Community-based Care: An Experience in Hong Kong East

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Continuing Care Service
St. James' Settlement

HA Convention 2006
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Background of SJS (1)

- St. James' Settlement (聖雅各福群會)
- Established in 1949
- A multi-service NGO that HQ situated in Wanchai
- Serve the community in HKE and HKW

Background of SJS (2)

- Continuing care services:
  - District elderly community centre (2)
  - Enhanced home and community care service (2)
  - Integrated home and community service team (2/7)
  - Day care centre (1)
  - Residential care home for the elderly (2)
  - Pilot and pioneer service projects, e.g. charity projects, funeral navigation services etc
- Health services: health centre and dietitian service

SJS-HA Collaboration

- Joined the Hong Kong East Cluster Elderly Service Liaison Committee in 2000
- SJS has already joined 10 projects and is starting the 11th project: the extension of maintenance rehabilitation in weight reduction
- Beneficiaries and targets include the elders with mild to moderate impairment, the carers, discharged patients, volunteers, youth, community people etc
- List of projects

Types of collaboration

- (A) Joint services- for the same clients
- (B) Extension of services to community
- (C) Service Promotion and Referral
- (D) Health Promotion and Prevention
- (E) Training and Expertise Sharing

(A) Joint services

- 1. Service Purchase Scheme (started in 2001)
  - For Enhanced Home & Community Care Services (EHCCS) and Integrated Home Care Service (IHCS) loyal customers
  - CGAT team + Allied health team
  - To care the frail elders together

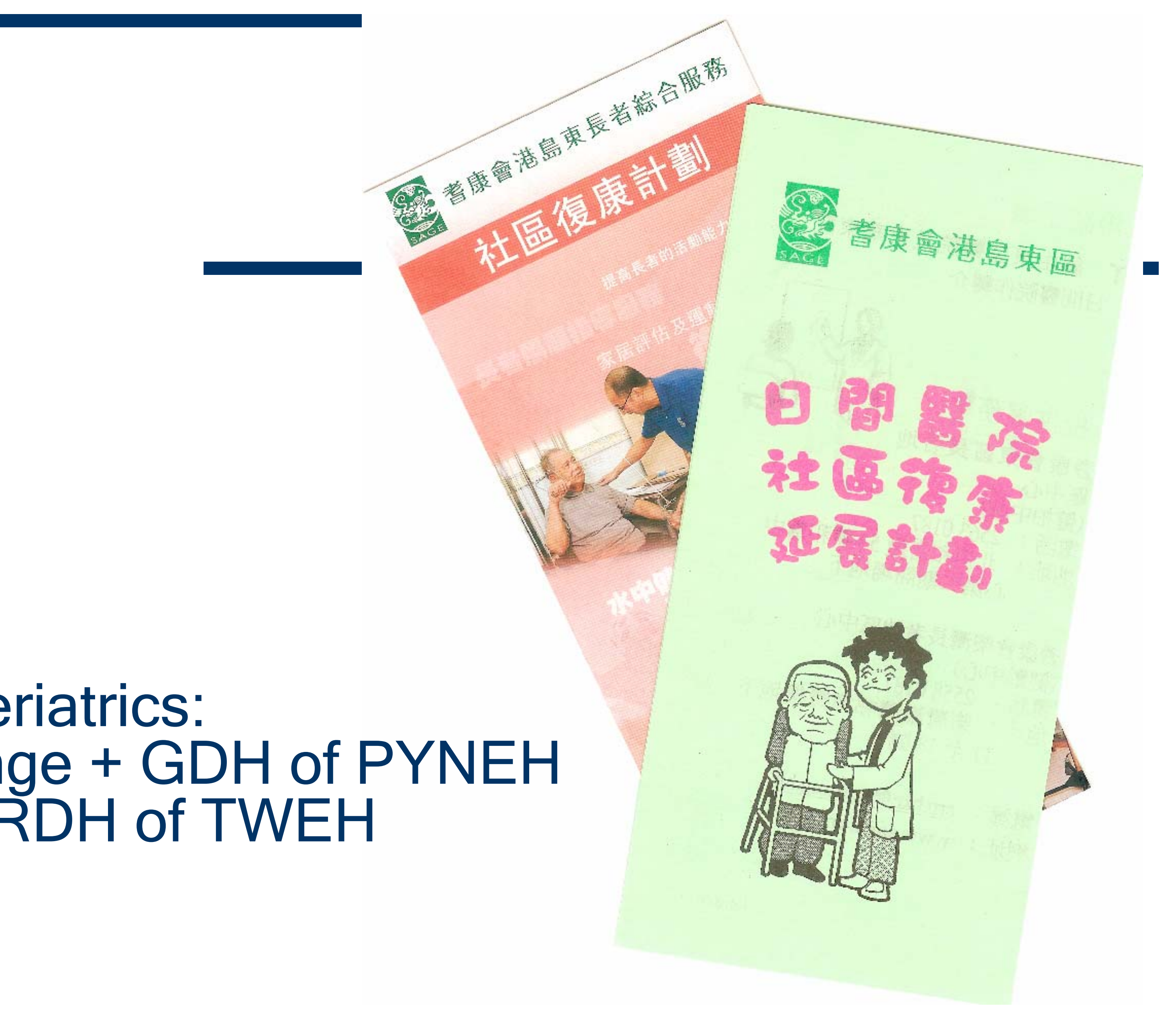
- Benefit:
  - Information exchange thru PCC and protocols
  - Smooth transferral and handshake
  - Expertise building
  - SJS has kept its EHCCS service in Wanchai and expanded to Central & Western

2. Elderly Carer Training Programme

- Carer training to informal carers of frail elders and discharged patients

(B) Extension of services to community

- 1. Extension of Maintenance Rehabilitation (社區復康延展計劃)
  - Targets: discharged patients from hospitals
  - Orthopedics: TWGH(FSC) + Orthopaedics of PYNEH (SPP-P1.7)
    - Rehabilitation exercise
    - High Risk Database and TNCS



- Geriatrics:
  Sage + GDH of PYNEH
  & RDH of TWEH

- Cardiac: Methodist (Wanchai) + CRRC (TWEH), & PRC (PYNEH)
- Weight Reduction: SJS + Dietitian (PYNEH, RHTSK) & PRC (PYNEH) (coming)
  - To maintain the motivation and support the effect before next appointment

- 2. Community Foot Care Service (社區足病診療服務)
  - Pilot project of SJS and HA (Podiatry and Geriatrics) collaboration
  - Started with a donation fund
  - Focus on enhancing podiatric care to the poor and socially deprived elderly, who is neglecting their foot health

- To maintain post hospital discharged high risk patients and minimizes unplanned readmission and ulcer recurrence rate
- To reduce the demand on HA hospital podiatry service
- Future development: to extend the podiatric service coverage to other NGO, & to conduct podiatric research and need assessment

Algorithm of Referral

CGAT Referrals

Podiatric wound problem

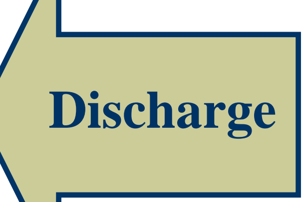
Foot problem except ulcer

Community Foot Care Team

(Podiatrist+PT+OT)

- Preventative foot treatment
- Maintenance care to high risk foot among frail elderly

Exacerbated



Discharge

RHTSKH

High risk foot stabilized after hospital podiatry

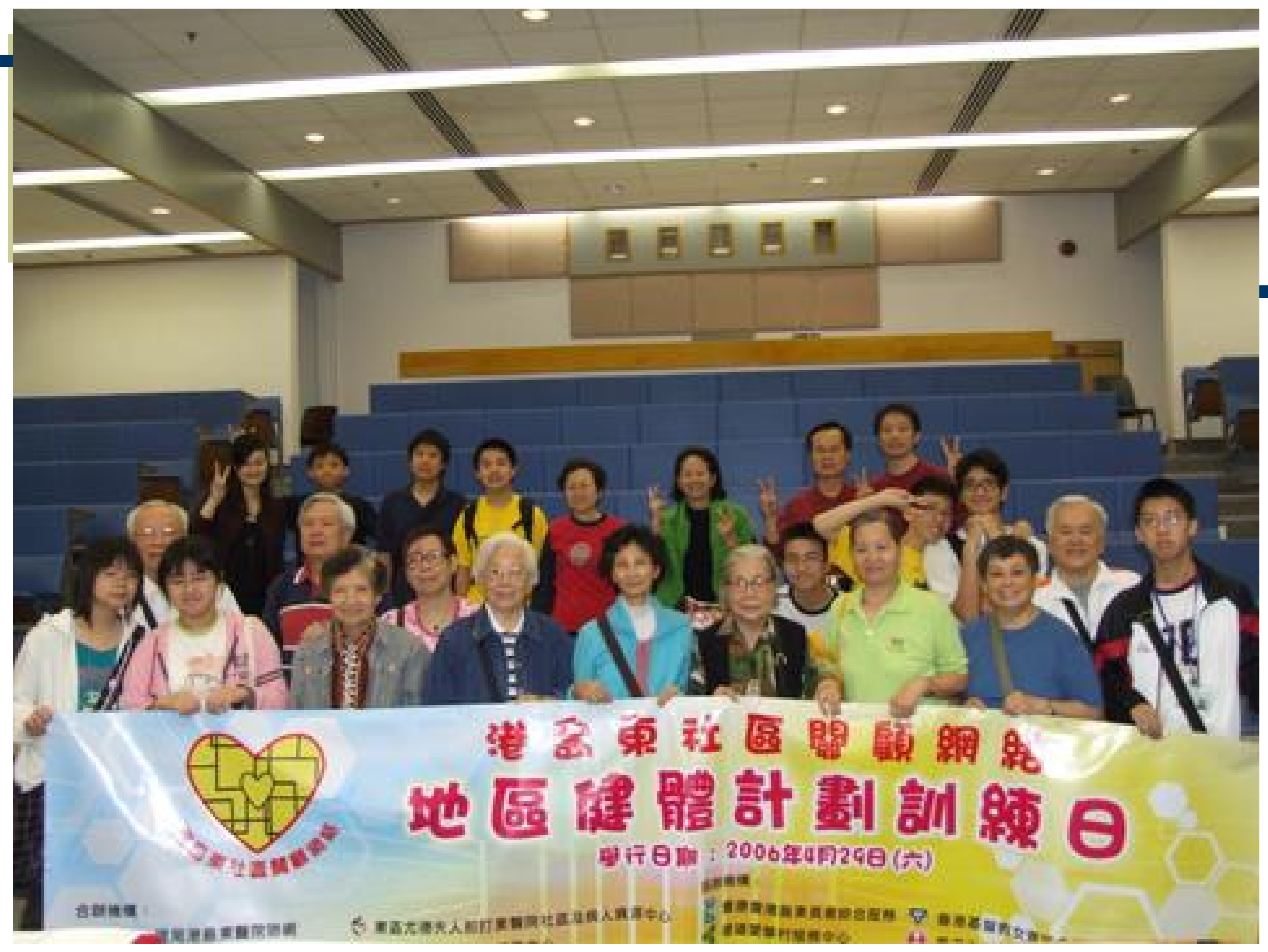
(C) Service Promotion and Referral

- 1. Community Care Network of Hong Kong Island East (港島東社區關顧網絡計劃)
  - Funded by Community Investment and Inclusion Fund
  - 2 years: Oct 2005 - Sept 2007
  - "2+6" Synergy: HKEC, TWGH(FSC), Methodist (Wanchai) & SJS (total 3 network projects) + 4 NGOs in HKE

- Aims to promote a healthier and more harmonious community, by promoting community health and developing social capital
- Services: discharged patients service, youth mentorship programme, community health programme etc

- Various projects launched in collaboration with clinical departments
  - Community exercise group for patients aged 50 and above with hypertension, DM, orthopaedics problem and etc

- It is also a “health promotion and prevention programme”


地區健體計劃訓練日
舉行日期：2006年4月29日(六)

- 2. High Risk Elderly Data Base and Telephone Nursing Consultation Service
  - Discharged patients with high risk referred to DECCs for follow-up and service provision
  - "SPP-6.4 - Telephone Nursing Consultation Service (TCNS)“ by Ms Joan HO, DOM, RHTSK on **9 May 10:45 am**, at **Theatre II**

- 3. Carer Empowerment and Training Program (護老者聚一聚)
  - 10 programmes completed in 05-06 with the support of PRCs
  - Resources kit will be made in 06-07

- 4. Service Promotion in SOPDs and GOPCs

(D) Health Promotion and Prevention

- 1. Community Care Network of Hong Kong Island East (港島東社區關顧網絡計劃)
  - Healthier community
- 2. Community Based Fall Prevention and Hypertension Management Programme (CRP)
  - SPP-P1.18

3. Volunteer Support Network for the Elderly (健康先鋒惠社區)

- Started for 3 years
- 577 volunteers trained
- Localized teams of volunteer support network formed for home visits and telephone concern calls for frail elderly identified

- Service offered
  - 1046 home visits
  - 1596 concern call
  - 1242 assessment
  - for 364 discharged frail elder
- Application of health checking protocol
- Details: SPP-P1.61 by Ms Daisy Wong

(E) Training and Expertise Sharing

- 1. Elderly Carer Training Programme
  - Traning for home care workers (formal)
  - A training programme for NGOs social workers is being considered
- 2. Clinical Protocols for Assessment of Elderly in Community by NGO
  - CP for home care workers
  - Simplified version for volunteers (pilot)

Reflection

- Positive experience?
  - For the service recipients: Definitely yes.
  - For the NGO staffs: Yes, a good learning process
  - For the HA staffs?

- Benefits to NGOs
  - Experiments of pilot projects
  - More cases
  - Quality staff, quality volunteers
  - Quality service to elders
  - Healthier community

- Difficulties
  - Need to build up a culture of mutual understanding and win-win-win feeling among organization
  - Understanding and support from NGOs staffs
  - Resources
- Success?

Success factors

- From “Policy” to “Practice”
- Well-defined structure for integration and governance
- Communication and collaboration platform
- Facilitator- PRC
- Excellent partners- HA and NGOs
- Feasible and win-win-win projects

But need to improve

- Sustainability of projects
- Resources limitations
- Outcome measurement (on NGO side)
- Patient information exchange
- Engagment of GPs and community partners
- Strategic direction and leadership
- Long-term holistic planning by HA, SWD and HWFB

- Collaboration in other service areas
  - Kid Fit Programme (SPP-P2.19)
  - Referral system to Adolescent Clinic, PYNEC
  - Outreaching service to MR residential home
  - What else?

Thank You!

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