A Population Health Approach for Mental Health Care

Dr Chua Hong Choon
CEO, Institute of Mental Health

A Member of the National Healthcare Group
About IMH

- Singapore’s only tertiary psychiatric institution
- Looks after the most severe cases
- Provides acute and long-term care
- Conducts professional training and research

**589**
Daily Visits
(Outpatient Clinics Only)

**40,109**
Outpatients
(ES Included)

**656**
Acute

**1,078**
Long-stay

**1,735**
Average no. of inpatients per day

* Excluding 23-hr observation ward
HOSPITAL-BASED SERVICES
- General Psychiatry
- Geriatric Psychiatry
- Child & Adolescent Psychiatry
- Community Psychiatry
- Forensic Psychiatry
- Rehabilitation Psychiatry
- Emergency Psychiatry
- Early Psychosis Intervention
- Addiction Medicine
- Psychotherapy
- Allied Health

COMMUNITY-BASED SERVICES

YOUNG
- REACH
- EPIP
- SWAP
- CHAT

ADULTS
- CMHT
- Job Club
- GP-Partnership

ELDERLY
- APCATS

National Mental Health Blueprint Programmes
Specialised Units

Emergency Services  High Dependency Psychiatric Care Unit  Addictions Ward

Dementia-Friendly Ward  Mood Disorders Unit  EPIP Inpatient Service

Loving Hearts, Beautiful Minds  A Member of the National Healthcare Group
Challenges in mental health care

- Working in Silos
- Minimal Upstream Interventions
- Non-Disease Driven

- Prevalence Rates
  - Lifetime prevalence: 12%
  - 12mth prevalence: 4.4%

- Uncoordinated Care

- Lack of Right-Siting Care
Changing our paradigm

<table>
<thead>
<tr>
<th>Mainly Acute Care</th>
<th>All Segments of Care (From Living Well to Dying Well)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainly Inpatient Care</td>
<td>Focus on Upstream Care Plans (Early Detection and Health Promotion) with Strategic Community partners, Inpatient Care, Discharge Planning, Rehabilitation and Post Discharge Support</td>
</tr>
<tr>
<td>Mainly Transactional</td>
<td>Relationship and Partnership</td>
</tr>
<tr>
<td>Many Clinicians to One Patient</td>
<td>One Patient, One Clinician, One Team</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Mental &amp; Medical Health, Lifestyle Changes, Social Support</td>
</tr>
<tr>
<td>IMH Centric</td>
<td>IMH and RHS Centric</td>
</tr>
<tr>
<td>Education</td>
<td>Better People, Better Care</td>
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</tbody>
</table>
Changing our paradigm

The National Healthcare Group

CARE FOR EACH OTHER, CARE FOR OTHERS

- Relationship
- Building Foundations
- Expectations
- Activation

BETTER PEOPLE, BETTER CARE

Activation of Persons/Patients/Community via Relationship

- Relationship
- Building Foundations
- Expectations
- Activation

Activated Patients, Better Outcomes

Living Well

Living with Illness

Crisis and Complex Care

Living with Frailty

Dying Well

Experience by Patients

Understand & Know ME

Care for ME

Make Care Easy For ME

PEOPLE CENTRIC

- Alignment
- Engagement Collaboration
- Empowerment
- Growth

SUSTAINABILITY

- Innovation
- Continuous Improvements
- Technology
- Optimal Use of Resources
- Data & Evidence Practice

TRIPLE AIM

Population Health

Experience of Care

Per Cap Cost
Adopting a Population Health Approach

- **Pre-Pop.Health**
  - Child And Adolescent Psychiatry
  - General Psychiatry
  - Community Psychiatry
  - Early Psychosis Intervention Programme
  - Forensic Psychiatry
  - National Addictions Management Service
  - Geriatric Psychiatry

- **Pop.Health**
  - Living Well
  - Crisis Care
  - Living with Illness
  - Living with Frailty
  - Dying Well

- **Post-Pop.HealthPlan**
  - Facilitate Effective Mental Health Promotion and Prevention
  - Deliver Effective Holistic Care and Optimise Patients’ Mental and Physical Well-Being
  - Facilitate the Development of Primary, Secondary and Long-term Mental Health Services for Singapore’s Population

- **Central Region**
  - Through Clinical Services Thrust & Depression Drivers

- **All Patients**
  - Through Empanelment & Clinical Services Thrust Drivers

- **Community Partners**
  - Schools, workplaces, constituencies, community centres

- **IMH Medical Care Clinic**

- **GP Partnerships**
  - Assessment and Shared Care Team
  - Integrated Patient Assessment and Continuous Engagement program

- **Mobile Crisis Team**
- **Mental Health Helpline**
To Build A Mentally Healthy Population and Reduce The Burden of Mental Illnesses

P3: Facilitate effective mental health promotion & prevention
P4: Deliver effective holistic care & optimise patients’ mental & physical well-being
P5: Facilitate the development of primary, secondary & long-term mental health services for S’pore’s population

Implement Evidence-based Activities

Create Mechanism to Enhance Adoption

Build Supporting Structures

Goal Statement

Primary Drivers

Secondary Drivers

Driver Diagram – Mental Illness

19/9/2016

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Driver Diagram – Mental Illness

19/9/2016
Empanelment: One-Patient-One-Clinician Team

- Re-organise acute patient care to provide better continuity post discharge
- Consider one-patient-one-clinician team concept
Provide **integrated** services across the care spectrum, from prevention, early detection, treatment to long term care in **collaboration** with community partners, based on **patients’ and caregivers’ needs**.
1) Single Point of Contact determined for each patient

2) Panel Teams Established

3) Risk and Needs Analysis

<table>
<thead>
<tr>
<th>Zone</th>
<th>Jan-16</th>
<th>Feb-16</th>
<th>Mar-16</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
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<tbody>
<tr>
<td>Overall</td>
<td>NARA Done</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>17</td>
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<td>181</td>
<td>243</td>
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<td></td>
<td>4.1%</td>
<td>20.9%</td>
<td>42.8%</td>
<td>52.0%</td>
<td>59.3%</td>
<td>59.6%</td>
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<tr>
<td>Discharges</td>
<td>413</td>
<td>392</td>
<td>423</td>
<td>467</td>
<td>420</td>
<td>394</td>
</tr>
</tbody>
</table>

4) Reducing Frequent Admitters

![Graph showing Total Empanelment Admitters (unique headcount)](image)
Harnessing the power of teams

• The power of cohesive teams to create the multiplier effect
Harnessing the power of teams

• Multi-disciplinary, inter-disciplinary, trans-disciplinary care... getting more done
• Working at the top of your license

Implementing a transdisciplinary care model – health professionals’ experiences of barriers and solutions

Doug Murtagh¹, Marguerite Bennetts²
1 Darling Downs Hospital and Health Service

Context
The Darling Downs Hospital and Health Service is responsible for delivering health services to a population of almost 300,000 people in a regional area. The major regional centre of Toowoomba features a 200-bed hospital, which includes a Medical Assessment and Planning Unit (MAPU) that has been identified as a clinical area of high allied health service use and high staff turnover of large volumes of patients. Investigations have documented delays in allied health service provision, including delays in timelines for commencement of intervention, duplication of assessments and treatments, lack of discharge planning and co-ordination of care across the care pathway.

Solution
The introduction of a transdisciplinary advanced allied health team (i.e. MAPU) was proposed. It was felt that transdisciplinary care had the potential to facilitate efficient, efficacious allied health care.

Transdisciplinary Care: Opportunities and Challenges for Behavioral Health Providers

Virna Little, PsyD, LCSW-r, SAP

Integrated care and integrated care models have been in the forefront of much recent discussion in both local and national forums. The idea that care can be delivered in teams has evolved from integrated care to the development of transdisciplinary care teams. A major contributor to the development of team-based care was Project IMPACT (Improving Mood—Promoting Access to Collaborative Treatment for Late-Life Depression), which addressed geriatric depression in primary care settings and created the foundation for integrated care.¹ Following IMPACT, the model for utilizing a team-based approach became recognized as an effective method for treating chronic illness in primary care settings.

The IMPACT research project demonstrated for the first time that community health settings provide the majority of the nation’s mental health services, due primarily to the fact that the public chooses to seek care where there is less stigma and where they have existing relationships. At the same time, primary care providers began to acknowledge that they lacked both the expertise and the resources to do an optimal job of either identifying or treating the mental health disorders they encountered in these practices. These providers have, for the most part, readily embraced integrated and team-based models.¹
Our patients’ physical health

- How about our patients’ physical health?
- Are we winning the battle but losing the war?

People with schizophrenia - average health profile that is **10 to 15 years older than their counterparts** in the general population and have a higher mortality rate especially from cardiovascular diseases.

Greater risk of premature death, dying as much as **25 years younger** than the general population (1).

Contributing factors to overall excess mortality is cardiovascular disease (2) - high rates of cigarette smoking, obesity, diabetes, hypertension and triglyceridemia.

A recent meta-analysis of quality of medical care for people with co-morbid mental illness reported that the majority of studies demonstrate significant inequalities in receipt or uptake of medical care for people with SMI (4).

Higher than expected prevalent rates of co-morbid general medical conditions, particularly metabolic and cardiovascular disease.
Current Medical Care Services - Overview

Specialist Outpatient & Satellite Clinics

DHL screening for:
- Patients prescribed with medication for at least one of the DHL conditions
- New patients age 40 & above
- Smoking Cessation Prog.

Dental services for long stay patients

Dental services

Allied Health Services

Program for inpatient with risk of Dysphagia

Speech and Language Therapy Service

Physiotherapy + Occupational Therapy Services

Inpatient (Long Stay)

Screening for:
- DHL
- DRP, DFS
- Mammography
- BMD

• Osteoporosis Detection and Treatment Prog
• Tele-Dermatology
Engaging the Community

Multi-pronged Approach

1. Understand needs of community
2. Build capability through mental health training
3. Direct liaison with GRLs
Community Engagement
List of Partners

- **43** FSCs
- **52** SACs
- **7** TCs
- **7** VWOs
- **16** Constituencies
- **8** CREST agencies
- **5** Cluster support
- **1** Hospital
- **3** Others

**Total: 141**

MHH has trained **almost 700 pax** from FSCs, SACs, TCs and VWOs, as well as **330 grassroots and community partners via the constituency engagement**

Oct 2015
Listening to patients... *I mean really listen!*

- Not ‘what’s the matter with you’, but ‘what really matters to you’
- “Nothing about me, without me”
Use of “passports” to enhance communication among patient, care providers and coordinators
• 30 patients updated the patient/caregiver section, & included information such as “their daily BP reading” & “how am I feeling today”
• 20 patients updated the healthcare service providers section on their health progress
• 22 utilized both patient/caregiver & healthcare service providers sections
Giving Persons with Mental Illness A Voice: “Voices of Experience” Programme

Patients and caregivers as:

**Advocates** who are willing to speak positively about their recovery

**Consultants** who give input to new and existing services, programmes

**Peer Specialists** who help others along the journey of recovery

Patient commissioned to illustrate a series of display posters on what mattered most to her about IMH

Patients were involved in the planning and design phase of the new mood disorders and psychosis wards
Giving Persons with Mental Illness A Voice: “Voices of Experience” Programme

Speaking opportunities at public forums & conferences

Singapore Mental Health Conference 2013

Psychosis Symposium 2013
What the future has in store...