Background & Aim

An analysis of our hospital readmissions during the period Jan – Oct 2015 showed that 1.3% of patients with readmissions contributed to 8.89% of all readmission episodes.

This provided an impetus for the formation of the Frequent Readmitter (FR) committee to review FR associated with high healthcare costs, and better manage care to improve health from the perspective of medical and social needs.

*Definition of readmission: Unplanned admission within 30 days post-discharged

Project Summary

In line with our national movement “Beyond Hospital to Community” and TTSH Better Care strategy, the FR Programme was established to develop effective and robust processes for proactive identification and management of patients with a pre-determined number of readmission episodes within a year.

When the programme first started in June 2016, patients with 27 readmissions within a year were tracked and reviewed. The committee seeks to continually improve and refine the programme to ensure sustainability. With the intent to benefit more patients, the committee expanded the criteria in January 2018 to include patients with 26 readmissions and subsequently in October 2018 to 25 readmissions.

From initial batches of case reviews, the committee gleaned insights on common FR profiles and recommended interventions.

They recognised that readmissions stemmed from interacting medical and social issues extending beyond hospital walls, highlighting the need for a holistic approach involving different care providers across care settings.

Key Achievements

All outcome indicators are tracked over a minimum 2-year period since the programme started. Patients discharged from the programme are also monitored to ensure their positive outcomes are sustained for at least one year from discharge.

1. An updated analysis of our hospital readmissions during the period Jan – Oct 2018 showed 80% reduction in the number of patients with 27 readmission episodes compared to that in 2015, which translates into 65% reduction in total readmission episodes.

2. Number of newly identified FRs with each batch due to proactive clinical ownership of patient care plans

3. ED admissions and attendances that is sustained into the second year

Greater ↓ in admissions than attendances, which may be attributed to:

- Execution of pre-formulated care plans at ED
- Better support structure to discharge patients from ED preventing admission

4. Total admissions and length of stay (LOS) that is sustained into the second year

5. % of discharged patients

6. 3,308.8 patient days avoided with a projected cost avoidance of $3,308,800

The programme has moved away from doctor-centric to patient-centric with a multi-disciplinary approach.

With focus on patient-centred care and to better synergise efforts, a systematic framework was developed.

Oversight of patient care plan and admissions by Primary Coordinating Doctor ensures that care delivered is coordinated across outpatient, and community settings. Partnerships with CHT and MSW serve as a bridge for engagements with community partners i.e. VWOs and allow targeted interventions to be initiated in the community. Case discussions and quarterly reviews not only enable relationship building and gathering of consensus among a diverse team, but also serves as a platform to discuss perspectives and align care goals for patients benefit.

Conclusion

With our population rapidly ageing and experiencing dynamic healthcare needs, it has and will be an iterative process for the committee in understanding, managing and impacting this group of vulnerable patients.

The programme remains one of our hospital’s strategic projects over the last 3 years. Throughout this journey, the direction has become clearer on the need for a multi-disciplinary approach and systematic framework to anchor the programme so that the processes remain productive and aligned to meet patient goals.

The programme not only brings health care value to patients by viewing them holistically, but also propels us forward in care design and delivery as we shift beyond hospital to community.