出國報告（出國類別：研習）

2014 年長期照護與醫療服務整合-國際研習暨參訪報告

服務機關：衛生福利部中央健康保險署
出國人員：醫務管理組專門委員　王淑華
出國地區：美國俄亥俄州克里芙蘭市
出國期間：103.8.16~103.8.23
報告日期：103.09.

目錄

摘要

衛生福利部委託財團法人國家衛生研究院(以下稱國衛院)辦理「103 年度長期照護與醫療服務資訊整合研究計畫」，國衛院鑑於國內人口比率快速增加，整合照護模式之提供有其迫切性，規劃於 103 年 8 月 18 日至 8 月 22 日於美國俄亥俄州克里芙蘭市辦理「整合照護」國際研習活動。旨在借鏡美國「醫療保險(Medicare) 」與「醫療補助(Medicaid) 」相關經驗，並就國際上醫療與長期照護已成功整合運作之模式進行探討及交流。

本次研習活動共計 4 天，包括國際研討會 1 天、工作坊 1 天及實地參訪 2 天。研討會邀請美國聯邦及州政府政策專家、醫院、長期護理和社區提供服務者參與，我方則將健保及十年長照經驗帶往美國，藉以發展適合我國國情和文化的整合照護模式。103 年 8 月 20 日國際研討會衛生福利部邱部長文達蒞臨演講，題目爲 “Toward Integrating Acute and Long Term Care in Taiwan: Opportunities and Challenges”；7 位與會美國專家則就各自專長領域演講並研討，包括 Accountable Care Organizations (ACO)、CARE Assessment and Care Planning Project 等。8 月 21 日工作坊則由我國專家學者就研究計畫之 5 個子計畫分別報告研討。

2 天參訪包含位於克里芙蘭的大學醫院(University Hospitals, UH)、Kindred Health Care，美國最大的 PAC(post-acute care)經營機構、Kindred Transitional Care and Rehabilitation Centers: The Greens、Cleveland Clinic Foundation。參訪中瞭解技術型護理之家(SNF skilled nursing facility)、急性長期照護醫院(ALTCH acute long term care hospital)、失智中心、PAC 照護機構之運作，以做爲日後規劃全民健康保險與長期照護保險整合之參考。

壹、目的:

透過研討會了解美國現今整合照顧政策，包含照護模式、財源、評估工具、資訊、人力等面向，成功的模式與失敗的模式之關鍵因素。藉由各主題的報告討論，了解整合照護過去的經驗、未來的發展趨勢和問題解決可能方案。

透過工作坊由我方研究團隊人員，提出目前規劃中整合照護草案中 5 個子計畫報告，與美方專家討論並獲取其建議。

透過參訪技術型護理之家(SNF, Skilled Nursing Facility)、急性長期照護醫院(ALTCH, Acute Long Term Care Hospital)、失智中心、PAC 照護機構，了解推動整合照護之政策和實務執行的誘因和阻力。

在整個研討及參訪中，探索創新和成功模式並分析其成功原則。並藉以建立跨國聯繫管道與國際接軌，以達持續性的合作與交流。

貳、參訪行程、會議及工作坊內容

一、參訪行程

8月18日前往大學醫院(University Hospitals, UH)

8:00 於大學醫院(University Hospitals, UH)，由凱斯西儲大學家庭醫學科教授George Kikano致歡迎詞後，接續爲三場簡報，分別爲：

第一場 8:35-9:30

由老年醫學科Gowrishankar Gnanasekaran醫師介紹「以老年醫學角度控制再住院率」。

第二場 9:30-11:00

由技術型護理之家Hanna House負責人Lori Lozier介紹「醫院附設護理之家執行急性後期照護之現況」，並參訪護理之家。

第三場 11:00-12:00

由老年醫學科Stefan Gravenstein醫師介紹「連續照護中的轉銜管理」。

13:00 前往McGregor Community Center

由執行長Tangi McCoy及負責人Stephanie Morley帶領導覽技術型護理機構及失智中心，再由McGregor PACE的醫療部主任Peter DeGolia醫師及執行長Tangi McCoy介紹 PACE (Program for All-inclusive Care for the Elderly)的演進、內涵與特色。

15:30 前往Margaret Wagner House

參與PACE團隊小組會議討論，隨後上三樓及四樓參觀Margaret Wagner Apartments，接著由護理師Carole Fordham、社工師Beth Sipple、以及具有41年服務資歷的照服員Linda Van Horne三人介紹如何在私營住宅提供居家照護服務。

8月19日

9:00 參觀Kindred Hospital

Kindred Health Care是美國最大的PAC(Post-Acute Care)經營機構，與克里夫蘭診所機構(Cleveland Clinic Foundation)有密切的合作關係，由護理師Leslie Vajner 及醫務主任Dr. Michael Felver負責簡報，該機構執行的Center for Connected Care計畫，。該簡報扼要卻詳實地將PAC的設計與精神、作法與現況做了介紹，其內容摘要如下：

所謂PAC，係爲了有效控制急性醫療支出，美國實施DRG(disease related group)來控制醫療費用的高漲；然而隨之而來的住院日數減少，不完全住院問題便接續出現，PAC制度便應運而生。PAC的給付較急性醫療低，其目的在降低病患因此次住院造成的失能，並以成功返家爲目標，目前有進行PAC的場域、評估工具、及給付方式都有不同，請參見下列附表。

Location	Instrument	Payment	嚴重度
Long Term Care Hospital		DRG	++++(可使用呼吸器)
Inpatient Rehabilitation Facility	FIM	Per discharge	+++
Skilled Nursing Facility(SNF)	MDS 2.0	Per diem	++
Home Health Agency	OASIS	60 days	+

Kindred Hospital在醫院裡同時設有SNF(skilled nursing facility)及ALTCH(acute long term care hospital)，當病人狀況不佳時可由SNF直接轉進ALTCH，進行transition care。ALTCH診治病患的狀況複雜，備有簡易手術室、呼吸器及血液透析機，類似台灣的一般急性內科病房。

11:00 由台大醫院北護分院韓德生主任簡報台灣2014年PAC試辦計畫，讓與會成員知悉台灣半年來之執行成效及面對問題、未來展望。

13:00 前往Kindred Transitional Care and Rehabilitation Centers: The Greens

由 Kindred Transitional Care 執行長Elizabeth Ribar介紹該單位。

15:30 參觀 Cleveland Clinic Foundation 老年醫學中心

由主任 Barbara Messinger-Rapport 醫師簡介 Geriatric Assessment and Case Management Operations. 其主要內容如下：

各國所面對的重要課題，爲人口高齡化，必須加重老人的照護。雖然醫療水準持續進展，但過度專科化的結果，使得照護費用逐年升高，照護品質卻不升反降。爲了避免重複就醫、重複用藥、以及無單一專科診治的症候群，一群專門治療老年病患的primary care physician (PCP)專科醫師便應運而生。

克里芙蘭診所的老年醫學中心排名全美第六，診治的不僅是美國的病人，更是國際知名的診所。該診所的病人一律接受老年周全性評估，初診約需時60分鐘，複診則要40分鐘。除了作周全老人評估外，老年專科醫師亦負責護理之家、社區日照中心、及居家的初級照護。

二、會議內容

8月20日

研討會爲此次研習的主軸，由美國專家就各自領域演講並研討。首先由Benjamin Rose Institute on Aging 的執行長Richard Browdie、王懿範教授致歡迎詞。凱斯西儲大學教務長兼副校長William A. Baeslack III 致國家衛生研究院龔行健院長歡迎及感謝詞。當日議程如下：

- 8:40 - 9:15

  演講者：台灣衛福部邱文達部長及護理及照護司鄧素文司長

  講題：“Toward Integrating Acute and Long Term Care in Taiwan: Opportunities and Challenges”

- 9:15-10:15

  演講者：克里夫蘭大學醫院醫務部主任暨 ACO 總裁 Dr. Eric Bieber

  講題：Accountable Care Organizations (ACO)

- 10:30 - 11:30

演講者：Kindred 健康照護機構醫務部主任 Dr. Marc Rothman

講題：Kindred Integration Demonstration

- 11:30 - 12:15

演講者：Brookings Institute Engelberg Center for Health Reform 的 Barbara Gage 博士

講題：CARE Assessment and Care Planning Project

- 13:00 - 13:45

演講者：RTI International 的 Josh Wiener博士

講題：Long Term Care in the US: What are the Elements of a Comprehensive System and How Should They Work Together?

- 13:45 - 14:30

演講者：Lewin Group 資深副總裁 Lisa Alecxih

講題：Accessing the System, Determining Eligibility, and Developing Care Plans

- 14:45 - 15:30

演講者：Boston College 社會工作研究所 Kevin Mahoney教授

講題：Agencies vs. Self- Directed Care, including the Role of Families

- 15:30 - 16:15

演講者：LeadingAge 應用研究中心資深研究副總裁 Robyn Stone 博士

講題：A New System of Care Requires a New Workforce Strategy

由於與會人員來自各界，有專家學者、實際從事相關工作人員、退休華人醫師等，會議進行當中討論熱烈。

三、工作坊內容

8月21日 8:00 – 16:00

台灣代表及國外講者於Benjamin Rose老化研究中心共同參與「Toward Integrating Acute and Long Term Care: Lessons Learned From the U.S.」工作坊。首先由王懿範教授開場，就整體面說明研究計畫及五個子計畫，再由實際參與研究計畫之與會代表報告各子計畫，再由美國專家主導討論。

■子計畫 1：Workforce Development

台北醫學大學賴甫誌助理教授報告，Robyn Stone 博士主導討論。

■子計畫 2：Integrated Service Network Development

台北醫學大學洪燕妮助理教授報告，Lisa Alecxih資深副總裁主導討論。

■子計畫 3：Integrated Financing

國立陽明大學李玉春教授報告，Josh Weiner博士主導討論。

■子計畫 4：Integrated Care Management Development

台北榮民總醫院陳亮恭主任報告，Kevin Mahoney教授主導討論。

■子計畫 5：Integrated IT Support

國立陽明大學張博論教授報告，Barbara Gage博士主導討論。

總結討論：Lessons Learned: Toward an Integrated Strategies and Road Map Formation

由Benjamin Rose老化研究所的執行長Richard Browdie 及王懿範教授就本次研討會及工作坊做綜合結論，整合照護成功的要件應包含下列要項：標準化的個案評估、整合性的照護計畫、有效可靠一致性的評估量表、尊重被照顧者意願的合理給付、協調的照護管理及教育系統、適當的財務誘因、整合的資訊系統。其終極目標在避免孤立，不相連貫的評估與照護。

參、心得與建議：

一、心得

經過數日的參觀及研討，對於美國的連貫式的照護系統、長照機構的設施與環境有了更深一層的認識，綜整本次研習結論，醫療和長期照護整合成功要件應包含下列要項：

(一)完善的整合照護計畫

(二)標準化的個案評估：有效可靠且一致性的評估量表

(三)尊重被照顧者的意願

(四)協調的照護管理及教育系統

(五)適當的財務誘因

(六)整合的資訊系統。

反觀，台灣目前長期照顧仍在立法階段，僅行政院於 96 年 4 月核定「我國長期照顧 10 年計畫」執行迄今，急性醫療則由全民健康保險提供，但由於人口老化、醫療科技發達、醫療資源有限，健保署已努力擴展財源，有效運用現有資源讓其效益極大化。長期照顧服務法及長期照顧保險法如能順利通過立法，未來如何整合是一大考驗。

相較於台灣的護理之家、社區醫院，美國的技術型護理之家(SNF, Skilled Nursing Facility)及急性長期照護醫院(ALTCH, Acute Long Term Care Hospital)其環境及設施遠高於台灣，長期照顧保險若如期於 106 年實施，應儘速建置相關機構及設施，沒有完善的設施，將影響民眾轉銜的意願。

全民健康保險與長期照顧保險間有著許多重疊和模糊地帶，兩者之間如何區隔，是當前急需處理釐清事項，期經由專家學者研究探討，找出最合宜的模式。另台灣民眾對大醫院的迷思及醫療提供者之思維，亦是日後是順利下轉之難題，目前健保署正試辦之急性後期整合照護計畫，該計畫是日後長期照顧保險銜接的橋樑，執行半年來，醫療提供者、民眾下轉的意願不如預期，需再加以檢討改善。

綜觀，美國由急性醫療到居家照護的整合照護，有著諸多值得我們參考學習之處，然而對於如此複雜的體系是否適用於台灣仍有待討論。台灣應考量有限的資源、民眾的接受度及相關問題，以既有的條件、環境設計出一套適用於台灣的制度。

二、建議

台灣面臨特有的問題包括超高速的人口老化、低生育率等，及不同的文化背景及環境如自由就醫、醫學中心迷思、醫療資源浪費、過細的次專科醫師制度等；另未來全民健保如何銜接長照保險，值得我們重視。其中如何提高生育率、減緩人口老化的問題是另一項議題，不加以論述。針對與全民健保有關的爲改善自由就醫、醫學中心迷思及未來二個保險銜接問題，健保署雖自 93 年起實施家庭醫師整合照護計畫，並經歷提高逕付醫學中心就醫的部分負擔，仍無法避免醫學中心人滿爲患的窘境，顯見其成效有限。如何在急性醫療保險抑制不當醫療資源耗用、減緩失能，順利銜接長照是當前最重要的課題。建議及看法如下：

一、加強民眾宣導教育：期使民眾瞭解家庭醫師、分級醫療的重要性，有效抑制不當醫療資源耗用。

二、建立急性後期照護：目前僅就腦中風試辦急性後期照護，屬草創階段，未來如何逐步擴大，按功能別或仍按疾病別？如何建立簡單易評的標準化評估量表？及提高上游醫院下轉病人的意願等問題，需逐步思考解決。

三、提供以病人爲中心的整合照護：重視預防醫學，建立非從醫療提供者角度思考的整合照護制度，以有效增加病人照護成效及滿意度。

附錄:

一、2014 年 8 月 20 日衛生福利部邱部長文達簡報

Toward Integrating Acute and Long Term Care in Taiwan: Opportunities and Challenges

Wen-Ta Chiu M.D., Ph.D.
Minister, Ministry of Health and Welfare
August 20, 2014

Health Integration System

- **Acute care: 1st and 2nd NHI**
- **Post-acute care, PAC (sub-acute care, medium-term care)** — Develop the ability to live independently
- **Long-term care : Networking and Insurance**
- **Build a comprehensively integrated health and LTC system**

Historical Development of National Health Insurance

1st Generation NHI

Profile

Population	23 million
Land area	36,191 km²
Aging population (2013)	11.5%
GDP (2012)	US $ 20,423 per capita US $ 38,462 per capita (ppp)
NHE (2012)	US $ 1,350 per capita US $ 2,546 per capita (ppp)
NHE to GDP (2012)	6.6%
Life expectancy (2013)	76.69 (M) / 83.25 (F)

Source: Directorate-General of Budget, Accounting and Statistics; ROC; MOHW

Development of Social Insurance

- 1950 Labor Insurance (40.1%)
- 1958 Government Employees' Insurance (8.5%)
- 1985 Farmers' Insurance (8.2%)
- 1995 National Health Insurance (99%)
- 2013 2nd Generation NHI
- 2017 Long-term Care Insurance

*( ) indicates % of total population insured as of 1995

Characteristics of 1st NHI

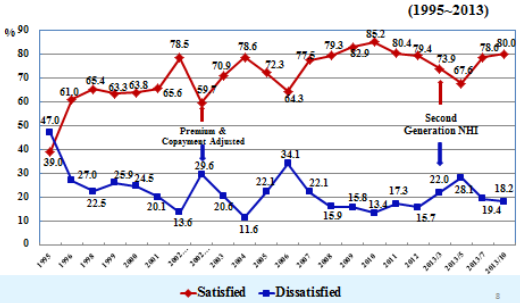
Coverage	Compulsory enrollment for all citizens
Administration	Single-payer system
Financing	Premium contributed by payroll
Benefits	Uniform package, copayment required
Providers	93% of providers contracted with NHI
Payment	Plural payment schemes under a global budget
Privileges	Subsidies for the disadvantaged

Assistances for the Disadvantaged - 1 billion USD

Statutory premium subsidies	Financial assistance for the near poor	Medical assistance for the disadvantaged
Low-income households	Interest-free Loans	Guaranteed emergency services
Disabled persons	Payment by installments	Copayment subsidies and exemptions
The elderly	Referrals to charity organizations	
The temporarily unemployed		

High Public Satisfaction

(1995~2013)



Assured Quality of Care

	Life Expectancy (2012)	
	Female	Male
Japan	86.4	79.9
Switzerland	84.9	80.6
Italy	85.6	80.4
Australia	84.4	79.9
Spain	85.4	79.5
Sweden	83.6	79.9
France	86.1	79.2
Canada	83.4	79.1
Norway	83.5	79.5
Austria	83.6	78.4
New Zealand	83.0	79.4
Netherlands	83.0	79.3
Germany	83.3	78.6
Belgium	83.1	77.8
United Kingdom	83.6	79.5
Finland	83.7	77.7
Korea	84.8	78.1
Taiwan	82.8	76.4
United States	81.2	76.4
Czech Republic	81.2	75.1
Mexico	79.8	74.8

Infant Mortality Rate(2012): 3.7 per 1,000

Source: The World Bank on line ; MOHW

Up-to-standard Quality

Five-year Survival Rates for Cancer

Unit: %

	Colon Cancer		Lung Cancer		Breast Cancer
	male	female	male	female	female
Taiwan(2004-2008)	59	61	12	18	86
United States (1999-2005)	65	65	13	18	89
Australia (1998-2004)	61	62	11	14	88

Organ Transplant Survival Rates

	Taiwan No. of Cases (2001-2011)	3-month Survival Rate			1 Year Survival Rate			3-year Survival Rate		
		Taiwan (2008-2009)	US (2007-2008) deceased	living	Taiwan (2008-2009)	US (2007-2008) deceased	living	Taiwan (2006-2009)	US (2005-2008) deceased	living
Kidney graft	2727	*98.3%*	98.30%	99.50%	*96.9%*	96.0%	98.6%	*94.5%*	90.0%	95.8%
Liver graft	2626	*90.7%*	94.60%	94.60%	*85.6%*	88.9%	92.0%	*78.3%*	79.9%	84.7%
Heart graft	772	*87.2%*	93.60%		*76.2%*	88.9%		*68.9%*	81.7%	

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衛生福利部 MINISTRY OF HEALTH AND WELFARE

International Recognition

2012	Taiwan's Progress on Health Care by Uwe E. Reinhardt	The New York Times
	NGC Documentary featuring "Taiwan's Medical Miracle" to premiere	
	Health Insurance Is for Everyone by Fareed Zakaria	TIME
	GPS Special: Global Lessons-The GPS Road Map for Saving Health Care	CNN
2009	5 Myths About Health Care Around the World by T.R. Reid	wp
2008	Taiwan featured in the U.S. Public Broadcasting Service's (PBS)Frontline series: "Sick around the world"	PBS
2005	"Pride, Prejudice, Insurance" by Paul Krugman	The New York Times

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衛生福利部 MINISTRY OF HEALTH AND WELFARE

Challenges of 1st Generation NHI

- Financial Imbalance
- Lack of a check and balance mechanism
- Premium is based only on monthly payroll
- Further improvement needed in Controlling expenditures

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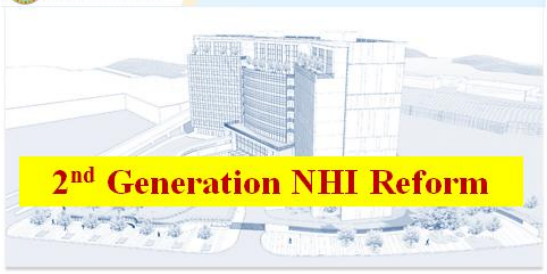
衛生福利部 MINISTRY OF HEALTH AND WELFARE



2nd Generation NHI Reform

衛生福利部 MINISTRY OF HEALTH AND WELFARE

Highlights of 2nd Generation NHI

- took effect on Jan. 1st, 2013

- Establishing a Linkage between Revenues and Expenditures
- Disclosing Important Information
- Imposing Supplementary Premiums
- Promoting Diversified Payment Schemes

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衛生福利部 MINISTRY OF HEALTH AND WELFARE

Supplementary Premium

Basic premium	Monthly salary × Premium rate × Employee contribution share × (1+ 0~3 dependents) Capped at 3
Supplementary premium	Bonuses; Income from professional practice; Income from part-time job or moonlighting; Stock dividends; Interest from savings; Rental income — × 2%

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衛生福利部 MINISTRY OF HEALTH AND WELFARE

Disclosure of Essential Information

Decision-making meetings
- Disclosure of meeting proceedings and possible conflicts of interest of the participants

Financial reports
- Disclosure of financial data of the contracted providers with medical claims exceeding a certain amount

Medical-care quality
- Disclosure of information on quality of care

Major violations
- Disclosure of serious rule violators

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Health Technology Assessment

- **Establishing a national HTA center to be in charge of:**
  - ✓ Health resource allocation
  - ✓ NHI payment recommendation
  - ✓ Health needs assessment
  - ✓ New drug, technologies, communication technologies assessment

Preparatory HTA office opened on Jan. 16, 2013

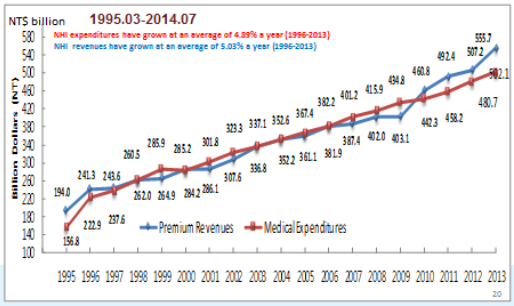
e-Health Environment

- Establishing nationwide EMR and image exchange in 2015
- Completed 507 hospitals and over 20,000 Clinics
- Developing automatic system searches for high medical services utilization records

NHI PharmaCloud System

- Record patients' drug utilization data of the last 3 months
- Making available real-time searches for hospitals and physicians to avoid repeated drug dispensing and guarantee drug safety and quality.

NHI Revenues and Costs Since 1995
— Cumulative balance 3.4 billion USD



Health Integration System

Acute care: 1st and 2nd NHI

↓

Post-acute care, PAC (sub-acute care, medium-term care)
Develop the ability to live independently

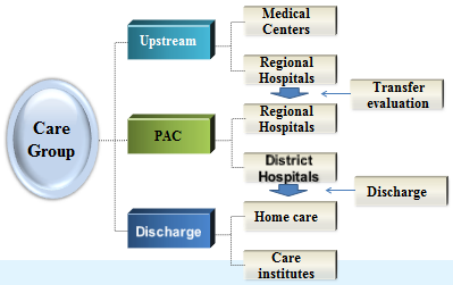
↓

Long-term care : Networking and Insurance

↓

Build a comprehensively integrated health and LTC system

Post Acute Care Model
(to promote vertical integration)



PAC Project — 3 Stages

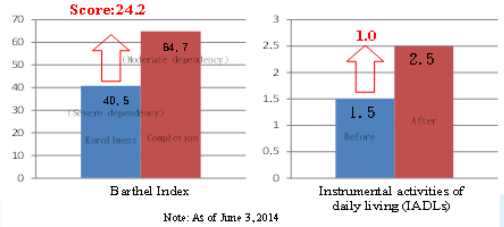
Stage 1 — Stroke, 129 hospitals(39 teams)
March, 1, 2014

Stage 2 — All other fields
Jan., 1, 2015

Stage 3 — NHI full coverage
Jan., 1 2016

Preliminary Results (Stroke)

- **87% of patients showed improvement post PAC**
- **81% of patients returned to homecare or OPD rehabilitation**



Note: As of June 3, 2014

Health Integration System

Acute care: 1st and 2nd NHI

Post-acute care, PAC
(sub-acute care, medium-term care)
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Long-term care :
Networking and Insurance

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Developing a Long-term Care System

Three Stages of LTCS Development

2008 2010 2012 2014 2016 2017

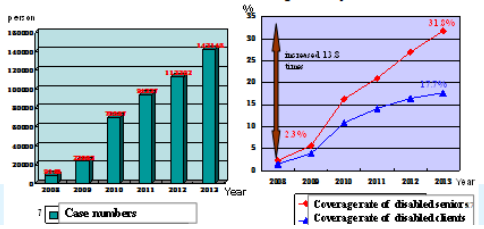
First Stage: Long-term 10-year Care Program

Second Stage: Long-term Care Act (2014)
Long-term Care Network (2015)

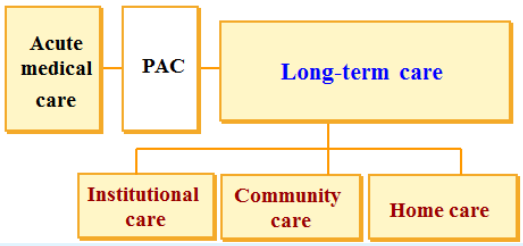
Third Stage : Long-term Care Insurance

Long-term 10-year Care Program
— To develop LTC Services Model since 2008

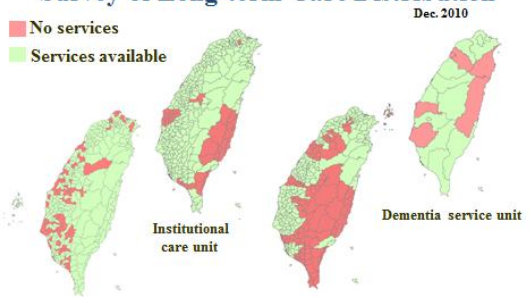
- More than 140,000 clients served.
- Coverage rates: **32%** of elderly with disability.
- Client load increased **14 times** in past 5 years.



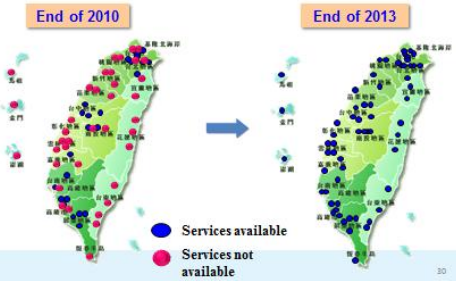
Introduction to Long-term Care Services
— De-institutionalization



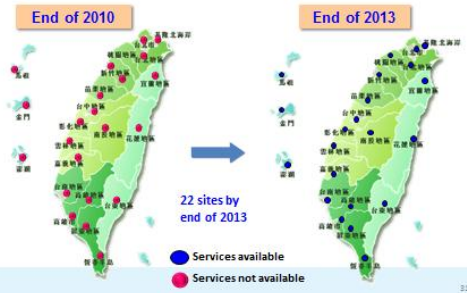
Survey of Long-term Care Distribution



Strategy 1 : Completed 63 Community Long-term Care Services in 2013

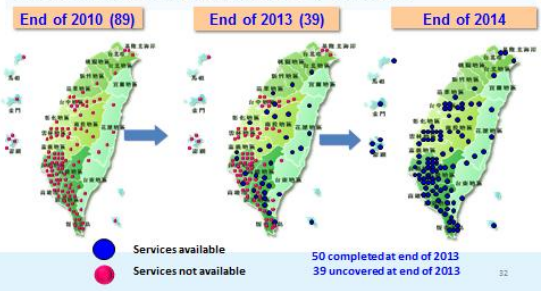


Strategy 2 : Completed PAC in 2014



Strategy 3 : Comprehensive Home Care Service for 89 Low-Resource Areas in 2014

50 locations by end of 2013 (56%), completed by end of 2014



Strategy 4 : Institutional Care Services with 700 Beds per 10,000 Incapacitated Persons in 2015

End of 2010
8 regions and 13 sub-regions (20.6%) not up to standard

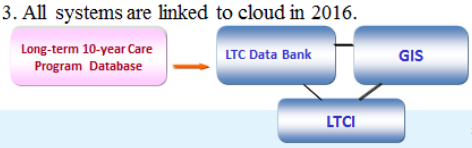
End of 2015

Strategy 5 : LTC Care Givers Training Completed by 2016
— Need 38,700 More Care Givers in 2016

Manpower	Base (2010)	Demand (2016)	Shortage
Home Care workers	19,154	57,854	38,700
Social workers	2,932	5,998	3,066
Nurses	8,647	16,494	7,847
Physiotherapists	1,301	2,692	1,391
Occupational therapists	653	2,777	2,124

Strategy 6 : Information System Links Cloud Services & Applications

1. Complete community care and home care information systems and Geographic Information System (GIS) in 2014.
2. Complete institutional care information system and LTCI information system in 2016.
3. All systems are linked to cloud in 2016.



Strategy 7 : Legislation and Implementation of LTCI

1. **Long-term Care Service Act to be passed in 2014.**
2. **Long-term Care Insurance Act to be passed in 2015.**
3. **Complete Long-term Care Insurance related sub-regulations in 2016.**
4. **Start Long-term Care Insurance in 2017.**

Characteristics of LTCI

- Coverage: Compulsory enrollment of all citizens
- Administration: Single-payer system
- Financing: Similar to NHI, but separate system
  Linkage between Revenues and Expenditures
- Payment: Plural payment
- Premium rate: 1/5 NHI, timely adjustment
  Reserve fund equivalent to 8 months

LTC Financing in Different Countries

- Tax-based LTC system
  — Northern Europe
- LTC Insurance
  — Japan, Korea, Germany, Netherlands
- Private LTCI
  — U.S.A.

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二、參訪及研討會照片

<table>
<tr><td> 
</td><td>  </td></tr>
<tr><td>參訪 University Hospital 家醫科合影</td><td>Ms. Lori Lozier 介紹醫院設施</td></tr>
<tr><td> 
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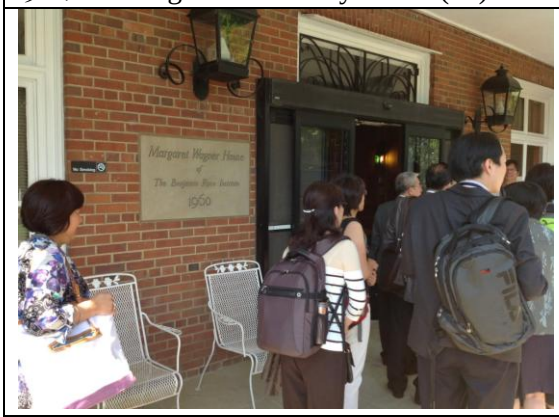
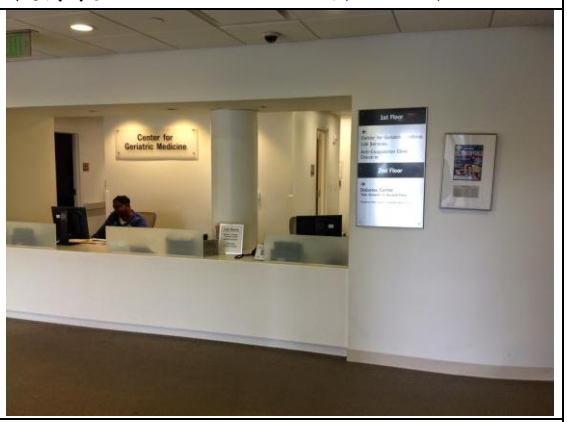
<tr><td>參訪 McGregor Community Center(一)</td><td>參訪 McGregor Community Center(二)</td></tr>
<tr><td>  </td><td>  </td></tr>
<tr><td>參訪 Margaret Wagner House</td><td>參與 PACE 團隊小組會議討論</td></tr>
<tr><td>  </td><td> 
</td></tr>
<tr><td>居家服務人員介紹服務提供模式</td><td>參訪 Kindred Hospital</td></tr>
</table>

	
Leslie Vajner 及 Dr .Michael Felver 簡報 Kindred 之急性後期照護	韓德生醫師簡報台灣之急性後期照護
	
參訪 Kindred Transitional Care Center	執行長 Elizabeth Ribar 介紹該中心
	
Kindred Transitional Care Center 餐廳	參訪 Cleveland Clinic 老人醫學中心
	
老人醫學中心主任 Messinger Rapport 簡介該中心	與會人員 Cleveland Clinic 前合影

	
邱部長於研討會簡報	鄧司長於研討會簡報
	
研討會留影	台灣代表與邱部長合影
	
工作坊討論情形	