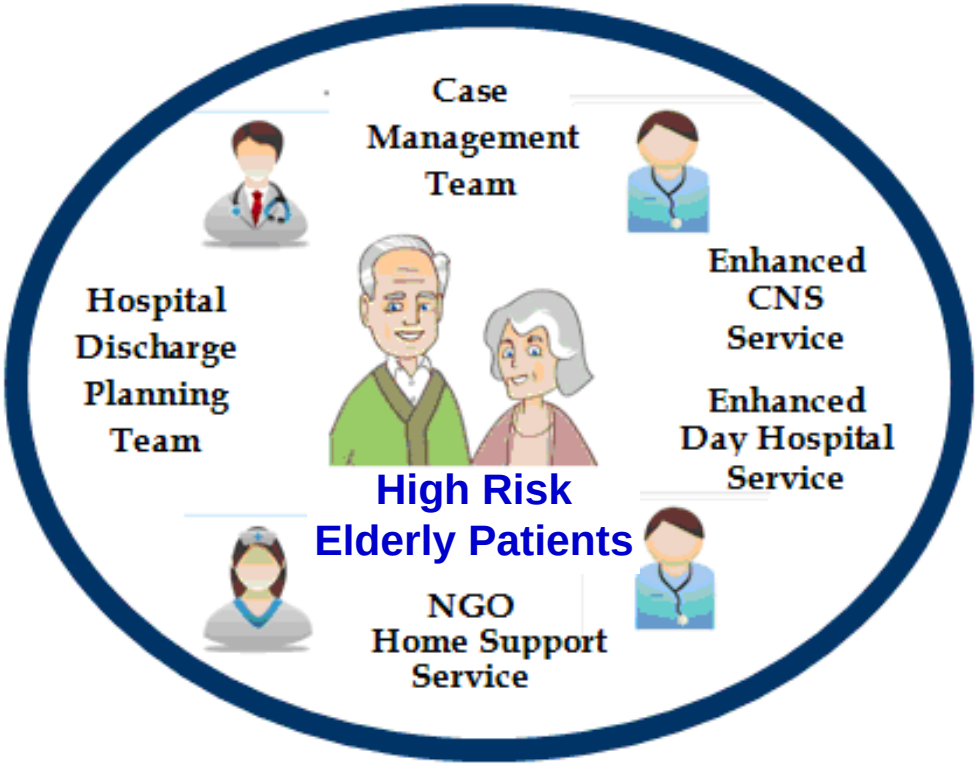
NTEC

Integrated Care and Discharge Support (ICDS) for Elderly Patients 支援長者離院綜合服務

HA Convention 2013

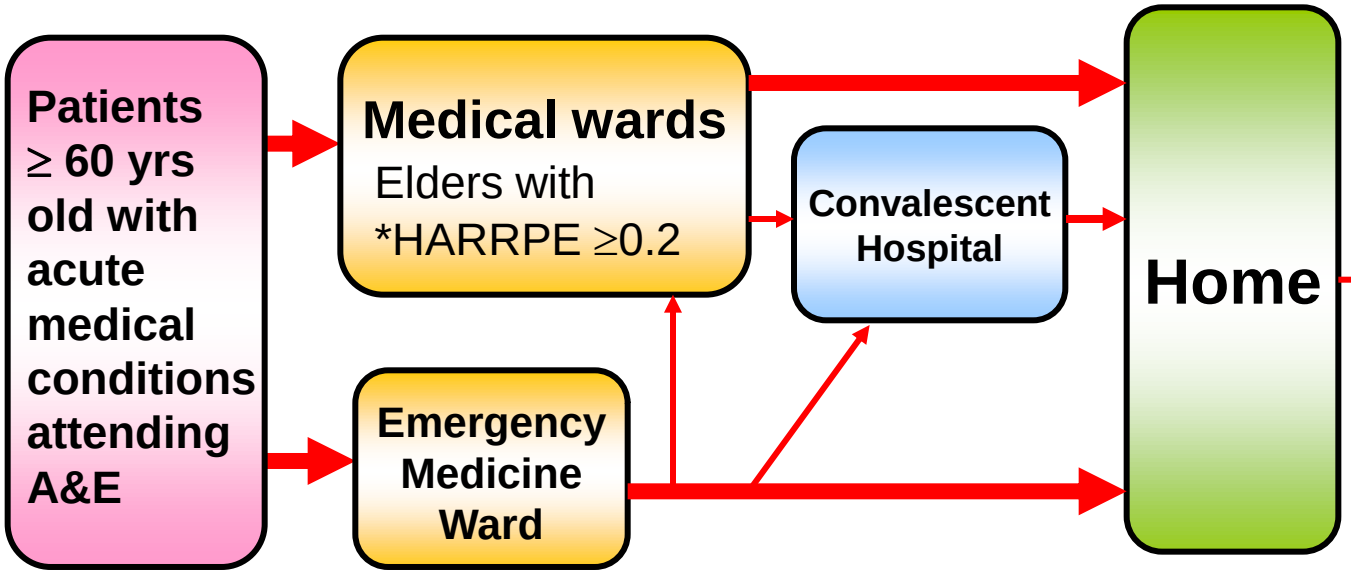


新界東醫院聯網
NEW TERRITORIES EAST CLUSTER

Phase of support by ICDS in hospital and after discharge

Based on HARRPE scores, clinical & social needs, a Link Nurse and a Geriatrician will perform:

- ✓ Risk stratification;
- ✓ Pre-discharge planning;
- ✓ Assign seamless post-discharge support services.



- ✓ To initiate in the first 48 hours of admission
- ✓ To facilitate early, supported discharge

HA Community Call Centre

Case close & refer to

- **HARRPE >0.2 -0.3 or need specific nursing care** → CNS Enhance Support
- **HARRPE >0.3 or disease-specific + complex need** → Case Management (Nurse, PT, OT)
- Home Support by NGO
- GDH training Fast Track Clinic

*HARRPE = Hospital Admission Risk Reduction Program for the Elderly Living in the Community

A Win-Win Situation

High Risk Elderly Patients	☺ Post-discharge support is strengthened ➢ multi-disciplinary, multi-dimensional ☺ Increase patients' satisfaction
Clinical Service	☺ Reduced Hospital Length of Stay ➢ Saved 0.8 days/patient (v.s. average MED LOS of 5 days/patient) ☺ Reduced 28-days Unplanned A&E Readmission ➢ Actual 12.3% (v.s. >30% predicted risk based on HARRPE)
Non-government organization	☺ Enhanced inter-sectorial partnership with medico-social service integration

Key Obstacles

Upon Recruitment	😐 **Some patients or carers do not perceive the need for our offer.** 😐 **Some patients or carers refuse NGO Home Support services due to charging issues.**
During Service Period	😐 **Some patients or carers may not cooperate:** ➢ **reluctant for home visit;** ➢ **reluctant to take advices.**
After Case Close	😐 **Service gaps prevent smooth transition from our Home Support services to usual home help services.**

Suggestions to overcome obstacles

Upon Recruitment	☆ To enhance communication with patients and carers for better understanding of our service. ☆ ? Charges for Home Support services can be waived for patients who can't afford.
During Service Period	☆ To enhance communication and education of patients and carers.
After Case Close	☆ ? Liase with Social Welfare Department & other NGO stakeholders in the community for smooth home help services transition.

How to achieve better integration?

ICDS is an integrated care model already:-

1. **Inpatient ↔ Outpatient / Community**
2. **Health care ↔ Social care providers**
3. **Interdisciplinary**

Better Integration

A named clinical (doctor) leader at the core of the service;

Back up by Fast Track Clinic, clinical admission rights and early clinical referrals.