Delivering Person-Centric, Seamless Care: The NUHS Patient Appointment Consolidation (PAC) Programme

NUHS
National University Health System

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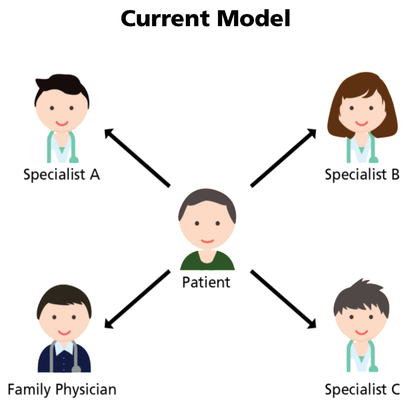
The Issue

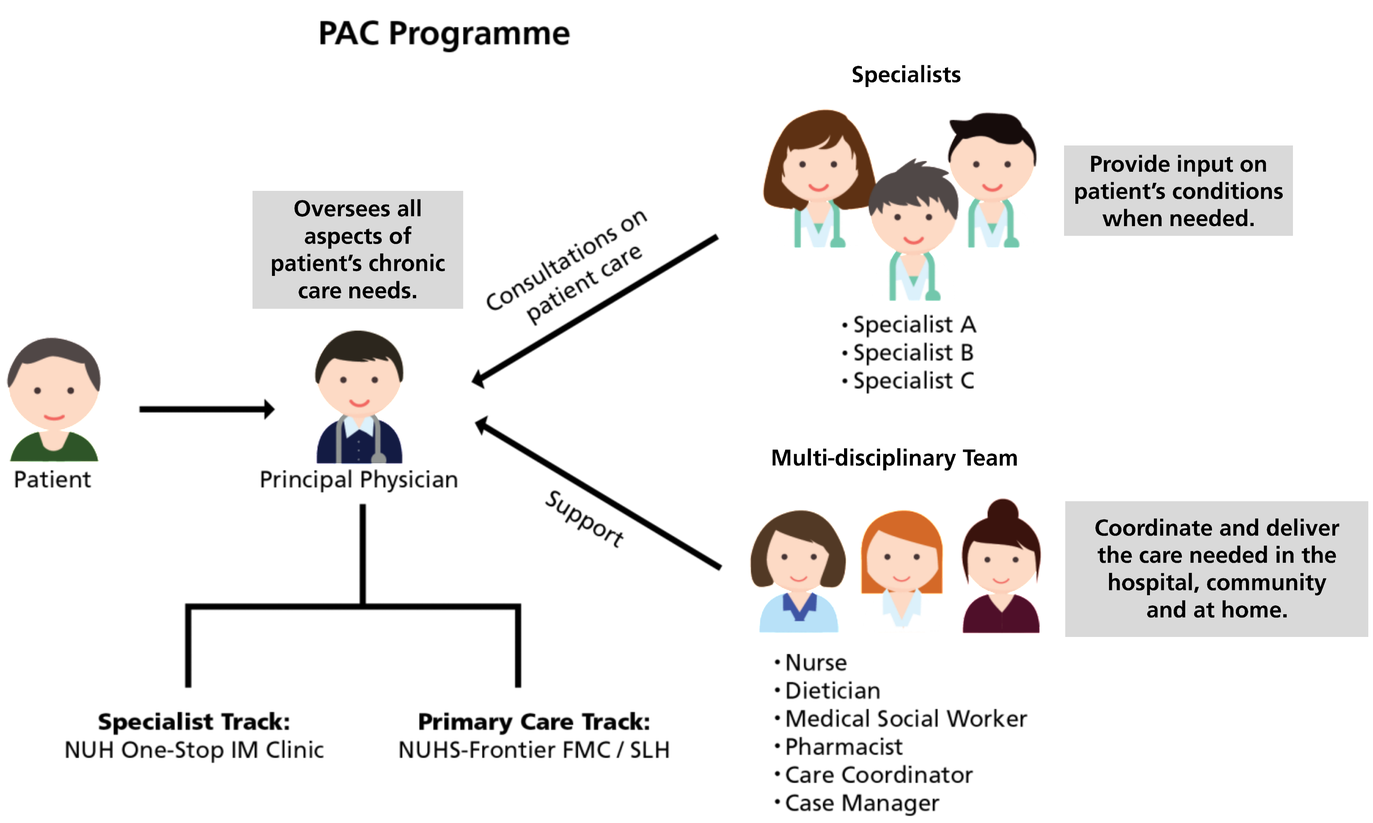
Increasing prevalence of patients with multiple chronic diseases (MCD) + Hospital-centric, disease-specific approach to care →



Patients consult different specialists for each of their chronic conditions, resulting in:
- Fragmentation of care
- Significant time burden and cost to patients
- Risk for poor healthcare outcomes

Strategy

CONSOLIDATE MEDICAL APPOINTMENTS OF PATIENTS WITH MCD AND FACILITATE SHARED CARE ARRANGEMENTS ACROSS CARE SETTINGS



Desired Outcomes

- ✓ Reduce care fragmentation
- ✓ Reduce utilisation of high-cost healthcare services
- ✓ Cost savings to the system, with same or better patient outcomes
- ✓ Patient and caregiver empowerment

Success Factors

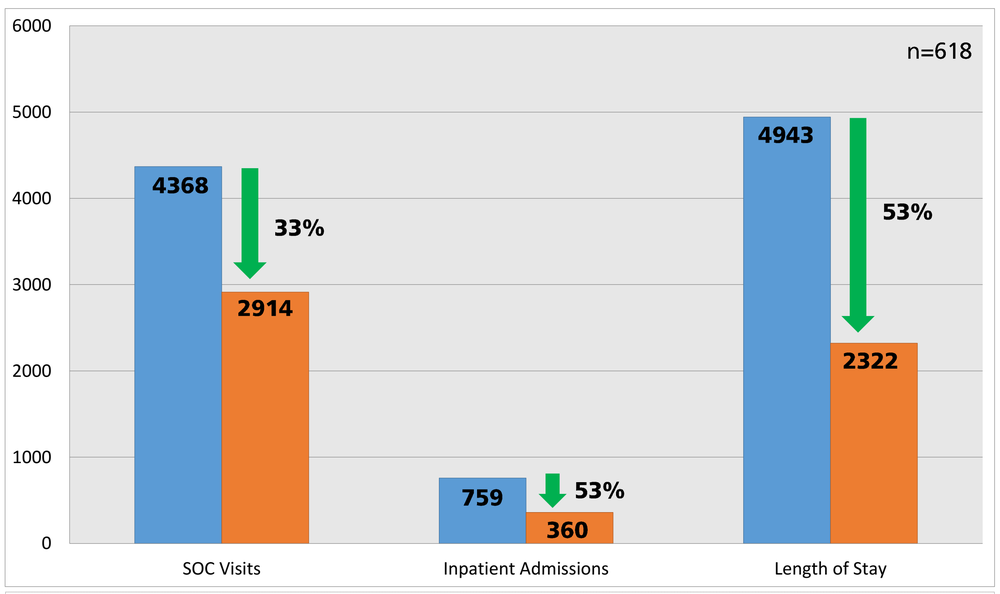
The Primary Care Coordinator (PCC) recruits patients and performs patient counselling
- ➢ Increases patient buy-in and promotes greater self-management.

A common IT platform between hospital and community partners
- ➢ Enables information exchange and communication.
- ➢ Smoothens the transition of care to the principal physician.

Regular engagements between hospital and community partners
- ➢ Facilitates knowledge sharing and shared care arrangements.

Outcomes

✓ REDUCTION IN HOSPITAL UTILISATION



12-month pre and post analysis of changes in hospital utilisation, for NUHS PAC patients enrolled from FY14Q3-FY15Q2. Data as at Sept 2016.

- Largest reduction in hospital utilisation amongst piloting RHSes.[1]
- Key elements of the NUHS PAC programme are now adopted in the mainstream national programme (FY17-FY18).

✓ POSITIVE PRELIMINARY, EVALUATION FINDINGS

Enables Shared Care, Reduces Care Fragmentation

"It is good that we share the same medical records, as I am able to inform them about medication changes via memos. We communicate quite freely via emails as well." – Hospital Specialist

"I can still send my patients to the family physician clinic for check up every 2-3 months for their diabetes, hypertension, high cholesterol and so on. But I will see the patient every 8 months or yearly." – Hospital Specialist

Quality Patient Experience

"I think his medical records were passed over to the Primary Care Physician, so she knows what his conditions are. She never failed to ask my father whether he has any other issues or not." – Patient's daughter

"The hospital specialist and assistant were very detailed in explaining the process to us during transfer. They gave us all the necessary forms, and the transition was quite smooth." – Caregiver

Lessons Learnt

Importance of leadership alignment to lead and execute mindset change.

PCCs play an important role to gain both clinicians and patients' buy-in.

Relationships between hospital specialists, primary care partners and management are strengthened through regular engagements and information exchange (enabled by a shared IT system).

[1] Findings are based on a outcome analysis with propensity matched controls performed in 2016, by the Ministry of Health, for all RHS clusters with similar programmes implemented under RHS programme funding for Priority 4: 'Deliver person-centric, seamless care'.