ANCHOR & INTEGRATE CARE IN THE COMMUNITY (AICC)

- ❑ CARE REDESIGN
- ☑ WORKFORCE TRANSFORMATION
- ❑ AUTOMATION, IT, ROBOTICS INNOVATION

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1. Background

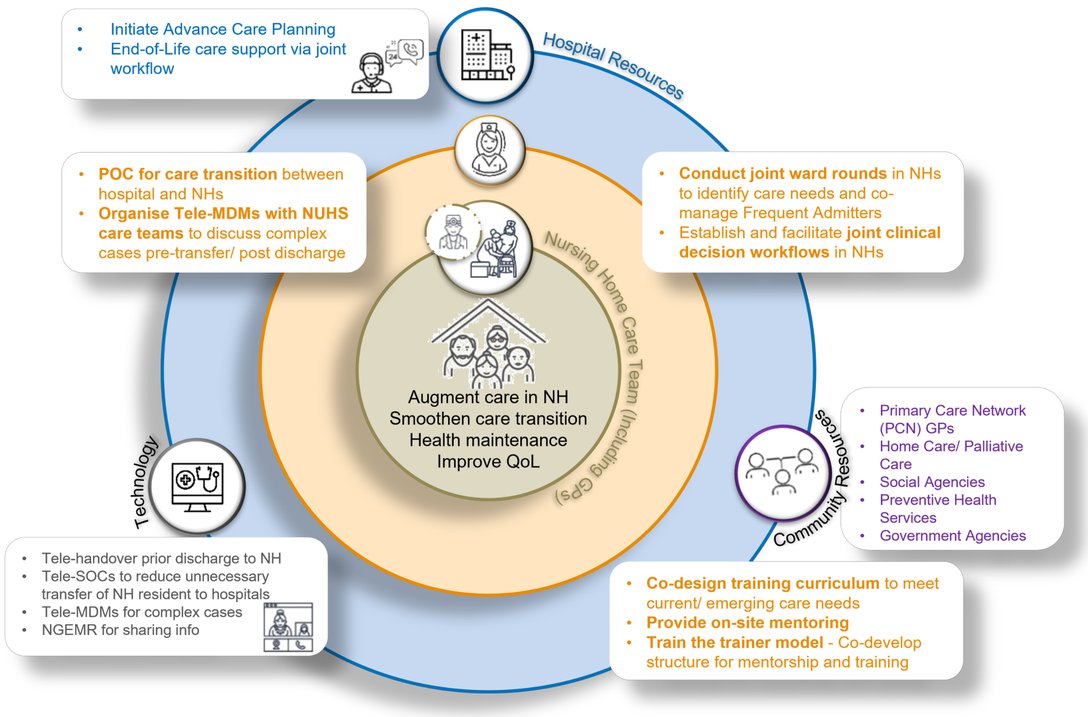
(Problem) NTFGH has observed an increase in hospital admission rates coming from the nursing homes (NHs), of these admissions, it was observed that some transfers were unnecessary. The problem was quantified by data showing these admissions lead to 2,673 acute bed days and $2.94 million in costs annually for NTFGH.
(Cause) Suboptimal communication during transition between hospital and NHs, gaps in workflow and lack of clinical coverage in NHs.
(Intervention) AICC is a pilot care model funded by the JurongHealth Fund (JHF) that sees nurses being deployed in participating NHs as trainers and healthcare navigators. They provide training and coordinate care transitions between hospitals and NHs by co-developing care protocols and workflows based on needs co-identified with the NHs.
(Outcome) The number of residents with multiple emergency department (ED) admissions to both NH1 and NH2 decreased over FY2021 and FY2022, despite an overall increase in total NH1 admissions.
For ED discharges, there was no clear trend observed at either NH1 or NH2 over this period. The data does not indicate a statistically significant reduction in ED discharges from FY2021 to FY2022.

2. Strategy for Change

The plan focused on building and enhancing capabilities within the NHs through sustainable training, improving care transitions, provision of on-site clinical support and guidance on care protocols and workflows. These changes transform the working model in NHs to strengthen care for residents, smoothen care transitions and support NHs based on their needs. Two community nurses were deployed to collaborate with the NHs. Point-of-contacts (POCs) and nursing leads were identified within each NH. A multi-pronged approach was adopted, targeting co-identified areas of improvement:

1. Improve communication during care transitions between hospitals and NHs and reduce the tendency for residents to U-turn.
2. Improve clinical coverage and install senior nurses to reduce unnecessary transfers to ED.
3. Improve competency through increasing training opportunities thus reducing attrition rates and re-training.

These changes represented a redesign of the existing care model as the areas of improvement that are co-identified by community nurses and NH staff are enhanced through training, education, evaluation, and clinical support.

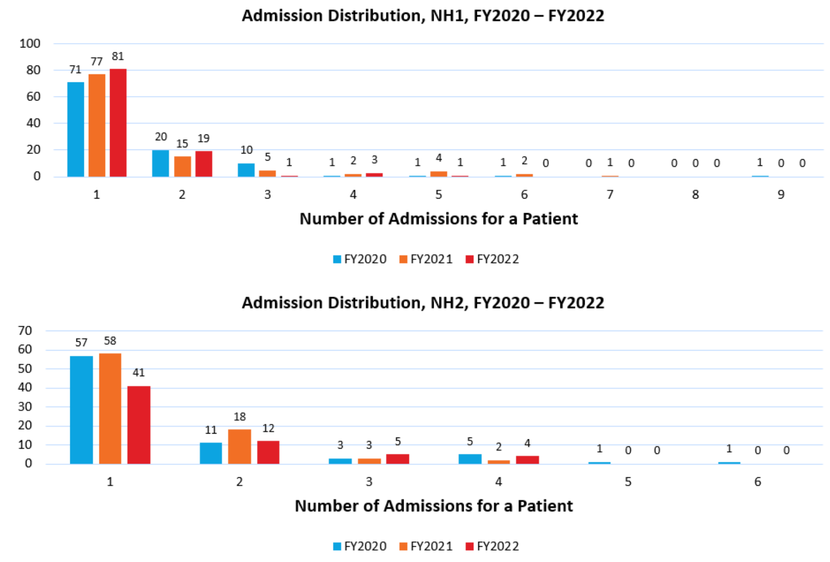


3. Outcomes

Key measurements of improvement for the proposed AICC pilot collaboration are reductions in unnecessary transfers, readmissions within 30 days, and total admission for NH residents to NTFGH.
Baseline data from FY2020 shows there are currently an average of 250 transfers per month from NHs to the NTFGH ED. The target is a 20% reduction for ED referrals, 30-day readmission and total admission from the participating NHs, two years into the pilot.

	NH1	Difference	NH2	Difference
Number of total admissions from the partner NHs to NTFGH	Baseline: 165 FY2021: 169 FY2022: 139	- +2% -16%	Baseline: 121 FY2021: 110 FY2022: 95	- -9% -21%
Number of 30-day readmissions from the partner NHs to NTFGH	Baseline: 36 FY2021: 53 FY2022: 24	- +47% -33%	Baseline: 31 FY2021: 18 FY2022: 6	- -42% -81%

Despite an increase in admissions at NH1, both NH1 and NH2 observed a general decrease in residents with multiple ED admissions over FY2021 and FY2022.
The reduction in multiple ED admissions per resident at both nursing homes indicates improvements in resident management or healthcare delivery, suggesting an area that could benefit from further exploration. This trend could hold significant implications for enhancing care quality and efficiency in such settings.



4. Learning Points

Management and staff buy-in to the collaboration were the key drivers for the implementation of this transformation. Improvements were observed where management and staff were committed to review the impact on the care pathway and implement new guidelines to drive change.

The community nurses have learned to appreciate the challenges faced by NH staff who have managed residents under a different care environment and thus render appropriate support.

The AICC programme reduced nursing home residents' hospital admissions and unnecessary referrals by empowering staff with relevant skills and tools. Further evaluation over a longer timeframe will help quantify the effects of improved communication, workflows, and clinical coverage through the AICC programme.

The innovative solution of deploying community nurses to build capabilities in the NHs is a viable solution that can be replicated across other NHs in Singapore.

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