Team Based Learning – A Way to Integrated Patient Centric Care

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JurongHealth


JurongHealth
Ng Teng Fong General Hospital

Wu Guanzhong 吴冠中; (August 29, 1919 – June 25, 2010)

About JurongHealth

- Managed **Alexandra Hospital** (AH) until 29 June 2015

- The 700-bed **Ng Teng Fong General Hospital** (NTFGH) will be the anchor regional hospital of JurongHealth. It is Singapore's first acute hospital to be twinned with the 400-bed **Jurong Community Hospital** (JCH) to provide integrated and hassle-free acute and rehabilitative care.

- Managing **Jurong Medical Centre** (JMC) to serve the community in the west.

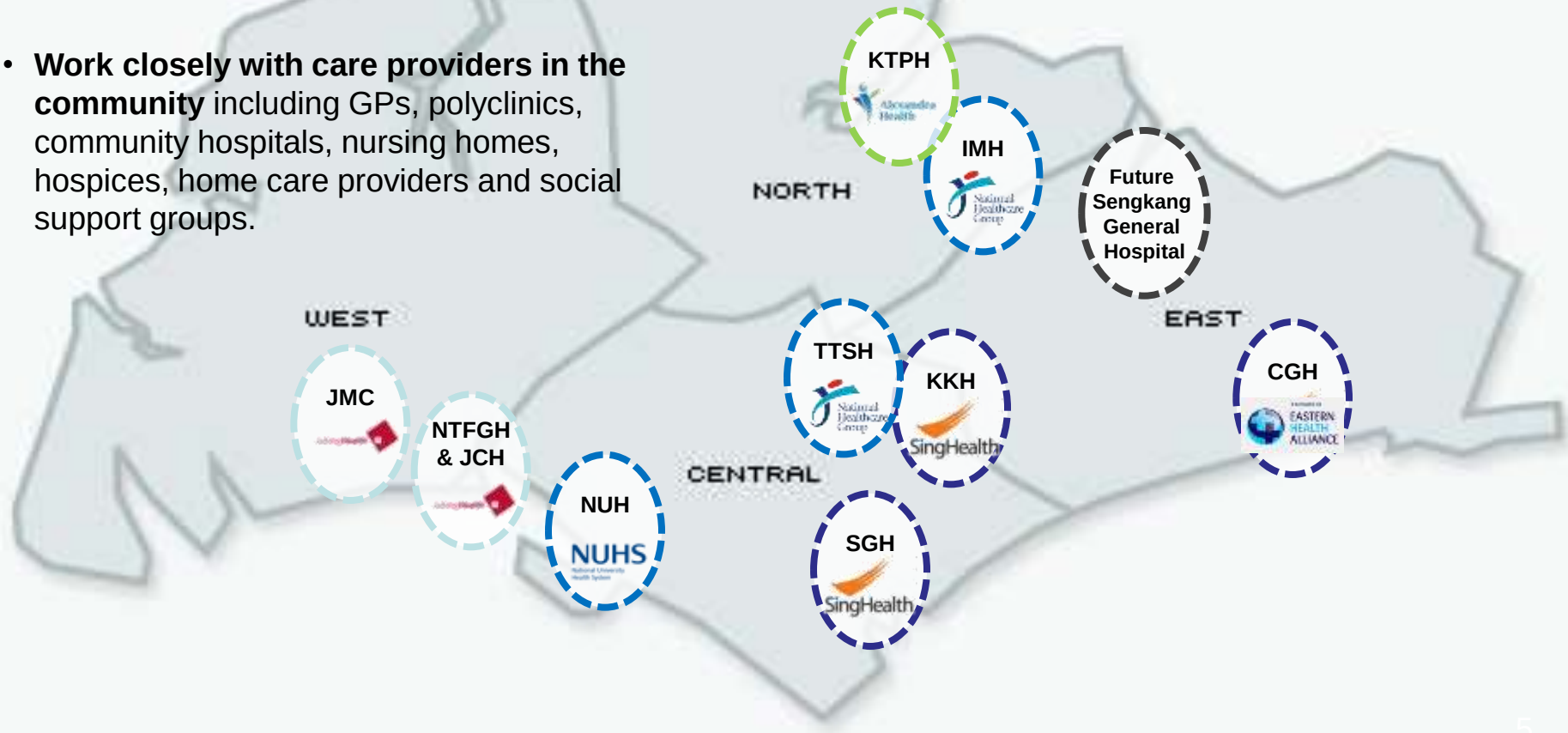
- Partnering GPs in the west at the **Lakeside Family Medicine Clinic** (LFMC) to provide care for patients with chronic conditions.

A regional healthcare cluster for the west

- **Provide integrated and seamless care experience** for our community requiring various healthcare services.

- **Work closely with care providers in the community** including GPs, polyclinics, community hospitals, nursing homes, hospices, home care providers and social support groups.

- **Engage non-healthcare community partners** e.g. grassroots organisations, employers, sports and other interest groups to help residents stay healthy in the community – away from the hospital.



Jurong Health

Jurong Community Hospital (JCH)

Total of 12 levels

400 beds (11% Private, 89% Subsidised)

- **Level 1**
  Admission & JCH Specialist Outpatient Clinics
- **Mezzanine Level**
  Clinical and Administration Space
- **Level 2 and 3**
  Private Wards
- **Level 4 to 12**
  Subsidised Wards

Ng Teng Fong General Hospital (NTFGH)

Total of 16 levels

700 beds (25% Private, 75% Subsidised)

28 Intensive Care Unit beds and 42 High Dependency beds

15-bed Isolation Ward next to Accident & Emergency Department

18 Operating Theatres

- **Level 1 to 4**
  Diagnostics and Treatment
- **Level 5 to 10 (West Wing)**
  Private Wards
- **Level 5 to 16 (East Wing)**
  Subsidised Wards

Specialist Outpatient Clinics

Total of 8 levels

Training Centre

Auditorium

Diagnostic services

Pharmacy on every clinic floor

- **Level 1**
  Training facilities (including an auditorium) and Diagnostic Imaging services
- **Level 2**
  Pre-admission testing, Medical Social Services and retail
- **Level 3 to 7**
  Specialist Outpatient Clinics (120 consult rooms)
- **Level 8**
  Administration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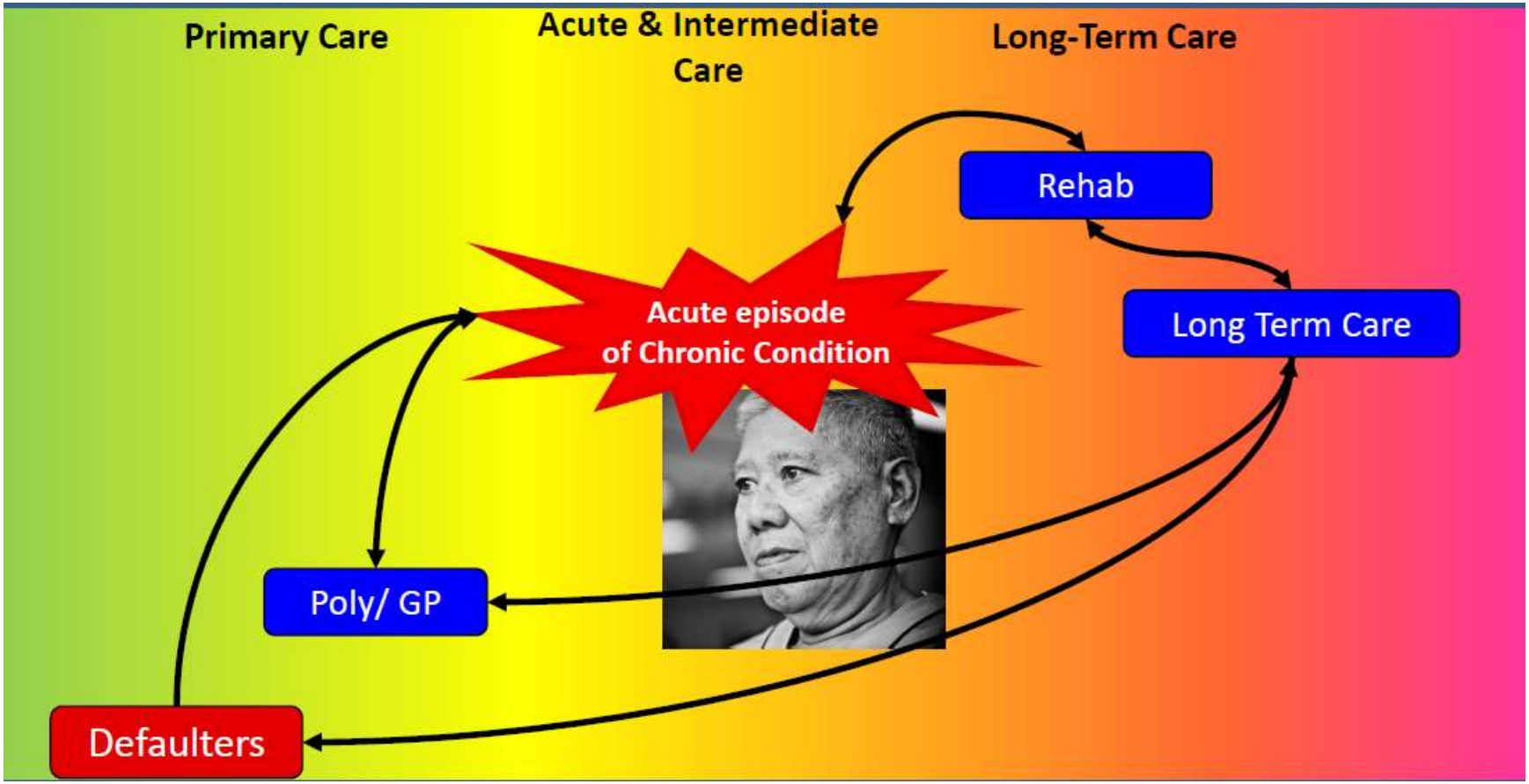
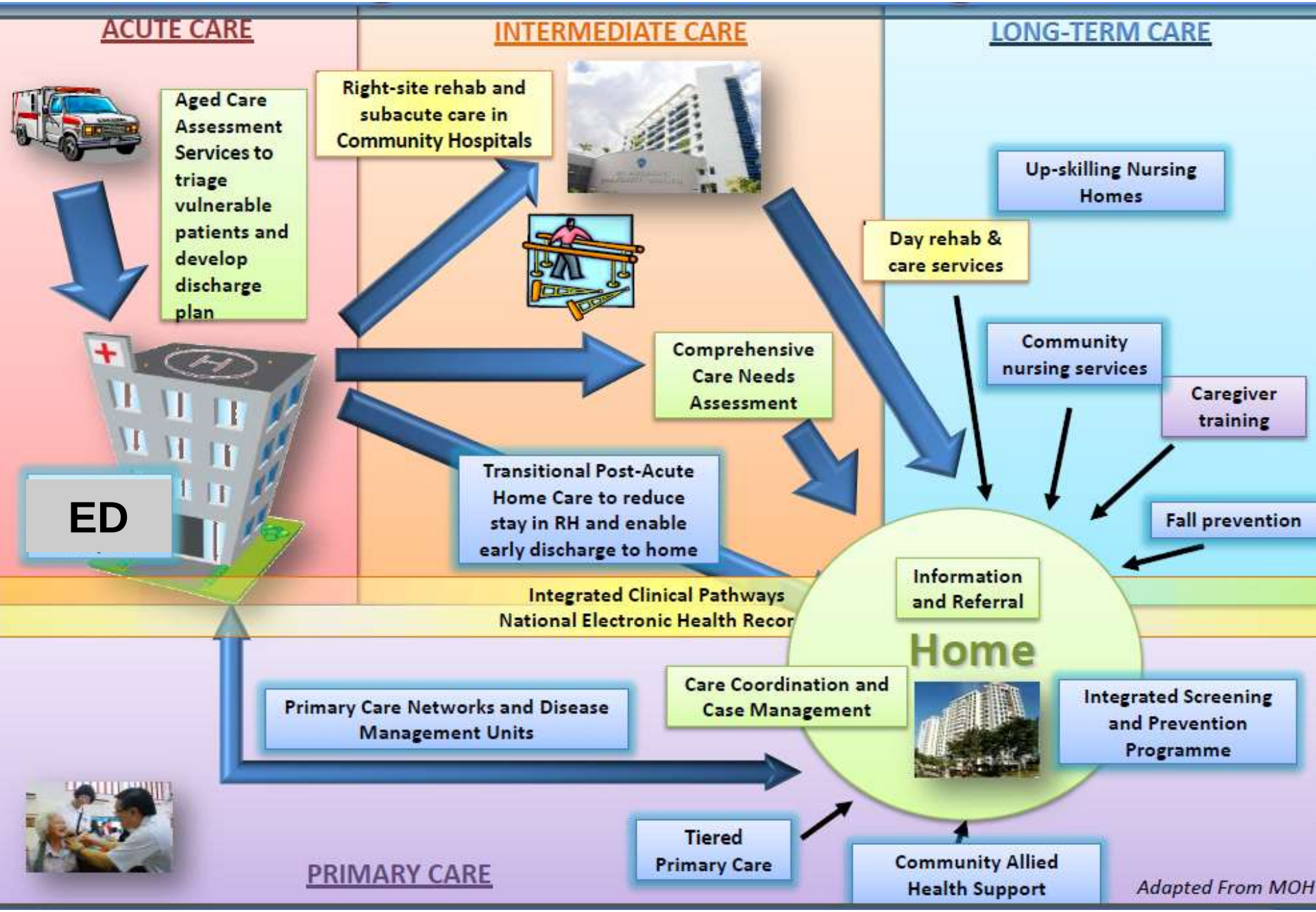
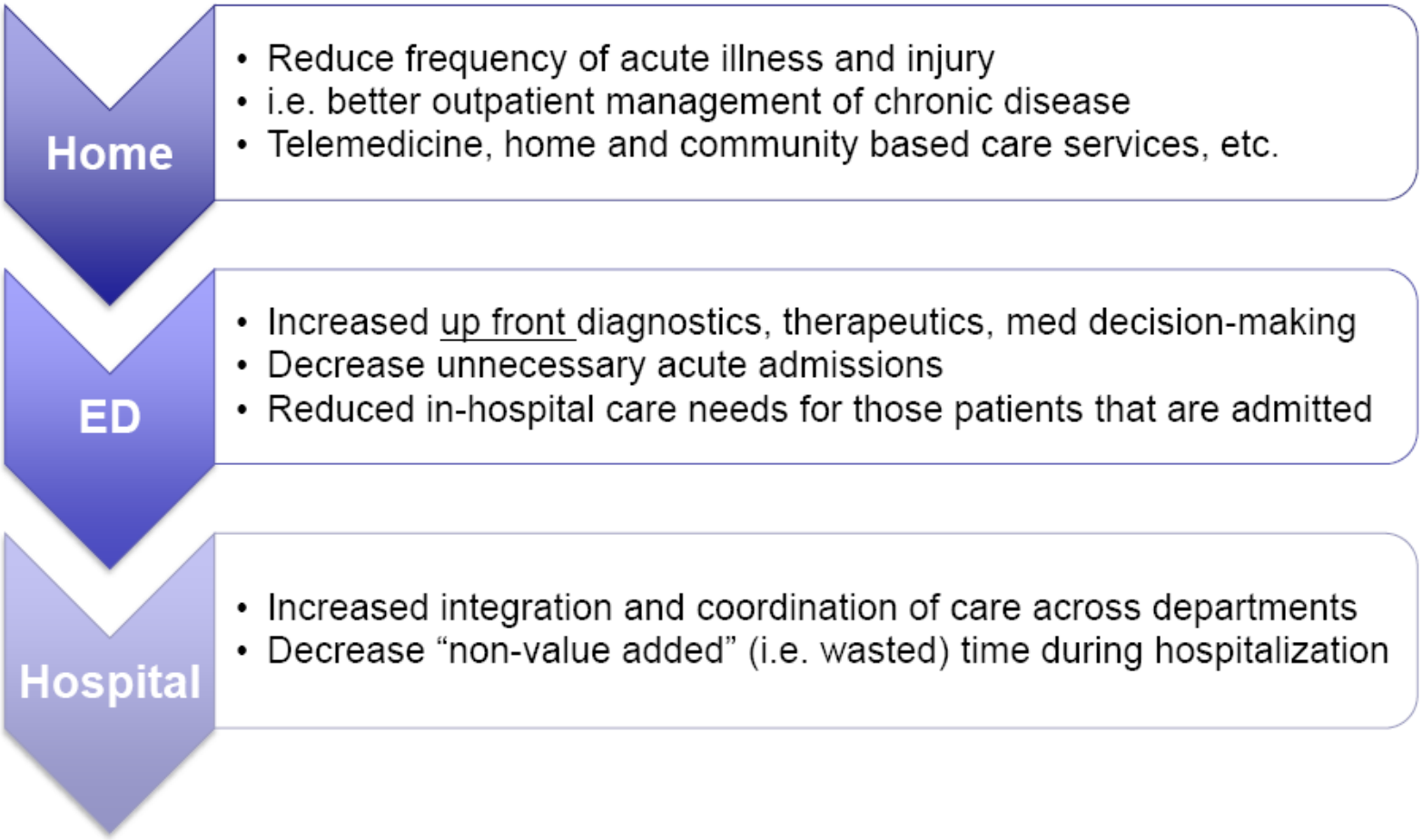
The Current


Primary Care
Acute & Intermediate Care
Long-Term Care
Rehab
Acute episode of Chronic Condition
Long Term Care
Poly/ GP
Defaulters


ACUTE CARE
INTERMEDIATE CARE
LONG-TERM CARE
Aged Care Assessment Services to triage vulnerable patients and develop discharge plan
Right-site rehab and subacute care in Community Hospitals
Up-skilling Nursing Homes
Day rehab & care services
Community nursing services
Caregiver training
Comprehensive Care Needs Assessment
Transitional Post-Acute Home Care to reduce stay in RH and enable early discharge to home
ED
Fall prevention
Information and Referral
Integrated Clinical Pathways
National Electronic Health Recor
Home
Care Coordination and Case Management
Integrated Screening and Prevention Programme
Primary Care Networks and Disease Management Units
Tiered Primary Care
Community Allied Health Support
PRIMARY CARE
Adapted From MOH

Strategies for Reducing Demand for Inpatient Hospital Care




Singapore
'Silver Tsunami'
By the year **2030**, 1 in 5 Singaporeans, or **900,000**, will be 65 years of age, or over

Models of Care

SAFE Program

SUBACUTE

AMBULATORY CARE FOR THE

FUNCTIONALLY CHALLENGED AND

ELDERLY

PROGRAM DESCRIPTION

- Home visits made by a multidisciplinary team with doctors, nurses and medical social workers, therapists, dieticians and pharmacist.
- Opportunistic screening and prevention
- Patients will be observed in the program over a 3 month period with an estimated 4 visits from the multi-disciplinary team; estimated of 1 doctor visit, 2 nurse visits and 1 allied health visit as determined by the clinician depending on patient's condition.
- Final goal is to discharge the patient to a community partner.

Inclusion Criteria - Diagnosis

1. **Falls/Trauma** cases with **minor injuries**

- ✓ Minor Head injury
- ✓ Minor Contusions
- ✓ Compression spine fracture
- ✓ Stable limb fractures
- ✓ Haemodynamically Stable
- ✓ Conservative treatment
- ✓ Pain control and Rehabilitation at home

Medical Cases

2. **Infections** (Chest infection, UTI, Cellulitis)

3. **Exacerbation of chronic medical conditions** (COPD/Asthma/CCF/DM/Hypt) – for optimization

4. **Dementia** with behavioural and psychological symptoms – for symptom control and caregiver support

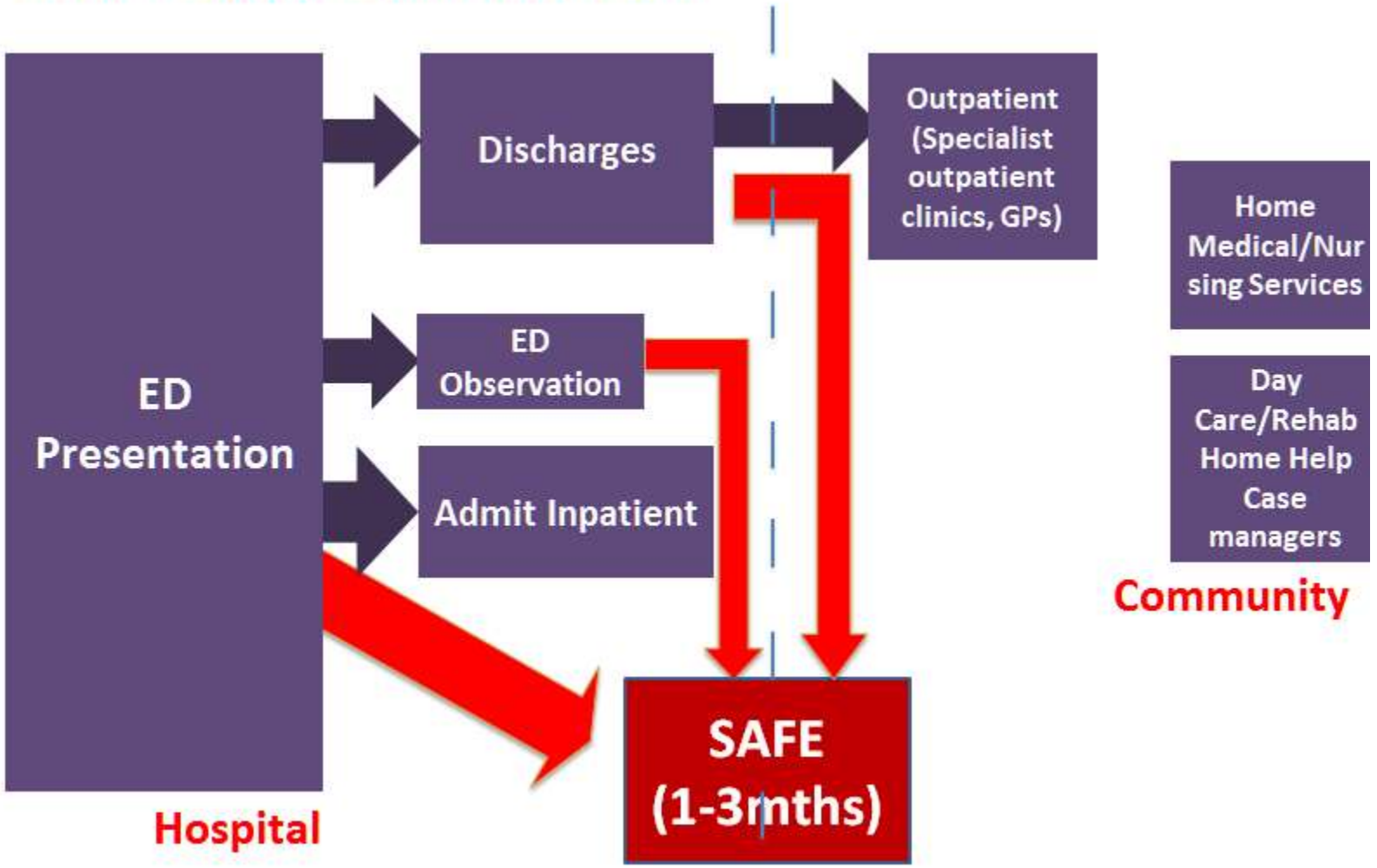
5. **Frequent ED Re-attenders** (with possible social or care issues)

6. **Functional decline** (sub-acute)

Exclusion Criteria

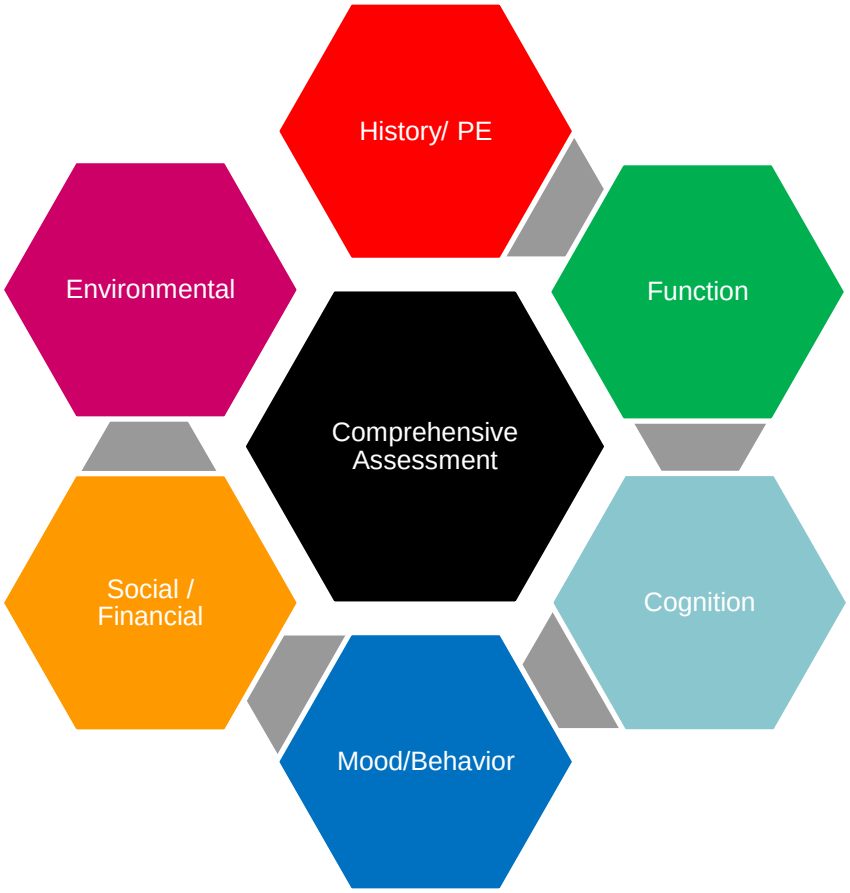
- Haemodynamically unstable
- Unstable mental status (active psychosis)
- No clear diagnosis
- Intensive monitoring (e.g. 4hourly or more)
- Urgent surgical or radiological interventions
- Addiction to alcohol, drugs, gambling, etc.
- Vagrants and homeless

ENTRY POINTS FOR SAFE PATIENTS



Core Components of SAFE

- ✓ Comprehensive Geriatric Assessment in the Home



Multiple chronic diseases
DM, Hypertension, Hyperlipidemia, Peripheral vascular Disease, IHD, CVA, COPD

Cognitive impairment
Dementia with BPSD, Depression

Social issues
Caregiver burden
Environment safety
Elder Abuse

Limited mobility
Wheelchair or bed bound
Transportation issue
Dependent on caregiver

Financial issues
Limited resources
Cost sensitive

CARE PLANS FOR ELDERLY

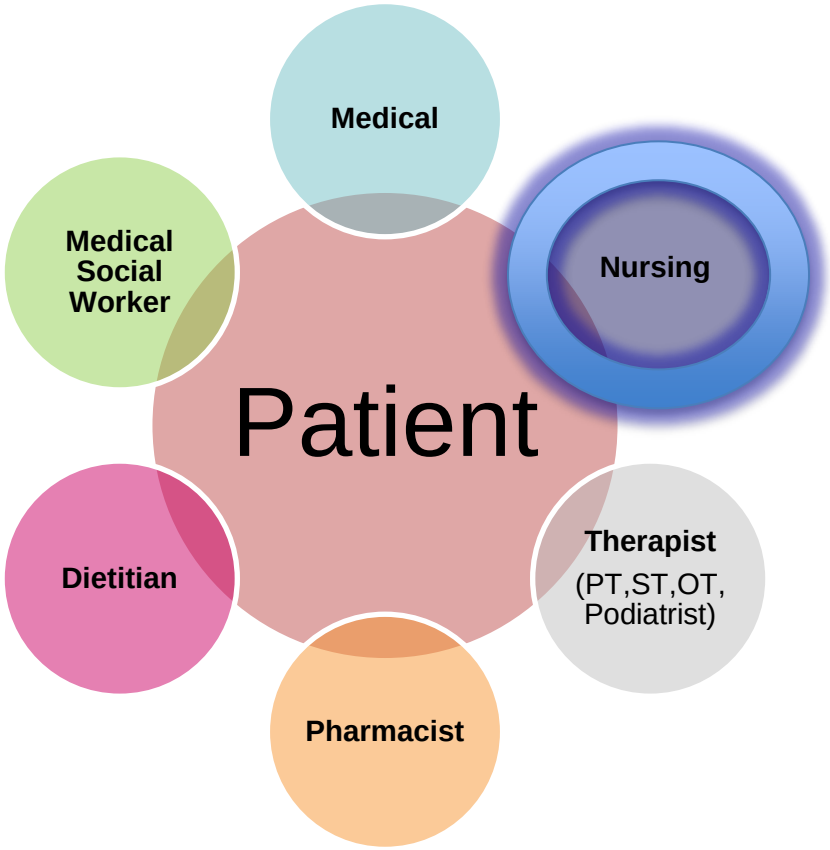
Core Components of SAFE

- ✓ Comprehensive Geriatric Assessment in the Home
- ✓ Multi-disciplinary Team

SAFE Multidisciplinary Team

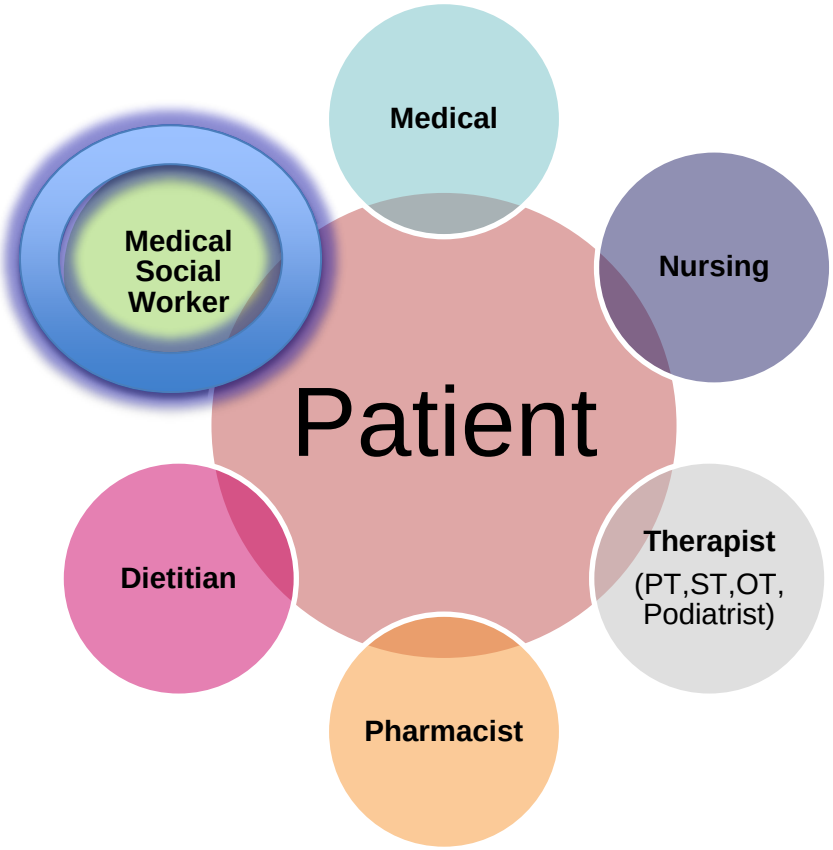
Core Components of SAFE

- ✓ Comprehensive Geriatric Assessment in the Home
- ✓ Multi-disciplinary Team
- ✓ Weekly telephone follow-up



Core Components of SAFE

- ✓ Comprehensive Geriatric Assessment in the Home
- ✓ Multi-disciplinary Team
- ✓ Weekly telephone follow-up
- ✓ Direct liaison and referral to community services



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agency for integrated care

Integration with Community Partners

- Home Medical/Nursing
- Home Therapy
- Home Help
- Meal delivery/ Laundry/ Housekeeping
- Personal Hygiene/ Escort/ Transport
- Day Rehab/Care services
- Dementia Day Care
- Community Case Managers
- Palliative and Hospice Home Care

St Luke's Hospital

Tzu Chi

家护基金 Home Nursing Foundation

TSAO foundation For Successful Ageing

TOUCH Community Services

aic agency for integrated care

Centre for Enabled Living

ntuc Eldercare

Sathya Sai Social Service

Core Components of SAFE

- ✓ Comprehensive Geriatric Assessment in the Home
- ✓ Multi-disciplinary Team
- ✓ Weekly telephone follow-up
- ✓ Direct liaison and referral to community services
- ✓ Personalized Discharge Plan

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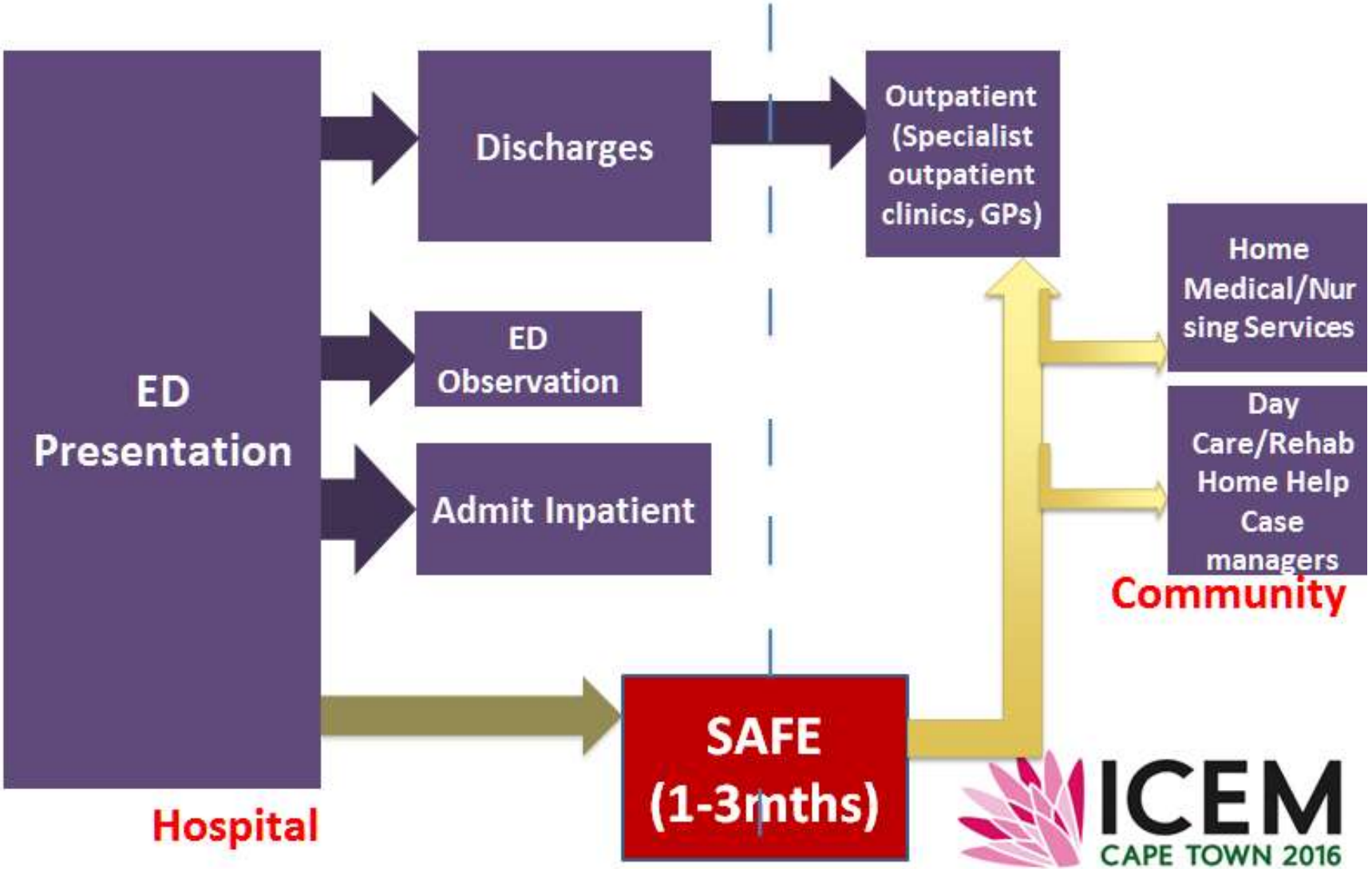
EXIT POINTS FOR SAFE PATIENTS



ICEM CAPE TOWN 2016

Benefits

- At an Individual Level
  1. Improved home safety
  2. Decreased fall risk
  3. Improved medical compliance
  4. Improved balance and gait
  5. Improved psycho-social conditions
  6. Care-giver satisfaction
- At Hospital/National Level
  1. Reduced ED re-attendances
  2. Reduced hospital admissions
  3. Positive impact on future of elder care

Applying TBL to Patient Care Sessions

What is TBL?

- **Team Based Learning is** a small learning group method where individual work is done outside the class and team work is completed in class.

What makes TBL?

- **The four principles of TBL** are:
  - properly formed and managed groups,
  - individual accountability,
  - team assignments that promote learning, group interaction and team development, and
  - frequent and immediate feedback to individuals.

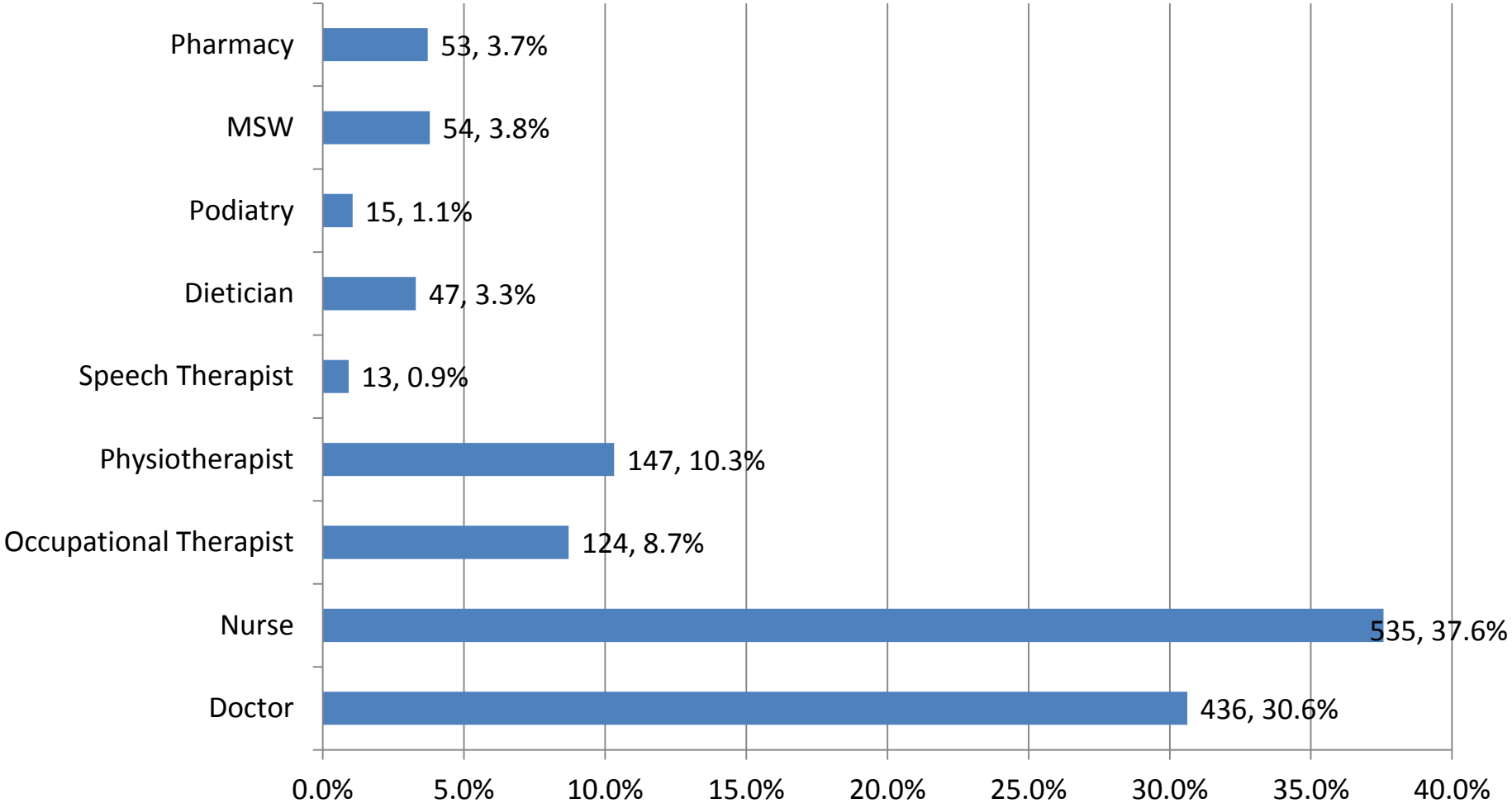
Why use TBL?

- **The rationale for using TBL** is that it is a good interactive alternative to passive lectures, requires no extra facilities or faculty, develops interpersonal skills and assists “at risk” individuals.

How to do TBL?

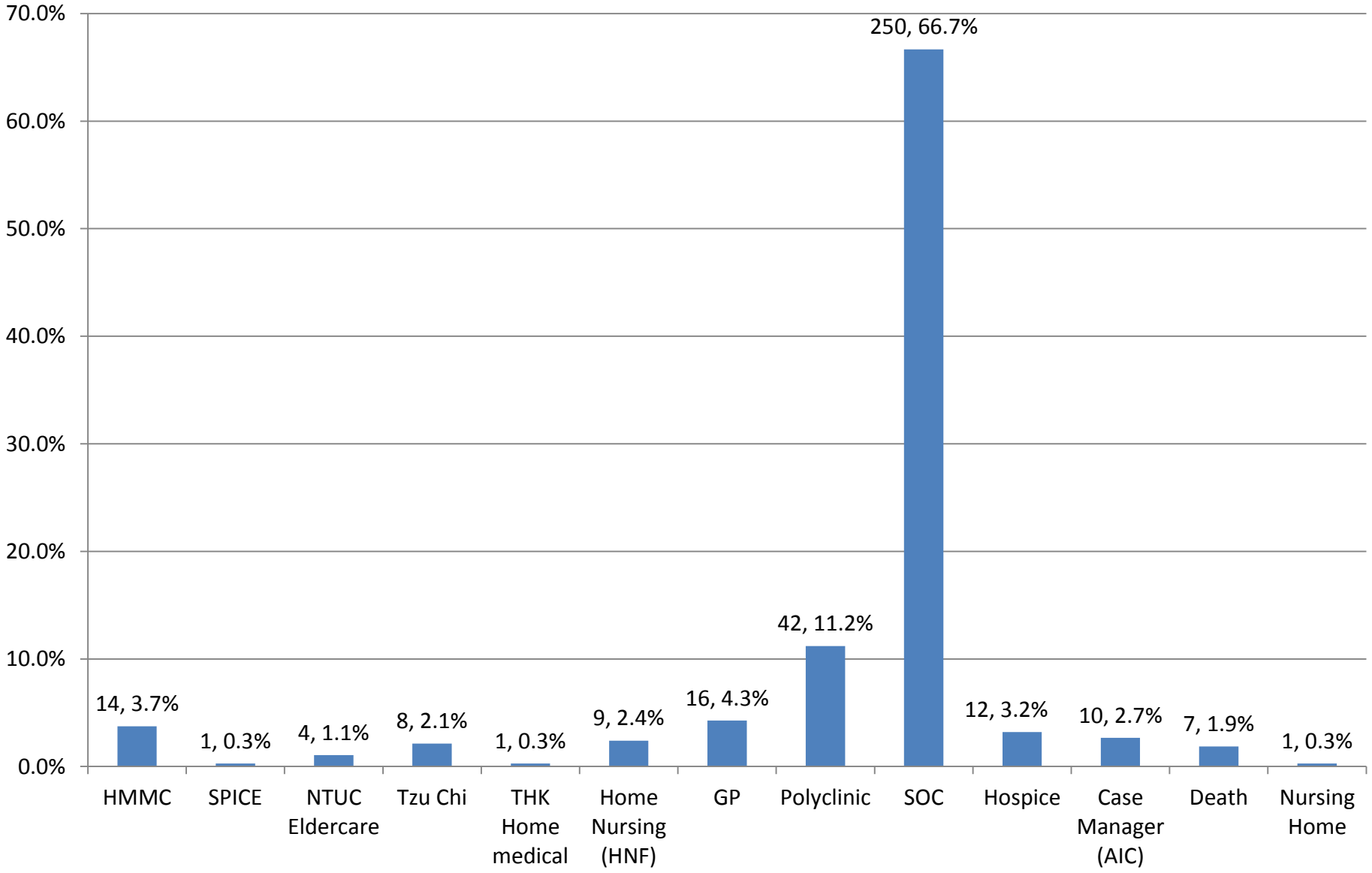
- **Implementation of TBL** involves planning before the session, forming groups in the 1st class and reminding the individuals of the learning objectives, content application and team work near the end of the session.

SAFE Multidisciplinary team (Jan 13 till Dec 14)

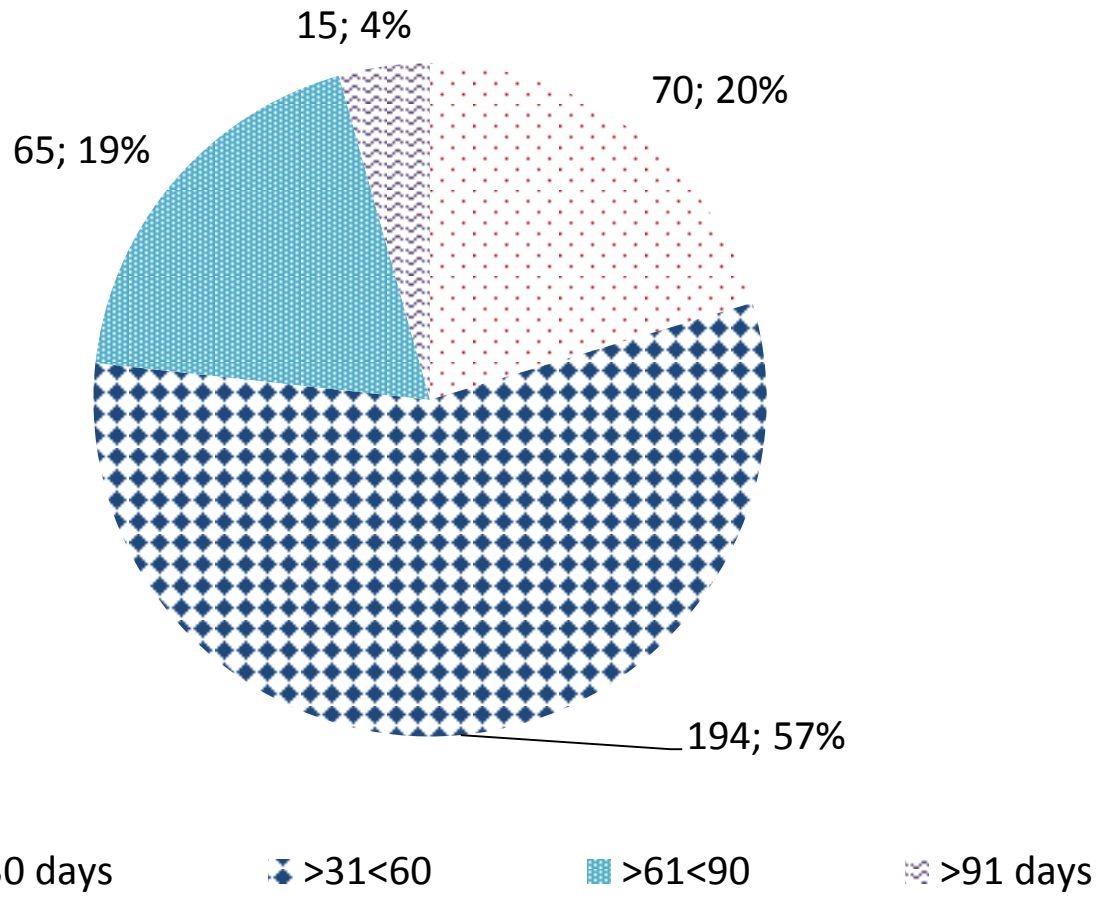


Average number of visits per patient : 4

Types of Referrals SAFE discharged patients to (Jan 13 till Dec 14)



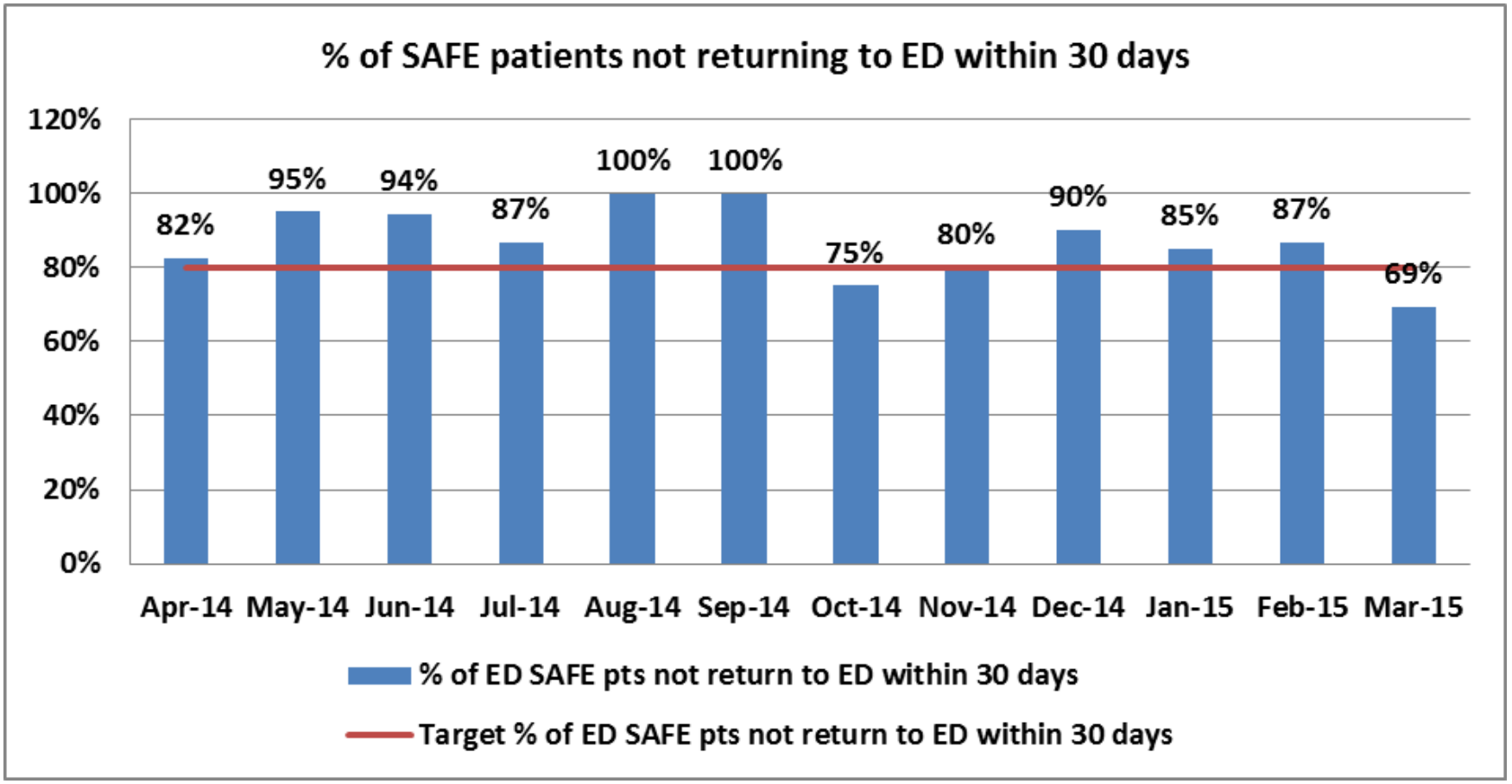
Duration of SAFE patients in SAFE program (Jan 13 – Dec 14)



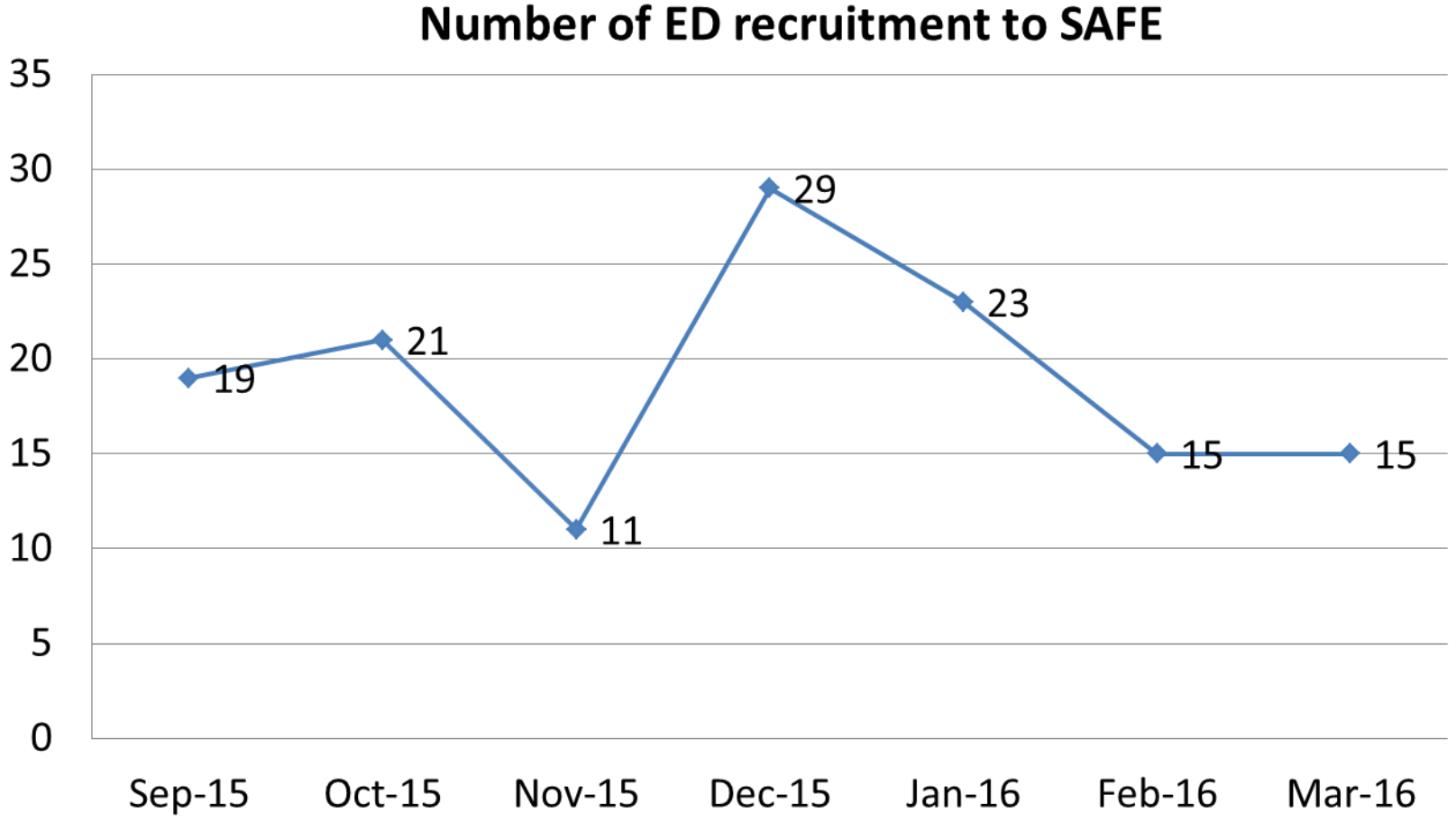
Median is 41 days

SAFE KPI - % of patients not returning to ED at 30 days

86.76% of SAFE patients did not return to ED within 30 days in Apr 2014 – Mar 2015



SAFE KPI – No. of patients recruited (NTFGH)



GIFT Program

GP

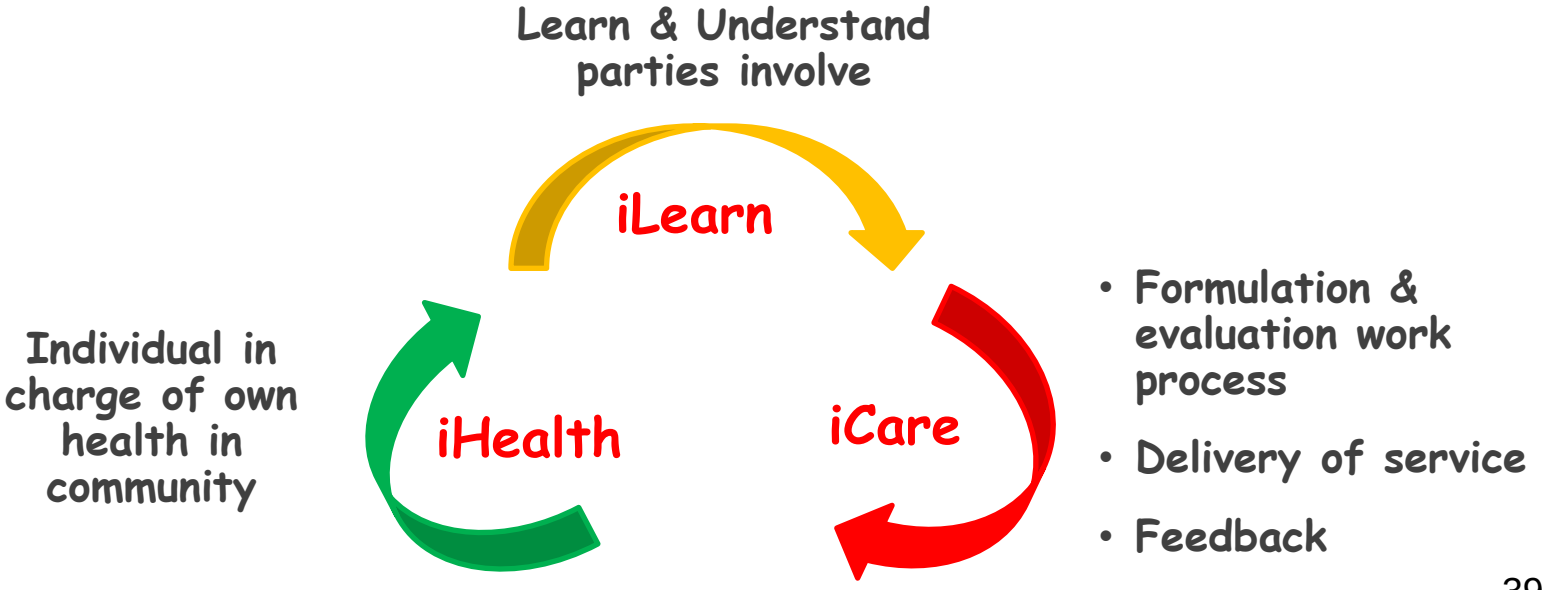
INTEGRATED

FAMILY CARE

TEAM

Referral to Community

- Initiative with GP partners and Community Operations:- **General Practitioner Integrated Family care Team (GIFT)** program; aims to augment ED - GP collaboration framework to provide a seamless continuation of care for patient at community level after visit from ED.




Discussions
- Types of wound in your practice?
- Types of patients in your practice?
- Issues ?


HEART DISEASE

Acute Hospital and Community Hospital Collaboration

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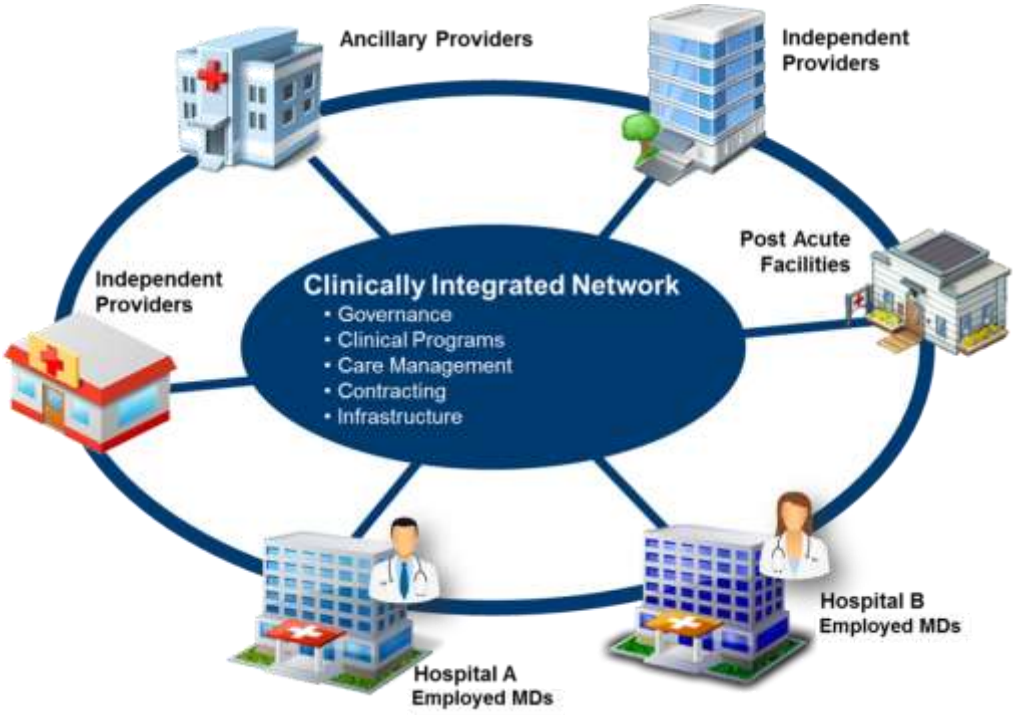
Monthly Transfers to Jurong Community Hospital

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NTFGH	21	18	28	61	95	80	101	111	128	124
NUH		18	15	13	13	11	22	15	19	18
SGH		2	8	10	15	15	16	9	9	11
TTSH		2	56	4	5	4	5	1	3	2
KTPH		1	0	9	4	6	1	0	3	0
CGH		0	0	0	0	0	1	1	0	1
Private		0	0	1	1	2	0	0	0	2

THE FUTURE

Clinically Integrated Network

- CINs are a group of physician and physician groups across multiple specialties using proven protocols and best practices to improve patient care. They encourage collaboration between members to meet quality benchmarks that improve outcomes and demonstrate value to the market..



Thank You

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