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POSTER ABSTRACT

Bridging the gap from theoretical framework to practical implementation : the integrated primary care house

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Theoretical background: Chronic disease has become the major cause of morbidity and mortality in Belgium, similar to other European countries . Diseases of the cardiovascular system 33% and tumors 27 % cause the biggest burden. At the same time multimorbidity offers another challenge : 40 % of the older than 75 have 4 or more chronic diseases.

The mean life expectancy in the European Union in 2016 is for men 84.6 and for women 89.1 years. As these figures are getting higher throughout the years, the importance of chronic disease and multimorbidity will raise in the future

50 % of the Belgian general practitioners are older than 50 years. The age group between 45 and 65 have 70 % of all patient contacts. Twice as much GP aged 25-30 quit the job compared to collegues in the 50-65 group. There will be a shortness of general practitioners in the future

The lack of coördination of care for chronic and complex care patients gives us a bad outcome on quality, high level of financing and also minimal satisfaction on care experience.

There is worldwide a large consensus that integrated care with its management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system, may provide a solution for the above.

The integratedprimary care house: To counterweight the above outlined evolution and realise de WHO guideline, we started "the integratedprimary care house "

"The Integrated Primary Care House" stands for a way of caregiving based on the following fundaments :

- a fully integrated primary care containing all services available in primary care
- a "patient-centred approach"with shared decision making
- motivational interviewing style based
- evidence based practice

- upgrade of tasks of the caregivers
- working within the existing financing of the health care
- workplacelearning
- organic entity : working under one roof

Where it is not possible for structural or organisational reasons to offer an aspect of primary care, an active link is made to the primary person or organisation to fill these gaps

Health care provision is based on Wagner's chronic care mode : a number of tasks of different health care providers will be strengthened and valued and where necessary upgraded. Nurses take over tasks from doctorscoordination of chronic care managing diabetes care and cardiovascular prevention , midwives from gynaecologists, optometrists from opthalmologists, and so on

The caregivers; working in de integrated primary care house are : general practitioners, psychologists, nurses, midwives, dieticians, smoking specialist, occupational therapist, speech therapist, pedicurist, chiropodist ,dentists , physiotherapists , optometrist, pharmacist, social workera psychosocial team and finally a secretary and receptionist.

Conclusion: The integrated primary care house is a fully operational and innovative project whose intention is to meet expectations for forward-looking health care. The challenge for the next years will consist in proving the health gain and the cost effectiveness the project claims

Summary: The presentation shows that within an existing health care system and starting from GP practices health care can evolve towards a fully operational integrated primary care in its broadest meaning

Keywords: integrated primary care; practical implementation