The Hong Kong Geriatrics Society

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Discharge Planning in Public Hospitals

The Hong Kong Geriatrics Society (HKGS) is a specialist society of over 180 doctors responsible for the management of acute illness, chronic disease and disability, as well as terminal conditions among elderly people. HKGS is pleased to give our professional views on discharge planning.

1. Discharge planning is the development of an individualized discharge plan for the patient prior to leaving hospital. Effective transfer of care plus post-discharge support for older patients could reduce readmission rates and improve health outcomes such as survival and quality of life.

2. Discharge-planning involves determining patient needs and wishes, assessing family resources and preferences, facilitating communication between patients and family members, deciding on discharge destination, coordinating plans and working with other government departments e.g. Social Welfare Department, Police and Immigration Department, as well as community agencies.

3. Patient centred multi-disciplinary assessment should be carried out at the earliest opportunity. However, it should be noted that hospitalization may be hazardous for older patients and admission may be avoided if timely assessment and interventions can be obtained in the community. The appropriate use of community geriatric services, visiting medical officers and family physicians may impact on this aspect of planning.

4. Some patients require significant stays in hospital in order to achieve optimal health status, whilst others who may have reached full rehabilitation potential may benefit from ongoing community rehabilitation in geriatric day hospitals or at home.

5. The discharge from hospital for an older patient with complex needs is a critical juncture, when decisions are made that may influence that person's well-being as well as that of his/ her family. Discharge planning is a challenging task under the best of circumstances and information from many sources must be gathered, including functional status, rehabilitation potential, patient and family preferences, as well as information about available community resources. Added to this complexity is the environment in which these decisions are made, which is often one of time constraints and emotional distress.

6. Geriatric assessments are important for a variety of reasons, including the improvement of diagnostic accuracy, selection of interventions to restore or improve health, determination of the optimal environment for care, prognostication, monitoring of functional change, and determination of service needs. Factors assessed include physical and psycho-social functioning, support systems and family caregiving capabilities, financial situation, patient and family desires, and environmental hazards in

the patient's home. The variety of domains that need to be assessed reflects the diversity of skills needed for comprehensive multi-disciplinary assessment.

7. Once an assessment has been conducted, the hospital staff must translate the care needs and patient / family preferences into service needs. Ideally, the decision about the best type of care would be based on information about the benefits and risks associated with different approaches. The patients and their families are the ultimate decision-makers, and the hospital staff are the sources of information facilitating that decision.

8. Reaching a consensus on discharge planning may be difficult because of the differing value structures of patient, family, and the hospital. Conflict could arise among family members as they readjust roles and relationships in the face of the crisis of illness. Some family members may even refuse or turn down reasonable discharge plans proposed by hospital staff for a variety of reasons.

9. In general, when the dependence level cannot be met by existing family support, residential care has to be considered. Since the waiting time for subvented residential care may take up to 3 – 7 years, private old aged home (POAH) placement may be the only solution. Restricted options make the decisions easier in one respect but frustrate attempts to provide real consumer choice.

10. Patients and families are often encouraged to visit old aged homes for the patient, but it may be difficult for them to know what to ask or look for, and how to integrate the information obtained into a choice. Moreover, the general reputation of privately run old aged homes are of variable standard, thus discouraging family to accept the private sector.

11. Financial "dis-incentive" is often involved - keeping a patient in a public hospital with full medical support costs only HK$ 68 x 30 = HK$ 2,040 per month, whilst fees are waived for patients on Comprehensive Social Security Allowance (CSSA). Even in the lower end of the market, a mediocre POAH would cost around HK$ 4,000 -5,000 per month. To resolve this kind of problem, an explicit change in policy on fees and charges is required e.g. differential charges and/ or with-holding CSSA during hospitalization. It remains the responsibility of the Government to revise our long term care funding policy.

12. Continuity of care between acute, post-acute, and community care can be improved by structured care plan involving community nurses, case managers, community geriatric assessment teams, hospital specialists and family doctors, along with information flow by means of paper form, or electronic patient records. Discharge coordinator/ liaison nurse posts have been developed in many clusters. They have a pivotal role in liaising with members of the multidisciplinary team and can improve communication between various parties.

13. Transfer of care of an older patient from the hospital to the community is one of the most challenging and satisfying aspects of Geriatric Medicine. The complex health and social needs of this group requires the expertise of the multi-disciplinary team consisting of doctors, nurses, therapists and social workers, working in harmony with patients and their family. Without careful coordination, not only will this process disintegrate to the detriment of the patient and their family, it will also lead to the woeful "revolving door phenomenon" and escalating health care costs.

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