NEW FRONTIERS IN GERIATRIC SERVICE - THE COMMUNITY GERIATRIC ASSESSMENT TEAMS

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Summary

In line with the corporate vision of the Hospital Authority to lead in collaborating with other health care providers and carers in the community to create a seamless health care system, nine Community Geriatric Assessment Teams (CGATs) were set up in 1994. The CGATs serve to provide timely assessment and appropriate management of health problems, improve the interfacing between medical and social services, develop community based rehabilitation programmes, ensure appropriate placement of elderly people into residential care and promote the quality of care for elderly persons through training and education for professional as well as informal carers.

Specific service areas defined at this early stage of community aged care service in Hong Kong include the provision of specialist geriatric service to local subvented Care & Attention Homes (C&A Homes) through regular visits, pre-admission assessment for clients on the Central Infirmary Waiting List (CIWL), multi-faceted medical examinations for clients entering subvented C&A Homes, co-ordination of community domiciliary services and referrals to specialist outpatient departments and Day Hospitals.

The Ruttonjee Hospital - Buddhist Li Ka Shing C&A Home collaboration, commenced in May 1993, a pilot project of community geriatric outreach service, has already justified the value of its existence, by showing a significant drop in the number of attendances by the C&A Home residents to the Accident & Emergency Departments and the number of admissions to general hospital wards. Likewise, there has been a marked decline in the number of visits to the outpatient department, saving escort and transport time, and a decrease in the number of bed-days left vacant in the C&A Home.

As the community ages, the quality of life depends more and more on the availability and quality of health care. The care for the elderly requires sustained and concerted efforts among various service providers, namely, those in the medical, nursing, allied health professions and welfare sectors. The CGATs mission is to ensure that aged care services are not confined within the four walls of the hospital; it serves as a link between hospital geriatric service and community care.

Introduction

Along with socio-economic progress, good public health measures and improvement in our health care services, the people of Hong Kong have attained excellent health indices of life expectancy, infant mortality and maternal mortality rates. As a result, Hong Kong has become a rapidly ageing society, and in particular the percentage of "old elderly" people - 75+ and 85+, is increasing even faster. It is estimated that by the year 2000, over 15% of the local population will be aged over 60. (Census and Statistics Department, 1993)

Health problems associated with elderly people are often characterised by multiple pathology, chronic disability, atypical symptomatology, medication problems, together with diminishing family and social support. If these problems are not timely and appropriately managed, the clinical and functional conditions of elderly people will be prone to wide fluctuation and rapid deterioration. Health and welfare services for the frail and disabled elderly persons require sustained and concerted efforts met by various service providers, namely, those in the medical, nursing, allied health professions and welfare sectors.

The health care needs of elderly people can be listed as follows:

- Acute medical care
- Rehabilitation
- Respite care
• Long-term care
• Psycho-geriatric service
• Community care

A comprehensive geriatric service should either directly provide, or ensure that other agencies provide, all of the above elements to elderly disabled persons living within the catchment area.

Background

Hospital-based geriatric services

It is not surprising that elderly people are the major consumers of hospital services. Analysis of hospital data showed that 63% of our inpatients in a typical medical ward are aged 65 or above, and this percentage is increasing progressively. Of necessity, hospitals are required to meet the needs of the elderly individuals, who are admitted for two reasons:

• Treatment of an acute illness
• Assessment and management of a non-acute on-going problem/disorder, where formal or informal community support systems have failed

Due to inadequate responsiveness elsewhere in the health system, the latter group is particularly likely to present to general hospitals - a referral to the Accident and Emergency Department often being considered to be the only solution when the domestic situation reaches crisis-point. Once admitted, these individuals will require comprehensive assessment, and in many cases acute care, rehabilitation, and discharge planning. To ignore these needs and discharge the patient directly back into the community, in the hope that the existing fragmented community services will address them, is no longer acceptable, since it can be expected to lead to increased re-admission rates - the so-called “revolving door” phenomenon, worse clinical outcomes and a more expensive health care system. The existing geriatric services in the Hospital Authority are largely hospital-based. As at end of 1994, these comprise of 1064 hospital beds, 10 specialist outpatient clinics and 270 Day Hospital places.

Community-based geriatric services

Traditionally, care for elderly people in Hong Kong has been family based, care in dependency being the responsibility usually of the eldest son, whose duty is established in the notion of “filial piety”. Over recent years, the migration of younger family members, women’s greater participation in the workforce and the erosion of traditional values have reduced the availability of family support. A range of community-based geriatric services were therefore developed. These include home-help services, social centres, multi-service centres, day care centres, and community nursing, as well as institutional care by way of C&A homes, hostels, homes for the elderly and infirmaries. However, these community services are relatively under-developed. In these developments, the initiative and policy thrusts have come mainly from the voluntary agencies and non-government organisations. In addition, the private sector has been playing an important role in providing community support for elderly people. A significant number of elderly persons, whilst on the waiting list for subvented C&A Homes or infirmaries, are residing in private aged homes where the standard of care varies widely.

Interface between hospital services and community services

The link between hospital services and community services has traditionally relied on the dedication of medical social workers. However, there has been no other structured co-ordinating or communication mechanisms between the service providers in the medical and welfare sectors. The degree of integration and coordination depends very much on mutual good will between all different concerned parties.

Staff involved in institutional care for elderly people encounter much stress and difficulties in meeting the needs of the frail and disabled individuals. There has been a general lack of specialist multi-disciplinary geriatric service and support in C&A Homes, hostels and homes for elderly people. Visiting medical officers employed in these homes are usually general practitioners whose service tends to focus on primary medical care. Specialist geriatric support on the other hand, is quite inadequate. The scale of rehabilitation activities that can be carried out in these homes are therefore limited. When the clinical conditions of the elderly person deteriorate or when the carers face uncertainties in looking after them, there would be no alternatives but to send them to the Accident & Emergency Department.

From the results of a recently carried out survey involving 13 C&A homes during January to March 1993 by the authors, it was noted that 59 - 72% of home inmates were sent to out-patient clinic and 12-14% to A&E departments each month. Staff working in the hospital system are often then over-burdened with these unscheduled admissions which are perceived to be inappropriate and unnecessary. On the other hand, home operators face
tremendous difficulties in organising transport and escorts for their clients. It is believed that the poor interfacing between hospital and community services has led to much grievances and this may jeopardize the goodwill and trust between the frontline colleagues.

The Ruttonjee Hospital - Buddhist Li Ka Shing C & A Home Experience

The Ruttonjee Hospital-Buddhist Li Ka Shing C&A Home collaboration, was started on the 7th May 1993. The services provided by Ruttonjee Hospital included the followings:

- Visiting doctor service (specialist care)
- Specialist clinic at the aged Home
- 24-hour direct admission support
- 24-hour hot-line advice
- Specialist advice on client cares
- Educational lectures to staff
- Assessment for special allowances, infirmary placements and housing

The provision of specialist geriatric service at the C&A Home through weekly visits by geriatricians has resulted in the following achievements:

- There is high degree of integration between the two institutions. Apart from direct dialogue, actual collaboration in service delivery is reinforced.
- Improved quality of care of the elderly residents is provided. The visiting general practitioner is still available for providing primary care whilst the geriatrician can offer specialist advice and care.
- There is good continuity of care given to clients. They are treated and followed-up by the same team of service providers both in hospital and after discharge.
- Better understanding of service provision and environment settings on both institutions helps considerably the planning and management of health care to the elderly individuals.
- Through training and education programmes, the quality of care delivered by the Home staff is improved.
- There is the bonus of boosting the morale of the Home staff. Home operators and nurses feel they are readily supported by the hospital service.
- As evidenced by the statistical data, there has been a significant drop in - the number of visits to the outpatient department (Fig 1) by 39%
The number of the attendance by the C&A Home residents to the Accident & Emergency Department (Fig 2) by 35%
- the number of unplanned admission to general hospital wards (Fig 3) by 28%
- the number of bed-days left vacant in the C&A Home (Fig 4) by 16%
- The savings is estimated to be $63,000 per annum out-patient services and $1.45 million per annum for in-patient services.
- Other indirect savings such as ambulance transfer of residents to and from the service points cannot be accurately accounted for.

**New Frontiers - Community Geriatric Assessment Service (CGAS)**

The Ruttonjee Hospital - Buddhist Li Ka Shing C&A Home experience has thus given insights into a new boundary of geriatric care. In order to tackle the problems arising from poor interfacing between hospital and community services, nine CGAT’s were set up in mid-1994. The mission of this new service is to ensure that aged care services are not confined within the four walls of the hospital, and to enhance and preserve the health and quality of life of elderly person in the community through timely assessment and appropriate management. This is in line with the corporate vision of the Hospital Authority to lead in collaborating with other health care providers and carers in the community to create a seamless health care system.\(^7\)

The typical community geriatric assessment team comprises of geriatrician, occupational therapist, physiotherapist, community nurse/health visitor, medical social worker, and clerical officer.

The objectives of the community geriatric assessment service are detailed as follows:
- To provide timely assessment and specialised early treatment for elderly patients with chronic illnesses and special needs.
- To improve the interfacing between hospitals and welfare institutions at the district level.
- To develop and provide community based rehabilitation programme for elderly person.
- To ensure that placement into residential care for elderly persons is appropriate.
- To promote quality of care of elderly persons through teaching and education.

**Discussion**

It is believed that the CGAS will enhance the elderly persons’ health, functional status and quality of life. The CGAS will undoubtedly identify many previously unreported and undiagnosed treatable medical conditions in the elderly population.\(^8\)

Through timely assessment and appropriate management, the incidence of common “geriatric problems” such as polypharmacy, adverse drug reactions, inappropriate use of restraints and catheterization, pressure sores and faecal impaction etc will hopefully be reduced in the community care settings.

Through the provision of specialist multi-disciplinary geriatric service and the development of rehabilitation activities in the homes for elderly people, the standard of care can be upgraded. Deterioration in health will be deferred and the elderly persons can be trained to reach their maximal potential in terms of functional status. In addition, better support by the CGATs allow the C&A Home staff to save much administrative time and effort in arranging transport and escort for their residents to seek medical intervention outside the home. More time can be devoted to professional and personal care.

The dedication, goodwill and commitment of the community carers for elderly people are often taken for granted. In looking after the frail and fragile elderly persons, they face tremendous stress and strains.\(^9\) By the promotion of health education, training programmes and co-ordination of medical as well as social services for the elderly persons, the CGATs provide much valued support to the carers in the community setting, including those in residential homes and elderly persons’ homes.

It is well recognized that there are long waiting lists for subvented C&A Homes and infirmaries.\(^10\) There is no end to meet the forever increasing demand unless additional places in residential care are complemented by parallel improvement in community care in optimising the functional independence of elderly people. The CGAS will be an essential step in this direction.

As the community ages, the quality of life depends more and more on the availability and quality of health care. It is hoped that the CGAS will form a solid starting point towards better, sustained and concerted efforts in the delivery of care for elderly people in the community. Determination of priorities between curative and preventive care, institutional and community-based care, public and private services in the presence of limited resources make the tasks of the CGAS in its role in co-ordination of service difficult in the extreme. As well as structural problems, gaps in mutual understanding and some power struggle between professions need to be overcome.

In tracing the development of aged care services,
the intention of the medical sector to provide appropriately for elderly people become apparent. Over the years, those intentions have been overtaken by pressures on curative medicine and by the domination of the private sector in medical practice. As far back as 1938, the government identified the aged as a category in the Medical Department Statistics.11 In 1964, the White Paper on the Development of Medical Services in Hong Kong clearly identified the efforts of an ageing population on the demand for hospital beds. Development of geriatric service in Hong Kong has been slow since the setting up of the first government geriatric unit at Princess Margaret Hospital. However, elderly services have been well supported by the present Governor and the Hospital Authority in the past few years. More and more geriatric services have been set up. The CGAS has certainly become a new frontier in geriatric service. It serves as a vital link in the continuum of services for elderly people. Matching the appropriate service to the needs of the elderly persons is critical to well-being, particularly as this encompasses functional ability and quality of life - enhancing functional well-being is the highest goal of Geriatric Medicine. We strive to add life to years but not years to life. It is the CGAT’s responsibility, therefore, to coordinate the variety of aged care services in the community, the scope of care provided by each, and the accessibility of the service to our clients.

References
4. Utilisation of Medical Unit, QEH, Medical & Geriatric Unit, UCH by Age Groups from July to December 1993. Source M.R.A.S.