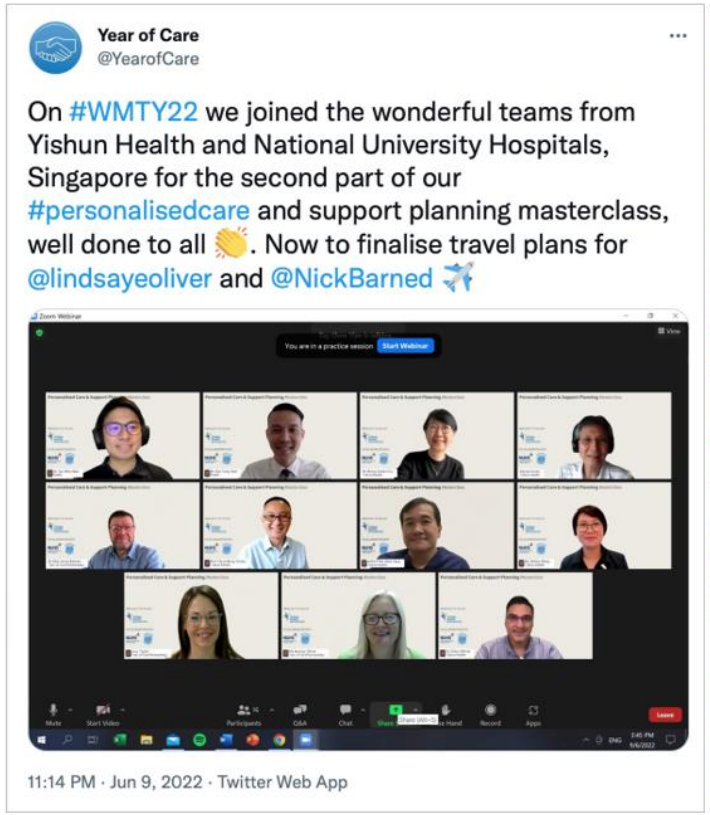
Person-centred Care through Personalised Care and Support Planning

Ng Huoy Ling
Senior Nurse Manager
Population Health & Community Transformation
Yishun Health
ng.huoy.ling@ktph.com.sg

Tay Choo Yian
Assistant Director
Population Health & Community Transformation
Yishun Health
tay.choo.yian@ktph.com.sg

Background

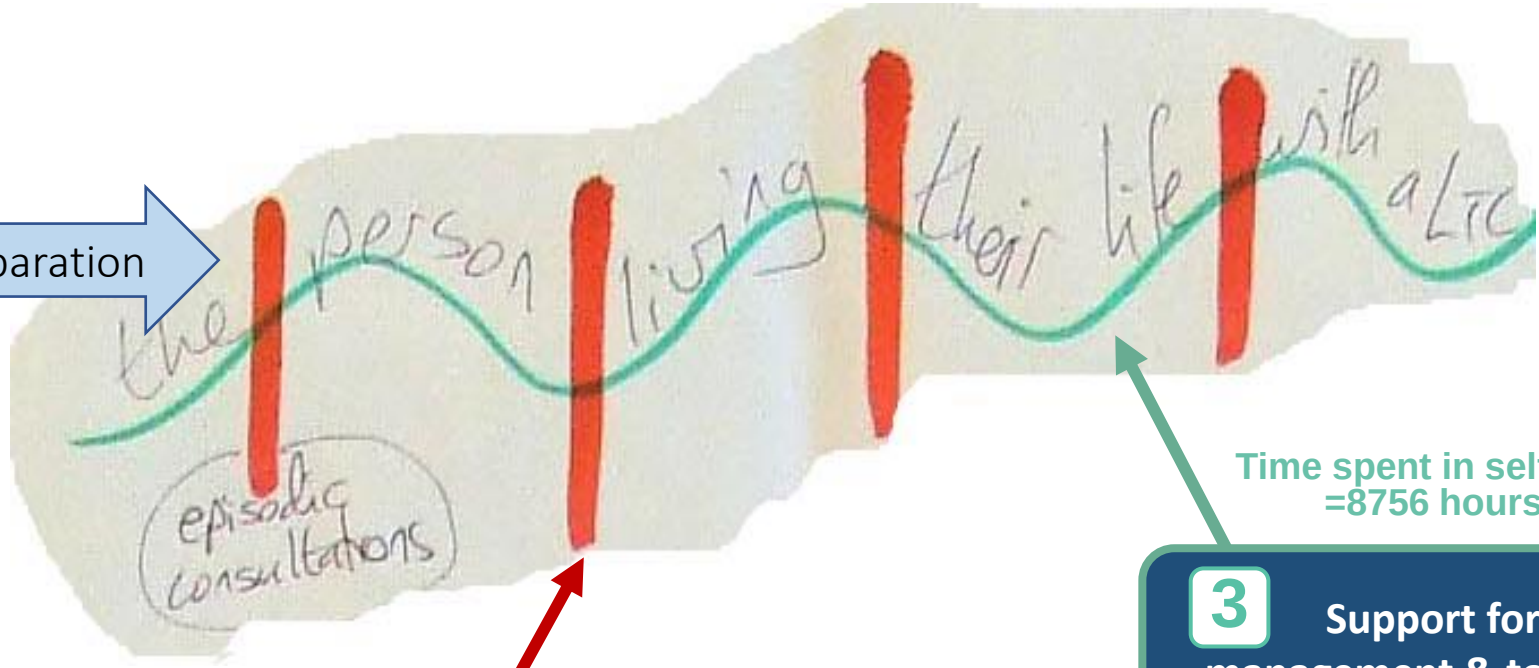
Year of Care & Personalised Care & Support Planning



Picture credit: Year of Care Partnerships, UK

Background

Living with a Long Term Condition



1 Preparation

Time spent with a health and care professional (H&CP) =4 hours in a year

2 More meaningful conversations "Care and support planning"

Time spent in self-management =8756 hours in a year

3 Support for self-management & to live well

A scanned drawing at a world café event by a participant living with a LTC & his relationship to contact with health services

Picture credit: Year of Care Partnerships, UK

Background

The evidence base in *all* long-term conditions

Engaged patient

Organised system

Care and support planning

Productive interactions

Wagner Chronic Care Model (USA)

PCSP & YOC: Pulling it Together

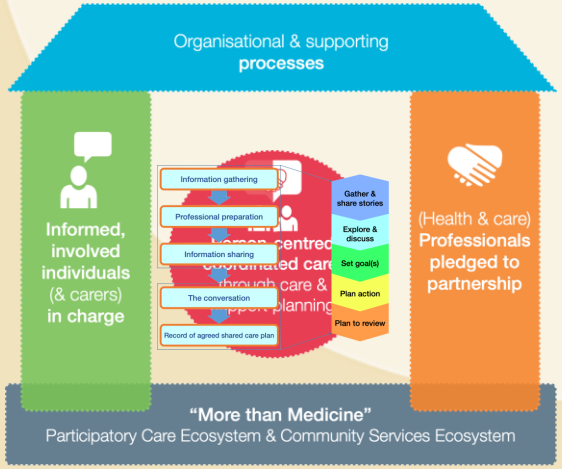
Year of Care: *All the planned care that a person with long term condition(s) should expect to receive, usually over the course of a year, including support for self-management.*

Personalised Care & Support Planning

The process of agreeing on a care plan which offers people active involvement in deciding, agreeing & owning how their long term condition(s) will be managed

- Robust reproducible 5-step model: preparation, conversation, recording, actions, review
- Solution-focused, practical, systematic approach to planned care
- Forward looking, uncluttered conversation
- Emphasis on people, not diseases

Implementation Framework: House of Care



- 4 elements for success: engaged, empowered person *working with* committed health & care professionals, *supported by* appropriate robust organisational systems *& underpinned by* responsive whole system commissioning
- Interdependent elements
- Flexible framework for localisation

Roberts et al https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-019-1042-4

Workflow for Annual PCSP at Community Health Posts

1 Preparation & Information Gathering

Connector/Nurse

- Introduces PCSP & *A Healthier Me* booklet to the resident for the 1st time
- Guides resident to access HealthHub
- Resident thinks through prompters & fills in past health readings in booklet
- The next appointment is scheduled in 1-2 weeks' time

2 PCSP Conversation

Connector/Nurse

- Conducts a PCSP conversation & reviews A Healthier Me with the resident
- Summarises the conversation and guides the resident to write down his/her goal(s) and action plan(s)

3 Documentation

Connector/Nurse

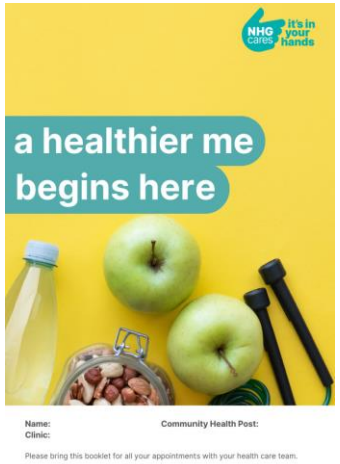
- Documents the conversation & the resident's goal(s) & action plan in the NGEMR documentation system.

4 Interim Follow-up

(6 months)

Connector/Nurse

- Checks in with the resident on the progress of his/her action plan(s) & goal(s)
- Schedules the next annual PCSP conversation in another 6 months' time
- Repeat from 1



https://for.sg/healthierme-e

Story of Mdm Emily

Emily (May 2022)

BP 180/113

BMI 31.1

PCSP: Improve health, find a job

Emily (Feb 2023)

BP 126/80, anti-HPT dose reduced by GP

BMI 28.9

Works at a bakery

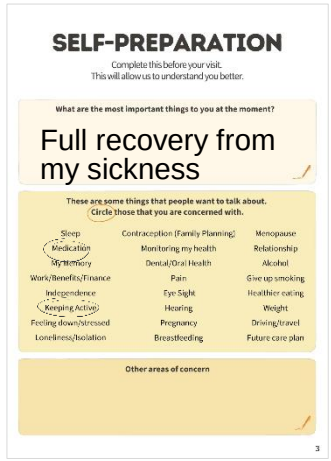
Active in community group “Mums with Mugs”

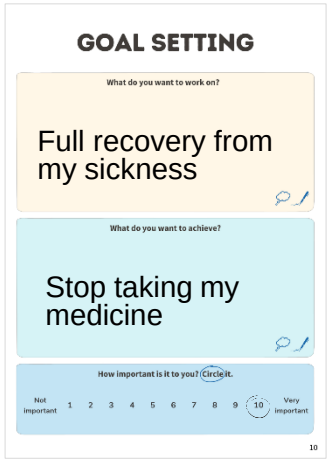
Emily (Feb 2023)

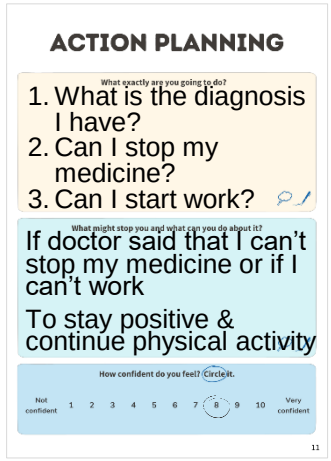
Entered a community beauty pageant organised by grassroot organisation, to celebrate her success and new-found confidence

Story of Mr Soon

Open Access Poster (Sep 2022)







Regional Team@CHP

Mr Soon visited the Community Health Post at Blossom Seeds on 4 Oct 2022. A community nurse explained his condition & treatment to him, a connector engaged with him in PCSP.

Mr Soon contributing back to the Community

Mr Soon is now a Medical Escort with Blossom Seeds, volunteers his free time at the rooftop garden and is back to doing the thing he enjoys most – cycling with his friends.

Impact on Practitioners

More meaningful conversations

*With PCSP, **I listened more to residents on what mattered to them.** I am able to engage them in a more **meaningful conversation**.*

*PCSP has taught me to **reserve my judgement** and **hold back from making assessment** without first listening to resident's full story.*

*PCSP has **changed my practice** at CHP, now I focus more on what is **the most important things**/what **motivate** the resident to live well with their long term conditions.*

Resident-led goal setting

*Sometimes we just need to **slow down** and **take a step back**, to **allows resident to do self-reflection** and **set goal by themselves**.*

*The **preparation** process allows the residents to have time to **think and prepare** for the PCSP conversation. **A realistic goal** and **specific action** can be set by residents.*

*It has made a difference to **the way I speak with residents**, and how I can support the resident to set specific goal and **what the residents want to achieve.***

Our PCSP Journey in Yishun Health

Training

- Level 1 Practitioners Training: 271 trained (Yishun Health, NHG and other partners)
- Level 2 Train-the-Trainers: 9 accredited trainers
- Embedded as one of the multidisciplinary programmes within Yishun Health (YH)

Implementation Sites in YH

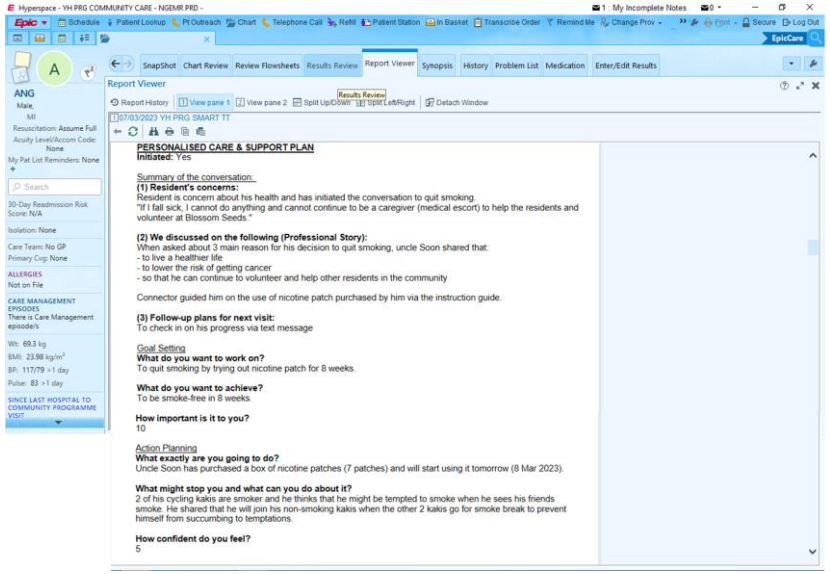
- 20 Community Health Posts (CHPs) in Yishun & Sembawang
- Geriatric Clinic and Diabetes Clinic
- Plans to systematise PCSP as a Person-Centred Care practice to the rest of YH

PCSP in NGEMR (Epic) Documentation System

- Launched in YH from Feb 2023
- Integrated PCSP care plan across care settings

Accreditation of Yishun Health's PCSP trainers at a Level 1 Practitioners Training by NUHS' PCSP Master Trainers

Visit by Dr Nick Lewis-Barned and Ms Lindsay Oliver from Year of Care Partnership UK to a CHP in Sep 2022



Residents' care plan jointly developed with their care team is linked to a PCSP Episode of Care in Epic

Summary

Key Challenges

1. **Health & Care Professional's mindset**
   "*How is this different from what we are already doing?*"

   Preparation as a key component of PCSP; two-way conversation to co-develop the care plan with the person

2. **Patient's/ Resident's mindset**
   "*Can't you just tell me what to do?*"

   Takes time to practise self-management

3. **Implementation**
   "*Who is missing from the table?*"

   Systemic approach to build the House of Care (e.g. process, IT, manpower, community resources)

Tips & Recommendations

1. **Engage key stakeholders as key drivers**

   Clinical champions (e.g. doctors, nurses, allied health) supported by a strong implementation team (e.g. HRD, Ops and IT)

2. **Train the whole care team**

   For an impactful rollout and consistent care experience for the patients/ residents

3. **Conduct regular monitoring and improvements to the implementation**

   e.g. Community of Practice, learning sessions, feedback from practitioners and patients/ residents

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Caring for patients • staff • community • environment