

Paradigm-Shift for Primary Health Care Delivery: Concept of Community Health Practitioners

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Primary Health Care Strategic Development

- Develop comprehensive care by **multi-disciplinary** teams
- Improve **continuity** of care for individuals
- Improve co-ordination of care among healthcare professionals across **different sectors**
- Strengthen **preventive** approach to tackle major disease burden
- Enhance inter-sectoral collaboration to improve the **availability** of quality care, especially care for chronic disease patients
- Emphasise person-centred care and **patient empowerment**
- Support **professional development** and quality improvement
- Strengthen organisational and infrastructural **support** for the changes

Multi-disciplinary teams

- Western medicine practitioners
- Chinese medicine practitioners
- Dentists
- Pharmacists
- Other healthcare professionals like nurses, chiropractors, allied health professionals
- **Trained to cure diseases and treat health problems at clinics**

Continuity

- Relationship continuity
 - Long term relationship between healthcare providers and patients; so that
- Information continuity
 - Use of past medical history to inform current treatment; so that
- Management continuity
 - Responsive to changing needs, especially for chronic diseases
- **This allows doctors to deliver better healthcare at the clinic**

Coordination across sectors

- Coordination of the multi-disciplinary teams across various sectors (public, private, NGO) to provide the continuity of care
- To enhance disease treatment and management

Availability of quality care

- 31.4 % of Hong Kong public doctors suffered from high burnout (Siu et al, 2012)
- Public sector Nurse:Patient Ratio (Hong Kong 1:10-12; International 1:4-6) (AHKNS, 2014)
- Hong Kong has started to train more healthcare workers

Siu CFY, Yuen SK, Cheung A. Burnout among public doctors in Hong Kong: cross-sectional survey. Hong Kong Medical Journal. 2012;18:186-192

Association of Hong Kong Nursing Staff. 護理服務及人力資源規劃建議書. May 2014.

Preventive approach

- Population approach
- High-risk individual approach
- Promotion of healthy behavior
 - Need more than making pamphlets, posters, and health talks
 - Not part of healthcare providers' training, and shouldn't be
- Primary, secondary, and tertiary prevention

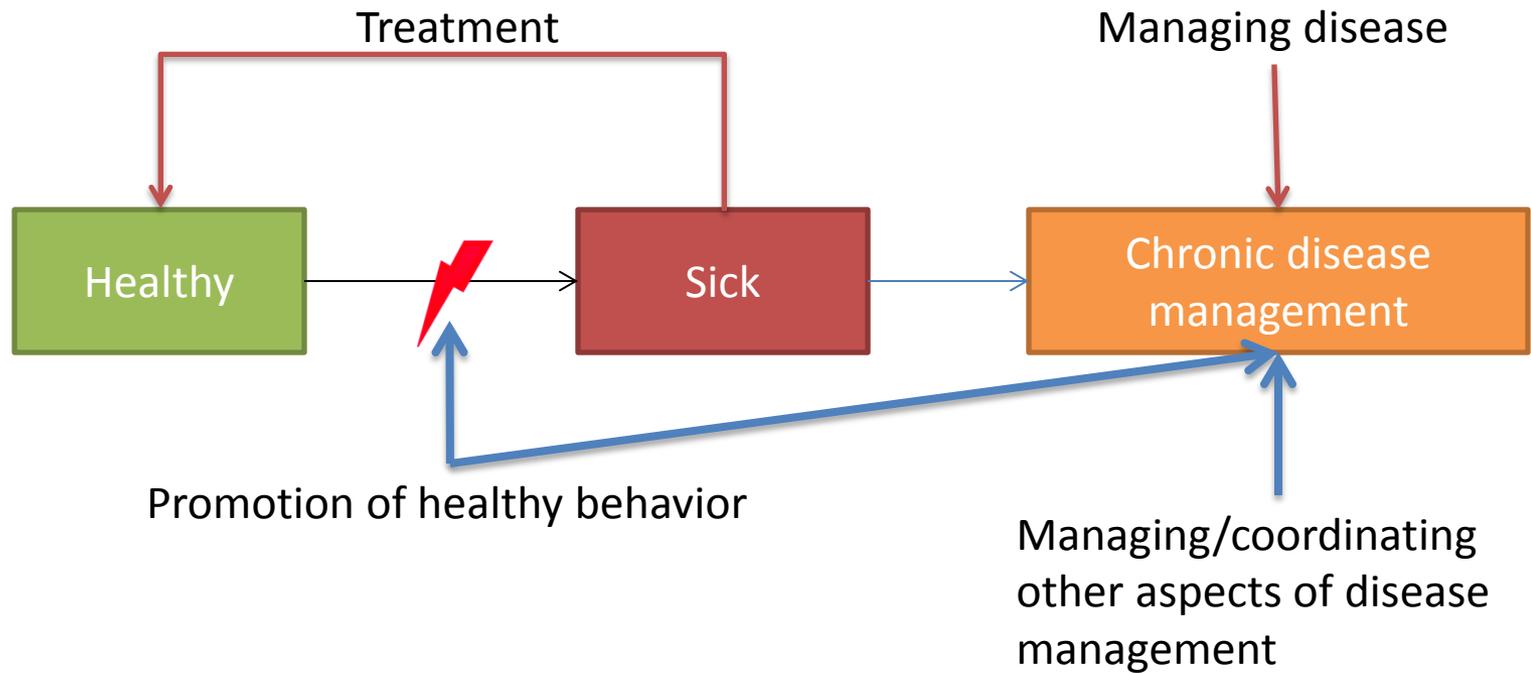
Patient empowerment

- What is “patient empowerment”?
- “Doctors know best” (evidence-based) vs. “Patients taking responsibility” (contextual-based)
- “...in imposing patient empowerment on clinical care, medicine unwittingly opposes patients' interests” (Salmon and Hall, 2004)
- **Often the environmental/external factors are not addressed**

Professional development and support

- Choices:
 1. Re-train healthcare workers to do health promotion, which will involve knowing and changing the environment, under the current heavy workload; or
 2. Train a new workforce to carry out health promotion works so that healthcare workers can focus on and enhance primary care

Community Health Practitioner (CHP)



Community health practitioners

Healthcare workers

CHP Skill Set

- Mindset
 - People-centered (not patient-centered)
 - Digging for actionable insights
 - Mindful of costs/benefits to the people
 - One-size doesn't fit all
 - “Make the healthier choice the easier choice” (Ottawa Charter for Health Promotion)
- Skills
 - Basic epidemiology and biostatistics
 - Health promotion program planning
 - Theoretical knowledge (behavioral change theories, communication theories, etc.)
 - Promotion material design
 - Knowledge of chronic disease management

BSc in Community Health Practice at CUHK

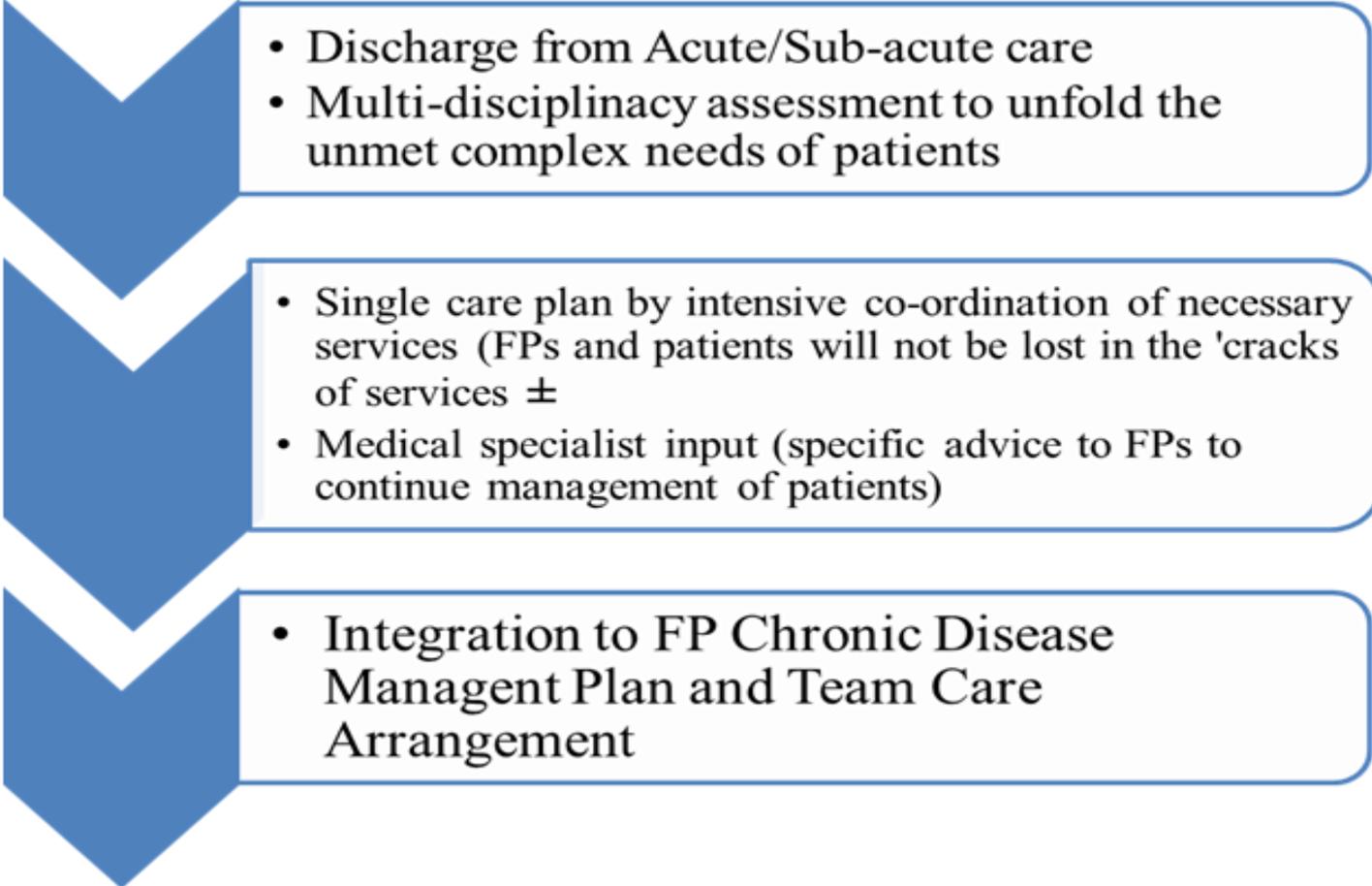
- Started in 2013
- 2-year top-up degree program for Associate Degree / Higher Diploma graduates

Is current health care system empowering patients to improve their health literacy in self management?

Do health professionals have the skills to empower patients for self management?

- Substantial proportion of patients still expect their health to be responsibility of medical team rather than their own control
- Most health care professionals are trained in the acute medical model of care with treatment provided by medical team and little contribution to outcome from patient's perspectives
- Ample of evidence showing that *if the professionals remain in control, the outcome are worse* (Kaplan RM, Chadwick MV, Schimmel LE. Diabetes Care 1985;8:152-5.)
- The “contract” between patient and carers in chronic disease management is markedly different from acute situations. It needs to be explicit, negotiated and modified in response to various life and disease events.
- The predominant role of the professional is to meet the medical agenda to improve outcome (glycaemic control, blood pressure). Although technical targets are important, they are unlikely to be satisfied if psycho-social aspects are not addressed.
- Admission to hospitals, exercise demands to review results of investigations would erode patient's feelings of self-control.

Outline of clinical pathway of patients with chronic illnesses to be discharged back to community

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- Discharge from Acute/Sub-acute care
 - Multi-disciplinary assessment to unfold the unmet complex needs of patients

- Single care plan by intensive co-ordination of necessary services (FPs and patients will not be lost in the 'cracks of services ±
- Medical specialist input (specific advice to FPs to continue management of patients)

- Integration to FP Chronic Disease Management Plan and Team Care Arrangement

Flow Chart GP and Hospital Admission Risk Programme (HARP)⁴¹

Source: Lee A. *Report to Sub-acute Medical Services on (HARP), Ballarat Health Services*. Aug 2013⁴¹

Cases of chronic diseases with complex needs and multiple inputs⁴¹

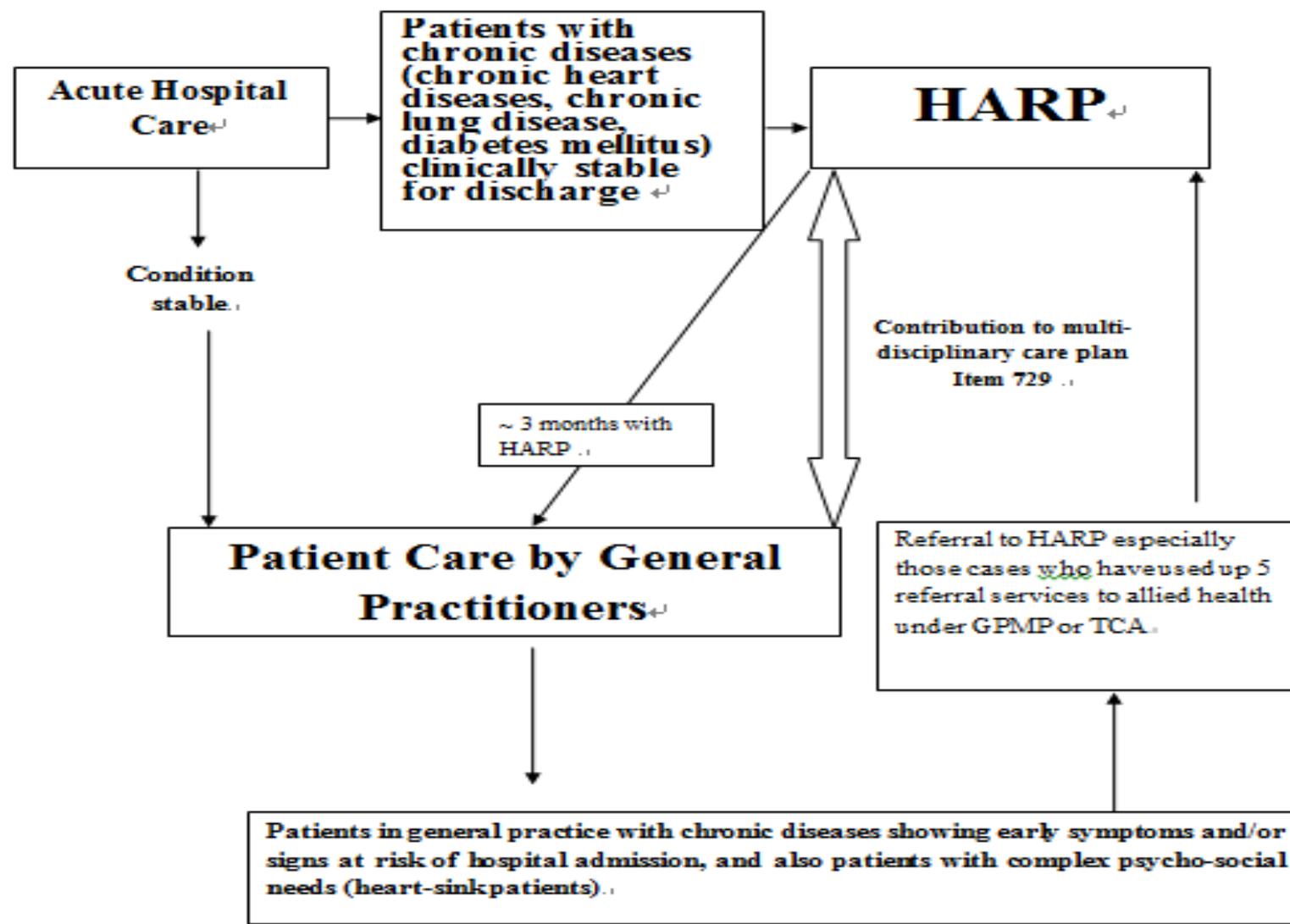


Figure 4

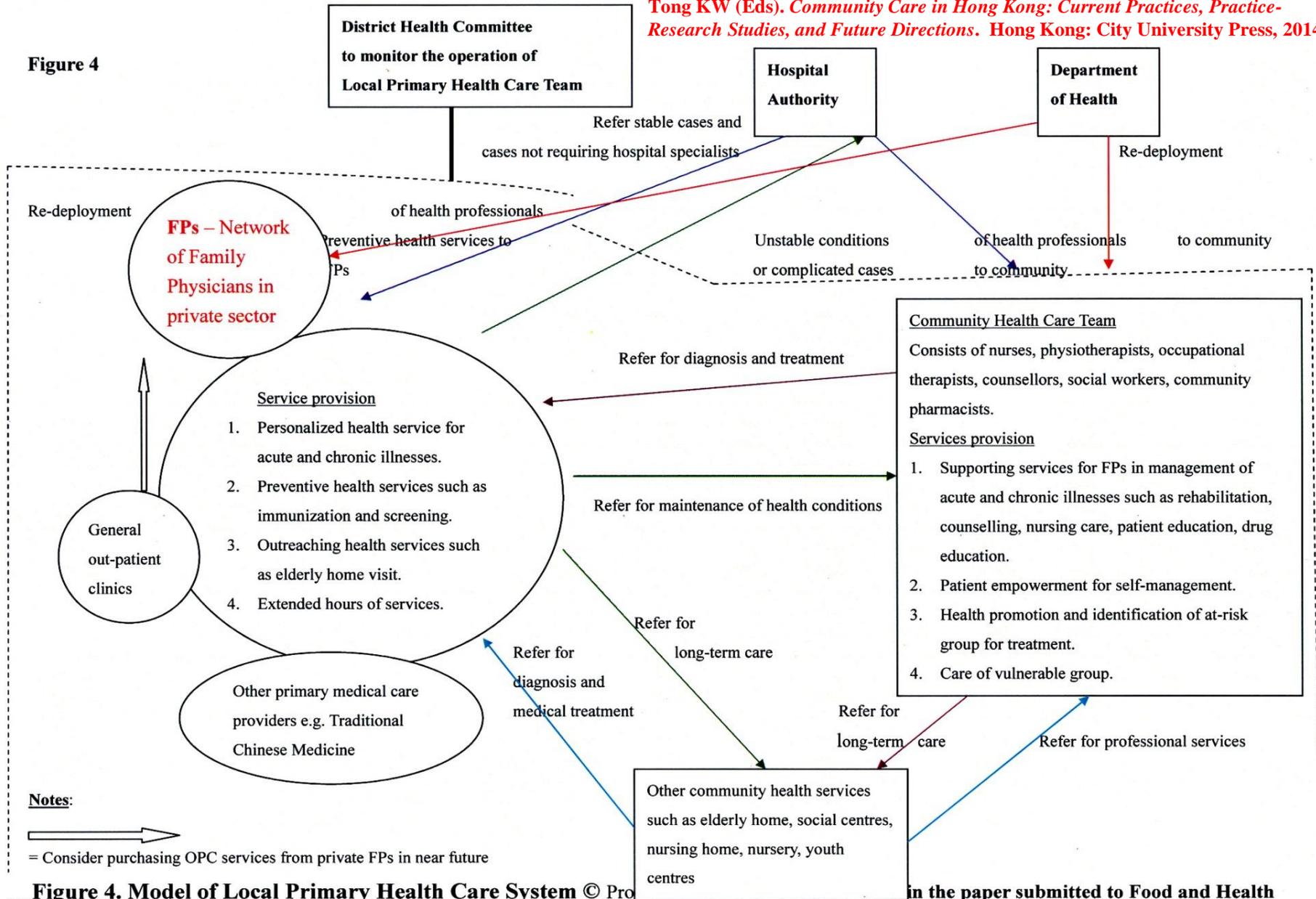


Figure 4. Model of Local Primary Health Care System © Pro in the paper submitted to Food and Health Bureau on 'Your Health, Your Life. - Healthcare Reform Consultation Document 2008' by Hong Kong Association Professional and Senior Executive