HOSPITAL AUTHORITY
STRATEGIC SERVICE FRAMEWORK
for ELDERLY PATIENTS

醫院管理局
HOSPITAL AUTHORITY

The cover design is inspired by ginkgo leaf, which symbolises longevity, hope and peace, conveying our respect for the elderly and a positive future for patient care.

Issued in 2012

CONTENTS

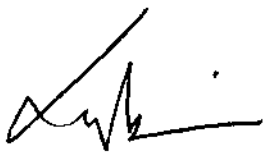
1 PREFACE

I am delighted to present the Hospital Authority's (HA) Strategic Service Framework for Elderly Patients, which will guide the development and provision of HA elderly services over the next five years.

Hong Kong is proud of its population's life expectancy, but population ageing is also one of our greatest challenges. As we live longer, our healthcare demands, as well as expectations for higher quality and safer services, continue to rise. It is thus timely to publish a renewed vision and strategic priorities for HA elderly services.

The Framework reflects the culmination of an intense period of research, stakeholder engagement and expert views on HA service needs of elderly patients. It places emphasis on improving the provision of integrated care to targeted elderly patients through multi-disciplinary approaches, enhanced patient/carer empowerment and strengthened collaboration with partner organisations. My gratitude goes to the wide range of staff and stakeholders who have contributed to its development.

The Strategic Service Framework for Elderly Patients will support clinicians and executives in aligning programme development in the service planning process of HA, contributing to our vision for HA elderly services of enhancing the well-being of elderly patients, and will contribute to healthy ageing by raising the standards and quality of healthcare wherever care is given.



Dr P Y LEUNG
Chief Executive

2 ACKNOWLEDGEMENTS

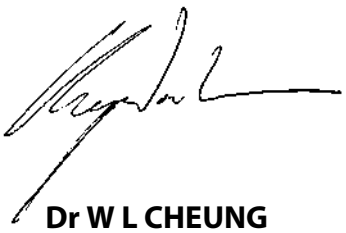
The HA Strategic Service Framework for Elderly Patients, as proposed in the HA's Strategic Service Plan 2009–2012, addresses existing and emerging challenges and capitalises on foreseeable opportunities in the development of services for elderly patients in Hong Kong.

We would like to acknowledge the guidance provided by the Taskforce on the HA Strategic Service Framework for Elderly Patients, which has had overall responsibility for developing this document. In addition, we would like to express our gratitude for the input from frontline healthcare professionals, whose knowledge of the local settings helped to lay the foundation of this work. The development of the Framework would also not be possible without the help of external advisers who provided valuable international perspectives. We are also grateful to members of the Geriatrics Sub-committee for providing specialised skills and expertise to manage elderly patients within the HA over the past decades.

During the two-month consultation on the draft Framework, we received responses from 40 individuals and organisations, and met with patients, carers, non-governmental organisations and representatives from private old age homes. We are very grateful to everyone who took time to respond. These suggestions and comments were all carefully considered and helped us to refine the Framework further.

Although this Framework mainly addresses the physical healthcare needs of elderly patients, we are very aware of the importance of elderly mental health. It is the intention of the HA to consider the mental health needs of elderly people in upcoming prioritisation of strategic service framework development.

Dr S V LO
Director, Strategy and Planning Division



Dr W L CHEUNG
Director, Cluster Services Division

3 EXECUTIVE SUMMARY

Issued in 2012, the Strategic Service Framework for Elderly Patients ("the Framework") will guide the development and provision of HA elderly services over the next five years.

The Framework emphasises improving the provision of integrated care to targeted elderly patients through multi-disciplinary approaches, enhanced patient/carer empowerment and strengthened collaboration with partner organisations.

Work on the Framework was approved in 2010 and development has been overseen by an expert Taskforce. The terms of reference of the Taskforce are:

- To review current and anticipated service need for elderly patient health services in HA.
- To identify strategies and priority services to address major anticipated gaps over the next five years.
- To advise on the future service model(s) to enhance the quality and outcome of elderly patient health services.

A highly interactive and broad engagement approach has been adopted in the development process, during which patients, carers, clinicians, professional bodies, the Government and non-governmental organisations (NGOs) have been involved.

The HA's Vision and Mission for its elderly patient services are:

Vision: ***To enhance the well-being of elderly people, and to contribute to healthy ageing, by raising the standards and quality of healthcare wherever care is given.***

Mission: ***To offer seamless and high-quality care in primary, community and hospital settings in order for elderly patients to receive services appropriate to their needs.***

In order to meet the identified challenges of (i) managing growing elderly service demand, (ii) ensuring service quality and safety and (iii) maintaining an adequate workforce that is skilled in elderly care, the HA will aim to fulfill the following five strategic goals for its elderly services over the next five years:

I. High quality, integrated elderly care to meet the needs of elderly patients, and which is delivered in a timely, accessible and appropriate manner.

II. Elderly patients and their carers engaged by HA as enabled and active partners in the management of their own care.

III. The HA will work with its partners to improve coordination and continuity of services across settings, to provide better care and improve health outcomes for elderly patients and their carers.

IV. The HA will nurture a skilled, competent and responsive workforce to meet the needs of increasing numbers of elderly patients.

V. The HA will support continuous service improvement in elderly care, for both patients and staff and where possible, optimise the use of information and technology to support this.

The five key long-term strategic objectives to realise the above vision and goals are:

1. Develop multi-disciplinary integrated elderly services across the continuum of HA care.
2. Promote patient-centred care and engage patients and their carers as active partners in their healthcare.
3. Greater collaboration with partners involved in elderly care outside of HA.
4. Enhance HA workforce capacity and engage staff.
5. Develop quality, outcomes-driven HA elderly services.

To achieve each of these objectives, a number of actions and priorities will need to be implemented. A proposed timetable for these actions and priorities is outlined in section 15 of this Framework, with a summary shown below.

Objective 1

Develop multi-disciplinary integrated elderly services across the continuum of HA care

The HA will:

i. Adopt a **system-wide approach** in the development of an integrated care service for elderly patients.

ii. Perform **integrated patient assessment** for identified high risk elderly patients to determine their specific needs upon admission to hospital.

iii. Perform **early discharge planning** and formulation of **individualised care plan** to allow for better care planning of elderly patients requiring frequent attention.

iv. **Enhance coordination** of multi-disciplinary services, to better support elderly patients who have chronic disease and complex needs.

v. Improve evidence-based **rehabilitation care** for elderly patients who have chronic diseases and complex needs (e.g. chronic obstructive pulmonary disease, chronic heart failure and stroke), to enable optimal recovery and transition to the community.

vi. Strengthen **integrated community care** to facilitate multi-disciplinary HA health professionals to fulfill their roles in providing timely coordinated assessment and management of elderly patients.

Objective 2

Promote patient-centred care and engage patients and their carers as active partners in their healthcare

The HA will:

i. Advocate **dignity**, **respect and autonomy** for elderly patients in all HA settings, such as through listening to their concerns about their care, and **promoting the concept of the patient as an active partner in their healthcare.**

ii. **Promote communication** and information sharing with elderly patients and their carers to **enable them to participate and make informed shared decisions** related to their care, where appropriate.

iii. Support **self-management** of chronic diseases through better patient empowerment to enable elderly patients, their families and carers to better manage post-discharge care, management of risk factors and acute flare-ups of illness in the community.

Objective 3

Greater collaboration with partners involved in elderly care outside HA

The HA will:

i. Develop improved **service networks with community partners**, including primary care practitioners, Department of Health Elderly Health Service and NGOs to enhance service continuity and appropriate transitional care for elderly patients.

ii Work with the Social Welfare Department (SWD), NGOs and private practitioners to further support **better long term care** provision for elderly patients who live in **Residential Care Homes for the Elderly (RCHE).**

iii **Work with the Department of Health (DH) and other stakeholders in the development of primary care strategies for the elderly** to ensure that future development of primary care services take into account the different needs of elderly people.

Objective 4

Enhance workforce capacity and engage staff

The HA will:

i **Use workforce planning**, which addresses the implications of an ageing population, to anticipate HA elderly service needs and help develop the supply of a sufficiently trained workforce.

ii **Design and implement specific educational and training programmes** for different HA staff groups, including medical, nursing, allied health, and other health professionals, to bring them up-to-date with this Framework and developments in HA elderly services.

iii Work towards **improving the training and continuing professional development needs of staff** involved in the care of elderly patients; such as through up-skilling courses, clinical exposure and mentorship, as part of HA's commitment to spreading the knowledge and expertise of geriatric specialists to the wider workforce; so that staff are equipped with the necessary knowledge, skills and competencies in elderly care.

iv **Support the dissemination of knowledge of elderly services** available within the community to facilitate HA staff to engage and empower elderly patients and their carers.

Objective 5

Develop quality, outcomes-driven elderly services

The HA will:

i. Support development and implementation of **agreed principles**, **referral pathways and care protocols** for elderly patients in acute settings, as part of the "Acute Care for the Elderly" Project, so hospital services can respond effectively and appropriately to the needs of elderly patients.

ii. **Explore the development of quality indicators**, with corresponding areas aligned to the HA hospital accreditation programme, to benchmark the performance of acute, rehabilitation/convalescence, transitional and community HA services.

iii. Develop guidelines to inform the **future planning** and development of HA hospitals and facilities to ensure elderly patient needs are considered in the design of the environment. For example, consideration of problems common to elderly patients, such as reduced balance, lack of stamina and strength, sensory impairment and way-finding, as well as increased risk of confusion in unfamiliar environments.

iv. Advocate and promote **better care standards for elderly patients** in non-HA settings, including RCHE, such as through HA being an exemplar of best practice care in community settings.

v. **Utilise development of the HA's Clinical Management System,** where possible, to support and improve the quality and continuity of care delivery and workflow efficiency.

Implementation of the HA Strategic Service Framework for Elderly Patients

This Framework will be a significant catalyst for improving HA elderly patient services. Success will require all stakeholders to work together to implement the strategic directions and operational priorities set-out. The Framework is expected to link with the HA annual planning cycle for resources to support implementation, as well as monitoring of the progress and success of initiatives on elderly patient care.

PART I

SETTING THE SCENE

4 INTRODUCTION

Longer life expectancy is one of Hong Kong's greatest achievements, however it is also one of our greatest challenges. Decreasing fertility rates and increasing longevity have resulted in a shift in population composition to increasing older age. However, Hong Kong is not unique in this challenge – population ageing is a global phenomenon which is demanding international, national and local action[1].

As populations age, non-communicable diseases become the leading causes of morbidity, disability and mortality in all regions of the world[1]. Many non-communicable diseases are preventable, or can be postponed, and innovative policies, planning and management of long-term conditions have been developed to meet the increasing need and support the sustainable delivery of healthcare. Thus, while there is no doubt that ageing populations will increase the demand for healthcare; collaboration, planning ahead and making evidence-based and culturally appropriate service developments will enable health systems to successfully manage the economics of an ageing population[1].

Traditionally, old age has been associated with retirement, illness, vulnerability and dependency. This is an outdated paradigm that does not reflect reality. Indeed, most people remain independent until a very old age. Many health systems are moving to new models of care that view older people as active participants in an age-integrated society and as active contributors, as well as beneficiaries, of development. Many people enjoy healthy, active and meaningful lives as they grow old. For those who do have health needs, these should be managed in a way that promotes quality of life, independence and individual choice.

[1] *Active Ageing: A Policy Framework, WHO (2002).*

About the HA Strategic Service Framework for Elderly Patients

This Framework is guided by the Government's direction, set forth by the Secretary for Food and Health in the report, "Building a Healthy Tomorrow" (2005), which is for HA to focus on four priority areas:

1. Acute and emergency care,
2. Services for the low income group and the underprivileged,
3. Illnesses that entail high cost, advanced technology and multi-disciplinary professional teamwork in their treatment, and
4. Training of healthcare professionals.

Work on the Framework was approved in 2010 and development conducted under the guidance of an expert Taskforce (**Appendix 1**) made up of HA professionals involved in the delivery of elderly care, and co-chaired by the Director of Cluster Services and Director of Strategy and Planning of HA. The Taskforce sought to review and anticipate the need for elderly patient services in HA, and to recommend the overarching service directions and priority actions that the HA and its clusters will be pursuing over the next five years.

Elderly patient healthcare is a priority of HA, as reflected in the HA Strategic Plan 2012–2017. A highly interactive and broad engagement approach has been adopted in the planning process, during which patients, carers, clinicians, professional bodies, the Government and NGOs have been involved.

In order to obtain good assessment of the current situation, 25 field-visit meetings were held by the project team with more than 100 frontline healthcare professionals from various specialties involved in the care of elderly patients (including Accident and Emergency, Family Medicine, Internal Medicine, Geriatric Medicine, Orthopaedics and Psychiatry). The field visits covered facilities in which services are provided by HA, from acute care, extended care, to ambulatory and community care – including geriatric day hospitals (GDHs) and outreach services, as well as those provided by subvented and private RCHE.

In addition, a discussion forum involving patients and carers was convened to obtain their views and suggestions on HA services for elderly patients. With the support of international experts (**Appendix 2**), a workshop was held in July 2010 with over 60 clinicians from various specialties, nursing, allied health professionals and representatives from DH, SWD and NGOs to validate issues and map service directions. To achieve wider engagement and participation from frontline colleagues, a seminar was then conducted shortly after, involving some 120 professionals, to consider the service trends and developments in elderly care in Hong Kong. A second series of workshops was conducted in February 2011, in which 150 colleagues were engaged to propose specific actions and outcomes for the Framework. Finally, briefings to senior officials of the

Government's Food and Health Bureau, Labour and Welfare Bureau, SWD and the Elderly Commission were organised as part of the Framework development process, to solicit their views on elderly care provision.

From 31 August 2011, the Framework was made available as a consultation document to internal and external stakeholders in the health and welfare sectors, as well as patient and carer support groups. In addition, NGOs, Private Old Age Home (POAH) operators, patients and carers were further consulted through six focus group meetings in October 2011. The consultation exercise was completed on 31 October 2011. Responses received were carefully analysed and deliberated by the Taskforce, and finally incorporated into the Framework.

The Framework will help ensure that as we grow old we are enabled to maintain our health, well-being and independence for as long as possible, and receive prompt, seamless, quality treatment and support when required from the HA.

5 SCOPE OF THE HA STRATEGIC SERVICE FRAMEWORK FOR ELDERLY PATIENTS

Issued in 2012, the Framework is intended to guide the provision of HA services for elderly patients over the next five years and beyond. This is a strategic service framework for the HA and thus its scope does not include the overall service developments involving public health, private services, or the wider role of the Government, NGOs and independent sectors. However, the HA is the significant provider of health services in Hong Kong and acknowledgement is made to other organisations where appropriate.

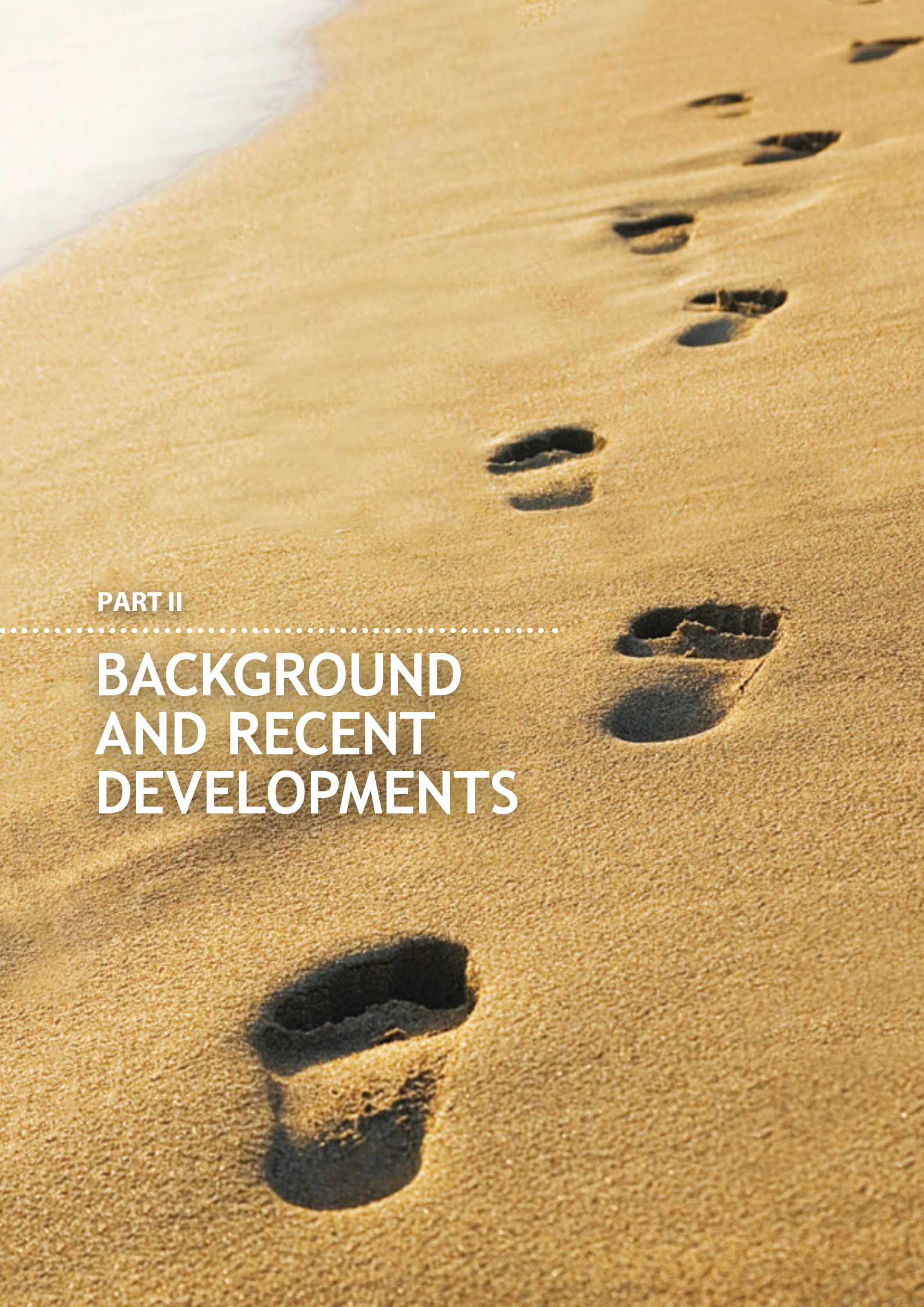
The purpose of this Framework is to anticipate the need for health services by providing a systematic approach to development and quality enhancement. It provides a high level overarching description of the service directions that the HA and its clusters will be pursuing to address existing and emerging challenges in the years to come in relation to elderly patients. Specific operational details of service development are therefore outside the scope of this Framework.

Given the importance of the mental health of elderly people, in particular dementia, it is regarded to be more appropriately addressed through a separate strategic service framework.

Defining Elderly

Although we may generally define elderly people as those aged 65 years or over for planning purposes, it is clear that defining their need by reference to age is not always an effective strategic response. Elderly people are not a homogenous group and the experience of ageing varies from person to person. HA services should therefore be provided according to assessment of individual need, rather than according to a person's age.

As such, a strict definition of "old age" or "elderly" is not given in this Framework, although age groups are specified where necessary for the illustration of certain points.



PART II

BACKGROUND AND RECENT DEVELOPMENTS

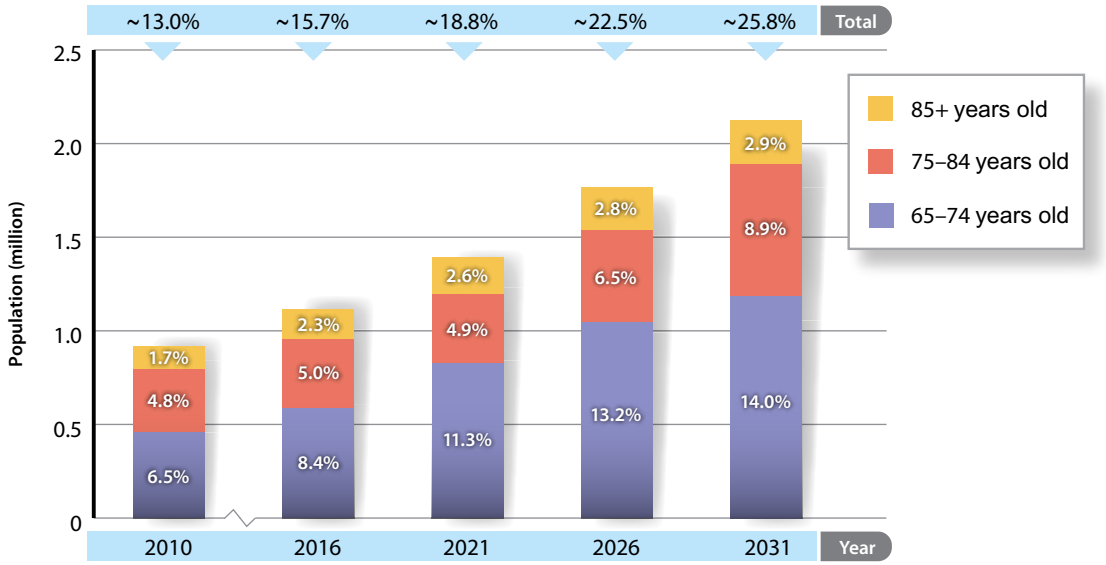
6 LEVEL OF NEED IN HONG KONG

Number of Elderly People

Hong Kong has a rapidly growing population, which is projected to increase by around 5% from the current 7.07 million to 7.44 million persons in 2016. More than two-thirds of this gain is attributable to growth in the age group of 65 years or over.

To illustrate, in 2010 there were around 0.91 million people aged 65 years or over in Hong Kong, accounting for around 13% of the total population. However, by 2016 this number is projected to increase to 1.17 million (around 16% of the total population), and by 2031 to 2.18 million (around 26% of the total population) (**Figure 1**). Impressively, for the age group of 85 years or over, there will be an increase from 118,800 persons in 2010 to 168,900 in 2016, and 244,400 in 2031, representing growth of around 42% and 106% respectively, compared to 2010 [2, 3].

Figure 1. Population estimates and projection for people aged 65 years or over and percentage of total population by age group in Hong Kong (2010 to 2031)



[2] *Population estimates in 2010, Census and Statistics Department, Hong Kong website; accessed in July 2011.*

[3] *Census and Statistics Department (2011). Population Projections 2010–2039, Hong Kong.*

A major reason for this demographic shift is that people in Hong Kong are living longer. Life expectancies, estimated at 80.2 years for men and 86.4 years for women in 2011, were among the highest in the world. Furthermore, they are projected to continue to increase to 81.1 and 87.3 years respectively, by 2016[4].

For the purpose of service planning, an important consideration of the difference in life expectancies between men and women is that there are progressively more women in the older population. For example, in 2010 the male to female ratio decreased from around 1.1 for those aged 65–69 years to 0.5 for those aged 85 years or over[5]. This can have implications for types of diseases encountered and the way services are provided.

The rapidly ageing population demographic and consequent projected increase in healthcare needs and demands has been highlighted by the Hong Kong Government as one of the major challenges faced by the healthcare system, and in particular the public healthcare system[6, 7].

Living Arrangement in the Elderly Population

Different living arrangements result in different levels of social participation and support, which in turn influence health and well-being. Usually older people living in domestic households can have more freedom in their choice of social participation, and those living with family or others are more likely to gain mutual support. On the other hand, older people living alone tend to seek social support outside the household, and those living in institutions may have a relatively limited social support network.

According to Census data, around 90% of the Hong Kong population aged 65 years or over lived in domestic households in 2006, with around 13% of them living alone. The remaining 10% lived in non-domestic households (mainly

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4 *Projected Hong Kong Life Tables, 2010–2039, Census and Statistics Department, Hong Kong website; accessed in May 2012.*

5 *Hong Kong Statistics, Population and Vital Events, Population by Age Group and Sex in mid-2010, Census and Statistics Department, Hong Kong website; accessed in July 2011.*

6 *Food and Health Bureau (2008). Your Health, Your Life: Healthcare Reform Consultation Document. Hong Kong.*

7 *Food and Health Bureau (2010). My Health My Choice – Healthcare Reform Second Stage Public Consultation. Hong Kong.*

homes for the aged). As age advances the percentage living in non-domestic households increases to around 33% (for those aged 85 years or above), whereas the percentage of people aged 85 years or over living alone is around 18% [8].

Coupled with population growth and ageing, this may indicate a potential rising need for organised community support and discharge planning for elderly people who live alone or in non-domestic households and with limited support networks.

The Self-perception of Health by Elderly People in Hong Kong

Many elderly people in Hong Kong remain healthy, active and independent with little or no reliance on health and social care services. However, increasing age is generally associated with increasing disability, loss of independence and functional impairment.

Self-rated health can be used as a subjective measure to describe the health and well-being of an individual and may predict future healthcare use. As age increases self-rated health declines towards "poor". According to a health-related survey conducted by Census and Statistics Department (C&SD) in late 2009, around 12% of Hong Kong residents aged 65 years or over rate their health as "poor", compared to around 2.4% of persons aged 15 to 64 years old. Furthermore, almost a third of persons aged 65 years or over rate their health status as "worse" or "much worse" compared to 12 months previously [9].

While it is encouraging that many Hong Kong residents aged 65 years or over rate their health as "fair" to "excellent", it is a concern that a significant proportion reports their health as having declined compared to the previous 12 months.

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[8] *Population By-Census 2006, Census and Statistics Department, Hong Kong website; accessed in July 2011.*

[9] *Census and Statistics Department (2010). Thematic Household Survey Report No. 45. Hong Kong.*

Elderly People and Chronic Disease Prevalence

Although many people perceive that chronic disease is a part of the ageing process, it is not inevitable and there are many people free of chronic disease as they age. However, recent survey by the C&SD showed that around 70% and 97% of community-dwelling and institutionalised elderly people aged 60 years or over, respectively, reported having a chronic illness [10].

For community-dwelling elderly people aged 60 years or over, 29.8% reported to have one chronic illness, 19.5% with two, and 21.0% with three or more. On the other hand, for institutionalised elderly people aged 60 years or over, 15.9% reported to have one chronic illness, 26.0% with two and 55.2% with three or more chronic illnesses. These figures indicate that multiple morbidities are more common in institutionalised elderly people (81.2%), compared to less than half (40.5%) in community-dwelling elderly people (it should be noted that these observations may be affected by difference in age composition between the two groups) [11].

Hypertension was the most common chronic illness in both community dwelling and institutionalised elderly people (62.5% and 59.1%, respectively). Stroke (32.2%) and Alzheimer's disease/dementia (31.6%) were the second and third most common chronic illness among institutionalised elderly people, while diabetes (21.7%) and arthritis (19.9%) were more common among community-dwelling elderly people aged 60 years or over (**Figure 2**)[10].

Other chronic conditions affecting older people include incontinence and malnutrition. While they may be independent of age, they can be a side effect of other age related factors, such as polypharmacy (multiple medication). Incontinence is a distressing but often treatable condition which affects a significant number of older people, particularly those within care homes. Local survey data revealed that of institutionalised elderly people aged 60 years or over, around 54% reported urinary incontinence and 52% reported faecal incontinence in the week prior to enumeration[11].

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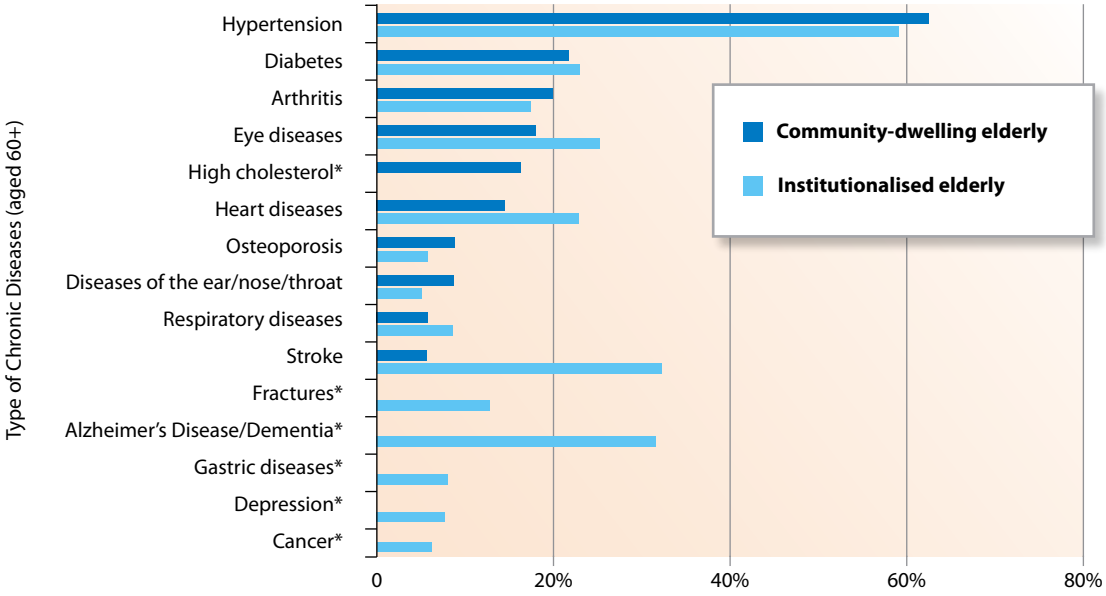
[10] *Census and Statistics Department (2009). Thematic Household Survey Report No. 40. Hong Kong.*

[11] *Census and Statistics Department (2010). Thematic Household Survey Report No. 45. Hong Kong.*

Figure 2: Prevalence of self-reported chronic diseases in community dwelling and institutionalised elderly people aged 60 years or over (2007)



Data source: Thematic Household Survey Report No. 40 Socio-demographic Profile, Health Status and Self-care Capability of Older Persons, Census and Statistics Department, HKSAR, published in August 2009

** Data not available*

Analysis of leading causes of death shows that cancer, diseases of the heart, pneumonia, stroke, respiratory diseases and renal diseases are the main causes of mortality in the elderly population aged 65 years or over (2009), accounting for almost 80% of deaths in this age group [12].

Healthcare Utilisation

For many of the reasons above, elderly people are major consumers of health services. As illustrated in the graph below (**Figure 3**), the utilisation rate of healthcare services rises almost exponentially for people aged 65 years or over. The relative risk of an elderly person, aged 65 years or over, being hospitalised is about 4 times that of a non-elderly person, aged less than 65 years [13].

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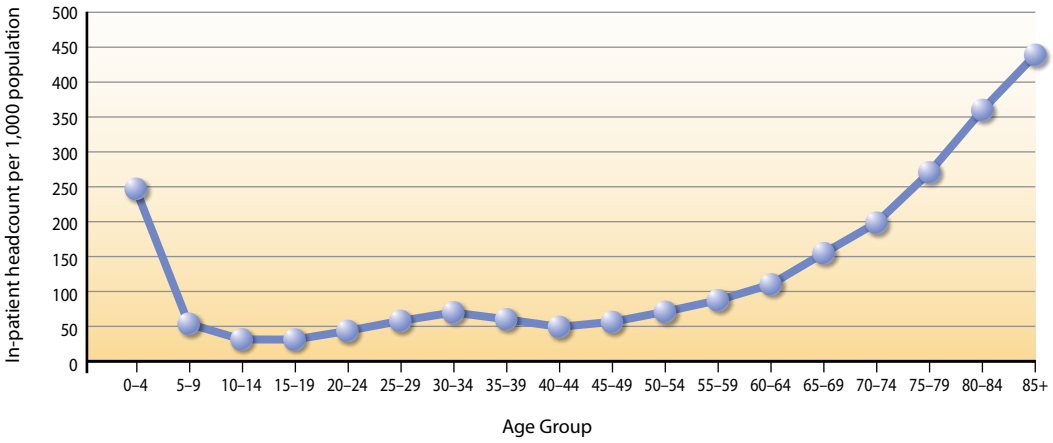
[12] *Number of Deaths by Leading Causes of Death by Sex by Age in 2009, Vital Statistics, Centre for Health Protection, Hong Kong website; accessed in June 2011.*

[13] *Hospital Authority Administration System, 2010.*

Apart from volume increase, the complexities of illness of elderly people are also more profound, placing an even greater demand on the public hospital system. To illustrate in terms of General Specialty bed utilisation, in 2010 non-elderly people aged less than 65 years required 1.3 beds per 1,000 population. However, for elderly people aged 65 years or over the bed requirement was 11.8 beds per 1,000 population, eight times greater than that for non-elderly people. Projection to 2016 suggests that under the current service delivery model, for every 1 bed increase for the non-elderly population aged less than 65 years, the elderly population aged 65 years or over will require 20.2 beds [14].

Figure 3: Population ageing increases healthcare services consumption – Average number of in-patients in HA hospitals by age (2010)



Source: Hospital Authority Administration System, 2010

In 2010, elderly people aged 65 years or over accounted for around 50% of all patient days in HA, despite making up only about 13% of the Hong Kong population. While the proportion of elderly people is projected to reach 16% of the population in 2016, their share of HA patient days will rise to 56%[14].

Furthermore, elderly people (aged 65 years or over) accounted for 53% of all accident and emergency admissions, and 68% of all unplanned emergency readmissions to hospitals, in 2010[13].

[14] *Statistics and Workforce Planning Department, Strategy and Planning Division, Hospital Authority.*

HA Community Services

The HA Community Geriatric Assessment Service (CGAS) is a community-based geriatric specialists service which provides multi-disciplinary care to enable assessment and management of elderly people living in RCHE. Currently, about 88% of RCHE are served by the CGAS[15]. The number of CGAS team/Visiting Medical Officer (VMO) attendances in RCHE has increased thirteen-fold from around 52,500 attendances in 1998 to around 744,700 attendances in 2010 [16].

The HA also provides Community Nursing Services (CNS) to patients at home. These services are mostly task-oriented, such as management of wounds and nasogastric feeding tubes. Community nurses performed over 835,000 home visits in 2010[16] and more than 87% of CNS home visits were to people aged over 65 years[17]. There is currently minimal direct community allied health services from the HA.

HA Specialist Out-patient and General Out-patient Services, Geriatric Day Hospital

The HA provides significant ambulatory care services. Overall, about 5 million General Out-patient Clinic (GOPC) visits and 6 million Specialist Out-patient Clinic (SOPC) visits took place in 2010, of which 37.5% of all attendances at GOPC and one-third of the attendances at SOPC were taken up by patients aged 65 years or over[18]. By 2016, these are projected to increase to 43% and 38%, respectively[19].

Attending multiple SOPCs is common in elderly patients. In 2010, about 29% of elderly SOPC patients consulted two specialties, around 12% for three specialties, and another 5% for four or more specialties[16].

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15 *As at 31.3.11, Primary and Community Services, Strategy and Planning Division, Hospital Authority.*

16 *Executive Information System, Hospital Authority.*

17 *HA Statistical Report 2009/10, Statistics and Workforce Planning Department, Strategy and Planning Division, Hospital Authority.*

18 *Hospital Authority Administration System, 2010.*

19 *Statistics and Workforce Planning Department, Strategy and Planning Division, Hospital Authority.*

Geriatric Day Hospitals (GDH) are ambulatory healthcare facilities in which multi-disciplinary assessment, treatment and rehabilitation are available. Attendance is for a full or part-day basis for elderly people living in the community. There are a total of sixteen GDH in the HA, which provided around 139,300 attendances in 2010[20] – with a variety of specialised services for patients with complex problems. These include fall, memory and continence clinics.

The above service utilisation statistics show that across acute, transitional, ambulatory and community HA services, a rapidly ageing society will result in dramatic increases in the demand for healthcare services. Clearly this requires new and innovative models of care to sustainably manage and enable the delivery of high quality and safe services.

[20] *Executive Information System, Hospital Authority.*

7 OVERVIEW OF ELDERLY PATIENT SERVICES

The strategic development of elderly services in the HA has been overseen by the Primary and Community Services Department of the Strategy and Planning Division. Hospitals and clusters play a fundamentally important role in the development and delivery of many local initiatives.

Hospital Authority Services

Hospital-based Care

The HA provides significant hospital-based services for elderly patients. Hospital-based care for the elderly includes acute care, extended care and infirmary care. Sixteen of the forty-one HA hospitals have Accident and Emergency Departments and therefore receive acute emergency admissions. Admissions into acute medical services are based on clinical and needs related criteria. Furthermore, direct admission to acute specialist care, from RCHE, is also possible based on specialist clinical judgement. Extended care services are often provided by hospitals which do not take acute emergency admissions.

Not all elderly patients are admitted under the care of a geriatrician and not all hospitals have geriatric wards. Geriatric medicine is a subspecialty under the broad umbrella of Medicine and Geriatrics. Conjoint services, such as ortho-geriatric and psycho-geriatric, are often provided to contribute to elderly care and help ensure that the multiple needs of elderly patients are addressed.

Specialist Out-patient Clinics

Specialist Out-patient Clinics provide consultation, treatment and investigations to patients referred by hospitals, GOPCs and private practitioners. Specialist geriatric clinics provide services for patients who were managed by geriatricians during their acute admission, or for those who have been referred by other medical specialists. These patients are usually frail, with chronic illness and multiple problems. Some hospitals provide sub-specialised clinics such as memory, fall, dementia and continence clinics. In addition, sixteen GDH provide multi-disciplinary assessment, treatment and rehabilitation for elderly patients in the community, as mentioned previously.

Community-based Care

The HA provides direct outreach services for patients in the community, including:

- Community Geriatric Assessment Service (CGAS) led by geriatricians
- Community Nursing Services (CNS)
- Community Allied Health Services
- Community Psychiatric and Psycho-geriatric services

In 2004, a CGAS/VMO collaboration scheme was established in RCHE, whereby both part-time and full-time doctors have been recruited to help manage the increasing demand of services.

General Out-patient Clinics

The HA provides primary care through its GOPC services, which target low-income groups, the under-privileged and those who have chronic diseases. Most of the services provided are on an episodic basis. Over the past two years, a multi-disciplinary approach to care has been developed and chronic disease management programmes provided for targeted conditions.

Palliative Care Services

The HA provides end-of-life care through a spectrum of palliative care services to terminally ill patients and their families, which include in-patient, out-patient, day-centre, home-care and bereavement services. Historically, the provision of end-of-life care has mainly focused on patients with cancer; however service coverage has expanded in recent years to better meet the needs of patients with end-stage organ failure. Palliative services are delivered through 15 units[21] in HA by multi-disciplinary teams, which include clinicians, nurses, allied health professionals, pastoral staff and volunteers.

In 2007, through collaboration with community partners, the palliative care service was expanded with the establishment of new hospice day-centres, enhanced home-care services, volunteer services, as well as patient and carer education.

[21] *As at January 2012.*

Recent Development of HA Elderly Patient Services

The following diagram gives an overview of recent HA elderly service developments. Both hospital and community-based service developments have progressed in parallel.

2004

- Community Geriatric Assessment Team (CGAT)/ Visiting Medical Officer (VMO) Scheme developed
- Remote Clinical Management System (CMS) access in old age homes
- Telephone Nursing Consultation Service for high risk patients established in Hong Kong East Cluster (HKEC)

2006

- HA-wide risk prediction tool – the Hospital Admission Risk Reduction Programme for the Elderly (HARRPE) established to identify high risk elderly patients on discharge

2007

- Elderly Care at Home (EC@Home) service established at Kowloon Central Cluster (KCC)

2008

- Integrated Discharge Support Programme (IDSP) piloted in New Territories West Cluster (NTWC), Kowloon East Cluster (KEC) and Kowloon West Cluster (KWC)
- The Chinese University of Hong Kong (CUHK) and The University of Hong Kong (HKU) commissioned to study on reducing avoidable hospitalization in HA

2009

- Community Health Call Centre (CHCC) established at Tang Shiu Kin Community and Ambulatory Care Centre
- Acute Care for the Elderly (ACE) Project initiated
- Enhanced primary care programmes at General Out-patient Clinics (GOPC)

2010

- A taskforce established to develop the HA Strategic Service Framework for Elderly Patients

Acute Care for the Elderly Project

A new HA-wide project called Acute Care for the Elderly (ACE) was established in 2009 to guide the development of quality care for elderly patients during their stay in the acute HA setting and transition back to the community. The aim of the ACE project is to support the design of care pathways so that elderly patients receive timely and optimum care. Ten areas which the ACE project focuses on include: discharge planning, medication management, cognitive impairment, acute confusion, rehabilitation potential, falls, nutrition and enteral feeding, urinary incontinence, pressure sores and end-of-life care. The ACE project seeks to ensure that the diverse healthcare needs of elderly patients and their carers are met, and a culture of safety is embedded across different HA care settings, whereby corporate and local best practices are promulgated.

Hospital Admission Risk Reduction Programme for the Elderly (HARRPE)

The HA has put increased focus on post-discharge care for elderly patients who are at highest risk of emergency readmissions, since some of these hospitalisations may be avoidable. Taking into account patient demographic, clinical and hospital attendance history, an HA risk prediction tool (HARRPE score) has been developed to better screen and identify high-risk elderly patients who are likely to require emergency care relatively shortly after discharge from hospital. This has facilitated the development of HA programmes to target and support those elderly patients who are at the highest risk of re-hospitalisation.

Integrated Discharge Support Programme Pilot

In 2009 the Integrated Discharge Support Programme (IDSP) was piloted to enhance discharge planning and post-discharge support services (including medical, nursing and personal care services) in New Territories West Cluster, Kowloon West Cluster and Kowloon East Cluster. The IDSP targets elderly patients at high risk of unplanned emergency readmission (identified by HARRPE) and those in greater need of personal care services, such as the frail elderly, or those with impaired mobility.

Community Health Call Centre

The HA has established a system-wide Community Health Call Centre (CHCC) to provide early post-discharge support for elderly patients who have been identified as high risk by HARRPE. This builds on two successful cluster programmes (i.e., the Telephone Nursing Consultation Service in Hong Kong East Cluster and the EC@Home programme in Kowloon Central Cluster) to improve post-discharge support services for elderly patients discharged from general medical and geriatric wards. The CHCC service provides advice and home care instruction by defined protocols, as well as referral to other supporting care resources. It also provides arrangement for specific interventions, including direct admission to hospital wards, follow-up at fast track and SOPCs, admission to GDH and CNS home visits when necessary.

Non-Hospital Authority Services

Apart from healthcare services provided by the HA, a range of other health and social care services are provided by the Government and non-government agencies for elderly people in the community.

The DH runs eighteen elderly health centres which provide health assessment, physical check-ups and health education for elderly people on a membership basis. These clinics also provide visiting health teams in the community, to provide regular vaccination and training programmes to caregivers to enhance health knowledge and skills in caring for elderly people. The aims of DH's Elderly Health Service include improving elderly primary care to support self-care ability, encouraging healthy living and strengthening family and carer support, so as to minimise illness and disability [22].

[22] *Elderly Health Service of the Department of Health, Government of the HKSAR. Website accessed July 2011.*

The SWD subsidises NGOs to operate District Elderly Community Centres, Neighbourhood Elderly Centres, Social Centres for the Elderly, Integrated Home and Community Care Services, Enhanced Home and Community Care Services and Home Help Teams to assist elderly people to remain in the community for as long as possible. These services also provide support to carers, such as through respite care, skills training and education programmes, as well as mutual support groups. In addition, Community Support Services provide social and recreational activities to enable elderly people to enjoy life in the community, to develop their potential and to continue to play a contributing role in society[23].

[23] *Social Welfare Department of the Government of the HKSAR. Website accessed July 2011.*

8 OVERARCHING CHALLENGES TO HA ELDERLY PATIENT SERVICES

Given finite resources, the most immediate and pressing challenge is to continue to develop services focusing on areas where patient care needs to improve. Previous sections in this report highlight the following overarching key challenges the HA faces, which include:

Demographic Change

People are living longer and the population is ageing. While many people live both long and healthy lives, increasing numbers are affected by conditions such as dementia, which affects their quality of life and places demands on families, carers and the health and social care system.

Social Change

More people live alone as they age. This can mean less support for people as they get older and increased demand on paid/statutory support.

Shifting Burden of Disease

Chronic conditions, such as diabetes, asthma, chronic obstructive pulmonary disease, heart failure, arthritis and dementia have become more prevalent. As the population ages, a higher proportion of funds will be spent on meeting the needs of increasing numbers of older frail people with multiple conditions and co-morbidities.

Medical Advances

New forms of diagnosis and treatment have contributed to long-term improvements in population health and development, including the longevity of younger patients with chronic conditions. In addition, advances in new technologies to manage diseases associated with advancing age have significant implications for spending in healthcare.

Public Expectations

Increased levels of wealth and educational attainment have contributed to rising public expectations of the HA. The HA will need to deliver more personalised patient-centred services that give greater choice and control.

9 CURRENT CHALLENGES IN HA ELDERLY PATIENT SERVICES

In addition to the overarching challenges described previously, the following specific challenges to HA's elderly patient services have been identified:

Managing Growing Elderly Service Demand

Service Integration, Coordination and Collaboration

Across HA there are many examples of excellence in elderly patient care. In particular, in recent years many projects, programmes and initiatives have been developed to address elderly patient needs (see section 7). However, this has led to variation in care across HA. There are inefficiencies in service integration and coordination, which could be better optimised across, and within, the elderly care continuum. For example:

1. **Service Organisation Institutional and Specialty-focused**

   Organisation of elderly services in Hong Kong is still predominantly institutional, focused in individual departments within hospitals. Geriatricians are scattered throughout the domain of internal medicine, but their expertise and knowledge of networks and community resources are not widely known or utilised by colleagues in other medical specialties.

2. **Coordination of Multi-specialty Care**

   Many elderly patients have multiple problems which require complex multi-disciplinary packages of care. However, coordinated multi-specialty care and access to geriatric specialist care in different HA settings can be variable and the timing is not well geared to maximising patient outcomes. In some care settings HA services are delivered under separate management arrangements, for example outreach services, services for RCHE and other community-based services. This creates inefficiencies in care delivery.

3. Coordination and Collaboration with Other Providers of Elderly Services

Coordination and collaboration between HA and partner organisations, such as DH, SWD, NGO and other service providers, such as RCHE, could be better strengthened to optimise the continuity of elderly care. Historically each organisation has focused on their own priorities, which has created a system with providers of different scales and scope of elderly services. Often patients and their carers have to coordinate their own care. Navigation within different systems can be difficult and means that the transition and delivery of care between organisations may not be smooth.

Proactive Management of Elderly Patients

A key emphasis to managing growing elderly health service demand is on minimising the need for hospital admission and readmission. However, there is a lack of a "whole-system" proactive approach to elderly care, including:

1. Care and Discharge Planning

Although some good care and discharge planning does occur in the HA, much is not comprehensive and does not address the needs of elderly patients. In a recent local study, formal discharge programmes were implemented in only two-thirds of acute units, mostly confined to medical and geriatric wards[24]. Sub-optimal care planning can lead to premature discharge, persistence of unrecognised problems, poor coordination and inefficient use of care resources both pre- and post-discharge, affecting patient and staff satisfaction, and may ultimately increase healthcare expenditure, such as through repeated hospital admissions.

[24] *Acute Care for the Elderly Project.*

2. Rehabilitation

Rehabilitation is vital to optimise patient function upon return to their usual place of residence. Sometimes patients are not assessed in a timely manner before being transferred to rehabilitation. However, assessment of aims and objectives should be a pre-requisite of all rehabilitation. Access to rehabilitation services in hospital and ambulatory settings is variable and dependent on individual cluster and specialty resources. Finally, rationale for the use of rehabilitation, convalescent and local infirmary beds can be unclear, leading to suboptimal use of resources and outcomes for elderly patients.

3. HA Community Services

HA community services, such as the CGAS and CNS, are experiencing rising demand. Some services, such as the CNS, are predominantly task-based and skilled nursing care is provided episodically, with most patients being referred to the CNS for wound care, catheter care and management of naso-gastric tubes. Much could be achieved proactively to reduce avoidable hospitalisations and there is much staff enthusiasm for doing things better. Coupled to this, patients have reflected that fees and charges for HA community care services are relatively expensive compared to Accident and Emergency and in-patient services, creating a health-seeking incentive toward hospitalisation.

4. Primary Care

Primary care entails the provision of accessible first contact care that is comprehensive, continuous, coordinated and patient-centred. However, many elderly patients do not have access to a regular primary care clinician for continuity of care and local clinics lack multi-disciplinary teams, which can act to proactively manage and support the chronic conditions of selected patients.

5. Patient and Carer Empowerment

To enable successful return from hospital to usual place of residence, patients and carers play a key role in their care. However, many patients and carers are not aware of the importance of self-management and their role as 'co-producers' of their care. On the other hand, patients who are able to express their views are often not asked what they would prefer. In some cases, a lack of knowledge of what services or care options are available means that patients and carers are disempowered from participating in decision-making processes or navigating the system of care efficiently.

As a result, patients and carers become dependent and passive recipients of care, which can lead to poor service satisfaction, sense of lack of control and perceived barriers to care. Furthermore, with an empowered society and continuing rise in expectations in care, the rights and entitlements of elderly patients are likely to become more dominant issues in the future and more will be demanded from the public health service.

Quality and Safety of HA Elderly Services

1. In-patient Care

Admission to hospital is a major life event for many patients, especially for the elderly. Elderly patients are particularly vulnerable to untoward events during hospital stay. If not well managed an elderly patient's stay in hospital can result in poorer outcomes, such as prolonged stay, cognitive and functional decline, increased rates of readmission, premature institutionalisation and mortality.

Conditions to which elderly patients are particularly vulnerable, and which early identification, management and quality and safety of care can improve outcomes include: acute confusion (delirium), adverse drug reactions (such as through polypharmacy), malnutrition, pressure sores, urinary incontinence, falls and dementia.

Within the HA some elderly patients are given procedures without sufficient information and proper assessment, such as naso-gastric tubes, urinary catheters and restraints. Restraints are not good practice and can cause serious problems. Naso-gastric tubes should only be used in carefully selected patients. Catheters are a last resort, which in well run wards should be uncommon. Given increasing patient numbers, maintaining a culture of reducing undesirable iatrogenic outcomes is of utmost importance.

2. End-of-life Care

Elderly people face increasing medical problems as they approach the end of life, with many often having several co-existing health problems. Due to a mix of cultural and system factors, elderly people in Hong Kong are more likely to be transferred to hospital for end-of-life services, rather than remaining at home or in RCHE. This not only increases demand on acute hospital care, but also means many elderly patients are exposed to unnecessary treatments and interventions, which may cause discomfort and may not fully address their needs.

3. HA Elderly Service Outcomes

There is limited local data regarding the effectiveness and outcomes of HA elderly services. Although some elderly services (such as the IDSP and CHCC) have reported outcomes, this is not consistent across the continuum of HA elderly care. There is a lack of systematic data and analysis on service quality, in terms of patient outcomes, patient and carer experience and patient and staff satisfaction.

Workforce Capacity and Training

1. Skills and Training

Many healthcare staff looking after elderly patients are not optimally trained or equipped to meet the special needs of elderly people. This can mean that while staff aspire to provide the best possible care, quality can vary across different specialties and settings in HA. Often elderly patients have multiple problems with atypical presentations, require complex care provision, and are more vulnerable to adverse events and rapid deterioration of condition within the hospital setting. If not well managed, an elderly patient's stay in hospital can result in poorer outcomes. Early identification of need, linked to appropriate interventions and management are therefore important, but this can be a more difficult task without specific training.

2. Workforce Capacity

The HA is significantly challenged by an increasing demand for elderly services. Indeed, workforce shortage is a global phenomenon. While many staff deliver high quality elderly services and are efficient in treating and managing large patient numbers, improving efficiency alone is not enough to cope with future demand challenges without planning and developing a sustainable workforce.

PART III

STRATEGIC SERVICE FRAMEWORK FOR ELDERLY PATIENTS

10 A NEW STRATEGIC DIRECTION (OUR VISION FOR HA ELDERLY SERVICES)

The HA will embrace a new vision and mission for its elderly services:

VISION:

To enhance the well-being of elderly people, and to contribute to healthy ageing, by raising the standards and quality of healthcare wherever care is given.

MISSION:

To offer seamless and high-quality care in primary, community and hospital settings in order for elderly patients to receive services appropriate to their needs.

The aim of this Framework is to build sustainable models of care for elderly patients best suited to their respective needs. This Framework proposes a shift from a reactive system of unscheduled care towards one which is founded on an anticipatory approach to identify and manage the conditions of elderly patients.

The model will promote integration of HA hospital elderly services with other elements of the health system to provide better coordination and continuity of care, including specialist geriatric care.

Elderly patients and their carers will be encouraged to be co-producers of their care and empowered to manage their conditions, where possible. This will help support elderly patients to maintain their health and independence for as long as possible, but receive more specialised care from the HA when needed.

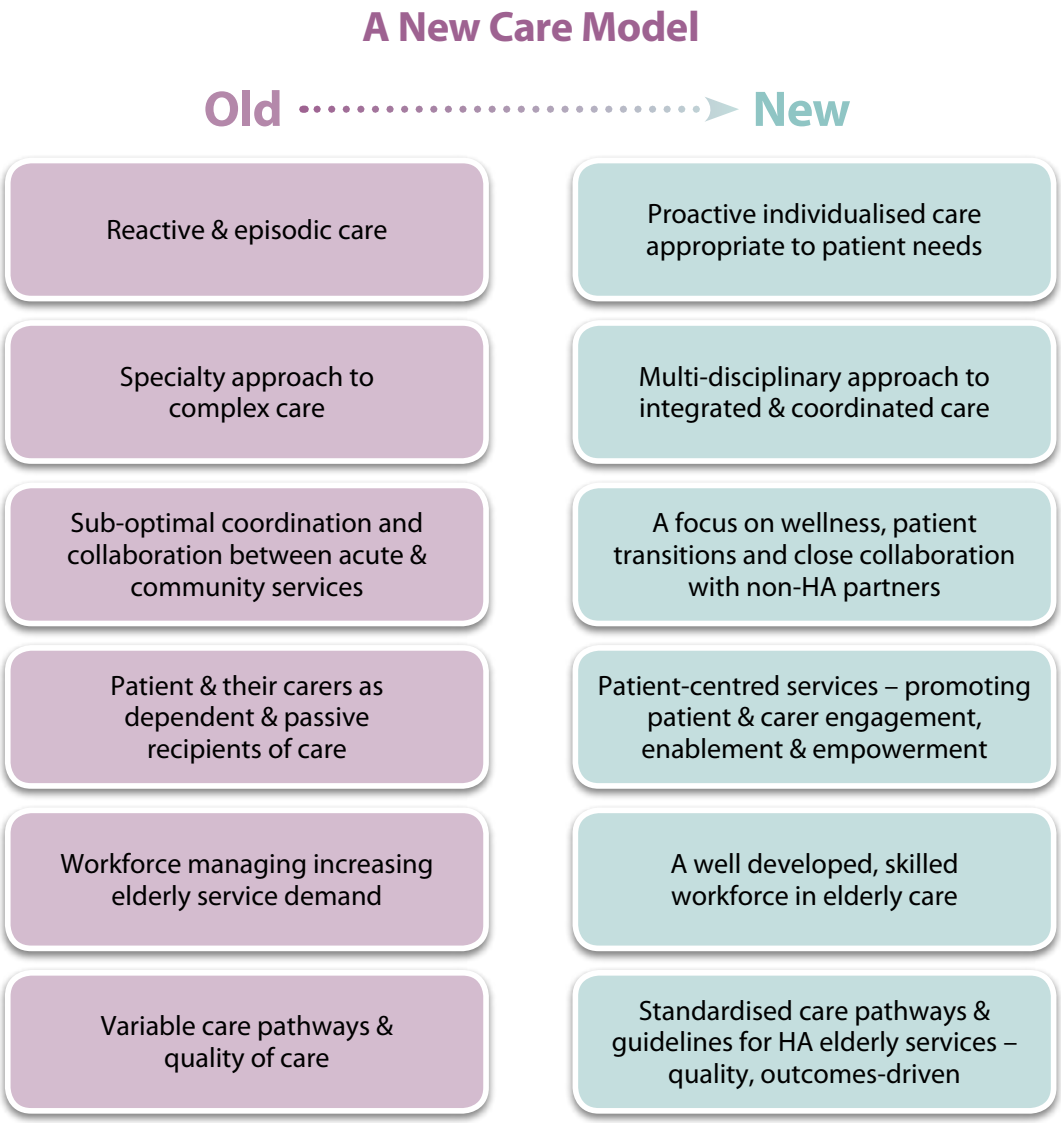
This Framework will support the management of future elderly services demand and help anticipate workforce needs, supporting the training, skills development, competence and well-being of staff.

In moving from the current management of elderly patients, we should acknowledge that the HA's hospital geriatric services are centres of great expertise which achieve international standards of care. However, the quality of care provided by specialist geriatric services has yet to be spread throughout the rest of HA's hospital departments and community services.

The new model will emphasise standardising care around best practice guidelines, supported by routine monitoring of performance and transparent reporting. This means moving toward more effective coordination around the needs of elderly patients to improve their quality of care.

A new model of care that is oriented towards the proactive prevention and management of illness in elderly patients should contribute to the improvement of patient experience, better health outcomes and more efficient care. Moving to the "integrated care model" requires a comprehensive approach to enhance the coordination of HA services for elderly patients and promote greater collaboration in the delivery of care.

The new model is summarised in the diagram below:



The new strategic direction for elderly patient services in this Framework is in line with the Vision, Mission and Values of HA [25].

[25] *Strategic Service Plan 2009–12, Hospital Authority.*

11 STRATEGIC GOALS (WHAT WE WANT TO ACHIEVE)

Meeting the health needs of an increasing number of elderly patients should be a high priority. While many will live long and for the most part healthy lives, others will require support from the HA and other organisations. The aim should be for all services to support active ageing[26] and ageing in place, wherever possible.

In developing this Framework, the HA has concentrated on its role within the Hong Kong health system, with a focus on delivering high quality care, based on need. The HA will achieve the following five strategic goals over the next five years, based upon the new model of care:

I. High quality, integrated elderly care to meet the needs of elderly patients, and which is delivered in a timely, accessible and appropriate manner.

II. Elderly patients and their carers engaged by HA as enabled and active partners in the management of their own care.

III. The HA will work with its partners to improve coordination and continuity of services across settings, to provide better care and improve health outcomes for elderly patients and their carers.

IV. The HA will nurture a skilled, competent and responsive workforce to meet the needs of increasing numbers of elderly patients.

V. The HA will support continuous service improvement in elderly care, for both patients and staff, and where possible optimise the use of information and technology to support this.

[26] *The WHO definition of active ageing includes optimising opportunities for health to enhance quality of life. Active Ageing: A Policy Framework, WHO (2002).*

12 STRATEGIC OBJECTIVES (WHERE WE ARE GOING)

The five key long-term strategic objectives to realise the above vision and goals for HA's elderly patient services are:

1. Develop Multi-disciplinary Integrated Elderly Services Across the Care Continuum

While the emphasis of care is on minimising the need for hospital admission, stay and readmission, when hospital is the most appropriate care setting, it is important that the services provided are of high quality and meet patient needs. An integrated "whole system" approach to delivering care from admission, through to discharge and the community, is the cornerstone to achieving better patient outcomes.

It is increasingly difficult for health systems to remain responsive to the rapidly expanding needs of elderly patients, often with complex multiple co-morbidities, without establishing well coordinated care provided by different healthcare professionals, from across different settings and working closely with the patient. Coordinated multi-disciplinary care improves health outcomes, reduces duplication and provides more appropriate support to patients. This is particularly important for those elderly patients who are at risk of rapid deterioration in health and require greater intensive management and support.

All high risk elderly in-patients should have an individualised care and discharge plan appropriate to need. Planning for discharge should start prior to the hospital stay for planned admissions and as soon as possible during the hospital stay for other admissions.

Integrated assessment of elderly patients will facilitate the development of individualised care plans, providing a more streamlined and coordinated approach to care by identifying the needs, planned interventions and specialist multi-disciplinary input to maximise patient outcomes, both in-hospital through to transition back into the community. Care planning will allow partner organisations to prepare appropriate personal and social services in advance, to support elderly patients outside hospital, as well as provision for step-down and step-up care, should more specialist services be required.

Access to specialist assessment, treatment and care should be provided on the basis of clinical need and never denied on the basis of age alone.

2. Promote Patient-centred Care and Engage Patients and their Carers as Active Partners in their Healthcare

Involving elderly patients in their healthcare is critical to achieving engagement and empowerment. This is a paradigm shift from paternalistic models of care, towards that of partnership and shared ownership of decision-making.

Communication with patients and their carers is essential, to share information to enable them to make informed choices about their care and navigate their way around available services. Rising public expectations of public healthcare services mean that HA will need to deliver more personalised care, taking into account the dignity and respect of the wishes of patients. Empowering patients in the management of their care will also improve quality of service, self-efficacy, patient satisfaction and improve health outcomes.

3. Seek Greater Collaboration with Partners Involved in Elderly Care Outside the Hospital Authority

The HA should work towards better collaboration and coordination with non-HA services, such as the DH, SWD, Primary Care, NGOs and RCHE, to improve communication and enhance accessibility for elderly patients who require services from multiple organisations or professionals. Better coordination across different organisations could improve continuity of care, reduce service duplication and optimise resources to support elderly patients and their carers.

Innovative multi-sector solutions to support elderly patients in the community, such as those living alone, could assist maintenance of independence and autonomy; for example, development of telemedicine.

4. Enhance Workforce Capacity and Engage Staff

A skilled workforce is critical for the sustainable development of any service. All HA staff working with elderly patients should be competent.

Better workforce planning and development, which address the implications of an ageing population, will help to increase supply and guide training. Adopting new ways of working will enhance efficiency and make best use of the skills of existing staff, provide opportunities to upgrade skills and competence, and facilitate the potential for role redesign, or extended roles, to complement service delivery. Specialists in the care of elderly patients will have a key role in supporting and informing the training of other staff.

5. Develop Quality, Outcomes-driven Elderly Services

A major objective of any healthcare system is to do no harm, which can be promoted through a collective culture of safety and risk management. High standards and competent staff are fundamental to help mitigate risk and to optimise patient care.

HA services should be organised and guided by a set of common service principles to provide a safe and elderly-friendly environment. Service guidelines and standards of care for elderly patients should be aligned and aimed at delivering best practice, wherever HA care is provided. Continuous service developments, such as embracing new information technology, can support improved care delivery and workflow efficiency. Quality indicators of care, which take into account outcomes, as well as patient and carer satisfaction, should be agreed, measured and monitored.

Quality of care depends not only on good health and personal care, but also on respect for elderly patients as individuals and continuity across the care pathway. It is important that HA services across the continuum of care promote autonomy, as well as respect, privacy and dignity, encouraging patient confidence in the services they receive. This is of particular significance during end-of-life care. Patient-centred care and enhancement of patient and carer empowerment will support delivery of high quality care and ultimately improve patient and carer outcomes.

13 OPERATIONAL PRIORITIES (HOW WE WILL GET THERE)

To achieve each of these objectives, a number of detailed operational priorities and actions are expected to be implemented. An indicative timetable for these priorities and actions is set out in Section 15, with a summary given below.

Objective 1

Develop multi-disciplinary integrated elderly services across the continuum of HA care

The HA will:

i. Adopt a **system-wide approach** in the development of an integrated care service for elderly patients.

ii. Perform **integrated patient assessment** for identified high risk[27] elderly patients to determine their specific needs upon admission to hospital.

iii. Perform **early discharge planning** and formulation of **individualised care plan** to allow for better care planning of elderly patients requiring frequent attention.

[27] *In the context of the HA Strategic Service Framework for Elderly Patients, high risk refers to elderly patients at risk of hospital readmission.*

iv **Enhance coordination** of multi-disciplinary services, to better support elderly patients who have chronic disease and complex needs [28].

v Improve evidence-based **rehabilitation care** for elderly patients who have chronic diseases and complex needs (e.g. chronic obstructive pulmonary disease, chronic heart failure and stroke), to enable optimal recovery and transition to the community.

vi Strengthen **integrated community care** to facilitate multi-disciplinary HA health professionals to fulfill their roles in providing timely coordinated assessment and management of elderly patients.

Key Actions:

- Apply a validated risk-stratification tool (such as HARRPE) to facilitate the screening of all elderly patients on admission to hospital
- Develop a user-friendly integrated patient assessment tool to ensure health professionals are able to effectively identify and manage elderly patient needs
- Recruit nurse coordinators to facilitate the care coordination and formulation of discharge plans in hospitals
- Deliver timely post-discharge support services to enable the transition and recovery of frail elderly patients, with the support of the CHCC

[28] *Complex needs refer to elderly patients with medical, social and physical care needs, with multiple interacting co-morbidities.*

- Strengthen the structures and processes of coordination to support elderly patients who have been identified to benefit from a higher level of care (e.g. some chronic obstructive pulmonary disease and chronic heart failure patients) and to help prevent acute disease exacerbations
- Strengthen the provision of ambulatory care to improve rehabilitation and transitional care, e.g. GDH
- The Community Geriatrics Assessment Service (CGAS) to provide quality geriatric care to high risk elderly patients living in the community, through a multi-disciplinary approach
- Provide better access to non-emergency transportation services for elderly patients, to facilitate their access to HA services
- Set up a HA joint-specialty working group involving Orthopaedics and Geriatrics, to explore co-development of services, to better meet the multiple needs of elderly patients and improve the quality of care
- Support hospital cluster management and clinical leaders (such as Cluster Chief Executives and Cluster Service Directors) to oversee service developments and coordinate systematic enhancement of integrated services for elderly patients across different specialties and settings, and where appropriate link with partner organisations to improve continuity of care

Objective 2

Promote patient-centred care and engage patients and their carers as active partners in their healthcare

The HA will:

i. Advocate **dignity, respect and autonomy** for elderly patients in all HA settings, such as through listening to their concerns about their care, **promoting the concept of the patient as an active partner in healthcare**.

ii. **Promote communication** and information sharing with elderly patients and their carers to **enable them to participate and make informed shared decisions** related to their care, where appropriate.

iii. Support **self-management** of chronic diseases through better patient empowerment to enable elderly patients, their families and carers to better manage post-discharge care, management of risk factors and acute flare-ups of illness in the community.

Key Actions:

- Extend the services of HA CHCC to support the delivery of patient empowerment and education for elderly patients with chronic diseases and to improve skills such as self monitoring and medication management
- Work with NGOs to provide patient empowerment programmes for elderly patients, their families and informal carers, regarding management of chronic diseases and risk factors
- Support NGO training activities to improve family and carer coping skills related to elderly care
- Develop HA engagement with patient and self-help groups to promulgate patient empowerment and better understand the needs of elderly patients and their carers, helping to support them in the community

- Improve the HA SmartPatient website to facilitate the dissemination of education materials for elderly patients and carers in the community

Objective 3

Greater collaboration with partners involved in elderly care outside of HA

The HA will:

i. Develop improved **service networks with community partners**, including primary care practitioners, DH Elderly Health Service and NGOs to enhance service continuity and appropriate transitional care for elderly patients.

ii. Work with SWD, NGOs and private practitioners to further support **better long term care** provision for elderly patients who live in **RCHE**.

iii **Work with DH and other stakeholders in the development of primary care strategies for the elderly** to ensure that the future development of primary care services take into account the different needs of elderly people.

Key Actions:

- Build and strengthen service links with NGOs to better support frail elderly patients after discharge from hospital
- Improve collaboration between the CGAS and primary care doctors to improve care for the elderly in RCHE
- Work with SWD, DH, NGOs and private practitioners to jointly strengthen the planning and coordination of health and social care, in order for elderly patients to receive high quality care in the community
- Support the use of personal electronic health records to improve continuity of care

Objective 4

Enhance workforce capacity and engage staff

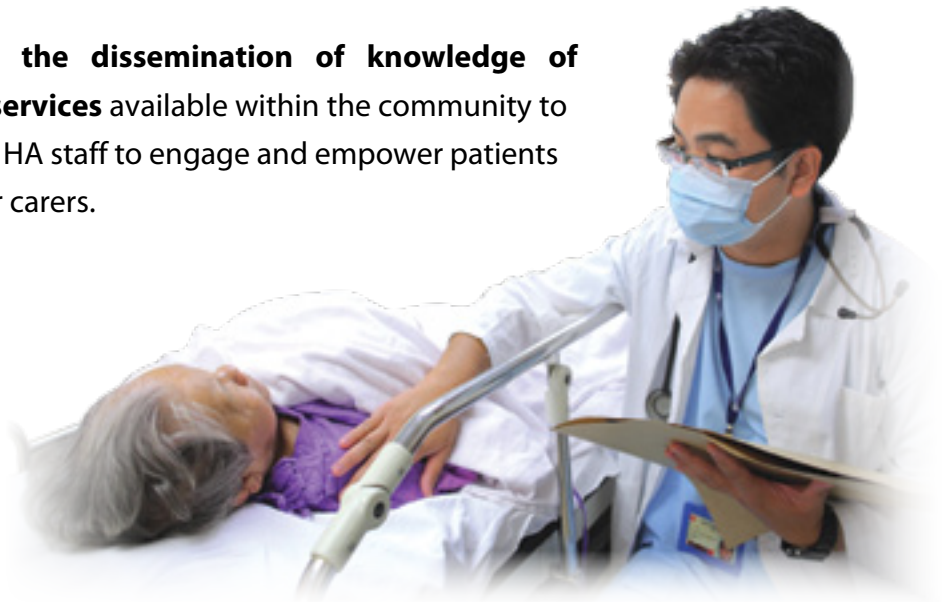
The HA will:

i. **Use workforce planning**, which addresses the implications of an ageing population, to anticipate HA elderly service needs and help develop the supply of a sufficiently trained workforce.

ii. **Design and implement specific educational and training programmes** for different HA staff groups, including medical, nursing, allied health and other health professionals, to bring them up-to-date with this Framework and developments in HA elderly services.

iii. Work towards **improving the training and continuing professional development needs of staff** involved in the care of elderly patients, such as through up-skilling courses, clinical exposure and mentorship, as part of HA's commitment to spreading the knowledge and expertise of geriatric specialists to the wider workforce, so that staff are equipped with the necessary knowledge, skills and competencies in elderly care.

iv. **Support the dissemination of knowledge of elderly services** available within the community to facilitate HA staff to engage and empower patients and their carers.



Objective 5

Develop quality, outcomes-driven elderly services

The HA will:

i. Support development and implementation of **agreed principles, referral pathways and care protocols** for elderly patients in acute settings, as part of the ACE Project, so hospital services can respond effectively and appropriately to the needs of elderly patients.

ii. **Explore the development of quality indicators**, with corresponding areas aligned to the HA hospital accreditation programme, to benchmark the performance of acute, rehabilitation/convalescence, transitional and community HA services.

iii. Develop guidelines to inform the **future planning** and development of HA hospitals and facilities to ensure elderly patient needs are considered in the design of the environment. For example, consideration of problems common to elderly patients, such as reduced balance, lack of stamina and strength, sensory impairment and way-finding, as well as increased risk of confusion in unfamiliar environments.

iv. Advocate and promote **better care standards for elderly patients** in non-HA settings, including RCHE, such as through HA being an exemplar of best practice care in community settings.

v. **Utilise development of HA's Clinical Management System**, where possible, to support and improve the quality and continuity of care delivery and workflow efficiency.

Key Actions:

- Develop agreed clinical protocols and referral pathways for the management of elderly patients, including discharge planning, medication management, cognitive impairment, acute confusion, rehabilitation potential, falls, nutrition and enteral feeding, urinary incontinence, pressure sores and end-of-life care
- Undertake pilots in medical and surgical specialties to implement standards from the ACE Project
- Update and unify guidelines for the use of in-hospital restraints, naso-gastric tubes and catheters, together with staff training and education on appropriate alternatives
- Explore development of quality indicators, with corresponding areas aligned to the HA hospital accreditation programme, to benchmark the performance of acute, rehabilitation/convalescence, transitional and community HA elderly services – such as via the ACE Project
- Provide training opportunities for HA staff to improve standards of elderly care in acute, rehabilitation/convalescence, transitional and community settings
- Work with SWD and other partners to improve standards and delivery of care in RCHE

- Develop local guidelines to inform capital planning projects on the development of age-appropriate/elderly-friendly environments in hospitals and other HA facilities, to optimise patient safety, care delivery and recovery. For example, consideration of enhancing mobility and access, strengthening infection control, suitable and safe floor and wall finishes, well placed seating and handrails, appropriate illumination and acoustic enhancement, clear visual keys for safe way-finding and elderly accessible toilet facilities
- Leverage information technology to improve continuity of care and communication of information between acute, rehabilitation/convalescence, transitional and community settings, including:
  - Integration of clinical data into the Clinical Management System
  - Enable real-time access to essential clinical information, clinical decision support and management protocols by designated HA professionals
  - Provide alerts for discharge planning nurse coordinators, community care teams and relevant health professionals following trigger by A&E admission
  - Sharing of information beyond HA settings

The above strategic goals, objectives and operational priorities are summarised in the following table. How these help to address the challenges of HA elderly services are also presented.

HA STRATEGIC SERVICE FRAMEWORK FOR ELDERLY PATIENTS

1

Strategic Goal
(What we want to achieve)

High quality, integrated elderly care, to meet the needs of elderly patients, and which is delivered in a timely, accessible and appropriate manner.

Strategic Objective
(Where we are going)

Develop multi-disciplinary integrated elderly services across the care continuum.

Operational Priorities
(How we will get there)

Adopt a system-wide approach in the development of an integrated care service for elderly patients.

Perform integrated patient assessment for identified high risk elderly patients to determine their specific needs upon admission to hospital.

Perform early discharge planning and formulation of individualised care plan to allow for better care planning of elderly patients requiring frequent attention.

Enhance coordination of multi-disciplinary services, to better support elderly patients who have chronic disease and complex needs.

Improve evidence-based rehabilitation care for elderly patients who have chronic diseases and complex needs (e.g. chronic obstructive pulmonary disease, chronic heart failure and stroke), to enable optimal recovery and transition to the community.

Strengthen integrated community care to facilitate multi-disciplinary HA health professionals to fulfill their roles in providing timely coordinated assessment and management of elderly patients.

Challenge Addressed

Manage growing demand and ensure service quality and safety.

HA STRATEGIC SERVICE FRAMEWORK FOR ELDERLY PATIENTS

2

Strategic Goal
(What we want to achieve)

Elderly patients and their carers engaged by HA as enabled and active partners in the management of their own care.

Strategic Objective
(Where we are going)

Promote patient-centred care and engage patients and their carers as active partners in their healthcare.

Operational Priorities
(How we will get there)

Advocate dignity, respect and autonomy for elderly patients in all HA settings, such as through listening to their concerns about their care, promoting the concept of the patient as an active partner in their healthcare.

Promote communication and information sharing with elderly patients and their carers to enable them to participate and make informed shared decisions related to their care, where appropriate.

Support self-management of chronic diseases through better patient empowerment to enable elderly patients, their families and carers to better manage post-discharge care, management of risk factors and acute flare-ups of illness in the community.

Challenge Addressed

Manage growing demand and ensure service quality and safety.

3

Strategic Goal
(What we want to achieve)

The HA will work with its partners to improve co-ordination and continuity of services across settings, to provide better care and improve health outcomes for elderly patients and their carers.

Strategic Objective
(Where we are going)

Greater collaboration with partners involved in elderly care outside of HA.

Operational Priorities
(How we will get there)

Develop improved service networks with community partners, including primary care practitioners, DH Elderly Health Service and NGOs to enhance service continuity and appropriate transitional care for elderly patients.

Work with SWD, NGOs and private practitioners to further support better long term care provision for elderly patients who live in RCHE.

Work with DH and other stakeholders in the development of primary care strategies for the elderly, to ensure that the future development of primary care services take into account of the different needs of elderly people.

Challenge Addressed

Manage growing demand and ensure service quality and safety.

HA STRATEGIC SERVICE FRAMEWORK FOR ELDERLY PATIENTS

4

Strategic Goal
(What we want to achieve)

The HA will nurture a skilled, competent and responsive workforce to meet the needs of increasing numbers of elderly patients.

Strategic Objective
(Where we are going)

Enhance workforce capacity and engage staff.

Operational Priorities
(How we will get there)

Use workforce planning, which addresses the implications of an ageing population, to anticipate HA elderly service needs and help develop the supply of a sufficiently trained workforce.

Design and implement specific educational and training programmes for different HA staff groups, including medical, nursing, allied health and other health professionals, to bring them up-to-date with this Framework and developments in HA elderly services.

Work towards improving the training and continuing professional development needs of staff involved in the care of elderly patients, such as through up-skilling courses, clinical exposure and mentorship, as part of HA's commitment to spreading the knowledge and expertise of geriatric specialists to the wider workforce, so that staff are equipped with the necessary knowledge, skills and competencies in caring for elderly patients.

Support the dissemination of knowledge of elderly services available within the community to facilitate HA staff to engage and empower patients and their carers.

Challenge Addressed

Maintain an adequate skilled workforce.

5

Strategic Goal
(What we want to achieve)

The HA will support continuous service improvement in elderly care, for both patients and staff, and where possible optimise the use of information and technology to support this.

Strategic Objective
(Where we are going)

Develop quality, outcomes-driven elderly services.

Operational Priorities
(How we will get there)

Support development and implementation of agreed principles, referral pathways and care protocols for elderly patients in acute settings, as part of the ACE Project, so hospital services can respond effectively and appropriately to the needs of elderly patients.

Explore the development of quality indicators, with corresponding areas aligned to the HA hospital accreditation programme, to benchmark the performance of acute, rehabilitation/convalescence, transitional and community HA services.

Develop guidelines to inform the future planning and development of HA hospitals and facilities to ensure elderly patient needs are considered in the design of the environment. For example, consideration of problems common to elderly patients, such as reduced balance, lack of stamina and strength, sensory impairment and way-finding, as well as increased risk of confusion in unfamiliar environments.

Advocate and promote better care standards for elderly patients in non-HA settings, including RCHE, such as through HA being an exemplar of best practice care in community settings.

Utilise development of HA's Clinical Management System, where possible, to support and improve the quality and continuity of care delivery and workflow efficiency.

Challenge Addressed

Ensure service quality and safety.

14 HA ELDERLY SERVICES IN FIVE YEARS

In five years, the HA will have developed more sustainable and proactive services for the care and management of elderly patients. HA acute hospital services will be much more focused on specialised services for elderly patients with severe or complex illness whose needs cannot be adequately met in community settings.

Care in Five Years – Mrs C

Mrs C is an 86-year-old lady who lives alone in an apartment. Her son and daughter visit her once a week for family dinner, otherwise, she has been managing by herself. Mrs C arrived at a hospital A&E Department by ambulance, with fever and shortness of breath. Being identified as at-risk of hospital readmission by a validated risk-stratification tool, she was the target for an integrated patient assessment. She was noted to have communication problems because of confusion, in addition to impaired hearing, immobility because of infected leg ulcers and osteoarthritis of her knees, as well as renal failure due to uncontrolled diabetes with dehydration. After admission, she was treated with antibiotics, diuretics, fluid support, insulin and analgesics. Her confusion and shortness of breath soon improved. Her hearing also improved with removal of impacted ear wax. The infected leg ulcers were attended to by a nurse and podiatrist. She was also started on physiotherapy to improve mobility. A discharge care plan was drawn up during a multi-disciplinary team meeting, upon which a liaison nurse/ therapist coordinated with a NGO for arranging meal and personal services at home after discharge. Because of her complexity and frailty, she received a higher level of coordination with the HA community outreach team in the implementation of the care plan, transitional care and support.

A systematic and integrated approach will be adopted to assist clinical teams to identify and assess those elderly patients who require more specialised or more frequent interventions, and enable the tailoring of individualised planned care based on need. These will be delivered through a coordinated, multi-disciplinary model, involving the patient and their carers, as appropriate, and across different care settings, with a focus on enablement and return to independence and autonomy, where possible.

Chronic disease management programmes will further allow improved patient empowerment and, coupled with more coordinated care for patients with higher needs, support the optimised control and management of chronic diseases, with the goal of improving patient outcomes and reducing avoidable hospital admissions.

Integrated Care

Integrated services will be strengthened for elderly patients identified as requiring higher levels of care, or with complex needs and at risk of deterioration. Early comprehensive

multi-disciplinary assessment and discharge planning will be conducted for these patients so services provided meet their needs. Nurse coordinators will formulate individualised discharge care plans in hospital and coordinate appropriate care delivery, including those provided in transitional, ambulatory and community settings. Patients with assessed anticipated complex discharge needs will receive coordinated chronic disease management, to reduce the likelihood of acute exacerbations and complications, as well as to promote re-conditioning. Integrated community care services will have access to updated patient information for coordination and continuity of care.

Patient/Carer Empowerment and Patient/Carer Mutual Help Groups

A significant component of chronic disease management is empowering patients to successfully manage their own health. In addition to patients and carers being informed co-producers of their care, there will be encouragement for them to take a greater role in understanding their condition, treatment and how to reduce the likelihood of deterioration. Patients, families and informal carers will be engaged to participate in Patient Empowerment Programmes, or seek education and information through the HA's SmartPatient website, to facilitate self-management.

The HA will further engage with patient/carer mutual self-help groups to promulgate patient and carer empowerment, and to better understand the needs of elderly patients and their families/carers. In addition, patient/carer mutual self-help groups will support elderly patients and their carers in the community through enabling information exchange, advocacy, peer support and sharing of experience.

Care in Five Years – Mr W

Mr W is a 78-year-old retired clerk who has had a long history of smoking and has been suffering from chronic bronchitis for the past 2 years. Although he lives with his son, Mr W enjoys an active social life through telephone conversations and visits to his neighbours. He also enjoys walking in the local public park twice a week, despite his respiratory conditions. Recently, Mr W's shortness of breath deteriorated significantly, requiring hospital attendance. Mr W was prescribed with medications to stabilise his condition. Following an integrated patient assessment, rehabilitation potential was identified and Mr W promptly received coordinated multi-disciplinary care, through which he was educated on how he might manage an exacerbation of his illness and the importance of medication compliance. Although he required another attendance to A&E, the coordinated care approach facilitated immediate re-conditioning, which resulted in hospitalisation being avoided. Mr W was subsequently referred to a Patient Empowerment Programme, with access to the HA CHCC for further support. His son was also able to access information, via the HA SmartPatient website, to learn more about his father's condition.

The HA CHCC will also support patient-centred care and empowerment, helping to improve self-management, monitoring of disease and timely links with ambulatory and personal care services, including primary care clinicians and NGOs. Patients will be better equipped by receiving advice on self-monitoring, medication management, diet, exercise, risk factor management, problem solving and coping skills.

Collaboration

The HA will continue to work with DH, SWD and NGOs to help provide elderly patients with improved personal and social care. Elderly patients will also be encouraged to find a primary care clinician where continuous and long-term care can be provided. The HA will have developed better links with primary care providers via the territory-wide Primary Care directory and electronic patient records, so that they may play a greater role in coordinated care, provision of health assessments and management of risk factors in the community.

End-of-life Care

Palliative care services will continue to be enhanced to support timely and optimal end-of-life care for elderly patients, as well as to their families and carers, by a well-trained workforce. Development of end-of-life care services for the elderly will be initiated through the ACE Project. Such enhancements may encompass pain control, symptom management, psycho-social support, patient and carer education, as well as collaboration with community partners. Although patient management towards the end of life can involve complex decisions by healthcare professionals, patients and their carers, adoption of more proactive approaches will enable timely patient and carer engagement, empowerment and autonomy.

Quality of Care

Regardless of the clinical specialty or location, proactive interventions and prevention will be provided by competent multi-disciplinary health professionals, with the guidance of treatment plans, to ensure patient safety. Quality of care will be supported by the implementation of HA-wide standards from the ACE project. The dignity and respect of elderly patients, their families and carers will be upheld throughout the HA.

Care in Five Years – Mrs Y

Mrs Y is a 76 year-old woman admitted through A&E for a fractured neck of femur, following a fall at home. Through an integrated patient assessment initiated upon admission, she was found to have complex medical and social factors making her at risk of falls and fractures: pneumonia with dehydration, drug-induced hypotension, malnutrition and being a childless widow. After stabilising her acute medical condition by the geriatric specialist team, she was operated on successfully. Mrs Y was further reviewed by the geriatric multi-disciplinary team, given her multiple co-morbidities and functional decline, with an aim to optimise her medications, correct nutritional deficiencies, maximise her rehabilitation potential, as well as to provide necessary support after discharge. A pre-discharge home visit was made to ensure home safety and to advise on the installation of appropriate aids and equipments. She was discharged with home support services and follow-up rehabilitation at a Geriatric Day Hospital.

15 IMPLEMENTATION

The HA Strategic Service Framework for Elderly Patients seeks to create improvement in the quality and sustainability of elderly care, by learning from the best features of current services that have improved patient outcomes and adopting them systematically across the whole of the HA. Although this Framework will be a significant catalyst for improving HA elderly services over the next five years and beyond, it will require commitment and resources to fulfill.

Success in improving elderly services will require all clusters, hospitals and teams to seek ways to implement the strategic directions and operational priorities set-out herein. Change will be led by frontline professionals across different specialties, with the leadership to steer overall service developments in clusters provided by HA Head Office, senior cluster management and clinical leaders. This Framework is expected to link with the HA annual planning cycle for resources to support implementation, as well as monitoring and review of the success of service initiatives and improvement in patient outcomes.

Although this is primarily a strategic document, proposed stages of implementing some of its recommendations are given below.

Stage 1

In the first three years, these operational priorities and actions shall be met:

Develop Multi-disciplinary Integrated Elderly Services Across the Care Continuum

- Apply a validated risk-stratification tool (such as HARRPE) to facilitate the screening of all elderly patients on admission to hospital
- Develop a user-friendly integrated patient assessment tool to ensure health professionals are able to effectively identify and manage elderly patient needs

- Recruit nurse coordinators to facilitate the care coordination and formulation of discharge plans in hospitals
- Deliver timely post-discharge support services to enable the transition and recovery of frail elderly patients, with the support of the HA CHCC
- Strengthen the structures and processes of coordination to support elderly patients who have been identified to benefit from a higher level of care (e.g. some chronic obstructive pulmonary disease and chronic heart failure patients), and to help prevent acute disease exacerbations
- Strengthen the provision of ambulatory care to improve rehabilitation and transitional care, e.g. GDH
- The CGAS to provide quality geriatric care to high risk elderly patients living in the community, through a multi-disciplinary approach
- Provide better access to non-emergency transportation services for frail elderly patients, to facilitate their access to HA services
- Set up a HA joint-specialty working group involving Orthopaedics and Geriatrics, to explore co-development of services, to better meet the multiple needs of elderly patients and improve the quality of care
- Support hospital cluster management and clinical leaders (such as Cluster Chief Executives and Cluster Service Directors) to oversee service developments and coordinate systematic enhancement of integrated services for elderly patients across different specialties and settings, and where appropriate link with partner organisations to improve continuity of care

Promote Patient-centred Care and Engage Patients and their Carers as Active Partners in their Healthcare

- Extend the services of the HA CHCC to support the delivery of patient empowerment and education for elderly patients with chronic diseases and to improve skills such as self monitoring and medication management
- Work with NGOs to provide patient empowerment programmes for elderly patients, their families and informal carers, regarding management of chronic diseases and risk factors
- Support NGO training activities to improve family and carer coping skills over the course of long-term care
- Develop HA engagement with patient and self-help groups to promulgate patient empowerment and better understand the needs of elderly patients
- Improve the HA SmartPatient website to facilitate the dissemination of education materials for patient and carers in the community

Greater Collaboration with Partners Involved in Elderly Care Outside the Hospital Authority

- Work with DH and other stakeholders in the development of primary care strategies for the elderly, to ensure that the future development of primary care services take into account the different needs of elderly people
- Build and strengthen service links with NGOs to better support frail elderly after discharge from hospital

Enhance Workforce Capacity and Engage Staff

- Use workforce planning, which addresses the implications of an ageing population, to anticipate HA elderly service needs and help develop the supply of a sufficiently trained workforce
- Design and implement specific educational and training programmes for different HA staff groups, including medical, nursing, allied health and other health professionals, to bring them up-to-date with this Framework and developments in HA elderly services
- Support the dissemination of knowledge of elderly services available within the community to facilitate HA staff to engage and empower patients and their carers

Develop Quality, Outcomes-driven Elderly Services

- Develop agreed clinical protocols and referral pathways for the management of elderly patients, including discharge planning, medication management, cognitive impairment, acute confusion, rehabilitation potential, falls, nutrition and enteral feeding, urinary incontinence, pressure sores and end-of-life care
- Undertake pilots in medical and surgical specialties to implement standards from the ACE Project
- Update and unify guidelines for use of in-hospital restraints, naso-gastric tube and catheters, together with staff training and education on appropriate alternatives
- Provide training opportunities for HA staff to improve standards of elderly care in acute, rehabilitation/convalescence, transitional and community settings

Stage 2

In subsequent years after the third year, these operational priorities and actions shall be delivered:

Greater Collaboration with Partners Involved in Elderly Care Outside the Hospital Authority

- Improve collaboration between the CGAS and primary care doctors to improve care for the elderly in RCHE
- Work with SWD, DH, NGOs and private practitioners to jointly strengthen the planning and coordination of health and social care, in order for elderly patients receive high quality care in the community
- Support the use of personal electronic health records to improve continuity of care

Enhance Workforce Capacity and Engage Staff

- Work towards improving the training and continuing professional development needs of staff involved in the care of elderly patients, such as through up-skilling courses, clinical exposure and mentorship, as part of HA's commitment to spreading the knowledge and expertise of geriatric specialists to the wider workforce, so that staff are equipped with the necessary knowledge, skills and competencies in caring for elderly patients

Develop Quality, Outcomes-driven Elderly Services

- Explore the development of quality indicators, with corresponding areas aligned to the HA hospital accreditation programme, to benchmark the performance of acute, rehabilitation/convalescence, transitional, and community HA elderly services – such as via the ACE Project
- Work with the SWD and other partners to improve standards and delivery of care in RCHE
- Develop guidelines to inform the future planning and development of HA hospitals and facilities to ensure elderly patient needs are considered in the design of the environment. For example, consideration of problems common to elderly patients, such as reduced balance, lack of stamina and strength, sensory impairment and way-finding, as well as increased risk of confusion in unfamiliar environments
- Leverage information technology to improve continuity of care and communication of information between acute, rehabilitation/convalescence, transitional and community settings
- Develop training and development modules for staff involved with the care of elderly patients, as part of HA's commitment to spreading the knowledge and expertise of geriatric specialists to the wider workforce, so that staff are equipped with the necessary knowledge, skills and competencies in elderly patient care

16 MONITORING AND ONGOING REVIEW

Measuring progress is essential to delivering improvement in patient outcomes. As strategies are implemented, it is important that outcomes and quality indicators are introduced to ensure changes are effective and that optimum care is delivered to elderly patients. Linking the Framework with the HA annual planning process will facilitate implementation and outcomes monitoring.

It is anticipated that agreed quality indicators will be systemically recorded, analysed and reported, developed across specialties to ensure common ownership of care, continuous service improvement and transparency. Development of quality indicators, with corresponding areas aligned to the hospital accreditation programme, should be explored to benchmark the performance of acute, rehabilitation/convalescence, transitional and community elderly services.

Ultimately, monitoring of progress and outcomes will be fundamental to ensure continuous improvement in the quality and safety of HA services for elderly patients.

PART IV

APPENDICES

APPENDIX 1

TASKFORCE ON THE HA STRATEGIC SERVICE FRAMEWORK FOR ELDERLY PATIENTS

Terms of Reference

- To review current and anticipated service need for elderly patient health services in HA
- To identify strategies and priority services to address major anticipated gaps over the next 5 years
- To advise on the future service model(s) to enhance the quality and outcome of elderly patient health services

Membership [30]

Co-Chairs

Dr W L CHEUNG	Director (Cluster Services), HA Head Office
Dr S V LO	Director (Strategy and Planning), HA Head Office

Members

Dr S Y AU	Service Director (Primary and Community Health Care) New Territories West Cluster / Chief of Service (Medicine and Geriatrics), Tuen Mun Hospital and Pok Oi Hospital *(up to Nov 2011)*
Dr C P WONG	Service Director (Primary and Community Health Care) Hong Kong East Cluster / Chief of Service (Integrated Medical Services) and Consultant (Geriatrics), Ruttonjee and Tang Shiu Kin Hospitals *(from Nov 2011)*
Dr Derrick AU	Head of Human Resources, HA Head Office

[30] *Membership list as of November 2011.*

Dr Felix CHAN	Service Director (Primary and Community Health Care), Hong Kong West Cluster / Chief of Service (Medicine), Tung Wah Group of Hospitals–Fung Yiu King Hospital / Consultant (Medicine), Queen Mary Hospital and Tung Wah Hospital
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Dr M F LEUNG	Clinical Stream Coordinator (Medicine), Kowloon East Cluster / Consultant (Medicine and Geriatrics) and Service Director (Community Service and Planning), United Christian Hospital
Dr Elsie HUI	Cluster Coordinator (Community Geriatric Assessment Team), New Territories East Cluster / Consultant (Medicine and Geriatrics), Shatin Hospital
Dr W Y SHEN	Consultant (Orthopaedics and Traumatology), Queen Elizabeth Hospital
Dr Daisy DAI	Chief Manager (Primary and Community Services), HA Head Office
Dr Tony KO	Chief Manager (Strategy, Service Planning and Knowledge Management), HA Head Office *(up to Mar 2011)*
Dr Libby LEE	Chief Manager (Strategy, Service Planning and Knowledge Management), HA Head Office *(from Mar 2011)*
Ms Margaret TAY	Chief Manager (Integrated Care Programmes), HA Head Office

Ms Sylvia FUNG	Chief Manager (Nursing) / Chief Nurse Executive, HA Head Office
Ms Ivis CHUNG	Chief Manager (Allied Health), HA Head Office
Ms Eva TSUI	Chief Manager (Statistics and Workforce Planning), HA Head Office
Mr Ian WYLIE	Senior Manager (Service Plan Development), HA Head Office *(up to Sept 2010)*
Dr Bennie NG	Senior Manager (Service Plan Development), HA Head Office *(up to Oct 2011)*
Dr Christina MAW	Senior Manager (Elderly and Community Care), HA Head Office *(from Jan 2011)*
Ms Adah CHEUNG	Manager (Elderly Care), HA Head Office

Secretary

Ms Wendy LEUNG	Manager (Service Plan Development), HA Head Office *(up to June 2011)*
Dr Douglas WEST	Manager (Service Planning), HA Head Office *(from June 2011)*

APPENDIX 2
EXTERNAL ADVISERS

- Prof John CAMPBELL, Professor of Geriatric Medicine, Dunedin School of Medicine, New Zealand
- Baroness Julia NEUBERGER, DBE, Member of the House of Lords, and former Chief Executive of the King's Fund, United Kingdom
- Dr Andrew ELDER, Consultant in Acute Elderly Medicine, Edinburgh, United Kingdom

Reviewers

- Prof Graham MULLEY, Past President, British Geriatrics Society, United Kingdom
- Prof Brian WILLIAMS, CBE, Past President, Royal College of Physicians and Surgeons of Glasgow, United Kingdom

APPENDIX 3
CONSULTATION

The draft Framework was made available as a consultation document between 31 August to 31 October 2011 to key stakeholders, including HA executives, service heads and staff members, and externally to partner organisations and individuals. Over 1,000 copies of the consultation document were distributed to colleagues, professional bodies and academic institutions, relevant Government bureaux and departments, as well as NGOs. Responses were received from 40 organisations and individuals. In addition, focus group meetings with NGOs, representatives from POAHs, patients and carers were held during October 2011 to solicit their views on existing and future HA elderly services.

The Taskforce reviewed consultation stakeholder suggestions and comments on the draft Framework at its meeting on 28 November 2011. All responses were carefully considered in the final drafting of the Framework.

A list of the 40 respondents who provided comments to HA on the consultation document is given on the following pages:

Colleagues Within HA

Staff Group	No. of comments received	
Medical	Orthopaedics & Traumatology	2
	Psychiatry	4
	Family Medicine	1
	Geriatrics Sub-committee	1
Allied Health	Rehabilitation	1
	Clinical Psychology	1
	Dietetics	1
Nursing	Geriatrics	1
	Planning & Commission	1
TOTAL		**13**

External Stakeholders

External Party	No. of comments received
Government Departments	
Food and Health Bureau	1
Labour and Welfare Bureau	3
Department of Health	1
Social Welfare Department	1
Elderly Commission	2
Professional Bodies/Associations	
Association of Hong Kong Nursing Staff	1
Hong Kong College of Physicians	1
Occupational Therapists Board	1
Hong Kong College of Family Physicians	1
Hong Kong College of Gerontology Nursing	1
Hong Kong College of Psychiatrists	1
Hong Kong College of Community Medicine	1
Hong Kong Geriatrics Society	1
The Hong Kong Medical Association	1
University departments in related disciplines	3
Non-governmental organisations	5
Anonymous responses	2
TOTAL	**27**

APPENDIX 4
GLOSSARY

In this document the following terms are used:

Acute Conditions:

Illness that is of short duration, rapidly progressive and in need of urgent care (in contrast with chronic conditions).

At-risk Groups:

People who because of old age, or low health status, may become ill or suffer a health problem and so be at risk of being admitted to hospital or needing the services of a specialist healthcare team.

Chronic Disease:

Enduring illness or disability which requires healthcare treatment or management over long-term (in contrast with acute conditions).

Community Care:

In-patient or out-patient care provided outside hospital, in homes or smaller healthcare premises, such as community centres, RCHE, etc.

Complex Needs:

Refer to elderly patients with medical, social and physical care needs, with multiple interacting co-morbidities.

Elderly People:

Although elderly people for general planning purposes in Hong Kong refers to those 65 years and over, in this Framework elderly people are categorised by their health and other care needs, rather than by arbitrary age.

the Framework:

In the context of this document, the Framework refers to the HA Strategic Service Framework for Elderly Patients.

Geriatrics or Geriatric Medicine:

That branch of medicine which deals with clinical, preventive, remedial and social aspects of health and disease in old age.

High Risk:

In the context of this Framework, high risk refers to elderly patients at risk of hospital readmission.

Infirmary Care:

Refers to the type of institutional care given to patients who have little or no prospect of discharge, and who cannot be managed in RCHE. The care emphasis is on quality of life, identity and dignity of patients, and the importance of breaking away from the traditional "institutional" model to a "psychosocial" or "home in hospital" model of care.

Iatrogenesis:

Inadvertent and preventable induction of disease or complications by medical treatment or procedures.

Integrated Patient Assessment (or Comprehensive Geriatric Assessment):

An evidence-based multidimensional, and often multi-professional, diagnostic process to determine an elderly person's medical, psychological and functional capabilities to develop a comprehensive plan for treatment and long-term follow-up.

Primary Care:

The first point of contact with health services, often provided by a general practitioner or family medicine doctor.

Rehabilitation Services:

Health services which are aimed at restoring people to optimum health, well-being and functionality following an episode of ill-health.

APPENDIX 5
ABBREVIATIONS

A&E	Accident and Emergency
ACE	Acute Care for the Elderly (Project)
CHCC	Community Health Call Centre
CGAS/CGAT	Community Geriatric Assessment Service / Team
CNS	Community Nursing Service
DH	Department of Health
EC@Home	Elderly Care at Home
GDH	Geriatric Day Hospital
GOPC	General Out-Patient Clinic
HA	Hospital Authority
HARRPE	Hospital Admission Risk Reduction Programme for the Elderly
HKEC	Hong Kong East Cluster (of HA)
HKWC	Hong Kong West Cluster (of HA)
IDSP	Integrated Discharge Support Programme
KCC	Kowloon Central Cluster (of HA)
KEC	Kowloon East Cluster (of HA)
KWC	Kowloon West Cluster (of HA)
NGO	Non-governmental organisation
NTEC	New Territories East Cluster (of HA)
NTWC	New Territories West Cluster (of HA)
POAH	Private Old Age Home
RCHE	Residential Care Home for the Elderly
SOPC	Specialist Out-Patient Clinic
SWD	Social Welfare Department
VMO	Visiting Medical Officer

APPENDIX 6
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