



香港復康會
The Hong Kong Society
for Rehabilitation

Practising Self-Management in Cardiac Rehabilitation

**The Hong Kong Society for Rehabilitation
Community Rehabilitation Network**

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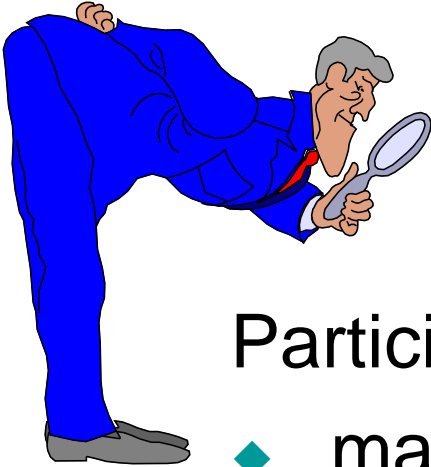
History of chronic disease self-management

- The self-management program originated from the School of Medicine at Stanford University in the 1991
- Developed by several investigators:
Dr H.Holman, Dr K. Lorig, Dr. D. Sobel et al
- Over 1000 people with heart disease and other chronic illness joined the program with positive feedback
- Favorable results include improvements in exercise, communication with physicians, health distress, fewer outpatients visits and hospitalization.....

Chronic Disease Self Management Program

- Based on patient perceived problems
- Builds self-efficacy and skills to perform
 - Disease Management
 - Role Management
 - Emotional Management

Self Management (K. Lorig 1993)



Participants can:

- ◆ make informed choices
- ◆ Adapt new perspectives and generic skills on problem solving
- ◆ Practice new health behaviors
- ◆ Maintain and regain emotional stability

Essentials of Self- management

- **Knowledge** on disease management
- **Involvement** in decision making
- Follow **care plan**
- **Monitor** symptoms and **respond** to different conditions
- Manage the physical, emotional and social **impact**
- Live a healthy **lifestyle**

Active participation of the patient

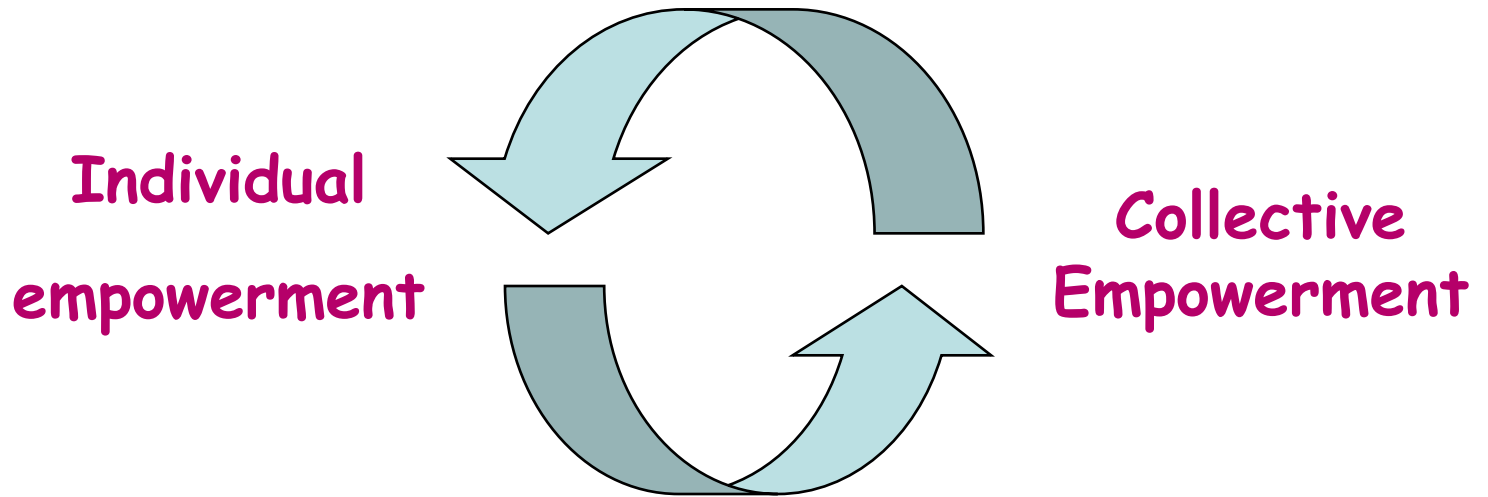
- Goal setting
- Implementation of action plan
- Evaluating
- Problem solving skills
- Seeking help from the peers or professionals

Community Rehabilitation Network (社區復康網絡)

- Service Target: People with chronic illness and their families. Heart disease is one of the serving illness.
- Providing self management course, exercise rehabilitation training, therapeutic groups, social recreational activities and mutual aid support groups



Strategies of CRN



Self-acceptance awareness → **Self-care/management** → **Self-help Mutual aid** → **Advocacy Public**

Heart Disease in Hong Kong

- About 200, 000 patients, mainly suffering from coronary artery disease
- Patients in Hong Kong are of younger age
- Cardiac rehabilitation: Phase I and II rehabilitation training in hospital while Phase III and IV in the community

Needs of Patients with Heart Disease in Hong Kong

Some observations:

- “Should I stop doing exercise after having a heart attack?”
- “My heart is beating really fast, is that a heart attack?”
- “I felt a boom in my heart, will I have sudden death?”
- “I feel unease around my chest/ my arm, should I take the TNG?”
- “After having my pacemaker op, I never raise my arm”
- “I don’t need to pay attention to my cholesterol level as long as I take my medication”
- “Diabetes and heart disease are unrelated illnesses. But I think heart disease is more serious than diabetes ”

Cardiac Self-management Program in CRN

- Phase 2.5 cardiac rehabilitation in community setting, most participants are suffering from CAD
- 6 sessions: Once a week, 2.5 hours
- Areas covered: CAD symptoms and treatment, exercise, medication, nutrition, maintaining active lives and stress management
- Exercise in each session

Session 1: Symptoms and Treatment of CAD

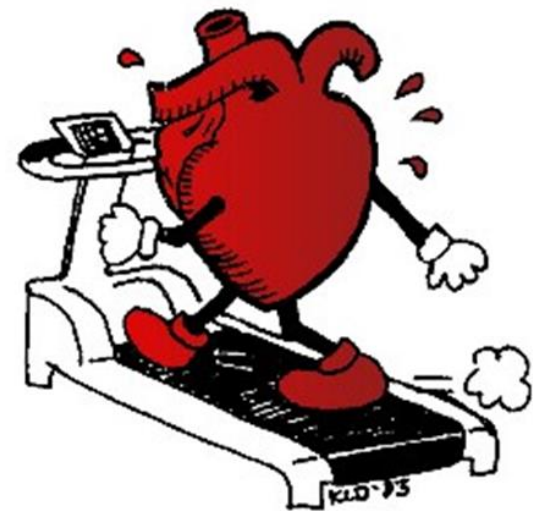
Knowing more about your condition / problems:

- 1) What is CAD
- 2) Symptoms and treatment
- 3) Changeable and un-changeable risk factors
- 4) Self monitoring and self review
- 5) Exercise practice
- 6) **Homework**: walking exercise and record your time

Session 2: Exercise

Active involvement in individual's care plan:

- 1) Significance of exercise training for CAD patients
- 2) Appropriate exercise level
- 3) Self monitoring
- 4) Precautions before and during exercise
- 5) **Homework:** exercise record with self monitoring record (blood pressure, heart rate, rating of perceived exertion RPE)



Session 2: Exercise

- Mastering the skills for self-monitoring

| 級別 | 運動強度 |
|-----|--------|
| 1. | 非常非常容易 |
| 2. | 非常容易 |
| 3. | 較容易 |
| 4. | 中等 |
| 5. | 中等偏難 |
| 6. | 吃力 |
| 7. | 吃力 |
| 8. | 非常辛苦 |
| 9. | 非常非常辛苦 |
| 10. | 極度辛苦 |

Let's TRY

Session 3: Medications

Active involvement in the care plan:

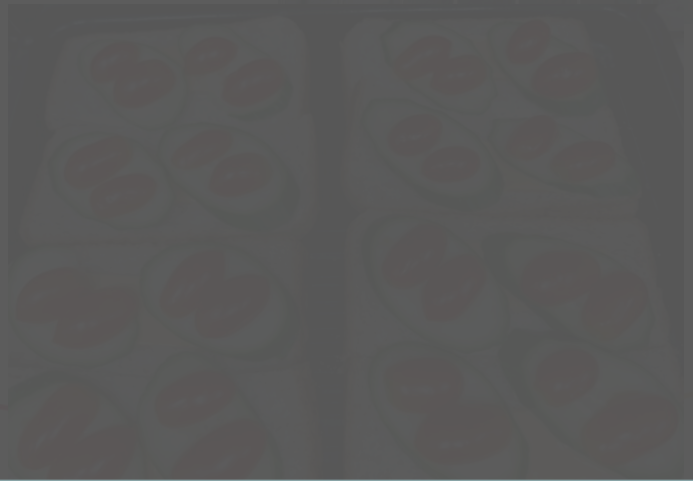
- 1) Importance of medications compliance
- 2) The benefits of your drugs and possible side effects
- 3) The use of TNG and its storage
- 4) Communicating effectively with your doctors

Session 4: Healthy Diet

Active involvement in the care plan:

- 1) Cholesterol monitoring and control
- 2) Choosing the appropriate food
- 3) High fibre and balanced diet
- 4) Home visits, Let's record

Let's TRY



Session 5: Role management

Active involvement in the care plan:

- 1) Social / family role changes after onset of heart disease
- 2) Understanding limitations
- 3) Tips for sustaining the fullest social / role activities as possible
- 4) Sex life rehabilitation

Session 6: Emotional Management

Active involvement in the care plan:

- Sources of stress and its impact
- Discussion on stress management
- A temporary respite
Mindfulness

Let's TRY



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- Live a healthy **lifestyle**

Active participation of the patient

- Goal setting
- Implementation of action plan
- Evaluating
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Phase III Cardiac Rehabilitation

- Sustain healthy life style by joining different classes including:
 - 1) Diet Control
 - 2) Walking/ other exercise
 - 3) Weight management
- Lead by instructors
- Self-monitoring heart-rate and any negative responses to exercise and daily activity



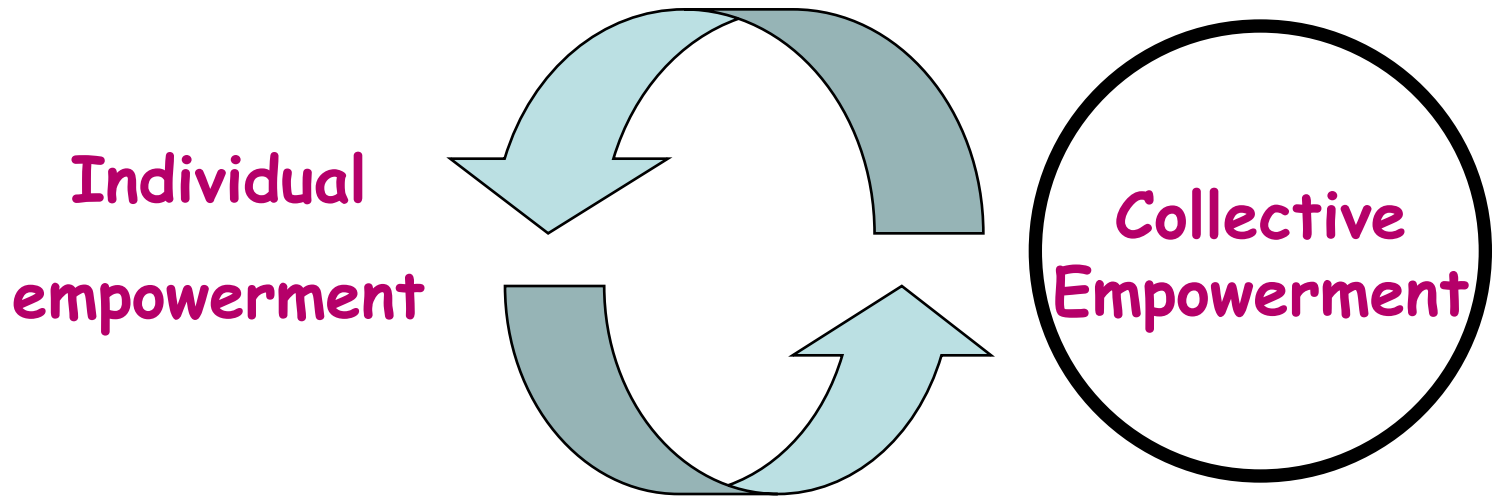
Phase IV: Mutual Aid Network Building

- Self help exercise groups specifically tailored for the patients with heart disease (Gymnastic exercise, walking, BaDuanJin, Ping-Pong and Tai Chi)
- Weekly base, 1.5-2 hours
- Led by the patient leaders
- Contents: regular exercise, personal symptoms sharing and disease information update



| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 新纪录 |
|----|-----|----|----|-----|----|----|-----|-----|-----|----|-----|
| 75 | | | 82 | 80 | | 79 | | | | | |
| 80 | | | | | | | | | | | |
| 76 | | | | | | | | | | | |
| | | | 89 | | | | | | 106 | 43 | |
| | | | | 98 | | | | | 85 | | |
| 81 | 101 | | | 102 | 85 | | | | | | |
| 9 | | | | | | | | | | | |
| 10 | 76 | | | | | 79 | | | 77 | | |
| 11 | 91 | 76 | | | | 76 | | | 96 | | |
| 12 | 94 | 91 | | | | | | | 95 | 99 | 99 |
| 13 | 79 | 54 | | | | 85 | | | | | |
| 14 | 17 | | | | | | 108 | 101 | 109 | | |
| 15 | 50 | | | | | 87 | | 98 | 83 | | |
| 16 | 50 | | | | | 54 | 122 | | | 78 | |
| 17 | 25 | | | | | | | 81 | | | |
| 18 | | | | | | | | | | | |
| 19 | | | | | | | | | | | |
| 20 | | | | | | | | | | | |
| 21 | | | | | | | | | | | |

Strategies of CRN



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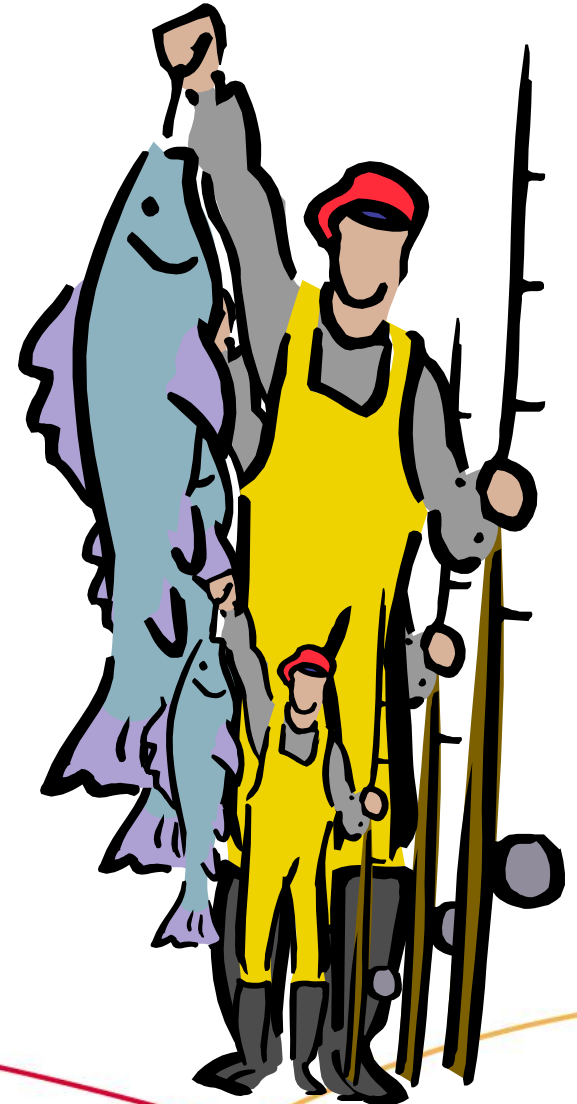
Further Development

- Use of whatsapp group for updated disease knowledge and mutual support
- Use of mobile apps for self-monitoring
- Use of media : Facebook, e2care from the HKSR



The emergence of the concept of Community Based Rehabilitation

*“If you give a
person a fish,
he’ll eat for a day;
if you teach him to
fish,
he’ll eat for a lifetime.”*





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Thank You