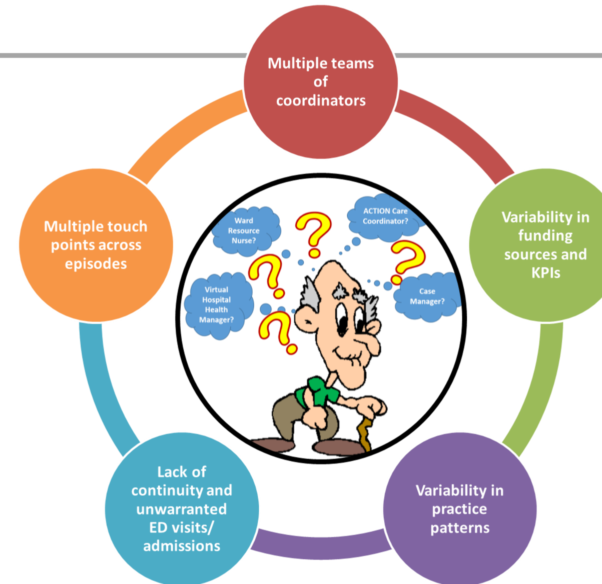
RETHINKING THE ROLES AND CONVENTIONS IN TRANSITIONAL CARE

A/Prof John Abisheganaden, A/Prof Ian Leong, Dr Tan Kok Leong, Ng Kucy Ping, Dr Fereen Liew, Lim Sing Yong, Ng Yi Teng, How Shermaine
Tan Tock Seng Hospital (TTSH)

BACKGROUND & PROBLEM

Patients with complex care needs, typically require a range of care and support services, and ongoing monitoring and review of their changing care needs. As such, many care co-ordination initiatives were developed to achieve patient-centred care and timely, safe and appropriate siting.



However, over time unintended outcomes of these multiple initiatives created the following increasingly **confusing experiences for patients**:

- Receiving **variable practice patterns** and **multiple touch points** by different coordinators across admission episodes;
- **Lack of continuity** in follow-up for the frail in the community and home post-discharge;
- Facing **difficulty navigating** resources in the community and home for their needs; and
- Resulting in **unwarranted Emergency Department (ED) visits and readmissions**

AIM OF PROJECT

Redesigning and redefining of staff roles was undertaken for the development of a Transitional Care (TC) model to achieve:

- **Seamless care coordination**, and
- **Holistically meet the evolving needs of complex patients**

across their care journey as they transit from the hospital to the community and home.

METHODOLOGY

VALUE STREAM MAPPING EXERCISE

Healthcare professions of varying backgrounds including doctors, nurses, other allied health professionals participated in a Value Stream Mapping (VSM) exercise with the aim of **mapping and conceptualizing a model of transitional care to better meet the needs of complex patients**. An element of gamification was introduced by having **participants assume roles different from that of their profession** or that of a patient/ next-of-kin.

ADVANTAGES OF THE METHODOLOGY

- Participants were encouraged to **break out of their current role expectations and associated perceived constraints** in envisaging the ideal state of care coordination.
- Participants were encouraged to **rethink roles within the care team** to develop a model that would best meet patient needs in the most efficient manner.

Emergent Thoughts

"What is the definition of "follow-through"? To what extent and covering what scope?"

"How can we ensure that the Community Providers will be responsive to patients' needs?"

"It's difficult to differentiate psychosocial readmission from real medical needs."

"Could the Coordinator/ Single Point of Contact (SPOC) have too many roles?" "Should the Coordinator/ SPOC be the jack of all trades?"

"Have we been too presumptuous in assuming that the Pharmacist is always there?"

"How can we help the community provider be a good substitute to the ED?"

"We need strong IT systems to collect data for care pathways."

RESULTS

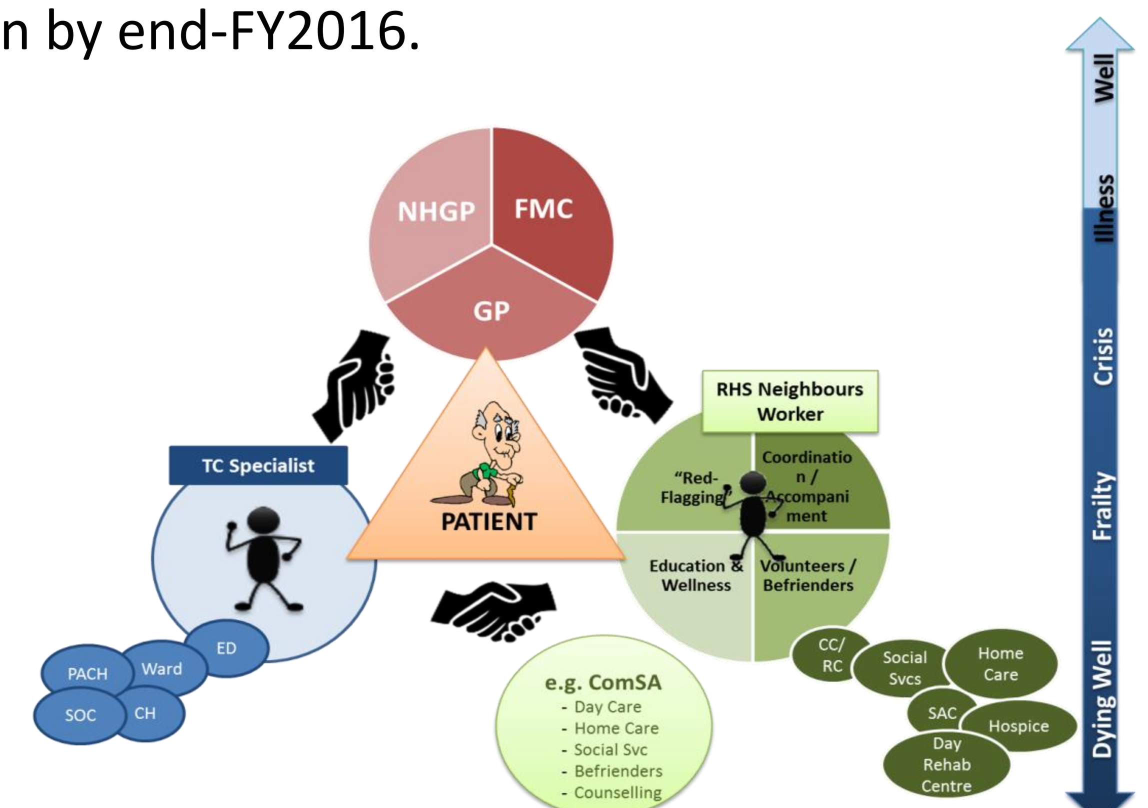
The exercise in ideation allowed much discussion and emergent thoughts from the team. Common themes arose and participants could conceptualize a TC model with the following components:

- A **standardized protocol** for triaging of discharge needs
- A **single-point-of-contact** for patients in the hospital and the community
- A **single team of coordinators** for care coordination and transition
- **Smaller teams within the team** to service patients based on geographical boundaries
- A single TC programme based on a **global source of funding and global set of KPIs**

The underlying principle was that every patient with complex care needs should have a **Single Point of Contact** to coordinate his care plan and support his care transition from the hospital to the community and home. The TC team would work closely with community partners to help the patient navigate the social system and establish the required primary care support to ensure he stays well in the community.

PROTOTYPING

This model was subsequently prototyped in TTSH from Jan 2016 with two teams of 3 coordinators in selected TTSH wards, with a progressive expansion in geographical coverage in the central region. This model had also been presented at various platforms and had led to discussions with MOH and other health-clusters to mainstream the model. A review of the model is targeted for completion by end-FY2016.



CONCLUSION

Ideation was enabled through creating time and space to rethink the current roles within the care team, challenge existing conventions of transitional care and consider how an ideal state could be achieved through transformation.