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Poster Abstract

Supporting General Practitioners in Long Term Chronic Disease Care

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Abstract

Singapore's population is aging rapidly and the burden of chronic disease is growing in tandem. There is increasing realization that there should be greater focus on empowering primary care to deliver quality and cost-effective chronic disease management. General practitioners (GPs) in the private sector, which form the bulk of primary care here, tend to manage far fewer patients with chronic conditions when compared with the public sector's polyclinics. This is partly due to limited availability of supporting nursing and allied health services in the community. The fee-for-service structure as well as the pricing gradient between the public and private sectors also makes it financially non-viable for GPs to provide such services to their patients.

As a result, most patients with diabetes and other chronic conditions are managed in the increasingly over-burdened polyclinics. For instance, over 60% of diabetic patients are currently treated in the polyclinics which are 20% of primary care by service attendance (and about 18% by strength in terms of medical manpower).

The difficulty in accessing screening and monitoring services leading to inadequate follow-up raises the risk of complications down the road for patients with chronic conditions.

As part of a larger collaborative effort to construct a regional health system, the GP community has been engaged to voice their need for support services to complement their medical services. Based on the GPs' feedback, a Community Health Center (CHC) has been set up to perform digital diabetic retinal photography, diabetic foot screening as well as nurse counseling and education service for the GPs' patients, with a strong focus on chronic disease management. Later on, following further inputs from the collaborating GPs, dietetics and physiotherapy services have been added to the range of services provided through the CHC.

GPs refer their patients to receive assessments and tests at the CHC and the reports are sent back to the GPs for their follow-up and management. Supported by dedicated funding, the pilot CHC charged affordable fees for the services, which were comparable with the rates for similar services offered in the polyclinics. The fee structure has since been taken over by a tiered pricing mechanism aligned with a national health financing framework, which keeps the services affordable for needy patients.

Our report will describe the successes and challenges of this model, and report on the workload, pick-up rates for complications, patients' and GPs' feedback. Based on the initial reports, between 1 in 6 and 1 in 10 diabetic patients screened at the CHC were found to have signs of complications requiring referral to specialist care for further work-up or treatment. As the CHC plays a primarily supportive role, patients with abnormal reports are always sent back to their GPs for the clinical decision on treatment or referral, and GPs are happy with such a care partnership where they continue to have oversight of their patients' care.

A larger pilot study is being funded with several more CHCs set-up across the nation. Newer services such as physiotherapy for conditioning and balance training have been offered. We are also studying the feasibility of offering mental health support, COPD assessments, life-style education classes at the CHC. The key concept of this CHC model is the foundation of engaging the GPs to determine the support required to complement their clinical care, so that GPs are able to manage their patients holistically in the community.

Keywords

primary care; chronic disease management; screening for complications; GPs; financing

PowerPoint presentation

<http://integratedcarefoundation.org/resource/icic15-presentations>