Homeward-bound

Dr Susan Yau
AC, Fung Yiu King Hospital

Ms TC Law
APN (CCS), QMH, HKWC

Grand Round
Queen Mary Hospital
4 June 2019
We are living longer

Life expectancy in Hong Kong

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>81.9</td>
<td>87.6</td>
</tr>
<tr>
<td>2018</td>
<td>82.2</td>
<td>87.6</td>
</tr>
<tr>
<td>2066</td>
<td>87.1</td>
<td>93.1</td>
</tr>
</tbody>
</table>
The proportion of elderly is growing

- Worldwide, number of adults >60 years old will top 2 billion by 2050
  - >20% of the world's population

HK population by age

- 1 elderly in every 3 persons

<table>
<thead>
<tr>
<th>Year</th>
<th>Aged 65 years or over</th>
<th>Aged 85 years or over</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>1.25</td>
<td>0.18</td>
</tr>
<tr>
<td>2026</td>
<td>1.3</td>
<td>0.24</td>
</tr>
<tr>
<td>2036</td>
<td>2.37</td>
<td>0.37</td>
</tr>
</tbody>
</table>
Where are we residing?

• In 2016
  – 91.9% of those aged ≥65 years lived in domestic households
    • 13.1% living alone
  – The remaining 8.1% lived in non-domestic households

• 535 patients in 2 convalescence hospitals in HK
  – Upon discharge, 116 patients (21.7%) institutionalised
Institutionalisation

• When elder leaves behind their own life habits and environment, it can be a traumatic event

• Institutionalisation can be associated with
  – Loneliness and social isolation
  – Lack of social support from family or community
  – Increased risk of depression
Institutionalisation

- 333 nursing home patients living in the Netherlands
  - Prevalence of major depression 8.1%
  - Prevalence of minor depression 14.1%

- For major depression significant risk indicators
  - Pain, stroke, visual impairment, functional limitations, loneliness, lack of social support, negative life events, perceived inadequacy of care
Heath service utilisation

• In 2010, elderly (≥65 years) accounted for
  – 53% of all accident and emergency admissions
  – 68% of all unplanned emergency readmissions

• Relative risk of person aged ≥65 years being hospitalised is 4 times that of a person aged <65 years

• Proportion of preventable readmissions among all readmissions is 9 - 59%
Hospitalisation

• Hospitalisation can potentially lead to a terminal downward spiral for an older person

• Complications from hospitalisation for the elderly
  – Delirium
  – Falls, functional decline
  – Increased rate of serious iatrogenic complications
    • Often unrelated to admitting diagnoses
    • Such as nosocomial infections, dehydration, malnutrition, immobilization, psychoactive medication use
  – Death
Convalescence
AED
Acute hospital
Patient journey

Lack of motivation for caring for self
Lack of skill in caring for self
Lack of confidence in caring for self
Lack of social support
Still recovering
Not yet back to premorbid status
Lack of access to health professionals
Lack of engagement in care planning
Hospital Admission Risk Reduction Program for the Elderly (HARRPE)

- Risk prediction tool
- Takes into account
  - Socio-demographics
  - Co-morbidities
  - Hospital attendance

- Identifies high-risk elderly patients who are likely to require emergency care relatively shortly after hospital discharge
Hospital Admission Risk Reduction Program for the Elderly (HARRPE)

• HARRPE score
  – Predicted probability of emergency admission to medical ward of any HA hospital within 28 days after an index episode in which elderly patient was discharged alive

• Range 0-1
  – Higher score → higher likelihood of readmission
What can be done to reduce avoidable readmissions?

• Cochrane review (2016)
  – For elderly patients who were admitted to hospital with a medical condition, personalised discharge plan probably brings about small reduction in
    • Hospital length of stay
      – Mean – 0.73 days
    • Readmission rate
      – 3 fewer readmissions per 100 participants
  – May increase patient satisfaction
What can be done to reduce avoidable readmissions?

• Avoidable readmissions in HK
  – System, clinician, patient, social factor

• Postulated that readmissions could be prevented by
  • Ongoing review of clinical practice/decision for discharge
  • Enhancing patient knowledge of early warning signs for relapse
  • Ambulatory care to support the patients in the community
  • Education on patient self-management

• Development of discharge planning system
  – Patients and carers = primacy focus of care
  – Engaging them and healthcare professionals in the discharge planning process
Discharge planning

• Discharge planning
  – Development of a personalised plan for each patient who will be discharged from hospital
    • Patients leave hospital at an appropriate time in the course of their care
    • Organisation of post-discharge services

• Discharge planning in other countries
  – In the USA, discharge planning is mandatory for hospitals participating in the Medicare and Medicaid programmes
  – In the UK, the Department of Health has guidance on discharge practice for health and social care
Ms L

- F/91
- Widow, no children
- Lives with younger brother
- Premorbid
  - Walks unaided indoors
  - Walks with stick outdoors
  - BADL independent
- No financial difficulty

- Admission to the medical ward for management of anaemia
- Referred to ICDS Case Manager
- HARRPE score 0.0941
- Patient and family agreed for ICDS service

- PMH
  - IHD
  - Osteoporosis
  - Kyphosis, TS and LS degeneration
  - Fractured right NOF with surgery done (2012)
  - Fractured left NOF with surgery done (2018)
At the home

• Lifestyle
  – Before
    • Goes out for walking exercise
    • Goes out for tea with younger brother
    • Had done volunteer work for 10+ years
  – Currently
    • Mostly homebound in view of back pain
    • Volunteer work discontinued for the past 1 year

• Home care
  – Brother prepares the meals
  – Accompanies patient to follow-up appointments
  – Wished to age-in-place
At the home

• Medication management
  – Managed by self
  – Educated on medication storage and regimen

• Medical condition
  – Health education given (diet, chronic disease, falls prevention)
  – Reminded on upcoming medical appointments
  – Briefed on GOPC booking via IVAS and healthcare vouchers

• Home environment assessment
  – Handrail at shower but not toilet
  – Shower chair available for bathing
  – No safety alarm available
  – Advice given
At the home

• c/o chronic back pain
  – Affected her mobility and social life

• s/b PT
  – Education on
    • Postural correction, transfer technique
    • Basic pain management skills (eg heat pack)
    • Stretching, active back mobilisation exercises
  – Adjustment of stick height
  – Walking exercise with stick
  – Reminder on exercise, positioning and fall prevention
Upon completion of programme

- Subjective >90% improvement in pain
- Stable unaided walking at home

- Goes out every day for social gathering
- Able to play mahjong without pain
- Goes to elderly centre
INTEGRATED CARE AND DISCHARGE SUPPORT FOR ELDERLY PATIENTS (ICDS)
ICDS: during hospitalisation

• High-risk home-dwelling older patients
  – Comprehensive assessment
  – Early discharge planning
  – Individualised holistic care plan

• Early identification of differing needs of older patients
ICDS: post-discharge

• Comprehensive home support for elderly patients with self-care difficulties
  – Improve quality of home care

• Enhanced coordination of multi-disciplinary services and community support services
  – Better support elderly patients with chronic disease and complex needs

• Patient and carer engagement
  – Patient is an active partner in healthcare
  – Better patient empowerment
  – Support self-management of chronic diseases
  – Enhance self-care management
ICDS: patients

• Age ≥ 60 years

• High-risk home-dwelling elders
  – HARRPE ≥ 0.2
  – Clinical referral
  – Proactive screening

• Discharged from HKWC hospitals and assessed by the Discharge Planning Team to be in need of community support
Multi-disciplinary healthcare team

- Discharge Planning Team
- Case Management Team
- Home Support Team

- Geriatricians
- Specialty nurses
- Occupational Therapists
- Physiotherapists
- Social workers
- Speech therapist
- Podiatry
- Dietician
- P&O
- Clinical psychologist
- Specialty nurses
Risk stratification
HARRPE ≥ 0.2, proactive screening, clinical referral

Comprehensive Geriatric Assessment & Discharge Planning

Integrated Care Model
Case Management

Integrated Discharge Support Program
Home Support Team (HST)
In the ward

• Discharge Planning Team
  – Geriatricians, link nurses
• Comprehensive assessment for high-risk elder hospital patients
• Formulation of discharge care plan
Comprehensive geriatric assessment
Case recruitment
Ward round & follow-up on progress
Discharge planning
Care coordination
Post-discharge service planning
港島西醫院聯網
支援長者離院綜合服務

支援長者離院綜合服務
是為有困難自理之離院長者提供全
家居綜合支著。港島西醫院聯網與香港
社會福利署將聯手推
進社區醫療及復康服務以支援出院長者在家中康復。

小病留社區
大病到醫院
康復回社區

地址：香港薄扶林道 102 號瑪麗醫院護士學校三樓 108 及 113 室

瑪麗醫院 東華三院黃院長

港島西醫院聯網

28
IN THE COMMUNITY:
CASE MANAGER
Case manager

- A bridge between patients, family members, carers and health care workers
  - Coordination of post-discharge interventions and their delivery

- Follow-up on the patient’s need for home care, medical and rehabilitation service
  - Post-discharge phone calls and home visits

- Empowerment of patient and carer
  - Enhancement of chronic disease knowledge and caring skills
Nurse

- Continence management
- Skin care
- Chronic disease education
- Glucose and BP monitoring
- Drug compliance and education
- Nutrition management
Physiotherapist

Rehabilitation
- Home-based rehabilitation program
- Fall risk assessment and fall prevention program
- Balance, mobility and gait training

Disease management
- Pain management
- Weight control training
- Respiratory care

Environment
- Walking aid and rehabilitation equipment prescription
- Environmental adaptation
- Community reintegration
Occupational therapist

- ADL home program
- ADL safety assessment

- ADL assistive devices
  - Seating devices
  - Pressure relieving devices

- Cognitive training

- Patient and carer education
Social Worker

- Patient and carer empowerment program
- Psychosocial support to patient and carer
- Liaise with local social service providers
IN THE COMMUNITY:
HOME SUPPORT TEAM (HST)
Home support team

• Patient assessment and formulation of care plan
• Comprehensive care plan implementation
• Phone contact and monitoring
• Carer training
• Emphasis on self-management
• Identify long-term need and formulate long-term care plan
• Community resources
Ms Y

- F/80
- Lives with husband and son
- Walks with stick
- BADL independent

- PMH
  - HT
  - IHD
  - DM
  - Cataract

- Admitted to medical ward
- Referred to ICDS HST
- HARRPE score 0.2429
- Patient and family agreed for ICDS service
At the home

• Nurse
  – General diet and fluid education
  – BP monitoring and education
  – Medication knowledge, storage and compliance
  – Simple home exercise advice
  – Review of long term care plan
At the home

• Occupational therapist
  – Home modification
• Escort
• Elderly sitter
Nursing care  | Personal care  | Elderly sitter  | Home modifications
---|---|---|---
Meals provision  | Home exercise  | Referral to social services  | Home-making service
Emotional support  | Transitional residential care services  | Carer training  | Escort Transportation
HOW DOES IT HELP?
How does it help the patient?

• Patient-centred care
  – Service is coordinated according to patient need
• Individualised care plan
• Contributes to reducing hospital stay
• Strengthened home and community support
• Patient empowerment
• Enhanced patient satisfaction
How does it help the carer?

• Carer empowerment
• Strengthened carer skills
• Reduced carer stress
• Increased care satisfaction
Lack of skill in caring for self
Lack of confidence in caring for self
Lack of social support
Lack of motivation for caring for self
Lack of access to health professionals
Lack of engagement in care planning

Convalescence
Acute hospital
AED

Still recovering Not yet back to premorbid status

Patient journey
What about hospital attendance?

- 1090 home-dwelling patients aged ≥60 years

- 6 months after ICDS recruitment
  - AED attendance reduced by 40%
  - Unplanned acute hospital admission reduced by 47%
  - Hospital bed days reduced by 31%

- Only 2.4% required institutionalisation in RCHEs within 6 months after the programme
Future direction

• Orthopaedics patients
• Stroke patients

• In February 2018, Community Care Fund rolled out a Pilot Scheme on Support for Elderly Persons Discharged from Public Hospitals after Treatment
  – 3 year Pilot Scheme
  – Administered by the Social Welfare Department
  – Aged 60 or above, newly discharged from public hospitals (not covered by IDSP)
  – Transitional residential care and/or community care and support services
  – Aim for continuation of ageing-in-place
Take home message

• Elderly population growing
• Many are community-dwelling
• Need for care in the hospital and in the community
• Discharge planning and individualised care plan
• Support in the community
• Expansion in the future
Staying active in old age