TSAO Foundation

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Person-Centred Care in Action : Integrating Care Management and Community Partnerships to Sustain Living Well in the Community

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Long-term care is not just about living longer, but about living well — with purpose, independence and dignity, surrounded by the people, relationships and communities that matter.

“What matters most to you?”
instead of
“What’s the matter with you?”



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What Does Person-Centred Care Really Mean?

Before we think about the care, do we know the person?

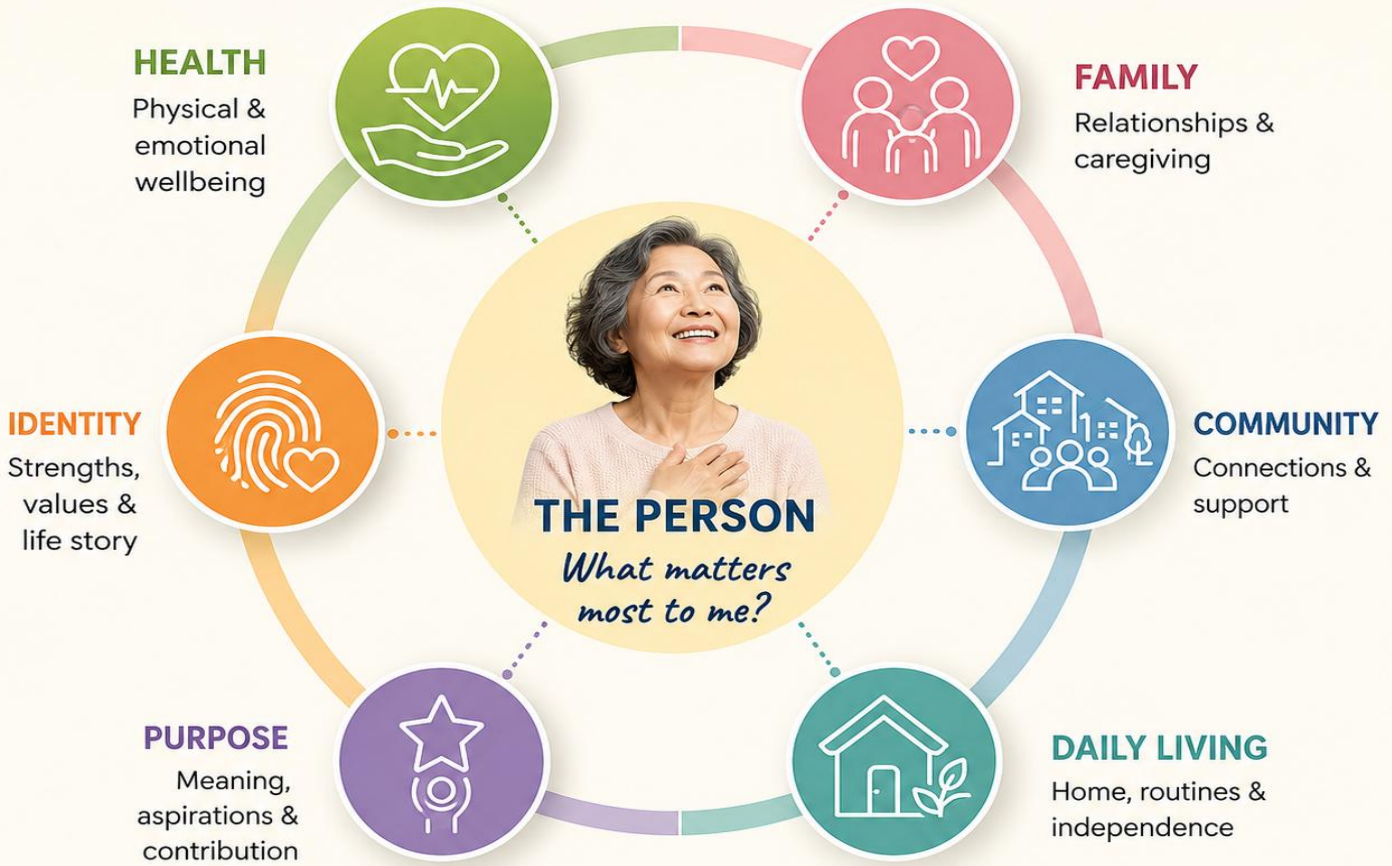
- Who is this person — beyond their diagnosis?
- What matters most to them?
- What are their strengths, hopes and aspirations?
- What brings meaning, joy or purpose to their life?
- Who are the people who matter to them?
- What is important about their family, relationships and community?
- What do they like, dislike, value or worry about?
- How can we build care around what matters to them?

It shifts the mindset from **"What services can we provide?"** to **"What does this person need to live the life they value?"**

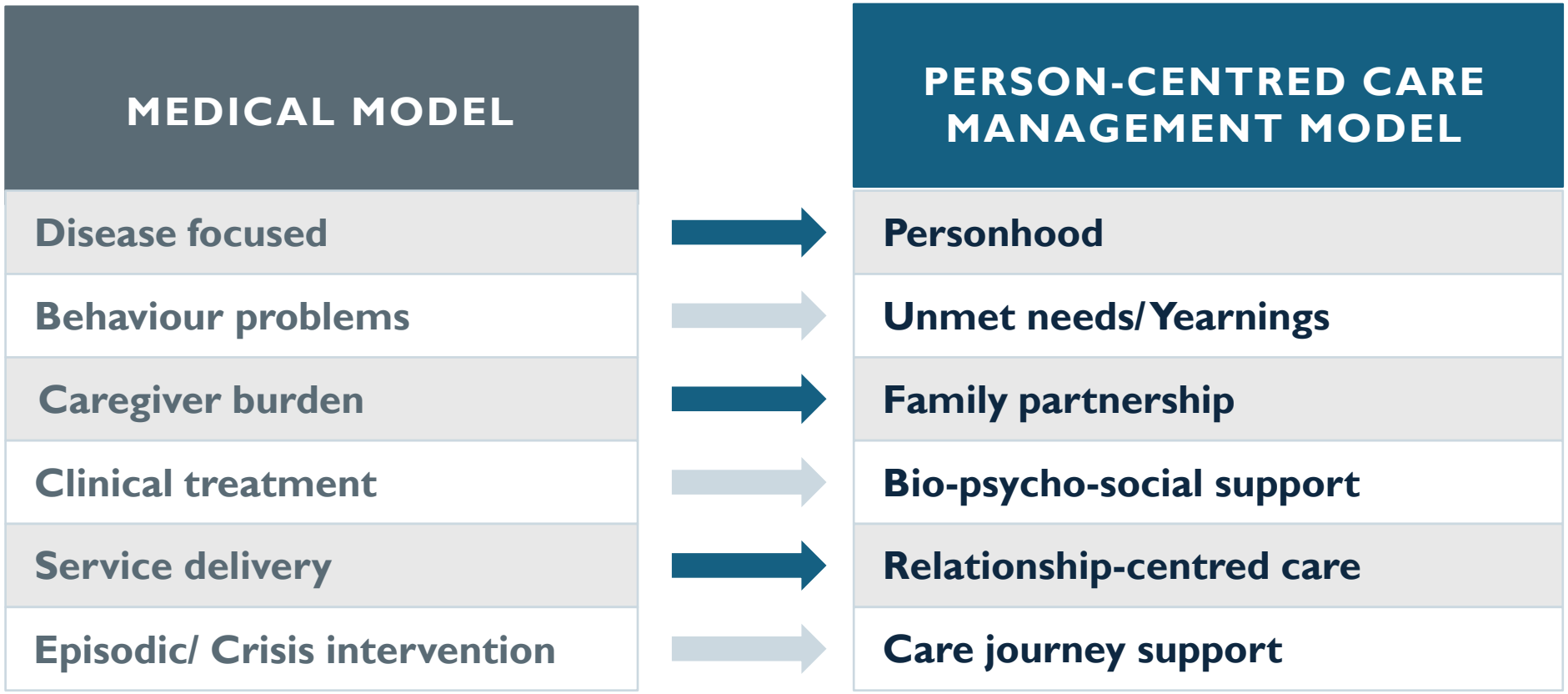
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See the Person, Not Just the Needs

Person-centred care connects the different parts of a person's life to support dignity, choice and meaningful living.



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The Model Of Care

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Biological

How is the person doing physically?

- Physical health
- Medical conditions
- Function & mobility
- Nutrition, sleep, pain

Psychological

How is the person experiencing life?

- Emotions & mental wellbeing
- Resilience & coping
- Anxiety, depression, stress
- Sense of control

Centre: Person & Family



Social

Who and what surrounds the person?

- Family & relationships
- Community & culture
- Social connection
- Housing & financial resources

Spiritual

What gives the person meaning?

- Values & beliefs
- Identity & purpose
- Hope & dignity
- Faith practices

What matters most to the person

Connect • Support • Empower • Live well



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Practical Strategies in ACTION

1. **Strengthen Family Capacity,** *working alongside families*

- Caregiver coaching & support
- Family conversations
- Shared care planning
- Build confidence and capability to manage care at home

2. **Mobilise Community Support,** *build a circle of support around the person*

- Community Care Partners
- Volunteer & Peer support
- Neighbourhood networks and informal support
- Connect people to resources that enable ageing in place

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3. Connect across sectors, **navigate the system together**

- Healthcare
- Social Services Agencies and Community Services
- Mental Health Support and Community resources
- Community Organisations
- Coordinate across services to **reduce fragmentation**

Listen → **Understand** → **Connect** → **Coordinate** → **Empower**

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Adopting a Care Management Approach

Sustainable support is not simply provided — it is **co-created.**

With the **person, family, community and care partners** working together to build sustainable support.

Family Participation :
Move from: **"Family as Caregiver" to "Family as Care Partner"**

From carrying the care alone to sharing responsibility, strengths and decisions.

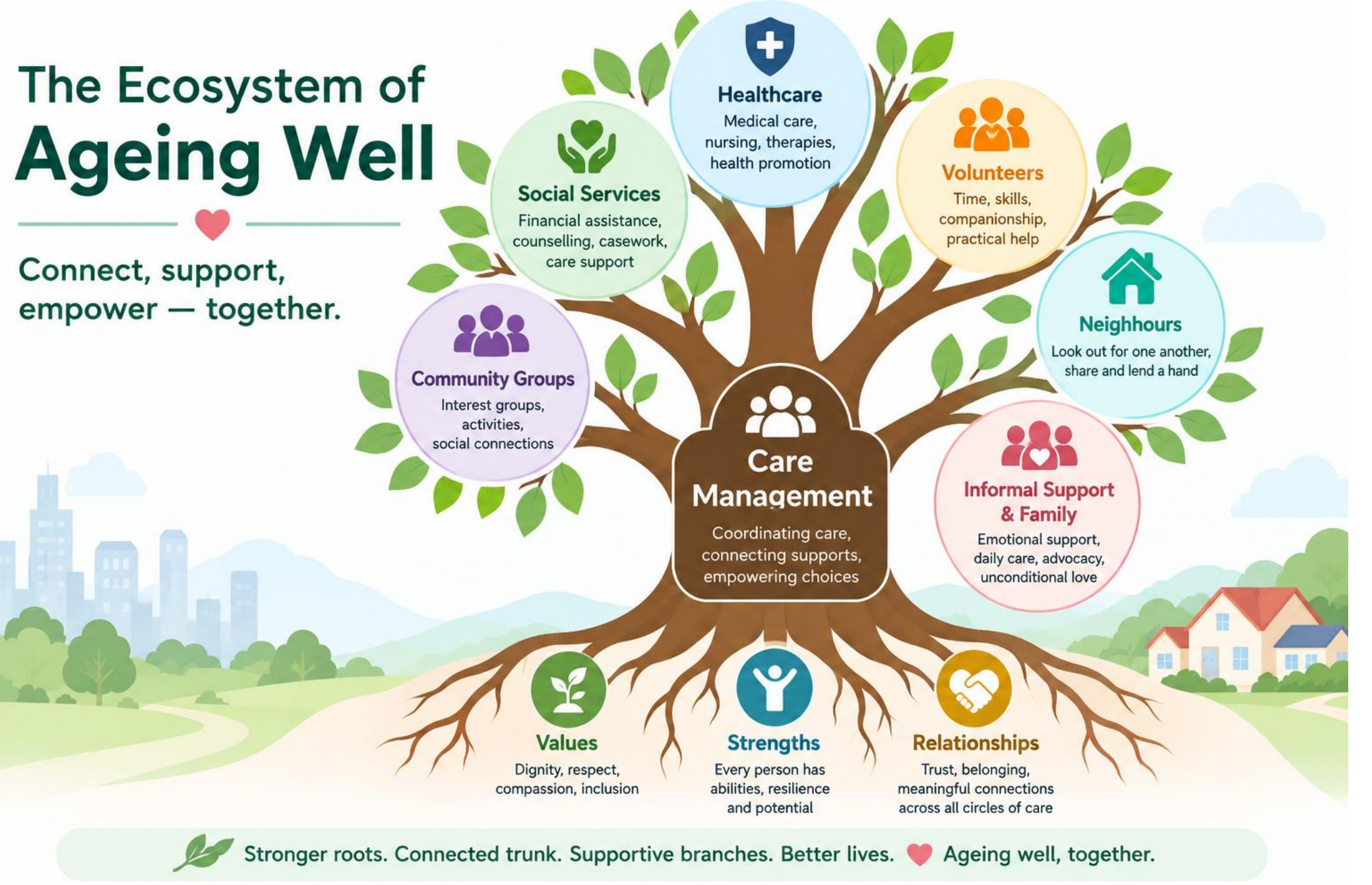
"We do not care *for* families. We work *with* families."



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The Ecosystem of Ageing Well

Connect, support, empower — together.



Stronger roots. Connected trunk. Supportive branches. Better lives. Ageing well, together.

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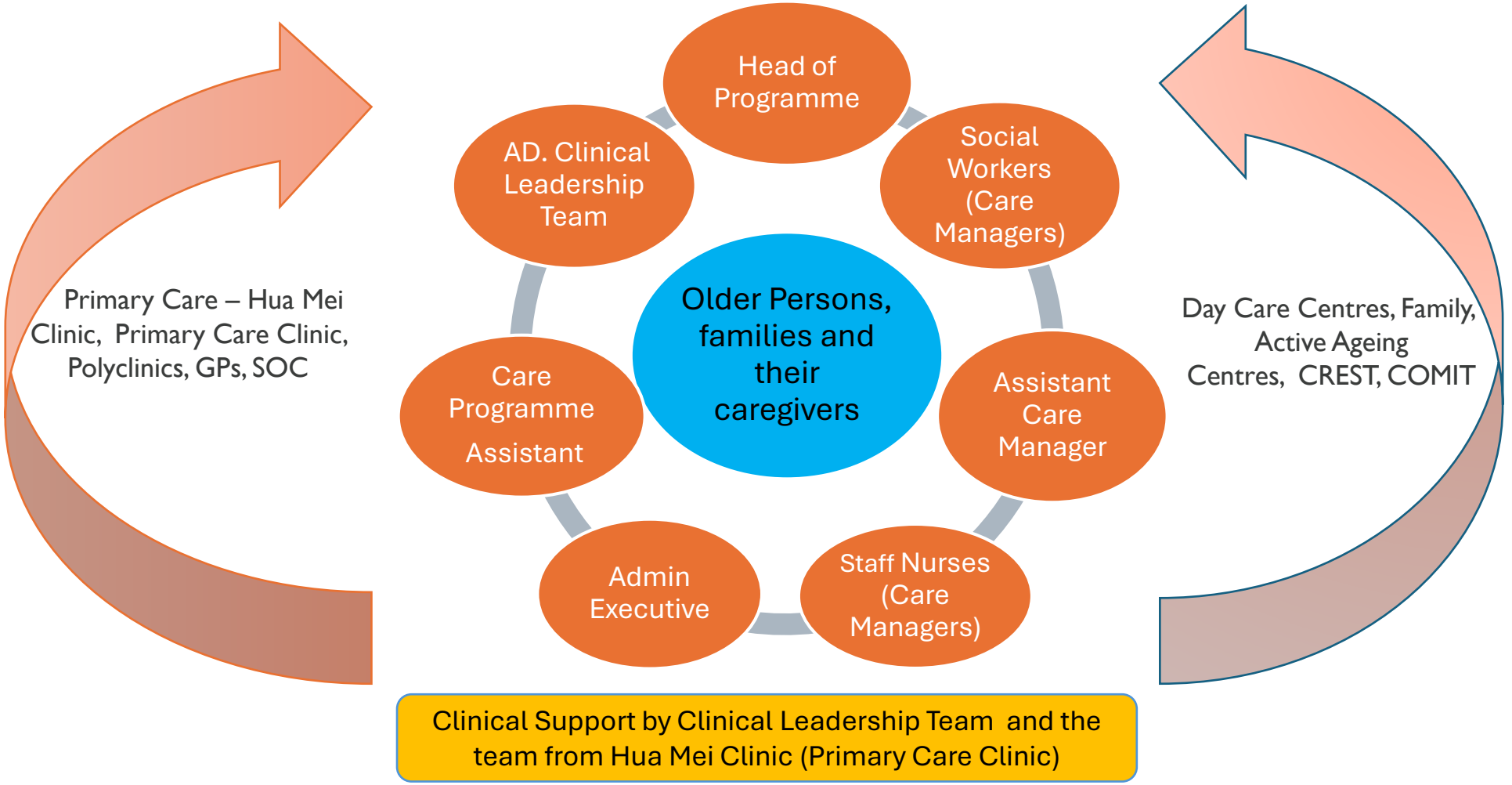
A Sense of Our Work,

Care Management: Connecting Care Around What Matters

Care Management is a ***holistic, person-centred*** *approach to make assessment, do care planning, coordinating, and delivering care and support services for individuals—especially older adults or those with complex needs—so they can live* ***with dignity, independence, and purpose, ideally in their own homes or communities (ageing-in-place).*** *It integrates* ***compassionate service delivery*** *with strategic care planning, built on trust, teamwork, and continuous collaboration among care managers, clients, families/ caregivers and service partners.*

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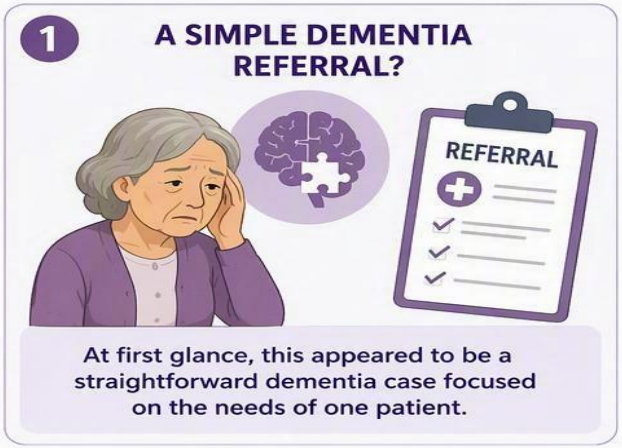
The Model of Care, the TEAM Approach

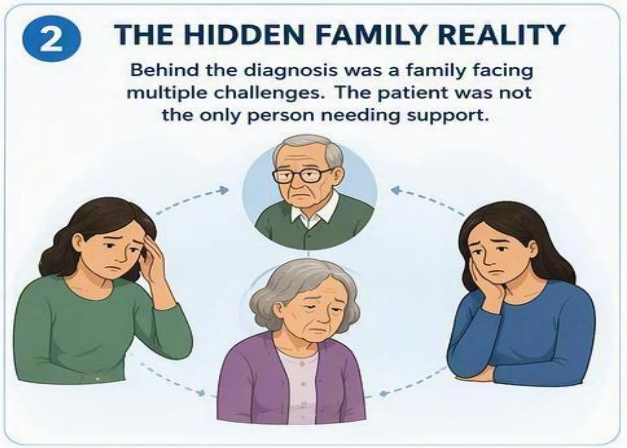


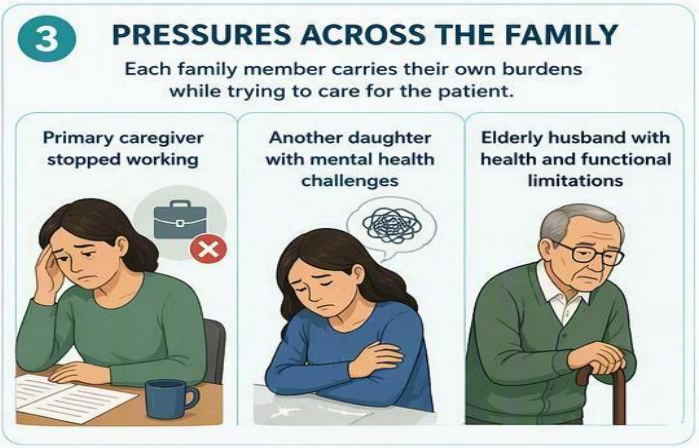
Clinical Support by Clinical Leadership Team and the team from Hua Mei Clinic (Primary Care Clinic)

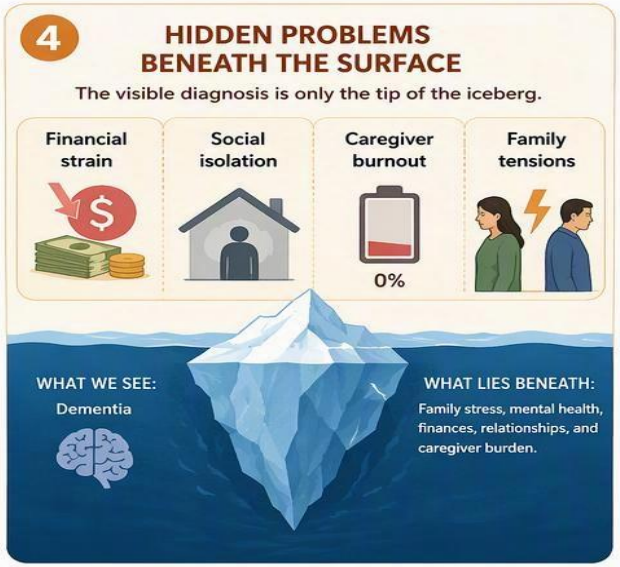
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Case Illustration :
Dementia + Mental Health + Financial Stress = Systems Thinking













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Navigating Community Complexity



Fragmented Systems

When each service sees only one part of the picture, **no single provide**r fully sees the whole person—or the whole family facing burnout, isolated adult children, or complex dynamics.



Family as the Unit of Care

The older person is not the only focus of care. **WE** must adopt family-systems thinking, caregiver assessments, and expectation management to understand how decisions impact everyone.



Sustainable Care Plans

A care plan that ignores the family system often will not hold. **Sustainable care** requires recognizing caregiver limits, managing expectations, and aligning home support.

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The Future of Community Care



From Doing FOR to Working WITH

- Older persons seek autonomy
- Shared decision-making
- Goal-oriented care plans
- Person-centred communication
- Personalised solutions

New Community Care Landscape

Healthier SG
- Prevention
- Family doctor relationships
- Medication continuity

Age Well SG
- Active Ageing Centres
- Connection & learning
- Early risk identification

Beyond knowing services :

✓ Notice risk early
✓ Engage meaningfully
✓ Manage complexity
✓ Coordinate across systems
✓ Help older persons live well

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“Ageing-in-place is not simply about **where** people live,

but how well they are **supported** to live a life **that matters to them.**”



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We hope to alongside with our older persons and their families so that people can live well, with dignity, meaning and connection.

Thank You

