An Interfacing Model for Empowering Patients with Chronic Illness to Self-Manage their Health: Experience in Hong Kong East Cluster

Anna KWOK[1,2], Rebecca WONG[3,4]
Community Rehabilitation Network[1]
The Hong Kong Society for Rehabilitation[2]
Community & Patient Resource Centre[3],
PYNEH[4]

Introduction:
The Interfacing Model has been developed since 2000 for referring Patients with Chronic Illness from hospitals to community, with the major goal to empower the patients to self-manage their health. It is a close collaboration between Patients' Resource Centres (PYNEH, RH & TWEH), various clinical departments in Hong Kong East Cluster, Community Rehabilitation Network (CRN) and some patients' associations.

Purposes of the Project:
Why the Patients with Chronic Illness need to "Self-manage"?
"Self-management" has been proved to be a significant and essential part for improving patients' compliance with medical treatments and sustaining their adherence to health-related behaviors. It is also a proactive and adaptive way for strengthening patients' self-efficacy to cope with the lots of health-induced problems in their daily life.

Materials & Methods:
Overview of the Model:
Starting from 2000, PRCs of HKEC [mainly from PYNEH, RHTSK & TWEH] and CRN explored further collaboration with clinical units in view of patients rehabilitation. Interfacing models were therefore widely discussed for different chronic disease groups such as Stroke, Systemic Lupus Erythematous, Respiratory, Parkinson's Disease and Epilepsy based on patients' demographic data and their needs of long term rehabilitation. 'Interfacing Protocols' were also mutually designed between clinical units, PRCs and CRN to set up a service flow from hospitals to the community. In 2003, service of community networking was developed intensively into other chronic disease groups such as Diabetes Mellitus, Cardiac, Rheumatoid Arthritis, Ankylosing Spondylitis, Scleroderma and Chronic Pain with diversified formats. The Interfacing models became a platform for the patients and their caregivers not only to grasp specific knowledge on rehabilitation but also to learn from ex-patients the benefits of self-management. It is crucial that the participants could 'taste the honey' and were motivated to join the rehabilitation programs held by CRN and other patients' associations in future. Besides, Promotion Station in SOPDs of HKEC was also another platform for CRN & other patients' associations to introduce suitable service to needy out-patients & their caregivers.

Partnership Roles between PRCs, Clinical partners and CRN:
Patients' Resource Centre has performed a "leader" role in this interfacing collaboration. It is responsible for coordinating the whole project and liaising with all those related internal and external partners.

Major role of Clinical partners is to actively refer and encourage patients to participate in the programs. They also act as one of the facilitators or speakers in some of the programs.

For the role of CRN, it is responsible for enhancing patients' awareness and motivation to self-manage, as well as to follow-up for service matching after the interfacing programs. CRN will also liaise with different patients' associations for necessary involvement.

Results:
Statistics:
Since 2000, over thirty large-scaled seminars and fifty small-scaled programs have been jointly organized. It is estimated that over three thousands chronic patients and their caregivers have participated in the programs and nearly half of them have been followed-up to join different types of community support services.

Conclusion and Future Recommendations:
In conclusion, the project has a rapid and very satisfactory development in these few years. For the further improvement to reach a greater success, it is recommended that "self-management" should be viewed as an essential "prescription" for chronic patients' disease management. "Referral out for Empowerment in Self-management" should be added into the critical pathway.