# INTEGRATED ELDERCARE

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Singapore is facing an aging population. By 2030, it is projected that one in five Singaporeans will be above the age of 65 years. Instead of seven adults aged 15-59 years supporting an older person, the number will decline to two. Increase in physical and mental disabilities will parallel the rising life expectancy. The number of caregivers in Singapore will correspondingly increase to take care of the expanding number of people who need daily assistance with activities of daily living.

The caregiver's role is demanding and often is a lifelong commitment. Caregivers' stress is common and will inversely impact on their health and adequacy of care provision for the care recipient. These caregivers need training and other support to mitigate their physical and emotional burden. Studies have shown that caregiver education and support programmes can delay nursing home placement and reduce healthcare costs of care recipients. Interventions targeting and improving caregivers' knowledge are most effective, with benefits arising from training in general problem solving skills, management of both care recipient's behaviour and their emotional response to their caregiving role.

Financial burden is another potential strain to the caregivers. Low-income families with multiple financial and social stressors, often have difficulties coping if they are unable to tap onto the community-based support system. This affects the quality of life of the elderly person and the family and often results in premature placement in a nursing home. Bridging this gap becomes critical and the focus is to strengthen the broad-based support for these caregivers though training programmes, information services and mutual self-help network. Government subsidy for needy patients based on means testing is being introduced.

In recent years, new and expanded community-based services are established to support the caregivers. These include the provision of home or community-based medical, nursing and rehabilitative care, palliative care, home help, day care, counseling and befriending services. A huge challenge now is to coordinate and integrate the various community service providers so that care is patient-centric; otherwise caregivers' attempts to seek multiple service providers will only add to their strains and burdens of care.

Care integration can be achieved at three levels: linkage, coordination and full integration. There are various models of integrated care globally but none has been shown to be effective in all aspects of care delivery. Using multidisciplinary care/case managers who can access a range of health and social services seem to be a vital factor in the more successful models. Key components of integrated care include (1) assessment of patient's needs, (2), deployment of multidisciplinary team, (3) access to appropriate resources and (4) discharge planning.

Discharging a patient from hospital to the community is a complex process and has its own set of challenges. Organised discharge planning is thus important to ensure proper transition of care and patient's safety. It also reduces hospital length of stay, prevent adverse outcomes after discharge and coordinate services between hospital and community. Discharge planning begins at admission, involves the assessment and identification of high risk patients (with the 8P), determining the post-discharge site of care, medication reconciliation, patient education and instruction and detailing in an adequate discharge summary.

The establishment of the Agency of Integrated Care (AIC) is an official endeavour to provide a centralized agency to coordinate provision of short-term, long-term and social care, and rehabilitative services in the community. At the ground level, the Centre for Enabled Living (CEL) is another initiative to enhance access to social care support services and schemes by functioning as a convenient first-stop information centre.

The ideal goal is for patients to move seamlessly across institutions without having to repeat investigations and to undergo duplicative care. Nonetheless, there remain barriers to overcome, including inadequacy of public funding and infrastructure to cope with rapidly rising demands, insufficient human resources such as trained healthcare professionals to support the community services, interface issues between professionals and disparate cost-benefits.

The family physician plays an important role to facilitate this seamless care integration. As the first point of contact for many of these patients who require integrated care, the family physicians are at an advantageous position to coordinate the care for these patients between different community service providers, assess their needs and to provide caregiver education and support.

A critical area of assessment includes falls risk evaluation, as more vulnerable elderly patients with chronic health problems and associated functional decline including ambulation will be seen at primary care clinics. Thus family physicians should recognize and be alerted to patients at risks of falls and advocate the safe use of various ambulatory aids, which will enhance patient's stability and improve balance for those with unsteady gait. They can prescribe ambulatory aids through an eight-step approach to ensure an appropriate choice is recommended.

The Editorial team has collaborated with AIC to bring out this issue to provide readers with an overview of care integration for elderly patients in the local community. This is a work in progress. It is important for the family physician to be aware of this initiative and proactively fit into this enhanced model of care for the benefits of their patients.

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