Joining Hands

Sharing Good Practice In Rehab Between The Western Pacific WHO CCs

E-Newsletter- Issue No. 8 (June, 2017)

Edited by Ms. Sheila Purves & Ms. Carol Kwong

Linking patients with community rehabilitation services

Discharge from rehabilitation centres is an anxiety-producing period for patients and their families who have become used to a busy hospital routine and gradual change in their conditions. Who will manage my medications and therapy at home? Does this mean I won't improve anymore? I am not better. And frequently, clients become depressed and unwilling to go out except for medical follow-up. Indeed, carers may become increasingly burdened and apprehensive.

Health systems and hospitals are continually trying to improve the discharge planning process to smooth the transition. There are many initiatives to strengthen the link between hospital and community: starting discharge planning at a very early stage, designating case managers, in-reach programmes by community teams, out-reach teams for "at risk" or vulnerable patients, e-documentation, APPs and mobile health tools, etc.

Research from the USA, reports that increased hospital investment in Occupational Therapy services for heart failure, pneumonia and acute myocardial infarction does have a significant impact on 30-day hospital readmission rates. It is suggested, that this is because OT focuses on a patient's functional and social needs. (Rogers, Bai, et.al (2016). *Higher Hospital Spending on Occupational Therapy Is Associated With Lower Readmission Rates.* Medical Care Research and Review.

In many countries in this region, we are still struggling with a lack of skilled manpower and little emphasis on discharge planning perhaps due to overwhelming patient numbers or financial incentives to keep specific patients longer. And in some countries we lack comprehensive community services and integrated referral systems.

Part One of this issue highlights the enormous potential for action research and innovative planning to ensure smooth transitions between hospital and community services.

Part Two includes update reports of ongoing work, starting with a summary by Darryl Barrett Technical Lead, Disabilities & Rehabilitation, Division of NCD and Health through the Life-Course, at the WPRO

PART ONE

From NRCD WHOCC, Japan

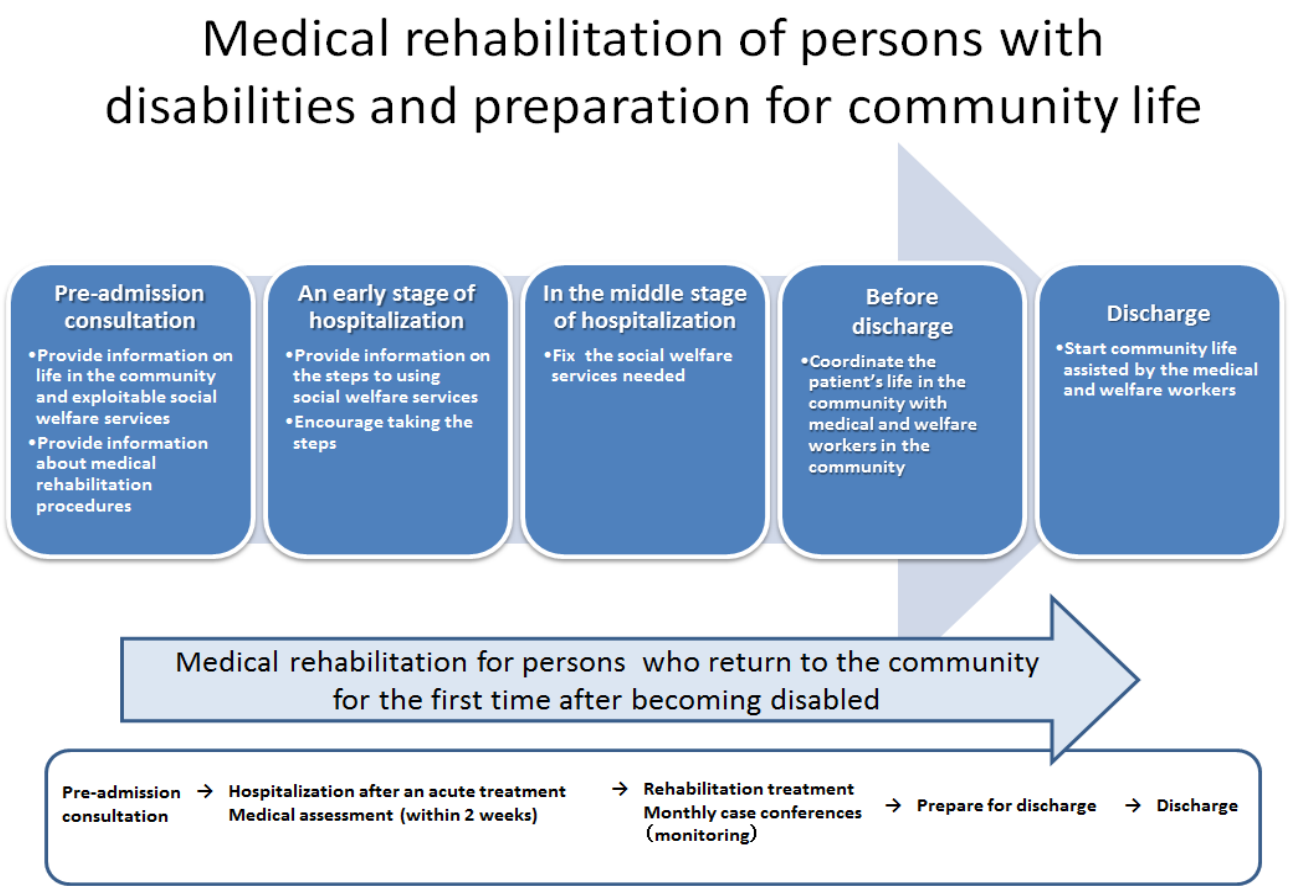
Preparing persons with disabilities for community life through medical rehabilitation

Reported by Kumiko Ueno and Yoshiko Tobimatsu

The hospital of NRCD provides medical rehabilitation for patients at an early stage after the onset of illness or injury, and general treatment for persons with disabilities in the community. In medical rehabilitation we provide functional training and ADL training suited to each patient's needs. Rehabilitation specialists work together as a team formed of doctors, nurses, PTs, OTs, sports therapists, STs, POs, clinical psychologists, medical social workers and others as required. The medical rehabilitation service includes not only functional therapy but also preparation for community life such as recommending home modifications, introducing assistive devices, instructing the family in care techniques, supporting reinstatement in a former job and pre-vocational rehabilitation support and job training according to the patient's needs.

The medical rehabilitation at the NRCD Hospital treats paralysis caused by spinal cord injuries or myelopathy, amputations, multiple fractures, physical and cognitive disabilities due to central nervous system dysfunction including brain dysfunction, and also developmental disorders. This is described at http://www.rehab.go.jp/english/pdf/pamphlet.pdf

【The procedure of medical rehabilitation and return to the community 】



Preparing persons with disabilities for community life through medical rehabilitation (con't)

At a pre-admission consultation, we set an approximate period of hospitalization and provide information about the welfare services and programs available. At the beginning of the hospitalization the rehabilitation team carries out a medical, functional and psycho-social assessment. After the first case conference the comprehensive assessment is shared with the patient, his or her family and the team which will make the rehabilitation plan. After that, the medical rehabilitation and social and environmental preparation begin.

A case conference is held for every patient once a month to monitor the progression of the rehabilitation process.

About a month before the scheduled day of discharge, the set-up of life in the community is arranged by the team of hospital staff in cooperation with medical and welfare workers in the community.

【Social resources in Japan】

Please refer to these websites:

- Long-Term Care Insurance System: http://www.mhlw.go.jp/english/wp/wp-hw9/dl/10e.pdf
- Health and Welfare Services for Persons with Disabilities
  http://www.mhlw.go.jp/english/wp/wp-hw9/dl/09e.pdf

  The current status and establishment of rehabilitation service delivery system after discharge

From NRC WHOCC, Korea

The current status and establishment of rehabilitation service delivery system after discharge

Reported by Wanho Kim

In the Korean referral system for medical rehabilitation, patients receive acute care from tertiary hospitals and restorative care from general hospitals, small hospitals and nursing homes to help them reintegrate into society. Unlike other countries like the U.S. where specialized rehabilitation hospitals are widely available, specialized rehabilitation hospitals are not generally available in Korea due to the medical reimbursement system. The functions of such hospitals are scattered amongst general hospitals, small hospitals and nursing homes. The 2010 physical therapy cost reimbursement data show that 15.4% of reimbursement for the total cost of rehabilitation was made to general hospitals, 35.9% to small hospitals, and 32.8% to nursing homes.

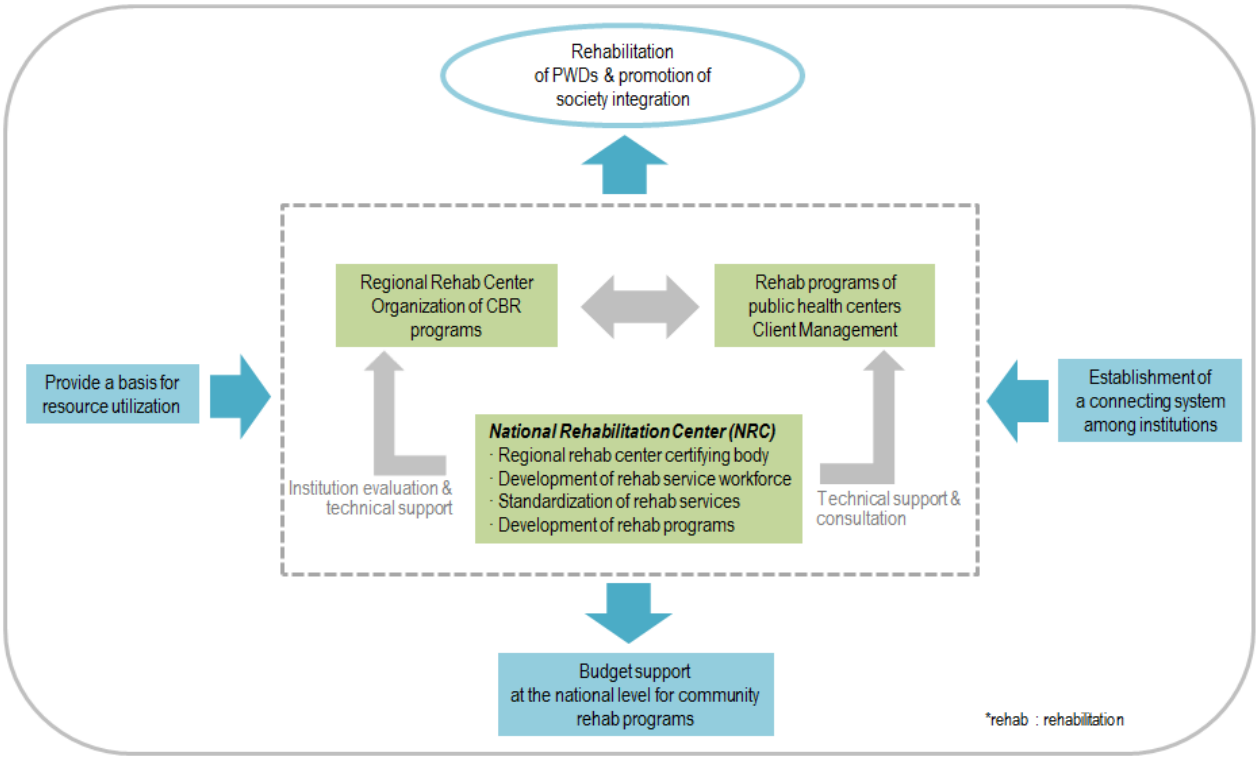
One of the most significant issues in Korea's referral system for medical rehabilitation today is that in cases of disability, no comprehensive medical rehabilitation is offered. That leads to prolonged hospitalization and heavy medical expenses. To reduce the overall period of treatment, intensive medical rehabilitation services need to be provided earlier. Nonetheless, due to certain issues in the medical reimbursement system, tertiary hospitals are unable to provide satisfactory medical rehabilitation services. In addition, a shortage of community adjustment or reintegration programs frequently drives patients who have been discharged after rehabilitation to return to the hospital, as they cannot adjust to their home environment properly (White Paper on People with Disabilities, 2013).

The current status and establishment of rehabilitation service delivery system after discharge (con't)

Effective treatment requires that medical rehabilitation services be provided in a customized way according to the nature of the disability, when it occurred and the patient's social environment. However, that is not the situation in Korea. The current referral system focuses mainly on brain lesions and physical disabilities, which have the highest demand. Other types of disability are not effectively treated. In particular, the private sector avoids treating severe spinal cord injury, traumatic brain lesions or pediatric and adolescent disabilities due to their poor profitability.

To address such issues, medical rehabilitation services should be tailored to different stages from the acute through to reintegration. In other words, instead of being a mere regulation which limits patients' choices, the referral system for rehabilitation should function as a continuum in which services automatically proceed at the appropriate time. Those with a disability and their families should not have to seek out a solution themselves.

The medical rehabilitation institutions and programs needed to support an effective referral system are inpatient rehabilitation care in a general hospital in the acute phase, followed by inpatient care in a rehabilitation hospital, and then inpatient or outpatient care from a long-term care facility in the subacute and chronic phases. In an effort to establish such a system and to connect and support each service, a support system that centers on community-based rehabilitation (CBR) is required. It should be coordinated by the National Rehabilitation Center (a main national center) and should involve regional rehabilitation hospitals and public health centers. This has been proposed (White Paper on People with Disabilities, 2013).



The current status of rehabilitation medical service delivery system

From Tongji WHOCC, China

An Exploration of Discharge Planning in the Rehabilitation Department of a Tertiary Hospital

Reported by Ling Meng, Lixing Cui, Xiaolin Huang, Lu Min, Nan Xia

In order to explore the possibility of more effective discharge planning for patients with spinal cord injury in Tongji Hospital, Wuhan, 40 SCI inpatients, receiving training in the Rehabilitation Department from 2013 to 2015, were randomly divided into two groups of 20. The control group received conventional nursing, health education, rehabilitation training guidance, discharge guidance and home care education. Those in the study group also received a more systematic discharge plan. This involved a comprehensive assessment and needs analysis on the second day after admission. After full communication with the patients and their families, a work team was formed to discuss and set out the patient's short-term and long-term treatment goals and to develop a personalized discharge plan. Any change in the discharge plan would be considered in light of the patient's wishes. According to each patient's interests, hobbies, habits and needs, a daily schedule was developed and followed while in the hospital. Before discharge the patient was given a contact card and a health manual. There was telephone follow-up within one week after discharge to assess their sleep, diet and medication status. One month after discharge another follow up by the intervention team was intended to help the patient establish good living habits and healthy behavior.

These efforts resulted in a significant decrease in the average length of stay among the study group. Their average health education awareness and nursing satisfaction were significantly higher than among the controls. The Barthel Index (quantifying ability in the activities of daily living) of both groups improved significantly, and there was no significant difference between the two groups. But the 1-month follow-up revealed significantly more persistent improvement in the Barthel Index among the study group.

Urinary and defecation dysfunction are common complications of spinal cord injury and can be the main problems in home care. In the discharge planning and the regular rectal and bladder function training and education were conducted by a special training team. Application of basic self-care techniques (clean intermittent catheterization; diet planning; ongoing bladder and rectal function training; diary products limitation and other measures) were observed at follow-up. Pressure ulcers and urinary system infections after discharge were significantly less frequent. During the follow-up visits the staff often suggested environmental improvements such as reducing the height of the bed, modifying the toilet, fitting a stair rail, laying a non-slip floor, etc.

Discharge planning can help to shorten hospital stays and improve the satisfaction of SCI survivors and their families. It promotes functional independence and learning self-care skills. Through systematic training, paraplegics can master basic home training techniques and fix potential problems after discharge. This research has demonstrated a reasonable model of discharge planning with detailed execution plans for SCI survivors which delivers stable and sustained functional improvement in the lives of paraplegics.

From Zhongshan U WHOCC, China

Using an APP to bridge institution and community

Reported by Ambrose Li

Our centre has begun piloting the mobile app WELL Health for musculoskeletal disorders. The app has embedded artificial intelligence and can provide personalized rehabilitation exercise routines based on a subject's symptoms. The primary purpose of the app is to encourage self-management and active participation. We are currently developing the stroke rehabilitation module which will focus on ADL functional practice, diet control and a physical rehabilitation programme after hospital discharge. This will act as a bridge between institutional and community care, as there are many patients who receive minimal rehabilitation support after discharge due to poor access to service.

Other Activities of our WHO Collaborating Centre in 2016

Reported by Huang Dongfang and Ambrose Li

2nd Western Pacific CBR Forum

The second annual Western Pacific Regional Seminar on Community-based Rehabilitation was held at the Poly World Trade Expo Center in Guangzhou on the 24th of March. The theme this year was the communication gap between institutions and communities and what needs to be done to improve the transition. More than 120 delegates attended this year, and the speakers were from countries with different cultures and social and health systems Malaysia, Australia, the USA, Singapore, China including Hong Kong and Macau.

A range of important topics were discussed, including the current policies and management systems promoting seamless rehabilitation from institutions to the community. Multi-functional county CBR centres were proposed as a bridge between institutional and community rehabilitation services, facilitating a change from the medical perspective to social service approaches. This is happening in Yunnan, China. In Malaysia they emphasize community-based services in the rehabilitation medicine curriculum and in practice.

Our centre delivered the first CBR training programme for disability assessment in Shun De. The programme was developed in response to the government's strengthening the disability badge programme. Badge holders will be entitled to certain benefits depending on their needs and functional impairments. Health care professionals who work in the relevant area are expected to participate in this type of training to ensure people with disability are assessed consistently and that their benefit entitlements are calculated systematically.

Other Activities of our WHO Collaborating Centre in 2016 (con't)

We have worked with our Region's new technical lead Mr. Darryl Barrett from the WHO to refine our work plan for the next two years. Our centre had been re-designated as a WHO Collaborating Centre for the coming two years.

From HKSR WHOCC, Hong Kong SAR

Linking Patients with Community Rehabilitation Services and Programmes

Reported by Christine Leung Mee-yee

The Patient Empowerment Programme (PEP) was initiated by The Hong Kong Society for Rehabilitation (HKSR) and funded by the Hospital Authority (HA) in 2010. It aims at improving chronic disease patients' knowledge about their conditions and enhancing their self-efficacy and their self-management abilities. This has been one of the HA's public-private partnership programs in which Diabetes Mellitus (DM) and hypertension HT patients are directly referred by HA to participating NGOs through the electronic health records (eHR) system.

The HKSR has been participating actively in the PEP, and through the years the Society has served more than 40,000 persons with chronic disease sufferers through this program. The majority of those referred have Diabetes Mellitus and hypertension or both as diagnosed in Family Medicine clinics. Upon receiving an electronic referral from a clinic, the HKSR telephones the patient and enrolls them in a 5-session training class. Since diet control and habitual exercise are important lifestyle modifications for such patients, their caregivers are also invited to join the class with the patient. The training focuses on disease monitoring knowledge and skills, lifestyle modification and emotional adaption. Establishing a health improvement action plan is also a vital aspect of the empowerment process. Patients go through the 5 interactive sessions in the same group in which mutual learning and encouragement is reinforced. Moreover, all 5 sessions are led by the same social worker or nurse so that performance is consistently supported and monitored throughout the sessions.

Afterwards, the HKSR inputs its own resources and organizes patients to form exercise support groups. To date more than 12 mutual aid support groups have been formed by graduates of the classes, and more than 200 graduates have joined the service as peer support volunteers.

Linking Patients with Community Rehabilitation Services and Programmes (con't)

The PEP lays the foundation for referring patients out for community rehabilitation, which facilitates their community participation and engagement. This demonstrates the success of the PEP—participants are empowered and are involved in service delivery in return.

The eHR system is another contributing factor for the success of PEP. It is a powerful link between public and private health care providers established by the Health and Welfare Bureau. Personal data and medical information of HA patients are recorded in electronic form where they can be stored and, with the patient's consent, retrieved by collaborating parties like NGOs. Patients are for cared seamlessly between government clinics and operating NGOs because clinicians from both sides can view the same medical history and clinical observations.

A piece of homework on daily food intake of a PEP participant.

Learning blood glucose self-monitoring

Self-recording daily blood glucose in log book

The PEP has proven effective in improving clinical outcomes and reducing the rate of utilization of the general outpatient clinics. A report from Hong Kong University credits it with improving the metabolic control of patients through empowering them in self-care and enhancing the quality of clinical care. The PEP has also facilitated significant improvement in pain management, emotional stability and overall quality of life.

The research reports by HKU and CUHK on the effectiveness of the PEP can be accessed at:
http://hub.hku.hk/handle/10722/213831
https://hqlo.biomedcentral.com/articles/10.1186/s12955-015-0324-3

From Chengdu, China (project partner with HKSR)

Strengthening links between rehabilitation providers: experience from Chengdu City Second People's Hospital

Reported by Sheila Purves and Luo Lun

Chengdu is the provincial capital of Sichuan Province, with an urban population of over 10 million (2014). The Chengdu Second People's Hospital is a tertiary hospital, which is also the designated city-level, rehabilitation quality control centre. Since the 2008 Wenchuan Earthquake in Sichuan Province, China, the hospital has recognized the significance of rehabilitation and made great strides in developing a centre of excellence. The rehabilitation department now has a 65 bed rehabilitation ward and outpatient clinic, and also provides services to many of the hospital's acute wards. Length of stay on the rehabilitation ward has gradually decreased to 21 day average (patients include neurological, neurosurgical, orthopaedic and those in the work injury system).

Dr Luo is the director of Rehabilitation Medicine Department, Chengdu Second Hospital

Question: Dr. Luo, *what are your three biggest challenges to discharging your rehabilitation patients?*

1. Rehabilitation services are not readily available at district level, and even less so at community level. This is the stage of development that we are at
2. Patients find ways to come back to third level rehabilitation centre because they believe it is the best.
3. Before, our rehab team was not used to making discharge plans together with the family and the patient
4. Patients don't understand that finally they must do "rehab" in their homes and communities where they live; we need to promote that some outcomes can only be achieved in the home.

Question: *In the last few years, what changes have you made to solve these problems?*

1. We have established a "one-stop model" of rehabilitation, with an interdisciplinary team and common goal setting, with the help of the Hong Kong Red Cross (HKRC). Our team includes a psychologist, social worker and prosthetist/orthotist, as well as the more usual PTs, OTs, Rehab Nurses and Doctors and even though our HKRC project is finished, the hospital has agreed to continue the employment of all these staff. In China, there few city level hospitals' rehabilitation services which include a social worker, psychologist and prosthetist/orthotist.

2. For our more complex patients, our interdisciplinary team starts discharge planning at early stage. Our Social Worker not only works in the hospital but links up with the community social workers. It is important that both hospital and community are actively involved.

3. I have personally been to all the second level hospitals, which are mainly rehab-oriented and helped them to: (1) develop a team approach, (2) understand rehabilitation concepts better, and (3) help them solve management issues.

4. In order to demonstrate a successful rehabilitation team (and one-stop model), we invite the rehab staff from these district services to take part in a weekly educational ward round, on Tuesdays, so they can see how we work; as well as meet the relevant patients before discharge.

5. Because we now have established relationships, it is easier to discuss the positioning and responsibilities of different levels, so we can share instead of only competing for resources. Our health care policies are driving us to increased clarity of roles [分级医疗] as well as decreased length of stay, and establishing the three level rehabilitation referral system.

Question: what remain your biggest challenges?

1. We are still developing the connections at district level; we haven't yet made great progress at community level, because we do not have rehabilitation knowledge and experience in the community. It's too easy in the city for patients to return to our hospital departments, and we are lacking trained rehabilitation staff even in the hospitals.

2. I have worked with the head of an established diploma course for rehabilitation therapists, to set up a diploma of rehabilitation therapy (OT) and it has a big section on community. We are also writing the community OT section for a national textbook. The diploma graduates cannot get positions in tertiary hospitals, but if they have the skills and knowledge to work in the community settings (eg. organize self-help groups, teach self-management groups, and make effective use of assistive technology in addition to their usual clinical skills), they will be a significant asset to strengthening the community rehabilitation services.

Comment: this conversation was done in Chinese, and interpreted into English so there may be some mis-understandings, for which we apologize.

PART TWO

From the Western Pacific Regional Office

WHO updates

Reported by Darryl Barrett, Technical Lead, Disabilities and Rehabilitation
Division of NCD and Health through the Life-Course

Global

· *Rehabilitation 2030: A call for action* took place at WHO Headquarters, Geneva, Switzerland in February 2017. This meeting brought together a diverse range of stakeholders to discuss strategies for action and commitment to raise the profile of rehabilitation as a health strategy, relevant to the whole population, across the lifespan and across the continuum of care. More information can be found here http://www.who.int/disabilities/care/rehab-2030/en/

· CBR training programme INCLUDE is available via the WHO website, providing managers and practitioners with a detailed overview and training related to CBR and the components of the guidelines. More information can be found here http://www.who.int/disabilities/cbr/en/

· World Health Day 2017 was held on 7 April 2017, with the theme of *'Depression, let's talk'*, with a range of information to assist greater understanding related to depression and the promotion of good mental health http://www.who.int/campaigns/world-health-day/2017/en/

WHO updates (con't)

Regional

- The third Pacific sub-regional CBR workshop (Polynesia) was held in Tonga 10-12 May, bringing government focal points, CBR practitioners and DPO representatives together from the Cook Islands, Samoa, Tonga and Tuvalu to share knowledge and practices, learn more on governance issues related to CBR, and to plan future steps for their national programs. A report will be shared through the Pacific CBR network.

- A series of psychosocial disability and human rights workshops are being conducted in the Pacific (Tonga, Samoa and Vanuatu) to deliver the WHO Quality Rights Training. This training looks at quality and human rights related to mental health services. This is the first time this type of training is being conducted in the Pacific, with more planned for the northern Pacific in 2018.

- Work is ongoing to develop a disability-inclusive health toolkit (Nossal-Melbourne University), rehabilitation resources for the current workforce (Sydney University) and rehabilitation and health emergencies (Sydney University).

Country

- Vanuatu – the National CBR action plan is being reviewed, and a paper on 'CBR and Governance' is being developed to inform future CBR development considerations related to governance.
- Solomon Islands – preparation is underway for training on mental health for the CBR workforce to assist in developing a mental health community outreach service; and a workshop on data mechanisms for the CBR and rehabilitation services to link with broader Health Information Systems in the country.
- Fiji – preparation for a review of the Mobile Rehabilitation Outreach Unit to understand the progress of the service and inform other Pacific Island countries regarding developing a similar service
- Cambodia – recently developed a health and ageing policy, which included considerations for rehabilitation as a means to improve and maintain function as people age.
- Tonga – recently held their first national CBR stakeholder workshop, to introduce disability stakeholders to CBR and prepare options to develop CBR in the country.
- Federated States of Micronesia – are in the process of developing an assistive technology program through consultation with Motivation Australia
- Philippines – the government is implementing the Model Disability Survey for the first time, to gather greater information on people with disability and their participation in the Philippines (http://www.who.int/disabilities/data/mds/en/)

For further information on any of these points, please contact Darryl Barrett at the WHO Western Pacific Regional Office (dbarrett@who.int).

From Zhongshan U WHOCC, China

3rd Western Pacific Community Based Rehabilitation Forum (31 March-2 April 2017)

Reported by Ambrose Li

Sun Yat-sen University hosted this CBR Forum, in collaboration with 10 supporting units including University of Sydney – WHOCC for Health Workforce Development in Rehabilitation and Long Term Care, National Rehabilitation Centre for Persons with Disabilities - WHOCC for Disability Prevention and Rehabilitation, Nanjing Child Mental Health Research Centre -WHOCC for Research and Training in Child Mental Health, Tongji Medical College, Tongji Hospital – WHOCC for Training and Research in Rehabilitation, Hong Kong Society of Rehabilitation – WHOCC for Rehabilitation, and China Disabled People Federation. This year's theme was the inclusive community development and how universal health insurance coverage may affect rehabilitation services. Speakers came from Philippines, Malaysia, Australia, USA, Thailand, Japan and China including Hong Kong and Macau. The varied professional background of the speakers included government officials, front line health care and social work professionals, policy makers and scientists, providing different perspectives on topics such as: the rehabilitation service provision model in China, current policies to increase service provision at community level, discharge planning, provision of assistive technology and referral pathways to enable seamless transition from institutional health care to community. Other topics addressed were the sustainability of service provision, using research to evaluate service quality and education for health care professionals.

This year we offered a short study tour and site visits to several rehabilitation centers and education institutes to exchange and discuss the evolution of CBR to CBID, assistive technology and education of health care professionals as part of the symposium. The study tour provided support for low or middle-income countries delegates to strengthen their work in rehabilitation and share our rehabilitation experiences in Guangzhou.

3rd Western Pacific Community Based Rehabilitation Forum (con't)

Research activities

(1) Led by Professor Dong Feng Huang, we have been working along with partners in the Hong Kong Special Administrative Region to develop a database on stroke survivors and patients with spinal cord injury. The bespoke database ensures secure storage and processing of the large amount of data being collected. The goal of this database is to allow accurate tracing of people with disability in order to understand impact of inpatient hospital/centre-based management, to support informed decision regarding both the discharge planning process and community support requirements. Results will be shared with WHO/WPRO and disseminated in internationally. The programme is jointly funded by our university, Guangzhou City and Guangdong Science and Technology Department.

(2) An ongoing research on the impact of AFOs on lower limb biomechanics in people with disability using 3D motion analysis, is led by Dr. Li Le. The project provides evidence and further improves the effectiveness and comfort of the use of AFO. The grant was awarded by the International Society of Biomechanics society's 25th Annual Conference, Glasgow, Scotland, 2015 as it demonstrated sustainable solutions to the challenges faced in economically developing countries.

(3) Currently we are conducting an evaluation study to assess the feasibility of using a mobile app powered by artificial intelligence for the self-management of musculoskeletal disorders. Preliminary analysis of the evaluation questionnaires indicates patients have a 2-point reduction on the numerical pain rating scale, 68 % self-perceived improvement and reduced medication use. The research was funded by the China Post-Doctoral Science Foundation and was awarded 2nd runner up in the 4th Novelty Competition of Guangzhou City.

Celebrations

We would also like to celebrate the opening of Cong Hua Region, Le Cong Town, Da Luo District Rehabilitation Centre. Professor Dong Feng Huang is on their technical advisory board. The centre provides day care services, adult education, mental health and physical rehabilitation, occupational rehabilitation, family support and opportunities for volunteers.

From Tongji Hospital WHO CC, China

Reported by Lu Min

In 2015-2017, with the help of WHO WPRO, we initiated a co-operation with Mongolia.

11-16 June, 2016:

Study visit by a Mongolian delegation of 9 persons, representing the health ministry, different hospitals and a community health programme, being officials, doctors and physical therapists.

16 June-5 Aug, 2016:

Three doctors and 2 therapists from the above delegation stayed for a longer placement in our clinical rehabilitation departments. Ms Monique Kuo, Director of International & China Division, HKSR and her team attended the final half-day seminar. Mongolia presented on their health system, HKSR presented on a self-management programme for stroke, and our head nurse presented on discharge planning. For these visits, we invited two therapists from Inner Mongolia to join the study opportunity and to help with interpretation (Mongolian-Chinese).

7-13 August, 2016:

Prof Huang Xiaolin (Director of our WHO CC) led a 4 person team for a study and assessment visit to rehabilitation medicine programmes in Ulaanbaatar, when we also presented in a seminar.

1-4 December, 2016:

Tongji Hospital sent two physiotherapists, Ms Huang Jie and Mr Xia Nan, to present at the Mongolian Society of Physical & Rehabilitation Medicine (SPRM) annual meeting and hold a half-day workshop for PTs, demonstrating with people with neurological conditions.

22-26 February 2017:

Dr O. Batgerel, President, Mongolian SPRM, initiated and led a study visit of 3 persons, including clinical visits, and discussion about future co-operation (rehab nursing, orthotics, ultrasound, and perhaps a joint project to support stroke patients after discharge). We also introduced Dr. Leonard Li, (Vice-President, ISPRM; President, World Neurological Rehabilitation Association; & Advisor, HKSR WHO CC), who was at Tongji for another event.

5-6 May 2017:

Facilitated by Mrs Sheila Purves, the Mongolian Society of PRM held a two day seminar: day one on Low Back Pain and day two on Musculoskeletal Ultrasound Diagonosis (taught by Hong Kong experts supported by Dr Leonard Li and Mrs Purves). We sent Prof Fang Zhengyu, of our department to teach on day one and support the Hong Kong experts on day two.

We welcome collaboration from our sister WHO CCs to support this interesting work.

From The Hong Kong Society for Rehabilitation (HKSR)

Reported by Monique Kuo

9th September 2016:

80 people attended the Disability Inclusive Disaster Management Seminar organized by HKSR with Hong Kong Red Cross. Speakers and participants included people with disabilities, NGOs working in disaster response, health care staff. Prof Hiroshi Kawamura (Japan) of the Assistive Technology Development Organization, and Professor Yayoi Kitamuri of our sister WHO CC, Japan. Prof Kawamura inspired us to consider a new paradigm: that not only should we think about how to help vulnerable people in time of emergencies and disasters, but how, with training and practice, people with disabilities can stimulate rapid and timely evacuation in their local communities, just because they are practised in self-management

14th September 2016:

HKSR and Hong Kong Red Cross partnered with Sichuan Disabled Persons Federation to hold a similar half-day seminar in Chengdu, with 70 participants, including Prof Kitamuri from Japan. With the Hong Kong delegation, she also visited Beichuan, both the destroyed old city and the newly rebuilt city, and chatted with a self-help group of people with disabilities, that grew out of the 2008 earthquake response, and is now registered as a social organization, as well as visiting key medical rehabilitation centres, such as Chengdu 2nd People's Hospital. This hospital, initially supported by HK Red Cross and HKSR, has now formed an interdisciplinary emergency rehabilitation response team.

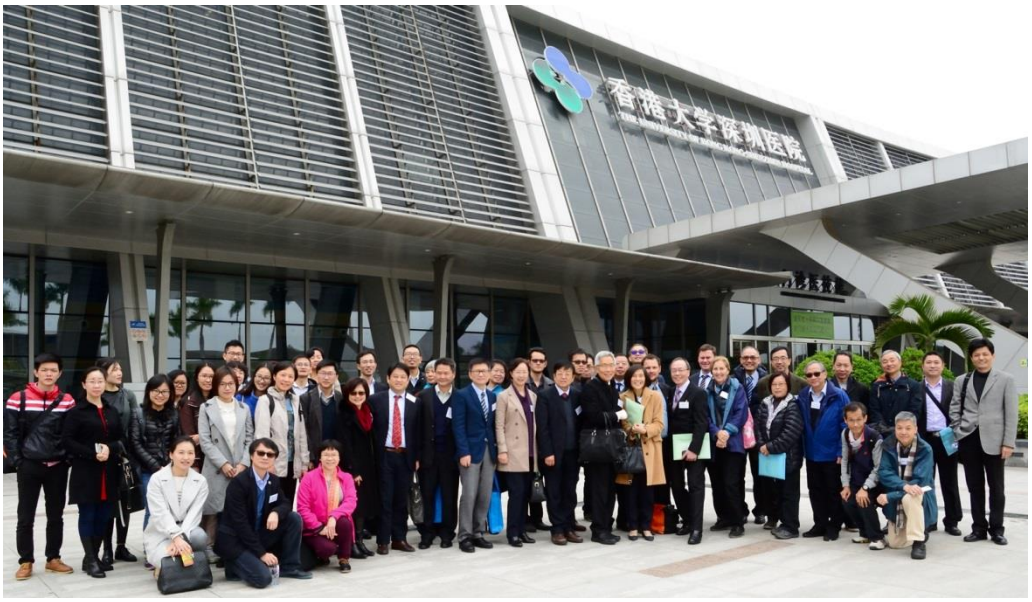
3rd December 2016:

At the invitation of Prof Li Jianjun and the 11th Beijing International Rehabilitation Forum, we co-organized a session on Disaster Prevention: disability inclusive disaster management. Japan responded immediately to our request for help: Dr. Tobimatsu Yoshiko (President, Japan National Rehabilitation Centre for Persons with Disabilities), took up the role of chair for the final talks and summary, and also brought Ms. Hiromi Agarie to speak on her experience working with young people with autism and intellectual disabilities in post-earthquake conditions, and how it has driven better preparation for the future. Prof Kawamura, now chair of ICTA (RI) again inspired us as did other speakers, and interesting questions were mainly raised by people with disabilities in the audience. We are reminded that there is much we can do together to improved disaster preparation and response.

The Hong Kong Society for Rehabilitation Updates *(con't)*

14th January 2017:

HKSR celebrated our WHO CC 30th anniversary with an international symposium, with the theme of Rehabilitation: looking forward to 2020 (jointly organized with the University of Hong Kong-Shenzhen Hospital). Mr Darryl Barrett of WHO WPRO, gave the keynote address on "International Perspectives of Health-related Rehabilitation", followed by Dr Wesley Pryor of the Nossal Institute for Global Health, Melbourne University, who gave the 5th Harry Fang Rehabilitation Lecture: "Towards strengthened, extended & connected rehabilitation services: evidence and good practice to inform new policies and practice". This was followed by a fascinating panel discussion with speakers from Xinjiang, Hubei (Tongji WHOCC), and Guangdong Provinces. It was a superb opportunity to re-connect with representatives of many of our rehabilitation training projects, who are now leaders and officials, teachers and clinicians, and researchers throughout China.



Full reports for the above meetings are available on request.