LINK

A shared-care program by SKH

Restricted, Sensitive (Normal)

Sengkang General Hospital
SingHealth

LINK Programme (Outpatient2Community)

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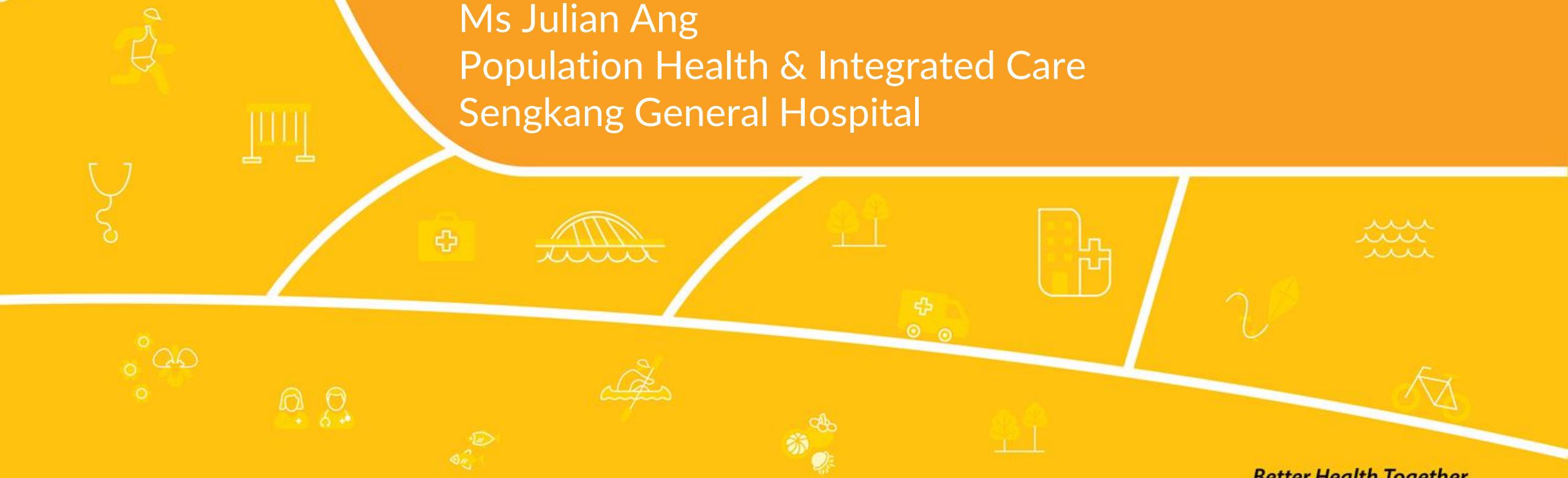


Better Health Together

Outpatient2Community: What are we trying to tackle?

- Discharge and appropriately-site medically stable patients and ensure continued care in Primary Care.
- Reduce the number of repeat SOC visits, in turn free up time for new patients (i.e. reduce wait times for new appointments).
- Streamlining SOC appointments by leveraging on shared care arrangements with primary care
- Anchoring of patients in Primary Care & Community

Why anchor care of patients in Primary Care & Community?

Rapidly ageing population

1 in 4 Singaporeans will be above aged 65 by 2030

Increased prevalence of chronic disease

1 in 10 Singapore residents has diabetes
1 in 3 has high blood pressure
2 in 5 has high cholesterol

+2.1 years longer

Increased life expectancy

Life expectancy of Singaporeans is among the highest in the world at **84.9**

Source: MOH HSG Briefing Slides

SKH Specialist Outpatient Clinics Utilisation Patterns

Helped us gain insights of the patient profiles in SKH SOCs to target the specialties suited for right-siting of care.

(1) Top 10 SKH SOC Specialties Utilization

Specialty	No. of Patients	Avg No. of Dr Visits	Avg. Duration F/Up (mths)
Orthopaedic Surgery	713	4.0	16.7
Urology	507	4.3	21.8
Psychiatry	403	8.9	24.1
Otolaryngology	363	3.6	13.9
Endocrinology	362	6.3	25.0
Renal Medicine / Nephro..	347	6.1	25.1
Rheumatology	276	7.8	25.7
Dermatology	256	6.8	27.4
Gastroenterology	249	4.7	19.5
Breast Surgery	245	3.8	16.4

(2) SKH SOC Specialties with Longest Follow-up Duration

Specialty	No. of Patients	Avg No. of Dr Visits	Avg. Duration F/Up (mths)
ORAL & MAXILLOFACIAL ..	1	8.0	43.7
Lung	8	8.1	36.9
Infectious Disease	6	9.8	32.0
Diabetes	138	8.6	31.2
Haematology	109	7.4	29.0
General Medicine	116	6.0	27.8
Dermatology	256	6.8	27.4
Geriatric Medicine	138	6.2	25.9
Rheumatology	276	7.8	25.7
Renal Medicine / Nephro..	347	6.1	25.1
Endocrinology	362	6.3	25.0

(3) Majority of Patients are only on follow-up with 1-2 SKH SOC Specialties

No. of F/Up Specialties for Active Patients w/o History of DS/ ED / IP Case

Age Group	1	2	3	4	5	6	7	8
40 to 59 yrs..	17,946	5,369	1,634	554	166	72	26	8
20 to 39 yrs..	13,198	2,788	660	168	60	9	5	3
60 to 69 yrs..	10,045	3,460	1,265	416	168	63	22	4
70 to 79 yrs..	6,936	2,992	1,156	504	213	72	34	6
Above 80 yr..	3,367	1,683	735	291	117	41	19	6
Below 20 yr..	1,940	152	19	8	1			
Grand Total	53,432	16,444	5,469	1,941	725	257	106	27

Improving the Right-Siting Experience

- Co-developed with GPs and Specialists, with multiple discussions and consultations to understand what worked/ what didn't.
- This is not a new initiative; many other PHIs have been doing it for a long time and consultations with PHIs were also held to understand the challenges and difficulties in right-siting.

Specialist Referral Workflows & Templates

- Clear referral workflows and escalation pathways for GPs to know what to manage, how to manage.
- Specialist-led improvement change to create simple discharge templates to facilitate referrals.

Facilitated Subsidised Drugs – Access to Subsidised Medications

Working with Pharmacy to allow workflow tweaks and variations for delivery of subsidized medications to patients' home for patients requiring chronic medications post-discharge.

Closed Loop Coordination

Care Coordinator as a single point of contact for GPs, patients & specialists for post-discharge coordination matters.

Managing Patient's Experience

Post-discharge financial counselling, appointment scheduling and expectations of GP visit.

About the LINK Programme (Outpatient2Community – O2C)

LINK (Outpatient2Community) aims to right-site care of mild and stable cases chronic patients from SOCs to the partner GPs by connecting patients to the GPs.

- Co-developed and designed with GPs and Specialists, LINK launched in November 2019 and have since right-sited care from >10 SKH SOC Specialties for >20 conditions to **38 GP Partners** onboard

Features of the LINK Programme (O2C)

LINK Protocols

GPs are guided by protocols and workflows

Moderating Costs

Patient co-payment for 1st two GP visits

Drug Support

Patient receives SKH subsidised medication delivered to home

Relationship Building & Training

- ✓ GP and SKH Specialist to develop close-knit relationship through open communication via clinical correspondence
- ✓ Regular CMEs to upskill the GPs

Seamless Coordination

- ✓ SKH GP Helpline 24/7
- ✓ Care Coordinator as a single point of contact for patient, GP partner & Specialist
- ✓ Fast track options available

LINK (O2C) is an effective collaboration with SOC & Primary Care, demonstrating value and promoting care retention at GP.

LINK Patients are Comfortable

>92%

OF LINK PATIENTS

STICK WITH LINK GP EVEN AFTER 1 YEAR

LINK Patients see $ Savings

EACH LINK PATIENT SAVES

{ $ 338* }

ON AVERAGE IN A YEAR

Care is Closer to Home

TOTAL **130KM**

TRAVEL DISTANCE SAVED FOR LINK PATIENTS (~2KM PER PATIENT)

LINK Patients see Time Savings

EACH LINK PATIENT SAVES

1 Hr

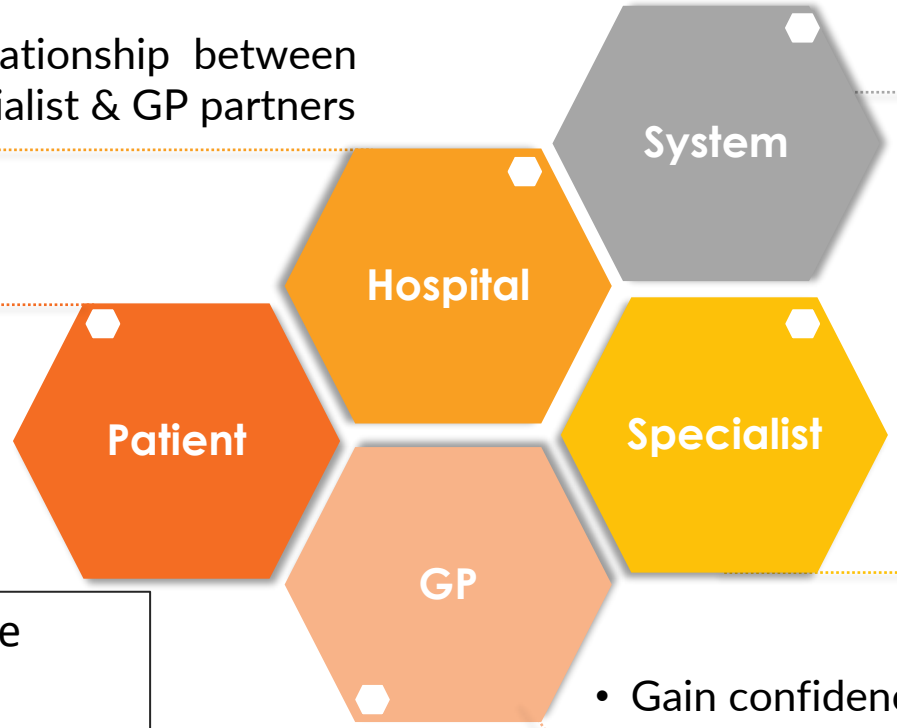
ON AVERAGE EACH SESSION

* $ savings may be due to the reduced investigations and ancillary services done in Primary Care.

There is **demonstrated value** in shifting stable chronic patients from SOC to primary care at multiple levels

- Decongest SOC and channel resources to support complex patients in a more timely manner
- Build platforms to enhance relationship between specialist & GP partners

- Build pipeline, capability and resources to enable transition of care for patients who can be right-sited



- Build relationship with primary care partners
- Assurance that patients are well managed at primary care by building robust clinical protocols and workflow to facilitate timely flow back of patients where required

- Care provided closer to home
- Faster access to care

An MOH conducted PHIs-wide evaluation findings:

- **1.7 less** SOC visits
- **0.88 more** Polyclinic/CHAS GP chronic visits.

- Gain confidence & empowered to manage stable SOC patients
- Establish GP as primary medical resource/touchpoint for patients

Learning from this journey together

Lessons we learnt	• Communication and engagement is key • Power of co-design • Discrepancies in patient experience despite managing patient's expectations • Differing clinic operations (e.g., appt booking systems) across GP clinics which may cause difficulties to operationalize and streamline certain processes • GP partners require more training to receive more complex cases
Challenges	• Leveled financial gradient to anchor patients in Primary Care • Lack of centralised IT platform to facilitate transition of care across care settings • Patient are still sticky to SOC (requires mindset shift)

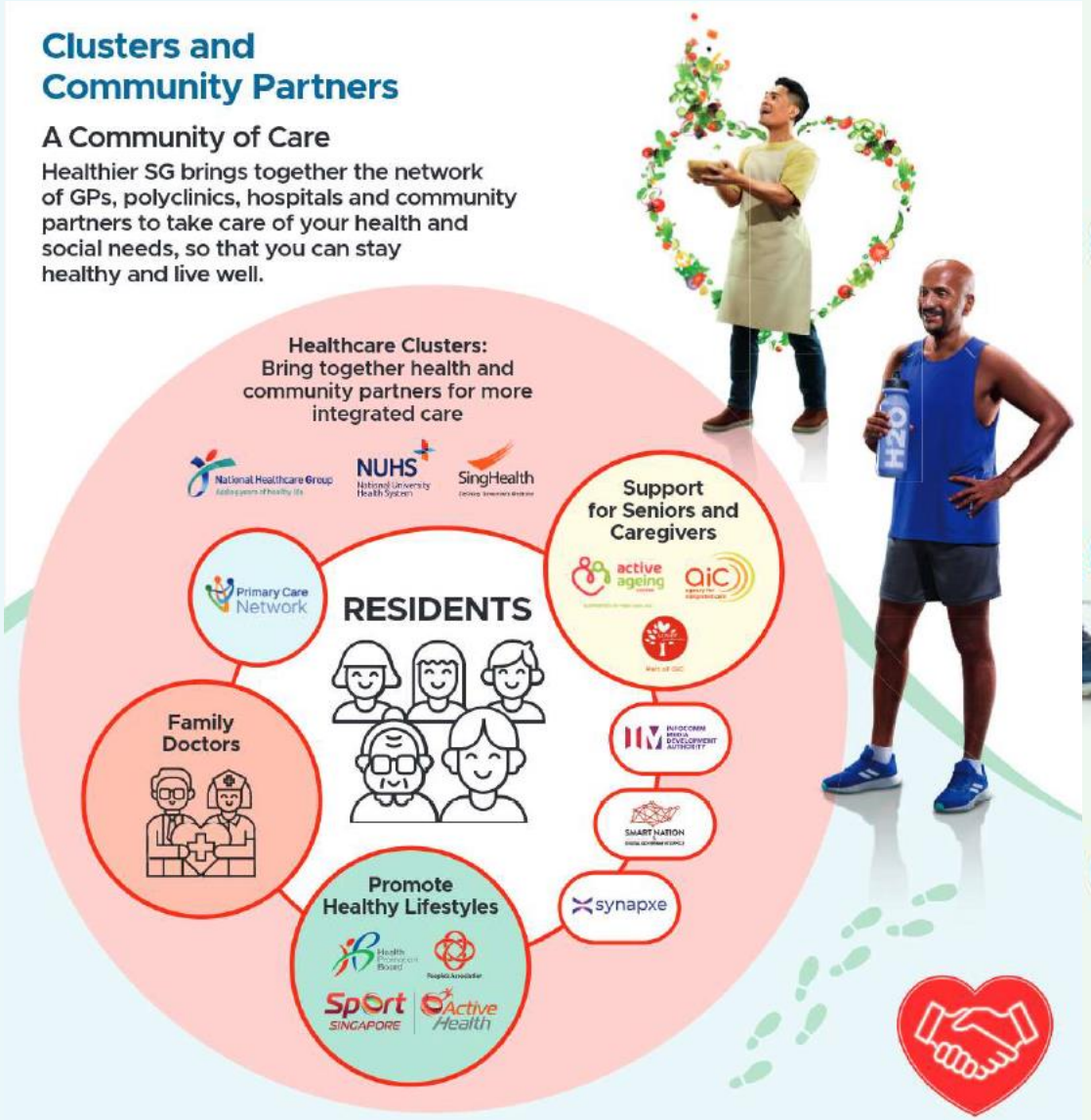
What's next?

Step into a Healthier You

Clusters and Community Partners

A Community of Care

Healthier SG brings together the network of GPs, polyclinics, hospitals and community partners to take care of your health and social needs, so that you can stay healthy and live well.



Three easy steps to start your Healthier SG Journey!

Step 1 Register

- Enrol when you receive MOH's SMS invitation
- Download HealthHub app
- Choose your preferred Healthier SG clinic

Step 2 See your doctor

- Schedule your first Health Plan consultation, which will be fully subsidised
- Create your Health Plan with your family doctor

Step 3 Participate

- Follow your personalised Health Plan
- Participate in activities on the Healthy 365 app
- Check-in with your family doctor at least once a year

Source: MOH HSG Brochures & Collaterals

Aligning to the overall objectives of Healthier SG, the LINK Programme (O2C) will streamline to support the national agenda of Healthier SG

Healthier SG will help address systemic challenges faced to facilitate Right-Siting and Anchoring Care of patients into Primary Care & Community

- ✓ **National Primary Care Enrolment:** Raising awareness for residents to have a Family Physician manage care in the Community.
- ✓ **Centralising IT requirements:** Healthier SG GP clinics are expected to contribute to NEHR and join a Healthier SG compatible GP Clinic Management System.
- ✓ **Subsidised Drug Scheme (2024):** Access to subsidized chronic drugs at HSG GP clinics.
- ✓ **Care Protocols:** 12 Healthier SG Care Protocols has launched to guide GPs in management of chronic conditions. MOH to progressively launch new care protocols in the next few years.

Thank You!