Improving the Health of the Population – The Singapore Model

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Residential Long Term Care - Public (36%) - Not for profit (40%) - Private (24%)

Secondary & Tertiary Specialist Care - Restructured Hospitals & National Centres (80%) - Private Hospitals (20%)

Primary Healthcare - Polyclinics (20%) - Private GP Clinics (80%)

Hybrid Healthcare System
Healthcare 2020: Improving Accessibility, Quality & Affordability

In March this year, the Ministry of Health unveiled the Healthcare 2020 Masterplan - essentially measures to enhance the accessibility, affordability, and quality of healthcare – to better meet the needs of Singaporeans.

Strategies

- Improve Quality Outcomes · Raise Care Standards
- Integrate Care Through Regional Health Systems
  - Improve Primary Care Services
  - Build Up Aged Care Sector
    - Expand healthcare infrastructure capacity
  - Grow and retain our pool of healthcare professionals
  - Improve healthcare financing to keep healthcare affordable
Singapore tops in life expectancy at 84.8 years

Rising demand of healthcare with an ageing population

1 in 4 Singaporeans will be aged 65 & above in 2030

4.9% of GDP spent on healthcare in 2016

2016: ~$21 billion
2010: $10.9 billion
Beyond Healthcare 2020

Three Key Shifts to Better Health

To enable Singaporeans to receive appropriate care in the community and closer to home

To give every Singaporean best value, while keeping our system sustainable

To help and support Singaporeans to lead healthier lives
Ecosystemic approach to influence lifestyle behaviours across life-course

Prevention of Non-Communicable Diseases

Mental Wellbeing Promotion

Lifestyle Risk Factors

Obesity Control
- Healthier food
- Physical activity
- Weight management

Tobacco Control
- Prevent initiation
- Promote cessation

School

Workplace

Community

Life course Approach

Youth Preventive Health
- Growth & Development
- Immunisation
- Oral Health

Early detection & follow up: chronic diseases and cancers
Formation of 3 Integrated Clusters
SingHealth Regional Health System

Vision
Transforming Care. Improving Health

Mission
Partnering communities to

Keep Well
Population Health Improvement
Keeping the population as healthy as possible in the community

Get Well
Population Health Management
Access to right care at the right place and time

Age Well
Ageing in Place
The ability to live in one’s own home and community safely, independently, and comfortably, regardless of age, income or ability level
Life Journey Approach to Population Health

- **Build** Enabled Communities by Leveraging Strengths of the Community
- **Integrate** Healthcare Teams for Seamless Care
- **Bridge** Health and Social Care Services

**Determinants of Health**
- Genetics
- Gender
- Environmental
- Healthcare
- Social & Economic
- Age
- Behavioural
Delivering Care That Matters

Taking into consideration **behavioral and social determinants** of health and a **life course perspective**

**Bio-psychosocial characteristics**

+ **Acuity and severity of disease**

+ **Health care utilisation**

+ **Socio-demographic groupings**

**Improved risk stratification of our populations, resulting in more effective and efficient interventions and implementation**
Communities of Care

Geographical Team-Based Approach

- Deeper understanding of the **population needs in the respective zones**
- **Skill-mix** to cater to different levels of needs and care
- **Greater accessibility**
- **Ease of collaboration** and building capability for health & social care personnel
- **Increase efficiency** in resource allocation
Enabling Seamless and Coordinated Care

Hospital Care Team

- Coordination of care within the hospital
- Direct medical and nursing care (as needed)
- Multidisciplinary reviews
- Care coordination and monitoring
- Supported through virtual care

Patient Navigators/Care Case Managers

- Handover of cases. Community team may be involved before discharge
- Coordination and link back to medical team in hospital

Integrated Community Care Team

Community Nurse

- Doctors
- Allied Health Professionals
- Community Coordinators

Community Partnerships

- Primary Care e.g. Polyclinic & GPs
- ILTC providers e.g. Home medical & home nursing, SCC
- Community partners e.g. GROs, SGO

Flow from Hospital to Community

Link to Community Resources

Hold in Community

Handover of cases. Community team may be involved before discharge
Coordination and link back to medical team in hospital

Enabling Seamless and Coordinated Care
SingHealth Community Nursing

Objectives

- Building healthy & empowered community
- Right siting & Integration of care
- Continuing quality care in community and ageing in place

Roles

- Prevent
  - Preventive Health for Seniors
- Empower
  - Empowerment of Self-management of Chronic Conditions
- Re-enable
  - Transitional Care for High Risk Clients, Post Acute Care
- Palliate
  - Palliative Care for Clients with Non-malignant Conditions

- Managing Well
- Vulnerable
- Mildly Frail
- Moderately Frail
- Post Hospital Care
- Complex Care Needs
- Terminally Ill
Preventive Health for the Well & Pre-frail

Community Health Posts

• Located at RCs & CCs

• Nurses’ roles:
  • Regular health coaching and monitoring individuals with abnormal screening results to
    o Make healthy lifestyle changes
    o Promote follow-up with primary care providers

• Individual & group education and activities
Preventive & Self-Management Service for Frail Seniors

Community Falls Prevention Programme

Developed by Community Nursing, Community Geriatrics, Ophthalmology, and Rehabilitation Service

Are you STEADY?!?

1. SCREENING

Did you have a fall recently?
Do you feel unbalance or weak in your legs?
Do you feel dizzy when you get up from bed or chair?
Do you want to know if you at-risk of a fall?

If your answers are “YES” to the above, and you are 65 years & above, join us for fun interactive activities at #03-33, 2pm to 5pm

- Healthy Bones
- Home Safe Home
- Oops I fell! How do I get up?
- How steady are your shoes?
- Do I have steady feet?

WHERE TO FIND US?

Eastern Community Health Centre
Our Tamplins Hub, #03-33
6 Aug 2017, 2pm to 5pm

2. REFERRALS

Failed eye function test
- OPS for further referral to Eye Clinic

Short Physical Performance Battery Test
- Balance
- Gait Speed
- Chair Stand

Falls Assessment Form
- Personal health information
- Cognitive Screening
- Fracture Risk
- Specific falls assessment

SPPB > 6 with no significant medical history
- Structured Exercise Programme
- If participants are keen, to administer the PARQ

SPPB </>= 6 + positive screen for risk factors for falls
- PT @ CHC
  - No other risk factors
  - </>= 2 falls in last 1 yr
  - Fear of falling
- Polyclinic + PT @ CHC
  - Postural weakness
- Falls Clinic (get referral from OPS)
  - </>= 3 falls in last 3 months
  - </>= 3 falls in last 1 year
  - Injurious falls
  - LOC
  - Dizziness
  - Impaired cognition
  - Significant fracture risk

3. EDUCATION

Falls Prevention Education to all + following topics if needed.
- Vision care
- Structured Exercise Programme
- Postural dizziness
- Osteoporosis
- Footwear

* If the participant screens positive for > 1 domain, to refer to the service with higher level of intervention.
Community Falls Prevention Programme

1st Level: Falls Screening & Awareness

2nd Level: Comprehensive Falls Assessment, Education & Follow Up Interventions

Screening

Vision Screening

Education

Gait & Balance

Falls Risk Questionnaire & Education

Images of people engaging in activities related to falls prevention and assessment.
Community Nurse Posts
Self-management & empowerment for frail seniors & their caregivers

Services

- Health & Geriatric Assessment e.g. falls, forgetfulness
- Health Coaching for Disease Prevention
- Chronic Disease Monitoring & Self-management Education
- Medication Self Management Support & Education
- Care Referral & Coordination

43 SingHealth Community Nursing Posts have served

> 9,000 Unique Residents Since launch in 2017
Support for patients with high risks & complex care needs

Hospital to Home (H2H) Service

Basic and advanced nursing care and procedures
Specialized care management
Care and case management
Patient and caregiver education and training

Early-Discharge Services

Community OPAT: complete IV antibiotics treatment via home care
Subcutaneous injection for chemotherapy
Community vascular wound management

Safe and timely transit from hospital to home for

- Frail patients with complex care needs, high healthcare utilisation, and/or
- High risk of preventable readmissions
Health Management Unit

Telecare for chronic disease management

Telecarers (trained nurses) provide regular phone support to patients with diabetes, COPD, heart failure, hip fracture and acute myocardial infarct.

Tele-monitoring
Monitor parameters such as blood glucose, pulse rate, blood pressure and weight

Tele-education
Patients are educated on how to recognise and manage symptoms

Care Coordination
Telecarers coordinate patients' care with partners: polyclinics and GPs, case managers, psychologists, AHPs, ILTC sector

Patient Relations Management IT system
Alerts telecarers when patients visit the A&E, are admitted to the hospital, miss their follow-up appointments, or have any abnormal lab results

Early intervention and follow-up care
Oversight of Community Nursing Development

SingHealth RHS
Community Nursing Committee

Advisors:
• GCN; CN, SGH
• Dy GCN; CN, CGH
• CN, SHP

Strategic direction & governance

Alignment and harmonization of services & practice

Professional development of community nurses

Learning, sharing and co-development of best practices

Endorsement of new guidelines/protocols related to community nursing

Recommendation on issues requiring discussion or approval in higher level management platforms
Community Palliative Nursing (Generalist) Training & Competency Framework

Aim
Equip community nurses with the knowledge and skills to provide palliative home care

Competencies

A. Palliative care management
• Assessment and care planning including Advanced Care Planning
• Symptom management, comfort and well being
• Communications

B. Procedural Skills
• Subcutaneous insertion & management
• High fleet enema
• Per rectal examination
• Oral care
• Fentanyl patch application, disposal & patient education

Training providers

Basic ELNEC (2 days) + subset training OR E-learning
20-hour clinical attachment to hospices / palliative care services
Palliative care journal club, case logs, other related training
Thank You

For more info on SingHealth Regional Health System, please visit www.singhealth.com.sg/rhs