Taking the hospital team home

A post-discharge service where doctors, nurses and therapists make house calls is winning over patients and caregivers. Ng Wan Ching reports

TAN TOCK SENG’S HOME CARE

The Post-Acute Care At Home programme is for patients who need post-discharge care. Patients will be visited by a team of doctors, nurses and therapists, according to their needs, for as long as they need, until they are discharged from the hospital.

The charges range from $75 to $180 per visit by a doctor, $50 to $500 per visit by a nurse and $50 to $150 per visit by a therapist. The fees are based on three patient categories — private, permanent resident and subsidised at 62 or 2.

Patients who have chronic diseases can use their Medisave, under the Chronic Disease Management Programme. Newly employed patients will be assessed by a medical social worker for Medisave assistance.

Madam Choo is grateful for the TTSH service as she no longer has to take her father to hospital for medical reviews or therapy. “The first TTSH home visit – which lasted more than an hour – came a week after he was discharged. There was a doctor who made house calls. He reviewed my father’s medical notes on him, took his blood pressure and checked that he was all right,” said Madam Choo, a homemaker and mother of two. She noted each visit saved her at least half a day of her time. “If I had to take him to the hospital, I would have to call for an ambulance as he is immobile,” she said.

For her father, Madam Choo says, the hospital, they would have to wait to see the doctor and then collect the medication. “Now, the doctor and nurse come to his house at a stated time and she pays no more for the service than she had to take him to the hospital.”

“Preventive care is important, as my father is at risk of complications. The programme is timely for him,” said Madam Choo.

Walking away

A diabetic patient credits Tan Tock Seng Hospital’s (TTSH) Post Acute Care At Home for helping him to walk away after he refused to have both his feet amputated.

Mr Neo Ah Thian, 65, had gangrene in both legs. His had deteriorations when damaged tissue was removed from his feet and underwent rehabilitation at Renci Hospital.

At his home, the TTSH home-care team managed his diabetes and low blood pressure, in collaboration with a doctor from TTSH’s foot clinic.

After the first visit by the team in December last year and subsequent home visits by a doctor, nurse, physiotherapist and occupational therapist, Mr Neo was able to get out of bed and move around with a walking frame at home.

He needs a wheelchair only when he goes out.

He was recently discharged from the TTSH homecare team as he has achieved some mobility. “The service is helpful to my family. He is our only caregiver and she is quite old too. It was not that convenient for her to push him in a wheelchair whenever I have to go to the hospital,” said Mr Neo, who has no children.

Mr Neo did not have to pay for his home care as he qualifies for Medisave.

Home care from other hospitals

SINGAPORE GENERAL HOSPITAL (SGH)

The Home Based Intermediate Care programme serves as a bridging service to help families of patients who have been discharged from hospital. Doctors, nurses and therapists from SGH go to the patient’s home when needed.

“From the initial home visit, the team conducted 20 patients regularly. The cost for a nurse is $64 and for a doctor is $230.”

Medifund and MediShield are not applicable. Patients seeking outpatient treatment for the eight chronic illnesses – diabetes, hypertension, joint disorders, stroke, asthma, chronic obstructive pulmonary disease, schizophrenia and major depression – are allowed to use Medisave.

KK WOMEN’S AND CHILDREN’S HOSPITAL (KKH)

A second programme, the Aged Psychiatry Home-Based Care, is for patients who have been discharged from hospital after medical intervention for elderly people. Patients have to sign up for packages of either five or 35 sessions.

Subsidised patients pay $225 for five sessions. Patients can use Medisave.

Aged patients who are referred to medical social workers. The programme has benefited more than 1,000 elderly patients in the community.

INSTITUTE OF MENTAL HEALTH

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It assesses the condition of patients and their families in the community. The programme started in April 2007. From January 2008 to December last year, the team conducted 28,244 home visits.

The team also aims at mental illness living in the community for as long as possible and reducing hospital readmissions and length of stay.

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These services are also available at KTPH. At the moment, the transitional care nurse works with 150 patients a month in 2009 and Dr Ang Yan Hoe, a senior consultant at its geriatric medicine department, visits about 20 patients regularly.

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