

A CLINICAL INTEGRATED CARE (CIC) MODEL INCORPORATING
COMPREHENSIVE NEEDS ASSESSMENT AND LONGITUDINAL
CLINICAL INTEGRATION IN HONG KONG

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- By transforming isolated clinical assessments into a dynamic, data-driven Integrated Care Plan, this CIC model bridges Hong Kong's medical-social gap to shift dementia care from reactive crisis management to proactive, person-centered support.

INTRODUCTION	METHODS	RESULTS	CONCLUSIONS	ACKNOWLEDGEMENTS
► Demographic Pressure: Hong Kong faces a rapidly aging population, accompanied by a sharp rise in the prevalence of people with dementia (PwD). ► Fragmented Landscape: Despite current medical-social initiatives, the existing care network remains highly disconnected and siloed. ► The “One-off” Gap: Clinical assessments are treated as isolated, static events that fail to dynamically inform long-term care plans. ► Urgent Need: A cohesive model is urgently required to operationalize clinical data into actionable, continuous care management.	► Novel CIC Framework: Proposes a structured Clinical Integrated Care model tailored for urban, high-density healthcare systems. ► Multidimensional DNA: Leverages comprehensive Dementia Needs Assessments (DNAs) to capture psychosocial and clinical requirements. ► Data-driven Protocol: Utilizes algorithm-based pathways (e.g. cross-analyzing weight, sleep, and depression) to automatically adjust social care intensity. ► Digital Care Navigation: Introduces an Integrated Care Plan (ICP) to bridge medical specialists and NGO providers for seamless execution.	► Proactive Alert Mechanism: The DNA system converts clinical metrics into early warning alerts, enabling families to intervene before health crises escalate into hospitalizations. ► Targeted Hospital Avoidance: By identifying subtle clinical fluctuations earlier than current care pathways, the model is architected to systematically reduce unplanned clinic and A&E visits. ► Precision Resource Allocation: Dynamically matches social care intensity with actual clinical severity (via DNAs & ICP), eliminating service redundancy and optimizing healthcare cost-effectiveness. ► Dual-Target Outcomes: Establishes a synchronized feedback loop that simultaneously stabilizes the PwD's clinical trajectory and mitigates informal caregiver burnout.	► Bridging the Gap: Successfully addresses the long-standing "implementation gap" between medical policy and community practice. ► Proactive Shift: Transitions the entire dementia care ecosystem from a reactive, crisis-based approach to a proactive, patient-centered model. ► Scalable Solution: Offers a highly adaptable, future-proof framework for global cities facing similar rapid demographic aging.	This study was supported by the Jockey Club Centre for Positive Ageing under The Chinese University of Hong Kong. We express our sincere gratitude to all the multidisciplinary care experts, case managers, and NGO partners for their invaluable contributions to the conceptualization and development of this CIC framework. Most importantly, we thank the individuals with dementia and their care partners whose real-world experiences and feedback inspired the design of this person-centered care model. CONTACT Kingsley PUN MPH, BNurs, Hon. APN-NTEC Specialty Nurse (Community, Primary and Public Health Nursing), PhD student (CUHK) Deputy Superintendent & Nursing Officer Jockey Club Centre for Positive Ageing General: 2636 6323 Fax: 2636 0323 Email: kingsley.pun@jccpa.org.hk Website: https://www.jccpa.org.hk  賽馬會耆智園 Jockey Club Centre for Positive Ageing