The Roles and Responsibilities of Care Coordinators in DHC

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17 August 2019 (3:30 pm – 4:15 pm)
Kwai Tsing District Health Centre
Care Coordinator (CC)

- Who is s/he?
- What does s/he do?
- Who isn’t s/he?
- What does s/he not do?
Key questions

- Why DHC?
- Why the involvement of different stakeholders?
- Why CC?
Table 1: Prevalence of hypertension in Hong Kong by age groups

<table>
<thead>
<tr>
<th>Age Group (Years)</th>
<th>Self-reported, doctor diagnosed hypertension (%)</th>
<th>Undiagnosed but measured (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>1.0</td>
<td>3.4</td>
<td>4.5</td>
</tr>
<tr>
<td>25-34</td>
<td>0.4</td>
<td>5.2</td>
<td>5.6</td>
</tr>
<tr>
<td>35-44</td>
<td>3.9</td>
<td>11.3</td>
<td>15.2</td>
</tr>
<tr>
<td>45-54</td>
<td>10.5</td>
<td>16.2</td>
<td>26.7</td>
</tr>
<tr>
<td>55-64</td>
<td>27.0</td>
<td>19.4</td>
<td>46.4</td>
</tr>
<tr>
<td>65-84</td>
<td>43.8</td>
<td>20.9</td>
<td>64.8</td>
</tr>
</tbody>
</table>

All age groups  | 14.6                                          | 13.2                          | 27.7      |
Hypertension

Rates of awareness, treatment, and control in different regions

(Chow et al., 2013)
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.
Figure 1. Decision cycle for patient-centered glycemic management in type 2 diabetes. Adapted from Davies MJ, D’Alessio DA, Fradkin J, et al. Diabetes Care 2018;41:2669–2701.
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

<table>
<thead>
<tr>
<th>BP measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>● 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Less conservative treatment of BP in older and very old patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>● 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).</td>
</tr>
<tr>
<td>● Recommendation that treatment should never be denied or withdrawn on the basis of age, provided that treatment is tolerated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A SPC treatment strategy to improve BP control</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Preferred use of two-drug combination therapy for the initial treatment of most people with hypertension.</td>
</tr>
<tr>
<td>● A single-pill treatment strategy for hypertension with the preferred use of SPC therapy for most patients.</td>
</tr>
<tr>
<td>● 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New target ranges for BP in treated patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>● 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Detecting poor adherence to drug therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>● A strong emphasis on the importance of evaluating treatment adherence as a major cause of poor BP control.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A key role for nurses and pharmacists in the longer-term management of hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>● 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.</td>
</tr>
</tbody>
</table>
Table 6  Risk modifiers increasing cardiovascular risk estimated by the Systemic COronary Risk Evaluation (SCORE) system

- Social deprivation, the origin of many causes of CVD
- Obesity (measured by BMI) and central obesity (measured by waist circumference)
- Physical inactivity
- Psychosocial stress, including vital exhaustion
- Family history of premature CVD (occurring at age <55 years in men and <60 years in women)
- Autoimmune and other inflammatory disorders
- Major psychiatric disorders
- Treatment for infection with human immunodeficiency virus
- Atrial fibrillation
- LV hypertrophy
- CKD
- Obstructive sleep apnoea syndrome

BMI = body mass index; CKD = chronic kidney disease; CVD = cardiovascular disease; LV = left ventricular.

Lifestyle interventions for patients with hypertension or high-normal BP

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Classa</th>
<th>Levelb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salt restriction to &lt;5 g per day is recommended.</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>It is recommended to restrict alcohol consumption to:</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>- Less than 14 units per week for men.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Less than 8 units per week for women.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is recommended to avoid binge drinking.</td>
<td>III</td>
<td>C</td>
</tr>
<tr>
<td>Increased consumption of vegetables, fresh fruits, fish, nuts, and unsaturated fatty acids (olive oil); low consumption of red meat; and consumption of low-fat dairy products are recommended.</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>Body-weight control is indicated to avoid obesity (BMI &gt; 30 kg/m² or waist circumference &gt;102 cm in men and &gt;88 cm in women), as is aiming at healthy BMI (about 20–25 kg/m²) and waist circumference values (&lt;94 cm in men and &lt;80 cm in women) to reduce BP and CV risk.</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>Regular aerobic exercise (e.g. at least 30 min of moderate dynamic exercise on 5–7 days per week) is recommended.</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>Smoking cessation, supportive care, and referral to smoking cessation programs are recommended.</td>
<td>I</td>
<td>B</td>
</tr>
</tbody>
</table>

BMI = body mass index; BP = blood pressure; CV = cardiovascular.

*aClass of recommendation.

*bLevel of evidence mostly based on the effect on BP and/or CV risk profile.
The Chronic Care Model

Community
Resources and Policies
Self-Management Support

Health Systems
Organization of Health Care
Delivery System Design
Decision Support
Clinical Information Systems

Informed, Activated Patient
Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes
The NHS and Social Care Long Term Conditions Model

**Infrastructure**
- Community resources
- Decision support tools and clinical information system (NPttT)
- Health and social care system environment

**Delivery System**
- Case management
- Disease management
- Supported self care
- Promoting better health

**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:
(A) RE-ORGANISING THE PRIMARY HEALTHCARE SYSTEM
(B) ESTABLISHMENT OF DHCS IN ALL DISTRICTS
(C) ENHANCING MEDICAL-SOCIAL COLLABORATION
(D) CONNECTING STAKEHOLDERS THROUGH ELECTRONIC PLATFORM
(E) STRENGTHENING MANPOWER AND TRAINING
(F) PUBLIC EDUCATION AND PARADIGM SHIFT
An experience in Guangzhou
Research site

- 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
<table>
<thead>
<tr>
<th>Chronic Care Model (Wagner, 1998)</th>
<th>Four-Cs Model (Wong, 2005)</th>
<th>NHM model</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| Self-management support         |                           | • A self-management booklet: knowledge and skills  
• Behaviour contract  
• Health promotion |                  |
| 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) |                  |
|                                 |                           |            | • BP  
• Self-care behavior  
• Self-efficacy  
• QoL  
• Utilization of healthcare service  
• Patient satisfaction |
Development of the NHM model

Protocol-based intervention:
- Training protocol
- Protocol of home visit
- Protocol of telephone follow-up
- Protocol of assessment
- Protocol of intervention
- Protocol of referral

Protocols were developed based on:
- Literature review
- Guidelines for hypertension management
- Expert consultant
- Pilot study (Zhu et al., 2014)
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
Adherence rate of anti-hypertensive drug

Adherence rate of home BP monitoring

Adherence rate of salt restriction

Adherence rate of regular physical activity

Adherence rate in the two groups at three time points
Table 4.15 Comparison of pharmacological treatment from T0 to T1 for the study group and the control group

<table>
<thead>
<tr>
<th>T1 medication used</th>
<th>Study Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>decrease</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>increase</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>change</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>maintain</td>
<td>34</td>
<td>44</td>
</tr>
</tbody>
</table>

T0 = baseline, T1 = 12 weeks after recruitment
An experience in Hong Kong
<table>
<thead>
<tr>
<th>Problems</th>
<th>Health-focused</th>
<th>Social-focused</th>
<th>Health-social Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Income</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>2. Sanitation</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>3. Residence</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>4. Neighborhood/workplace safety</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>5. Communication with community resources</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>6. Social contact</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>7. Role change</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>8. Interpersonal relationship</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>9. Spirituality</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>10. Grief</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>11. Mental health</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>12. Sexuality</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>13. Caregiving/ Parenting</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>14. Neglect</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>15. Abuse</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>16. Growth and development</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>17. Hearing</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Vision</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Speech and language</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Oral health</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Cognition</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Pain</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Consciousness</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Skin</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Neuro-musculo-skeletal function</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Respiration</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Circulation</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Digestion-hydration</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Bowel function</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Urinary function</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Reproductive function</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Communicable/ Infectious condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Nutrition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Sleep and rest patterns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Physical activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Personal care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Substance use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Health care supervision</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Medication regimen</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Case 1
A. 個人資料—Personal information

1. 性別:  □ 男  ❑ 女

2. 年齡:  

3. 婚姻狀況:  □ 未婚  □ 已婚  □ 離婚  ❑ 喪偶

4. 你的最高教育程度是:  ❑ 沒正式接受教育  □ 小學或以下  □ 中學  
   □ 報讀學院/大學  □ 其他 (請註明)  

5. 職業:  □ 全職  □ 兼職  □ 待業  ❑ 退休

6. 你現在的居所是:  □ 整個單位  ❑ 一房間/畳房  □ 築屋  □ 其他  
   (請註明)  

7. 你的居住狀況:  ❑ 獨居  □ 兩老雙居  □ 與家人同住

8. 你覺得你的經濟狀況如何？ □ 足夠有餘  ❑ 剛剛足夠應付日常開支
   □ 不足夠應付日常開支  □ 十分不足夠

9. 你的經濟主要來源是?  □ 自己的薪水  □ 家人提供  □ 個人積蓄
   □ 退休金/長俸  ❑ 綜合援助  □ 高齡津貼
   □ 傷殘津貼 ($1580/月)  □ 高傷殘津貼 ($3160/月)
   □ 其他 (請註明)  

10. 有那些人會照顧你？ (可選多項):  ❑ 自己  □ 配偶  □ 兄弟姊妹
    □ 子女  □ 媳婦/女婿  □ 朋友  □ 鄰居  □ 機構義工
    □ 傭人  □ 其他 (請註明)  

11. 所得的照顧是（除了自己之外）:  □ 隨時  ❑ 間中到訪/幫助
    □ 只在晚上  □ 沒其他人幫助  □ 其他 (請註明)  

THE HONG KONG POLYTECHNIC UNIVERSITY
香港理工大學
<table>
<thead>
<tr>
<th>Date</th>
<th>Measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/9/2016</td>
<td></td>
</tr>
<tr>
<td>1 血壓： <em>146/83</em> 毫米水銀</td>
<td></td>
</tr>
<tr>
<td>2 脈膊： <em><strong>93</strong></em>/分鍾</td>
<td></td>
</tr>
<tr>
<td>3 體溫： <em>37.2</em> 攝氏</td>
<td></td>
</tr>
<tr>
<td>4 身高： <em><strong>1.42</strong></em>/米</td>
<td></td>
</tr>
<tr>
<td>5 體重： <em><strong>36.7</strong></em>/千克</td>
<td></td>
</tr>
<tr>
<td>6 身高體重指數 (BMI): <em><strong>18.2</strong></em></td>
<td></td>
</tr>
<tr>
<td>7 血糖： _____12.6 (2 hours post breakfast) _____</td>
<td></td>
</tr>
<tr>
<td>8 含氧量: _<em><em><strong>97</strong></em>% (RA</em>)</td>
<td></td>
</tr>
</tbody>
</table>
Medical consultant referral form

To: 西九龍 GOPD Dr
Cc:

Part A: Personal Information
Date: 6/10/2016 | Time: 1100
Name: 蔡 XX
Gender: Female
Age: 91
Phone number: 2xxxxxxx

Part B: Present Condition
Reason for referral:
- H’stitx 12.6 mmol/L on 12/9 (2 hrs post meal).
- No history of DM.
- Son was informed on 13/9 about the high blood glucose level.
- However, son preferred to keep observe.
- Her son phoned call on 6/10 and asked for an referral letter to attend GOPD
- For medical consultation.
- Past health history good. No history of DM/HT.

Blood pressure: 146 / 83
mmHg
SpO₂: 97 % ( RA )
Pulse: 93 beats/min
RR: 20 breaths/min
Temp: 36.7 °C
GCS: 15 / 15

Principal Problem: Spot H’stitx 12.6 (2 hrs post meal) on 12/9/16

Medical history:
- No history of DM
- Previous medications: Enervoc C tab 1 daily, Calperos D3 tab 1 daily, Enzyplex tab 1 TDS, Panadol 500 mg po PRN, Pepcidine 20mg Daily po
- Allergies: Not known

Referring Person: _Yuen Fung Ki Francis _____________
Position: __Registered Nurse __
Contact number: ___9__________
<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>Problems or Concepts</th>
<th>Actual problem (Briefly describe the patient’s needs &amp; strength)</th>
<th>Modifiers</th>
<th>Problem rating</th>
<th>Intervention</th>
<th>Problem rating for Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Health promotion Actual or Potential</td>
<td>Individual; family; or community</td>
<td>DATE</td>
<td>Knowledge (1-5)</td>
<td>Behavior (1-5)</td>
</tr>
<tr>
<td>33. Nutrition</td>
<td>Hyperglycemia, H’s tix 12.6 mmol/L (2 hours post breakfast on 12/9/16) No history of DM in the past</td>
<td>Actual</td>
<td>Individual</td>
<td>12/9/16</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Date: 29/11/2016</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>혈압: 150/87</td>
<td>毫米水銀</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>脈膊: 102</td>
<td>分鐘</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>體溫: 36.9</td>
<td>攝氏</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>身高: 1.42</td>
<td>米</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>體重: 37.8</td>
<td>千克</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>身高體重指數(BMI): 18.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>血糖: 7.1 (0.5 hr post meal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>含氧量: 95% (RA)</td>
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</table>
Case 2
A. Demographic data—Personal information

1. 性別: □ 男  □ 女

2. 年齡: ___ 92 ___

3. 婚姻狀況: □ 未婚  □ 已婚  □ 離婚  □ 喪偶

4. 你的最高教育程度是: □ 沒正式接受教育  □ 小學或以下  □ 中學
   □ 專上學院/大學  □ 其他 (請註明) _______ __________________________

5. 職業: □ 全職 □ 兼職 □ 待業 □ 退休

6. 你現在的居所是: □ 整個單位  □ 一房間/副房  □ 隱居  □ 其他 (請註明) _______ __________________________

7. 你的居住狀況: □ 獨居 □ 兩老雙居 □ 與家人同住

8. 你覺得你的經濟狀況如何? □ 足夠有餘 □ 剛剛足夠應付日常開支
   □ 不足夠應付日常開支 □ 十分不足夠

9. 你的經濟主要來源是? □ 自己的薪水 □ 家人提供 □ 個人積蓄
   □ 退休金/長俸 □ 綜合援助 □ 高齡津貼
   □ 傷殘津貼 ($1580/月) □ 高傷殘津貼 ($3160/月)
   □ 其他 (請註明) __________________________

10. 有那些人會照顧你? (可選多項) □ 自己 □ 配偶 □ 兄弟姊妹
    □ 子女 □ 媳婦/女婿 □ 朋友 □ 鄰居 □ 機構義工
    □ 傭人 □ 其他 (請註明) __________________________

11. 所得的照顧是 (除了自己之外): □ 隨時 □ 寢中到訪/幫助
    □ 只在晚上 □ 沒其他人幫助 □ 其他 (請註明) __________________________
<table>
<thead>
<tr>
<th>問題</th>
<th>是</th>
<th>否</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 你基本上對自己的生活感到滿意嗎？</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>2. 你是否已放棄了很多以往的活動和嗜好？</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>3. 你是否覺得生活空虛？</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>4. 你是否常常感到煩悶？</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>5. 你是否很多時候感到心情愉快呢？</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>6. 你是否害怕將會有不好的事情發生在你身上呢？</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>7. 你是否大部份時間感到快樂呢？</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>8. 你是否常常感到無助？</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>9. 你是否寧願留在院舍/屋企裡，而不出外做些有意義的事情？</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>10.你是否覺得你比大多數人有多些記憶的问题呢？</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>11.你認為現在活著是一件好事嗎？</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>12.你是否覺得自己現在一無是處呢？</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>13.你是否感到精力充足？</td>
<td>✔</td>
<td></td>
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<tr>
<td>14.你是否覺得自己的處境無望？</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>15.你覺得大部份人的境況比自己好嗎？</td>
<td>✔</td>
<td></td>
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<tr>
<td>總分</td>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>

Social Care Referral Form

To:  
Name of Referee:  
Gender: Female  
Age: 92  
Marital Status: Married  
Education: Primary  
Telephone number:  
Home Address:  
Type of accommodation: Rooms  
Financial Support: None  
Name of care:  
Relationship with reference: Husband  
Contact Number:  
Reason for referral: Client had depression (GDS 12/15). Client expressed helplessness and felt being a burden to her husband. She needed to be taken care by her husband including bathing, going to toilet and walking outdoor. She thought that life is suffering. She had difficulty feeling on and off with no concrete suicidal plan.  
Care needs (Husband felt stress in taking care of client):  
Poor social support  
Psychological counseling  
Home Care Support  
Community Resources  

- Undesirable habits (anti-social behavior, Heavy smoking, Alcoholism, Drug addiction, Gambling, Others:  
- Violent/Agressive behavior  

- Poor living environment and hygiene  
- Family support and social support  
- Lack of community services information  

- Daily living assistance and caring arrangements  

Check: Depression (GDS 12/15)  
Suicidal tendency  

Referring Person:  
Name:  
Position: Registered nurse  
Contact number:  
Follow up record (filled by social worker or staff in community center):  

Any action done:  

Name of staff:  
Position:  
Contact number:  

*Please circle as appropriate  
Please send the completed form to anker.wong@polyu.edu.hk
Medical consultant referral form

To: 診療 GOPD
Cc: 

Part A: Personal Information
Date: 8/8/2017
Name: 
Gender: Female
Age: 52
Phone number: 2:

Part B: Present Condition
Reason for referral: Home care visited client on 7/8/2017
Client had hearing deficit of both ears.
Please kindly arrange hearing test.

Blood pressure: 140 /57 mmHg
Pulse: 53 beats/min
SpO2: 98 % (RA)
RR: 20 breaths/min
Temp: 36.7 °C
GCS: 15 /15
ADL: Walk

Principal Problem: Hearing deficit of both ears.
Medical history: H/T. Depression
Previous medications:
Allergies:

Part C: Follow up record (Filled by medical consultant)
Any action done:

Medical consultant: ___________ Contact number: ___________

Please send the completed form to arkers.wong@polyu.edu.hk
Short Form Berg Balance Scale – 3 Point (SF BBS-3P)

Mark the lowest category that applies for each function.

1. Reaching forward with outstretched arm while standing
INSTRUCTIONS: Lift arm to 90 degrees. Stretch out your fingers and reach forward as far as you can. (Examiner places a ruler at the end of fingertips when arm is at 90 degrees. Fingers should not touch the ruler while reaching forward. The recorded measure is the distance forward that the fingers reach while the subject is in the most forward lean position. If possible, ask subject to use both arms when reaching to avoid rotation of the trunk.)
   \( \checkmark \) 4 can reach forward confidently 25 cm (10 inches)
   \( \checkmark \) 3 can reach forward 12 cm (5 inches)
   \( \checkmark \) 2 can reach forward 5 cm (2 inches)
   \( \checkmark \) reaches forward but needs supervision
   \( \) 0 loses balance while trying/requires external support

2. Standing unsupported with eyes closed
INSTRUCTIONS: Please close your eyes and stand still for 10 seconds.
   \( \checkmark \) 4 able to stand 10 seconds safely
   \( \checkmark \) 3 able to stand 10 seconds with supervision
   \( \checkmark \) 2 able to stand 3 seconds
   \( \) 1 unable to keep eyes closed 3 seconds but stays safely
   \( \) 0 needs help to keep from falling

3. Standing unsupported one foot in front
INSTRUCTIONS: (DEMONSTRATE TO SUBJECT) Place one foot directly in front of the other. If you feel that you cannot place your foot directly in front, try to step far enough ahead that the heel of your forward foot is ahead of the toes of the other foot. (To score 3 points, the length of the step should exceed the length of the other foot and the width of the stance should approximate the subject’s normal stride width.)
   \( \checkmark \) 4 able to place foot tandem independently and hold 30 seconds

4. Turning to look behind over left and right shoulders while standing
INSTRUCTIONS: Turn to look directly behind you over toward the left shoulder. Repeat to the right. Examiner may pick an object to look at directly behind the subject to encourage a better twist turn.
   \( \) 4 looks behind from both sides and weight shifts well
   \( \checkmark \) 3 looks behind one side only other side shows less weight shift
   \( \) 2 turns sideways only but maintains balance
   \( \) 1 needs supervision when turning
   \( \) 0 needs assist to keep from losing balance or falling

5. Pick up object from the floor from a standing position
INSTRUCTIONS: Pick up the shoe/slipper, which is place in front of your feet.
   \( \) 4 able to pick up slipper safely and easily
   \( \checkmark \) 3 able to pick up slipper but needs supervision
   \( \) 2 unable to pick up but reaches 2-5 cm(1-2 inches) from slipper and keeps balance independently
   \( \) 1 unable to pick up and needs supervision while trying
   \( \checkmark \) unable to try/needs assist to keep from losing balance or falling

6. Standing on one leg
INSTRUCTIONS: Stand on one leg as long as you can without holding on.
   \( \checkmark \) 4 able to lift leg independently and hold > 10 seconds
   \( \checkmark \) 3 able to lift leg independently and hold 5-10 seconds
   \( \) 2 able to lift leg independently and hold ≥ 3 seconds
   \( \) 1 tries to lift leg unable to hold 3 seconds but remains standing independently
   \( \checkmark \) unable to try of needs assist to prevent fall
7. Sitting to standing

INSTRUCTIONS: Please stand up. Try not to use your hand for support.

( ) 4 able to stand without using hands and stabilize independently
( ) 3 able to stand independently using hands
( ) 2 able to stand using hands after several tries
( ) 1 needs minimal aid to stand or stabilize
( ) 0 needs moderate or maximal assist to stand

Total Score (Maximum = 28)  

Scoring:

4 (able to complete the task) = 4,
3/2/1 (partially complete the task) = 2,
0 (unable to complete the task) = 0

Score of 23 or below suggests high risk of falling

References:

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<tr>
<th>評估事項</th>
<th>情況</th>
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<tbody>
<tr>
<td>1. 知道定時、定量服用所處方的藥物*</td>
<td>知道</td>
</tr>
<tr>
<td>2. 需要他人預先準備需用藥物及分量</td>
<td>需要</td>
</tr>
<tr>
<td>3. 藥物儲存地方環境</td>
<td>清潔</td>
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<tr>
<td>4. 藥物標籤</td>
<td>清楚</td>
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<tr>
<td>5. 藥物包裝（例如：包裝完好、開啟緊閉）</td>
<td>是</td>
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<tr>
<td>6. 不同的藥物分別裝在不同的藥袋或藥盒中</td>
<td>有</td>
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<tr>
<td>7. 儲存 a) 過期藥物</td>
<td>有</td>
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<tr>
<td>b) 不知道藥物</td>
<td>有</td>
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<tr>
<td>8. 知道如何處理服藥後可能出現的不適（例如：頭暈）</td>
<td>知道</td>
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<tr>
<td>9. 瞭解續藥使用方法（例如：口服或吸入等）*</td>
<td>瞭解</td>
</tr>
<tr>
<td>10. 如服用中成藥或中藥必須與醫生處方藥物相隔至少2小時</td>
<td>知道</td>
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<tr>
<td>11. 藥物分量足夠下次複診前服用</td>
<td>足夠</td>
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<tr>
<td>12. 服用醫生處方藥物以外成藥</td>
<td>有</td>
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<tr>
<td>Domain</td>
<td>Problem classification</td>
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</tr>
<tr>
<td>Problems or Concepts</td>
<td>Actual problem (Briefly describe the patient’s needs &amp; strength)</td>
</tr>
<tr>
<td>1. Income</td>
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<td>2. Sanitation</td>
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<tr>
<td>3. Residence</td>
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<tr>
<td>4. Neighborhood/work place safety</td>
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<td>5. Communication with community resources</td>
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<tr>
<td>6. Social contact</td>
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<td>DOMAIN</td>
<td>Problems or Concepts</td>
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<tr>
<td>Physiological</td>
<td>17. Hearing</td>
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<td>18. Vision</td>
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<td>19. Speech and language</td>
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<td>20. Grol health</td>
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<td>21. Cognition</td>
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<td>34. Sleep and rest patterns</td>
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<td></td>
<td>35. Physical activity</td>
</tr>
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<td>36. Personal care</td>
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</tbody>
</table>
Referral rate 14.3%
Reasons of medical referral

- Hypertension: 6
- Hyperglycaemia: 5
- Cognition: 1
- Pain: 1
- Hearing: 1
- Wound infection: 1
What a CC is not?
http://www.improvingchroniccare.org/index.php?p=Care_Coordination_Model&s=353

A Case Study in Coordinated Care

Ms. H, Ms. G’s sister, is a 55-year-old grandmother with a 12-year history of Type 2 diabetes complicated by elevated blood pressure and recurrent episodes of major depression. ... Her primary care doctor (PCP) postponed adjusting her hypoglycemic and anti-hypertensive drug doses until her depression was under better control, and referred her to the mental health center to review and update her depression treatment. ....

When Ms. H saw Dr. P (Psychiatrist), he had her clinical information in front of him. He adjusted her depression medication, but also found that her blood pressure was elevated. Ms. H also complained of headache and fatigue. Dr. P became alarmed about her blood pressure and headache, and arranged for her to be seen that afternoon by her PCP, who adjusted her anti-hypertensive medications. The receptionist/referral coordinator suggested that Ms. H have her BP checked by the EMTs at the neighborhood fire station every other day, which she did. Ms. H slowly began to feel less depressed and her BP slowly came down to target levels with one more medication adjustment.
What is a CC in DHC?

(a) **Increase** people’s sense of **ownership of health**:
   - (i) healthy diet;
   - (ii) regular physical activity;
   - (iii) weight control;
   - (iv) smoking cessation;
   - (v) alcohol abstinence;

(b) **Promote** healthy lifestyle
   - (i) healthy diet;
   - (ii) regular physical activity;
   - (iii) weight control;
   - (iv) smoking cessation;
   - (v) alcohol abstinence;

(c) **Increase** awareness of risk factors for non-communicable diseases;

(d) **Support and assist clients** to achieve and maintain **optimal control of health risk factor and chronic disease** through the following measures -
   - (i) shift paradigm from physician-centered care to self-motivated person-centered care;
   - (ii) take into account the physical, psychological and social factors associated with the health condition;
   - (iii) reinforce clients’ good practice and healthy lifestyle behaviour;

(e) **Encourage** clients to form **peer support groups** to promote and maintain physical and psychological health;

(f) **Introduce** health **resources** and facilitate clients’ **access** to them - focus on how clients can make the best use of available information, provide information tailored for the individual; for some, an internet resource is the best solution, whereas others may prefer a leaflet or book.
What is a CC in DHC?

4. The care coordinators in the DHC Scheme also take active role in communicating public health information and enhancing coordination and integration of district-based primary healthcare:

   (a) Promote government initiatives in primary healthcare;
   (b) Strengthen coordination of primary care services;
   (c) Promote cross-sector and cross-profession collaboration services;
   (d) Identify and promote technologies which are useful in health management.
   (e) Engage volunteers e.g. Health Ambassador / Fitness Coach;
DHC Health Risk Factor Assessment (Appendix I.1)

- History of DM
  - Yes: Refer for PEP/SMSP
  - No: Criteria for DM screening (any one of the following):
    - Age ≥45 and increased body mass index (BMI ≥23kg/m² for Asian, BMI ≥25kg/m² for non-Asian) / waist circumference (≥80cm for female, ≥90cm for male);
    - Family history (1st degree relatives) of DM;
    - History of prediabetes/gestational DM or big baby (>9 lbs or 4.1kg)/random h’stix ≥6.1mmol/L;
    - History of HT, hyperlipidaemia, CVA, IHD/MI, peripheral vascular disease.

  - Yes: Arrange NMP appointment for DM screening
    - *1st NMP medical consultation
      - Refer for *medical laboratory tests and *optometry assessment
        - Yes: Care coordinator reviews OGTT and HbA1c results
          - DM: *Check urine ACR, Optometry assessment, Foot assessment
            - *2nd NMP medical consultation
              - Review reports
              - Refer individual healthcare service if indicated
              - DM Management Programme
          - Prediabetes
          - Normal
            - *2nd NMP medical consultation
              - Telephone or face-to-face review

  - No: Care coordinator refers for PEP/SMSP

1. Telephone or face-to-face review
2. Remind client for annual DHC Health Risk Factors Assessment

*Telephone or face-to-face review

DHC Health Risk Factors Assessment 1 year later and refer to NMP for re-screening.
3.4 Workflow of HT Screening

DHC Health Risk Factors Assessment

Care coordinator advises client to attend AED.

SBP ≥ 220mmHg or DBP ≥ 120mmHg at DHC (despite adequate rest for at least 5 mins)

History of HT

SBP ≥ 140mmHg or DBP ≥ 90mmHg at DHC OR on SBPM

- Refer NMP (If SBP ≥ 180mmHg or DBP ≥ 110mmHg at DHC: NMP appointment within 1 week. Otherwise, NMP appointment 1 week after.)
- Educate on 1-week SBFM

NMP Medical Consultation

HT

Normal BP

Refer for PEP/SMSP

Telephone or face-to-face review

Refer for SMSF

NMP refers for
1. *Medical laboratory tests:
2. *Optometry assessment (performed once for newly diagnosed HT cases)

NMP Medical Consultation
- Review laboratory and optometry reports
- Refer individual healthcare services, e.g. dietetic service, physiotherapy
Care coordinator refers for PEP

HT Annual Assessment

Telephone or face-to-face review

Remind client for annual DHC Health Risk Factors Assessment
7.9 Workflow of Community Rehabilitation Programme

At the consultation, doctors identify clients indicated for Community Rehabilitation Programme.

Prepare Referral Letter
Referred by NMP: Manual referral form (Appendix J.1).

HA/NMP clinic staff sends the referral form to DHC by fax.

Care Coordinator contacts the client:
• Enrol client in DHC Community Rehabilitation Programme;
• Refer PEP;
• Discuss care plan;
• Make appointment for individual healthcare service.

Client attends DHC services and medical follow-up as scheduled.

Care coordinators conduct telephone or face-to-face review after completion of programme, or earlier if indicated.
<table>
<thead>
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<th></th>
<th>Comprehensive PHC</th>
<th>Selective PHC</th>
<th>Medical Model</th>
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<tbody>
<tr>
<td><strong>View of health</strong></td>
<td>Positive wellbeing</td>
<td>Absence of disease</td>
<td>Absence of disease</td>
</tr>
<tr>
<td><strong>Locus of control over health</strong></td>
<td>Communities and individuals</td>
<td>Health professionals</td>
<td>Medical Practitioners</td>
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<tr>
<td><strong>Major focus</strong></td>
<td>Health through equity and community empowerment</td>
<td>Health through medical interventions</td>
<td>Disease eradication through medical interventions</td>
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<tr>
<td><strong>Health care providers</strong></td>
<td>Multi-disciplinary teams</td>
<td>Medical doctors plus other health professionals</td>
<td>Medical doctors</td>
</tr>
<tr>
<td><strong>Strategies for health</strong></td>
<td>Multi-sectoral collaboration</td>
<td>Medical interventions</td>
<td>Medical interventions</td>
</tr>
</tbody>
</table>
三隻牛喫草。
一隻羊也喫草，
一隻羊不喫草，
他看着花。

第10課 三只牛吃草
三只牛吃草。一只羊也吃草。一只羊不吃草，他看着花。
Thank you!