QUALITY FESTIVAL 2025

The journey to THRIVE: Transforming Health & Resilience In Vulnerable Elders. A collaboration between Woodlands Health and Ren Ci Woodlands Nursing Home

Problem

Frequent hospitalisations and transitions between care settings can adversely affect nursing home (NH) residents and strain limited healthcare resources. Additional issues include polypharmacy and inappropriate medication use and multiple specialist consultations across various healthcare institutions.

Aim Statement

In line with Woodlands Health (WH)'s strategic focus on a) fostering relevant and collaborative care, and b) enhancing value and resource management, the WH-Ren Ci Woodlands Nursing Home (RCWNH) collaboration aims to achieve the following for geriatric NH residents:

Reduce hospitali-sation	Consolidate SOC appoint-ments	Reduce poly-pharmacy	Optimise medical conditions on-site	Initiate ACP discussions	Upskill NH staff

Team Members

Woodlands Health	Ren Ci Woodlands Nursing Home
1. Dr Sharen Lim Pei Wen, Consultant, Geriatric Medicine (Clinical Lead)	1. Dr David Ng Wei Han, Clinical Director (Clinical Lead)
2. Ms Yeo Hui Quan, Asst Manager, CIC Ops	2. Mr Choo Jui Sheng, Executive Director
3. Ms Sheila Chua, Executive, CIC Ops	3. Mr Nelson Coronado Rosales, Nurse Manager (Nurse Lead)
4. Ms Chew May Qi, Principal Epidemiologist, PHOM (Evaluation)	4. Mr Bryan Nicholas Bayle, Clinical Ops

WH Collaboration With Ren Ci 仁慈

Current State

- Since 2014, Regional Health Systems have been building NHs' capabilities in managing end-of-life (EOL) care with support from the Ministry of Health. While positive outcomes have been reported, not all NH residents are at the stage of receiving specialist palliative care; many are frail and frequent utilisers of acute resources.
- As Singaporeans live longer but face declining health in their final years, we anticipate an increase in NH residents and their healthcare utilisation. A local study revealed a hospitalisation rate of 2.23 admissions per 1,000 resident days among subsidised NH residents, nearly double that of the general population aged 65 years and above.
- With three standalone NHs in Woodlands and one new NH strategically co-located with WH on the same integrated campus, there is an opportunity to explore innovative and collaborative care models to enhance the overall care for NH residents.

Root Cause Analysis

5 Whys? – Why are NH residents frequently hospitalised?

Because they have unmanaged health issues that lead to complications

Why do they have unmanaged health issues?

Because many residents have underlying frailty, multiple comorbidities, cognitive impairment coupled with physical dependency

Why is there insufficient management of these health issues?

Because there is insufficient coordination and care rationalisation among multiple providers

Why is coordination and care rationalisation a challenge in NH?

Because NH staff lack the necessary support and resources to manage residents' complex health needs effectively

Why is there a lack of support and resources?

Because there are no established processes for regular case management and collaboration with geriatric specialists

Interventions

A multi-disciplinary WH-RCWNH Clinical Collaboration Workgroup was established and convened regularly before the NH's opening. The need for upstream geriatric care was identified, leading to weekly in-person case management meetings (CMMs) led by a Geriatrician, who conducted on-site patient reviews. This approach enabled two-way feedback between WH and NH, facilitating process refinements and on-the-job training while incorporating residents' and NOK's perspectives. A mid-term mixed-methods evaluation for the pilot was planned.

Results

Over 7 months, 26 CMMs were conducted, covering 181 of the total 218 residents, with most (174) required fewer than 3 sessions.

Care Aims	Results
Optimise care on-site	• 98 residents had 158 unnecessary SOC appointments cancelled, and care transferred to the NH with WH's support. • 24 residents had their care consolidated and transferred to WH. ➢ Saved resources, improved care coordination, and reduced hospital visits across the healthcare system.
Reduce poly-pharmacy	• 77 residents had medications deprescribed during CMMs. ➢ With over 50% of geriatric NH residents prescribed ≥5 medications and inappropriate use observed in 70%, deprescribing is expected to enhance quality of life by reducing drug-induced disabilities and confusion, lowering medication costs, and minimising medication-related issues.
Initiate ACP discussions	• Compared to another Ren Ci NH, RCWNH residents were 2.3 times more likely to pass away in the NH than in the hospital, improving to 2.9 times for those in the EOL program, with 100% concordance to preferred place of death.
Upskill NH staff	• A survey of 30 RCWNH nurses and community care associates showed strong agreement on perceived benefits to staff (≥93%) and residents (≥83%). • Emerging themes aligned with the Quadruple Aim of Healthcare: improved patient experience, better outcomes, improved clinician experience and lower cost.

Benefits

Tangible benefits	• Positive economic outcomes were observed at resident, NOK, NH, hospital and system levels. For every $1 invested by WH, the return on investment is nearly doubled to $2, excluding significant NH manhours savings and other unevaluated costs. • Complications from unmanaged health issues, like readmissions and extended hospital stays, can be financially burdensome.
Intangible benefits	3 case studies highlighted the positive impact on • Residents (improved behaviours and quality of life) • NOK (reduced emotional burden and opportunity costs) • NH staff (decreased administrative burden)

As a new facility, RCWNH had a higher admission rate from acute care facilities and accepted more residents with unstable health conditions than other Ren Ci NH without similar collaboration. While this initial evaluation did not show a reduction in ED visits or hospitalisations, we are optimistic about future improvements as we aim to enhance the NH's internal capabilities to manage most care needs effectively within the NH.

Sustain & Spread

By leveraging established relationships, the pilot has shown potential for cost-effective right-sited care, freeing up hospital resources for other patients while improving the care experience for patient and their NOK. Revamped as THRIVE (Transforming Health & Resilience In Vulnerable Elders), the programme plans to expand to other NHs in Woodlands.