Προαγωγή Υγείας, Πρόληψη Νόσου, Ιατρική της Κοινότητας

Κλινική πρόληψη στην πράξη, Εθνικό Πρόγραμμα Πρόληψης «Προλαμβάνω», Τριτογενής πρόληψη και Αποκατάσταση, Εξατομικευμένο προληπτικό πλάνο

ΕΛΕΝΗ ΓΕΛΑΣΤΟΠΟΥΛΟΥ

ΙΑΤΡΌΣ ΔΗΜΟΣΙΑΣ ΥΓΕΙΑΣ ΚΑΙ ΚΟΙΝΩΝΙΚΗΣ ΙΑΤΡΙΚΗΣ

ΚΑΘΗΓΗΤΡΙΑ ΥΓΙΕΙΝΗΣ

ΕΡΓΑΣΤΗΡΙΟ ΥΓΙΕΙΝΗΣ, ΕΠΙΔΗΜΙΟΛΟΓΙΑΣ ΚΑΙ ΠΟΙΟΤΗΤΑΣ ΖΩΗΣ

ΠΑΝΕΠΙΣΤΗΜΙΟ ΠΑΤΡΩΝ

Clinical Prevention in Practice, National Prevention Program "Prolambano", Tertiary Prevention and Rehabilitation, Personalized Preventive Plan

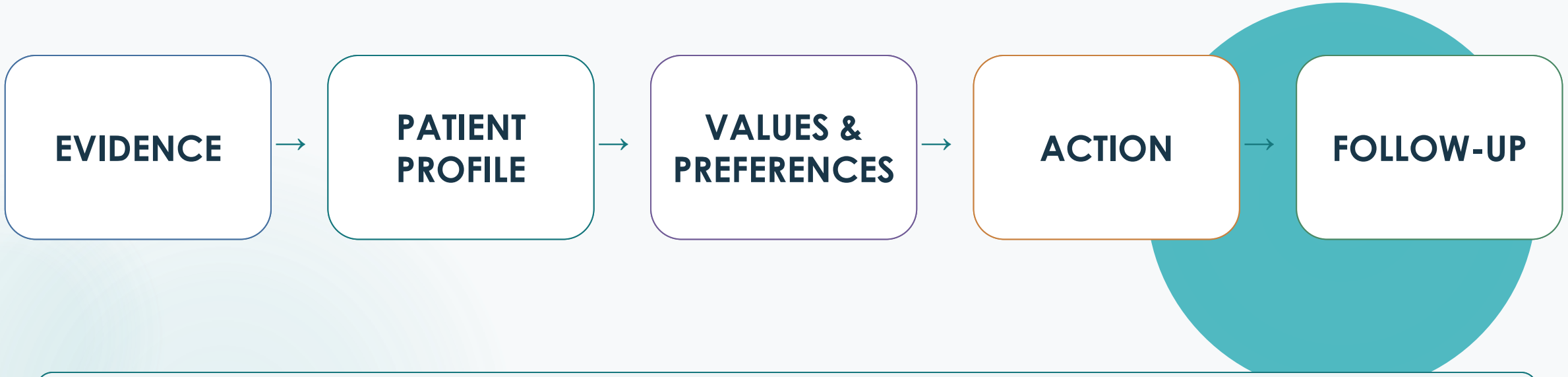
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Clinical Prevention in Practice

From Evidence-Based Recommendations to the Individual Prevention Plan

From Evidence to the Person

Clinical prevention is a decision-and-follow-up pathway



Evidence becomes preventive care only when it is implemented and reviewed.

Original teaching synthesis based on evidence-based, person-centred preventive care.

Learning Outcomes

- Build an individual prevention profile
- Translate evidence into appropriate recommendations
- Use the 5A model for brief behavioural counselling
- Integrate tertiary prevention and rehabilitation
- Create and document an individualized preventive plan

Opening Case • What Would You Do Today?

52-year-old • asymptomatic

Smokes • elevated BP • BMI 31 kg/m²

No known CVD

Several preventive opportunities

What should be done today — and what can wait?

What Is Clinical Preventive Care?

Evidence-based preventive services

Risk assessment

Counselling / behaviour support

Vaccination / preventive medication when indicated

Screening when evidence supports it

Follow-up and continuity

A Life-Course Prevention Continuum

WHO/WRA continuum of health services



Rehabilitation is an essential health service — prevention does not end at diagnosis.

Adapted from WHO/WRA: promotion–prevention–treatment–rehabilitation–palliation continuum.

Source: WHO PHC / UHC 2025–2026

Step 1 • Build the Prevention Profile

Build the prevention profile before recommending interventions

BIOLOGY

Age • sex • relevant factors

CLINICAL

History • conditions • medicines

BEHAVIOUR

Tobacco • diet • activity • alcohol

PREVENTIVE HISTORY

Vaccination • screening

CONTEXT

Access • social circumstances

PERSON

Goals • preferences • priorities

Original teaching figure: individualized prevention profile domains.

Risk Is More Than a Number

Absolute risk can inform decisions

But risk scores do not replace clinical judgement

Context, competing risks, benefit–harm balance and preferences matter

Step 2 • Identify Evidence-Based Preventive Needs

What is recommended for this person?

For whom?

At what interval?

What is the expected benefit and harm?

What is already up to date?

Recommendation ≠ Automatic Action

Evidence informs the decision

Clinical context modifies applicability

Preferences matter when trade-offs exist

A recommendation still requires implementation and follow-up

Step 3 • Prioritise

Preventive care needs prioritisation — not a longer checklist

HIGH VALUE / URGENT

DUE NOW

DISCUSS / PREFERENCE-SENSITIVE

UP TO DATE / NOT INDICATED

FOLLOW-UP

Priority = expected benefit + timing + patient context + feasibility

Original clinical teaching matrix; no disease-specific recommendation implied.

Shared Decision-Making

Shared decision-making when trade-offs or preferences matter

EVIDENCE

Benefits
Harms
Uncertainty

+

PERSON

Values
Preferences
Context

→

AGREED DECISION

Feasible
Documented
Reviewable

Teaching synthesis of evidence-based shared decision-making.

From Advice to Behaviour Change

Information alone rarely changes behaviour

Brief counselling should be structured, personalised and followed up

The 5A Framework

The Five A's: a practical structure for brief behavioural counselling

ASSESS

risk • readiness • barriers

ADVISE

clear • specific • personalised

AGREE

goal • method • priorities

ASSIST

skills • support • referral

ARRANGE

follow-up • review • adjust

Cross-behaviour USPSTF construct: Assess → Advise → Agree → Assist → Arrange

Tobacco-specific USPSTF implementation commonly uses Ask → Advise → Assess → Assist → Arrange.

Source: USPSTF behavioural-counselling framework; tobacco-specific variant explicitly distinguished.

Source: USPSTF Five A's framework

Assess

Ask about the behaviour and context

Assess readiness, barriers, confidence and priorities

Source: USPSTF Five A's

Advise

Give clear, specific, personalised advice

Connect the recommendation to the person's health goals

Source: USPSTF Five A's

Agree

Collaboratively select a realistic goal

Match the plan to willingness and priorities

Source: USPSTF Five A's

Assist

Build skills and confidence

Problem-solve barriers

Offer tools, treatment or referral when appropriate

Source: USPSTF Five A's

Arrange

- Schedule follow-up
- Review progress
- Adjust the plan
- Support maintenance and relapse prevention

Source: USPSTF Five A's

Micro-Consultation • 5A in 5 Minutes

5A in a brief consultation: one behaviour • one goal • one follow-up

1
ASSESS

2
ADVISE

3
AGREE

4
ASSIST

5
ARRANGE

Behaviour
What matters now?

Goal
What is achievable?

Follow-up
When will we review?

Teaching adaptation of the USPSTF Five A's organizational construct.

Greece in Practice • ΠΡΟΛΑΜΒΑΝΩ

ΠΡΟΛΑΜΒΑΝΩ: a current Greek population-prevention implementation case

ORGANISED

Eligible citizens
Active invitation
Digital referrals

ACCESSIBLE

Free preventive examinations
Insured or uninsured

LONG-TERM

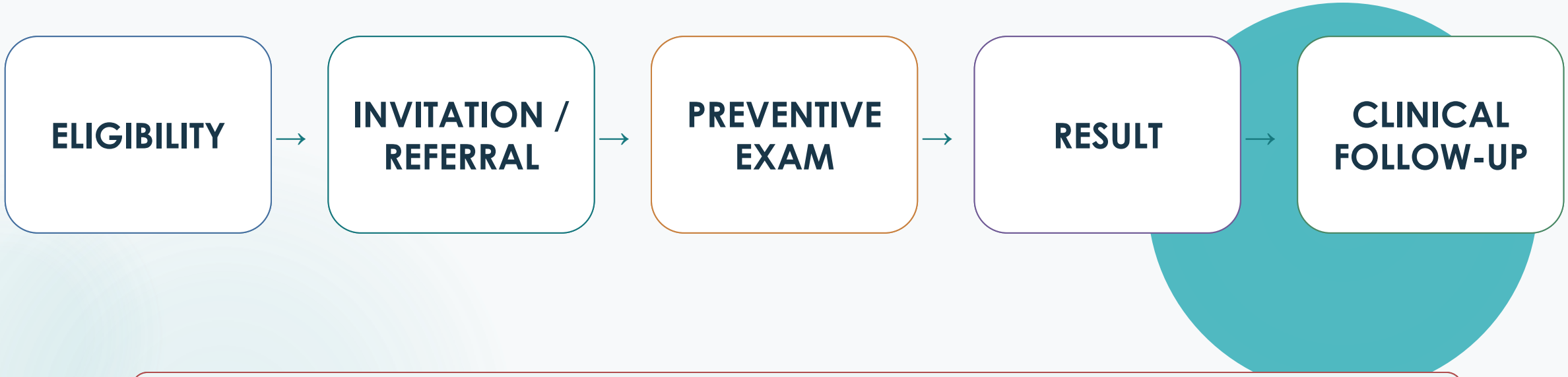
New phase from 1 Sep 2026 through 2030

Source: Hellenic Ministry of Health, 12 June 2026. Teaching reconstruction; not an official programme graphic.

Source: Greek Ministry of Health, 12 Jun 2026

ΠΡΟΛΑΜΒΑΝΩ as a Population-to-Clinic Pathway

Population prevention must connect to clinical follow-up



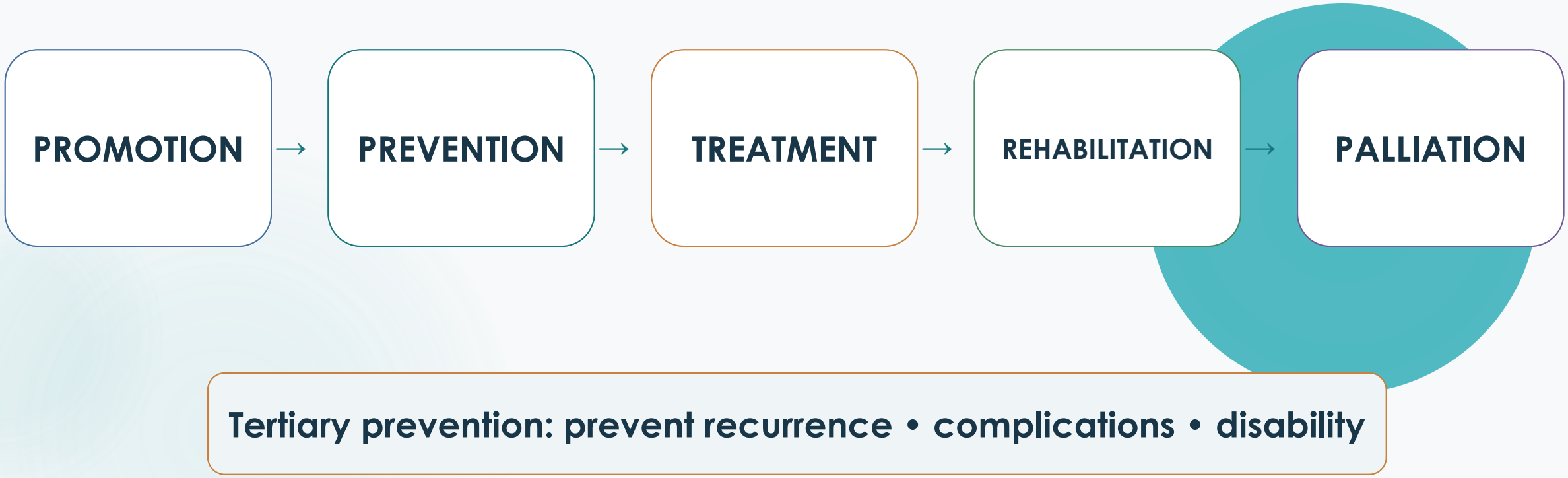
Invitation is not the endpoint — close the loop after an abnormal result.

Original teaching pathway based on current Ministry of Health ΠΡΟΛΑΜΒΑΝΩ information.

Source: Greek Ministry of Health 2026

From Prevention to Treatment and Rehabilitation

Clinical prevention continues after disease is established



Tertiary prevention: prevent recurrence • complications • disability

Adapted from WHO/WRA continuum of care.

Source: WHO PHC continuum

Tertiary Prevention in Clinical Practice

- Control disease
- Prevent recurrence
- Prevent complications
- Preserve function
- Support participation and quality of life

Rehabilitation Is an Essential Health Service

Rehabilitation: beyond survival to functioning and participation

OPTIMISE FUNCTIONING

What can the person do?

REDUCE DISABILITY

Prevent or limit impact

SUPPORT PARTICIPATION

Daily life • work • community

WHO/WRA: rehabilitation in primary care; functioning, disability reduction and participation.

Source: WHO Rehabilitation in Primary Care, 8 Jul 2026

Continuity of Care • Do Not Stop at Referral

Referral is not the endpoint

Confirm completion

Reassess outcomes

Coordinate services

Update the prevention plan

Build the Individual Prevention Plan

The Individual Prevention Plan: concise, actionable, longitudinal

1	Patient profile
2	Preventive needs / evidence
3	Priorities
4	Agreed actions
5	5A behavioural goal
6	Referrals / rehabilitation
7	Follow-up date

Original teaching template synthesising the lecture; no disease-specific guideline claim.

Case Challenge • Complete the Plan

For the opening patient:

What is due now?

What requires shared decision-making?

What behavioural goal will you address?

What will you arrange for follow-up?

The One-Page Clinical Prevention Algorithm

One-page clinical prevention algorithm



Prevention is a cycle — update the plan as evidence, risk and priorities change.

Original evidence-derived clinical teaching algorithm.

Take-Home Messages • Key References

Clinical prevention is personalised, evidence-based and longitudinal.

Use 5A to turn advice into action.

ΠΡΟΛΑΜΒΑΝΩ links organised population prevention with clinical pathways.

Tertiary prevention and rehabilitation remain preventive care.

A preventive plan is incomplete without follow-up.