Service Flow of the CDCC Pilot Scheme



Screening Phase

Treatment Phase

Life Course Preventive Care

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



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

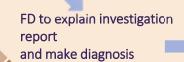
Screening consultation

- HT screening: BP measured by DHC / DHCE / FD / Self- BP monitoring
- testing: Referral to designated Investigation



FD

DM screening and blood lipid Service Provider for test(s)



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

Admit to **Treatment** Phase and FD to continue

follow-up

Diagnosed with HT / DM / Prediabetes*/ Dyslipidaemia

No HT / DM / Prediabetes*/ Dyslipidaemia

clinical condition

Health coaching

- · 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 -

- Dedicated Nurse Clinic
- Dedicated Allied Health services
 - Prediabetes: Dietitian / PT
 - DM / HT: Optometrist / Podiatrist / Dietitian / PT
 - Dvslipidaemia: Dietitian / PT
- HA designated Medicine & Geriatrics specialist consultation for DM / HT



Structured programme

- Prediabetes: IDPP
- DM / HT: PEP



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



*Prediabetes [HbA1c 6.0 - 6.4%; or FPG 6.1-6.9 mmol/L]

• To collaborate with DHC / DHCE to arrange -

• Repeat DM / HT screening based on OM and

Lifestyle modification activities as needed

Laboratory Test(s) for Screening Phase

Condition	Initial Screening Test(s)	Follow-up		
Not HT upon BP measurement	HbA1c or FPG, full lipid profile	 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 albumin to creatinine ratio (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) o no need to recheck blood and management can be provided accordingly If HbA1c ≥ 6.5% and FPG ≥ 7 mmol/L (confirmed DM) o check urine ACR If HbA1c ≥ 6.5% and FPG < 7 mmol/L (discordant blood results*) o repeat HbA1c after around one month to confirm diagnosis of DM o check urine ACR if confirmed DM If HbA1c < 6.5% and FPG ≥ 7 mmol/L (discordant blood results*) o repeat FPG to confirm diagnosis of DM o 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 or specified condition of dyslipidaemia#	Package B: Prediabetes [HbA1c 6.0 – 6.4% or FPG 6.1 – 6.9mmol/L] without HT	Package C: DM/HT	Package D: Specified condition of dyslipidaemia# without Prediabetes [HbA1c 6.0 – 6.4% or FPG 6.1 – 6.9mmol/L] or DM or HT
HRFA	Annually	Annually	Annually	Annually
Life Course Preventive Care	V	٧	٧	٧
Medical Consultation	NA	Maximum 4 Subsidised Visits every year*	Maximum 6 Subsidised Visits every year	Maximum 4 Subsidised Visits in 1 st year and maximum 2 Subsidised Visits in subsequent years
Drug Treatment	NA	On an as-needed basis	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	Annually and on an as-needed basis
HA Designated M&G Specialist Consultation	NA	NA	٧	NA
Health Coaching/ Dedicated NC	Health coaching (annually)	2 subsidised NC visits (annually)	2 subsidised NC visits (annually)	2 subsidised NC visits (annually)
Lifestyle Intervention/ Structured Programme	Lifestyle modification activities as needed	IDPP	PEP	Lifestyle modification activities as needed
Optometry Assessment	NA	NA	Annually for DM patients; Once in the first year for patients with newly diagnosed HT without DM	NA
Other Dedicated AH services	NA	Maximum 3 subsidised visits every year (Dietitian/ Physiotherapist)	Maximum 3 subsidised visits every year (Dietitian/ Physiotherapist/ Podiatrist)	Maximum 3 subsidised visits every year (Dietitian/ Physiotherapist)

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

^{#(}i) LDL-C ≥ 5 mmol/L; or (ii) LDL 2.6 - < 5.0 mmol/L and cardiovascular disease risk ≥20%

Overview of the Clinical Pathway for Scheme Participants of the CDCC Pilot Scheme

