YISHUN HEALTH
&
Personalised Care and Support Planning
UK YEAR OF CARE MODEL
Designed for clinic setting

1st visit
Gather information

Between visits
Share information

2nd visit
The conversation

Record the agreed shared care plan

Disease surveillance
Patients are organised by birthday month
Patient attends an appointment with a HCA to get appropriate “annual review” test & checks

Preparation
Patient receives results & agenda setting prompts >1 week before 2nd visit to review and prepare for the conversation

Conversation
A meeting of equals and experts
Prepared practitioner (GP/practice nurse) & patient:
- review how things are going
- consider what’s important
- share ideas, discuss options
- develop a care plan
Activities involved are consultation, joint decision-making, goal setting & action planning. The agreed care plan is documented.

Disease surveillance & preparation
Patient meets community nurse 1 week before doctor visit to review test results on HealthHub.
Patient goes through agenda setting prompts with community nurse to review and prepare for the conversation.

Pre-visit
Gather & share information

Clinic visit
The conversation

Record the agreed shared care plan

Conversation
A meeting of equals and experts
Prepared practitioner (Specialist/GP/Nurse) & patient:
- review how things are going
- consider what’s important
- share ideas, discuss options
- develop a care plan
Activities involved are consultation, joint decision-making, goal setting & action planning. The agreed care plan is documented.

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PCSP Yishun Health: Adaptations for Community Setting

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### Care Planning Appointment

<table>
<thead>
<tr>
<th>Appointment Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Appointment Time</td>
<td></td>
</tr>
<tr>
<td>Name of your doctor/nurse</td>
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<tr>
<td>Location</td>
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</tbody>
</table>

Your care planning appointment is for you to discuss with your care team on your personalised care plan. Before the session, please think about and answer the questions with [ ] . These are some questions to help you think ahead and plan what you would like to discuss during your appointment.

### Preparing for care planning

**Getting it right in the caregiving of her infant daughter**

<table>
<thead>
<tr>
<th>Sleep</th>
<th>Feeling down/ stressed/lonely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>Eating the right amount</td>
</tr>
<tr>
<td>Memory</td>
<td>Giving up smoking</td>
</tr>
<tr>
<td>Food choices</td>
<td>Coping with my day-to-day health</td>
</tr>
<tr>
<td>Driving/Travel</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Work/benefits/money</td>
<td>Keeping active and getting around</td>
</tr>
<tr>
<td>Pain/discomfort</td>
<td>Relationships/sexual health</td>
</tr>
<tr>
<td>Managing my symptoms</td>
<td>My future health</td>
</tr>
</tbody>
</table>

What else would you like to discuss at your appointment?

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Strengths

- 17 years of experience in the F&B industry
- Cooks & bakes well
- Receptive & open to feedback
- Adaptable

Health concerns not prioritised

- BMI 34
- Smoking
- Neglects health
- Unaware of health resources
Positive Mindset Shift
• Improved emotional state
• Improved anger management

Part-time Employment
Utilised her 17 years of experience in the F&B industry and secured a part-time role as a barkeep at a F&B establishment.

Caregiving for her Daughter
• Infant care placement allowed her to secure employment
• 3-day work week to spend time with her daughter

Working on Interpersonal Relationships
• Conflict resolution without anger and violence
• Encouraged to attend YFSC’s Group Counselling – Project Kindle

Emphasis on her Health
• Obtained her CHAS card
• Requested Connector to check her BGM and BP
• Requested to go for health screening

Working on Mother-Son Relationship
• Empathising with her son
• Gaining his trust
• Trying to lash out at him less
• Letting him come to her at his own time
• Giving both of them space to heal

PCSP Yishun Health: Adaptations for Community Setting
BUILDING THE YISHUN HEALTH HOUSE OF CARE & Personalised Care and Support Planning
Identify population

IT: clinical record and support for care planning

Admin for prompts, tests, assessments

Preparation for consultation

Informed / structured education

Emotional and psychological support

Key contact and continuity

Organisational processes

Triage and safety netting

Attitudes / consultation skills

Integrated, multi-disciplinary team and expertise

Senior buy-in / champions and role models

Personalised care and support planning conversation

Engaged informed individuals

Responsive Commissioning

HCP committed to partnership working

Identify population needs

Commission care and support planning

Community activities ‘More than Medicine’

Quality assure and monitor

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Yishun Health House of Care

Organisational & supporting processes

Engaged, informed individuals & carers

Person-centred coordinated care, through care & support planning

Health & care professionals committed to partnership working

“More than medicine” Participatory Care Eco-system & Community Services Eco-system
Yishun Health House of Care

Organisational & supporting processes

Engaged, informed individuals & carers

Personalised Care & Support Planning

Health & care professionals committed to partnership working

“More than medicine” Participatory Care Eco-system & Community Services Eco-system
House of Care: Deconstructed

Items in italicised font indicate work-in-progress or work to be implemented.
House of Care: Deconstructed

THINK Centre
Customer Contact Centre
AIP System, enhanced with Omaha System → NGEMR
Operational, financial (+funding), governance support

“UP” menu of programmes
Mini Medical School

Skills for Life Diabetes Empowerment Programme

Supported self-management Health Action Coaching

HealthHub

Peer support
Peer motivation
Peer-led programmes

Community Health Posts
Wellness Kampung
Share a Pot®

Regional Teams
Care coordination (Nurses, SWs)
Local area coordination (Connectors)

Operationalise Personalised Care & Support Planning

Shared Care Partnerships
Regular networking platforms

LAC, ABCD
Omaha System
Self-managed teams
YOC PCSP

Omaha System
YOC PCSP

Shared Care Partnerships
Integrated Medical Clinic
Ageing in Place Suite
Regional Teams

Restricted, Non-sensitive

Graphics adapted; source jargonautical

Items in italicised font indicate work-in-progress or work to be implemented
YISHUN HEALTH UNIFIED CARE MODEL (UCM)
An aspirational care model that is person and community centred

The UCM ensures that all residents have a “one care plan” emphasizing a fit and healthy life, as well as hassle-free access to dignified, safe and value-driven care by collaborative teams and networks.

The UCM represents our aspiration to co-create with all our staff and our communities the highest form of integrated care that is person and community centred, built upon collective strengths and shared goals, trust and relationships.

PERSONALISED CARE & SUPPORT PLANNING
A systematic process for collaborative planning between clinicians and persons living with long term conditions to personalize care and support

PREPARATION
- MEANINGFUL CONVERSATIONS
- PRODUCTIVE INTERACTIONS

SELF MANAGEMENT SUPPORT
- LIVE WITH
- LIVE WELL WITH

“provider of care → partner in care”

“first identifying and then mobilizing existing, often unrecognized, community assets”

LOCAL AREA COORDINATION (LAC)
An approach to support people in their pursuit of a good life

A capacity-building approach to work alongside people of all ages & backgrounds, based in and connected to local communities to help people find their own, informal & local solutions before resorting to and/or relying on formal services, to achieve:

1. Rich & fulfilling lives, supportive natural relationships, citizenship, contribution and resilience for individuals and families
2. More inclusive, welcoming, supportive and resourceful communities
3. Stronger partnerships and connections between services and local people & communities to COMPLEMENT & SUPPORT, rather than replace, informal & community solutions

NATIONAL HEALTHCARE GROUP (NHG) RIVER OF LIFE
NHG’s future-facing framework of a holistic approach to sustaining good health

ASSET BASED COMMUNITY DEVELOPMENT (ABCD)
An approach to sustainable community-driven development
DOCUMENTATION

&

Personalised Care and Support Planning
The Omaha System

The Omaha System is a research-based, comprehensive, standardized classification that exists in the public domain, designed to enhance practice, documentation of care, and information management. It is intended for use across the continuum of care for individuals, families, and communities who represent all ages, geographic locations, medical diagnoses, socio-economic ranges, spiritual beliefs, ethnicity, and cultural values.

It includes 3 relational, reliable, and valid components designed to be used together:
1. Problem Classification Scheme (client assessment)
2. Intervention Scheme (care plans and services)
3. Problem Rating Scale for Outcomes (client change/evaluation)
Personalised Care and Support Planning

Care Planning Appointment

| Appointment Date |  |
| Appointment Time |  |
| Name of your doctor/nurse |  |
| Location |  |

Your care planning appointment is for you to discuss with your care team on your personalised care plan. Before the session, please think about and answer the questions with [📝]. These are some questions to help you think ahead and plan what you would like to discuss during your appointment.

Preparing for care planning

What are the most important things to you at the moment?

What else would you like to discuss at your appointment?

These are some things that people sometimes want to talk about. Circle any that are important to you.

- Sleep
- Medication
- Memory
- Food choices
- Driving/Travel
- Work/benefits/money
- Pain/discomfort
- Managing my symptoms

Sleep: Feeling down/stressed/lonely
Medication: Eating the right amount
Memory: Giving up smoking
Food choices: Coping with my day-to-day health
Driving/Travel: Alcohol
Work/benefits/money: Keeping active and getting around
Pain/discomfort: Relationships/sexual health
Managing my symptoms: My future health

My Care Planning

Blood pressure

- Previous:
- Latest:

Blood glucose test (HbA1c)

- Previous:
- Latest:

Kidney test (eGFR)

- Previous:
- Latest:

Cholesterol and blood fats

- Previous:
- Latest:

Your mood

- Your thoughts:

Smoking

- Tobacco consumption:

Waist circumference

- Previous:
- Latest:

BMI

- Previous:
- Latest:

Any questions or thoughts?
# Your Personalised Care and Support Planning Summary

We will use this to record the goals that we make together about your care plan. Please write down during/after the appointment.

## Summary of the conversation

## Goal setting
- **Specific:**
- **Measurable:**
- **Attainable:**
- **Relevant:**
- **Time-bound:**

### What do you want to work on?

### What do you want to achieve?

### How important is it to you? (Circle it)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<th>8</th>
<th>9</th>
<th>10</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Not important</td>
<td>Very important</td>
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</table>

## Action Plan
- **Specific:**
- **Measurable:**
- **Attainable:**
- **Relevant:**
- **Time-bound:**

### What exactly are you going to do?

### What might stop you and what can you do about it?

### How confident do you feel? (Circle it)

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<tbody>
<tr>
<td></td>
<td>Not confident</td>
<td>Very confident</td>
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### Follow up / Review of goal/action plan
- Formal review once a year;

### When: Where:

## Your Personalised Care and Support Planning Follow-up

### Date:

### How are you progressing?

### Date:

### How are you progressing?
<table>
<thead>
<tr>
<th>Problem Classification</th>
<th>Psychosocial Domain</th>
<th>Environmental Domain</th>
<th>Physiological Domain</th>
<th>Health-Related Behaviours Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>Communication with community resources</td>
<td>Income</td>
<td>Nutrition</td>
<td>Nutrition select, consume, and use food and fluid for energy, maintenance, growth, and health.</td>
</tr>
<tr>
<td>Sanitation</td>
<td>Social contact</td>
<td>Sanitation</td>
<td>Vision</td>
<td>Sleep and rest patterns Periods of sustained socio- and sensory activity and periods of rest, sleep, or mental calm.</td>
</tr>
<tr>
<td>Residence</td>
<td>Interpersonal relation</td>
<td>Residence</td>
<td>Speech and language</td>
<td>Physical activity</td>
</tr>
<tr>
<td>Neighborhood/workplace safety</td>
<td>Spirituality</td>
<td>Neighborhood/workplace safety</td>
<td>Oral health</td>
<td>Personal care</td>
</tr>
<tr>
<td></td>
<td>Grief</td>
<td></td>
<td>Cognition</td>
<td>Substance use</td>
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<tr>
<td></td>
<td>Mental health</td>
<td></td>
<td>Pain</td>
<td>Family planning</td>
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<tr>
<td></td>
<td>Caring/parenting</td>
<td></td>
<td>Consciousness</td>
<td>Health care supervision</td>
</tr>
<tr>
<td></td>
<td>Neglect</td>
<td></td>
<td>Skin</td>
<td>Medication regimen</td>
</tr>
<tr>
<td></td>
<td>Abuse</td>
<td></td>
<td>Neuro-musculo-skeletal function</td>
<td>Urinary function</td>
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<tr>
<td></td>
<td>Growth and development</td>
<td></td>
<td>Respiration</td>
<td>Reproductive function</td>
</tr>
<tr>
<td></td>
<td>Role change</td>
<td></td>
<td>Circulation</td>
<td>Pregnancy</td>
</tr>
<tr>
<td></td>
<td>Sexuality</td>
<td></td>
<td>Digestion and hydration</td>
<td>Postpartum</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Urinary function</td>
<td>Communicable/infectious condition</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reproductive function</td>
<td>Bowel function</td>
</tr>
</tbody>
</table>
Problem Details

### 2. Intervention Scheme

#### 2.1 Intervention Categories

- Teaching, Guidance, and Counseling
  Activities designed to provide information and materials, encourage action and responsibility for self-care and coping, and assist the individual, family, or community to make decisions and solve problems.

- Treatments and Procedures
  Technical activities such as wound care, specimen collection, exercise, and medication prescriptions that are designed to prevent, decrease, or alleviate signs and symptoms for the individual, family or community.

- Case Management
  Activities such as coordination, advocacy, and referral that facilitate service delivery, promote awareness, guide the individual, family, or community toward use of appropriate resources, and improve communication among health and human service providers.

- Surveillance
  Activities such as detection, measurement, critical analysis, and monitoring intended the status of the individual, family, or community's status related to a given condition or phenomenon.

#### 3.1 Status

- **3.1 Status**
  - **Extreme signs/symptoms**
  - **Severe signs/symptoms**
  - **Moderate signs/symptoms**
  - **Minimal signs/symptoms**
  - **No signs/symptoms**

#### 3.2 Knowledge

- **No knowledge**
- **Minimal knowledge**
- **Basic knowledge**
- **Adequate knowledge**
- **Superior knowledge**

#### 3.3 Behaviour

- **Not appropriate behaviour**
- **Rarely appropriate behaviour**
- **Inconsistently appropriate behaviour**
- **Usually appropriate behaviour**
- **Consistently appropriate behaviour**

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### Problem Rating Scale for Outcomes

- **1**

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### Problem Classification Scheme

#### 1. Problem Classification Scheme

- **1.1 Domain Modifiers**
  - Individual
  - Family
  - Community

- **1.2 Type Modifiers**
  - Health Promotion
  - Potential
  - Actual

- **1.3 Sign and Symptoms**
  - Unfamiliar with options/procedures for obtaining services
  - Difficulty understanding roles/regulations of service providers
  - Unable to communicate concerns to provider
  - Inadequate/unavailable resources
  - Language barrier
  - Cultural barrier
  - Educational barrier
  - Transportation barrier
  - Limited access to care/services/goods
  - Unable to use/has inadequate communication devices/equipment
  - Dissatisfaction with services
  - Other

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### Communication with Community Resources

- Psychosocial Domain
- Interaction between the individual/family/community and social service organizations, schools, and business in regard to services, information, and goods/supplies.
Thank you