

# Integrated Community Care for All:

## an opportunity for Primary Care

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# Challenges...

The Environmental



The Economic



The Political



(democracy revitalizing)

The Demographic



The Technological

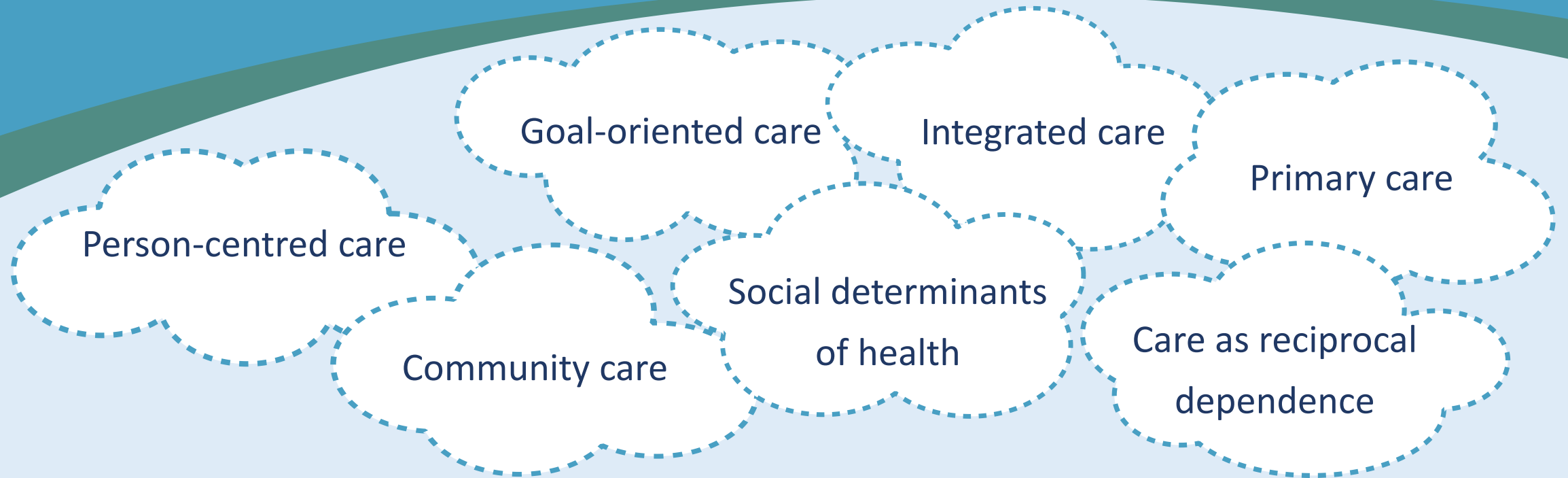


The Social



With the issue of equity (the problem of raising inequalities) as a crosscutting challenge

# “Care”



## Primary Health Care according to WHO:

*“Primary health care (PHC) addresses the majority of a person’s health needs throughout their lifetime. This includes physical, mental and social well-being and it is people-centred rather than disease-centred. PHC is a whole-of-society approach that includes health promotion, disease prevention, treatment, rehabilitation and palliative care.”*

# What is Integrated Community Care (ICC)

- ICC acknowledges that **communities** are essential **partners**
- ICC envisions a paradigm shift in the way health and care systems are organised From delivery' to genuine **'co development'**
- ICC emphatically addresses **the broader determinants of health**
- ICC pivots on greater **integration** between primary care, public health functions, social work and neighbourhood development within a given territory.
- Focus on both quality of care and **quality of life** and Broad definition of care.
- **Place-based governance** is a crucial competence to continuously form new alliances
- ICC comes down to a continuous process of **'whole system innovation'**
- **Distributed power** and collective learning

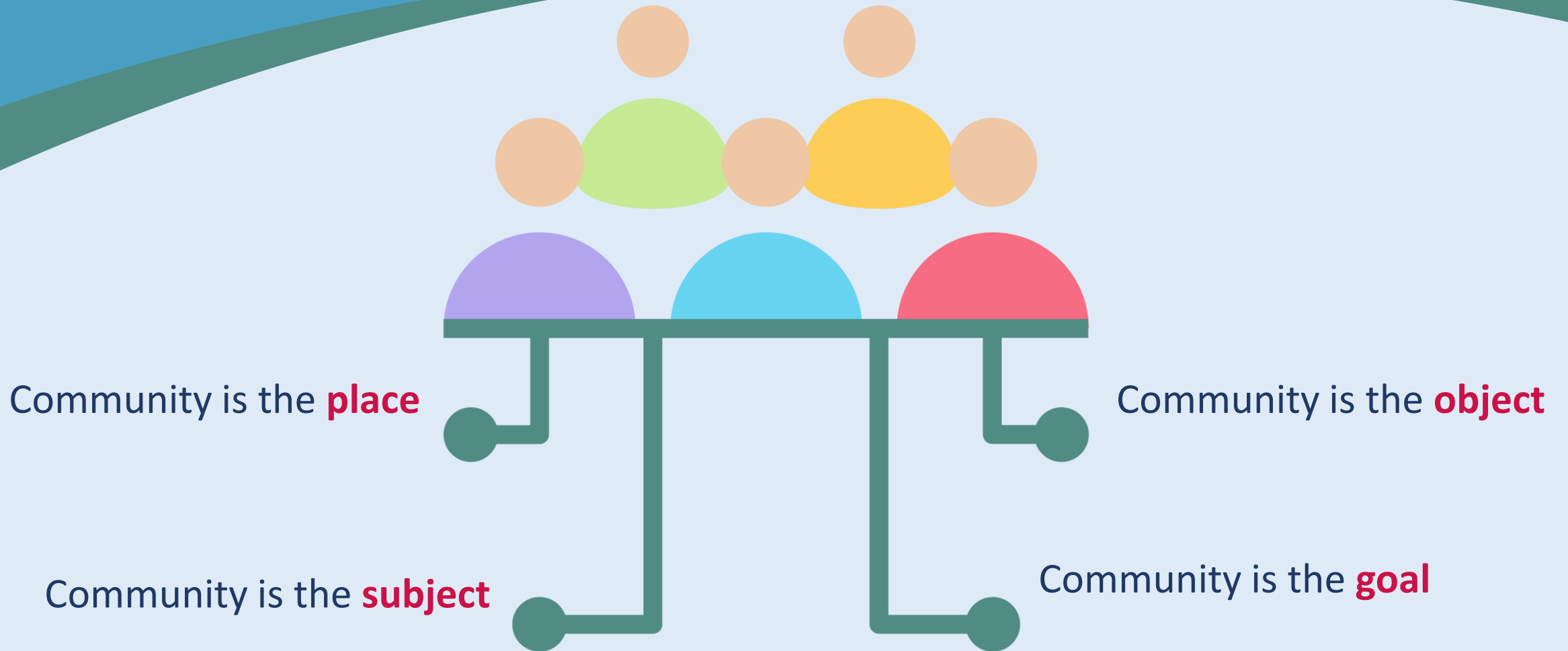
# What, how and why of Integrated Community Care (ICC)



## Root definition

ICC encompasses a range of strategies to support local organizations, community members, professionals, and policy makers in a continuous process of co-developing health, care and social support infrastructures and services with the aim to enhance the quality of life, social cohesion and resilience of a territorially defined community

# Where is “Community” in ICC?



# 7 Effectiveness Principles



CO-DEVELOP HEALTH  
AND WELLBEING,  
ENABLE  
PARTICIPATION

- 1** **Value and foster** the capacities of all actors, including citizens, in the community to **become change agents** and to coproduce health and wellbeing. This requires the **active involvement of all actors**, with an extra sensitivity to the most vulnerable ones.
- 2** **Foster** the creation of **local alliances** among all actors which are involved in the production of health and wellbeing in the community. Develop a shared vision and common goals. Actively strive for **balanced power relations and mutual trust** within these alliances.
- 3** **Strengthen community-oriented primary care** that stimulates people's capabilities to maintain health and/or to live in the community with complex chronic conditions. Take **people's life goals** as the starting point to define the desired outcomes of care and support.

# 7 Effectiveness Principles

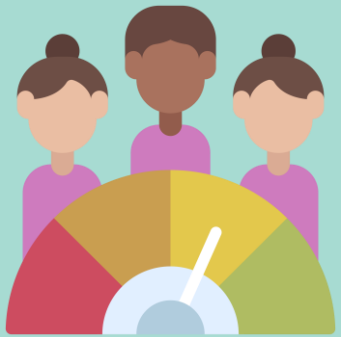


BUILD RESILIENT  
COMMUNITIES

- 4** **Improve** the health of the population and reduce **health disparities** by addressing the social, economic and environmental **determinants of health** in the community and investing in **prevention** and health **promotion**.
- 5** **Support** healthy and inclusive communities by providing opportunities to bring people together and by investing in both **social care and social infrastructure**.
- 6** **Develop the legal and financial conditions** to enable the co-creation of care and support at community level.



# 7 Effectiveness Principles



MONITOR, EVALUATE  
AND ADAPT

7

**Evaluate** continuously the quality of care and support and the status of health and wellbeing in the community by using methods and indicators which are grounded within the foregoing principles and documented **by participatory community diagnosis** involving all stakeholders. Provide opportunities for **joint learning**. Adapt policies, services and activities in accordance with the evaluation outcomes.

# 3 Examples of ICC



## Community Health Centres

# Community Health Centre (community-oriented primary care)



Community health centers (CHC) aim to meet a territorially defined group of citizens' needs by offering **high quality, accessible and integrated primary care** from a broad, psychological and social perspective.

The patient is considered as someone with a **personal history** within the context of a family, a community and a professional and socio-economic environment.

## Community-Oriented Primary Care: Health Care for the 21st Century



Edited by Robert Rhyne, M.D., Richard Bogue, Ph.D.,  
Gary Kukulka, Ph.D., Hugh Fulmer, M.D.

*Community-Oriented Primary Care (COPC) is defined as the systematic assessment of health needs in a population, identification of community health and wellbeing problems, implementation of systematic interventions involving target population and monitoring the effect of changes to ensure that health services are improved and congruent with community needs. The interprofessional team, consisting of primary care workers and community members, assesses resources and develops strategic plans to deal with problems that have been identified. COPC integrates individual and population-based care, blending clinical skills of practitioners with epidemiology, preventive medicine, health promotion and empowerment, minimising the separation between public health and individual health care.*





Community Health Centre  
Botermarkt Ledeburg 2006  
(Founded in 1978)

Visie

Ontstaan

Multidisciplinair team

Globaal Medisch Dossier

Forfaitair betalingssysteem

Raadplegingen, afspraken  
en huisbezoeken

Preventieprojecten en  
gezondheidsbevordering

Inschrijven in het WGC

Voor onze patiënten

## Community Health Centre:

- Family physicians/GPs; nurses; dieticians; health promoters; dentists and oral hygienists; social workers; psychologists; tabacologists; community health workers;....
- 6100 patients; 95 nationalities
- Integrated mixed needs-based capitation; no co-payment



# COPC-project : from individual care to community health care



Mothers present with their toddlers with problems of: feeding problems, crying, not sleeping,...



Identified health problem by family physicians/nurses/school teachers: problematic oral condition of toddlers

# 1. Focus group discussion in health center

A dentist?  
I cannot afford that.

I don't know where  
to find a dentist

My child is to afraid of  
the dentist and to be  
honest, me too

I'm doing Fristi in his  
bottle to stop him cry





## 2. Exploratory study in the community

### **Survey: children 30 months old:**

- 18,5 % symptoms of early childhood caries (7,4 % in high SES – 29,6 % in low SES)
- 100% need for treatment!

### **Correlation with**

- deprivation
- nationality (Eastern-Europe)
- no previous dentist consultations

(S. Willems et. al 2005)



# 3. Bring together stakeholders from different sectors



Brugse Poort

De Sleep



Botermarkt



# 3. Bring together stakeholders from different sectors



Socio-economic actors

Brugse Poort

De Sleep



Botermarkt





# 3. Bring together stakeholders from different sectors



Socio-economic actors

Brugse Poort

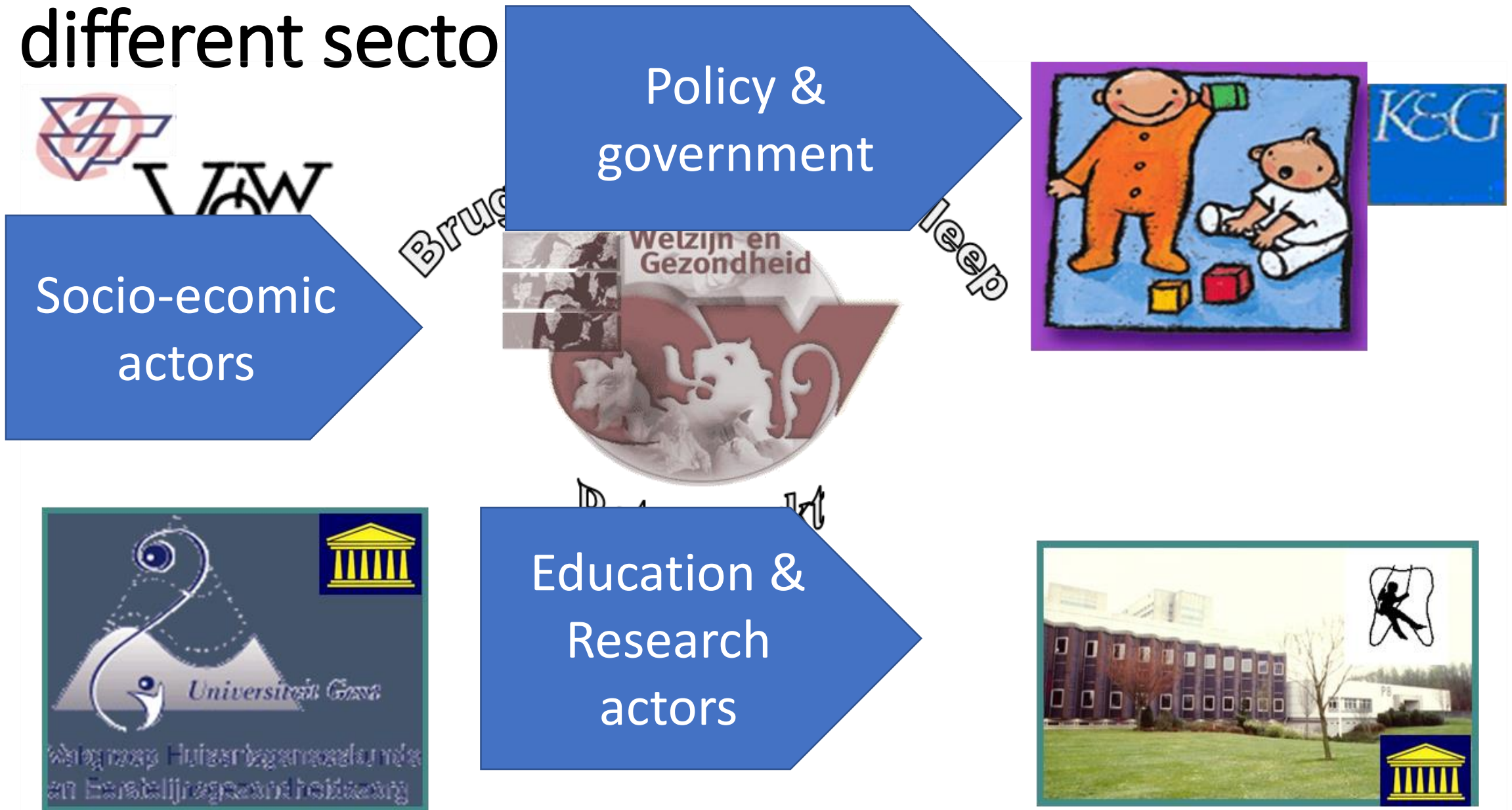
De Sleep



Education & Research actors



# 3. Bring together stakeholders from different sectors



# 4. Collaborations & results

- Accessible dental health care (direct “third-party” payment by social insurance)
- Dental health care integrated in interprofessional primary health care center (lowering threshold)
- Developing a new profession at BA-level: “oral hygienists” working in the community and in dental practices
- Involvement of University College (ArteveldeHS) students in screening and follow-up of children
- Involvement of regional governmental public health services for children’s health (Kind & Gezin)
- Involvement of preventive school health public health services (CLB) (continuity)

Socio-economic  
actors

Education &  
research

Policy &  
government

# 5. Today...

- 11 % early childhood caries in toddlers (from 18% in 2004) at 30 months
- Same at-risk groups
- Ongoing efforts for prevention and sensibilisation : all children screened at 30 months
- Increasing involvement of dentists, oral hygienists and dental students in the community

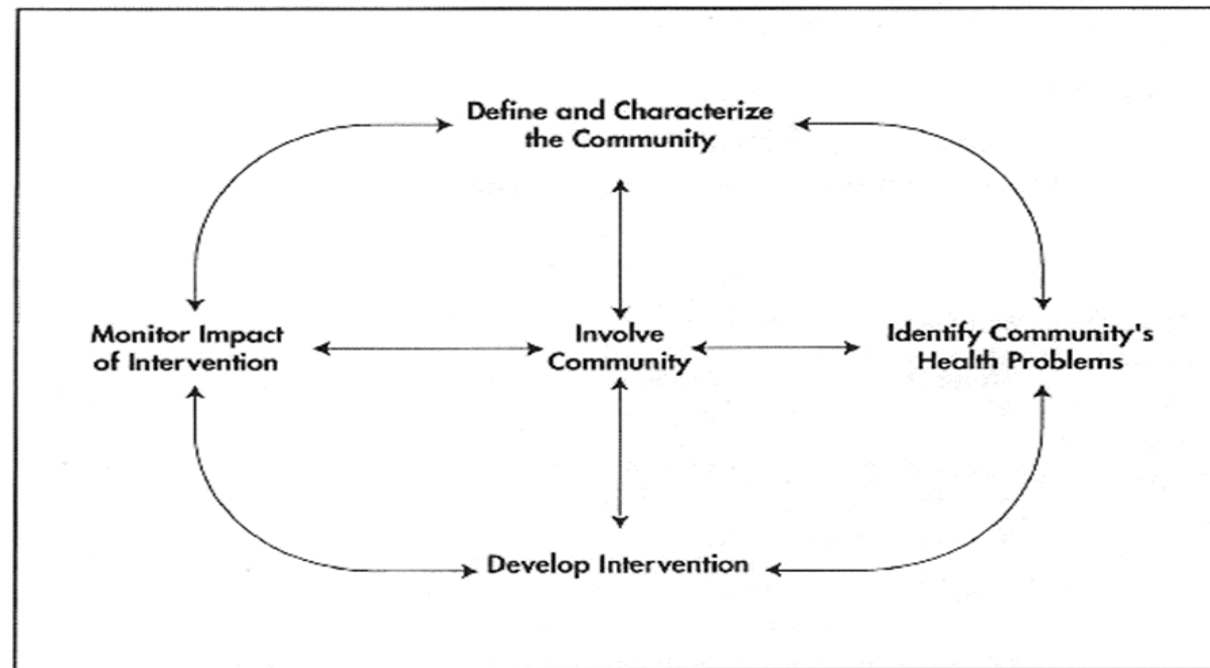


# 6. Define strategies

## Strategies?

- Community oriented
- Intersectoral
- Participatory

FIGURE 1.2: The COPC Process





# COPC : Looking for upstream causes

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Accident: scholar severely invalidated :1 September 1983



Acute Intervention: FP with Nurse; ambulance; ED



Jan De Maeseneer  
Family Medicine  
and Primary Care  
*At the Crossroads of Societal Change*

# Platform of stakeholders:

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**Meeting: police, family physicians, schools, nurses, elderly-organisations, traffic experts, housing, ...**

- 40 to 50 people
- Exchange of information
- “Community diagnosis” unsafe traffic situation
- Proposal for safer traffic condition
- Survey with 500 inhabitants from neighbourhood: voting for the best scenario



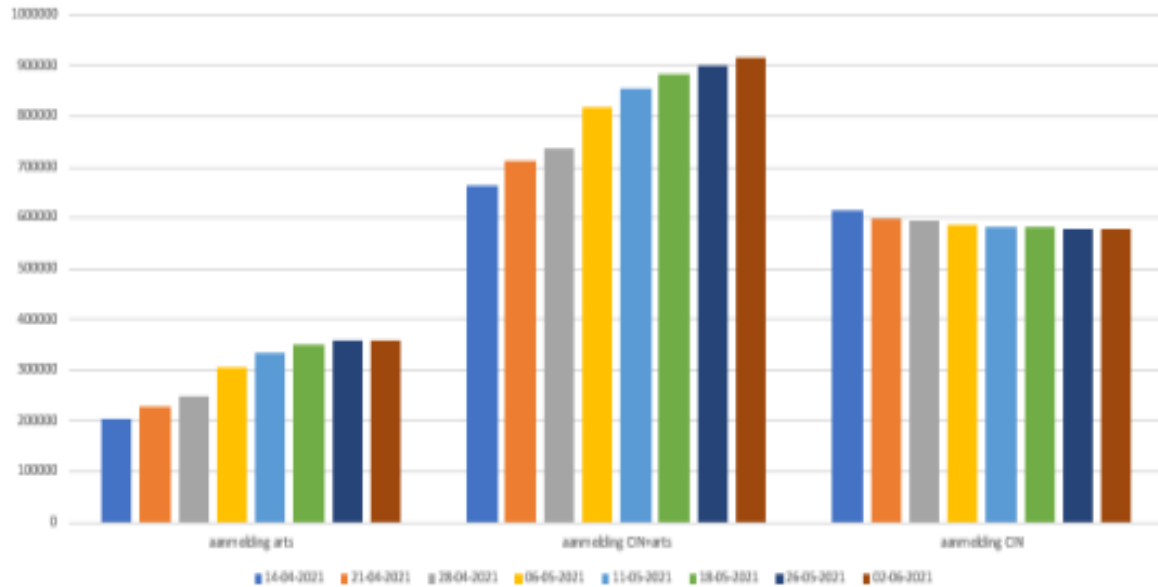


**Establishment safer traffic situation**

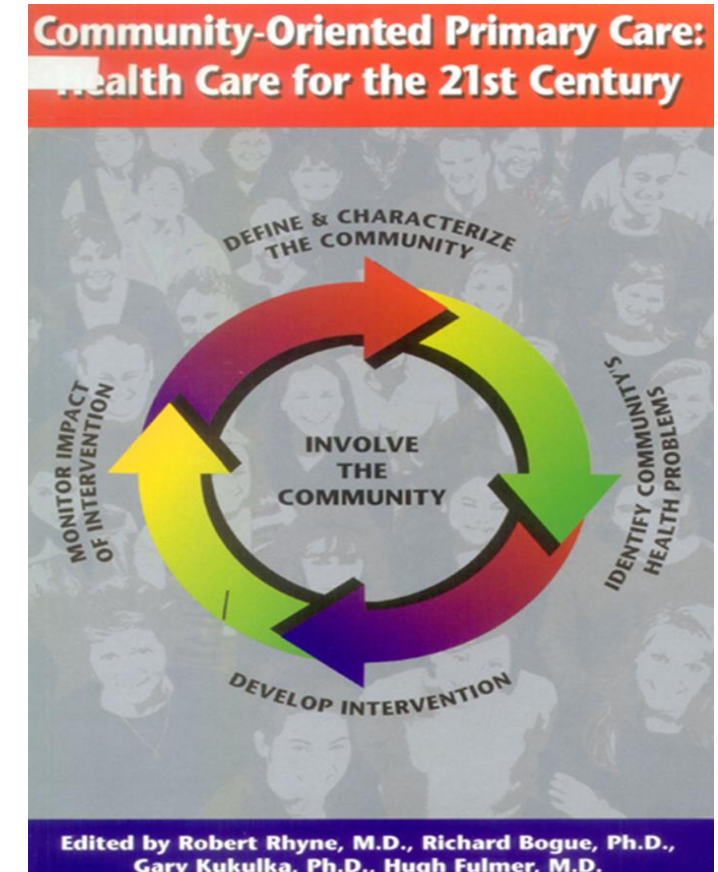
**Assessment: no more severe accidents**

°Implementing “**Community-Oriented Primary Care**” strategy in the context of Population Health Management: integrating decentral and central data to perform a “Community Diagnosis” with involvement of the Community and developing a priority vaccination for people 18-64 yr with increased risk for Covid-19, addressing the upstream causes of ill health, including mental health (Belgian Federal Taskforce Covid-19 Vaccination Strategy)

Figure 4: Dynamic overview of the number of patients selected by CIN (health insurance fund-IMA), by general practitioners, and by both



Registration by doctor  
 Registration by CNN and doctor  
 Registration by CNN



## How to make change happen? Need for new organisational and financing models:

- Increased investment in PHC and in health promotion : from 14 % and (less than) 3 % of Total Health Expenditure (THE) to 30 % and 5 % of THE
- Integration of Primary Care and Public Health services in 'Primary Care Zones'/Districts ....
- (GDPR-proof) Integration of EHR in Primary Care and Public Health enabling goal-oriented care at the individual level and establishing a 'Community Diagnosis' at population level



# Shared Electronic Patient Record

FICTIVO, Denisa (V): Dos. N°01FICTIEF; 01/01/1964 - 50 Jaar 2 Maand(en) 17 Dag(en)

Bestand Bewerken Beeld Vensters Help

Medisch overzicht

Roker : 20 [s/dag] (05/03/2013)

**Belangrijke actieve GE**

- Tabaksmisbruik
- Menopauzale symptomen/klachten
- Hypertensie zonder orga
- Niet insuline-afhankelijke diabetes
- Symptomen/klachten schouder
- Overgewicht
- Hypertensie zonder orgaanbeschadiging
- Sociaal probleem nao, begeleiding maatschappelijk werk

**Familiale antecedenten**

- Acuut myocardiinfarct (Vader)
- Niet insuline-afhankelijke diabetes (Moeder)

**Medische antecedenten**

- Zwangerschap, vlotte partus, zoon
- Zwangerschap, vlotte partus, dochter
- Zwangerschap, vlotte partus, dochter

**Chirurgische antecedenten**

- appendectomie in 1999

**Chronische medicatie**

- Metformine Sandoz tab 100x 850mg
- Asaflo tab EC 168x 80mg
- Simvastatin Sandoz tab 100x 20mg

**Vaccins**

- Toegediende vaccins
- Geplande vaccins

**GezondheidsElementen**

Beschrijving	A	B	R	Begin	Einde	Zekerheid	Duur	Code	Presteerder	Specialiteit
Acute infectie bovenste l				12/02/2014	16/02/2014	Niet bepaald	Acuut	R74	VANDEDRINCK, E	Huisarts
Hypertensie zonder orga	A	E		20/03/2013		Niet bepaald	Chronisch	K86	VANDEDRINCK, E	Huisarts
Menopauzale symptomen	A	E		15/01/2014		Niet bepaald	Sub-acuut	X11	VANDEDRINCK, E	Huisarts
Niet insuline-afhankelijke	A	E		01/03/2011		Niet bepaald	Chronisch	T90	VANDEDRINCK, E	Huisarts
Overgewicht	A	E		05/03/2010		Niet bepaald	Chronisch	T83	VANDEDRINCK, E	Huisarts
Preventie	A			05/03/2013		Niet bepaald	Chronisch	A98	VANDEDRINCK, E	Huisarts
Sociaal probleem nao, be	A	E		20/06/2013		Niet bepaald	Chronisch	Z29	DEWAELE, Liesbe	Maatschappelijk wer
Symptomen/klachten sch	A	E		01/03/2013		Niet bepaald	Chronisch	L08	VANDEDRINCK, E	Huisarts
Tabaksmisbruik	A	E		01/01/1990		Niet bepaald	Chronisch	P17	VANDEDRINCK, E	Huisarts
Zwangerschap, vlotte par	E			01/05/1995	16/02/1996	Niet bepaald	Chronisch	W78	VANDEDRINCK, E	Huisarts
Zwangerschap, vlotte par	E			01/04/1998	06/01/1999	Niet bepaald	Chronisch	W78	VANDEDRINCK, E	Huisarts
Zwangerschap, vlotte par	E			01/07/1993	12/05/1994	Niet bepaald	Chronisch	W78	VANDEDRINCK, E	Huisarts

**Geneesmiddelen**

Beschrijving	Begindatum	Einddatum	A	Presteerder	Specialiteit
<input checked="" type="checkbox"/> Metformine Sandoz tab 100	01/03/2013		<input checked="" type="checkbox"/>	VANDEDRINCK, E	Huisarts
<input checked="" type="checkbox"/> Asaflo tab EC 168x 80mg	05/03/2013		<input checked="" type="checkbox"/>	VANDEDRINCK, E	Huisarts
<input checked="" type="checkbox"/> Simvastatin Sandoz tab 100	05/03/2013		<input checked="" type="checkbox"/>	VANDEDRINCK, E	Huisarts
<input type="checkbox"/> Hygroton tab 30x 50mg	20/03/2013		<input checked="" type="checkbox"/>	VANDEDRINCK, E	Huisarts

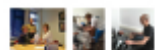
**Planning**

Datum	Beschrijving	Statuut	Presteerder	T	Te doe	Specialiteit
11/03/2014	aanvraag aangepast rijbewijs	Te doen	VANDE KERCKHO	S	<input checked="" type="checkbox"/>	Verpleegkundige
11/03/2014	Opvolgcontact bijeen diëtist	Te doen	VANDE KERCKHO	S	<input checked="" type="checkbox"/>	Verpleegkundige
11/03/2014	verwijzing - oogarts	Te doen	VANDE KERCKHO	S	<input checked="" type="checkbox"/>	Verpleegkundige
11/03/2014	Test op microalbuminurie	Te doen	VANDEDRINCK, E	S	<input checked="" type="checkbox"/>	Huisarts
11/03/2014	Bepaling glucose/HbA1c	Te doen	VANDEDRINCK, E	S	<input checked="" type="checkbox"/>	Huisarts
12/03/2014	Onderzoek diabetische voet	Te doen	VANDE KERCKHO	S	<input checked="" type="checkbox"/>	Verpleegkundige
11/06/2014	DiabetesSpreekUur, educator	Te doen	VANDE KERCKHO	I	<input checked="" type="checkbox"/>	Verpleegkundige
05/09/2014	vaccin griep	Te doen	VANDEDRINCK, E	I	<input checked="" type="checkbox"/>	Huisarts
05/03/2020	vaccin difterie/tetanus	Te doen	VANDEDRINCK, E	I	<input checked="" type="checkbox"/>	Huisarts
25/06/2013	DiabetesSpreekUur	Uitvoerd	BLOKLAND, INEK	I	<input type="checkbox"/>	Huisarts

**Contacten**

Datum	Type	Presteerder	Specialiteit
15/05/2014	Raadpleging	VANDEDRINCK, E	Huisarts
11/03/2014	Raadpleging	BLOKLAND, INEK	Huisarts
12/02/2014	Raadpleging	VANDEDRINCK, E	Huisarts
15/01/2014	Raadpleging	VANDEDRINCK, E	Huisarts
01/11/2013	Raadpleging	DEWAELE, Liesbe	Maatschappelijk we
16/10/2013	Raadpleging	LANCKSWEERDT,	Dietiste
03/09/2013	Raadpleging	VANDE KERCKHO	Verpleegkundige

Integrated  
Interprofessional  
Health Record

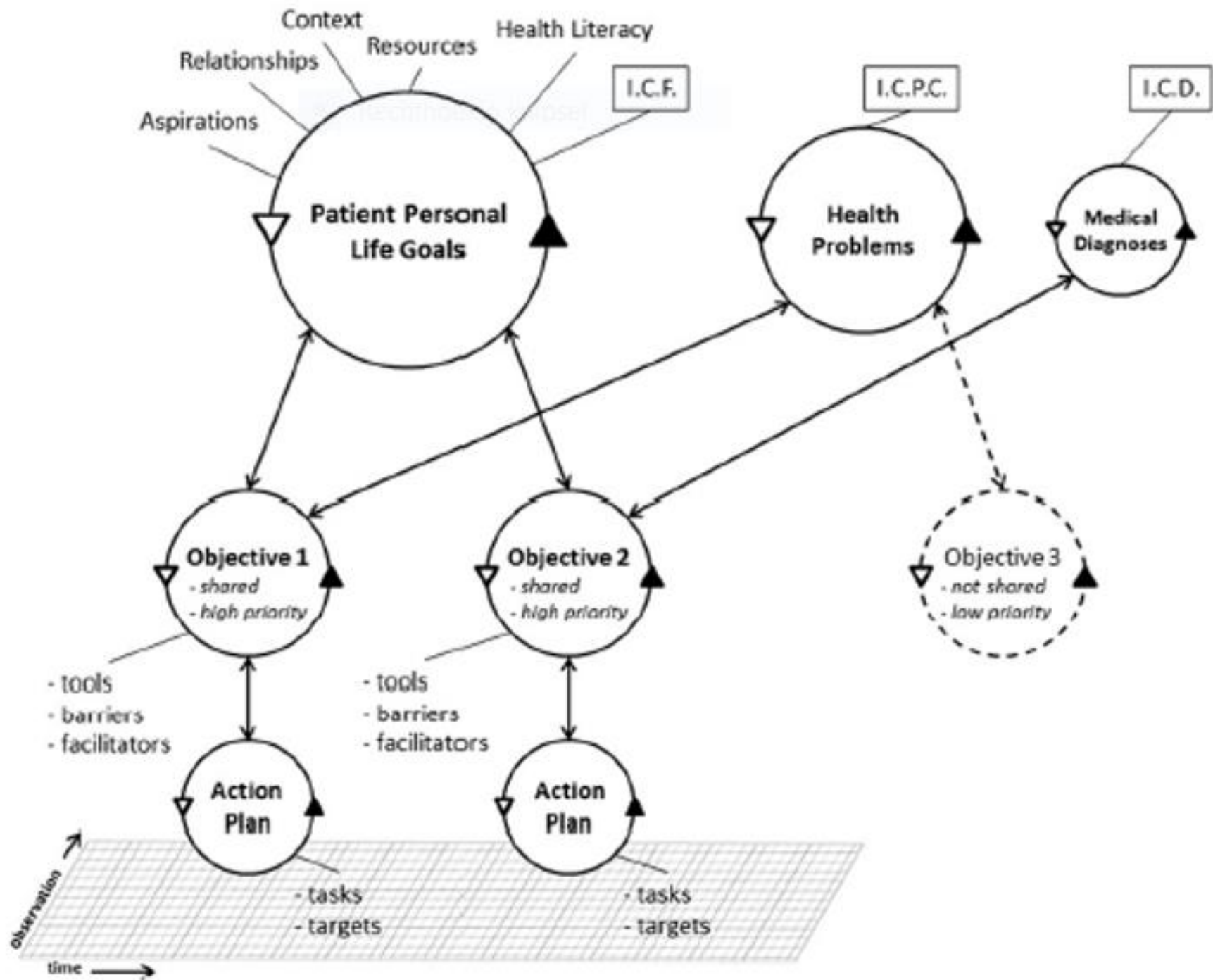


## Towards an overarching model for electronic medical-record systems, including problem-oriented, goal-oriented, and other approaches

Huibert Tange, Zsolt Nagykaldi & Jan De Maeseneer

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To link to this article: <https://doi.org/10.1080/13814788.2017.1374367>

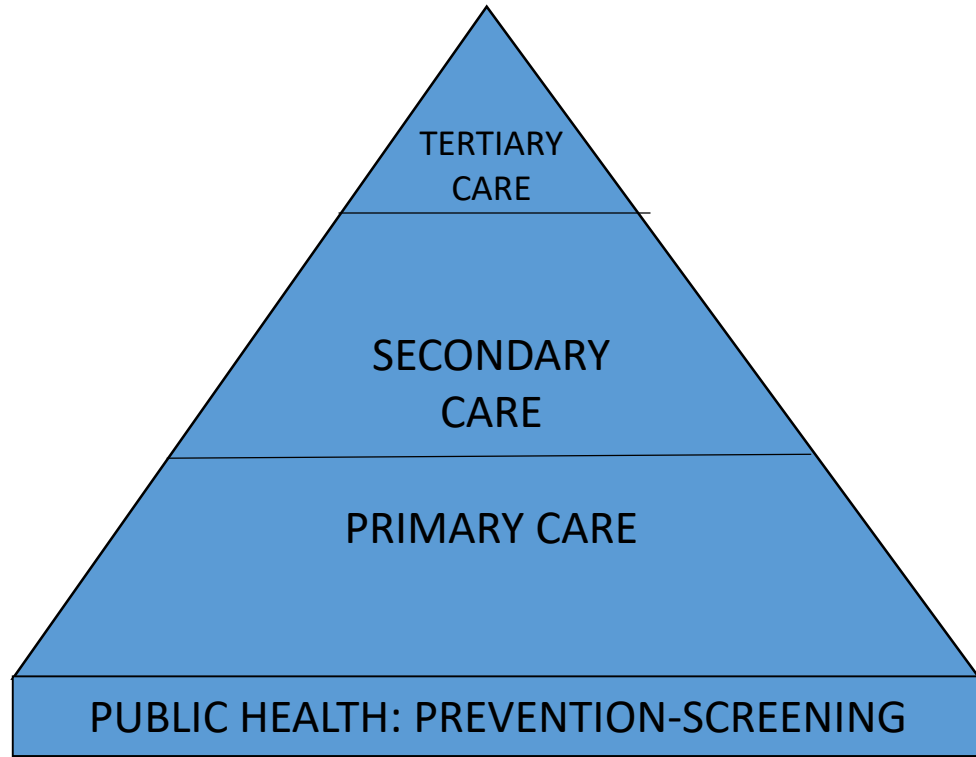




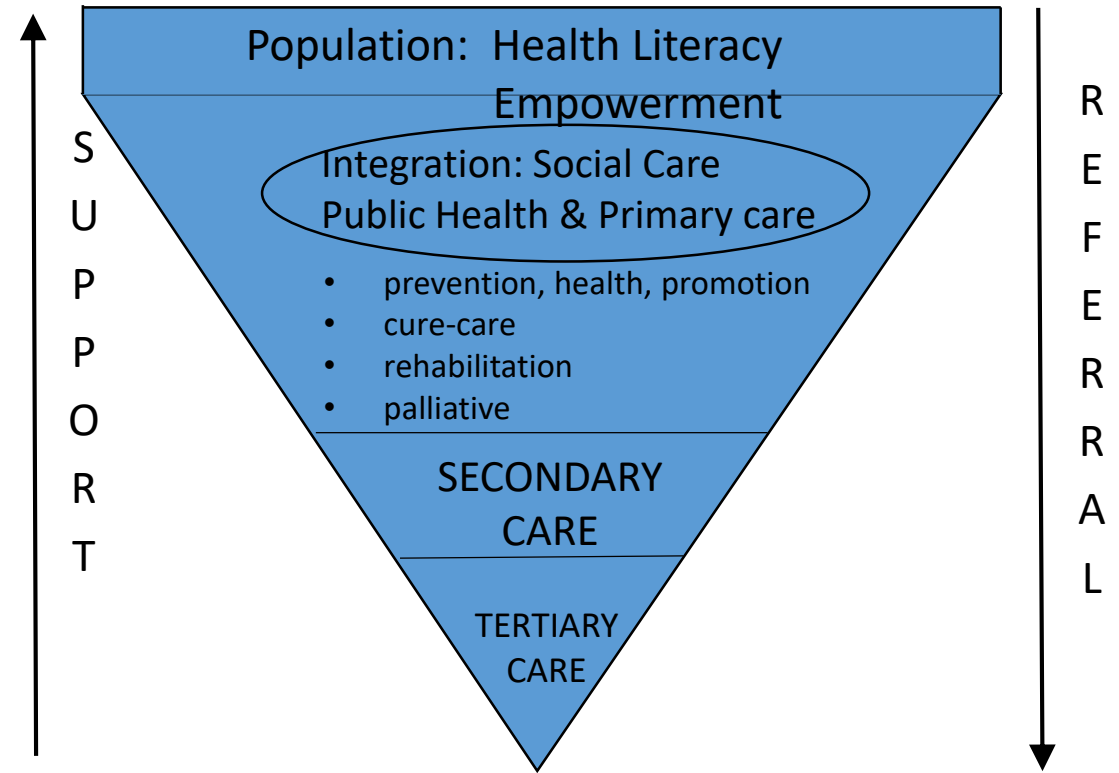
## Reorientation: Need for new organisational and financing models:

- Increased investment in PHC: from 14 % of Total Health Expenditure (THE) to 30 % of THE
- Integration of Primary Care and Public Health services in 'Primary Care Zones'/Districts ....
- (GDPR-proof) Integration of EPR in Primary Care and Public Health enabling goal-oriented care and establishing a 'Community Diagnosis'
- *Interprofessional teams providing care, cure, prevention, health promotion and population management at local level in an integrated way with task shifting and competency sharing*
- *Integrated population-oriented financing systems to stimulate interprofessional cooperation; integrated financing for hospital networks*
- *New health system design: reversing the pyramid*

# Primary Care and hospitals : turning the pyramid upside down (after H. Vuori).



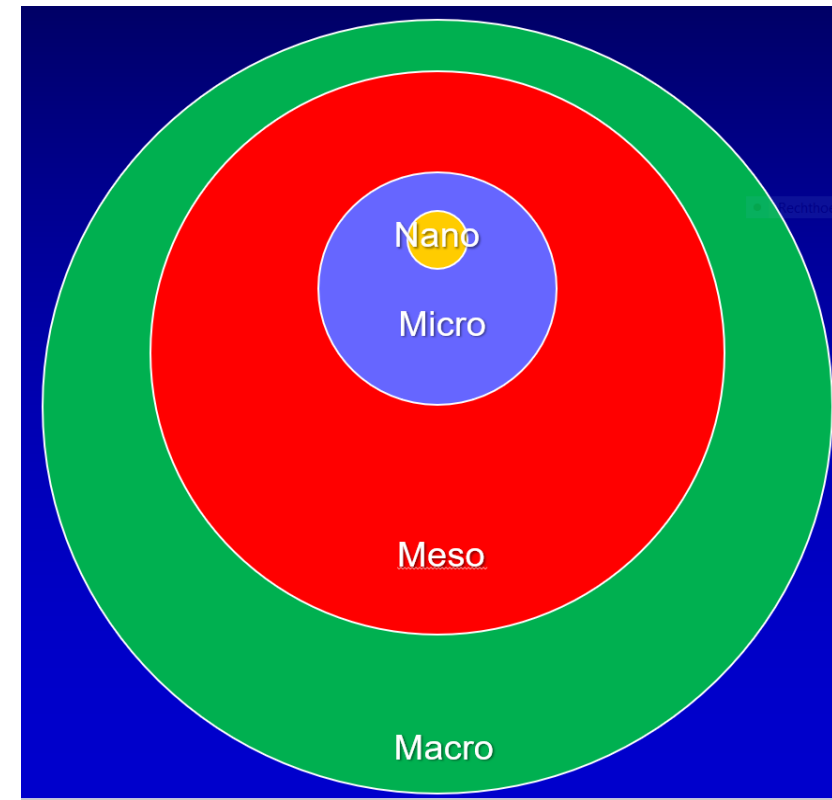
P A S T



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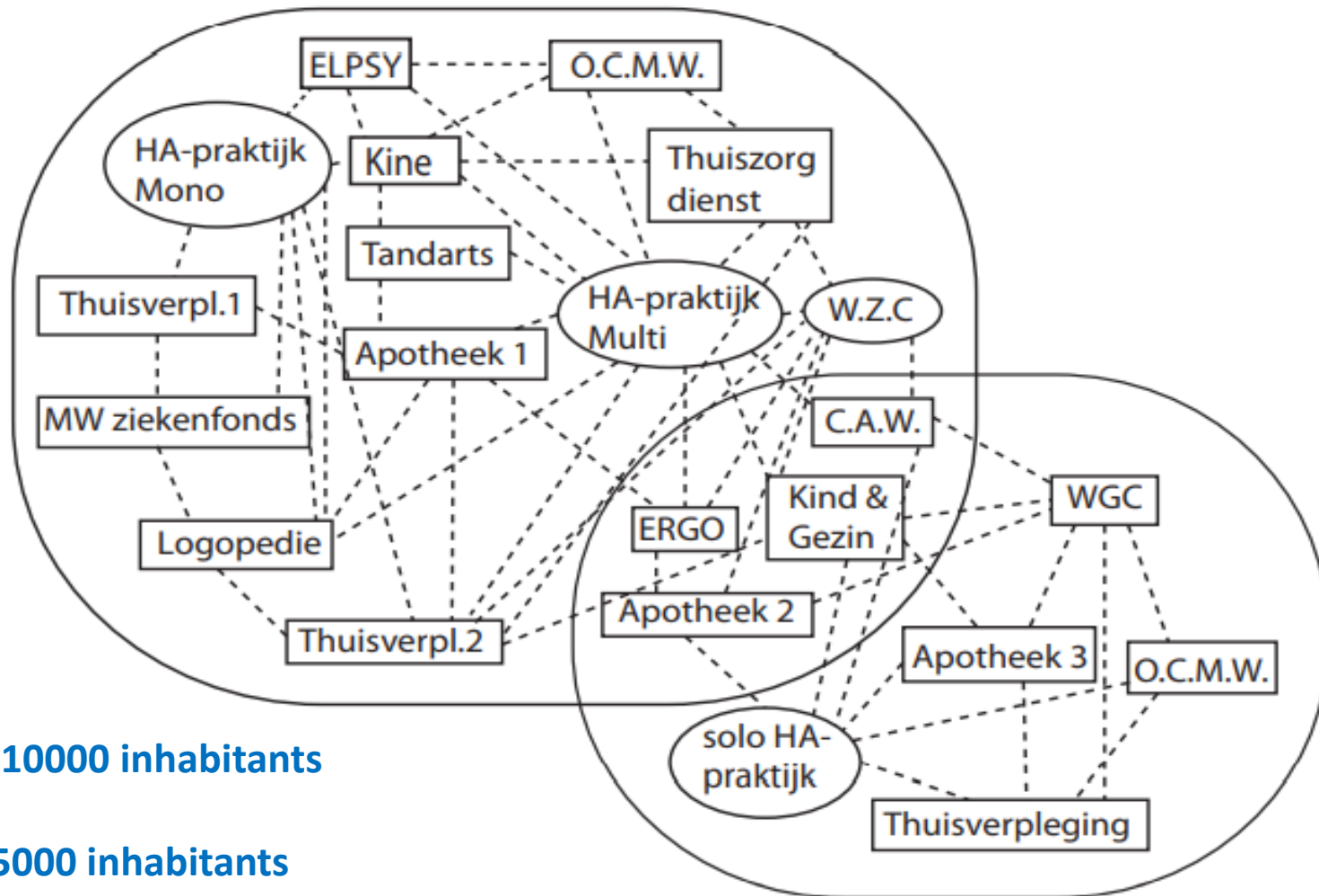
# Involvement of PHC with other levels: health for all policies

- **Micro-level:** from isolated mono-disciplinary practices to interprofessional Primary Care Networks and integrated Community Health Centres.



## Interprofessional cooperation at micro-level : Primary Care Networks

**Figuur 8: Illustratie van het concept Eerstelijnsnetwerk.**

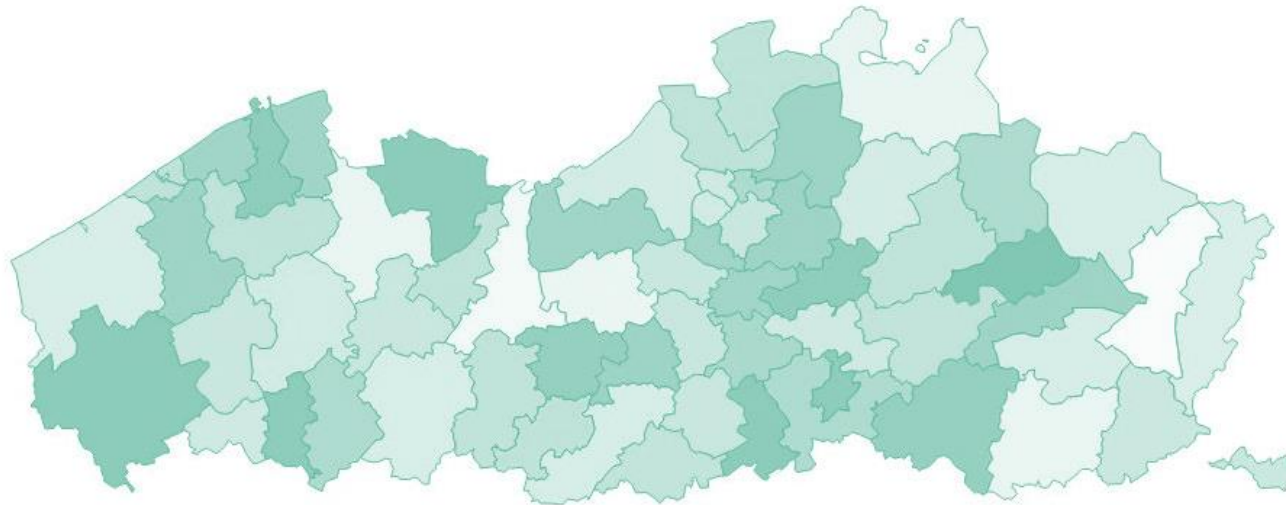


In urban areas : >10000 inhabitants

In rural areas : > 5000 inhabitants



# Meso-Level : Primary Care Zones



AZG 2021

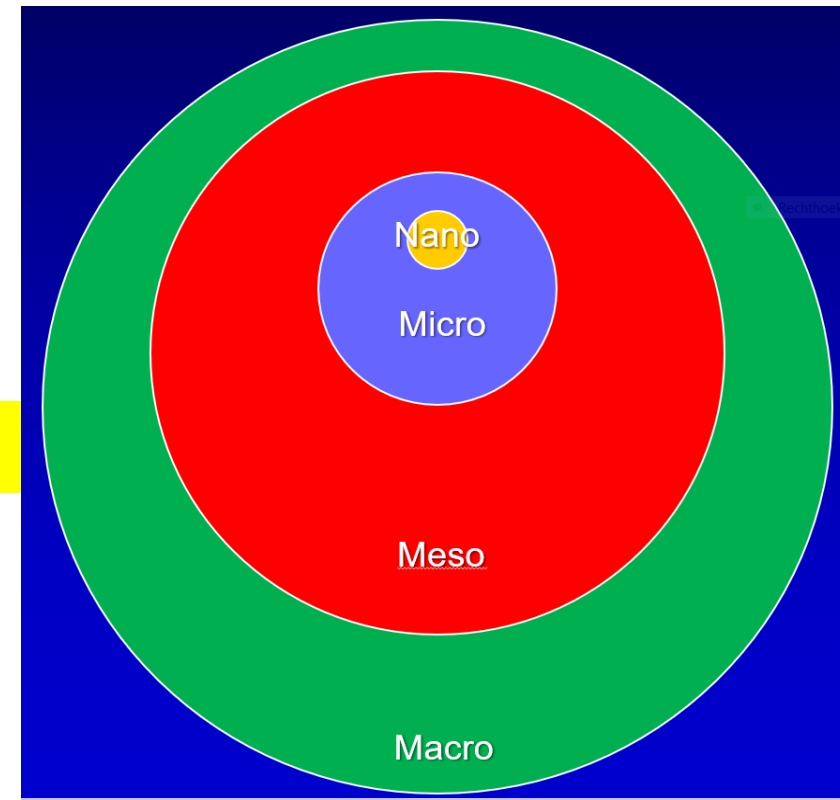


60 primary care zones in Flanders

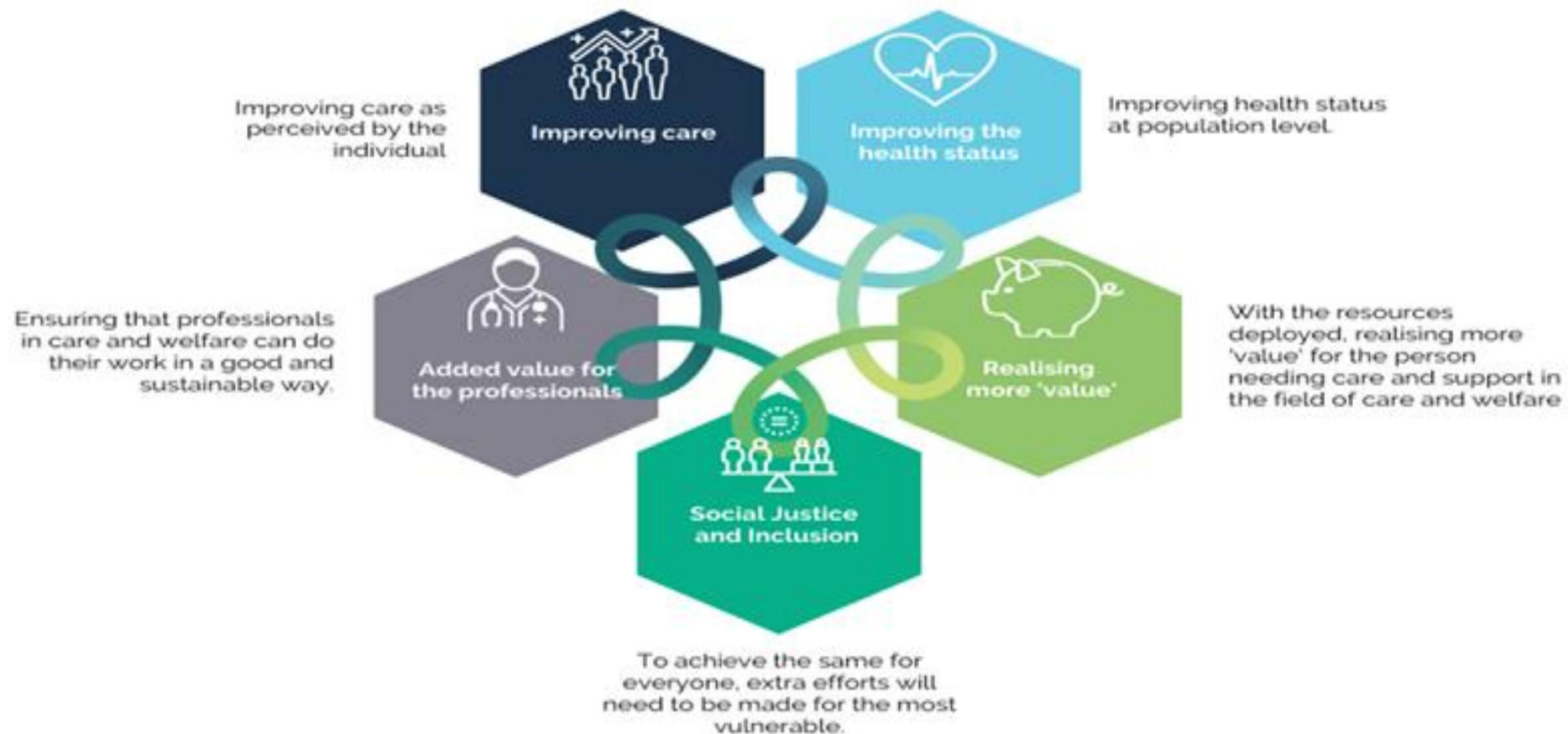
- 70.000 to 125.000 inhabitants
- GOVERNANCE : INTEGRATION PRIMARY HEALTH CARE, SOCIAL CARE, PATIENTS AND INFORMAL CARE GIVERS AND **LOCAL AUTHORITIES**

# Involvement of PHC with other levels: health for all policies

- **Micro-level:** from isolated mono-disciplinary practices to interprofessional Primary Care Networks and integrated Community Health Centres.
- **Meso-level:** 2020: Primary Care Zones: 100000 people.
- **Macro-level:** Defining overarching Health Goals: Quintuple Aim



# Quintuple Aim



Michael Malherby, Sonoo Thadanev Israni, Mahnoor Ahmed, and Danielle Whicher, Editors, 2019. Artificial Intelligence in Health Care: The Hope, the Hype, the Promise, the Peril. NAM Special Publication. Washington, DC: National Academy of Medicine. Translated, adapted, and reproduced with permission from the National Academy of Sciences. Courtesy of the National Academies Press, Washington, D.C.

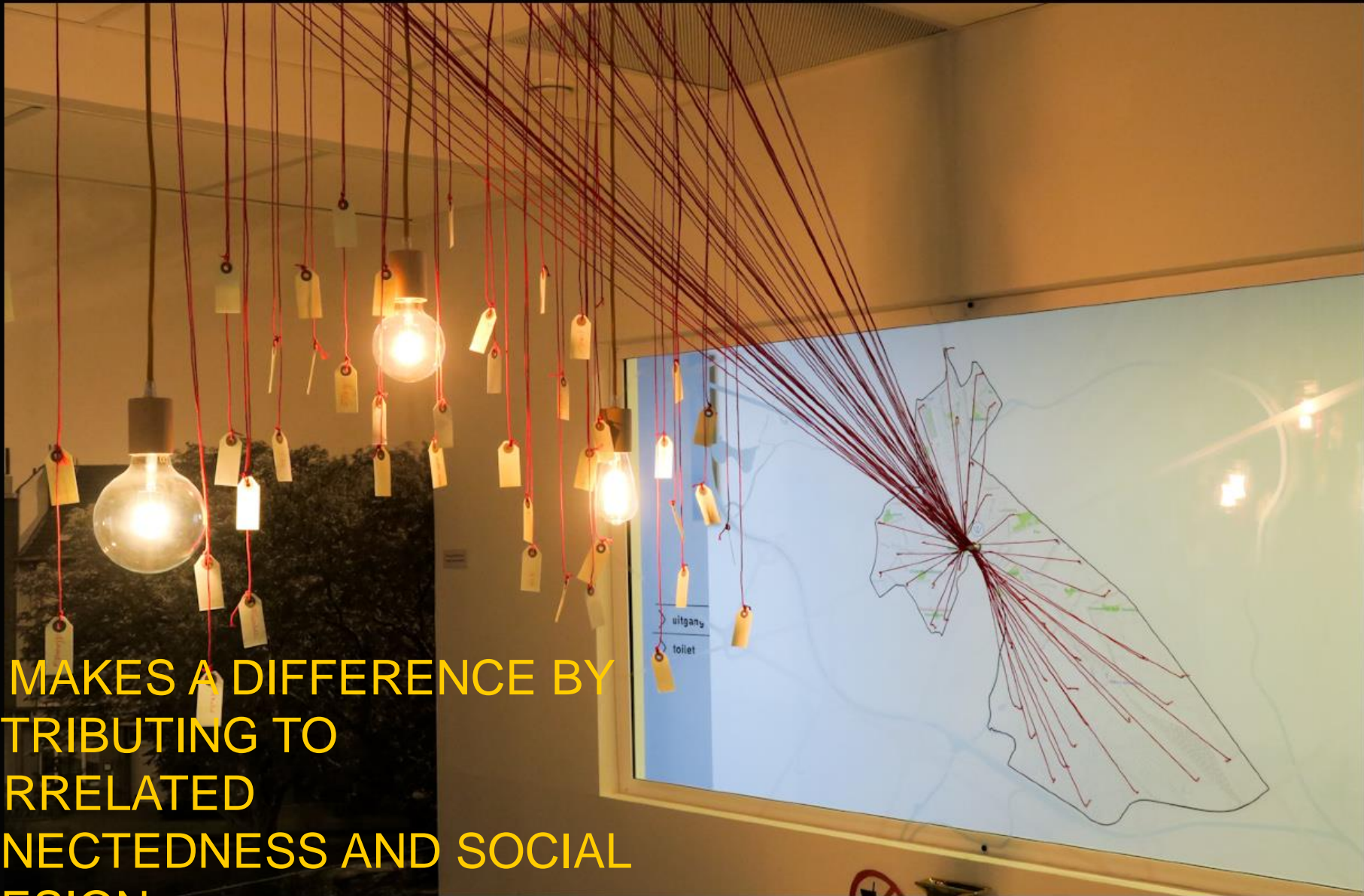


VIVEL





**PHC MAKES A DIFFERENCE BY  
CONTRIBUTING TO  
INTERRELATED  
CONNECTEDNESS AND SOCIAL  
COHESION**



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LANNOO  
CAMPUS



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Familienmedizin und  
Primärversorgung

Am Scheideweg des  
gesellschaftlichen Wandels

KIENER

Thank you....



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**TransForm** Integrated  
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