HOME FIRST!

Delivering Care Closer to Home

Philosophy Statement

"*Home First* is a person-centred approach to care focused on keeping seniors safe in their homes for as long as possible with community support. If they were to be admitted to hospitals, it aims to enable elderly to return and remain home.

Under *Home First*, transferring elderly patients to a residential facility is explored only after all community care options (e.g. non-residential facilities, home-based services) are considered."

Adapted from Ontario LHIN Collaborative

What is ‘Home First’?

- 2 Key aspects of ‘Home First’
  - There are adequate community care options, in terms of range and type, to be considered BEFORE residential care options following hospital admission episodes
  - To maintain patients needing long-term care safe in their homes for as long as possible with community support.

- Key objectives
  - Ensure smooth transition of care
  - Allow high needs patients to remain at their homes with community support
  - Enable patients and caregivers to partner the providers and participate in the care delivery
  - Community care as a variable alternative to residential care for patients needing long-term care
  - Support Caregivers in their roles

Some barriers to 'Home First'

- Lack of system capacity in caring for high-needs patients
  - While capacity for both centre-based and home-based services is expanding, it does not meet the needs of patients with
    - Dementia with behavioral problems
    - Multiple medical conditions, e.g. renal failure with hip facture
    - Complex care needs, e.g. ventilation support
    - Fragile caregiver support
  - Very limited options for caregiver respite
  - Challenges in obtaining other support services to enable patients to remain at home
- Lack of standard care assessment framework to consistently assess long-term care needs for service matching and placement
- Lack of community capability in managing care transition
- Lack of awareness and understanding of community care options among the healthcare professionals and with the general public
- Lack of appropriate funding gradient in supporting community care options

In a nutshell..

Managing Transition Well

- Service Link (I&R) to tailor to patients' needs
- Care assessment Team
- Transitional care to handhold

Primary Care

Supporting Community Care

- GPs
- Geriatric/Medical assessment
- Pharmacy for medication dispensary
- Diagnostic services

Improving Capability & Comprehensiveness of Community Care

- Home-based Care
- Centre-based Care
- Embedded respite option

Supporting Patients and Caregivers

Improving Community Integration

- Complex case management
- Community I&R
- One-stop contact centre

Home/Centre-based care + **Case Management**

Go Local

Imagining a Hybrid of Health-Social …

Inspirations from the Anglican Community: St. Hilda's Link

1999

St. Hilda's Church formed its own Community Outreach Programme for the Elderly (initiated by Marine Parade CDC) team to harness community efforts to help with challenges of ageing

2002

St. Hilda's Community Services Centre established and registered as Society with Registrar of Societies and Charities Act

March 2005

St. Hilda's Link established at Marine Parade as a Neighbourhood Link serving purchased units at 13 blocks of Tanjong Rhu's residents and 22 blocks at Dakota Crescent and Old Airport Road with cross-generational activities

Dementia Day Care, Senior Day Care & Drop-in Centre in pipeline

Friends Special (disability and rehab) partners SACH and Friends Plus (day care) started; SATA CommHealth partners to provide free/subsidized medical services with SATA Doctors-on-wheels

Historical Development:
PEACE-Connect Senior Activity Centre (SAC)

Nov 1995
Known as SHALOM SAC – manage Alert Alarm System

Jan 2003
PCNL – service 5 rental blocks on community self-help and volunteerism

2011
Became PEACE-Connect SAC
I) Provide social service information
II) Local hub for volunteerism and inter-generational activities

Historical Development:
JOY Connect – St. Andrew's Senior Care

Inception:
SACH PTs/OTs partners PECCO SAC to provide maintenance exercises programmes since 2010

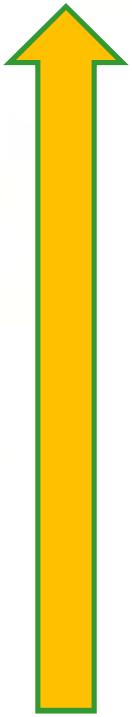
2015:
Integrated day centre JOY-Connect set up

- centre-based care (dementia day care, rehab, nursing)
- Home care services
- Community case management services

Temasek Cares - Care Close to Home (C2H) & Care From your Community (CFC)

A Demonstration Project

- Leverages on Senior Acitivity Centre (SACs) to provide a “nuclei of services” to deliver care coordination and personal care services to help the poor and low income seniors age at home within their community.
- Re-examines the current mode of service delivery by leveraging on existing services within the community to provide a "closer to home," client-centric services to the seniors.



SAC (Demonstration)
- Provide information on preventive care, personal care support (ADL and IDAL), medication reminders
- Coordinate other necessary support including transitional care, functional and home environment assessment, mental health, palliative care.

SAC (CS)
- Provide social support through monitoring, casework management and counseling services
- Co-ordination of community-based care and support services

SAC
- Social recreational activities
- Befriending
- Detect and manage social isolation issues as well as those who are frail and home bound

Service Delivery Gap Leading to New Model

Suite of Home Care Services :

- Personal hygiene
- House keeping
- Medication reminder
- Mind stimulating activities
- Other personal care tasks
- Home Medical
- Home Nursing
- Home Therapy
- Home Palliative

Gaps:

- Service fragmentation
- Insufficient care management
- Providers are located remotely
- Unable to deal with those who require more intensive services

Profiles of clients who are facing challenges with the current form of services:

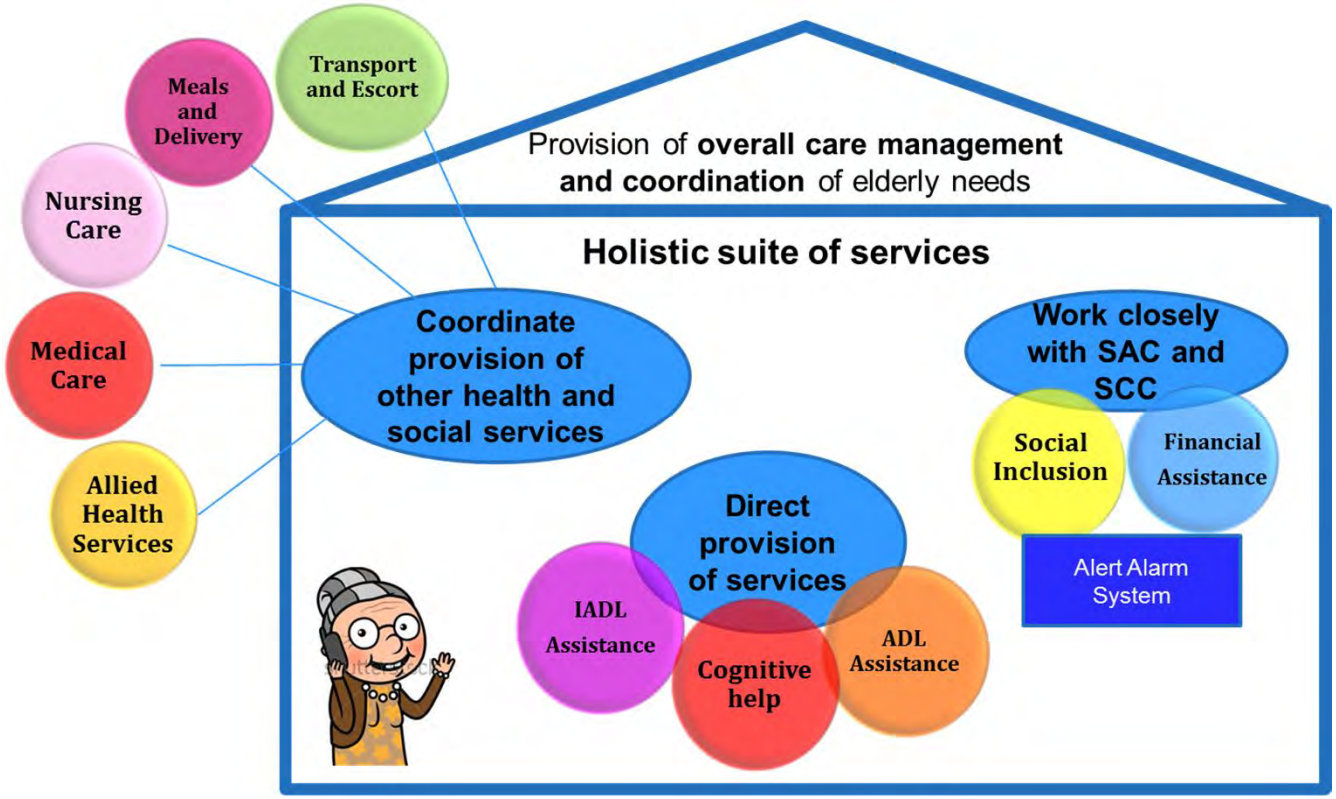
- Caregiver is elderly or no caregiver support - unable to perform housekeeping and marketing. Usually had to consider maids (not suitable for 1-2 room rentals) or institutional care
- Client has high fall risk with no regular supervision and require assistance for daily ADL. The 9 -12 hours/week Home Personal Care package is insufficient
- Clients who do not follow the frequency and dosage of medication and not consuming meals on times.
- Usually home bound and not much interaction with community

Objectives of C2H & CFC

- Provide a close-knitted support with holistic care coordination, personal care assistance, and social support within the community
- Provide vulnerable elderly with regular supervision in self-management of their chronic disease management
- Support Community Health Providers in their delivery of care
- Prevent or delay the transition to institutional care for as long as possible

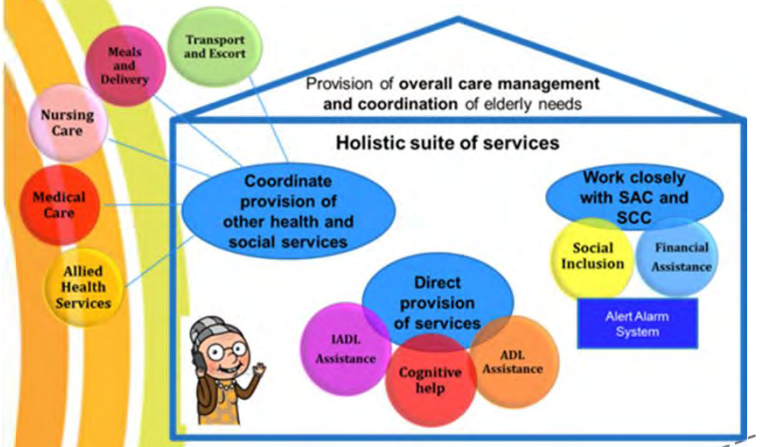
Initial Pilot:
Temasek Cares - Care Close to Home (C2H)

- Programme that spring-boards from SACs/SCCs housed within HDB residential blocks, to provide **basic nursing and personal care services, basic case coordination** to enable seniors staying in the 1-2 room rental HDB flats to age at home



2nd Phase of Pilot:
TB - Care From your Community (CFC)

CFC = C2H + Volunteer Management



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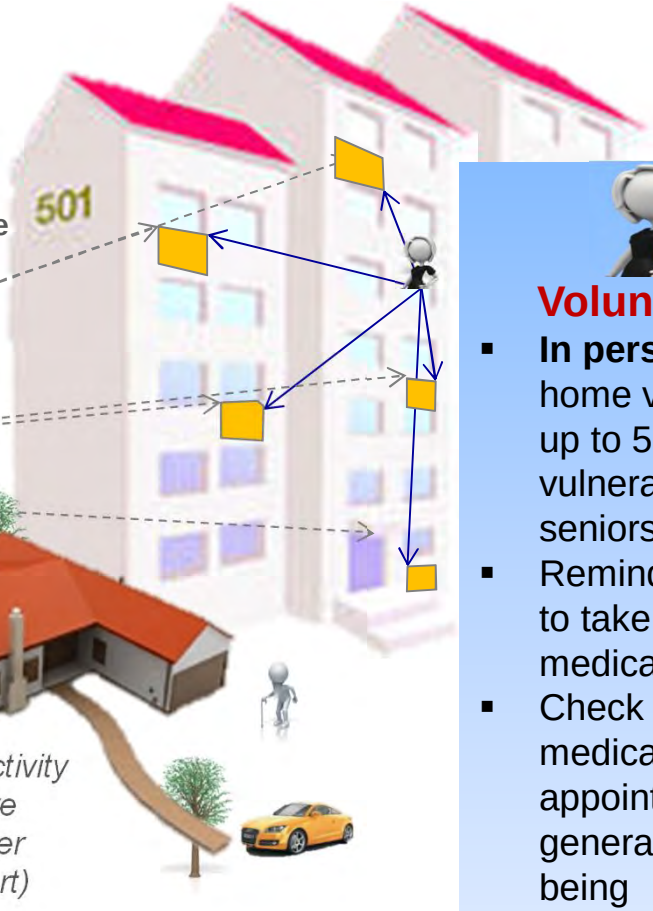
5 Vulnerable Seniors

Flats with high volume of vulnerable seniors



Senior Activity Centre (Cluster Support)

Volunteer Coordinator:

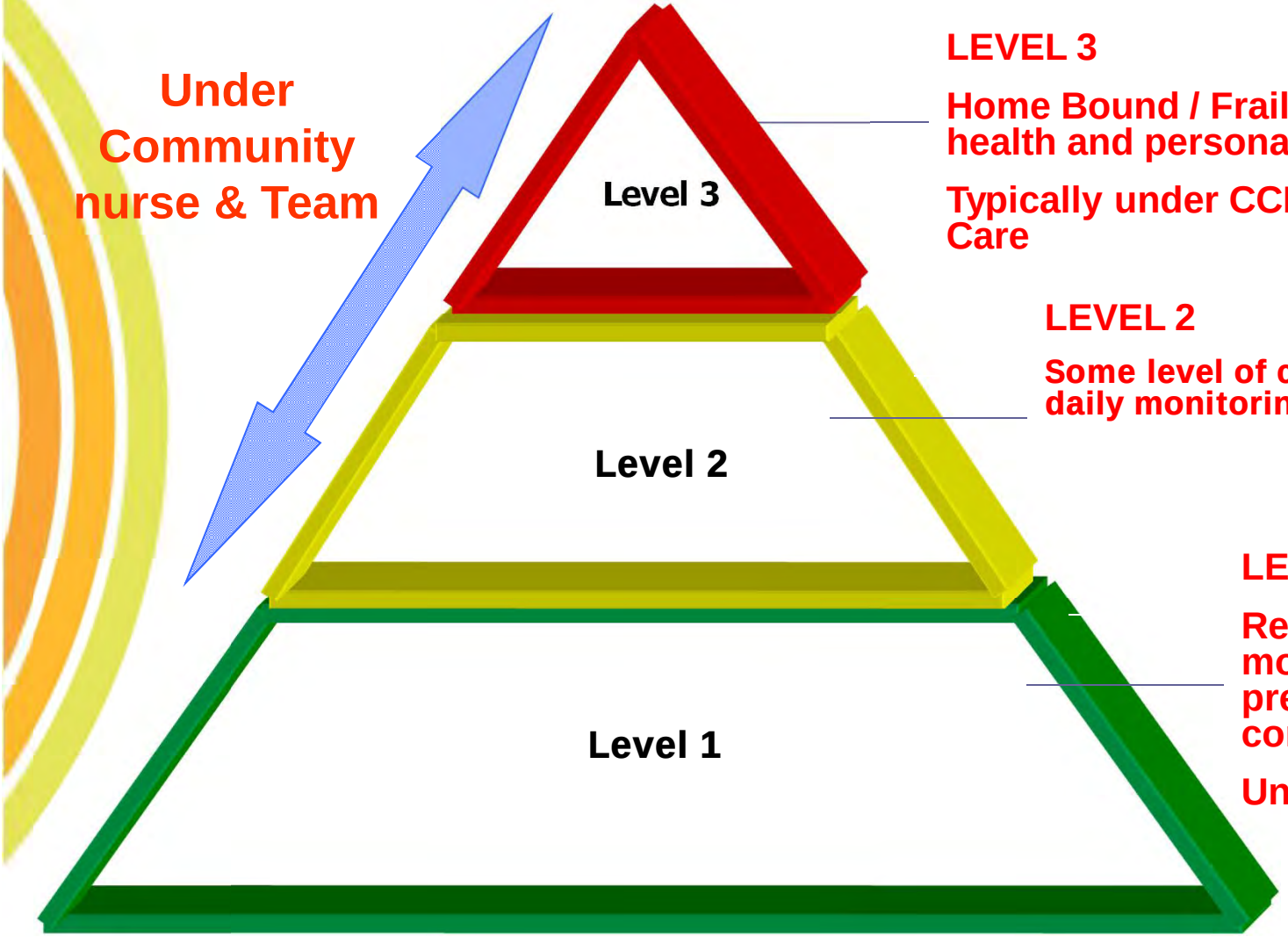
- **Monitor** seniors taking medication.
- **Coordinate & Assign** volunteers to seniors
- **Supervise** the Volunteers

Volunteer:

- **In person** home visits to up to 5 vulnerable seniors' homes
- Remind elderly to take medication
- Check on medical appointment & general well-being

To fold TC - Caring Assistance from Neighbours Programme (CAN2) into C2H

Segmentation of needs to services



LEVEL 3

Home Bound / Frail Patients with health and personal care needs

Typically under CCMS, SPICE, Home Care

LEVEL 2

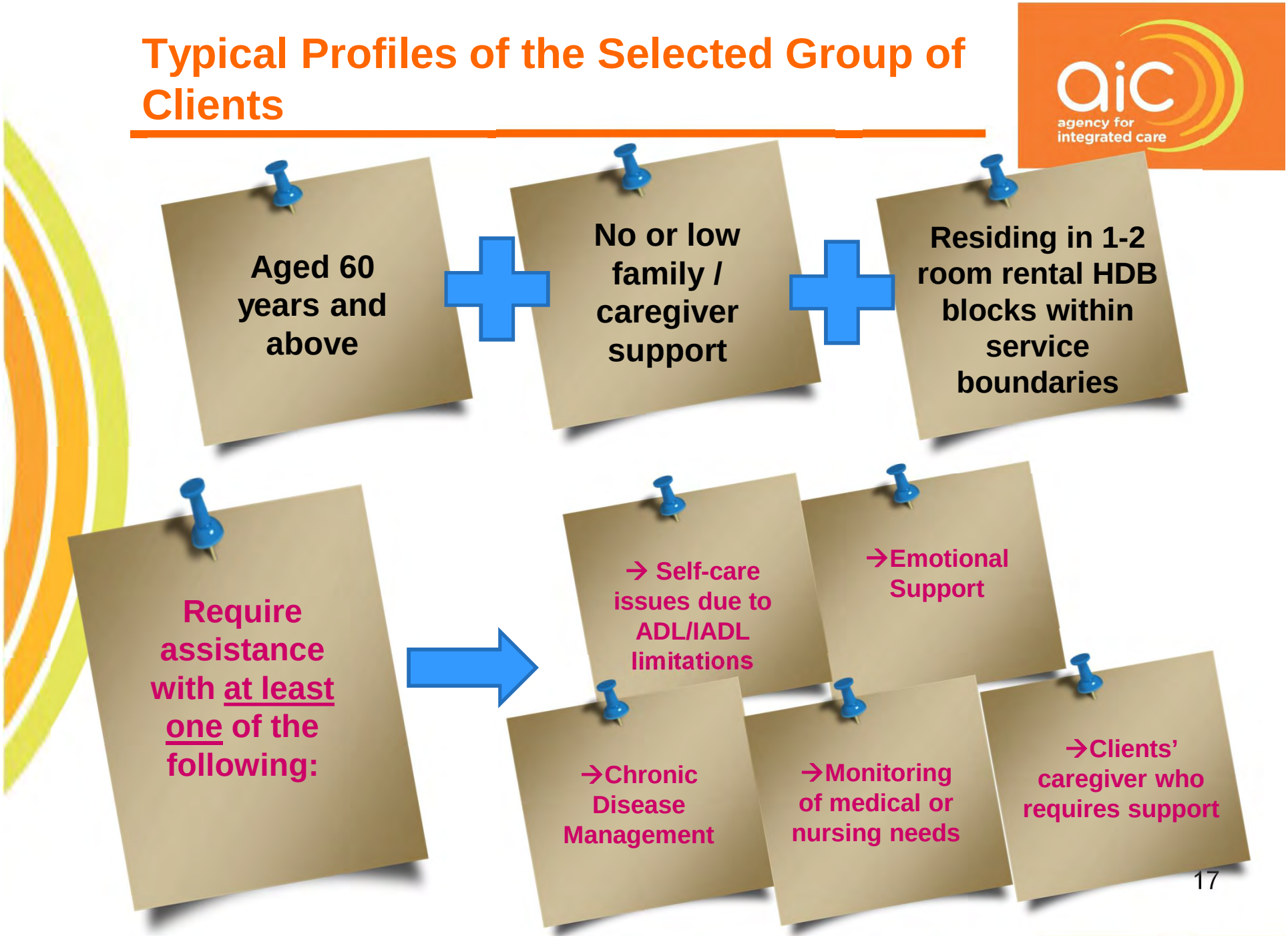
Some level of close supervision and daily monitoring of their conditions

LEVEL 1

Require some monitoring and to prevent deterioration of condition

Under SAC purview

Typical Profiles of the Selected Group of Clients



Thanks