香港復康會
The Hong Kong Society for Rehabilitation

Topic: Medical-Social Collaboration in supporting carer: A service experience in Hong Kong East

Ms. Zoe MA / Deputy Manager & RSW
(The Hong Kong Society for Rehabilitation
- Community Rehabilitation Network)

Background of SMARTCare Movement

Hospital

Support service from hospital to community was fragmented

Medical-Social Collaboration in supporting carer

Community
Carer play an important role in patient recovery

Unprepared for the tasks

Carer Burden & Stress

Background of SMARTCare Movement

- SMARTCare movement was launched by The Hong Kong Society for Rehabilitation.
- Funded by Community Investment & Inclusion Fund (CIIF), strategic partnering with Hospital Authority Hong Kong East Cluster
- Two phases:
  - Phase I: 2011-2014 (SMARTCare · 齊"喜"動)
  - Phase II: 2014-2017 (SMARTCare · 有您友里)

Target:
Family carers of persons with chronic diseases experience high level of stress

Improve well-being of carers of person with chronic diseases

An early intervention support

To bridge a service gap of caregiver support

To advocate the importance of carer's role along patient journey

Strategies: Development of medical and social collaboration *in supporting carers*
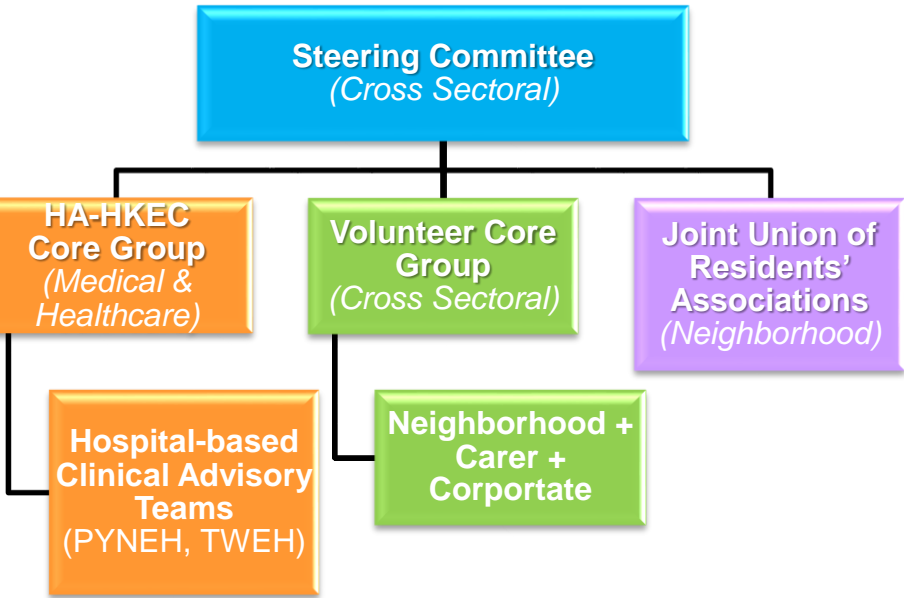
Medical

Collaboration with Hospital Authority Hong Kong East Cluster

to set up an early intervention support and referral system

Social

Carer Community Empowerment Services

Community capacity building

alliance with Community stakeholders and volunteer to launch a caring carer action

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Medical Sector: Partnering with HA Hong Kong East Cluster

Steering Committee
(Cross Sectoral)

HA-HKEC Core Group
(Medical & Healthcare)

Volunteer Core Group
(Cross Sectoral)

Joint Union of Residents' Associations
(Neighborhood)

Hospital-based Clinical Advisory Teams
(PYNEH, TWEH)

Neighborhood + Carer + Corportate

Role of Hong Kong East Cluster

~Develop strategies and platforms to support carers in medical sector

~Mobilize healthcare professionals engaged in carer support action and the project.

Result:

1. Start a carer support collaboration in three major hospital.

~PYNEH in 2011

~Rolled out to TWEH and RTSKH in 2014 & 2016

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HA-HKEC Core Group Member

~to facilitate the better communication between medical and community in carer support planning and actions.

Organization	Core Group Representatives
CRN	Ms. Anna KWOK, Ms.Zoe MA, Ms.Eva YIP, Ms. Zita MAN, Ms. Tweety LEUNG
PYNEH	Ms. Eva LO & Ms. Doris KOT & Ms. Rebecca WONG
RTSKH	Ms. Flora MAK & Ms. Edith YIM
TWEH	Ms. S W TANG & Ms. Ann WONG
CCH	Ms. Lily CHOA & Ms. Carol HO (apology)*
HKEC	Ms Daisy WONG

Clinical Professional Advisory Team

More than 10 specialties and departments are mobilized indifferent levels of participation.

- Referral systems
- Carer interfacing program
- Community education events.

PYNEH Clinical Professional Advisory Team
Supported by:

Department of Medicine
Community Services,
HKEC , Community & Patient Resource Department
Cardiac, DM, Neurology, Renal, Geriatric
Respiratory, Neurosurgery
ICM, CNS, SOPD
MSW, Clinical Psychology
Chaplaincy

TWEH Clinical Professional Advisory Team
Supported by:

M&R
NSD
Neurology/Respiratory & ICRC
Geriatric (A2&F2) & DMC
Geriatric(A1&F1) & RDH
MSS
PRC
HKEC Community Service

Medical Sector: An Early Intervention Support and Referral systems

An early Intervention Support and Referral systems

+

Carer Interfacing Program

➡

1. Well prepared for a long term care of patients and carer

2. Carers in need are identified in an early stage through referrals to the project

- Bridge the carers to access SMARTCare and community support service.

- 500 carers were referred and supported

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Carer Interfacing Program in PYNEH & TWEH

Medical Sector: Medical and community action on carer's support.

- Form alliances with community stakeholders (i.e. clinical advisory teams, core group and volunteer core group) to organize different carer support events and caring carer actions in medical and community sector
- All these collaborations are effective increasing medical and community awareness on carers'support.

Carer Lunch Seminar in PYNEH, RTSKH & TWEH.
Mobilize healthcare professionals engaged in carer support action and the project

PYNEH and TWEH's healthcare professional team participated in
Carer Engagement Program (SMARTCare·有您友里 - 照顧者健樂日) in Chai Wan community

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Social sector : Carer Community Empowerment Services

- Carer Community Empowerment Service which included social worker and volunteer intervention will be provided to support their caring needs.
- Establishes integrated partnership between hospitals and community partners
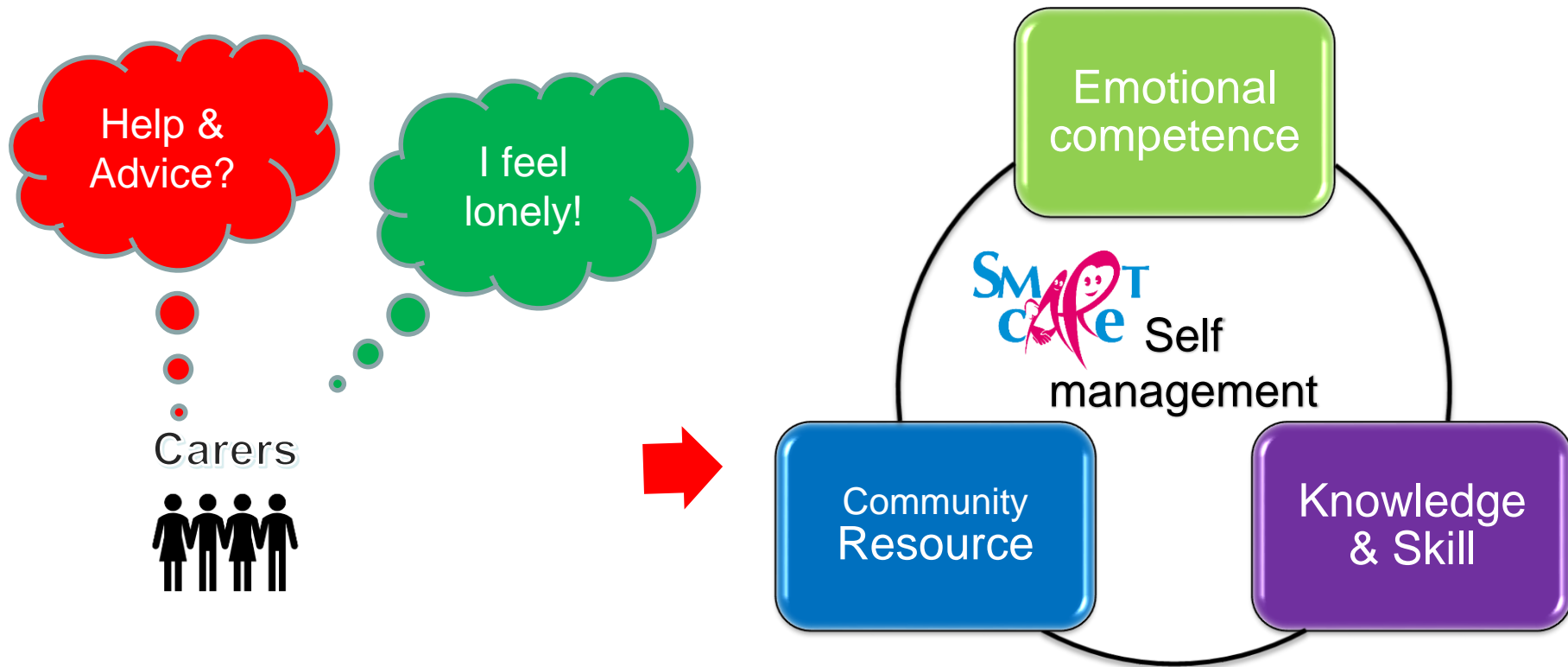
Carer Community Empowerment Service
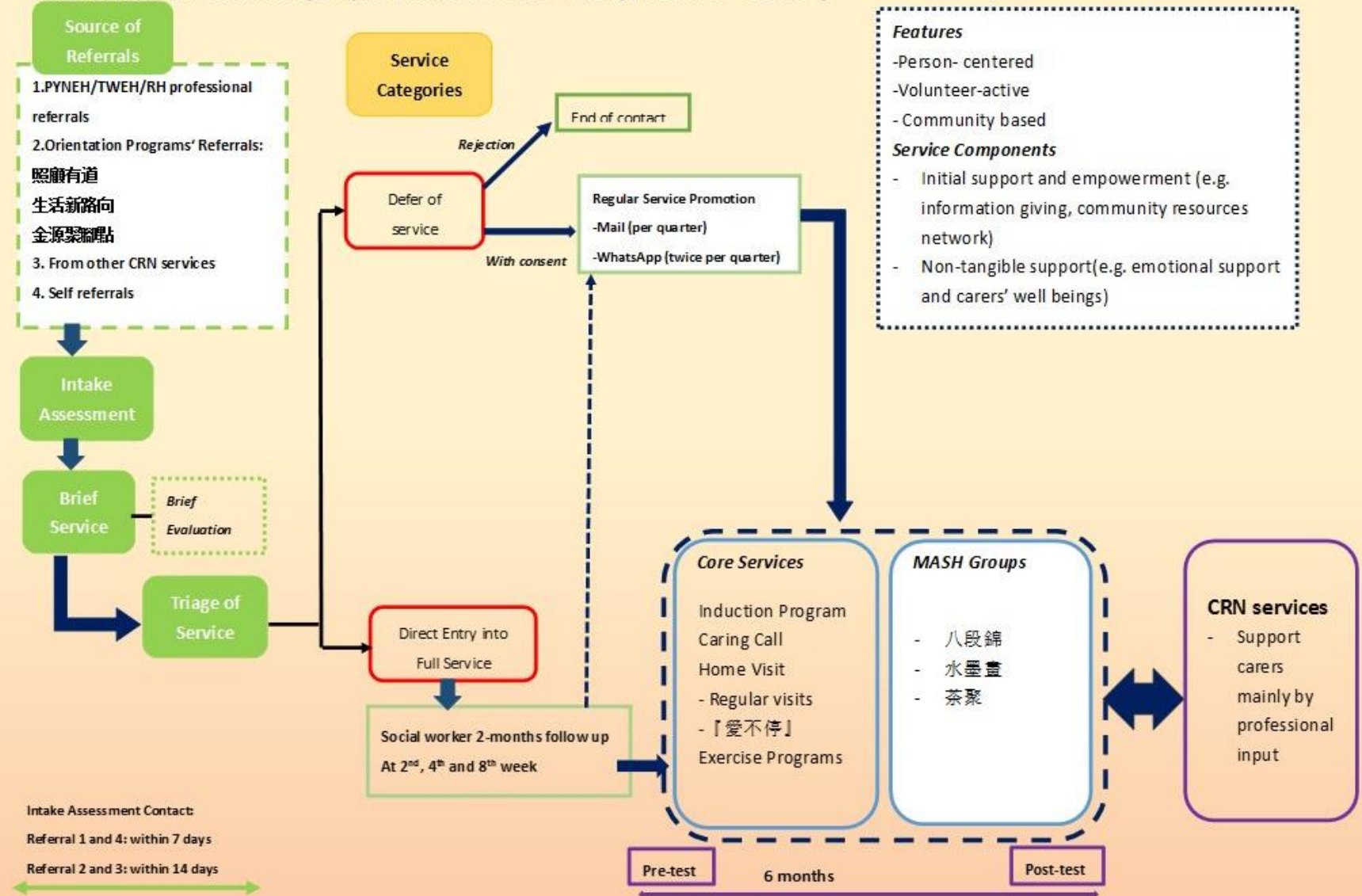
SMARTCare: Carer Community Empowerment Service Model （8 Dec 2016 Version ）

Elements of SMARTcare Service

Source of Referrals

1.PYNEH/TWEH/RH professional referrals

2.Orientation Programs' Referrals:

照顧有道

生活新路向

金源聚腳點

3. From other CRN services

4. Self referrals

Service Categories

Rejection

End of contact

Defer of service

With consent

Regular Service Promotion

-Mail (per quarter)

-WhatsApp (twice per quarter)

Features

-Person- centered

-Volunteer-active

- Community based

Service Components

- Initial support and empowerment (e.g. information giving, community resources network)

- Non-tangible support(e.g. emotional support and carers' well beings)

Intake Assessment

Brief Service

Brief Evaluation

Triage of Service

Direct Entry into Full Service

Social workers 2-months follow up At 2nd, 4th and 8th week

Core Services

Induction Program

Caring Call

Home Visit

- Regular visits

- 『愛不停』

Exercise Programs

MASH Groups

- 八段錦
- 水墨畫
- 茶聚

CRN services

- Support carers mainly by professional input

Intake Assessment Contact:

Referral 1 and 4: within 7 days

Referral 2 and 3: within 14 days

Pre-test   6 months   Post-test

Carer Community Empowerment Service

Referrals → **Assessment** → **Brief Service** → **Core Service**

Social worker support :Professional advice on care plans for prescribing service.
Carer empowerment program for learning the necessary caregiving skill, disease management and self-management concept.

• Professional advice

• Carer empowerment program

• Disease Self Management course

Volunteer support : Experience carers will be invited as volunteers to share their knowledge, experience, emotional assistance, practice help in caring and empower new carers through regular call, home visit and mutual support groups.

Volunteers Support
Home Visit

Volunteers Support
Care call

Mutual Support Group
knowledge, experience, emotional assistance

Mutual Support Group
Ink wash painting group

Carer's story

Service outcome:

Focus: Service Outcomes of Core Service

1. A study to evaluate our service outcomes from the period of 2015 to 2017

2. Collection of background of carers and care-recipients

3. Measurement of:

   2.1 Carer burden – Burden Scale for Family Caregiving (BSFC)

   2.2 Self-efficacy of chronic disease management – Partners in Health (PIH)

   2.3 Personal gain from caregiving - GAIN

4. Timeline:

   3.1 BSFC & PIH – before & after enrollment to full service (10-month)

   3.2 GAIN – after 10-month enrolled to full service

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Carers' Characteristics

- 78 carers received full service participated in the evaluation *(voluntary-basis)*

- Age:
  - **Mean = 63.3**

- Gender:
  - **Male: 32.1%** (N=25)
  - **Female: 67.9%** (n=53)

- Taking care of:
  - **Spouse: 55.1%** (n=43)
  - **Parent: 32.1%** (n=25)
  - **Others: 12.8%** (n=10)

Characteristics		Percentage (count)
Caregiver		
Age	Mean = 63.3	
	SD = 12.27	
	N = 68	
Gender	Female	32.1% (n=53)
	Male	67.9% (n=25)
Taking care of	Spouse	55.1% (n=43)
	Parent	32.1% (n=25)
	Other	12.8% (n=10)
Care-recipient		
No. of chronic diseases	1	59.0% (n=46)
	2	26.9% (n=21)
	3 or more	14.1% (n=11)
Common chronic disease	Stroke	42.3% (n=33)
	Cognitive impairment	15.4% (n=12)
	Heart Disease	11.5% (n=9)
	Parkinson Disease	10.3% (n=8)
	Other diagnoses	20.5% (n=16)

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Care Recipients

No. of Chronic Diseases:

– **1** (59.0%, n=46)

– **2** (26.9%, n=21)

– **3 or more** (14.1%, n=11)

• Common chronic diseases:

– **Stroke** (42.3%, n=33)

– **Cognitive impairment** (15.4%, n=12)

– **Heart disease** (11.5%, n=9)

– **Parkinson's disease** (10.3%, n=8)

– **Other diagnoses** (20.5%, n=16)

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Carer Burden (BSFC)

- The overall mean initial BSFC score was 65.92, and the mean reassessment score decreased to 61.92. The mean difference in score was 4.00 with a p-vale of 0.031, which was statistically significant.
- The third group (n=20) received 4 or more units of Smartcare services. (68.95 : the greatest burden at baseline.)

- Showed that the group of caregivers who received 4 units or more Smartcare services had a reduction of caregiving burden.

About the scale

- No of items: 28
- Scale range: 28 - 112
- midpoint: 70, higher score means greater burden

2nd assessment

- Mean initial score: 65.92
- 2nd assessment: 61.92
- Difference = -4.0 (statistically significant p = 0.031)
- n=78
- Mean time interval: 10.87 months

Burden Scale by unit of service

	0 unit (n=19)	1 or 4 units (n=41)	5 + units (n=20)
Mean initial score	65.89	64.38	68.95
re-assessment	59.26	62.21	63.90
Difference	-6.63 (p-value = 0.229)	-2.18 (p-value = 0.265)	-5.05 (p-value = 0.036*)
Mean time interval	9.63 months	11.54 months	10.75 months

Self-efficacy of chronic disease management (PIH)

- PIH initial mean score : 72.12
- Reassessments mean score : 76.05.
- The difference in score was 3.06 with a p-value of 0.042, statistically significant.

About the scale
- No of items: 12
- Scale range: 0 - 96,
- midpoint: 48, higher score means greater competence in self-management

2nd assessment
- Mean initial score: 72.12
- re-assessment: 76.05
- n=81
- Difference in score: 3.06 (statistically significant at p=0.0423)
- Mean time interval: 10.85 months

PIH score =   caregivers competence in chronic disease management of the care-recipient.

GAIN（Mandarin）好處與正面的成果問卷

以下是關於照顧病人的一些好處與正面的陳述。請選出你對每個陳述的看法。

照顧我的親人使我… …
個人成長
● 更有耐心和更能體諒別人。
● 更堅強和更開朗。

● 提高我的自我意識，使我更了解自己的優點和缺點。

● 增長我對長期病護理的知識與技巧。

與他人關係
● 增進我和患病親人的關係。

● 家人之間的關係更親密。

● 能與患病親人更好地相處。

靈性成長
● 讓我更深入地體會人生的意義和自己的人生觀。
● 得到精神上的提升，如：更接近神和能夠超越物質世界。
● 激起我一些無私的想法，如希望更多人去幫助別人和為其他經歷類似困境的人的福利做出貢獻。

Mean score range of 1 to 5.
• A higher score indicating greater gain.

The results showed that the mean total score at reassessment was 3.83

- Personal Gain: 3.96
- Relationship Gain:4.13
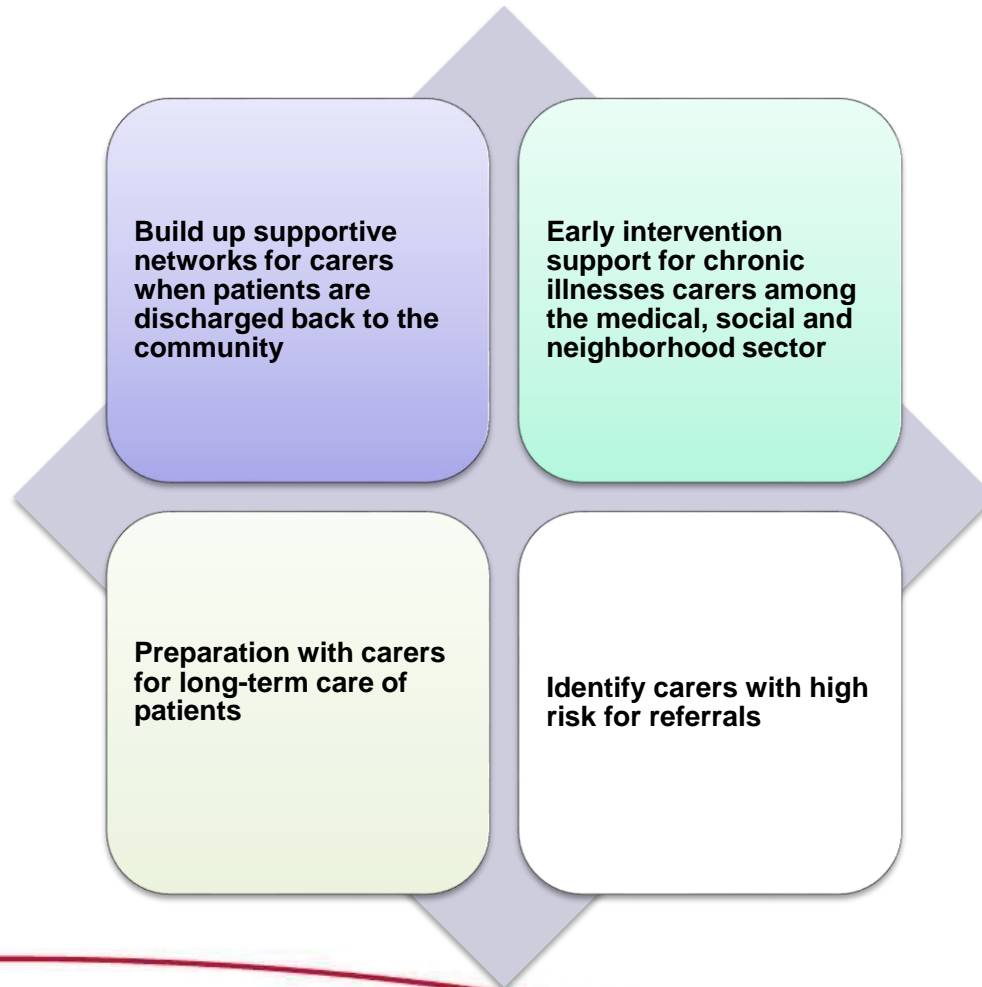- Spirituality Gain:3.36

Conclusion

- **Full service was associated with positive outcomes:**
  - BSFC overall mean change=4.00 (p=0.031)
  - Difference in PIH=3.06 (p=0.042)
  - GAIN=3.83
- **Reduction of caregiver burden was most significant for carers who received 4 or more units of services**
  - BSFC change score 5.05, p=0.035
  - Carers who had baseline score
- **Carers who had higher burden & received more service units resulted in positive outcomes**
- **SMARTCare full service should consider targeting caregivers who are in higher needs & provide more intense services**

Major Achievements

- The Medical and social collaboration strategies have effectively mobilized community in a large extent through various levels in building support for carers and in the long run.

Build up supportive networks for carers when patients are discharged back to the community

Early intervention support for chronic illnesses carers among the medical, social and neighborhood sector

Preparation with carers for long-term care of patients

Identify carers with high risk for referrals

Acknowledgement

- HKSR SMARTCare Project team

- Dr. Teresa CHIU (independent researcher)

- Community Investment & Inclusion Fund

- "SMARTCare Movement" – Steering Committee

- Hospital Authority Hong Kong East Cluster

  – Core Team

  – Community Service & Patient Resource Centres

  – Department of Medicine & various Allied Health Departments

- Neighborhood organizations & Volunteer Teams