Creating Synergy for Community Health

Community Involvement in HKEC

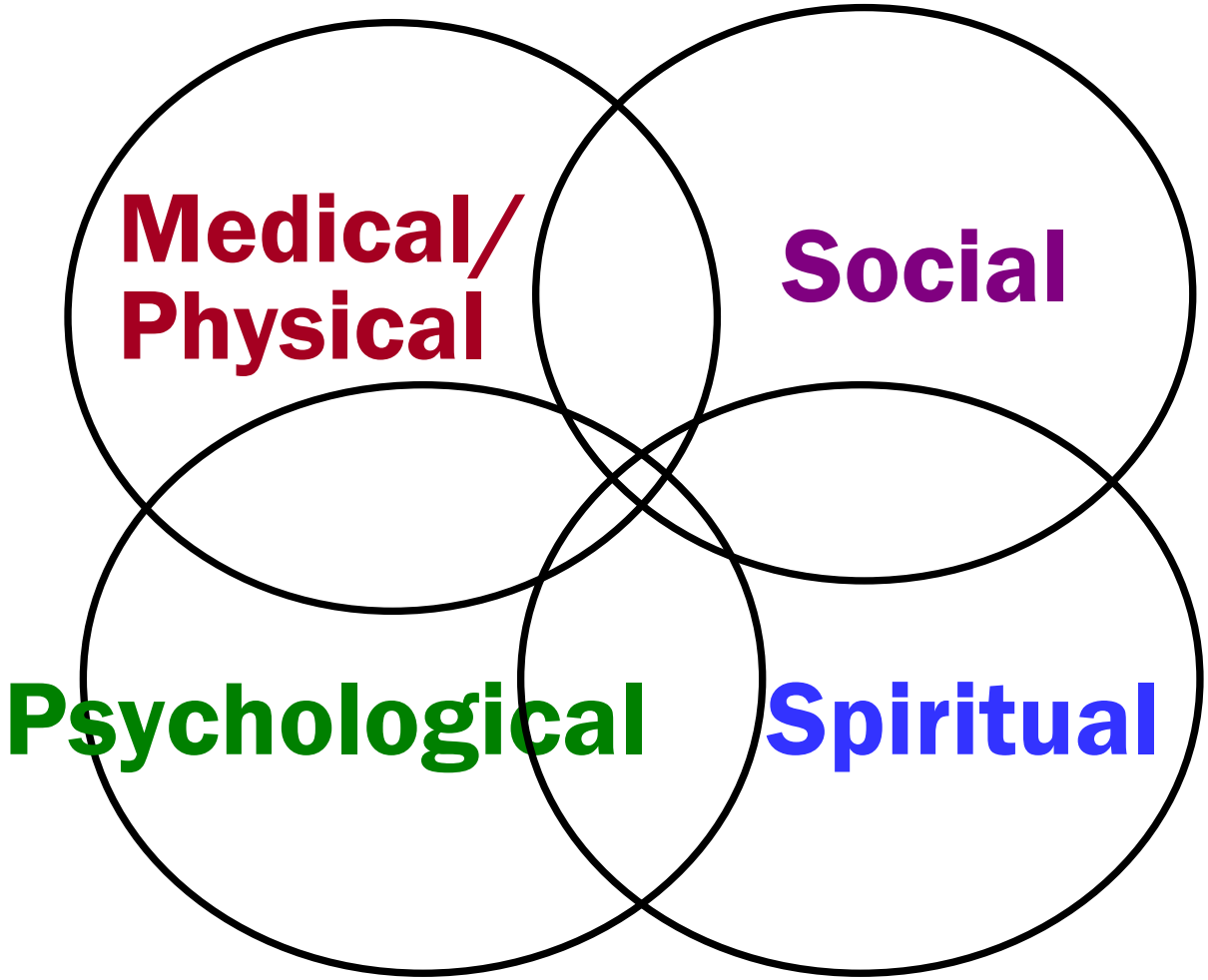
L Yam

Cluster Chief Executive

14 March 2008

Determinants of a Healthy Community

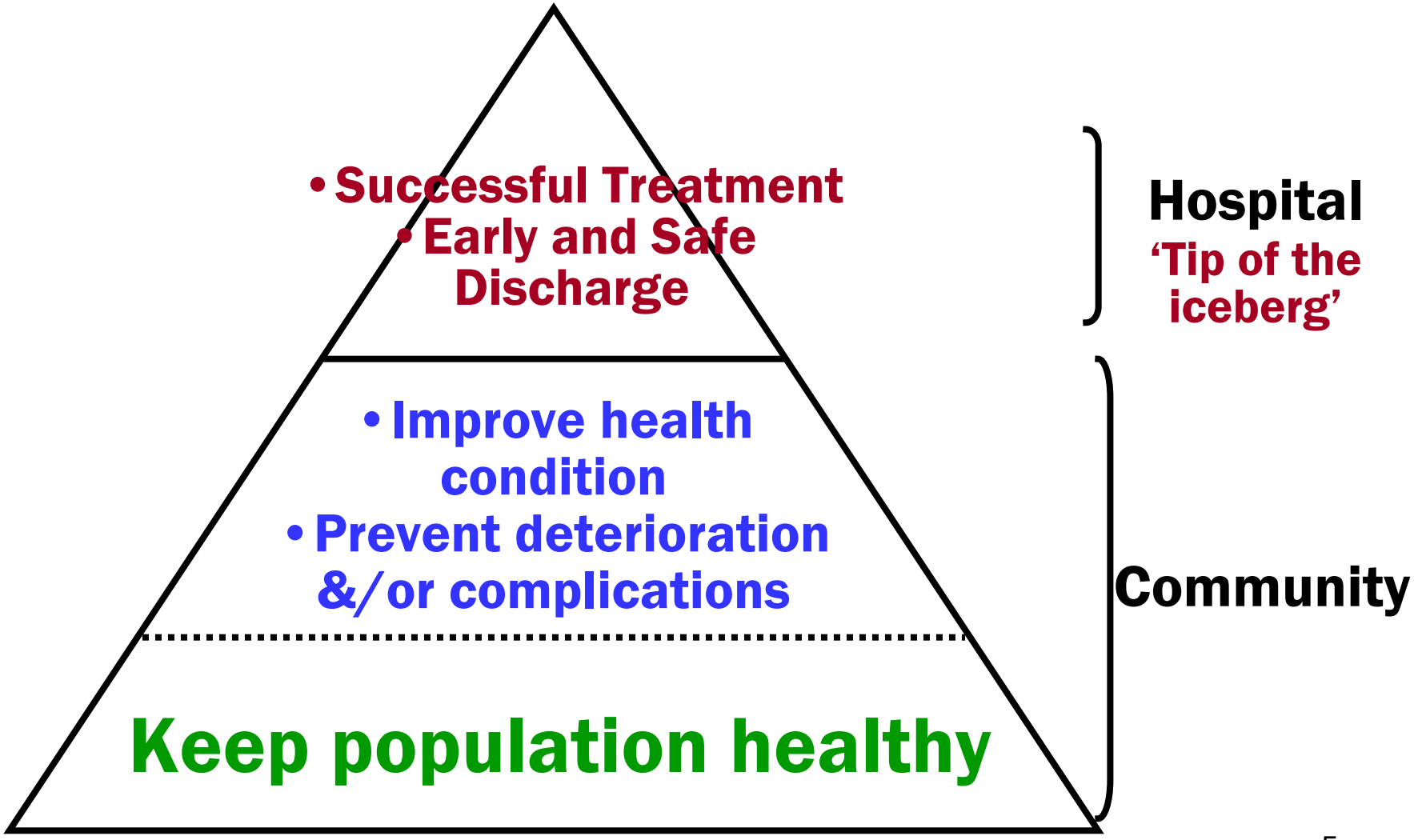
When we are sick



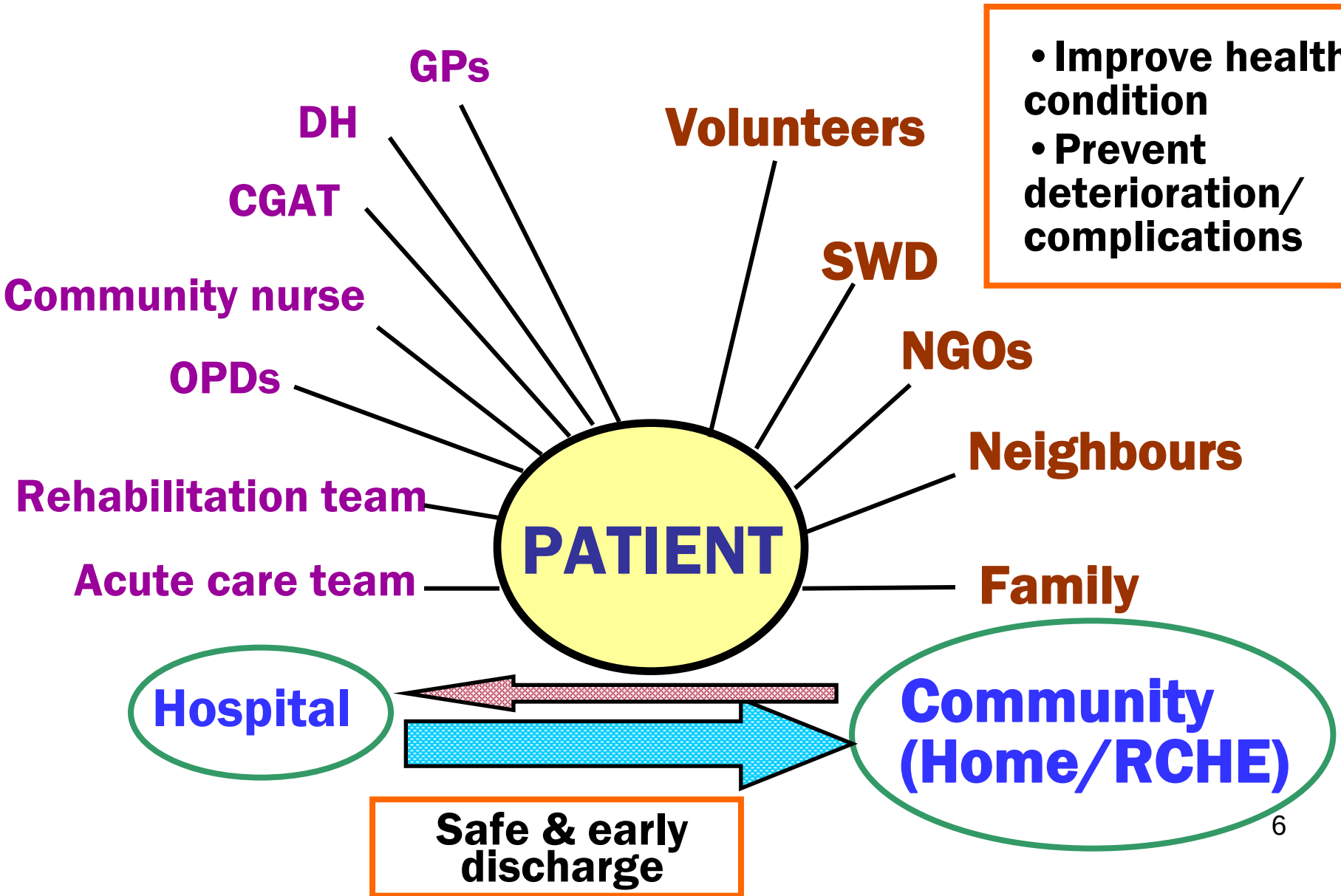
Changing Health Care Needs

• Episodic care →	Continuity of care
• Acute care →	Rehabilitative care
• Disease treatment →	Disease prevention
• Drug therapy →	Healthy life style
• Organ-specific care →	Holistic care
• Responsibility of healthcare teams →	Patients/cargiver empowerment
• Hospital systems & clinics →	Integration/Interface with community partners

How do we see Population Health & Community-Based Care



Healthcare Partners of a HK Patient



- Improve health condition
- Prevent deterioration/ complications

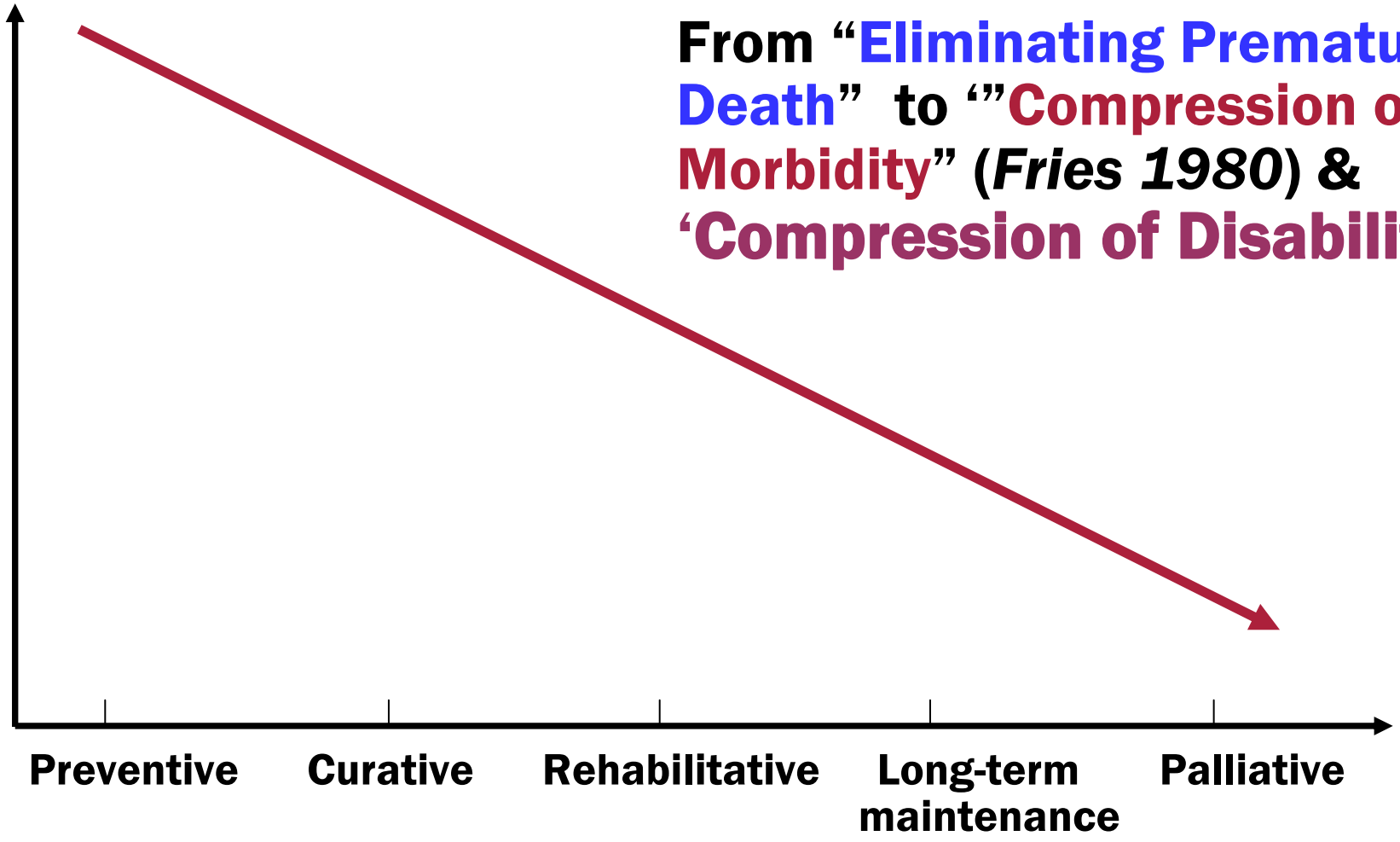
Keeping the population healthy

- **Healthcare institutions cannot act alone to create healthy communities**
- **"Inform, educate and empower people about health issues" and "Mobilize community partnerships and actions to identify and solve health problems" are 2 of *'Ten essential Services for Public Health'* of the Centres for Disease Control and Prevention (CDC)**

HKEC Hospitals

- **Vision & Core value**
  - **United in Caring for the Health of the Community**
- **Mission**
  - **In collaboration with other healthcare providers and the community, we shall ensure appropriate provision of holistic care for the Hong Kong East population through an integrated and sustainable healthcare delivery model**

Community Care in HKEC
Focusing on the Continuum of Care



The HKEC Approach to Community Care

- HKEC hospitals
- Dept of Health
- Private medical practitioners

Strategies

1. Direct service
2. Empowerment
3. Engagement & Partnership

- SWD
- NGOs
- Formal/ Informal caregivers
- Volunteers

HKEC Journey of Community Involvement : 1

- **Before 1994: Mostly Direct Service + Volunteerism**
  - **Community Nursing Service (CNS)**
  - **Numerous community projects for elderly and chronic diseases**

HKEC Journey of Community Involvement : 2

- **1994-2000: Direct Service + Volunteerism + Empowerment programs**
  - **Additional community projects on child care & school health, mental health, cancer care, etc**
  - **Community Geriatric Assessment Team (CGAT) and CGAT nursing team for residential home for the elderly (RCHE)**
  - **Community Psychiatric Nursing Service (CPNS)**

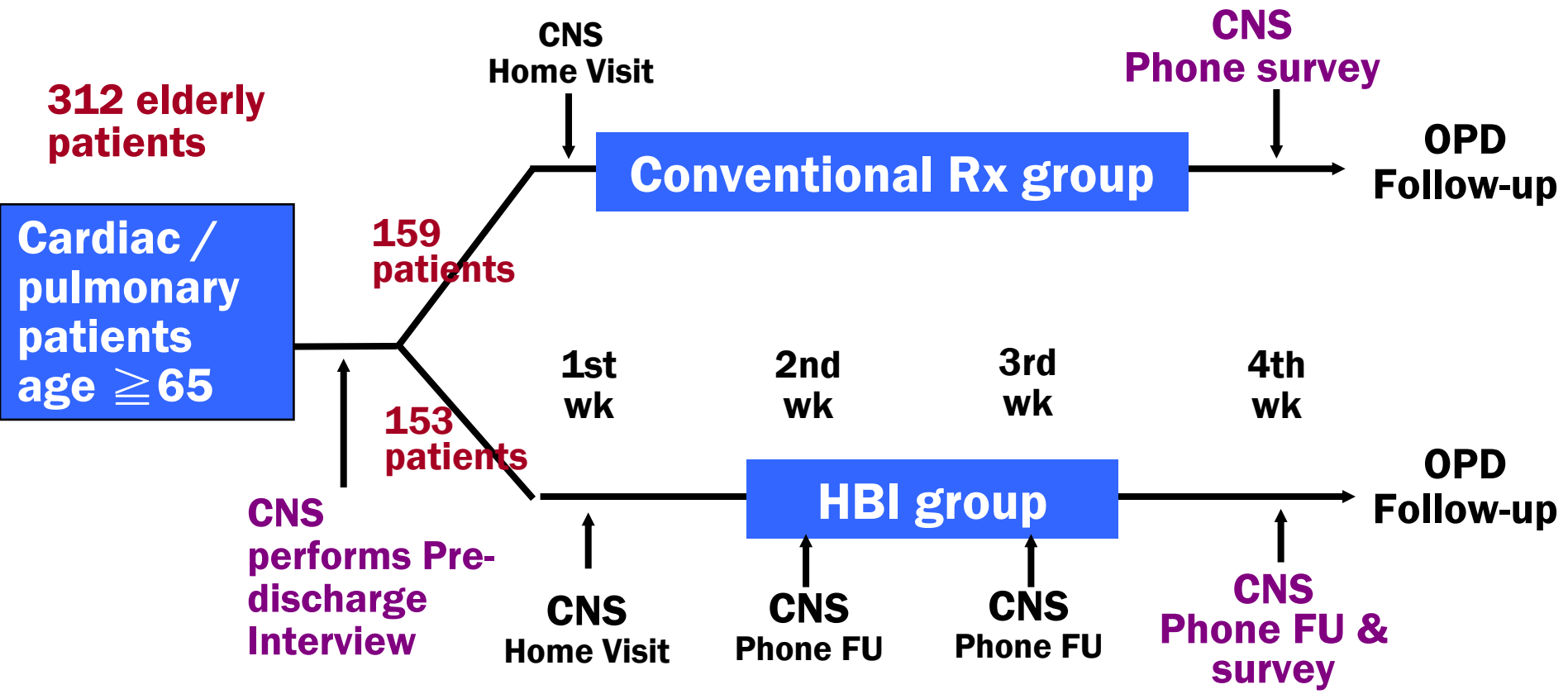
HKEC Journey of Community Involvement : 3

HKEC-Initiated
Post-discharge (virtual) FU & Support
with active participation of
Community Partners

2003 - current

Home-Based Intervention Program (HBI)

PYNEH Randomized Control Trial (RCT) 2001-02



Doctors' back-up to CNS phone services

Weekly doctor & nurse case conference

Result of HBI Program

- 18.2% ↓ of all types of hospital admissions
- 35.4% ↓ in total Length of Stay for all patients, contributed mainly by reduction in duration of convalescent care
- No significant ↑ in utilization of other health services except those related to the program like CNS visits and ad hoc clinic visits

Post-Discharge Follow-Up Program & Telephone Nursing Consultation Service (TNCS) 2003

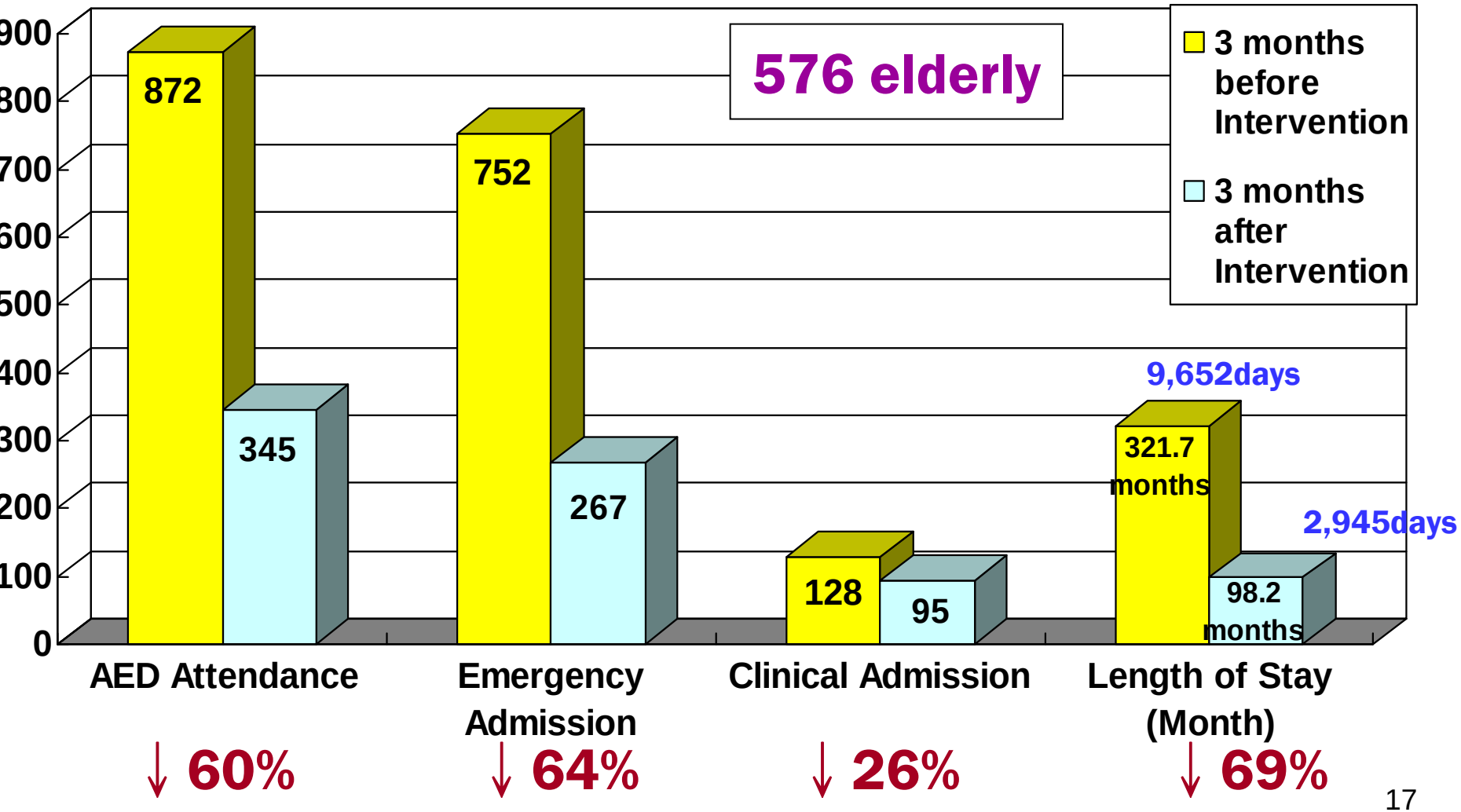
- Timely phone assessment of health status and post-discharge problems, to institute appropriate treatment utilizing appropriate health care resources
- Act as long-term community healthcare resource for the "high risk" elderly*
- Intensive back-up by Geriatric Day Hospital, ad hoc SOPD visits, direct clinical admissions + SWD/NGO-operated community health services

* High Risk Elderly

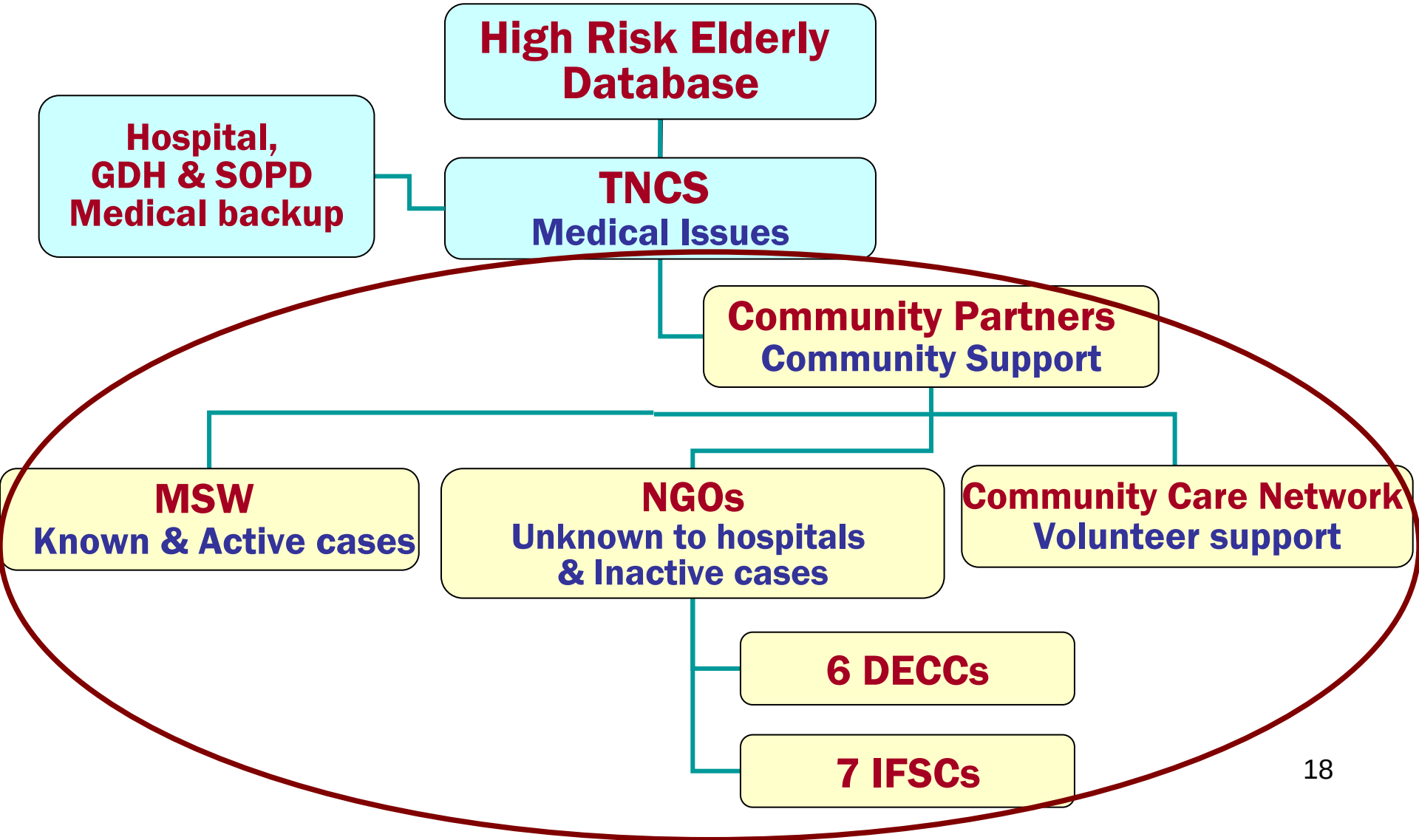
Any 2 of the following-

- > 3 A&E Admissions per year
- Any 1 of these disease groups: Congestive heart failure, chronic kidney failure, chronic obstructive airways diseases, cancer difficulty in swallowing
- > 3 co-morbidities

Effectiveness of TNCS
(Jun 2003 – Jul 2004)



HKEC High Risk Elderly Database (Since 2005)
The Power of Networking



Post-Discharge Home Support Schemes Further Evaluation & Development

- **Post-discharge home FU program 2005-6**: RCT of 209 high risk patients – ↓ 60% AED and ↓ 68% unplanned readmission rates

- **TNCS + High Risk Elderly Database (HRED) 2006-7**: RCT of 230 high risk patients– ↓ 36% AED attendance AND admissions

- **Visiting Medical Officer (VMO) scheme 2003-current:** 22 part time/full time VMO serving 68 RCHE serving 4846 residents – further ↓ 8% AED attendance

HKEC Post-Discharge FU Program & TNCS 2008

High Risk Elderly Database
(Since Sep 2004)

Elderly clients receiving Service from NGO-operated Home Care Teams
(Since Jan 2003)

Patients who have completed Post-Discharge FU Programs
(Since Jan 2003)

HARRPEC
Hospital Admission Risk Reduction Program for Elderly living in the Community
(Since Oct 2007)

HKEC Journey of Community Involvement : 4

HKEC
Cluster Community Service

Jul 2005 - current

Background: HKEC as service provider

- **Need**: Relatively low acute/convalescent bed-to-population and bed-to-elderly population ratios spurred community services development since 1991
- **Status as of Apr 2005**: HKEC collaborated with **241** service units of NGOs to co-conduct **48** community projects in **10** specialties/ subspecialties, and recruited **1855** volunteers to serve patients in **6** hospitals
- Major integration and governance issues still prevalent, however

Structural change in HKEC Community Service

- Director of Community Service appointed July 2005
- Responsible for ALL community health services within the Cluster
- Focus on inter-personal/inter-organizational liaison
  - To work as a bridge between 6,000^{+} HA staff, government units/departments, 200^{+} NGO/other organizations, and nearly 2,000 volunteers

Community Health Service Planning Workshop

Partnering with Community Care Providers

Hong Kong East Cluster
Hospital Authority

13 August 2005

Our Vision

“A Healthier Community in Hong Kong East”

Outcome of Workshop 13/08/05
4 Strategic Areas for Enhancement

- To strengthen community health infrastructure by establishing a Liaison Office
- To ensure quality of care by defining health outcome indicators, setting protocols/ guidelines, and performing evaluation studies
- To improve networking and communications by setting up 7 platforms, enhancing information exchange and engaging community support for (HRED)
- To enhance staff training and capacity building through pooling of resources in the cluster and the community

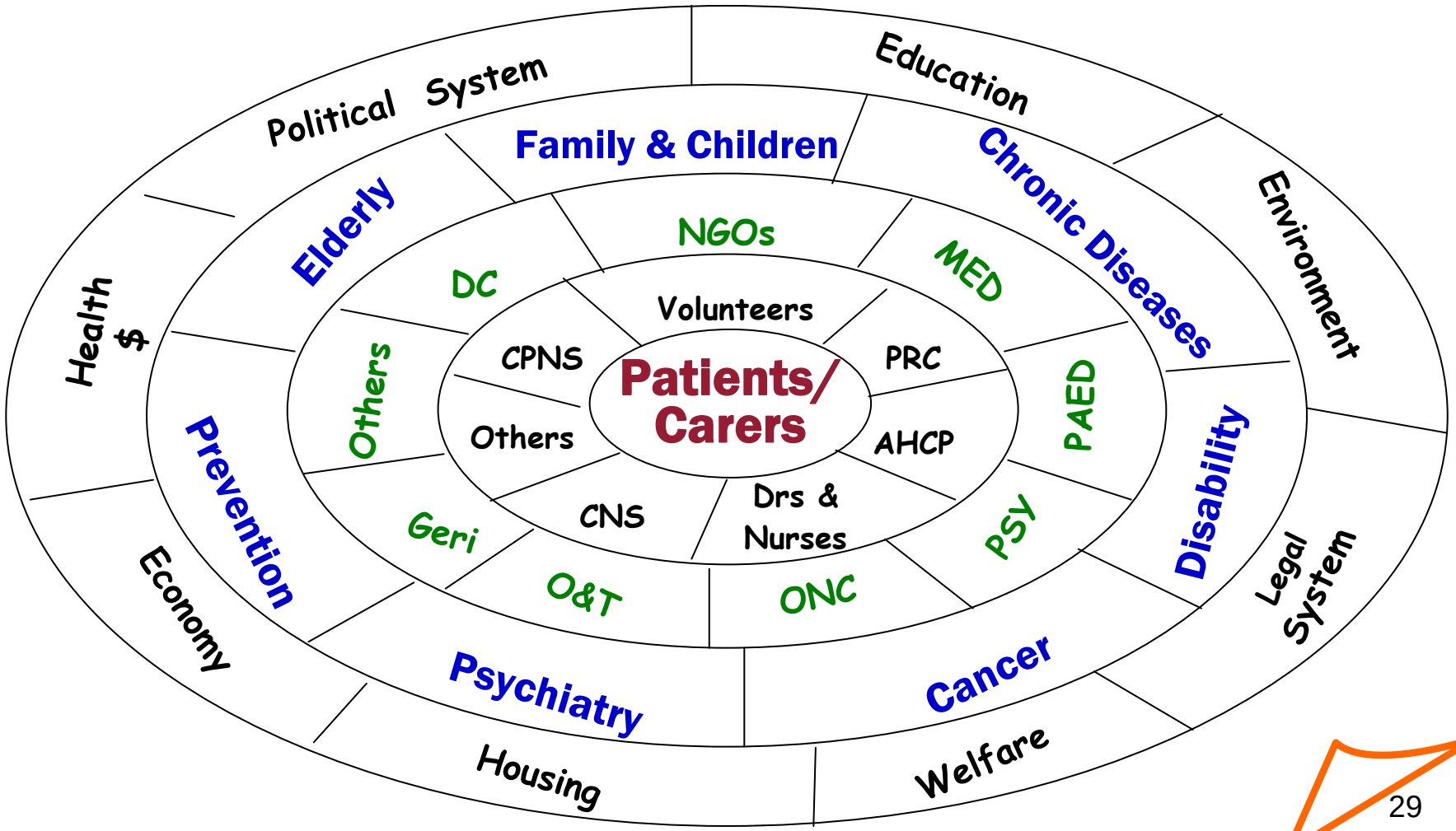
HKEC Community Care Program
Our Aspirations

- **Committed staff, leaders & community partners**
- **Structured approach**
- **Multidisciplinary teams**
- **Comprehensive and holistic patient assessment & management**
- **Integrative collaboration with community partners: trust and interdependence to foster new initiatives & research**

Critical Success Factors

- Appropriate health promotion skill base
- Long term commitment
- Strong leadership
- Strong hospital partnership with community to harmonize into a "United Front"
- Integration of all facilities + resources of hospitals and community
- Non-ambivalent funding

"UNITED FRONT" 統一戰線 for Community Service in HKEC



Integration of Cluster Community Service: Continuing Efforts

- **Internal Dissemination**

HKEC Workshop on
"From Hospital to Community – Involvement of Clinical Services in HKEC"
Share your views on
Successes & Failures
Obstacles & Opportunities
Saturday 4 March 2006

HKEC Journey of Community Involvement : 5

- **Community Engagement Seminars**
  - NGO-HKEC Workshop 13 August 2005
  - HA Convention 9 May 2006
  - 2nd Symposium 23 Sep 2006
  - **3rd Symposium 14 Mar 2008:**

HKEC Journey of Community Involvement : 6 Development of 7 Platforms: I

- New **Community Network Office** with **7 Platforms:** ***Chronic Diseases, Elderly, Family & Children, Disabled, Cancer, Mental Health and Health Promotion***
- **NGO representatives** actively participate in every Platform with **rotating co-chairmanship**
- **All Platforms expected to efficiently function through interacting with a (continually-integrated) network** of ***Clinicians, CNS/CPNS, CGAT, Allied Health Services, GOPC/IC/FMSC, Patient Resource Centres, Volunteers and Chaplaincy Services***

Development of 7 Platforms: II

- **7 Platforms now supported by Working Groups, to focus on *Quality of Care, Management Protocols, Communication and Information Sharing, Staff Training and Outcome Evaluation***
- **Key Performance Indicators being developed, to eventually include indices of health services utilization, hospital staff & community partners participation, and health indicators of the population**

HKEC Journey of Community Involvement : 7

HKEC eResources Website

HKEC
"e-Resources"
港島東健康資源網

首頁

聯網資訊 社區協作 出院錦囊 社區資源 資源中心服務 健康學堂

資料搜尋器 | 下載區 | 有用連結 | 聯絡我們 | 網站地圖

歡迎瀏覽
「港島東健康資源網」!
我們會定期更新網頁的內容, 為你提供最新的資訊

歡迎瀏覽「港島東健康資源網」!

「港島東健康資源網」是一個跨病類社區復康資訊平台。配合「港島東醫院聯網」社區爲本服務發展目標，透過本網頁，你可得知港島東多方面的健康資訊，掌握及善用各種社區復康資源。

HKEC Liaison Office

- **Organizational Liaison**
  - Community Network Office headed by social worker
- **Patients Liaison**
  - Extension of Telephone Nursing Consultation Service

HKEC Journey of Community Involvement : 8 Further partnering initiatives

2004 - Current

- **Partnering with 7 major elderly agencies in Community Involvement & Inclusion Fund (CIIF) project**
  - **Expansion of local networks**
  - **Project funding HK$ 2Mn from HWFB**
  - **Sustainable social + health partnerships and health promotion initiatives for sick and well elderly**
- **Visiting Medical Practitioner Project in RCHE for Disabled with 8 NGOs**
- **HKJC-sponsored Cadenza Projects with 2 NGOs in application stage**

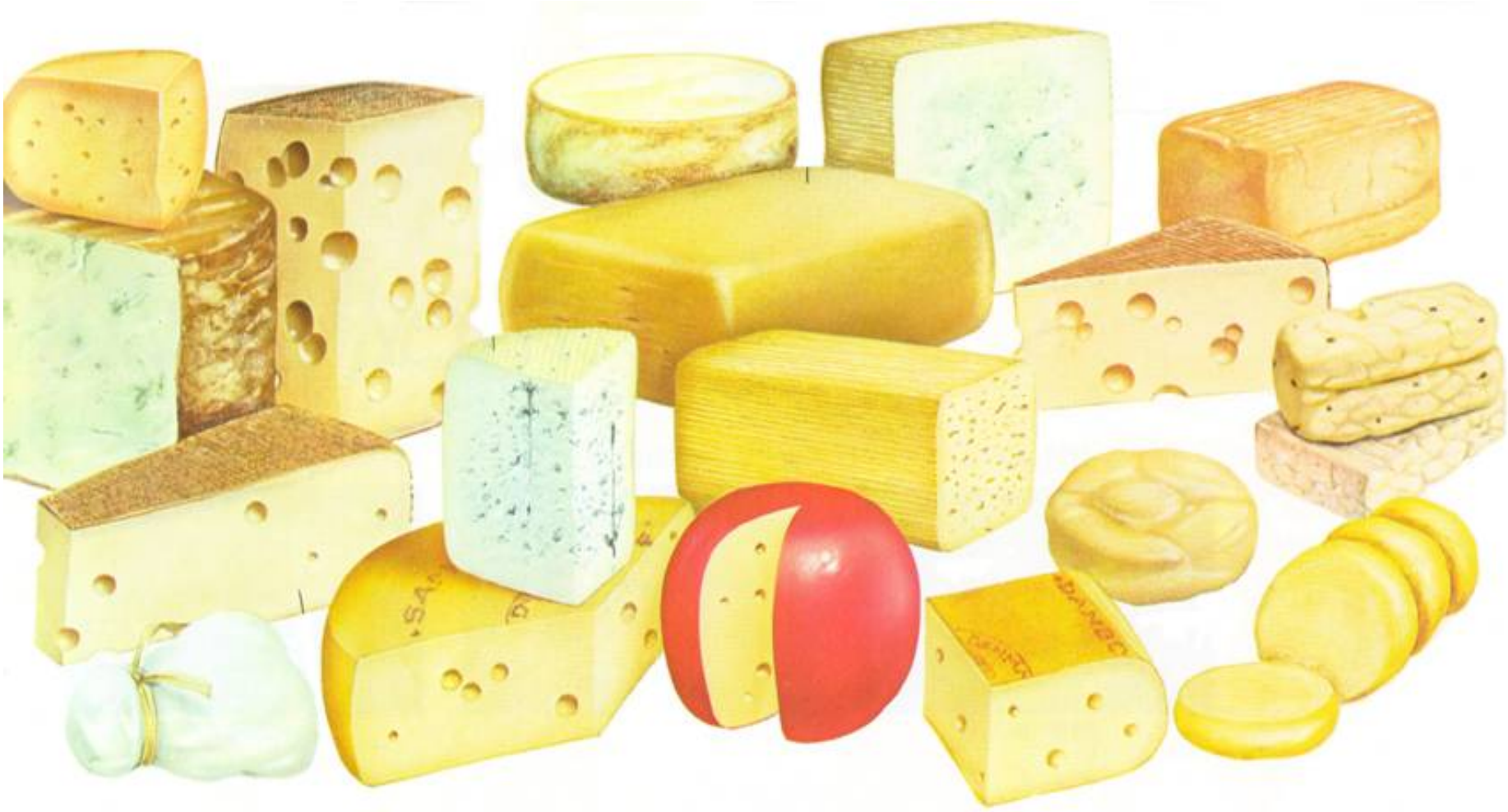
Limitations & Areas for Improvement

- Service fragmentation still exists
- Cultural differences remain among service providers
- Further enhancement required in communication and information exchange
- Platform for sharing of clinical, social information & expertise needs broadening & strengthening
- Primary care support for the community to be strengthened
- Unknowns and uncertainties
  - Point of care testing & interpretation
  - Alternative Medicine: TCM, Acupuncture, etc

The Current HKEC Community Service Overall Approach

- To enhance safe and early discharge from the hospital by establishing a good community support environment and utilizing ambulatory care services offered by hospitals
- To keep patients healthy and safe in the community via effective referral systems, community rehabilitation/support & 2° prevention programs, and patient & caregiver empowerment programs
- To keep the population healthy by collaborative primary prevention programs and early detection of diseases in the community

Community Engagement and Community-Based Services
Where do we go from here?



Community-Based Health Services
The future in partnership

- **Technology-based development** in the community
  - Electronic Health Record & e-Health
  - Community Database Information System
- **Protocols** to improve referral and care in the community
- **Key Performance Indicators** for structure, process & outcome
- Cluster- or region-based collaborative **Community Health Centre(s)**
- Collaboration towards Community Health Diagnoses and Public Health Targets towards conversion of HKE to a **Healthy City**

The Ideal District-Based Community (Primary) Health Centre: Practical Issues

- Amidst high density population
- Targeted at lower income groups
- Easily accessible even to the old/frail/disabled
- More user-friendly than hospitals
- High community ownership and commitment: Activities are initiated and driven by the community
- Low operating costs and low charges for clients
- All infection control problems overcome

Community-Based Health Services
The future: What we need

- Policy endorsement for Integrated Medical-Social Care services & Socioeconomic approaches to Community-based Care
- Policy support for related research
- Health care financing
- Plans to promote ‘ageing in place’ and address increasing needs for long-term care of the elderly
- Changes in mindset, behaviour, work patterns and habits

Acknowledgments

- Our valued Community Partners: NGOs, Volunteers, Schools, District Council
- Government departments: SWD, HAD
- Sponsoring organizations: HKJC, CIIF
- PYNEH Hospital Governing Committee:
  - The late Dr Raymond Wu, Past Chairman
  - Ms Ophelia Chan, Member
- Office of the HKEC Cluster Community Service
- HKEC cluster Management

Thank you