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People's Republic of China: Social Work Services Policy and Delivery Modes for the Elderly with Special Difficulties

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ABBREVIATIONS

ADB	–	Asian Development Bank
ADL	–	activities of daily living
CCM	–	chronic care model
CM	–	case management
CRN	–	community response network
ESD	–	elderly with special difficulties
IADL	–	instrumental activities of daily living
LTC	–	long-term care
MOCA	–	Ministry of Civil Affairs
NHS	–	National Health Service
PARR	–	Patients At Risk for Re-hospitalization
PRC	–	People's Republic of China

GLOSSARY

activities of daily living (ADLs)	–	Self-care activities that a person must perform every day, such as bathing, dressing, eating, getting in and out of bed, moving around, using the toilet, and controlling bladder and bowel. Often they are referred to as personal care.
access	–	Client ease of obtaining appropriate service.
advocacy	–	The act of recommending, pleading the cause of another; to speak or write in favor of.
assessment	–	A systematic process of data collection and analysis involving multiple elements and sources.
at risk	–	Exposure to the chance of injury or loss (e.g., harm) or dangerous condition (e.g., disaster)[1] and requiring temporary or ongoing intervention.
care	–	Means supervision that is provided to an adult who is: 1) Vulnerable because of family circumstances, age, disability, illness or frailty, and Dependent on caregivers for continuing assistance or direction in the form of personal assistance or services.
care coordination	–	The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care (AHRQ, 2007).

[1] http://dictionary.reference.com/browse/at--risk

care management	–	A health and social care delivery process that helps achieve better health outcomes by anticipating and linking clients with the services they need more quickly. This term often refers to the management of long-term health condition, legal, and financial services by professionals serving social welfare, aging and nonprofit care delivery systems. (Powell & Tahan, 2008).
case finding[2]	–	A strategy for targeting resources at individuals or groups who are suspected to be at risk for a particular disease. It involves actively searching systematically for at risk people, rather than waiting for them to present with symptoms or signs of active disease. Note the similarities to screening—both seek to risk stratify the population for further investigation.
case management	–	A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to facilitate an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes (CMSA, 2010).
certification	–	A process by which a government or nongovernment agency grants recognition to those who have met predetermined qualifications as set forth by a credentialing body.
client	–	Individual who is the recipient of case management service. This individual can be a patient, beneficiary, member, resident, or social service and/or health care consumer of any age group. In addition, when client is used, it may also infer the inclusion of the client's informal and formal support.
collaboration	–	An active and ongoing partnership, often involving people from diverse backgrounds who work together to solve problems, provide services, and enhance outcomes.
dementia	–	A loss of brain function that affects mental function related to memory impairment, low level of consciousness and executive function. The most common form of dementia is Alzheimer's disease.
disability or dependency	–	Inability to perform one or more ADLs without help. Specific definitions, i.e., how many ADLs, differ across countries making comparisons difficult.
eligibility	–	Entitlement of an individual to access the programs/services funded directly or indirectly by the Ministry of Health
frailty	–	A clinical syndrome that focuses on loss of reserve, energy and wellbeing. Older people with frailty tend to present late and often in crisis to health and care services so their care may be hospital-based, episodic and unplanned. Frailty should be reframed as a long-term condition that can be managed proactively in primary and community settings by supported self-management and person-centered care.[3]
home and community based care (HCC)	–	Services designed to help older people stay independent and in their own homes. It also applies to the use of institutions on a temporary basis to support continued living at home – such as respite care. Home care also includes specially designed,

[2] http://www.healthknowledge.org.uk/public-health-textbook/disease-causation-diagnostic/2c-diagnosis-screening/screening-diagnostic-case-finding

[3] http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/long-term-conditions-improvement-programme/frailty.aspx#sthash.18BLen8n.dpuf

assisted or adapted living arrangements for persons who require help on a regular basis while guaranteeing a high degree of autonomy and self-control.

instrumental activities of daily living (IADL) – Include help with housework, meals, shopping and transportation. They can also be referred to as domestic care or homemaking or home help.

interdisciplinary collaboration – A type of interdisciplinary (or professional) work involving various health and social care professionals, and others e.g., housing, who come together regularly to solve problems, provide services, and enhance health outcomes.

long-term care (LTC) – Is defined as a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living (ADL). This personal care component is frequently provided in combination with help with basic medical services such as nursing care (help with wound dressing, pain management, medication, health monitoring), as well as prevention, rehabilitation or services of palliative care. Long-term care services can also be combined with lower-level of care related to domestic help or help with instrumental activities of daily living (IADL). Divided into formal and informal long-term care where, on average, the latter makes up the bigger part.

Elements of LTC include, but are not limited to:

1. Maintenance of involvement in community, social and family life.
2. Environmental adaptations in housing and assistive devices to compensate for diminished function.
3. Assessment and evaluation of social and health care status, resulting in explicit care plans and follow-up by appropriate professionals and paraprofessionals.
4. Programs to reduce disability or prevent further deterioration through risk reduction measures and quality assurance.
5. Care in an institutional or residential setting when necessary.
6. Provision for recognizing and meeting spiritual, emotional and psychological needs.
7. Palliative care and bereavement support as necessary and appropriate.
8. Support of family, friends, and other informal caregivers.

Supportive services and care provided by culturally sensitive professionals and paraprofessionals.

outcomes – Measurable results of case management interventions, such as client knowledge, adherence, self-care, satisfaction, and attainment of a meaningful lifestyle.

provider – The individual, service organization, or vendor who provides health care services to the client.

risk and risk management – Risk can also be defined as a potential loss or harm. Risk management is the ongoing identification, assessment, prioritization, mitigation and monitoring of risk.[4]

[4] Efficiency Unit, Hong Kong Special Administration Region. 2010. *Guide to Corporate Governance for Subvented Organizations*. May. Hong Kong, China.

risk stratification:	–	The process of categorizing individuals and populations according to their likelihood of experiencing adverse outcomes, e.g., high risk for hospitalization.
social care	–	Social care services help people who are in need of support due to illness, disability, old age or poverty. It enables older people to remain living independently in their own home. If a person is no longer able to live at home independently, such as sheltered accommodation or extra care housing. Social care services are available to everyone, regardless of background. However, social care is subject to needs and financial assessment. Services can also support the families or carers of people who receive social care. The concept is widely used in UK and OECD, which is equivalent to the concept of home and community care in North America. http://www.nhs.uk/CarersDirect/social-care/Pages/what-is-social-care.aspx
standard	–	An authoritative statement agreed to and promulgated by the practice by which the quality of practice and service can be judged.
universal design	–	Or **inclusive design** refers to broad-spectrum ideas meant to produce buildings, products and environments that are inherently accessible to older people, people with and without disabilities. Principles of universal designs are: 1. Equitable use 2. Flexibility in use 3. Simple and intuitive 4. Perceptible information 5. Tolerance for error 6. Low physical effort 7. Size and space for approach and use http://en.wikipedia.org/wiki/Universal_design

NOTE

In this report, "$" refers to US dollars unless otherwise stated.

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A. Why We Did This Study

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2. There are three more specific report objectives, which are to:

(i) define and identify the ESD;
(ii) identify social service models for working with ESD; and
(iii) clarify the role of social workers in assisting ESD.

B. How We Did This Study

3. The report involved a literature review of experiences in Canada, Hong Kong, China (and/or Taipei,China, where applicable), the UK, and the US. Criteria for the selection of these localities were the presence of:

(i) active social and health services or related work pertaining to ESD or equivalent populations at risk;
(ii) various applied social and health service models for people with complex social needs, such as the ESD or an equivalent population at risk; and that the models identified could be easily adapted for use in the PRC;
(iii) international approaches used by PRC government agencies, such as the China National Committee on Ageing or Ministry of Civil Affairs (MOCA), in the past; and
(iv) sufficient documentation in English.

4. Where possible, the study involved expert informants, such as academics, policy analysts, and/or practitioners experienced in working with ESD in the selected localities.

C. What We Found

5. The ESD are not a unique feature of the PRC—other countries/regions have a similar social problem, although it may be referring ed to different terms, such as the "vulnerable elderly" or "elderly at risk". These localities have also been working towards better case finding mechanisms for ESD. This process involves developing standardized screening tools and making continuous improvement in tool predictability. Older adults found to be at risk are then stratified according to their level of risk into categories of "high", "moderate", "low" level, or "no risk".

6. ESD is a complex problem because its underlying causes may be multifaceted and intertwined. Some other countries and regions have tested a collaborative interdisciplinary approach toward the elderly at risk of abuse, and similar at risk groups such as those with chronic health and social conditions, sexually exploited children, or even whole communities experiencing tensions. This collaborative interdisciplinary approach is both proactive and aims

to prevent the occurrence or reoccurrence of harmful conditions, through means that could not be achieved by just one discipline, profession or sector. Collaborative interdisciplinary approaches involve direct intervention and the use of enabling strategies such as information sharing and integrated service, collaborative guidelines/protocols, care or case management; and the creation of a supportive social policy and environment.

7. Social workers play a significant role in such a collaborative interdisciplinary approach. The social worker may use direct interventions such as psychosocial support or person-system links. They can support the development and/or implementation of enabling strategies such as care management, service integration, and the creation of a supportive environment and social policies. Many social workers also assume the role of a case manager. In these localities, case management is not specific to a discipline or profession. Instead, it is a function undertaken by all professionals engaged in direct practice, and especially those working in health care, such as nurses, rehabilitation specialists, and social workers. Such case management can be intensive, supportive, or involve self-management, depending on the risk levels of the older person concerned. Professional case management bodies have also emerged and have helped to build case management competency, accreditation and registration.

D. What We Have Learnt Is Necessary

(i) Identification of ESD
- (a) Enrich the definition (and/or characteristics) of ESD.
- (b) Enhance the predictability of case finding or identification.
- (c) Improve case finding efficiency.
- (d) Make good use of social capital and risk management among ESD themselves.

(ii) A Collaborative, Interdisciplinary Model for Dealing with ESD
- (a) Create a bundled approach consisting of direct intervention and other enabling strategies.
- (b) Develop interdisciplinary collaborative approaches.
- (c) Foster government leadership of this collaboration.
- (d) Reactivate the role of social work within interdisciplinary collaboration.

(iii) Case Management
- (a) Use case management as part of ESD management.
- (b) Position the social worker as ESD case manager.
- (c) Ensure case management forms part of social work education/training programs.
- (d) Monitor case management at the levels of service and administration.

II. INTRODUCTION

"We cannot solve our problems with the same thinking we used when we created them."

- Albert Einstein.

A. Objectives

8. This report reviews international literature and good social work practices to examine how selected countries and regions:

(i) define and identify ESD;
(ii) determine social service models for working with ESD; and
(iii) delineate the role of social workers in working with ESD.

B. Background

9. The Government of the PRC requested support from ADB to strengthen policies and delivery modes for social work services for the elderly with special difficulties. A fact-finding mission took place in Beijing, PRC in January 2015, and the resulting project technical assistance report noted that:

> "The main demographic challenges facing the PRC in this century are the dramatic aging of its population, scale of internal migration largely driven by urbanization, and new social and economic vulnerabilities arising from these changes. The elderly with special physical, psychological, and/or financial difficulties now have more diverse and individualized needs. They require a combination of targeted poverty-reduction measures and affordable medical and social services…A range of gender-related disparities include women's poorer health status, lower cognitive performance, and poorer financial security than men of similar age".[5]

10. The PRC has responded to overall elderly care needs with new policy and legal initiatives, including its Twelfth Five-Year Plan for the Development of Social Care Services for the Elderly (2011–2015) and the revised Law on the Protection of the Rights and Interests of the Elderly (2013). Both of these documents call for developing social services for the elderly, including through:

(i) expansion and professionalization of elderly care social workers, social work standards, and the social work sector and
(ii) encouragement for government agencies and social organizations to engage in the delivery of outsourced elderly care social services.

11. These documents have been supported by guidance on implementation modalities. For example, the Opinions on Strengthening the Development of Professional Social Workers, jointly issued by 19 ministries; the Medium- and Long-Term Development Plan for the Development of Social Work Forces (2011–2020); and the Guidelines for Government Purchase of Social Work Services, which included using state lottery funds to fund government outsourcing of elderly care services to social organizations. The reform agenda of the Third

[5] ADB. 2015. *Technical Assistance to the People's Republic of China for Social Work Services Policy and Delivery Modes for the Elderly with Special Difficulties*. Manila.

Plenary Session of the 18th Central Committee of the Chinese Communist Party in November 2013 called for acceleration of these reforms to improve and expand the provision of social services, such as education, health, elderly care, and social protection, and ensure the benefits of development became more equally shared by all.

12. However, several key issues now require urgent action to promote professional and community-based social work and the outsourcing of ESD focused social services:

(i) development of a strong policy framework and guidelines for ESD care;
(ii) development of a rewarding career path for social workers, starting with appropriate education and training, and decent pay and working conditions; and
(iii) better government procurement mechanisms, including volunteer incentive mechanisms, and the incorporation of ESD services into social organization-operated programs for elderly care, community development, and poverty reduction, particularly in remote or difficult-to-access conditions.[6]

13. The MOCA request for ADB technical assistance also included better understanding (i) international and national trends in professionalizing social work, especially to provide services to the elderly; and (ii) tools to MOCA to standardize, monitor, and evaluate social work services for the ESD. Such improved understanding would strengthen the education and practical experiences of social workers and social organizations caring for ESD, and provide more effective and relevant social support and delivery modes that could potentially be replicable nationwide.

C. Methodology

14. This review of relevant regional and international experience mainly draws on literature from Canada, Hong Kong, China (or Taipei,China), the UK, and the US. Criteria for localities selected were that they had:

(i) active social and health service activities or related work for populations with complex social needs, such as ESD;
(ii) various social and health service models to assist people with complex social needs, such as ESD or equivalent populations at risk; and that these models could be easily adapted for the use in the PRC;
(iii) been used by PRC government agencies in the past, such as the China National Committee on Ageing, MOCA for cross-national study; and
(iv) sufficient documentation in English.

15. Research for this report also involved expert informants, where necessary and possible. These included academics, policy analysts, and experienced practitioners working with ESD in the selected countries and regions.

[6] Social organizations are defined as not-for-profit organizations that are formed voluntarily by Chinese citizens in order to realize the shared objectives of their members, carrying out activities in accordance with their charter. (Government of the PRC, State Council. 1998. *Regulations on the Registration and Administration of Social Organizations.* Beijing).

16. **Differences in context.** The introduction of universal and occupational pensions in most developed countries (such as Canada, the UK, and the US) has helped to limit and manage elderly poverty, and particularly absolute poverty.[7] However, comprehensive pension and/or social security systems are only just developing in the PRC and Hong Kong, China. Thus, elderly poverty may still be an important indicator of ESD in these localities.

17. Moreover, the development and formulation of elderly care policy, funding, and programs in Canada, the UK, and the US is undertaken by both health authorities (i.e., the Ministry of Health) and the social service administration (i.e., the Ministry of Civil Affairs). Social workers are employed in both of these systems. This may not be the case in the PRC and Hong Kong, China, where the PRC Ministry of Civil Affairs or the Hong Kong Department of Social Welfare, which is the official champion for elder care. In this situation, social workers are predominantly employed in the social service sector.

18. The report found that much good ESD service practice was health related. This may therefore necessitate a forward looking approach toward better integrating PRC healthcare with social care and services. Social work and health, particularly public health, have traditionally been good partners as two disciplines that share one mission from two perspectives. Social and health workers also function well together and a number of US universities offer joint MSW/MPH degree programs (Pelt, 2009).

D. Report Structure

Section 1: Objectives and methodology
Section 2: How selected localities define and identify ESD or equivalent populations
Section 3: ESD service models used in other localities and similar issues. The selected models are not necessarily social work specific since most selected localities have abandoned a discipline-specific approach for addressing complex social issues.
Section 4: The role of social workers in a collaborative and interdisciplinary ESD working model is that focused on case management.
Section 5: A summary and some general principles for next steps

Note: Good practices are highlighted in each section of the report in terms of study objectives, rather than by locality.

[7] http://www.conferenceboard.ca/hcp/details/society/elderly-poverty.aspx

III. DEFINING AND IDENTIFYING THE ELDERLY WITH SPECIAL DIFFICULTIES

"If I had an hour to solve a problem I'd spend 55 minutes thinking about the problem and 5 minutes thinking about solutions."

– Albert Einstein.

A. Introduction

19. **The elderly with ESD.** In 2013, the PRC had 100 million elderly living in "empty-nest" households (without co-resident children), a 100 million living with chronic illnesses, 50 million isolated in rural areas, 38 million unable to perform daily activities, 23 million impoverished or on low incomes, and 10 million having lost their only child. The number of elderly aged 80 years and over had reached about 22.7 million. Moreover, a range of gender-related disparities include the poorer health status of elderly women, their lower cognitive performance, and poorer financial security than men of a similar age (ADB, 2015).

B. Why Focus on the Elderly with Special Difficulties

20. Concern for people in difficulty, including the elderly, is driven by societal values of humanity, love and kindness. The innate desire to alleviate suffering and "treat others as you would like to be treated" is an ancient and universal norm, and can also be found in Confucianism. Compassion is also a measurable indicator of community wellbeing and the wellbeing of all its members. Both compassion and humanity are essential ingredients in building and maintaining thriving, healthy, resilient and innovative enterprises, institutions, and communities.[8]

21. Failure to address the needs of ESD may also have significant ramifications for society beyond the norms of compassion and humanity, such as[9]

(i) serious adverse effects on human health and life expectancy e.g., due to serious nutritional deficiencies;
(ii) extensive human suffering and misery with significant environmental and social flow on effects, such as economic desperation leading to environmentally destructive deforestation for fuel.;
(iii) loss of a potential talent pool and consumer markets for business;
(iv) social unrest; and
(v) enormous loss of human productive capacity e.g., through precluding the elderly from becoming either customers or productive employees, especially when the elderly population is increasing.

22. Addressing the needs of ESD is particularly important in the PRC as it is a traditional Chinese cultural practice to honor filial piety and respect the elderly.

C. Characteristics of the Elderly with Special Difficulties in the PRC

23. ESD in the PRC are likely to experience at least several of the following conditions:

[8] https://charterforcompassion.org/node/8015
[9] Kiernan, M.J. (2009). *Investment in a Sustainable World.* AMACOM. New York. pp 104–105.

(i) living in "empty-nest" households;
(ii) having chronic illness(es);
(iii) being left behind alone in the countryside after family members have migrated;
(iv) being unable to perform daily activities;
(v) living in poverty or on low incomes;
(vi) having lost their only child;
(vii) being aged 80 or over; and
(viii) being female. There are a range of gender-related disparities of the elderly including poorer female health status, cognitive performance, and financial security compared with older men of a similar age.

24. The number of elderly with these characteristics, (excluding gender-related factors), was estimated to be about 22.7 million in 2013.[10] Since these ESD are, by definition, in need of social assistance and support, this potential burden on society is huge.

D. The Elderly with Special Difficulties, the Vulnerable Elderly, or Elderly at Risk

25. The elderly with characteristics outlined above are not unique to the PRC. Difficulties faced by elderly in the rural US are very similar to those of elderly in the rural PRC. Census data indicates that the most rapidly aging localities in the US are not the popular retirement spots, but rather the withering, remote places from which many younger people flee. For decades, the major export commodity of these towns has been these young people, shipped out for education and jobs, mostly never to return. It is the elderly who remain— increasingly stranded and isolated—facing an existence that is made intrinsically harder by virtue of geography compared with life in the cities and suburbs. Public transportation is almost unheard of. Medical care is only accessible in some localities and cellphone service can be unreliable. Even religion and the internet differ in rural areas. Churches have either consolidated or closed—a particular hardship for older people, who tend to be avid churchgoers. And a lack of high-speed broadband service in many rural areas compounds the sense of separation from children and grandchildren, as well as the wider world.[11]

Case Study 1: Life is Distinctly Harder for Elderly in the Rural USA[12]

Verna Bairn, 67, is a farm widow who has lived all her life in Oshkosh, Nebraska, about 115 mostly empty miles southeast of Lingle. She has seen the young people leave she said, and the businesses on Main Street close. She has seen the median age in Garden County—where Oshkosh, with a population about 900, is the county seat—climb from 45 to 50 years old, according to the census, more than 10 years older than the national average. The counties in northwest Nebraska are now some of the oldest in the country: "One foot in the grave, the other sliding," said Ms. Bairn in describing her town. Ms. Bairn has a daughter in Wyoming and a son in Wisconsin. Her husband, Edgar, died of cancer at 60 in 1998. "He and I had one plan for our life, and God had another," she said of her husband's early death and the personal hard times that followed. "We played our cards the best we could." In fact, it is quite easy to find older people who take comfort in the surroundings they have known since they were young, however difficult things have become. Memory is everywhere, and hardship has been their norm in life, and so many say, what's new?

[10] Government of the People's Republic of China, Ministry of Social Affairs. 2013. *Report on the Development of Elderly Undertakings in China*. Beijing (internal government publication).
[11] Johnson Kirk. 2009. For Elderly in Rural Areas, Times are Distinctly Harder. *The New York Times*, Dec 9, 2009. Sources: http://www.nytimes.com/2009/12/10/us/10rural.html?_r=1
[12] Johnson Kirk. 2009. For Elderly in Rural Areas, Times are Distinctly Harder. *The New York Times*, 9 December. http://www.nytimes.com/2009/12/10/us/10rural.html?_r=1

26. In the countries/regions selected for comparison in this report, the elderly with similar ESD characteristics are typically referred to as (i) the vulnerable elderly and (ii) the elderly at risk.

27. **The vulnerable elderly** are disadvantaged in some way. Typically, they have less power and fewer resources than the majority of their peers, and are less capable of protecting their own interests.[13]

28. **The elderly at risk** are those elderly exposed to the chance of injury or loss (e.g., harm) or dangerous conditions (e.g., safety),[14] and may require temporary or ongoing intervention (e.g., social resources).

1. Conceptual Differences between ESD, Elderly at Risk, and the Vulnerable Elderly

29. The concepts of ESD, elderly at risk, and the vulnerable elderly may sound similar, but they differ conceptually. Firstly, the elderly at risk and the vulnerable elderly are important concepts in identifying elderly in need of help or case finding (see glossary). It is unclear if ESD constitutes a case finding or screening mechanism. Secondly, elderly that meet the "at risk" or "vulnerable" criteria may still not need assistance. Whether or not an elderly person at risk or vulnerable actually needs assistance depends on the outcome of a subsequent "needs" assessment. By definition, ESD seems to suggest that the elderly with ESD characteristics are people in need of support, assistance, or services. However, it is unclear if there will be a subsequent needs assessment to determine their eligibility for ESD public assistance or services. Thirdly, a risk stratification system underlies the concepts of vulnerable elderly and the elderly at risk. People's risk levels are stratified into high, moderate, low, or no risk and service intensity is adjusted to these levels of risk. The concept of ESD makes no distinction between levels of need and also seems to suggest that the needs of all ESD are equal. This may also be unfair for people with more needs, since they may not receive the intensity of service necessary to alleviate their difficulties. Therefore, allocating services equally to all people with ESD characteristics may not make good use of private and/or public resources.

30. The concepts of "elderly at risk" and "vulnerable elderly" have different origins. Elderly at risk is about the probability of a harmful event (injury or loss). That harmful event may or may not occur and the individual may or may not be affected by it. Thus, "at risk" is an issue of likelihood or probability, whereas vulnerability is a *de facto* disadvantageous situation. The concept of elderly at risk is closely linked to risk management. Risk management involves risk assessment to determine the degree of risk by weighing up its potential benefits and harm. This is then used to develop a strategy for dealing with potential risks and to reduce or prevent the likelihood and effects of any harm, including positive risk taking. Any policy initiative should therefore aim for risk preparedness through adoption of a risk identification and stratification system, with mitigation and damage control strategies.

31. Social value affects how society views "vulnerabilities", whether as victims or sinners, and thus whether or not public assistance should be provided. Vulnerability has also been viewed from the perspective of capacity and social capital. Graz (1997) of the International Red Cross and Red Crescent Movement defined "the vulnerables" as "those at greater risk from

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[13] http://www.feinsteininstitute.org/wp-content/uploads/2014/09/PREP-15__FINAL.pdf
[14] http://dictionary.reference.com/browse/at--risk

situations that threaten their survival or their capacity to live with a minimum of social and economic security and human dignity." In Graz's view, even the most vulnerable person may have some skills, resources, and strengths for self-help and perhaps to help others. This perspective is consistent with the European understanding of vulnerability, which considers the vulnerable elderly as those whose reserve capacity has fallen below the threshold needed to cope successfully with the challenges they face. Thus building the capacity of a vulnerable person or making good use of their remaining capacity may help them to reduce their own and even other's vulnerability. Social policy initiatives should therefore ensure that people reach later life with more 'reserves', fewer later life challenges, and sufficient compensatory supports. Programs that promote a lifetime of healthy lifestyles, and the acquisition of coping skills, strong family and social ties, active interests, savings and assets, will develop reserves and ensure that people are strong in later life (Grundy, 2006).

Case Study 2: The Elderly Helping the Elderly[15]

Agustina Badia is 82 years old. For the past eight years, she has been living in an apartment building owned by the Barcelona Red Cross. The building provides housing to the aged of Barcelona. Agustina moved in because she was living alone and could no longer climb the stairs to reach her third floor apartment.

Many of the volunteers in the Barcelona Red Cross know a great deal about being vulnerable. They were once, or still are, receiving assistance from the Red Cross. The Spanish Red Cross has organized a campaign to include its beneficiaries as volunteers in the planning and management of agency programmes. This is all part of the effort by National Societies and the International Federation to enhance people's capacities and build up local support services for the most vulnerable in the community.

Agustina is volunteering with her local chapter of the Red Cross. She has been visiting Florinda, a 77 year old who has problems walking and cannot get out of her house. "I go to see the doctor for prescriptions then I go to the pharmacy to buy medicines and take them home to Florinda. Afterwards we spend a long time talking. In our talks, we remember old times and former neighbours. My visits to Florinda are very pleasant for both of us. It is like taking a great trip back to the past."

Agustina is grateful for the assistance she has received from the Red Cross, but she is even more pleased to be a volunteer. As she says, "I have learned a great deal from all this experience. Indeed, perhaps, the most important part of giving oneself to others is all that one can learn."

32. Vulnerability in the US has been linked to individual social capital i.e., those personal networks that link people together in useful ways (bridging capital) and which build reciprocity and social solidarity through shared norms and loyalties (bonding capital). Building individual social capital can become a way of tackling one's vulnerability (Mechanic and Tanner, 2007).

Case Study 3: Toughened by the Experience

Frank Robinson, 92, had to quit school at 16 and take over the family farm, near Oshkosh, when his father died in 1934 during the depths of the Great Depression. He said he remembered times when the cash economy had all but broken down in rural Nebraska and bartering was the only way to put food on the table—trading milk and cream from his family cows for what others in town had to spare. He worked the land for the next 61 years before retiring and moving into town in 1994. Now a widower, with his extended family and step children far away, Mr. Robinson

[15] http://www.redcross.int/EN/mag/magazine1997_3/2-7.html

occasionally hears suggestions from friends that he might be happier in an assisted living community somewhere. Those friends say the idea goes in one ear and out the other; still, Mr. Robinson bemoans the increasing difficulty of staying where he is. “I don’t see how these towns can keep on going,” he said, sitting ramrod straight in a housing project meeting room, a feed store cap on his head. “Years ago on a Saturday, Main Street was filled solid with people, and there was two or three cafes to eat at—it might be 10, 11 o’clock before they went home,” he said. “Now on Main Street on Saturday, there’s nothing.”

Ms. Clark, an 80 year old with a bad hip, said she did not suffer from solitude either. Her chair is positioned to look through the big picture window that dominates her living room. On a clear day, you can see across her land and all the way, 60 miles or so, to Laramie Peak. It is a landscape drenched with the memory, she said, of her husband, Leo, who died last year after a long illness, and the six daughters they raised together on the land. “I sit, and I look,” she said.

33. One way of looking at the concept of “at risk” and “vulnerability” is that when a potentially harmful event (risk) turns into a personal disadvantage, it makes the person vulnerable (vulnerability).[16] If the risk is managed well, the probability of the person becoming vulnerable may be mitigated, reduced, or prevented. Even when an older person is vulnerable, his or her need for help or assistance will depend on individual capacity. Thus, the vulnerable elderly may still have the capacity to withstand disadvantageous conditions.

Case Study 4: Building Social Capital for Elderly in Taipei,China

According to a 1998 study, 27 per cent of Taipei,China elderly that lived alone or only with their spouse were in poverty. In general, women were poorer than men, and older women living alone were the poorest group. So, vulnerability varied with gender and increased among those living alone (Smeeding T. et al., 2008. p.9). Being able to share living arrangements was thus considered a protective factor against poverty and a component of the social safety net. Moreover, when the income of the elderly was split from his/her nuclear families, the poverty rate of the elderly would increase to 45%. Thus, other household members contributing to the income of elderly affected whether or not the elderly lived in poverty. In addition, 90% of the elderly lived in a home owned by themselves or another household member. This was significantly higher than in western countries with a lower poverty rate. And finally, the elderly in Taipei,China relied little on income from private saving despite the overall high personal saving rate in Taipei,China. There was thus some capacity for poverty alleviation. In another study undertaken of 1,000 elderly aged 65 to 74 in 2001, religious attendance of the community-based elderly was found to a protective factor against geriatric depression. Those who never attended religious activities were 2.70 times more likely to be depressed compared with those who attended religious activities, even after socio-demographics and social capital were taken into consideration (Hahn et al., 2004). Shared living arrangements, income contributed by other household members, home ownership, personal savings and religious attendance were all potential forms of social capital for the elderly tackling vulnerability in Taipei,China.

34. Vulnerability can be either temporary or persistent. It is temporary during particular crises such as acute illness, family breakup, unemployment, or community disasters. However, people and communities may also face persistent and permanent vulnerabilities through a long-term pattern of severe or persistent poverty (even from one generation to the next), chronic unemployment or illness and disability. Vulnerability among the elderly tends to be persistent.

[16] http://www.redcross.int/EN/mag/magazine1997_3/2-7.html

They are likely to have profound and persistent disabilities that require intensive and continuing care and social support.

35. For the purpose of this report, the terms ESD, vulnerable elderly, and elderly at risk will be used interchangeably.

2. Characteristics or Indicators of the Vulnerable Elderly and the Elderly at Risk

36. The concept of the vulnerable elderly or elderly at risk has been used to identify or case find those elderly who are

(i) generally vulnerable;
(ii) at risk of abuse or maltreatment;
(iii) at risk of extra health care needs; and
(iv) vulnerable in a particular situation, such as a community in transition, disaster, etc.

37. The following people are considered to be generally vulnerable in the US: the poor, uninsured, homeless, elderly and frail, those suffering from a range of chronic diseases, or being special populations in need, such as Native Americans or low-income veterans. According to Mechanic and Tanner, the US list of vulnerable people has not changed significantly since 1987 (2007).

38. The UK government has issued English Indices of Deprivation annually since 1970. These indices aim to create a simple local measure for deprivation in England that is made possible through the availability of local level administrative data. The indices are not age specific and are used to reflect the level of deprivation among all UK communities. However, the elderly and children are likely to be the most affected population and at risk or vulnerable in deprived areas. These indices have been used by central and local governments, for-profit or not-for-profit service providers, to develop strategies and target interventions.

39. Deprivation is made up of the following seven domains (Department of Communities and Local Government. 2015):

(i) **Low income:** the proportion of the population that experiences deprivation due to low income. This includes two sub-indices:
  (a) Income deprivation affecting children, and
  (b) Income deprivation affecting older people (aged 60 and over).
(ii) **Employment:** the proportion of the population involuntarily excluded from the labor market.
(iii) **Health and disability:** the risk of premature death or impaired quality of life through poor physical or mental health.
(iv) **Education, skills, and training:** the lack of educational attainment and skills in the local population – children, youth and adults.
(v) **Barriers to housing and services:** the physical and financial accessibility of housing and local services.
(vi) **Crime:** the risk of personal and material victimization at local level.
(vii) **Living environment:** local environmental quality.

40. These indices also recognize that not every person in a highly deprived area will be deprived themselves and there will be some deprived people living in the least deprived areas.

41. A study report of individuals aged 65 years and over and living in Metro Vancouver and the Sea to Sky corridor, and in the United Way of Lower Mainland, British Columbia, Canada, identified certain elderly groups as mostly vulnerable. These included

(i) the “oldest old” women (85+),
(ii) unattached, single-income seniors,
(iii) visible minority seniors,
(iv) aboriginal seniors,
(v) recent immigrant seniors,
(vi) seniors without a certificate, degree, or diploma, and
(vii) seniors with mobility limitations and/or chronic illnesses.[17]

42. These groups of elderly were very likely to lack material resources and/or social support, to be excluded from full social participation, and to live in areas with high levels of deprivation: the inner cities and isolated rural communities.

43. In 2008, Hong Kong, China initiated a new service for the “hidden and vulnerable elderly”, defined rather broadly as those who

(i) were socially disengaged;
(ii) did not know where to seek help when needed;
(iii) were not known to the current social support network;
(iv) lived alone or only with a spouse;
(v) did not have support from family or friends; and
(vi) did not have a normal social life.

44. More specifically, these “hidden and vulnerable elderly” were

(i) “disengaged” from the community. They might be unaware of available services due to illiteracy or low level of education or physical or social isolation (e.g., those living alone or in remote place, lack social networks, or isolated or excluded due to ill health or lack of financial resources); and
(ii) might have some special or unfavorable circumstances, e.g., they did not get along well with their families and had no financial capability on their own, but were not eligible for assistance after taking into account of their total family income and assets (SAGE, 2009, p. 6).

45. The definition of “hidden and vulnerable elderly” used in Hong Kong, China differs from other localities in being more focused on psycho-social and economic aspects and less on physical aspects such as diseases, functionality and disability. This lack of specificity by the Hong Kong government gave significant leeway for the District Elderly Community Centre (DECC) and the Neighborhood Elderly Centre (NEC) — two government contracted organizations responsible for the identification and interventions of the “hidden and vulnerable” elderly.

[17] United Way, 2011, P.11

46. Another use of the concept of “elderly at risk” or “vulnerable elderly” is in the prevention of elderly abuse or maltreatment. Two social workers in Ontario, Canada, identified five characteristics of the elderly at risk of abuse in rural communities (MacKay-Barr and Csiernik, 2012):

(i) being socially isolated, as the abused usually had fewer contacts than the non-abused elderly;
(ii) a poor quality, long-term relationship between the abused person and the abuser;
(iii) a pattern of family violence arising from the abuser having previously been abused as a child;
(iv) dependence of the abuser on the abused for instrumental support, such as accommodation, finances, and/or emotional support; and
(v) an abuser with a history of mental health problems e.g., suffering from a personality disorder or from substance abuse problems.

47. Vancouver Coastal Health, British Columbia, Canada considered older adults with the following conditions to be highly complex and at risk of high health care utilization:[18]

(i) Family/Caregiver Indicators (8)
  (a) No primary caregiver or the primary caregiver not living with the client.
  (b) Open expression of conflict with family/friends.
  (c) The caregiver is unable to continue providing care.
  (d) Caregiver is unsatisfied with level of care.
  (e) Caregiver expressed feelings of distress/anger/depression.
  (f) Potential for abuse/neglect.
  (g) Caregiver and client goals of care are not congruent.
  (h) Presence of dependents.
(ii) Client Psychosocial Indicators (6)
  (a) Awareness and acceptance of prognosis.
  (b) Client exhibiting depression.
  (c) Client exhibiting anxiety.
  (d) Client exhibiting anger
  (e) Client expressing the presence of unresolved life issues.
  (f) Cultural considerations and/or beliefs that influence the provision of care.
(iii) Environmental/Economic Indicators (5)
  (a) Limited financial resources.
  (b) Economic trade-offs.
  (c) Environment is not necessarily safe to provide care.
  (d) Environmental Clinical Assessment Protocols (CAP) are triggered.
  (e) Client would ideally receive a treatment, but it cannot or will not be provided.
(iv) Clinical/Care Indicators (9)
  (a) Three or more fluctuating health criteria.
  (b) Cognitive Performance Scale rating (degree of impairment).
  (c) Lack of a primary medical practitioner.
  (d) Specialized educational needs of client/caregivers exist, together with technical equipment or an involved regimen.

[18] Vancouver Community Services Redesign Integrated Team. 2004. *Client Population Definitions: Specific Complexity Indicators*. Vancouver Coastal Health Services. Available at: Dropbox\ADB_SW for elderly\case management\complex care package

(e) High priority care issues in more than one domain (e.g., nursing, personal care, equipment, etc.), that require intensive care planning and intervention. This may only be short term.
(f) Lack of congruence between providers over the care plan and/or goals of care.
(g) Lack of congruence between providers and client/family over the care plan and/or goals of care.
(h) Long history of substance use.
(i) Active substance use.

48. In comparison with the Canadian approach, the UK National Health Services (NHS) uses over 20 “at risk” indictors grouped into four main categories of patient and community characteristics, diagnosis, and prior use of health services. These aim to predict the risk of future health care utilization, especially relating to hospital and emergency room admission. The NHS variables (Appendix 2) have a strong medical orientation e.g., toward diagnosis and prior health care use. Therefore, these indicators may not be entirely suited to the situation of ESD. However, they can provide a good reference for developing a similar mechanism targeted toward ESD.

49. The US Government uses the acronym CMIST or Communication, Medical, Independence, Supervision, and Transportation services, to describe the needs of people at risk before, during, and after a disaster. CMIST consists of detailed characteristics about people who are at risk and/or vulnerable. In reality, the majority of these people are actually the elderly.

(a) Communications

50. People with limitations that affect their receipt of, and effective response to, information can still be considered self-sufficient, but they need information provision in a way that they can understand and use. This relates to a very large number and diverse group of those who will not be able to (easily) hear, see, or understand. This group includes people who:

(i) are from culturally diverse groups;
(ii) have limited or no ability to speak, read, or understand English;
(iii) have reduced or no ability to speak, see, and hear; and
(iv) have limitations in learning and understanding.

(b) Medical

51. This refers to people who are not self-sufficient and do not have, or have lost, adequate support from family or friends and need assistance with:

(i) activities of daily living such as bathing, feeding, toiletry, dressing, and grooming;
(ii) managing unstable, chronic, terminal, or contagious health conditions that require observation and ongoing treatment;
(iii) managing medications, intravenous (IV) therapy, tube feeding, and/or regular reading of vital signs;
(iv) dialysis, oxygen, and suction administration;
(v) managing wounds, catheters, or ostomies; and
(vi) operating power-dependent equipment to sustain life.

52. A great majority of people requiring medical assistance are the elderly.

(c) Independence

53. People who have difficulties in maintaining functional independence:

(i) **medical stabilization:** replacing essential medications for blood pressure, seizures, diabetes, etc., and
(ii) **functional mobility restoration:** replacing lost or damaged durable medical equipment (wheelchairs, walkers, scooters, canes, crutches, etc.), and essential consumable supplies (catheters, ostomy supplies, padding, dressings, sterile gloves, etc.), and assistance with orientation for those with restricted vision.

(d) Supervision Needs

54. People at risk of losing adequate support from family or friends:

(i) people who require assistance from a personal care attendant;
(ii) people affected by transfer trauma, trauma stressors that exceed their ability to cope, or overall lack of ability;
(iii) people who function in a foreign environment;
(iv) people with conditions such as dementia, Alzheimer's and psychiatric conditions such as depression, schizophrenia, or intense anxiety;
(v) people who function adequately in a familiar environment but become disoriented and unable to function in an unfamiliar environment; and
(vi) unaccompanied children.

55. Again, a great majority of those people at risk of losing adequate support or friends are likely to be elderly.

(e) Transportation Needs

56. People who cannot drive due to disability, advanced age, addictions, legal restrictions, etc. (Littman, 2005). This may include people who are old, poor, and people who need wheelchair accessible transportation.

57. These people are particularly vulnerable in any disaster situation.[19] Such disasters can be natural, e.g., earthquakes or hurricanes, and/or non-natural, such as communities in transition e.g., the Oshkosh, Nebraska case study cited earlier.

58. The UK has adopted a much simpler definition than the US Government definition. The 1995 definition used by the Research and Planning Department of British Red Cross[20] considers the most vulnerable people, including the elderly, to be those who:

(i) lack material resources and/or social support;
(ii) are excluded from full social participation;

[19] The US National Response Framework (NRF) of the US Department of Health and Human Services, At Risk, Behavioral Health, and Human Services Coordination (ABC) and the US Association of State and Territorial Health Officials (ASTHO) defines people at risk, including the elderly, as those who may have additional needs before, during, and after a disaster.

[20] http://www.redcross.int/EN/mag/magazine1997_3/2-7.html

(iii) live in areas marked by high levels of deprivation i.e., the inner cities, former industrial areas, etc.; and
(iv) live in isolated rural communities.

E. Case Finding for Screening the Elderly at Risk

59. Case finding has hastened the development of indicators for vulnerable elderly and elderly at risk. Traditionally, case finding was a public health tool for identifying people at risk of infectious or chronic diseases. It continues to be an important tool in disease control and management. In most countries and/or regions, health care practitioners are required to report "reportable high risk" cases (e.g., Avian Flu) to the authorities for early identification and intervention. Case finding thus involves actively and systematically searching for vulnerable or at risk people, rather than waiting for them to present with symptoms or signs of a problem. Case finding has subsequently been expanded to other sectors, including the identification of people at risk of family violence; children, spouses and the elderly at risk of abuse or maltreatment; and youth at risk of becoming juvenile delinquents. Case finding uses highly specific local or nationally validated criteria (indicators) to screen the relative risk of the affected population. It thus identifies vulnerable people who may not otherwise intersect with health and social care services.

60. Effective case finding mechanisms identify as many people at high risk as possible but are not so broad as to include large numbers of people who may not experience vulnerability or who do not require any intervention. An effective case finding tool must be sensitive and specific. Sensitivity is defined as the percentage of high risk people who are correctly identified with the relevant conditions. Specificity is the percentage of not-at-risk people who are correctly identified as having no risk conditions.

1. Types of Case Finding Techniques

(a) The Threshold Approach

61. The threshold approach is also known as the rules-based or criterion-based approach. It uses a set of *a priori* (previously designed) criteria (or indicators) to define or describe high risk patients. No statistical modeling is used.

62. The technique identifies any potential client that meets a specified criterion or threshold for a parameter of interest, e.g., elderly abuse. For example, the threshold may be anyone who is over 65 years-old who meets one or more elderly abuse criteria. Therefore, everyone within the defined population who meets these criteria would be identified as being at "high risk" and targeted with further investigation, needs assessment, and intervention, if any.

63. Although widely used, this approach has been shown to yield low levels of accuracy in predicting future risk. This is mainly because individuals who are at risk in one month may not be at risk in the following month and vice versa. The result is that a large number of people may be considered at high risk although, in fact, they are not. This method is inefficient and expensive.

(b) Using Clinical Knowledge

64. This approach is widely used in Canada, the UK, and the US. It is based on clinical knowledge. Practitioners (including social workers) use their instinct and experience to identify

individuals who are likely to become high risk. Practitioners then refer these clients to a case manager further investigation, needs assessment, and intervention is anticipated to help reduce risk.

65. Very little formal evaluation has been undertaken to assess the relative accuracy of using practical knowledge and wisdom to predict future risk. However, evidence points to this approach having a low level of predictive accuracy. Practitioners may be able to identify clients who are *currently* at high risk but are less able to identify those who will be at high risk in future. This approach is also limited to those individuals who come into contact with social and health care practitioners. It is less likely to identify individuals for targeted interventions before they become high risk or vulnerable.

(c) Predictive Modelling: A Data-Led Process

66. Predictive modeling seeks to establish relationships between sets of variables through statistical modeling to predict future outcomes. It usually incorporates formulae that allow users to interpret historical data. It then forecasts future events based on identified relationships.

67. Evidence points to predictive models having impressive predictive ability. However, a large range of techniques exists, with some more developed than others. Literature on the subject is extensive, yet it is clear that no consensus exists on which technique is best. The most developed approach uses regression models, but there is emerging interest in using artificial intelligence. In regression modeling, predictive power varies according to the data variables used.

68. Experience from case finding is leading the countries/regions reviewed in this report to move away from a simple threshold and/or clinical knowledge toward more objective, predictive modeling. This is particularly true in health care but not necessarily in social services. This partly reflects the availability of big data for health and also the urgency to contain health costs. This may not be the case for social service provision.

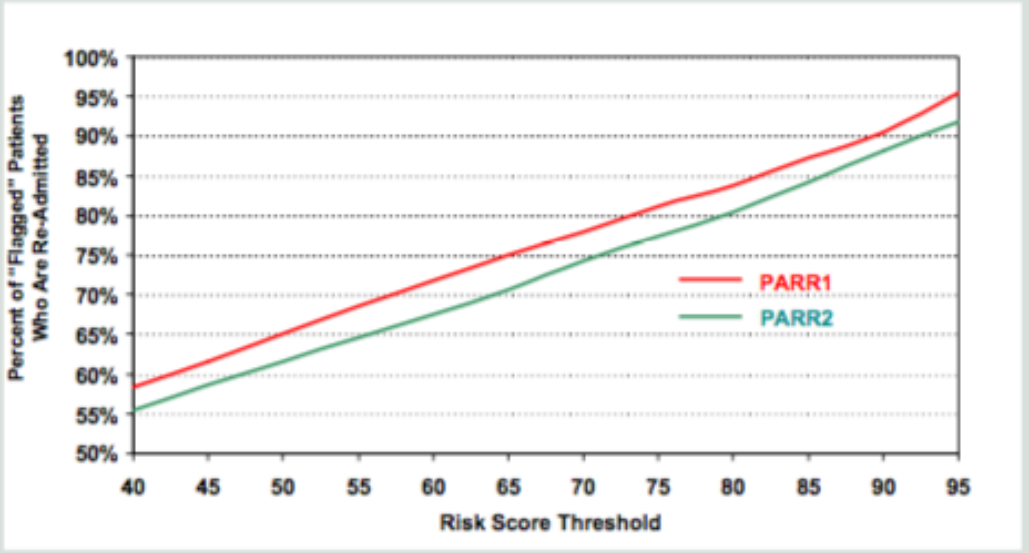
(d) Improving Predictability in Case Finding

69. In the UK, the King's Fund, and the New York University Center for Health and Public Service Research (US), were contracted to develop algorithms for Patients at Risk of Re-hospitalization (PARR) Case Finding. This is regarded as a good case finding practice based on a data-led predictive model. The goal is to improve the predictability of case finding by providing a mechanism to flag patients with a high probability of subsequent emergency admissions and for whom improved health care and social service management may reduce risk of re-hospitalization. The algorithms produce a risk score for probability of future admissions that draws on a broad range of information about the patient, including the current hospitalization and any hospitalization in the previous three years, the geographic area where the patient resides, and the hospital of current admission.

70. Three major tools based on the Patients At Risk for Re-hospitalization (PARR) model (PARR1, PARR2, and combined model) are used to identify very high risk patients through use of patient data to produce a risk score of patient likelihood of re-hospitalization within the next 12 months. Risk scores range from 0–100, with 100 being the highest risk. PARR incorporates a broad range of variables about the patient, the community, and hospital to help predict risk of re-hospitalization. Data includes characteristics of the patient and community, past diagnosis, and prior use of health care, including both acute and primary care. PARR1 focuses on

information about general admission whereas PARR2 targets emergency hospital admission (Billings et al., 2006).

Figure 1: PARR Algorithms for Proportion of Flagged Patients Re-admitted

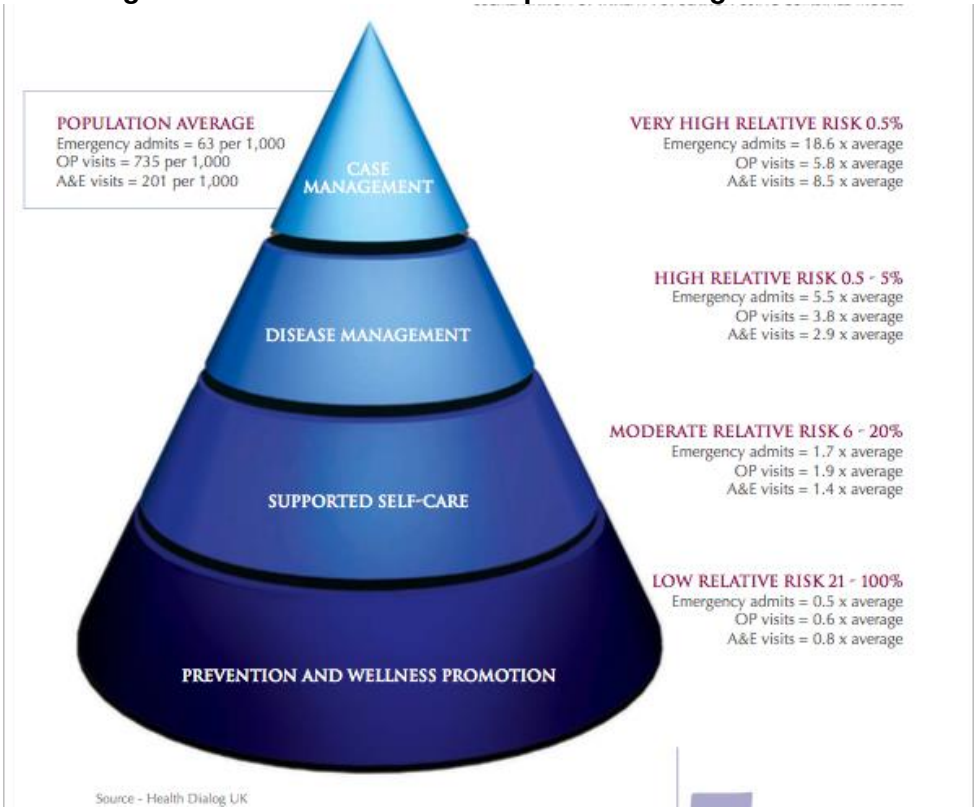


71. Both PARR1 and PARR2 have a high degree of predictability (Figure 1). Patients with risk scores above 50 had a high chance of a subsequent admission, and 73–95% of patients with risk scores above 70 were readmitted within 12 months (Billings et al., 2006. p.6).

72. The combined predictive model (or combined model) is even more powerful. It includes a more comprehensive dataset of patient information, including inpatient, outpatient, accident, and emergency statistics, data from secondary care sources, and general practice. Big data, sophisticated statistical techniques, and computing capacity have made this model possible as it draws on a population of 560,000 patients and 850 variables. Patients in the top 0.5% segment of predicted risk were 18.6 times more likely to have an emergency admission in the following year than was the average patient (Wennberg et al., 2006:5). PARR1, PARR2, and the combined model are non-age specific but, in practice, the great majority of high health care users are actually elderly.

73. Another useful feature of the combined model is its capacity to stratify patient risks into four different segments (Figure 2). This is critical for three reasons: (i) patient segmentation or stratification allows the medical authority to provide proactive care and to develop a targeted intervention strategy for different segments of patients; (ii) whereas much current intervention focuses on the tip of the pyramid, need is actually distributed along its continuum; and (iii) the model recognizes that more care is not always wanted or needed. A generic intervention model applied to all patients would likely increase resource utilization among those at the bottom of the pyramid. This model enables clinicians and managers to use resources more wisely.

Figure 2: Segmentation of the At Risk Population Using the Combined Model



Source: Health Dialogue, UK.

74. The Hong Kong, China Hospital Authority developed a very similar age-specific model to that of the UK in 2006, the Hospital Admission Risk Reduction Program for the Elderly. This case finding system scores patients between 0 and 1 and predicts their probability of emergency admission to a medical ward in any Hospital Authority hospital within 28 days of medical and emergency admission or Accident and Emergency attendance for a medical condition. The higher the score, the higher the likelihood of hospital care utilization.[21] This case finding algorithm is largely based on four categories of information: (i) the **patient:** socioeconomic status, patient behavior and health status; (ii) **social:** the coping and carer system and community services; (iii) **clinical:** adequacy and appropriateness of assessment and treatment; and (iv) the **system:** its availability, accessibility, and coordination in relation to, and within, the health care delivery system (Yam, 2010:386).

75. A parallel development has occurred in the US. The US RAND Health team and Neil Wenger from UCLA developed the Vulnerably Elders Survey (VES-13)[22] in 2001 (Appendix 1) to identify the elderly at risk of health and functional decline. The survey is designed for use in multiple settings and is scored by clinicians or non-clinicians. A screener score of 3+ (vs. 0-2) identifies individuals as vulnerable. The vulnerable were found to be four times more at risk of death or functional decline than elders scoring 3 or less.[23] This survey tool has been used in many studies, including the Vulnerable Elders-13 Survey Predicts Five–Year Functional Decline and Mortality Outcomes in Older Ambulatory Care Patients (Min and Yoon, 2009).

[21] http://www.ha.org.hk/haconvention/hac2011/proceedings/pdf/Community%20Collaboration%20Forum/CCF3.pdf
[22] http://www.rand.org/health/projects/acove/survey.html
[23] http://www.rand.org/health/projects/acove/survey.html

76. The School of Public Health at Johns Hopkins University in the US uses two sets of instruments that are similar to VES-13. These were originally developed by the University of Minnesota in 1992. Pra (Probability of Repeated Admission)™ and PraPlus™ identify those elderly highly likely to use health services heavily in the near future.

Pra™ consists of an 8-item questionnaire:[24]

(i) Age
(ii) Gender (male)
(iii) Poor self-rated general health
(iv) Availability of an informal caregiver
(v) Having had coronary artery disease
(vi) Having had diabetes during the previous year
(vii) A hospital admission during the previous year
(viii) More than six doctor visits during the previous year

77. A scoring formula was developed from answers to these eight questions to estimate the probability of hospital readmission within 4 years.

78. PraPlus™ contains nine additional questions about medical conditions, functional ability, living circumstances, nutrition, and depression. Responses to these questions give further insight into the risk of hospital readmission for elderly patients.

79. Pra™ has been used by hundreds of healthcare organizations throughout the US. For instance, the Robert Wood Johnson Foundation recommends Pra™ as the primary indicator of risk for Medicare Health Maintenance Organizations (HMOs). The Health Care Financing Administration requires its use as a condition of federal support for relevant national demonstration projects. The Blue Cross Blue Shield Association recommends its use in constituent health plans. Health care management consulting corporations also recommend Pra™ to their Medicare HMO clients.

80. Pra™ and PraPlus™ have also been tested and validated in Germany, the UK, and Switzerland where a study of 9,730 people aged 65 and living independently in community-dwellings, yielded a result similar to that in the US.[25]

(e) Case Finding in Practice

81. Case finding can be an active or passive process. Active case finding involves soliciting the direct support of service providers (hospitals, community health centers, primary care clinics, the police, social service organizations, neighborhood organizations, and neighborhoods at large) to identify cases at risk. Active case finding can also involve a screening tool to screen all people aged over 60 or 65 and identify elderly at risk. Passive case finding is less direct and involves examining official statistical data to identify cases that meet “at risk” or “vulnerable criteria” e.g., in terms of age, gender or location. This method requires fewer resources.

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[24] Office of Technology Commercialization #97145: *Assessing the Risk of Repeated Hospital Admission for Elderly Patients*. Sources: http://license.umn.edu/technologies/97145_assessing-the-risk-of-repeated-hospital-admission-for-elderly-patients

[25] Wagner, J.T., Bachmann LM, Boult C, Harari D, von Renteln-Kruse W, Egger M, Beck JC, Stuck AE. (2006). Predicting the risk of hospital admission in older persons--validation of a brief self-administered questionnaire in three European countries. *Journal of the American Geriatric Society*; 54(8):1271-6.

82. In practice, both active and passive case finding are deployed. In Canada, the US, UK, and Hong Kong, China, for instance, a medical social worker (case manager or discharge planning nurse), frequently uses a passive strategy, asking the hospital admitting office to flag patients who are over 80 years old, female, and living in a certain area of the city. This is followed by an active strategy to review relevant patient records and/or interview clinicians about the patient to accurately determine their risk status. Other creative means may also be employed, such as local television, radio or newspaper items to alert the community to people at risk of maltreatment and negligence. India and Brazil use case finders to identify people with dementia (see below).

Case Study 5: Casefinder Studies in India and Brazil

Background: Research from the 10/66 Dementia Research Group has indicated that dementia is largely a hidden problem. Although the syndrome is widely recognized, it is considered a normal part of ageing and not a medical condition. Therefore, families do not seek help and primary care doctors are rarely involved. In India, the community health workers who visited all homes in their area to provide preventive maternal and child health care were aware of cases in the community and considered this to be a significant family burden (Patel and Prince. 2001). A simple, inexpensive method for identifying cases in the community is necessary to offer targeted interventions for people with dementia and their families.

Method: The 10/66 Dementia Research Group developed a half day, manual based, training programme for community health workers to sensitize them to characteristic features, symptoms, and presentations of dementia in the community. The effectiveness of this training, and the subsequent use of community health workers as a practical case finding method, has been evaluated in Thrissur and Vellore in India, and in Botucatu in Brazil.

Conclusions: A community health worker casefinder method can be a simple and cost-effective approach to identifying those with dementia in the community, where levels of help seeking through formal healthcare are low. One half to two thirds of those identified typically had dementia, and others had different chronic conditions, with much unmet need. However, the sensitivity of this approach (as assessed in the Vellore study) may still be low, with many dementia cases missed.

83. Services for the “hidden and vulnerable elderly” in Hong Kong, China commenced in 2008. Government created 199 social work positions and allocated $7.7M to 41 providers of District Elderly Community Centers and 117 providers of Neighborhood Elderly Centers.[26] Each center had contractual responsibility for identifying at least 40 hidden and vulnerable elderly per month, with a 25% turnover rate per year.[27]

84. In Vancouver Coastal Health, Canada, information on risk is imbedded in the client assessment system. High risk clients are flagged at the point of assessment to ensure timely intervention. Over time, these regularly collected data have become useful information for service planning and development (Table 1).

[26] http://www.lwb.gov.hk/chi/legco/12012011_2.htm

[27] Funding and Service Agreements, District Elderly Community Centre (DECC) and Neighborhood Elderly Centre (NEC), April, 2008. Social Welfare Department, HKSAR Government.
Sources: http://www.swd.gov.hk/doc/ngo/District%20Elderly%20Community%20Centre%20(Apr%202008).pdf, http://www.swd.gov.hk/doc/ngo/Neighbourhood%20Elderly%20Centre%20April%202008.pdf

Table 1: Outcomes of High Risk Screening (2010), Vancouver Coastal Health, Canada

High Risk Screening Outcome	%
Aged 75+	64.9
A main language other than English	35.8
At high to very high risk of care and supported to remain at home, care giver burnout/institutionalization	48.7
Have difficulty managing daily decision-making	30
Do not have a caregiver	13
Have caregivers	67
caregivers show signs of stress	26
Receive weight bearing assistance with ADLs	12.3
Show symptoms of minor to major depressive disorders	18.2
Exhibit signs of delirium	4.1
Are medically complex	10.1
Have daily pain which is non-severe to severe	46.3
Take nine or more different medications	32.1
Take psychotropic medications	38.6

Source: Coles. 2010.[28]

F. Important Lessons

1. Understanding the Influence of Psychosocial Factors on Risk, Vulnerability and the ESD

85. Case finding was originally used in the health sector, and especially in public health to identify people at risk. However, its application has now been expanded to other sectors, such as social services. Many variables or indicators used in health care for case finding people at risk are not necessarily health related—they are very much psychosocial issues. This is evident from the indicators used in PARR1, PARR2, the Combined Model, Hospital Admission Risk Reduction Program for the Elderly, VES, Pra™ or PraPlus™, and SES which show that social relationships, residential, and community environments all affect risk and vulnerability levels of the elderly. Table 1 indicates that half of the outcomes from high risk screening in Vancouver, Canada can be attributed to "psychosocial" related factors. Clinical information is only part of the overall risk profile. These psychosocial risk factors need to be properly addressed to prevent and reduce future risk.

86. This has two implications. Firstly, psychosocial factors are major contributors to risk and vulnerability of the elderly and these factors are identifiable. Secondly, the accurate identification of psychosocial risk factors is important for managing ESD.

2. Enriching the Definition of ESD

87. There is little difference in the characteristics of ESD, the vulnerable elderly, and elderly at risk across countries/regions. Table 2 indicates characteristics for finding the vulnerable elderly or elderly at risk that have been identified in other localities but are not mentioned in the current PRC definition of ESD (Section 2.3 and the shaded area of Table 2).

[28] Teresa Coles, RAI-HC High risk indicators report. Slide Presentation, Oct 22, 2010. Vancouver Coastal Health. British Columbia, Canada.

Table 2: Characteristics of ESD/Vulnerable Elderly, and Elderly at Risk

Characteristics of ESD	Canada	PRC[d]	HK, China[e]	UK[f]	US[g]
1. Living in empty-nest households		✓			
2. Having chronic illness(es)	✓[a,b]	✓	✓		✓
3. Left behind alone in rural areas	✓[b]	✓	✓	✓	✓
4. Unable to perform daily activities	✓[a,b]	✓			✓
5. Impoverished or with low income	✓[a,b]	✓	✓	✓	✓
6. Lost their only child		✓			
7. Aged 80 and above	✓[b]	✓			
8. Being female	✓[a]	✓			
9. Low education – no degree or diploma	✓[b]		✓	✓[h]	
10. Unable to read, speak or understand the main language (communication)					✓
11. Immigrant	✓[b]				
12. Visible minority	✓[b]				✓
13. Living alone	✓[a]		✓		
14. No primary caregivers - inadequate social support	✓[a]		✓		✓
15. Dependence on caregiver	✓[c]		✓		
16. Caregivers unable to continue	✓[a]				
17. Poor social relationship – openly expressed conflicts	✓[a,c]		✓		
18. Potential abuse/neglect	✓[a]				
19. Family with history of violence	✓[c]				
20. Living with caregivers that have mental health problems	✓[c]				
21. Excluded from social participation, facing social isolation	✓[c]		✓	✓	
22. Exhibiting anger, anxiety or depression					
23. Dementia or cognitive impairment	✓[a]				✓
24. Mental illness	✓[a]				
25. Sensory impairment	✓[a]				
26. Over- or under-weight[29]	✓[a]				
27. Food insecurity	✓[b]				
28. Unable to operate complicated medical equipment or procedures					✓
29. Presence of dependency or requiring supervision	✓[a]				✓
30. Unsanitary environment	✓[a]			✓[h]	
31. Unsafe environment	✓[a]			✓[h]	
32. Unfamiliar environment					✓
33. Living in a high deprivation area (inner city, high crime area, area	✓[b]			✓[h]	

[29] The China Health and Retirement Longitudinal Study (CHARLS) study showed that almost 19.1% of men over 75 years of age were over-weight and 17.8% under-weight. The corresponding figures for women were 24.2% and 18.4%. Sources: http://ije.oxfordjournals.org/content/43/1/61.full.pdf+html

Characteristics of ESD	Canada	PRC[d]	HK, China[e]	UK[f]	US[g]
with no community resources)					
34. Inaccessibility to transportation (including wheelchair)					✓

a. Vancouver Coastal Health (2004)
b. United Way. Canada. 2011
c. MacKay-Barr and Csiernik. 2012
d. ADB. 2015. People's Republic of China: Social Work Services Policy and Delivery Modes for the Elderly with Special Difficulties.
e. Sage. 2009
f. British Red Cross. 1995
g. Minnesota Department of Health, 2010
h. Department for Communities and Local Government, 2015
i. Culo, Canada. 2011.

88. This is not to suggest that other localities have a more comprehensive list of indicators for the elderly at risk or vulnerable than those used in the PRC. Rather, it does suggest that there may be gaps needing filled. For instance, comparison with the English Indices of Deprivation (Section 2.4.2) indicates missing categories for employment, education, crime, barriers to housing and services, and the living environment. A comparison of elderly vulnerability, risk, or ESD across localities can help enrich understanding of ESD, and enhance capability for ESD case finding. Should the PRC decide to develop an ESD case finding tool, these indicators could form a useful basis.

3. Enhance the Predictability of Case Finding

89. The refinement of ESD indicators or characteristics is likely to increase the number of ESD who need public assistance, and this may exceed the current capacity of public resources. It may also explain why other localities are developing more accurate techniques to improve the sensitivity and predictability of their case finding mechanisms. The UK statistical algorithm is a good example. The higher its risk score, the greater is likelihood of health utilization. Such an approach may be new in the area of social service provision.

90. Enhanced predictability of ESD permits case stratification. The output of the UK algorithm generates four categories or levels of risk: very high, high, moderate or low (Figure 2). This classification allows the health and social care system to provide proactive care and a service intensity level matched to each risk level. Thus scarce public resources, such as professional support, will be directed more strategically towards those at greater risk. This allows the elderly at moderate risk to be handled by nonprofessional staff, including trained volunteers. Low risk cases can be encouraged to develop mutual and/or self-support mechanisms. This stratification screens-out the large number of elderly at no or low risk, or who may not benefit from highly professional intervention programs, and instead targets those resources toward elderly at greatest risk.

91. These highly precise indicators (e.g., VSE-13, Pra™ and PraPlus™, etc.) can also help to eliminate approaches where local government officials do not use strict criteria to identify ESD. A 2015 World Bank study[30] noted that such approaches can breed corruption and undermine central government efforts to eliminate poverty in the PRC. It documented a case where lack of clear indicators and a poverty threshold had resulted in social protection benefits

[30] Anonymous. 2015. Ham-fisted handouts – China's biggest anti-poverty programme isn't working. *The Economist.* 31 October pp. 43-44.

(*dibao*) leaking to non-poor but well-connected households. As one central government official responsible for rural welfare provision noted: "we need to improve the quality of our data and really solve the issue of who we are supporting," especially when the central government is financing two-thirds of the *dibao* allowance. Refining ESD indicators characteristics would also help to improve data quality.

4. Make Good Use of "Social Capital" and "Risk Management"

92. The terms vulnerable elderly and elderly at risk have given rise to two essential perspectives of ESD, those of social capital and risk management. The International Red Cross and Red Crescent Movement notes that: "even the most vulnerable person may have some skills, resources and strengths to help themselves and perhaps others. Thus, building the capacity of the vulnerable elderly, including their community, may help to reduce their own and even other's vulnerability. Assistance to the "vulnerable" should not cultivate a "sense of helplessness". Instead, assistance should be built on the "resilience" of vulnerable individuals and groups.

Case Study 6: Is Living Alone Necessarily Unpleasant for the Elderly?

The China Health and Retirement Longitudinal Study (CHARLS) showed that living separately from children or living alone may not necessarily be unpleasant. An increase in the numbers of PRC elderly living alone or with only a spouse had raised concerns over elderly support, especially in situations where public support is inadequate. However, CHARLS findings indicate that the increasing trend of elderly to living alone was accompanied by a rise in other family members living nearby. This type of living arrangement helped to resolve conflicts between the need for privacy and independence and for family support. This was confirmed through further investigation—children living close by visited their parents more frequently. Moreover, children living far away provided larger net transfers to their parents, consistent with the sharing of elderly care responsibilities among siblings. Having more children was associated with living with a child or having a child nearby, while investing more in a child's schooling was associated with more net transfers to parents (Lei, 2011). However, living alone did present a challenge for men in poor health. US-based research of 325,649 adults aged 65 years and older also found that those living alone, had poorer care and less immunization, particularly for men (Beckett, 2015).

93. It is important to note that risk management and ESD are related in at least two aspects. (i) Good risk management may prevent an adverse effect from occurring. Likewise, ESD implies that if potential harm is adequately handled, actual harm may not occur. (ii) The focus of risk management is not necessarily risk elimination but rather mitigation through risk reduction and prevention. ESD strategies are also mitigation focused. They may include reducing the severity of harm or suffering to ESD and preventing the elderly from becoming ESD through better use of social protection networks and improved living environments such as through use of technology.

Case Study 7: Technology and Environmental Improvement Reduce Vulnerability[31]

A study of people aged 65 years+ in Taipei,China showed substantial decline in sight and hearing impediments and IADLs, but mixed trends for physical functions, and flat trends for ADLs. A remarkable improvement in making telephone calls— an IADL indicator— may reflect changes in telecommunication infrastructure and highlight the roles of environment and technology in disability outcomes. Improvement in vision and hearing was greater for urban than rural residents but less marked for physical functions and IADLs.

IV. ASCERTAINING SERVICE MODELS FOR WORKING WITH ESD

For every complex problem, there is an answer that is concise, clear, simple and wrong.
(H.L. Mencken)[32]

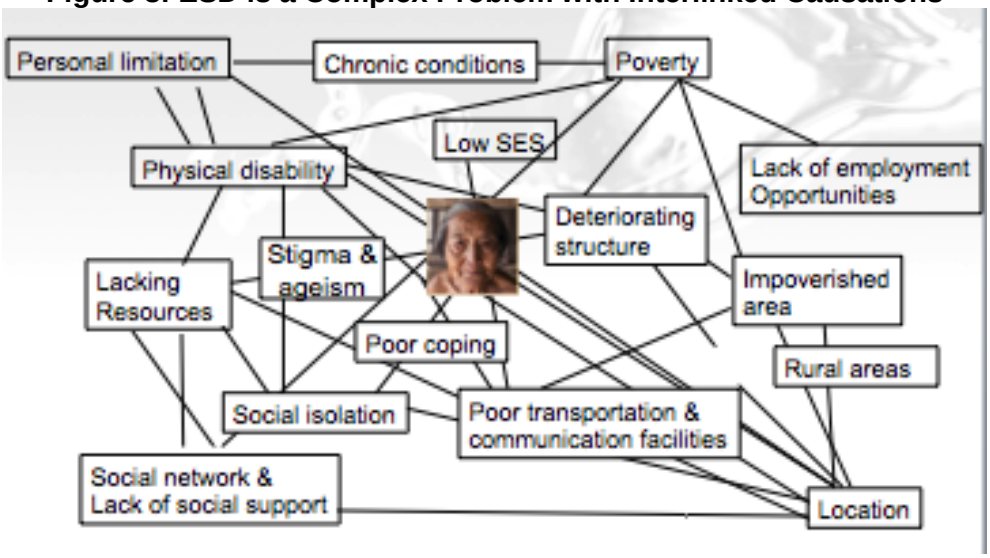
A. Introduction

94. The concept of ESD is complex and the management of ESD can also be very complicated. A common misunderstanding is that ESD issues can be resolved by only one discipline, such as social work. In most cases, a single discipline can only minimize risk and reduce ESD suffering whereas tackling the causes of ESD is a complex problem requiring complex and multidisciplinary solutions.

B. ESD as a Complex Problem

95. The factors which place the elderly at risk or as ESD are multifaceted and intertwined (Mechanic and Tanner, 2007). These include personal limitations, geography, poverty, lack of social networks, or social support (Figure 3).

Figure 3: ESD is a Complex Problem with Interlinked Causations



[31] http://www.tandfonline.com/doi/abs/10.1080/00324728.2011.604730#.VeNLLdNViko
[32] Sources: http://www.brainyquote.com/quotes/quotes/h/hlmencke129796.html

1. Personal Limitations

96. Physical and cognitive impairments and serious chronic conditions exacerbate vulnerabilities. Many of these problems, such as poverty and physical disability, may begin in early life and increase the likelihood of later problems. Therefore, early recognition and intervention may prevent serious harm. Moderating the effects of such personal vulnerabilities also requires good access to poverty alleviation programs, high-quality health care, and specialized rehabilitation services. However, these are usually less accessible to the poor and the elderly.

2. Poverty and Ethnicity (Socioeconomic Status, Race, Ethnicity, and Cultural Context)

97. Vulnerability frequently involves issues of poverty, ethnicity, stigma, and discrimination. Low education and income in early life frequently affects a whole life course. Early low social status and later adversities can also contribute to elderly vulnerability. The vulnerability of older people is also exacerbated by stigma toward the elderly, age prejudice, and age discrimination, which can lead to segregation and high concentrations of disadvantaged elderly in poor neighborhoods. Such factors frequently interact in complex ways.

98. A number of studies indicate that being female can affect whether an elderly person is at risk or vulnerable of becoming an ESD. For example, in the Luxembourg Income Study (LIS), Smeeding and Torrey (1992) found that during the mid-1980s, elderly persons in female-headed households across seven countries were poorer than those in male-headed households for almost every age group (the 55–59 cohort, 60–64, 65–74, and 75+). These findings revealed that elderly women were especially at risk of poverty in the US, where 25% or more of elderly persons in female-headed households were poor. Other LIS-based studies have further underscored these extreme outcomes found in the US: more than one-fifth of single elderly women (defined as all women aged 65 and over who live alone) in the US have incomes 40% below the national median (adjusted for household size), a common measure of poverty used in cross national studies. A comparison of poverty among single elderly women with elderly couples and non-aged units indicated that single elderly women in the US were the poorest group across the eight countries and also the only group with a significantly higher poverty rate than non-aged counterparts (Smeeding 2003). A more recent LIS study by Brady and Kall (2007) indicated that poverty among the elderly has reduced but that women in general, and American older women in particular, still had the highest poverty rates among wealthy countries—with poverty defined at both 40 and 50 percent of the national median. By comparison, Brady and Kall found that poverty outcomes for older women in Canada and in two Nordic countries of Finland and Sweden were markedly better than for the US.[33]

99. Research findings have widely substantiated that gender is a risk factor for poor health. Women in general have a lower mortality but higher morbidity than men. In a study of older adults in three districts in Beijing in 1992 and 1997, men were more likely to die earlier and women more likely to be dependent later in life. Women's health status was adversely affected by their education and other socioeconomic conditions, and by some psychological factors such as feelings of control over their lives or the locus of control. Men were disadvantaged in terms of behaviors such as smoking and also in terms of social support mechanisms.[34] In terms of

[33] http://www.lisdatacenter.org/wps/liswps/497.pdf

[34] "Gender Differences in Functional Health and Mortality Among the Chinese Elderly," by Toshiko Kaneda, Population Reference Bureau; Zachary Zimmer, University of Utah; and Xianghua Fang and Zhe Tang, Capital

mental health, 4% of women and 1.7% of men were diagnosed with major depression. Given this greater prevalence of depression in women, a correspondingly greater prevalence of depression among older women than older men is also anticipated.[35]

3. Social Networks and Lack of Social Support (Social Relationships)

100. Social networks provide both emotional and practical help in dealing with vulnerable situations and can often make the difference between successful or inadequate levels of coping. Social isolation is commonly found among the oldest old, whose social networks have become depleted by deaths and incapacitating illnesses. These elderly are especially vulnerable during community disruptions and disasters as they lack resources to protect themselves. The large numbers of elderly deaths that occurred in the US during Hurricane Katrina and in Europe during past heat waves have reflected inadequacies in personal and community resources, networks, and preparedness.

4. Location (Residential and Community Context)

101. Many elderly are vulnerable because of their residential location, such as in low-density and impoverished rural areas, in urban ghettos, or other places associated with underdeveloped or deteriorating infrastructure. These localities lack employment opportunities, have inadequate medical, social, and educational services, poor transport and communication, as well as high rates of crime and victimization, and exposure to environmentally adverse conditions. Economic deprivation and limited opportunities have led to outmigration of the young and better educated, and to unbalanced age distributions, with those left-behind becoming more vulnerable and inadequately supported.

102. Cula identified internal and external factors that resulted in vulnerable elderly or elderly living at risk in British Columbia, Canada (2011). Internal factors were cognitive, psychosocial, and/or physical problems and external factors related to unfavorable environments. Both sets of factors also affected each another.

Table 3: Internal and External Factors Contributing to Creation of the Elderly at Risk

Internal	External
• Increasing age • Being female • Medical comorbidities • Substance abuse • Mental illness • Cognitive impairment • Sensory impairment • Impairment in activities of daily living (ADL) • Malnutrition	• Lack of a social network • Dependence on a care provider • Living alone • Lack of community resources • Inadequate housing • Unsanitary living conditions • Residing in a high-crime neighborhood • Adverse life events • Poverty

103. A study of needs of the “hidden elderly” on Hong Kong Island, China identified three major causes of vulnerability (Sage, 2009):

Medical University (published in *Research on Aging* in May 2009). Available at http://www.prb.org/Publications/Articles/2009/chinaelderlyhealth.aspx

[35] http://www.psychiatrictimes.com/geriatric-psychiatry/geriatric-depression-does-gender-make-difference

(i) **Personal characteristics**: not trusting people or making friends with others, not talking to other people, not accepting help from others or bothering other people; not getting along with others, being lonely, close-minded, stubborn, introverted, or pessimistic. The vulnerable elderly generally tend to view the external world negatively, being helpless, angry and adopting an "I don't care" attitude. They feel depressed, and are withdrawn and lonely. They either deny their problems or think of their problems as being minor and unimportant to other people. They also consider seeking help as causing trouble to others, including their own children; and are therefore reluctant to reach out for help.

(ii) **Difficulties in old age**: They vulnerable elderly attribute their difficulties to old age and try to cope with these difficulties themselves. For instance, they regard being old as 'naturally' being in poor health, less mobile, experiencing financial constraints (with going out meaning more money spent), and having fewer or no friends etc.

(iii) **No formal or informal social support**: family members have to make a living and have no time for the vulnerable elderly, who may experience poor family relationships, feel discriminated against or that society ignores them, and they may be living in poverty not knowing where to seek help, etc. These elderly are frequently not entirely socially isolated. A significant number live with spouses and others (45%), watch TV (60%), and listen to radio (33%). Rather than isolating themselves from the rest of the society, they felt isolated because other people paid no attention to them. They either had no knowledge of external help or considered external help to be useless.

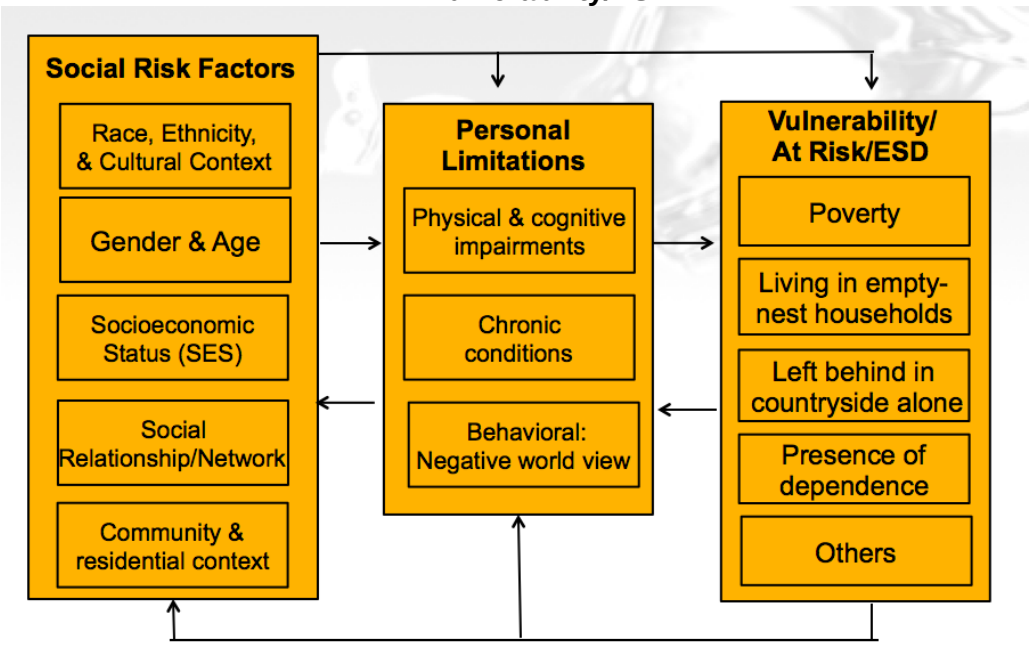
104. All these factors formed a causal chain of interrelated pathways which were direct, indirect or mediated. For instance, poor transportation and communication facilities indirectly hindered the development of social networks and worsened poverty of the vulnerable elderly. Living in poverty and in deteriorating structures also affected capacity for self- care.

105. To summarize, the problem of ESD may also relate to ageism, marginalization through age, gender, income or poverty, social isolation, housing conditions, environmental safety, access to health and social care services. All of these also affect access to help, help seeing behavior and other social and health problems such as chronic disease, increased mortality, community violence and abuse of the elderly.

106. An elderly person's vulnerability may therefore result from a complex mix of personal limitations, social, and environmental risks. Figure 4 presents a proposed conceptual framework for linking social risks with personal limitations and the vulnerable elderly, elderly at risk, or ESD. Social risks include socioeconomic status, religion, culture, education, social support, and environmental status. It may also include social issues such as the psychosocial aspects of one's person's life that influence thoughts, feelings, behaviors, health, functioning, wellbeing, and/or quality of life. A position paper for training geriatricians highlights that psychosocial concerns are also prevalent, associated with substantial morbidity, and can influence disease progression, function, and mortality. It is necessary to address older adult social and environmental risks to maintain overall functions, quality of life, and wellbeing of the elderly.[36]

[36] http://www.cornellcares.org/education/pdf/Psychosocial_Health.pdf

Figure 4: Conceptual Framework of Social Risk, Personal Limitation, and Elderly Vulnerability/ESD



107. The complexity of ESD means that it cannot be addressed by only one discipline or profession. The limitations of such a single discipline and professional approach would result in (i) inadequate understanding of the problem, (ii) failure to appreciate what other disciplines or professionals can contribute to problem solving or management, and (iii) the need for complex assessment and intervention methods. For instance, health care professionals have focused on physical concerns and often failed to appreciate the critical importance of psychosocial aspects in health interventions. Optimization of overall wellbeing cannot be achieved without addressing these challenges from psychosocial factors of health (Bronstein, 2003).

C. Complex Problems Call for Complex Solutions

108. The phenomena of ESD results from individual, social, and environmental challenges that require different types of individual and policy interventions: from the social and economic development of neighborhoods and communities, to educational and income policies, and health and psychosocial interventions at the individual level (Mechanic and Tanner, 2007).

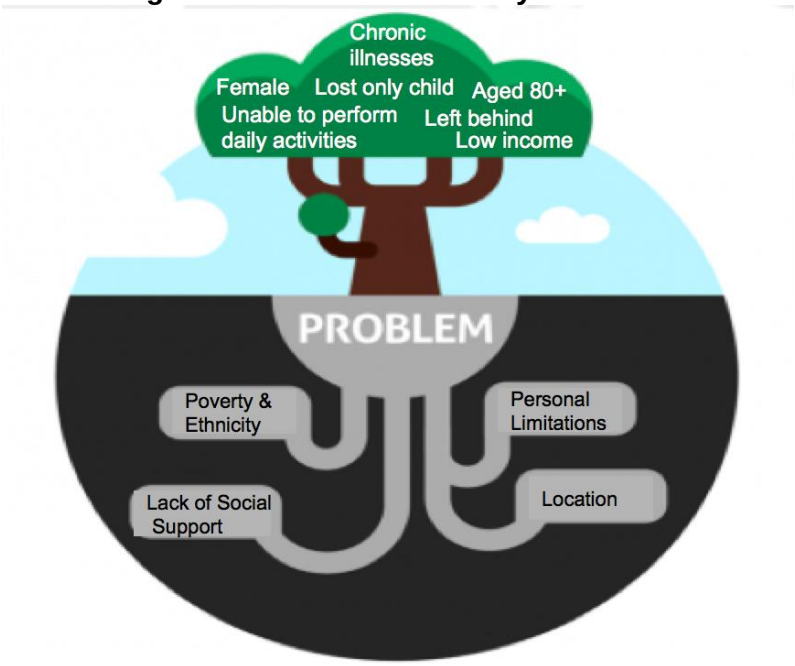
109. In Hong Kong, China, a number of measures were proposed by the Study on Needs of the Hidden Elderly to address problems of the “hidden and vulnerable elderly” in Hong Kong, China. Aims included to:

(i) rebuild the self-image of the vulnerable elderly,
(ii) reach out to the elderly to avoid them isolating themselves from the rest of society,
(iii) overcome the psychosocial barrier that seeking help is bothering others,
(iv) provide helpful information to the elderly, especially those living on public housing estates, and
(v) promote the participation of corporations in elderly care (SAGE, 2009).

110. These measures may be useful in mitigating (or relieving) the vulnerability of individual elderly with special difficulties. However, they are insufficient over the longer term. These measures are often referred to in public health as “downstream measures” that are designed to relieve the vulnerability of an individual, but insufficient to prevent the elderly from becoming at risk or vulnerable in future. Measures to address such future problems are called “upstream measures.”

111. Risk management calls for digging deeply into the root causes of a risk rather than just treating its symptoms. This is called root cause analysis. Most characteristics of ESD are in fact symptoms of a root problem (Figure 5). To prevent ESD, it is necessary to tackle the root causes and upstream or systemic ESD issues such as disparity in socioeconomic status, isolated locations, and the need for poverty alleviation and comprehensive health care coverage. However, public systems are generally better at addressing ESD symptoms than their root causes.

Figure 5: A Root Cause Analysis of ESD



Case Study 8: The Health Impact of Additional Income for the Elderly

A recent study of two cities in Mexico provided the elderly with an additional $67 per month. This resulted in a 44% increase in average household income that was attributed to the significant health benefits associated with additional income. There was a statistically significant improvement in elderly lung function relative to the control sample and also an improvement in elderly memory. These improvements were equivalent to a gain of 5–10 years of life. Residents used their extra income to see a doctor, buy medications, and alleviate hunger.

Source: http://www.rand.org/pubs/external_publications/EP50569.html

112. The needs of vulnerable people in the US, including the elderly, are being addressed through a number of upstream and downstream measures:

1. Reduce Disparity in Socioeconomic Status

113. Education, income, wealth, and occupational status shape vulnerability and resilience through complex pathways. There is no consensus about which of the interrelated elements of socio-economic status has the greatest impact over a life course, as each element operates through causal pathways that may be common or unique. A policy agenda on vulnerability must therefore carefully examine the balance between the upstream determinants of health and more immediate client needs.

2. Address Persistent Vulnerability

114. Institutions and programs that provide assistance to clients with persistent or long-term vulnerabilities face different challenges from those designed to serve people and groups in temporary distress, such as that following disaster. These long-term problems require a comprehensive economic, psycho-social, medical, or rehabilitative commitment. However, most public care and assistance systems are basically built around meeting the needs of individuals and groups experiencing temporary need. This approach is insufficient to assist those experiencing persistent vulnerability.

3. Differentiate Program Costs for Different Levels of Vulnerability

115. A “one size fits all” approach is not conducive to supporting vulnerable people. Otherwise, the minority that experiences the greatest vulnerability, and has the most intense needs, will absorb a large proportion of available expenditure. In US health care in 1996, for instance, 1% of the population accounted for 27% of aggregate health spending, 5% for more than half of the total, and the top 10% for over two-thirds (Berk and Monheit, 2001). In the US Medicaid system, 3% of its 51.4 million enrollees accounted for one-third of all spending in 2002, and 7% for over 50% (Mechanic and Tanner, 2007). Thus, the ability to stratify the elderly into different levels of risk, and to target resources toward those in greater need, makes good business sense. It is also only fair that people with greater need receive more services.

4. Intervene at Both Neighborhood and Community Levels

116. The neighborhood and community context affects health and wellbeing at a level beyond personal characteristics and resources. Much of this vulnerability arises from the way in which many community environments have been neglected. Degraded neighborhoods, such as low-density and impoverished rural communities, can be targeted for intensive interventions that are crucial to elderly quality of life. This includes housing stock, employment opportunities, transportation, safety and freedom from victimization, educational enrichment, and recreational opportunities.

117. A World Bank community-driven development project helped to finance the construction and rehabilitation of social infrastructure, such as schools, health posts and water points; to deliver basic social services; and implement community-level economic investments, such as construction of local markets. The project involved a community-based participatory process, in

which residents of the community or village assessed their needs, identified areas for community investment and ranked them by priority.[37]

5. Balancing Individual and Systemic Intervention

118. It is important to promote self responsibility and individual resilience through interventions that build individual capacity e.g., increasing individual social capital and resilience to deal with stressful situations. This approach helps to relieve vulnerability but can also favor those poor with greater personal and social resources, and who are better positioned to take advantage of new opportunities.

119. So, systemic interventions that could benefit populations more broadly are equally vital in assisting ESD. Pension plans, minimum income supplements, and old age allowances automatically cover all elderly, and are the best way to alleviate poverty among the elderly poor.

Case Study 9: Structural Factors Affecting Elderly Poverty in Taipei,China

> The distinctive poverty pattern in Taipei,China has arisen from factors such as differences in household composition, labor market inequality, and welfare efficiency. Differences in welfare provisions are the most important reason for a higher elderly poverty rate in Taipei,China than in Western countries. In the absence of the generous social welfare provisions found in other localities, the prevalence of elderly co-residence in Taipei,China, (often with adult children), is a very important strategy for buffering older adult poverty risk and addressing their financial needs after leaving the labor force. The Taipei,China government introduced and expanded several social programs to provide income support to older adults from the late 1990s. These included Elderly Farmer Allowances and Low- and Medium-income Allowances for older adults. Taipei,China scholars have pointed out that the majority of older adults are covered by one of these programs. So, co-residence with adult children is considered to be both an ideal cultural arrangement for older adults and also a practical strategy for obtaining financial support. A universal “pay as you go” National Pension Program and National Health Care Program were introduced in 2011 and the poverty rate for older adults is expected to decrease gradually (Tai, 2008).

Source: www.sprc.unsw.edu.au/media/SPRCFile/DP081.pdf

120. An individual and systemic perspective on gaps, such as those in SES and/or social disparity, is necessary to address social determinants of ESD. Social work is well-suited to addressing individual needs on a one-to-one basis. However, social work is also capable of encouraging policy-makers to widen access to services, and facilitate cross-sector collaboration and connections. The chairman of social welfare policy at the Touro College Graduate School of Social Work considers that social workers are uniquely qualified to collaborate and make a contribution within both primary and secondary prevention of social problems such as social disparity, etc. (Jackson, 2015). However, for the past decade, professionalization has been moving social work away from addressing upstream and systemic issues and the profession has become dominated by individual therapies (Kam, 2014).

[37] Gibbons C. A. et al. 2004. Addressing the Needs of Highly Vulnerable Groups through Demand-Driven Projects: A review of a sample of World Bank projects serving excluded ethnic groups, disabled people and war-affected groups.
Sources:http://siteresources.worldbank.org/INTSF/Resources/3956691124228420001/1563161-1127938262697/CDDandVulnerableGrps_FINAL_DRAFT.pdf

D. Using a Collaborative Interdisciplinary Approach in Assisting the ESD

121. **Collaboration is an effective process for achieving goals that cannot be reached through an individual discipline, profession, or sector alone** (Bronstein, 2003). Collaboration resembles cooperation, coordination and partnership, but differs in some key respects. All parties involved in cooperation, coordination and partnership may share information and offer help to others. However, the process does not necessarily co-create or co-produce the result together.[38] Collaboration calls for a higher order of skills that include networking, building alliances, and partnerships (e.g., seeking like-minded people or organizations, working with multiple players, and team members), managing meaning (e.g., helping people to understand problems, ideas, and opportunities), negotiating, persisting (e.g., especially in times of high pressure), overcoming obstacles, and being flexible.

122. **Collaborative inter-disciplinary professional practice has become a key element of efficient and productive elder care intervention efforts.** This work involves health, community, housing, and other professionals in sharing a team or network identity and working closely together in an integrated and interdependent manner to solve problems, deliver services, and enhance outcomes. Effective interdisciplinary collaboration requires an alignment of values, skills, and resources toward attaining these goals. Clients, families, consumers, and communities, which have traditionally been excluded from being integral team members, have now become part of the collaboration (Cox and Naylor, 2013; Hibbard, 2003; Hibbard et al., 2005; Hovey et al., 2011; IOM, 2003, 2006; WestRasmus et al., 2012; WHO, 2010).

123. **Collaboration is often used in projects that involve multiple sectors**, such as when government, non-profits, private and public organizations, community groups, and individual community members come together to solve problems that affect the whole community. Such an approach is good for tackling upstream issues, root causes and/or systemic issues of a problem through the multiple resources involved: government, the private sector and nonprofits (social organizations). It creates more power than one organization or even a group of similar organizations.[39] A study in Taipei,China concluded that no single organization can provide a comprehensive range of services for ESD or the elderly in need of protection (Liu, 2004). The study identified two key organizational factors that influence protection services for the elderly in Taipei,China (or Taipei City more specifically). They are

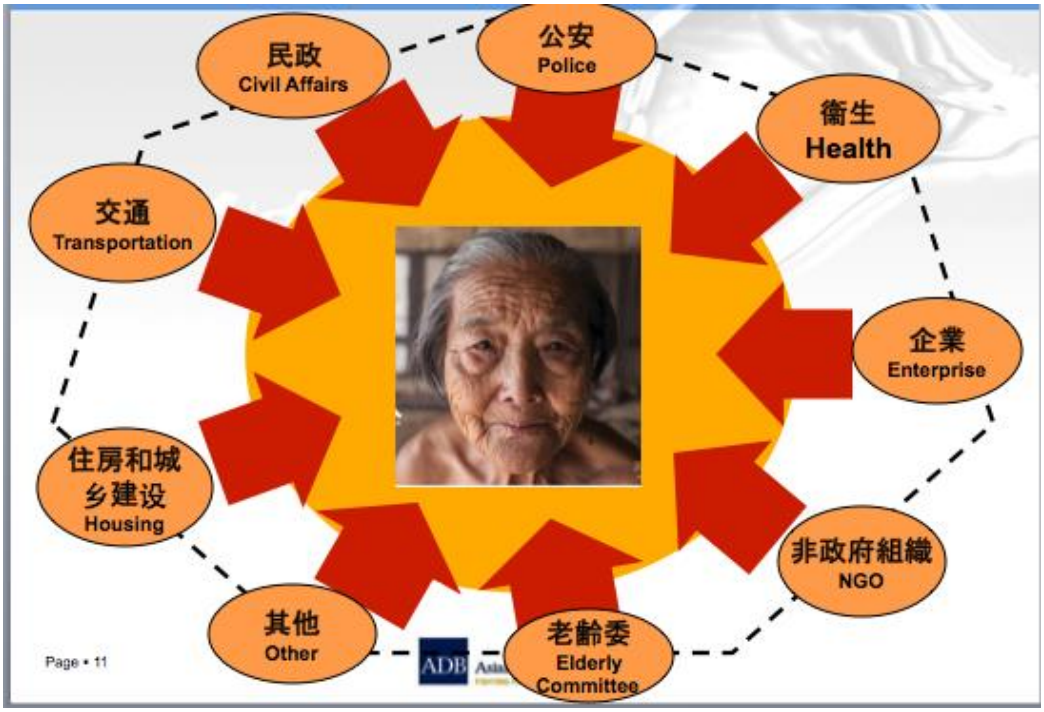
(i) a coordinated client referral network to protect the elderly as client referrals are an important mechanism for organizations to address the multiple needs of the elderly; and

(ii) government entities such as the Taipei Municipal Government Bureau of Social Affairs, Taipei City Police Bureau, and the Yung-Ming Hospital played a crucial role in leading protective services coordination for the elderly. This leading role of government was important as both funder and regulator to help remove barriers to service coordination, overcome institutional turf issues, inconsistency in administrative procedures, and differences in protective service approaches.

[38] http://www.selectioncriteria.com.au/a-cooperate.html

[39] http://ctb.ku.edu/en/table-of-contents/implement/improving-services/multisector-collaboration/main

Figure 6: ESD Support Requires Multisectoral Collaboration



124. **Collaborative interdisciplinary approaches can be challenging.** Other sectors, such as the airline industry, have demonstrated effective collaboration and teamwork to minimize error and improve safety, and may deserve comparative study (Baker et al., 2006; de Korne et al., 2010; Helmreich et al., 1999; Manser, 2009; Shaw and Calder, 2008; WHO, 2009). Social workers have also collaborated with colleagues in other disciplines from the earliest days of the profession, despite the lack of clear models to guide such collaborative and interdisciplinary work. Explicit models to guide social work practice within a collaborative interdisciplinary approach have only emerged more recently (Bronstein, 2003).

E. Collaboration in Action

1. Model of Care

125. A model of care is the way in which health/social services are delivered. It describes best practice in care and services for a person, population group or patient/client cohort as they progress through the stages of a condition, injury or event. It aims to ensure that people receive the right care, at the right time, from the right team and in the right place[40]. Implementation of new models of care requires changes in traditional staffing patterns and provider roles[41]. A number of social and health service models of care for the elderly and other age groups have been developed since the 1990s. Some of these are listed below. The first ten are specific to elder care whereas items 11 and 12 are nonspecific models. However, these last two also merit consideration as the problems they seek to address are also very complex and their approaches have been very similar to those employed in elderly care. A detailed description of these last models of care can also be found in Appendices 3 and 4. Only the first three approaches are

[40] NSW Agency for Clinical Innovation ACI. (2015). P.3
[41] Institute of Medicine (2008), p.75

included in this report as they represent models of care which have originated in three different countries i.e., Canada, the US, and the UK.

(i) Community Response Network (CRN), British Columbia (BC), Canada
(ii) Chronic Care Model (CCM) in Geriatric Service, US
(iii) House of Care for People with Long-Term Care Conditions, UK
(iv) IMPACT: Improving Mood: Promoting Access to Collaborative Treatment for Late Life Depression
(v) GRACE: Geriatric Resources for Assessment and Care of Elders
(vi) The Green House Model (Eden Alternative)
(vii) AIM: The Advanced Illness Management Program (end of life care)
(viii) PACE: Programs of all-inclusive care for the elderly
(ix) Evercare: intensive primary care
(x) Social HMO Demonstrations: coordinated acute and community care for client at risk for residential care placement.
(xi) The UK's Children Safeguarding Model – Multisector Collaboration
(xii) Community resilience model, DC, US.

126. Models such as the CCM, PACE, IMPACT have been used for a number of years and their effectiveness has been proven scientifically. Some others are government initiated working frameworks (e.g., CRN in Canada and House of Care for People with LTC Conditions in the UK). Diffusion of those models not initiated by government has been limited and partly reflects external constraints such as insufficient funding. The US Institute of Medicine has recommended improved dissemination of models that have been shown to be effective and also increased support for research and demonstration programs to promote development of new models of care.[42] One of the reasons that CRN, CCM, and House of Care for People with LTC Conditions were selected for further deliberation in this report is their wider diffusion and endorsement by respective governments. The listing and discussion of these models is not intended to suggest that the PRC adopt any of them. Rather, it is to show how other countries have used a collaborative approach to assist the elderly experiencing complex issues.

2. Community Response Network, British Columbia, Canada[43]

127. A CRN is a diverse network of concerned local community members, businesses, and agencies (including local Health Authorities) which have come together to create a coordinated community response and to help adults experiencing or at risk of experiencing abuse, neglect or self-neglect. The CRN has a provincial organizing body to provide funding, materials, training, support staff, and to maintain a website. It focuses on identification of the vulnerable elderly, and especially the elderly at risk of abuse.

128. **The actual work of a CRN is undertaken through its CRN gatekeeping team**. This is a network or loose grouping of people and organizations that care about adult abuse and neglect, and that aims to contribute toward a coordinated community response. A CRN recruits and trains gatekeepers who may be parking meter readers, city workers, church members, neighborhood watch members, emergency program volunteers, bus drivers, restaurant staff or retail clerks. These gatekeepers help to systematically identify high-risk vulnerable adults, and particularly those who are isolated, living alone, and in need of some type of assistance to

[42] Institute of Medicine (2008), p.75
[43] Web: www.bccrns.ca

maintain their independence. The role of the gatekeeper is critical to the success of the program as the gatekeeper identifies those older people who most need help. CRN members can also provide a point of continuity amid staff turnover in other organizations.

3. The Chronic Care Model in Geriatric Service, USA[44]

129. **The Chronic Care Model (CCM) was developed in 1989 by Ed Wagner to assist people with "chronic conditions."** A chronic condition is characterized as any condition that requires ongoing adjustments by the affected individual and interactions with the health and/or social care system. The CCM endeavors to correct the many deficiencies in chronic condition management, which include:

(i) Rushed practitioners not following established practice guidelines.
(ii) Lack of care coordination.
(iii) Lack of active follow-up to ensure the best outcomes.
(iv) Clients inadequately trained to manage their conditions.

130. Overcoming these deficiencies requires the health and social care system to transform from a system that is essentially reactive and primarily responds when a person is sick, into one that is proactive and focused on keeping a person as healthy as possible.

131. **The Chronic Care Model has been further defined by The Robert Wood Johnson Foundation** with inputs from a large panel of national experts (1997). The Foundation initiated a rigorous independent evaluation of the collaborative improvement process and implementation of the CCM. A multidisciplinary research team from the RAND Corporation[45] and University of California at Berkeley cooperated with Improving Chronic Illness Care (ICIC)[46] to undertake the evaluation work in 1999. The evaluation team conducted in-depth assessments in 51 participating sites in four collaboratives, involving almost 4,000 patients with diabetes, congestive heart failure, asthma, and depression. Over fifteen papers have been published on the evaluation findings, which are very convincing. The effectiveness of the study was further confirmed by Coleman et al. (2009). In addition, care teams contacted a year later reported that their involvement in the collaborative was rewarding. Over that year, 82% of sites had sustained the initial changes and 79% of sites extended those changes to other localities or chronic conditions/problems.

132. **WHO referred to this approach as Innovative Care for Chronic Conditions** and suggested member countries adjust their care model according to the context of member countries (WHO, 2002). Shanghai, in the PRC also used this model to assist patients with diabetes (Fu, 2003). Moreover, the model has survived the test of time and has been widely used by practitioners to deal with chronic health issues and other social issues such as palliative care, long term care, mental illness and deficiency.[47]

133. **The Chronic Care Model can be modified slightly to fit the needs of the ESD** (Figure 7) as follows:

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[44] http://www.improvingchroniccare.org/index.php?p=Geriatric_Care&s=89
[45] http://www.rand.org/about.html
[46] http://www.improvingchroniccare.org/
[47] Rehabilitation Division of St. James' Settlement, Hong Kong used CCM to revamp its service delivery model between 2004 – 05.

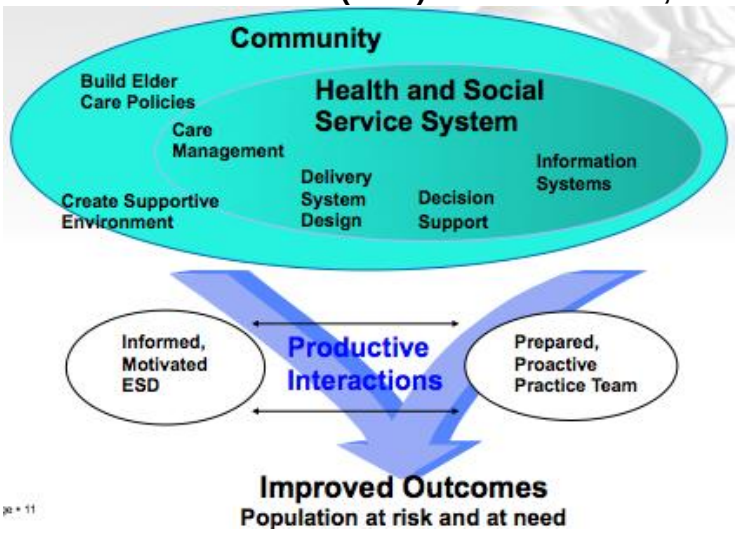
(i) Health and social service system
  (a) **Delivery system design.** Create an integrated service and an interdisciplinary team, define the roles and responsibilities of multidisciplinary service providers, planned and evidence-based interventions, and arrange regular follow up and monitoring.
  (b) **Decision support.** Use robust, interdisciplinary, evidence-based guidelines and protocols and proven education methods.
  (c) **Clinical information system.** Share information among service providers, and create a system for timely feedback and reminders to assist service providers.
  (d) **Care management.** Use a service user stratification system for case management in high risk cases, shared management in moderate risk cases, and self-management in low and no risk cases.

(ii) Community
  (a) Advocate for elderly friendly public policies, including for housing, universal design, transportation, intergenerational harmony, healthcare, and social services.
  (b) Collaborate with community agencies to support elderly care and mobilize community resources to meet the needs of service users.

(iii) Productive Interactions
  (a) Build a well prepared interdisciplinary team to provide proactive care and early intervention, rather than only providing reactive care and crisis intervention.
  (b) Foster well informed and motivated ESDs who are empowered to take part in the planning and delivery of their care and services.
  (c) Stimulate productive interactions between informed ESD and providers with resources and expertise.

(iv) Outcomes
  (a) ESD problems are prevented or reduced.
  (b) Providers are satisfied.
  (c) Cost savings to the system are realized.

Figure 7: Chronic Care Model (CCM) in Geriatric Care, USA



Source: http://www.longwoods.com/content/16763

F. Key Lessons

134. All of the collaborative models above involve multiple disciplines, professions, and sectors and focus on

(i) **proactive service:** trying to prevent ESD from deteriorating by (a) stratifying the elderly according to their levels of vulnerability and (b) providing adequate levels of service intensity and support in advance;
(ii) **preventive service:** trying to prevent ESD, where possible;
(iii) **collaboration among providers:** including information sharing and use of practice guidelines; and
(iv) **case management:** case stratification for allocation of professional and nonprofessional service based on levels of need/risk.

135. **Whether these models involve social work professions is not pre-determined**. The focus is on the work or functions to be accomplished rather than the professionals to be involved. For example, if a community assessment can be completed by either a nurse or social worker, then the work will likely be completed by a social worker as they are better trained to complete the task—provided that the social worker is also a team member. Otherwise, an adequately trained health care practitioner is equally capable of completing the task. Given that a significant number of social workers are employed in the health care system, it is very likely that the social worker will be a key player in the above systems or models. Above all, most governments in these localities no longer rely on single discipline, profession or sector to solve complex social issues.

1. Create a Bundled Approach for Direct Intervention and Other Enabling Strategies

136. **Direct intervention is insufficient to deal with complex issues in the chronic care or house of care model.** The success of these models requires other enabling and supporting strategies. In the chronic care model, its enabling strategies are the shared information system, practice guidelines, integrated services and case management, and supportive elderly policy and environment. In the house of care model for people with long term conditions, the enabling strategies are commissioning; engaged, informed individuals and carers; organizational and clinical processes; and health and care professionals working in partnership. Direct intervention alone is insufficient to create a long lasting impact on a complex social issue such as ESD. Other supporting strategies are needed to enhance the effect of direct intervention and to create a long lasting impact. In searching for a service model for ESD, the PRC should avoid the traditional thinking of an intervention model based on one single discipline, such as social work. Instead, the PRC could embrace a concept of bundle service.

2. Develop Interdisciplinary Collaborative Approach

137. **The need for collaboration among disciplines, professionals, and sectors has emerged as a clear theme in all the models discussed.** The success of the CRN mainly builds on its capacity to connect resources and networking. The chronic care model is basically a collaborative model that promotes integration of service providers through service redesign. The UK takes (i) engaging and informing individuals and carers, and (ii) partnership between health and care professionals as two essential components in its House of Care for people with long term conditions.

138. **It is recommended that a PRC service model for ESD be based on a similar operating principle - an interdisciplinary and multisector collaborative approach.** This would move beyond the scope of Civil Affairs to also include other government and nongovernment agencies. Such an approach will not be easy but the impact of such collaboration for ESD will be large and significant.

3. Government Assumes Leadership in Collaboration

139. **Most governments assume a leadership role in service coordination and collaboration on issues of national or provincial importance.** For instance, the UK National Health Services champions the House of Care approach for people with long term conditions. This involves a senior official in the major's office taking the lead in coordinating a multi-agency strategic group for child protection.[48] The senior official's job is not to micromanage other government departments but to ensure the aims of ESD work are translated for, and percolate down to, the ministry, bureau and local government levels of bureaucracy. This senior official ensures that coordination occurs and, more importantly, that no gaps exist because each player (agency, government, and nongovernment) thinks that another player is addressing.

Case Study 10: The Coordinating Ministers in the Singapore Government

The Singapore government introduced the position of Coordinating Minister in 2003. At first, there was one coordinating minister but now there are three. Some commentators consider that the role of coordinating minister reflects Government recognition of the interrelated nature of its social policies and the need to avoid miscommunication.

The issue of miscommunication is not actually with the ministers, as they attend Cabinet meetings and are fully aware of the national interest and the Prime Minister's objectives in various fields. The challenge is actually how to ensure this intent translates, and percolates down, to the various levels of bureaucracy, (including to the permanent secretaries, different ministries, and statutory boards) to ensure a whole-of-government approach to policy implementation.

Source: http://www.channelnewsasia.com/news/singapore/singapore-s-coordinating/2169480.html

4. Reactivate the Social Worker Role in Interdisciplinary Collaboration

140. **The definition of collaboration** is "a relational system in which two or more stakeholders pool their resources to meet objectives that neither could meet individually" (Graham & Barter, 1999, p.7). Collaboration emphasizes the collective effectiveness of professionals from different training programs, creates mutual respect for fellow professions and professionals, and recognizes the worth of each member of the ESD intervention team. Collaboration, and especially interdisciplinary collaboration, is a cornerstone of social work practice and part of formal social work training in many tertiary institutions (Graham & Barter, 1999). Unfortunately, social workers have rarely undertaken this role and responsibility. However, if this role were to be formally acknowledged, the social worker would be more than adequate to work with a designated coordinator to promote collaborative work for ESD.

[48] http://www.thebromleytrust.org.uk/files/chidrens-commission.pdf.

V. IDENTIFYING THE SOCIAL WORKER ROLE IN WORKING WITH ESD

"Confusion is often but the first step to clarity"

– unknown author.

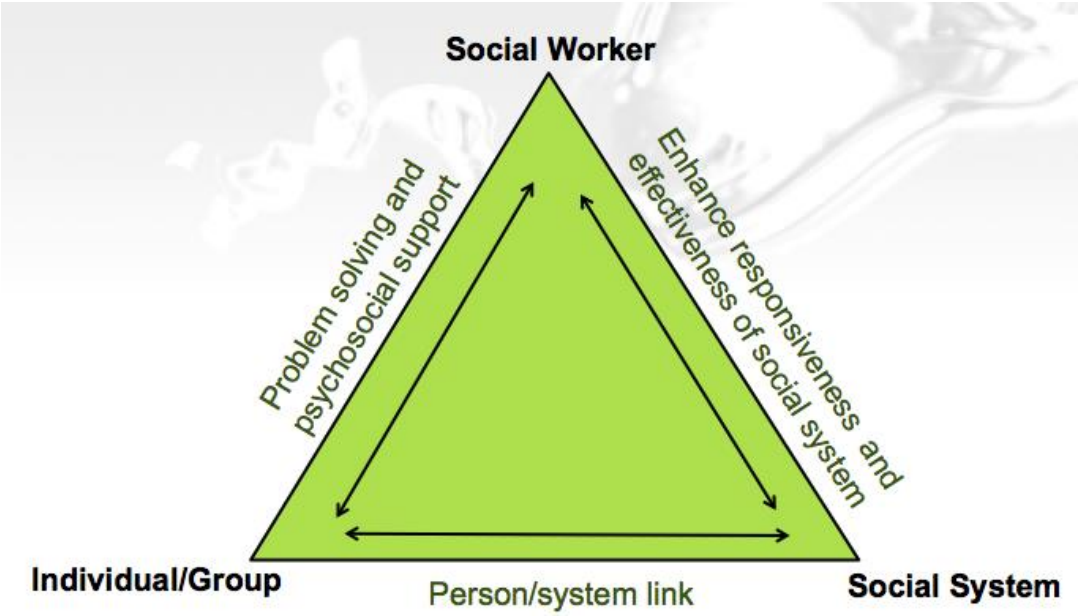
A. Introduction

141. The large number of social workers employed in elderly service provision indicates that social workers clearly have an important role in working with ESD. In a collaborative approach or model, these social workers form part of the collaborative interdisciplinary framework. This may involve direct intervention such as counseling, conducting group activities for the elderly, or work towards the realization of enabling strategies, service redesign, or case management. In the absence of such a clear collaborative interdisciplinary framework, social workers function within the traditional social work practice model (Figure 8). This may involve counseling, brokering, mediating or advocating.

B. The Person-System Link

142. **The person-system link is one of the three traditional social work roles**, namely (i) providing psychosocial support and assisting problem solving for individual service users (e.g., an individual or group); (ii) linking individuals to the social system, including social resources (the person-system link); and (iii) enhancing the responsiveness and efficiency of the social system.

Figure 8: The Traditional Social Work Practice Model



143. The person-system link has been referred to as the information and referral service within social work practice. However, it has not received a lot of attention in social work education and is less documented in social work literature as it involves few "professional skills," and has come to be viewed as less "professional". Instead, the person-system link has received much higher attention in health care as the health care system can be very complex and an

individual may easily become lost or confused within it. Examples include the organization and delivery of long term care or cancer care. Long term care consists of many services, ranging from home-based to community-based or residential care. An older adult and/or family members will require a lot of expert guidance to navigate this system, access its services, and make the system responsive to their individual needs. In addition, there are at least three types of barriers that can prevent an individual from accessing services and from services reaching those individuals in need.[49]

1. System Barriers

(i) **Unavailability of service.** This can be due to lack of recognition that the ESD are a problem; lack of ideas on where to start to deal with the problem; unwillingness to address the problem, etc. The social worker may have to advocate for problem recognition and funding support.

(ii) **Inadequate service.** Lack of local resources or inadequate services to cope with demand. The social worker may have to solicit support from government, private foundations, run community fundraising, or use other methods, such as sharing staff, space, equipment, materials/supplies, involving volunteers or outsourcing services.

(iii) **Physical barriers.** Lack of barrier-free and universal design. The social worker may have to organize volunteer labor and donated materials or convince a landlord to provide accommodation.

2. Service Barriers

144. Service barriers relate to inadequate or ineffective outreach capacity, the affordability and eligibility for services, negative perceptions of the service, and the quality service (staff credentials and skills, appropriateness and effectiveness of the service, and its organization).

(i) **Ineffective outreach capacity.** The social worker may have bring awareness of the service onto the community "radar" or map; to hire an outreach coordinator, use appropriate media, other organizations, and satisfied service users to publicize the service, take advantage of community networks and connections, and to use a language that the target population can understand, and to which it can respond.

(ii) **Negative perceptions.** The social worker may need to communicate with those who are distrustful and to correct misunderstandings and misinformation.

(iii) **Issues pertaining to affordability and eligibility.** The social worker may need to employ a sliding fee scale for participants or make alternative arrangements for people who simply cannot pay.

(iv) **Quality.** The social worker may have to continuously evaluate the service to determine which programs are working well and to discussing how to improve other services with current and former service users and staff.

3. Individual Barriers

(i) **Transportation problems.** The social worker may arrange transportation for clients, coordinate car pools, provide bus fares, organize public transportation

[49] http://ctb.ku.edu/en/table-of-contents/implement/improving-services/access-health-and-community-services/main

pools, share transportation arrangements with other organizations or set up satellite sites.

(ii) **Program location problems.** The social worker may seek spaces that the target population considers to be neutral. High schools, colleges, and government buildings may intimidate some people, whereas commercial space may be neutral. Alternatively, only outreach may be used for client interaction.

(iii) **Program scheduling problems.** the social worker may have to find times convenient to service users, although these may not necessarily be so for staff.

(iv) **Denial.** A target population may not perceive an ESD issue to be a (priority) problem, and so the social worker may have to enlist the help of trusted professionals and community leaders to help educate service users. This involves providing facts, statistics, and personal anecdotes, where possible, to help people understand how the service affects them, at present and in future.

(v) **Cultural issues.** The social worker may have to hire members from different culture groups to facilitate understanding and access.

145. **The person-system link remains a matter of concern.** The UK government initiated 16 social work practice pilots for older adults in 2010.[50] One of the requirements for social workers in these projects is to enable older adults to use their skills and talents to build stronger relationships and networks with friends, family, and the wider community i.e., the person-system link. This is considered to be a more flexible and creative way to deploy social workers to support older adults. It aims to liberate social workers from traditional case and group work thinking, and to focus instead on promoting active and inclusive person-system links, and empowering people to make their own decisions about their services and support. The social workers need to work in partnership with community organizations to link people to peer-support networks and befriending schemes that reduce client risk of isolation and promote greater prevention and early intervention for problems.[51] These projects are conducted as social enterprises in which surpluses from the project can only reinvested for the purpose of the project or within the community, rather than to maximize personal shareholder profit (Social Care Institute for Excellence, 2013). Case studies 11 and 12 provide two typical examples of these projects.

Case Study 11: Social Work for the Vulnerable Elderly

Mrs. X is 85 years old and lives alone. She has macular degeneration, difficulty with her hearing, wears a hearing aid and has spinal cyanosis. This means that she has to keep her back straight at all times and suffers with a lot of pain. She also has a frozen left shoulder, arthritis in her knees, and quite severe gout. Her mobility is poor and she has suffered a number of falls.

[50] The social work practice pilots originated from the belief that these two pilots might enable social workers to (i) spend more time with the individuals in their care and reduce bureaucratic burdens on individual social workers; (ii) create a more responsive service by bringing decisions much closer to clients; (iii) feel empowered, with more control over the day-to-day management of their practice; (iv) step back and think creatively about the use of resources and use increased financial flexibility to deliver better outcomes; and (v) enjoy their jobs more.

[51] In general, the social workers involved in the projects agreed to (i) follow social work values and principles at every level, including direct work with clients, working as a staff team, engaging communities, and running the project; (ii) use a person-centered approach, including empowering people and working to promote social justice; (iii) ensure clear social work theories and methods are identified, embedded, and implemented within the project; (iv) be clear about the vision of social work and what the role of social work is within the project; and (v) promote and foster the autonomy of social workers and allow them to work and to make decisions.

I became involved with Mrs. X following her contact with social care for an assessment for day care services. On visiting Mrs. X, she initially asked me to arrange day care for her as she felt very isolated living on her own and rather down. I talked with her about her interests and family relationships and what was important to her. During this discussion Mrs. X told me how she had always been at the helm of her family and how she used to write letters make telephone calls and kept in touch several times a week. She was the person who managed to keep her family together and in touch with each other. Her sons, daughters and grandchildren previously visited regularly.

However, over the years her family had moved away, some overseas. Due to her vision problems, she was now unable to write letters, unless someone helped her and this affected what she could say freely, since letters are personal. She was unable to telephone as often as before because of the cost, and difficulties in holding the telephone. Her computer was broken and irreparable. It became very clear as our conversation progressed that her main need was to regain contact with her family and to be able to regularly speak with them and keep them all in touch with each other—it was not to attend the day center as she had first requested. She really wanted a modern computer specially designed for her visual impairment, but did not have the money to buy one.

As practitioners we were able to be creative. I completed the assessment with Mrs. X and made enquiries on the cost of a computer designed for someone who was visually impaired and made a request for a one-off direct payment to enable her to purchase it. This request was approved and Mrs. X chose her computer, which had a web cam and large screen. She cancelled her request for the day center. I have since reviewed the care delivered and Mrs. X informed me she is the happiest she has been in months. She showed me pictures of grandchildren and family members sent via email. She has subscribed to Skype and talks to family free of charge. She is once again the matriarch of the family and back in the position that meant so much to her, but felt she had lost. She tells me she never has enough time in the day now to chat with everyone! (Social Care Institute for Excellence, 2013:2).

Case Study 12: Royal Greenwich Social Work Practice Pioneer Project: Pilot Family Group Conferences and Restorative Approaches to Protect Adults at Risk

Online peer support – Tyze Personal Networks. Jill, in her early 60s, has lived alone for the past 20 years and struggled with her weight and had depression for most of her adult life. In 2008, a life-threatening illness saw Jill rushed to hospital. Jill's two older sisters used Tyze Personal Networks to create a secure, online network of support, 'Team Jill', to help strengthen the relationships around Jill and address her isolation. Jill's health stabilized but she was told she would not be going home as she couldn't transfer herself from bed. Team Jill was able to connect with expertise in the medical team to enable Jill to achieve her ambition of going home. They started a list of 'Get Jill Home' goals, like exercise routines and sessions with the physiotherapist. Tyze includes practical tools such as a calendar for goals and tasks as well as stories and photos, and a private vault for confidential information. Gradually Jill regained her strength and she was able to go home. Source: http://www.scie.org.uk/workforce/socialworkpractice/files/pioneers/RoyalGreenwich.pdf

146. **An individual approach has been used and a high-tech solution found in both Case studies 11 and 12**. However, the problems of Mrs. X and Jill are only symptoms and downstream issues. Upstream issues are likely to be complex. However, if they are addressed,

they would benefit more elderly. Social workers need to collaborate with other disciplines (such as sociology, economics, architecture, design, health, and medicine), professionals (such as doctors, nurses, dieticians, rehabilitation specialists, and universal designers) and sectors (including organizations that are for-profit or not-for-profit, governmental or nongovernmental, and private or public sector).

C. Case Management

147. **Case management involves a professional worker as the primary contact point for the ESD.** That professional worker is responsible for the person (the client) and system link and the coordination between services. The primary contact person is the case manager. Case management is a generic term, with no single definition. Hutt et al. (2004) describe it as "the process of planning, coordinating and reviewing the care of an individual." Different localities may have slightly different definitions of case management.

148. **The Case Management Society of America (CMSA, USA) defines case management** as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health and social needs through communication and available resources to promote quality cost-effective outcomes" (CMSA website).[52] Advocacy should occur at three levels: service delivery, benefits administration, and policy making. In terms of service delivery, it includes facilitating (such as brokering and mediating) and client access to necessary and appropriate services, whilst also educating the client and family about resource availability. These definitions suggests that, rather than being intervention focused, case management refers to a service delivery process and to an arrangement for a basket of care or services. This may involve a range of activities that can vary widely between programs, e.g., ESD, children at risk of exploitation, etc. The goal should be to improve care and services for the elderly through partnerships that focus on collaborative problem solving.

149. **Case management In the US is so well developed that a growing industry of businesses are gearing their services toward the elderly.**[53] For example, Aging Wisdom is a care management company based in Seattle and Bellevue. It functions as a geriatric case manager to help bridge gaps for families that are scattered across the country or/and the world. The company provides money management services, takes the client grocery shopping, and can arrange cooking in their home, as well as providing companionship. The company hires case managers to oversee these services.

150. **Case management is a key strand in the UK Department of Health** model for caring for people with long-term conditions (Department of Health, 2005a & 2005b). Segmentation of the population at risk (report Section 2.5) recognizes that these people have a varying intensity of needs and that care and service should be targeted accordingly. The premise of the risk segmentation model (Section 2.5) is that targeted, proactive, community-based care is more cost-effective than downstream hospital care. In this model (i) case management, (ii) shared (supportive) care management, and (iii) self-management (self-help) form a full "case management system."

151. **Canada takes a slightly different approach to case management than the US and UK.** The Canadian National Case Management Network (NCMN) is wider in scope and includes

[52] http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx
[53] http://www.usatoday.com/story/news/nation/2012/12/08/boomer-services-blossom/1754597/

both health and social services. This is reflected in the core competency profiles of its case management providers, developed by NCMN-Canada in 2012 (NCMN, 2012). As an example, case management for Vancouver Coastal Health, Canada covers a range of professional competencies to coordinate and manage care for individuals with complex health and social conditions, such as disability. This is not a job description but an element of all professional practice that includes social work, nursing, rehabilitation, and medicine. In this approach, case management is not the function of a specific profession but part of the role descriptions for all professionals involved in care of the elderly. It is the nature of the presenting problem of an elderly person that determines which profession takes the role of case manager. If the presenting problem is a rehabilitation issue, then a rehabilitation specialist may become the case manager. If the issue is more psychosocial, then a social worker will likely be designated as the case manager.

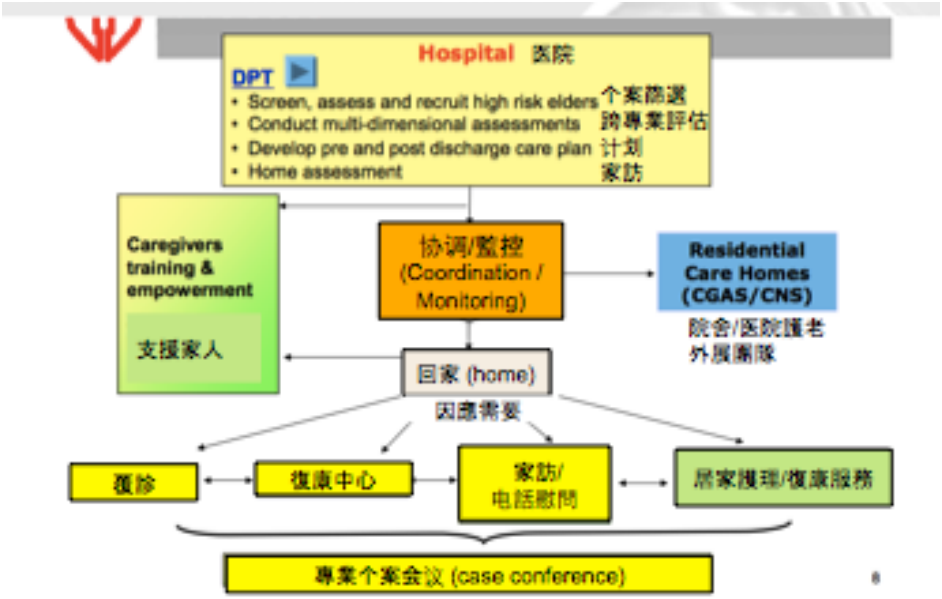
152. **Vancouver Coastal Health has adopted a risk stratification system similar to the UK.** Its case management system also consists of (i) intensive case management for those at high risk, (ii) supportive case management for those at moderate risk, and (iii) self-management for those with low or no risk. Case managers in remote parts of Canada may even travel with the elderly who need to leave their community for care e.g., in the case of vulnerable seniors from the First Nations, Inuit, and Metis.[54]

153. **Most social workers helping the hidden and vulnerable elderly in Hong Kong, China, are employed by social service organizations**, such as NGOs through Funding Service Agreements between the Social Welfare Department and District Elderly Community Centers and Neighborhood Elderly Centers. Many of these social service organizations call themselves case managers because the person-system link is a key function of their work with ESD.

154. **The Hong Kong Hospital Authority is another key provider of services for ESD or the elderly at risk**. The Authority has a Discharge Planning Framework (Figure 9) in which social work plays a role within and beyond the Hospital Authority. Inside the Authority, a social worker or nurse may be the designated as case manager and serve as a point person to coordinate services between the hospital and the community for the high risk elderly. Social workers outside the Hospital Authority may act as service providers and offer various types of direct community care and services to the elderly at risk. They may also call themselves case managers since they help to provide (the elderly) person and system (services) link to the elderly under their care.

[54] http://www.metisnation.org/media/422632/senior_ab_report_2013_en_final.pdf (p.32)

Figure 9: Case Management by the HK Hospital Authority Discharge Planning Team



155. **Elderly care in Taipei,China is governed by the *Senior Citizen Welfare Law*** enacted in 1980 and amended in 1997. The Law makes surrender of duties and responsibilities for supporting one's elderly parents a prosecutable crime. Services for older adults in the community include homecare, day care, meals-on-wheels, medical and health care. This has been undertaken through the government Intensive Elderly Care Project since 1998. In 2008, government initiated a ten-year long term care plan (2008–2017).[55] Taipei,China scholars have been critical of government's work on elderly care and have argued that it shifts responsibility for elderly care to the family and community. However, instead of providing care in the community, this is more about care by the community or what has been termed "welfare communitilization" (Metteri, 2004). Taipei,China welfare services are generally considered to be fragmented and uncoordinated, with very little communication among professional providers.[56] Most welfare services are concentrated in urban areas, making it difficult for the rural elderly to obtain services.

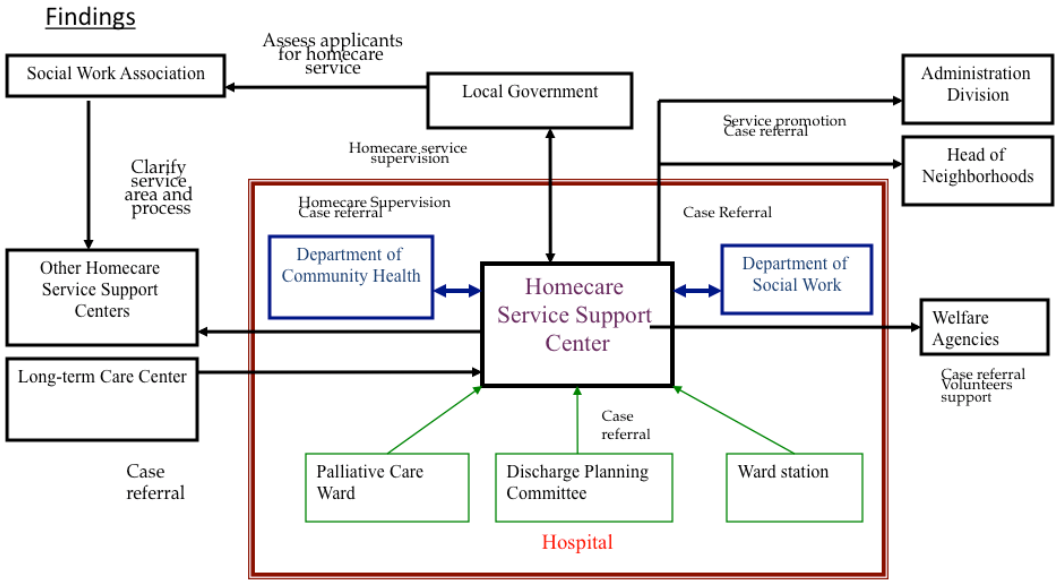
156. **Case management, is still fairly new in Taipei,China.** Most case management activities occur in hospitals as part of managed care and aim to balance quality of care and cost. Case management is also being developed to manage chronic conditions within long term care. Case management within community care is the newest such development and tends to focus on older people, those with low incomes, and the mentally ill (Liu, 2007). Most case managers are nurses.

157. **Social workers in Taipei,China use community service networking** to link their elderly clients with nongovernmental resources such as NGOs, informal caregivers (e.g., female carers), and the private sector. Social work services also provide psychosocial support and the person-system link (resources management) e.g., by linking the needy elderly with financial assistance and housing (Figure 10).

[55] http://www.sparc.tcd.ie/newsAndEvents/Nov4_2011_Chou%20Taiwan%20Older%20people%20and%20social%20care--Nov%204-%202011.pdf

[56] https://www.google.com.hk/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=social%20work%20for%20elderly%20in%20taiwan

Figure 10: Homecare Support Service Centre in a Taipei,China Hospital



Source:https://www.google.com.hk/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=social%20work%20for%20elderly%20in%20taiwan

158. **Many elderly care services in Taipei,China are provided by NGOs** such as the Hondao Senior Citizen's Welfare Foundation. This agency offers services for the elderly ranging from community education (e.g., awards for families residing with three generations), to domestic care, day care, and short stay services. Social workers provide the person-system link and coordinate services provided. These include domestic care, and information and referral services such as senior consultation services. The Foundation has also targeted home modification and fall prevention for those elderly at risk who live in dilapidated housing. A social worker makes assessments and plans, seeks approval from the elderly, costs and contracts the service, examines the final product, and closes the case.[57] Although these social workers function like a case manager, they are rarely called case managers.

D. Role Descriptions and Key Competencies of a Case Manager

159. Kodner (2003) and Challis et al. (2010) consider the core activities of case management to be:

(i) **Case-finding and/or screening.** This is the case identification and eligibility determination of case management (NCMN, 2009).

(ii) **Case assessment using a "standardized" method.** This is the process of collecting accurate and relevant information about a service user in order to set baselines, monitor and measure the outcomes of an intervention. It is also the art of gathering relevant information in order to define the problem to be tackled, or identify the priorities or goal to be attained, and to establish a baseline for planning (CMSUK, 2009).

[57] http://www.hondao.org.tw/hondao/2015home/#02

(iii) **Case/care service planning.** This is a comprehensive plan that includes a statement of problems or needs determined at assessment, strategies to address those problems or needs; and measurable goals to demonstrate resolution based on those problems or needs, including the time frame, resources available, and desires/motivation of the client (CMSA, 2010).

(iv) **Case/care coordination – linking to services.** This is the deliberate organization of client service activities between two or more players (including the client) involved in a client's care to facilitate the appropriate delivery of care and services. The organization of care and service involves the marshaling of professionals and other resources needed to carry out all required client care and service activities, including across sectors. This is often managed through the exchange of information among players, parties, or stakeholders responsible for different aspects of services (CMSA, 2010).

(v) **Case conference.** Case conferences are arranged by the case manager to talk over concerns about ESD among all stakeholders, including the conference chairperson, case manager, social worker, police officer, nurse, physician, other healthcare professionals, the ESD and family, and representative(s) from neighborhood organizations. The structure and process for case conferences affects the case conference outcomes. Thus, the case manager needs to have a good understanding of the purpose, agenda, conference participants, and meeting dynamics. At the end of the meeting, the case manager will have to ensure that the decisions of the case conference are implemented.

(vi) **Implementation – management of services.** This is usually undertaken by a case manager in the context of a multidisciplinary team. It may include, but is not limited to, direct psychosocial support, service connectivity, health and social care services, self-care support, advocacy and negotiation.

(vii) **Continual case review** involves monitoring, outcome evaluation, and care plan adjustment. A periodic reassessment is conducted to identify the client's current needs and to monitor progress within the client's individualized plan (National Case Management Network of Canada, 2009).

(viii) **Case disengagement for time-limited interventions** involves either discharge or service completion. The case manager needs to allow for an effective case closure by reviewing the intervention goals and achievements and giving assurance of assistance if a need should arise in the future.

160. These role descriptions might suggest that case management is a linear process with sequential elements. In practice, it is not. Many individuals may undergo repeated monitoring and review, as well as further Assessment and care planning until they are fit for disengagement.

Case Study 13: Case Management for the Elderly at Risk in the United Kingdom

- **Application of frailty screening tools** i.e., use of the Rockwood Clinical Frailty Scale and the Gait Speed Test for all persons aged 75 years and over at hospital entry and via community teams.
- **Ongoing case management** or key worker allocation for elderly who score 5-8 on the Rockwood Clinical Frailty Scale and have a positive gait speed test result.
- **Personalized care plans** are in place for all persons who score 5–8 on the Rockwood Clinical Frailty Scale and record a positive gait speed test.
- **Advanced care planning** is offered and discussed with all people who score 8–9 on the Rockwood Clinical Frailty Scale.

Source: https://www.england.nhs.uk/wp-content/uploads/2015/01/cquin-krnw.pdf

161. In 2012, the National Case Management Network of Canada issued a core competency profile for case management providers that included:

(i) **A case management expert.** Case management (CM) providers can demonstrate expertise in planning complex health and social needs. They lead coordination and facilitation and integrate all CM roles to promote and optimize the health and well-being of targeted client populations. CM providers are able to
   (a) screen clients for eligibility;
   (b) perform a comprehensive assessment;
   (c) develop a collaborative CM plan;
   (d) facilitate coordination, communication and collaboration with clients and stakeholders to maximize their outcomes;
   (e) evaluate the outcomes of the CM plan; and
   (f) facilitate the transition process.

(ii) **Communicator.** CM providers use effective communication to develop and enrich the client's health and social networks, and employ a variety of different communication strategies/methods/techniques to build partnerships and to address barriers at the client and systemic levels. The case managers are able to
   (a) develop rapport, trust, and ethical relationships with clients and stakeholders;
   (b) elicit and synthesize relevant information and perspectives from clients, social networks, and stakeholders, where applicable; and
   (c) employ effective means of communication (e.g., verbal, nonverbal, written, electronic and social media communications.)

   Case managers should be able to develop good relationships and communicate with a range of people, especially to help their clients feel supported psychosocially and to have a sense of reassurance that someone is "looking out" for them. They need to be approachable and able to demonstrate empathy, even when addressing "minor concerns" (Sargent et al., 2007, p 516; Cubby and Bowler 2010; Goodman et al., 2010).

(iii) **Collaborator.** CM providers facilitate the achievement of optimal client and system outcomes by working with a range of broad health and social networks. CM providers skilfully engage individuals and groups to reach consensus by providing direct or indirect assistance and guidance or supervision along the continuum of care. These case managers are able to
   (a) establish and maintain team relationships that foster continuity and client-centered collaboration;

(b) collaborate with stakeholders to prevent, manage and resolve conflict; and
(c) build networks of resources.

(iv) **Navigator.** CM providers help clients navigate health and social systems by working with their networks to identify and address disparities and barriers. These case managers are able to
(a) anticipate, identify, and help remove barriers to holistic care; and
(b) facilitate safe and effective connections to services across settings (different situations).

(v) **Manager.** CM providers are integral participants in making decisions about the time, resources, and priorities that affect a CM plan and to contribute toward the effectiveness of a clients' healthcare plan, social networks and related organizational systems. These case managers are able to manage
(a) decision-making around the CM plan,
(b) unplanned changes that impact the CM plan,
(c) personal and organizational relationships, and
(d) information in a timely manner according to agency and legislative requirements.

(vi) **Advocate** CM providers can use their expertise and influence to speak on behalf of their clients, community, or population to advance their health and well-being. These case managers are able to
(a) identify and act on service gaps and overlaps at the client, community, and population levels; and
(b) assist clients to become autonomous and informed decision-makers.

(vii) **Professional.** CM providers demonstrate professional behaviour in the best interests of their clients and society by adhering to the Canadian Standards of Practice for Care Managers and through ethical and evidence-informed practice. These case managers are able to
(a) comply with all relevant policies, standards and laws,
(b) demonstrate respect for clients' individuality and autonomy,
(c) contribute to the development of the CM body of knowledge, and
(d) use self-reflective practice to enhance professional development.

162. All case management professional organizations, societies, and networks consider it important that case managers can access the right training, support, and mentoring. There is no consensus about the level of training and education needed to be an effective case manager. Case studies show that the content and intensity of training for case managers varies widely, depending on the background of the case manager (Goodman et al., 2010). Also, working across the boundaries of different disciplines can offer the opportunity to learn new and different skills (Graffy et al., 2008; Chapman et al., 2009).

E. Key Lessons

163. **Case management is a traditional role of social work within the person-system link** shown in Figure 8. However, this case management role is perceived as being a less professional form of social work, particularly since more and more social workers are moving towards a "therapeutic role", which is perceived as "more professional." The spread of case management has largely resulted from the development of managed care, which aims to strike a balance between health care quality and cost. Case management is considered as a driving force for health care system efficiency as it helps to focus health care utilization on the most appropriate individuals in need. Thus, health care case management tends to focus on the identification of (high risk) high health care users and determination of the real health care need

(vs. other service needs) of these users. It is considered effective in providing better service coordination to help individuals cope with the demands of long term conditions, especially for those people with complex conditions and needs. Case management has therefore become an indispensable part of managing chronic disease management, long term care, and family violence. Moreover, the elderly account for the bulk of people in these complex conditions.

164. In situations where both a case manager and social worker are hired, the case manager determines the best services for the client and the social worker implements the case plan to achieve the goals laid out for the client. The case manager may be responsible for physical and psychosocial assessment, motivational interviewing, coaching for self-management, and management of chronic conditions such as poor family relationships. An initial case review will include case finding and assessment. The case manager may then assign the case (client) to an appropriate social worker, as necessary. The case manager periodically reviews case progress and requires the social worker to report on all occurrences that pertain to the client.

165. By comparison, the social worker is regarded as a direct service provider who works directly and closely with the case (client), and especially those clients without family, in destitution, who are homeless, facing substance abuse or experiencing mental health problems. The social worker makes sure the client has access to community resources, when necessary, but does not have a role in coordinating with other service providers and/or practitioners.[58]

1. Use Case Management in ESD Management

166. Case management has been widely used in managing clients with complex needs. It has made significant advancement in the localities reviewed for this report, especially in terms of case stratification. For instance, the UK and Canada both use case stratification or segmentation (as discussed in Section 2.5) to group the elderly at risk and the vulnerable elderly into four categories of very high risk, high, moderate and low or no risk. The distribution of elderly at risk across this case stratification system is 10% in the high category, 30% moderate, and 60% at low or no risk. The UK and Canada only employ case management for those classified as high risk. The needs of elderly with moderate or low levels of assessed risk are addressed through shared or supportive case management and self-management. This has two implications:

167. Firstly, the scope of case management has been expanded to include self-management, supportive and intensive case management.

(i) **Intensive case management**. This is the traditional form of case management for people with complex health, psychosocial, and/or environmental needs. These needs can be fluctuating (changing and/or rapidly declining health and social conditions) and involve a high level of resource utilization, inability of the ESD to direct their own care or support, and no appropriate decision maker.

(ii) **Supportive case management** for people with a moderate level of health, psychosocial or environmental risk. These people may experience some challenges but are generally able to direct their own care or support. This creates opportunities for optimization of independence and self-management. This approach is also called shared care in the UK and New Zealand. It involves

[58] http://work.chron.com/difference-between-social-worker-case-manager-3394.html

increased client involvement in managing their service and support needs.[59] The case manager has correspondingly less involvement in supportive case management. Supportive case management has been found to improve the efficiency and use of resources and to enhance communication and the client and provider relationship through client participation. In practice, the case manager or worker and the client collaborate to identify the client's main concerns and to create an action plan that includes an agreed pathway or guidelines that the client and providers will follow to manage the client's conditions or problems.

(iii) **Self-management** is to help people with chronic conditions learn how to manage and improve their own conditions. This is done through interactive learning, behavior modelling, problem solving, decision making, and social support for change. The affected elderly work in a group with guidance from a case manager. The case manager may also provide education for ESD at low risk and for their caregivers, and serve as a system and resource broker for the affected elderly. Self-management is appropriate for elderly people at general risk, such all elderly in a disaster zone, or those with a specific risk such as elderly abuse, or with a specific health condition.[60] It can be provided by early career professionals such as junior social workers or those providing social work assistance.

168. Further deliberation is required on what supportive case management and self-management to include in PRC management for ESD and how to do so. This may have to take into consideration the knowledge and skills base of providers, as well as the cultural, social, and economic context of the elderly involved.

169. Secondly, these intensive, supportive, and self-management categories can also be a useful workload management tool for ESD management. The case manager will have to deploy various levels of intervention in managing these cases. If more cases require intensive case management, then case load in the supportive and self-management categories may be adjusted accordingly.

2. Make the Social Worker the ESD Case Manager

170. Given the complexity of ESD, key social work functions for ESD support are case identification, linking these individuals with the system, and ensuring service coordination. These are all core activities of case management. However, unlike professional case management in health care, case management in social work is less developed, for the reasons mentioned above. It is therefore imperative to upgrade case management skills of the social workers involved in ESD case management

171. Vancouver Coastal Health, Canada has been upgrading its health care professionals and its case management is relatively mature. Vancouver Coastal Health compiled and submitted a list of anticipated skills to the Ministry of Advanced Education for its consideration in 2010. This list included physical and psychosocial assessment, motivational interviewing, coaching for self-management, and management of chronic conditions. Upgrading has subsequently been achieved through (i) inclusion of case management skills in the clinical skill

[59] http://www.sharedcareplan.co.nz/Portals/0/documents/News-and-Publications/110928-SharedCarePilot-CaseStudy-A4-Final_0.pdf

[60] https://www.ncoa.org/news/resources-for-reporters/get-the-facts/chronic-disease-facts/

modules of post-secondary curricula under the Ministry of Advanced Education, and (ii) refresher programs for existing staff.

172. It is equally important that the role of social work in ESD case management be designated by the authorities concerned. This both legitimizes social work functions and promotes social work leadership in ESD case management. Canada is a good example of this experience. In 2002, the Romanow Report (Royal Commission report on the Future of Health Care in Canada) recommended expanding the Canada Health Act to include case management coverage in three priority areas: home-based case management services for mental health, post-acute home care and rehabilitation service case management, and case management of palliative home care services. Such recommendations enhanced the case management functions in these three areas and significantly boosted the role of the case manager in Canada.

VI. SUMMARY AND DISCUSSION

> *"The system is perfectly designed to get the results it gets, so doing the same things over and over again and expecting to get different results is insane."*
>
> *- Albert Einstein.*

173. **The elderly with special difficulties are not unique phenomena of the PRC.** Other localities also face similar social problems. However, these localities use different terminologies to describe the ESD, such as the vulnerable elderly or elderly at risk. These localities have also been working towards a better case finding mechanism for ESD that uses standardized screening tools and continuously improves the predictability of those tools. Older adults at risk are also stratified according to their levels of risk into high, moderate, low or no risk categories.

174. **ESD is a complex problem with multifaceted and intertwined causation**. Countries and regions reviewed in this report are using a collaborative, interdisciplinary approach to assist the elderly at risk of abuse, elderly living with chronic health and social conditions, and to support stressed communities. Such a collaborative, interdisciplinary approach is proactive by nature and tries to prevent the occurrence (or reoccurrence) of a harmful condition. This is something that no one single discipline, profession or sector can achieve on its own. These strategies for a collaborative, interdisciplinary approach involve direct intervention, and the use of enabling strategies such as information sharing, integrated services, collaborative guidelines or protocols, case management, and the creation of a supporting social policy and environment.

175. **The social worker plays a key role in this collaborative interdisciplinary approach.** Social workers may provide direct interventions, such as psychosocial support or linking to the person system. The social worker may also support the development and/or implementation of enabling strategies, such as case management, service integration or the creation of supporting social policy and environment. Many social workers also assume the role of case manager. In countries and regions reviewed for this report, case management is not specific to a particular discipline or profession. It is a function of involvement by all direct practice professionals, such as nurses, rehabilitation specialists or social workers. Case management varies in accordance with an older person's level of risk and may be intensive and supportive or only require client self-management. Professional case management bodies have emerged to help establish case manager competency levels, case management standards, and accreditation and registration processes.

A. Most Localities are Dissatisfied with Current ESD Approaches

176. The issues associated with ESD (including vulnerable elderly or elderly at risk) remain static and appear to be under control in most of the countries and regions discussed in report. However, if nothing remains unchanged, the number of ESD is likely to grow through increased population ageing. Thus, policy makers and service providers in these localities are generally unsatisfied with current ESD management. This is because the existing system for supporting ESD is characterized by the following weaknesses:

(i) inadequate capacity to identify those at risk;
(ii) use of ensiled or single discipline practices and approaches;
(iii) poor service coordination;
(iv) limited information sharing among providers;
(v) insufficient training for personnel that deal with ESD;
(vi) inadequate management of professionals;
(vii) unclear role of the case manager as the service gatekeeper;
(viii) limited use of evidence-based protocols or guidelines; and
(ix) lack of client involvement in management of their own conditions e.g., making good use of their capacities for problem solving.

177. Efforts have been made to either improve the current system or use an entirely new approach. The UK is a good example of trying to improve the existing system. In recent years, the UK's social (care) programs for ESD (elderly with long term conditions, frail older people, and people requiring end of life care), are largely based on three revamped strategies (NHS England/ Domain Team/LTC, 2015):

(i) **Case finding and risk stratification:** focusing on how to segment a population and provide person-centred service and to support those most in need, whilst also recognising resource constraints. This is similar to defining and identifying ESD.
(ii) **Multidisciplinary team work:** how health and care professionals work together to support people with complex care needs that have been identified through case finding and risk stratification. This is similar to ascertaining social service models for working with ESD.
(iii) **Personalised care and support planning:** the key vehicle by which health and care professionals work together with clients and carers to meet individual client care needs. This is similar to distinguishing the social worker's role in working with ESD in terms of case management and as a case manager.

B. Collaboration is the New Norm

178. **Another direction of change is to adopt new approaches.** Most reviewed countries and regions have recognized ESD as a complex social issue with no quick fix and have abandoned discipline specific or profession specific interventions and adopted a collaborative interdisciplinary model. The model has been based on three key elements: (i) multidisciplinary and multisector involvement and cooperation, (ii) the use of intervening as well as supporting strategies (the bundled approach), and (iii) proactive rather than reactive care. This approach is holistic in the sense that it addresses both individual needs and systemic deficiencies. A primary contact person is appointed to (i) coordinate different service providers, and (ii) assist the ESD in navigating and connecting with the system. The primary contact in many countries/regions is the case manager of the ESD who uses a case management approach.

179. Vancouver Costal Health, British Columbia, Canada is a good example. The issue of ESD is addressed by using a collaborative interdisciplinary model, followed by a case management approach that supports the elderly to achieve a safe, realistic, and reasonable outcome in a complex physical-psycho-social environment. The case management strategy requires a shift in professional practice to enable a broader range of clinical services and interdisciplinary collaboration.

C. Raise the Profile of the Social Worker as Case Manager

180. A question worthy of consideration is: *If social workers excel in case management, why are so few of them are doing it?* There are two possible explanations. The first is that only a few social work training institutes are offering case management as part of their elderly care curriculum. The second is that only a few professional social work organizations are trying to raise the profile of social work in case management through certification and designation of social workers as case managers. In most states of the US, anyone can call themselves a case (care) manager without any requirement for related training or certification (Stone et al., 2002), Many case managers are actually certified in other professions, most frequently in social work or nursing. Recently, the number of certification programs for case (care) managers has surged, with one survey finding more than 40 different certification designations that might be appropriate for case managers. These included “certified family life educator” and “certified case manager” (Reinhardt, 2003). The need for health and social care professionals who can assume the role of case manager is anticipated to increase as more people become aware of the importance of case management, especially for the elderly and frail elderly.

D. Move Beyond the Comfort Zone and Meet the Needs of ESD Clients on their Terms

181. In addition to the changes in working with ESD outlined above, there has been a gradual paradigm shift in some countries/regions. Table 4 provides a summary of differences between current and evolving models for working with ESD.

Table 4: Differences between Current and Evolving Models for Working with ESD

Existing Model	Evolving Model
Service focus	Outcome orientation
Reactive	Proactive
Intervention (broker) and treatment (therapy) model	Collaborative and interdisciplinary team and case management approach for populations with complex needs, including ESD
Intervention focused	Intervention together with enabling strategies
Individual focused (One-to-One)	Systemic and individual focused, including the use of technology
Single sector	Multiple sectors
Single discipline	Interdisciplinary

Existing Model	Evolving Model
Generalist	Detailed knowledge of ESD
One size fits all	Risk stratification and the use of intensive and supportive case management and self-management
Access – 5 days/week	Access – 7 Days/week

E. Create the Economic Incentives for Working with ESD

182. Just revamping social service delivery modes (such as case finding, interdisciplinary collaboration, and case management) will be insufficient if these changes are not supported by economic incentives. Economic incentives are a powerful means for making the new ESD service delivery mode workable, especially where government is considering outsourcing services for ESD. A number of economic incentives have been used by governments to increase service provider enthusiasm, including for (i) finding ESD in hard to reach populations; and (ii) adopting new modes of service operation, such as interdisciplinary collaboration and case management. Economic incentives have mainly been created through

(i) **Global funding.** The provider is contracted for the delivery of service(s) to ESD for a fixed time period in return for a fixed amount of funding. The contract caps the amount of expenditure and may include performance indicators. One weakness of this funding mode is that there is very little incentive for providers to improve efficiency, invest in quality improvement, and service integration.

(ii) **Activity-based funding.** The provider is funded based on activity type (e.g., levels of risk or difficulties) and the amount of service provided. For instance, funding for services to elderly clients with greater difficulties is larger than for those elderly clients with less difficulty. This provides an incentive for providers to work with harder to reach elderly or those in greater difficulties. However, client stratification will be required. The intensity of information required for client stratification may advertently increate room for data manipulation.

(iii) **Payment for performance (P4P).** The provider will be paid for achieving specified, pre-set objectives, such as reaching the threshold where an ESD can become a “non” ESD. Different localities and communities may have their own specific ESD issues. This funding mode creates an incentive to address local differences and avoid applying “one size fits all” approaches.

(iv) **Bundles of care.** The provider will be paid for providing a package of services to the ESD, including direct interventions and enabling strategies such as those used in the chronic care model. This funding mode creates financial incentives for collaboration among providers and for better coordination. It enables the implementation of a collaborative interdisciplinary approach. In practice, it is rare for government to fund providers based on one pure funding mode. Normally, a mix of funding modes is employed (Sutherland. 2012).

1. Ensure Case Management is Part of Social Work Education and Training

183. Case management has become more complex over the years, with developments in philosophies and guiding principles for case managers to observe and follow, as well as the

skills and competencies described in Section 4.4. The CMSA (US) has developed the following guiding principles (CMSA, 2010):

(i) Use a client-centric, collaborative, partnership approach.
(ii) Wherever possible, facilitate self-determination and self-care through the tenets of advocacy, shared decision-making, and education.
(iii) Use a comprehensive, holistic approach.
(iv) Practice cultural competence, with awareness and respect for diversity.
(v) Promote the use of evidence-based care, as available.
(vi) Promote optimal client safety.
(vii) Promote the integration of behavioral change science and principles.
(viii) Link into community resources.
(ix) Assist with navigating the health care system to achieve successful care, for example, during life transitions.
    (a) Pursue professional excellence and maintain competence in practice.
    (b) Promote quality outcomes and measurement of those outcomes.
    (c) Support and maintain compliance with federal, state, local, organizational, and certification rules and regulations.

184. In Hong Kong, China, both the Department of Social Work and Social Administration and the Sau Po Centre on Ageing at the University of Hong Kong offer courses on “case management” that assist professionals (including social workers working with the elderly), to acquire the necessary values, knowledge, and skills. Appendix 7 is a detailed course outline of the case management training program at the Sau Po Centre on Ageing at the University of Hong Kong.

185. Such formal training in case management is necessary to significantly improve the role of social workers in working with ESD. Case management must be made part of the PRC social work curriculum to better prepare and enable social workers to assume this role in future. Refresher programs and/or in-service training in case management will also be necessary for existing staff.

2. Monitor Case Management at Service and Administration Levels

186. **Case management is both a service provision system and a good administrative system.** With good information and a case tracking system, the administrator or manager of case managers can monitor case progress, and variation in levels of risk and the intensity of intervention. This allows appropriate proactive and reactive measures to be taken to reduce and contain risk. In Vancouver Coastal Health, high risk cases are monitored using the High Risk Indicators Report. The report contains a number of high risk indicators for each client concerned. Each indicator functions as a flag that provides key pieces of information at a glance. This knowledge of individuals, together with critical thinking, can be used to identify risks, to prioritize care, and arrange visits for clients based on the case manager caseload.

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APPENDIX 1: The Vulnerable Elders-13 Survey

1. Age _____

SCORE: *1 POINT FOR AGE 75-84*
3 POINTS FOR AGE ≥ 85

2. In general, compared to other people your age, would you say that your health is:

- ☐ Poor,* *(1 POINT)*
- ☐ Fair,* *(1 POINT)*
- ☐ Good,
- ☐ Very good, or
- ☐ Excellent

SCORE: *1 POINT FOR FAIR or POOR*

3. How much difficulty, on average, do you have with the following physical activities:

	No Difficulty	A little Difficulty	Some Difficulty	A Lot of Difficulty	Unable to do
a. stooping, crouching or kneeling?	☐	☐	☐	☐ *	☐ *
b. lifting, or carrying objects as heavy as 10 pounds?	☐	☐	☐	☐ *	☐ *
c. reaching or extending arms above shoulder level?	☐	☐	☐	☐ *	☐ *
d. writing, or handling and grasping small objects?	☐	☐	☐	☐ *	☐ *
e. walking a quarter of a mile?	☐	☐	☐	☐ *	☐ *
f. heavy housework such as scrubbing floors or washing windows?	☐	☐	☐	☐ *	☐ *

SCORE: *1 POINT FOR EACH * RESPONSE IN Q3a THROUGH f . MAXIMUM OF POINTS.*

4. Because of your health or a physical condition, do you have any difficulty:

a. shopping for personal items (like toilet items or medicines)?

☐ YES → Do you get help with shopping? ☐ YES * ☐ NO
☐ NO
☐ DON'T DO → Is that because of your health? ☐ YES * ☐ NO

b. managing money (like keeping track of expenses or paying bills)?

☐ YES → Do you get help with managing money? ☐ YES * ☐ NO
☐ NO
☐ DON'T DO → Is that because of your health? ☐ YES * ☐ NO

c. walking across the room? USE OF CANE OR WALKER IS OK.

☐ YES → Do you get help with walking? ☐ YES * ☐ NO
☐ NO
☐ DON'T DO → Is that because of your health? ☐ YES * ☐ NO

d. doing light housework (like washing dishes, straightening up, or light cleaning)?

☐ YES → Do you get help with light housework? ☐ YES * ☐ NO
☐ NO
☐ DON'T DO → Is that because of your health? ☐ YES * ☐ NO

e. bathing or showering?

☐ YES → Do you get help with bathing or showering? ☐ YES * ☐ NO
☐ NO
☐ DON'T DO → Is that because of your health? ☐ YES * ☐ NO

SCORE: *4 POINTS FOR ONE OR MORE * RESPONSES IN Q4a THROUGH Q4e*

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Source: http://www.rand.org/content/dam/rand/www/external/health/projects/acove/docs/acove_ves13.pdf

APPENDIX 2: VARIABLES INCLUDED IN PARR1

1. Alcohol related diagnoses Cerebrovascular disease. CVD)
2. Chronic obstructive pulmonary disease. COPD)
3. Connective tissue disease/rheumatoid arthritis
4. Developmental disability
5. Diabetes
6. Ischaemic heart disease
7. Peripheral vascular disease
8. Renal failure
9. Sickle cell disease
10. Prior respiratory infection admission
11. Number of different treatment specialists seen
12. Age 65-74,
13. Age 75+
14. Gender
15. Patient ethnicity
16. Prior admission for a "reference" condition
17. Number of emergency admission in the previous 90, 180, and 365 days
18. Number of non-emergency admission in the previous 365 days
19. Total number of prior emergency admissions in previous 3 years
20. Average number of episodes per spell for emergency admissions
21. Observed/expected ratio for MD practice style sensitive admissions in ward of residence
22. Observed/expected ratio for rate of rehospitalizations for hospital of current admission
23. Diagnostic Cost Groups/Hierarchical Condition Category - 71 categories)

Source: Billings et al., 2006, p.5

APPENDIX 3: ACTIVITIES FOR BUILDING COMMUNITY RESILIENCE

Lever	Activities
Wellness	Ensure pre–health incident access to health services and post–health incident continuity of care.
Access	Provide "psychological first aid" or other early psychological or behavioral health interventions after disaster.
Education	Bolster coping skills and psychological wellness by developing public health campaigns focused on these messages.
Engagement	Build the capacity of social and volunteer organizations. i.e., nongovernmental organizations) to engage citizens in collective action to address an issue or problem. e.g., a community development or service project).
Self-Sufficiency	Develop programs that recognize the vital role citizens can and must play as "first responders" to help their own families and neighbours in the first hours and days of a major disaster.
Partnership	Engage established and local organizations. e.g., cultural, civic, and faith-based group; schools; and businesses) and social networks to develop and disseminate preparedness information and supplies.
Quality	Ensure that all disaster plans have identified common data elements. e.g., benchmarks for disaster operations) to facilitate seamless monitoring and evaluation of health, behavioral health, and social services pre-incident, during, and post-incident.
Efficiency	Develop policies for effective donation management and provide the public with clear guidance on donations.

Source: http://www.rand.org/pubs/research_briefs/RB9574/index1.html

APPENDIX 4: THE COMMUNITY RESILIENCE MODEL, WASHINGTON, D.C., USA

187. In light of increasing averse events such as natural disasters and terrorist attacks, many communities in the US have adopted a community resilience model to increase their capacities to (1) withstand and recover from community-level averse events, and (2) to learn from past adverse events to strengthen future responses and recovery efforts (RAND, 2015).[61] A resilient community is one in which:

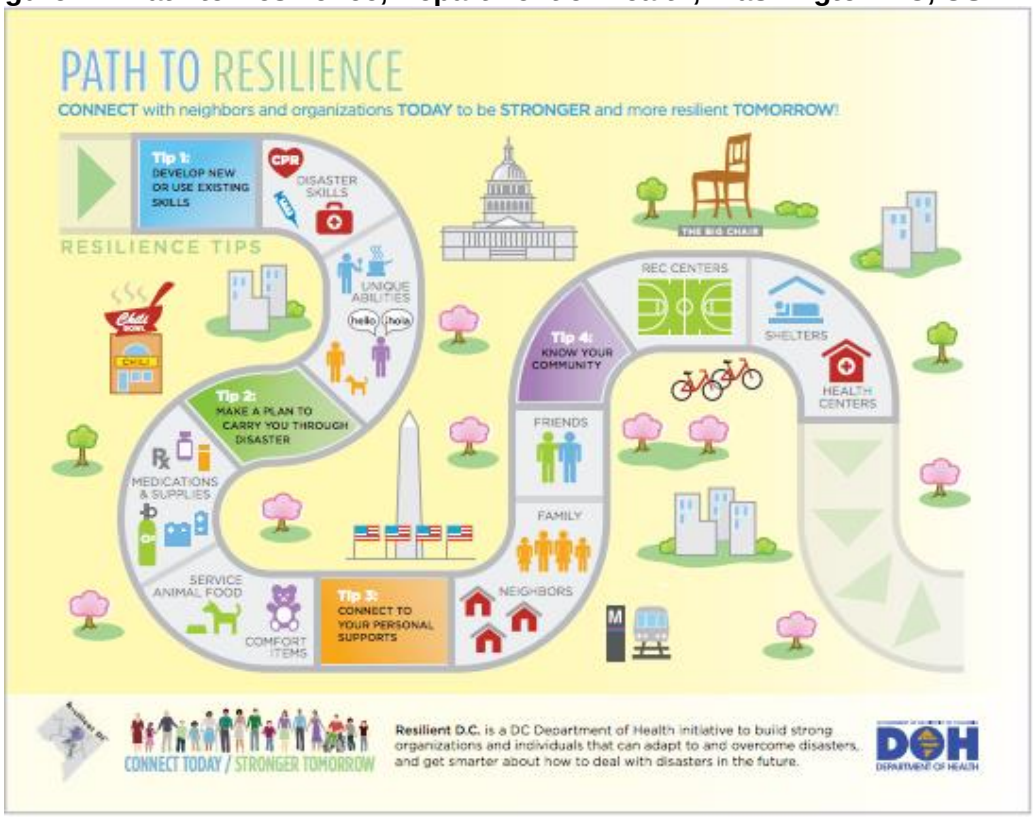
(i) community members are physically and mentally well;
(ii) people can access the health care, healthy foods, and basic services they need;
(iii) community members are self-sufficient and can take care of each other during tough times; and
(iv) residents are engaged in the community and connected to each other.

188. **Community resilience** is based on the concept of social capital and the principle that the community is resourceful with what it has (matter its condition, or whether it has a lot of resources. Resilience requires participation from the whole community, partnership among organizations, sustained local leadership, culturally relevant education on risks, and individual-level and community-level preparedness and self-sufficiency.[62]

189. **A community can become stressed when affected by negative events** such as weather-related disasters (e.g., hurricanes or severe snowstorms), economic downturn or high poverty rates, gun violence or drug-related crimes, and environmental issues (such as climate change or global warming). The elderly are particularly vulnerable in communities affected by such adverse events e.g. the elderly may be considered as ESD in situations where most young people have left home and the remaining population are mainly the very old and young. A resilient community can respond to, and recover quickly from, averse community-level events. The level of community resilience will determine what is needed to reduce damage caused and to how to use community assets and resources wisely. It is hoped that building community resilience can help communities under stress to respond quickly and take the opportunity to continue to strengthen their overall health, social, and economic structure. It is with this understanding that the community resilience approach may also be a useful social service model for working with ESD.

[61] http://www.rand.org/content/dam/rand/pubs/tools/TL100/TL163/RAND_TL163.pdf
[62] http://www.rand.org/pubs/research_briefs/RB9574/index1.html

Figure 11: Path to Resilience, Department of Health, Washington DC, US



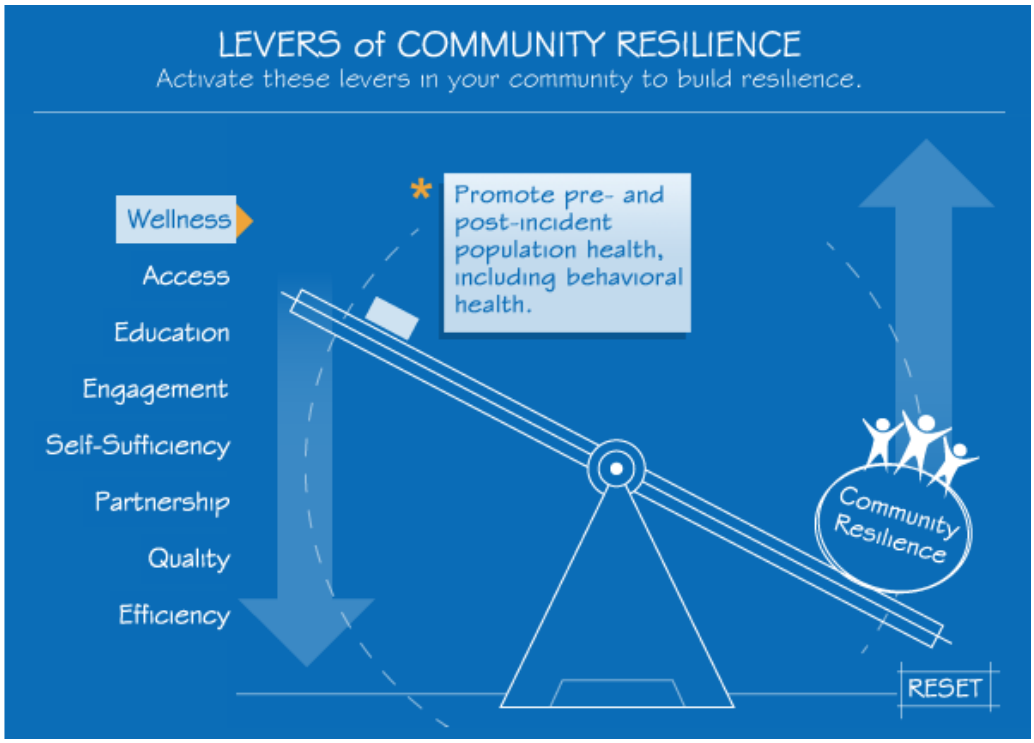
Source: http://www.rand.org/content/dam/rand/pubs/tools/TL100/TL163/RAND_TL163.pdf P.29

190. **The Path to Resilience** is a collaborative project sponsored by the District of Columbia, US. It targets people of all ages in an affected community and is not elderly specific. The Department of Health brings together residents, community-based partners, businesses, and District and Federal agencies to strengthen the community as a whole. There is a similar project in New York City where the partnership has expanded to include all sectors, such as the arts and entertainment, education, business, banking and finance, faith-based groups, health care, hospitality and services, the community, nonprofits and government.[63] These organizations can contribute to community resilience by exploring and listing their skillsets and strengths, competencies, human resources, infrastructure, equipment, services, and relationships of the organizations and provide needed training to staff in case of community stress.

191. **Areas in which communities need to build capacity may vary.** RAND has proposed a roadmap, which includes eight levers of wellness, access, education, engagement, self-sufficiency, partnership, quality, and efficiency. Communities can improve their capacity to withstand and recover from emergencies by conducting capacity-building activities in these identified areas. For example, wellness and access contribute to development of the social and economic well-being of a community and the physical and psychological health of its population. Education can be used to support effective risk communication. Engagement and self-sufficiency are needed to build social connectedness, and partnership helps ensure that governmental and nongovernmental organizations are integrated and involved in preemptive resilience building and disaster planning. Quality and efficiency are important to all areas of community resilience. Activities for different levers of community resilience can be found in Appendix 3.

[63] http://www1.nyc.gov/site/em/community_business/partners-preparedness.page

Figure 12: Levers of Community Resilience



192. Table 5 shows differences in response to community stressors between the traditional approach to community stress and that of Community Resilience.[64]

Table 5: Traditional Approach and Community Resilience in Dealing with Stressed Communities

Traditional Approach	Community Resilience Approach
Individual household readiness to respond to need	Community members work together to respond to need
Issue specific functions	Community efforts merge to build social, economic, and health well being
Government responds first	A diverse network of government and NGOs respond
Emergency plans and supplies	Collaboration and engagement of communities for problem solving
Self-sufficient individual or households	Self-sufficient community

[64] Uscher-Pines, L., Chandra, A., Acosta, J. (2013). The promise and pitfalls of community resilience. *Disaster Medicine Public Health.* (6):603-6.

1. House of Care for People with Long Term Care Conditions, United Kingdom

193. **The UK has a very similar model to the US Chronic Care Model, called The House of Care**.[65] The House describes four key interdependent components that, if implemented together, will achieve client centered, coordinated service for people living with long term conditions and for their carers. The focus is on engaging the affected person as part of the team that is working to develop a personalized support plan. Care is coordinated to deliver services that achieve the best outcomes and experiences for the individual.

Figure 13: House of Care for People with Long-Term Conditions, UK

194. These four components are:

(i) **Commissioning:** Not simply procurement but a process for systemic improvement in which outcomes from each component cycle inform the next one. Commissioning provides information and resources on needs assessment, strategic planning, and how to reduce inequalities.

(ii) **Engaged, informed individuals and carers:** To enable individuals to self-manage and know how to access the services they need, when and where they need them. Carers provide information and resources on personal budgets, lifestyle, and other self-management support.

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[65] http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/long-term-conditions-improvement-programme/house-of-care-toolkit.aspx

(iii) **Organizational and clinical processes.** These are structured around the needs of clients and carers, and use the best evidence available, co-designed with service users, where possible.

(iv) **Health and care professionals:** Working in partnership, through listening, supporting, and collaborating for continuity of care. Professionals provide information and resources on delivering a partnership approach to care.

195. **The House of Care Toolkit**

(i) Provides a framework to bring together all the relevant national guidance, published evidence, local case studies, and information for clients and their carers.

(ii) Includes information on what tools and resources are required to achieve person-centered, coordinated care and how these can be effectively commissioned.

(iii) Contains resources arranged by key component, together with details on where to find additional information.

Case Study 14: Good Practice for an Integrated Frailty Pathway—Cornwall & Isles of Scilly, the UK

The NHS Kernow (Cornwall and Isles of Scilly Clinical Commissioning Group) proposed to commission an 'end-to-end,' integrated frailty pathway. From April 2014, fifteen health and social care organizations from local councils, charities, community services, general practitioners and social workers came together to transform the way health, social care, the voluntary and community sectors could work together. The following preparatory steps were taken:

1. A cross-organizational frailty pathway steering group was established with effective clinical leadership and programme management support.
2. A definition of frailty and a high-level frailty model and pathway were agreed.
3. Principles on thresholds for access to services were considered and interventions across the elements of the pathway identified.
4. Providers mapped current services to the pathway to identify duplication and potential gaps.
5. Approaches to case-finding for the frail elderly were identified for piloting in practice.
6. High-level, cross-organizational standards were developed to inform commissioning intentions and contracts.
7. Plans were made to map the elderly frailty cohort, based on an assumptive primary care level model for age cohorts aged 75 years+ and the costs and use of acute/community health care.
8. A standardized CGA template and personalized care plan is now under development as a shared assessment for use across all organizations. An electronic portal is being developed to facilitate information-sharing.

196. **The UK has a fairly comprehensive system for safeguarding and promoting the wellbeing of children**, and especially those who are more vulnerable. There are a lot of similarities between vulnerable children and elderly. Thus the framework for protecting for vulnerable children will be a useful reference for services for the ESD. The model includes (i) children living away from home; (ii) children abused (bullied) by other children and young people; (iii) children lacking parental control; (iv) children from ethnic minority groups; (v) children affected by violent extremism e.g., (e.g., international terrorist organizations); (vi) children suffering from domestic violence, (vii) child abuse in an information communication technology (ICT) environment; (viii) children with families whose whereabouts are unknown; (ix) children who go missing; (x) children who go missing from schooling; (xi) children living in temporary accommodation; (xii) migrant children; and (xiii) unaccompanied asylum-seeking children.

APPENDIX 5: The United Kingdom Child Safeguarding Model—Multisector Collaboration

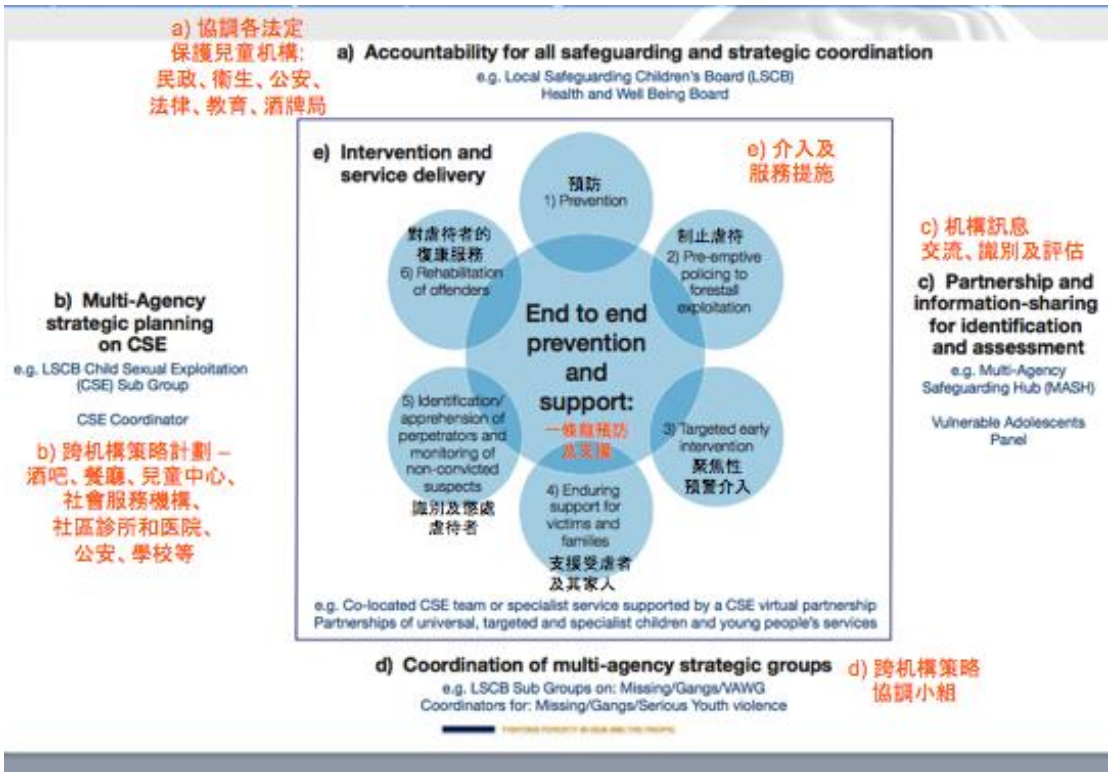
197. There are a lot of similarities between vulnerable children and the vulnerable elderly. Thus the service delivery model for vulnerable children can be a useful reference for ESD services

198. The UK has a fairly comprehensive system to safeguard and promote the wellbeing of children, and especially those who are more vulnerable i.e., (i) children living away from home; (ii) children abused by other children or young people; (iii) children lacking parental control; (iv) children from ethnic minority groups; (v) children affected by violent extremism, e.g., international terrorist organizations; (vi) children suffering from domestic violence; (vii) child abuse in an information communication technology (ICT) environment; (viii) children with families whose whereabouts are unknown; (ix) children who go missing; (x) children who go missing from education, (xi) children living in temporary accommodation; (xii) migrant children; and (xiii) unaccompanied asylum-seeking children.

199. For children at risk of sexual exploitation, the UK's Children's Commission issued a report on "If only someone had listened" − the Final Report of the Inquiry of the Office of the Children's Commissioner into Child Sexual Exploitation in Gangs and Groups (Children's Commission, 2013). The report identified factors that led to poor services for children at risk of sexual exploitation. These included lack of leadership and strategic planning, failure to recognize problems, denial and delayed responses, and failure to monitor conditions. Many professionals and organizations worked in isolation e.g., nearly half of all agencies involved in child protection had no specific representative from the sexual health services. Information sharing remained an issue with some agencies holding information on sexual exploitation that was not shared with the police or children's services, among others. Although some agencies did engage in collaborative or partnership work, they did not all communicate effectively (Children's Commission, 2003, p. 9). In light of this, the report outlined a multisector collaborative approach so that children at risk of sexual exploitation could be effectively identified and kept safe. This involved decision-making at senior levels and also for the practitioner working with individual child victims – e.g., the social worker, police officer, health clinician, teacher or anyone else who had contact with children. Diagram 1 illustrates this new framework for multisector collaboration.

200. Multisector and/or agency collaboration is mandated by the *Children's Act* of 1989. Sections 325–327 of the *Criminal Justice Act* (2003) also DESIGNATE the police, prisons, and probation services as the "Responsible Authority". Other agencies – including children's services, health, housing, social services, Youth Offending Teams, Jobcentre Plus, and electronic monitoring providers – are under statutory duty to cooperate with the Responsible Authority (Department for Children, Schools and Families, 2009, p.237-265). This law makes information sharing mandatory. It classifies risks into four categories: low, medium, high, and very high. Management of these cases is grouped into three categories, according to level of risk. Multi-agency management must be used for children with medium, high and very high risk Department for Children, Schools and Families, 2009)

DIAGRAM 1: See Me, Hear Me – A Framework for Protecting Children, UK[66]



201. The collaborative framework is based on a principle that that no single agency should tackle child sexual exploitation on its own or in isolation from other safeguarding issues. All agencies need to collaborate and agree on their unique and shared roles and functions to ensure the system works effectively and that children and young people are protected. The collaborative framework consists of the following five elements:

(i) **Accountability for all safeguarding and strategic coordination.** The government mandates all stakeholders to strictly follow the collaboration guideline under the Working Together Guidance on Child Sexual Exploitation (DCSF, 2009). It also mandates the establishment of a Local Safeguarding Children Board (LSCB) in each local authority (e.g., municipal government), that is responsible for coordinating the work of agencies for the safeguarding and promotion of child wellbeing. This includes coordinating the police, and agency and NGO services for children and young people, education, probation and correction, health, primary care, sexual health, drug and alcohol misuse, child and adolescent mental health services, and housing.

(ii) **Multi-agency strategic planning on Child Sexual Exploitation(CSE).** This involves the creation of a dedicated team led by a coordinator to effectively respond to child sexual exploitation. The coordinator (i) brings together agencies to focus on the strategic and operational response to child sexual exploitation, (ii) takes a leadership role, (iii) has specialist oversight, and (iv) ensures adherence to an information-sharing protocol.

(iii) **Partnership and information-sharing for identification and assessment.** Some examples are:

[66] http://www.thebromleytrust.org.uk/files/chidrens-commission.pdf. P.76

(a) **The Multi-Agency Safeguarding Hub (MASH).** This pulls together multi-agency information based on an initial referral in order to identify and assess a child's vulnerability and make relevant onward referrals to appropriate agencies.

(b) **Vulnerable Adolescents** or **Children and Young People's Panels** provide strategic oversight of cases. They cross-reference victims who are known to several agencies for different reasons, (e.g., a young person who is known as both a gang member and as being sexually exploited), and discuss how to best address these cases.

(iv) **Coordination of multi-agency strategic groups.** The framework sets out the importance of involving other multi-agency networks and panels in a local area, and the individuals who coordinate them, in order to develop a coherent, coordinated response. Rather than relying on an individual coordinator or agency, the framework itself links the strategies, agencies, and coordinators of services addressing child sexual exploitation.

(v) **Interventions and service delivery.** These are end-to-end services focused on preventing and eliminating the sexual exploitation of children and young people, and supporting victims including through (a) prevention, (b) preemptive policing to forestall exploitation, (c) targeted early intervention, (d) enduring support for victims and families, (e) identification or apprehension of perpetrators and monitoring of non-convicted suspects, and (f) rehabilitation of offenders.

Sources: http://www.thebromleytrust.org.uk/files/chidrens-commission.pdf p.75

APPENDIX 6: STEPS FOR COLLABORATION

1. Identify stakeholders.
2. Make a commitment to collaborate.
3. Establish procedural ground rules.
4. Teach potential participants process skills−i.e., skills that help people work together constructively.
5. Build trust, learn process skills, and explore beliefs.
6. Identify problems.
7. Clarify a vision and develop a mission statement.
8. Keep the process open and get input from community members.
9. Create options for solving problems.
10. Formulate goals, objectives, and an action plan.
11. Implement the action plan.
12. Evaluate the results.
13. Celebrate every success, large and small.
14. Continue to collaborate.[67]

[67] http://ctb.ku.edu/en/table-of-contents/implement/improving-services/multisector collaboration/main

APPENDIX 7: CASE MANAGEMENT OUTLINE: SAU PO CENTRE ON AGEING, THE UNIVERSITY OF HONG KONG

A. The Training Course

202. Participants targeted for the training program are senior and middle level managers (including social workers and nurses) working in aging services in the field of elderly care. The overall objective is to prepare them for the implementation of a new integrated Service System. This program will help develop knowledge and skills through using various interRAI assessment systems (interRAI-HC, interRAI-CHA, & interRAI-LTCF) during planning and implementation of elderly care in long term care settings. At program completion, participants will be able to apply their knowledge and practice their skills in case management to enhance the quality of care and quality of life for older people under their care.

B. Course Objectives

203. Upon completion of the course, participants should be able to:

(i) better understand the concepts, values and skills required to implement a case management program within a long term care setting;
(ii) better understand the role of comprehensive assessment in case management;
(iii) acquire the skills and knowledge to conduct assessment using interRAI assessment instruments (interRAI HC, LTC, and CHA);
(iv) use protocols (CAPs/RAPs) to facilitate the development and implementation of an individualized care plan for older adults in long term care settings;
(v) evaluate the effectiveness of a case management program; and
(vi) demonstrate the ability to act effectively as a case manager.

C. Format

204. The training program comprises 5-day long workshops, conducted on weekdays between 9:30 to 17:30 (with one hour lunch break in between the morning and afternoon sessions). All courses are delivered in Cantonese Chinese. Course materials are in both Chinese and English. A certificate is issued for all staff who complete the 5-day workshop.

D. Course Content

Day 1 - Concept of case management intervention

205. Approximately 4 hours of lectures and 3 hours of workshops (including group exercises and discussions)

(i) Introduction to case management
(ii) Evidence based case management intervention
(iii) Different models of case management intervention across cultures
(iv) Case management models in Hong Kong, China
(v) Impacts and limitations of case management intervention (including resources implications)

Day 2 - interRAI assessment instruments

206. With approximately 3 hours of lectures and 4 hours of workshops (including group exercises and discussions)

(i) Introduction to comprehensive psychosocial and geriatric assessments.
(ii) Overview of various interRAI assessment systems
(iii) Assessment of healthy older adults in the community (interRAI - CHA) and its
(iv) applications
(v) Assessment of older adults in community-based settings (interRAI - HC) and its applications
(vi) Assessment of frail older adults and those in nursing home settings (interRAI - LTCF) and its applications

Day 3 Skill training

207. With approximately 3 hours of lectures and 4 hours of workshops (including group exercises and discussions)

(i) Skills in conducting comprehensive psychosocial and geriatric assessments.
(ii) Skills in using various interRAI assessment tools.
(iii) Skills in working with older adults and their families to develop individual care plans
(iv) For participants working in an LTC setting, the focus will be on interRAI-LTC & HC
(v) For participants working in an HC setting, the focus will be on interRAI-HC & CHA
(vi) For participants working in a CH setting, the focus will be on interRAI CHA & HC

Day 4 - Clinical assessment protocols (CAPS/RAPS)

208. With approximately 3 hours of lectures and 4 hours of workshops (including group exercise and discussions)

(i) interRAI HC
(ii) interRAI LTCF
(iii) interRAI CHA
(iv) Assessment Package: Triggers, CAP, outcome measures

Day 5 - Case management intervention and evaluation

209. With approximately 4 hours of lectures and 3 hours of workshops (including group exercises and discussions)

(i) Develop and evaluate an individualized case management plan and the role and functions of a care manager
(ii) Develop and evaluate a case management program
(iii) Future issues of case management for older adults in Hong Kong