

Framework for development of urgent care services towards strengthening primary healthcare in India – Joint position paper by the Academy of Family Physician of India and the Academic College of Emergency Experts

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ABSTRACT

Urgent care practice (UCP) is a novel concept for India. Urgent care primarily deals with injuries or illnesses requiring immediate care. Medical emergency and urgency can happen anywhere unannounced. Research has shown that 90% of the morbidities can be resolved within the community by primary care physicians lead teams. Given the changing professional demands, non-specialists tend to refer away far too many cases to specialists, undermining generalist medical care, particularly in Indian settings. The spillover of the patient load from the primary care setting to the tertiary care centers is enormous leading to resource mismatch. Family physicians and other primary care providers are best positioned to develop practices and provide good quality urgent care to society. Family physicians, general practitioners, and medical officers are already functioning as the frontline care providers for any emergency or medical urgency arising within communities. Urgent care is essentially ambulatory care or outpatient care outside of a traditional hospital emergency room. "UCP aims to provide timely support, which is easily accessible with a focus on good clinical outcomes, e.g. survival, recovery, lack of adverse events, and complications. Core interventions of urgent care are centered on the 4Rs - Rescue, Resuscitate, Relate, and Refer. At present, there are no available, established training model for future faculty, residents, and medical students on "UCP" in India.

Keywords: Academy of family physicians of India, emergency care, emergency medicine, family medicine, national health policy, primary care, urgent care

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We propose the development of a 1-year modular Fellowship course in Urgent Care Practice (FUCP), for M.B.B.S doctors with a valid registration number from State Council/MCI. Fellowship will be awarded after the successful completion of the exit

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examination. Online as well as contact classes for the fellowship will be organized. In the current scenario, the introduction of a training cum certification program in the form of FUCP can help in skill development and confidence building of practitioners to provide urgent care rationally thus reducing the referral burden. The fellowship curriculum shall be framed within the ambit of principles of family medicine.

This position paper is an attempt to recognize the background and opportunities in developing an academic FUCP in India. This paper also endorses the position of AFPI – INDO US EM for recognized FUCP, how it can be developed.

Background

India is marked by immense ethnic, socioeconomic, and geographic diversity. Delivering affordable and equitable healthcare to India's billion-plus people presents an enormous challenge. Decades of orchestrated policy making and implementation by the government has empowered India with an enviable arsenal of a robust infrastructure, modern technology, and trained manpower aimed at providing the best of healthcare. And yet, the gaps in health outcomes continue to ever widen, with perpetual large-scale morbidity, mortality, and human suffering present all around. The reality is straightforward. The power of existing interventions is not matched by the power of health systems to deliver them to those in greatest need, in a comprehensive way, and on an adequate scale.

Healthcare in India is multi-pronged with a tiered national health system, private hospitals, and alternative medicine practitioners. The National Health Policy (NHP), first formulated in 1983, aims to provide "health for all" based on a time-bound, phased, setting up of comprehensive primary healthcare service throughout the country.^[1] The National Health Policy 2015 (NHP-2015)^[2] (available as a draft in the public domain) addresses the improved performance of health systems. The policy draft emphasized to strengthen and prioritize the role of the government in the multidimensional remodeling of health systems. It stated that that *"The need of the day is not a headlong (market-driven) expansion of the pool of professional and technical human resources for health, but a planned increase that creates human resources that meet the specific requirements for professional and technical skills that are needed most. The key principle around which we build a policy on human resources for health is that workforce performance of the system would be best when we have the most appropriate person, in terms of both skills and motivation, for the right job in the right place, working within the right professional and incentive environment."*

The National Health Policy 2017 (NHP-2017)^[3] emphasized on *"Private providers, especially those working in rural and remote areas, or with under-served communities, require access to opportunities for skill up-gradation to meet public health goals, to serve the community better, for participation in disease notification and surveillance efforts, and for sharing and support through provision of certain high value services."* The NHP 2017 suggest *"exploring collaboration for primary care services with*

not-for-profit organizations having a track record of public services where critical gaps exist". *Collaboration can be done for certain services where a team of specialized human resources and domain specific organizational experience is required. Private providers, especially those working in rural and remote areas or with under-served communities, could be offered encouragement through provision of appropriate skills to meet public health goals, opportunities for skill up-gradation to serve the community better.*^[3]

The National Health Policy 2017 recognizes that human resource management is critical to health system strengthening and healthcare delivery and therefore the policy supports measures aimed at continuing medical and nursing education and on the job support to providers, especially those working in professional isolation in rural areas using digital tools and other appropriate training resources.

"Given the changing professional norms, non-specialists tend to refer away far too many cases to specialists, undermining general practice. For a number of conditions general practice is as good as or even better than specialists in that domain. A large number of distance and continuing education options by which general practitioners in both the private sector and the public sector who work in such areas and with under-served communities can upgrade their skills in what would otherwise have to be referred away, would be used to address this problem- so that general practitioners at all levels can resolve more problems and refer less."^[2] *"This will not only improve availability of manpower with appropriate skills in public health system in remote areas but will also provide additional promotional avenues to many cadres and attract them to work in remote areas. Locale based selection, a special curriculum of training close to the place where they live and work; conditional licensing and a positive practice environment will ensure that this new cadre is preferentially available where they are needed most, i.e. in the under-served areas"*^[2]

The NHP 2017 recommends *creation of a large number of distance and continuing education options for general practitioners in both the private and the public sectors, which would upgrade their skills to manage the large majority of cases at local level, thus avoiding unnecessary referrals.*

The above sounds are so resonant with the concept of "Urgent care Practice" (UCP) which is the range of healthcare services available to people who need medical advice, diagnosis, treatment, and/or rehabilitation quickly.

Key Concepts

Urgent care Practice is a specialty focused on the delivery of ambulatory (outpatient) care in a dedicated medical facility outside of a traditional emergency room. Urgent care centers primarily treat injuries or illnesses requiring immediate care.^[4]

UCP is the response before the next in-hours or routine (primary care) service is available. Urgent care is the range of healthcare services available to people who need medical advice, diagnosis, and/or treatment quickly and unexpectedly.^[5]

The focus of ideal "UCP": Good urgent care is: Patient and public centered; focuses on good clinical outcomes, e.g., survival,

recovery, lack of adverse events and complications through service integration; A good patient experience, including ease of access and convenience; timely; supports innovation; available 24/7 to the same standard. The 4Rs of urgent care are Rescue, Resuscitate, Relate, and Refer.

Problem Statement

Having to travel long distances to the nearest healthcare facility coupled with long waiting times to see the healthcare professional is a toxic combination. Statistics reveal that the majority of Indians present with acute illnesses that are not life-threatening. Others have chronic health issues with a waxing and waning course. Despite the nonlife-threatening nature of presenting complaints, prompt, and proper treatment advice from the healthcare professional is of paramount importance from the patient's perspective. We are left with a small percentage of patients who suffer from a serious illness or a major injury that requires swift access to specialized care to give them the best chance of survival. This may be challenging due to various reasons. To begin with, one may not know which specialist to seek medical-care with. The strategic principle of "the right patient to the right hospital in the shortest time" faces serious constraints.^[6] National or regional guidelines for triage, patient delivery decisions, and pre-hospital treatment plans do not exist. Ramanujam *et al.* reported that nearly 50% of trauma victims admitted to a premier hospital in an Indian city had received no prehospital care.^[7] The vast majority of rural physicians lack specific training focused on "UCP."

Several disasters, natural or manmade, occur every year in India that challenges the robustness of our health system. Be it, cyclones, floods, earthquakes, tsunamis or terrorist attacks, planned prehospital care is again almost nonexistent. During such disasters, in the current scenario, local physicians are not organized or trained enough to play major, constructive roles. All victims are thus sent to the already overburdened, nearest tertiary care centers. Common obstetric problems, advice regarding contraceptive practices, or contraceptive failure issues are required to be addressed urgently but should preferably be sorted out at the community level, rather than being shunted to the tertiary level.

All the issues highlighted above can be cured by the panacea of training in the field of "UCP." The need of the hour is universal, timely availability of a cadre of trained doctors, and healthcare providers specially trained in "UCP" within easy reach of the community. Physicians and paramedics can be trained through a well-coordinated curriculum to enhance the skill to enable them to provide these services at the community level. NHP-2017 also envisages the use of telemedicine, online training, etc., to support continuing medical and nursing education and on the job support to providers, especially those working in professional isolation in rural areas.

Currently, in India, there is no approved formal training/courses/curriculum in the training of medical and nonmedical

staff involved in providing "UCP." Although the urgent care movement began in the US, urgent care centers are now an important healthcare delivery component in several other countries, including Canada, the United Kingdom, Ireland, Australia, and New Zealand.

Context of training and practice

1. For people with urgent but non-life-threatening needs, we must provide responsive, effective, and personalized services at the community level, preferably in or as close to people's homes as possible, minimizing disruption for patients and their families
2. For those with more serious but non-life-threatening emergencies, we should ensure they reach and are treated in centers with the best expertise and facilities to maximize their chances of survival and recovery. There should be set norms of triage, referral guidelines, and locally appropriate referral information.

Urgent care in the primary care setting

UCP is a novel concept for India. Urgent care primarily deals with injuries or illnesses requiring immediate care. Medical emergencies and urgencies can happen anywhere unannounced. Research has shown that 90% of the morbidities can be resolved within the community by primary care physicians lead teams. Given the changing professional demands, nonspecialists tend to refer away far too many cases to specialists, undermining generalist medical care, particularly in Indian settings. The spillover of the patient load from the primary care setting to the tertiary care centers is enormous leading to resource mismatch. Family physicians and other primary care providers are best positioned to develop practices and provide good quality UCP. Family physicians, general practitioners, and medical officers already function as the frontline care providers for any emergency or medical urgency arising within communities. Urgent care is essentially ambulatory care or outpatient care outside of a traditional hospital emergency room.

Suggested Model for the solution

We propose the development of a 1-year modular FUCP, for M.B.B.S doctors with valid registration numbers from State Council/MCI. Fellowship will be awarded after the successful completion of the exit examination. Online as well as contact classes for the fellowship will be organized. In the current scenario, the introduction of a training cum certification program in the form of FUCP can help in skill development and confidence building of practitioners to provide urgent care rationally thus reducing the referral burden. The fellowship curriculum shall be framed within the ambit of principles of family medicine

1. Development of an academic course for health professionals including doctors, nurses, and paramedics for "UCP". This would allow a new workforce model to be developed
2. The introduction of simulation facilities and a variety of training programs in "UCP" throughout the country will further interest in the field among family medicine physicians.

“UCP” needs to be patient and public centered. Timely support including ease of access and convenience of services focusing on good clinical outcomes, e.g. survival, recovery, lack of adverse events and complications through service integration is desired. Core interventions are centered on the 4Rs - Rescue, Resuscitate, Relate, and Refer.

Positional Stand of AFPI – INDO US EM

Vision

Ardent and unified advocacy to make “UCP” a practicable mission in India in the coming 3 years.

Positional stands

1. A Council (*Urgent Care Practice Council of India*) and a Steering Group to be formed who will develop the principles for “UCP” in India. It will include clinicians and representatives from key stakeholder bodies
2. Develop a “UCP” training curriculum. Develop a national framework, protocols, and educational products for training
3. Creating accreditation guidelines and approval from competent authorities/ministries/councils
4. Introduction of Modular 1-year fellowship course – FUCP, can be completed maximum in three years. The program will be online, and a contact session will be of three days twice a year. Eligibility will be M.B.B.S with a valid registration number from State Council/MCI. Fellowship will be awarded after a successful exit examination
5. There is also a lack of concept of what is exactly “urgent care” among medical and non-medical personnel. Promoting Academic awareness for best practice models for “UCP” in India is essential.

Academic Leadership in UCP

For UCP to progress in India, academic institutions must commit to creating continued support focused on cultivating a module in UCP. The faculties, initially arising from diverse medical fields, shall enroll for being in the “*Urgent Care Practice Council of India*”. Once this is accomplished, a formal workshop is to be held for ‘*Faculty Development Program*’ (FDP). The individual members can go back to their respective institutes and initiate their faculty development by sharing the knowledge and come up as centers for conducting training “*Fellowship in Urgent Care Practice*”.

Urgent care way forward

A significant percentage of patients visiting ER can be treated at the community level by family physicians and medical officers in the public sector. All they need is skill development

and strengthening in this regard. Thus, UCP is the need of the hour. Currently, an initiation to introduce FUCP can help in skill development of practitioners and confidence to provide urgent care rationally. We should aim to sensitize the young fresh family physicians graduates and community medicine practitioners, to the concept of “UCP” so that they perceive it as a career opportunity as well as try to influence decision-makers to formulate policy conducive to such training modules.

Suggestions, advice and constructive criticism are asked from academia and individuals which will help in better shaping “UCP” in India.

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Conflicts of interest

There are no conflicts of interest.

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