Concise guide

Service Flow of the CDCC Pilot Scheme

Screening Phase

Treatment Phase

Life Course Preventive Care

Participant

Eligible individuals
- Hong Kong residents aged ≥ 45 years
- No known medical history of DM / HT, nor related symptom(s)

DHC/DHCE/FD's clinic which supports participant enrolment

1. Register as a DHC / DHCE member
2. Join eHealth
3. Enrol in the CDCC Pilot Scheme and FD pairing

Screening consultation
- HT screening: BP measured by DHC / DHCE / FD / Self-BP monitoring
- DM screening: Referral to designated Investigation Service Provider for test(s)

FD

FD to explain investigation report and make diagnosis

Diagnosed with HT / DM / Prediabetes with HbA1c 6.0 - 6.4% or FPG 6.1-6.9 mmol/L

Admit to Treatment Phase and FD to continue follow-up

- Treatment consultation
- Prescribe medication as clinically indicated

Referral to designated Investigation Service Provider for appropriate tests based on OM and clinical condition

Referral to other healthcare services based on OM and clinical condition with coordination and arrangement by DHC / DHCE -
- Nurse Clinic
- Allied Health
  - Prediabetes: Dietitian / PT
  - DM / HT: Optometrist / Podiatrist / Dietitian / PT
- HA designated Medicine & Geriatrics specialist consultation for DM / HT

Structured programme
- Prediabetes: IDPP
- DM / HT: PEP

No HT / DM / Prediabetes with HbA1c 6.0 - 6.4% or FPG 6.1-6.9 mmol/L

- Repeat DM / HT screening based on OM and clinical condition
- To collaborate with DHC / DHCE to arrange -
  - Health coaching
  - Lifestyle modification activities as needed

For the details about the available resources for healthcare professionals, please scan the QR code here

DHC: District Health Centre; DHCE: DHC Express; DM: Diabetes Mellitus; FD: Family Doctor; HT: Hypertension; IDPP: Intensive Diabetes Prevention Programme; OM: Operation Manual; PEP: Patient Empowerment Programme; PT: Physiotherapist

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Laboratory Test(s) for Screening Phase

Condition	Initial Screening Test(s)	Follow-up
Not HT upon BP measurement	• **HbA1c; or** • **FPG**	• If HbA1c ≤ 6.4% or FPG ≤ 6.9 mmol/L *(normal or prediabetic range)* ◦ no need to recheck blood and management can be provided accordingly • If HbA1c ≥ 6.5% or FPG ≥ 7 mmol/L *(suspected DM*)* ◦ check FPG, HbA1c, RFT, eGFR and full lipid profile after around one month to confirm diagnosis of DM ◦ check urine ACR if confirmed DM
Confirmed new diagnosis of HT upon BP measurement	• **HbA1c,** • **FPG,** • **full lipid profile,** • **RFT,** • **eGFR, and** • **urine analysis (including urine protein, blood and microscopy)**	• If HbA1c ≤ 6.4% and FPG ≤ 6.9 mmol/L *(normal or prediabetic range)* ◦ no need to recheck blood and management can be provided accordingly • If HbA1c ≥ 6.5% and FPG ≥ 7 mmol/L *(confirmed DM)* ◦ check urine ACR • If HbA1c ≥ 6.5% and FPG < 7 mmol/L *(discordant blood results*)* ◦ repeat HbA1c after around one month to confirm diagnosis of DM ◦ check urine ACR if confirmed DM • If HbA1c < 6.5% and FPG ≥ 7 mmol/L *(discordant blood results*)* ◦ repeat FPG to confirm diagnosis of DM ◦ check urine ACR if confirmed DM

BP: Blood pressure; DM: Diabetes Mellitus; eGFR: Estimated glomerular filtration rate; FPG: Fasting plasma glucose; HT: Hypertension; RFT: Renal function test; Urine ACR: Urine albumin to creatinine ratio

*Lifestyle intervention is offered before confirmation of DM

Summary of Management Packages for Scheme Participants

Screening Result / Intervention	Package A: HbA1c ≤ 5.9% or FPG ≤ 6.0 mmol/L without HT	Package B: Prediabetes [HbA1c 6.0 – 6.4% or FPG 6.1 – 6.9mmol/L] without HT	Package C: DM/HT
HRFA	Annually	Annually	Annually
Life Course Preventive Care	✓	✓	✓
Medical Consultation	NA	Maximum 4 subsidised visits every year*	Maximum 6 subsidised visits every year
Drug Treatment	NA	On an as-needed basis	On an as-needed basis
Laboratory Tests	Repeat blood taking every 3 years or more frequently as clinically indicated	Annually and on an as-needed basis	Annually and on an as-needed basis
HA Designated Medicine & Geriatrics Specialist Consultation	NA	NA	✓
Health Coaching/ Nurse Clinic	Health coaching (annually)	2 subsidised Nurse Clinic visits (annually)	2 subsidised Nurse Clinic visits (annually)
Lifestyle Intervention/ Structured Programme	Lifestyle modification activities as needed	IDPP	PEP
Optometry Assessment	NA	NA	Annually for DM patients; once in the first year for patients with newly diagnosed HT without DM
Other AH Services	NA	Maximum 3 subsidised visits every year (Dietitian/ Physiotherapist)	Maximum 3 subsidised visits every year (Dietitian/ Physiotherapist/ Podiatrist)

HRFA: Health Risk Factors Assessment; IDPP: Intensive Diabetes Prevention Programme; NA: Not applicable; PEP: Patient Empowerment Programme

*Maximum 4 subsidised visits every year is recommended for individuals on drug treatment for prediabetes; maximum 2 subsidised visits every year is recommended for those not on drug treatment for prediabetes.

For the details of Clinical Pathway for Participants of the Chronic Disease Co-Care (CDCC) Pilot Scheme, please scan the QR code here