Submission of Abstract

A community health care programme to reduce unnecessary hospital admissions

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Introduction:

Frail elderly patients with chronic diseases are prone to become destabilized and have repeated unplanned hospital readmissions in the early post-discharge period. In 1999, the Community Health Programme empowered our community nurses (CNs) to serve frail elderly discharged patients.

Objectives:

(1) to stabilize the disease conditions for post-discharge patients with COPD, stroke or DM; (2) to minimize hospital admissions, readmissions and overall health services use (3) To maintain or improve their physical and cognitive functions.

Methodology:

A "Pre-test" vs. "Post-test' design was employed. Subjects were (1) emergency hospitalized patients with a principal diagnosis of DM, stroke or COPD (2) planned to be discharged (3) scheduled to go home or private old aged homes. Outcome measures were categorized as: (1) Health related parameters for cognitive function, (2) Health services utilization and cost data, (3) Satisfaction survey.

Results:

From March 1999 to February 2000, 126 patients were served and 56% were females. There were 62% (p=0.001, paired t-test), 70% (p<0.001, paired t-test) and 45% (p<0.001, paired t-test) reduction in planned and unplanned bed-days and A&E visits after the intervention. There was a net saving of HK$31,336 per patient or HK$3.9 millions for 126 patients.

Conclusions:

The community health care intervention programme was effective in reducing unnecessary health services utilization, saving health care cost and achieving stabilization of the diseases status.