

GP BUZZ

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JULY-DECEMBER 2019



**GETTING TO THE
HEART OF HEALTHCARE**

**FLOWING ALONG THE RIVER OF
LIFE IN CENTRAL HEALTH**



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JULY - DECEMBER 2019

About the Cover Page:

CENTRAL HEALTH

SERVING PATIENTS COMING INTO HOSPITAL
AND WORKING WITH PARTNERS TO CARE
FOR RESIDENTS LIVING IN THE CENTRAL
POPULATION ZONE

Do you remember a time when there were no subspecialties, fewer social care organisations, and fewer professionals in any of the helping occupations? When a person fell ill or needed any kind of help, their family, friends and neighbours rallied around them. People received the help they needed through personal connections. Of course, in those days, many people fell through the cracks because the necessary help could not always be found.

That sense of connectedness seems to have gradually been eroded. As services have become more subspecialised and professional, boundaries have become more distinct.

Central Health aims to marry the best of both worlds. The new reality we hope to create is to understand issues from the patients' and the caregivers' points of view. It is also about building collaboration with general practitioners, specialists, voluntary welfare organisations, and with the people living in the neighbourhood. The aim is to build a joint vision for better connected care for the people in the neighbourhood.

The journey will be challenging, as it will be about learning new ways of thinking and new ways of working together. In this issue of GPBUZZ, we share a range of exciting trainings, partnership opportunities for our primary care physicians to care for the population in their neighbourhoods.

We welcome you to walk along with us in this journey. **GPBUZZ**



Building collaborations with our GP partners: Our primary care clinical lead, Adj A/Prof David Foo, engaging in a focus group discussion with GP partners during a CME event



Better care in the neighbourhood: Community Nurse Katherine Lai from our Community Health Team conducting a home visit for a resident

Building Health Together With You



It was a night of celebration as Tan Tock Seng Hospital (TTSH) came together for its 175th Founder's Day Dinner on 27 July 2019 at Marina Bay Sands Convention Centre. The event was graced by President Halimah Yacob, who commended TTSH's efforts to bring care closer to the 1.4 million residents in Singapore's central region, through initiatives intended to help seniors stay out of hospital and be treated closer to home. "This is especially pertinent for Singapore as we face an ageing population. It is important for the health teams to be anchored in the community to help Singaporeans manage their chronic conditions well and keep them safe at their homes," said President Halimah.

The dinner also saw the Community Right-Siting Programme (CRiSP) achieving this year's Tan Tock Seng Milestone Award, an award presented to well-sustained projects with continued high impactful outcomes after five years of implementation. **GPBUZZ**

"We would like to thank all our GP and primary care partners for your continued support since the programme was launched in 2014. We look forward to building closer partnerships with you."

Counting Down to SINGAPORE

PATIENT Conference®

2019

25 October 2019 | 10am to 4pm
Centre for Healthcare Innovation (Opposite Tan Tock Seng Hospital)

A Community of Carers starts with you! Regardless of whether you are a patient, caregiver, volunteer, health or social care professional, we are all carers in our own way and can be part of building a happier and healthier community.

Into its 7th year, the Singapore Patient Conference (SPC) is a dedicated patient conference with a difference - one where carers come together to share their care journeys and to spark new ideas in co-creating a better health and social care system for all.

Themed 'Building a Community of Carers', SPC 2019 explores the complex needs of carers and patients today and the support available in the community. The conference is also complemented by the 5th edition of the Singapore Patient Action Awards, which honours unsung heroes in health and social care. **GPBUZZ**

Register for SPC 2019 today and be part of the journey in Building a Community of Carers!



Scan the QR code or visit <http://bit.ly/sgpc2019> for more information.

CME (SEPTEMBER – DECEMBER 2019)

TITLE	CME POINTS	DATE	TIME	VENUE	REGISTRATION DETAILS
Liver, Gall Bladder & Pancreas Disorders: Patient-Centric Good Clinical Practices	2 CME points	19 Oct 2019	1.00pm to 4.00pm	Tan Tock Seng Hospital, Theatrette, Level 1	Ms Daphne Loh 6357 7782 daphne_ly_loh@ttsh.com.sg
Medicine in the Older Adults Masterclass 2019	4 CME points	9 Nov 2019	12.30pm to 5.30pm	Ng Teng Fong Centre for Healthcare Innovation (CHI)	iga@ttsh.com.sg
Orthopaedic CME	2 CME points*	30 Nov 2019	1.00pm to 5.00pm	Tan Tock Seng Hospital	gp@ttsh.com.sg

*Pending SMC approval

A confirmation email will be sent after your registration. Kindly email the contact person if you do not receive any confirmation after your registration. Thank you.

AT THE HEART OF HEALTHCARE FOR 175 YEARS

Perhaps it's fitting that Tan Tock Seng Hospital celebrates its 175th Anniversary in the same year Singapore celebrates its Bicentennial. The man the hospital is named after and who inspired a culture of care, Mr Tan Tock Seng, arrived in the country in 1819, around the same time that Sir Stamford Raffles himself did.

Our Founder's History - Mr Tan Tock Seng

An avid businessman, Mr Tan first started his business through a small roadside stall selling fruits, vegetables and fowl that he bought from the rural areas. His hard work and thrift paid dividends, and as his fortune grew, so did his influence. Known for his skill at settling disputes among the Chinese, nipping problems in the bud before they became expensive legal tussles, he was the first Asian to be named a Justice of the Peace.

Not forgetting his humble roots, he responded to the call to take care of the disadvantaged in the community. He contributed to charitable causes and his compassion and generosity rallied many other community leaders to donate towards the building of the first hospital for the poor - the Chinese Pauper Hospital on Pearl's Hill - a hospital that would care for the "sick poor of all nations". It was, of course, later renamed in recognition of its founder, and eventually moved to its current location.

Transforming Care in Central Health

Part of the National Healthcare Group today, Tan Tock Seng Hospital has expanded its mission of being a "Hospital Without Walls", transforming healthcare for the future beyond patients to population, by not just serving patients coming to the hospital, but also caring for the 1.4 million residents living in the Central Singapore. Just as its founder

solved brewing issues before they became problems, Tan Tock Seng Hospital today addresses emerging health issues such as our rapidly ageing population through fostering holistic health and expanding the scope of care into the community. It is bringing care closer to residents with Community Health Teams, bringing community partners together and empowering caregivers and volunteers through developing their capabilities, building a care ecosystem around the residents and helping our seniors to age in place.

Throughout most of modern Singapore's history, Tan Tock Seng Hospital has cared for the health of Singaporeans from all walks of life. Today, it continues the mission its founder set all those years ago. Started and supported by the community, always ready to care for the community, the way Mr Tan Tock Seng himself would want. [GPBUZZ](#)



“Yet ever since I begun running my business, in my private heart I have always desired to be able to do something for abandoned and suffering people”

Mr Tan Tock Seng, 1845



GETTING TO THE HEART OF HEALTHCARE IN CENTRAL SINGAPORE

Healthcare is not a static endeavour. The needs of our population change with time, and healthcare providers need to adapt to the changing situation and requirements. Our ageing population and the rise of chronic diseases are just two of our current concerns. Emerging infectious diseases and sustainability of our healthcare efforts are also principal considerations.

At Tan Tock Seng Hospital, we embrace our mission to care for the health of the 1.4 million residents of Central Singapore. After all, we have had our roots in the community since the hospital was founded 175 years ago. Our new, holistic model of health care will see us increasingly become a “Hospital Without Walls”, reaching out to create a **Network of Health & Social Care Providers** that operate within communities, and putting the patient at the centre of our efforts in implementing an **Integrated Care Model**.

The current model of healthcare has served us well, but it is not without deficiencies. It created an unintended consequence of a fragmented approach, dealing with diseases only when they occur, at medical facilities. Going beyond this in Integrated Care means embracing a more holistic form of care, preventing diseases, managing conditions, bringing care closer to home, and educating the population on better self-care. To do that, we will need to provide a joined-up network of care providers, needs-based intervention, neighbourhood-based care closer to our residents, and a Community of Carers to build relationships, supported by multi-disciplined Community Health Teams.

With Integrated Care, we will collaborate with over 70 community partners:

- Primary care in the form of polyclinics and General Practitioners
- Transitional care in home services
- Intermediate care with Community Hospitals
- Long-term care in nursing homes
- End-of-life care through palliative care in nursing home and home care

With this integrated model of care, we will enter into a continuum of care that better supports our population health aims – Better People, Better Care and Better Community, to deliver Better Health and Better Value to the residents in the central region. [GPBUZZ](#)

**TOP 3
CHRONIC
DISEASES**

**DYSLIPIDAEMIA
HYPERTENSION
DIABETES MELLITUS**

**RISING MENTAL
HEALTH
CONDITIONS**

ANG MO KIO



17% 25% 38% 20%

165,770
Residents

72% Well
14% Mildly Frail
7% Moderately Frail
7% Frail



SERANGOON



17% 27% 38% 17%

117,280
Residents

82% Well
7% Mildly Frail
2% Moderately Frail
9% Frail



HOUGANG



18% 28% 39% 15%

223,080
Residents

69% Well
14% Mildly Frail
11% Moderately Frail
6% Frail



BISHAN



18% 27% 39% 16%

88,530
Residents

73% Well
21% Mildly Frail
3% Moderately Frail
3% Frail



THE 7 SUBZONES OF CENTRAL HEALTH

TOA PAYOH



17% 25% 38% 20%

120,610
Residents

63% Well
22% Mildly Frail
9% Moderately Frail
6% Frail



GEYLANG



17% 27% 38% 18%

111,550
Residents

64% Well
16% Mildly Frail
8% Moderately Frail
12% Frail



NOVENA • KALLANG • ROCHOR



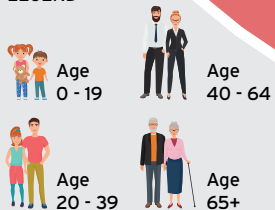
18% 25% 38% 19%

163,980
Residents

58% Well
25% Mildly Frail
9% Moderately Frail
8% Frail



LEGEND



FLOWING ALONG THE RIVER OF LIFE IN CENTRAL HEALTH

Recognising the need to transform care beyond simply treating illnesses to fostering the holistic health of the population, “River of Life” (ROL) is a population health framework that supports residents in living well at every stage of their lives, from beginning to end. The ROL framework, which includes physical, mental and social dimensions, addresses care needs in 5 segments:

- Living Well
- Living with Illness
- Crisis and Complex Care
- Living with Frailty
- Leaving Well

In this feature, we will share some of the key community health programmes initiated by Central Health, how these tie in with the ROL framework, and how primary care partners have contributed, or can further contribute, towards caring for our population.

GPBUZZ

“Life is like a River – always moving, always flowing. We have to move with it, live with it, come what may.”

LIVING WITH ILLNESS, WITH PRIMARY CARE

With our rapidly ageing population and sedentary lifestyles, and the consequent rise in incidences of chronic diseases, primary care is expected to take on an even bigger role in the community.

TTSH’s Primary Care Partners Office (PCPO), with the support of primary care partners such as General Practitioners (GPs), Primary Care Networks, Family Medicine Clinics and Polyclinics, developed a suite of partnership initiatives to foster better collaboration for seamless, affordable and accessible care.

These initiatives facilitate proactive management of chronic conditions, providing care for residents closer to home and allowing suitable patients to be co-managed by GPs.

Community Right-Siting Programme (CRiSP)

CRiSP allows patients with stabilised chronic conditions to be managed closer to home, by Family Physicians or GPs in the community. GP partners are empowered to provide quality care, through clinical up-skilling and access to affordable clinical support services. Today, CRiSP has benefitted over 3,700 patients, across 36 chronic conditions, at more than 150 GP partner clinics.

GPNext

Looking at emergency care beyond hospital walls and within the community, GPNext recognises the pivotal

role hospital partners can play in ensuring the continuum of care for patients’ post emergency care. Under this scheme, stable, ambulatory patients under 14 GPNext conditions can be referred to a partner GP for follow-up treatment. Patients will not need to wait months for a specialist appointment, but instead see a GP within a week!

Coordinating & Advisory Care Team (CoACT)

Recognising the need for effective communications to enable these community-based primary care initiatives, a team of specialists from 20 clinical specialties form CoACT. Together with administrators and Right-Siting Officers from PCPO, CoACT serves as a liaison with primary care partners for effective two-way communications between specialists and GPs, allowing better design of safe and effective health outcomes for patients. GPBUZZ

To find out more about our partnerships, or if you are interested to join us as a GP partner, email us at gp@ttsh.com.sg

» Our PCPO Team led by Adj A/Prof David Foo (Clinical Lead, Primary Care) with the close support of our Right-Siting Officers and Community Operations Team (Primary Care)



LIVING WELL, WITH PREVENTIVE CARE

Studies have shown that early life health choices can affect health in later life - poor health choices and adverse conditions can have deleterious impacts as we age, affecting us as individuals and as a society. Healthcare has long been evolving from just treating illnesses towards including preventive strategies, beyond healthcare to health, and this has yielded positive dividends. Living Well focuses not only on prevention, but encourages a 'culture of health ownership', engaging the population as active agents in their own health.

Health Coaches, a part of TTSH's Community Health Teams (CHT), encourages healthier, active living to residents, offering personalised guidance and motivating participants on how to make sustainable lifestyle changes through exercise and diet. Interaction among participants during these activities also encourages the building and strengthening of peer support groups, further contributing toward the goal of activating the community to not just look after themselves, but their peers and the community as well! **GPBUZZ**



Programmes and services offered by Health Coaches

Screening Events	Health Coaching & Monitoring @ Community Health Posts	Mass Activities @ Community Health Posts	Structured Programmes @ Community Partner Site(s)
Chronic Illness Screening	Coaching on diet and lifestyle changes	Be Active! Health Talk Mass Exercises	Steady (Falls & Balance)
Functional Screening		Cooking Workshops	Stronger Joint, Steadier You!
Falls Screening (with physiotherapists)	Monitoring of blood pressure, blood glucose level and weight management		Lean (Metabolic Syndrome)
Nutrition Screening (with dietitians)			Walking Foodpedia Make it "Siew Dai"



<< Mass exercise led by our Health Coach at a Community Health Post in Novena-Kallang-Rochor



Scan the QR code to find out more about CHT services and to locate a Community Health Post near you!

If you are a GP practising in the central region of Singapore and keen to refer a resident to our CHT services or health coaches programmes, email us at chp@ttsh.com.sg

INTERMEDIATE CARE
for Rehabilitation to Daily Living



PALLIATIVE CARE
For Wellness in End-of-Life and Long-Term Care

AGEING IN PLACE, WITH COMMUNITY CARE

To support our seniors in managing their chronic conditions well at home, it is important for health teams to be anchored in the community.

Within each subzone of Central Health, there is a designated Community Health Team (CHT), which plays a major role in coordinating care, building relationships and enabling health engagement with social care partners to support ageing-in-place. CHTs are inter-professional teams of doctors, community nurses, allied health professionals, pharmacists, health coaches and operations staff. They collaborate with partners within the vicinity to operate Community Health Posts (CHPs). Residents may be referred to a CHT by a primary care provider, or walk-in to any CHPs, to be reviewed and get personalised advice on appropriate intervention, in areas such as medication reconciliation, assessment and education on fall risk, nutrition and lifestyle education. CHTs can also provide links to nearby GPs for continued follow-up on the issues identified. For home-bound residents, CHTs may also make home visits!

Today, Central Health has 80 CHPs in place, each working hard on the ground with their community partners to deliver more integrated and joined up care to residents with complex care needs. **GPBUZZ**

LEAVING WELL, WITH PALLIATIVE CARE

Palliative care is increasingly vital as the number of frail elderly in Singapore grows, indicating a need to establish palliative care networks that support End-of-Life and Long-Term Care in the community.

A survey by Lien Foundation¹ revealed that while the majority (77%) of Singaporeans would prefer to die at home, only 27% actually do. A more concerted effort in primary care can help increase the chances of a terminally ill patient realising this wish.

Central Health has developed two programmes - Programme IMPACT and Project CARE - to help support our patients and primary care providers to care for persons at their end of lives.

We would like to connect with you

If you are a GP practising in the central region of Singapore and are interested in finding out how you could provide palliative care* in your neighbourhood, email us at gp@ttsh.com.sg

* Training can be provided

Programme IMPACT

Programme of Integrated Management & Palliative Care for the Terminally-ill non-cancer patients hopes to enable good palliative care at home for persons with end organ failures who have opted against aggressive treatment, e.g. a person with end-stage kidney failure who has not opted for dialysis.

Project CARE

Care At the end-of-life for Residents in the homes for Elderly aims to enable good palliative care in nursing homes for persons with limited prognoses, who themselves or whose families have opted for the comfort of care in a nursing home setting.

We hope to reach out to interested GPs to join us in this work to provide good palliative care for patients in the community, whether at home or in nursing homes.

Together we can better enable ageing with grace and dying with dignity for our population! **GPBUZZ**

¹ Lien Foundation, 'Death Attitudes Survey', 8 April 2014



« Our Occupational Therapist and Community Nurse from the Geylang Community Health Team on a home visit to assess a resident's functional status within her neighbourhood



« Our Community Nurse conducting basic medication reconciliation with a resident at a Community Health Post in Novena-Kallang-Rochor



⤴ Programme IMPACT nurse educating a patient on the use of a portable oxygen concentrator



« Project CARE doctor conducting an assessment on a patient at a nursing home