Project Title

Integrated Home Palliative Care Programme for Non Cancer Conditions (Programme IMPACT)

Project Lead and Members

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- Dr Yang Sze Yee
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- Adj A/Prof Mervyn Koh

Organisation(s) Involved

Tan Tock Seng Hospital, Dover Park Hospice

Healthcare Family Group(s) Involved in this Project

Medical, Nursing, Medical Social Services

Applicable Specialty or Discipline

Palliative Care

Aim(s)

- Aim to improve the quality of life of terminally ill non cancer patients and reduce unnecessary admissions to acute hospital. Through collaborative partnerships and capability building efforts with DPH
- Aim to ensure that the care for non-cancer EOL patients at home will eventually be anchored by ILTC home hospice providers.

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Lessons Learnt

See poster appended/ below

Conclusion

See poster appended/ below

Additional Information

This project was featured at the Central Health Action & Learning Kampung (CHALK) Poster Showcase 2022.

Project Category

Care Continuum

Palliative Care

Keywords

Home Palliative Care, Non-Cancer Patients, Multidisciplinary Team

Name and Email of Project Contact Person(s)

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Integrated Home Palliative Care Programme for Non-Cancer Conditions (Programme IMPACT)

Team Members

Adj A/Prof Wu Huei Yaw (TTSH) | Adj A/Prof Ian Leong (TTSH) | Dr Yang Sze Yee (TTSH) | Dr Lee Khar Suan (TTSH) | Chen Wei Ting | Loh I-Yee (TTSH) | Tang Sie Min (TTSH) | Dr Yee Choon Meng (Dover Park Hospice) | Adj A/Prof Mervyn Koh (Dover Park Hospice)

Background & Objectives

With an ageing population and access to better medical care, patients are living longer with an increasing burden of care along the illness trajectory.

Patients with End Stage Organ Failure (ESOF) present a disease trajectory with prolonged functional decline. The current end-of-life (EOL) care landscape does not sufficiently support ESOF patients, with existing home hospice service providers catering mainly to patients with cancer.

Thus, the **Integrated Home Palliative Care Programme for Non-Cancer Conditions (Programme IMPACT) @ TTSH** was implemented in 2017 with the aim to improve the quality of life of terminally-ill non-cancer patients and reduce unnecessary admissions to acute hospital. Through collaborative partnerships and capability building efforts with DPH, Programme IMPACT also aims to ensure that the care for non-cancer EOL patients at home will eventually be anchored by ILTC home hospice providers.

Programme IMPACT

MULTI-DISCIPLINARY TEAM

A **multi-disciplinary team** comprising nurses, doctors and medical social workers, and administration team was created to provide holistic continuous care to patients.

CASE TYPES

Cases enrolled directly to DPH wef:

Jun 2019	*Aug 2020*	*Jul 2021*	*FY2023*
Frailty	**End Stage Renal Failure**	**End Stage Heart Failure**	**End Stage Lung Failure**

SERVICES

Caregiver Training | **Psychosocial Support** | **Advance Care Planning**

+ Palliative Home Care Service

+ 24/7 on-call service for patients

Outcomes

Acute Utilisation

49.3% Reduction in ED admissions

35.2% Reduction in hospital admissions

Unnecessary acute utilisation is reduced

Patient Enrolment

571 Patients enrolled in Programme IMPACT

87 Patients enrolled directly to Dover Park Hospice (DPH)

Build-up of non-cancer palliative capabilities by community providers

Resource and Cost Savings

Mean reduction of

21 days Length of Stay (LOS)

6.58 visits ED visits

0.86 visits SOC visits

With a net cost savings of

$2,800 per patient per month

Cost effectiveness of programme is achieved

Home Hospice Care Provision

90% of non-cancer EOL home care cases are managed by Dover Park Hospice

Build-up of non-cancer palliative capabilities by community providers

ACP Conversations

66% of patients have completed ACP, of which

71% passed on at home

82% Place of death concordance

Initiated ACP conversations and honouring patients' choices in preferred place of death

Conclusion

Through Programme IMPACT, DPH home care has built capabilities in managing non-cancer EOL cases at the ILTC setting.

Concluding the collaboration, the team would work together to include direct enrolment for End Stage Lung Failure cases from TTSH to DPH from FY2023.