The roles and responsibilities of Care Coordinators in DHC & Health coaching

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Primary Healthcare in District Health Centre Scheme (Online Seminar hosted by Primary Healthcare Office, FHB)

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THE HONG KONG POLYTECHNIC UNIVERSITY
香港理工大學

The Hong Kong Academy of Nursing
香港護理專科學院

Red / Blue Ocean

Red Ocean Strategy	VS	Blue Ocean Strategy
Compete in existing market space		Create uncontested market space
Beat the competition		Make the competition irrelevant
Differentiation OR low cost		Differentiation AND low cost
Competitive Advantage		Value Innovation
Segment existing customers		Attract non-customers
Exploit existing demand		Created new demand

Primary Health Care

Hong Kong Reference Framework for Hypertension Care for Adults in Primary Care Settings

Revised Edition December 2018

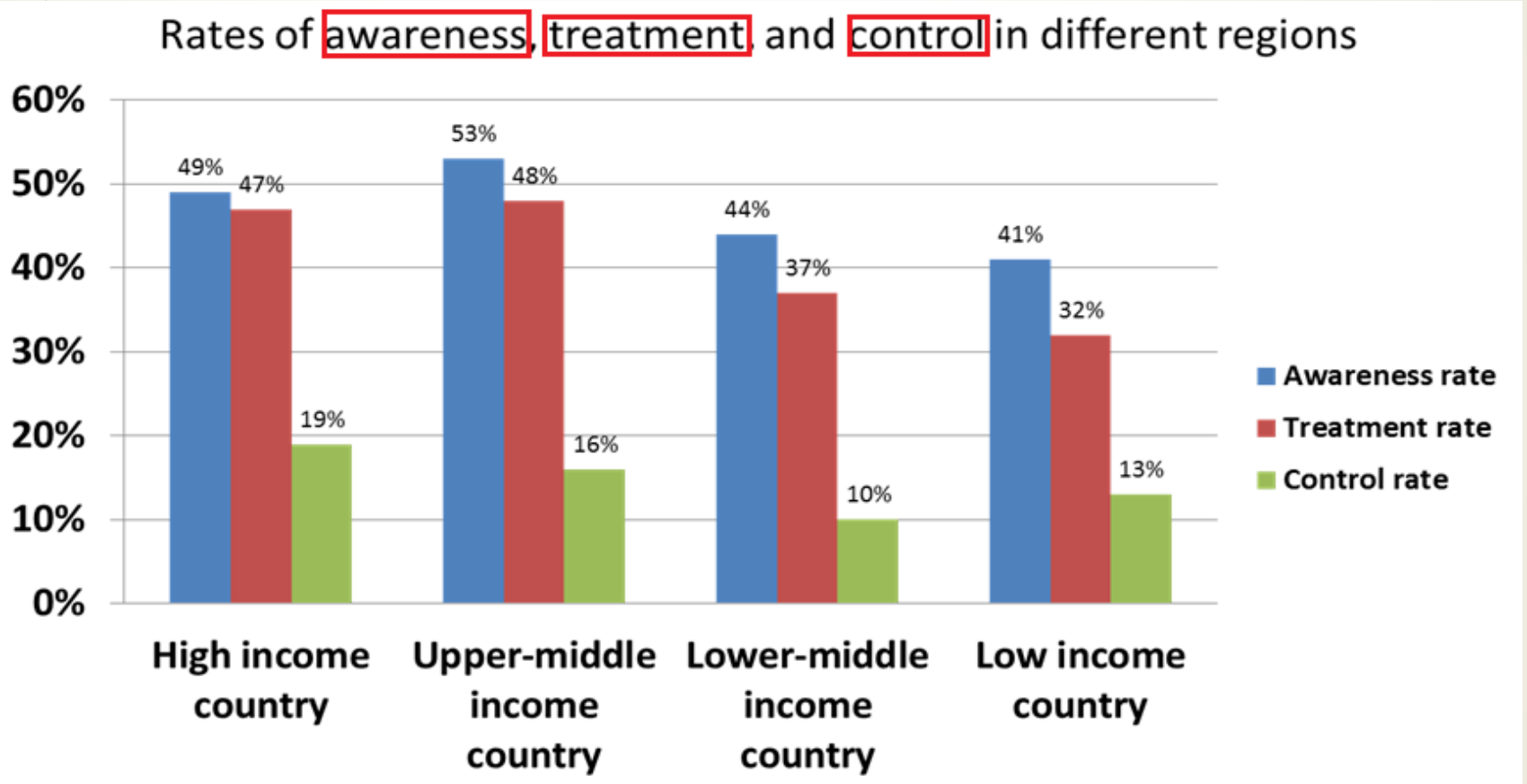
Developed by: 基層醫療概念模式及預防工作常規專責小組 Task Force on Conceptual Model and Preventive Protocols · 基層醫療工作小組 Working Group on Primary Care · 食物及衞生局 Food and Health Bureau

With the professional advice of: 衞生署 Department of Health · 醫院管理局 HOSPITAL AUTHORITY

Table 1: Prevalence of hypertension in Hong Kong by age groups[2]

Age Group (Years)	Self-reported, doctor diagnosed hypertension (%)	Undiagnosed but measured (%)	Total (%)
15-24	1.0	3.4	4.5
25-34	0.4	5.2	5.6
35-44	3.9	11.3	15.2
45-54	10.5	16.2	26.7
55-64	27.0	19.4	46.4
65-84	43.8	20.9	64.8
All age groups	14.6	13.2	27.7

Hypertension



(Chow et al., 2013)

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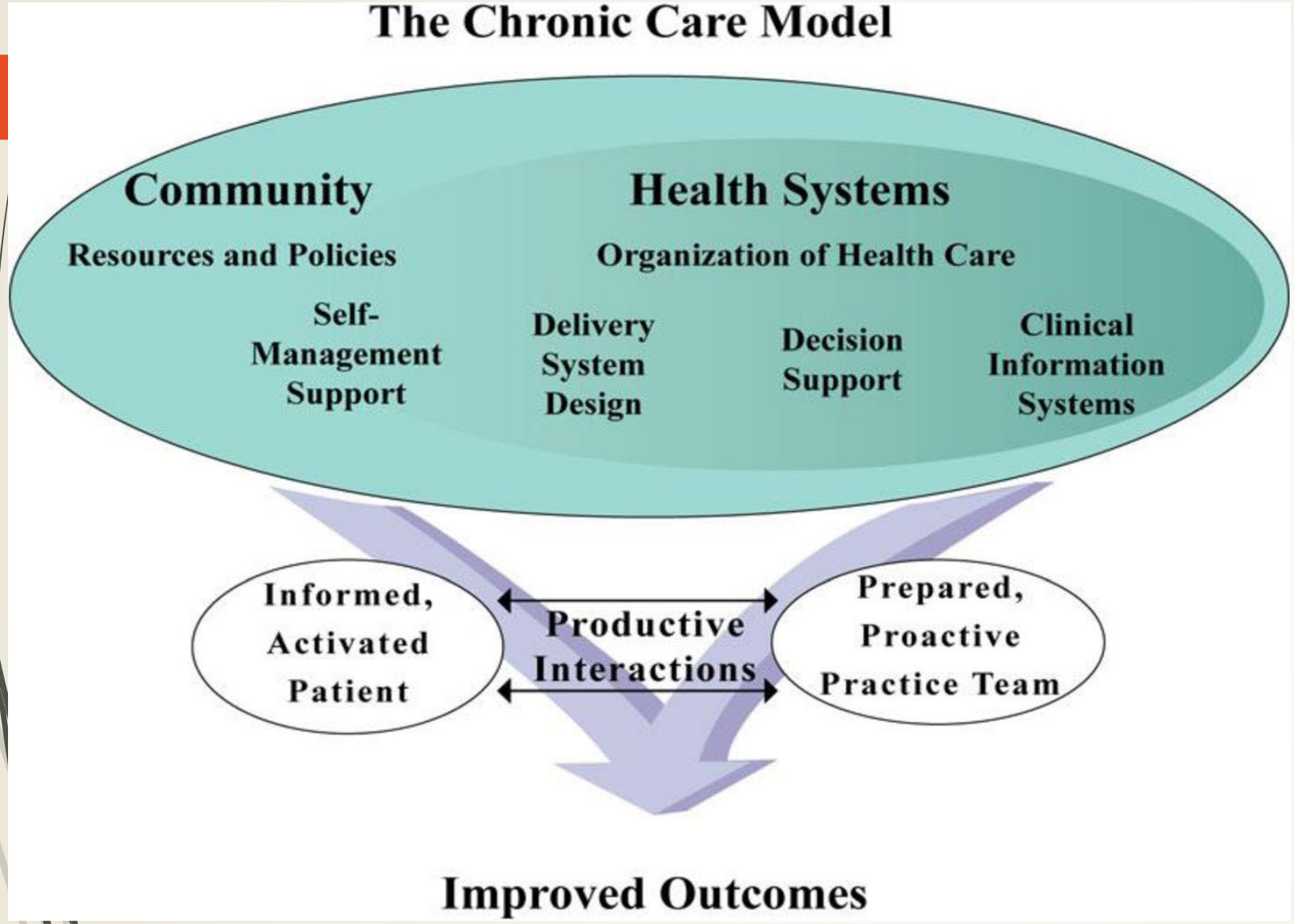
Primary care is the first point of contact in the healthcare system and is easily accessible to the majority of the population. With support and training, primary care practitioners form an invaluable workforce in the community to deliver coordinated care to hypertensive patients, especially those with clinically stable conditions and to identify high risk subjects for referral to other experts. By applying the principles of family medicine and working in partnership with other healthcare professionals such as dietitians, nurses, occupational therapists, optometrists, pharmacists and physiotherapists, primary care practitioners are in a prime position to provide patient-centered, continuing and comprehensive care taking into account individual patients' needs and values.

ESC European Society of Cardiology
European Heart Journal (2018) **39**, 3021–3104
doi:10.1093/eurheartj/ehy339

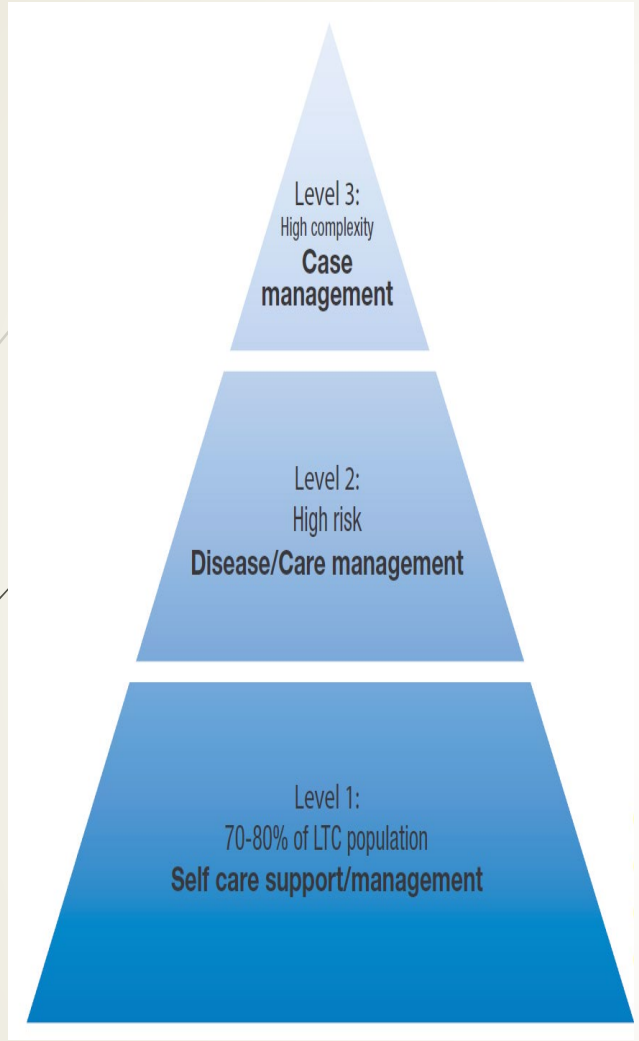
2018 ESC/ESH Guidelines for the management of arterial hypertension

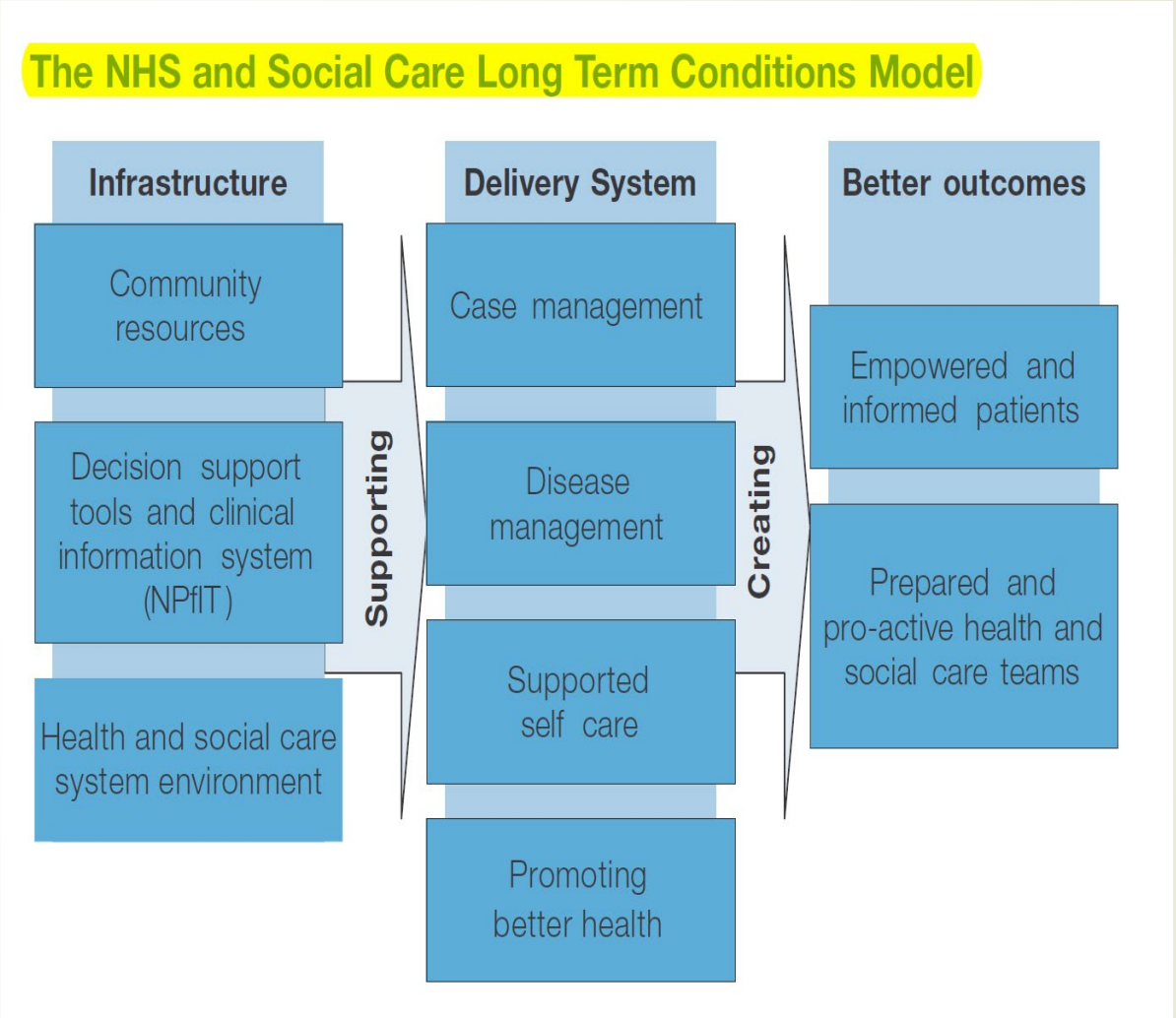
The Task Force for the management of arterial hypertension of the European Society of Cardiology (ESC) and the European Society of Hypertension (ESH)

New concepts
BP measurement • **Wider use of out-of-office BP measurement with ABPM and/or HBPM, especially HBPM**, as an option to confirm the diagnosis of hypertension, detect white-coat and masked hypertension, and monitor BP control.
Less conservative treatment of BP in older and very old patients • **Lower BP thresholds and treatment targets for older patients**, with emphasis on considerations of biological rather than chronological age (i.e. the importance of frailty, independence, and the tolerability of treatment). • Recommendation that **treatment should never be denied or withdrawn on the basis of age**, provided that treatment is tolerated.
A SPC treatment strategy to improve BP control • **Preferred use of two-drug combination** therapy for the initial treatment of most people with hypertension. • **A single-pill treatment strategy for hypertension** with the preferred use of SPC therapy for most patients. • **Simplified drug treatment algorithms** with the preferred use of an ACE inhibitor or ARB, combined with a CCB and/or a thiazide/thiazide-like diuretic, as the core treatment strategy for most patients, with beta-blockers used for specific indications.
New target ranges for BP in treated patients • **Target *BP ranges* for treated patients** to better identify the recommended BP target and **lower safety boundaries for treated BP**, according to a patient's age and specific comorbidities.
Detecting poor adherence to drug therapy • A strong emphasis on the **importance of evaluating treatment adherence** as a major cause of poor BP control.
A key role for nurses and pharmacists in the longer-term management of hypertension • **The important role of nurses and pharmacists** in the education, support, and follow-up of treated hypertensive patients is emphasized as part of the overall strategy to improve BP control.



- Interdisciplinary approach;
- Mobilization of resources at various levels and sources
- Health-social partnership
- Self-empowerment


Level 3:
High complexity
Case management
Level 2:
High risk
Disease/Care management
Level 1:
70-80% of LTC population
Self care support/management


The NHS and Social Care Long Term Conditions Model
Infrastructure
Community resources
Decision support tools and clinical information system (NPfIT)
Health and social care system environment
Supporting
Delivery System
Case management
Disease management
Supported self care
Promoting better health
Creating
Better outcomes
Empowered and informed patients
Prepared and pro-active health and social care teams

Hong Kong

SCPHD Paper no. 21/2018 **18 October 2018**

District Health Ecosystem

(a) Greater policy co-ordination and service consolidation:

(b) Promoting health management and holistic primary care:

(c) Greater emphasis on continuity and integration of care:

Food and Health Bureau
The Government of the Hong Kong Special Administrative Region

地區康健中心
District Health Centre

Key Functions and Features of DHC

Key Functions

A service / resource hub

Health promotion

Disease prevention and screening

Chronic disease management

Community rehabilitation

Key Features

1 Community based services

- Convenient location of Core Centre and Satellite Centres

2 District based services

- Scope of DHC service based on the needs and the characteristics of the district

3 Public private partnership

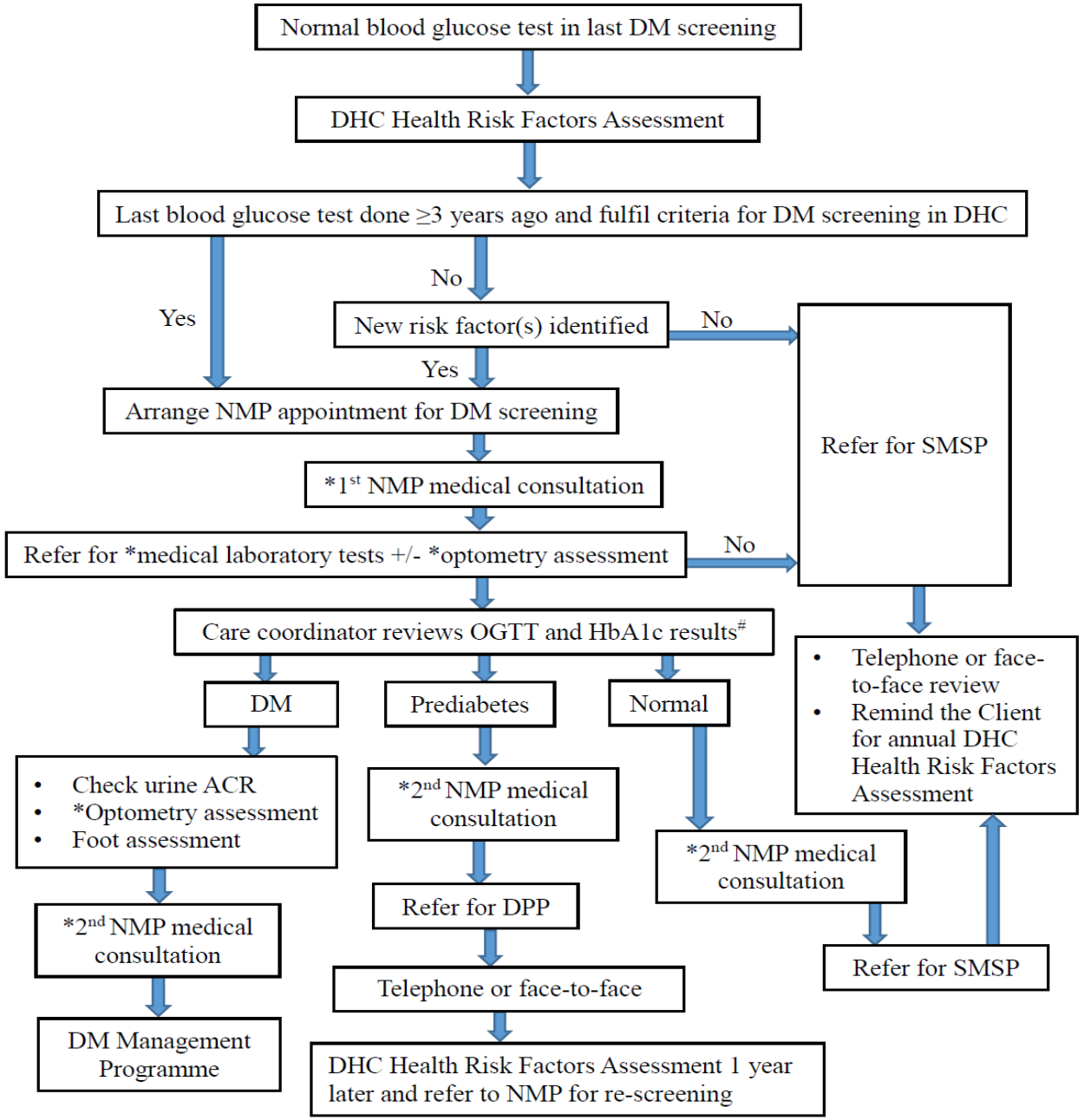
- Appointment of a DHC Operator (a non-governmental organization) through open tender
- Purchase of services from private service providers
- Foundation of a network

4 Medical social collaboration

- Members of the core team include:
  - Executive director
  - Chief care coordinator (Nurse)
  - Care coordinator (Nurse)
  - Physiotherapist
  - Occupational therapist
  - Dietitian
  - Pharmacist
  - Social worker
  - Administrative staff
- Multidisciplinary care approach

5 Outreach service

(f) **Workflow of SUBSEQUENT DM Screening for Screened-Normal Cases**

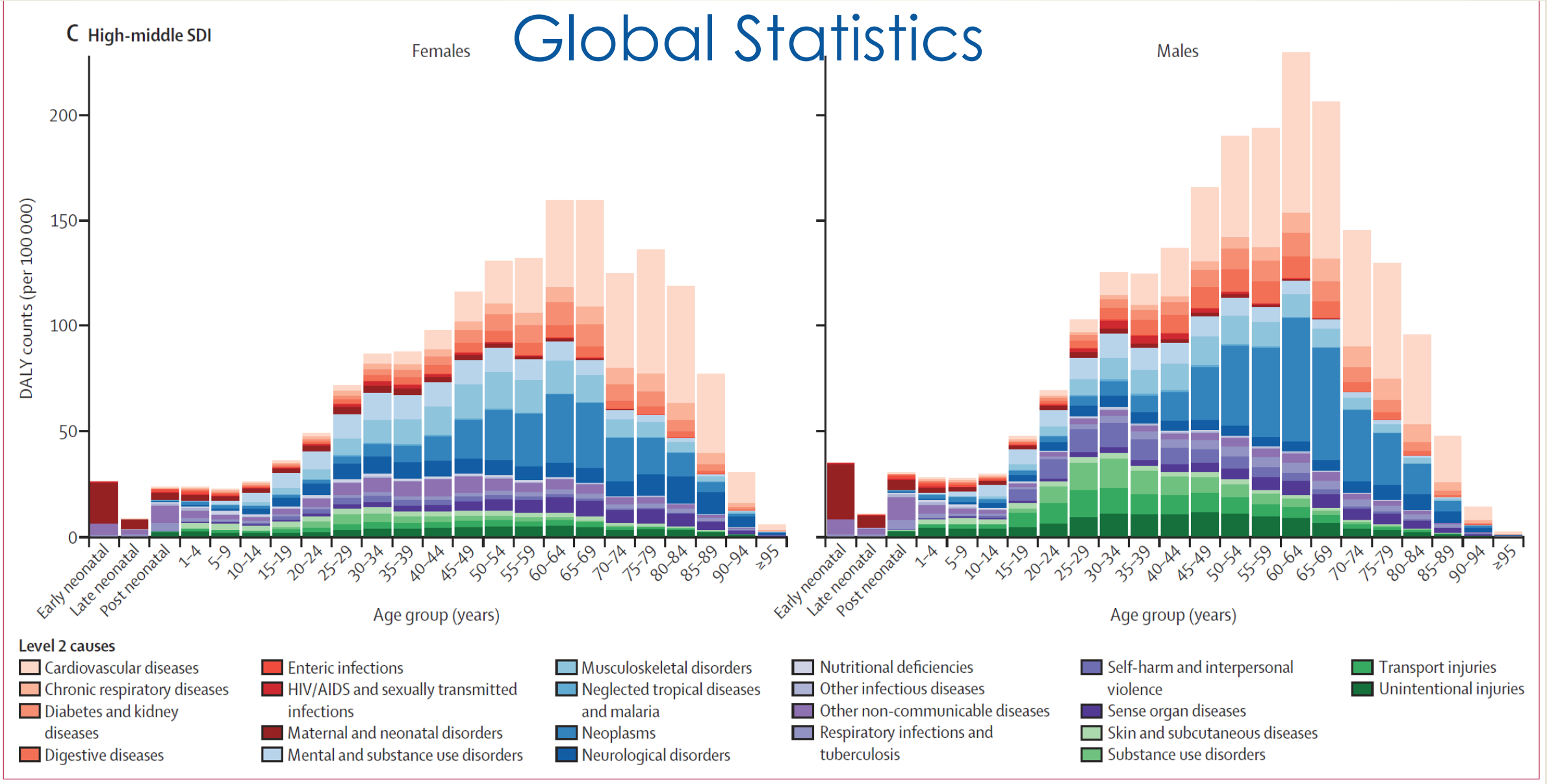


Roles of Care Coordinator in DHC Scheme

- Health coach for the Clients and families in holistic approach
- Public Health Advocate - communicate public health information and enhance coordination and integration of district-based primary healthcare
- Conduct primary, secondary and tertiary prevention programmes
- Support and assist the clients in chronic disease management
- Offer non-pharmacological intervention
- Complication screening for DM and HT
- Case manager
- Arrange outreach services
- Encourage the Clients to form peers support groups to promote and maintain physical and psychological health
- Training for junior nurses

DHC Service Manual and Guidelines, PHO, FHB, November 2020.

Global Statistics



Kyu et.al. (2018). Global, regional, and national disability-adjusted life-years (DALYs) for 359 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. The Lancet, 392(10159), 1859-1922.

NOTE: Level 2 refers to strong evidence for an association but without adequate evidence of a causal link

Global Statistics

- Increase in overall life expectancy > Increase in healthy life expectancy
  → more years lived in poor health

- Noncommunicable diseases accounted for
  62·0% of total Disability Adjusted Life Years (DALYs)
  (27.9% - communicable, maternal, neonatal, and nutritional causes)

- Between 1990 and 2017, global DALYs ↑ 40·1% for non-communicable diseases

- Five leading DALYs causes: (i) neonatal disorders, (ii) ischaemic heart disease, (iii) stroke, (iv) lower respiratory infections, and (v) chronic obstructive pulmonary disease

Kyu et.al. (2018). Global, regional, and national disability-adjusted life-years (DALYs) for 359 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. The Lancet, 392(10159), 1859-1922.

Background Statistics – Hong Kong

All persons with chronic diseases

Year	2019
Total number	2 202100
Overall prevalence rate (as percentage of total population)	31.1%

20.8% in selected chronic health conditions (e.g. DM, HT, heart, stroke),

表 3.1a 按年齡及性別劃分的患有慢性疾病的人士數目
Table 3.1a Persons who had chronic health conditions by age and sex

年齡組別 Age group	男 Male 人數 No. of persons ('000)	男 Male 百分比 %	男 Male 比率* Rate*	女 Female 人數 No. of persons ('000)	女 Female 百分比 %	女 Female 比率* Rate*	合計 Overall 人數 No. of persons ('000)	合計 Overall 百分比 %	合計 Overall 比率* Rate*
< 15	46.5	4.4	10.5	28.7	2.5	6.9	75.2	3.4	8.7
15 - 24	46.7	4.4	13.1	40.3	3.5	11.7	87.1	4.0	12.4
25 - 34	46.3	4.4	10.3	54.3	4.8	11.2	100.7	4.6	10.7
35 - 44	68.3	6.4	14.7	78.0	6.8	13.8	146.3	6.6	14.2
45 - 54	133.7	12.6	26.8	149.2	13.1	24.3	282.9	12.8	25.4
55 - 64	274.3	25.8	47.1	270.6	23.7	44.2	544.9	24.7	45.6
≥ 65	446.8	42.0	76.7	518.3	45.5	79.4	965.1	43.8	78.1
合計# Overall#	1 062.6	100.0 (48.3)	31.5	1 139.5	100.0 (51.7)	30.8	2 202.1	100.0 (100.0)	31.1
年齡中位數（歲） Median age (years)		61			63			62	

(Census and Statistics Department, 2019)

Importance of healthy lifestyle

In a multicohort study of 116 043 participants …

- *1-point improvement* in overall healthy lifestyle score was associated with 0.96/0.89 (men/women) disease free years

4 lifestyle profiles associating with highest number of disease free years:

- *BMI <25*; AND *never smoking, physical activity, and moderate alcohol consumption* (at least 2 of the 3)
- Healthy lifestyle profiles appear to be associated with extended gains in life lived *without type 2 diabetes, cardiovascular and respiratory diseases, and cancer*.

Nyberg S. et.al. (2020) Association of healthy lifestyle with years lived without major chronic disease. JAMA Intern Med. 180(5):760-768

Health Coaching

- You may think: 'What's the big deal about Health Coaching? I do health education in my clinic consultation all the time.'

- Question to you: 'After each consultation, my patient learns more from me than me learning more about him/her?'

Coaching by nature is …

relational and **dialogic**, where two or more people discover **new meaning** and **co-create new thinking** and ways of being and doing in the world between them.

Hawkins P & Turner E (2020) Systemic Coaching. Delivering value beyond the individual. Routledge,

Health coaching is defined as

"a **goal-oriented**, **client centered** partnership that is **health-focused** and occurs through a process of client enlightenment and empowerment"

(Olsen 2014; p. 18cited from Hale & Giese 2017)

Health Coaching

found effective in chronic disease management such as hypertension, diabetes, and hyperlipidemia

as a **motivational interview** for patients.

patients discovered a responsibility to take action **in maintaining their her health**.

peer coaching to increase patient activation and quality of life

(Hale & Giese 2017)

Dose of health coaching *(selected studies)*

Structured interactions with a Transition Coach weekly in hospital, 48–72 hours after discharge at home, three follow-up phone calls. Creation of a Personal Health Record. (Parry et al 2006)

12-wk telephonic health coaching program consisting of six outbound calls from a health coach and support materials by mail. (Schuessler et al. 2007)

Behavioral counseling by two RNs using **MI** strategies to help participants select their behavior goals during a face-to-face meeting, followed by telephone or email contact at least once per month for 6 mo. (Bennett et al. 2005)

Source: Olsen et.al. (2010) Health Coaching to Improve Healthy Lifestyle Behaviors: An Integrative Review. American Journal of Health Promotion, Inc. DOI: 10.4278/ajhp.090313-LIT-101

Dose of health coaching *(selected studies)*

Intervention consisted of (1) health coaching and education by a **nurse care manager**, (2) **case conference between GP and case manager**, (3) referrals to specialists and support services, (4) coordination and information sharing with specialists, (5) development of individualized patient care plans, and (6) patient health education. (Mola et al. 2007)

3-mo health coaching intervention with a minimum of one initial session and two follow-up contacts. Participants determined the number of sessions they needed. Sessions limited to 30 min. Health issues focused on weight loss, fitness, stress, and nutrition. (Butterworth et.al 2007.)

Source: Olsen et.al. (2010) Health Coaching to Improve Healthy Lifestyle Behaviors: An Integrative Review. American Journal of Health Promotion, Inc. DOI: 10.4278/ajhp.090313-LIT-101

Dose summary

Duration. Significant behavior changes were reported in studies lasting 6 months, 8 months, and 12 months (Olsen et.al. 2010)

Frequency: Outcomes not significantly related to the number of coaching sessions … significant health behavior change results were reported in studies that conducted coaching sessions multiple times per week, once every 4 to 6 weeks, at least quarterly, and as determined by the coach and participant. (Olsen et.al. 2010)

Method of Delivery. face-to-face (n=6), telephonic (n=5), Internet, or a combination (n 5). No effectiveness found on a particular means (Olsen et.al. 2010)

Coaches. Nurses (most commonly cited), dietitians, physical therapists, and physicians (Hayle & Giese 2017; Long et.a. 2019)

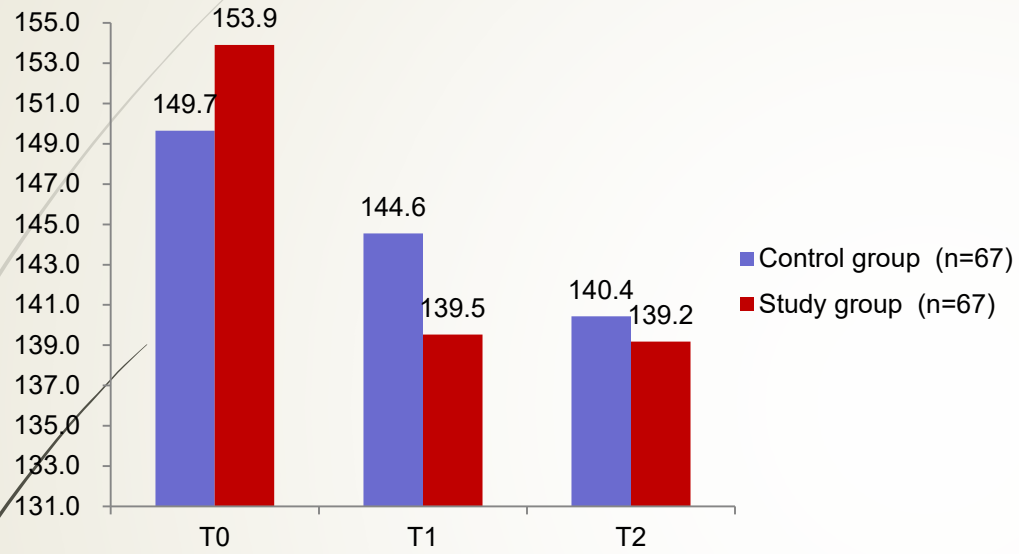
Illustration with 2 studies

Example: In Guangzhou

- A community health center (CHC) in Guangdong, China
- 100,000 residents
- ≈23,000 (23%) hypertensive patients (Song & Meng, 2009)
- ≈10% hypertensive patients had healthcare records established

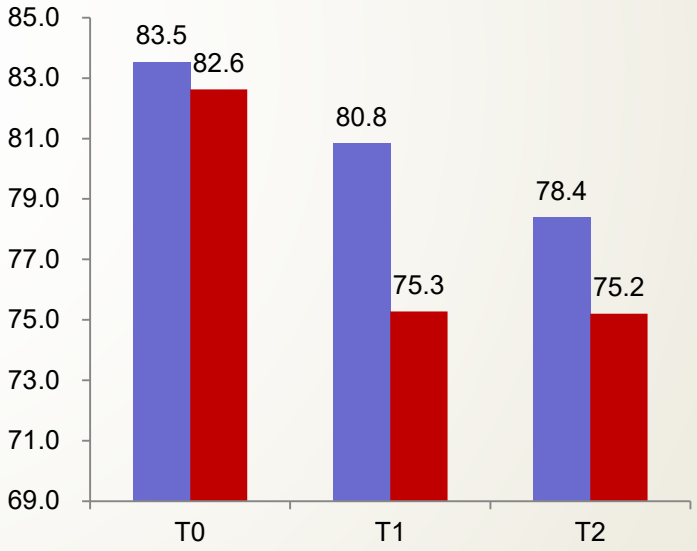
Chronic Care Model (Wagner, 1998)	Four-Cs Model (Wong, 2005)	NHM model	Outcome
Self-management support		• A self-management booklet: knowledge and skills • Behaviour contract • Health promotion	• BP • Self-care behavior • Self-efficacy • QoL • Utilization of healthcare service • Patient satisfaction
Decision support		• Intervention protocols • A 36-hour training program • Regular meetings	
Delivery system design	Comprehensiveness Collaboration Coordination Continuity	A nurse-led hypertension management team: • Home visit • Telephone follow-up • Referral	
Clinical information system		• Health records • The Omaha System (Martin, 2005; Wong et al., ?nd)	

Results



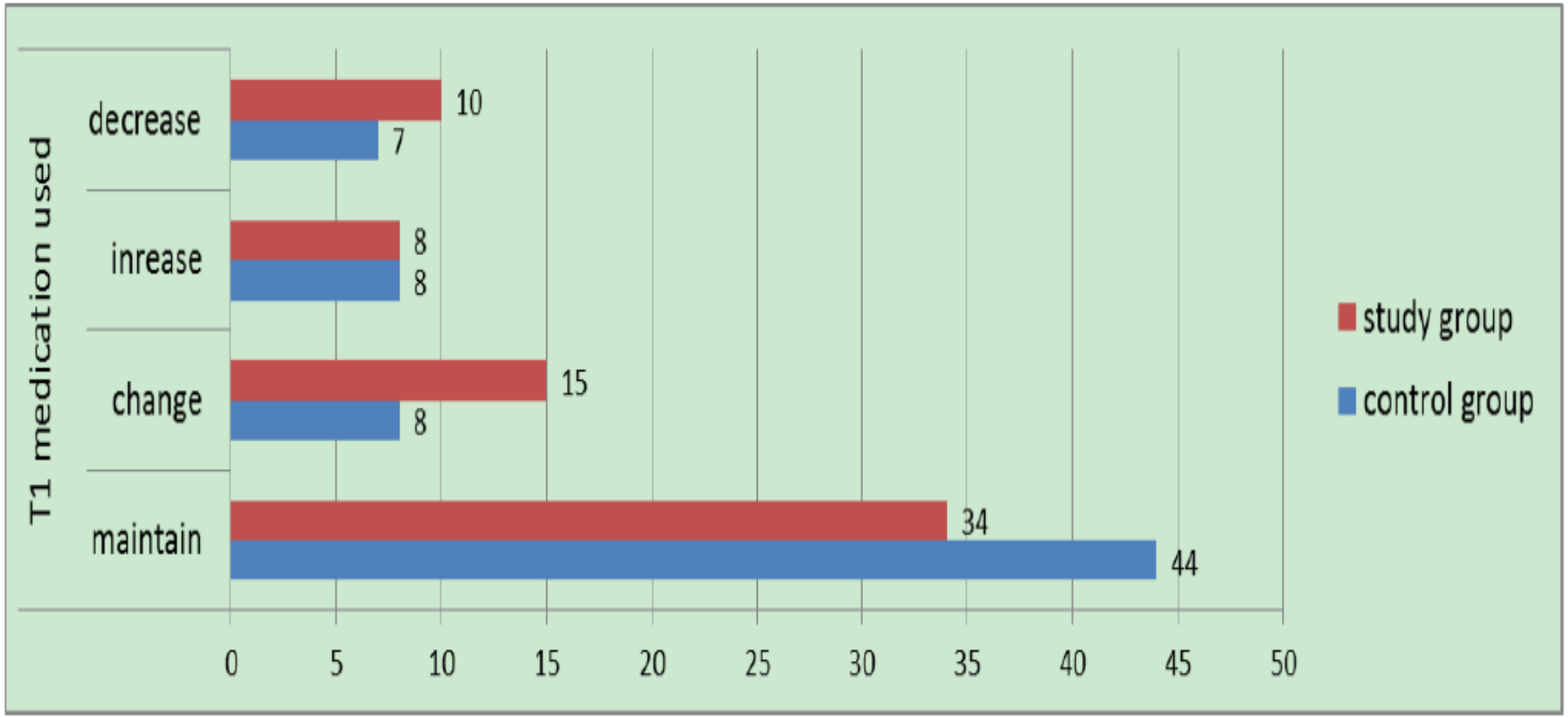
SBP readings in the control group and the study group at three time points

T0: at recruitment
T1: immediately after intervention
T2: 4 weeks after intervention



DBP readings in the control group and the study group at three time points

Table 4.15 Comparison of pharmacological treatment from T0 to T1 for the study group and the control group



T0 = baseline, T1 = 12 weeks after recruitment

A Transitional Care Program using Holistic Care Interventions for Chinese Stroke Survivors

Yeung Siu Ming, PhD student
Professor Frances Wong
Supervisor

The Hong Kong Polytechnic University
香港理工大學

The Hong Kong Academy of Nursing
香港護理專科學院

Concerns immediate after stroke

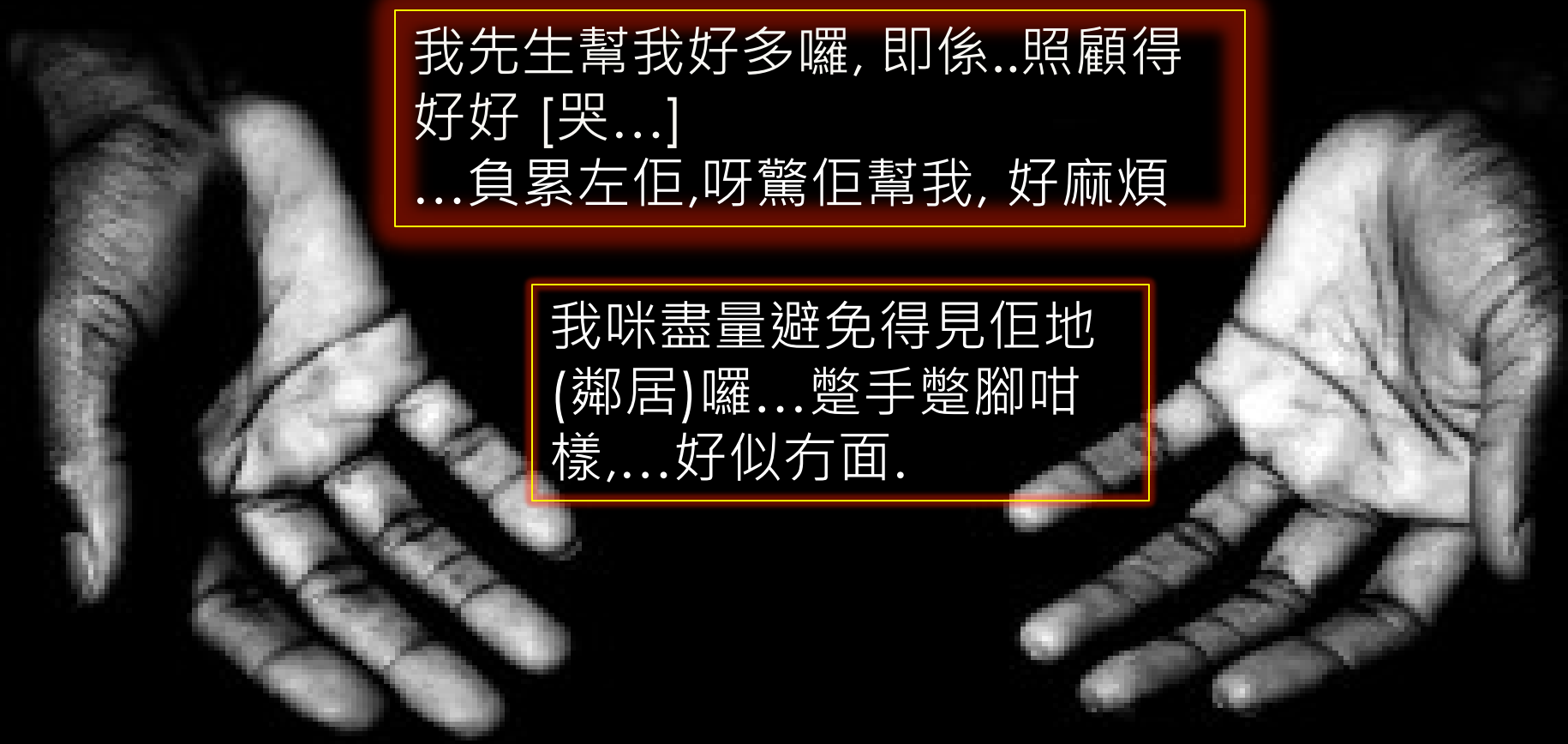
喺...醫院喊咗四日,喊到個心好唔舒服 .我驚 !總然之個人呢，好似好凍個陣時，牙臼吸吸聲, 個心好震, 唔係好穩定...

點解隻手好似蹩咗咁嘅？！

我想知道自己乜嘢事？

點解啲姑娘淨係問我呢樣個樣，無停落嚟聽嚇我講…

Concerns in transition to home

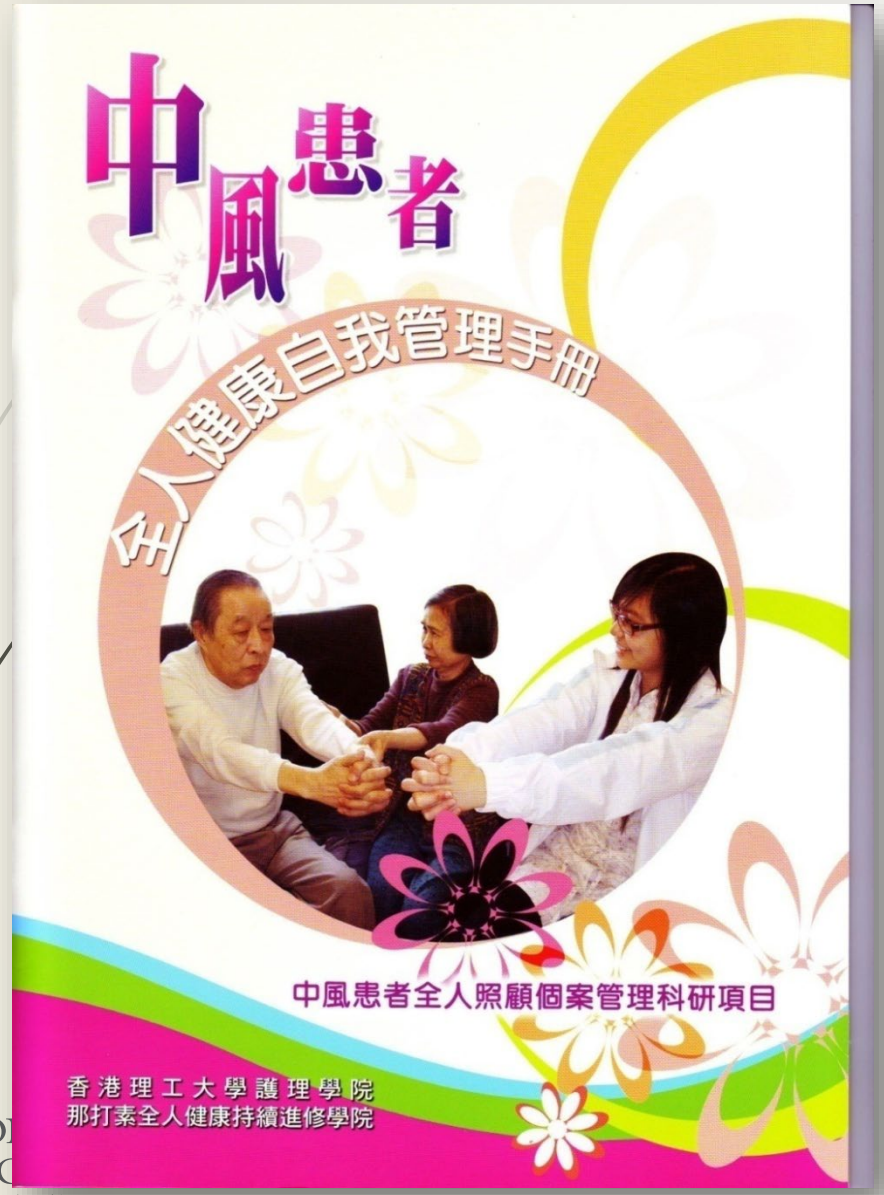


我先生幫我好多囉, 即係..照顧得好好 [哭...]
...負累左佢,呀驚佢幫我, 好麻煩

我咪盡量避免得見佢地(鄰居)囉...蹩手蹩腳咁樣,...好似冇面.

啲啲傷口係我用艾香來燙我隻腿，將□啲邪風驅出嚟！

Holistic Care Interventions (HCIs)



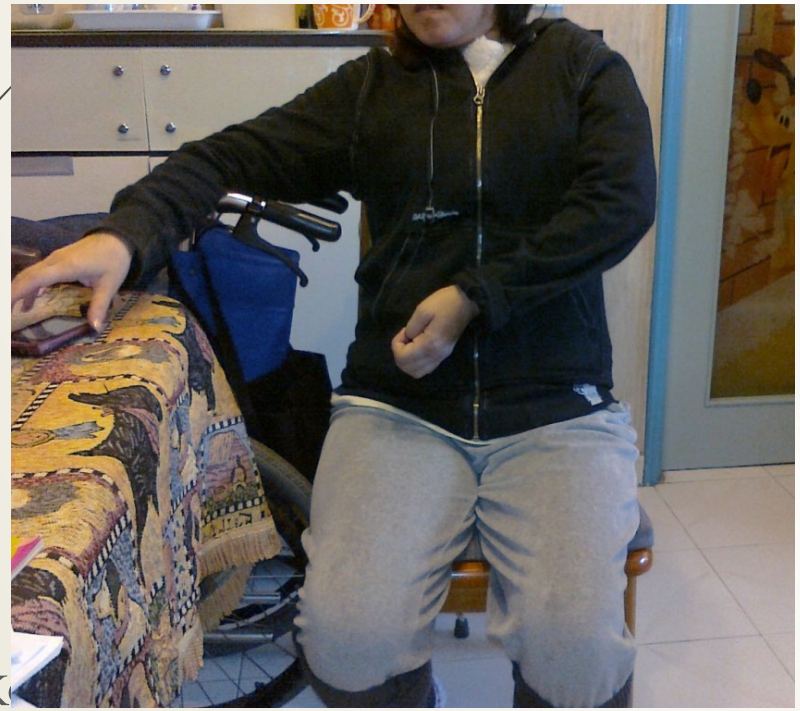
- **Management & Prevention of Stroke Recurrence**
  預防中風再發的疾病管理
- **Symptoms Assessment & Management**
  症狀評估與處理
- **Enhancement of Physical Function:**
  提升身體功能
- **Health Behaviors: Adherence with medication & diet**
  健康生活行為
- **Building Resilience: Connecting self, family, social life & Higher Being**
  提升抗逆力
- **Emotion Management**
  情緒管理

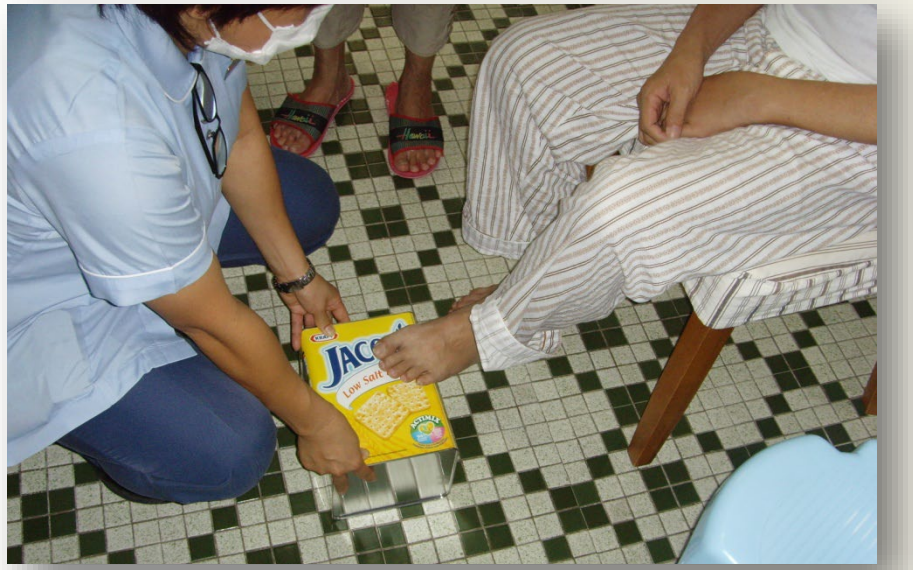
Six evidence-based Protocols for HCIs

Protocols	Level of Evidence / Grade of Recommendation
Protocol 1: Training of Holistic Care Manager (HCM) 全人關顧個案經理	Ib / Grade A
Protocol 2: The Omaha System ~ holistic health assessment & care plans 全人關顧 護理評估及計劃	Ib / Grade A
Protocol 3: Entry & Exit Family Meetings 家庭會議	GPP / Grade D
Protocol 4: Home Visits 家庭訪視	Ib / Grade A
Protocol 5: Telephone Follow-ups 電話跟進	Ib / Grade A
Protocol 6: Referral System ~ community & health resources 雙向轉介	Ib / Grade A

Implementation

Intervention 3: Enhancement of Physical Function

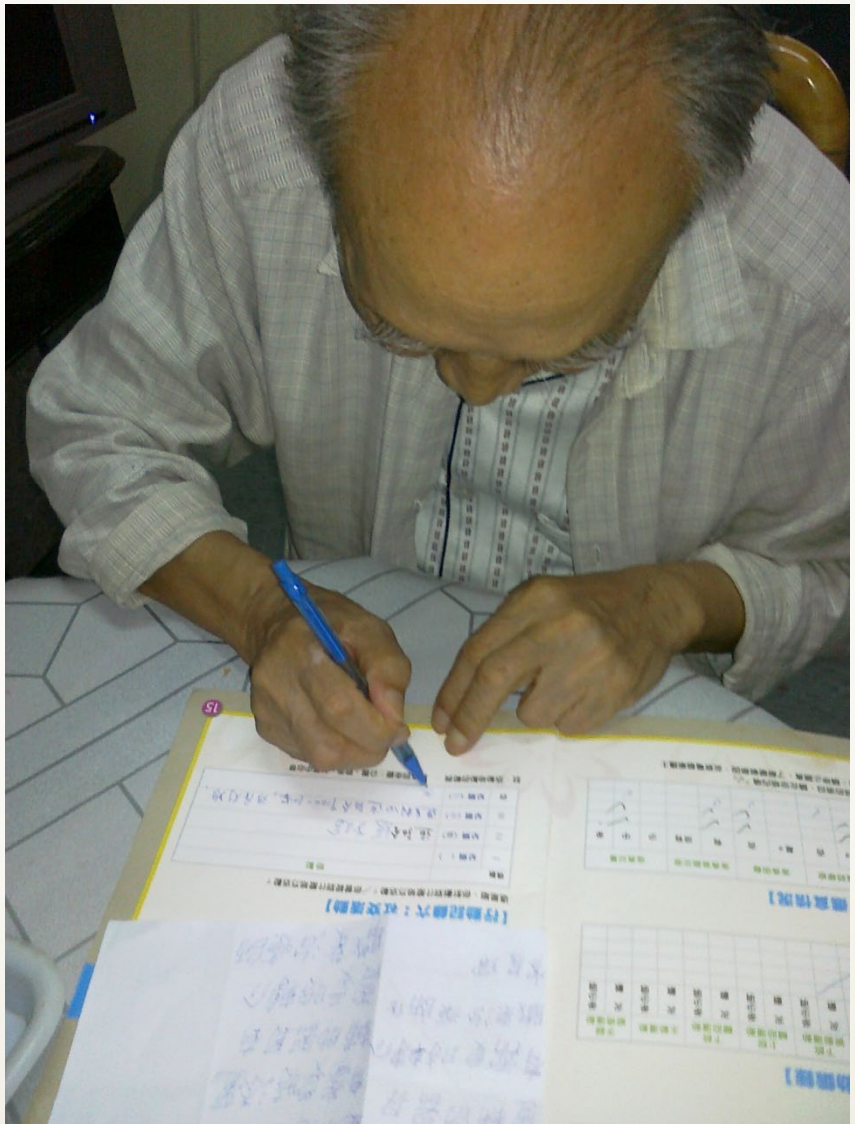




Creativity & Affirmation

Intervention 2: Symptoms Assessment & Management
Intervention 4: Health Behaviors:Adherence with medication

Manage their own health




【行動記錄七：給你支持者的一封信】
自己
親愛的謝生：
我要努力報答自己，我一定要行得，於二十天時間自己，我一定做得到要好似以前一樣。
繼續努力！我一定得嘅！
自我監察
家人
各位：
好多謝你地對我關心，對我支持，每一分鐘都照顧我，如果我無努力，一定對你地唔住。
上天/神
親愛的天父 / 天主 /上蒼：
上蒼已對我好好，但可唔可以再對我好啲，謝先生小小已經對我不薄，但先對人對事從來沒有做對不起的事今次佢我的禱文
我一定再對其它人其它事再做得好的！
16

Love & Affirmation

Theme 3:HCM as a healer

Sub-theme 3: Health Outcomes

FG1, Carer 4:

One thing that impressed me most is that my wife was very happy every time you came. She was worried about not being able to accomplish the things you've asked her to do, … Then I asked her to do it once in front of me. "See? You can do it!" Then when you came, she wouldn't be stressed. Things were the best in the first month…Of course! Whatever practice you give her, she remembers, for sure.

FG3, HCM3:

I think what impressed me most is how to teach a Chinese to thank his better half. It's so touching… [] We have to guide him to actually speak it out. Like once, you tried it, he had to write "thank you", which means I had to teach the patient to write the two words. Well, the pride of men is a funny thing. Chinese men in Hong Kong are different from men from western culture that Chinese rarely say "I love you" or "I appreciate what you've done" .(F3, C10)

敬啓者:

在楊姑娘和葉姑娘悉心指導了，使我身體漸漸康復，進展理想!

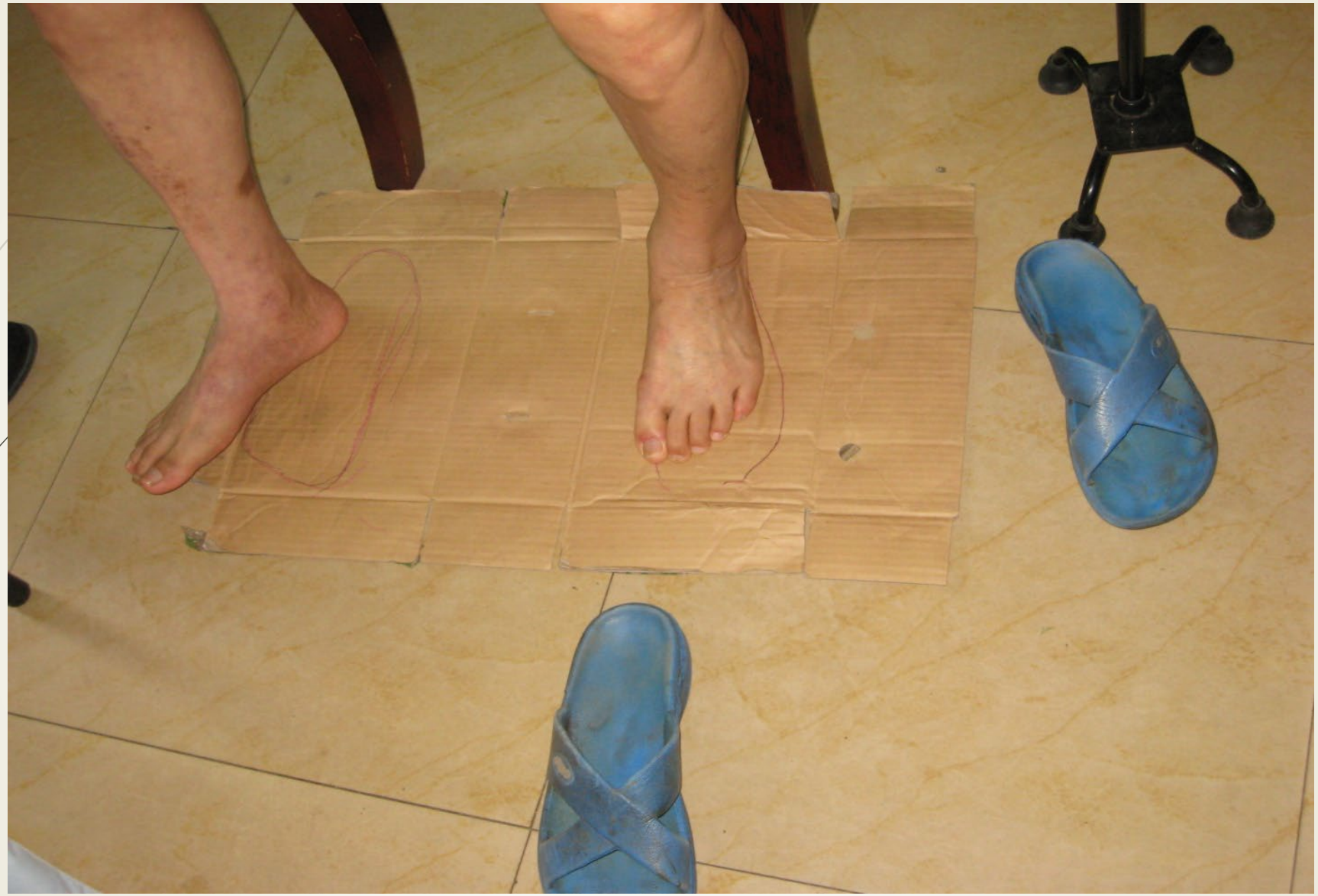
1. 手指活動 --- 數手指，鉗豆，用鉗夾簿，切積木和拉泥膠，增加手指靈活度.
2. 下肢活動 --- 上落樓梯，口訣“好上壞落”，踏鞋盒，踏脚，轉腰，配合身體協調，行路更穩固.
3. 上肢活動 --- 舉水樽，拉橡根，增加手力.
4. 口部運動 ---呼氣運動，鼻吸口(似豬嘴) 呼氣，加強肺部功能. 舌頭運動，慎防喀嚥出現困難.

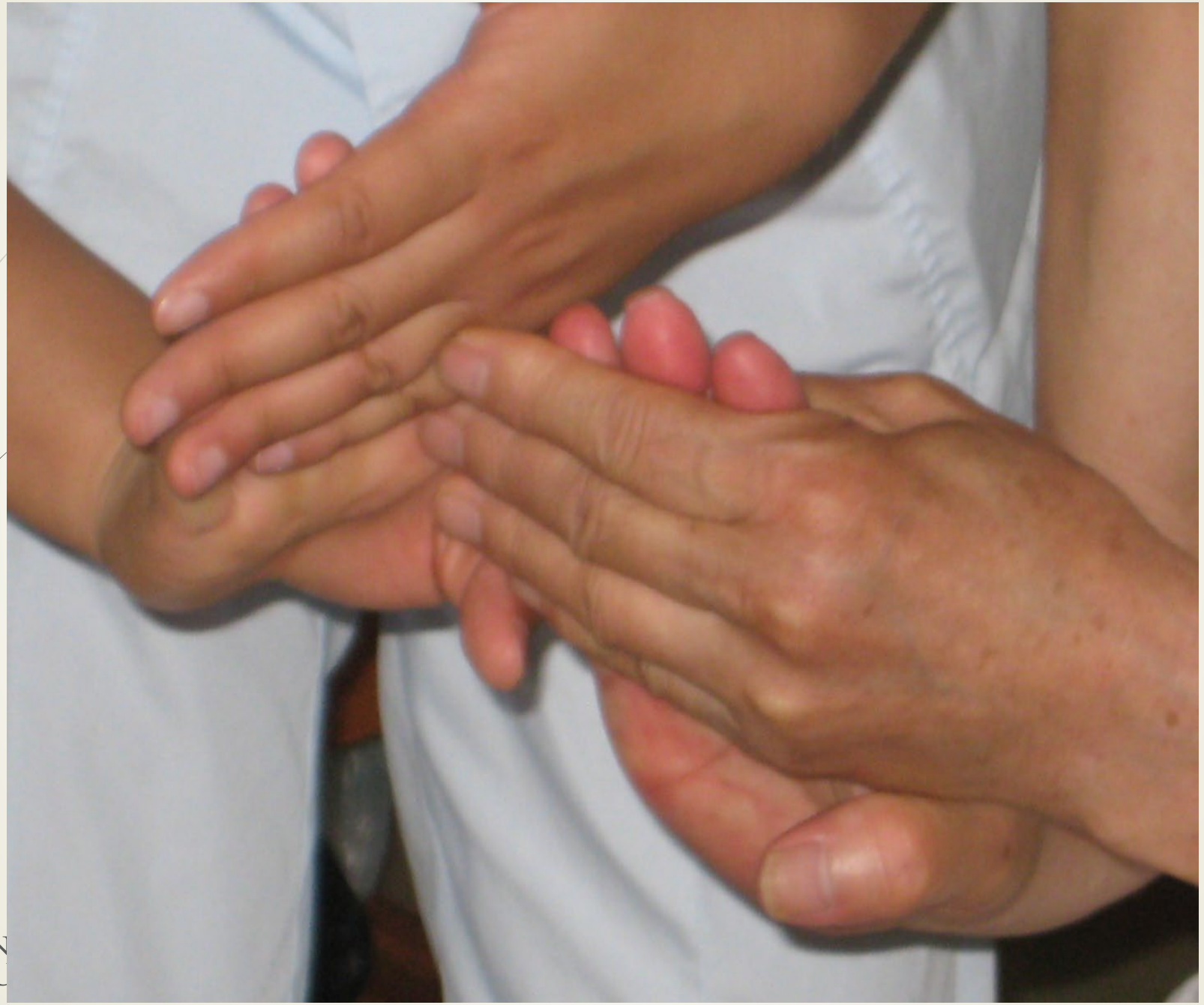
本人陳池特此函深深感謝楊姑娘和葉姑娘兩位姑娘對我耐心指導本人，減少本人在中風後的恐懼，增加自信心，加強與家人的溝通，使康復進展理想.

此致

那打素醫院社康服務部

1. **手指活動**– 數手指，鉗豆，用鉗夾簿，切積木和拉泥膠，增加手指靈活度。
2. **下肢活動**– 上落樓梯，口訣“好上壞落”，踏鞋盒，踏腳，轉腰，配合身體協調，行路更穩固。
3. **上肢活動**– 舉水樽，拉橡根，增加手力。
4. **口部運動**– 呼氣運動，鼻吸口(似豬嘴)呼氣，加強肺部功能。舌頭運動，慎防喀咽出現困難。





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The Hong Kong Academy of Nursing
香港護理專科學院

敬啟者：

在楊姑娘和葉姑娘悉心指導了，使我身體漸漸康復，進展理想！

1. 手指活動– 數手指，鉗豆，用鉗夾簿，切積木和拉泥膠，增加手指靈活度。
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本人陳池特此函深深感謝楊姑娘和葉姑娘兩位姑娘對我耐心指導本人，減少本人在中風後的恐懼，增加自信心，加強與家人的溝通，使*康復進展理想*。

此致

那打素醫院社康服務部

In conclusion ….

Table 1. Health Coaching Antecedents, Attributes, and Consequences

Antecedents	Attributes	Consequences
• Client experiencing a health concern or a desire for enhanced health or well-being • Health coach with a desire to help and with some levels of training	• Health-focused • Partnership • Client-centered • Goal-oriented • Process • Enlightening • Empowering	• Improved physical and/or mental health • Health behavior change • Health goal attainment

Olsen JM (2014) Health Coaching: A concept analysis. Nursing Forum 49(1), 18-29

National Society Of Health Coache

Health Coaching Core Competencies:

- NSHC Code of Ethics & Standards of Practice
- Active Listening
- Communication Styles
- Transtheoretical Model of Change / Change Readiness
- Societal Influences on Behavior Change
- Cultural Competence
- Goal-setting
- Guiding the Agenda

https://www.nshcoa.com/core-competencies

Use of Evidence-based Practice Interventions

- Motivational Interviewing (MI)
  - Open-ended questions
  - Affirmation
  - Reflection
  - Summary
  - Managing resistance
  - Empowering
- Telephonic *[Virtual]* Coaching

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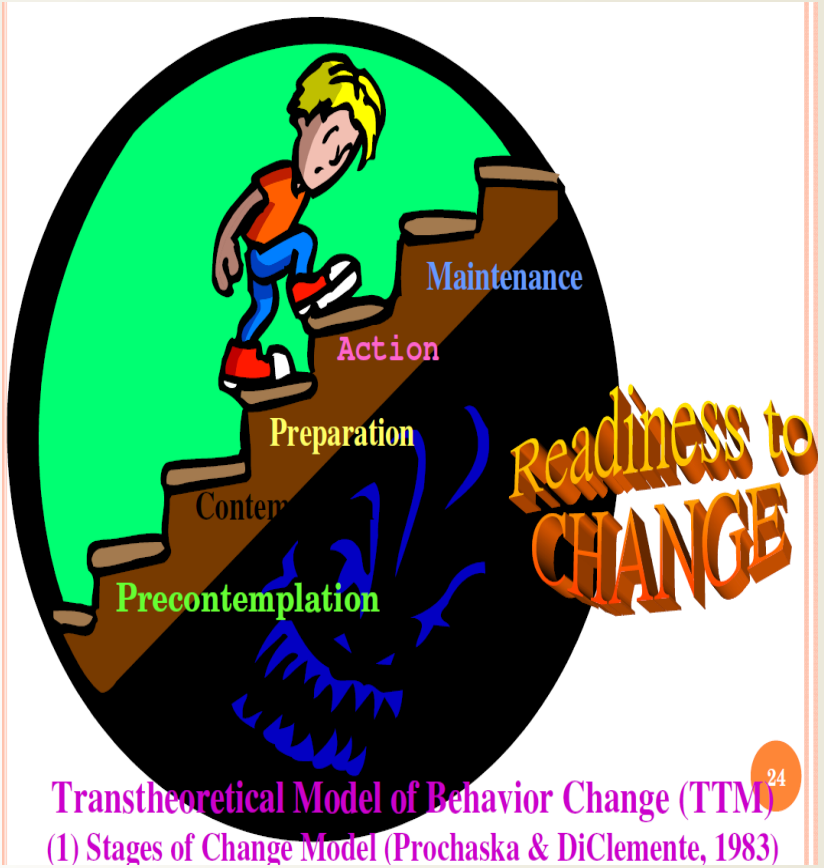
THE TRANSTHEORETICAL MODEL OF BEHAVIOR CHANGE (TTM)

② Decisional balance ③ Self-efficacy ④ the Processes of change

Precontemplation	Contemplation	Preparation	Action	Maintenance
I won't	I might	I will	I am	I have been
Raise awareness	Positive self image, confidence *Considering	Contract with self Make small steps	Behavior alternatives	Positive reinforcement
Helping relationship	List pros & cons *value clarification	Add support Give information	Compliment Reinforce behavior	Reinforce change Prevent relapse



Transtheoretical Model of Behavior Change (TTM)

(1) Stages of Change Model (Prochaska & DiClemente, 1983)

Conclusion – care coordination & health coaching

- Optimizing outcomes for patient journey
- Enhancing patient experience

Questions are welcomed

Thank you!