(continued from Page 17: Pioneering Primary Care in the West)

DT:
We are empanelling all patients who require continuity of care, such as those with chronic conditions such as Diabetes, Hypertension, Asthma and COPD.

CM:
Do you have previous experiences in other Polyclinics? What are the results?

DT:
Yes, we have been analysing results of patients being followed up by the teamlets compared to those that were not, and have found improvement in their clinical indicators (such as HbA1c) and uptake of preventive health screening (such as DRP/DFS uptake, MMG, Pap).

CM:
Does Pioneer Polyclinic engage surrounding healthcare providers like GPs, FMC, Medical Groups, nursing homes etc? Any plans like GP nearby, CMEs, engagement like "meet-the-GPs sessions" etc?

DT:
Yes. The management team of Pioneer Polyclinic has been engaging the GPs around the area early on from the stage of the clinic design and will continue to do so in the coming years.

CM:
How does Pioneer Polyclinic intend to integrate care with the acute hospitals so as to facilitate right siting of patients from hospital to community?

DT:
Being part of the NUHS family, this provides more opportunities to collaborate with the hospitals to better manage our patients together.

CM:
The Pioneer Polyclinic is impressive with colour codes, can you share what they mean?

DT:
Being the first polyclinic in Singapore to go beyond 4 levels (we're 7 storeys high!), the team designed the clinic with the patient in mind, hoping to reduce patient movement as much as possible. Hence, services such as phlebotomy services have been decentralised to the teamlet floors, meaning that patients should be able to receive most of their care on the same floor. The floors have been colour-coded according to different nature themes, so that patients can identify with their own floor colour over time. This also allows the staff to have a sense of belonging to their 'floor'.

CM

Advancing Academic Family Medicine *in NUHS and Beyond ...*

Interviewed by Dr Fok Wai Yee Rose, MCFP(S), Editor (Team A)

Professor Doris Young
MBBS (Melb) MD (Melb) FRACGP

Doris Young graduated from Faculty of Medicine, University of Melbourne and completed Family Medicine training in Australia. Over the last 35 years, Doris has been involved extensively in educating and training medical students, registrars, general practitioners and other health professionals in adolescent medicine, general practice and primary care research. Over the last 10 years, she has been actively building General Practice /Family Medicine education and research capacity in Hong Kong and in China.

Doris Young has published widely in the area of General Practice integration models with the wider health care system and her research focussed on trialling innovative models of care in the primary care setting to improve health outcomes for people with chronic diseases in culturally and linguistically diverse and disadvantaged communities.

Doris moved to Singapore in January 2015 and in 2016 took up a part time role as research advisor to National Healthcare Group Polyclinics. She joined National University of Singapore January 2017 as Professor in the Division of Family Medicine.

On 1 Feb 2018, she was appointed the inaugural Head of a new Department of Family Medicine at NUHS.

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College Mirror (CM):
Can you share on the development of Family Medicine (FM) in other countries and "what works" and "what doesn't"?

Prof Doris Young (DY):
What works?
From my experience looking at countries where they have good health outcomes, good accessibility, good equity, those countries have a strong primary care system. This means that their patient's first port of call is the General Practitioner (GP) who is properly remunerated to provide evidence-based care to the community. These countries invest money in primary care and the community value their family doctor and they have trust their GPs to provide value-added care. In addition, their FM academic fraternity is a strong discipline that work together to deliver care strategically that is well aligned and this may take quite a lot of time to develop.

The most cost-effective healthcare system is where the majority of care is delivered in the community that is co-ordinated by well-trained Family doctors / GPs working with a multidisciplinary team and where the primary care system is well integrated with secondary and tertiary hospital care.

What does not work?
This is when family doctors don't look after a family/ population providing only episodic care that is not well integrated with the rest of the healthcare system. This encourages 'doctor-shopping' behaviour resulting in fragmented care. FM development also doesn't work in those countries where Family Medicine is not perceived as a specialty in its own right and not valued by their community including their government.

CM:
What is the funding model of primary care in Australia?

DY:
A. Paying GPs to manage patients
Currently, most primary care services like GP visits are funded through Medicare. GPs receive most of their remuneration through fee-for-service (FFS) payments, which is where the GP bills an amount for the provision of an individual service. Around 82% of GP services are bulk billed, meaning the GP directly bills Medicare for the patient visit rather than billing the patient.

But not all GP services are paid for in this way. A growing number involve 'blended payments', where as well as FFS, the GP receives an incentive payment as a 'reward' for providing an improved level of service. Practice incentive payments (PIP) are currently paid for a wide range of enhanced services such as the provision of after-hours care; teaching medical students managing patients with chronic conditions such as asthma or diabetes.

FFS and incentive payments make up the bulk of GP remuneration in Australia. But the rise of chronic diseases like diabetes has led to calls to reform this blended payment system in order to support more multidisciplinary team care, with alternative models such as capitation[2].

B. Paying GPs to train students
It took a 10-year journey from an honorary system "begging GPs to teach" to the current system whereby GPs receive remuneration for teaching students. It is never money making but to compensate them for time and income lost. In return these designated "teaching-GP clinics" have to undergo training and meet accreditation guidelines which raise the status of the GP clinic as a quality practice involved in student teaching.

Thus "teaching money" must follow the "teachers and the learners" and now in Australia, there are many very passionate GPs teachers who provide good role models and competent training for our residents and students.

CM:
How does the College of Family Physicians play a role to advance Family Medicine?

DY:
We need to see the "end product" then work backwards. The end product is to have a highly regarded GP who is respected by the community and recognised as a specialist in their own right, who receive proper remuneration and have good work life balance. The respect from the public is very important, that every person or family should have a family doctor. In Australia, 90% of the people have a general practitioner. In the UK, it is 100%[1]. Everyone should have a good GP who looks after them and their family members.

In order to produce high quality GPs/FPs, we need to expose the students early to Family Medicine, provide good role models and mentors, craft an interesting curriculum which will make family medicine residency attractive. We need every player to play their part to encourage more quality residents to choose family medicine as a speciality. The College of Family Physicians has a big role to raise the status and standards of FM as a specialist discipline, make it financially attractive and have a strong voice in the relevant healthcare decision making bodies to promote the value of having a robust primary care system in Singapore.

CM:
Is there any fundamental similarity and difference between Family Medicine and Specialist training and education?

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DY:
What is similar?
Family medicine is a speciality in its own right, just like cardiology or neurology etc. We also have our own core curriculum and skillsets that require training to reach competencies. CME is also crucial to maintain knowledge and skills adopting evidence based practices to improve health outcomes.

What is different?
Breadth and not depth of scope of practice is the focus of FM. In order to acquire skillsets in various disciplines, across multiple settings (e.g. GP, polyclinics, home care) FM doctors need to receive relevant training for their practice needs. The core curriculum cannot be too diffuse, but sets the standard to what is required to train family doctors to provide safe and unsupervised medical practice in the community.

CM:
Can you share on your experiences in teaching Family Medicine to under and post graduates?

DY:
From my experience working at University of Melbourne for the past 30 years teaching General Practice to medical students and residents, we need to expose undergraduates to General Practice early and also throughout the medical course so that they have an understanding of the role of GPs in the healthcare system. We need a defined curriculum to develop knowledge, skills and attitudes unique to general practice and these must then continue into residency training.

CM:
How can Family Medicine in NUHS develop as an academic Clinical Program?

DY:
It is very exciting for NUHS to have a stand-alone department of FM whose mission is to raise the academic standing of FM. To do this well we need to have more FM curriculum time throughout the five years of the course, recruit passionate teachers to deliver education using innovative technologies. We will also need to integrate undergraduates with post graduate residency training and develop continuing medical education so that everything we do has an evidence base to them.

The academic standing of FM is also measured by its success in research. I plan to set up a primary care research unit and bring together collaborators to develop research themes and answering research questions that arise from primary care perspectives. I hope to instil a research culture amongst the staff, the medical students, residents, and GPs and provide training for them to engage in research. Finally, in order to move towards delivering world class research I want to link up our GP researchers with FM / GP colleagues internationally as well as exposing our younger doctors to other primary care research experts.

CM:
What roles can Family Medicine play in a Specialist-centric restructured hospital?

DY:
In Singapore, some FM doctors already provide high quality clinical services in the areas of aged care and rehabilitation, especially in community hospitals. However, I see the added value of FM doctors in hospitals to focus on providing ambulatory care and establish a unique role in facilitating transitional and home care from hospital to the community. Ultimately FM doctors can also help to navigate care back to the patient's GP.

CM:
We are now at an exciting time for development of Family Medicine in Singapore. Our Minister of Health, Mr Gan Kim Yong explained that in the Healthcare 2020 Master Plan, we need to:

(i) move beyond hospital to the community;
(ii) move beyond quality to value; and
(iii) move beyond healthcare to health.

These 3 moves are critical in preparing us to meet our long-term healthcare needs in a sustainable manner. What do you think of these Singapore initiatives?

DY:
I think the move is timely, in particular the move from hospital care to the community.

Hospital to community
The most important criteria for the successful implementation is to select the right type of patients that can be appropriately shifted to the community. Many people after receiving acute and subacute care in hospitals and are now stable, can go back to the community to receive care. These can be shared medical care or social and community support care.

Quality to value
When a government invest so much money into the healthcare system, they want to know whether there is "value for money". I think this is important to quantify to avoid too much spending to get "quality" and yet you might not get the value of the dollar spent. Measuring this is important for an effective affordable healthcare system.

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Healthcare to health
Finally, this is obvious that we should not treat the sick too late or when they develop multiple advanced complications. We need to emphasize the importance of health promotion, self-management and staying healthy. This shift of the mind-set of the community to be more self-reliant and responsible to maintain their own health rather than merely depending on doctors and nurses to fix their problems. This revamped healthcare with a broad base in the community will then truly be good value for money!

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CM

Advocating Community Cancer Survivorship in NCCS

An interview on 26 October 2017 with Professor Soo Khee Chee, Senior Consultant and Director* of National Cancer Centre Singapore
Interviewed by Dr Fok Wai Yee Rose, MCFP(S), Editor (Team A)

DEFINING CANCER SURVIVORSHIP

College Mirror (CM):
What is Cancer Survivorship?

Prof Soo Khee Chee (PS):
As the cancer survivor transits from active treatment to recovery and wellness, care need changes and the care model should give priority to health promotion, disease prevention and management of chronic diseases.

This new model should be patient-centric and holistic, best sited in the community closer to patient's home, with our preferred partner being the primary care physician (PCP).

Professor Soo Khee Chee

Images courtesy of National Cancer Centre Singapore (NCCS)

CANCER AS A CHRONIC DISEASE

CM:
Being diagnosed with cancer is a life-changing experience and the survivor has to live with the fear of recurrence for the rest of their lives. Do you have advice for cancer survivors?

PS:
Accepting cancer to be a chronic disease is the cornerstone of transition from fear to temperance and they should be encouraged to optimise control of this new chronic disease. We need to reassure survivors of our commitments to train a wider base of PCP to better manage their cancer survivorship issues at the community level and this would increase patients' confidence in community cancer survivorship to take charge of their health.

NEED FOR COMMUNITY CANCER CARE

CM:
Why do we need Community Cancer Survivorship?

PS:
Headlines in Straits Times recently announced a sharp rise in breast and prostate cancers as a result of aging population, sedentary lifestyle and obesity. With more cancers, there are now more survivors as a result of better healthcare and improved supportive care.

Survivors are living longer and developing more comorbidities and remaining susceptible to treatment complications.

MODEL of NCCS COMMUNITY CANCER CARE

CM:
What model of community cancer care will NCCS adopt?

PS:
The American Society of Clinical Oncology recommends a shared care model, where the general practitioner co-manages with the oncologist on cancer survivor's post-treatment issues and this level of follow-up care should be dependent on provider and survivor preferences, and also the resources available in that country.

And why a shared care model is because randomized control trials conducted in the West have found that GP-based survivorship care was not inferior to oncologist-based care.

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