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Manage Frail Elderly from Hospital to Community: A service of Integrated Care Model for COPD patient

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Introduction

Chronic Obstructive Pulmonary Disease (COPD) was ranked second as a respiratory cause of hospitalization (14.6%) and inpatient bed-days (20.5%) among common respiratory diseases in Hong Kong. The data was consistent in a local district hospital. In line with the Hospital Authority's strategic service plan 2009-2012 of managing growing demand, a service of Integrated Care Mode (ICM) for high risk elderly was established since October 2011. In United Christian Hospital we also focus on transitional care (from hospital to community), symptoms early detection and prompt intervention to reduce the need for intensive hospital care. This year review aims to evaluate the effectiveness of Integrated Care Mode on reducing these patients' avoidable healthcare utilization.

Objectives

Integrated Care Mode demonstrates the effective in reducing 28day unplanned admission for high risk elderly patient in COPD.

Methodology

The ICM for COPD was established in October 2011. COPD patients who were hospitalized & HARRPE score $\geqq$0.2 could be recruited. The model was run by multidisciplinary profession staff with Case Management training. We provide COPD care according to an approved protocol. There are the key components of the protocol as follows: Hospital Admission Risk Reduction Program for Elderly (HARRPE) Score Hospital Authority was established one of risk prediction score for high risk elderly. According the HARRPE score report, COPD patients have systematically screening and proactively manage the care of them. Case Management The Case Management components include Case Manager home visit, multidisciplinary assessment at home, risk factor reduction, comprehensive case conference, stable COPD care and

exacerbation COPD care in community. Integrated Discharge Support Program Collaborate with NGO having expertise in community care of the elderly in providing home support services to targeted patients Patient and Carer Empowerment With reference to corporate guideline, patients are empowered with the required knowledge and skills for self-care management of COPD. Hotline In order to improve the health access, service hotline is available for the COPD patients. It can provide health advices, triage for medical services and early follow up arrangement as appropriate. Respiratory Specialty Nurse- Led Clinic Provide regular respiratory nurse clinic follow up for continuity COPD care in community after accomplish case manager home visit.

Result

There were 74 COPD patients recruited and analyzed between October 2011 and September 2012. Their mean age was 78. More than 90% of them were in COPD stage III or IV. They have case manager home visit 6-8 times and took 30- 45 minute per visit on average in the home visit for post hospital discharge 1-2 months. It was statistically significant showing that the average number of unplanned admission by 35.4% ($p<0.001$) in COPD patient with 0.2-0.5 HARRPE score. The healthcare utilization of the COPD patients was significantly reduced after they were under the care of the Integrated Care Model in terms of emergency department attendance and unplanned admission. More outcome indicators will be evaluated in one-year review such as Quality of Life and CAT Scale.