Project Title

Supporting Population Mental Health Wellness through Case Managed Aftercare Care Service

Project Lead and Members

- Junyuan Tey

Organisation(s) Involved

Institute of Mental Health, Montfort Care

Healthcare Family Group(s) Involved in this Project

Allied Health, Medical

Applicable Specialty or Discipline

Case Management, Mental Health

Aim(s)

A case manager plays a vital role in linking up community services for clients effectively. Under the Aftercare program, a creation of support network for each client was developed with community partners and AIC. Weekly home visits were made with community partners to understand clients

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Conclusion

See poster appended/ below

Project Category

Care Continuum

Population Health, Mental Health

Keywords

Collaboration with Community Partners, After Care

Name and Email of Project Contact Person(s)

Name: Junyuan Tey

Email: jun_yuan_tey@imh.com.sg

ABSTRACT

Supporting Population Mental Health Wellness through Case Managed Aftercare Care Service.

INSTITUTE of MENTAL HEALTH

INTRODUCTION

A case manager plays a vital role in linking up community services for clients effectively (Fitzgerald et al, 1994). Therefore, under the Aftercare program, a creation of support network for each client was developed with community partners and AIC. Weekly home visits were made with community partners to understand clients (Lord et al, 1998). This study reports the outcomes of collaboration between IMH and Montfort Care in Kreta Ayer and Henderson regions from 2017 to 2023.

METHODOLOGIES

Microsoft Excel was used to process study data. Consent from caregivers was sought before including clients. They received regular updates on their condition during appointments.

RESULTS

A total of 125 clients in the Kreta Ayer and Henderson areas were involved in this study. 50 were co-managed with Montfort Care, 57 were monitored by the case manager and 18 were transferred to Montfort Care. 1056 telephonic management calls were made to ensure treatment compliance. Clients were met 389 times at the outpatient clinic and 192 times in wards when patients were admitted. 50 linkages were made to relevant agencies for financial/social issues. 280 home visits were done with Montfort care

Since the collaboration in 2017, readmission rates, emergency room visit rates decreased by 80%. Appointment default rates decreased by 90%.

CONCLUSION

Hospital and community carers understood their clients in a patient-centric manner (Audet et al, 2006). Clients were stable with regular follow-up in the community and medically compliant (Fitzgerald et al, 1994). Caring for clients in a supportive community ecosystem is an important strategy that the Aftercare program uses successfully.

REFERENCES

Audet, A., Davis, K., and Schoenbaum, S., Adoption of patient-centered care practices by physicians: Results from a national survey. *Arch. Intern. Med.* 166:754–759, 2006.

Fitzgerald JF, Smith DM, Martin DK, Freedman JA, Katz BP. A case manager intervention to reduce readmissions. Arch Intern Med. 1994;154:1721–9.

Lord J, Ochocka J, Czarny W, MacGillivary H. Analysi s of change within a mental health organization: a participatory process. Psychiatr Rehabil J 1998; 21: 327–339.

FIGURES/ DIAGRAMS (Optional)