UNIT NO. 5

COMMUNITY-BASED RESOURCES

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OBJECTIVES

At the end of this unit, the course participants should be able to describe:

1. the importance of the bio-psycho-social approach and a multi-disciplinary mindset
2. the community-based resources available to the family physician
3. how to gain access to community services
4. the liasion with health care providers for a more seamless care provision.

1. INTRODUCTION

The home-bound patient and his care-giver together have varying medical and social needs. Therefore, it is important to adopt a bio-psychosocial approach and take into consideration the various social/family factors, psychological and home environmental factors which result in final impact of medical illness on the elderly. The caregiver, often called the hidden patient, needs to be adequately supported, failing which the elderly becomes at risk of institutionalisation.

The family physician on his own, will not be able to provide all the care for the varying needs and hence the importance of having a multi-disciplinary mindset and knowing the community-based resources he can refer to. The expertise of the following disciplines commonly called on include the nurse practitioner, the occupational therapist, the physiotherapist and the social worker.

2. COMMUNITY-BASED RESOURCES AVAILABLE TO THE FAMILY PHYSICIAN

a. Community Care Management Services (CCMS)

Recently, community care management services have become available and serve island-wide in three sectors- the West , East and Central sectors. For the family physician, this potentially serves as a one-stop referral and minimises the need to make multiple referrals to different community agencies.

Community care management services focus on service delivery. The care manager upon receiving a referral assesses the patient's needs, then coordinates and ensures the patient is able to access the appropriate community service required e.g. meals on wheels, home help services. The care manager also continues to follow up with service delivery from various agencies. The family physician can remain part of a multi-disciplinary team coordinated by the care manager.

b. Home Care Services

K HOME MEDICAL CARE

Currently homecare physicians providing on-going primary care for home-bound patients with chronic illnesses mostly practise in VWO-driven multi-disciplinary set-ups. The multi-disciplinary team may include a nurse, social worker and therapist.

The home care physician is ideally placed to manage medical complications which may otherwise result in a hospital admission or strenuous efforts by family to bring patient for a medical complaint which could be attended to in the home.

The advantages of a multi-disciplinary team also allows for management of more complex medical and social problems.

The GP may thus consider referring to homecare physicians such patients, who will benefit from a multi-disciplinary homecare team. Once the home-bound elderly and the caregiver/family are stabilised and managing well, the home medical service can refer the patient back to the GP for follow up.

K HOME NURSING CARE

Homecare nurses provide usual nursing procedures, as well as caregiver training, health education, assessment of patient's needs and simple home environment assessment.

Usual nursing procedures include:

i) wound care
ii) maintenance of tubes – urinary catheters, nasogastric tubes, gastrostomy tubes, drainage tubes and tracheostomy
iii) administration of injections
iv) stoma care
v) assistance with bowel elimination e.g. enemas or manual evacuation
vi) pain control and palliative care
vii) monitoring of patient's medical condition e.g. blood pressure and blood sugar levels.

The homecare nurse provides invaluable feedback to the attending physician on patient's condition. The home visits by the attending physician can be minimised as the homecare nurse can attend to minor ailments such as URTI and minor skin rashes and advice the patient's family accordingly. The home-bound elderly who is often frail also benefit from increased surveillance and monitoring by the homecare nurse.

The home care nurse may practice in a multi-disciplinary homecare team, in HNF or in private nursing.

K HOME REHABILITATION

The work of the occupational therapists and physiotherapists in community care has gained increased recognition over the past few years.

The Community OT

The community OT aims to maintain the elderly in their own homes and maximise their level of independence and quality of life.

The community OT:

i) teaches appropriate skills and prescribes appropriate assistive devices to maximise the level of independence in self-care activities and IADL
ii) assesses the home and advices/does home modification to make the home environment more elder and disabled – friendly e.g. ramps for kerbs and wheelchair accessability
iii) does stroke contractures management – prevention through exercises and use of splints
iv) advises on constructive and creative use of leisure time with ideas of hobbies and social activities
v) does caregiver training e.g. transfer techniques in wheel-chair bound and bed-bound elderly.

The Community PT

The community PT aims to improve mobility and psychological well-being thus enabling the elderly to optimize their functional ability.

The scope of their services include:

i) gait analysis and gait training
ii) post amputee stump care and rehabilitation
iii) pressure care
iv) pain management.

The community therapists are integral members of the multidisciplinary homecare team. Improving functional independence is key in elderly care and community therapists provide essential expertise in this area.They are involved in both rehabilitative care e.g. regaining function after a stroke or after deconditioning from prolonged hospitalisation, as well as preventive care e.g. fall prevention in the home and community.

The community therapists who do home visits may work with a homecare team or in the private sector. Hospital- based therapists also increasingly do home visits for their recently discharged patients.

K HOME HELP SERVICES

Home help services are beneficial for the elderly who can manage self-care activities but have problems doing higher tasks needed to remain at home. The elderly who cannot manage even self-care activities either needs a caregiver or needs to be in a nursing home. Home help services are not set up to provide the level of supervision required for such dependant patients.

Home help services are also helpful for caregivers in need of some assistance with caring for the elderly e.g. toilet bathing. This is particularly for the caregiver who may be an elderly spouse with chronic ill-health.

Home help services include:

i) Meals delivery – usually once a day delivery with lunch and dinner meals delivered
ii) Household chores – mopping, sweeping, laundry
iii) Marketing and buying of groceries and essential items
iv) Escort services for hospital appointments
v) Packing of medications – the elderly is often on polypharmacy and may be confused with dosages and timing. Packing of medications helps to improve compliance
vi) Personal hygiene and grooming – e.g. giving haircuts and trimming nails. This includes assisting caregivers in toilet bathing of patients.

c. Respite care services

The burden of caregiving can become overwhelming if the caregiver suffers from psychological distress, physical exhaustion or illness.

For the elderly to stay at home for as long as possible, it is essential to consider the welfare of the caregiver. This involves regular periods of respite care.

Formal respite services for caregivers include:

i) pre-arranged in-home care provision by home help services allowing the caregiver some time off e.g. half a day for errands
ii) day care centres
iii) stay-in respite at nursing homes and community hospitals – usually a short continuous stay of at least 2 weeks. A trial of slow-stream rehabilitation during the respite is useful at times if elderly is previously deconditioned or not previously rehabilitated and will benefit from more intensive inpatient rehabilitation.

d. Day centres

They range from social day care to day rehabilitation to dementia day care centres. Half day or full day sessions are available. The elderly must either be able to do self-care activities or alternatively, the availability of a maid or family member available for those who need more supervision and assistance. Transport with staircrawler is usually available within vicinity.

i) Social day care centres – simple exercises and recreational activities are organised for the elderly. They can enable family members to work during the day and assume caregiving roles at night
ii) Day rehabilitation centres – provides more comprehensive therapy than outpatient therapy sessions and allows for interaction and group therapy
iii) Dementia day care centres – provide therapy for elderly with mild to moderate dementia to slow down deterioration of cognitive impairment.

e. Services for financial assistance and social issues

Several family service centres are available island-wide for counselling needs, financial needs and linking up with befrienders.

3. HOW TO GAIN ACCESS TO COMMUNITY SERVICES

- Be aware of the community services that are available in the vicinity of your clinic practice.
- Have a good understanding of the roles of services so that appropriate services can be activated to provide comprehensive care for the elderly.
- Home medical services or care management services are skilled in care management and help can always be sought from such agencies when in doubt.
- Most of the community-based services are VWO-driven and receive direct referrals from the GPs.

4. LIAISON WITH HEALTH CARE PROVIDERS FOR MORE SEAMLESS CARE PROVISION

Home medical care is defined as on-going chronic care in patient's home, is part of the framework for integrated health services for the elderly.

The concept of step-down care involves the concept of patient care needs moving from acute to subacute to chronic care needs. Step-down facilities include community hospitals, day care centres home care services, nursing homes and hospices.

Acute care		**Subacute care**		**Chronic care**
Acute Hospitals	→	Community Hospitals	→	Home Medical Services Home Help Services GP Day Care Centres Nursing Homes

Good delivery of home medical care starts with good discharge planning from referring institutions.

There should be:

i) discharge planning with management plans outlined and general assurance that patient and family have been adequately prepared and are able to cope at home

ii) communication on planned discharged date, bearing in mind that home health care are not usually services available on immediate demand. For more urgent needs, verbal communication in addition to faxed referrals is necessary to improve the coordination of service delivery

iii) adequate medical, rehabilitation and social information given.

How to then prepare for and implement home care will be covered in the next unit.

Learning Points:

1. The elderly and his caregiver have multiple medical and psychosocial needs which require a multi-disciplinary approach.
2. The GP can tap on community-based resources and be part of a broader multi-disciplinary team.
3. For continuity of care, there should be clear communication between the hospitals and the community agencies or GP subsequently delivering care.

REFERENCES AND RECOMMENDED READINGS

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