Project Title

Patient Care Collaboration with Community Partners using Central Health LinkUp (CHL)

Project Lead and Members

Project lead: Bernice Lin Lifang, Assistant Manager, Population Health Office, Community Operations, Tan Tock Seng Hospital

Project members:

- Ms Loh Shu Ching, Project Sponsor, Executive Director, Central Health, Tan Tock Seng Hospital
- Adj A/Prof Ian Leong, Project Sponsor, ACMB Community Care Integration, Central Health, Tan Tock Seng Hospital
- Dr Wong Chia Siong, Project Sponsor, Director, Central Health, Population Health Office
- Ms Lim Sing Yong, Project Sponsor, Deputy Director, Population Health Office, Community Operations, Tan Tock Seng Hospital
- Ms Elizabeth Pan, Manager, Population Health Office, Corporate Planning (Healthcare Intelligence), Tan Tock Seng Hospital
- Ms Evelyn Tan, Co-Lead, Manager, Population Health Office, Community Operations, Tan Tock Seng Hospital
- Mr Tay Tian Lin, Manager, Population Health Office, Community Operations, Tan Tock Seng Hospital
- Ms Shermaine How, Assistant Manager, Population Health Office, Community Operations, Tan Tock Seng Hospital
- Ms Ong Wee Ting, Senior Executive, Population Health Office, Community Operations, Tan Tock Seng Hospital
- Ms Sarah Tan, Co-Lead, Executive, Population Health Office, Community Operations, Tan Tock Seng Hospital

- Ms Jerilyn Hui, Executive, Population Health Office, Community Operations, Tan Tock Seng Hospital

Organisation(s) Involved

Tan Tock Seng Hospital

Project Period

Start date: 2018

Completed date: Ongoing

Aims

To overcome the lack of care continuity from hospital to community by resolving the communication gaps between organisations and allowing care providers to co-manage patients.

Background

See poster attached/ below

Methods

See poster attached/ below

Results

See poster attached/ below

Lessons Learnt

See poster attached/ below

Conclusion

Instead of creating new processes, CHL has redefined the existing care delivery structure to bridge the gaps within the hospital-to-home system. It is important to

create a self-sustaining ecosystem that is scalable, and can further benefit patients with post-discharge needs. Strengthened partnerships with community providers also ensure that care is delivered holistically and sustainably, as we move towards our nation's vision of "Beyond Hospital to Community, Beyond Healthcare to Health, Beyond Quality to Value".

Project Category

Care & Process Redesign

Keywords

Care & Process Redesign, Community Health, Care Continuum, Value Based Care, Communication, Healthcare Administration, Tan Tock Seng Hospital, Central Health LinkUp, Integrated Care, Transitional Care & Community Care Workstream, Corporate Planning, TigerConnect, One Care Plan

Name and Email of Project Contact Person(s)

Name: Bernice Lin

Email: bernice_lf_lin@ttsh.com.sg

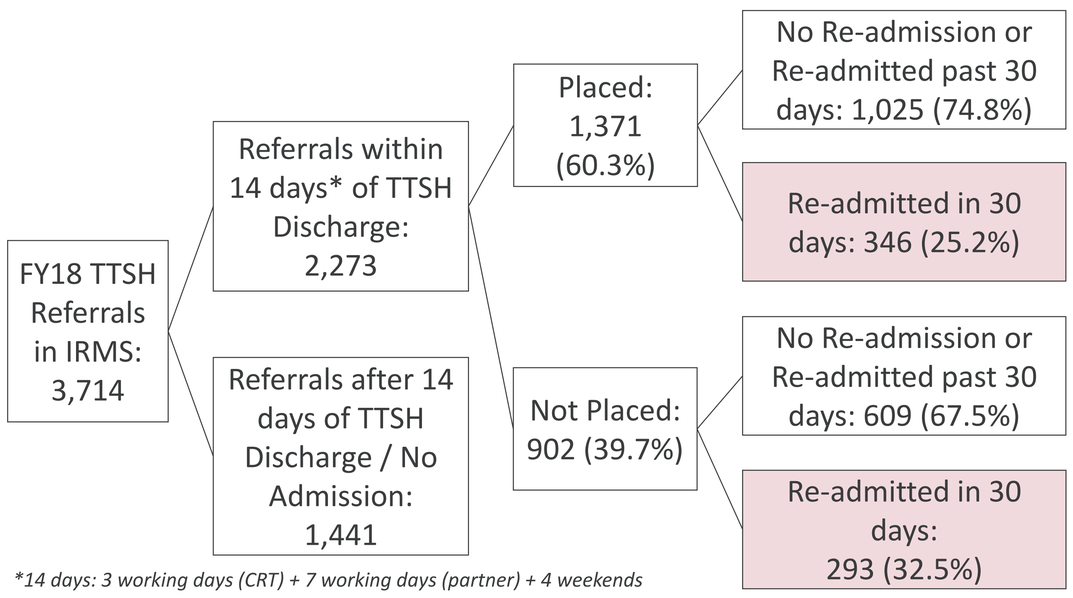
Patient Care Collaboration with Community Partners using Central Health LinkUp (CHL)

Loh Shu Ching, Adj A/Prof Ian Leong, Dr Wong Chia Siong, Lim Sing Yong, Elizabeth Pan, Evelyn Tan, Tay Tian Lin, Bernice Lin Lifang, Shermaine How, Ong Wee Ting, Sarah Tan, Jerilyn Hui

Community Operations, Population Health Office, Division for Central Health

Tan Tock Seng Hospital
National Healthcare Group

1. Outline of Issue



**14 days: 3 working days (CRT) + 7 working days (partner) + 4 weekends*

Figure 1: TTSH Referrals to Home Care Providers, Placements & Readmissions (FY18)

Based on FY18 data analysis on home care referrals (Figure 1), it is evident that successful home care placements reduce hospital readmissions. However, out of those who were placed, there was still a significant 25.2% of patients who were readmitted in 30 days.

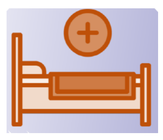
To assess the possible causes, the project team found out through our engagement with CHTs and community partners, that there were frequent communication lapses; partners were not privy to their client's care needs and health plans that were assessed by TTSH care teams. This resulted in the lack of care continuity from hospital to community, and could have contributed to patient readmissions.

2. Plan to Overcome Issue

A total approach was required to resolve the communication gaps between organisations and allow care providers to co-manage patients. Two elements were critical: (1) Information promptly delivered, (2) Platforms to facilitate care discussion across care sectors.

CHL facilitates intel sharing and sparks timely communication between TTSH and community providers by triggering alerts to them through emails informing partners that their client(s),

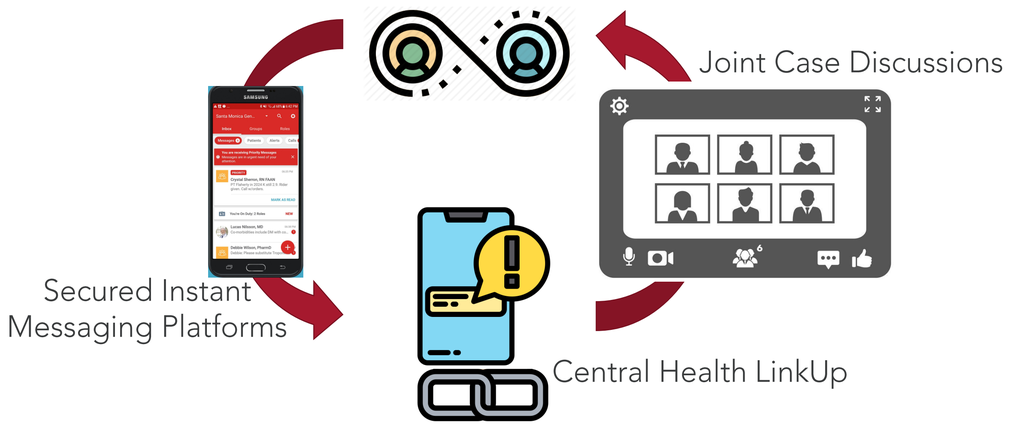
a) Visited TTSH Emergency Department



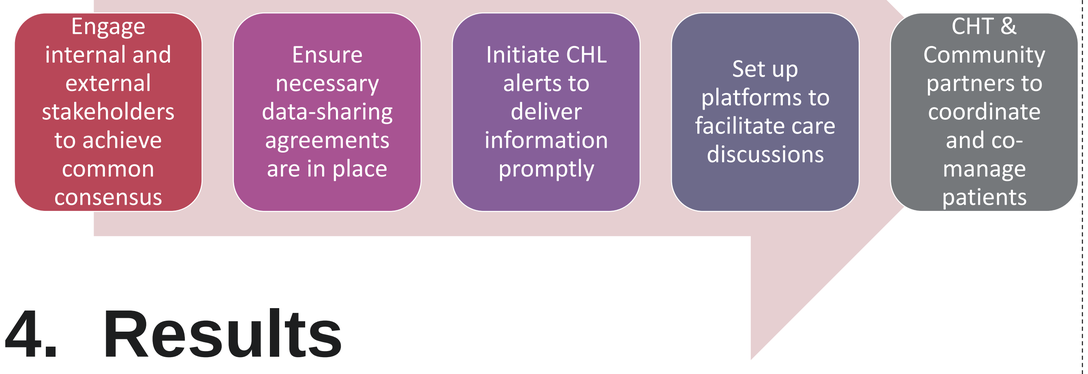
b) Were admitted to inpatient wards

c) Were discharged

While CHL served to deliver information promptly, more solutions were undertaken to facilitate a total care process redesign. For instance: Community partners now could have joint case discussions with CHTs; instant message platforms such as TigerConnect were introduced to facilitate instant and ad-hoc discussions on patient care.



3. Strategy for Change



4. Results

a) Increasing number of patients co-managed using CHL & Expanded Network of Community Partners on-board CHL

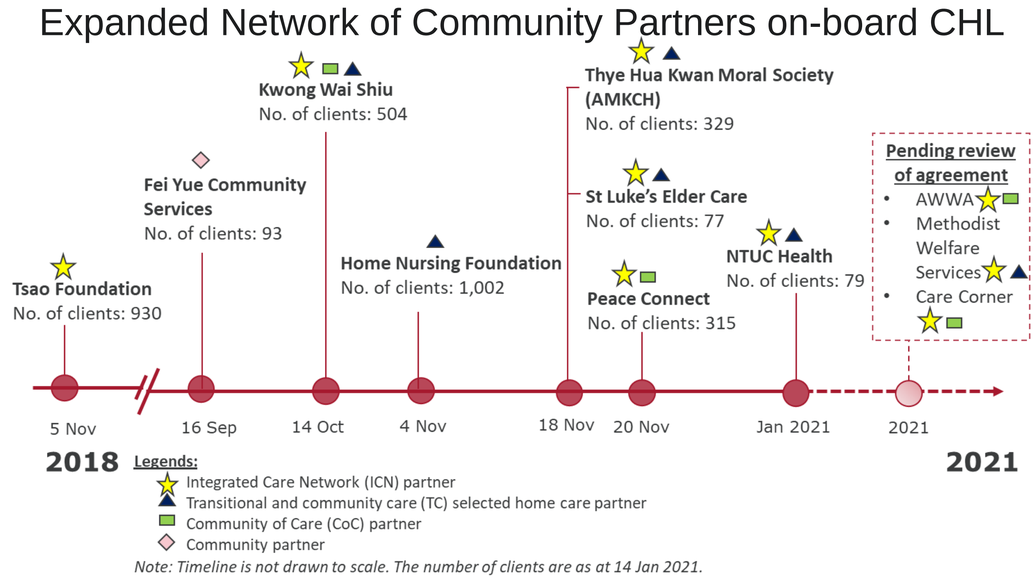


Figure 2: Community Partners On Board

b) Reduced or maintained ED attendance and Inpatient Admission rates

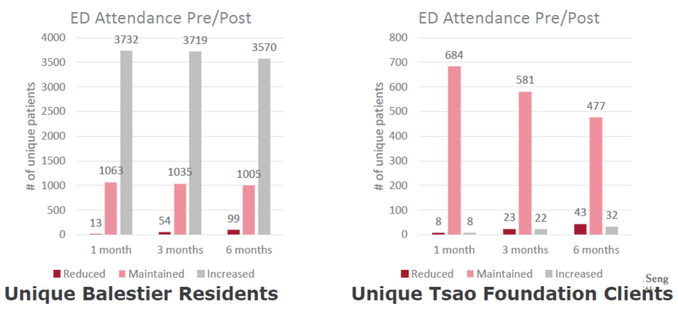


Figure 3: Number of Patients with ED Attendance by Pre-Post Utilisation Trend

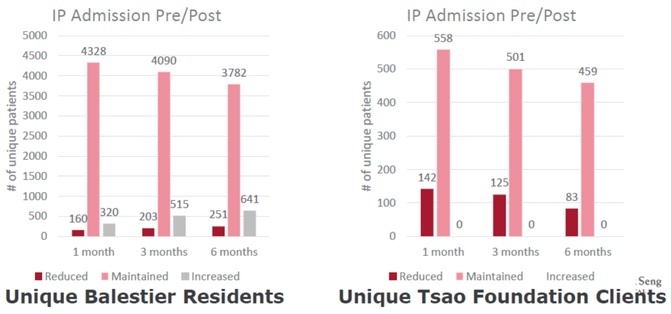


Figure 4: Number of Unique Patient with Inpatient Admission by Pre-Post Utilisation Trend

5. Lessons Learnt

In today's evolving Singapore healthcare landscape, a "do-it-alone" approach is not the best strategy. Institutions should pool resources to innovate and redesign care to achieve multiplier effects on the system and for our patients.

The process of change management across multiple organisations adds another layer of challenge. To develop the speed of trust, we learnt to understand each organisation's strategic intent, to internalise their target deliverables, challenges, strengths, so as to customise our strategy while working to standardise processes across partners to achieve operational excellence.

Supporting the Nation's vision of

"Beyond Hospital to Community, Beyond Healthcare to Health, Beyond Quality to Value"