

# Community of Care (CoC): Working Hand in Hand to Improve Lives for Ang Mo Kio Residents

## Team Members

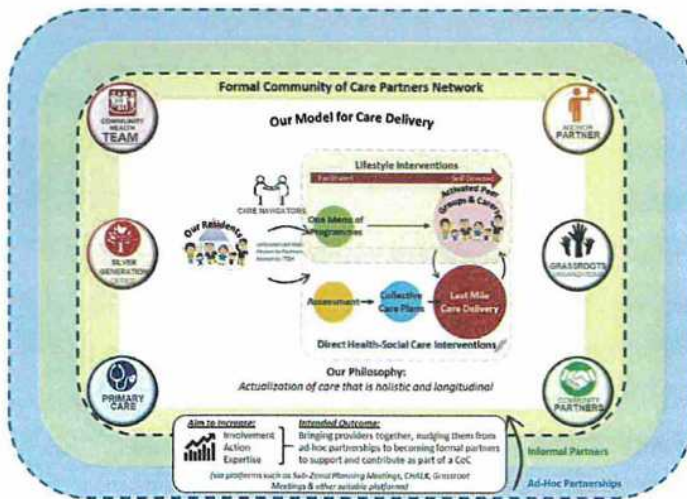
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## Project Synopsis



Community of Care (CoC), is a structured framework of holistic care within the neighbourhood which supports ageing in place. Building a strong CoC network provides timely care intervention as **“a multi-disciplinary comprising medical, nursing, life health service”** beyond hospital walls and out into the community.

## Background

Singapore’s ageing population has emerged increasing demand for health and social care needs. Hence, the importance for healthcare institutions and social service agencies to work closely hand in hand to provide holistic and appropriate One Care Plan for the seniors.

## What We Have Done Thus Far

The CoC network was first started as a tripartite partnership including AWWA, Tan Tock Seng Hospital Community Health Team (TTSH CHT) and National Healthcare Group Polyclinics (NHGP) in April 2020, reaching out to seniors at 16 HDB blocks and one private estate in Ang Mo Kio. Since then, Agency for Integrated Care-Silver Generation Office (AIC-SGO) has also joined in as part of the network.

AWWA conducts outreach through door-to-door, engaged and profiled residents to onboard the programme. Seniors were profiled using the AIC Community Screener Tool and recommended for A (Active ageing programme), B (if they require Befriending) or C (Care coordination and service).

The CoC network meet up monthly through virtual meetings to keep one another informed and check in on the clients. The monthly discussions efficiently help to direct client profiles to the right places, ensuring appropriate care interventions and referral decisions are made.

Close communication ensures the CoC network work collectively on the clients' One Care Plan to resolve their health and social care needs faster and effectively. Clients are further empowered to manage their health better and to stay well in the community longer.



## What We Have Achieved Thus Far

- Formalised data sharing agreement with the CoC network for continuity of care.
- Tap onto TTSH Central Health LinkUp (CHL) to proactively co-manage clients, who are admitted to TTSH; and facilitate interventions to improve continuity of care in the hospital and community.
- 75 cases have been discussed for clients who have high care needs and whose caregivers are facing difficulties in caring for them.
- 16 patients proactively flagged up through established post-discharged referral workflow.

## Forward Plans

The CoC network partners to co-organise regular preventive community health screening events with follow through interventions, for the residents. The residents will also signpost to appropriate activities/programmes using One Menu of Programmes.