Project Title

Improving Quality of Life of Residents through Care Connector Programme

Project Lead and Members

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Project members: R Abarna, Jesslyn Chong, Carol Leung, Chee Jia Yi , Lee Hee Hoon, Tan Seng Woan, Dr Edwin Lim

Organisation(s) Involved

Ng Teng Fong General Hospital

Healthcare Family Group Involved in this Project

Allied Health, Healthcare Administration

Applicable Specialty or Discipline

Community Care

Aims

The NTFGH Care Connector Programme aims to improve the average EQ-5D-3L index score of participants aged 60-69 by 10% within one year of enrolment, through connecting them to appropriate health resources, i.e. community health screenings, and social resources, i.e. counselling, financial assistance and caregiver training grant.

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Lessons Learnt

1) Connecting residents to beneficial health and social resources through a Care Connector whom they trust can lead to an improvement in quality of life.

2) Team work and collaboration between the Community Operations team and different social community partners can enable residents to be connected to the right resources, improving their quality of lives.

Conclusion

See poster appended/ below

Additional Information

This project is related to “Increasing screening and vaccination uptake through care connectors”.

Project Category

Care & Process Redesign

Value Based Care, Patient Reported Outcome Measures

Keywords

Quality of Life, EQ-5D-3L, Care Connector Programme, Senior Citizens

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IMPROVING QUALITY OF LIFE OF RESIDENTS THROUGH CARE CONNECTOR PROGRAMME

MEMBERS: R ABARNA , JESSLYN CHONG HWEI SING, CAROL LEUNG, CHEE JIA YI , LEE HEE HOON, TAN SENG WOAN, DR EDWIN LIM BOON HOWE

- ❑ SAFETY
- ☑ QUALITY
- ❑ PATIENT EXPERIENCE
- ❑ PRODUCTIVITY
- ❑ COST
- ☑ TEAMWORK
- ☑ COMMUNICATION

Introduction, Problem and Aims

Introduction

The Care Connector Programme is an initiative by NTFGH Community Operations in partnership with social community partners to understand community dwelling older adults' and senior residents' health needs, i.e. health screening/ vaccination needs, and social needs, i.e. low mood/ financial concerns/ caregiver stress, and connect them to beneficial resources. Through this initiative, NTFGH Community Operations hopes to improve programme participants' quality of life.

Programme participants' quality of life is assessed using a validated questionnaire, EuroQol-5Dimension-3Level (EQ-5D-3L). In this questionnaire, participants report their level of problems for 5 domains, namely, mobility, self-care, usual activities, pain/discomfort and anxiety/depression. An improvement in participants' quality of life will be indicative of the effectiveness of the programme.

Problem

In June 2019, Care Connector Programme participants (n=38), who are senior residents of Concern and Care and Tzu Chi Senior Centre, aged 60-69, had lower average EQ-5D-3L index scores at pre-enrolment than Singapore population norms by 16%.

Aim

The NTFGH Care Connector Programme aims to improve the average EQ-5D-3L index score of participants aged 60-69 by 10% within one year of enrolment, through connecting them to appropriate health resources, i.e. community health screenings, and social resources, i.e. counselling, financial assistance and caregiver training grant.

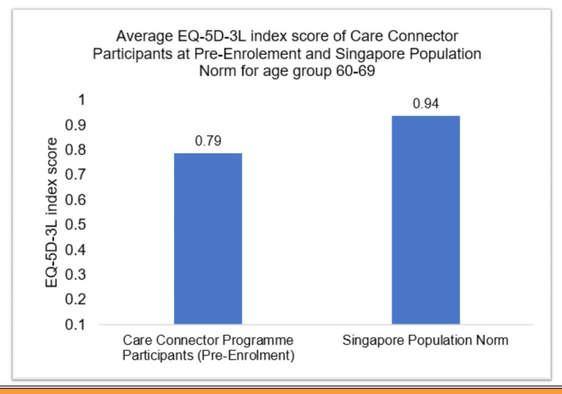
Establish Measures

Outcome Measure

The main outcome measure of this project is to improve quality of life of Care Connector Programme participants aged 60-69. This will be determined by participants completing the EQ-5D-3L questionnaire at pre, interim and post enrolment.

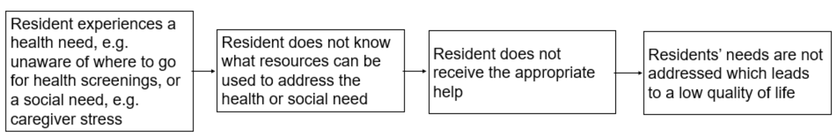
Baseline

The project bases its baseline data on the average EQ-5D-3L index score of participants aged 60-69 at pre-enrolment. This score was compared against Singapore population norms for the same age group.



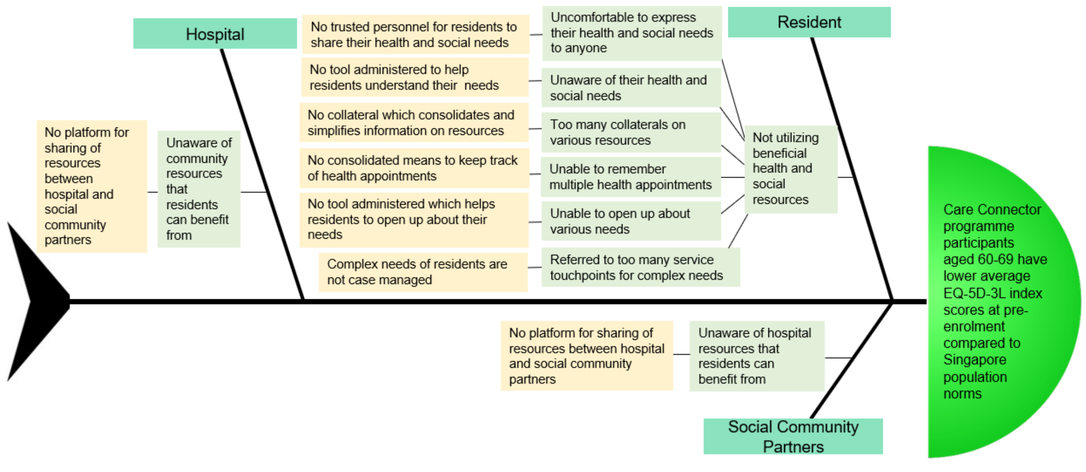
Analyse Problem

Process before intervention



Probable root causes?

Feedback was collected from programme participants, aged 60-69 during the weekly community immersion to understand the reasons that were affecting their quality of life. Areas of improvement highlighted by residents are illustrated below.



Select Changes

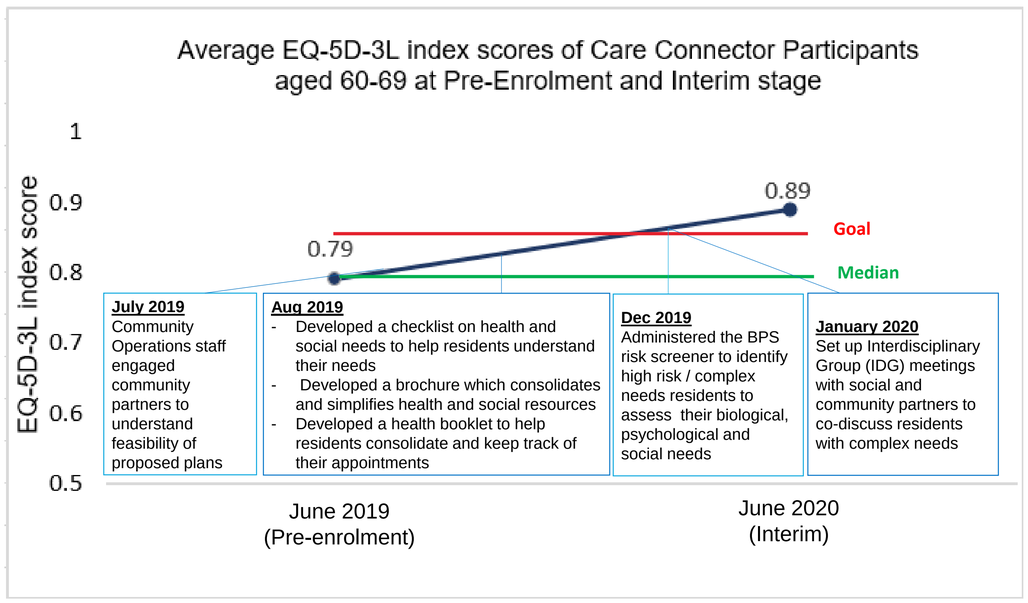
Matching root causes to probable solutions

Root Cause	Probable Solution
No platform for sharing of resources between hospital and social community partners	Regular meet ups with social community partners to facilitate collaboration and cross-sharing of resources
No trusted personnel for residents to share their needs	Community Operations staff to build trusting relationships with residents in the community, to enable them to share their needs
No tool administered to help residents understand their needs	Develop a checklist on health and social needs to help residents better understand their needs
No collateral which consolidates and simplifies information	Develop a brochure which consolidates and simplifies health and social resources.
No consolidated means to keep track of health appointments	Develop a health booklet to help residents consolidate and keep track of their appointments
No tool administered which helps residents to open up about their needs	Administer the ComSA BioPsychoSocial (BPS) risk screener to provide opportunity for residents to open up about their biological, psychological and social needs
Complex needs are not case managed	Set up Interdisciplinary Group (IDG) meetings to case manage residents with complex needs

Test & Implement Changes

How do we pilot the changes? What are the initial results?

CYCLE	PLAN	DO	STUDY	ACT
	What is the aim of this cycle? What do you need to do before you execute the test change? (Who, What, Where, When)	*Was the test change carried out as planned? What are the feedback & observations from participants?*	*What are the results? Use run charts to illustrate. What did you learn from this cycle?*	*What is the conclusion from "Study"? What is your plan for the next cycle (adopt / adapt / abandon)?*
1.1	We aim to improve the quality of life of participants' aged 60-69 by connecting them to the right health and social resources through the Care Connector Programme. Community Operations to engage and collaborate with social and community partners, and understand residents' health and social needs and resources available in the community over a period of 2 months.	Yes. Participants aged 60-69 had improved knowledge about appropriate health and social resources and benefitted from the use of health and social services in the community.	Average quality of life of participants aged 60-69 improved at interim stage of the programme compared to pre-enrolment. Residents' quality of life will improve if they are connected to the right resources in the community.	Connecting residents to beneficial health and social resources will improve their quality of life. This strategy will be adopted for the next cycle.



What were the results of the improvements made?

Care Connector Programme participants aged 60-69 had a **13%** improvement in their average EQ-5D-3L index score from 0.79 to 0.89 at the interim time point. This exceeded the initial predicted goal of 10% improvement in average EQ-5D-3L score.

Spread Changes, Learning Points

Strategies to spread change

The team intends to spread the changes to other Senior Activity Centres. The Care Connector programme has been shared with the center managers in other centres in Bukit Batok.

Key learnings

1) Connecting residents to beneficial health and social resources through a Care Connector whom they trust and open up to can lead to an improvement in quality of life.
2) Team work and collaboration between the Community Operations team and different social community partners can enable residents to be connected to the right resources, improving their quality of lives.

Ng Teng Fong General Hospital

Jurong Community Hospital