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Joint SGH-NTUC Health Cluster Support Case Conference to enhance patient care journey – An Experience from an Acute Hospital in Singapore

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Introduction

This paper will present the experience gained in bringing about better patient care in the community through such a joint SGH-NTUC Health Cluster Support case conference.

Journey of collaboration

April 2014

- **Medical Social Services (MSS) at Singapore General Hospital (SGH) started to have joint case conferences with NTUC Health Cluster Support, on cases that require continuing community care upon discharge from SGH, on a two-monthly basis**

January 2015

- **MSS extended the joint case conferences to include SGH Patient Navigators (PN) and Care Coordinators (CC) to provide nursing expertise.**

February 2016

- **With feedback gathered from the various care providers, the frequency of the joint case conference reduced to once quarterly to focus on patients with more complex medical and social circumstances.**

Aims of the joint case conference

- **to serve as a case discussion platform**
- **to understand the common difficulties**
- **to improve on the referral process**
- **to identify service gaps and examine the need for a more holistic case management outcome**

Methodology

Patients were short-listed by NTUC Health Cluster Support two weeks prior to the joint case conference.

Patients' concerns and updates were shared and the referring MSW or last known MSW were included in the case conference.

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The list of patients and their concerns were then tabled for discussion, where care providers (MSWs, PNs, CCs and NTUC Health Cluster Support) come together to give progress update and discuss on the challenges faced

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Joint assessment and intervention plans were formulated.
If time permits, there were exchanges of updates on community resources

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Following the discussions, the care providers followed up on the patients' care according to the co-created assessment and intervention plans

Results

Bringing care partners together via such care conference ensured better integration of care for patients. From April 2014 to February 2016, 89 patients who needed continuing care in the community have been discussed over 11 joint case conferences.

These patients are elderly, above 60 years, with poor social support, complex social circumstances, and coupled with medical and nursing needs.

These joint case conferences enabled:
(1) an establishment of common understanding and assessment of patients' needs, among the care providers,
(2) better and consistent care coordination for patients,
(3) right siting of patients' care needs.

More importantly, the co-sharing of responsibility to provide patient care brought about effective collaborative effort among care providers in providing care to the elderly sick in the community.

Case example

Mdm T was an elderly lady in her 80s when she was referred to NTUC Health Cluster Support. She suffered from multiple medical co-morbidities and was living alone. Mdm T's only daughter lived apart from her and could not provide additional care support for her.

Mdm T relied on her umbrella for support while she ambulate and is home-bound due to her weak legs. Concerns pertaining to her care needs were shared during a case conference. In view of her low mood and deteriorating memory, a joint care plan was developed to provide Mdm T with meals delivery, medication reminder and befriender services. Plans to refer Mdm T for social day care services were also explored.

Post case conference, the care plan was implemented by the respective community care providers. NTUC Health Cluster Support continued to monitor patient's status in the community. Mdm T's daughter also received added support from the service providers to cope with her caregiving role. Mdm T's health needs was well managed in the community and she did not require any re-admission to the hospital.

Conclusion

Follow-up care for the elderly who have none or little family support sees the need for medical and social care model integration in care arrangements.

Multi-stakeholder case conference also enhances collaboration among health care workers and community partners.

More importantly, it aligns care assessment and management so as to ensure a continuity of care for patients and in achieving a seamless transfer of their care from the hospital to the community.