Transforming Care

By Dr Tung Yew Cheong

THE TRANSFORMATION of Care Project, a pilot at Toa Payoh Polyclinic, is one of several initiatives undertaken by National Healthcare Group Polyclinics (NHGP) to address the changing primary healthcare needs of our ageing population.

Key considerations in this pilot

1. The appreciation of the increasing importance of relationships and continuity of care[1,2] in managing an ageing population, at risk or with existing chronic diseases and increasing multi-morbidities.
2. The recognition that the healthcare community cannot do this alone. The impact of social factors on health/disease[2] and vice versa, is frequently underestimated and undervalued. The formation of networks between healthcare and social care providers helps to bridge this gap.[3]
3. The importance of ownership and accountability at various levels. Patients and their families can be empowered through proactive engagement by their healthcare teams, to take greater ownership and accountability of their health (and illness). Primary healthcare teams, through the establishment of long term therapeutic relationships with their panels of patients, are in a good position to take shared ownership of their patients' health (and illness).
4. The benefits of including analytics as an essential component in healthcare for benchmarking and for the tracking of progress.
5. The continual investments in improvement work to achieve higher efficiency and effectiveness in the long term, which may include job redesigning, to allow each level of staff to practise at the top of their licences.
6. The opportunity to reduce patients' physical visits to the clinic through the use of various modalities of telemedicine and innovations in healthcare IT.

Key elements in this pilot

The study of a system of **risk stratification** will allow the tracking of patterns of healthcare-related service utilisation and the efficiency and effectiveness of resource allocation and care provision over time. Based on their history of recent hospitalisation, psychosocial and biomedical status, patients are categorised into four strata – mild, moderate, moderately severe and severe.

A pool of 6,000 patients will be **empanelled** to a **teamlet** comprising three physicians, three Care Managers (CMs) and three Care Coordinators (CCs). CMs are nurses specifically trained in the management of chronic diseases, while CCs are a new group of staff introduced into this pilot to support chronic care delivery to our patients. Patients are assigned to one of three CC/CM/physician subgroups within the teamlet, ie, each subgroup has a dedicated physician, CM and CC. The teamlet is also closely supported by in-house allied health experts – clinical pharmacists, psychologists, dieticians, medical social workers, community case managers and physiotherapists.

Members of the teamlet will be **co-located** to facilitate new dynamics and workflows in team care. The proximity facilitates closer communication, cross-training and team building among the various teamlet members, especially within the CC/CM/physician subgroups. Discussions to plan care for patients can take place conveniently. This arrangement also allows patients, who are generally more accustomed to the current physician-centric model of care, to feel more at ease when their physicians introduce the subgroup team members to them face to face.

Every patient in the panel is **screened annually** by the CCs as part of their pre-consultation activities, allowing the teamlet to identify patients with **psychosocial and functional needs**. CCs also take the opportunity to **systematically promote health** to patients (eg, smoking cessation for identified smokers, or evidence-based cancer screening for suitable patients).

Besides carrying out pre-consultation activities, CCs also help in the **tracking and following up of patients who default on their appointments**. In addition, CCs play a supportive role to the physicians in looking after patients in the **"mild"** stratum, using clinical protocols. For example, CCs review blood pressure readings of selected subgroups of stable patients with well-controlled hypertension and/or hyperlipidaemia, based on clinical protocols, in between physician consultations. Patients with validated home blood pressure devices can update their CCs about their home blood pressure readings by phone. If the readings are within the acceptable range, patients can then choose to have their medications delivered to their homes via courier services or self-collection at the pharmacy.

In line with the **extension of their clinical roles**, CMs will care for patients in the **"moderate"** and **"moderately severe"** strata. They work synergistically with physicians to execute the care plans jointly determined by the teamlet. CMs focus on actively engaging patients and their families on health education, empowerment of skills in self-care and resolution of behavioural related issues that are contributing to poor control of their chronic diseases.

A typical scene of elderly patients at a polyclinic

Patients under the **"severe"** category (the highest risk group) are attended to by their physicians at each visit. Appropriate patients identified with significant psychosocial and functional issues are discussed at regular **multidisciplinary team rounds**, where input from various allied health experts are sought to determine the best possible management plan for patients. Each team member is aware of the overall care plan and how they can contribute towards achieving the delineated objectives for these patients.

Relevant patients are also identified for community case management, where the community case managers actively follow up on these patients. They are the link between the healthcare team and the community partners, and help coordinate the provision of the medical and social services for these patients in the community.

The healthcare team will **continuously and proactively engage partners in the social and healthcare sectors** to join hands in looking after the multidimensional needs of the patients in their homes and community. Close collaboration with voluntary welfare organisations, like Tsao Foundation and Care Corner, enhances the management of care issues that patients face in their own environment and at the same time opens up a conduit for information flow. Engaging GPs, who can provide excellent access of care, can greatly benefit patients. By working closely with the tertiary hospitals and institutions in the Regional Health Systems, the healthcare team can provide reciprocal opportunities in enhancing seamless care for patients (and their families) as they transit from one institution to another. This is achieved through collaborations in standardisation of processes, sharing of information and right siting of patients.

With patients placed under the direct care of subgroups within the teamlet, there is increased **ownership** of patients. With the support of analytics, the subgroups receive better visibility of how well their patients are doing under their care, as compared to the cohorts of patients cared by other subgroups. The eventual goal is to make the performance of other similar primary healthcare teams within the clinic and across clinics, easily available for **benchmarking**.

Conclusion

In conclusion, we hope that this pilot with its key considerations and elements mentioned above will help to shed more light on new ways of repositioning primary care to effectively address the changing healthcare needs of our ageing population.

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