

**For information
on 9 November 2009**

Legislative Council Panel on Welfare Services

Integrated Discharge Support Trial Programme for Elderly Patients

Purpose

This paper outlines the Integrated Discharge Support Trial Programme for Elderly Patients (Programme), and reports to Members the latest progress of the Programme.

Background

2. At present, the Government is providing a range of community care and support services to facilitate elders to age in place. For community elders with long-term care needs, the Government provides them with home-based care services or centre-based day care services. These services enable elders to receive nursing, rehabilitation and care services in a familiar home or community environment. That said, it is not uncommon for elders to be re-admitted to hospitals or admitted to residential care homes for the elderly (RCHEs) shortly after hospital discharge. One of the major reasons is the deterioration of health conditions owing to the lack of family and/or social support during the rehabilitation stage.

3. The Government has been working closely with the Elderly Commission (EC) to look into ways to reduce unplanned hospital re-admissions as well as premature or unnecessary institutionalisation of elders, so as to actualise the policy objective of promoting “ageing in place”. Taking the advice of EC, the Labour and Welfare Bureau and the Social Welfare Department (SWD), in collaboration with the Hospital Authority (HA), launched the Programme in March 2008 to provide “one-stop” support services for elderly patients discharged from hospitals.

The Programme

Objectives

4. A one-off funding of \$96 million was earmarked in the 2007-08 Budget for running the Programme for three years to support elderly hospital discharges who have difficulty in taking care of themselves. The objectives of the Programme are two-fold, including:

- (a) to reduce the unplanned hospital re-admission rate of high-risk elderly hospital discharges through better discharge planning and post-discharge support; and
- (b) to relieve the stress of carers of elderly discharges through carer training and support services.

5. As part of the Programme, we will also collect information on whether the elderly hospital discharges can continue to stay at home six months after their hospital discharge.

Target beneficiaries

6. The Programme aims at supporting elderly patients aged 60 or above who have high risks of unplanned hospital re-admission, such as elders suffering from multiple illnesses and those in greater need for personal care services. Besides, having regard to the pressure faced by carers in taking care of discharged elderly patients whose unstable health conditions may render them more vulnerable, the Programme also provides pre- and post-discharge training to carers of elderly patients to enhance their care skills and confidence in caring for the discharged elders.

7. The Programme comprises a total of three pilots. They were launched in March and August 2008, and July 2009 in Kwun Tong, Kwai Tsing and Tuen Mun respectively. Details of individual pilots are set out at **Annex**. Each pilot will serve about 3 000 elders and 1 000 carers per year. It is expected that a total of about 20 000 elders and 7 000 carers will be served throughout the programme period.

Integrated support services provided under the Programme

A multi-disciplinary approach

8. The Programme adopts a multi-disciplinary approach to provide seamless care for elderly hospital dischargees by meeting both their rehabilitation and social needs. In each pilot under the Programme, there is a Discharge Planning Team (DPT) set up under the concerned HA hospital, and a Home Support Team (HST) operated by a non-governmental organisation. DPTs of the pilots mainly consist of medical and para-medical professionals including doctors, nurses, occupational therapists, physiotherapists, while HSTs comprise mainly social workers and care workers. Elderly patients assessed by DPTs to have high risks of unplanned hospital re-admission who require transitional rehabilitation services and/or community care and support services upon hospital discharge will be invited to join the Programme.

Pre-discharge services

9. The DPT and HST under each pilot work together to formulate discharge care plans for individual elderly patients, and will hold regular case conferences to monitor the elders' rehabilitation progress. Pre-discharge training will also be provided to carers of elderly patients to enhance their capability in the post-discharge care for elders.

Post-discharge services

10. Depending on the needs of individual elderly patients as recommended in their discharge care plans, post-discharge services including rehabilitation treatment at designated geriatric day hospitals (GDHs) and transitional community care and support services will be provided. Elders requiring rehabilitation treatment on average attend two to three GDH sessions a week for a period of about two to three months, depending on their progress of recovery.

11. For elders requiring short-term care and support after hospital discharge, HSTs provide them with a range of services covering personal care, home-based rehabilitation exercises, home modification, home-making, provision of meals, counselling, transportation and escort, out-of-hour emergency support, respite and "elder sitter" services, etc.

12. There are times when the elderly dischargees have psychological problems in adapting to the post-discharge life, or their carers face practical difficulties in taking care of the discharged elders. To enhance the support for them, the Programme also provides telephone consultation services which enable elderly hospital dischargees and their carers to directly call the nurses and social workers of DPTs/HSTs for advice when needed.

13. The integrated support services under the Programme are provided on a transitional basis. Depending on the recovery progress of individual elders, the service duration is on average six to eight weeks; and the maximum duration is about twelve weeks. If the elderly dischargees require care and support services on a long-term basis after being discharged from the Programme, SWD will assess their long-term care needs and arrange mainstream community care and support services for the elders as appropriate.

Latest progress

14. As at end-June 2009, a total of about 6 000 elderly hospital dischargees had been served under the first two pilots. More than 4 900 telephone calls were received from elderly hospital dischargees and their carers for telephone consultation services. Training programmes were also organised for more than 3 600 carers.

Way forward

15. Towards the completion of the Programme, we will evaluate the effectiveness of it based on the data collected throughout the programme period. In particular, the changes in the elders' functional capabilities (e.g. dependence in terms of mobility, feeding and bathing, etc.) and their psychological well-being, as well as the stress level of their carers before and after joining the Programme, will be reviewed. As stated above, we will also collect information on whether the participating elderly hospital dischargees can continue to stay at home six months after they are discharged from hospitals.

**Labour and Welfare Bureau
Social Welfare Department
Hospital Authority
November 2009**

Details of the three pilots under the Programme

	Period	Service hospital (providing the “DPT” services)	Service GDH	Operator of the HST	Areas covered
Kwun Tong pilot	March 2008 – March 2011	United Christian Hospital	Yung Fung Shee GDH	Haven of Hope Christian Service	Kwun Tong District, Choi Hung, Diamond Hill and Wong Tai Sin
Kwai Tsing pilot	August 2008 – March 2011	Princess Margaret Hospital (PMH)	The GDH attached to PMH	Po Leung Kuk	Kwai Tsing District and PMH’s catchment area (excluding North Lantau)
Tuen Mun pilot	July 2009 – May 2011	Tuen Mun Hospital (TMH)	The GDH attached to TMH	Social Service Unit of the Evangelical Lutheran Church of Hong Kong	Tuen Mun District and Yuen Long District