The Key Attributes of Good Primary Care

PRIMARY CARE OFFICE
DEPARTMENT OF HEALTH

26 FEB 2011
PRESENTATION OUTLINE

1. Primary Care System

2. Major Strategies to Improve Primary Care in Hong Kong

3. Concept of Family Doctor

4. Core Competencies of a Good Family Doctor

1. PRIMARY CARE SYSTEM
The Key Attributes of Good Primary Care

FAMILY DOCTOR IN PRIMARY CARE

X dispenser
X waiter to order investigation
X typist for referral letter
CHANGES IN CASEMIX IN PRIMARY CARE:

- **All Cases**
- **Chronic Illnesses**

The percentage of chronic patients is increasing. In addition, they are presented with multiple problems instead of a single problem, involving psychosocial issues.

Patients' expectations have changed... 37.2% patients are coded with more than 1 ICPC, i.e. come with more than 1 problem.

Besides, the figure may be under-estimated...
FAMILY DOCTOR IN PRIMARY CARE

✓ First level of contact of individuals, family and community
✓ Comprehensive care
✓ Continuous care
✓ Coordinated care
✓ Preventive and opportunistic care

PRIMARY CARE SYSTEM

Primary Care System

NGOs  Private  Public
Primary care is the first point of contact for individuals and families in a continuing healthcare process.

Covers a wide range of services:
- health promotion
- prevention of acute and chronic diseases
- health risk assessment and disease identification
- treatment and care for acute and chronic diseases
- self-management support
- Rehabilitative, supportive and palliative care for disability or end-stage diseases

Studies showed that health systems that rely on primary care:
- produce better population health outcomes
- reduce the rate of avoidable mortality
- improve continuity and access to healthcare
- result in higher patient satisfaction
- reduce health-related disparities at a lower overall cost for healthcare
2. MAJOR STRATEGIES TO IMPROVE PRIMARY CARE IN HK

1. Develop comprehensive care by multi-disciplinary teams
2. Improve continuity of care of individuals
3. Improve co-ordination of care among healthcare professionals across different sectors
4. Strengthen preventive approach to tackle major disease burden
MAJOR STRATEGIES TO IMPROVE PRIMARY CARE IN HK

5. Enhance inter-sectoral collaboration to improve the availability of quality care, especially care for chronic disease patients

6. Emphasize person-centred care and patient empowerment

7. Support professional development and quality improvement

8. Strengthen organizational and infrastructural support for the changes

1. DEVELOP COMPREHENSIVE CARE BY MULTI-DISCIPLINARY TEAMS

With expanding needs of chronic disease patients and the elderly, multi-disciplinary teams in community are needed in order to provide a more proactive, coordinated and comprehensive care.

Collaborative care provided by multi-disciplinary teams of providers improves health outcomes and provides more appropriate support to patients in the community.
MULTI-DISCIPLINARY COLLABORATION

- FM physicians
- Dietitians
- Physiotherapists
- Podiatrists
- Clinical Psychologists
- Prosthetics & Orthotics
- Optometrists
- Pharmacists

Multi-disciplinary Care Team

Allied Health Professionals
- Nurse
- Physiotherapy
- Occupational Therapy

RAMP (DM & HT)
- Outreach Services
- Community Call Centre

Smoking Cessation
- Shoulder Class
- Fall Prevention

Memory Training
- Stress Management
- Lifestyle Redesign

Body Weight Management
2. IMPROVE CONTINUITY OF CARE FOR INDIVIDUALS (1)

Better continuity of care:

- improves access to care
- reduces re-hospitalisation
- reduces consultations with specialists
- reduces emergency services
- detects adverse effects of medical interventions better
- enhances effectiveness, especially in chronic disease management, elderly care and maternal and child care

2. IMPROVE CONTINUITY OF CARE FOR INDIVIDUALS (2)

- Management
  - consistent and coherent approach to the management of a health condition that is responsive to a patient’s changing needs
- Relationship
  - on-going therapeutic relationship between a patient and healthcare provider(s)
- Information
  - use of information on past medical history and personal circumstances to make current care appropriate for each individual
2. IMPROVE CONTINUITY OF CARE FOR INDIVIDUALS (3)

Patient’s perspective
✓ it entails the experience of a 'continuous caring relationship' with an identified healthcare professional
✓ helps healthcare providers gain their patients’ confidence, become better co-ordinator of patients’ health services and more effective in providing holistic care and promoting health

Provider’s perspective
✓ focused on the continuity in management, and the delivery of a ‘seamless service’ through integration, co-ordination of care plan and the sharing of information among providers.

2. IMPROVE CONTINUITY OF CARE FOR INDIVIDUALS (4)

Major challenges:

✗ Development of specialty services and multi-disciplinary care make it increasingly common for patients to be seen by an array of providers in a wide variety of settings

✗ ‘Doctor-shopping’ is a fairly common phenomenon

✗ Sharing of patient records across different sectors needs further development
3. IMPROVE COORDINATION OF CARE AMONG HEALTHCARE PROFESSIONALS ACROSS DIFFERENT SECTORS

- Mr. C, 65 year-old
- Smoker for 40 years
- Body Mass Index: 32
- Recently diagnosed Diabetes Mellitus (DM) by his family doctor, Dr. Y
3. IMPROVE COORDINATION OF CARE AMONG HEALTHCARE PROFESSIONALS ACROSS DIFFERENT SECTORS (2)

<table>
<thead>
<tr>
<th>Problem Lists</th>
<th>Healthcare providers</th>
</tr>
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<tbody>
<tr>
<td>Newly diagnosed DM</td>
<td>Dr. Y advises Mr. C on lifestyle modifications and prescribes medications according to updated clinical guidelines.</td>
</tr>
<tr>
<td></td>
<td>Dr. Y arranges Mr. C to have fundus photo and foot exam in a Non-Government Organization (NGO)</td>
</tr>
<tr>
<td>Smoking</td>
<td>Smoking Cessation Clinic for counselling</td>
</tr>
<tr>
<td>Obesity</td>
<td>Dietitian assists Dr. Y in giving Mr. C dietary advice on DM and weight reduction.</td>
</tr>
</tbody>
</table>

DR. Y IS THE CASE MANAGER & COORDINATOR!

3. IMPROVE COORDINATION OF CARE AMONG HEALTHCARE PROFESSIONALS ACROSS DIFFERENT SECTORS (3)

Better coordinated care:
- improves continuity
- reduces duplication
- helps patients receiving optimal care based on their needs

Primary care professionals who provide longitudinal care and are familiar with the patients are their best partners and care co-ordinators to help them choose and access to various services based on their needs.
4. STRENGTHEN PREVENTIVE APPROACH TO TACKLE MAJOR DISEASE BURDEN (1)

Strategies to promote health of the whole population:

- promote of healthy behaviours to reduce the risk of diseases
- detect diseases and complications early
- provide high quality management

4. STRENGTHEN PREVENTIVE APPROACH TO TACKLE MAJOR DISEASE BURDEN (2)

Population approach

- a small shift in the average population levels of several risk factors can lead to a large reduction in chronic disease burden
- e.g. healthy diet, physical activity

High-risk individual approach

- e.g. people with obesity, older people or people with predisposing health conditions
- effective in reducing the incidence of diseases, delaying disease onset and reducing complications
5. ENHANCE INTER-SECTORAL COLLABORATION TO IMPROVE THE AVAILABILITY OF QUALITY CARE, ESPECIALLY CARE FOR CHRONIC DISEASE PATIENTS (1)

- **Public healthcare sector** provides a wide range of highly subsidized primary care services. The elderly rely heavily on the public system for chronic disease management and other health services.
  - Overcrowding and long queues for care
- Services in the **private healthcare sector** are widely and directly accessible to people who can afford to pay.

5. ENHANCE INTER-SECTORAL COLLABORATION TO IMPROVE THE AVAILABILITY OF QUALITY CARE, ESPECIALLY CARE FOR CHRONIC DISEASE PATIENTS (2)

Could the private primary care providers be more actively engaged, especially in the provision of care for chronic disease patients alongside the public sector?
5. ENHANCE INTER-SECTORAL COLLABORATION TO IMPROVE THE AVAILABILITY OF QUALITY CARE, ESPECIALLY CARE FOR CHRONIC DISEASE PATIENTS (3)

- More collaboration and co-ordination between the public and private sectors

- To achieve better public-private partnership:
  - More accessible information on costs and effectiveness of care provided by the private sector
    - to make patients easier to estimate their affordability and make informed choices
  - Develop systems to allow mutual communications and sharing of patient records
6. EMPHASIZE PERSON-CENTRED CARE AND PATIENT EMPOWERMENT (1)

An approach of care that consciously adopts the patient’s perspectives, taking into consideration one’s social, cultural and psychological background.

**Strengthening person-centred care:**
- enhances quality of care
- enhances treatment compliance
- improves patient satisfaction
- improves self-efficacy
- improves quality of life

6. EMPHASIZE PERSON-CENTRED CARE AND PATIENT EMPOWERMENT (2)

**Patient empowerment** aims to help patients
- understand their diseases and health needs
- build confidence
- develop skills in self-management,
- develop household capacities to stay healthy
- to make healthy decisions

*Empowering patients to participate actively in their disease management can improve care and health outcomes, especially for people with chronic diseases and other long-term conditions.*
6. EMPHASIZE PERSON-CENTRED CARE AND PATIENT EMPOWERMENT (3)

7. SUPPORT PROFESSIONAL DEVELOPMENT AND QUALITY IMPROVEMENT

- A strong and well-trained healthcare workforce is critical for the sustainable development of our health services.

- A well-trained primary care workforce with suitable professional skill-mix working together in collaboration is needed for effective delivery of the whole range of primary care functions.
8. STRENGTHEN ORGANISATIONAL AND INFRASTRUCTURAL SUPPORT FOR THE CHANGES (1)

With a view to raising standards and quality of primary care services across sectors, the Government would take the lead in setting up and support a dedicated organisational setup to support the implementation of the recommended strategies and to co-ordinate multi-partite efforts in realising the primary care development.

8. STRENGTHEN ORGANISATIONAL AND INFRASTRUCTURAL SUPPORT FOR THE CHANGES (2)

- The use of modern information technology for effective sharing of health records and disease management plans across healthcare providers from different sectors to enhance patient care.

- The ePR Sharing Project was launched at Apr 2006.

- With the patient’s consent, private medical practitioners registered in the project can view the patient’s clinical information online.

- Free of charge for both private practitioners and patients.
8. STRENGTHEN ORGANISATIONAL AND INFRASTRUCTURAL SUPPORT FOR THE CHANGES (3)

- Effective sharing of health records and disease management plans across healthcare providers from different sectors through electronic systems can enhance patient care by:
  - improving continuity
  - improving co-ordination
  - improving communications
  - improving patient safety
  - facilitating the monitoring and evaluation of service delivery
  - provision of more patient-centred integrated management.

8. STRENGTHEN ORGANISATIONAL AND INFRASTRUCTURAL SUPPORT FOR THE CHANGES (4)

Health information systems can also provide platforms to:

- strengthen professional training
- strengthen experience sharing among different providers
- help generate useful epidemiological information to direct health policies
CONCEPT OF FAMILY DOCTOR

A family doctor:

- cares about patients beyond the treatment of their diseases
- is capable of providing comprehensive, continuing, whole person and preventive care to an individual and family in their own community or environment
- ensures physical, psychological and social well-being for his patients
- coordinates the care provided by other healthcare professionals
他是一個怎樣的人？

他來自怎樣的家庭？
COMPETENCES IN MANAGEMENT

- Collaborations
  - Shared understanding of the problem
  - Patient empowerment

- Time
  - When clinic picture is uncertain
  - Sometimes the correct thing to do is to apparently do nothing

- Modify Help-seeking behaviours

PRINCIPLES OF FAMILY MEDICINE (1)

Case Example:

- **Mr. Lau**, 39 years old Surveyor saw his doctor one week ago for two weeks history of progressive loss of appetite and dull ache over epigastric region.

- On examination, doctor found that he was jaundiced. There was tender hepatomegaly with a span of 10 cm. Ultrasound, Hepatitis B status, LFT and AFP were arranged.
Results came back:
- USG: hepatic tumours in both lobes measuring up to 6 cm in diameter
- Hep B surface antigen: +ve
- LFT: ALP 259 AST 174 ALT 223 Bil 54
- AFP: 756
- Mr. Lau is waiting outside the consultation room.

What will a clinic doctor do?
### PRINCIPLES OF FAMILY MEDICINE (4)

#### Cross Analysis

<table>
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### PRINCIPLES OF FAMILY MEDICINE (5)

What will a Family Doctor do?
PRINCIPLES OF FAMILY MEDICINE (6)

Cross Analysis

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<tr>
<td><strong>Physical</strong></td>
<td>Prescription of pain-killers. Urgent referral for possibility of intervention.</td>
<td>Treatment Option</td>
<td>Terminal Care Pain control</td>
</tr>
<tr>
<td><strong>Psychological</strong></td>
<td>Shock &amp; Denial Stage of grief Fear Blame</td>
<td>Depression &amp; Escape Denial persist Emotional support</td>
<td>Facing death Worry of family</td>
</tr>
<tr>
<td><strong>Social</strong></td>
<td>Informing family Confidentiality Job disturbance</td>
<td>Family Reaction Financial stability Treatment cost</td>
<td>Family’s future Social support</td>
</tr>
</tbody>
</table>

4. CORE COMPETENCIES OF A GOOD FAMILY DOCTOR
CORE COMPETENCIES OF A GOOD FAMILY DOCTOR

1. Comprehensive care
2. Continuing care
3. Preventive care
4. Coordinated care
5. Patient-centred approach in the context of family and community

Family Physician’s Attributes
Attributes of a good family doctor, coupled with strong trunk of updated clinical knowledge, effective clinical and communication skills, and a strive to develop and maintain continuing learning and quality improvement, could breathe life to the primary care system and benefit the patients and community as a whole…

CONCLUSION
TOWARDS A NEW PHASE

- **Enhancing primary healthcare**
  - Keep patient healthy in the Community
  - Shift the health service from a disease model to a health model
- **Patient Empowerment**
  - Public & private Partnership
  - Shared care with private practitioners
- **Community Health Centre**
  - CHCs in 18 districts:
    - Public-led CHC
    - NGO CHC
    - Private CHC

The Key Attributes of Good Primary Care

The Key Attributes of Good Primary Care
YOUR SUPPORT WILL BE CRUCIAL IN THE PRIMARY CARE DEVELOPMENT!