Effectiveness of Community Partnership for End of Life Care Service to Chronic patients

“Life Rainbow” End-of-life Care

Service operated by The Hong Kong Society for Rehabilitation
PYNEH & HKEC as Strategic Partners

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End of Life Care as part of patient journey?

Late Stage Chronic ill patients

- COPD
- End Stage Renal Failure
- Motor Neuron Diseases
- Heart Failure
Outcome Pre & Post Analysis by HKU 2016 (N=48)

Service Effectiveness
Patients (Palliative Care Outcome Scale)
✓ Physical Relief
✓ Reduced Depression & Anxiety
✓ Enhanced Family Communication

Carers (Carergivers’ Health Condition & Wellbeing)
✓ Stress Release
✓ Bereavement Care

Service Satisfaction
✓ Patients expressed high satisfaction to the service

Service empowered me to live with my own ability
Service helped me live with dignity
Strategies & Stages

**Exploratory (June – Dec 2015)**
- Mutual Expectation
- Goal Setting
- Target Selection

**Trial (Jan – April 2016)**
- Selection Criteria
- Referral Mechanism
- Service for COPD & ESRF patients

**Implementation (May 2016 – now 2017)**
- Roll out to Motor Neuron Diseases & Heart Failure
- Service Monitoring

1st Exploratory Meeting in Sept 2015
1st Clinical Advisory Team Meeting in Jan 2016
Role of HKEC as Strategic Partner

1. Service Operation by The Hong Kong Society of Rehabilitation

2. Clinical partners & Allied Health professionals of Hong Kong East Cluster give advice and make referral

3. Patient Resource Centre (PRC), PYNEH as an interface to bridge throughout collaboration, monitor the overall project development and implementation

Clinical & Allied Health Team of PYNEH
- Respiratory Team
- Renal Team
- NeuroMedical Team
- Cardiac Team
- Physiotherapy
- Occupational Therapy
- Patient Resource Centre
- Medical Social Service
- Community Nurse Service

Clinical Team of RTSKH
- Palliative Team
Community Partnership for End of Life Care

(1) Advocated the importance of End of Life Care to late stage chronic ill patients & their carers, clinical partners and the community

(2) Filled in service gap to relieve patients’ distress, to enhance carers to perform caring role & reduce their stress

(3) Built up a Community Partnership Model

• Continuity of care via partnership
• Same expectation and goals shared
• Roles of different partners extended
• Understanding of mutual strength enhanced
For details, please visit Poster Display F-P6.39
Connecting to Service Gap

- Home based Symptom Management
- Psychosocial Support for Patients & Carers
- Personalized Positive Death Preparation
- Line up to Community Resources

Life Rainbow

Photos of people engaging in various activities.
## Case Profile & Service Provision

<table>
<thead>
<tr>
<th></th>
<th>Target Set</th>
<th>Target Accumulated</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>50</td>
<td>59</td>
<td>118%</td>
</tr>
<tr>
<td>Carers</td>
<td>80</td>
<td>86</td>
<td>107.5%</td>
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</tbody>
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### Case Profile & Service Provision

- **Chronic Obstructive Pulmonary Disease**: 33 (55.9%)
- **End-Stage Renal Failure**: 15 (25.4%)
- **Parkinson’s Disease**: 8 (13.6%)
- **Late-stage Motor Neuron Disease (MND)**: 2 (3.4%)
- **Others**: 1 (1.7%)

All cases were referred by PYNEH

- **Volunteers Mobilized**: 84
- **Home Visit by Social Worker**: 323
- **Home Visit by Volunteers**: 95
- **Public Education & Training Program**: 95
A pre-post analysis was applied. Structured questionnaires were filled by patients and their family caregivers.
Disease Groups among those with Outcome Assessments (N=48)

- Parkinson's Disease (G20); 7; 14.6%
- COPD (J44); 29; 60.4%
- Kidney Disease (N18); 9; 18.8%
- Motor Neurone Disease (G12.2); 2; 4.2%
- Others; 1; 2.1%

Patient has been Diagnosed with Dementia (N=30)

- (Green) Yes: 2; 7%
- (Yellow) No: 27; 93%