Changi General Hospital
SingHealth

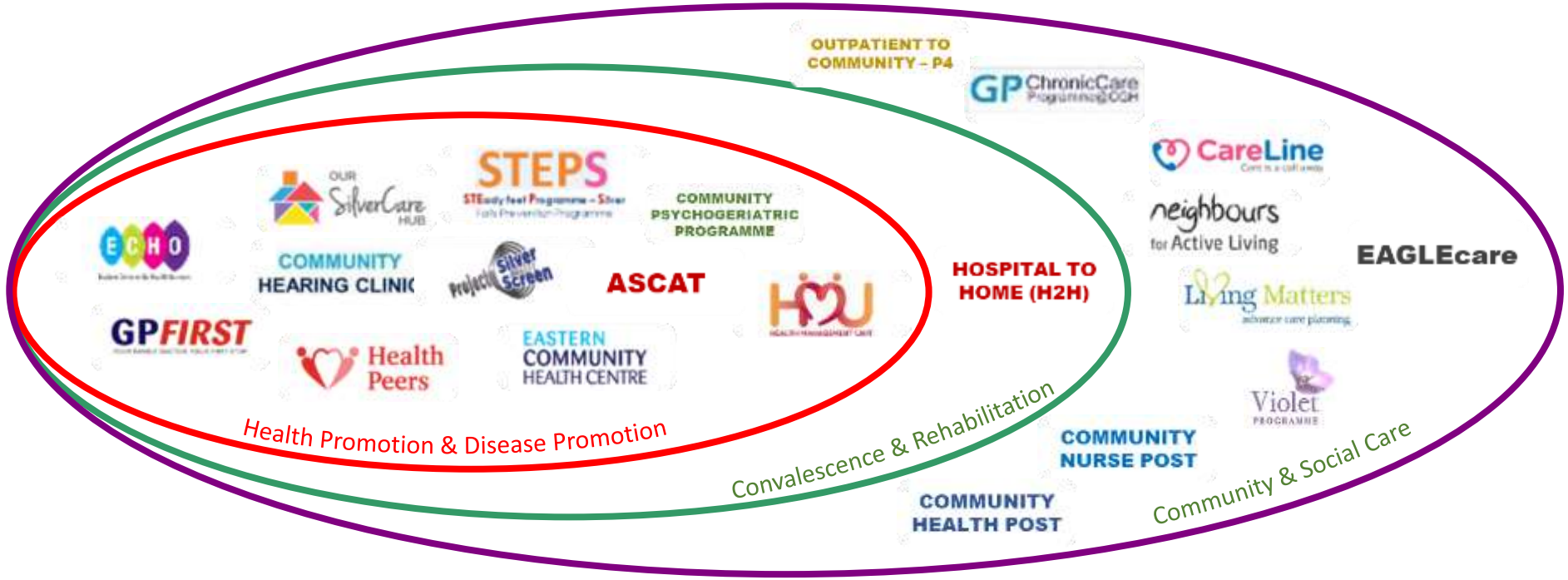
CGH RHS Programmes

Clin A/P How Choon How
Jan 2022

From Programmes to Population Health

Whole of Life Journey

Antenatal	<1 yo	1-6 yo	7-17 yo	18-24	25-39	40-49	50-59	60-69	70-79	80 & >
Antenatal	Newborns	Pre-school children	School-going children	Transition years	Early adulthood	40s	50s	60s	70s	80s



Health Status

Partnering Communities to

Keep Well, Get Well, Live Well

Keep Well

Link to Community Resources

Get Well

Flow from Hospital to Community

Live Well

Hold in Community

Community	Primary Care	Acute Care	Intermediate Long Term Care	Community
Grassroots Org, VWOs, National Agencies	Polyclinics FMC, GPs, PCNs	Hospital	Community Hospital Nursing Homes	Senior Care/Activity Ctrs Day Rehab Ctrs
Community Health Screening	Right-Siting Programmes		Hospital-To-Home (H2H)	Advance Care Planning
Falls and Frailty Screening	Community Health Centre (CHC)		Telecare for Patients (Medical)	End of Life Care
Functional Screening & Follow-Up Care	Geriatric Services Hub		Tele-monitoring Tele-consultation	Community Health & Nurse Post
Mental Health Promotion			ACP & EOL for Nursing Home	Telecare for Seniors (Psychosocial)

Community Nursing

Community Partnership

Partnering Communities to

Keep Well, Get Well, Live Well

Keep Well

Link to Community Resources

Get Well

Flow from Hospital to Community

Live Well

Hold in Community

Community	Primary Care	Acute Care	Intermediate Long Term Care	Community
Grassroots Org, VWOs, National Agencies	Polyclinics FMC, GPs, PCNs	Hospital	Community Hospital Nursing Homes	Senior Care/Activity Ctrs Day Rehab Ctrs
ECHO	GPFIRST – Your Family Doctor, Your First Stop	Hospital to Home (H2H)	CareLine – Care is a call away	
Community Hearing Clinic	Tampines Family Medicine Clinic; Eastern Community Health Centre	neighbours for Active Living	Living Matters – advance care planning	Health Peers
STEPS – STEady feet Programme – Silver Falls Prevention Programme; Project Silver Screen	Our SilverCare Hub	HMU – Health Management Unit	Community Nurse Post (CNP)	Violet Programme
ECHO @CHP	GP ChronicCare Programme@CGH	Telehealth Initiatives	EAGLEcare	
Comm Psychogeriatric Programme (CPGP)	P4 – Delivering Person Centric Seamless Care; ASCAT Programme			

Partnering Communities to

Keep Well, Get Well, Live Well

Keep Well

Link to Community Resources

Get Well

Flow from Hospital to Community

Live Well

Hold in Community

Community | Primary Care | Acute Care | Intermediate Long Term Care | Community

Voluntary Welfare Organisations

Community Hospitals & Nursing Homes

Others

Community Development Councils (CDC) & Grassroots Organisations

Primary Care

Primary Care Network (PCN) GPs

National Agencies

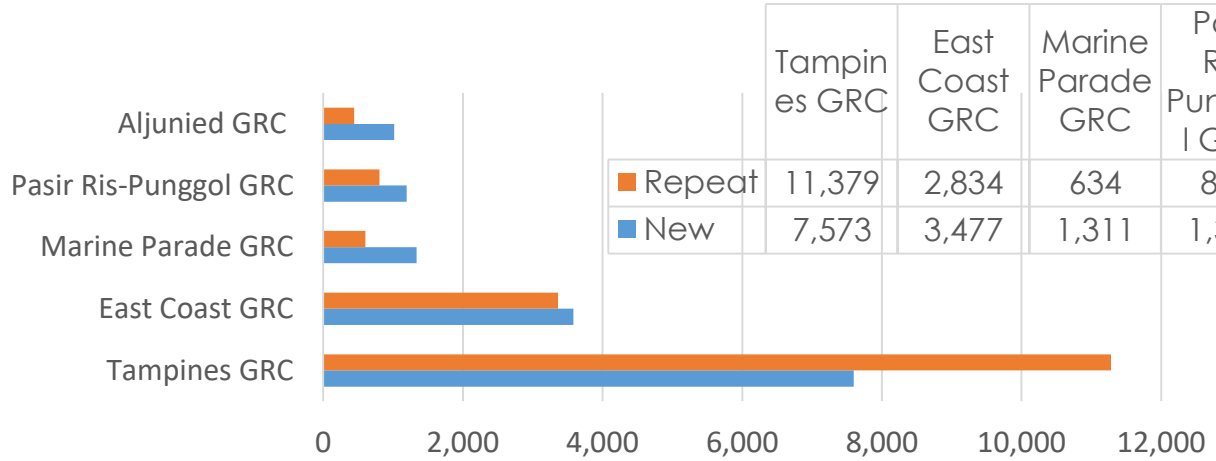
Community Networks for Seniors – 3S approach

Case Master Action Planning (MAP)

CGH RHS Programmes

Eastern Community Health Outreach (ECHO)

>30,000 screening attendances from FY2011 to FY2021 (3rd Quarter)



	Tampines GRC	East Coast GRC	Marine Parade GRC	Pasir Ris-Punggol GRC	Aljunied GRC
Repeat	11,379	2,834	634	835	465
New	7,573	3,477	1,311	1,335	1,006

Key focus from FY2022 onward

Continued alignment with Screen For Life (SFL) to drive screening to Partnered CHAS GP Clinics

ECHO screening continued on a smaller scale to comply with Safe Management Measures (SMMs)

ECHO Team to support Health Up! Programme operation and ECHO screening incorporated into the Programme

A chronic disease **prevention** and **intervention** programme

Early detection of conditions or risk factors

Intervention to prevent or delay onset of chronic diseases

High blood pressure, high cholesterol and diabetes

Functional Screening

Detect functional decline in vision, hearing, and oral health among seniors in the community early, and to provide timely follow-up as well as affordable assistive devices to seniors who need them

1 Outreach / Registration

People's Association

2 Level 1 Functional Screening

Project Silver Screen (PSS)

Health Promotion Board

2 Community Health Screening

SingHealth

Coordinating role:
Health screening with L1 Functional Screening

3 Screening & Follow Up

SNEC Eye Bus parked at designated locations.

Singapore National Eye Centre

NDCS service using dental facilities in designated schools

National Dental Centre Singapore
SingHealth

Community Hearing Clinic
- Setup at Heartbeat@Bedok and Our Tampines Hub (OTH)
- Supported by CGH Audiologists

Changi General Hospital
SingHealth

Heartbeat@ Bedok
Started in 1 Nov 2018

Our Tampines Hub
Started in 3 Aug 2020

Community Mental Health Care

Provides services, support and training on Community Mental Health through:

TRaCS
Trauma Recovery & Corporate Solutions

Building resilience in the community and workplace

Provide consultation, training and counselling services to:

- **Build human resilience**
- **Enhance emotional support** during crisis
- **Improved mental health literacy** at the workplace

ASCAT
CGH Assessment & Shared Care Team

15yrs & above, general mental health conditions

- **Fast-tracking and timely access** for primary care and identified community partners for assessment and stabilisation @ CGH
- **Right-site suitable** patients back to primary care or community providers
- **Build capabilities** for primary healthcare providers and community partners
- **Build and integrate** a network of health and social support

CPGP
CGH Community Psychogeriatric Programme

65yrs & above with psychiatric disorder(s) started since Apr 2007

- **Early detection** of seniors mental health
- Equipping & working with community health & social care agencies, through **training & support**
- **"Shared care"** with SHP Bedok Tampines Polyclinic – Grace Memory Clinics

GPFirst

Collaboration between A&E & GP Clinics to encourage and educate community to visit GPs for mild-to-moderate conditions

173 Participating Clinics *(as of Dec 2021)*

Formation of GPFirst Extension Action Team (GPFEAT)

CGH to oversee implementation

FY2020 — FY2022

Share domain expertise, alignment of content, develop campaign themes and messages across institutions

STEady feet Programme – Silver (**STEPS**: Falls Prevention)

Programme Objectives:

- **Identify seniors with risk of falls** for appropriate intervention
- **Increase community awareness** of falls and how these can be prevented
- **Build capability of community and primary care partners** for falls prevention in the community

L1 Screening

Target group: ≥ 60 yo
Using a 3-qn FROP-Com to screen:

- Falls, Function, Balance
- Balance: Appear unsteady or at risk of losing balance

LOW RISK

Education

HIGH RISK

Proceed L2 detailed assessment

L2 Assessment

Community Nurses & Community Care teams

Comprehensive assessment and appropriate referrals to clinical care and intervention programmes

Health & Medical

Vision

Short Physical Performance battery (SPPB)

L3 Intervention

"Steady Feet" Structured Group Exercises

Falls &/or Frailty specific

Medical Mgt @ Polyclinic, Tampines FMC or CGH SOC

Diet counselling & workshop

Community Nurse Posts

1 to 1 Physiotherapy

Referral Sources:

Community Health Post

Senior Activity Centre

Community Falls Prevention (Steady Feet Programme – Silver)

A community initiative by CGH to **reduce the risk of falls for community-dwelling older adults**. It is conducted in **3 levels**.

ID Seniors at-risk of falls in community

Holistic assessment & Education

Steady Feet Exercise Class

In Partnership:

ActiveSG

Community Service Providers

Health

Medical

Physiotherapy

Care services

Nutrition

Recommend interventions

Programme was affected by COVID19 as it was put on hold from Apr20 to Oct20 and is was impacted again recently due to recent heighten SMM measures.

Status of Yr 1 POC stage:

- 92% eligible participants enrolled in STEPS programme
- 29 intervention & 33 control
- 71% completed SF exercise class
- More improvement observed in intervention group relative to control group over time

Progress from Nov 2020 to May 2021:

No of pax screened is

244

No of potential @ risk for L2 assessment

175

20

No of L1 screening activities

3

Public talks on falls prevention

FY2022 Workplans:

- To achieve Year 2 Proof-of-Value (POV) target size of 300pax
- Planning for Year 3 Implementation stage
- Train more Fitness Instructors from Active SG, NTUC Health, and other partners

Community Geriatric Care (Our SilverCare Hub)

A HSDP project (aka Geriatric Service Hub) to **identify and site older patients** (65yo & above) with appropriate geriatric syndromes, from A&E **to the community for continuing care services**, through **targeted geriatric assessment and care coordination**.

ID & refer at-risk Seniors from CGH A&E to Our SilverCare Hub (OSH)

Holistic assessment & care plans

Our SilverCare Hub

Geriatric Service Hub

In partnership:

Changi General Hospital SingHealth

TAMPINES FAMILY MEDICINE CLINIC

EASTERN COMMUNITY HEALTH CENTRE

ST. ANDREW'S SENIOR CARE

- Training
- Physiotherapy
- Investigations
- Nutrition
- Case discussion
- Care services

Interventions to seniors with support to partners

FY2022 Workplans:

- Working with **Bedok Polyclinic** as 2nd site for patients residing in Bedok
- Enhancing and scaling ➔ more components & service offerings & more referral sites to increase accessibility
- **Shared care** between primary care & CGH Geri SOC
- **Strengthen** referral and care **integration across CGH community programmes** e.g. Community Nursing
- Develop/enhance the **partnerships with community service providers** to enhance care service offerings e.g. home rehab therapy

Progress from Oct2018 to Mar 2020:

452
Total Referrals into OSH Programme

41%
First Visit Actualisation Rate

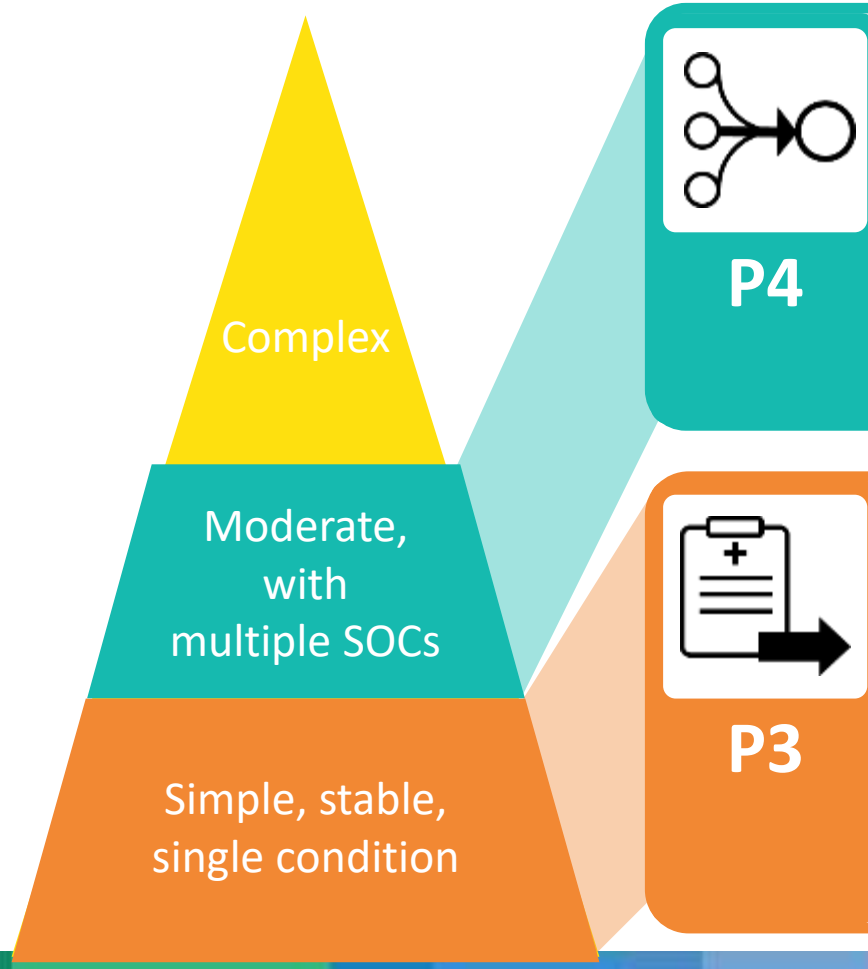
117
Onward referrals to Interventions/Services

- Open access diagnostic support
- Nutritional & physio services
- Right-site A&E referred patients with subsidised drugs

Outpatient to Community (O2C)

A right-siting programme aimed at

- **Discharging and appropriately-site** medically stable patients, ensure continued care under a Family Physician or General Practitioner.
- **Reducing the fragmentation** of specialist care by coordinating the care of patients across specialties, **Streamlining SOC appointments** by leveraging on shared care arrangements with primary care where appropriate



P4

Delivering Person-centric Seamless Care

- RHS P4 Prog aims to **streamline multiple SOC** appointments for patients, and promote right-siting to appropriate care setting – CHI clinic.
- To develop **shared care** protocols and workflows between SOC and primary care receptacle – new initiative to partner closely with 7 GPs within eastern region.

P3

Right-Siting from SOC to Primary Care

- RHS P3 Prog / GP Chronic Care Programme (GPCCP) aims to discharge and **appropriately-site** clinically stable SOC patients to GPs.
- To facilitate **care continuity** under a Family Physician or General Practitioner
- > 25 Panel GPs
- Covers 19 conditions under 8 Specialties (CVM, END, RES, NEM, URO, OTO, GAS, RHE).

Community Health Centre (CHC)

Eastern Community Health Centre (CHC) is set up to provide essential healthcare services to complement the clinical care provided by GPs in the management of chronic and long-term diseases in the community, with greater proximity convenience for the patients

Location: **Level 3, Our Tampines Hub**

CHC provides allied health services to complement clinical care by GPs such as:

- Diabetic Eye Screening (DRP)
- Diabetic Foot Screening (DFS)
- Dietetics Service (DS)
- Nurse counselling and education (NCE)
- Physiotherapy services

>27,000 Patients since FY10

Health Management Unit (HMU)

Empower patients with the knowledge and skills to manage their conditions at home

Changi General Hospital SingHealth

Tele-education

Recognize and manage symptoms related to patient's condition

Tele-monitoring

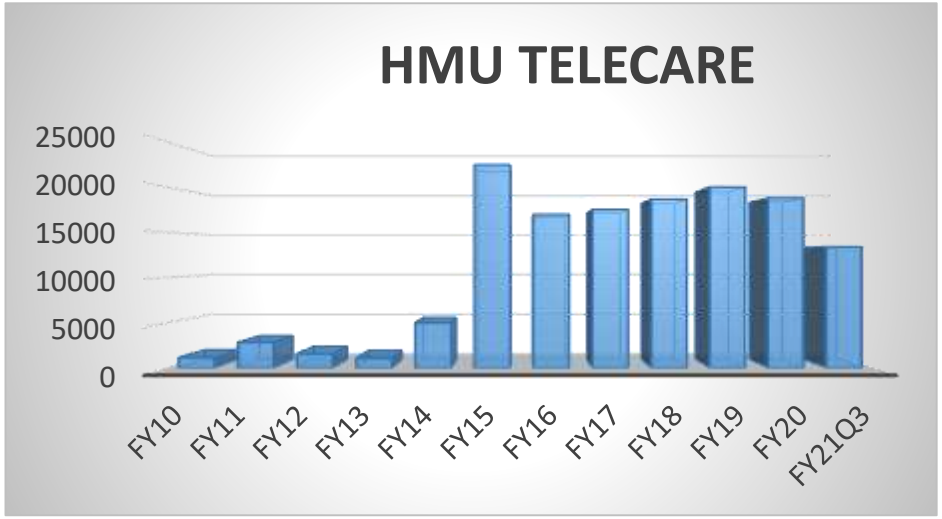
Blood glucose, pulse rate, blood pressure and weight of patient

Care Co-ordination

Work with other health care partners to co-ordinate patient's care

Supported by Patient Relationship Management (PRM) system

Access to clinical indicators and information for early intervention and follow up care



Hospital to Home (H2H)

Objectives:

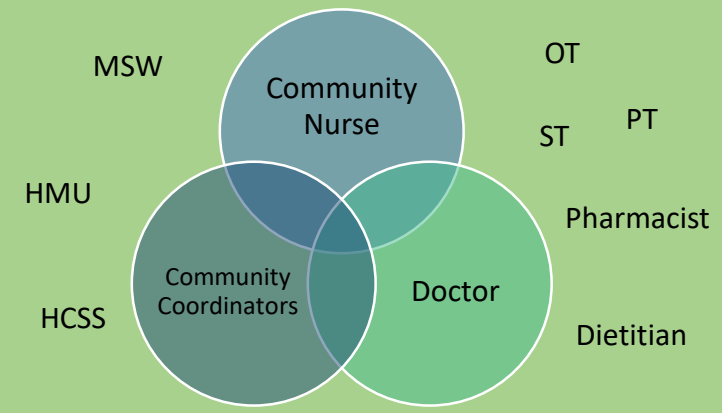
1. To facilitate timely discharge from hospital
2. To address patients' medical, nursing, functional and psychosocial needs while they transits from hospital to home
3. To reduce unplanned readmissions to hospital and re-attendances at ED

Patient Navigators Assess All Frequent Admitters

- Coordination of care within the hospital

Handover of cases
Community team may be involved before discharge

CGH Integrated Community Team

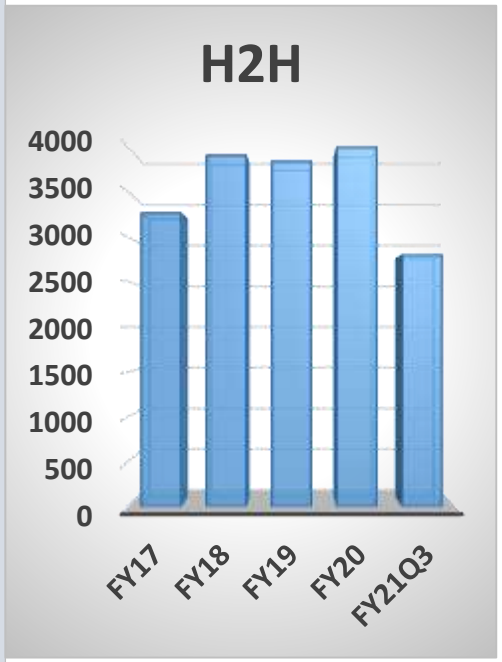


- Direct medical , nursing , rehabilitative and psychosocial care (up to 6 months)
- MDM Case Discussions
- Supported through virtual care e.g HMU, HCSS

Coordination and link
back to medical team in hospital

Post H2H Support

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



Telehealth for Post Discharge & SOC Patients

Leveraging on technology to provide continuity of care via Vital Signs Monitoring (VSM) @ home

Equipping post discharge patients with blue-tooth enabled devices

Tablet

Or using Handphone

Weighing Scale

Glucometer

BP Monitoring Set

Conditions: Heart Failure Diabetes

Coming soon!

Proof of Value pilot in collaboration with IHIS, MOH and other participating cluster institutions

Neighbours for Active Living

neighbours for Active Living

A unique programme **integrating both health and social expertise** to help seniors at risk of frequent admissions

SingHealth Regional Health System

Changi General Hospital SingHealth

Informal Networks

e.g. Grassroots Organisations, volunteers

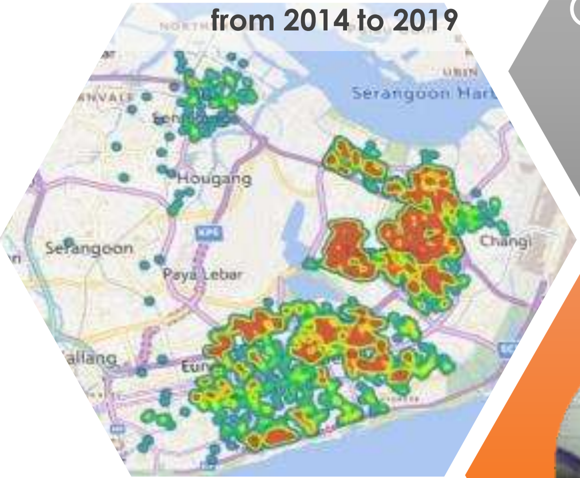
Social Service Agencies

CGH Healthcare professionals

Nursing skills

Social work skills

7,500 residents reached from 2014 to 2019

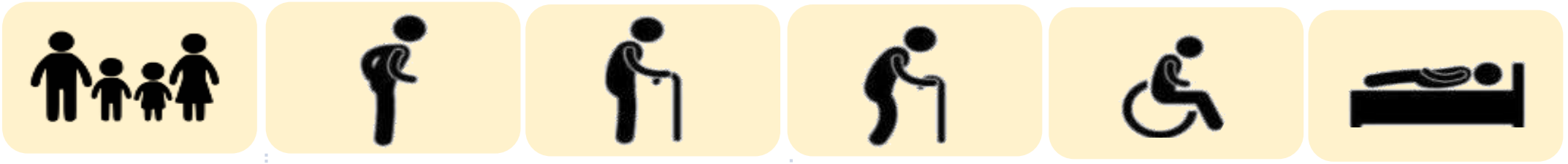


Client

- Coordinate medical care
- Link up with community and volunteers
- Refer to formal services
- Reminders
- Identify Red Flags

Community Nursing

Services organised around Life Journey



Well | Pre-frail & Frail | Post-hospital/ Complex Care | Palliative

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



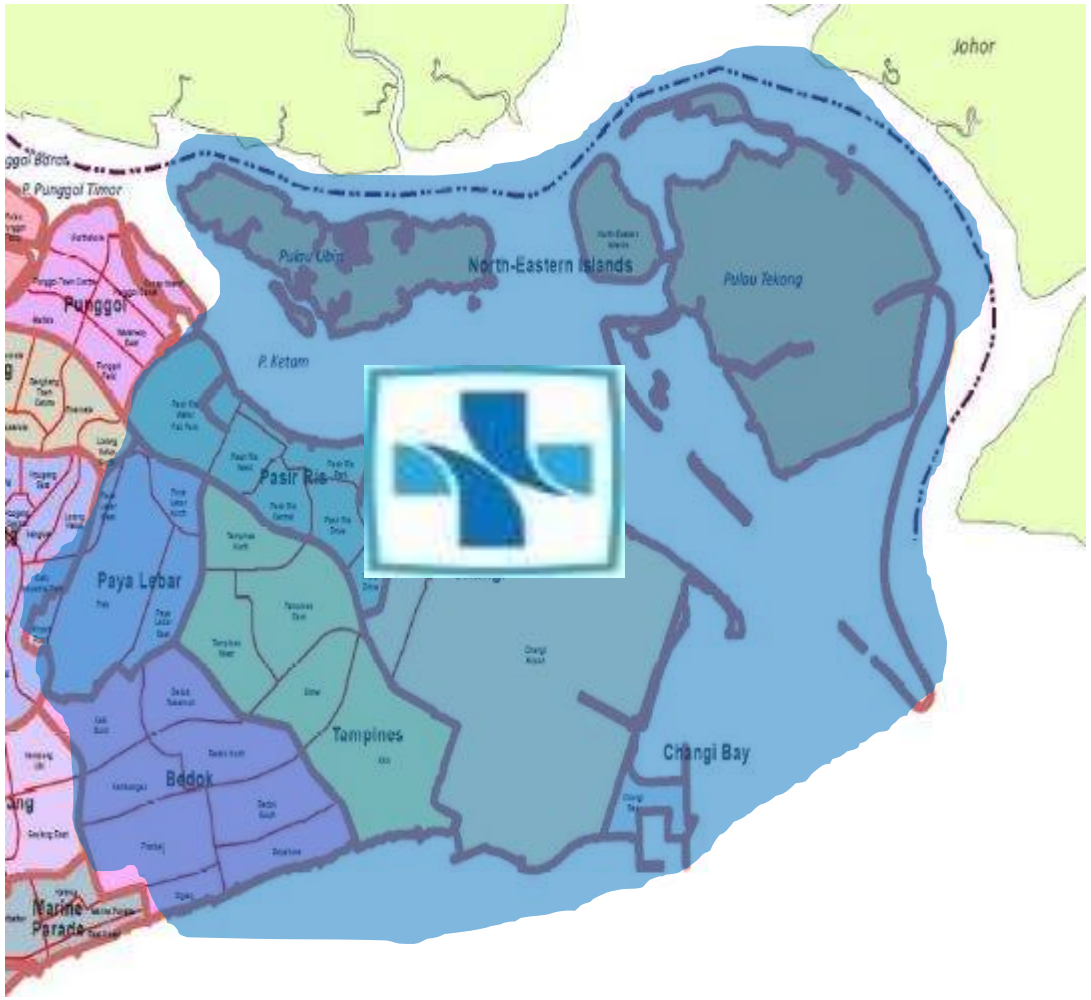


Community Nursing Post

East

No. of CNP Posts

30



COC	CNP
Pasir Ris	Golden Lily @ Pasir Ris MWS SAC Brontosaur Park RC COMNET @ Blk 467 Pasir Ris
Tampines	Evergreen Circle SAC Pacific Activity Centre Anglican Senior Center (Tampines) Lions Befrienders SAC @ 499C Tampines Lions Befrienders SAC @ 494E Tampines Darul Ghufran Mosque Lions Befrienders SAC @ 434 Tampines Our Tampines Hub
East Coast	THK Bedok Radiance SAC THK SAC @ Fengshan 114 THK SAC @ Fengshan 101 Bethesda (Bedok-Tampines) Church Siglap Community Centre Social Service Office @ Bedok Bedok Sunflower RC Brahm Centre @ Simei Peacehaven @ Bedok Arena
Marine Parade	Tembusu SAC Kembangan-Chai Chee SAC Sunlove Kampong Chai Chee SAC Ping An Green RC Sunlove Day Activity Centre (Eunos) Masjid Darul Aman
Aljunied	THK SAC @ Kaki Bukit Moral SAC (Kaki Bukit) EconLife! Hub @ Bedok Montfort Care GoodLife!@Bedok (Referral Only)

LIVE WELL

Telehealth for Vulnerable Population

Leveraging technology to provide uninterrupted and better care for seniors at home

Equipping seniors at home with Telehealth Kits

BP Monitoring Set

Tablet

Weighing Scale

Glucometer

Pulse Oximeter

Pilot Areas in Bedok & Marine Parade are funded by AMF Silver Care Fund

Health education & coaching

Active Ageing Centre @ Bedok Radiance Jan 2021

Self-monitoring & review for chronic medical conditions

VC @ Home Aug 2021

Active management of health conditions

Pacific Activity Centre @Tampines Sept 2021

CareLine
Care is a call away

Care Model

- 24/7 telecare model for seniors
- Proactive and preventive
- Establish strong relationship

Supporting our seniors

- Link seniors with agencies
- Coordinate care or urgent assistance
- Activate 995 emergency ambulance

MINISTRY OF HEALTH SINGAPORE

HOUSING & DEVELOPMENT BOARD

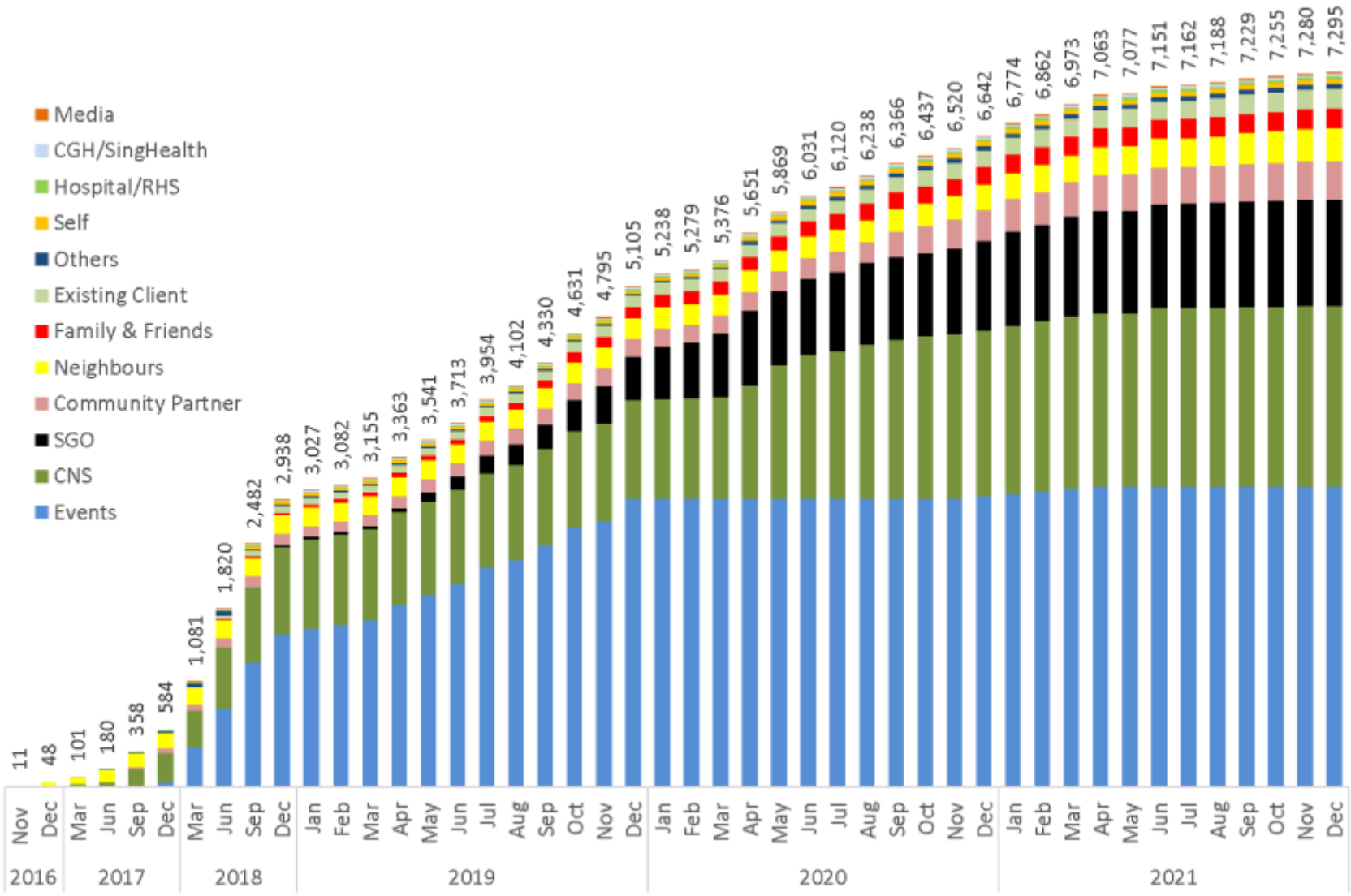
Hong Kong Senior Citizen Home Safety Association

28 Jan 2018 - Sunday Times


'Touch and hold' approach to senior healthcare

CareLine

CareLine
Care is a call away



Funding

MOH and MND (L2NIC)	2016 – 2019	$ 9,2m
MOH	2019 – 2024	$14.7m

Donations

Temasek Foundation	2017 – 2020	$657k
Singtel	2018 – 2020	$552k
Community Silver Trust		$276k
Pending		$414k

CareLine – Community Partnerships

CareLine Partners (n = 131)

as of Dec 2021

Visit by SMS Amy Khor

31 July 2017

Visit by Speaker Tan Chuan Jin

12 March 2018

Visit by Tampines GRC MPs

4 Nov 2020

Roadshows

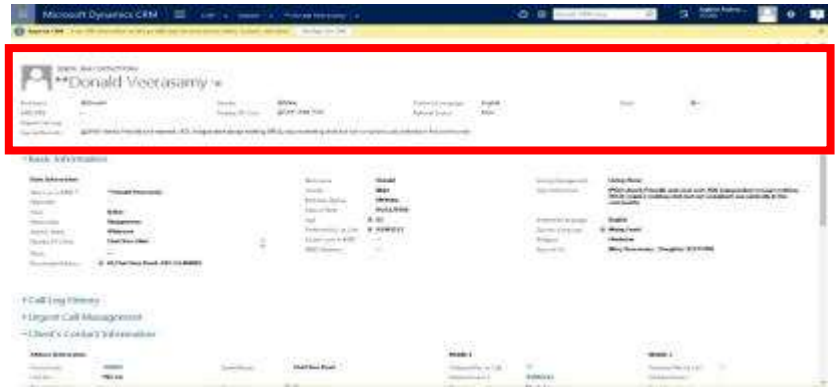
30 Mar 2019

13 July 2019

CareLine CRM and Mobile App

CareLine
Care is a call away

CRM



- Microsoft Dynamics 365 CRM
- Fast pop-up of client info
- Main client info header
- Record of all calls – promotes relationship building
- Enables a team approach

Mobile phones & App

- Low income seniors without phones
- One push button to connect to CareLine
- Remote access to trigger phone functions (E.g. Extracting GPS coordinates)

Funders:

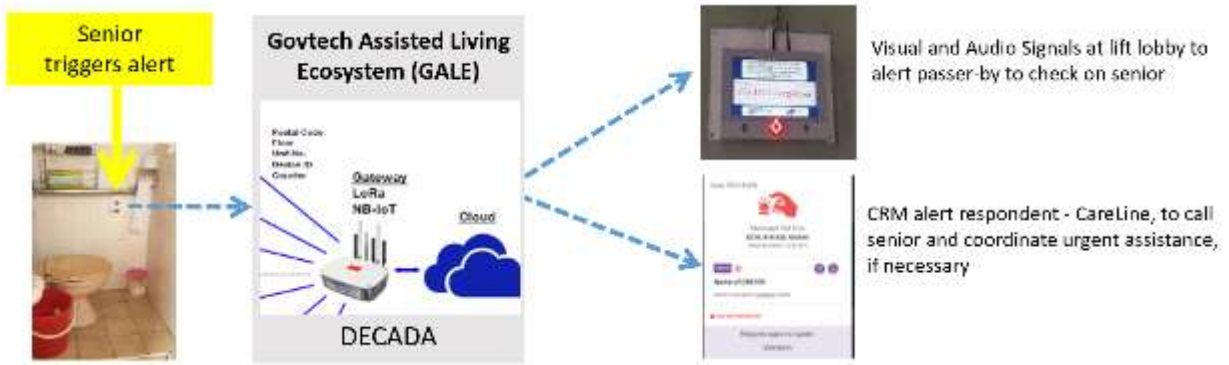
TEMASEK FOUNDATION Singtel

1,500 Phones Deployed

Project LIFE

CareLine
Care is a call away

Wireless Alert Alarm System



12,806 Seniors in Rental Blocks (as of 31 Dec 2021)

ProjectLIFE: Target 14, 270 seniors in 53 rental blocks

- Supporting seniors who triggers wireless Alarm Alert System (wAAS) for urgent coordination
- Using GALE system: **One CRM for all SACs and CareLine** to input case notes for better continuation of care

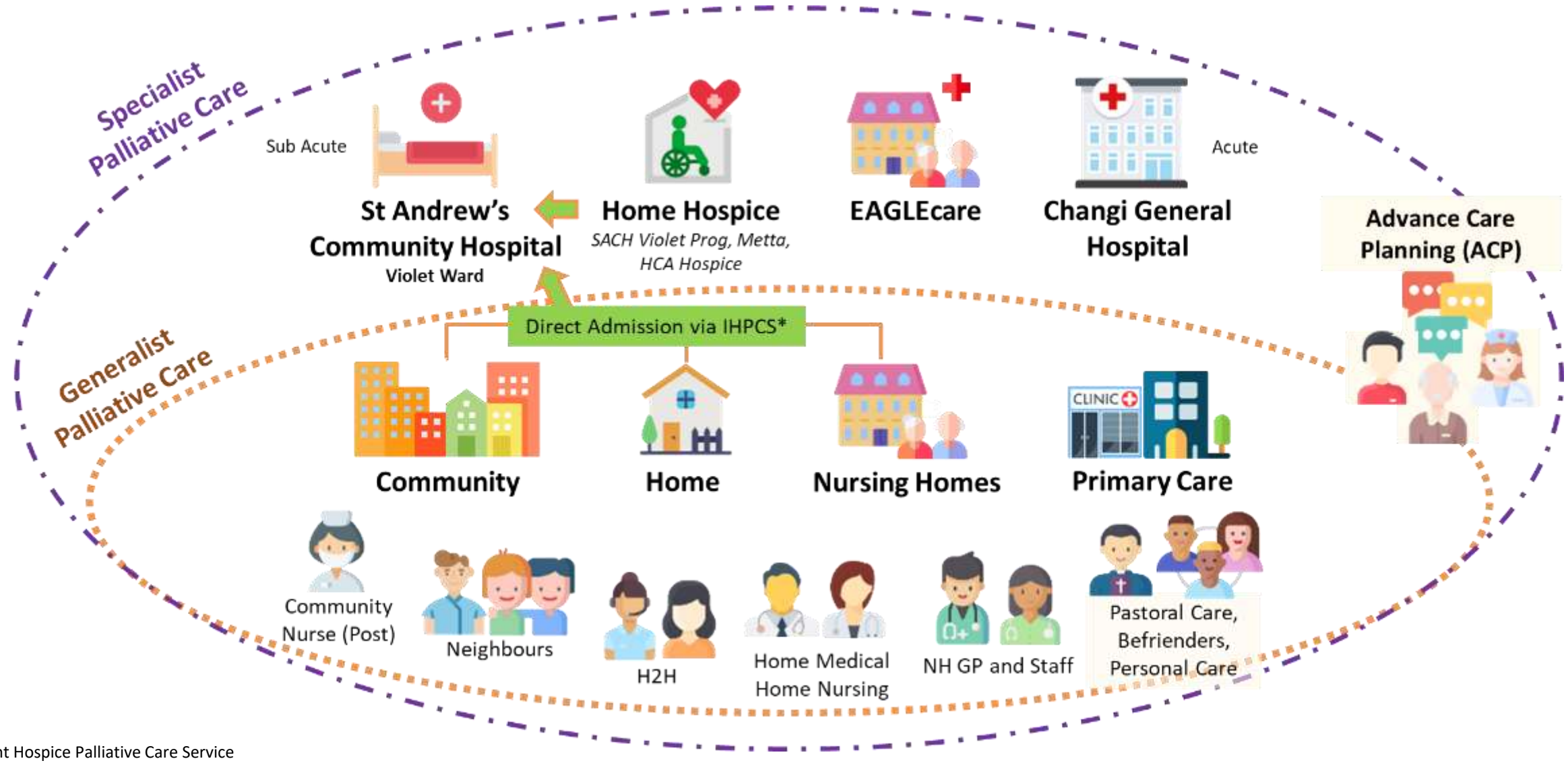
Partnership with HDB and GovTech

GOVTECH SINGAPORE

HOUSING & DEVELOPMENT BOARD

2022 onwards: Obtained **$276,000** from Community Silver Trust (CST) grant to scale this beyond ProjectLIFE

Designing End of Life Landscape in the East



* Inpatient Hospice Palliative Care Service

LIVE WELL

Advance Care Planning (ACP)

A **guided process of conversation** with patient and loved ones about their preferences for care & treatment in view of their **life values**, **beliefs** and **goals of care**

Embed ACP as part of good patient care and standard clinical practice in CGH

Pilot implementation in Cardiology, Geriatric, Renal and Respiratory & Critical Care Medicine

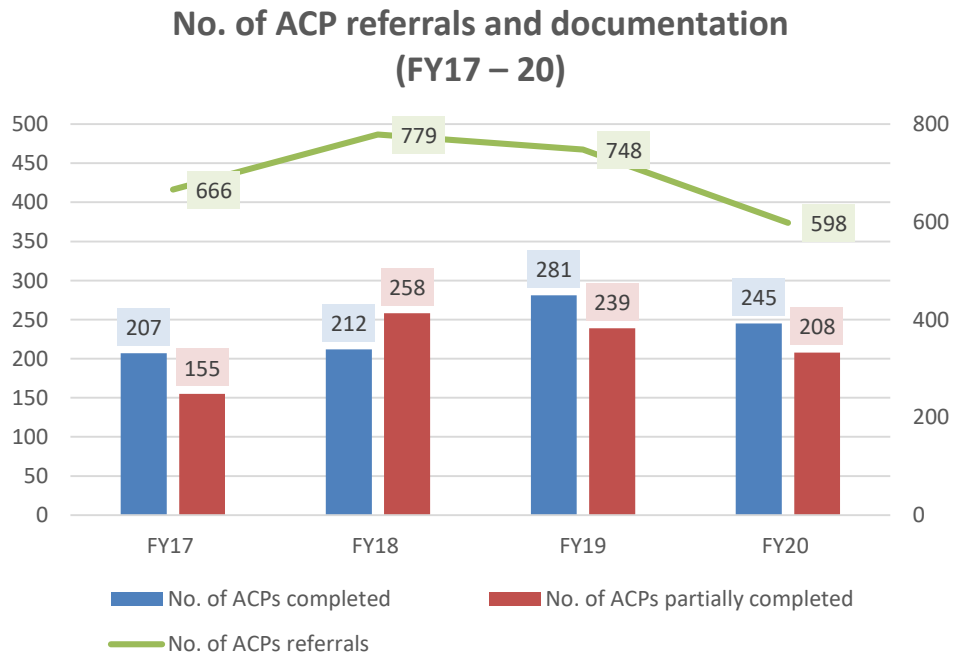
- ACP Champions appointed in each discipline
- Patient groups for ACP identified

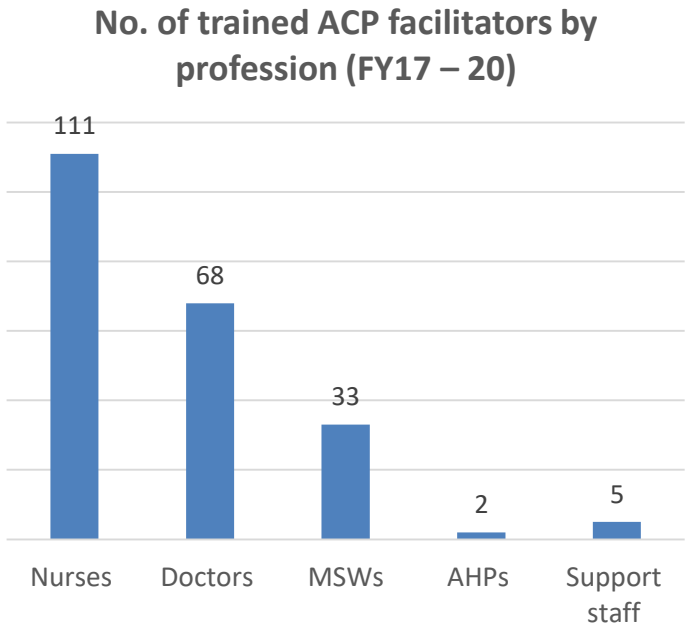
Strengthen the 4 pillars of ACP: a) Awareness; b) Training; c) Enhance systems; d) Audit/ Evaluation

- 17 ACP awareness talks conducted
- 219 CGH ACP facilitators trained
- ACP referral and documentation IT platforms implemented

(2018-2021)

ACP Discussion Framework:





PATIENTS AT THE HEART OF ALL WE DO.

EAGLEcare Programme

Enhancing **A**dvance Care Planning, **G**eriatric Care and End of **L**ife care in the Nursing Homes in the **E**ast

1. Upskill NH staff in providing ACP services

- >678 ACP/ PPC conversations completed with NH residents
- 71 NH staff trained to conduct ACP/ PPC discussions

(2016-2021)

2. Build professional capabilities of NH staff in Geriatric and EOL care

- 259 NH staff* trained across 3 Geriatric and EOL care courses

** Combined total. Staff may participate in multiple trainings*

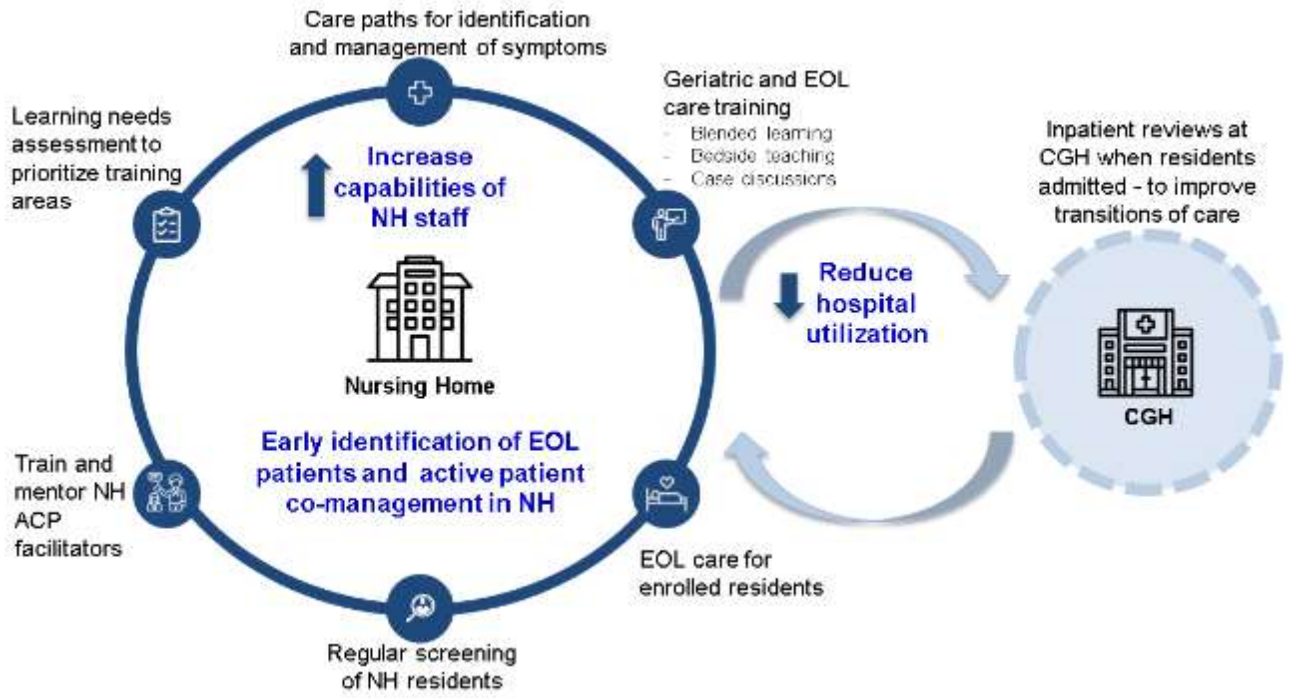
(2018-2021)

3. Develop shared-model to deliver EOL care for suitable NH residents

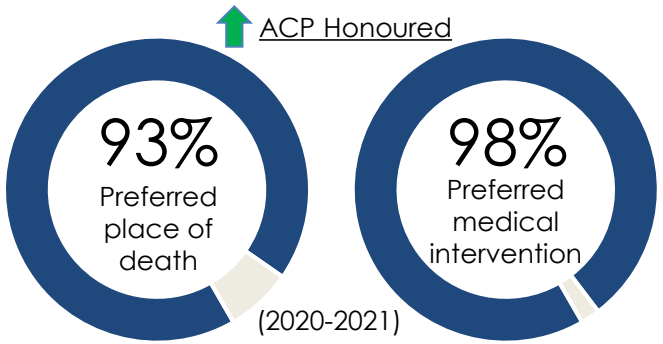
- 1,079 NH residents screened
- 488 NH residents eligible
- 409 NH residents enrolled

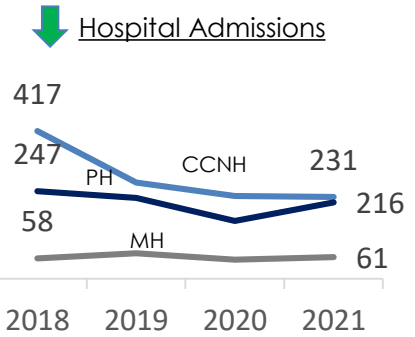
(2018-2021)

Framework:



Key outcomes achieved:



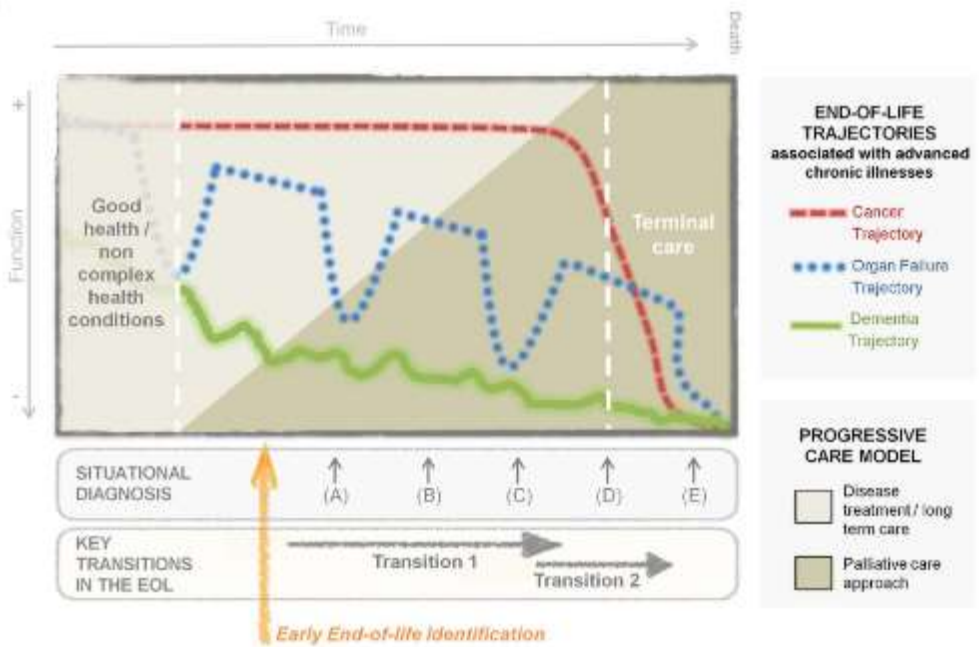


NH partners in the East:

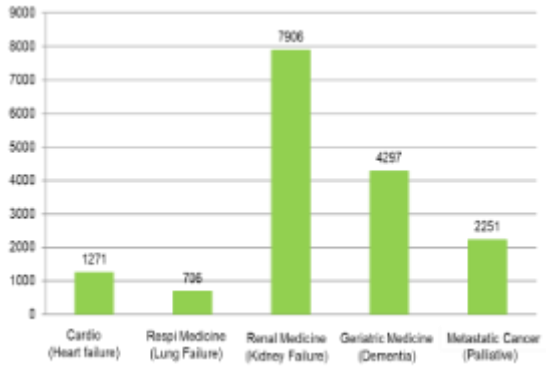
Peacehaven Nursing Home	Moral Home for the Aged Sick	NTUC Health (Chai Chee) Nursing Home	Lions Home for the Elders (Bedok)
Since Jan 2016	Since Sep 2016	Since Nov 2017	Since Feb 2017

Palliative Care in the East

The **Violet Programme (ViP)**, a collaboration home hospice programme with clinical leads from both SACH and CGH, for end organ failure and frailty patients. Weekly MDMs are held with both clinical leads , close communication with patient's end organ primary physician for better continuity of care.



Source: bmjopen-2016-Sep



CGH FY18 - Number of Inpatients from the varied Disease Trajectory

Developing Generalist-Specialist Model of Care

Extended 24/7 support to EAGLEcare NHs from Jan 2021