Teamwork is also relevant in the context of GP clinics. MOH is developing the Primary Care Networks concept to bring solo GPs together in networks. We hope that this will enable them to share administrative and clinical resources, and explore opportunities for collaboration. We have also developed GPConnect, an IT solution for GPs, to strengthen links across the sector and with Regional Health Systems.

ON TEAMS:
"The most important element for team-based care …is not structure and systems, but people."

The most important element for team-based care to succeed is however not structure and systems, but people. Beyond the acquisition of clinical knowledge, emphasis will need to be placed during the education and training of young family physicians, on practical skills in team-based practice. We hope that family physicians and Family Medicine educators can embrace this philosophy of inter-professional collaboration in their practice, learning, as well as teaching of junior doctors.

Conclusion

Ladies and Gentlemen, the NUS Yong Loo Lin School of Medicine has made commendable efforts to nurture the growth of Family Medicine in Singapore over the past three decades. We know that it will continue to play a leading role in Family Medicine. I am confident it will evolve its education and training system and methods to meet the challenges ahead, including the three elements which I just spoke about.

To all family physicians with us this evening, thank you for your dedicated service. We believe the future holds exciting prospects for primary care and Family Medicine. We look forward to your continued contributions in shaping our healthcare system for the future, so that Singaporean can enjoy better health, better care and a better life.

Images courtesy of NUS Division of Family Medicine CM

A Tale of 3 Clusters

Interviewed by Dr Phua Cheng Pau Kelvin, FCFP(S), Editorial Board Member

The six regional health systems in Singapore will be reorganised into three healthcare clusters for the central, eastern and western regions. Polyclinics will also be reorganised, in line with the geographical reach of the three new clusters.

- **Central**: Alexandra Health System will merge with National Healthcare Group (NHG)
- **East**: Eastern Health Alliance will merge with Singapore Health Services (SingHealth)
- **West**: Jurong Health Services will merge with National University Health System (NUHS)

There are a few major challenges in healthcare for Singapore over the next few decades:

1. The increasing healthcare needs of an ageing population
2. Increased chronic disease burden
3. The need to manage future growth in healthcare manpower and spending (i.e. increase productivity and efficiency)

MOH stated that this reorganisation will enable Singapore to meet "future healthcare challenges" with the following improvements:

- Each cluster will have a fuller range of capabilities and facilities across different care settings
- Will be able to deliver more comprehensive care and person-centred health promotion.
- Able to implement changes more swiftly and decisively.

Family Physicians: How will these changes affect patient care especially primary care?

The editorial team sought to appreciate how the above changes will affect family physicians and the way they care for their patients. We interviewed a few family physicians practicing in different settings for their view on this matter. There were a few common themes voiced out:

1. They recognise that care coordination and case management are essential to care for patients in the community;
2. IT enablers are crucial for successful implementation of common platforms for communications between the various providers, including primary care;
3. The key to a healthier population starts with a strong primary care team.

We also spoke to a few family physicians who run their own clinics. They felt that these changes are unlikely to affect their practice in the near future. This is not surprising as this is a recent announcement and the Ministry and the clusters have yet to announce detailed plans on any changes to the current model of care or collaborations with GPs.

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Dr David Tan Hsien Yung, Head, Pioneer Polyclinic, NUP

College Mirror (CM):
What is your role in NUP?

Dr David Tan (DT):
I am a Family Physician first of all, and still have very much of a clinical role in attending to patients and their health and psychosocial issues. I am also heading the new Pioneer Polyclinic development in Jurong West area, and am looking forward to the opening of the new clinic in the latter half of 2017.

Pioneer Polyclinic is unique in that we hope to empanel most of our patients to teamlets, such that patients have continuity of care with their providers, and the teamlets have a panel of patients whose outcomes they are ultimately responsible for. My role as clinic head is to also help develop the teamlets as this is a new care model which many doctors and nurses may not be too familiar with.

Apart from my clinical and administrative role, I continue to be involved in teaching and training matters for NUP.

CM:
How will the larger cluster affect the delivery of care to the community in the western part of Singapore?

DT:
The formation of NUP will better align the polyclinics in the West under one group and being part of NUHS will also enable the entire healthcare cluster to deliver more integrated, patient-centric and comprehensive care.

As there will be a need for more capacity and capability in primary care, having an additional polyclinic group like NUP will help to support these needs, especially working closely with both NHGP and SingHealth Polyclinics as well as GP partners. NUP, which is part of the academic health system of NUHS, will also leverage on the research strengths and the hinterland of NUS to advance the practice of Family Medicine to better serve our population.

CM:
What are the key areas of integration that will benefit the community?

DT:
Our service to our patients will still continue amidst the integration that is occurring, but I foresee that all this should help to ensure continuity of care across the different care settings (i.e. primary, tertiary, ILTC) and cover the needs of the community from 'cradle to grave'.

To achieve this, we will need to continue to closely engage our patients and their caregivers, so that they are empowered to take better care of themselves and be more responsible for their own health. At the same time, we need to coordinate well with GP partners, other community health and social care providers to ensure the wellbeing of the community we serve.

Dr Tan Kok Leong, Senior Consultant, TTSH

College Mirror (CM):
What is your role in TTSH?

Dr Tan Kok Leong (TKL):
I am a Family Physician, Senior Consultant, and Deputy Head of the Department of Continuing & Community Care, Tan Tock Seng Hospital (TTSH). I am also the Programme Director for the TTSH Transitional Care (TC) Programme.

The TC Programme was formed and became operational in July 2016. This followed the merger of 2 services, the Action Care & Coordination (CC) and the Virtual Hospital (VH). These 2 services were previously operating as separate entities in TTSH and focused on facilitating the transition of patients from the hospital back to the community. Action CC emphasised inpatient care coordination (i.e. prior to planned discharge), while VH focused on care coordination in the community.

In Jan 2017, the Post-Acute Care at Home (PACH) Service was merged into the TC Programme. PACH managed post-hospital discharge patients who were home-bound/bed-bound with complex medical and nursing needs.

With the merger of the three services (Action CC, VH, & PACH) into one Transitional Care (TC) service, the care planning and coordination are better streamlined with each patient having one Transitional Care Specialist (TCS, registered nurse) to oversee care coordination from inpatient to the community and to be the point-of-contact (POC) in the community for patients, caregivers, and community partners who are involved in providing care.

The key objective of the TC Programme is to reduce avoidable hospital emergency service attendance and hospital admissions through:

- Empowering the patients and their caregivers to better manage and cope with their medical conditions, and
- Having a tripartite model of care collaboration with TC Service representing the hospital arm, collaborating with

primary care services, and community medical/nursing and social services to render a timely and responsive care to the patients in their home

CM:
With these new larger integrated clusters in place, what are the potential opportunities to improve patient care in the area of transitional care?

TKL:
The family physicians play a very important role in providing the medical care component to patients in the community. As described in the above on the tripartite care model, the family physicians are key to:

- Working with hospital SOC specialists in the provision of stabilisation and maintenance clinical care to patients with complex diseases, timely and accessible intervention in the early phase of disease exacerbation, and/or close monitoring and treatment titration to prevent disease progression or exacerbation
- Being the primary care physician for the patient by managing and coordinating clinical care and performing periodic medication reconciliation, to avoid adverse events arising from polypharmacy, and reduce stress on the patients and their caregivers on having to go for multiple SOC appointments and performing overlapping lab investigations
- Working with community partners in the management of identified frail elderly patients through preventive care, such as performing a comprehensive geriatric assessment, and making the appropriate referrals to various health and social care providers in order to better support patients in their home and community

CM:
What are the key areas that are crucial for this integration to work well?

TKL:
Crucial areas to ensure that the Care Integration can work

- A strong sense of collective ownership by members of the care team and both hospital and community providers
- Clarity in the roles and functions of the various stakeholders from the hospital and community in achieving a continuity of care using a trans-disciplinary approach involving various professionals
- Attainment of necessary knowledge and skill sets in managing patient with complex medical & social needs; these include clinical knowledge in disease management, case management, nursing procedures, etc.
- A common platform for timely sharing of information by the care team members; IT, regular case discussion sessions, multi-disciplinary rounds, etc.
- Use of IT in clinical monitoring that can be make critical information available in a timely manner to all members in the team
- Agreed upon work processes to facilitate care amongst the members in the care team
- Agreed upon common KPIs and outcome indicators to ensure alignment of care goals
- Funding from MOH and the regional clusters to support collaborating partners in the community

Dr Chong Chin Kwang, Director (GP Clinic Network), Frontier Healthcare Group

College Mirror (CM):
Hello Dr Chong Chin Kwang, tell me about your role in Frontier Healthcare Group?

Dr Chong Chin Kwang (CCK):
I am the Director of the GP Clinic Network.

CM:
How will the new clusters affect patient care for Frontier Healthcare Group?

CCK:
While patient care at the individual level may not be affected, GPs do need to appreciate the potential systems-level implications as a result of the cluster integration. I am optimistic that with some of the latest developments in our healthcare scene, GPs will be better engaged and there will be better care integration.

CM:
How are the potential areas of improvement?

CCK:
Engagement is likely to develop more positively when there are common objectives and workflows between the two sides of the engagement. I would think that this is more likely to happen when both sides of the engagement are more consolidated - re-clustering into the 3 health clusters on one side and GPs coming together to form Primary Care Networks (PCNs) on the other side. For example, in our PCN, to align with the re-clustering, we have organised our PCN into 3 regions and each region is headed by two GP clinical leads to help in the engagement with our public healthcare sector colleagues.

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Dr Chua Chi Siong, Medical Director, Jurong Community Hospital

College Mirror (CM):
What is your role in Jurong Community Hospital?

Dr Chua Chi Siong (CCS):
I am the Medical Director of Jurong Community Hospital (JCH) and together with my team of clinicians, nurses, operations, HR and finance personnel, oversee the running of the hospital. From the clinical viewpoint, apart from being responsible for the standards of clinical care at JCH, I worked very closely with the clinicians in Ng Teng Fong General Hospital (NTFGH) to ensure that patients who require post-acute and rehabilitative care are seamlessly and safely transferred across to receive the required care at JCH en-route to recovery. Knowing that many of the patients will require well-coordinated post-discharge care involving not just family physicians, but also other community health and social partners, I worked with different teams to ensure that discharge care plans are developed and communicated to relevant partners for good continuity of care.

CM:
How will the larger cluster affect the delivery of care to community hospital patients in the western part of Singapore?

CCS:
Prior to the latest reorganisation, there was already strong vertical integration between the restructured and the community hospitals. With the larger cluster, we aim to build on the existing relationship and work arrangements to better integrate care from the community to the home. As a larger cluster, we will be able to leverage combined resources, expertise and greater opportunities to ensure patients receive well-coordinated care across both restructured and community hospitals. For example, one of the key changes in this reorganisation is that each of the new cluster now has a Polyclinic group so that post-discharge care can be further smoothened for better continuity of care.

CM:
What are the opportunities the re-organisation present to a family physician in ILTC sector.

CCS:
A well-trained family physician will have skill sets and ethos that allow him to contribute in a variety of healthcare setting. MOH has identified family physicians to play a crucial role in the further development of the ILTC sector. There is now greater opportunity in terms of training to realize the full potential of family physicians to contribute to patient care across setting and, for those who are interested, to participate in care in more than one setting (as well as involvement in teaching and research).

■ CM

A Primary Care Doctor's Perspective of Public Healthcare Sector Restructuring

by Dr Ng Chee Chin David, FCFP(S)

From a macro perspective, restructuring our public healthcare system into 3 regional clusters is a move in the right direction. The perceptible duplication and fragmentation arising from having 6 fairly autonomous regional health systems will hopefully be reduced in time to come with the breakdown of boundaries and better interfacing between services. In the spirit of care integration, this reorganisation places the cluster HQ firmer in the driver's seat by overseeing a larger geographical area as well as crucial components of the public healthcare system from tertiary hospital to polyclinics. It however remains to be seen how well the mergers will drive the clusters to focus more on community and primary care, an objective clearly desired by the Ministry of Health.

The shift of care into the community has always been the intention of Ministry in the face of an increasingly aged population. Care provision in the community necessitates the building of meaningful and mutually beneficial relationships with community healthcare elements like the GPs, ILTC providers and also social organisations as well as other government or grassroots agencies like the Police, schools, People's Association. That network of relationships built on trust undergirds every collaboration that true integration within each region will ensue.

Thus, it is important that the clusters take on the mantle of managing the health of a population by going beyond traditional institutional barriers, bridging the public-private divide and looking hard at what will really benefit the health of the population they serve.

Some potentially thorny issues, however, need further in-depth exploration: