Medico-social Collaboration Models for Supporting Elders Discharged from Hospitals
醫社合作 – 支援離院長者

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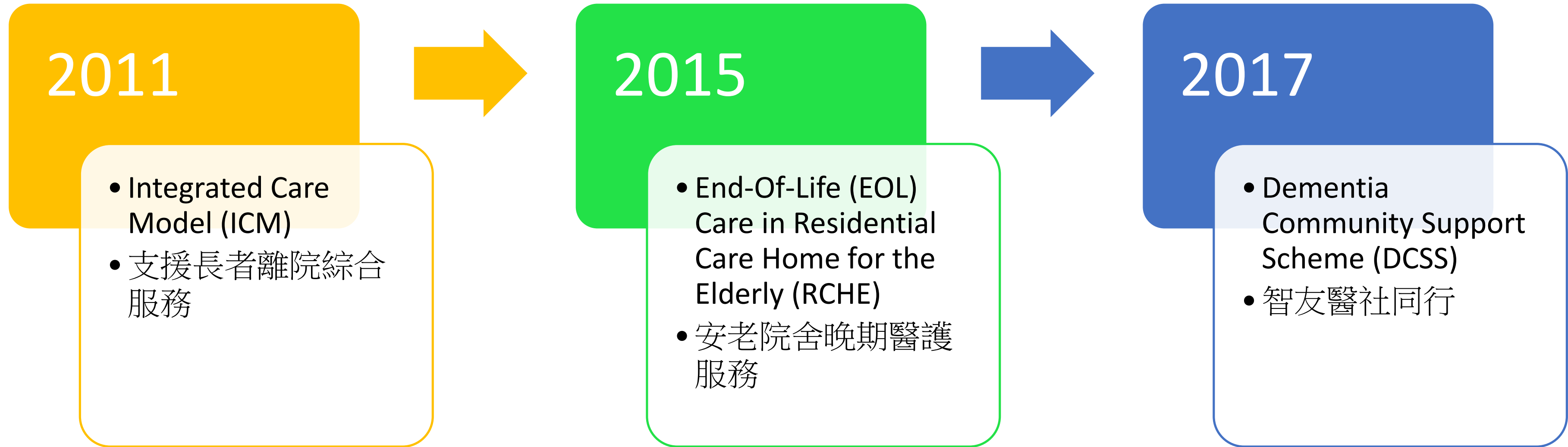
Flagship Programmes between HA and Community Partners



Integrated Care Model (ICM)
支援長者離院綜合服務

- Enhance and integrate services through a systematic approach
  - ✓ Cater for multi-faceted needs of frail elderly people
  - ✓ Facilitate ageing in place

- Targeted elderly patients (aged ≥ 60) at high risk of readmission upon discharge (identified by a predictive score)

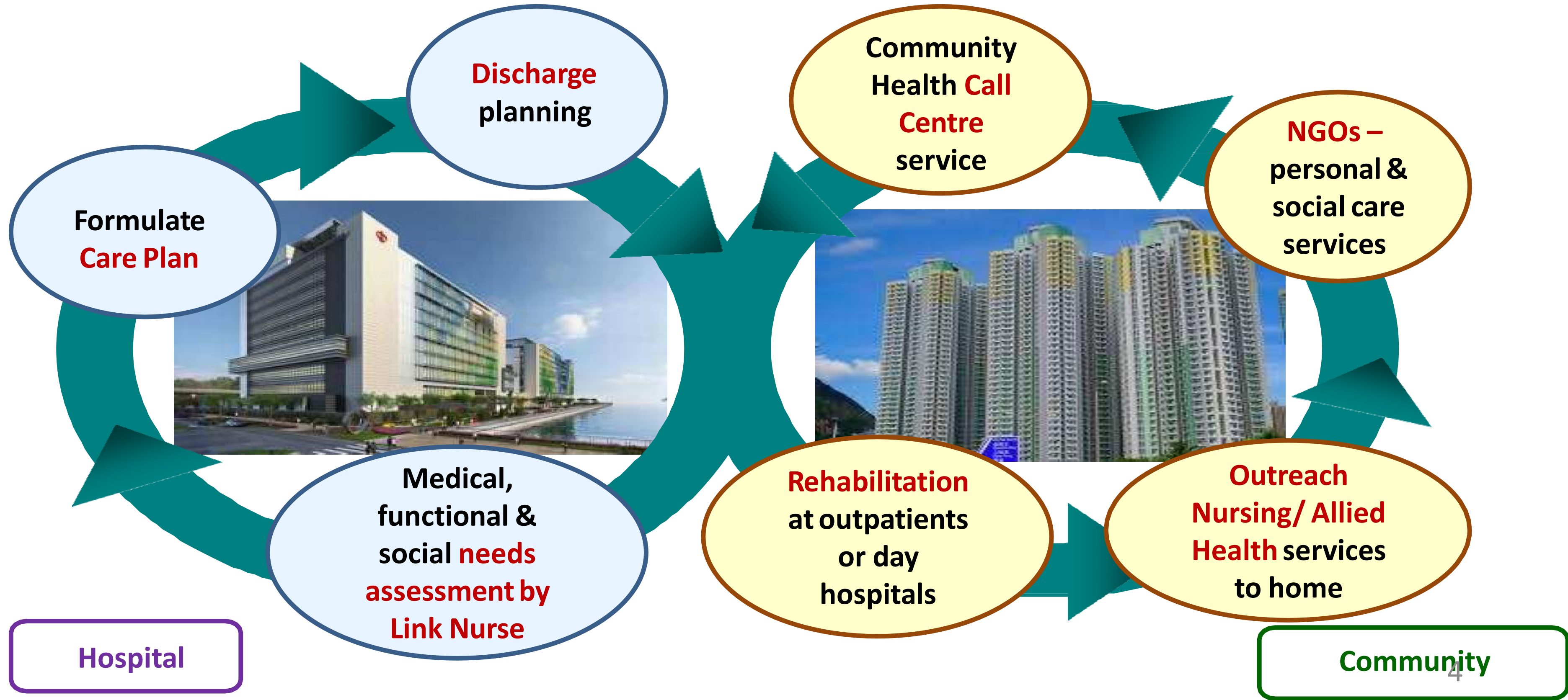
- Post-discharge medical support and rehabilitation service (by HA)

- Collaborate with non-government organisation (NGO) for transitional post-discharge social support

- Fully implemented in all hospitals in 2011/12

Overview

Highlights:
- Led by Geriatricians
- Integrated multidisciplinary teams
- Contractual Partner with NGOs



NGO Support under ICM

- Home-based Community Support, including:
  - Personal and social care, e.g. provision of meals, home-making
  - Escort services
  - Nursing care according to the discharge care plan (formulated by the respective hospital teams)
  - Assistance in carrying out prescribed rehabilitative exercises at home
  - Home modifications
  - 24-hour emergency support
- Transitional Residential Care
- Carer Training and Support

Recent Development in ICM

- To enhance medical-social collaboration to support more elderly patients with needs (e.g. hip fracture or acute stroke) in phases

- Refer suitable elderly patients to "Pilot Scheme on Support for Elderly Persons Discharged from Public Hospitals After Treatment" under the Social Welfare Department (SWD)

- Piloted in 3 clusters in 1Q 2018
  - Kowloon East Cluster (KEC)
  - New Territories East Cluster (NTEC)
  - New Territories West Cluster (NTWC)

2020-21 COST-EIS ICM Monthly Report

1. Enhance CNS (Started in Oct 2011)	12 month target	Overall	Target achieved %
AHNH	156	157	101%
NDH	156	156	100%
PWH	208	369	177%
Overall (NTEC)	520	682	131%
2. DC Planning (Started in Oct 2011)	**12 month target**	**Overall**	**Target achieved %**
No. of episodes with assessment and discharge planning			
AHNH	3,048	3,290	108%
NDH	3,048	3,057	100%
PWH	6,094	6,218	102%
Overall	12,190	12,565	103%

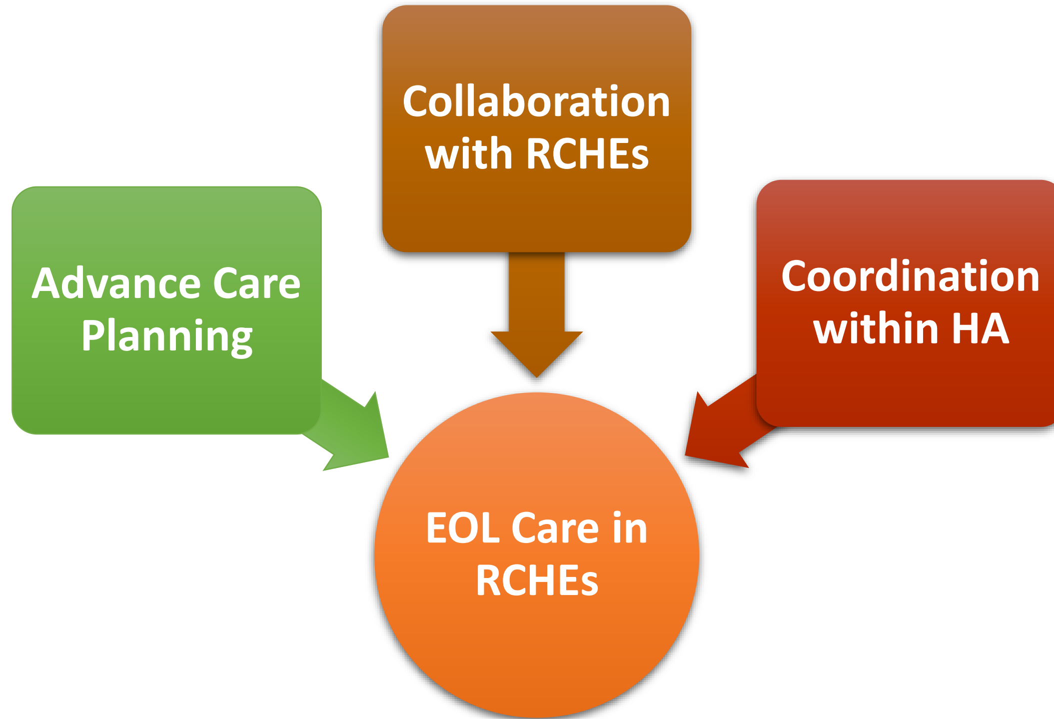
EOL Care Programme in RCHE
安老院舍晚期醫護服務

- To provide care options and facilitate a more dignified and peaceful dying process for patients approaching end-of-life (EOL) in RCHE
- Piloted in HA hospitals since 2015 and fully implemented in 2018
- Collaboration between HA Community Geriatric Outreach Teams (CGAT) and RCHE operators
- 8% of RCHE residents

Scope of Service

- ✓ To formulate **Advance Care Planning (ACP)** involving patients and/or their families on care options approaching EOL (e.g. not prefer nasogastric tube feeding)
- ✓ To enhance **on-site support** (e.g. symptom control, supportive treatments)
- ✓ To facilitate **coordinated** admission, when needed
- ✓ To provide psychosocial care to RCHE residents & caregivers
- ✓ To **train / empower RCHE** staff on EOL care

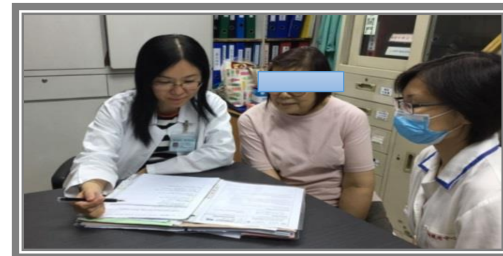
Key Factors for Implementation



Advance Care Planning (ACP)
預設照顧計劃

- **On-going communication process** on patients' / families' preference on care options approaching EOL, e.g.
  - Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR)
  - Treatment options, including
    - Artificial enteral feeding
    - Use of non-invasive positive pressure ventilation (NIPPV)

- ACP at RCHE: **Tripartite Partnership**
  CGAT – Patient/Family – RCHE Carer



Collaboration with RCHEs

- Provided **staff training** through seminars & training sessions including:
  - Role, value & attributes
  - Knowledge on ACP, DNACPR & AD
  - Communication skills
  - Physical, psychosocial & spiritual care
  - Grief & bereavement support

- **Sharing forum** with social sector to exchange views on EOL Care in RCHEs from medical & social perspectives

Dementia Community Support Scheme (DCSS)
智友醫社同行

- To develop a medical-social collaboration model in providing community support services to elderly persons with mild to moderate dementia

- To enhance the capacity and expertise of the staff of NGO at the community level in the provision of dementia support services to the elderly persons

- Piloted since 2017 and fully implemented in all HA hospitals since 2019

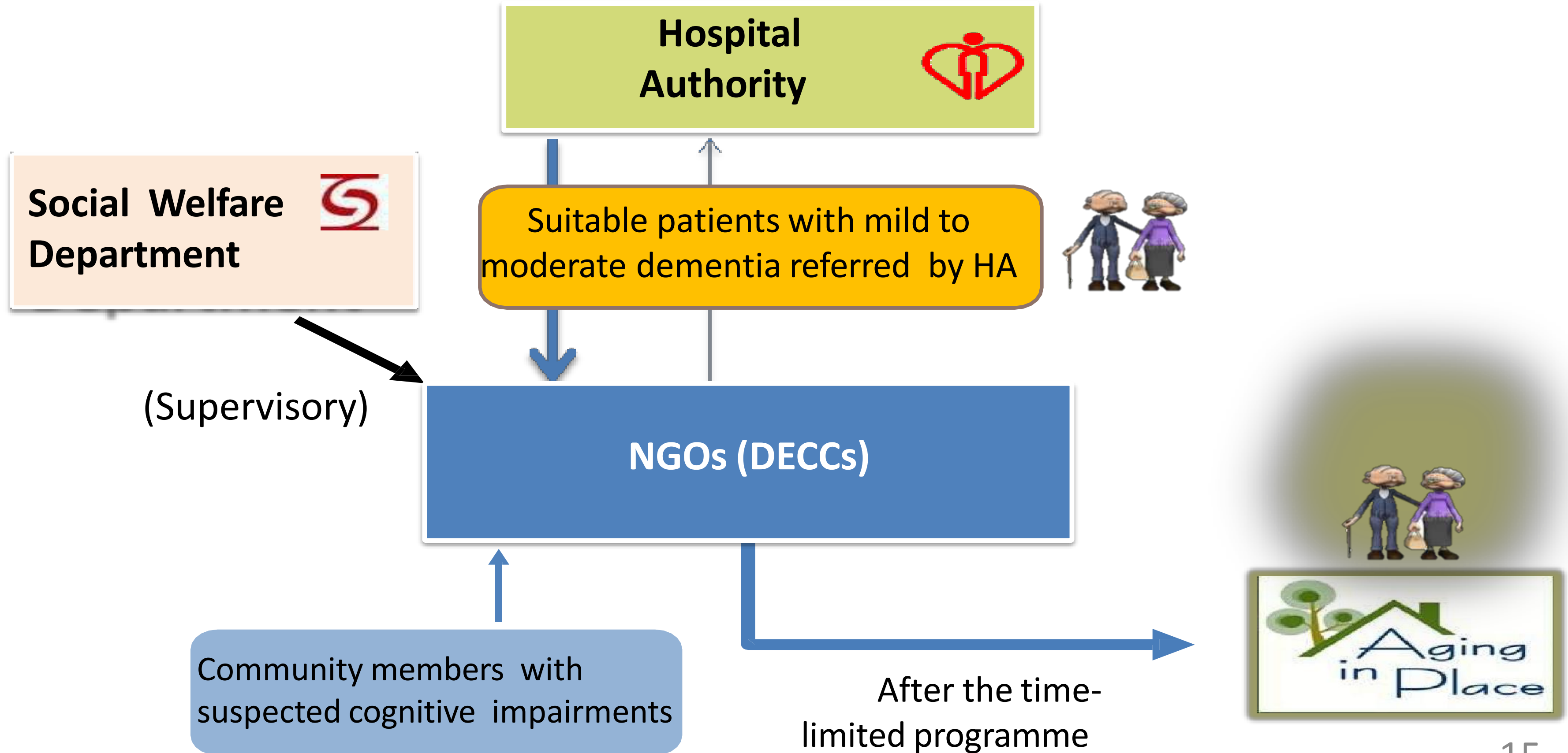
- Serves 400 clients/ year in NTEC

Target Participants

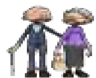
Aged 60 or above; and

- HA's patients (referred by Geriatric or Psychogeriatric Teams) diagnosed of having mild or moderate dementia (based on a standardised dementia staging tool); or
- Registered members of respective DECCs who are suspected to have suffered from early dementia or cognitive impairment.

Service Model



Patient Flow Arrangement



Source of referral:
-Geriatrics
-Psychogeriatrics

Assessment tools

Suitable cases

Consent Form
+
Referral Form

Medical-social collaboration platform:
- Care coordination
- Assessment and care plan formulation
- Case conference
- Case review and follow-up

Review of Care Plan

5~9 months programme

Level of Care		
	Dementia with simple needs	Dementia with complex needs
Core Modules	✓ Cognitive Modules ✓ Functional Modules ✓ Caregiver Modules ✓ Psychosocial Modules	✓ Cognitive Modules ✓ Functional Modules ✓ Caregiver Modules (Enhanced) ✓ Psychosocial Modules (Enhanced)
Additional Modules	+/- Behavioural and Psychological Symptoms of Dementia (BPSDs) +/- Physical Co-morbidities Training +/- Booster	+/- Behavioural and Psychological Symptoms of Dementia (BPSDs) +/- Physical Co-morbidities Training +/- Booster
Duration	5-7 months	7-9 months

6-month FU assessment

✓ Structured post-programme assessment

Thank you