



**Service Priorities and Programmes**  
**Electronic Presentations**

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**Integrated Care & Discharge Support (ICDS) program for the elderly– An Innovative Community Service**

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**Introduction**

Case Management is defined by the Hong Kong Hospital Authority as a “systematic process of assessment, service co-ordination, referral monitoring and evaluation, through which the unique needs of clients are met”. Integrated Care & Discharge Support (ICDS) program for the elderly was launched in Hong Kong since January of 2012. Health care professionals collaborated in managing manage the patients with advanced illness as they are prone to be hospital dependent due to brittle physical condition and need of close monitoring. Case management model is adopted and aimed at keeping patient safe in community and reduce hospital re-admission rate. Case manager (CM) provides regular home visitations with medical backup. Patients with HARRPE predictor over 0.3 or with complex chronic diseases e.g. chronic obstructive pulmonary disease (COPD), stroke & heart failure will be recruited to the program for a service period of 8 weeks.

**Objectives**

1 To prevention unplanned re-admission      2 To address individual biopsychosocial impacts      3 To empower patients to have positive measures to health and life challenges      4 To improve patient’ s quality of life      5 To ensure patient stays safe in community

**Methodology**

Link nurse performs proactive integrated patient assessment and early discharge planning for identified high risk elderly patients upon admission to hospital. CMs tailor makes of individual care plan for each elderly patient through home visitation. CMs also enhance liaison and coordination of multiple-disciplinary services, to better support elderly patient who have chronic diseases and complex needs in the community. CMs proactively telephone support patients 2 – 3 times per week since October, 2012. Weekly case conference between Geriatrician, CMs and Medical

Social Worker (MSW) to discuss about care plan and social needs for each patient.  
Fast-track medical consultation for patients with health deterioration.

### **Result**

Since January of 2012, 195 patients were recruited to the ICDS program. Their age between 60 to 95 years old. With CMs support, 1869 home visitations were provided. 1320 proactively phone-call out by CMs to provide support to patients and 105 phone-call in by patients to address their needs and assistance. 76.4% of patients could have their problem completely solved in 8 weeks of time. Remaining 23.6% of patients required further support after service period. Conclusion The program showed that case management process can help to reduce unplanned readmission of patients with advanced diseases. And this is believed to be one of the keys to support community-based care and ageing in place of the elderly in their homes in the Chinese Community of Hong Kong.