The Roles and Responsibilities of Care Coordinators in DHC

Frances Kam Yuet Wong
President, The Hong Kong Academy of Nursing
Professor in Nursing & Associate Dean, Faculty of Health & Social Sciences
The Hong Kong Polytechnic University

17August 2019 (3:30 pm – 4:15 pm)

Kwai Tsing District Health Centre

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

Care Coordinator (CC)

- Who is s/she?
- 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?

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

Revised Edition December 2018

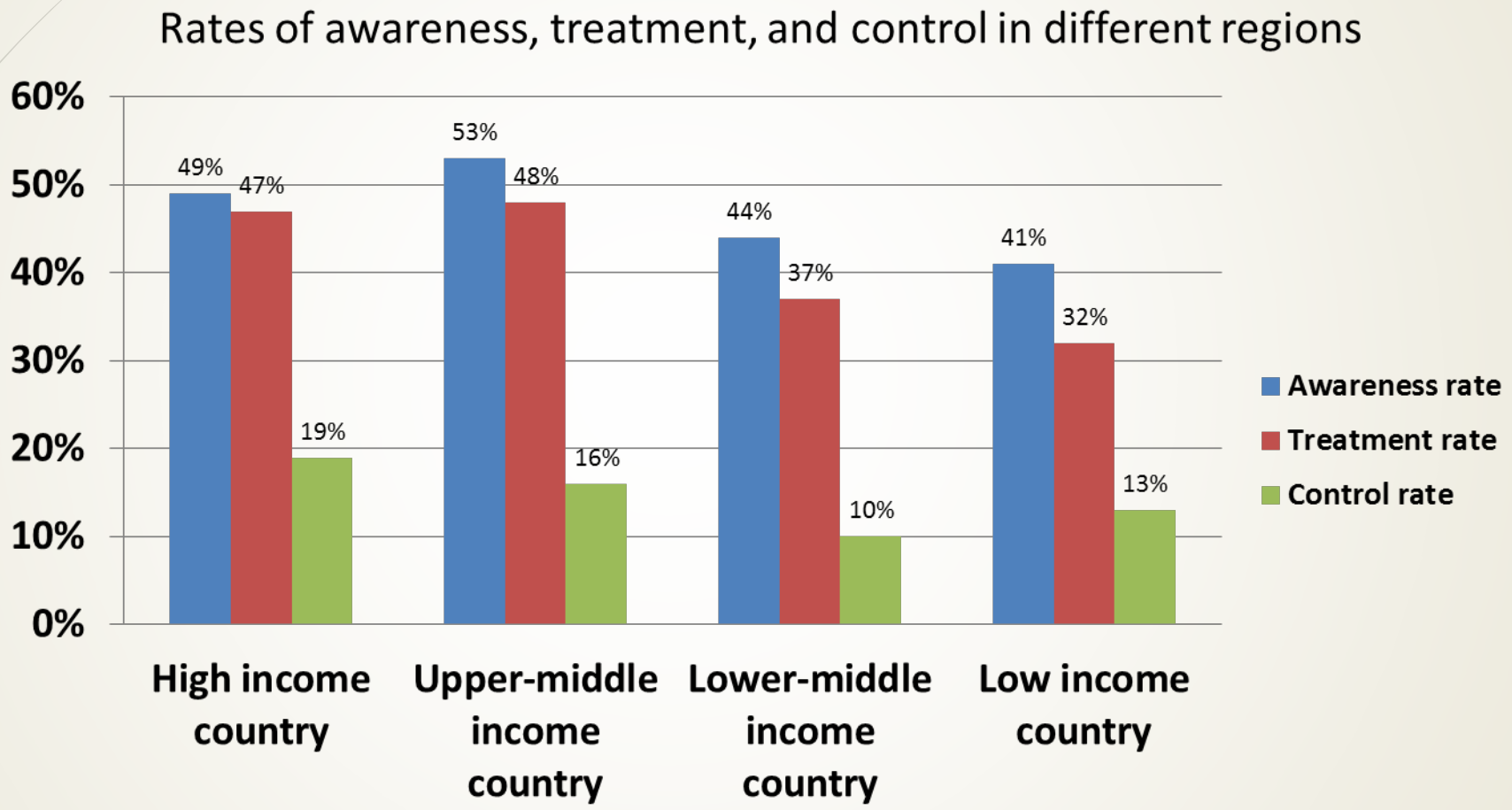
Developed by: 基層醫療概念模式及預防工作常規專責小組 Task Force on Conceptual Model and Preventive Protocols · 基層醫療工作小組 Working Group on Primary Care · 食物及衞生局 Food and Health Bureau

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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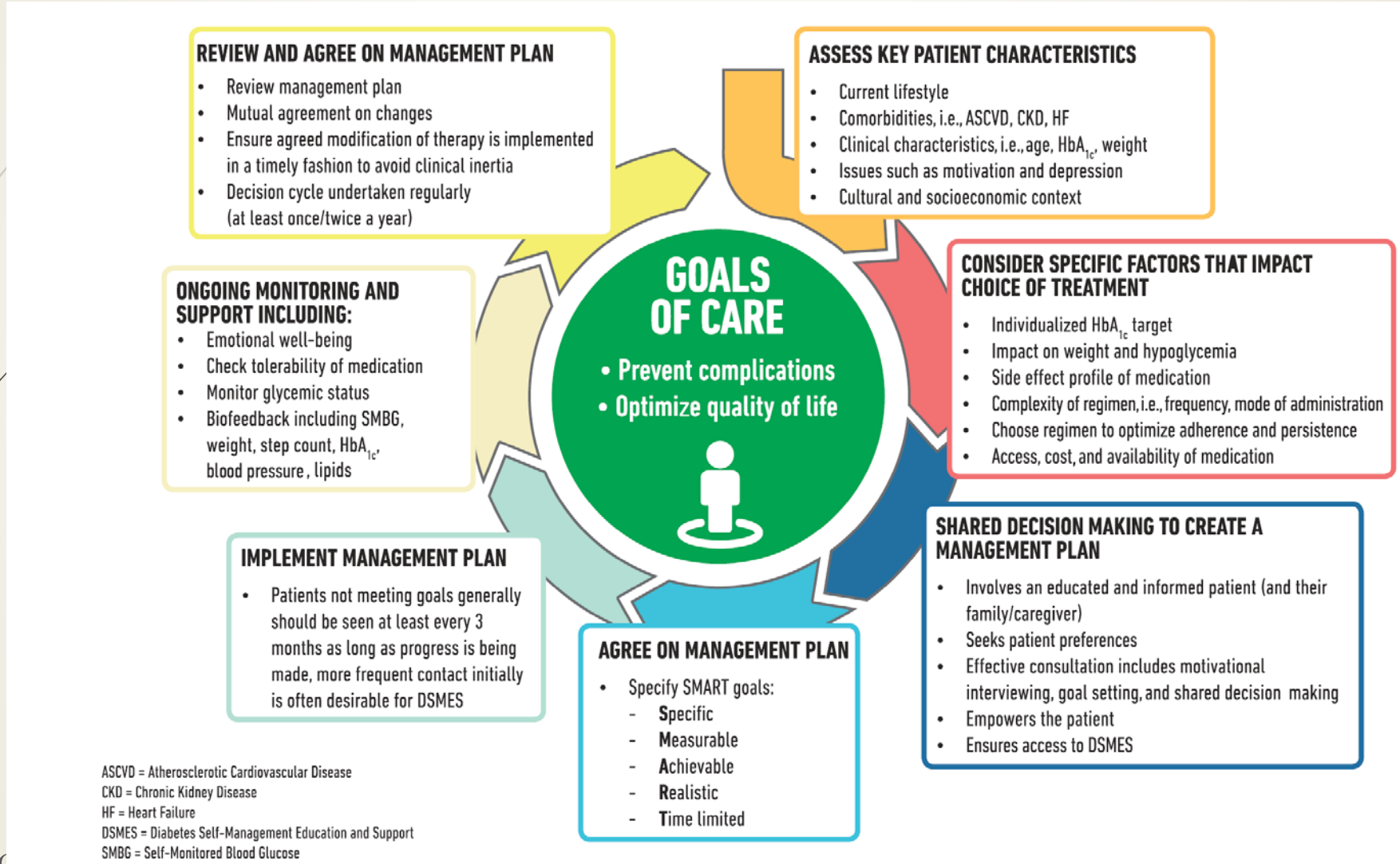
Primary care is the first point of contact in the healthcare system and is easily accessible to the majority of the population. With support and training, primary care practitioners form an invaluable workforce in the community to deliver coordinated care to hypertensive patients, especially those with 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.

POSITION STATEMENT

Standards of Medical Care in Diabetes—2019 Abridged for Primary Care Providers

American Diabetes Association



ASCVD = Atherosclerotic Cardiovascular Disease
CKD = Chronic Kidney Disease
HF = Heart Failure
DSMES = Diabetes Self-Management Education and Support
SMBG = Self-Monitored Blood Glucose

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.

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

ESC/ESH GUIDELINES

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.

Table 6 Risk modifiers increasing cardiovascular risk estimated by the Systemic COronary Risk Evaluation (SCORE) system[35]

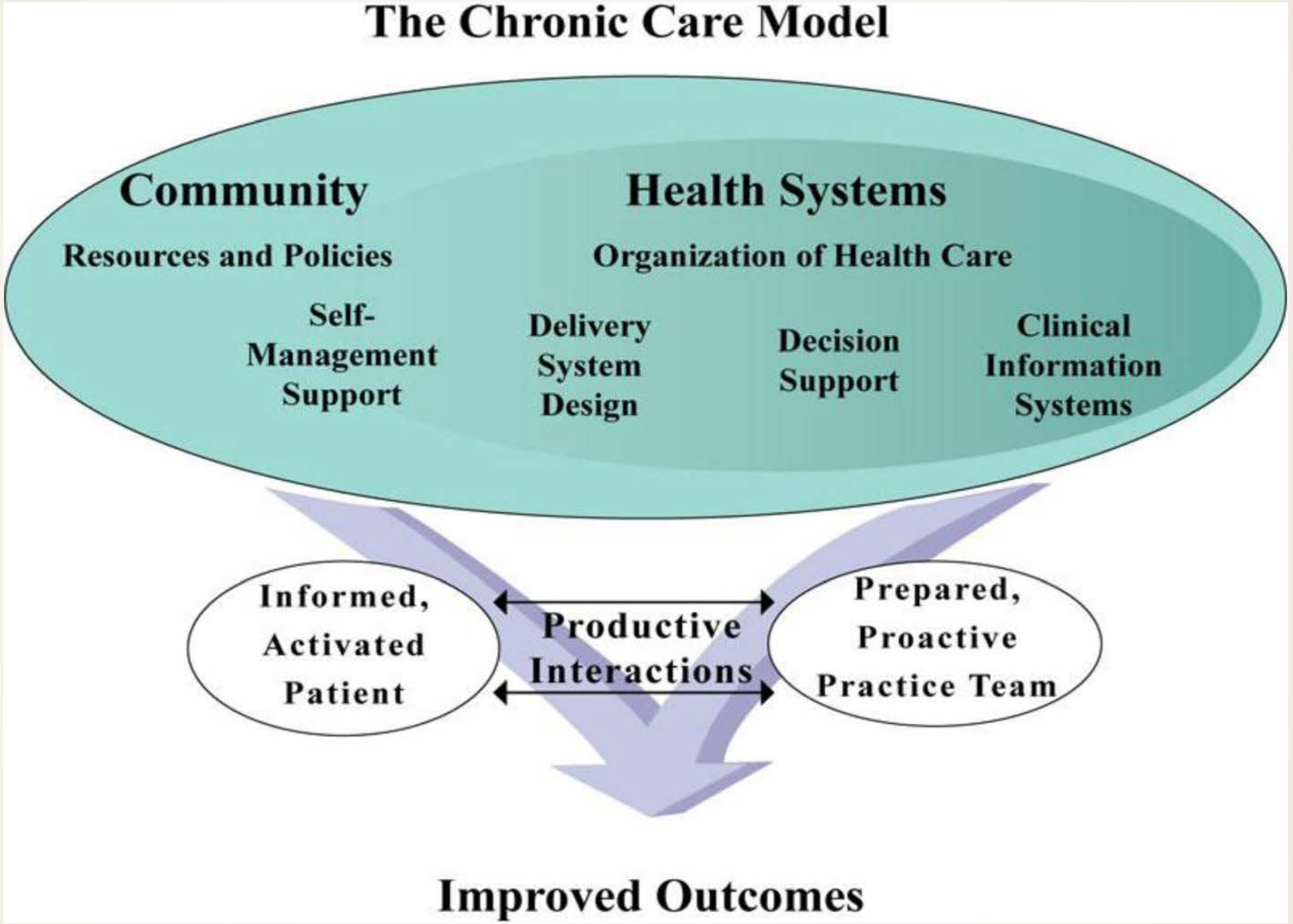
Social deprivation, the origin of many causes of CVD
Obesity (measured by BMI) and central obesity (measured by waist circumference)
Physical inactivity
Psychosocial stress, including vital exhaustion
Family history of premature CVD (occurring at age <55 years in men and <60 years in women)
Autoimmune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

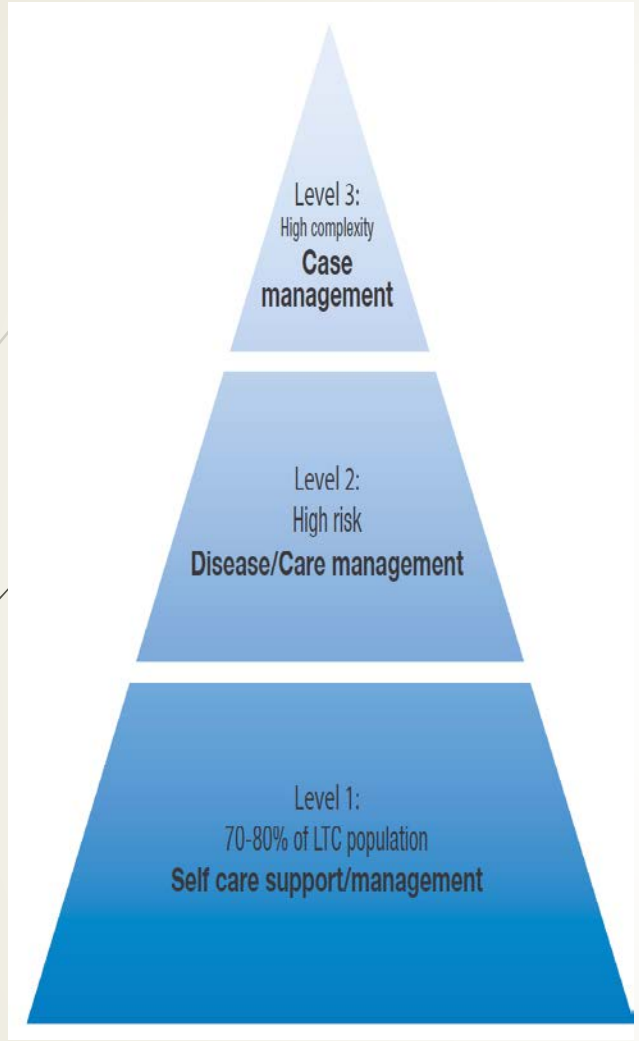
BMI = body mass index; CKD = chronic kidney disease; CVD = cardiovascular disease; LV = left ventricular.

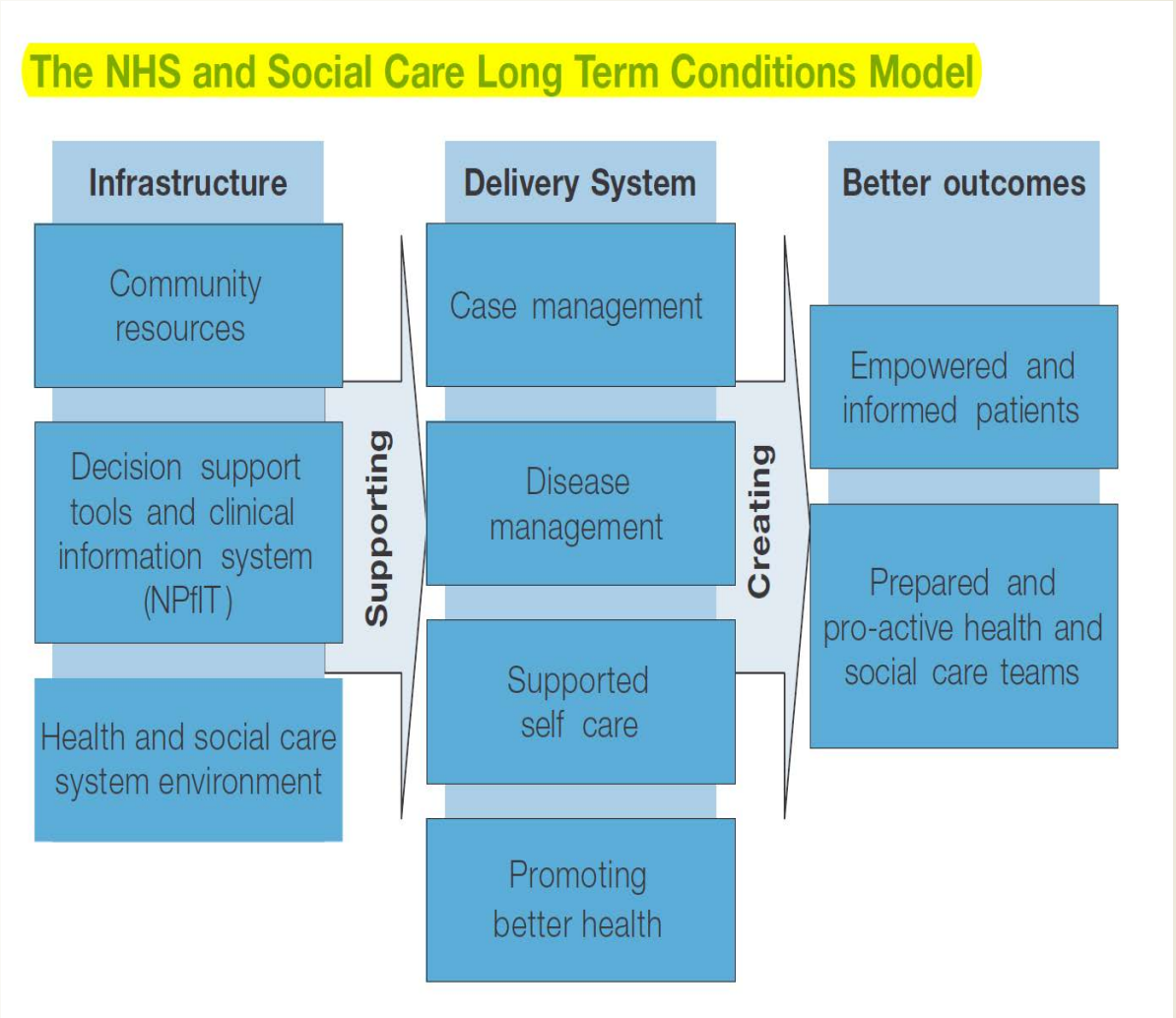
Lifestyle interventions for patients with hypertension or high-normal BP

Recommendations	Class[a]	Level[b]
Salt restriction to <5 g per day is recommended.[248,250,255,258]	I	A
It is recommended to restrict alcohol consumption to: • Less than 14 units per week for men. • Less than 8 units per week for women.[35]	I	A
It is recommended to avoid binge drinking.	III	C
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.[262,265]	I	A
Body-weight control is indicated to avoid obesity (BMI >30 kg/m^2 or waist circumference >102 cm in men and >88 cm in women), as is aiming at healthy BMI (about 20–25 kg/m^2) and waist circumference values (<94 cm in men and <80 cm in women) to reduce BP and CV risk.[262,271,273,290]	I	A
Regular aerobic exercise (e.g. at least 30 min of moderate dynamic exercise on 5–7 days per week) is recommended.[262,278,279]	I	A
Smoking cessation, supportive care, and referral to smoking cessation programs are recommended.[286,288,291]	I	B

BMI = body mass index; BP = blood pressure; CV = cardiovascular.
[a]Class of recommendation.
[b]Level of evidence mostly based on the effect on BP and/or CV risk profile.


The Chronic Care Model
Community
Health Systems
Resources and Policies
Organization of Health Care
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Improved Outcomes


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:

(A) RE-ORGANISING THE PRIMARY HEALTHCARE SYSTEM

(B) ESTABLISHMENT OF DHCS IN ALL DISTRICTS

(C) ENHANCING MEDICAL-SOCIAL COLLABORATION

(D) CONNECTING STAKHOLDERS THROUGH ELECTRONIC PLATFORM

(E) STRENTHENING 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

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)	

Development of the NHM model

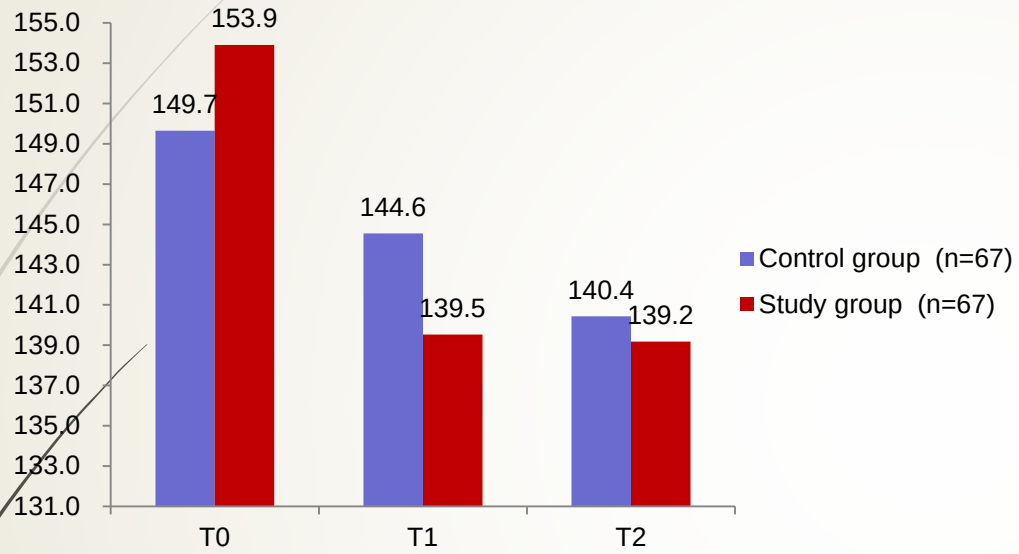
Protocol-based intervention:

- 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 :

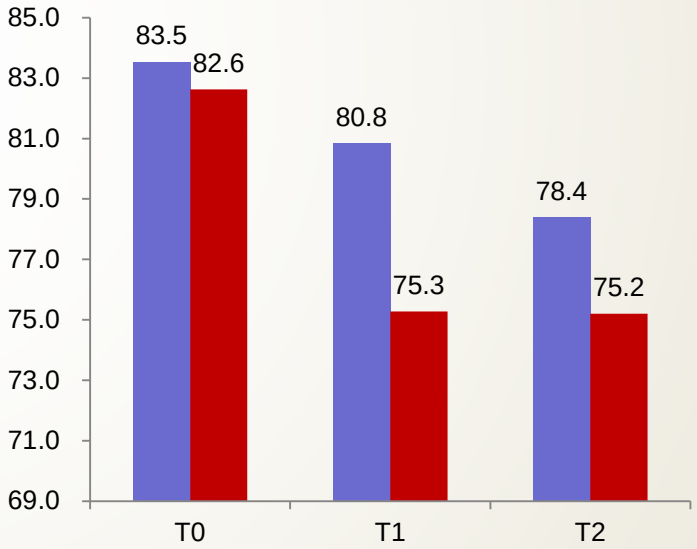
- Literature review
- Guidelines for hypertension management
- Expert consultant
- Pilot study (Zhu et al., 2014)

Results



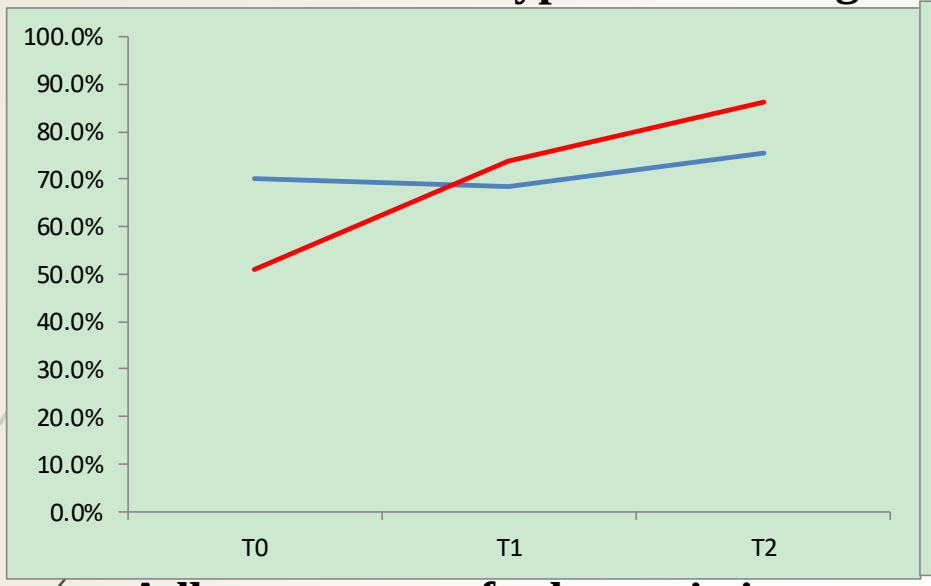
SBP readings in the control group and the study group at three time points

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

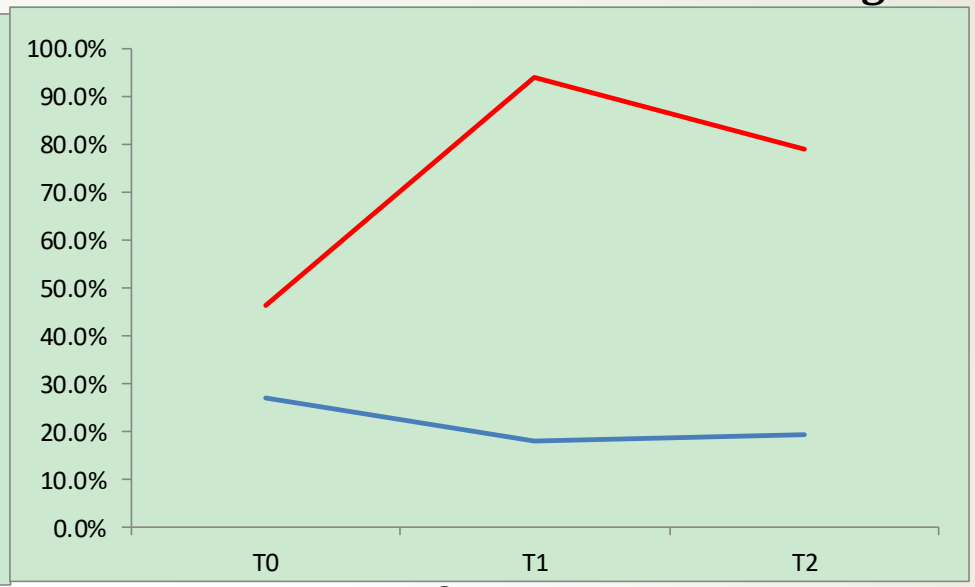


DBP readings in the control group and the study group at three time points

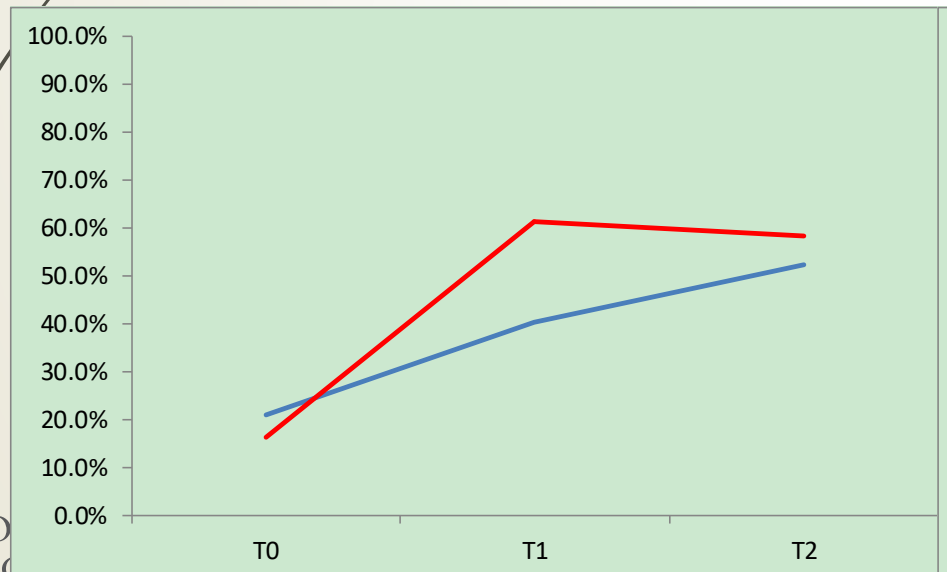
Adherence rate of anti-hypertensive drug



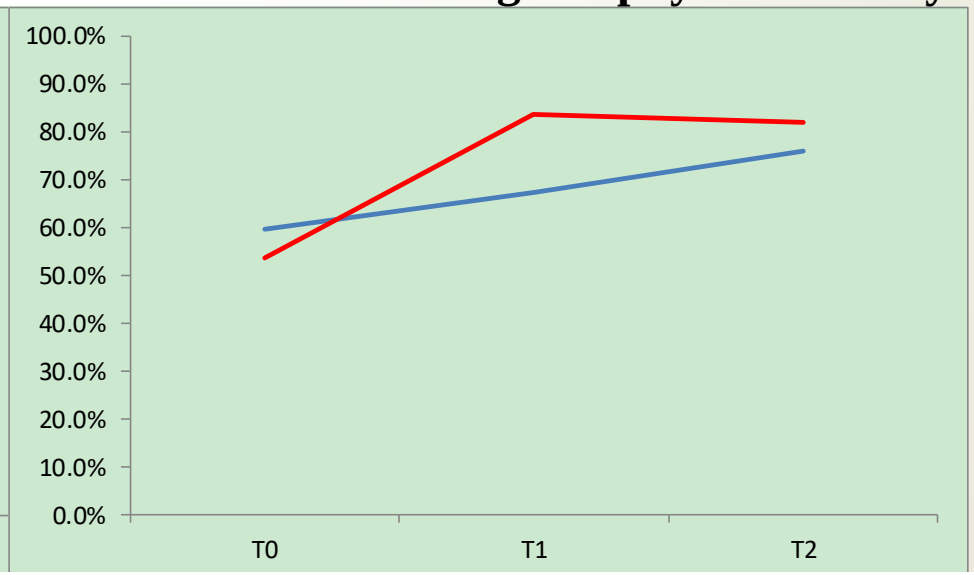
Adherence rate of home BP monitoring



Adherence rate of salt restriction

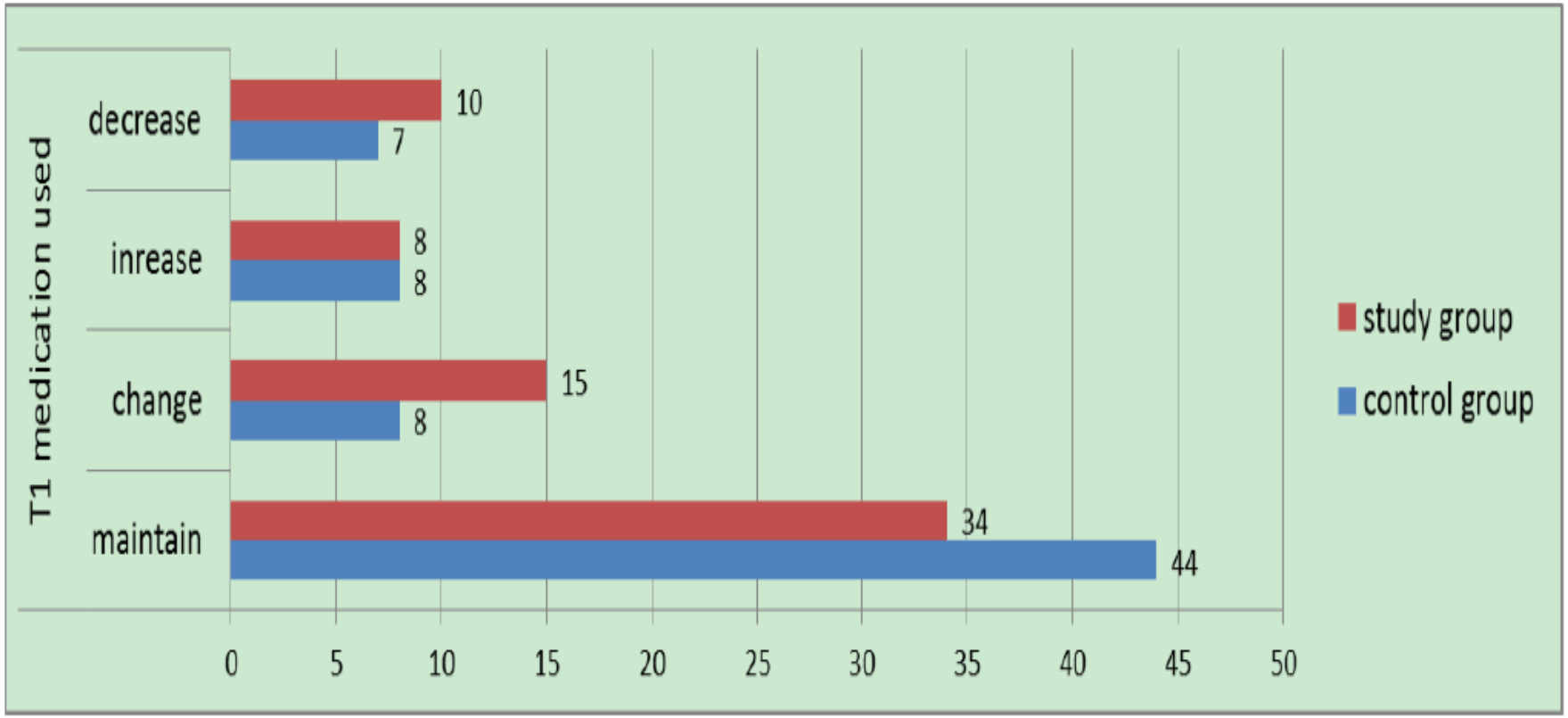


Adherence rate of regular physical activity



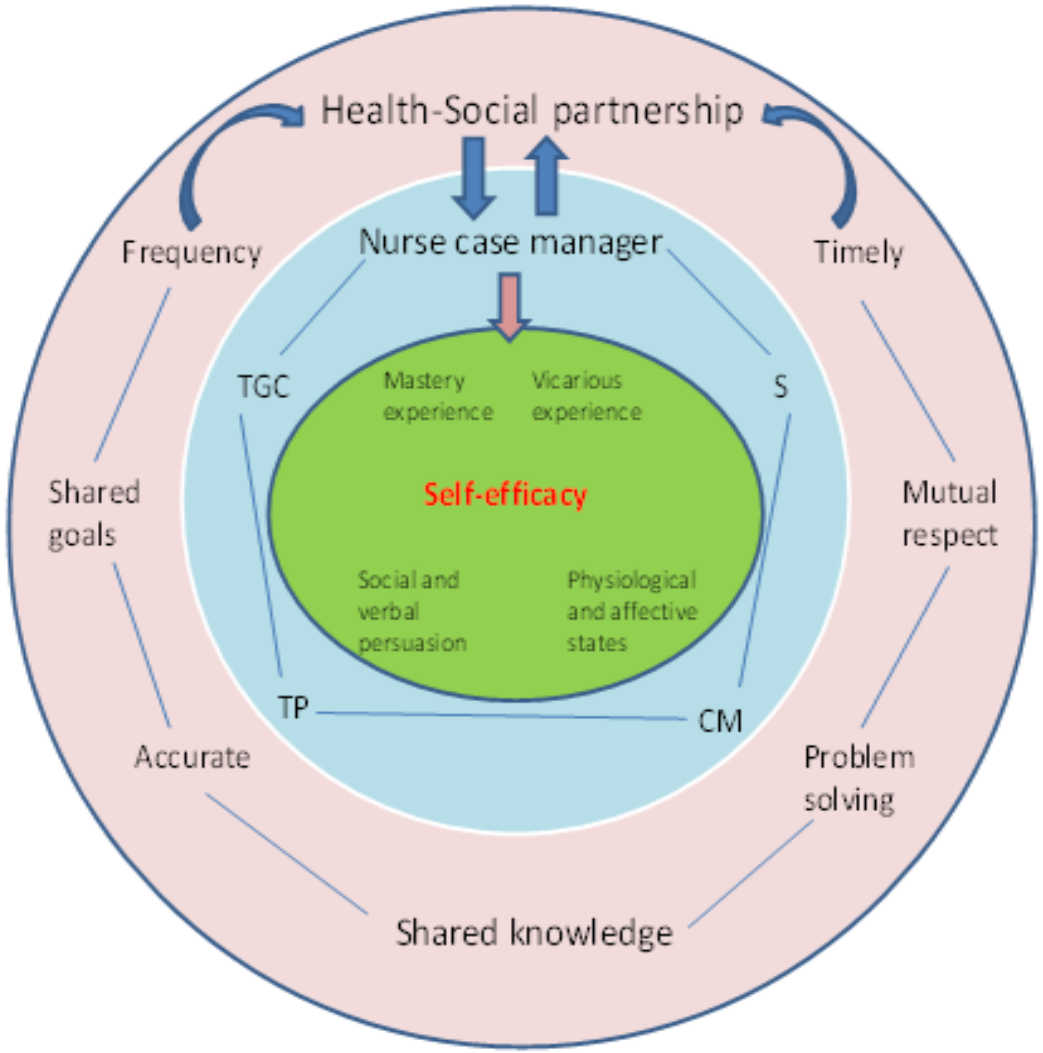
Adherence rate in the two groups at three time points

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



T0 = baseline, T1 = 12 weeks after recruitment

An experience in Hong Kong


Health-Social partnership
Frequency
Nurse case manager
Timely
TGC
Mastery experience
Vicarious experience
S
Shared goals
Self-efficacy
Mutual respect
Social and verbal persuasion
Physiological and affective states
TP
CM
Accurate
Problem solving
Shared knowledge

The Omaha System

Solving the Clinical Data-Information Puzzle

Omaha System

		Problems	Health-focussed	Social-focussed	Health-social Partnership
Environmental	1.	Income		√	
	2.	Sanitation			√
	3.	Residence			√
	4.	Neighborhood/workplace safety		√	
Psychosocial	5.	Communication with community resources		√	
	6.	Social contact		√	
	7.	Role change		√	
	8.	Interpersonal relationship		√	
	9.	Spirituality			√
	10.	Grief		√	
	11.	Mental health			√
	12.	Sexuality			√
	13.	Caretaking/ Parenting			√
	14.	Neglect			√
	15.	Abuse			√
	16.	Growth and development			√
Physiological	17.	Hearing	√		
	18.	Vision	√		
	19.	Speech and language	√		
	20.	Oral health	√		
	21.	Cognition	√		
	22.	Pain	√		
	23.	Consciousness	√		
	24.	Skin	√		
	25.	Neuro-musculo-skeletal function	√		
	26.	Respiration	√		
	27.	Circulation	√		
	28.	Digestion-hydration	√		
	29.	Bowel function	√		
	30.	Urinary function	√		
	31.	Reproductive function	√		
	32.	Communicable/ Infectious condition	√		
Health Related Behaviour	33.	Nutrition			√
	34.	Sleep and rest patterns			√
	35.	Physical activity			√
	36.	Personal care			√
	37.	Substance use			√
	38.	Health care supervision	√		
	39.	Medication regimen	√		

Case 1

A. 個人資料 Demographic data—Personal information

1. 性別: ☐1 男 ☑2 女
2. 年齡: 91
3. 婚姻狀況: ☐1 未婚 ☐2 已婚 ☐3 離婚 ☑4 喪偶
4. 你的最高教育程度是: ☑1 沒正式接受教育 ☐2 小學或以下 ☐3 中學 ☐4 專上學院/ 大學 ☐5 其他 (請註明) _____
5. 職業: ☐1 全職 ☐2 兼職 ☐3 待業 ☑4 退休
6. 你現在的居所是: ☐1 整個單位 ☑2 一房間/ 劏房 ☐3 籠屋 ☐4 其他 (請註明) _____
7. 你的居住狀況: ☑1 獨居 ☐2 兩老雙居 ☐3 與家人同住
8. 你覺得你的經濟狀況如何？ ☐1 足夠有餘 ☑2 剛剛足夠應付日常開支 ☐3 不足夠應付日常開支 ☐4 十分不足夠
9. 你的經濟主要來源是？ ☐1 自己的薪水 ☐2 家人提供 ☐3 個人積蓄 ☐4 退休金/長俸 ☑5 綜合援助 ☐6 高齡津貼 ☐7 傷殘津貼 ($1580/月) ☐8 高傷殘津貼 ($3160/ 月) ☐9 其他 (請註明) _____
10. 有那些人會照顧你? (可選多項) ☑1 自己 ☐2 配偶 ☐3 兄弟姊妹 ☑4 子女 ☐5 媳婦/ 女婿 ☐6 朋友 ☐7 鄰居 ☐8 機構義工 ☐9 傭人 ☐10 其他 (請註明) _____
11. 所得的照顧是（除了自己之外）: ☐1 隨時 ☑2 間中到訪/ 幫助 ☐3 只在晚上 ☐4 沒其他人幫助 ☐5 其他 (請註明) _____

12/9/2016
1 血壓：_146/83_____毫米水銀
2 脉膊：_____93_____/分鐘
3體温：_37.2_____攝氏
4 身高：____1.42_____/ 米
5 體重：___36.7_____/ 千克
6 身高體重指數 (BMI): ___18.2_____
7 血糖：_____12.6 (2 hours post breakfast)_____
8 含氧量: _____97_____% (RA_)

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:	Home care visited client on12/9/2016 morning . H'stix 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		Pulse: 93 beats/min	
SpO_2: 97 % (RA)		RR: 20 breaths/min	
Temp: 36.7 °C		GCS: 15 /15	
ADL	Independent		
Principal Problem: Spot H'stix 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[redacted]_____

Research code：_0126_____ **OMAHA System for case management (NF-OS2)** Date of home visit: _12/9/16 , 29/11/16____

Date of telephone follow-up: _19/9/16 , _4/11/16_____

Problem classification									Intervention		Problem rating for Outcome			
DOMAIN	Problems or Concepts	Actual problem (Briefly describe the patient's needs & strength)	Modifiers		Problem rating									
			Health promotion Actual or Potential	Individual; family; or community	DATE	Knowledge (1 – 5)	Behavior (1 – 5)	Status (1 – 5)	Categories 1. Teaching, guidance, & counseling 2. Treatments & procedure 3. Case management 4. Surveillance	Target(s) & Client-specific information	DATE	Knowledge (1 – 5)	Behavior (1 – 5)	Status (1 – 5)
ehavior	33. Nutrition	Hyperglyceamia , H'stix 12.6 mmol/L (2 hours post breakfast on 12/9/16) No history of DM in the past	Actual	Individual	12 /9/ 16	2	3	3	1,2,3,4 Client had attended 西九龍 GOPD on 9/10/2016 Fasting blood has taken on 10/10/2016 with normal finding (Fasting blood sugar 5.6)	Advise client to have low sugar diet and low salt diet Refer social worker to follow (refer GOPD for DR consultation by MSW)	29 /1 1	4	4	4

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香港理工大學

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

29/11/2016

1 血壓：___150/87_____ 毫米水銀

2 脉膊：_102_____/分鐘

3體温：__36.9_____攝氏

4 身高：___1.42_____/米

5 體重：__37.8_____/千克

6 身高體重指數 (BMI): __18.7_____

7 血糖：7.1 (0.5 hr post meal)_____

8 含氧量: ___95_____%(RA)

Case 2

長者編號: 0580

A. 個人資料 Demographic data—Personal information

1. 性別: ☐1 男 ☑2 女
2. 年齡: 92
3. 婚姻狀況: ☐1 未婚 ☑2 已婚 ☐3 離婚 ☐4 喪偶
4. 你的最高教育程度是: ☑1 沒正式接受教育 ☐2 小學或以下 ☐3 中學 ☐4 專上學院/ 大學 ☐5 其他 (請註明) _____
5. 職業: ☐1 全職 ☐2 兼職 ☐3 待業 ☑4 退休
6. 你現在的居所是: ☑1 整個單位 ☐2 一房間/ 劏房 ☐3 籠屋 ☐4 其他 (請註明) _____
7. 你的居住狀況: ☐1 獨居 ☑2 兩老雙居 ☐3 與家人同住
8. 你覺得你的經濟狀況如何？ ☑1 足夠有餘 ☐2 剛剛足夠應付日常開支 ☐3 不足夠應付日常開支 ☐4 十分不足夠
9. 你的經濟主要來源是？ ☐1 自己的薪水 ☐2 家人提供 ☐3 個人積蓄 ☐4 退休金/長俸 ☐5 綜合援助 ☑6 高齡津貼 ☐7 傷殘津貼 ($1580/月) ☐8 高傷殘津貼 ($3160/ 月) ☐9 其他 (請註明) _____
10. 有那些人會照顧你? (可選多項) ☐1 自己 ☑2 配偶 ☐3 兄弟姊妹 ☐4 子女 ☐5 媳婦/ 女婿 ☐6 朋友 ☐7 鄰居 ☐8 機構義工 ☐9 傭人 ☐10 其他 (請註明) _____
11. 所得的照顧是（除了自己之外）: ☑1 隨時 ☐2 間中到訪/ 幫助 ☐3 只在晚上 ☐4 沒其他人幫助 ☐5 其他 (請註明) _____

老人抑鬱短量表 Geriatric Depression Scale short-form / GDS short-form

以下的問題是人們對一些事物的感受，答案沒有對與不對。在過去一星期內，你是否曾有以下的感受。如有的話，請 ✓「是」，若無的話，請 ✓「否」。

問題	是	否
1. 你基本上對自己的生活感到滿意嗎?		1
2. 你是否已放棄了很多以往的活動和嗜好?	1	
3. 你是否覺得生活空虛?	1	
4. 你是否常常感到煩悶?	1	
5. 你是否很多時感到心情愉快呢?		1
6. 你是否害怕將會有不好的事情發生在你身上呢?	1	
7. 你是否大部份時間感到快樂呢?		1
8. 你是否常常感到無助?	1	
9. 你是否寧願留在院舍/屋企裡，而不出外做些有新意的事情?	1	
10.你是否覺得你比大多數人有多些記憶的問題呢?	1	
11.你認為現在活著是一件好事嗎?		1
12.你是否覺得自己現在一無是處呢?	1	
13.你是否感到精力充足?		1
14.你是否覺得自己的處境無望?	1	
15.你覺得大部份人的境況比自己好嗎?	1	
總分		13

Wong M.T.P., Ho T.P., Ho M.Y., Yu C.S., Wong Y.H., Lee S.Y. (2008) Development and inter-rater reliability of a standardized verbal instruction manual for the Chinese Geriatric Depression Scale—Short form. *International Journal of Geriatric Psychiatry* **17**, 459-463.

Social Care Referral Form

To: 長者鄰舍中心 (祖堯村)

Cc :

Name of Referee: _____

Age: 92

Gender: Female

Marital Status: Married

Education level: Primary

Telephone number: _2 _____

Home Address: 祖堯村 ;樓 室

_____

Type of accommodation: Room

Financial Support: HDA 和長者生活津貼

Name of carer: _ _____ Relationship with referee: _Husband _____

Contact Number: __ 2 _____

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 厭世 feeling on and off with No concrete suicidal plan.

Carer stress (Husband felt stress in taking care of client). 兩老相依為命, 無子女 , No brother and sister in HK

Poor social support

Psychological counseling	Home care support	Community resources
☐ Undesirable habits (Anti-social behavior/ Heavy smoking/ Alcoholism/ Drug addiction/ Gambling/ Others: _____*)	☐ Poor living environment and hygiene	☐ Family support and social support
	✓ : Daily living assistance and caring arrangements	☐ Lack of community services information
☐ Violent/ Aggressive behavior		

✓ : Depression (GDS ≧ 8)

☐ Suicidal tendency

Referring Person: __ ; Yuen _____ Position: _Registered nurse _____

Contact number: _97 _____

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 arkers.wong@polyu.edu.hk

Medical consultant referral form

To: 下葵涌 GOPD

Cc:

Part A: Personal Information	
Date: 8/8/2017	Time: 1600
Name:	
Gender : Female	
Age: 92	
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	
SpO_2: 98 % (RA)		RR: 20 breaths/min	
Temp: 36.7 ^{o}C		GCS: 15 /15	
ADL	Walk		
Principal Problem: Hearing deficit of both ears.			
Medical history: H/T , Depression			
Previous medications:			
Allergies:			

Referring Person: Yuen [redacted] Position: Registered Nurse

Contact number: [redacted]

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. When possible, ask subject to use both arms when reaching to avoid rotation of the trunk.)

( ) 4 can reach forward confidently 25 cm (10 inches)
( ) 3 can reach forward 12 cm (5 inches)
( ) 2 can reach forward 5 cm (2 inches)
(✓) 1 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.

( ) 4 able to stand 10 seconds safely
(✓) 3 able to stand 10 seconds with supervision
( ) 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.)

( ) 4 able to place foot tandem independently and hold 30 seconds
( ) 3 able to place foot ahead independently and hold 30 seconds
( ) 2 able to take small step independently and hold 30 seconds
( ) 1 needs help to step but can hold 15 seconds
(✓) 0 loses balance while stepping or standing

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
(✓) 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
( ) 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
(✓) 0 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.

( ) 4 able to lift leg independently and hold > 10 seconds
( ) 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.
(✓) 0 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

(9) **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:

1. Rehabilitation Measures Database. Short Form Berg Balance Scale 3 Point. Available at: http://www.rehabmeasures.org/Lists/RehabMeasures/DispForm.aspx?ID=1106 Accessed February 27, 2016.
2. Chou, CY, et al. Developing a short form of the Berg Balance Scale for people with stroke. (2006). Phys Ther. 86:195-204.
3. Physiopedia. Berg Balance Scale. Available at http://www.physio-pedia.com/Berg_Balance_Scale Accessed February 27, 2016.

個案護士評估病人藥物管理表

Medication Management NCM Assessment Form

Note: * If answered 不知道 or 不瞭解 NCM need to make additional telephone calls to follow-up.

評估事項	情況	
1. 知道定時、定量服用所處方的藥物*	☑1 知道	☐0 不知道
2. 需要別人預先準備需用藥物及分量	☑1 需要	☐0 不需要
3. 藥物儲存地方環境	☐1 清潔、乾燥	☑0 存放不當
4. 藥物標籤	☐1 清楚	☑0 不清楚
5. 藥物包裝（例如：包裝完好，開口緊閉）	☐1 是	☑0 不妥當
6. 不同的藥物分別裝在不同的藥袋或藥盒中	☑1 有	☐0 沒有
7. 儲存 a) 過期藥物	☑a1) 有	☐a0) 沒有
儲存 b) 不知藥名藥物	☐b1) 有	☑b0) 沒有
8. 知道如何處理服藥後可能出現的不適（例如：頭暈）	☐1 知道	☑0 不知道
9. 瞭解藥物使用方法（例如：口服或吸入等）*	☑1 瞭解	☐0 不瞭解
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	☐1 知道	☑0 不知道
11. 藥物分量足夠下次複診前服用	☑1 足夠	☐0 不足夠
12. 服用醫生處方藥物以外成藥	☐1 有	☑0 沒有

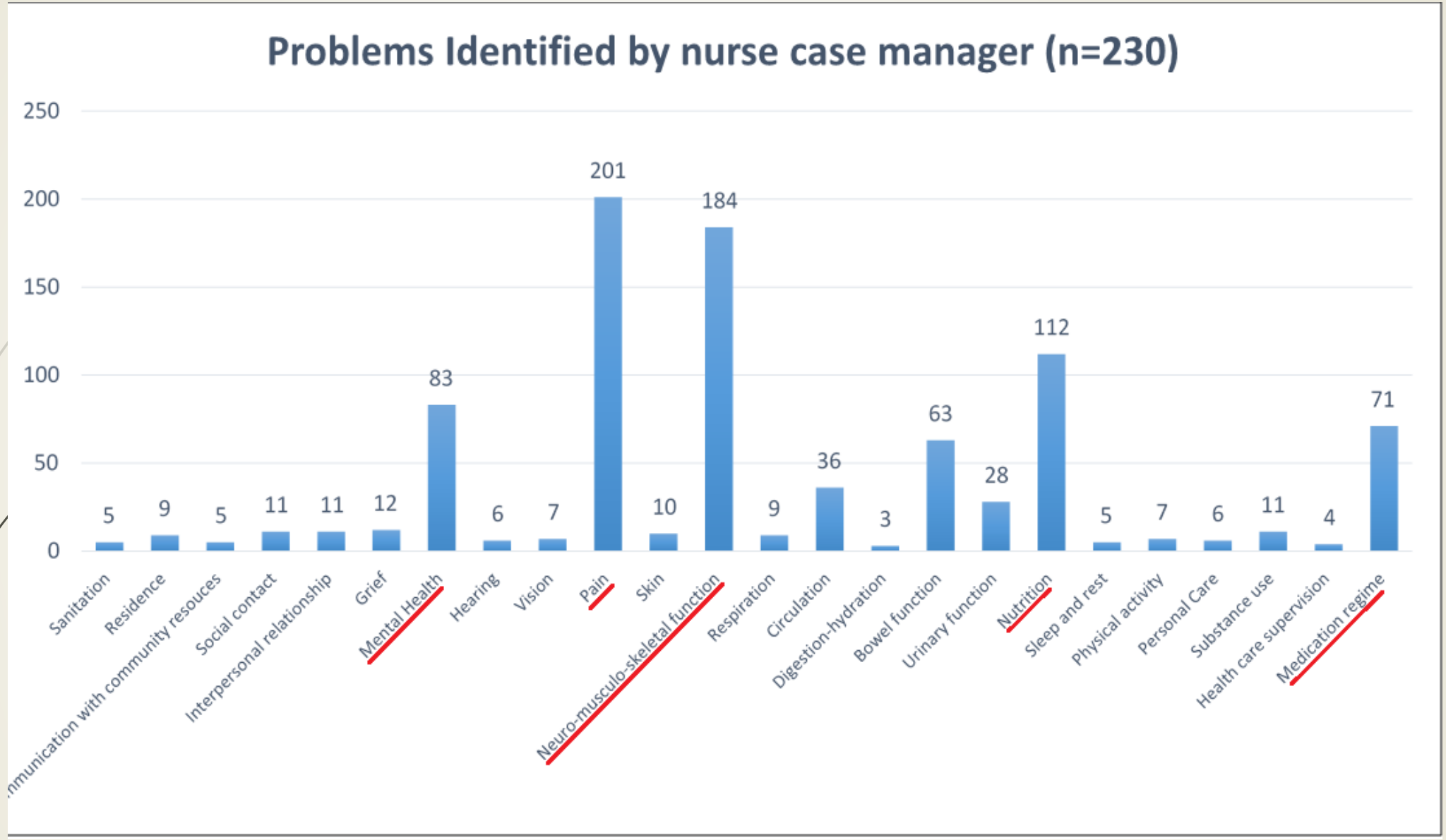
Research code : __0276_____ **OMAHA System for case management (NF-OS2** Date of home visit: _10/1/17,27/3/17_____
Date of telephone follow-up: 18/1/17_,3/3/2017_____

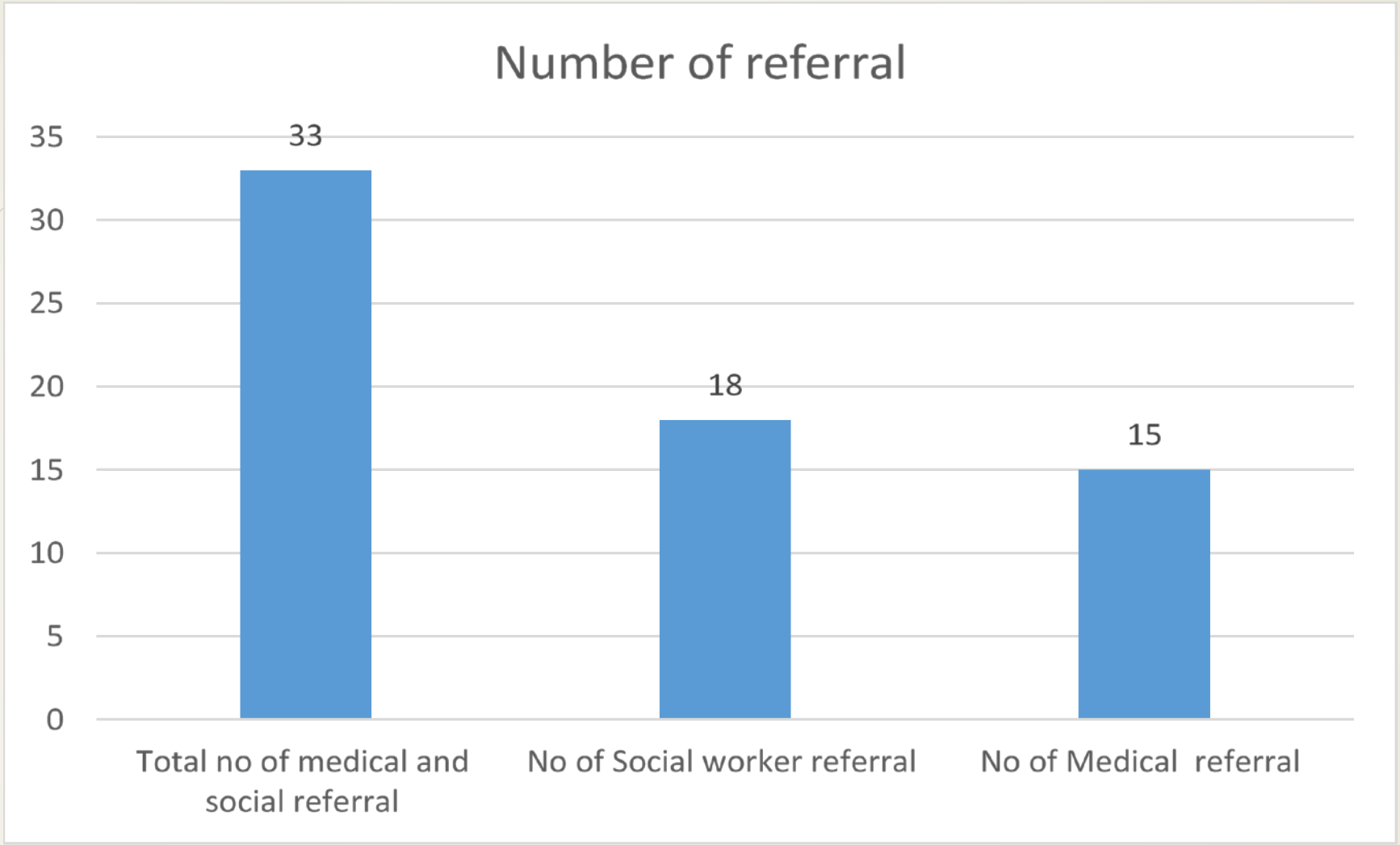
Problem classification									Intervention		Problem rating for Outcome			
DOMAIN	Problems or Concepts	Actual problem (Briefly describe the patient's needs & strength)	Modifiers		Problem rating				Categories 1. Teaching, guidance, & counseling 2. Treatments & procedure 3. Case management 4. Surveillance	Target(s) & Client-specific information	DATE	Knowledge (1 – 5)	Behavior (1 – 5)	Status (1 – 5)
			Health promotion Actual or Potential	Individual; family; or community	DATE	Knowledge (1 – 5)	Behavior (1 – 5)	Status (1 – 5)						
Environmental	1. Income													
	2. Sanitation													
	3. Residence													
	4. Neighborhood/work place safety													
Psychosocial	5. Communication with community resources													
	6. Social contact													

THE HONG KONG POLYTECHNIC UNIVERSITY
香港理工大學

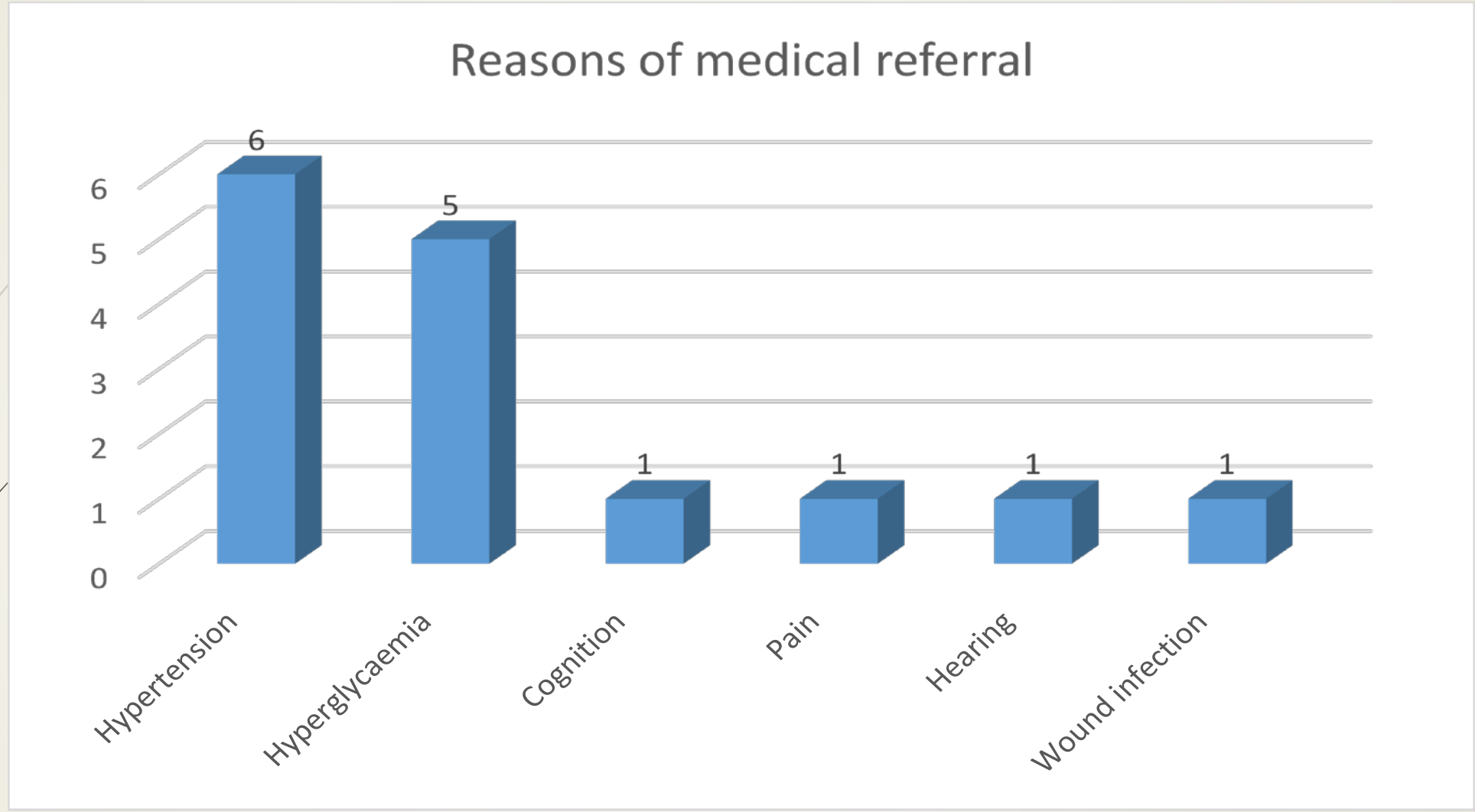
The Hong Kong Academy of Nursing
香港護理專科學院

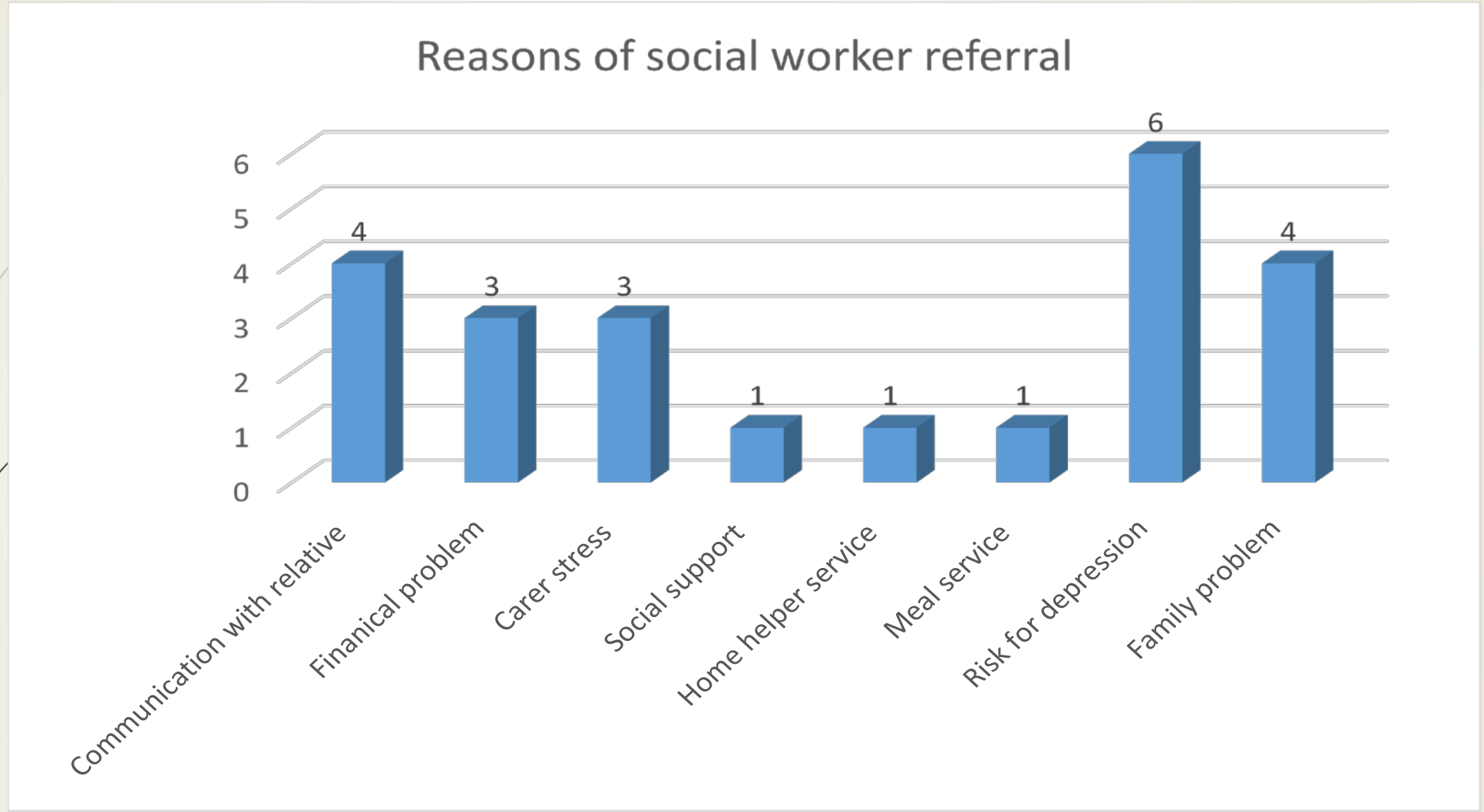
Problem classification									Intervention		Problem rating for Outcome			
DOMAIN	Problems or Concepts	Actual problem (Briefly describe the patient's needs & strength)	Modifiers: Health promotion Actual or Potential	Modifiers: Individual; family; or community	Problem rating: DATE	Problem rating: Knowledge (1 – 5)	Problem rating: Behavior (1 – 5)	Problem rating: Status (1 – 5)	Categories 1. Teaching, guidance, & counseling 2. Treatments & procedure 3. Case management 4. Surveillance	Target(s) & Client-specific information	DATE	Knowledge (1 – 5)	Behavior (1 – 5)	Status (1 – 5)
Physiological	17. Hearing													
	18. Vision													
	19. Speech and language													
	20. Oral health													
	21. Cognition													
Health related behavior	33. Nutrition	Overweight – BMI 27.49	Actual	Individual	10 /1	2	2	3	1,3,4	Advice to do regular exercise with well balanced diet	27 /3	5	4	4
	34. Sleep and rest patterns													
	35. Physical activity													
	36. Personal care													


Problems Identified by nurse case manager (n=230)
250
200
150
100
50
0
5
9
5
11
11
12
83
6
7
201
10
184
9
36
3
63
28
112
5
7
6
11
4
71
Sanitation
Residence
nmunication with community resouces
Social contact
Interpersonal relationship
Grief
Mental Health
Hearing
Vision
Pain
Skin
Neuro-musculo-skeletal function
Respiration
Circulation
Digestion-hydration
Bowel function
Urinary function
Nutrition
Sleep and rest
Physical activity
Personal Care
Substance use
Health care supervision
Medication regime



Referral rate 14.3%


Reasons of medical referral
6
5
1
1
1
1
0
1
2
3
4
5
6
Hypertension
Hyperglycaemia
Cognition
Pain
Hearing
Wound infection


Reasons of social worker referral
6
5
4
3
2
1
0
4
3
3
1
1
1
6
4
Communication with relative
Finanical problem
Carer stress
Social support
Home helper service
Meal service
Risk for depression
Family problem

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;

(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;
- (iv) identify & eliminate barriers to behavioural changes;
- (v) enhance clients' self-management skills;
- (vi) assist clients in setting realistic goal;
- (vii) formulate and implement tailor-made management plan;

(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:

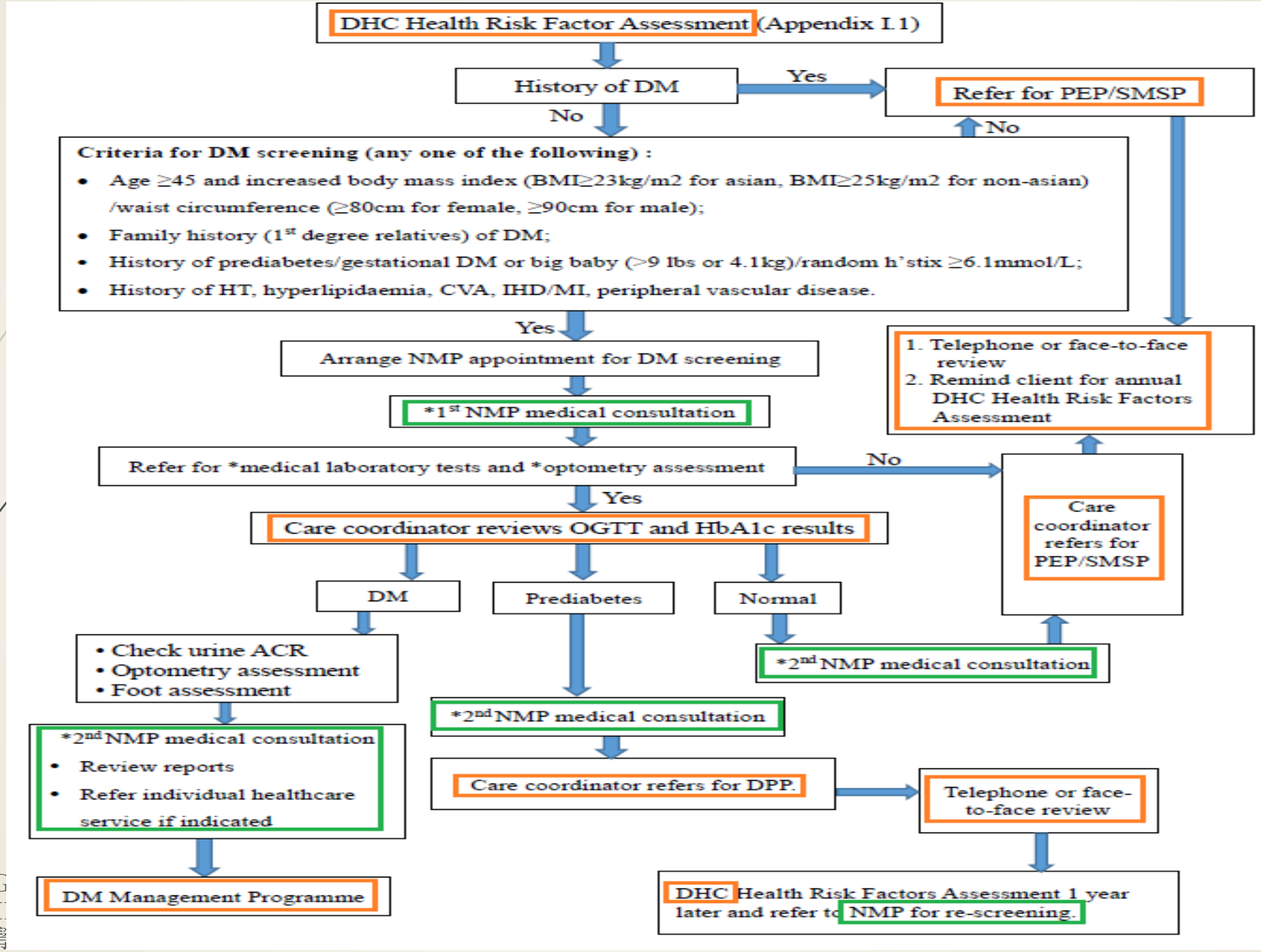
   (a) Promote government initiatives in primary healthcare;

   (b) Strengthen coordination of primary care services;

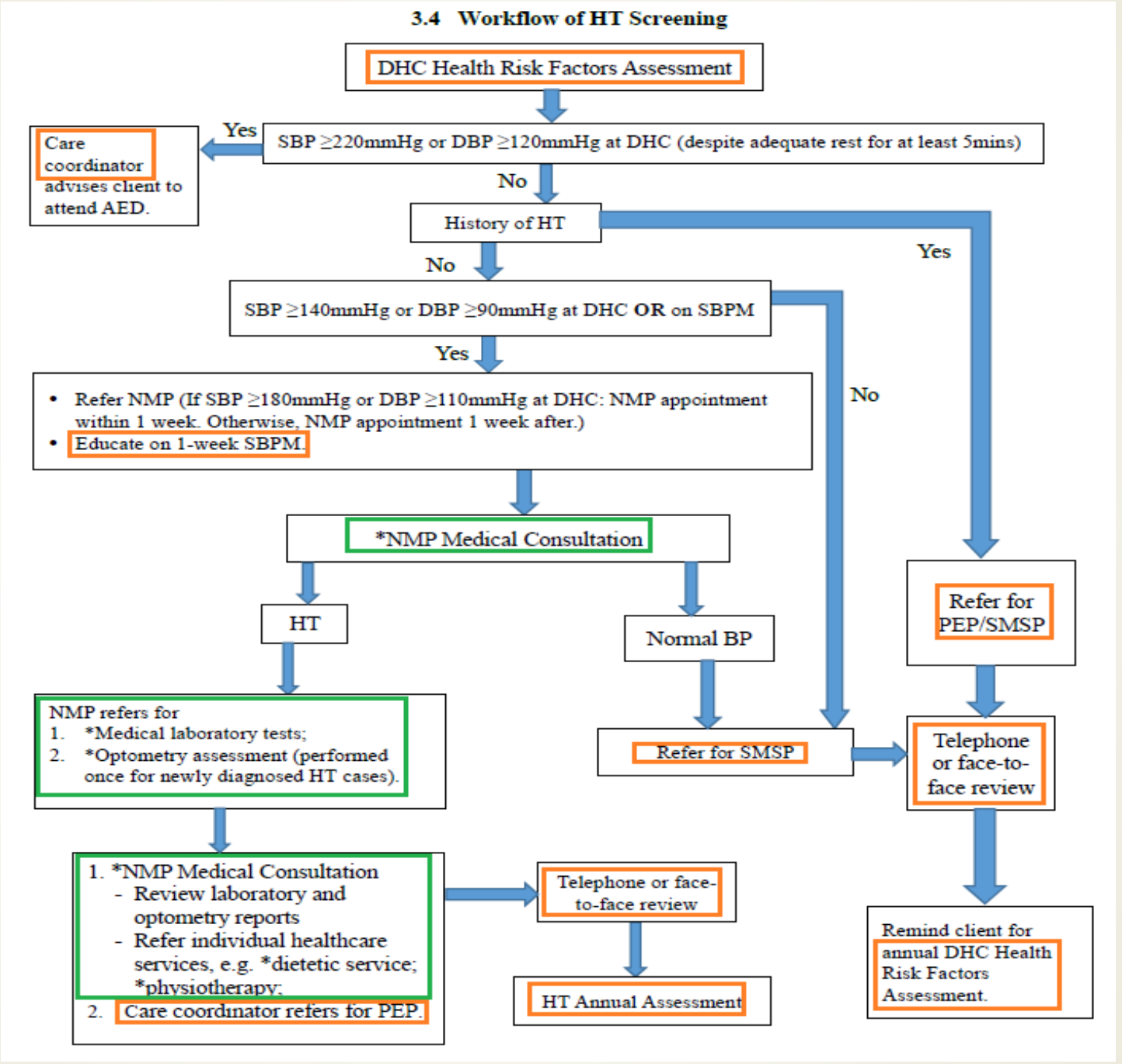
   (c) Promote cross-sector and cross-profession collaboration services;

   (d) Identify and promote technologies which are useful in health management.

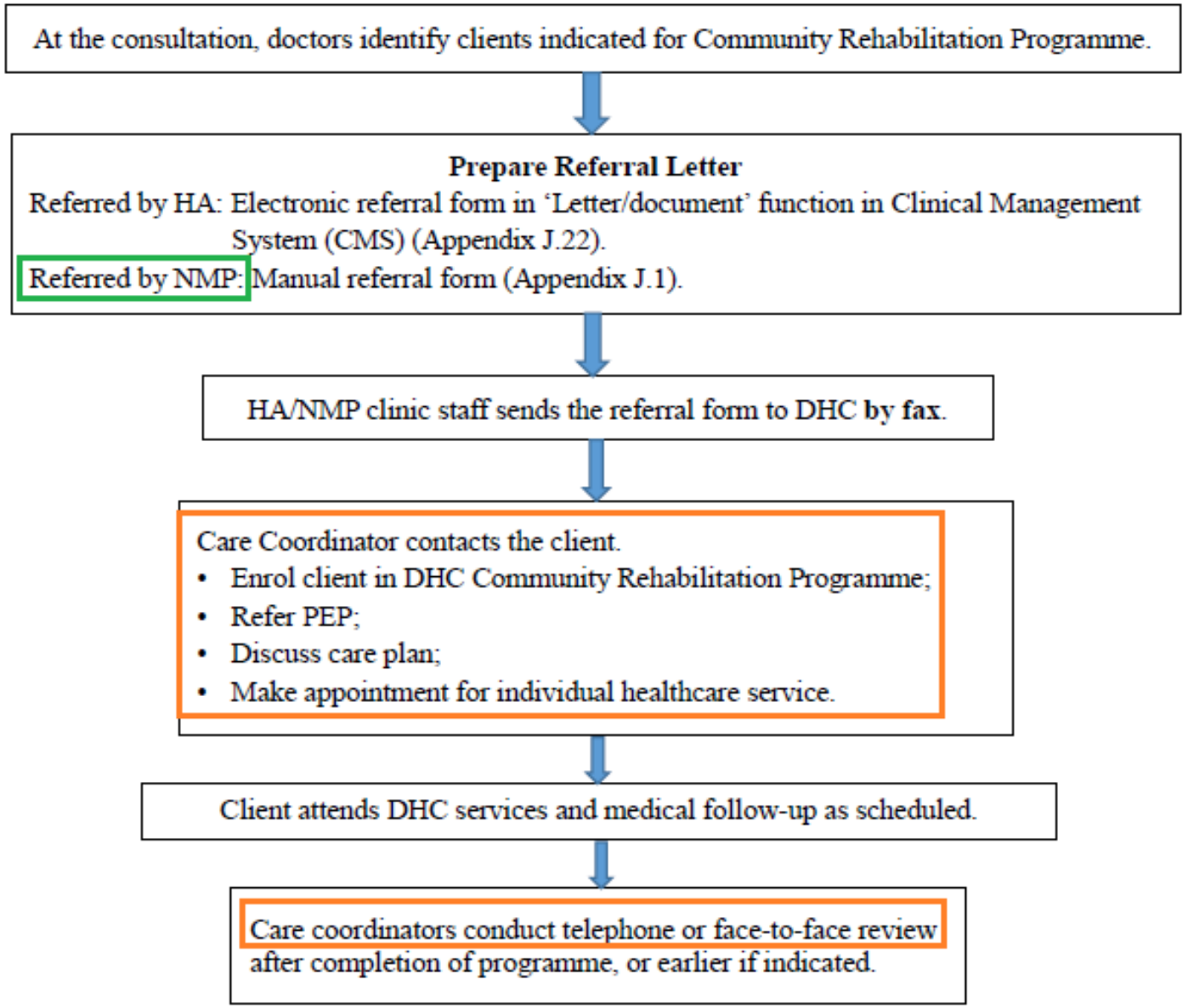
   (e) Engage volunteers e.g. Health Ambassador / Fitness Coach;


DHC Health Risk Factor Assessment (Appendix I.1)
History of DM
Yes
Refer for PEP/SMSP
No
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
1. Telephone or face-to-face review
2. Remind client for annual DHC Health Risk Factors Assessment
Refer for *medical laboratory tests and *optometry assessment
No
Yes
Care coordinator reviews OGTT and HbA1c results
Care coordinator refers for PEP/SMSP
DM
Prediabetes
Normal
• Check urine ACR
• Optometry assessment
• Foot assessment
*2nd NMP medical consultation
*2nd NMP medical consultation
*2nd NMP medical consultation
• Review reports
• Refer individual healthcare service if indicated
*2nd NMP medical consultation
Care coordinator refers for DPP.
Telephone or face-to-face review
DM Management Programme
DHC Health Risk Factors Assessment 1 year later and refer to NMP for re-screening.

3.4 Workflow of HT Screening



7.9 Workflow of Community Rehabilitation Programme



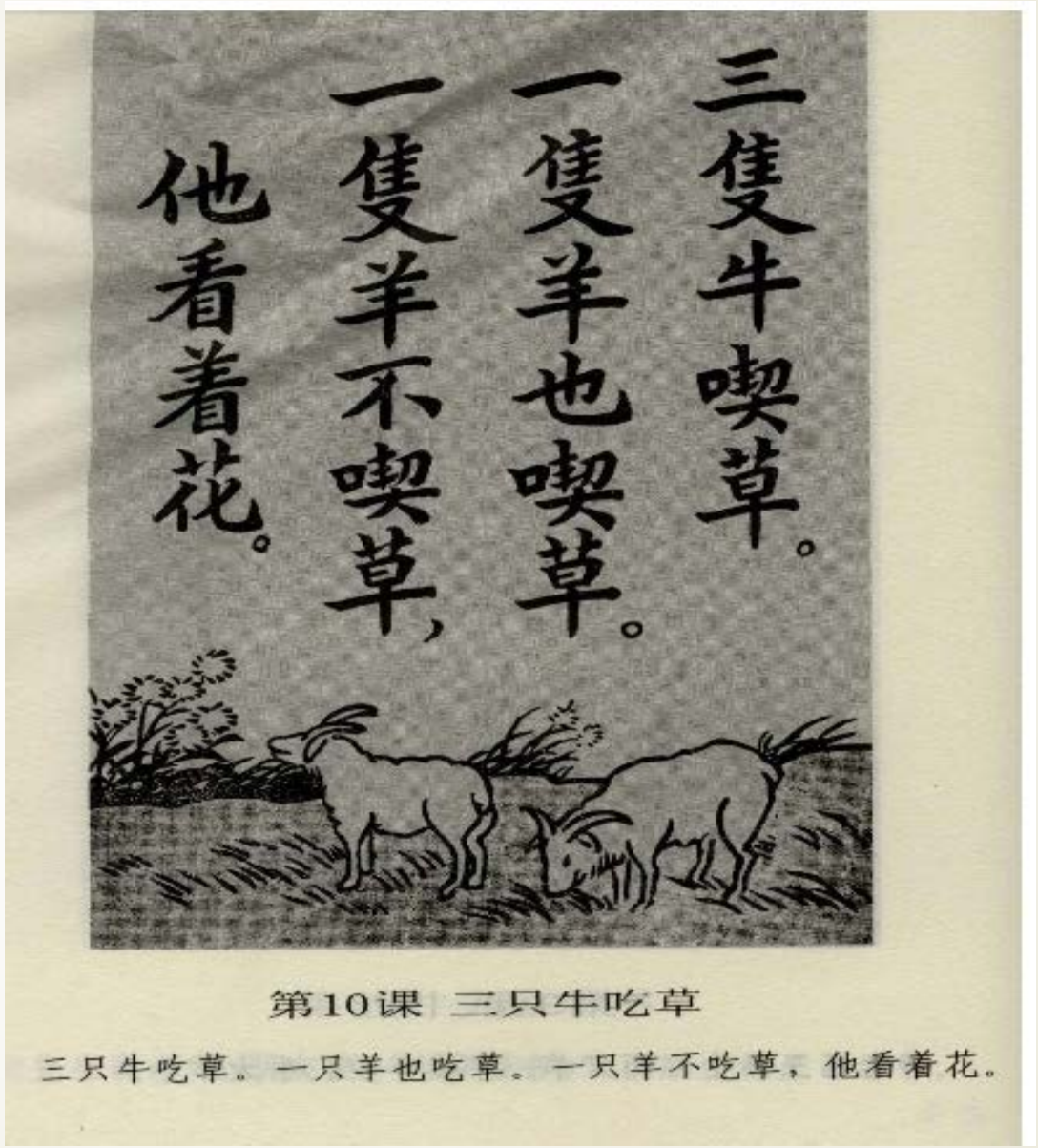
National Information Service
of the General Practice Evaluation Program

Primary Health Care and General Practice:
A scoping report

Box 12: Differences between comprehensive and selective primary health care

	Comprehensive PHC	Selective PHC	Medical Model
View of health	Positive wellbeing	Absence of disease	Absence of disease
Locus of control over health	Communities and individuals	Health professionals	Medical Practitioners
Major focus	Health through equity and community empowerment	Health through medical interventions	Disease eradication through medical interventions
Health care providers	Multi-disciplinary teams	Medical doctors plus other health professionals	Medical doctors
Strategies for health	Multi-sectoral collaboration	Medical interventions	Medical interventions


老课本
小学初级学生用
开明国语课本
上册
叶圣陶 编
丰子恺 绘
上海科学技术文献出版社


三隻牛喫草。
一隻羊也喫草。
一隻羊不喫草，
他看着花。
第10课 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!