

Project Title

Delivering Person-Centric, Seamless Care: The NUHS Patient Appointment Consolidate (PAC) Programme

Organisation(s) Involved

National University Health System (NUHS), Regional Health System (RHS) Planning Office, National University Hospital (NUH), Care Integration and Alliance (CIA), Participating NUH Specialist Outpatient Clinics (SOC), NUH One-Stop Internal Medicine (IM) Clinic, NUHS-Frontier Family Medicine Clinic (FMC), St Luke's Hospital (SLH)

Lessons Learnt

- Importance of leadership alignment to lead and execute mindset change
- Primary Care Coordinator (PCCs) play an important role to gain both clinicians and patients' buy-in
- Relationship between hospital specialists, primary care partners are strengthened through regular engagements and information exchange (enabled by a Shared IT system)

Project Category

Process Improvement, Care Redesign

Keywords

Process Improvement, Care Redesign, Process Redesign, Quality Improvement, Information Technology, Person-Centred Care, Patient Experience, Chronic Disease Management, Multiple Chronic Disease, Primary Care, Multi-Disciplinary Team, Hospital Utilisation, Inpatient Admission, Length of Stay, Care Continuity, Transitional Care, Seamless Care, National University Hospital, NUH One-Stop Internal Medicine (IM) Clinic, NUHS-Frontier Family Medicine Clinic, St Luke's Hospital, Care Integration and Alliance, Regional Health System Planning Office, Patient Appointment, Patient Appointment Consolidation Programme, Specialist Outpatient Clinic, Primary Care

Coordinator, Shared IT System, Shared Care Arrangement, Community Partners Engagement, Cost Saving, Patient & Caregiver Empowerment, Reduce Care Fragmentation, Leadership Alignment, Change Management, Strengthening Multi-stakeholders' Relationships

Delivering Person-Centric, Seamless Care: The NUHS Patient Appointment Consolidation (PAC) Programme

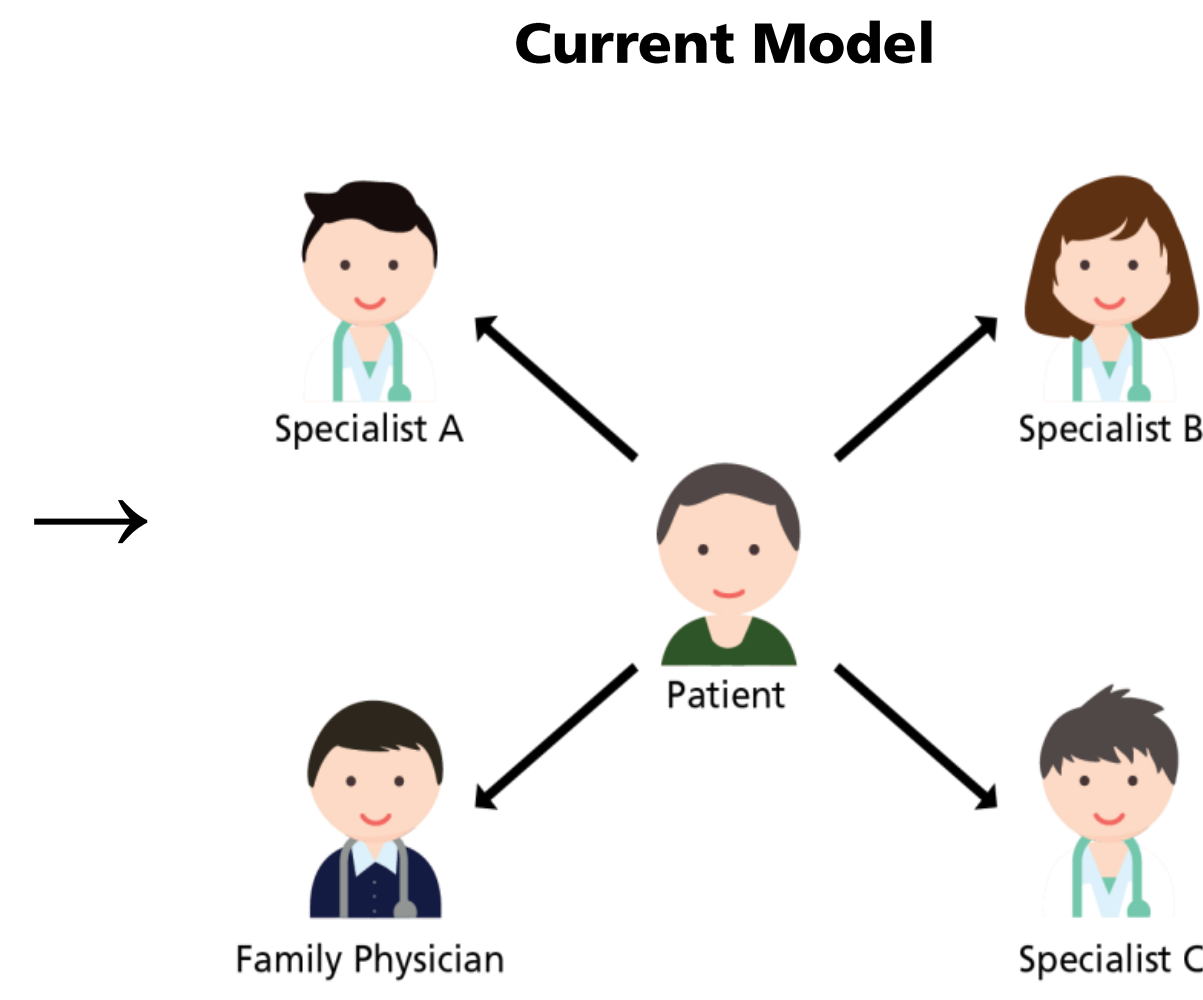
Team: National University Health System (NUHS) Regional Health System (RHS) Planning Office, National University Hospital (NUH) Care Integration and Alliance (CIA), Participating NUH Specialist Outpatient Clinics (SOCs), NUH One-Stop Internal Medicine (IM) Clinic, NUHS-Frontier Family Medicine Clinic (FMC), St Luke's Hospital (SLH)

The Issue

Increasing prevalence of patients with multiple chronic diseases (MCD)

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Hospital-centric, disease-specific approach to care

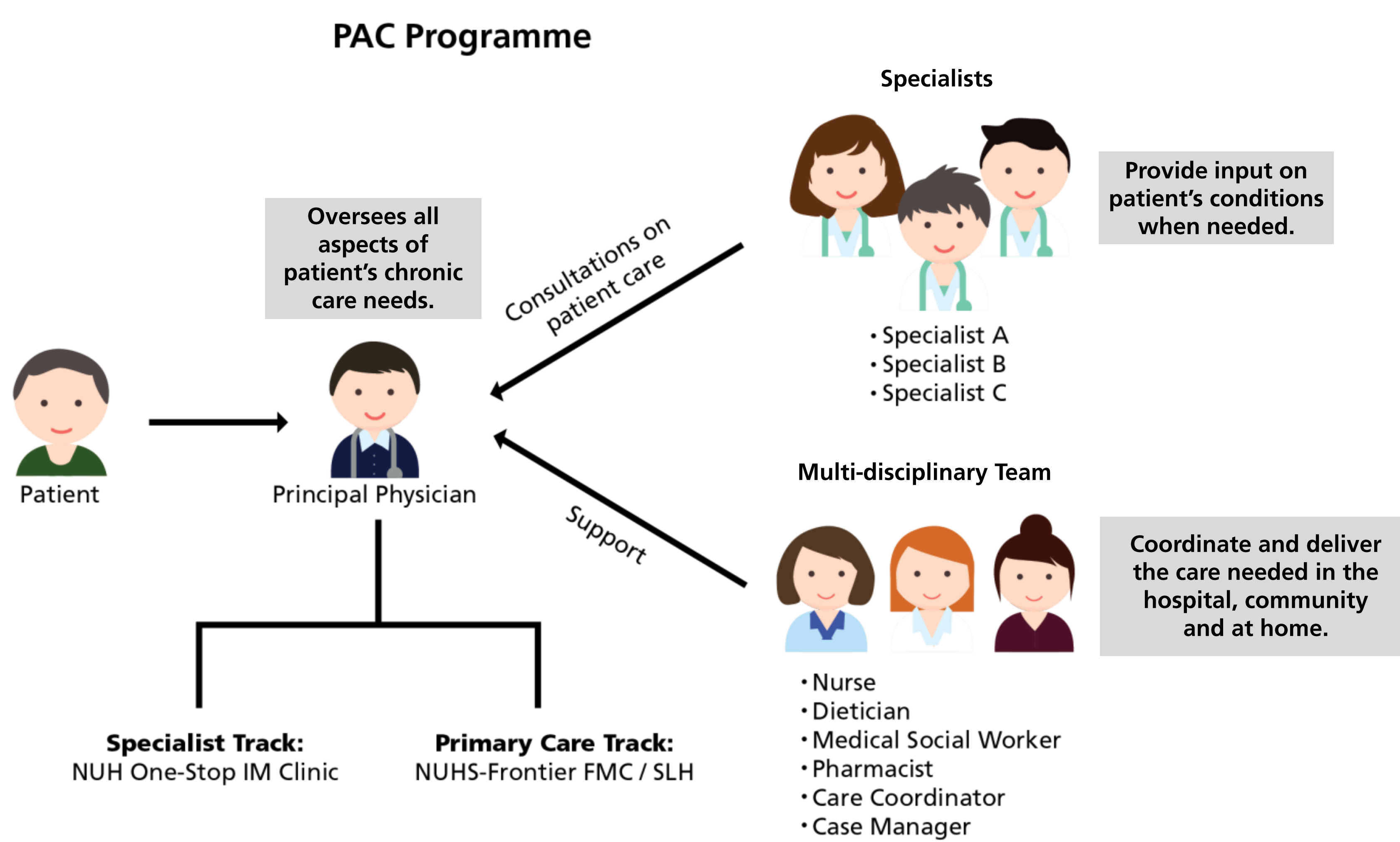


Patients consult different specialists for each of their chronic conditions, resulting in:

- Fragmentation of care
- Significant time burden and cost to patients
- Risk for poor healthcare outcomes

Strategy

CONSOLIDATE MEDICAL APPOINTMENTS OF PATIENTS WITH MCD AND FACILITATE SHARED CARE ARRANGEMENTS ACROSS CARE SETTINGS



Desired Outcomes

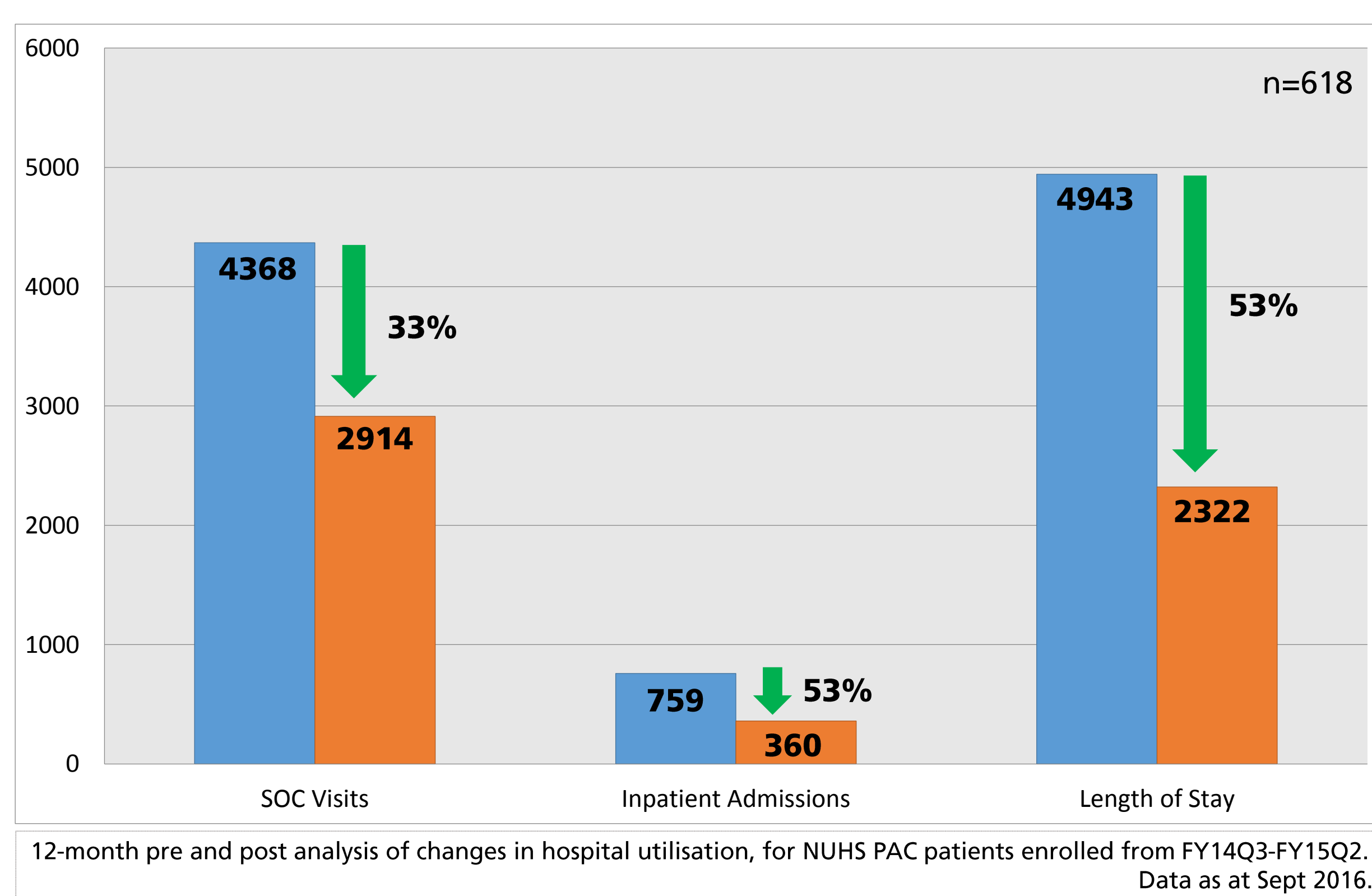
- ✓ Reduce care fragmentation
- ✓ Reduce utilisation of high-cost healthcare services
- ✓ Cost savings to the system, with same or better patient outcomes
- ✓ Patient and caregiver empowerment

Success Factors

- The Primary Care Coordinator (PCC) recruits patients and performs patient counselling**
 - Increases patient buy-in and promotes greater self-management.
- A common IT platform between hospital and community partners**
 - Enables information exchange and communication.
 - Smoothens the transition of care to the principal physician.
- Regular engagements between hospital and community partners**
 - Facilitates knowledge sharing and shared care arrangements.

Outcomes

✓ REDUCTION IN HOSPITAL UTILISATION



- Largest reduction in hospital utilisation amongst piloting RHSes.¹
- Key elements of the NUHS PAC programme are now adopted in the mainstream national programme (FY17-FY18).

✓ POSITIVE PRELIMINARY, EVALUATION FINDINGS

Enables Shared Care, Reduces Care Fragmentation

"It is good that we share the same medical records, as I am able to inform them about medication changes via memos. We communicate quite freely via emails as well." – Hospital Specialist

"I can still send my patients to the family physician clinic for check up every 2-3 months for their diabetes, hypertension, high cholesterol and so on. But I will see the patient every 8 months or yearly." – Hospital Specialist

Quality Patient Experience

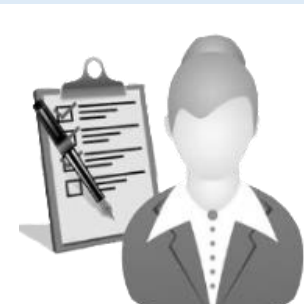
"I think his medical records were passed over to the Primary Care Physician, so she knows what his conditions are. She never failed to ask my father whether he has any other issues or not." – Patient's daughter

"The hospital specialist and assistant were very detailed in explaining the process to us during transfer. They gave us all the necessary forms, and the transition was quite smooth." – Caregiver

Lessons Learnt



Importance of leadership alignment to lead and execute mindset change.



PCCs play an important role to gain both clinicians and patients' buy-in.



Relationships between hospital specialists, primary care partners and management are strengthened through regular engagements and information exchange (enabled by a shared IT system).

¹ Findings are based on an outcome analysis with propensity matched controls performed in 2016, by the Ministry of Health, for all RHS clusters with similar programmes implemented under RHS programme funding for Priority 4: 'Deliver person-centric, seamless care'.