Service Priorities and Programmes

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Siginificant reduction of hospital readmission through timely assessment and intervention for high risk elderly in community

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Introduction

Hospital Authority's Key strategic priority for demand management is to reduce avoidable hospitalization. As a transitional care hospital, hundreds of patients were admitted directly from the AED of hospitals in Kowloon West Cluster every month.These patients would miss the comprehensive admission assessment and discharge planning from the acute hospital. To bridge the gap, the Integrated Care Model Program(ICM) was implemented in Our Lady of Maryknoll Hospital.

Objectives

1. To reduce avoidable hospital readmission of high risk elderly. 2. To enhance better service coordination among multidisciplinary team in the cluster.

Methodology

All at risk patients were categorized by Hospital Admission Risk Reduction Program for the Elderly (HARRPE) Score. Link nurse performed comprehensive assessment for risk identification and stratification, and formulated the discharge care plan for individual elderly. After discharged, case manager provided post-discharge home visits to the elderly for timely intervention and home care support. Both patient and care giver were empowered to manage the disease problems appropriately in the community. The program also enhance better service coordination among multidisciplinary team and improved continuity of care

Result

Retrospective review on data from Nov 2012 to Oct 2013, there were 307 episodes of assessment and discharge planning for targeted patients. Total 20 targeted elderly were referred to the ICM team of other hospital for post-discharged support. In addition, 49 elderly patients were recruited for case management with 414 post discharged home visits provided by the case manager. The mean HARRPE Score of the recruited elderly was 0.28 and the mean age was 83.8 years. The elderly were dominated with Diabetes Mellitus, Hypertension, COPD and heart disease. Compared the total number of AED admission in 3-month period before and after recruitment to the program, there was a reduction of 36.8%. In conclusion, well discharge planning

with post discharged support by case manager is effective in reducing the avoidable hospital readmission.