Building Care Teams for Every Resident in the Community - A Co-Learning Exchange

Co-authored by Deborah Chin Jiamin; Reviewed by Tan Yan Lin, Dr Wei Ting Chen, Chio Shu Yu; Edited by Shermaine Ong; Content Layout by Germaine Tan. 12 August 2025.

Photo of CHI 21st Masterclass. From left to right: Dr Doug Eby and Mr Gerard Asselin from Southcentral Federation, Dr Jonty Heaversedge from CHI, Dr Ziliang Lim from Yishun Polyclinic, and Dr Wei Ting Chen from NHG Population Health.

The Centre for Healthcare Innovation (CHI)'s 21st Masterclass (co-organised with POP Class), "Building Care Teams for Every Resident in the Community – A Co-Learning Exchange" brought together leaders from two leading systems in population health that are transforming care in the community. Dr Doug Eby, Executive Vice President of Specialty Services, Southcentral Foundation, Mr Gerard Asselin, M.S., Director of Operations, Southcentral Foundation, Dr Ziliang Lim, Head, NHG Yishun Polyclinic, and Dr Wei Ting Chen, Clinical Director, Community Health, NHG Population Health, explored how two distinct healthcare systems, operating in vastly different geographical and cultural contexts, were working to achieve similar goals of **accessible, relationship-based and place-based care.**

The case for Southcentral Foundation (SCF) in Alaska, United States – The power of customer-ownership and having them at the core

Over three decades, SCF has transformed their care model, maintaining an unwavering dedication to relationship-centricity and customer-ownership. SCF has fundamentally reimagined healthcare delivery by placing customer-owners **(reframed from what we recognise as 'patients')** at the centre of everything they do, achieving remarkable outcomes while maintaining high levels of satisfaction among both customer-owners and staff.

> *"We went from being the usual medical model to being completely driven by the people for whom we exist," - Dr Doug Eby*

Drawing from their experience, Dr Eby and Mr Asselin presented their perspectives on the successes of SCF's Nuka System of Care that has earned them the prestigious Malcolm Baldrige Quality Award in 2011 and 2017, which offers profound lessons for healthcare systems worldwide.

1. Strong foundation and alignment across the organisation through "RELATIONSHIPS"

SCF's commitment to relationship-based, customer-owned care is reflected in its enduring vision of "A Native Community that enjoys physical, mental, emotional and spiritual wellness", supported by its mission to "Work Together with the Native Community to achieve wellness through health and related services".

Rather than relying on rigid rules and regulations, SCF brings these values to life through thirteen operational principles,

forming the acronym "RELATIONSHIPS". These principles ensure that meaningful connections remain at the heart of SCF's care delivery, where SCF places focus on customer-owners and their needs, and how SCF can support them.

Together with the operational principles, SCF's Core Concepts serves as the organisation-wide relational culture cornerstone that guides all staff, regardless of position, in connecting, creating and sustaining healthy, trusted relationships with both customer-owners and colleagues.

> *"From day 1, we set the stage about what it is to work at Southcentral Foundation and the purpose around the mission and vision and then how to work together as a team." – Mr Gerard Asselin*

DID YOU KNOW?

CSF's customer-owner and family-centred approach is exemplified in their paediatric care model. Rather than maintaining separate paediatric clinics, SCF strategically integrated paediatricians into every primary care clinic to better support customer-owners.

> *"Healthy child development depends not on isolated clinical encounters, but on the entire family ecosystem – the parents, grandparents, extended family members, and the broader environment within which the child is growing." - Dr Doug Eby*

This "healthy nest" approach recognises that supporting children within their family context strengthens continuity of care and enables more comprehensive support for the whole family unit.

2. Customer-owners and their family at the core of everything

SCF's philosophy centres on recognising customers as active owners of their health journey rather than passive recipients. This approach enables SCF to build supportive, empowering systems that adapt to customer-owners instead of judging or controlling them.

Their commitment extends beyond clinical care to practical considerations such as ensuring the most convenient parking spaces were reserved for customer-owners rather than staff to help customer-owners get to their appointments smoothly.

> *We (healthcare), at our core, are a service industry; and (our) value is evaluated by people on the receiving side. They decide whether to pick up the medications or to follow instructions... these are under their control." – Dr Doug Eby*

Implementing such model required significant cultural change. Over 10 years, SCF educated their population about customer-ownership, helping individuals transition from passive care recipients to active participants who ask questions and expect excellence from their healthcare providers. The transformation proved generational – with those under 40 embraced the model quickly, while older customers took longer to adapt.

3. Integrated care and ensuring access to care

SCF's dedication to accessibility is perhaps their next most distinctive feature. For 25 years, they have mandated same-day access through channels convenient to customer-owners – phone, text, email, or in-person – five days a week.

> *"People have concerns now. We need to connect to them now... If we are going to be their trusted companion, we need to be immediately available." – Dr Doug Eby*

The care team structure centres around an integrated team of a primary care provider, case manager, and medical assistant, with each team serving approximately 800-1,100 customer-owners. While each team sees only 10-12 customer-owners in person daily, they connect with 30-60 customer-owners through virtual channels, maintaining continuous, longitudinal relationships and providing comprehensive support.

Their integrated care model also co-locates specialists directly within primary care settings based on two criteria: high volume needs (such as paediatrics, pregnancy care, and behavioural health) and high frustration areas for primary care providers (including pain management, addiction, and trauma). This co-location strategy has reduced specialist referrals by over 60% and emergency room well as hospital admissions by over 40%, while improving clinical outcomes, satisfaction ratings and reducing costs.

Photo of SCF's Integrated Care Team

SCF's 30-year journey demonstrates that transforming healthcare systems requires more than operational changes – it demands a fundamental shift in philosophy, sustained organisational commitment, and the courage to prioritise customer needs and ownership. Their model offers valuable lessons for healthcare systems worldwide seeking to build truly patient-centred, relationship-based care that delivers both better outcomes and greater satisfaction for all involved.

The case for NHG Health in Singapore - Building Care Teams for Every Resident in the Community

Over more than a decade, NHG Health has restructured its approach to primary care, moving away from a volume-based model to one that prioritises continuity, relationships, and meeting residents where they are in the community.

Highlighting NHG Health's Primary Care Teamlets and Community Health Teams (CHT), Dr Lim and Dr Chen advocated that effective healthcare cannot be imposed from above but must be developed in partnership with residents, respecting their choices, family dynamics, and cultural contexts.

The integration between clinic-based teamlets and community-based CHTs creates a comprehensive care ecosystem, where teamlets provide relationship-based primary care in clinical settings, while CHT extends care into the community, ensuring that support reaches residents wherever they are. This dual approach addresses both the need for accessible primary care and the reality that many health determinants exist outside traditional healthcare settings.

1. NHG Health's Primary Care Teamlet - Team-based Care Model as Foundation for Relationship-based Primary Care

NHG Health's evolution began with recognising the limitations of their highly efficient but transactional care model. Dr Lim explained how they previously operated like "an assembly line" with clusters of doctors, nurses, and pharmacists seeing up to 100 patients per day. While efficient, this approach left something to be desired – patients were not getting better, and the cookie-cutter approach faced challenges in addressing the diverse needs of different populations.

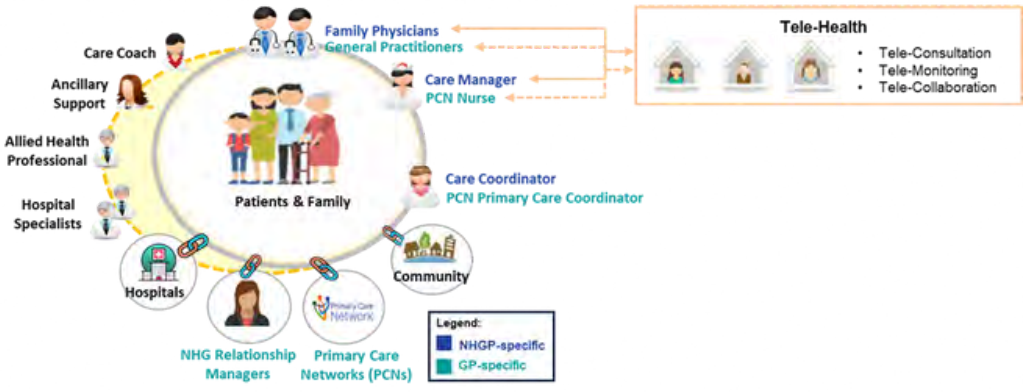


Photo of NHG Population Health's Teamlet model

The solution was the teamlet model, which fundamentally transformed care delivery around relationships rather than volume. Each teamlet consists of two family physicians, one care manager and one care coordinator working in co-located spaces to build meaningful relationships with their patients. This organisation allows teams to serve panels of approximately 5,000 patients, seeing 35-40 patients per day – significantly fewer than before but allowing more time to understand each patient and maintain continuity of care.

Dr Lim emphasised the importance of this relationship-based approach, noting that teamlets now have the opportunity to "continue the conversation and their story" with patients over time. This model has been successfully adapted beyond polyclinics to General Practitioner partners through Central-North Primary Care Network (PCN), demonstrating its scalability and effectiveness across different primary care settings. The impact of this transformation is evident in improved clinical and process outcomes, such as better management of diabetes, high cholesterol and high blood pressure. With 45 teamlets across 9 NHG Polyclinics now caring for more than 200,000 patients, NHG Health has created a foundation where healthcare professionals can build genuine relationships with residents while maintaining quality care standards.

2. NHG Population Health Community Health Team (CHT)

Complementing the clinic-based teamlet model, NHG Population Health's Community Health Team (CHT) represents a bold approach to place-based care. Dr Chen describes her team as "quite unique" – a mobile workforce of fewer than 130 healthcare professionals who are "always somewhere out there, anywhere and everywhere" in the community, rarely seen in traditional healthcare settings.

> *"We want to be accessible to our people, really be there when they need them. You can sometimes see us in the community health post... we can be in a patient's home whether it is a flat or rental housing, a day centre... sometimes at the void deck." – Dr Wei Ting Chen*

The CHT operates on the principle of accessibility, bringing care directly to where residents live, work, and gather. This approach makes healthcare "simple for our residents," particularly for the nearly 4,000 post-discharge patients they support annually across about 100 community health posts in Central and North Singapore.

Dr Chen emphasises that the CHT's value lies in "what truly matters to the residents." Rather than imposing predetermined, immediate solutions, the team journeys alongside residents, recognising that sustainable behavioural change often takes years to achieve.

The team's approach acknowledges that not everyone exercises regularly or follows prescribed lifestyle changes, and their role is to support residents in making gradual, achievable progress.

The CHT operates through an extensive network of collaborations with community partners, teamlets, and hospital counterparts. Coined as the "Underground Network", Dr Chen shared that this interconnected approach among CHT and various partners enables comprehensive wraparound services, from just-in-time occupational therapy for people with functional decline to coordinated care transitions. The team's extensive community network ensures that vulnerable residents receive timely support, as illustrated by their response to an elderly lady who fell after an eye appointment and went home alone with no contact information.

3. NHG Health's One Care Plan

Central to the NHG Population Health philosophy in enabling seamless care delivery is the development of **One Care Plan** where multiple stakeholders contribute, and residents actively participate in their own care decisions. This collaborative approach ensures that health and social interventions are coordinated and meaningful to those receiving them.

NHG Health's transformation demonstrates that relationship-based and place-based care can be successfully implemented at scale while maintaining efficiency and quality. By anchoring on teamlets and extending care into the community through the CHTs, NHG Population Health has created a model that prioritises what truly matters to residents while building the meaningful relationships essential for effective healthcare delivery. This approach offers valuable insights for healthcare systems seeking to balance efficiency with the human connections that drive better health outcomes.

Scan to find out more about our latest happenings!

Email: chi@nhghealth.com.sg

A Quick Glance: Lessons Learnt from Southcentral Foundation and NHG Population Health

Unique to CHI's 21st Masterclass and POP Class, the Southcentral Foundation and NHG Population Health were brought together in a joint design challenge to surface design principles, explore cultural and contextual differences to stimulate shared learning. Through their exchange, both organisations identified valuable practices they could adopt from each other, revealing common principles that transcend geographical and cultural boundaries while highlighting the potential for convergence in relationship-based and place-based care models.

Centre for Healthcare Innovation NHG Health | POP CLASS | Southcentral Foundation | SOUTHCENTRAL FOUNDATION NUKA SYSTEM OF CARE

1 Breaking Down Barriers: The Quest for Care Anytime, Anywhere

Both organisations recognised accessibility as fundamental to effective healthcare delivery, though approaches vary between the organisations based on their unique context. SCF's model of guaranteed same-day access through multiple channels – phone, text, email, or in-person – particularly impressed the NHG Health team.

Dr Wei Ting Chen (NHG Health) expressed her desire for accessibility especially for vulnerable populations, recognising the power of SCF's commitment to being available "all day, every day during work hours" to their customer-owners.

Mr Gerard Asselin (SCF) emphasised that accessibility must extend beyond clinical interactions to every aspect of the patient experience.

SCF's approach of connecting with majority of their customer-owners daily through virtual channels while maintaining a smaller number of in-person visits demonstrates how accessibility can be scaled without compromising relationship and care quality. Both models offer valuable lessons for healthcare systems seeking to expand access while maintaining meaningful connections with patients.

2 From Prescription to Partnership: Empowering People in the Driver's Seat, Without Backseat Driving

Both teams strongly emphasised moving away from prescriptive healthcare models towards collaborative approaches that centred on what truly matters to individuals.

Dr Chen highlighted this as a core principle she wanted to hold onto: "What matters to the individual is very important because when we have a lot of prescribing, we end up imposing our thoughts or our perceptions of issues on our residents and patients."

Dr Doug Eby (SCF) reinforced this philosophy, noting that customer-owners "own their own journey, they own their own health issues. We offer options. They choose the options."

This collaborative approach acknowledges the reality that patients make the ultimate decisions about their health behaviours, from medication adherence to lifestyle choices

The cultural sensitivity of this approach was particularly evident in Dr Chen's examples of family dynamics in Singapore, where patients might struggle to follow dietary recommendations during family meals. Both organisations recognised that effective healthcare must respect individual choices, family contexts, and cultural considerations rather than imposing standardised solutions.

3 The Human Connection: The Heart of Healthcare Transformation

The centrality of relationships emerged as a shared value across both systems.

Dr Ziliang Lim (NHG Health) emphasised wanting to build relationships with residents, focusing on individuals rather than diseases. This relationship-based approach requires healthcare providers to truly know their patients and families over time.

SCF's smaller panel sizes enable deeper relationships, while NHG Health's teamlet model restructures care delivery to balance efficiency, relationships and continuity even with larger, more heterogenous panels. Both approaches recognise that sustainable health improvements require trust and understanding that develop through ongoing relationships rather than episodic encounters.

Mr Asselin highlighted the importance of "being in relationship both as teams and in true relationship with customer-owners and being able to truly know them." This philosophy extends beyond clinical care to encompass understanding patients' values, goals, and life circumstances.

4 Digital Transformation Done Right: Inclusion Without Isolation

The discussion revealed nuanced approaches to digital transformation in healthcare.

Dr Eby emphasised a critical principle: "Customer-owners must still always have access to the physician" because "the fact that the physician is always available actually diminishes the demand for talking to the physician."

This counterintuitive insight suggests that guaranteed physician access enables patients to feel comfortable engaging with other team members, knowing they can reach their doctor when needed. SCF's experience demonstrates that when customer-owners trust they can access physicians immediately, they become more willing to engage with behaviourists, case managers, and other team members for appropriate concerns.

The NHG Health team acknowledged the challenges of digital inclusion in Singapore's diverse population. Dr Lim noted that while they welcomed innovation, careful selection of patient populations and gradual implementation of digital solutions were necessary since "we still have populations that are not digitally savvy". The key is ensuring that digital transformation enhances rather than replaces human connections and maintains equity across different demographic groups.

5 Rewiring Healthcare DNA: The Art of Cultural Transformation

Both organisations recognised that transforming healthcare delivery requires fundamental cultural changes among both staff and patients.

Dr Chen acknowledged the significant "mindset shift needed for residents and staff" to move from prescriptive, face-to-face models to team-based, person-centred approaches that emphasise empowerment and choice.

SCF's experience demonstrates the time and intentionality required for such transformation.

Dr Eby shared that they spent "10 years of very intentional education and retraining of the entire population" about their new model, with generational differences in adoption rates. Staff also required training to use different language and approaches, moving away from terms like "non-compliant" towards more collaborative and respectful communication.

Mr Asselin emphasised the importance of "creating culture and setting the expectation of that culture from day one," ensuring that organisational values are embedded in every aspect of operations. This includes being responsive to both community needs and employee needs, recognising that staff satisfaction and patient satisfaction are interconnected.

The cultural shift extends to redefining professional roles and expectations. As Dr Eby noted, when done right, providers will be happy to focus entirely on being available to their assigned populations, prioritising customer-owner needs over professional preferences.

Convergence: The Future Towards Relationship-Based and Place-Based Care

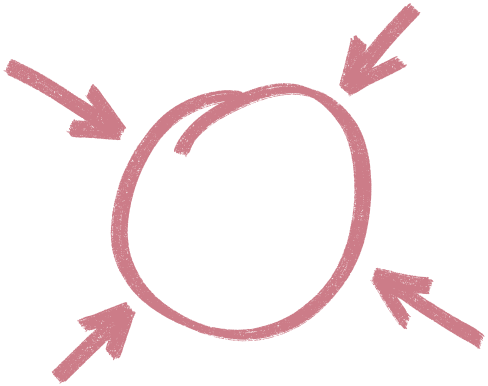
The discussion revealed growing recognition that relationship-based and place-based care models may converge over the coming decade, as healthcare systems need both strong primary care relationships and community-based care systems.

This convergence may involve several key elements with careful coordination and resourcing:

1. Co-locating specialists into primary care settings to address high-volume and high-frustration areas;
2. Closer collaboration between community health teams and clinic-based teams for seamless care transitions; and
3. Technology platforms that enable coordination across care settings while maintaining relationship continuity.

The challenge, as Dr Eby noted, lies in minimising confusion while maximising accessibility, quality of care and relationships. Future models must clearly define roles and pathways whist ensuring that residents, customer-owners and patients understand how to access the right care at the right time through the right channel.

Despite different geographical, cultural, and operational contexts between SCF and NHG Health, successful healthcare transformation relies on common principles: prioritising accessibility, respecting what matters to individuals, building meaningful relationships, implementing inclusive digital solutions, and fostering supportive cultures for both staff and patients. As healthcare systems worldwide grapple with similar challenges - aging populations, chronic disease management, and resource constraints - the convergence of relationship-based and place-based care models offers a promising pathway towards more effective, equitable, and sustainable healthcare delivery.



Scan to find out more about our latest happenings!

Email: chi@nhghealth.com.sg