Provision of life-long care in the primary care setting
Chinese and Western Practitioner collaboration

Dr Donald Li
President
World Organization of Family Doctors
WONCA
Role of a Family Doctor

“We are uniquely at the frontline of continuous and lifelong patient-facing health services.”
Effective Primary Health Care

- Person Centered – not just disease orientated
- Comprehensive – Acute and Chronic care
- Holistic – Takes into consideration of Physical, social, mental aspects
- Continuous – Trusted relation, primary healthcare team working with doctors
- Life-course approach
- Preventive, risk reduction, lifestyle modification
- Community-orientatated – public health conscious
- Coordinated – multidisciplinary, teamwork, avoiding duplications and wastes
- Matches Patients values and expectations
- Cost-effective, supports healthcare financing and policies
Life long care / Continuous Care

- Management of **Acute** problems as well as
- Management of **Chronic** problems – NCDs

- **Preparation** for hospitalization
- **Post** Hospitalization Follow-up
- Public Private Services Co-operation
- Two-way referrals
- Supporting healthcare financing policies
- BUT…………..

- Need appropriate health seeking behavior - Modifying through Incentives
- Difficulties in achieving preventive and anticipatory care due to Patient values
Patients’ Patterns – creating challenges

- become more and more media- and technology-savvy
- prefer the traditional practice of seeking secondary and curative health care rather than primary and preventive health care
- self-medicate directly by going to the local pharmacy
- tend to treat the medical consultation merely as a service, instead of viewing the doctor as a caring long-term health partner
- Used to the low cost Hospital Authority services
Mission and Vision of District Health Centers

People become engaged with medical professionals in the community providing quality care and will benefit from improvement of their health and well-being. This leads to a reduction in the need for secondary and tertiary care, hospitalization and wider social benefits.

1. I have a trusting relationship with professionals that will help me stay healthy and well.
2. I am working with a team of supporting professionals.
3. I have support, choice and control over my healthcare.
4. I understand my health status and will look after myself.
“The family doctor as a friendly extended member of the family”
Taking care of the patient throughout the life course
Cradle to Grave?

Family Doctors - Caring for you for the whole of your life
Cradle

• Child care by Family Doctors – often neglected by Family Doctors / Not sought by parents?
• Leave it to the Pediatricians?
• Records / Data / Growth Charts / Vaccination records
• Reluctant to stock and dispensing Pediatric dosage of medicine
• The need to treat the parent rather than the child
• The Family Doctor can however provide influence – behavior and health seeking behavior modification
Immunization

HK Childhood Immunization program provides free vaccines to children in HK for 11 infectious diseases

Family Doctors to provide proper information and clear myths (carry our preventive role)

Encourage and check on compliance
Child Development
Child Development

Role of Family Doctor – watching the child grow – accompanying the parent
Knowledge
Show concern
Attention and care
Be inquisitive
Be prepared to Answer questions

Primary Healthcare
Teamwork - Care coordinators

Hong Kong Reference Framework for Preventive Care for Children in Primary Care Settings
Module on Development

Assessment of children with developmental problems (Ch. 3)

Major domains
- Gross and fine motor
- Language and communication
- Hearing
- Vision
- Health problems
- Performance and cognition

Developmental milestones for babies from 0 to 12 months old

Developmental milestones for children from 1 to 6 years old

Developmental Delay (Ch. 4.4)

Specific Learning Difficulties (Ch. 4.6)

- Gross and fine motor
- Language and communication
- Hearing
- Vision
- Health problems
- Performance and cognition

Developmental milestones for children from 1 to 6 years old

1-2 years
- Walk across table by 2 years
- Follow basic rules in games by 2 years
- Identify 1-2 colors by 2 years
- Use simple sentences to ask question by 2 years

2-3 years
- Stand on one foot for 10 seconds by 3 years
- Identify 3-4 colors by 3 years
- Ask questions to express needs

3-4 years
- Understand simple stories
- Identify 5 colors by 4 years
- Ask questions to express needs

4-5 years
- Understand simple stories
- Identify 6 colors by 5 years
- Ask questions to express needs

5-6 years
- Understand simple stories
- Identify 7 colors by 6 years
- Ask questions to express needs

Developmental difficulties (Ch. 4.6)

- Understated achievement: difficulties in learning, writing, or calculation
- Usually not discovered until children enter school
- Should avoid self-esteem issues, peer relationships, and bullying

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Developmental difficulties (Ch. 4.6)

- Understated achievement: difficulties in learning, writing, or calculation
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Childhood Injury Prevention

Share your Knowledge
Engagement with parents
Proactively remind / discuss / educate parents

### Hong Kong Reference Framework for Preventive Care for Children in Primary Care Settings

#### Module on Childhood Injury Prevention

<table>
<thead>
<tr>
<th>Injury Prevention (Chapter 3)</th>
<th>5 year</th>
<th>6 year</th>
<th>7 year</th>
<th>8 year</th>
<th>9 year</th>
<th>10 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td></td>
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<td>Install window guards and locks or railings around balconies.</td>
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<tr>
<td>Keep child away from objects that may cause injury.</td>
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<tr>
<td>Avoid falling hazards.</td>
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<tr>
<td>Burns</td>
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<tr>
<td>Protect heated areas from children.</td>
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<tr>
<td>Avoid hot water bottles or hot beverages before cooling</td>
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<tr>
<td>Avoid direct sunlight.</td>
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<tr>
<td>Choking and suffocation</td>
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<tr>
<td>Avoid choking hazards.</td>
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<tr>
<td>Avoid sharp objects.</td>
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<tr>
<td>Avoid loose objects.</td>
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<tr>
<td>Drowning</td>
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<tr>
<td>Wear an appropriate lifejacket.</td>
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<tr>
<td>Poisoning</td>
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<tr>
<td>Avoid using household chemicals.</td>
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<tr>
<td>Avoid using chemicals that are harmful to children.</td>
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<tr>
<td>Traffic accident</td>
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<tr>
<td>Avoid leaving children unattended.</td>
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<tr>
<td>Others</td>
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<tr>
<td>Maintain a smoke-free environment.</td>
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<tr>
<td>Avoid leaving children unattended.</td>
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<tr>
<td>Finger pinching:</td>
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<tr>
<td>Supervise children when opening or closing doors.</td>
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<tr>
<td>Supervise children when reaching for objects on high shelves.</td>
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<tr>
<td>Use safety locks on cupboards and drawers.</td>
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</tbody>
</table>

### Teamwork - Education

- Hong Kong Reference Framework for Preventive Care for Children in Primary Care Settings

2018

Module on Childhood Injury Prevention

Counsel parents on the following evidence-based strategies to prevent childhood injury.
Parent Empowerment – Promote Booklets on Health Care Tips

Show interest and Care – you as the Family Doctor is part of the “Family”
A team approach is necessary in Life long care
Take the Management of Diabetes Mellitus as an example

From early detection to diagnosis to treatment to managing complication through a life course

Integrating:

Nursing services – general / community/specialized
Pharmacy
Occupational Therapy
Physiotherapy
Optometry
Nutrition
Podiatry

Introducing Care Coordinators
Benefits of the Primary Health Team in the management of NCD
基層醫療團隊在非傳染性疾病管理的益處

- Optometrist 視光師
- Nutritionist 營養師
- Podiatrists 足部治療師
- Mental Health 精神健康
- Community Nursing 社區護理
- Occupational Therapists 職業治療師
- Physiotherapist 物理治療師
- Social Worker 社工
Present Allied Health in HA

Audiology
Clinical Psychology
Dietetics
Occupational Therapy (Physical)
Occupational Therapy (Psychiatric)
Physiotherapy
Podiatry
Prosthetic & Orthotic
Speech Therapy

Can we make these services available in DHC?
The Primary Healthcare Team
Service Providers available at future District Health Centres

• Medical Doctors – Family Doctors
• Case Coordinator
• Nurses
• Chinese Medicine Practitioner
• Dietitian
• Occupational Therapist
• Optometrist
• Physiotherapist
• Podiatrist
• Speech Therapist

The team will provide support to the Medical Doctor to provide education, support, counselling to the parent and child throughout the life course.
Life-long Care Introducing Care Coordinators
Providing Guiding and Coaching

• Perform Health screening and assessment
• Provide Health coaching that helps people to set goals and take actions to improve their health and lifestyle
• Makes contacts and referrals to network health partners and other services/programs in K&TDHC
• Works with Family Doctors, acting as the Case Manager to monitor and follow up on the individual self-managing health plan

• TEAMWORK
Benefits of having support by a Primary Healthcare Team in providing life-long care

• Family Doctors working with Care Coordinator - Referral to appropriate care
• Compliance – Reminders for follow-up, monitoring, RAMP programs
• Monitoring progress
• Education, lifestyle modification, exercise prescription, Diet advice
• Rehabilitation – coordinating Physiotherapy, Occupational therapy
• Post trauma support
• Coordinating social services support
• General mental support
• Proper use of medication, prescription
• Providing supportive care and advise to family members
• Coordinating home care, support at home
家庭醫生團隊與社區衛生服務中心平台的關係

A Community Healthcare Centre in Shanghai China

家庭醫生團隊

為簽約居民提供有針對性服務

立足社區, 中心與站為主要服務場所

社區衛生服務中心平台的關係

主要提供群體性、專業條線服務功能

形成若干個輔助部門作為對家庭醫生團隊的支撐
社區衛生服務中心 公共衛生工作開展策略

- **老年人** *(elderly)* 為主的家庭 - 以慢性病管理、助老關愛服務作為切入點
- **年輕人** *(young)* 為主的家庭 - 以免疫接種、婦女兒童保健服務、網路管理作為切入點
- **特殊人群** *(terminal care)* 為主的家庭 - 以關愛服務作為切入點
Aim elderly care

Add life to years instead of years to life
What influences Health in Older Age

Prof Niel J De Wit
Julius Centre for Health SCIENCES AND primary Care
UMC Utrecht, Netherlands
WHAT IS NEEDED FOR HEALTHY AGEING

A change in the way we think about ageing and older people

Creation of age-friendly environments

Alignment of health systems to the needs of older people

Development of systems for long-term care

Healthy Ageing...being able to do the things we value for a long as possible #yearsahead
Core document
  • Evidence-based recommendations according to the conceptual model for preventive care of older adults in primary care settings

Modules
  • Elaboration of health domains in the preventive care for older adults in primary care setting
    • Modules
      • Health assessment
      • Falls
      • Dental health care
      • Visual impairment
      • Cognitive impairment
# Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings

Perform the following evidence-based recommendations on preventive activities for older adults in your clinics:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaccination</strong></td>
<td>Seasonal influenza vaccination: Annually for age ≥65 and high risk groups</td>
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<tr>
<td></td>
<td>23-valent pneumococcal polysaccharide vaccination: 1 dose for age ≥65 if not received before, or have received 1 dose before age 65 but &gt;5 years earlier</td>
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<tr>
<td><strong>Practice of healthy lifestyle</strong></td>
<td>Smoking: Ask about tobacco use at every opportunity and advise all current smokers to quit smoking</td>
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<td></td>
<td>Drinking: Assess the quantity and frequency of alcohol intake, Advise on drinking to minimise alcohol-related harm</td>
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<tr>
<td></td>
<td>Physical Activity: Assess current level of activities and promote regular physical activity whenever possible</td>
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<td></td>
<td>Weight Management: Screen for overweight and obesity, and advise on behavioural interventions to optimise body weight</td>
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<tr>
<td><strong>Dental health</strong></td>
<td>Promote oral hygiene and assess oral health problems periodically</td>
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<tr>
<td><strong>Chronic diseases</strong></td>
<td>Hypertension: Measure blood pressure annually for older adults</td>
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<td></td>
<td>Diabetes Mellitus: Screen every 3 years for age ≥45 Annually when risk factors are present</td>
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<td></td>
<td>Hyperlipidaemia: Screen every 3 years for age 50-75 Annually when risk factors are present</td>
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<tr>
<td><strong>Cancer screening</strong></td>
<td>Cervical Cancer: Cervical cytology test every 3 years for women aged 25-64 who have ever had sex after 2 consecutive normal annual tests May be discontinued for age ≥65 after 3 previous consecutive normal tests For women aged &gt;65 who have never had test should be screened</td>
</tr>
<tr>
<td></td>
<td>Colorectal Cancer: Screen by one of the methods including annual or biennial faecal occult blood test (FOBT), flexible sigmoidoscopy every 5 years and colonoscopy every 10 years for age 50-75</td>
</tr>
<tr>
<td><strong>Functional disability</strong></td>
<td>Hearing Impairment: Opportunistic screening</td>
</tr>
<tr>
<td></td>
<td>Visual Impairment: Opportunistic screening</td>
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<tr>
<td></td>
<td>Urinary Incontinence: Opportunistic screening</td>
</tr>
<tr>
<td></td>
<td>Risk of Falls: Opportunistic screening</td>
</tr>
<tr>
<td><strong>Mental disorders</strong></td>
<td>Depression: Opportunistic screening</td>
</tr>
<tr>
<td></td>
<td>Dementia: Assess cognitive function when cognitive impairment or deterioration is suspected</td>
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<tr>
<td><strong>Polypharmacy &amp; adverse drug reactions</strong></td>
<td>Review all the medications (include over-the-counter drugs and herbal remedies) so as to avoid possible drug duplications, interactions or adverse drug reactions</td>
</tr>
<tr>
<td><strong>Assessment of social network and support</strong></td>
<td>Opportunistic screening on the social support networks Provide support to carers enabling them to remain mentally and physically well</td>
</tr>
</tbody>
</table>

Extracted from the [Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings](http://www.fyb.gov.hk) available at [www.fyb.gov.hk](http://www.fyb.gov.hk) and [www.nco.gov.hk](http://www.nco.gov.hk)

Developed by the Task Force on Conceptual Model and Preventive Protocols of the Working Group on Primary Care

May 2013

*(Please turnover to continue)*
Health Assessment of the Elderly

Cue cards for doctors – a quick reference of the functional assessment tools

Definite role for the Family Doctor and team-Care Coordinator can initiate and assist
The trusted relationship developed over the years
The accepted advice
Visual Impairment

Initial evaluation by Family Doctor / Optometrist and referral as necessary

Awareness

Associated problems – family support, home arrangement, safety, accident prevention
Falls in Elderly

Time consuming but worthwhile
Demonstrate care and concern
A real life hazard
Not to forget possibility of osteoporosis and fragile bones
Associate with life style advise
Family Support
Primary Healthcare Team need to provide coordinated care and support – care coordinator, occupation, physiotherapists
Cognitive Impairment

Role of Family Doctor:
Awareness / proactive discussion with family
Provide Information
Assessment – Hong Kong Brief Cognitive Test HKBC, MMSE
Work with Geriatrician
Promote family support – stimulation
Involve primary healthcare team to provide comprehensive support – nurses can perform HKBC
Towards End of Life

Preparing for end of life

Advanced directives

Certification

Power of Attorney

Wills
Medical Social Integration

Integrating End of Life Services in the community setting

• Not necessary in Hospitals
• Hospice care
• Certification by Family Doctor
• Coroner's role
• Work with Social Workers
社區衛生服務中心
特色工作

安寧療護

生活輔助區

服務區

鎮痛門診

傾談室

配膳室及沐浴室

關懷室

管理區

護士站
Medical-Social Integration in China

醫養結合

融合

醫：全科、中醫、康復

養：養老院、日照中心、鄰里匯

護：護理院、日間照護

居：居家照護、家庭病床

送：安寧療護

整合資源，為社區居民提供全生命週期的健康管理和服务
社區衛生服務中心
社工與社區

多專業團隊
以社工為核心的
跨學科團隊式查房
多學科治療團隊
Multi-disciplinary team
MDT
基於全科醫學社區安寧療護
多專業團隊
Hospice Multi-professional team, based on GP

醫療社工
服務
志願者管理
連結社會資源
個案管理
社區
生命教育
Strengthening support for Elderly Care

Jockey Club Community eHealth Care Project

The population in Hong Kong is ageing, and the number of older people with chronic conditions will continue to grow. In this relation, The Hong Kong Jockey Club Charities Trust has adopted a proactive approach to strengthen the support for senior citizens, and has earmarked HK$138 million to carry out the three-year “Jockey Club Community eHealth Care Project” together with the Senior Citizen Home Safety Association (SCHSA), the CUHK Jockey Club Institute of Ageing (IoA) and various NGOs. The Project adopts an innovative approach to encourage the elderly to build self-management habits and gain a better understanding of their own health.

Objectives:

› To apply eHealth solutions to empower individuals to build self-management habits
› To promote elderly centres as the first point of contact for detecting and addressing the health and social needs of the elderly
› To pilot eHealth technology to improve quality of life for the elderly, and analyse the health characteristics and patterns of the elderly through big data analytics

The Jockey Club Community eHealth Care Project consists of three main components:

1. Tele-care programme. E-health corners will be set up in 80 elderly centres, benefiting some 5,000 elderly people over the three-year project period. After logging into the e-health stations with their smart cards, the elderly will be assisted to conduct health measurements of blood pressure, blood glucose and weight by trained staff or professional health workers. This data will then be transferred to SCHSA by cloud technology for real-time monitoring and analysis. If the readings fall outside expected norms or no data is recorded for a prolonged period, the SCHSA nursing team will call those participants and follow up. Regular outreach visits will also be provided by a multi-disciplinary team of nurses, health workers and social workers to share health information with the elderly. The project is not aimed at replacing existing medical services or body checks received by the participants; instead, it will encourage them to build self-management habits and gain a better understanding of their own health.

2. Well-being surveys. The IoA will support the participating elderly centres in carrying out regular well-being surveys for around 10,000 people, focusing on their cognitive, psychological and social well-being. The results will help give the elderly centres a comprehensive understanding of their users’ needs, enabling them to design suitable activities and services for them.

3. Big data analysis. IoA will apply big data analysis to the information collected from the tele-care programme and well-being surveys to better understand the health status and health trends of the elderly in Hong Kong.
Challenges to Family Doctors in providing life-long care in Hong Kong

• Healthcare financing – Resource allocation – Fundholding by Hospital Authority

• Behavior change of providers, end-users and administrators

• Patient Culture – health seeking behavior

• Values system / appreciation

• Mismatch of Expectations

• Government Policy - Bureaucracy – Need of Stewardship
Way Forward –
Primary Healthcare development –
District Health Centre

Stay Healthy in the Community
Hospital Care only when necessary

Equipping community based doctors with more support
A team care approach
Subsidize allied medical services
Providing comprehensive holistic care
Keeping patients away from hospitals
Avoid overload of Hospital Authority services
Common health concerns  
Target focus of services at the future District Health Centers

<table>
<thead>
<tr>
<th>Obesity – Anticipatory care, prevention, management</th>
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</thead>
<tbody>
<tr>
<td>Screening by Case Coordinator Team, Education, Monitoring. Involve dietitian. Exercise prescription.</td>
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<tr>
<td>Chronic Disease Management with holistic approach Screening / multidisciplinary team approach –</td>
</tr>
<tr>
<td>Family Doctor, Case Coordinator, Nurses, dietitian, Occupational therapist, Optometrist</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
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<tr>
<td>Hypertension</td>
</tr>
<tr>
<td>Musculoskeletal – assessment by family doctor, coordinate physio and occupational therapy by case coordinator.</td>
</tr>
<tr>
<td>Low back pain, Osteoarthritis of knee</td>
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<tr>
<td>Fracture hip – rehabilitation, follow-up</td>
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</tbody>
</table>
Common health concerns
Target focus of services at the future District Health Centers

<table>
<thead>
<tr>
<th>Rehabilitation</th>
<th>Post Specialist Intervention, prevention of recurrence, continued care, Family Doctor Case Coordinator leading and coordinating multidisciplinary team care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke, Coronary artery disease</td>
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<tr>
<td>Promotion of Good practice and appropriate health seeking behavior</td>
<td>understanding prescribed medication, avoiding polypharmacy, doctor shopping behavior</td>
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<tr>
<td>Whole team, involve pharmacists</td>
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<tr>
<td>Lifestyle modification</td>
<td>Smoking Cessation, Exercise Prescription, Diet advice</td>
</tr>
<tr>
<td>Multi-disciplinary team led by case coordinator, nurses under direction of Family Doctor involving Special Skills – e.g. Motivational Interviewing</td>
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</tr>
</tbody>
</table>
Present Allied Health in HA

Audiology
Clinical Psychology
Dietetics
Occupational Therapy (Physical)
Occupational Therapy (Psychiatric)
Physiotherapy
Podiatry
Prosthetic & Orthotic
Speech Therapy

Can we make these services available in DHC?
<table>
<thead>
<tr>
<th>THE KTDHC TEAM</th>
<th>Number</th>
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<tbody>
<tr>
<td>Executive Director</td>
<td>1</td>
</tr>
<tr>
<td>Chief Care Coordinator (Registered nurse)</td>
<td>1</td>
</tr>
<tr>
<td>Care Coordinators (Registered nurse)</td>
<td>≥ 6</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>≥ 1</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>≥ 1</td>
</tr>
<tr>
<td>Pharmacist (Full-time equivalent)</td>
<td>≥ 1</td>
</tr>
<tr>
<td>Social Workers</td>
<td>≥ 3</td>
</tr>
<tr>
<td>Administrative Staff</td>
<td>≥ 6</td>
</tr>
<tr>
<td>Dietitian (Part-time)</td>
<td>≥ 1</td>
</tr>
<tr>
<td>Others, e.g. supporting staff</td>
<td></td>
</tr>
</tbody>
</table>

Working with a Network of Family Doctors
KTDHC Network Service Providers

• Medical Doctors – Family Doctors
• Chinese Medicine Practitioner
• Dietitian
• Occupational Therapist
• Optometrist
• Physiotherapist
• Podiatrist
• Speech Therapist
• Not yet – clinical psychology
醫療趨勢  Trends of Medicine

21st Century
急性病照護
Acute diseases care

22nd Century
慢性病管理
Chronic diseases management

替代醫學
alternative medicine

社區醫療照顧
Care provided in the community

預防、保健與自我照顧
Prevention, health maintenance and self care

生物醫藥
醫院為基礎
急重症照護
Medication and hospital based acute care
全科醫生的發展趨勢 - 中西醫結合
Development Trend in General Practice - Integration of Chinese and Western medicine

➢ 全科醫生增加對中醫藥的瞭解，世界各地包括西方社會都對中藥有濃厚興趣
➢ General practitioners are enhancing their knowledge about Traditional Chinese medicine (TCM), different countries around the world including the West, have an intense interest in Chinese medicine
➢ 不少西方人士也有接觸中醫，甚至接受中醫治療
➢ Many Westerners have experience and contact with TCM, and some have even undergone TCM treatment.
There is no contradiction between traditional and modern medicine. In health care, the two disciplines can facilitate a harmonious care, supplement each others’ merits and weaknesses.
Dr. Tu Youyou became the first Chinese woman to accept the Lasker Prize for her lifelong malaria research in 2011 and later the Nobel Prize.

2011年拉斯克獎日前揭曉，中國科學家屠呦呦獲得其中的臨床醫學獎。獲獎理由是“因為發現青蒿素 -- 一種用於治療瘧疾的藥物，挽救了全球特別是發展中國家的數百萬人的生命。” 其後獲諾貝爾獎
- The root of TCM is in primary care 中醫藥的根在基層
- TCM itself is general practice / medicine 中醫本身就是全科
- TCM is unique and precious resources 中醫藥是獨特、寶貴的資源
- TCM has been trusted by local communities Globally 中醫藥服務獲全球社區居民信賴
- TCM compliments and enhance western Medical practice
中醫在全科醫療上的優勢
The strength of TCM in general Practice

❖ Holistic care 整體觀
❖ Emphasis on health preservation 注重養生
❖ The ideology and implementation of health prevention “治未病”的理念與實踐
❖ Individual care model 個體化的診療模式
❖ A combined application of medicine, acupuncture, diet and exercises 藥、針、食、體兼通的綜合技術

中醫在社區的發展迎合了全科發展的趨勢
符合中國國家醫改的政策
The development of Chinese medicine in the community aligns with the development of general medicine, and is in line with China's national health care reform
Positioning of General Chinese Medicine Practitioners

中醫全科醫師的定位

• Service providers of TCM for solving health problems in the community 中醫師是綜合運用中醫藥理論和技能解決健康問題的服務提供者
• Managers who guide the development of TCM in the community and bring the benefits to the people 中醫師是指導中醫藥進社區，發揮社區中醫藥應用的綜合效益的管理者
• Successors of TCM knowledge and skills 傳統中醫藥知識、技能的繼承者
• Promotors of TCM culture 中醫藥文化的傳播者

HIGHER DEMAND 要求越來越來高
Hong Kong is a place featured with fusion of cultures. Many patients may have both Chinese and Western medicine treatments concurrently in their search for a quicker cure.

General practitioners, during treatments, can incorporate the TCM theory to achieve better treatment

General practitioners should communicate with Chinese medicine practitioners to increase mutual understanding and enhance application of TCM
A group of senior Western doctors, TCM practitioners and university professors established the Association in 2001, with a mission to further develop and promote the integration of Chinese and Western medicine.

一群貲深的西醫、中醫和大學教授於2001年抱著以結合運用中西醫學知識，發展更好的醫學理念下成立香港中西醫結合醫學會。
Highly respected former chairmen, including Prof Chow Shew-ping, Dr Ko Wing-man, Dr. Vivian Wong Tam Chi-woon, Dr Yu Chau-leung, have laid a good foundation for the Association.

歷任德高望重的會長周肇平教授、高永文醫生、黃譚智媛醫生、余秋良醫生/中醫師為學會打下良好基礎。

會議、研討會
Conference and seminars

課程
Curriculum
在病人間常見因中醫西醫間不溝通而承受的病苦。見諸於情，引發我等爭取設立中西醫醫學平台，尋求各界支持；發之於心，希望中醫西醫一起提升醫療健康水平。

在醫學中，既可藉西方科研方法學來研究分析，又可從中醫累積千年的思維及經驗中琢磨觀點。可望求同存異，發展和擴闊醫學精準療效，讓智慧重新，共識疾病治療和健康調理。
The Integrative Joint Organizational Platform - IJOP
介紹「中西醫醫學平台」

- **IJOP 1** – set the direction and recommendation for integrative CM-WM collaboration
  第一期 2015 —— 訂定方向和提出建議，以備中西醫協作之用

- **IJOP 2** - Disease Management Information Network
  第二期 2019 —— 疾病治理共策網絡
    - Funded by ITC 由創新科技署資助
    - 病 Diseases - 3 Chosen: Breast Cancer, Stroke and Eczema
      疾病 - 三種選定：乳腺癌半恢復期、中風後治理和濕疹
    - 方 Framework for CM-WM collaboration
      中西醫協作框架
    - 人 Community Network
      社協醫網
    - 網 Web-based platform for CM-WM collaboration
      供中西醫協作之用的網絡平台
Integrative Medicine 結合醫學

- Patient-centered care (individualized) 病人為中心的照顧 (個體化)
- Holistic analysis 整體分析
- Apply all proper treatments (routine or non routine) 利用所有適當的治療方法 (常規或非常規)
- Enhance self-healing through self health maintenance 透過自我保健照顧提升人體自癒能力
- Emphasis on prevention and protection 強調預防與保健
- Evidence-based medicine 實證醫學
- Diversification in clinical practice 臨床實踐中的多樣化
The best of the two types of medicine: 兩種醫學的最佳:
The essence of integrated medicine: 東西醫學模式的關鍵點

• Use the strength of biomedical knowledge, such as diseases detection, acute diseases management and methods for stabilizing vital signs: 利用生物醫學的強項，如發現疾病，急性病管理和穩定生命指征的方法
• Rely on the “perspective of balance” of TCM: 依賴傳統中醫的平衡觀
• Believe in self-healing ability of our inner bodies: 相信機體內在的自愈能力
• Flexible and comprehensive treatment for individuals: 靈活和全面性的個體化治療
• Investigate the root cause of diseases through symptoms and presentations of diseases: 在症狀和疾病的“標”之背後，尋求疾病的“根本”
• Treat patients through targeting at parts or the overall health problems: 通過處理局部和全身的問題，治療病人
• Actively engaged in preventive and promotive health: 積極參與預防和促進健康
• Safe, effective and affordable health care: 安全，有效和價廉的治療
Clinical model of Chinese and Western Medicine Centre
中西醫學中心臨床模式

Patients referral
患者轉介

Comprehensive assessment
整體評估
(Diagnosis by Chinese medicine practitioners and western doctors)
(中醫診斷與西醫診斷)

Patients education
病患教育
(nutrition, acupressure, stress management)
(營養, 指壓, 壓力管理)

Treatment
治療
(acupuncture, trigger points injection, medication adjustment)
(針灸, 激痛點注射, 藥物調整)

Prognosis assessment
預後評估

Before consultation
就診前

During consultation
就診時

After consultation
就診後

Self protection
自我保健
Healthy life-style 健康的生活方式

70% of premature death is lifestyle-related
50% of all illness & injuries in the last third of life can be eliminated by changing lifestyle


### Education 教育

- The importance of balance 平衡的重要性
- Life-style adjustment 生活方式調整
- Sports/sleep/diet 運動/休眠/營養建議
- Self Massage and acupressure 自我按摩與指壓
- Stress management 壓力管理

### Treatment 治療

- Acupuncture 針灸
- Acupressure 穴位按摩療法
- Trigger Point Injections 激痛點注射(TPI)
- Medication adjustment 藥物調整
Features of success for integrated medicine
成功的結合醫學專案的特點

Boon HS, et al. 2008

• Open and inclusive institutional culture 開放相容的機構文化;

• Integration of outstanding CAM with western doctors 能力突出的 CAM 聯合西醫從業者 (同時具有兩種醫學知識者為佳);

• Effective communications among team members 團隊成員間的有效溝通;

• Sustainable environment for medical practice 可持續的醫療實踐環境 (實體和經濟上的); 以及

• Competency to handle some difficult cases 有能力處理一些特殊的疑難病情
<table>
<thead>
<tr>
<th>The present medical model is changed from ...</th>
<th>To an Integrated medical practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors playing an authoritative role</td>
<td>Doctors play the role as a partner</td>
</tr>
<tr>
<td>Intervention mainly targeted at specific disease treatment</td>
<td>Intervention is given after an overall assessment of health, psychology, sentiment and social factors</td>
</tr>
<tr>
<td>Ignored Patients diet and eating habits</td>
<td>Food is an important health factor, patients would be given diet and nutrition advice</td>
</tr>
<tr>
<td>Patients'psychological factors or stress are not normally considered</td>
<td>Educate patients how to manage stress</td>
</tr>
<tr>
<td>Treatments are fragmented</td>
<td>Treatments are coordinated by several clinicians</td>
</tr>
</tbody>
</table>

Source: IOM Summit on Integrative medicine, 2009
中醫在社區醫療健康中心的工作

平台建設深化內涵

- 打造中醫藥健康管理服務網路
- 設立中醫藥健康管理服務站
- 一體化中醫藥服務區建設
- 制定中醫健康管理服務規範
- 制定中醫健康管理服務流程
- 建立中醫健康管理服務品質控制與考核體系
中醫在社區醫療健康中心的工作

中醫基本公共衛生服務

- 高血壓患者中醫藥服務試點
- 中醫孕產婦健康管理
- 中醫體質辨識
- 重點人群中醫養生保健
- 慢性病中醫健康管理
- 中醫參與傳染病防治
中醫在社區醫療健康中心的工作

建造一個平台

在各社區衛生服務站點心及中心建立“中醫健康管理”流動服務站；社區衛生資訊中心積極推進中醫預防保健資訊管理平臺建設，強化與家庭醫生工作站資訊管理平臺對接，及社區居民健康檔案管理共用的功能，體現政策宣傳、知識普及、文化傳播互動一體的中醫資訊化特色。
社區衛生服務中心工作

提升健康促進內涵

- 確保經費投入, 保證工作成效
  Ensure adequate resources, Ensure efficiency

- 建立監測系統, 評估工作效果
  Audit, assessment

- 突出工作重點, 培育健教品牌
  Highlight work focus, Create branding

- 完善網絡建設, 加強部門合作
  Network construction, Interdisciplinary cooperation

- 拓展健康傳播, 深化行為干預
  Develop and strengthen Health education

五項舉措
An effective District Health Centre

• Comprehensive 服務全面
• Accessible 方便
• Attractive / Innovative 有創意、具吸引力
• Affordable 能負擔
• Quality assured 優質保証
• Competitive 俱競爭力
“Once qualified, we cannot be complacent, storage vessels of knowledge and wisdom.”
Thank you!