
Age-Friendly Health Care and Health Promotion- Framework, Standards & Recognition

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- Global Vice President for Partnership, International Union for Health Promotion & Education
- Chair, Task Force on HPH & Age-friendly Health Care
- Chair, Task Force on HPH & Environment



Outline

- The need for developing age-friendly health care
- How do we become age-friendly health care?
- The framework, standards & examples
- Collaborative learning and the recognition process
- The way forward



The need for developing age-friendly health care



The world is rapidly aging

- The world's number of persons aged 60 or over will double by 2025 compared to 2006.
- By 2050, this number will reach 2 billion or higher and **exceed the number of children under 15**.
- About **30%** of the European population will be 65 or over in 2050, **the old age dependency ratio** will be 1 elderly to only 2 people of working age by then.



**Within 12 years, 1 in every 3 citizens will *Shu-Ti*
be aged 60 or more in many countries.**

Table 1. Countries with more than 10 million inhabitants (in 2002) with the highest proportion of persons above age 60			
2002		2025	
Italy	24.5%	Japan	35.1%
Japan	24.3%	Italy	34.0%
Germany	24.0%	Germany	33.2%
Greece	23.9%	Greece	31.6%
Belgium	22.3%	Spain	31.4%
Spain	22.1%	Belgium	31.2%
Portugal	21.1%	United Kingdom	29.4%
United Kingdom	20.8%	Netherlands	29.4%
Ukraine	20.7%	France	28.7%
France	20.5%	Canada	27.9%

Source: UN, 2001



Unaffordable future?

- New technologies/ new drugs
- Growing demand for disability care
- Can the healthcare expenditure grow proportionately as well?



Functional status at 70 and total life expectancy

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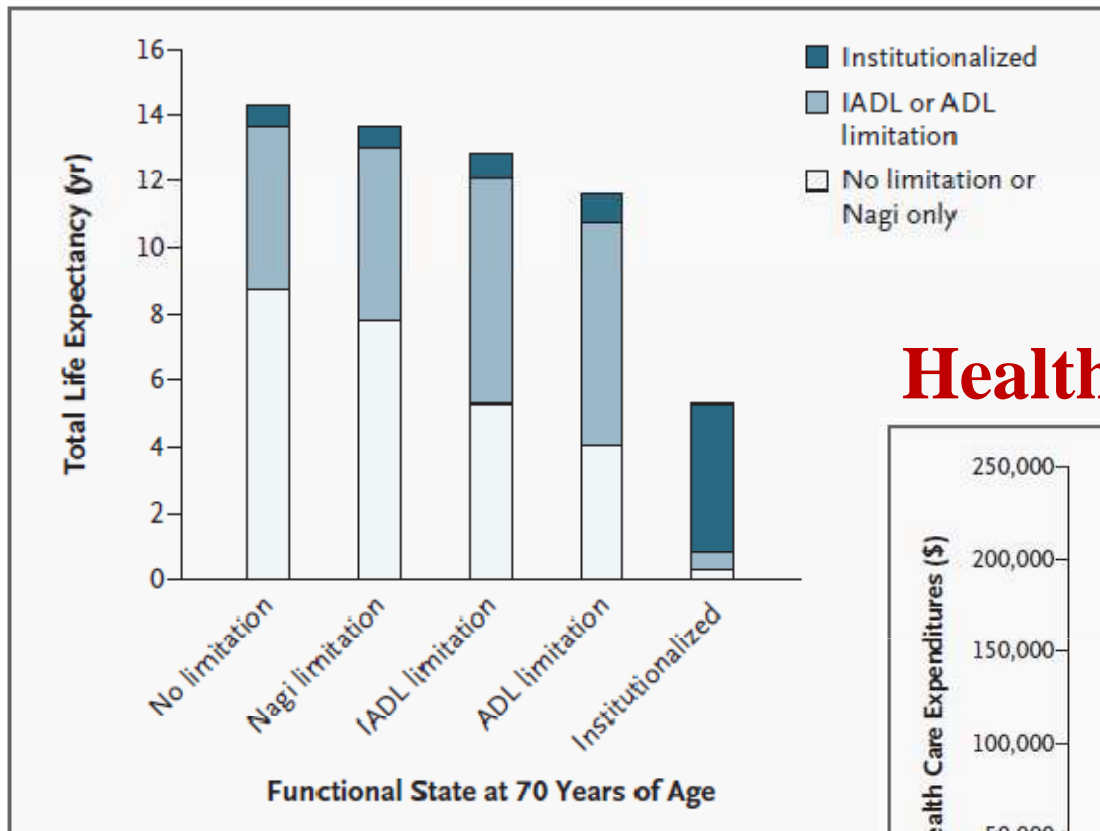


Figure 1. Life Expectancy at 70 Years of Age According to Functional State at the Age of 70.

Health, Life Expectancy, and Health Care Spending among the Elderly

James Lubitz, M.P.H., Liming Cai, Ph.D., Ellen Kramarow, Ph.D., and Harold Lentzner, Ph.D.

N Engl J Med 2003;349:1048-55.

Healthcare expenditure

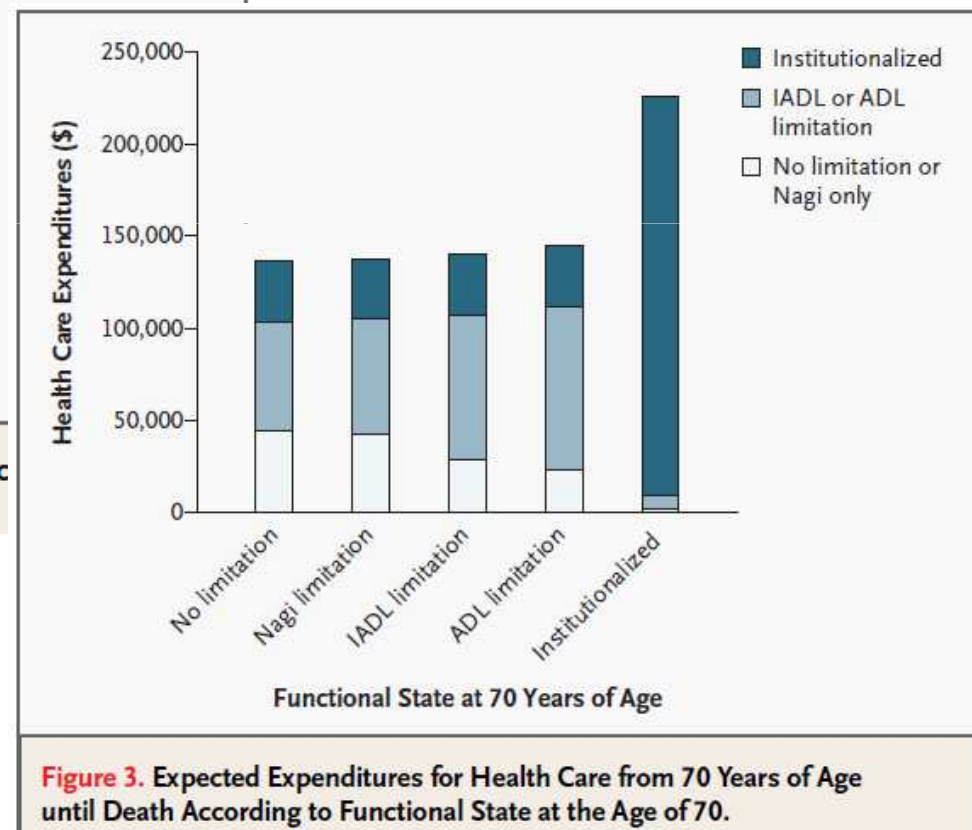


Figure 3. Expected Expenditures for Health Care from 70 Years of Age until Death According to Functional State at the Age of 70.

In healthcare sector...

- In 2009, **96.3%** elders had at least 1NHI visit, in average each elderly had **27.8 visits per year** (General population: 91.8%; 15 visits).
- Healthcare utilization (including all types of health institutions):

		Ambulatory Care	Hospitalization
65+	% of visits	23.3	32.8
	% of payment	31.9	44.8
50+	% of visits	45.0	53.8
	% of payment	59.9	67.6

Source: 2009 NHI Statistics Information, Taiwan



Older persons have unique needs

- Chronic conditions and co-morbidity
- Different manifestations
- High utilization of healthcare, but vulnerable to hospitalization and healthcare (may impose risks to older persons)
- Older persons said they suffered from unfriendliness of healthcare.

=> Can we turn challenges into opportunities?



Chronic diseases among 65+ elderly

Gender, Age		1 disease	2 diseases	3 diseases
65+		88.7%	71.7%	51.3%
75+		90.9%	76.8%	56.4%
Male	65+	85.8%	65.6%	43.9%
	75+	89.1%	71.2%	50.2%
Female	65+	91.7%	77.8%	58.8%
	75+	92.8%	82.8%	63.0%

Note: 1. Sample: 2,699 (Male 1,362, Female 1,337) Chronic diseases mentioned above including the following 17 diseases: hypertension, diabetes, heart problems, stroke, lung or breathing problems (bronchitis, emphysema, pneumonia, lung disease, asthma) , arthritis / rheumatism, stomach ulcer or stomach disease, liver and gall disease, hip fracture, cataract, kidney disease, gout, vertebral entophyte, osteoporosis, cancer, hyperlipidemia, anemia (percentage is weighted calculated)

2. Source: (6th) Survey of health and living status of the middle aged and elderly in Taiwan survey report, Bureau of Health Promotion, 2007



The system is not designed for chronic conditions....

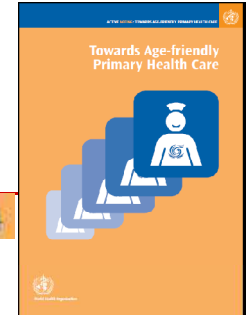
Shu-Ti

- Hospitals and other acute care settings are **not ideally designed to care for older persons** in many aspects.
- highly specialized professionals
- working individually
- at rapid pace
- services are delivered in a fragmented and reactive manner.



Different manifestations

© World Health Organization 2004



Problem in elder health care: Elders \neq older adults

- **Multiple unclear or atypical symptoms** vs. busy or untrained medical staff
- Unclear symptoms \neq **less serious**; ex. infection without fever, painless acute myocardial infarction,
- Frontline healthcare staff not familiar with common elderly problems, ex. fall, incontinence, immobility and confusion.
- Sometimes health and medical problems are not perceived as the most urgent by patients if they have family or social problems unsolved



The complaints from frontline

WHO organized focus groups in 5 developed & developing countries to consult older people and their health care providers about improving care in 2002 (WHO, 2004a):

1. **Attitudes** (no listening, no respect, no discussions with elderly, inadequate autonomy);
2. The lack of **Training and education**;
3. **Gender issues**;
4. **Language**;
5. **Obstructive management systems**;
6. **Cost** (too high);
7. **Waiting time** too long;
8. **Inadequate time for complete assessment and treatment**;
9. **Lack of continuity and fragmentation of services**;
10. **No special clinic or consultation hours for older persons**;
11. **Physical environment** (distance, transportation, barrier-free facilities, signs, cleanliness)

Unfriendly environment & unpleasant experiences may result in lack of intention to visit again



Health Service: Opportunity or Risk?

- Elderly are likely to have **complications** during hospitalization: infection, pressure sore, dehydration and malnutrition, falls, adverse drug events, depression and anxiety, cognitive dysfunction, etc..
- Hospitalization may cause **irreversible functional decline, admission to institutions;**
- **Rehabilitative services & intervention** during hospitalization or after discharge help recover and return home
- **Health promotion:** Elder AMI patients received smoking-cessation advice or counseling improved 5-year survival by 22%
- **Prevention of falls and adverse events**
- **Adequate control of chronic conditions**



We can make a difference...

- *Health promotion, disease management and patient safety interventions* delivered in and by clinical settings have been shown to improve health outcomes.
- However, it can only happen if there are some *redesigns of the healthcare system* to allow these interventions being provided in a more **proactive, coordinated and well-organized way** to achieve predictable and equitable health gains.



How do we become age-friendly?



The Age-friendly Health Care Initiative

■ Aims:

- ❑ innovate and apply state-of-the-art **knowledge and best practices** and
- ❑ help hospitals and health services develop **age-friendly culture, structures, decisions, and processes** to improve health gain for older persons in and by healthcare settings.

■ Objectives:

1. To develop an organizational **framework** both for internal implementation and for external recognition
2. To develop **tools** for clinical quality improvement
3. To develop **indicators** for monitoring and benchmarking
4. To launch **organizational plan** of CQI for age-friendly care

- ## ■ Who can join:
- hospitals, primary care centers, long-term care facilities, etc.



Initial Sources of Standards

Published in: Archives of Gerontology and Geriatrics 49 Suppl. 2 (2009) S3-S6

- Based on
 - WHO age-friendly principles
 - WHO Standards of Health Promoting Hospitals
- World's first government-driven, nationwide Age-Friendly Hospitals and Health Services Recognition



Towards age-friendly hospitals and health services

Shu-Ti Chiou^{a,b,*}, Liang-Kung Chen^{c,d,e}

The AF module

1. The AF framework;
2. **Tools** for clinical practice;
3. **Indicators** for monitoring and benchmarking
4. **Organizational plan chart**



1. AF Framework

- **Vision, values and missions**
- **Strategies:** --4 standards, 11 sub-standards, 60 measurable items



Vision, Values & Missions of Taiwan's Age-friendly Health Care *Shu-Ti*

- **Vision:** An age-friendly hospital (or health service) is an organization promoting **health, dignity** and **participation** of senior people
- **Values:** Health, Humanity, Human Rights
- **Missions:**
 - To create a friendly, supportive, respectful and accessible **healing environment** tailored to the unique needs of senior persons;
 - To facilitate safe, health promoting, effective, holistic, patient-centered and coordinated **care** in a planned manner to the older persons;
 - To empower **older persons and their families** to increase control over their health and care.



Strategies

--4 standards, 11 sub-standards, 60 measurable items

1. Management Policy (12)

- 1.1 Developing an age-friendly policy (3)
- 1.2 Organizational support (7)
- 1.3 Continuous monitoring and improvement (2)

2. Communication and Services (9)

- 2.1 Communication (5)
- 2.2 Services (4)

3. Care Processes (25)

- 3.1 Patient assessment (7)
- 3.2 Intervention and management (9)
- 3.3 Community partnership and continuity of care (9)

4. Physical Environment (14)

- 4.1 general environment and equipment (7)
- 4.2 transportation and accessibility (4)
- 4.3 signage and identification (3)



2. **Tools** for clinical practice

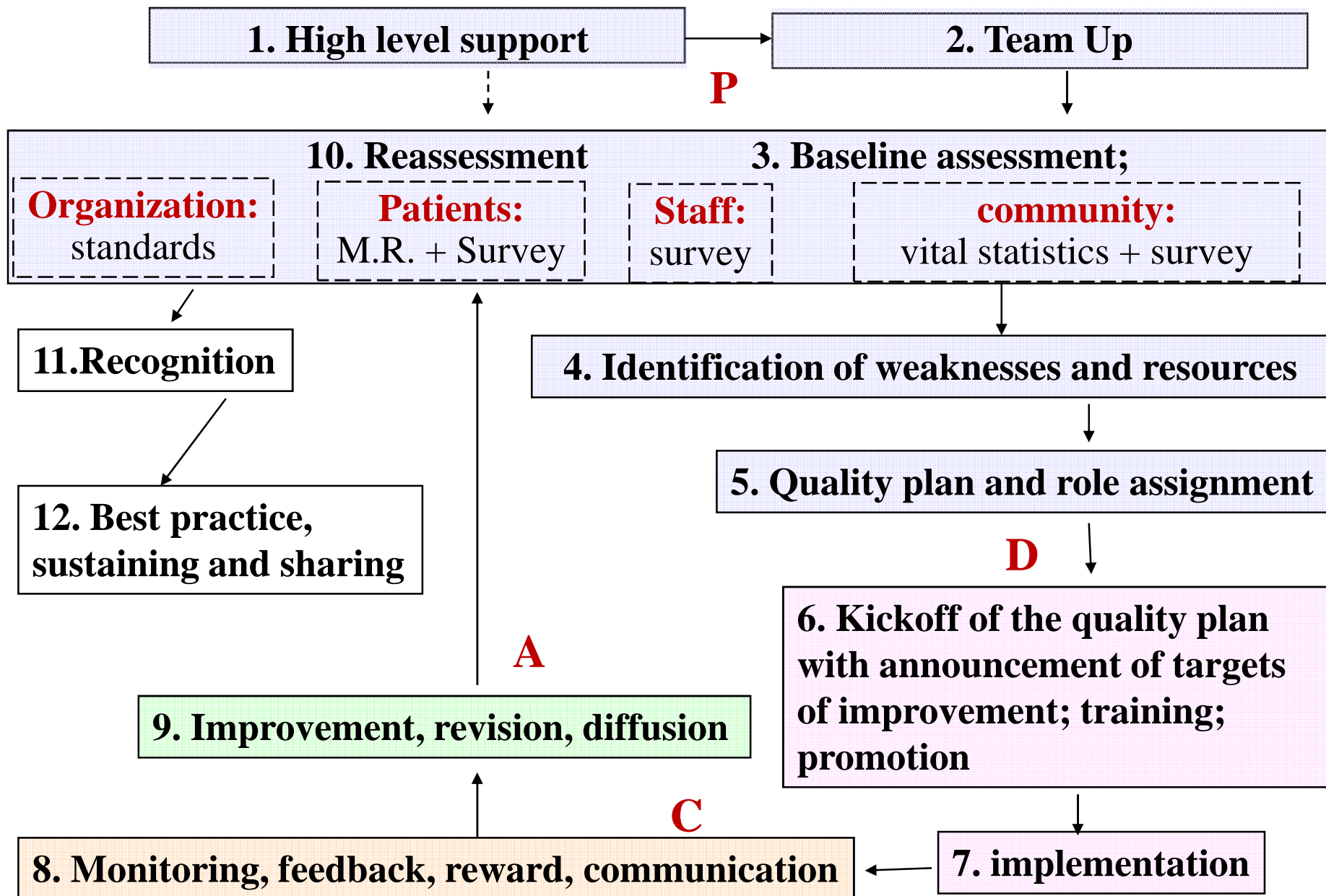
- Lifestyle assessment and intervention
- Stepwise fall risk screening
- Frailty screening
- Medication safety check
- High risk screening and geriatric assessment for hospitalized patients
- Clinical pathways for major NCDs
- etc.



3. **Indicators** for monitoring and benchmarking

- Awareness
- Satisfaction
- Inequity
- Completion of risk factor assessment and intervention
- Quality performance on major NCDs
- Falls
- Readmission
- Functional deterioration





The framework, standards & examples



ISQua's International Accreditation Programme

- By Charles D Shaw, ISQua, supported by World Bank and WHO



Some issues in the design and redesign
of external health care assessment
and improvement systems



by Charles D Shaw
International Society for Quality in Health Care

Toolkit for accreditation programs

Foreword: THE WORLD BANK

Modernizing and improving health systems lies at the heart of efforts by the international development community to help poor countries reach their 2015 Millennium Development Goals (MDGs)—with their promise of vastly improved human and economic welfare. Despite broad agreement on the urgency of such an overhaul, the practical difficulties involved in grappling with the complex and multi-disciplinary nature of health systems, and resolving widespread concerns about their quality, cannot be underestimated.

It is widely recognized that good governance is required in the health care sector. The general public, organizations of patients and disabled persons, and third party payers want to have more objective assessments of health service quality. Countries have taken different approaches to maintaining quality and improving standards. In some countries, professional organizations and provider associations try to exercise quality control over members to improve standards for care, often without input from government or society. In other countries, the state exercises rigid control over the health sector, leaving almost no scope for professional judgment—resulting in defensive medicine and unnecessary referrals to higher levels of care. The challenge is to balance the roles of health professionals, government policymakers, members of the public, and other stakeholders in enhancing the quality of, and setting the standards for, the health sector.

Accreditation is therefore an important contribution to this process. It is proposed as an objective method to verify the status of health service providers and their compliance with accepted standards. This Toolkit for Accreditation Programs is timely. It provides guidance for government officials, health services providers, and technical staff of donor and aid organizations on how to develop, maintain, and improve external assessment systems over time. The Toolkit reviews international experience and brings together useful sources on options for establishing or upgrading an accreditation system for health services providers.

As standards and quality of health care evolve, and experience with accreditation systems develop, so should this Toolkit. Therefore, users are encouraged to provide regular feedback to ISQua, The International Society for Quality in Health Care, which has endorsed the Toolkit, in order that it be adapted over time to meet changing needs.

Jacques F. Baudouy
Director

Health, Nutrition and Population Network
World Bank, Washington, D.C.



THE WORLD BANK

Toolkit for accreditation programs

Foreword: THE WORLD HEALTH ORGANIZATION

Less than a decade ago, accreditation was still waiting to be included in the agendas of many countries and health institutions. Now, in every region of the world there are established accreditation bodies and agencies. Some experience has been built on how to implement accreditation and on how to improve the quality of the services, knowledge and products that are provided to the population. This experience is primarily framed in developed economies.

During the last decade, the health care systems in many countries were reformed with respect to organization and forms of administration. From having been a system based on 'trust' in the professions, health systems are now closer to other types of organizations, services and industries, including private industry. Appropriate 'standards' of care have become an issue not only for local managers and political bodies, but also for patients, who are increasingly referred to as 'consumers'.

If we look at the map of accreditation adoption, it appears that countries with developed economies were the beginners during the fifties until the nineties. And if we look at speed this adoption happened, it is possible to recognize a slow beginning along the first three decades with a very small number of countries adopting the innovation. Only in the nineties, a significant increase of countries adopting accreditation operations begins to change the curve (Fig. 1). In 2002, accreditation systems were clearly identified in over 39 countries which means that there is huge work to be done in order to promote similar commitment in countries where there is not yet an accreditation system in place.

The toolkit for accreditation programs provides a broad audience of health managers, researchers, decision makers, health professionals in general, with the very concrete resources needed to build an accreditation system. As it is a process that should be designed according to each country's profile of requirements and expectations, the tools are based in the presentation of experiences and lessons learned. During the building stage of a national system of accreditation, each country has experienced different ways to bring together a diversity of players, interest and political approaches. This diversity is reflected in the way the tools are presented in this book, not as rigid guidelines but as good practices to be discussed and improved in every new utilization.

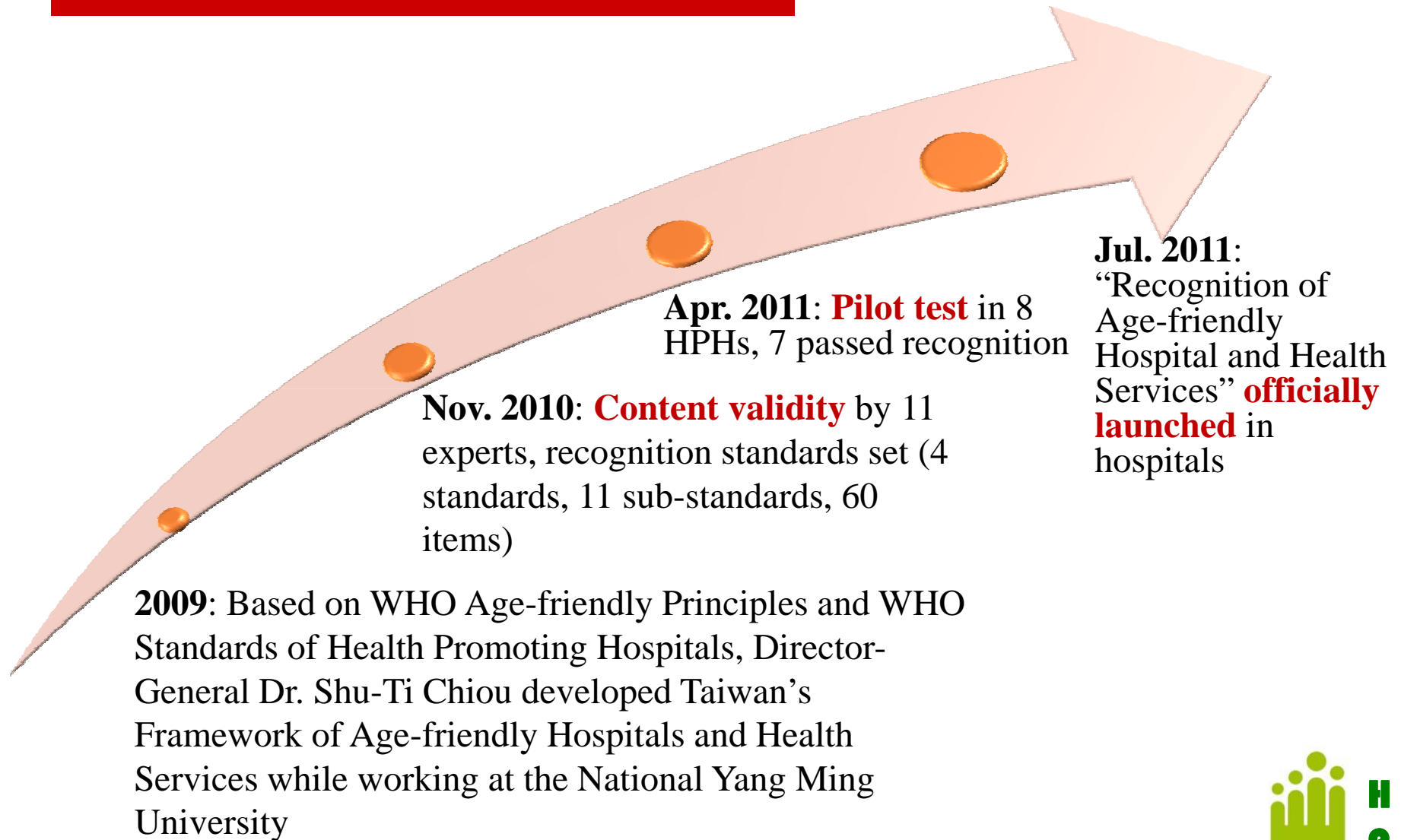
The next stage in the adoption of accreditation practices is going to be of greater expansion. Many countries are interested in providing better health services to their population. In this sense, the contents of this Toolkit are the appropriate ones for the process of building an accreditation system. First, the definition of the purpose of an accreditation policy and which are the best types of institutions for the achievement of this purpose. Decision makers and practitioners, will later face the difficult task of selecting the agency composition, financing and social participation models. Again, the Toolkit will be a source and a critical mirror on where to compare the choices adopted by a country. The toolkit covers the concrete way an agency works, its staffing and the interaction with health system stakeholders. The Toolkit provides, in this sense, a mature discussion about the knowledge needed to define the agency structure; how to develop the accreditation standards; how to train the staff and pilot testing its progress. Finally, to assure the stability of the accreditation system, the Toolkit offers orientation on the costs of the services the agency provides, and experience on the types of financial arrangements with participating institutions.

During the next decade, a greater increase in the establishment of national health accreditation systems is expected. This Toolkit arrives precisely when it is needed and will be a significant contribution for both the already 'experienced' systems and also for the ones that are joining the challenge of improving the quality every day. The Toolkit is a relevant contribution of the International Society for Quality in Healthcare and the World Bank. The WHO has been a permanent partner in the promotion of accreditation systems, and with this Toolkit for Accreditation Programs, our activities will benefit.

Mr Orville Adams
Director
Department of Human Resources for Health (EIP/HRH)
World Health Organization, Geneva



Timeline of development of age-friendly framework for health care *Shu-Ti*



Contents and Analysis of Surveyors' Report

Shu-Ti

- Implementation of each measurable item:
0%, 25%, 50%, 75%, 100%

Standard 1: Management Policy (12)

- 1.1 Developing an age-friendly **policy** (3)
- 1.2 Organizational Support (7)
- 1.3 Continuous **monitoring and improvement** (2)

1.1 Developing an age-friendly **policy** (3)

Standards, Sub-standards, Measurable Items				Low Score <80	Middle 80≤score <90	High 90 ≤score
1			Management Policy	85.6		
1	1		Developing an age-friendly policy	94.2		
1	1	1	The hospital's current quality and business plans identify age-friendliness as one of the priority issues.	93.2		
1	1	2	The hospital develops a written age-friendly policy that values and promotes older persons' health, dignity and participation in care.	92.5		
1	1	3	The hospital identifies personnel and functions for coordination and implementation of the age-friendly policy.	96.8		



**Age-friendly leadership
and culture**



Age-friendly policy
signed by St. Martin De
Porres H.'s
superintendent

1.2 Organizational Support (7)

Standards, Sub-standards, Measurable Items				Low Score <80	Middle $80 \leq \text{score} < 90$	High 90 $\leq \text{score}$
1	2		Organizational support			
1	2	1	The hospital identifies budget for age-friendly services and materials.	82.8		
				91.2		
1	2	2	The hospital improves the function of its information system to support implementation, coordination and evaluation of the age-friendly policy.	83.1		
1	2	3	The hospital recruits staff knowledgeable in the care of older adults and their families.	69.2		

Standards, Sub-standards, Measurable Items				Low Score <80	Middle $80 \leq \text{score} < 90$	High 90 $\leq \text{score}$
1	2	4	All staff receives basic training in age, gender, and culturally sensitive practices that address knowledge, attitude and skills.	78.0		
1	2	5	All clinical staff who provide care to older persons receive basic training in core competences of elder care.	78.2		
1	2	6	The hospital honors age-friendly best practices and innovations.		89.1	
1	2	7	Staff are involved in age-friendly policy-making, audit and reviews.			90.4



A driver innovated a stepper for the bus



Buddhist Tzu Chi General H., Taipei Branch,
honors age-friendly best practice and innovations



More age-friendly innovations



Ophthalmologist uses portable devices to exam patients, En Chu Kong H.



Handrail for body weight scale, Lukang Branch, Changhua Christian H.



Ladder for examination bed



Patients can sit for examination



Heating equipment for blood test, YuanSheng H.

1.3 Continuous Monitoring & Improvement (2)

Standards, Sub-standards, Measurable Items				Low Score <80	Middle $80 \leq \text{score} < 90$	High $90 \leq \text{score}$
1	3		Continuous monitoring and improvement	82.9		
1	3	1	The hospital includes sex- and age-specific analysis in its measurements of quality, safety and patient satisfaction whenever appropriate. These data are available to staff for evaluation.	85.7		
1	3	2	A program for quality assessment of the age-friendly policy and its related activities is established. The assessment addresses development of organizational culture and perspectives of the seniors and the providers, as well as development of resources, performance of practices and outcome of care.	80.1		

Performance indicators for age-friendly healthcare (1/4)

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Indicators	Definition
Staff awareness of the institution's age-friendly policy	<p>Question:</p> <p>Are you aware or have heard about the promotion of Age-Friendly Hospital?</p> <p><input type="checkbox"/> (1) Yes , <input type="checkbox"/> (2) somewhat , <input type="checkbox"/> (3) Not really , <input type="checkbox"/> (4) No</p> <p>Numerator : number of employees that answered “yes” and “somewhat”</p> <p>Denominator : number of employees that answered</p>
The overall satisfaction of patients of different age and gender	<p>Question:</p> <p>Generally speaking, how satisfied are you with the services of our hospital?</p> <p><input type="checkbox"/> (1) Very satisfied , <input type="checkbox"/> (2) satisfied , <input type="checkbox"/> (3) Normal , <input type="checkbox"/> (4) not satisfied , <input type="checkbox"/> (5) Very dissatisfied</p> <p>Numerator : number of “Very satisfied” and “Yes” answers</p> <p>Denominator : number of all answers</p>



Performance indicators for age-friendly healthcare (2/4)

Shu-Ti

Indicators	Definition
Patient experience on age-friendliness & HP services	<p>Questions: in what area(s) are you satisfied with our hospital's services?</p> <ul style="list-style-type: none"> (1) <u>Short waiting time</u> (2) <u>Health education</u> (3) <u>Intervention on unhealthy behaviors</u> (4) <u>Actively reminds cancer screening</u> (5) <u>Actively recommends smoke cessation</u> (6) <u>Attitude of services</u> (7) <u>Detailed explanation on your conditions</u> (8) <u>Emphasize patient rights and interests</u> (9) <u>Excellent medical practice</u> (10) <u>High quality equipment</u> (11) <u>Clean and comfortable environment</u> (12) <u>Others</u> <p>Options : <input type="checkbox"/> (1) Very satisfied , <input type="checkbox"/> (2) Satisfied , <input type="checkbox"/> (3) Normal , <input type="checkbox"/> (4) Not satisfied , <input type="checkbox"/> (5) Very dissatisfied</p> <p>Numerator : number of "Very satisfied" and "Satisfied" answers</p> <p>Denominator : number of all answers</p>



Performance indicators for age-friendly healthcare (3/4)

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Indicators		Definition
Rate of re-hospitalization within 14 days of discharge	(sub-indicator 1) Unplanned re-hospitalization within 14 days of discharge due to disease-related reasons	Numerator: number of unplanned re-hospitalized patients, due to disease-related reasons, within 14 days of discharge. Excluding: <ul style="list-style-type: none"> ● Re-hospitalized for childbirth ● Planned re-hospitalization ● Due to disease-unrelated reasons
		Denominator: number of discharged patients from acute care unit Excluding: <ul style="list-style-type: none"> ● Number of patient death ● Automatic discharge for dying patients
	(sub-indicator 2) re-hospitalization within 14 days of discharge	Numerator: number of unplanned re-hospitalized patients within 14 days of discharge
		Denominator: number of total discharged patients (including automatic discharge and referral) Excluding: <ul style="list-style-type: none"> ● Number of patient death

Performance indicators for age-friendly healthcare (4/4)

Shu-Ti

Indicators	Definition
Prevalence of fall-related injuries among patients in recent one year	Numerator: number of patients hospitalized due to fall injuries in the denominator. Denominator: number of surveyed patients age 65 yrs and above.
Fall incidence in hospitalized patients	Numerator: recorded cases of fall incidents Denominator: numbers of hospitalized patients and days



Standard 2: Communication and Services (9)

2.1 Communication (5)

2.2 Services (4)



2.1 Communication (5)

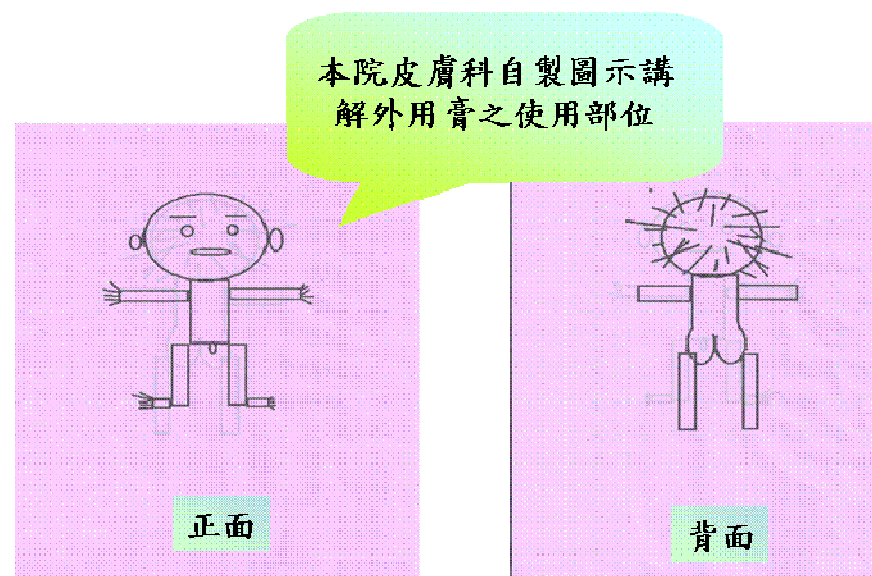
Standards, Sub-standards, Measurable Items				Low <80	Middle 80~ <90	High ≥90
2			Communication and Services	93.5		
2	1		Communication	92.5		
2	1	1	Hospital staff speak to older persons in a respectful manner using understandable language and words.	96.2		
2	1	2	Provide information on the operation of the hospital, such as opening hours, fee schedules, medication and investigation charges, and registration procedures in an age-appropriate way.	94.2		

Ex. Verbal communications;
Easily understandable pictures
or instructions.



Standards, Sub-standards, Measurable Items				Low Score <80	Middle 80≤score <90	High 90 ≤score
2	1	3	Printed educational materials are designed in an age-appropriate way.	89.9		
2	1	4	The hospital provides adequate information and involves the older persons and their families at all stages of care.	90.4		
2	1	5	The hospital respects older persons' ability and right to make decisions on their care.	92.1		

- ✓ The right to know;
- ✓ The right to choose;
- ✓ The right to refuse (ex. “DNR”)



Easily understandable HE materials



Use models to explain to seniors, En Chu Kong H.

台中醫院
Taichung Hospital
Department of Health

單一胰島素抽取步驟

- 注射前清洗雙手。
- 自冰箱冷藏室取出座標時，胰島素會有苦澀感或過稠。
- 將胰島素與瓶底攪拌，使瓶底鬆動，切勿上下搖晃。
- 用酒精棉片由內向外，環形消毒胰島素瓶瓶口。
- 針頭刺上，並以手指封蓋，抽出所需注射胰島素同等量空氣。
- 將瓶底平放桌面，針筒插入瓶口之橡皮塞內，將空氣推入瓶內以利正確的抽出胰島素。
- 將針筒與瓶口同時轉轉，(瓶口朝下)，針筒緩慢垂直緩緩往下抽出所需劑量。
- 將手指鬆開針筒內之氣泡，以利空氣排注 (看到一滴藥液出現至針尖為止)。
- 針筒置於針筒上，準備開始注射。

姓名：_____
病歷：_____

以上【單一胰島素抽取步驟】請按說明，如能您了解，請簽到門診處：_____ 謝謝！
附贈人員：_____ 日期：_____ 評鑑：_____ 再評鑑：_____
評鑑方式：至少問3題 A組(各占1題) B組(各占2題) C組(各占1題)
再評鑑：此評鑑或心得請於下次門診時再行評鑑。

行政院衛生署台中醫院藥房

Steps to take insulin, Taichung H.
DOH

2.2 Services (4)

Standards, Sub-standards, Measurable Items				Low <80	Middle 80~ <90	High ≥90
2	2		Services	94.7		
2	2	1	The hospital makes every effort to adapt its administrative procedures to the special needs of older persons, including older persons with low educational levels or with cognitive impairments.	93.0		
2	2	2	The hospital identifies and supports older persons with financial difficulties to receive appropriate care.	94.9		



Age-friendly sticker on NHI card

編號方式編輯功能畫面

編號方式：1 ~ 1 0 0 編號方式：1 0 1 ~ 2 0 0

	1	2	3	4	5	6	7	8	9	10
0	*	*	*	*	V	F	F	F	F	0
10	*	0	*	0	V	0	*	0	*	*
20	*	*	*	*	V	*	*	*	*	*
30	*	*	*	*	V	*	*	*	*	*
40	*	*	*	*	V	*	*	*	*	*
50										
60										
70										
80										
90										

F：現場初診
 R：現場複診
 N：預約初診
 T：預約複診
 A：約診
 B：外載患者
 *：不限
 X：不可掛號
 S：醫師特約
 V：VIP
 0：敬老號
 :清除

存檔 取消



Signs for age-friendly service, Saint Mary's H. Luodong



Standards, Sub-standards, Measurable Items				Low Score <80	Middle 80≤score <90	High 90 ≤score
2	2	3	The hospital has volunteer programs to support patients and visitors in reception, navigation, transport, reading, writing, accompanying, or other helps as appropriate in outpatient and inpatient services.	95.3		
2	2	4	The hospital encourages older persons, including community seniors, patients and their families, to participate in hospital's volunteer services.	95.5		



**Older persons as
volunteers**

**Cross-generation
volunteers**



Standard 3: Care Processes (25)

3.1 Patient assessment (7)

3.2 Intervention and management (9)

3.3 Community partnership and continuity of care (9)

3.1 Patient Assessment (7)

Standards, Sub-standards, Measurable Items				Low Score <80	Middle $80 \leq \text{score} < 90$	High 90 $\leq \text{score}$
3			Care Processes	90.8		
3	1		Patient assessment	90.2		
3	1	1	The hospital has age- and gender- appropriate guidelines on assessment of patient's needs for health promotion and disease prevention, including lifestyles, nutritional status, psycho-social-economic status, fall prevention , etc.	87.6		
3	1	2	The hospital has guidelines on assessment of patient's condition-related needs for health promotion, disease management and rehabilitation , such as needs of asthma patients, diabetes patients, stroke patients, patients with heart failure , patients with chronic obstructive pulmonary disease, patients with coronary artery disease, patients undergoing arthroplasty, patients undergoing other surgeries or procedures, patients with terminal illness, etc.	85.9		



Standards, Sub-standards, Measurable Items				Low Score <80	Middle 80≤score <90	High 90 ≤score
3	1	3	The hospital has guidelines on high-risk screening for the seniors	90.7		
3	1	4	Use of medications is reviewed at admission and regularly at outpatient services.	93.1		
3	1	5	The assessment of a patient's needs is done at first contact with the hospital and is kept under review and adjusted as necessary according to changes in the patient's clinical condition or on request.	87.3		
3	1	6	The assessment is documented in the patients' record.	91.0		
3	1	7	Information from referring physician or other relevant sources is available in the patient's record.	95.5		

General Condition Assessment

General Condition

1. 身體狀態

發育:

2. 心理狀態

態度:

注意力:

情緒:

行為:

正常
低落
亢奮
無法評估

3. 社會狀態

入院互動:

就醫主要照顧者:

家人對就醫態度:

是否保險:

有無社會資源:

預設值

5. 出院準備服務篩檢

評估分數: 5分 (>=20分收為重點個案)

■ 照護需求評估

生理方面: 巴氏量表(ADL): 10分中重度失能
患者意識: 清醒
K氏量表(等級): 完全獨立

精神心理方面: 穩定

■ 家庭支持系統評估

主要照顧者: 有
家庭問題: 無

4. 成人營養評估

BW: 67.2 BH: 152 29.1

A. 營養不良狀況

☒ **0分**
近期體重增加、無明顯流失或攝食正常

☐ **1分**
非刻意體重減輕>=3kg/3個月，過去一週飲食攝取約 50-75% 需要量

☐ **2分**
非刻意體重減輕>=3kg/2個月，或體重過輕(BMI:18.5-20.5)且體能比平日虛弱，過去一週飲食攝取約 25-50% 需要量

☐ **3分**
非刻意體重減輕>=3kg/1個月，或體重減輕>=9kg/3個月，消瘦(BMI<18.5)且體能比平日虛弱，過去一週飲食攝取<25% 需要量

B. 疾病嚴重程度(壓力代謝程度)

☒ 0分, 疾病不額外增加營養需要量

☐ 1分, 髖骨骨折

☐ 1分, 慢性阻塞性肺病

☐ 1分, 肝硬化

☐ 1分, 慢性腎病

☐ 1分, 糖尿病

☐ 1分, 癌症

☐ 1分, 肺炎

☐ 2分, 消化道手術

☐ 2分, 大面積或深度傷口

☐ 2分, 中風合併吞嚥障礙

☐ 2分, 血液腫瘤疾病

☐ 2分, 心膜炎

☐ 2分, 胰臟炎

☐ 2分, 癌症(on CCRT)

☐ 3分, 多重性創傷

☐ 3分, 多重性骨折

☐ 3分, 重度燒傷

☐ 3分, 嚴重腦部創傷(GCS3-8)

☐ 3分, 長期傷口癒合不佳

☐ 3分, 骨髓移植

☐ 3分, 腹膜炎

☐ 3分, ICU(APACHE>15)

☐ 3分, 嚴重敗血症

6. 疼痛評估 **執行疼痛評估**

住院疼痛評估: 2010-08-04 16:17:29

疼痛評估結果: 無疼痛相關問題

評估者: 李婉伊

7. 生活功能評估:

患者生活功能評估: 2010-08-04 16:10:13

1. 吞嚥困難評估: 無

2. 跌倒評估: 6分

重要因素: 年齡>=65歲, 使用-降血壓, 降血糖

次要因素: GCS 7-14分, 移位或起身站立障礙

3. 巴氏量表: 10分

個人衛生/修飾: 0-需別人協助

洗澡: 0-需別人協助

8. 安寧照護詢問內容 (非癌症患者免填)

☐ 1. 癌症末期患者

☐ 2. 近期(6個月)內病程進行至死亡不可避免

☐ 病患曾簽署-不施行心肺復甦術意願書/同意書

☐ 提醒病患及家屬有拒絕施行心肺復甦術的權利及指導簽署同意書

☐ 同意會診安寧緩和療護科

A+B+1= 0+0+1 = 1 (年齡>=70歲再加1分)

(成人超過3分為營養不良高危險群, 請會診營養師)

確認(Y)



3.2 Intervention & Management (9)

Standards, Sub-standards, Measurable Items				Low <80	Middle 80~ <90	High ≥90
3	2		Intervention and management	88.4		
3	2	1	The patient (and the caregiver, as appropriate) is informed of factors impacting on their health and, in partnership with the patient (and the caregiver as appropriate), a plan for relevant intervention is agreed.	88.6		
3	2	2	Information given to the patient (and the caregiver) is recorded in the patient's record .	92.8		
3	2	3	The intervention and the expected results are documented and evaluated in the records.	89.4		



Standards, Sub-standards, Measurable Items				Low <80	Middle 80~ <90	High ≥90
3	2	4	Information on healthy ageing and information on specific risks or conditions is available to patients, families, visitors and staff.	90.7		
3	2	5	Clinical departments incorporate health promotion, rehabilitation and risk management into their clinical practice guidelines or pathways as appropriate.	83.4		
3	2	6	Diagnostic investigations and procedures should take age-related changes and level of tolerance into consideration.	85.7		
3	2	7	Guidelines on multidisciplinary geriatric assessment and interventions on high-risk seniors are available.	81.4		
3	2	8	The discharge planning is initiated as early as appropriate.	95.0		
3	2	9	The right length of hospital stay should be achieved.	88.1		

Intelligent Reminding System

0990717 A 301診3654-蔡宗佑 跟診: 邱俊仁 [正式開診]

電子查章 醫療查詢 離線作業

Ver. 1.22 11:33:53

狀態	預約	診號	姓名	性別	年齡	病歷號碼	IC	檢驗	結果	身份	報到時間	順序
	預約	5	吳○峻	男	40	788XXXX				健保口		
	初診	11				0						
完成	預約	1	江林○葉	女	56	692XXXX	Y			健保大乳子口		
完成	預約	2	蔡○津	女	50	228XXXX	Y	簽收		健保大乳子口		
完成	當診	3	莊○平	男	50	515XXXX	Y	簽收		健保大口		
完成	當診	6	陳○雄	男	68	1193XXXX	Y			健保大口		
完成	預約	7	陳○市	女	86	818XXXX	Y			老人子口		
完成	預約	8	徐呂○綢	女	72	150XXXX	Y			老人子口		
完成	當診	9	黃○和	男	74	606XXXX	Y			老人口		
完成	預約	10	莊○月	女	72	241XXXX	Y			老人子口		
完成	當診	12	王○郁	男	13	757XXXX	Y			健保		
完成	預約	13	陳○成	男	66	1280XXXX	Y			健保大口		

全部患者 未完患者 已完患者 明細表 調病歷 減敏設定 住院借閱 報到 表單

IC卡登錄 IC卡查詢 IC卡處方明細[醫] 特殊醫療查詢
IC卡更新 IC卡就醫履歷 重大傷病[醫] 醫事卡登入 離開



住院醫囑(南郭院區)

線(O) 處置(I) 復健(R) 輔具(H) 牙科(D) 特殊(S) 精神科(C)

方 停用/作廢 重整處方 已開處方 飲食 輸血/手術 會診單 UpToDate

身份 HI-11 床號 K865-B 入院 97/08/23 DNR 認傷 運送 C

重整 97/09/09 診斷 434.01 腦血栓症合併腦梗塞

管內科 蔡正道 SO

目(4) MTZDP [F5] 複製 [F6] 刪除 體重 0.0

PRN	首量	劑量	劑單	服法	天數	押	總量	銷單	目	途徑	應急	執行地點	生效時間	失效時間	備註
<input type="checkbox"/>											<input type="checkbox"/>		09/02 11:11		

跌倒危險患者及使用致跌藥物提示

◎護理跌倒評估量表內容:

- 重要因素:
年齡>=65歲
步態不穩
使用-軟便劑,
- 次要因素:
移位或起身站立障礙
需使用助行輔具
- 跌倒高危險評估分數: 8

×此病患>=18歲且跌倒危險評估總分數為 8分,
使用(Imovane 7.5mg)請多加注意跌倒預防!

[確認(Y)]

Warning: Fall prevention for high risk patient, Changhua Christian H.

一院診隨視診清單-[Opoc106]

醫測作業(O) 醫次處方(E) 其他診隨(O) 處方簽章印(E) 取消掛號(D) 其他約診(E) IC卡(I) 煙戒單(E) 健康調查作業(O) 電子病歷簽章(E) 檢驗登記(E)

未診清單(N) (17:58) 院內門診 101/7/17 已診清單(E) 按滑鼠右鍵即可 查看完整明細 圖例說明

診號	病歷號	病患姓名	科別	時間	禁指	取次
3	00584409	黃	心臟內科			
5	00454985	賴	心臟內科			
6	00560533	洪	心臟內科			
11	00577241	江	心臟內科			
15	00468017	陳	心臟內科			

國健局醫院藥品醫療品質提升計畫(FmOpoc129)

病歷號 00560533 洪無額 就醫日期 1010717 就醫序號 1

指標1: 病人吸菸狀態登錄比率
目前是否有吸菸(從以前到現在吸菸累計超過100支(5包)・且最近30天內曾經使用菸品)?
是 否

指標2: 醫事人員給予吸菸病人勸戒建議比率
是否建議該個案戒菸?
是 否

口腔危險因子登錄
嚼檳榔現況 0_無 吸菸狀態 0_無

時段 上午 診號

90 天內不再提示菸害防治指標問題。 [確認(Y)] [離開]

Smoking-cessation advice,
Chiayi Branch, Taichung
Veterans General Hospital



Computer-integrated medication records with auto-check of duplication, overdose, and interactions

門診藥歷資訊整合系統

病歷號: 姓名:

目前用藥:

藥品	起始日	終止日	天	劑	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
QUINI	98/10/09	98/11/05	28	7																				
XALAL	98/10/09	98/11/05	28	7																				
ERISP	98/10/19	98/11/01	14	3																				
KETOC	98/10/19	98/11/01	14	3																				
MUNDO	98/10/19	98/11/01	14	3																				
ST	98/10/19	98/11/01	14	3																				
MOPRT	98/10/23	98/11/05	14	7																				
TAKES	98/10/23	98/11/05	14	7																				

住院藥歷資訊整合系統

醫令主畫面

F1醫令 F2醫令(UD RENEM) F3出院帶藥 F7診斷 F8化療處方 F4危急回 SF1刪ST處方
 F0換病人 CF0結束 CFA DRG判讀 SF5重印醫囑 CF1清除醫令 CF4重印長期醫囑 CF5轉院

患者: T1租金 DNR(+) 154 床號: 100 -B健保 PRN筆數: 0 操作者: 劉醫師
 主治醫師: 洪伯斌 主治醫師: 100/02/09 11:14
 診斷1: 000 急診虛癡碼 診斷3: 抗生素TPH
 診斷2: 診斷4: BIS 過敏 Berotec 2.5mg tab

序	醫令碼	次劑量	單位	服法	途運	天	起始時間	終止時間	ST	單位	磨1意
016	Baktar tab	2	粒	Q8H	PO	2	1000208+10	1000210+09		粒	N 1
017	APAP 500mg tab	1	粒	QD	PO	3	1000209+11	1000212+10		粒	N 1
018	Fortun 1000mg in 1000		MG	QOD	IVD	2	1000209+11	1000211+10		支	N 1
019	塑膠空針	10cc 22 1		QOD		2	1000209+11	1000211+10			N 1
020	Rocephin 500mg i 1000		MG	Q12H	IVD	2	1000208+10	1000210+09		支	N 1
021	塑膠空針	10cc 22 1		Q12H		2	1000208+10	1000210+09			N 1
022	(針) Diflucan 100 100		MG	QD	IVD	2	1000208+10	1000210+09		支	N 1
023											
024											
025											
026											
027											
028											

3.2.5 COPD pathway

(Tai-chung Veterans' General Hospital, Chia-yi Branch)



3.3 Community Partnership and Continuity of Care (9) *Shu-Ti*

Standards, Sub-standards, Measurable Items				Low Score <80	Middle 80≤score <90	High 90 ≤score
3	3		Community partnership and continuity of care	93.8		
3	3	1	Information on patient organizations is available to patients.	96.2		
3	3	2	A list of health and social care providers working in partnership with the hospital is available.	96.2		
3	3	3	An operation procedure for referral services is in place with assigned personnel.	97.9		

Standards, Sub-standards, Measurable Items				Low <80	Middle 80~ <90	High ≥90
3	3	4	There is a written plan for collaboration with partners to improve the patients' continuity of care.	92.6		
3	3	5	There is an agreed-upon procedure for information exchange practices between organizations for all relevant patient information .	88.8		
3	3	6	Patients (and their families, as appropriate) are given understandable follow-up instructions at out-patient consultation, referral or discharge.	93.0		
3	3	7	The receiving organization is given in timely manner a written summary of the patient's condition and health needs, and interventions provided by the referring organization.	92.8		
3	3	8	If appropriate, a plan for rehabilitation describing the role of the organization and the cooperating partners is documented in the patient's record.	89.2		
3	3	9	The hospital provides care services to the community elders .	97.3		

Rehabilitation and community HP activities

Shu-Ti



Community Service



Health check-up in community, Chest H. DOH



**Volunteers cutting hair
for community elderly**



Meal delivery service



Buddhist Tzu Chi General H., Taipei Branch



Free transportation to hospital
for seniors health check-up



Standard 4: Physical Environment (14)

- 4.1 General environment and equipment (7)
- 4.2 Transportation and accessibility (4)
- 4.3 Signage and identification (3)

4.1 General Environment and equipment (7)

Standards, Sub-standards, Measurable Items				Low Score <80	Middle $80 \leq \text{score} < 90$	High $90 \leq \text{score}$
4			Physical Environment			94.4
4	1		General environment and equipment			93.8
4	1	1	The hospital applies the common principles of Universal Design to its physical environment whenever practical, affordable and possible.		88.0	
4	1	2	The facilities , including waiting areas, are clean and comfortable throughout.			98.3
4	1	3	The facilities are equipped with good lighting, non-slip floor surfaces, stable furniture and clear walkways.			91.5



Standards, Sub-standards, Measurable Items				Low Score <80	Middle $80 \leq \text{score} < 90$	High $90 \leq \text{score}$
4	1	4	The toilet, bathing facilities and hospital beds are equipped with emergency alarm systems.			96.4
4	1	5	The hospital has barrier-free washrooms equipped with basic washing facilities.			92.5
4	1	6	There are hand railings on both sides of hallways.			95.5
4	1	7	Bed heights are appropriate for older persons.			94.2

Examples of 4.1

Washroom renovation

Chair with armrest



Senior examination rooms,
independent and privacy protected,
Taichung H. DOH



Before



Before



After

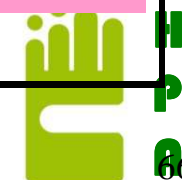


After

Taichung Hospital, DOH

4.2 Transportation and accessibility (4)

Standards, Sub-standards, Measurable Items				Low Score <80	Middle $80 \leq \text{score} < 90$	High $90 \leq \text{score}$
4	2		Transportation and accessibility			96.7
4	2	1	The main hospital premise has convenient transportation connections .			97.0
4	2	2	The hospital with larger premises offers shuttle van .			96.4
4	2	3	The hospital's main entrance has a passenger drop off / pick up area with staff on site to provide assistance.			97.4
4	2	4	For people with disabilities , there is enough space for them to get on / off and mobility aids are provided. (ex. wheelchair)			96.4



Transportation and accessibility



Shuttle van between two branches,
Tri-Service General H.



Assistance at the main entrance,
St. Martin De Porres H.

4.3 signage and identification (3)

Standards, Sub-standards, Measurable Items				Low Score <80	Middle 80≤score <90	High 90 ≤score
4	3		Signage and identification	92.9		
4	3	1	Simple and easily readable signages are posted throughout the hospital to facilitate orientation and personalize providers and services.	91.7		
4	3	2	The hospital applies common signanges for directions and makes it easy for older persons to identify.	89.5		
4	3	3	Key health care staff are easily identifiable using name badges and name boards.	97.4		

Signage and identification



Orientation Markers on Floor



Larger signs

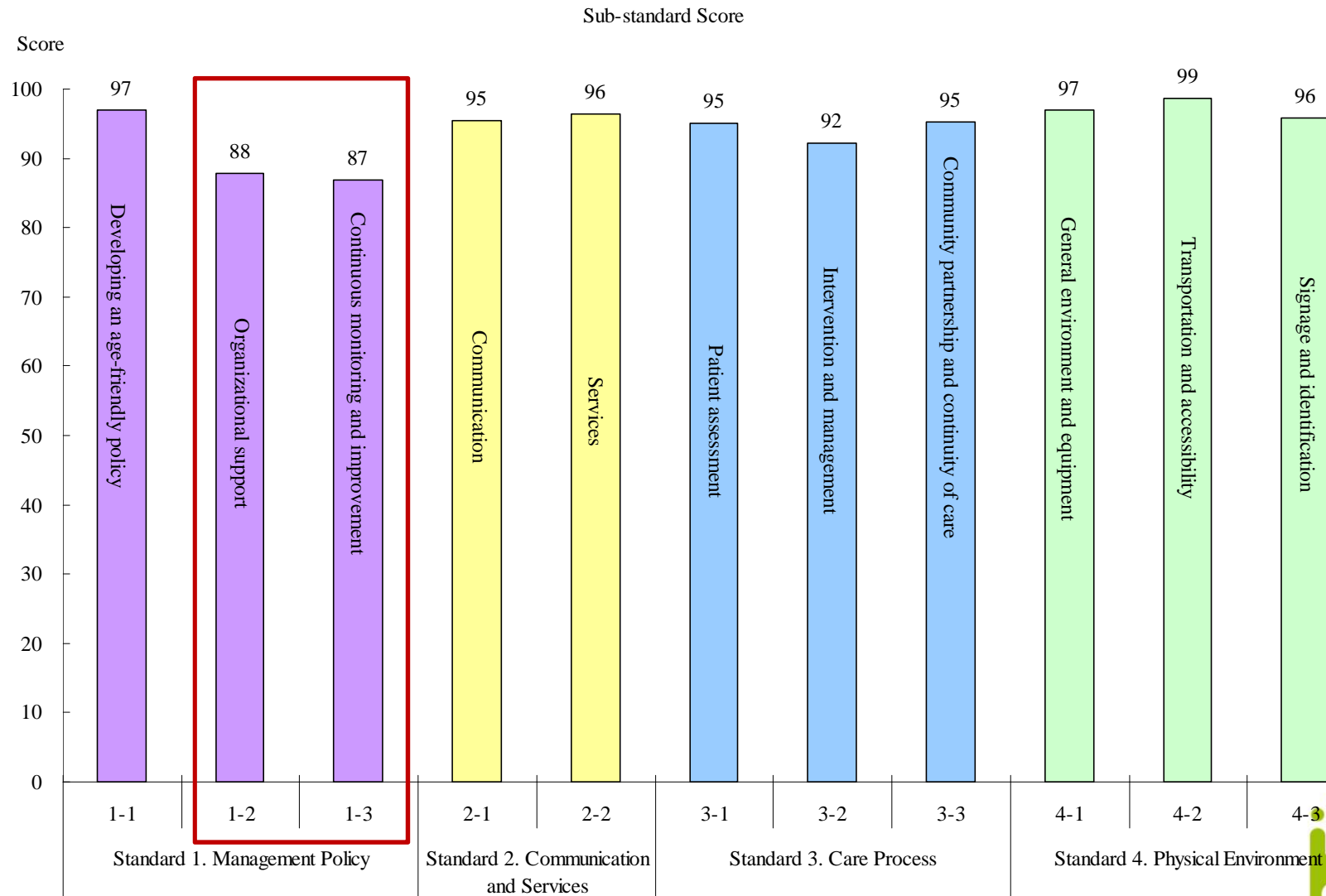


Weaknesses: items scored < 85

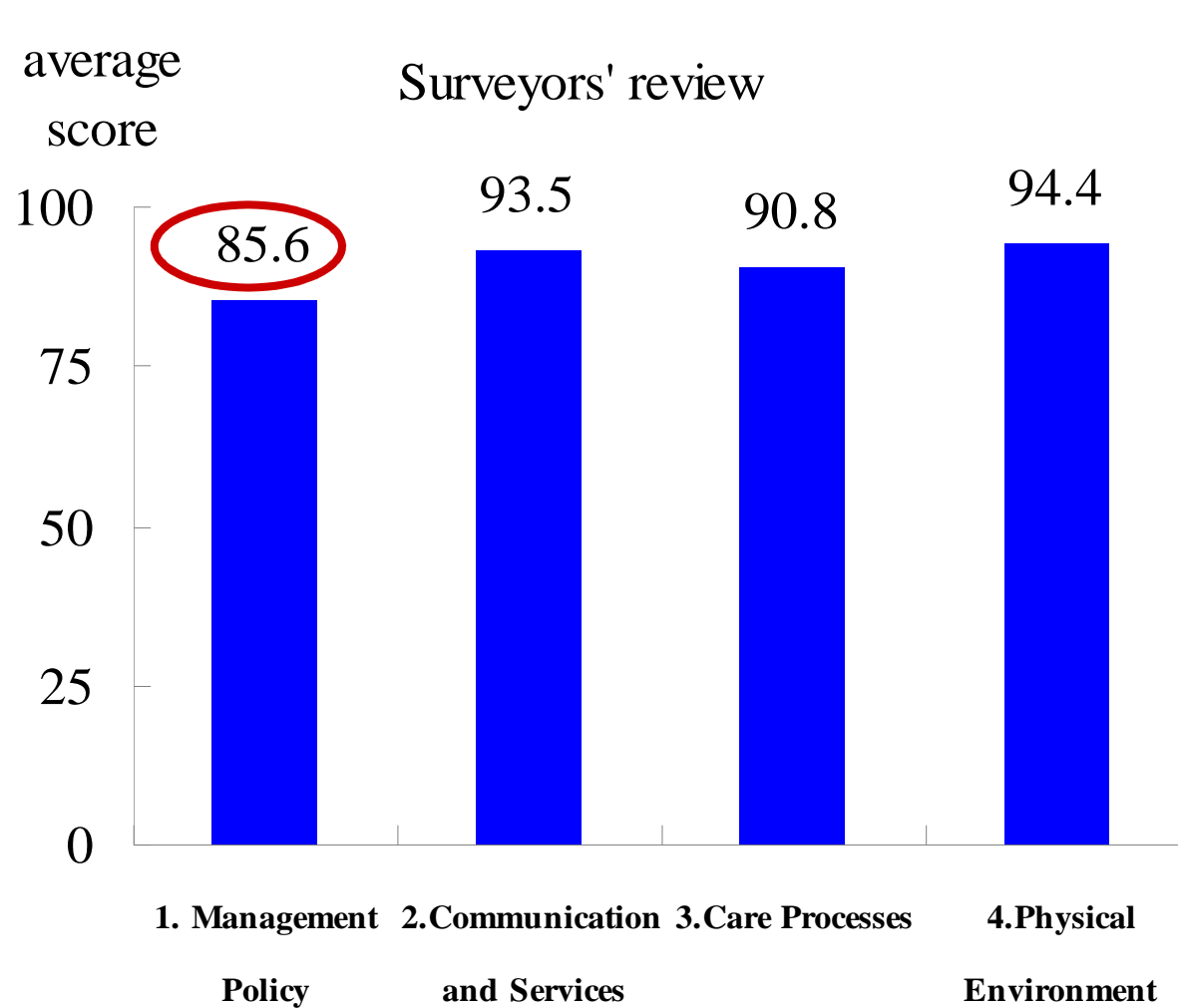
- **IT support** for implementation and evaluation of age-friendly policy (1.2.2, 83.1);
- **Staffing and capacity building:**
 - staffing in geriatric care (1.2.3, 69.2),
 - basic training for all staff (1.2.4, 78),
 - training in core competence for clinical staff (1.2.5, 78.2)
- Existence of **quality assessment program** (1.3.1, 80.1),
- **Incorporating** health promotion into **clinical practice guidelines** (3.2.5, 83.4), and
- Existence of **guidelines on** multidisciplinary geriatric assessment and interventions on **high-risk seniors** (3.2.7, 81.4).



Surveyors' Score: 12 Sub-standards



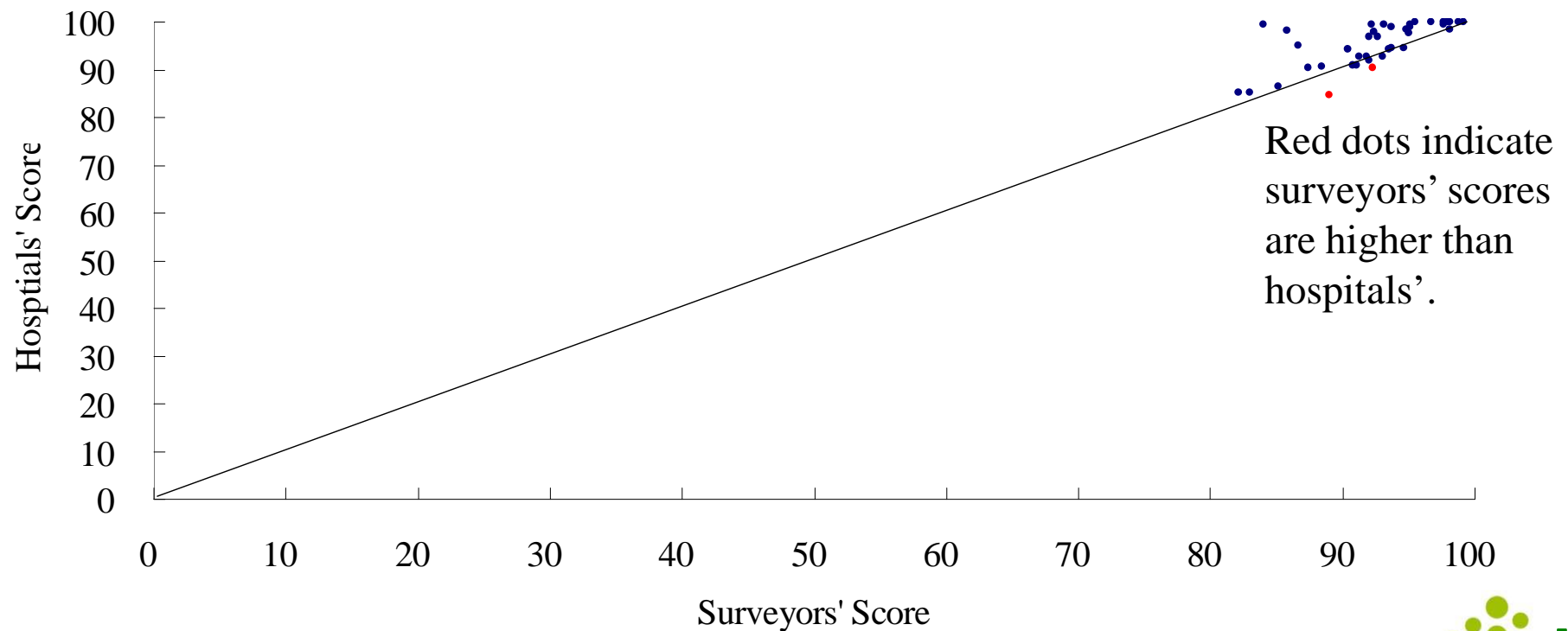
Surveyors' Score: 4 Standards



“Management Policy” still has rooms for improvement



Reliability: Hospitals' & Surveyors' Score



Surveyors' Comments on organizational preparedness -1

Shu-Ti

Leadership support	%
High	96.6
Moderate	3.4
Low	0

Resource allocation and role assignments	%
Good	84.6
Adequate	15.4
Inadequate	0

Surveyors' Comments on organizational preparedness -2

Shu-Ti

Achieved progresses	%
High	62.4
Moderate	34.2
Low	3.4

Future development	%
Promising and optimistic	92.3
Somewhat promising	7.7
Pessimistic	0



Collaborative learning and the recognition process

Training Program for Surveyors

- “Age-friendly Healthcare On-Site Visit Surveyors Consensus Camp”
 - Standards’ interpretation
 - Survey process
 - Interviewing and observation skills
 - Documentation review
 - Report-writing techniques



Evaluation for Surveyors

- systematic appraisal on surveyor each year:
 - Participation
 - Performance
 - Enthusiasm
 - Suitability
 - Reliability
 - Hospitals' Satisfaction
 - Audit Report Quality



7 steps of learning & recognition

1. Leadership & team-up
2. Coordinator training
3. Self assessment
4. Improvement plan
5. Site visit
6. Feedback & recognition
7. Award competition



Core Training Course for Hospitals who intend to apply for Recognition

Shu-Ti

Time	Content
30 min	(Visit) An Age-friendly Hospital and its Achievements
50 min	Promoting Age-friendly Health Care
50 min	How to draft your own Age-friendly Health Care Plan
10 min	Break
50 min	How to Prepare and Implement Age-friendly Health Care Self-assessment
20 min	Discussion



Hospital Self-Assessment (Overall)

	0%	25%	50%	75%	100%	
Standard 1: Management Policy						
	12	12	12	12	12	(Item)
Standard 2: Communication and Services						
	9	9	9	9	9	(Item)
Standard 3: Care Processes						
	25	25	25	25	25	(Item)
Standard 4: Physical Environment						
	14	14	14	14	14	(Item)
Sum						
	60	60	60	60	60	(Item)

Overall Action

Actions and Time Table	Coordinator



Agenda for site visit

Time	Content
5 min	Introduction of personnel 1. Superintendent introduces hospital staff (usually department directors) 2. Surveying team leader introduces surveyors
50 min	Hospital presentation: 1. Basic Information and background 2. Report on self-assessment (Including policies and preparation for resource improvement)
60 min	On-site visit and verification of documents Note: Planned route (Basic route: entrance, registration, pharmacy, laboratory, examination rooms and wards)
40 min	Interactions and discussions Note: Interactions between hospital and on-site visit surveyors
10 min	Discussion and consensus-formation by the on-site visit surveyors Note: Closed-door consensus meeting (Retrieving surveyors' total evaluation forms and hospital's self-assessment (Surveyors will go through each item of the self-assessment))



Site visit: 3 surveyors + 1 senior



Visiting hospital facility



Senior volunteers



Examining barrier-free washroom



Verification of documents



In their shoes:
Experiencing elders' world



Overall discussion



Overall Evaluation by Surveyors

- High-level support: ☐High , ☐Moderate , ☐Low ,
- Resource, allocation and tasking: ☐Good , ☐Adequate ,
☐Inadequate
- Concrete results: ☐Abundant , ☐ a few , ☐ still need work
- Future prospect: ☐Positive and optimistic , ☐somewhat
positive , ☐hardship or doldrum
- Features:
- Assistance from BHP:
- Summary and recommendation:
- Overall Evaluation: ☐ Outstanding (95) , ☐ Excellent (90) ,
☐ Great (80) , ☐Good (70) , ☐ Satisfactory(60) ,
☐ Need Improvement (<60)



38 recognized as age-friendly hospitals

- An honorable board for each of the AF healthcare organizations
- 2012. 11.20: recognition awarded by Dr. Wen-Ta Chiu, Minister of Health & Welfare



Annual selection of outstanding organizations

- Age-friendly Hospitals Model Competition
 - **Model** Award: 1 hospital, awarded medal & 5,000USD.
 - **Outstanding** Awards: 8 hospitals, awarded certificate & 2,667USD.
 - Best Practice Awards in 3 areas, each awarded a medal & 1,667USD.
 - ✓ **Process Reengineering** Prize
 - ✓ **Age-friendly Services** Prize
 - ✓ **Age-friendly Environment** Prize
- 15 Hospitals participated in 2012

Model Award



Annual selection of outstanding frontline workers

Shu-Ti

- Innovation in AF Healthcare
 - 6 selected from 44 submitted innovations in 2012
 - each winner was awarded 33~100USD
- Best articles on AF healthcare
 - 3 selected from 55 submitted articles from hospital staff or volunteers in 2012;
 - each winner was awarded 33~100 USD



Innovation by the bus driver: pedestal for vehicle boarding



DG. Chiou honors the innovation on Award Ceremony, 2012

Engaging the leaders

- Emphasize on organizational changes and management policy
- Site visits with leaders sitting in
- National recognition and annual award
- Benchmarking and positive competition



The way forward

Task Force on HPH and Age-Friendly Health Care

Shu-Ti

- After 1 year operation of the “**Working Group on HPH and Age-Friendly Health Care**”,
- the “**Task Force on HPH and Age-Friendly Health Care**” was approved by General Assembly of the Intl. Network of HPH & HS in May 2013.
- Chair: DG Chiou ST
- Members: 17 members from 13 nations
 - Prof. Jürgen Pelikan, Dr. Ulrike Sommeregger (Austria), Dr. Belinda Parke, Dr. Barbara Liu (Canada), Mr. Jeff Svane (Denmark), Dr. Tiiu Härm (Estonia), Dr. Heli Hatonen (Finland), Ms. Ioanna Petroulia (Greece), Ms. Anne Harris (Ireland), Mr. Raffaele Zoratti (Italy), Herbert Habets (Netherlands), Mrs. Kjersti Johanne Flotten (Norway), Dr. Shu-Ti Chiou, Dr. Yu-Chen Chang, Prof. Nicole Huang (Taiwan), Dr. Somsak Pattarakulwani (Thailand), Prof. (Marie Boltz) USA



Content Validity of Taiwan's Framework

- Developing an **internationally** applicable framework on age-friendly health care
- Time: Jan. – March 2013
- Method: 3 criteria for each measurable item
 - Importance, Suitability, Clarity
 - Rating from 1 to 5, with 5 represents highest
- Response: 12 members rated 60 measurable items; 1 replied with feedbacks
- Result: 51 measurable items scored 4 or above in all 3 criteria
- 9 items: reworded or added description after 1st TF meeting in May, 2013



International Pilot Test Recruitment

- Welcome!



Price of Becoming Age-friendly?

- **Price of “not” becoming age-friendly**
 - Patient and family member—dissatisfied, unwilling to seek medical help, poor control of conditions;
 - Employees—lack of skills and confidence => burnout, errors
 - Hospital managers—risks (misdiagnosis, malpractice, adverse events, loss of trust, negative social image)
 - Society—unhealthy and unaffordable future
- **Price of positive attitude => Priceless**
- **Consequences of positive attitude: mutually productive partnerships**



*Let health, dignity & equity
be the only products of health care.*

*With Evidence, Love & Collaboration,
we will get there!*



Promoting Your Health

Health Promotion Administration,
Ministry of Health and Welfare