Service Priorities and Programmes

Electronic Presentations

Convention ID: 932
Submitting author: Ms Lee Hoi Shan, Alice
Post title: Occupational Therapist I, United Christian Hospital,

Enhancement of Occupational Therapist's Role in Integrated Case Management program for High Risk Elderly with Stroke in a Local Hospital – One year experience sharing

Lee Alice(1), Hui Peggy(1), Wan Maurice(1), Sim TC(2)
1. Department of Occupational Therapy, United Christian Hospital 2. Department of Medicine & Geriatrics, United Christian Hospital

Keywords:
Occupational Therapist
Integrated case management program
Stroke
High risk elderly

Introduction

Hospital readmission is common among elderly with stroke. The phenomenon might reflect unresolved issues at discharge or lack of resources in post-hospital care. The Integrated Case Management program for high risk elderly with stroke has been established in United Christian Hospital. With the provision of pre-discharge risk assessment and post-discharge home based interventions, OT's role as case manager was enhanced in October 2011.

Objectives

To determine the effectiveness of Integrated Case Management Program through enhancement of Occupational therapists role in reducing hospital readmission and improving patient's health-related quality of life for high risk elder patients with stroke.

Methodology

High risk elderly (HARPPE score ≥0.2) aged over 60 with recent diagnosis of stroke indicated for Occupational Therapy were screened and assigned to OT as the case manager. During 6-8 weeks post-discharge follow up period, the OT case manager maintained contact with patients through regular home visits and telephone follow up. OT as the case manager, adopted the multidisciplinary approach by providing medication review, ad hoc clinic, hotline access to a call center, self-management and lifestyle redesign intervention, home-based training and caregiver empowerment to the stroke patient. OT as the case manager also acted as the primary coordinator to facilitate communication and collaboration among patient, caregiver, health care professions and providers. The primary outcome variables were numbers of hospital readmissions within 28 days and 2 months after discharged. The secondary outcome measure was health-related quality of life measured by Short-Form 36.

Result

A total of 32 participants (78.1% men, mean age 75.2) were recruited from Oct 2011 to

March 2013, with HARPPE score range from 0.2 to 0.5. The mean number of home visit each patient was 9 and were completed within post-discharge 8-week. A total of 288 home visits were conducted in which 90% were provided by occupational therapist case manager. Results also showed that 96.8% participants without unplanned readmission within 28 days after discharged. 93.7% participants without unplanned readmission within 2-month after discharged. After completion of the program, participants also demonstrated an improvement in health-related quality of life measured by Short-Form 36. Conclusion The Integrated Case management program could provide comprehensive and coordinated care for these high risk elderly with stroke. Enhancement of OT's role as the case manager was shown to be effective in improving health-related quality of life meanwhile decreasing the number of avoidable hospital readmissions.