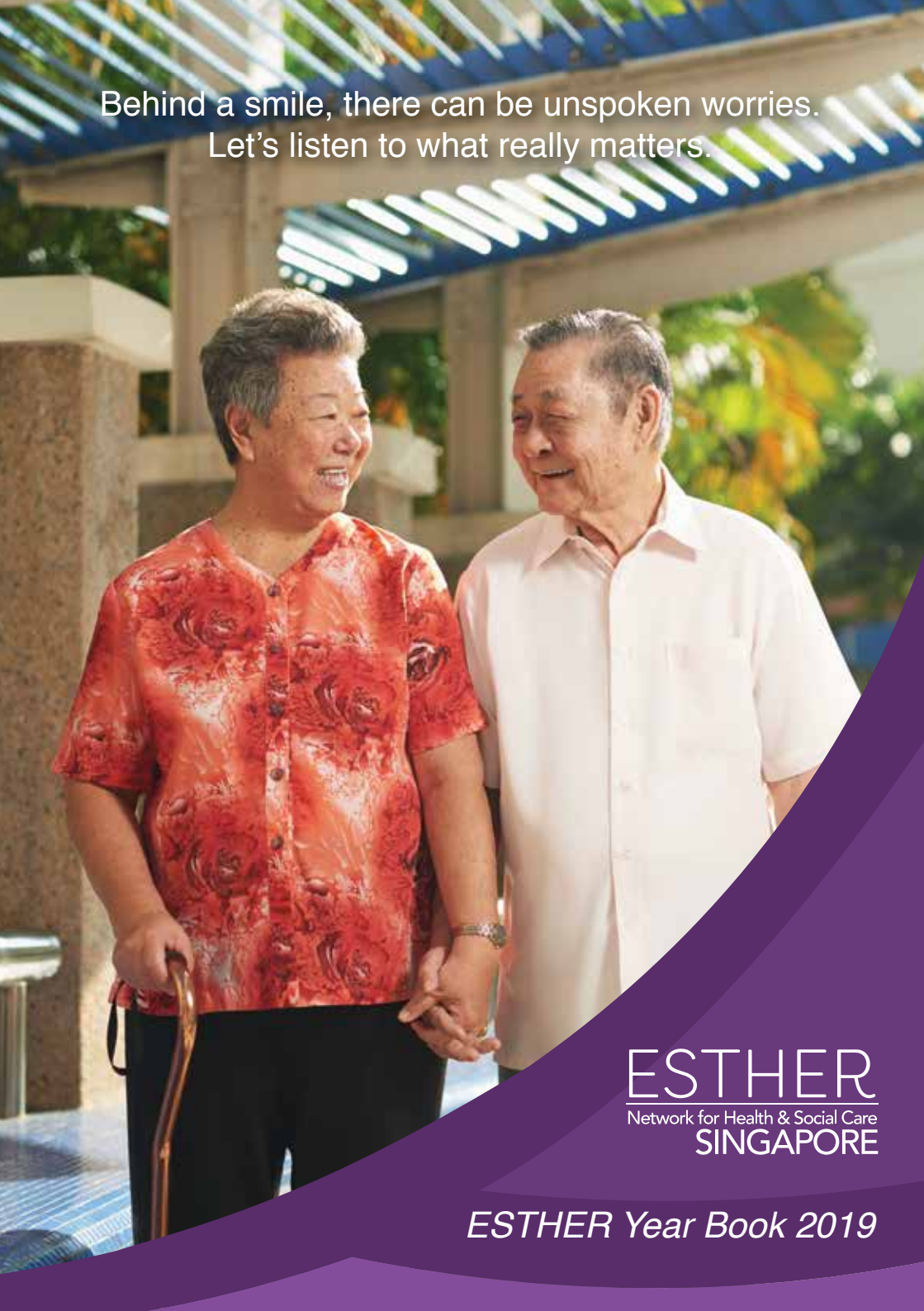

ESTHER

Network for Health & Social Care
SINGAPORE

ESTHER Year Book 2019

ESTHER

Network for Health & Social Care

SINGAPORE

SingHealth DukeNUS

ACADEMIC MEDICAL CENTRE

Singapore General Hospital

ESTHER Year Book 2019

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Foreword

At SingHealth, we champion the ESTHER Network as our Philosophy of Care to refresh the way we live up to our motto of 'Patients at the heart of all we do'. Unlike our patients or ESTHERs of the past, today's ESTHER is someone with more complex medical and social needs. The ESTHER Network brings us all together to ensure the care we deliver is well coordinated and in line with ESTHER's needs and wishes.

Since we started ESTHER Network, healthcare and community partners have come together to do some amazing things. Dr Loo Yuxian and Gabriel Yee from the palliative unit at Bright Vision Hospital piloted a simple but impactful 'About Me' form which helps us better understand ESTHER's preferences, likes and dislikes, before going on to arrange hospital care. This simple yet personal act meant a lot to the ESTHERs who rated their satisfaction an 8 on a 10-point scale, a jump from the 5-point average previously. This may be a small start, but it can grow to make a huge impact on lives, as the ESTHER Network guides us to think big.

Our community partners are showing the way forward in using their newly acquired knowledge and skills to benefit patients and residents in the community. An example is the ABLE-programme, which aims to provide a safe space in the community for persons with speech and language difficulties to practise communicating and socialising in a casual and non-threatening environment. ESTHER coach and community speech therapist Evelyn Khoo also piloted a monthly pop-up cafe to support ESTHERs with aphasia.

To design such projects, collaboration with our community partners is fundamental for us to better understand our patients and to extend our care. I am heartened by the impact of ESTHER Network and how as a community, we come together, learning from one another and supporting one another in placing Patients at the Heart of All We Do.

My vision for the ESTHER Network is that we provide the care that patients deserve, even before they know they need it, delighting our patients, caregivers and residents in the community. By placing ourselves in ESTHERs' shoes, we can better appreciate how we ourselves would like to be treated as a care recipient.

Care is and should not be determined by the location where we practise, or confined within the hospital walls. It is where the patient, our ESTHER, needs it. What ESTHER wants at different stages of her life or care journey, will also be different. We need to respond by adapting our processes. In this way, we can be truly relevant in meeting ESTHER's needs and truly improve lives.

I want to congratulate the ESTHER coaches who are graduating. Thank you for leading change to benefit the people we serve. We are going far, because we are going together. THINK BIG. START SMALL. ACT FAST.

Prof Kenneth Kwek
Deputy Group Chief Executive Officer (Organisational Transformation and Informatics), SingHealth
Chief Executive Officer, Singapore General Hospital

Bringing Value to ESTHERs

What does "value" mean to ESTHER? By improving outcomes and putting the patient at the heart of all its work, such as her functional abilities so that ESTHER can continue with her routine before she fell sick, or by reducing the cost of her care?

Many people have this notion that being person-centered is costly. However, it will cost us more as a society if we overlook the key component of the patient experience. Financial consideration is necessary, but it should not be a hindrance to innovations looking to balance both the social and health needs of ESTHERs.

ESTHER Network advocates what ESTHERs want. It is both a person-centered and value-based model. We provide value by either improving the outcomes that ESTHERs want, or by reducing the overall cost such as unnecessary hospital visits, tests and scans, and reducing wastages by improving processes and communication.

By asking ESTHERs directly what outcomes matter to them, it can save us hours of research and give us a complete story of what requires our attention. From the ESTHER cafés conducted, ESTHERs have illuminated us with insights that are not on the balance score cards that we typically track. A workgroup tasked to come up with a predictive model for Total Knee Replacement (TKR) pathway found out that who the surgeon was, the patient's muscle strength post-operation or the number of intensive therapy sessions that she received, made little difference to ESTHER's length of stay in the hospital. Her level of confidence to manage her care at home determined her decision to go home or not. The more we identify this earlier and work with key partners to strengthen that confidence, the more we can value-add to ESTHER without increasing the cost of overstay or the cost of having to manage an unnecessary re-admission.

Many ESTHER coaches are direct care or service providers. But we need more finance, administrative, planning and policy personnel to come forward and listen to ESTHERs themselves. Only then will the care design that we come up with, be congruent and sustainable.

Mr Ang Kwok Ann
Chief Financial Officer, Singapore General Hospital

My Journey as a Caregiver

In my journey as a caregiver to my son for the past 40 years, I have learnt that striving, even when the odds seem insurmountable, would not necessarily be fruitless.

At five months old, my son was confirmed as suffering from spastic quadriplegia involving all four limbs, as a result of the brain trauma he suffered at birth. We were told that his condition was hopeless and that he would be bedridden for life.

My first instinct was to find out the diagnosis and prognosis of the condition. I had to understand and identify the problems that my son would face in life. Then I proceeded to find possible solutions. I visited various establishments to see how and what they provide to treat persons with such conditions. I read up, observed and discussed with his care providers on matters that I did not understand.

Only when armed with the information could I go about caring for my son. I had to decide how much sacrifice I was prepared to make and how far I was prepared to go. I realised the importance of communication and compassion. I also had to be resourceful in order to help my son.

I eventually decided that I want my child to be treated as a whole person - physically, emotionally and socially - with the capacity to understand and communicate. He should not be treated as just an object. With this end goal in mind, I worked towards smaller achievable goals through various stages. Staying focused under all circumstances was important.

In the course of caring and training my son, I received a lot of help from various healthcare providers. Usually I would observe, take note of what was being done, and ask questions. Sometimes healthcare providers would go out of their way to demonstrate how I could

go about doing various care tasks. This encouraged me to push on. I realised healthcare providers are as human as we are, who feel happy and motivated to do more if they see improvements in their patients with the help of the caregivers.

Seeing my anxiety and commitment to help my son progress on the right track, one physiotherapist offered to see my son every week, and I was allowed to bring my son into the department for therapy every Saturday. I would speak to the therapists and observe the therapy sessions in order to incorporate them into my son's daily living. All the exercises were then replicated at home, whether at play, while sleeping, standing, dressing and feeding, to enable him to accomplish the very basic actions.

My son had to learn all these movements in order to progress to more complicated tasks. In order to kill two birds with one stone, I would read to him in order to distract him from the vomiting (as he did not have the ability to swallow), pain and boredom of the exercise routine. As my son was unable to experience the many things that a physically abled child can, he experienced them through the stories that were read to him. His knowledge increased and his mental capability was nurtured this way. All these and many other activities were done in order to prepare him for integration into the society, so that he could experience the many joys of being able to live life.

My experience with the healthcare providers who crossed our paths was very positive. First and foremost, I did not allow any negative responses to stop me from achieving our goal. Communication was also key in ensuring this.

1. The communication between the patient and caregiver, as well as between patient/caregiver and the healthcare provider, is of paramount importance. Patient and caregiver should feel free to find out and understand the physical and medical conditions of the patient. They should ask the healthcare providers and not be afraid (healthcare providers would not eat you up! At most, they might scold or ignore you). If you do not receive any response, move on to ask another. Be mindful that you need the help and do not point fingers or play the blaming game, as nobody likes to be blamed. It helps when healthcare providers show compassion by putting themselves in the shoes of the patients or caregivers.

2. Patients too play an important role in the relationship with healthcare providers. They should take responsibility of what they want for themselves, including what they can do and communicating how they want to be helped. Patients could set goals to motivate and challenge themselves. This would require much patience and hard work, and sometimes there may be setbacks before any progress is made. However, this is normal. Patients and caregivers could communicate their progress as well as setbacks, so that healthcare providers appreciate the effort that was put in.

My Experience in ESTHER Network

I first got to know the team in ESTHER Network after participating in a SingHealth Regional Health System Forum in January 2018. I was intrigued with the Network's philosophy of person-centred care through the involvement of patients, caregivers and residents. It very much resonated with my personal experience and belief that the partnership between care providers and patients/caregivers is of great importance.

I contribute as an ESTHER (patient, caregiver or resident) in the Network. Through the participation in the ESTHER coach training workshops, I gained knowledge from the sharing of the various healthcare professionals and social service providers. The ESTHER coaches are open and often look to me to confirm or verify their understanding of the experience of patients and caregivers. Sometimes they get it right, and sometimes, they miss the little things that matter a huge deal to us. I feel fulfilled and empowered that I could point these out to benefit other fellow caregivers. Most importantly, it was a breath of fresh air for me to interact with both health and community providers in the same room, who show openness in listening to both caregivers and patients.

Sometime in May last year, I was invited by Jie Bin to share my story during the ESTHER café. It was an open format and I could share anything that was important to me and my son, in our care journey. Initially I was nervous but with the help and assurance from Jie Bin, I was able to share both the positive experience, as well as the areas to improve, with the healthcare team at SingHealth, including the leaders, and the graduating ESTHER coaches.

Lately, I joined Elizabeth and Mike from the SGH Community Integration team for a few project discussions to explore the issue of isolation amongst the elderly. We realise it was a challenging area to tackle and appreciate their efforts for reaching out to the out-of-reach.
I hope for the continual success of ESTHER Network, and that more patients, caregivers and providers would take part in it to create a real change to the way care is provided in Singapore. I salute the busy, doctors, nurses, community providers, social workers and therapists who double up as ESTHER coaches to advocate for care that always stems from where the patient/caregiver is.

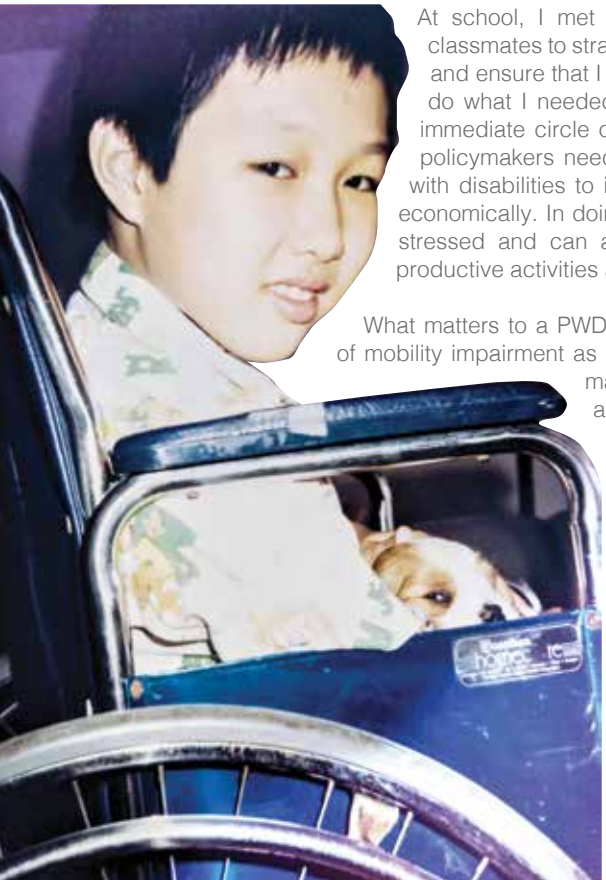
"YOU ARE DOING A HIGHLY COMMENDABLE JOB – HELPING THE INDIVIDUAL LEAD A DIGNIFIED AND MEANINGFUL LIFE. KEEP UP THE GOOD WORK WITH YOUR HIGH LEVELS OF PASSSION AND DEDICATION. WELL DONE!"

Love, Jessie
Mother of Julian

What Matters when I Live with a disability?

My experience of growing up in Singapore as a Person With Disability (PWD) has shown me that the way society views the issue of disability has enormous bearing on us and our quality of life.

I was diagnosed with spastic quadriplegia not long after birth. As it was an overly medicalised care model still in the late 1970s, when the doctors saw that there was not much they could do for me clinically, they concluded to my parents that I would be bedridden for life. Fortunately for me, my parents had a different belief system. They believe there is a life to live even with a disability. They wanted me to read, write, learn and move around independently like any other children. They sought out intensive therapy to maximise my physical abilities. They ensured that I was exposed to the society as far possible by registering me for mainstream school. This was a very important choice as it not only provided me with the education and academic qualifications for my participation in the workforce, but also helped me as a PWD to be comfortable in dealing with the society at large. Thanks to my parents, today at the age of 42, I have enjoyed a career in the finance industry lasting over 20 years and counting.



At school, I met many individuals, from teachers and classmates to strangers, who went out of their way to help and ensure that I could get to where I needed to go, and do what I needed to do. Besides my own parents and immediate circle of teachers and schoolmates, I believe policymakers need to do a lot more to support persons with disabilities to integrate and contribute to the society economically. In doing so, caregivers will not be so heavily stressed and can also be freed up to engage in other productive activities as well.

What matters to a PWD? I would say a holistic understanding of mobility impairment as something not to be "cured" but to be managed - how policymakers, healthcare and social care services can support us by providing accessibility in our living environment and public spaces. With the aging population, people moving around in wheelchairs and mobility aids are going to become a norm. Many buildings today have ramps for wheelchair users. However, not all are user-friendly. Some are too steep and dangerous. If these can be part of forethought in building any services, rather than an afterthought, the design would be far more intuitive.

The other perpetual concern of a PWD is the well-being of our caregiver. When they need a break from the arduous task of caring for us 24/7, the help may not be forthcoming. The respite services are limited to office hours at designated timeslots, and not flexible enough to fit the PWD's daily routine - something that caregivers need in order to have a peace of mind even when they take a break. Furthermore, some services are only available when a caregiver has an emergency to attend to. However, my hope as a PWD is that respite services for caregivers can be made more readily available, in recognition of the fact that caregivers need a regular break for their physical, emotional and psychological well-being. This requires a mind-set shift across the society, requiring an understanding of the challenges persons with disabilities and their caregivers go through, and the support we need to be as independent, well and free for as long possible.

What does a PWD want? For society to recognize that it is in both the interests of PWDs and the society at large to have PWDs living independently, participating in social and community activities, and contributing economically. This would be the hallmark of a fair and inclusive society.

Julian Wee
Son of Jessie

What Happened after Graduation?

ESTHER Improvement Project winning the "Ground-Breaking Effective, Momentous (GEM) Award" at the 12th Allied Health Innovation Practice (AHIP)

Our ESTHER Improvement Project titled: ***To Enable Wheelchair Users and their Caregivers to Ambulate in the Community with Greater Ease During Bad Weather*** has won the 12th Allied Health Innovation Practice (AHIP) Ground-Breaking Effective, Momentous (GEM) Award 2019. They were one of the 7 winners (out of 19 submissions) in the GEM award category.

GEM Award Abstract Submission

This ESTHER Improvement project hopes to enable wheelchair users and their caregivers, especially older persons, to maneuver the wheelchair in the community with greater ease during bad weather. We applied the three-step Design Thinking methodology - Understand, Explore and Test, a user-centered approach to guide our project. We engaged users and caregivers, researched on existing mobility accessories for bicycles and prams, and conducted observation studies in the community. We also worked with tertiary institutions and innovation centres such as Ngee Ann Polytechnic and NUS-CUTE Centre to develop a prototype for testing. Our collaboration with Ngee Ann Polytechnic tested our preliminary ideas to create wheelchair accessories to provide protection for both wheelchair users and caregivers. The phase-one prototype designed by a group of final year student was not adequate to meet commercialization standards. Nevertheless, we identified areas of improvement such as (1) to re-scope realistic functions for the accessory, (2) choice of material and (3) user-friendliness. This is an on-going project as we are currently applying for funds to move to the commercialization phase with industry partners.

Project Team:
Vivian Chan, Koh Sock Sim, Amanda Tan, Andy Sim, **Medical Social Services, Singapore General Hospital**
Chee Ching Yee, **Allied Health Department, SingHealth Polyclinic**
Mervy Quek, **Institute for Patient Safety & Quality, SingHealth HQ**
Ng Wen Xu, **Occupational Therapy, Singapore General Hospital**

Prototype of wheelchair accessories designed by Ngee Ann Polytechnic Students – Presented during one of the school's project development meeting

Prototype of wheelchair accessories designed by Ngee Ann Polytechnic Students – further refinement made to increase the protection for user

We contacted Mr Tan Ban Ho, a retired lecturer who was featured in the news after he modified his wife's wheelchair to facilitate their traveling in the community. According to Mr Tan, who is also an older person and caregiver, the ability to venture outdoors has improved both his wife and his own mental and psychological well-being

We presented our learning experience as a poster during the Inaugural SingHealth Regional Health System Forum at St Andrews Community Hospital in 2017

Meeting the lecturers from Keio-NUS CUTE Centre to further discuss on the project in 2018

ESTHER Improvement Project winning the "Best Poster Award" at the SingHealth Duke-NUS Quality Innovative Day 2018

Extracted from Sister Magdalene's Facebook post:
"Sharing the feeling of my rewarding and meaningful experience through the First Batch of ESTHER Coaches Training Programme in 2016. This small scale project aimed to support the transition of our 'Local ESTHER' from hospital to home, received the Best Poster Award at the SingHealth Duke-NUS Quality Innovative Day on 16.3.18. This project has turned out to be one of the good examples to share that our 'Local ESTHER' can ceased visits to the emergency department and admission to any of the restructure hospitals since July '16 till date. This is in comparison to the 11 visits to emergency visits and 8 hospital admissions the few months prior to us working with her. This patient care improvement work was made possible with the close coordination and collaboration of patient navigators and community providers to support the journey of our Local ESTHER in the community. Moving forward, the support from community nursing team will further add strength to this model of care to provide better support to those in needs. Never stop sharing happy months that add life to days."

About the Project:
Madam Tan, "ESTHER", is a single 75-year-old Chinese lady. She had visited Department of Emergency Medicine (DEM) 11 times and was admitted eight times over five months due to suboptimal management of her chronic diseases and psycho- social issues. She lives with an elderly flat-mate in a rental flat. The project team interviewed ESTHER to understand her needs and implemented solutions such as (1) initiating early referral to community case manager (CM), (2) on-going communication between the Patient Navigator (PN) and CM and (3) the provision of on-going psycho-education to ESTHER by the PNs. ESTHER's confidence to manage her care needs at home improved and was sustain overtime. She did not require any DEM visits and hospitalization even after two months. This project highlights the importance of the early "handshake" between PN and community partners, as well as team-based care planning. This project one of the three projects that is identified for project escalation to strengthen care transition at the cluster level.

Project Team:
Zunaitha Begum, Seng Gek Siang, Xu Yi, **SingHealth Office of Integrated Care**,
Magdalene Ng Kim Choo, **Singapore General Hospital Nursing Division**
Audrey Leo Kah Loon, **Bukit Merah NTUC Health**

In the News:

Volunteers start free pop-up cafe for people with language disorders

(Extracted from Straits Times on Dec 22, 2018)

SINGAPORE - Ms Evelyn Khoo, 41, runs a pop-up cafe with an unusual concept.

It is open just one Saturday a month, at a different location each time, and charges no money - orders are paid for in free vouchers issued to customers as they enter.

At Chit Chat Cafe, where volunteers serve toasted sandwiches, cake and drinks, the only "customers" are people with a condition known as aphasia.

People with aphasia can have difficulty speaking and understanding speech, reading and writing, or some combination of these. It is acquired when the regions of the brain responsible for language are affected after a stroke.

Ms Khoo, a speech and language therapist at the Abilities Beyond Limitations and Expectations (Able) rehabilitation centre, decided to start Chit Chat Cafe as a support network for people with aphasia when she realised there was little awareness about the condition even among those who have it and their caregivers.

The cafe held its first official session on Saturday morning (Dec 22) at the NTUC Health Silver Circle Senior Care Centre in Serangoon Central with the help of 17 volunteers. The participants included 19 people with aphasia and 18 caregivers.

About half the participants had attended a pilot session, held at the Able Respite Centre office in Toa Payoh last month.

Participants were grouped according to their age, interests and the severity of their aphasia. One to two facilitators - professional speech therapists like Ms Khoo - joined each group at their table as the participants chatted about their lives and shared their experiences with aphasia.

Mr Wong has had aphasia for the last nine years. His wife and caretaker, Mrs Wong Lee Yong, 71, said he had been looking forward to coming for the session since he attended the pilot session last month.

Anyone who is interested in attending can contact the volunteers by e-mail at ***aphasiasg@gmail.com*** or join the Chit Chat Cafe Facebook group.

SNSA is in the process of applying for grants for Chit Chat Cafe, with plans for expansion.

Chit Chat Café – the 1st Aphasia Support Network in Singapore

By: Evelyn Khoo P.L., Voon S.W., Zheng J.W., Lee J.L., Cheryl Lee, Siti Khairiyah M.J.

Background

Aphasia is an acquired language impairment, affecting the production or comprehension of speech and the ability to read or write, due to brain injury such as stroke or head trauma. Although 30% of strokes result in Aphasia, there is no support group available in Singapore for Persons with Aphasia (PWA) and their caregivers. Studies have documented high levels of depression and social isolation as well as low participation in leisure and social activities in Persons with Aphasia. A research study in Canada also revealed that Aphasia has greater negative impact on a person's quality of life compared to conditions like cancer or Alzheimer's Disease.

Chit Chat Café aims to empower all Persons with Aphasia to be independent and meaningfully engaged in the community.

Objectives

- To create a "safe space" that simulates a casual café setting for Persons with Aphasia to interact and socialize with the support of speech and language therapist (SLTs), thereby enabling them to gain confidence to communicate in public
- To provide opportunities for caregivers to network and share strategies
- To raise public awareness of Aphasia

Methodology

- Formation of a working team with speech and language therapists (SLT)
- across various clinical settings
- Informal interviews with individual PWA (current and former patients) to
- understand their challenges and aspirations
- Research on current models of Aphasia support groups overseas
- Adopted an "Aphasia Café" model that operates on a monthly basis

Implementation Process

- Invited Singapore National Stroke Association (SNSA) to be a collaborator
- Team decision to operate Chit Chat Café every 4th Saturday morning
- Recruitment of PWA participants through SLT network across institutions
- island-wide and via SNSA membership network
- Development of activities and aphasia-friendly resources including menus, conversation cards etc.
- The pilot of Chit Chat Café was launched on 24 November 2018 at ABLE Respite Centre; a total of 17 PWA and 12 caregivers attended. 15 healthcare volunteers facilitated conversations in an aphasia-friendly "café" setting
- Chit Chat Café was officially launched on 22 December 2018 at NTUC Health Silver Circle Day Centre; was attended by 19 PWA, 18 caregivers and supported by 17 volunteers
- Chit Chat Café was featured on Straits Times and Shin Min Daily News (https://www.straitstimes.com/singapore/health/volunteers-start-free-pop-up-cafe-for-people-with-aphasia)
- Since then, many PWA and caregivers have contacted SNSA and our team to inquire and participate in subsequent runs of the project
- The initiative is supported and funded by the Singapore National Stroke Association (SNSA) and venue sponsors such as NTUC Health and Able

Outcomes

- Very positive feedback from most PWA and caregivers; caregivers felt that PWA opened up and spoke more in session than at home
- All healthcare volunteers felt that the PWA and caregivers benefited from the event
- 70% of the attendees from the pilot project came for the next session
- SLTs reported that their pts were more participative in the next therapy session

Challenges & Learning Points

- PWA who had severe aphasia needed much coaxing to engage in conversation - undiagnosed low mood or depression
- Difficulty screening stroke survivors to include only PWA
- Catering to PWA who do not speak English
- Project sustainability and having to source for suitable venues as PWA participants increase

Chit Chat Cafe held its first official session on Dec 22, 2018, at the NTUC Health Silver Circle Senior Care Centre in Serangoon Central with the help of 17 volunteers. ST PHOTO: TIMOTHY DAVID

Future Plans

- Increasing frequency of Chit Chat Café sessions to include Mandarin and/or Malay-only sessions
- Introducing PWA-led small group activities outside of Chit Chat Café to foster deeper friendships
- SNSA is in the process of applying for grants for Chit Chat Cafe, with plans for expansion

*Reference: Lam, J.M.C. & Wodchis, W. P. (2010) The relationship of 60 disease diagnoses and 15 conditions to preference-based health-related quality of life in Ontario hospital-based long-term care residents. Medical Care, 48, 380-387

Milestones

Signing of MOU with Region Jönköping County in April 2018

Front row (left to right)

1. Dr Mats Bojestig, MD, PhD, Chief of department of Health Care, Region Jönköping County
2. Ms Agneta Jansmyr CEO Region Jönköping County
3. Ms Malin Wengholm, President of the Regional Executive Board, Region Jönköping County
4. Mr Håkan Jevrell, Ambassador, Embassy of Sweden
5. Prof Ivy Ng, Group CEO, SingHealth
6. Adjunct Prof Lee Chien Earn, Deputy Group CEO (Regional Health System), SingHealth

Back row (left to right)

1. Ms Vijaya Rao, Director, International Collaboration Office, SingHealth
2. Dr Edwin Low, Group Director, Regional Health System, SingHealth
3. Professor Boel Andersson Gäre, Director of Futurum, Department of Clinical Research and Education, Region Jönköping County and Professor in Improvement Science at the Jönköping Academy for Improvement of Health and Welfare, Jönköping University, Region Jönköping County
4. Ms Hema Selva, Commercial Officer, Embassy of Sweden
5. Dr Low Lian Leng, Director, SingHealth Office of Regional Health, SGH Campus
6. Mr Göran Henriks, Chief Executive of Learning and Innovation, Region Jönköping County
7. Mr Emil Akander, Trade Commissioner, Embassy of Sweden
8. Ms Helena Reitberger, Counsellor/ Deputy Head of Mission, Embassy of Sweden
9. Ms Esther Lim, Assistant Director, SingHealth Office of Regional Health, SGH Campus and Coordinator, ESTHER Network Singapore

Extract from GCEO Memo for April 2018: Taking strides forward for our patients!

> *"We are on the right track with our Regional Health System (RHS) and partnerships with health and social care providers to explore new ways of delivering care – care that is meaningful to our patients and meet their health goals. The Region Jönköping County have shared generously and been an integral part of our journey since we first set out to learn about the ESTHER Network in 2014. We subsequently launched our very own ESTHER Network Singapore in 2016 and to date, we have trained 100 ESTHER Coaches from 27 health and community organisations in Singapore under the guidance of Swedish ESTHER Coaches. Just last week, we signed a Memorandum of Understanding (MOU) with Region Jönköping County to cement the collaboration between our two organisations and reaffirmed our shared aspiration to build person-centered care through closer collaborations and deeper learning from the voices of individual patients and their experiences."*

ESTHER
Project Reports
2017 - 2018
(2nd batch ESTHER Coaches)

1

Meeting Birthday Wish of ESTHERs

Team Leader: Dr Kyaw Naing, Deputy Medical Director
Team Members: Ms Tan Joo Eng, Asst Nurse Manager
Mr Jazz Ang, SQA Executive
Sponsor: Ms Angela Tan

Background

HCA Hospice Care is Singapore's largest home hospice provider, providing comfort and support to patients with life-limiting illnesses. Most family caregivers are overwhelmed with burden of caring for the patient as the disease progresses.

Objectives

- To provide opportunities for patients and families to create happy memories and family bonding time, as ESTHERs have limited life expectancy
- Bring cheer to the family and make little wishes come true

Methodology

- The idea generally came from the nurses as they had celebrated ESTHERs' birthday previously
- Birthday dates of ESTHERs were retrieved
- Selection of ESTHERs was based on the following criteria :
  - Financial and socially needy
  - Physical condition is relatively stable with symptoms well controlled
  - Willingness to participate
- Based on the above criteria, primary care nurses then recommended suitable candidates
- Candidates were then asked:
  - How were past birthday celebrated, if any
  - What is their wish for the coming birthday
- After the celebration, post-event feedback was conducted through:
  - Observation or self report from ESTHER or caregivers
  - Interviews with primary care nurses or team members

Intervention

- ESTHERs with birthday in the month of October, November and December 2017 were identified from our patient database (two satellite on trial basis)
- From this list, Primary Care Nurses were asked to review if these ESTHERs met the criteria

Outcomes and Learning Points

- Primary care team observed positive outcomes during the celebrations, such as the cheer and bonding between patients and family members, and their appreciation of the nurses' participation
- Timely execution and planning for event is crucial as our ESTHERs condition could changed unexpectedly
- Primary care team reflected that creating meaningful moments and touching the spirit were critical factors in hospice care. The team was motivated by this project as they felt that it brought positive impact on patients' lives, to complement medical care

The Impact

"Yes it is very meaningful. I feel that I can do more for my patients on top of using my clinical skills and knowledge to help with their physical symptoms."
– by Primary Care Nurse

"Joy is the fuel for us clinicians as well as patient & caregiver to live this ardent season of life. ESTHER Project has this impact."
– by Primary Care Nurse

"Yes, it is meaningful. It was interesting to see our patients beyond their medical diagnosis, and to interact with them in a more informal setting."
– by Medical Social Worker

"It gave me joy seeing the smile on his face. He and his family enjoying the cake and as we mingled with them it was laughter everywhere….. It made me feel that I am doing something worthwhile."
– by Primary Care Nurse

"Hospice care would go to this extent to bring cheer & care to my mum at end of life. This is valuable in building a comfortable and trusting relationship….
– by Caregiver

Future Plans

- Continue with the current project execution, securing sponsors through our fund raising team would affirm sustainability
- Enhancement of project would involve celebration of other festive occasions
- Roll out project to include patients from all other satellite centres
- Getting Happiness Score pre and post intervention from ESTHERs and their caregivers

We wish to thank all HCA Nurses at Central, Hougang and Jurong satellite centres, the Psychosocial Team and support given by Ms Angela Tan (Sponsor)

2

Enhancing ESTHER's Community Support Network & Empowering Heart Failure Patients Using a Self Management Tool

Team Members:
Dr Julian Loh, & SSN Nor Syamsul & SMSW Clarice Ng
Sponsors:
Dr David Sim, SNC(APN) Teo Lee Wah & MMSW Genevieve Wong

National Heart Centre Singapore
SingHealth

Introduction

Establishing a direct care pathway with community service providers to monitor and support the care of heart failure patients in the community is key to improved long term health outcomes. This ensures that patients with medical and social risk factors have their symptoms, psychological and social needs closely monitored and well supported at home. A secondary component includes empowering the patients through better education and training them to confidently self monitor their symptoms. The goal of this project is to improve ESTHER's experience through a wider source of medical, nursing and psychosocial care and support in the community from chronic disease to end-of-life care. This project will present the key strategies to the

1) establishment of the holistic community partnerships
2) engagement of patients and internal stakeholders in the development of the self-management guide.

Methodology

Using a multi pronged approach, several networking sessions with the inter-disciplinary team were arranged between various community service partners to discuss the operational details of partnership. Regular follow ups through phone calls provided feedback to improve the workflow. Table 1 highlights the agreed target population. The self management book went through several rounds of edits using overseas and local materials as reference. Feedback were also sought from patients both from the outpatient clinics and inpatient wards. Heart Failure doctors and nurses also worked on simplifying the content of the guide after gathering feedback from patients. Collaboration with the NHCS corporate development provided design support.

Table 1

Type of risk factors	Target population
Medical	NYHA Class II - IV
	Readmitted at least once in the last 6 months
	Polypharmacy (>5 types)
Social	Frail with impaired senses
	Elderly and socially isolated

Home visit to our first ESTHER

Home visits were conducted to understand the needs of our ESTHERs at home. We also engaged our ESTHER's family members to hear from their perspectives on what matters to them. From this, we narrowed our target population to those with the greatest medical and social risk factors identified from our ESTHERs

Result

Each community partnership gave rise to improvements to the program development. To date, 4 partnerships have been established and 5 ESTHERs have been followed up at home. We will be holding quarterly team meetings with 2 of our partners to discuss our ESTHER's progress and the workflow. Training would be conducted to increase the capabilities of our community service partners. Table 2 depicts the outcomes of the project to date.

Table 2

Outcomes of project to date	Results
No. of ESTHERs interviewed to understand their HF baseline knowledge	12
No. of ESTHERs referred to community service partners for follow up	5
No. of community partnerships engaged	4
No. of training scheduled for community partners	2

Team visit to community provider

Team meeting with community partner

Team meetings were held regularly

Team visits to community service partners were conducted to discuss alignment of workflow and organization's capacity. We also approached organizations who were able to provide chronic care to end-of-life support.

Transformation from a 4 page black and white copy to a colourful 15 page copy

Interviews with patients to seek feedback

ESTHERs and inter-disciplinary team feedback were sought on the original patient education material. Fonts were enlarged, colours and pictures were added to increase its attractiveness. Final product is a 21-page heart failure self-management guide, which includes self monitoring charts.

Conclusion

The success of this project depends greatly on the deployment of effective communication and acting on feedback given from our collaborators (I.e. ESTHERs and community partners). Plans in place include quarterly team meetings to discuss project progression and to provide heart failure training for community doctors, nurses and social workers.

3

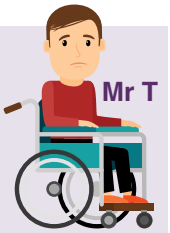
Empowering client and family to take charge of their own health to reduce unplanned admission

Team Leader: ANC Kee Mong Nee, Changi General Hospital (CGH)
Team Members: APN/ANC Gan Peiying,
Dr Julinda Concepcion, Changi General Hospital (CGH)
Sponsors: Ms Zhang Di, Changi General Hospital (CGH)

Background and Methodology

Mr T is a 47 years old gentleman, married with no children. He is chair bound and requires assistance in his Activities of Daily Living (ADLs) due to a recent stroke. He has been admitted multiple times since then.

Medical History
- DM/HTN
- Nephropathy with ESRF on dialysis
- ICH with seizure
- Depression
- Retinopathy
- Gastroparesis
- Gout



Problem

His wife verbalised feeling extremely stressed with the multiple admissions and felt extremely helpless with the situation (Table 1).

MAY 17	JUN 17	JUL 17	AUG 17
Adm 1: Seizure Abdominal pain	**Adm 2**: Hypotension Abdominal pain	**Adm 3**: Diarrhoea ? GE **Adm 4**: Hypotension	**Adm 5**: Fever, pneumonia **Adm 6**: Pneumonia

6 ADMISSIONS!

Out of 6 admissions, 5 of them are potentially avoidable!

Table 1: Details of Admissions From May to Aug 2017

> *"I was told by the ward to send back to hospital if he is unwell"*
> *"I do not know what to do if he has fever" "I am scared!"*
>
> Mrs T

Methodology

Mrs T was engaged through 1 to 1 interviews conducted during home visits. The nurse worked with Mrs T to identify the causes of readmissions and designed a plan to prevent avoidable admissions in partnership with Mrs T (Diagram 1).

Diagram 1: Causes of Readmissions

Aim

1. To empower Mrs T in decision-making during crisis periods
2. To increase Mrs T's confidence in managing ESTHER's condition
3. To decrease unplanned visit to ED

Proposed Solution

To empower Mrs T in her decision making, the home team focuses on addressing her gaps in knowledge by conducting a family conference. In consultation with the team physician, an individualized escalation guideline was developed so that Mrs T has clear instructions to aid her decision-making (Table 2). Caregiver's training was done to ensure that she is capable of performing interventions stated in the guideline. Acknowledging that time is needed for Mrs T to build her confidence in managing these clinical situations, the Home Team continued to support her with their clinical expertise during the care episodes.

	Regular Monitoring	Close Monitoring and Update Team	Call Team immediately (office hours)
Blood Pressure	SBP < 160mmHg	SBP < 100mmHg, client alert – Elevate both legs and recheck 30min later.	SBP < 100mmHg, client drowsy or lethargic
Bowel	Stools between type 3-5. Continue laxatives.	No bowel movement X 1 day – Insert bisacodyl suppository and monitor No bowel movement in 2 days despite bisacodyl suppository Stools between type 6-7, stop laxatives.	Stools with blood
Fever	Temperature < 37.5	Temperature between 37.5 to 38 – Serve Panadol strictly	Temperature > 38 X 2 episodes, start antibiotics. Continue Panadol strictly.

Table 2: Escalation Guideline

Outcome

After intervention, ESTHER's wife managed to handle 3 crises at home without any ED visit and there is NO admission from Sept 2017 to Nov 2017.

26 Sept	Wife managed to initiate PR bisacodyl insertion when patient BNO (Bowel Not Open) for 1 day
20 Oct	Patient developed low-grade fever. Antibiotic was given for standby and advised wife to serve if temperature was more than 38 degrees Celsius.
25 Oct	Wife initiated Augmentin when temperature spiked more than 38 degree celsius.

Learning Point

In the community, while the competency of the home care team is important, the ability to motivate and empower ESTHER as well as their families to take responsibility over their health is even more essential. This can come in the form of clear instructions and support. It is only through empowerment that ESTHER and their families can gain confidence and continue the care of their loved ones in the community. As such, the act of empowering the ESTHER and family to take charge of their health is the best strategy for long-term management of chronic conditions and decreasing unnecessary stress from avoidable admissions.

4

Reducing surplus medications dispensed by CGH outpatient pharmacy to ESTHERs living in the community

Team Leader: Cheryl Lau, Community Manager
Members: Dzulhelmy Idrus, Sr Community Coordinator
Rosidah Binte Adnan, Community Coordinator
Quek Keng Tian, Community Assistant
Nur Kamilah bte Abdul Karim, Community Assistant
Bernard Koh, Community Assistant
Mehrvn Abdul Salam, Community Assistant

neighbours for Active Living

Background

- Through home visits, there was observation that a number of clients have an over supply of medications
- Client, Mr Abdul Aziz, voiced concern that he had been paying a lot for his medications
- He had accumulated a huge amount of medications and requested help to reduce the amount and costs of medications prescribed to him
- 64 year-old Mr Aziz lives alone in a rented room in a shop house. Twice married, his family lives in Indonesia and he sees his family only occasionally. He currently works as a part-time hawker stall assistant
- Mr Aziz suffers from hypertension, end stage kidney disease (ESRD), diabetes, anaemia, gout and hyperkalaemia. He is a patient of SGH, CGH and the National Kidney Foundation





Medication problem Mr Aziz faced:

1. *Mr Aziz had medication stored all over his home (From fridge, to cabinet, or just laying around the kitchen).*
2. *It is so overwhelming that he can no longer track the quantity , type of medication he is missing (either due to expiration or that he have already finished his prescription).*
3. *Mr Aziz would always ask for the maximum amount of prescription, as he is unsure whether he has any left at home. The problem eventually snowballs.*

Objectives

- Empower Mr Aziz to know the types of medication that he is currently prescribed
- Help Mr Aziz manage the daily intake of his medications by introducing alarm and proper medications packing
- Develop Mr Aziz's awareness about over-collecting and keeping of unused drugs at home

Intervention

- Neighbours Team spent 2 hours counting and recording all the medications Mr Aziz had

The process of documenting the medications:

1. With the guidance of a trained pharmacist, the Neighbours Team documented the medications in his house
2. They sorted the medications based on expiry date, then the type of treatment.

- Results of medication counting revealed:
  - Out of 33 prescriptions, 18 (3501 tablets) had expired
  - After the count, Mr Aziz had 11,882 units of medications left ($5,252)
  - Estimation of what he really needs in the next 3 months cost $3,605
  - The remaining medications in his possession were no longer required
  - The team liaised with a Medical Social Worker to schedule an appointment with the pharmacists to address the Mr Aziz's issues and to reconcile all his unused medications and better manage the medications that he is taking

Medications to be thrown away worth about $707

Examples of expensive medications used by patients with kidney disease. Costs: $1480 for the first one and $997 for the second

Outcome

- Mr Aziz gained confidence over the process of medication reconciliation and education. He is able to communicate more effectively and work with his pharmacists to manage his medications at home.

Future Plans

- Identify other clients known to Neighbours programme who have CKD/Diabetes with polypharmacy.
- Assess their medication understanding and recruit them to the programme for better medication management.

5

Shared Renal-Palliative Care Model For Conservatively Managed End Stage Renal Disease Patients

Project Team: Dr Alethea Yee, SC, National Cancer Centre Singapore
Amy Lim, NC, Singapore General Hospital
Clinton Shi, MSW, Singapore General Hospital
Partner: Dr Patricia Neo, Assisi Home & Hospice
Sponsors: Dr Jason Choo, Renal Medicine, Singapore General Hospital
Dr Tracy Carol, Chief Nurse, Singapore General Hospital
Dr Nicholas Tay, COO, Palliative Support, NCCS

Background and Methodology

As Singapore faces an ageing tsunami, palliative care becomes increasingly important. While most Singaporeans prefer to pass away at home[1], only 27% of deaths happened at home, with majority in hospitals[2]. Ministry of Health (MOH) aims to increase the percentage of home deaths by promoting home hospice services and advanced care planning. For end-stage renal disease (ESRD) patients who opt for conservative management, palliative care becomes an important alternative to RRT and as they become frailer, community services take on an increasing important role to support them. But referrals to home hospice for such patients remain patchy while visits to hospital visits continue despite increasing difficulty by patients to do so as they deteriorate. Yet there is evidence that a good home hospice program can reduce hospital admissions and increase home deaths[3].

We interviewed 27 conservatively managed ESRD patients ("ESTHERS") that attends the Low Creatinine Clearance Clinic (LCC) at SGH from May 2017 to address their concerns and needs. (Refer to Table 1) We aim to reduce hospital clinic visits and admissions, as well as increase home hospice referrals and home deaths.

Proposed Solution: New Model of Care

From Jan 2018, a multidisciplinary healthcare team comprising of Nephrologist, Palliative Care Physician, Nurse Clinician, Renal Coordinator, Medical Social Worker, Dietician and Pharmacist, discuss all ESTHER cases before each clinic and agree on their care plans, medication reviews, and future case management. A referral criteria to home hospice was agreed. Assisi home care was chosen to ensure consistent standard of

Renal-Supportive Care & Assisi Hospice teams

care. We started monthly teleconference with Assisi on ESTHERs known to both teams. Queries arising from patient care in between teleconference are quickly resolved through secured group chats, with main point of contact between the teams being the Home Care Nurses and the Renal Nurse Clinician.

Results from interview

What mattered to ESTHER most?

- Being comfortable and independent
- Free from pain
- Ability to attend clinic appointments with less difficulties
- Medications delivered to homes
- No cash payment for blood tests at home
- Majority wish to be cared for at home in their last days and demise there.

Desired Impact of new model of care on ESTHER:

- Reduce hospital clinic visits
- Reduce transportation costs
- Reduce need for caregivers to take time-off from work to accompany patient for clinic visits
- Increase home deaths

Desired Impact on Hospital System:

- Reduce hospital admissions

Future Plans

To track hospital admissions and clinic visits, place of death of ESTHERS up to Jan 2018 and compare with historical cohort before implementation of the shared care model.

ESTHER is able to do what he enjoys (Left) and remaining independent (Right)

S/N	Interview Questions (n=27)	No. agrees
1	What matters to you most?	
	• Physical comfort & Independence	15
	• No pain	6
	• Nil for now	6
2	What are your concerns about your illness?	
	• Pain	5
	• Admissions to hospital	4
	• No care giver	2
	• No worries for now	16
3	What are the difficulties you encounter to get to the clinic?	
	• Care giver need to accompany / take leave	18
	• No issues for now	9

S/N	Interview Questions (n=27)	Yes	No	Neutral
1	Would you prefer Medications delivered to your home?	12	7	8
2	Would you prefer Bloods taken at home BUT need to pay cash?	4	15	8
3	Would your prefer to pass away at home?	14	3	10
4	Would you prefer to be cared for at home in your last days?	11	2	14

Table 1: Interview Questions and Result

References

1. Lien Foundation. (2014, April 8). 77% of Singaporeans wish to die at home. http://lienfoundation.org/sites/default/files/Death%20survey%20Presser%20Final%20-%20Combined_0.pdf
2. Singapore Demographic Bulletin, December 2013, http://www.ica.gov.sg/page.aspx?pageid=369
3. Jean Elnadry. Home-Based Palliative Care Reduces Hospital Readmissions .JPSM Feb 2017, Volume 53, Issue 2, Pages 428–429

6

Share-a-Pot Programme in Marsiling - Meeting ESTHERs' Needs Through Intergenerational Bonding

Team Leader: Amy Chan, Assistant Manager
Members: Tham Sinma, Assistant Director,
Eh Li Qi, Senior Executive
Chew May Qi, Executive
Project Sponsor: Pua Lay Hoon, Chief Nurse

Background and Methodology

Share-a-pot (SaP) is a community-based project that hopes to improve the nutrition and fitness of community dwelling seniors. The program empowers the seniors to exercise appropriately, eat nutritious food, and build strong bonds of friendship around a pot of hot soup.

The vision of SaP resonated strongly with volunteers, sponsors and social service partners, and with their help, SaP at Marsiling Heights was launched in January 2017. To improve participation, the program stopped in June 2017 for a review.

Aim

This project aims to improve the participation rate by 80% by the end of the pilot, through asking and involving ESTHERs prior to programme relaunch.

Intervention

A simple but critical problem was uncovered when we interviewed senior residents living at Marsiling Heights in August 2017 (Picture 1). 53% (39 out of 73) of the interviewed senior residents who did not join the SaP were unaware of the programme (figures 1 & 2).

Picture 1. Residents' Interview

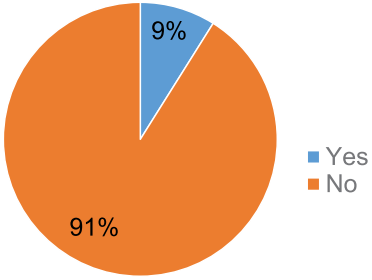


Figure 1. Share-a-pot attendance amongst interviewees

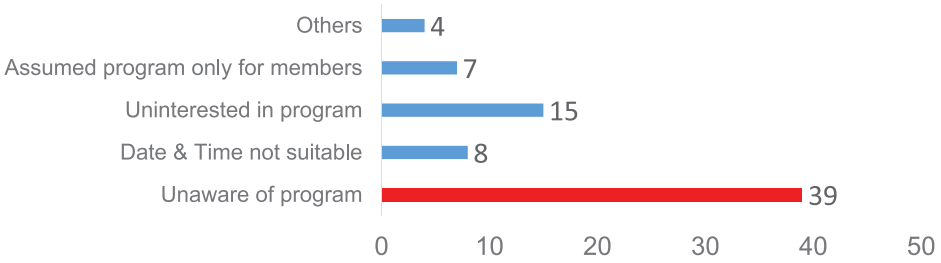


Figure 2. Reasons for not joining the SaP program

With this knowledge, our team sourced for new community partners to increase awareness amongst the target residents. Our partners include Woodlands Secondary School and the Residents' Committee (RC) at Block 123, located 60m from Marsiling Heights. The RC at Block 123 would be providing the venue and kitchen space to conduct the SaP.

A total of 220 secondary two student volunteers were coached on survey design and trained to conduct SaP functional assessments. The students conducted their own interviews with the ESTHERs to better understand their hobbies, needs and preferences for social activities at the same time.

Groups of 20 – 30 student volunteers would pilot the weekly SaP session over a period of 14 weeks. The student volunteers would be involved in soup preparation, exercise coaching, conducting functional assessments and implementing intergenerational social activities for the seniors.

Efforts to improve program publicity and awareness include monthly flyer distribution by the student volunteers, and a scheduled media coverage on the 3rd SaP session.

Future Plans

The pilot program is scheduled to start from 19 April 2018. Regular program review would be in place to monitor its progress, identify and resolve issues that arise. At the end of the 14 weeks, a post program evaluation with Woodlands Secondary School and ESTHERs would be conducted.

7

Improving ESTHER's Experience Transiting from Hospital to Assisi Hospice

Project Leaders: [1]Dr Lo Tong Jen, [2]Samantha Soh, [2]Tan Beng Le
Members: [2]Dr Rina Nga, [2]Celine Yong, [2]Grace Ong, [2]Leong Pei Ying
Project Sponsors: [1]Dr Alethea Yee, [2]Dr Patricia Neo, [2]Chiew Cheng Fong

[1] *Division of Supportive and Palliative Care, National Cancer Centre Singapore*
[2] *Assisi Hospice*

Background

Transfer of care between hospitals and inpatient hospices can be a distressing experience for patients with life-limiting illness and their caregivers. Assisi Hospice (AH) provides inpatient hospice stay for those who require specialist palliative care that cannot be provided at home. The purpose of this project is to improve ESTHERs' and/or their caregivers' experience in (1) care transition from Singapore General Hospital (SGH) to AH, as well as (2) their stay in AH.

Methodology & Discussion

Recruitment and Journey Mapping of 3 ESTHERs and their caregivers who allowed our team to observe their transition from SGH to AH, and subsequently interview them.

Analysis of the results, to understand ESTHERs' and their caregivers' experience(s) and identify what was important to them during the process (Table 1). The team decided to focus improvement efforts on item 3 as it was within the team's scope of influence.

A Survey, administered with 15 ESTHERs and/or their caregivers between 24/01/18 and 9/02/18, was developed to understand information most important (Table 2) and information not provided (Table 3) to ESTHERs and their caregivers.

Item	Identified Issues
1	Communication lapse between SGH/AH health care professionals (HCPs) and ESTHER
2	Short notice on date of transfer
3	Lack of information, awareness of AH services and purpose for transfer
4	Bad experience transferring to AH via ambulance services
5	Meal choices in AH

Table 1: Issues Identified through the process mapping exercise

Ranking based on importance	Type of Information
1	Purpose of care transfer to AH
2	Financial matters/ documentation
3	AH Services
4	AH Accessibility
5	AH Physical Environment
6	AH Facility
7	Meals in AH
8	Things to bring to AH

Table 2: Ranking of desired information

No.	Lack of information prior to transfer	Frequency
1	Financial Matters	4
2	AH Services	2
3	Meals in AH	2
4	Things to bring to AH	1
5	Time needed for admission	1
6	Purpose of care transfer to AH	1

Table 3: Frequency of information not provided

Proposed Intervention

Based on the team discussion with respective stakeholders in AH, we developed a 3-Pronged Approach (Figure 1) to improve the dissemination of information of (1) AH services, (2) purpose of care transfer, and (3) items to prepare prior to their admission in AH. We aim to implement the intervention in SGH Ward 48, by April 2018 and evaluate its effectiveness over two months.

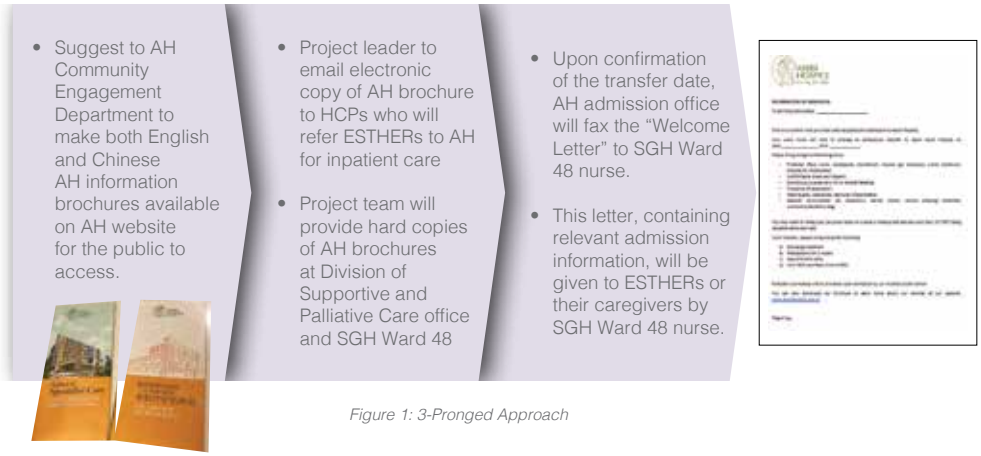


Figure 1: 3-Pronged Approach

Learning Points

- Feedback and input from caregivers is particularly important to enable HCPs to understand and provide relevant palliative care services to ESTHERs at the end of life.
- Collection of feedback from ESTHERs and their caregivers is especially time-sensitive in a palliative care context.

Moving Forward

We aim for future ESTHERs and their caregivers to receive a copy of the AH information brochure prior to their admission to AH. The intervention will be evaluated with a survey of future ESTHERs in May and June 2018.

8

Empower ESTHERs & Caregiver in Managing Medication at Home

Susan Lim SY[1], Jess Ho SY[2], Wong TT[3],
Pearline Koe LW[4], and Patricia Jin HX[4]

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[2] *Cluster Support @ Bukit Merah, NTUC Health*
[3] *Cluster Support @ Taman Jurong, NTUC Health*
[4] *Department of Medical Social Services, Singapore General Hospital*

Background and Methodology

With the increasing number of ESTHERs with chronic diseases, there may be a parallel increase in the number of medications prescribed. When medications are not well managed, this can predispose ESTHERs to medication errors, unnecessary wastage and higher cost incurred.

To assess ESTHER's ability in medication management, a questionnaire on medication taking, collection and management was administered. We interviewed a total of 8 ESTHERs. The following knowledge gaps were identified:

- 63% have the tendency to take old medications before new ones
- 57% do not know where to locate the expiry date on their medications
- 75% do not read expiry date & medication label before taking medications
- 67% do not know how to handle multiple (≥ 2) prescriptions
- 0% know how to read and understand partial stamp on prescription

Fig 1: Expired & discontinued medications seen in patient's medication bags

Fig 2: Excessive medication stock due to multiple collection from various prescribers

Mission Statement

- To increase the confidence level of ESTHERs and caregiver in medication management

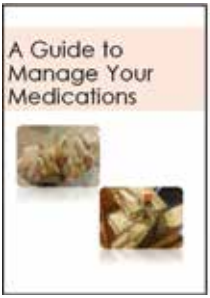
Proposed Solutions

Intervention 1: Medication stock tracking form

- Helps ESTHERs manage their medications at home by encouraging routine stock check prior to doctor's appointment / visit to the pharmacy
- Tool for promoting independence
- Column for attaching physical pill image helps illiterate ESTHERs to identify their medications easily & correctly

Intervention 2:
Educational Leaflet

- Pictorial guide on how to use medication stock take form & manage medications at home
- Useful tool for community partners (CP) to educate ESTHERs on medication management at home



Current Progress & Future Plans

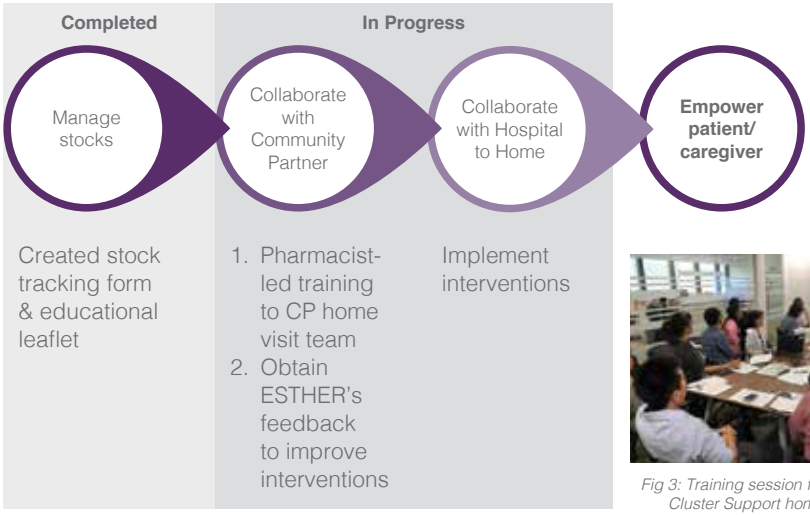


Fig 3: Training session for NTUC Health Cluster Support home visit team

Outcomes

- Five ESTHERs have completed the baseline questionnaire
  - With a maximum score of 10, confidence level in medication management vary from 3 to 8 (n=5)
  - Potential cost savings with proper utilization of medication stock (n=2): $24 and $289 per month

Learning Points

- ESTHER involvement is the key to provision of patient centered care
- Collaborative efforts with different health care providers is essential for ESTHER's care

9

To reduce ESTHERs' Turn-Around-Time in SGH to access to care plan options

Team Members: Kavitha D/O Sindaya, Agency for Integrated Care
Wong Yuen Yun, Singapore General Hospital
Project Sponsors: Loong Mun Wong, Agency for Integrated Care
Olivia Khoo, Singapore General Hospital

Background and Methodology

- ESTHERs visit Specialist Outpatient Clinic (SOC)
- Community referral needs are raised upon consultation
- ESTHERs are referred to Medical Social Workers (MSWs) in Medical Social Services (MSS) department

- ESTHERs would be given an appointment to meet MSW for care arrangement

- After ESTHERs discussed care arrangement with MSW, MSW would contact the doctors to fill up the medical report in order to submit the referral in Integrated Referral Management System.

- Average waiting time is **11 days**
- It caused inconvenience to ESTHERs and their caregiver as they are required to come back another day.

- Average waiting time is **12 days**

The whole ESTHERs' journey took average of **23 days**.

- The team conducted phone interviews to 10 ESTHERs and their caregiver to understand their journey and what matters to them.

What do ESTHERs want?

Problems Identified

- What ESTHERs want is to reduce the trip(s) to SGH and the waiting time to access to care plan options.
- We identified that there are the two causes contributed to the waiting time:
  1. Awaiting an appointment to meet MSW for care discussion
  2. Awaiting doctors to fill up the medical report of the referral form

AICARE LINK SERVICES

- AICare Link was set up May 2017 in SGH
- One stop information and referral touchpoint for seniors and their caregivers
  - Assistive financial grants and schemes
  - Intermediate and long term care (ILTC) services
  - Caregiving resources and support services
- Proactive screening of care needs
- ILTC knowledge resource to the hospital

Proposed Solutions

- For easy accessibility of the forms -Community referral forms will be printed out and kept in the clinic, SOC doctors will fill up the AIC hardcopy referral form in the clinic & ESTHERs will proceed to AICare Link counter to submit the referral form.
- AICare Link explains the Community referral services to ESTHERs and proceeds to submit to Service Provider.

- ESTHERs visit SOC
- Community referral
- needs are raised upon consultation

- Doctors fill up AIC hardcopy referral form in the clinic

- ESTHERs proceed to AICare Link
- ESTERs submits AIC referral form to AICare Link

- AICare Link explains the services to ESTHERs and submits form to Service Provider

aic
agency for integrated care

Future Plans

- Moving forward, to incorporate a paperless process and encourage doctors to go online for referral submission, doctors will be given refresher courses for e-training.
- Alternatively, SOC doctors to complete the Community referral form at the end of clinic hours.
- Empower clinic nurses and assistants to expand their scope to facilitate online referrals and submit e- referrals (based on doctor's inputs in the referral).

Our Target is to reduce the Turn-Around-Time to **FIVE DAYS**

10

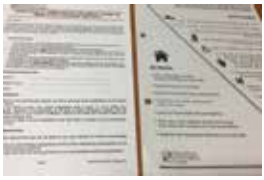
Improving Patient Education for New Chemotherapy Patients

Team leader: Joen Chiang, Principal Pharmacist
Members: Lew Kaung Yuan, Principal Clinical Pharmacist,
Teo Wei Ling, Pharmacist,
Koh Sze Fui, Nurse Manager,
Katherine Ho, Asst Nurse Clinician,
Sharon Boo, Senior Staff Nurse and
Ng Hui Cheng, Pharmacy Practice Manager
Sponsor: Lita Chew, Head, Pharmacy

National Cancer Centre Singapore
SingHealth

Background and Methodology

- Patients who come for first cycle of chemotherapy at NCCS Ambulatory Treatment Unit (ATU) may be overwhelmed by the information they have to provide as well as receive. This is in addition to the emotional/psychological stress that they may be feeling. We would like to improve patient's understanding of chemotherapy-related information when coming for the first cycle of chemotherapy at NCC ATU.

Average number of educational materials supplied to a patient receiving capecitabine/oxaliplatin (XELOX) chemotherapy:

- We interviewed 6 "ESTHERs" (5 patients, 1 caregiver) at Cycle 2 of XELOX chemotherapy to better understand their experience during Cycle 1.

Aims / Objectives / Mission Statement

- To formulate a strategy to personalize our patient counseling content/materials according to the needs of the patient

Proposed Solutions

We identified 2 main areas that require improvement:

1) There is a need to assess caregiver support / literacy level for a patient planned for chemotherapy such that appropriate amount of education and suitable materials can be provided

Proposed solution:

Incorporate assessment of caregiver support / literacy level in work process and document on a common platform. More time and resources may be allocated to patients who require more support.

2) There is a need to streamline education materials used by doctors, nurses and pharmacists in order to reduce overlap in information provided as well as prevent information overload

Proposed solution:

A) Nurses/pharmacists to share a common chemotherapy education checklist (points covered by nurses will not be repeated by pharmacists)

B) Explore a means of personalizing information provided to patients based on the specific chemotherapy protocol they are receiving. This will ensure that all the education materials received are relevant to them. To explore creating personalized folders (physical / electronic)

Learning Points

- We can only learn about the true needs of patients by talking to them. There may be incongruence between what we think is useful for patients and what they find to be useful

- Different patients have different needs – we need to be open to using different approaches for different patients.

Future Plans

- Higher level approval needs to be obtained for revamping of patient education materials as well as the platforms that they are provided on.

11

To Improve Patient Glycaemic Control so as to Reduce Hypolycaemic Episodes

Karen Thomson, Executive, Office of Improvement Science.
Sri Rahayu Masjum, Advanced Practice Nurse.

Changi General Hospital
SingHealth

Background and Methodology

In Singapore, more than 400,000 Singaporeans are living with diabetes. One in three Singaporeans has a lifetime risk of getting diabetes and these figures are expected to double over the next 25 years[1].

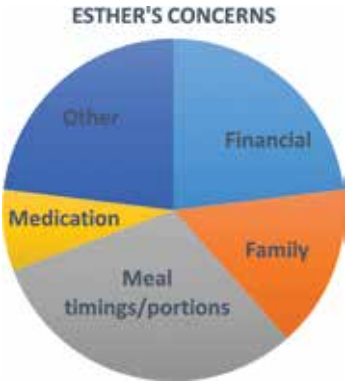
One of the complications of diabetes and its resultant medications is the occurrence of hypoglycaemic episodes. For people with diabetes, low blood sugar (hypoglycemia) occurs when the level of glucose in the blood drops below 4mmol/L[2]. Several risk factors can lead to hypoglycemia in patients with diabetes including taking too much insulin or other diabetic medication, skipping meals or exercising more than usual. Hypoglycemia can also lead to further complications, additional cost and length of stay in hospital[3].

This project was undertaken to understand better the needs of ESTHERs with diabetes and find ways to address any gaps identified.

Discussion

The team decided to adopt patient-centric methodologies to their approach of reducing hypoglycaemia in patients with diabetes. Three ESTHERs were interviewed to garner a deeper understanding of their concerns and discuss possible solutions. Interviews were one to one with open-ended style questions. Although only a small number of ESTHERs were interviewed, the problems which they encountered were consistent and mostly related to meal quantity/timings, medication and financial difficulties.

- **Meal timings/ portions**
  It is important to maintain a good balance of food intake and medication taken to reduce the likelihood of occurrence of hypogylocaemic episodes. Diabetic medications such as Insulin or Sulfonylureas can lead to hypogylcaemia if not balanced appropriately with food intake[4]. All of the ESTHERs spoken to said it was difficult to balance the level of food intake required with the medication they were taking. This was the main hurdle they faced on a day to day basis which required a lot of self-awareness and readjustments to their diet in order to avoid the unpleasant effects of hypoglycaemia and resultant negative impact to their overall health.



- **Financial concerns**
  ESTHERs also said financial implications were of concern. Blood glucose testing kits and strips were an ongoing cost, therefore not all ESTHERS could afford to use them to check their blood glucose levels regularly. People with type 2 diabetes can benefit significantly from testing their blood sugar levels as this provides immediate feedback on how food, lifestyle and illness affects blood glucose levels[2]. One of the ESTHERs was reliant upon family members for the purchase of medical equipment and expressed concern regarding being a financial burden to them, therefore did not want to purchase equipment such as blood glucose monitoring kit/strips.

Proposed Solutions

The findings from the ESTHER interviews were consistent with other ongoing work at CGH in relation to the prevention of hypoglycaemia. Thus, tests were already underway to tighten the timings of medication and meal serving in the hospital setting and also use this opportunity to help patients further understand the effects of different meals/ quantities on blood glucose levels. A plating chart can also be used as a reference for patients to identify how much food they have consumed.

Outcomes and Learning Points

- Working in a non-patient facing environment meant that access to patients was more challenging. Furthermore, patients build up trust over time with healthcare workers and are more likely to have more open discussions with them. Perhaps this is one of the reasons that the majority of ESTHER coaches are nurses or allied health professionals. However, I do believe that many of the approaches are applicable or adaptable to my work in improvement science.
- It is important to balance the individual needs of the patient with pragmatism and what is attainable by healthcare providers. Furthermore, it is important to recognise there is a wide disparity between patients in the level of care to which they wish to be self-involved. This is line with recent literature on 'Coproduction of Healthcare Service'[5]. In addition, in the ever-changing healthcare landscape, patient-centric care models should be adaptable to attain maximum benefit taking into account the local context.

1. https://www.moh.gov.sg/content/moh_web/home/pressRoom/pressRoomItemRelease/2017/diabetes--the-war-continues.html
2. https://www.diabetes.co.uk/Diabetes-and-Hypoglycaemia.html
3. Alexander Turchin, Michael E. Matheny, Maria Shubina, James V. Scanlon, Bonnie Greenwood, Merri Pendergrass. (2009). Hypoglycemia and Clinical Outcomes in Patients With Diabetes Hospitalized in the General Ward. Diabetes Care. 32 (7)
4. https://dtc.ucsf.edu/living-with-diabetes/complications/hypoglycemia/
5. Maren Batalden, Paul Batalden, Peter Margolis, Michael Seid, Gail Armstrong, Lisa Opipari-Arrigan,Hans Hartung. (2016). Coproduction of healthcare service. British Medical Journal. October

12

Integrated Care Delivery for 'ESTHER' Amongst Hospitals, Homes and Centres

Team Leader: Kung Beng Keng, Principal Physiotherapist
Member: Desmond Wong, Executive
Sponsor: Ng Lay Ling, Deputy Dir, Community-based Services

Introduction

In 2016, Home Therapy (HT) was piloted at St. Luke's ElderCare Ltd (SLEC) to fill a gap for ESTHERs who had been discharged from acute care, but were unable to access centre-based community care. As 'community-based physiotherapy' (Rajan, 2017), HT would help to meet rehabilitation needs and ensure ESTHERs flow to centres, or the services "best for each ESTHER". HT had high demand and very strong upward trends, even in comparison to home nursing services (Figure 1).

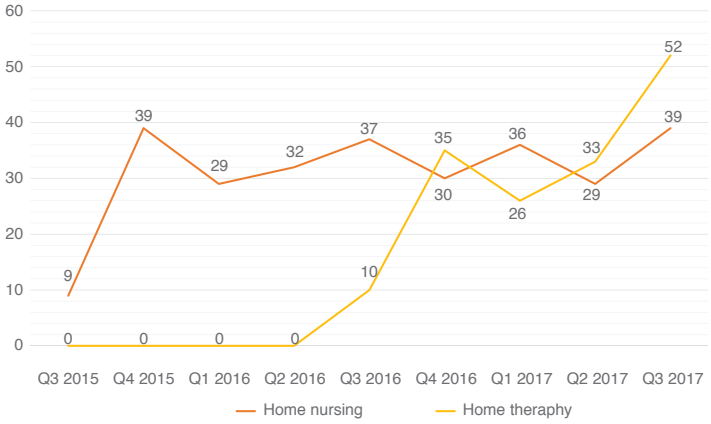


Figure 1. Demand for home therapy and nursing

Aims

Following ESTHER coach training, we sought to evaluate ESTHER flow to the next stage of the care cycle by tracking discharge destinations of patients who took up HT between September 2016 to December 2017 (n = 208).

Description

For our analyses, we excluded ESTHERs with no discharge destination ((n = 174): those who were still in-service, had withdrawn from the service, or had successfully completed HT and did no require further rehabilitation.

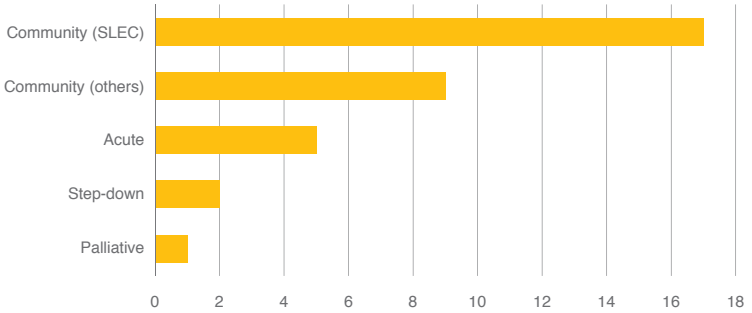


Figure 2. Discharge destinations by continuum of care

For patients with discharge destinations (n = 34), our numerical analyses suggest that post-HT:

1. **76% of patients (n = 26) accessed community care**;
2. **50% of patients (n = 17) accessed community care within SLEC's internal ecosystem**; and
3. 23% of patients (n = 8) went to acute, step-down or palliative care.

In comparison, retrospective statistical analyses on variables associated with discharge destinations were inconclusive: we were unable to identify predictors for either discharge destination or better ESTHER flow. HT generated **cost savings vis-à-vis continued rehabilitation over a median and mean period of 48 to 69 days**, respectively. Anecdotally, caregivers, ESTHERs, and staff were satisfied with the continuity of rehabilitation, which **prevented deterioration while waiting to access centre-based community care**. Caregivers and ESTHERs were also satisfied with 'seamless referral', **shorter waiting time between stages** in their care cycle, and **professional guidance** within community care.

Comments and Conclusion

Overall, HT is sustainable and transferable to similar community care settings. In the short-term, we seek to expand HT to centre-based patients whose conditions are deteriorating. We gather after starting HT service that some ESTHERs are experiencing difficulties in accessing cente-based rehab, citing reasons like high blood pressure when they arrived at the centre, making rehab unsuitable; anxiety causing muscle spasm sets in upon the effort of coming out of the house also rendered centre-based rehab unsuitable; caregivers constraint to accompany their ESTHERs for centre-based rehab is also a valid reason for HT vs centre-based. In the mid-term, we seek to improve on ESTHERs' flow within SLEC's internal ecosystem (i.e. from home to centres, and vice versa), which will require process mapping of the care cycle for each 'ESTHER', staff education, and 'seamless referral' procedures to be prototyped at local centres. In the longer-term, we plan to scale and replicate this across the organization, by tapping on our infrastructure across the city.

Reference

1. Institute for Healthcare Improvement (2018). Improving Patient Flow: The ESTHER Project in Sweden. Retrieved from: http://www.ihi.org/resources/Pages/ImprovementStories/ImprovingPatientFlowTheESTHERProjectinSweden.aspx
2. SingHealth (2018). Getting connected: The "ESTHER Network". Retrieved from: https://www.singhealth.com.sg/TomorrowsMed/Article/Pages/GettingconnectedTheESTHERNetwork.aspx
3. Rajan, P. (2017). Community physiotherapy or community-based physiotherapy, Health Promotoin Perspectives, 7(2), 50-51.

13

Self-care in Caregiving

Team members: Lim Lutin, Christina Goh &
Ng Siew Lee (Medical Social Workers)
Sponsor: Eunice Chin (Manager)

Bright Vision Hospital

Background and Methodology

Caregivers of ESTHERs give compassion and care to ESTHERs by providing physical care, financial support for medical/transport expenses and emotional support. However, these caregivers often neglect their own needs. The tangible and intangible costs of care can exact a heavy price on the health and wellbeing of a caregiver. With prolonged disregard for their personal wellness, the caregiver can suffer negative physical and emotional effects, such as burnout and falling ill. See Figure 1 on case examples. This will affect their ability to care for ESTHERs.

Hypothesis: Caregivers do not make future plans for their own financial, health and wellbeing.

Analysis: Initial brainstorming with team members to identify the root causes. Followed by interviews with Caregivers of ESTHERs. Findings on Caregivers:

- Do not make financial plans in the future due to (1) no financial means (2) depend on others to help such as pastor
- Do not have family/relatives available so rely on (1) self (2) BVH staff or (3) pastor
- Do not feel comfortable to discuss ACP as (1) it creates stress since there is no one to rely on (2) not urgent for now (3) they live in the present of one day at a time

Evidences in BVH of At-risk Caregivers

1. Mdm T (aged 79) mother of CSU patient. She was admitted into hospital twice in 2017. She has knee pain and back pain. However, she refused MRI. She is alone with poor social support.
2. Mr D (aged 69) son of CSU patient. He had heart disease and even collapsed once in our hospital while visiting patient. He is married with no children.
3. Mdm O (aged 50) mother of CSU patient. She experiences secondary stressors with marital issues related to her caregiving concerns.
4. Mdm M (aged 46) wife of CSU patient. Now has glaucoma and knee pain. Stressed with juggling care of patient and managing one teenaged son who is rebellious.
5. Mdm L (aged 48) wife of CSU patient. Diagnosed with breast cancer 2 years ago and now mets to bone and need long term care. She has 4 young children.
6. Mdm L (aged 63) wife of CSU patient. She has diabetes and leg pain which affects her work. She has one son in NS.
7. Mdm R (aged 61) mother of CSU patient. She has diabetes and ray amputations. Her diabetes complications occur very often. Family members are not supportive.
8. Mdm Z (aged 63) wife of CSU patient. She has poor health and now unable to get out of house. She has no one to rely on.

Figure 1: Case Examples of At-risk Caregivers

Aim: To raise awareness in caregivers of the importance of caring for themselves.

Proposed Solutions

Psychoeducation Group Work

- 3-session group work programme was piloted in BVH from late October to Nov 2017
- Open-group of 3 participants who are Caregivers of ESTHERs
- Duration: 1.5hr per session
- Topics presented:
  (1) Emotional management
  (2) How to communicate with healthcare professionals
  (3) Advanced Care Planning
  (4) Lasting Power of Attorney
  (5) Problem-solving strategies
  (6) Stress management exercise

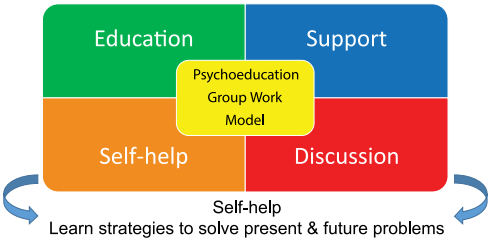


Figure 2: Model for Psychoeducation Group Work

Outcomes and Learning Points

Post-Programme evaluation by participants:

- Derived new learnings: 100%
- Able to apply the learnings: 100%

Pre-Programme Interview	Brainstorm	Co-facilitation
• Identify expectations • Understand needs	• Selection of topics • Develop content	• By former Caregivers • Empowerment through shared experience

Figure 3: Key Learning Points – Involvement of Caregivers at Planning and Implementation Phases

Future Plans

- Pilot a psychoeducation programme in 2018 in BVH inpatient rehabilitation programme, as part of discharge care process and to create awareness of self-care, for both ESTHERs and their Caregivers.
- Enhance existing BVH Caregiver support programme by involving caregivers as early as the planning stage.

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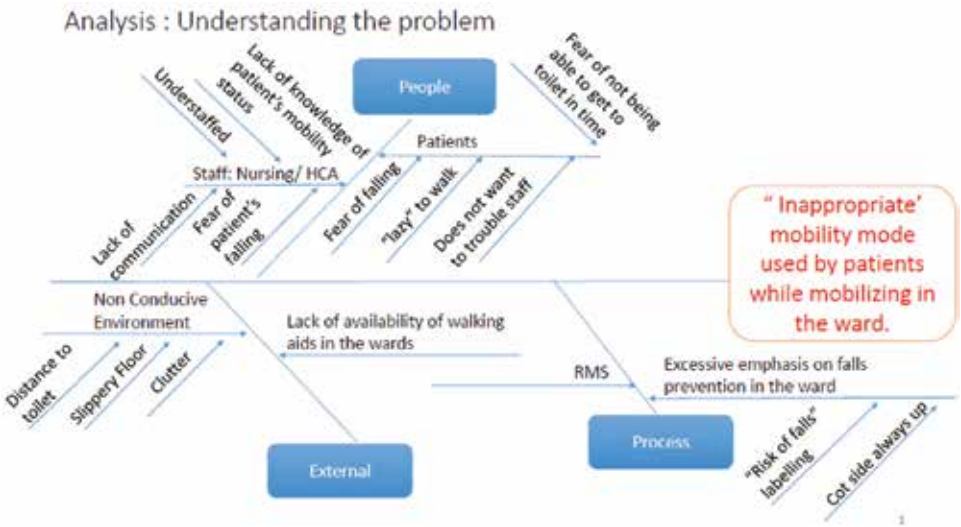
Triple M: appropriateness in Mode of Mobilization by patients Mobilizing in ward

Project team members:
Mah Shi Min, Sengkang General Hospital
Tay Ee Ling, Sengkang General Hospital
Jeyamany Jacob, Sengkang General Hospital
Eunice Chua, Singapore General Hospital

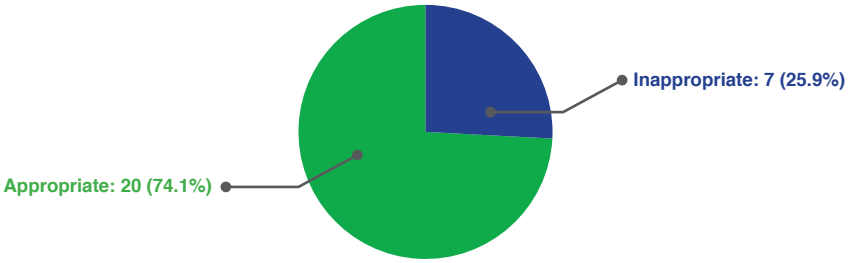
Background and Methodology

- During the ESTHER Coach workshop, we conducted an ESTHER interview. Our ESTHER reported that she had the ability to walk to the toilet with a walking aid. However, due to several reasons including healthcare workers' perceived fear of her falling, she was brought to the toilet via commode instead
- Our fishbone analysis in trying to better understand ESTHER's problem as illustrated:



Data collection and outcomes:

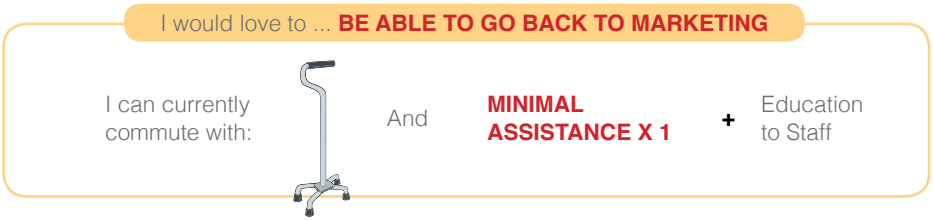
- Mode of transport to toilet/ TV area were recorded by observers and compared to suggested mobility mode by therapist



- Informal interviews with 6 patients and 14 staff were carried out:
- **Patient's responses:**
  - Felt they had been 'robbed of their freedom'; happy to bear the consequences of their own actions.
  - Felt that 'perceived fear of falling' by staff may not be accurate
- **Nurses and therapists responses:**
  - Under-staffing was the main barrier
  - Visual cues and improved communication between the healthcare providers, patient and family members may lead to patients being more mobile in the ward

Intervention Plan:

Design board



- Our project is designed based on these 3 principles:
  1) What is best for ESTHER
  2) What can ESTHER do by themselves
  3) What does ESTHER need help with

Future Plans:

Collect post-intervention data and carry out informal interviews to find out if there has been an improvement since implementation of our intervention

ESTHER
Project Reports
2018 - 2019
(3rd batch ESTHER Coaches)

1 Experience of Care

Empowering the SKCH ESTHER – HEalth JouRnal

Project team members:
Dr Luke Low Sher Guan, SingHealth Community Hospitals
Adeline Kwan Li Feng, SingHealth Community Hospitals
Yong Lee Ling, Sengkang Health

Project Sponsor:
Prof Wong Kok Seng, SingHealth Community Hospitals

Background of the problem

- Length of stay (LOS) at a Community Hospital (CH) is about 3 to 4 weeks
- Patients may not always understand the progress of their recovery and are not involved in their care and treatment plans.
- Low levels of patient engagement and involvement are causes for concern as these have been evidenced to have positive correlation to patient health status
- Longer stay in the CH compared to acute hospitals might require patients to be more engaged

Mission Statement

We aim to empower our SKCH ESTHERs

Analysis of problem

Through 1-on-1 interviews with ESTHERs at Bright Vision Hospital (BVH), we discovered the following challenges:

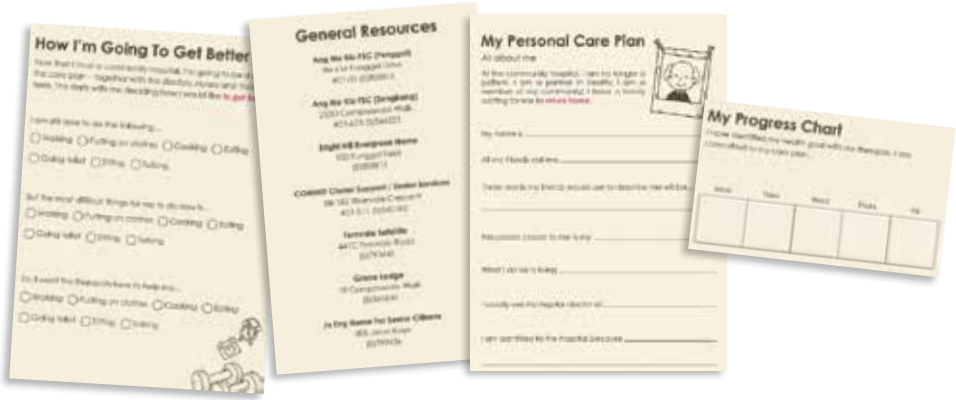
- 33.3% of them expressed that their family visit them only after office hours and thus were not able to communicate with the care team
- 67% of ESTHERs would like to have a file or a book that lists down needs, preferred options and type of treatment and medicine received in hospital

Interventions / Initiatives

Based on ESTHERs' suggestions at BVH, we co-created a health journal that engages and encourages them to voice out their preferences and needs, so that their teams' management plans can better cater to their individual preferences and challenges.

The journal also hopes to improve ESTHERs' understanding of both their health and social goals, providing them with action plans during the stay and frontloading any social concerns that patients might have prior to discharge.

Upon discharge, the journal serves as an integrated material (together with discharge summary) to communicate care goals and progress to the community partners.



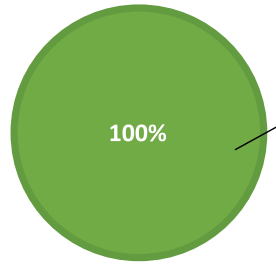
Sample pages from the Health Journal

Results / Impact

1. **Sharing details on myself have helped the hospital staff in helping me.**
2. **I understand how to take my medications and how each of them help with my health.**
3. **I understand my therapy plan and my progress thus far.**
4. **During my stay in the hospital, I knew who to approach if I had questions on my health.**
5. **When I return home, I know when I do need to go to a doctor, and when I can take care of a health problem myself.**
6. **When I return home, I understand what I can/need to do the things I want to do most.**
7. **When I return home, I know who I can approach if I need help on my health.**
8. **When I return home, I know what to do if I need help on my health.**
9. **I show my patient journal and share details in the journal with my family caregivers when they visit me in hospital.**
10. **My family caregivers find the patient journal useful to help them understand mv needs and care for me better.**

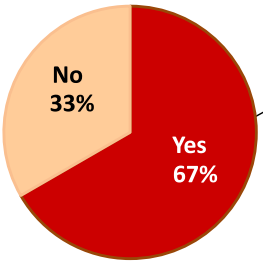
An adapted PAM-13 tool was used to gauge the effectiveness of the Health Journal. The questions target both ESTHERs (seek to understand if ESTHERs have increased in knowledge, confidence and ownership of their health through inputs in the journal) and caregivers (seek to understand caregivers' stake in the journal).

Finding:
Referencing interim survey results through the adapted PAM-13 tool, our ESTHERs might have gained some knowledge and ownership through the journal, but still lack confidence in managing their health. This can be seen in the pie charts below.



3 areas achieved 100% positive response:

- Understand my therapy plans and progress thus far [*knowledge*]
- Understand what I can/need to do the things I want to do most when I return home [*ownership*]
- Know who I can approach if I need help on my health [*knowledge*]



1 area that ranked the least positive and hence requiring improvement:

- Know when I need to go to a doctor, and when I can take care of health problem myself [*confidence*]

We went through PDSA cycles and gathered the following feedback from our ESTHERs:

- Hard copies of the journals can be misplaced
- Some are still unsure of how to fill up and require more guidance by staff
- Only English literate patients are able to use the journal effectively
- Journal and discharge summaries/memos are currently discrete documents and difficult to keep track of so many documents

Following feedback from ESTHERs and staff, these are the following refinements that we have implemented recently/intend to implement:

- Developed a Chinese version of the journal
- Changed from Likert scale to "Yes/No" responses for ease of response
- Incorporate advance care planning section into journal
- Therapists will print out exercise sheets and insert into journal
- Staff will print out discharge summary and insert into journal (single discharge journal with relevant documents inserted)
- Incorporate the journal questions into relevant sections of SCM documentation as part of daily work (no more need for hard copy journal)
- Non-clinical patient ambassadors to help patients with journal administration (improve effectiveness, reduces time needed for clinical staff to administer non-clinical portions)
- Patients who have been given the journal will have magnet sign posting at bedside and in SCM
- Work on gathering insights through focus group discussions with patients and caregivers
- May develop an app for patients to login

Limitations

- SKCH is a new organization. Most are concerned with meeting patients' routine care needs, and may perceive administering the journal as extra work.
- Busy ramp-up of wards, coupled with rapid build-up of workload, makes it difficult to juggle time between delivering patient care and improvement work
- Unable to administer effectively for non-English literate ESTHERs
- Not sure which ESTHERs have the journal, and which do not have - to have a better system for distribution to selected patients
- Need buy-in from various stakeholders and members of the allied health team to administer the journal
- It is a very new concept for elderly ESTHERs and they are not always used to the empowerment
- Internet separation makes app development and information sharing a lot more difficult

Moving Forward:

- We intend to try out in more wards as we open up the rest of SKCH, and in OCH as well when it is opened
- We plan to share the journal with SKH and BVH and synchronise similar efforts from t hese institutions

My Personal Care Plan

All about me

At the community hospital, I am no longer a patient. I am a partner in health; I am a member of my community; I have a family waiting for me to **return home.**

My name is _____

All my friends call me _____

Three words my friends would use to describe me will be...

_____

The persen closest to me is my _____

What I do / used to do for a living _____

I usually see my regular doctor at _____

I am admitted to the hospital because _____

_____

Useful Resources

Ang Mo Kio FSC (Punggol)
Blk 616 Punggol Drive
#01-01 (S)820616
Tel: 6435 5323

Ang Mo Kio FSC (Sengkang)
Blk 223D Compassvale Walk
#01-673 (S)544223
Tel: 6312 8100

Bright Hill Evergreen Home
100 Punggol Field
(S)828811
Tel: 6459 3492

COMNET Cluster Support / Senior Services
Blk 182 Rivervale Crescent
#01-311 (S)540182
Tel: 6385 0260

COMNET Cluster Support / Senior Services
Blk 206A Punggol Place
#01-2030 (S)821206
Tel: 6904 9965

Grace Lodge
19 Compassvale Walk
(S)544644
Tel: 6715 8870

My Caregivers

I have discussed with the care team, and I hope to be home by

_____

These are the people who can care for me

◯ Self ◯ Spouse ◯ Daughter ◯ Son ◯ Maid

◯ Others _____

I will contact my _____ at _____
to update and discuss my needs.

On discharge, I will need to make arrangements to:

See my primary care doctor at _____ on _____

See my hospitcl doctors at _____ on _____

Attend activities at _____ (i.e. day care / day rehab)

I hope to receive help from:

◯ Meals on Wheels ◯ Home help services

◯ Home therapy ◯ Others _____

Things I do that give me the most joy...

◯ Cook for my family ◯ Walk around the neighbourhood

◯ Send my grandchildren to school ◯ Go out with my friends

◯ Others: _____

Before my current condition, this is what a normal day is like for me...

_____

_____

_____

When I return home, what I want to do most is...

_____

_____

_____

What I do not like...

_____

_____

_____

How I'm Going To Get Better

Now that I'm at a community hospital, I'm going to be a part of the care plan – together with the doctors, nurses and therapists here. This starts with me deciding how I would like **to get better.**

I am still able to do the following...

◯ Walking ◯ Putting on clothes ◯ Cooking ◯ Eating

◯ Going toilet ◯ Sitting ◯ Talking

But the most difficult things for me to do now is...

◯ Walking ◯ Putting on clothes ◯ Cooking ◯ Eating

◯ Going toilet ◯ Sitting ◯ Talking ◯ Others:_____

So, I want the healthcare team here to help me in...

◯ Walking ◯ Putting on clothes ◯ Cooking ◯ Eating

◯ Going toilet ◯ Sitting ◯ Talking

◯ Financial assistance ◯ Relationships in the community

◯ Others:_____

About Me – Enhancing satisfaction of ESTHERs through exploration and documentation of their preferences

Dr Loo Yuxian, Bright Vision Hospital
Dr Gabriel Yee, Bright Vision Hospital

Background

Through our encounters with ESTHERs (patients and relatives) in our inpatient hospice, we discovered that ESTHERs were distressed when healthcare providers were unaware of their healthcare preferences (e.g. their likes, dislikes and goals of care). This problem is exacerbated by the lack of explicit documentation of such preferences as well as the nature of our healthcare system where staff change shifts and handover frequently.

Methodology

Through private interviews with ESTHERs, we worked with them to come up with an "About Me" form that would guide exploration of ESTHERs' preferences and facilitate handover of information between healthcare staff.

Outcomes

We measured the satisfaction scores of 28 ESTHERs towards their healthcare providers' understanding of their values, beliefs and preferences. We collected these scores before and after administering the "About Me" form, and weekly thereafter.

General information

Likes

Dislikes

My goals and wishes

Figure 1: Pre-intervention satisfaction

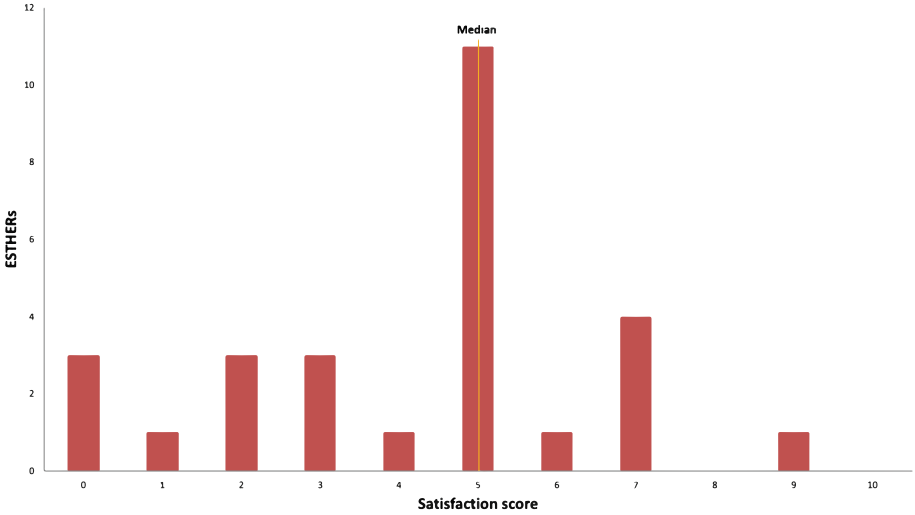


Figure 2: Post-intervention satisfaction

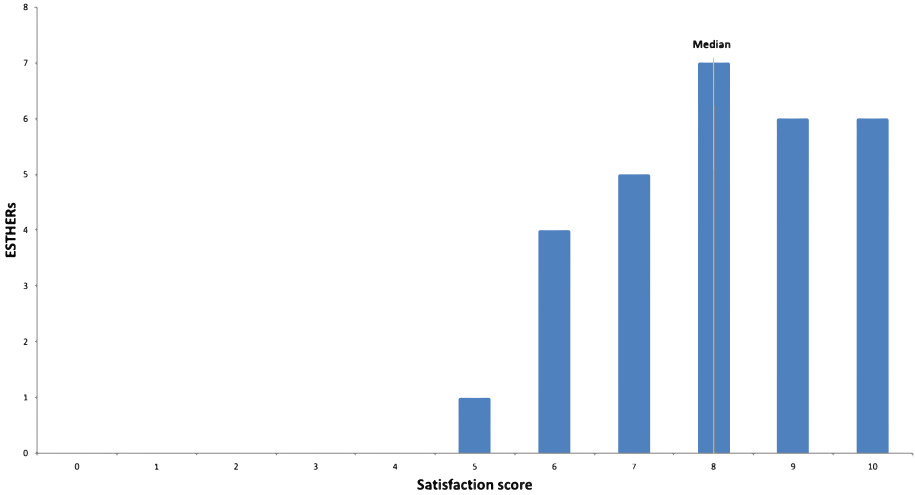
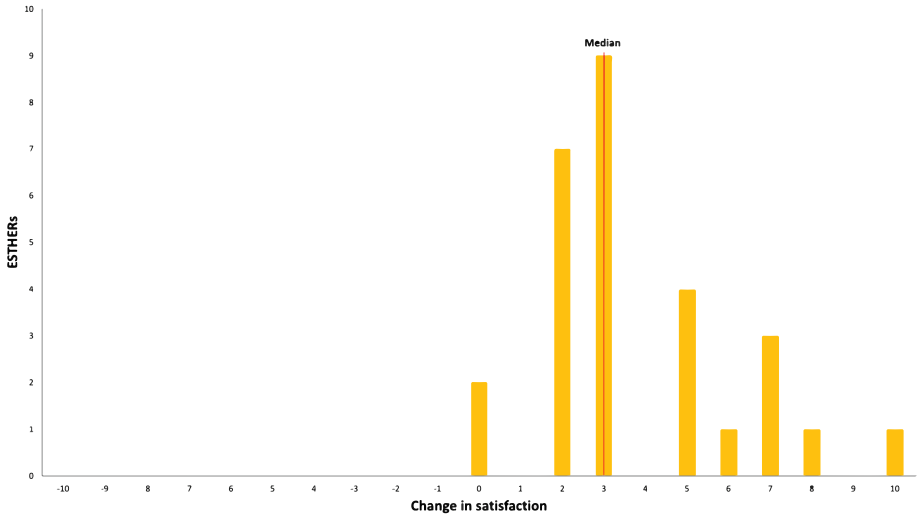


Figure 3: Change in satisfaction



Figures 1 and **2** show the distribution of satisfaction scores before and after use of the "About Me" form respectively. **Figure 3** shows the intra-individual change in satisfaction score after use of the "About Me" form.

Learning Points

- Many ESTHERs were not satisfied with their previous healthcare providers' understanding of their preferences (79% had a score of 5 or less).
- Most ESTHERs had an increase in satisfaction following the intervention (93%). No ESTHER had a decrease in satisfaction.
- A significant proportion of ESTHERs improved by 5 points or more with the relatively simple intervention (36%).
- Improvement was sustained or increased in the majority of ESTHERs in subsequent weeks (93%).
- In an inpatient hospice setting, the intervention did not require significantly more time than what is usually required.
- The "About Me" form became a platform to naturally transition into ACP discussions and helped facilitate subsequent treatment decisions.

Future Plans

- We intend to spread the use of the "About Me" form beyond the confines of the hospice ward, to our subacute palliative and possibly rehab patients.
- We intend to contact other service providers who believe in the same philosophy to see how we can collaborate to further improve the idea.

Understanding ESTHERs' Journey in SGH

Team Leader: Dr Tushar Gosavi, Department of Neurology
Team Members: Jelvin Sim, Community Integration Specialist Outpatient Clinic L
Ms Tay Xin Ying, Outpatient Pharmacy
Mr Ong Kheng Yong, Outpatient Pharmacy
Ms Nah Szu Chin, Outpatient Pharmacy
Sponsors: Dr De Silva Deidre Anne, Department of Neurology
Ms Tan Mui Chai, Department of Pharmacy

ESTHER Café & the Patients' Journey

- Six different visitors of Clinic L (patients/caregivers)
- Three are first-time visitors

Understanding the Problem

- ESTHERs' expectations of hospital visits is similar to that of General Practitioner (GP) visits
- Their most frequently visited medical facility is a GP clinic
- Used to the one-stop patient journey in a GP clinic

Hence (ESTHERs) ….

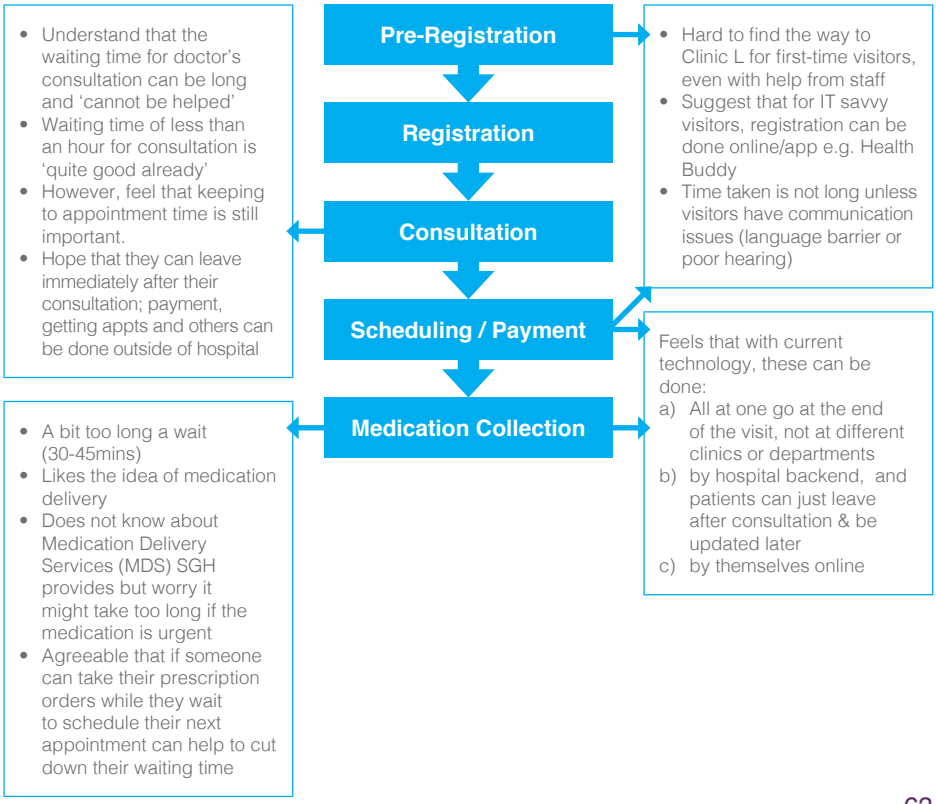
- Want to leave hospital as fast as possible
- Feel that they can handle appointment scheduling and payment themselves (outside of hospital grounds)
- Hospital trips should be more about the **consultation and not about payment, scheduling or medication**

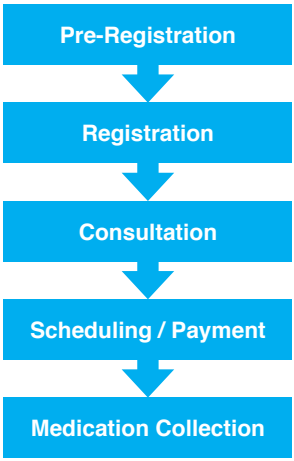
Long queue and large crowd at pharmacy at the end of the day after most of the visitors have finished their SOC consultation

Start by listening to ESTHER's voice

Neurology Clinic L: Patient Journey & interview	
Where did you come from? (Home/office) **Time arrived** **How frequent do you visit? (Clinic /Hospital)** **How long do you have to wait for your appointment (appt)?**	Background information to understand ESTHERs better. Also a way to map the journey without following them outside of clinic
Start to end, time taken (Registration, waiting, consultation, appointment, payment, pharmacy; others)	Patient Journey
Do you prefer if you could place your medication orders at the clinic, while waiting for payment? Medication orders can be processed while you are on your way to the pharmacy	Feedback on possible interventions, also a tool to get ESTHERs thinking so that they can share more
Any other suggestions?	This is where ESTHERs speak up the most. Cover areas the questions did not

Connect ESTHER's voice to their journey





Interventions:

1) Help promote Medication Delivery Service (MDS) by pharmacy
2) Place medication review, reconciliation & order-taking at the clinic, while waiting for payment

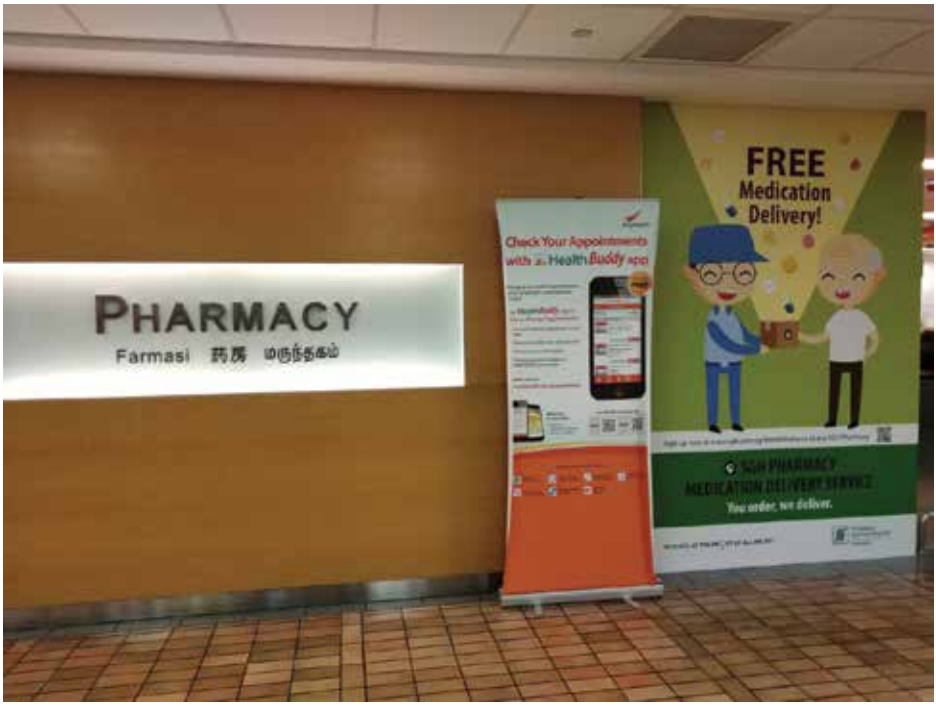
Methodology: (Nov 2018 – mid 2019)

November to December 2018:

1) Road shows on MDS to Clinic L staff & neurologists
2) Promotional materials at Specialist Outpatient Clinics & Clinic L
3) Work on a workflow between Clinic L & Pharmacy for MDS; a right-siting pharmacy staff at Clinic L to facilitate the process of MDS

January 2019 onwards:

1) Data collection & analysis



MDS poster outside the pharmacy to raise awareness of the service

Measurement(s):

1) Measure clinic L staff knowledge of pharmacy services pre & post intervention
2) Measure changes in monthly application by Clinic L patients for MDS
3) Measure Patient/Visitor satisfaction score before & after the changes in the workflow

Current Challenge(s):

1) Challenging to explain MDS in detail during peak hours
2) Decline of MDS due to:
    - Preference to collect on site since they are already there
    - Do not see the need for it as they are coming back to SGH due to multiple appointments in SGH

What Matters to ESTHER in Preventive Health?

Project Team
Leader: Elizabeth Pang, Assistant Manager, Community Integration
Member: Mike Loo, Senior Executive, Community Integration
Sponsor: Jean Luay, Senior Manager, Community Integration

Introduction – Preventive Health

The Community Integration team on SGH Campus partners MOH , grassroots and community partners in rolling out national preventive and wellness programmes such as health screening, functioning screening, health coaching and health talks. Beyond national level programmes, the team examines the profile of the resident population around the southeast region of Singapore, and hopes to target our local intervention programmes to meet the unique needs of the residents we serve. The southeast region covers an estimated resident population of about 300,000 people, with more than 18% aged 65 and above. An estimated 7.5% within this group lives alone.

Keeping ESTHERs Active and Well

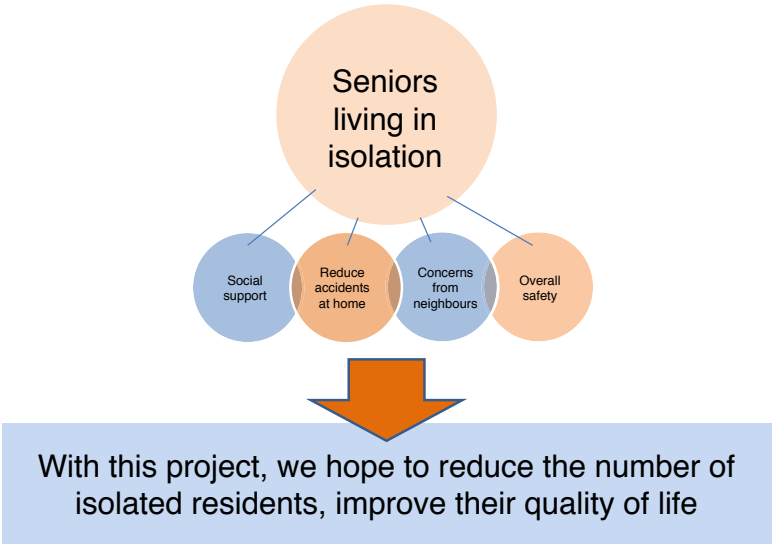
In addition to the statistics on the profile of our population, it was important for us to see the issues presented from the perspectives of ESTHER. In preventive health, we may think that we know the best approaches for our ESTHERs , for example – "I think ESTHERs need this.", "I think ESTHER should do this…". But how often do we actually speak to our ESTHERs and ask them "What do you like?", "What makes you happier?". Our hypothesis is that if we start involving ESTHERs early to know their thoughts and priorities, any upstream intervention programmes we invent later may receive better buy-in and higher resident satisfaction.

Hence, besides checking in with our community partners on their views and the challenges faced, we conducted an ESTHER café with residents in the comfort of their community to understand what matters to ESTHER in preventive health.

ESTHER Café

The ESTHER café was conducted informally, in the community where residents gather. Residents were asked a broad, open question: "What are the concerns you and your neighbours have, in keeping well and active in the community?". These were the voices of ESTHERs:

The issue on isolation and safety, not socialising enough due to constraints, caught our attention. It is also backed by our data that 7.5% of our elderly cohort aged 65 and above lives alone. We decided to explore the concern of social isolation leading to vulnerability in the elderly.



With the objective of improving the quality of life for ESTHERs, especially those who live in isolation, we conducted another round of ESTHER café targeting at residents living in isolation, as identified by our community partners, Montfort Care and Kreta Ayer Senior Activity Centre (Banda). This is to allow them to live well, age well, and be active by being supported in the community. We visited several residents at their homes. One of them was not at home and was roaming around the neighbourhood alone. We were not able to locate her. We managed to chat to two ESTHERs.

We spoke to Uncle A, who was in his 60s with irritable bowel syndrome (IBS). We had a long chat and he shared with us some of the most painful experiences in his life and how he used to struggle with depression. He had even tried to take his own life previously. He was open to share, but declined attending any organised or centre programmes as he felt most at ease at home. Due to his IBS, it was a stress to hunt for toilets outside the comfort and convenience of his own home.

Grandma B turned out to be a jovial and chatty Hakka lady in her 80s, although she appeared to keep to herself. She loved cooking and her eyes light up as we discussed about food. However, due to her weak limbs, she was unable to manage the heavy cooking utensils. She had a high fall risk, hence her family members who lived apart, discouraged her from getting out of her house. As a result, she had not participated in any activities organised by the Senior Activity Centre (SAC) situated at her block.

Learning Points

ESTHERs do need autonomy to decide what is best for themselves. Their challenges need to be viewed in the context of their circumstances. And the only way to find out is to inquire directly from ESTHERs. In our findings, some ESTHERs are just contented to be left alone. The reasons could be due to their individual preferences, circumstances or health-related issues. Their priorities could be to maintain their current conditions and minimise incidents from happening. Grandma B is a good example where she prefers to be in the security and comfort of her home, and not be a burden to her family should anything happen to her.

These interactions allow us to realise that we tend to focus on what we need for the service to run (e.g. how to increase participation rate?) rather than the needs of the person. ESTHERs have their views on what is best for them, their own priorities and constraints in life. We need to see ESTHERs as an equal partner in the planning of such activities or care for them, and that getting their opinion is an important first step.

In planning preventive health programmes including future approaches to engage out-of-reach residents, we are now more comfortable in involving ESTHERs and recalibrating our approach to ensure our programmes are truly person-centric.

Improving the awareness of the quality of Meals-on-Wheels (MOWs)

Stephy Yang Yajie, Cluster Support, Fei Yue Community Services
How Ai Xin, Community Health, TTSH
Eunice Lim Yi Xin, Community Health, TTSH
Clarice Woon, Community Health, TTSH
Ng Tzer Wee, Community Health, TTSH

Introduction

With an ageing population, there are more elderly who are frail and home bound. Hence nutritional meals with variety become increasingly important to ensure their well-being. The Meals-on-Wheels (MOW) initiative was introduced to address nutritional problems faced by elderly who are too weak to cook at home and for elderly with no caregivers.

Taking into consideration the nutritional needs and dietary preference, food prepared were recommended to be low in salt with lesser oil. The challenges posed to MOW service providers include having to prepare food for many clients and also to deliver the food to clients staying in different residential areas. Service providers do provide Halal and blended diet options. However, this variation makes it difficult for the service providers to manage due to intricate logistical challenges.

In collaboration with service providers serving elderly in the community, this project serves to increase the awareness of the quality of MOWs for service providers and explore the option of bringing about a variety to the elderly through different venues. Through ESTHER cafes with the elderly and service providers, feedback and suggestions were shared. In addition, surveys were also conducted with six domains such as food presentation, portion, taste, variety, texture and temperature to find out client's current meal experience.

Learning Points

From ESTHERs' Point of View

1. Variety and choice are important in the client's meal experience. Most of the time, clients have small requests such as smaller meal portion, softer rice texture and adding gravy or chili to enhance the meal experience.
2. 65% of respondents rated their overall experience with MOW as fair or poor.

From MOW Service Providers' Point of View

1. There are limitations to the amount of customization MOW service providers provide due to logistical and meal preparation guidelines.
2. However, MOW service providers do cater to some needs of clients such as adopting bento-style containers, removing citrus fruits or changing rice to porridge when requested by clients.

Sharing of meal experience during 2nd ESTHER Café by clients receiving MOW at Fei Yue SAC @ Hougang

Objective

To increase the awareness of quality of Meals-on-Wheels amongst service providers to improve client's experience.

Proposed Solutions

1. Engage more ESTHERs for survey to identify the essential issues
2. Engage MOW providers to assess baseline awareness
3. Engage ESTHERs and providers to develop possible solutions

Methodology

What matters to ESTHER? – Project Selection	1st round of meeting with different service providers and gathering perspective from partners to narrow down the common issues raised among elderly in the community
What Matters to ESTHER? – ESTHER Café	2nd round of meeting with clients receiving MOW and listening to their feedback on current MOW services
Surveys conducted for 20 clients who are receiving MOW and their feedback	Based on the ESTHER Café, a survey form was created based on the factors of what matters to ESTHERs and 20 elderly. The six domains in the survey include food presentation, portion, taste, variety, texture and temperature
Analysis and sharing of survey results with MOW service providers	3rd round of meeting involving MOW service providers – Touch Home Care, Sunlove Community Services and staff from Agency for Integrated Care (AIC). Survey results were shared with the partners and feedbacks were also gathered
Implementing different meal options and comparing pre and post meal experience	Different food options will be shared with three elderly in addition to their daily MOW service. Pre and post survey with be conducted to evaluate the meal experience

Acknowledgement

We would like to acknowledge and thank Touch Home Care and Sunlove Community Services for their participation and contribution towards the project. We would also like to extend the appreciation to members of Fei Yue Senior Activity Centres for their participation in the focus groups and surveys.

Reference

Tai, Janice (2014, Jan 29). Homebound elderly on Meals-on-Wheels programme to get healthier, tastier meals. Retrieved from https://www.straitstimes.com/singapore/homebound-elderly-on-meals-on-wheels-programme-to-get-healthier-tastier-meals

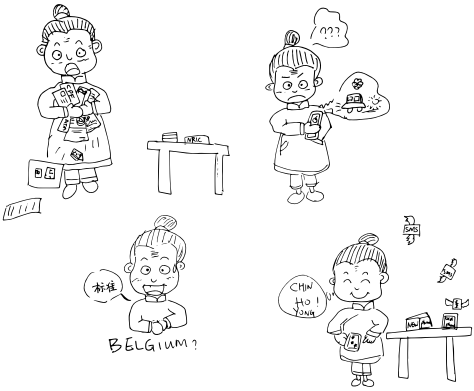
To help ESTHERS expedite their Medifund application

Team members: MSW Peter Cheng (Leader)
SWA Chris Liu Jiawei
Dr Gosavi Tushar Divakar
Sponsor: Olivia Khoo Ruey Lin

Singapore General Hospital
SingHealth

Background and Methodology

Medifund is an endowment fund set up by the government that provides a safety net for ESTHERs who are financially needy.

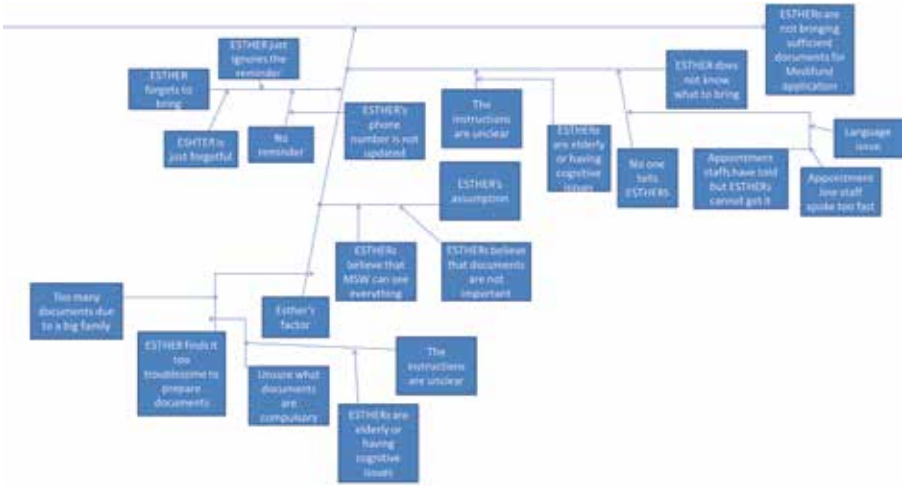


ESTHERs may make an appointment with a medical social worker (MSW) to apply for Medifund through

- calling the appointment line or
- walk-in directly to MSW department or
- through a doctor's referral.

However, miscommunication due to multiple requirements can lead to ESTHER requiring multiple trips for a successful application.

Through ESTHER café (N = 16), we found our the root causes to the issues experienced by ESTHERs:



Objectives

- To reduce the number of trips ESTHERs make for Medifund applications
- To increase the percentage of ESTHERs who can complete Medifund application with sufficient documents on the first appointment with MSW

Outcome Measurement

- Number of trips ESTHERs require for completion of Medifund application
- Percentage of ESTHERs who are able to complete Medifund application on the first appointment with MSW

Distributions of Issues

16 ESTHERs who were interviewed indicated the challenges that they faced.

Challenges	Number *
Too many documents due to a big family;	8
Forgetfulness of the patient	4
Patient's telephone number is not updated	2
Patients are elderly or have cognitive issues	3
Language issues;	4
Staffs spoke too fast in appointment line;	3
Other concerns	1

** The numbers do not add up to 16 as ESTHERs can have multiple indications*

Proposed Solutions

To combine the above forms into one form that is made available at any touch points for ESTHERs. It should help as a reminder to ESTHERs. This initiative is being piloted at Clinic L in Singapore General Hospital from Feb to Apr 2019 for at least 30 ESTHERs. Measurements will be compared against the experience of ESTHERs who go through the routine process.

Family info and household expenses breakdown

Checklist

Referral form

Learning Points

Cooperation - This project needs the contribution of different stakeholders to see the common purpose of dedicating resources to improve ESTHER's experience.

Task focusing - It is important to work towards a common challenge that most ESTHERs are facing.

Future Plans

- If the initiative proves effective, we plan to expand to other clinical units by the second half of FY 2019.
- We will explore to collaborate with MSWs from Tan Tock Seng Hospital to develop a common tool.
- We will continue to explore other areas or approaches which can further smoothen the process of Medifund application for ESTHERs.

Enhancing ESTHERs' Readiness for MediFund Application

Project team members:
Karen Kwa , Kelly Tan , Amanda Yap,
Edmund Lim, Elaine Low,
Tan Tock Seng Hospital

Introduction

Healthcare cost is a concern for many ESTHERs, especially those who have limited financial resources. MediFund, an endowment fund provided by the Government, can help ESTHERs who face genuine financial difficulties to manage their medical bills. Nevertheless, they will have to undergo an application process to determine if they qualify for the MediFund assistance. Expediting the MediFund application process is pivotal in ensuring that ESTHERs who are in need of help get timely financial assistance.

At Tan Tock Seng hospital Care and Counselling department, we put up an average of 16,500 MediFund applications per year. We observed that multiple sessions were required by some ESTHERs to complete their MediFund application. The multiple visits could result in tangible and intangible costs to ESTHERs (e.g. time, travelling expenses, disruption to work etc.). In addition, the multiple visits could also lead to longer turnaround time for them to receive financial aid, hence heightening their anxieties and interrupting their access to healthcare.

A key contributing factor to the multiple visits is ESTHERs' readiness for the MediFund application process. Figure 1 below illustrates the significance of the problem.

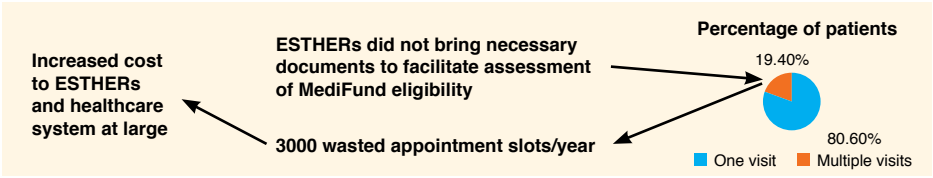


Figure 1

We therefore embarked on this project to explore ESTHERs' experiences and readiness in relation to their application for MediFund assistance. With the ESTHERs' inputs we hope to develop effective strategies to enable ESTHERs to better navigate and complete the MediFund application process.

Methodology

Collect baseline data	Outpatient Medical Social Workers (MSW) were asked to collate the number of ESTHERs who:1) came for MediFund review without necessary documents; 2) have multiple visits to complete a MediFund application; 3) dropped out of the MediFund application process and 4) had completed their MediFund application in one sitting, over a one week period.
Interviewed ESTHERs	• Project team members interviewed a total of 6 ESTHERs, 4 Males and 2 females • Feedback provided by the ESTHERs were collated and analyzed
My Care	• A group of 6 participants were engaged in Quality Improvement workshop for a period of 3 days. • The 'Go and See' methodology was adopted. 2 participants were assigned to observe the reception area, 2 to observe MSWs interviewing patients and 2 to observe the hotline staff. The purpose of this exercise is to understand the entire process ESTHERs have to go through for MediFund application and to identify waste areas. Participants also proceeded to do value stream mapping, in which their observations of ESTHER's experience and pain points were noted.
Choose Intervention tool	• Potential strategies to enhance ESTHERs' readiness for the MediFund were identified through the inputs provided by interviewed ESTHERs and the MyCare review process • Project team had decided to embark on an education initiative (create a brochure to educate ESTHERs on MediFund application procedures) as their first pilot
Develop intervention tool	• ESTHER project team sat to discuss content of brochure. • 5 ESTHERs were consulted and provided comments on the brochure. Edits to the brochure were made accordingly. • Project team intends to conduct a trial in collaboration with one of the medical units in the hospital. The brochures will be placed at strategic areas in the medical clinic for ESTHERs' easy access. The brochure will also be given to ESTHERs when they verbalized challenges in managing their medical bill and at the point of referral. The project team will evaluate the effectiveness of the brochure in enhancing ESTHERs' readiness and completion of their MediFund application within one sitting.

Results

ESTHER Interviews

Reasons for not being ready to complete MediFund in one sitting

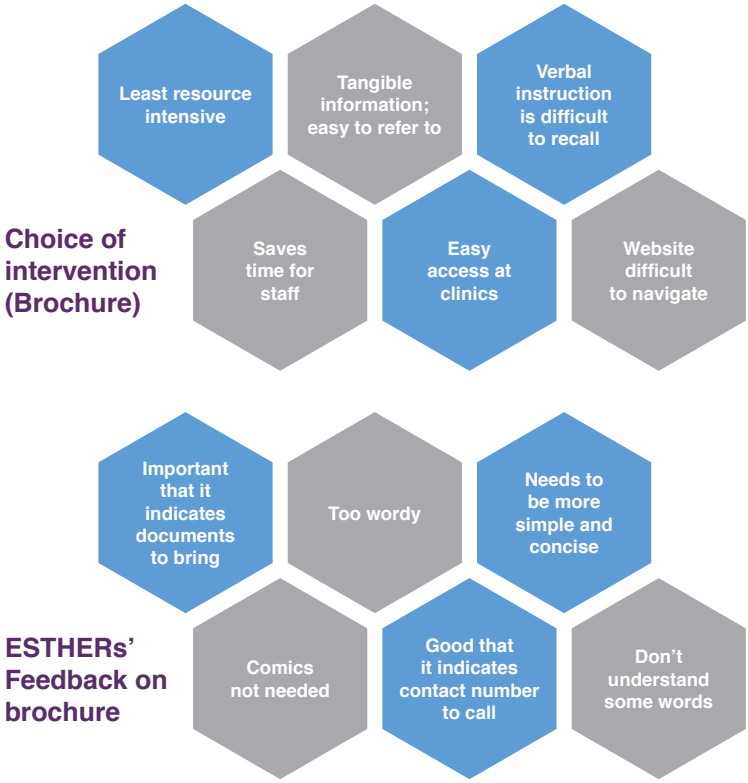
- Stressors and mental/emotional state
- Time constraints and accessibility issues
- Lack of adequate understanding of MediFund requirements
- No initial advice on what documents to bring
- Staff did not clarify ESTHERs' understanding of what documents to bring
- Uncertainty of who to contact to clarify about documents

What matters most to ESTHERs?

- Clear understanding of MediFund process
- Clear and prompt information of documents required
- Reminders about documents
- Alternative methods to submit outstanding documents
- Working relationship with MSW
- Space and safety to clarify about documents and/or MediFund process
- Understanding & empathy from staff
- Confidence gained through learning and experience

‘Go and See’

WASTES	ESTHER’S EXPERIENCE	PAIN POINTS
• Unnecessary waiting time (obtaining documents, submitting of documents, arranging another appointment when there is insufficient documents submitted) • Current document checklist not utilized • *list is not exhaustive	• Requires a lot of documents from different sources • Feels lack of transparency of approval criteria which leads to confusion, frustration and fear. • Feels MSW are too strict.	• Getting documents • Spending time away from work to attend appointment/s • Getting family members involved. • Repeating information • Bouncing of appointment between staff and also between patient and staff.



MediFund Brochure after ESTHER's Feedback

Plans Ahead

Learning Points

Engaging ESTHERs throughout a project can be time consuming but insights provided are very valuable and sometimes even unexpected.

There is a need for flexibility in tailoring project plans and strategies for ESTHERs.

There is a possibility of using various QI methodologies. Nevertheless, it is important that ESTHERs remain central in all approaches and regarded as cocreators of valued strategies and outcomes.

Acknowledgement:

We would like to acknowledge and thank Doreen Yeo (Sponsor), Clarice Woon, Ng Tzer Wee, Ivan Woo, My Care participants, CNC Patient Education and Activation team members and all our ESTHERs for their support and valuable contribution to this project.

8 Empowerment

Grow Senior Volunteerism of ESTHERs in Project IRENE

Tan Pei Qi, Social Work Associate
Radhakrishnan Maheswari, Centre Supervisor

AWWA
PEOPLE GIVING TO PEOPLE

Background and Methodology

Volunteering is a meaningful activity for seniors to stay connected to the society. Through volunteering, seniors take on the role of an active agent and utilize their expertise to make an impact on other people's lives. The benefits of senior volunteerism includes, increased life satisfaction, emotional well-being and physical health.

The aim of the project is to co-develop volunteerism programmes with AWWA Project IRENE, so as to foster and promote the spirit of volunteerism among the older population.

Proposed Solutions

We conducted four ESTHER cafes to gather some insights to senior volunteerism. These were some of our key findings:

Motivations to Volunteer	Barriers to Volunteers	What Matters Most to ESTHERs	Areas to Volunteer
• To contribute back to the society • Meaningful utilization of time • Making friends	• Personal Commitments • Lack of communication between volunteers & organization • Burnout/Lack of Confidence	• Self Care • Flexibility in volunteering schedule • Supportive staff • Training & support • Recognition & Acknowledgement	• Befriending • Programme planning and support • Exercise Trainers • Sales assistants (For handicraft sales)

Keeping these in mind, we developed two key areas for ESTHERs to volunteer.

HAPPY Exercise
- A multicomponent exercise programme developed by NUH.
- Two ESTHERs underwent a 4-week training course.
- ESTHERs helped to conduct the exercises weekly.

Programme Planning & Support
- Co-organizing festive celebrations with ESTHERs.
- ESTHERs took charge of the preparation and facilitation during the programme.

Outcomes and Learning Points

- It is essential to promote open and consistent communication between ESTHERs and staff. This will help to minimize any communication breakdown and facilitate the exchange of feedback.
- For some ESTHERs, it was their first time volunteering. Hence, it would be helpful if staff were to provide constant encouragement and support, especially during the initial phase of their volunteering journey. This would help to build their confidence and sustain their interests in volunteering.
- The effect of social modelling was observed as a few clients took the initiative to help out after observing their fellow ESTHERs.

Future Plans

- To open up more volunteering opportunities within the Centre.
- Collaborate with external organizations for relevant trainings and courses for ESTHERs and staff.

9 Empowerment

To Honour ESTHER's Wishes to Stay at Home for As Long As Possible

Project Leader: Angela Tan Sock Mui, Psychosocial Support Services (PSS)
Members: Claire Anne Rayco Ricafort, Home Care
Yap Ching Sian, PSS
Project Sponsors: Peh Cheng Wan, PSS
Dr Peh Tan Ying, Home Care
Chiew Cheng Fong, Nursing

Background

Advance Care Planning (ACP) is a series of conversations that seeks to help a person reflect on, discuss and document future healthcare preferences based on the individual's values, beliefs and wishes. Preferred Plan of Care (PPC) is one of the three types of ACP and is suitable for a person suffering from serious and life-limiting illnesses. It explores the person's end-of-life care preferences, including his/her Preferred Place of Care (PPOC) and Preferred Place of Death (PPOD).

Many ESTHERs (patients in Assisi Hospice) often indicated their PPOC and PPOD as remaining in the Inpatient Hospice facility. These ESTHERs are usually above 60 years old and are either staying alone in (i) a flat, (ii) a rented room or (iii) sharing a rental unit with a flat mate. Interestingly, medical social workers (MSWs) from the Psychosocial Support Services (PSS) and Home Care Nurses have consistently observed that the real wishes of these ESTHERs were to stay in their own homes. This generated the team's interest to examine ESTHER's real wishes at the end-of-life and to honor their wishes as much as possible.

Methodology

A survey with 13 ESTHERs was conducted in Assisi Hospice (Inpatient, Day Care and Home Care Services) to explore ESTHER and their caregivers' experiences and concerns when discussing ACP.

ESTHER Cafés were subsequently conducted for staff members from the three services to examine work processes and identify areas of concern. A total of three doctors, nine nurses, and seven MSWs/counsellors were invited to the cafes. Two sets of semi-structured questionnaires were created to guide the interviews with ESTHERs and healthcare professionals.

Interviewing ESTHERs

ESTHER Café with MSWs

ESTHER Café with Nurses

Findings

Table 1 highlights the result of the interview with 13 ESTHERs on their PPOC and PPOD choices. All respondents were NOT adverse to talking about their end-of-life wishes including their PPOC and PPOD. One indicated that "no one ask her about her PPOC and PPOD". Six stated lacked of caregiver at home as a primary concern. Table 2 showcases findings from ESTHER Cafés with various care providers.

Options / Choices	PPOC	PPOD
Inpatient Hospice	6	5
Home	7	1
Others (no preference, hospital)	0	7

Table 1 – Results of PPOC and PPOD Choices

	Doctors	Nurses	MSWs / Counsellors
Training	• Confidence level (6-8/10) • Junior doctors not formally trained in ACP • On-the-job training	• Confidence level (6-8/10) • Formally trained • Desire for mentorship and guidance	• Confidence level (7-8.5/10) • Lower confidence of Pediatric team (4) • Formally trained
Values	• Able to explore patient's values and preferences • Pragmatic approach in decision-making (patient's medical status is a strong determinant) • Will refer to PSS for support	• Guided by what is best for patients • Try to fulfill patient's wishes as far as possible • Concerned that initiating ACP may jeopardize patient-nurse-relationship	• Mindful and respectful of patient's expressed wishes • Focuses on patient's values and family dynamics when discussing ACP
Process	• No standardized ACP documentation. Not all clinical services adopts the National ACP Form • Focuses more on PPOC & PPOD during intake/ clerking	• No standardized ACP documentation • No clearly-stated place to record ACP conversations between inpatient and home care team • ACP is not explored with patient if collusion is at play	• No standardized ACP documentation • Doctors are usually the ones leading the conversation during intake/clerking • Sees the need for PSS to be more active to facilitate ACP discussion

Table 2 – Results ESTHER Cafés with Care Providers

Problem identification & solutions

A Fishbone Diagram (not shown in the poster) followed by a Pareto chart Figure 1, highlights the top five factors that inhibit (1) ESTHERs to voice their real wishes and/or (2) the team in honouring ESTHERs expressed wishes. Five solutions were subsequently identified.

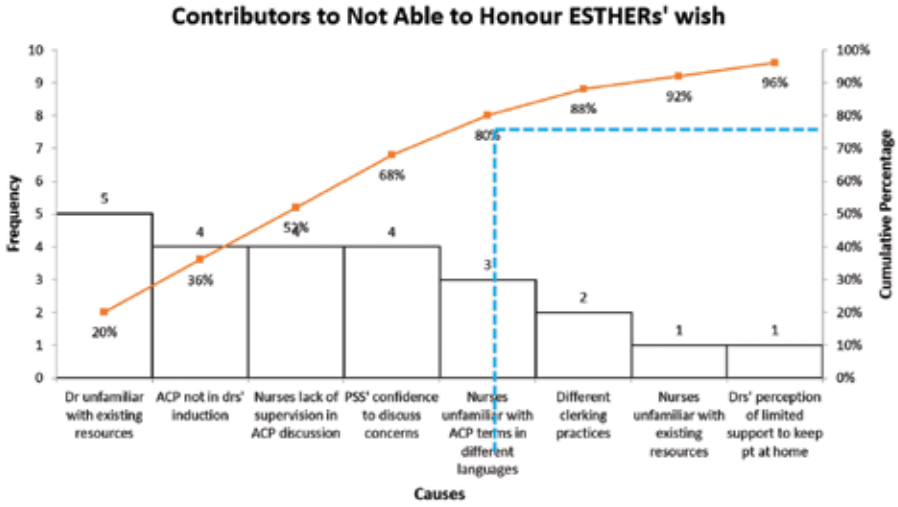


Figure 1 – Pareto Chart

S/N	Identified Solutions	PDSA Timeline
1	ACP Sharing at a weekly Journal Club	18 January 2019
2	Sharing of existing resources at doctors' orientation	Starting January 2019
3	Cheat sheet for doctors on existing resources	Starting February 2019
4	Identifying in house ACP champions	February 2019
5	Attend Train-the-Trainer for ACP	29 March 2019

Table 3 shows the proposed solutions and PDSA timeline.

Moving forward

This is an on-going project and our team plan to interview another cohort of 10 newly admitted ESTHERs and also survey the healthcare team in March 2019 to measure (1) changes in ESTHER's experiences during ACP discussion and (2) changes in the level of confidence and comfort of healthcare team in leading ACP discussions.

Empowering COPD patient & family on disease management using COPD action plan

NC/PN Lee Siew Ling (Project Leader)
SSN/PN Wang Li (Team Member)
APN/PN Rachel Marie Towle (Project Sponsor)

Singapore General Hospital
SingHealth

Background and Problems Identified

COPD is the 8th leading cause of death in Singapore. During our ESTHER journey mapping, we found that ESTHERs with COPD have limited understanding of their condition. Example, ESTHER – Mr Ng who was recently referred for counselling exhibited poor knowledge of his diagnosis. This resulted in poor compliance to use of inhalers and refusal towards smoking cessation. He was anxious and panicky whenever there was an exacerbation. Mr Ng exhibited a lack of confidence in managing his symptoms which was attributed to poor disease awareness and misconceptions that his lungwas 'weak'.

Ensuring ESTHERs with COPD have better understanding of their condition and management through education, engagement and empowerment will promote ESTHER's independence and reduce their high readmissions and visits to Restructured Hospital/General Practitioner/ Outpatient Settings/Department of Emergency Medicine.

Method/Solution

The COPD action plan which included education and "teach-back" method was adopted and used to empower ESTHER during their education session. Questionnaires were administered with pre and post COPD action plan as per figure (1).

Questions were developed to assess ESTHER's understanding of the condition and confidence in management (Figure 2). COPD Assessment Test (CAT) score (Figure 3) and exacerbation history were used to measure ESTHER's symptoms control and it's impact on daily life before and after the education on COPD.

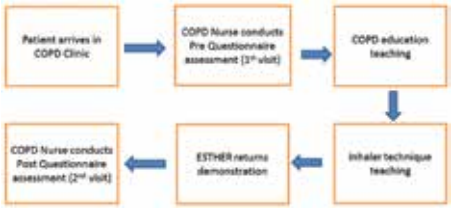


Figure (2): Pre & Post COPD counselling questionnaire

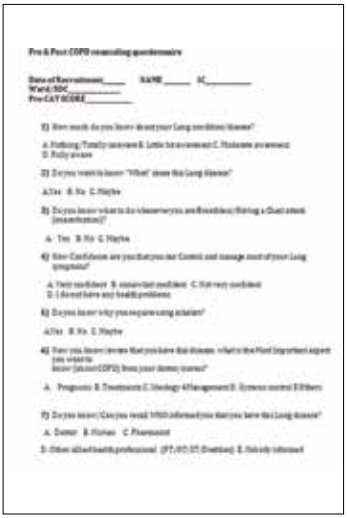


Figure (3): Pre & Post COPD counselling questionnaire

Results

Through the COPD action plan, ESTHER was empowered with better disease awareness of the COPD condition. ESTHER's confidence level was increased and was able to manage his own medications (refer Table 1). This can also be shown when ESTHER reached out to his doctor immediately after the COPD action plan was taught. ESTHER requested for "Reliever-MDI Salbutamol" which was not in his prescription. While there was no change in CAT score pre and post COPD action plan, ESTHER presented with no admission and no chest exacerbation. Most importantly, ESTHER demonstrated greater confidence in managing his COPD condition.

		Pre-Counselling	Post-Counselling
1.	How much do you know about your Lung condition/disease?	1 (Nothing/Totally Unaware)	3 (Moderate awareness)
2.	How confidence are you that you can Control and Manage most of your Lung symptoms?	3 (Not very confident)	1 (Very Confident)
3.	Do you know why you require to use inhalers?	1 (Yes)	1 (Yes)
4.	CAT score	4	4
5.	Do you know what to do whenever you are Breathless/Having a Chest attack (exacerbation)?	No	No

Table (1)

Learning Points

The experience gained from engaging ESTHER highlighted the importance of COPD education in establishing self-reliance and compliance towards treatment strategy. The crucial connection of engaging ESTHER early led to better health outcomes and better healthcare experiences which in turn will reduce healthcare cost and hospitalizations.

During the course of this project, we discovered that many factors can complicate the outcomes of this study e.g. patients with overlap syndromes such as multiple co-morbidities. In summary, we recommend the upscaling of the project with analysis of outcome on a subgroup of patients.

11 Accessibility

Mister Handy-Man

Team Members: Derrick Lewis, Sammy Leong, Tan Wee Tai & Dr Fazlullah
Sponsor: Dr Kelvin Phua

Background:

- This project was inspired during our workshop field trip in May 2018, where team members observed that the residences of the patients visited were in a state of disrepair.
- Blown lightbulbs, leaking faucets and frayed electrical wiring were amongst the most common safety hazards in ESTHERs' household.
- Part of SATA CommHealth's mission is "Serving the community". Through our core value of "Compassion", we selected this project which enabled us to serve the community and make ESTHERs' lives more comfortable.

Objectives:

- Enable ESTHER to get help with general household repairs.
- Connect ESTHER to handyman service within 3 to 5 working days.
- Empower SATA Homecare Nurses to identify needs of ESTHERs in household maintenance to connect with dedicated Handyman.
- ESTHERs mentioned that they wish to improve the quality of their home surroundings and to feel more comfortable at home.
- Address the concerns of ESTHERs such as:
  - No malfunctions in ESTHERs' home.
  - Able to move around the house at night without knocking into things or falling over in the dark
  - Not slipping on wet floor
  - Not getting electrocuted due to poor wiring
  - Appliances in proper working order

Metholodogy:

- SATA Homecare takes care of around 150 patients.
- A random sample of 10 ESTHERs were selected for the survey.
- Based on a sample size of 10 ESTHERs, 3 (30%) patients needed assistance with home maintenance.

Gender	Age	Mobility	Lives with?	Owned/Rental	Needs help with house maintenance
Male	73	Ambulating independently	With Sister	Rental	No
Male	79	Ambulating with walking stick	With flatmate	Rental	Yes
Male	70	Ambulating independently	Alone	Rental	No
Male	70	Ambulating with walking stick	Alone	Rental	Yes
Female	71	Ambulating independently	Alone	Rental	Yes
Male	61	Ambulating independently	Alone	Rental	No
Female	61	Ambulating with walking stick	With flatmate	Seniors Group Home	No
Female	67	Ambulating independently	With family	Owned	No
Female	75	Ambulating with walking stick	With flatmate	Seniors Group Home	No

Solutions:

- SATA Homecare staff would take note of any repair requests during their visits and submit the Work Order Request Form.
- SATA Handy-Man will evaluate the request and check for the acquiring of necessary parts that need replacement.

- SATA Handy-Man will visit ESTHER for the repair work, individually or with HomeCare staff (depending on their request preference)

Outcomes:

- ESTHERs provided feedback that they encountered less bruising, as they were previously moving about in darkness at home
- ESTHERs also provided feedback that their homes have become safer and much more comfortable

Future Plans:

Phase	1	2	3
Time Frame	Immediate	by Dec 2019	by Dec 2020
Esthers	SATA HomeCare Esthers	All eligible SATA Esthers (includes HomeCare and Physio patients)	All eligible Esthers
Response Time	6 to 8 working days	3 to 5 working days	1 to 4 working days
Number of Maintenance Technician	One	Two	Team/s
Accompaniment	with HomeCare staff	with/without HomeCare staff	with/without MSW etc
Funding	SATA HEF	SATA HEF/Donations	SAGE/THK/Equipment manufacturer
Request for Service	by HomeCare staff	by HomeCare staff or Patients	IT Infrastructure (eg Phone App)

12 Accessibility

Improve Actualization of Medical Appointments for Frail ESTHERs Who Need Escort Service

Loh Yiqi , NTUC Cluster Support
Wong Huey Ping, Care Corner Cluster Support
Ng Tzer Wee , Clarice Woon , Tan Tock Seng Hospital

Background & Methodology

ESTHERs in Toa Payoh and Taman Jurong estates comprise seniors who are frail and mostly of a lower education level, with difficulties in reading signages. Thus, they have difficulty navigating the hospitals independently.

As such, we see the need to "Enhance the independence of ESTHERs to be able to navigate hospitals for their appointments".

Who are Our ESTHERs?

ESTHERs who are frail and illiterate are experiencing difficulty in navigating the hospital for their appointments when they are alone. Some ESTHERs get frustrated with finding their way to and within the hospitals which cause them to miss their appointments if they did not have any escorts.

How did we help?

Tabulate	Feel the ground and Verify facts	Understand via Questionnaires	Conduct ESTHER Cafés	Gather Baseline Data
ESTHERs with approaching medical appointments	Sample size of 4 ESTHERs	Understand the difficulties and concerns	Brainstorm with Medical Escort Teams from service providers (TOUCH MET), CAN Carer Volunteer Escorts and SAC staff in July 2018	Nos. of nonactualized appointments due to 'No escorts'

What matters to ESTHERs ?

Ambulant ESTHERs are usually not afraid to ask for directions and read signages. They say they do not require escorts.

Frail ESTHERs with multiple chronic health conditions expressed that they appreciate escorts as they can be prone to dizziness and fall risks during hospital visits

Interventions

Immediate:

1) Deployment of Volunteers
   - Started in Dec 2018 with one volunteer who served as escort for half-day a week at highvolume clinics e.g. Eye Clinic. The 2nd volunteer will start in Feb 2019.
   - We are working with various sources such as schools, corporate and the TTSH Centre for Healthcare Activation to increase the pool of volunteers for deployment as 'escorts'
2) Streamline Processes - Hospital helped with Verification of Appointments
   - MET providers sent a list of appointments prior to the appointment day to the Hospital Call Centre
   - Call Centre matched these clients' appointments against actual appointment bookings in the Hospital system to ensure that escort resources are optimized for actual appointments. Those who were rescheduled could have escorts re-channelled for others who really need them (prevent wasted trips & escort resources)

3) Hospital to cohort patients who need escorts to reduce no. of transportation trips
   - This will be worked on upon data analysis to determine feasibility
4) MET Providers to also review their internal operational processes (in progress)

Longer- Term :

1) Policy Review
   - MOH has completed costing exercise with MET providers
   - Initial responses from providers involved in the pilot costing exercise had been positive
   - Implementation is planned for 2H 2019
2) Autonomous Wheelchair
   - Exploring usage of and funding for wheelchairs with artificial intelligence based on spatial mapping as a different type of 'escort' prototype

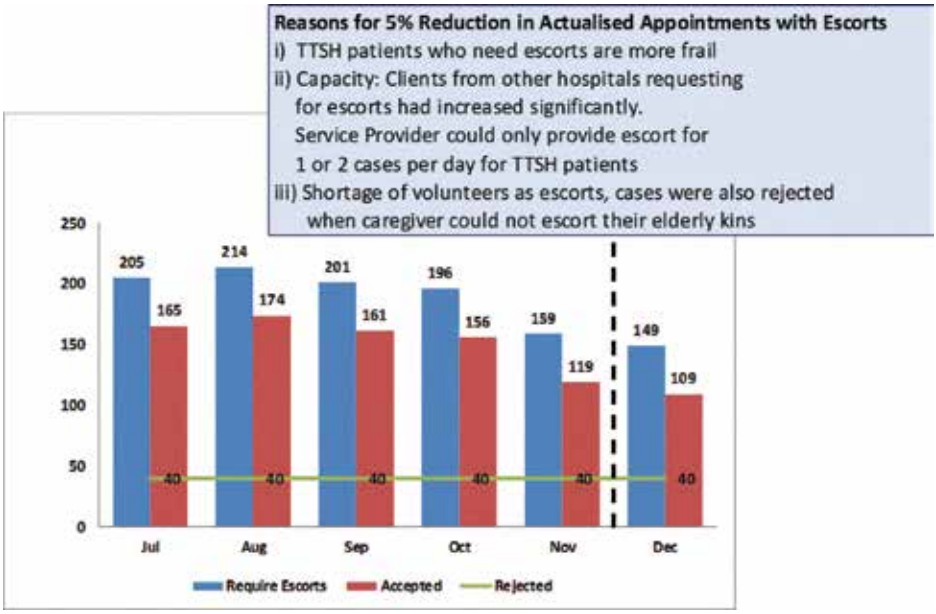
Results

TOUCH MET service saved 2 Days per week from not having to phone Hospital Call Centre to verify appointments

Multiplier Effect:

- Thye Hwa Kwan MET as 2nd MET provider has taken up this improved process
- 3rd MET provider, Handicap Welfare Association, will be offered this in Q2 2019.

Actualized Appointments with Escorts



Future Plans

1. Spoke with higher learning institutions on using AI for Autonomous Escort Prototype(~$10K)
2. AIC Informed of Near-Future Policy Review to make escort services more sustainable.

Learning Points

- ESTHERs Selection: The Team refocused on frail ESTHERs who require physical escorts given the scarce resource.
- Involve Service Providers: TTSH Call Centre partnered with TOUCH MET Team to shorten the process of confirming appointments and deployment of escorts to those who needed them
- Innovative Solution: The Team learnt that we need new solutions in view of the scarcity of human escorts. The Team explored AI as a longer term solution, now pending funding availability.

Acknowledgements

Handicap Welfare Association
ESTHERs: Mdm Teo CL, Mr Ng KC, Mr Say LT, Mdm Sandra

13 Accessibility

To fast track access of services for complex dementia ESTHERs and their caregivers

Team leader: Rebecca Seah, Manager Elderly services
Team member: Hannah Lew, Senior Programme Executive
Sponsor: Dr Foo Fung Fong, Executive Director

Filos Community Services 天友社区服务中心

Mission

The project focused on helping ESTHER with dementia and their caregivers to access care services. The primary objective was to reduce the waiting time for care services particularly nursing home placement for ESTHERs with complex care. The secondary objective was to provide interim care at community level while pending for nursing placement.

Introduction

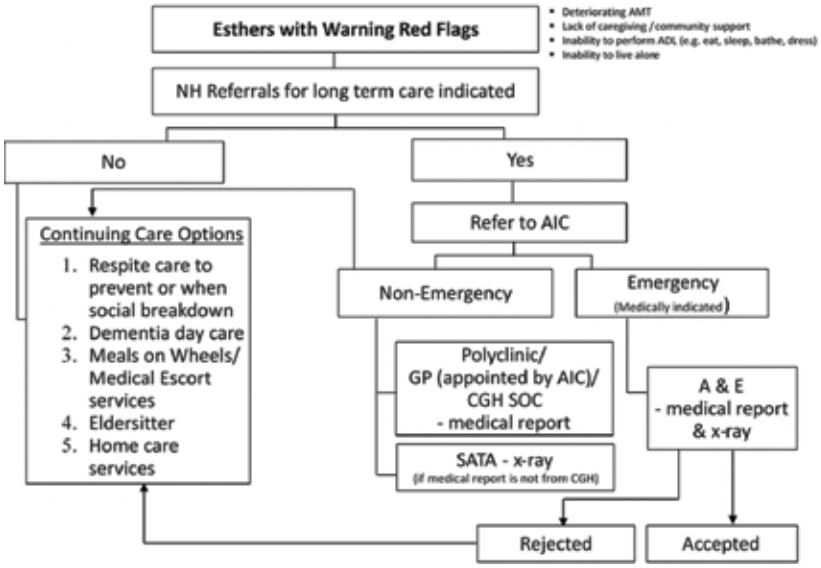
According to the Well-being of the Singapore Elderly (WiSE) study led by the Institute of Mental Health in 2015, one in 10 people aged 60 and above in Singapore has dementia. 40,000 suffered from dementia in 2015 and this number is to triple by 2050. Similarly the diagnosis has an impact on their caregivers. The team sees a gap in accessibility to services especially for dementia ESTHERs living alone in the community. The project will benefit and help ESTHERs (clients and caregivers) to have quick access to care services. While ESTHERs are on waiting list for care services, community partners will step in to provide interim care. The project selection is aligned with Filos' mission to build resilience and empower individuals and families.

Methods

The project adopted a personal survey using a face to face interview method to collect data. Two ESTHERs with dementia were interviewed at their homes and one caregiver was interviewed at Filos' office.

The ESTHERs expressed challenges and issues on Active Daily Livings, safety in the community, communication and relationship issues as well as lack of emotional support from caregivers. On the other hand, issues faced by the caregiver mainly focused on caregiving stress and financial burnout including uncertainty of accessibility to care services. A flow chart was done to assist ESTHERs and their caregivers on accessibility to care services. Flowchart 1 clearly indicates the types of services at different agencies, polyclinics, hospitals, nursing homes, homes and community care organizations.

Two screening tools were adopted in this project. ZBI (Zarit Burden Interview) was to screen caregivers' stress level and QOL (Quality of Life) was used to measure ESTHERs' quality of life related to health and social care. The baselines are cut off score set by the scale developer and using previous assessment as reference. Assessments are recommended to be conducted three months periodically.



FlowChart 1. Care services for ESTHERs with dementia and their caregivers

Results

The results focused on only ESTHER A as ESTHER B was admitted to hospital, and thus unable to complete the project.

ESTHER was referred by Silver Generation Office (SGO) in August 2018. ESTHER had a few warning red flags. She was admitted to Changi General Hospital (CGH) Accident & Emergency (A&E) in Oct 2018 as she had difficulties managing in the community. CGH Medical Social Worker from A&E, Agency Integrated Care (AIC), Filos and a few nursing homes collaborated to escalate the Nursing Home application. ESTHER was admitted to Tampines Care Home in November 2018. Pre and post screening results were :

Pre Screening in September 2018	Post Screening in January 2019
ZBI: 35/48	ZBI: 4/48
QOL: Poor	QOL: Good

Contact
Rebecca Seah
Filos Community Services Ltd Email: Rebecca@filos.sg Website: www.filos.sg Phone: 62425978

References

1. Chong, S. A. et al. (2015). Well-Being of the Singapore Elderly (WiSE) Study. Retrieved January 4, 2019, from https://www.imh.com.sg/uploadedFiles /Newsroom/News_Releases/23Mar15_WiSE%20Study%20Results.pdf

14 Goal Setting

To empower ESTHER with freezing gait to access the community

Lee Sin Yee, AWWA Ltd
Seetharaman Prabakaran, AWWA Ltd
Special credits to: Sairam Azad, NUS Cute Centre, Clarice, Tze Han, Esther, Hui Shan, Suresh, Jasmine & everyone who contributed to make this project successful.

Background

Freezing gait is a common and disabling symptom in patients with Parksinson's disease. It is characterised by sudden and brief episodes of inability to produce effective forward stepping.

- Freezing episodes disallow patients access to the community, promotes home bound lifestyle and eventually leads to other undesired physical and mental health complications.
- Clients who suffer from freezing gait are found to be able to lift up their legs and cross over obstacles when visual cues are given.
- Visual cues that can be brought outside of the bars could benefit patients who wish to go out to the community.
- The team has explored the use of motorized wheelchair to enable the client to access the community due to compromised exercise tolerance of the ESTHER.
- In collaboration with the researchers in NUS Cute Centre, a customized device (Portalaser) was developed to assist ESTHER's ambulation with constant visual cues outside of the usual training parallel bars.

Methodology

ESTHER Café to Understand ESTHER's needs → Developing Prototype (Portalaser) by NUS → Training with The Prototype → Motorised Wheelchair Training → Community Training → Collecting Results

ESTHER'S WISH LIST

- To walk continuously without much freezing.
- To be able to shop at the market near her home.
- To be able to go out to the community.



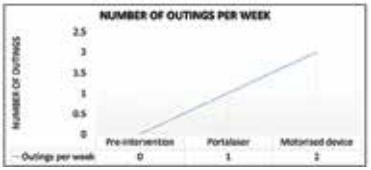




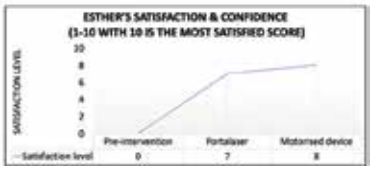
Distance to the market: 352 meters
The intervention was completed in 4 months


Outcomes and Learning Points

- Goal: To enable ESTHER to go out to the community for social events and/or shopping with supervision for at least once a week in 6 months.
- Results:



Prior to intervention, ESTHER was unable to go to the community. Post-intervention, ESTHER was able to go to the community 2 times a week.



Prior to intervention, ESTHER rated her satisfaction and confidence to go to the community as 0. Post-intervention, she rated her satisfaction and confidence score as 8.

- There was also no fall event during this period of intervention.

Learning Points

- To include ESTHER in the goal setting and treatment planning.
- Effort to treat neuro-degenerative diseases is extensive. Therefore, multiple considerations are required during resource allocation.
- Monitoring of ESTHER's functional status and modifying the training approach from time to time are essential for the changing needs.
- Maintenance of devices has to be included into the treatment plan. (Eg. fixing broken device and maintaining motorized wheelchair.)

Strengths and Limitations

STRENGTHS:

- Motivated ESTHER- ESTHER's motivation to try a new intervention was a crucial factor.
- ESTHER is able to follow and comply to instructions given- ESTHER needs to have the cognitive ability to follow and comply with instructions given.
- ESTHER lives near to the market- It was helpful to start with a goal that was close to ESTHER's home. This makes the goal achievable and boosts the confidence of ESTHER and the team.

LIMITATIONS:

- Fluctuating performance due to the Parkinson's Disease- ESTHER's functional performance fluctuates due to the condition and medicine active time.
- Need at least one person to accompany ESTHER- ESTHER has high fall risk and requires a caregiver to assist whenever she walks.
- Limited walking tolerance- ESTHER's walking tolerance is limited by her condition and we need to work within her capabilities.

Sustaining & Spreading

- ESTHER's roommate is engaged to accompany her during outings and medical appointments.
- Ongoing follow up with ESTHER's functional status and her overall wellbeing.
- Replicate the treatment approach for clients who encounter the same condition.

15 Goal Setting

To Enhance ESTHER's Transitional Care Experience through Patient-Centric Goal Setting

Team Members:
Raihana Bte Imberan, H2H Community Nurse, SGH
Joy Tan Meiling, Principal Physiotherapist, SGH
Yeo Chee Keong, Case Manager, Filos Community Services
Tess Hng Lijie, Senior MSW, TTSH
Clarice Woon, Deputy Director, Division of Central Health, TTSH
Sponsors:
Sharon Sew, Head, Allied Health- Rehab Services, TTSH
Dr Rachel Marie Towle, APN/SNM, H2H Community Nursing, OIC, SGH
Jennifer Liaw Suet Ching, Head, Department of Physiotherapy, SGH
Dr Foo Fung Fong,Executive Director, Filos Community Services

Background and Methodology

"What is best for ESTHER?"-The central focus of our ESTHER project begins by asking ourselves this question. It is also a reflection on our daily work and challenges faced. We believe that by meeting the needs of ESTHER, we will be able to improve our work quality concurrently.

Working in post acute-care setting, i.e. Rehabilitation and Home Care, we have the opportunity to work with patients' transitions back home. The transitions are often not easy and the rehabilitation journey is tedious due to various challenges such as financial difficulty, inadequate social support, lack of understanding of their medical condition and emotional struggles such as fear, anxiety and depression.

Through our ESTHER' Café, three needs were identified that could be better addressed based on their experiences. Table 1 below summarized the needs identified by ESTHERs.

ESTHERs' experiences	ESTHERs' expressed needs
1) Being told what to do and to follow blindly 2) Being prepared well in inpatient but not prepared for home 3) Being known by their medical condition and impairment	1) Need to understand the benefits of the therapy sessions 2) Need to know post-discharge activities (community rehab activities, coping with daily living, access to community) 3) Need to be valued as an individual with personal goals and unique strengths

Table 1- ESTHERs' identified needs

In line with the philosophy of Patient-Centric Care, our team decided to focus on No. 3: ESTHERs' needs to be valued as an individual with personal goals and unique strengths. We hope that by highlighting ESTHERs' personal goals and unique strengths, healthcare staff will be more aware of ESTHERs' goals when providing treatment plans and increase ESTHERs' transitional care satisfaction.

Objectives

1) To increase healthcare staff awareness of patient-centric goals by 80% in four months.
2) To improve ESTHERs' satisfaction on their transitional care experience by 50% in four months.

Images on the left: ESTHER cafés

Proposed Solutions

The team piloted the Patient-Centric Goal Setting form on 15 patients in SGH inpatient wards, TTSH Rehab Centre and Filos Community Services.

The form was developed with two intentions in mind: (1) To help healthcare staff identify what is important to ESTHERs and (2) To help healthcare staff to focus their intervention efforts on what is important to them. The form listed the six global areas of goals that patients are likely to mention, i.e. health, financial, family, social interactions, work and interests/hobbies. Patients were asked to rank the goals according to their priority.

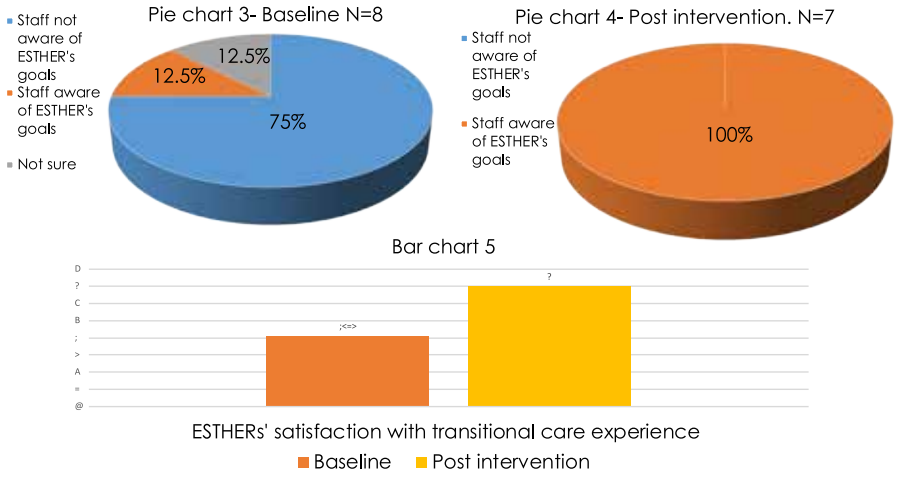
Step 1: Selection of ESTHER	Step 2: Handover	Step 3: ESTHER feedback
Criteria: ESTHER with multiple needs, requiring continuous care support by community partners	- ESTHER discharged from hospital - Healthcare staff make contact with community partners for handover	Healthcare staff contact ESTHER for feedback

Flowchart 2- Suggested form & workflow/handover to community partner

Images on the left: Healthcare staff understanding ESTHERs' care experiences at home

Outcomes and Learning Points

Baseline data were collected from 8 patients for comparison. We measured healthcare staff awareness of patient's goal and ESTHER's satisfaction using a simple scale on a pre and post Patient-Centric Goal Setting form. We trialed the form on 15 patients but completed 7. Reasons for incompletion were: demise of ESTHER, re-admission and incomplete transition to community partners when the trial ended. The characteristics of the patients in both control group and intervention group are comparable. Pie chart 3 and 4 illustrate the outcome of the trial on staff awareness of ESTHERs' goals.



We compared healthcare staff awareness of patient-centric goals at Baseline (8 ESTHERs) and post intervention (7 ESTHERs). At baseline (Pie chart 3), only 12.5% of healthcare staff in the community are aware of ESTHERs' goals. This improved to 100% post intervention.

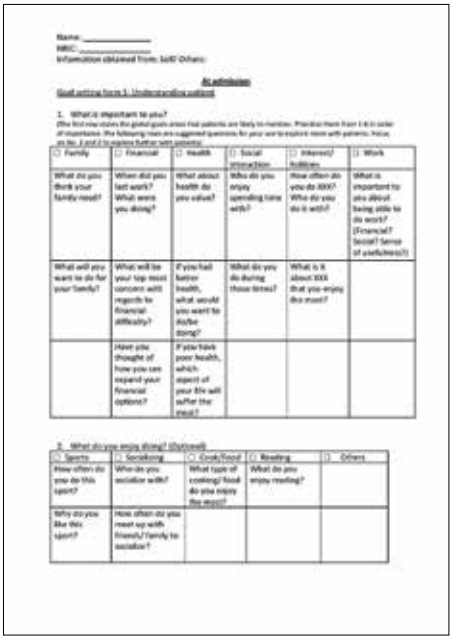
We also compared ESTHERs' satisfaction with their transitional care experience at baseline and post intervention (Bar chart 5). At baseline, the average score for satisfaction with their transitional care experience is 4.13, while the average score post intervention is 7.

Overall, this ESTHER project has met both objectives of increasing healthcare staff awareness of ESTHER's goals and also increase ESTHER's satisfaction in their transitional care experience. As illustrated in Pie chart 3 and 4, and Bar chart 5, there is an improvement in both scales.

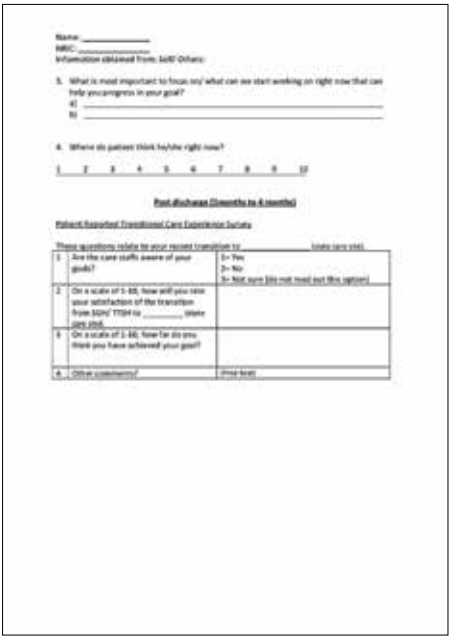
Even though the pilot project involved a few patients, there were a lot of valuable learning points. Table 6 below captures them.

A) Value of patient centric goal setting
i. Improved understanding of ESTHER's goals added meaning and relevance to care of ESTHER ii. Improved ESTHER's sense of being valued as an individual as she knows that care providers are aware of her goals for treatment iii. Improved ESTHER's motivation and adherence to treatment
B) Lack of integration in current system and the Importance of integration
i. In this pilot, some ESTHERs did not transit directly from inpatient to specific community services for follow-up care due to fragmented services and communication. This resulted in frustration among the ESTHERs. We could not follow through with ESTHERs' feedback. ii. Due to lack of informatics support, the transfer of patient-centric goals and related information from acute inpatient to community partners is not seamless or automatic. Staff had to put in extra effort to track outcomes of each patient and to ensure information flow.
C) Lack of common language on patient centric goals amongst care providers
i. Despite best efforts to highlight ESTHERs' values and goals, there were service providers who are still unfamiliar with the treatment approach using patient-centric goals.

Table 6- Learning points



Patient centric goal setting form, page 1.



Patient centric goal setting form, page 2.

Future Plans

There are plans to share the Patient-centric Goal-setting Form and the process with SGH Physiotherapy Department, SGH PHICO (H2H) department, TTSH Rehabilitation Centre and Filos Community Services to garner interest and increase awareness among care providers about the benefits of Patient-Centric Goal-setting.

16 Goal Setting

Empower ESTHERs with Mental Illness to work Towards Their Personal Recovery Goals

Kenneth Lim[1], Tan Teck Hui[1], Chang Gett Lim[2], Yvette Oh[2], Karen Kwa[2]

[1] *Hougang Sheng Hong Family Service Centre*
[2] *Tan Tock Seng Hospital*

Introduction

Traditionally, management of ESTHERs suffering from mental illness tends to adopt a medical model which emphasizes on compliance with treatment, symptom reduction and risk management. Such an approach focuses on disease and ESTHERs' sick role, which may in turn inculcate their dependence on healthcare on a long-term basis. This inherently increases healthcare cost and results in outcomes that may not necessarily be valued by ESTHERs.

Personal recovery is an alternative approach to working with ESTHERs to achieve outcomes that are meaningful for them. It is a strength-based approach which recognizes ESTHERs to have the ability to articulate what matters most to them. It encourages ESTHERs to develop realistic goals towards personal recovery. In doing so, they feel more hopeful and empowered to pursue their goals.

Aim

This project aimed to explore the extent to which the personal recovery approach can enhance ESTHERs' sense of hope and empowerment.

Methodology

Pilot	1. Establish criteria 2. Invite ESTHERs who meet criteria to participate in the project 3. Engage ESTHERs for discussion about clinical recovery and personal recovery 4. Formulate their personal recovery goals
Review	1. Review with ESTHERs with regards to their goal attainment 2. Obtain ESTHERs feedback regarding their participation in the recovery model 3. Identify learning points or areas for improvement in implementation
Implementation	1. Finalise selection criteria 2. Develop a structure and standardise process for personal recovery model 3. Incorporate outcome measurement based on definition of hope and empowerment

Results

Value Creation Story	ESTHER A	ESTHER B	ESTHER C	ESTHER D	ESTHER E
Gender	Male	Female	Female	Female	Female
Age	51	48	70	53	41
Mental Health condition	Major Depressive Disorder	Reactive Depression	Anxiety Depression with Obsessive Compulsive features	Bipolar Disorder	Depression
Activity	Conducted counselling session to identify personal recovery goals and the desired outcome is to set up his own online business.	Conducted counselling to identify personal recovery goal, which is to get out of the house for social activities.	Joint home visit from TTSH & FSC to help ESTHER identify a personal recovery goal, for which she expressed interest to continue working as a home nanny after her grandchild goes to childcare	NA	Interviewed ESTHER to identify a personal recovery goal which is to start exercising
Outputs	- Enrolled in a computer course to learn about the use of internet to start his online business. - Started to acquire items for his online business	- Participated in Hougang Serangoon Network Meeting in October 2018 and managed to share during ESTHER café to an audience of 50 people. - ESTHER practises positive self-talk to encourage herself to step out of her house.	NA	NA	NA
Outcome	ESTHER articulated his goal and has taken steps towards it.	Currently goes out for regular badminton games and managed to take action towards her goal	ESTHER articulated her goal but may not be ready to work towards it	ESTHER unable to articulate her goal	ESTHER was uncontactable
New definition of success	To break down his goal to smaller achievable steps while managing his health and recent loss of his mother	ESTHER to articulate ways to sustain her sense of fulfilment and empowerment	To manage her stress level before moving on to goal achievement	To improve engagement with ESTHER	To improve engagement with ESTHER

Lessons Learnt

- ESTHERs who agreed to be engaged for counselling appreciated the opportunity to formulate meaningful personal goals.
- Ongoing and person-centred engagement with ESTHERs is important to draw out their personal goals despite the challenges they face in life.
- Celebrating small successes is helpful in empowering and enhancing ESTHERs' sense of hope in working towards bigger success.

ESTHER B managed to overcome her anxiety and shared her experience in Hougang Serangoon Networking Session in October 2018.

Conclusion

Inquiring about ESTHERs' personal goals in counselling and treatment increases hope and empowerment for some ESTHERs. The team has plans to incorporate the development of personal recovery goals of ESTHERs as part of routine intervention and measure its impact on hope and empowerment on a larger group of ESTHERs.

Acknowledgement
We would like to thank our sponsors Mrs Sara Tan and Ms Doreen Yeo, our ESTHERs, Dr Ivan Woo, Ms Clarice Woon, Ms Ng Tzer Wee and colleagues of Sheng Hong FSC for all your support.

17 Goal Setting

Other than A&E, what is helpful for ESTHERs who frequent A&E?

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Background

Visits to hospital Accident & Emergency (A&E) are high and patients with non-serious and non-life threatening conditions account for high utilization of the service. From Jan to May 2018, there were 33 patients with number of A&E visits ranging from 11 to 37. While some of these visits warranted hospitalisation, most of the visits saw these patients being treated, discharged and referred for outpatient follow-ups.

Aims

This project aims to better understand the needs of the top 3 users (ESTHER 1, ESTHER 2 and ESTHER 3) of CGH A&E and to explore with them possible initiatives and support which are helpful to enable them to better manage their health care needs and reduce their AE attendances post intervention.

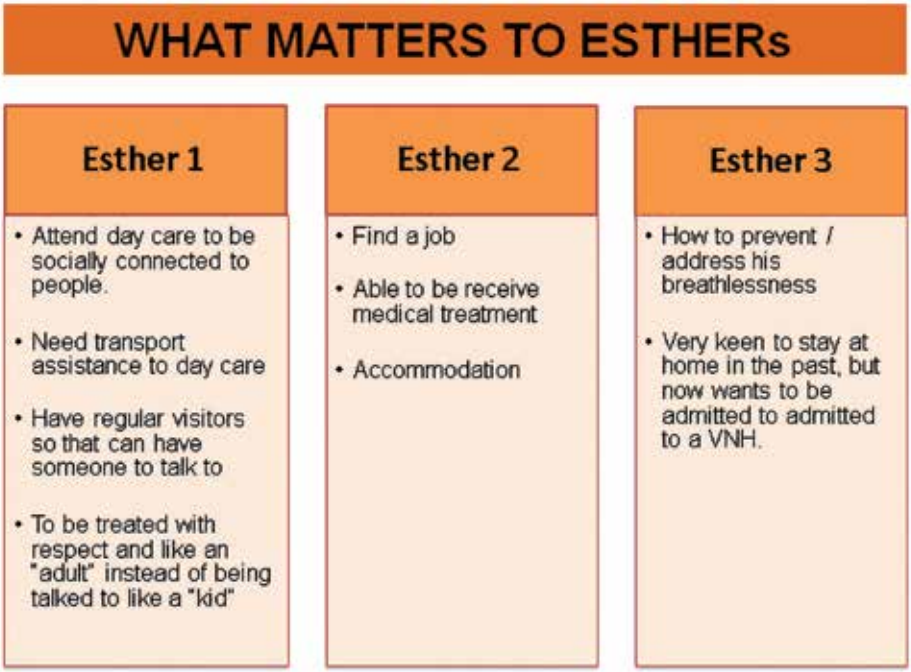
Methodology

We identified top 3 users of CGH AE services [extractedfrom the hospital Systems Applications and Products (SAP)]. Their profiles, medical conditions and AE visit patterns from 1 Jan 2017 to 31 Dec 2018 were examined.

In-depth interviews were conducted using semi-structured questionnaires, to better understand their needs, as well as predisposing (e.g. mental health), enabling (e.g. accessibility & cost), and social factors which influence their usage of the A&E service. Interviews also seek to hear from the top users their understanding of own medical conditions and what actually matters to them.

REASONS FOR VISITING AE

Esther 1	Esther 2	Esther 3
"Sick"	Collect medications because not given other appointment to collect CDM medications	Feel breathless"
"Boredom"	No need to pay	AE has the "puff" which polyclinic doesn't
Unable to cope with stressors and caregiving role	Convenient	Anticipate his visit will increase because of deteriorating conditions
Good care and services rendered by AE staff & the "good Milo" served		
But does not like to be admitted, because "boring" to stay in hospital		



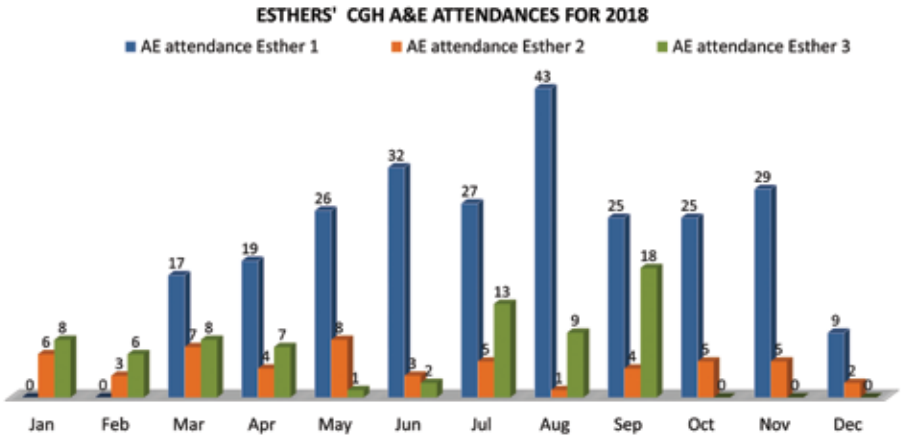
Interventions

- Intensive case management (face to face engagement & regular phone calls of at least 2 times per week) by designated Medical Social Worker for identified ESTHERs took place from Aug 2018 till to date. Home visits were also conducted for 2 ESTHERs who have a home.
- Increased ESTHERs' social support by addressing their accommodation, social and financial needs.
- Engaged internal (AE team, Patient Navigator, psychiatrist) and external stakeholders (family, health care workers of other hospitals and social service and other government organisations) to seek their support in developing a more holistic, unified and consistent approach to address ESTHERs' medical and social care needs.
- Patient education (e.g. the appropriate institution to seek non-urgent medical treatment) and motivational counseling to understand ESTHERs motivation and goals and helping ESTHERs achieve these goals.
- "Incentivized" (provide transport assistance to day care and top her hand phone) effort made by ESTHER reduce A&E visits for non emergency needs.

Outcome

- ESTHER 3 showed the most significant reduction in his CGH AE attendances (zero admission from Oct –Dec 2018) with his admission to a voluntary nursing home (VNH) in Oct 2018. Both ESTHER 3 and staff of his current VNH indicated that he is coping well with only 2 inpatient admissions to another hospital in the last quarter of 2018.
- There is a 33% decrease in the AE attendance for ESTHER 2 from 5.1 visits / mth prior to intervention to 3.4 / mth visits post intervention.
- The A&E attendance rate for ESTHER 1 peaked in Aug 2018 and continued to remain high, mainly due to her difficulty in dealing with personal crisis (one of her live-in friends got admitted to a VNH and she was given the impression that her brother has passed away). ESTHER 1 was admitted to IMH and AH in the last 2 months of 2018.
- Financial incentive did not work for ESTHER 1 though she was excited when the idea was first broached .
- Their articulation of "What Matters Most" may not be what they deemed as priority. While ESTHER 1 expressed that she was keen to attend day care and ESTHER 2 expressed that he wanted to have his rental unit, both were passive when MSW made attempts to bring them to the day care centre and HDB respectively.
- Ownership as to who should address the high A&E attendance rate and case managed ESTHERs in the community is an issue. As these tops users have multiple medical conditions and are being seen by several disciplines, the question lies in who would be in the best position to tackle this issue within the organisation and across institutions. For example, mental health agencies are reluctant to admit ESTHER 1 for more structured programmes citing that her medical conditions render her unsuitable for their services.

PROFILE OF ESTHERs			
	ESTHER 1	**ESTHER 2**	**ESTHER 3**
Social Background	50 yo old single Indian lady of Catholic faith. Incomplete Primary school education Ex-cleaner now unemployed Subsists on financial assistance from Social Service Organisation (SSO) and Central Provident Fund (CPF) pay-out. Lodges with 2 friends. Has her own room but lodges at corridor along CGH AE.	41yo old single Malay Muslim man. Incomplete Primary school education Ex-cleaner now unemployed Subsists on financial assistance from SSO Homeless and has been lodging at CGH A&E for the past 6 years.	70 yo single Chinese man. Secondary school education Ex-taxi driver. Now retired Subsists on savings Lives with a flatmate in a 1-room rental flat.
Medical Conditions	Cardiovascular (Hyperlipidemia, Tetralogy of Fallot, Mitral Valve Prolapse, Atrial flutter), Stroke 2008, Epilepsy, chronic edema, Type 2 Respiratory Failure, Photosensitive dermatitis, Hypothyroidism, DM, Paranoid schizophrenia / Munchausen's syndrome & Obstructive Sleep Apnoea	Diabetes , Hypertension, Hyperlipidemia & Elephantiasis verrucosa, Non-alcoholic Fatty Liver Disease	Delusional disorder, Ischemic Heart Disease, Hypertension, Hyperlipidemia, Diabetes, Asthma with recurrent admissions for exacerbation, moderate Obstructive Sleep Apnea & cataract, Left Neurovascular Glaucoma
Support in Community	SSO, Institute of Mental Health Case Manager, Neighbours, Trans Safe, Anglican Care Centre, CGH MSW, brother and live-friends	SSO, mosque, CGH MSW and friends in CGH	Singapore Handicapped Association, CGH Hospital-to Home, Neighbours, CGH MSW, Moral Home Help Service, Metta Home Care, Geylang Polyclinic MSW, uncle and nephew
No of CGH AE from Jan – Jun 2018	94	31	32



Learning Points

Frequent A&E users are associated with multiple chronic medical conditions, mental health issues and other socioeconomic determinants. It is too simplistic to attribute frequent users as misusing the A&E service when their upstream social and chronic health needs may not be adequately managed.

Addressing the complex needs of these frequent A&E users is very labour intensive especially when the current services and care coordination within and across institutions is fragmented and inadequate. At the community level, there is service gap for homeless patients and those with mental health conditions. Other than intensive case management within the hospital, a more effective strategy involving multi-disciplines and multi -agencies across health and social setting needs to be developed.

Future Plans

To present to the hospital higher management for advice and directive to develop a more concerted approach internally to tackle the complex health care needs of this group of frequent users. Engage the relevant ministries, senior management of mental health and other community agencies for support and active collaboration in addressing the mental health, accommodation and social support for these patients in the community.

Looking Forward - ESTHER Project Escalation

1. Health Pocket – Beyond Hospital to Community

Escalation plans:

The Health Pocket is a tool to bridge information sharing and communication between healthcare and community providers.

An easy-to-carry green folder with specific compartments for care providers to file care information on patient, the Health Pocket will be issued to patients with complex needs requiring multiple providers. Hospital-to-Home (H2H) nurses and community providers will triage and issue them to an estimated 2000 ESTHERs in the southeast region. Nurses will educate ESTHERs on

1. When to bring the Health Pocket
2. What should be filed inside
3. Who should they show their Health Pocket to.

Community service providers and community nurses will reinforce the proper use of the folder.

With this intervention, we hope to reduce the following:

1. Difficulties managing multiple medical documents
2. No-show/missed appointments
3. Incidence of not bringing correct lab forms
4. Not bringing correct prescription to collect medications

Rollout is targeted for FY19 and there would be evaluation of the impact of the Health Pocket for improvisation or spread.

Period: By Mar 2020

Team leads:

1. Khee Giat Yeng, Principal Clinical Pharmacist, Singapore General Hospital
2. Haslinda Binte Barman, H2H Nurse, Singapore General Hospital

Sponsors:

1. Prof Kenneth Kwek, CEO, Singapore General Hospital
2. Dr Tracy Carol Ayre, Group Chief Nurse, Singapore General Hospital
3. A/Prof Lee Kheng Hock, H2H Programme Director, Singapore General Hospital

2. SGH-NTUC Health Programme to Increase Confidence in ESTHER for Self Care

Escalation plans:

Understanding and measuring ESTHER's confidence in self-care tasks at various time points of her illness and recovery trajectory has great implications on her ability to cope at home and in the community , avoiding visits to A & E and hospital readmissions.

Inpatient, H2H and community nurses as well NTUC Health are trialling a newly established workflow that incorporated early handover to service providers while patient is still inflight. The workflow also included the enquiry of patient's confidence level in the various self-care tasks at pre-intervention phase, as well as three months and six months post intervention.

The measurements include ESTHER's confidence level in:
1. Moving around at home
2. Showering, toileting, dressing
3. Eating
4. Medication-taking
5. Shopping
6. Moving around in the community
7. Sleeping

The team will apply the formalised workflow to another 8 to 10 ESTHERs for refinement before adoption.

This workflow also aligns with our Regional Health System (RHS) mission of partnering communities to keep well, get well and age well. We will continue to analyse and evaluate the workflow for further enhancement, sustainability and scalability to other Community of Care (CoC) and community partners covering different service boundaries.


More schemes to help care for patients after they leave hospital

ST

Picture for SGH-NTUC Health Programme

Period: **By Dec 2019**

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1. Rachel Towle, H2H Nurse, Singapore General Hospital
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3. Xu Yi, SGH Community Nurse, Singapore General Hospital

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2. Dr Low Lian Leng, PHICO Director, Singapore General Hospital
3. Jeannie Ho, Director, NTUC Health
4. A/Prof Lee Kheng Hock, H2H Programme Director, Singapore General Hospital
5. Dr Tracy Carol, Group Chief Nurse, Singapore General Hospital

3. About Me 2.0 – Beyond the Hospice

Escalation plans:

Given the positive results of our current ESTHER project using the "About Me" form to improve satisfaction of ESTHERs in our inpatient hospice ward, we are keen to extend the usage of our "About Me" form to ESTHERs in our subacute and rehab wards who may benefit from it. We will review the reaction and utility of the "About Me" form within this group and continue to improve it based on feedback.

We are also keen to explore collaborative efforts between like-minded care providers. We will reach out to care providers and ESTHER coaches who subscribe to the same philosophy of care to see if we can build upon our mutual efforts. We are willing to work with anyone who is keen to adapt our "About Me" for use in their own setting.

Period: **2019 - TBD**

Team Leads:
1. Dr Loo Yuxian, SingHealth Community Hospitals
2. Dr Gabriel Yee, SingHealth Community Hospitals

Sponsors:
1. Prof Lee Kheng Hock, Medical Director, Bright Vision Hospital

ESTHER Song

Let us learn and share it with the world
Let us learn and share it with the world

Somewhere in our heart we know what is right
And in our minds we already got this goal just in sight
How to do it is this challenge we face
Now there is time for us to show it
To keep up and embrace:

What is best for ESTHER? Right on spot!
Is this best for ESTHER? Is or not?
So let's open that door we have never used before
Let us ask! Let us learn! And then do more and more!

Let us learn and share it with the world
Let us learn and share it with the world

Close to ESTHER we are ready to go
Finding the reasons to get better and even make it come true
Every measurement will show us the way
Help us to find the right direction,
With compassion we say:

What is best for ESTHER? Right on spot!
Is this best for ESTHER? Is or not?
So let's open that door we have never used before
Let us ask! Let us learn! And then do more and more!

What is best for ESTHER? Right on spot!
Is this best for ESTHER? Is or not?
So let's open that door we have never used before
Let us ask! Let us learn! And then do more and more!

Music by Tan Teck Tian
Lyrics by Marie Winald Karlstörm
Sang by Lim Jingfen & ESTHER coaches

Acknowledgement

ESTHER Network Singapore recognises the partnership and contributions of the following community and healthcare institutions, the ESTHER Network Taskforce and Coach Trainers in promoting and co-creating a person-centric ecosystem and approach to provide better care for our clients, patients and residents in the larger community.

Our Partners

Agency for Integrated Care
ABLE – Abilities Beyond Limitations and Expectations
Assisi Hospice
AWWA
Bright Vision Hospital
Care corner Seniors Services Ltd
Changi General Hospital
Fei Yue Community Services
Filos Community Services
HCA Hospice Care
Institute of Advance Nursing
Kandang Kerbau Hospital
KK Women's and Children's Hospital
Ministry of Social Service & Family
Montfort Care
National Dental Centre Singapore
National Cancer Centre Singapore
National Heart Centre Singapore
National Kidney Foundation Singapore
National Neuroscience Institute
NTUC Health
Peacehaven Nursing Home
Rainbow Centre
SATA CommHealth
Sengkang Health
SingHealth
SingHealth Community Hospitals
SingHealth Polyclinic
Society of Sheng Hong Welfare Services & Hougang Sheng Hong Family Service Centre
SPD
St Luke's ElderCare Ltd
Tan Tock Seng Hospital
The Salvation Army Peacehaven Nursing Home
Thye Hua Kwan Moral Charities
Tsao Foundation
Woodlands Health Campus

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