UNIT NO. 6

LINKING MEDICAL AND SOCIAL CARE

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ABSTRACT

Singapore has a rapidly ageing population with an increasingly complex chronic disease burden. The number of seniors living alone has also tripled in the last 15 years. Primary care physicians will have to change the way that we delivery primary care. Patients have multi-comorbidities and are sicker. Family Physician Practice has to enhance the coordination of medical and social care and the provision of comprehensive care across the entire cycle of care. This can be achieved by being connected to the health system and resources, making additional efforts in providing care coordination to navigate the health system, and optimising clinical social care around the patient's needs with a multi-disciplinary team (MDT). There has been an increase in the number of services in the community but gaps still exist, especially in the coordination of healthcare and psychosocial care services. The team will need to tap on all available services to ensure patients' medical and social needs are taken care of and they are enabled to age gracefully in place.

Keywords: Complex Patient; Multi-disciplinary Team; Care Resources;

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INTRODUCTION

Singapore has a population that is ageing rapidly, and it has been estimated that there will be about 900,000 people aged above 65 in the year 2030.[1] The number of seniors aged 65 and above who live by themselves has tripled from 14,500 in year 2000 to 42,100 in 2014.[2] These households are common now due to factors such as the ageing population and changing family structures, resulting from personal preferences or unfortunate circumstances, or others[3].

As the population ages, their care needs will increase both medically and socially. Many in Singapore will need to tap on community resources to help them age gracefully in place. As the population care needs become more complex, they often need a multi-disciplinary team comprising doctors, nurses, medical social workers, physiotherapists, occupational therapists and pharmacists to formulate care plans and link them to the appropriate community and financial resources that will meet their needs. Apart from patients' medical conditions and functional status, other aspects such as patients' and their families' resources and relationships, and their psychosocial needs will be taken into consideration when formulating a care plan for them.

To ensure that patients can age gracefully in place and have their needs taken care of, the team needs to tap on not just the available formal community resources but there is a need to enlist the help of the patient's friends, volunteers and religious services as well, when appropriate. There have been an increased number of services in the community but gaps still exist, especially in the coordination of healthcare and psychosocial care services. There is also a need to ensure that the elderly living alone are able to access help and support easily so that they can be supported earlier. This may delay an escalation of a crisis, where these elderly have to seek treatment at an acute hospital or eventually be cared for in a nursing home.

COMPLEX MEDICAL AND SOCIAL CARE

Singapore's population is rapidly ageing and people are living longer, with an increasingly complex chronic disease burden. The traditional model of delivering primary care will need to be remodelled and increased in intensity to take care of this high-risk group of patients and keep them safe in the community. Intensive Primary Care involves providing care to the sickest, highest–utilising patients in the practice to improve their health outcomes and satisfaction, far beyond what is offered in traditional primary care practices. This is done by enhancing the coordination of medical and social care and by providing comprehensive care across the entire cycle of care. This can be achieved by being connected to the health system and resources, making additional efforts in providing care coordination to navigate the health system, and optimising clinical social care around the patient's needs through a 3-step approach:

A. Defragment: Assess and identify care issues that must be resolved urgently;
B. Integrate: Develop a comprehensive care plan and optimise the medical and social care; and
C. Link: Muster resources to support continuing care in the community.

ROLE OF THE MULTI-DISCIPLINARY TEAM

The multi-disciplinary team (MDT)[4] comprises individuals with different educational backgrounds, training, experience, skills and practices. They come together to make unified decision on the care of the patient. The members of the team share and exchange information about the patient's health, illness, functional status and social situations to formulate goals and

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action plans that are tailored to the individual's ideas, concerns, and expectations. The roles and functions of members of the team are summarised in Table 1. Used effectively, the MDT can reduce acute hospital emergency department visits, hospital readmissions, and shorten the duration of stay.[5] With the MDT, assessments are more comprehensive and individualised care plans can be provided to patients with high disease burden and complex medical issues.

MDT commonly does this, with the physician assimilating all the information to come up with a care plan. Working with the patient's caregiver and family in the discharge process is part of effective planning. Several sessions of family engagement may be needed to understand the family dynamics and help improve their understanding of the patient's current medical conditions and functional status. A schema used by Family Physicians in Singapore General Hospital published in several issues of the *Singapore Family Physician* can be downloaded from the world wide web: http://www.cfps.org.sg and used as a planning guide.[6,7]

Table 1: Members of MDT and Their Roles

Members	Roles
Doctors	1. Leaders of teams 2. Provide medical input and management of patients 3. Decide when patients are fit for discharge and refer them for ILTC services if needed 4. Convey patients' and family's ideas, concerns and expectations to the teams
Nurses	1. Assess IADL 2. Wound care and assessment 3. General nursing care 4. Phone call follow-up of patients post-discharge 5. Initiation of ILTC referral in AIC IRMS system
PT/OT/ST	1. Assess patients' functional status, rehab goals 2. Assess ability for self-care and the need for mobility aids 3. STs assess patients' swallowing and the need for modified diets 4. Home assessment for safety
Pharmacists	1. Medications review and counselling 2. Education and provider of drug information to patients 3. Optimisation of medications regimen to reduce ADR 4. Ensure compliance to drug therapy
MSWs	1. Assess patients' psychosocial well-being and needs 2. Assess patients' financial resources and provision of financial assistance 3. Link patients and family to community resources

CARE INTEGRATION

The ideal care integration provides a smooth transition of patients from the hospital to step-down care and subsequently to the community. If care is not coordinated, gaps of care will start to appear during the transition of complex patients. A good discharge plan during admission to the hospital is a critical component of transitional care integration to reduce unnecessary hospital stay and unscheduled readmission. It also helps to channel patients to the appropriate community resources to match their needs. Discharge planning should start early, preferably on the day of admission, identifying discharged destination and community services required. There is a lag time from application to the allocation of resources needed, hence the application needs to be placed early so as not to delay the patient's discharge when he is fit. The elements of a discharge plan include the following:

Identify Discharge Destination

Not all patients will be able to be discharged home after hospitalisation. A comprehensive assessment taking into account the patient's acute and chronic medical conditions, functional and social status will determine the discharge destination. An

Identifying Risk Factors for Interventions

Common risk factors that place patients at increased risk of readmission within 30 days of discharge from the hospital are well known.[8] These patients also are at risk of poorer outcomes after discharge. These are patients who have:

- Problem medications such as warfarin, insulin antiplatelet dual therapy, and narcotics;
- Psychological issues;
- Principal diagnosis with poorer outcomes such stroke, COPD, CCF, etc.;
- Polypharmacy: > 5 drugs;
- Poor health literacy;
- Poor social support;
- Prior non-elective admission; or
- Palliative care with life expectancy less than a year.

Medication Reconciliation

This is needed to identify the accurate list of medications that the patient is taking, including the name, route, dosage, and frequency. This list will be subsequently used to provide correct medications to the patient. Patients can be under multiple

providers in various hospitals, and having an accurate list of medications is essential to prevent medication errors, duplications, and ADR.

Provide a Clear and Succinct Discharge Summary and Instructions

In an ideal situation, there should be closed-loop communications between discharging physicians and receiving physicians. Having a well-written discharge summary that clearly communicates the care plans is crucial to the receiving physicians or community partners to avoid adverse outcomes. Having access to the National Electronic Health Records (NEHR) is a step closer to realising this.

Communicating the Care Plans to Patients and Caregivers

Communicating a clear care plan free of medical jargon and in simple language to help the patient understand his medical condition, and how to manage post discharge, is important. A teach-back method can be used to assess patients' understanding.

HOW TO ASSESS PATIENT'S NEEDS?

Assess the Level of Care Needed and Match Patient's Needs to the Appropriate Resources

Across the Intermediate Long-Term Care (ILTC) sector and care providers, the functional status of the patient is assessed using mainly the Resident Assessment Form (RAF) and the Modified Bartel Index (MBI). The RAF uses a series of 9 indicators with a point-scoring system to categorise patients from 1 to 4 (Annex A). The functional status of the patient is categorised in the 4 categories (Table 2).[9]

Table 2: RAF Categories

Category	1 (<6pts)	2 (7–24 pts)	3 (25–48 pts)	4 (>48 pts)
Functional Status	•Physically and mentally independent	• Semi-ambulant • Require some physical assistance and supervision in activities of daily living	• Wheelchair / bed-bound • Need help in activities of daily living and supervision most of the time	• Highly dependent • Require total assistance and supervision for every aspect of activities of daily living

The Modified Bartel Index (MBI) uses a 10-point system to establish the degree of independence of the patient from any help, however minor and for whatever purpose. The ten points establish patient dependence on feeding, bathing, grooming, dressing, bowel continence, bladder continence, toilet use, transfers, mobility and ability to climb stairs. Depending on the scores, patients are classified into categories, reflecting their level of dependency (Table 3).[10]

Table 3: MBI Score

MBI score	Dependency level
0-24	Total
25-49	Severe
50-74	Moderate
75-90	Mild
91-99	Minimal
100	Independent

The RAF and MBI are used by community providers to assess a patient's suitability to be admitted to their institutions and the level of care needed. A guide (Annex B) that matches the community service with a patient's functional status is provided for reference.

Do Means Testing to Ascertain the Subsidies

Household means-testing is a method used to calculate the subsidies that one will get for ILTC services.[11] It takes into consideration the following:

- Total monthly gross earnings of patient and family members living in the same household who are 21 years old and above;
- Number of family members; and
- Ownership of major assets such as private property.

The per capita monthly household income is derived from the division of the total household monthly gross earning by the number of family members living in the same household[11] (Table 4). If the household has no income, the annual value of their residence is considered instead.

The person applying for household means-testing has to be a Singapore citizen or permanent resident. The form can be downloaded from the AIC website at http://aic.sg. The completed forms, together with supporting documents such as photocopies of NRICs, birth certificates and pay slips for those earning more than $5000 per month or who are foreigners, need to be sent to Ministry of Health Holdings (MOHH) at

Table 4: Subsidy Levels for Home and Community-based Services and Community Hospitals

Per Capita Monthly household Income	Subsidy levels			
	Singapore Citizen		Permanent Residents	
Singapore Dollars	NRS	CH (subsidised wards)	NRS	CH (subsidised wards)
0–700	80%	75%	55%	50%
701–1100	75%	60%	50%	40%
1101–1600	60%	50%	40%	30%
1601–1800	50%		30%	
1801–2600	30%	45%	15%	25%
2601–3100	0%	40%	0%	20%
3101 and above		20%		10%
NRS: Non-residential Service CH: Community Hospital				

Harbourfront for processing. This is a self-declaration form and the doctor's certification is needed only for patients who are unable to give consent due to lack of mental capacity. Once completed, the means testing is valid for 2 years and registered in the National Means Testing System (NTMS).

AGENCY FOR INTEGRATED CARE AND SG ENABLE

The Agency for Integrated Care (AIC) was set up in 2009 as a National Integrator. It provides a one-stop portal for referrals to most MOH ILTC services. It also manages the Senior Mobility and Enabling Fund (SMF). All e-referrals to the various ILTC services are made via the AIC portal at http://aic.sg.

SG Enable (an agency dedicated to enabling persons with disabilities) provides a one-stop service for applications to disability homes, day activity centres, sheltered workshops, and financial assistance. Their office is at Redhill and all their services can be accessed via their web portal at https://www.sgenable.sg. The agency also provides funding to help those with disabilities purchase mobility aids, especially those who are below the age of 60.

TYPES OF COMMUNITY RESOURCES

The resources available to help patients are divided essentially into 3 types: financial; psychosocial emotional support; and care resources. Care resources available to patients are further subdivided into home-based care, centre-based care, and residential care. The detailed reviews are available in the author's article published in the Singapore Family Physician: SFP 2015;41(1):32–45.[12] A summary of the various care resources is illustrated from **Table 5 to 8**. [13,14,15,16,17,18,19]

What Is New?

The Integrated Home and Day Care (IHDC) package[20,21] is a pilot programme introduced by AIC in 2016 to cater to the diverse care needs of clients and their families. One such service provider is Peacehaven Bedok Multi-Service Centre. IHDC aims to provide holistic care to more frail elderly with multiple health and social needs through their suite of care services customised for each elderly, depending on the elderly's needs. Applications will be made to AIC through the social worker in the hospital.

There are also many voluntary welfare organisations, philanthropic organisations, or individuals and religious groups that are doing a great job in providing meal delivery and help to needy individuals in the community, keeping the concept of "Many Helping Hands" alive.

Financial Resources

Singapore Healthcare Financing is well known and has been a subject of studies and books by many countries and individuals respectively. It is a tiered system based on Government subsidies, Medisave, Medishield, Medifund (3Ms), and philanthropy in the ILTC sector. Medishield Life was introduced in November 2015 and it covers pre-existing illness as well, for life. Premiums are paid through individuals' Medisave.[22] Patients can also use their own Medisave to pay for their hospitalisation at both acute and community hospitals.[23] Medifund is a safety net for those who cannot afford the subsidised bill charges, despite Medisave and Medishield Life coverage.[24]

The Community Health Assist Scheme (CHAS), and Public Assistance Card (PA) are provided to patients who require help in paying their outpatient bills at Family Physician clinics. To qualify for the CHAS card, the patient's household monthly income per person must be less than $1800. The **Pioneer Generation (PG) card has** privileges accorded by the Government to Singapore citizens aged 65 and above in 2014 and who obtained citizenship on or before 31st December 1986.[25] The benefits are similar to the blue CHAS card except that the cardholders are able to claim higher subsidies for acute

Table 5: Homecare

Types	Description	Examples
Home Personal Hygiene	• Help seniors with daily activities such as personal hygiene, assistance with medication administration at home	Thye Hua Kwan Home Help service, Dorcas Home Care Service, Touch Community Services
Meals-On-Wheels	• Deliver meals to seniors who are home-bound	
Medical Escort/ Transport Service	• Provide transport services and assigned personnel to accompany seniors to and from medical appointments	
Home Therapy (PT/OT/ST)	• Provide home bound clients with rehabilitation to improve or maintain their ADLs for a period of time	Handicap Welfare Association (HWA) SPD (Serving People with Disabilities – formerly known as Society for the Physically Disabled), Thye Hua Kwan (THK)
Home Nursing	• Provide nursing care such as wound dressing, injections, changing of feeding tubes and medication packing	Home Nursing Foundation (HNF), Yong En Home Nursing, Swami Home Nursing
Home Medical	• Cater to frail or bedridden clients who need medical consultation and treatment	Hua Mei Mobile Clinic, MW Home Medical care, House call to individual GP
Home Palliative	• Provide end of life care for patients terminally-ill with cancer or illness	Metta Hospice, Agape Methodist Hospice, Assisi Hospice, HCA Hospice Singapore Cancer Society
Transitional Home Care	• Provide MDT follow-up for a period of 3 months upon discharge from hospital before transiting the patients to community services	Hospital homecare team e.g. SGH transitional homecare team

Table 6: Other Types of Home-based Services

Types	Description	Examples
Case Management	• Provide health and psychosocial support to seniors • Depend on different practice models, criteria, and service boundaries • Refer to respective organisations via hard-copy forms	Cluster Support (as part of Senior Cluster Network), Community Case Management Service, Family Service centres
Befrienders	• Volunteers from formal organisations, religious organisations, etc., will befriend seniors who are living alone or those with poor social support • Refer to respective organisations via hard-copy forms	Religious groups, Lions Befrienders
Home Modification	• Assess and recommend elder-friendly modifications (such as grab-bars, ramps, non-slip treatment at toilet) at home • Provided by different organisations • Apply online or in person at HDB branch offices for EASE scheme	Enhancement for Active Seniors (EASE) by Housing and Development Board (HDB)
Interim Caregiver Service	• Provide temporary support to patients who are transiting back to home from hospital for about 12 days, while families work on long-term caregiving arrangements • Refer to AIC via AIC IRMS during patient's inpatient stay at acute or community hospital by relevant healthcare professionals	NTUC Health, THK

Table 7: Centre-based Services

Type	Description	Remarks
Singapore Programme for Integrated Care for the Elderly (SPICE)	• Provide support for frail seniors who choose to stay at home, but need a higher level of care at home, without admitting them to a nursing home	Referrals are to be made via AIC IRMS system May take at least two weeks for AIC and service providers to liaise with patient and family on whether the centre can meet patient's needs Service boundary Transport and door-to-door escort availability may be subjected to individual centres
Senior Care Centres (day care + rehabilitation + nursing)	• Support frail elderly with multiple social and healthcare needs • Provide day care, dementia day care, day rehabilitation services and basic nursing services	
Day Rehabilitation Centres	• Provide sessional therapy sessions for patients who are assessed to benefit from active rehabilitation, such as those post-stroke, post-surgery, etc. • Some centres offer day care service	
Day Care Centres	• Provide daycare, maintenance exercise, and recreational activities for frail seniors when their family or caregiver are at work	
Dementia Day Care Centres	• Provide a structured day care service for people with dementia • Requires a formal diagnosis of dementia for application	
Hospice Day Care	• Provide Structured day care service for people who are terminally ill • Provide nursing and medical care for symptom management, counselling and caregiver support and therapy service • Requires formal diagnosis and prognosis • Only two hospices: HCA and Assisi.	
Centre-based Weekend Respite Care	• Provide day care for adult or senior clients whose caregivers require weekend day respite • Family may need to arrange own transportation	Public can apply directly to centres by downloading the form from AIC and submitting it to them Do not require doctor referral
Senior Activity Centres	• Provide drop-in centres for seniors to take part in recreational activities and stay connected to their community	Usually serves needy and vulnerable seniors living in HDB rental flats and studio apartments

Table 8: Residential-based Services

Types	Description	Remarks
Welfare Homes	• Admissions are statutory and under the provisions of the Destitute Persons Act.	Call Destitute Persons Service (DPS) at Ministry of Social and Family Development (MSF) to enquire about welfare home's admission Tel: 1800 2220000
Sheltered Homes	• Offer residential care for seniors above 60 years old who are ambulant and able to care for themselves	Refer to AIC via hard-copy referral form with supporting documents Under the purview of MSF. AIC assists with the facilitation of referrals Call Singapore Silver Line for more information Tel: 1800-650-6060 <u>Supporting documents:</u> NRIC, referral form, medical report, social report, results of chest X-rays (<6 months), certified fit for communal living, RAF, AMT, discharge summary, financial information documents
Senior Group Homes	• Aim to provide an assisted living home for seniors above 60 years old to co-reside independently in designated HDB rental flats retrofitted with elder-friendly features • Community support services will be referred, if needed	
Community Hospitals	• Provide rehabilitation and sub-acute care for up to 30 days • Examples: Bright Vision Hospital, St. Luke CH. Ang Mo Kio CH, Ren Ci CH, St Andrew CH, Jurong CH and Yishun CH	Refer to AIC via AIC IRMS
Nursing Home	• Provide nursing care and help with ADLs for patients, who are unable to be cared for at home and community • Examples: Pearl's Hill Care Home, All Saints Home, Home for the Aged Sick	Approach AIC, service provider or Medical Social Worker for more information VNH: through AIC IRMS PNH: own family's arrangement
Chronic Sick Unit	• To provide residential care for patients with high nursing needs due to tracheostomy or serious chronic wounds. • Examples: Ren Ci Community Hospital & Bright Vision Hospital	Approach AIC, service provider or Medical Social Worker for more information Refer to AIC via AIC IRMS as per VNH application
Inpatient Hospice	• To provide residential care for patients with terminal illness (both cancer and non-cancer) with less than 3 months' prognosis • Examples: Bright Vision Hospital, Assisi Hospice, Dover Park	Approach AIC, service provider or Medical Social Worker for more information

and chronic conditions. For further information log on to https://www.chas.sg.

Other financial schemes include Foreign Domestic Worker (FDW) levy concessions for persons with disabilities, FDW grant, Eldershield, Pioneer Generation Disability Assistance Scheme (Pioneer DAS), Interim Disability Assistance Programme for the Elderly (IDAPE), Dependent Protection scheme and Silver support scheme. To be eligible for the FDW grant, the care recipient must be a Singaporean who needs permanent assistance in at least three ADLs. The functional assessment report needs to be filled by an assessor (e.g. SMF fully registered doctor) and sent together with the application form to AIC via email, snail mail or walk-in at their main office (Maxwell).

Social Services Offices (SSO) provide assistance for low-income individuals and families who are temporarily or permanently unfit to work.[26] The applicant must have little or no family support, savings or assets to rely on for daily needs. They will receive rental, utilities or service and conservancy charges vouchers, monthly cash grants, education assistance, and medical assistance. To apply, the client can email to comcare@msf.gov.sg or visit the respective SSOs. Patients can also approach the nearest community club or their grassroot leader for assistance.

Senior Mobility and Enabling Fund (SMF) is a government subsidy for assistive devices, consumables and transportation for Singaporeans.[27] There is a slight difference in criteria for SMF application for assistive devices, consumables, and transportation.

- For assistive devices, only those aged 60 years and above can apply for SMF funding (per capita household income < $1800).
- For transportation, only those aged 55 years and above that attend an MOH-funded day rehabilitation centre, dialysis centre, or dementia daycare centre can apply for SMF funding (per capita household income < $2600).
- For consumables, the application can only be made by Home Medical/Nursing services/SPICE service providers and the per capita household income must be $1800 and below.

For households without income, the annual value of their residence will need to be less than $13,000. For patients who need assistance and are not followed up by any therapist, you may email the SMF application form (downloaded from Silver Pages website) with the patient's signature to smf.community@aic.sg.

Psycho-emotional Support

Family Service Centres located conveniently within housing estates provide financial assistance, referrals, counselling services, and psychosocial support to affected individuals and families. Some of the services, such as counselling, are chargeable. They only serve the clients within their service boundary. To locate the nearest FSC, go to http://app.msf.gov.sg /dfcs/familyservice /default.aspx and enter your postal code. For caregiver support, go to Sage Counselling, O'Joy Care Services, Tsao Foundation, and Caregiver Welfare Association (CWA). Besides counselling support, CWA also provides financial assistance, food rations, and home nursing care. For dementia-related support, approach the Alzheimer's Disease Association.

For **Mental Healthcare Resources**, there have been several programmes and organisations that provide outreach and support people with mental health concerns such as dementia. Examples include Community Resource, Engagement and Support Team (CREST); Temasek Cares—Integrated Promoters of Active living (I-PAL Elder sitting); Person-centred home-based intervention by Alzheimer's Disease Association; Hua Mei Dementia Care System; and Aged Psychiatry Community Assessment and Treatment services (APCATS). For more information, one can download the Directory on Mental Health Services (updated as of January 2016) at https://www.ncss.gov.sg/NCSS/media/NCSS-Documents-and-Forms/NCSS%20Internal%20Documents/Directory-on-Mental-Health-Services_Jan-2016.pdf. Referrals are made directly to the respective organisations via hard-copy referral forms.

How To Find These Community Resources?

It can be a daunting task for healthcare professionals and the clients to navigate this web of services available. For the computer savvy, you can access and find the resources that you need from the Agency for Integrated Care website at http://aic.sg or send an email enquiry to enquiries@aic.sg. The Apps called **ELDERCARE LOCATOR** and **AlCare Link** for smart phones are available on the Apple app store and the Google play store for download free of charge. You can also call the Singapore Silver hotline at 1800-650-6060. Other services are usually a phone call away or a click of the mouse (Table 9).
To facilitate enquiry from the patients and their caregivers AIC has set up hubs at various restructured hospitals (Table 10).

Linking to Services

Finally, how do you link the patients to the services that they need? Let us enlist the help of this patient and use him as an illustration.

He is a 68-year-old man, married with no children. The main caregivers are his wife and domestic helper. Prior to this, he was a very healthy and active man, having a stable income. He has had Parkinson's disease since 2012. He had multiple admissions to the hospital mainly for pneumonia. In recent months, he has deteriorated drastically, becoming more bed-bound. He has been started on tube feeding as he was assessed by the speech therapist to be unsafe for oral feeding. He is now on diapers and needs suctioning at times for his secretions. He has slurred speech and during the recent admission, found to have a sacral ulcer.

Patient's care was taken over by the hospital's Family Medicine department because of recurrent admission.

A care conference was held with the wife and domestic helper to discuss care goals and plans. An MDT discussion was held with the doctor, medical social worker, physiotherapist, occupational therapist, speech therapist, and pharmacist in the hospital to discuss future care plans and to look into the family's psychosocial needs.

1. The patient feels depressed and frustrated over his loss of independence and being a burden. With his recurrent lung infections/pneumonia, he is confused and/or agitated at times.
2. His wife is highly anxious in caregiving because, in view of several episodes of "near death", she is worried about losing him. She does not talk to friends/relatives about her own problems. She tries her best to provide care for the patient and respect his wishes to be at home. However, she finds it more difficult to with his increased care needs.
3. When a crisis happens (e.g. lung infection/persistent fever), his wife admits him to hospital though he prefers to stay at home. The wife expressed difficulties in managing his care and anticipating the "worst" scenario that could happen. She feels that it would be safer for the patient to be cared at the hospital.

Using RAF, the patient would fall into category 4. He has high care needs. Referral can be made to the community hospital for wound care and caregiver training for the domestic helper. However, the patient and wife prefers him to be cared for at

Table 9: Useful Contacts [28,29]

General	
Comcare — 1800-222 0000 - Directs caller to the appropriate agency for assistance when the caller does not know how to go about seeking assistance	Monday to Sunday: 7.00am to 12 midnight
Silver Line — 1800-650 6060 - Provides information and assistance on eldercare-related services & for loss of PG card	Monday to Friday: 8.30 am to 8.30 pm Saturday: 8.30 am to 4.00 pm
SG Enable — 1800-8585 885 - Provides information and assistance on child and adult disability-related services	Monday to Friday: 8.30 am to 6.00 pm Saturday: 8.30 am to 12.30 pm Closed on Sundays and Public Holidays
Dementia Helpline by Alzheimer's Disease Association — 6377 0700 - Provides assistance and information in caring for a person with dementia.	Monday to Friday: 9 am to 6.00 pm
Dementia InfoLine by Health Promotion Board — 1800-223 1123 - Provides information on dementia-related matters	Monday to Friday: 8.30 am to 5.00 pm Saturday: 8.30 am to 1.00 pm
Samaritans of Singapore (SOS) — 1800-221 4444 - Provides confidential emotional support for those in crisis, thinking of suicide or affected by suicide	24 hours
Institute of Mental Health (IMH) Helpline — 6389 2222 - Provides support for those facing a mental health crisis	
Singapore Association for Mental Health (SAMH) Helpline- 1800-283 7019 - Provides information and assistance on mental health matters and psychosocial issues	Monday to Friday: 9.00 am to 6.00 pm
National Addictions Management Service (NAMS) All Addictions Helpline — 6732 6837; nams@imh.com.sg (general enquiries) - Provides services to assist people who face with addiction problems	Monday to Friday: 8.30 am to 6.00 pm Closed on Public Holidays

Counselling/ Support	
Seniors Helpline — 1800-555 5555	Monday to Friday: 9.00 am – 7.00 pm Saturday: 9.00 am to 1.00 pm Closed on Sundays and Public Holidays
Singapore Action Group of Elders (SAGE) Counselling Centre — 6354 1191; counselling@sagecc.org.sg	Monday to Friday: 8.30 am to 5.30 pm
O'Joy Care Services (for older persons) — 6749 0190; admin@ojoy.org	Monday to Friday: 8.00 am to 5.30 pm
AWWA Caregiver Service — 6511 5318 / 6636 8194; caregiver@awwa.org.sg	Monday to Friday: 9.00 am to 6.00 pm Closed on Public Holidays
Caregiver Welfare Association — 6466 7957 or 6466 7996	-
Association of Women for Action and Research (AWARE) ,— 1800-774 5935 - Offers empathy, support, information and encouragement to women in need of assistance	Monday to Friday: 3.00 pm to 9.30 pm
Care Line by Touch Caregivers Centre — 68046555; caregivers@touch.org.sg	Monday to Friday: 9.00 am to 5.00 pm Saturday: 9.00 am to 1.00 pm Closed on Public Holidays and eves of Christmas, New Year and Chinese New Year
Family Violence Specialist Centres in Singapore	
TRANS SAFE Centre — 6449 9088; transsafe@trans.org.sg	Monday to Friday: 9.00 am to 5.00 pm
PAVE — 6555 0390; admin@pave.org.sg	Monday, Tuesday, Thursday & Friday: 9.00 am to 1.00 pm & 2.00 pm to 6.00 pm Wednesday: 9.00 am to 6.00 pm & 6.30 pm to 9.30 pm (appointment only) Closed on Saturdays, Sundays & Public Holidays
Care Corner Project StART — 6476 1482; projectstart@carecorner.org.sg	Monday to Friday: 10.00 am to 5.00 pm Monday & Tuesday: 5.00 pm to 9.00 pm (appointment only) Closed on Saturdays, Sundays & Public Holidays
Others	
Central Provident Fund (CPF) — 1800-227 1188	Monday to Friday: 8.00 am to 5.30 pm

Table 10: Location of AICare Links[30]

Touch point	Address	Nearest MRT station	Operating hours
AICare Link @ Changi General Hospital	2 Simei Street 3 S(529889) Located within CGH Discharge Lounge at CGH Main Building, Level 1, Atrium (next to Pharmacy B)	Simei (EW3)	Monday to Friday: 9.30 am to 6.00 pm Saturday: 9.00 am to 1.00 pm Closed on Sunday and public holiday
AICare Link @ National University Hospital	5 Lower Kent Ridge Road Singapore 119074 Located within NUH Information Centre, NUH Main Building Lobby B, Level 1 (opposite the Coffee Bean and Tea Leaf Café)	Kent Ridge (CC24)	
AICare Link @ Tan Tock Seng Hospital (TTSH)	11 Jalan Tan Tock Seng Singapore 308433 CareConnect, Level 1, Atrium	Novena	
AICare Link @ Ng Teng Fong General Hospital (NTFGH)	1 Jurong East Street 21 Singapore 609606 Tower B, Level 2 (near Visitor Self-registration Kiosk)	Jurong East	
AICare Link @ Khoo Teck Puat Hospital	90 Yishun Central Singapore 768828 Located within Patient Service Centre, Tower B, Level 1	Yishun (NS13)	Monday to Friday: 9.30 am to 6.00 pm Saturday: 8.30 am to 12.30 pm Closed on Sunday and public holiday
AICare Link @ Maxwell	7 Maxwell Road Annexe B Level 4, Singapore 069111	Tanjong Pagar (EW15)	Monday to Friday: 8.30 am to 5.30 pm Closed on weekends and public holiday

home. Means testing was done and they qualified for 80 percent subsidies and 90 percent SMF funding. The care plan formulated for him is as follows:

- In view of frequent admissions and seeing the need to manage the patient's fluctuating medical conditions and symptoms, a referral was made to the Transitional Home Care (THC) Service, to provide an interim tier of support for smoother transition of care within three months' post-acute hospitalisation stay.
- PT/OT/ST will do home visits as well for maintenance as part of the THC programme.
- MSW will provide psychosocial support for the patient and his wife.
- Home nursing service was referred for NGT care and wound care.
- Home personal hygiene service was referred to help the wife in caregiving (showering) when the helper has her day off during the weekend.
- Caregiver training was given to the domestic helper and wife on how to care for the wound and on pressure-relieving techniques.
- SMF funding was applied to help purchase a hospital bed and pressure-relieving mattress for the patient.

Regular MDT discussion will also be done during the course of follow-up at the patient's home to chart his progress and look into his care needs. The team will also look into an alternative homecare provider for the patient when he completes THC.

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LEARNING POINTS

- **It is important to recognise the trajectory of the medical condition and its impact on the medical management and goal of treatment. Not only that, the medical progression affects beyond just the medical realm; it affects a person's psychological and social realms.**
- **Caregiving is the impact of the progression of the medical condition, which may have underlying family, financial or psycho-emotional issues. It would be helpful to see the connection between the trajectory of the medical conditions and their impact on the medical and psychological care. An MDT is needed to support the patient and caregiver in this journey.**
- **The doctor-patient relationship and trust is crucial in care planning and is the crux to the establishment of treatment goals. MSWs'/ case managers' involvement are important in bridging the social and medical care.**
- **With the complex health issues (medical/ mental health) existing in both patient and caregiver, it is crucial to link the patient's medical and social care needs. At the same time, the team will need to look at both the patient's and caregiver's issues as they are inter-related.**
- **Although currently there has been an increase in the number of services in the community, gaps still exist, especially in the coordination of healthcare and psychosocial care services.**
- **The ideal care integration provides a smooth transition of patients from the hospital to ILTC and subsequently to the community. Good discharge planning during admission to the hospital is a critical component of transitional care integration to reduce unnecessary hospital stay and unscheduled readmission. It will help to channel patients to the appropriate community resources to match their needs.**

Annex A: RAF

Resident Assessment Form (For Nursing Home Resident) [to be completed by nurse, nurse case manager or doctor]				
Name:			NRIC No:	
Rating	A	B	C	D
Q1 Mobility (Guide Bk Pg1)	Independent 0	Requires some Assistance (physical/assistive device 3	Requires frequent assistance/ turning in bed 10	Requires total physical assistance 16
Q2 Feeding (Guide Bk Pg 2)	Independent 0	Requires some Assistance 3	Requires total Assistance 10	Tube-feeding 10
Q3 Toileting (Guide Bk Pg 3)	Independent 0	Requires some physical assistance 3	Requires commodes / bedpans / urinals 8	Incontinent and totally dependent 16
Q4 Personal Grooming & Hygiene (Guide Bk Pg 4)	Requires no assistance 0	Requires assistance for some activities/ supervision 2	Requires assistance for all activities 4	Bed/ trolley bathing 6
Q5 Treatment (Guide Bk 5-6)	Daily Medication Oral/Topical : 1 pt	Daily Medication Oral/Topical : 1 pt Injection: 2 pts	Daily Medication Oral/Topical : 1 pt Injection: 2 pts Physiotherapy:4 pts	Daily Medication Oral/Topical : 1 pt Injection: 2 pts Physiotherapy:4 pts Sp*procedures @1 pt/ 5 min
Q6 Social & Emotional Needs (Guide Bk pg 7)	Nil 0	Occasionally 1	Often 2	Always 3
Q7 Confusion (Guide Bk Pg 8-9) ▪ loses way ▪ loses things ▪ disorientated	Nil 0	Occasionally (1-3 times a week) 3	Often (4-6 times a week) 8	Always (Daily) 10
Q8 Psychiatric Problems (Guide Bk 10-11) ▪ hallucination ▪ delusions ▪ anxiety ▪ depression	Nil 0	Mild Interference in Life 2	Moderate Interference in Life 4	Severe Interference in Life 6
Q9 Behaviour Problem (Guide Bk pg 12-13) ▪ restless ▪ disruptive ▪ absconds ▪ uncooperative	Nil 0	Occasionally (1-3 times a week) 3	Often (4-6 times a week) 10	Always (Daily) 16
Total Points		**Category 1 2 3 4** *(Circle)*		

* Sp – Special #Pt – Points

Category 1	<6 pts	Category 2	7 – 24 pts
Category 3	25 – 48 pts	Category 4	>48 pts

Name of Officer Completing RAF : _____/ NRIC/FIN number: _____

Designation/Institution _____/_____

Date _____

Community Resource Sheet

Type of Service applicable/ available	Level of Care required based on Resident Assessment Form (RAF)			
	Category 1 (<6pts) • **Ambulant** • **ADL- independent**	**Category 2 (7-24 pts)** • **Semi-ambulant** • **ADL semi-independent/ wheelchair-independent** • **Low cat 2 vs. High cat 2**	**Category 3 (25-48pts)** • **ADL-assisted, Wheelchair-bound** • **Requires medical and nursing care**	**Category 4 (>48 pts)** • **Bedbound, ADL-dependent, NGT-feeding/ IDC/ diapers** • **Requires medical and nursing care**
Home-based	**Dementia/ Psychiatric** • Person-Centred Home-Based Intervention by Alzheimer's Disease Association • Community Rehabilitation Support & Service (CRSS) programme	• Interim caregiver service • Respective restructured hospital's Transitional Home Care (THC) (Up to 3 months' post-discharge follow up) • Home Medical service • Home Nursing service • Meals-on-Wheels, Medical Escort and Transport, Home Personal Hygiene services • Home Therapy services (Active rehab) • Home modification (E.g. HDB EASE or Safe Home Scheme by TOUCH) • Senior Mobility and Enabling Fund (SMF) • Senior Activity Centre's Cluster Support • AIC Community Case Management Service (CCMS) • Home Hospice Service **Dementia/ Psychiatric** • Senior Activity Centre's Community Resource, Engagement and Support Team (CREST) • Integrated Promoters of Active Living (i-PAL Elder sitting) • Person-Centred Home-Based Intervention by Alzheimer's Disease Association • Project Angels @27FSC • Aged Psychiatry Community Assessment & Treatment Services (APCATS) by IMH • Community Rehabilitation Support & Service (CRSS) programme • Hua Mei Dementia Care System	• Interim caregiver service • Respective restructured hospital's Transitional Home Care (THC) • Home Medical service • Home Nursing service • Meals-on-Wheels, Medical Escort and Transport, Home Personal Hygiene services • Home Therapy services (Active or maintenance rehab) • Home modification (E.g. HDB EASE or Safe Home Scheme by TOUCH) • Senior Mobility and Enabling Fund (SMF) • Senior Activity Centre's Cluster Support • AIC Community Case Management Service (CCMS) • Home Hospice Service **Dementia/ Psychiatric** • Senior Activity Centre's Community Resource, Engagement and Support Team (CREST) • Integrated Promoters of Active Living (i-PAL Elder sitting) • Person-Centred Home-Based Intervention by Alzheimer's Disease Association • Project Angels @27FSC • Aged Psychiatry Community Assessment & Treatment Services (APCATS) by IMH • Community Rehabilitation Support & Service (CRSS) programme • Hua Mei Dementia Care System	• Interim caregiver service • Respective restructured hospital's Transitional Home Care (THC) • Home Medical service • Home Nursing service • Meals-on-Wheels, Medical Escort and Transport, Home Personal Hygiene services • Home Therapy services (maintenance rehab and CGT) • Senior Mobility and Enabling Fund (SMF) • Senior Activity Centre's Cluster Support • AIC Community Case Management Service (CCMS) • Home Hospice Service
Integrated Home and Day Care Package (Pilot)	NA	NA	Integrated Home and Day care Package (Has service boundary and assessed based on type and level of care needs and tailor the suite of services, which can be home based and/or centre based).	
Community-based/ Centre-based	• Senior Activity Centres (Elderly drop-in centres under rental HDB blocks and provides less structured activities) • Social Day Care (Provides more structured activities)	• Day rehabilitation Centre • Day Care • Senior Care Centre (3-in-1) • Weekend centre-based respite service • Hospice Day Care (transportation available but no door-to-door escort available) **Dementia** • Dementia Care Centre (preferably with no BPSD)	• Day rehabilitation Centre • Social Day Care • Senior Care Centre (3-in-1) • Weekend centre-based respite service • Singapore Programme for Integrated Care for the Elderly (SPICE) (For those who can tolerate at least 4 hours of sitting tolerance and within service boundary) **Dementia** • Dementia Care Centre (preferably with no BPSD)	NA
Residential-based	• Community/Sheltered Home • Destitute home (for people who are homeless)	• Sheltered home (for low Cat 2 only but limited spaces) • Senior Group Home • Community Hospital (for good rehab potential or caregiver, arrival of new maid, sub-acute care) • Transitional Convalescent Facility (TCF) (more than one month of rehab but has good rehab potential and viable discharge plan) • Dementia-specific/ Psychiatric nursing home • Private Nursing Home • Inpatient hospice (prognosis of <3 months)	• Community Hospital (for rehab/ new maid/ sub-acute care) • Transitional Convalescent Facility (TCF) (more than one month rehab, has good rehab potential and has a care plan) • Voluntary Nursing Home • Dementia-specific/ Psychiatric nursing home • Nursing Home Respite Programme (via AIC-IRMS referral) • Private Nursing Home • Inpatient hospice (prognosis of <3 months)	• Community Hospital (eg. for arrival of new maid/ sub-acute care) • Voluntary Nursing Home (general vs Chronic Sick units) • Dementia-specific voluntary nursing home • Nursing Home Respite Programme (via AIC-IRMS referral) • Private Nursing Home • Inpatient hospice (prognosis of <3 months)

Updated by Christine Lim as at 13/09/2016