Project Title

Beyond the Walls – Promoting Safe Transitions Home

Project Lead and Members

Project Lead(s): Esther Koh Hwee Cheng

Project Members:

- Chua E.C.
- Goh J.Y.N.
- Fong L.A.X.
- Cheng J.K.
- Lee K.K.

Organisation(s) Involved

Yishun Community Hospital

Healthcare Family Group(s) Involved in this Project

Healthcare Administration

Applicable Specialty or Discipline

Medical Social Workers, Social Work Assistants

Project Period

Start date: October 2017

Completed date: September 2020

Aim(s)

- Facilitate the discharge and post-acute care of complex elderly patients
- Reduce subsequent Emergency Department (ED) attendances and non-elective hospital admissions

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Lessons Learnt

Good discharge outcomes for the seniors are supported by a clear understanding and commitment to Continuity of Care. When hospital teams work in collaboration with patients, caregivers and community partners, an ecosystem is formed that promotes patient and caregiver well-being, respects what is important for them, and supports our seniors to age-in-place.

Conclusion

See poster appended/ below

Additional Information

Winner of the AIC Community Care Excellence Awards (CCEA) 2022: Productivity Improvement Gold Award

Project Category

Care & Process Redesign, Quality Improvement, Lean Methodology, Workflow Redesign, Value Based Care, Safe Care, Productivity

Care Continuum

Keywords

Aged Care Transition Team, Hospital to Home, Plan Do Study Act, Health-Social Integration

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CommunityCare EXCELLENCE AWARDS 2022

Yishun Community Hospital National Healthcare Group

Beyond the Walls – Promoting Safe Transitions Home

Yishun Community Hospital

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Introduction / Background

Transitions from hospital to home are vulnerable exchange points where miscommunication, errors, discontinuity of care and safety risks abound.

The Yishun Community Hospital (YCH) Aged Care Transition (ACTION) team comprises Medical Social Workers (MSW) and Social Work Assistants (SWA) who help to facilitate safe transitions of patients beyond our hospital walls.

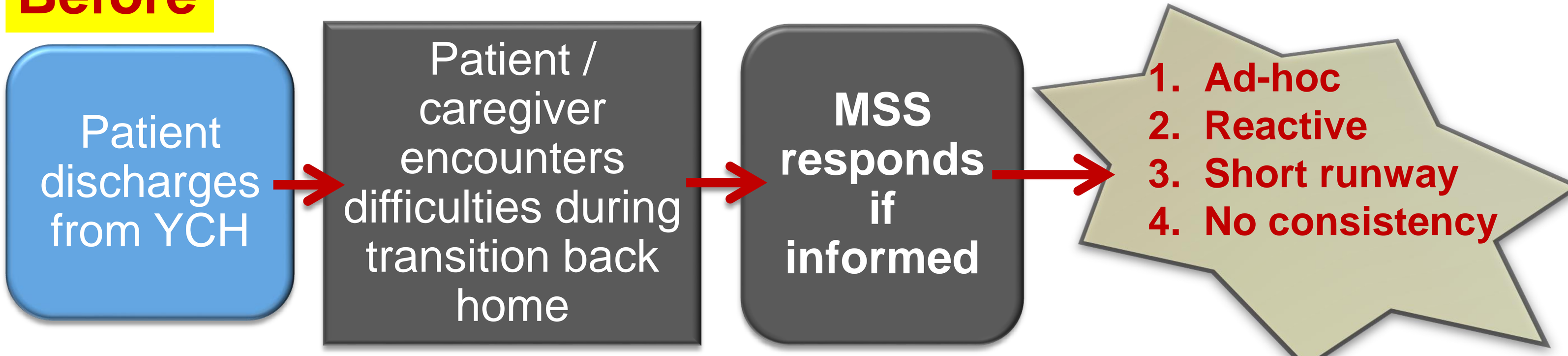
Objective

Funded by MOH, the CH ACTION programme ran from October 2017 to September 2020 and aimed to:

1. Facilitate the discharge and post-acute care of complex elderly patients
2. Reduce subsequent Emergency Department (ED) attendances and non-elective hospital admissions

Problem Analysis

Before

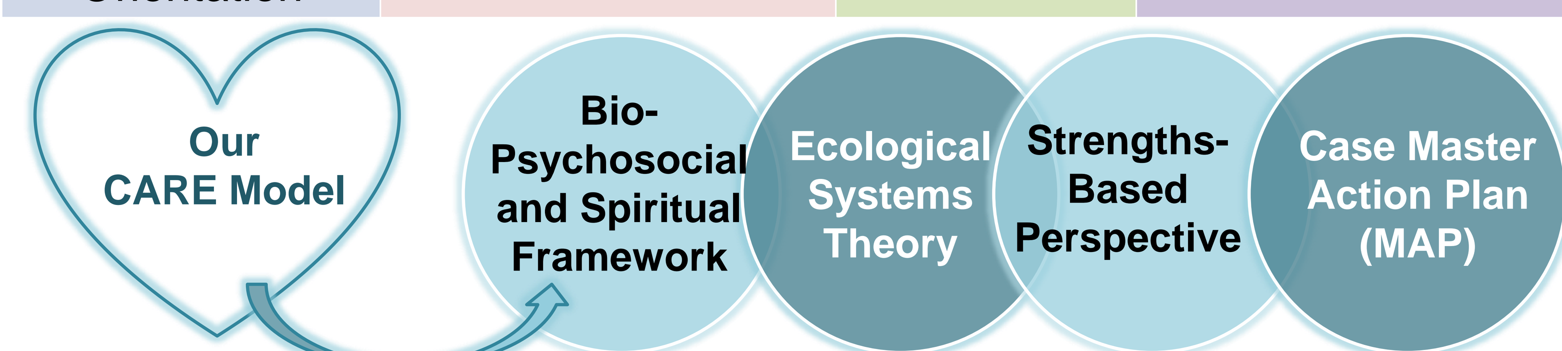


When there was no proactive and consistent approach to support patients in transiting home, patients received ad-hoc post-discharge care; patients tend to return to ED when they were unable to cope.

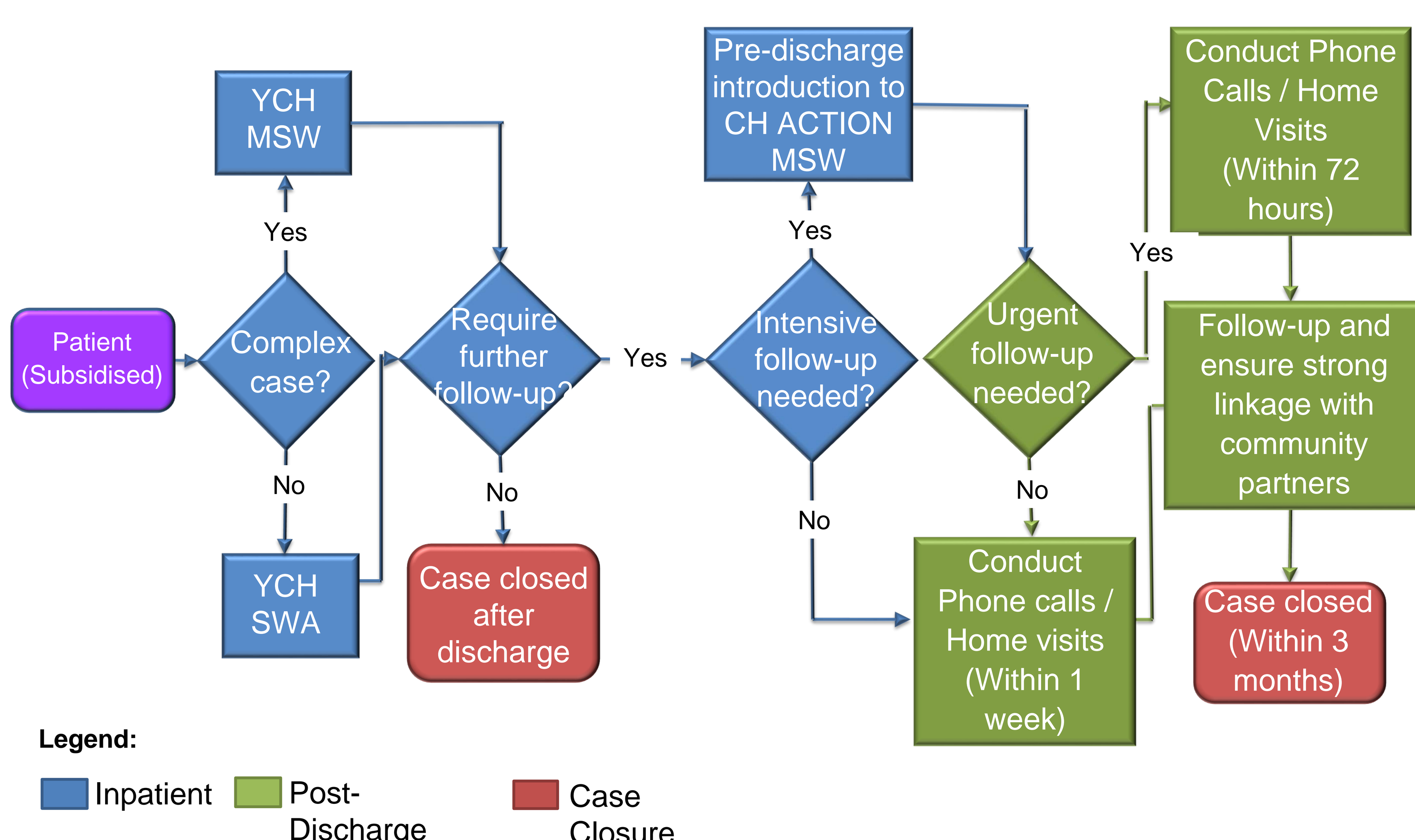
Implementation Plan

The team thus came together to formulate our care model and workflow using Plan-Do-Study-Act (PDSA).

Plan	Do	Study	Act
Staff Recruitment	Post Discharge follow-up on complex cases	Data Collection	Ongoing Post Discharge Follow-Up On Complex Cases
Establish Model of Care and Work flow	Post Discharge Call for all non-complex cases (preventive strategy)	Project Mid-Evaluation	Post Discharge Call for Non-complex Cases (selected)
Staff Training & Orientation			Ongoing Review



After Our current workflow emphasised early identification of patients and good handover:



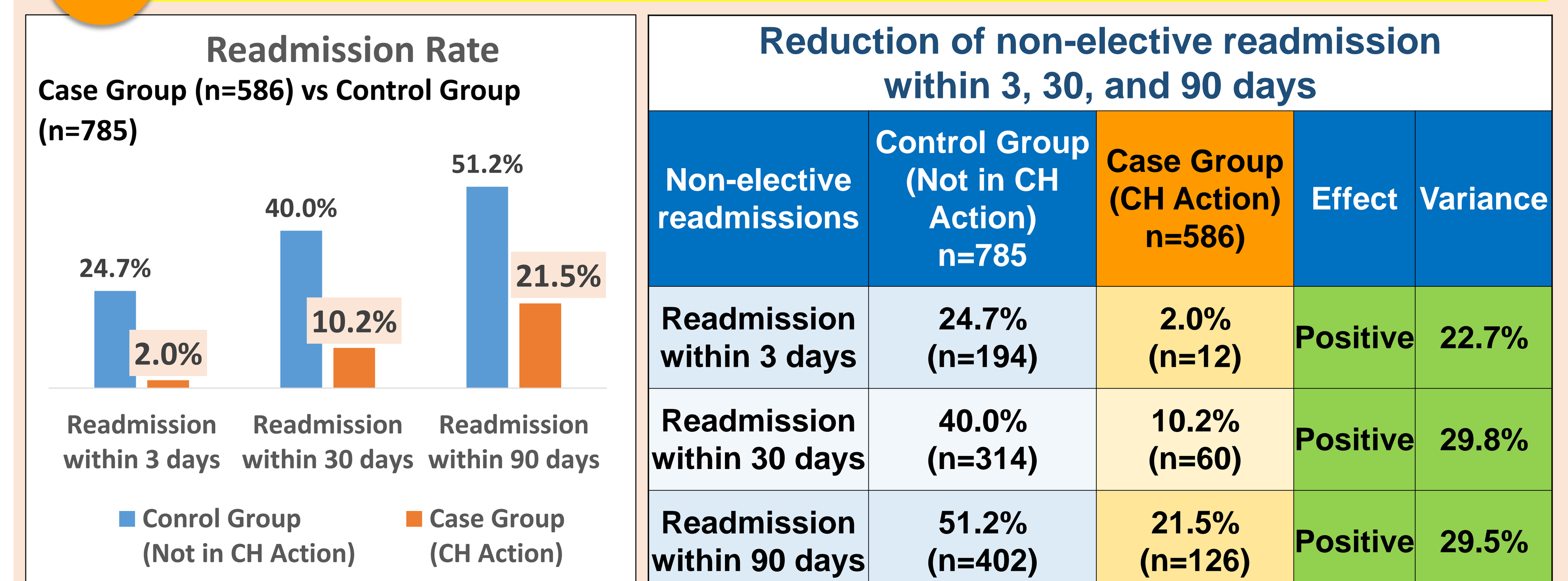
Benefits / Results

There was a **reduction of non-elective readmission rates** before and after the implementation of the CH ACTION programme, which **impacted cost savings** for both the organisation and patients.

A comparison study was done in 2021 with 586 CH ACTION patients vs control group of patients without CH ACTION:

→ **positive outcome** on enrolled patients with % variance from 22% to 29% for readmission within 3, 30 and 90 days.

1 Decrease in Readmission Rate



Reduction of non-elective readmission within 3, 30, and 90 days

Non-elective readmissions	Control Group (Not in CH Action) n=785	Case Group (CH Action) n=586)	Effect	Variance
Readmission within 3 days	24.7% (n=194)	2.0% (n=12)	Positive	22.7%
Readmission within 30 days	40.0% (n=314)	10.2% (n=60)	Positive	29.8%
Readmission within 90 days	51.2% (n=402)	21.5% (n=126)	Positive	29.5%

2 KTPH annual cost avoidance of $2,263,004.29

3 Patient's cost savings is $2,805.58

Project Impact

Patient

➲Decreased risks of hospital acquired infections and deconditioning, avoid increase in burden of care

➲Improvement in Patient and Caregiver's Wellbeing

"MSW visited often to ensure my caregiver and I are managing. She linked me with many critical services and guided me on my insurance claims to support my care after discharge. MSW showed dedication and good follow through."
~ Carole Ann, CH ACTION Patient

Organisation

➲Efficient Utilisation of Hospital Resources

Cost-savings, alleviation of "bed-crunch"

➲Capitalises on MSW's Training

Utilise MSWs' competencies in relationship building, systems navigation, care coordination, case management and behavioural health counselling

Staff

➲Development of Community MSW Capabilities

"CH ACTION work helped me realise the importance of ensuring continuity of care when we discharge patients. I have built networking skills and stronger connections with community partners."
~ Pee Abigail, MSW

"Community is the natural environment for patients. By gaining a better understanding of our patients' health and social challenges beyond hospital walls, I can work with them more effectively."
~ Jovina Cheng, MSW

Partners

➲Better Health-Social Integration

Stronger linkage and collaboration with community partners

" Working with CH ACTION team has made it possible for Community Social Workers to stay in touch with the health and medical needs of our clients. The partnership has enabled us to think of clients' needs more holistically"
~ Goodlife! @ Yishun

Sustainability & Reflections

1. Setting Standards and Ensuring Consistency

- Post-Discharge Follow-Up documentation template
- Quarterly internal audits of case notes
- Planned review of timeliness of first follow-up

2. Lowered Readmission Rates

- More than 5% reduction in baseline rate for 3-day & 30-day readmissions (470 enrolled patients from Jul 2019 – Sep 2020)

3. Scaling Up

- Can be scaled across YH campus to support KTPH patients with high social needs

MSWs play a key role in transitional care, aligned to "*Relationship-Based Shared Care Partnerships*". Good transitional care work starts at inpatient setting when the multi-disciplinary team sets good discharge care goals. Early identification of patients requiring transitional support, good handover and follow through by CH ACTION team ensures that **our care continues Beyond The Walls and promotes good outcomes** for our patients and their caregivers, hospital and community partners.