Project Title

A Care Coordination Framework to Reduce Unnecessary Readmissions to IMH

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Organisation(s) Involved

Institute of Mental Health

Healthcare Family Group(s) Involved in this Project

Medical, Medical Social worker, Occupational Therapist, clinical psychologist

Applicable Specialty or Discipline

Psychiatry

Aim(s)

The framework involves regular networking, training and joint management of complex cases between staff from both the hospital and THK-ADH alongside with the identification of single point of contact, with the aim of developing a comprehensive care plan for the patient.

By working together, staff can share information, expertise, and resources to ensure that patients receive the best possible management and care.

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Conclusion

See poster appended/ below

Project Category

Care & Process Redesign

Productivity: Cost Saving, Manhour Saving, Time Saving, Valued Based Care, Discharge Planning, Functional Outcome, Length of Stay, Utilization, Risk Management, Adverse Outcome Reduction, Preventive Approach

Keywords

Care Coordination Framework, Behavioural Challenges, Reduce Readmission

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BACKGROUND

Adults Disability Homes (ADHs) often face challenges to manage residents who present with behavioural challenges that overwhelms staff's ability to manage care. This often results in a knee jerk reaction to send them to the hospital's emergency services which has a negative impact on staff's morale and residents' adjustment & recovery from the episodes which is often out of their control.

Failure to address this also results in reluctance of ADHs to accept these patients back to the home or admit new cases for fear that similar episodes would recur or believe that residents would or could change. Overall, this results in hospitals facing challenges in right siting this group of patients who face prolonged & unnecessary stay in hospitals, hence inappropriate use of resources.

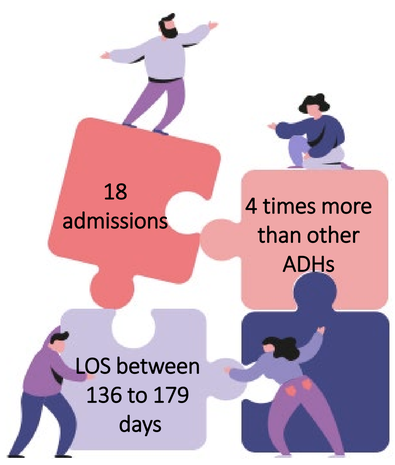


ASSESSMENT OF PROBLEM

A care coordination framework was implemented between IMH and Thye Hua Kwan – Adult Disability Home (THK-ADH) to reduce readmissions of their residents when faced with challenges in managing challenging behaviours. THK-ADH was identified for this project as 58.5% of their residents are known to IMH and readmissions rates as well as average length of stay (LOS) were on the increase.

In 2021, there was 18 admissions from THK-ADH and 9 (50%) required psychologist (PST)'s interventions to address their behavioral challenges. These 9 residents also had a longer inpatient LOS with average duration of stay between 136 to 179 days.

In view of these observations, there was concurrence between both institutions as equal partners to co-manage ID residents with challenging behaviours and to explore a partnership to work on the issue together.



ROOT CAUSES

The following root causes were identified as contributory to high readmissions:

Challenges by Staff	Lack of staff training and expertise in managing patients with behavioural challenges
Resource Limitations	Limited resources and funding, and inadequate staffing levels
Fatigue	Fatigue & discouragement from failures to manage resident's behaviours
Lack of Support	Lack of professionals or medical experts to consult regarding resident's behavior changes and reasons behind them
Easier Option	Easier for staff to send residents to IMH than to keep failing in trying to manage behaviours

SOLUTION

To address the root issues, the care coordination framework was proposed to guide the partnership between IMH and THK-ADH, and to help both parties to concur on the problem statement and targeted outcome.

The framework involves regular networking, training and joint management of complex cases between staff from both the hospital and THK-ADH alongside with the identification of single point of contact, with the aim of developing a comprehensive care plan for the patient.

By working together, staff can share information, expertise, and resources to ensure that patients receive the best possible management and care.

Networking

Regular monthly networking meetings were initially held to focus on project aims through identification of challenges faced by THK-ADH & joint solutioning which includes:

- Jointly developed templates for sharing information & criteria for attendance at ES
- Regular meetings among identified team members from both agencies to scope the project targets, along with development of standardized discharge plan workflow and communication forms, with review at 6th month

Single Point of Contact (SPOC)

A MSW from the Adult Neurodevelopmental Service (ANDS) was identified as THK-ADH's SPOC as 1st point contact for ADH to highlight and discuss challenging cases. The SPOC MSW coordinates case conferences & liaises care between THK-ADH and IMH's MDT members.

Care Coordination Framework

Joint Management of Complex Cases

A Monthly Red Case Discussion (RCD) platform was initiated with a focus on upstream work to increase staff's capacity to care for their residents, and to reduce the need to send residents to IMH's emergency services for review or admission.

Key treating doctors, nurses or allied health members are pulled in by IMH MSW SPOC for reviews of cases raised by THK-ADH.

Training

Besides the consult and training provided through the monthly RCD platform, THK-ADH may also be invited to relevant sharing platforms by the hospital e.g., Journal Club sharing or IMH networking circle based on the presenting topic.

MEASUREMENT OF IMPROVEMENT

3 shared outcomes were achieved from this project:

a) For Patients cared by both THK-ADH & IMH

		2021	2022	% Difference
To reduce ES presentations	No. of THK-ADH residents with ES Presentation	31	18	-42
To reduce admissions of existing residents	No. of THK-ADH residents with inpt admission	18	11	-39
To shorten length of stay in IMH	Median LOS	60	36	-39
To reduce readmission of new residents within 30 days	Readmission rate within 30 days	6%	0%	-6

b) For IMH

No. of inpatient bed days avoided in 2022: **1,658 bed days**, which translated into estimated of **$964K saved** for healthcare cost (using private rates without subsidy i.e., $581.37 per bed per day)

c) For THK-ADH

Improvement in Staff Perception & Satisfaction (Survey Dec '22)

- Feels more supported in managing residents' behaviors +
- Doesn't think sending residents to IMH's ES will resolve most behavioral concerns +
- Gained more knowledge to better understand resident's behaviors through RCD platform +
- Feels more patient and understanding towards resident's challenging behaviors +
- Feels that there are new ways staff can try to manage resident's behaviors +
- Feels more confident overall in managing resident's behaviors through networking platform +

FUTURE PLANS

To provide guidance to other acute wards in adopting the practice and principals of early discharge planning with the ADHs. There are also plans to engage 2 other ADHs and expand this initiative to the other 7 regional acute wards in IMH.

Poster designed by: Gideon NG