary Care Respiratory Medicine

Η πρόκληση της επένδυσης στην πρόληψη και την προαγωγή της υγείας

Vardavas *et al. Tobacco Induced Diseases* 2013, **11**:6
http://www.tobaccoinduceddiseases.com/content/11/1/6

TOBACCO INDUCED DISEASES

EDITORIAL **Open Access**

Dealing with tobacco use and dependence within primary health care: time for action

Constantine Ilias Vardavas[1,2*], Emmanouil K Symvoulakis[1] and Christos Lionis[1]

Main text

Primary health care has an operational advantage in overall health promotion, as preventive activities and the management of multimorbidity are placed highly within its agenda. A key component of health promotion is tobacco prevention and smoking cessation, which in the developed world, is the largest preventable cause of death and disability, and estimated to cause 6 million preventable and premature deaths every year [1]. With the above dire number in mind, the World Health Organization has called for smoking cessation to be integrated into primary health care globally [2,3].

Patient centered primary care is seen as the most suitable health system "environment" for providing advice on smoking cessation and general practitioners/family physicians thus have a framework to advocate for smoking cessation within their daily practice [4]. Based on this framework, guidelines have been issued and identified amongst others to be associated with the lack of official training in tobacco control during undergraduate years or residency [9], the lack of time due to organizational constraints and increased work load [10], the smoking habits of the primary care provider [11], or the lack of appropriate social-cognitive training [12].

While understaffing, work load and the lack of time with each patient may constrain the ability to fully develop smoking cessation programmes, screening for nicotine dependence and potential relapse among patients can be performed by nurses, health care workers and psychologists as part of the multidisciplinary team [13]. This integrated primary health care team can subsequently engage smokers or refer them to a more specialized smoking cessation clinic, which makes their potential involvement furthermore promising [14]. Research has indicated that smoking cessation treatments applied by non-specialists, may be equally effective in pri-

ΑΚεΠΥ

Ανοικτά Κέντρα Προστασίας της Υγείας

Family Practice 2011; 28:589–591
doi:10.1093/fampra/cmr110

Early detection of colorectal cancer: barriers to screening in the primary care setting

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Clinic of Social and Family Medicine, Faculty of Medicine, University of Crete, Greece.
*Correspondence to Christos Lionis; E-mail: lionis@ med.uoc.gr

Colorectal cancer (CRC) is one of the leading causes of illness and death in the Western world and the second most common cause of cancer morbidity in Europe.[1] Yet, if detected early, CRC is highly treatable. Good news has recently arrived from across the Atlantic, where decision analysis tools were employed to inform recommendation updates and 'microsimulation modelling demonstrated that declines in CRC death rates are consistent with a relatively large contribution from screening'.[2]

Nevertheless, and despite the fact that U.S. CRC mortality and incidence rates have improved, CRC screening remains underused: only 77.5% of physicians report use of the national screening guidelines and only 51.7% reported recommendations consistent with the guidelines.[3] However, there are still European countries without a national population-based CRC screening programme, and even in those with established national screening programmes, they are underutilized. A survey in France, which has an established population-based screening programme, indicated that although 83% of the GPs were convinced of the importance of CRC screening, only 30% recommended the procedure to their patients.[4]

of CRC screening, especially in younger patients,[6] while few physicians recommend screening for the majority of their patients.[7] Also, one-third of the PCPs use chart reminders and only 15% use outreach mechanisms to contact patients most likely to benefit from screening.[8] Despite the evidence that screening contributes to early diagnosis, with indicators such as reduced mortality, participation rates remain low even when there is an active nationwide screening programme.

In terms of population-wide screening, however, the GPs and PCPs might also need to receive further education and training regarding early diagnosis and prevention, including health promotion. A very interesting study undertaken in France, and published in the current issue of *Family Practice*,[9] employed a qualitative approach to explore GP and patient barriers to undergoing CRC screening. This study highlights several important issues: GPs reported insufficient training and some doubted the relevance of screening. They expressed concerns in terms of the time available for the test during the consultation and they, also, reported practical and administrative obstacles.

Other barriers to CRC screening reported by the GPs included the difficulties in convincing patients es-

Source: Vardavas, et al, Tob Induc Dis 2013; Lionis and Petelos Fam Pract 2011

Η πρόκληση της υποστήριξης στην κλινική απόφαση - αναφορά στις κατευθυντήριες οδηγίες

«Ανάπτυξη 13 Κατευθυντήριων Οδηγιών Γενικής Ιατρικής για τη διαχείριση των πιο συχνών νοσημάτων και καταστάσεων υγείας στην Πρωτοβάθμια Φροντίδα Υγείας» , Κωδικός MIS: 464637

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Με την συγχρηματοδότηση της Ελλάδας και της Ευρωπαϊκής Ένωσης

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Η επένδυση στην εκπαίδευση των υγειονομικών - εστίαση στην αλλαγή της συμπεριφοράς

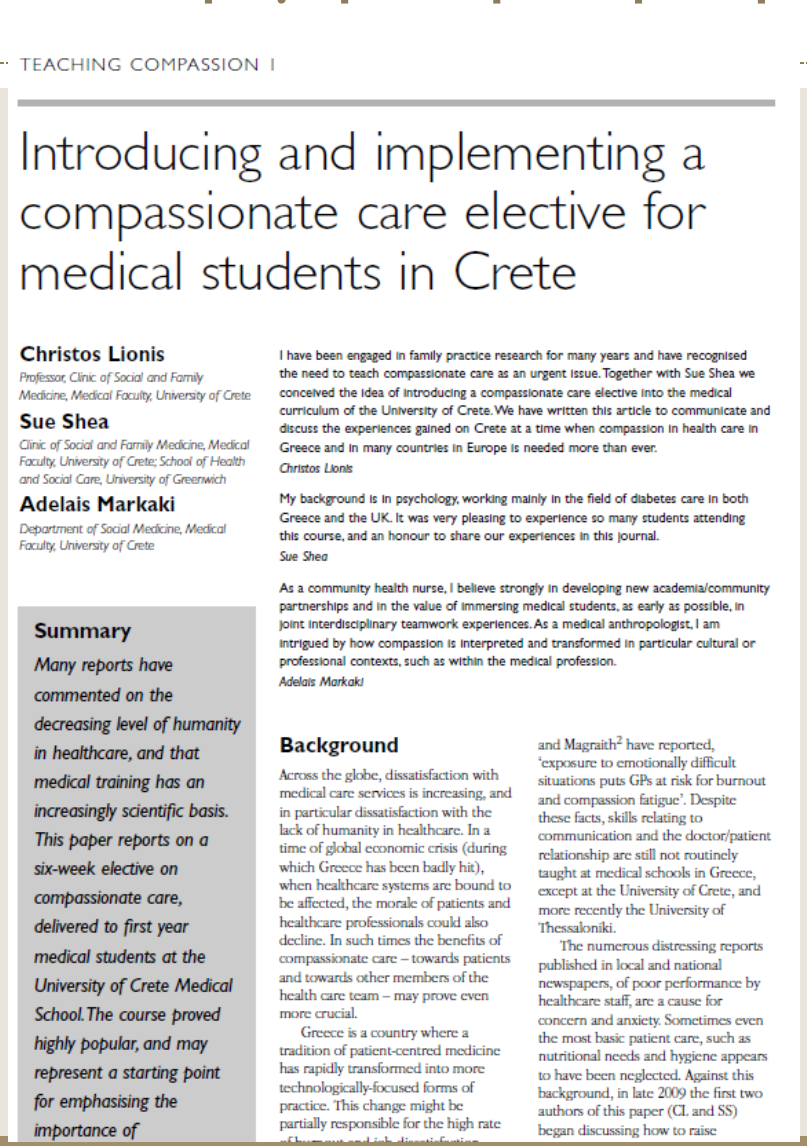
- **Transtheoretical (Stages of Change) Model – proposes change as a process of 6 stages**
  - **1. Precontemplation** – people are not intending to make a change in the near future (within the next 6 months)
  - **2. Contemplation** – people intend to change and are aware of the pros of changing but also can identify the cons (within the next 6 months)
  - **3. Preparation** – people have a plan of action and intend to take action in the immediate future (within a month)
  - **4. Action** – people make the behavior change
  - **5. Maintenance** - represents the stage where people work to prevent relapse.
  - **6. Termination** – individuals have 100% efficacy and will maintain the behaviour – difficult to maintain and most individuals remain at stage 5.

Figure 3. Stages of Change

Source: Prochaska, J., Johnson, S., & Lee, P. (1998). The transtheoretical model of behavior change. In S. Schumaker, E. Schron, J. Ockene & W. McBee (eds.), The Handbook of Health Behavior Change, 2nd ed. new York, NY: springer.

- Η αλλαγή στο περιεχόμενο της προπτυχιακής και επαγγελματικής εκπαίδευσης
- Η έμφαση στην αλλαγή της συμπεριφοράς
- Η έμφαση στην αλλαγή της κουλτούρας

Η επένδυση στην ανάπτυξη της κουλτούρας – η έμφαση στην προπτυχιακή εκπαίδευση



TEACHING COMPASSION I

Introducing and implementing a compassionate care elective for medical students in Crete

Christos Lionis
Professor, Clinic of Social and Family Medicine, Medical Faculty, University of Crete
Sue Shea
Clinic of Social and Family Medicine, Medical Faculty, University of Crete; School of Health and Social Care, University of Greenwich
Adelais Markaki
Department of Social Medicine, Medical Faculty, University of Crete

Summary

Many reports have commented on the decreasing level of humanity in healthcare, and that medical training has an increasingly scientific basis. This paper reports on a six-week elective on compassionate care, delivered to first year medical students at the University of Crete Medical School. The course proved highly popular, and may represent a starting point for emphasising the importance of

I have been engaged in family practice research for many years and have recognised the need to teach compassionate care as an urgent issue. Together with Sue Shea we conceived the idea of introducing a compassionate care elective into the medical curriculum of the University of Crete. We have written this article to communicate and discuss the experiences gained on Crete at a time when compassion in health care in Greece and in many countries in Europe is needed more than ever.
Christos Lionis

My background is in psychology, working mainly in the field of diabetes care in both Greece and the UK. It was very pleasing to experience so many students attending this course, and an honour to share our experiences in this journal.
Sue Shea

As a community health nurse, I believe strongly in developing new academia/community partnerships and in the value of immersing medical students, as early as possible, in joint interdisciplinary teamwork experiences. As a medical anthropologist, I am intrigued by how compassion is interpreted and transformed in particular cultural or professional contexts, such as within the medical profession.
Adelais Markaki

Background

Across the globe, dissatisfaction with medical care services is increasing, and in particular dissatisfaction with the lack of humanity in healthcare. In a time of global economic crisis (during which Greece has been badly hit), when healthcare systems are bound to be affected, the morale of patients and healthcare professionals could also decline. In such times the benefits of compassionate care – towards patients and towards other members of the health care team – may prove even more crucial.

Greece is a country where a tradition of patient-centred medicine has rapidly transformed into more technologically-focused forms of practice. This change might be partially responsible for the high rate

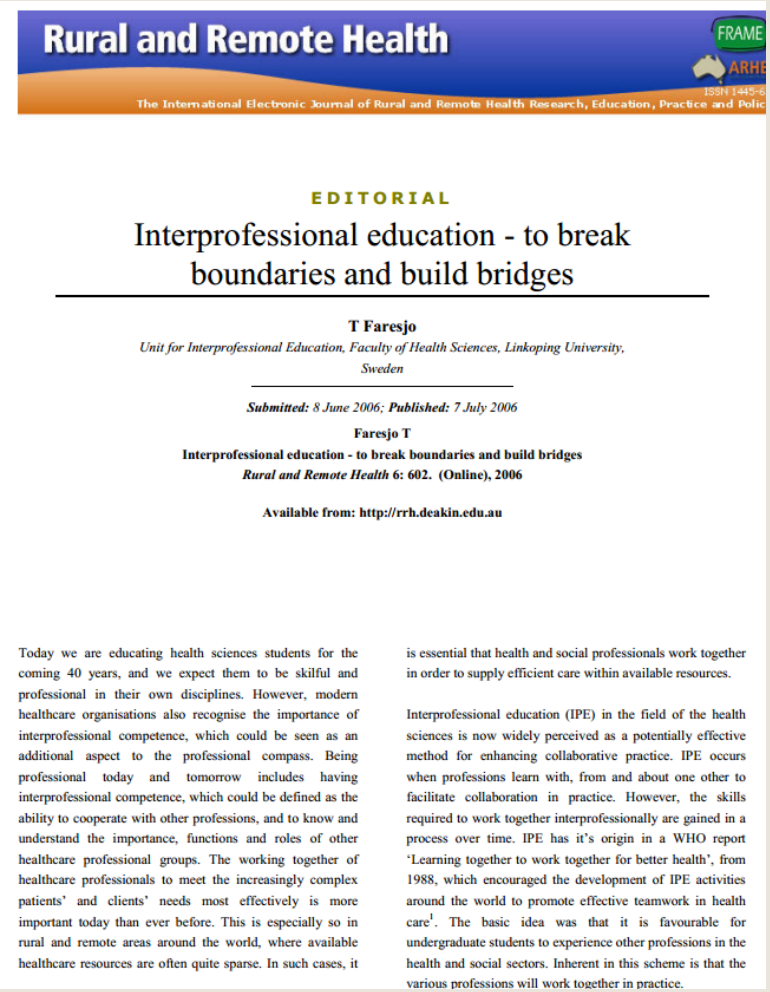
and Magraith[2] have reported, 'exposure to emotionally difficult situations puts GPs at risk for burnout and compassion fatigue'. Despite these facts, skills relating to communication and the doctor/patient relationship are still not routinely taught at medical schools in Greece, except at the University of Crete, and more recently the University of Thessaloniki.

The numerous distressing reports published in local and national newspapers, of poor performance by healthcare staff, are a cause for concern and anxiety. Sometimes even the most basic patient care, such as nutritional needs and hygiene appears to have been neglected. Against this background, in late 2009 the first two authors of this paper (CL and SS) began discussing how to raise

- Συζήτηση για ένα νέο πρόγραμμα σπουδών
- Το περιεχόμενο Social accountability
- Ο ρόλος της τεχνολογίας και της διάδρασης
- Η διεπιστημονική προσέγγιση και η συμμετοχή των ασθενών

Source: Lionis C, Shea S, Markaki A, Teaching Compassion 2012

Η εκπαίδευση στην ανάπτυξη της κουλτούρας – η έμφαση στη διεπιστημονική συνεργασία



Rural and Remote Health

The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Polic

EDITORIAL

Interprofessional education - to break boundaries and build bridges

T Faresjo

Unit for Interprofessional Education, Faculty of Health Sciences, Linkoping University, Sweden

Submitted: *8 June 2006;* ***Published:*** *7 July 2006*

Faresjo T

Interprofessional education - to break boundaries and build bridges

Rural and Remote Health **6: 602. (Online), 2006**

Available from: http://rrh.deakin.edu.au

Today we are educating health sciences students for the coming 40 years, and we expect them to be skilful and professional in their own disciplines. However, modern healthcare organisations also recognise the importance of interprofessional competence, which could be seen as an additional aspect to the professional compass. Being professional today and tomorrow includes having interprofessional competence, which could be defined as the ability to cooperate with other professions, and to know and understand the importance, functions and roles of other healthcare professional groups. The working together of healthcare professionals to meet the increasingly complex patients' and clients' needs most effectively is more important today than ever before. This is especially so in rural and remote areas around the world, where available healthcare resources are often quite sparse. In such cases, it is essential that health and social professionals work together in order to supply efficient care within available resources.

Interprofessional education (IPE) in the field of the health sciences is now widely perceived as a potentially effective method for enhancing collaborative practice. IPE occurs when professions learn with, from and about one other to facilitate collaboration in practice. However, the skills required to work together interprofessionally are gained in a process over time. IPE has it's origin in a WHO report 'Learning together to work together for better health', from 1988, which encouraged the development of IPE activities around the world to promote effective teamwork in health care[1]. The basic idea was that it is favourable for undergraduate students to experience other professions in the health and social sectors. Inherent in this scheme is that the various professions will work together in practice.

- Αναγκαιότητα αλλαγής του μοντέλου εκπαίδευσης στις Ιατρικές Σχολές
- Η διεπαγγελματική συνεργασία στην εκπαίδευση και στην έρευνα

Source: Faresjo T, RRH 2006

Η επένδυση στην εκπαίδευση του ασθενούς και στην αυτο-φροντίδα

Koetsenruijter *et al. Health and Quality of Life Outcomes* 2014, **12**:29
http://www.hqlo.com/content/12/1/29

STUDY PROTOCOL **Open Access**

Social support systems as determinants of self-management and quality of life of people with diabetes across Europe: study protocol for an observational study

Jan Koetsenruijter[1*], Jan van Lieshout[1], Ivaylo Vassilev[2], Mari Carmen Portillo[3], Manuel Serrano[4], Ingrid Knutsen[7], Poli Roukova[6], Christos Lionis[5], Elka Todorova[6], Christina Foss[7], Anne Rogers[2] and Michel Wensing[1]

Abstract

Background: Long-term conditions pose major challenges for healthcare systems. Optimizing self-management of people with long-term conditions is an important strategy to improve quality of life, health outcomes, patient experiences in healthcare, and the sustainability of healthcare systems. Much research on self-management focuses on individual competencies, while the social systems of support that facilitate self-management are underexplored. The presented study aims to explore the role of social systems of support for self-management and quality of life, focusing on the social networks of people with diabetes and community organisations that serve them.

Methods: The protocol concerns a cross-sectional study in 18 geographic areas in six European countries, involving a total of 1800 individuals with diabetes and 900 representatives of community organisations. In each country, we include a deprived rural area, a deprived urban area, and an affluent urban area. Individuals are recruited through healthcare practices in the targeted areas. A patient questionnaire comprises measures for quality of life, self-management behaviours, social network and social support, as well as individual characteristics. A community organisations' survey maps out interconnections between community and voluntary organisations that support patients with chronic illness and documents the scope of work of the different types of organisations. We first explore the structure of social networks of individuals and of community organisations. Then linkages between these social networks, self-management and quality of life will be examined, taking deprivation and other factors into account.

Discussion: This study will provide insight into determinants of self-management and quality of life in individuals with diabetes, focusing on the role of social networks and community organisations.

Keywords: Quality of life, Self-management, Chronic illness, Diabetes type 2, Social networks, Community organisations, Deprivation

- Ο ρόλος της θεωρίας και της συστημικής προσέγγισης
- Η ένταξη του θέματος στην προπτυχιακή και επαγγελματική εκπαίδευση
- Τα δάνεια από τις επιστήμες της συμπεριφοράς και τις κοινωνικές επιστήμες

Source: Koetsenruijter et al, Health Qual Life Outcomes 2014

Η επένδυση στις οργανωτικές αλλαγές: η έμφαση στην ανάπτυξη της ολοκλήρωσης ΠΦΥ

Family Practice 2010; 27:48–54
doi:10.1093/fampra/cmp078
Advance Access published on 1 November 2009

Implementing family practice research in countries with limited resources: a stepwise model experienced in Crete, Greece

Christos Lionis*, Emmanouil K Symvoulakis and Constantine I Vardavas

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The need for a cost-effective decision-making process is increasingly seen as a challenge within modern family practice. The role of family practice research is well recognized in countries with readily available resources and capacity. However, the situation is different in a number of countries with limited financial resources and current low research capacity. This article reports on an empirical model of 10 steps developed and applied in Crete, Greece. It aims to exchange views on how to better design and undertake actions in order to develop future family practice research in countries with limited resources.

Keywords. Capacity, family practice, research, resources.

Describing a stepwise model in developing effective family practice research in countries with limited research capacity and resources

- Use an electronic patient record system.
- Explore opportunities to work together with an academic department.
- Start with assessment of population health needs.
- Identify common ill conditions and health problems.
- Ask about the local use of common diagnostic tools (if not discuss the possibility of translating and adapting into local and cultural setting those already well assessed in the literature).
- Start to identify the burden of common diseases and measure diagnostic probabilities.
- Discuss opportunities to publish your initial non-experimental work.
- Look at possibilities to work together with other teams and researchers in a neighbouring country.
- Try to expand your networking to other larger research bodies and consider a solid partnership with European and international organizations.
- See to what extent your collaborative work should be the starting point in looking for funding from those international bodies, including the European Union.

Source: Lionis C et al. Fam Pract 2010

European Journal of General Practice, 2013; Early Online: 1–6

Background Paper

Exploring health care reform in a changing Europe: Lessons from Greece

Antonis A. Kousoulis[1,2], Konstantina-Eleni Angelopoulou[3] & Christos Lionis[4]

[1]Medical School, University of Athens, Athens, Greece, [2]Society of Junior Doctors, Athens, Greece, [3]School of Business Administration, University of Piraeus, Athens, Greece, and [4]Clinic of Social and Family Medicine, Medical School, University of Crete, Heraklion, Greece

KEY MESSAGE:

- The economic crisis sets the timing to shift to a primary care system in Greece
- Apart from health care, Greece should focus on general changes, primarily decentralization and education
- In a changing Europe, approaches on health care reform via primary care in settings similar to Greece could be discussed and explored

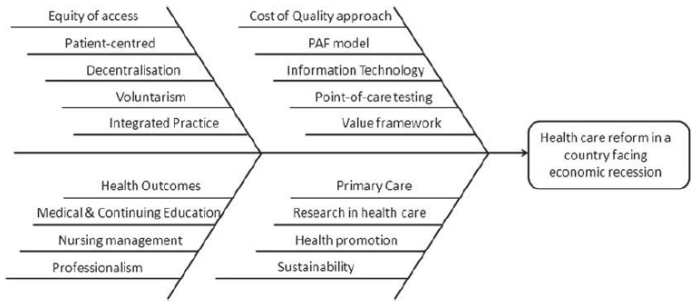

Figure 1. Fishbone diagram presenting the major suggestions for substantial changes in the health care system in Greece, a country facing economic crisis. PAF, prevention-appraisal-failure.

Source: Kousoulis A, Angelopoulou KA, Lionis C et al, EJGP 2013

- Ουσιαστική μετατόπιση της πολιτικής στην ΠΦΥ
- Εστίαση σε ουσιαστικές αλλαγές στην αποκέντρωση και στην εκπαίδευση
- Η αναφορά ιδιαίτερα στις αξίες

Η πρόκληση στην ανάπτυξη της αυτόχθονης έρευνας

HORMONES 2013, 12(3):385-398

Research paper

Impact of religiosity/spirituality on biological and preclinical markers related to cardiovascular disease. Results from the SPILI III study

Dimitrios Anyfantakis,[1] Emmanouil K. Symvoulakis,[1] Demosthenes B. Panagiotakos,[2] Dimitrios Tsetis,[3] Elias Castanas,[4] Sue Shea,[1] Maria Venihaki,[5] Christos Lionis[1]

[1]*Clinic of Social and Family Medicine, School of Medicine, University of Crete, Heraklion,* [2]*Department of Nutrition and Dietetics, Harokopio University, Athens,* [3]*Department of Radiology,* [4]*Laboratory of Experimental Endocrinology,* [5]*Department of Clinical Chemistry, School of Medicine, University of Crete, Heraklion, Greece*

ABSTRACT

OBJECTIVE: This study aimed at exploring to what extent psychosocial factors, such as religiosity/spirituality and sense of coherence, mediate the negative effects of stress on a variety of cardiometabolic indicators, i.e., hypertension, diabetes, cardiovascular and cerebrovascular disease, and atherosclerotic bio-clinical markers. DESIGN: A total of 220 subjects (66.2±16.0 years) of the SPILI III cohort (1988-2012) attending a primary care setting in Spili, a rural town in Crete, represented the target group for the present study. Of these, 195 (88.6%) participated in the re-examination (67.2±15.2 years). All participants underwent a standardized procedure including evaluation of anthropometric measurements, biochemical indicators of atherosclerosis, stress hormones, in parallel with ultrasound measurements of carotid intima media thickness (IMT). Religiosity, spirituality and sense of coherence were evaluated with the use of international questionnaires translated into the Greek language and linguistically validated. RESULTS: Participants with higher levels of religious and spiritual beliefs presented lower levels of carotid IMT (1.01±0.101 vs 1.53±.0.502 mm, p<0.001). Patterns of inverse relationships were also observed between religiosity/spirituality and prevalence of diabetes (35.1% vs. 2%, p<0.001) with an estimated diabetes risk, fully adjusted odds ratio, 95% CI: 0.90 (0.87-0.93). Highly religious participants presented lower serum cortisol levels (12.3±5.8 vs. 18.2±5.1 μg/dl, p<0.001). Sense of coherence was positively associated with religiosity/spirituality [mean SOC (SD): 123±20 vs.158±15) p<0.001]. CONCLUSIONS: These findings may be associated with a possible favourable effect of religiosity/spirituality on several cardio-

- Για τους μη αναγνωρισμένους προσδιοριστές των χρόνιων νοσημάτων με χρήση συμβατικών και μη μεθόδων ανάλυσης δεδομένων
- Μετεγγραφή της αυτόχθονης γνώσης σε θεραπευτικές πρακτικές
- Για την αποτελεσματικότητα πολυεπίπεδων παρεμβάσεων σε ασθενείς με πολλαπλή νοσηρότητα

Sources: Lionis, et al. BMC Research Notes 2010
Lionis, et al. Lancet 1998
Samoutis, et al. Fam Pract 2010

Τι χρειαζόμαστε στην ΠΦΥ - Σύνοψη προτάσεων

- Μια νέα κουλτούρα
- Ένα νέο πρότυπο εκπαίδευσης (προπτυχιακή και επαγγελματική εκπαίδευση)
- Εστίαση σε δεξιότητες αλλαγής της συμπεριφοράς
- Υποστήριξη στη λήψη της κλινικής απόφασης

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