Seminar on Promoting Decentralized Rehabilitation and Prevention of Fragility Fractures in Community

Theme: Planning and utilization of the "Pilot Scheme on Community Care Service Voucher for the Elderly" on the Fragility Fracture Elderly

Perspectives from Medical Social Workers

Anne YUEN, MSW/BH/HA
Lorna TSANG, MSW/KWH/HA
Hong Kong
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- **Patient Journey** of Kwong Wah Hospital fragility fracture elderly
  - Admitted; for surgery; referred to orthogeriatric team (+ ICM) for ward consultation; transferred to Caritas Medical Centre for 2-week in-patient rehab or tr to Wong Tai Sin Hospital x rehab; discharge back to community
  - Integrated Care Model (ICM) provides max. 8-week community/home support service; +/- referred gov’t subvented Community Care Service upon discharge from ICM

- **Characteristics** of KWH orthogeriatric hip fracture pts

- **Service study** of KWH ICM orthogeriatric pts covered April – June 2013

- **Total 69 cases**
  - Male : female = 25 : 44 = 36% : 64%
  - Age range: 65-74 (6=8.6%); 75-84 (35=50.7%); 85-94 (24=34.7%); 95+ (4=5.7%)

<table>
<thead>
<tr>
<th>Age range (No.)</th>
<th>%</th>
<th>Male</th>
<th>Female</th>
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<tbody>
<tr>
<td>65-74 (6)</td>
<td>8.6</td>
<td>5</td>
<td>1</td>
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<tr>
<td>75-84 (35)</td>
<td>50.7</td>
<td>10</td>
<td>25</td>
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<tr>
<td>85-94 (24)</td>
<td>34.7</td>
<td>9</td>
<td>15</td>
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<tr>
<td>&gt;95 (4)</td>
<td>5.7</td>
<td>1</td>
<td>3</td>
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<tr>
<td>Total (69)</td>
<td>100</td>
<td>25</td>
<td>44</td>
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- No. of OAHR before admission – 21 (30%)
- Average LOS in: KWH – 14.03 (12.47 days) & CMC – 17.65; WTSH – 36.15. Average total LOS of KWH+CMC is 31.68 or KWH+WTSH is 50.18 days
- No. transfer out from KWH to rehab units (Total 55): CMC - 26 (38%); WTSH - 28 (41%); TMH - 1 (1.5%)
- No. discharge home (Total 36): from KWH - 8 (12%); (CMC + WTSH) - 28 (41%)
- No. discharge to OAH (Total 20): from KWH - 6 (9%) & (CMC + WTSH) - 14 (20%)
- No. of death (Total 7): at KWH - 2 (3%); CMC – 0; WTSH - 5

- Living alone – 9 (13%)
- Living with other – 60 (87%)
- Daytime alone – 11 (16%)
- Care-giver: self – 19 (28%); spouse – 17 (25%); children - 3 (4%); maid – 9 (13%); OAH staff – 21 (30%)
- Community service receiving / waitlisted – 15 pts
- Financial status: 20 (29%) pts on CSSA
- Direct-lift-landing vs non-DLL residence
  DLL - 60 (87%); lift+stairs - 6 (9%); no-lift - 3 (4%)

- No. referred for Home Support Team (meals) – 13 (19%)
- No. referred for PT – 18 (26%)
- No. referred for OT – 4 (6%)
- No. referred for nurse supervision – 1 (1.5%)
- If not recruited to ICM, referred Discharge Planning Service Team for phone FU – 31
- No. of OAHR before admission – 21 (30%)
- Out of 48 non-OAHR (70%), i.e. 47 home residents + 1 street sleeper, 27 pts recruited to ICM Case Manager for home support services (57%)

- Photos of non-DLL residences
From ICM → NGO CCS - Service gap? waiting time?
Waiting time for IHCS meals-on-wheels & escort service for FU:

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<tr>
<th>District</th>
<th>Meal-delivery</th>
<th>Escort</th>
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<tr>
<td>Yaumatei</td>
<td>Case by case</td>
<td>2 months</td>
</tr>
<tr>
<td>Sham Shui Po</td>
<td>2 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Wong Tai Sin</td>
<td>6 months</td>
<td>not wkly PT</td>
</tr>
<tr>
<td>Kwun Tong</td>
<td>3 months</td>
<td>not wkly PT</td>
</tr>
<tr>
<td>Diamond Hill</td>
<td>Short waiting list</td>
<td>w/ strict criteria</td>
</tr>
<tr>
<td>Chai Wan</td>
<td>Short waiting list</td>
<td>w/ strict criteria</td>
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- Waiting time for SWD Long Term Care (RCS & CCS)
- for Enhanced Home & Community Care Service: home exercise / PT training – 6-9 months
- for Day Care Centre, including Eligibility Screening – 6 months above
- for gov’t subsidised OAH – 6 mths for Enhanced Bought Place Scheme placement as a short cut to long term care
- for Care and Attention Home - 3.5 yr

Eligibility Criteria of SWD Pilot Scheme on Community Care Service Voucher for Elderly

- Those are on SWD Long Term Care Service Central Waiting List assessed as moderately impaired plus without receiving any residential care service or subsidized community care service.

Let us support the hip fracture orthogeriatric patients going home!

Thank you
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BY MSW / BH Ms Anne Yuen

Criteria for the issue of CCS Vouchers
1. Those applicants on the list of Long Term Care Services Delivery System (LDS);
2. Documents to be completed via the responsible worker (RW) if they are eligible for the CCS Vouchers;
3. Date of LTC matters a lot, since it can be backdated. A delay in one day really means delay in getting the CCS Vouchers.

Ways to help the frail elderly to be eligible for the Community Care Service Vouchers, just implemented in Sept 2013

1. Responsible worker to help fill in Form 1 of the Long Term Care Services during admission. It depends
   1. on the date of Form 1 lodged to respective SCNAMO (5 centres in Hong Kong)
   2. Date of assessment by the SCNAMO. Rarely assessment is done in ward.
   3. There is agency quota for MSW to conduct assessment for particular patient(s) in hospital

2. Missing out elderly are those not yet known to any social worker in hospitals or in the community, including Neighborhood Elderly Centre (NEC), District Elderly Community Centre (DECC), Integrated Home Care Services (IHCS) or SWD Family Service Centre;

• High Risk elderly: live alone, no relatives, hidden elderly, poor social support with no community support, elderly with high risk of fall and yet lack of insight about the risk;
• Elderly who cannot express his / her needs due to lack of knowledge, poor MMSE, cognitive impairment (mild or moderate), hearing impairment, poor vision
• Potential risks of fall causing Geriatric Hip Fracture.
• Medical Social Services at the Medical/Geriatric Ward Vs Orthopaedic Ward differ across clusters. Length of Stay allowed varied too. There is no alignment of Medical Social Services since HA MSWs and SWD MSWs are still working as “one country two systems”.
• As some of the patients will be discharged to the private aged homes, they may not be invited for health care vouchers. Very often, rehabilitation training is limited at the private aged homes.

Clinical Audit of MSW referrals at the Medical-Geriatric ward of sub acute hospital from Aug-Dec 2013
• Total= 56, Male =17, Female= 39, average age= 81.9; Length of stay = 27.8 days;
• Financial aspect: 5 pts - $2200p.m.
  3 pts - NDA
  4 pts - HDA
  27 pts - CSSA
  8 pts - OAA
  3 pts - No social security payments
• Extra Health Care Vouchers can help this group of elderly

Advocacy for the Need of the Registry of Illnesses
• The Cancer Registry has been set up for some time in Hong Kong
• the newly set up Registry of Geriatric Hip Fracture can help identify the group of elderly in need of rehabilitation in the community
The future set up of the Registry other illnesses e.g. Dementia, the Blind persons; the Hearing Impairments; the Registry of those elderly with high risk of falls for prevention programs initiated by the service providers
• Public health education to prevent fall is needed at Primary Care Level. This may help the public to be aware of the potential risks and help to reduce the risk of admission due to slip & fall. Social networking amongst different service providers can bring closer the gap of services in the community.

On waiting list of the long term care services: 17 patients;
Not on waiting list of LDS: 34 patients, that means they are not invited to the pilot scheme of Health Care Vouchers
• 2 patients on Bought Place schemes
• 2 missing data
• 52 patients transferred in from acute hospital-QEH; 4 patients transferred in from UCH;
• Discharge Destination:
• Returning home: 14 patients
• Private aged home: 19 patients
• Subvented old aged home: 6
• Death: 16
• Referrals to the KCC ICM (Integrated Care Model) = 12 patients, 43 without referral to ICM
• Limitation: No correlation done yet

**Case scenario**
Female/73

- lived at public housing unit, retired hospital supporting staff, on pensions and the $2,200 p.m. elderly allowance;

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<th>Admission History</th>
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- Readmitted on 27.4.2013 at Hosp A, A & E due to slip & fall; Geriatric Hip fractured, operation done at Orthopaedic ward, stayed till 11.5.2013 to another orthopaedic ward of the Rehab Hospital C, back to hosp A Ortho ward on 5.6.2013, D/C home on 28.6.2013.
- Patient called the safety alarm service, readmitted again on 3.7.2013, admitted to Hosp A Ortho ward, stayed for 2 months till 3.9.2013;

THANK YOU!
• Again readmitted less than 24 hours on 4.9.2013 Hosp A Ortho ward, discharged home on 8.11.2013;
• Patient discharged to private aged home on 16.1.2014.

Questions & Comments from MSW:
• What happened to this lady?
• Why frequently admitted?
• Her needs?
• She did stay at one hospital long enough for rehabilitation, but why turned up at A & E so often, about 7 times per year?
• Any community back up?

• Liaison work done, Patient applied for long term care services for 1 year, just opted for one specific subvented old aged home,
• On home help service for house cleaning, meals delivery
• ICM referred at Hosp A, no service rendered due to frequent admission;
• Patient shared being a retired G.S. only $49 per day compared to $100 per day for others

Patient was referred to see clinical psychologist due to depression, diagnosed as adjustment problem to disability in Dec 2013 at Hospital A; no other follow up counselling services;
Solution Focused Therapy applied by MSW to help patient think about options of care, including private aged home, maid, IHCS; Magic questions asked to find her strengths, wishes, what she can do better for herself in discharge planning...Happy ending upon discharge at Hosp B. (14.12.2012-16.1.2014)
• In hind sight, who really knows what the patient is thinking?
• How to empower a patient, especially the long stay patient or difficult patient known to both Ortho & Med wards, almost hospitals A, B, C of the same cluster. The length of stay matters if they added up, i.e., most of the time are spending in hospitals;
• The assessment of impact of such patient is crucial, whether the patient wants her life to be that way or any alternative;

• Empathy, trust and rapport is much needed to work with difficult patient for a better solution, to uphold the integrity and dignity of the vulnerable and frail elderly.
• Up till now, the patient has not been invited for the Health Care Voucher, she is staying at the private aged home since last discharge on 16.1. 2014. No A & E admission after the last discharge.
• There is no CGAT at the newly opened POAH; no Physiotherapist/ or occupational therapist. No referral to GDH upon discharge.
• Thank you for sharing the MSW perspectives