香港復康會
The Hong Kong Society for Rehabilitation
社區復康網絡
Community Rehabilitation Network

Roundtable on Patient Empowerment & Self-Management

病人自我管理與病人增權(自強)

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Hospital Authority Convention 2012
8 May 2012. Hong Kong

Chronic Diseases in HK (1)
香港慢病情況（一）

- **The facts (2008, Census & Statistics Department)**

  統計處2008年資料

  - **Some 1,152,700 persons reported that they required long-term (i.e. lasting at least 6 months medical treatment, consultation or medication at the time of enumeration). Prevalence rate per total population was 16.7%**

    在統計時，約有1,152,700 人表示需要長期（即持續最少六個月的時間）接受藥物治療、覆診或打針服藥(簡稱為「長期病患者」。長期病患者的普遍率（以佔整體人口的百分比計算）為16.7%

Chronic Diseases in HK (2)
香港慢病情況（二）

- **94.1% are living in the community while 5.9% are in institutions**

  在該**1 152 700** 名長期病患者中，約**94.1%**居住於住户内；而**5.9%**則居住於院舍**(**包括社會福利院舍、長期護理醫院、私營安老院等**)**

- **Suffering from hypertension (48.9% or 8.2% of the total population); diabetes (20.0% or 3.3%); heart disease (11.7% or 2.0%); stroke (4.6% or 0.8%)**

  首三類最普遍的病患為高血壓、糖尿病及心臟病。分別有**48.9% (**佔整體人口的**8.2%)**、**20.0% (3.3%)**及**11.7% (2.0%)**的人士患有該等病患

Chronic Diseases in HK (3)
香港慢病情況（三）

- **58.8% were aged 60 and the median age was 64, as against the median age of 39 for the total population; persons with chronic diseases were much older than the total population.**

  在長期病患者中，**60**歲及以上人士佔**58.8%**。長期病患者的年齡中位數為**64**歲，而整體人口的年齡中位數則為**39**歲

- **54.6% male and 45.4% female having chronic diseases. The overall prevalence rate for females was 17.3%, as against 16.0% for males.**

  女性較男性為多，分別佔所有長期病患者的**54.6%**及**45.4%** 。女性的整體普遍率為**17.3%**，而男性則為**16.0%**。

Ratio of Shared Professional Care to Self Care across the Chronic Illness Population base

Paradigm Shift – Chronic Diseases
處理長期慢性病患的變化手段

a)

- **Biomedical Model**
- 醫學模式

→

- **Patient Empowerment Model**
- 病人充權模式

b)

Start from
- **Disease Management**
- 疾病管理

→

2006 – IAPO Congress
- **Patient-Centred Care**
- 『病人為本』照顧

→

2007 – WHO
- **People-Centred Healthcare**
- 『人本醫療』概念

Adapted from:
- DH Lau, HK Medical Journal Vol. 8 No 5 October 2002, P372-374; and Prof Jean Woo, Medical Bulletin Vol.13 No 9 September 2008, P.3-4
- WHO websites extracted on 7 Jan 2012 (http://www.wpro.who.int/home.htm and http://www.who.int/publications/en/)

Patient-centred Care – Definition
『病人為本』定義

- **Wikipedia: Patient-centered care (PCC) presumes active involvement of patients and their families in the design of new care models and in decision-making about individual options, benefits and risks for treatment**
- **4 key attributes: 四個關鍵屬性**
  1. **"Whole-person" care – beyond hospital, treatment, prevention 全人照顧 – 超越醫院、治療及預防**
  2. **Coordination and communication – active engagement of patient 病人參與**
  3. **Patient support and empowerment 病人增權**
  4. **Ready access 能使用服務**
- **Empowering patients by giving the right weight to their opinions about the health-care system 能接納病人的聲音**

Patient-Centred Healthcare: Building Principles 病人為本醫療

- **Respect 尊重**
- **Choice and empowerment 選擇和增權**
- **Patient involvement in health policy 病人參與醫療政策**
- **Access and support 服務使用權和支援**
- **Information 資訊**

國際病人組織聯盟宣言 **(2006)**

Declaration of IAPO Principles (2006)

Patient to People–centred Healthcare
『病人為本』至『人本醫療』

Four key policy and action domains: 四個關鍵政策及行動領域

(1) Individuals, families and communities – informed and empowered

個人，家庭與社區 – 知情權，增權

(2) Health practitioners – competent and responsive

健康衛生從業者 – 能幹，適當的反應

(3) Healthcare organizations – efficient and benevolent

衛生保健機構 – 效率高 ， 慈善

(4) Healthcare systems – supportive and humanitarian

健康衛生系統 – 有支持作用，人道主義

Broader context - begins well before anyone becomes a patient

宏觀 - 遠在患病前準備

'People at the Centre of Health Care – harmonizing mind and body, people and systems', published by WHO in 2007.

Challenges & Reflection on Chronic Diseases
長期病患的挑戰和啟示

- **Emphasizes active patient participation and partnership with health care professionals**

  強調病患者主動參與和與醫療專業成為合作伙伴

- **By learning the knowledge and skills for active participation, patients can be empowered to manage their own chronic disease and ultimately enhance their health**

  通過學習知識和技能並積極參與，病患者能增權學懂管理好自己的病患，最終能提升自己的健康

Definition of Patient Empowerment (1)
病人增權(自強)定義 (一)

- **A patient-centered collaborative approach where professionals and patients are equal"**

  以病人為本的協作模式，病人和醫護專業同等重要

- **"Helping patients to discover and develop the inherent capacity to be responsible for one's own life"**

  協助病患者發現和發展他們潛在能力負責管理自己的健康

Funnell, Anderson, Arnold, Barr …. (1991)

Definition of Patient Empowerment (2)
病人增權(自強)定義 (二)

- **"An empowered patient is one who has the knowledge, skills, attitudes and self-awareness necessary to influence their own behavior and that of others to improve the quality of their lives"**

  一位經過增權的病患者能掌握知識、技能、態度及自醒能力足以影響其及他人的行為，從而改善生活質量

Funnell, Anderson, Arnold, Barr …. (1991)

Empowerment and Coping
增權與應對

- **Maximizing the patient's power resources facilitates the patient's ability to cope with chronic illness**

  最大化病患者的力量資源，促進病患者的能力，以應付其面對的長期病思患

- **The central focus of empowerment for the chronically ill is to maintain and enhance the quality of life**

  重點在於增加長期病患者的能力，以維持和提高其生活質量

Patient Empowerment Programme of HA
醫院管理局病人自強計劃

- **NTEC: 1/3/2010 Hong Kong Society for Rehabilitation**
  新界東醫院聯網 - 香港復康會
- **HKEC: 1/3/2010 St. James Settlement**
  香港東醫院聯網 - 聖雅各福群會
- **KWC: 1/9/2010 Hong Kong Society for Rehabilitation**
  九龍西醫院聯網 - 香港復康會
- **KCC: 1/9/2010 TWGHs**
  九龍中醫院聯網 -東華三院
- **KEC: 1/4/2011 Hong Kong Society for Rehabilitation**
  九龍東醫院聯網 - 香港復康會
- **NTWC: 1/4/2011 Yan Oi Tong**
  新界西醫院聯網 - 仁愛堂
- **HKWC: 1/8/2011 Hong Kong Society for Rehabilitation**
  香港西醫院聯網 - 香港復康會

Patient Empowerment Programme
病人自強計劃

- **Three years project**
  為期三年項目

- **Funding from HA via competitive bidding. NGOs were invited to submit proposal**
  通過由非政府組織競投，資金由醫院管理局提供

- **Number of patients per year 2,000 per each cluster; attendance varies from cluster, ranging from 6,500 to12,000 per year**
  每一聯網每年產出為二千名病人，服務節數由**6,500**至**12,000**不等

Patient Empowerment Programme
病人自強計劃

- **Target groups for the first year: DM and HT; second year: COPD and Cardiac Disease. Referred by HA Family Physician at GOPC**

  服務對象首年為糖尿病患者及高血壓；第二年為慢性阻塞性肺病及心臟病；第三年為中風。由醫院管理局普通科門診家庭醫生轉介

- **Maximum service fee for each year is HKD 1.5 million. Bonus schemes apply**

  每聯網每年最高撥款額為港幣150萬元，按據NGO競投的每節單位成本獲撥款。設有超出產出量及服務表現獎金

Objectives of PEP (1)
目標

- **To provide participants a combination of knowledge, skills and heightened self-awareness regarding their own disease conditions so that they can use this power to act in their own self-interest**
  讓參加者能結合知識，技能和加強自我意識醒覺去應對其疾病並以其利益行事

- **To promote autonomous self-regulation so that the participants' potential for health and wellness can be maximized**
  促進參加者的潛能和自主性

Objectives of PEP (2)
目標

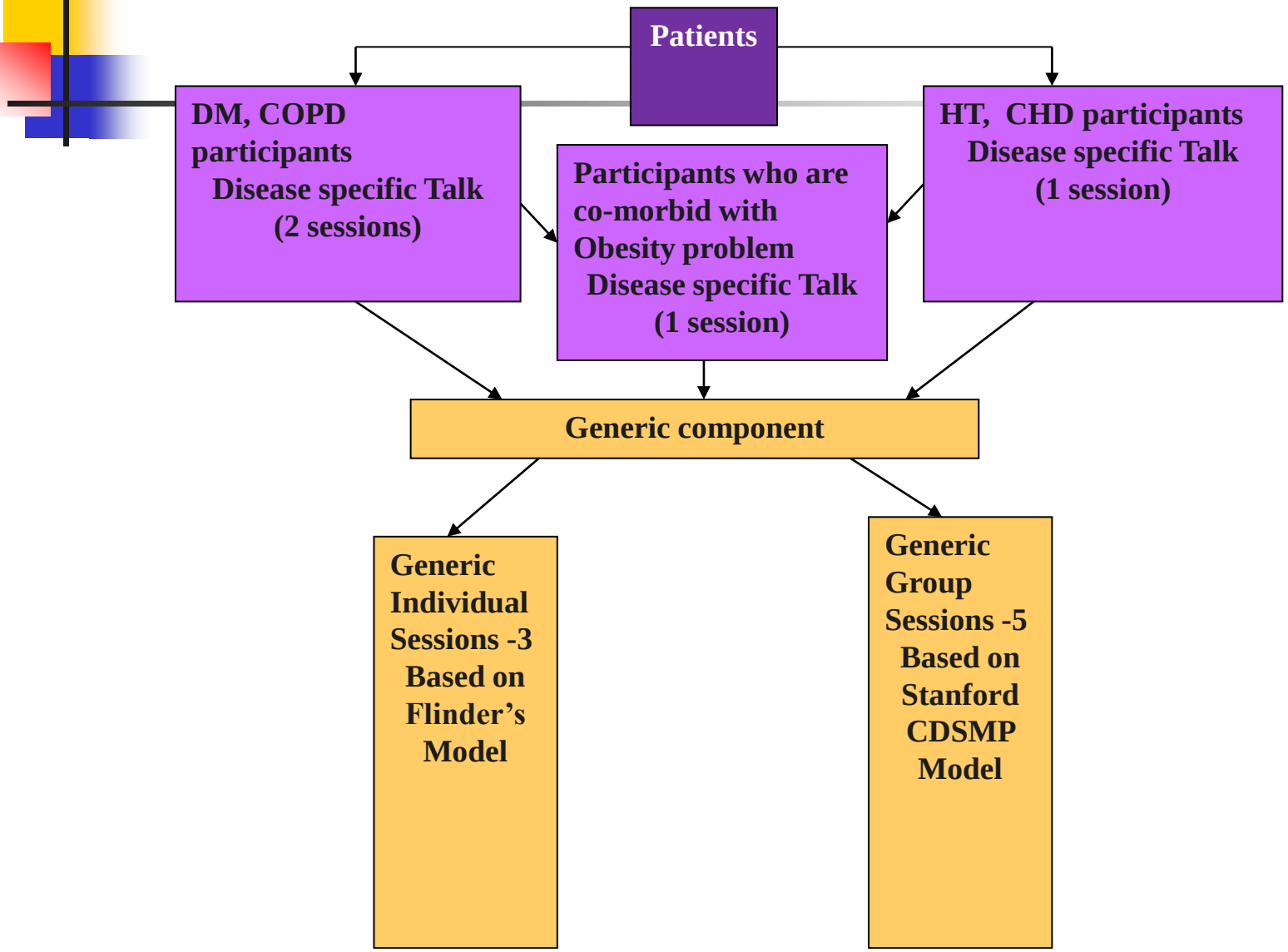
- **At the end of the programme, participants should understand that they are responsible for their diseases and have knowledge and ability to manager their own health**

  在活動完結後，參加者明白他們是要對其所患疾病負責，並獲取到知識和能力去管理自己的健康

Patient Referral 參加者轉介

病人自強計劃 – 預約便條 編號：DM/10/14_10	醫院管理局 香港復康會社區復康網絡 **病人自強計劃 - 預約便條** 地址：九龍長沙灣李鄭屋邨孝廉樓地下　　電話：2361 2838
轉介病科： ☐ 糖尿病	日　　期：**2010 年 x 月 xx 日 (星期二)** 登記時間：下午 **2** 時 **00** 分 地　　點：九龍長沙灣李鄭屋邨孝廉樓地下 **(李鄭屋漢古墓斜對面)** 電　　話：**2361 2838** （敬 請 準 時 出 席）

Service Delivery Mode 服務提施模式



Intervention Pathway
干預路徑

Patient is referred for PEP

Patient Profiling Assessment

Pre-programme Assessment

Individual Self-management facilitation

Empowerment Sessions (Disease Specific and Generic)

Post-programme Assessment

Follow-up and Value Added Support

Programme 病人自強課程

1. 進入服務前評估：

- 由護士或社工爲你進行健康指標評估，並協助你訂立個人「自強計劃」
- 一堂（約 1 小時）
- 費用全免

2.「病理新知」講座

- 由醫護人員主講，讓你獲得最新的病理知識及學習如何管理自己的病患
- 一至兩堂（每堂兩個半小時）
- 費用全免

3.「身心力行」健康生活小組

- 由專業社工及朋輩導師(過來人)帶領，以小組形式協助你重新檢視及改良個人生活習慣，坐言起行，改善健康
- 五堂（每堂兩個半小時）
- 費用爲每堂十元

(65 歲以上或綜援人士免費)

4.「自我管理」健康生活輔導

- 由專業社工或護士進行，協助如何處理個人的健康問題，讓你更有信心管理好自己的疾病
- 三堂（每堂不多於 1 小時）
- 費用爲每堂十元

(65 歲以上或綜援人士免費)

Individual Empowerment Curriculum (Generic) 自我管理健康生活輔導

Target 對象	• **People who are unable to attend empowerment sessions on regular basis** 由於不同原因未能參與小組課程 • **People who are less motivated but with high risk in developing more complicated health problems** 動機較低但健康風險較高
Objective 目標	• **Make collaborative problem definition** 共同訂定問題 • **Patient-centered goal setting and action planning** 目標設定及行動計劃 • **Motivate patients to regain control and responsibility on their well-being** 鼓勵患者重新掌管自己健康責任
Format 形式	• **Face by face interview OR telephone interview** 面談或電談 • **Delivered by: health and social work professionals**由社工或其他醫療專業提供
Sessions 節數	• **3 sessions (30 mins per session)** 三節 (每節30分鐘)

Group Empowerment Curriculum (Generic)

- In Action Programme (身心力行健康生活小組)
- (Modified from Stanford's Model on CDSMP)

Objective 目標	• **Empower the patients with skills and attitude in life style modification and self-efficacy enhancement** • 增強患者維持生活態度改變的技能和提升其自我效能
Format 形式	• **5 sessions (150 mins per session)** • 五節 (每節150分鐘) • **Conducted by 1 social worker/health educator and 1 peer leader to optimize the results** • 由一名社工和一名病人領袖共同帶領
Group size 小組人數	• **15**
Feature 特徵	• **Exercise training is provided in each session** • 運動訓練是在每節小組都會提供 • **Individual exercise feedback to establish the goals & precautions to specific participants**

Process Component of Health In Action Program 身心力行健康生活小組元素

- Interactive Approach 互動模式
- Strategies to enhance self-efficacy 運用及增強自我效能
- Problem solving techniques 強調問題解決方法
- Peer leader sharing to facilitate mutual support 促進有相同經驗患者分享和互相扶持
- Action Plan for Life Style Modification 以行動支持行為改變
- Homework assignment 設有功課

病人自強有效控制病情

改善飲食及運動 胖漢血糖值近乎正常

【本報訊】慢性病患者加強自我健康管理，有助減慢病情惡化，醫院管理局計劃明年將病人自強計劃擴大至全港公立醫院，除原有的高血壓及糖尿病自我管理課程外，服務更伸延至心臟病及慢性肺病患者。有患上糖尿病20年的病人，一直忽視病情，導致血糖「爆燈」，參加課程後，成功在半年減掉18磅贅肉，並有效改善「糖尿眼」。 記者：王智君

■病人自強計劃為長期病患者開辦疾病知識講座及自我管理課程，費用由醫管局資助。 李家皓攝

現年54歲的王先生任職酒店西餅師傅，20年前確診糖尿病，但一直愛理不理，直至兩年多前轉工，接受入職前身體檢查才驚覺血糖指數高達24度，超出正常水平逾兩倍。

教導選擇食物竅門

接受治療初期，王先生刻意戒吃糖及油份高的食物，但嗜甜的他很快便破戒，令體重和血糖節節上升。今年初他獲醫生轉介參加病人自強計劃，學習管理糖尿病技巧。他表示營養師會與學員一同逛超級市場，教他們閱讀營養標籤；課程教練又會因應學員體質，建議合適減磅運動，幫助糖尿病患者輕鬆改善病情。

王先生笑言曾以為糖尿病人會「無啖好食」，但現在懂得選擇食物及烹調竅門，例如以代糖、蘋果乾代替砂糖和薯片，同樣吃得津津有味。教練知道他屢次跑步減肥都不能持之以恒，便建議他改為急步走路，由最初每星期兩次，每次45分鐘，逐步增加至每星期五次，每次1小時15分鐘，半年間由190磅減至172磅，只要再減27磅便達到其目標體重。均衡飲食加上勤做運動，令他的空腹血糖值降至約6度（正常水平應少於5.6度），「糖尿上眼」情況有顯著改善。

醫局資助部份費用

醫管局綜合護理計劃總行政經理鄭淑梅表示，病人自強計劃由今年3月推行至今，約有4,500名病人參加，惟不足25%完成課程，主要是因為病人工作太繁忙。課程堂數視乎病情而定，但病人若要對疾病知識有一定掌握，最少要上四堂。計劃明年將推廣至全港公立醫院，並加設心臟病及慢性肺病自我管理課程，2013年則會再加入精神病及中風課程。

計劃協辦機構有聖雅各福群會、復康會及東華三院。聖雅各福群會高級經理容美端表示，一般會安排病人上四至八堂，費用由醫管局資助，病人若想參加額外課程，便須自費。

Evaluation (1)
評估 (一)

- **Exceeded the agreed output, both the number of patients and the therapeutic sessions (four clusters that provided by HKSR)**

  由香港復康會負責的四個醫院聯網病人自強計劃，無論參與病人數目和節數，都超出原先定下指標

Evaluation (2)
評估 (二)

- **PEP of NTEC and HKEC. N=1,244**

  新界東及香港西醫院聯網。**1,244**名完成課程參加者
- **Conducted by The University of Hong Kong**

  由香港大學負責調研工作
- **Preliminary result: Over 96% were enabled after PEP, fit for purpose**

  初步結果：超過**96%**參加者完成課程後都能“增權”，符合課程目的
- **Both DM & HT patients showed significant improvement in knowledge**

  糖尿及高血壓病人對有關知識有明顯增加

Evaluation (3)
評估 (三)

- **PEP of Kowloon East. N=317**

  九龍東醫院聯網。317名完成課程參加者
- **Conducted by Department of Family Medicine & Primary Health Care of KEC and CRN of the HKSR**

  由醫管局九龍東醫院聯網家庭醫學部及香港復康會進行
- **Result: Ideal body weight increased, knowledge increased & BP target showed significant improvement**

  結果：參加者在理想體重指數有增加、知識有增加及血壓有明顯改善

Definition of Self-Management (1)
自我管理的定義 (一)

- **Learning and practicing skills necessary to carry on an active and emotionally satisfying life in the face of a chronic condition**

  學習如何可以積極及正面去面對長期健康問題

- **Aimed at helping the participant become an active, not adversarial, partner with health care**

  目標是令參加者採納積極和配合的態度與醫護人員合作

Kate Lorig, Stanford Patient Education Center, 1993

Self Management: What Is it?
甚麼是自我管理

- **Based on patient perceived problems**

  是建基於患者現有或要面對的問題
- **Builds confidence (self-efficacy) to perform 3 tasks**

  要建立及提升自信心（自我效能）達致3個目標或方針
  - **Disease management 疾病管理**
  - **Role Management 角色管理**
  - **Emotional Management 情緒管理**
- **Focus on improved health status and appropriate health care utilization**

  目標是善用醫護服務或設施去改善生活質素

Why focus on Self-Management?
為何需要自我管理

- **Poor compliance with medical management by patients (50%)**

  只有**50%**病患者跟從醫生治療及處方
- **Poor adherence to behavioural – lifestyle changes by patients (30%)**

  只有**30%**病患者能依從專業人士指導改變行為和實踐健康生活模式
- **Knowing but not doing**

  絕大多數的患者只停留在知識層面，知而不行
- **Strong evidence**

  有豐富驗証數據

Purposes of Self-management
自我管理的目的

Enabling participants to:

讓參加者能：

- **Make informed choices** 有知情選擇
- **Adapt new perspectives and generic skills on problem solving** 以新視角學習解決問題方法
- **Practice new health behaviors** 實踐新健康行為模式
- **Maintain and regain emotion stability** 保持穩定情緒

Kate Lorig (Stanford University 1993)

Chronic Disease Self-Management Program
長期病自我管理課程（一）

- **Developed by Dr. Kate Lorig of Stanford University in 1999**

  本課程由美國史丹福大學病人教育研究中心創辦

- **A community-based patient self-management education course**

  是一個以社區為基礎的病人自我管理教育課程

- **Chinese version of CDSMP was translated and developed by The Hong Kong Society for Rehabilitation**

  課程中文版由香港復康會翻譯及開發

Chronic Disease Self-Management Program
長期病自我管理課程（二）

- Assumptions 假設
  - **Similar problems despite of the difference in the health conditions**

    縱使不同的長期病患，也會面對相似的健康問題
  - **Patients can learn to take responsibility for day to day management of their disease(s)**

    患者可以學習到管理疾病的責任
  - **Confident, knowledgeable patients practicing self-management will experience various positive health outcomes**

    具信心和自我管理知識的患者，會享受到健康成果
  - **Person with chronic health conditions are best role model for self-management**

    患有長期病的人是最好的自我管理的榜樣

Structure of CDSMP
課程結構

- **Standardized training and program protocol**
  身心力行課程是透過標準化的小組模式
- **A 6 week program (one session per week, 2.5 hours per session)　每節為時2小時30分、共6節**
- **Led by trained professional and/or lay persons with chronic diseases　可用醫護專業及/或患者共同帶領**
- **Content covers diet, exercise, medications, fitness, emotion management, action planning and problem solving skills, and communication with health professionals**
  課程內容包含營養、運動、藥物、情緒管理、行動計劃，與醫護溝通技巧等

What works?
有用嗎?

Improve

改善及增強下列各方面：

- **Client knowledge of illness**
  服務使用者對所患的疾病之認知
- **Knowledge of treatment and interventions**
  對可行的治療及方法的認知
- **Involvement in decision making**
  在決策過程的參與

What works?
有用嗎?

Improve

改善及增強下列各方面：

- **Ability to take action if symptoms worsen**
  當病患惡化時有動力去面對
- **Ability to arrange and attend appointments**
  可以安排覆診及應診
- **Ability to manage the impact of their illness**
  可以處理因病患帶來的衝擊
- **Support client to live a healthier life style**
  鼓勵實踐健康生活

Self-Management Outcomes
自我管理效用

- **6-month improvement in health outcomes**

  參加者6個月後在以下健康指標有改善：

  - **Self-Rated Health** 自我評核健康量表
  - **Social and Role Activities Limitations** 社交及活動限制
  - **Energy/Fatigue** 體能/疲勞程度
  - **Distress with Health State** 心理健康情況

Evaluations of CDSMP, Global Studies

Self-Management Outcomes
自我管理的效用

Improvements in Utilization and Costs

改善醫療服務使用情況

- **Average .8 fewer days in hospital in the past six months (p=.02)**

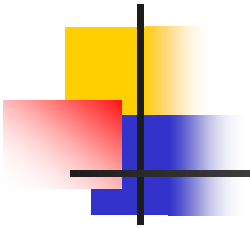
  在6個月內平均減少0.8日住院 **(p=.02)**

- **Trend toward fewer outpatient and ER visits (p=.14)**

  門診服務及急症亦有減少趨勢 **(p=.14)**

Outcome Studies conducted by HKSR
香港復康會曾進行之有關研 (1)

Study 課題	Outcomes 結果
Quasi-experimental evaluation study of CDSMP 「長期病患者自我管理課程」半實驗組研究 CDSMP「長期病患者自我管理課程」**2002-04** (n = 76) vs. Tai-Chi interest class「太極班」 in a mass format (n = 72).	After 6-week program: ↑ **self-efficacy** ↑ **exercising, cognitive symptom management** ↑ **coping (diverting attention, ignoring sensation, re-interpreting pain)** ↑ **energy** 課程6週後: ↑ 自我效能 ↑ 運動、管理認知癥狀 ↑ 處理痛楚能力 ↑ 體能



THANK YOU

多謝