香港復康會
The Hong Kong Society for Rehabilitation
社區復康網絡
Community Rehabilitation Network

New Role of Community Rehabilitation Network (HKSR CRN) in Primary Health Care

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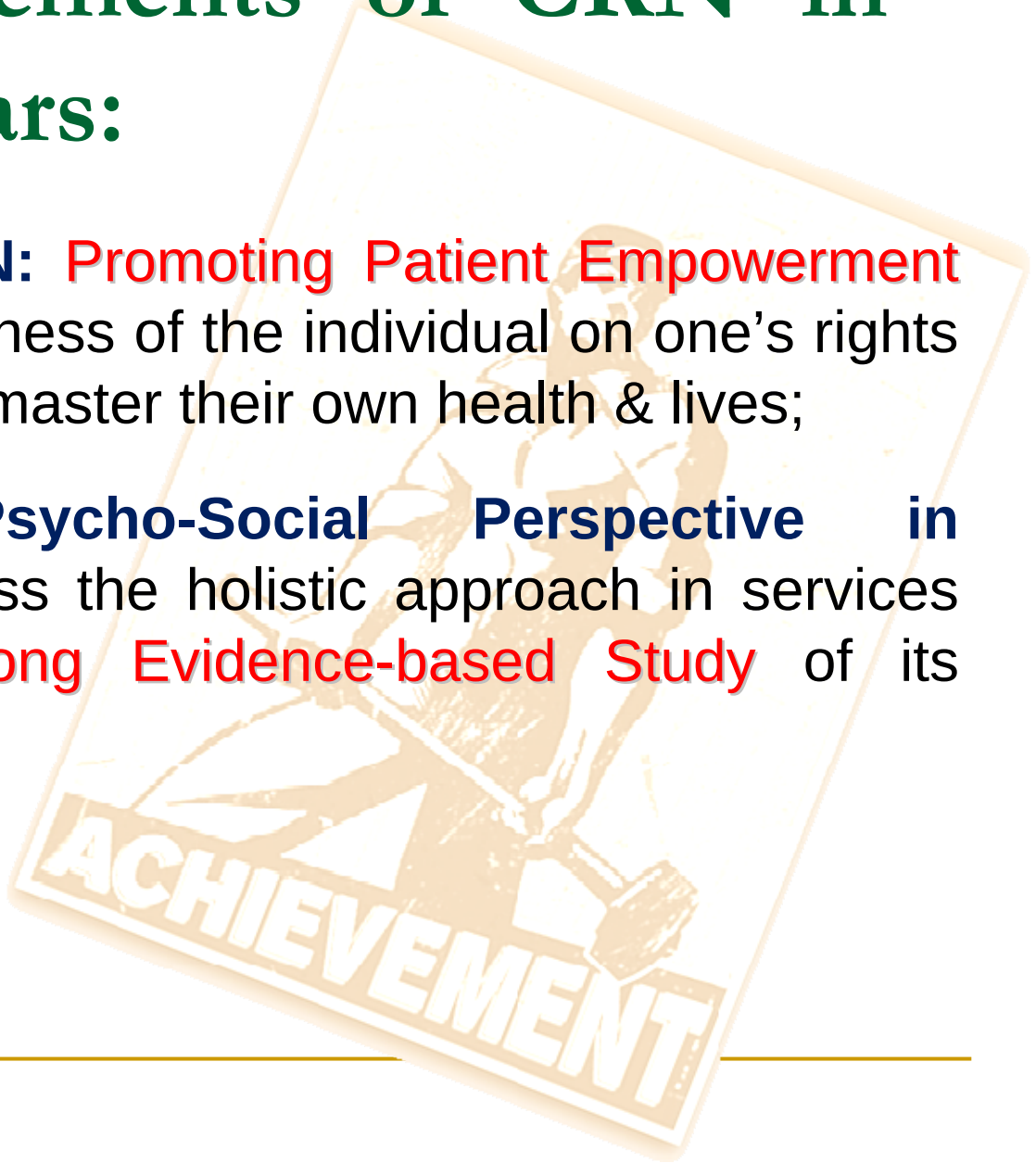
Major achievements of CRN in the past 15 years:

- **Core Value of CRN:** Promoting Patient Empowerment by raising the awareness of the individual on one's rights & responsibilities to master their own health & lives;
- **Promoting Bio-Psycho-Social Perspective in Rehabilitation:** stress the holistic approach in services provision; with Strong Evidence-based Study of its effectiveness



Evidence-based of CRN Interventions

- **Outcome Studies**
  - DM Self-Management Program
  - Chronic Disease Self-Management Program
  - Rheumatoid Arthritis Self-Management Program
  - 「心情新角度」Emotional Management by CBT
  - Stage of Change in Self-Management of Chronic Disease

~30 EBP projects were conducted

For details, please visit http://www.rehabsociety.org.hk/93.0.html

Key findings of the studies

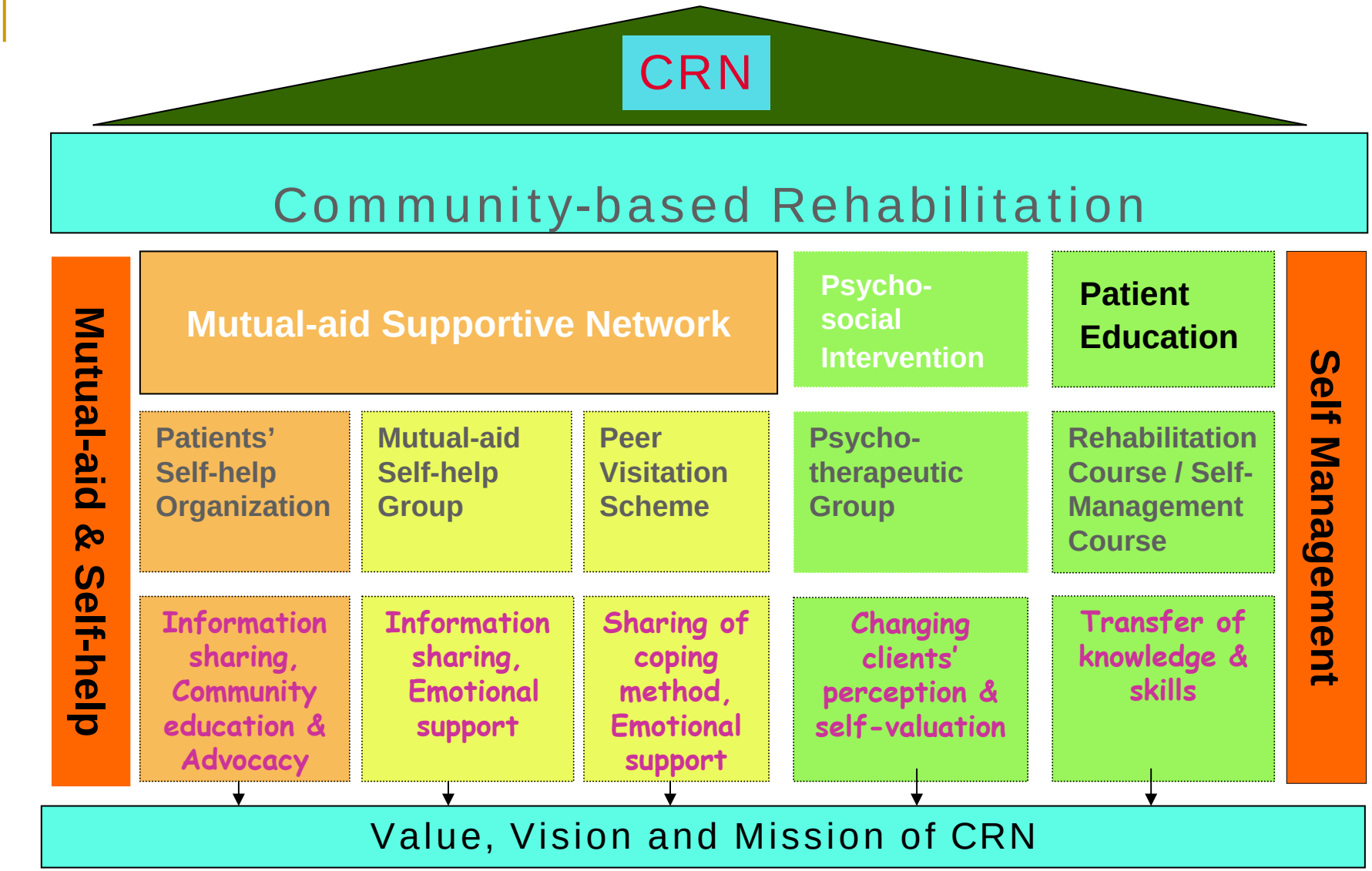
- Enhanced Self-Efficacy
- Sustainable Behavioral Change
- Improvement in Health Outcomes
- Improvement in Psychological Well-being
- Decreased "Unnecessary" Utilization of Healthcare Resources

Major achievements of CRN in the past 15 years:

- Introduced the Chronic Disease Self-Management Program to HK& China: derive effective interventions in modifying the attitudinal & behavioral change of the patients
- Leading the development of patients' Mutual Aid & Self Help: facilitate the formation and development of the SHO & promote the MASH
- Developing quality psychotherapeutics programs: address the different psychological needs & demands induced by chronic illnesses

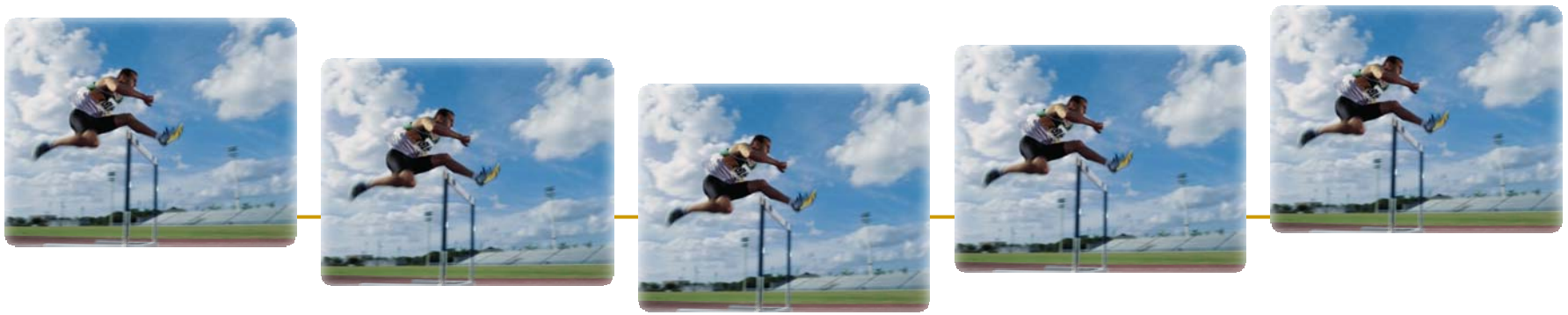
Major achievements of CRN in the past 15 years:

- Pioneering the peer-led approach: introduce the professionals-and-patients co-lead model so as to maximize the strengths of both sides via partnership
- Shared knowledge with community partners via training of the trainer (TOT): particular achievements at the elderly units on diseases such as Stroke & DM
- Building up a supportive community towards chronic illness: carry out projects such as 無障礙運動、照顧者支援平台 in promoting care to the people with chronic illness & their families


CRN
Community-based Rehabilitation
Mutual-aid & Self-help
Mutual-aid Supportive Network
Psycho-social Intervention
Patient Education
Self Management
Patients' Self-help Organization
Mutual-aid Self-help Group
Peer Visitation Scheme
Psycho-therapeutic Group
Rehabilitation Course / Self-Management Course
Information sharing, Community education & Advocacy
Information sharing, Emotional support
Sharing of coping method, Emotional support
Changing clients' perception & self-valuation
Transfer of knowledge & skills
Value, Vision and Mission of CRN
PMSC
CRSC
Both

Major hurdles in these years

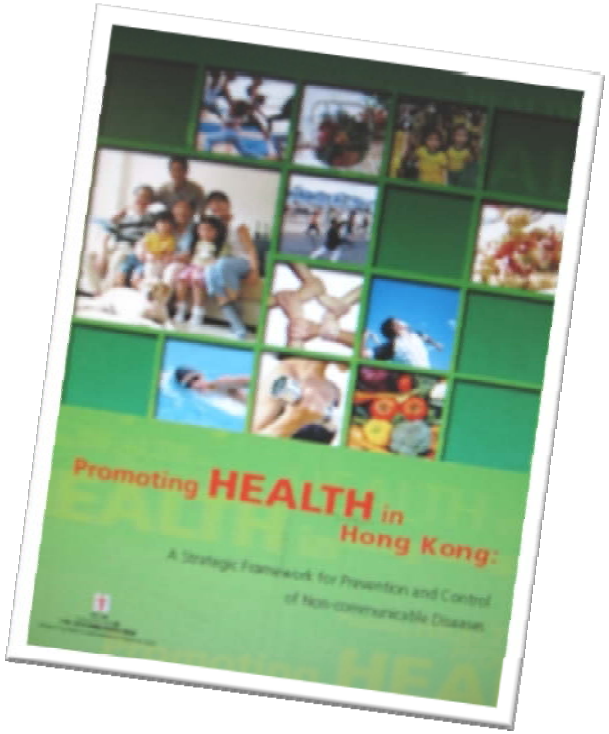
- **Huge population of chronic illnesses:** services provided by CRN & the community partners are limited comparing to the large pool;
- **Orientation of self management of the health care professionals (HCP):** some are supportive but some are distant; some know well about it but some just have a brief idea
- **Referral mechanism:** depends upon the manpower resources of the clinical units & the orientation of the HCP, usually is piecemeal and not coordinated
- **Away from the mainstream of health system:** self management support in community is isolated from the health services (problems in refer-in and feedback for follow up)



Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non Communicable Disease (Department of Health, 2008)

Problems of preventing & control of NCD:

- Rapid ageing population;
- Change in population health risk profile (rise of central obesity & hypertension);
- It takes time & joint efforts of the government, community & individual to bring the attitudinal and behavioral change in avoiding NCD risk factors



What is need:

- To establish a cost-effective prevention & control strategies in combating NCD

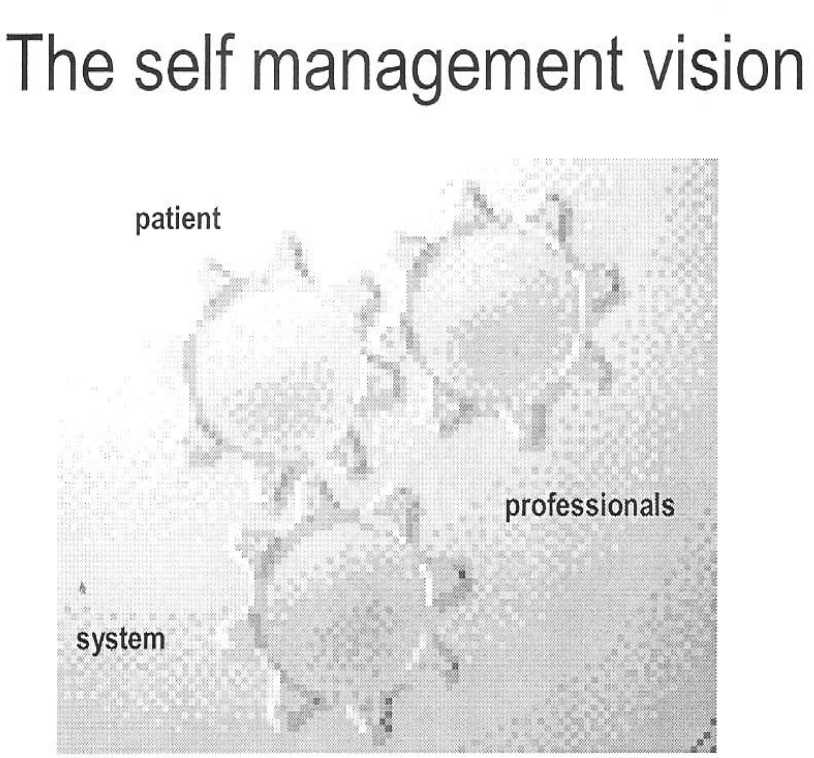
A Strategic Framework for Prevention and Control of Non Communicable Disease

- **Partnership:** draw together the strengths from various sectors with different knowledge & skills
- **Environment:** Link health promotion & disease control with total environment, e.g. healthy restaurants
- **Outcome-focus:** monitoring the health outcomes
- **Population based-intervention:** emphasis on whole population for collective health benefits
- **Life-course approach:** addressing health from womb to tomb
- **Empowerment:** for those working in health & non-health sectors to equip with knowledge and skills in health promotion & disease control

The Expanded Chronic Care Model (Professor Wagner in USA): Integrating Population Health Promotion

Barr V et al. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. *Hospital Quarterly* 2003;7(1):73-82

Co-creating Health Initiative, UK



- People should take more active role in their health by getting support from their clinicians & health care systems.
- Patients need the support from their clinicians to self manage their illness.
- Self management support should be embedded within the mainstream health services

New Directions & Roles of CRN

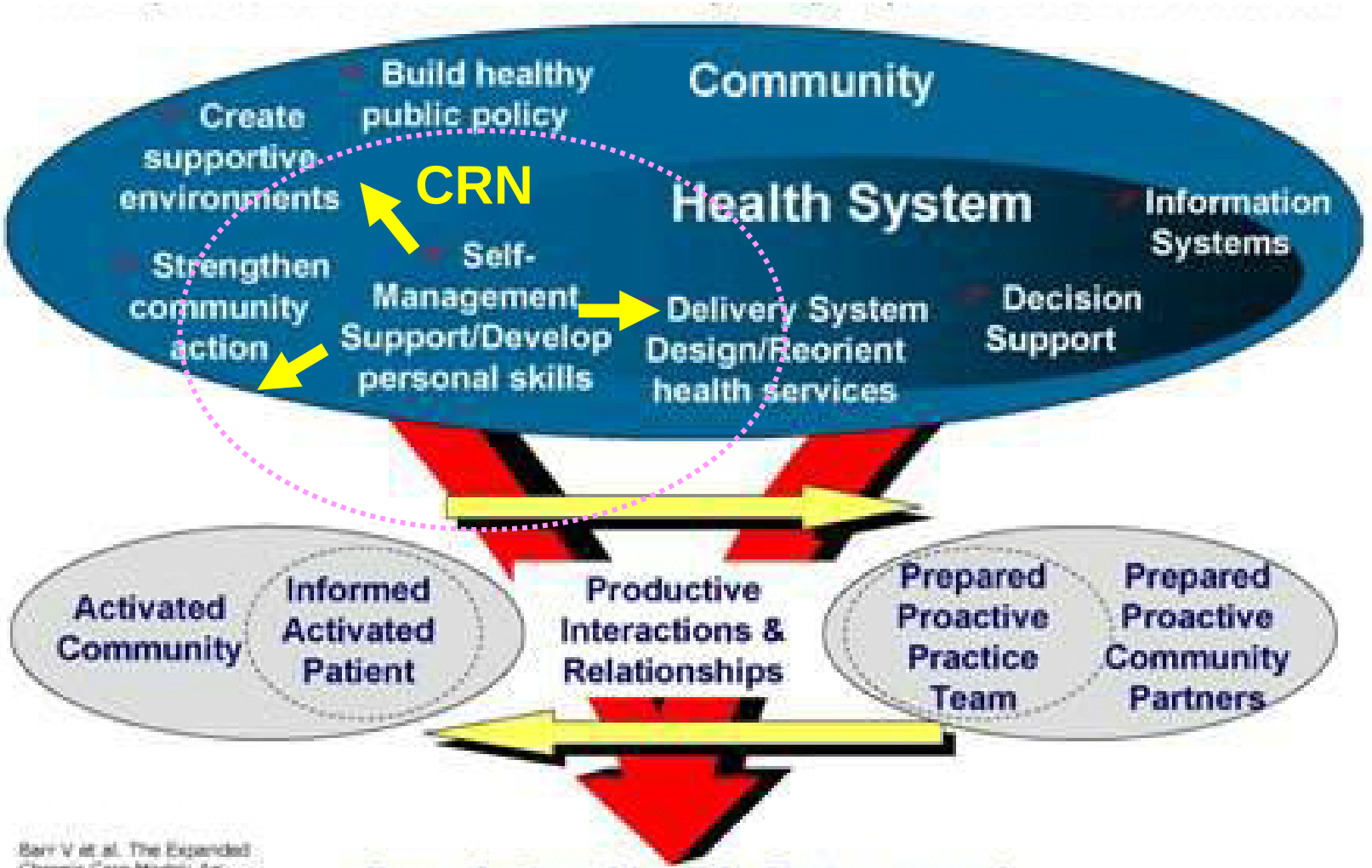
Directions

- From "mainly on secondary care on rehabilitation" more towards "primary care on NCD control";
- From "intervention in the community" to more on "intervention in both the community and health systems"
- From "patients training" to more emphasis on "professional training";
- From "disease based" intervention to "symptom based"

Roles and tasks

- Develop stronger partnership with GOPCs, GPs, NGOs, SHOs, districts partners (District Board), etc;
- Integrate self management support into the formal training of medical & nursing school;
- Expanding the symptoms based services such as, weight management, hypertension, pain management

The Expanded Chronic Care Model (Professor Wagner in USA): Integrating Population Health Promotion



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(A) From "Patient Empowerment" to "Professional Empowerment"

1. Commissioned trainings for Institute of Advanced Nursing Studies, Hospital Authority:

- Seminars and Workshops on "Chronic Disease Self-Management" (Since 2006, with over 400 Attendance);
- Stroke Care Nursing Course (2009 with about 200 attendance);
- Rheumatology Nursing Course (2009 with more than 40 attendance);
- Specialty Diploma Course in Geriatric & Stroke Medicine for Nurses from Guangdong Province (2008 with more than 60 attendance)

2. Department of Community & Family Medicine, Medical School, The Chinese University of Hong Kong:

- CRN clinical attachment (since 2008 with about 60 attendances)

3. Central Nursing Department, Kowloon East Cluster, Hospital Authority:

- Empowerment approach in nursing care (Since 2007, with more than 120 attendance)

4. Department of Medicine and Therapeutics, The Chinese University of Hong Kong:

- Master Course in Stroke and Clinical Neuroscience (Since 2006, with more than 140 attendance)

Aims of the trainings:

- To raise the awareness and interest on “Chronic Disease Self-management”
- To equip health care professionals with the knowledge, skills and confidence in applying self-management strategies in clinical practice

(B) New partners of primary health care system:

From 2005 till now:

- Family Medicine of The Chinese University of Hong Kong
- Lei Yuen GOPC
- Ma On Shan GOPC
- Sai Wan Ho GOPC
- Ngau Tau Kok GOPC
- West Kowloon GOPC
- Lower Kwai Chung GOPC

Targets patient:

- DM patients with HbA1C more than seven percent but under stable medical conditions;

Aim of the collaboration project:

- Encourage the DM patients to modify the unhealthy life style by self management;

Content of the collaboration:

- Orientation of self-management to the medical officers and the nurses at the GOPC;
- Direct referral to CRN for the patients in need;
- Patients empowerment programs (educational talk, self help course & mutual aid support group) conducted by GOPC nurses & CRN social workers;
- Feedback of the patients' participation to GOPC for necessary clinical action

Outcome study & results:

- See the next presentation of our project “Patient Empowerment for Management of Chronic Illness: Study on Diabetes Mellitus”

Insights:

- This new partnership at GOPC project imply “prescription” to certain extend, prescribed referral could enhance the motivation of the patients to take action;
- Integrating self management support into the health system can produce more effective outcome, it will be more cost-effective to bring the behavioral change by joint efforts of the collaboration between community and health care professionals

(C) Shift from "disease based" intervention to "symptom based"

- New self-management initiatives on weight management, hypertension & pain services
- Expected Outcomes: better control of these symptoms will lead to better prevention from other NCDs

Conclusion

- New Role of CRN: Explore & advocate for **better chronic care**
  - Provide **training & support to the health care professionals** on self management;
  - Develop **new partnership in primary care**
  - **Integrate self management support** into the health care system
  - More emphasis on the **symptom-based services**