









#### HEALTHIER SG SINGHEALTH'S APPROACH TO POPULATION HEALTH

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Singapore's Healthcare Challenges

**Building a Healthier SG** 

3

4

SingHealth's Approach to Population Health

Social Prescribing as Key Enabler

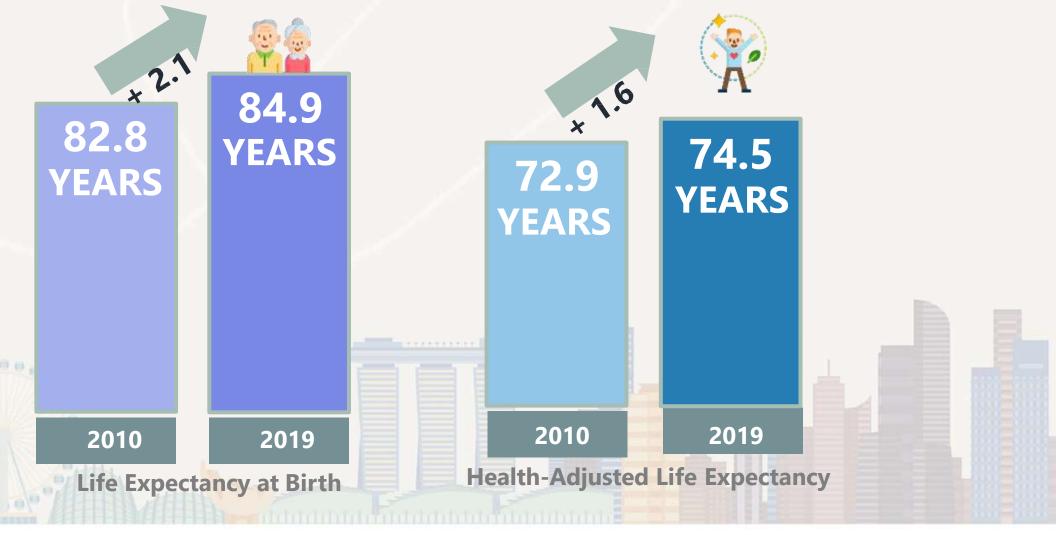








#### Much has been achieved





Source: Ministry of Health Workplan Seminar 2022



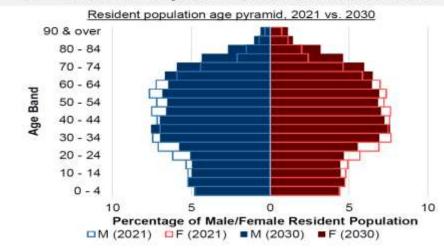






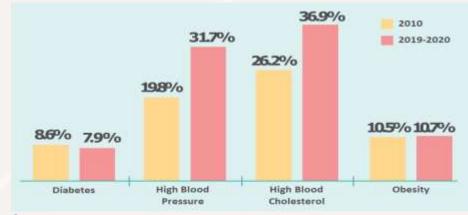
### **Key Challenges**

#### 1 in 5 residents ≥ 65 yo in 2030, from around 1 in 7 in 2020



#### **OLD-AGE SUPPORT RATIO**

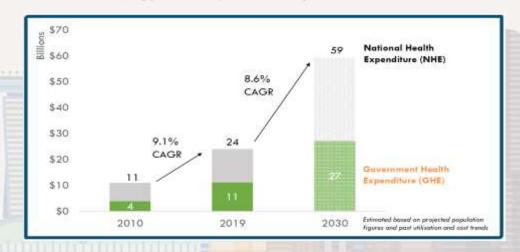




Sources

Epidemiology & Disease Control Division, Ministry of Health, Singapore. National Health Survey 2010.

Epidemiology & Disease Control Division and Policy, Research & Surveillance Group, Ministry of Health and Health Promotion Board, Singapore. National Population Health Survey 2020.





CONFERENCE

Source: White Paper on Healthier SG















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#### Building a Healthier SG

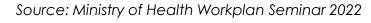




















#### Building a Healthier SG







#### The Regional Health & Social Ecosystem





### Stronger Mandate for Clusters

- Accountable for regional health outcomes
- Build & integrate ecosystem in its region, incl. GPs
- 2 Primary Care Transformation

Enable primary care providers (PCPs) to step up and enrol residents

Activate Community
Partners

Engage residents to adopt and support healthy living in community











### Core Elements of Healthier Sg



1) National Healthier SG Enrolment Programme



You will have a regular doctor to partner you in caring for your health.



3) Health Plan

Your doctor will work with you on a **health plan** to improve your health.



(4) Community Support

Your doctor will also recommend programmes and activities you can join to stay fit and healthy.





- **Support Structures** 
  - Restructuring of healthcare financing
  - Healthcare manpower transformation

- IT enablement
- Introduction of key monitoring indicators









### How will our patients and residents benefit?

Residents will be empowered to take charge of their health through a customised Health Plan and a trusted long-term relationship with their family doctor



#### A Health Plan is a simple document for:

- ✓ Residents to better understand their overall state of health and take actionable steps (vaccinations, screening, chronic disease management, lifestyle adjustments)
- ✓ **Develop health and lifestyle goals** with family doctors
- ✓ Easily accessed through HealthHub, including by caregivers











### System Level Goals

**Better Health Outcomes** 



Address Needs Of An Ageing Population Along With An Increasing Prevalence Of Chronic Diseases

**Improved Patient** Experience



Patients Want Better Service And To Be Involved In Taking Charge Of Their Health Outcomes

Value-Based Care



Ensure Quality Of Care Is Maintained While We Act To Slow National Healthcare Expenditure

**Improved** Provider Experience



Supporting Care Providers to Focus on Delivering Quality Care to their Patients











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# Making a strategic shift in care redesign for Population Health

Extended Roles and Accountabilities of Healthcare Clusters

01 Service Provider

Clinical care provision/services

02 Population Health Manager

Accountable for regional health outcomes

03 Regional Health Manager

Build and Integrate ecosystem in its region

This is in addition to our national role of providing tertiary and quaternary care, undergirded by academic excellence









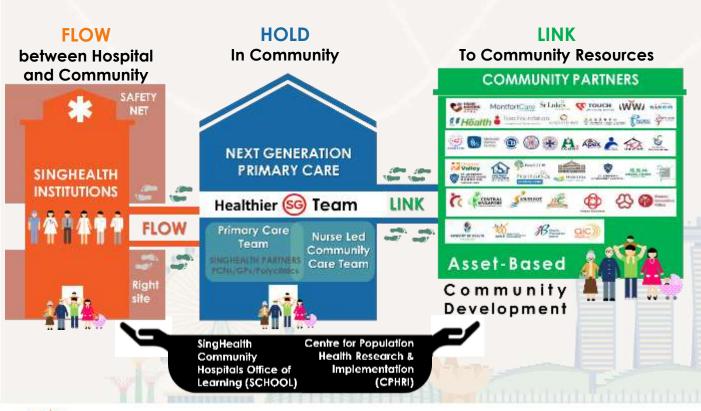




### SingHealth as Regional Health Manager

Integrating Health and Community Ecosystem

**Anchoring Care in Primary Care and Community** 

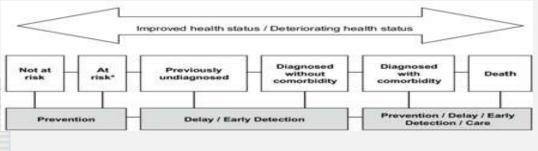


#### Inclusive

#### Life Course



#### **Disease Complexity**





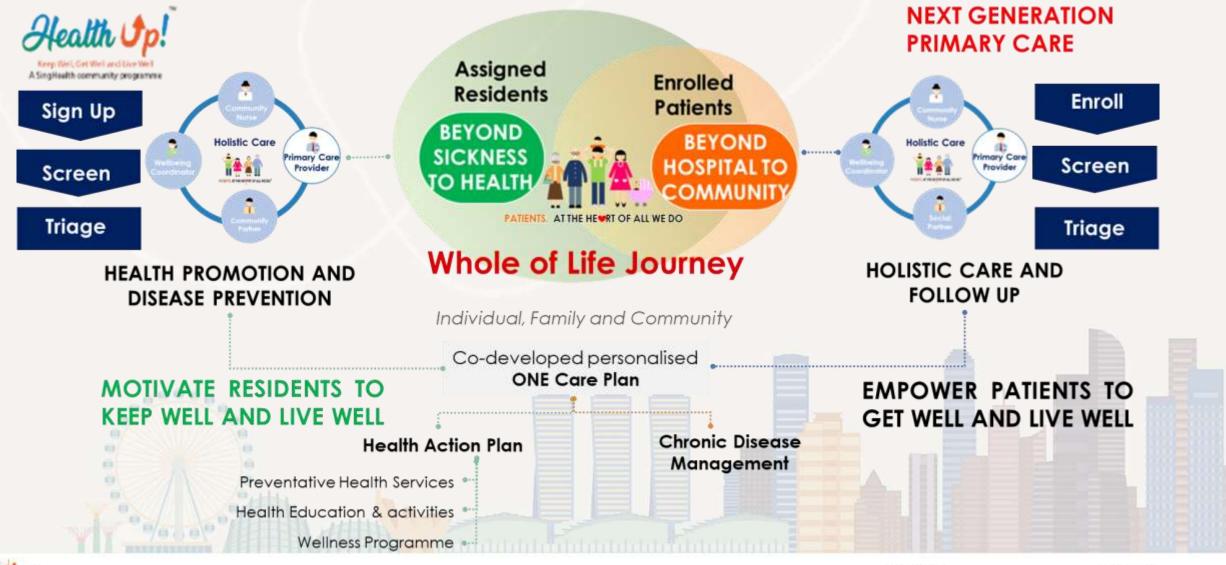








### Enabling our residents to keep well, get well and live well











#### **Engaging and Building relationships**

**Learning together** through Close Partnerships Community Engagement Across All Level









LOCAL LEADERSHIP







STRATEGIC LEADERSHIP













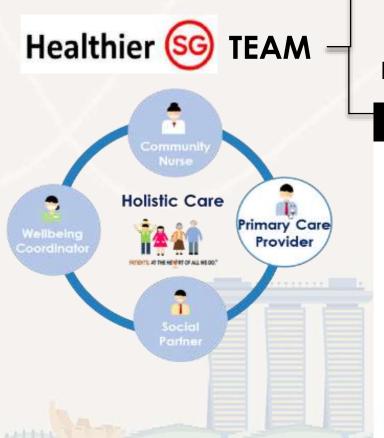


### Place based Integrated Care Team

Anchoring care in primary care and the community

**Deep understanding** of needs and aspirations of residents and partners

> **Flexibility** for local customization



Coordinating care for health-social care integration

Ensuring holistic person-centered care

#### Individual, Family, Community

























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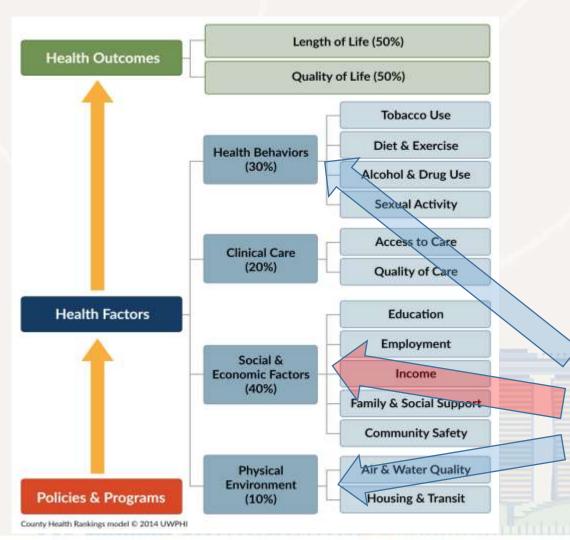








### **Defining Social Prescribing**



"Social prescribing is a means for health-care workers to connect patients to a range of nonclinical services in the community to improve health and well-being." WHO WPRO

"Social prescribing, also sometimes known as community referral, is a means of enabling health professionals to refer people to a range of local, non-clinical services." King's Fund UK

"Social prescribing is a means of improving the wellbeing of patients through the optimization of social determinants of health by connecting patients to the community." SingHealth RHS











#### Closing the Last Mile

Six Key Elements of Social **Prescribing** 

Supportive Organisation

Referral

**Trained** Workforce Personalised Plan

Screening &

Community Collaboration

Common **Outcome** 













#### From Health-Social Interaction



**Social Service Offices** 

**Social Assistance** 

Service management of **MSF-funded regional** services

Family Services @ Bedok



**Health Coaching** 

**Medication Self Management Support & Education** 

**Chronic Disease Monitoring & Self-Management Education** 

**Care Referral & Coordination** 













To Health-Social Integration

#### **Regular Case Discussions**





#### **Physical Co-located and Coordinated Team**



**SSO:** Partner volunteers, agencies and social and health services







Nursing services, home visits for Active Living



Preventive care, care coordination, joint outreach with SSO/ComLink



















### Community Ageing in Place

Integrate clinical care, social determinants of health, built environment design and technology

Provide wrap around support and layer on community-based research for seniors

#### Our Approach:

1 Identify clients

Community Partners, Agencies, SingHealth

2 Co-develop Care Plan

Care needs assessment

Social Prescribing

Drive adoption of Care Plan

Journey with clients

4 Care escalation

Supported by Healthier SG Team

5 Technology

Facilitate monitoring of clients with appropriate response











### Developing a Living Asset Map



Data Source





**Community Walk/** Community Street Audit →



Online Map →







**Individuals** 







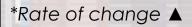




























### Social Prescribing for Mental Wellbeing Through Nature Placemaking & Placekeeping



Role of physical environment in mental well-being. Reimage common spaces to meet emerging needs



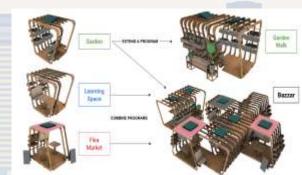
Complementing social programmes and augmenting citizen's mental well-being across demographic groups

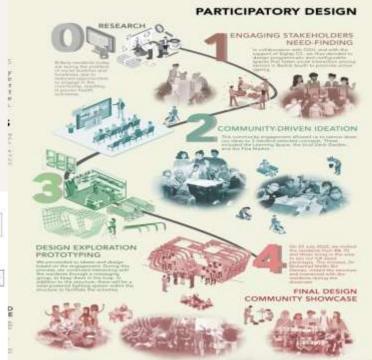




#### SUTD Capstone Project – Cosy Contours

In collaboration with CGH to design programmatic and configurable spaces that foster social interaction among seniors in Bedok South to promote active ageing

























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## THANK YOU

Patients at the heart of all we do!