Different Care Engagement in Patient Journey with Complex COPD
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Introduction
Severe COPD is characterized by frequent exacerbation and hospital admissions. This underpins the need for more effective prevention and management strategies. The multi-professional care team such as ICDS-case manager, Virtual ward, palliative home care team and respiratory nurse clinic was pioneer a comprehensive respiratory case conference for complex COPD patients. The conference aimed of triage suitable care team to manage patients’ complex need in their different staging of COPD.

Objectives
The targeted of improved patient outcome, prevent complications and reduced readmission.

Methodology
1. Identify high risks patients and invited multidisciplinary team for participate the case conference. 2. The multidisciplinary care team include: - Ward Manager in respiratory ward, - Respiratory nurse specialist - ICDS case manager - Nurse Consultant of community care service and CNS - APN - Virtual ward 3. Regular case conference conducted and patient care service triage. 4. Electronic documentation for enhanced communication with multidisciplinary team approach. 5. Though this platform provided comprehensive patients’ needs and care hand-over.

Result
There were 30 high risk (HAPPRE score >0.4) COPD patients recruited from Dec 2014 to Feb 2015. Regular weekly conference conducted and reported. Patient care triage distributed on nurse clinic FU, case manager home visit, enhanced CNS service and virtual ward intensive care for end stage COPD patients. Moreover, there
were statistically significant showing that the average number of reduction of readmission by 30.6% (p<0.001) in this COPD group patients. The respiratory complex case conference was effective to engage multidisciplinary care team and accurate to triage patient care needs in their COPD journey.