FREQUENT READMITTERS PROGRAMME

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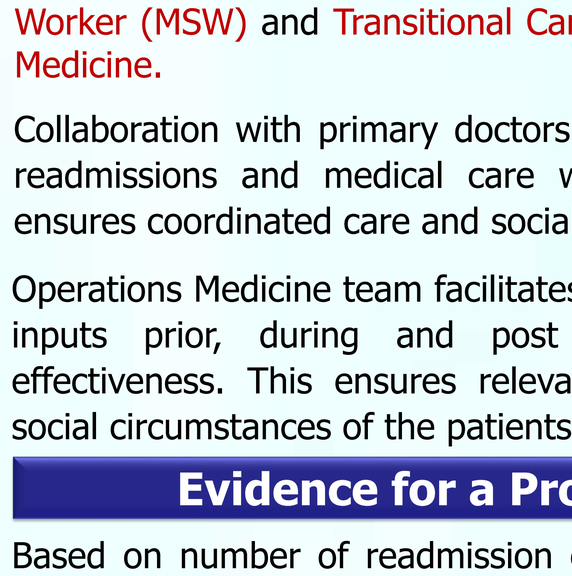
Mission Statement

The Frequent Readmitters Committee takes a systemic multi-disciplinary approach to identify patients with pre-determined episodes of readmissions[1] within a year[2] and propose interventions to better manage patient care and reduce readmissions. To collectively support the implementation of interventions for frequent readmitters, case discussions and reviews are conducted quarterly.



Identified patients will have a careplan formulated with a named primary doctor (PD) assigned to oversee it.

This includes but are not limited to:

1. Formulation and review of care plan
2. Oversight of care coordination with clinical departments, ED, MSW and TC
3. Execution of recommended intervention based on profile

[1] Readmission Definition – Unplanned admission within 30 days post-discharged
[2] Programme Criteria – ≥7 readmissions in 1 year since the start of the programme in Jun 2016. Criteria was expanded to ≥6 readmissions in 1 year in Jan 2018 to benefit more patients.

Team Members

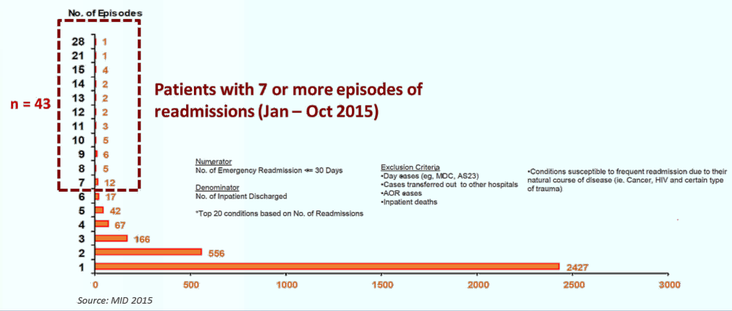
The Frequent Readmitters Committee is a hospital-level team, anchored by clinical leadership (Divisional Chairman and HODs). Team members include Clinical HODs/Doctors, Emergency Department (ED), Medical Social Worker (MSW) and Transitional Care Team (TC), supported by Operations Medicine.

Collaboration with primary doctors and ED provides oversight to patient readmissions and medical care while partnership with MSW and TC ensures coordinated care and social support in the community.

Operations Medicine team facilitates the collaboration and consolidation of inputs prior, during and post discussion to determine careplan effectiveness. This ensures relevance of careplan as the medical and social circumstances of the patients change.

Evidence for a Problem Worth Solving

Based on number of readmission episodes from Jan 2015 to Oct 2015, patients with ≥7 readmissions in a year made up only 1.3% of patients with readmissions yet contributed to 10% of all readmission episodes. This provided the impetus to form a committee to review and better manage the care of frequent readmitters.

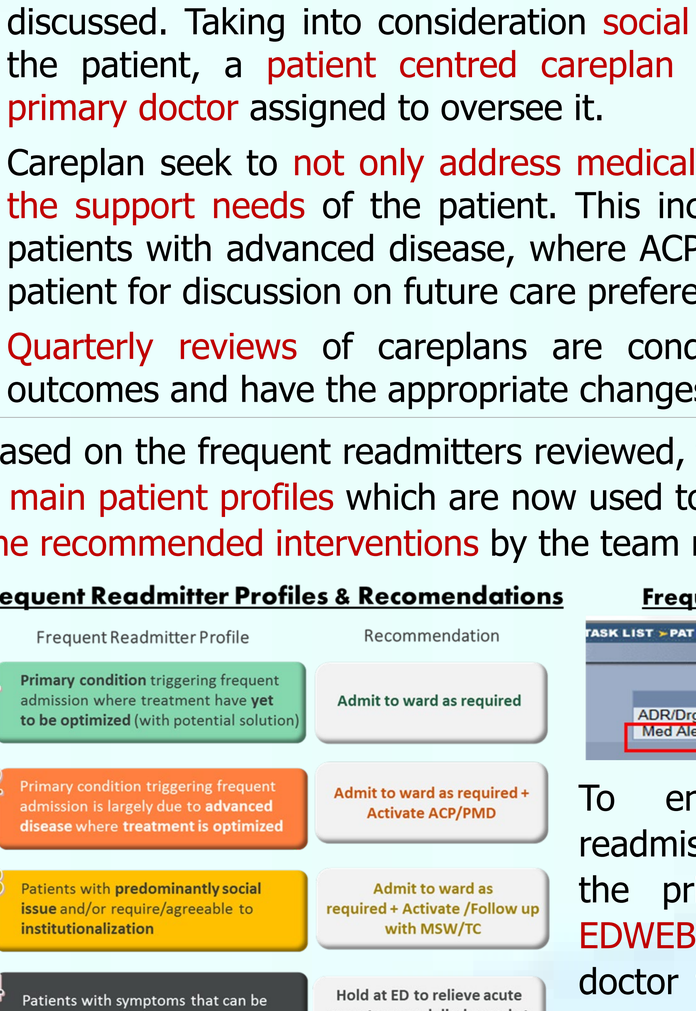


Source: MID 2015

Implementation

A programme framework guides and ensures the establishment of effective and robust processes to review and formulate careplan, with the key people involved in patient care.

Frequent Readmitter Programme Framework



Core elements:
- Patient identification
- Primary doctor assignment
- Systemic multi-disciplinary discussion

Enablers:
- Identification criteria
- Ownership of clinical departments and doctors
- Patient profiles and recommendations

Reinforced by :
- Plan-Do-Study-Act (PDSA): Quarterly reviews of careplans and indicators tracking

Systemic Multi-Disciplinary Case Discussion

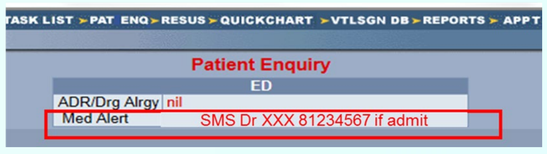
- At case discussions, root causes of readmissions are determined and discussed. Taking into consideration social and personal goals of care of the patient, a patient centred careplan is formulated, with a named primary doctor assigned to oversee it.
- Careplan seek to not only address medical needs but also the social and the support needs of the patient. This includes end-of-life careplans for patients with advanced disease, where ACP is established with family and patient for discussion on future care preferences.
- Quarterly reviews of careplans are conducted to determine careplan outcomes and have the appropriate changes made, if needed.

Based on the frequent readmitters reviewed, the committee managed to elicit 4 main patient profiles which are now used to guide patient identification and the recommended interventions by the team members.

Frequent Readmitter Profiles & Recomendations

	Frequent Readmitter Profile	Recommendation
1	**Primary condition** triggering frequent admission where treatment have **yet to be optimized** (with potential solution)	Admit to ward as required
2	Primary condition triggering frequent admission is largely due to **advanced disease** where **treatment is optimized**	Admit to ward as required + Activate ACP/PMD
3	Patients with **predominantly social issue** and/or require/agreeable to **institutionalization**	Admit to ward as required + Activate /Follow up with MSW/TC
4	Patients with symptoms that can be **treated at ED a**nd discharged	Hold at ED to relieve acute symptoms and discharged at ED with MSW/TC support

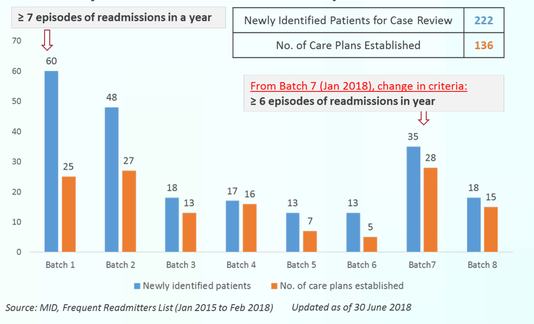
Frequent Readmitter ED Web Alert



To ensure oversight of patient readmissions and care, the contact of the primary doctor is indicated in EDWEB to allow the ED attending doctor to discuss careplan and review the need for admission with the primary doctor.

Results

Summary of Identified Patients and Careplan Established



Newly Identified Patients for Case Review	222
No. of Care Plans Established	136

Source: MID, Frequent Readmitters List (Jan 2015 to Feb 2018) Updated as of 30 June 2018

ED Indicators – Pre and Post 12 months Intervention

Data Period: Jun 2015 to Jun 2018

	ED Admissions (per pt per year)			ED Attendance (per pt per year)			Total ED Admissions and Attendances (per pt per year)		
	Pre 12 months	Post 12 months	Difference	Pre 12 months	Post 12 months	Difference	Pre 12 months	Post 12 months	Difference
Pre and Post 12 months from Enrolment (N =38) (N: Pts who fulfilled 12 months in programme)	10.4	6.3	-39% ↓	3.1	3.8	23% ↑	13.4	10.1	-25% ↓
Pre and Post 12 months from Year 1 (N =6) (N: Pts who fulfilled 24 months in programme)	7.3	4.5	-38% ↓	2	1.8	-10% ↓	9.3	6.3	-32% ↓

Updated as of 30 June 2018

Source: SAP – ED Attendances (Jun2015 to Jun2018)
1. Only ED attendances of frequent readmitters with a tagged primary doctor and interventions recommended (active) for the full 12 months and 24 months are considered. Patients who passed away post review are not considered.
2. Pre and post intervention is based on actualized 12 months

Since Jun 2016, the committee had reviewed a total of 8 batches of frequent readmitters. Of which, 222 unique patients had been identified and 136 careplans established.

Notably, the number of newly identified frequent readmitters had decreased with each batch due to the efforts of the committee and an increased awareness amongst the departments.

ED indicators pre and post 12 months from enrolment date showed that patients generally had a decrease in ED admissions. While there was a 23% increase in ED attendances, there was a 39% decrease in ED admissions. This is attributed to the execution of the pre-formulated careplans at ED and better support structure to discharge patients from ED.

From the first year to second year of enrolment, there was also an overall decrease of 32% in both ED admissions and attendances.

By reducing ED admissions by 39% in the first year and 38% in the second year, the project avoided 1441 patient days and reaped a projected cost avoidance of $1,441,000.

Strategies to Sustain

- **Structured framework reinforced by PDSA** to guide the committee with effective and robust processes to manage patient care.
- **Systemic multi-disciplinary approach** anchored by clinical leadership (Divisional Chairman and HODs) to ensure synergy of the efforts across the different teams and that patient care is appropriate and coordinated from hospital to home.