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NEW TERRITORIES EAST CLUSTER

Enhancing Community & Trust Relationship between COPD Patient and Community Nurses through Case Management Model in Tai PO

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Introduction

Chronic Obstructive Pulmonary Disease (COPD) is a non-curable obstructive airway disease. Changing patient's lifestyle may control the disease severity and hence prevent disease deterioration. Patients with Hospital Admission Risk Reduction Program for Elderly (HARRPE) score 0.3 are frequently admitted to acute hospital due to stress, COPD exacerbation and declining lung-function. Frequent hospital admissions will create social-economical problems for these patients.

Since September, 2010, an innovative approach with case manager model is devised by Community Outreach Services Team (COST) in Tai Po to build up a trust-based bridge between these COPD patients and case manager (community nurse) via mutual communication and embracing holistic care service.

COPD case manager takes a proactive role in empowerment of patient self-care capability in the community via a series of communication, education and timely intervention to influence patients' health lifestyle so as to reduce avoidable hospitalization effectively.

Objective

For patients:
To empower self-care capability of COPD patients in their community
To enhance quality of life of COPD patients

For case managers:
To establish rapport and trust environment between COPD patients and medical professionals
To enhance knowledge and skill in COPD care
To push up the bar of staff engagement

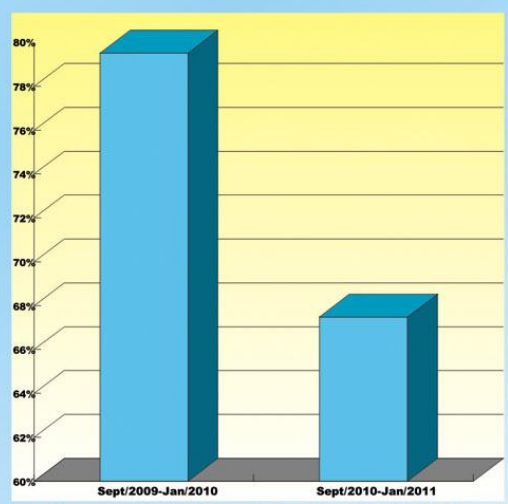
For services:
To actualize a cohesive linkage between community services and hospital medical service
To reduce unplanned/avoidable readmission, in a whole

Methodology

- Assign a community nurse as case manager for each targeted patient
- Generate COPD protocol and guidelines to drive the caring progress
- Monitor patient by schedule and ad-hoc on site assessments
- Early detect any deterioration and provide timely intervention, e.g. specialist consultation or clinical admission
- Share care with multidisciplinary teams
- Review services through case conference with the team
- Retrieve and analyze the date for these group of patient

Results

- 58 cases were recruited within 4 months and assigned with case manager
- 298 communication phone calls were made in which 40% was incoming enquiry calls
- 13 (20.6%) clinical admission beds arranged
- 15 (26%) respiratory specialist consultation arranged
- Lessen 7% utilized AED services as compared with the same period in previous year
- Unplanned AED admission within 28 days was reduced by 11%
- Reason for Admission related to COPD was decreased to 67.5% compared with 79.5% in previous years



Reason for Admission Related to COPD

Conclusion

Caring COPD patient with case management approach has been proven to enhance a trust-based linkage platform between patients and health care providers. The patient would contact their case managers when required that could lessen the utilization of acute hospital services. It also contributes to a remarkable enhancement in patient's quality of life, self-care capability and knowledge and to help avoiding hospitalization. This Program can be sustained effectively by retrieving more information from Patient Satisfaction Survey and enhancing training to community volunteers in the future.

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