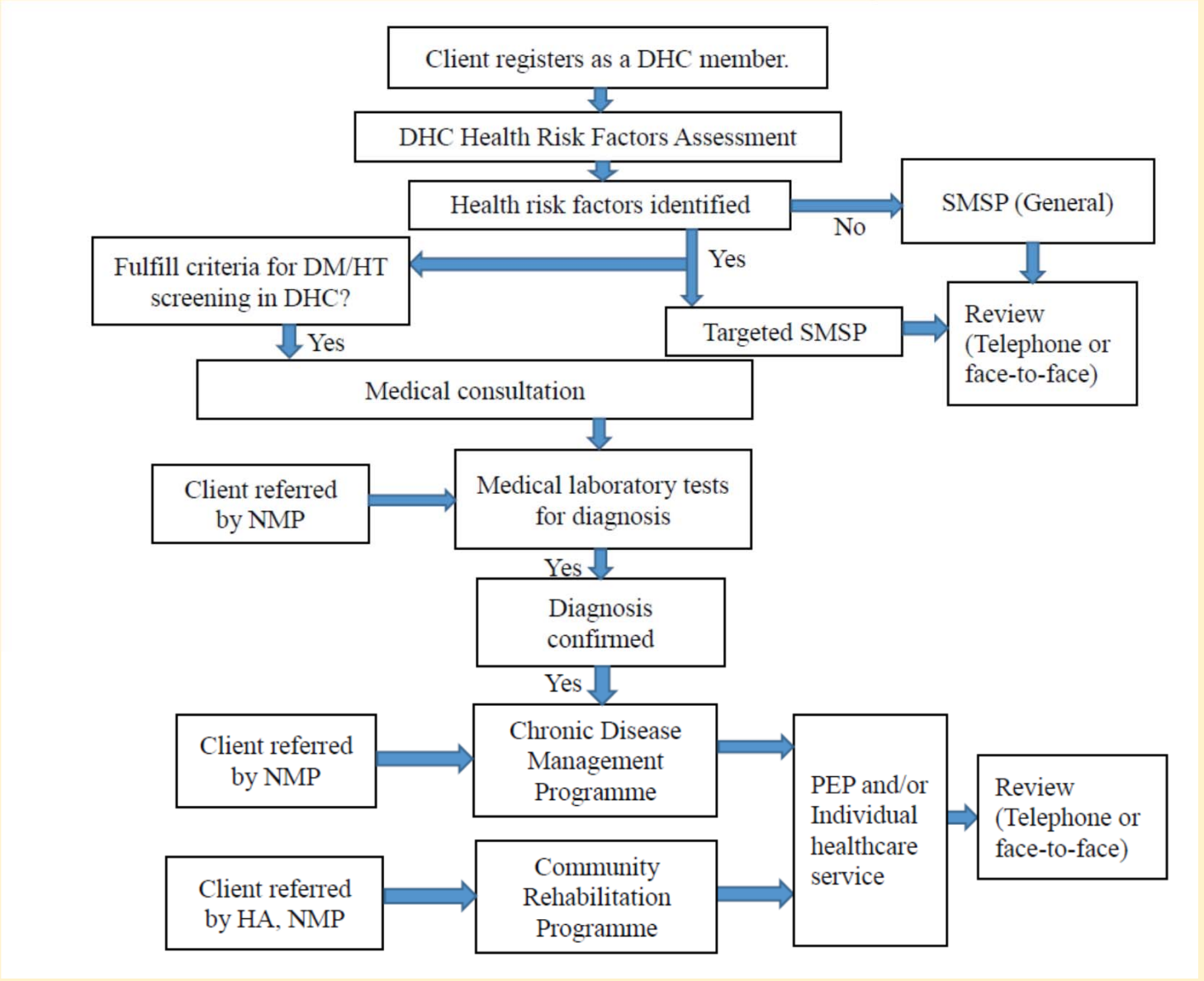
葵青地區康健中心
Kwai Tsing District Health Centre

DHC Service and Client Journey

DHC Induction Course

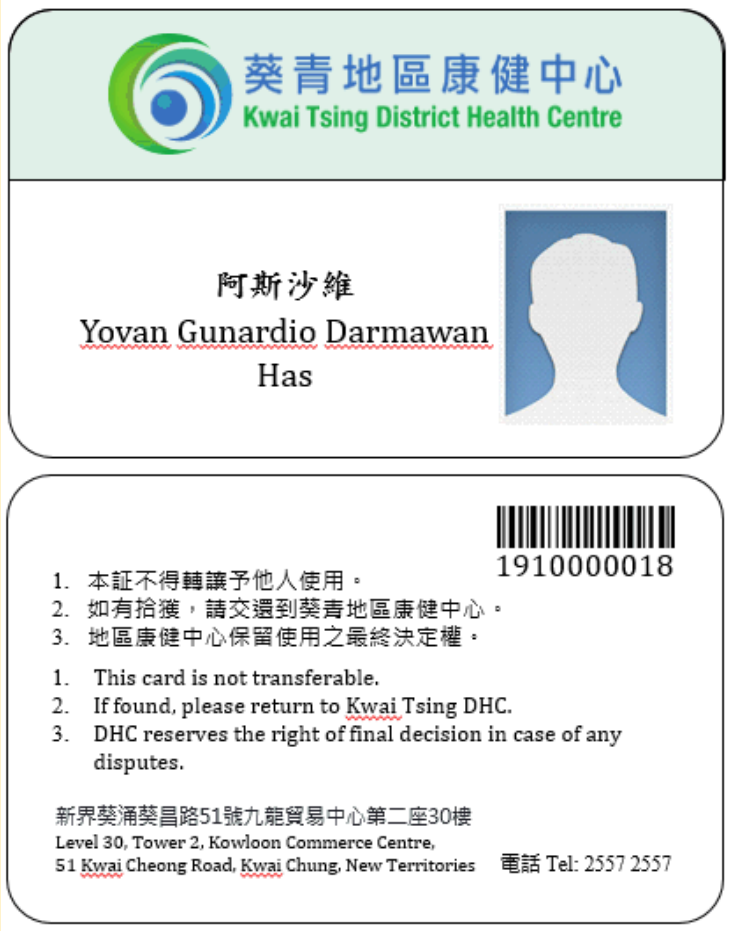
7 September 2019

Overview of Client Journey



DHC Member

- Membership is free and lifelong
- Membership Card



Clinical Documentation

- A comprehensive medical record enables **continuing care**.
- All clinical information related to DHC Scheme
  - recorded in the DHC IT Module
  - uploaded to the eHRSS
  - be accurate, sufficiently detailed, legible, complete and organised
- Facilitates subsidy claim by the NSP
- Documentation **MUST** be made **within 3 days** of service delivery.

1st Consultation – DM Screening

Consultation Details **Quota: 0/2**

Attendance Details		**Payment Details**	**Fee**	**Paid By Patient**	
Consultation Date	24-Sep-2018	Consultation	$300	$50	Change Payment Type
Programme	DM screen/manage				
Consultation Type	DM Screening	Additional Item		$0	Additional Charging
		Total		**$50**	

Assessment | Investigation | Medication

* BP 120 / 90 mmHg * Pulse 76 /min

* BW 90 kg * BH 1.8 m BMI 27.7 kg/m^2

H'stix mmol/L

*Clinical Note

Date & Time of Next Appointment

Save Cancel

1st Consultation – DM Screening

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		Total		**$50**	

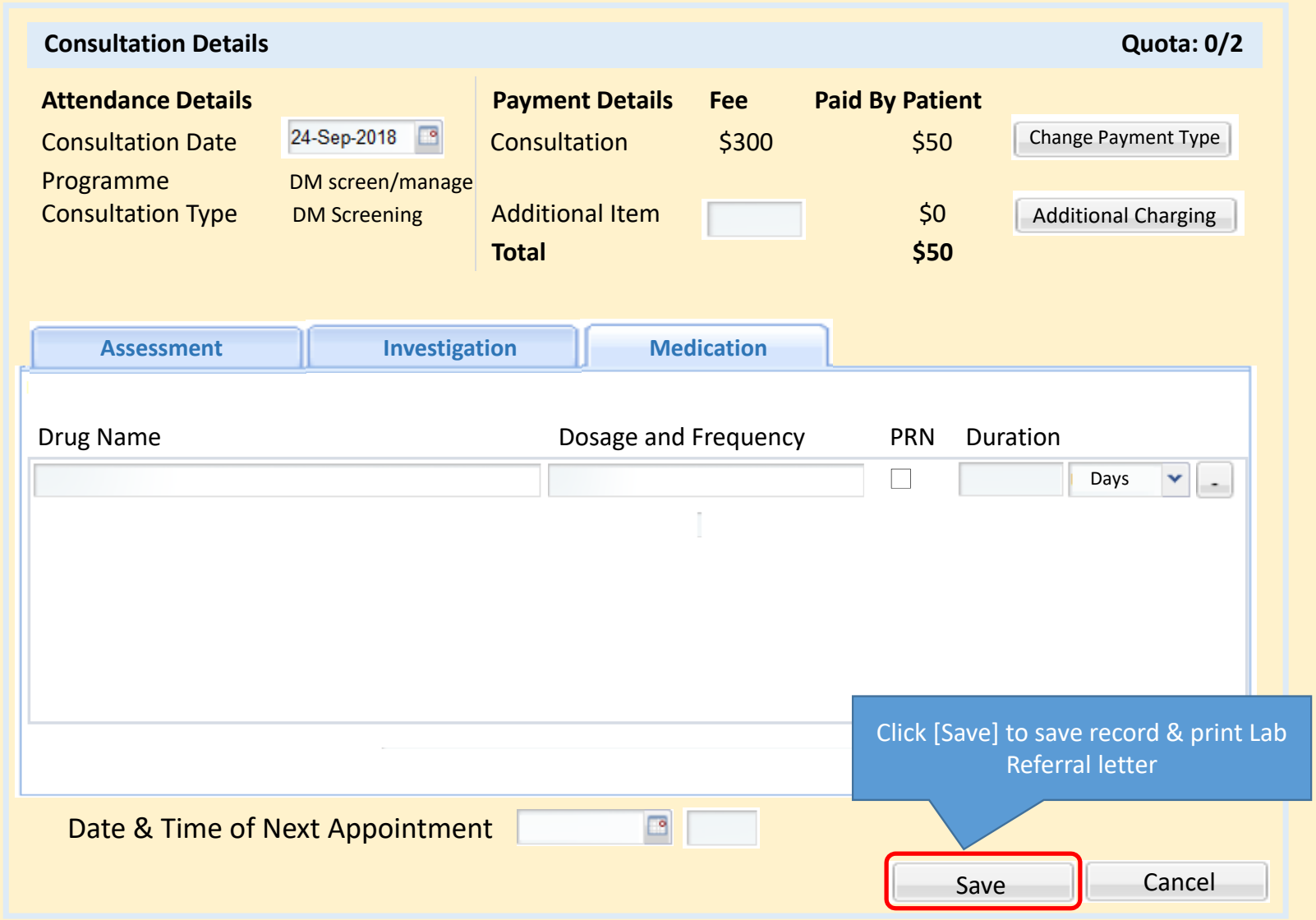
Assessment | Investigation | Medication

Referral for Laboratory Tests

- ☐ Screening
  - ☐ HbA1c
  - ☐ Fasting blood glucose
  - ☐ 2-hour blood glucose (post-75g glucose load)
  - ☐ Lipid Profile (TC, TG, HDL-C, LDL-C)
  - ☐ Renal Function Test
  - ☐ Urine Analysis

Save Cancel

1st Consultation – DM Screening



Primary Prevention Programme - Self-management Support Programme

What is Self-management Support?

Self-management support is when health professionals, teams and services work in ways that ensure that people with long-term conditions have **the knowledge, skills, confidence and support** they need to manage their condition(s) effectively in the context of their everyday life. (Health Foundation, 2015)

The K&TDHC Primary Prevention Programs acknowledge this and aims to support people to **develop the knowledge, confidence and skills they need to make the optimal decisions and actions to better manage their health** in a sustainable manner and enjoy the outcomes in relating to the healthier lifestyle and behaviors.

The full range of person-centered support services to be offered by K&TDHC will include physical, emotional and social dimensions to address the multi-dimensional needs in relating to health and wellbeing.

Attributes of the K&TDHC Programmes

Co-create and Co-design by multi-professionals and service users

(Co-creation)

Emphasize on Self-management skills, confidence and sustainable healthcare behavioral changes

(Self-management)

Goals driven and action oriented

(where they want to be and how to achieve)

(Goal-Go-Go)

Baseline assessment for individuals to know why they are

(Baseline Assessment)

On-going feedback, monitoring and support

(Self-monitoring)

Group-based process to make it fun, interesting and dynamic

(Buddies and Group)

Peer learning and mutual support

(Peer Learning)

Connect and use of community resources

(Connection)

DO-IT-YOURSELF

(DIY)

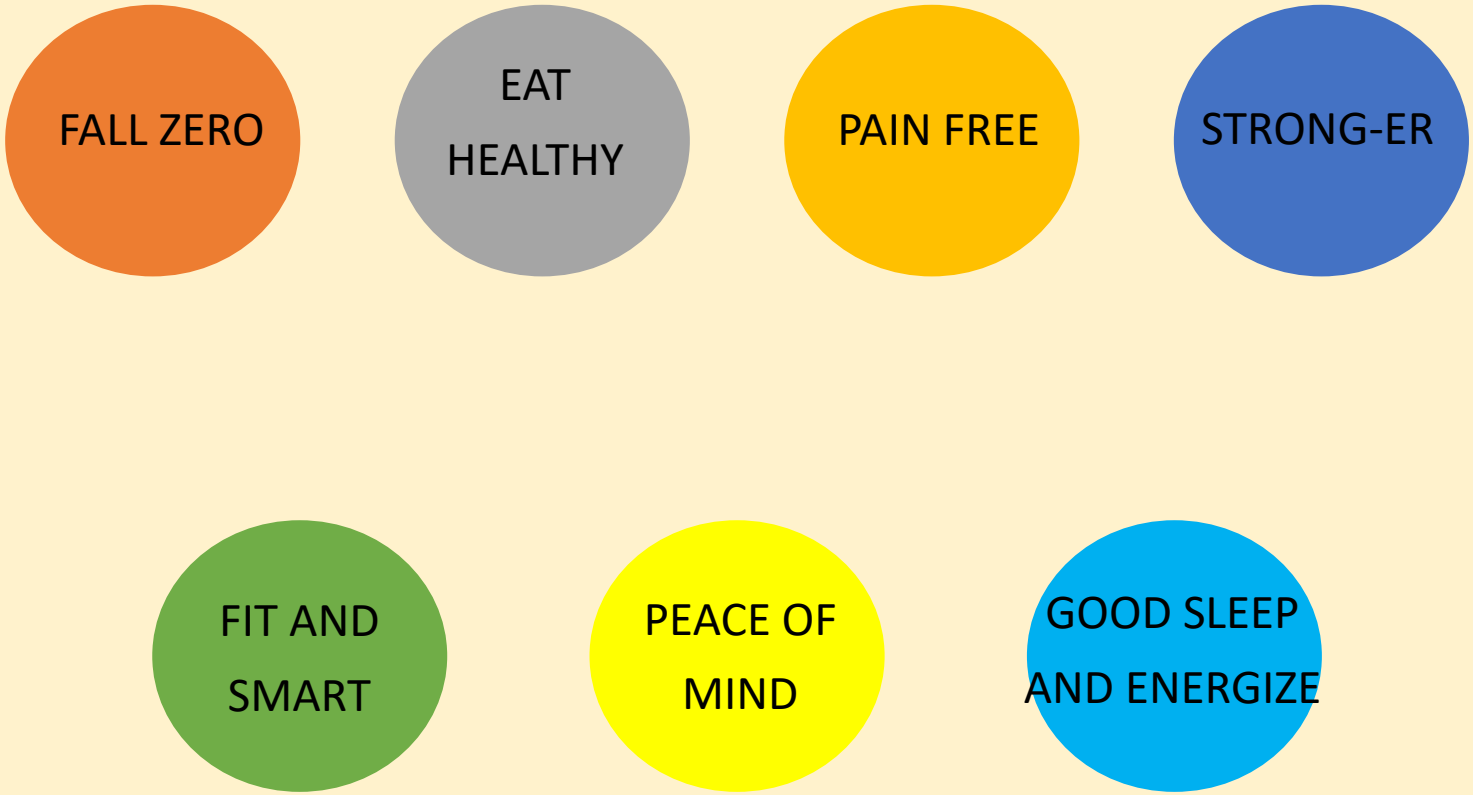
Use of information and community technology

(Tech assisted)

Build on and connect the initiatives with the existing assets of K&TDHC

(Asset-based)

7 Main Themes@ Launching



FALL ZERO
(站穩陣腳)

Risk Factor:
- Fall is multifactorial
- Intrinsic factor: Individual related
- Extrinsic factors: Environment related

Issues raised:
- Falls are a major threat to older adults' quality of life
- Decline in physical and functional ability
- Inhibit social participation
- Economical burden to the healthcare system in Hong Kong

Objectives:
For early detection of clients at risk of fall in the community
To provide health education and empowerment to the clients in the community
To provide individualized fall prevention program for high risk group

Intervention/Program:
- *Fall risk assessment & screening*
- *Health talk on Fall prevention*
- *Lifestyle-integrated Functional Exercise (LiFE) program for fall prevention*
- *Home safety tour*
- Individualized fall prevention for high risk group
- *Home visit/ Assistive devices prescription*

Expected Outcome:
(1) reduce the chances of falling,
(2) reduce the risk of injury,
(3) maintain the highest possible level of mobility,

Effective falls prevention programmes in Hong Kong might reduce falls and fall-related health service utilisation

LiFE for Fall Prevention Program

Objectives

- Early detection of clients at risk of fall in the community
- To provide health education and empowerment to the clients in the community

Baseline Fall Risk SCREENING Assessment

Risk factors identified in Basic Health Risk Assessment

- Two or more episodes of fall within the past one year
- Acute fall (falls requiring medical attention or presenting to emergency department)
- Osteoarthritis of knee
- Osteoarthritis of hip
- Lower limb weakness
- Unsteady gait
- Musculoskeletal pain related to accidental injury
- Parkinsonism
- Stroke
- Post hip fracture

Health Talks on Fall Prevention

Target audience: Clients admitted to the fall prevention group/ caregiver interested towards fall prevention

Aims: To raise the awareness of the public towards fall

Proposed Themes	Refer to the Risk Factors
What measures they can take to prevent further falls.	Fall risk behaviours, environmental factors
The physical and psychological benefits of modifying falls risk	Fear of falling
The preventable nature of some falls	Environmental factors in falls
General home exercises for limbs strengthening	Age-related physiological changes, decrease in muscle strength
Optimize bone health by nutritional advices and supplements	Osteoporosis, lack of vitamin D

Fall Prevention Activities

Test your weight distribution

- Can be a **screening** assessment or **training** activity
- Treax pads to show the **weight distribution** of an elderly in standing
- **Visual biofeedback training** for fall prevention: “a therapeutic method for the elderly to improve weight distribution, stability, and effectiveness in preventing falls”
- **measure** the degree of risk of falling or the status of physical balance using a force plate

Kang, K. Y. (2013). Effects of visual biofeedback training for fall prevention in the elderly. *Journal of physical therapy science*, *25*(11), 1393-1395.

Home Safety Tour

- *Target: **12 people in a group** in fall prevention program*
- *Aims: to introduce environmental fall prevention strategies in terms of home design and assistive aids*

LiFE Fall Prevention Program

- For **moderate risk to high risk** individuals
- **Objectives**: to reduce falls and improve functioning in older people by embedding activities that improve their balance and strength into the participant's daily tasks and routine.
- **Program structure**
  - reviews daily routine chart with participant
  - LiFE training on strength and balance
  - Activities to integrate the strength/balance activities into daily life activities

Interventions for High-fall Risk Group

- Individualized **fall prevention interventions** incorporated into community rehab program
- Individualized **balance and strength training** at wellness area
- ***Home visit/ Assistive devices prescription***
  - Home hazard and safety intervention/modifications
  - Clients who have high fall risks should be offered a home hazard assessment and safety intervention/modifications by occupational therapist as appropriate.

Risk Factor:

- Suboptimal diet pattern
- Heavy marketing of energy-dense foods and fast food

Issues raised:

- Nutritional imbalance
- Overweight and obesity and related health problems
- Increase the risk of chronic disease,
- Increased morbidity and mortality

Objectives:

To educate the knowledge of healthy diet

To teach how to attain healthy diet and motivate the clients to have the behavior change by various innovative classes

To sustain the behavior change by coached self-monitoring and support group activities

Intervention/Program:

- *Healthy diet workshops*
- *Healthy menu (健康入廚樂) (Cooking class)*
- *How to shop for healthy food*
- *Healthy Diet support group activities*
- *Healthy cuisine competitions*

Expected Outcome:

- Build up a healthy diet pattern and cooking method, not only to an individual but also extend to the family level
- Reduce the risk of health problem related to diet

EAT HEALTHY (日日食醒啲)

Risk Factor:

- Poor posture
- Poor physical fitness and flexibility
- Fatigue and overexertion

Issues raised:

- Muscle tightness and pain due to muscle strain
- Repetitive strain injury (RSI)
- Decreased physical activity due to musculoskeletal pain
- Affecting emotional wellness and quality of life

Objectives:

To introduce benefits of stretching exercise for musculoskeletal pain
To teach clients stretching, self-massage and relaxation technique to relieve musculoskeletal tightness
To support clients in self-management for musculoskeletal pain
To sustain habit of self-management via coached self-monitoring and support group activities

Intervention/Program:

- Exercise therapy educational talk
- Musculoskeletal fitness check
- Demonstration and practice stretching exercise, self-massage and relaxation technique for different muscle groups

Expected Outcome:

(1) Reduce pain level
(2) Reduce chance of RSI
(3) Improve musculoskeletal fitness
(4) Decrease muscle tension
(5) Improve work productivity and quality of life via pain reduction

PAIN FREE
(飛苦行動)

Risk Factor:
- Excess alcohol consumption
- Unhealthy diet(eg. Insufficient protein intake)
- Cigarette smoking
- Physical inactivity/sedentary lifestyle

Issues raised:
- Sarcopenia leads to osteoporosis
- Increase fall risk
- Increased morbidity and mortality

Objectives:
- Increase public awareness about sarcopenia
- Identify high risk participants and lead to intervention group for sarcopenia

Intervention/Program:
- Health talk and screening
- **Sarcopenia Programme**
  - Pre-test and post test
  - Health seminar
  - Comprehensive exercise training program for sarcopenia
  - Diet education
  - Peer support group

Expected Outcome:
(1) Improve muscle strength, stability and tolerance
(2) Reduce fall risk
(3) Slower the progression of sarcopenia and osteoporosis

STRONG-ER
「肯得肌」小組

FIT AND SMART
(復瘦者聯盟)

Risk Factor:
- Physical Inactive
- Suboptimal diet
- Unhealthy Lifestyle

Issues raised:
- Overweight and obesity and related health problems in overweight: HT, DM, cardiovascular diseases etc.
- Increase the risk of chronic disease,
- Increased morbidity and mortality

Objectives:
-To provide a multidisciplinary weight management program incorporating diet, lifestyle physical activity, and behavioral modification.
- To educate the clients methods lead to healthier lifestyle and weight loss to minimize the development of obesity- related disease

Intervention/Program:
- Weight and Health Screening Assessment
- Health talk on Weight management
- Lifestyle challenge program
- Weight management program DM/HT
- Weight management program OA/LBP
- Weight management support group

Expected Outcome:
(1) Healthier Lifestyle
(2) Stay active with regular exercise habit
(3) Weight loss
(4) Improve self image
(5) Reduce health risks

PEACE OF MIND (生活靜觀)

Risk factors:
- Stressful lifestyle
- Improper coping skills for stress and anxiety

Issues raised:
- Increase population of psychological distress – depression and anxiety
- Reduce economic productivity
- Affect interpersonal and family relationship
- Increase risk of suicide

Objectives:
1.) To introduce the concepts and benefits of mindfulness
2.) To promote mindfulness in improving self-awareness and mental health in daily living
3.)To render clients to have heightened body awareness and increased self-acceptance
4.)To help alleviate clients' stress and anxiety by improving emotion regulation

Intervention/Program:
- Mindfulness experiential workshop and talk
- Mindfulness Stress Reduction Group

Expected Outcome:
(1) Increase subjective well-being
(2) Improve self-awareness and self-acceptance
(3) Reduce psychological symptoms
(4) Improve emotion regulation

Risk factors:

- Psychological - including stress, anxiety, depression
- Lifestyle - jet lag, smoking, consuming drinks with caffeine or other stimulants just before bed-time
- Environment - noise, light or strange odor, insect bites, or uncomfortable bed or extreme room temperatures (hot or cold)
- Physical - frequent urination, coughing, pain and other forms of discomfort.

Issue raised:

- Reduction of creativity
- Slowing of response
- Loss of memory
- Inability to perform complicated tasks

Good Sleep and Energize (不再數綿羊)

Objectives:

- To provide multidisciplinary sleep hygiene programme including diet, exercises and behavioural modification
- Enhanced effective sleep hygiene practices to improve overall quality of life.

Intervention/Programme

Health talk on sleep hygiene related topics

Relaxation training and workshop

Cognitive behavioral therapy

Mindfulness meditation

Expected Outcome:

- insomnia can be treated through life style changes and cognitive behavioral interventions.
- Insomnia also be prevented from recurrence by paying attention to sleep hygiene.

Secondary Prevention and Tertiary Prevention Programme

- Free services (Patient Empowerment Programme and other group activities)
- Subsidized service sessions (valid for 1 calendar year from the date of programme enrolment)

Individual Healthcare Service (Co-payment Required)									
Programme	NMP Consultation	Physiotherapy	Occupational Therapy	Optometry	Dietetics	Speech Therapy	Podiatry	Chinese Medicine Service (Acupuncture/ Acupressure)	Medical Laboratory Service
DM	✓	✓	✓	✓	✓		✓		✓
HT	✓	✓	✓	✓	✓		✓		✓
OA Knee		✓	✓		✓			✓	
Low Back Pain		✓	✓		✓			✓	
Stroke Rehabilitation		✓	✓		✓	✓		✓	
Hip Fracture Rehabilitation		✓	✓		✓				
Post AMI Cardiac Rehabilitation		✓	✓		✓				

Secondary Prevention Programme

- Health Risk Factors Assessment (Annual)
  - Demographics
  - Medical History
  - Lifestyle behaviour
  - Physical health parameters e.g. BP/P, BMI, waist circumference
  - Utilization of healthcare service
- DM Screening
- HT Screening

Health Risk Factors Assessment

地區康健中心健康風險評估
(18 歲或以上)

姓名:_____
會員號碼:_____
日期:_____

背景資料	
出生日期	
年齡	
性別	☐ 男 ☐ 女
婚姻狀況	☐ 未婚 ☐ 已婚 ☐ 離婚 ☐ 喪偶
子女數目	
家居成員	☐ 獨居 ☐ 與_____(配偶/父母/兄弟姊妹/子女/傭工/朋友)同住
居住面積	_____平方呎
居住房屋類型	☐ 私人物業 ☐ 公共房屋
教育	未曾接受教育 / 小學 / 中學 / 大專
就業情況	☐ 受僱或自僱，職業: _____ ☐ 兼職 / ☐ 全職 輪班工作: ☐ 否 ☐ 是 ☐ 失業 ☐ 退休 ☐ 其他 (學生 / 家庭主婦)
國籍	_____ (選單)
宗教	☐ 沒有 ☐ 有 _____ (選單)
活動狀況	☐ 不需要輔助工具 ☐ 需要輔助工具 (種類: 拐杖/四腳拐杖/助行架/助行車) ☐ 輪椅輔助
日常生活的活動	完全獨立 / 部分需要協助

Health Risk Factors Assessment

家族病史	
家族病史（直系親屬）	☐ 糖尿病 ☐ 高血壓 ☐ 冠心病 ☐ 中風
過往病史	
心血管病	☐ 高血壓 ☐ 冠心病 ☐ 中風 ☐ 周邊血管疾病
內分泌 / 新陳代謝疾病	☐ 糖尿病 ☐ 妊娠糖尿病 / 曾誕下超重的嬰兒(即多於 9 磅或 4.1 公斤) ☐ 血糖水平超標(例如隨機血糖測試多於 6.1)，但未達糖尿病水平

Health Risk Factors Assessment

	☐ 高血脂症
神經系統	☐ 柏金遜症
在過去 12 個月內跌倒	☐ 没有 ☐ 有： 1. _____次 2. ☐ 跌倒以至需要到診所就診或到急症室求診
骨骼肌腱病症	☐ 膝關節炎 ☐ 髖關節炎 ☐ 下肢乏力 ☐ 意外受傷引致的骨骼肌腱痛症
需要醫生或社工介入的精神問題	☐ 抑鬱症 ☐ 焦慮症 ☐ 思覺失調
睡眠	☐ 正常 ☐ 難以入睡或保持睡眠狀態 ☐ 睡得過多
其他病史	

Health Risk Factors Assessment

藥物	
長期用藥	☐ 沒有　☐ 有（如有，服用口服類固醇多於 3 個月？☐沒有　☐有）
藥物過敏	☐ 沒有 ☐ 有 _____

生活方式	
體力活動	☐ 每星期少於 2.5 小時　☐ 每星期最少 2.5 小時
水果食用量	☐ 每天_____份 (1 份相當於 1 個中型水果，即一個拳頭的大小) 1 份的例子: 1 個中型水果，半杯切粒水果，¼杯 100%果汁，¼杯乾果
蔬菜食用量	☐ 每天_____份 (1 份=1 碗未煮的蔬菜) 1 份的例子： 1 杯未煮的葉菜，半杯切碎蔬菜，半杯煮熟的豆類或碗豆，¼杯 100%蔬菜汁
吸煙	☐ 從不 ☐ 已戒煙_____年 ☐ 有吸煙習慣，每天 _____ 支，一共 _____年 ☐ 傳統香煙 ☐ 其他煙草產品，請註明_____
飲酒	☐ 不飲酒 ☐ 曾經長時間飲酒 ☐ 只在社交場合飲酒 ☐ 長期飲酒，每星期飲 _____ 毫升_____酒(啤酒/葡萄酒/烈酒)

Health Risk Factors Assessment

身體檢查	
生理指標	
血壓及脈搏	_____/_____毫米水銀柱，脈搏每分鐘_____ 如果上血壓≥140 或下血壓≥90 毫米水銀柱，請休息五分鐘後再次量度 _____/_____毫米水銀柱，脈搏每分鐘_____
體重、身高、 體重指標	體重_____公斤，身高_____米，體重指標_____公斤/平方米
腰圍	_____厘米 （ _____吋）
心理健康狀況	
情緒	☐ 平和 ☐ 焦慮 ☐ 抑鬱

1. 你是否有家庭醫生？☐否 ☐是，姓名:_____
2. 你是否有定期參加身體健康檢查？☐否 ☐是(如有，請列明所屬計劃及服務機構）_____
3. 你是否有恒常使用醫療服務？☐否 ☐是，_____(醫院管理局/衛生署/非政府機構/私營服務，服務類別_____
4. 你上一次接種流感疫苗是多久之前？☐ _____月前
   ☐ 從沒接種

Referral Criteria to NMP for DM screening

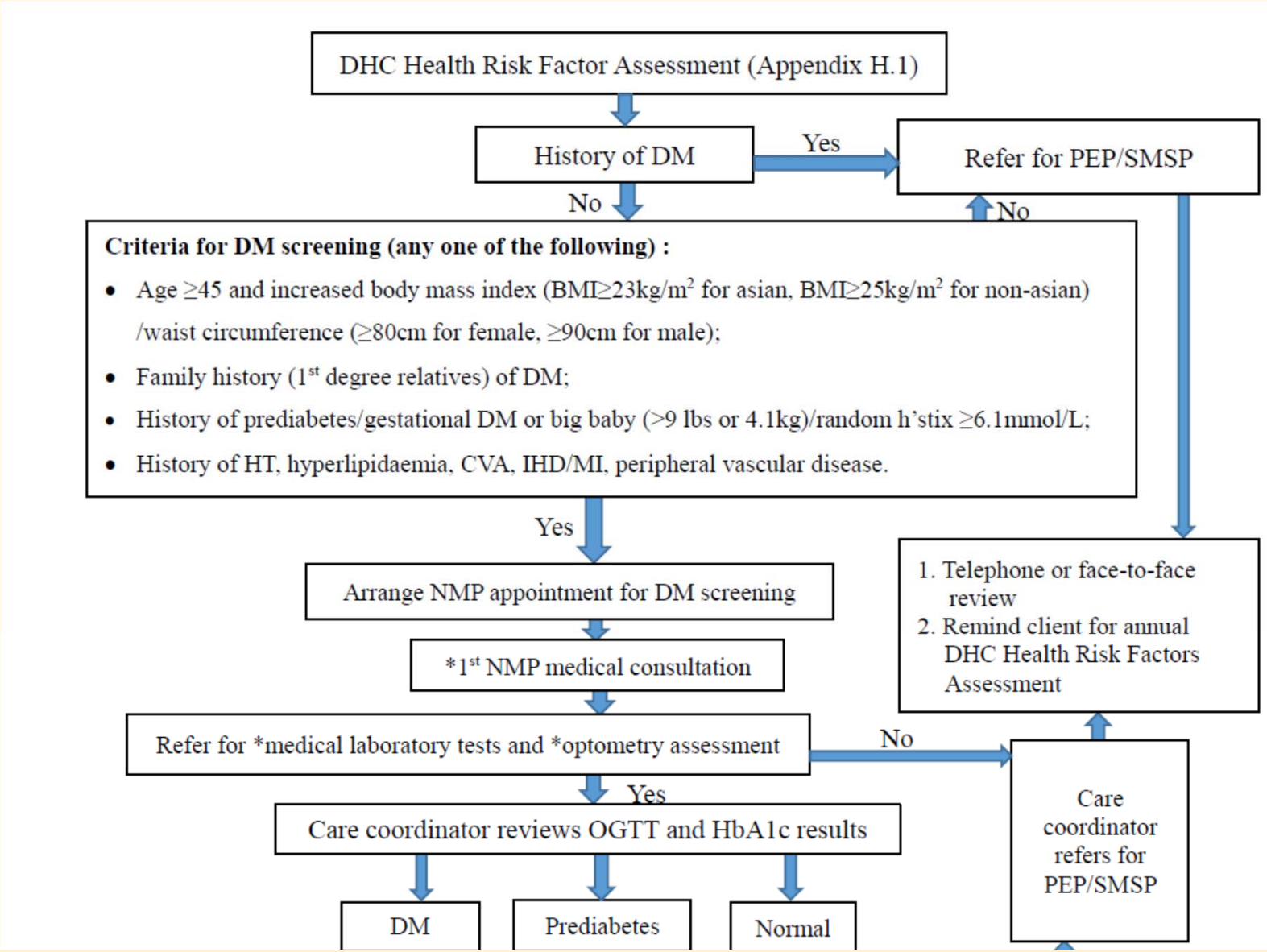
- Any one of the following -
  - **age ≥45 and increased body mass index** (BMI ≥23kg/m2 for asian, BMI ≥25kg/m2 for non-asian) / **waist circumference** (≥80cm for female, ≥90cm for male)
  - **family history** (first-degree relatives) of DM
  - history of prediabetes, gestational diabetes, big baby (>9 lbs or 4.1kg) or random haemoglucostix (h'stix) ≥6.1mmol/L
  - history of HT, hyperlipidaemia, cerebrovascular accident (CVA), ischaemic heart disease (IHD) / myocardial infarction (MI) or peripheral vascular disease (PVD)

DM Programme

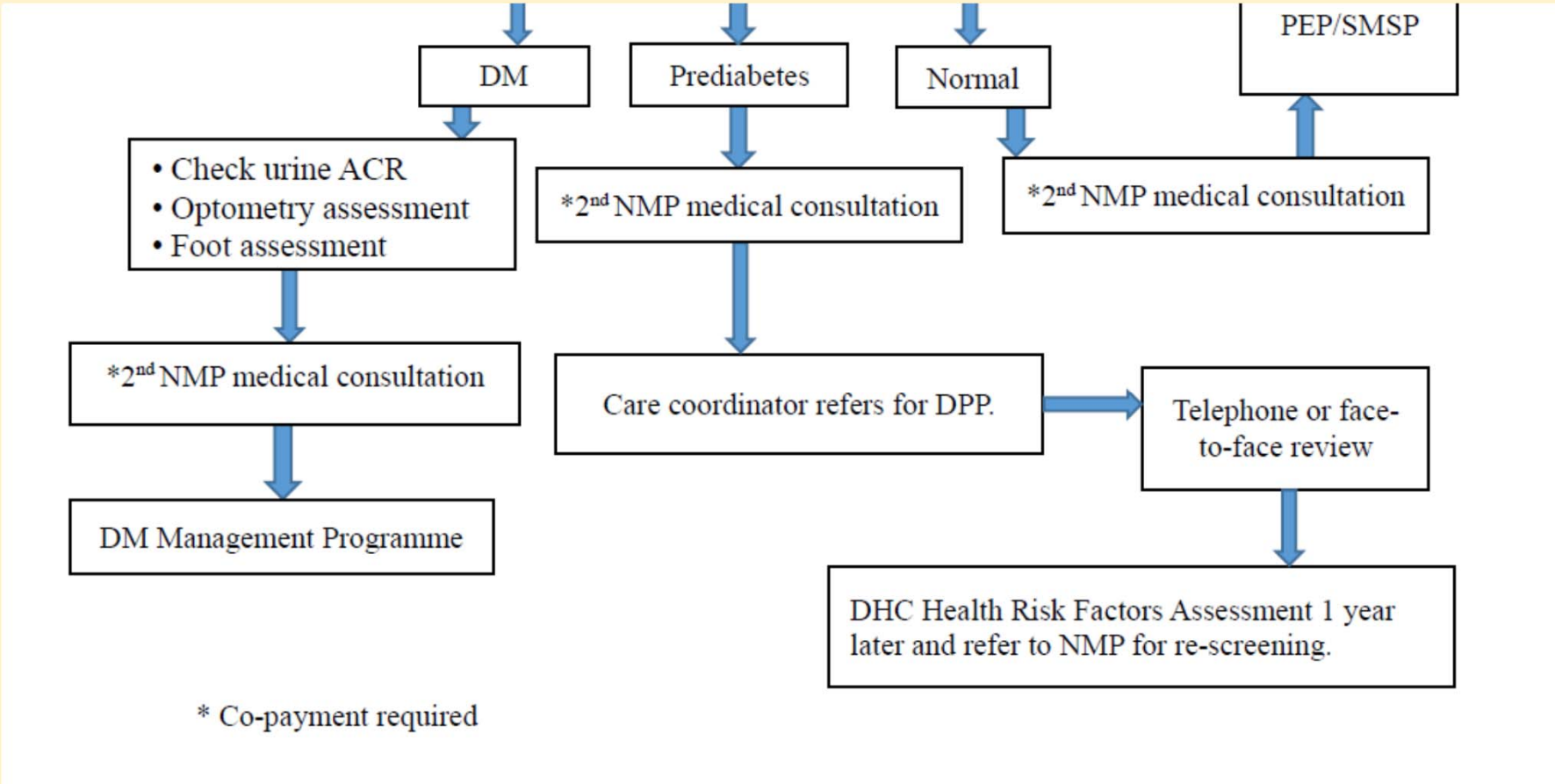
- Screening
  - TWO *NMP consultations
    - 1st : arrange laboratory tests (HbA1c, OGTT, full lipid profile, RFT)
    - Between 1st and 2nd NMP consultations: For urine ACR/optometry assessment/foot assessment if results confirm DM
    - 2nd: review results and assessment reports, make diagnosis, refer to health services accordingly

*co-payment required

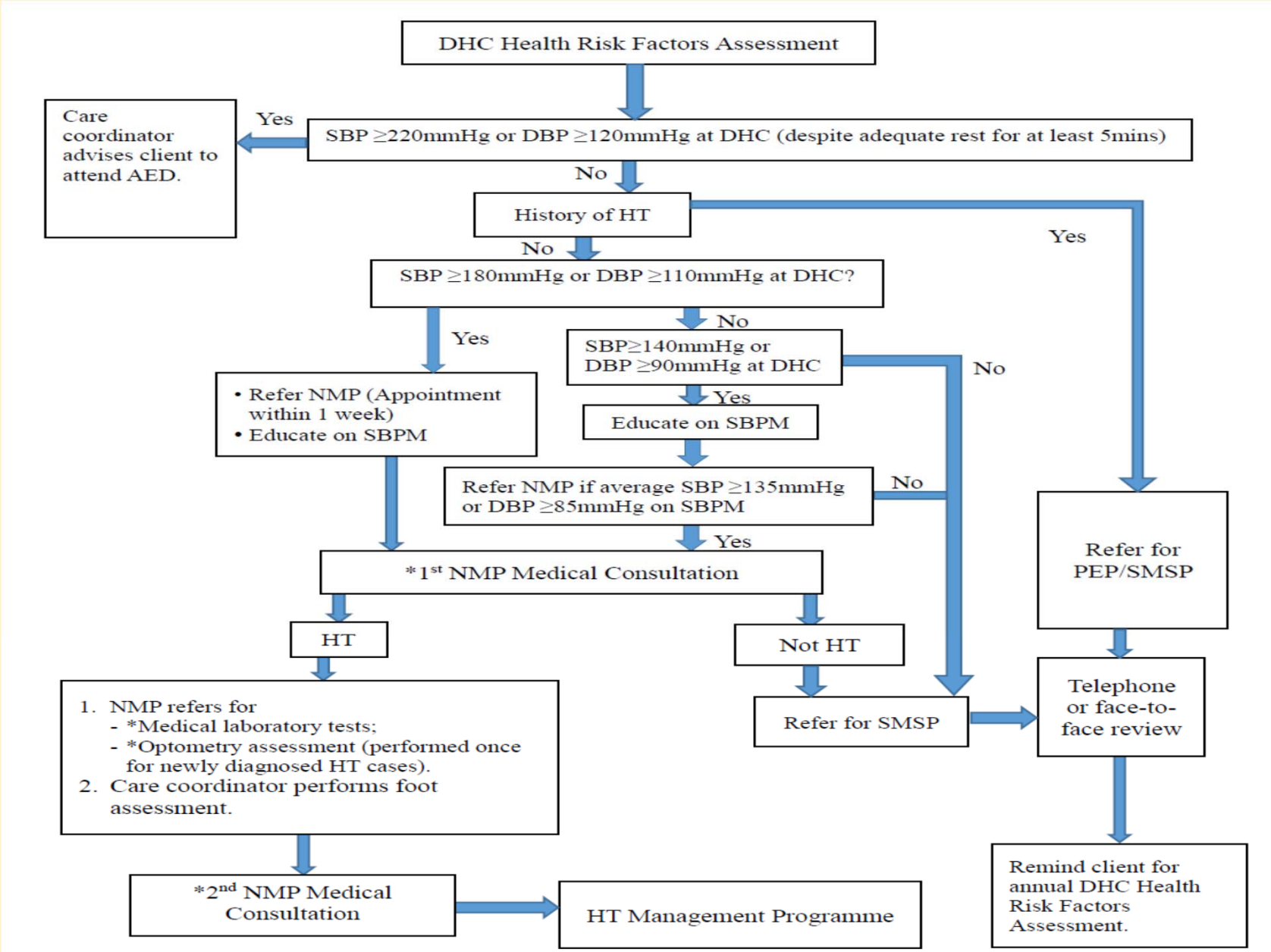
Workflow of DM Screening



Workflow of DM Screening



Workflow of HT Screening



COMBINED DM AND HT SCREENING PROGRAMME

- **Screening for DM and HT**: the number of subsidized medical consultation and medical laboratory tests will be equivalent to that of **DM** Screening Programme.
- Client has joined DM Management Programme & subsequently found to have elevated BP → **2 subsidized medical consultations** for screening
- Client has joined HT Management Programme & subsequently requires DM screening → **2 subsidized medical consultations, a set of medical laboratory tests**

Tertiary Prevention Programme

- Chronic Disease Management (DM, HT, OA knee, LBP)
- Community Rehabilitation Programme (Stroke, Hip Fracture, Post-AMI)

DM MANAGEMENT PROGRAMME - OBJECTIVES

- Enhance clients' understanding of the disease
- Equip clients with skills in management of DM and monitoring of blood glucose control
- Treat to target
- Management of co-morbidities related to DM
- Early identification and management of DM complications

DM MANAGEMENT PROGRAMME - Target Clients

- Clients diagnosed with DM through DHC Screening Programme
- Clients with known DM who are under the care of NMP
- Clients with regular follow-up in HA for DM will be excluded

DM MANAGEMENT PROGRAMME – Program Content

- Nursing assessment, counselling and coordination include –
  - coordination of care and empowerment of clients to achieve treatment targets
  - screening for diabetic foot complication
  - education and advice on self-monitoring of blood glucose (SMBG)
  - telephone/face-to-face review
  - education on insulin injection technique (if applicable)
- Drug review and counselling by pharmacist
- PEP

DM MANAGEMENT PROGRAMME – Program Content

- Subsidized individual healthcare services -
- DM diagnosed through DHC Screening Programme
  - A maximum of **6** (including optometry assessment) subsidized individual healthcare service sessions **in the first year**.

Referral Criteria for Individual Healthcare Services

Service	Referral Criteria / Problem
Dietetic Service ($)	• Special dietary needs (e.g. vegetarian, ethnic minorities, fluid diet, shift work) • Require insulin • Poor dietary control despite nurse intervention • BMI ≥ 27.5kg/m^2 for weight reduction • Poor DM Control – HbA1c ≥ 8% • eGFR <60 ml/min/1.73m^2
Drug Review and Counselling by Pharmacist	• Newly initiated medication regimen • Suboptimal DM and cardiovascular risk factors control • Polypharmacy ≥ 5 drugs (from one or multiple clinics)
Occupational Therapy ($)	• Activities of daily living training
Optometry Service (DM Retinopathy Screening) ($)	• All DM cases
Physiotherapy ($)	• BMI ≥ 27.5kg/m^2 for weight reduction
Podiatry ($)	• Abnormal foot assessment
Community resource support and counselling by social worker	• Psychosocial need

Annual DM Assessment and Management

- 1 subsidized medical consultation
- 1 set of medical laboratory tests (FBG, HbA1c, full lipid profile, RFT, urine ACR)
- Diabetic foot assessment
- Optometry assessment
- A maximum of 4 subsidized individual healthcare service sessions (including optometry assessment)

DM Complication Screening

1. **Diabetic Retinopathy** (by optometrist)
    - visual acuity test, slit lamp examination and retinal photo taking
    - report recorded in the DHC IT Module by optometrist, reviewed by NMP
2. **DM Nephropathy** - Urine ACR
3. **Diabetic Foot** (by care coordinator)
    - Neurological assessment (10g monofilament test, Vibration perception threshold)
    - Examination of dorsalis pedis pulse or tibialis posterior pulse (by palpation or doppler)
    - Assess for any skin abnormality or joint deformity

HT MANAGEMENT PROGRAMME - Objectives

- Enhance clients' understanding of the disease
- Equip clients with skills in management of HT and monitoring of BP control
- Treat to target
- Management of co-morbidities related to HT
- Early identification and management of HT complications

HT MANAGEMENT PROGRAMME – Target Clients

- Clients diagnosed with HT through DHC Screening Programme
- Clients with known HT who are under the care of NMP
- Clients with regular follow-up in HA or DH for HT will be excluded

HT MANAGEMENT PROGRAMME

- Patient empowerment programme
- Arrange laboratory tests (FBS, full lipid profile, RFT, urine analysis)
- HT complication screening (Foot assessment by nurse, *retinopathy screening by optometrist for newly diagnosed case)
- Allied health service (e.g. drug review and counselling by pharmacist, *dietetic service, *physiotherapy)
- Annual assessment (1 *NMP consultation, * laboratory tests including FBS, full lipid profile, RFT, urine ACR)

*co-payment required

HT MANAGEMENT PROGRAMME – Programme Content

Clients diagnosed with HT in the 1st NMP consultation, arrange

- Medical laboratory tests - FBG, full lipid profile, RFT, Urine analysis including urine protein, blood and microscopy
- Optometry assessment for screening for HT retinopathy (for newly diagnosed cases only)
- Foot assessment

- 2nd medical consultation
  - NMP reviews laboratory and assessment reports

HT MANAGEMENT PROGRAMME

- Nursing assessment, counselling and coordination include -
  - coordination of care and empowerment of clients to achieve treatment targets
  - screening for HT foot complication e.g. PVD
  - diet advice e.g. Dietary Approach to Stop Hypertension
  - review of SBPM technique and record
  - estimation of 10-year cardiovascular risk using the Joint British Societies' Coronary Risk Prediction Chart
  - telephone or face-to-face review

HT MANAGEMENT PROGRAMME

- Drug review and counselling by pharmacist
- PEP
- A maximum of 4 subsidized individual healthcare service sessions

Referral Criteria for Individual Healthcare Services

Service	**Referral criteria / problem**
Dietetic Service ($)	• Poor dietary control despite nurse intervention • BMI ≥ 27.5kg/m^2 for weight reduction • eGFR <60 ml/min/1.73m^2
Drug Review and Counselling by Pharmacist	• Newly initiated medication regimen • Suboptimal BP and CV risk factors control • Polypharmacy ≥ 5 drugs (from one or multiple clinics)
Occupational Therapy Service ($)	• Activities of daily living training
Optometry Service ($)	• HT retinopathy screening (for newly diagnosed HT cases)
Physiotherapy Service($)	• BMI ≥ 27.5kg/m^2 for weight reduction
Podiatry Service ($)	• Abnormal foot assessment
Community resource support and counselling by social worker	• Psychosocial need

HT Complication Screening

- Visual acuity test, slit lamp examination and retinopathy screening by optomterist, results recorded in the DHC IT module.
- Foot assessment by care coordinator -
  - examination (by palpation or doppler) of dorsalis pedis pulse or tibialis posterior pulse;
  - checking for any skin abnormality e.g. ulcer.
- HT nephropathy screening with urine ACR to detect and monitor HT nephropathy.

Annual HT Assessment and Management

Annual HT assessment and management include

- 1 subsidized medical consultation
- medical laboratory tests (FBG, full lipid profile, RFT and urine ACR),
- HT foot assessment
- CV risk stratification

A maximum of 4 subsidized individual healthcare service sessions.

Referral of Known HT Cases under the Care of NMP for HT Management Programme

- NMPs can refer HT clients under their care for HT Management Programme.
- 1 subsidized medical consultation
- A set of medical laboratory tests
- A maximum of 4 subsidized individual healthcare service sessions every year.

Combined DM and HT Management Programme

- Enrol in DM/HT Management Programme
- The number of subsidized individual healthcare service sessions will be **equivalent to that of DM** Management Programme.
- Annual assessments for DM and HT will be performed simultaneously.
  - 1 subsidized medical consultation
  - A set of medical laboratory tests
  - A maximum of 4 subsidized individual healthcare service sessions

in every subsequent year.

Combined DM and HT Management Programme

- Enrolled in HT Management Programme → later on diagnosed with DM →enrol in DM/HT Management Programme.
- A maximum of **6 individual healthcare service sessions in the first year** from the date of enrolment in DM/HT programme.
- The unused individual healthcare service sessions of HT Management Programme will not be carried forward.

Combined DM and HT Management Programme

- Enrol in DM Management Programme →later on diagnosed with HT

  → enrol in DM/HT Management Programme.

- The maximum number of individual healthcare service sessions will be reset i.e. 4 or the number of unused sessions for DM, whichever is more, from the date of enrolment in DM programme.

- Annual assessment will be due 1 calendar year from the date of enrolment in DM programme.

地區康健中心
District Health Centre

Referral Form for Kwai Tsing DHC Services

Name of Client: _____ HKID No./DHC Membership No.: _____

Diagnosis/Problem: _____

Please select as appropriate ☑

DM/HT Screening Programme ☐ *DM (HbA1c, OGTT, Lipid Profile, RFT), check Urine ACR and arrange optometry assessment if confirmed DM ☐ *HT **DM/HT Management Programme** *Laboratory tests ☐ FBG ☐ HbA1c ☐ Lipid Profile ☐ RFT ☐ Urine ACR ☐ Urine analysis ☐ Nurse Counselling and Coordination ☐ Drug Counselling/Review by Pharmacist ☐ Community resource support/counselling by social worker ☐ *Physiotherapy Service ☐ *Dietetic Service ☐ *Optometry Service ☐ *Podiatry Service ☐ *Occupational Therapy Service	**Low Back Pain/OA Knee** ☐ Nurse Counselling and Coordination ☐ Drug Counselling/Review by Pharmacist ☐ Community Resource Support / Counselling by Social Worker ☐ *Physiotherapy Service ☐ *Occupational Therapy Service ☐ *Dietetic Service ☐ *Speech Therapy Service (for Stroke Cases only)

* Co-payment required

_____ _____ _____

Date Name of Clinic Name and Signature of Doctor

Low Back Pain Programme - Objectives

- Educate and enrich clients' knowledge about low back pain and related conditions
- Empower clients with low back pain to self-manage their conditions
- Reduce pain, increase physical fitness and improve function
- Decrease the effects of pain on lifestyle and improve quality of life
- Restore confidence in performing activities

Low Back Pain Programme

Target Clients: adults with non-specific subacute or chronic LBP

Referral Criteria

- Persistent LBP despite medical treatment and PEP
- LBP beyond the acute period
- Persistent LBP which significantly impairs functionality, activity participation and quality of life

Exclusion Criteria

- Severe acute pain
- Back pain potentially associated with radiculopathy or spinal stenosis and any other specific spinal causes

Enrol once only

Low Back Pain Programme - Programme Content

- Risk stratification using **The Keele STarT Back Screening Tool**
- Severity, impact and risk of permanent disability, allowing the assessor to target treatment for clients.
- Categorises clients into **low, medium and high risk**.
- Treatment strategies - physical therapy, manual therapy, acupuncture, massage and transcutaneous electrical nerve stimulation (TENS) to a more psychosocial approach for those at high risk.

Low Back Pain Programme - Programme Content

- Outline of PEP provided in DHC -
  - education on disease knowledge;
  - training on coping strategy;
  - exercise programme to enhance strength, flexibility, mobility, balance and pain control;
  - functional activities and tolerance training.

Low Back Pain Programme - Programme Content

- A **maximum of 8 subsidized individual healthcare service sessions**
  - Dietetic service
  - Occupational therapy
  - Physiotherapy
  - Chinese medicine (acupuncture and acupressure)

OA Knee Programme - Objectives

- Educate and enrich clients' knowledge about OA knee pain and related conditions
- Empower people with OA knee pain to actively participate in the management of their conditions and enhance self-management skills
- Relief of pain and inflammation, reduction of stiffness, improvement and preservation of range of motion
- Improvement in and maintenance of mobility, function including ADLs, and health-related quality of life

OA Knee Programme

Target Clients

- Clients with moderate to severe OA knee

Referral Criteria

- Persistent knee pain despite medical treatment and PEP.
- Moderate to severe OA knee having persistent pain which significantly impairs functionality, activity participation and quality of life.

Enrol once for each knee separately or both knees simultaneously

OA Knee Programme

Exclusion Criteria

- Inability to walk without aid for at least 15 minutes.
- Severe knee valgus or varus deformity (30 degrees or more) or fixed flexion deformity of more than 10 degrees.
- Large osteophytes, marked joint space narrowing, severe sclerosis and definite bony deformity on X-ray.

OA Knee Programme - Programme Content

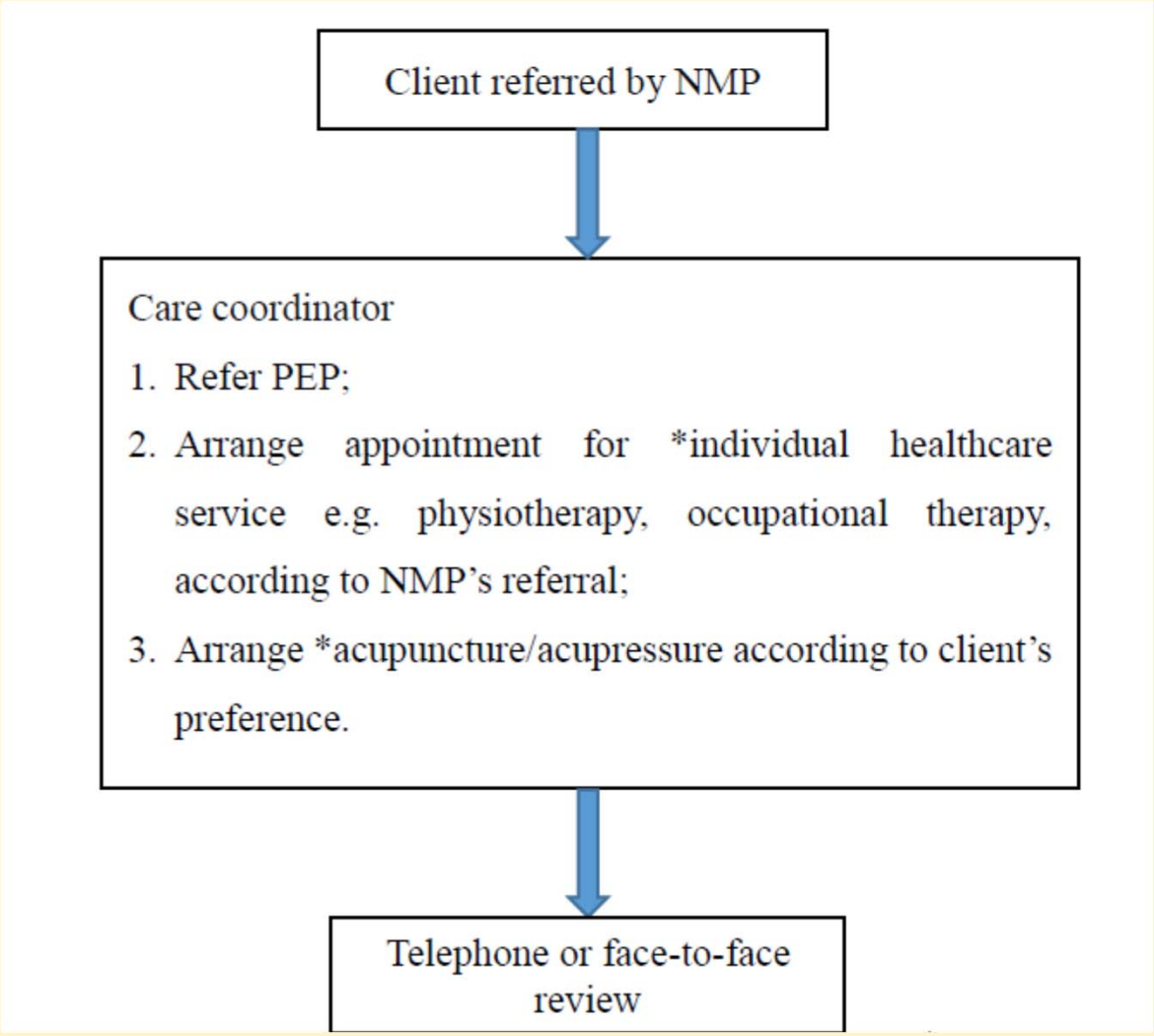
Outline of PEP provided in DHC -

- education on disease knowledge;
- training on coping strategy;
- exercise programme to enhance strength, flexibility, mobility, balance and pain control;
- functional activities and tolerance training.

OA Knee Programme - Programme Content

- Individual Healthcare Service
- A **maximum of 12 subsidized individual healthcare service sessions**
  - Dietetic service
  - Occupational therapy
  - Physiotherapy
  - Chinese medicine service (Acupuncture / acupressure)

Workflow of OA Knee and LBP Programme



OA knee and LBP Programmes

- PEP
  - Education on disease knowledge
  - Exercise programme to enhance strength, flexibility, mobility and balance
- *Individual therapy session (physiotherapy, occupational therapy, dietetics)
  - Individualized exercise programme
  - Personalized pain relieving treatment
  - Training on coping strategy
  - Functional activities and tolerance training
  - Dietary counselling
- *Chinese medicine service (Acupuncture and acupressure) by client's self-referral

Community Rehabilitation Programme

- Stroke
- Hip fracture
- Post acute myocardial infarction

Community Rehabilitation Programme - Objectives

- Assist patients discharged from hospital's rehabilitation programme to attain **optimal functioning in the community,** improve their physical, psychosocial and vocational potential, with consideration of the physiological and environmental limitations
- Assist patients to return to pre-morbid physical and mental state
- Regain strength, improve health and quality of life
- Prevent complication
- Reduce risk of deterioration and prevent recurrence

Referral Criteria

Stroke	Hip Fracture	Post-acute MI Phase IV
• Age < 65 • Carers having difficulty in managing patients at home • Swallowing problem / on modified diet • Speech, language /or communication problem • Drug compliance problem	• MFAC III-V requiring higher-intensity training and carer support • MFAC VI-VII patients requiring lower-intensity group empowerment / exercise program	• Completed phase II rehabilitation • Low to moderate risk according to AACVPR risk stratification: ➢ Left ventricular EF > 40% ➢ No resting or exercise induced complex dysrhythmias ➢ Normal hemodynamic and ECG responses with exercise and recovery ➢ Max functional capacity > 5METS ➢ Absent or mild to moderate silent ischemia (ST depression less than 2mm) with exercise or in recovery

Community Rehabilitation Programmes

Components of Structured Programmes	Stroke (Max 11 sessions)	Hip Fracture (Max 8 sessions)	Cardiac (Max 8 sessions)
1. Individualized exercise programme	✓	✓	✓
2. Education on disease knowledge	✓	✓	✓
3. Training on coping strategy	✓	✓	✓
4. Exercise/training programme to enhance strength, mobility, balance and function	✓	✓	
5. Speech therapy	✓		
6. Community-based PEP	✓	✓	✓

*Chinese medicine service (Acupuncture and acupressure) for stroke by client's self-referral

Subsidized Individual Healthcare Service Session

Stroke Rehabilitation Programme

Period	No. of Sessions 11
1st week	2
2nd week	2
3rd week	1
4th week	1
2nd to 6th month	1 per month

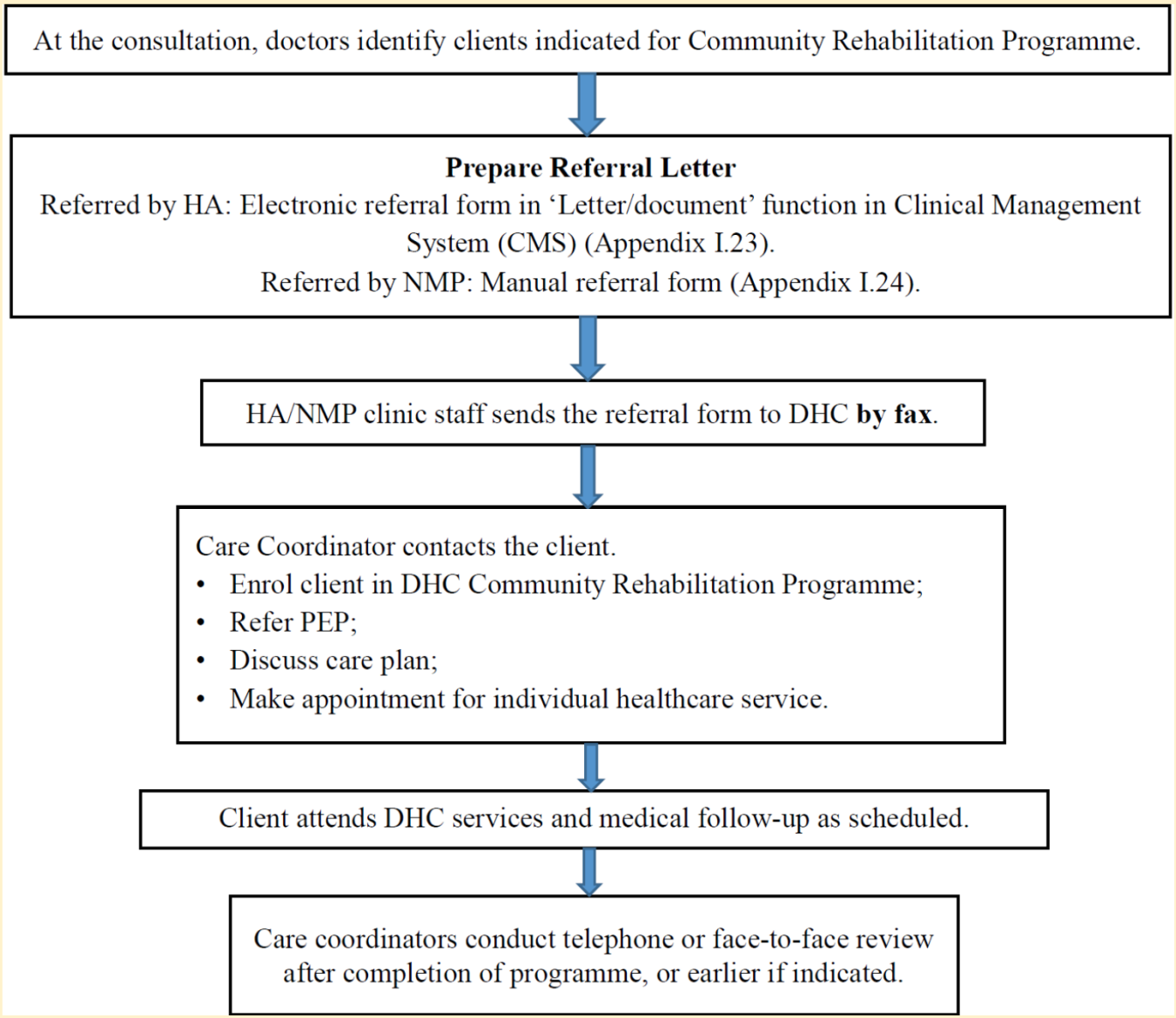
Hip Fracture / Post-AMI Rehabilitation Programme

Period	No. of Sessions 8
1st week	2
2nd week	2
3rd week	1
4th week	1
2nd to 3rd month	1 per month

Outcome Measures

Outcome Measuring Tools	Stroke	Hip Fracture	Post-AMI
Modified Functional Ambulation Classification	Yes	Yes	Yes
Ambulatory Status (Walking aids)	Yes	Yes	Yes
Elderly Mobility Scale	No	Yes	No
Modified Barthel Index	Yes	Yes	Yes

Workflow of Community Rehabilitation Programme



NMP Referral Form for Community Rehabilitation Programme of Kwai Tsing DHC

Name of Client: _____ HKID No./DHC Membership No.: _____

[Please tick the appropriate box(es)]

1. **Diagnosis:**
   - ☐ Stroke
   - ☐ Myocardial Infarction
   - Hip Fracture: ☐ Left ☐ Right
   - ☐ Others (please specify): _____

2. **Medical History** (Please provide key information)
   - ☐ DM ☐ HT ☐ CHF ☐ COPD ☐ CVA ☐ Dementia
   - ☐ Others (please specify): _____

3. **Community Rehabilitation Programme (Co-payment REQUIRED)**

Stroke Rehabilitation	Hip Fracture Rehabilitation	Cardiac Rehabilitation
☐ Physical & functional training including mobility and daily activities	☐ Mobility training	☐ Exercise
☐ Cognitive training	☐ ADL training	☐ Education and advice for patients and carers on daily function including work and lifestyle
☐ Advise on speech or swallowing problem	☐ Fall prevention	☐ Education and advice on diet
☐ Education and advice on diet	☐ Carer education	☐ Others (please specify): _____
☐ Education and advice on daily function for patients and carers	☐ Education and advice on diet	
☐ Others (please specify): _____	☐ Others (please specify): _____	

Allied Health Individual Therapy Service:
- ☐ Physiotherapy
- ☐ Occupational Therapy
- ☐ Dietitian
- ☐ Speech Therapy (for Stroke Rehabilitation only)

4. **Other Individual Service (Co-payment NOT required)**
   - ☐ Pharmacist (Drug Review and Counselling)
   - ☐ Social Worker (Community resource support and Counselling)

Remarks: _____

Name of Referrer: _____ Clinic/ Hospital : _____

Signature: _____ Date: _____

Kwai Tsing District Health Centre Community Rehabilitation Programme

POINTS TO NOTE

All patients referred for community rehabilitation programme will be enrolled to Patient Empowerment Programme. These programmes are group activities comprising of disease education, lifestyle intervention and carer education. After completion of the programme, telephone or face-to-face review will be conducted by the DHC nurse to offer advice and support as appropriate.

Doctors may refer patients for individual healthcare professional service if indicated. The number of government-subsidized sessions (co-payment required) for each programme is listed below.

Rehabilitation Programme	No. of subsidized individual healthcare service sessions
Stroke	11
Hip Fracture	8
Post-Acute Myocardial Infarction	8

Rehabilitation Programme	Referral Criteria
Stroke	• Age <65 • Carers having difficulty in managing patient at home • Patients with swallowing problems / on modified diet • Patients with speech, language and / or communication problems • Patients with drug compliance problems
Hip Fracture	• MFAC III-V patients (i.e. requiring assistance / supervision for walking) requiring higher intensity training and carer support • MFAC VI-VII patients (independent indoor/outdoor walkers) requiring lower intensity group empowerment / exercise programs
Post-Acute Myocardial Infarction	• Completed Phase II cardiac rehabilitation • Low to moderate risk according to American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) risk stratification (all of the following factors should be present): ➢ Left ventricular ejection fraction > 40% ➢ No resting or exercise-induced complex dysrhythmias ➢ Normal hemodynamic and ECG responses with exercise and in recovery ➢ Maximal functional capacity > 5 METs ➢ Absent or mild to moderate silent ischemia (ST depression less than 2mm) with exercise or in recovery

Programme	Year of Enrolment	No. of NMP Consultations in a Year	No. of Allied Health Service Sessions in a Year	Set of Medical Laboratory Tests in a Year
DM Screening	-	2	-	1
DM Management	First year	-	6	-
DM Annual Assessment	Subsequent years	1	4	1
HT Screening	-	2	-	1
HT Management	First year	-	4	-
HT Annual Assessment	Subsequent years	1	4	1
DM&HT Screening	-	2	-	1
DM&HT Management	First year	-	6	-
DM&HT Annual Assessment	Subsequent years	1	4	1
Known DM/HT Cases Referred by NMP for Management Programme	First and subsequent years	1	4	1
Low Back Pain			8 (include CM service)	
OA Knee Pain			12 (include CM service)	
Stroke Rehabilitation			11 (include CM service)	
Hip Fracture Rehabilitation			8	
Post-AMI Phase IV Cardiac Rehabilitation			8	

THANK YOU