Changing Landscape of Long Term Care

Dr Leong Yi Onn Ian
Senior Consultant, Geriatric Medicine
Department of Continuing and Community Care

Definition of Long Term Care

- **Long-term care** (LTC) is a variety of services which help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods of time.
  - Home
  - Institutionalised

Apologies

Many wonderful programmes

Apologies for not mentioning you

Themes

1. Day facilities catering to an increased number of needs at one site
2. Sheltered / Assisted accommodation for frailer groups
3. Allowing the entire spectrum of care to be delivered at one site
4. Increasing Social – Medical Integration

1. Day facilities catering to an increased number of needs at one site

Day Centers

- In the days of old…
  - Specific in their roles
    - Social Day Care Centres
    - Day Rehabilitation Centres
    - Dementia Day Care Centres
  - Specific in their clientele
    - Supervision
    - Dementia
    - Rehabilitation

Day Centers

- Short sessions (half-a-day)
- Intact carer arrangement
  - Sometimes the helper had to come along as well…

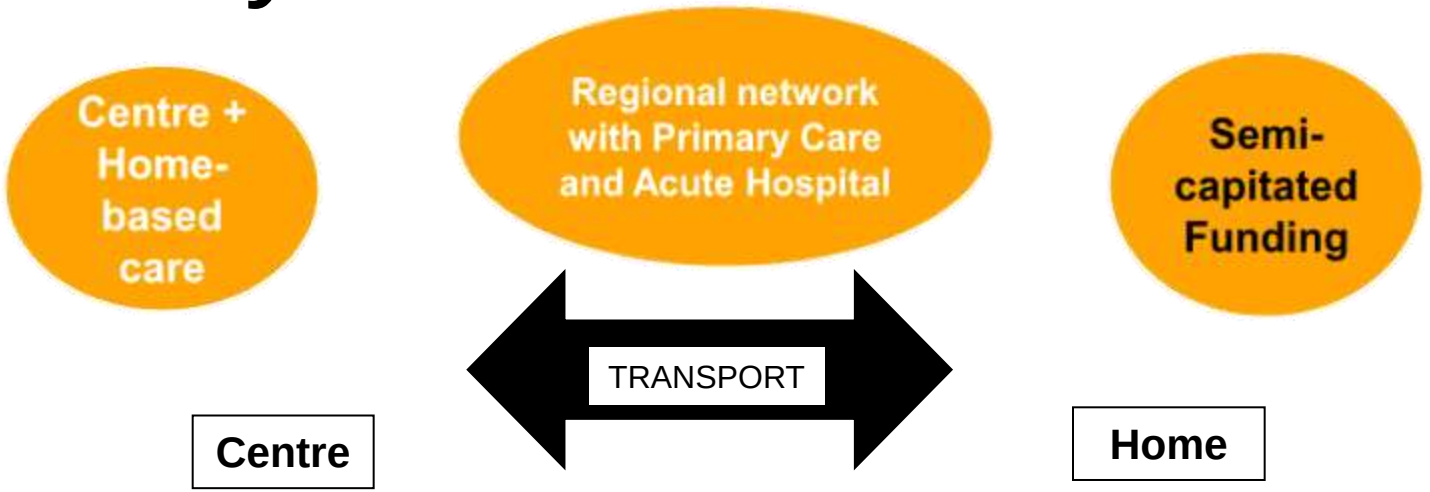
But now…

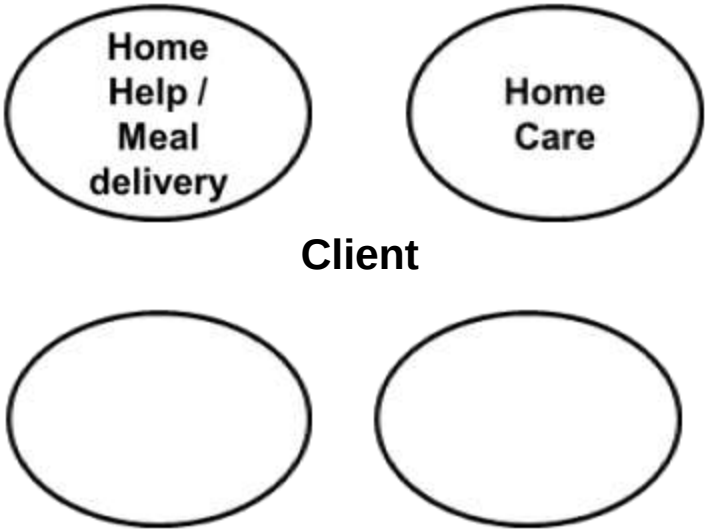
The caregiver situation could be more precarious

Day Centers - SPICE

- SPICE (Singapore Programme for Integrated Care in the Elderly)
  - Based on Programme for All-Inclusive Care (PACE) for the Elderly
- **At high risk of** or **eligible for nursing home care**
- Remain within the community, thereby **delaying institutional care**.

Day Centers - SPICE





Day Centers - SPICE

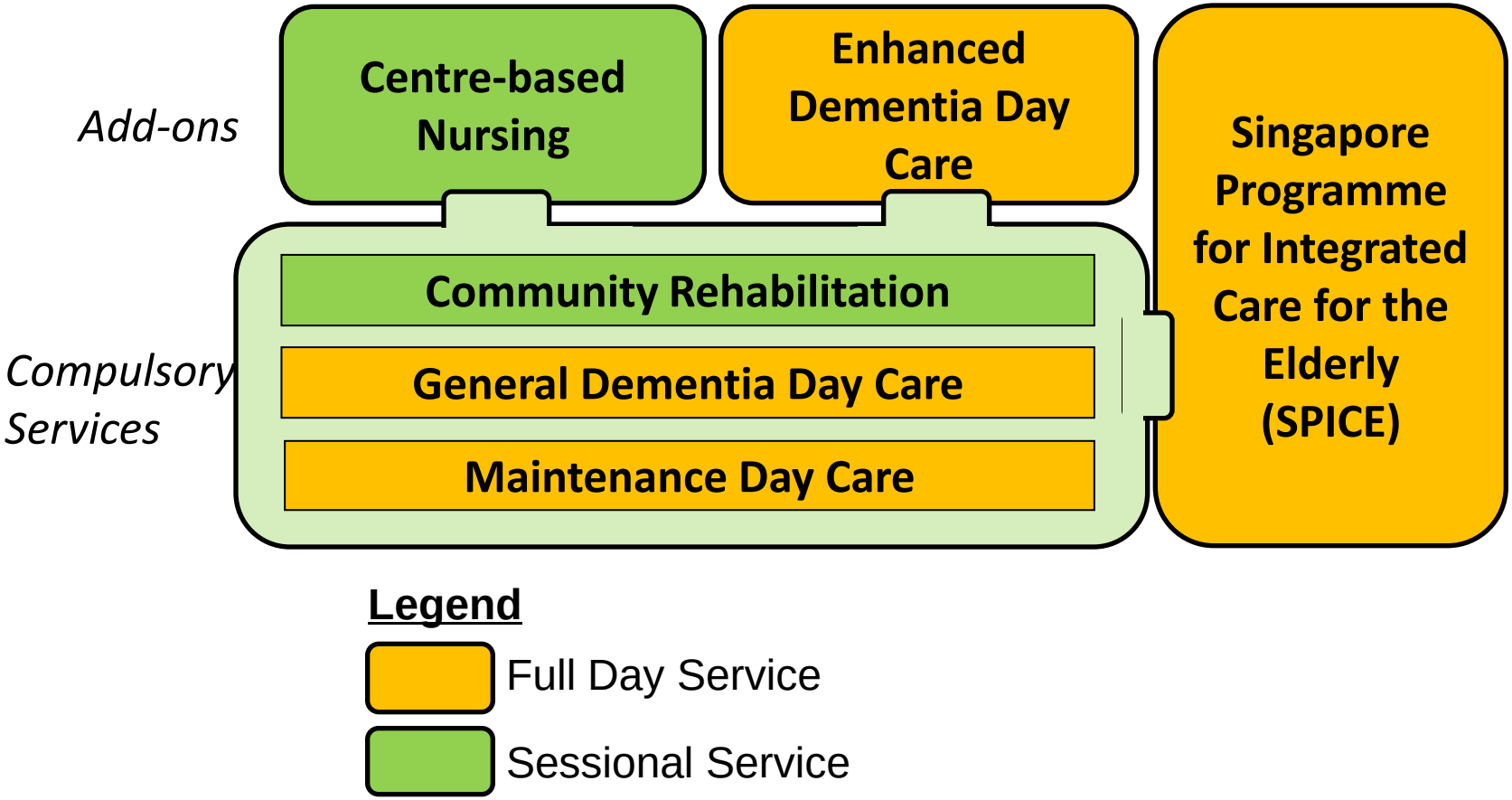
- Results
  - Reduction in unplanned hospital admissions by 69%
  - Reduction in ED visits by 64%
  - 9.8% of enrolled clients have been admitted to nursing homes

But now…

More than one “type” of client can be served at one centre

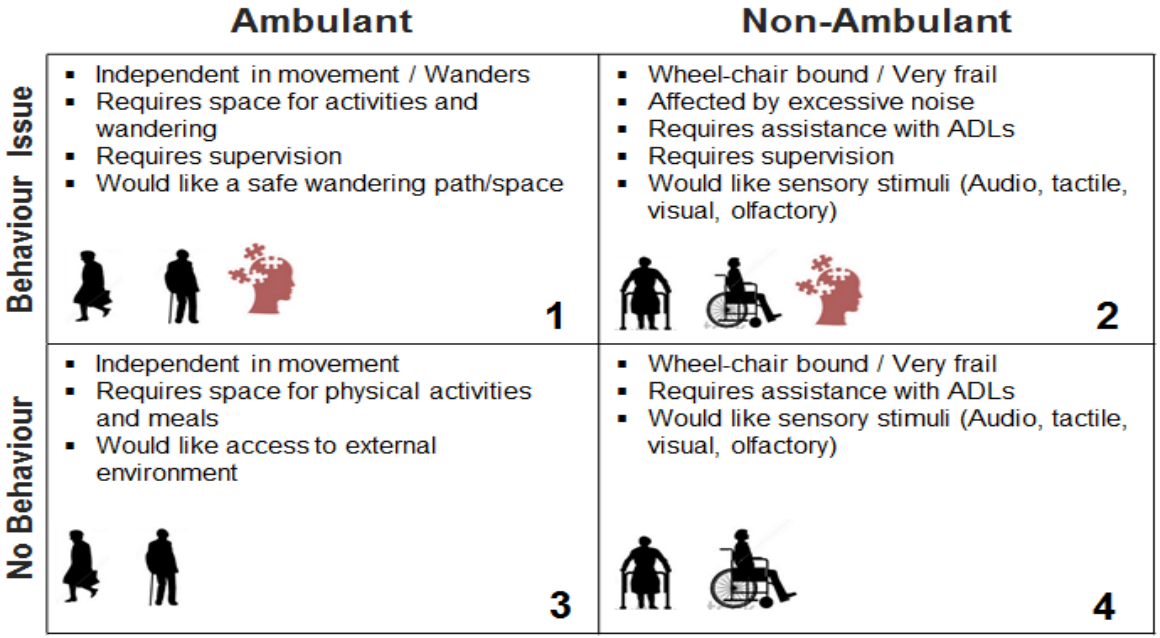
Senior Care Centre Service Model

An integrated day centre to support frail elderly with multiple social and healthcare needs to age-in-place at a single setting within the community as far as possible.



SCC Design Considerations

- Complex mix of clients
  - Ambulant to the wheel-chair bound,
  - Behavioural issues
- The design brief is guided by **person-centred and dementia-friendly principles**.



Client Profile Matrix

Designing SCC to meet needs of different client profiles in **ONE INTEGRATED CENTRE**

- Patients with multiple problems can be managed at one site
- No issue of “graduation”
- Clients need not re-familiarise to another facility
- Overall increase in the capability of community providers

Diversity in Unity

2. Sheltered / Assisted accommodation for frailer groups

Sheltered Accommodation

- Residents needed to be rather fit, safe, independent in IADLs (in some Sheltered Homes), and needed to have knowledge in management of medications
- Tended to be cohorted together in stand-alone facilities, or in a few floors in a HDB block

Senior Group Homes

- Independent living “unit” of 2-3 seniors scattered among a HDB block
- 12-15 seniors per site
- 1-2 staff per site
- Integrated with other services
- Facilitate independent living and community spirit
  - Minimal in-house services
  - Residents expected to help each other: making up for each other’s disabilities

Assisted Living Unit of Lion's Home

- Within the nursing home
- 15 physically fit residents
- Minimal nursing support usually
  - 1 nursing aide in the day.
  - Care in the night, if necessary, is by the night-duty nursing staff
- Potentially, 24 hour nursing and medical supervision is available

Assisted Living Unit of Lion's Home

- Common living area, with dining area and pantry
- Promotes independence
  - Meals are buffet style
  - Decides amount they eat
  - Have their own daily schedule

Dementia Sheltered Home (Peacehaven)

- Ambulant residents with mild dementia
- Environment is
  - Home-like,
  - Therapeutic
  - Compensate for disabilities unobtrusively and imperceptibly
- Continue certain self-care activities
- Well being of residents have improved from 10-50% on the **well-being profile indicators**

Mutual Beneficence and Subtle Supervision

3. Allowing the entire spectrum of care to be delivered at one site

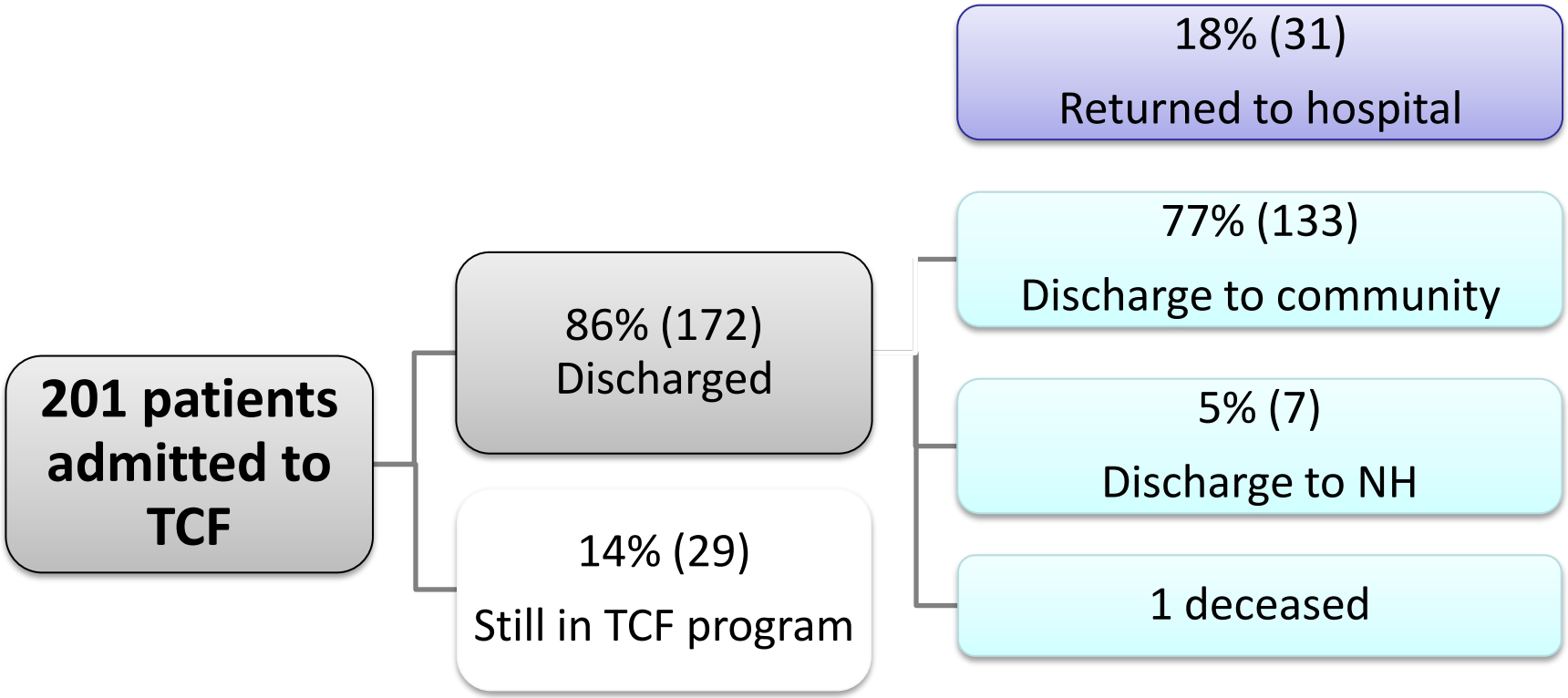
Nursing Homes

- It is forever
- Hopeless place of no return
- Death will usually be in the hospital, because residents are usually in hospital when they are ill

Transitional Care Facility

- A rehabilitative facility in the nursing home
- Provide rehabilitation for up to 3 or 6 months
  - Rehabilitation in community hospital is up to one month
- Allows for patients who would have had to be institutionalised in the previous system to be rehabilitated so that they can go home

Transitional Care Facility



Based on results from 1 Dec 2012 to 30 Jun 2014

Transitional Care Facility

- Improvements in ADL and IADL scores
- More than 90% of participants still living in the community after one year
- High caregiver satisfaction

Handholding Programme

- A programme by Ren Ci NH to aid residents who have become independent in nursing homes to return home
- Case Example: Mr M
  - Resident who had an amputation
  - Stayed in the nursing home from 14th Feb 2013
  - Discharged on 29th August 2014

Handholding Programme

- What was done
  - Post surgery rehabilitation
  - Prosthesis fitting
  - Seek funding for motorised wheelchair and other assistive items
  - Seek financial assistance from CDC
  - Petitioned to HDB to grant a wheelchair friendly rental flat
  - Source for furniture and appliances for his flat
  - Coordinate cleaning of his flat by volunteers
  - Post-discharge support

Project CARE

- TTSH collaboration with 7 nursing homes
- Provides training for NH staff and delivers direct care to patients who are at the EOL
- **Systematic identification** of residents who may be at the end-of-life
- Engaging in an **Advanced Care Planning** conversation with the patient and their NOK
- Providing care during exacerbations and at the terminal stage

Project CARE

- **Higher satisfaction scores** reported by NOK on a post-bereavement survey in those who were under Project CARE than those who were not
- **Shorter Acute Hospital LOS** for residents under Project CARE compared to a historical control

Able to Grave

4. Increasing Social – Medical Integration

Frequent Admitter Programmes

- Management of people who have both complex medical and social needs
- Needs manifesting as frequent admissions
- Examples:
  - Ageing in Place Programme by KTPH
  - Virtual Hospital by TTSH
- Medical input provided by nurses or case managers
- Working with a variety of providers ranging from befrienders, to resident committees, to community case managers

Frequent Admitter Programmes

- Both programmes have demonstrated a decrease in admissions and LOS

Binding the Gap

Looking Ahead

- Diversity in Unity: to other strata of care
- Able to Grave
  - Not many players in a game of musical chair but one provider / team
- Mutual Beneficence to Subtle Supervision:
  - Funding programmes that seek to re-engineer a kampung spirit
  - Augmenting natural behaviours rather than creating artificial ones
- Bind the Gap
  - Going beyond local initiatives
  - A Ministry of A?

Acknowledgements

- My thanks to Mr Eric Ho and Dr Wong Loong Mun, AIC, Dr Lina Ma, and Ms Low Mui Lang for providing the details for many of the programmes