# CENTRE FOR HEALTHCARE INNOVATION

#### CHI Learning & Development (CHILD) System

#### **Project Title**

Increasing Screening and Vaccination Uptake Through Care Connectors

#### **Project Lead and Members**

Project lead: Poh Sijie

Project members: Lee Hee Hoon, Carol Leung, Jesslyn Chong, Katherine Tan,

Sim Ling Ling, & Alvin Lee

#### Organisation(s) Involved

Ng Teng Fong General Hospital

#### **Healthcare Family Group Involved in this Project**

Allied Health

#### **Applicable Specialty or Discipline**

**Community Operations** 

#### **Aims**

We aimed to improve participants' screening and vaccination uptake rates to at least 10% above corresponding national uptake rates or baseline# within 1.5 years\* from enrolment into My Health Map.

#### **Background**

See poster appended/below

#### Methods

See poster appended/below

#### Results

See poster appended/ below



**Lessons Learnt** 

We have learnt that Care Connectors (lay health advocates) as an enabler for better

Bukit Batok health can be effective. During our work in Bukit Batok, we have also

experienced the need for further synchronisation of direction and interventions with

other key players as there may be duplication of interventions and overservicing. More

multilateral communication across partners will aid in our attempt to synchronise our

efforts in Bukit Batok.

Conclusion

See poster appended/below

**Project Category** 

Care & Process Redesign, Access to Care, Quality Improvement

Care Continuum, Preventive Care, Health Promotion, Community Health

Workforce Transformation, Informal Workforce Transformation

**Keywords** 

Screening for Chronic Disease Risk, Influenza Vaccinations, Pneumococcal Vaccinations,

Community Screening, Lay Health Advocates, National Screening Uptake Rate

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# INCREASING SCREENING AND VACCINATION UPTAKE THROUGH CARE CONNECTORS

MEMBERS: LEE HEE HOON, CAROL LEUNG, JESSLYN CHONG, POH SIJIE, KATHERINE TAN, SIM LING LING, & ALVIN LEE

# SAFETY QUALITY PATIENT EXPERIENCE

# ✓ PRODUCTIVITY □ COST

# Define Problem, Set Aim

#### Opportunity for Improvement

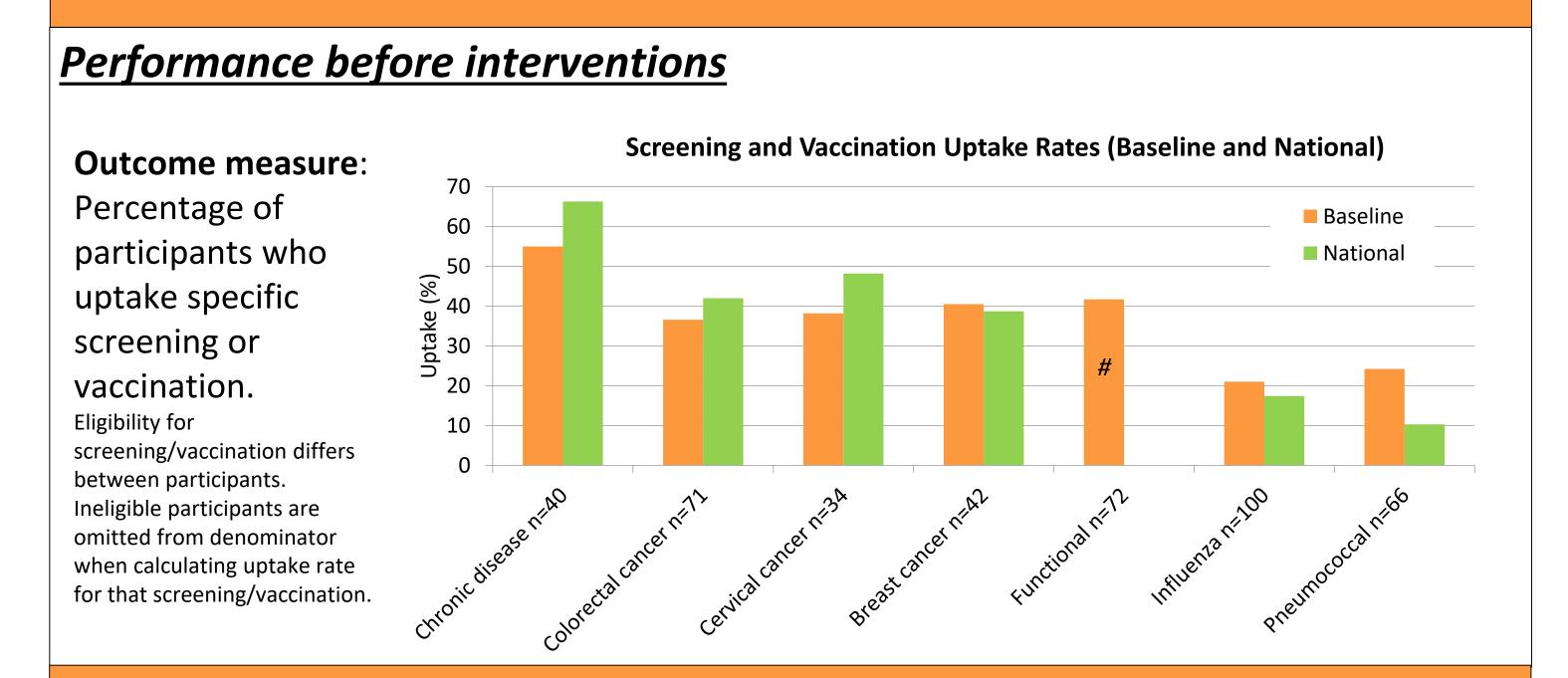
My Health Map is a NUHS initiative which aims to enable a healthier Bukit Batok by promoting health among Bukit Batok residents and anchoring their care in the community. 101 participants recruited from 2019 through Care Connectors under My Health Map were found to have screening (chronic disease, colorectal cancer, cervical cancer, breast cancer, and functional) and vaccination (influenza and pneumococcal) uptake rates of around 21-55% at baseline (uptake rates recorded at enrolment). The uptake rates were near to or below national uptake rates of 10-66% found by the National Population Health Survey (NPHS) 2019 conducted in 2018-2019. We wanted to improve uptake rates in our participants as screenings and vaccinations may reduce disease risk and associated healthcare costs.

#### Aim

We aimed to improve participants' screening and vaccination uptake rates to at least 10% above corresponding national uptake rates or baseline# within 1.5 years\* from enrolment into My Health Map.

#improve at least 10% above baseline for components not reported in NHPS 2019 (functional screening) or with national uptake rates below baseline (influenza and pneumococcal vaccinations)
\*extended from a year due to COVID-19

# Establish Measures



# Analyse Problem

### Process before intervention

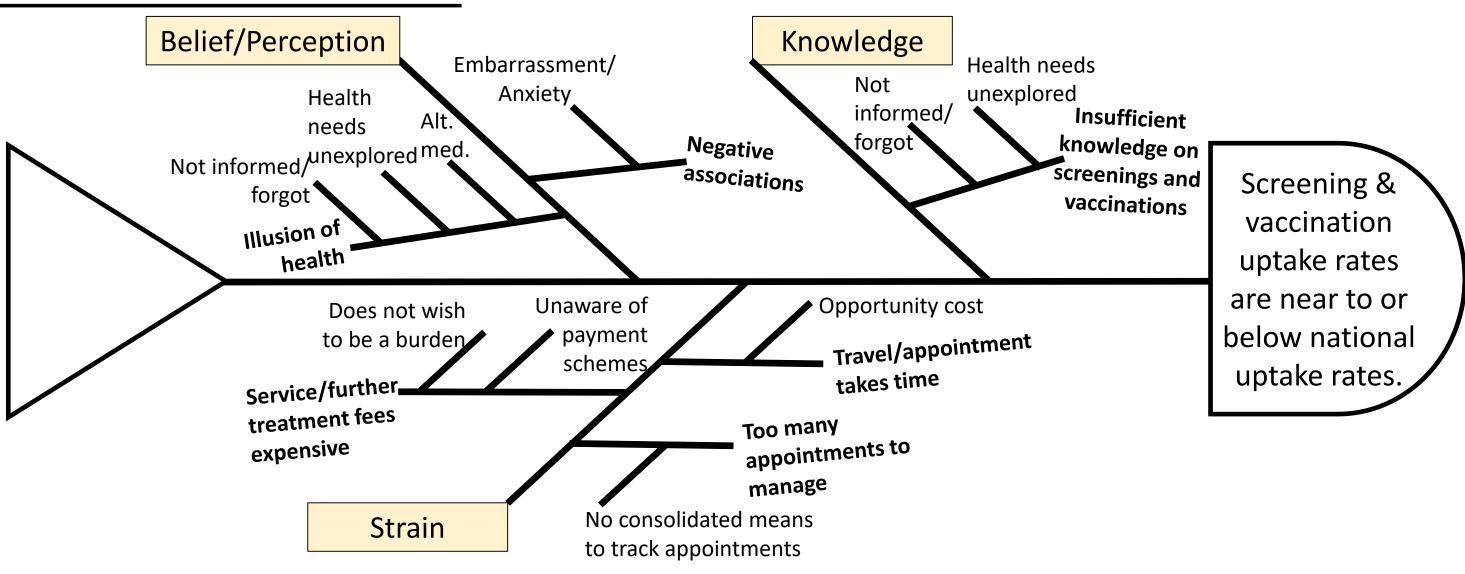
Resident
experiences or may
be unaware of a
health need

Resident may not know what resources to utilise or remains unaware of need

Resident does not receive appropriate help

Resident's need is unaddressed and may lead to decline in health and quality of life

# Probable root causes



# Select Changes

#### Probable solutions **Potential Solutions Root Cause** Care Connector (CC) shares consequences of Not informed/ not going for screenings and vaccinations forgot CC links resident to health talks **Do Last** Do First Participant visits doctor for health consultation to explore health needs Health needs unexplored CC explores health needs through conversations and based on checklist CC assures and explains about screening and **Never Do Do Next** Embarrassment/ vaccination Anxiety Sharing of screening and vaccination experience by peers Hard Easy CC helps to make screening and vaccination No consolidated **Implementation** appointment and reminds participant to means to track attend appointment

# Test & Implement Changes

## Results of piloting changes

	PLAN	DO		STUDY		ACT	
participal vaccinational least 10% national baseline from enring Health M We equipaged with known and vacce establish communicas we recand trust	ed to improve ints' screening and ion uptake rates to at above corresponding uptake rates or within 1.5 years* folment into My lap.  Toped Care Connectors whedge on screening ination and led workflows to guide dication with residents cognise that rapport is crucial to bring lange over time.	as planned.  Participants for Connector Programmed beneficial as it and created award Participants also desire to improve were motivated.	gramme to be was informative vareness. To expressed a	Screening and vacuptake rates were increase to at least national uptake or rates at the post to with the exception cancer screening (2.3%).	found to t 10% above baseline me point, of cervical	advocates) improving s vaccination healthier But This strateg for the next opportuniti will be explosuccessful a	y will be adopted cycle. More es for telehealth ored in view of adaptation to e.g., use of virtual
80	Pre-Post My Health Map Screening and Vaccination Uptake Rates 77.5						
						71	<ul><li>Chronic disease</li><li>Colorectal cance</li></ul>
70 -						70.8	Cervical cancer
						64.8	→ Breast cancer
60						59.5	→ Functional → Influenza
						55.9	Pneumococcal
(8)		55				33.3	Goal (Achieved)
50 -							<ul><li>Goal (Missed)</li></ul>
© Drake (%)						47	
		41.7					
40 -		40.5					
		38.2 36.6					
30 -							
		24.2					
20		21					
	lood	Pre				Post	
	Jun 2019	iest June 2019)	Aug 2019			Aarch 2021)	
	CC built rapport with p	participant and	Aug 2019 CC explored health	needs based on	Sustained engored CC continued	engaging part	cicipants to
	explored health needs	•	checklist develope			d motivate the	-
	conversations. CC share		· '	g and vaccinations	•	an influenza v	
	consequences of not g	•	•	o expressed doubts.	pilot to motiv	ate participan	

# Spread Changes, Learning Points

CC also helped to make appointments

and reminded participant to attend

screening and vaccinations booked.

subsidised flu shots in Oct 2020. This

national enhancement of subsidies for

pilot has been phased out with the

vaccinations under NAIS.

## Spread Change

screenings and vaccinations and linked

participants to health talks.

We intend to spread the model to other Bukit Batok programmes, Active Ageing/Senior Activity Centres, and Bukit Batok Primary Care Network to anchor health in the community. We will facilitate this spread by sharing our learnings and caring for residents together with partners through My Health Map.

#### **Learning Points**

We have learnt that Care Connectors (lay health advocates) as an enabler for better Bukit Batok health can be effective. During our work in Bukit Batok, we have also experienced the need for further synchronisation of direction and interventions with other key players as there may be duplication of interventions and overservicing. More multilateral communication across partners will aid in our attempt to synchronise our efforts in Bukit Batok.



