Project Title

TTSH Community Right Siting Programme – Shifting of low complexity care from TTSH Specialist Outpatient Clinics to Primary Care

Project Lead and Members

Project Leads: Adj A/Prof David Foo Chee Guan, Clinical Lead, Primary Care, Division for Central Health; Evelyn Tan, Manager, Population Health Office (Community Operations), Division for Central Health

Project members: From Population Health Office (Community Operations): Lynn Lee, Vionna Fong

Organisation(s) Involved

Tan Tock Seng Hospital, Primary Care Network under TTSH Community Right Siting Programme

Project Period

Start date: April 2014

Completed date: Ongoing

Aims

Instead of managing low complexity chronic patients by specialists at TTSH Specialist Outpatient Clinics (SOCs), TTSH launched the Community Right-Siting Programme (CRiSP) to address the evolving needs of Singapore's healthcare landscape. CRiSP is a partnership between TTSH and the Primary Care community such as General Practitioners (GPs), which facilities the transition of low-complexity patients from SOCs to be appropriately reviewed at primary care. CRiSP also enables TTSH, Central Pharmacy and NHG Diagnostics to collaborate closely with GPs to provide continued care to right-sited patients.

Background

There is a rising prevalence of chronic diseases due to Singapore's rapidly ageing population and sedentary lifestyles. Chronic diseases can lead to serious complications if not well-managed, and are amongst the most expensive and yet preventable health burden that Singaporeans face. Hence the need to redesign our healthcare delivery system for patients to receive quality chronic care that is affordable and accessible across the entire continuum of care. The GP sector traditionally provides episodic, acute care while the public healthcare institutions are increasingly burdened with higher patient loads: - including low complexity and those with chronic diseases. This results in severe capacity constraints in polyclinics and hospitals, and longer waiting time for patients. To improve disease management in the community, CRiSP aims to establish public-private collaborations to shift chronic disease management to a more team-based approach at the primary care setting.

Methods

TTSH launched CRiSP as a partnership programme to collaborate with primary care physicians and community partners to appropriately-site these patient groups to primary care; and ensure continued care under a suitable primary care receptacle. CRiSP established an extensive primary care network across Singapore, based on patients' geographical spread and targeted the hot-spot regions. Through exchanges and trials piloted with our partners, CRiSP identified gaps and brought together stakeholders from the Ministry, regional healthcare clusters and community partners to pool resources such as financial subsidies, clinical support services and clinical practice guidelines, which were previously not available in primary care to collectively facilitate patients' transition from hospital to primary care setting.

Results

Increasing number of SOC patients discharged to Primary Care: Since April 2014 to date, CRiSP has facilitated close to 6,100 discharges from TTSH SOC to GPs. This has resulted in an average reduction of close to 18,300* SOC repeat visits for the hospital.

There is an increasing trend in the number of discharges from TTSH SOC to GPs, which can be attributed to three factors: (1) Increased awareness amongst specialists of the alternative mode of discharge to GPs, (2) Increased number of discharge care paths being developed, and (3) Increased awareness amongst patients on the benefits of having follow-up care with 1 family doctor as a result of education and counselling through Right-Siting Coordinators.

**Assuming an average of 3 SOC repeat visits per patient per calendar year.*

Low Readmission Rate: About 5% of SOC discharged patients returned to TTSH due to exacerbation of their condition, far below MOH's target of 10%. The low admission rate highlighted that the appropriate patients were identified in SOC by specialists, transited and properly co-managed with GPs to receive continued and safe care in the community.

Strategic expansion of TTSH Preferred GP Partners: Our network comprises of approximately 150 Community Health Assist Scheme accredited GP clinics island-wide, who are committed to improve clinical outcomes and to provide affordable and responsive primary care that is essential to manage TTSH discharged patients.

High Right-Siting Efficiency: MOH had set a target for right siting efficiency of at least 50 patients right sited per FTE per year. CRiSP has achieved a healthy productivity of managing 245.6 patient discharges per FTE hired per year, close to 5 times higher than the benchmark set by MOH. In comparison to the other clusters, CRiSP has performed well in our productivity.

Cost Effectiveness: In comparison with other clusters, CRiSP has performed well in keeping the lowest cost ($323) per patient transited to GPs.

Lessons Learnt

Opportunities lie within our healthcare ecosystem for collaboration between healthcare providers and care settings in sharing the care management of our patients. In today's evolving Singapore healthcare landscape, a "do-it-alone" approach is not the best strategy. Institutions should leverage and pool strength and resources to come up

with creative ways to innovate and redesign care models. The resulting outcomes can have multiplying effects at the systems level, institution, community and at the patient level.

Conclusion

Instead of creating new processes, CRiSP has redefined the existing care delivery model to lift and enable the primary care community by bridging gaps between hospital to community. It is important to create a self-sustaining ecosystem that is scalable and can benefit patients. Strengthened partnerships with GPs also ensure that care is delivered holistically and sustainably, as we move towards our nation's vision of "One Singaporean, One Family Doctor".

Additional Information

CRiSP has been in the running for the last 6 years and will continue to expand with more partnership initiatives to strengthen relationships between TTSH and GP partners. Initiatives include addition of enablers, training attachments and recognition for partners.

- TTSH Milestone Award 2019
- Gold Award, Asia Hospital Management Award 2016

Project Category

Care Redesign

Keywords

Care Redesign, Quality Improvement, Right Siting, Chronic Care, Primary Care, Care Continuity, Holistic Care, Tan Tock Seng Hospital, Hospital to Community, Community Right Siting Programme, Private-Public Collaboration

Name and Email of Project Contact Person(s)

Name: Evelyn Tan Si Miao; David Foo Chee Guan

Email: Evelyn_SM_Tan@ttsh.com.sg; David_Foo@ttsh.com.sg

Private-public collaboration with Primary Care
to improve and deliver care in the community

A/Prof David Foo, Ms Kucy Ping, Ms Lim Sim Yong, Ms Evelyn Tan, Ms Lynn Lee, Ms Teo Li Huan, Ms Vionna Fong
Community Operations, Primary Care Partners Office, Division for Central Health, Tan Tock Seng Hospital

Challenges in Primary Care

Singapore's population is ageing rapidly. This silver tsunami coupled with the increasing prevalence of chronic diseases puts a strain on public healthcare institutions (PHIs) and their limited resources. There is hence a need to transform the nation's primary care landscape. Private General Practitioners (GPs) remain as an untapped but valuable resource. While PHIs manage patients with complex chronic conditions, GPs traditionally provide episodic care of acute conditions to the population. Separate governance structures lead to varying delivery of care between GPs who may also lack the necessary support systems at the primary care level. Collectively, these challenges impede the provision of care that is similar to the public primary care sector.

Our Partnerships

Tan Tock Seng Hospital's (TTSH's) Division for Central Health established the Primary Care workstream to develop strategic private-public collaborations with primary care providers for appropriate right-siting of patients from TTSH to GPs for improved continuity of care. The partnerships were developed to appropriately transit patients with stable, chronic diseases and minor ailments in a safe and cost-effective manner for seamless continuity of care management by GPs in the community. GPs are empowered to manage chronic conditions past the typical acute conditions, and patients receive holistic and accessible care that remains cost effective.

Community Right Siting Programme (CRiSP)

Launched in 2014, CRiSP is a partnership between TTSH and GPs to ensure that patients with stable, chronic conditions are appropriately reviewed and cared for at the primary care environment upon discharge from TTSH Specialist Outpatient Clinics (SOCs).

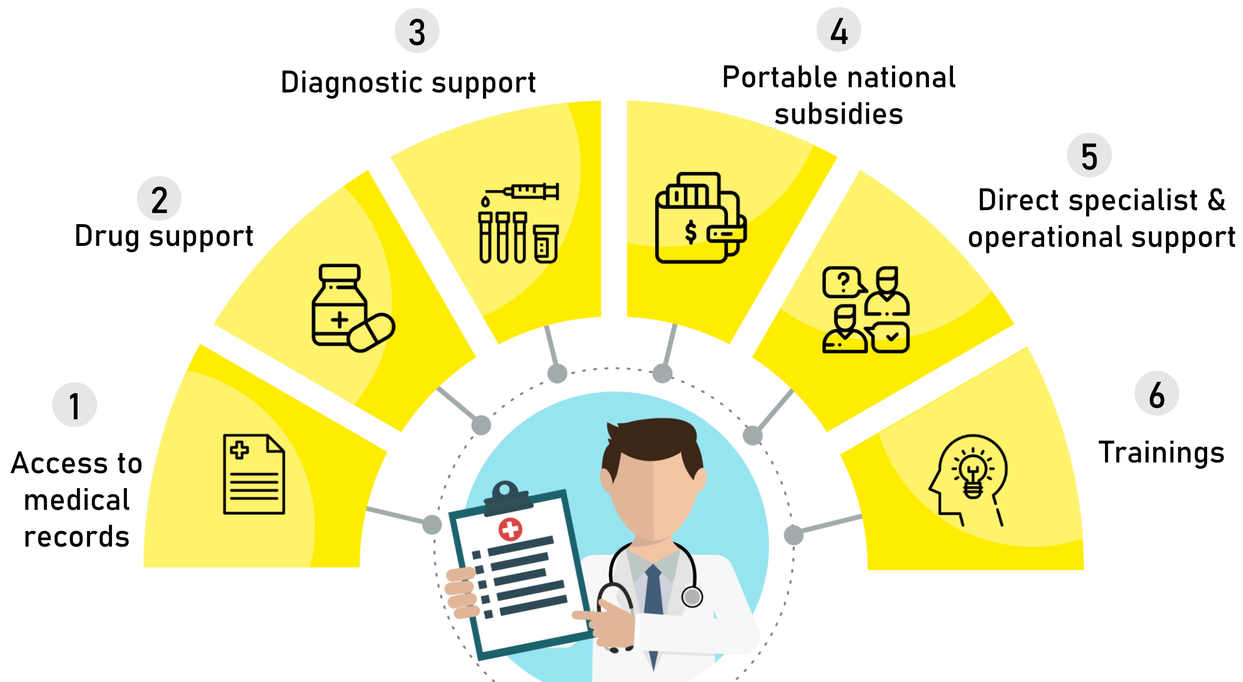
Shared Care

Shared Care was initiated in 2017 and is focused on the co-management of moderately stable patients between TTSH specialists and GPs. This concept of shared care delivers holistic care management of chronic conditions to patients who occasionally require review with a specialist.

GP*Next*

GP*Next* was launched in 2018 to facilitate the appropriate transition of stable patients with chronic diseases, minor or no emergencies directly from TTSH Emergency Department (ED) to GPs.

Support for GPs



Our partnerships with primary care are overseen by multiple layers of governance:

Primary Care	**Institutional**	**Regional**	**National**
Quarterly meeting with Family Medicine Clinic and Primary Care Network	Tan Tock Seng Hospital	National Healthcare Group	Ministry Of Health; Agency of Integrative Care

Results

Preferred GP partners:
150
and growing

Average of:
5%
Readmission within 4 years

Over
6000
discharges facilitated

Yearly cost of:
$323*
per patient managed in the community

Through our collaborations, GPs are supported with the necessary tools and infrastructures to enable them to deliver holistic and quality care to our mutual patients within the community. Our mutual patients continue to access affordable healthcare upon transition from public to private setting. With strong collaborations, mutual trust and the necessary support enablers in place, our GP partners are now clinically and infrastructurally equipped to manage patients with chronic medical conditions of higher acuity.

> *"CRiSP facilitates patients with new disease profiles for continual management with GPs. The programme supports such as drugs delivery and CHAS subsidy allows GPs to focus more on providing quality care, instead of managing non-clinical aspect of patient care. CRiSP is simply another way that the care plan maintains focus on the patients – demanding care excellence while also providing convenience, flexibility and affordability within the community."*
>
> Dr Theresa Yap
> *Yang & Yap Clinic and Surgery*

Future plans

More training and upskilling initiatives are being developed to equip GPs with relevant skill sets to better manage patients with chronic conditions in primary care. There are also plans to expand CRiSP, Shared Care and GP*Next* to ensure that every patient receives the right care at the right place and at the right time.

GP Training

Partnership growth

Partnership recruitment

Supporting the Nation's vision of
"One Singaporean, One Family Doctor"

*Data source:
Agency of Integrative Care, Outpatient to Community (O2C), FY2017
Cost comparison against average of $1544 across 5 similar programmes island-wide.