SingHealth Regional Health System

Partnering Communities to Keep Well, Get Well & Live Well

Dr Michael Wong

Group Director, Regional Health System, SingHealth

Population Health

The **Health outcomes of a group of individuals**[1] in a defined population.

Underpinned by 3 foundational concepts:

- **Health and well-being** develop over a lifetime
- **Social determinants** drive health and well-being outcomes throughout the life course
- **Place** (i.e., where they live, learn, play work and pray) is a determinant of health, well-being and equity

[1] *Kindig D, Stoddart G.Am J Public Health. 2003 March; 93(3): 380-383*

Restricted, Non-Sensitive

We play a Dual Role in transforming care to improve our patients' lives and help our population stay healthy

Our Dual Role

National Role	Regional Role
Cutting Edge Tertiary and Quaternary Care	Community and Population Health

PRIMARY CARE

HOSPITALS

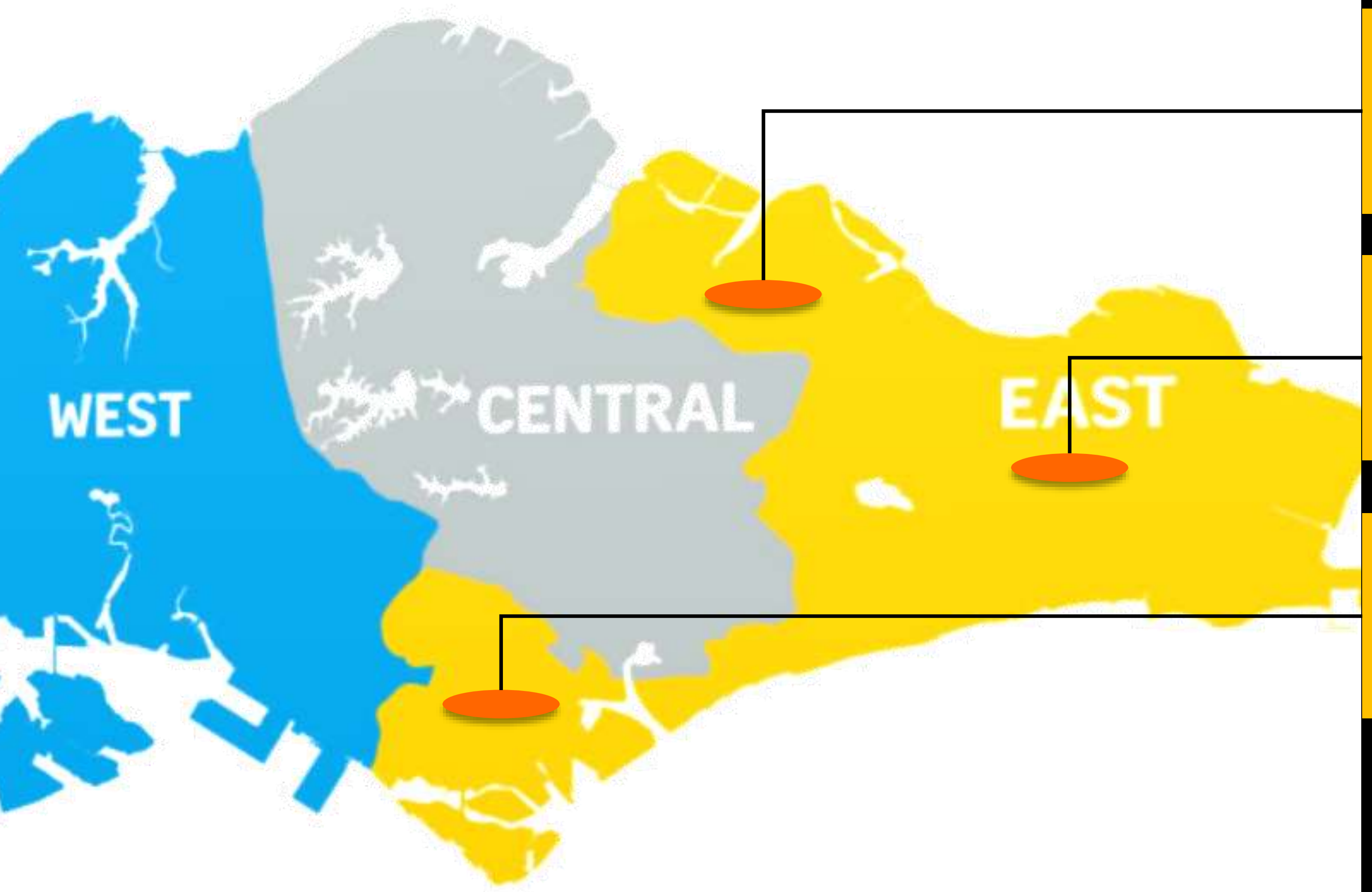
NATIONAL CENTRES

INTERMEDIATE / LONG TERM

Bright Vision • Outram • Sengkang

Restricted, Non-Sensitive

Three **Distinct Demographics** Within Singapore's Eastern Population



Total Population: 1.37M

North-East Region
Population: 415,760
60 and above: 13%
Living in 1 & 2 room flats: 4%

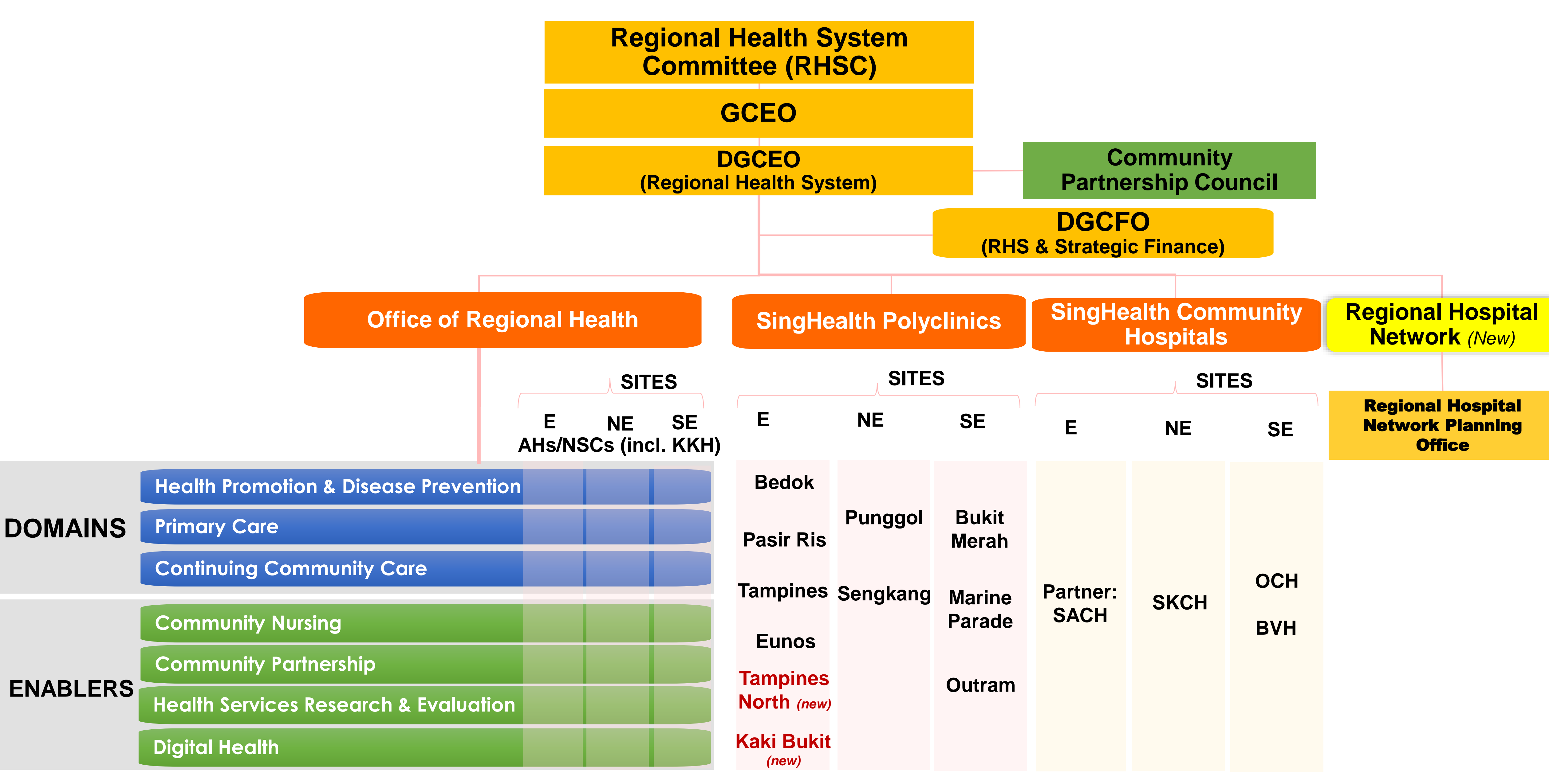
East Region
Population: 686,660
60 and above: 23%
Living in 1 & 2 room flats: 3%

South-East Region
Population: 266,680
60 and above: 27%
Living in 1 & 2 room flats: 12%

Source: Population Trends 2019 from Department of Statistics Singapore

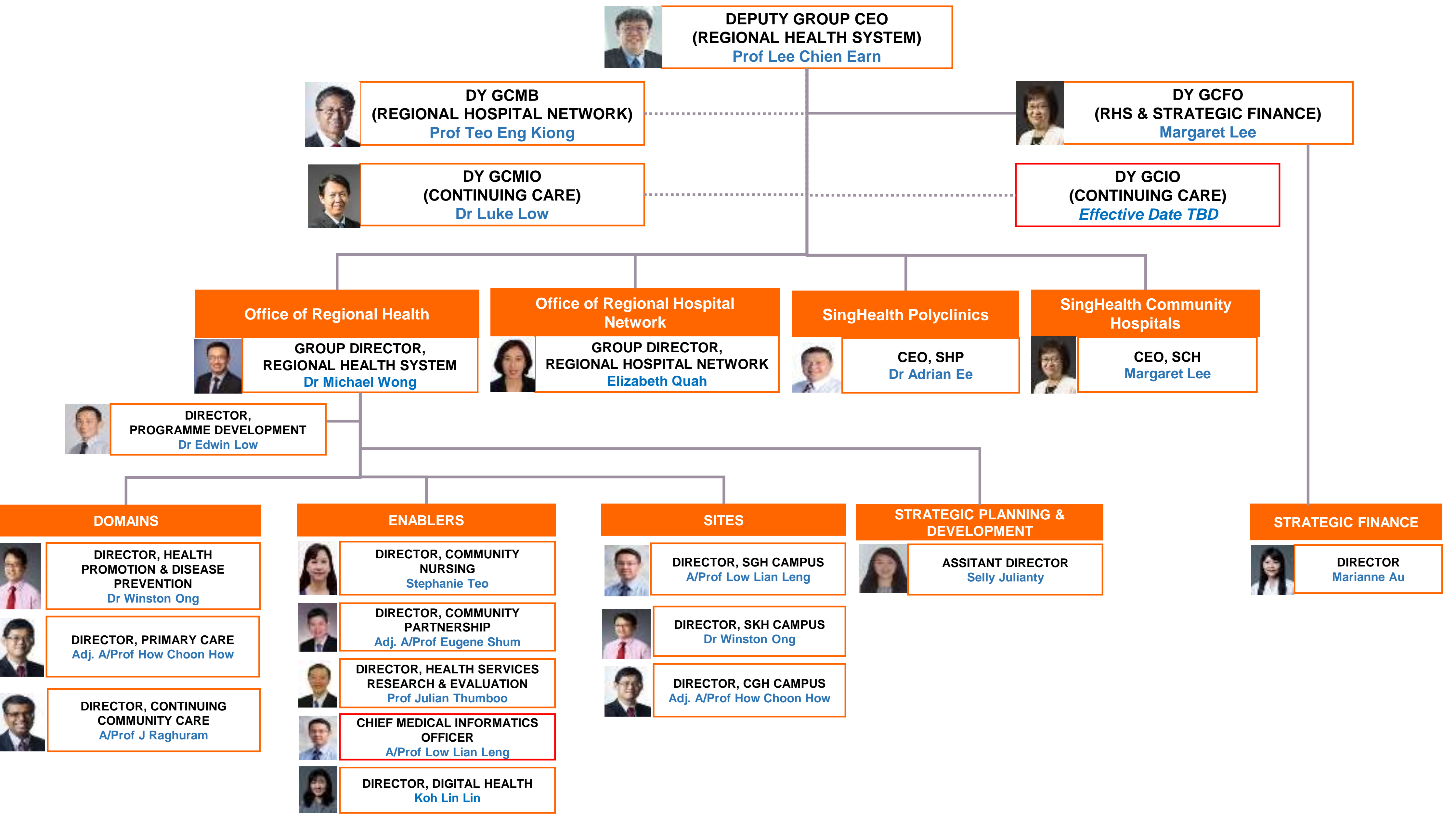
Restricted, Non-Sensitive

Organised for Population Health



Restricted, Non-Sensitive

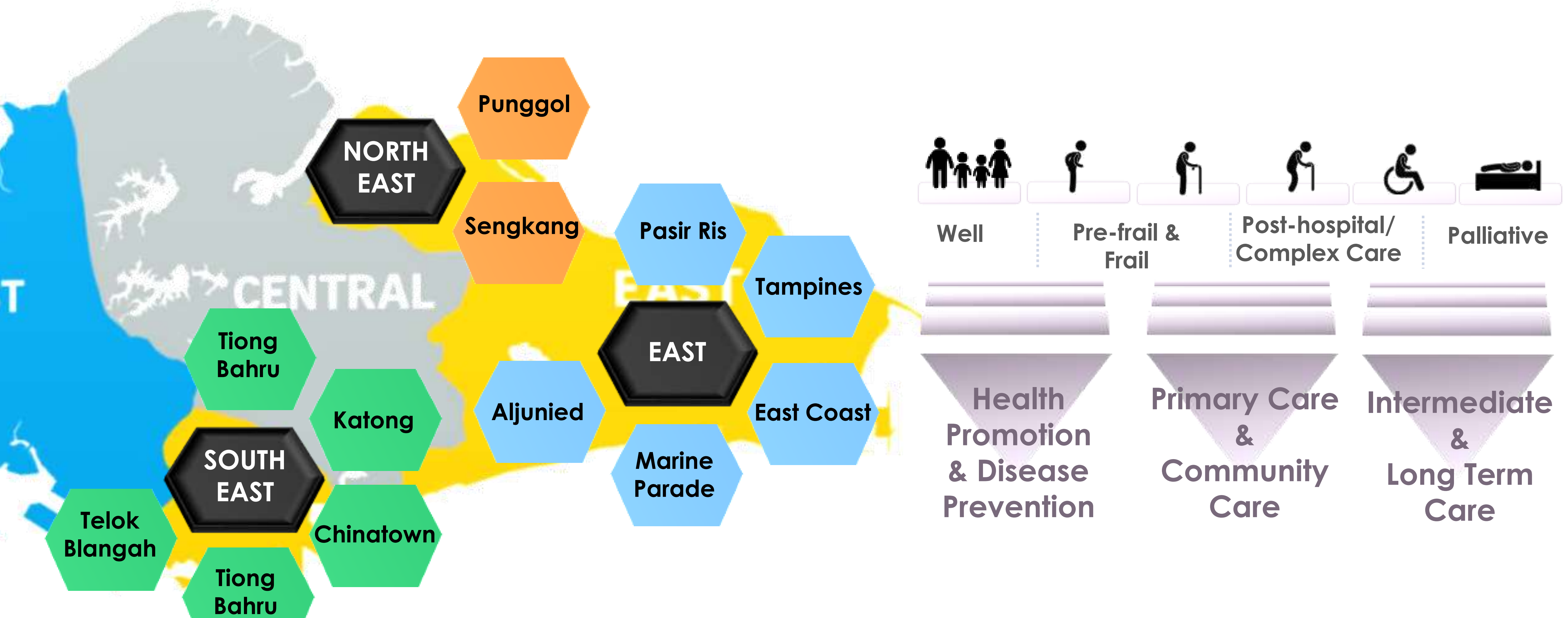
SingHealth RHS Integrated Functional Chart



Restricted, Sensitive (Normal)

Geographical based communities of care for all ages

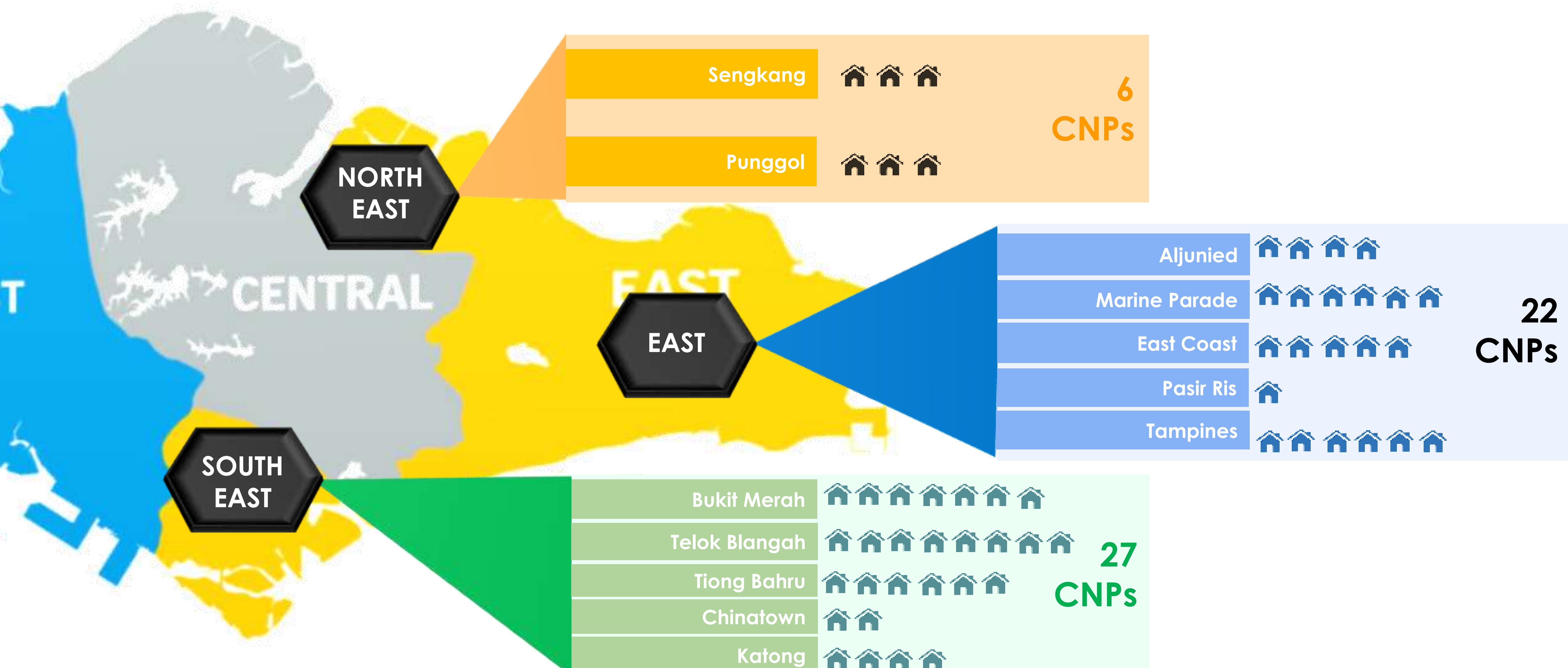
12 Communities of Care supporting services organised around one's life journey



Restricted, Non-Sensitive

55 SingHealth Community Nurse Posts

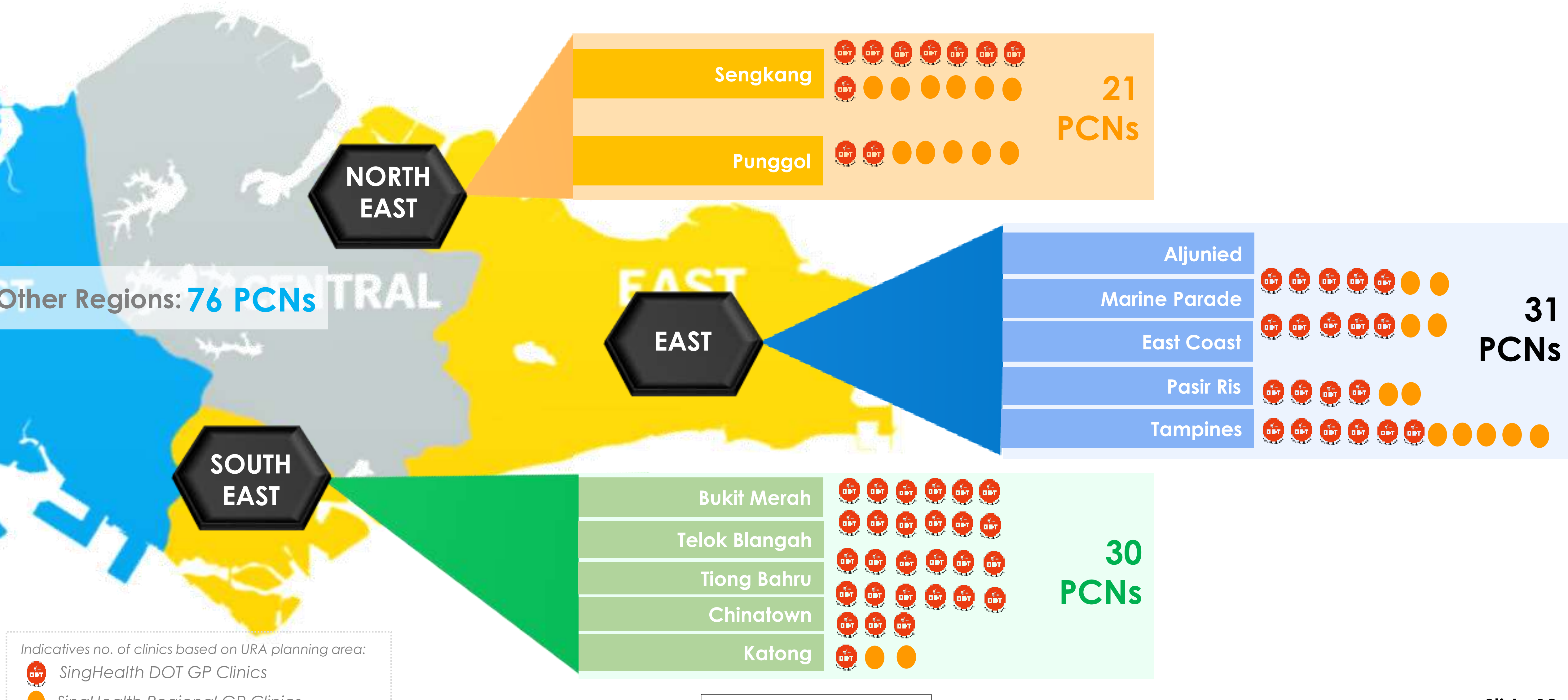
Care Nodes embedded in Communities of Care



Restricted, Non-Sensitive

158 SingHealth Partners Primary Care Networks

Care Nodes embedded in Communities of Care



Restricted, Non-Sensitive

Geographical based communities of care for all ages

Deep understanding the needs and aspirations of the community

Empowered Community of Care
Strategy & approaches

Asset 3M
- Map, Mine, Mobilize
- Partners Engagement & Collaborations

Bridging Generations
- Intergenerational Network
- Befriending, Volunteerism

Care Integration
- Health/social/Primary transition workflows (referrals, escalations)
- One Care team/plan

Digitalisation
- Data Blueprint, Information Sharing
- Telehealth, Innovative Solutions

ESTHER Network
- Person-centred Care Philosophy
- Quality Improvement

Research, Education, Innovation

Restricted, Non-Sensitive

Geographical based communities of care for all ages

Deep understanding the needs and aspirations of the community

"Co-produced" with community in physical and virtual realms

Build Enabled Communities by Leveraging Strengths of the Community

WEST

CENTRAL

EAST

Partner

ST. ANDREW'S COMMUNITY HOSPITAL

Restricted, Non-Sensitive

Geographical based communities of care for all ages

Deep understanding the needs and aspirations of the community

"Co-produced" with community in physical and virtual realms

Anchored by Primary Care and Community Nurses

Flow from Hospital to Community

Hold in Community

Link to Community Resources

HOSPITAL CARE TEAM

SingHealth DukeNUS
ACADEMIC MEDICAL CENTRE

FLOW

"NEXT GENERATION" POLYCLINIC

Primary Care Based Integrated Community Care Team

Empanelment of Population

Primary Care Team

Nurse Led Community Care Team

LINK

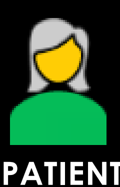
COMMUNITY PARTNERS

SINGHEALTH PARTNERS
PRIMARY CARE NETWORKS/GPs

Asset-Based Community Development

Improving Chronic Disease Management

A Simplified View of Patient's Envisioned Journey



Seeking Assistance → Community Care → Follow Up Visit → Continuous Support

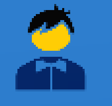
Seeking Assistance

Prescribed patient **integrated holistic care (social prescription)** plan

Closest CNP near patient's home **auto-assigned patient care**

Connect with patient via call and arranges schedule for visits and calls

Community Care



Call patient daily to check in. **Reminds** her of upcoming appointment

Pings for befriender support (non-mobile patient)

Available volunteer **is 'pinged' to escort** patient to appointment

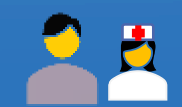
Follow Up Visit

Prescribed medication and **improved care plan with Virtual Care**

Continuous Support

Deliver telehealth kit to patient's home before VC session

Coach patient to use telehealth kit for VC



Doctor conduct **regular VC session** with patient

Receives trending and charting of vital sign monitoring in system

CNP attends to patient's medical needs at home

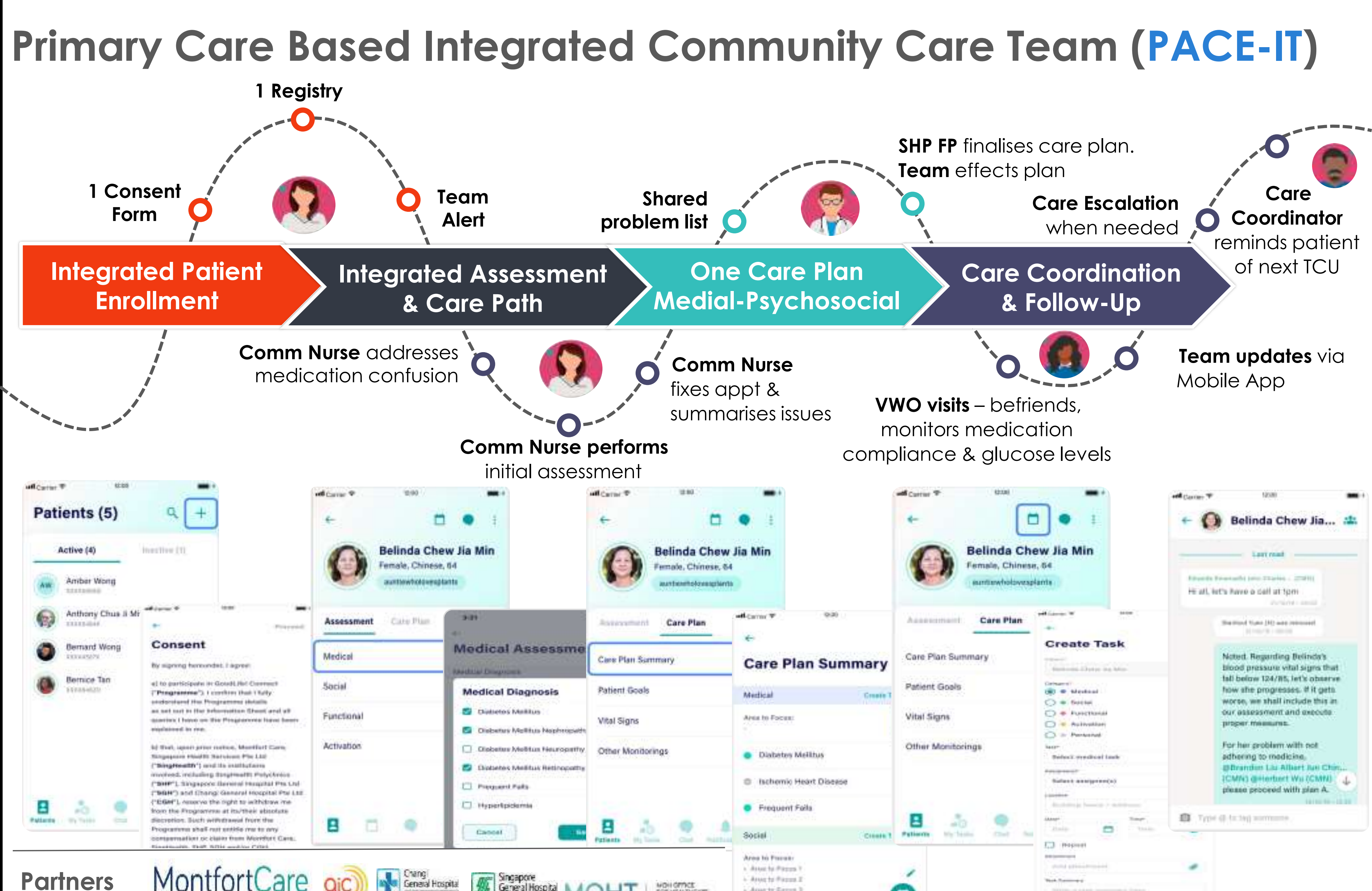
Integrated System to link all stakeholders

Involvement of **community partners and patient**

Care coordinator as the facilitator of care and POC for patient

Enrolment from any touch-point, **one consent form**

Semi-structured care path



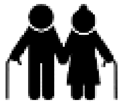
Improve Access to Care Using Technology

Remote Vital Signs Monitoring (VSM) for Residents with Hypertension

Empower residents to self-measure their BP at Community Nurse Posts

Trended readings fed to Community Nurses for follow-up

BP self-monitoring kiosks at **20 Senior Activity Centres**



Recruited **112 residents** as of May 2021
(Target: 500 residents)

Equipping seniors at home with Telehealth Kits for Virtual Care Delivery

Leveraging technology to provide uninterrupted and better care for seniors at home

Thermometer

BP Monitoring Set

Weighing Scale

Glucometer

Tablet

Pulse Oximeter

- **Health education & coaching**
- **Self-monitoring & review for chronic medical conditions**
- **Active management of health conditions**

TEMASEK FOUNDATION AsianMedicalFoundation

Restricted, Non-Sensitive

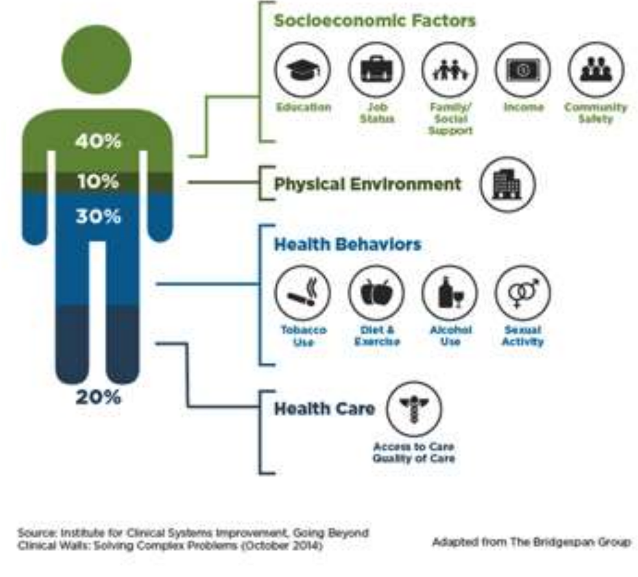
Improving Chronic Disease Management

Bridging Health & Social Care

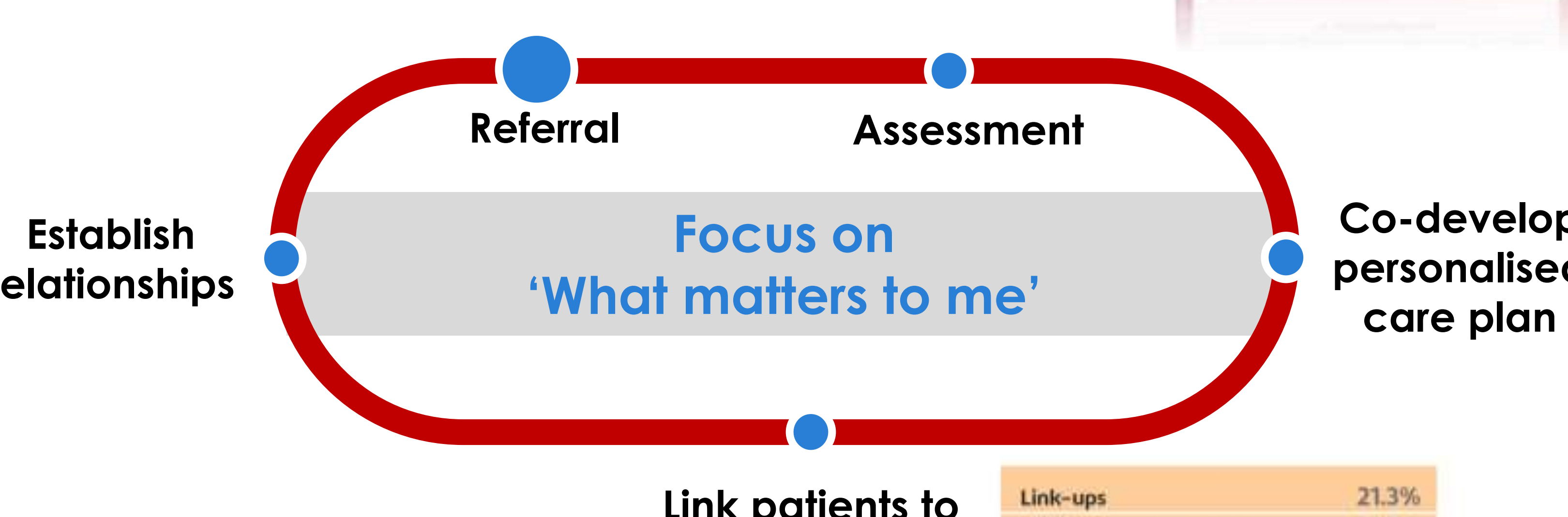
Social Prescribing – Well-being Coordinators

Enabling healthcare professionals to improve patient's health and well-being in the community

What Goes Into Your Health?



Reaching out to 10,000 patients
from SingHealth Community Hospitals and SingHealth Polyclinics by 2021



Link-ups	21.3%
Senior Activity Centre	11.5%
Housing & Senior Activity Centre	3.3%
Housing	1.6%
AIC	1.6%
Faith-based Organisation	1.6%
Job	1.6%
No link-ups	78.7%

Restricted, Non-Sensitive

Social Prescribing at SHP

Intended Outreach: 790 patients (High Touch) by Aug 2022

WBC activated

Patient arrives at clinic

WBC administers PAM® to patient

Waiting to see doctor

Dr reviews patients and PAM® score. Refers patient to WBC via ***Social Prescribing Service Referral Form if High Touch SP is required***

Doctor consultation

Appointment made with High Touch SP patient for SP session with WBC

Post consultation

Connecting Patients to Care in the Community

1 **General Assessment**
Well Being Coordinator

2 **Co-develop personalised action plan**

Discuss with patient to ***understand his/her social care needs*** *(meet on one-to-one basis) and co-produce a simple* ***Personalised action plan***

3 **Link to community assets**

WBC refer patient to local support services and follow-up with patients for an average of 6 encounters

4 **Feedback loop**

WBC FPC updates doctor/teamlet on patient's progress

PAM® *is a 10- or 13-item survey that assesses a person's underlying knowledge, skills and confidence integral to managing his or her own health and healthcare.*

Restricted, Non-Sensitive

Improving Chronic Disease Management

Bridging Health & Social Care

Upstream Preventative and Primary Care

Community Wellness Programme

Supporting the individual and family to keep well, get well and live well

Bridging SHP to the local community

Preventative Health Journey of Life Framework

Empowerment to achieve whole person Health: Mental, physical and Social

Anticipatory Care

Proposed Population Health space in the Tampines North Polyclinic

Child Health | Adult Health | Senior Health

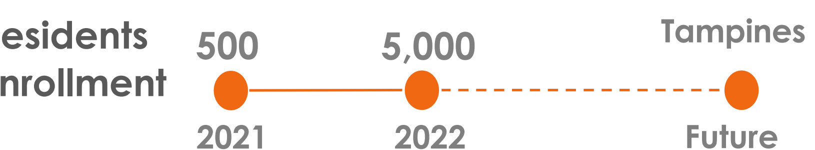
Partnering community stakeholders

Population Empanelment

Study the effectiveness of **last mile delivery interventions**

Learning loops on whether interventions work , behavioural science , innovations

Residents Enrollment



Restricted, Non-Sensitive

Journeying together with residents through Health Up!

Personalised care plan & Health Up! member booklet

Regular nudges, coaching and check-in by Health Up! team

Onboarding at Active Health Lab @ OTH

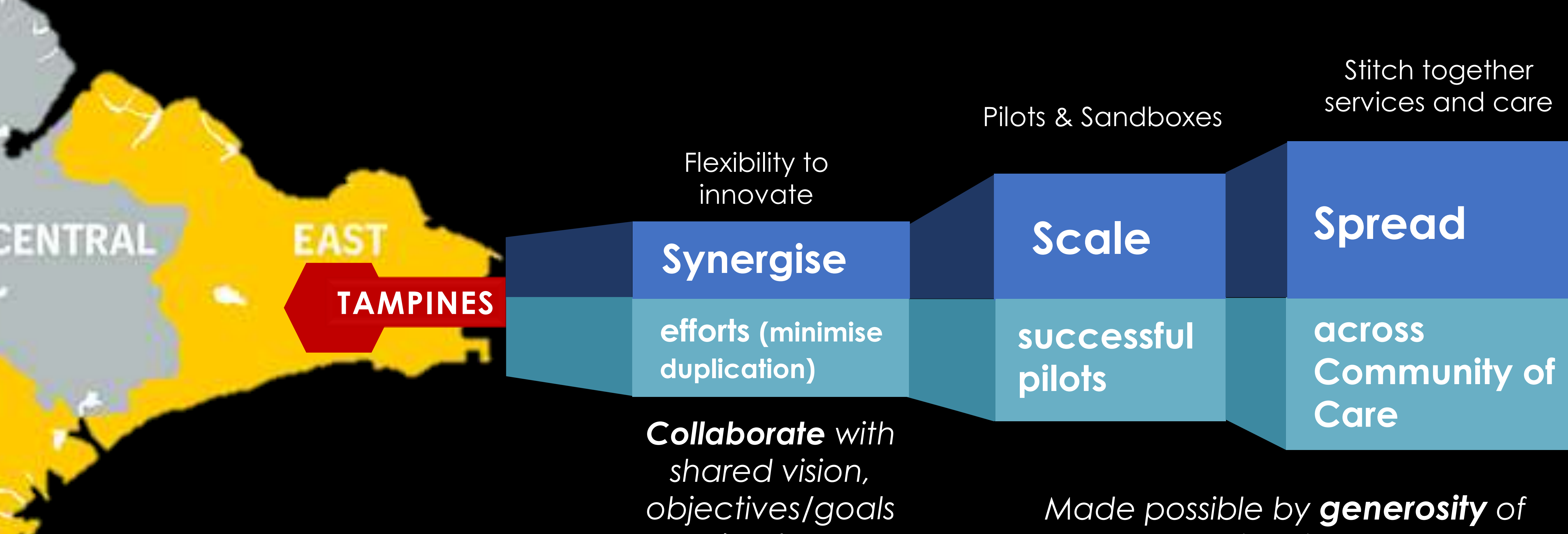
Project AH_2

Coordinated by the SingHealth/SHP Health Up! Team

**Phase 2 will involve partnering with other agencies, outreach to residents via block ambassadors, and the development of new Programmes.*

Restricted, Non-Sensitive

Pilot empanelment and whole-of-life approach in one geographical zone

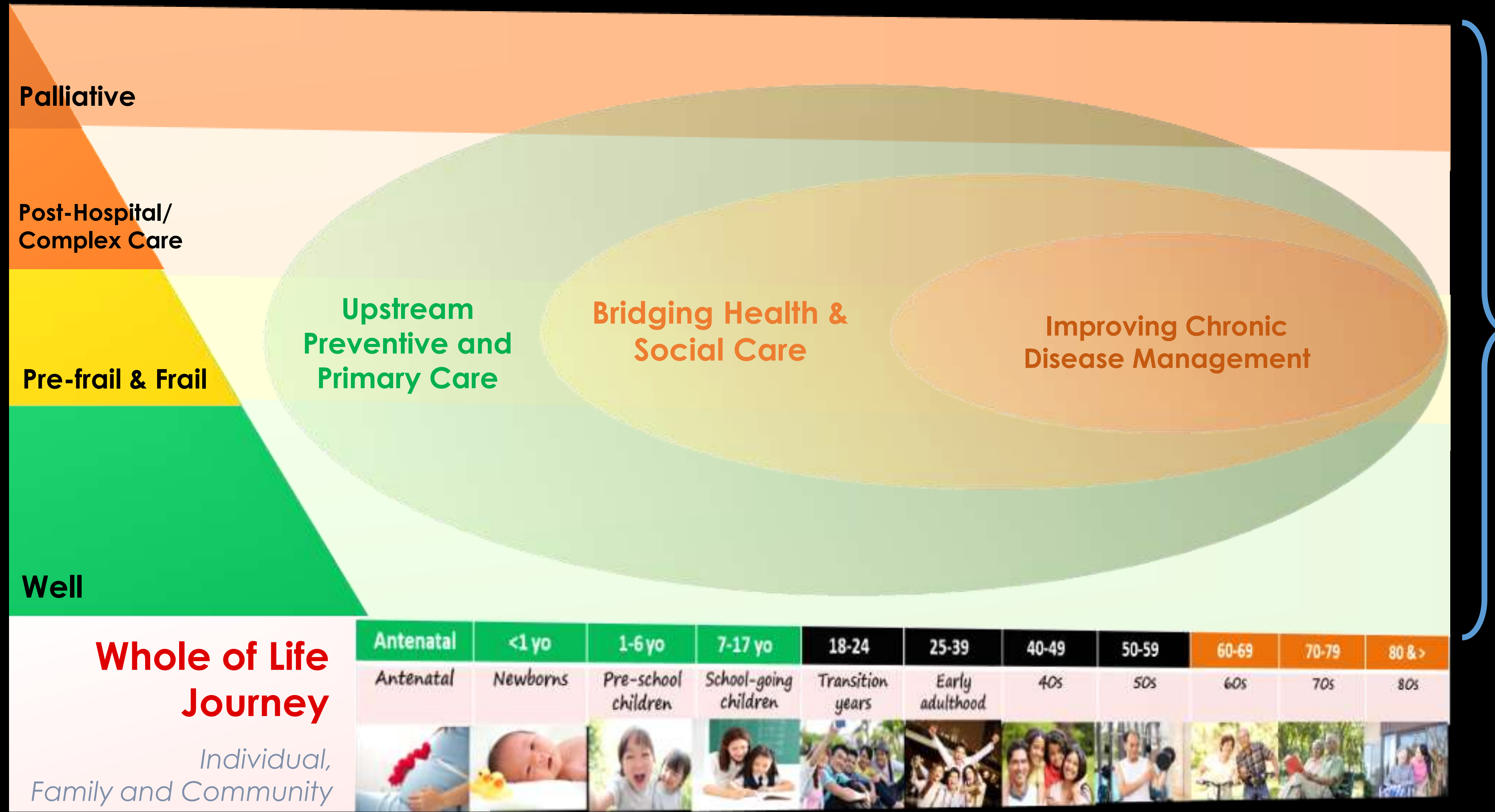


*Made possible by **generosity** of the pilot site and **openness** of the receiving sites*

WHOLE-OF-LIFE APPROACH TO POPULATION HEALTH

Empowered Community of Care

Help our residents to keep well, get well and live well



Integrated Primary & Community Care Team

SHP/PCNs/GPs
Community Nurses
Care Coordinators
Community Partners

SingHealth Communities of Care

Help our residents to
keep well, get well and live well

Flexibility to innovate	*Pilots & Sandboxes*	*Stitch together services and care*
Synergise efforts (minimise duplication)	**Scale** successful pilots	**Spread** across campuses/ clusters
Singapore Oral Health Movement 8020 Health Up! Social Prescribing Next Generation Polyclinic	PACE IT Virtual Care Delivery to Improve access to care for vulnerable population Empowered Communities of Care EAGLECare Enhancing ACP, Geriatric Care and EOL care in the Eastern Region – Building Capability among NH Partners	Maternal and Child Health SingHealth Community Nursing Health Management Unit

SCH Office of Learning (SCHOOL) | **Digital Health** | **Population Health Research & Innovation**

Restricted, Non-Sensitive

Thank You

PATIENTS. AT THE HEART OF ALL WE DO.