COPD Alliance Project

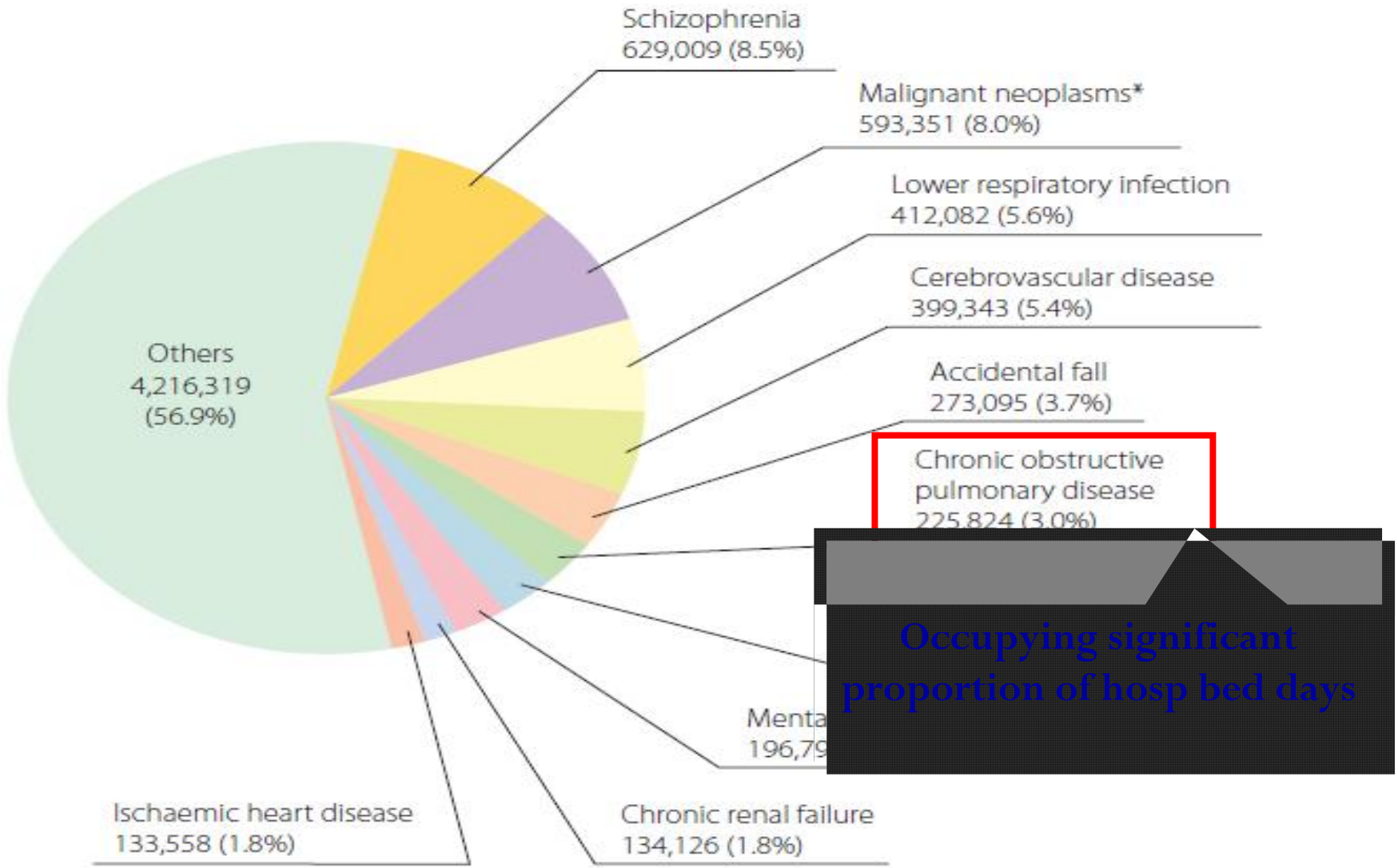




Disease Burden in HA

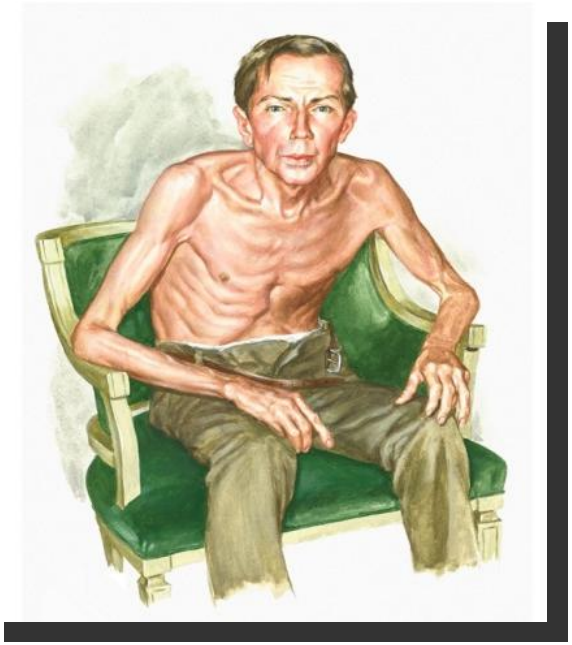
Chronic diseases account for the highest hospital bed utilization

Top 10 conditions with highest bed day consumption in HA (2007)



HA Strategic Service Plan 2009-12

COPD



A paradigm shift in chronic disease management

Loss of Vitality

Dyspnoea

Recurrent Chest Infections

Sputum

Helplessness

Fear

Depression

Cough

Social Isolation

Immobility

Decrease in Fitness

Anxiety

Methodology

- Identify high risk patients i.e. > 3 hospital admissions or emergency room visits for COPD exacerbations per year, using 2nd line combination therapy from Medical Record Department.

- Call back for assessment in CDRC

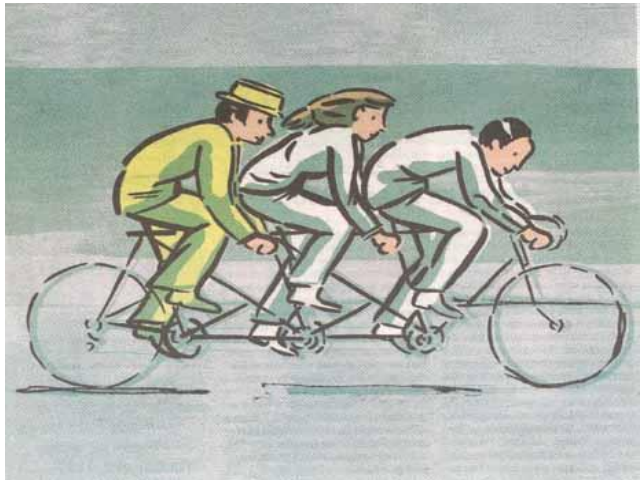
Integrated Care Team

Respiratory Physician

Respiratory Nurse

AED specialist

Volunteers/NGO



Occupational therapist

Physiotherapist

Social worker

COST Team

Case Manager

CDRC Assessment

- Smoking cessation
- Oxygen therapy
- Increasing exercise
- Improving nutrition
- Self-treatment of exacerbations
- Inhalation technique
- Check drug compliance
- Coping with activities of daily living
- Nocturnal NIPPV

Self Management of COPD

Service Pathway @A&E

Risk identification

Protocol Driven

Case Manager

Immediate checking of "**HIGH RISK REGISTRY**" in CMS

- On site Counselling
  - Early Discharge
- EM Ward
- Convalescent Hospital
- Respiratory Ward

Service Pathway @Respiratory Ward

Clinical Assessment + Risk Identification

Case Manager

Specialist Consultation Round
(Treatment)

- Plan Early Discharge
- Convalescent Hospital

Multi-disciplinary Team
(Rapport Development** + **Habitual Change)

- PT
- COST
- OT

Regular case conference

Early discharge/Community Support

Objectives: PATIENT ENGAGEMENT

Discharge

HOME CARE WITH CARERS

Early phase

Home visit by CNS

Stable phase

Patient empowerment programme

- *Empower carers*
- *Health education*
- *Promote self management*
- *Motivate and support patient and carers*
- *refer NGO for community PRP*

Discharge

PRIVATE/SUBVENTED ELDERLY HOME

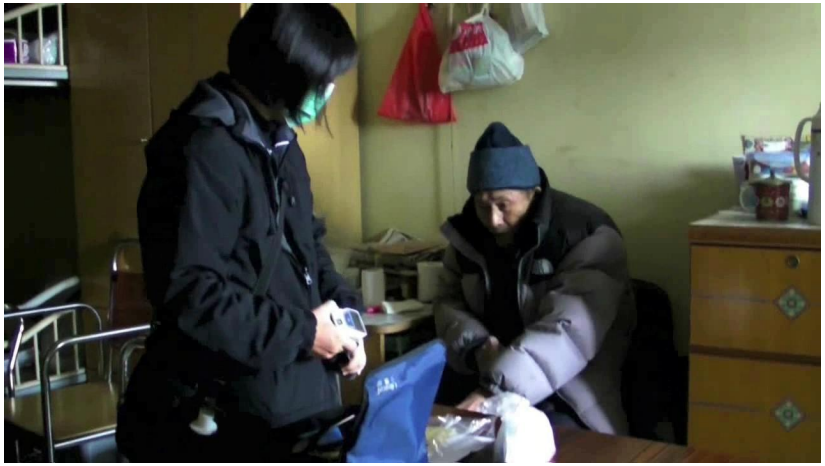
FU by CGAT nurses

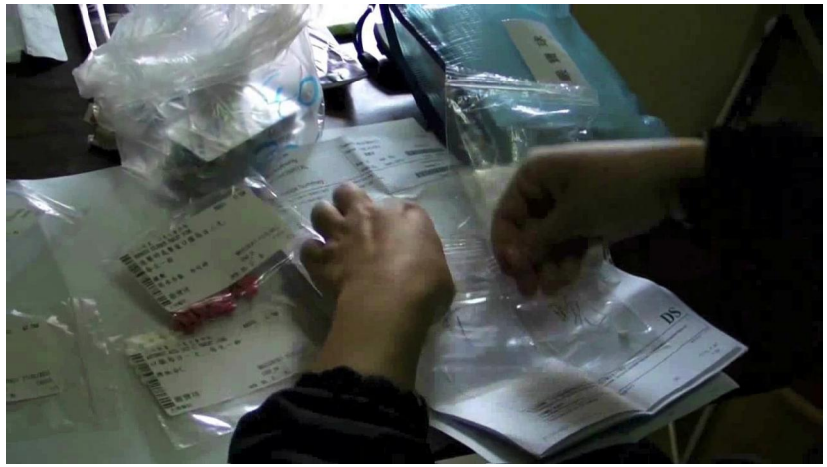
Engage elderly home staff for :

- *Early screening of respiratory symptoms*
- *Health education + infection control*
- *Support early discharge, shorten LOS*


Discharge
LIVING ALONE with NO SUPPORT
Early phase
- Home visit by CNS
- Meal arrangement
- Home adaption by COT
- Breathing exercise by CPT
Stable phase
- Rapport by community neighborhood network
- Refer Day Care Centre

Home visit by CNS





Engage volunteers

Engage volunteers

Elderly Day Care Center

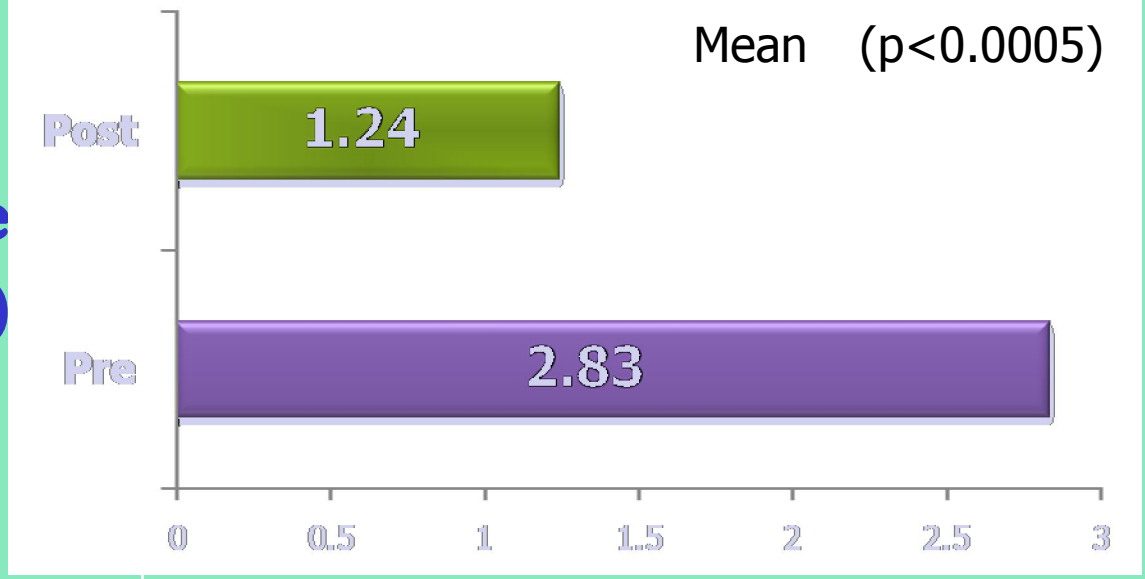
Side room for infection control

Consultation room with CMS

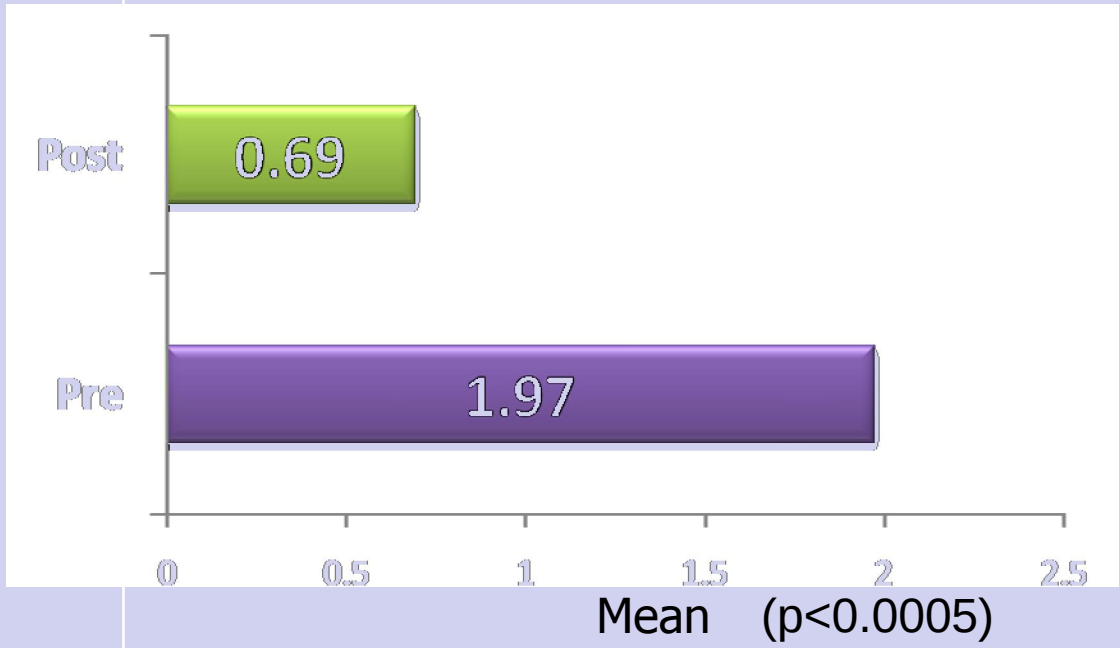
Results (in 6 months)

- Total no. of patients recruited , n=100
  - 14 patients died during this period
  - 14 excluded due to other co-morbidities : CRF,CA lung, TB, alcoholic, stroke, psychiatric problems, etc.
- Mean age = 61.96 (n= 72, range 48-98)
- M:F = 54 : 18
- Age <60, n = 7
- OAH, n=13; home alone, n=8 ; home, n=53
- 9 patients with no HARPPES because frequent hospitalizations but not related to COPD exacerbations
- Mean HARRPES score = 0.32 (n = 56)

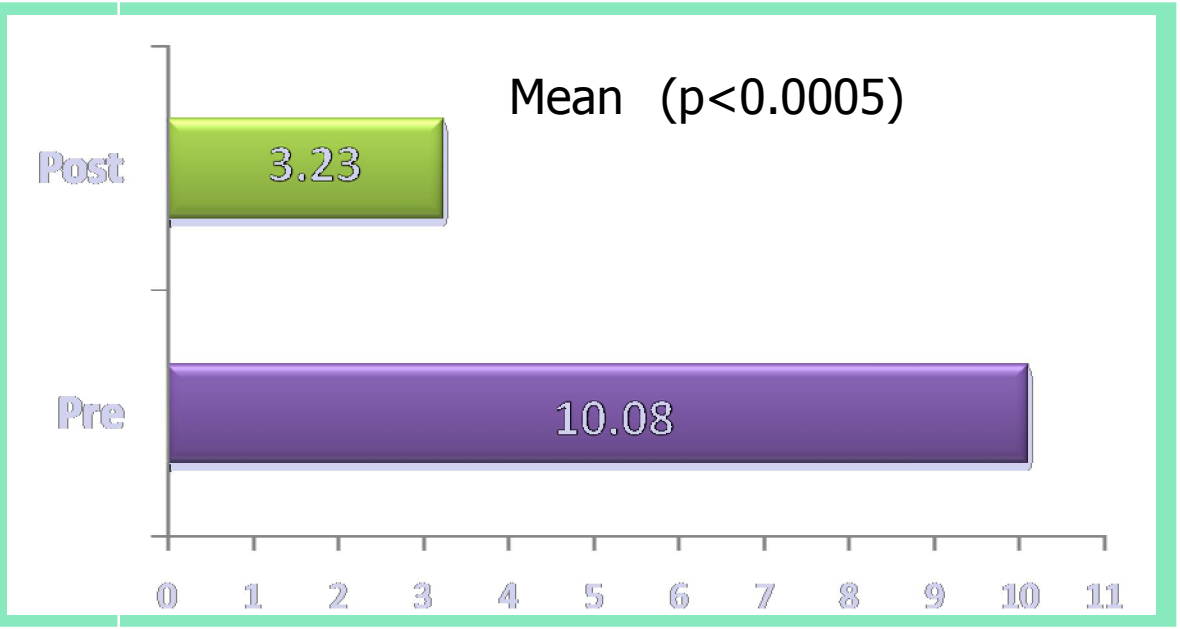
AED attendance (6 months)



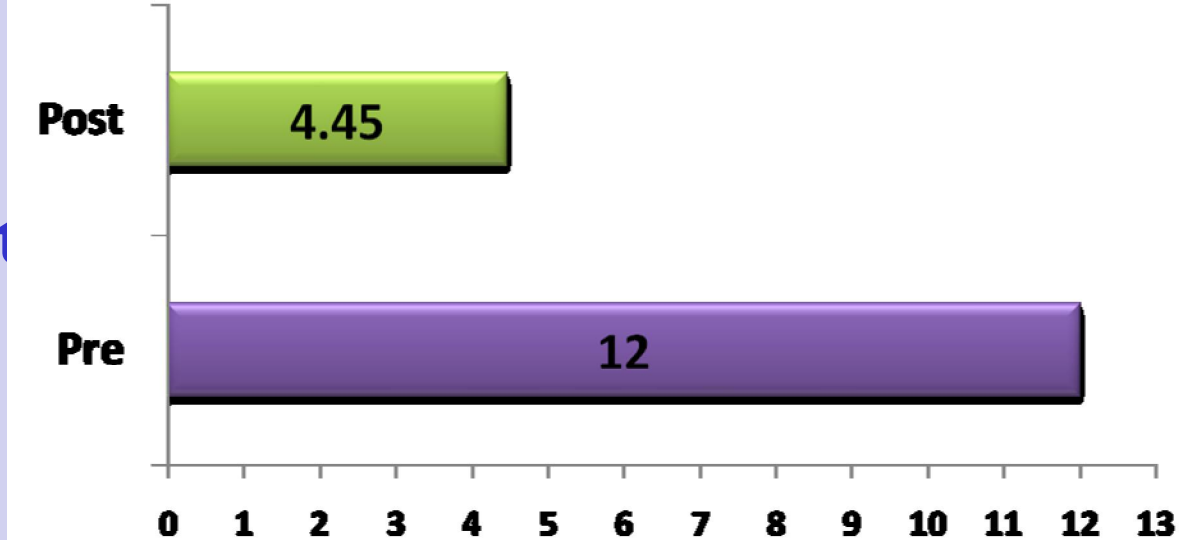
Acute medical admissions (6 months)



Acute Medical LOS (days)



Convalescent LOS (days)

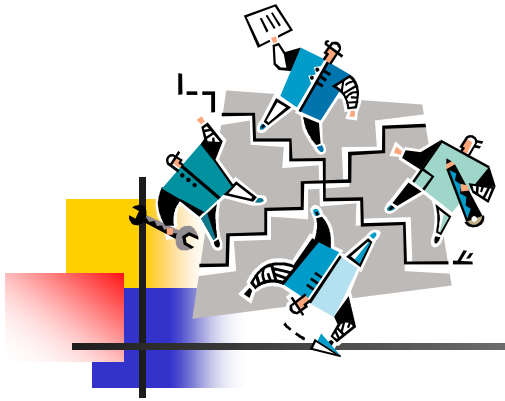


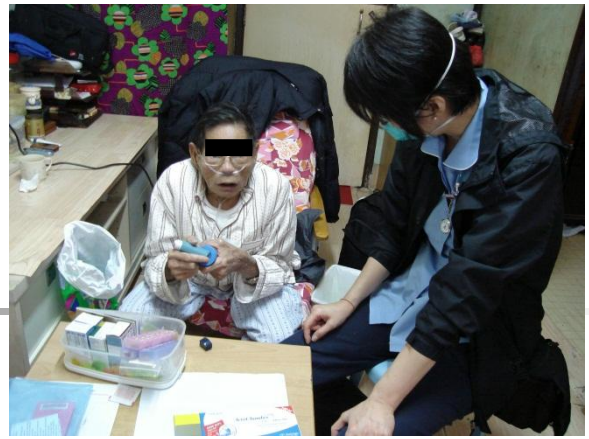
Mean (p<0.0005)

Conclusions

- The multidisciplinary approach was effective in reducing no. of AED attendances/medical admissions, IP ALOS and a significant reduction in total inpatient bed days of 1066.
- Reduce the overall healthcare expenditure, and allows the patient to enjoy a reasonable quality of life in the community.

COPD (496)				
	IP ALOS (days)			
Discharge period	2009/10	2010/11	2010/11 Vs 2009/10	
	day	day	day	%
AHNH	4.14	3.71	-0.43	-10.4%
BBH	7.00		-7.0	-
NDH	5.25	4.33	-0.92	-17.5%
PWH	4.69	4.71	+0.02	+0.4%
SCH		441.50	-	-
SH	13.77	13.87	+0.10	+0.7%
TPH	10.47	11.05	+0.58	+5.5%
Overall (NTEC)	6.59	6.64	+0.05	+0.8%





There is no magic, there is no cure…

But there is always something that can be done!

"Collaborative Healthcare"

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