Project Title

Reducing low social risk referrals to Medical Social Services

Project Lead and Members

Project lead: Lim Boon Chee

Project members: Chew Tee Kit, Chin Chi Hsien, Ong Mei Yan, Zeng Hui Hui

Organisation(s) Involved

Ng Teng Fong General Hospital

Healthcare Family Group Involved in this Project

Allied Health

Applicable Specialty or Discipline

Medical Social Workers, Geriatric Medicine, Neurology

Aims

To reduce low social risk MSW referrals in Ward 11 and Ward 12 from **30% to 10%** to improve work efficiency from May 2018 to Dec 2018.

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Lessons Learnt

- To take system changes into consideration e.g. the project was delayed as the MSS department underwent two major system change management: NGEMR and NeMSW systems. The last intervention was conducted in Aug 2019.

- Change is easier when the stakeholders are internal department customers.

- Communication is important to help staff to understand role of MSW and workflow changes.

Conclusion

See poster appended/ below

Project Category

Care & Process Redesign

Access to Care, Referral Rate, Quality Improvement

Keywords

Low Risk, MSW referrals

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REDUCING LOW SOCIAL RISK REFERRALS TO MEDICAL SOCIAL SERVICES

MEMBERS: CHEW TEE KIT, CHIN CHI HSIEN, LIM BOON CHEE, ONG MEI YAN, ZENG HUI HUI

- ☐ SAFETY
- ☑ QUALITY
- ☐ PATIENT EXPERIENCE
- ☑ PRODUCTIVITY
- ☐ COST
- ☐ TEAMWORK
- ☐ COMMUNICATION

Define Problem, Set Aim

Problem/Opportunity for Improvement

Between 9 April to 20 April 2018, 35% of inpatient MSW referrals were deemed as low social risk cases, which do not warrant MSW interventions. This led to unnecessary time in attending to such cases as more man hours were used. This also created delay in attending to medium and high social risk referrals which resulted in low patient and internal customers' (treatment team's and MSWs') satisfaction.
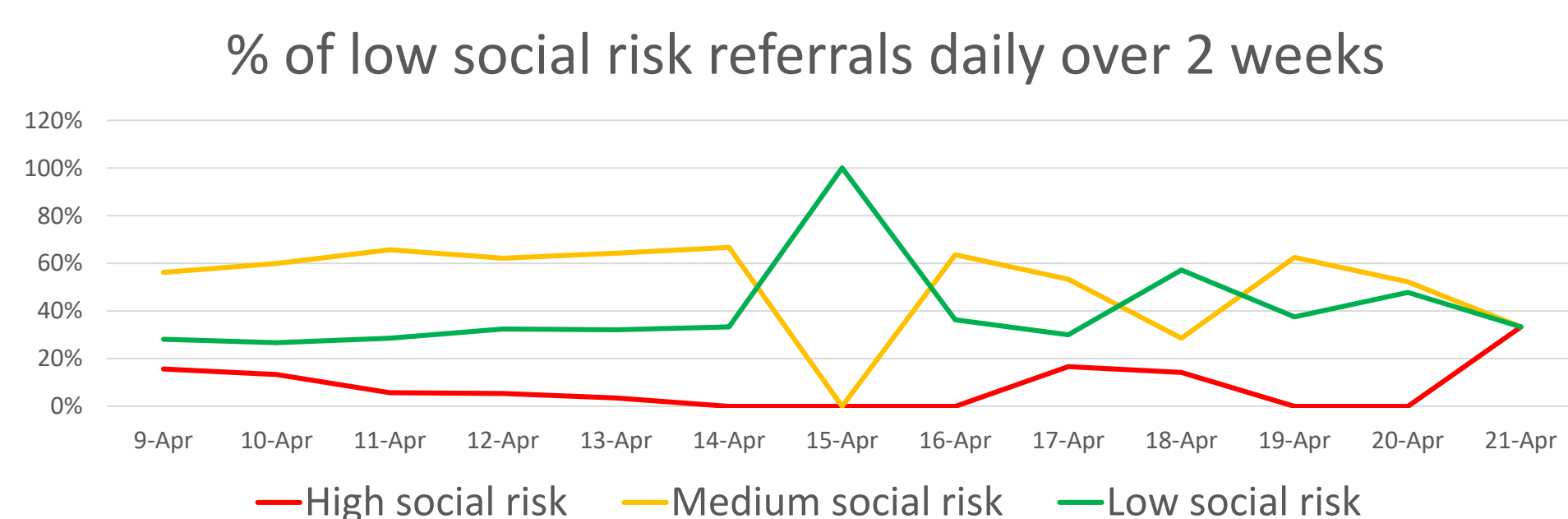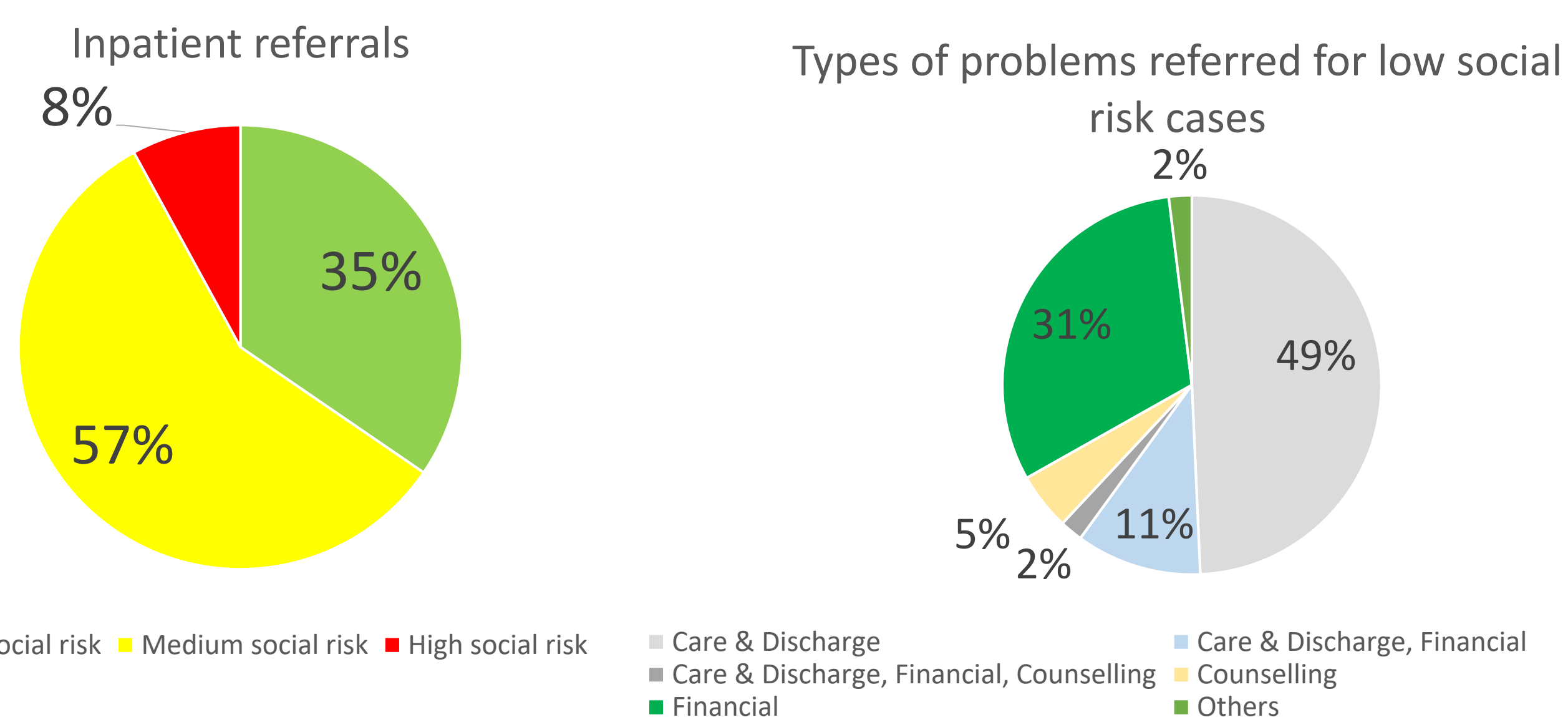
Ward 11 (Main Geriatric ward) and Ward 12 (Main Neurology and Neurosurgical ward) were identified for intervention as Geriatric and Neurology/Neurosurgical units have the highest number of low social risk MSW referrals (47% and 36% respectively).

Aim

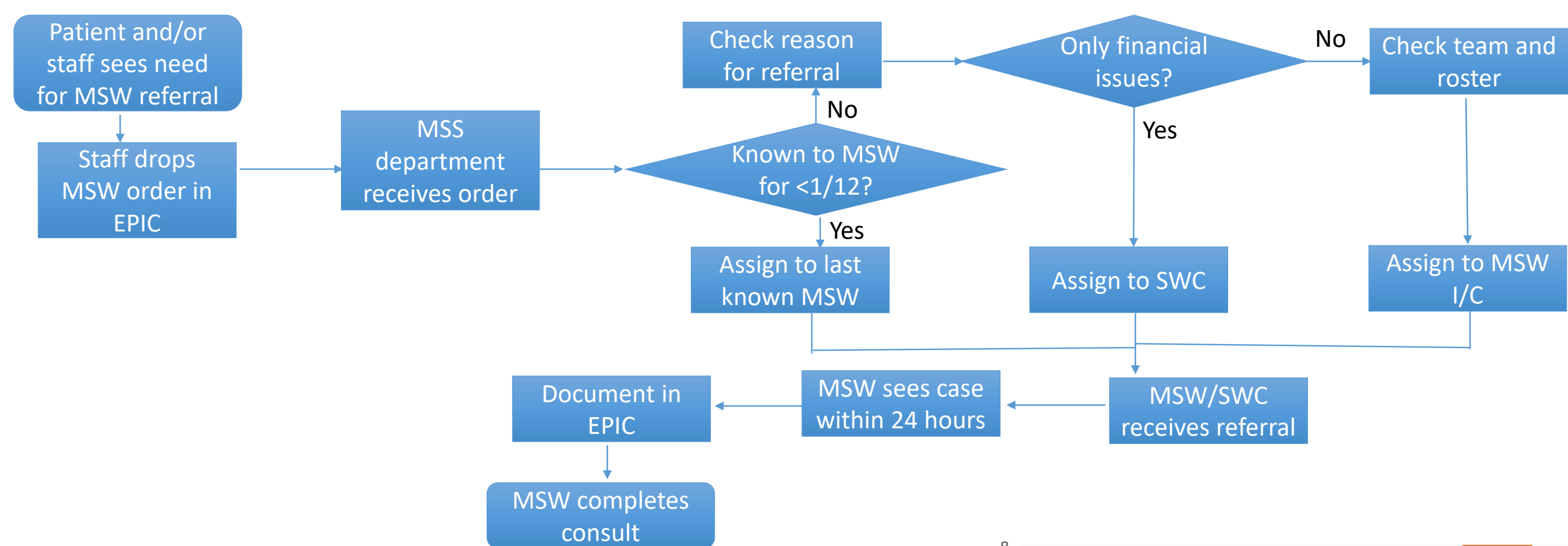To reduce low social risk MSW referrals in Ward 11 and Ward 12 from **30%**

Establish Measures
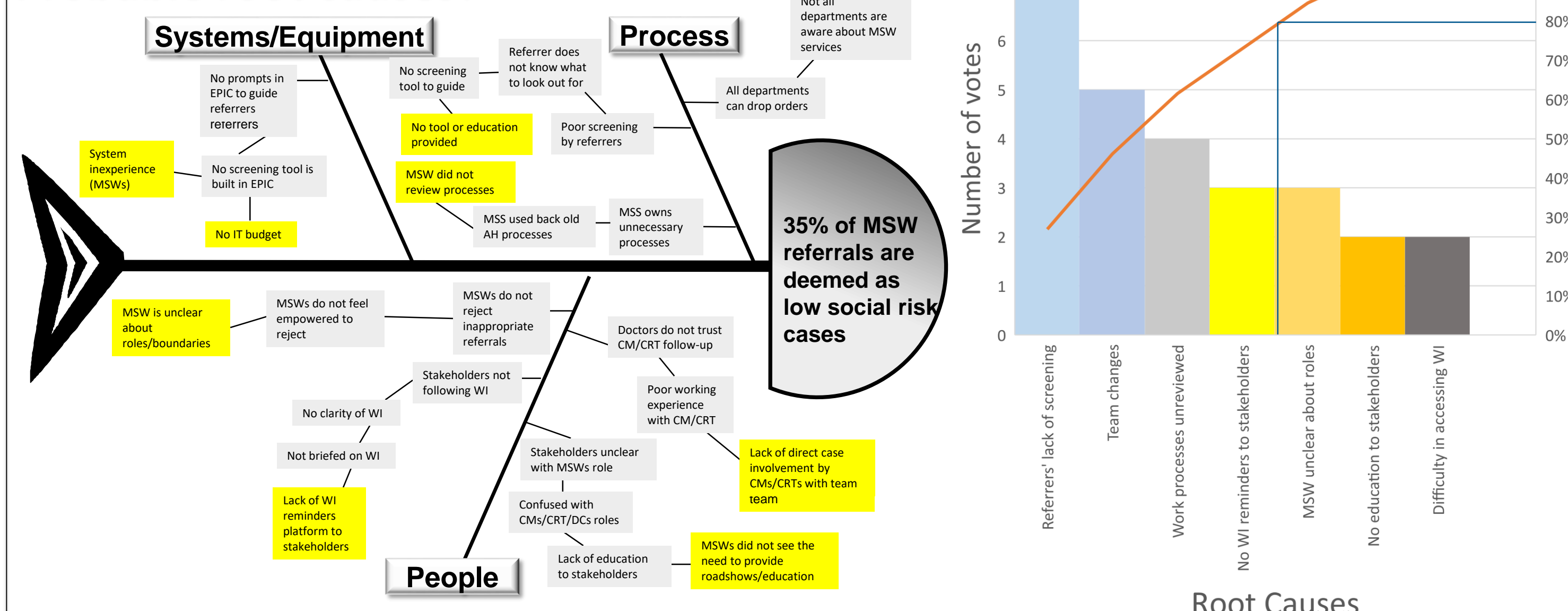
Performance before interventions

Inpatient referrals
- 35% Low social risk
- 57% Medium social risk
- 8% High social risk

Types of problems referred for low social risk cases
- 49% Care & Discharge
- 11% Care & Discharge, Financial
- 2% Care & Discharge, Financial, Counselling
- 5% Counselling
- 31% Financial
- 2% Others

% of low social risk referrals daily over 2 weeks
(line chart from 9-Apr to 21-Apr: High social risk, Medium social risk, Low social risk)

Analyse Problem

Process before interventions

(Flowchart: Patient and/or staff sees need for MSW referral → Staff drops MSW order in EPIC → MSS department receives order → Check reason for referral → Only financial issues? → No → Check team and roster; Known to MSW for <1/12? → Yes → Assign to last known MSW; Assign to SWC; Assign to MSW I/C → MSW/SWC receives referral → MSW sees case within 24 hours → Document in EPIC → MSW completes consult)

Probable root causes?

(Fishbone diagram: Systems/Equipment, Process, People)
- No prompts in EPIC to guide referrers referrers
- No screening tool to guide referrals
- Referrer does not know what to look out for
- All departments can drop orders
- System inexperience (MSWs)
- No tool or education provided
- Poor screening by referrers
- No IT budget
- MSW did not review processes
- MSS used back old AH processes
- MSS owns unnecessary processes
- MSW is unclear about roles/boundaries
- MSWs do not reject inappropriate referrals
- Doctors do not trust CM/CRT follow up
- Stakeholders not following WI
- Poor working experience with CM/CRT
- No clarity of WI
- Not briefed on WI
- Stakeholders unclear with MSWs role
- Lack of direct case involvement by CMs/CRTs with team seam
- Lack of WI reminders to stakeholders
- Confused with CM/CRT/DCs roles
- Lack of education to stakeholders
- MSWs did not see the need to provide roadshows/education

Not all departments are aware about MSW services

35% of MSW referrals are deemed as low social risk cases

(Pareto chart: Number of votes vs Root Causes - Referrers lack of screening, Team changes, Work processes unreviewed, No WI reminders to stakeholders, MSW unclear about roles, No education to stakeholders, Difficulty in accessing WI)
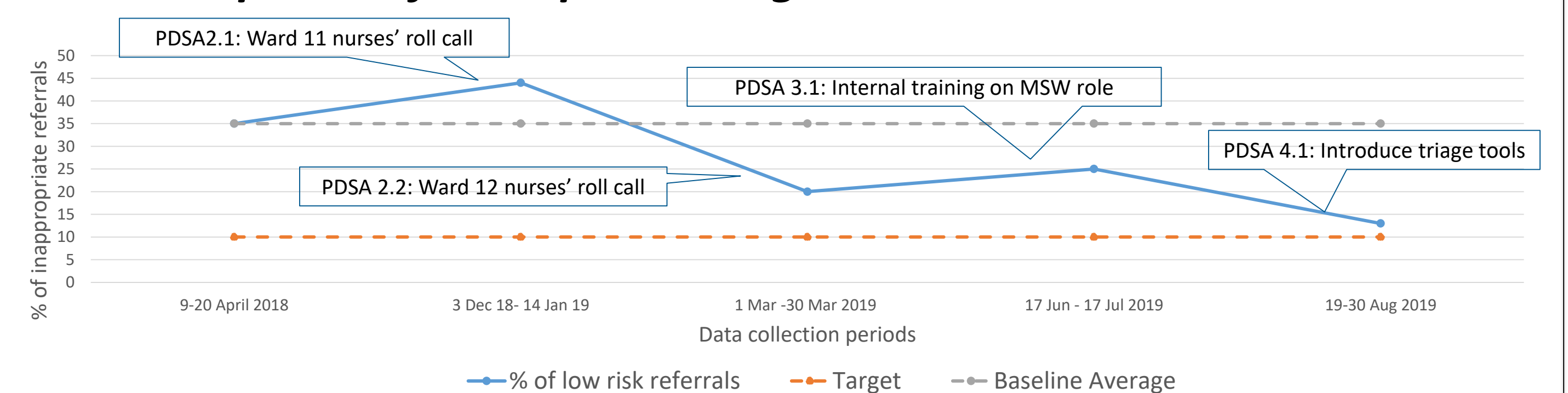
Select Changes

What are all the probable solutions? Which ones are selected for testing?

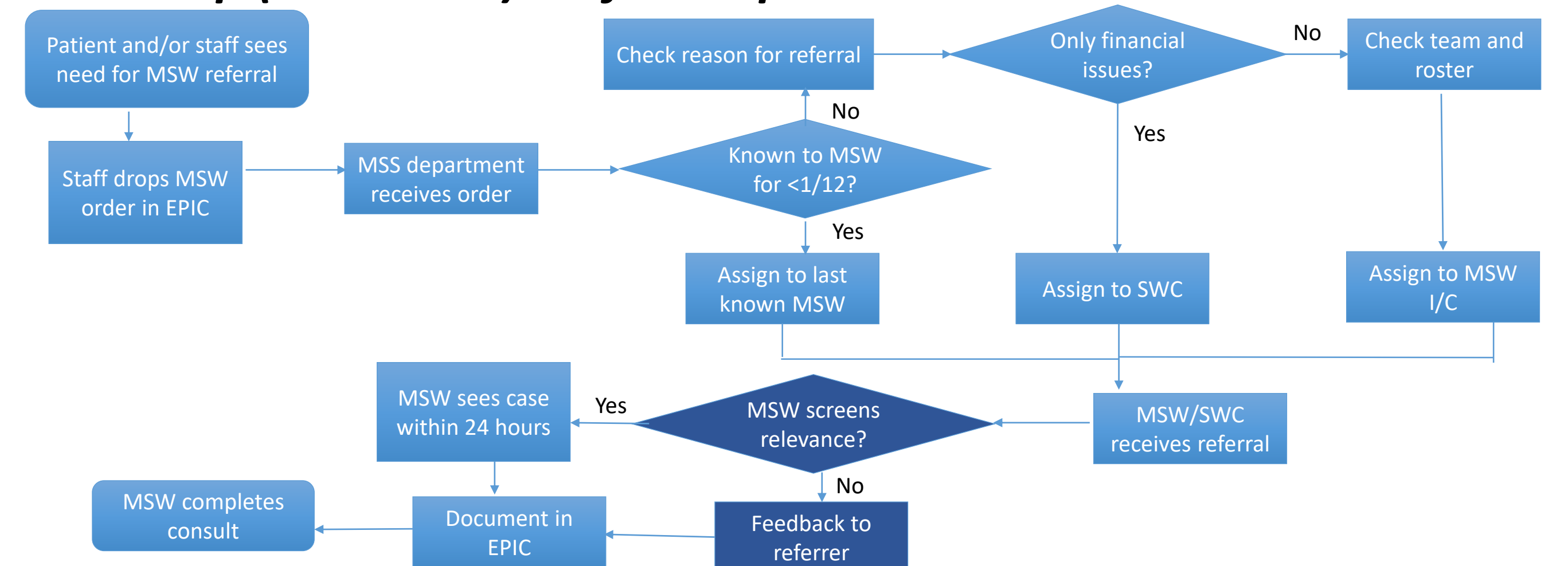| Root Cause		Potential Solutions
Referrers' lack of screening – increasing awareness and accessibility to resources	1	Road shows to medical team (Drs and nurses) with AIC
	2	Cheat sheet for medical team
	3	Resource file to be placed in each ward
	4	Dr needs to complete a checklist in EPIC before a referral can be dropped
Work processes not reviewed	5	Change of workflow - Internal training to be given to MSW on MSW roles
	6	Triage of cases to be implemented

Test & Implement Changes

CYCLE	PLAN	DO	STUDY	ACT
1	To include a screening tool in EPIC before a referral can be dropped to MSS.	EPIC team could not make changes to EPIC as it is not budgeted in the new change to the system.	NIL	This solution appeared to be the most effective but was abandoned due to lack of budget.
2	Referrer's behavior (Drs and nurses) will change after they are educated on the screening tools and are aware of resources.	• Engaged Drs. • Engaged AIC Link. • Roll call with nurses. • Cheat sheet given to wards.	Increase in low social risk referrals. • Hard to change Dr's referring behavior due to regular team rotations. • Busy nature in wards which hinders team reminders.	• Intervention abandoned. • Cheat sheet is still maintained in wards.
3	To review MSW work process.	• Educate MSW on their roles. • Add a new step of triaging cases, instead of blanket acceptance of all referrals.	Decrease in low social risk referrals. • MSW are better equipped to triage cases. • Some Drs cancelled referrals after their discussion with MSW, resulting in less social risk referrals.	• To try to have a consistent person to triage the referrals. • To review the triage tools.

Intervention periods from Apr 18 - Aug 19

(Line chart: % of inappropriate referrals over Data collection periods)
- PDSA2.1: Ward 11 nurses' roll call
- PDSA 2.2: Ward 12 nurses' roll call
- PDSA 3.1: Internal training on MSW role
- PDSA 4.1: Introduce triage tools
- Legend: % of low risk referrals, Target, Baseline Average
- Data collection periods: 9-20 April 2018, 3 Dec 18- 14 Jan 19, 1 Mar -30 Mar 2019, 17 Jun – 17 Jul 2019, 19-30 Aug 2019

Process Map (Flowchart) – After Improvement

(Flowchart: Patient and/or staff sees need for MSW referral → Staff drops MSW order in EPIC → MSS department receives order → Check reason for referral → Only financial issues? → No → Check team and roster; Known to MSW for <1/12? → Yes → Assign to last known MSW; Assign to SWC; Assign to MSW I/C → MSW/SWC receives referral → MSW screens relevance? → No → Feedback to referrer; Yes → MSW sees case within 24 hours → Document in EPIC → MSW completes consult)

Spread Changes, Learning Points

What are/were the strategies to spread change after implementation?
- Conduct clear communication to stakeholders and MSW department on the changes.
- Provide training to new staff to ensure consistency in MSW triage.
- Empower MSWs in referral prioritization with a standardized triage tool.

What are the key learnings from this project?
- To take system changes into consideration e.g. the project was delayed as the MSS department underwent two major system change management: NGEMR and NeMSW systems. The last intervention was conducted in Aug 2019.
- Change is easier when the stakeholders are internal department customers.
- Communication is important to help staff to understand role of MSW and workflow changes.

Ng Teng Fong General Hospital

Jurong Community Hospital