Singapore Healthcare Management 2019

Bright Vision Hospital

Wong PY[1],Tan YH[3],Ng BH[2], Chan FY[2], Tan SK[4], Lee KH[1]

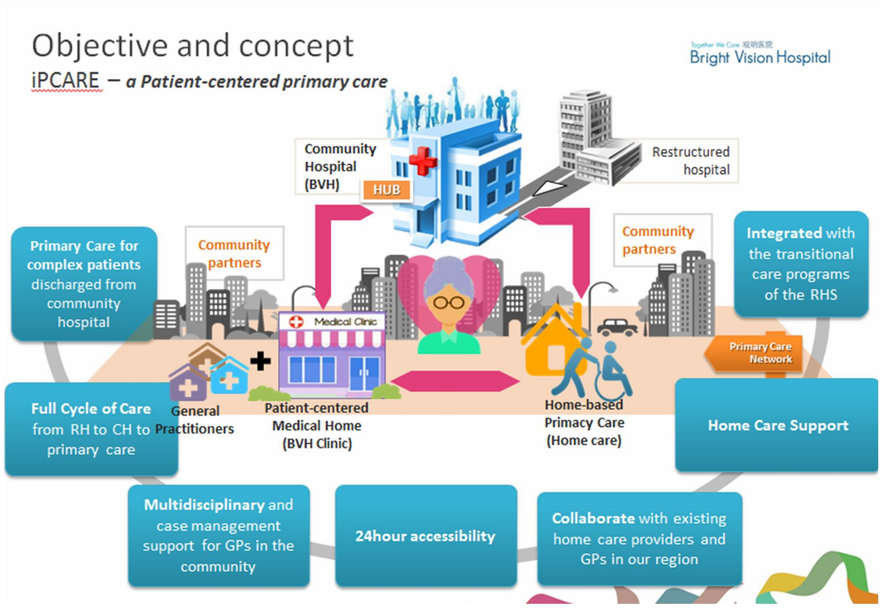
[1]Medical Admin, [2]Nursing Admin, [3]Medical Social Services, [4]Ambulatory Care Services

Integrated Primary Care for At-Risk Elderly (IPCARE)

BACKGROUND

About 5% of patients discharged from acute hospitals need subacute or rehabilitative care in a community hospital before they can return to the community . With the aging population this is expected to rise to beyond 10% within a few years. These patients are elderly with multiple co-morbidities.They have complex health and social care needs. The present primary care system cannot meet their needs. As a result their condition deteriorate and they continue to receive most of their care from the hospital system. This is costly and unsustainable. Supporting primary care with resources and expertise through community hospitals may be a better solution.

PROJECT AIM



Bright Vision Hospital (BVH) piloted IPCARE (Integrated Primary Care for At Risk Elderly). We operate BVH Community and Continuing Care Clinic (CCCC) which provides transitional primary care for patients with complex care needs. The care model combines the organizing principles of the patient centred medical home and transitional care. We recruited GP clinics in the community around our hospital who are willing to partner us and take over the primary care of such patients after the transitional care period of between 3 to 6 months. Our hospital continue to support the GP partners with case management and multidisciplinary care support. The services provided include ambulatory care; home medical/nursing visits; 24hour access; case management; ambulatory/home physiotherapy /occupational therapy, medical social support and coordination of social care services.

DETAILS OF PROJECT

Eligible Patients

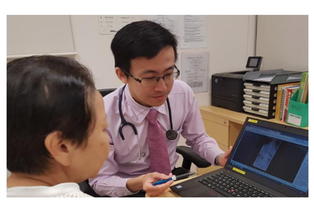
1. BVH inpatients
2. BVH Clinic patients
3. BVH Day Rehabilation patients

Recruitment Criterion

- ≥ 60 years old
- Residents
- Not discharging to nursing homes
- Lives with 2km of BVH

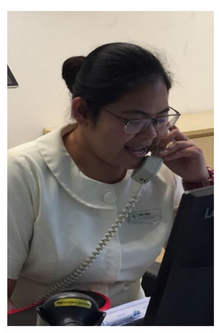
Our IPCARE pilot will complete in 3 years. Phase 1 (first 1.5 years) aims to care for our patients through BVH CCCC and home visits (target: 300 patients). Phase 2 (next 1.5 years) involves recruitment of general practice (GP) partners and subsequently transiting these patients to them (target 600 patients and 20 GPs.

THE SERVICES


Medical Consultation

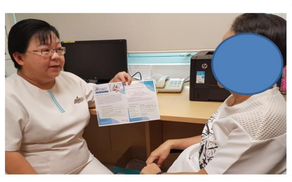

Nursing Care


Support and resources for GPs


24hour Accessibility


Home Therapy


Medical Social Worker Support


Case Management

PATIENT CENTREDNESS ANCHORED IN PRIMARY CARE

Bright Vision Hospital

Criterion for transiting care to GPs

- Medically stable patients
- Patients who consent to the transit of care

Transit of care does not mean cessation of care from BVH.

Continuing care still continues in the form of

1. Case management
2. Community-based coordination of services
3. Assisting GPs in house calls, coordinating specialist and community support and providing ambulatory care when the GPs are unavailable.

Dr Teo (left), our GP partner with our successfully transited patient under iPCARE.

RESULTS SO FAR

As of 16 January 2018, we are 9 months into our 36 months program. The acceptance of both patients and GP partners for this new model of care was better than expected. We have recruited 218 patients (phase 1 target 300). Due to the enthusiastic response from potential GPs in our community, we have decided to proceed ahead of schedule and started recruiting GP partners. We have recruited 8 GPs (phase 2 target 20)

To date, we have managed to transit 6 patients to each of the 8 partners. The feedback from both patients and GP partners had been very positive

IMPACT OF IPCARE

" IPCARE Nurse S is able to advise my dad on what he should and should not do in his native language. Dr A is patient to hear our concerns and explain clearly…provide next step for my dad."

Ms PLL, daughter of our IPCARE patient Mr PKC

" I'm happy and glad that I was decanted to ** Family Medicine Clinic."

Our IPCARE patient Mr TBK

" My family is glad that the IPCARE team can come and visit my husband who is bedbound. We have received useful advice on how to manage him at home (suctioning of secretions, tube feeding and monitoring ."

Mdm Y, wife of Our IPCARE patient Mr YAT

"… I'm grateful to the IPCARE team for being so supportive and available during the difficult times when my mother was suffering from end stage lung disease. I wish them all the best in the endeavors…"

Ms V, daughter of our late IPCARE patient Mdm TAM

"… I'm so happy that my mum has found a GP close to her house. It is so convenient for her…."

Mdm Y, daughter of our IPCARE patient Mdm KSK

" I'm proud to be part of a team providing holistic and realistic care to patients with complex conditions. It's only in going through this humbling process of coordinating care from hospital to home that made me realize there's so many unmet challenges faced by our primary care colleagues and patients and appreciate the vital role of timely primary care in the community "

Dr Andrew Wong, Family Physician

SUSTAINABILITY AND SPREAD

IPCARE is the proof of concept of a new and sustainable model of primary care that will meet the needs of elderly patients with complex medical and social care needs. Presently these patients are at high risk of receiving suboptimal care when they use hospitals as providers of primary care. This model of care can be easily replicated by community hospitals with a network of empowered GPs in the community.