

Social Prescribing – Building a Community Care Network @ Marsiling



Shane Lek, NHG Population Health Campus, Dolly Cheng, NHG Population Health Campus, Esther Tho, NHG Population Health Campus, Zhao Dan, Woodlands Health, Poh Chee Lien, Woodlands Health

BACKGROUND

The blurring of the health and social care divide as well as the importance of addressing social determinants of health, demands an innovative care approach towards improving our residents' health. This Community Care Network (CCN) brought together tertiary care providers and community partners to identify residents with unmet needs and pre-emptively connected them to relevant health and social services before their health worsened. The ultimate goal is to address social determinants of health and enhanced care quality for previously unidentified vulnerable residents.

Specific Aims

- To increase in service utilisation within the CCN for case management and link to programmes/ providers to address health and social needs;
- To Increase the communication and collaboration between PHC and CCN partners in managing complex health issues;
- To improve health outcomes through enhanced care coordination for residents; and
- To establish a common resource platform.

METHODOLOGY

A feasibility trial started in Marsiling in December 2023 and targeted rental blocks (Fig. 1). The CCN comprised NHG Population Health Campus and key community partners including:

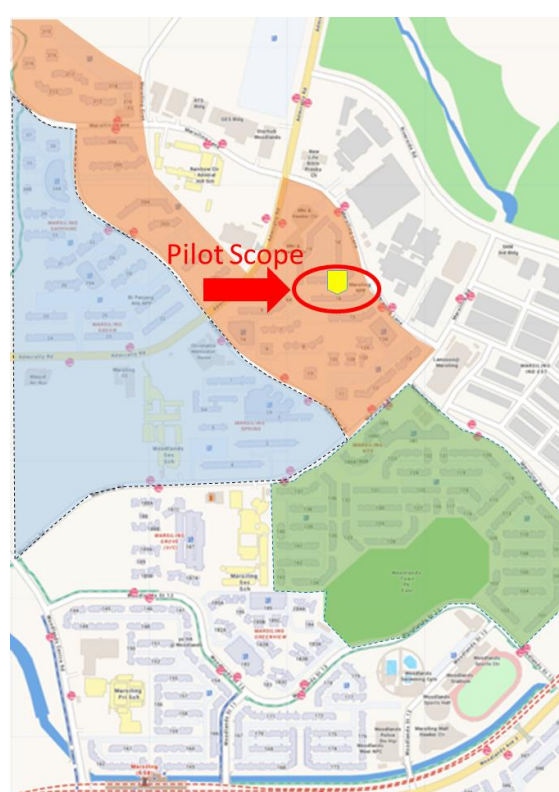
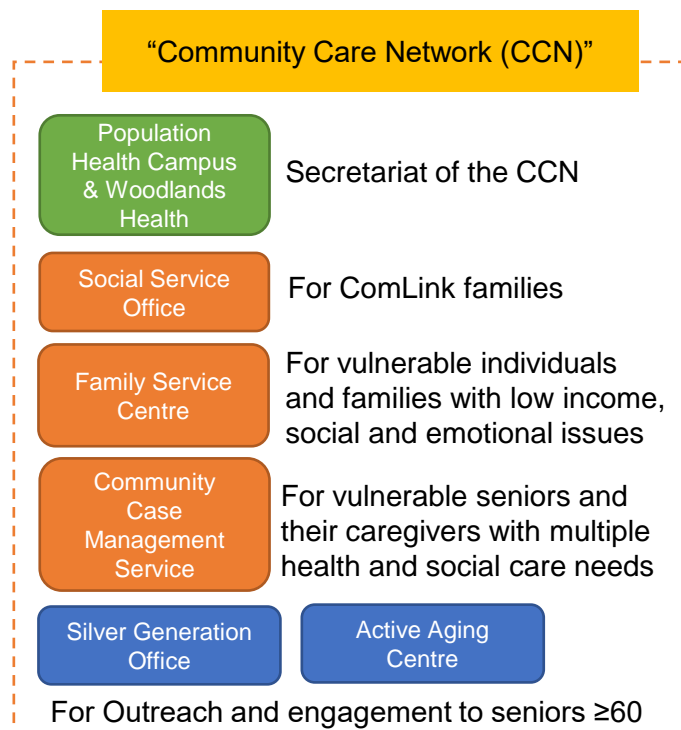


Fig. 1 Pilot region – Marsiling Block 16 (rental block)

The CCN-Marsiling partners mapped out households that were “known” and “unknown” to them within the rental block. They ensured that the needs of the “known” households were met and followed on with door-knocking to reach the “unknown” to their database. High-risk residents were identified for multi-disciplinary care discussions, with Lead Case Coordinators assigned to oversee their care until they were stabilised (Fig. 2).

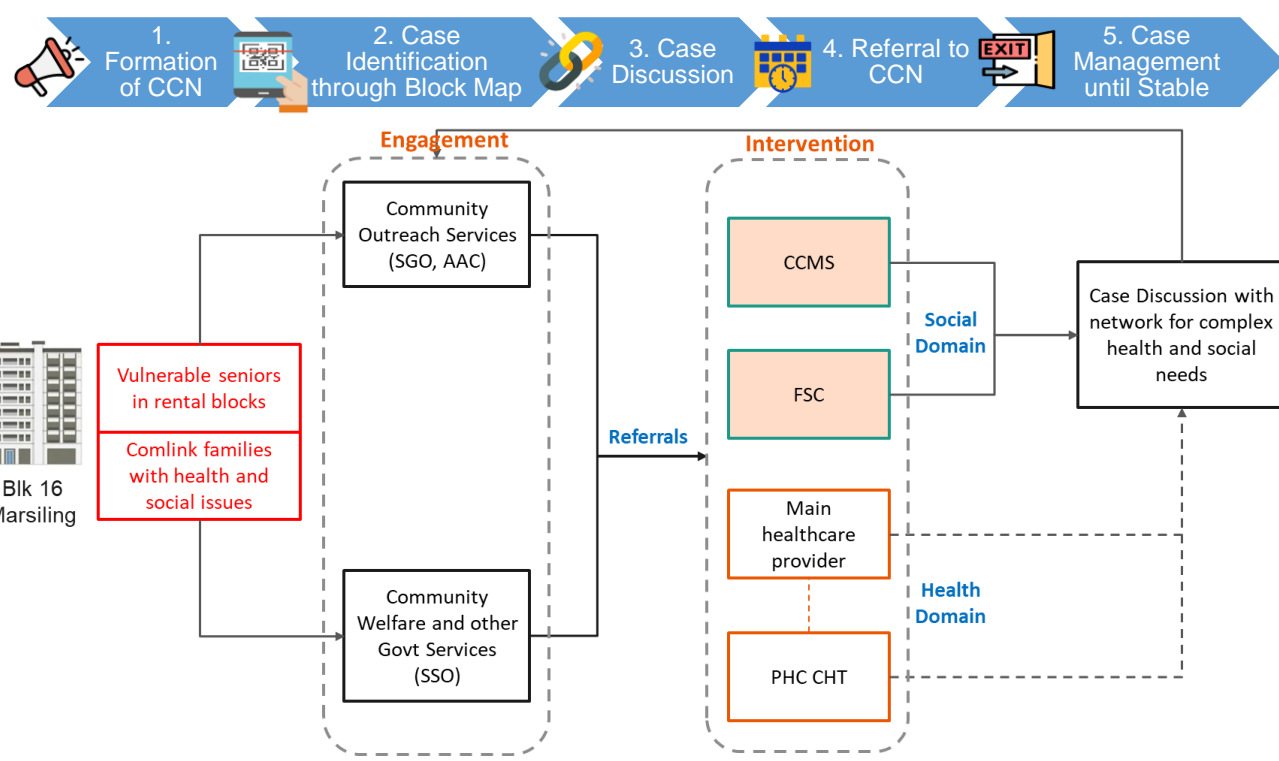
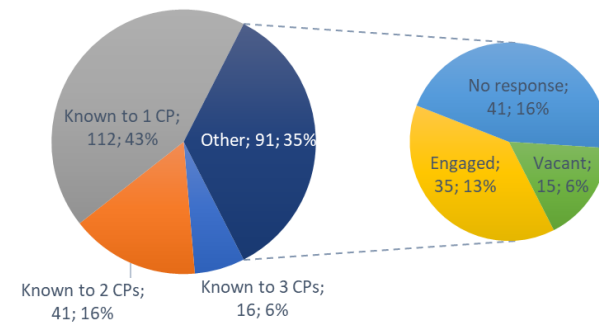


Fig. 2 Overview of the CCN workflow

Results

Block Mapping and Cases Identified

260 households in Block 16 were mapped: 22% (57/260) are known to at least 2 community partners, 43% (112/260) known to 1, and 35% (91/260) were unknown to any partner.



Two rounds of door knocking were conducted and the team identified 10 cases, which were discussed in network meetings to create clear action plans for resolution.

Case Referral and Services Shared

A total of 15 referrals were raised for individuals with complex health needs. 100% referrals were accepted and acted upon by the CCN, demonstrating strong collaboration, trust among providers and clients received timely support.

↑ in the utilisation of services and resources within the CCN was also observed, facilitated by partners sharing information about their services and collaborating effectively. This collaboration strengthened ties to programmes and providers that met both health and social needs, promoting a better understanding of one another's roles and services.

Partner Experience Survey

There was an overall consistent positive experience among community partners, indicating the network developed effective process and communication for managing disagreement. It also leveraged on the combined strengths of the members and built strong working relationships.



DISCUSSION

The CCN-Marsiling pilot has successfully showcased the feasibility of a multi-sectoral partnership in proactively identifying residents with unmet needs and addressing their social determinants of health through enhanced care coordination.

Networking and Resource Sharing

A platform to share resources and community assets available in Marsiling.

Policy and Initiative Sharing

A platform for the various team members to share policy directions and new initiatives from MOH and other ministries/agencies.

Problem Solicitation

A platform to solicit collective feedback and brainstorm solutions on ground problems. This helps in identifying and addressing local needs more effectively.

Plan Ahead: Geographical Expansion & Collaboration

Community partners appreciated the CCN for its networking opportunities and suggested extending its coverage to the entire Marsiling area to increase impact. They also recommended inviting general practitioners (GPs) to future meetings for the HealthierSG initiative.

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