Project Title

Community Management of Dementia by a Community Hospital (Community Response Team)

Project Lead and Members

Project Lead: Cheung Siew Li

Project Members: Dr Linus Chua Kee Loon, Phua Lee Lian, Dynn Leong, A/Prof Tan Boon Yeow

Organisation(s) Involved

St Luke's Hospital

Healthcare Family Group(s) Involved in this Project

Allied Health, Ancillary Care

Applicable Specialty or Discipline

Public Health, Mental Health, Psychiatry

Project Period

Start date: Financial Year 19

Completed date: Financial Year 21

Aims

To address gaps of lack of dementia management and access to mental health services highlighted in the National Dementia Strategy

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Lessons Learnt

Covid can only restrict the physical movements but not the leisure and happiness.

1. Community management of dementia is a cost effective and responsive model of care that brings cost savings and enables right-siting of care as well as allows for ageing in place.
2. The assessment and intervention from a Physician complementing the support from Allied Health Professionals makes for a holistic and responsive model of care for PLWDs.
3. Assessment and intervention within the clients' homes encouraged greater responsiveness from families and better clinical outcomes, esp. since the team could address hidden factors that cannot be observed at a clinical setting.
4. Community management of dementia not only meet the needs of PLWDs, it allows holistic support for family caregivers, effectively reducing their stress.
5. No fees charged reduces barriers and help incentivizes families to seek help.
6. CRT provided timely care that they otherwise would not access and achieved prevention and reduction of inappropriate emergency department attendances and admissions.
7. Community management of dementia can achieve social-health integration as it can serve as a bridge between community mental health service providers and the healthcare system.
8. The pilot programme enabled learning of the appropriate levels of staff of each profession and the skills set appropriate for a mobile multidisciplinary team providing community management of dementia and geriatric mental health. It also highlighted the need for other professionals (e.g., clinical psychologist for comprehensive intervention and treatment and project manager).

What we would do differently is to have a clinical ops personnel or project manager who can effectively engage community partners and healthcare teams to bring about greater awareness of the service and bring this service to more PLWDs to access it.

Conclusion

See poster appended/ below

Additional Information

2022 National Healthcare Innovation and Productivity (HIP) Best Practice Medal – Care Redesign

Project Category

Care Continuum, Intermediate and Long Term Care & Community Care, Nursing Home, Right-Siting, Population Health, Mental Health

Care & Process Redesign, Access to Care, Bed Occupancy Rate, Referral Rate, Quality Improvement, Clinical Practice Improvement, Value Based Care, Productivity, Cost Saving

Keywords

Dementia, Community Support Services, Behavioural and Psychological Symptoms of Dementia (BPSD), Persons Living with Dementia (PLWD), Care Model, Occupancy Rate

Name and Email of Project Contact Person(s)

Name: Cheung Siew Li

Email: siewlicheung@stluke.org.sg

Community Management of Dementia by a Community Hospital (Community Response Team)

Cheung Siew Li[1], Linus Chua[1], Phua Lee Lian[1] , Dynn Leong[1] , Tan Boon Yeow[1]
1. St Luke's Hospital

Introduction

The prevalence of dementia and mental health conditions is increasing with Singapore's aging population. This vulnerable population face the risks of limited access to health services due to their physical frailty and fear of stigma. Fragmentation of medical and mental health services adds to the difficulty they face in navigating our healthcare system. Unmet health needs lead to rapid disease progression and inapt use of healthcare system through inappropriate Emergency Department (ED) attendance, hospital admissions or premature institutionalisation.

The Community Response Team (CRT) was set up by St Luke's Hospital (SLH) to reach Persons Living with Dementia (PLWDs) with Behavioural and Psychological Symptoms of Dementia (BPSD) and Seniors with suspected dementia. The mutli-disciplinary team conducted assessment and diagnosis within their homes, care coordination, service linkages and community management of dementia.

Taking on a population health approach, timely diagnosis and intervention, holistic care and community support are key initiatives of the mobile multi-disciplinary team to right-site the care for PLWDs and enable ageing in place.

Goal/Objective

This new home based/community based care model was to address gaps of lack of dementia management and access to mental health services highlighted in the National Dementia Strategy.

The goal was to prevent and reduce inappropriate hospital admissions for dementia related behavioural issues by achieving quick assessment and diagnosis, timely intervention and treatment as well as providing community support and service linkages.

This care model was also to allow learning of what resources were needed to carry effective community management of dementia.

Assessment of Problem and Analysis of its Causes

The National Dementia Strategy and Acute Hospital admission statistics against the prevalence rate of dementia in our rapid ageing population informed the need for a cost effective model that could achieve better clinical outcomes for the PLWD community and Seniors suspected to have dementia.

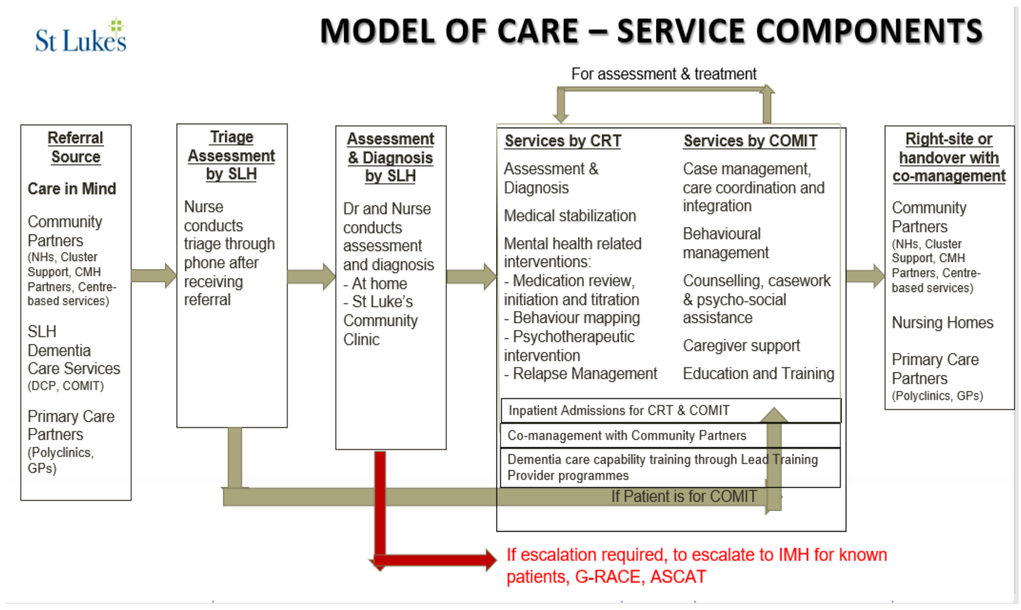
The availability of a community based assessment and treatment service for dementia was especially needed during the COVID years of FY19 to FY21 as the Acute Care System was geared up to battle the pandemic. Many medical and mental health services were scaled down which in turn resulted in many not being able to access assessment and support services for PLWDs, particularly in the management of Behavioural and Psychological Symptoms of Dementia and assessment of Seniors presenting with cognitive impairment orr behavioural issues.

Strategy for Change/Intervention

Key elements of the Intervention were:
-Home-based/community based – provide assessment and treatment within the clients' homes and the community they reside in, especially for the frail.
-Rapid response – respond within 2 working days to conduct assessment, diagnosis and begin intervention
-Integrated and coordinated care from Physician and Allied Health Professionals for holistic approach through pharmacological and non-pharmacological interventions, care coordination and psychosocial care
-Linkage to appropriate healthcare resources (primary care and specialist care)
-Linkages to community support services for continuity of care

Implementation of Community Response Team

The diagram illustrates the implementation model of CRT:



The strength of the service is that it co-manages or handovers the client to community support services while keeping them connected to the healthcare system (primary care or specialist care) for continued management

Effects of Changes

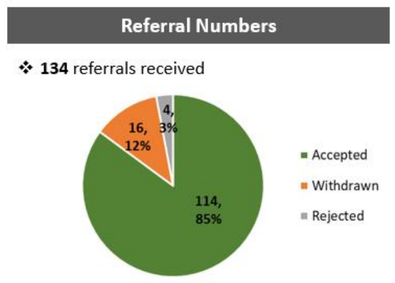


Fig 1. No. of Referrals & Cases

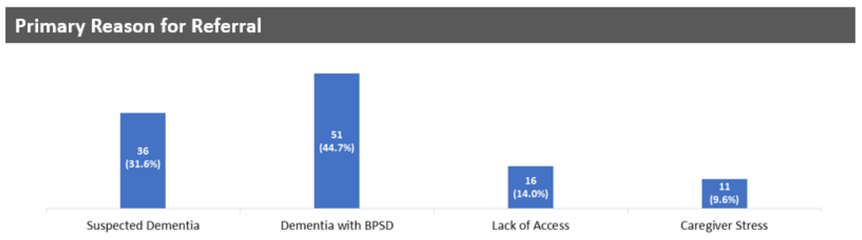


Fig 2. Reasons for Referrals to CRT

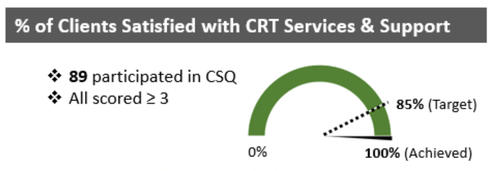


Fig 3. Client Satisfaction

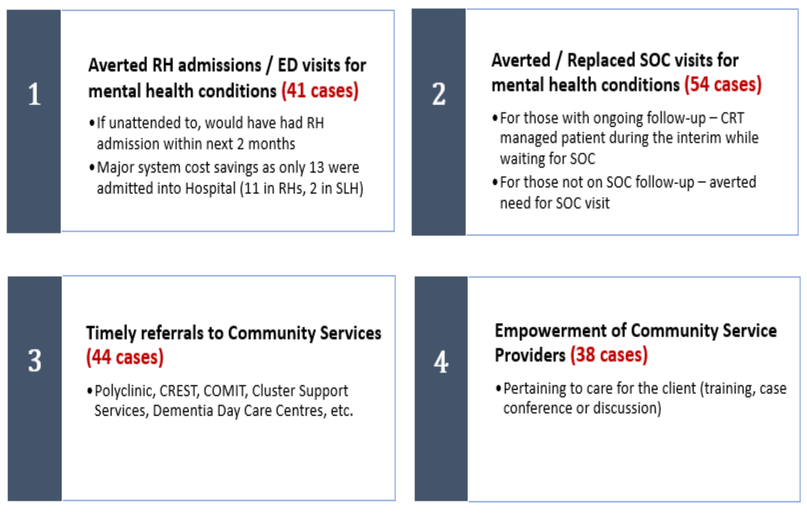


Fig 4. Benefits and Value Achieved

Outcomes Achieved:

Response Time: **100%** had first contact within 2 working days of referrals

No. of Clients Admitted to Acute Hospitals for BPSD: **0 of 114 cases**

No. of Clients Admitted to SLH for BPSD: **2 of 114 cases (1.8%)**

No. of Clients Admitted to Acute Hospitals for Non-dementia related Medical Conditions: **11 of 114 cases (9.6%)**

Lessons Learnt:

1.Community management of dementia is a cost effective and responsive model of care that brings cost savings and enables right-siting of care as well as allows for ageing in place.
2.The assessment and intervention from a Physician complementing the support from Allied Health Professionals makes for a holistic and responsive model of care for PLWDs.
3.Assessment and intervention within the clients' homes encouraged greater responsiveness from families and better clinical outcomes, esp. since the team could address hidden factors that cannot be observed at a clinical setting.
4.Community management of dementia not only meet the needs of PLWDs, it allows holistic support for family caregivers, effectively reducing their stress.
5.No fees charged reduces barriers and help incentivizes families to seek help.
6.CRT provided timely care that they otherwise would not access and achieved prevention and reduction of inappropriate emergency department attendances and admissions.
7.Community management of dementia can achieve social-health integration as it bridges community mental health service providers and the healthcare system.
8.The pilot programme enabled learning of the appropriate levels of staff per profession and the skills set appropriate for a mobile multidisciplinary team providing community management of dementia and geriatric mental health.

Way Ahead:

With the multiple benefits to users, their caregivers and the healthcare system, the next step is to scale this model of community management of dementia across Singapore with 2 other service providers from FY2023 onwards, with funding support from Ministry of Health and Agency for Integrated Care.