For Discussion
on 12 June 2006

LC Paper No. CB(2)2301/05-06(01)

Legislative Council Panel on Health Services and Panel on Welfare Services

Discharge Planning in Public Hospitals

PURPOSE

This paper provides a profile of the patients with discharge difficulties in public hospitals and sets out further information on the social and community support facilities and services available for discharged patients.

BACKGROUND

2. At the meeting of the Panel on Health Services on 8 May 2006, Members, having considered LC Paper No. CB(2)1871/05-06(04), requested the Administration to provide a paper setting out the profile of patients who insisted on staying in hospitals, the reasons and duration of their overstay, the measures taken by the Hospital Authority (HA) to address the discharge problem, and the effectiveness of these measures for discussion at a joint meeting of the Panel on Health Services and the Panel on Welfare Services in June 2006.

PROFILE OF PATIENTS WITH DISCHARGE DIFFICULTIES

3. According to a survey conducted by the HA in May 2006, there are a total of 104 patients[1] in public hospitals who have failed to commit to a definite discharge date for three months or more after being assessed to be clinically suitable to do so. The profile of these patients can be summarised below -

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[1] The figure excludes mentally-ill and mentally handicapped patients, patients in infirmary beds or intensive care units, and infants (less than 1 month old).

Age	Condition		No of CSSA Recipients amongst (a) and (b)
	(a) Need some assistance	(b) Completely Dependent	
Below 60	24	35	19
60 and above	24	21	10
Total	48	56	29

4. The HA has also requested individual hospitals to provide information on the reasons of the relevant patients' discharge difficulties in the survey. These reasons are not mutually exclusive. In some cases, more than one reason is applicable to the same patient. The results are summarised in the table below.

Reason of Discharge Difficulty	Number of Patients
1. Patients or family members perceive the medical illness of the patients differently from the clinical assessments	53
2. Concern of the family members or patients in continuation of self care at home	35
3. Financial or other considerations (e.g. awaiting placement in community or residential facilities, pending guardianship application, awaiting home modification or re-housing, etc)	52
4. Not satisfied with social support after discharge	9

SUPPORT SERVICES FOR DISCHARGED PATIENTS

5. To facilitate the discharge of patients from public hospitals, the HA works closely with relevant parties (e.g. the Social Welfare Department (SWD) and non-governmental organisations (NGOs)) in arranging for the appropriate support and assistance for patients after their discharge.

Depending on the specific situation and needs of the patients, various types of social support services are available to assist their reintegration into the community. These include emergency placements, community support services, day care centres, respite services and carers' support, and residential services.

Emergency placement and temporary residential care

6. Elderly patients who are not able to receive proper care at home immediately upon discharge from hospitals may apply for emergency placement in subvented residential care homes for the elderly (RCHEs) or nursing homes. Currently there are 76 designated emergency places in 26 subvented homes. The duration of stay for emergency placement will normally be three months, but can be extended on a need basis. Emergency placement is free of charge for the first three months of stay. Elders who have financial difficulties may apply for CSSA or other charitable funds to cover the charges for the subsequent period of stay if necessary.

7. For patients with disability, temporary residential care is available for destitute and homeless adults with disabilities at the age of 15 and above to prevent them from exposure to risks due to the lack of immediate care and shelter. Temporary accommodation is also available for eligible disabled children and juveniles between the age of 8 and 18, who are in need of temporary care and protection.

Community Support Services

8. We encourage and facilitate elders to live at their domestic homes as far as possible, with recourse to subsidised community care and support services. In appropriate cases, public hospital staff would arrange elderly patients to undergo the Standardised Care Needs Assessment before their discharge. Those assessed to have long-term care (LTC) needs may receive non-means tested subsidised home-based community care services comprising a package of services including meals delivery, household cleaning, escort services, personal care, special nursing care and rehabilitation exercise. At present, 60 Integrated Home Care Services (IHCS) Teams (these cases are

known as (IHCS (Frail Cases)) and 18 Enhanced Home and Community Care Services Teams are providing this type of services. There is currently no waiting list for such services. In urgent cases, the necessary services can be made available within one working day upon SWD's referral of the case to the NGOs. More than 3 000 frail elders are using the services. About 64% of them are paying the lowest rate on the charging scale.

9. Elderly patients with no LTC needs but requiring assistance in daily living at home after being discharged from hospitals may receive non-means tested subsidised meals delivery, household cleaning and escort services, which are targeted at elders in general. The service is also available to disabled persons, and individuals and families with social need. At present, there are 60 IHCS Teams operated by subvented NGOs which provide these services (known as IHCS (Ordinary Cases)), with about 18 000 users (including elders, disabled persons, and individuals and families with social need). About 74% of them are paying the lowest rate on the charging scale. Users with urgent needs will be provided with services imminently.

10. The projected government expenditure in 2006/07 on home-based and centre-based community care and support services for frail and non-frail elders (not including the expenditure on elderly centres) is estimated to be around $667 million.

11. Similarly, a wide range of community care, training and support services are available to discharged patients with disabilities, with the view to supporting and enabling their continuous living and integration in the community. These services include home-based training and support service, home care service, holiday care service, community rehabilitation network, training and activity centre, community mental health link and community mental health care services. In addition to providing training, care and support, these programmes also seek to facilitate the establishment of support networks, promote self-help and social networking amongst people with disabilities, and empower and provide relief for their carers and family members. There is currently no waiting time for all of the above community support services. The projected Government expenditure on the above community support services as well as day care for people with disabilities in 2006-07 is estimated to be $124 million, for the provision of a total of 17 593 relevant places and 209 426 training/service hours.

Day Care Centres

12. Discharged elderly patients assessed to have LTC needs may also receive subsidised day care services at Day Care Centres/Units for the Elderly (D/Es/DCUs). Currently, there are 50 subsidised day care centres/units for the elderly, providing 1 955 subsidized day care places for frail elders. Day care services are also available to severely disabled persons for enhancing their opportunity to continue living in the community.

Respite Services and Carers' Support

13. Elderly discharged patients living at home and requiring care during the absence of their carers (e.g. carers taking a break) may receive respite care at subsidised RCHEs (for those staying overnight) or at D/Es/DCUs (for those not staying overnight). Both are heavily subsidised by the Government, though the users are required to pay a small daily fee. In addition, more than 150 District Elderly Community Centres and Neighbourhood Elderly Centres are providing a wide range of support services for carers, from counselling and emotional support to the organisation of carers' groups and the loaning of rehabilitation equipment. A family-based respite service has also been made available to the carers of persons with disabilities.

Residential Care

14. Elderly patients discharged from hospitals, who have been assessed to have LTC needs and cannot be adequately taken care of at home, may apply for heavily subsidised residential care services. The projected government expenditure on subsidised residential care places in 2006-07 is around $2,000 million. Elders staying in the subsidised residential care places are not subject to means-test and are only required to pay a low monthly fee at around 20% of the actual unit cost. Those who have financial difficulties can apply for CSSA to cover the monthly fees. Due to their popularity and high demand, elders wishing to take up subsidised residential care places have to wait 39 months on average, but the waiting time is about 10 months if the elders accept placement in private elderly homes participating

in the Enhanced Bought Place Scheme. Nevertheless, elders may make use of the home-based community care services or the day care services at D/Es/DCUs mentioned in paragraphs 8 and 12 above during the waiting period. Elders with financial difficulties can also apply for CSSA to cover the monthly fees for staying in private residential homes. An elderly CSSA recipient in private RCHEs on average receives about $5,090 per month. The amount can be as high as $5,820.

15. The Government has increased the number of subsidised residential care places from 17 000 in 1997 to the current 26 000. Taking into account that around 22 000 elders are living in private residential homes by means of CSSA at the present moment, there are about 48 000 elders in total, or 90% of the elderly RCHE residents, who are receiving residential services with Government subsidy. The total amount of the Government's expenditure on subsidised RCHE places and CSSA payments to elders staying in both subsidised and non-subsidised RCHE places exceeds $4,000 million.

16. Elderly patients coming from RCHEs will normally return to their respective RCHEs upon discharge from hospital. More than 70% of RCHEs are served by the Geriatric Community Assessment Teams of the HA, whereby geriatricians and nurses make regular visits, conduct medical consultation and follow-up on discharged patients. In addition, most of the RCHEs are having their own visiting doctors.

17. Discharged patients with disabilities, who are not able to take care of themselves and cannot receive adequate family care or social support, may similarly apply for heavily subsidised residential care services provided by the Government. These include hostels for severely mentally handicapped persons, hostels for moderately mentally handicapped persons, supported hostels, hostels for severely physically handicapped persons, care and attention home for severely disabled, halfway house, long stay care home as well as care and attention home for the aged blind. There are a total of 10 147 of these residential places. The projected government expenditure on these places in 2006-07 is around $830 million. Although we have been steadily increasing the number of residential places over the years, the demand for such service has been increasing rapidly. In this regard, the Government will continue to increase the provision for residential services, while further developing the relevant community support services at the same time to enable people with

disabilities to live quality lives at home or in the community.

Service Enhancements

18. Elders will enjoy better physical and mental health if they live in the community and maintain a normal social life. To facilitate elders to live in their domestic homes, we will continue to enhance our community care and support services. The Financial Secretary has earmarked a recurrent amount of $20 million to strengthen home care services for the elderly. We will make use of the additional resources to increase the capacity of the IHCS (Ordinary Cases). Also, we will continue to increase the supply of subsidized RCHE places as appropriate to meet the growing demand.

19. In line with our policy objective of achieving full integration of people with disabilities in society, we will continue to develop our rehabilitation programme towards the strategic direction of enhancing community support to enable and encourage people with disabilities to return to community living. Accordingly we are initiating a number of enhancement programmes this year, which are briefly introduced below.

Transitional residential and day training services for severely disabled patients

20. We are setting up a transitional care and support centre for people with severe disabilities, including tetraplegic patients, to improve their physical, cognitive, communicative, behavioural, psychological and social functioning in a less medical intensive setting in preparation of their return to community living.

21. It will be a goal-oriented, community-based rehabilitation programme providing comprehensive psychosocial, health care and support services. It aims to offer a flexible, client-centred rehabilitation service that enables clients to continue to work towards their rehabilitation goals in a supportive environment after being discharged from hospital/medical rehabilitation centre.

Community rehabilitation day services to discharged patients with mental, neurological or physical impairment

22. Also in the pipeline are five Community Continuing Rehabilitation Day Centres (CRDCs) to provide short-term and time-defined rehabilitation services to discharged patients with mental, neurological or physical impairments who require continuing rehabilitation training as referred by hospitals under the HA in respective districts. The CRDCs aim to prevent the discharged patients from becoming home bound, to postpone premature institutionalization and to minimize the need for long-term care.

Training and support services for family members and carers

23. The contributions of family members and carers of people with disabilities are essential in encouraging and sustaining the latter's participation in community life. We will enhance the support and training for these family members and carers, and will provide respite and other services to cater to their needs. These are provided and enhanced through our various new and existing rehabilitation programmes.

CONCLUSION

24. The reasons for certain patients being reluctant to be discharged from hospital are multifaceted and sometimes complicated. As mentioned in paragraph 4 above, patients or family members may perceive the medical illness of the patients differently from the clinical assessment. In considering whether to be discharged, patients and family members may naturally compare the level of clinical care available in a hospital setting with that in the community setting, and this may result in the lack of confidence in continuation of self care at home. The HA staff will continue to work closely with the patients and their families as well as other relevant Government Departments to facilitate patients who are clinically suitable to re-integrate into the community.

Health, Welfare and Food Bureau
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