# PHICO

## COMMUNITY HIGHLIGHTS //

A publication by Population Health and Integrated Care Office (PHICO), Singapore General Hospital

AN ANNUAL NEWSLETTER FOR COMMUNITY PARTNERS

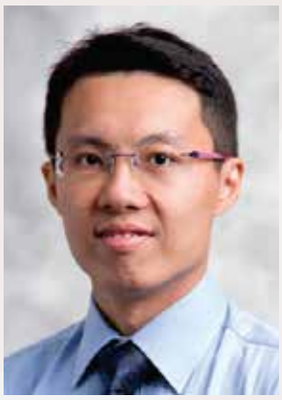
**YEAR 2020**

# CO - CREATING EMPOWERED COMMUNITIES OF CARE FOR ALL AGES

Singapore General Hospital

SingHealth

## Director's Message



Dear Partners,

Welcome to the first edition of PHICO Community Highlights - an annual newsletter by Population Health and Integrated Care Office (PHICO) - that commemorates our achievements together and showcases latest initiatives in the community.

In retrospect, 2019 was truly a remarkable year as tremendous progress had been made and milestones were achieved in areas of population health enhancement as well as integration of primary and acute care services beyond the hospital setting. These accomplishments were only possible thanks to the strong collaborative spirit that we embody.

In the past year, we forged new relationships and strengthened old ones through a series of meaningful events - "Stronger together" CEO Brunch in January, two Communities of Care Get-Together sessions in August and October, and our first-ever PHICO Retreat, during which we discussed about our shared mission and vision to co-create empowered Communities of Care of tomorrow, for all ages.

Our collaborative efforts in both up-stream and down-stream interventions place us in a highly critical position in the Singapore health system. Being on this transformative journey is both exciting and rewarding but it is more so with you in company.

Let us continue to stay close and be updated on the latest ground initiatives by joining the Communities of Care Facebook group at https://tinyurl.com/smx47gy or simply scan the QR code below:

SCAN ME

Wishing you a blessed year ahead.

**Best regards,**
**A/Prof Low Lian Leng**
**Director**
**Population Health and Integrated Care Office (PHICO)**
**Singapore General Hospital**

## Population Health and Integrated Care Office

Population Health and Integrated Care Office (PHICO) was established under Singapore General Hospital (SGH) Medical Board through the merger of Office of Integrated Care and SingHealth Office of Regional Health (SORH), SGH Campus on 1 November 2018.

PHICO was formed to oversee care integration initiatives of SGH and chart the overarching direction in population health by developing strategic models of care. PHICO hopes to achieve its aims by forging synergistic partnerships with community service providers, who hold valuable expertise in case management and social care support, to co-create an empowered community where holistic care is delivered to enable every resident to live and age well.

## One Empowered Community of Care

PHICO's empowered Community of Care (COC) model leverages on valuable resources in the community and hospital, to form a close-knit network of domain experts comprising community partners and a multi-disciplinary team from SGH that provides the appropriate medical and allied health care advice. The COC model is supported by the A,B,C,D,E approach that is based on continuous research, innovation and education.


**Asset 3M (Map, Mine, Mobilise)**
Collaborate with community partners to Map, Mine and Mobilise valuable resources in the community, and to implement programmes that enhance the well-being of residents who are mobile and active.


**Bridging the Generations**
Collaborate with community partners to organize activities and implement befriending programmes to reach out to isolated families and home-bound residents.


**Care Integration**
Integrate social and health care services for residents in the community through combined efforts with existing partners and programmes.


**Digitalisation, Data-driven**
Use digital platforms to facilitate data sharing and effective communication of patient's care plan among various care providers.


**ESTHER Network**
A person-centered care philosophy that strongly advocates for continuous improvement of patients' care design and delivery.

**Research, Innovation & Education**

Empowering the community through stakeholders' capability building and innovation projects that are strongly driven by research and collaboration with educational institutions.

## Teams under Population Health and Integrated Care Office

### Community Integration

Community Integration (CI) is actively involved in engagement work with key stakeholders in the community, to foster a strong collaborative spirit among community partners and SGH staff. CI also manages preventive health events and programmes such as Community Health Screening, Community Health Post and Geriatric Services Hub. On 1 January 2020, the team took over management and operational duties of Tiong Bahru Community Health Centre, which is an integrated care hub where health advice and screening for diabetes-related complications are available to the public.

Besides the team's involvement in up-stream intervention work, they also manage the ESTHER Network programme which focuses on capability building of health and social care professionals, who are transformed to become strong advocates for patient-centric care design and delivery. The team is currently exploring possible collaboration opportunities with interested parties to spearhead innovation projects in the community.

### SGH Community Nursing

Funded by the Ministry of Health (MOH), SingHealth Community Nursing Programme is a key anchor for population health management and an enabler for person-centred care beyond hospital to the community.

On 28 February 2018, the SGH Community Nursing Programme was implemented as part of existing efforts by SingHealth Office of Regional Health (SORH) to strengthen community care across the five COC zones: Bukit Merah, Chinatown, Telok Blangah, Tiong Bahru and Katong. Currently, SGH Community Nursing comprises 37 Community Nurses, stationed at 27 Community Nurse Posts (CNP), and three Community Care Associates (CCA). The Community Nurses provide chronic disease management services for pre-frail and frail seniors either at CNPs or the senior's home. They also conduct community outreach programmes focusing mainly on health promotion and disease prevention.

**Integrated Care Operations and Services**

Integrated Care Operations and Services team ensures seamless transition of quality care for patients discharged from the hospital to the community, through close collaboration among 66 nurses and Community Care Associates (CCAs) from the Patient Navigators team and Hospital to Home (H2H) programme.

Since 1 April 2017, the MOH-funded H2H programme plays a pivotal role in providing smooth care transition through post-discharge care assessments and delivering health advice at patients' homes over a six-month period after discharge. The programme is supported by a dedicated team of 39 nurses and five CCAs who work closely with a multi-disciplinary care team comprising doctors, therapists and social workers to formulate personalized care plans, with the aim of providing holistic patient-centric care and reducing preventable readmissions. H2H is complemented by efforts of 22 Patient Navigators working in the wards to facilitate discharge planning.

## Medical Social Services Community Care Team

In July 2018, the Medical Social Services Community Care Team (MSS CCT) was set up to strengthen interdisciplinary collaboration for care continuity, bridge service gaps between hospital and community, provide linkage between hospital and social service partners, and manage care referrals from the community. The team comprises six Medical Social Workers, one Social Work Assistant and one Executive.

MSS CCT collaborates with healthcare and community service partners to ease patients' transition from hospital to their homes as well as to meet residents' health and social needs in the community. The team aspires to influence the local health-social care landscape through strong leadership and advocacy for our population's needs.

## Clinical Networks

Clinical Networks collaborates with partners for the SingHealth Delivering on Target Primary Care Network (DOT PCN) and SingHealth Delivering On Target (DOT) programme.

DOT PCN is an island-wide collaboration with General Practitioner (GP) partners to enhance chronic disease management in the community. Through DOT PCN, GPs are better supported in providing holistic and person-centred care for patients with chronic conditions. Led by Dr Emily Ho, Director, Clinical Networks, SORH and Dr Lily Aw, Consultant Family Physician of Lily Aw Pasir Ris Family Clinic and Surgery, the SingHealth DOT PCN is the largest PCN in Singapore with a network of 121 clinics and 158 GPs.

SingHealth DOT PCN also serves as a platform to facilitate more seamless and coordinated flow of care between the tertiary centers of SGH campus and the GPs. A dedicated DOT PCN support team and primary care coordinators from Clinical Networks work closely together with GPs and ancillary service providers to facilitate tracking and better coordinated patient care.

SingHealth Delivering on Target (DOT) programme right-sites patients with stable chronic conditions from the Specialist Outpatient Clinic at SGH and National Heart Centre Singapore to partner DOT GPs.

## Fostering Community Spirit and Strengthening Ties

*By Community Integration*

2019 had been a fruitful year for CI as the team forged new partnerships and strengthened existing friendships with key community stakeholders. The past year had begun with a Chinese New Year celebration with 58 community partners at the "Stronger Together" CEO Brunch event. The session was a great opportunity for partners to share their views on the current state of collaboration and identify key areas to focus on in the next three years. To further address the feedback received, small-scale engagement events were organized in the different COC zones, for partners in the same kampong to share updates on various programmes and deepen discussion about common challenges faced.

On 6 December 2019, PHICO held its inaugural work plan retreat, where community partners were invited to present and co-facilitate meaningful discussions that generated fresh ideas on health and social care integration to build one empowered community.

*"Stronger Together" CEO Brunch & Chinese New Year Celebration in January 2019*

*Population Health Integrated Care Office (PHICO) Retreat in December 2019*

*Bukit Merah & Telok Blangah CoC Get-Together in August 2019*


*Tiong Bahru & Chinatown CoC Get-Together in October 2019*


Aside from engagement events, CI also organized a series of community events for residents including Community Health Talk, Community Health Workshop, Community Health Post, Community Health Screening and combined events with Functional screening. The team partners with internal and external stakeholders such as Agency for Integrated Care, SGH Community Nursing, National Dental Centre Singapore, People's Association, Health Promotion Board, Volunteer Welfare Organisations, religious institutions, faith-based organisations and Grassroots to organize these events.


*Combined Community Health Screening at Leng Kee Community Club*

*Community Health Post at Katong Community Centre*

CI is heartened to receive community partners' strong support over the years. The team greatly appreciates every partner's active participation and valuable inputs thus far. In the new year, CI continues to look forward to more exciting collaboration opportunities for betterment of the community.

***For enquiries on collaboration opportunities, please write to community.integration@sgh.com.sg***

## ESTHER Network Singapore: Driving Excellence through Person-centered Care

*By Community Integration*

ESTHER Network advocates a philosophy of person-centred care that seeks to answer the question: 'What matters to Esther (pseudonym for patient and caregiver)?'.

*ESTHER Network Ambassador, Mdm Teo with her husband, Mr Chang*

*"Our vision is to develop a responsive and robust network committed to person-centric improvement in care delivery so that Esther can live confidently and independently in the community."*

ESTHER Network partners health and social care providers to deliver meaningful care that meet patients' recovery goals. To achieve this, the programme identifies and administers person-centred measurements such as increasing a patient's confidence in providing self-care or improving functional abilities to meet life goals such as gaining employment, regaining the ability to shop for groceries and cook for the family.

The programme comprises a series of training workshops and events such as ESTHER Festival and ESTHER Café.

ESTHER Coach Workshops encourage participants to adopt a dialogue-based and goal-focused approach when designing and delivering care for patients. At the end of the workshop, each participant is expected to work in a team to develop a person-centred quality improvement project with the participant's department head as one of the project sponsors. This improvement project will last six to nine months after the workshop. Participants who complete their projects will become ESTHER Coaches. ESTHER Network has trained 192 ESTHER Coaches and facilitated the development and completion of 62 person-centred improvement initiatives. The upcoming ESTHER Coach Workshop will be in May-June 2020.

The programme will culminate with the annual ESTHER Festival event where improvement projects are showcased using posters at a cluster-level, multi-agency platform where selected teams are given the opportunity to make presentations. Themed "Making Esthers Stronger in the Community", ESTHER Festival recognizes the hard work of newly-trained ESTHER Coaches towards person-centric care in the past year. The event will also feature person-centric initiatives inspired by sharing during ESTHER Café - a platform for service providers to hear about Esthers' stories and empathise with their experiences. Through Esthers' heartfelt and candid sharing, ESTHER Café hopes that service providers will be sensitised to Esthers' challenges and appreciate their strengths and resilience. Through such engagement, service providers are spurred to challenge status quo and work on enhancing person-centric care. The goal is to create concrete improvement that leads to improved care and outcomes for Esthers.

## ESTHER Coach Workshop 2019

A total of 51 participants comprising healthcare professionals from SGH, Changi General Hospital, Tan Tock Seng Hospital and Social Workers from various Volunteer Welfare Organisations, participated in ESTHER Coach Workshop 2019. The new batch of coaches worked on different patient improvement projects in teams until their graduation ceremony which will be held during the next ESTHER Festival.


*2019 ESTHER Coaches*

*ESTHER Coach Workshop 2019*

## ESTHER Festival 2019

51 ESTHER Coaches from the Class of 2018-2019 graduated during ESTHER Festival 2019 at Radin Mas Community Centre on 1 March 2019. The event was attended by 160 participants (including Esthers) during which, 19 improvement projects were completed. The new batch of ESTHER Coaches presented their projects and Esthers also openly shared about their personal experiences during the event.

*ESTHER Network Champions with Esthers during an inaugural Mandarin Esther Cafe*

*Jessie (an Esther) shared her experiences as a caregiver to her son who suffers from spastic quadriplegia*

***For enquiries on collaboration opportunities, please write to esther.network@singhealth.com.sg***

## Seamless Transition of Care from Hospital to Community

*By SGH Community Nursing and Integrated Care Operations and Services*

### SGH Community Nursing Programme

Since its beginning, SGH Community Nursing programme has benefitted 5,394 residents in total by providing a wide range of services that focus on chronic disease monitoring and prevention through nurse consultations. The programme accepts suitable walk-in residents at Community Nurse Posts (CNPs) as well as referrals from healthcare and social service providers. In addition to running the CNPs, community nurses also conduct home visits for home-bound residents, and joint visits with community partners for residents with complex issues.


*Community Nursing Services*

Community nurses also conduct outreach programmes that focus on health promotion and disease prevention through individual and group health coaching. In 2019, 253 Group Health Talks and 26 Community Falls Prevention Programme were organised. The Falls Prevention Programme aims to identify pre-frail seniors with high fall risk through comprehensive screening before educating them on cost-effective fall-prevention measures and helping them to regain confidence in performing daily tasks.


*Community Nursing Outreach Programmes*

Moving forward, SGH Community Nursing team will continue to work closely with community partners for capability building, collaboration on outreach events and shared care management to enhance care and services for residents in the community.

***For enquiries on SGH Community Nursing Programme and collaboration opportunities, please write to community.nurse@sgh.com.sg, call 9771 8842 or visit www.sgh.com.sg/community-nurse***

**SGH Patient Navigators & Hospital to Home Programme**

In the past year, the Integrated Care Operations and Services team worked closely with internal and external partners on several quality improvement projects.

In May 2018, the Long Stayer Focus Team and Community Hospital and Hospice Referral Team (CHRT) were formed to review patient stays and referrals so as to ensure compatibility between patients' needs and services provided by referred partners. This helps to reduce hospital length of stay and waiting time for transfers. Since 2018, the CHRT team has collaborated with six Community Hospitals, which makes up more than 96% of all referrals from SGH.

In January 2019, Hospital to Home (H2H) programme collaborated with Jaga Me Home Care, which allowed 162 patients with stable conditions living outside the SGH care boundaries, to be referred to Jaga Me for post-discharge continuity of care. This collaboration was presented at the 2019 Innovation and Quality Circles event and was awarded the prestigious Star Award.

In August 2019, H2H also successfully collaborated with the Orthopedic Department and Physiotherapy department to roll out bundled care service for Total Knee Replacement. Comprising surgery, one-day hospital stay and two post-discharge home visits by physiotherapist and nurse, the bundle has since been piloted on 44 private patients who have all recovered with no hospital readmission within 30 days of discharge, which is the critical period with the highest readmission risk.

H2H nurses also work closely with Tri-Gen, a volunteer group comprising students from Medicine, Nursing, Social Work and Occupational Therapy, to provide social and befriending support for seniors while nurturing the next generation of healthcare professionals with valuable skills that go beyond their medical expertise.

H2H nurses work to cultivate a stronger patient-centric care culture among nursing and medical professionals. In 2019, more than 150 doctors and nurses-in-training from National University of Singapore (NUS), Duke-NUS, Nanyang Polytechnic and Ngee Ann Polytechnic have been attached to H2H nurses for exposure to transitional and community-based care. Between December 2018 and May 2019, H2H also collaborated with Duke-NUS researchers for nurses' training in patient engagement and motivational interview skills.

*H2H nurse with patient during home visit*

The nurses' hard work and dedication in serving SGH patients had been commended and featured in the media. On 1 August 2019, H2H was featured in Lianhe Zaobao for a special visit made by patients and their caregivers to the Istana to meet President Halimah Yacob.

In the new year, the Integrated Care Operations and Services team wants to strengthen connections and work closely with community partners on continuous innovation and improvement.

*Duke-NUS visit to Chin Swee*

*Ensuring quality patient-centric care through personalized care plans*

***For enquiries on collaboration opportunities, please call 6326 6100***

## Care Collaboration in the Community

*By Medical Social Services Community Care Team*

In July 2018, the Medical Social Services Community Care Team (MSS CCT) was set up to support care continuity and population health by extending its clinical services to the community, and establishing partnerships with key stakeholders to meet the psychosocial needs of residents living in the five COC zones.

MSS CCT serves residents through home-based assessments, case management, consultations with community service providers and interdisciplinary teams as well as talks and trainings.


MSS CCT serves as a conduit between hospital and community as such the team works closely with Social Service Agencies for patients' care continuity in the community. Partners have found care collaboration with the team to be helpful for patients with psychosocial issues and complex needs.

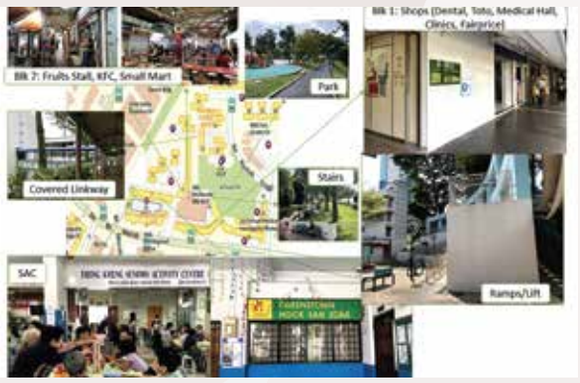
To foster strong relationships and promote capability building with partners, MSS CCT has participated and hosted a few cross attachments to better understand how each partner agency works so as to streamline current work processes. The team was also invited to speak and train in several specialty areas, namely psychosocial typology of illness, healthcare financing and navigating resources, overview of hospital-based social work and treatment adherence.

*Cross attachment with CGH Neighbour's programme*

*Training on financial resources at SouthCentral Community Family Service Center*

MSS CCT also conducts regular community walks to map assets, evaluate strengths, and seek opportunities in the community to meet residents' needs. Between September and December 2019, a department community walk was organised to expose staff to community-based assessments and allow them to reflect on the relationship between residents' health and their surrounding environment in the community.

*Interacting with Tung Ling Community Services during community walk*




*Sample of community walk photo-documentation*

Moving ahead, MSS CCT is interested to understand more about the community and its culture in identified areas through research and partnerships with key agencies, so as to support lower income families and other vulnerable groups. The team is also interested to work with community partners on various care models and to devise solutions that complement the overburdened Medical Escort and Transport Services. Last but not least, MSS CCT will continue to develop community-based programmes and services to foster a strong community spirit among residents and key stakeholders.

***For enquiries on collaboration opportunities, please write to sherylene.heah.g.s@sgh.com.sg and christine.hindarto.lim@sgh.com.sg***

## Congratulatory Note to A/Prof Low Lian Leng

We are delighted to announce that Dr. Low Lian Leng had been appointed the title of Adjunct Associate Professor (A/Prof) in Duke-NUS Medical School with effect from 1 January 2020.

A/Prof Low is a man of many hats. He has made extensive contributions in the areas of research, clinical, administrative and educational work. Besides his administrative roles as the Director of PHICO and the Director of SORH for the SGH Campus, he is also a consultant in the Department of Family Medicine and Continuing Care at SGH. Furthermore, he was appointed Head of the medical team in the newly-opened Outram Community Hospital since 1 July 2019.

A/Prof Low is also passionate for research work. As the Director of Health Services and Outcomes research for the SingHealth Duke-NUS Family Medicine Academic Clinical Programme, he is deeply interested in health services research, especially in the areas of population health, innovative integrated care delivery models, value-based care and data analytics. He is also the core lead of the Data Analytics platform in the SingHealth PULSES Centre grant.

Last but not least, A/Prof Low is also an avid educator where he mentors third year Duke-NUS medical students and family medicine residents and fellows for their research projects.

Please join us in our heartfelt congratulations to A/Prof Low for his appointment and let us continue to lend him our unwavering support as we forge ahead on this exciting journey as one.

## We want to hear from you!

As PHICO Community Highlights is an annual newsletter to commemorate achievements and showcase innovative initiatives for the betterment of our empowered community, we would like to hear from you too!

If you would like to be featured in the next issue of the newsletter, please write to
***community.integration@sgh.com.sg***

Please note that materials for publishing will ultimately be decided by the editor and management team of PHICO.

**PHICO** Community Highlights

PATIENTS. AT THE HEART OF ALL WE DO.®