KOWLOON WEST CLUSTER

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Chronic Disease Management in Community: COPD Care Model

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BURDEN OF PROBLEM:

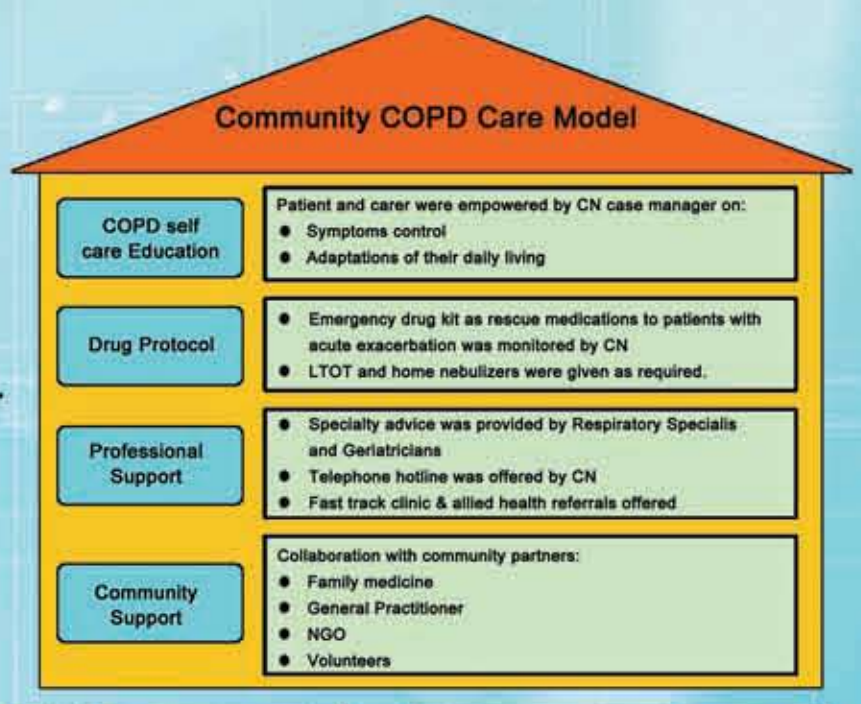
- Chronic Obstructive Pulmonary Disease (COPD) is a progressive chronic disease burden in HA.
- In 2009, COPD patients had >25,000 episodes of admission per year with overall 8% medical bed days occupied and highest unplanned readmission rate in HA.

OBJECTIVES:

- Reduce hospital admission and length of stay of COPD patients
- Empower patients and carers on COPD care
- Enhance CNS on chronic disease management
- Develop an infra-structure for chronic disease management

METHODOLOGY:

- CNS provided case management and home visits to manage acute respiratory distress of COPD patients in community.
- Advanced practice on COPD management was trained to all CNS.
- Post-discharge care protocol and rehabilitation




Emergency drug kit


Patient empowerment by Community Nurse


COPD Support Group

RESULT:

- Median of patient/carer empowerment scores showed an increase from 13/18 to 17/18

CONCLUSION:

- The program achieved remarkable outcome and will be developed as a territory-wide service in CNS.
- This becomes a jumping board for a development of chronic disease management from hospital to community.

Helping people stay healthy in the community