

# Private-public collaboration with Primary Care to improve and deliver care in the community

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## Challenges in Primary Care

Singapore's population is ageing rapidly. This silver tsunami coupled with the increasing prevalence of chronic diseases puts a strain on public healthcare institutions (PHIs) and their limited resources. There is hence a need to transform the nation's primary care landscape. Private General Practitioners (GPs) remain as an untapped but valuable resource. While PHIs manage patients with complex chronic conditions, GPs traditionally provide episodic care of acute conditions to the population. Separate governance structures lead to varying delivery of care between GPs who may also lack the necessary support systems at the primary care level. Collectively, these challenges impede the provision of care that is similar to the public primary care sector.

## Our Partnerships

Tan Tock Seng Hospital's (TTSH's) Division for Central Health established the Primary Care workstream to develop strategic private-public collaborations with primary care providers for appropriate right-siting of patients from TTSH to GPs for improved continuity of care. The partnerships were developed to appropriately transit patients with stable, chronic diseases and minor ailments in a safe and cost-effective manner for seamless continuity of care management by GPs in the community. GPs are empowered to manage chronic conditions past the typical acute conditions, and patients receive holistic and accessible care that remains cost effective.



### Community Right Siting Programme (CRiSP)

Launched in 2014, CRiSP is a partnership between TTSH and GPs to ensure that patients with stable, chronic conditions are appropriately reviewed and cared for at the primary care environment upon discharge from TTSH Specialist Outpatient Clinics (SOCs).



### Shared Care

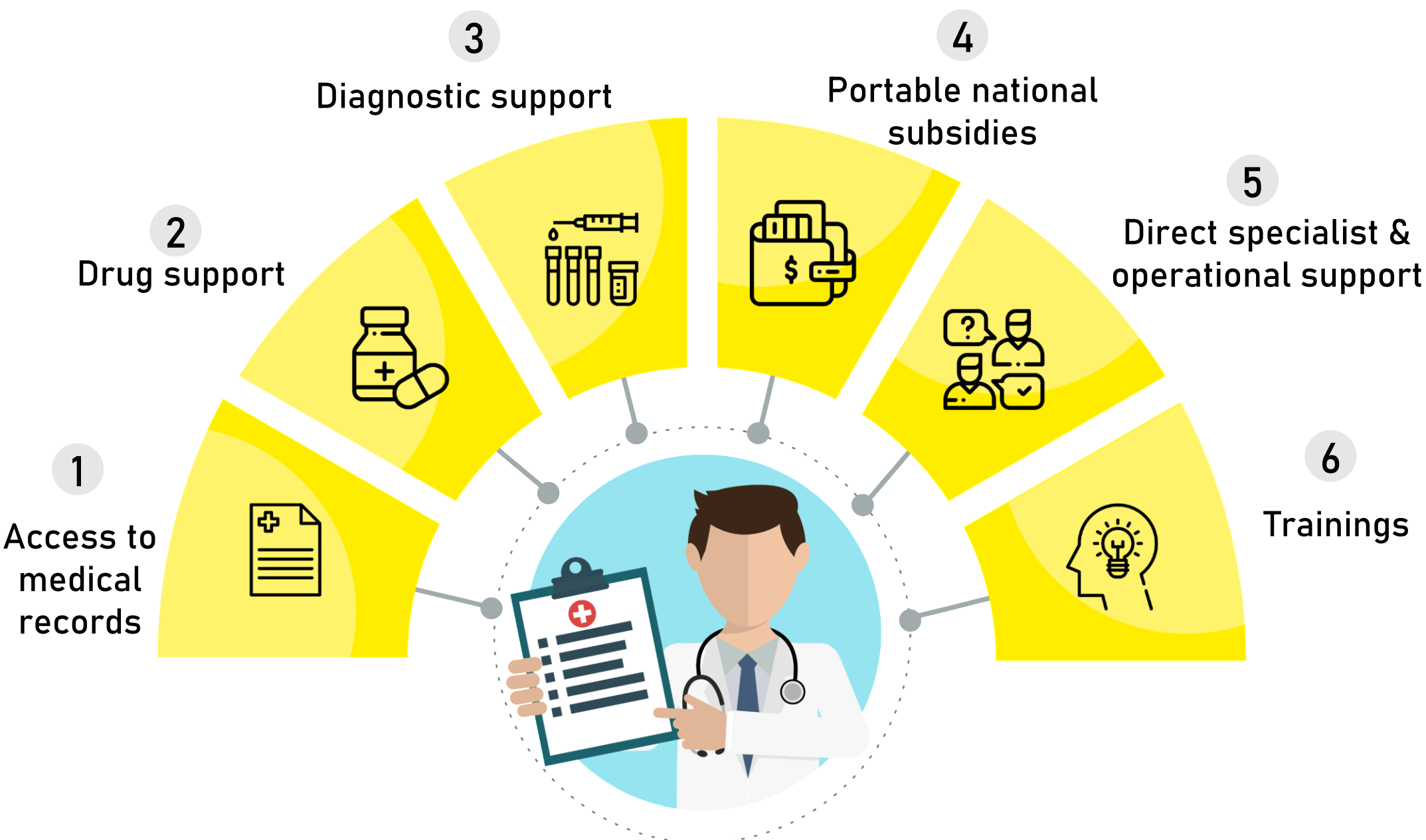
Shared Care was initiated in 2017 and is focused on the co-management of moderately stable patients between TTSH specialists and GPs. This concept of shared care delivers holistic care management of chronic conditions to patients who occasionally require review with a specialist.



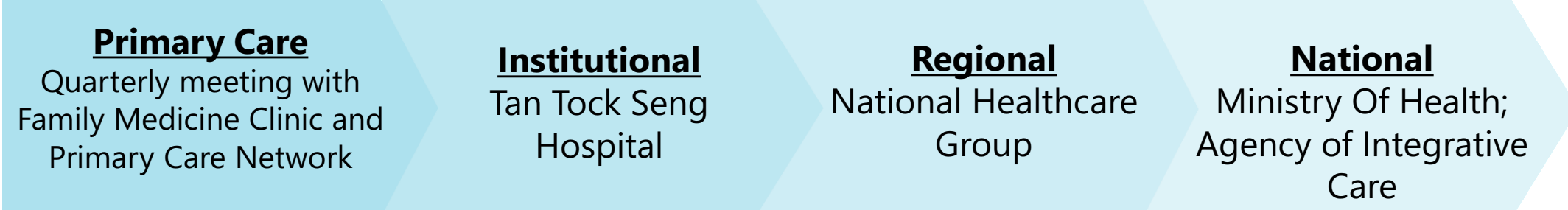
### GPNext

GPNext was launched in 2018 to facilitate the appropriate transition of stable patients with chronic diseases, minor or no emergencies directly from TTSH Emergency Department (ED) to GPs.

## Support for GPs



Our partnerships with primary care are overseen by multiple layers of governance:



## Results

Preferred GP partners:

**150**  
and growing

Average of:

**5%**

Readmission within 4 years

Over  
**6000**  
discharges facilitated

Yearly cost of:

**\$323\***

per patient managed in the community

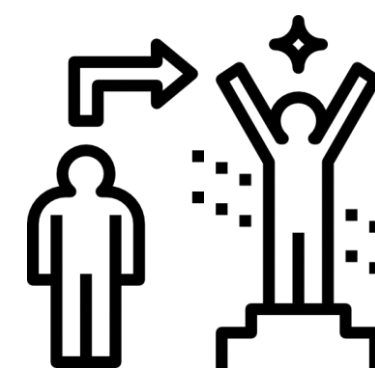
Through our collaborations, GPs are supported with the necessary tools and infrastructures to enable them to deliver holistic and quality care to our mutual patients within the community. Our mutual patients continue to access affordable healthcare upon transition from public to private setting. With strong collaborations, mutual trust and the necessary support enablers in place, our GP partners are now clinically and infrastructurally equipped to manage patients with chronic medical conditions of higher acuity.

“CRiSP facilitates patients with new disease profiles for continual management with GPs. The programme supports such as drugs delivery and CHAS subsidy allows GPs to focus more on providing quality care, instead of managing non-clinical aspect of patient care. CRiSP is simply another way that the care plan maintains focus on the patients – demanding care excellence while also providing convenience, flexibility and affordability within the community.”

Dr Theresa Yap  
 Yang & Yap Clinic and Surgery

## Future plans

More training and upskilling initiatives are being developed to equip GPs with relevant skill sets to better manage patients with chronic conditions in primary care. There are also plans to expand CRiSP, Shared Care and GPNext to ensure that every patient receives the right care at the right place and at the right time.



GP Training



Partnership growth



Partnership recruitment

Supporting the Nation's vision of  
**“One Singaporean, One Family Doctor”**

\* Data source:  
 Agency of Integrative Care, Outpatient to Community (O2C), FY2017  
 Cost comparison against average of \$1544 across 5 similar programmes island-wide.