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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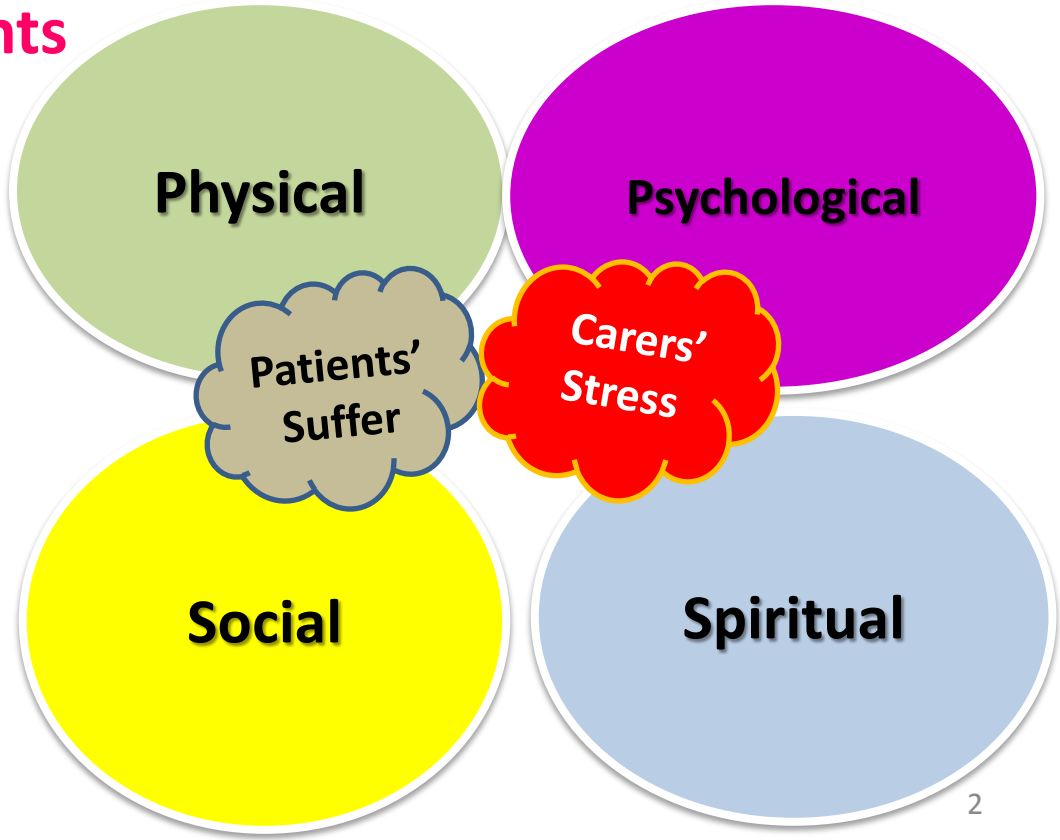
End of Life Care as part of patient journey?

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

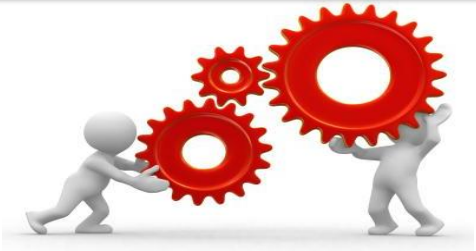
1. Service Operation by The Hong Kong Society of Rehabilitation
2. Clinical partners & Allied Health professionals of Hong Kong East Cluster give advice and make referral
3. Patient Resource Centre (PRC), PYNEH as an interface to bridge throughout collaboration, monitor the overall project development 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



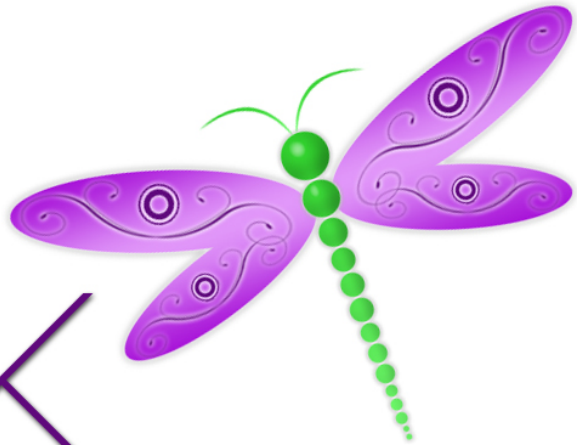
Community Partnership for End of Life Care

(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



thank you . . .

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Connecting to Service Gap

Home based

Symptom Management

Psychosocial Support for Patients & Carers

Life Rainbow

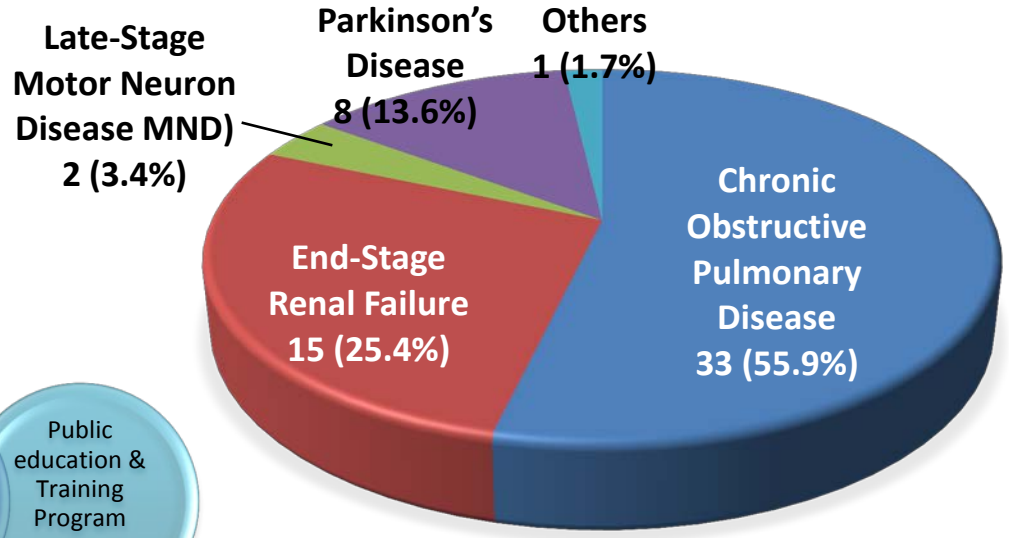
「安晴」生命彩虹」社區安寧照顧計劃

Personalized Positive Death Preparation

Line up to Community Resources

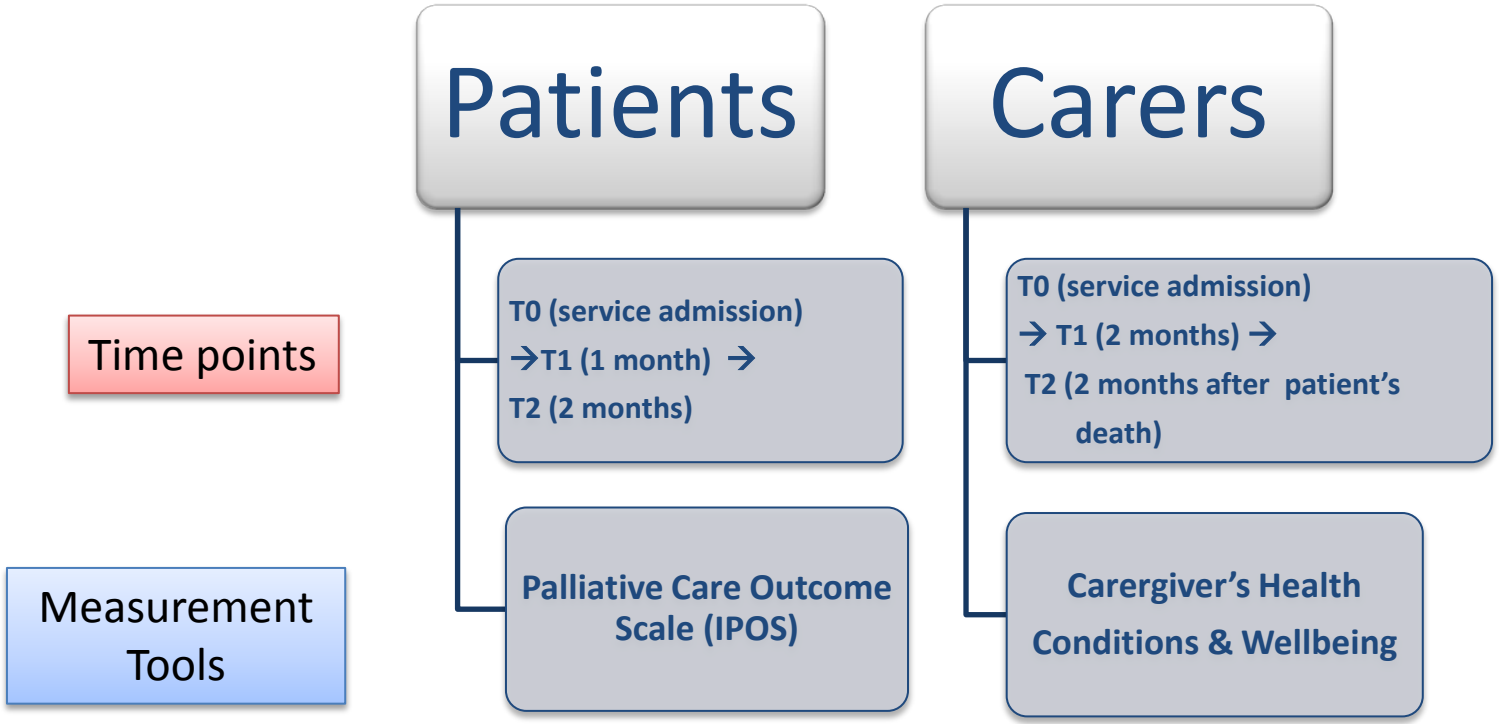
Case Profile & Service Provision

	Target Set	Target Accumulated	Percentage
Patients	50	59	118%
Carers	80	86	107.5%



All cases were referred by PYNEH

Method



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)