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A New Model of Care: Home Continual Care and Response Service (HCCRS)

Target Patient Population:

Activities of Daily Living (ADL) dependent patients

Services:

Ranging from subacute care services to long term nursing services up till palliative care services

Liken step down care services but entirely home based, relying on trained caregivers and remote monitoring technologies and usage of electronic medical recordings.

1. Present situation consisting of a few scenarios:

   i. Acute hospital to Community hospital to Nursing home
   ii. Acute hospital to Nursing home
   iii. Acute hospital to community hospital – care giver training to home
   iv. Acute hospital – care giver training to home

2. Home Care Environment setup:

   1. Hospital Bed
   2. Pressure relieving mattress
   3. Nasogastric Feeding Set
   4. Tracheostomy Cleaning Set
   5. Suction Set with catheters
   6. Urinary Catheter Set
   7. Nebulisation Set
   8. Normal/Reclining Wheelchair
   9. Geriatric Chair
   10. Oxygen concentrator
   11. Any extra equipment like electric hoist/bathing trolley etc
   12. Expendables (Diapers/Sterile sets/ Dressing set and Dressings – various)

3. Workflow:

Team consisting of Home Care Physician/Nurse/Physiotherapist/Medical Social worker/Caregivers having family conference in hospital before discharge/at first home review:

Major difference is that care giver is part of the team, and can be provided by the service with interchangeable care givers or provided by the family. They will have more training in monitoring and input into electronic medical records of the patient similar to a hospital service and directly link to the caring team.

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Nurse in charge functions as the case manager and supervises the caregiver and provides timely training for the care givers when needed, for example wound management

Physiotherapy in charge will do rehab planning or maintenance rehab as required

Doctor in charge is the primary physician does chronic medical reviews and managing acute medical conditions to prevent readmissions.

Care of the patient will be sole at home with any forms of admission avoided if possible, palliative and pastoral care services are provided as well when required.

4. Information technology usage:

   i. Remote monitoring of vital signs via electronic medical records and tele conferencing with the caregivers
   ii. Tele rehab with "live" supervision of physiotherapist via video conferencing provided
   iii. Virtual rehab possible as well with computing programs

Advantages:

- Able to tap in eSMF for the patient and reuse the hospital furniture for more needy patients
- More streamline and cost saving process, no further land/building/maintenance/equipment cost to the government like setting up another community hospital or nursing home
- Will tap into National Electronic Health Records to provide monitoring data (functions as a home based virtual hospital/community hospital/nursing home) Both MOH and restructured hospital will have patient's home monitoring data and most updated clinical records and management plans
- Less conflict with family and staff since we now work in tandem rather that the family shifting all the responsibility to the caring institution

5. Business model:

- MEANS tested subscription model, liken cost of staying in community hospital or nursing home
- Private insurance/Medisave/Medishield Life *(in future)* /Medifund/VWO support for patients
- FDWG eligible for the caregivers under the service, or any further grants for the care givers
- Can be partially funded out of hospital programs such as transitional care services
- Can be linked up with VWO to provide the services e.g. VWO-HCCRS Ang Mo Kio etc
- Pooling and bulk buying of resources for more economical pricing
- Recycling of hospital furniture or rental equipment
- Private entity with government/VWO support plus private patients

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