ESTHER

Network for Health & Social Care

SINGAPORE

Behind a smile, there can be unspoken worries.
Let's listen to what really matters.

A Philosophy of care by SingHealth Regional Health System

With support from:

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FOREWORD

Everyone deserves to live a good life; if one gets sick, how can it disturb his or her life as little as possible. How can we contribute to a health and social care system that supports our people to be lean on worries, and rich in the motivation to live life.

The healthcare sector tends to adopt a hospital-centric view, even though it is better to manage patients early in the community, before they develop multiple health issues later on. We started ESTHER Network as it is less prescriptive, and ensures that multiple agencies partner one another in caring for the patient in a coordinated manner. While this may seem labour-intensive initially when numbers are small, efficiency will improve as the network expands, as what is already in-place for one patient may also be suitable for other patients.

We are fortunate to have ESTHER coaches from the health and community sectors working together to empower ESTHER. While doing so, the staff members around ESTHER are empowered themselves to do continuous improvement work within their microsystems. At the meso and macro levels, their leaders and sponsors support with resources and guidance to push the envelope to spread the change at the organisation level.

Sweden started ESTHER Network in the 1990s as an attempt to keep costs down. Building more hospital beds was not sustainable and they had to look for alternative ways to take care of their citizens in the community. Region Jönköping did it very well. With the tight network of support and contact points that residents receive in the community, they find no reasons to come to the hospitals.

It may be a long way for us, but it is a vision we hold. And we start by doing what is possible today, together! As a unified cluster, we strive to build care around our people, adding value to their lives not just within, but beyond the hospital walls. We have great hopes that this will be hugely impactful on the health and social care landscape in Singapore.

"It is only when we see people as an integral part of the system, and stand guided by the question "What matters most to our patients?" that we can offer the care they truly need."

Prof Ivy Ng
Group Chief Executive Officer
SingHealth

WORDS OF ENCOURAGEMENT FROM OUR LEADERS

The starting point for all our programmes and initiatives should be the person whom we are trying to help: what do they think of their care, what do they want to achieve e.g. to be independent at home, to have someone to talk to etc.

ESTHER can be a resident, patient, caregiver, or a staff member. We work through the care providers to identify these ESTHERs. We need to learn to listen more to our patients and reflect on what matters to them. The experience from Jönköping (where ESTHER Network started) was that rather than being demanding, patients were realistic in their expectations. Understanding our patients better could lead to a reduction in the need for surgery and costs.

We appreciate the commitment and dedication of the 100 ESTHER Coaches, of which more than 50 have completed their learning projects, and are graduating today. These projects use process-mapping to identify the bottlenecks in the patient journey, and contextualises the improvement to the patient's experience. Using measures like the ESTHER's Confidence Score, ESTHER Coaches understand how well ESTHER feels she is transiting to the home environment.

We envision the ESTHER Network developing into a social movement where asking what matters to our patients becomes second nature. In the meantime, let's enjoy the journey.

ESTHER Network is not a programme. It is a Philosophy of Person-Centred Care accompanied by a Process to make this a reality.

Adjunct Professor Lee Chien Earn
Deputy Group CEO (Regional Health System)
SingHealth

WORDS OF ENCOURAGEMENT FROM OUR LEADERS

The SingHealth Duke-NUS Institute for Patient Safety & Quality (IPSQ) is happy to partner ESTHER Network Singapore by providing training and facilitation support to the ESTHER Coaches.

I am pleased to note that the Coaches find the IPSQ Academic Medicine – Enhancing Performance, Improving Care (AM-EPIC) framework useful in analysing ESTHER's needs and developing impactful, sustainable solutions.

I applaud the Coaches' efforts to go beyond institutional boundaries and work together to improve person-centred care. The road to improvement is not easy but it has been well worth it, as you find in this book.

Sharing of best practices is key to any improvement journey. I encourage you to read through the projects in this book and approach the teams if you find their work useful to your department or organisation.

To the Coaches: you are the pioneers driving and leading person-centred care in your respective organisations. Heartiest congratulations on your graduation!

Prof Tan Kok Hian
Group Director & Senior Associate Dean
SingHealth Duke-NUS Institute for Patient Safety & Quality

PREFACE

This has been a long-awaited graduation of the 1st batch of ESTHER Coaches. ESTHER Network Singapore was launched in June 2016, and the Coaches started working with one another across sectors, engaging sponsors and trialling in their improvement projects that begin and end with ESTHERs. The process involved: Taking the first step and knowing how to engage ESTHERs about their ideas and experience of care, doing something about it as a team—something that creates a win-win for both recipients and providers of care, checking back with our ESTHERs, and finally, sharing the improvement for opportunities for a region wide impact.

The Coaches and sponsors owe the success of their projects to their passion to make things better for ESTHERs, and how they value-add to their existing professional roles. "It breaks the monotony of my day-to-day job, and gives me renewed energy as I know I am working for our ESTHERs!"

PREFACE

We did well in having ESTHER Coaches from both health and social sectors, as well as all levels of staff from the agency administrators, clinicians to homecare and health workers. Through the course, the Coaches had the opportunity to conduct a field trip and map the full process of ESTHERs' daily living in the community, which they normally see only a segment of. It was mind-blowing for the coaches to witness how making small improvements to frequently overlooked needs can positively impact ESTHERs care experiences and lives. An example was the feared poor turnout for the Community Health Coaching session. When ESTHERs were interviewed over coffee (at a coffee shop in Jalan Kukoh), we found that ESTHERs are positive about the idea of Health Coaching.

They would attend if (1) they could come with friends i.e. group coaching, (2) the session are fun, and (3) the session starts at 10a.m. instead of 8a.m. And the residents kept to their word! When changes were made to the programme, a good 85 per cent turned up and participated enthusiastically!
A statement made by one of the residents struck us most. He said (in Mandarin): "别象那无情的火车，匆匆的来又匆匆地走". At the end of it all, it is the genuine relationship and partnership with our ESTHERs that matter and sustain every effort we make.

In Jönköping, we were inspired at how ESTHERs participated & taught at the orientation of new healthcare workers. What we would continue doing is to find ways to involve our residents, patients and caregivers more at various stages of the improvement journey. It is often a mind-set issue that has to be overcome.

We have our amazing ESTHER Network taskforce members and ESTHER Coach Trainers to thank for their unwavering support and effort in assisting the Coaches, and keeping this work alive.

Esther Lim
ESTHER Coordinator
ESTHER Network Singapore

MESSAGE FROM OUR PARTNERS

The SingHealth Regional Health System's effort to build a new network of care was inspired by Sweden's successful ESTHER project, which approached health care from a patient-rather than provider-centred view. Here are the words from our community partners on person-centred care and care integration...

"A successful regional health system (RHS) is one in which it empowers the patients and the family members to take charge of their health, so that they, supported by community services, can live healthy and meaningful lives."

Dr Loh Yik Hin, CEO
St. Andrew's Community Hospital

"At the macro-level and patient-level [of a successful RHS], there is effective coordination and collaboration between ministries, the tertiary health institutions and the community agencies in terms of plans, allocation of resources and service delivery. [Partners should be] open-minded, principled yet respectful of each other's constraints."

Mr Chan Whee Peng, General Manager
Social Service Office @ Bukit Merah & Kreta Ayer

"RHS can support our endeavour to reach out to every sub-community, every constituency to creating awareness of end of life issues and no one with terminal illness should die without support."

Dr Tan Poh Kiang, President
HCA Hospice

"A successful regional health system is to be freely available and shall be accessible to the residents of the region with respect to every person's race, colour, creed, language and religion."

Mr Lee Kim Siang, Chairman
Thye Hua Kwan Moral Charities

"A successful RHS should be integrated and harmonise its work priorities with all stakeholders. (We hope) to partner and support initiatives that we conceptualise and implement in helping residents to age gracefully in the community."

Mr Sean Tan, Deputy Director
Regional Engagement & Integration Division
Agency for Integrated Care

A successful RHS should be integrated and harmonise its work priorities with all stakeholders. (We hope) to partner and support initiatives that we conceptualise and implement in helping residents to age gracefully in the community.

Dr Cherian Thomas, General Practitioner
Thomas Clinic & Surgery

"Hospital environments are very fast-paced and can be intimidating. Patients are sometimes afraid to ask questions about their treatment. I hope that our local "ESTHER Network" will encourage all care providers — hospitals, general practitioners, intermediate and long-term care agencies, voluntary welfare organisations — to tap on one another's expertise and pool resources together to help patients. My case workers and volunteers will benefit from the medical expertise of healthcare professionals on how best to care for patients when they are discharged.
The most successful cases I've worked on showed that trust and a common goal between all partners is important. We may be from different agencies, but we have one goal in mind — to help the individual lead a dignified life. When this goal is clear, barriers break down and we share all that we know and have, to help. We all feel responsible for the well-being for the individual, regardless of where he/she is being cared for." "We may be from different agencies, but we have one goal in mind — to help the individual lead a dignified life."

Ms Jess Ho
Centre Manager, Cluster support @ Bukit Merah
NTUC Health
ESTHER sponsor and coach

ESTHER *Insights*

What is Best for Mdm Teo?

Reproduced from Singapore Health, May-June 2017 issue

She is health care's Everyman and what she needs is the question SingHealth seeks to answer as it develops a health and social care network that will give residents and patients in the Outram area easy access to different types and levels of care.

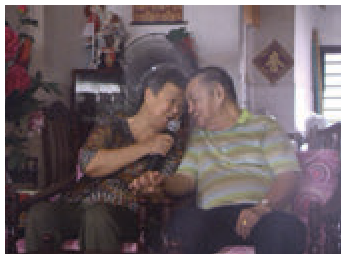
She is 72, and suffers from diabetes, high cholesterol, high blood pressure, dry eyes and gout. She is on a pacemaker and has undergone a procedure for inflammation of the bladder. She walks with the help of a cane, and can no longer dance—a once-loved pastime.

She is the sole carer for her husband, who suffers from eye conditions and diabetes. Being the more mobile of the two, she is responsible for not just their meals but also their medications and clinic appointments. She is Mdm Teo Gek Hoon and she is the focus of the SingHealth Regional Health System's (RHS) efforts to build a new network of care.

The network brings together and links medical and social care providers in the Singapore General Hospital (SGH) Campus vicinity to offer residents in the community easy access to different types and levels of care. Singapore has a rapidly ageing society, but in the southern region where SGH is located, there are more elderly residents aged 65 and above. As the numbers of elderly increase faster than the rest of the resident population, demand for health care is expected to grow at a correspondingly faster rate.

"We are pooling expertise and resources with our community partners to ensure people can be cared for adequately in the community, and eventually in the comfort of their homes," said Professor Fong Kok Yong, Deputy Group Chief Executive Officer (Regional Health and Medical), SingHealth, and Chairman, Medical Board, SGH.To remain at home and be cared for safely by doctors, nurses and other care providers in the neighbourhood should be an option for everyone, not just those with the means.

Mdm Teo typically sees different doctors in the various SingHealth Group institutions, like SGH's Diabetes and Metabolism Centre for diabetes, the National Heart Centre Singapore for her cardiac-related problems, and the Singapore National Eye Centre for dry eyes. So, she embodies the typical patient passing through the doors of SingHealth institutions.



The needs of the elderly, especially those who live alone, are unique. After they are discharged from an acute hospital for an ailment or surgery, they need to be watched over closely at home. If not, many tend to be re-admitted to hospital shortly after. They fall easily because they are still frail. Or their carer, even if a live-in, has not been sufficiently trained to spot early signs of trouble.

SGH, like many hospitals, offers a post-discharge Transitional Home Care service that monitors such frail patients closely. But the elderly tend to need a prolonged period of care, albeit not necessarily the sort of specialised care that an acute hospital provides.

Involving social care agencies and voluntary welfare organisations in eldercare is crucial, because they know the communities they serve well. Indeed, forging formal relationships between the partners to form a care network for the community ensures that “individuals do not fall through the gaps when they transit from one care setting to another”, said Ms Peh Kim Choo, Chief of Programmes, Tsao Foundation. The Foundation champions successful ageing, the idea of physical, mental and social well-being in older age. Ms Peh is also Chief Executive Officer, and Director, Hua Mei Centre for Successful Ageing.

In addition to their medical and health care needs, patients also have emotional and social needs, said Ms Esther Lim, Assistant Director, SingHealth RHS . “In a busy hospital setting, we sometimes neglect this fact. We need to take these needs into account when we involve them in their care decisions,” she added.
Neighbourhood general practitioners (GPs) are another key partner in the network. As primary care physicians in their communities, GPs are responsible for their general well-being. Unlike hospital doctors, they are able to spend more time with patients, and can gain intimate knowledge of them and care for them from the proverbial cradle to grave.

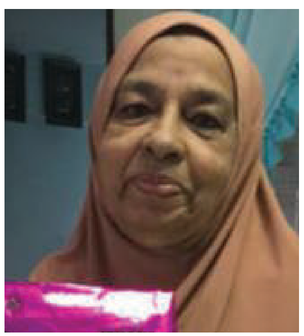
Knowing their patients well means that GPs are able to tell when something is amiss and refer them to a specialist when they suspect or diagnose something serious. So GP s are the central figure in this network linking patients and other health care providers.

As the Everyman of healthcare in Singapore, Mdm Teo’s journey embodies what elderly patients with multiple conditions go through. To watch her story, go to **www.youtube.com/embed/YG2xB0poGo0**

Person-Centred Care in the Community

Ms Zahara Mahmood, Assistant Director,
Community Care, SingHealth

Simple intervention goes a long way for Mdm Amirbee Binte Maidin



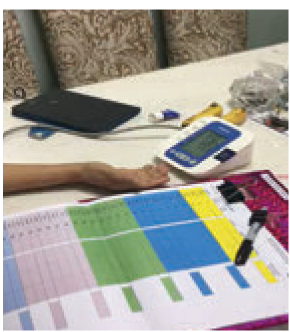
80-year-old Mdm Amirbee, was referred by the Marine Parade Polyclinic to the Neighbours programme. A widow, she stays alone in an HDB flat while her children lives abroad. Her only child who still lives in Singapore travels a lot in her job. The case manager at Marine Parade Polyclinic was concerned about Mdm Amirbee's management of her diabetes condition. Apart from diabe tes, she also suffers from hypertension, hyperlipidemia, ischemic heart disease, congestive heart failure, anaemia, and renal impairment.

When our team visited Mdm Amirbee, she was not able to check her blood glucose accurately. She complaint about her blurred vision and inability to record her blood glucose and blood pressure (BP) results in the small log book that was issued to her by Marine Parade Polyclinic. She also said that she needed help to organise her medications as she had difficulty reading off the small font labels. As a result, Mdm Amirbee had not been adhering to her required medications intake despite her many health conditions.

Our improvement project aims to empower patients to better manage the intake of their medications and monitor their vitals sign daily. Mdm Amirbee was excited when we shared with her about our project idea and she volunteered to be part of our team. Together, we identified a few issues that needed immediate attention.

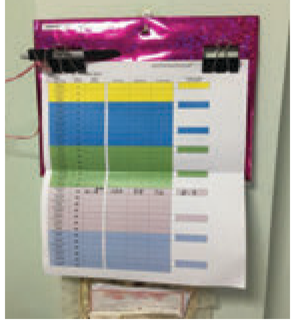
Despite the instruction that was given to her at the polyclinic, we had to ensure that the process is easy enough for her to follow. With input from Mdm Amirbee, we developed an A3-size version of the log book and added colour codes.

We also created an A3-size brochure in Malay on "Tips on Measuring Blood Glucose Level" for Mdm Amirbee to have easy reference and placed it on the living room wall in her home.



Newly improved log book

After a few months of working with Mdm Amirbee, she is now able to pack her own medications in a pillbox, take her medications regularly, and monitor her blood glucose level regularly. She shared that she has gained confidence using the personalised BP and blood glucose monitoring chart, which we've co-created. The enlarged space in the log book allows her to record her vitals signs and the translated brochure provides her with quick and easy reference when needed. She has decided to do away with the small logbook given by the Marine Parade Polyclinic and has been bringing her new charts to show her doctor for all her follow-up appointments.



Brochure and Log book placed on the wall

Furthermore, Mdm Amirbee has also expressed her interest to use "Face-time" software on the iPad to communicate with us as she is learning to use her iPad and iPhone to communicate with her daughters who are residing overseas. Mdm Amirbee definitely feels empowered and confident now to manage her medical conditions. She shares:

" I am happy that I feel more confident now in doing my own glucose monitoring at home. Through my participation in the ESTHER project, I have learnt to voice out and give feedback to the Neighbours team on things that concern me and how I want to be helped".

Mdm Amirbee with her personalised Log book

We will continue to work with Mdm Amirbee to improve other aspecst of her health and social care needs.

Empowering Mr Abdul Aziz Bin Abdullah to manage his medications

64 year-old Mr Abdul Aziz, lives alone in a rented room of a shop house. Twice married, his current family is living in Indonesia and he sees them only occasionally. Mr Abdul Aziz has been renting the room at the same shop-house for the past five years and has expressed difficulty paying for the $200 monthly rent. He currently works as a part-time hawker stall assistant to help him pay for the rental fee.

Healthwise, Mr Abdul Aziz suffers from multiple chronic illnesses such as hypertension, end stage kidney disease (ESRD) , diabetes, anaemia, gout and hyperkalaemia. He is receiving follow-up treatment at Changi General Hospital (CGH) for diabetes, and is known to Podiatry, Renal Medicine and Orthopaedic Surgery in Singapore General Hospital (SGH). Mr Abdul Aziz is also presently receiving routine subsidised haemodialysis treatment from the National Kidney Foundation Singapore (NKF).

Mr Abdul Aziz shared that he sometimes misses his medical appointments at CGH and SGH due to his work commitments and inability to pay for public transport. At the same time, he was concerned about accumulation a huge amount of unused medications at home. He asked Mr Dzulhilmy, one of our Neighbours Community Coordinator, to help him to reduce the amount of medications at home and also look at ways to reduce the cost of medications to be prescribed to him.

Mr Abdul Aziz was delighted to participate in our ESTHER improvement project, which targetted to help ESTHERs reduce accummulation of unused medications at home. Our objectives are to:

- Empower ESTHER to know the types and function of the medications that they are currently prescribed;
- Help ESTHER manage the daily intake of their medications by introducing alarm and proper medications packing and;
- Develop ESTHER's awareness about the financial impact of over-collecting and keeping of unused drugs at home

Our Intervention

Our Neighbours team embarked (with Mr Abdul Aziz) on an intensive exercise to take stock of his medications in October 2017. Together, we found that out of the 33 prescription drugs that he had, 18 (3501 tablets) had expired and had to be discarded. These medications were estimated to cost $707.00. At the end of the day, Mr Abdul Aziz had 11,882 units of drugs left (costing $5,252.00). We estimated that the actual medications that he really needs to use for his daily intake for the next three months cost $3,605.00. The remaining medications in Mr Abdul Aziz's possession were no longer required for him to consume due to his improved health conditions.

Team found out that...

Medications to be thrown away......

"I have learnt that I can resolve my medication issues by being actively involved in my care at home and also by working closely with the Neighbours Team and the pharmacists. I am happy that I chose to participate in this ESTHER project. I have learnt a lot from this experience".
Mr Abdul Aziz

Our team also liaised with a CGH MSW to schedule an appointment with the pharmacists to address Mr Abdul Aziz's medication issues. To date, the pharmacists have reconciled all his medications and are monitoring all his unused medications. The pharmacists also worked with Mr Abdul Aziz to better manage and account for his 33 prescribed medications.

Being part of this project, Mr Abdul Aziz was given the opportunity to work on his identified concerns. He has gained confidence and is able to communicate more effectively and work with his pharmacists to manage his medication at home.

Being part of an ESTHER Café, Mr Robert & Ms Jenny's Experience

Ms Tan Jie Bin,
ESTHER Network Deputy Coordinator, Medical Social Worker, SGH

Mr Robert (Far Left) and Ms Jenny (Third from the Left)

Mr Robert with Nicoline

Some say siblings are the only people that qualify as partners for life. The close-knitted relationship Ms Jenny Ng and Mr Robert Ng shares truly exemplifies that. They are each other's cheerleader, supporter, and caregiver, and one cannot help but be amazed by the amount of care and concern they show toward each other.

Mr Robert, 70, is single and suffers from multiple medical conditions. He is on long-term follow-up with various medical disciplines in SGH. Despite all that he has gone through, Mr Robert Ng comes across as a resilient individual who maintains a positive outlook in life. An unassuming lady with a pleasant smile, Ms Jenny, 65, is a retiree and is Mr Robert's main caregiver. She single-handedly navigates the care systems and sees to every aspect of Mr Robert's care.

The ESTHER Coaches attending the training conducted in May 2017 had a precious opportunity to hear from Ms Jenny and Mr Robert about their experiences with the care systems during an ESTHER café. While Ms Jenny and Mr Robert recognized the efforts and commitment of care providers, they also shared with the class about their less positive experiences with the systems as well as possible areas for improvement.

Nicoline, ESTHER Coordinator from Sweden, co-facilitating an ESTHER Café during the May 2017 ESTHER Coach Training Workshop

Ms Jenny and Mr Robert shared that receiving compassionate care was one of the things that mattered to them when they are unwell. They hoped for care providers to put themselves in the shoes of the patient, and to treat the patient like how care providers would like to be treated. They also felt that communication between the patient and care providers could be improved. Open and transparent sharing of information can promote good understanding of the patient's condition and manage the expectations and cooperation of both the patient and his family. Further, good communication between a patient and care providers can empower a patient to be more involved in his own care, leading to better care outcomes.

The ESTHER café was an invaluable time of sharing. Participates left feeling inspired by the stories of Ms Jenny and Mr Robert and were driven to improve the way care is delivered to our patients. Ending off the session, Ms Jenny affirmed the efforts of the care providers and encouraged more to be done:

> *"We give credit and recognize the work of all health and social care providers in Singapore. We have personally seen your high levels of passion and dedication. Keep up the good work and remember that there is always room for improvement."*

What ESTHER wants and hopes: Focus groups at three senior activity centres (SACs)

Ms Lim Zhi Ying,
ESTHER Network Singapore Taskforce Member,
Senior Medical Social Worker, SGH

Developing A Patient-Centred Model

As the population ages and the prevalence of chronic illnesses increases, there is a greater demand on health and social care. The changing family structure adds pressure to improve the availability and affordability of these health and social care services. Issues such as long waiting time, 'bed crunch' and increased health and social care spending are common in Singapore and other countries with ageing population.

Against this background, there are calls to re-organise our current health care delivery model from hospital- and organisation-centric to one that is more patient-centric, which is proposed to be more sustainable with our finite resources such as low manpower. This concept of patient-centric care is embraced by different regions, which faced similar issues as Singapore. The ESTHER Network in Jönkö ping, Sweden, is one of the models of care which has achieved impressive clinical outcomes such as reduced length, a decrease in hospital admission and an increase in patient satisfaction, through emphasizing on person-centred care and focusing quality improvement.

A crtical initiative of the ESTHER Network in Jönköping is the " ESTHER Cafes" held quarterly, which allow patients and professionals from both health and social care organisations to gather and discuss about aspect of the care delivery that can be improved. ESTHER Coaches, who are Quality-Improvement trained, would facilitate these intra- and inter-organisations' collaboration.

In partnership with our patients and community partners, SingHealth Regional Health System Office (RHSO) adopted the Sweden model of ESTHER Network, with the aims of improving health and social care coordination.

Discovering Patients' Wants and Hopes

Focus Group conducted at Kreta Ayer (Chin Swee) Senior Activity Centre

To kickstart this concept of patient-centric care, RHSO partnered with Department of Medical Social Services from Singapore General Hospital in 2015 to understand the needs and hopes of the elderly. Thirty participants were recruited through three senior activity centres (SACs), within SingHealth RHS vicinity. Three focus groups were conducted in these SACs. Participants were asked about their experiences on the current healthcare system, community support, and services and transition of care between different care systems.

Focus Group Conducted at Yong En Senior Activity Centre

The participants were aged 75 and above and were attendees of SACs. Most of them were independent and living alone or with their spouses only. Most of them had been living in this neighbourhood for at least 10 years. The hopes and wishes of these elderly were:

1. Being independent to continue living in the community

Participants expressed their hope to be independent because they did not want to be a burden to their families. They also expressed their desire to age-in-place because they are familiar with their environment and neighbours. This gave them peace of mind.

2. Better communication between them and the care providers

Most of the participants wished to be involved in their care affairs when they were being listened to and their opinions were sought by the care teams. Although they wished to find out more about their medical conditions, they were conscious of the number of patients waiting to see the doctor. Hence, they assumed that their medical conditions were considered stable when the care providers did not explain further. Nevertheless, participants felt encouraged in their treatment journey when the care team affirmed and assured them.

3. Greater accessibility to services

Participants were generally satisfied with current services. They used both acute (i.e. specialist outpatient clinics) and primary care services. In addition, they sought consultation or help provided by community service providers at no or nominal cost. They also avoided seeking treatment at emergency department because of the long waiting time and cost. Participants hoped that they could have better accessibility to medical treatment, especially in times of emergency.

Focus Group conducted at Kreta Ayer (Banda) Senior Activity Centre

Moving Forward

The wishes and hopes of these elderly are probably common goals amongst many of us, whether we are providers or current and future users of these services. These service users provide us, the service providers, with insights from their experience. Hence by eliciting services users' voices and involving them in our design, delivery and coordination of our health and social care, we are one step closer in meeting their goals and achieving betterment in their care journey. Let's start by asking "What do our patients or clients want"?

Acknowledgement: We would like to acknowledge and thank the management, staff and members of Kreta Ayer (Chin Swee) SAC, Kreta Ayer (Banda) SAC and Yong En Care Centre for their support and valuable contribution in this project.

Co-production as the Way of Care Moving Forward: Reflections from Health Manpower Development Plan (HMDP) Study Trip on Sweden ESTHER Network, by Dr Low Sher Guan Luke, Associate Consultant, Dept of Endocrinology, Sengkang Health (Team members: Tay Pei Yoke, Yong Lee Ling, Mah Shi Min, Jeyamany Ruth Jacob)

Presenting our HMDP learning journey to our Swedish counterparts

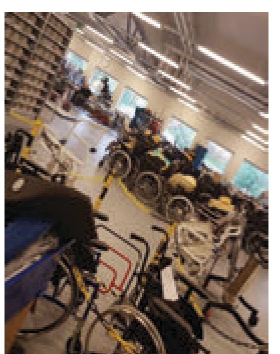
We have seen co-production in Jonkoping, Sweden! It's not just talk, they really do it well!" This is what our Sengkang Health (SKH) HMDP team that spent four fruitful weeks were spent learning about the healthcare and social care landscape of Region Jonkoping lan, Sweden.

Our team was exposed to site visits and had the opportunity to shadow different healthcare professionals to understand better how putting ESTHER first is practised. We were attached to our respective professions (doctors, nurses, social workers, physiotherapists and occupational therapists) in various units (general medicine team, mobile geriatric team, primary care, psychiatric team, self-dialysis unit, home care, municipality social care, stroke, rehabilitation wards and nursing home). These units gave us a good overview of how their patient " ESTHER " transited from admission, through various healthcare providers, all the way to discharge back in ESTHER's home. We observed Eksjo municipality, Nassjo Municipality, Jonkoping Municipality, Mobile Geriatric Team (MGT), Stroke and Rehabilitation unit and Disability Care.

Everyone there talks about "What's best for ESTHER?" Everyone is an advocate for ESTHER, doing things with ESTHER in mind and the goal is to keep ESTHER happy and healthy at home with lesser need for acute hospital and specialist care if not necessary. And ESTHER is involved in every process, project and part of the journey. Questions like 'What is important for you?', 'What can you do yourself?' and 'What do you need help with?' are often asked on top of the usual medical questions.

Even the way some forward-thinking clinicians do their ward rounds are revolutionary and person-centric. It is conducted with a team of doctors and nurses in a consultation room with display screens at 9am after the medications are served, and the nurses have finished the important part of their morning routine so that they are not distracted and can participate in the rounds. Before every patient is seen, the ward nurse presents the case to the team doctors, including the usual clinical information such as the reason for admission, changes in conditions etc., but also personal information such as his hobbies, “what is important to him” e.g. being able to eat independently, “what can he do himself” and “what does he need help with”, so that the patient is presented as a “unique person” who happens to be sick, rather than just a “patient”. The team then discusses the patient, have a rough idea on what to propose to the patient, and then the nurse goes out to the patient to invite him into the consultation room, either through ambulating there if able to do so safely, or being pushed there in a wheelchair. The patient is presented with the findings, any recent results, asked for his own understanding of the illness and what has been said so far, as well as how he thinks he should be treated, i.e. his treatment wishes and what matters to him. Thereafter, the team will discuss and co-produce with a care plan together with the patient to ensure that the patient is involved in his care journey, understands and is agreeable to the plan. This style of ward rounds allows the team and the patient more private time and space to go in depth into many issues including clinical and non-clinical ones that are meaningful to the patient, in a protected, private space that allows the patient to air his views more freely and promote a deeper discussion and greater sense of involvement in care plan production. This certainly works well in units where slow and unhurried medicine is practised, such as in community hospitals, rehabilitation and geriatric units.

The trip may be over, but our team has a lot of work ahead of us, trying to start this new way of thinking and working together to do “What’s best for our ESTHER” and in a value-based model of care in Singapore!



Wheelchair storage for patients

Dinner at a nursing home

Team photo with Prof Ong Biauw Chi, SKH Chairman Medical Board, joining in the trip

Models of Care in the Community: Observership and Learnings from MOH Strategic Nursing Development Programme (SNDP) Study Trip on Sweden ESTHER Network, by Alina Hong, Patient Navigator, Singapore General Hospital (Team leader: Mas Rizalynda Binte Mohd Razali,; Team members: Aishabi Binte Sidik, Lim Ei Shen)

Engaging in a team building activity with our trainer

My team embarked on a study trip to Sweden in Oct 2017 to learn about their high-performance health care system and also to share our experiences to foster greater collaboration for improved healthcare outcomes. Our study trip was funded partially by the MOH Strategic Nursing Development Programme (SNDP).

While staying in the city of Jönköping, we have had the opportunity to visit several primary and community care establishments along with the hospitals in three municipalities (districts) namely Eksjö Municipality, Tranås Municipality and Vetlanda Municipality. We learnt the Swedish healthcare authorities had adopted the "ESHTER Model" approach to address redundancies and gaps in their medical and community care fields. The patient according to this approach is placed at the centre of the whole process. The consensus was with patients' involvement, their views are expressed and it led to improved clinical outcomes over the years. These efforts have indicated a positive correaltion with positive care experiences for both patients and healthcare institutions. As a result, they have successfully transformed from a traditional service provider to a patient-centric healthcare organization. Another interesting snippet we learnt about patient engagement was patients had an impetus to undertake a greater role on their health, a willingness to foster a closer relationship with the service provider as well as co-design and co-produce the delivery of their care. An example is Christian Farman, a renal dialysis patient who transformed the way care was administered to him.

He simply asked the nurse, "why can't you teach me to do that myself?" which led to the complete transformation of the dialysis unit. This initiative led to a transformation on Jönköping County dialysis patient set up. It became the world's first self-dialysis unit with healthcare professional collaboration to meet Faman and other renal patient care delivery. It was inspiring to witness an open-minded organizational culture that instigate ideas leading toradical changes thereafter.

Quality improvement has an impact on healthcare professionals. The healthcare professionals undertake quality improvement projects as they believe that there is a need to make changes in the work processes. They are motivated and empowered to make changes. They involve patients in quality improvement projects to make it sustainable and compare changes created through these improvement initiatives with other districts to see the difference. More importantly, healthcare professionals continue to improve upon current projects to ensure that these projects are sustainable.

Through this study trip, our team learnt the most current and extensive knowledge, which is necessary for Patient Navigators to approach and improved the care of elderly patients with multiple chronic diseases. Future development and Quality Improvement (QI) projects will be focused on partnership between Patient Navigators and other medical professionals both in the hospital as well as in the community setting to ensure continuity of care and reduce unscheduled hospital readmissions. Through inculcation of the importance of patient centric care amongst the healthcare providers and the support rendered by the community services providers, patients will receive optimum and feasible health care within the community itself instead of in an institutionalized care.

Participating in an ESTHER Café in Sweden

ESTHER

Project Reports

Empower ESTHERs and Caregiver in Managing Medical Documents to Prevent Miscommunication

Team Leader : **Giat Yeng Khee**, Singapore General Hospital
Members : **Siew Woon Low, Haslinda Bte Barman**, and **Nur Zarifah Binte Mustapha,** Singapore General Hospital
Siti Saleha Binte Ahmad, Marine Parade Polyclinic
Joanne Anthony and **Keat Yeng Lau**, SingHealth Alice Lee Institute of Advanced Nursing
Project Sponsor : **Elena Bte Mohamed Ayob**, Singapore General Hospital

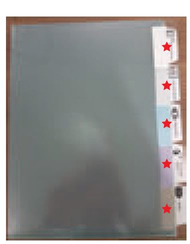
BACKGROUND AND METHODOLOGY

It is not uncommon for ESTHERs or caregivers to misplace or overlook bringing relevant medical documents, such as laboratory test form, prescription, and memo, for their routine outpatient visits. This often results in the disruption of the care journey of ESTHERs and leads to miscommunication between ESTHERs & healthcare professionals (HCPs). Through conducting several ESTHER Cafés involving 10 ESTHERs, we found that 80% of them had difficulties handling their medical documents. Empowering ESTHERs in managing medical documents using folders to help organise information was proposed and ESTHERs' feedback were gathered subsequently.

AIM

This project aims to improve communication between ESTHERs, caregivers and HCPs. As ESTHERs feel greater ownership of their folders and are able to manage their health information, they could direct intermediate and long-term care providers to refer to it and document the home and community interventions.

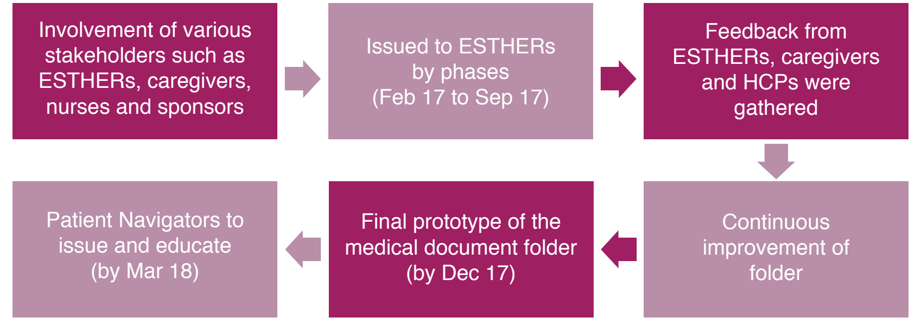
PROPOSED SOLUTIONS



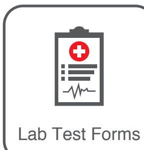
My Medical Document Folder

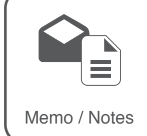
'I carry valuable information so bring me along for your appointments'

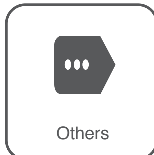
Dear healthcare professionals,
Kindly arrange the documents according to the designated compartments. Thank you.



Timeline to develop the proposed interventions (Top)
and Category of proposed folder (Bottom)







OUTCOMES

With the issuance of folder and relevant education provided, ESTHERs felt more confident to handle their medical documents, including complicated information such as those that involved instructions prior to lab investigations. All interviewed ESTHERs (N=7) brought their medical document folders during appointments and all documents were filed appropriately. One suggestion for improvement was to further reduce the size of the existing folder.

LEARNING POINTS

HCPs should implement initiatives based on what ESTHERs need and want. We should identify common goals towards person-centric approach and collaborate across various departments. Moreover, early involvement of relevant stakeholders is crucial to ensure the success of the initiative.

FUTURE PLANS

With the support of Nursing Administration, we were able to escalate and expand the scope of our project. To date, we have tested our intervention on 20 ESTHERs and our team is working to roll out this initiative to ESTHERs recruited under the Hospital-to-Home Programme.

Navigating Singapore Silver Pages

Project Leader	: **Ang Kexin,** National Neuroscience Institute
Members	: **Eleanor Chew Shuxian**, Singapore General Hospital
	Suriyati Bte Ahmad, KK Women's and Children's Hospital
	Daniel Quah, National Cancer Centre Singapore
	Lee Lai Heng, Singapore General Hospital
	Cheryl Ong, Agency for Integrated Care
Project Sponsor	: **Chern Siang Jye,** Agency for Integrated Care
	: **Au Wing Lok,** National Neuroscience Institute

BACKGROUND AND METHODOLOGY

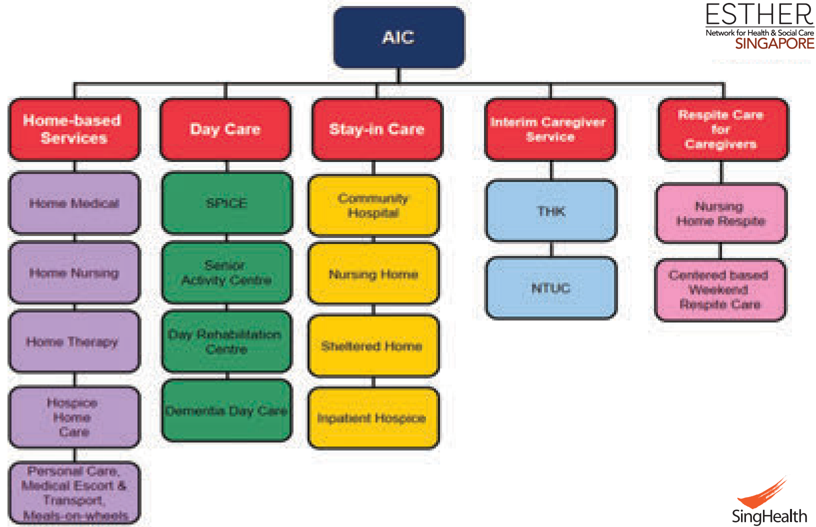
Our patient had a problem with accessing information on respite care options for his caregiver. Through an ESTHER café and discussion among ESTHER coaches, we found that patients want access to relevant available community resources. However, many front line healthcare professionals e.g. doctors, allied health and nurses do not know what resources are available for their patients or find it difficult to make use of the Singapore Silver Pages to gather information about resources because it requires a lot of clicking through and time.

We provided feedback to the AIC Singapore Silver Pages team on the problem and were taught how to navigate the AIC Singapore Silver Pages more efficiently using the "Advanced Search" function. Our ESTHERs here are the healthcare professionals. Our project aimed to shorten the time taken for the healthcare professionals to access relevant information on community resources so that they can better help their patients and caregivers.

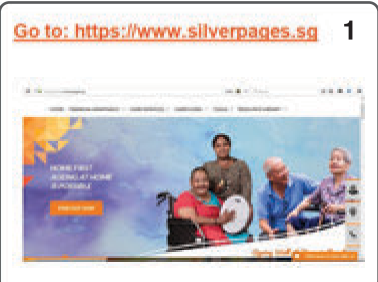
INTERVENTION

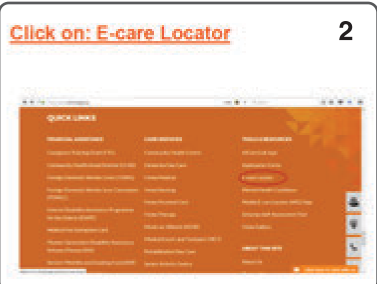
We came up with a simplified version of education guide that takes less than 10 minutes for users to read through (Table 1). It has two components: 1) Resources available via AIC are clearly categorised in a chart; 2) Demonstration on navigation using the 'Advanced Search Function'. We timed how quickly 15 healthcare professionals (5 doctors, 5 nurses and 5 physiotherapists) can access information on community resources prior to and after our intervention.

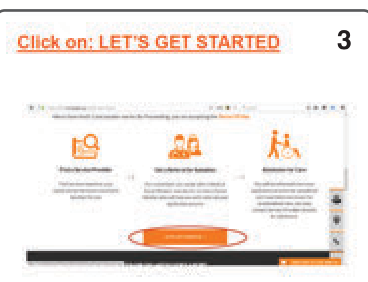
Education on what resources are available via AIC

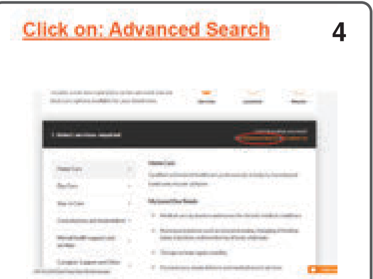


Demonstration on navigation using the "Advanced Search" function









OUTCOMES AND LEARNING POINTS

Our intervention enabled all 15 healthcare professionals involved to access relevant information on community resources within three minutes—a definite improvement from the pre-test results, which showed 10 out of 15 giving up during the pre-test ***(Table 2).***

In working with AIC, we learnt that collaboration can enhance existing processes/ products, so as not to reinvent the wheel.

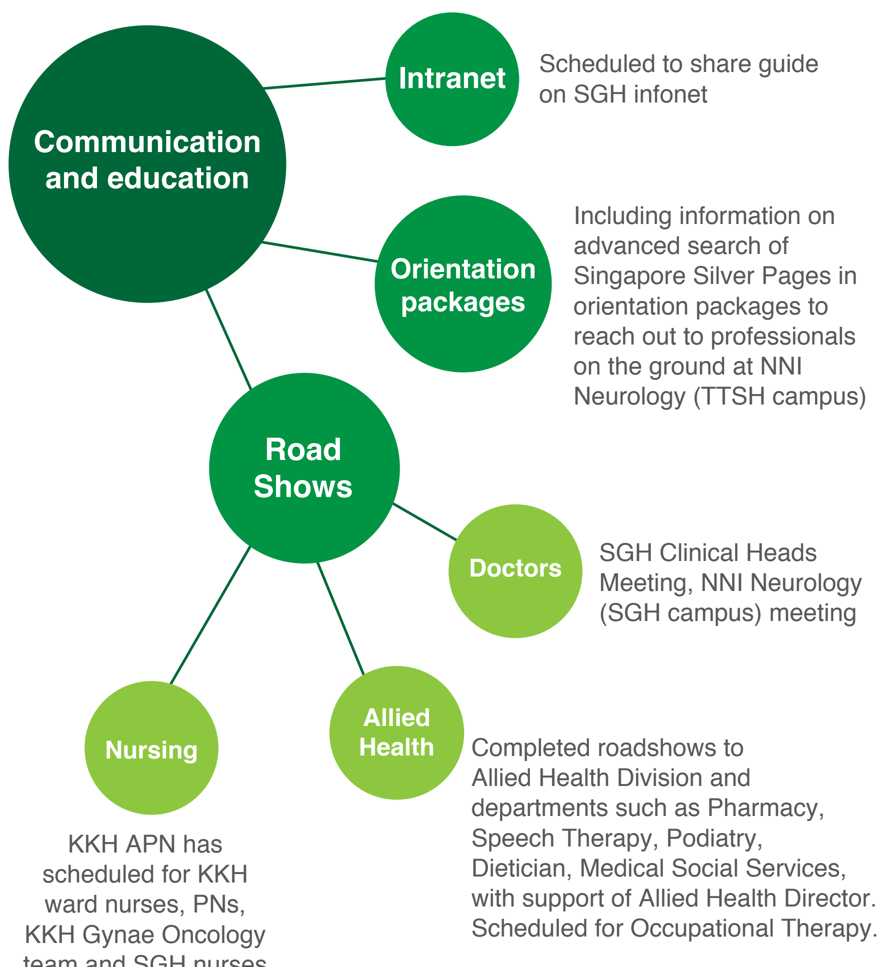
	Pre-test	Post-test
Dr1	>10 mins	2 mins
Dr2	>12 mins	1 min
Dr3	>10 mins	1 min
Dr4	>10 mins	1 min
Dr5	6 mins	1 min
Geri Nurse	>5 mins	1 min
Pall Nurse	>10 mins	2 mins
Resident Nurse	16 mins	2 mins
PN 1	>6 mins	3 mins
PN 2	>5 mins	1 min
PT1	5 mins	3 mins
PT2	>10 mins	2 mins
PT3	>10 mins	2 mins
PT4	4 mins	1 min
PT5	3 mins	2 mins

Table 2

ESCALATION PROGRESS AND FUTURE PLANS

We plan to expand the reach of our project by introducing our education guide in road shows, orientation packages, and hospital intranet ***(Figure 1).***

Figure 1



Social and Health Care Collaboration: The GreenLane Project

Project Leader	: **Lim Yong Zhang,** Social Service Office, MSF
Members	: **Florence Fong/Jasmine Chen,** Singapore General Hospital **Kenny Wong,** Social Service Office, MSF **Sentil Anathan,** Social Service Office, MSF
Project Sponsor	: **Chan Whee Peng,** Social Service Office, MSF : **Olivia Khoo,** Medical Social Services, SGH

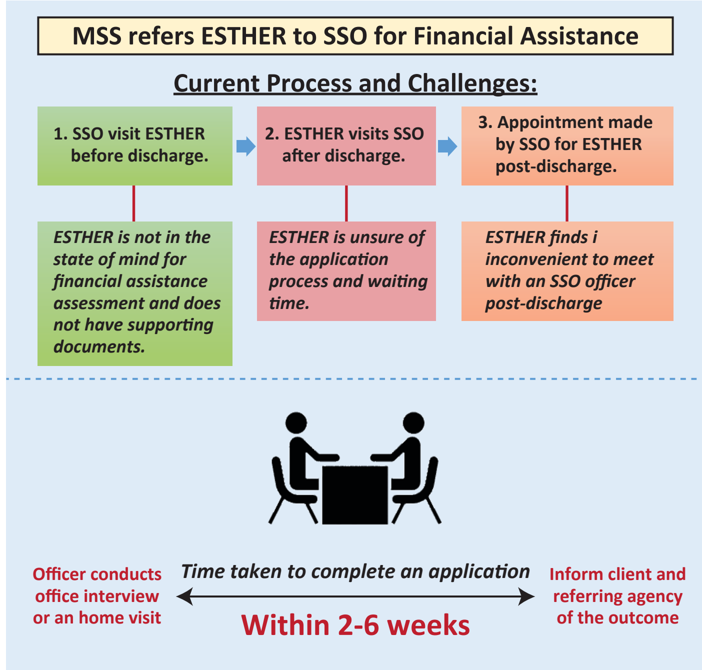
INTRODUCTION

Due to an ageing population, ESTHERs have to manage multiple chronic illnesses and live with compromised state of physical health in the community. They often experience difficulties in seeking social service assistance, especially after they are discharged from hospital. They have limited knowledge and information on the application processes for financial and social assistance in the community and are unable to differentiate between the roles of social workers from Medical Social Services (MSS) and the Social Service Office (SSO).

Our team embarked on this project to understand ESTHERs' needs, identify service gaps, and develop and pilot effective improvement strategies to improve ESTHERs' experience in applying for social and financial assistance in the community.

METHODOLOGY

We interviewed four ESTHERs regarding their application for social and healthcare services, and mapped their application experiences after they were referred by MSS to SSO.



Feedback from ESTHERs:

1. Tedious and duplicative application process
2. ESTHER needs to travel to two agencies to apply for help
3. Long waiting time at both agencies

INTERVENTION

To streamline the application process, an **Inter-Agency Referral Form** was created that consolidates the information required from ESTHER ***(Form 1)***. A **Point of Contact** was also introduced at both agencies. The **Workflow** includes early visit to patients at the hospital by SSO officer when necessary.

INTERAGENCY REFERRAL FORM

Part A: Referral Details [Compulsary]

Case Ref: (if applicable)		Name of Agency:	
Name of Officer:		Tel (DID)/Email:	
Name of Covering officer(if applicable):		Tel (DID)/Email:	
Service(s) Referred for:	Employment Assistance If Others:		
Language Spoken	Chinese If Others:		
Service(s) Rendered by Referring Agency:	Others If Others:		
Brief description for referral or specific requests:			

Part B: Applicant's Personal Particulars [where applicable,unless provided in attached supporting documents]

Name (as in NRIC):		NRIC No.:	
Gender:		Date of Birth:	
Race:		Tel (Home) / HP / Email:	
Residential Address: (as in NRIC)		Corresponding Address: (If different from NRIC)	
Status of Applicant:	Mobile If Others:		
Highest Education:	No Formal Education		
Marital Status:	Married If Others:		
Housing Type			

Part C: Household Information [where applicable,unless provided in attached supporting documents]

Gross Total Household Income: $0 Total No. Of Hosehold Members:

(II) Other Relevant information

Part D: Client's consent for referral [Compulsory]

☐ I have explained to the client the purpose of referral to the SSO and he/she has given consent to be referred

Date of Referral:

Part E: Supporting Documents

The documents listed below are relevant to the SSO's assessment of the application. Referring agencies should attach these supporting documents, where available, together with this referral. These are the documents which when received as part of the referral, would help to facilitate the assessment process. For any documents not attached, SSOs would need to request for them from the clients.

Form 1

Necessary Documents		Good to have Documents	
1. NRIC (of **all** adults in household)	☐	1. Marriage/Divorce certificate	☐
2. Birth certificate (of **all** children in household)	☐	2. Latest Employment/Termination letter (of **all** adults in household, if any)	☐
3. Latest payslip/CPF statement [Transaction History Statement and Contribution History for past 15 months] (for **all** adults in household, if any)	☐	3. Latest Service and Conservancy Charges bill	☐
4. Updated bank account passbook/statement showing all pages (of **all** adults in household)	☐	4. Latest HDB Statement/Letter stating monthly payment arrears	☐
5. Latest Medical Certificate (of **all** adults in household, if any), stating its **duration** and whether they are currently **fit/unfit for work**	☐	5. Latest Prison/DRC Visitor's Card/ letter	☐
6. Latest Power Supply bill	☐	6. Any other relevant supporting documents	☐

The interventions have helped to:

- Pre-empt MSWs to provide the information required by SSO while patients are hospitalised
- This facilitated SSO officers to be able to assess the case early, and if necessary make a visit to the hospital with the required information at hand
- Reduced delay when MSW refers to SSO with a SSO officer as a common point of contact for MSWs and vice-versa

BENEFITS

- Reduced both financial and time burden for ESTHER by reducing the need to travel between agencies to complete the application

NEXT STEPS

1. Ongoing cross-sector attachments for SSO officers and SGH MSWs to understand each other's work processes and foster stronger working relationships in case management and coordination.
2. Regular sharing sessions and joint case conferences to co-manage complex cases and share knowledge and resources.

ESCALATION

We hope that this model could be duplicated in other agencies to enable health and social service providers to provide relevant and timely help to ESTHER.

To Enable ESTHER to go Outdoors in Rain or Shine

Project Leader : **Chan Vivian, Koh Sock Sim, Yang Jojo**
Amanda Tan, Singapore General Hospital
Chee Ching Yee, SingHealth Polyclinic
Prof Tan Lam Wing, Ngee Ann Polyclinic

Project Sponsor : **Prof Celia Tan,** Group Allied Health, SingHealth

BACKGROUND

In the last decade, Singapore has seen vast improvement made to help people with disabilities integrate into the community. According to the SPD, these changes1 include improvements to building access such as ensuring more toilets for people with disabilities, designating more tables at food centres for people with disabilities, installation of lifts and tactile tiles at train stations, provision of more wheel-chair-friendly buses and amenities as well as formulating of the Enabling Master Plan to enhance the inclusion of people with disabilities. However, ESTHER still face barriers and challenges when they are out and about. The aim of our project is to enable persons who are wheelchair-dependent (ESTHER) to go outdoor in rain or shine.

METHODOLOGY

We conducted an ESTHER Café with six participants and gathered insights on what really matters to them. Refer to ***Diagram 1***. Thereafter, we asked ESTHER to priori-tise what matters most and brainstormed on ways to address the identified problem. Through this exercise, we decided to explore on ways to allow ESTHERs and their caregivers to travel around on rainy days.

Diagram 1

ANALYSIS

We adopted the Three-Step Design Thinking process to further understand what matters to ESTHER. Refer to ***Diagram 2.***

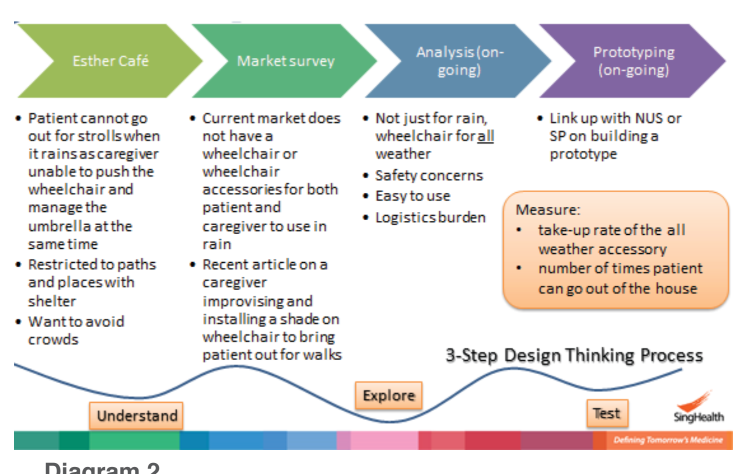


Diagram 2

INTERVENTION

We collaborated with students from Ngee Ann Polytechnic (NP) to work on the prototype of an all-weather wheelchair. We had several brainstorming sessions with the NP students, and our ideas and NP students' solution were presented twice at the SingHealth Group Allied Health-Ngee Ann Polytechnic Partnership Prototype Review. We received positive feedback from the panel and will work on further refinement of our original design. Concurrently, we met up with a caregiver who has modified his wife's wheelchair, to learn from his wheelchair modification experiences.

NEXT STEPS

We will continue to work with SingHealth Group Allied Health, NP lecturers and ESTHER to refine and improve our design. NP has also engaged an external vendor to develop the second prototype for the wheelchair.

Society for Physically Disabled Website:
http://www.spd.org.sg/updates/detail/barriers-to-integrating-people-with-disabilities-in-mainstream-society-72.html

Empowering ESTHER with Her Medication – A learning Journey

Team Leader : **Jan Koh,** National Heart Centre Singapore (NHCS)
Team Members : **Siti Fidawati Bte Jasman, Doris Lim Yanshan Yong Huey Shyan, Huang Tingting,** National Heart Centre Singapore (NHCS)

Sponsors : **David Sim Kheng Leng, Genevieve Wong Cheng Sim,** National Heart Centre Singapore (NHCS)

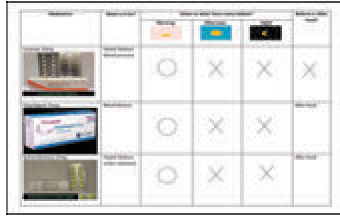
BACKGROUND

Elderly with multiple chronic diseases are living longer with advancement in medical technology and care. This has resulted in them having to cope with polypharmacy. Despite healthcare institutions' efforts in medication education, elderly at home continue to face difficulty taking correct medication at the correct dosage and frequency. This may be due to their (1) inability to retain information provided by pharmacists, (2) difficulty in reconciling newly prescribed medications with existing ones at home, and (3) inability to find others for consult when faced with medication challenges. This project hence aims to gain an in-depth understanding of the experience of community-dwelling elderly (ESTHER) with chronic cardiac conditions, in particular, their management of their medication regime.

METHODOLOGY

ESTHERs on the Ministry of Health (MOH) "frequent admission" list were approached when they were admitted during the project recruitment phase. Consent was sought to allow team to conduct post-discharge home visits. Qualitative data collection via journey mapping, observations and interviews with ESTHER and their caregivers were conducted, when available. Quantitative data was captured via ESTHER's medication chart. Four ESTHER who were above 55-years-old with history of frequent admissions were recruited.

Assessing ESTHER's understanding of his medication

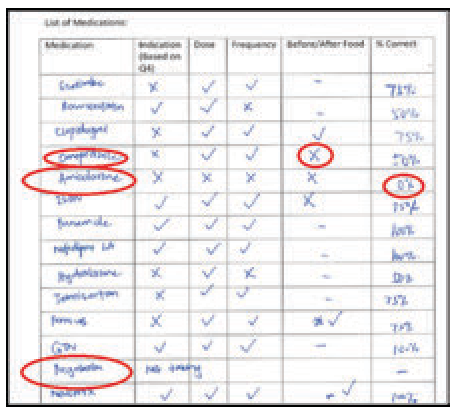


Pictorial chart used to educate ESTHER about their medication

DISCUSSION

Interestingly, one of our participants who rated himself to have good grasp of his medications, made significant medication errors in a test ***(Table 1).*** On the other hand, journey mapping and home visits provided alternate insights into ESTHER's lives in the community. We learned that ESTHER may be able to secure and harness natural support from within the community.

- ESTHER A, for instance, lived alone and spoke only his mother-tongue. However, he could depend on a neighborhood shopkeeper to help with his medication. His neighborhood coffeeshop assistant also knows to prepare his coffee according to his dietary requirement whenever he visits the coffeeshop.



List of Medications:

Medication	Indication (Based on Q4)	Dose	Frequency	Before/After Food	% Correct
[illegible]	✗	✓	✓	–	75%
[illegible]	✓	✓	✗	–	50%
[illegible]	✗	✓	✓	✓	75%
[illegible]	✗	✓	✓	✗	50%
[illegible]	✗	✗	✗	✗	0%
[illegible]	✓	✓	✓	✗	75%
[illegible]	✓	✓	✓	–	100%
[illegible]	✓	✓	✓	–	100%
[illegible]	✗	✓	✗	–	[illegible]
[illegible]	✗	✓	✓	–	75%
[illegible]	✗	✓	✓	✓	75%
GTN	✓	✓	✓	–	100%
[illegible]	[illegible]				–
[illegible]	✓	✓	✓	✓	100%

Table 1: Participant made errors such as taking a wrong dose or skipping medication altogether.

Through this project, we were able to enrol suitable ESTHER to the SingHealth Hospital to Home (H2H) programme for Community Patient Navigators (PNs) for follow up services. The H2H programme enables healthcare team to observe ESTHER in their own environment and co-create care interventions with them. For instance, some ESTHERs do not like to use pill boxes. They may develop mechanism of their own over the years and PNs can help to enhance these mechanisms instead of changing them.

This project also created opportunities to collaborate with partners such as Montfort Care@27 Family Service Centre, and NUS Pharmacy Department. We believe that ccollaborating with community organisations is a sustainable approach in improvement work.

LEARNING POINTS

- There is a need for a paradigm shift to understand ESTHERs and the challenges that they face in the community.
- Commonly cited risk factors may not be indicative of treatment adherence for elderly living in the community.
- There is no one-size-fit all strategy to empower and support ESTHERs in the community.
- There is a need to engage and train community service providers as partners to increase their level of confidence to support ESTHERs with medication-related interventions in the community.

FUTURE PLANS

We hope to strengthen efforts to collaborate with community partners to support ESTHERs in the community. Acute hospital could offer training to develop the capability and confidence of community care providers to provide health-related support services to ESTHER in the community.

Increase ESTHER's / Caregiver's Confidence in Taking Public Transport with Wheelchair Bound ESTHER

Project Leader : **Lely Gunawan,** Sengkang Health

Members : **Michelle Tan-Ng,** SingHealth Polyclinics
Eunice Chua, Ng Shi Ying,
Singapore General Hospital
Alicia Tan,Tay Pei Yoke Sengkang Health
Wang Yu Hsuan, Tsao Foundation

Project Sponsor : **Leila Nasron,** Singapore General Hospital

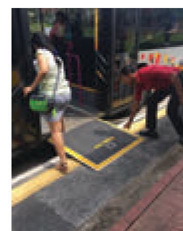
BACKGROUND

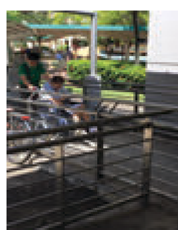
- During our ESTHER journey mapping, we found out that ESTHERs who become wheelchair bound limited their commute and activities, with some remaining homebound.
- There are several pertinent factors that affect the confidence of wheelchair bound ESTHER and/or their caregiver when taking public transport. The project looked at the accessibility, user-friendliness and limitations of the current public transport system (train, bus, taxi) for the wheelchair bound ESTHER, and proposed appropriate interventions.
- Helping wheelchair bound ESTHERs and caregivers feel safer and more confident when using the public transport resulted in independence, greater mobility, social inclusion and financial savings from making special transport arrangements.

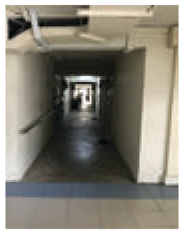
PROBLEMS IDENTIFIED

- Four ESTHERs (who are wheelchair bound and had just been discharged from hospital) and their caregivers were interviewed in their homes. The table indicates the limiting factors that deter them from taking public transport .

Limiting Factors	Case 1	Case 2	Case 3	Case 4
Physical Environment (slopes, kerbs)	✓	✓	N/A	✓
Perceptions of Safety of Public Transport	N/A	✓	N/A	N/A
Confidence Level	N/A	✓	✓	✓
Bad Experiences with Public Transport	N/A	✓	N/A	N/A
Lack of Awareness of Wheelchair – Friendly Facilities	N/A	✓	N/A	N/A
Skills and Capabilities of Caregivers	N/A	N/A	✓	✓







PROPOSED SOLUTIONS

- The most pertinent issue identified was the ***Confidence Level*** of ESTHERs and/or their caregivers.
- The proposed solution was to conduct a training cum outing with ESTHERs and their caregivers together with the ESTHER Coaches (who are Occupational Therapists). During the outing, caregivers were taught hands-on skills in overcoming environmental barriers and in accessing public transport. Techniques of navigating the wheelchair were demonstrated and practised to increase the confidence level of the caregiver in taking public transport with the wheelchair bound ESTHERs.

OUTCOMES

- A follow up phone call was made to ESTHERs and/or their caregivers a few days following the training cum outing. Increased confidence in bringing ESTHER out on public transport and increased frequencies were reported. They were imperative to increasing ESTHER's social mobility and social space.
- ESTHER and/or their caregivers expressed satisfaction in integrating back into community. One lady who had not been to Chinatown for the last one year after she became wheelchair bound was happy to be able to shop for Chinese New Year goodies again.

FUTURE PLANS

- To extend mobility training of ESTHERs beyond the wards and ESTHERs' homes to helping ESTHERs navigate the home surrounding and taking public transport to continue their activities and routine. To explore trialling this at SingHealth Community Hospitals.
- To ensure ESTHERs receive continual support from the community partners, hospital Occupational Therapists could train community partners by embarking on a Community Capacity-Building Programme (via Train – the-Trainer).

To reduce ESTHER's outpatient visits to Centre Digestive Liver Disease (CDLD) with early provision of education on stoma during hospitalization

Project Leader : **Mas Rizalynda Binte Mohd Razali**

Members : **Rose Bte Borhan, Wong Kwai Meng**
Kalsom Bte Saptu, Manisah Bte Somadi
Singapore General Hospital

Project Sponsor : **Ong Choo Eng,** Senior Nurse Clinician,
Singapore General Hospital

BACKGROUND

Every week, 3 to 5 ESTHERs with newly created stoma come to Stoma Clinic of Centre for Digestive and Liver Diseases (CDLD) to change their stoma's wafer. Depending on the types of stoma bag they use, ESTHERs will come 1-2 times per week to change their stoma wafer.

What matters to ESTHER?

1. They lack confidence to change their stoma bags by themselves.
2. They experienced leakage a few times at home and were fearful of repeated leakage.
3. They want to save cost as wafer changed by specialty nurse can last longer.
4. Caregivers are not confident to change by themselves.
5. ESTHERs/ caregivers feel more secure and comfortable with the presence of the specialty nurse.
6. ESTHERs with visual impairment are unable to change their stoma bags by themselves.
7. ESTHERs may be unable to cut or paste the wafer by themselves if they have issues with dexterity.

Analysis: Understanding the problem

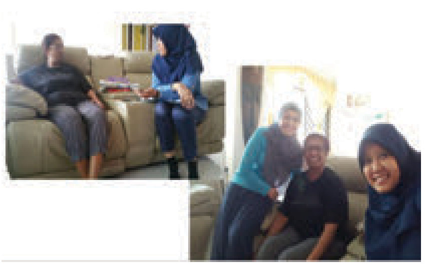
- **Current practice :**
  - **Start teaching on 5th post-operative day (POD)**
  - **Return demonstration on day of discharge -/+ 7 POD**

Newly created stoma patient's who are willing to learn	Newly created stoma patient's who are unwilling to learn
Start teaching on 5th POD	Start teaching on 5th POD
Return demonstration on day of discharge -/+ 7 POD	Patient not keen for participate with return demonstration
Return to clinic only when problems encountered	Return to clinic with scheduled appointment for change of stoma

- **Gathering information from Enterostoma Nurse regarding patients who come frequently to her clinic to change stoma bag**

ESTHER Café Home Visit : ESTHER with Stoma

ESTHER Café Home Visit : ESTHER with Stoma



Project Objectives

- To reduce outpatient revisits to CDLD for ESTHERs with stoma by 50% in 6 months' time
- Ensure the continuity of care from hospital to the community
- Instill confidence in promoting self care, thus improving ESTHER's quality of life
- Personalized care empowers ESTHER to be independent and more involved in their care
- Reducing visits to department of Emergency Medicine, CDLD clinic, and readmissions to hospital and thus, keeping ESTHER in the community as long as possible with community resources and support

Intervention

- Education to be given with model to ESTHER on day of admission
- Reinforcement of education with hands-on to be done on 5th POD & 7th POD
- Patient Navigator (PN) to conduct 1st phone call within 24 to 48 hours to check on ESTHER's coping
- Advice given to ESTHER to call if help is needed for any issues
- 1st home visit to be on the day of stoma base change
- Weekly home visits up to one month

Results

- With the interventions, we were able to reduce the need for ESTHERs to travel to CDLD Stoma clinic
- ESTHER made one visit to CDLD clinic 2 weeks after he was discharged. Visit was due to complication of stoma and not due to lack of confidence or incapability of coping.
- With provision of personalized care and PN as point of contact, ESTHERs have enhanced confidence and are empowered for self care

Recommendation

- PN as point of contact for advice and expedited interventions
- Early linkage to Specialty Nurse and thus, early treatment
- To allow video recording during changing of stoma bag and base
- ESTHER's caregiver changes stoma bag and base frequently to achieve competency and build up caregiver's confidence

Learning Points

- Early education, early intervention, and personalized care will benefit ESTHERs with colostomy by reducing their readmissions and need to travel to CDLD clinic for stoma change
- PNs need to be well equipped with specialized skills by having attachments with enterostomy nurse to enhance skills in stoma care and management
- Video recording of ward based teaching on stoma care by specialty nurse benefits both ESTHER and caregiver

To Improve ESTHER's Care Experience When They are Referred to Emergency Department by the Satellite Haemodialysis Centres

Project Leader : **Job Loei,** National Kidney Foundation Singapore
Members : **Lim Shu Jing,** National Kidney Foundation Singapore
Sherwin Soriaga, National Kidney Foundation Singapore
Grace Poon, SingHealth

Project Sponsor : **Chua Wei Bin,** National Kidney Foundation Singapore

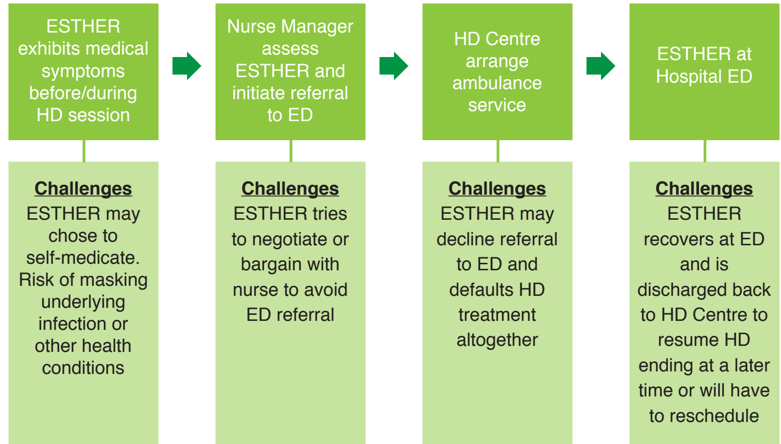
BACKGROUND

The National Kidney Foundation Singapore (NKF) is a non-profit health organisation in Singapore. Its mission is to render quality renal services to ESTHER (patients diagnosed with renal failure), promote renal research, and increase kidney disease awareness through public education initiatives. To ensure patient safety and uphold service quality, policies and procedures have been put in place at all NKF Satellite Haemodialysis (HD) Centres.

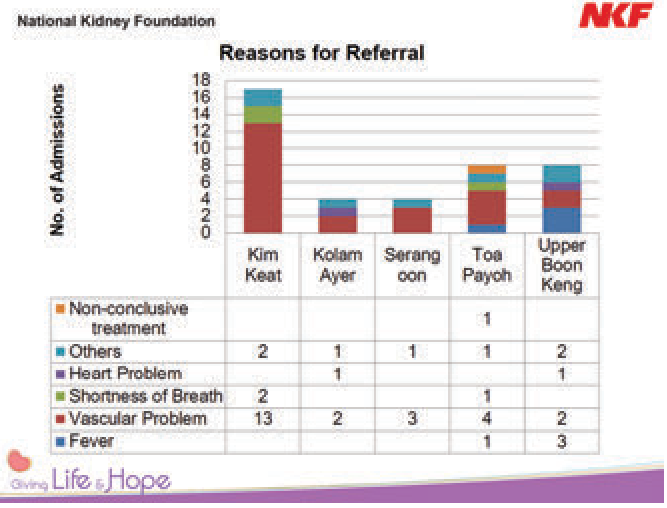
Based on NKF policy, ESTHER must be referred to a hospital emergency department (ED) when they present symptoms indicative of medical complications before/during routine HD sessions. To ESTHER, referral to ED is often an anxiety-provoking and frustrating experience as they will incur additional costs and long waiting time to see a doctor. Furthermore, it also disrupts the ESTHER's regular HD treatment schedule. This project aims to understand ESTHER's care needs and identify possible solutions to improve their care experience when they need to be referred to ED.

METHODOLOGY

To understand what matters to ESTHER, we organised an ESTHER Café and invited six ESTHERs and a HD nurse. A simple Process Map ***(Figure 1)*** of ESTHER's experience and potential challenges was created based on the café .



To understand the scale and impact of the problem, retrospective data was collected from five NKF HD Centres over one-week in April 2016. (Refer to *Table 1*)



	Kim Keat	Kolam Ayer	Serangoon	Toa Payoh	Upper Boon Keng
Non-conclusive treatment				1	
Others	2	1	1	1	2
Heart Problem		1			1
Shortness of Breath	2			1	
Vascular Problem	13	2	3	4	2
Fever				1	3

Table 1

DISCUSSION

Based on the ESTHER Café, our team identified the common reasons for referral to ED and ESTHER's concerns. We also realized that ESTHERs were unaware of the implications when they self-medicated to avoid being referred to the ED. Furthermore, ESTHERs are often resistant toward ED referral due to the following reasons:

1. Cost of transport i.e. ambulance or taxi services
2. Public ambulance services DO NOT allow choice of hospital
   - ESTHER prefer to be transferred to their known hospital
   - ESTHER have difficulty articulating their medical history
3. Cost of each ED visit ranges from $120 and above
4. Long waiting time at ED

Reasons for ED Referral

- Fever and/or diarrhea
- Fluid overload
- Shortness of breath
- Irregular blood pressure
- Irregular heart rate
- Vascular problems
- Falling at home/HD center
- Blisters

ESTHER Café (Left) and Reasons for Referral (Top Right)

Based on the retrospective data collected, there were a total of **35** referrals made to ED over a week. One of the common reasons for referral was vascular problems. We propose to examine the presenting problem through Three Phases:

PHASE 1 : To engage NKF medical and nursing staff to review its clinical protocols and guidelines for ED referral

PHASE 2 : To address ESTHER's concerns regarding transport arrangement to ED

PHASE 3 : To enhance ESTHER's care experience at ED

We also hope to streamline work processes by:

1) exploring alternative referral options for ESTHER e.g. to the general practitioners or polyclinics
2) developing education material/resources to help ESTHER understand the need for ED referral
3) engaging both the public and private ambulance providers
4) exploring option of renal dialysis pathway at ED

NEXT STEP

This improvement project endeavours to improve ESTHER's care experience, right-site ESTHER's care to appropriate providers such as primary care, and minimize financial burden of ED referrals. We also hope to improve job satisfaction of HD nurses and enhance inter-agency collaboration. Moving forward, we need to engage potential stakeholders to support the project. They are NKF medical director and nursing division, public and private ambulance services, GPs and polyclinics and SGH ED department.

What's Best for ESTHER at Diabetes Metabolism Centre (DMC)?

Project Leader : **Yeo Shuan Khiag,** Manager, SOC
Members : **Dr Ibrahim Muhammad Hanif,** Associate Consultant, DIM
Irene Tan Cheng Gaik, Nurse Clinician, Patient Navigator, OIC
Stephen Wong Kah Wai, Senior Operations Executive, SOC

Project Sponsor : **Dr Goh Su-Yen,** Senior Consultant, Head, Dept of Endocrinology

BACKGROUND & METHODOLOGY

Our team was formed with the intention of looking at the issues encountered by "ESTHERs" (patients) with multiple specialist outpatient appointments, in particular, to the Diabetes and Metabolism Centre (DMC). DMC started operations in May 2015. As at September 2017, the centre has seen more than 53,000 unique "ESTHERs" under the 4 main specialties of Endocrinology, Department of Internal Medicine (DIM), Renal Medicine and Vascular Surgery (VAS). A total of 12% or 6000 of these patients see at least two specialists in DMC with regular visits throughout the year. Three patients were interviewed with the use of a questionnaire to identify the problems they may have with these multiple visits.

Questionnaire for "ESTHER" on keeping TCUs

1. On average how many appointments do you have in a month? Tick the appropriate answer:
   ____1 ____2 ____3 ____4 or more

2. Do you have any difficulties keeping them?
   a) No difficulty b) Slight difficulty c) Neutral d) Moderate difficulty e) Extremely difficult

3. List down some of the difficulties you encountered: ______________________________

4. Do you know the specific condition that you are being followed up by the specific Specialist clinic Dr.?
   Tick the appropriate answer: ____Yes ____No

5. List the Specific Specialist Clinic Visit and State the specific condition for doctor's follow up:

List the Specific Specialist Clinic:	State the specific condition for follow up:

6. List the 3 most important areas that you would like to see improvement in the appointment system?
   1. ______________________________ 3. ______________________________
   2. ______________________________

7. What do you remember from the advice given to you during this doctor's visit :
   ____

Summary of Interview:

- Between 65 and 75 years old
- All three ESTHERs need to use walking aids
- Two were on wheelchairs during the interview
- Accompanied by children
- With multiple co-morbidities
- Between two to four outpatient consult visits every month
- One patient said he had to change his appointments when his children could not take leave
- Long wait time to see the doctor at every visit

Main issues:

- There are multiple specialties in DMC:
  - Internal Medicine (DIM) - Renal Medicine - Endocrinology - Vascular Surgery (VAS)
  - Others including Rehabilitation Medicine, Geriatric Medicine and Family Medicine
- Although these disciplines are housed within the same building, patients may have to see each specialist on different appointment dates. It is challenging to synchronise these dates due to various factors
- Should there be a need to refer the patient to another department within DMC, appointment may still be given on a different date
- Should there be an urgent medical issue during ESTHERs routine appointment, the patient will be referred directly to the Department of Emergency Medicine (DEM) rather than to the relevant specialty clinics within DMC.

PROPOSED INTERVENTION

Collaboration among various departments within DMC e.g. VAS and DIM.

- Doctor tele-consult – doctors call each other to discuss cases and refer patient when needed. **Patient can be managed by a single doctor which reduces the overall number of outpatient visits; it also helps to optimize doctor's resource by cutting down unnecessary referrals**
- Multidisciplinary fast track system – for patients requiring urgent attention, to refer on the same day after tele-consult. **This will ensure prompt attention is given to ESTHER and multiple visits may be eliminated.**
- To pilot with DIM and VAS – the plan is to select new patients with few specialty appointments so as not to disrupt any balance or current follow-ups. Proposed collaboration as follows:

Internal Medicine (DIM)	Vascular Surgery (VAS)
a. Provide consults for VAS patients with multiple co-morbidities: • this will save VAS from referring patients to multiple specialities (e.g. Renal, Endo, CVM) • it will also serve Esther as she will have fewer appointments and potentially receive faster medical consults b. If there is some urgent medical issue during a VAS clinic session, DIM can be called for consultation (e.g. tele-consult for high BP or high sugar) and this may save the patient from being referred to DEM c. DIM can also be tele-consulted to manage patients who are planned for elective surgery and are assessed to be optimum	a. VAS will provide teaching to DIM doctors so that the department can better manage patients with vascular issues and consequently help prevent unnecessary referrals to VAS b. VAS can review and allow a few appointed DIM consultants to order certain tests which are currently restricted (e.g. AO scan, toe pressure). This will save the patient a referral to VAS for tests only, the results of which can only be reviewed at another follow up appointment c. Provide same day consults to DIM patients with urgent vascular issues such as non-healing vascular leg ulcers so that patientreceives prompt medical attention

DIM plans to come up with a roster where there will be a consultant every day (Mon-Fri) on standby to receive any calls on medical issues from the vascular surgeons. However, the proposed solution has not been implemented due to the restructuring of RHS with the merging of Singhealth with EHA.

LEARNING POINTS

- The doctor plays a very important role in the team to facilitate communication and coordination between the different departments within DMC. His active participation are vital to the success of this project
- It is crucial to have sponsors' buy in to pilot the proposed solution

PROPOSED MEASUREMENT METHOD

- Comparison of ESTHER's journey pre- and post-intervention in terms of total number of outpatient visits and the overall waiting time to appointment for new referrals.

Improving Communication Amongst Community Care Providers, ESTHERs and their Caregivers

Project Leader : **Dr Tan Shu Yun,** SGH, Family Medicine & Continuing Care
Members : **Dr Tay Wei Yi,** SGH, Family Medicine & Continuing Care
APN Rachel Towle, SGH, Division of Nursing
ANC Siti Hajar Binte Ninhadi, SGH, Division of Nursing
Ms Helen Hyena Alburque'V, Community Nurse
Project Sponsor : **A/Prof Lee Kheng Hock,** Office of Integrated Care, Singapore General Hospital

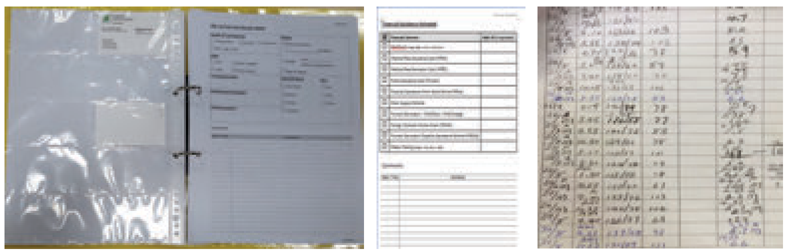
BACKGROUND

ESTHERs in the community are generally cared for by multiple care providers. ESTHERs have reported being confused and burdened by the duplication of services and monitoring by different agencies. Further, communication between various care providers may sometimes be absent due to the lack of a converging point for communication.

Our team comprises members from Family Medicine and Continuing Care, Singapore General Hospital (SGH-FMCC), as well as members from Care Close to Home, Agency of Integrated Care (AIC-C2H). Both agencies are collaborating to provide care for vulnerable ESTHERs living in Chin Swee area, presenting an opportunity for this project. In this project, we set out to pilot a communication log book for use between two community care providers to improve communication in care-giving tasks. We aim to improve communication amongst community care providers, ESTHERs, and their caregivers.

METHODOLOGY

The team completed a needs assessment by conducting various site visits to understand how different care providers operate. We also conducted two home visits to understand the concerns of ESTHERs and gather feedback from them on their needs and formulate. Thereafter, team members had multiple rounds of discussion to design a communication booklet for use by multiple stakeholders.



Prototype of the communication booklet and forms used to improve communication between ESTHER, their caregiver and care providers

PROPOSED SOLUTION & FINDINGS

The team came up with a written communication booklet for tasks done to be logged in with succinct information. Other information includes contact details of various care providers, vital signs of ESTHERs, and active medication lists. The prototype was piloted for 20 patients with mixed responses. ***Table 1*** shows some anecdotal reactions of ESTHERs who participated in the pilot:

Positive Reactions	Negative Reactions
“Now I can understand my uncle’s health status better.”	“We find it hard to maintain of the logbook in the long term.”
“Now we know when the last vital signs were taken by other agencies”	“There is too many items to record”

Table 1

LEARNING POINTS

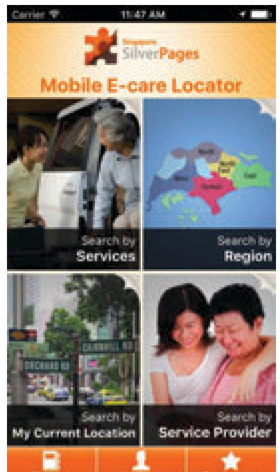
Through this pilot project, we learned that:

- Hardcopy communication material is inadequate to keep up with the dynamic changing needs of ESTHERs and their caregivers. Electronic record and communication may be more suitable.
- Buy-in from all stakeholders, including ESTHERs and their primary caregivers is important to pilot new interventions such as a communication booklet.
- The communication booklets may also be unsuitable for users with low literacy.

FUTURE PLANS

During this same period, we found an existing mobile application called "eCareApp" had been developed to improve communication between care providers. We would like to engage the application developer to trial the effectiveness of the app for the intended purpose. We hope to share our improvement project and learning points with the developer and explore opportunities to collaborate and improve on the function of the existing mobile application in the near future.

We also hope to create a common platform such as joint face-to-face conferences or teleconferences that will allow care providers and stakeholders to share information and co-develop effective care plans for ESTHER.



To Increase Confidence Level of "ESTHER" During Transition From Hospital To Home

Project Leader	: **Zunaitha Begum, Seng Gek Siang and Xu Yi,** Office of Integrated Care
Members	: **Audrey Leo Kah Loon,** Bukit Merah NTUC Health **Magdalene Ng Kim Choo,** Nursing Division Singapore General Hospital
Project Sponsor	: **Dr Tracy Carol Ayre,** Group Chief Nurse, SingHealth **Jess Ho,** Centre Manager, NTUC Health

BACKGROUND AND METHODOLOGY

Madam Tan, "ESTHER", is a single 75-year-old Chinese lady. She had visited Department of Emergency Medicine (DEM) 11 times and was admitted eight times over five months due to suboptimal management of her chronic diseases and psycho-social issues. She lives with an elderly flat-mate in a rental flat. We interviewed her in the ward and identified her concerns regarding the lack of confidence in independent living, confusion with the multiple care providers, and being unclear about who to approach should she need help. Madam Tan wanted to be in reasonably good health and preferred to return to her home and community instead of staying in a senior group home. She also desired to be able to cope with her own care at home. Through our interview, we identified the following problems:

1. There was no immediate handshake between acute care and community care partners upon discharge

2. There was a lack of contact point in the different settings

3. Transition of ESTHER's hospital admission and discharge care were disjointed

As a result of aforementioned problems, issues such as medications error and misplacement of medical documents arose. The aim of the project is to (1)increase confidence level of ESTHER, (2) keep ESTHER in the community as long as possible, (3) facilitate early handover to community service provider, and (4) avoid unnecessary visit to DEM.

PROPOSED SOLUTIONS

Our proposed interventions in response to the identified problems are highlighted in ***Figure 1*** and ***Figure 2.***

A questionnaire was developed and administered to assess ESTHER's confidence level in self care, perception of Quality of Life, and self-perceived ability to live independently in the community. The questionnaire was conducted pre-intervention, at two months post-intervention, and four months post-intervention, to track ESTHER's progress over time.

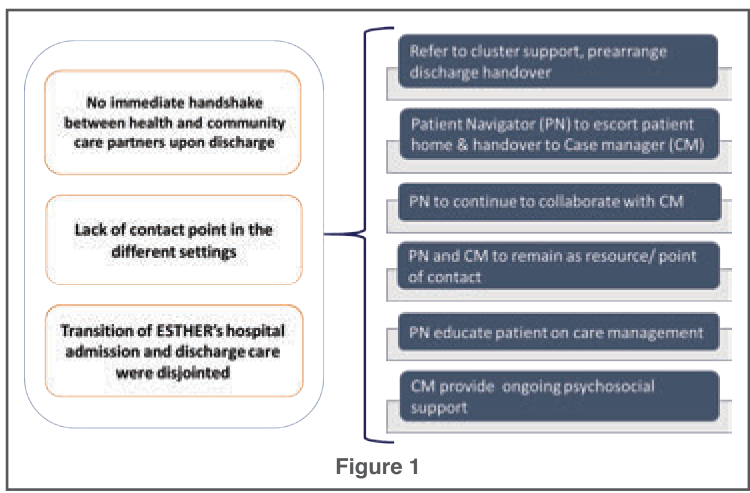


Figure 1

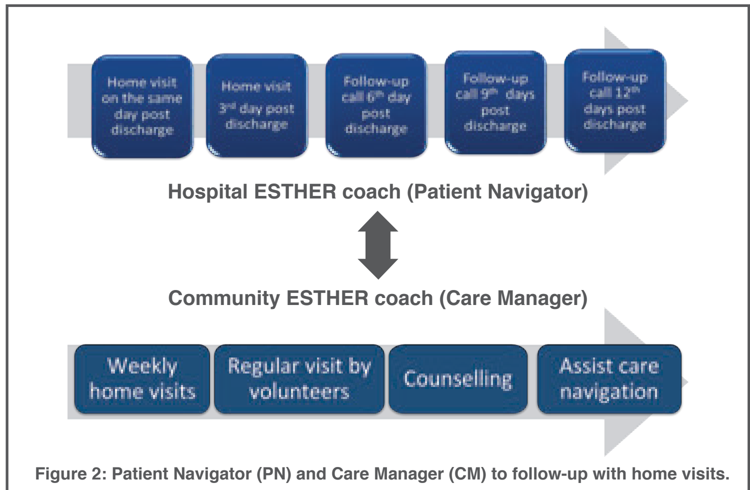


Figure 2: Patient Navigator (PN) and Care Manager (CM) to follow-up with home visits.

OUTCOMES

Figure 3 highlights ESTHER's increased level of confidence after receiving the intervention.

Through the home visits, ESTHER was empowered by learning proper medication usage and storage, as well as making preparation before any outpatient procedures. Till date, ESTHER did not require further DEM visits and/or readmissions ***(Figure 4).***

0	(Score 0-10) (No confident) to 10 (Most Confident)	Pre-I 19.7.16	Post-I 9.9.16	Post -II 6.1.17
1	Moving around at home	2-3	4-5	8 to 9
2	Showering	2	3	8 to 9
3	Toileting	7-8	7-8	8 to 9
4	Dressing	7-8	9-10	8 to 9
5	Eating	5	5	8 to 9
9	Medication-taking knowledge	1-2	4-5	8 to 9
7	Shopping	0	4-5	8 to 9
8	Moving around in my community	1	4	8 to 9
9	Sleeping	1-2	4	5

Figure 3

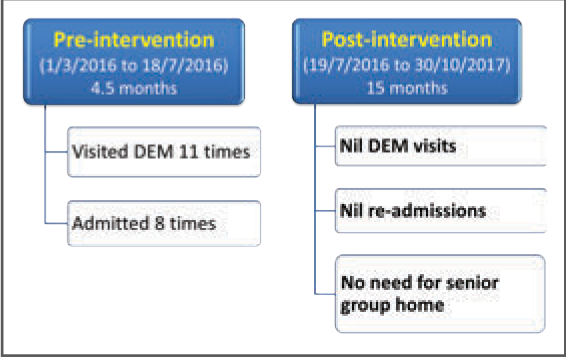


Figure 4

FUTURE PLANS

The experience from this ESTHER Project highlights the importance of the early "handshake" between PN and community partners, as well as team-based care planning. It is also important to close the communication loop between care settings. The design of intervention was also in line with a person-centric care model, by focusing on the needs and wishes of ESTHER. We also propose to extend cluster support services to facilitate seamless care transition across settings. Learning points from this project have contributed to the strengthening of the Hospital to Home (H2H) care model in our hospital.

Dear Staff of Department of Radiation Oncology, May we Have a Chat?

Project Leader : **Dr Daniel Quah Song Chiek, Dr Jeffery Tuan Kit Loong,**
Department of Radiation Oncology, National Cancer Centre
Members : **Nurse Clinician Loh Chiat Sian,**
Manager Yusnita Binte Omar,
Department of Radiation Oncology, National Cancer Centre

Project Sponsor : **Dr Fong Kam Weng,** Head and Senior Consultant

BACKGROUND

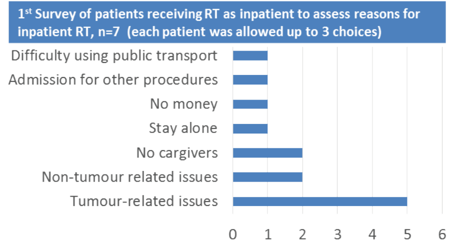
- Radiotherapy (RT) uses high-energy rays to treat disease.
- The full dose of radiation is usually divided into a number of smaller doses called fractions, usually one fraction is treated per day.
- Curative radiotherapy can use as many as 33 daily fractions, over 6 to 7 weeks.
- Impose an additional logistical challenge to some patients who are unable to come to and fro, and thus require institutionalization during their RT.
- From Jan to Jun 2016 , a total of 250 patients had RT as an inpatient in SGH - taking up valuable resource

CURIOSITY AND PROBLEM IDENTIFICATION

- How many of these 250 patients could have been on outpatient RT? What were the reasons for their inpatient stay? Social issues?
- If we solve these social issues, can we decrease bed occupancy in SGH for inpatient RT?

DATA COLLECTION

- Surveyed patients and found that there was a myriad of reasons to why they do not access outpatient RT



2nd Survey of patients who have mobility issues on support they require for outpatient RT, n=3	
Financial Support	1
Transport Assistance	1
Not sure if he needs any support	1
* All 3 stated that they will get relatives or caregivers to make arrangements to bring them for RT	

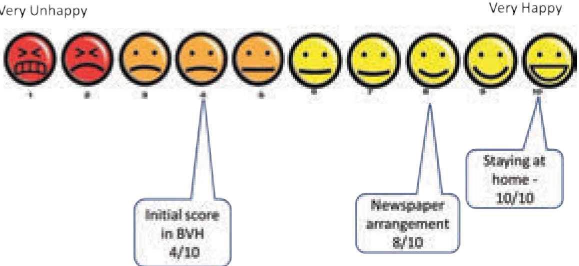
- **It was an assumption of the team that lack of social support was the main reason!!!!**

Team was unsure how to proceed until…
…. the turning point on Chinese New Year Eve 2017

- We reviewed an elderly male patient with locally advanced head and neck cancer who absconded from inpatient RT. However, admitted himself through ED because of symptoms.
- He understood his cancer and the need for daily treatment.
- He was staying alone. No relatives. He admits that care will be an issue if he stays alone at home.
- He was unhappy with hospital because he felt restricted in his activities and freedom. Thus absconded to be able to lead his normal life.

What is a normal life to him?

- To him, normalcy is to be able to read newspaper everyday.
- So a small but critical intervention to his continuous treatment was to provide him access to newspaper everyday when he comes for RT.
- And that made him happy!!

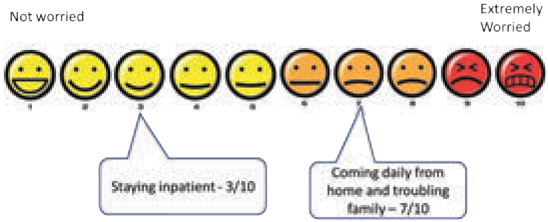


Realisation

- A thoughtful understanding of Esthers would go a long way in having the collaboration of Esther in her own treatment, beyond mere 'Information-taking' that has no meaning to Esther

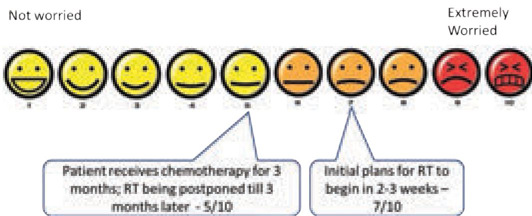
- **Tested this idea on three other patients :**

- Patient #1
  - Elderly male with colon cancer that was bleeding was planned for a course of RT of 5 fractions.
  - He was married and lives with wife in Ang Mo Kio. They have two children who lived on their own. He would need his daughter to take time off from work to bring him to NCC for treatment



  - Asked for inpatient RT, which the Medical Oncologist kindly allowed.

- Patient #2
  - Elderly male who was planned for radical chemoradiotherapy for locally advanced lung cancer. 33 fractions in total.
  - He was married with 4 children, one of whom is mentally challenged. The other 3 children share the care of that sibling as well as their infirmed mother.
  - Daughter sounded concerned about the impending treatment.



  - When asked why, daughter said that she and family now have more time to sort out the logistics of the complex care needs of family

- Patient #3
  - Young lady with spine metastases.
  - Married with two young children, in primary school. Cared for by her sister when she was in hospital.
  - Stormy stay in hospital over a long time.
  - When seen for discussion about radiotherapy, she was very homesick and crying ++
  - Made arrangements to get her analgesia infusion converted to oral medications to allow her to be discharged and had her RT outpatient.

Outcomes, Solutions and Learning Points

- To take a detailed social history to allow optimal adaptations of treatment for the holistic well being for patients
- Service to patients first – it is on us to work around our constraints and not the other way
- Spending time to communicate with a person-centred approach helps with:
  - Stratification
  - Patient satisfaction
  - Adherence to treatment agreement
- Extra time taken to conduct such conversations – about 5 to 10 mins

Future Plans

- The Palliative Radiotherapy Team in Department of Radiation Oncology is starting to add patient-centered segments into our daily practice
- Hope that with support from cluster, such patient-centered approaches can be common place in other radiotherapy teams and departments
- “Patients, at the heart of all we do.” It is easy to talk the talk. Now let us walk the walk.

What is **Best for ESTHER?**

The hallmark of an ESTHER coach is to always ask **"What is Best for ESTHER?"** and to let the answer, guide subsequent actions.

ESTHER Coach Training

As Göran Henriks, Director of Learning and Innovation, Head of Qulturum in Region Jönköping County, aptly puts it, ***“Today, the task of providing health and social care has become so complex that it is simply impossible for care providers to achieve using a traditional approach to service delivery.”***

ESTHER coaches play pivotal roles in re-defining the way care is deliver for our patients. They are like car engines—ESTHER coaches supply the energy that drives the progress of the network. Without the ESTHER coaches, ESTHER Network would remain a stationary vehicle.

ESTHER coach trainees engaging in group work

Our ESTHER coaches are a mix of healthcare and community care professionals from different organizations and are trained to take on key roles in improving care delivery. Coach trainees are first identified by their respective department heads to be passionate about improvement and positive changes. They are also required to have prior experiences and knowledge in quality improvement techniques. Through the ESTHER coach training, ESTHER coaches are trained to be attuned to the needs of patients and are equipped with a solution-focused approach to person-centric improvement work.

The ESTHER coach training spans across three days and covers a variety of topics to prepare the ESTHER coaches as change catalysts. Apart from learning how to engage patients, part of the training requires the coaches to conduct fieldwork and shadow one of their patients for half a day.

This allows care providers to better understand the needs and empathise with the challenges patients face in accessing care. Further, participants are trained to coach, which is about connecting with people, inspiring them to do their best, and helping them to grow. Coming together with a common purpose of improving status quo for patients, ESTHER coaches are also encouraged to look beyond institutional boundaries and to work across organisations to improve care delivery for patients.

ESTHER coach training has challenged our ESTHER coaches to focus on "what is best for ESTHER" and to become person-centric. ***"I used to think I know what my patient wants. After attending ESTHER coach training, my main learning point was that I need to find out more about a patient's life and to know that he or she has a life beyond discharge, so that we can then work appropriately to achieve those goals,"*** said Ms Eunice Chua, an occupational therapist from the pioneer batch of ESTHER coaches.

ESTHER Coaches - Class of 2016-2017

ESTHER Network International

Formed in April 2016, ESTHER Network International spans across different continents and countries, from Region Jönköping and other counties and municipalities in Sweden and Europe, to Singapore in Asia, Toronto in Canada and Kent in England. The formation of the international network exemplifies the spirit of ESTHER, which is to connect, collaborate and contribute towards the betterment of ESTHERs in our community.

What is Best for ESTHER?
- Let us learn and share it with the world-

Letter from Region Jönköping, Sweden

First of all, congratulation to you for your achievements in Singapore. It is an impressive amount of work. We are so proud to see the ESTHER Network expanding in Singapore and other parts of the world.

Networking is all about sharing, learning, encouraging, and co-creating creatively. Exploring creative methods and encouraging each other are fundamental ways to sustain the energy and joy of being in the Network. The structure of having goals measured, sharing of best practices, and mutual learning are key to building knowledge and local evidence to answer a simple question—"Is this Best for ESTHER?" This simple question is the guide for quality improvement in a complex world. It also directs the focus of the Network and motivates every member of the Network to work toward a common goal.

Yet, at the same time, we know that it is also very easy to overlook the need to focus on ESTHER's needs and misplace our focus on our organization instead. That's where our ESTHER coaches need to appear. I encourage our ESTHER coaches to keep their focus, keep on supporting each other, and keep on improving! Remember the importance of person-centric care while working with the needs of the organization.

My best hope for ESTHER International is that we keep on working, sharing, and learning together. I hope that we would continue to develop strong relationships with our own local ESTHERs and their families, and empower them to co-create care with us. I also hope that strong relationships between ESTHER coaches from different parts of the world will continue to flourish so that we can inspire each other, develop the training of our coaches, and keep up the good work.

ESTHER Network receiving an award in the category of Active and Healthy Aging, at the Opening Up to An Era of Social Innovation Conference November 2017 Lisbon, Portugal

I look forward to having an annual virtual ESTHER conference on the web so that we can regularly meet and learn from each other. I also hope to spread the ESTHER International song. This song makes me and many ESTHER coaches sing in our hearts. I hope you would also enjoy the song and be inspired by it. This song is a real work of co-production between Singapore, Sweden, and England, as well as between care providers, ESTHERs, and their families. I hope it will give you energy and hope, and help you to do what is needed. This is what I believe in: “It is not what you think but what you do that makes a difference!”

It is wonderful to see that we can make a difference in the world when our actions are guided by a simple question, “What is best for ESTHER?”

You are amazing!
Keep up the good work.
Keep connected ☺

Hugs and bows,

Nicoline Vackerberg Coordinator
ESTHER Network International
December 2017

ESTHER

Let us learn and share it with the world
Let us learn and share it with the world

Somewhere in our heart we know what is right
And in our minds we already got this goal just in sight
How to do it it this challenge we face
Now there is time for us to show it
To keep up and embrace:

What is best for Esther? Right on spot!
Is this best for Esther? Is or not?
So let's open that door we have never used before
Let us ask! Let us learn! And then do more and more!

Let us learn and share it with the world
Let us learn and share it with the world

Close to Esther we are ready to go
Finding the reasons to get better and even make it come true
Every measurement will show us the way
Help us to find the right direction,
With compassion we say:

What is best for Esther? Right on spot!
Is this best for Esther? Is or not?
So let's open that door we have never used before
Let us ask! Let us learn! And then do more and more!

What is best for Esther? Right on spot!
Is this best for Esther? Is or not?
So let's open that door we have never used before
Let us ask! Let us learn! And then do more and more!

Greetings from Kent, England

Esther Lim (Singapore) taking a photo with the newest batch of ESTHER Coaches graduating from their training in Kent, England

My best hopes and wishes for the ESTHER Network International onwards are: By being an open network we can share and learn from each other progress and good examples as well as helping each other to avoid "dead ends". The culture and philosophy of ESTHER will continue to spread and be successful both within and outside our three countries. Last but not least, our unique ESTHERs will feel included and that all stakeholders listen to “What matters to ESTHER"!

Anna Carlbom, RN
ESTHER co-ordinator
The Graham Care Group AND Kent and Medway Integration Pioneers, United Kingdom

December 2017

A Note from ESTHER Singapore

As we learn the humble way of making improvements ground up, via microsystems, the international partnership and regular sharing we have, help us avoid pitfalls and shorten the time needed to make sustainable improvements for our ESTHERs.

One great thing Jönköping, Sweden emphasised to us was the importance of having sponsors to support the ESTHER coaches in their endeavour from the start, as person-centred improvement work sometimes involve systemic changes that require interventions at all levels. What amazes me from the efforts in Kent, UK, is how ESTHER Network is driven by the community. There is strong leadership from the social sector and intimate partnership between health and social care. Key leaders from both sectors sit in the same office at the Design and Learning Centre!

The way ahead is challenging and exciting as we seek to find the best practices that sit well with us as we transform the way we deliver care. Having this international partnership provides the support, experience and knowledge we need to make sustainable changes. It serves as a reminder to one another to always involve ESTHERs!

Esther Lim
ESTHER Coordinator
ESTHER Network
Singapore

Follow our conversations - ESTHER International Blog, June 2016.
Available at **https://ESTHERnetworkblog.wordpress.com/2016/06/26/launching-ESTHER-coach-program/#comments**

Learn more about our International Network of ESTHER Coaches. Watch their videos via the links provided:

Mr Håkan Karlsson
ESTHER Coach in Sweden
https://vimeo.com/214636403

Ms. Caroline Ärleskog
ESTHER Coach in Sweden
https://vimeo.com/213823152

Ms. Wendy Davie
ESTHER Coach in Kent, UK
https://vimeo.com/225400485

Ms. Helen Murray
ESTHER Coach in Kent, UK
https://vimeo.com/225575993

Dr Jeffrey Tuan
ESTHER Coach in Singapore
https://youtu.be/bkOaBW0vUOc

Ms. Eunice Gwendolene Chua
ESTHER Coach in Singapore
https://youtu.be/0FYZTRGaxoc

ACKNOWLEDGEMENT

Our Partners

- Agency for Integrated Care
- Assisi Hospice and Home Care
- HCA Hospice Care
- Social Service Office @ Kreta Ayer, Ministry of Social Service & Family
- Montfort Care
- National Kidney Foundation Singapore
- NTUC Health
- Peacehaven Nursing Home
- Rainbow Centre
- SPD
- St. Andrew’s Nursing Home
- St Luke’s ElderCare
- Thye Hua Kwan Moral Charities
- Tsao Foundation
- Tan Tock Seng Hospital
- Woodlands Health Campus, Alexandra Health
- Singapore General Hospital
- KK Women's and Children's Hospital
- Sengkang Health
- Changi General Hospital
- National Cancer Centre Singapore
- National Dental Centre Singapore
- National Heart Centre Singapore
- National Neuroscience Institute
- Singapore National Eye Centre
- SingHealth Polyclinics
- Bright Vision Hospital

ESTHER Network Task Force

Esther Lim Li Ping (Coordinator)
Assistant Director, RHS, SingHealth

Tan Jie Bin (Deputy Coordinator)
Medical Social Worker, MSS, Singapore General Hospital

Andy Sim Gim Hong
Principal Medical Social Worker, MSS, Singapore General Hospital

Pamela Poh Yong Hui
Senior Executive, Group Communications, SingHealth

Ken Lim Chee Seng
Assistant Manager, IPSQ, SingHealth

Elizabeth Pang Puay Ting
Assistant Manager, RHS, SingHealth

Lim Zhi Ying
Senior Medical Social Worker, MSS, Singapore General Hospital

Tang Joo Ying
Assistant Manager, IPSQ, SingHealth

Lee Fong Sin
Senior Executive, IPSQ, SingHealth

Ong Ai Ling
Senior Executive, IPSQ, SingHealth

Mervy Quek Rui Tian
Executive, IPSQ, SingHealth

Keith Heng Swee Kok
Senior Executive, IPSQ SingHealth

Jelvin Sim
Executive, RHS, SingHealth

Ng Swee Leng
Senior Associate, RHS, SingHealth

ESTHER Coach Trainers

Qulturum, Region Jönköping County
Nicoline Vackerberg

Montfort Care
Wang Yu Hsuan
Mark Lin Bing Ming

SingHealth
Esther Lim Li Ping
Ken Lim Chee Seng
Mervy Quek Rui Tian
Zahara Mahmood

Singapore General Hospital
Andy Sim Gim Hong
Tan Jie Bin
Amanda Tan Wei Li
Chua Jiayu Eunice Gwendolene
Joanne Anthony
Khee Giat Yeng
Koh Sock Sim
Lau Keat Yeng Emily
Ng Shi Ying

National Cancer Centre Singapore
Dr Daniel Quah Song Chiek

National Neuroscience Institute
Dr Kexin Ang

ESTHER Coaches - Class of 2017-2018

2017 ESTHER Improvement Projects

Project Title	Team Members	Sponsors
Reduction of over prescription by pharmacy	• Lau May Ling Cheryl Changi General Hospital	• Zahara Mahmood
To improve experience & comprehension of information by ESTHER coming to NCCS for AC Chemotherapy	• Chiang Yuet Ling Joen National Cancer Centre Singapore	• Lita Chew Siu Tsien
Enhancing ESTHER' community experience - be engaged by iPCARE!	• Ratna Indra Putri Bright Vision Hospital	• Christopher Teo
Improving ESTHER's experience in transition from SGH to Assis Hospice and stay within Assis Hospice	• Dr Lo Tong Jen National Cancer Centre Singapore • Soh Chiat Sua Samantha Assisi Hospice • Tan Beng Le Assisi Hospice	• Dr Yee Chung Pheng Alethea • Dr Neo Soek Hui Patricia • Chiew Cheng Fong
Empowering patients in medication management to improve medication adherence	• Ho Jess NTUC Health • Lim Suyu Susan Singapore General Hospital Jin Patricia • Singapore General Hospital	• Olivia Khoo

LOOKING FORWARD

Project Title	Team Members	Sponsors
Integrating Seamless transition of community care through the St Luke's family	• Kung Beng Keng St Luke's ElderCare	• Ng Lay Ling
Caregivers to manage their health issues and able to navigate the healthcare system	• Lim Lutin Bright Vision Hospital	• Eunice Chin
Gathering client perspectives on the early intervention service delivery before and after enrolment to a local early intervention centre	• Choy Mian Yee Rainbow Centre	• Tan Sze Wee
Meeting ESTHER's wish	• Dr Kyaw Naing HCA Hospice Care • Ang Beng Lee Jazz HCA Hospice Care • Tan Joo Eng HCA Hospice Care	• Dr Chong Poh Heng • Angela Tan
To increase access to return to work for patient with mild cognitive impairment	• Dr Chiong Yi Singapore General Hospital • Trivedi Neha Umang SPD	• Dr Bok Chek Wai • Kam Jin Chieh
Empowering patients to monitor their heart failure symptoms through a self-management tool and community partnership	• Dr Loh Julian Kenrick National Heart Centre Singapore • Nor Syamsul Nazly Bin Mohamed Said National Heart Centre Singapore • Ng Shu Hwa Clarice National Heart Centre Singapore	• Dr Aaron Wong Sung Lung • Prof Terrance Chua Siang Jin • Genevieve Wong Cheng Sim • Phoon Poh Choo
To maintain 'ESTHER' ambulation function after discharge from SACH until her first Ortho TCU – for only those ESTHER' that decline Day Rehab Centre service	• Wong Suen Kwong St. Andrew's Community Hospital	• Dr Loh Yik Hin • Dr Edward Menon • Mrs Yuen-Chiew Yew Mee

Project Title	Team Members	Sponsors
To facilitate more challenging activities for clients at day care centre	• Phua Mui Kian Stella Peacehaven Nursing Home	• Low Mui Lang
Empowering ESTHER in Managing her Medications Efficiently	• Wong Teck Tian NTUC Health • Koe Ling Wan Pearline Singapore General Hospital	• Jeannie Ho • Olivia Khoo
Creating an aphasia-friendly space in the community to help patients with communication impairment regain confidence and participation	• Khoo Pei Lee Evelyn Singapore General Hospital	• Deirdre Tay Dan Yi
To reduce ESTHER's touchpoint in SGH to access to care plan options in six months	• Kavitha D/O Sindaya Agency for Intergrated Care • Wong Yuen Yun Singapore General Hospital	• Dr Wong Loong Mun • Olivia Khoo
Enhancing support for ESTHER at the onset of cancer diagnosis	• Lim Chiew Yi Jasmine KK Women's and Children's Hospital	• Mavis Teo Poh Wah
Empowering frequent P2A1P3 ED attendees to access primary care & community services for acute medical and social needs	• Chan Hui Sian Amy Woodlands Health Campus	• Pua Lay Hoon • Tan Lai Hong
To reduce clinic visits by 30% and hospital admissions by 10% for conservatively managed ESRD patients in 12 months	• Lim Ee Lin Amy Singapore General Hospital • Dr Yee Chung Pheng Alethea National Cancer Centre Singapore	• Dr Tay Choo Wei Nicholas
To have a strategic education booklet for COPD patient in the community	• Kee Mong Nee Changi General Hospital	• Zhang Di
To improve patient glycemic control so as to reduce readmission rates	• Karen Thomson Lynn Changi General Hospital	• Debbie Wild