Abstracts

Primary Care for the Elderly: The Need for Integrated Medical and Social Care

Professor Jean Woo

Introduction

The CADENZA Project aims to promote an elder-friendly Hong Kong. Health and social needs are major concerns of older people. The theme of this Symposium is to highlight these needs from the users' perspective, using two case histories as illustration of the current situation. Key features of needs include living with chronic diseases or multi-morbidity; a patient-centred approach versus system approach; and integration of multiple services versus fragmentation of delivery. The primary care setting is key to meeting the demands of an ageing population. We are fortunate in having distinguished speakers from overseas as well as key institutions to discuss the various facets of how we may provide needed care: the management of chronic diseases, the role of social services and examples of successes and obstacles, caregivers, psychological problems, outreach support, self-management, and the Family Doctor's perspective from the private sector. CADENZA has supported the development and evaluation of some innovative models of care, including a primary care model in Tai Po, details of which will also be presented and for which visits have been arranged for interested participants.

Redesigning Primary Care of Chronic Diseases

Professor Barbara Starfield

Chronic Illness in the Context of Primary Care

This presentation addresses the concept and rationale for primary (health) care in the context of changing health needs in populations. Defining primary care as the practice of person (not disease) focused care over time that deals with a wide range of undifferentiated ailments as well as particular health conditions and coordinates care wherever else it is provided, it distinguishes the system components (Primary Health Care) that make it possible to provide the clinical component (Primary Care) that meets the health-related needs of patients and populations.

The presentation discusses recently proposed 'innovations' in primary care, including the chronic care model (CCM) and concludes that any proposed 'improvements' to primary care will fail unless they are pursuant to the attainment of the main functions of primary care.

Chronic Disease Management and Its Relevance to Older People

Professor Steve Iliffe

The management of long term conditions and chronic diseases is the main challenge for primary care, worldwide (Bodenheimer et al 2002a). Individuals with long term conditions consume a large proportion of health and social care resources, including 60% of hospital bed days in British hospitals (Department of Health 2004), and 78% of all health care spending in the USA. It is estimated that 17.5 million adults in the UK are living with a chronic disease and that the incidence of chronic diseases and disabilities (long-term conditions) among those aged over 65 will double by 2030 (Department of Health 2004, 2005).

There is some evidence from studies in the USA that targeted needs assessment of older people followed by active management may improve both survival and functional ability (Stuck et al 2004). In North America comprehensive geriatric assessment with subsequent systematic management reduces hospital admission rates (Stuck et al 1993), and models of chronic disease management have evolved (Bodenheimer et al 2002b) to exploit this impact and contain care costs for an ageing population. Whole systems approaches in the USA, using case management methods (Wagner 1998, Dixon et al 2004), have been championed as a means of ensuring continuity of care, improving patient outcomes and achieving efficient management of resources (Department

of Health 2004, 2005). The core elements of any case management activity are: identification of individuals likely to benefit from case management, assessment of the individuals' problems and need for services, care planning of activities and services to address the agreed needs, referral to and co-ordination of services and agencies to implement a care plan, and regular review, monitoring and consequent adaptation of the care plan.

Is this new approach to health care a decisive breakthrough in person-centred service provision? We should be cautious about the emphasis given to chronic disease management in health care systems seeking cheaper forms of care that deliver better outcomes. Chronic disease management remains problematic as a model of care, with evidence from the USA of limited effectiveness, reliance on traditional forms of patient education, poor linkages to primary care and dependence on referrals rather than active case-finding approaches (Wagner et al 2002). In other countries primary care organisations should be able to overcome some of the negative features of American experience especially if they have integrated systems of primary care, with a relatively influential discipline of public health. But they may not be able to overcome them all, for a number of reasons.

Firstly, there is some doubt about whether chronic disease management is wanted by all patients. Patient priorities may differ from those health service managers and clinicians, and older people who may feel that their independence and autonomy is threatened by an intrusive care system (Drennan et al 2003).

Secondly, there is the problem of how to identify those who are likely to need high levels of care, for there is no linear and unambiguous link between the presence of a condition that can be labelled chronic and the need for health or social care (De Lepeleire & Heyrman 2003). Patients with multiple emergency admissions ("frequent fliers") are often identified as a high-risk group for subsequent admission and substantial claims are made for interventions - like case management - designed to avoid such admissions. However, simply monitoring admission rates cannot assess the effectiveness of case management, since admission rates fall without any intervention (Roland et al 2005). Promotion of case management on the basis of before-and-after comparisons of admission rates is, therefore, reliant on potentially flawed evidence.

Finally, case management as a technique is not a single or simple entity, there being several different types which require different types of work organisation, demand different skills and respond to different needs.

The current emphasis on chronic disease management could require extensive changes in service provision, significant re-training of staff, and widespread re-negotiation of relationships between disciplines and agencies. The opportunities for innovation are huge, and the need for rigorous evaluation of new approaches to care is equally great.

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Experience of HK NGOs in Primary Care: Success, Obstacles and Future Plans (1)

Rev Dorothy Lau

1. ***Challenges in Primary Care***

Hong Kong in the face of an ageing population and an increase in longevity calls for prompt action from the public and the community in building a healthcare system, capable of *"accessing to lifelong, comprehensive and holistic primary care, with emphasis on health-improving preventive care"*.[1] Otherwise, the "revolving door phenomenon", that is, a low awareness in disease prevention and a failure of the care providers in "gate-keeping" primary health, will surely lead to great pressure on secondary and tertiary health care resulting in a marked increase in health care expenditure.[2]

2. ***The Roles of NGOs in Primary Health Care***

NGOs possess specific strengths and characteristics to serve as an effective link and dynamic agents between the community and the government as well as in response to expressed needs flexibility. To make 'Primary Care' a movement, a pluralistic perspective, which involves the leadership of the government, participation of the health care sector, NGOs and individuals, should be promoted. Well recognised the importance of holistic care and preventive health, NGOs have successful track record in the delivery of primary health care as illustrated below:-

2.1 Preservation and promotion of health through offer of comprehensive primary care package to the community;

2.2 Advocacy and empowerment on self-management of health and diseases among individuals in the community;

2.3 Collaboration with medical sector in initiating community-based health care programme through strategic partnership;

2.4 Community diagnosis on health related parameters and variables to identify community needs.

3. ***Comparative Advantages of NGOs in Primary Health Care***

3.1 To address primary care in a holistic way with the 'Total Health" concept;

3.2 To allow efficient use of scarce resources and respond to expressed needs in creative ways;

3.3 To facilitate easy access of seniors, in particular those in disadvantageous circumstances, to essential health care services;

3.4 To enhance collaboration from diverse sectors;

3.5 To advocate the self-help movement: an effective measure in health promotion.

4. ***Obstacles of NGOs in the Delivery of Primary Health Care***

The primary health care projects of NGOs have survived largely on volunteerism, alternative sources of income and time limited fund rather than on long-term government revenues. These projects usually operate in smaller scale, for a particular group of people and under the good will and ad hoc participation of medical sector instead of being carried out under formal and structural collaboration. Obstacles faced by NGOs in the delivery of primary health care include:

4.1 Rigid service boundary and specialisation between medical and welfare sectors;

4.2 Limited platform for shared information;

4.3 No formalised structure for interfacing and collaboration between medical and welfare sectors;

4.4 Insufficient resources for implementation of Primary Health Care Programme.

5. *Looking Ahead*

5.1 To set up policies for the future development of primary health care in Hong Kong;

5.2 To adopt a total health and community based approach in the provision of comprehensive primary health care;

5.3 To devise mid and long term plans for the development of primary health care programme both at the community and district levels;

5.4 To implement community diagnosis to collect information on health parameters for policy and programme planning;

5.5 To consider the setting up of "Integrated Primary Health Care Centre" and a primary health care network in each district;.

5.6 To involve the public and the stakeholders to discuss on the future development of primary health care in Hong Kong.

1 'Your Health, Your Life', Healthcare Reform Consultation Paper,2008,

2 Health Care for Elderly People, 1997, P.50

Dr Lam Ching-choi

Experience of Haven of Hope Christian Service in Primary Care: Success, Obstacles and Future Plans

Primary care is the first point of contact individuals and families have with a continuing care process, and it constitutes the first level of a care system. Based on the World Health Organisation definition of primary health care, primary care for older persons may be defined as "essential care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford". Ideally, this care approach has a strong emphasis on working with communities and individuals to improve their health and social well-being by supporting people to care for themselves and their families, improving wellness, preventing both physical and psycho-social illnesses, and supporting those with long-term problems, from a health and social well-being perspective. The paper shares the experience of Haven of Hope Christian Service in providing integrated health and social services to older persons when they approach two of our services, viz. our District Elderly Community Service and our Community Health Service.

Success

In the Haven of Hope District Elderly Community Service, the service incorporates health elements into its social service provision. Success is seen in:

- Accessibility for 'early detection' of health and social care needs of older persons and their prevention through operating the Service as three satellite centres located in older persons' own local communities of housing estates;
- Early and timely detection of medical care needs as a result of regular simple health checks and the regular availability of health consultations through employment of a nurse in the Service;
- Development of a network of 'healthier' older persons caring their weaker members;
- Isolated singletons becoming members of the Service as a result of addressing their health needs.

In the Community Health Service, the Haven of Hope operates a network of community clinics and community health centres that use social work approaches. Success may be seen in:

- The outreach Western and Chinese Medicine services to residential homes and social centres for elderly people;
- Collaborations with CGAT of Hospital Authority to receive stable chronic hypertension and/or diabetes sufferers for medical care in the community clinics, diet control, healthy lifestyle classes and support groups in the community health centres;
- Individual health checks, physical assessments of joints, spine and exercise advice and nutritional assessments are available at our community health centres and are well-received by older persons in the local community;
- Community building and large-scale wellness promoting programmes using social work approaches.

Obstacles

Hindrances that limit success include:

- Lack of full and formal recognition by the government on the health elements in the elderly social centres despite the fact that every conducted survey shows health as the major concern of older persons. The result is, firstly, a lack of appropriate manpower to address primary health care needs of older persons in social centres; and secondly, space and facility limitation in the centres as only social aspects were included in government planning;
- The 'all or nothing' financing arrangements: while an elderly person remains in the public system, the service is subsidised; once he/she goes to our health service, however, the elderly person has to pay in full. This has discouraged NGOs to provide a comprehensive primary care;

- Lack of full and formal recognition by the government on the social determinants on well-being and wellness when primary healthcare services are provided. Our community health centres are funded by The Hong Kong Jockey Club and Community Chest allocations and donations.

Proposed Future Plans

All but the most complicated and acute care needs of older individuals, families and groups may be effectively met within the primary care provision. The principal change required is a change in the balance from secondary specialist care to primary generalist care. This will need major investment in the development of an appropriate infrastructure for primary care. Integration of medical and social services should be facilitated in the planning of elderly services. Continuous professional training in the direction of trans-disciplinary approach would be beneficial to the users as well as to the care teams.

Ms Maggie Chan

The Need for Integrated Medical and Social Care for the Elderly

Both the practitioners of the welfare and medical sectors recognise the needs for collaboration so as to better serve the elderly people. Initiatives had been made by frontline workers of both sectors to launch pilot projects at local districts to provide integrated service and holistic care for the elderly.

During the past decade, experimental projects had been launched successfully by NGOs and the medical profession to serve various objectives. They included promotion of health literacy and awareness, prevention of disease and assessment of health risk, education of self-management of chronic disease, direct referrals between welfare and medical services, sharing of patients' records, rehabilitative service, formulating care plans for discharged elderly patients, mobilisation and development of volunteers, as well as training of carers. The ultimate goal of these projects is to meet the social and health care needs of aged people of different segments and with different health conditions.

Undoubtedly, these pilot projects have encouraged the development of strategic partnership to draw on the expertise of the medical and social work professions in the local community for the delivery of integrated service. Joint effort has also facilitated the provision of tailored made and quality service to serve the specific needs of the elderly. The organisation of these pilot projects is not solely driven by needs, but also relies on the initiatives and the sensitivity of frontline practitioners as well as the provision of resources. However, sustaining these pilot projects has been a great challenge for the practitioners. Sometimes, change of personnel of the organisers may have an impact on the continuation of the projects. Most importantly, resources available are usually provided on short-term basis. Despite all the effort made in the past, the practitioners find that the development of integrated service is piecemeal and fragmented.

In response to an ageing population and an increase in longevity, it is doubtful whether both the welfare and medical sectors are prepared for an increased demand for an integrated medical and care service for the elderly. There has been a misconception that old age equates with frailty and infirmity. There are two possible developments related to the rise in life expectancy. One assumption is that an increase in life expectancy will lead to greater demand of residential and medical service. The argument is that if aged people have health problems, they will have more years spent in poor health. The second assumption is that increasing life expectancy will correspond with an improvement in the state of health. Thus, most elderly people, especially those between 65 and 75, are still healthy and capable of living independently. Only a small portion of people aged 65 and above, especially the oldest group (above 80) will have difficulties in caring for themselves and require the support of residential care service. International overviews estimate the proportion of persons aged 65 and above who are severely handicapped at 10% to 20% (Dooghe, 1992). Obviously, health conditions of the elderly will be an important factor affecting the demand of medical and care service in future. If our elderly people are in good health, the demand for care service will be postponed to older age groups. In this connection, it is essential to deploy more resources for the promotion of primary health care for the elderly so as to enhance their ability to live independently and actively in community.

Considering the limitation of bottom up approach to design integrated service for the elderly, systematic planning is essential. It is time for policy makers to take the lead to work out an integrated policy to provide a continuum of social and medical services for the elderly to meet our future challenge.

Experience of HK NGOs in Primary Care: Success, Obstacles and Future Plans (2)

Mr Ngai Kong-yiu

The Experience of a Small NGO in HK - Mobilizing Partners for Better Support and Care for the Elders

Evangelical Lutheran Church Social Service - Hong Kong (ELCSS-HK) was founded in 1976. As a multi-service NGO, our target group is the grassroots, especially the disadvantaged and the vulnerable. There are about 20 community based centres and projects with about 200 staff members serving the needy elders in the community in Shatin , Kwai Chung and Tuen Mun districts, New Territories of Hong Kong.

Our first social centre for the elderly was established in 1979 in a public estate in Kwai Chung by Norwegian Mission Society which was afterwards transferred to be under ELCSS-HK's management. In facing the ageing society and challenges it will bring to Hong Kong, ELCSS-HK has been actively involved in promoting community care through innovative projects. Other than the regular services in the community centres, with the support of various funding, we have been trying out projects to promote primary care for the elderly, for examples, Life Garden for elders with depressed symptoms, Oasis Pain management project, Senior Man Association, Integrated Discharge Support Programme for the elderly patients and Elder Academy (with CUHK). Practitioners and resource mobiliser of a small NGO will share with you the success, obstacles and their visions in the Symposium.

Mr Michael Lai

It has been recognised that both medical care and social care are serving the same target group (the elderly) but the two systems have yet to be fully integrated. Despite various efforts and pilot schemes tried out over the years, many difficulties and problems encountered remain unresolved. It is now timely to have a comprehensive scheme to integrate the two systems in "Long Term Care" for the elderly. With ageing population, we must try to overcome the difficulties and strive to create a seamless system of primary care for the elderly in Hong Kong.

St. James' Settlement has been a pioneer in providing services to the elderly in Hong Kong and has launched a number of health-related projects since the late eighties. In recent years the move towards collaboration with the Medical and Health sector saw closer tie but there is still a long way ahead. "The Chronic Care Model" has been explored and the "TMPACT Model" which focus on late life depression is being developed. All these called for supports and collaboration from the Medical and Health Sector.

The Primary Care Approach to Dealing with Psychological Problems in the Elderly

Professor Cindy Lam

Cindy L K Lam, Weng-Yee Chin, Peter W H Lee, Daniel Y T Fong; The University of Hong Kong

Introduction: Ill health and poverty predispose the elderly to psychological problems, which are often unrecognised. The aim of this paper is to explore the epidemiology of screened positive psychological problems and the outcomes of problem-solving therapy (PSF-PC) for the elderly presenting to primary care.

Methods: 1853 elderly patients were screened by the Hospital Anxiety & Depression Scale (HADS). 299 subjects who were screened positive were randomized to 3 sessions of PST-PC or video-viewing (placebo) in five weeks. All subjects continued with their usual care and were followed up by telephone at 6, 12, 26 and 52 weeks. The SF-36 (quality of life) scores, HADS scores and consultation rates at baseline and different time points were assessed and compared, controlling for sociodemographics and chronic morbidity.

Results: 26% of the elderly were screened positive of psychological problems, which was associated with lower SF-36 scores and higher consultation rates. Being female, no schooling, living with a spouse, and having more than two chronic diseases increased the likelihood of psychological problems. There was significant improvement in the SF-36 role-emotional (RE) and mental component summary (MCS) scores immediately after PST-PC group but not in the placebo group. Several SF-36 scores improved significantly in the placebo (video)

group at weeks 6 to 52. Mixed effects analysis adjusting for baseline values and cofounders did not show any difference in outcomes between the PST-PC and placebo (video) groups.

Conclusion: Undiagnosed psychological problems are common and have significant impact on quality of life and consultation rates. PST-PC may have a short-term improvement in HRQOL but the benefit is not greater than the placebo intervention of group-viewing of health education videos.

Professor Samuel Wong

Anxiety and depressive disorders are associated with significant morbidity, disability and healthcare utilisation. Although DSM diagnosed anxiety and depressive disorders may not be prevalent in the primary care settings, sub-threshold depressive and anxiety symptoms are found to be prevalent in primary care. In Hong Kong, studies showed that the prevalence of sub-threshold anxiety and depressive symptoms are comparable or even higher than that found in overseas studies. Although these patients do not have DSM diagnosed anxiety and depressive disorders, evidence shows that up to 1/3 of these patients may develop a major depressive or anxiety disorder in one year. Therefore, preventing the onset and development of these disorders should receive a high priority particularly in the primary care settings where the prevalence of sub-threshold anxiety and depression is high.

There are three types of prevention in mental health: (1) indicated, addressing high-risk individuals with pre-morbid signs and symptoms; (2) selective, for selected individuals with demonstrated increased risk of developing illness; and (3) universal, for a whole population in a group with all levels of risk. Although the ultimate goal of mental health preventive intervention is universal, it is suggested that the most cost-effective goal is to identify a population at sufficiently high risk to justify the expense of intervention and to shorten the duration of the persistence of the early symptoms and to stop the progression of severity so that the participant does not meet DSM IV diagnostic levels of mental problems. Evidence from meta-analysis showed that well designed indicated interventions were effective and could reduce the incidence of depression and anxiety. These studies also showed that these well designed indicated interventions are likely to be more cost-effective than alternative approaches. As a result, indicated prevention that is targeted at selected groups of individuals at high risk of developing anxiety or depressive disorders should be designed and tested.

Since not all patients with sub-threshold anxiety or depression need the same type and intensity of preventive intervention, the stepped care model may be a model that can provide more cost-effective care in primary care settings. In this presentation, the stepped care model, the evidence relating to its effectiveness and its potential applicability in Hong Kong will be discussed.

Results from Community Group Models (CDSMP and DM)

Mr Wayne Chan

CADENZA Community Project: Chronic Disease Self-Management Programme (CDSMP)

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Introduction:

Chronic disease is one of the most important causes of health care expenditure and put a great burden on the health care system. In 2009, more than 670,000 people aged over 60 years in Hong Kong had at least one chronic disease. Self-management has been found to be able to meet the challenges of chronic diseases through patient empowerment.

Objectives:

1. To evaluate the outcomes of the community-based CDSMP for older people with chronic diseases in Hong Kong;
2. To compare the effectiveness between the programmes led by professional staff leaders and elder lay-leaders.

Methods:

A non-randomised controlled trial was conducted from November 2007 to June 2009. Adults aged 55 years and over, had at least one chronic disease and living in the community, were invited to participate in this programme. The programme consisted of 6 sessions, each lasted for 2.5 hours, and it was conducted by 2-3 professional staff leaders or elder lay-leaders. Participants in the study group joined the

programmes led by either professional staff leaders or elder lay-leaders, while those in the wait-list control group received usual care for 6 months. The changes of outcomes at 6 months were compared between study and control groups, and the effectiveness of the programmes led by professional staff and elder lay-led was also compared. Focus group interviews were also conducted to investigate the experiences of participants and leaders in this programme.

Results:

210 and 244 study and control group participants completed 6 months follow-up respectively. Participants in the study group showed significant improvements in practising stretching and strengthening exercises, aerobic exercises, cognitive symptom management skills, communication with physician, self-efficacy in managing disease in general, self-efficacy in managing symptoms, social and role activities limitation, depressive symptoms, health distress, pain and discomfort and self-rated health when compared with those in control group. No significant difference was observed between the effectiveness of the programmes led by professional staff leaders and elder lay-leaders in most of the outcome measures.

Results of the focus group study showed that the programme was able to help participants to gain self-management skills and to reinforce their healthy behaviours, and this may reduce the burden of chronic diseases on current healthcare services.

Conclusion:

CDSMP may improve self-management behaviours, self-efficacy and health status of the older adults with chronic diseases. The programme led by well-trained, empowered elder leaders can be as effective as that led by professional staff. The concept of self-management could be disseminated and the programme could be incorporated in community setting as a source of primary care. Engaging empowered peer experts in managing chronic diseases could help to promote the concept among older adults.

Dr Elsie Hui

A Community Model for Care of Older Persons with Diabetes Mellitus: A Randomised Controlled Trial - A CADENZA Initiated Research

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[1]Shatin Hospital, [2]Department of Medicine and Therapeutics, The Chinese University of Hong Kong, [3]CADENZA Research Team

Introduction:

In Hong Kong, the prevalence of diabetes mellitus (DM) is around 22% in the older population. Traditional services and programmes for DM relied heavily on specialised health care professionals in public hospitals and out-patient clinics. Apart from regular follow-up by physicians in hospitals and clinics, older people with DM need further support in their disease management and daily living within the community setting. A community-based programme which incorporated knowledge delivery, patient empowerment and exercise, leading by health care professionals who are not specialised in DM, may have potential to fill in the service gap in the care of older diabetics.

Objectives:

1. To develop a new model of care for older people with DM in the community setting;
2. To evaluate the effectiveness of the community-based DM programme for older people.

Methods:

An 8-week, 2 hour-session DM programme was designed, which involved 3 components: 1) educational talks; 2) behavioural strategy; and 3) group exercise. The programme was conducted by 1-2 trained health care professionals, who were not specialised in DM management, in various elderly centres in the community. People aged 50 and over, with confirmed diagnosis of DM and medication treatments (oral hypoglycemic agent or insulin injection), were recruited from community elderly centres and specialty out-patient clinic. A randomised controlled trial was initiated to compare the changes of outcomes between the intervention and wait-list control groups at the end of programme. In addition, focus groups were conducted to gather feedback from the participants.

Results:

Since 2008, 12 community elderly centres joined the programme, and around 200 older people with DM and their caregivers participated in the programme. Preliminary results showed that participants in the intervention group had significant improvement in systolic and diastolic blood pressure, DM knowledge, DM quality of life (reduced impact and worry), and mental health at 8 weeks. DM knowledge and mental health of participants in the intervention group were significantly improved when compared with those in the control group. The intervention group also showed trend of improvement in HbA1c level and random glucose. The focus groups revealed that the programme allowed them to share their experience, build supportive network and change their self-management behaviours.

More groups will be conducted in the coming months and the final results will be released in the end of 2009.

Conclusion:

The diabetes programme was accepted by the older people with diabetes and had a potential to improve their physical health and quality of life. The concept of this new model, using a programme with multiple components and non-specialist leaders, could be widely disseminated across both medical and social sectors.

Outreach Support

Mrs Victoria Kwok

In Hong Kong, both the medical and social welfare sectors have been providing various kinds of outreach support service to senior citizens living in the community, with frail health and chronic diseases. Practitioners in both sectors have long realised that medical or social community service alone do not give adequate support to senior citizens and unnecessary hospitalisation or pre-mature residential care is avoidable. In the past few years, both sectors have taken initiatives to roll out innovative integrated cross-sector outreach support services. Inter-sector outreach collaboration requires not only initiatives from practitioners and individual organisations. User buy-in and empowerment are also important. Government policies support and facilitation are crucial.

Dr Felix Chan

Medical & Social Integration: A Community Volunteer Service for Discharged Frail Elderly Patients in Hong Kong West

Introduction:

Elderly patients with multiple co-morbidities and inadequate social support are at high risk of hospital re-admissions. A community-based volunteer project initiated by the Community Service Team of Hong Kong West Cluster for the elderly was launched with the collaboration of 8 NGOs, including Aberdeen Kai Fong Welfare Association, Caritas - Hong Kong Aberdeen Social Centre for the Elderly, Sheng Kung Hui Western District Elderly Community Centre, St. James' Settlement Western District Community Centre for the Elderly, Hong Kong Red Cross, Hong Kong Women's Foundation Ho Kwok Pui Chun Social Centre for the Elderly, Hospital Christian Chaplaincy and Catholic Pastoral Care Services. Volunteers were trained and matched to provide regular home visits and phone contacts to the discharged frail elderly patients in their own neighbourhood.

Objectives:

1. To enable elderly people to stay healthy in the community;
2. To enhance post-discharge support to elderly patients through collaboration with the medical and welfare sectors;
3. To provide early and timely intervention by volunteers and community partners.

Methodology:

Patients with a "Hospital Admission Risk Reduction Programme for the Elderly" (HARRPE) score of 0.17 – 0.20 were recruited. Volunteers were matched according to their place of residence to provide psycho-social support to the discharged elderly patients. When ad hoc medical problems were encountered, volunteers were instructed to consult the social workers of their respective NGOs and a telephone hot-line operated by the community nursing service. Protocols were in place to facilitate the nurse's triage role for booking early general outpatient, specialist outpatient appointments or emergency department attendance. A pre- & post- 90 days design was adopted for evaluation and outcome measures included A&E attendance, hospital admissions and number of bed-days saved. Satisfaction surveys were conducted among the volunteers and the patients.

Results:

From April 2008 to October 2008, 90 patients were served. Their mean age was 79.8 years old, 51% were male and 11.9% of the patients lived alone. 75.6% of the elderly were previously not engaged in community social services. The number of Accident & Emergency attendance, number of Accident & Emergency admission and length of stay were decreased by 53.3% ($p<0.001$, paired t-test), 57.4% ($P<0.001$, paired t-test) and 44% ($p<0.001$, paired t-test) respectively.

Conclusions:

This collaborative programme of the Hong Kong West Cluster of Hospital Authority and NGOs, utilising existing community resources, is effective in building a post-discharge supportive network for the elderly, reducing unnecessary health services utilisation and saving health care costs.

Dr Bernard Kong

"Mr Watson, come here. I want you!"

This is the famous line from Alexander Graham Bell (1847-1922) who was better known as the inventor of the TELEPHONE.

On March 10, 1876, as he and Mr Watson set out to test their finding, Bell knocked over what they were using as a transmitting liquid-battery acid. Reacting to the spilled acid, Mr Bell was alleged to have shouted, "Mr Watson, come here. I want you!" Exactly what Bell shouted -- or whether the spilling of acid ever occurred -- is a matter of some dispute. Its result, however, was not. Watson, working in the next room, heard Bell's voice through the wire. Watson had received the first telephone call, and quickly went to answer it.

In any form of success, one of the key factors is good communication. Since 2002, Hong Kong East Cluster has worked on utilising telephone as a tool to communicate with high risk elders living within our service network. This paper described our evolution stage in development of verbal communication, computer technical support and the clinical support to make the project a success.

Since 2007, with the additional implementation of a Hospital Admission Risk Reduction Programme for the Elderly (HARRPE) and utilising the HARRPE score generated automatically on admission, we are able to focus on the target patients. Evaluation of outcomes showed that the programme has enabled the reduction of hospital utilisation compared with control groups: by up to 37% in Accident & Emergency Department (AED) attendances, 60% in AED admissions, 48% in non-AED admission, 26% in acute bed days, and 9% in non-acute bed days.

Hong Kong East Cluster will continue to improve on the present model and explore better ways to serve our ageing population.

Medical Social Integration from a Family Doctor's Perspective

Dr Sammy Tsoi

Providing effective, good quality care to elders in the community requires special effort, medical social integration in particular is necessary. In order to understand why family doctor can play a vital role in the delivery of such care, discussion on the following topics is deemed advisable.

- What are the differences between caring for a sick elder and a sick young adult?
- Why family doctors are in the best position to deliver community elderly care?
- Case examples to demonstrate why medical and social integration are necessary for the delivery of optimal community elderly care.
- What are the obstacles of providing elderly care by family doctors?

Role of CADENZA in Development of a Primary Care Model

Mr Peter Chan

The Jockey Club CADENZA Hub (賽馬會流金匯) in Tai Po is one of the major strategic initiatives of CADENZA to promote primary health and social care for the old and soon-to-be-old. It attempts to meet the needs of the following older persons: (1) recently discharged from the hospital; (2) with chronic conditions; and (3) to continue a healthy living in the community. The Hub is self-financed, one stop and user-focused, aiming at reducing the need of community and hospital care especially for older persons with chronic condition and promoting ageing in place.

The Hub will be managed by a team of multidisciplinary healthcare professionals who (1) are experienced in elder care; (2) practise comprehensive and preventive geriatric medicine, health and social care; and (3) adopt an integrated and not a "silo" approach in managing health and social issues pertaining to ageing. The Hub includes other alternate primary healthcare services such as Chinese medicine clinic, ear health, eye care and rehabilitation aids. It is hoped that older people, especially those with chronic conditions, will benefit from the integration of traditional and non traditional primary health and social care.