NATIONAL UNIVERSITY HOSPITAL

Cancer Survivorship Follow-up Care in the Community

Category: Cost Reduction

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BACKGROUND

Cancer incidence is projected to increase in Singapore by more than 50%[1]. With new treatment modalities and improved cancer screening efforts, survival rates for common cancers such as breast and colorectal have risen. As the risk of recurrence is low after five years, a cancer survivor in remission does not need to be managed by a specialist. Instead, routine healthcare and screening for other chronic conditions can be provided by primary care providers (PCPs). Under the current local practice, cancer survivors remain in a tertiary care setting. Recognising the need to right-site patients to reduce stress on hospital services, the National University Cancer Institute, Singapore (NCIS) formed the first formal partnership with PCPs to provide cancer follow-up care in the community.

EXECUTION BY TEAM

1 Define the Programme

The clinicians and administrators came together to determine (i) **Patient Criteria**, (ii) **Model of Care** and (iii) **Enablers**

2 Partner Engagement

PCPs under the National University Health Systems (NUHS) such as the National University Polyclinics (NUP), family medicine clinics and general practitioners in the primary care network were engaged. An overview of the differences in resource capabilities were addressed.

3 Defining Workflow

Referral workflows to transit patients from hospital to PCP and fast track back to hospital for suspicion of recurrence were worked out.

4 Enabling the Programme

(i) A survivorship care plan summarising patients' treatment and follow-up care was developed to bridge the knowledge gap between specialists and PCPs

(ii) Teaching seminars to educate PCPs

5 Communication

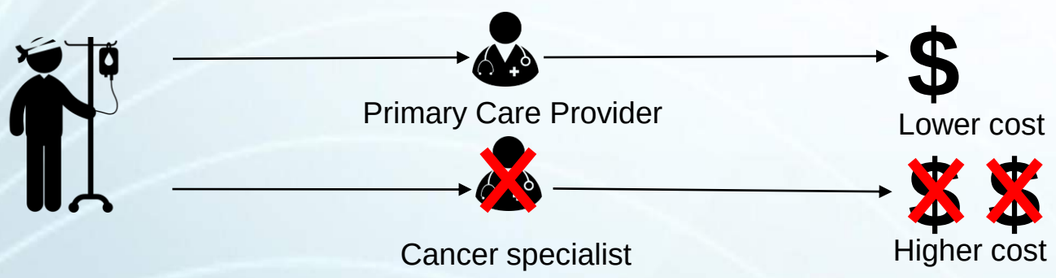
Information was disseminated via multiple platforms before the launch. Communication is kept open between PCPs and the hospital for patient management.

6 Evaluation and Improvement

Monthly audits and a quality improvement project are been done to improve discharges in the clinics.

RESULTS

Patients Save Money Visiting a Non-Specialist



A patient on regular follow-up with a PCP for other chronic diseases can combine cancer follow-up care with the existing consults. This will result in **100% savings** on one specialist consult.

Patients Save Time Visiting a Non-Specialist

Travelling time for the patients is saved by choosing follow-up near home.

Reduction of Waste to Manage Stable Patient by Specialists in a Hospital

Right-siting of two patients on repeat visits enables the availability of a first visit slot for new cancer cases. These are wasted capacity for our specialists if the survivors had continued appointments in the hospital.

Conclusion

We have demonstrated that a cancer survivorship shared-care model between a cancer centre in tertiary care and primary care is feasible. This is an example of right-siting patients to optimise delivery of care and costs.

[1] *MOH Cancer Data Package for National Advisory Committee on Cancer – 2019*