UNIT NO. 2

ROLE OF THE MULTI-DISCIPLINARY TEAM IN INTEGRATED CARE

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ABSTRACT

Integration of care has become a major theme of healthcare organizations throughout the world and Singapore is no exception. The Agency for Integrated Care (AIC) plays the role of National Integrator in this endeavour. By and large the healthcare model in Singapore today is an acute care centric model. This has strengths but also has weaknesses and gaps that must be addressed through health care integration. Hence, Singapore is moving towards a new model of care — managing holistic approach of care for service needs and taking a patient-centric approach. We need to leverage on the multidisciplinary base of acute care healthcare providers to form the multidisciplinary base for intermediate care and long term care integration. For patients with complex medical and social needs, the ACTION Team project seeks to develop referral management teams to enable and support care integration and transition care for these patients.

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INTRODUCTION

This paper covers the following aspects of integration of care in the Singapore setting.

- Healthcare Integration in Singapore
- Role of AIC in integration – National Integrator
- Moving towards a new model of care – managing holistic approach of care for service needs
- The experience of the Aged Care Transition (ACTION) team project for patients with complex medical and social needs.

HEALTHCARE INTEGRATION IN SINGAPORE

Integration of care has become a major theme of healthcare organizations throughout the world and Singapore is no exception. Figure 1 shows the direction that Singapore is taking in developing new services and community engagement to implement the healthcare integration vision. There will be integration of short term care delivered by family physicians, acute hospitals with intermediate care in community hospitals, and on to integration with long term care in the community, day rehabilitation and care services, and back to the patient's home.

There is also the translation of integration into regional healthcare services as shown in Figure 2. The links with be through IT systems (the electronic health records (EHR), the 4 restructured hospitals – KTPH, JGH, TTSH, and CGH, the 2 Academic Medical Centres (AMC) – NUHS, and Outram, with co-ordination of care across regions by the Agency of Integrated Care (AIC).

ROLE OF AIC IN CARE INTEGRATION

For integration of care to be successful there is a need for a National Care Integrator. This is the Agency for Integrated Care (AIC) in the Singapore setting.

Table 1. History of Agency for Integrated Care

Year	Name	Key Functions
1992	Care Liaison Service (Ministry)	Nursing homes and chronic sick units placements (A)
2001	Integrated Care Services (Healthcare Clusters)	(A) + Coordinate the referrals to day rehabilitation centres (B)
2008	Agency for Integrated Care (Healthcare Clusters)	(A) + (B) + Coordinate referrals to home medical, home nursing and home therapy + Aged Care Transition (ACTION) Teams

History of Agency for Integrated Care

This is shown in Table 1. It has thus taken the Care Liaison Service 16 years to evolve from a service of nursing home and chronic sick units placements in 1992, to the Integrated Care Services which besides the function to nursing home and chronic sick units placements also co-ordinates referrals to day rehabilitation centres from 2001 onwards. In 2008, it the Integrated Care Services became the Agency for Integration of Care (AIC) with the additional tasks of co-ordinating referrals to home medical, home nursing, and home therapy. AIC is also running the Aged Transition (ACTION) Team project to help patient transition from hospital to their homes or community by streamlining and co-ordinating care services thereby optimizing patients' outcomes throughout and following an episode of illness. More of this will discussed later.

Creating a National Integrator

Creating a National Integrator out of the Agency for Integrated Care creates a body which functions as the:

- Facilitator for integration of healthcare services.
- Informed neutral Buyer of services on behalf of patients.
  - o Implement a national Care Assessment framework.
  - o Referrals to intermediate and long-term care services.
  - o Case management for complex cases.
- Developer of primary care and community care services.
  - o Improving quality of long-term care services.
- Body which works closely with Offices of Integration in each Restructured Hospital Service to operationalise and monitor the progress of the RF projects.

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Figure 1. Developing New Services : Community Engagement

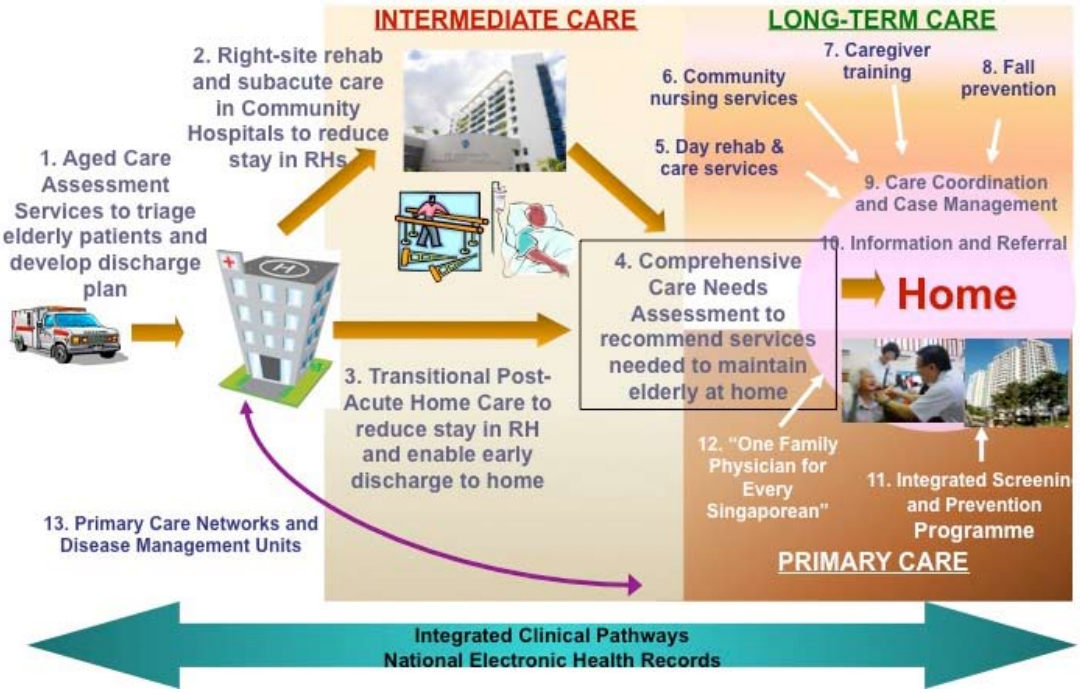
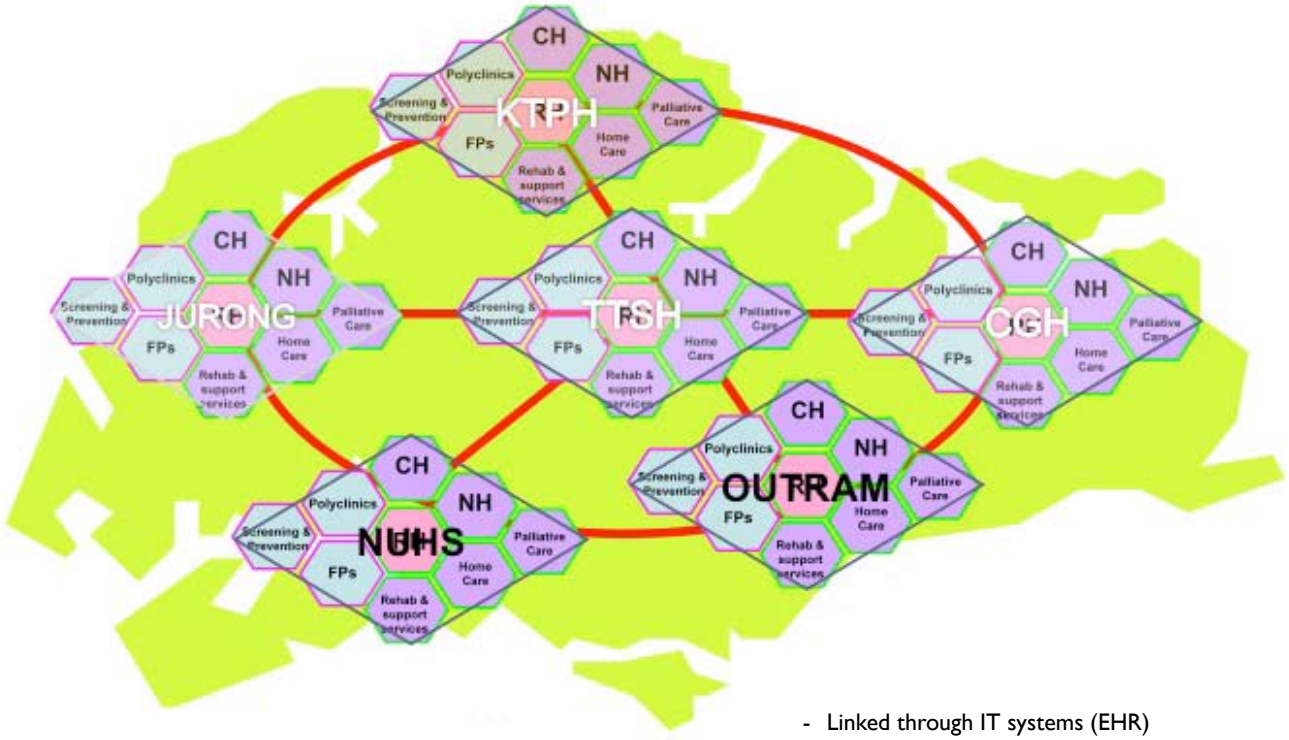


Figure 2. Translating Integration to Regional Health Services



- Linked through IT systems (EHR)
- $_4$ RHS (including KTPH/ JGH), $_2$ AMCs
- Coordinated care across regions (AIC)

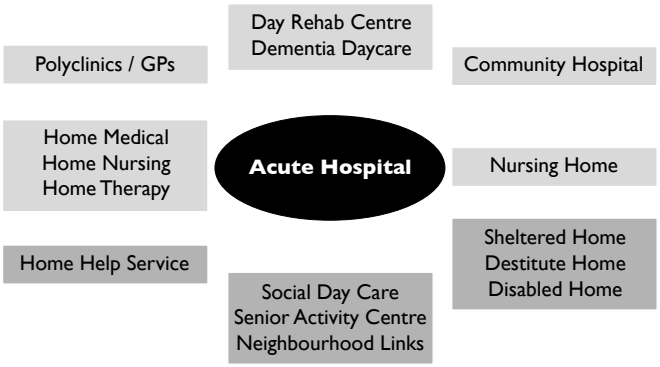
AIC today as a National Integrator

AIC has the following tasks:

- As the "glue" for integration of healthcare services.
- Implement national care assessment framework.
- Referral to intermediate and long-term care services.
- Case management for complex cases.
- Development of primary care and community care services.
- Improving quality of long-term care services.

AIC has to integrate the different services in the current healthcare landscape in Singapore. See Figure 3. By and large the healthcare model in Singapore today is an acute care centric model. See Figure 4.

Figure 3. The Landscape - What's out there



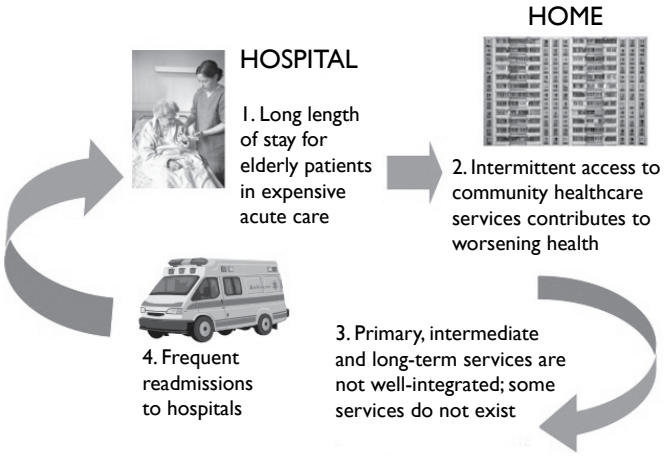
Weaknesses & Gaps in Current Healthcare System in Singapore

In Singapore the acute sector is well built up, BUT there are many weaknesses and gaps that must be addressed:

- Lack of transfer structures and mechanisms to plan discharge and post-discharge.
  - o Good quality outcomes within acute, but poor quality outcomes for episode and patient.
  - o Unnecessary readmissions.
  - o Longer stay than necessary in acute.
- Non-acute sector not ready to play an equal role to the acute sector.
  - o Largely VWO-driven and limited funding.
  - o Difficulty gaining capacity and capabilities.
- Patients are "lost" in the system.
  - o Healthcare system and offerings remain opaque to patients and their families.

Problems will worsen with the growing elderly population.

Figure 4. Acute Care Centric Model



MOVING TOWARDS A NEW MODEL OF CARE

The solution in solving the problems in the health care system is to move towards a new model of care that adopts a holistic approach of care for service needs. The vision is to integrate care by taking a patient-centric approach. The different healthcare service providers and their services need to fit seamlessly into one another like a honeycomb for primary care, acute & intermediate care, and long-term care. This is shown graphically in Figure 5.

Multidisciplinary base in acute care

We need to leverage on the multidisciplinary base in acute care. The healthcare providers forming this multidisciplinary base are:

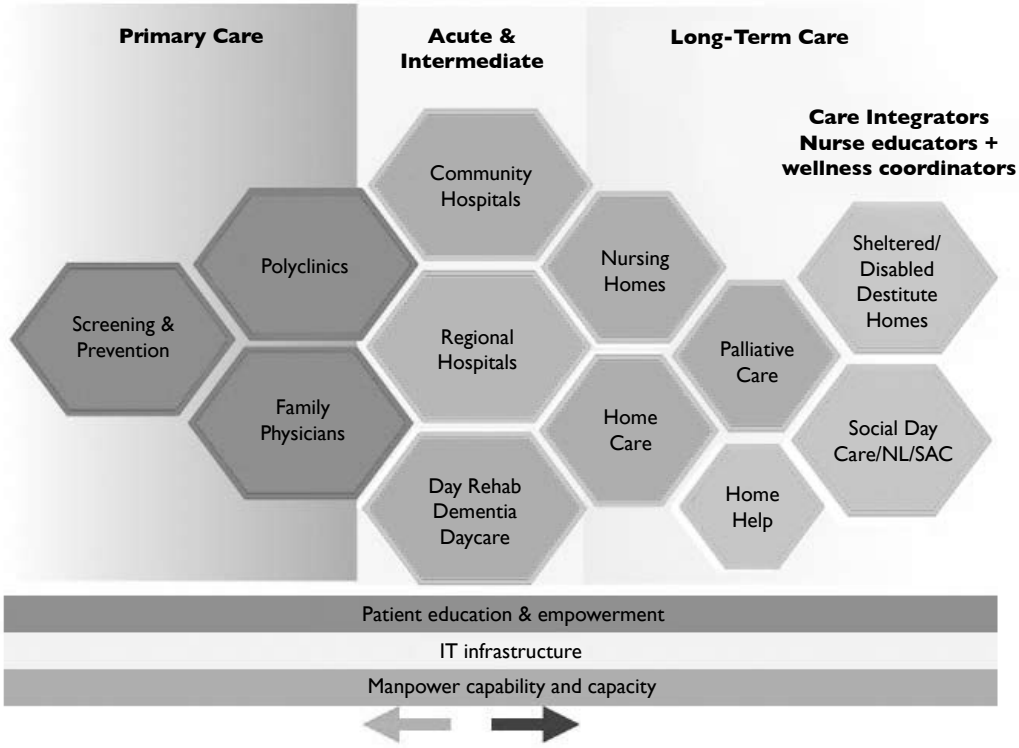
- Doctors.
- Nurses.
- Physiotherapist.
- Occupational therapist.
- Speech therapist.
- Medical social worker.
- Pharmacist.
- Case managers.

Referring source of care

The referring source of care into the other settings of care come from acute care. It is therefore imperative for acute care providers to have the following:

- Clinical Skills.
- Accurate & Complete Assessment.
- Pro-active involvement in discharge planning.
- Skills & Knowledge in discharge planning.
- Healthcare landscape & continuum of care.
- Right siting.
  - o Community resources.
  - o Social / environmental.
  - o Health Care financing.

Figure 5. Integrate care by taking a patient-centric approach



Challenges: acute care

We will also need to deal with the challenges of acute care. These are:

- Time constraints due to short length of stay.
- Teams working in silos.
- History from various sources.
- Abundance paper work.
- Skill mix of staff.

The challenges result in several suboptimal outcomes:

- Poor referral quality.
- Inadequate history.
- Incomplete information.
- Inaccurate information.
- Wrong referral.

AIC's strategy is develop referral management teams to enable and support care integration and transition care for patients with complex medical and social needs.

Referral Management Team

The referral management team has several tasks. These are:

- Screening and Triaging.
- "Case Management".
- Coordination of services.
- "Safety Net".

Community/Intermediate & Long Term Care (ILTC) setting

In the community/ILTC setting, healthcare providers need to have the following:

- Clinical Skills.
- Care Needs Assessment.
  - o Multi-dimensional care needs.
- Case Management Skills.
  - o Health and Social service landscape.
  - o Care planning and coordination with stake holders such as VWOs, social service & healthcare professionals.
  - o Linking and accessing community resources.

An Everyday Case…

- 70-year-old female patient with multiple co-morbidities.
- Has identified caregiver at home.
- On multiple medications.
- Repeated hospital admissions within a short time.
  - o Burnout caregiver.
  - o Gaps in care services.
  - o Care providers with silo mindset.

There is a need to fill the gaps in the current health care delivery system under the integrative efforts of AIC working in synergy with all providers.

THE AGED CARE TRANSITION (ACTION) TEAM PROJECT

About ACTION

ACTION stands for Aged Care Transition Team. The details are:

- Aged Care Transition (ACTION) Team is a 4-year, 22-million project funded by the government.
- The aim is to help patients make the important transition from hospital into their home or community, by streamlining and coordinating care services thereby optimizing patients' outcomes throughout and following an episode of illness.

The team

The Aged Care Transition (ACTION) team is made up of Care Coordinators, stationed at 5 acute hospitals (NUH, CGH, TTSH, SGH and AH) and 1 national centre (NHC) to help patients make the important transition from hospital to their home and community. By placing these Care Coordinators to these pilot sites, the project aims to establish a single contact point for these patients in acute hospitals, AIC office and the community service providers.

Pillars of care integration and processes

Figure 6 shows the three pillars of care integration. Figure 7 shows the ACTION processes.

The 3 pillars (Figure 6) are:

Pillar 1 – Equip team with capabilities to provide transition care – Initiatives: infrastructure setup. Capacity building. Engaging the stakeholders.

Pillar 2 – Enable safe & effective transition care across sites – Initiatives: Utilisation of hospital and community resources. Interagency collaboration.

Pillar 3 – Improve quality of life for patients and their caregivers – Initiatives: Assess satisfaction with ACTION services.

Profile of those requiring ACTION services

- Since start of project 10,000 patients have been managed through ACTION services.
- More than half of patients managed were aged 70 years and above; had 3 – 6 co-morbidities and above; and were taking more than 5 medications.
- The top 5 reasons requiring interventions were:
  - Significant functional decline.
  - Complex medical issues.
  - Caregiver unable to cope.
  - Confusion/cognitive impairment.
  - Has no caregiver.

Figure 6. Aged Care Transition (ACTION) Team

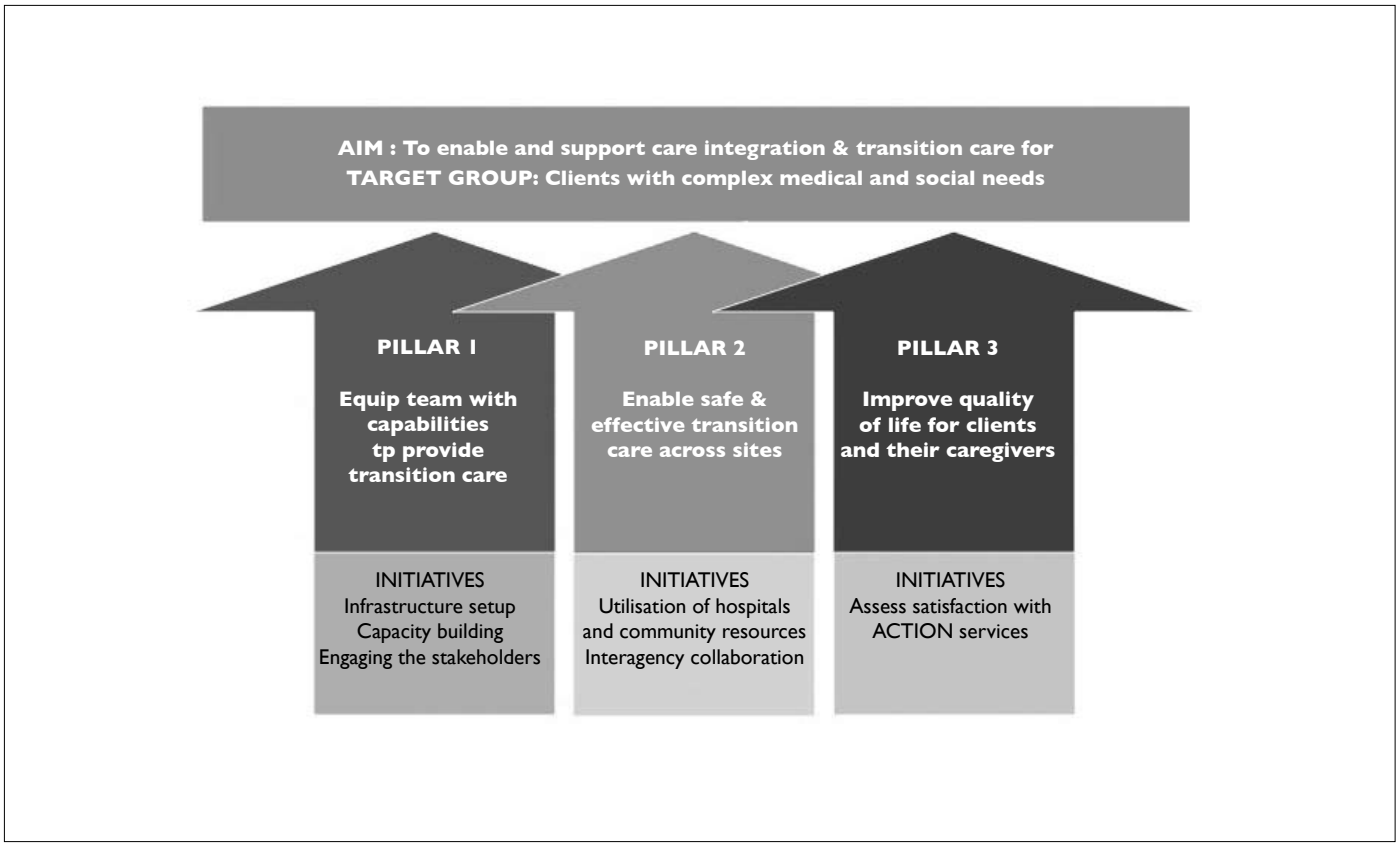
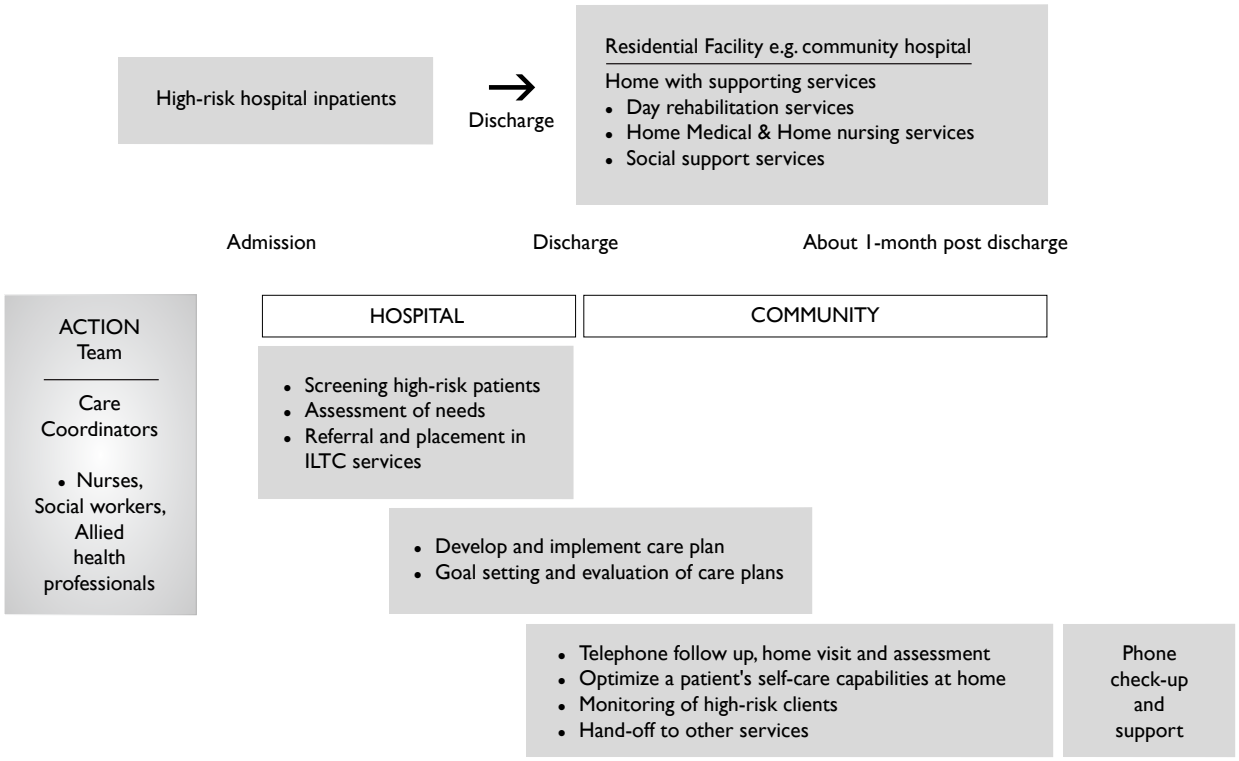


Figure 7. ACTION Process



CONCLUSIONS

- Effective care integration is possible
  - o Understanding the impact of individuals' actions on the care supply chain -- Calls for greater understanding, collaboration and tolerance across all stakeholders (health, social, environment, infrastructure development).
  - o About embracing traditional values in new practices
    - – The importance of strong fundamentals.
    - – All about building relationships.
- With integration comes opportunities for true innovation
  - o Consumer-centric services and programmes that meet their true wants and needs
  - o Resource-effective — Leveraging and maximising on existing infrastructure and resources (manpower, finances) while encompassing business discipline.

LEARNING POINTS

- **By and large the healthcare model in Singapore today is an acute care centric model.**
- **This has strengths but also has weaknesses and gaps that must be addressed through health care integration.**
- **AIC plays the role of a national integrator.**
- **To succeed in healthcare integration, Singapore needs to move towards a new model of care that adopts a holistic approach of care for service needs and take a patient-centric approach.**
- **We need to leverage on the multidisciplinary base of acute care healthcare providers to form the multidisciplinary base for intermediate care and long term care integration.**
- **For patients with complex medical and social needs, the ACTION Team project seeks to develop referral management teams to enable and support care integration and transition care for these patients.**