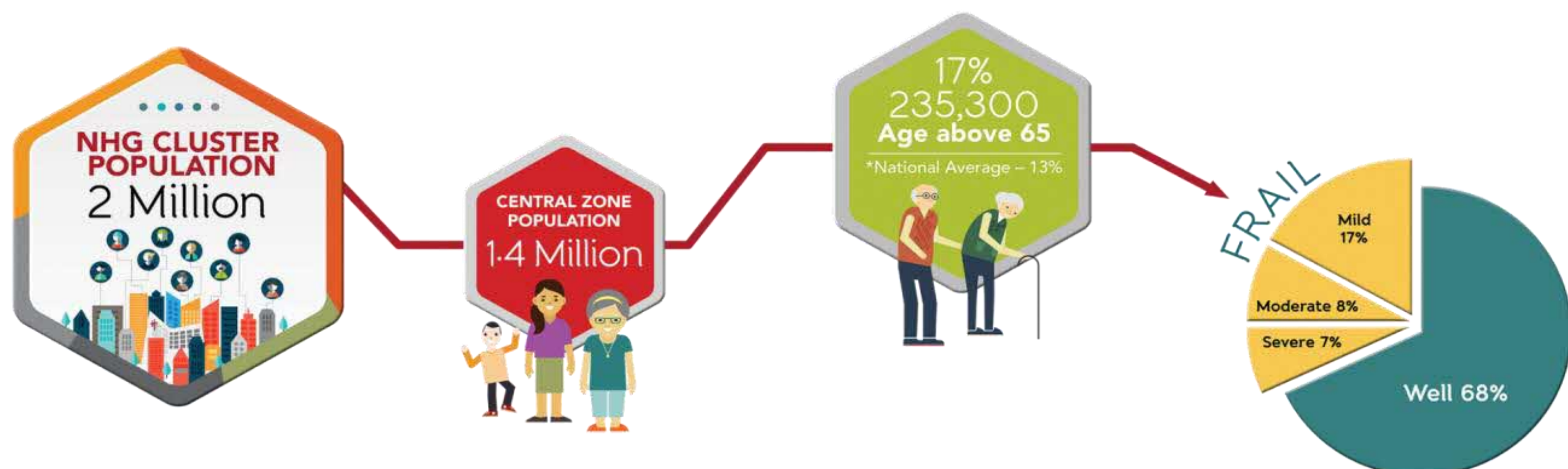


## BACKGROUND

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".

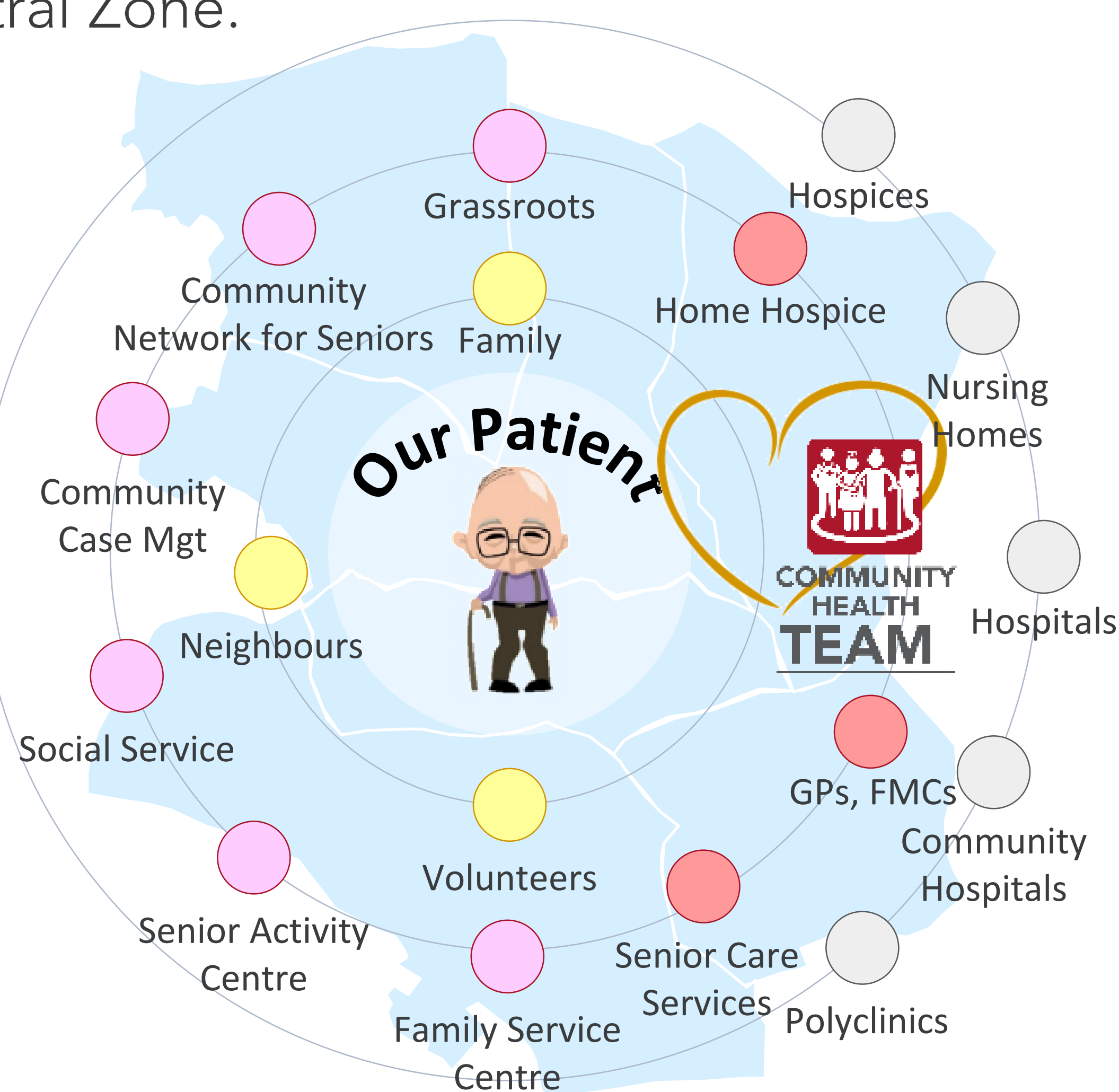


## INITIAL STATE

- 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.

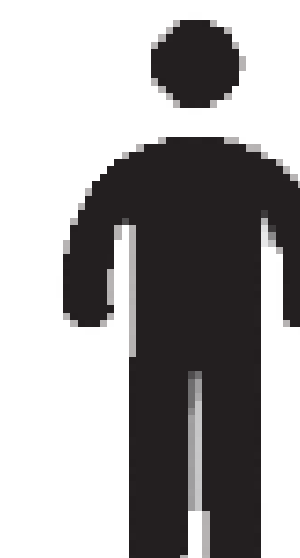
## Team Focus

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

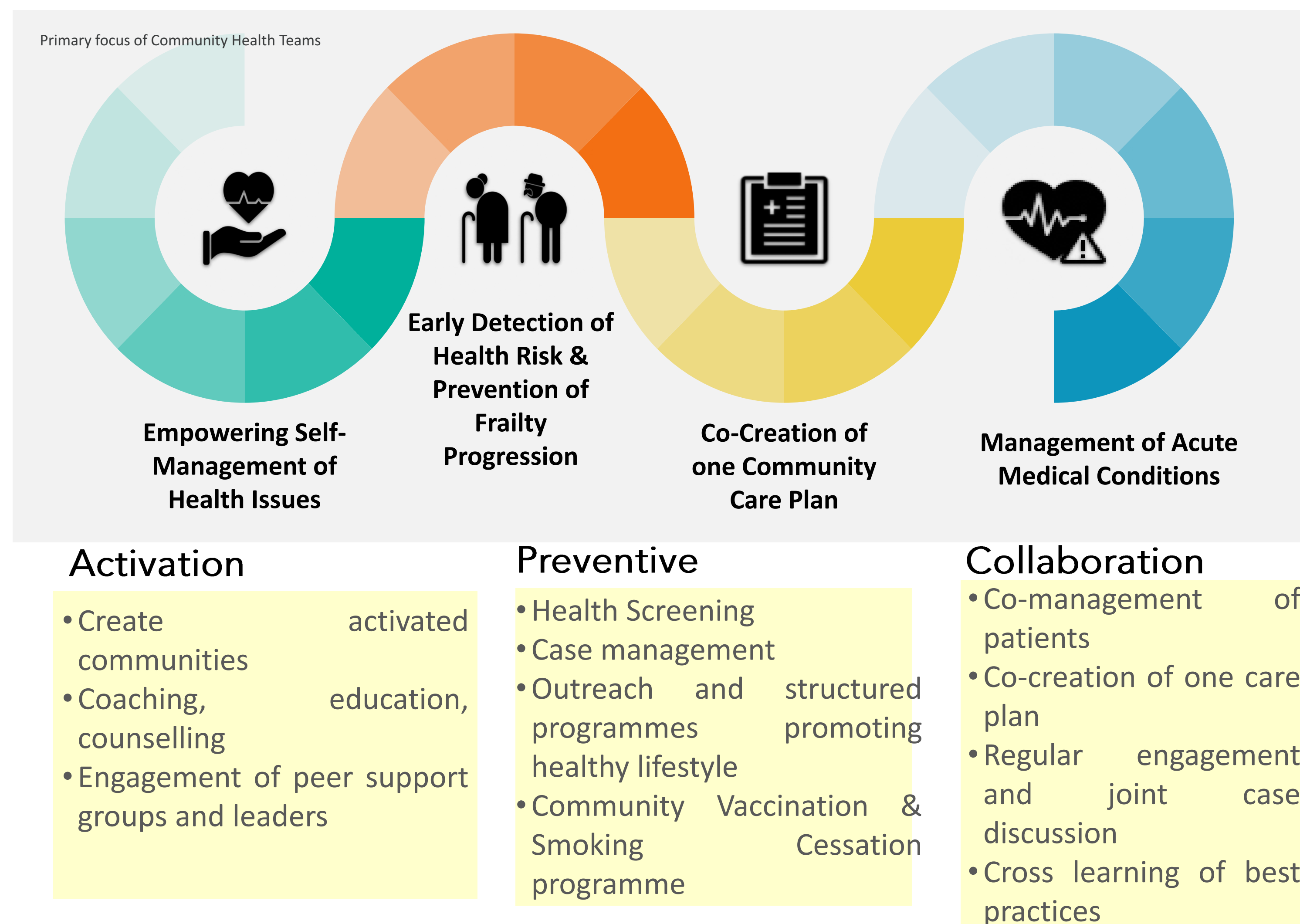
Dynamic nature of frailty which needs a "whole of community" to manage



### 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

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.

Sustainable engagement with staff.

Reduction in ED attendances and admissions post-enrolment.

<b>59.2%</b> & <b>76.5%</b>	30 days, respectively
<b>41.2%</b> & <b>60.8%</b>	3 months, respectively
<b>26.7%</b> & <b>43.3%</b>	6 months, respectively

Reduction in Bed days

Reduced an average of **1.6** bed days per enrolled patient in a 90 days period.