UNIT NO. 6

ASSESSING SOCIAL CARE NEEDS AND COMMUNITY RESOURCES FOR COMPLEX PATIENTS

Ms Christine Hindarto Lim, Dr Matthew Ng Joo Ming

ABSTRACT

Improvements in medical science and increasing survival rates on a background of an ageing population have changed the disease demographics in Singapore towards one with an increasingly complex chronic disease burden. Many will need to tap on community resources to age gracefully in place. The increasing number of single elderly who live alone also provides a challenge as research has shown that they are the highest users of healthcare resources. In Singapore, there is no lack of schemes to help the elderly poor as compared to other countries in the region. The problem, rather, is that there are too many targeted help schemes – with varying criteria and limiting conditions attached. This leads to an application process that is daunting and has many gaps where some who will benefit from the schemes but don't qualify because they don't meet the providers criteria.

Keywords: Ageing Population; Complex Chronic Disease; Daunting Application;

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INTRODUCTION

The Singapore population is rapidly ageing and living longer, with an increasingly complex chronic disease burden. With improvements in medical science, patients today are living longer but with changing disease profiles. Patients tend to have multimorbidities with at least 3 or more chronic diseases existing in the same individual. It has been estimated that 80 percent of patients have multimorbidities. Today's Family Physicians need to change the way they practice in order to be able to provide 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 will involve enhanced coordination of medical and social care, and providing comprehensive care across the entire cycle of care. This can be achieved by being connected to the health system and resources, 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 Care: Assessment and identification of care issues that must be resolved urgently
B. Integrate Care: Develop a comprehensive care plan and optimise the medical and social care
C. Link: Muster resources to support continuing care in the community

CHRISTINE HINDARTO LIM
Medical Social Worker, Singapore General Hospital

MATTHEW NG JOO MING
Head and Senior Consultant,
Family Medicine & Continuing Care,
Singapore General Hospital

With an ageing population and the increasing complexity of the disease burden, many in Singapore will need to tap on community resources to help them age gracefully in place. As the population care needs get more complex, what is needed is a multi-disciplinary team comprised of doctors, nurses, medical social workers, physiotherapists, occupational therapists, and pharmacists to formulate care plans and link them with the appropriate community and financial resources that meet their needs. Apart from patients' medical conditions and functional status, other aspects such as patients' and their families' resources and relationships, and psychosocial needs will be taken into consideration when formulating a care plan for them. To ensure that patients can age gracefully in place and their needs can be taken care of, the team does not just need to tap on the available formal community resources, but there is a need to enlist the help of patients' friends, volunteers, and religious services as well, when appropriate. 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 elderlies need to seek treatment at acute hospitals or eventually be cared for in nursing homes.

TYPES OF COMMUNITY RESOURCES

The resources available to help patients are divided essentially into three 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 authors' article published in the Singapore Family Physician [2015;41(1):32–45][1] and a summary of the various care resources can be found in the their other article published, also in the Singapore Family Physician [2016:42(4):39–54].[2] Both articles can be assessed and downloaded from the College of Family Physicians' website: http://www.cfps.org.sg

HOW TO ASSESS PATIENTS' NEEDS?

Institutional service providers in the community that are run by private bodies and VWOs are doing a very good job providing care and assistance to families in need. Many rely on philanthropy and government grants to run these services. Services provided by the restructured hospitals are dependent on funding from MOH, while services provided by the hospitals' integrated care teams are subjected to change depending on funding support. 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.

For hospitalised patients, good discharge planning[3] during admission to the hospital is a critical component of transitional care integration. This reduces unnecessary hospital stays and unscheduled readmissions, and it helps to channel patients to the appropriate community resources to match their needs.

Discharge planning should start early, preferably on the first day of admission, identifying discharge destination and community services required. There is a lag time from application to the allocation of resources needed. Therefore, applications need to be submitted early so as not to delay the patient's discharge when he is fit. In addition, we need to ensure that the following are assessed as well:

1. Assess the level of care needed and match patient's needs to the appropriate resources.

Across the Intermediate and Long-term Care (ILTC) sector and among 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** form 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 1).[4]

Table 1: RAF Categories

Category	1 (<6pts)	2 (7–24 pts)	3 (25–48 pts)	4 (>48 pts)
Functional Status	• Physically and mentally independent	• Semi-ambulant • Requires some physical assistance and supervision in activities of daily living	• Wheelchair / bed-bound • Needs help in activities of daily living and supervision most of the time	• Highly dependent • Requires 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 10 points establish patient dependence for feeding, bathing, grooming, dressing, bowel continence, bladder continence, toilet use, transfers, mobility, and ability to climb stairs. Depending on the scores, patients were classified into categories, reflecting their level of dependency (Table 2).[5]

Table 2: 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 services and the level of care needed. A guide (Annex B) that matches the community service with patient's functional status provided for reference.

2. 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.[6] It takes into consideration the following:

2.1 Total monthly gross earnings of patient and family members living in the same household who are 21 years old and above;

2.2 Number of family members; and

2.3 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 (Table 3). If the household has no income, the annual value of their residence is considered instead.

Table 3: Subsidies level for home and community-based services and community hospitals

Per Capita Monthly household Income	Subsidy levels			
	Singapore Citizen		Permanent Residents	
Singapore Dollars	NRS	CH (subsidized wards)	NRS	CH (subsidized 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				

Anyone 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 foreigners, need to be sent to Ministry of Health Holdings (MOHH) at 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 a lack of mental capacity. Once completed, the means testing is valid for two years and registered in the National Means Testing System (NTMS).

IMPORTANT PARTNERS IN MANAGING CARE RESOURCES

There are a number of organisations and Government bodies that provide regulatory oversight for social and healthcare services in Singapore. The important ones are:

1. Agency for Integrated Care (AIC)

The 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. The SMF provides subsidies for mobility aids and equipment up to 90% of the cost for needy patients.

The amount of subsidies depends on means testing and it is usually done when the means testing form is submitted to MOHH. Things to note are that the funds provide subsidies for one item in each category only. The norm cost that is cap for each category of equipment is illustrated in Table 4.

Table 4: Norm Cost cap for device category

Device Category	SMF Norm Cost Cap
Walking Aid	$150
Basic Wheelchair and Pushchair	$500
Motorised Wheelchair and Scooter	$2,000
Commode	$200
Hospital Bed	$1,700
Pressure Relief Cushion	$150
Pressure Relief Mattress	$500
Special Equipment	$3,000
Others	$400

The fund also provides subsidies for transportation and consumables. For transportation, only those aged 55 years and above who attend an MOH-funded day rehabilitation centre, dialysis centre and 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 only and the per capita household income must be $1800 and below.

2. SG Enable

SG Enable is an agency dedicated to enabling persons with disabilities. It 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 who do not qualify for SMF funding.

WHAT'S NEW?

Homecare

The model of transitional homecare mentioned in the Singapore Family Physician [2016:42(4):39–54, Table 5][2] for restructured hospitals has been replace by the Hospital to Home (H2H) programme. Patients at risk of readmission are flagged up by MOH's risk scores and are recruited by the Patient Navigators in the ward. These patients are subdivided into 3 different tiers based on the social, nursing, and medical care needs. The programme is means tested and the amount of copayment that the patients need to pay will depend on the percentage of subsidies. For needy patients, each hospital will have their own needy patients' fund to help with the copayment. Tier 1 patients are usually well patients who do not need any medical or nursing intervention upon discharge. These patients are admitted to a virtual ward system and are followed up with regular phone calls to check on their wellbeing. Patients categorised as Tier 2 need nursing intervention after discharge. The nurses will do home visits to look after these patients at home. Tier 3 patients are those with complex medical problems and care needs. They will be visited by a team of nurses and doctors after discharge from the hospitals. Most, if not all, the programmes in different restructured hospitals are free for the first visit by the nurse or doctor. Subsequent visits and charges will depend on the means testing level. Regular multidisciplinary team meetings are held to discuss these patients' medical conditions and social care needs.

Financial resources

Singapore Healthcare Financing is a tiered system based on government subsidies, Medisave, Medishield life, Medifund (3Ms) and philanthropy in the ILTC sector.[7,8,9] Each individual hospital also has its own needy patients' fund to help the poor. Recently, many people are using social medial platforms such as Facebook and fund-raising website to raise funds to pay for medical and surgical therapy, keeping the "Many Hands" concept alive and active in the community. However, it is timely to remind ourselves and patients that such fund-raising and appeals conducted online are still regulated by the Charities Regulations 2012 if they are targeting the public of Singapore. Fund-raisers will need to fulfil certain obligations:

1. Disclose clear and accurate information to donors about beneficiaries;
2. Provide information on the purpose of the donations; and
3. Keep proper records of donations received and disbursed.

The Commissioners of Charities (COC) that oversee all charities in Singapore can issue restriction and prohibition orders to stop or limit fund-raising activities conducted by organisations and individuals if the activities are deemed improper. Anyone who flouts the fund-raising laws can be fined up to $5000 or jailed up to 12 months or both.

HOW TO ASSESS AND FIND RESOURCES TO MATCH PATIENTS' NEEDS?

For the uninitiated, it can be a daunting task to navigate the web of services available. For the computer savvy, you can access and find the resources that you need from the AIC 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 Line at 1800-650-6060. Other services are usually a phone call or a click of the mouse away [Singapore Family Physician. 2016;42(4):39–54, Tables 9 and 10].

Case Study

Let's take a look at Mr and Mrs C. Mr C is 98 years old, while Mrs C is 89. Mr C is being followed up in the Family Medicine Department Specialist Outpatient Clinic for hypertension, ischaemic heart disease, and dyslipidemia. His wife has no medical problems and is not being followed up by any doctors for any care issues, but she has dementia. Both of them depend on each other for their care needs. They both live in a 1-room rental flat and have a community case manager who comes by to look after them and a neighbor who brings Mr C to the hospital for his regular follow ups. Mr C has been well cared for in the outpatient clinic and has had no admissions since 2015 when he was admitted for falls. Recently, it has become more difficult for Mr C to look after himself and his wife as he has become more frail and has fallen a few times at home. It has been assessed that he is not safe by himself at home. However, he is still independent and able to ambulate short distances with a stick and is able to perform all his ADLs. His RAF score classified him as Category 2. His wife is also Category 2, but she has dementia.

Applications were put up for both of them to be admitted to a voluntary nursing home. His application was rejected but his wife's application was accepted because she has dementia. Looking at the patients' social backgrounds and their dependence on each other, even if they were admitted to the nursing home, they would not be able to stay together. The ideal solution for both of them, and with Mr C's increasing care needs, would be to place them both in a senior group home as they would be able to stay together. The senior group home would have to be able to provide meals, laundry and transportation for Mr C's follow ups in the hospitals. An orientation session was arranged with an NTUC senior group home for Mr and Mrs C and they were happy with the services and facilities. Furthermore, the group home was within walking distance of their current 1-room rental flat.

CONCLUSION

Singapore has a population that is ageing rapidly, and it is estimated that there will be about 900,000 people aged above 65 in the year 2030.[10] 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[11]. These households are not uncommon now due to factors such as ageing population and changing family structures, resulting from personal preferences or unfortunate circumstances or others.

In Singapore, there are many programmes targeting and supporting individuals staying in 1-room government rental flats. Low LL et al, in an article published in Frontiers in Public Health, analysed 14,000 unique patients from the hospital electronic medical and found a correlation between public housing and readmission risk and increased utilisations of hospital services.[12] There is no shortage of programmes and services supporting these patients in the community. In Singapore, there is no lack of schemes to help the elderly poor, unlike in some other countries in the region. The problem, rather, is that there are too many targeted help schemes; with varying criteria and limiting conditions attached. This creates two types of problems.

1. Confusion and lack of understanding, leading to the elderly not to seeking support.

2. Having to jump through hoops to meet criteria, which means that some will fall through the cracks.

For example, when an elderly poor applies for Comcare assistance, the process is so daunting. As a result of the rigorous checks, many who may qualify end up giving up halfway.

Another bigger problem is social isolation for those who live alone, who are unable to work, or who are homebound due to disability, failing health or mental illness. This isolation from the outside world feeds depression and suicidal tendencies, aggravates mental conditions, and worsens their physical health. These individuals usually pass under the radar unless someone, such as a neighbour, visits them or when they are hospitalised. Luckily for most, there is now a thriving network of welfare groups, charities, cluster support, hospitals, and operators like NTUC healthcare providing companionship and looking after their wellbeing. A poor senior who is homebound can be served by a network of befrienders, meal delivery services, home nurses, housekeeping services, and social workers.

Sometimes, as healthcare workers, we may not have solutions that fit every individual need. At the end of the day, what matters most is the journey that we travel with these patients and the knowledge that we have made a difference to their lives.

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LEARNING POINTS

- **With the complex health issues (medical/mental health) existing in both patient and caregiver, it is crucial to link both the patient's medical and social care needs.**
- **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 problem is not the lack of services in Singapore, rather, it is that there are too many targeted help schemes — with varying criteria and limiting conditions attached. The application process is daunting, leading to the applicant giving up rather than following through.**
- **The ideal care integration provides a smooth transition for patients from the hospital to ILTC care 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 stays and unscheduled readmissions. It helps to channel patients to the appropriate community resources to match their needs.**
- **To have a better understanding of the community resources available, the authors' previous two articles published in the Singapore Family Physician should be read together: SFP. 2015;41(1);32–45 and SFP. 2016;42(4):39–54.**

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 • COMmunity Intervention Team (COMIT)	• Interim caregiver service (Application applicable only during inpatient stay at restructured hospitals or community hospital) • 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** • COMmunity Intervention Team (COMIT) • 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 • Aged Psychiatry Community Assessment & Treatment Services (APCATS) by IMH • Community Rehabilitation Support & Service (CRSS) programme • Hua Mei Dementia Care System	• Interim caregiver service (Application applicable only during inpatient stay at restructured hospitals or community hospital) • 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** • COMmunity Intervention Team (COMIT) • 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 • Aged Psychiatry Community Assessment & Treatment Services (APCATS) by IMH • Community Rehabilitation Support & Service (CRSS) programme • Hua Mei Dementia Care System	• Interim caregiver service (Application applicable only during inpatient stay at restructured hospitals or community hospital) • 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	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) • 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) • Private Nursing Home • Inpatient hospice (prognosis of <3 months)

For more information on eldercare services, please log on to Agency for Integrated Care (AIC) website – www.aic.sg or Silver Pages - www.silverpages.sg/ or call Silver Line at 1800-650-6060.

Updated by Christine Lim as at 02/05/2017