CENTRE FOR HEALTHCARE INNOVATION

CHI Learning & Development System (CHILD)

Project Title

Moving Beyond Hospital to Community: TTSH Community Health Team

Project Lead and Members

Project lead: Adj. A/Prof Ian Leong, ACMB (Community Care Integration)

Project members:

Dr Wong Chia Siong, Director, Population Health Office

Dr Tan Kok Leong, Head, Continuing & Community Care

Ms Ng Woei Kian, Asst Director of Nursing, Community Health

Ms Lee Sin Yi, Principal Physiotherapist, Community Health

Ms Lim Sing Yong, Deputy Director, Population Health Office

Organisation(s) Involved

Tan Tock Seng Hospital

Project Period

Start date: 2016

Completed date: Ongoing

Aims

To achieve a holistic place-based care for both patients and residents in Central Singapore.

Background

See poster attached/ below

Methods

See poster attached/ below

Results

See poster attached/ below

Lessons Learnt

In today's constantly evolving healthcare landscape, the "do-it-all" approach of having interventions only within the hospital walls is no longer adequate. With existing community partners and activated residents available to collaborate with and provide services in care management, organisations should leverage and pool together these resources to innovate and redesign effective and efficient interventions that could deliver multiplier results on the system, institution, partners and the central population.

Conclusion

See poster attached/ below

Additional Information

Instead of focusing solely on the frail patients admitted to the hospital, CHT has expanded provision of care to residents in the Central Zone. Strengthened partnerships with our community partners ensure that care is delivered holistically and sustainably. The creation of Peer Support Groups and "One to Many" approach are our first steps towards a scalable ecosystem to ensure health of central residents.

Project Category

Care & Process Redesign

Keywords

Care & Process Redesign, Community Health, Population Health, Preventive Care, Right-Siting, Self-Management, Health Literacy, Multi-Disciplinary, Medical Services, Nursing, Allied Health, Pharmacy, Healthcare Administration, Tan Tock Seng Hospital, Biopsychosocial, One Care Plan, Community Health Posts, Peer Support Leaders

Name and Email of Project Contact Person(s)

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Moving Beyond Hospital to Community: TTSH Community Health Team

Community Health, Division for Central Health

Tan Tock Seng Hospital

National Healthcare Group

Adding years of healthy life

BACKGROUND

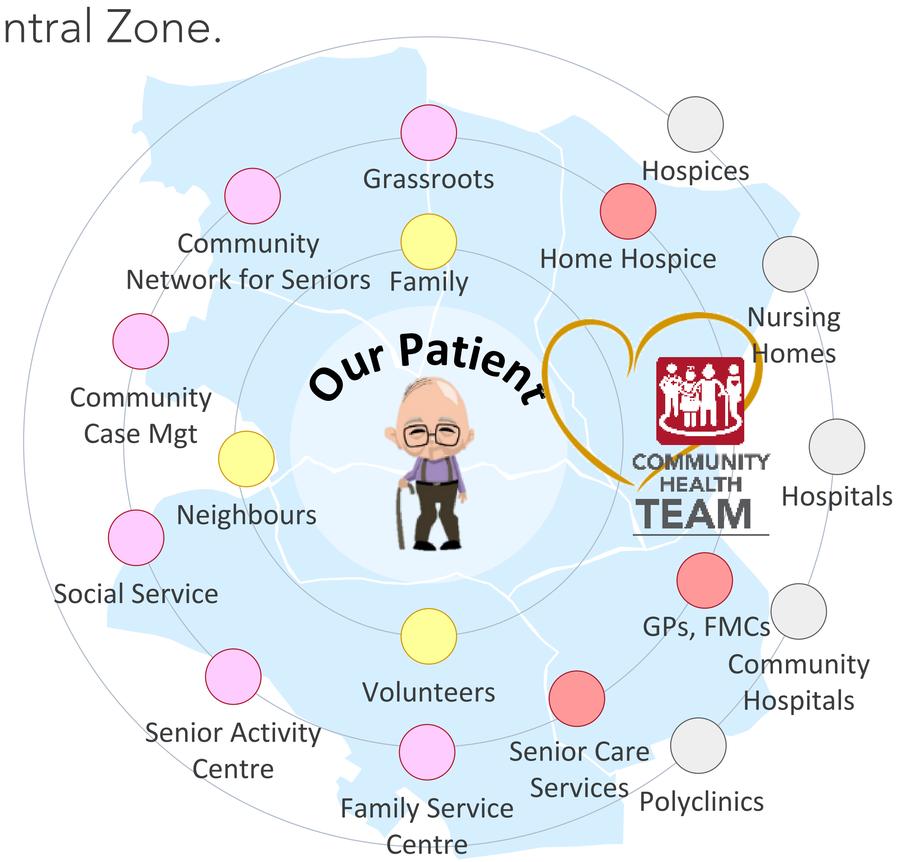
The healthcare system is increasingly challenged by the demands of an ageing population and an upward trend in the prevalence of frailty. This thus requiring a strategy that goes "Beyond Hospital to Community, Beyond Healthcare to Health and Beyond Quality to Value".

INITIAL STATE

- Multiple care coordination initiatives (ACTION, Virtual Hospital, Post-Acute Care at Home) to manage the care of complex patients operating in silo, resulting in fragmentation of care delivery and difficulties in navigating systems.
- Non-sustainable system of care delivery (*fragmentation*, *disease-based*, *facility-based* and *episodic*) in the face of an ageing population and increasing prevalence of frailty.

DESIRED STATE

Establishment of ***place-based, multi-disciplinary Community Health Team as part of the local network of providers*** embedded within each of the seven sub-zones of the Central Zone.



OUR PLANS FORWARD

Going forward, the team will continue reviewing the ***population health care model*** to achieve a more ***holistic place-based*** care for both the patients and residents in Central Singapore.

Attain through ***building relationships*** and ***working with local partners*** across health and social care domains to ***enable health engagement, care coordination and ageing in place*** with the care providers in the community.

Team Focus

CHT aims to tackle the diverse needs of the population that are biopsychosocial in nature:

Healthy

Low participation rates and non-persistence of healthy lifestyles post participation in formal programmes

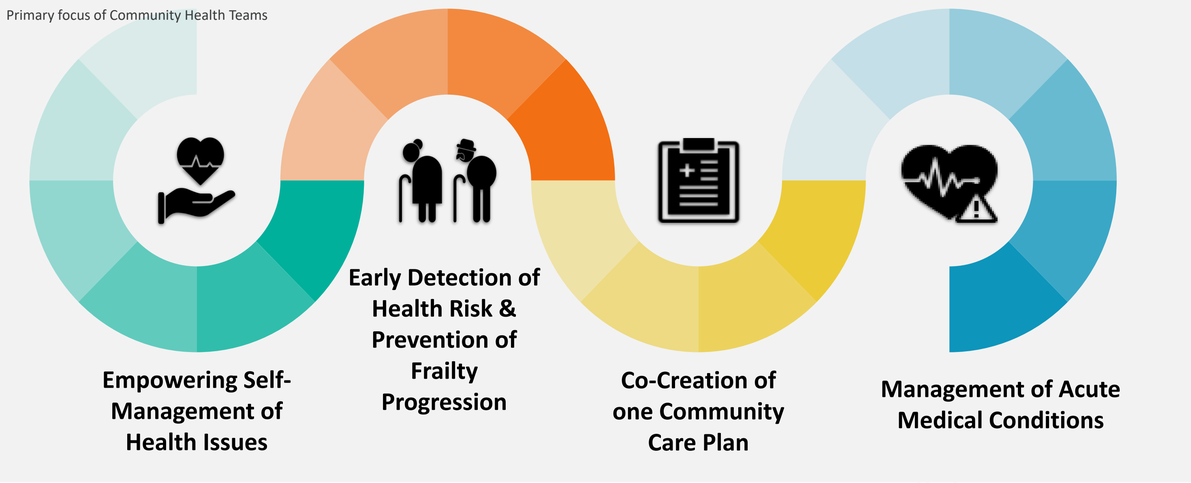
Less Healthy

Dynamic nature of frailty which needs a "whole of community" to manage

Least Healthy

Lack of continuity of care across care settings and unsustainable professionals-heavy models

The team aims to address the needs through:



Activation

- Create activated communities
- Coaching, education, counselling
- Engagement of peer support groups and leaders

Preventive

- Health Screening
- Case management
- Outreach and structured programmes promoting healthy lifestyle
- Community Vaccination & Smoking Cessation programme

Collaboration

- Co-management of patients
- Co-creation of one care plan
- Regular engagement and joint case discussion
- Cross learning of best practices

OUTCOMES

More than **26** Partners engaged in collaboration across Central Zone

5 Quarterly networking sessions with partners established

82 Community Health Posts set-up (21 by nurses, 61 by health coaches)

29 Peer Group Leader identified

143 Engagement session have been conducted by PGLs

Scoring **87** (of 100) in Employee Climate Survey

Sustainable engagement with staff.

Staff feels empowered to do what is necessary for the overall benefit of the hospital/ institute on/organisation

Staff well-being is supported by the management team

Staff understands their role in strategic changes implemented.

Reduction in ED attendances and admissions post-enrolment.

59.2% & 76.5%	30 days, respectively
41.2% & 60.8%	3 months, respectively
26.7% & 43.3%	6 months, respectively

Reduction in Bed days

Reduced an average of 1.6 bed days per enrolled patient in a 90 days period.