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7th GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

Person- and People-Centered Integrated Care for All

Core Conference on April 28 – 30, 2014

Pre-Conference Workmeeting on April 27, 2014

Geneva University Hospital and World Health Organization

CONFERENCE BOOKLET

❁ Program

❁ Presenters

❁ Abstracts

www.personcenteredmedicine.org

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www.ijpcm.org

The Seventh Geneva Conference on Person-centered Medicine is organized by the International College of Person-centered Medicine (ICPCM) in collaboration with the World Medical Association (WMA), the World Health Organization (WHO), the International Alliance of Patients' Organizations (IAPO), the International Council of Nurses ICN), the International Foundation for Integrated Care (IFIC), the International Federation of Social Workers (IFSW), the International Pharmaceutical Federation (FIP), the World Federation for Mental Health (WFMH), the Council for International Organizations of Medical Sciences (CIOMS), the International College of Surgeon's (ICS), the International Federation of Gynecology and Obstetrics (FIGO), the Medical Women's International Association (MWIA), the International Federation for Ageing (IFA), the World Association for Sexual Health (WAS), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), the World Federation for Medical Education (WFME), the International Association of Medical Colleges (IAOMC), the Paul Tournier Association, the World Association for Dynamic Psychiatry (WADP), the European Association for Communication in Health Care (EACH), L'Observatoire de Medecine de la Personne, the WHO Collaborating Center at Imperial College London, the International Francophone Psychiatric Federation (ALFAPSY), the French Psychiatric Association, the International Federation of Medical Students' Associations (IFMSA), the Zagreb University Medical School, the Peruvian University Cayetano Heredia, Francisco de Vitoria University, the Universite de Bretagne Occidentale, the Medical University of Plovdiv, the Belgrade University Institute of Mental Health, and University of Buckingham Press, with the auspices of the Geneva University Medical School and Hospital.



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CONFERENCE PROGRAM

Organizing Committee: James Appleyard, Juan E. Mezzich, Michel Botbol, TesfamicaelGhebrehwet, Jo Groves, IhsanSalloum, and Sandra Van Dulmen (all Board Members of the International College of Person-Centered Medicine), Edward Kelley and Hernan Montenegro (World Health Organization), and Lourdes Ferrer and Nick Goodwin (Int'l Foundation for Integrated Care).

Presentation Formats will include a keynote lecture, plenary symposia, teaching workshops, presentations by younger researchers with senior panel feedback, brief oral presentations, and poster presentations. Awards will be presented to the best oral presentation and the best poster. Abstracts are due March 15, 2014. Each submission should include a title, authors with location and e-mail address, and an abstract text of up to 200 words and two references.

Conference Participants will be clinicians and scholars in medicine and other health fields as well as other interested individuals. ICPCM Continuing Professional Development (CME) Certificates will be e-mailed upon request to all registered participants. The registration fee is 400 Euros for persons residing in World Bank Group A (High Income Countries) and 250 Euros for persons in other countries. Documented full time students and members of patient and family associations will pay discounted half-rate fees.

Conference Secretariat: For further information as well as Registration and Abstract Forms, please visit www.personcenteredmedicine.org and write to the ICPCM Secretariat at Int'l Center for Mental Health, Mount Sinai School of Medicine, Fifth Ave & 100 St, Box 1093, New York NY 10029, USA. E-mail: ICPCMsecretariat@aol.com.

April 24, 2014

PRE-CONFERENCE INSTITUTIONAL WORK MEETINGS ON PERSON-CENTERED MEDICINE:

SUNDAY APRIL 27, 2014

**Venue: Geneva University Hospital Auxiliary Halls on a floor below the Main Auditorium,
4 rue Gabrielle-Perret-Gentil CH-1211 Geneva 4, Switzerland.**

1:00 – 4:00 PM

Pre Conference Institutional Work Meetings:

Chairs: *Sandra Van Dulmen, T Ghebrehwet*

- a) 2014 Geneva Declaration Draft Initial Presentation: *Lead by R Cloninger (St. Louis), J Groves (London), L Salvador (Sydney), H Montenegro (Geneva), L Ferrer (Oxford), M Hermans (Brussels), W Van Staden (Pretoria), M Schwartz (Austin, Texas), J Mezzich (New York), S Rawaf (London).*
- b) Update and advancement on Person-centered Diagnosis: *Lead by JE Mezzich (New York), IhsanSalloum (Miami), R Cloninger (St. Louis), L Salvador (Sydney), M Botbol (Brest), J Appleyard (London), J Snaedal (Reykjavik), T Epperly (Boise, Idaho).*
- c) Update and advancement on Guiding Principles for Person-centered Clinical Care: *Lead by Jim Appleyard (London), Jon Snaedal (Reykjavik), S Van Dulmen (Nijmegen), T Ghebrehwet (Alberta), and Jo Groves (London).*
 - Using different sources of evidence to optimize individual treatment: *Luis Flores (London)*

3:00 – 3:15

Coffee Break

- d) Books Workgroup: *Lead by J Mezzich (New York), R Cloninger (St. Louis), M Botbol (Brest), G Christodoulou (Athens), I Salloum (Miami).*
- e) WFMH-INPCM Alliance: Proposal for a WFMH Global Programme to Advance Person-centred and People-centred Mental Health Care: *M Abou-Saleh (London)*

4:15 – 5:15 PM IJPCM Editorial Board Meeting
 5:15 – 6:45 PM ICPCM Board Meeting

CORE CONFERENCE FIRST DAY, MONDAY APRIL 28, 2014 Geneva University Hospital Marcel Jenny Main Auditorium and Auxiliary Halls

8:00 – 8:30 AM Registration and check-in

8:30 – 9:00 AM Conference Opening

- Welcoming words from officers of the ICPCM: *Jim Appleyard (London), Juan Mezzich (New York), Geneva University (P. Giannakopoulos), World Health Organization (Edward Kelley, Geneva) and the International Foundation for Integrated Care (Nick Goodwin, Oxford)*
- Keynote Presentation on person-centered and integrated care across the life-cycle: *Jim Appleyard (London)*

Organizational Note for Symposia, Workshops and Oral Sessions: In general, each presentation should last 8 minutes followed by a 7 minutes discussion, unless more time is available. Chairs are expected to introduce the presenters, time closely the presentations and the Q&As to follow each, and offer conclusions at the session's end.

9:00 – 10:30 AM Plenary Symposium 1: Conceptual issues on health complexity and person-centered integrated care

Chairs: *Jim Appleyard (London), J. Snaedal (Reykjavic)*

- WHO perspectives on conceptualizing people-centered integrated care for all: *E Kelley/H Montenegro (Geneva)*
- Philosophical considerations in approaching health complexity: *W Van Staden (Pretoria, South Africa)*
- Understanding person-centered integrated care: principle and process: *N. Goodwin (Oxford)*
- Engaging complexity: from psychobiology to social systems: *R Cloninger (St. Louis)*
- Integrating the complexity of human development in person-centered care: *M Botbol (Brest, France)*

10:30 – 11:00 AM Coffee Break.

Posters Session:

Chair: *L Brajkovic (Zagreb)*

- A Person-centered Integral Health Self-evaluation System and Update (1985-2014): *Efren Ramirez (San Juan)*
- Building Person centered medicine in Burkina Faso: *Robert Kargougou (Burkina Faso),*
- Person centered approach to patients with laryngeal cancer: *Ana Krpan, Zoran Rakusic, Vesna Bisof, Kristina Ruzsa Samardjic (Zagreb)*

11:00 – 12:30 PM Plenary Symposium 2: Communication for person- and people-centered integrated care.

Chairs: *Ted Epperly (Boise, Idaho), Veljko Djordjevic (Zagreb)*

- Patient perspectives on effective clinical communication: *Joanna Groves (London)*
- Person-centered integration of interdisciplinary teams: *T Ghebrehivet (Alberta, Canada)*
- Cultural and linguistic communication for person-centered integrated care: *Rachid Bennegadi, Stephanie Larchanche, & Rachel Wadoux (Paris)*
- Clinical communication research to support person-centered integrated care: *Sandra Van Dulmen (Nijmegen)*

- Communication in the WHO Coordinated/Integrated Health Service Delivery Framework: *Viktorija Stein (Copenhagen)*

12:30 – 1:30 PM

Lunch (open)

1:30 – 3:00 PM

Plenary Symposium 3: Diagnosis, treatment and care management for person-centered integrated care

Chairs: *M Botbol (Brest)*, *R Cloninger (St. Louis)*

- Principles, strategies, and prospects for person-centered diagnosis: *J Mezzich (New York)*
- Continuity of Life: development and evaluation of a novel concept and instrument in person-centred medicine: *Aleksandar Janca, Alyssa Lillee (Perth)*
- Palliative Medicine as Integrated Care for All: *Marijana Bras, N Komnenic (Zagreb)*
- Holistic assessment of needs, care management, and continuity in people centered integrated care: *N Goodwin (Oxford)*

3:00 – 3:15 PM

Coffee Break

3:15 – 4:45 PM

Parallel Sessions 1:

A. Brief Oral Conceptual Presentations 1 (Main Auditorium)

Chairs: *H-R Pfeifer (Zurich)*, *M Bras (Zagreb)*

- “Competent” Medical Practice must be Person-Centered and Evidence-Based: *Michael Schwartz, Osborne P Wiggins (Austin, Texas)*
- Non Oncological Supportive and Palliative Care: a Multidisciplinary, Multidimensional Person-Centered Approach in an Advanced Heart Failure Clinic: *Kira Stellato, Franco Humar, Donatella Radini, Andrea Di Lenarda (Trieste)*
- Demographic Challenges for Person-Centred Medicine in the Czech Republic: *Hana Konecna, Ludek Sidlo, Catriona Menzies, Ondrej Doskocil (Ceske Budejovice, Czech Republic)*
- Entrepreneurship-The path to Empower the impaired: *Ishita Sanyal (Kolkata, India)*

B. Teaching Workshop 1 (Auxiliary Hall E1-2): Communication for person-centered integrated care

Chairs: *T Ghebrehivet (Alberta)*, *M Ammon (Berlin)*

- Optimizing clinical communication: *S. Van Dulmen (Nijmegen)*
- Spanish speaking countries consensus on core curriculum of communication competencies (CCCC) in the Medicine: *Cristina Garcia Leonardo, Fernando Caballero, Roger Ruiz, Juan Pérez-Miranda (Madrid)*
- How to teach communication skills to medical students: the role of CEPAMET: *Lovorka Brajkovic, Nadja Komnenic, Veljko Djordjevic, Marijana Bras (Zagreb)*
- Knowledge and training needed for good communication in coordinated/integrated health service delivery: *V. Stein (Copenhagen)*

C. Teaching Workshop 2 (Auxiliary Hall E3): Patient, Family and Community Engagement

Chairs: *Y Pongsupap (Bangkok)*, *R Hovey (Montreal)*

- Patient empowerment: *Jo Groves (London)*
- Family/Caregiver involvement: *A Svetini (Bolzano, Italy)*
- Industry engagement: *S Skovlund (Copenhagen)*

D. Workgroups Meeting 1 (Auxiliary Hall E4): Person Centered Integrative Diagnosis (*J Mezzich (New York)*, *I Salloum (Miami)*, *R Cloninger (St. Louis)*, *M Botbol (Brest)*, *L Salvador (Sydney)*, *J Appleyard (London)*, *J Snaedal (Reykjavik)*, *T Epperly (Boise, Idaho)*, *W Van Staden (Pretoria)*)

4:45 – 5:00 PM

Coffee Break

5:00 – 6:30 PM General Assembly of the International College of Person-centered Medicine

7:00 PM Conference Dinner

Invitation to Conference Dinner organized by the Paul Tournier Association

Monday April 28, 7:00 pm
All Conference Participants

CHF 50.-
(Dinner, music, dancing and taxes included)

**please register at
welcome desk**

**Restaurant des
Vieux-Grenadiers**
92 rue de Carouge - 1205 Genève
Téléphone : 022 320 13 27 -
Tram 12, 13 et 14 arrêt "Augustins"



CORE CONFERENCE SECOND DAY, TUESDAY APRIL 29, 2014 Geneva University Hospital Marcel Jenny Main Auditorium and Auxiliary Halls

- 9:00 AM – 10:30 AM Plenary Symposium 4: Public health and people-centered integrated care for all
Chairs: *N Goodwin (Oxford), W Holzgrevé (Basel)*
- The emerging WHO Strategy on People-centered and Integrated Services: *E Kelley/H Montenegro (Geneva)*
 - Person-centered integrated care: what it is, and what is not: *L Salvador (Sydney)*
 - International examples of successful approaches integrating public health and people-centered integrated care: *L Ferrer (Oxford)*
 - The specific relevance of Andrija Stampar's legacy to person and people-centered integrated care for all: *Veljko Djordjevic, Nadja Komnenic (Zagreb)*
- 10:30 – 10:45 AM Coffee Break
- 10:45 AM – 12:15 PM Jitendra Trivedi Memorial Plenary Symposium 5: Education and training for person-centered integrated care
Chairs: *J Appleyard (London), L Ferrer (Oxford)*
- Person-centered undergraduate medical education for integrated care: *S Rawaf (London)*
 - Person-centered residency training for integrated care: *T Epperly (Boise, Idaho)*
 - International experience with person-and people-centered health education: *R Kallivayalil (Kerala, India)*
 - The place of the team approach for person-centered health care training: *T Ghebrehewet (Alberta, Canada)*
 - Competencies as an action area of the WHO Europe Coordinated/Integrated Health Services Delivery Framework: *Viktorja Stein (Copenhagen)*
- 12:15 – 1:30 PM Lunch (open)
- 1:30 – 3:00 PM Plenary Symposium 6: Metrics for person- and people-centered integrated care
Chairs: *L Salvador (Sydney), Y Pongsupap (Bangkok)*
- Advancing the conceptualization and measurement of person-centered care: *J Mezrich (New York)*
 - Statistical approaches to scale development, refinement and validation: *L Kirisci (Pittsburgh)*
 - Measuring the person's experience of integrated care: *N Goodwin (Oxford)*

- Conceptual and cultural strategies for the measurement of person-centered care: *W Van Staden (Pretoria)*

3:00 – 3:15 PM

Coffee Break

3:15 – 4:45 PM

Parallel Sessions 2:

A. Teaching Workshop 3 (Main Auditorium): Person Centered Health Policies

Chairs: *L Salvador (Sydney), A Janca (Perth)*

- Academic perspectives for developing person-centered health policies: *S Rawaf (London)*
- Policy as an action area of the WHO Coordinated/Integrated Health Service Delivery Framework: *Viktorija Stein (Copenhagen)*
- Building central political narratives to support person-centered integrated care: *N Goodwin (Oxford)*
- Research and policy synergism for advancing people-centered Care in Thailand: *Yongyuth Pongsupap (Bangkok)*

B. Teaching Workshop 4 (Auxiliary Hall E1-2): Stakeholders for Person Centered Integrated Care

Chairs: *T Ghebrehivwet (Alberta), Bernard Ruedi (Neuchatel)*

- Patient perspectives: *J Groves (London)*
- Physician perspectives: *Michel Botbol (Brest)*
- Nurse perspectives: *Yukiko Kusano (ICN, Geneva)*
- Pharmacist perspectives: *O Bugnon (Lausanne)*

C. Teaching Workshop 5 (Auxiliary Hall E3): Psychotherapy in Person Centered Medicine

Chairs: *H-R Pfeifer (Zurich), Michael Schwartz (Texas)*

- Working through disclosure and apology with the person and family: a humanizing approach to medical error: *Richard Hovey (Montreal)*
- Dynamic Psychiatry-An Integrative Psychiatric Psychotherapeutic Concept: *Maria Ammon (Berlin)*
- Psychomotricity in person centered medicine: *Elena Gayvoronskaya (Voronezh)*

D. Workgroups Meeting 2 (Auxiliary Hall E4): Person-centered Clinical Care Guiding Principles:

Lead by *Jim Appleyard (London), Jon Snaedal (Reykjavik), S Van Dulmen (Nijmegen), T Ghebrehivwet (Alberta), and Jo Groves (London)*.

4:45 – 5:00 PM

Coffee Break

5:00 – 6:30 PM

Parallel Sessions 3:

A. Brief Oral Research Presentations 2 (Main Auditorium)

Chairs: *S Van Dulmen (Nijmegen), L Kirisci (Pittsburgh)*

- The hermeneutics of suffering: researching chronic pain: *Richard Hovey (Montreal)*
- Person centered medicine in modern pregnancy care: *Wolfgang Holzgreve (Bonn)*
- Patient narratives in person-centered integrated care: *Geva Greenfield, Agnieszka M Ignatowicz, Yannis Pappas, Azeem Majeed, Matthew Harris (London)*
- Work of the Nutrition and Obesity Advisory Centre: *Maja Vukmirović (Zagreb)*

B. Teaching Workshop 6 (Auxiliary Hall E 1-2): Integrating Primary Care and Mental Health Care

Chairs: *M Abou-Saleh (London), Elena Gayvoronskaya (Voronezh)*

- Family Medicine Perspectives: Integrating Primary Care and Mental Health Care: *T Epperly (Boise, Idaho)*
- Multimorbidity in the Severely Mentally Ill: the Need for a Person-centered Integrated Approach: *H Millar (Dundee, Scotland)*

- Integrated person-centered care for dementia: *J Snaedal (Reykjavik)*
 - International perspectives on integrated care: *R Kallivayalil (Kerala, India)*
- C. Teaching Workshop 7 (Auxiliary Hall E3): Person-centered Child Healthcare
Chairs: *E Shemesh (New York), A Svettini (Bolzano, Italy)*
- Patient-centered model for mental health screening development in pediatric allergy outpatient clinic: *Brianna Lewis, Rachel A. Annunziato, Melissa Rubes, Christina Supelana, Scott Sicherer, and Eyal Shemesh (New York)*
 - Person-centered child health: *Jim Appleyard (London)*
 - Person-centered child and adolescent mental health: *Michel Botbol (Brest, France)*
- D. Workgroups Meeting 3 (Auxiliary Hall E4): 2014 Geneva Declaration finalization (*R Cloninger (St. Louis), J Groves (London), L Salvador (Sydney), H Montenegro (Geneva), L Ferrer (Oxford), M Hermans (Brussels), W Van Staden (Pretoria), M Schwartz (Austin, Texas), J Mezzich (New York), S Rawaf (London)*)

CORE CONFERENCE THIRD DAY, WEDNESDAY April 30, 2014
Geneva University Hospital and World Health Organization Headquarters

Geneva University Hospital Main Auditorium

- 9:00 AM – 10:30 AM Plenary Symposium 7: Ethical bases for person-centered integrated care for all
Chairs: *J Appleyard (London), E Villar (Geneva)*
- WMA's perspectives on ethics and person centered medicine: *J Snaedal (Reykjavik)*
 - The ethics in 'patient-centered' care: *Samia Hurst (Geneva)*
 - WHO's perspectives on integrating person-centered ethics into public health: *MC Bouesseau (Geneva)*
- 10:30 -10:45 AM Coffee Break
- 10:45 AM – 11:30 AM Conference Closing
- Presentation of the 2014 Geneva Declaration: *R. Cloninger (St. Louis)*
 - Concluding remarks and next steps: *Jim Appleyard (London), JE Mezzich (New York)*

Post-closing Session at WHO Headquarters Salle B

- 12:30 – 2:00PM Special Session with leaders of ICPCM Cooperating Organizations and WHO officers on collaboration for the development of the WHO Strategy on People-Centered and Integrated Services
Chairs: *H. Montenegro (Geneva) and Jim Appleyard (London)*
- Presentation of the WHO Strategy under development: *E Kelley (Geneva)*
 - Contributions from collaborating Organizations: ICPCM, World Medical Association, International Council of Nurses, International Alliance of Patients' Organizations, International Pharmaceutical Federation, World Federation for Mental Health, World Psychiatric Association, International Francophone Psychiatric Federation, International Association of Medical Colleges, World Association for Dynamic Psychiatry, European Association for Communication in Health Care, American Academy of Family Physicians, Paul Tournier Association, European Federation of Associations of Families of Persons with Mental Illness, International Federation of Medical Students' Associations, Zagreb University, Pushpagiri University, Imperial College London, University of Sydney, Texas A&M University, Mount Sinai School of Medicine, University of Pretoria, University of Western Brittany, Peruvian University Cayetano Heredia, University of Geneva, International Foundation for Integrated Care as well as other key scholars.
 - Next steps towards strategy implementation: *E. Kelley (Geneva), H Montenegro (Geneva), J Appleyard (London) and JE Mezzich (New York)*



SEVENTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

GALLERY OF PRESENTERS



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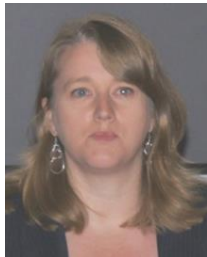
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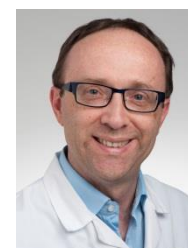
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SEVENTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

ABSTRACTS

PRE-CONFERENCE INSTITUTIONAL WORKMEETINGS

Update and Advancement on Person Centered Diagnosis

UPDATE AND ADVANCEMENT ON PERSON CENTERED DIAGNOSIS

Juan E. Mezzich

This workmeeting will start with an update on the Person-centered Integrative Diagnostic (PID) Model published in the *Canadian J Psychiatry* in 2010. It will also review more recent activities on various aspects of this model and its validation.

It will then review a practical application of the PID model, the Latin American Guide for Psychiatric Diagnosis, recently published by the Latin American Psychiatric Association (APAL) for its official use by mental health professionals in Latin America.

The session will then focus on the how to develop a practical person-centered diagnosis guide for use in general medicine, with the participation, among others, of representatives of the current PID workgroup as well as experts in pediatrics, geriatrics and family medicine from the ICPCM. Discussions are expected to deal with the following questions:

How should we organize diagnosis of health for use in general medicine?

- Should this be just a formulation or an interactive collaborative process?
- Should it focus just on illness or also functioning and wellbeing?
- Should it also consider contributory factors?
- Should it also consider experience, values, and expectations?
- Should it only use categories or also dimensions and narratives?
- Should it be produced just by clinicians or represent joint understanding with patients and families?

How should we assess personhood? Should it focus on the personal life project? How should such assessments be organized?

Update and advancement on Guiding Principles for Person-centered Clinical Care

THE CHALLENGE OF USING DIFFERENT SOURCES OF EVIDENCE TO FIND THE BEST POSSIBLE TREATMENT IN PARTICULAR PATIENTS.

Luis Flores

How to suggest the best possible treatment approach for each individual patient is one of the fundamental challenges of medicine. This task involves not only the assessment of several sources of information, but also paying careful attention to patients' values and preferences (1). While Evidence Based Medicine has highlighted the importance of incorporating evidence from valid controlled into clinical decisions (2), there is no total agreement on (i) how research should be used in particular patients and (ii) what is the role of non-research evidence when apparently relevant research evidence is available.

This paper considers bayesian inference as a method to incorporate any information affecting the probabilities of outcomes in the patient at hand. Doctors are familiar with this approach when assessing the level of certainty of standard diagnostic hypotheses; however, it has not been

proposed to estimate the probabilities of treatment outcomes for more comprehensive diagnostic formulations.

Within this framework, treatment effects from research, if relevant, should be interpreted as provisional estimates, which need to be individualized after updating probabilities in the light of all what the doctor knows about his patient, context, and the circumstances of the clinical encounter.

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Haines A et al. Decision Analysis and the Implementation of Research Findings. In *Getting Research Findings Into Practice*, 2nd Edition. 2008.

Kravitz RL et al. Evidence-based medicine, heterogeneity of treatment effects, and the trouble with averages. *Milbank Q.* 2004;82:661-687.

Books Workgroup

DEVELOPMENT OF THE ICPCM BOOKS PROGRAM

Juan E. Mezzich

Building on our institutional experience with the International Journal of Person Centered Medicine, a books program on Person Centered Medicine is being started. As a first project, we are developing an ICPCM book on Person Centered Psychiatry requested and contracted by Springer Verlag of Heidelberg. This volume will have as editors JE Mezzich, M Botbol, G Christodoulou, CR Cloninger, and IM Salloum. The sections of this book include the following:

Principles: The person as center of health, Ethics in person centered psychiatry, Holistic framework for ill and positive health, Subjectivity, intersubjectivity and psychological functioning, The role of communication, Cultural sensitivity, Recovery, empowerment, and person centeredness, Person-centered patient perspectives, and Person-centered family perspectives.

Diagnosis and Assessment: Person-centered Integrative Diagnosis, Health status from illness to wellbeing, Health contributory factors, Health experience and values, Categories, Dimensions and narratives, Joint diagnostic understanding: Interviewing and assessment, and Shared decision-making among clinicians, patients and families.

Person Centered Care Approaches: Interdisciplinary team approach for clinical care, Person-centered prevention, Person-centered psychopharmacotherapy, Person-centered psychotherapy, Person-centered sociotherapy, Person-centered rehabilitation, and Person-centered health promotion.

Person-Centered Care for Specific Mental Conditions: Dementia and other neuro-psychiatric disorders, Substance abuse, Schizophrenia and related disorders, Bipolar disorder, Depression and anxiety disorders, Eating Disorders, Sexual Disorders, Trauma, Personality disorders, Disorders starting in childhood and adolescence, and Psychiatric, and general medical comorbidity.

Special Topics: Spirituality and person centered care, Person-centered forensic psychiatry, People-centered organization of psychiatric services, Evaluation of person-centered health services, Person-centered public mental health, Person-centered psychiatric education, and Person-centered psychiatric and mental health research.

Future projects under the ICPCM Books program may include a volume on Person Centered Medicine and possibly volumes on more specific topics from the viewpoint of particular health professional disciplines.

Other Workgroups: Person centered Mental Health

WFMH-ICPCM ALLIANCE: PROPOSAL FOR A WFMH GLOBAL PROGRAMME TO ADVANCE PERSON-CENTRED AND PEOPLE-CENTRED MENTAL HEALTH CARE

Mohamed Abou-Saleh

The World Federation for Mental Health has demonstrated a commitment to the International Network (now College) of Person Centered Medicine by co-sponsoring the Geneva Conferences on Person Centered Medicine since their first edition. Furthermore, the WFMH established a collaborative alliance with the INPCM in 2011 to promote longstanding principles of inclusiveness of consumers and families at the centre of the decision making process in order to reduce stigmatization, ensure fair distribution of resources, equal access to health care, and equal representation at government level. Since then the WFMH has demonstrated global leadership in the development and the launch of the

WHO Global Mental Health Action Plan (2013-2020), the Great Push for Mental Health, People's Charter for Mental Health in 2014 and the WFMH Action Plan in 2013. These programmes are all of relevance to the guiding principles and actions of the ICPCM.

It is timely that the WFMH-ICPCM collaboration develop a global programme to advance person-centred and people-centred mental health care in the context of the above initiatives and propose to have Person-centred Care as the theme of a future World Mental Health Day.

CORE CONFERENCE

OPENING

PERSON-CENTERED AND INTEGRATED CARE ACROSS THE LIFE-CYCLE: JIM APPELYARD (LONDON)

Jim Appleyard (London)

The Health and Wellbeing of a person are adaptive processes related to the consequences of genetic, biological, social, cultural behavioral and economic determinants. Circumstances change as the person develops with accumulative risk and protective factors especially during critical and sensitive periods. A life course perspective offers a more joined up approach with implications for long term health gain. There is an emphasis on an integrated continuum of early intervention and education rather than of disconnected and unrelated stages. Each life stage exerts influence on the next. Detailed recommendations for a life course approach starting with childhood health and the implications for the later stages of a lifespan have been set out in the BMA Report on Growing up in the UK.

Disparities in health outcomes and in the psychosocial factors contributing to them are present early in life and are expressed and compounded during a person's lifetime. Risk factors are embedded in a person's biological makeup, manifested in the disparities in a population's health, and maintained by social, cultural, and economic forces.

Because research on health disparities has demonstrated the effect of many determinants interacting in various contexts at developmentally sensitive points, we need an integrated conceptual model to translate evidence into policies, practices, and health systems.

Plenary Symposium 1: Conceptual issues on health complexity and person-centered integrated care

WHO PERSPECTIVES ON CONCEPTUALIZING PEOPLE-CENTERED INTEGRATED CARE FOR ALL

Hernan Montenegro

A conceptual framework was developed by WHO to help map the relationships between the different constructs examined in the Global Strategy on People-centered and Integrated Health Services. This framework presents individuals, families and community at its center, placed within a service delivery context that offers, universal, equitable, people-centered and integrated health services. These types of services are driven through productive linkages between communities and health services, as well as direct inputs from the overall health sector including governance, financing and other resources such as human resources for health. In addition this framework acknowledges linkages between health services and other sectors. Progress toward people-centered and integrated service delivery, will be supported by a policy environment that recognizes the importance of equity and encourages close collaboration between health and other sectors. Finally, the varying country and regional settings in which this strategy will be applied, with their different features in terms of political stability, economic development and governance, provide the environmental context for the framework.

Key operational definitions that complement the above framework are:

People-centred - An approach to care that consciously adopts individuals', families', and communities' perspectives as

participants in and beneficiaries of trusted health systems, that respond to their needs and preferences in humane and holistic ways. People-centered care also requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases."

Source: Adapted from World Health Organization and USAID as quoted by the National Ageing Research Institute.

Integrated Services - The management and delivery of health services such that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course.

Source: Adapted from WHO

Universal health coverage - Ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship"

Source: The World Health Organization

PHILOSOPHICAL CONSIDERATIONS IN APPROACHING HEALTH COMPLEXITY

Werdie Van Staden

Philosophy may be described as a disciplined and scholarly activity that seeks clarity on a subject of interest or difficulty – in the words of William James: an unusual stubborn effort to think clearly. Health complexity is no doubt critically about difficulty, no less so for its lack of clarity by which it is identified as a complexity. The turn to philosophy is thus apt in the face of health complexity and its conceptual relations with Person-Centred Medicine (PCM).

The clarity that philosophy brings about health complexity is conceptual: that is *inter alia*, on what health complexity is; on its kinds; its underpinnings; its importance; and the conceptual ways in which health complexity is espoused, reduced, avoided, and accounted for theoretically and practically. That clarity is required to understand the complexities that PCM is

contracted to conceptually. For example, an ethics that has sufficient scope for pursuing person-centredness, will need to espouse both theoretically and practically the complexity of values diversity, resist a reduction to 4 bio-ethical principles, and find recourse in dynamic (interpersonal) processes in dealing with complexity rather than expecting erroneously that ready-made answers or evidence or universally true solutions would be available and sufficient.

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2) Plsek PE, Greenhalgh T. The challenge of complexity in health care. *British Medical Journal*, 323:625-628.

UNDERSTANDING PERSON-CENTERED INTEGRATED CARE: PRINCIPLE AND PROCESS

Nick Goodwin

Person-centered and integrated care are key concepts underpinning the health reforms of many countries across the World and are central to strategies being taken forward by the World Health Organisation and the European Commission. Yet

there remain different interpretations on what these terms mean in practice. This presentation will seek to clarify the two concepts and outline why they should be considered as core principles to improving care systems around the World.

ENGAGING COMPLEXITY: FROM PSYCHOBIOLOGY TO SOCIAL SYSTEMS

Robert Cloninger

Care and promotion of health involve feedback interactions among many variables at multiple levels of organization. There is complexity within the bodies of persons; among the physical, mental, and social aspects of persons; among people in families, communities, countries; and among countries internationally through various people, organizations, institutions, and governments. The characteristics of complex adaptive systems will be described in general and as applied to the psychobiology of persons and the interactions within and between systems for health care and health promotion. The main characteristics of complex adaptive systems can be compared to the development of living organisms: they are holistic, non-deterministic, show abrupt jumps in development, involve local initiative and dialogue that is simultaneously bottom-up and top-down, and focus on diversity and variability in a person-centered way. In contrast, deterministic systems

are comparable to the assembly of machines from separate parts: they are reductionistic, show gradual incremental change, involve global control through vertical management by experts, and focus on averages. Systems for health care and promotion operate as complex adaptive systems, just as does the psychobiological development of well-being within a person.

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INTEGRATING THE COMPLEXITY OF HUMAN DEVELOPMENT IN PERSON-CENTERED CARE

Michel Botbol

PCM should not be reduced to the individualization of care or the respect for patients' rights, as it aspires to something more: the recognition of the individual subjectivity of the whole person of the patient beyond what characterizes his or her illness or the status of a patient. What is of interest here is dealing with the inner world and the story of a patient (meaning both his development and his life events), in his particular situation of suffering and dependence caused by illness. Like in Aristotle's *Nicomachean Ethics*, PCM aims to the "Cure of a unique person and not a generalized nosological case, in a specific situation, within a specific, unrepeatable period of one's life" (Warne 2007). Such a

stance imposes to consider the complexity of the person as the essence of medicine, its authentic epistemic object.

What becomes crucial here is the commitment of the physician to approach the patient's subjectivity and story in his singular vital situation. In this regard, PCM shares with PCA and Dynamic Psychiatry the conviction that it is of central importance for clinical practice to empathically understand the inner world of the other and to accept that there are as many realities as there are persons in their complexity. "One cannot be a person if he does not believe in his self identity and continuity. No one is in a state of alertness without believing he is awaked" (D. Anzieu)

Posters Session

A PERSON-CENTERED INTEGRAL HEALTH SELF-EVALUATION SYSTEM AND UPDATE (1985-2014)

Efren Ramirez

The Octagonal Assessment of Personality (OAP) is a Person-Centered Integral Health Dimensional Self-Evaluation System utilized at the Ocean Park Ambulatory Therapeutic Community (OPATC) as a pre-admission requirement for (20,000 plus) candidates for treatment since 1993. The Dimensional Intensity Scale (DIS) utilized in the OAP, an adaptation of the DSM-IV GAF Scale, is used to assess the severity of common personality dysfunctions as identified in eight angles/axes (Ref. www.addapr.info/cibernetclinic.html).

At the OPATC in San Juan, Puerto Rico, we practice Adaptogenetic Nutrigenomics (essential nutrients including all amino acids, catalyzed by chelated Lithium, of vegetable origin, not to be confused with lithium carbonate, instead of psychotropic drugs), to epigenetically modify the personality

dysfunctions identified in the OAP (Ref. www.club120.net and www.chelatedlithiumformankind.org).

With the OAP we identify 250 chelated lithium-responsive dysfunctions, and monitor intervention outcomes in the promotion of integral healing and in primary, secondary and tertiary prevention initiatives as determined by the DIS. The Nutrigenomic Adaptogenetic protocol structured around the OAP could become a future world-wide, drug-free person-centered comprehensive health system, operated in a cost-effective way by trained professionals and lay practitioners. Training consists of a 2 hour-workshop (available at this conference) and followed up by internet supervision, as long as required (Ref. eramirezmd@gmail.com and <https://groups.google.com/individuanes>)

BUILDING PERSON CENTERED MEDICINE IN BURKINA FASO

Robert Kargougou

Burkina Faso has seen progress on the various pillars of its health system. However, a closer analysis reveals that many challenges remain regarding the quality and use of services (National Health Development Plan Burkina, 2011). The values of fairness, ethics, respect for the cultural identity of individuals and communities, people's right to information must guide planning and services delivery. Burkina Faso reaffirms also that it adheres to the principles of primary health care (National Health Policy Burkina, 2011). However, declination of these values and principles in the National Health Development Plan 2011-2020 and the operational plans of structures is still mixed or still borders on wishful thinking.

Face to people which are increasingly demanding respect for their dignity, their perceptions and representations deal with the disease, the doctor-patient relationship remains in distancing based on biomedicine.

The following areas could be part of the solution to enhance performances:

- Build alliances in search of national and international allies;
- Revisiting pre services curricula;
- Take into account people centred medicine in the annual planning guideline of the Ministry of Health and in performance based financing evaluation criteria's..

PERSON CENTERED APPROACH TO PATIENTS WITH LARYNGEAL CANCER

Ana Krpan, Zoran Rakusic, Vesna Bisof, Kristina Ruza Samardjic

Development of science and technology gave us more successful methods of treating cancer patients. We can choose among several modalities of treatment individualizing approach and taking into account the most efficient treatment that is in accordance with patients' wishes and acceptable side effects. Patients with head and neck tumors are particularly vulnerable group. The incidence of tumors of the oral cavity, pharynx and larynx is higher in lower socio - economic subgroups with low incomes, smokers and alcoholics. As a large proportion of them are being potentially curable, radical treatment methods are applied such as surgery, radiotherapy ± chemotherapy. In some stages of disease the same results are obtained by surgery or radiotherapy. Surgery is usually extremely mutilated, for example laryngectomy (1). Patients cannot speak, they have a tracheostomy, neck dissection, and they are socially stigmatized leading to further isolation and introversion. Larynx preservation approach is sometimes a reasonable option (2). A good integration in life is relatively

successfully achieved in countries with well-established clubs of laryngectomy patients that provide psychological and professional help. Voice and speech rehabilitation is of paramount importance. Particularly interesting are choirs of laryngectomy patients. Multidisciplinary work achieves the best results of treatment.

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Plenary Symposium 2: Communication for person- and people-centered integrated care

PATIENT PERSPECTIVES ON EFFECTIVE CLINICAL COMMUNICATION

Joanna Groves

Health systems in all world regions are under pressure and cannot cope if they continue to focus on diseases rather than patients (1). To fairly and effectively improve health outcomes and quality of life for patients, people and patients need to be brought to the centre of healthcare (a patient-centred approach). Individual patients need to be empowered to be actively involved in the management of their health in order to make healthy lifestyle and behavioural choices and take their medicines correctly.

According to the principles of patient-centred healthcare (2), information exchange, communications and a constructive dialogue between patients and healthcare professionals are key. During this presentation, what this means for the roles of healthcare professionals and patients and how they work together towards meaningful and ongoing shared decision making which improves healthcare and quality of life outcomes for patients will be considered. A number of examples will be shared to highlight how patients' organizations and patients are contributing to shared decision making and patient information initiatives around the world.

The International Alliance of Patients' Organizations (IAPO) is a unique global alliance representing patients of all nationalities across all disease areas and promoting patient-centred healthcare around the world. Our members are patients' organizations working at the local, national, regional and international levels to represent and support patients, their families and carers. A patient is a person with any chronic disease, illness, syndrome, impairment or disability.

IAPO's vision is that patients throughout the world are at the centre of healthcare.

IAPO's mission is to help build patient-centred healthcare worldwide by:

- Realizing active partnerships with patients' organizations, maximizing their impact through capacity building
- Advocating internationally with a strong patients' voice on relevant aspects of healthcare policy, with the aim of influencing international, regional and national health agendas and policies
- Building cross-sector alliances and working collaboratively with like-minded medical and health professionals, policy makers, academics, researchers and industry representatives

To find out more about IAPO and our activities, please visit our website at www.patientsorganizations.org

- (1) Chronic diseases (including cancers, heart disease and diabetes) are the leading cause of mortality in the world accounting for over 60% of all deaths causing 36 million deaths in 2008 and many people live with chronic diseases which impacts on individuals, their families and communities and presents a growing economic and social challenge for both developed and developing countries. World Health Organization (2005) figures available at www.who.int/nmh/publications/ncd_report_summary_en.pdf
- (2) As outlined in IAPO's Declaration on Patient-Centred Healthcare (the 1st global declaration on patient-centred healthcare which has been developed and agreed by patients and patients' organizations themselves) available online at www.patientsorganizations.org/declaration

PERSON-CENTERED INTEGRATION OF INTERDISCIPLINARY TEAMS

Ghebrehiwet Tesfamicael

In an era of increased consumer demand, shifting disease patterns and increasing chronic disease, providing quality, cost-effective care, calls for a more coordinated approach. Integration of the different health professionals into a team is one solution [1]. This approach can be effectively introduced in the delivery of comprehensive primary health care services as well as for episodic and continuous care of specialized patient populations. Team approach or collaborative practice in health-care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings [2].

It is well accepted that, within each profession, there are progressive levels of competence from novice to expert. Different disciplines also have overlapping areas of mutual expertise.

No single health profession can claim ownership over knowledge that could contribute to health. Working together,

the healthcare providers in the team can integrate their knowledge and experience – their expertise – for the benefit of their patients.

The presentation will highlight how the expertise of health professionals can be integrated into a team to provide coordinated and person-centred care.

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CULTURAL AND LINGUISTIC COMMUNICATION FOR PERSON-CENTERED INTEGRATED CARE

Rachid Bennegadi, Stephanie Larchanche, & Rachel Wadoux

Mental healthcare provision in the transcultural context has highlighted issues that are transversal to other health disciplines. As a public health institution providing person-centered transcultural psychiatric care, our fifty-year long experience has led us to confront various obstacles and to experiment with innovative tools to improve clinical communication with our linguistically and culturally-diverse patients. First, we had to identify those very obstacles and the extent to which they are intrinsic to the French social healthcare system. Through both clinical practice and training activities, we then developed a multi-media tool based on clinical medical anthropology. In this symposium, we present

an approach that illustrates how, beneath the chronicity of mental health disorders, the person – from a phenomenological standpoint – holds a unique perspective onto what he or she feels and expresses. This person-centered approach has allowed us to enable communication by integrating cultural and linguistic characteristics and integrate the medical, social, and personal dimensions of care. This provides strong ethical bases to healthcare which, following the words of Levinas, recognize the face of the other.

CLINICAL COMMUNICATION RESEARCH TO SUPPORT PERSON-CENTERED INTEGRATED CARE

Sandra Van Dulmen

For integrated person centered care to be successful, it is important for health care professionals to work effectively together. Collaboration is one of the six widely endorsed CanMeds competencies for medical professionals, underlining its relevance and value. Unfortunately, there are hardly any controlled studies investigating the type and outcome of interdisciplinary collaboration. Besides, interdisciplinary collaboration is complicated by the fact that professionals from different specialties have their own (working) culture and priorities. In my presentation, I present the latest practical guidelines that could be helpful when setting up an effective interdisciplinary collaboration. In addition, I will present the little evidence that exist from research into the

effectiveness of interventions aimed at promoting interdisciplinary collaboration.

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COMMUNICATION IN THE WHO COORDINATED/INTEGRATED HEALTH SERVICE DELIVERY FRAMEWORK

Viktoria Stein

Communication is more than just two people talking to each other. To effectively communicate, one needs to know which language to use for which audience, which channels and instruments to apply and how to combine them, as well as the ability to react to miscommunication or unintended communication. It also means communicating the reasons for change effectively, sharing a compelling vision for CIHSD, and mobilising across the system all actors as agents of change.

Informing about and communicating the aims of a specific Coordinated/Integrated Health Services Delivery (CIHSD) initiative and why it is being implemented to providers, patients and the general public has also proven to be a key success factor for sustainability. In this regard, it is paramount to clarify the specific target groups and appropriate channels for communication, depending on whether one wants to convince health professionals to implement CIHSD, patients and the general public to actively involve themselves in their own care

or managers to create the right environment for high-quality CIHSD.

Thus, strengthening communication skills must be seen within the broader area of developing adequate competencies on all levels and in all stakeholders to enable them to participate in coordinated/integrated health services delivery.

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Plenary Symposium 3: Diagnosis, treatment and care management for person-centered integrated care

PRINCIPLES, STRATEGIES, AND PROSPECTS FOR PERSON-CENTERED DIAGNOSIS

Juan E. Mezzich

A model for person-centered integrative diagnosis (PID) has been developed within the framework of a paradigmatic initiative for person centered medicine, building on modern diagnostic methodology developments, and expanding the concept of diagnostic validity [1]. It addresses the diagnosis of a person's total health through three informational levels (health status, health contributors, and health experience and expectations), the utilization of categories, dimensions and narratives as descriptive instruments, and the interactive engagement of clinicians, patients, and families in the diagnostic process. This model is broader than those of conventional diagnostic systems which are focused on classifying and diagnosing only illness and do not incorporate the features mentioned above. The PID model has been applied recently in the latest version of the Latin American Guide for Psychiatric Diagnosis (GLADP-VR) published by the

Latin American Psychiatric Association [2]. The model is also being engaged in the preparation of other practical guides for general medical diagnosis under the auspices of the International College of Person Centered Medicine.

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CONTINUITY OF LIFE: DEVELOPMENT AND EVALUATION OF A NOVEL CONCEPT AND INSTRUMENT IN PERSON-CENTRED MEDICINE

Aleksandar Janca, Alyssa Liliee

Over the past decades the "Quality of Life" concept has come to have increasingly broad meanings which reduced its usefulness within clinical and research settings. As a result, a novel concept "Continuity of Life" has been proposed. It can be defined as "the degree to which an event or process has interrupted the continuity of an individual's life with regard to his or her activities, hopes and plans". The formulation of the Continuity of Life concept makes it particularly appropriate for evaluation of the impact of stressful life events including onset of mental or physical illness or injury, hospital admission, change of a significant life role, or the presence of disability.

The Continuity of Life Interview (COLI) is a semi-structured interview designed to assess an individual's perception of the impact of an event or illness-related disruption, or interference with, relevant life areas and global life regarding their present situation and expectations for the future. The COLI has been evaluated for its feasibility and reliability in a number of clinical settings and cultures. It was found to be a reliable and convenient tool for measuring patient recovery and other important aspects and principles embedded in person-centered medicine.

PALLIATIVE MEDICINE AS INTEGRATED CARE FOR ALL

Marijana Bras, Nadja Komnenc

A World Health Organisation statement describes palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" [1].

While palliative care may seem to offer a broad range of services, the goals of palliative treatment are concrete[2]. Palliative medicine is one of the best examples of person-centered medicine, which is evidenced by the principles of modern palliative medicine. National strategies of palliative care may vary, because they depend on the various factors and specificities of individual nations. The government of Croatia adopted a Strategic plan for palliative care in 2013, the efforts towards which lasted a few years and demanded great multiprofessional collaboration from over one hundred participants. One of the basic directives in this strategic

document is universal access to palliative care for all the citizens of a nation, as well as integrated care.

The goal of this presentation is to demonstrate the opportunities for and barriers to the creation of high-quality, accessible palliative medicine within a community as an example of person-centered medicine and people-centered healthcare.

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2. Walsh D, Gombeski W, Goldstein P, Hayes D, Armour M. Managing a palliative oncology program: the role of a business plan. *Journal of Pain Symptom Management*. 1994; 9(2): p109-18.

HOLISTIC ASSESSMENT OF NEEDS, CARE MANAGEMENT, AND CONTINUITY IN PEOPLE CENTERED INTEGRATED CARE

Nick Goodwin

Working in partnership with patients and service users to better co-ordinate services that meet their holistic needs is the core activity of person-centered integrated care. Using case examples, this presentation examines how holistic needs

assessment and effective care management can significantly improve quality of care. It examines some of the key challenges in the effective deployment of care management and concludes with a set of key messages for effective care.

Parallel Sessions 1:

A. Brief Oral Conceptual Presentations 1

"COMPETENT" MEDICAL PRACTICE MUST BE PERSON-CENTERED AND EVIDENCE-BASED

Michael Schwartz, Osborne P Wiggins

In the US, practitioners must achieve competency in six domains: Patient Care; Medical Knowledge; Interpersonal/Communication Skills; Professionalism; Practice-Based Learning; Systems-Based Practice¹. A broad array of humanistic and scientific knowledge and skills are required. How, in an "evidence-based" world, to advance humanistic competencies such as caring, interpersonal/communication skills, and professionalism? The problem is the vagueness of humanism in contrast to the exactitude of medical science.

We begin by noting that sciences are not alike – there is a "hierarchy of sciences" nested around the person, with some – biology, chemistry, and physics – more abstract, and others – social and cultural sciences, more concrete². Furthermore, what is most "fundamental" to medicine, the experiences and behaviors of healthy and ill persons, form a concrete domain of values and meanings. Other domains relevant to practice – eg., genetics, biochemistry and physiology – are not "more basic" – they are more abstract. We abstract their data from. The gain is extraordinary – scientific abstractions are real and

more amenable to exact/precise analysis. But as extraordinary can be the loss of relevance. A person-centered medicine attends to all appropriate evidence – that which is abstract and that which is concrete – knowing how to critically evaluate each and situate it in the larger, person-centered whole.

1. Accreditation Council for Graduate Medical Education. Program Directors' "Virtual Handbook." <http://www.acgme.org/acgmeweb/tabid/279/GraduateMedicalEducation/InstitutionalReview/ProgramDirectorsVirtualHandbook.aspx>
2. Schwartz MA, Wiggins O: Science, humanism and the nature of medical practice: a phenomenological view. *Perspectives in Biology and Medicine* 28:331-361, 1985 (Reprinted in Odegaard CE: *Dear Doctor: A Personal Letter to a Physician* The Henry J. Kaiser Family Foundation, Menlo Park, California, pps. 117-156, 1987).

NON ONCOLOGICAL SUPPORTIVE AND PALLIATIVE CARE: A MULTIDISCIPLINARY, MULTIDIMENSIONAL PERSON-CENTERED APPROACH IN AN ADVANCED HEART FAILURE CLINIC

Kira Stellato, Franco Humar, Donatella Radini, Andrea Di Lenarda

Research has shown that people dying from heart disease experience a wide array of symptoms, oftenwise distressing and lasting for over six months (1). Hence, the need arises for the integration of multidisciplinary, multidimensional aspects of supportive and palliative care (2) to bypass fragmentation of vision and to ensure ethical, sustainable, and socially responsible care. In Trieste, Italy, the Cardiovascular Center's outpatient Advanced Heart Failure Clinic has been implementing a 'person-centered' approach based on a collaborative beehive model that encourages formal and informal stakeholders to work seamlessly across subspecialties to provide optimal supportive and palliative management of advanced heart disease. In 2013, 173 outpatients received integrated healthcare services for a total of 479 total visits, 2.77 visits/patient, 83 deaths. Evidence-based and narrative-based approaches were implemented to

identify personal well-being, social support and perceived quality of healthcare. In the terminal stages of the disease, transition was ensured through integration and communication with the District social and healthcare territorial network. Challenges lie in ensuring clear, empathic communication among team members, effective handling of 'milestone' discussions to reassess treatment goals, and providing person-centered state-of-the-art care by holistically integrating the scientific, social and interpersonal aspects of healthcare interventions.

- (1) Wilson J., McMillan S. *J Hospice and Pall Nurs.* 2013;15:13-21.
- (2) Goodlin S.J., Hauptman P., Arnold R. et al. Consensus statement: palliative and supportive care in advanced heart failure. *J Card Fail.* 2004; 10:200-209

DEMOGRAPHIC CHALLENGES FOR PERSON-CENTRED MEDICINE IN THE CZECH REPUBLIC

Hana Konecna, Ludek Sidlo, Catriona Menzies, Ondrej Doskocil

This presentation will look at the demographic challenges that will have to be overcome if person-centered medicine is to be implemented in the Czech Republic. Demography impacts in a number of ways. Firstly, there is the general process of demographic ageing occurring in many countries, which means that populations are seeing an increase in the proportion of elderly people, esp. the oldest-old, in relation to other age categories. Healthcare expenditure and the demands placed on health and social care are increasing for this age group in particular (United Nations, 2001). It is expected that the process of demographic ageing will be rapid in the Czech Republic. This raises questions as to the number of healthcare professionals required in order to provide person-centered healthcare. However, the age breakdown of healthcare workers in the Czech Republic is highly regressive. There is a lack of young qualified doctors and nurses, and a considerable number are approaching retirement age. This presentation will look at the demography and current

predictions on healthcare worker numbers. It will consider how it might be possible to meet these challenges through the provision of initial training and continuing professional development for person-centered medicine and the patients' organisations might play in this.

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<http://www.patientsorganizations.org/declaration>.

United Nations, Department of Economic and Social Affairs, Population Division. 2001. World Population Aging: 1950–2050. United Nations Publications, New York, 2001. ISBN 92-1-051092-5; Available on-line:

<http://www.un.org/esa/population/publications/worldageing19502050/>.

ENTREPRENEURSHIP-THE PATH TO EMPOWER THE IMPAIRED

Ishita Sanyal

Introduction

According to World Health Report around 450 million people are suffering from mental disorder in India. Research shows that the most important need of a person suffering from major psychological problem is meaningful engagement & earning a livelihood. Many and varied employment obstacles are faced by people suffering from psychiatric disabilities which increases the unemployment rates.

Aims and Objectives

Transforming a non productive member in to a productive money earning member of the society

Creating a working community where professionals, volunteers and people with MI work together towards economic empowerment & recovery.

Creating equal opportunity for people suffering from mental illness

Livelihood generation & meaningful engagement.

Making them entrepreneurs by nurturing their art, creativity, & other potentialities Social Inclusion

Reducing the economic burden of the society

Methodology

A control group of 85 persons were given training in computer, Costume jewelleryes & other handicrafts works. They are given the scope to sale their products & earn their livelihood through it along with pharmacotherapy & psychotherapy.

Results

Meaningful engagement of the stakeholders which leads to decrease in illness & acts as a therapy to them

Referance

1) ALAN DOYLE, EdD, Director of Education Fountain House 425 West 47th Street, New York, NY 10036-2304. T. 212.582.0340, ext. 303 C. 917.417.6919

2) Lois Holzman, Ph.D. Director, East Side Institute for Group and Short Term Psychotherapy 104-106 South Oxford St. Brooklyn NY 11217. Chair, Global Outreach for All Stars Project UX. tel. 212.941.8906 ext. 324 fax 718.797.3966

B. Teaching Workshop 1: Communication for person-centered integrated care

SPANISH SPEAKING COUNTRIES CONSENSUS ON CORE CURRICULUM OF COMMUNICATION COMPETENCIES (CCCC) IN THE MEDICINE

Cristina García Leonardo, Fernando Caballero, Roger Ruiz, Juan Pérez-Miranda

CONTEXT: The Project falls in line with similar recent initiatives which have been developed in the United Kingdom (2008), and in German speaking countries (2011) as well as throughout the European community from the group t-EACH (2013). These initiatives have created a transnational consensus with the purpose of unifying the communicational contents of university studies in Medicine. These proposals have not been conveniently translated or adapted to Spanish,

and are not directly applicable to the countries which make up the Spanish speaking community.

OBJECTIVE: To develop and reach an international consensus among experts from Spain, Portugal and Latin America, who explicitly define the communicational competencies to be acquired by medical students during their university career, as well as the aspired outcomes to be reached by the end of the university training process.

METHODOLOGY AND RESULTS: The Delphi Consensus is divided into two cycles (by correspondence), through an online questionnaire accessed on a website specific to the project. For this, the International Scientific Committee, (15 members) developed a proposal for the questionnaire based on a review of literature. Each item of this survey is a possible communicational learning outcome. A Panel of International Experts (46 members), selected through the "snowball sample" strategy, participated in the Consensus (8 states). Following two cycles of interaction, a sufficient agreement was reached in 98.4% of the items.

CONCLUSIONS: The Project has reached a high degree of consensus and its conclusions are in the process of scientific publication as a proposal for debate and application in undergraduate Medical training within the Latin American community. The dimensions of clinical communication in which a consensus was reached included the following: communication with the patient, with the patient's family, self-reflection, inter/intra-professional communication, different forms of communication, and in extraordinary situations.

HOW TO TEACH COMMUNICATION SKILLS TO MEDICAL STUDENTS: THE ROLE OF CEPAMET

Lovorka Brajkovic, Nadja Komnenc, Veljko Djordjevic, Marijana Bras

Person-centered medicine has seen an enthusiastic advancement in the last five years in Croatia. Among other things, a multitude of programs were introduced to the curriculum of the University of Zagreb School of Medicine at the undergraduate and post-graduate levels, with the aim of perfecting the curriculum to reflect the concepts of person-centered medicine. The Centre for Palliative Medicine, Medical Ethics, and Communication Skills (CEPAMET) was founded as part of the University of Zagreb School of Medicine [1]. It is within this centre that the education of students and healthcare professionals takes place on the topic of communication in medicine and the person-centered medical interview [2]. Person-centered medicine relies on strong teamwork, and teamwork is a subject of interest of CEPAMET. The interdisciplinary team is one of the most widely accepted

innovations in the delivery of health care and social services. It is important to identify the competencies related to effective teamwork within a health service workplace, such as interpersonal skills and professionalism, interactions with patients and family and mentoring/teaching students.

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KNOWLEDGE AND TRAINING NEEDED FOR GOOD COMMUNICATION IN COORDINATED/INTEGRATED HEALTH SERVICE DELIVERY

Viktoria Stein

Apart from the skills to communicate, a key ingredient for successful communication is how to transfer the available information into comprehensible knowledge. Information and data generation are essential tools for CIHSD implementation. The lack of access to data is often cited as a key challenge to health system improvement, and data protection often used as an excuse not to analyse data at all. The area for action 'Knowledge' thus encompasses a process from information generation to knowledge transfer, using adequate technological tools, research principles and ethical considerations along this continuum of data utilisation and communication. Special attention needs to be paid to the dissemination and implementation of research in order to improve care.

To ensure the effective transfer and application of knowledge to inform the delivery of care, the way information flows needs to be clearly defined and managed. In order to build meaningful relationships, including between people and

providers to partner in shared decision-making, and ultimately transform information into knowledge, information pathways should parallel and support the communication channels established between and within all levels of stakeholders and support decision-making based on reliable data and adequate knowledge.

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C. Teaching Workshop 2 : Patient, Family and Community Engagement

THE ROLE OF FAMILIES IN PERSON-CENTERED AND INTEGRATED CARE

Alessandro Svetini

Family and carers, the ones who closely live around the patient, especially in chronic illness represent the primary source of companionship, involvement in activities and assistance for the patient in coping with day-to-day problems, ensuring continuity of support and advocacy.

In order to facilitate a more person-centered approach to the health problem, the unique perspective of families must be taken into account as an important source for understanding the weaknesses but also the strengths of the ill person. But family members have several needs too, often overlooked and neglected: they need to be informed and educated on the nature of the illness and its therapeutic possibilities; they need to be trained in order to develop skills to cope with symptoms and disabilities, to be supported in their caring role and given respite opportunities, to be involved and empowered in shared information and decision-making together with patient and

professionals through adequate communication skills. Families must have the possibility to state their needs and define the role they are willing and able to play.

Relatives gain much experience and expertise, which should be acknowledged and valued integrating them in the patient's treatment plan as well as in person-centered education and training of medical staff.

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THE DAWN2 STUDY INITIATIVE: MEASURING AND ADVANCING PERSON-CENTRED DIABETES CARE WORLDWIDE

Soren Skovlund

The increasing prevalence of diabetes worldwide – coupled with the broad impact diabetes has on all aspects of life – calls for a new and collaborative approach, in which self-management and psychosocial issues are managed as an integral part of team-based chronic illness care, including people with diabetes, their family members, healthcare professionals and the healthcare system, and the wider community.

The DAWN2 (Diabetes Attitudes Wishes and Needs) study initiative provides a new global scientific platform for the advancement of global and local partnership action for person-centred diabetes care.

In 2001 the initial DAWN study, a study overseen by the International Diabetes Federation (IDF) and a large international expert advisory board, showed that people with diabetes were struggling severely with achieving good diabetes self-management and psychosocial well-being and their healthcare providers were frustrated with not achieving clinical targets. This second study, DAWN2, with the first results published in June 2012 represents opinions from more than 15,000 people living with, or caring for people with diabetes in 17 countries across four continents and highlights

important improvements the past decade as well as significant gaps in availability of person-centred diabetes care.

The study objectives were to advance understanding and broad global and local awareness of the unmet needs of people with diabetes and their families, to facilitate cross-sector and multi-disciplinary dialogue national as well as multi-national collaboration to strengthen involvement of people with diabetes and their families in the care process and specifically improve self-management and psychosocial support offerings to all populations. DAWN2 involved family members of people with diabetes and allows for cross-national comparisons, therefore allowing countries to assess their outcomes relative to other similar countries and identification of countries that could act as models for best practices. Furthermore the study provides scientific data at individual, healthcare delivery, and policy level to assess quality of life, self-management and health determinants in diabetes from a whole-person and ecological care model.

The long-term aim of the DAWN initiative to facilitate that new national programs and local initiatives are put in motion, inspired by multi-disciplinary and multi-national dialogue, that will help people and families with diabetes get engaged and achieve full, healthy and productive lives with their diabetes

Plenary Symposium 4: Public health and people-centered integrated care for all

THE EMERGING WHO GLOBAL STRATEGY ON PEOPLE-CENTERED AND INTEGRATED HEALTH SERVICES

Hernan Montenegro

The path to universal health coverage (UHC) draws attention to various barriers in access to quality health services linked to significant shortages in resources, fragmentation of health services and lack of people-centeredness. Worldwide, it is estimated that over one billion people lack access to essential

health services. In many countries health services can be too far away (accessibility barrier), or poorly staffed with long waiting hours (availability barrier), or do not conform to people's cultural, ethnic or gender preferences (acceptability barrier). Even when people do access services, those are

often of poor quality, and in some cases, even harmful. Services tend to be fragmented, curative, hospital-based and disease-oriented rather than person-centered, all of which further hampers access to quality health services. Moreover, rapid population aging; the emergence of chronic diseases and multi-morbidity, the ever increasing demands and expectations of the population, and the need to be more efficient in health care spending, require a more integrated and people-centered approach to service delivery.

To respond to this challenge WHO recently developed a new strategy on "People-centered and Integrated Health Services". The Strategy is forward-looking, evidence-informed and action-oriented. The emphasis of the Strategy is on the how of health care delivery reform, including reforms in both hospital and primary care settings. The Strategy provides a wide range of policy options and reform strategies that should allow for context-specific tailoring of policy recommendations at the regional and country levels. The Strategy addresses

successful models and trends in service delivery reform and how this would potentially apply in various country settings. It also builds on WHO's past work on service delivery across all levels of the Organization as well as on the lessons learnt from Member States and other development agencies. This strategy proposes four main tracks of activity, namely:-

- empowering people
- strengthening engagement and accountability;
- coordinating services; and
- setting and managing system priorities.

However the strategy document also argues that the precise actions to be pursued will need to be tailored to varying country contexts, and that there is no blueprint for strengthening people-centered and integrated health services. Instead implementation approaches need to be supplemented by real time research that tracks progress, highlights potential disparities and informs path corrections.

PERSON-CENTERED INTEGRATED CARE: WHAT IT IS, AND WHAT IS NOT

Luis Salvador-Carulla

In the recent years there has been a major change in the conceptualization of health systems and care provision, mainly guided by the models of person- and people-centered care, integrated care, and chronic care. WHO has played a major role in the development of this new area of care planning and delivery.

"People-centred Healthcare" was defined by the WHO West Pacific Regional Office as "one in which individuals, families and communities are served by and are able to participate in trusted health systems that respond to their needs in humane and holistic ways. The health system is designed around stakeholder needs and enables individuals, families and communities to collaborate with health practitioners and health care organizations in the public, private and not-for-profit health and related sectors in driving improvements in the quality and responsiveness of health care" (WPRO, 2007).

Following prior definitions by experts and the conceptualization of its different domains (Mezzich et al, 2010) "Person-centered health" was defined by the International College of Person-Centered Medicine (ICPM) as a "holistic, multidisciplinary and relational perspective aimed at promoting the highest attainable level of health both for individuals and people collectively. It encompasses a wide range of concepts, tasks, technologies and practices which aim to place the whole person in context at the center and as the goal of clinical practice and public health. To this effect, it articulates science and humanism for a bio-psycho-socio-cultural understanding of health and for the undertaking of health care actions from individual interventions to general health policy" (2013 Geneva Declaration on Person Centered Health Research). From an ontology point of view, people- and person-centered health are semantically related terms that describe different facets of the same entity. However the formal relationship between these two categories has yet to be established.

"Integrated care" has been defined in very different ways. It was defined as "coherent and coordinated set of services which are planned, managed and delivered to Individual

service users across a range of organisations and by a range of cooperating professionals and informal carers" (Van Raag, 2003), whereas WHO has defined it as "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money" (WHO, 2008) (<http://www.who.int/healthsystems/en/>).

The principles of universality and equity of health care have determined a progressive convergence of integrated care and people/person-centered care into a single model of care planning and delivery. "People-centered Integrated Care" was defined by WHO as "integrated [care] across time, place, and conditions, and members of health-care team should collaborate with one another as well as with patients and their families to develop treatment goals, plans, and implementation strategies that are centered on patient needs, values, and preferences." (PAHO, 2013). It has also been defined as "the coordination of person-focused care in a single process across time, place and discipline" (Valentijn, 2013). As a matter of fact Valentijn places person-centeredness at the core of the integrated care model. It is possible to merge the different components of the integrated care model (Valentijn, 2013) and the person-centered health model (Mezzich et al, 2013) into a single framework.

In spite of the growing consensus on the key definitions and components, its actual formalization and its implementation into policy and practice is far from being completed.

It is also important to define is not "integrated people-centered care", as a broad adherence to its principles does not translate into practical implementation. Practical examples of this gap are found in disease management, personalized medicine and hospital centered "integrated-care" (Salvador-Carulla and Mezzich, 2012).

"Single Disease management" (e.g. programs for diabetes or brain injury) could be person-oriented and could also develop integration across sectors and levels of care for the targeted

disease but they are not fully person-centered and integrated as they are not holistic.

“Personalized medicine” aimed at tailoring diagnosis and treatment to every individual’s genomic profile and biomedical characteristics. ‘Theranostics’ (a term formed by the combination of ‘Therapeutics’ and ‘Diagnostics’) describes the process of diagnostic and therapy for individual patients using biomarkers to test possible reaction to taking a new medication and to predict the most suitable drug for a patient along with assessing the efficacy of the drug and other care interventions (e.g. changes in health-related habits) based on the test results. Both personalised medicine and theranostics are highly commoditised and have raised an increasing interest by health companies and governments in contrast with the limited commercial and governmental support provided to implement person-centred medicine into actual practice (Salvador-Carulla & Mezzich, 2012). An example of this trend can be found in the recent Horizon 20/20 health research programme in Europe. The recent ROAMER Roadmap of Mental Health research in Europe does not refer to “person-centered care” but to “personalized care”. The domains included under personalized care include: 1) Using basic (biological, psychological and social) science to improve accounts of the mechanisms of mental disorders, mental health and related behaviours; 2) Research into diagnostic strategies, aimed at discovering valid subtypes of mental disorders and individual variations with differential treatment outcomes; 3) Research into the comorbidity of mental disorders with one another, and with physical disorders; and 4) Standardising methodologies for research that evaluates mental health treatments and interventions. Although relevant, none of these topics actually refer to person centered health.

On the other hand, health systems where hospitals and not primary care play a leading role in the overall organization and funding of the health care sector could not be regarded as person-centered integrated care. Examples of countries which rely heavily on the hospital system may include France, Austria or Australia.

It is necessary to develop international comparisons that may allow for a better understanding to the extent to which person centered integrated care can be effectively delivered from hospitals in comparison to community based, primary care driven systems such as those in Spain or Chile. New tools and

research methods are required to provide adequate answers to these complex questions. The recent analysis of the mental health system in the Basque Country can provide an example of how this can be assessed in the next future (Iruin et al, 2013).

It is also important to move towards a “synset” approach to person-centered integrated care” in which a semantic cloud includes the different related terms, their formal definition and links following a polynomic/polysemic approach that accepts the use of different terms and meanings as far as a glossary of terms is developed.

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INTERNATIONAL EXAMPLES OF SUCCESSFUL APPROACHES INTEGRATING PUBLIC HEALTH AND PEOPLE-CENTERED INTEGRATED CARE

Lourdes Ferrer

There are a range of approaches used to support people to enjoy their full health and wellness: the provision of treatment, disease management, end of life care, prevention, health promotion and the fostering of healthy living conditions. These approaches are features of both public health and integrated care strategies and both areas have their unique contributions, historical developments and perspectives for improving population health. Yet, too often, there is a lack of explicit collaboration and synergy between actors and initiatives that bring public health and integrated care perspectives together. This paper will look at the important relationship between

public health and integrated care. Examples of how collaboration and synergy has taken place internationally will be provided. Future and current challenges and opportunities will be highlighted.

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THE SPECIFIC RELEVANCE OF ANDRIJA STAMPAR'S LEGACY TO PERSON AND PEOPLE-CENTERED INTEGRATED CARE FOR ALL

Veljko Djordjevic, Nadja Komnenic

Croatia has a rich heritage of person-centered medicine and people-centered healthcare. Professor Andrija Stampar made an enormous contribution to this field by pioneering various public health projects in Croatia and abroad. Stampar took it upon himself to visit Croatia's rural regions in order to acquaint himself with the problems faced by the segment of the population that resided there and soon realized that there was a great deal of work to be done in improving the hygiene of the rural population, and with great enthusiasm he organized various public health campaigns for the eradication of infectious disease [1]. His work included direct actions in promoting health and organizing healthcare, as well as presenting it professionally. He was instrumental in the

creation of the World Health Organization, serving as president of the 1948 inaugural Assembly Meeting of the WHO [2] and was an early advocate of the now-popular idea of health for all.

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Jitendra Trivedi Memorial Plenary Symposium 5: Education and training for person-centered integrated care

PERSON-CENTERED UNDERGRADUATE MEDICAL EDUCATION FOR INTEGRATED CARE

Salman Rawaf

Introduction

With advance in medicine technology, epidemiological and demographic transition, changing population's health needs and escalating public expectations modern undergraduate medical education is under extreme challenge. The experience of innovative medical schools, the emergence of learner-centred teaching methods and the implications of healthcare developments in many countries around the globe, focusing around person and patients needs, are major factors influencing change in medical education (and indeed in postgraduate training).

Methods:

Extensive review of the literature will look at the current practices in advanced universities and in particular on the modernization of curricula. In addition, the paper will consider the experience of medical students in some countries and how they are advancing their health systems around persons and patients needs.

Findings:

In most of the 2372 (Feb 2014) medical schools worldwide medical education is developed on historical basis, tradition and faculty members' personal strengths and influence, and type of funding rather than on scientific evidence. Indeed,

much of the learning is NOT based on populations and patients' needs. Studies show that leaning based on competencies, needed for the craft, is by far much more effective. The methods and the settings of delivery such competencies are complex and require resources, integrated health system and above all focus on those we will serve: both the health to maintain and promote and the illness to cure (preventing complications and / or minimizing harm. This is the only way to graduate doctors ready for further skilling through higher professional training and making them fit for purpose. It is a challenging task to all highly performing universities and indeed for many of universities it is almost impossible taking into account the limited resources at their disposal.

Conclusion:

There are tremendous pressures for changes to the organisation, content and delivery of both undergraduate and postgraduate medical education and training around the world. The sources of such increasing pressure are the changing population needs and public expectations, amongst many other factors. The paper will address these and highlight the experience of highly performing medical schools and training programme and draw some lessons to other countries around the world.

PERSON-CENTERED RESIDENCY TRAINING FOR INTEGRATED CARE

Ted Epperly

Family Medicine is a specialty requiring three years of training to include surgery, medicine, obstetrics, pediatrics, public health, psychiatry, ER, behavioral medicine, and other areas. These broad scope family physicians can really be looked at as "pleury potent stem cells" that are well-prepared for any setting they might find themselves in. The best definition of a family physician is "the type of physician a community needs". The training of family physicians in all arenas of medicine

allows them to morph into the communities they find themselves in and then use those broad skills to care for patients, people, and the community as a whole.

Family medicine is built on the pillars of continuous, comprehensive, compassionate, contextual, and relational care.

All residency training in the United States in all specialties follows the Accreditation Council for Graduate Medical Education (ACGME) which works off of the following six competencies: 1) Professionalism, 2) Patient (Person) Care, 3) Medical Knowledge, 4) Systems-based practice, 5) Practice-based learning and improvement, 6) Interpersonal Communication.[1] By ensuring all residents that train in the United States are trained in these six competencies, the US is helping transform its healthcare system to be a more person-centered, integrated, and coordinated healthcare system that focuses on quality improvement, performance improvement, and patient outcomes. Additionally, within training programs in family medicine, the National Committee on Quality Assurance has standards for practices that are recognized as being patient-centered medical homes. These 2014 standards are

the following: 1) Patient-centered access, 2) Team-based care, 3) Population health management, 4) Care management and support, 5) Care coordination and care transition, 6) Performance measurement and quality improvement. By ensuring that these six standards are a part of the patient and person care that family medicine residency training programs provide, helps ensure that family doctors are working with the patient towards person-centered outcomes.[2]

[1]<http://www.acgme.org/acgmeweb/Portals/0/PDFs/SlideDecks/SLIDEDECK-FDMilestones2013.pptx>

[2]http://www.ncqa.org/Portals/0/PublicComment/Product%20Development%202014/Appendix%20_2014%20DM%20Standards%20and%20Guidelines%20Proposed%20Changes.pdf

INTERNATIONAL EXPERIENCE WITH PERSON-AND PEOPLE-CENTERED HEALTH EDUCATION

Roy Kallivayalil

Person and people centered health education is the need for the future. It should be central to integrated care. There have been attempts at many parts of the world towards this goal. In India, Psychiatry has now been made a compulsory subject for internship for all medical graduates. Many Universities have incorporated person centered health education into this training. Unfortunately, in India as well as in many countries of the world, the part that gets most attention and recognition is a relatively small tertiary segment with advanced technology and highly sophisticated procedures. In contrast to tertiary care medicine, person-centered health education will make a huge and positive impact. There has been attempts to develop educational interventions for primary care, promoting person centered responses to people experiencing cognitive decline. This has helped in the early diagnosis of dementia

Teaching Psychiatry in undergraduate medical training, supporting the branch of Family Medicine, training lay counselors and social workers, co-operation with NGOs, religious and spiritual leaders and advocacy should be part of the future agenda for education and training for person centered integrated care.

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INTERPROFESSIONAL EDUCATION FOR PERSON-CENTRED HEALTH CARE

Ghebrehiwet Tesfamicael

Governments around the world are looking for innovative, system-transforming solutions that will ensure the appropriate supply, mix and distribution of the health workforce [1]. One of the most promising solutions can be found in interprofessional collaboration and education. Effective interprofessional education fosters respect among the health professions, eliminates harmful stereotypes, and evokes a patient-centred ethic in practice. Interprofessional education occurs when students from two or more professions learn with each other to enable effective collaboration and improve health outcomes. Once students understand how to work interprofessionally, they are ready to enter the workplace as a member of the collaborative practice team.

There is a growing evidence that multidisciplinary teams with reorganization of tasks among providers ("task shifting") offer an effective means of care delivery, particularly for primary care services, in a variety of settings. However, the form and content of medical, nursing and midwifery, and other curricula must adapt to adequately prepare health professionals to

practice within the health team model [2]. This will require the implementation of well-planned educational strategies, such as interdisciplinary and inter-professional training so that health professionals learn together in order to work together in delivering person-centred care.

The presentation will highlight key issues in interprofessional education and its benefits for patients, health systems and the health professionals.

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- [2]. World Health Organization (2011). Transformative Scale Up of Health Professionals Education http://whqlibdoc.who.int/hq/2011/WHO_HSS_HRH_HEP2011_01_eng.pdf?ua=1.

COMPETENCIES AS AN ACTION AREA OF THE WHO EUROPE COORDINATED/INTEGRATED HEALTH SERVICES DELIVERY FRAMEWORK

Viktoria Stein

Education and Training are emphasised by many authors and described as a key element to more people-centred care. Here they are summarised under the area of “Competencies” to reinforce the many-faceted topic. In order to enable health professionals to fill the new roles assigned to them, to manage health and care rather than disease and cure, to work in teams across professions and sectors, they need to acquire different skills from what they have traditionally been taught. In supporting and training staff to work in an inter-disciplinary and integrated environment, a gradual change of organisational and professional cultures may also be achieved, thus enabling long-term transformation of service delivery to be conducive to CIHSD. Education and training, however, must also include health promotion efforts, strengthening the health literacy of the population and creating a more conducive environment to continuous learning. Special attention has to be paid to the

fostering of management and leadership skills within health professionals. It is also emphasised that leaders need to be found on the policy as well as the professional level, since one of the biggest obstacles remains to transfer CIHSD policies ‘on the ground’.

Selected References:

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Plenary Symposium 6: Metrics for person- and people-centered integrated care

ADVANCING THE CONCEPTUALIZATION AND MEASUREMENT OF PERSON-CENTERED CARE

Juan E. Mezzich

The process of advancing the conceptualization of person-centered medicine can benefit from the consideration of historical roots, contemporary developments, our institutional journey, and recent systematic studies. From ancient civilizations, we appreciate their broad understanding of health and their personalized approaches to restore and improve health. From contemporary developments, we clarify, on one hand, our understanding of the distortions of medicine derived from excessive focus on organs and diseases and from the hyperbolic compartmentalization and commoditization of our field, and, on the other, the value of engaging and promoting personhood. From our institutional journey to build person centered medicine, we are deriving lessons from early contributions of related organizations, the six Geneva Conferences and their main themes and associated Geneva Declarations, and the five-year old International Network (now College) of Person-centered Medicine and its scholarly Journal and workgroups (1). And we are being enlightened by the ongoing results of our research project on systematic conceptualization and measurement of person- and people-centered care (2). It was based on critical literature reviews and broad international consultations. The key concepts

emerging from this project as underlying person-centered medicine are ethical commitment, holistic scope, cultural sensitivity, relationship focus, individualized care, common ground for joint diagnostic understanding and shared clinical decision-making, people-centered systems of care, and person-centered education and research. These concepts and their components have been the bases for developing a prototype Person Centered Care Index (PCI). Efforts to further refine the PCI in terms of wording, scaling, and correlational structure followed as well as ongoing research to validate the PCI in terms of applicability, reliability and content validity.

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QUICK SCREEN TO DETECT SUBSTANCE USE DISORDER IN ADOLESCENT FEMALES AND MALES

Levent Kirisci

Background. Prevention of substance use disorder (SUD) is impeded by the large number, manifold complexity and idiosyncratic configuration of etiological factors. Prevention of SUD is feasible, however when resources are prioritized to individuals having objectively determined risk so that comprehensive individualized assessment is cost effective. Objective. This study aims to develop a rapid accurate screening instrument to inform whether detailed evaluation for

SUD is needed to design an intervention tailored to the unique characteristics and circumstances of the individual. Methods. This study conducted on 182 girls and 329 boys tracked from 10 to 22 years of age demonstrated that the Drug Use Screening Inventory Quick Screen (DQS) accurately detects in three minutes girls and boys who currently qualify for SUD as well as those at high risk for SUD. Results. The Drug Use Screening Inventory (revised) Quick Screen for Females and

Males (DQS-F; DQS-M) has high sensitivity for identifying girls and boys who currently qualify for SUD diagnosis. Furthermore, accuracy of predicting future SUD with the DQS-F and DQS-M is in good range at age 16 and in very good range at age 19. Conclusions. The DQS is a brief efficient web-based assessment tool to identify girls and boys requiring thorough assessment prior to implementing intervention tailored to the person's specific needs.

Kirisci, L., Reynolds, M., Carver, D., Tarter, R. (2012). Quick screen to detect current substance use disorder in adolescents and the likelihood of future disorder. *Drug and Alcohol Dependence*. 128, 116-122.

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MEASURING THE PERSON'S EXPERIENCE OF INTEGRATED CARE

Nick Goodwin

This paper examines what might need to be measured and evaluated to assess the degree to which care systems are achieving people-centered integrated care. It examines what should be evaluated and what should be measured in an integrated care programme and provides examples of potential

approaches. The paper concludes that many different measures and measurement tools could be used, and their use depends on the nature of the goals of the service to the specific client group being targeted.

CONCEPTUAL AND CULTURAL STRATEGIES FOR THE MEASUREMENT OF PERSON-CENTERED CARE

Werdie Van Staden

The complexity of measuring person-centred care (PCC) certainly exceeds many, if not most, commonly used measures in medicine. Some may be sceptical about PCC per se being measurable. They may point to similarly complex constructs, such as Evidence Based Medicine, for which instruments and measurements of effectiveness have been rather elusive in spite of much appeal and uptake of the construct during more than 2 decades. This paper, however, argues that measuring PCC is possible provided that we unpack the complexities involved.

For example, the complexity of PCC requires that for developing valid and reliable instruments, it becomes clear what do we look for that are expressions of PCC; and where (among which kinds of objects) do we look. The best answers to both these what and where questions, would be critically about whether the items and the objects of evaluation are

person-centred (i.e. have depth and validity); would have adequate and representative scope (for one swallow does not make a summer); and would ensure consistency of identification across different observers (i.e., reliability). Conceptual and cultural strategies hitherto and our practical options are considered in this paper, showing how the complexities may be unpacked and PCC may be measured.

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2) Mezzich JE, Miles A, Snaedal J, van Weel C, Botbol M, Salloum I, Van Lerberghe W. The fourth Geneva conference on person-centered medicine: articulating person-centered medicine and people-centered public health. *International Journal of Person-Centered Medicine*. 2012, 2:1-5.

Parallel Sessions 2:

A. Teaching Workshop 3: Person Centered Health Policies

ACADEMIC PERSPECTIVES FOR DEVELOPING PERSON-CENTERED HEALTH POLICIES

Salman Rawaf

Introduction

In today's world of rapid changes, easy and quick access to information and advancing medical technology, people perception and expectations of the health services, both in health and illness, are rapidly changing too. The ways we seek services are evolving and all of us expect, quite rightly, personal attention and care. However, health policies are not developing in the same speed as our expectations. Academia can play key role in enhancing health policies to enrich public and patients' experience and their relatives with the health service.

Methods:

Extensive review of the literature, looking at the current practices in academic world and in particular on the preparing

the next generation of health professionals, targeting research and translation of research finding. In addition the paper will consider the experience of academics in shaping health and healthcare policies for better health.

Findings:

Research on health policies is not very common. This is mainly due to the nature of funding which most of it focus on diseases rather than health systems and its policies. This paper will illustrate how academic can improve the formulation of health and healthcare policies and the decision making process associated with it. Through producing scientific evidence academia will ensure that policies are formulated within evidence-based framework: through preparing the next generations of health professionals they will produce the shift

needed with the social values which are emerging (ie person-centred approaches); and through evaluation they will safeguard quality and safety.

Conclusion:

Health and healthcare policies are developed on the bases of complex analysis of population's health and social needs. They aim at improving health, ensuring efficiency, quality and safety. Health leaders are better informed when evidence is based on scientific ground rather than ad hoc policies, which is often the case in many countries of the world.

POLICY AS AN ACTION AREA OF THE WHO COORDINATED/INTEGRATED HEALTH SERVICE DELIVERY FRAMEWORK

Viktoria Stein

Strengthening the coordination/integration of how health services are delivered requires strategic policy frameworks that are combined with effective governance, coalition building, regulation and attention to system-design, priority setting and accountability. This area requires strong political leadership to challenge the status quo and drive the message home, rallying support on all levels. 'Policy' is at the core of promoting CIHSD and is essential for system transformation. Thus it goes beyond the provision of rules and regulations, putting a vision for CIHSD in place.

Policy is the area where the legal, systems and resource frameworks for CIHSD are formulated and formalised. It is key to scaling up CIHSD initiatives to the systems level and creating sustainability. Without priority setting for CIHSD on a policy and systems level, bottom-up initiatives will eventually fail or will not even be implemented.

However, health is not the sole responsibility of the health system, and thus alliances need to be sought with all sectors impacting on the health and wellbeing of the population. This entails coalition building within governments promoting a health in all policies approach. It is necessary to align policies and strategies in education, social services, or provision of infrastructure to name but a few.

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BUILDING CENTRAL POLITICAL NARRATIVES TO SUPPORT PERSON-CENTERED INTEGRATED CARE

Nick Goodwin

Lessons from the successful deployment of integrated care strategies in many countries, such as England and the Basque country in Spain, suggest that there needs to be both central political ownership of the approach and long-term

commitment. To support this, developing a central narrative – or value case – is an important first step to underpin the direction of travel being adopted.

RESEARCH AND POLICY SYNERGISM FOR ADVANCING PEOPLE-CENTERED CARE IN THAILAND

Yongyuth Pongsupap

Thailand's health system, dating back to the 1880s, was traditionally anchored in hospital medicine. Thus, when the family medicine concept was introduced in the 1980s, it was immediately perceived as relating to a hospital-based doctor without a specific specialization. Workforce is a crucial issue for the reform. Overall shortage of human resources is not the only issue. In each facility there should be staff fit to function. The question of human resources can indeed be tackled only when there is an agreement on what is expected from first line services that are close to the population.

When the push for universal health coverage gained political momentum starting in Ayutthaya province, in the 1990s, primary care reform became necessary and urgent. It was within this context that person-centered care, family medicine, and community-based care finally made headway in Thailand's hospital-centred medical culture. A strategy which proved instrumental in facilitating the reforms was that of 'demonstration' and 'diffusion'. The idea behind the 'demonstration health centers' was to develop and

demonstrate the family practice concept in a few selected areas in order to stimulate interest and demand for primary health care towards person- and people-centered care [1,2]. When the universal coverage policy was adopted some years later, family practice as a cornerstone for health sector development had already proven its worth and was therefore taken up as a tested model of care.

Keywords:

Family medicine, primary care, person-centered care, people-centered care

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B. Teaching Workshop 4: Stakeholders for Person Centered Integrated Care

NURSE PERSPECTIVES

Yukiko Kusano

Nursing is person-centred

Person-centredness resides at the heart of nursing. The International Council of Nurses (ICN) has a long history of advocacy and support for person-centred nursing services. This person-centred care is articulated in the ICN Code of Ethics for Nurses (ICN 2012), which states that the nurse's primary professional responsibility is to people requiring nursing care. The unique function of nurses is to assist individuals, sick or well, in their activities contributing to the state which means health or recovery (or to peaceful death) – to the person – and to do this in a way to help them gain independence as rapidly as possible (Henderson 2004). This means that nurses respect the value and belief of the person and support their choices and autonomy. Nursing care is based on an holistic approach. Nurses treat the person as a whole and use the nursing process to structure care delivery – assess physical, psychological, social and spiritual aspects of the person; make a nursing diagnosis; plan and carry out the interventions; and evaluate the outcomes.

ICN policy on person-centred care

ICN's commitment to deliver person-centred care is evident in the ICN Code of Ethics for Nurses and a number of ICN policy papers:

- Respect – “Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect” (ICN 2012);
- Information – Nurses ensure that patients and the public have access to appropriate information about health and health services (ICN 2012, 2008a); Nurses and other health professionals should acknowledge individuals' rights to make informed decisions and choices about how to manage their own health and to accept or reject healthcare or treatment (ICN 2008a).
- Access – Nurses have professional responsibilities to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal (ICN 2012);
- Quality care – Nurses are responsible and accountable for their nursing practice and have a duty to comply with their code of practice and maintain their competence (ICN 2006, 2012);
- Sharing decision making – The Framework of Competencies (ICN 2008b) outlines nursing competencies that formulate a plan of care in collaboration with patients, clients and or carers. ICN calls on public and patients for participating as an active partner in care (ICN 2006).

The role of nurses

Besides delivering safe and high quality nursing care services, nurses have the role to collaborate with other members of the healthcare team and to coordinate for timely and effective care delivery (ICN 2012). Growing research evidence shows that the team approach in healthcare is associated with better patient outcome, cost savings, reduced hospitalisation, improved service provision, and enhanced patient and staff satisfaction (Ghebrehiwet 2013). Nurses who spend a great

amount of time with patients in delivering care have an opportunity to provide effective coordination to the healthcare team.

Nurses' professional responsibilities go beyond bedside. Advocacy, promotion of a safe environment, research, participation in shaping health policy and management of inpatient and health systems, are also key nursing roles (ICN 1987). Because of their close interaction with patients/clients and their families in all settings, nurses help interpret people's needs and expectations for healthcare. ICN believes that nurses have an important contribution to make in health services planning and decision-making, and in development of appropriate and effective health policy (ICN 2008c). This should include public policy related to preparation of health workers, care delivery systems, healthcare financing, ethics in healthcare and determinants of health and there is evidence that involvement of nurses in decision-making is associated with benefit for both patients and nurses (J. Houser et al. 2012).

Policy into actions

ICN's policy is translated into various guidelines, programmes and research. These initiatives also demonstrate ICN's collaboration with patient organisations, other health professionals and other partners.

- The ICN TB/ MDR-TB Project, as part of the Lilly MDR-TB Partnership since 2005, uses transformational training methodology, designed specifically to encourage practice development. This means that experienced nurses working mainly in the TB and HIV fields, are trained to cascade information to nursing colleagues and other health workers with the purpose of making improvements to patient care delivery. The project co-sponsored a supplement entitled "Achieving patient-centred care for people affected by tuberculosis" published alongside the October 2013 issue of the International Journal of Tuberculosis and Lung Disease. Nurses from different parts of the world presented a variety of perspectives with regard to patient-centred care.
- The African Nurse Training Programme (ANTP) aims to improve awareness, recognition and management of co-morbid diabetes and depression, delivered by ICN in partnership with Dialogue on Diabetes and Depression (DDD). Started in October 2011, the ANTP has trained more than 200 nurse educators and other health professionals on management of co-morbid diabetes and depression.
- An ongoing study of telehealth research for evidence of person-centredness (Bartz 2013).
- Patient safety: ICN contributed to the development of the WHO Multi-Professional Curriculum Guide (WHO 2011) and is an active partner of the Fight the fakes campaign to address the infiltration and sale of counterfeit medical products within the legitimate supply chain causing life threatening, adverse effects in patients. ICN also promotes Positive Practice Environments to ensure provision of safe healthcare.
- Consensus Framework for Ethical Collaboration between patients' organisations, healthcare professionals and the pharmaceutical industry (IAPO, ICN, WMA, FPI, IFPMA 2014)

was established to deliver greater patient benefits and support high quality patient care, highlighting the central role of patients in healthcare.

Conclusions

Nurses continuously provide tailored care according to the individual needs of the person. Coordination of healthcare team is another important role of nurses. Quality of care can be improved by enhanced communication among people who require care, health professionals and other partners and increased mutual consultations in healthcare. Active involvement of care recipients and nurses in healthcare design and decision making is essential.

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PHARMACIST PERSPECTIVES

Olivier Bugnon

On the occasion of its 100th anniversary in 2012, the International Pharmaceutical Federation (FIP) committed pharmacists and pharmaceutical scientists to accept responsibility and accountability for improving global health and patient outcomes by improving the development, distribution and responsible use of medicines [1]. Obviously, person-centeredness and interprofessional collaboration remain fundamental in order to implement this FIP Centennial Declaration.

Fingolimod is the first oral therapy approved in Switzerland as first-line treatment for patients with relapsing-remitting multiple sclerosis (MS). It creates new opportunities for MS-patients but exposes them to potential serious side effects. Therefore an integrated post-marketing risk mitigation strategy was developed by our university team [2]; this case history illustrates some pharmacist perspectives, such as:

- Structured motivational person-centered interviews are periodically led by community pharmacists, with the collaboration of neurologists, general practitioners and MS nurses.

- A shared patient record, within a secured web-platform, facilitates interprofessional collaboration and long-term monitoring of medication adherence, patients related outcomes and safety indicators.

The initial results are very encouraging, however the translation from our reference centre to practice requires investments, training, culture change and new technologies.

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C. Teaching Workshop 5: Psychotherapy in Person Centered Medicine

WORKING THROUGH DISCLOSURE AND APOLOGY WITH THE PERSON AND FAMILY: A HUMANIZING APPROACH TO MEDICAL ERROR

Richard Hovey

Disclosing and communicating a medical error to a person (as patient) and/or family members can be an overwhelming and difficult conversation. The act of disclosing a medical error in addition to an apology is complex, intense and demanding for the person and family with the healthcare provider because it makes transparent which human or systems error(s), has caused the harm. This workshop re-interprets narrative data from people (patients) and families who have experienced medical harm through an adaptation of Richard Kearney's

threefold approach to working through human trauma: (1) practical understanding, (2) cathartic narrative and (3) forgiveness (pardon) [1]. Through this analytical approach, the emphasis is on the nature of working through trauma as a dynamic process in the interaction among and between healthcare providers, patients and family members.

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DYNAMIC PSYCHIATRY-AN INTEGRATIVE PSYCHIATRIC PSYCHOTHERAPEUTIC CONCEPT

Maria Ammon

The author lines out the history of Dynamic Psychiatry starting from the 19th century to the present integrative concept of Giinter Ammon. The integrative model for psychiatric-psychotherapeutic treatment comprises the following features and approaches: 1 holistic view of a person as an individual human being, influenced by the dynamics of the surrounded groups. The author will present the theoretical conception of development, with the personality structurology as a central integrative model. The therapeutic conception and intervention methods of

Dynamic Psychiatry as an integrative treatment concept will be demonstrated as verbal and non-verbal approaches.

Maria Ammon: Dynamic Psychiatry—an Integrative Psychiatric-Psychotherapeutic Concept

Dynamische Psychiatric/Dynamic Psychiatry Pages 162-166, Volume 30, 1.-4. issue 1997

Maria Ammon: Theory and Practice of Dynamic Psychiatry, *Dynamische Psychiatric/Dynamic Psychiatry* 1996.

Volume 29

PSYCHOMOTRICITY IN PERSON CENTERED MEDICINE

Elena Gayvoronskaya

Modern medicine is increasingly becoming an integrative, multi-component system, within which a lot of smaller systems (various approaches and methods) are formed. Integrated application of such smaller systems creates an individual pattern of care for the person. In this system, a promising element is psychomotricity described as any motor activity acting as a provider between body and psyche – motor, intellectual and emotional development of a person.

Psychomotricity combines the features of evidence-based therapy, holding a high position in the rehabilitation process for various cohorts with different disorders, and the features of sports activity and artistic performances.

Working with rhythm, equilibrium, dance/movement activity and many other methods and techniques contribute to the positive transfiguration of human psyche and address to the whole person as the main value of integrated care.

The materials for psychomotor therapy are constantly being improving, their diversity is increasing. But remember that

these materials are entry gate for deeper processes of personal interactions and relationships including “a care giver - a recipient” therapeutic alliance.

Considering psychomotricity as a link between theory and practice within an integrated person-centered care is surely an important approach enriching the concept of person-centered medicine.

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Parallel Sessions 3:

A. Brief Oral Research Presentations 2

THE HERMENEUTICS OF SUFFERING: RESEARCHING CHRONIC PAIN

Richard Hovey

Through this presentation, we will explore as compassionate researchers, the meaning of suffering, its language and consequence with the intention to understand, inform, enlighten and challenge ourselves to learn from each other. We offer a perspective for human science research created through a hermeneutic consciousness about suffering where understanding takes its form analytically as an interpretation, of an interpretation. My life penciled in ...“Oh life, life remaining always outside” [Rilke]. Humanizing our understanding of chronic pain as whole-life altering experiences. This unquiet understanding, a chaotic bricolage of suffering was brought together hermeneutically to unify a diversity of suffering narratives within the context of honouring personal narratives, while confronting the challenges of academic writing [1]. “I do not think realizing that we who

[suffer] are utterly lost and broken, necessarily causes despair. What breaks us is the impression that everyone else isn't” [2].

Our work as researchers, healthcare providers writers and teachers is to bring the meaning of suffering into language and understanding. We also explore what challenges us to confront and humanize research beyond the academic expectations of “...clean and reasonable scholarship about messy, unreasonable experiences” [2].

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Sozialforschung/Forum: Qualitative Social Research.

PERSON CENTERED MEDICINE IN MODERN PREGNANCY CARE

Wolfgang Holzgreve

The possibilities for screening to detect fetal anomalies early in gestation have increased. The screening results offer choices,

but can also create anxieties. Person-centered counselling is required to deal with this progress.

PATIENT NARRATIVES IN PERSON-CENTERED INTEGRATED CARE

Geva Greenfield, Agnieszka M Ignatowicz, Yannis Pappas, Azeem Majeed, Matthew Harris

Background: Person-centred care emphasises the benefits of a holistic, humanistic approach that puts patients first and at the centre of clinical care. Person-centeredness is also considered a core element of integrated care. Typologies of integrated care mainly describe how patients fit within services, rather than how services fit into the patient's world.

Purpose and objectives: We aimed to explore patient narratives on person-centeredness in the integrated care context.

Method: We conducted a phenomenological, qualitative study, borrowing from Grounded Theory approach principles. The study included semi-structured interviews with 22 patients registered in the Northwest London Integrated Care Pilot.

Findings: We identified six themes representing core 'ingredients' of person-centeredness in the integrated care

context: "Holism", "Naming", "Heed", "Caring", "Continuity of care", and "Agency and Empowerment", all depicting patient assumptions on doctor and patient roles in an integrated care. We bring positive examples showing that when these needs are met, person-centeredness can make a whole difference for the patient, but also examples of loaded with emotional tone expressing deep frustration from encounters with health providers, and an experience of being 'unseen' and unheard. **Conclusions:** Integrated care models can benefit from incorporating person-centeredness as a core element. Such implementations apparently require deep attitudinal and cultural change in care models, on top of organizational changes

WORK OF THE NUTRITION AND OBESITY ADVISORY CENTRE

Maja Vukmirović

The Association for Overweight Prevention was founded in 2002 as a voluntary and non-profit association. The basic aim of the Association is to spread knowledge about proper nutrition habits in overweight prevention, achieving and maintaining the health of individuals and society as a whole. To this end, the Association has organized public health campaigns and the Nutrition and Obesity Advisory Centre.

The aim of our presentation is to show what obesity is and what are its causes and consequences. It shows the parameters used to determine whether a person is overweight (BMI, waist circumference, percentage of body fat), habits that cause obesity (inadequate nutrition habits and lack of physical

activity), as well as diseases that are the direct result of excessive weight or obesity (hypertension, type 2 diabetes, cardiovascular diseases).

During public health campaigns 1026 people were interviewed of which 926 were statistically processed. Of those 926 people 50% regularly visit the Advisory Centre out of which 40% have changed their habits, reduced weight and therapy for hypertension and/or diabetes, 50% improved their health by proper nutrition regardless of weight reduction while 10% withdrew from further meetings. A large number of people who reduced weight by 15% per year reduced the prescribed treatment for hypertension and/or diabetes.

B. Teaching Workshop 6: Integrating Primary Care and Mental Health Care

FAMILY MEDICINE PERSPECTIVES: INTEGRATING PRIMARY CARE AND MENTAL HEALTH CARE

Ted Epperly

Person-centered care, by its very nature, integrates behavioral and mental health problems along with primary care. The person is a whole human being and is not separated into body parts or organ systems as traditional medical thinking views it. The specialty of family medicine in particular sees the whole person as a four-dimensional being functioning in a four-dimensional world. This speciality values comprehensive and continuous care of a human being over time that cares for all the person's problems in the context of their families, their jobs, and their communities.

Family Medicine is the integrator of whole-person care by combining mental and behavioral health issues while dealing with the person's medical and surgical illnesses. In fact, it may be called the "neck" that connects the head to the rest of the body. [1]. There are seven joint principles around integrating behavioral health care with primary care though the patient centered medical home model. [2] These seven principles are the following: 1) Personal physician, 2) Physician directed medical practice as a team, 3) Whole

person orientation, 4) Care is coordinated and integrated, 5) Quality and Safety, 6) Enhanced Access, and 7) Payment.

The integration of primary care with mental and behavioral health care is an imperative for future delivery models. This care will incorporate the basic fundamental model of primary care with enhanced team-based models of mental and behavioral health care that is person-centered. This will help lead to the triple aim of enhanced population health, improved

individual patient care, and lower cost because of this integration and coordination.

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MULTIMORBIDITY IN THE SEVERELY MENTALLY ILL: THE NEED FOR A PERSON-CENTERED INTEGRATED APPROACH

Helen Millar

The concept of multimorbidity has attracted increasing interest over the past decade with the recognition of multiple burdens of disease, their costs for the individual, society and economic consequences. It has become evident that multimorbidity is the norm rather than the exception and occurring in an increasingly younger population particularly in areas of socioeconomic deprivation and low income countries. It is well established that the severely mentally ill have a markedly reduced life expectancy due to predominantly multimorbidity including cardiovascular and metabolic diseases.

The combination of a chronic medical condition and a mental health problem presents specific challenges for the current single disease framework model of health care.

This presentation will demonstrate the growing evidence and experience for adopting an integrated collaborative person centered approach and demonstrating how to make it happen in reality given limited resources. The approach requires

innovation in comprehensive person-centered assessment and treatment including early detection, co-ordinated multidisciplinary care with access to healthy lifestyle programmes to improve personal, social and clinical outcomes for people living with these long term mental health problems and physical illnesses.

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INTEGRATED PERSON-CENTERED CARE FOR DEMENTIA

Jon Snaedal

Dementia care is provided by health care workers that are a part of a team, irrespective of site, whether in society or in an inpatient setting. In primary care, the team member that is primarily responsible for the service is typically a nurse, in some settings defined as a dementia coordinator. Other team members are active as consultants such as the physician for the medical treatment, social worker for social service and occupational therapist for evaluation of need of technical support. In the inpatient setting, the responsible team member is the physician, responsible for the inpatient service.

A diagnosis of cognitive impairment or dementia is made either in a memory clinic or in the primary care but it is the

team in the primary care that typically provides the long-term service. The service needs to be individually adopted and to be sensitive for changes. There are mainly three different modes of changes that call for intervention; progress of cognitive impairment, development of psychiatric co-morbidity or change in social situation. Input of different health care workers is needed in the different situations but a dementia coordinator organizes the intervention.

Reference: Quincy Miles Samus et al. Maximizing Independence (MIND) at Home. *American Journal of Geriatric Psychology* 2014. Published online Feb 11

INTERNATIONAL PERSPECTIVES ON INTEGRATED CARE

Roy Kallivayalil

The resources available for mental health care are far too inadequate in many parts of the world and especially in the low and middle income countries. Integrating mental health care and primary care is the best answer. World Health Organization (WHO) Multi-country project: "Strategies for extending mental health services into the community" (1976-1981) and the "Declaration of Alma Ata"- to achieve "Health for All by 2000" by universal provision of primary health care (1978) have been major milestones. India had launched a National Mental Health Program (NMHP) in 1982 with the aim of diffusion of mental health skills to the periphery of the health care system, equitable and balanced territorial distribution of

resources and integration of basic mental health care with general health services. This can be a model for the developing world. All countries should have a mental health policy which identifies major issues and objectives, providing guidance for prioritizing expenditure, linking problems with resource allocation and providing Mental Health Services in the community. Mental health problems are amenable to cost-effective treatments. The "risk-flag" approach, where in individuals at-risk of treatment failure are identified and routed into more intensive mental health screening and intervention has been suggested from Africa. The risk of piling resources

into integrated services without the necessary systems in place has also to be avoided.

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C. Teaching Workshop 7: Person-centered Child Healthcare

PATIENT-CENTERED MODEL FOR MENTAL HEALTH SCREENING DEVELOPMENT IN PEDIATRIC ALLERGY OUTPATIENT CLINIC

Brianna Lewis, Rachel A. Annunziato, Melissa Rubes, Christina Supelana, Scott Sicherer, and Eyal Shemesh

The EMPOWER (Enhancing, Managing, and PrOmoting WEll-being and Resiliency) program within an outpatient pediatric allergy clinic provides patient and family-centered care which includes emotional support and consultation to children who suffer from food allergy and their parents. 1 Based on a needs assessment,2 it was determined that a screening program was essential within the clinic to identify patients and families who experience distress, signs of anxiety, and/or disruption to quality of life, or those that would benefit from a mental health consultation for any reason. The end goal of screening is to connect families to needed services.

Involvement of patients in the development of assessment tools to target their own specific symptoms, functioning, and concerns, is widely accepted as improving face validity and construct validity of a measure. A patient-centered approach in creating patient assessment tools strives towards identification of meaningful and appropriate question content and form. This approach may enhance patient engagement with the screening measure, and decrease potential stigmatizing effects from the end product. 2

Focus on patient involvement in their own self-report measures was brought to the forefront recently in a review of asthma-specific patient-reported outcome measures (PROMs).3 Three levels of patient involvement have been previously defined as 1) Consultation – When patients are consulted for their views via survey or focus group; 2) Collaboration – Active, ongoing partnership between researchers and patients; and 3) User-Led – Patients control, direct, and manage research.4 Variability of patient involvement in measure development was cited as the norm,3 typically ranging from consultation to collaboration, but never user-led. Furthermore, patient involvement rarely occurred during all stages of measure development (i.e. concept generation, item generation, item reduction, and content validation). Greater transparency and detailed recording of patient involvement in patient reported outcome measures were recommended.3 Additionally, improvement in recording patient involvement builds a foundation of evidence for a more systematic approach to patient involvement in measure creation and builds the science of such an approach that is already used informally so frequently in medicine.

Keeping with the focus of the EMPOWER program since its inception, continuous patient and family involvement in all aspect of measure development was a priority. Patients and families of the Jaffe Institute for Food Allergy, and children with food allergies and their families nationally, were involved in creating the EMPOWER screening measure through all stages: concept generation, item generation, item reduction, content validation, initial testing, review of results from the first

iteration, and modification. The screen was developed in several stages. The screening program was created by a patient's family in concert with the chief of the Jaffe Institute clinical program; thus for concept generation stage the level of patient involvement can be categorized as User Led. Generating items for the screening measure moved to a Consultation process between medical staff and patients. Initially, a national needs assessment was conducted within Food Allergy Research and Education forums across the country.2 Findings from this needs assessment led to the development of a questionnaire packet including validated measures related to mood, anxiety and quality of life related to medical illness, in addition to modified items. This questionnaire was then tested on a clinic sample.5 The results were analyzed to determine which constructs were related to a substantial decrease of quality-of-life (QoL) for patients and parents. Thus, the item reduction stage of the screen development falls within the Consultation level with patients and families. The resulting one-page questionnaire was reviewed in two stages using a Collaborative approach for content validation. An internal hospital and patient group, consisting of two parents, an allergist, a psychiatrist, a psychologist, and two research assistants reviewed the content and clarity of the screen and revised the questionnaire accordingly. Then, the questionnaire was sent to a group of 14 parent-leaders of a patient advocacy group who also provided detailed comments.1 An additional question regarding parents' motivation to seek mental health support was added to the parent screen as a result of feedback and following recommendation from a doctor in the Jaffe Institute. Further feedback will be incorporated following the analysis of screening outcomes at the conclusion of phase one of the screening program.

The final screening measure consists of a parent and child questionnaire, to be completed for children age 8-years-old and older. The parent form includes three questions addressing responsibility for self-care, two questions inquiring about bullying as a result of food allergies and bullying for any other reason, in addition to five questions from the Pediatric Quality of Life Inventory Parent-Proxy (Parent Q o L)6 adapted to specifically target food allergies, and the Impact of Event Scale-6 (IES-6).7 The child form consists of three comparable allocation of medical responsibility questions two questions inquiring about bullying related to food allergies and bullying for any other reason, two subsections of the Pediatric Quality of Life Inventory,6 specifically the social and school domains consisting of five questions each, and finally nine questions from the Screen for Child Anxiety Related Emotional Disorders (SCARED).8

The screening program was implemented in the Jaffe Institute for Food Allergy beginning March 2013. Ongoing feedback from current patients and families following screening is welcomed, logged, and reviewed for possible adaptation of the screen, in addition to continued collaboration with the original patient family who created the screening initiative. Since March, 1,272 patients and/or parents have been screened and offered feedback, brief support during their visit, or referred for a free psychiatric consultation. Overall, the non-response rate for the screen is about 10%. In conclusion, undergoing a patient-centered process from concept generation through content validation for a patient-reported screening measure likely contributed to the high engagement from patients and their families during implementation.

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PERSON-CENTERED CHILD HEALTHCARE

Jim Appleyard

Each child is a *unique individual* - mentally, physically, intellectually emotionally and spiritually as he or she grows and develops toward adulthood

Different physiological, psychological and pathogenic features occur at the different ages from the premature newborn infant through adolescence

Individually, professional care for a child is crucial – each child must be treated as a 'person' and the workshop will explore the practical ways this is best achieved

A **profile of the child** should be constructed within the medical record which includes:

1. Full name with any shortened family version, age and sex
2. A list of medical and related problems including the main presenting symptoms and signs
3. A record of Growth and maturation
4. Programme of prophylaxis – immunizations and other preventive measures
5. Developmental progress from infancy through 'nursery' and school
6. The family
7. Social Environment – urban/country housing
8. Culture and Religion/Spirituality

PERSON-CENTERED CHILD AND ADOLESCENT MENTAL HEALTH

Michel Botbol

This teaching workshop will present a person-centred perspective to child and adolescent psychiatric care, first through an examination of the particular specificities of diagnosis in child and adolescent psychiatry, and second through a review of the importance of empathy to approach

these specificities and give enough attention to subjectivity in clinical care. As such, this discussion highlights some key issues for person-centred care in psychiatry and medicine at large.

Plenary Symposium 7: Ethical bases for person-centered integrated care for all

WMA'S PERSPECTIVES ON ETHICS AND PERSON CENTERED MEDICINE

Jon Snaedal

The World Medical Association (WMA) is representing doctors world-wide. Since its foundation in 1947 it has produced many policy documents on various items but the major involvement

is in medical ethics. The best-known WMA ethical policy is on Ethical Principles for Medical Research Involving Human Subjects, known as the Document of Helsinki, the most recent

version since 2013. It is currently working on two important policies regarding rights and integrity of persons, a document on Health Databases and Biobanks and another one on Person Centered Medicine. The main issue of concern in the former is the balance between databases as a tool for research on one hand and human rights and integrity on the other. This balance is difficult to achieve in respecting the

different views. The main concern in the latter is to differentiate between person centered medicine as a broad concept and patient centered medicine as a more narrow concept. At the 7GC, these concerns have been discussed just days before in the spring meeting of WMA in Tokyo.

www.wma.net/policies

THE ETHICS IN 'PATIENT-CENTERED' CARE

Samia Hurst

Health care can be 'patient-centered' in at least three different ways, which as sometimes confused in discussions regarding how to enhance the 'patient-centeredness' of health care. First, health care can focus on the patient's re-establishing the patient's functioning; fixing what is damaged not strictly anatomically or physiologically, but functionally in a broader manner. This is part of the traditional ethos of medicine, but recently calls have again been made for such a focusing of the

meaning of 'patient-centered' care. Second, health care can focus on the patient's good more generally, without making functioning a central part of the definition of this good. Third, health care can focus on the patient's own priorities and on her autonomy. These are different views. Although they can co-exist, they sometimes conflict with each other and also come into tension with other aspects of health care institutions.

WHO'S PERSPECTIVES ON INTEGRATING PERSON-CENTERED ETHICS INTO PUBLIC HEALTH

Marie Charlotte Bouesseau

One of the WHO core functions is "articulating ethics and evidence-based policy options". In this perspective it is essential to define an ethical framework applicable to person-centered integrated care. Three main sources should be considered: a set of core values including coordination of health services, empowerment of health care users, equitable access to quality and safe care; clinical ethics principles, including respect for the dignity of the persons, optimization of risk-benefit ration in all health interventions, justice; and public health ethics principles that emphasize fair processes and good governance. We suggest to combine these principles and use the concept of respectful care as the ethical framework for person-centered integrated care. Respectful care supposes to treat people as individuals, with consideration and courtesy. It consists of respect for the dignity of persons which implies to promote the right to make autonomous and informed decisions, the right to privacy, the

protection of most vulnerable people against risks of discrimination. Equity in access to efficient health services is also pivotal in this framework. The expected impacts are to prevent abuse, empower people and promote a culture of safety; this requires concrete mechanisms of implementation that will be illustrated with the example of maternity care.

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