



A Model of Care for Chronic Disease Management by GPs

By Agency for Integrated Care

A Primary Care Network (PCN) is a network of General Practitioner (GP) clinics supported by nurses and primary care coordinators to provide team-based care to chronic disease patients. It aims to complement existing primary care models such as Family Medicine Centres and Community Health Centres, so as to better support GPs in managing chronic diseases burden in the community.

Key elements of a Primary Care Network are:

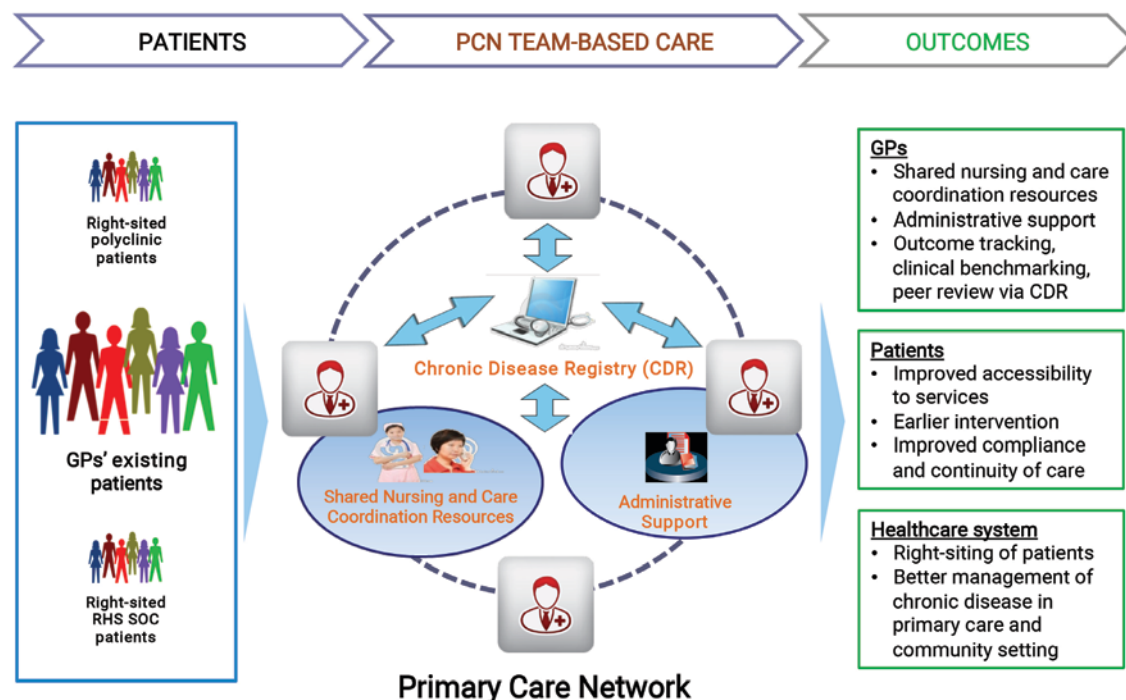
- 1 Availability of a roving team of dedicated nursing and primary care coordinators to provide team-based care in the form of care coordination, patient education and access to ancillary services, e.g. podiatry services, smoking cessation, etc.
- 2 Development and maintenance of a Chronic Disease Registry (CDR) of patients whose chronic conditions are being managed by PCN Clinics. This registry contains process and outcome indicators reflecting patients' compliance to recommended Chronic Disease Management Programme (CDMP)

care components, helping GPs keep track of their patients' clinical outcomes. The chronic diseases tracked under the CDR are diabetes, hypertension, hyperlipidaemia, asthma and chronic obstructive pulmonary disease.

- 3 Access to clinical data from the CDR allows GPs to have an ongoing view of their management of chronic disease patients, including benchmarking against national standards. Regularly scheduled PCN meetings provide a platform for GPs within the network to share and update clinical outcomes and best practices with their peers.

With these services and network provided by PCN to support chronic disease management, it is anticipated that GPs will be better equipped to take on a larger and more complex chronic disease caseload and better manage these patients in the community. Together with right-siting initiatives by polyclinics and hospitals' specialist outpatient clinics (SOCs), this will alleviate the load on our public healthcare system.

Primary Care Network



Benefits for primary care providers and patients

The PCN is envisioned as a “win-win” for all involved. For GPs, the network provides access to shared nursing and administrative resources through economies of scale. A common gripe of GPs is insufficient time and resources to deliver comprehensive preventive and chronic disease services. The ability to tap on these shared resources will expand the GPs' range of services and allow them to provide more comprehensive care to their patients.

The Chronic Disease Registry, in addition to providing a systematic way of tracking patients' disease control and clinical outcomes, allows self-evaluation and clinical benchmarking among doctors. It also helps to identify higher-risk patients for closer follow-up. Dr Tan Eng Chun, partner doctor of EJ Family Clinic and Surgery that has been part of PCN for almost two years, shared, “Meeting other clinicians in the PCN at regular meetings to discuss and monitor our clinical outcomes motivates us to improve our management of patients.”

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For patients, easier access to chronic disease services within PCN helps in early detection of complications, with the necessary referrals to relevant services such as podiatry, smoking cessation and even mental health services. Nurse counselling helps motivate patients to make lifestyle changes, equips them with self-management skills and improves treatment compliance. With such holistic care, patients are also more likely to follow up with the same primary care provider in the long term, resulting in greater continuity of care.

Dr Tan Eng Chun feels that PCN provides the “missing piece of the puzzle” for GPs in the continuum of chronic

disease care. Previously, patients had to seek their own eye screenings at TTSH or private clinics. With PCN providing mobile services literally at the clinic's doorstep, patients have more convenient access to these services.

Dr Tan Beng Teck from Woodlands Family Clinic, whose clinic joined PCN in early 2016, has been seeing some chronic disease patients who were previously followed up at the nearby Woodlands Polyclinic. He says, “Prior to joining PCN, I used to refer my patients to either KTPH or polyclinics for allied health services after their consults. Now, the PCN serves as a ‘one-stop shop’ where they can access both doctor and allied health services at the same location. This is a convenience my patients greatly appreciate and it helps to increase their compliance to treatment. In fact the nurse educator sessions at my clinic got filled up so quickly, I can't keep up with demand!”

Providing holistic care to the community

Dr Tan Eng Chun shared his personal experience of being in a PCN, “Our clinic in Toa Payoh has seen many multi-generational families of up to 20-30 members, many of whom are elderly. We have built a trusted relationship with them over the past 20 years. Last year, I saw an elderly patient with suspected advanced malignancy in our clinic. His follow-ups at the hospitals had been lost after persistent defaulting and refusal to go for further diagnostic procedures, but he still came to our clinic as he was familiar with us. I even started making house calls to see him. However my ability to adequately manage his condition was limited as I was busy running the clinic and did not have access to appropriate analgesia (morphine). With the help of the PCN Primary Care Coordinator, he was referred to home palliative care services. This was possible only because our clinic is part of PCN, which facilitates seamless patient referrals to relevant services.”

Promising results from pilot PCN with Frontier

AIC partnered with Frontier Healthcare to launch a pilot PCN in Apr 2012. Improvements have been seen in process indicators of diabetes, hypertension and hyperlipidaemia. Patient and doctor satisfaction survey results have also been very encouraging. This has since moved beyond the pilot phase, with over 20 GP clinics and nearly 5,000 patients currently enrolled in PCN.

Being part of a Primary Care Network

A vital element contributing to the success of PCN is clinician leadership and commitment. It was heartening to see the positive response at the recent GP Townhall in July 2016, where a majority of GPs surveyed agreed that being part of a PCN would bring value to their practice.

If you are interested in participating in PCN and would like more information, please contact the GP hotline at **6632 1199** or email gp@aic.sg.