出國報告（出國類別：考察）

105 年度「國際健康產業佈局規劃案」加拿大考察

服務機關：衛生福利部醫事司
姓名職稱：石崇良司長、卓琍萍技正
派赴國家：加拿大
出國期間：105 年 08 月 28 日至 09 月 05 日
報告日期：105 年 09 月 20 日

摘要

加拿大實施整合性智慧醫療計畫多年，著重以病人為核心之連續性照護概念，強調以遠距科技輔助達到預防疾病、整合照護及居家照護等目的。衛生福利部為推動長期照護之相關制度，以「提升醫療品質，加值照護服務」為目標，學習有關長期照護、遠距醫療等照護政策之規劃與相關配套措施。藉由考察政府單位、智慧醫療整合單位、遠距醫療網絡、醫療照護整合醫院與整合型社區照護機構，學習國外中央、地方政府與社區機構合作之配套措施。同時，參考加拿大照護服務產業及遠距醫療照護推動之經驗、相關醫療照護機構運作與品質管理之機制，為我國未來醫療與照護銜接及照護產業發展，提出規劃建議，並推廣國內與加拿大雙邊機構、企業間合作之可行性。

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一、 緣起

因應老年化和少子化時代的來臨，醫療費用逐年高漲，強化預防醫學及完善高齡照護已成為未來重點發展之趨勢。我國政府自 2006 年以來，持續推廣健康促進政策，並強化衛生局與轄區醫療院所間的夥伴關係，整合健康促進、預防保健及長照服務之資源。醫療公衛領域關注的焦點，也從急症治療轉為預防保健，健康照護服務方式已從傳統醫院床邊服務，轉而以居家照護及生活服務為主軸。資通技術應用於預防保健與照護等相關服務，已愈趨廣泛，必為未來解決健康管理需求的重要策略。其中，遠距健康照護（tele health care）結合醫療照護及資通訊科技，在民間已陸續發展，更待全面性之推廣應用。2015 年，我國政府將健康照護產業，列為經濟發展願景四大新興產業之一，為國家發展重大政策。為協助國內健康照護產業發展完備，並具備與國際接軌之產業基礎，學習其他國家之健康照護產業規劃與發展、及政府與民間之合作模式建立將為重要關鍵。

本考察係衛生福利部為配合國家發展政策推動方向，進行國際健康產業佈局規劃，以提升臺灣整體健康照護產業之發展，並進一步帶動臺灣醫療服務高附加價值化，向國外學習健康照護產業佈局規劃，同時吸引國外健康照護機構及其相關產業業者來臺並與臺灣健康照護相關機構業者進行合作人才交流、技術、投資或通路等合作契機。

加拿大是 2015 年英國國際助老會（HelpAge International）公布之全球高齡人口宜居國家第五名，主要特點包括健全的養老系統、連續性照護服務及整合的醫療與社福資源。此外，為推動連續性照護服務，加拿大政府更於 2001 年實施全國整合性智慧醫療計畫，強調資訊系統整合平台及遠距醫療照護之應用。透過遠距照護，護士可遠端監測慢性病或高齡人者的生理訊號，並與其進行電話溝通或提供緊急協助，不僅實現病人居家安養之目標，更有效提升醫療效率、並降低醫療成本。

綜觀加拿大與臺灣之健康保險制度有諸多相似，包括皆採公營單一社會保險總額預算制、100%落實全民健康保險等。此外，加拿大近年極力發展「連續性照護（Continuum of Care）」之概念，並採取諸多醫療及社會服務改革，以達疾病預防、復健、長期照顧及安寧療護之連續性服務，並

強化以遠距科技協助居家醫療與照護之發展。爰此，本次加拿大之參訪，除了著重對加拿大醫療及健康照護整合運作機制與模式之了解外，更進一步學習加拿大中央及地方政府，對於健康照護產業及遠距醫療照護之政策規劃、地方政府與各服務機構間之配套合作、及當地醫療與照護服務機構間之品質管理機制，藉以擬定完善之醫療照護整合發展相關政策，為臺灣的健康照護產業奠定良好之市場運作機制。

二、 參訪對象概要

本次加拿大參訪團，共參訪 7 處健康照護產業業者與機構，深入了解加拿大醫療、照護及遠距應用之實際運作模式與政策配套機制，包含 2 個政府單位(與整合性醫療照護服務或遠距醫療照護規劃與執行相關單位)、1 家智慧醫療整合單位、1 家遠距醫療網絡、2 家醫療照護整合醫院、1 家整合型社區照護機構。

三、 參訪目的

(一) 了解並學習加拿大針對整合照護及遠距照護之政策規劃與合作配套措施之長處，供作國內未來長照或遠距政策擬定方向之參考。

(二) 了解加拿大地方政府與照護機構間之運作及品質管理機制，及其針對居家照護之配套措施，供作國內落實社區及居家照護之參考。

(三) 發掘加拿大健康照護產業業者/機構產品與國內醫院或健康照護產業業者進一步合作或導入臺灣的可能性。

貳、 過程

一、 參訪機構及參訪流程說明

參訪機構共有 2 個政府單位、1 家智慧醫療整合單位、1 家遠距醫療網絡、2 家醫療照護整合醫院、1 家整合型社區照護機構，其名稱詳下表 1 所示：

表 1　參訪機構名單彙整

政府單位	安大略省衛生及長期照護部（MoHLTC）
	魁北克省衛生及社會服務部（MSSS）
遠距醫療網絡	Ontario Telemedicine Network（OTN）
智慧醫療整合單位	Canada Health Infoway（CHI）
醫療照護整合醫院	Baycrest
	Jeffrey Hale – St Brigid's Hospital（JHSB）
整合型社區照護機構	多倫多中央社區照顧管理中心（Central CCAC）

在政府單位（安大略省衛生及長期照護部與魁北克省衛生及社會服務部）的參訪，著重於了解政策制度及配套措施的規劃、中央及地方政府間的分工及資源分配、地方政府與業者間的溝通、監督及獎勵機制。

在遠距醫療網絡（Ontario Telemedicine Network, OTN）的參訪，著重於了解遠距醫療照護之實際操作、執行模式。

在智慧醫療整合單位（Canada Health Infoway, CHI）的參訪，著重於了解整合各省之智慧醫療之關鍵與合作模式。

在醫療照護整合醫院（Baycrest 與 Jeffrey Hale–St Brigid's Hospital）的參訪，著重於了解各種複合式社區照護機構之整合及運作模式現況。

在整合型社區照護機構（多倫多中央社區照顧管理中心，Central CCAC）的參訪，著重了解各種需求評估整合之運作模式、服務品質管理的運作機制與模式。

本次整體行程概要如下表 2。

表 2　加拿大參訪團整體行程概要

天數／日期	行程概要
第一天 8 月 29 日	上午：參訪政府單位（安大略省衛生及長期照護部） Ontario Ministry of Health and Long-Term Care
	下午：參訪遠距醫療網絡 Ontario Telemedicine Network（OTN）
第二天 8 月 30 日	上午:參訪智慧醫療整合單位 Canada Health Infoway（CHI）
	下午：參訪醫療照護整合醫院 Baycrest
第三天 8 月 31 日	上午：參訪整合型社區照護機構（Central CCAC） Central Community Care Access Centre
	下午：移動至魁北克市
第四天 9 月 1 日	上午：健康產業說明會
	下午：參訪政府單位（魁北克省衛生及社會服務部） Quebec Ministry of Health（MSSS） 部門： • 國際事務部 Planning & Strategic Orientation • 電子病歷部 Electronic Medical Record • 臨床支援部 Clinical Assistance and Support
第五天 9 月 2 日	上午：參訪醫療照護整合醫院 Jeffery Hale - Saint Brigid's Hospital *與會者包含 MSSS 的 Home Support Services 部門
	下午：參訪政府單位（魁北克省衛生及社會服務部） Quebec Ministry of Health（MSSS） 部門：品質評鑑部 Quality Evaluation

在機構及政府單位參訪的流程上，首先由訪問對象以簡報方式，說明其服務或產品內容、運作及品質管理的機制與模式及其在當地或海外事業的拓展現況與未來方向，再由衛生福利部介紹臺灣健康系統概況、長期照護現況及目前或未來可能面臨之課題、遠距醫療照護發展現況面臨之課題、及討論學習之重點。於雙方了解彼此之運作模式後，再互相提問以更進一步交流。

透過此種直接進行意見交流、實地查訪之方式，使衛生福利部更深入瞭解加拿大於長期照護服務或遠距醫療照護的運作模式，作為未來臺灣健

康照護產業佈局政策規劃與執行之參據。另對臺灣國際健康產業進行合作交流，與加拿大雙邊機構企業間合作之可能性進行研討。

二、 政府單位參訪

本次加拿大參訪，進行二個政府單位（安大略省衛生及長期照護部、魁北克省衛生及社會服務部）之參訪，主要目的著重於了解政策制度及配套措施的規劃、中央及地方政府間的分工及資源分配、地方政府與業者間的溝通、監督及獎勵機制。依據參訪時間順序，分別為安大略省衛生及長期照護部及魁北克省衛生及社會服務部。以下分別就二家機關之背景與參訪重點進行介紹：

(一) 安大略省衛生及長期照護部

1.背景概要

安大略省衛生及長期照護部（Ontario Ministry of Health and Long-Term Care, MoHLTC）主要為安大略省建立一個以病人為核心、以結果為驅動力、具持續性的整合型公共健康照護系統，如地方健康整合網絡(Local Health Integration Networks（LHINs）)。地方健康整合網絡(LHINs)為安大略省 14 個區，提供包括健康照護服務規劃（Plan）、提供醫療照護服務提供者相關補助（Fund）及整合各區公共健康照護系統（Integrate）的功能與服務。

2015 至 2016 年，衛生及長期照護部（MoHLTC）經費預算約 508 億加元，其中有五成（約 256 億加元）花費於地方健康整合網絡（LHINs）上，以提供逾 2000 家服務提供者之經費補助。地方健康整合網絡（LHINs）補助的對象，包括 155 家公私立或專科醫院、600 多家長照之家（擁有約 7.8 萬床）、800 多個社區服務機構、76 個社區健康中心、800 多個以社區為主的心理健康或藥物戒斷服務之家、及 14 個受地方健康整合網絡（LHINs）主管的中央社區照顧管理中心（CCACs）。

整體而言，衛生及長期照護部（MoHLTC）扮演管家角色，提供公共健康照護政策方向及資源分配，以達成公共健康照護系統的最大效用化。衛生及長期照護部（MoHLTC）並提供多種服務及課程，包括藥物戒斷課程、長期照護服務、居家照護服務、社區及公共健康等。

衛生及長期照護部（MoHLTC）亦負責監督管理醫院及護理之家、經營精神病院及藥物實驗室，並統籌安大略省的緊急醫療服務。每年衛生及長期照護部（MoHLTC）皆會對機構進行不預警訪查，設立個案管理員進行住民服務品質之追蹤，並透過外部評核機制落實機構管理。

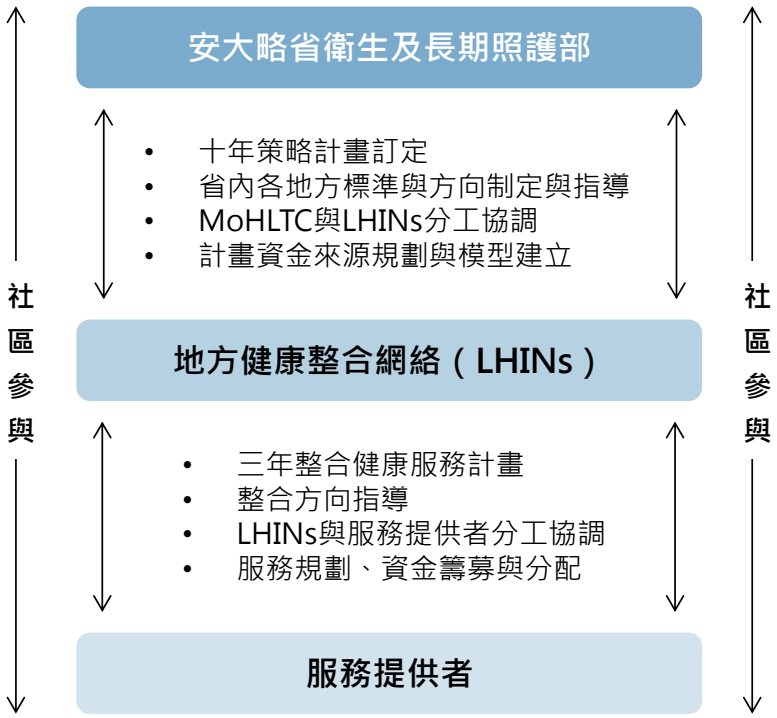

圖 1　安大略省地方健康整合網絡計畫（LHINs Plan）

資料來源：Ontario Ministry of Health and Long-Term Care

2.參訪摘要

本次參訪主要由衛生及長期照護部（MoHLTC）居家及社區照護部門的總監 Mrs. Amy Olmstead、與醫療數位化部門的經理 Mrs. Christine Sham 及其下屬 Mr. Kyle Tsang 接待，並向參訪團介紹安大略省居家及社區照護、及智慧醫療的發展現況。

加拿大智慧醫療發展雖較台灣為先，但面臨之課題大致相同。目前衛生及長期照護部（MoHLTC）面臨的四大挑戰包括：科技市場快速變遷、醫療服務提供者間缺乏協調與整合、公私立部門的經費來源分散、及私人健康資訊的濫用或誤用。

為整合及改善安大略省的健康照護系統，安大略省政府於 2012 年推出 Action Plan for Health Care，並進一步於 2106 年 4 月推出「病人優先法案（The Patient First Act）」與執行「病人優先計畫（Patients Fist: Action Plan for Health Care）」。病人優先計畫的核心為「自病人需求出發、強調以病人為中心」的概念。該計畫並有 4 個主要的目標，分別為 Access（提高病人獲得正確醫療照護服務的效率）、Connect（整合串聯社區內各服務提供者至居家服務）、Inform（提供病人及人民透明且正確的資訊，以協助其作出正確的健康決策）及 Protect（依據事實做出針對價值及品質的決策，以利健康照護系統的永續發展）。

此外，病人優先計畫（Patients Fist: Action Plan for Health Care）也透過建置整體照護計畫、強化居家照護價值、強化照護服務、提供護理及居家照護支持與提供自我照護能力等步驟，促使安大略省政府全力發展可整合各健康照護服務提供者的智慧醫療與遠距醫療，並注重其發展品質與提供之價值。

在智慧醫療的發展方向，為科技與照護結合。安大略省政府目前正致力推行 eHealth Strategy 2.0。受市場快速變遷影響，eHealth Strategy 2.0 與以往多以大專案計畫投資為主不同。安大略省政府策略性轉變，從大型的研發專案投資，逐漸轉為較小的計畫專案投資。安大略省政府認為，目前市場變遷速度太快，許多業者已能自行開發所需之產品，且醫療照護效率的提升，不在於持續科技創新，而在如何讓科技與醫療照護有效的結合。此外，較小的計畫專案投資，可於同一時間進行不同領域的創新研發，即便計畫專案失敗，也可以從中獲得經驗與學習。舉例而言，過去科技端研發之智慧醫療產品，不一定是醫療照護人員或使用者願意使用的科技，未來應朝向使用者友善(user-friendly)的產品發展。

而在資訊整合與相互流通的過程中，隱私權成為重要的討論主題。衛生及長期照護部（MoHLTC）指出，各省皆有其保護病人隱私的法條與規範；惟整體而言，加拿大在個人資料的共享，是採較強制態度。除非病人個別要求不讓醫護人員共享資訊，否則於一般情況下，醫護人員皆可共享病人資訊。安大略省政府（Ontario）的個人隱私保護法為 Personal Health Information Protection Act（PHIPA）。PHIPA 採默認法，默認所有病人皆願意提供其個人健康資訊予健康照護服務提供者。該法使醫護人員在共享

病人資訊時，不需每次填寫同意書或口頭詢問，並且通常由病人的家庭醫師決定甚麼樣的資訊可被共用。惟，對健康照護服務提供者資料濫用這一方面，目前安大略省並未有明確的規範，亦無良好的監管機制或單位。

表 3　安大略省衛生及長期照護部（MoHLTC）參訪情形

<table>
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<td> 
衛福部石司長崇良與 MoHLTC 居家及社區照護部門總監 Mrs. Amy Olmstead 交換名片</td>
<td> 
MoHLTC 醫療數位化部門經理 Mrs. Christine Sham 向衛福部簡報安大略省智慧醫療發展情形</td>
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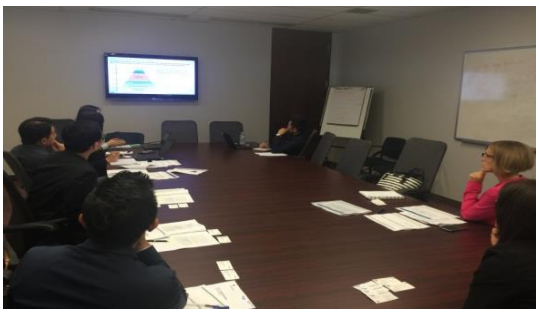
<tr>
<td> 
MoHLTC 社區照護部門總監 Mrs. Amy Olmstead 向衛福部簡報安大略省長期照護現況與面臨之課題</td>
<td> 
衛福部石司長崇良向 MoHLTC 介紹台灣健康醫療系統概況、長照及遠距醫療發展情形</td>
</tr>
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<td colspan="2"> 
衛福部石司長崇良與 MoHLTC 醫療數位化部門經理 Mrs. Christine Sham 交流雙方國家之醫療數位化現況與面臨之課題</td>
</tr>
</table>

MoHLTC 居家及社區照護部門總監 Mrs. Amy Olmstead 與衛福部石司長崇良交流雙方國家之長期照護現況與面臨之課題

MoHLTC 醫療數位化部門經理 Mrs. Christine Sham 與衛福部石司長崇良交流加拿大長期照護與醫療數位化整合之現況與面臨之課題

衛福部石司長崇良致贈 MoHLTC 禮物及衛福部年報
（左起：MoHLTC 居家及社區照護部門總監 Mrs. Amy Olmstead、MoHLTC 醫療數位化部門經理 Mrs. Christine Sham、衛福部石司長崇良）

(二) 魁北克省衛生及社會服務部

1.背景概要

魁北克省衛生及社會服務部（MSSS）前身為社會事務部，於 1985 年因魁北克省制定的「Act respecting the Ministère de la Santé et des Services sociaux（醫療衛生服務和社會服務尊重法案）」而成立。在醫療衛生服務和社會服務尊重法案中，定義了五個主要的任務中心，分別為地方社區服務中心（CLSC）、醫療中心（CH）、居民及長照中心（CHSLD）、孩童及青少年保護中心（CPEJ）及復健中心（CR）。衛生及社會服務部(MSSS)負責監督與評估各中心的執行成果，促進其組成的整合網絡可維持良好之運作。

此外，衛生及社會服務部(MSSS)也負責管理與訂定魁北克省相關的醫療衛生及社會服務政策目標，以提供魁北克省民眾高品質的醫療衛生服務及社會服務。衛生及社會服務部(MSSS)於 2015 年提出「2015-2020 醫療衛生服務和社會服務策略計畫」(如表 4)，期許能提供符合魁北克省居民需求：易取得且有效率的醫療及照護服務。在這樣的願景下，衛生及社會服務部(MSSS)開始諸多醫療照護改革，包括 2015 年將前述五個主要任務中心統整，改以整合性醫療與社會服務中心（CIUSSS）來提供各社區醫療及照護服務，以達減少緊急醫療的等待時間、提倡健康生活，降低得慢性病或癌症之機率、強化醫療與照護品質、改善高齡居家照護等效果。

表 4　2015-2020 醫療衛生服務和社會服務策略計畫之願景、挑戰及策略方向

Vision: **Accessible and efficient** health care and social services adapted to the **needs** of Quebeckers	
Challenges	Strategic Directions
1. New gain in population health	Promote healthy lifestyles and prevent health problems
2. A system centered on users and adapted to their needs	Provide accessible, integrated and quality care and services for the benefit of users
3. Resources mobilized towards achieving optimal results	Implement and innovative and efficient organizational culture in a context of change

資料來源：魁北克省衛生及社會服務部

2.參訪摘要

本次參訪衛生及社會服務部（MSSS）分為 9 月 1 日及 9 月 2 日兩天，9 月 1 日下午的參訪，由衛生及社會服務部（MSSS）國際事務部門的助理顧問師 Mr. Francis Dubois、規劃及策略部門（Planning & Strategic Orientation）的顧問師 Mrs. Caroline Boucher 及助理顧問師 Mr. Julien Sirois、電子病歷部門（Electronic Medical Record）的副局長 Mr. Renald Lemieux 及臨床支援部門（Clinical Assistance and Support）的顧問師 Mrs. Sylvie Collette 接待，並向參訪團介紹魁北克省健康照護系統及智慧醫療的發展現況與面臨之困境。9 月 2 日下午的參訪，由衛生及社會服務部（MSSS）品質評鑑（Quality Evaluation）部門的副局長 Mr. Eric Fournier 接待，並向參訪團介紹魁北克省之醫療與照護機構評鑑相關法規及實際執行內容。

魁北克省於 2014 年至 2015 年之年度預算為 746 億加元，其中有 43.4% 為醫療衛生服務和社會服務支出。為有效控制逐年增加的醫療衛生服務和社會服務支出，衛生及社會服務部（MSSS）於 2015 年整併醫療與照護服務，強化整合性醫療與社會服務中心(CIUSSS)的角色，以整合性醫療與社會服務中心（CIUSSS）為核心，連接其他夥伴如社區藥局、非營利組織（NPO）、學校、日照中心、家醫診所、醫學中心及其他整合性醫療與社會服務中心（CIUSSS）等，以提供病人更全面的連續性照護服務。

此外，高齡族群及慢性病人人數逐年上升，因移動、就醫的不便性，導致該族群想在家治療的意願提高。另，由於專業人員的短缺、多數醫護人員集中於人口稠密的大城市等因素影響，衛生及社會服務部（MSSS）亦積極強化居家照護領域，並投入資源與人力發展遠距服務，以使魁北克省居民在家中也能受到良好的照護及治療。

衛生及社會服務部（MSSS）推行遠距服務的方式，採教育醫護人員與選擇病人族群二大面向，齊頭進行。於教育醫護人員方面，為提升醫護人員使用遠距方式，提供病人醫療與照護服務之意願，於規劃遠距服務時，即邀請醫護人員共同參與制定遠距服務的計畫與共同研擬規劃執行，以利後續醫護人員實際操作。於選擇病人族群方面，主要選擇之對象，以慢性病（如心血管疾病、糖尿病及腎臟病）及剛做完手術，需要定期持續

觀察或監測的病人為主。同時，需確認這些病人有能力使用遠距服務所需之儀器、或附近有人可協助使用這些儀器。

衛生及社會服務部（MSSS）的遠距推行策略，獲得良好的成效。目前魁北克省約有近 1,500 名病人已註冊遠距居家照護服務。使用遠距照護服務者，約占整體遠距服務的七成，其餘三成則為遠距醫療服務。遠距服務的提供者，主要為護士及治療師。透過遠距科技，以觀察病人活動及病情康復情形，並適時提醒病人須注意之環節，同時也監測、記錄病人資訊，以供醫師參考。

衛生及社會服務部（MSSS）表示，推動遠距服務的目的，是為了讓病人能以更簡單及便利的方式，獲得醫療與照護服務，並同時教育病人了解自己的疾病、學會自我照護及自行使用網路尋找相關的醫療照護資訊等。因此，在衛生及社會服務部（MSSS）推動的遠距服務中，通常僅會依據病人病情，提供 4~6 個月不等的遠距居家照護服務。俟病人病情穩定或學會自我照護後，便會回收相關之遠距儀器產品，供下一名有需要之病人使用。

衛生及社會服務部（MSSS）目前將整個魁北克省分為 4 個區域，由 4 所學校於各區域內，引導推動不同的遠距前導計畫。衛生及社會服務部（MSSS）期望未來可整合魁北克省的遠距資源，致力使這些已成功推行的遠距前導計畫，可在不同區域間擴大執行。

表 5　魁北克省衛生及社會服務部（MSSS）參訪情形

	
衛福部石司長崇良與 MSSS 國際事務部門的助理顧問師 Mr. Francis Dubois 交換名片	MSSS 國際事務部門的助理顧問師 Mr. Francis Dubois 解說本次參訪重點

衛福部石司長崇良與 MSSS 針對兩國之智慧醫療及遠距醫療發展作意見交流

MSSS 與衛福部石司長崇良與針對兩國之健康照護系統作意見交流

衛福部石司長崇良與 MSSS 針對兩國之健康照護系統發展面臨之挑戰作意見交流

衛福部石司長崇良致贈 MSSS 電子病歷部門及臨床支援部門禮物及衛福部年報（左起：衛福部石司長崇良、MSSS 電子病歷部門副局長 Mr. Renald Lemieux、MSSS 臨床支援部門顧問師 Mrs. Sylvie Collette）

衛福部石司長崇良致贈 MSSS 規劃及策略部門禮物及衛福部年報
（左起：衛福部石司長崇良、MSSS 規劃及策略部門助理顧問師 Mr. Julien Sirois、MSSS 規劃及策略部門顧問師 Mrs. Caroline Boucher）

有關醫療照護的品質與安全，魁北克省立法規定，醫療或照護機構須成立品質安全管理委員會。當有事故發生時，需由事故第一發現者（醫護人員）或相關人員，陳報至該機構內部之品質安全管理委員會，復由該機構之品質安全管理委員會，定期向上陳報至衛生及社會服務部（MSSS）專責單位（事故通報處）。衛生及社會服務部(MSSS)的事故通報處，每年定期彙整，並統計各醫療照護機構通報的事故資料，向大眾公布。

據統計資料顯示，魁北克省醫療或照護事故發生次數最多之項目，為病人跌倒（占 35%），其次為用藥錯誤（占 29%），其他為診療錯誤、檢驗錯誤等。為了可有效降低醫療、照護事故發生的機率，魁北克省立法規定，除了品質安全管理委員會，醫療照護機構也應成立風險管理委員會，以共同監督、控管並降低醫療照護事故之發生。此外，衛生及社會服務部（MSSS）也會定期邀請公立機構的品質安全管理委員會負責人共同開會，以討論降低醫療照護事故發生之機率。另外，衛生及社會服務部（MSSS）重視病人的權益，病人可至機構內投訴委員會、及外部的用戶保障機構、衛生及社會服務部（MSSS）進行申訴。

於機構品質評核部分，魁北克省的各醫療照護機構，每五年都需要接受一次獨立第三方機構的完整評核。總評核項目約 100 多項，依據各醫療照護機構的性質、規模不同，評核項目部分可免接受評核。當醫療照護機構未通過評核時，須先提出改善報告，並於一定期限內改善品質。若再次

評核仍未通過，公立的醫療照護機構，會由政府介入協助進行改善；私立醫療照護機構，則會面臨吊銷執照。

表 6　魁北克省衛生服務部（MSSS）品質評鑑部門參訪情形

衛福部卓技正琍萍與 MSSS 品質評鑑部門副局長 Mr. Eric Fournier 交流醫療與照護評鑑之相關議題

MSSS 品質評鑑部門副局長 Mr. Eric Fournier 解說魁北克省針對醫療及照護機構採用之品質評鑑法規及方式

衛福部卓技正琍萍與 MSSS 針對醫療與照護評鑑作意見交流

衛福部卓技正琍萍致贈 MSSS 品質評鑑部門副局長 Mr. Eric Fournier 禮物及年報

三、 遠距醫療網絡參訪

本次加拿大參訪拜訪一家遠距醫療網絡中心：Ontario Telemedicine Network（OTN）。在遠距醫療網絡中心（Ontario Telemedicine Network, OTN）的參訪，著重於了解遠距醫療照護之實際操作、執行模式。以下分別就其背景與參訪重點進行介紹。

(一) 遠距醫療網絡中心 Ontario Telemedicine Network

1.背景概要

遠距醫療網絡中心 Ontario Telemedicine Network（OTN）由安大略省政府及加拿大 Health Infoway 資助成立，為全球最大的遠距醫療網絡之一。遠距醫療網絡中心（OTN）前身為對安大略省北邊偏遠地區，提供醫療服務的單位。過去，透過電話方式提供醫療諮詢及轉診相關服務。依據病人病情狀況，提供移轉病人至安大略省南部多倫多都會區就醫。目前的服務宗旨，為利用科技來提高照護服務的普及率，並有效降低成本。因此，強調與相關服務提供者更有效的緊密合作。目前遠距醫療網絡中心（OTN）成員包括 1,289 個健康照護及教育組織，並與安大略智慧醫療（eHealth Ontario）、OntarioMD（EMR 電子病歷執行機構）、Canada Health Infoway（CHI）等為合作夥伴。

遠距醫療網絡中心（OTN）利用資訊平台，串聯相關服務提供者。於資訊平台上，提供雙向視訊會議服務（eConsult、eVisit 及 eCare），使醫療服務提供者可採取遠距醫療之方式，為病人提供醫療保健服務，或使醫療服務提供者間之相互交流。目前在安大略省各大公立醫院和數百個醫療中心，都有提供遠距醫療服務。依資料顯示，遠距醫療服務前五大類型，分別為精神疾病診療、戒酒或毒癮的診療、內科、腫瘤治療、手術及術後康復服務。遠距醫療網絡中心（OTN）的資訊平台，提供約 30.8 萬名病人遠端醫療服務，並讓服務提供者、個案管理師（照護整合管理者）及病人可以看到各自需要的資訊。

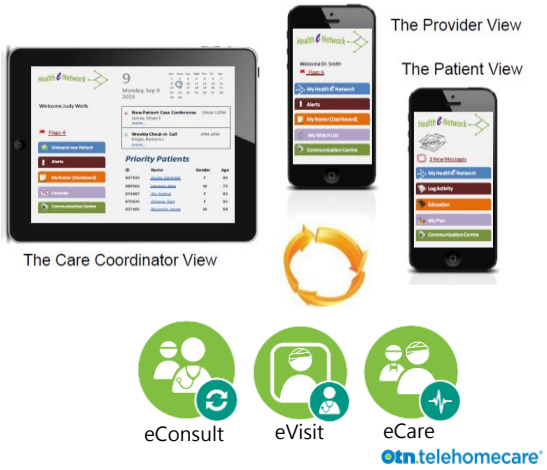


圖 2　OTN 資訊平台操作介面

資料來源：Ontario Telemedicine Network

2.參訪概要

本次參訪遠距醫療網絡中心（OTN）主要由負責外部聯繫的 Senior Telemedicine Consultant Mrs. Karen Waite 及副總 Mrs. Laurie Poole 接待，並向參訪團介紹遠距醫療網絡中心（OTN）的運作機制與組織架構。

加拿大 2014 年遠距醫療經費為 2.2 億加元，外加專案計畫的相關編列經費。目前遠距醫療服務，由各醫療機構提供。相關之服務衍生費用由政府支付，軟硬體設施則由規劃及整合當地居民醫療照護服務的地方健康整合網絡(Local Health Integration Networks（LHINs）)免費提供。

遠距醫療網絡中心(OTN)，為安大略省遠距醫療服務網絡的經營者。由於遠距醫療網絡中心（OTN），是非營利的獨立民營機構，且經費全部來自於政府。因此，民眾普遍認為遠距醫療網絡中心（OTN），是可以信賴的資訊來源及服務提供者，使用遠距醫療網絡中心（OTN）平台的意願也較高。針對醫療照護服務提供者，遠距醫療網絡中心（OTN）則採會員模式運作。當一家醫療照護服務提供者，欲加入遠距醫療網絡(OTN)的網絡時，須付費加入會員。惟若該服務提供者，原本於加拿大公醫制度下，由政府健保費用給付的單位，則其會員費由政府支付；其他單位則依照其對遠距醫療網絡中心（OTN）服務的不同需求，有不同而合理的價格。

遠距醫療網絡中心（OTN）於提供遠距醫療服務同時，特別強調適應及應變管理。除了協助提供病人眾多生活與醫療照護服務的遠距科技應

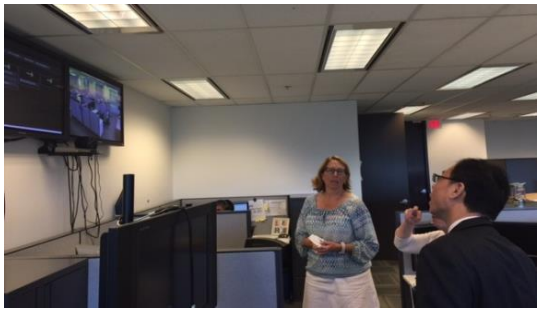
用，同時也協助醫療照護提供者，將遠距科技及服務流程導入日常服務中。目前，在遠距醫療網絡中心（OTN）自行開發建立的 OTNHub 網路平台系統上，提供包含遠距醫療諮詢（eConsult）、遠距門診（eVisit）、遠距照護（eCare）、遠距教育訓練（ePodium）─由專業醫療人士提供健康照護資訊、遠距學習（eLearning）─大眾可取得醫療照護資訊等服務。此外，遠距醫療網絡中心（OTN）亦扮演解決方案促進者，擔任醫療服務界以及創新產品間的橋樑。遠距醫療網絡中心（OTN）並透過和許多學術單位創新合作，鼓勵符合「對病人有幫助、對醫護人員有幫助、可提升服務普及率」等三種基本要求的 APP 研發商投入市場，實例如 Welldoc 公司研發，可協助糖尿病人自我健康管理的 BlueStar APP。

在遠距醫療照護服務上，資訊安全一向為重點關注項目。在加拿大，個人醫療資訊的相關隱私權法規相當嚴格，遠距醫療網絡中心（OTN）除需符合相關準則才能拿到政府的經費以外，因其角色為遠距醫療服務網絡的經營者，遠距醫療網絡中心（OTN）亦會在合約中要求會員必須符合相同的準則。此外，遠距醫療網絡中心(OTN)旗下資訊安全部門，會定期提供會員資訊安全相關訓練課程，來對遠距醫療服務所牽涉的相關隱私權議題等把關。前述提及的 OTNHub 網路平台系統，也藉由透過不同等級的隱私權限，管控不同單位的資訊取得程度，以符合加拿大的醫療資訊隱私權法令規範。

表 7　遠距醫療網絡中心（Ontario Telemedicine Network, OTN）參訪情形

	
OTN 資深遠距顧問 Mrs. Karen Waite 及副總 Mr. Payam Pakravan 向衛福部表達歡迎及開場	OTN 資深遠距顧問 Mrs. Karen Waite 及副總 Mrs. Laurie Poole 與衛福部石司長崇良針對遠距服務作交流

衛福部石司長崇良致贈 OTN 禮物及衛福部年報
(左起：OTN 資深遠距顧問 Mrs. Karen Waite、衛福部石司長崇良、OTN 副總 Mrs. Laurie Poole)



OTN 資深遠距顧問 Mrs. Karen Waite 向衛福部石司長崇良解說遠距產品之使用方式

OTN 資深遠距顧問 Mrs. Karen Waite 向衛福部石司長崇良示範遠距產品之使用方式

OTN 資深遠距顧問 Mrs. Karen Waite 向衛福部石司長崇良解說 OTN 推動遠距服務之執行方式

衛福部參訪團全體合照
（左起：衛福部卓技正琍萍、衛福部石司長崇良、OTN 資深遠距顧問 Mrs. Karen Waite、OTN 副總 Mrs. Laurie Poole、台灣野村總研成員）

四、 智慧醫療整合單位參訪

本次加拿大參訪拜訪一家智慧醫療整合機構：Canada Health Infoway, (CHI）。在智慧醫療整合機構（Canada Health Infoway, CHI）的參訪，著重於了解整合各省之智慧醫療之關鍵與合作模式。以下分別就其背景與參訪重點進行介紹。

1.背景概要

智慧醫療整合機構 Canada Health Infoway（CHI）為 2001 年加拿大聯邦政府為整合全國智慧醫療，發起計畫並成立之非營利及非政府組織。智慧醫療整合機構（CHI）經費來源，來自聯邦政府預算，並對加拿大衛生部負責。智慧醫療整合機構（CHI）執行長，由加拿大衛生部指派，日常庶務則由專業管理團隊負責。其機構之計畫執行，需受董事會及執行委員會之雙層監控。智慧醫療整合機構（CHI）之董事會，由 10 省的衛生次長、3 個地區及中央聯邦政府組成，執行委員會組成成分則非常多元，包括各行各業的專業人士如律師、商業人士及醫師等。

智慧醫療整合機構（CHI）致力於規劃與執行國家層級的智慧醫療願景，提供服務包括：全國電子健康資訊系統（EHR）、電子病歷（EMR）、臨床醫生電子服務、消費者健康電子服務、及遠端醫療等。自成立以來，智慧醫療整合機構（CHI）已獲得來自五個獨立聯邦政府單位的資助，資

助金額達 21 億美元，並用於 419 個省內、地區內、或其他夥伴共同投資的專案上。

自 2007 年以來，智慧醫療整合機構（CHI）的專案計畫，帶來的收益預估超過 130 億加元。目前智慧醫療整合機構（CHI）之推行成果頗佳，例如全國電子健康資訊系統（EHR）系統使用人次明顯增長。由 2006 年系統使用人次低於 1 萬人，成長至 2016 年系統使用人次達到近 14 萬人，成長幅度超逾 14 倍；家庭醫師使用全國電子健康資訊系統（EHR）系統的比率，亦有顯著成長。從 2006 年的 23%，成長至 2015 年的 73%。

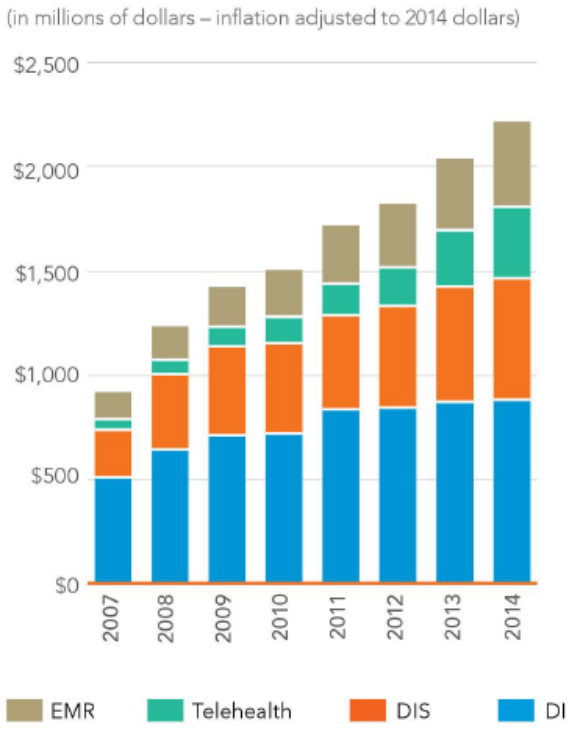


圖 3　CHI 推行智慧醫療計畫帶來的收益

資料來源：Canada Health Infoway

2.參訪摘要

本次參訪智慧醫療整合機構(CHI)，主要由專責溝通及服務評價的副總 Mrs. Shelagh Maloney 及消費者健康及創新部門的主任 Mr. Fraser Ratchford 接待，並向參訪團介紹智慧醫療整合機構(CHI)的運作機制與智慧醫療策略規劃方向。

目前，加拿大健康照護系統著重的前三大推廣項目，包括：遠距居家照護（tele-homecare）、心理健康（mental health）及健康照護服務的創新及數位化（innovation and digital health）。加拿大政府於 2016 年，投入社區及居家照護經費，高達 30 億加元，其中遠距醫療占相當重要的一部分。智慧醫療整合機構(CHI)在加拿大健康照護系統發展上的策略，與政府一致。近年來，同樣著墨於發展虛擬照護（virtual care）、智慧醫療照護（e-health care）及遠距居家照護（tele-homecare）此三大領域。目前，重點推廣項目為電子處方簽系統。智慧醫療整合機構(CHI)每年獲得的智慧醫療照護經費 0.5 億加元中，即有近八成投入於相關的數位化服務上。

智慧醫療整合機構(CHI)與各省政府間的合作模式，為成功推行全國智慧醫療之關鍵。智慧醫療整合機構(CHI)運用聯邦政府撥付的經費，每年制定欲發展之項目別，以計畫補助的方式，提供各省在虛擬照護創新與研發上良性競爭的機會。一般而言，省政府與智慧醫療整合機構(CHI)對一個計畫的補助，各佔 50%；因此，當某省廠商或非營利組織，欲向智慧醫療整合機構(CHI)申請計畫補助時，亦須先徵得省政府同意。另外，由於智慧醫療整合機構(CHI)成立之宗旨，為推動全國性智慧醫療，亦鼓勵各省間的合作。所以，當各省間合作發展智慧醫療時，智慧醫療整合機構(CHI)即給予 100%的補助支持。舉例而言，加拿大南方四個不同的省分，若共同實行電子病歷系統，並使其可相互串聯時，智慧醫療整合機構(CHI)即提供 100%的經費補助，而非一般情形的 50%經費補助。

智慧醫療整合機構(CHI)於其他專案的補助，亦多有彈性。除了對省政府的計畫案外，智慧醫療整合機構(CHI)也對四種類型的專案做計畫經費補助，如：新創服務（start-up）、服務的佈署執行（deploy）、服務擴張（scale and spread）及新領域發展（investigate and trial）。以新領域發展舉例而言，智慧醫療整合機構(CHI)目前執行有關心肺疾病與急診虛擬治療相關的補助項目；未來，如果另有廠商或省分欲推行其他領域的疾病，即可向智慧醫療整合機構(CHI) 申請計畫經費補助。

智慧醫療整合機構(CHI)每年皆採用問卷調查模式，全面性彙整民眾對於數位醫療的需求及意見迴饋（listen），並作為下年度推廣重點項目之參據。由調查結果顯示，75%至 80%的使用者，對於數位醫療採取正面態度，表示民眾相當支持政府對於數位醫療的發展。

表 8　Canada Health Infoway 參訪情形

<table>
<tr>
<td> 
衛福部卓技正琍萍與 CHI 副總 Mr. Fraser Ratchford 交換名片</td>
<td> 
CHI 副總 Mrs. Shelagh Maloney、主任 Mr. Fraser Ratchford 說明智慧醫療相關議題</td>
</tr>
<tr>
<td colspan="2"> 
衛福部石司長崇良針對智慧醫療相關議題作交流</td>
</tr>
<tr>
<td colspan="2"> 
衛福部石司長崇良贈與 CHI 禮品及衛福部年報
（左起：衛福部石司長崇良、CHI 副總 Mrs. Shelagh Maloney、CHI 主任 Mr. Fraser Ratchford）</td>
</tr>
</table>

衛福部參訪團全體合照
(左起：台灣野村總研成員兩位、衛福部卓技正琍萍、衛福部石司長崇良、CHI 副總 Mrs. Shelagh Maloney、CHI 主任 Mr. Fraser Ratchford)

五、 整合型社區照護機構參訪

本次加拿大參訪，拜訪一家整合型社區照護機構：Central Community Care Access Centre（中央社區照顧管理中心）。中央社區照顧管理中心（Central CCAC）的參訪，著重於了解各種需求評估整合之運作模式、服務品質管理的運作機制與模式。以下分別就其背景與參訪重點進行介紹。

(一) 中央社區照顧管理中心（Central Community Care Access Centre, Central CCAC）

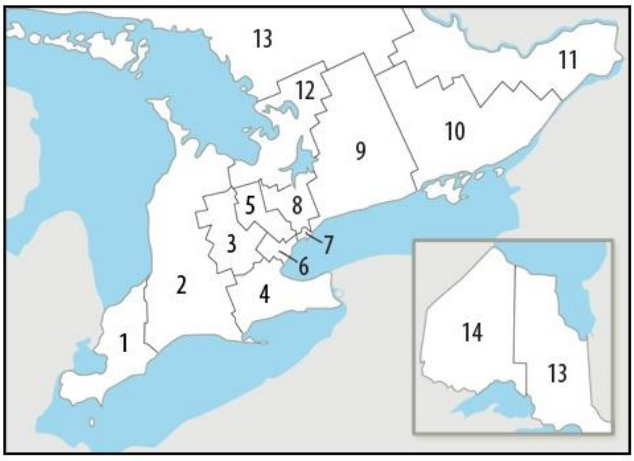
1.背景概要

在 1997 年以前，加拿大的居家照護，是由地區市政府提供，且服務內容由地區市政府自行決定。但因有預算上限的壓力，遂轉由省政府提供居家照護服務的統籌角色。在這樣的時空背景下，社區照顧管理中心 Community Care Access Centre（CCAC）應運而生。

中央社區照顧管理中心（Central CCAC）為安大略省 14 個社區照顧管理中心（Community Care Access Centre, CCAC）之一。社區照顧管理中心（CCAC）隸屬於政府單位，相當於台灣社區照護資源中心的角色，營運主要受自願者組成的董事會監督。中央社區照顧管理中心（Central CCAC）員工人數約 800 人，提供健康與照護相關社會福利之統籌服務。社區照顧管理中心（CCAC）與各家醫院、社區、其他 CCACs、學校或長

照之家合作，藉由安大略省政府撥付之社區照顧經費，管理社區居民的各種照顧或照護服務，並提供醫療照護資訊、轉介服務、個案（Client）服務需求規劃與統籌，同時將相關服務提供者(如醫院、急診中心、長照機構、學校、社區健康中心等)予以串聯。建置一個以個案為中心，提供整合型的服務，並使其可選擇適合的照護方案、家庭醫生和護士。

中央社區照顧管理中心（Central CCAC）經費來源為 LHINs，每年約獲得 2~3 億加元的年度預算，以提供當地約 7.8 萬人民醫療照護需求的相關服務。目前，中央社區照顧管理中心（Central CCAC）與其區域內的 6 家公立醫院、3 家私立醫院、11 個家醫團體、2 個社區健康中心、46 所長照之家、64 所退休之家、763 所學校、2 家收容所、33 家社區支援服務機構等皆有合作。



1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West

圖 4　安大略省 14 個社區照顧管理中心（CCAC）分佈圖

資料來源：Community Care Access Centre

2.參訪摘要

本次參訪中央社區照顧管理中心（Central CCAC）主要由其副總 Mrs. Lynn Harrett 及主任 Mrs. Cheryl Cheung 接待，並向參訪團介紹中央社區照顧管理中心（Central CCAC）的運作機制及執行細節。

社區照顧管理中心（CCAC）透過合約與各家醫院、社區、其他 CCACs、學校及長照之家互為夥伴，提供各種需求評估服務（資訊提供與轉介、服務計畫規劃、服務統籌等），針對服務提供者提供合約及管理，並制定及管理合作夥伴服務品質的標準等。

由於社區照顧管理中心（CCAC）負責規劃個案的整體照護方案，故對於醫療及照護銜接的掌控，為是否成功之關鍵要素。在醫療及照護銜接之運作上，社區照顧管理中心（CCAC）會先派遣人員或 Nurse Practitioners 至醫院駐點、進行跟診、臨床監督及評估病人社區照護服務需求，以利聯繫安排病人後續的照護服務。

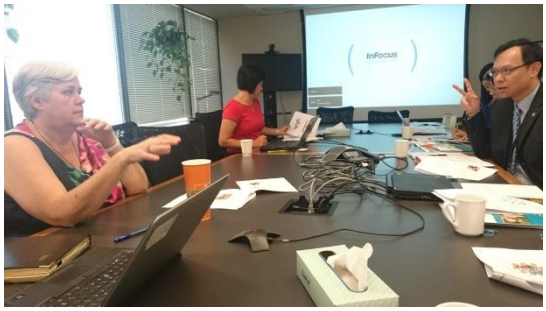
在執行之實務面，社區照顧管理中心（CCAC）亦曾遇到一些困境。舉例而言，假日及平日夜晚，無法要求醫師前往社區看診。為了改善此問題，社區照顧管理中心（CCAC）於 2016 年度推出 Community-Based Nurse Practitioners，整合醫療及照護資源，以快速回應病人需求。

在預算分配方面，由於 LHINs 的預算編列方式，採歷史軌跡（當時人口數）預估，而非按實際需求（人口成長幅度）計算，導致各地區之社區照顧管理中心(CCAC)預算分配不均衡，出現人口數多但成長幅度相對較低的地區，經費編列較多；人口數少但成長幅度相對較高的地區，預算編列不足之問題。

在照護人力方面，中央社區照顧管理中心（Central CCAC）並無人力不足之問題。探究其原因，為加拿大移民人數眾多（48%皆為外來移民），且多數移民者會選擇成為 nurse practitioners（NP）所致。成為 NP 除獲取學位時間短，僅需一年半以外，更有助於移民或其依親者留在加拿大工作的機率大幅提高。因此，目前加拿大並無照護人員缺乏之問題。

表 9　Central CCAC 參訪情形

	
Central CCAC 副總 Mrs. Lynn Harrett 歡迎衛福部石司長崇良率團拜訪	Central CCAC 副總 Mrs. Lynn Harrett 歡迎衛福部卓技正琍萍



Central CCAC 副總 Mrs. Lynn Harrett 向衛福部介紹 Central CCAC 運作機制

衛福部石司長崇良提出醫療與照護服務整合相關之議題作交流

衛福部石司長崇良贈與 Central CCAC 副總 Mrs. Lynn Harrett 禮品及衛福部年報

衛福部參訪團全體合照

（左起：台灣野村總研成員、衛福部卓技正琍萍、衛福部石司長崇良、Central CCAC 副總 Mrs. Lynn Harrett、Central CCAC 主任 Mrs. Cheryl Cheung、台灣野村總研成員）

六、 醫療照護整合醫院參訪

本次加拿大參訪，共拜訪二家醫療照護整合醫院，依據參訪時間順序分別為 Baycrest 及 Jeffrey-Hale St. Brigid's Hospital。在醫療照護整合醫院（Baycrest 與 Jeffrey Hale–St. Brigid's Hospital）的參訪，著重於了解各種複合式社區照護機構之整合及運作模式現況。以下分別就二家醫療照護整合醫院之背景與參訪重點進行介紹。

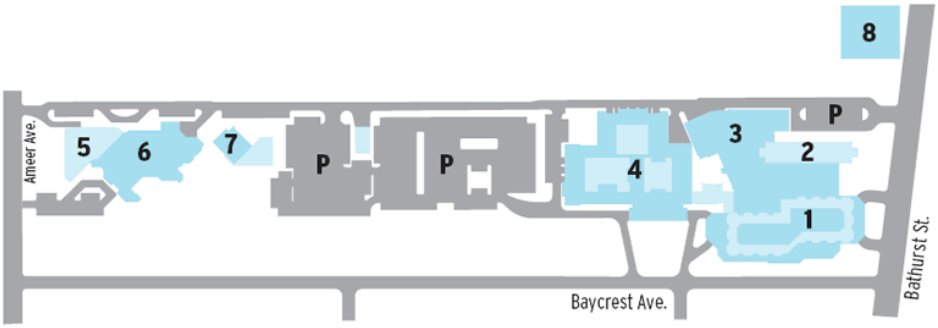
(一) Baycrest

1.背景概要

醫療照護整合醫院（Baycrest），於 1918 年創立初期，為一間專門為猶太裔年長者開設的民營養老院。近年來，逐漸發展為全球唯一結合老人照護與醫療的研究教育機構，成為安大略省最大的高齡醫學照護中心，隸屬於加拿大多倫多大學醫學院，並在衰老與腦部健康創新研究領域方面，躍升為全球領導者。

醫療照護整合醫院（Baycrest）位於多倫多大學校園北方的院區內，院區內具備許多機構，為高齡民眾提供多元化的服務。包含：300 間住院病房的複合復健門診醫院、472 間單獨住家單元的失智高齡住宅、200 戶為部分失能的老人，提供生活支援服務之退休住宅、125 張床的健康老人住宅（非政府經費支援，由使用者自行付費）、與專為高齡民眾提供的健康活動中心等。

此外，由於安大略省老年人口總數位居各省最多，安大略省政府與聯邦政府，更進一步於 2013 年投資 1.23 億加元於醫療照護整合醫院（Baycrest）院區，用以建設「加拿大老化和腦部健康創新中心（CC-ABHI）」，預計將於 2020 年完工。加拿大老化和腦部健康創新中心（CC-ABHI）成立之主要目的，包含創新研究、產品開發及人才育成，並期許能夠大幅改善高齡化社會帶來的負擔。可預見在未來加拿大老化和腦部健康創新中心（CC-ABHI）成立後，醫療照護整合醫院（Baycrest）將會成為加拿大年長者照護與醫療產品開發、臨床實驗與商業化的樞紐。



1. Baycrest Hospital
2. Brain Health Centre
3. Jewish Home
4. Jewish Home for the Aged (Apotex)
5. Terraces of Baycrest
6. Seniors Community Centre (Wagman)
7. Child Care Centre
8. Healthy Living Community

P. Parking

圖 5　Baycrest 院區地圖

資料來源：Baycrest

2.參訪概要

本次參訪醫療照護整合醫院（Baycrest）主要由其 CEO Mr. William E. Reichman 及 CFO Mr. Brian Mackie 接待，並向參訪團介紹醫療照護整合醫院（Baycrest）的運作機制及進行院區導覽。

醫療照護整合醫院（Baycrest）致力在醫院及失智高齡住宅中，營造住家的感覺。Baycest 醫院大廳採中空挑高天井設計，增加採光度，使空間變明亮。此外，更於大廳植樹，營造居家休閒的感覺。在失智高齡住宅的部分，每個單獨住家單元的居民，都可以自行佈置住家單元的外部櫥窗，包括家人的照片、自己喜愛的畫、花或一些家中的裝飾品等。

醫療照護整合醫院（Baycrest）擁有安大略省最大規模的失智住宅，惟與許多加拿大醫療照護機構相同，面臨長期照護病床不足的問題。事實上，由於醫療照護整合醫院（Baycrest）的失智高齡住宅營運，仰賴政府高齡照護制度經費，目前每年仍有約 800 位在等待入住的名單中。

醫療照護整合醫院（Baycrest）的複合復健門診醫院，有 90%病人來自家醫轉診、其餘 10%病人來自專科轉診。因此，醫療照護整合醫院（Baycrest）提供多種提升高齡整合照護的服務模式，包含：家醫整合照護服務模式、全方位照護服務模式、日照服務計畫、遠距醫療及遠距居家服務及高齡醫學諮詢等。

在家醫整合照護服務模式中，對複合病症複雜程度超過一般家醫可以處理的病人，醫療照護整合醫院（Baycrest）整合物理治療師、醫生、護士等專業，提供病人銜接性的整合高齡照護服務，病人在接受此服務而控制病情至可由原本的家醫處理的情況之後，則回歸原本家醫追蹤。

在全方位照護服務模式中，雖然也是接受病症複雜程度超過家醫能力可處置的病人，但與家醫整合照護服務不同，是直接住院，由醫療照護整合醫院（Baycrest）提供病人後續完整的復健及全方位照護服務。

醫療照護整合醫院（Baycrest）有提供日照服務計畫，針對開始出現需仰賴照護服務之病症的病人，提供每周二到三次的照護服務，控制其病情狀況，讓病人回復健康或可獨立自主生活的狀態。

醫療照護整合醫院（Baycrest）也提供遠距醫療及遠距居家服務，但較廣泛應用的仍為精神科，透過遠端視訊方式來提供病人心理諮詢服務。

針對家醫，醫療照護整合醫院（Baycrest）則有提供高齡醫學諮詢，由高齡醫學專科醫生提供基礎醫療的家醫們相關診療的諮詢服務。此外，醫療照護整合醫院（Baycrest）同時也為加拿大全國的照護機構，提供針對失智症人者的照護服務訓練，以提升其他照護機構單位照護失智症病人的能力。

醫療照護整合醫院（Baycrest）已逐漸奠定北美洲第一間，也是最大的腦部健康研究的訓練與教育中心地位。除了國內的研究與教學，Baycrest 亦與國際保持良好的連結。目前 Baycrest 在北美洲、南美洲、歐洲、中東、亞洲皆有學術合作夥伴，提供不同地區的高齡腦部醫生及學生遠距教學訓練。透過視訊的方式，世界各地的醫生可即時分享病人病狀，並與各地專家討論診療方式。

此外，醫療照護整合醫院（Baycrest）亦持續與產業界共同合作創新。舉例而言，台灣廣達電子目前即有與 Baycrest 共同的研究開發計畫，希望研發出符合高齡照護服務的方案，提升病人自主健康管理的能力。

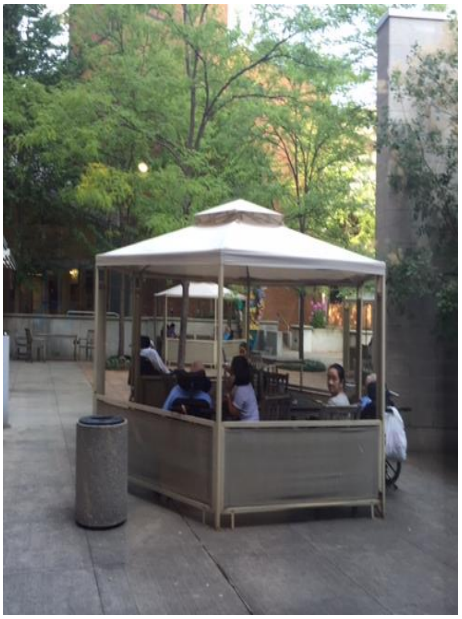
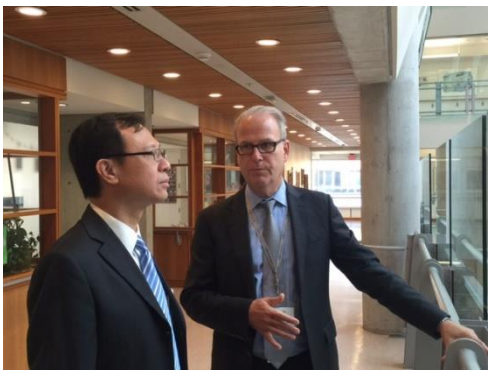
醫療照護整合醫院（Baycrest）亦提出目前醫療照護整合者所面臨之困境，例如許多的服務項目，雖然更能符合高齡者的照護需求，但卻因為不符合既有給付項目而得不到給付，成為醫療提供者之整合服務的阻力；

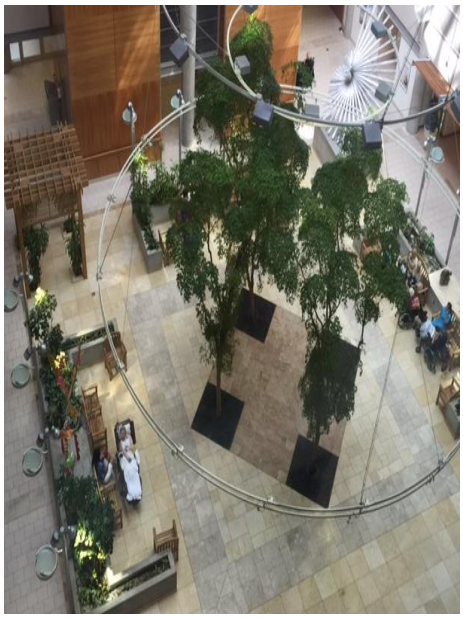
而在過去五到十年間，針對長期照護需求認定的標準，已有非常大的變化。許多過去被認定為需要長期照護服務的病人，在現行的標準下，並不應該進入長期照護體系，而是應該由家庭支援照護服務處理。如何處理這些情形，在也成為加拿大所面臨之困境。此外，政府在醫療照護服務上所應該扮演的角色以及其責任，這些都是未來加拿大醫療照護制度改革中，所需審慎衡量與評估的議題。

表 10　Baycrest 參訪情形

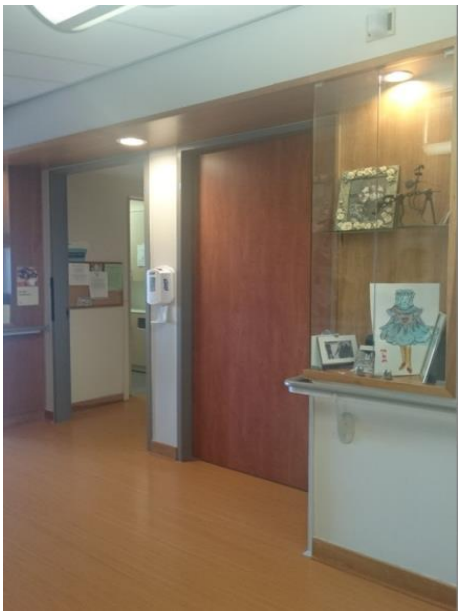
<table>
<tr><td colspan="2"> 

Baycrest CEO Mr. William E. Reichman 向衛福部參訪團致歡迎詞</td></tr>
<tr><td> 
衛福部石司長崇良與 Baycrest CEO Mr. William E. Reichman 及 CFO Mr. Brian Mackie 進行長照相關議題之交流</td><td> 
衛福部石司長崇良贈與禮品及衛福部年報予 Baycrest CEO Mr. William E. Reichman 並合影</td></tr>
</table>

 Baycrest CEO Mr. William E. Reichman 以院區模型向衛福部石司長崇良進行院區介紹	 Baycrest 醫院中庭一景
 Baycrest CEO Mr. William E. Reichman 向衛福部石司長崇良介紹 Baycrest 失智高齡住宅	 Baycrest CEO Mr. William E. Reichman 向衛福部石司長崇良介紹 Baycrest 失智高齡照護住宅之運作模式
 Baycrest CEO Mr. William E. Reichman 向衛福部石司長崇良解說病房護理站運作模式	 Baycrest CEO Mr. William E. Reichman 向衛福部石司長崇良解說 Baycrest 醫療照護整合之運作模式



Baycrest 醫院大廳一景



Baycrest 照護之家一景

衛福部參訪團合照

（左起：Baycrest CFO Mr. Brian Mackie、Baycrest CEO Mr. William E. Reichman、衛福部石司長崇良、衛福部卓技正琍萍）

(二) Jeffrey Hale - St. Brigid's Hospital

1.背景概要

複合式社區照護機構（Jeffrey Hale - St. Brigid's, JHSB）是一家在大魁北克市地區提供雙語和基層醫療照護服務的公家機構，歷史最早可追溯到 150 年前。1856 年 Bernard McGauran 神父為愛爾蘭移民創立的 Saint Brigid's Home，及 1865 年 Jeffery Hale 希望為新教派的病人及殘障人士蓋

一家醫院。兩人對病人的同情心與愛護被一群機構延續，2007 年，它們聯合起來成立了複合式社區照護機構（JHSB）。

複合式社區照護機構（JHSB）致力於提供大魁北克市地區的連續性醫療照護。在社區服務方面，也成立地方社區服務中心（CLSC），提供各年齡層英語的健康及社區服務；醫療服務方面則包含英法雙語的各種一般醫療、急診及老年病理專科；高齡照護方面則致力於提供老年人口獨立的家庭照護能力，並提供 Jeffery Hale Residence 及 Saint Brigid's Home 作為老人之家。複合式社區照護機構（JHSB）的高齡照護中心（CHSLD）提供高齡失能者 241 張長照服務床位及 26 張高齡床位。

2015 年，受魁北克省衛生及社會服務部（MSSS）的醫療與照護改革影響，複合式社區照護機構（JHSB）整併 11 家規模大小不等的醫療院所及照護機構，並與 4 家大學院校共同進行研究合作，轉型為整合性醫療與社會服務中心（CIUSSS），提供以病人需求為核心、支援服務為導向的整合性社區醫療與照護服務。

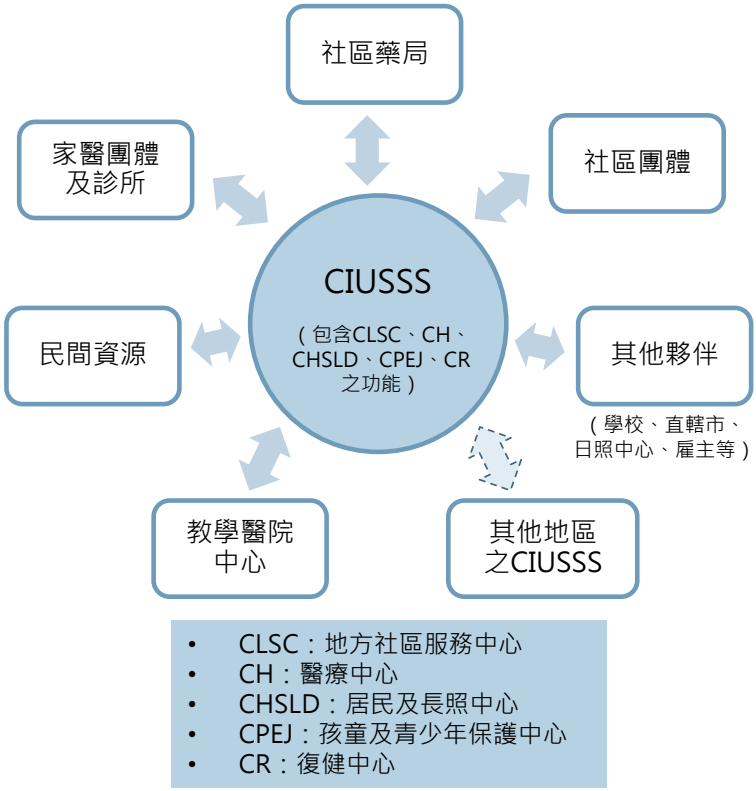


圖 6　整合性醫療與社會服務中心（CIUSSS）扮演之角色

資料來源：魁北克省衛生及社會服務部

2.參訪摘要

本次參訪首先由魁北克省衛生及社會服務部居家照護服務部門的顧問師 Mrs. Annie Janelle 及 Mrs. Hélène Garon 針對加拿大高齡者及殘疾者的連續性照護現況作介紹，再由複合式社區照護機構（JHSB）的副司長 Mr. Guy Thibodeau、助理副總 Mrs. Brigitte Paquette 以及 JHSB 活動服務組組長 Mr. Stéphane Marcoux 針對 Capitale-Nationale 地區的衛生及社會服務體系以及複合式社區照護機構（JHSB）目前扮演的角色作介紹。最後，由複合式社區照護機構（JHSB）助理副總 Mrs. Brigitte Paquette 及複合式社區照護機構（JHSB）活動服務組組長 Mr. Stéphane Marcoux 帶領參訪複合式社區照護機構（JHSB）的醫院、急診、照護之家、安寧病房、復健病房等設施。

加拿大的醫療保健制度採公費制，即由政府出資、私營醫院或醫師提供醫護服務。因此，控制醫療支出、著重疾病預防成為加拿大衛生局重要的政策目標。在這樣的目標前提下，形成「照護為主，治療為輔」的架構；加拿大政府更進一步提出個人核心的連續性照護（Continuum of Care）概念，以期讓加拿大高齡者，皆能擁有並延長健康及有品質的生活。

在這樣的理念下，即便不再以醫生為核心，醫療機構仍扮演重要的評估與領導角色。複合式社區照護機構（JHSB）身為整合性醫療與社會服務中心（CIUSSS），即扮演從個案診療，到決定病人照護服務等級及指派照護單位的角色。事實上，由於提供醫療及照護的整合性服務，複合式社區照護機構（JHSB）可更有效地在病人進入醫療系統之前，即先考慮與規劃病人出院後的後續照護服務。

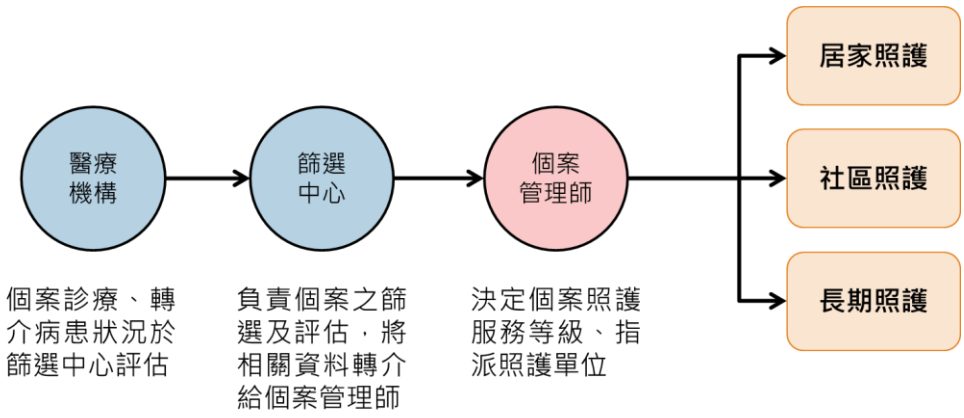


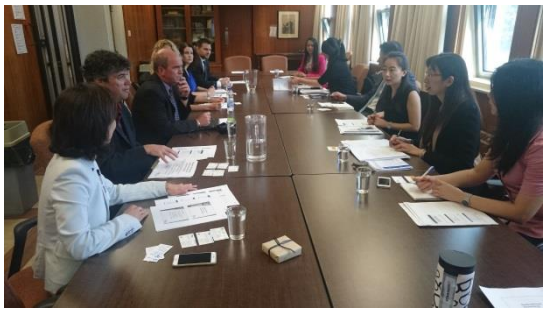
圖 7　連續性照護流程示意圖

而針對病人所需的照護服務機構，複合式社區照護機構（JHSB）有其一套評估之工具。先依病人情況，分照護等級。3-6 級的病人照護需求較低，僅需要定期前往日照中心接受復健服務；10-14 級則為照護需求較高之病人，需要使用長期照護服務。

設施部分，複合式社區照護機構（JHSB）一樓設有一般門診及急診部門、二樓設有病人及醫護人員活動中心、三樓為安寧病房及復健中心、四~六樓則為長期照護之家。複合式社區照護機構（JHSB）的長期照護床多數為單人房，居民平均居住天期為 300 天；安寧病房有 10 床，病人平均居住天期為 60~90 天；復健病房有 16 床，病人平均居住天期為 21 天，復健後可恢復獨立生活能力者約佔 60%。

目前複合式社區照護機構（JHSB）內部品質及服務控管，皆採用標準流程準則，針對住院天數或復健規劃等皆有其質化或量化的標準管控。

表 11　Jeffrey Hale - St Brigid’s 參訪情形

<table>
<tr>
<td> 
衛福部卓技正琍萍與 JHSB 助理副總 Mrs. Brigitte Paquette 交換名片</td>
<td> 
JHSB 的副司長 Mr. Guy Thibodeau 向大家自我介紹及致歡迎詞</td>
</tr>
<tr>
<td colspan="2"> 
衛福部卓技正琍萍向 JHSB 開場及致感謝詞，並提出台灣目前長期照護發展現況與面臨之課題與 JHSB 討論</td>
</tr>
</table>

衛福部卓技正琍萍贈與禮品及衛福部年報予 JHSB 副司長 Mr. Guy Thibodeau（左起:JHSB 活動服務組組長 Mr. Stéphane Marcoux、JHSB 助理副總 Mrs. Brigitte Paquette、JHSB 副司長 Mr. Guy Thibodeau、衛福部卓技正琍萍、JHSB 當日活動主持人）

衛福部卓技正琍萍贈與禮品及衛福部年報予 MSSS 居家照護服務部門（左起：MSSS 居家照護服務部門顧問師 Mrs. Annie Janelle、MSSS 居家照護服務部門顧問師 Mrs. Hélène Garon、衛福部卓技正琍萍、MSSS 國際事務部門 Mr. Francis Dubois）

JHSB 副司長 Mr. Guy Thibodeau 致贈禮物予衛福部卓技正琍萍

JHSB 助理副總 Mrs. Brigitte Paquette 介紹地方社區服務中心之環境

衛福部參訪團及與會人員全體大合照

（後排左起：JHSB 活動服務組組長 Mr. Stéphane Marcoux、JHSB 助理副總 Mrs. Brigitte Paquette、JHSB 當日活動主持人、JHSB 副司長 Mr. Guy Thibodeau、衛福部卓技正琍萍、MSSS 居家照護服務部門顧問師 Mrs. Hélène Garon、MSSS 居家照護服務部門顧問師 Mrs. Annie JanelleMSSS 國際事務部門 Mr. Francis Dubois、台灣野村總研成員；前排：台灣野村總研成員）

JHSB 活動服務組組長 Mr. Stéphane Marcoux 向衛福部卓技正琍萍解說醫院評估病患之照護模式

衛福部卓技正琍萍參訪 JHSB 醫院一景

<table>
<tr>
<td> 
地方社區服務中心的日間照顧活動聯誼區一景</td>
<td> 
鄰近 JHSB 的私人高齡住宅外觀（月費約為公立高齡住宅的 2~3 倍）</td>
</tr>
<tr>
<td> 
JHSB 門診等待區一景</td>
<td> 
JHSB 長照之家居民房間一景（居民可自由布置自己的住所）</td>
</tr>
<tr>
<td> 
JHSB 病人病歷（未使用病例電子化系統）</td>
<td> 
JHSB 長照之家的浴室（有協助護理人員移動病人的機器手臂）</td>
</tr>
</table>

	
JHSB 安寧病房交誼廳一景	JHSB 美容理髮廳一景

七、 辦理說明會

9 月 1 日於魁北克市 Hilton Quebec 飯店，舉辦一場說明會，邀請當地健康產業相關業者共約十二家參與活動，當日執行議程如下表。

表 12 說明會議程

時間	議程	備註
09:45－10:00	與會廠商簽到	
10:00－10:10	主辦機關開場致詞 衛生福利部 石崇良司長	
10:10－10:40	台灣醫療生技產業國際策略合作簡介	
10:40－11:10	各機關簡介（各 1 至 2 分鐘） 各與會機關人員	
11:10－11:30	討論與問答 Q&A	
11:30－12:00	會後交流	

本次說明會先以簡報方式進行，並輔以他國與台灣企業合作並成功推展國際市場之案例，讓與會者了解台灣醫療產業之政策規劃及市場商機。最後開放討論與問答，由衛生福利部與國外廠商進行交流，活動相當成功。

本次魁北克說明會共計有 12 間公司/機構報名參加，大部分與會者對於台灣健康照護發展之市場商機及如何整合魁北克省創新能量與台灣產業優勢等議題特別感興趣。

說明會問答情形彙整如下表：

表 13　說明會 Q&A 彙整

參與者提問	衛生福利部答覆
台灣實施居家照護的整體架構及時程規劃為何？	在長期照護領域，台灣過去曾頒布過多項政策，並試行各種專案計畫，目前則以「長照十年計畫 2.0」為主要的施行架構，希望在未來十年間，以建立我國社區整體照顧模式、佈建綿密的照顧網為目標，提供台灣高齡者連續性照護服務。
台灣如何協助延長高齡者的健康狀態？	在長照十年計畫 2.0 中，社區照顧中心依據照護需求的高低分為 A、B、C 三級，其中，A 級著重高照護需求的高齡者或慢性病人者；B 級以中度或輕度照護需求的高齡者或慢性病人者為主；C 級即為以協助高齡者獨立生活、延長高齡者健康狀態為目標，提供高齡者適當的輔助及活動，如社區團康活動、高齡陪伴等。
在台灣照護整體架構及計畫時程下，國外的廠商可以扮演甚麼樣的角色？	在以社區為中心的照顧網絡下，廠商可著力的面向多元，包括高齡輔具或穿戴式器具的供應、遠距照護器材的提供、照護活動的直接提供或間接輔助、及科技輔助之居家照護產品的共同研發等。另外在高齡健康管理的部分，疫苗或健康食品的共同研發都是可討論的合作範圍。
魁北克市的一大重點優勢為創新及創業精神，尤其在研究方面有很強的基礎，未來業者可如何跟台灣合作？	台灣擁有十分良好的臨床試驗環境及與國際接軌的法律規範，且台灣廠商的製造能力強，多數藥廠皆有 GMP 認證；過去在台灣的臨床試驗申請普遍多為第二期及第三期，近年來第一期臨床試驗的申請案件則逐年增加，顯示台灣在新藥的研發能力逐年上升。 魁北克市的創新及創業精神正好可以與台灣的製造強項及正在逐漸提升的研發能力相互補；此外，台灣重點研發慢性病及癌症新藥及新治療方式，魁北克市藥廠眾多，且一向以研究能力聞名，新藥共同研發將成為未來合作主軸。

表 14　說明會執行情形

<table>
<tr><td colspan="2"> 
衛生福利部石司長崇良進行開場致詞</td></tr>
<tr><td> 
介紹台灣醫療現況</td><td> 
現場與會人員聆聽簡報情形</td></tr>
<tr><td> 
各機構與會人員進行任職機構簡介</td><td> 
與會人員與衛生福利部進行 Q&A 情形，互動熱絡</td></tr>
</table>

與會人員與衛生福利部進行會後意見交流情形，互動熱絡

與會人員之一與衛生福利部進行合影

（左起：Quebec International 生命科學事業發展部門總監 Jean-Michel Garro、衛福部卓技正琍萍、衛福部石司長崇良、Quebec International 外國投資顧問 Sara Tapia）

參、 心得及建議

本次透過參訪加拿大社區整合照護、智慧與遠距醫療相關政府主管單位與機構，了解加拿大社區照護、智慧及遠距醫療架構、與推行之政策，及未來改革方向，作為政府持續推動長期照顧、導入遠距醫療與規劃之政策參考。

本次加拿大參訪團，總共參訪 7 處不同機關與機構。包括 2 個政府單位：安大略省衛生與長期照護部及魁北克省衛生與社會服務部、1 家智慧醫療整合機構、1 家遠距醫療網絡、2 家醫療照護整合醫院、1 家整合型社區照護機構。對此次參訪心得與建議分述如下：

一、 心得

加拿大為聯邦政府制度，在政策制定上，由中央政府擬定發展主軸，但實際規劃及執行面，則由各省政府主掌。因此，各省在醫療與照護制度上雖有不同面貌，但仍依循共同主軸架構發展。近年來，加拿大政府強調提供整合性醫療照護服務，並強化醫療與照護間之銜接；同時，亦推動以病人優先、普遍且具高取得性之醫療照護服務。依此兩大發展主軸，加拿大各省政府逐步整併原有醫療與照護體系，同時結合醫療照護與科技，提供創新的服務通路，使全民皆能在居住的社區範圍內，有效且迅速地接受醫療與照護服務，值得我國規劃未來長照與智慧醫療政策之參考。

(一) 從中央整合醫療照護，有效分配資源：

安大略省原整合系統分別有地方健康整合網絡（Local Health Integration Network, LHINs）及社區照顧管理中心（Community Care Access Centre, CCAC）。雖經費透過地方健康整合網絡（LHINs）分配，各自管轄單位也不同，但任務職掌重疊且各自獨立，並無橫向綜整。安大略省在 2015 年提出的 Patient First Action Plan（病人優先行動方案）中，強化地方健康整合網絡（LHINs）的角色。將社區照顧管理中心（CCAC）的任務，轉移至地方健康整合網絡（LHINs），以更有效分配資源，並與醫療端銜接。而魁北克省也於 2015 年提出 Act Respecting Healthcare and Social Services，整併原本隸屬醫療與社會服務兩種不同體系之機構，透過以醫療端主導的醫療與社會服務整合中心，對各社區內病人及高齡者，提供所需服務，以利有效運用相關資源，減少不必要的資源浪費。在國內，規劃長照服務與相關經費的同時，可參考魁北克省之經驗，透過以醫療端主導的

服務整合中心，擴大醫療端於照護服務中的角色，藉此垂直整合醫療與照護，同時更能有效控制支出，掌握資源分配。

(二) 以法令輔助政策推動：

加拿大政府近年來政策發展主軸，強調更貼近全民需求、以病人為中心的醫療照護服務。各省政府於執行相關制度改革時，於確立規劃與發展方向後，透過法案制定，賦予推動制度之依據。例如，安大略省的病人優先法案，強化地方健康整合網絡（LHINs）於整合醫療照護服務的職掌，以及魁北克省的醫療衛生與社會服務尊重法，其中特別定義遠距健康服務，以賦予其為提升醫療照護服務可取得性的功能。國內在推廣長照 2.0 落實社區照護服務概念的同時，亦可參考此推動模式，輔以長照服務法之施行細則或鬆綁相關醫療法規，賦予相關政策執行的法律依據。

(三) 提倡病人優先的醫療照護與支援服務：

近年各先進國家皆意識到，為因應高齡化社會之需求，在地化社區整合服務，為提供最符合民眾需求的模式。此概念亦在加拿大得到落實：安大略省由社區照顧管理中心（CCAC）提供之服務不僅止於醫療照護端，更強調其他居家支援服務。即便有再好的醫療服務，於病人離開醫院的那一刻，回到熟悉的居家環境後，日常生活中的瑣事才為最重大的挑戰。例如：居家清潔、食物採買、繳納水電瓦斯費用等，特別是針對獨居的病人族群，更是需要多元化之支援項目。安大略省透過社區照顧管理中心（CCAC），提供相關的居家服務支援，使病人在出院後，不但有照護端的銜接服務，同時生活服務上也能得到良好的支援，完善照護體系。

(四) 以智慧與遠距健康為支援醫療照護服務：

加拿大推廣智慧及遠距健康服務，其發展宗旨為提供人民更方便與即時的醫療照護服務。因此，在發展智慧與遠距健康服務時，主要考量方向為：如何更有效地提供人民服務、縮短人民與醫療照護人員為了獲得或提供服務時所耗費的人力、物力。秉持這政策主軸，加拿大政府在規劃發展遠距健康服務時，並沒有為提高醫護人員使用遠距服務而給予特別的誘因。政府主要規劃方向，著重於思考哪些遠距服務項目，最能達成降低不必要資源消耗的目的。例如線上掛號系統、線上連續處方、追蹤報告遠距門診等。另一方面，加拿大政府更重視透過遠距居家服務，鼓勵病人建立自我健康管理的概念。例如：魁北克省落實遠距照護服務的推廣，雖然藉由提供免費平板及相關系統儀器給病人使用，但服務期間卻只有幾個月。

主要目的，是讓病人建立自主健康管理的概念與能力，而非長期依賴遠距居家服務，如此才能真正達成有效降低醫療照護服務支出的目的。

(五) **標準化服務，控制資源分配**：

在整合醫療照護服務的趨勢下，各國皆以強化在地社區服務為發展主軸。但，在為達到有效的運用及分配資源之目標，又需兼顧高齡者多元化的照護需求，便成為政府須面臨的挑戰。為此，加拿大各省政府制定了「整合醫療標準與照護服務的評估量表」制度，並依據量表評分來制定標準化的服務項目。以魁北克省為例，整合衛生與社會服務支援中心使用的 Multicliente Assessment 量表共分為 14 等級，透過醫療端的評估，給予照護服務需求者分級。照護服務端則針對其分級，提供不同的照護服務。例如 3 至 6 級高齡者至日照中心接受服務、10 至 14 級高齡者可以住進長照中心;而安大略省同樣於社區照顧管理中心(CCAC)則導入 The Method for Assigning Priority Levels（MAPLe）score，依據照護需求者評分之程度，給予相關服務。此標準化的評估以及對應的照護服務設計，不但能更有系統的記錄照護需求者的健康狀況，更大的效益是能更精準的給予照護需求者最適合的服務內容，藉此控制照護資源的支出，同樣的模式也在日本介護服務制度上可以看見。

二、 建議

藉由本次參訪，可分別由政策面、制度面與產業面出發，給予國內相關產業發展政策與制度給予建議，其內容分述如下：

(一) 政策面

1. 以醫療引導社區支援中心，落實在地照護銜接

目前長照十年 2.0 計畫中，已規劃 A-B-C 三級醫療與照護組織架構，以及相關任務職掌：A 級為社區整合型服務中心，同時擔任長照照護服務主導角色，對 B 級複合型日間服務中心、與 C 級巷弄長照站提供督導與技術支援，以結合區域醫療資源銜接照護服務。而參考加拿大模式，未來應更擴大 A 級的整合服務能量，落實醫療端引導社區整合照護服務的角色，透過評估量表分配與統籌相關銜接性照護服務之供應，以更有效的落實醫療照護銜接。

2. 因應新型整合醫療照護服務，規劃多元給付制度

為因應高齡者多重疾病需求，目前多家醫院已提供聯合門診服務。而未來因應長照服務規劃，可預期須有更多元的醫療照護整合服務。在長照財源尚處於規劃階段，應思考未來新型整合服務架構，預先規劃整合健保與長照財源提供相關給付，藉此才能鼓勵各醫療照護院所創新能量，提供全民更好的醫療照護服務。

3. 提供民眾可近性之醫療照護需求，擴大遠距健康服務

隨著醫療照護服務項目的擴大，科技支援的效益也更顯著。參考加拿大模式，遠距健康服務不僅於為偏遠地區提供醫療服務，而更廣泛的提升全民醫療照護服務之普遍性與可近性。藉由全民問卷調查，了解民眾的需求，並對電子連續處方評估、檢驗報告查詢或慢性病之衛教等，逐步推廣為遠距照護之重點項目。而具有穩固科技產業基礎的台灣，更應該利用既有優勢，有效利用遠距健康服務支援現有服務模式，減少慢性病、手術後追蹤等進入醫療系統，降低不必要的資源消耗。

(二) 制度面

1. 強化科技應用，促進病人自我健康管理

目前台灣長照服務規劃，強調透過不同層級的機構提供照護需求者多元服務，然而建置提供完善服務模式之同時，尚無強調建立長照

需求病人獨立自主健康管理的能力。然而加拿大政府強調，唯有真正達成病人自主健康管理，才能有效降低醫療與照護資源支出。因此，規劃以遠距居家照護服務，同步教導病人培養自我監控與管理健康狀態的能力，而不是依賴相關照護服務資源。台灣可參考此制度，自糖尿病照護網絡及腦中風登記網絡先行試辦實施遠距居家照護服務。既但可縮短照護服務人員以及病人在交通移動上的時間，更可藉此鼓勵病人建立自主健康管理的概念，降低對醫療與照護資源的依賴。

2. 整合照護服務分級標準

台灣已使用巴式量表及相關評估量表多年，惟目前並無標準化量表評分與對應照護服務項目的制度。參考加拿大與日本的規劃，評估量表對應實際上取得的服務項目，不僅可有效追蹤病人健康變化，也能提前針對其照護服務需求進行規劃，進而控管資源支出。在未來長照服務制度發展規劃中，應考量根據各評估量表整合出標準化的照護服務內容，並整合 A-B-C 三級服務架構，以管控相關資源消耗。

(三) 產業面

1. 鼓勵遠距健康與智慧醫療產業創新

參考加拿大遠距健康服務與智慧醫療發展，我國既有傳統電子產業與科技產業優勢，未來應鼓勵醫療與照護產業，結合科技業者針對高齡化社會整合醫療照護服務，以及居家照護需求，設計新型遠距與智慧服務之產品，以促進全民自主健康管理，同時也能帶動我國智慧健康相關產業發展，並達到鼓勵國人健康促進之效果。

2. 鼓勵遠距醫療資訊化整合

因應遠距健康服務與智慧醫療發展，資訊整合、大數據之彙整與應用為刻不容緩之辦理規劃。我國之科技產業優勢，未來應鼓勵建置整合性資料庫，結合智慧醫療產業，結合產學界的巨量數據分析技術，強化照顧資訊的即時連結及成效分析，有效控管醫療與照護產業支出之財源，並作為政府相關政策推動的規劃依據。

肆、 附件

附件一

Central
CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Centre

Central Community Care Access Centre Strategic Plan (2014-2017)

Executive Summary

Excellent Service,
Compassionate Care

EXCELLENT SERVICE, COMPASSIONATE CARE

The foundation of the Central CCAC Strategic Plan - Excellent Service, Compassionate Care is patient-centred care, which reaches beyond specific services and individual employees to be the driving force and cornerstone of our organization's culture. It is the lens through which we set shared priorities with our health and community care partners. It inspires all of us to transform how we work together to better meet the needs of patients.

The changing needs of our patients requires that we redefine patient-centred care. The population in the high-growth Central Local Health Integration Network (LHIN) region served by the Central CCAC is rapidly aging and increasingly diverse. Over 71 percent of Central CCAC patients have very high or high needs compared to 56 percent just four years ago. In the past, many of these people would have required hospitalization or some form of institutional care.

There is a need to improve how the health system delivers integrated care to patients with complex needs, to reduce avoidable emergency department visits and hospital stays, and reduce costs.

These changes are also occurring against a backdrop of financial restraint in which governments and the public expect health care organizations to use their resources wisely to deliver quality services and value for the taxpayer. Central CCAC's work is aligned with provincial and local priorities, which support a strong role for CCACs in care coordination and system navigation, particularly for high needs patients.

Examples include Central CCAC's evolving role to provide assessment and determine eligibility for adult day programs, assisted living, and exercise and falls prevention classes.

We are also leading the development of integrated, individualized coordinated care plans for Health Links patients in our region, and testing the new outcome-based funding approach for wound care.

Central CCAC's commitment to patient-centred care, our expertise in care coordination and system navigation, and our strong relationships with providers across the health system position us well for a leadership role in supporting complex and chronically ill patients to remain in their homes and communities.

"My Central CCAC care coordinator has been wonderful. She really listened to what was important to me."

Janelle – Health Links patient

What does patient-centred care mean?

Patient-centred care recognizes that understanding a patient's personal story is the first step in excellent service and compassionate care. It is about listening to what matters most to the person, and respecting their traditions, preferences, values and lifestyle. Patient-centred care focuses on achieving the best possible health outcome for each person.

This means patients will receive coordinated care that is safe and seamless, and that they and their loved ones are part of the care team, empowered with information, options and guidance to maximize their independence, helping them make informed decisions and manage their health.

Research tells us that patient-centred care results in better care and more efficient and effective organizations. Central CCAC has seen first-hand the benefits of patient-centred care and has embraced it as the basis for the Priorities for Action in our Strategic Plan.

An Advisory Panel with caregivers, care partners, Central CCAC staff and board members guided the development of the Central CCAC Strategic Plan with thoughtful perspectives, analysis and advice. Over 350 others also shared suggestions and ideas that are the foundations of this Plan.

Our thanks to everyone for their contributions and commitment to making a difference for patients and families through our Priorities for Action.

The Central CCAC Strategic Plan - Excellent Service, Compassionate Care describes the actions we will take, the results we will strive to achieve, and the difference this will make to the patients and communities we serve.

The Plan includes a full summary of what we heard from over 350 patients, caregivers, health and community partners, as well as Central CCAC staff. Patients and caregivers, with whom we spoke, expect to have a meaningful say in their care plan. They also want the care process to be more streamlined and less complicated, including having one person to contact about their care plan.

Our health and community partners acknowledged that to improve access to quality care, all providers will need to collaborate at a new level, within the health system and with social and community services. They also believe that Central CCAC plays a leadership role in care coordination for high needs patients.

Similarly, Central CCAC staff recognize that the organization's role will continue to shift with an increased role in system navigation – helping patients to access care from across the health and community system to ensure that patients receive the right services, at the right time, and in the right place.

"It's very important to have the community health services to support patients as they age and when their medical problems become more complicated. The Central CCAC has a major role in helping people to live independently."

Dr. Roshan Shafai – Chief of Medicine, Southlake Regional Health Centre

This requires the Central CCAC to redesign how it organizes and delivers care for complex and chronically ill patients.

PRIORITIES FOR ACTION

"If I had to do it on my own, I wouldn't have been able to manage. I truly believe that without Central CCAC my son wouldn't be here with me at home."

Rose – mother of Central CCAC patient

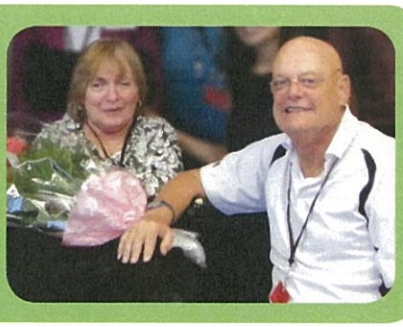
Driven by the goal of patient-centred care and the reality of the increasingly complex care being provided in the community, the Central CCAC Strategic Plan has three priorities for action:

- **Quality through Integrated Care**
- **Quality through Access to Care and Services**
- **Quality through Optimizing Patient Outcomes**

Quality through Integrated Care

"My wife and I are very pleased with the support we have received through our Central CCAC Health Links care coordinator. Everyone is now working together as a team and we appreciate her coordinating the action plan we developed."

Bob – spouse of Health Links patient



To improve care planning and service delivery across multiple providers to better meet the individual needs of complex patients.

Central CCAC will:

- Spearhead the creation of an individualized care plan for patients with complex care needs, which involves all of the patient's care providers, and the patient and family as part of the team.

Quality through Access to Care and Services

To improve patient and caregiver access to health, community and social services by embedding system navigation as a core service.

Central CCAC will:

- Empower patients and caregivers with information, options and guidance about the wide range of available services and resources to meet their needs.
- Use its relationships with other care providers and in-depth knowledge of health, community and social services to help patients and caregivers access services and resources that meet their individual needs.

Quality through Optimizing Patient Outcomes

"Once Central CCAC was called, there began the transition from what might have been long-term care and being bedridden for the rest of my life, to being an independent person."

Patricia – Central CCAC patient

To consistently deliver high-quality care and services that optimizes patient outcomes.

Central CCAC will:

- Leverage information and data to support quality improvement and deliver best practices.
- Develop and implement a proactive patient risk reduction strategy to support improved outcomes.
- Partner with our contracted service providers to optimize patient outcomes.

Measuring our Progress

The Central CCAC will make a difference for patients by striving to achieve the following measures and targets.

Priority	Measures
Integrated Care	• Improve patient satisfaction with CCAC care and services • Increase the number of end of life patients who die in their preferred location • Meet provincial wait times for CCAC service
Access to Care and Services	• Improve patient satisfaction with access to health and community services through the CCAC • Reduce time for completed patient applications for specific community support services (e.g., adult day programs, assisted living and physiotherapy)
Optimizing Patient Outcomes	• Reduce patient falls • Increase the number of short stay patients with wounds that heal according to best practices • Reduce hospital readmissions • Reduce emergency department visits

Central CCAC Sites

Newmarket
1100 Gorham Street, Unit 1
Newmarket, ON L3Y 8Y8

Richmond Hill
9050 Yonge Street, Suite 400
Richmond Hill, ON L4C 9S6

Sheppard
45 Sheppard Avenue East, Suite 700
North York, ON M2N 5W9

Toll-free
1-888-470-2222
TTY 416-222-0876
310-2222

GREATER TORONTO'S TOP 2014 EMPLOYERS

ACCREDITATION CANADA • AGRÉMENT CANADA
ACCREDITED • AGRÉÉ

Stay connected with us
www.healthcareathome.ca/central

For more information about health and community services visit

CentralHealthline.ca

Funded by
Ontario
Central Local Health Integration Network

Central CCAC
Community Care Access Centre
CASC
Centre d'accès aux soins communautaires du Centre

A complete copy of the Central CCAC Strategic Plan (2014-2017) - Excellent Service, Compassionate Care, is available at www.healthcareathome.ca/central or by calling 1-888-470-2222, extension 2672.

附件二

otn.
Care. Connected.

Connected care has deep roots in this province.

One of the largest telemedicine networks in the world.

After more than a decade of innovation, OTN is a global leader in telemedicine and built Ontario's first generation of telemedicine solutions. OTN's programs and services were developed with providers and partners in every part of Ontario's healthcare system. The result? Improved access to care, more efficient delivery, and more effective collaboration between providers.

And telemedicine innovations.

This solid foundation allowed OTN to rapidly develop and deploy real-world solutions that are aligned with Ontario's best practices. Like Telehomecare: CHF and COPD patients can be monitored and coached in their homes. Now, patients and caregivers can actively engage in managing their own health.

From **telemedicine** to **health care anywhere.**

Connected care continues to evolve. So does OTN.

We've grown beyond our original mandate. And are helping you deliver patient-centred, integrated care via OTNhub.

Designed with the needs of healthcare providers in mind, OTNhub is Ontario's telemedicine community.

Simplicity – everything providers need for patient care and professional development is in one place. Accessible from anywhere at any time via the cloud.

OTNhub offers choices – a wide range of curated features and tools. With innovations regularly introduced.

OTNhub gives providers control – they choose the features and tools that work for them, and decide when and where to use them.

Plus, a telemedicine partner they can trust – OTNhub is completely private and secure. And every part of OTNhub supports Ontario's healthcare transformation.

From **health care anywhere** to **connected care.** Whe

Together, we are working to make healthcare better across Ontario:

Reducing hospital readmissions

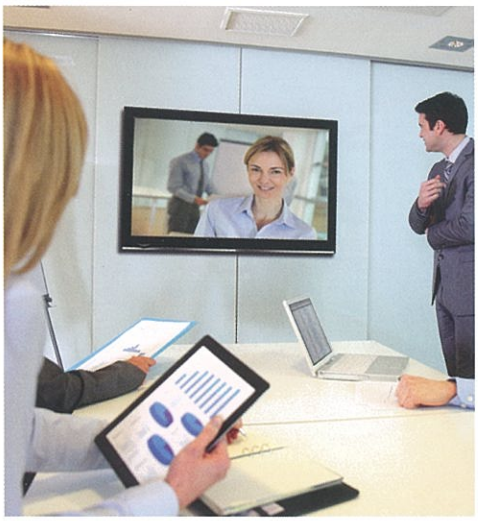
Providing new collaborative pathways for clinicians, including patient self-management tools.

Transforming primary care

Enabling care that is more integrated and responsive to local needs.

Putting patients first

Integrating home and community care with other parts of the healthcare system.



OTN can help you harness the power of connected care today.

Connected care can help you lead the way in Ontario's healthcare transformation. And OTN can work with you to determine where connected care makes sense in your organization. Plus, how to embed it into your planning processes and clinical workflow design.

And stay on the leading edge tomorrow.

As healthcare innovations emerge in the marketplace, OTN works with our diverse partners to curate best-in-class telemedicine solutions that align with Ontario's health needs. Only tools that are proven, private, secure, safe, and easy to use are introduced or recommended for use in OTNhub. And you decide which connected care innovations are right for you.

e are you on your **connected care journey?** **OTN can help.**

Connected care is reducing hospital readmissions, transforming primary care, and expanding home and community care across Ontario.

Here's how to make it work for you.

Expect more from your healthcare partner.

OTN is a not-for-profit organization funded by the Ministry of Health and Long-Term Care. We're helping Ontario build a sustainable and responsive virtual care system. As healthcare innovations emerge, we look for best-in-class telemedicine solutions that align with Ontario's needs. Only tools that are proven, private, secure, and safe to use are available or recommended for use in OTNhub. And healthcare organizations and professionals choose which digital tools to use to support their practices. The benefits to patients, providers, and the system drive everything we do.

Curious to learn how connected care can help you achieve your goals?

- Visit OTN.ca to discover the full range of connected care options.
- Are you a healthcare provider? Visit OTNhub.ca to discover patient care and professional development options.

otn
Care. Connected.

otnhub.ca
info@otn.ca

Ontario

OTN is a not-for-profit organization funded by the Ontario Government

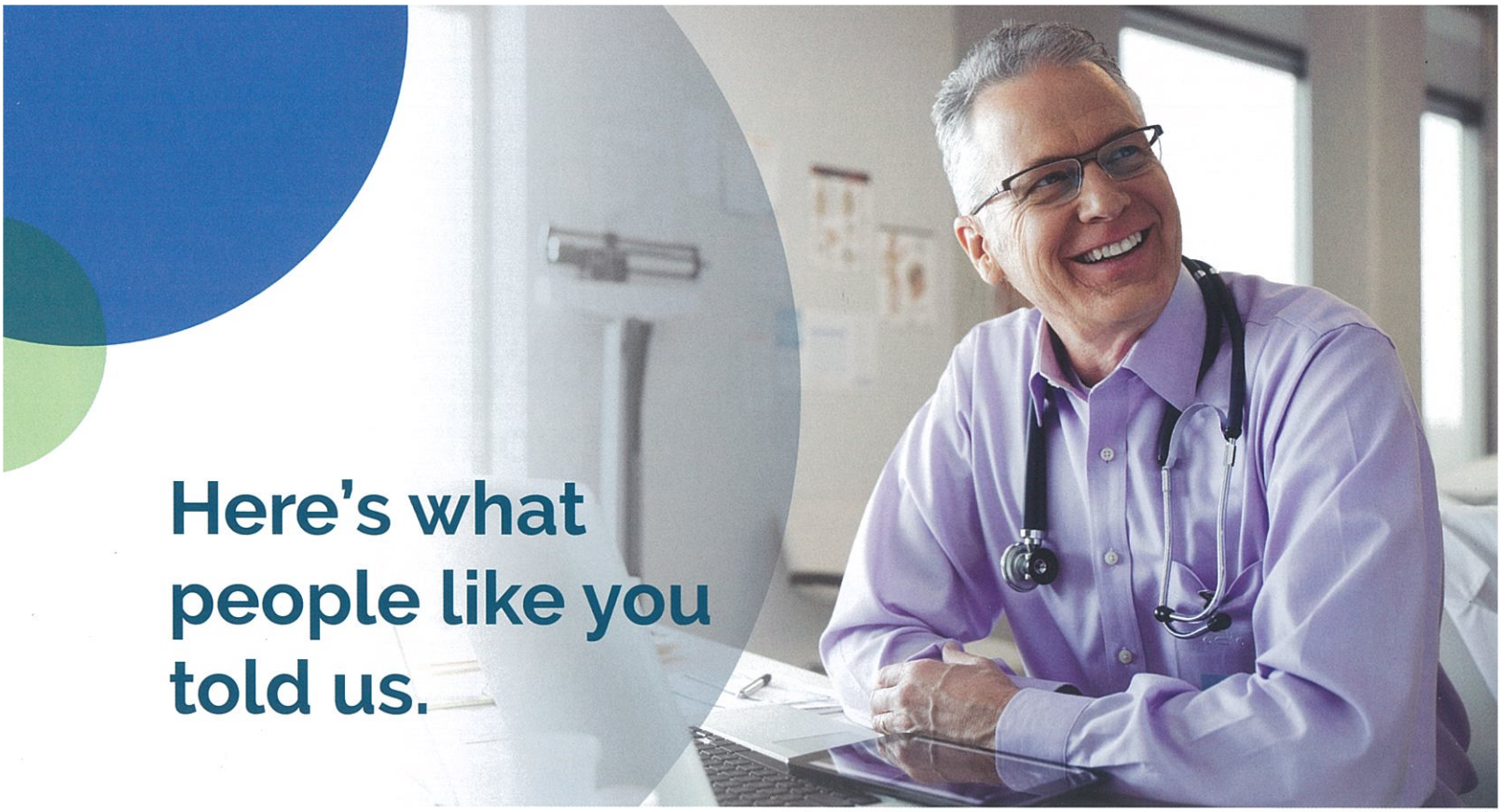
附件三

We asked physicians and other health professionals,

What do you need to support your practice?

otn.

Care. Connected.



Here's what people like you told us.

I need an easy way to ask a specialist for advice.

I need to stay up to date in an ever-changing world.

I need to know which new telemedicine solutions are best for my patients and my practice.

And then we asked, what if there is a place where you could get all of this and more?

Connected care is here.

You get simplicity.

Everything you need to practice telemedicine is in one place. And whether you do just one thing – or some of everything – you'll find OTNhub is easy to use.

You have choices.

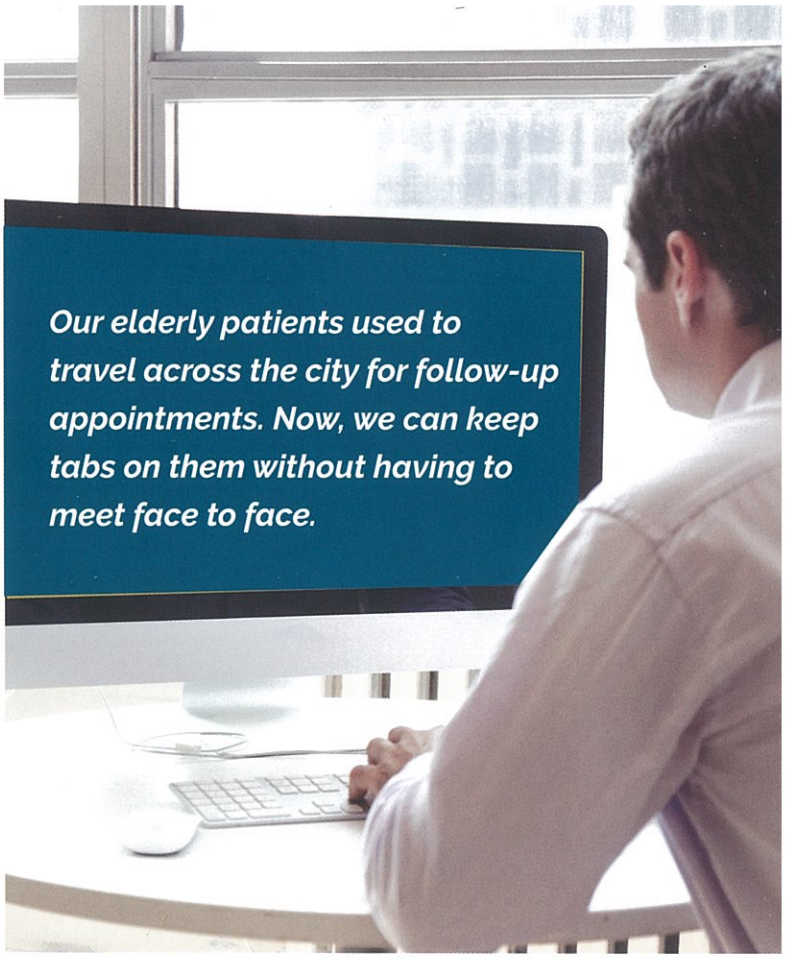
You'll discover a wide range of curated features and tools. And because you want to stay up to date, effective innovations are introduced on a regular basis.

With OTNhub, you're in control.

You decide which parts of OTNhub are right for your practice. And you choose when and where to use them.

And a telemedicine partner you can trust.

OTNhub is where Ontario's healthcare professionals work together online. It's completely private and secure. And every part of OTNhub supports healthcare delivery in Ontario.



How OTNhub helps you and your practice

- ✓ Private & Secure
- ✓ Free
- ✓ OHIP billable
- ✓ Use with PC, Mac or mobile device
- ✓ No equipment to buy

"New information and communications technologies are coming at me at the speed of light. Having a trusted online source for proven tools that align with Ontario's best practices is a huge relief."

Two indispensable paths. Endless ways to enhance what you do.

Patient care

More ways to deliver care to your patients.

eConsult

Consult with specialists in over 27 areas of care. Send data easily and securely from your PC or mobile device. Receive a response on average in 3 days. Or, specifically get a derm consult through OTN's Teledermatology program.

eVisit

Arrange real-time video visits with patients or peers. And choose the method that's best for you, in health facilities or in the home: Room based, PC, Mac or mobile.

eCare

Use apps and other devices to monitor patients or coach them to manage their condition at home. Ideal for patients with chronic conditions, mobility issues or post surgery, or, refer your COPD and CHF patients to OTN's Telehomecare program delivered in collaboration with the LHINs.

Professional development

Everything you need to connect and advance is at your finger tips.

eLearning

Discover an extensive library of resources: videos, peer-reviewed papers and other clinical information that may be relevant to your practice. From how to practice telemedicine to watching archived Grand Rounds, to the latest clinical developments and innovative programs.

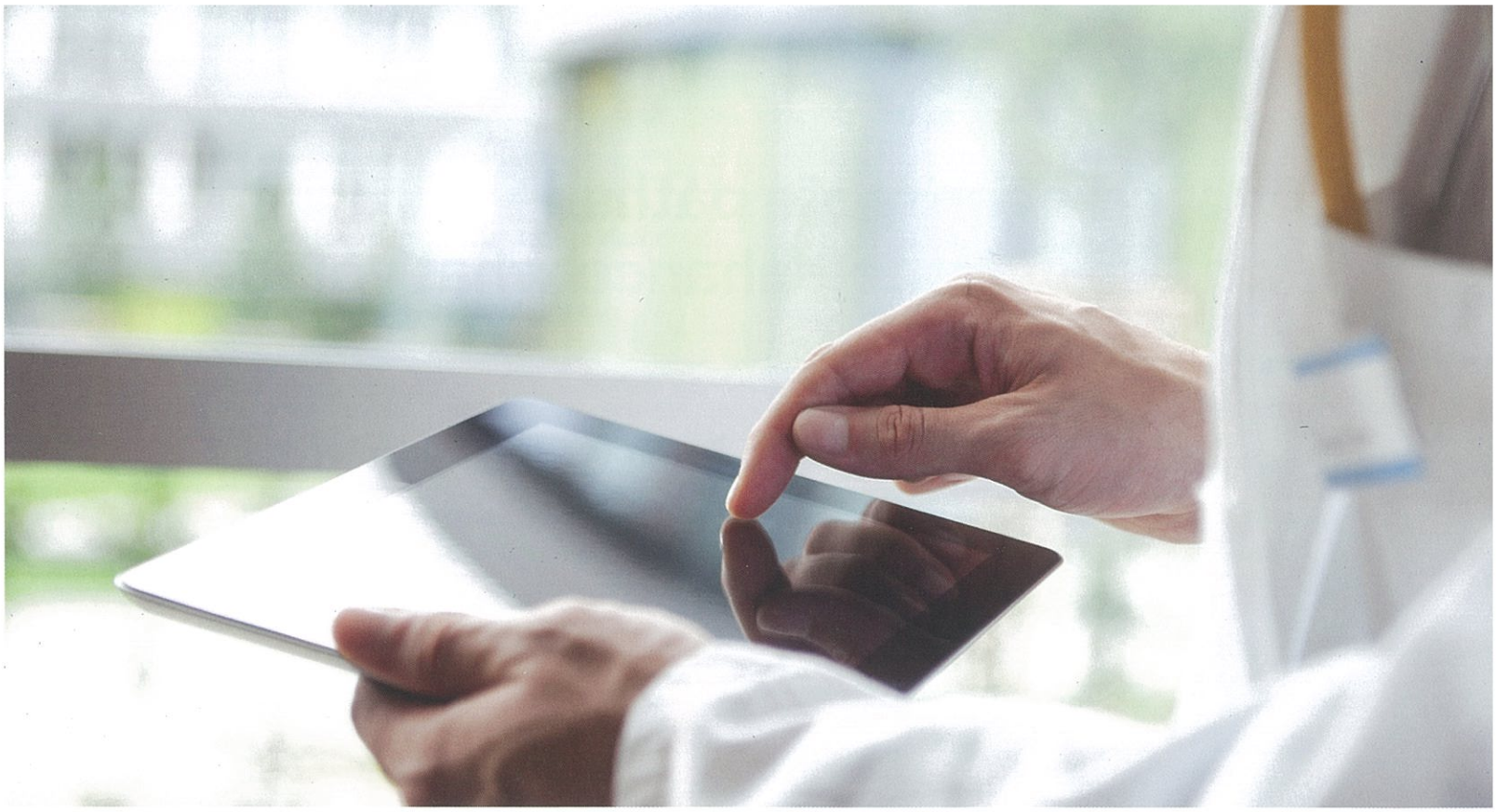
ePodium

Live learning events from providers on a range of topics. OTN hosts professional sessions (for credit). And OTNhub members host live events that are open to other members, like Grand Rounds.

Plug into Ontario's connected care network:

OTNhub's Directory helps you find people, places and telemedicine programs across the province. You can also manage your own telemedicine profile to connect with other practitioners in a way that supports your needs.

With all this in one place, you can **focus on what you do best.**



Introducing OTN HUB

OTNhub is Ontario's telemedicine community. Designed with the needs of health professionals like you in mind.

Expect more from your healthcare partner.

OTN is a not-for-profit organization funded by the Ministry of Health and Long-Term Care. We're helping Ontario build a sustainable and responsive virtual care system. As healthcare innovations emerge, we look for best-in-class telemedicine solutions that align with Ontario's needs. Only tools that are proven, private, secure, and safe to use are available or recommended to use in OTNhub. And healthcare organizations and professionals choose which digital tools to use to support their practices. The benefits to patients, providers, and the system drive everything we do.

Ready when you are.

Call us. We'd love to help you get started. 1-855-654-0888

Visit OTNhub.ca any time to discover how connected care can help you.

otn HUB

Ontario

OTN is a not-for-profit organization funded by the Ontario Government

附件四

NOVEMBER 2015

HOW CCACs CARE:

AN UPDATE ON QUALITY IMPROVEMENT FOR PATIENTS

oaccac
Ontario Association of Community Care Access Centres

acasco
Association des Centres d'accès aux soins communautaires de l'Ontario

ccac
Community Care Access Centre

casc
Centre d'accès aux soins communautaires

How CCACs care:
An update on quality improvement for patients

Updated November 2015

It is clear that the Ontario government puts home and community care as the cornerstone of its vision for providing care to patients.

Community Care Access Centres (CCACs) are serving more patients year-over-year and continue to focus on providing better care and value for Ontario's patients and families. In addition to increasing access to services, CCACs work together to give Ontarians the information they want and need. CCACs also strive to continuously improve the quality and consistency of home and community care across the province.

CCACs BY THE NUMBERS

CCACs SERVED MORE THAN 713,000 PEOPLE ACROSS ONTARIO IN 2014/2015 BY:

PROVIDING CARE AT HOME TO 580,000 PATIENTS

SUPPORTING 359,000 SENIORS, ENABLING THEM TO STAY IN THEIR HOMES INDEPENDENTLY

ENSURING 96,000 CHILDREN RECEIVED HEALTH SERVICES AT SCHOOL

SUPPORTING 28,000 PEOPLE THROUGH THEIR END-OF-LIFE EXPERIENCE WITH CARE AT HOME

HELPING 27,000 PEOPLE TRANSITION TO A LONG-TERM CARE HOME

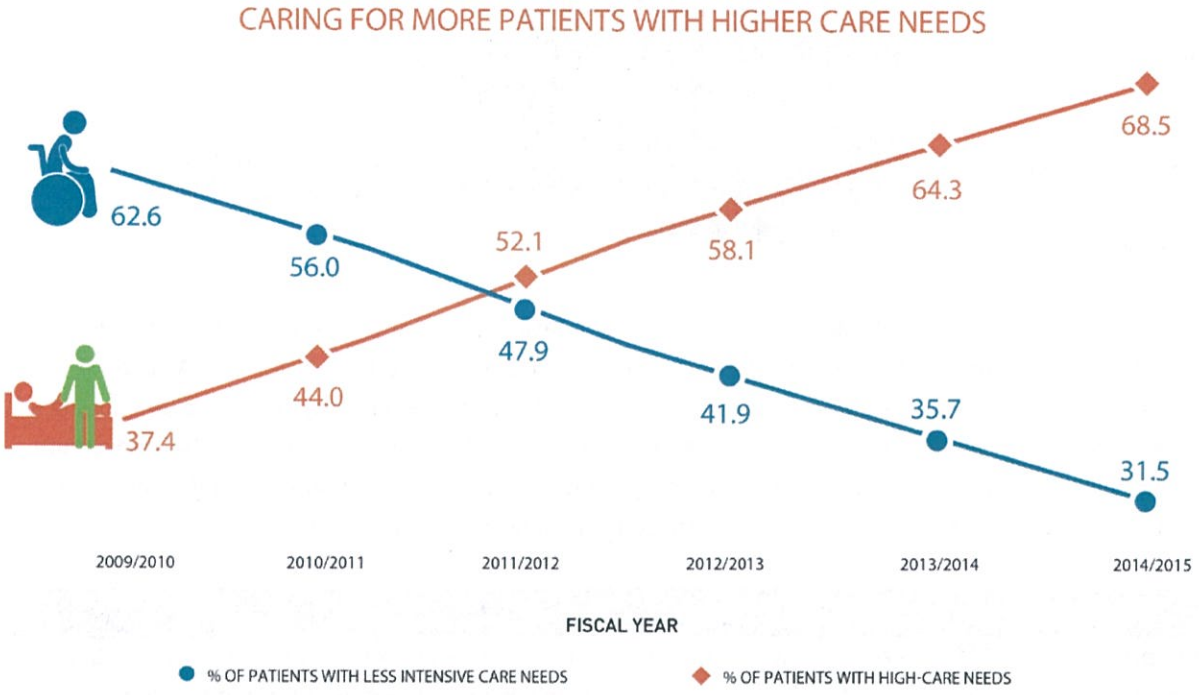
SUPPORTING AN AVERAGE OF 4,000 PEOPLE DISCHARGED FROM HOSPITAL PER WEEK WITH CCAC CARE

CONNECTING PATIENTS AND CAREGIVERS TO LOCAL HEALTH AND COMMUNITY SERVICES THROUGH 5.2 MILLION USER SESSIONS ON THEHEALTHLINE.CA

MAKING THOUSANDS OF REFERRALS EACH DAY TO OTHER COMMUNITY SUPPORT SERVICES TO ENSURE PEOPLE HAVE THE SUPPORT THEY NEED TO LIVE INDEPENDENTLY

Caring for those who need the most support

CCACs are caring for more and more people with multiple chronic and complex health issues – the number of patients with higher needs has increased by 83 per cent since 2009/2010.



Helping patients stay in their homes longer

Personal Support Workers (PSWs) play a vital role in helping people do the things they can no longer do on their own and to continue living in their own homes for as long as possible. Each year, CCACs are providing more personal support services to people in communities across Ontario.

Listening to what matters most to patients

CCACs regularly seek feedback from patients and their families to help improve quality of care.

This feedback helps CCACs learn which services need to improve.

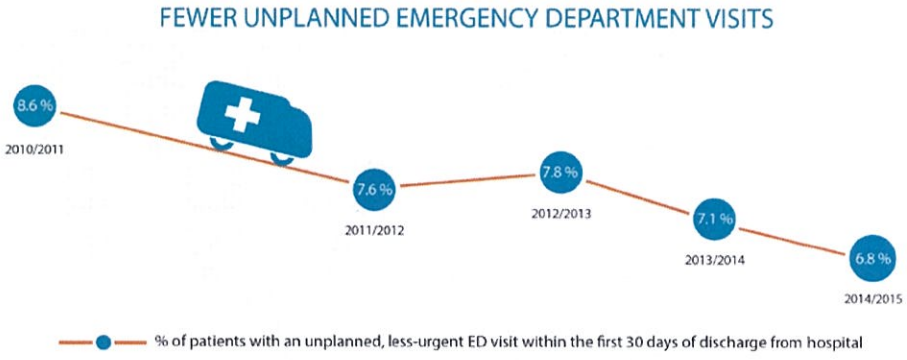
This year, CCACs were asked to look for ways to make it easier for patients when they move between two different locations where they receive care — like from a hospital to their home. CCACs are responding. In partnership with hospitals and the Ontario Hospital Association, CCACs are developing a guide that supports shared planning and improved patient transitions from hospitals to the community. In addition, as of January 2015, all CCACs are using a common protocol to support patients who move from one CCAC to another to make sure that these transitions happen smoothly.

Sharing information about quality

On April 1, 2014, CCACs began publicly posting their annual Quality Improvement Plans (QIPs) online and one year later, began reporting on their progress in achieving the targets set out in those plans. The QIP is one tool to help CCACs define and share their organization's quality improvement priorities. All CCACs report on a core set of quality-based indicators that support the Ontario government's health priorities. QIPs include measures and targets for improving patient safety, access and patient experience. CCACs use these measures to guide their ongoing efforts to improve the care patients receive.

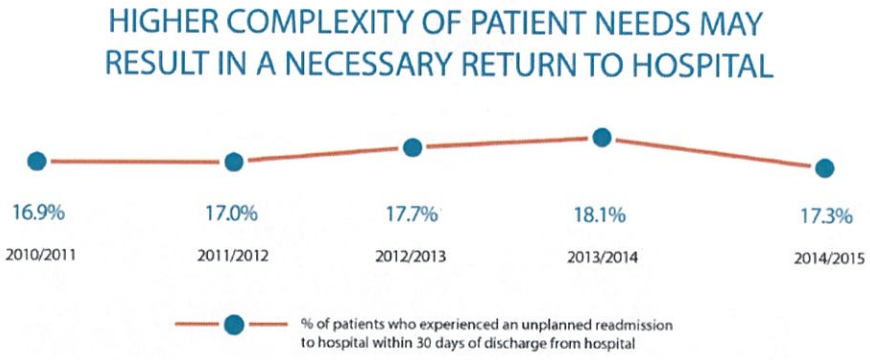
Keeping patients safe and at home

CCACs believe safety for patients at home is a top priority and are always working to ensure patients are as safe as possible. One way CCACs measure safety is by tracking patients' visits to hospital emergency departments, particularly visits that could have been prevented. CCACs continue efforts to reduce these unplanned emergency department visits.

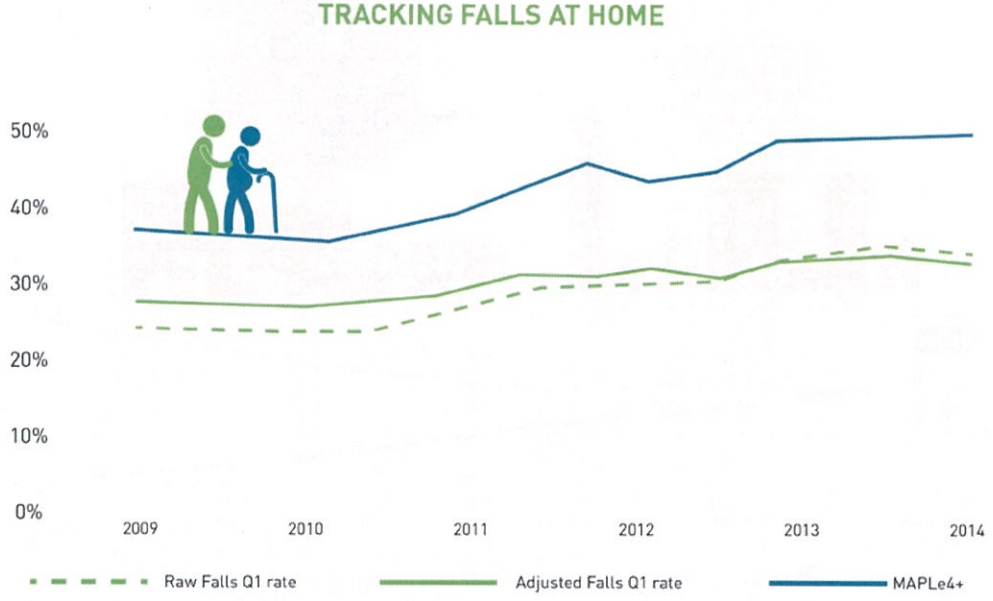


Patients with unstable, chronic health conditions, who have recently been in a hospital, are more likely to have to return there.

CCACs are serving more patients who have high health-care needs, so they are caring for more people who have to return to hospital. Their goal is to help people stay home, so CCACs are providing higher levels of immediate access to in-home care when patients are discharged from hospital. CCAC Rapid Response Nurses are now caring for patients within the first 24 hours after they return home. These nurses also ensure patients visit their family physician within the first seven days following discharge.



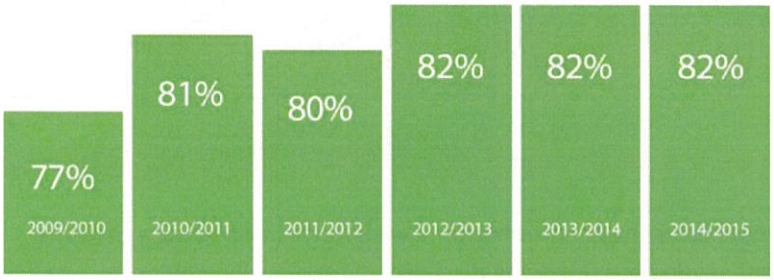
Tracking safety risks *in the home* – such as falls – is an important factor for improving the quality of patient care. By tracking falls at home and other safety information, CCACs gain a better understanding of the reasons behind an increase or decrease in overall safety, and can develop more effective prevention programs, targeted more effectively at the portion of the patient population most at risk. There is work to be done, but we have been having some success. As the graph below shows, the rate of falls among our patient population is slightly lower than experience would lead us to expect, given the growing portion of the patient population with higher care needs and more complex health issues.



Providing care in the right place

ENSURING PATIENTS IN LONG-TERM CARE NEED TO BE THERE

PERCENTAGE OF PATIENTS WITH HIGH-CARE NEEDS PLACED (%)

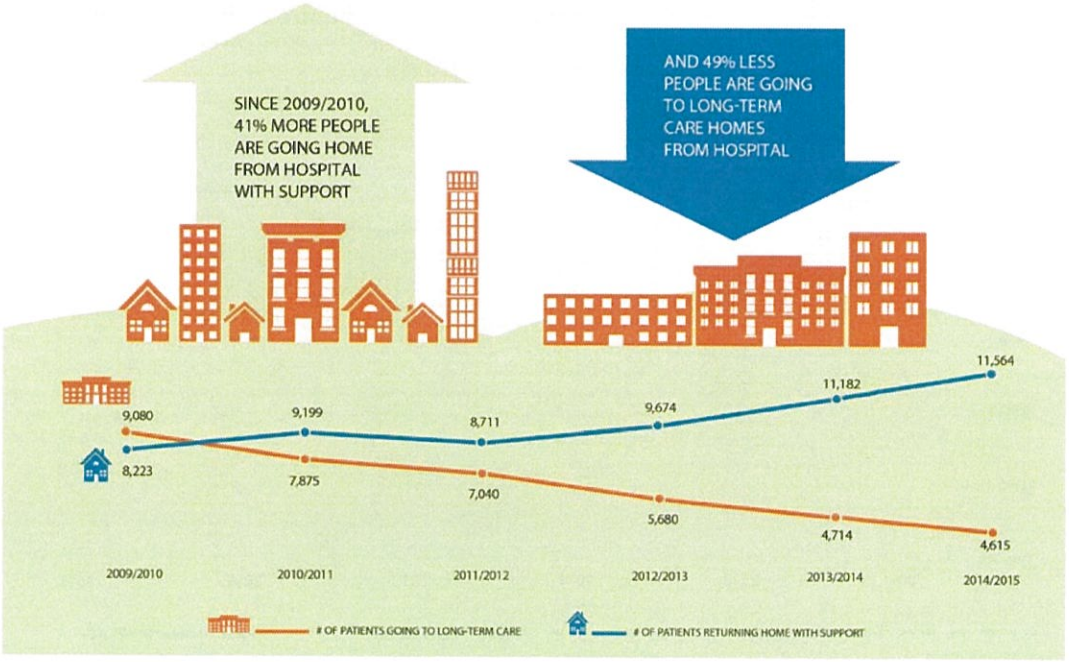


By caring for more patients with high-care needs at home, CCACs are ensuring people stay in their homes longer, which helps free up long-term care beds for those who need them the most.

Currently, 82% of patients in long-term care beds have high or very high needs.

CCACs have increased the number of patients whom they help to go *home* from hospital with supports in place, rather than stay in hospital longer or go to other institutions. This increase in service volumes has helped reduce the pressure on long-term care homes and hospitals.

PROVIDING THE CARE AND SUPPORT THAT PATIENTS NEED TO STAY AT HOME



Providing care to patients who need it most – first

Access to care is an important measure of home care quality. When assessing patient-care needs, CCAC Care Coordinators must prioritize people whose care needs are urgent. The Ministry of Health and Long-Term Care has emphasized the need to reduce wait times for patients with the greatest needs. That is why it has implemented a five-day wait time target for all nursing visits and personal support visits for patients with high needs.

IN 2014/2015

94%

OF PATIENTS RECEIVED THEIR FIRST NURSING VISIT WITHIN 5 DAYS

85%

OF COMPLEX PATIENTS RECEIVED THEIR FIRST PERSONAL SUPPORT SERVICE WITHIN 5 DAYS

Meeting Emerging Needs:
Providing the support people need at end-of-life

With the support of nursing visits, personal support services, therapy, social works, nutrition and respite care, CCACs helped more than 28,000 people through their end-of-life experience with care at home.

Studies suggest that 70 to 80 per cent of people would prefer to die at home, if supports were available, yet 66 per cent of Ontarians die in hospitals. CCACs support patients, their families and caregivers at each phase of their care journey. Building on the strong foundation of current CCAC hospice palliative care programs and services, CCACs are working together to develop a hospice palliative care action plan that identifies high-value, high-impact practices and opportunities to improve care across the province.

Supporting some of Ontario's most vulnerable patient populations

CCACs continue to care for more vulnerable patients: their health needs are more involved and the interventions and support they need are more complex than ever before. To address that need, CCACs are providing direct nursing care to the most vulnerable patients: students with mental health or addiction issues, frail seniors and adults, children with complex, serious illnesses as well as patients who need end-of-life care. CCACs' expertise working in different care settings – home, schools, hospitals and primary care – ensured these nursing roles are integrated within their unique settings.

In 2013, these programs were launched in all 14 CCACs. CCACs have been recruiting nurses who have the right expertise for providing this kind of care and the right kind of experience to help launch the programs. While it took longer than expected to find the right people, the majority of these nursing roles are now filled and the valuable care and support they provide are achieving results.

Rapid Response Nurses – These nurses reduce re-hospitalization and avoidable emergency department visits by improving the quality of transitions from acute care to home care for high-risk and medically complex children, seniors and frail adults. CCACs recognize that there is opportunity for improvement in the number of visits by rapid response nurses and are working to increase the number by up to 50% over time.

OVER 32,800 FACE-TO-FACE AND PHONE VISITS COMPLETED IN 2013/2014, AND

12 PERCENT

MORE VISITS IN 2014/2015.

*86 per cent of Rapid Response Nurses hired

Mental Health and Addictions Nurses (MHAN) – A strong relationship with the district school boards was necessary as these nurses help educators learn how to recognize students with mental health and addiction issues and provide early nursing interventions and support for students within the school setting. The program has demonstrated early wins by improving students' experiences with moving through the mental health system, decreasing hospital admission rates and increasing school attendance.

OVER 35,000 FACE-TO-FACE AND PHONE VISITS COMPLETED IN 2013/2014, AND

27 PERCENT

MORE VISITS IN 2014/2015.

*81 per cent of Mental Health and Addictions Nurses hired

OVER 21,000 FACE-TO-FACE AND PHONE VISITS COMPLETED IN 2013/2014, AND

44 PERCENT

MORE VISITS IN 2014/2015.

*87 per cent of Hospice Palliative Care Nurse Practitioners hired

Hospice Palliative Care Nurse Practitioners – Supporting people to die at home or in their place of choice, these nurses work collaboratively with patients, families and other care providers. They work in acute, hospice and primary care settings to reduce hospitalization and avoidable emergency department visits for patients who need hospice palliative care, by enhancing quality of care through combining therapies to comfort and support patients and their families and to better manage pain and symptoms.

2015/2016 Goals to improve patient care

Recently, the home and community care sector has been the focus of academic and government assessment and action-planning. CCACs welcome and support improvement initiatives and are together setting goals and targets for their delivery of outstanding care.

Providing the right information to help people make important decisions about their care

Access to timely and appropriate care is important to patients and caregivers, and is a measure of the quality of health care that a person receives. CCAC Care Coordinators assess a person's care needs to determine which, and how urgently, services are needed. Patients who need care urgently will get the care they need right away, while people with less urgent or less complex care needs may wait for their services to start or be connected with a community resource.

Publicly posting home care waitlist information provides people with the tools they need to make important decisions about their care.

2015/2016 Quality Goal: *By September 1, 2015, all CCACs will publicly post their waitlists for services, including nursing services, personal support services, physiotherapy, occupational therapy, speech and language pathology, nutrition and social work. Waitlist information will be updated monthly.*

Status: Complete

Working together with primary care to provide a seamless experience for patients

Working together and communicating effectively with primary care are essential for responding to the increasing needs of patients with complex conditions and their caregivers. Improved communication helps deliver a seamless care experience and meet the ongoing needs that patients have. CCACs are also making sure that primary care providers have the information they need so they can easily identify their contact at their local CCAC when they need more information about their patients. Together, we're delivering better coordinated and integrated care in the community, closer to home.

CCACs are building meaningful relationships with primary care providers. In addition, the expansion of Ontario's Health Links offers new structures that encourage greater collaboration between existing local health care providers.

CCACs are measuring this collaboration by tracking Care Coordinator connections with Family Health Teams, Community Health Centres, and primary care practitioners. A connection is made when the

primary care provider knows the name of the Care Coordinator and there is an understanding between them that they are working together and sharing in the care of their patients.

As of December 2014, the current connection rates are 72 per cent for Family Health Teams and 54 per cent for Community Health Centres, as reported provincially; and 45 per cent for primary care practitioners, as reported by seven CCACs.

2015/2016 Quality Goal: *By March 2016, CCACs will report the connection rate of CCAC Care Coordinators with all local Family Health Teams, Community Health Centres and primary care practitioners and demonstrate improvement over time.*

Status: Pending

Helping people understand what they can expect from their home care services

CCACs are making sure the right information is available to help Ontario's families understand their options and support them in making well-informed decisions about their care. CCACs are working toward clearly outlining what people can expect from their home care experience, including describing how the CCAC assessment process helps to determine eligibility for a range of home-based services.

2015/2016 Quality Goal: *By April 1, 2016, CCACs will publish the information used to determine the home care services patients receive.*

Status: Pending

Supporting patients better as they move between CCACs

Since January 2015, all CCACs have consistent protocols and practices to support patient transitions between CCACs, and the process for patients transferring from one CCAC to another is the same across the province. CCACs will continue enhancing these provincial guidelines, and are committed to improving the tracking of information about patients transitioning between CCACs, so that their experience can be better monitored and improved.

2015/2016 Quality Goal: *By April 2016, CCACs will be able to report on the success of provincial principles, protocols and practices and use the information as a basis for improving the experience of patients transitioning between CCACs.*

Status: Pending

ccac Community Care Access Centre

casc Centre d'accès aux soins communautaires

Ontario's 14 Community Care Access Centres (CCACs) get people the care they need in their homes and communities across the province. CCACs provide a single point of access to a wide range of home and community services, enabling people to get the specialized blend of the health-care services they need, when they need it.

www.healthcareathome.ca
310-2222 (CCAC) English
310-2272 (CASC) French

附件五

Connecting you with care
Votre lien aux soins
South West CCAC / CASC
Community Care Access Centre — Centre d'accès aux soins communautaires du Sud-Ouest

This is an **Interactive PDF Form**. You have the option of filling in this form electronically. Using the "TAB" key, move through the form OR put your cursor on the line or box you wish to complete. Type your data OR use your left mouse click to fill in check boxes. You do not need to fill in every line. When you are through, you can save a copy for your records (*File + Save as)* or print.

www.sw.ccac-ont.ca

***Site Office*:**
London (Head Office)
Owen Sound **Seaforth**
Stratford **St. Thomas**
Walkerton **Woodstock**

DETERMINATION OF ELIGIBILITY FOR ADMISSION TO A LTC HOME, PLACEMENT SERVICES

NAME OF CLIENT: _____ **HCN:** _____ **VERSION CODE:**_____

Applicant must meet ALL of the Below:	**YES**	**NO**
Applicant is 18 years of age or over	☐	☐
Applicant is insured under the Health Insurance Act	☐	☐
Applicant's care requirements can be met in LTCH	☐	☐
Eligibility Criteria *Applicant must meet One of: (check most relevant criteria)*		
Applicant requires that nursing care be available on-site 24 hours per day	☐	☐
Applicant requires assistance, at frequent intervals throughout the day, with activities of daily living	☐	☐
Applicant requires on-site supervision or monitoring at frequent intervals throughout the day to ensure his or her safety or well-being	☐	☐
Applicant does not meet care need requirements for LTC but is eligible. (Must check Spousal/Partner or Veteran see **Long-Stay Applications** below)	☐	☐
Long-Stay Applications *Applicant must meet One of (check most relevant criteria):*		
None of the publicly funded, community-based services available to the applicant and the other caregiving, support or companionship arrangements available to the person is sufficient, in any combination, to meet the person's requirements	☐	☐
Applicant does not meet care need requirements for LTC but wishes to reside in a long-term care home with spousal/partner	☐	☐
Applicant does not require long-term care services but is a Veteran	☐	☐
Short Stay Interim Care		
Applicant must be a hospital resident to apply; and	☐	☐
Applicant is eligible for Long-Term Care	☐	☐
Short Stay Respite Care *Applicant must meet both:*		
Applicant's caregiver requires temporary relief from his/her caregiving activities or requires temporary care in order to continue to reside in the community and is likely to benefit from a short stay in the home; and	☐	☐
It is anticipated that applicant will be returning to his/her residence within 60 days after admission.	☐	☐
Short Stay Convalescent Care *Applicant must meet Both of:*		
The applicant requires a period of time in which to recover strength, endurance or functioning and is likely to benefit from a short stay, and	☐	☐
It is anticipated that applicant will be returning to his/her residence within 90 days after admission.	☐	☐

RAI-HC Needs Assessment Score = _____

Date of RAI-HC Assessment:_____

RAI-Needs Legend

Low Need	=	**0 to 7**
Moderate Need	=	**8 to 10**
High Need	=	**11 to 15**
Very High Need	=	**16+**

MAPLe Score:
(PLEASE CHECK ONLY ONE)

- ☐ **(1) LOW**
- ☐ **(2) MILD**
- ☐ **(3) MODERATE**
- ☐ **(4) HIGH**
- ☐ **(5) VERY HIGH**

HAS CAREGIVER BURDEN

- ☐ **YES**
- ☐ **NO**

☐ DETERMINED **ELIGIBLE** for LTC Home Placement
(Day/Month/Year) _____

- ☐ **Long-Stay**
- ☐ **Short-Stay**
  - ☐ Convalescent Care
  - ☐ Interim Care
  - ☐ Respite Care

☐ DETERMINED **INELIGIBLE** for LTC Home Placement
(Day/Month/Year) _____

- ☐ **Long-Stay**
- ☐ **Short-Stay**
  - ☐ Convalescent Care
  - ☐ Interim Care
  - ☐ Respite Care

CM Signature & Position:

_____

Date Form Completed *(d/m/y)*:_____

附件六

The **Health** and **Social Services** System in **Québec**

In brief

15-731-02W

ENSEMBLE on fait avancer le Québec

Québec

Produced by
La Direction des communications
du ministère de la Santé et des Services sociaux

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Masculine pronouns are used generically in this document.

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Context

The health and social services system as we know it was created in 1971 following the adoption of the Act respecting health services and social services (chapter S-4.2) by the National Assembly of Québec.

Québec's system is a public system, with the government acting as the main insurer and administrator.

Insurance Plans

The population has access to hospital and medical services dispensed by the government through two universal plans:

- the Hospital Insurance Plan, introduced in 1961;
- and the Health Insurance Plan, introduced in 1970.

In addition, a number of services are available to specific groups free of charge, provided they meet certain criteria. These include dental services, vision-related services and devices that compensate for physical impairments.

Public health sector coverage for all Québecers was completed in 1997, with the introduction of the Public Prescription Drug Insurance Plan, a joint universal plan based on a partnership between the government and private insurers.

Lastly, individuals may subscribe to private plans offering additional insurance to pay for services and drugs not covered by the public plans.

Funding for services

Most of the funding for health and social services is taken from the general tax base, meaning that the risk can be spread more fairly throughout society. Most of the revenues are derived from the income taxes and other taxes charged by the Government of Québec and paid into the Consolidated Revenue Fund, from the contributions paid by individuals and employers into the Health Services Fund, and the Fund to Finance Health and Social Services Institutions and federal government transfers.

Health Expenditure

In 2012, total health expenditure[1] in Québec roughly totalled $43.5 billion. This includes both public expenses (including direct expenses covered by the federal government for the clienteles under its responsibility) and private expenses (amounts claimed from private insurance plans, direct payments – such as contributions to accommodation (CHSLD) and for the purchase of drugs – made by individuals, donations, etc.). Public health expenditure, which rose to $30.5 billion in 2012, accounted for 70.2% of the total.

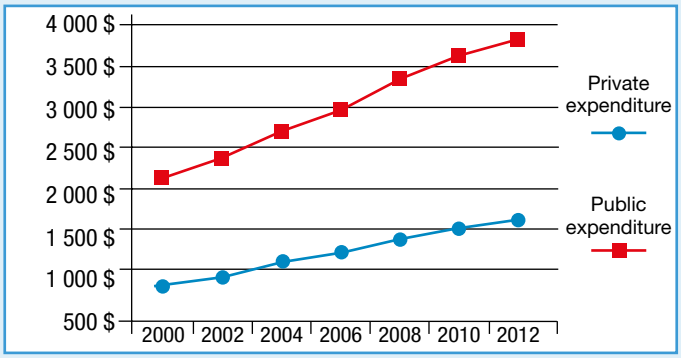
Comparative Health Expenditure, Québec and Canada, 2012

Expenditure	Québec	Canada**
Total health expenditure per capita*	$5,375	$5,911
Total health expenditure as a percentage of gross domestic product (GDP))	12,1 %	11,3 %
Public expenditure as a percentage of total health expenditure	70,2 %	70,6 %
Public health expenditure per capita*	$3,773	$4,175

* Data illustrated above are in current dollars.
** Including health expenditure in Québec.
Source: Canadian Institute for Health Information.

Between 2000 and 2012, public and private health expenditure grew annually by an average of 4.9 % and 5.8 % respectively.

Public and Private Health Expenditure per Inhabitant, in current dollars, Québec, 2000 to 2012



Source: Canadian Institute for Health Information.

1 Social services expenditure is not included in the estimates of the Canadian Institute for Health Information. It accounts for roughly 12% of total health and social services expenditure of the Government of Québec.

The Health and Well-Being of Québec's Population

The population's life expectancy at birth has risen since the 1920s, reaching 82.2 years in 2013.

Lifestyles have improved over recent years. However, in 2013, more than 50% of Québecers consumed fewer than five portions of fruit and vegetables a day. In 2011-2012, 22% of adults had a sedentary lifestyle and only 44% of adolescents were active during leisure time and engaged in active transport. The percentage of obese adults also increased from 11% to 18% between 1994 and 2013. Moreover, Québec has one of the highest percentages of smokers among the provinces of Canada.

An overwhelming percentage of the population describes themselves as being in good physical and mental health. Another positive sign is that, since the early 2000s, Québec's suicide rate has decreased, particularly among young men and adolescents.

In Québec, as in most industrialized countries, the increased prevalence of chronic disease and disability as well as the anticipation of greater needs related to long-term care are placing significant pressure on the health and social services system. Nearly half the population aged 15 or over reported at least one chronic health problem in 2010-2011. Today, 24% of Québecers aged 20 or over have high blood pressure, and 9% are diabetic (2012-2013).

The prevalence of cardiac disease and cancer is also increasing. Since 2000, cancer has been the leading cause of death despite an improvement in the survival rate five years after diagnosis. More than half of all new cancer cases involve prostate cancer, lung cancer, breast cancer or colorectal cancer. Alzheimer's disease and other types of dementia are also on the rise.

In 2010-2011, roughly 11% of the population, of all ages, had a moderate to severe disability.

This prevalence nevertheless increases with age. The disability rate among children has been increasing in Québec since 2001.

Québec's population is also ageing rapidly. The percentage of people aged 65 or over, which was between 12% and 13% in the late 1990s, will double to 25% by 2031. Only in Japan is the population ageing more quickly than in Québec.

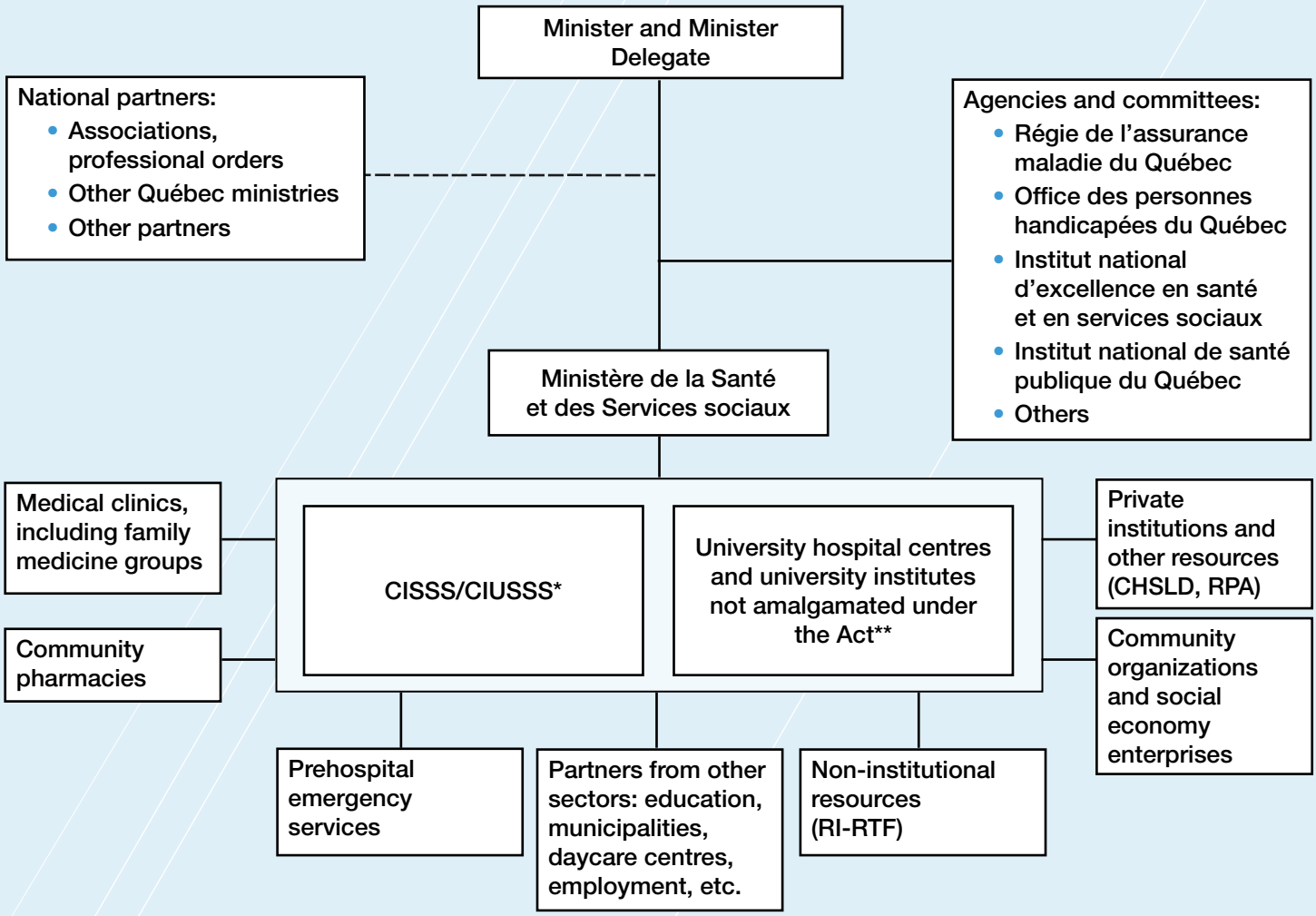
In addition to the pressure it places on the demand for health services and social services, this trend means that the supply must be adjusted to respond more effectively to the changing needs of people suffering from chronic diseases, cognitive disorders or disabilities in daily life.

In 2011-2012, 12% of the population were affected by diagnosed mental disorders.

A number of behavioral and social problems among Québec's population continue to be a challenge, such as problems related to alcohol, drug or gambling issues or dependency.

Lastly, despite gains made in recent years, health-related social inequalities still persist. These inequalities, which are related to poverty and other conditions, result among other things in a lower life expectancy and higher rates of chronic disease, drug and alcohol dependency and youth protection interventions.

Structure of the Health and Social Services System



* Nine of the 22 integrated centres can use the "integrated university health and social services centre" designation in their name.

** The following seven non-amalgamated institutions are attached to the Ministère and provide specialized and highly specialized services beyond their health region border : CHU de Québec - Université Laval; Institut universitaire de cardiologie et de pneumologie de Québec - Université Laval; Centre hospitalier de l'Université de Montréal; McGill University Health Centre; Centre hospitalier universitaire Sainte-Justine; Montreal Heart Institute; Institut Philippe-Pinel de Montréal.

In addition, five public institutions, not covered by the Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies (CQLR, chapter O-7.2), offer services to a northern and aboriginal population. They are not shown in the above illustration.

Abbreviations

- **CHSLD**: residential and long-term care centre
- **CISSS**: integrated health and social services centre
- **CIUSSS**: integrated university health and social services centre
- **"Act"**: An Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies
- **RI/RTF**: intermediate and family-type resource
- **RPA**: private residence for seniors

Main Roles and Responsibilities

The Québec health and social services system is comprised of two management levels and an integrated model of health and social services. Health and social services agencies were abolished when the Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies (CQLR, chapter O-7.2), came into force on April 1, 2015.

The functions and responsibilities of those agencies have been reassigned in part to the Ministère de la Santé et des Services sociaux (MSSS) and in part to new institutions that were created through the amalgamation of public institutions in a given region and its regional agency. These institutions are known either as integrated health and social services centres or integrated university health and social services centres. Integrated centres located in health regions where a university offers a complete undergraduate medical program or operates a centre that is designated as a university institute in the social field are called integrated university health and social services centres.

In health regions with more than one integrated centre (Montréal, Gaspésie—Îles-de-la-Madeleine and Montérégie), the previous agency has been amalgamated into only one of the new institutions.

Responsibilities of the Ministère de la Santé et des Services sociaux

- Regulate and coordinate the entire health and social services system;
- Determine health and welfare policy directions and standards that apply to service organization and human, material and financial resource management within the network, and ensure their application;
- Fulfill national public health functions (monitoring of population health; promotion of health and well-being; prevention of diseases, psychosocial problems and traumas; and health protection);
- Ensure interregional coordination of services;
- Ensure that inter-institutional service reference and coordination mechanisms are in place and functional;
- Divide financial, human and material resources fairly and monitor their use;
- Assess, for the entire network, results obtained compared to the goals set in order to improve system performance.

Responsibilities assigned to all health and social services institutions

- Provide quality health and social services that are accessible, ongoing, safe and respectful of individual rights;
- Ensure that users' rights are respected and complaints diligently treated;
- Distribute fairly the human, material and financial resources placed at their disposal, taking into account the characteristics of the population they serve, and ensure their economic and efficient use;
- Conduct teaching, research and assessment of intervention technologies and methods when the institution has a university mission;
- Take charge of monitoring and accountability to the MSSS, based on the latter's expectations.

Special responsibilities for integrated centres

- Ensure that the population participates in network management;
- Plan and coordinate services to be provided to the population within their territory in accordance with ministerial policy directions, the needs of the population and territorial realities;
- Put in place measures aimed at the protection of public health and the social protection of individuals, families and groups;
- Ensure availability of services for the whole population of their territory, with special attention to the most vulnerable;
- Establish any required regional or interregional service corridors and sign agreements with the institutions and other partners in their territorial service network so as to meet the needs of the population;
- Ensure the development and proper functioning of the local service networks within their territory;
- Subsidize community organizations and allocate funding to required private resources.

All integrated centres have identical functions and responsibilities, whether or not they have university designation. However, the composition of the boards of directors of integrated university health and social services centres is different, since two board members are appointed based on a list of names provided by the universities.

The Ministère and its Partners

The mission of the Ministère de la Santé et des Services sociaux (MSSS) and the health and social services network is to maintain, improve and restore the population's health and well-being by providing access to a range of integrated and quality health and social services and thereby, contributing to the social and economic development of Québec.

Here is the list of laws whose application falls under partial or complete authority of the Minister of Health and Social Services (**Appendice 1**).

Several agencies and other entities related field of health and social services are under the authority of the Minister.

These include:

- L'Institut national d'excellence en santé et en services sociaux;
- Héma-Québec;
- L'Institut national de santé publique du Québec;
- L'Office des personnes handicapées du Québec;
- La Régie de l'assurance maladie du Québec.

Québec Health Regions

The Ministry implements its mission by sharing its responsibilities with health facilities and social services in 18 regions health and social.

(View the map of health regions Québec in appendice 2)

Health and Social Services Institutions

Health and Social Services Institutions provide general and specialized services to the population that correspond to the five major missions defined in the Act Respecting Health Services and Social Services (CQLR, chapter S-4.2) and vary according to whether they are a:

- Local community service centre (CLSC);
- Hospital centre (CH);
- Residential and long-term care centre (CHSLD);
- Child and Youth protection centre (CPEJ);
- Rehabilitation centre (CR).

In Québec, institutions may carry out more than one mission. Thus, integrated health and social services centres and integrated university health and social services centres may operate one or more of the following: CLSC, CHSLD, CH, CPEJ or CR. Such mission groupings are aimed at improving the integration of services.

Local Community Service Centre

The mission of the local community service centre (CLSC) is to provide, to the population of its territory, frontline common health and social services, as well as preventive, curative, rehabilitative and/or reinsertion services and carry out public health activities. Integrated centres that assume this mission must ensure that persons needing such services for themselves or their loved ones are contacted, that their needs are evaluated and that the required services are provided at their sites or in the living environments of these individuals, meaning at school, at work or at home. If needed, the centres will ensure that they are directed to the centres, organisations or persons most likely to help them.

Hospital Centre

The mission of the hospital centre (CH) is to provide diagnostic services, as well as general and specialized medical care. There are two categories of hospital centres:

- General and specialized hospital centres;
- Psychiatric care hospital centres.

Residential and Long-term Care Centre

The mission of the residential and long-term care centre (CHSLD) is to provide temporary or permanent lodging, assistance, support and monitoring, as well as psychosocial, nursing, pharmaceutical, medical and rehabilitation services to adults who, because of their loss of functional and/or psychosocial autonomy, are no longer able to remain in their natural living environments.

Child and Youth Protection Centre

The mission of the child and youth protection centre (CPEJ) is to provide psychosocial services (including emergency social services) to youths who need them in situations defined by the Youth Protection Act (CQLR, chapter P-34.1) and the Youth Criminal Justice Act (SC 2002, chapter 1). This mission also covers child placement, family mediation, Superior Court child custody expertise, adoption and research of the biological family history.

Rehabilitation Centre

The mission of the rehabilitation centre (CR) is to provide adaptation and/or rehabilitation and social integration services to individuals that require them due to physical or intellectual disabilities, behavioural, psychosocial or family problems, dependency on alcohol, drug, or gambling issues, as well as any other form of dependency. Rehabilitation centres are also required to provide coaching and support for the immediate family of the people it serves.

Rehabilitation centres belong to one or more of the following categories, depending on their clientele:

- Rehabilitation centres for individuals with an intellectual disability or pervasive developmental disorder;
- Rehabilitation centres for individuals with a physical disability (hearing, sight, motor or speech);
- Rehabilitation centres for individuals with a dependency;
- Rehabilitation centres for youths in trouble of adaptation;
- Rehabilitation centre for mothers in trouble of adaptation.

Breakdown by types of institutions

Since the Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies came into force on April 1, 2015, the Québec health and social services network includes the following:

- Twenty-two integrated health and social services centres, nine of which are designated as university health and social services integrated centres. Only integrated centres located in a health region where a university offers a complete undergraduate medical program or operates a university institute in the social field are entitled to use the wording “integrated university health and social services centre” in their title;
- Seven institutions that were not amalgamated with an integrated centre of which four are university hospital centres (CHU) and three are university institutes (IU);
- Five institutions not covered by the Act offering services to an Aboriginal and northern population.

Each institution may offer services in several sites that are physical locations where health and social services are provided.

It should be noted that 17 institutions that were not amalgamated under the Act have been grouped into integrated centres, and are managed by the centre’s board of directors.

In addition to the services provided by public institutions, the population benefits from services such as lodging and long-term care that are provided by private institutions.

Moreover, four integrated university health networks (RUIS) promote collaboration and complementarity, and fulfill the combined mission of care, teaching and research that is incumbent upon the health institutions and the universities with which they are affiliated. These are the Université Laval, McGill University, Université de Montréal and Université de Sherbrooke integrated university health networks.

Partners of the system

In addition to institutional resources, the following partners contribute to the success of Québec's health and social services mission:

- General practitioners and specialists;
- Community-based pharmacists;
- Prehospital emergency services;
- Community organizations;
- Social economy enterprises for in-home support services;
- Intermediate and family-type resources;
- Private residences for seniors.

General practitioners and specialists

Although general practitioners and specialists are self-employed, an overwhelming majority of these physicians work exclusively within the public system, which has always been able to form partnerships with them.

The Régie de l'assurance maladie du Québec (RAMQ) is responsible for remunerating doctors that practice in the public system. New remuneration practices were introduced in 1999, but fee-for-service payment remains the principal method of remuneration for these health professionals.

Description of medicine groups

Among the various types of practice, family medicine groups (GMF), is favoured by Québec as a way of improving access to a family doctor for all citizens; and network clinics as well.

Family medicine groups

A family medicine group is defined as an organization of family doctors working as a group in close collaboration with nurses and other health professionals from the public network. These groups provide frontline medical services, with or without appointments, at its clinic or in patients' homes during weekday, weekend and holiday business hours. Registering with a family doctor who is a member of a family medicine group is voluntary and free of charge.

Network Clinics

Network clinics are designed on an organizational model that promotes access to frontline medical services.

Complementary to family medicine groups, network clinics provide access to a broader spectrum of medical services that are available during longer hours of operation. As an example, setting up a direct service corridor with an integrated health and social services centre or integrated university health and social services centre improves the general practitioners' access to technical platforms and specialized care .

Community pharmacists

Around 70% of pharmacists work in community-based pharmacies and 33% of them has their own pharmacy. In Québec, only a pharmacist may own a pharmacy, which is a unique situation in Canada.

Community-based pharmacists ensure access to pharmaceutical services for patients that receive ambulatory health care.

The role of the pharmacist is to assess and ensure the appropriate use of medication, in order to prevent drug-related problems in particular; and prepare, store and deliver medication in order to maintain and/or restore health.

Modifications to the Pharmacy Act (CQLR, chapter P-10), on June 20, 2015, permits pharmacists to exercise new activities such as:

- Extend a prescription;
- Prescribe medication when a diagnosis is not required;
- Prescribe and interpret laboratory analysis;
- Adjust a prescription;
- Substitute a medication should there be a break in supply;
- Prescribe medication for minor conditions in cases where diagnosis and treatment are known;
- Administer medication in order to demonstrate appropriate use.

Data on the health and social services workforce

The health and social services workforce represents approximately 6.9 % of the Québec's active population. As of March 31, 2014, the network employed:

- 975 managers, professionals and public servants at the Ministère itself, as well as 1,702 at the Régie de l'assurance maladie du Québec (RAMQ);
- 268,127 managers or employees in the regional authorities or other health and social services agencies, as well as public or private institutions under agreement:
  - 191,295 persons allocated to service programs including 112,973 nurses, nursing assistants or orderlies and 58,341 technicians or health and social services professionals;
  - 76,832 persons allocated to support programs or members of the management staff.

In addition, in 2013-2014, 30,318 professionals were remunerated by the RAMQ, of which 8,710 were general practitioners, 9,779 were specialist physicians and 3,544 were medical residents.

The health and social services agencies were abolished on April 1, 2015, when the Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies (CQLR, chapter O-7.2) came into force. Part of their workforce was transferred in the new institutions and in the Ministère.

Prehospital emergency services

In addition to ambulance services, other steps have been taken to ensure the population of an efficient response to any emergency situation.

This is the case for 911 emergency services whose response is assured by the municipal or territorial emergency call centre, which in turn directs calls to the health communication centre (CCS) whenever ambulance services are needed. CCS medical emergency dispatchers determine the nature of the situation and very quickly contact ambulance services.

Ambulance service paramedics are responsible for evaluating the health status of patients, providing them with any necessary immediate care and transporting them to a hospital centre. Ambulance services in Québec are provided by private enterprises, cooperatives and Urgences-santé, which is a public sector enterprise covering the Montréal and Laval areas.

Community organizations

Subsidized community organizations are recognized by the Ministère and its institutions as independent partners of the health and social services system. Their main roles are:

- Providing prevention, assistance and support services that include temporary lodging;
- Conducting activities aimed to promote and defend the rights and interests of individuals that use health and/or social services;
- Promoting social development, improvement of living conditions and better health for the population of Québec;
- Meeting new needs by using innovative approaches or targeting specific groups of individuals.

Social economy enterprises for in-home support services

Social economy enterprises for in-home support services provide light and heavy housekeeping, wardrobe care, meal preparation, supplies and such to individuals with disabilities. The type of service is paid for in part by users based on their income, and in part by the government.

These partners also provide respite and monitoring services to family caregivers and personal assistance services for activities of daily living that require the help of a third party (washing, dressing, eating, etc.) or that relate to personal care, such as urinary and intestinal functions, measurement of vital signs and administration of medication. These services are complementary to the ones provided by the public sector.

Intermediate and family-type resources

Complementary to natural and institutional living environments, intermediate and family-type resources have their proper place within the range of Québec's health and social services. Their individualized response to a diversity of changing needs makes it possible for the individuals to foster and maintain social integration, participation and recovery within the community. They provide support and assistance services to individuals of all ages.

Acting in a spirit of partnership with the public institutions that ensure the professional monitoring of the individuals under their care, these resources complement the public institutional mission by providing quality health and social services to people who need them.

The main types of residential organization in intermediate resources are supervised apartments, rooming houses, shelters and group homes, while family-type resources include foster care for children and shelters for adults and the elderly.

Private residences for seniors

A new government regulation came into effect in 2013 in order to tighten up the certification process regarding private residences for seniors.

The use of the designation "private residence for seniors" is now dependant on receiving compliance certification. There are two categories of private residences, the first providing services to independent seniors and the second, providing services to semi-independent seniors. The government has established criteria and operational standards for each category in order to ensure quality of services and safety to the residents.

Territorial and local service networks

Territorial integration of health and social services is supported through area networks (RTS) designed to ensure both proximity and continuity of services.

Integrated health and social services centres or integrated university health and social services centres (integrated centre) are responsible for ensuring the development and proper functioning of all local health and social service networks that operate within its territorial service network.

Integrated centres and their partners share collective responsibility for providing integrated services that correspond to the needs of the population they serve, with a view to maintaining and/or improving health and welfare. In order to properly fulfill this population-based responsibility, they are required to provide comprehensive treatment and services in close proximity to the living environments of their clients. They are also required to ensure proper care and follow-up of their clients within the health and social services system. Among other principles, the model is based on service hierarchy, which facilitates complementarity of services and patient migration between frontline, secondary and tertiary services.

Integrated centres ensure the coordination of services provided by all partners in the network, which are the following:

- Medical clinics and family medicine groups (GMF);
- Community-based pharmacies;
- Community organizations;
- Social economy enterprises;
- Private institutions and other resources such as residential and long-term care centres (CHSLD) or private residences for seniors (RPA);
- Non-institutional intermediate and family-type resources;
- Unamalgamated university hospital centres

and institutes that provide specialized or highly specialized services to the population;

- If applicable, other integrated centres with supra regional mandates that provide specialized or highly specialized services to patients in the service network may be added in compliance with established service corridors, such as a hospital centre, a child and youth protection centre or a rehab centre;
- Partners from other sectors: schools, municipalities, employment, etc.

(Appendice 3)

Service and Support Programs

In Québec, the health and social services system is divided into service and support programs. This provides a framework for planning, budgeting, resource allocation and reporting.

There are currently nine service programs:

- Two designed to answer to general population needs:
  - **Public health,** that promote, prevent and protect health and well-being, and monitor general population health;
  - **General services–clinical and assistance activities,** which covers frontline care for health issues and temporary social problems.
- Seven service programs that deal with specific issues:
  - Support for independant seniors;
  - Physical disabilities, for impairments related to hearing, vision, language, speech and motor activities;
  - Intellectual impairments and autism spectrum disorder;
  - Youth with difficulties;
  - Dependencies such as alcoholism, drug addiction and compulsive gambling;
  - Mental health;
  - Physical health, which covers emergency services, specialized and highly specialized services, continuous services requiring systematic follow-up (for example, chronic disease, cancer, etc.), as well as palliative care.

The three support programs provide administrative and technical functions that support service programs. They are :

- Administration;
- Service support;
- Building and equipment management.

Appendice **1**

List of laws whose application falls under partial or complete authority of the Minister of Health and Social Services

An Act respecting clinical and research activities relating to assisted procreation (CQLR, chapter A-5.01)

Hospital Insurance Act (CQLR, chapter A-28)

Health Insurance Act (CQLR, chapter A-29)

An Act respecting prescription drug insurance (CQLR, chapter A-29.01)

An Act respecting Cree, Inuit and Naskapi Native persons. (CQLR, chapter A-33.1)

An Act to prevent skin cancer caused by artificial tanning (CQLR, chapter C-5.2)

Non-Catholic Cemeteries Act (CQLR, chapter C-17)

An Act respecting the Health and Welfare Commissioner (CQLR, chapter C-32.1.1)

An Act to provide for balanced budgets in the public health and social services network (CQLR, chapter E-12.0001)

An Act to secure handicapped persons in the exercise of their rights with a view to achieving social, school and workplace integration (CQLR, chapter E-20.1)

An Act to establish the Fund for the promotion of a healthy lifestyle (CQLR, chapter F-4.0021)

An Act respecting Héma-Québec and the biovigilance committee (CQLR, chapter H-1.1)

Burial Act (CQLR, chapter I-11)

An Act respecting the Institut national d'excellence en santé et en services sociaux (CQLR, chapter I-13.03)

An Act respecting Institut national de santé publique du Québec (CQLR, chapter I-13.1.1)

An Act respecting medical laboratories, organ and tissue conservation and the disposal of human bodies (CQLR, chapter L-0.2)

An Act to ensure that essential services are maintained in the health and social services sector (CQLR, chapter M-1.1

An Act respecting the Ministère de la Santé et des Services sociaux (CQLR, chapter M-19.2)

An Act to implement the Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption (CQLR, chapter M-35.1.3)

Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies, (CQLR, chapter O-7.2)

An Act respecting the sharing of certain health information (CQLR, chapter P-9.0001)

Youth Protection Act (CQLR, chapter P-34.1)

An An Act respecting the protection of persons whose mental state presents a danger to themselves or to others (CQLR, chapter P-38.001)

Tobacco-related Damages and Health Care Costs Recovery Act (CQLR, chapter R-2.2.0.0.1)

An Act respecting the Régie de l'assurance maladie du Québec (CQLR, chapter R-5))

An Act respecting the representation of family-type resources and certain intermediate resources and the negotiation process for their group agreements (CQLR, chapter R-24.0.2)

Public Health Act (CQLR, chapter S-2.2)

An Act respecting health services and social services (CQLR, chapter S-4.2)

An Act respecting health services and social services for Cree Native persons (CQLR, chapter S-5)

An Act respecting pre-hospital emergency services (CQLR, chapter S-6.2)

An Act respecting end-of-life care (CQLR, chapter S-32.0001

Tobacco Act (CQLR, chapter T-0.01)

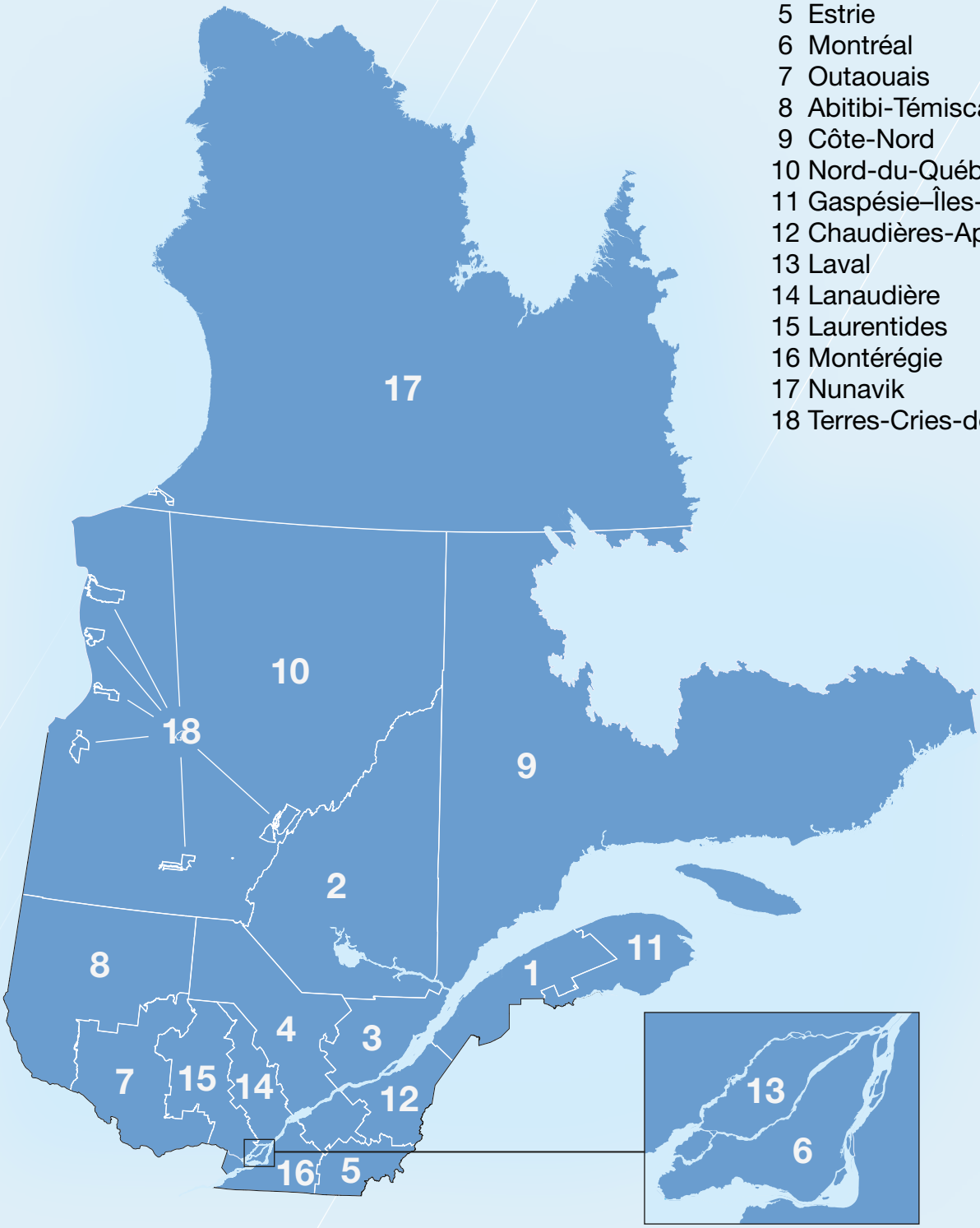
An Act respecting bargaining units in the social affairs sector (CQLR, chapter U-0.1)

Appendice **2**

The Ministère de la Santé et des Services sociaux fulfills its mission by sharing its responsibilities with health and social services institutions spread across 18 health regions. More than 60 % of the Québec population lives in the Montréal, Laval, Lanaudière, Laurentides and Montérégie regions.

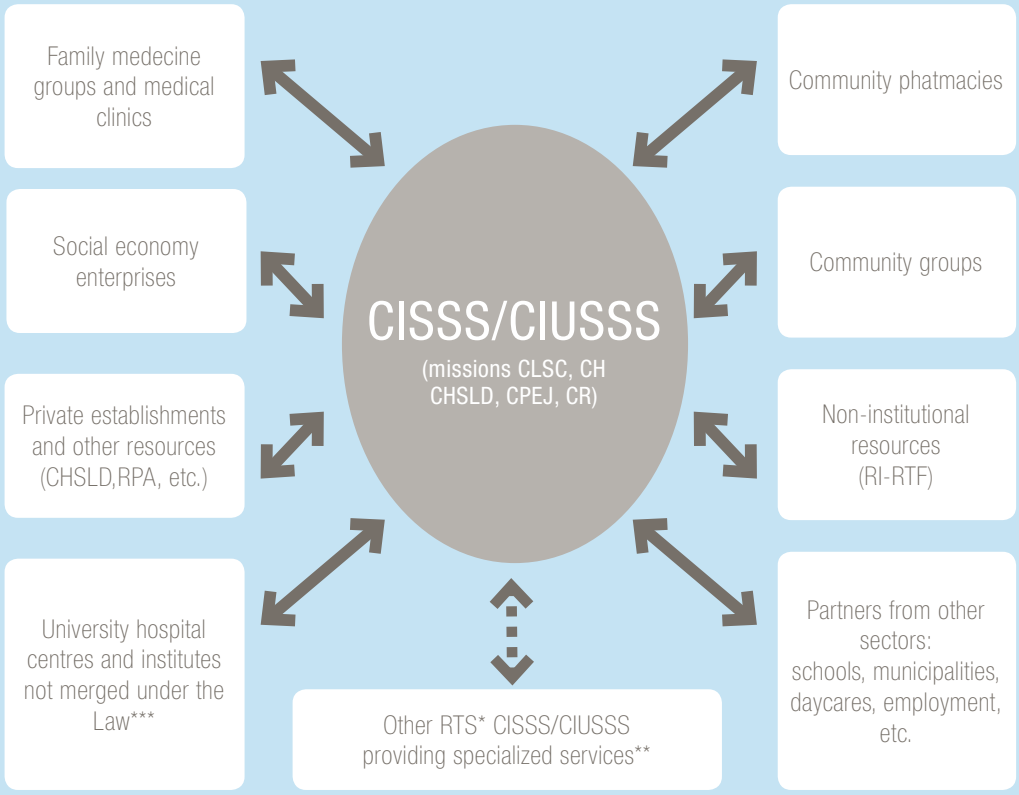
The Québec Health Regions

1 Bas-Saint-Laurent
2 Saguenay–Lac-Saint-Jean
3 Capitale-Nationale
4 Mauricie et Centre-du-Québec
5 Estrie
6 Montréal
7 Outaouais
8 Abitibi-Témiscamingue
9 Côte-Nord
10 Nord-du-Québec
11 Gaspésie–Îles-de-la-Madeleine
12 Chaudières-Appalaches
13 Laval
14 Lanaudière
15 Laurentides
16 Montérégie
17 Nunavik
18 Terres-Cries-de-la-Baie-James



Appendice **3**

MAIN ACTORS OF A TERRITORIAL OR LOCAL HEALTH AND SOCIAL SERVICES NETWORK*



* Any given RTS may include more than one RLS that uses identical categories and partners at the local level.
** The CISSS or CIUSSS must establish, if necessary, regional or interregional service corridors in order to complete the services provided to the population of their territory.
*** An Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies (CQLR, chapter O-7.2).

Abbreviations:

- CH: hospital centre
- CHSLD: residential and long-term care centre
- CISSS: integrated health and social services centre
- CIUSSS: integrated university health and social services centre
- CLSC: local community service centre
- CPEJ: child and youth protection centre
- CR: rehabilitation centre
- GMF: family medicine group
- RI/RTF: intermediate and family-type resource
- RPA: private residence for seniors

Appendice **4**

International Adoption

- Guide d'intervention en adoption internationale (2011)

Cancer

- Plan directeur en cancérologie : Ensemble, en réseau, pour vaincre le cancer (2013)
- Plan d'action en cancérologie 2013-2015 : Ensemble, en réseau, pour vaincre le cancer (2013)
- Mécanisme central de gestion d'accès à la chirurgie oncologique : cadre de référence (2012)
- Politique en soins palliatifs de fin de vie (2004)
- Programme québécois de lutte contre le cancer : Pour lutter efficacement contre le cancer, formons équipe (1997)
- Programme québécois de dépistage du cancer du sein : Cadre de référence (1996)
- Politique de suivi des femmes dans le cadre du Programme québécois de dépistage du cancer du sein (2013)
- L'évaluation et la désignation des établissements et des équipes 2005-2009 : bilan (2010)

Physical impairment, intellectual impairment and pervasive developmental disorders

- Bilan 2008-2011 et perspectives : Un geste porteur d'avenir – Des services aux personnes présentant un trouble envahissant du développement, à leurs familles et à leurs proches (2012)
- Plan d'action 2011-2014, pour l'intégration scolaire, professionnelle et sociale des personnes handicapées (2011)
- Plan d'accès aux services pour les personnes ayant une déficience : Afin de faire mieux ensemble (2008)
- Cadre de référence pour les services surspécialisés de réadaptation en déficience physique (2007)
- Pour une véritable participation à la vie de la communauté : Orientations ministérielles en déficience physique – Objectifs 2004-2009 (2003)
- De l'intégration sociale à la participation sociale : Politique de soutien aux personnes présentant une déficience intellectuelle, à leur famille et aux autres proches (2001)

Dependency and Homeless

- Plan d'action interministériel en itinérance 2015-2020 – Mobilisés et engagés pour prévenir et réduire l'itinérance (2015)
- Politique nationale de lutte à l'itinérance - Ensemble pour éviter la rue et en sortir (2014)
- L'itinérance au Québec : Cadre de référence (2008)
- Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience : Programme-services Dépendances – Offre de service 2007-2012 (2007)
- Plan d'action interministériel en toxicomanie 2006-2011 (2006)

Sustainable development

Plan d'action de développement durable 2009-2015 : Prévenir et agir, pour la santé de notre avenir (mise à jour 2013) (2013)

Women

- Au féminin… À l'écoute de nos besoins : Plan d'action en santé et bien-être des femmes 2010-2013 (2010)

Youth in difficulty

- Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience : Programme-services Jeunes en difficulté – Offre de service 2007-2012 (2007)
- De la complicité à la responsabilité : Rapport du Comité sur le continuum de services spécialisés destinés aux enfants, aux jeunes et à leur famille (2004)
- La protection des enfants au Québec : une responsabilité à mieux partager – Rapport du Comité d'experts sur la révision de la Loi sur la protection de la jeunesse (2004)
- Stratégie d'action pour les jeunes en difficulté et leur famille (2002)

Home support

- Cadre de référence - Les ressources intermédiaires et les ressources de type familial (2014)
- Cadre de référence sur le soutien communautaire en logement social : Une intervention intersectorielle des réseaux de la santé et des services sociaux et de l'habitation (2007)
- Chez soi : Le premier choix – La politique de soutien à domicile (2003)

Chronic disease

- Cadre de référence pour la prévention et la gestion des maladies chroniques physiques en première ligne (2012)

Medication

- La politique du médicament (2007)

Organization of the health and social services network

- Politique ministérielle de sécurité civile – Santé et Services sociaux (2014)
- Plan stratégique du ministère de la Santé et des Services sociaux 2015-2020 (2015)
- Cadre de référence pour la désignation universitaire des établissements du secteur des services sociaux : Mission, principes et critères (2010)
- Cadre de référence des établissements publics du réseau de la santé et des services sociaux pour l'autorisation d'une recherche menée dans plus d'un établissement (2014)
- Programme de financement et de soutien professionnel pour les groupes de médecine de famille (GMF) (2015)

Age-related loss of autonomy

- Approche adaptée à la personne âgée en milieu hospitalier : Cadre de référence (2011)
- Un défi de solidarité : Les services aux aînés en perte d'autonomie – Plan d'action 2005-2010 (2005)
- Un milieu de vie de qualité pour les personnes hébergées en CHSLD : Orientations ministérielles (2003)
- Orientations ministérielles sur les services offerts aux personnes âgées en perte d'autonomie (2001)

Perinatality and early childhood

- Programme québécois de dépistage de la surdité chez les nouveau-nés - Cadre de référence (2012)
- Stratégies de mise en œuvre de la Politique de périnatalité 2009-2012 : Un projet porteur de vie (2010)
- Politique de périnatalité 2008-2018 : Un projet porteur de vie (2008)
- Les services intégrés en périnatalité et pour la petite enfance à l'intention des familles vivant en contexte de vulnérabilité : Cadre de référence (2004)
- Naître égaux – Grandir en santé : Un programme intégré de promotion de la santé et de prévention en périnatalité (1995)

Respect for individuals

- Cadre de référence pour la promotion, le respect et la défense des droits en santé mentale (2006)
- Cadre de référence pour l'élaboration des protocoles d'application des mesures de contrôle – Contention, isolement et substance chimique (2015)

Mental health

- Plan d'action en santé mentale 2015-2020 Faire ensemble et autrement (2015)
- Orientations relatives à l'organisation des soins et des services offerts à la clientèle adulte par les équipes en santé mentale de première ligne en CSSS (2011)
- Guichet d'accès en santé mentale pour la clientèle adulte des CSSS (2008)

- Prévention du suicide - Guide de bonnes pratiques à l'intention des intervenants des centres de santé et de services sociaux (2010)
- Prévention du suicide : Guide de soutien au rehaussement des services à l'intention des gestionnaires des centres de santé et de services sociaux (2010)
- L'implantation de réseaux de sentinelles en prévention du suicide : Cadre de référence (2006)
- Stratégie québécoise d'action face au suicide : S'entraider pour la vie (1998)

Public health

- Pour une prestation sécuritaire des soins de santé au Québec - Plan d'action ministériel 2015-2020 sur la prévention et le contrôle des infections nosocomiales (2015)
- Programme national de santé publique 2015-2025 : Pour améliorer la santé de la population du Québec (2015)
- Stratégie de soutien à l'exercice de la responsabilité populationnelle (2011)
- La prévention et le contrôle des infections nosocomiales : Cadre de référence à l'intention des établissements de santé du Québec (2006)
- Plan québécois de prévention du tabagisme chez les jeunes 2010-2015 (2010)
- Cadre de référence en matière de sécurité alimentaire : Mise à jour 2008 (2008)
- Investir pour l'avenir : Plan d'action gouvernemental de promotion des saines habitudes de vie et de prévention des problèmes reliés au poids 2006-2012 (2006)
- Plan d'action de santé dentaire publique 2005-2012 (2006)
- Plan québécois de lutte à une pandémie d'influenza : Mission santé (2006)
- Cadre d'orientation pour le développement et l'évolution de la fonction de surveillance au Québec (2007)
- Pour une prestation sécuritaire des soins de santé au Québec : Plan d'action ministériel 2015-2020 sur la prévention et le contrôle des infections nosocomiales (2015)
- Stratégie québécoise de lutte contre l'infection par le VIH et le sida, l'infection par le VHC et les infections transmissibles sexuellement : Orientations 2003-2009 (2004)

General services

- Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience : Services sociaux généraux – Offre de service (2013)
- Services Info-Santé et Info-Social : Cadre de référence sur les aspects cliniques des volets santé et social des services de consultation téléphonique 24 heures, 7 jours à l'échelle du Québec (2007)

Domestic violence and sexual assault

- Orientations gouvernementales en matière d'agression sexuelle (2001)
- Politique d'intervention en matière de violence conjugale : Prévenir, dépister, contrer la violence conjugale (1995)

附件七

Santé et Services sociaux Québec

DT9144

Date of birth (Year / Month / Day)	Room no.	File no.

First and last name at birth

Usual name or spouse's name

Address

Postal code	Telephone no. (Area code)	Sex
		M ☐ F ☐

Health insurance no.	Name of attending physician

Date of assessment	Assessment no.

MULTICLIENTELE

AUTONOMY ASSESSMENT

File no.

Specify, if necessary, the source of information: **U**ser – **F**amily or **F**riend – **E**valuator | **Problem**

STATE OF HEALTH

1. PERSONAL AND FAMILY HEALTH HISTORY AND CURRENT DIAGNOSES (physical and mental illness, – including chronic or stabilized problems –, congenital defects, hospitalizations, surgeries, traumas)

Allergies (medication, food, environment) : _____

2. PHYSICAL HEALTH

Difficulties experienced or specific observations	No	Yes
• **Digestive** function (pain, nausea, vomiting, diarrhea, constipation, gas, dysphagia, etc.) If so, specify: _____	☐	☐
• **Respiratory** function (pain, coughing, sputum, breathing difficulties, etc.) If so, specify: _____	☐	☐
• **Cardiovascular** function (pain, palpitations, pacemaker, etc.) If so, specify: _____	☐	☐
• **Genitourinary** function (pain, urinary problems, genital or gynecological problems, etc.) If so, specify: _____	☐	☐
• **Motor** function (pain, deformation, limited movement, strength, coordination, trembling, balance, physical endurance, etc.) If so, specify: _____	☐	☐
• **Sensory** function: eyes, ears, nose, mouth, touch (pain, discharge, inflammation, sensitivity, etc.) If so, specify: _____	☐	☐
• **Skin** function (wounds, redness, swelling, discharge, etc.) If so, specify: _____	☐	☐
• Other information If so, specify: _____	☐	☐

Height: _____ Weight: _____ Weight gain or loss: _____ If relevant: _____ B.P. _____ Pulse _____ Resp. _____ T°

Comments: _____

Problem identified

No — **N**

Yes — **Y**

File no.

AUTONOMY ASSESSMENT

Specify, if necessary, the source of information: User – Family or Friend – Evaluator | **Problem**

3. PSYCHOLOGICAL HEALTH (depressed, suicidal, paranoid, delirious, violent, manic, etc.)

Difficulties experienced or specific observations: ☐ No

☐ If so, specify: _____

_____

_____

Comments: _____

_____

_____

Problem identified — **No** N / **Yes** Y

4. SPECIFIC CARE (care required by user: bandages, various catheter care, oxygen, aspiration of secretions, postural drainage, peritoneal dialysis, etc., and other care as requested)

☐ No

☐ Yes, description, frequency and by whom: _____

_____

_____

Comments: _____

_____

_____

Problem identified — **No** N / **Yes** Y

5. MEDICATION (prescribed or not prescribed)

Name of pharmacy: _____

Area code | Telephone no. | Area code | Fax no. | E-mail

Name of medication	Dosage and frequency	User's explanation of reason	Prescribing physician	Prescribed	
				Yes	No

Side effects: ☐ No ☐ Yes Medication compliance: ☐ No ☐ Yes

Comments: _____

_____

_____

Problem identified — **No** N / **Yes** Y

Specify, if necessary, the source of information: User – Family or Friend – Evaluator | **Problem**

6. HEALTH SERVICES (medical, rehabilitation, alternative medicine, psychology, podiatry, etc.)

Regular medical checkup: ☐ No ☐ Yes

Family doctor: _____

Area code | Telephone no. | Extension | Area code | Fax no. | E-mail

Specialist: _____

Area code | Telephone no. | Extension | Area code | Fax no. | E-mail

Specialist: _____

Area code | Telephone no. | Extension | Area code | Fax no. | E-mail

Other: _____

Area code | Telephone no. | Extension | Area code | Fax no. | E-mail

Comments (specify required services not yet received): _____

Problem identified — **No** — **N** / **Yes** — **Y**

LIVING HABITS

1. NUTRITION

Daily diet:

Milk and dairy products: ☐ Yes ☐ No

Meat and meat substitutes: ☐ Yes ☐ No

Fruits and vegetables: ☐ Yes ☐ No

Bread and cereals: ☐ Yes ☐ No

Liquid intake: _____ cups or glasses

Diet: ☐ No ☐ Yes, specify: _____

Prescribed: ☐ Yes ☐ No

Followed: ☐ Yes ☐ No

Alimentation for dysphagia: ☐ Yes ☐ No

Other observations (time and location of meals, eats with whom, appetite, etc.):

Difficulties experienced or specific observations: ☐ No

☐ Yes, specify: _____

Are the user's current eating habits satisfactory to him/her? ☐ Yes ☐ No

Dentition (pain, difficulty chewing, denture, etc.):

Difficulties experienced or specific observations: ☐ No

☐ Yes, specify: _____

Comments: _____

Problem identified — **No** — **N** / **Yes** — **Y**

File no.

AUTONOMY ASSESSMENT

Specify, if necessary, the source of information: User – Family or Friend – Evaluator | **Problem**

2. SLEEP (insomnia, wakes up and why, fear, agitation, medication, time of rising and retiring, nap, etc.)

Difficulties experienced or specific observations: ☐ No

☐ Yes, specify: _____

Are the user's current sleeping habits satisfactory to him/her? ☐ Yes ☐ No

Comments: _____

Problem identified — No — N / Yes — Y

3. TOBACCO USE (type of consumption, quantity, supervision required, motivation to stop smoking, etc.)

Smokes: ☐ No

☐ Yes, specify: _____

Does the user's smoking currently pose a problem to him/her? ☐ Yes ☐ No

Comments: _____

Problem identified — No — N / Yes — Y

4. ALCOHOL AND DRUG USE (odor of alcohol, outward signs, type of consumption, quantity, frequency, supervision required, motivation to change habit, etc.)

Uses alcohol or drugs: ☐ No

☐ Yes, specify: _____

Does this habit currently pose a problem to the user? ☐ Yes ☐ No

Comments: _____

Problem identified — No — N / Yes — Y

5. PERSONAL AND LEISURE ACTIVITIES (participation in work, study or leisure activities, usual activities, desired activities, obstacles, etc.)

Difficulties experienced or specific observations: ☐ No

☐ Yes, specify: _____

Are the user's current personal and leisure activities satisfactory to him/her? ☐ Yes ☐ No

Comments: _____

Problem identified — No — N / Yes — Y

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

A. ACTIVITIES OF DAILY LIVING (ADL)

1. EATING

0 Feeds self independently

-0,5 With difficulty

-1 Feeds self but needs stimulation or supervision
OR food must be prepared or cut or pureed first

-2 Needs some assistance to eat
OR dishes must be presented one after another

-3 Must be fed totally by another person
OR has a naso-gastric tube or a gastrostomy

☐ naso-gastric tube ☐ gastrostomy

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ___ ___ ___

− + •

Comments (e.g., technical aids used): _____

2. WASHING

0 Washes self independently (including getting in or out of the bathtub or shower)

-0,5 With difficulty

-1 Washes self but needs stimulation
OR needs supervision
OR needs preparation
OR needs help for the complete weekly bath only
(including washing feet and hair)

-2 Needs help for the daily wash but participates actively

-3 Must be washed by another person

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ___ ___ ___

− + •

Comments (habits and frequency: bath, shower, washing hair, equipment used, help getting in and out, etc.):

3. DRESSING (all seasons)

0 Dresses self independently

-0,5 With difficulty

-1 Dresses self but needs stimulation
OR needs supervision
OR clothing must be prepared and presented
OR needs help for finishing touches
(buttons, laces, support hose/stocking)

-2 Needs help dressing

-3 Must be dressed by another person

☐ support hose/stocking

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ___ ___ ___

− + •

Comments (usual clothing, technical aids used): _____

*** Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

4. GROOMING (brushes teeth or combs hair or shaves or trims finger or toenails or puts on makeup)

0 Grooms self independently

-0,5 With difficulty

-1 Needs stimulation
OR needs supervision for grooming

-2 Needs some assistance for grooming

-3 Must be groomed by another person

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

0 [−] [+] [•] -1 -2 -3

Comments (e.g., technical aids used): _____

5. URINARY FUNCTION

0 Normal voiding

-1 Occasional incontinence
OR dribbling
OR needs frequent stimulation to avoid incontinence

-2 Frequent urinary incontinence

-3 Complete and habitual urinary incontinence
OR wears an incontinence pad or an indwelling catheter
or a urinary condom

☐ incontinence pad ○ night incontinence

☐ urinary condom ○ day incontinence

☐ indwelling catheter

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

0 [−] [+] [•] -1 -2 -3

Comments: _____

6. BOWEL FUNCTION

0 Normal bowel function

-1 Occasional incontinence
OR needs cleansing enema occasionally

-2 Frequent incontinence
OR needs cleansing enema regularly

-3 Always incontinent
OR wears an incontinence pad or an ostomy

☐ incontinence pad ○ night incontinence

☐ ostomy ○ day incontinence

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

0 [−] [+] [•] -1 -2 -3

Comments: _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

7. TOILETING

0 Uses toilet independently
(including getting on/off toilet, wiping self and managing clothing)

-0,5 With difficulty

-1 Needs supervision for toileting
OR uses commode, urinal or bedpan

-2 Needs help to go to the toilet
OR uses commode, bedpan or urinal

-3 Does not use toilet, commode, bedpan or urinal

☐ commode ☐ bedpan ☐ urinal

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments (frequency, equipment used, number of people to help, etc.): _____

B. MOBILITY

1. TRANSFERS (bed to chair or wheelchair to standing and vice-versa)

0 Gets in and out of bed or chair independently

-0,5 With difficulty

-1 Gets in and out of bed/chair independently but needs stimulation, supervision or guidance
specify: _____

-2 Needs help to get in or out of bed/chair
specify: _____

-3 Bedridden (must be lifted in and out of bed)
☐ particular positioning
☐ lift ☐ transfer board

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments (number of people to help, mobility in bed, precision of positioning, etc.): _____

2. WALKING INSIDE (including in the building and going to the elevator) [1]

0 Walks independently (with or without cane, prosthesis, orthosis or walker)

-0,5 With difficulty

-1 Walks independently but needs guidance, stimulation or supervision in certain circumstances
OR unsafe gait

-2 Needs help of another person to walk

-3 Does not walk

☐ cane ☐ tripod cane ☐ quadripod cane ☐ walker

[1] Distance of at least 10 metres

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments (e.g., walking area): _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

3. INSTALLING PROSTHESIS OR ORTHOSIS

0 Does not wear prosthesis or orthosis

-1 Installs prosthesis or orthosis independently

-1,5 With difficulty

-2 Installing of prosthesis or orthosis needs checking OR needs some assistance

-3 Prosthesis or orthosis must be install by another person

Type of prosthesis or orthosis: _____

_____

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments: _____

_____

_____

4. PROPELLING A WHEELCHAIR (W/C) INSIDE

0 Does not need a wheelchair

-1 Propels wheelchair independently

-1,5 With difficulty

-2 Needs to have wheelchair pushed

-3 Unable to use wheelchair (must be transported on stretcher)

- ☐ standard wheelchair
- ☐ wheelchair with unilateral axis
- ☐ motorized wheelchair
- ☐ three-wheeled scooter
- ☐ four-wheeled scooter

• Does the user's residence allow for W/C or scooter mobility?

☐ Yes → 0

☐ No

• Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments: _____

_____

_____

5. NEGOTIATING STAIRS

0 Goes up and down stairs independently

-0,5 With difficulty

-1 Requires stimulation, supervision or guidance to negotiate stairs OR does not safely negotiate stairs

-2 Needs help of another person to go up and down stairs

-3 Does not negotiate stairs

Does the user have to negotiate stairs?

☐ No → 0

☐ Yes

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments: _____

_____

_____

*** Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: − lessen, + increase, • remain stable, or does not apply.

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

6. GETTING AROUND OUTSIDE

0 Walks independently (with or without cane, prosthesis, orthosis or walker) [2]

-0,5 With difficulty

-1 Uses a wheelchair or three/four-wheeled scooter independently **

-1,5 W/C with difficulty

OR walks independently but needs guidance, stimulation or supervision in certain circumstances
OR unsafe gait [2]

-2 Needs help of another person to walk [2]
OR to use W/C **

-3 Cannot move around outside (must be transported on a stretcher)

[2] Distance of at least 20 metres

** Does the outside environment of the user's residence allow for W/C or scooter access and mobility?

☐ Yes → 0

☐ No

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

− + •

Comments (e.g., walking area): _____

C. COMMUNICATION

1. VISION

0 Sees adequately with or without corrective lenses

-1 Vision problems but sees enough for ADLs

-2 Only sees outlines of objects and needs guidance in ADLs

-3 Blind

☐ corrective lenses ☐ magnifying glass

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments (e.g., which eye): _____

2. HEARING

0 Hears adequately with or without hearing aid

-1 Hears if spoken to in a loud voice
OR needs hearing aid put in by another person

-2 Only hears shouting or certain words
OR reads lips
OR understands gestures

-3 Completely deaf and unable to understand what is said to him/her

☐ hearing aid

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments (which ear, hearing aid installed on telephone, other technical aids, etc.): _____

*** Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

DISABILITIES | **HANDICAP**

Specify, if necessary, the cause and the user's reaction to this disability.

3. SPEAKING

0 Speaks normally

-1 Has a speech/language problem but able to express him/herself

-2 Has a major speech/language problem but able to express basic needs
OR answer simple questions (yes, no)
OR uses sign language

-3 Does not communicate

Technical aid: ☐ computer ☐ communication board

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0 − + •

☐ No → -1 -2 -3

Resources*: ☐☐☐

Comments (e.g., type of compensation): _____

Written expression and understanding: _____

D. MENTAL FUNCTIONS

For each element, specify when the disability started and the user's reaction to this disability.

1. MEMORY

0 Normal memory

-1 Minor recent memory deficit (names, appointments, etc.) but remembers important facts

-2 Serious memory lapses (shutting off stove, taking medications, putting things away, eating, visitors, etc.)

-3 Almost total memory loss or amnesia

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0 − + •

☐ No → -1 -2 -3

Resources*: ☐☐☐

Comments: _____

2. ORIENTATION

0 Well oriented to time, place and persons

-1 Sometimes disoriented to time, place and persons

-2 Only oriented for immediate events (i.e., time of day) and in the usual living environment and with familiar persons

-3 Complete disorientation

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0 − + •

☐ No → -1 -2 -3

Resources*: ☐☐☐

Comments: _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

3. COMPREHENSION

0 Understands instructions and requests

-1 Slow to understand instructions and requests

-2 Partial understanding even after repeated instructions OR is incapable of learning

-3 Does not understand what goes on around him/her

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments: _____

4. JUDGMENT

0 Evaluates situations and makes sound decisions

-1 Evaluates situations but needs help in making sound decisions

-2 Poorly evaluates situations and only makes sound decisions with strong suggestions

-3 Does not evaluate situations and is dependent on others for decision making

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments: _____

5. BEHAVIOR

0 Appropriate behavior

-1 Minor behavioral problems (whimpering, emotional lability, stubbornness, apathy) requiring occasional supervision or a reminder or stimulation

-2 Major behavioral problems requiring more intensive supervision (aggressive towards self or others, disturbs others, wanders, yells out constantly)

-3 Dangerous, requires restraint OR harmful to others or self-destructive OR tries to run away

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments: _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (household tasks)

1. HOUSEKEEPING

0 Does housekeeping alone (including daily housework and occasional heavy jobs)

-0,5 With difficulty

-1 Does housekeeping (including washing the dishes) but needs stimulation or supervision to ensure cleanliness OR needs help for occasional heavy jobs (floors, windows, painting, lawn, shoveling snow, etc.)

-2 Needs help for daily housework

-3 Does not do housework

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

Stability ■: 0 [−] [+] [•]

Comments: _____

2. MEAL PREPARATION

0 Prepares own meals independently

-0,5 With difficulty

-1 Prepares meals but needs stimulation to maintain adequate nutrition

-2 Only prepares light meals OR reheats pre-prepared meals (including handling the plates)

-3 Does not prepare meals

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

Stability ■: 0 [−] [+] [•]

Comments: _____

3. SHOPPING

0 Plans and does shopping independently (food, clothes, etc.)

-0,5 With difficulty

-1 Plans and shops independently but needs to be delivered service

-2 Needs help to plan or to shop

-3 Does not shop

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

Stability ■: 0 [−] [+] [•]

Comments (specify the activities the user cannot perform): _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

4. LAUNDRY

0 Does all laundry independently

-0,5 With difficulty

-1 Does laundry but needs stimulation or supervision to maintain standards of cleanliness

-2 Needs help to do laundry

-3 Does not do laundry

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments: _____

5. TELEPHONE

0 Uses telephone independently (including the use of a directory)

-0,5 With difficulty

-1 Answers telephone but only dials a few memorized numbers or emergency numbers

-2 Communicates by telephone but does not dial numbers or lift the receiver off the hook

-3 Does not use the telephone

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments (e.g., special equipment): _____

6. TRANSPORTATION

0 Able to use transportation alone (car, adapted vehicle, taxi, bus, etc.)

-0,5 With difficulty

-1 Must be accompanied to use transportation OR uses paratransit independently

-2 Uses car or paratransit only if accompanied and has help getting in and out of the vehicle

-3 Must be transported on a stretcher

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments: _____

*** Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

7. MEDICATION USE

0 Takes medication unaided according to prescription
OR does not need medication

-0,5 With difficulty

-1 Needs supervision (including supervision from afar)
to ensure compliance to prescription
OR uses a medication dispenser aid (prepared by someone else)

-2 Takes medication if prepared daily

-3 Must be given each dosage of medication (as prescribed)

☐ medication dispenser aid

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments: _____

8. BUDGETING

0 Manages budget independently (including banking)

-0,5 With difficulty

-1 Needs help for certain major transactions

-2 Needs help for some regular transactions
(cashing checks, paying bills) but uses pocket money wisely

-3 Does not manage budget

Does the user presently have the human resources ((help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments (e.g., banking procuration): _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

File no.

Specify, if necessary, the source of information: **U**ser – **F**amily or **F**riend – **E**valuator | **Problem**

PSYCHOSOCIAL SITUATION

1. SOCIAL HISTORY (occupation, married, divorced, mourning, education level, immigration, moves, other major events, etc.)

Comments:

Problem identified — No — N; Yes — Y

2. FAMILY SITUATION

Family makeup (age, sex, place of residence or genogram):

Family dynamics (interaction of user with family and family members with each other, user's satisfaction with family situation, how the family reacts or is affected by the user's situation, signs of abuse, violence or negligence, etc.):

Comments:

Problem identified — No — N; Yes — Y

3. MAIN CAREGIVERS (involvement, level of fatigue, impressions of their situation, expectations, desire to get involved, etc.)

Comments:

Problem identified — No — N; Yes — Y

File no.

Specify, if necessary, the source of information: User – Family or Friend – Evaluator | **Problem**

4. SOCIAL NETWORK (including school and work environment)

Significant persons (friends, neighbors, colleagues, teachers, etc.): _____

Relationship dynamics (interaction of user with members of his/her social network, satisfaction of user with regard to his/her relations with them, how they react to or are affected by the user's situation, signs of abuse, violence or negligence, etc.):

Comments: _____

Problem identified — No — N / Yes — Y

5. COMMUNITY, PUBLIC AND PRIVATE RESOURCES (volunteers, associations, day centers, paratransit, services included in lease, etc.)

Specify the type of services, their frequency, and the user's interaction with them: _____

Comments (services required but not yet received): _____

Problem identified — No — N / Yes — Y

6. AFFECTIVE STATE (mood, self esteem, feelings of usefulness or isolation, anxiety, etc.)

Comments: _____

Problem identified — No — N / Yes — Y

File no.

Specify, if necessary, the source of information: User – Family or Friend – Evaluator | **Problem**

7. USER'S IMPRESSIONS (how user perceives his/her situation, reacts or adapts to it, motivation, solutions envisioned, etc.)

Comments:

Problem identified — No — N; Yes — Y

8. SEXUALITY (satisfaction of user, preoccupation, socially unacceptable behavior, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify:

Comments:

Problem identified — No — N; Yes — Y

9. PERSONAL, CULTURAL AND SPIRITUAL BELIEFS AND VALUES (e.g., expression)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify:

Comments:

Problem identified — No — N; Yes — Y

ECONOMIC CONDITIONS

CAPACITY TO MEET FINANCIAL OBLIGATIONS WITH CURRENT INCOME (rent, food, clothing, medication, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify:

Does the user benefit from one of the following programs: guaranteed income supplement, Quebec pension, housing assistance, disability pension, income security, special family allowance, other: ☐ No ☐ Yes

Yes, specify:

Comments:

Problem identified — No — N; Yes — Y

File no.

Specify, if necessary, the source of information: **U**ser – **F**amily or **F**riend – **E**valuator | **Problem**

PHYSICAL ENVIRONMENT

1. HOUSING CONDITIONS (cleanliness, space, satisfaction, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify: _____

☐ Owner ☐ Tenant ☐ Boarder ☐ Address unknown Lived there since: _____

Residence on: _____ floor Number of rooms: _____

Access: ☐ elevator ☐ interior strairway, number of steps: _____ ☐ exterior stairway, number of steps: _____

Comments: _____

Problem identified — **No** N / **Yes** Y

2. PERSONAL AND ENVIRONMENTAL SAFETY (risk of falling, fire, running away, emergency telephone system, warning lights, telemonitoring, remote monitoring system, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify: _____

Comments (needs not met): _____

Problem identified — **No** N / **Yes** Y

3. ACCESSIBILITY (architectural barriers, location of equipment, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify: _____

Comments (needs not met): _____

Problem identified — **No** N / **Yes** Y

4. PROXIMITY OF SERVICES (grocery store, bank, church, laundromat, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify: _____

Comments: _____

Problem identified — **No** N / **Yes** Y

File no.

SUMMARY (context of assessment, urgent problems identified, user's expectations, risk factors, suggested orientations)

Year Month Day

Signature Title Date

附件八

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Santé et Services sociaux Québec

CARE TABLE

Name	Room	Date

SMAF

Ⓖ INDEPENDENTLY Ⓣ WITH DIFFICULTY Ⓑ SUPERVISION OR STIMULATION Ⓨ HELP Ⓡ DEPENDENT Criteria for scoring on back

G: Green **T:** Turquoise **B:** Blue **Y:** Yellow **R:** Red

A. ACTIVITIES OF DAILY LIVING

Getting out to bed:

Daily rounds:

Bed time:
- Hospital gown ☐
- Personal sleepwear ☐
- Remove dentures ☐

Other:

1. EATING

a) ○ b) ○ _____

c) ○ d) ○

Dishes one at a time ☐

2. WASHING

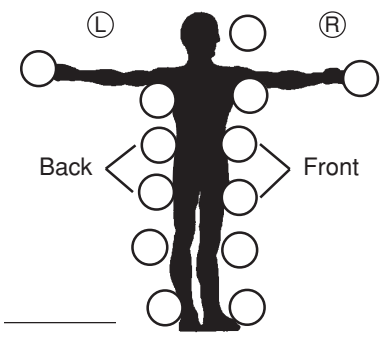
a) Hair: _____ **b)** Nails: _____

c) Cream: _____

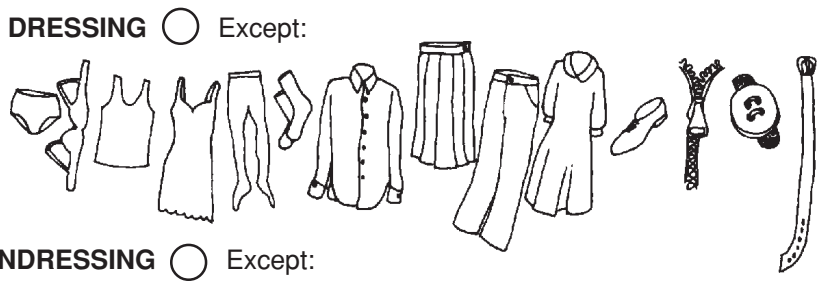
_____

d) ☐ Bed ☐ Sink ☐ Bath ☐ Shower ☐ Whirlpool bath ☐ Supervision

e) Schedule: Mini-wash: _____ Sponge bath: _____ Full bath: _____



3. DRESSING ○ Except:



UNDRESSING ○ Except:

a) Dirty laundry: _____

b) Change clothes: Sun. Mon. Tue. Wed. Thu. Fri. Sat.

c) Look after clothes: _____

4. GROOMING

a) ○ b) ○ c) ○ d) ○

e) Own teeth ☐
Upper denture ☐
Lower denture ☐
Put in ○
Take out ○

f) Mouthwash ○

Tongue sponge ☐

5. URINARY FUNCTION ○

6. BOWEL FUNCTION ○

Incontinence products
D ○ _____
E ○ _____
N ○ _____

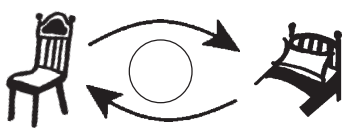
7. TOILETING

Toilet ○ Bedpan ○
Urinal ○ Commode ○

Incontinence pad D ○ E ○ N ○
Other: _____ D ○ E ○ N ○
Incontinence undergarment ☐ Ostomy ☐ Catheter ☐

B. MOBILITY

1. Transfers

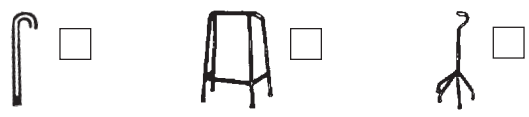


☐

Walking program ☐

2. Walking

○ Room ○ Unit ○ Institution ○ Outside



3. Prothesis or orthosis

N/A ☐ ○

4. Getting around

N/A ☐

○ Room
○ Unit
○ Institution
○ Outside

5. Negotiating

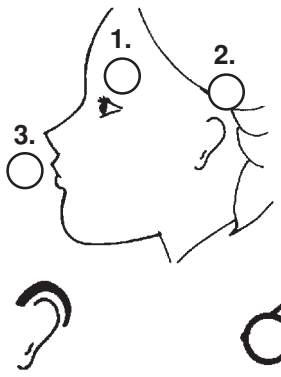
○

Elevator ○

Security
- WC/GC belt ☐
- Belt other chairs ☐
- Safety vest ☐
- Magnetic belt (Segufix) ☐
- Wandering bracelet ☐
- Bed rails 1. D ☐ E ☐ N ☐
  2. D ☐ E ☐ N ☐
- Other: _____

C. COMMUNICATION

Language spoken: _____



R ☐ Put in ○ Put on ○
L ☐ Take out ○ Take off ○

D. MENTAL FUNCTION

1. ○ 2. ○

3. ○ 4. ○

5. ○

☐ Self
☐ Other
☐ Runs away

E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1. Housekeeping ○

2. Meal preparation ○

3. Shopping ○

Delivery ☐

4. Laundry ○

5. Telephone ○

6. Transportation

Automobile ○
Adapted vehicle ○
Taxi ○
Bus ○
Paratransit vehicle ○
Ambulance ○

7. Medication use ○

Dispill ☐
Medication dispenser ☐

8. Budgeting ○

ADDITIONAL INFORMATION:

Smoker's apron ☐

The SMAF was developed and validated with a grant from the Conseil québécois de la recherche sociale and the Community Health Department of Hôtel Dieu Hospital, Lévis.
The CHSLDs of Lachine, Nazaire-Piché, and Foyer Dorval contributed to the preparation of this revised version.
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Ministère de la Santé et des Services sociaux

AS-755A (2003-05)

CRITERIA FOR SCORING SUBJECTS ON CARE TABLE

A. ACTIVITIES OF DAILY LIVING

Getting out of bed
Enter what has to be done to get the person out of bed

Daily rounds
Enter what has to be done during the rounds

Bed time
Check the appropriate sleepwear
Check if staff have to remove dentures
Other – Enter what has to be done to put the person to bed

1. EATING

a) Feeding self
Ⓖ Feeds self independently
Ⓣ Feeds self independently but with difficulty
Ⓑ Feeds self but needs stimulation or supervision
Ⓨ Participates actively but needs some assistance for part of the activity
Ⓡ Must be fed totally by another person
OR has a naso-gastric tube or a gastrostomy

b) Opening containers
Ⓖ Can open all containers independently
Ⓣ Can open all containers independently but with difficulty
Ⓑ Can open all containers independently but needs stimulation or supervision
Ⓨ Needs help to open some containers
Ⓡ Another person has to open all containers

c) Cutting food
Ⓖ Can cut all own food independently
Ⓣ Can cut all own food independently but with difficulty
Ⓑ Can cut all own food independently but needs stimulation or supervision
Ⓨ Needs help to cut food
Ⓡ Another person has to cut or puree all food

d) Buttering food
Ⓖ Can butter all food independently
Ⓣ Can butter all food independently but with difficulty
Ⓑ Can butter all food independently but needs stimulation or supervision
Ⓙ
Ⓡ Another person has to butter food

Dishes one at a time: Check if dishes have to be presented one after another

2. WASHING
For each part of the body
Ⓖ Washes self independently (including getting in or out of the bathtub or shower)
Ⓣ Washes self independently but with difficulty
Ⓑ Washes self independently but needs stimulation or supervision
OR another person has to prepare things
Ⓨ Needs help for the daily wash but participates actively
Ⓡ Must be washed by another person
Check and enter
a) Hair: Who provides care (resident, staff, hairdresser) if resident needs medicated shampoo
b) Nails: Who provides care
c) Cream: Name of cream for daily application and location of application
d) Location: Where personal care is given
– Check according to where full bath is done
– Check for independent residents if supervision is required
e) Schedule: Enter the day for each type of personal care
Mini-wash (face/buttocks)
Sponge bath (everything except lower extremities and back)
Full bath
Days abbreviations:
Sun., Mon., Tue., Wed., Thu., Fri., Sat.

3. DRESSING (all seasons)
In general
Ⓖ Dresses self independently
Ⓣ Dresses self independently but with difficulty
Ⓑ Dresses self but needs stimulation or supervision OR clothing must be prepared and presented
Ⓨ Needs help dressing but participates actively
Ⓡ Must be dressed by another person

Code the *upper* part of the clothing that does not meet the general rule according to:
Ⓖ Independently
Ⓣ With difficulty
Ⓑ Supervision, stimulation
Ⓨ Some assistance
Ⓡ Complete assistance

UNDRESSING (all seasons)
In general
Ⓖ Undresses self independently
Ⓣ Undresses self independently but with difficulty
Ⓑ Undresses self independently but needs stimulation or supervision OR another person has to put clothes away
Ⓨ Needs help undressing but participates actively
Ⓡ Must be undressed by another person

Code the *lower* part of the clothing that does not meet the general rule according to:
Ⓖ Independently
Ⓣ With difficulty
Ⓑ Supervision, stimulation
Ⓨ Some assistance
Ⓡ Complete assistance
Enter
a) Place where dirty laundry is put
b) If applicable, the evening when clothes are changed
c) Person who looks after the clothes

4. GROOMING
a) Shaves with electric razor
b) Brushes teeth, looks after dentures
c) Combs hair
d) Puts on makeup
e) Puts in and takes out dentures
f) If applicable, uses mouthwash
For *each* of these activities
Ⓖ Grooms self independently
Ⓣ Grooms self independently but with difficulty
Ⓑ Grooms self but needs stimulation or supervision OR another person has to prepare things
Ⓨ Needs some assistance for grooming
Ⓡ Must be groomed by another person
Check if the person has
✓ Own teeth
✓ An upper denture
✓ A lower denture
Check if applicable
✓ Tongue sponge

5. URINARY FUNCTION
Ⓖ Normal voiding
Ⓑ Occasional urinary incontinence OR dribbling OR indwelling catheter that he/she can look after independently OR needs frequent stimulation to avoid incontinence
Ⓨ Frequent urinary incontinence
Ⓡ Complete and habitual urinary incontinence OR wears an incontinence pad OR needs daily help with indwelling catheter

6. BOWEL FUNCTION
Ⓖ Normal bowel function
Ⓑ Occasional feacal incontinence OR ostomy that he/she can look after independently OR needs a cleansing enema occasionally
Ⓨ Frequent feacal incontinence OR needs cleansing enema regularly
Ⓡ Complete feacal incontinence OR needs daily help with ostomy

7. TOILETING
✓ Toilet
✓ Urinal
✓ Bedpan
✓ Commode
Code according to use
Ⓖ Uses toilet independently (including sitting down and getting up, wiping self and managing clothing)
Ⓣ Uses toilet independently but with difficulty
Ⓑ Uses toilet independently but needs stimulation or supervision
Ⓨ Needs help from another person to use toilet
Ⓡ Does not use toilet
Use of incontinence products
Day (D), Evening (E), Night (N)
✓ Pad
✓ Sanitary napkin
✓ Incontinence pad
S (small) M (medium) L (large)
✓ Diapercover
✓ Other: _____
Code according to use and time of day
Ⓖ Uses it independently
Ⓑ Uses it independently but with difficulty
Ⓨ Uses it independently but needs stimulation or supervision
Ⓡ Needs help from another person to use it
Check if applicable
✓ Ostomy
✓ Catheter
✓ Incontinence undergarment

B. MOBILITY

1. TRANSFERS
(bed to chair or wheelchair and to stand and vice-versa)
Ⓖ Gets in and out of bed or chair independently
Ⓣ Gets in and out of bed or chair independently but with difficulty
Ⓑ Needs stimulation, supervision or guidance to get in and out of bed or chair
Ⓨ Needs help to get in and out of bed or chair
Ⓡ Bedridden (must be lifted in and out of bed)
Check if lever required
Enter what has to be done to transfer and move the person
Walking program
Check if the person is registered in the walking program
Enter what has to be done related to the resident's walking program

2. WALKING
For each place, code according to
Ⓖ Walks independently (with or without a cane, prosthesis, orthosis or walker)
Ⓣ Walks independently but with difficulty
Ⓑ Walks independently but needs guidance, stimulation or supervision in certain circumstances OR unsafe gait
Ⓨ Needs help from another person to walk
Ⓡ Does not walk
Check if person has a
✓ Cane
✓ Walker
✓ Quadripod

3. INSTALLING PROSTHESIS OR ORTHOSIS
N/A Does not wear prosthesis or orthosis
Ⓖ Installs prosthesis or orthosis independently
Ⓣ With difficulty
Ⓑ
Ⓨ Installing of prosthesis or orthosis needs checking OR needs some assistance
Ⓡ Prosthesis or orthosis must be put on by another person

4. PROPELLING A WHEELCHAIR (W/C)
For each place, code according to
N/A Does not need a wheelchair
Ⓖ Propels wheelchair independently
Ⓣ Propels wheelchair independently but with difficulty
Ⓑ
Ⓨ Needs to have wheelchair pushed
Ⓡ Unable to use wheelchair (must be transported on a stretcher)

5. NEGOTIATING STAIRS AND ELEVATORS
Code
Ⓖ Uses it independently
Ⓣ Uses it independently but with difficulty
Ⓑ Uses it independently but needs guidance, stimulation or supervision OR does not use it safely
Ⓨ Uses it with the help of another person
Ⓡ Does not use it
Security
Check if applicable
✓ Belt on wheelchair (W/C) – geriatric chair (G/C)
✓ Belt on other chairs
✓ Safety vest
✓ Magnetic belt (Segufix)
✓ Wandering bracelet
✓ Bed rail(s) raised
1 side ✓ Day ✓ Evening ✓ Night
2 sides ✓ Day ✓ Evening ✓ Night
✓ Other: _____

C. COMMUNICATION

Language spoken: _____

1. VISION
Code
Ⓖ Sees adequately with or without corrective lenses
Ⓑ Visual problems but sees enough to do ADLs
Ⓨ Only sees outlines of objects and needs guidance in ADLs
Ⓡ Blind

2. HEARING
Code
Ⓖ Hears adequately with or without hearing aid
Ⓑ Hears if spoken to in a loud voice OR needs hearing aid put in by another person
Ⓨ Only hears shouting or certain words OR reads lips OR understands gestures
Ⓡ Deaf and unable to understand what is said to him/her
Check if applicable
✓ Glasses
✓ Hearing aid ✓ Right ear ✓ Left ear
Putting on/in and taking off/out glasses or hearing aid
Code
Ⓖ Independently
Ⓑ Supervision, stimulation
Ⓨ Some assistance
Ⓡ Complete assistance

3. SPEAKING
Ⓖ Speaks normally
Ⓑ Has a speech/language problem but able to express him/herself
Ⓨ Has a major speech/language problem but able to express basic needs or answer simple questions (yes, no) OR uses sign language
Ⓡ Does not communicate

D. MENTAL FUNCTIONS

1. MEMORY
Ⓖ Normal memory
Ⓑ Minor recent memory deficit (names, appointments, etc.) but remembers important facts
Ⓨ Serious memory lapses (shut off stove, medications, putting things away, eating, visitors, etc.)
Ⓡ Almost total memory loss or amnesia

2. ORIENTATION
Ⓖ Well oriented to time, place and persons
Ⓑ Sometimes disoriented to time, place and persons
Ⓨ Only oriented for immediate events (i.e., time of day) and in the usual living environment and with familiar persons
Ⓡ Complete disorientation

3. COMPREHENSION
Ⓖ Understands instructions and requests
Ⓑ Slow to understand instructions or requests
Ⓨ Partial understanding even after repeated instructions OR is incapable of learning
Ⓡ Does not understand what goes on around him/her

4. JUDGMENT
Ⓖ Evaluates situations and makes sound decisions
Ⓑ Evaluates situations but needs help in making sound decisions
Ⓨ Poorly evaluates situations and only makes sound decisions with strong suggestions
Ⓡ Does not evaluate situations and is dependent on others for decision making

5. BEHAVIOR
Ⓖ Appropriate behavior
Ⓑ Minor behavioral problems (whimpering, emotional lability, stubbornness, apathy) requiring occasional supervision or reminder or stimulation
Ⓨ Major behavioral problems requiring more intensive supervision (aggressive towards self or others, disturbs others, wanders, yells out constantly)
Ⓡ Dangerous, requires restraint OR harmful to others or self-destructive OR tries to run away
Check if applicable
✓ Self ✓ Other ✓ Runs away

ADDITIONAL INFORMATION
Indicate here all other relevant information
Check if applicable
✓ Smoker's apron

E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1. HOUSEKEEPING
Ⓖ Does housekeeping alone (including daily housework and occasional heavy jobs)
Ⓣ Does housekeeping alone but with difficulty
Ⓑ Does housekeeping (including washing the dishes) but needs supervision or stimulation to ensure cleanliness OR needs help for heavy jobs (floors, windows, painting, lawn, clearing the snow, etc.)
Ⓨ Needs help for daily housework
Ⓡ Does not do housework

2. MEAL PREPARATION
Ⓖ Prepares own meals independently
Ⓣ Prepares own meals independently but with difficulty
Ⓑ Prepares meals but needs stimulation to maintain adequate nutrition
Ⓨ Only prepares light meals OR heats up pre-prepared meals (including handling the plates)
Ⓡ Does not prepare meals

3. SHOPPING
Ⓖ Plans and does shopping independently (food, clothes, etc.)
Ⓣ Plans and does shopping independently but with difficulty
Ⓑ Plans and shops independently but needs to be delivered service
Ⓨ Needs help to plan or to shop
Ⓡ Does not shop

4. LAUNDRY
Ⓖ Does all laundry independently
Ⓣ Does all laundry independently but with difficulty
Ⓑ Does laundry but needs stimulation or supervision to maintain standards of cleanliness
Ⓨ Needs help to do laundry
Ⓡ Does not do laundry

5. TELEPHONE
Ⓖ Uses telephone independently (including the use of a directory)
Ⓣ Uses telephone independently but with difficulty
Ⓑ Answers telephone but only dials a few memorized numbers or emergency numbers
Ⓨ Communicates by telephone but does not dial numbers or lift the receiver off the hook
Ⓡ Does not use the telephone

6. TRANSPORTATION
Ⓖ Able to use transportation alone (car, adapted vehicle, taxi, bus, etc.)
Ⓣ Able to use transportation alone but with difficulty
Ⓑ Must be accompanied to use transportation OR uses paratransit independently
Ⓨ Uses car or paratransit only if accompanied and has help getting in and out of the vehicle
Ⓡ Must be transported on a stretcher

7. MEDICATION USE
Ⓖ Takes medication unaided according to prescription OR does not need medication
Ⓣ Takes medication unaided according to prescription but with difficulty
Ⓑ Needs supervision (including supervision from afar) to ensure compliance with prescription OR uses a medication dispenser aid (prepared by someone else)
Ⓨ Takes medication if prepared daily
Ⓡ Must be given each dosage of medication as prescribed

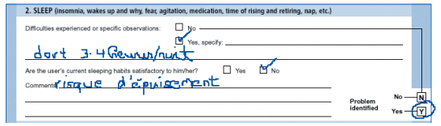
8. BUDGETING
Ⓖ Manages budget independently (including banking)
Ⓣ Manages budget independently but with difficulty
Ⓑ Needs help for certain major transactions
Ⓨ Needs help for some regular transactions (cashing checks, paying bills) but uses pocket money wisely
Ⓡ Does not manage budget

附件九

HOW TO COMPLETE

Checklist

- Look for to cover every aspect.
- Describe the problem, if difficulties arise.
- Specify the source of information:
  F:Family or Friend
  U:User
  E:Evaluator.
- Provide grounds for your choice (yes/no) in the comments section where appropriate.



- In case of doubt, it is better to over-estimate rather than under-estimate a disability.

CARE TABLE
Scale of cotation

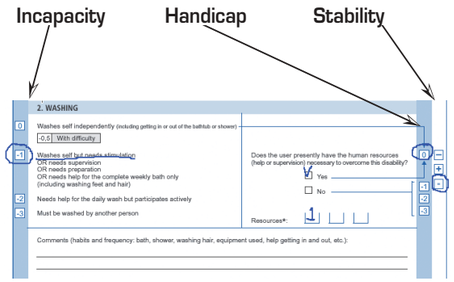
Letter	Color	Level of autonomy	Score
G	Green	Independent	0
T	Turquoise	Independent with difficulty	-0, 5 –1, 5
B	Blue	Supervision/stimulation	-1
Y	Yellow	Some assistance	-2
R	Red	Complete assistance	-3

N.B. Read attentively the definition of each colour on the back of the form.

- Paste the corresponding colour stickers to the user level of autonomy for each function represented by a pictogram.
- Tick the case to identify the complementary particularities.

SMAF

- Encircle the appropriate score in the section " Incapacity ".
- Underline the corresponding item if more than one choice.
- Make sure that the handicap score is the same as the disability score if the situation is not entirely overcome.
- Make sure the handicap score will be " 0 " if the situation is **entirely** overcome whatever the living environment (Home, CHSLD, IR …): a situation is overcome if the user has access to resources of sufficient quality and quantity at the time it is required.
- Identify the stability only if the resources are available. Indicate if the resources will [-] decrease, [+] increase or [.] remain stable in the coming three or four weeks.



- If the number " 7 " is ticked, indicate the type of resource in the comment section.

Access mechanism

- Users must not be assessed or reassessed in an acute phase of illness or in a **crisis** situation. Their rehabilitation must be completed.
- Requests to the regional access mechanism should only be submitted if users are in a stable condition.

Make sure that photocopies of the following forms are sent:

- Intake form (green) with up-to-date information.
- Multiclientele Autonomy Assessment form (blue).
- Evolutive Autonomy Profile form (salmon) with up-to-date information (if first assessment, transcribe information into first column).
- Medical evaluation.
- Consent form.
- Relevant reports (e.g., physiotherapy, occupational therapy, etc.).
- Care Table (if already complete).

Outil d'évaluation multiclientèle (OEMC)

www.msss.gouv.qc.ca/f/documentation/oemc

Functional Autonomy
Measuring System

Formation SMAF sur web CT : *www.iugs.ca*

03-806-02A

HOW TO USE IT

Summary guideline for the utilization of

Multiclientele Assessment Tool

Centre d'expertise de l'Institut universitaire de gériatrie de Sherbrooke

Santé et Services sociaux Québec

GENERAL DESCRIPTION OF MULTICLIENTELE ASSESSMENT TOOL

	Intake (green)	Autonomy Assessment (blue)	Evolutive Autonomy Profile (salmon)	Autonomy Assessment Short-Term Care Clientele (mallow)	Intervention and Service Allocation Plan (pink)
When	■ Registration ■ Preassessment ■ Request for change of living environment	■ Assessment ■ Request for change of living environment ■ Referral of client to another establishment ■ Care management transfer to integrated services network	■ Continuous assessment ■ Reassessment Request for change in living environment	■ Assessment of short-term care clientele (overall notion of state of health)	■ Intervention planning
Target Clientele	■ All target clienteles	■ Clienteles experiencing loss of autonomy, except those requiring short-term interventions or care (includes CLSCs, CHSLDs, RIs, RTF, CHSGSs, CRs)	■ Long-term care clientele in home care or care facility setting	■ Clientele requiring a single type of service for less than 3 months	■ All clienteles experiencing temporary or permanent loss of autonomy ■ Especially clientele receiving services from more than one professional ■ For CHSLDs already using computerized treatment plans, the print version of the OEMC Intervention Plan is not required
Frequency	■ Once per service episode	■ At transfer of care management for clients experiencing loss of autonomy ■ Generally once a year, or upon any major change ■ As part of continuous assessment	■ During review of autonomy assessment (use blue form for revision)	■ Once every care episode	■ Reviewed as required
Fonctions	■ Determine eligibility ■ Establish assessment priority ■ Identify profession most apt to respond to request ■ Or orient to another resource	■ Assess overall needs in view of preparing an intervention plan ■ Identify required services ■ Present case when a change of living environment is requested	■ Record results of autonomy assessment and reassessment ■ Observe any changes in client autonomy	■ Assess overall needs with emphasis on health dimension ■ Identify required services	■ Draw up intervention plan ■ Identify required services
Users (who completes it)	■ Professional in charge of screening or who requests the change in living environment	■ Professional in charge of client services, in cooperation with care and service team ■ Case manager for one-stop assessment of request for change in living environment	■ Professional in charge of client services, in cooperation with care and service team	■ Professional in charge of client services	■ Professional in charge of client services, in cooperation with care and service team
Additional information	*Information not obtained during intake must be added upon subsequent evaluation ("Autonomy Assessment" form)*	*As soon as the autonomy assessment is complete,transcribe the information on the "Evolutive Autonomy Profile" form (salmon)*			

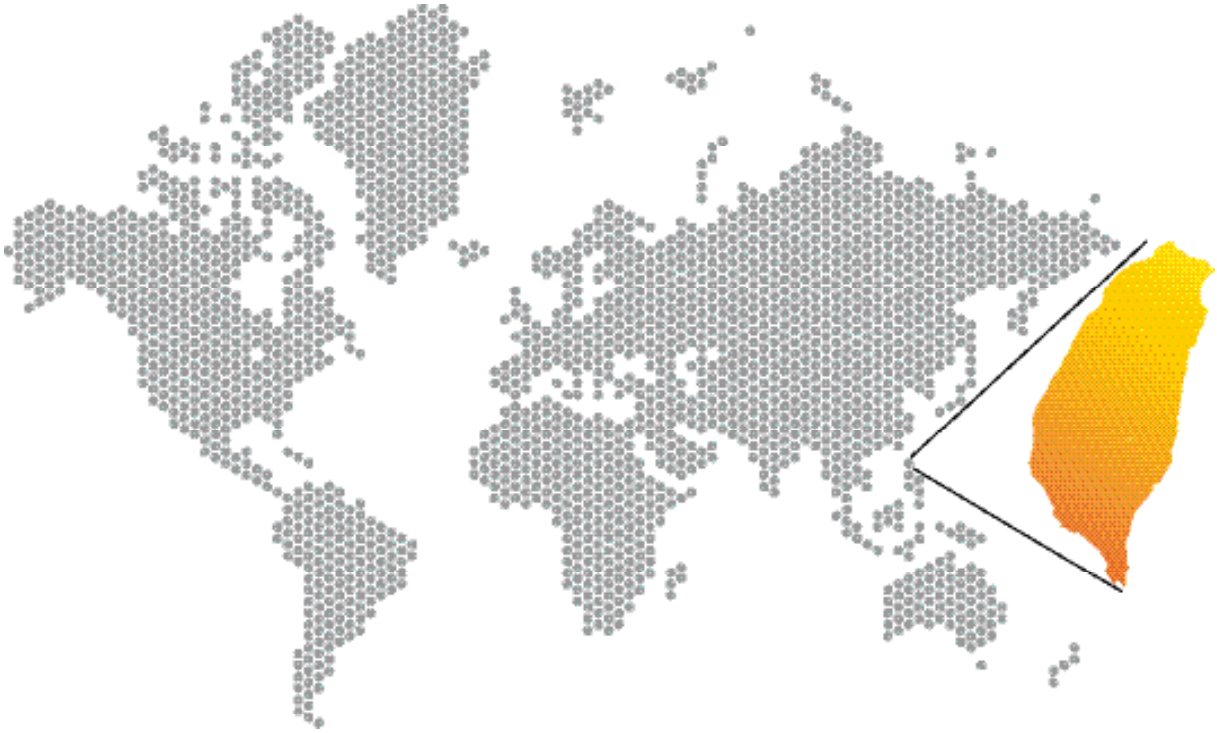
N. B.: The form "Care Table" is a synthesis portrait of the Functional Autonomy Measuring System of the evaluated client. It ensues from the results at the form "Autonomy Assessement".

GENERAL INSTRUCTIONS

- The form should be completed by one person.
- If more than one person is involved for completing the form, the person responsible must initial the sections completed and signed by other contributors and ensure that information is consistent throughout the document.
- Information must be written in pen.
- Whenever possible, use the detailed assessment (blue) rather than the short-term assessment (mallow), this last form is required for a specific service or care on a short-term basis.
- Before completing a section, read the description of each item carefully.
- When recording information, remember that other people will be using the assessment to determine their course of action.
- All sections must be completed. Write " no information collected " or " information unavailable ", along with " incomplete assessment ". Do not write " N/A " or " N/E " and do not leave blank spaces. Use a slash or vertical line to show that content has been completed and indicate that you have evaluated all the items.
- Use only recognized abbreviations.

附件十

Table of Contents



Country	The Republic of China (R.O.C, Taiwan)
Population	Approximately 23.5 million (May of 2016)
Capital	Taipei City (with the population about 2.66 million)
Main cities	New Taipei City, Kaohsiung, Taichung, Tainan and Taoyuan
Area	About 36,000 square kilometers
Currency	New Taiwan Dollar (NTD)
Nominal GDP	US$ 523.0 billion (2015)
GDP per Capita	US$ 22,294 (2015)
Number of Passengers Coming In or Out	10,439,785 (2015)
Number of Foreign Residents	562,233 (2015)
Basic Infrastructures	3 international airports and 7 international commercial ports in Taiwan. Both sea and air ways connect main countries and cities in the world. Composed of highways, MRT systems, railways and THSR (Taiwan High Speed Rail), inland transportation network is intensive and promises the smooth and convenient transportation heading to the inner areas of Taiwan.
Number of International Medical Service Use	About 305,045 (2015)

The Hub of Asia-Pacific Regions

- Taiwan, in a position of strategic and economical center in Asia, not only connects emerging markets to the western developed countries, but also acts as the key role for the international collaboration among industries.
- The average flying time from Taiwan to seven major Asia cities including Tokyo, Seoul, Beijing, Hong Kong, Singapore and Sydney is the shortest by about 2.55 hours.
- The average sailing time from Taiwan to five main Asia ports including Hong Kong, Manila, Shanghai, Tokyo and Singapore is the shortest by about 53 hours.

The Best Gateway to the Development in Mainland China

- Taiwan, with the closest distance to mainland China in both geographical and cultural perspectives, possesses advantages in mainland China that cannot be replaced by any other country. Moreover, Taiwanese investment in China has been deeply rooted and widely spread, which highlights the role of “gateway” for the world to China Taiwan has played for decades, creating an advantageous place for Taiwan, mainland China and foreign enterprises. The cross-strait relation in economics and trade has been even more tightly connected under the Cross-Straits Economic Cooperation Framework Agreement (ECFA).
- ECFA, which was implemented in January 1st of 2011, has an early harvest list of 539 items and services which cuts tariff to zero when improting from Taiwan to mainland China for the following industires: industries related to petrochemical raw materials, upstream and midstream spinning (textile) products, machines, orchids, groupers, and financial services. And the early harvest list in services makes Taiwan the only region that is allowed to make independent foreign investments into hospitals in China.
- In addition, on April 26th of 2016, China Food and Drug Administration (CFDA) announced that clinical trial data collected in four Taiwanese hospitals, namely Taipei Veterans General Hospital, National Taiwan University Hospital, Tri-Service General Hospital, and Linkou Chang Gung Memorial Hospital, will be accepted for new drug approval in China. In other words, pharmaceutical companies can conduct clinical trials in Taiwan and apply for drug licenses in both Taiwan and China at the same time.

The Best Investment Environment

Fully-Equipped with Basic Facilities

- There are 3 international airports and 7 international commercial ports in Taiwan. Both sea and air ways connect main countries and cities in the world, gathering great capacity in transportation and operation abroad. Composed of highways, MRT systems, railways and THSR (Taiwan High Speed Rail), the inland transportation network is intensive and promises the smooth and convenient transportation heading to the inner areas of Taiwan.
- Services from water and oil suppliers together with electricity and telecommunication services suppliers are cheap with quality. Those services secure stable and sufficient supplies and offer enterprises fast and cost efficient manufacturing supports.

Healthy Legal Environment

- The Constitution of ROC has clearly stated that any issues involved in civil and compulsory rights should be regulated by laws. And the laws related to tax treaties and fees shall be clear and transparent for the public. With sound legal system and correct legal mindsets held by the public, the high stability of enterprise operations is delivered in Taiwan.
- In Taiwan, intellectual rights such as patent, trademark, copyright, etc. are highly protected by the Interllectual Property Court and relevant laws. Thus, Taiwan provides an environment of innovation that attracts foreign entities for research and development activities in Taiwan.

Condensed Industry Cluster Groups

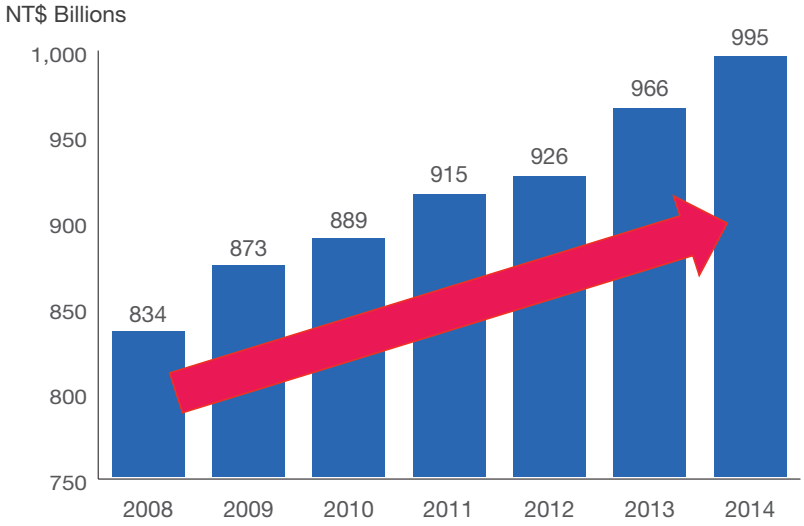
- In the Report of Global Competitiveness in Year of 2012-2013 issued by World Economic Forum (WEF), it is indicated that Taiwan made the first place in the state of cluster development. Complete industrial chains island-wide include industries of high-tech, electro-optical and mobile parts in northern Taiwan; precision machinery industries in the central area of Taiwan; industries that produce petrochemical raw materials, foods and healthcare devices and equipment in southern Taiwan.

Quality Human Resources

- Education is highly accessible and affordable in Taiwan. High education (above colleges and university) rate occupies 57.2‰ of population. Regarding to working population in 2015, there were 507 employees among a thousand with undergraduate qualifications, and 77 employees among a thousand with graduate diplomats, making Taiwan the hub of high quality human resoures.
- Approximately 250,000 students graduate from colleges and universities annually in Taiwan, injecting abundant supply of advanced human resources into labour market. Employees in Taiwan possess goo characteristics such as hard working and highly loyal to employers, which make them highly desirable among employers.

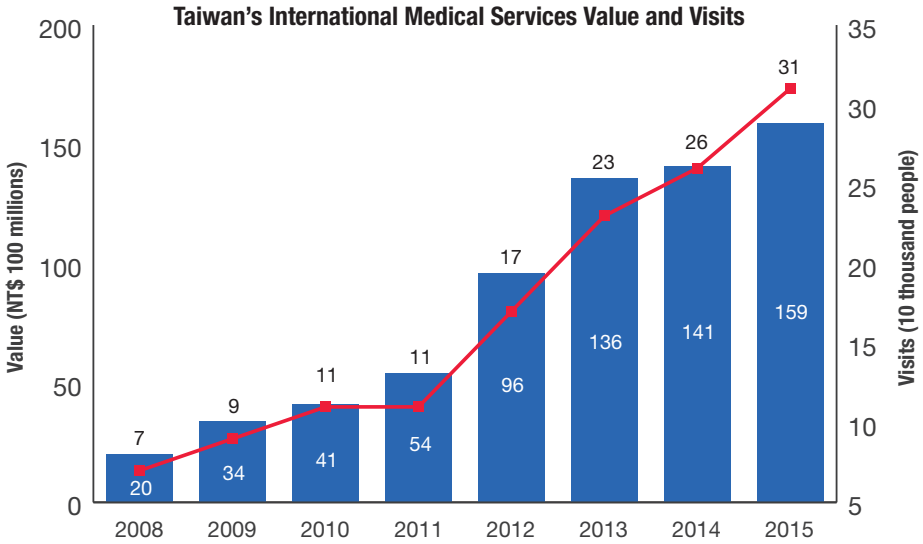
Domestic Markets with the Estimated Value over US$ 31 Billion

In 2014, healthcare expenditure per capita is US$ 1,324, which accounts for 5.9% of GDP and implies lucrative businesses.

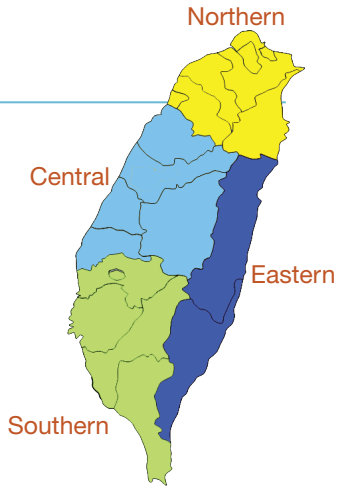


International Medical Treatment Opens up Overseas Market with Huge Potential

Since its latest introduction in 2006, Taiwan's international medical service has attracted increasing number of foreigners year after year. Among those who has experienced Taiwan's international medical services, people from China comprise the largest user number. In addition, the quality of international medical service in Taiwan is guaranteed by high satisfaction of those been served. The international medical service market in Taiwan is promising and has great potential in the future.



Abundant Medical Institutions Island-Wide



According to the statistics in 2014, there are 497 hospitals, 21,544 clinics in the medical services island-wide. In addition, 1,582 nursing institutions provide long-term care services as of 2015..

- The distribution of hospitals throughtout the island: 166 hospitals in the north; 147 in the central area; 166 in the south and 18 in the east.

Brief Introductions of Key Hospitals in Taiwan:

Names	Branch numbers around Taiwan	Strengths
National Taiwan University Hospital	North : 6 Central : 2	International medical treatments, healthcare management, body figure beauty medical treatments, breast medical treatments, cardiovascular treatments, clinical psychology treatments, sleep disorders therapies, sports medical treatments, physical therapies, complementary and integrated medical treatments (the collaboration between Chinese and West medicines), long-distance healthcare, early intervention treatments, the clinical medical treatments for neuroscience and behavior, cancer treatments, treatments for allergies and immune systems, anti-aging healthcare, hepatitis treatments, treatments for Parkinson and movement disorders, the clinical experiments and researches in congenital heart diseases.
Chang Gung Medical Foundation	North : 4 Central : 1 South : 2	• Cancer, strokes, excimer laser refractive surgeries for eyesight correction; pediatric allergy, asthma and rheumatology; severe wounds and injuries, organ transplant, medical treatments for genetic disorders. • The craniofacial center, reproductive medicine.
Taipei Veterans General Hospital	North : 4 Central : 3 South : 4 East : 3	Minimally invasive procedures (MIP) for aortic aneurysm treatment surgeries, the treatments for complications of chronic viral hepatitis and cirrhosis; chest cavity surgeries and middle-ear inflammation microsurgeries conducted in MIP; the surgical removal of cholesteatomas from middle ear; endoscopic nasal surgeries; the radiofrequency treatment for nasal diseases.
MacKay Memorial Hospital	North : 3 East : 1	Reproductive medicine; health examinations.
Taipei Medical University Hospital	North : 3	Cancer, cancer screening tests, healthcare management, beauty medical treatments, weight management, postpartum care, reproductive medicine, rehabilitation robotics, leukemia, breast healthcare management, sleep disorders therapies, and long-distance healthcare.
Taipei City Hospital	North : 9	The integrated outpatient clinics, wards and health examinations with both Chinese and West medical treatments
Changhua Christian Hospital	Central : 9	• Reproductive medicine : Equipped Taiwan's first and only reproductive laboratory accredited with the College of American Pathologist (CAP) certification. • Organ transplant; joint reconstruction; healthcare management center.
Kaohsiung Medical University Chung -Ho Memorial Hospital	South : 4	Featured surgery treatments include Da Vinci surgical system and Renaissance surgical robot arms; while inner medicine covers intervention treatments; sever and acute symptoms treatments; transplantation treatments and cancer treatments.
Cathay General Hospital	North : 4	Hepatitis medical treatments, cardiology, orthopedics, knee replacement surgeries.
Far Eastern Memorial Hospital	North :1	Cardiology, organ transplant, cancer prevention and treatments, nephrology, medical imaging, beauty medical treatments, excimer laser refractive surgeries, helical tomotheraphy system, healthcare.

Highly Competitive Medical Services

Internationally Acclaimed

- Taiwan's medical service is ranked top 1 aourn the world by The Richest in 2015.
- 14 of Taiwan's hospitals are ranked in global top 200, which is next only to America and Germany. That is, Taiwan's hospital quality is ranked 3rd in the world, and top 1 in Asia.

International Standards Achieved

- Taiwan established national accreditation for medical systems in 1978, which made Taiwan the 4th country around the world and also the 1st country with accreditation system for medical services in Asia.
- 17 hospitals have achieved the Gold Seal of Approval® as JCI-accredited (Joint Commission International-accredited) entities in Taiwan. In addition, most of the medical centers and regional hospitals in Taiwan have earned the cretification of Taiwan Joint Commission on Hospital Accreditation (TJCHA).
- 6 hospitals (National Taiwan University Hospital, Taipei Medical University Hospital, China Medical University Hospital, Changhua Christian Hospital, Taiwan Medical University-Shuang Ho Hospital, and Taipei Municipal Wanfang Hospital, Taipei Medical University Hospital) are certified by the Association for the Accreditation of Human Research Protection Programs (AAHRPP).

A Role Model of Healthcare System for Other Countries

Highly acclaimed as one of the world's best systems, Taiwan's healthcare system used to be greatly praised by Paul Krugman, Nobel Prize lauteate in Economic Sciences.

With the satisfaction rate reaching as high as 80%, the healthcare system of Taiwan is definitely a role model for other countries. Healthcare system in Taiwan is also listed as one of the top 10 achievements in the world by CNN.

- The domestic occupation rate of licensed medical institutions in Taiwan is 93.81%. The healthcare system in Taiwan encourages medical sevice providers to provide medical services in the same standard and quality, and rewards those which provide varied ways of illness treatment and payments.
- The healthcare system of Taiwan applies single pricing and payment mechanism. That is, the health insurance authority, National Health Insurance Administration, sets the budget of medical expenditure and is responsible for drugs and medical devices procurement.
- The coverage of National Health Insurance (NHI) in Taiwan has reached over 99%. The NHI IC card system was introduced in 2004 in Taiwan, signifying the start of the digital medical services era. And Taiwan became the first country that collects and stores medical records through IC cards in Asia.

Feature Medical Services in Taiwan

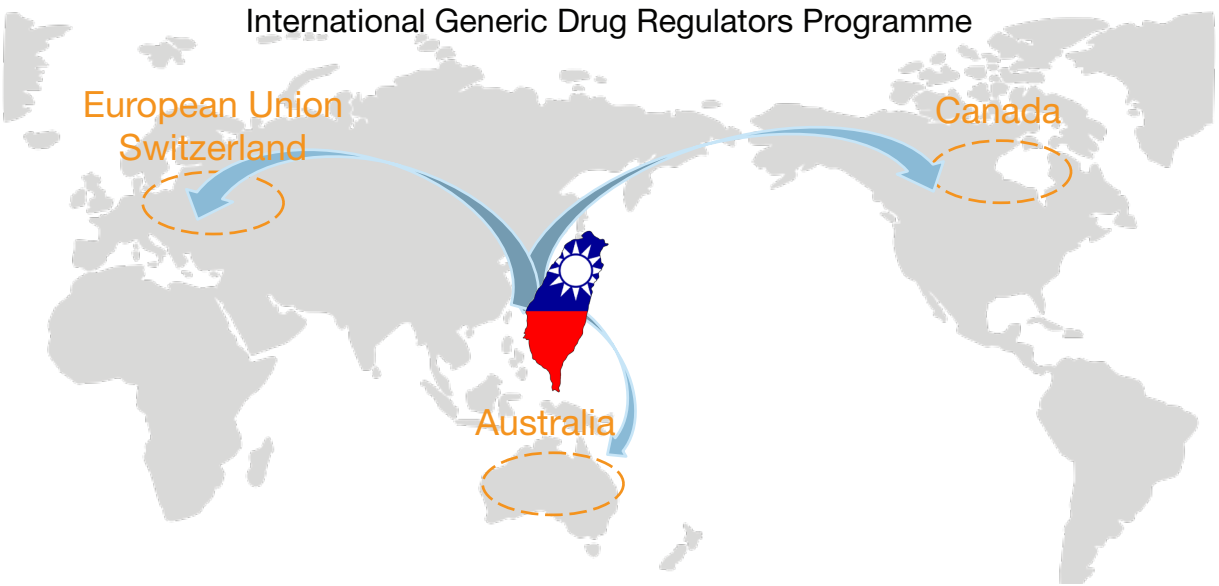
- **Joint replacement:** Taiwan is experienced in artificial knee replacement surgery. Nearly 20,000 artificial knee replacement surgeries are performed every year. Minimally invasive procedures are applied for smaller scars and faster recovery.
- **Cardiovascular treatment:** The first successful heart transplantation surgery in Asia was conducted in Taiwan. The successful rate of coronary artery angioplasty (PCI, heart stent surgery) reaches up to 99% with complication rate less than 1%.
- **Reproductive medicine:** Taiwan practices the world-leading egg freezing technology. The rate of pregnancy through assisted reproductive technology is up to 37.7% with 27.7% of the live birth rate. Treatment expense in Taiwan is cheaper than other countries.
- **Weight loss surgery:** Equipped with many weight loss centers and health planning services, Taiwan also completed the first scarless gastric bypass surgery through a laparoscopic procedure in the world.
- **Liver transplantation:** In 1997-2005, the 5-year-survival rate of liver transplantation surgery in Taiwan had surpassed America. The rate of 1-year-survival has reached 95.1%; the rate of 5-year-survival is up to 91.2%, a record that conquered the world.
- **Health examination:** In addition to standard one day health examination, customized health examination is offered as well. The examination items are optional to meet personal needs for better health management.
- **Medical cosmetology:** With both software and hardware facilities that can compete with the world standards together with quality medical treatment, medical beauty treatment has become a lucrative business. Meanwhile, the ideas such as plastic surgeries and medical beauty treatments are widely accepted by the public in Taiwan. That clinics and institutions offering medical beauty treatments packed in Chung Hsiao East Road located in the center of Taipei city made the best example of such phenomenon.

Taiwan Clinical Trial Consortium (TCTC)

- Taiwan Clinical Trial Consortium (TCTC) has 13 different disease-specific clinical trial consortiums: Lung Cancer, Liver Cancer, Gastro-Intestinal Disease and Helicobacter Pylori, Oncology Phase-1 Clinical Trials, Breast Cancer, Gynaecological Cancer, Respiratory Diseases, Hypertension and Cardiovascular Diseases, , Hypertension and Cardiovascular Diseases, Hyperlipidaemia and Atherosclerosis, Paediatric Infectious Diseases, Mental Disorders, Renal Diseases, Adult Infectious Disease, and Stroke.
- The strengths of conducting clinical trials in Taiwan include close distance from China, Japan, Korea and Singapore; the role of gateway to China under Cross-Strait Cooperation Agreement on Medicine and Public Health Affairs; lower cost & faster recruitment compared to other developed countries; big data from National Health Insurance Program; strong IT industry to support biotech R&D and data management; joint mechanism to expedite IRB review; lots clinical research excellence centers, medical centers, teaching hospitals, and high quality physicians and nurses that are globally acknowledged.
- TCTC provides one-stop shop for its partners. Partners of TCTC will be able to utilize various services provided by TCTC, including clinical information management system, education and training, clinical trial and biostatistics consulting, and laboratory service.

Regulatory Harmonization with the Globe

Taiwan participates in the Information Sharing Pilot under International Generic Drug Regulators programme (IGDRP). In addition, Taiwan will join the alliance with 11 other countries (UK, the US, Canada, Japan, South Korea, Singapore, Malaysia, Thailand, New Zealand, Indonesia and China) to evaluate bridging studies that allow results from clinical studies in one country to be extrapolated in another.



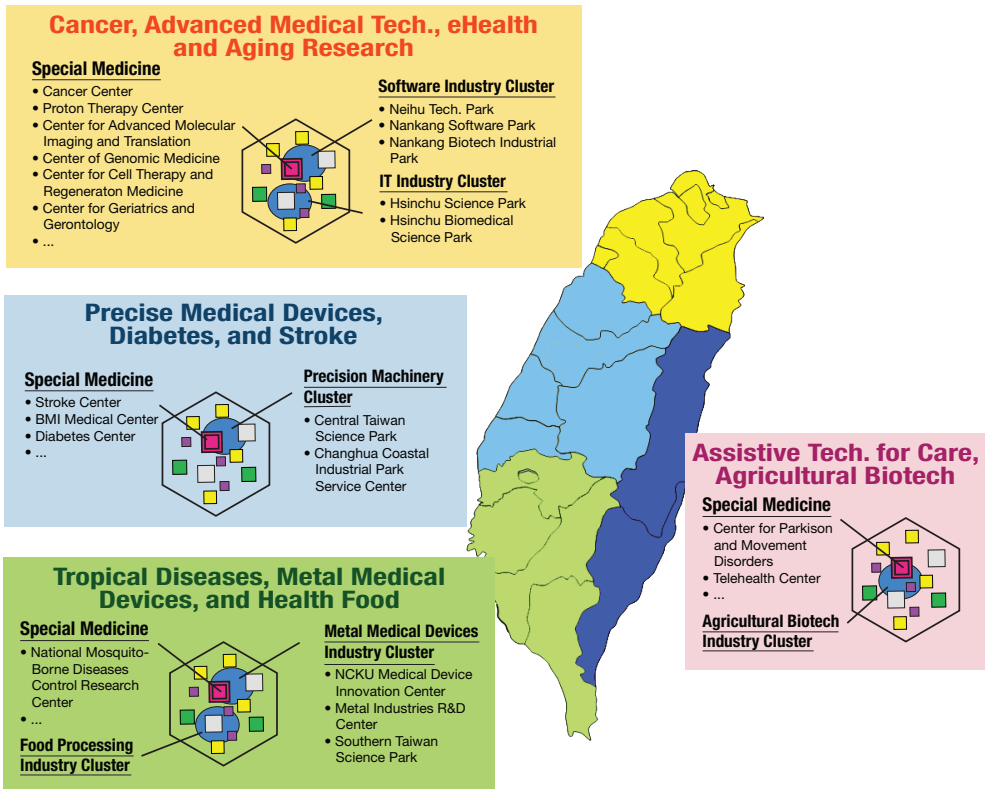
The Cross-Strait Cooperation of Clinical Trials Speeds up the Connection of Cross-Strait Medical Treatments

Since the Cross-Strait Cooperation Agreement on Medicine and Public Health Affairs was signed in December of 2010, the cooperation between Taiwan and China has started a new page. In the end of 2014, both countries agreed to expand cooperation by proposing the Cross-Strait Cooperation of Clinical Trials, and choosing 4 hospitals in each country to establish the platform of cross-strait cooperation of clinical trials. Besides, the Cross-Strait Human Test Committee was also established for censorship and cooperative mechanisms.

- Taiwan: National Taiwan University Hospital, Taipei Veterans General Hospital, Linkou Chang Gung Memorial Hospital and Tri-Service General Hospital
- China: Peking University First Hospital, Peking Union Medical College Hospital, Zhongshan Hospital Fudan University and Rui Jin Hospital Shanghai Jiao Tong University School of Medicine

In April 2016, the Cross-Strait Cooperation of Clinical Trials was implemented.

Solid Industry Clusters



North: Oncology, Advanced Medical Technology, eHealth, and Geriatric Research Clusters

- The northern part of Taiwan is the most population-dense, medical resources demanding, and medical technology advanced area. Therefore, special treatments and technology such as proton therapy, advanced molecular imaging, and regeneration medicine are focused especially for oncology: National Taiwan University Hospital and Taipei Medical University Hospital have both embarked on the projects to develop advanced medical technology such as cell therapy and regeneration medicine. Meanwhile, Linkou Chang Gung Memorial Hospital, as a key member of "Taiwan Proton Research League" alongside Academia Sinica, is expected to complete the construction of a large laboratory in 2018 to develop proton therapy, advanced molecular imaging research and products.
- In 2006, to provide integrated services for senior citizens, Taipei Veterans General Hospital established "Center for Geriatrics and Gerontology," which became the only Asian center awarded as world geriatric research center by International Association of Gerontology and Geriatrics in 2012.

Central: Precision Medical Devices, Diabetes, and Stoke

- The central part of Taiwan is well-known for its precision medical devices clusters, such as INTAI (minimally invasive surgery devices) and BIONIME (blood glucose meter).
- China Medical University Hospital leads the research center and establishes a stroke database with more than 49 medical centers and hospitals; Taichung Veterans General Hospital set up the first Diabetic Center to promote health issues related to diabetes; and Changhua Christian Hospital establishes the diabetes case database combined with telecare services for integrated diabetic care.

South: Tropical Diseases, Metal Medical Devices, and Health Food

- Dengue fever is prevalent in the southern part of Taiwan. To better study and prevent this air-borne infectious disease, the “Dengue Fever Preventive Research Center” has been set up by the Center for Disease Control (CDC) with Kaohsiung Medical University.
- The local government had targeted the “Southern Taiwan Science Park” for medical device subsidy plan since 1999; and the “Southern Taiwan Medical Device Industry Cluster (STMDIC)” project has entered the second phase to further promote the medical device industry of Taiwan.
- As 60% of the food manufacturers stay in Southern part of Taiwan, Academic Sinica and National Health Research Institute moved to the Southern Taiwan Science Park to promote health food research and development, as well as the agricultural biotechnology food. The more southern part of Taiwan already formed some functional food cluster or Chinese medicinal herb products cluster.

East: Assistive Technology for Care and Agricultural Biotech

- As the population density in eastern part of Taiwan is lower, telecare is a necessity in this area. In 2012, Hualien Tzu Chi Hospital starts to promote tele-healthcare in order to lower the inpatient rate and better utilize the scarce medical resource in eastern Taiwan.
- In 2015, the Industrial Technology Research Institute and the Stone & Resource Industry R&D Center set up “Eastern Taiwan Industry Technology Service Center” to aggregate the research and development in the field of agricultural biotechnology and life science products. National Taitung University further established “Eastern Taiwan Bio-Economy Development League” to combine local agriculture and biotechnology products.

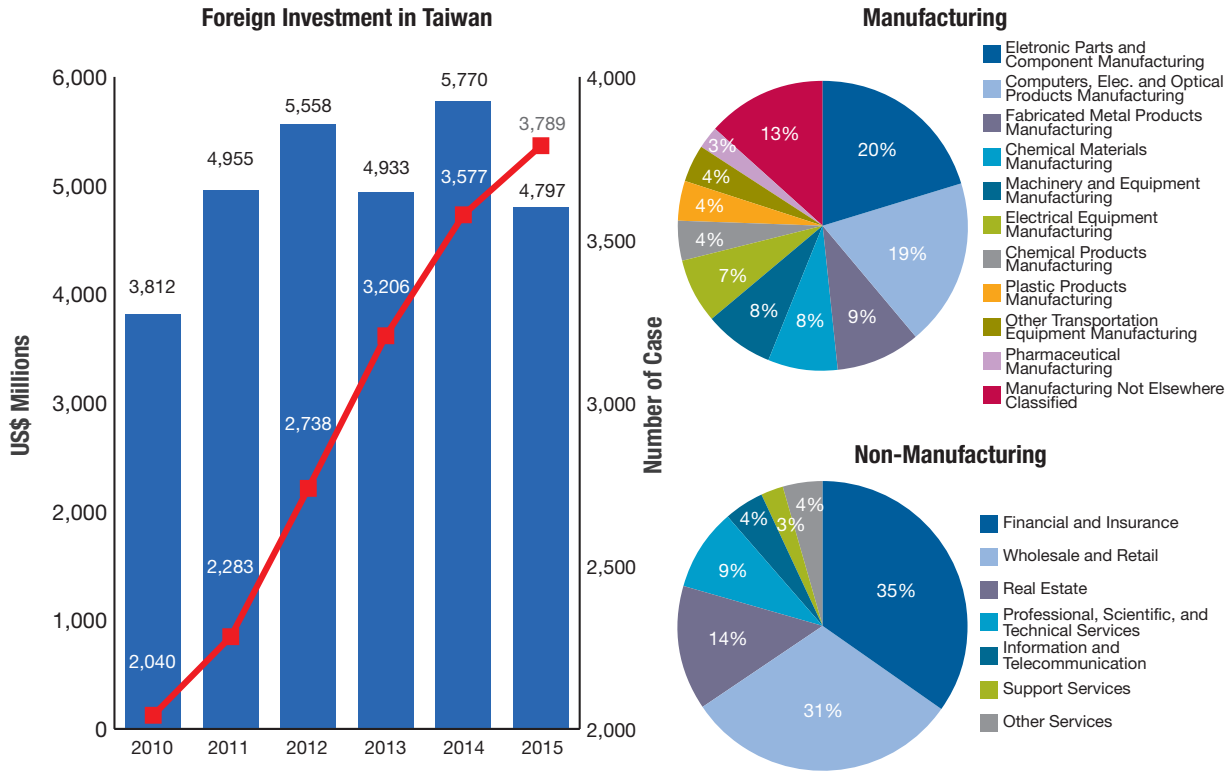
Cases of Foreign Investments Exceed 3,700

When the financial tsunami finally came to an end, foreign investments in Taiwan have recovered with the annual growth rate by 4.7% between 2010 and 2015. In 2015, cases of foreign investments in Taiwan reached up to 3,740 indicating that foreign investments still remain feverish.

The High Willingness of Investments from Drugs and Medicines Manufacturing

Among all manufacturings, electronic parts and components manufacturing and machinery and equipment manufacturing have gathered the highest value of foreign investments; drugs and medicines manufacturing ranked No.11 among all manufacturing industries in 2015.

As for non-manufacturings, finance, insurance, retailing and distribution are the industries that have attracted the largest foreign investments in 2015.



Google Founded in 2006

Investment scale: NT$ 3.7 billion

Website: http://www.google.com/

About Google:

Founded at Silicon Valley of the United States in 1998, Google mainly offered search services. It also offer specific advertising services together with tools to estimate advertising effects to industry clients including advertisers, content providers and web managers. Its tools and great convenience have been highly acclaimed by users around the world and thus been widely recognized as “the world’s best search engine”.

Google has made deep-rooted investment s Taiwan by its cooperation with academic institutions to promote Google’s Cloud Computing project. With efforts made by Google’s world leading engineers and local developers, ideas and experiences of program development can thus be shared so as to further help improve the capability/ capacity of network platforms and boost diverse and innovative network applications.

Reasons to Invest in Taiwan:

Most small and medium enterprises in Taiwan have practiced business modes of OEM (Original Equipment Manufacturer) and ODM (Original Design Manufacturer). And regarding to the scale, depth, intensity and agility of upstream and downstream systems, the benefits gained from those systems are hardly conquered by other countries around the world. Within Taiwan’s industry structure, more than 200 industries are gathered in some specific areas. The mode of competition and cooperation has been performed among key industries throughout upstream, midstream and downstream at the meantime to stimulate the gathering of industries. The techniques and talents in Taiwan not only particularly matter to Google, but also play the key role. Because of the strength in manufacturing hardware and consumer electronics products of Taiwan, Google promises the continual cooperation with hardware industries in Taiwan for the constant development of innovative products.

Main Achievements:

Google has offered small and medium enterprises in Taiwan more services and products such as Cloud Computing that saves industries from inner operation cost, Gtalk, Google Apps, Calendar, Maps and Youtube together with Google AdWords and AdSense projects that help the promotion of industries’ services and products by delivering advertisements related to contents of websites so as to improve both industries’ lucrative capability and users’ experiences in the meantime.

Google in Taiwan has also embarked a series of online marketing and brands forums for small and medium industries along with project activities such as online partnership days for advertising purposes so as to assist clients in advertisements to search for businesses through Google’s global platforms. Their markets throughout the world will be expanded as well. With the close collaboration between Google and clients, the visibility and competitiveness of both sides are surely secured.

3M Company Founded in 1969

Investment scale: NT$ 1.05 billion

Website: http:// solutions.3m.com.tw

About 3M Company:

3M, founded in 1902 at Minnesota of the United States, is fundamentally a science-based company. Its products range from transportation to diverse industrial supplies of profession including electronics, healthcare and optics. Daily life products and office stationery are covered as well. 3M's success begins with its ability to apply their core technologies – often in combination – to an endless array of real-world customer needs.

3M Taiwan is a great sales team of competence that can thoroughly meets clients' needs. With the professional support of technicians, the development of innovative products is boosted, which also further leads quality control experiences, manufacturing flows or intelligence/knowledge and capability to reach same international standards of 3M US headquarter.

Reasons to Invest in Taiwan:

3M has highly valued the power of traditional manufacturing industries in Taiwan as well as the needs to develop high-tech industries such as all electronics-related industries from upstream to downstream throughout islandwide. Needs developed from industrial clients like semiconductors, electro-optical and healthcare etc are perfectly met by 3M's innovative applications. The partnership with product developers is well established at the same time. In addition, 3M has a close collaboration with many foundries and electro-optical plants in Taiwan and has always been one step faster to require specifications from internationally-known plants so as to maintain advantageous. What's more, with 46 technical platforms around the world, 3M has always been very efficient in creation and innovation.

Main Achievements:

3M has made investments in Taiwan for 45 years. Among the 65 subsidiaries around the world, 3M Taiwan has been the role model in global competition. First, 3M Taiwan reached the highest revenue growth rate of year 2010. Secondly, 3M Taiwan has made the top-of-the-world performance in the markets of consumer and office supplies. And the rate of New Product Vitality Index (NPVI) in Taiwan has far surpassed other subsidiaries. NPVI indicates the annual revenue rate gained from new products developed in the past four years. It is 3M's requirement that the NPVI of all subsidiaries shall exceed 30%. Such requirement had been outdone by 3M Taiwan. Because of its great innovative competence, its NPVI had reached 40%, a brilliant performance that had outshone other companies in 3M Group. In addition, 3M Taiwan has been the cradle of general managers. The numbers of general managers cultivated in 3M Taiwan have been far more than those in other Asia subsidiaries: five general managers took offices in Singapore, Thailand, Malaysia and Hong Kong are from 3M Taiwan.

Pfizer Founded in 1962

Investment scale: NT$ 1.18 billion

Website: http:// www.pfizer.com.tw

About Pfizer:

Pfizer, the first foreign pharmaceutical corporation established in Taiwan, currently is regarded as the biggest multinational company islandwide. Markets mainly focus on two major business systems which are medicines (prescribed medicines and vaccines) and consumer healthcare products. The numbers of employees are 700 in total. Presently, Pfizer Taiwan headquarter is located in Tamsui; two other offices are respectively established in Taichung and Kaohsiung; one manufacturing plant in Hsinchu. Products such as nutritional supplements, injection products and other medicines are manufactured in Pfizer Taiwan.

Pfizer has been playing an active role in offering continuing medical education and help physicians and healthcare professionals updated with the latest information. In terms of the promotion of domestic clinical and medical trials, phase 3 trials have been constantly practiced so as to make both domestic and global trial standards connected. At present, Pfizer Taiwan has taken a part in approximately 50 global trials every year.

Reasons to Invest in Taiwan:

Among multinational pharmaceutical corporations from the US and European counties, Pfizer is the first and only company that made investments and conducted the manufacturing and selling in Taiwan. Pfizer Taiwan has sold more than half products to12 countries in Asia-Pacific region including Korea, Japan, Hong Kong, India, Thailand, Malaysia, Singapore, Indonesia and Australia etc, playing a critical role as “the Asia-Pacific operation center” in the Asia-Pacific market.

Since February of 2010, Pfizer Taiwan has also started to sell consumer healthcare products to Columbia, expanding the market to countries outside of Asia-Pacific regions. Pfizer currently has two global manufacturing plants that produce TAZOCIN Lyo-injection products and one is located in Taiwan. During manufacturing, injections are lyophilized in a sterile dryer.

Main Achievements:

Since year 2002, Pfizer Taiwan has regularly been PIC/S certified after the routine inspection conducted by TGA, Therapeutic Goods Administration based in Australia. Pfizer Taiwan has also accepted regular inspections practiced by governmental authorities to maintain the highest standards of manufacturing medicines.

In 2006, Pfizer Taiwan received the Industrial Sustainable Excellence Award of MOEA (Ministry of Economic Affairs, R.O.C.).

In 2010, Pfizer Taiwan was officially certified by PIC/s in the field of GMP (Good Manufacturing Practice).

In 2011, Pfizer Taiwan won the Best Performance in Energy Saving and Deduction of Carbon Dioxide Emission, Hsinchu County, Taiwan for its manufacturing plant.

Taxation Systems

National Taxes	Income taxes (enterprise and individual) Securities transaction tax Estate and gift tax Commodity tax	Custom duties Business tax Future transaction tax Tobacco and wine tax
Municipal Taxes	Land value tax Stamp tax Deed tax Building tax	Farm tax Land value increment tax Vehicle license tax Amusement tax

Business Income Tax Offers

Taiwan is one of countries that offer the world's lowest business income tax rate.

Taxable Income Bracket (NTD)	Tax Rate
Up to 120,000	None
Over 120,000	17% of total income, but income tax liability may not exceed 50% of the portion of taxable income over NTD120,000.

Countries within the Agreement for the Avoidance of Double Taxation

Until September 30 of 2013, Taiwan has agreed with 25 countries to mitigate the effects of double taxation (Double Tax Avoidance Agreement). Countries within this agreement may have benefits offered for dividends, interest and royalties.

Asia	Singapore Indonesia Malaysia	Vietnam Israel	Thailand India
Europe	Netherlands Belgium France Slovakia	Sweden Denmark Switzerland Macedonia	UK Hungary Germany
Other	Australia Gambia South Africa	New Zealand Senegal	Paraguay Shineijilan

Biotech and New Pharmaceuticals Industry

On the basis of the Act for the Development of Biotech and New Pharmaceuticals Industry and the MOEA Reward Strategies for Biotech and New Pharmaceuticals Industry, investment benefits include shareholder investment tax credits, rewards for research and development training programs, the suspense of tax payment for shareholders/ stockholder who made technical contributions for companies and possess companies' stock option certificates.

Investment Benefits for Shareholders

Business entities that made investments into the establishment or expansion of biotech and new pharmaceuticals companies and have become registered shareholders for more than 3 years may have individual income tax credits by/ if they make 20% of investments.

Senior professionals and the investors of technologies in biotech and new pharmaceuticals companies may be rewarded with newly issued technology stocks or stock option certificates. Stocks from either channel above do not need be included in tax payment.

Benefits for Expenditures in Research and Development Together with Training Programs

Biotech and new pharmaceuticals companies may have individual income tax credits by/ if they make 35% of investments in expenditures in research and development together with training programs; when expenditures exceed average records 2 years ago, the exceeding parts may have individual income tax credits by 50%.

The Suspense of Tax Payment for Shareholders Who Made Technical Contributions for Companies

Senior professionals of biotech and new pharmaceuticals companies may be rewarded with newly issued stocks which may not be included in individual income tax payment of the same year.

The Suspense of Tax Payment for Shareholders Who Possess Companies' Stock Option Certificates

Senior professionals of biotech and new pharmaceuticals companies are not allowed to transfer their stock option certificates. Stocks that are transferred, given out as gifts, or made as profits after property distribution will be included in individual income tax payment of the same year.

Benefits for Import Machines and Equipment that are Not Manufactured Domestically

When machines and equipment that have not been manufactured domestically yet are imported from other countries, those machines and equipment may be free from import tariffs.

Royalties and No Individual Income Tax Payment for Foreign Investments

When companies within programs certified by Industrial Development Bureau, Ministry of Economic Affairs introduce new manufacturing technologies or products from other countries, they may be involved in foreign rights of patent and trademark; various concession rights as well. Those foreign rights as royalties are promised rewards for foreign investments. So is no individual income tax payment concerned with royalties.

Investment Tax Credits For Private Institutions Participating in Public Infrastructure Projects

Private institutions participating in public infrastructure projects may be rewarded with tax credits such as no business income tax payment, the tax decrement for investments and no import tariffs for construction machines. House tax, land value tax and deed tax will be reduced or remitted. Business companies that make investment into those private institutions shall also be promised with the reduction and remittance of business income tax payment.

Taiwan is a small island that culitvates convenience-oriented lifestyles. Many foreigners believe that such lifestyles islandwide transform Taiwan into a large and multifunctional community. Taiwan society seeks for equality and residents here are amiable and friendly particularly for foreigners. Thus foreigners can easily make Taiwan as their home when getting used to lifestyles and environment in Taiwan. Taiwan encourages various religious beliefs such as Taoism, Buddhism, Christianity and Muslism, which proves Taiwan's great tolerance and acceptance.

Climate

Generally, Taiwan has warm weather all year long with the annual average temperature of 22 degrees Celsius and the lowest average about 12 to 17 degrees Celsius (54- 63°F). Taiwan, as an island located in the subtropical area, has mild sunshine. Surrounded by seas and thoroughly under the influence of ocean currents, Taiwan has that kind of weather that makes you feel moisturized and warm.

Housing

Housing in Taiwan is comparatively cheaper—such statement can be proved by the fact that rent approximately costs NT$ 1,000 per ping (around 3.3 square meters) in Taipei city. Rent varies by the numbers of facilities like swimming pools, air-conditionings and fitness rooms. And if you find places from other cities and counties instead of Taipei city, you will know that rent is much cheaper.

Public Infrastructure

Most basic public facilities that offer services such as electricity, tap water, gas, telephones and waste disposal have reached standards of developed countries. Because of the subtropical climate, houses in Taiwan do not have central heating system. And most families in cities use natural gas delivered through pipes to cook and heat water.

Tansportation

Public transportation

With a complete transportation network throughout the island, Taiwan promises convenient daily lives by offering diverse transportation means such as Taiwan High Speed Rail and MRT (Mass Rapid Train) systems in Taipei and Kaohsiung. THSR greatly shortens the travelling time from the north to south back and forth and MRT systems in metropolitan areas secure convenient lifestyles. The routes of city buses and highway coaches cover most areas of the major cities.

Driving

As the number of cars increases and drivers' skills have been improved, the highway network in Taiwan has become an intensive transportation network. A lot of foreigners rent or purchase cars in Taiwan and their overall experience of driving in Taiwan have been greatly improved in the past five years.

Education

There are many schools for foreign students live in Taiwan, including Taipei American School, Taipei Korean School, Taipei Japanese School and Taipei European School. Many other similar schools for foreign students are also available in Taichung and Kaohsiung.

There are lessons and programs arranged by various institutions, colleges and universities aiming to meet foreigners' need of learning Taiwanese or Chinese so as to enhance their commercial communication and comprehension competences. The Ministry of Education, Taiwan also established "The Test of Chinese as a Foreign Language" for the promotion of relevant tests.

附件十一

衛生福利部
Ministry of Health and Welfare

Partnering and Strategic Opportunities in Taiwan: the Biomedical and Healthcare Industry Landscape

September 2016

Forum Outline

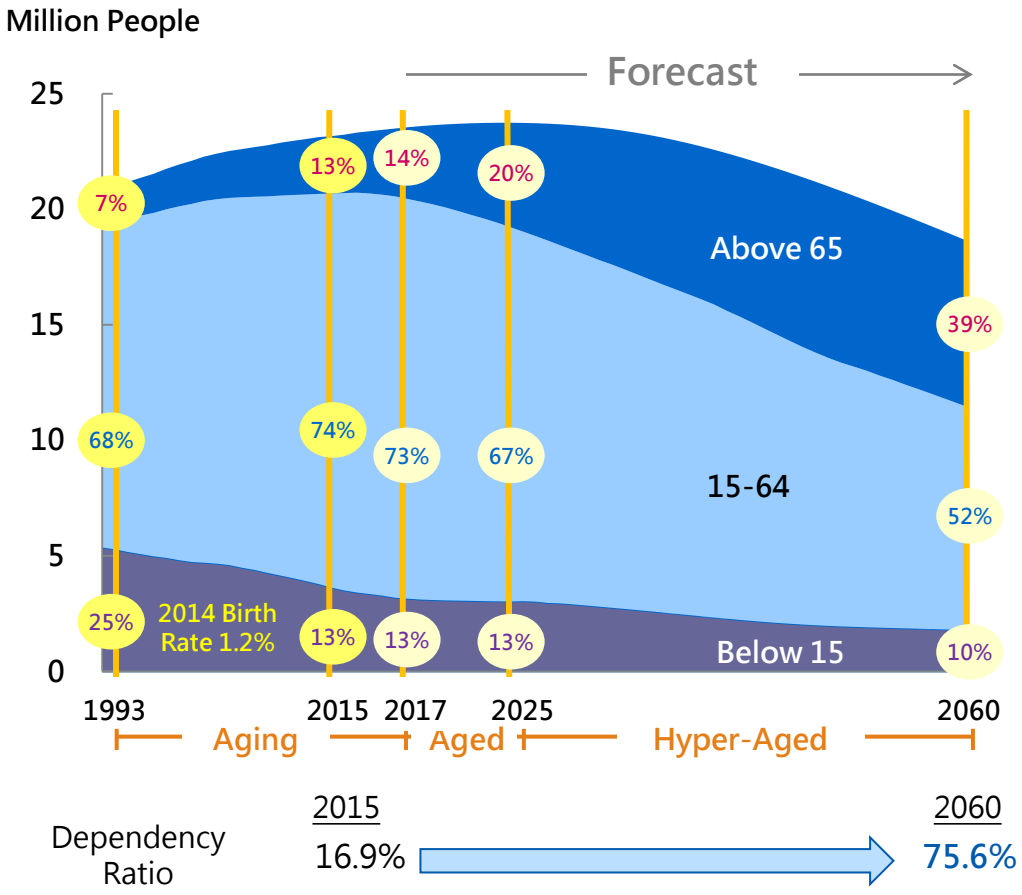
1. Overview of Healthcare System of Taiwan
2. Overview of Life Science Industry in Taiwan
3. Collaboration with Taiwan Pharm & Biotech Companies
4. Collaboration with Taiwan Medical Device Companies
5. Summary

Overview of Healthcare System of Taiwan

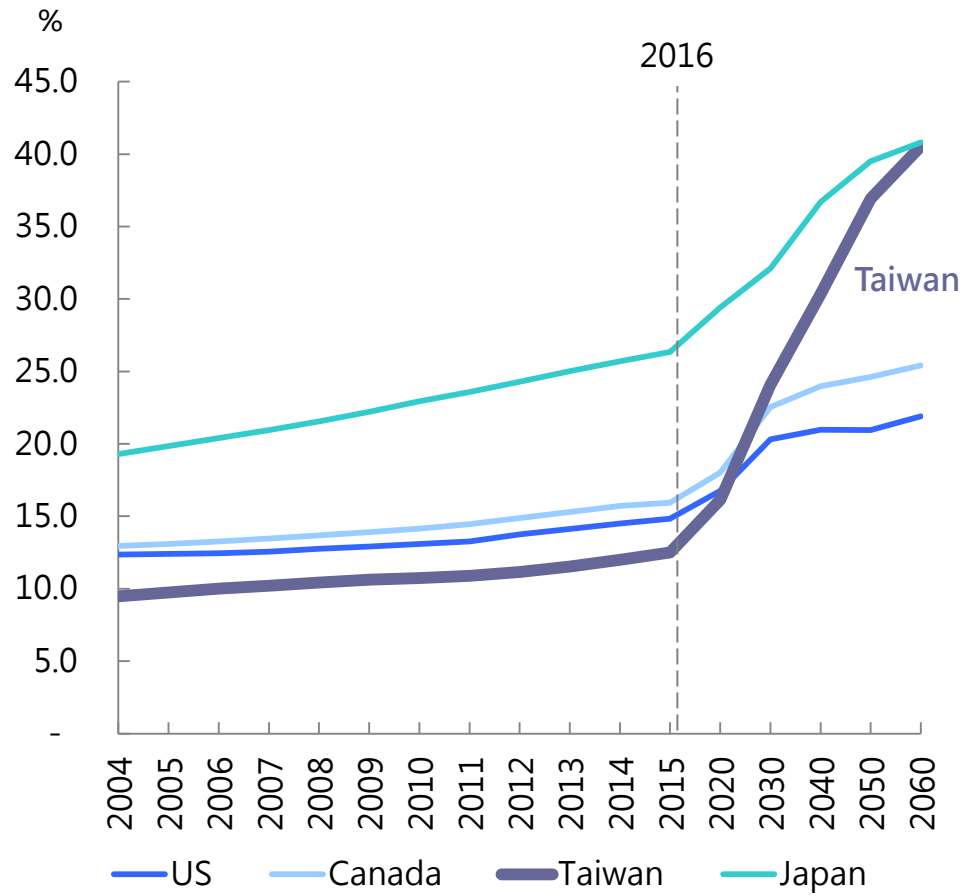
1. Overview of Healthcare System of Taiwan

Taiwan has became an aging society since 1993 and is expected to become a hyper-aged society in 10 years, surpassing most of the developed countries

The Structure of Population in Taiwan



Percentage of People Aged 65+ in the World

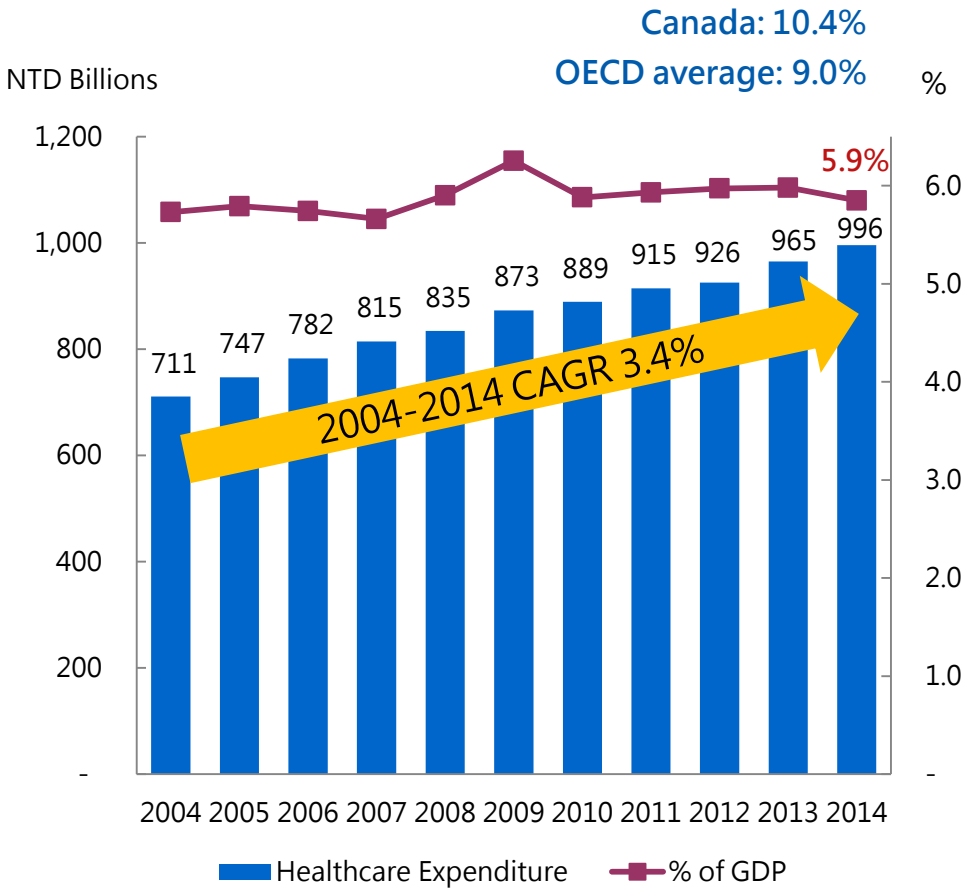


Source: OECD; National Development Council, Department of Statistics, MoHW

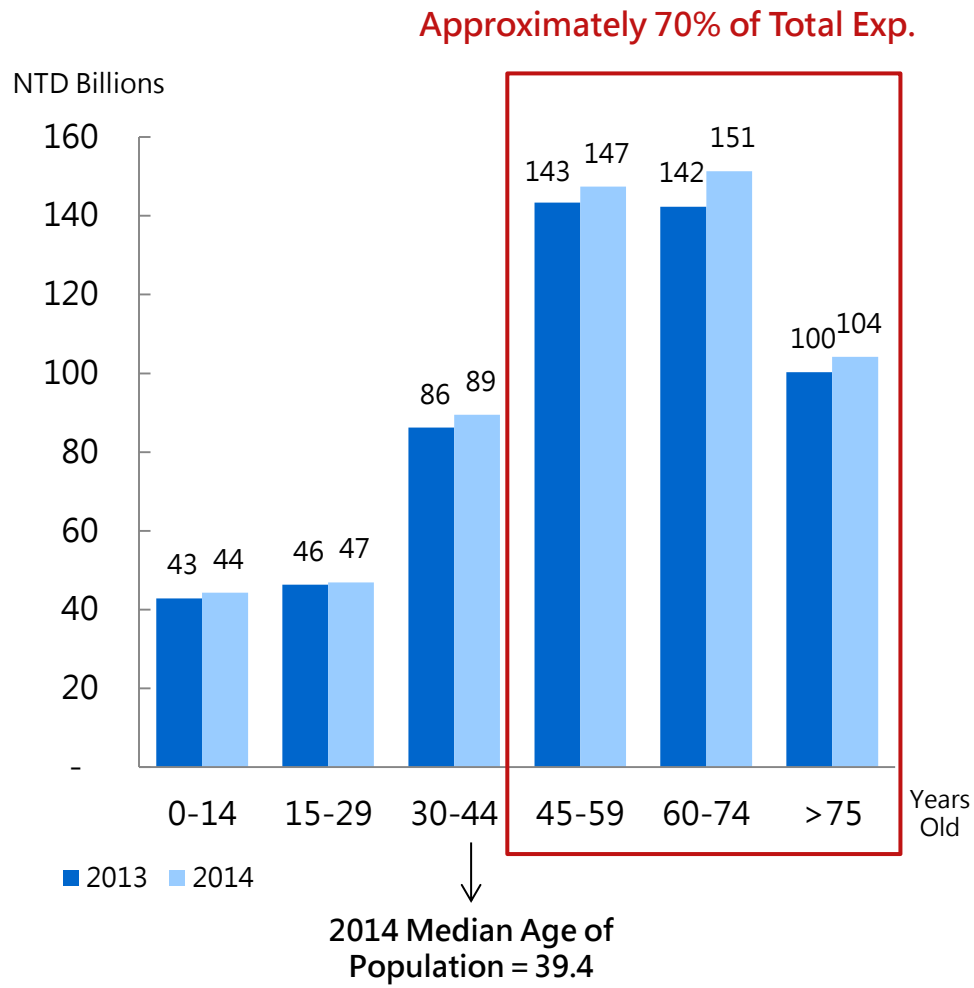
1. Overview of Healthcare System of Taiwan

The rising healthcare expenditure related to the aging society of Taiwan further pushes the government to focus on the long-term care issues

Healthcare Exp. in Taiwan



Healthcare Exp. of Different Age Groups in Taiwan



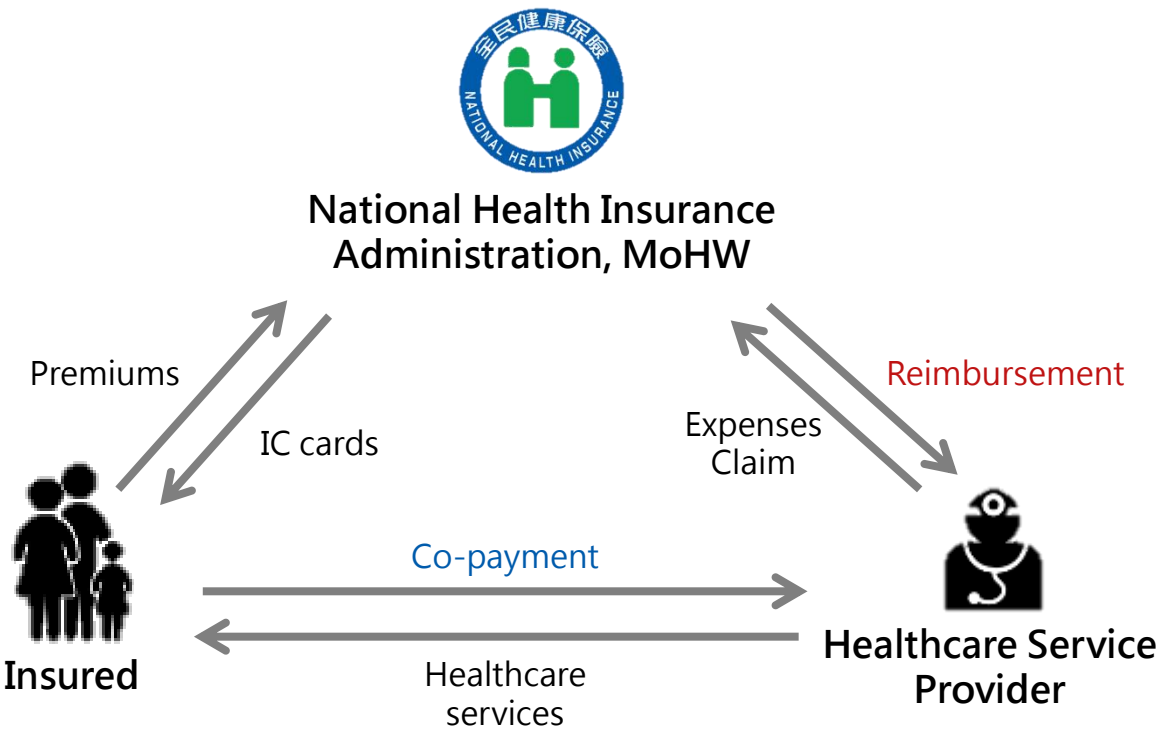
Source: OECD; MoHW

1. Overview of Healthcare System of Taiwan

The compulsory National Health Insurance (NHI) program adopted in Taiwan covers most of healthcare expenditure through reimbursement

- The National Health Insurance (NHI) program was launched in 1995, and the use of IC card national-wide was implemented in 2003
- The universal health coverage of Taiwan's NHI program is 99.6%

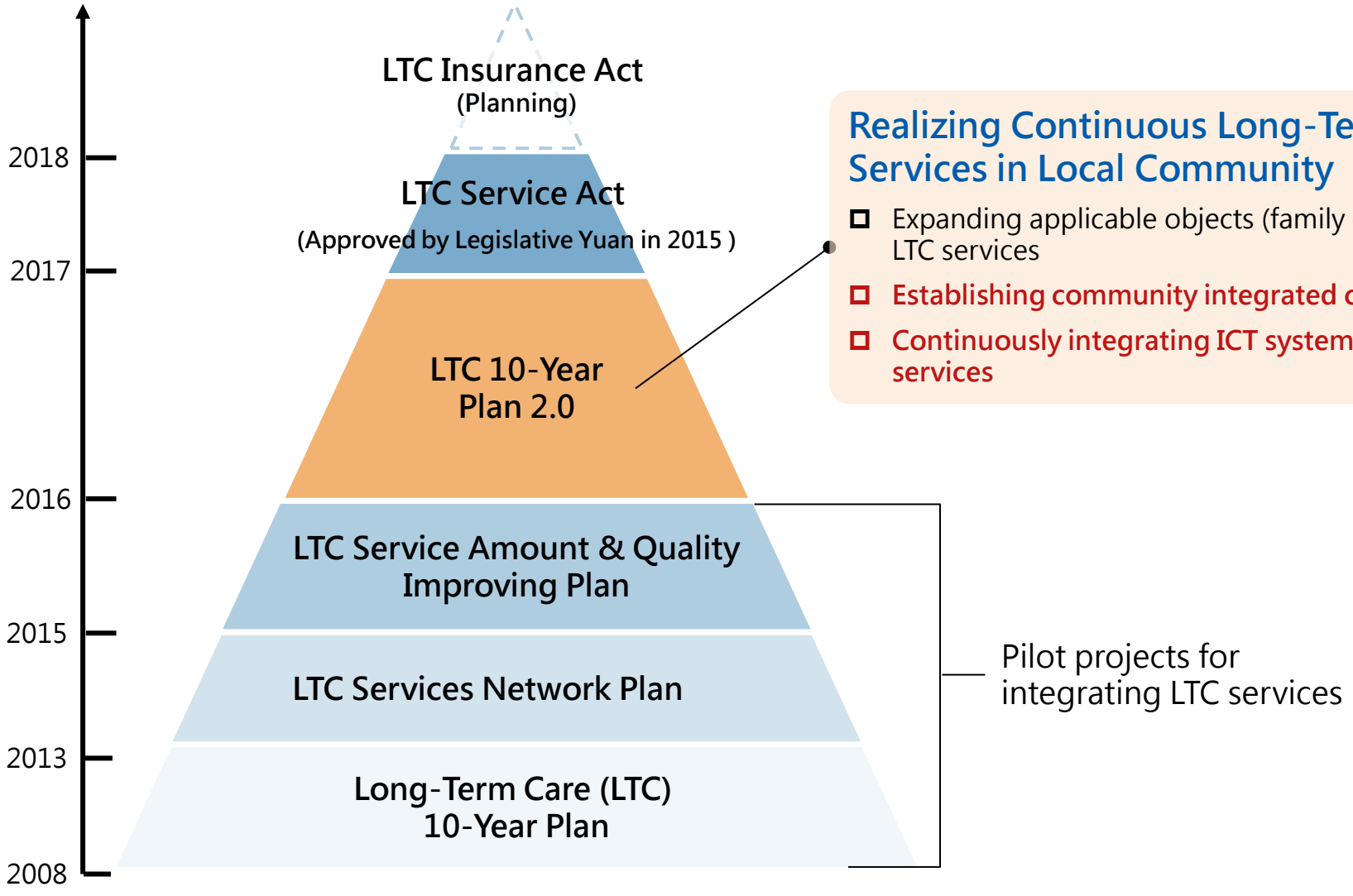
Operating Mechanism of NHI Program



Source: National Health Insurance Administration, MoHW

1. Overview of Healthcare System of Taiwan

To meet the needs of long-term care service, the government has focused on continuous care in local community in recent policy development



Source: Long-Term Care Policy Portal, MoHW

1. Overview of Healthcare System of Taiwan

To achieve the ultimate goal of "Aging in place," the community integrated caring model becomes future blueprint

LTC Models in Taiwan

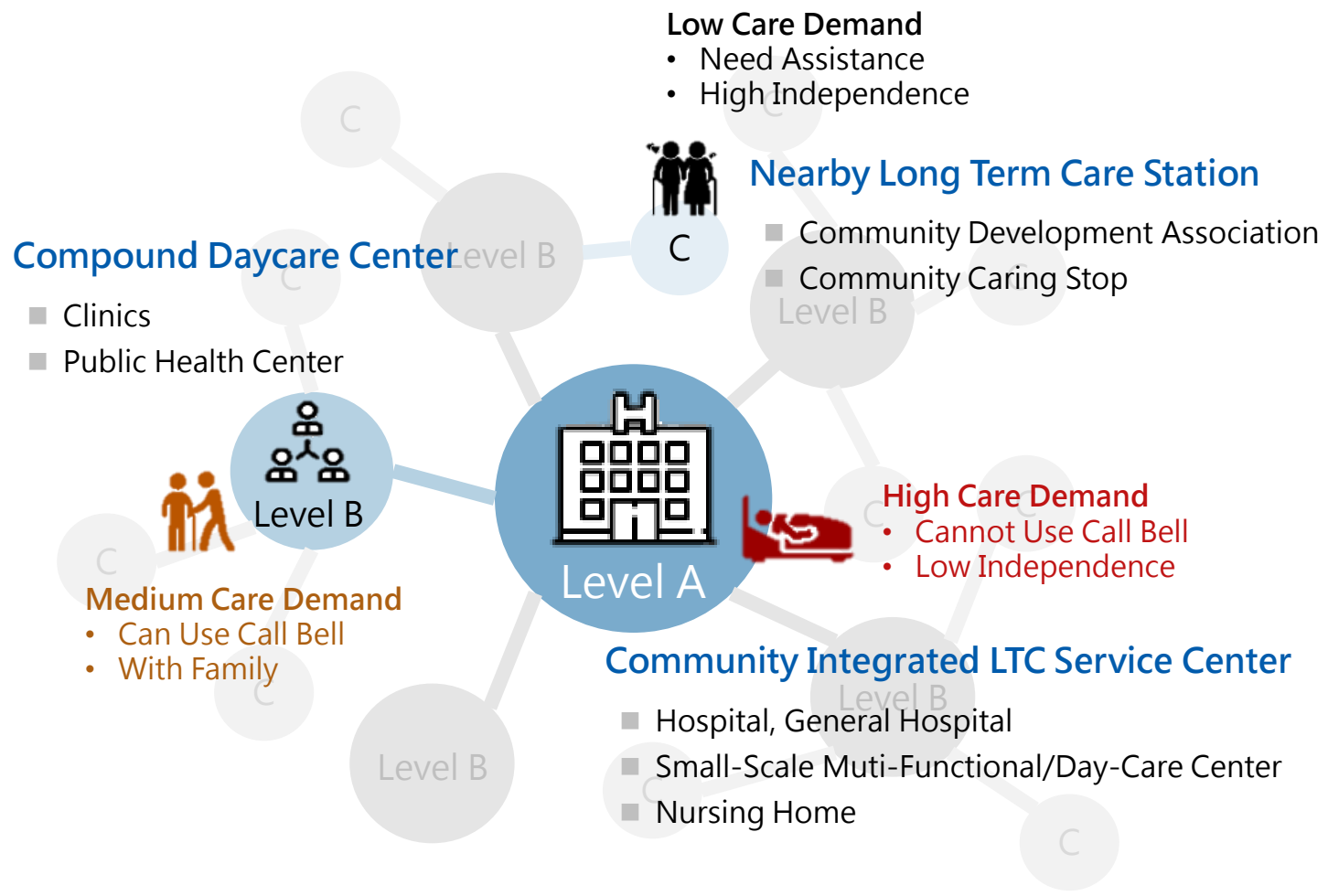
90% ↑

Home Care

Community Care

Institutional Care

Aging in Place Community Integrated Caring Model

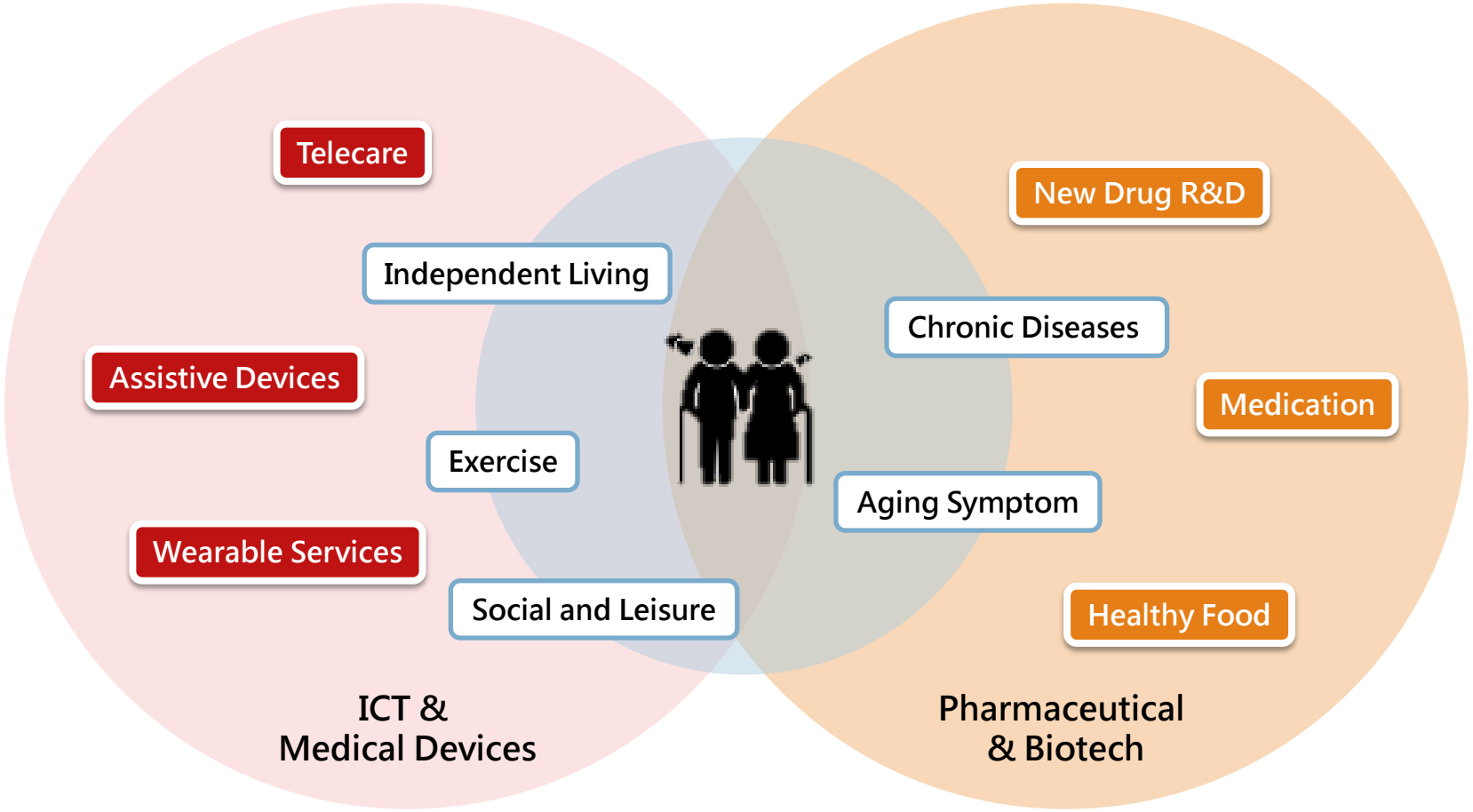


Source: Long-Term Care Policy Portal, MoHW

1. Overview of Healthcare System of Taiwan

The potential market of Taiwan's geriatric population is big, in terms of pharmaceutical, biotech, and medical devices industries

- According to National Development Council, the elderly market in Taiwan will grow to USD 9 billions in 2025.



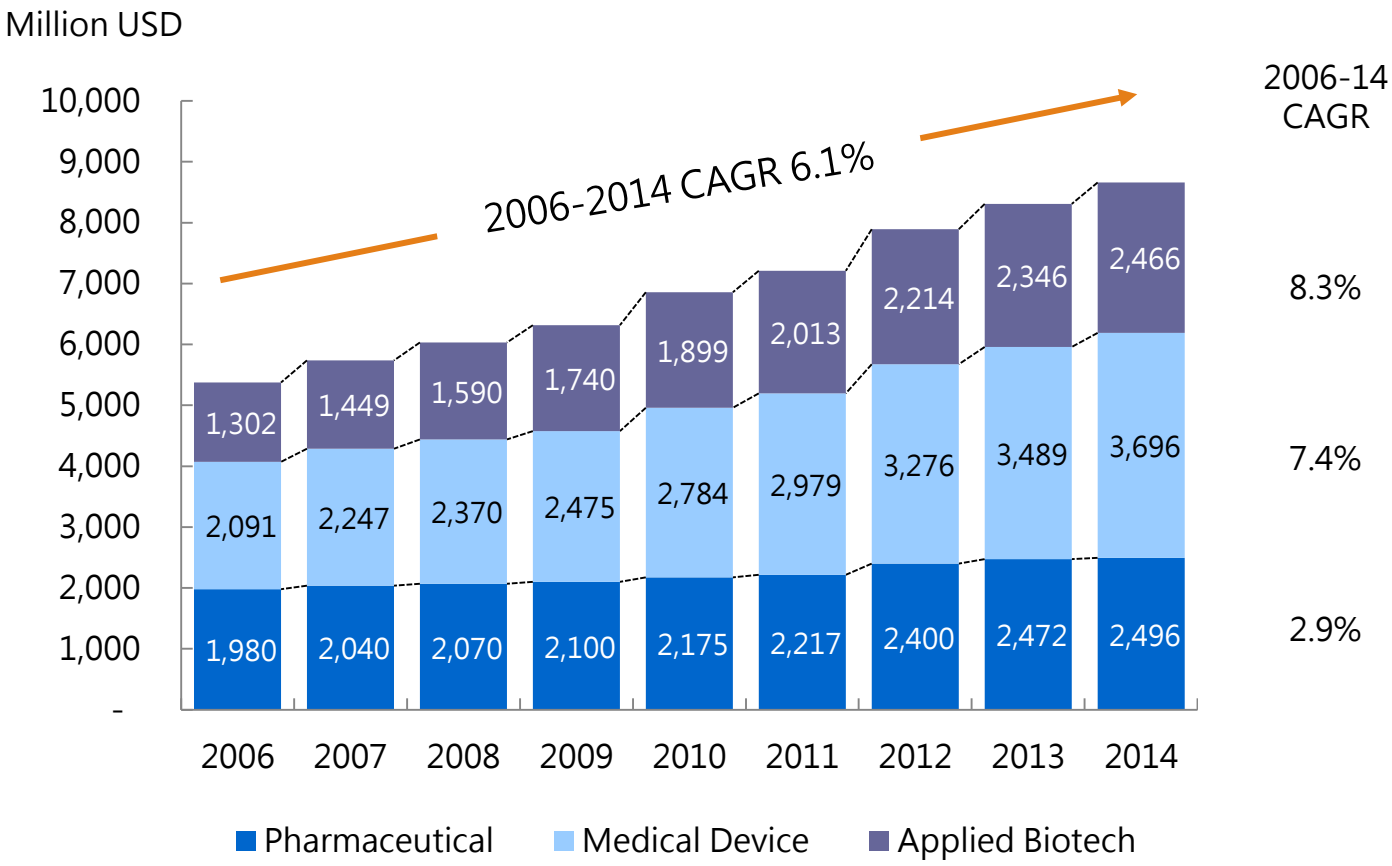
Source: National Development Council;
Industrial Technology Research Institute IEK; Introduction to Senior Services

Overview of Life Science Industry in Taiwan

2. Overview of Life Science Industry in Taiwan

The life science industry in Taiwan has experienced stable and constant growth in the past decade

Market Scale of Taiwan Life Science Industry

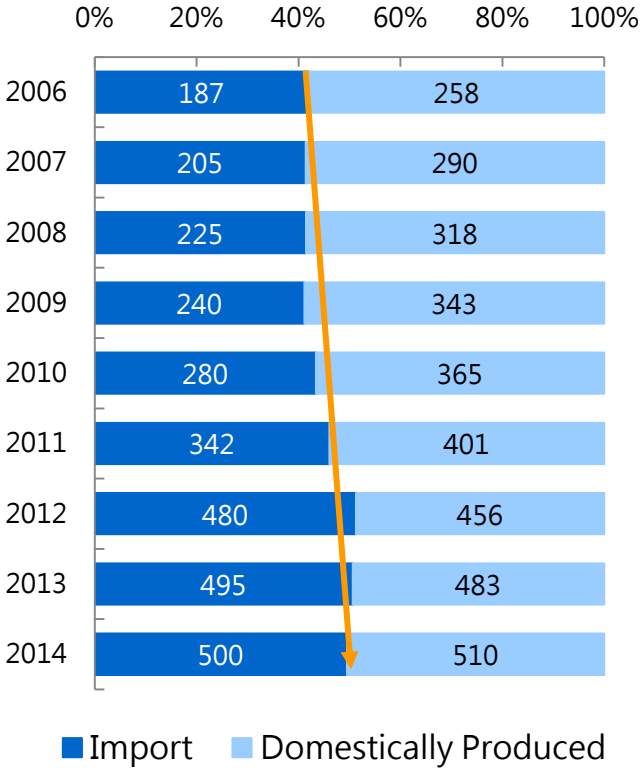


Source: 2015 Biotechnology industry in Taiwan

2. Overview of Life Science Industry in Taiwan

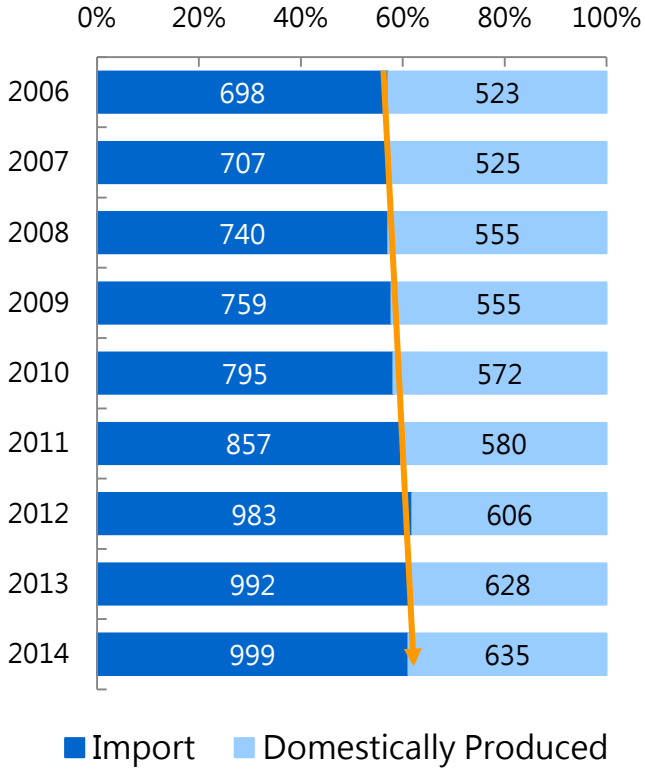
Applied biotech and pharmaceutical products in Taiwan rely on import whilst domestic medical device industry has prospered in recent years

Applied Biotech



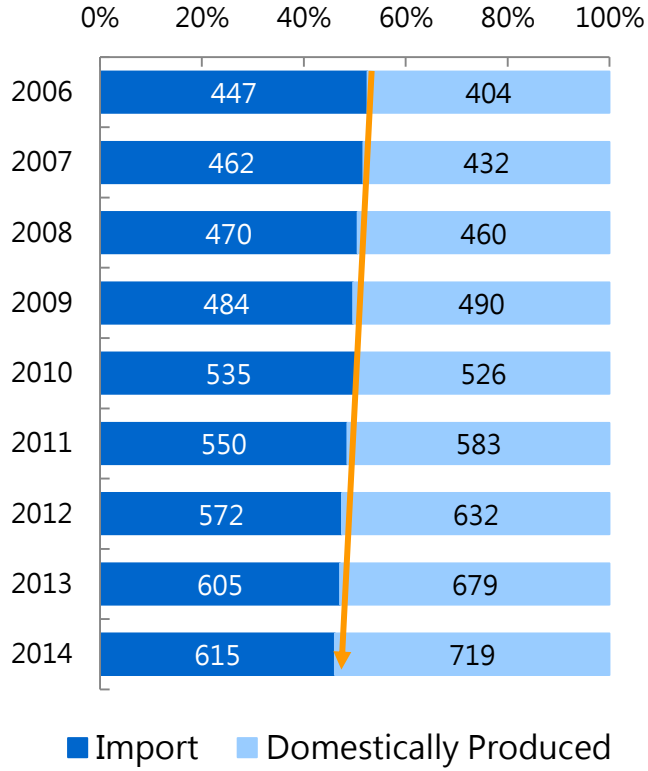
- Growth momentum comes from **food science** and **biotech**.

Pharmaceutical



- Domestic companies mainly produce **generic drugs** whilst multinational companies produce patented drugs

Medical Device



- Domestic companies cluster to attract international collaborations and growth

Source: 2015 Biotechnology industry in Taiwan

2. Overview of Life Science Industry in Taiwan

Taiwan's pharmaceutical market remains dominated by innovative multinational drug makers which are mainly engaged in patented drugs

- The rewards of Taiwan's patented drug market have led domestic pharmaceutical companies such as Yung Shin Pharm, CCPC, and TTY to engage in R&D, though many continue to have portfolios that specialize in generic drugs.

Top 20 Pharmaceutical Companies in 2013 (Unit: 100 Million N.T.$)

Ranking	Company Name	Sales Value
1	Pfizer	130.2
2	Novartis	102.0
3	Roche	81.3
4	Merck Sharp & Dohme	78.9
5	Sanofi	78.2
6	AstraZeneca	62.0
7	GlaxoSmithKline	61.9
8	Bayer	45.0
9	Lilly	41.1
10	Bistrol-Myers Squibb	35.2

Ranking	Company Name	Sales Value
11	Yung Shin Pharm.	31.2
12	CCPC	28.1
13	Janssen-Cilag	27.0
14	Novo Nordisk	26.6
15	Takeda	25.4
16	Boehringer Ingelheim	22.4
17	Astellas Pharma	22.3
18	Baxter Healthcare	22.0
19	Abbive	20.4
20	TTY	20.4

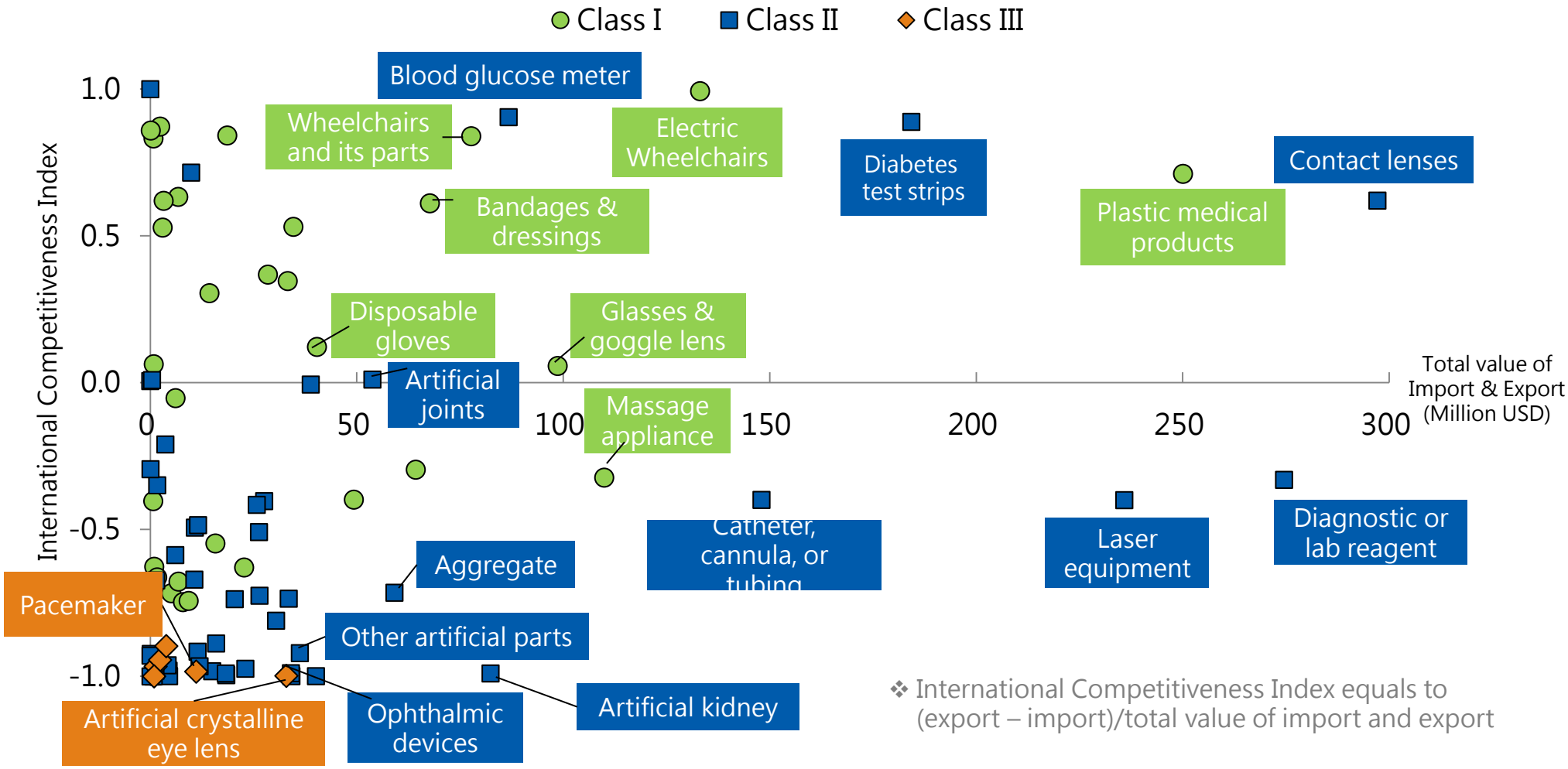
Domestic Company

Source: 2014 Pharmaceutical Industry Yearbook

2. Overview of Life Science Industry in Taiwan

Taiwan has strong export competitiveness in medical equipment of low-to-medium risk level but is less competent for devices of higher risk level

The Distribution of International Competitiveness Index in Medical Equipment Sector of Taiwan (2015, based on risk class)



❖ International Competitiveness Index equals to (export – import)/total value of import and export

Source: Import and export statistics from Customs Administration, Ministry of Finance

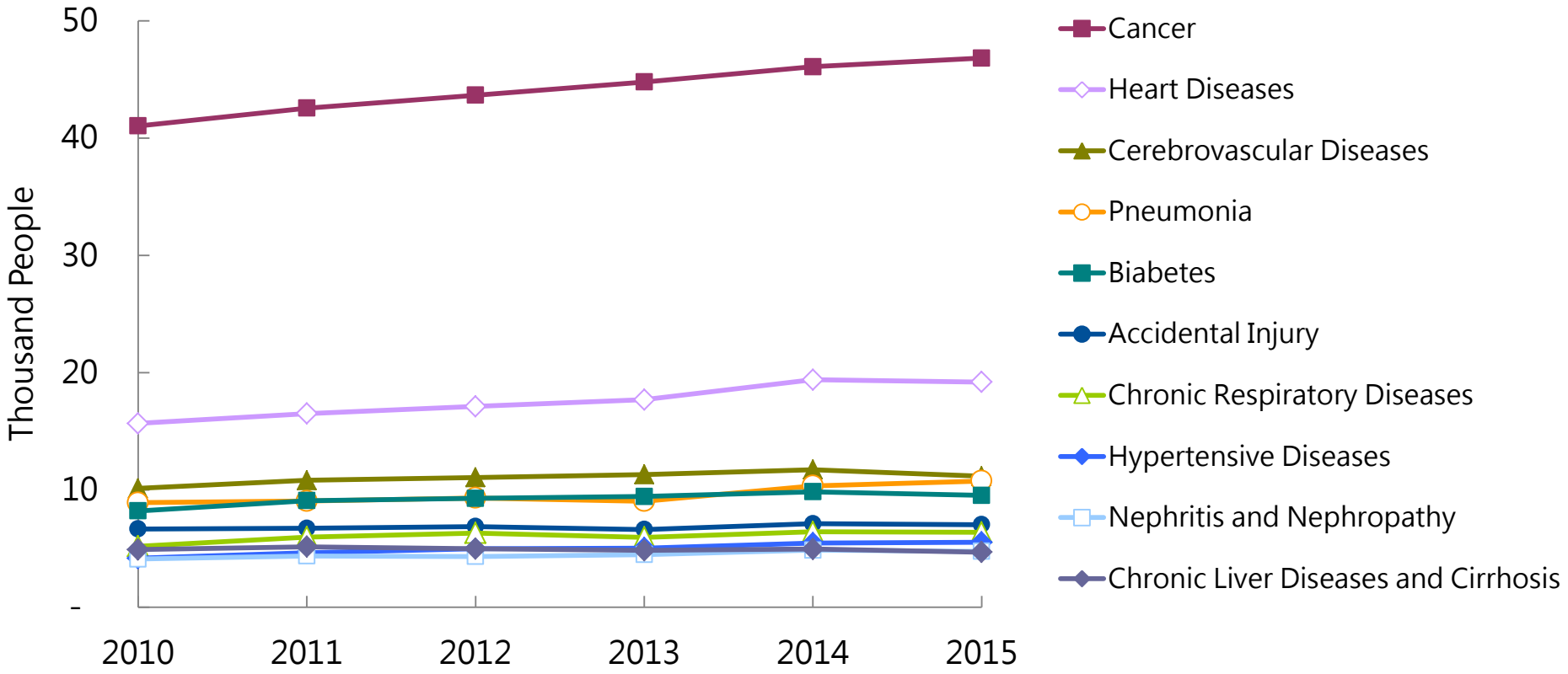
Collaboration with Taiwan Pharma & Biotech Companies

3. Collaboration with Taiwan Pharma & Biotech Companies

7 out of the top-10 causes of death in Taiwan are chronic diseases, and cancer has been the top-1 cause of death for more than 20 years

- 1 person died of cancer every 10 minutes in Taiwan

Top 10 Causes of Death in Taiwan



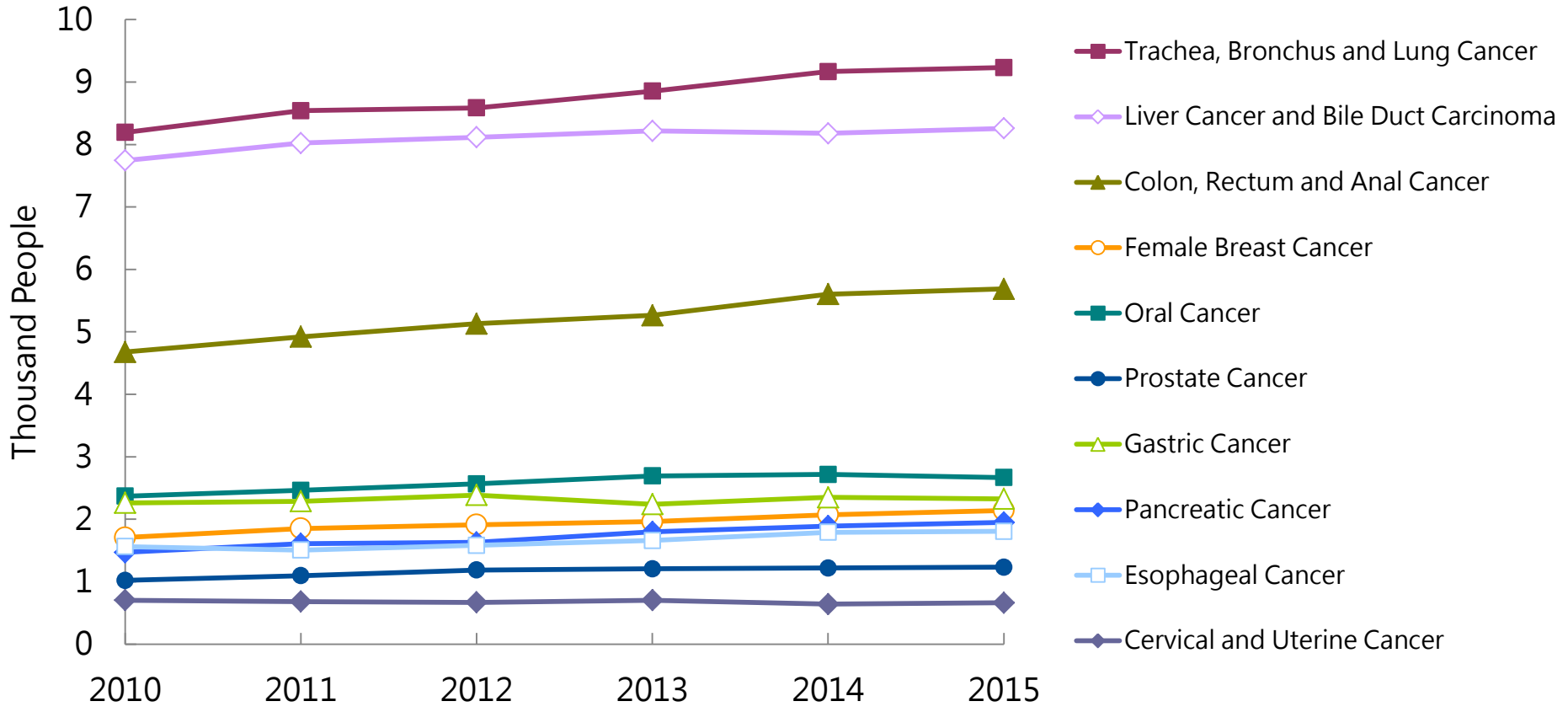
Source: MoHW

3. Collaboration with Taiwan Pharma & Biotech Companies

Lung cancer, liver cancer, and colon cancer are the top 3 fatal cancers in Taiwan, whilst lung adenocarcinoma is common among Taiwanese people

- Because of genetic factors, lung adenocarcinoma and head and neck cancers are common to Taiwanese

Top-10 Causes of Cancer Death in Taiwan

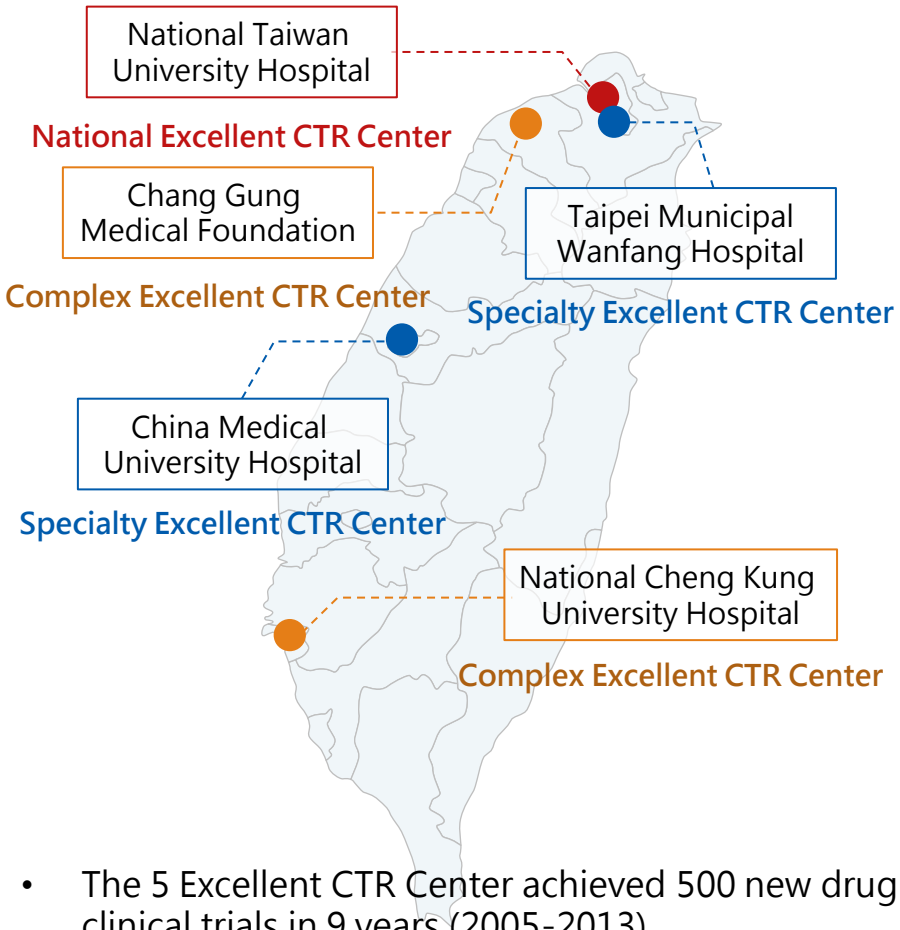


Source: MoHW

3. Collaboration with Taiwan Pharma & Biotech Companies

To accelerate the development of new drugs, five Excellent Clinical Trial Research Center and the Taiwan Clinical Trial Consortium (TCTC) were set up

5 Excellent Clinical Trial Research (CTR) Center



- The 5 Excellent CTR Center achieved 500 new drug clinical trials in 9 years (2005-2013).

Structure of Taiwan Clinical Trial Consortium

- TCTC provides one-stop service for member companies.
- TCTC conducted 361 clinical trials in 2 years.

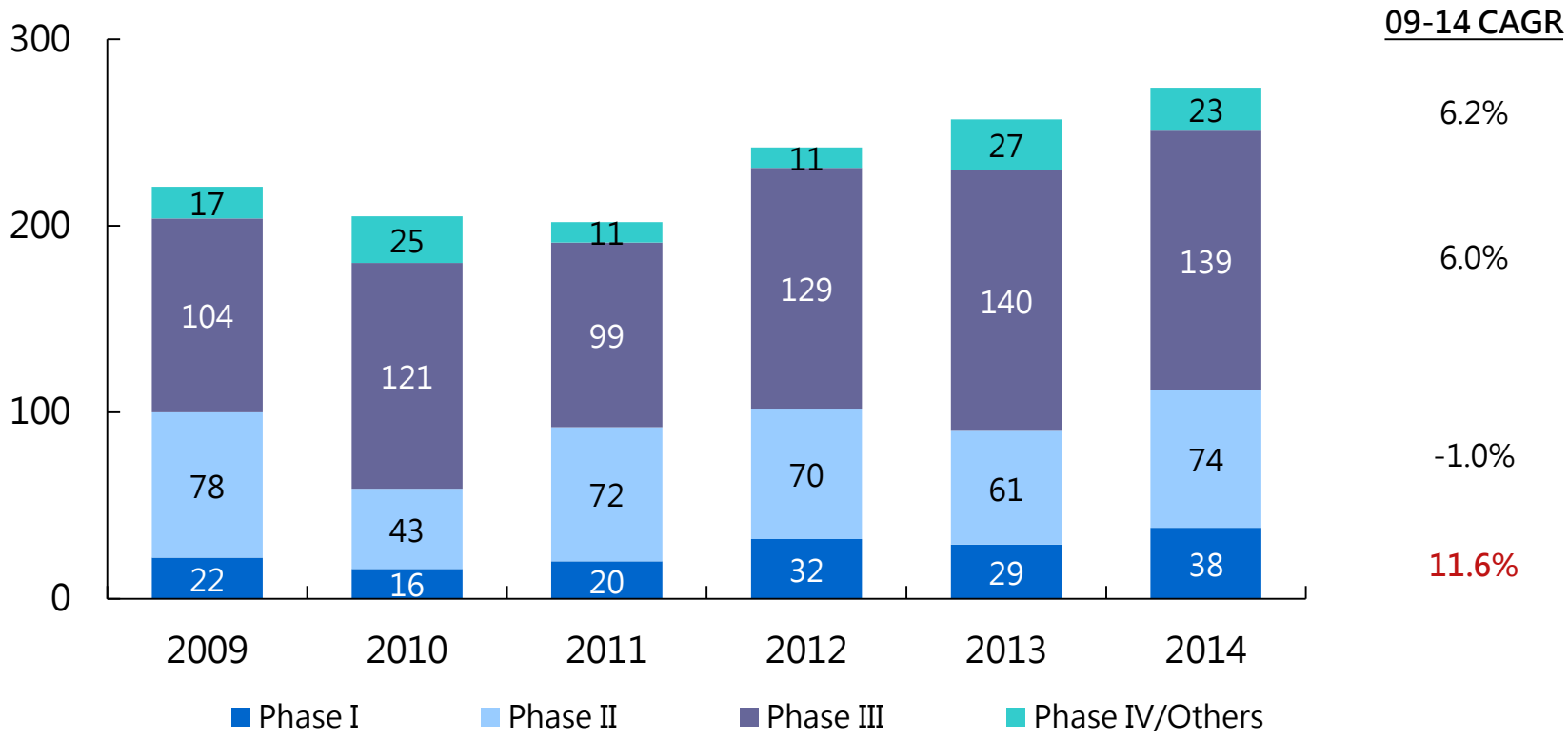
Source: Taiwan Clinical Trial Consortium

3. Collaboration with Taiwan Pharma & Biotech Companies

The application number of phase I clinical trials has increased, signifying the improving capability and environment for conducting clinical trial in Taiwan

- International Pharmaceutical companies has set up clinical R&D centers in Taiwan, including Pfizer, Novartis, GSK, MSD, Boehiringer Ingelheim, etc.

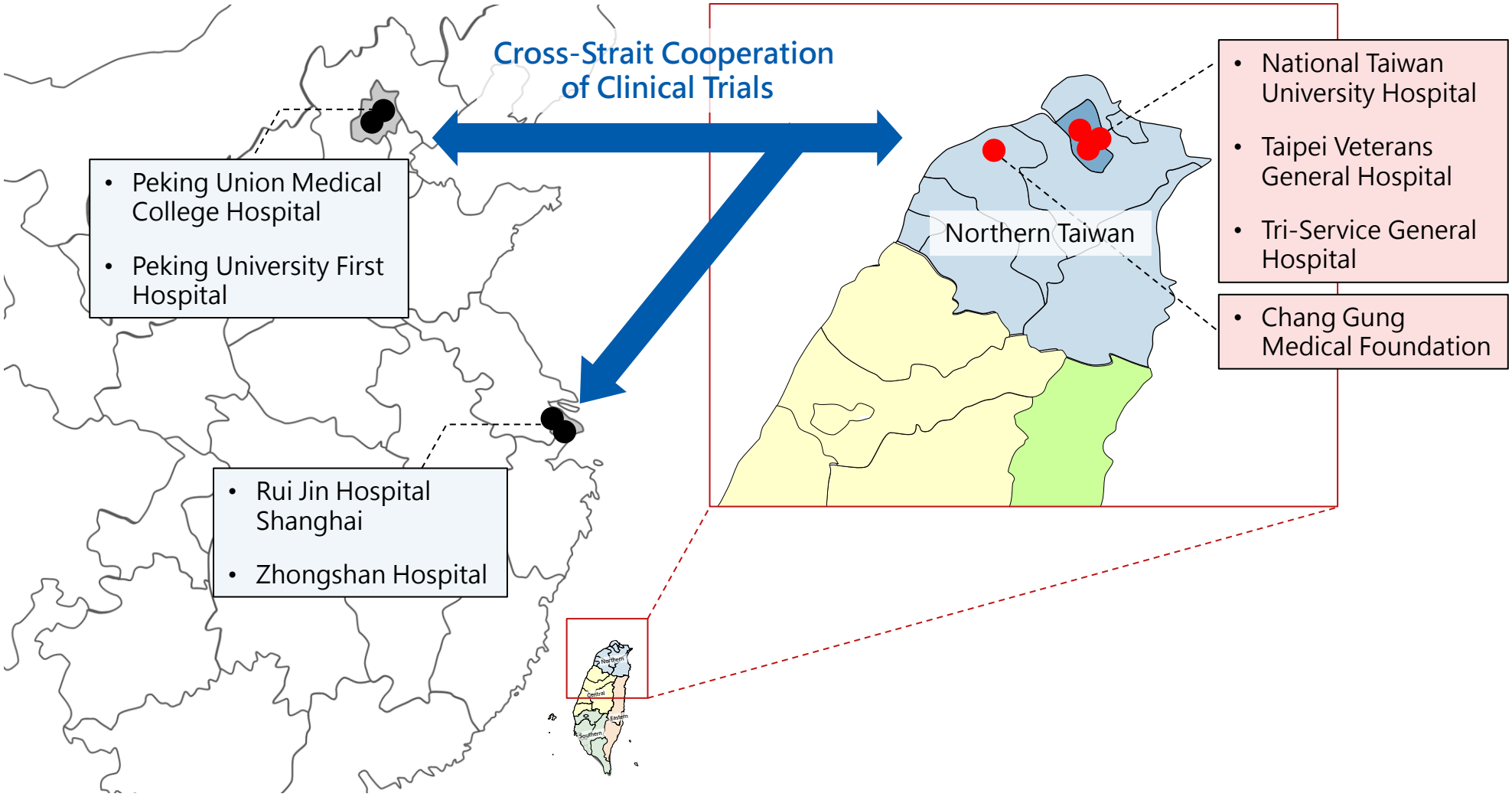
Application Number of Clinical Trials in Each Phase



Source: : Center for Drug Evaluation, Taiwan

3. Collaboration with Taiwan Pharma & Biotech Companies

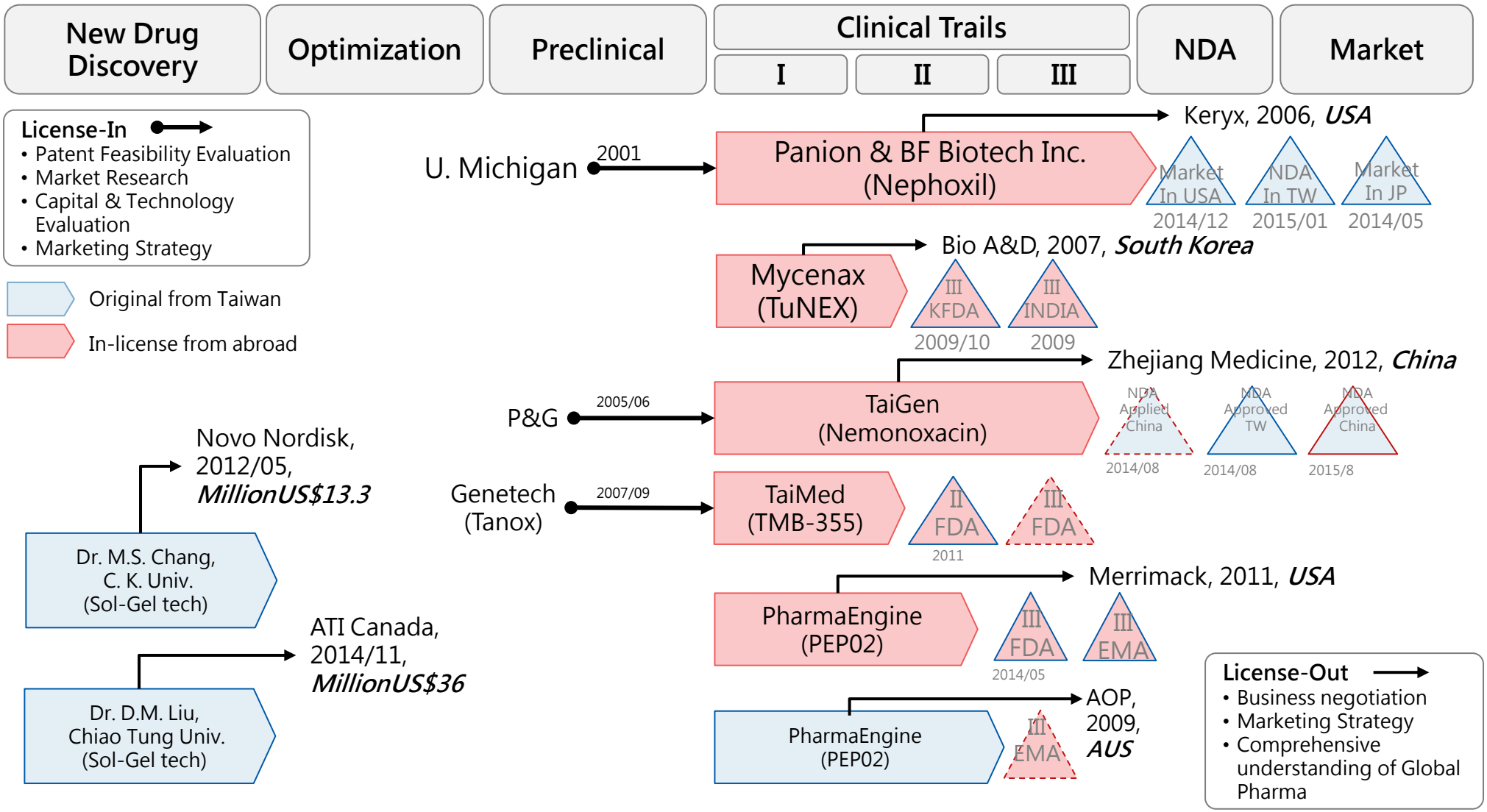
The "Cross-Strait Cooperation of Clinical Trials" facilitates collaboration between hospital, industry, and academia in China and Taiwan



Source: Food and Drug Administration, MoHW

3. Collaboration with Taiwan Pharma & Biotech Companies

Success story of collaboration with Taiwan for clinical trails:



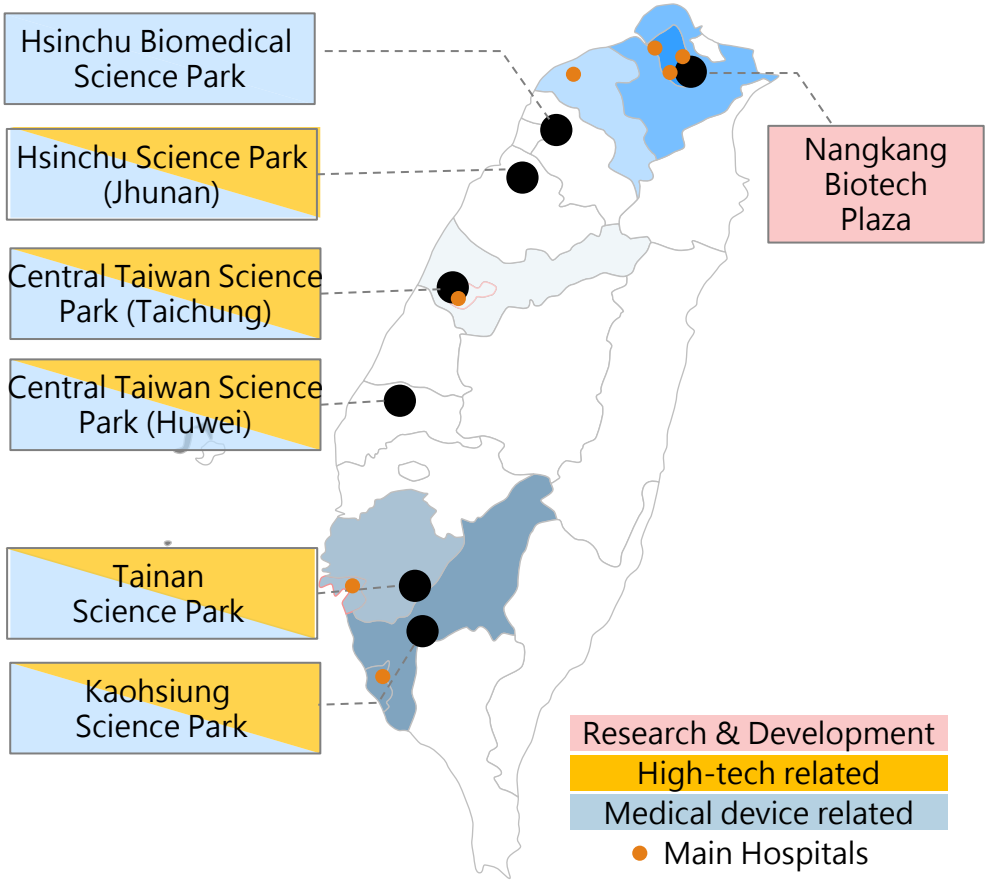
Source: Overview of Biotechnology Industry in Taiwan, BPIPO,2014

Collaboration with Taiwan Medical Device Companies

4. Overview of Medical Device Industry in Taiwan

Combined with the strength of existing science parks in high-tech and electronics, more and more firms have stepped into medical device industry

High-Tech & Medical Device Industry Clusters in Taiwan



Representative Cross-Industry Firms

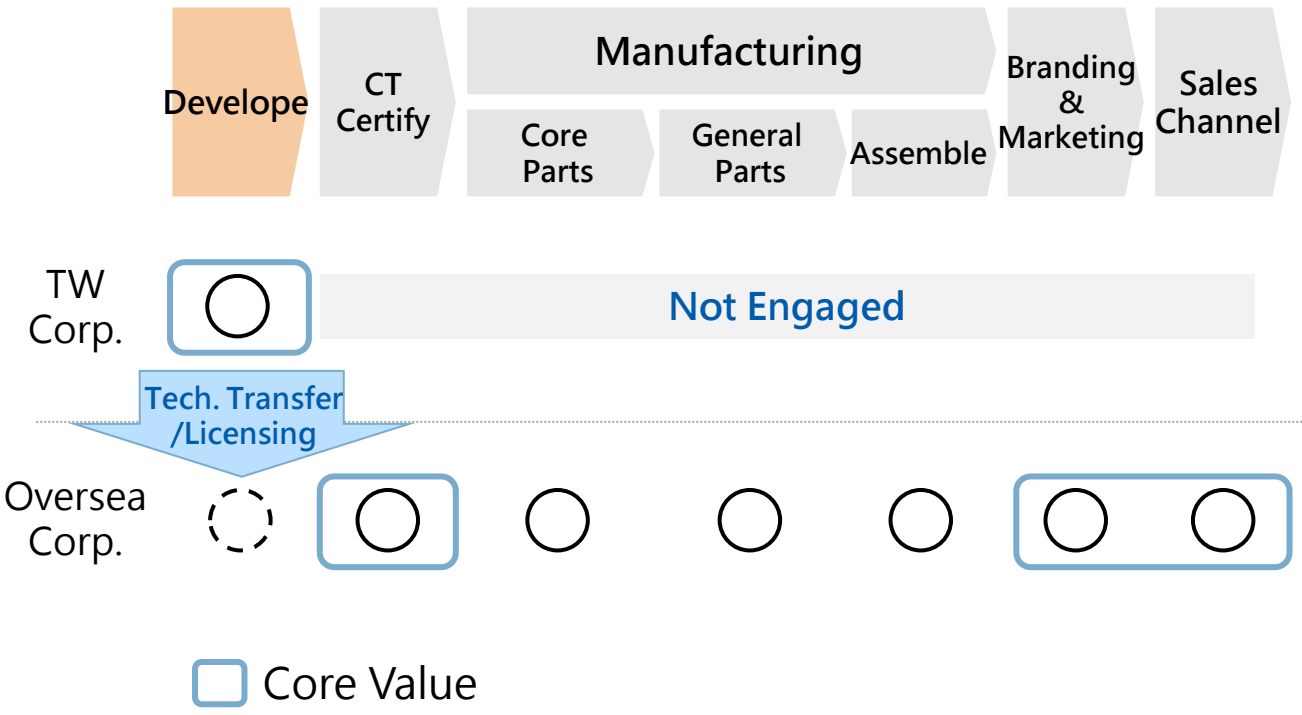
Source: Economic Power-UP Plan, Plastics Industry Development Centre; Hiwin; INAI

4. Overview of Medical Device Industry in Taiwan

Increasing cases of technology transfer/licensing model for medical devices in recent years indicates the improving R&D capability for high-end devices

■ **Choosing the correct topic** is the key successful factor for technology transfer/licensing model

Type I: Technology Transfer/Licensing Model



Representative Firm

MEDEON

- R&D targeted on high-end **minimally invasive surgery** medical device.
- **Tech transfer** to international medical device company after completion of pre-clinical trials and animal experiments.
- Main Products:
  - Cardiac catheterization minimally invasive surgery
  - Laparoscopic surgery

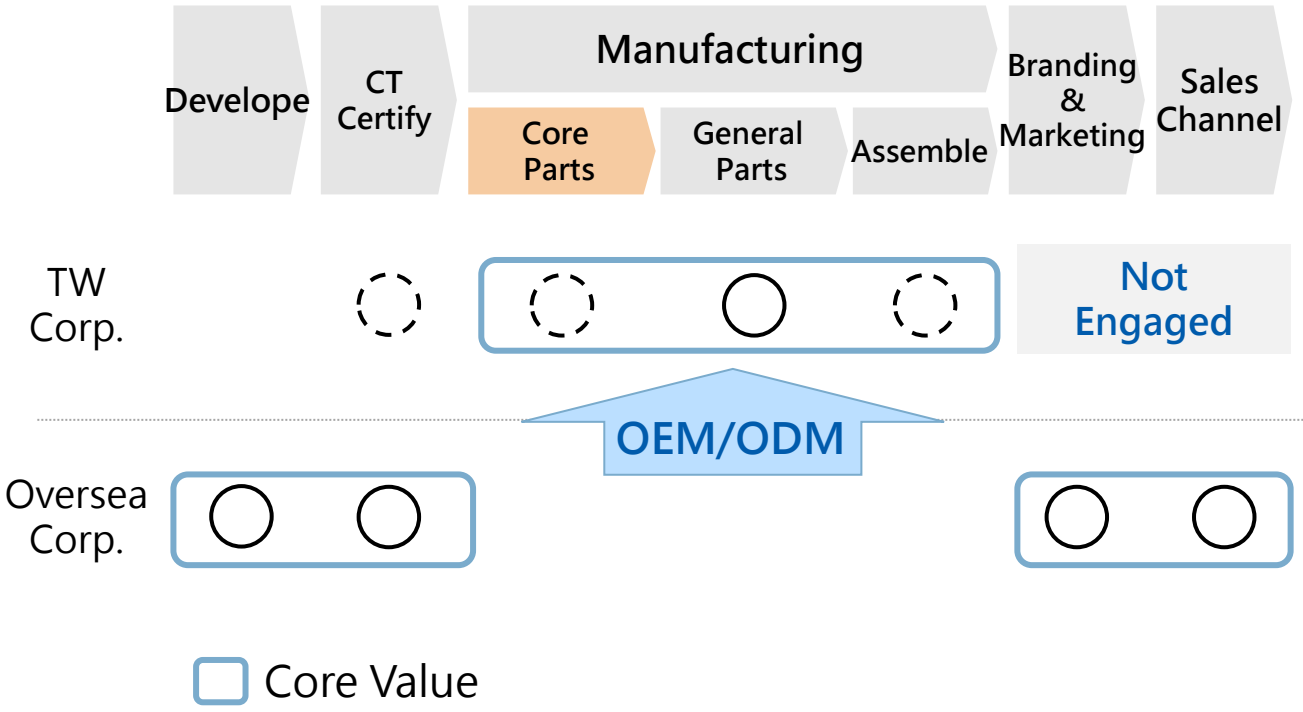
Source: Medeon; NRI collated

4. Overview of Medical Device Industry in Taiwan

Core parts OEM/ODM model focuses on the ability of mass production with high quality and is the most common model applied in Taiwan

■ **Core parts manufacturing** is the target to be focused for Taiwanese companies

Type II: Parts OEM/ODM Model



Representative Firm

- Located in Hsinchu Science Park.
- The 3rd largest semi-conductor company around the world.
- Manufacture the **core IC chip** of Australia company Cochlear's implantable electronic ear product (70% of global market share).

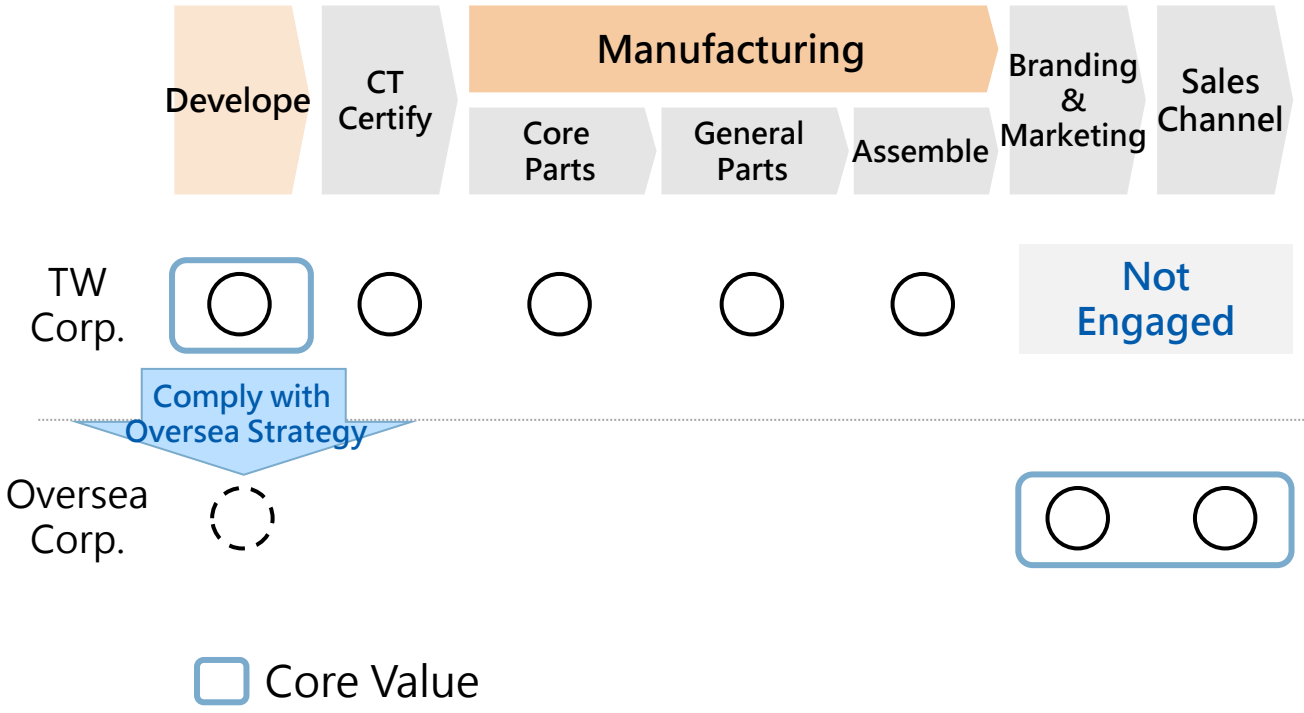
Source: TSMC; NRI collated

4. Overview of Medical Device Industry in Taiwan

As the oversea sales channel is difficult to master, some Taiwanese medical device companies choose to ally with companies abroad

- Global companies offers higher **added-value with their brand name** for medical device products that were manufactured in Taiwan

Type III: Product ODM and Oversea Alliance Model



Representative Firm

BIONIME
Better health for more people

- The core technology of BIONIME is electrochemical bio-sensing.
- Strategically allied with US company GE by design and manufacturing **blood glucose meter** under GE's brand name.
  - In developed countries, BIONIME tends to collaborate with existing large companies e.g. GE.
- BIONIME **uses its own brand in developing countries** and has take high market share.

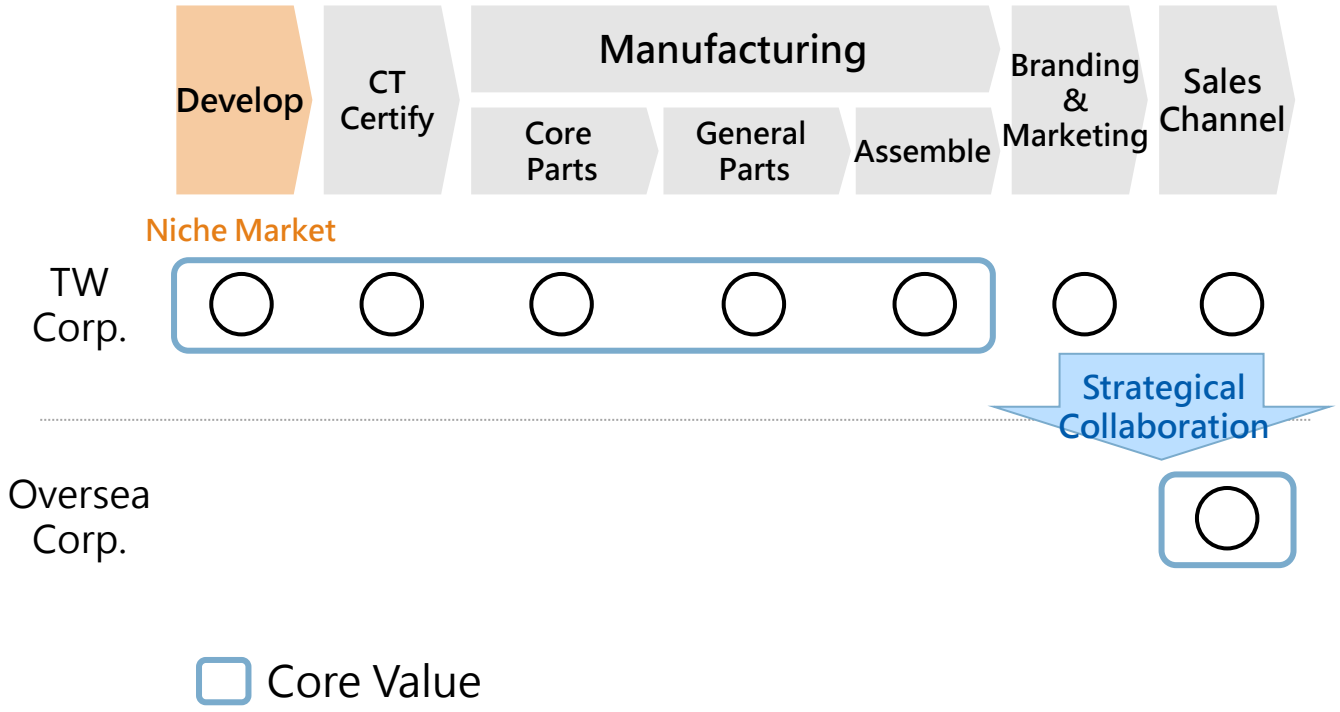
Source: BIONIME; NRI collated

4. Overview of Medical Device Industry in Taiwan

More and more Taiwanese medical device companies perceive the value of own brand, and transfer from traditional ODM/OEM model to OBM

- **International branding and marketing** is the key success factor for OBM companies

Type IV: OBM Model



Representative Firm

HIWIN
Motion Control and System Technology

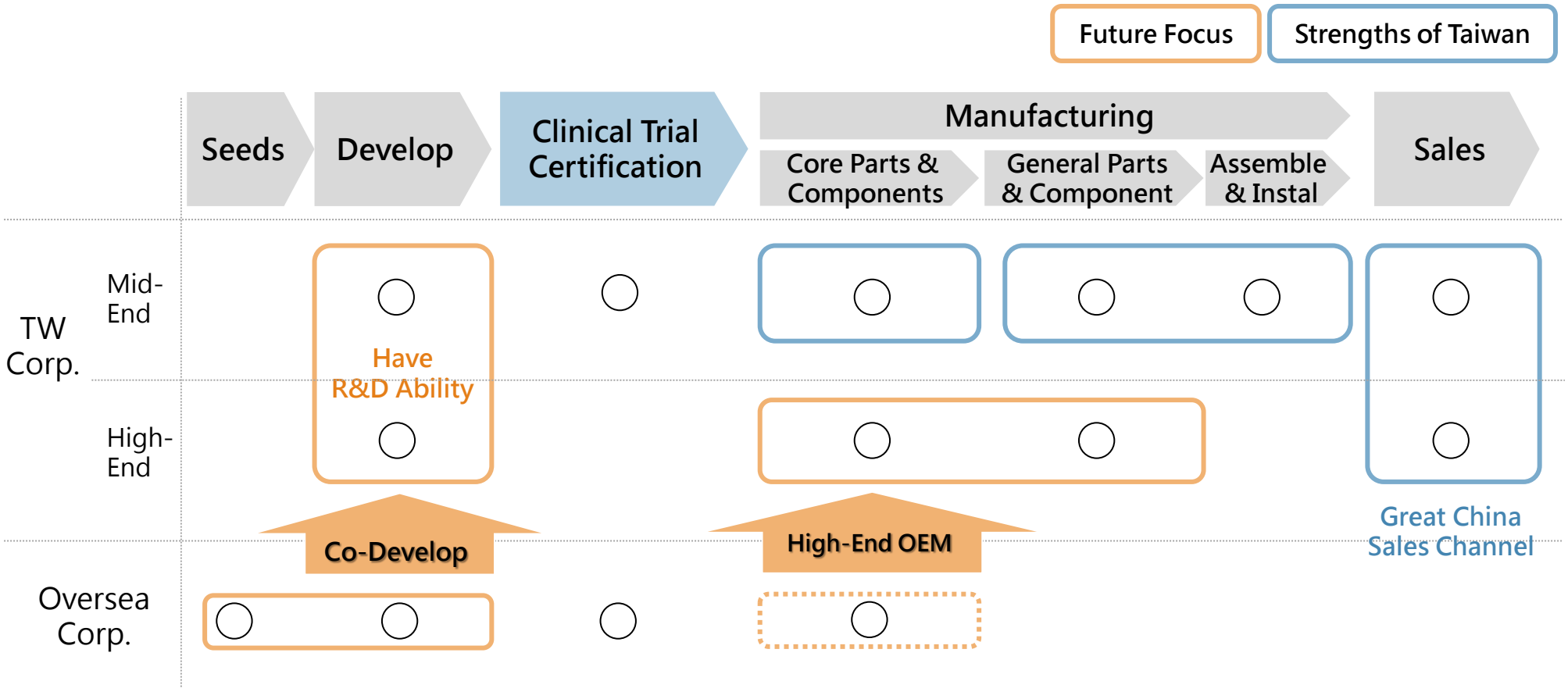
- Manufactured cross-industry product from machine tool to medical equipment.
- **Collaborated with China Medical University Hospital** to research and develop private brand HIWIN medical products such as **endoscopic support arm and leg rehabilitation robot.**
  - The leg rehabilitation robot had got certification of CFDA, and will start to sell in China this year.

Source: HIWIN; NRI collated

4. Overview of Medical Device Industry in Taiwan

With the strengths of manufacturing, Taiwanese medical device firms will keep pursuing partnership in R&D and OEM for high end products

Focused Collaboration Model of Taiwanese Medical Device Companies and Oversea Companies



Source: NRI collated

4. Overview of Medical Device Industry in Taiwan

Foreseeing the huge demand of ICT application in healthcare, traditional IT products manufacturers have diversified its portfolio to medical services

Example of Healthcare Solution Expansion of ICT Companies

2001 — 2004 — 2007

Brand BenQ → Global Expansion → Diversified Portfolio

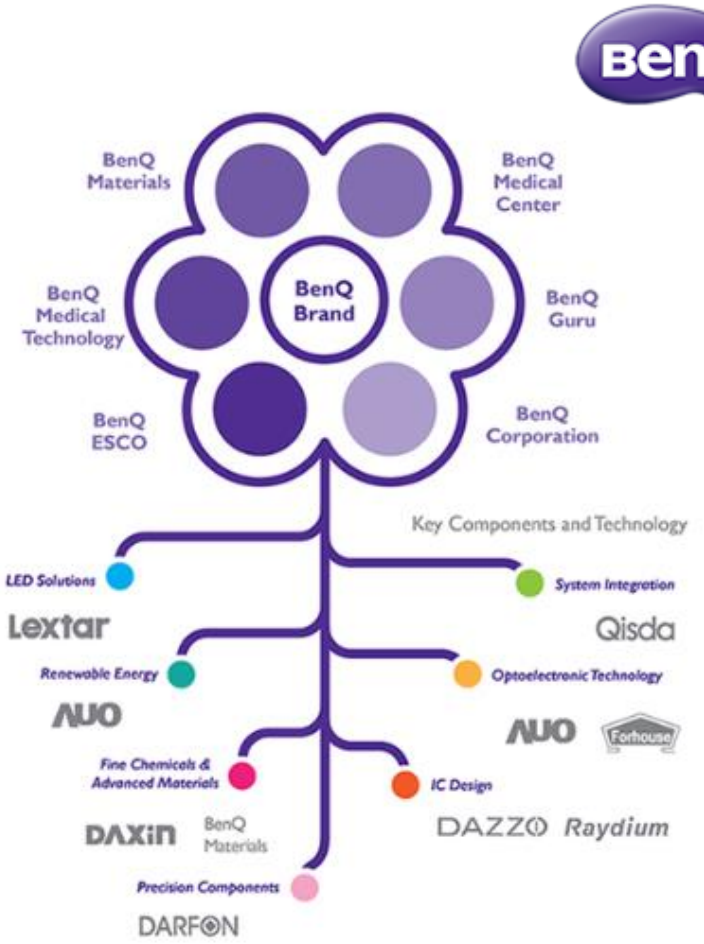
From 3C Products to Medical Devices

- Founded in 2001
- Cell-phone & monitor design and manufacture

Strength of ICT and Electronic Goods Manufacturing

- Top-100 IT company in the world
- Expand in Asia, America, and Europe

- Established BenQ Hospital (2008)
- Acquired medical equipment companies (2010)



Source: BenQ

4. Overview of Medical Device Industry in Taiwan

The integrated solution of eHealth is another main topic the traditional electronics manufacturers focus on

Example of Integrated eHealth Solution Expansion of ICT Companies

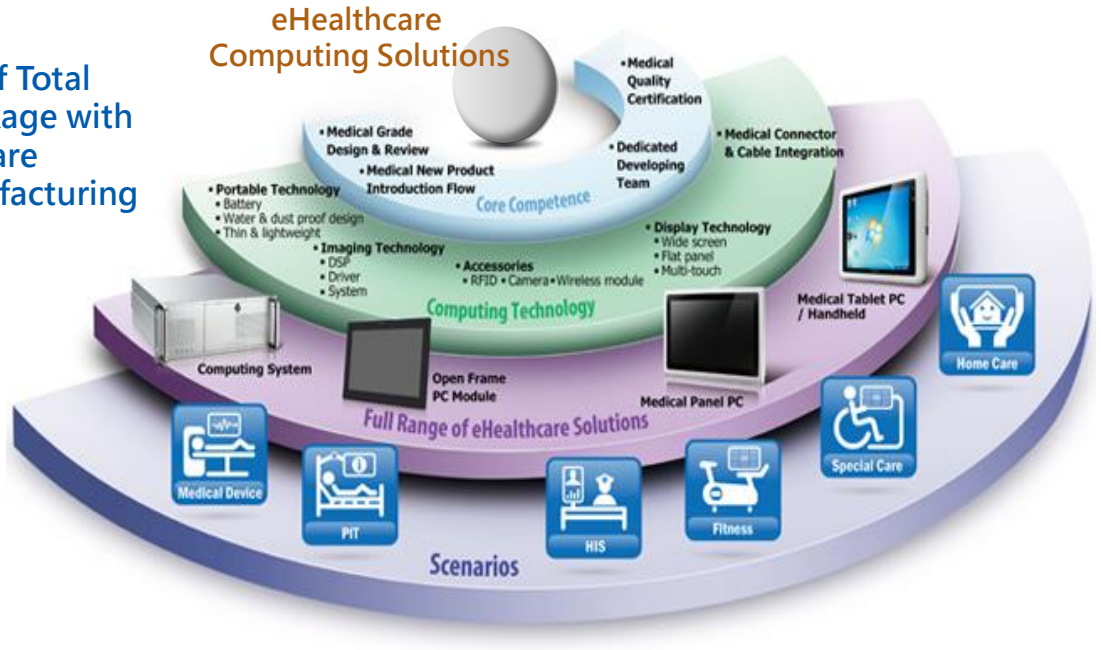
ADVANTECH
Enabling an Intelligent Planet

From Industrial Computer to Digital Healthcare Total Solutions

Industrial Automation Products

Strength of Total Solution Package with Hardware Design/Manufacturing

Digital Healthcare Total Solutions



Source: Advantech

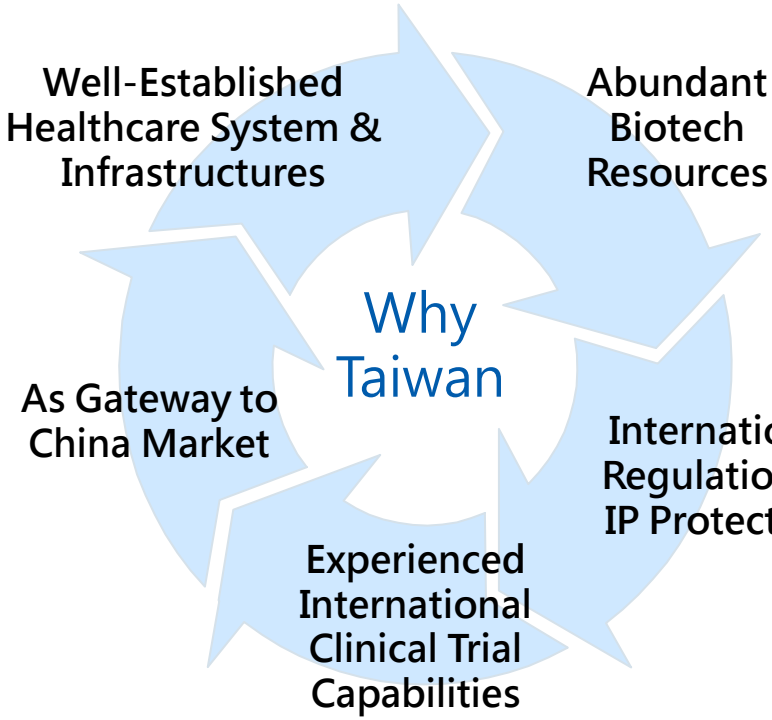
Summary

5. Summary

The advantages of collaborating with Taiwan includes well-established infra., experienced clinical trial capabilities, and gateway to China Market

Advantages of International Collaboration with Taiwan

- High healthcare quality
- Professional medical team
- Patient-oriented service
- Universal coverage/ low medical expenses
- Experienced healthcare management know-how



- Solid Industry clusters (ICT/Biotech) in Northern/Central/Southern Taiwan
- 1,631 firms & 73,769 employees in Biotech industry (2014)
- Qualified human resources
- More than 22,000 medical institutions

- ECFA (Cross-Straits Economic Cooperation Framework Agreement), 2011
- Cross-Strait cooperation Agreement on Medicine & Public Health Affairs, 2010

- International medical standards
- Internationally certified medicine quality
- Comprehensive IP protection
- Globally competitive medicine review efficiency

- No. of Multiple Center Trials Conducted in TW: around 210 each year
- Clinical R&D Center in TW
- International CRO companies in TW

Source: TFDA, MoHW

5. Summary

To meet the demand of the aging society of Taiwan, the focus of healthcare and medical industry will continue to encourage innovation

Future Focus of Pharma & Biotech Industry

- R&D of new drugs
  - Chronic diseases e.g. hypertension, diabetes, stroke, heart diseases
  - Cancers e.g. lung cancer and lung adenocarcinoma, head and neck cancers

Future Focus of Medical Device Industry

- Utilize existing advantages to upgrade current models
  - Collaborative R&D on innovative medical device or technology
  - Strategic private brand collaboration
- Combine with information and communication technology (ICT)
  - R&D of innovative products e.g. telecare, assistive medical device

附件十二

衛生福利部
Ministry of Health and Welfare

Introduction of Healthcare System of Taiwan

August 2016

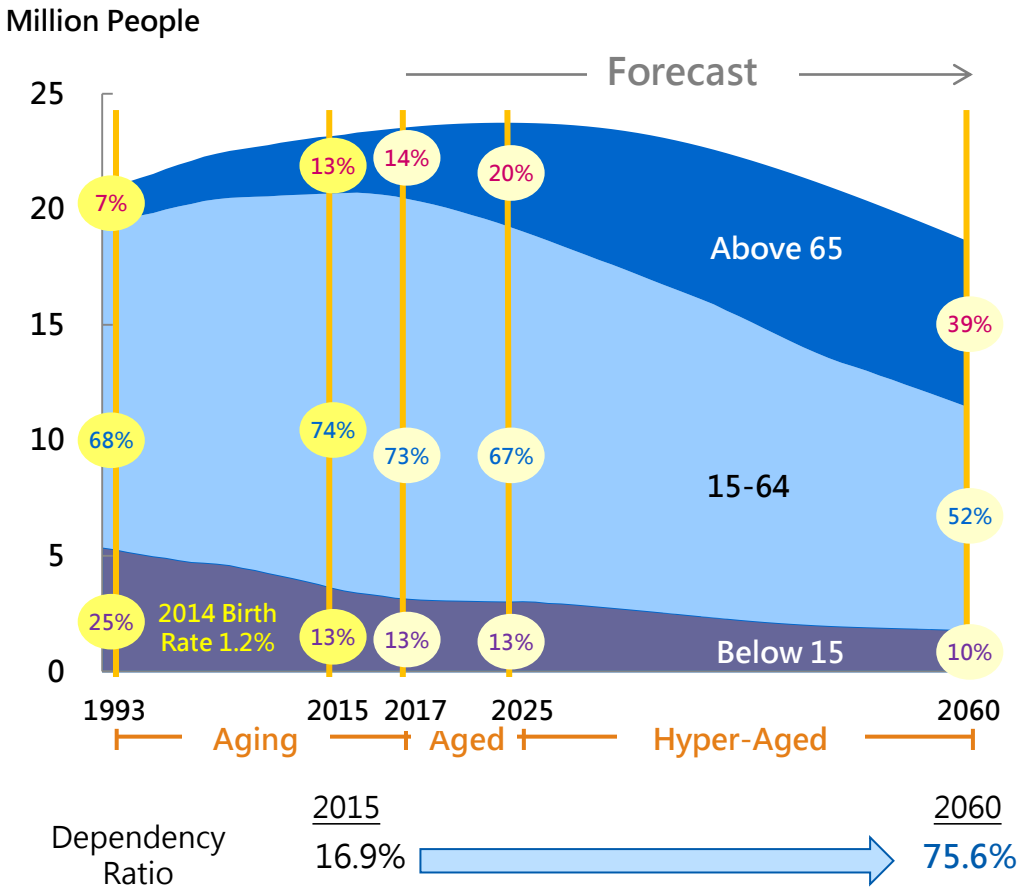
Agenda

1. Overview of Healthcare System of Taiwan
2. Overview of Long-Term Care Policies in Taiwan
3. Overview of Tele-Healthcare Projects in Taiwan

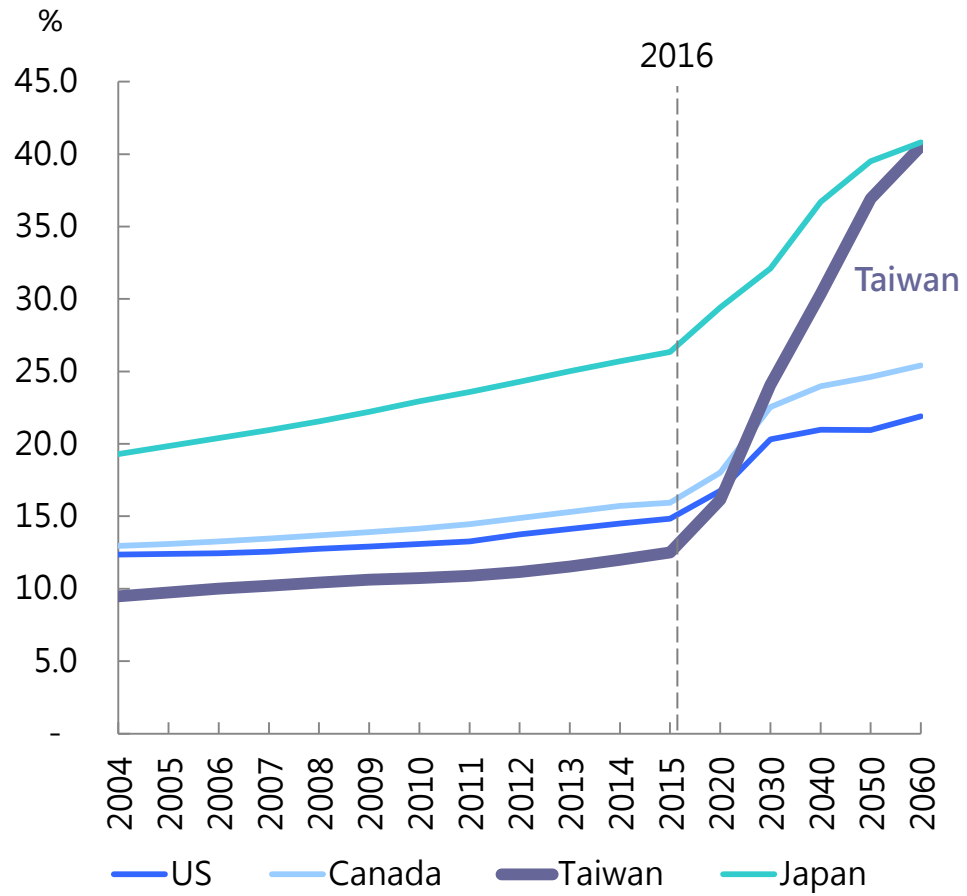
1. Overview of Healthcare System of Taiwan

Taiwan has became an aging society since 1993 and is expected to become a hyper-aged society in 10 years, surpassing most of the developed countries

The Structure of Population in Taiwan



Percentage of People Aged 65+ in the World

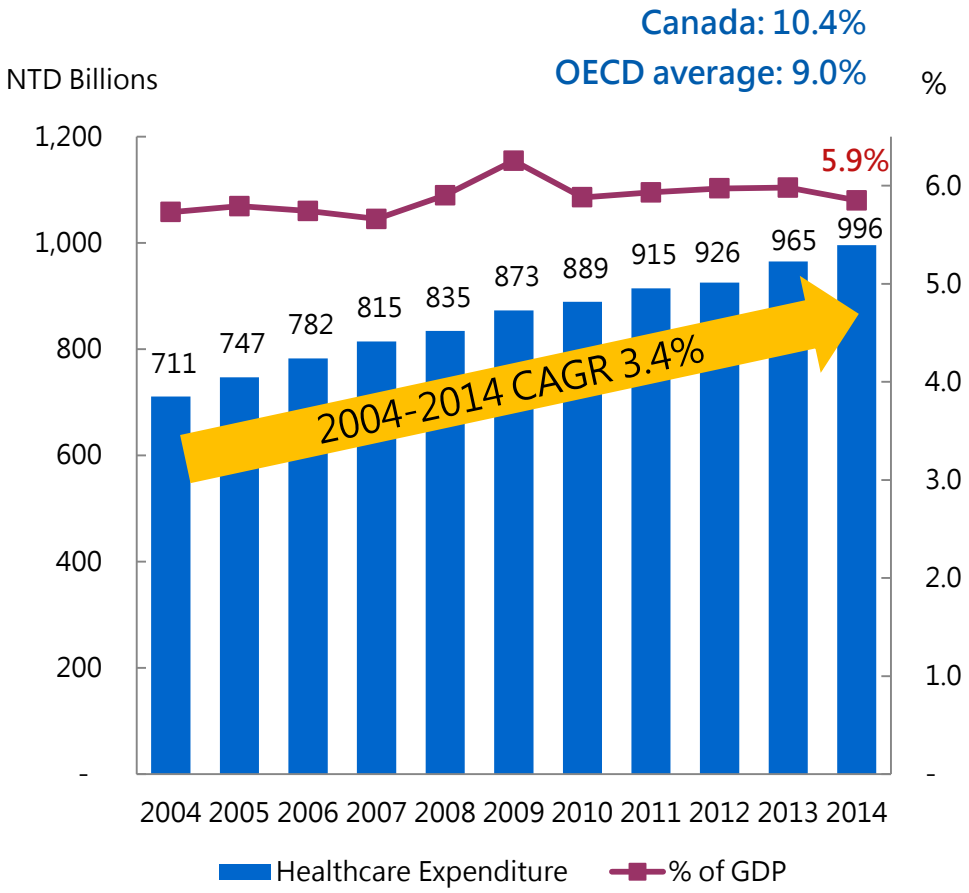


Source: OECD; National Development Council, Department of Statistics, MoHW

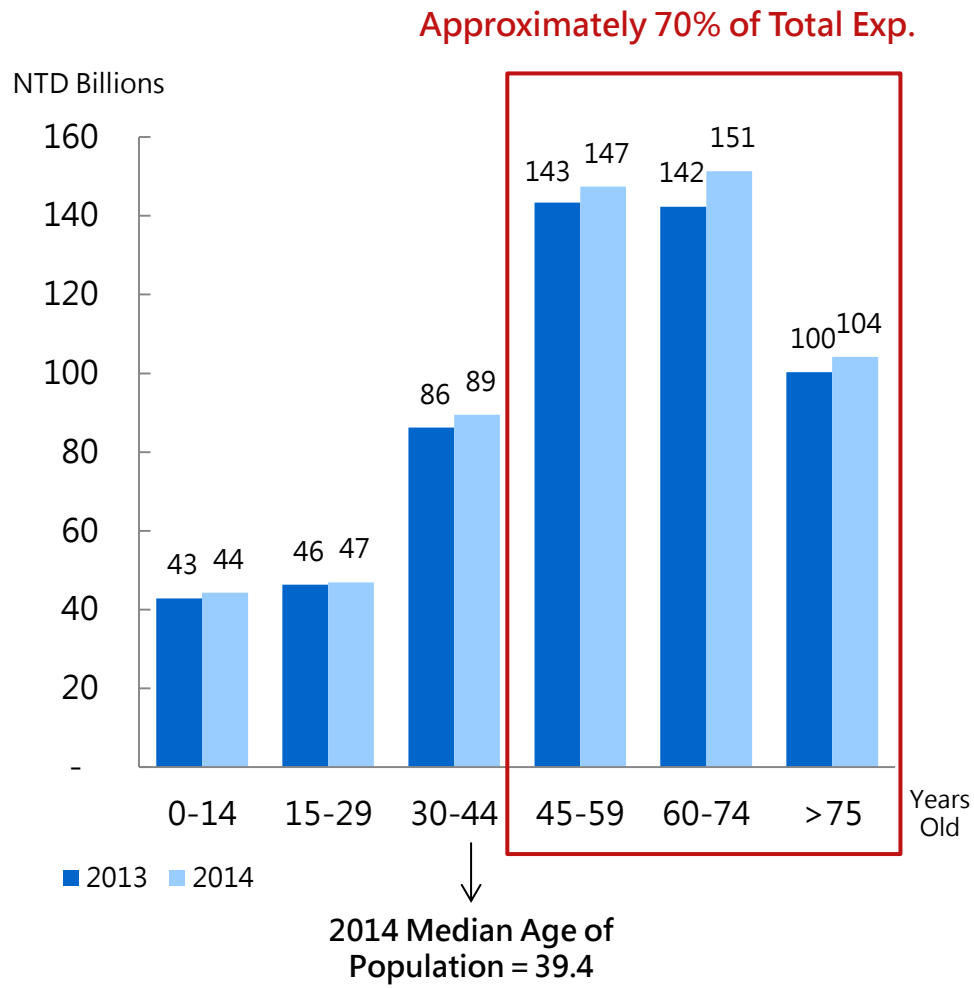
1. Overview of Healthcare System of Taiwan

The rising healthcare expenditure related to the aging society of Taiwan further pushes the government to focus on the long-term care issues

Healthcare Exp. in Taiwan



Healthcare Exp. of Different Age Groups in Taiwan



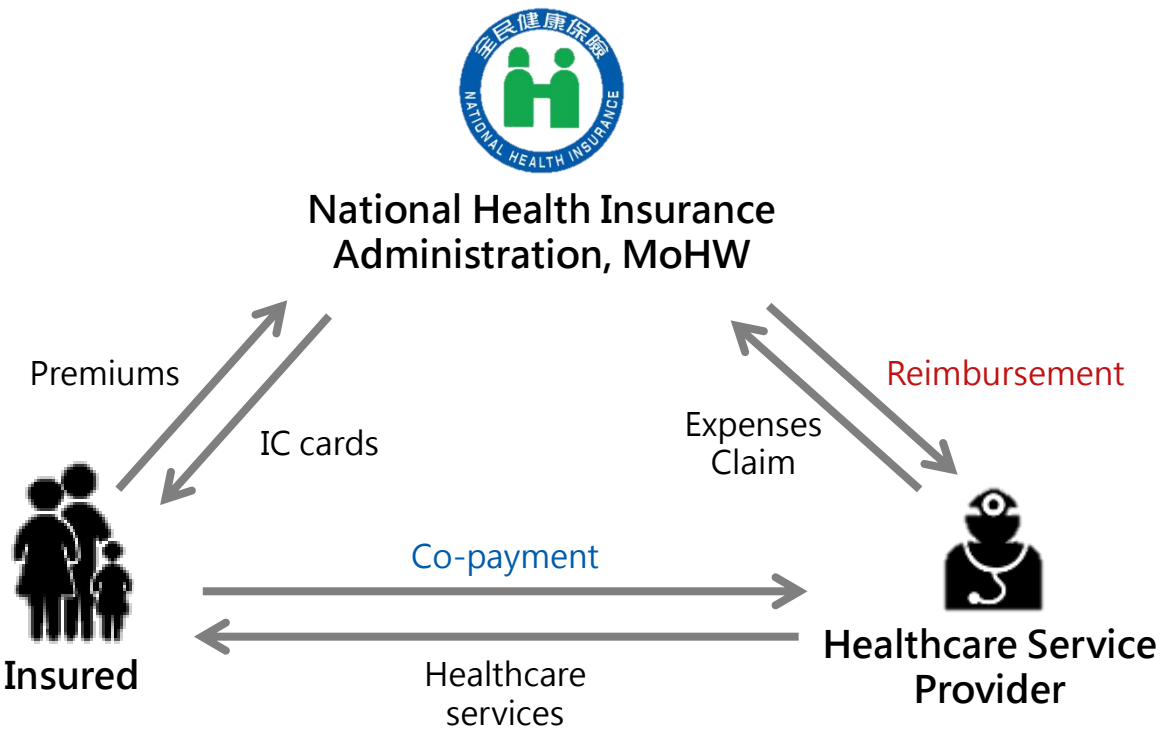
Source: OECD; MoHW

1. Overview of Healthcare System of Taiwan

The compulsory National Health Insurance (NHI) program adopted in Taiwan covers most of healthcare expenditure through reimbursement

- The National Health Insurance (NHI) program was launched in 1995, and the use of IC card national-wide was implemented in 2003
- The universal health coverage of Taiwan's NHI program is 99.6%

Operating Mechanism of NHI Program



Source: National Health Insurance Administration, MoHW

Agenda

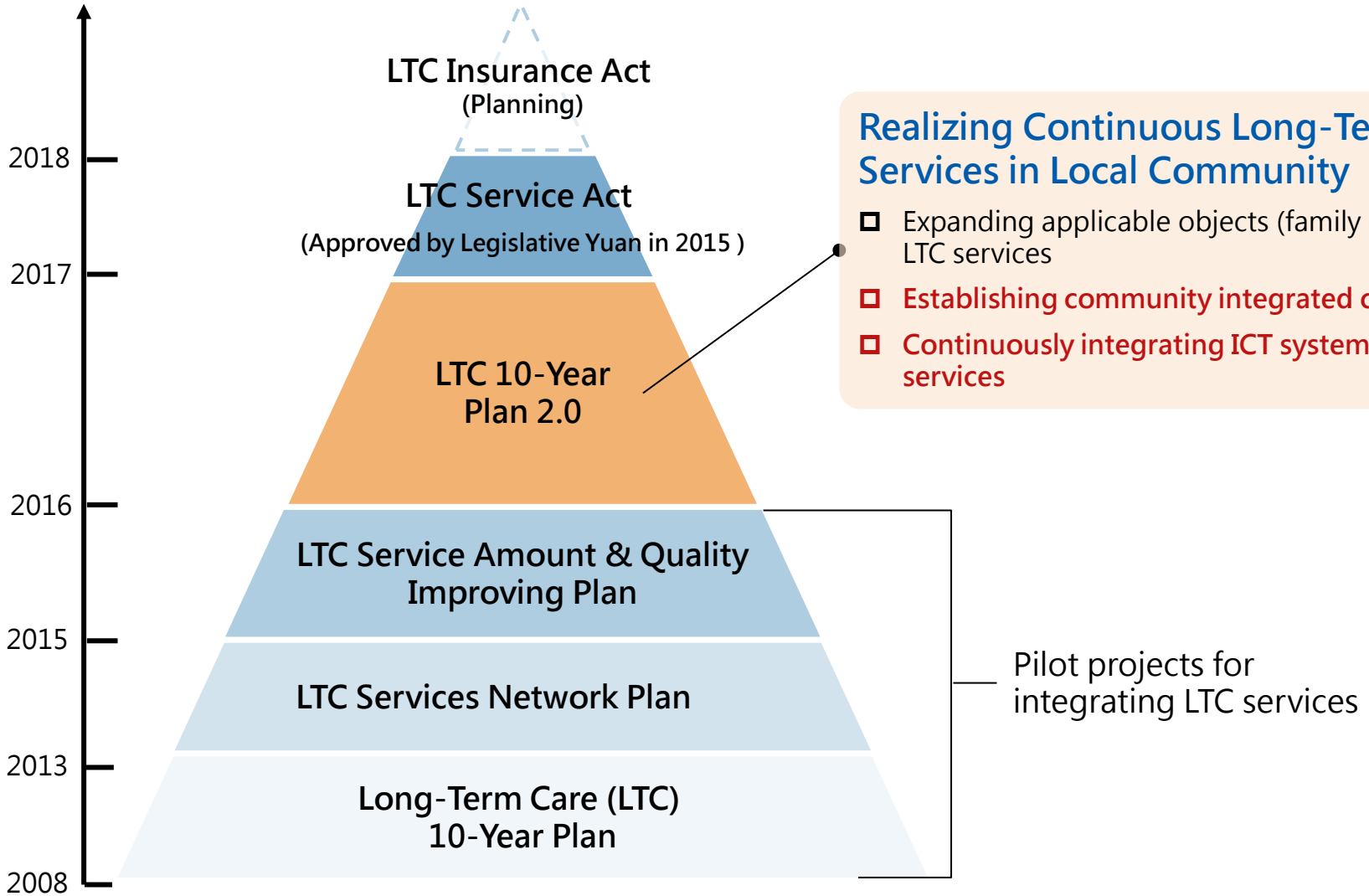
1. Overview of Healthcare System of Taiwan

2. Overview of Long-Term Care Policies in Taiwan

3. Overview of Tele-Healthcare Projects in Taiwan

2. Overview of Long-Term Care Policies in Taiwan

To meet the needs of long-term care service, the government has focused on continuous care in local community in recent policy development



Realizing Continuous Long-Term Care Services in Local Community

- Expanding applicable objects (family caregiver) of LTC services
- Establishing community integrated caring model
- Continuously integrating ICT system for LTC services

Source: Long-Term Care Policy Portal, MoHW

2. Overview of Long-Term Care Policies in Taiwan

To achieve the ultimate goal of "Aging in place," the community integrated caring model becomes future blueprint

LTC Models in Taiwan

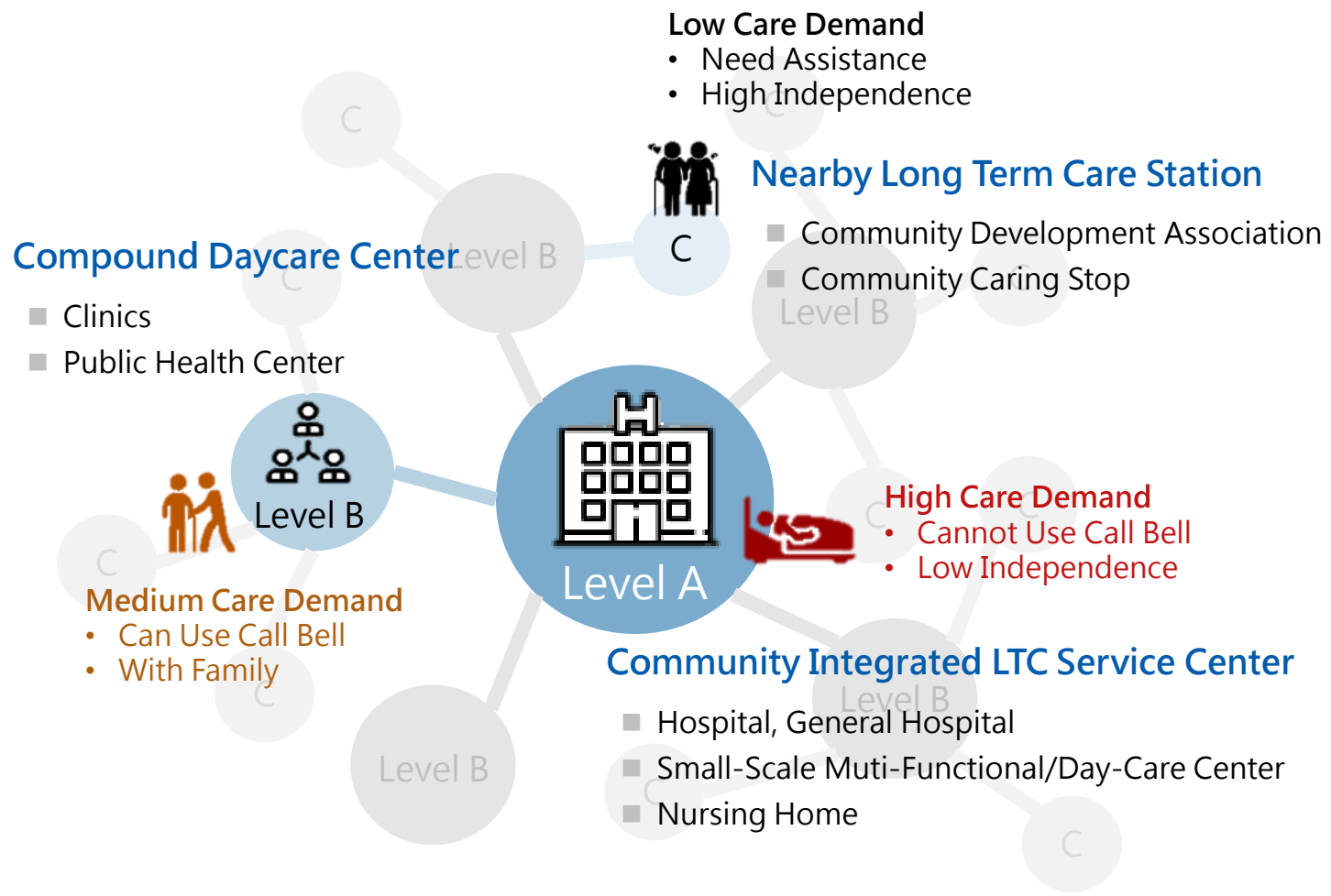
90% ↑

Home Care

Community Care

Institutional Care

Aging in Place Community Integrated Caring Model



Source: Long-Term Care Policy Portal, MoHW

2. Overview of Long-Term Care Policies in Taiwan

In addition to the integration of existing LTC network and capability, the LTC Service Act broadens the protection for the interest of informal caregivers

Services Defined in LTC Service Act


Caring Services


Housekeeping Services


Security Access


Nursing Services


Self-Care Training


Assistive Device Services


Accessible Environment Planning


Shuttle Services


Respite Services


LTC Care Training


LTC Care Consulting


Caring Visit


Cash Payment

Interests of family caregivers are protected in LTC Service Act

Source: Long-Term Care Policy Portal, MoHW

Agenda

1. Overview of Healthcare System of Taiwan

2. Overview of Long-Term Care Policies in Taiwan

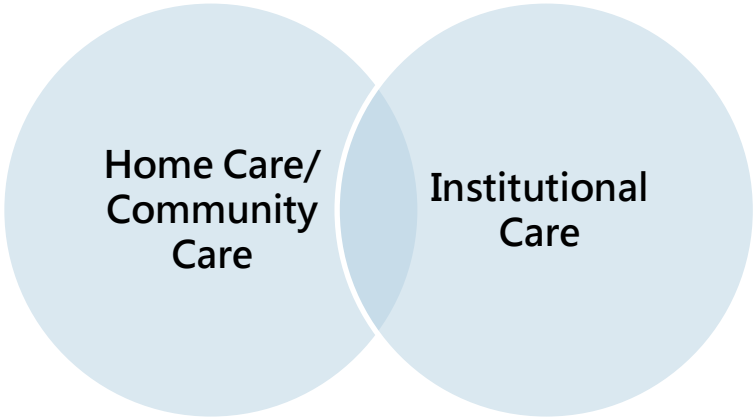
3. Overview of Tele-Healthcare Projects in Taiwan

3. Overview of Tele-healthcare Projects in Taiwan

Initially, the telecare service in Taiwan focused on providing medical services to remote areas; it has expanded to continuous of care nationwide

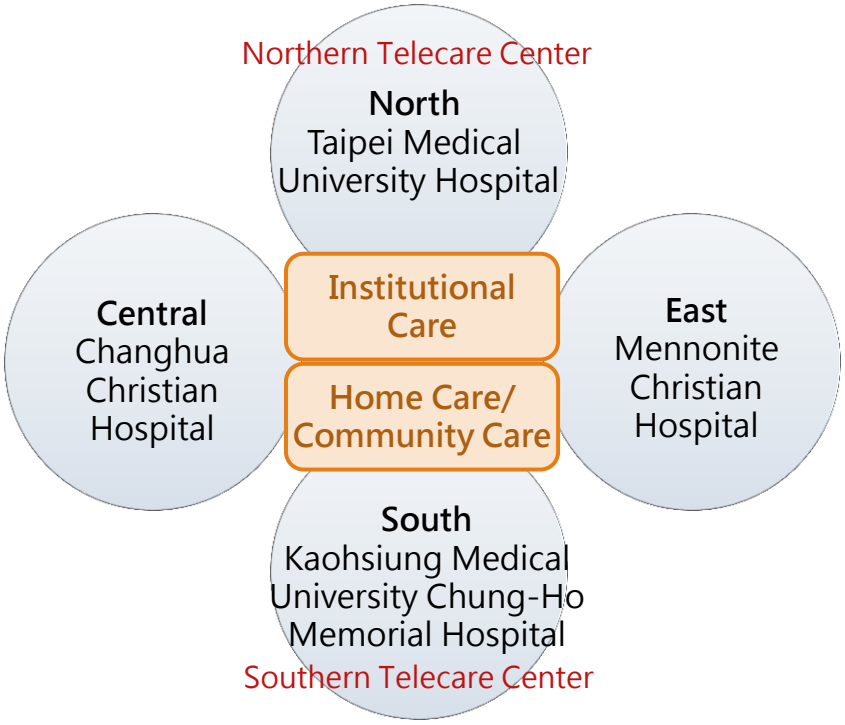
2007 — 2009 — 2010 — 2014

Continuous Care Pilot Project → **Continuous Care Expansion**



Target Users

- Remote area
- Scarce medical resource area
- High care demand area



Target Users

Patients of chronic diseases e.g. asthma, hemophilia, diabetes, and stroke

Source: Telecare projects, MoHW

3. Overview of Tele-healthcare Projects in Taiwan

The tele-healthcare center plays an assistant role to provide members integrated healthcare and long-term care services by utilizing ICT products

Brief of the Center

- Founded in 2009
- Paid memberships. Base on demand to charge, CAD 64-80/month.
- Serving Area: Southern and central part of Taiwan, including partial eastern part and islands

Community Support

Integrated Healthcare

資料來源：高醫遠距健康照護中心，NRI整理

3. Overview of Tele-healthcare Projects in Taiwan

The tele-healthcare in Taiwan utilises cloud service via smartphone apps and the case managers provide services based on analysis on collected data

Products and Services Provided by Tele-Healthcare Department in Hospitals

Mobile Cloud Monitoring

Home Care/Community Care

Professional Team Service

- Health Condition Monitoring
- Healthcare Referral
- 24-Hour Instant Consulting Service
- Personal Health Management
- Emergency Medical Treatment Assistance