Patients’ perceptions and expert opinions regarding a family medicine outpatient clinic embedded in a teaching hospital indicate the urge of qualified integrated care

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Background: HTP of Turkey

- During the last decade a health reform program called Health Transformation Program (HTP) was gradually introduced in Turkey including introduction of Family Medicine Scheme.
- **2003 -2010** extension of FM scheme.
- **New primary care doctor**: vocational training/orientation course. Capitation + performance based payment as independent contractor.
- Every citizen is free to choose his/her own Family Physician and register onto his/her list.
Background: current status

• Structural change completed. Time for quality improvements!!!

• The structure of primary care is ‘medium’, and the primary care service delivery process is ‘weak’ in Turkey relatively among countries in Europe (Kringos et al. BJGP 2013).

• The major issues for stronger primary care in Turkey are insufficient comprehensive care, lack of coordination of care and manpower, inadequate procedures supporting team and multidisciplinary work. (Tatar M et al. Health Sys inTransiton2011; Akman M. TJFP 2014)
Background: academic units

• 1985; first training position, 1993; first university department, currently, 63 departments of FM

• **Contradictory ‘de facto’ situation** of department clinics: providing primary care at tertiary health care units (FMOC in TH & PCC).

• **Non-existence of academic primary care centers.** No practitioner with an academic title in community.

• Non existence of obligatory referral chain: **patients’ choice**

• High patient numbers on FD lists (average approx. 3500)
Aim:

1. What are the perceptions and experiences of patients regarding FMOC embedded in teaching hospitals (TH)?

2. What are the perceptions of academicians and hospital managers regarding FMOC in TH? What are their reflections on patients’ perceptions?
Method

• Study planned in 3 phases: quantitative – qualitative

✓ 1. phase: academic unit outpatient clinic spectrum
✓ 2. phase: patient focus groups
✓ 3. phase: in depth interviews of academicians and hospital directors

• The results of third phase predominantly will be presented in this presentation.
Method

• This is a qualitative study based on **focus groups of patients** and in **depth interviews with experts** (4 teachers of family medicine and 4 hospital managers; purposeful, convenience sampling)

• Semi structured questions were prepared according to research questions.

• Patient focus group consisted of 6 to 8 patients (either male or female) who gave their informed consent (in total 19).
Method

• 1 interviewer (SS/DK) interviewed the experts. Lenght of in depth interviews between 20-50 min. And each was recorded (audio).

• In depth interviews were continued until no new theme had been emerged (saturation).

• Content analysis of the transcripts of the in depth interviews were done by two researches (MA, SÇ) independenly. Codings and their classification was discussed and agreement between the researches was established.

• Triangulation: agreed codes and classifications were evaluated by third researcher (SS).
RESULTS: Expert opinion about FMOC in TH:

- Experts were questioned in the following 3 main categories:

1- Functions of and expectations from FMOC in TH
2- Their reflection on patient perceptions
3- Future of these clinics
1-Functions of and expectations from FMOC in TH

- “Struggle of survival” for the sake of family medicine training. There seems to be a need for better integration between primary care and hospitals.

- *In Turkey family medicine discipline is not started from community based experiences of general practitioners, But it started from universities and THs with an emphasis on academic dimension.* (Ac.M 1)

- “**Functionality of FMOC in TH is shaped according to needs of THs**” (Ac M2)

- “FMOC functions as a *joker* OC in THs. This places are temporary, suitable for only transition periods. Not acceptable in long term” (AcM1)

- *If we have residents of FM in THs, then we should have a practice, FMOC.*” (Ac. F 1)

- “**Real place of FMOC should be in the community. In hospital we were seen as competitors**” (Ac. F 2)
1-Functions of and expectations from FMOC in TH

• “When 7000 patients per day comes to university hospital, FMOC in TH functions as a primary care unit for this environment. That will continue this way if we do not strengthen PC” (Direc. M4)

• “From the directors point of view FMOC seem as satellite clinic of THs in which many patients can be seen in one day and as a result brings easy income to THs” (Direc.M2)

• In Turkey it is difficult to say a three tier system exists. When everywhere is primary care, there is no patient demand for primary care specifically” (Direc M2)
Patient’s perspective: PCC vs FMOC

• Patients find health care provision at FM out patient clinic more **qualified** (professor effect).

• Patients prefer to go to hospital for **serious health problems + diagnostic tests** and go to their own FD for **simple health problems**.

• Patients declared that **coordination and quality** of healt care is superior in FMOC of TH, whereas **continuity** of care found to be superior in primary care setting.
2-Expert reflection on patient perspective

- FMOC is functional, but not efficient for coordination. Patient perception of hospital and primary care seems to be an obstacle.

- “continuity of care solely does not reflect same doctor. It is possible to integrate among physicians via electronic records” (Direc. M4)

- “having a teacher (assoc. Prof) in the unit will support the perception of patients linking FMOC to hospital” (Direc. M2)

- “physically FMOC in TH can not cover all health coordination needs of the hospitals” (Direc. M3)

- “coordination function of FMOC in our TH exists but not efficient for 7000 pt per day. I would like to open satellite outpatient clinics of hospital in the community and that would be great if FM runs these clinics.” (Direc M4)
2-Expert reflection on patient perspective

• “Expectations of the patients from FMOC in TH is high. **Attitude of patients changes in hospital settings** compared to community primary care centers” (Ac. F2)

• “**Patients should not decide by themselves** like preferring hospital for serious problems and going to FD for simple/lighter problems. FD should be **first contact of care** for all problems and then he/she refers if necessary...... **all the nation’s health care coordination can not be done** by FMOC in TH” (Ac. M1)

• “All patient’s words are expectable, no surprises. FMOC in TH are **functional** and therefore they are still open. Otherwise it is very easy to shut them down. A declaration of no financial reimbursement will be enough” (Ac. M2)

• “Perceived high quality of care in FMOC in TH is very normal. They are built as **ideal environments** as much as possible.... I do not think that current primary care diagnostic test capabilities is very narrow. **Patients just do not know.** Therefore they believe that more elective tests are done in hospitals. “ (Ac F1)
3-Future of FMOC in TH

• *Future is in the community, obligatory referral is suggested, uncertainty is the major threat*

• “We should *keep the functionality* of FMOC in TH and widen it especially in the days of *uncertainty*” (Ac. M2)

• “Family medicine departments should have their *practice in the community*. In 2010 a legislation was released for this but we waited for regulations for 4 years with some unacceptable conditions. So now we wait for new solutions” (Ac. M1)

• “As long as we do not have an *obligatory referral chain*, there will always be patients for and *need to FMOC* in THs. “ (Ac F1)
3-Future of FMOC in TH

• “No idea. Cause it is up to government’s health policy” (Direc. M4)

• “Lack of health management personnel makes reorganization of health care provision difficult. Everywhere is primary care now, all OC in THs. I think it is better to let social security institution take over the organization of primary care.” (Direc. M2)

• “I do not accept the idea of FMOC in TH solely for health service provision. This is contrary to the nature of things. They can only be used as a main center for coordination of teaching centers in the community “ (Direc M1)
Conclusion:

Patients’ perceptions and expert opinions indicate the urge of qualified integrated care. Absence of obligatory referral system, inadequate qualifications of primary care doctors, and the current vague description of FM training units and perception of low value of primary care compared to hospitals are the challenges for establishing integrated care provision. FMOC in TH does not seem to be the explicit solution for integration.