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行政院衛生署九十五年度委託研究計畫

實踐二代健保醫療品質提升之模式建構計畫

研究總報告

執行機構：國立台灣大學

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全程計畫：自 95 年 2 月 24 日至 96 年 12 月 31 日止

＊本研究報告僅供參考，不代表本署意見，依合約之規定：如對媒體發布研究成果應事先徵求本署同意＊

中文摘要

本計畫以彰化縣為研究社區，研究區域醫療服務體系整合的可行性，建立醫療品質提升與民眾參與之具體工作模式；以實踐二代健保『提升品質』、『擴大參與』的改革目標，並透過本土化家庭醫師制度的推廣與雙向轉診的質與量的提升，落實行政院核定之全人健康照護的目標。計畫內容重點包括：1. 民眾健康知能與健康自我照顧技巧提升；2. 建立區域性之慢性病照護與管理模式，共同提升地區之醫療服務品質；3. 建立由大醫院轉往地區醫院與基層診所的下轉機制。

本研究採用行動研究法，研究者藉由參與彰化縣醫療體系的整合工作，利用認識情境、發現問題、研究分析、提出假設與行動計畫、執行行動、評估結果的循環行動，達成本研究的目的。

第一年工作包括：

- 彰化鹿港社區健康促進網絡的建立(包括向日葵志工、社區專業人員如體能老師等、PGY 受訓學員)
- 健康促進診所建立(醫師充能)
- 社區參與(由社區內之民眾組織志工服務自己的社區)
- 自我照護能力(透過志工訓練與病友會學習)

- 推動社區醫療群與聯合執業群的建立，整合社會之醫療單位形成互相合作支援的醫療服務網絡

第二年工作包括：

- 第一年工作的繼續推動
- 將社區健康促進網絡、健康促進診所及糖尿病病友會計畫推廣至基隆市七堵
- 以「慢性腎臟病」及「膝關節置換手術」作為照護的項目，促進醫院與診所間建立以病人為中心之共同照護模式，及醫院與診所間良好的轉診系統

本研究發現社區民眾的健康行為與醫師的醫療行為是可以透過有系統的計畫去改變。但必須要有十分密切的協助與促導。但模式的實際應用與持續必須有一個支持這些行為的環境，在醫師行為方面，一個能針對期望的醫療行為的給付制度是最重要的關鍵。

本研究將過去兩年間推動各種工作的經驗作整理，希望這些獨特的經驗能對日後的計畫及健康醫療政策的制定有參考的價值。

關鍵字：慢性疾病、共同照護、醫療體系、健康促進、照護模式

Summary

The purpose of this study was to examine the possibility in developing an integrative health care system in Changhua community. It tried to fulfill the goals of the second-generation national insurance including quality improvement and community participation. In this study, we intended to implement the system of family physicians and to promote patients' transferal between primary care and hospital care system. Tangible objectives included the followings: 1. community empowerment and self-care, model in chronic disease care and management, mechanism of patients transferal from hospitals to primary care.

We used action research method in carrying out of this study. Researchers participated in the actions of health care integration in Changhua Lu-Kang community. From a sequence of understanding, problem identify, problem analysis, formation of hypotheses and action plans, implementation, and evaluation and improvement, we were able to develop a workable format in achieving our goals.

The first year project included the followings:

- the development of Lu-Kang community health supportive system (volunteers groups, PGY trainees and professional carers)
- health promotion clinics (empowerment of primary care physicians)
- community participation (volunteers recruited from the community serve their own community)
- self management of health (through volunteers training and diabetes patient groups)

- the development of "Community Medical Groups" and "Jointed Medical Groups" to form a community medical care network

The second year project included the followings:

- continue the works of the first year
- transfer the Lu-Kang experience to the Ci-Du community in Kee Lung
- use chronic renal disease and knee replacement surgery as example to coordinate primary care clinics and hospital to provide patient-centered joint care and promote appropriated transfer care

Conclusions:

1. It is very difficult to facilitate the reform of health care system without environmental and financial support.
2. Projects of small-scale, progressive, and tangible objectives are easier to adopt by health care institutes.
3. The development and utilization of community supportive networks may promote better diabetes care. Our study did not observe statistical significant change in patients LDL and HbA1c levels between the intervention group and the control group. The small number of patients included in this study may indicate a type 2 error.

Keywords: chronic diseases, integrative care, health care system, health promotion, health care model