IN FOCUS
Jan 2017 Issue
NUHS National University Health System
A quarterly publication by NUHS RHS Planning Office

NUHS is pleased to present this newsletter which brings to you the latest news and developments in our regional health system.

In this issue, we highlight CareHub, a care and call centre that aims to empower our patients to better manage their medical conditions when they return home from the hospital so that they can avoid unnecessary re-admissions.

If you wish to find out more or learn about how you can work with us, please contact us at ***nuhsrhs@nuhs.edu.sg***

Caring for our patients beyond the hospital

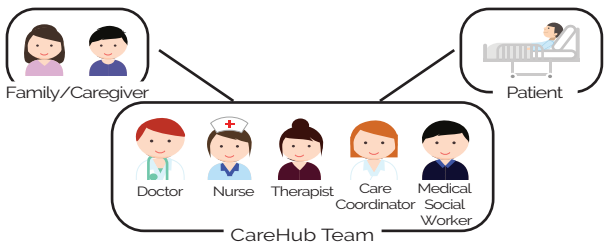
INTRODUCTION

When our patients are discharged from the hospital, it is crucial that their transitions from the hospital to their homes are managed well. Otherwise, it can have a negative impact on our patients' health, which will increase their chances of re-admission to the hospital. This in turn could add unnecessary strain on their caregivers and family members.

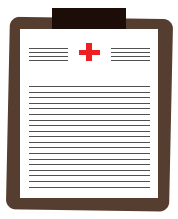
Recognising this, we piloted **CareHub**, a care and call centre initiative that aims to help patients maintain or improve their ability to carry out their everyday activities and manage their conditions after returning home. Upon being discharged, the CareHub team acts as the first point of contact for enrolled patients. This is to ensure our patients continue to receive the coordinated and continued care they require. The team also helps our patients navigate across care providers so that they can receive timely interventions, where necessary.

HOW CAREHUB WORKS

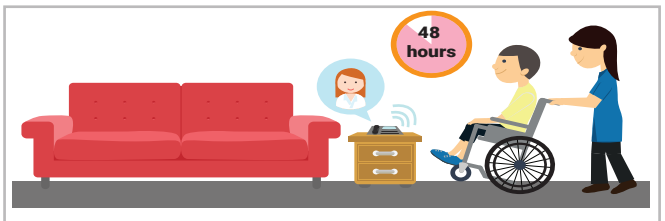
1 CareHub leverages on IT to stratify patients according to their risk of re-admission, and enrolls high-risk patients into the programme.



2 During hospitalisation, the CareHub team assesses and discusses with the patient and his/her family members/caregivers on their post-discharge care needs.

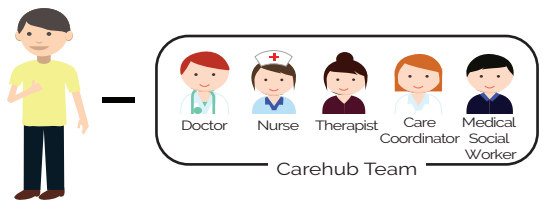


3 The CareHub and ward care teams develop a personalised multi-disciplinary discharge care plan for the patient.



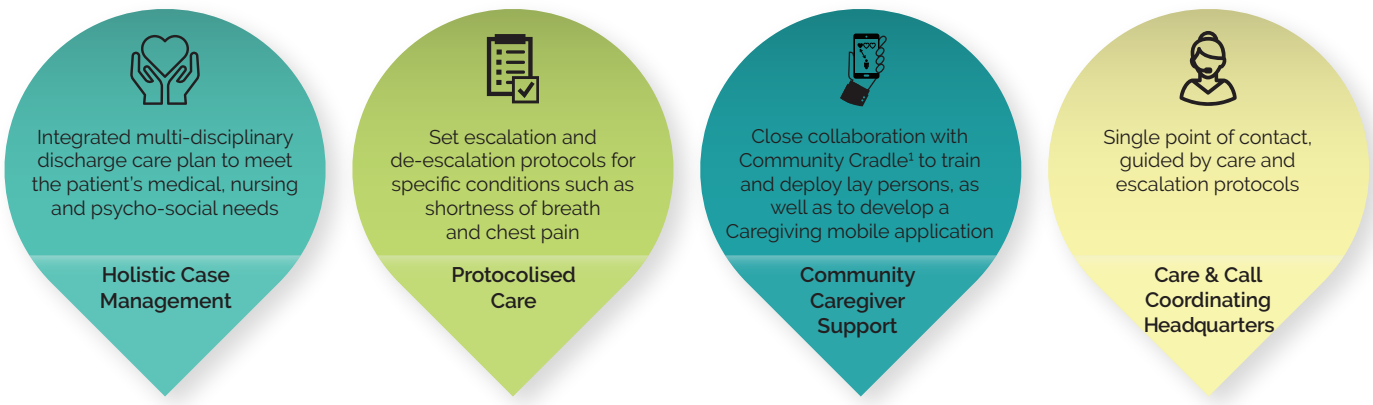
4 Upon discharge, the CareHub team calls the patient within 48 hours to check on the patient and escalate any issues to the doctor if needed. They will also conduct subsequent follow-up calls according to the patient's needs.

5 Patients and caregivers can call the CareHub hotline should they need to seek advice. The CareHub team will deploy or refer appropriate services to the patient and/or caregivers where necessary, e.g., consultations by clinicians, home care, rehabilitation, social or community services.



6 The CareHub team looks after the patient until care issues have been resolved and the patient's medical conditions have stabilised. CareHub also hands the patient over to the community providers where necessary.

UNIQUE FEATURES OF CAREHUB



> It is most satisfying when our patients are discharged back to their homes well. CareHub's telecommunication support and monitoring, guided by protocols, empower patients to proactively monitor their health.
>
> - Mr Jeffrey Yoo, Nurse Clinician

FAVOURABLE PRELIMINARY RESULTS

Since the launch of the initiative in April 2016, CareHub has served over 200 high-risk patients from NUH's cardiac wards. Early results have shown that patients recruited have yielded favourable preliminary outcomes as compared to the control group[2]. Overall, there has been a reduction in 60-day re-admissions by 40% and 60-day A&E visits by 60%.

RAMPING UP TO SERVE MORE PATIENT GROUPS

Looking ahead, the NUHS RHS Planning Office plans to scale this initiative to serve all NUH inpatient post-discharge patients, and subsequently to all NUH outpatients as well. In the longer term, suitable patients may also be enrolled from the community via the NUHS Primary Care Networks and Family Medicine Clinics.

The CareHub Team

This initiative is led by Associate Professor John Wong Chee Meng and Deputy Director of Nursing Helen Chen, and consists of nurses, medical social workers and case managers who work closely with our cardiologists, Wards 63 & 64 staff and pharmacists.

[1] Community Cradle is an initiative that aims to optimise healthcare resources through the training and deployment of laypersons to serve as community caregivers for patients with no caregivers or little family support.
[2] Both groups were randomised, and had the same average LACE score of 12, i.e.: both patient groups had a high risk of re-admission into the hospital.