

## **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

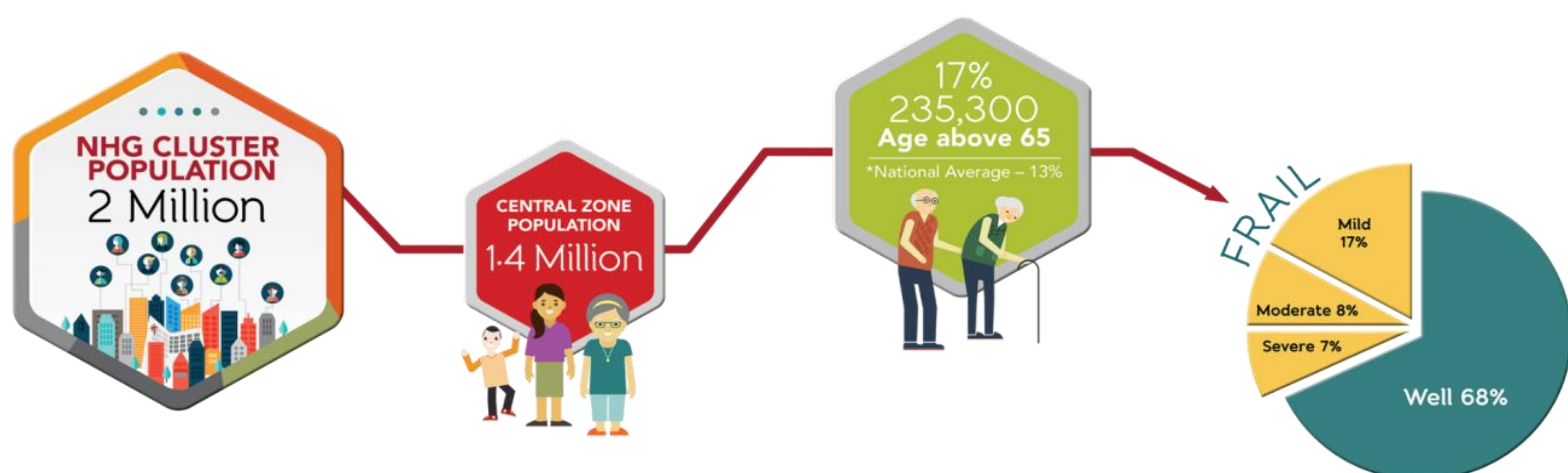
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## BACKGROUND

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".

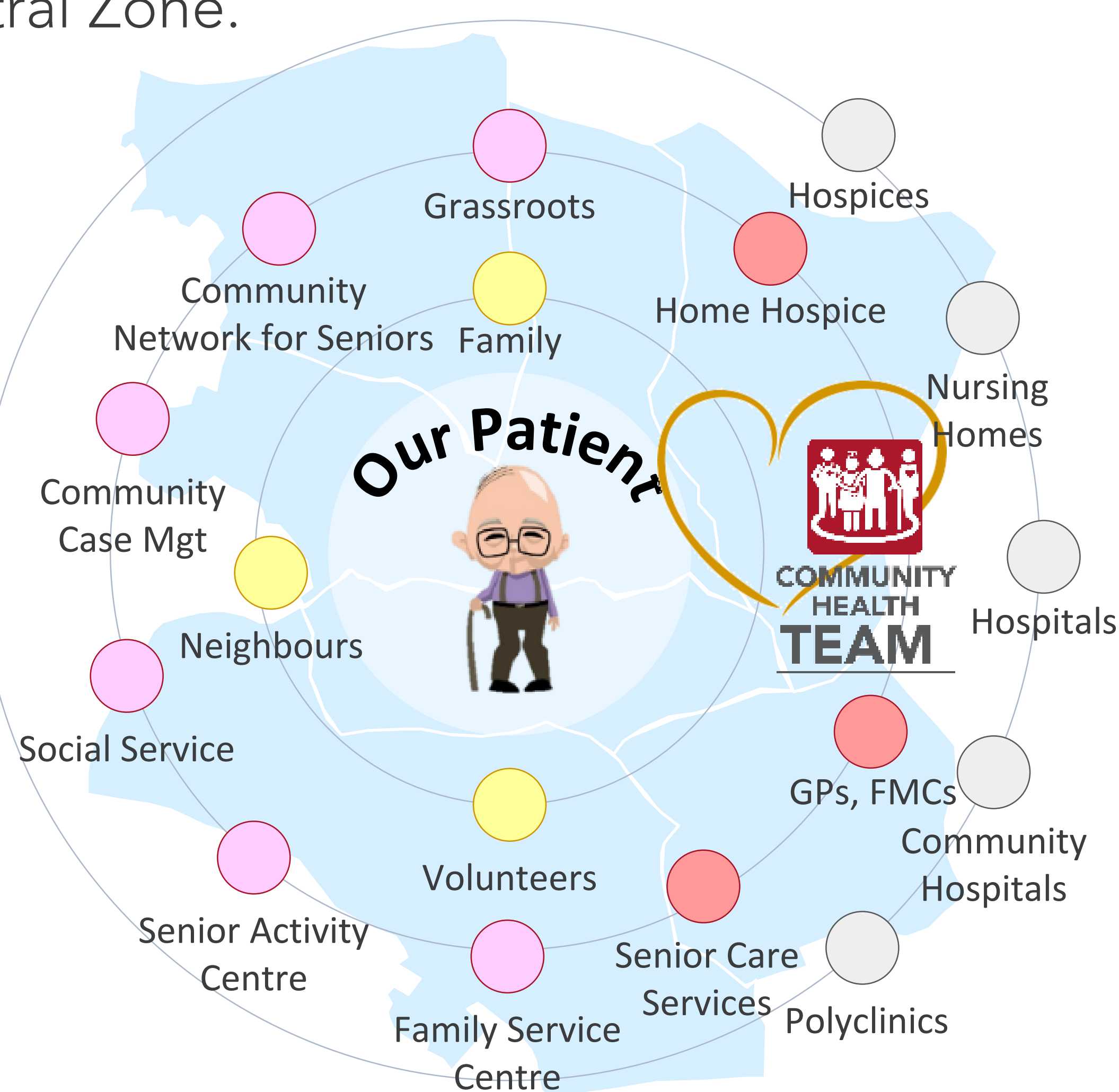


## INITIAL STATE

- 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.

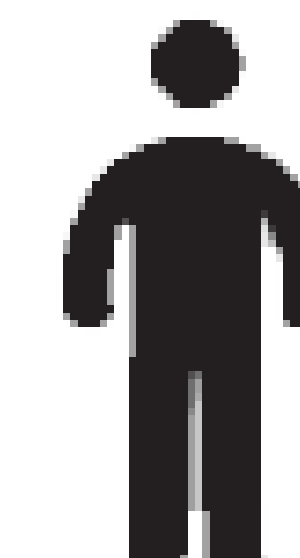
## Team Focus

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

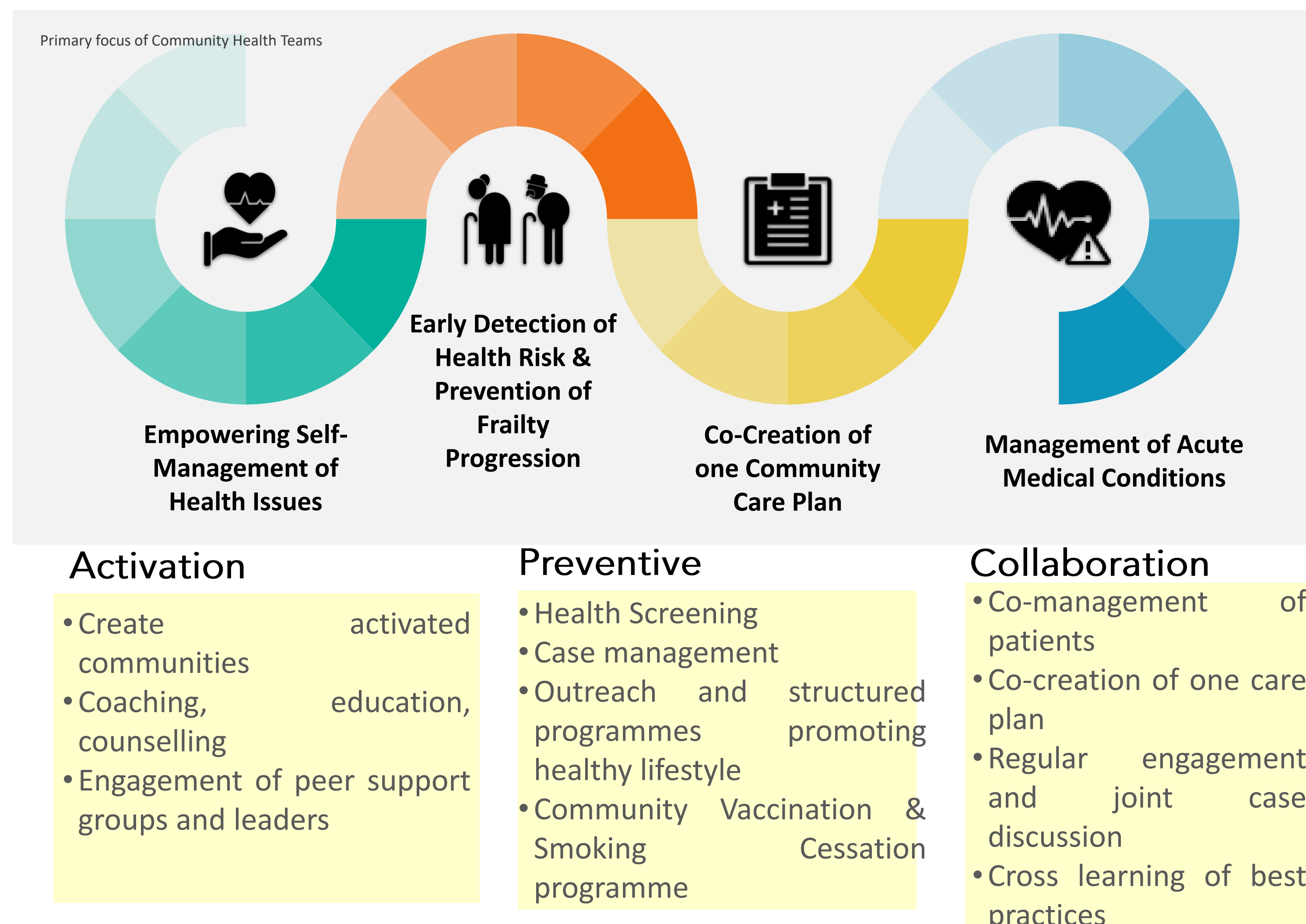
Dynamic nature of frailty which needs a "whole of community" to manage



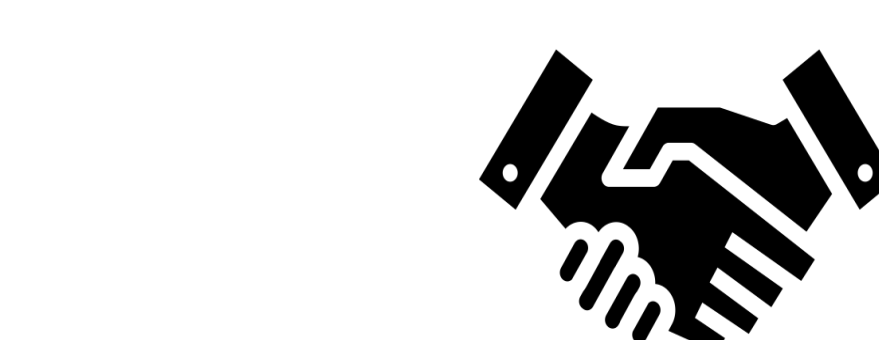
### Least Healthy

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

The team aims to address the needs through:

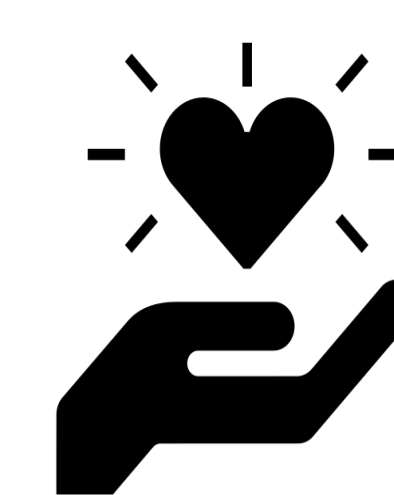


## OUTCOMES



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



Sustainable engagement with staff.

Scoring **87** (of 100) in

Employee Climate Survey  
**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.