National Healthcare Group
POLYCLINICS

MEDIA RELEASE

NHGP'S RELATE PROGRAMME ADDRESSES PATIENTS' HEALTH & SOCIAL NEEDS

Health-social integrated care empowers patients to improve health outcomes

Singapore, 15 September 2023 – Population health studies showed that unmet psychosocial needs are linked to higher prevalence of chronic diseases and mortality risk[1]. Recognising that health and social challenges often co-exist in patients with complex conditions and these affect their health and wellbeing, the National Healthcare Group Polyclinics (NHGP) proactively identifies the unique needs of complex patients and integrate their health and social care under the **RELationship-based heAlth and social inTEgration** (RELATE) programme to achieve better health outcomes in patients.

2 First piloted in September 2020, RELATE seeks to manage complex patients with psychosocial issues and aims to reduce their overall healthcare utilisation by reducing Emergency Department visits for crisis care, Specialist Outpatient Clinic referrals and polyclinic visits for poorly controlled chronic conditions. RELATE also seeks to improve these complex patients' clinical outcomes by improving compliance to medications and follow-ups and chronic disease control.

3 RELATE is operationalised through a comprehensive systematic assessment of unmet psychosocial needs in at-risk patients and the creation of shared care plans through partnerships with community healthcare partners around NHGP to integrate health and social care. This integration is made possible through continuing care coordination provided by the NHGP Care Coach, who is a non-clinical staff serving as a health buddy for complex patients with multiple biopsychosocial needs[2], and the health-social integrator for community partners.

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[1] *References include:*

a) Caroline G Heller, Preventive Medicine 153 (2021), The association between social needs and chronic conditions in a large, urban primary care population.

b) Megan B. Cole, Health Service Res. 2020 Unmet social needs among low-income adults in the United States: Associations with health care access and quality.

c) Kevin P. Fiori Am J Public Health. 2020 Unmet Social Needs and No-Show Visits in Primary Care in a US North-eastern Urban Health System, 2018–2019.

d) Mekdes Tsega, The commonwealth Fund review of evidence for health-related social needs interventions (2019).

[2] *Biopsychosocial needs refer to medical and psychosocial needs.*

Comprehensive, Coordinated and Continuous Care Through NHGP's Teamlet Care Model

4 For effective social prescribing to happen, NHGP, being the first line of care in the community and the first point of contact with patients, will be the integrator in this whole ecosystem of care to proactively intervene patients' health outcomes. NHGP will look after patients' medical needs and at the same time, identify, prioritise, and connect them to relevant agencies for further non-medical support.

5 Dr Valerie Teo, Family Physician, Consultant, Head of Kallang Polyclinic and Programme Lead for RELATE shared, "NHGP adopts a multi-disciplinary approach that looks into integrating health and social services support to improve the wellbeing of complex patients with psychosocial issues. This is in addition to our underlying Teamlet Care Model where patients are placed at the centre of care with the care team providing comprehensive, coordinated and continuous care. This is integral in improving the health outcomes of these patients."

6 NHGP's Teamlet Care Model[3], introduced since 2015, anchors on a close patient and Family Physician relationship. This relationship-based model of care provides comprehensive, coordinated and continuous care, enabling the multi-disciplinary team to not only identify patients' complications early, prevent and manage it, but also addresses underlying social factors and challenges the patients may face that could impact one's health.

7 Since the launch of the RELATE programme, the multi-disciplinary team comprising NHGP and community partners has intervened more than 400 NHGP patients with health and social needs. This group of patients are identified to have both clinical and psychosocial care complexities such as self-care difficulty, poor compliance to treatment; or risk factors such as frailty, cognitive impairment, frequent falls, nutritional deficiencies or complex medication regimes.

8 RELATE's comprehensive systematic assessment for unmet psychosocial needs in at-risk patients have seen significant improved health outcomes. Six months after these patients were enrolled in RELATE, nearly half of them saw a reduction in polyclinic visits. Compliance to medication also improved by 10%. Of those in the RELATE programme with diabetes mellitus, more than two third of them saw an improvement with an average reduction of a HbA1c mean level of 0.59. Patients who had poorly controlled diabetes at the start of the programme saw an improvement with an average reduction of HbA1c mean level of 1.1%. In addition, 1 in 5 patients were saved of Emergency Department and Specialist Outpatient Clinics visits.

NHGP's Care Coach improves Health Outcomes as Health-Social Integrator

9 A key component of RELATE is the continuing care coordination and follow-up provided by the NHGP Care Coach who acts as a health buddy and health-social integrator to the patients throughout their healthcare journey. When patients with complex medical and social needs are identified together with the multi-disciplinary team, the Care Coach will first perform a comprehensive assessment of patients' potential needs and challenges to identify

[3] *The Teamlet Care Model is a proactive approach of care delivery where sustainable and continuous care is given by a dedicated team of healthcare professionals comprising 2 Family Physicians, 1 Care Manager, and 1 Care Coordinator. The multi-disciplinary team manages patients with chronic disease, creating a strong relationship between the teamlet and patient.*

unmet psychosocial and clinical needs of the patients and follow up with patients under an individualised intervention plan – one that is patient-centred, holistic and tailored to individual patients' needs.

10 Throughout the programme, the Care Coach looks after the patients according to their individual needs and empowers and motivates them in their health journey. The Care Coach also helps patients navigate within NHG Polyclinics and between community partners and hospitals, serving as a single point of contact between the patient, caregivers and the multi-disciplinary team. For instance, the Care Coach will ensure medication compliance is observed for patients with complex social needs such as those who are socially isolated or lonely.

11 By identifying and resolving unmet psychosocial issues early through the Care Coach, this reduces the likelihood that patients need to return to the polyclinic for unscheduled acute visits, a worsened condition, or complications arising from their conditions that would require further medical interventions.

12 Ms Yeo Loo See, Deputy Director, Nursing Services, stresses that the Care Coach plays an integral role in helping patients with chronic conditions achieve their health goals. "Our Care Coach is trained not just in chronic disease management, but also in skills that help behavioural change such as motivational interviewing skills. As a 'buddy', they journey with patients with chronic conditions to support them in persisting with the lifestyle changes needed to achieve the best health outcomes. At NHGP, our Care Coach understands and will focus on "what matters most" to these patients in their life. Therefore, the Care Coach is able to provide the necessary support and empower patients with skills that are needed to care for their health in the long term."

13 "The Care Coach is the bridge between the patient, polyclinic care team and our community partners, and will help support the patients till their situation improves or stabilises," explains Dr Valerie Teo.

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About National Healthcare Group Polyclinics

National Healthcare Group Polyclinics (NHGP) forms the primary healthcare arm of the National Healthcare Group (NHG). Its seven polyclinics serve a significant proportion of the population in the central and northern regions of Singapore.

NHGP provides a comprehensive range of health services for the family, functioning as a one-stop health service centre providing treatment for acute medical conditions, management of chronic diseases, women & children services and dental care. The focus of NHGP's care is on health promotion and disease prevention, early and accurate diagnosis, disease management through physician led team-based care as well as enhancing the capability of Family Medicine through research and teaching.

Through the Family Medicine Academy and the NHG Family Medicine Residency Programme, NHGP plays an integral role in the delivery of primary care training at medical undergraduate and post-graduate levels. With the Primary Care Academy, NHGP provides training to caregivers and other primary care counterparts in the community sector.

More information is available at www.nhgp.com.sg.