

# The Role of Family Medicine in Chronic Disease Management: *the rising importance to healthcare*

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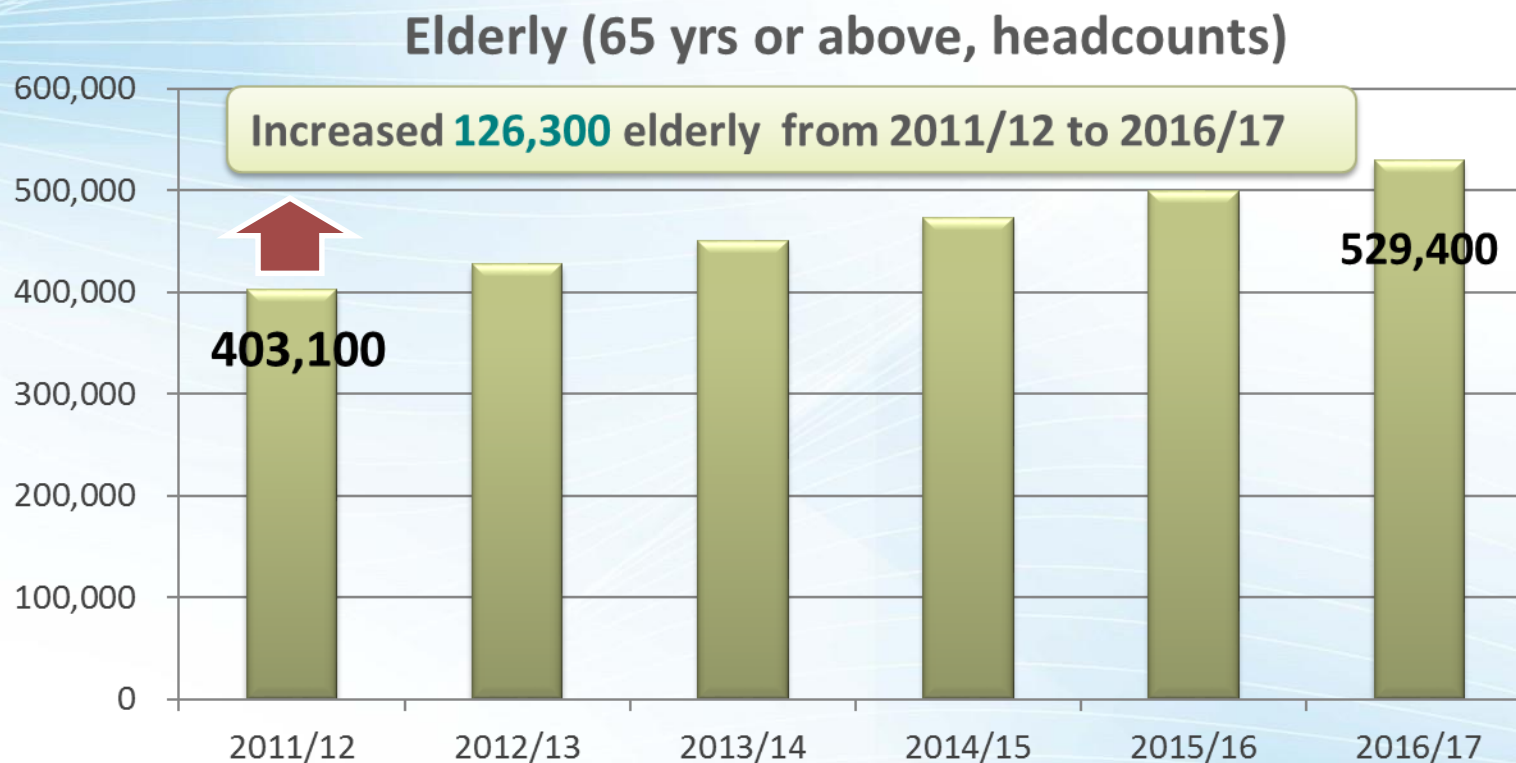


# Challenges of Chronic Disease Management

- Ageing
- Longevity
- Unhealthy Lifestyles
- Morbidity
- Disability
- Mortality



# Number of elderly patients in HA's General Outpatient Clinics (GOPCs) in past years



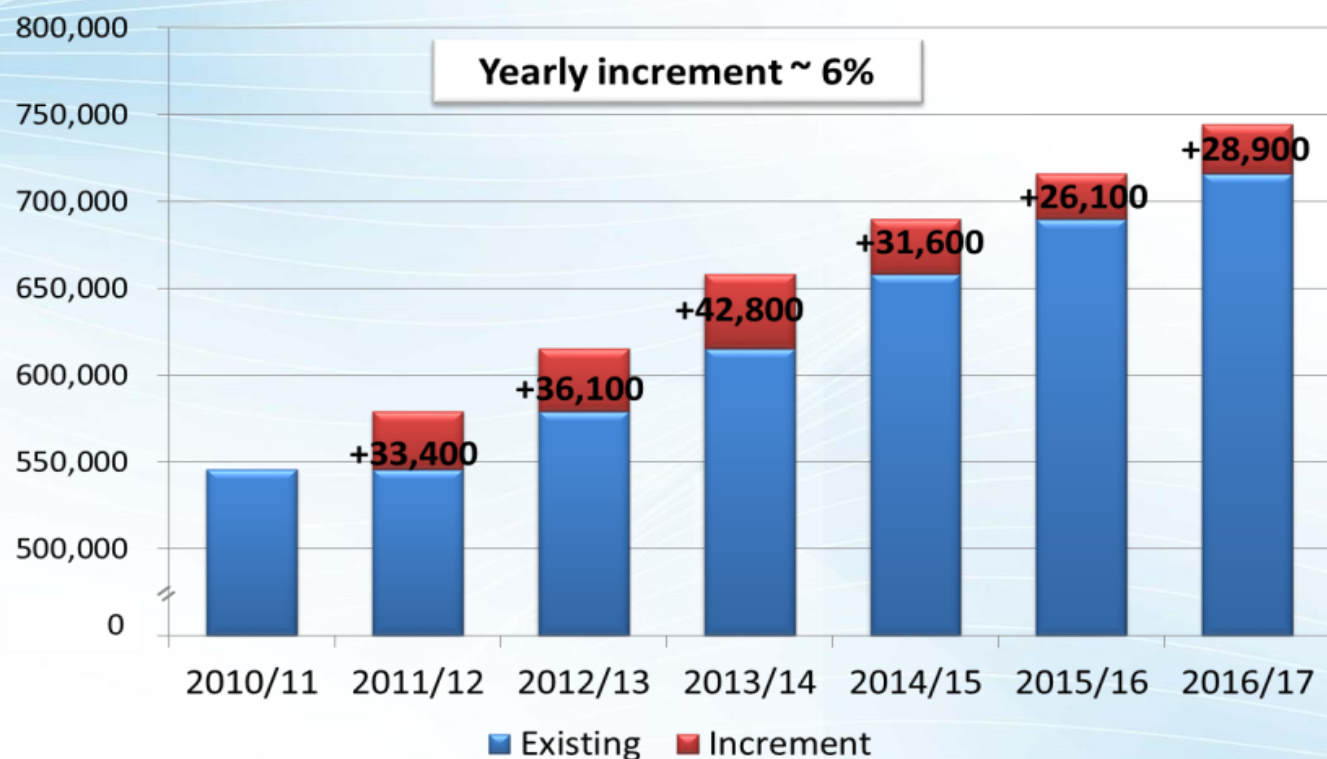
Source

Statistics and Workforce Planning Department, Hospital Authority Head Office,  
Hong Kong Hospital Authority (July 2017)

**Ageing: Elderly patients ↑ > 30% over last 5 years**



# Trend of patients with chronic diseases in HA's General Outpatient Clinics (GOPCs) in past years



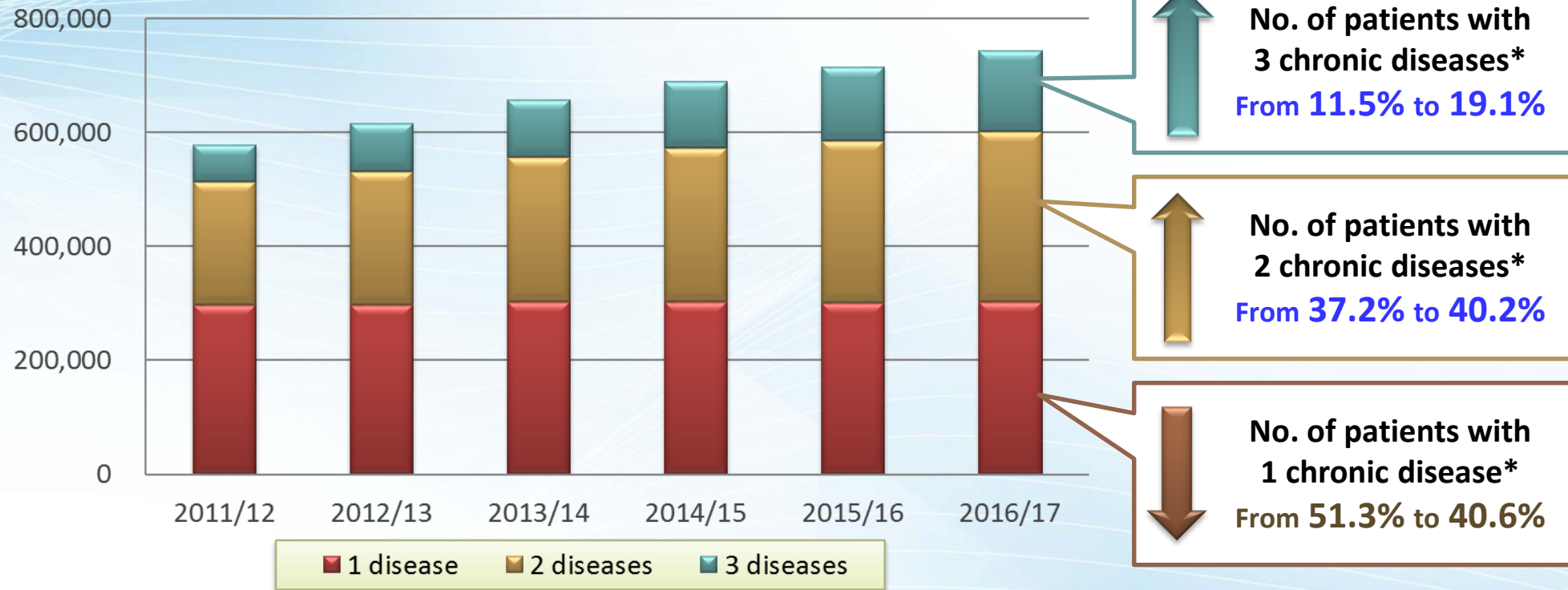
*\* Patients with diabetes, hypertension or lipid disorder*

Source

Statistics and Workforce Planning Department, Hospital Authority Head Office,  
Hong Kong Hospital Authority (August 2017)

**Volume: ↑ ~200K (>36%) of chronic patients\* in 6 years**

# Trend of increasing complexity in HA's General Outpatient Clinics (GOPCs) in past years



Source

Statistics and Workforce Planning Department, Hospital Authority Head Office,  
Hong Kong Hospital Authority (August 2017)

*\*Patients with diabetes,  
hypertension or lipid disorder*

**Complexity: ↑ patients having more than one disease**

# Family Medicine led Primary Care Service

**Primary care as the key element for modernizing health care in facing nowadays challenges**

- **Government reports of the Working Party on Primary Health Care (1990)**
- **Primary Care Development in Hong Kong (2011)**



# Meet Mr LEE



**Mr LEE**

## Age: 76

- Multiple chronic illnesses: DM, HT, COPD, Stroke with mild right hemiparesis, and prostate cancer with bilateral orchiectomy done
- Endless cycle of medication adjustments, AED visits and hospitalization
- Has seen 3 specialists last few months
- Insulin injection was offered and rejected





# What can I do for Mr LEE?



*I can send him back to the AED,  
and they'll admit him to the hospital.  
But that will just continue the cycle. . . .*

*Instead, I pause, and look this  
fragile, dignified man in the eye.*





# Meet Mr LEE

“I would like to be **able to walk without falling**,” he said. “Falling is horrible!”



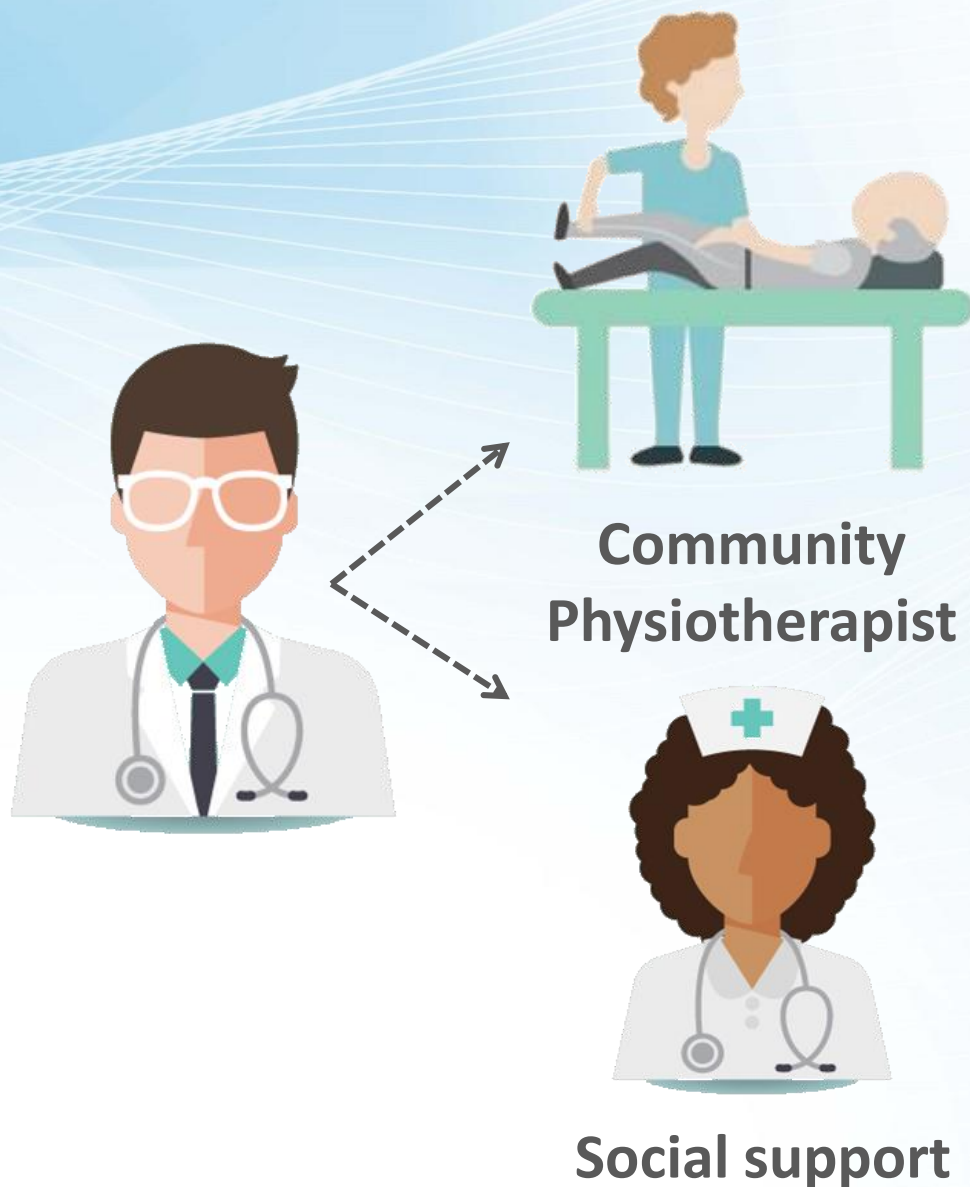
“I can arrange **physiotherapy** and **occupational therapy** for you,” I said. “You don’t have to be admitted to the hospital in this regard.”



“He really wants to stay home,” they said. “Also he’s **increasingly forgetful** and **easy to lose his temper**.”



# Follow-up action



## ACTION LIST

- Nurse
- Community Physiotherapist
- Fall Prevention Programme
- Cognitive Assessment - dementia
- Medication supervision
- Social support



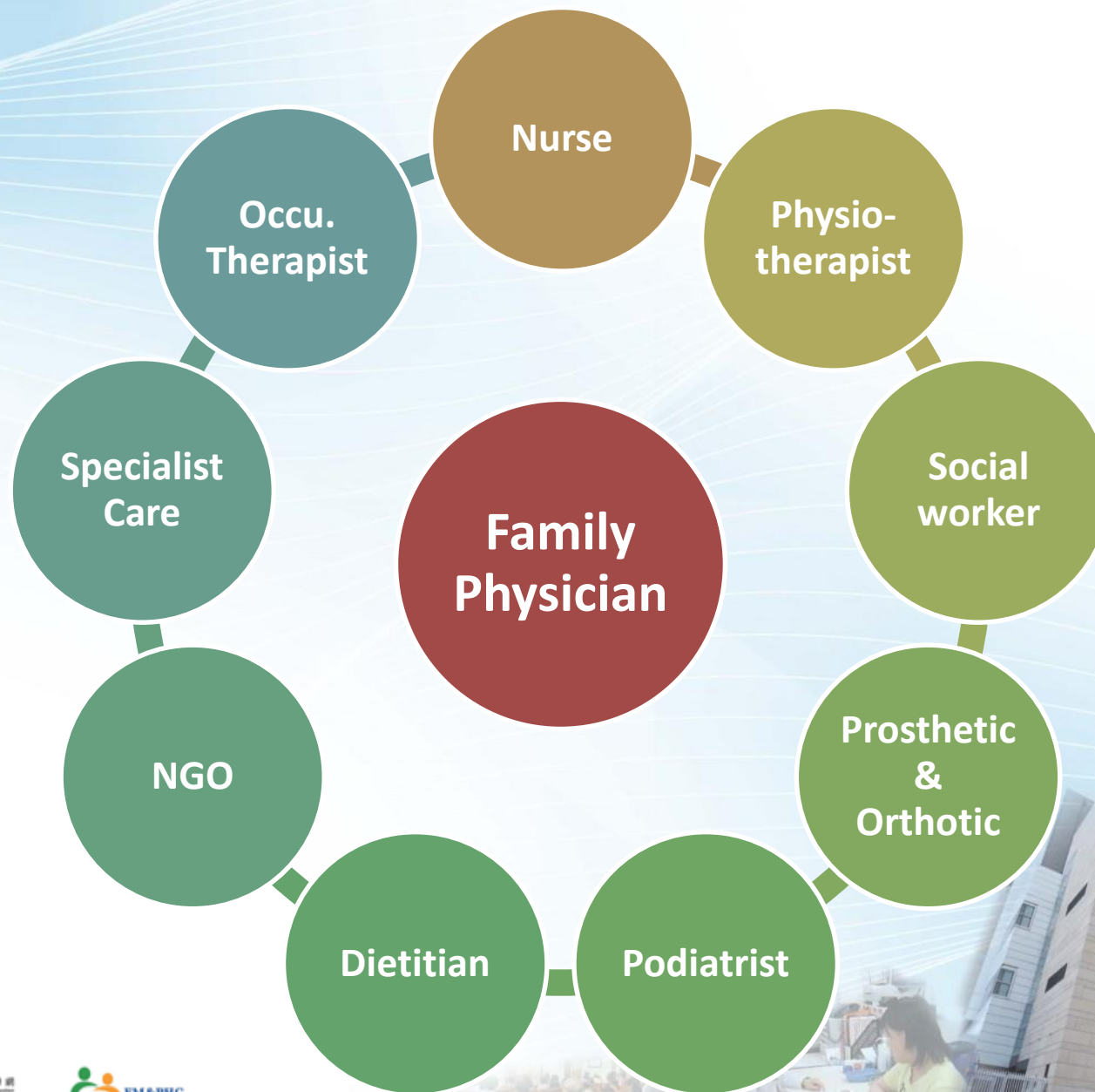
# Role of Family Medicine

- **Patient-centred Care**
- **Comprehensive Care**
- **Coordinative Care**
- **Prevention**





# Comprehensiveness



# Family Medicine led Primary Care Service Model

- Cultivate **long-term relationships** with patients  
➔ *Patient-centred & Comprehensive care*
- Find the **right place with right level** of care  
➔ *Coordinative care*
- Uniquely **well-placed** to help people age in good health  
➔ *Prevention*



## Source

Barbara Starfield, MD, MPH, The 19th WONCA World Conference of Family Doctors  
Cancu, Mexico (19-23 May 2010)



# Meet Mr CHAN



**Mr CHAN**

**Age: 40**

- DM, recently diagnosed
- Occupation: Bank Manager
- Smoker x15 years, social drinker
- Long working hours
- Fhx of DM, HT (both parents and 2/3 of his siblings)
- Couldn't sleep recently





# What can I do for Mr CHAN?



*By experience, I know it would be very difficult for this man to change his life style...*

*I can repeat the medications or give him more medications?!*

*Instead, I pause, and look this well built man in the eye.*



# Meet Mr CHAN

“I want to be **able to have a good sleep**,” he said. “Walking in the night is terrible!”



“There is service designed to deal with anxiety and sleeping issues,” I said.  
“**Anxiety counselling service** for sleep should be able to help you.”



# Follow-up action



Key worker

## **ACTION LIST**

- *Integrated Mental Health Programme*
- *Risk Assessment and Management Programme for Diabetes Mellitus*





# One year later .....

“I have **quitted smoking**, and **started to do exercise.**”



“You have **lost some weight** and the **blood pressure is well controlled,**” I said. “You’re **no longer anxious** and **walks at night.**”



# Integrated Mental Health Programme

- **Primary care-based Integrated Mental Health Programme**
- **Target group:**
  - ➔ Patients with Common Mental Disorder in HA's GOPCs
- **Outcome:**
  - ➔ 60% patients improved as shown by PHQ-9\*/GAD-7^



\* Patient Health Questionnaire (PHQ-9)

^ Generalized Anxiety Disorder 7-item (GAD-7) scale



# Risk Assessment and Management Programme (Diabetes Mellitus)

- Independent study revealed that **Risk Assessment and Management Programme (Diabetes Mellitus)** can significantly benefit patients by reducing:
  - ➔ *5-year mortality*
  - ➔ *Diabetes Mellitus complications*
  - ➔ *Cardiovascular diseases*
- In addition, it also proved to be cost saving by reducing:
  - ➔ *Specialty level of care*
  - ➔ *Hospital service costs*



## Source

Professor Cindy L K Lam, Danny D B Ho Professor in Family Medicine: Key note address at the Chronic Disease Management & Quality Improvement Course 2018 PCO & HKCEP





# Back to Basics: PEOPLE



# Thank You !

