



Promoting positive clinical outcomes through Engagement, Empowerment and Activation of patients with Mental Health Issues in an Integrated Case Management System

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**INSTITUTE
of MENTAL
HEALTH**

Loving Hearts, Beautiful Minds



The Institute of Mental Health is a 1800-bedded hospital that provides tertiary and sub-specialized psychiatric care for acute and chronic patients in Singapore.



Case Management at the Institute of Mental Health and its Scope

- 2000: for the Early Psychosis Intervention Program and the National Addiction Management Services (NAMS)
- 2003: for Acute General Psychiatry, Rehabilitation and Forensic Units

Case Management – Concept & Scope of Services

- Our Objective: To form a bridge from inpatient to outpatient care and the continuity of care and support in the community.

Service Gaps

- Lack of follow up for treatment default
- Lack of continuous patient/caregiver psychoeducation, training and therapeutic contact
- Lack of social & community agencies support for patient /caregiver

- Provide coordination, linkages, seamless integration and allocation of individualized care/resources through a relationship based case management model.

Case Management

DEFINING CASE MANAGEMENT

Case Management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality outcomes.

2003: the case manager worked with the multidisciplinary team to provide a “brokerage model” of case management.

2010: Integrated Case Management :

“Integrated case management is a process in which a single case manager assists patients with all the barriers to health...physical illness or mental health.”

Kathol et al 2010

Integrated Case Management: a holistic approach to care, assessing patient’s needs using a biopsychosocial framework, collaborating with patients, their families, caregivers and communities to deliver coordinated quality care and services.

Besides an Integrated case management framework, case managers also adopt a **Single Point of Contact (SPOC) system** for their patients.

In this system, the patient and their carer need only approach one source that is the case manager, to enquire about their health care needs.

Case Management – Single Point of Contact (SPOC)

Our health care team
BEFORE



Our Client



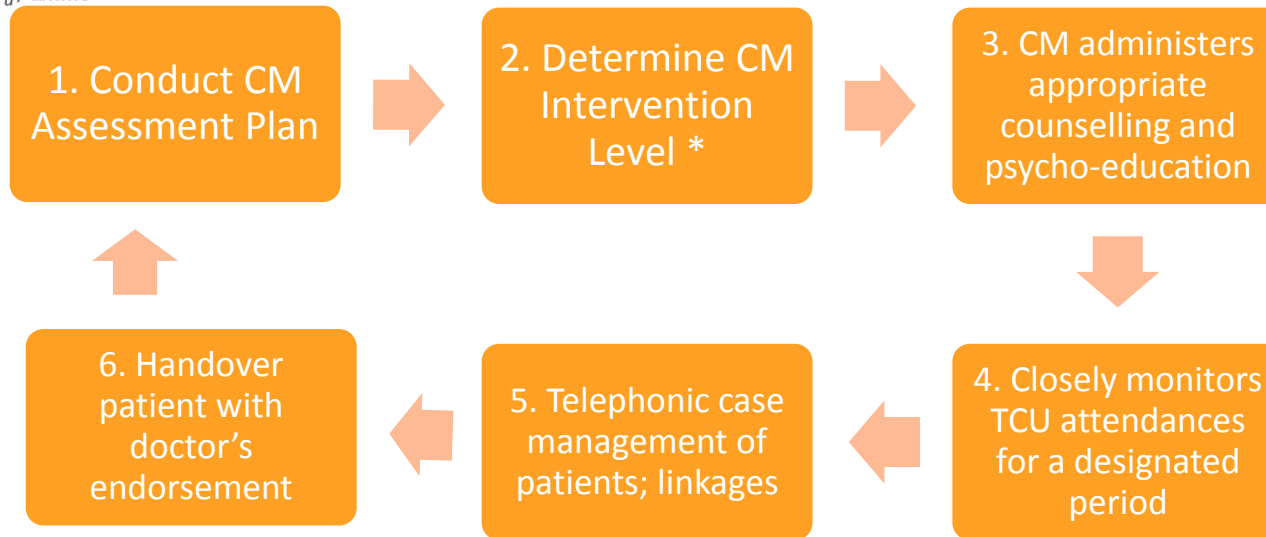
Our health care team
NOW



Our Client & CM

Case Management Framework

PROCESS FLOW - OVERVIEW



- ❖ CM will identify unmet clinical and social needs
- ❖ CM will determine the nature of intervention required based on 4 risk assessment levels.

Levels of Risk Stratification

SIMPLE	MINIMAL	MODERATE	INTENSIVE
Basic Counselling Basic Psycho Ed	Basic Counselling Basic Psycho Ed Telephone CM before 1 st TCU	Advanced Counselling Advanced Psycho Ed Telephone CM 2-3 days before all 3 TCUs	Advanced Counselling Advanced Psycho Ed Telephone CM 2-3 days before all 3 TCUs Weekly call till 1 st TCU
-	-	-	

Main Stream

- Emergency Service
- Acute Adult General Psychiatry (inpatient/outpatients)
- Department of Child and Adolescent Psychiatry
- Psychogeriatric services
- Forensic services
- Rehabilitation services

Specialized Programs

- Mandatory Treatment Order (MTO)
- General Practitioner Program (GPP)
- Adult Neurodevelopment Services (ANDS)
- Mood Disorder Unit (MDU)
- Aftercare Services
- Forensic Psychiatry Community Service
- Obsessive Compulsive Disorder Service

Some case management activities



MDT Review
Sessions



Tracking patients SOC
appointments and data
management



Providing
psychoeducation
and counseling to
patients



Linking with Nursing
Homes/ Community
Agencies



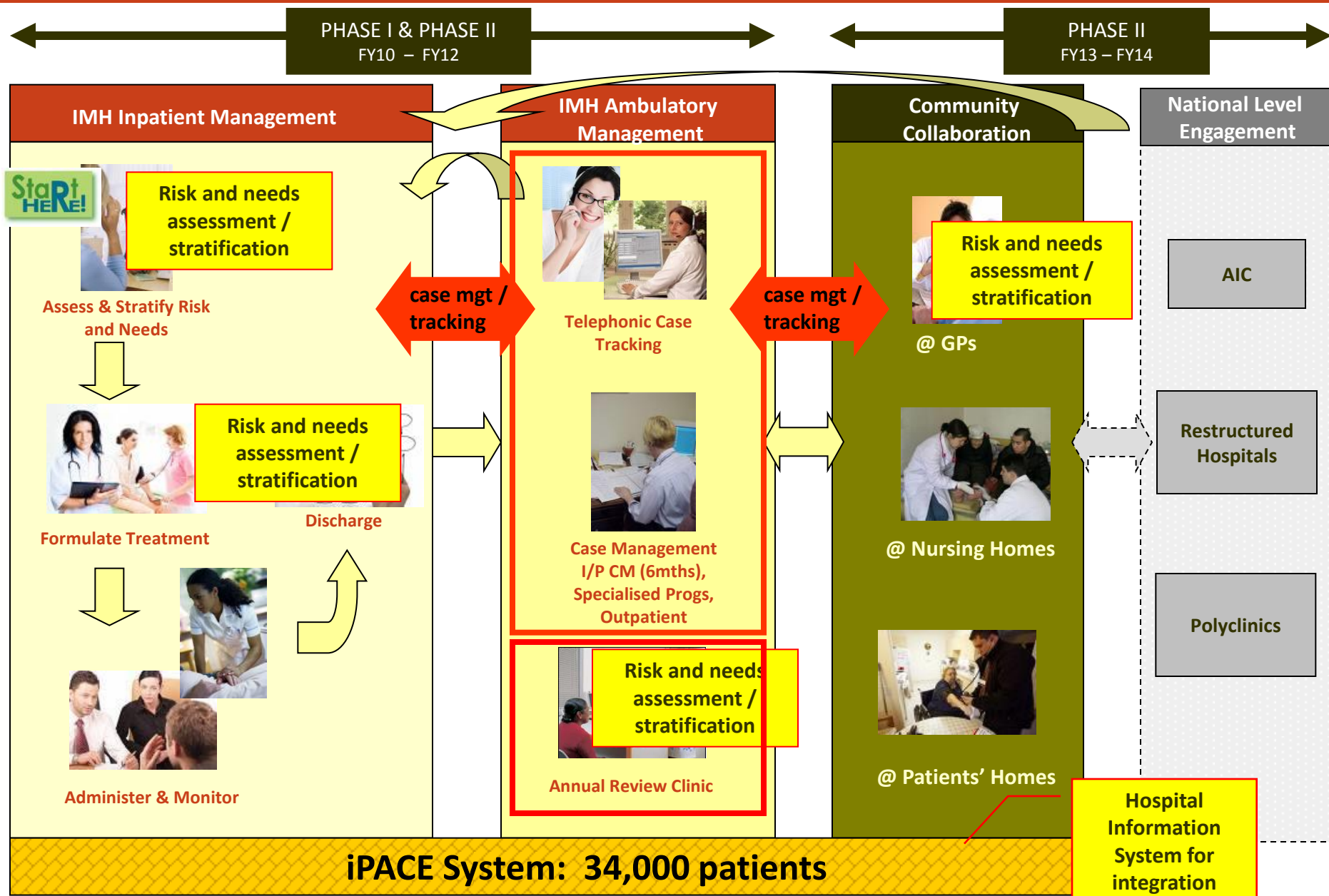
Providing
telephonic case
management
support



Meeting patients at
the Emergency Room
and outpatient clinics

OVERVIEW OF PROJECT

Integrated Patient Assessment Continuous Engagement (iPACE)



Role of Case Manager in Medical Services Clinic (MSC)

The role of MSC CM is to work with the multidisciplinary team to ensure continuity of holistic care to patients who are receiving treatment for any of the three chronic medical conditions (hypertension, diabetes mellitus and hyperlipidemia) in IMH.

The MSC CM's main responsibilities are:

1. Conduct telephonic follow-up and reminders with patients scheduled for MSCs, prior to their appointment.
2. Case discussion with visiting physicians on the treatment management and care plan for patients
3. Track and follow up with patients for their first three scheduled appointments at the polyclinic to ensure compliance and adherence.
4. Flow non-compliant patients back to the MSC for continued treatment of their HDL Conditions.
5. Psycho-educate patients on importance of compliance

Patient's Passport: The Wellness Booklet

serves as a communication and care tool between the patient and the care provider. It provides **immediate and important information** to doctors, allied health professionals, community partners and caregivers, which aims to **strengthen interdisciplinary collaboration** and help **achieve better health outcomes** for our patients. It empowers patients to be in control of their disease.



Project Benefits

Positive patient experience and empowerment

through enabling communication with healthcare and social care providers

Personalized source of information

that is less medicalized, strengthening communication process among healthcare providers, thus leading to better management of overall well-being of patient

Enhance patients' confidence and empowerment to manage illness

so patients are self-aware of biosocial psychological and risk issues,
and aware of avenues to seek assistance.



The Wellness Passport



MY WELLNESS PASSPORT

What you need to
know about ME

Help me achieve long-term wellness through patient-centred care and interdisciplinary collaboration and partnerships.

THINGS THAT ARE IMPORTANT TO ME



PREFERENCES

LANGUAGE TO COMMUNICATE
(E.g. English/Chinese/Malay/Tamil)

FOOD

E.g. Halal/Non-Halal/Vegetarian

LIKES AND DISLIKES

"Things I like" – what makes me happy, things I like to do
e.g. watching TV, music, reading, etc.

"Things I don't like" – what upsets me e.g. being shouted at,
physical touch, specific food types, etc.

THINGS I LIKE

Please do this:



THINGS I DON'T LIKE

Don't do this:



RELAPSE PREVENTION INFORMATION



Early warning signs are changes that occur when you start to feel unwell again. A personalised relapse signature are symptoms that are unique to you and can be used to predict if you are experiencing a relapse. It gives you an opportunity to take control of your illness and get help as soon as possible. Act early – a relapse may be prevented or severity of a relapse reduced.

THINKING / PERCEPTION

- ☐ Thoughts are racing
- ☐ Senses seem heightened
- ☐ More nightmares
- ☐ Hear voices
- ☐ Bizarre thoughts
- ☐ Preoccupied with 1 - 2 things
- ☐ Experience strange sensations
- ☐ Difficulty concentrating
- ☐ People are against you
- ☐ Have special powers
- ☐ Might be someone else
- ☐ Watched by others
- ☐ Seeing your thoughts are controlled
- ☐ People are talking about you
- ☐ See visions or things others cannot see
- ☐ Part of you has changed shape
- ☐ Able to read other people's minds
- ☐ Others can read your mind
- ☐ Receive personal messages from the radio or TV

MENTAL HEALTH HELPLINE 6389 2222

If you are facing a mental health crisis, please call our Mental Health Helpline or seek medical help at our 24-hour Emergency Services located in IMH.

Target Audience

Patients with mental health issues and/or medical comorbidity

OPS/GP/RHs for further management on their medical comorbidity

Community partners

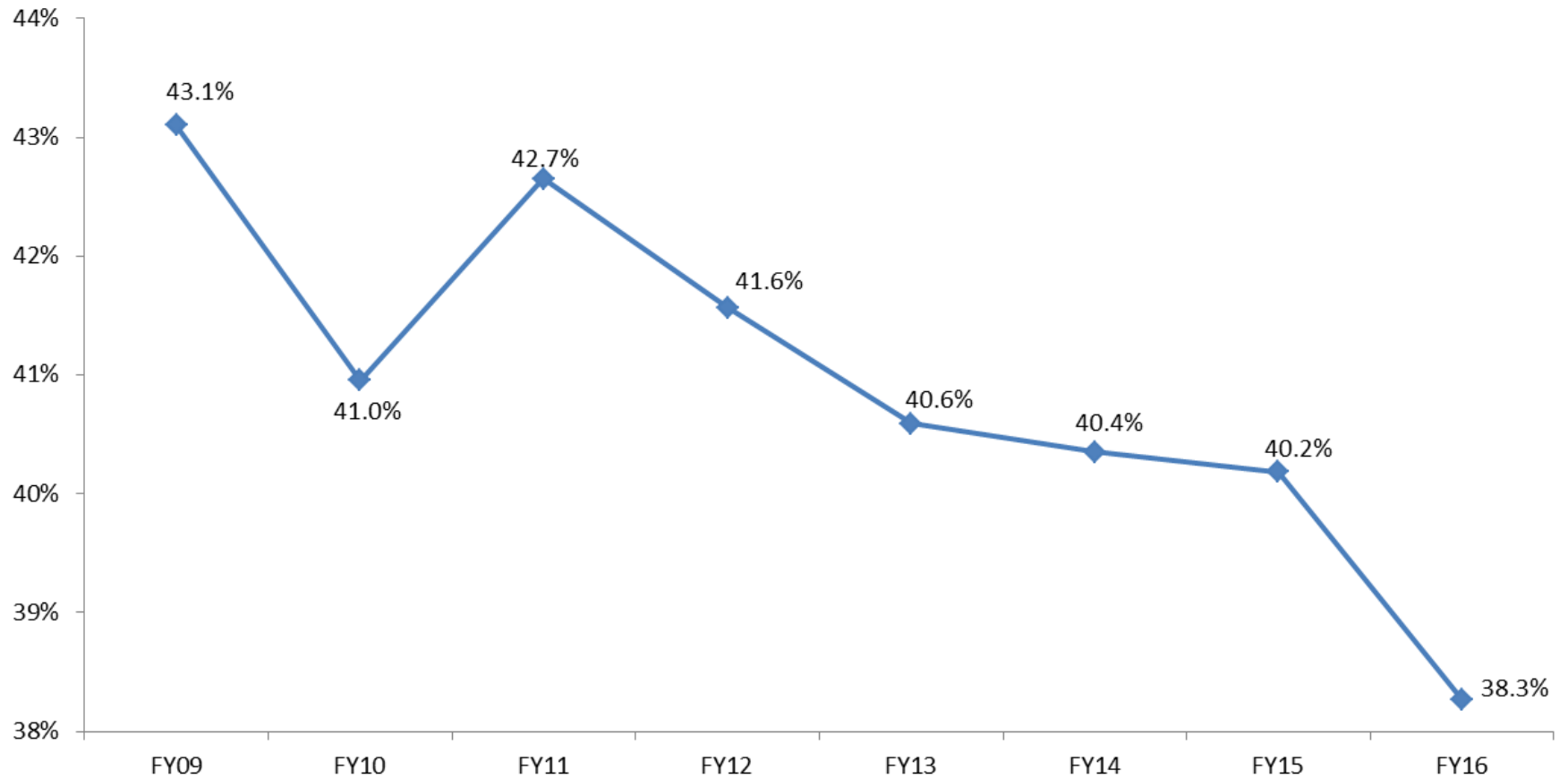
- Project commenced in 7 June 2016, 480 wellness passports have been issued to patients.



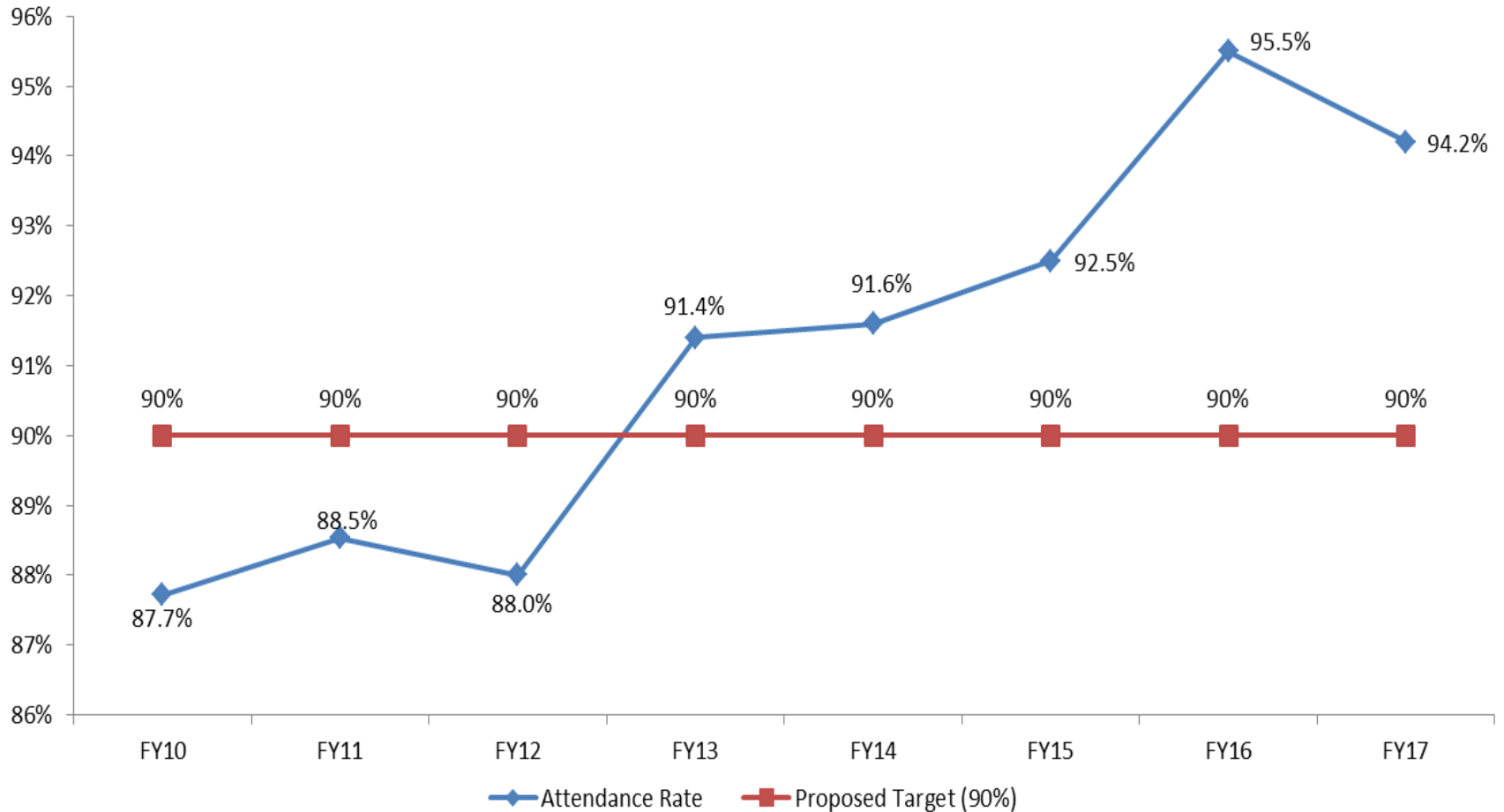
OUTCOME INDICATORS

- I. Continuity of Care
no of CM assessments done, psychoeducation & counseling sessions, linkages done, telephonic case management, home visits performed individually or with community partners.
- II. Specialist Clinic attendance rate after discharge
- III. Psychiatric and Medical complications such as
Recurrence of violence and forensic issues, medication side effects
development of forensic complications (reoffending), crisis interventions,
attempted suicide and complete suicide.
- II. Monitoring of unplanned readmissions
E.g. Readmissions < 30 Days,
readmissions > 30 Days,
admissions requiring Police assistance.

Readmission Rate for Schiz/DD Patients (FY09 to FY16)



1st SOC Attendance of Discharged Schiz/DD Patients (FY10 to FY17)



Conclusion

Adopting an engaging, empowering and activation relationship with patients within an integrated case management framework has resulted in positive clinical outcomes

Our service is evolving continuously as we seek to understand the needs of our patients and our carers as well as support our management to build effective, quality and cost effective programs.