Jockey Club Age-friendly City Project Public Forum -
Age-friendly Community Support and Health Services
「賽馬會齡活城市計劃」公眾論壇 -
長者及年齡友善的社區與健康服務

Age-friendly Health Services
齡活健康服務

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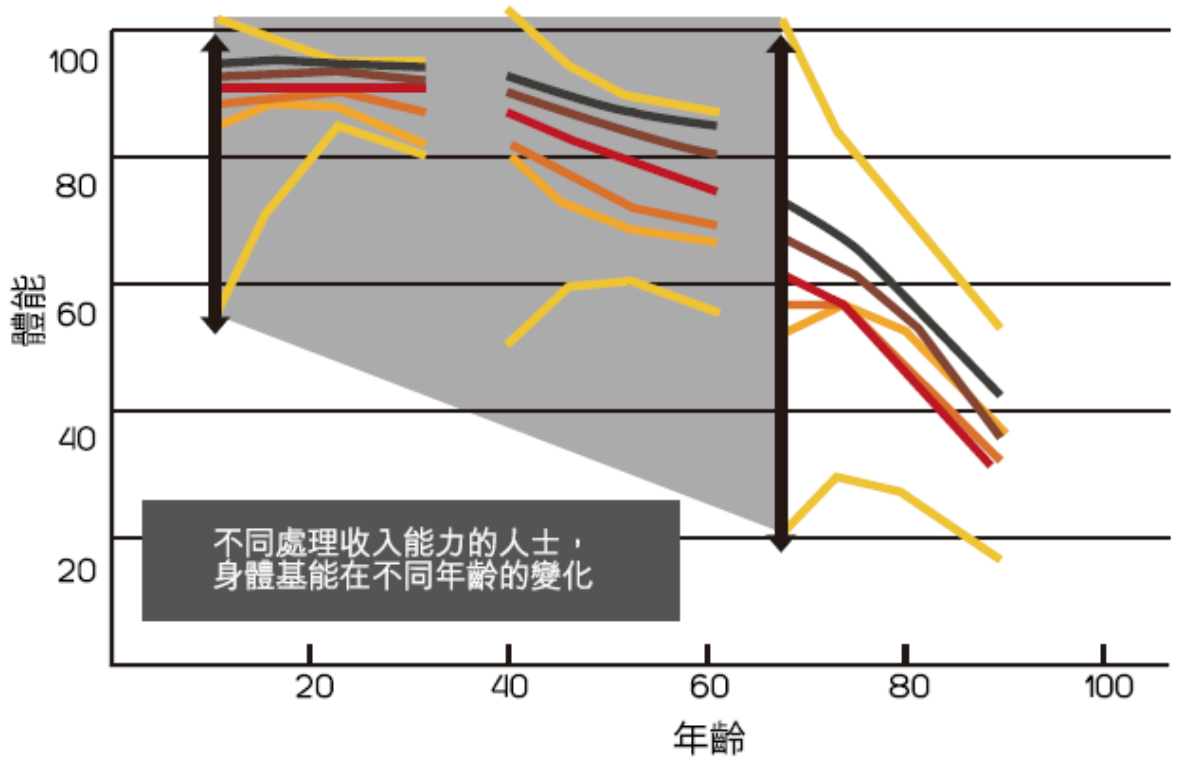
Diversity in ageing 老齡化的差異

現有收入下處於不同生活水平者在整個生命歷程中身體機能的變化

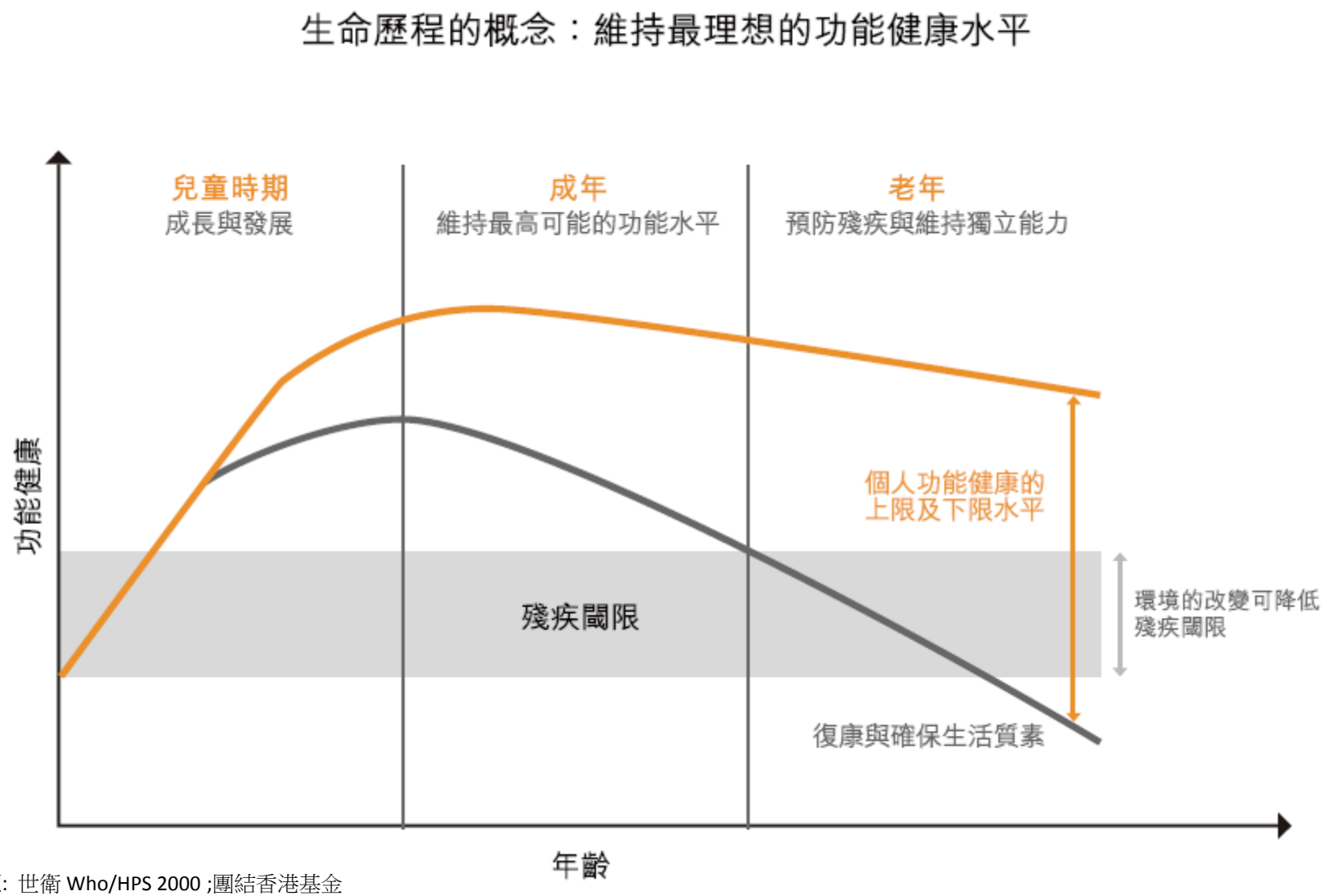


收入能力

- 無法生活
- 困難
- 有時困難
- 尚可
- 寬裕
- 體能范圍

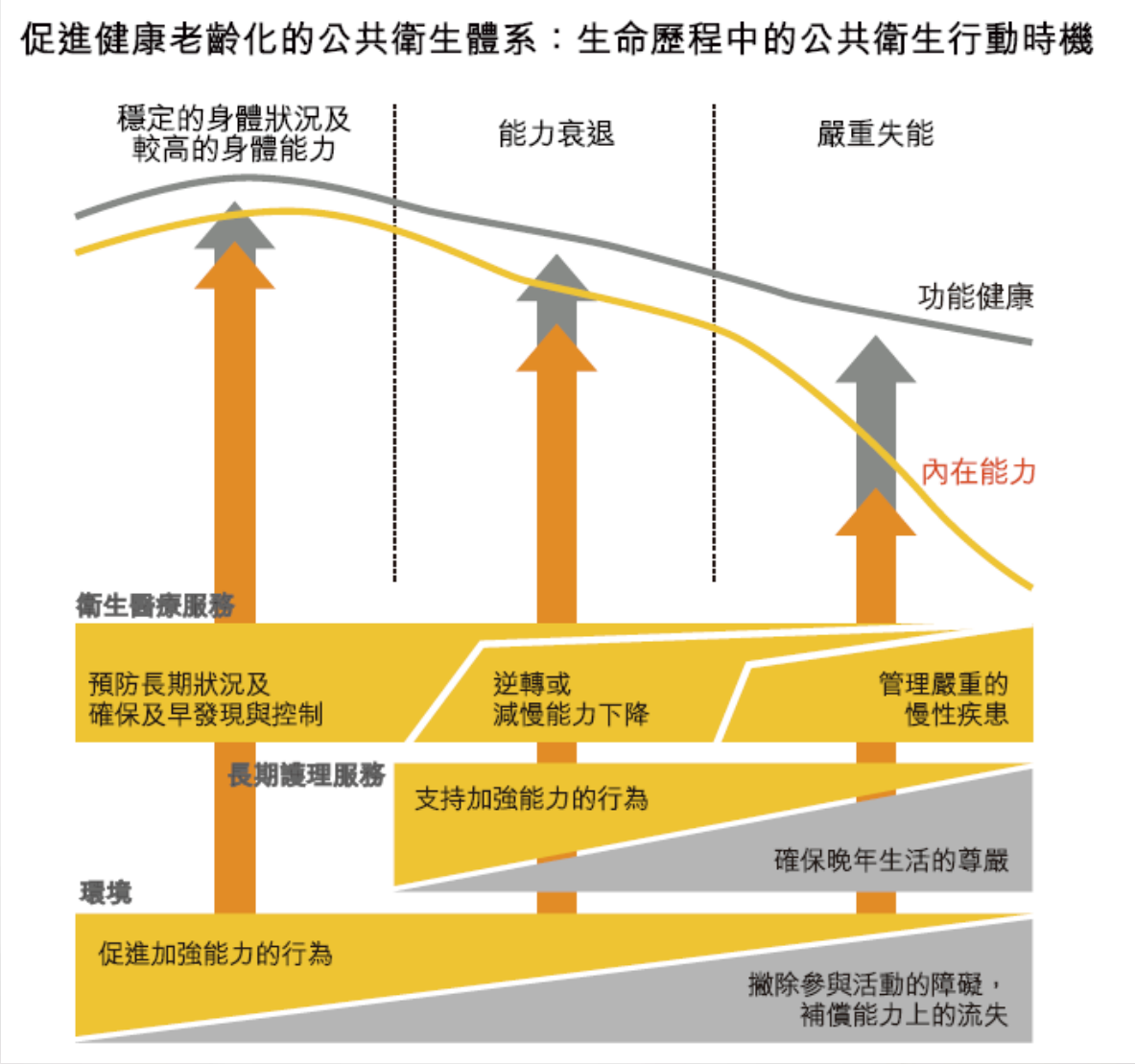
資料來源: 世衛 2015;團結香港基金

Functional capacity in a life course
在人生不同時期，身體功能的轉變



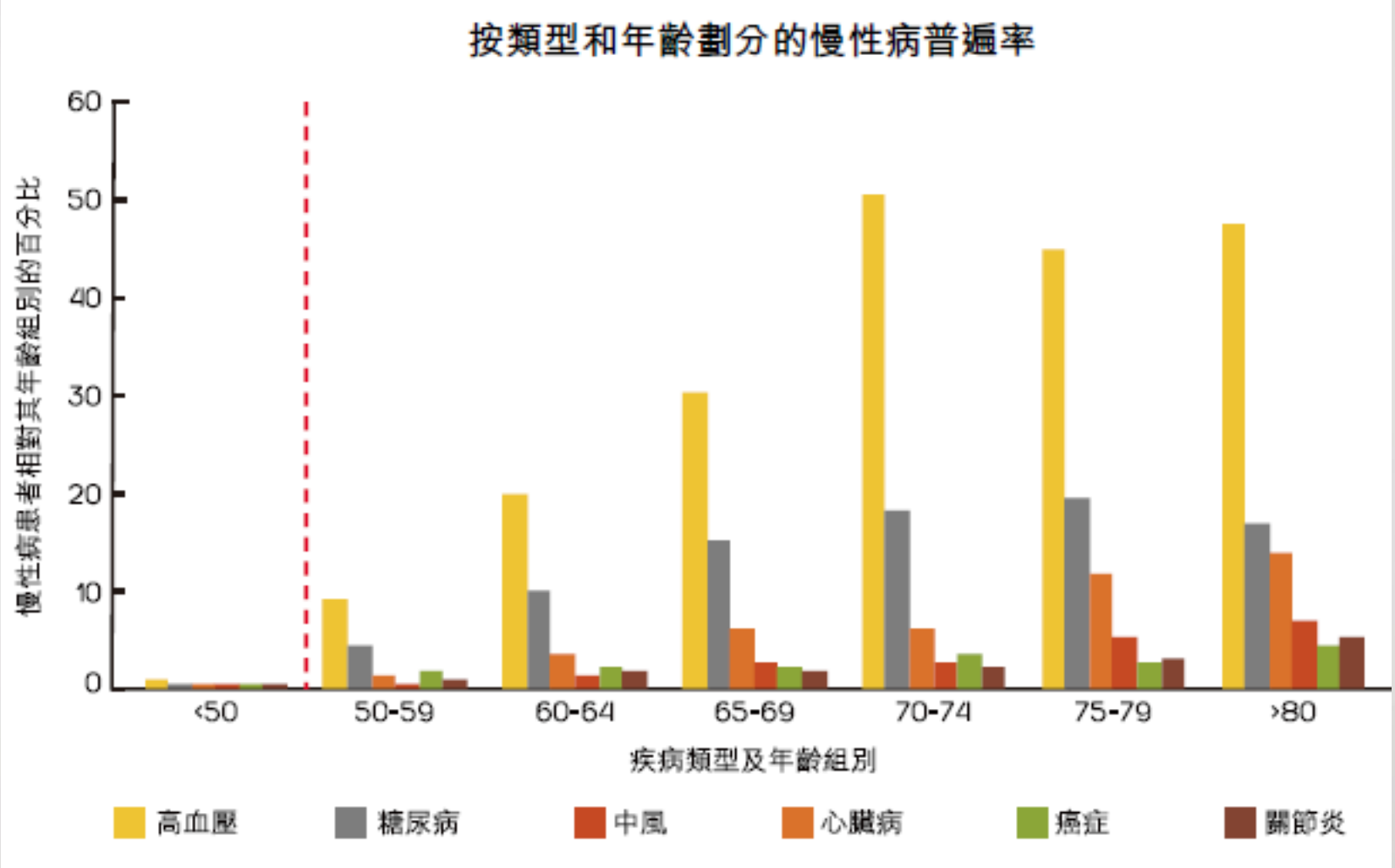
資料來源: 世衛 Who/HPS 2000 ;團結香港基金

Healthy ageing framework 健康老齡化的框架



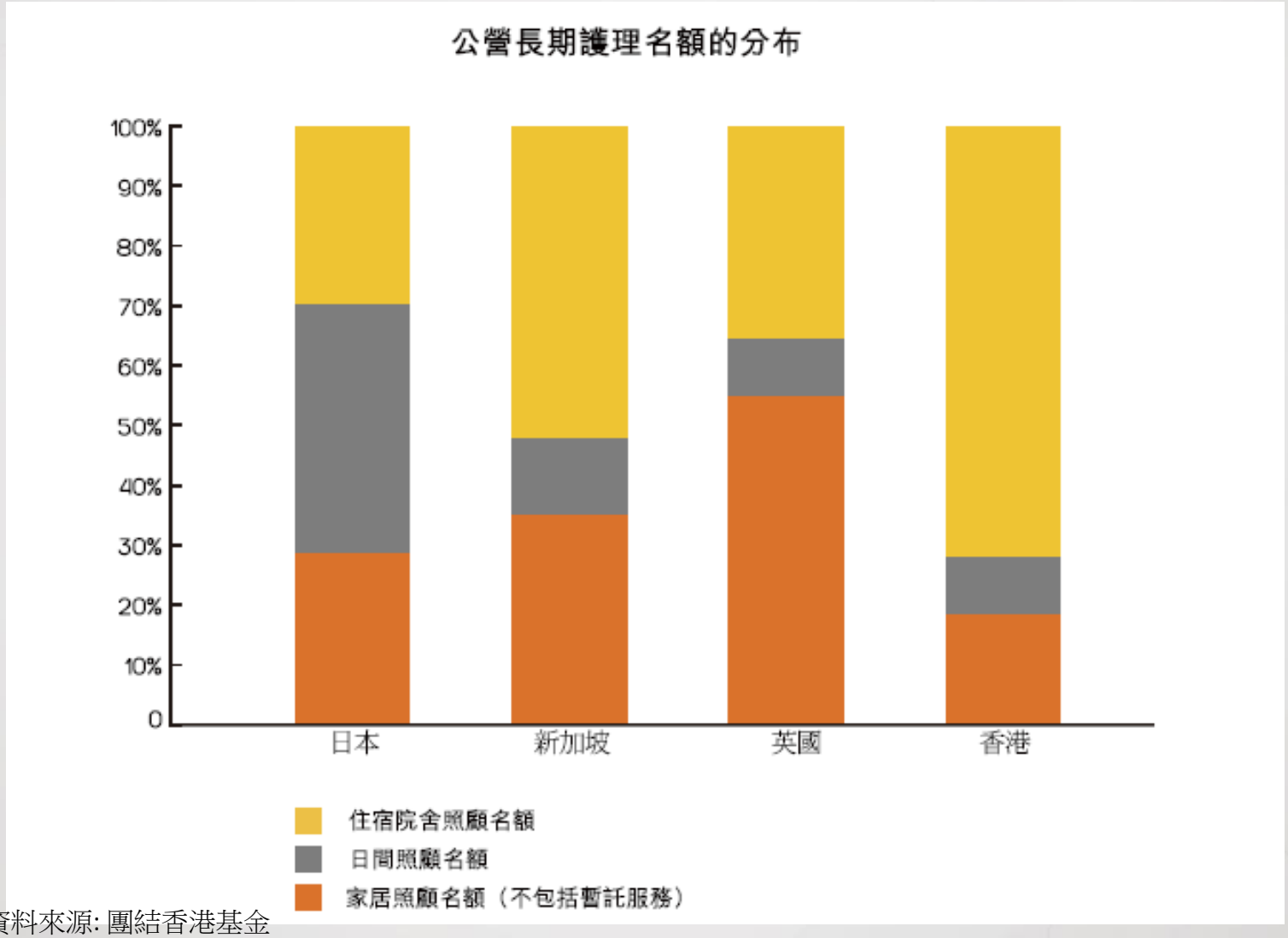
資料來源: 世衛 2015;團結香港基金

Ageing and chronic diseases in Hong Kong
香港的老齡與慢性疾病



資料來源: 香港特區政府統計處 2013;團結香港基金

Long term care in Hong Kong
香港的長期護理



資料來源: 團結香港基金

Commissioned by Health and Medical Research Fund

Quality of healthcare for the ageing – Health system and service models to better cater for an ageing population

Study Findings 研究結果

Perspectives: Providers
服務提供者的看法

"Due to our limited capacity, we are not able to provide health care and supporting services (meal delivery services, escort & transportation) to the elderly after their discharge from the hospital
因為機構能力界限問題，對於剛出院既長者，我們未能即時提供醫療或支援服務，如送飯、陪診或交通接送服務。"

Social
社福界

"Most elderly stay longer in the hospital due to social problems rather health problems

大部份長者住院時間延長是由於個人因素多於健康因素"

Health
醫護界

Admission/A&E: Identified issues
住院/急症: 問題

- Many needless admissions
- HARRPE score not sensitive for frail patients
- Immediate discharge limited by community service availability
- Few geriatric nurses/geriatricians available

Perspectives from Multi-morbid elderly – results from questionnaire survey
患有慢性疾病的老齡看法 – 問卷調查結果

- 在晚下、週末或假日期間， 24.9% 受訪者表示有困難或非常困難立即找到醫療護理，而不用到急症室求診。
- 約四成受訪者(39.1%) 表示只會到急症室求診。

- 受訪照顧者中，大部份(89.4%)是需要照顧家人。
- 在一個星期內，多過一半受訪者(58.8%) 花多於二十個鐘時間作為照顧其他人。

Results from a project commissioned by Food and Health Bureau.
Icon credits: 1. http://www.freepik.com; 2.https://www.flaticon.com; 3. Noun Project

Among all hospital admissions for HK elderly 65+
六十五歲或以上住院病人

15% RCHE vs 85% home
15% 住院舍 對 85% 自住

46.8% due to ambulatory care sensitive conditions (ACSC)
46.8% 入院原因是可被避免的

4% result in death in hosp.
4% 死於醫院

Hospital
醫院

About 20% avoidable readmission in 30days

30天內, 約20%病人再由於可被避免病因而入院

Summary of integration problems

- **Horizontal gaps** 橫向差距 exist between different services offering similar 'intensity' of care
  - Between specialist and geriatric wards in the hospital
  - Between different organisations in the community offering nursing services.

- **Vertical gaps**直向差距include inadequate mechanisms and procedures to refer patients at different levels of dependency, depending on the changing needs of patients
  - Transition between primary and hospital care
  - Transition between home and convalescent beds.

- **Temporal barriers** 時間性阻礙 include weak 'loops' in the system, whereby patients are ineffectively referred/transferred to other services within a sequence of care, so they do not experience seamless transition
  - no onward referral to other services when the duration of one service ends

- **Fragmented public-private system** 分離的公私營系統

Five key models are needed in elderly care in HK:
五個主要針對香港長者護理的模型

These span the spectrum of patient needs and address major barriers across the system

System-wide 系統性 Medical/Social service integration

A&E department 急症室

Address needless hospital admissions and refer to appropriate level of care

Hospital inpatient 住院

Patient assessments and referral to appropriate level of care (post-discharge sub-acute services)

Community services 社區服務

Primary Care-led Hub & Network of community services

End of life care 晚期照顧

Frameworks and recommendations for quality care across the spectrum of patient needs and along the patient journey

Five key models are needed in elderly care in HK:

These span the spectrum of patient needs and address major barriers across the system

1. **A&E department**

   急症室

2. **Hospital inpatient** 住院

3. **Community services**

   社區服務

4. **Med-social integration**

   醫社合作

5. **End of life care** 晚期照顧

Short-term goals are possible:

- Many important systems/components already in place
- Relatively small system changes can bring improvements

→ **Pilot studies** can identify best way to implement changes

These represent longer-term goals because:

- Systems are complex and services deeply fragmented
- Major current gap in manpower and skills

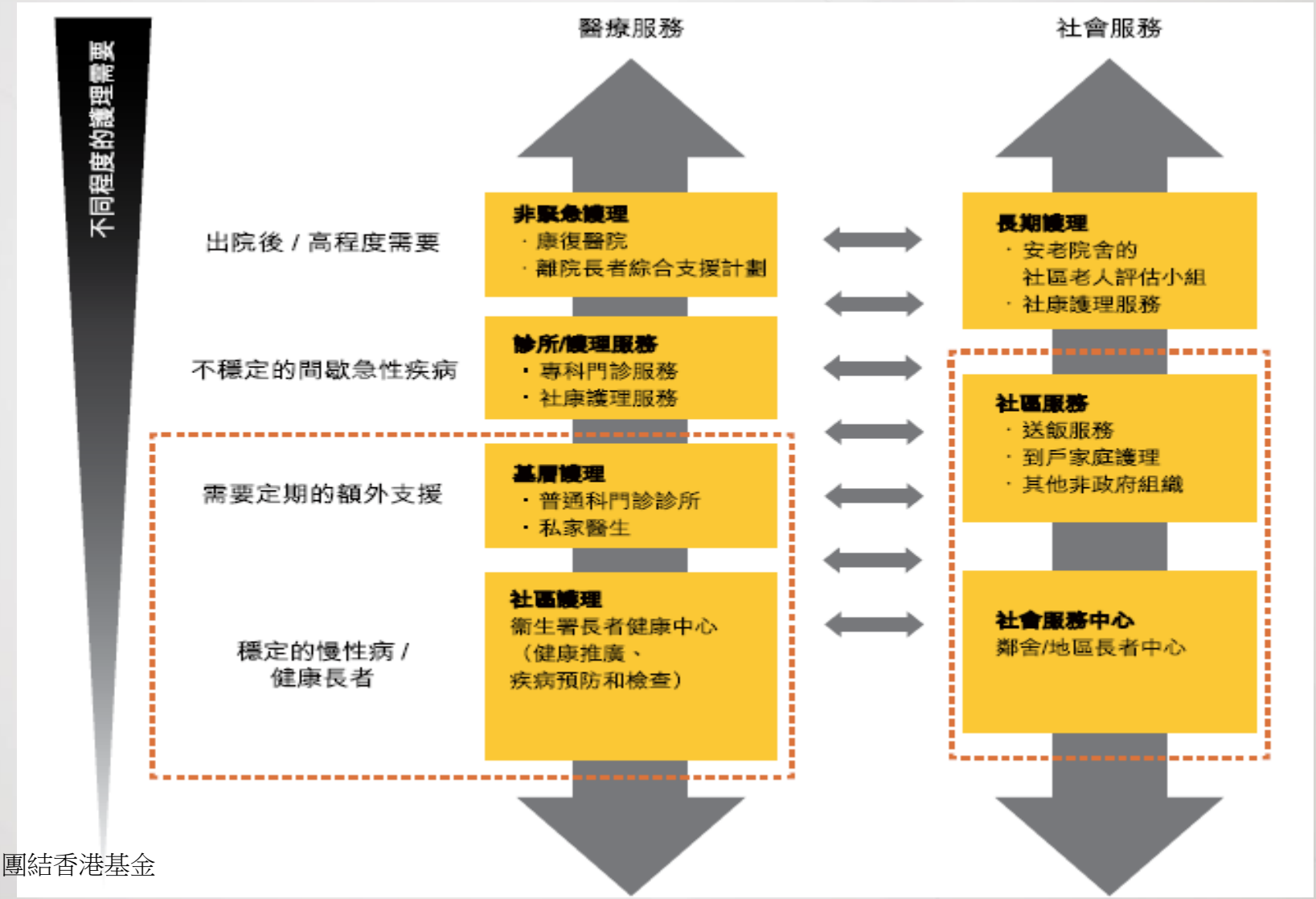
Complex/ lengthy changes are required:

- Reforms in inter-sectorial policy, including funding
- Horizontal/vertical integration within and across services/sectors

→ **Further groundwork is required** to fully evaluate issues, engage all sectors/providers in proactive collaboration and plan stages for service improvement

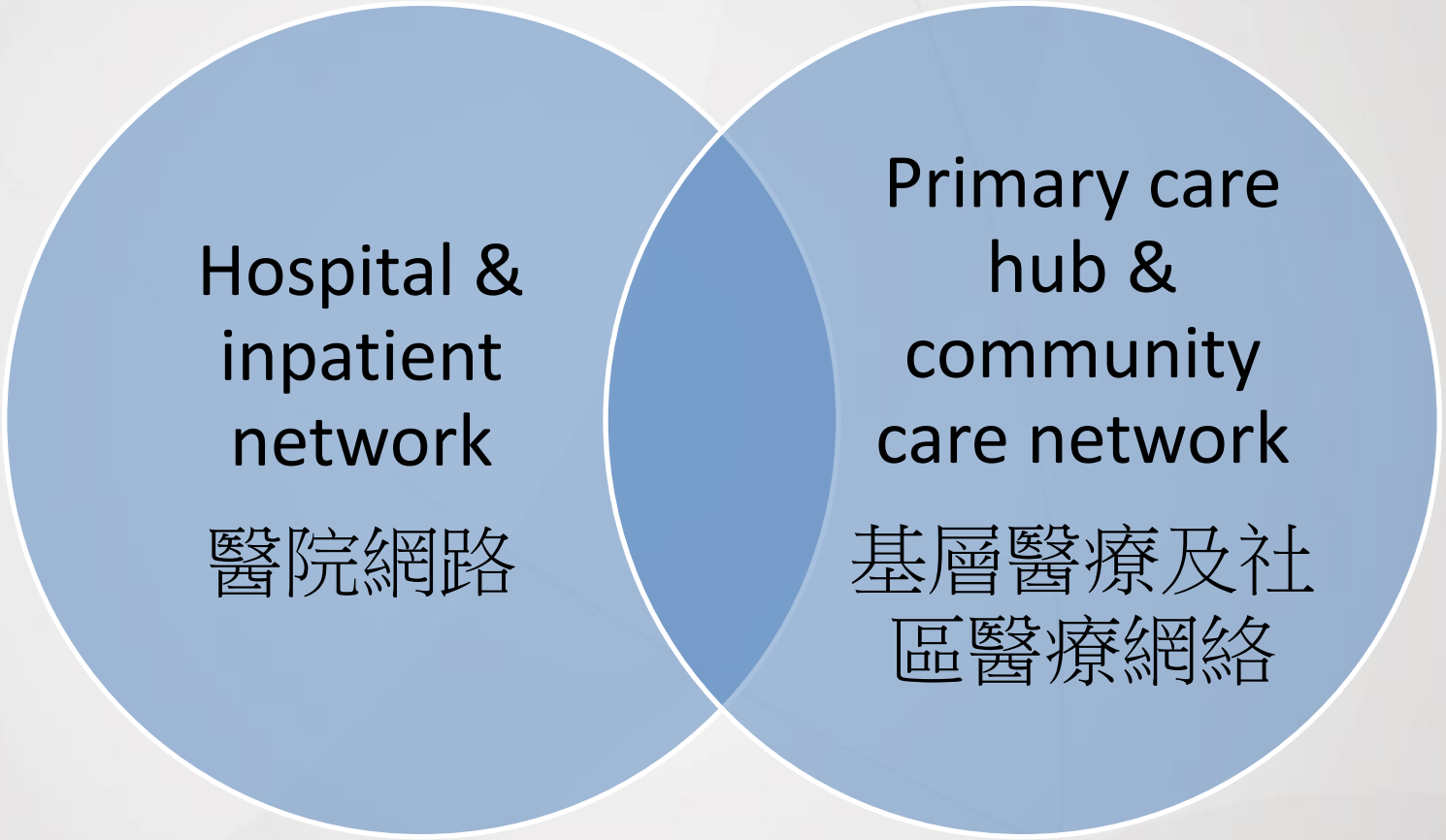
An integrated medical-social service network
for providing needs-matched care and support

Enabling policies | Commitment to change | Information sharing/ communication | Common goals & values | Improved training/ education | Linked budgets | Harness volunteer potential | Public-private partnership | EOL policy and programmes



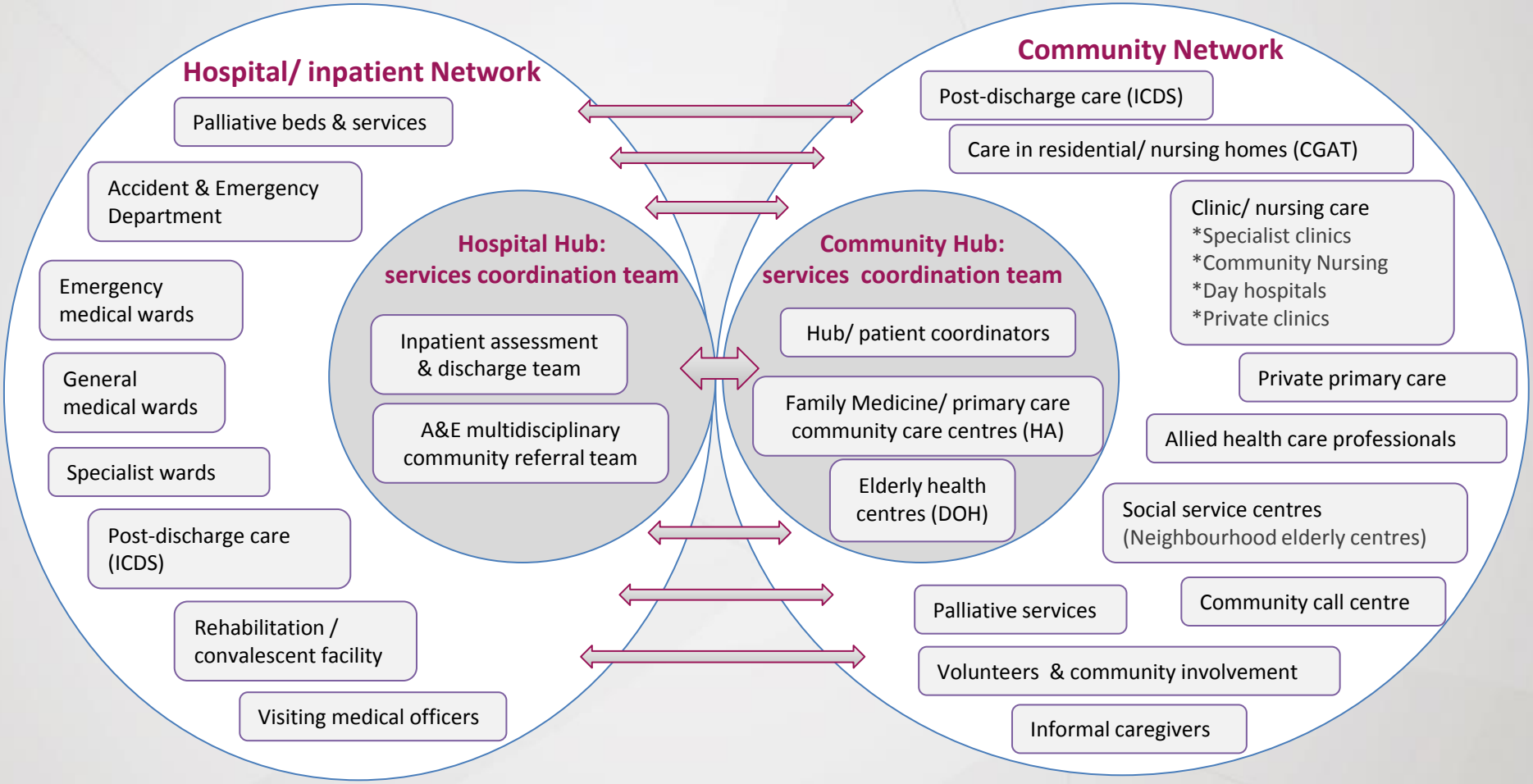
諮謝: 團結香港基金

Integrated model 綜合模型



Conceptual integrated system model: Hospital-Community Network

Enabling policies | Person-centered care | Common goals & values | Improved training/ education | Shared medical + social services records | Medical-social service connections | EOL policy and programmes | Geriatric-care focus (i.e. cognitive impairment)



Note: (1) Hubs and networks are intended as 'virtual connections', (2) Service lists are for illustrative purposes, and (3) many connections between services are encouraged, in addition to the close working connection between hospital and community hubs.

Components of community model

- **The hospital Hub** 醫院樞紐 will comprise teams and individuals involved with coordinating patient discharge to community care and will work closely with community sub-acute care services
- **The wider hospital network** 擴展醫院網絡 comprises all other inpatient/hospital teams or services. High-risk patients can be referred/identified for comprehensive assessment and discharge support
- **Primary care-led hubs** 以基層醫療為主的樞紐 will be a focal point for coordinating the diverse range of community services and work towards a *community-based care model*. The following services may be provided, among others:
  - Multidisciplinary case management clinics
  - Drop-in and preventive services
  - Assessments for cognitive impairment
  - Expanded day care
  - Caregiver support
  - Support of functional impairment
  - Volunteer training and coordination
- **The wider community network**擴展社區網絡 comprises all other medical and social services in the community, including private primary care
- **Community service coordinators** 社區服務協調者 are proposed to facilitate integration between community service providers and coordinate care for vulnerable/ frail community-based patients

Community Hub:
Services coordination team

●**Ongoing processes:** build, coordinate & link all stakeholders in the network

HA: Family Medicine/ primary care community care centres

DH: Elderly health centres

Hospital Hub & Network

Hub and patient coordinators

- Based in the 'Community Hub' (HA or DH location)
- **Aim of role:** Proactively encourage and facilitate good working relationships between services, plan local service needs and maintain high-risk patient register to enable 'ageing-in-place'
- **Close connection to 'Hospital Hub' teams**: manage transfer of patients from hospital to community care (when needed) and enlist appropriate community groups in providing care
- **Understand and disseminate roles and service scope of all community services**: Know responsibility & service scope of all providers and maintain an *accessible* and *up-to-date* service list
- **Maintain *accessible* and *up-to-date* register** for vulnerable elderly
- **Foster integration to eliminate service gaps** by initiating meetings/connection and ensure connections are maintained
- **Performance review & feedback** for continuous quality improvement

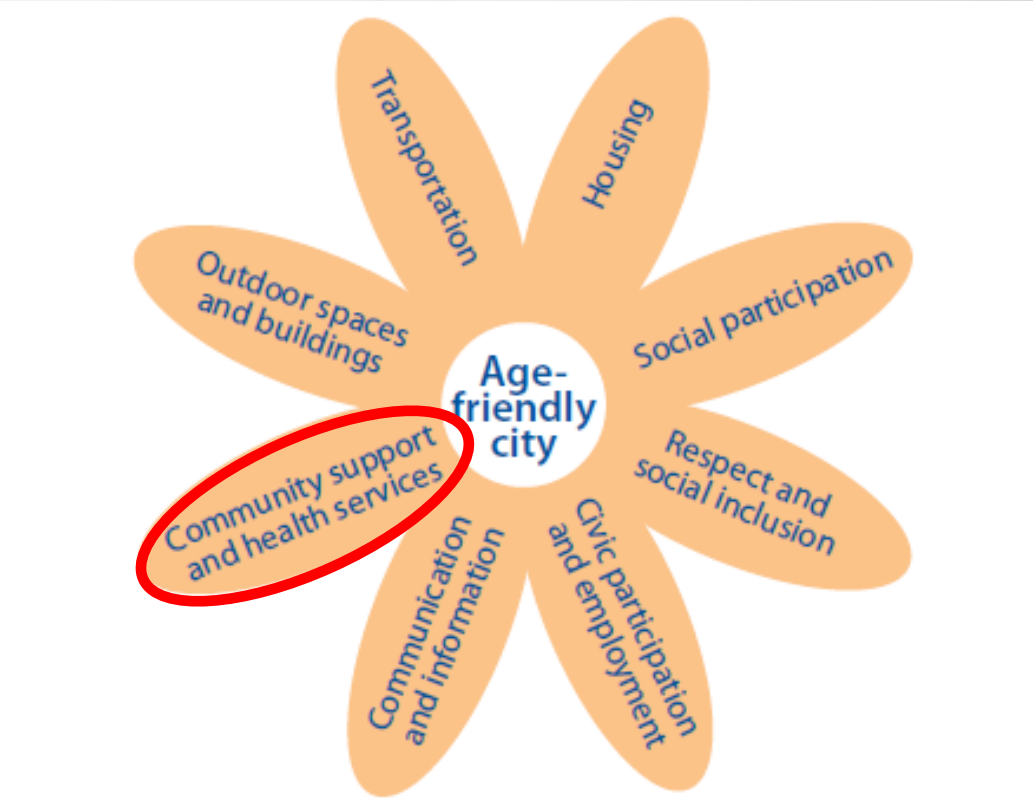
Community network (All community services)

Notes on proposed service model

- Hubs will ideally be a physical focal point for integrated & coordinated community medical and social services
- The Coordinators can interact with Primary care services and EHCs to ensure vulnerable elderly are 'picked-up' and that services are in place to support care/ageing in place

WHO age-friendly city features
世衛建議齡活城市的特徵

- "Community support and health services" is one of essential features 社區支援及健康服務是其中一個主要特徵

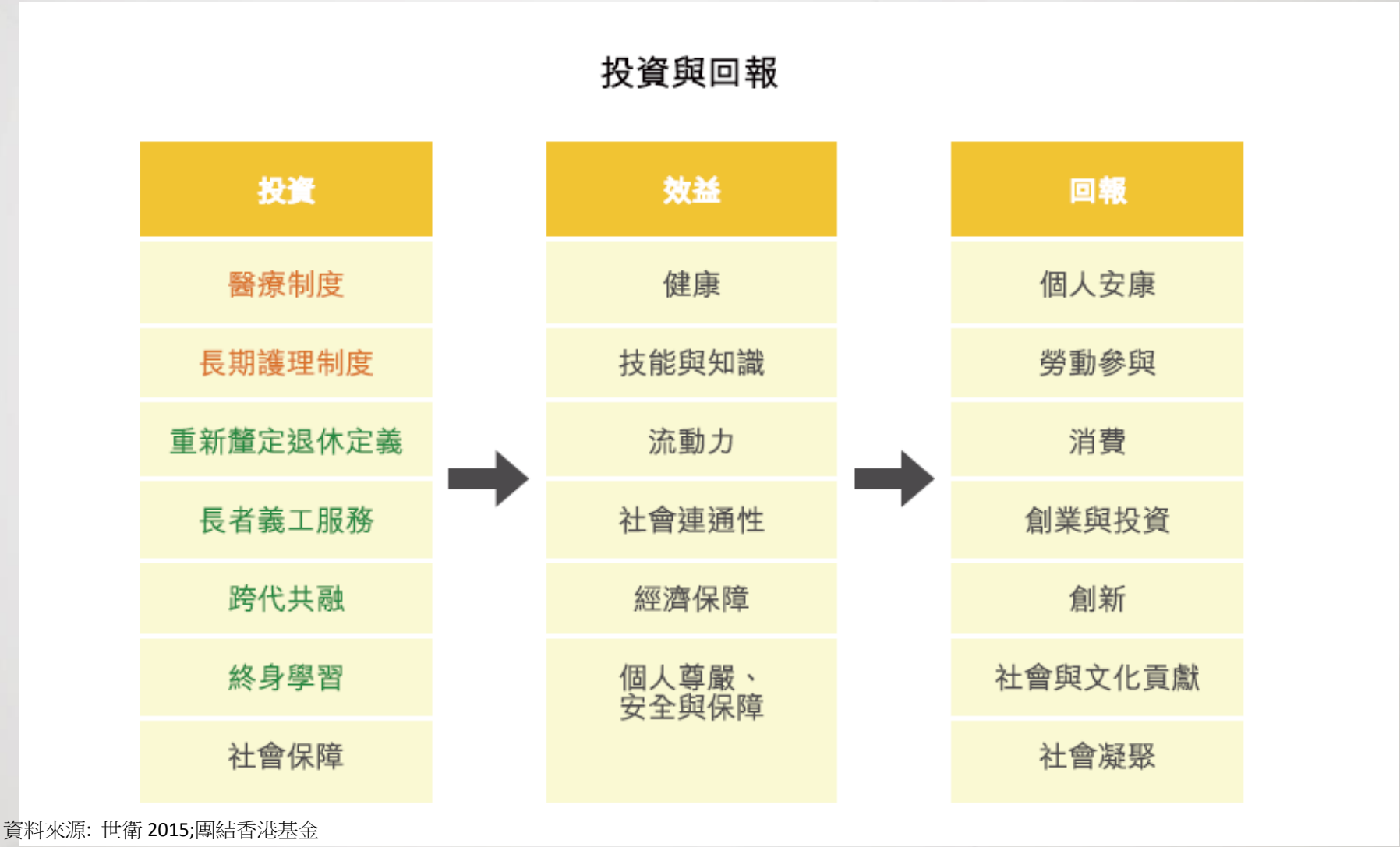


Source: WHO. Global Age-friendly Cities: A Guide. 2007

Checklist in community support and health services 社區支援及健康服務的考慮

- 12 items 十二個列舉
- Include health and social services, such as
  包括健康及社區服務, 如
  - Health services and community support 健康服務及社區支援
  - Home care services 家居服務
  - Residential care facilities 安老設施
  - Voluntary services 志願服務
- Very similar to the concept of 跟以下概念相似
  - Integrated services 綜合服務
  - Ageing in place 老有所屬

Investment for ageing 向老齡投資



資料來源: 世衛 2015;團結香港基金

Transform Hong Kong to an age-friendly city
建立香港作為 齡活城市

資料來源: 團結香港基金

Thank you!

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