Service Priorities and Programmes

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A quality service development for enhancement of chronic disease patient management in primary care

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Introduction

Diabetes Mellitus is an important disease managed in primary care setting. More than 40,000 DM patients with regular follow-up and management at 8 General Out-patient Clinics (GOPCs) at our New Territories West Cluster, Hong Kong. The programme aims to improve the quality of care for patients with chronic diseases in General Out-patient Clinics (GOPCs). The complication assessment is incorporated with the daily primary care practice. Diabetic patients will undergo regular and comprehensive risk assessment to identify complications and receive subsequent appropriate medical interventions and education from multi-disciplinary healthcare professionals, thus better control the disease progression. This project is a regular review aimed at assessment of the impact of Risk Assessment & Management Program [RAMP]. The result of the review data would be shared at various level of department meetings for service enhancement.

Objectives

To review the clinical outcome of RAMP, in term of key performance indexes [KPI] HbA1c, BP and LDL level

Methodology

Since March2011, our clinics has implemented the RAMP to enhance the quality care of DM patients. By structural and protocol-driven complication assessment, provided by nurses, optometrists and allied health professionals. The patients would be stratified into various risk categories for management by their usual doctors, nursing specialists, allied health professionals or experienced family physician for advance medical support such as insulin initiation and titration. Ongoing quality data in term of various KPIs retrieved for clinic peer review for service enhancement and patient care management.

Result

The KPIs after the implementation of RAMP are promising with the latest >50% of patient HbA1c<7%, >55% of patient BP<130/80mmHg & >65% of patient

LDL<2.6mmol/L The RAMP is well-accepted by the patients with more than 72,000 attendances benefit from the disease complication assessment and management program over this 4 years. With the structural program provided by the primary care team and regular KPIs review, the patients' chronic disease care improved and sustained, comparable to many international standard.