Tan Tock Seng HOSPITAL
National Healthcare Group

TTSH CELEBRATES 175 YEARS OF CARE

Transforming Healthcare for the Central Health Population

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Division For Central Health TTSH & Central Health
15 October 2019

Content

- General background
- The Central Health Model of Care
- 4 Principles & 6 Strategies
- Insights from our journey

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Singapore Healthcare – Longer life expectancy but also a rise in number of unhealthy years

Life expectancy and healthy years

Life expectancy (2017)

Male	Years	Female	Years
Switzerland	82.12	**Singapore**	**87.55**
Singapore	**81.94**	Japan	87.21
Israel	81.28	Hong Kong	86.11
Hong Kong	81.15	Iceland	85.94
Japan	81.08	Spain	85.83

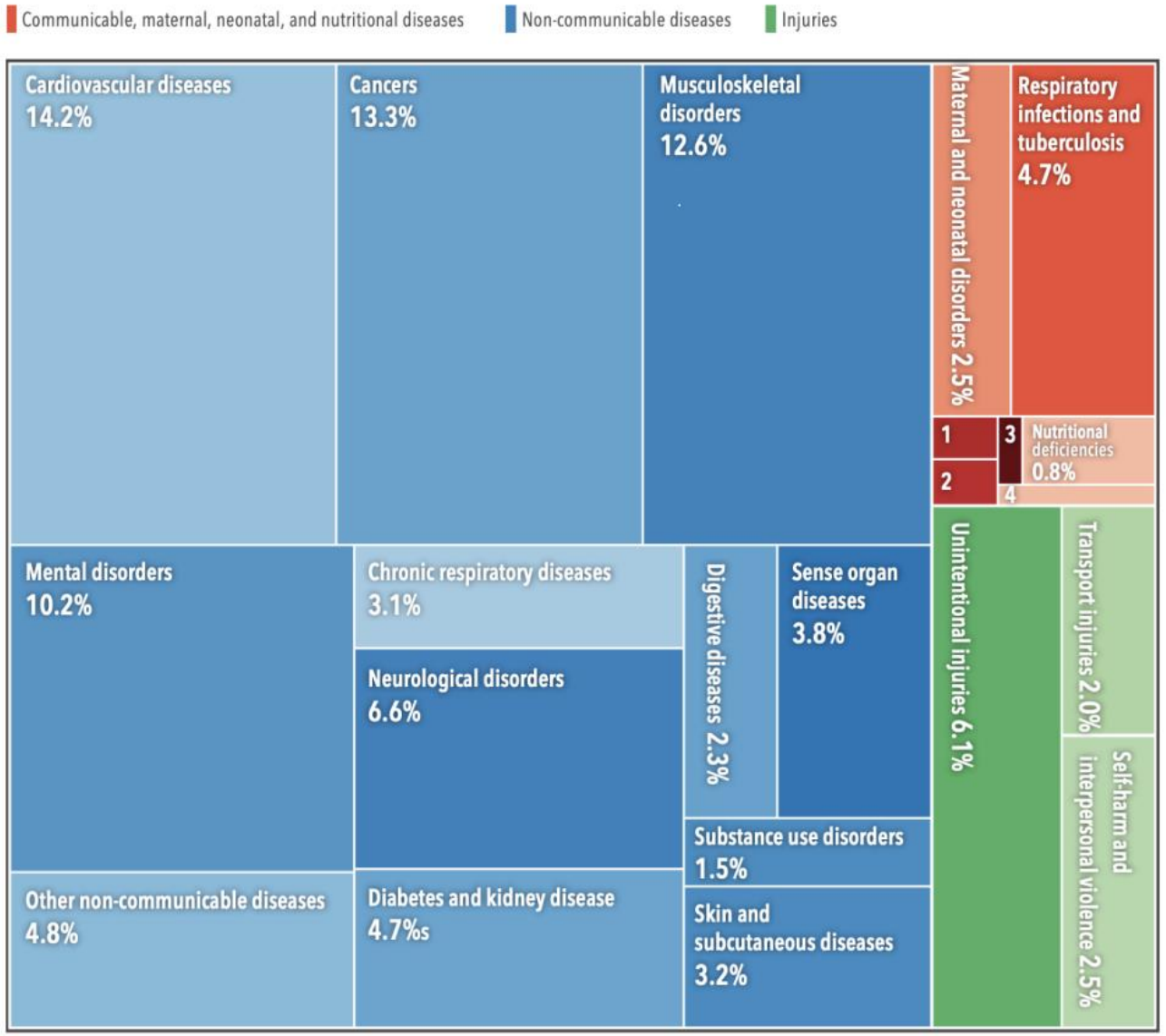
Years lived in good health (2017)

Male	Years	Female	Years
Singapore	**72.58**	**Singapore**	**75.81**
Hong Kong	72.34	Hong Kong	75.01
Japan	71.41	Japan	74.65
Switzerland	71.19	Spain	73.62
Italy	70.63	South Korea	73.45

Changes to Singaporeans' life expectancies

Source: THE BURDEN OF DISEASE IN SINGAPORE, 1990-2017
STRAITS TIMES GRAPHICS

Distribution of disease burden by cause in Singapore, 2017



Source: The Burden of Disease in Singapore, 1990 – 2017

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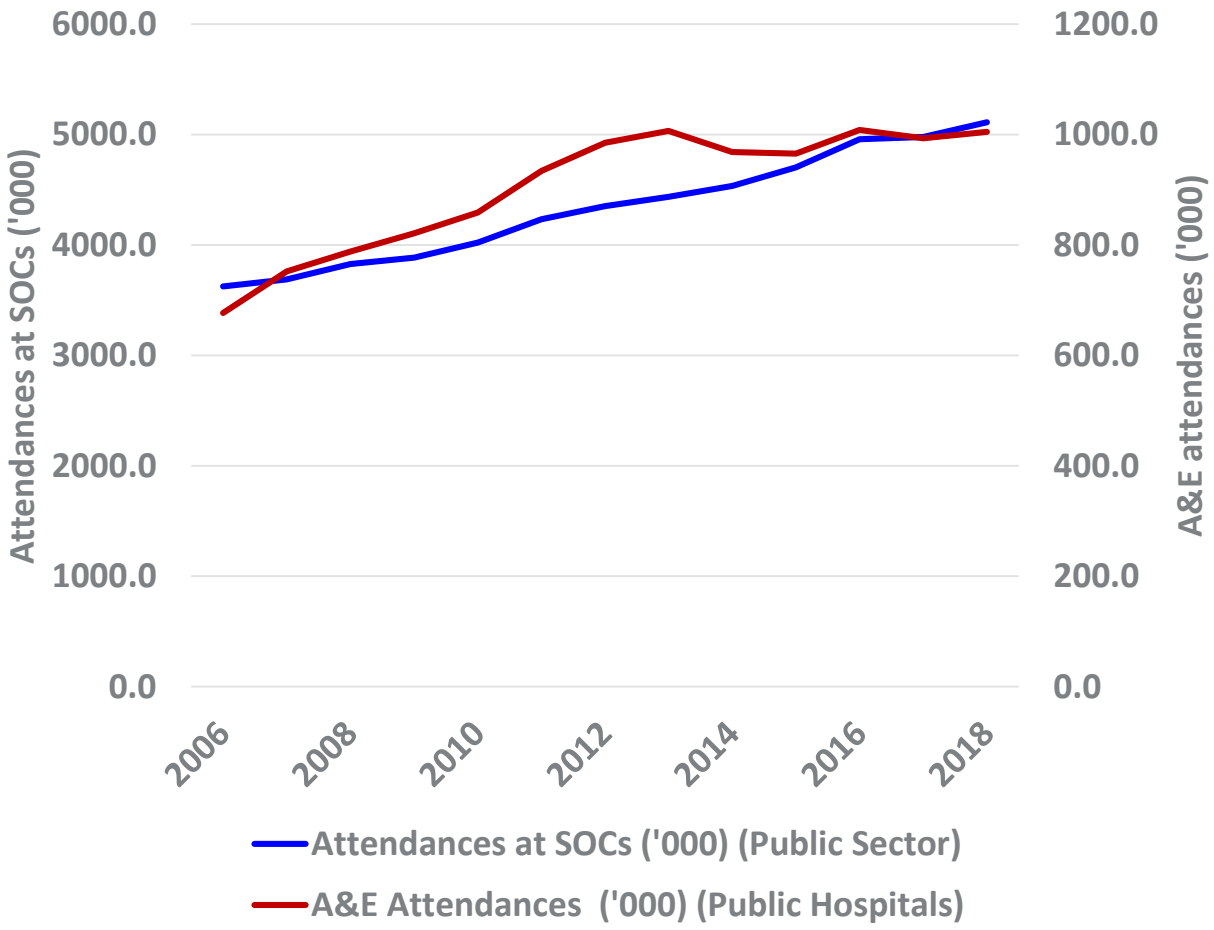
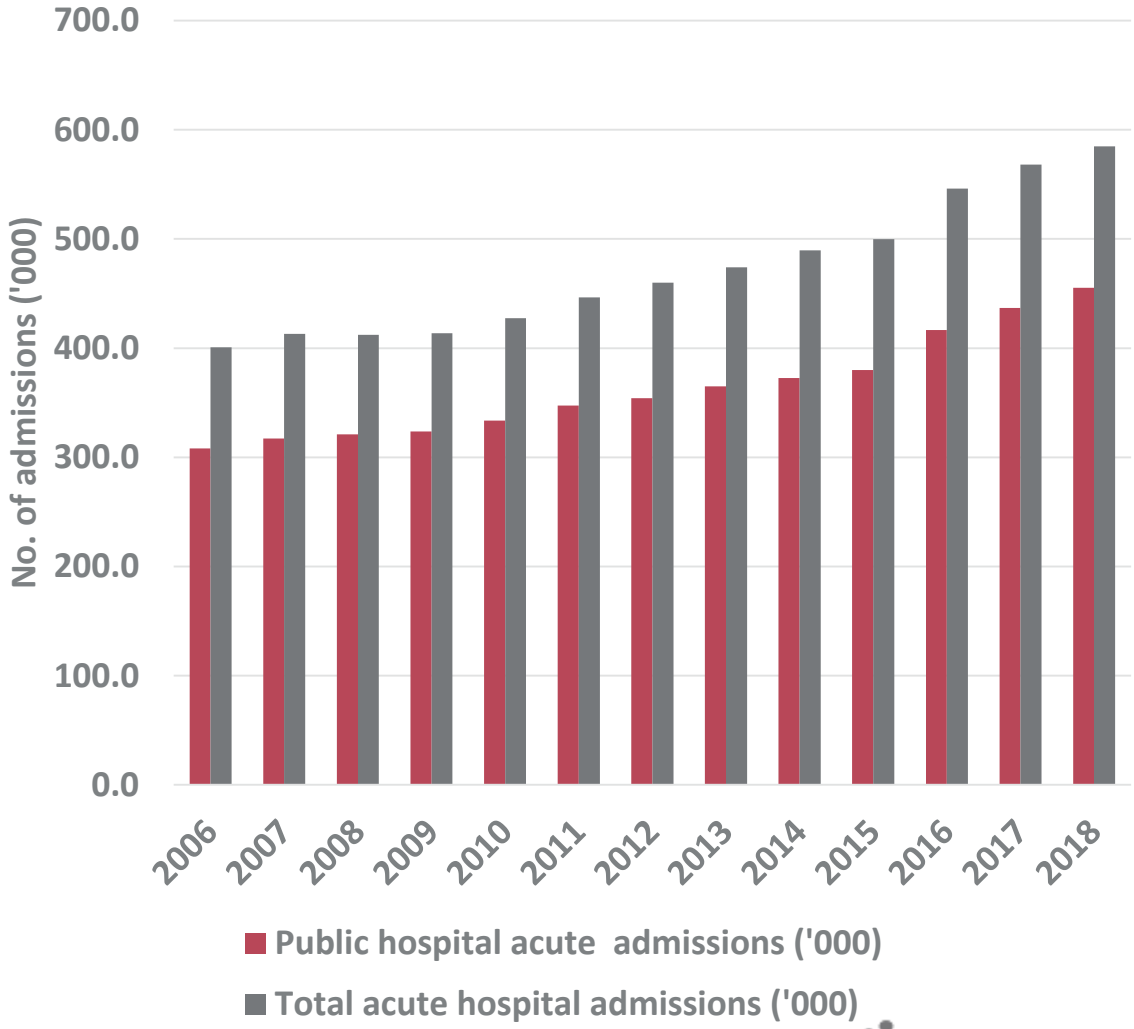
Attendances at public hospital accident & emergency (A&E) department & public sector specialist outpatient clinics (SOC), 2006 - 2018



No. of acute hospital admissions in Singapore, 2006-2018



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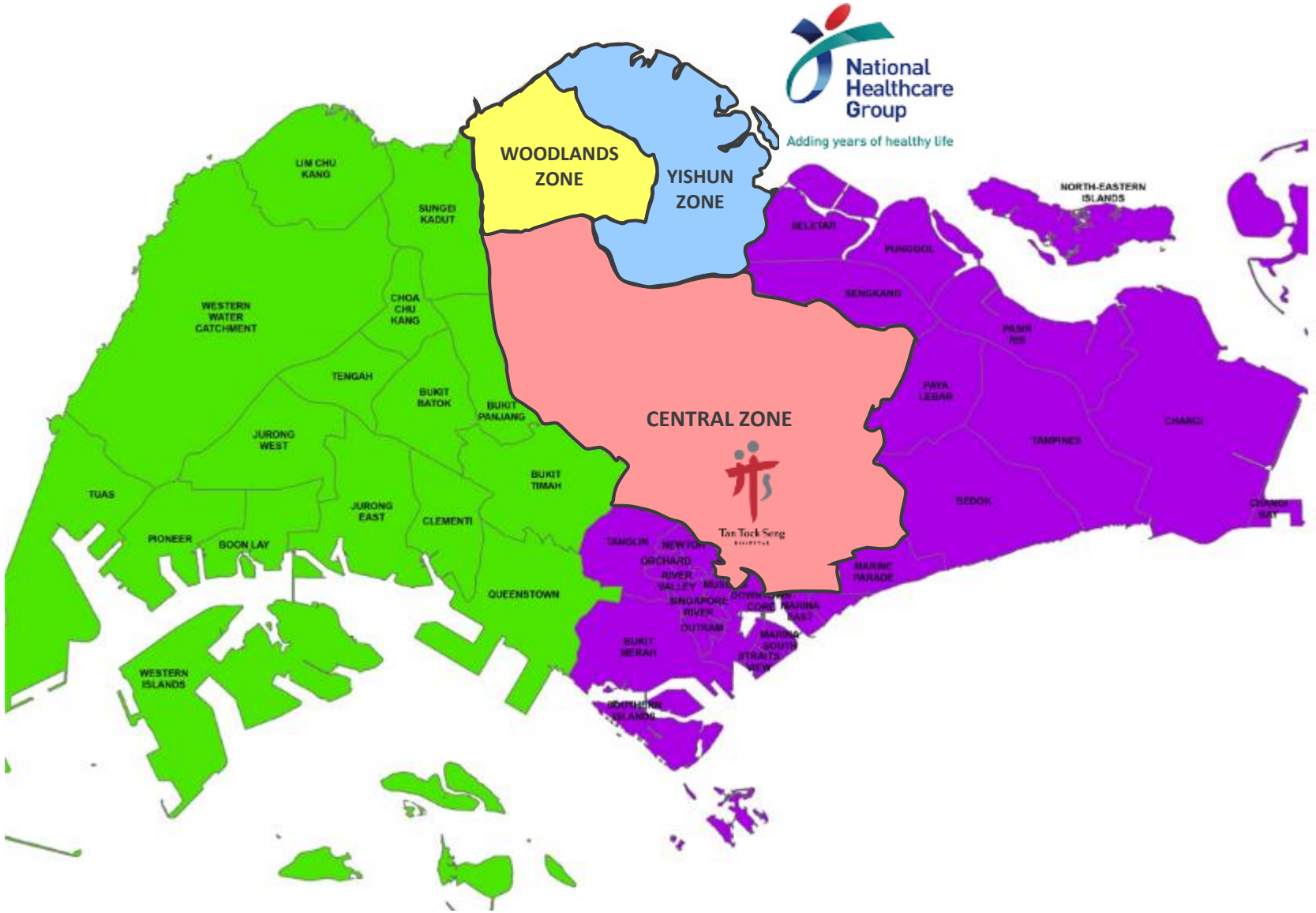
Source: MOH. Admission & Outpatient attendances

NHG RHS AND 3 POPULATION ZONES



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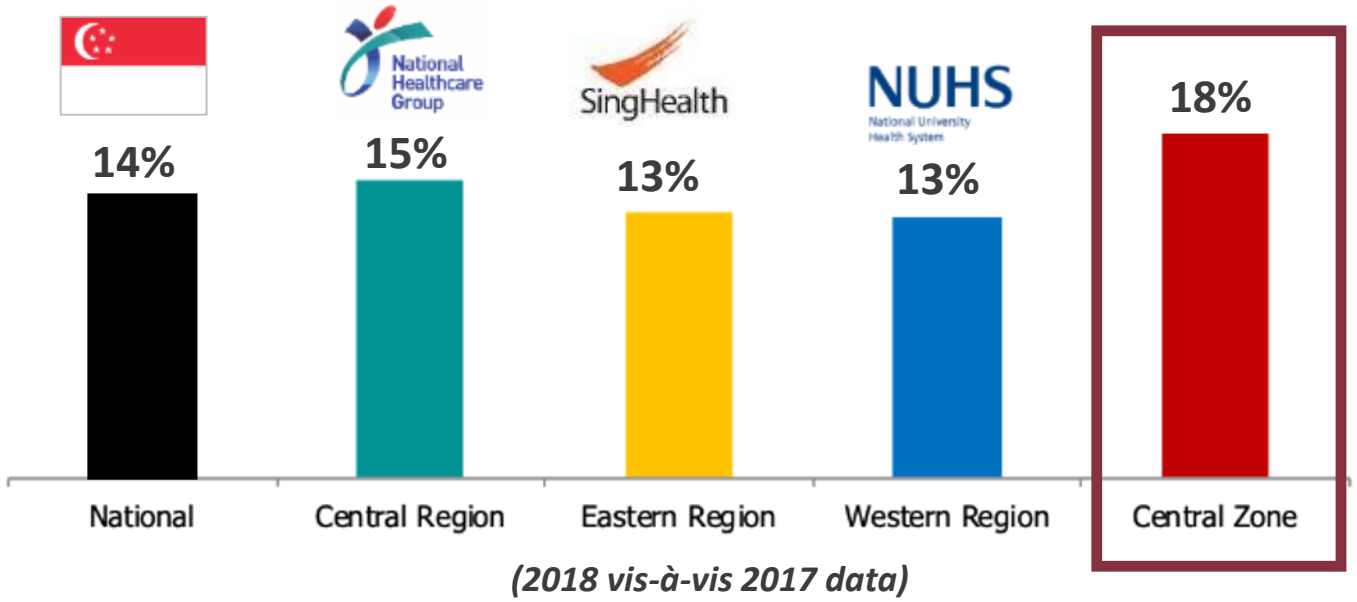
Source: NHG Townhall 21-22 July 2017

THE CENTRAL POPULATION WE SERVE

Makes up **25%** of Singapore's Population

Zone with the **Highest** Proportion of Residents **Aged ≥65***^



(2018 vis-à-vis 2017 data)

1 IN 3 Central Zone Elderly lives with Frailty#

*Singapore Department of Statistics, Population Trends, June 2018
^Statistics are compared again June 2017 data from Singapore Department of Statistics, Population Trends
Population Health Index 2016

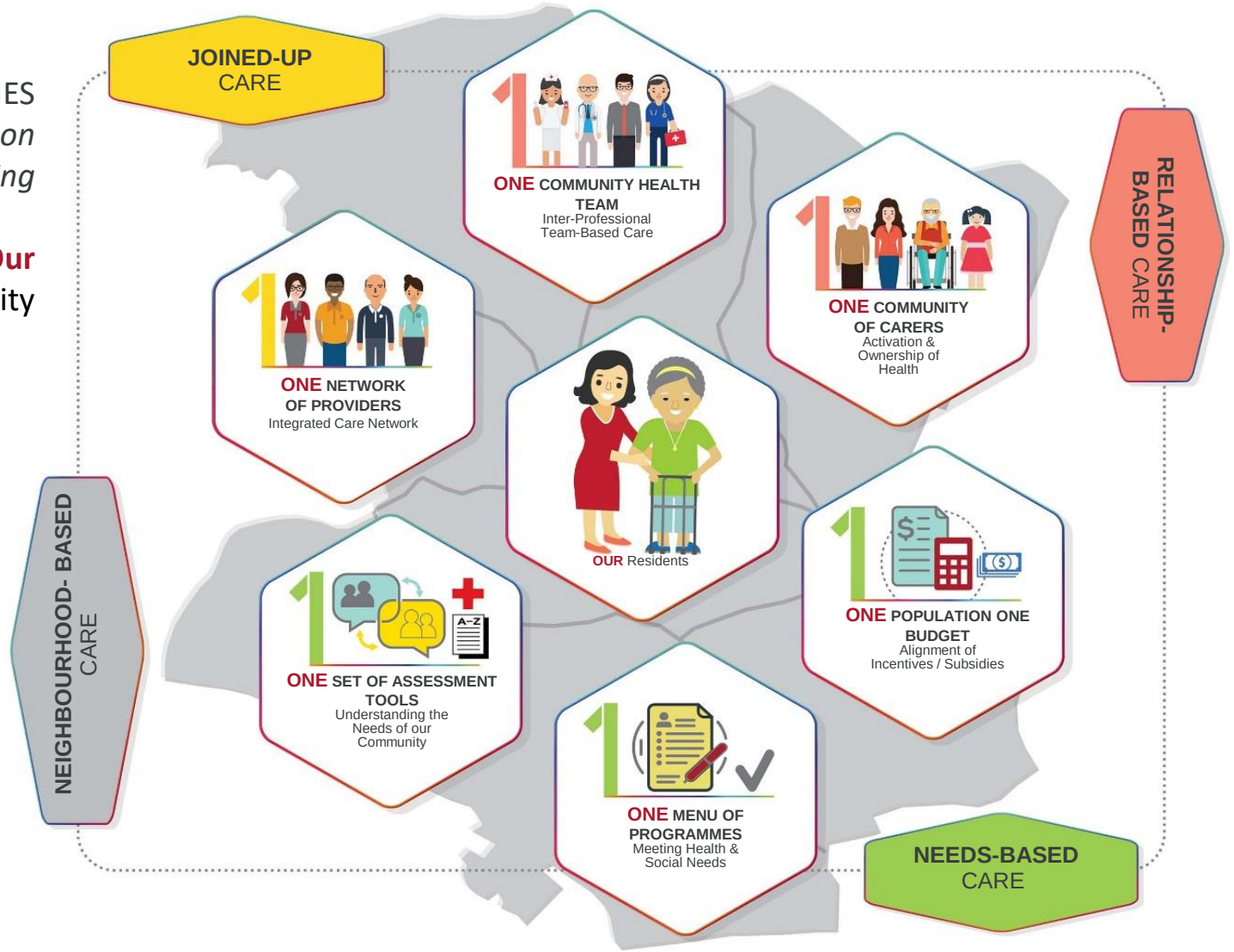
Central Health Integrated Care Model

Premised on 4 Principles

Central Health Model of Care

Our STRATEGIES
focused on
Activating

Our
Community



CENTRAL HEALTH'S MODEL OF CARE

CENTRAL HEALTH

Building Health Together With You

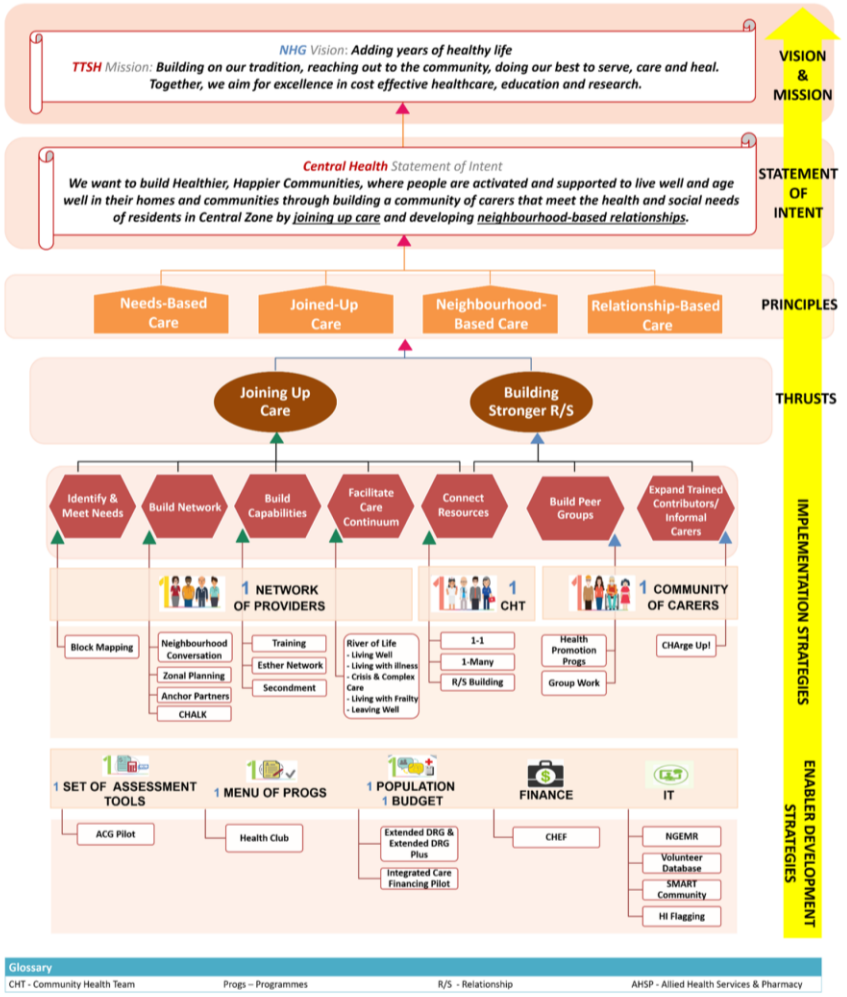
Central Health is an **Integrated Model of Care,**

building health together with you.

We function as an **Integrated Care Network**

serving Our Population in Central Singapore.

Community Health Development Road Map

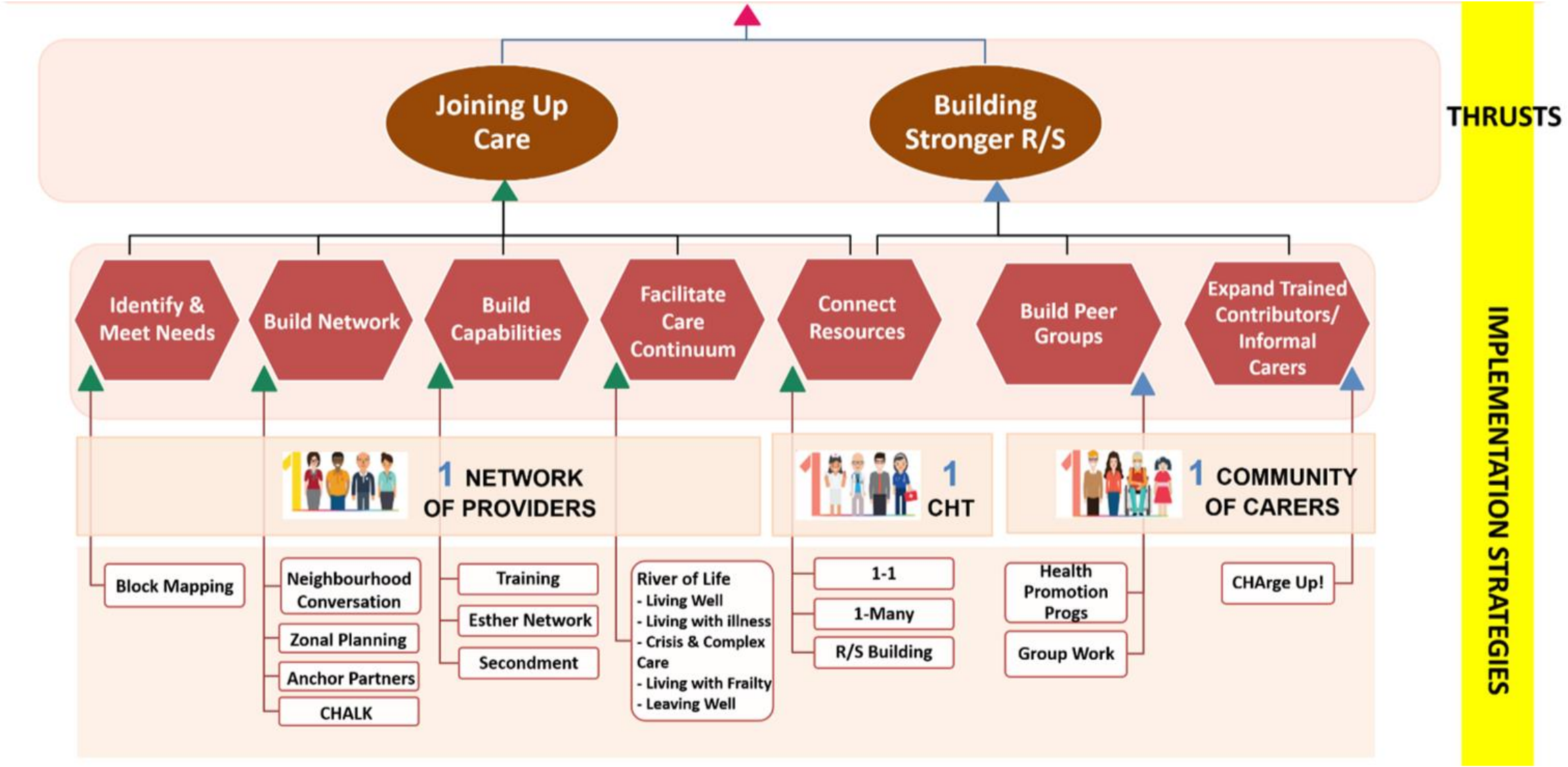


Version 2: 23rd April 2019

Community Health Development Road Map

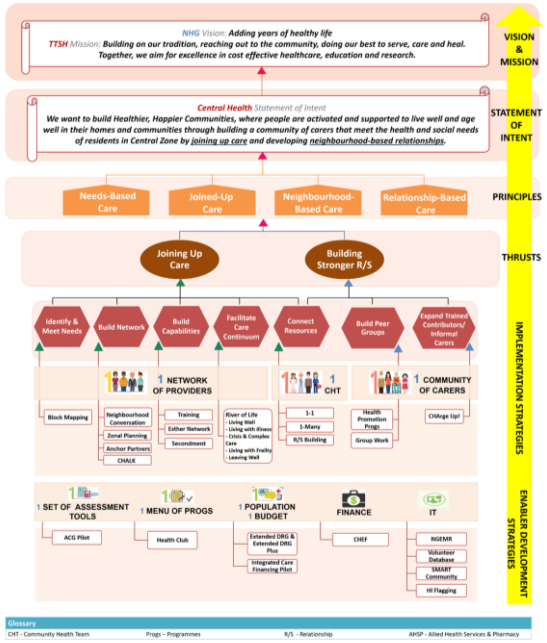
DCH Road Map | One Network of Providers | One CHT | One Community of Carers | One Population, One Budget | One Set Of Assessment Tools | One Menu of Programmes | Finance | IT

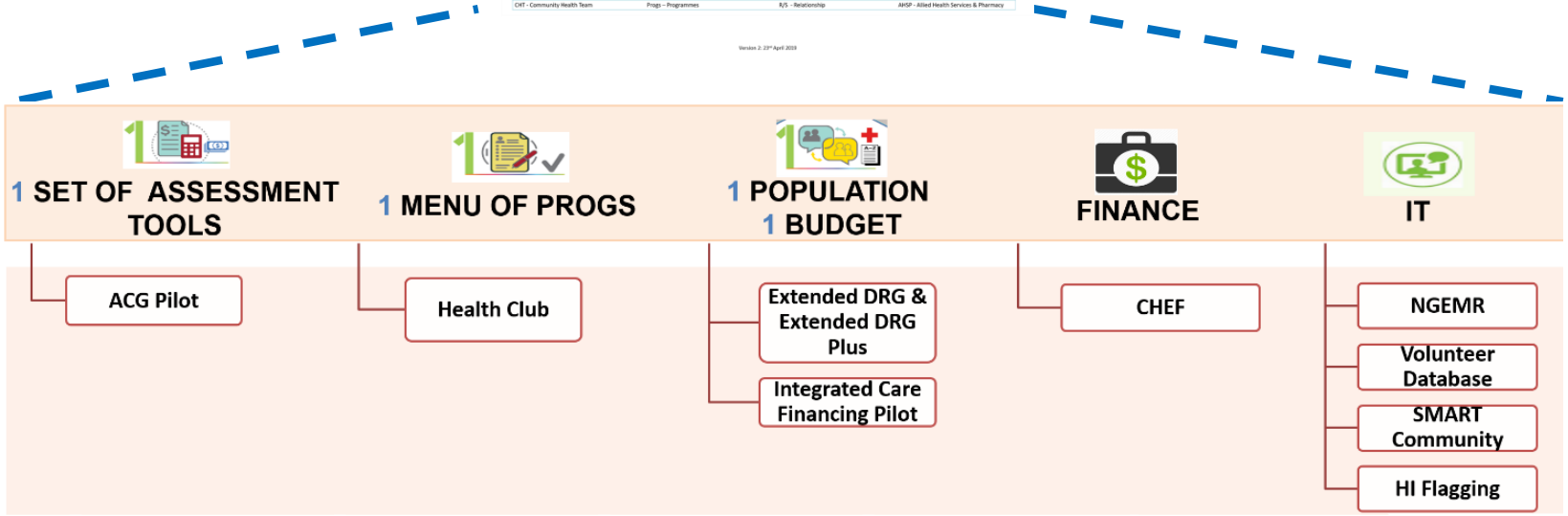
Community Health Development Road Map: Implementation Strategies



DCH Road Map | One Network of Providers | One CHT | One Community of Carers | One Population, One Budget | One Set Of Assessment Tools | One Menu of Programmes | Finance | IT

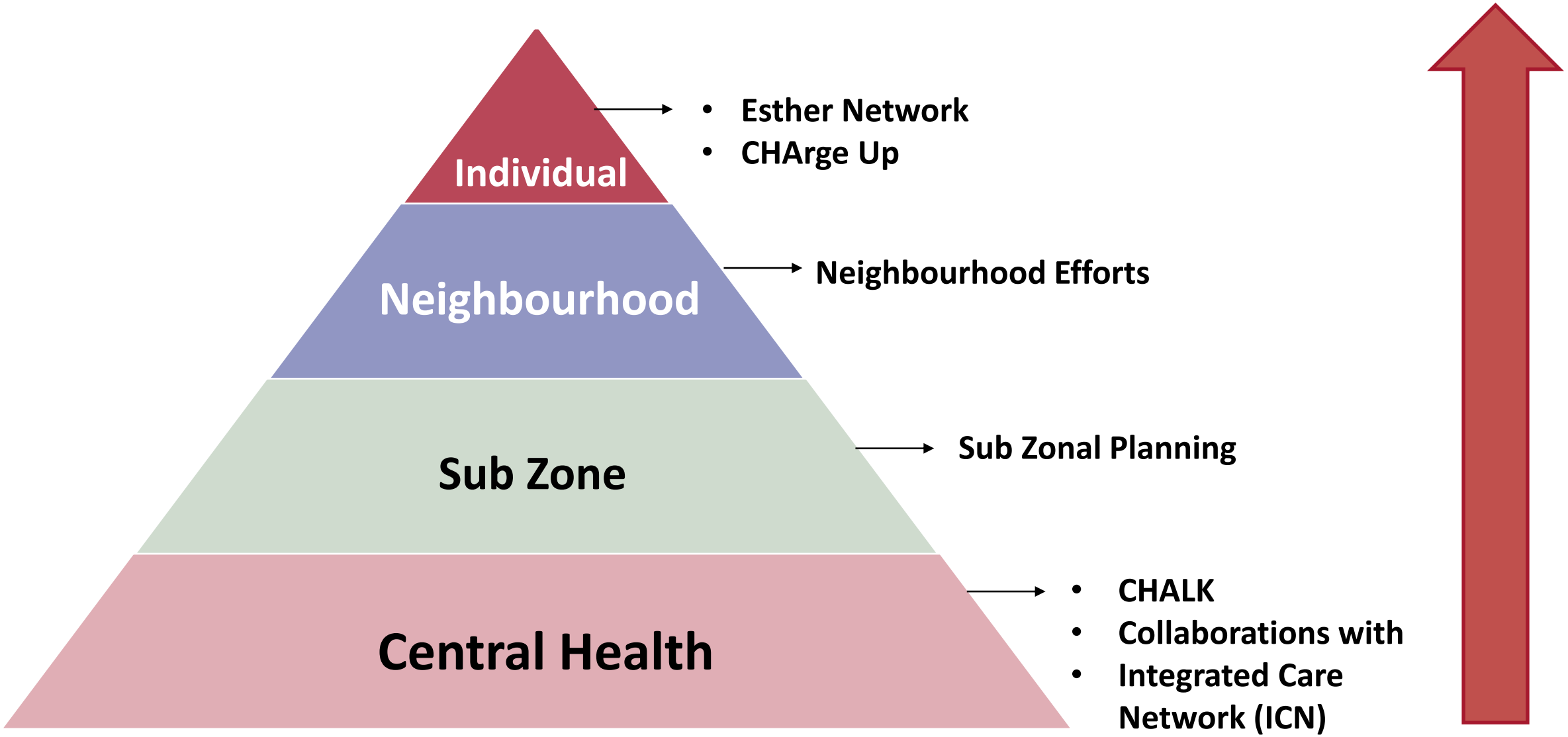
Community Health Development Road Map: Enabler Development Strategies





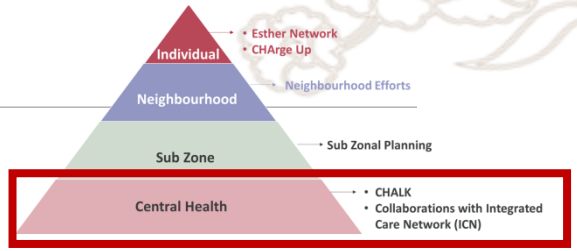
DCH Road Map | One Network of Providers | One CHT | One Community of Carers | One Population, One Budget | One Set Of Assessment Tools | One Menu of Programmes | Finance | IT

Levels of Engagement



Central Health Level Engagements:

Central Health Action & Learning Kampung (CHALK)



Objective: An **engagement and learning** event to **foster a sense of community** and work towards the **co-creation of common goals** for providers in Central Zone.

Inaugural CHALK:

Date: 29 Nov 2018 (Thu)

Theme: Central Health: Building Health Together with You

CENTRAL HEALTH
Action & Learning Kampung (CHALK)

Common Topics Discussed:

- Trust and collaboration
- Coming together
- Training/capability building
- Direct referral based on care needs
- Integrated information sharing
- Financing barriers and incentives

Central Health Strategic and Community Partners

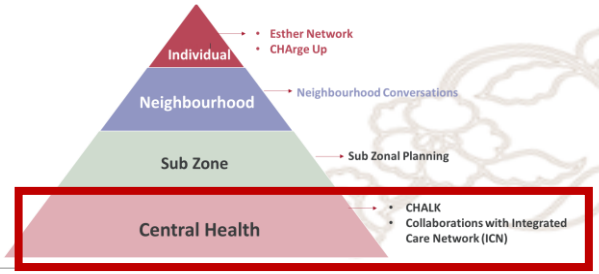
THYE HUA KWAN MORAL SOCIETY

Affiliated to Kampong Kapor Methodist Church

同 濾 安 老 院
Thong Teck Home for Senior Citizens

Tan Tock Seng HOSPITAL

Our Integrated Care Network (ICN)



AWWA
PEOPLE GIVING TO PEOPLE

TOUCH Community Services

Tsao Foundation
Longevity is Opportunity

KWONG WAI SHIU HOSPITAL
廣惠肇留醫院
Since 1910

Ren Ci 仁慈

St Luke's ELDERCARE

太和观 THK
THYE HUA KWAN MORAL SOCIETY

ntuc Health

DOVER PARK HOSPICE
Every Moment Matters

National Healthcare Group
POLYCLINICS

GPs

Vanguard Partners in Care Integration

(i.e. Those who are interested in community / population management)

Leaders in Flow Management

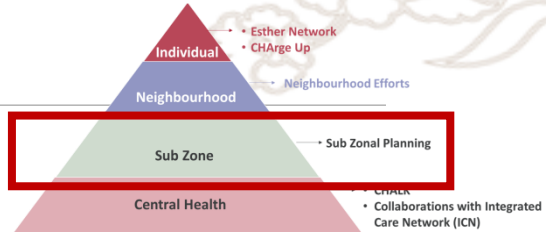
(i.e. Those who can offer beds or space)

Specialised Areas

(i.e. EOL/Primary Care)

Sub-Zone Level Engagements:

Sub Zonal Planning Committees



Objective:

Provide platforms to enable **relationship-building** amongst community partners for **advocacy** of services, **bonding** and **collaborations** to **drive mutually-agreed community initiatives** to **build holistic support** for residents

6

Zonal Planning Committees established across Central Zone

31

Partners engaged in planning and driving community initiatives at the sub-zone level

3

Key focus areas identified across Zonal Planning Committees

4

ESTHER projects completed to enable better patient-centred care in the community

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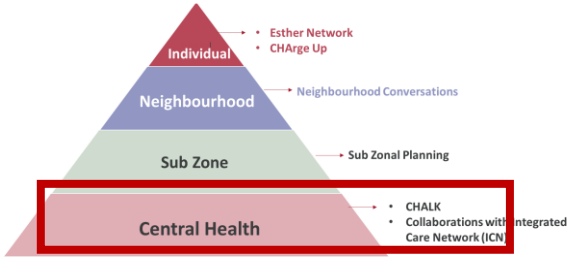
Sub-Zone Level Engagements

Sub Zonal Planning Committees



Example: Efforts by Ang Mo Kio Zonal Planning Committee

No. of Partners	Key Focus Area
8 (as at 31 Mar 2019)	Building Inclusive and Dementia-Friendly Communities
• AMKFSC Cluster Support • AMK-THK Community Hospital • AWWA • Ren Ci Nursing Home • SATA CommHealth • THK Moral Charity • TOUCH Community Services • TTSH	• First walkathon, Walk 2 Remember, completed on 16 Mar 2019 with 300 participants who are persons with dementia and their caregivers • Plans to continue with awareness event on a yearly basis

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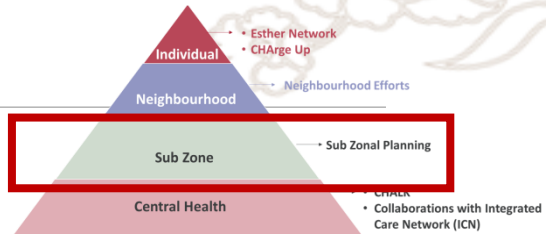
Sub-Zone Level Engagements:

NC & Sub Zonal Engagements



Cascading of strategies/plan for implementation and localization at the neighbourhood level

Sub Zone level – Sub Zonal Planning Committees

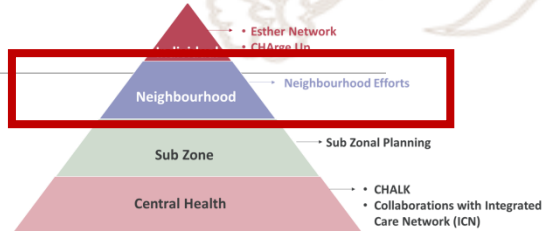
Neighbourhood level – Neighbourhood Conversations

To sustain, standardize, spread and feedback

ANG MO KIO

Neighbourhood Level Engagements:

Neighbourhood Conversations



Case Study: Ang Mo Kio Blk 400s (Teck Gee & Cheng San) Neighbourhood Conversations (Round 2)

Finessed Intent:

- Building towards a strong partnership in AMK
- Opportunities:
  - Block mapping / needs assessment to identify at risk subgroups;
  - Care coordination
  - Caregivers support

Projects Identified

- Block Mapping to further identify blocks to focus on and interventions to put in place
- Flagging of partners' clients when they uses TTSH services
- Expanding on the Dementia Friendly Community initiative

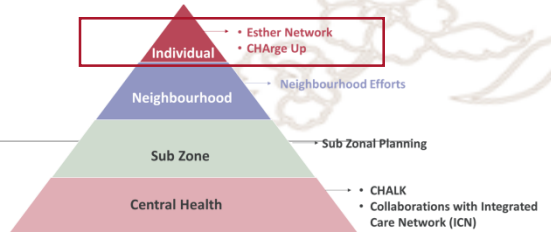
Participants:

Tan Tock Seng Hospital | AMKFSC Community Services | TOUCH Community Services | Ren Ci 仁慈

Tan Tock Seng Hospital

Individual Level Engagements:

Esther Network



Partner Empowerment

ESTHER
Network for Health & Social Care
SINGAPORE

The ESTHER Network helps to focus **clinical & social** care on the **needs**, expectations, priorities and fears of **elderly people** entering the care system

Embracing ESTHER Network in Central Health, NHG

ESTHER is a patient, caregiver or resident who needs multi-agency care

OBJECTIVES: To build a culture of quality improvement, focused on Person-Centered Care
- based on ESTHER's needs and preferences
- leads to improvements from ESTHER's perspective
- involves ESTHER from start to end process

- Mindset change towards **Person-Centred Care** "What Matters to ESTHER?"
- Respect ESTHER's own strengths, experiences and support system
- Involves all levels of staff
  - Ground up approach: builds ownership
  - Coaching: builds sustainability
  - Sponsors: builds leadership
- **Systems thinking**: Make it easier for the next provider in the care chain

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One CHT:

Enabling health engagement, care coordination and ageing-in-place

WHAT ARE COMMUNITY HEALTH TEAMS?

- ***7 place-based, multi-disciplinary teams*** embedded within each sub-zone of the Central Zone
- Aims to ***build relationships*** and ***work with local partners*** across health and social care domains to ***enable health engagement, care coordination and ageing in place***

HOW THE COMMUNITY HEALTH TEAMS FUNCTION

Direct Service Provision

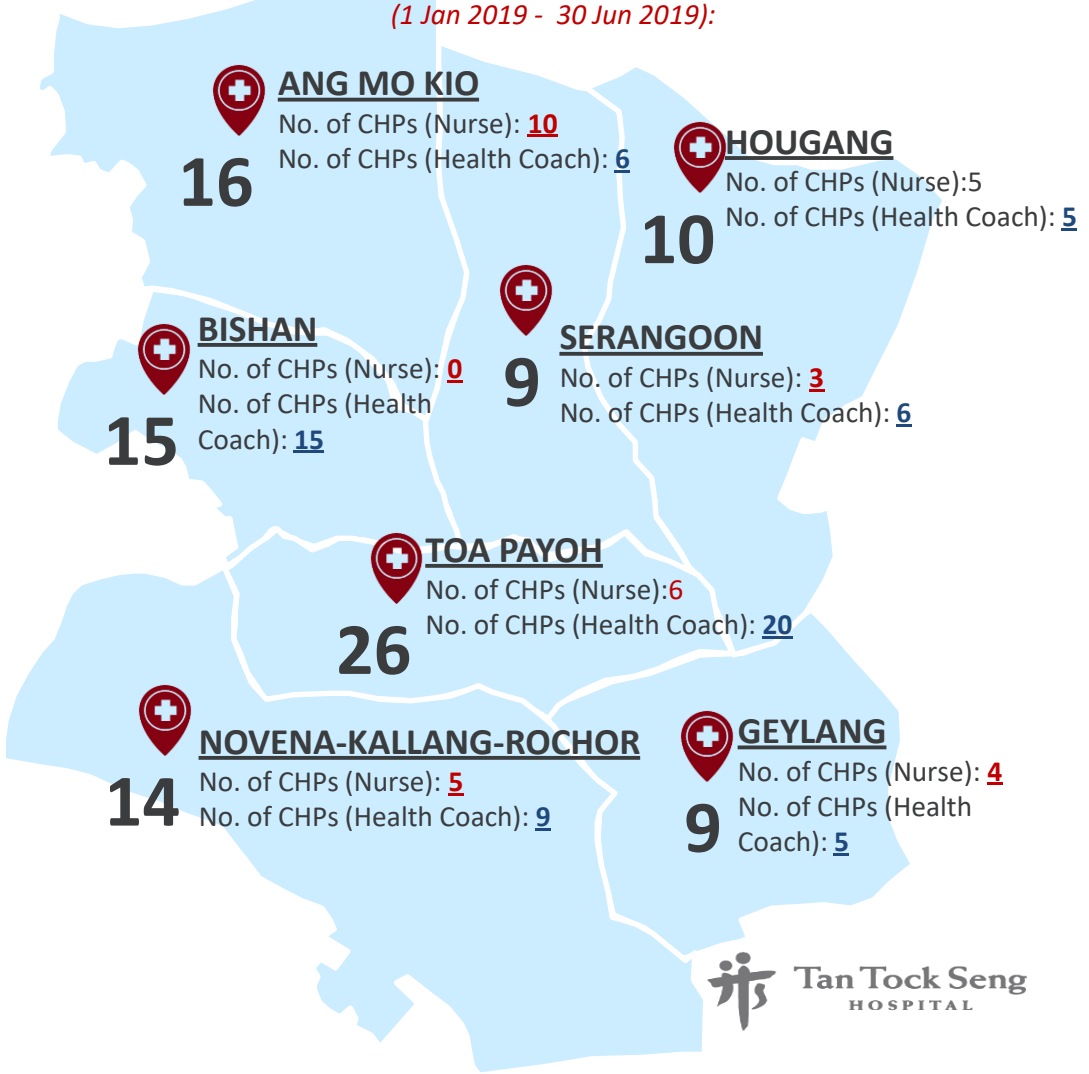
- Home visits
- Telephone reviews
- Site clinic reviews at Community Health Posts

Collaboration & Activation

- Co-develop programmes
- Group education and coaching
- Training for partners




Community Health Posts in Central Zone
(1 Jan 2019 - 30 Jun 2019):



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Community Health Programmes & Initiatives

One Community of Carers:

Building the Capabilities of Our Community of Carers

One Community of Carers:

Building the Capabilities of Our Community of Carers

TTSH Volunteers

584 Active Volunteers

100 Volunteers served more than 5 years

87 Age of oldest active volunteer

48 Hours spent on average per year by each volunteer

31 TTSH volunteer programmes in 4 categories

16 Age of youngest active volunteer

Community Volunteers

89 Trained Carers

59 Trained Carers Supporting Home Visits

5 Community Partners in collaboration

^Asset Based Community Development is an approach to sustainable community-driven development. It builds on the assets that are found in the community and mobilises individuals, associations and institutions to come together to realise and develop their strengths.

(Data are accurate as of 31 Jun 2019)

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One Population, One Budget:

Central Zone Integrated Care Financing Pilot

Current State		Future State	
	<u>Model of Care</u> Traditional hospital-centric model of care		<u>Model of Care</u> Integrated care through collaboration with partners
	<u>Financing Model</u> Volume-driven Attendance-based Program-based funding		<u>Financing Model</u> One which will enable integrated care to be delivered across the care continuum in a cost-efficient manner

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One Population, One Budget:

Extended DRG Bundles

3 Key Objectives:

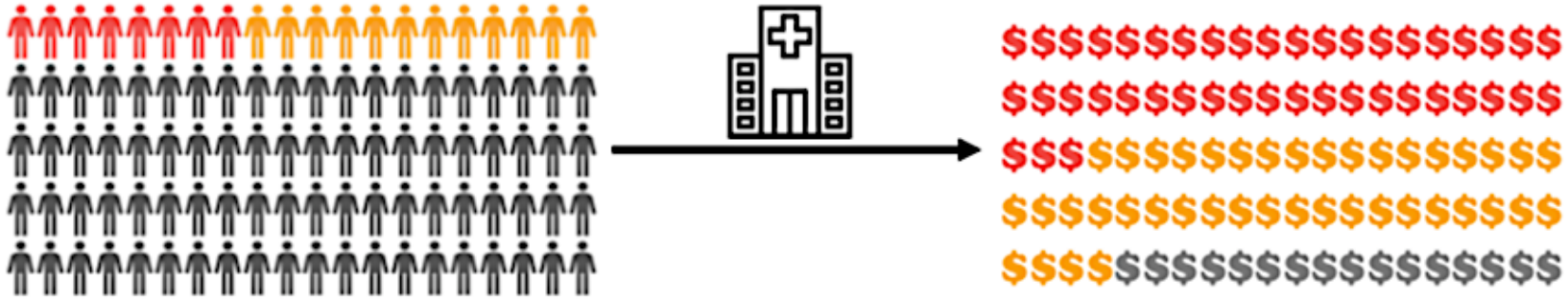
1. To manage the frailty curve through the integration of care and alignment of financial incentives.

2. To implement Extended DRG bundles with Social Service Agency (SSA)-run community hospitals.

3. To expand the Extended DRG bundles to include the Transitional Care component (Extended DRG **Plus**), with the aim to evaluate whether bundling TC helps to further optimise the system (care and savings).

DISPROPORTIONATE UTILISATION OF HEALTHCARE

Observation:
20% of patients living in Central/North utilize
84% of Central/North healthcare costs



Observation:
5% of patients living in Central/North utilize
57% of Central/North healthcare costs

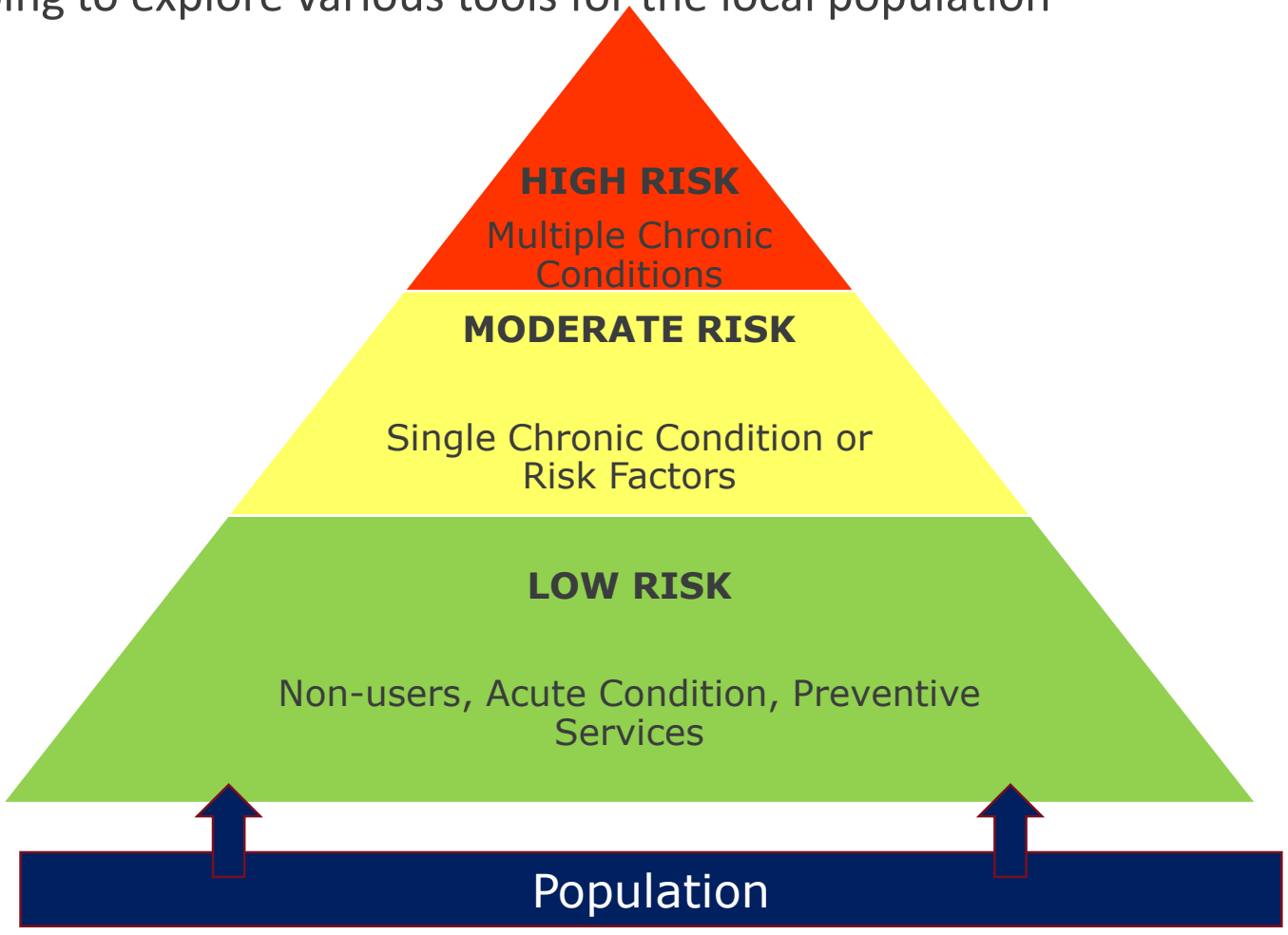
Source: NHG

One Set of Assessment Tools:

Population Risk Stratification

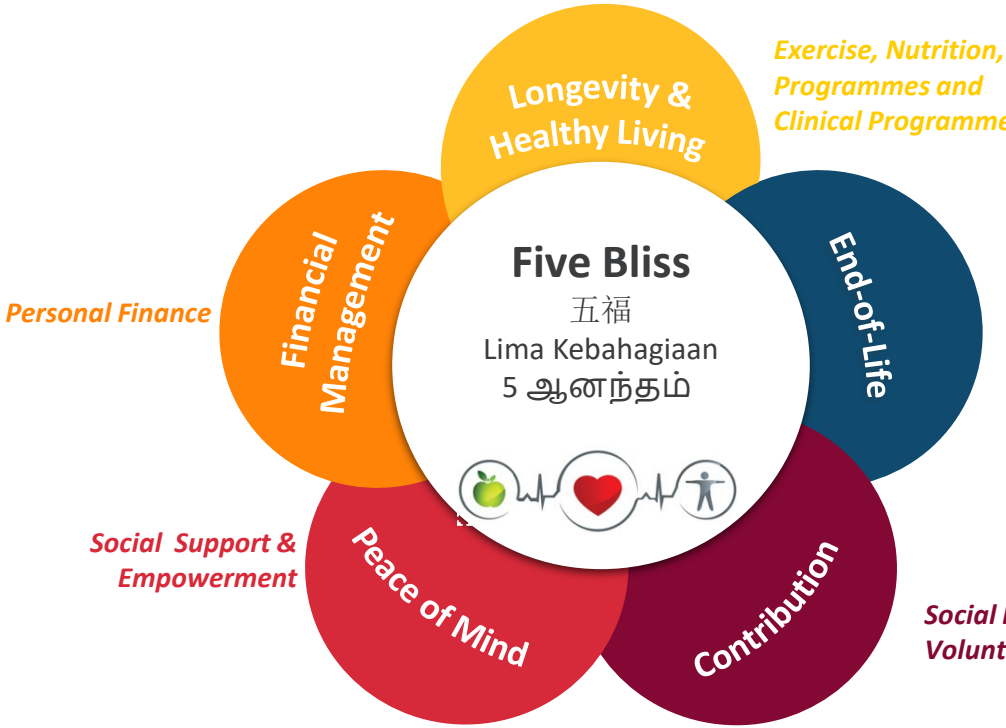
- Population risk stratification would allow us to better **target and optimise resources**

- Efforts on-going to explore various tools for the local population



One Menu of Programmes

- To create a repository of health & social programmes available in Central zone
- Potential partnerships (Health post, Social Service Agencies & Community Centre)
- Partners and Residents can seek out programs/activities on their own.



Finance

Central Health Enabling Fund

Objective:

- Dedicated to supporting community-related works that will help to achieve population health.

Examples of projects:

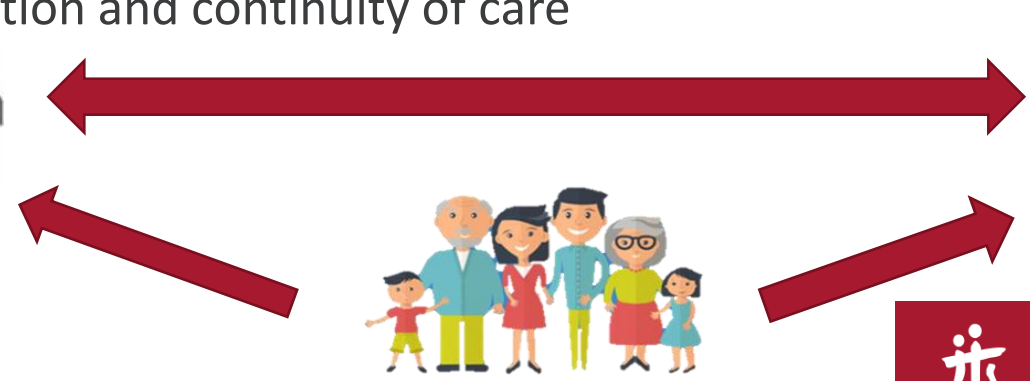
- **Esther Network**
- **Influenza vaccination program** for community-dwelling seniors in the Central zone region from the lower income groups
- **Collective leadership Workshop** for Central Health Community leaders

Graduation Ceremony of the inaugural batch of 16 ESTHER coaches from TTSH and Community Partners

Information Technology (IT)

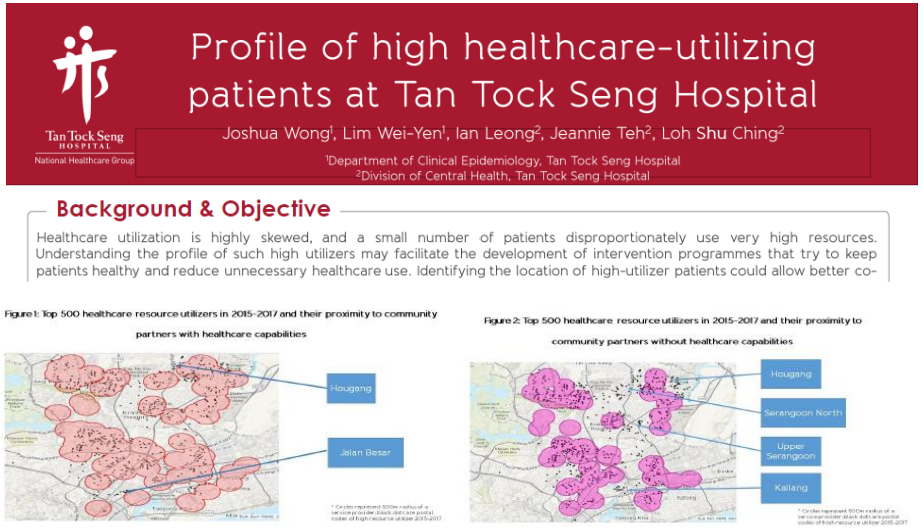
- **Health Intelligence (HI) platform triggers**
  - Improve care coordination and continuity of care

Tsao Foundation
Longevity is Opportunity



TTSH

Patient/ Client/ Resident



- **Geographic Information System** for hot spot mapping

- **Next Generation Electronic Medical Records (NGEMR)**
  - To engage with IHIS and MOH on Central Health IT matters
  - To develop governance framework & strategies for data sharing and IT integration for Central Health

Insights from journey thus far……

1. Working community partners - Unique and complex ecosystem

- Different agenda, focus and priorities

- *Different strokes for different folks*: Segmented engagement approach based on readiness & like-mindedness
  - One to one
  - One to few
  - One to many

- Different lingo
  - Important to frame goals / aspirations in the appropriate language
  - E.g. ↓ **average length of stay,** ↓ **re-admission rates** VS. **building a trusted and supportive ecosystem to support healthy ageing in the community**

Insights from journey thus far……

2. Greater need for investment of effort in developing a Community

*‘**The essential challenge** is to transform the isolation and self-interest within our communities into connectedness and caring for the whole’*

Community – The structure of belonging by Peter Block

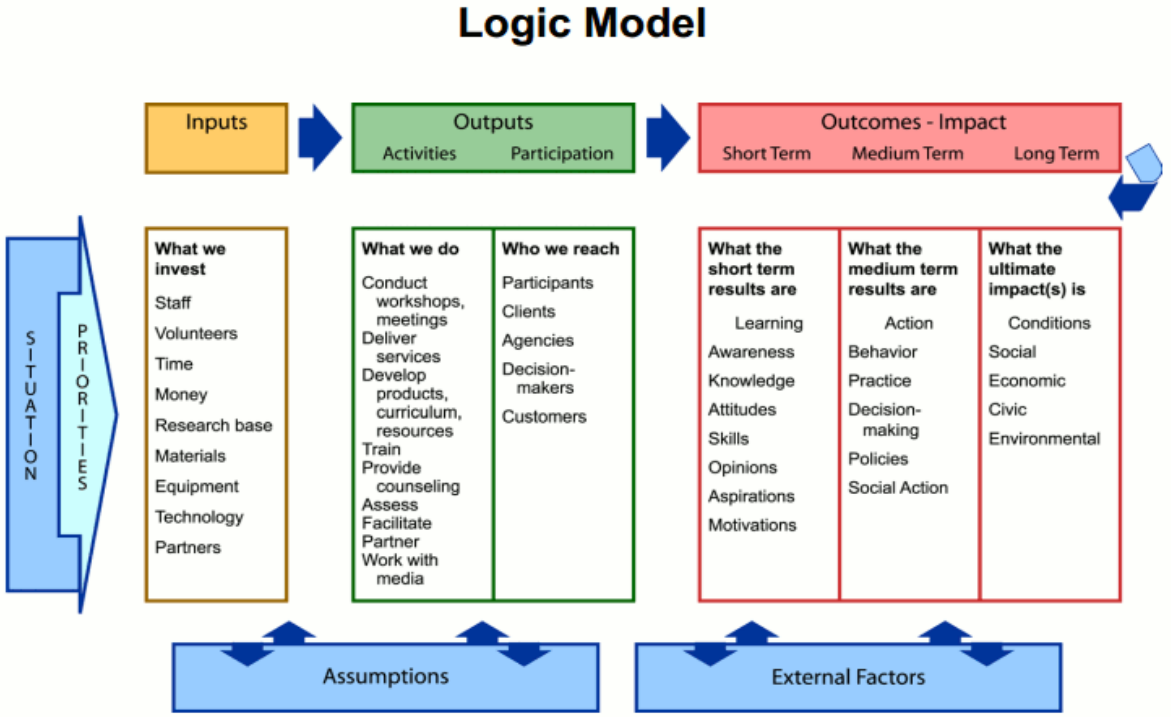
- Central Health Collective Leadership Development
- Change management – Shifting attention from the problems to the possibilities

Q: Describe in one word, your emotions as a Resident/ Service Provider/ Community Health Team/ Neighbour during the game (Round 1).

Insights from journey thus far……

3. Programme evaluation to be a standard practice and discipline in programme development, implementation and review

- For relevance, sustainability & scalability
- To justify investments in manpower and time
- Measurements:
  - Operational activities: Balance Score Care indicators
  - Programme effectiveness: Programme indicators
  - Population health strategy: Population Health Indicators



Source: Enhancing programme performance with logic models. University of Wisconsin-Extension, Feb 2003

Insights from journey thus far……

5. Important to involve the hospital staff

Population health management is not limited to only healthcare workers working in the community

- Benefits to both patients and hospital in ensuring continuity of care beyond hospital walls
- Care gaps and needs are often identified during hospitalization episodes
- Good understanding of community health strategies and programmes will promote active referral of cases to appropriate interventions; greater confidence in having patients managed in the community

- On-going road shows to internal clinical departments

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Insights from journey thus far……

6. The Public Health perspective

- To enhance Public Health capabilities within the organization
  - Plans to increase opportunities for training in Public Health
  - Senior residency position in Division for Central Health

DIVISION FOR CENTRAL HEALTH – THE SUM OF THE PARTS THAT MAKE UP THE WHOLE

Ms Loh Shu Ching
Executive Director
Division for Central Health

A/Prof Ian Leong
Clinical Director
Division for Central Health

Planning & Development	Communications	Activation	Community Health

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