Tan Tock Seng HOSPITAL
National Healthcare Group

A PUBLICATION FOR PRIMARY CARE PHYSICIANS

GPBUZZ

MCI(P) 037/05/2021
OCT - DEC 2021

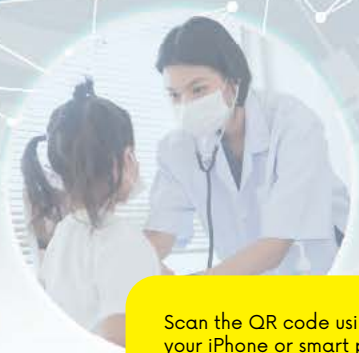
Commemorating TTSH's 177th Founder's Day –

" Better Together, Stronger Together"

GPs' Role
in Population Health
and Preventive Care

Community of Care (CoC):
Working Hand in Hand
to Improve Lives for All

Turning Challenges into
Opportunities for
Better Care



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Growing **'Better Together, Stronger Together'** with You as **We Build a Healthier and Happier Community**

Tan Tock Seng Hospital's (TTSH) 177th Founder's Day theme, 'Better Together, Stronger Together', celebrates the commitment, resilience and hopes that our hospital has displayed as we rode through the COVID-19 pandemic in the past 1.5 years. We would like to thank our network partners and medical colleagues in the community who have been working silently (and deserve way more recognition!) alongside TTSH.

Primary care is the first line of defence in cushioning the community's healthcare needs as hospitals fight the pandemic. Our General Practitioners (GPs) have also been pivotal in providing continuing care for chronic patients with stable conditions while allowing the hospitals to care for the very sick. That is our impetus to work closer with primary care physicians in continuing care from the hospital to the community, so as to manage chronic diseases and maintain the health of our residents.

In this GPBUZZ issue, we feature the contributions of some of our primary care physicians — not only for what they have done in the battle of the global pandemic, but also in the holistic care of patients through their dedicated work, alongside social agencies and co-management with specialists. They are truly the anchor for population health.

In the near future, TTSH will introduce Central Health 2030, which is a strategic plan for the next ten years to move beyond the hospital walls and embark on population health. In Central Health 2030, we recognise the importance of building relationships with our residents, with each of them being cared for by their family physician. At Central Health, we strive to partner every resident to build their own individual care plan. We will strengthen our focus on wellness and prevention, bring healthcare closer to our residents, and build relationships that make us resilient and strong as a community.

As we soldier on towards the new normal, our teams at TTSH and Central Health look forward to a meaningful partnership with you. Let us work together to bring care beyond the hospital walls, and build a Healthier and Happier Community!

Yours Sincerely,

Adj A/Prof Ian Leong
Assistant Chairman Medical Board
(Community Care Integration)

Ms Loh Shu Ching
Executive Director
Division for Central Health

#LightforSG movement on TTSH's building façade

Commemorating **TTSH's 177th Founder's Day**

Founded in 1844 by philanthropist Mr Tan Tock Seng, Tan Tock Seng Hospital (TTSH) was first known as the Chinese Pauper's Hospital and was located in Pearl's Hill. 177 years on, TTSH remains committed to its legacy of compassion, philanthropy and care.

This year, the Hospital celebrates its Founder's Day with a powerful message, 'Better Together, Stronger Together', to encourage us to lean onto one another and band as one during this extraordinary time in our lives.

"We are stronger together, because we have each other" was the message displayed across the façade of the iconic wards for over a week, illuminating the night sky almost like a warm, inviting hug. The projection of lights was part of the #LightforSG movement, a campaign in support and recognition of all healthcare workers in their fight against COVID-19.

CHArging up Our Communities:

Rediscovering Our Kampung Spirit

Living through a pandemic has proven to be a challenge for most Singaporeans, especially for many of our seniors living in Central Singapore. However, this shared experience was the much-needed spark to reignite the kampung spirit in many communities.

Equipping Volunteers with Knowledge and Skills

The onslaught of COVID-19 did not deter our carers from actively learning new skills and providing continuous care and support to their family members and peers. The carers, who are volunteers from Thye Hua Kwan (THK) Cluster Support @ Geylang, rose to the challenge and participated in the virtual **CHArge Up! Learning Programme** initiated by the Centre of Health Activation (CHA) at Tan Tock Seng Hospital (TTSH). Launched in 2018, this programme aims to equip carers with health skills, knowledge and confidence to care for themselves and for others around them.

Being avid volunteers at THK, 65-year-old Mdm Ong Poh Lian and 52-year-old Mdm Rosina Tan completed their virtual training on 'Creating a Safe Home Environment to Reduce Risks of Falls and Proper Handling of a Wheelchair'. After completing the training, both volunteers eagerly shared their newly learnt health knowledge and skills to help those around them.

Mdm Ong shared: "(This module) allows me to share the information that I have, and learn with my neighbours and those who require assistance in managing wheelchairs."

Adding on, Mdm Rosina said: "It also highlights areas of concerns for home hazards that I can share with my elderly befriendees."

Mdm Ong Poh Lian engaging with a senior during one of her volunteering sessions. She has been volunteering with THK as a THK Aviator since 2016.

Nurturing Supportive Networks of Care

For others, they found strength in forming local peer groups within their communities, which provided them with social support during these trying times. Mdm Florence Sie, 72, is one such example. Advocating for a healthy lifestyle through exercise among her peers, she was recognised for her efforts and was invited to join TTSH's Centre for Health Activation Peer Support Leaders (CHAPS) Club and has been an active member for 2 years.

Launched in 2019, CHAPS Club aims to develop and equip Peer Support Leaders (PSLs) with skills, knowledge and confidence to lead and empower peers to achieve a healthy lifestyle, in partnership with TTSH Health Coaches and Community Partners.

Peer Support Leaders, like Madam Sie, form strong pillars of social support and motivation for their peers and seniors in their communities. As Mdm Sie shared: "Virtual engagements are the next best choice due to the current pandemic situation. (It is a) good way to keep up with information about healthy diets and keep fit virtually alongside my peers."

Through these community-enabling programmes and initiatives, they foster the kampung spirit amongst our seniors and spark their desires to care for and encourage one another to live happier and healthier lifestyles.

Mdm Florence Sie has been a member of CHAPS Club since August 2019 and has actively encouraged her peers to participate in regular exercise sessions with her.

Help Bring Care to Every Corner

Anyone can participate in CHArge Up! Learning Programme or be a CHAPS Club member. Interested to be part of our community enabling programmes or initiatives?

Connect with us (**cha@ttsh.com.sg**) or visit our website (**https://bit.ly/TTSHCHA**) by scanning the QR code to learn more.

SINGAPORE PATIENT Conference® 2021 Online! 9TH EDITION

Empowering a Healthy Community Through Patient Education

Come on board to learn how you can play a part in building a more resilient and supportive society!

Into its 9th edition, this year's Singapore Patient Conference (SPC) presents 'Empowering a Healthy Community Through Patient Education'. A dedicated platform for sharing and learning, SPC aims to connect individuals and members of the wider community – through equipping them with knowledge and skills, to give them greater confidence in taking charge of their own health and making healthcare decisions, and thus become better neighbours and better carers in the process.

Happening on 19 and 20 November, SPC 2021 Main Conference will see health and social care professionals share perspectives on how health education has transformed communities. Through simple yet impactful initiatives, individuals will be empowered to understand their own health and be better supported to access personalised care. The virtual conference will also encourage open conversations on mental health education, to help the community gain a better grasp of mental health issues and play a crucial role in stigma reduction.

Mdm Ang Bong Chee (left), an active member of CHAPS Club, led a live aerobic exercise along with our TTSH health coach (right) during Let's CHAt! – A Journey to Wellness. Her warm and bubbly demeanour has attracted many of her peers to join her in keeping active.

Even as the pandemic limits our physical interactions, we are glad to be able to honour the contributions of invisible heroes through our virtual platform. Held in conjunction with SPC 2021, the 7th edition of the Singapore Patient Action Awards (SPAA) will celebrate everyday heroes who have demonstrated empathy, resilience and commitment to members of our communities in need of care and support. Earlier this year, we showcased inspiring stories of past SPAA recipients who have gone the extra mile and made a positive impact through our #InvisibleHEROES campaign. Join us to hear the stories of this year's recipients and be inspired to do more for your own community!

In Let's CHAt! – A Journey of Care, Mrs Karen Poh (centre) and Mr Nicholas Sim (right) led us through an inspiring and heartwarming sharing on their caregiving journeys and how they rediscovered self-love.

Mark your calendars

Join us virtually on 19 and 20 November for SPC and SPAA 2021 via our SPC Facebook page. Scan the QR codes below to register and be part of the action today!

Follow us to get the latest updates to SPC 2021!

@singaporepatientconference

Register now **Find out more**

Missed the exciting line-up of educational and interactive virtual fringe activities that took place from July to September? Simply scan the QR code below and visit our SPC Facebook page to watch the recorded videos at your convenience! From live aerobic exercises and healthy cooking demonstrations to caregiving seminars and more, there's surely something for everyone in the family!

Rewatch the videos of SPC 2021's fringe activities

New CRiSP Discharge Condition: Dyspepsia

Adjunct Associate Professor David Foo
Clinical Programme Director - CRiSP
Senior Consultant, Department of Cardiology, Tan Tock Seng Hospital

Update for TTSH's Community Right-Siting Programme (CRiSP) with GP Partners:

Dear Partners and Friends,

Thank you for your fervent partnership in providing continual primary care follow-up for patients who have been discharged from TTSH, and supporting the Nation's vision of "One Singaporean, One Family Doctor".

We are happy to introduce Dyspepsia as a new addition to our CRiSP discharge conditions from the Department of Gastroenterology and Hepatology. TTSH Pharmacy will continue to dispense drugs at patient's subsidised rates upon the doctor's prescription, and our diagnostic partners will also be offering CRiSP rates for the required laboratory and imaging tests.

TTSH and Central Health look forward to more collaboration opportunities with you, to add years of healthy life to our community!

Be Part of CRiSP!

CRiSP is a partnership between GPs and TTSH, where patients with stable chronic diseases are discharged from Specialist Outpatient Clinics and are appropriately managed by our GP partners.

If you are a GP practising in the central region of Singapore and are keen to find out more about our partnership programmes, email us at gp@ttsh.com.sg.

DID YOU KNOW?

2021 – 2030 has been designated the

Decade of Healthy Ageing by the United Nations!

With a rapidly ageing global population, it is imperative to support the older adults amongst us to age healthily – physically, emotionally and mentally.

The COVID-19 pandemic has resulted in reduced social interactions. This social isolation has affected many, especially the older adults with lower levels of well-being. There is an increased need to equip and empower our older adults with strategies to identify their social support structure and to encourage them to persevere in their goals to achieve healthy ageing in the midst of this protracted pandemic.

The Institute of Geriatrics and Active Ageing (IGA) and Centre for Health Activation (CHA) at TTSH arranged a webinar in celebration of International Day of Older Persons (IDOP) 2021, to share about the role of grit in building up emotional resilience for active ageing.

Held on 1st October, this year's event was aptly themed 'Healthy Ageing Starts with Me!' and is the third run of IGA's annual outreach efforts branded under IDOP that is catered to older adults, caregivers as well as the general public.

MISSED THE WEBINAR?

Head on over to TTSH IGA's Facebook page to gain insights on how **'Healthy Ageing Starts with Me!'**

https://www.facebook.com/ttshiga/

FEATURE

Turning Challenges into Opportunities for Better Care

By Dr James Cheong, Family Physician, C3 Family Clinic @ Aljunied Crescent

Dr James Cheong is a Family Physician practising in a GP clinic situated in the heartlands of Aljunied Crescent. Just as he believes that primary care, along with community health partners, play an important role in anchoring patient care in the community, he also advocates holistic patient-centred care through **collaboration**, **coordination and communication** between primary care, tertiary specialist care and patients.

Dr James Cheong, Family Physician

"COVID-19 has dealt huge challenges to Singaporeans' lives and livelihoods. Almost 18 months on, the war against COVID-19 is still raging, with healthcare and healthcare professionals right at the frontlines.

The pandemic has also unleashed implications on the task of providing care within the community. During the Circuit Breaker period in May 2020, some patients were afraid to seek care physically at the clinic, for fear of contracting COVID-19 while out. Many stayed away, raising concerns of a drop-off in care and treatment, especially for patients with chronic illnesses. Due to social distancing measures and cross-institution restrictions, it was no longer as easy for medical teams to meet and collaborate – posing a challenge for delivering care to patients with complex biopsychosocial issues, which required multi-disciplinary care.

Playing Our Part in the War Against COVID

As part of nationwide measures to reduce the risk of spread, GP clinics had to implement intensified infection control measures to ensure patients with fever and acute respiratory illness (ARI) were segregated from other patients. Clinics had to ramp up PPE and infection control supplies, and clinic staff had to be quickly trained and fitted with the appropriate personal protection equipment (PPE). Public Health Preparedness Clinics (PHPCs), such as the one that I work in, were activated by MOH to support the national effort in combating COVID-19. Many PHPCs gamely took on the role of Swab and Send Home (SASH) clinics, which were tapped on to provide COVID-19 testing for Polymerase Chain Reaction (PCR) and recently, Antigen Rapid Testing (ART), to quickly detect cases in the community.

All these spelt administrative, operational, logistical and infrastructural challenges for GP clinics, many of which are solo or small group GPs, operating small footprint healthcare establishments in the heartlands.

Like many fellow GP clinics, ***our clinic evolved to meet these and other challenges brought on by the pandemic***, with the support of MOH and AIC. We adopted telemedicine to ***extend our care beyond the physical confines of the clinic***, which enabled us to provide continued care for our patients with chronic diseases. To continue collaborating with our healthcare partners in tertiary care and the community, we learnt to use video-conference tools – an invaluable resource in training and coordinating care.

Staying Agile & Evolving Our Action Plan

Another measure we took was the sharpening of our existing triaging system to ensure patients with fever and ARI are segregated from other patients, and seen in a designated 'fever' area. This has led to greater awareness of hygiene, proper PPE use and social distancing for infection control amongst patients and staff. Daily cleaning and disinfection procedures were also reviewed and updated to commensurate with current infection control concerns. All these measures have helped to create a safer environment for patients and clinic staff alike!

To meet our role as a PHPC SASH clinic, our doctors upskilled to perform swab procedures for COVID-19 PCR testing and ART to detect and diagnose COVID-19. This has avoided the need to refer patients with fever and ARI to swab centres or other healthcare establishments for COVID-19 testing, hence allowing us to provide holistic and comprehensive care, while improving infection control.

As we continue to battle COVID-19, new challenges will continue to arise. ***Rather than seeing them as a burden or threat to our current routine, we have learnt to embrace them as opportunities for change to become better providers of care for our patients.***"

Tête à Tête with Dr Melvyn Tan:

GPs' Role in Population Health and Preventive Care

As strategic nodes in the neighbourhood, GP clinics play an instrumental role in Singapore's population health landscape through preventive and chronic care.

We caught up with **Dr Melvyn of AMK Family Clinic** — one of TTSH's community partners through an interview, to get his perspectives on GPs' role in improving overall population health in Singapore.

Dr Melvyn Tan MB,
BCH, BAO, LRCP & SI, AMK Family Clinic

Hi, Dr Melvyn! Please tell us more about your core job scope as GP, and what drew you to the practice.

I graduated from medical school in 1998 and have been a General Practitioner (GP) at Ang Mo Kio since 2004. What got me into primary care was the opportunity to manage a variety of medical conditions and because it allows me to take on a people-centric approach, through seeing patients of all ages.

As a GP, I assist patients and their family members throughout their life stages, by providing support and advice to help them cope with changes in their physiological and health status. My duties also include picking up early developmental abnormalities in children, recommending vaccinations for the young and old, looking out for ageing issues such as sarcopenia, assisting with smoking and drinking cessation, and even doubling up as a counsellor.

What does population health mean to you?

Population health should be facilitated within the neighbourhood, where the infrastructure and surrounding amenities can complement diverse health programmes. For example, residents living in East Coast have the luxury of the sea and beach for more outdoor activities as compared to those living in Bukit Timah! There will have a stronger sense of ownership in amalgamating with health programmes, although a concerted effort from residents, organisations and healthcare providers in the neighbourhood is required for a better population health approach.

You have been serving the community in the Ang Mo Kio neighborhood for 17 years. Have you noticed any significant changes in the community's health needs during this period? What are some of these changes?

In the past, GPs were mostly handling acute problems like cough, cold and flu, while screenings were not widely encouraged.

Today, the upcoming silver tsunami along with the increase in life expectancy in Singapore is expected to lead to a rise in the prevalence of chronic diseases within the population, especially in a high-stress society like ours. Hence, GPs have been shifting their roles to include encouraging patients to take up health screening, since Singaporeans are also becoming more affluent and health-conscious.

Thanks to the nationwide War on Diabetes, there is also an increased awareness of preventive care. However, the challenging part is that most do not take pro-active steps to change even with (our) repeated advice, until they find something wrong with their health.

Besides providing acute and chronic care, GPs also play an important role in managing chronic diseases and ameliorating the disease burden. In your view, how have GPs been involved in driving preventive healthcare and how can their role be further enhanced to improve outcomes for even more patients?

Other than the usual medication regime and referrals, we now offer lifestyle recommendations actively to our patients, in the spirit of preventing chronic disease and its complications.

One limitation is that GPs do not have enough time during each consultation session to do thorough counselling with our patients! Thus, Primary Care Network's (PCN) nurse counsellors have been a great help, by filling the gap and providing patients with dedicated counselling that complements the GP's clinical review.

Many GPs also offer their expertise for other types of screenings for early detection and treatment of diseases such as cancer. Personally, I would like to do more with regards to mental health and geriatric care in the community as these are pertinent issues on the rise.

In your opinion, how can hospitals work with GPs (and even community care partners) to encourage better health and chronic disease management?

The first step is having public healthcare institutions like hospitals and polyclinics engaging the GPs directly. With TTSH's Community Right-Siting Programme (CRiSP), GPs can help to continue management even after patients are discharged from Specialist Outpatient Clinics (SOCs). In addition, having access to a network of specialists also enables us to readily receive advice to help us better manage our patients.

Supporting GPs in connecting with social care partners also helps a lot, an instance is the TTSH's Community Health Team, who has provided invaluable help in facilitating this link-up. The PCN has also provided much-needed help for aspects that GPs usually do not have [the time] for, such as providing patients with lifestyle counselling and follow-up.

Finally, I feel that more preventive health campaigns can be rolled out on a nationwide level to encourage regular tests and health screenings, as well as keep the public informed of GP clinics in their residential areas with such services.

GPs are a vital part of the population's preventive health journey.
If you are a GP practising in the Central Zone and are interested to find out more about TTSH's preventive health campaigns (eg. Screen for Life), email us at **gp@ttsh.com.sg**

Creating a Community for Complex Care Management and Successful Ageing:

The 9Cs & Other Key Aspects

A crucial pillar of Singapore's health services, the challenges in healthcare delivery has exacerbated in recent years due to our ageing population and growing disease burden. To learn what is being done towards improving patient outcomes, we spoke with **Hua Mei Clinic's Senior Assistant Director Dr Tan Sai Tiang** and **Ms Chua Hui Keng**, **Manager of Tsao Foundation's Care Management Services** about how a patient-centric care system within the community can drive a more seamless healthcare journey for patients, and how public and private practitioners can work with primary care providers to better support patients.

Dr Tan Sai Tiang
Hua Mei Clinic's Senior Assistant Director

1 Share more about Hua Mei Clinic's model of care and its care philosophy.

The Hua Mei Clinic at Whampoa is a pilot community-based primary care model, aimed to provide continuing care to seniors with complex health and social care needs, to facilitate ageing-in-place for an enhanced quality of life.

It is modelled after the patient-centred PCMH[1] (Primary Care Medical Home) by the U.S. Department of Health & Human Services, and it follows an enhanced set of PCMH principles categorised as "9Cs":

1. First Contact
The patient's first stop for all their health and social needs

2. Continuity
Assigning patients to the relevant primary care team to provide them assurance and guidance for self-care

3. Comprehensive Care
Relationship-based care delivery from an interdisciplinary team to provide holistic and patient-centred mental, social and physical care services, with one of the key goals being the enablement of the patient's optimum ability for self-care

4. Care Management
Provision of a comprehensive, integrated health and social care plan – at the start, at mid-point to assess progress and new issues, and upon discharge

5. Coordinated Care
Coordinated transition of care sites across the health care and social care system within the community, especially seniors who require long-term care at home or in a nursing home

6. Counselling and Care
A holistic care system that brings attention to mental health and well-being

7. Care for the Caregiver

8. Effective Communication with patients and partners in a timely manner

9. Responsiveness to Community population issues, such as dementia and social isolation

Hua Mei's practice model delivers care from a Primary Care team and a Care Management (CM) team. The latter (comprising Social Worker, Nurse, Assistant Care Managers and a Programme Coordinator) carries out a short-term care management service (often 6 to 18 months) vis-à-vis the caretaking abilities of the patient and their family post-discharge. Continuous improvements are being made on the "9Cs" to refine quality and safety measures.

2 Hua Mei Clinic was set up in Whampoa in 2017. What are the key healthcare needs among residents in the area?

Knowledge and awareness

Whampoa has a majority of residents over 65, half of whom are socially isolated. This means many residents have not engaged with primary care, typically turning up in hospitals only when a medical crisis strikes. Furthermore, mental health issues complicate the problem, as it leads to delayed diagnosis and treatment.

Another survey finding of concern is that 10% of residents in Whampoa aged 60 years and above have been diagnosed with dementia, yet most of them do not know how to identify the symptoms and even harbour significant stigma, or lack information on seeking proper care. Improving accessibility to primary care, with a focus on holistic and continuous care is therefore needed.

Enhancing family and social support

The CM places a priority on those who have weak family and social support i.e., patients without caregivers. In this case, a thorough assessment will be conducted upon receiving a referral before linking the patients to the relevant service providers. Additionally, as the health conditions of the elderly fluctuate, it is also critical to educate caregivers on identifying red flags to promptly seek professional help.

3 How do you manage patients with complex clinical needs?

With many of our patients having complex clinical needs, we have a process that our Clinic care team follows during consultation.

Patient is empanelled

Initial assessment focusing on

- Management of acute issues
- Comprehensive review with attention to biopsychosocial aspects, aiming to understand patient holistically through his medical history and the impact it has on his function and self-care ability
- Medication reconciliation — reduce duplication, simplify, educate patient or caregiver
- Care plan is discussed and agreed with patient or caregiver, targets are set for optimisation of chronic diseases

Patient is stable for routine care

- Reviews are conducted every 2-4 months. subjected to patient's age, frailty, availability of dedicated care and support at home
- At each routine consult, we look for and manage:
  - Acute problems
  - Optimisation of chronic conditions
  - Proactive screening for geriatric giants
  - Health education to empower patient/ caregiver in self-care
  - An updated care plan for the patient and may also facilitate a referral where needed

For patients with shared care arrangements with other professionals, regular medication reconciliation and updates are conducted.

Patient is unstable and needs to be stabilised

- More frequent reviews are conducted while managing active problems
- Care goals are set with patient/caregiver
- A referral is initiated if patient can benefit from co-management with our CM teams (General or Dementia-specific), Counsellors, Day Care etc.

For such cases, a common care plan is set and reviewed during regular inter-disciplinary group discussions while the responsibility over the patient is still being anchored by the clinic's doctor and nurse.

The clinic care team works closely with the CM team to create and implement a comprehensive care plan addressing the medical, social, and psycho-emotional needs of the patients and their family through:

- Getting to know the patient's life history, premorbid personality, preferences, etc.
- Identifying psycho-social issues, including risk for elderly abuse and suicide ideation
- Assessing financial status, living environment and fall risks

Besides these, we also review the patient's current care arrangements to try to understand the client's family by establishing a genogram and identifying all caregiver(s) to get a picture of the family dynamics. Using *Zarit Caregiver's Burden Scale*, existing and required caregiver needs are determined – especially important in cases where the caregiver is another older person.

4 What are the key elements GPs should note when managing patients with more complex clinical needs?

Training

- Upskilling in Geriatric Medicine and/or Family Medicine with knowledge in dealing with mental health issues
- Awareness of community resources available to support patients and families
- Involvement in leading multidisciplinary discussions with other healthcare and community care professionals to manage patients holistically
- Good to have: Ability to perform simple care management (financial, social, rehab needs), often by nurses

Teamwork

- Communication and trust, as patients with complex care needs often require a multidisciplinary approach

Mindset

- Thinking beyond episodic care
- Adopting a pre-emptive strategy of promoting patients' health and preventing diseases
- Using a motivational interviewing (MI) method to engage patients in their progress towards sustained lifestyle changes

Collaboration with external partners

- Communicating seamlessly on different levels of care
- Working together to enable access and infrastructure to affordable drugs
- Specialised investigations, such as the collaboration between Tsao Foundation and the National Healthcare Group (NHG), where patients are right-sited to our Clinic

5 Please share any collaboration(s) that you have embarked on that helped you better manage your patients.

Since 2017, we have been working closely with NHG Polyclinics (Toa Payoh) and Tan Tock Seng Hospital (TTSH) – especially with TTSH's Department of Geriatric Medicine – to create a seamless transition in patients' care journeys from primary care to tertiary care, and vice versa.

With more older persons presenting boredom, helplessness and loneliness, the CM team also partners other social service agencies to provide befriending services and active ageing activities.

6 What does Hua Mei Clinic envision GPs doing to better co-manage patients with various organisations?

I envisage the GP being viewed as the patient's confidante and first point of contact; a true generalist knowing when and to whom they should refer patients to when the need arises.

From my experience with Tsao Foundation's Community for Successful Ageing (ComSA), GPs should work with Care Managers to manage patients with complex psycho and social needs, whereby the latter contributes expertise while GPs remain the central professionals responsible to their patients.

Although we have GPs who are fully capable of managing patients with complex care needs and can service as gatekeepers to more expensive tertiary care, this picture can only be realised when other stakeholders such as the Ministry, tertiary institutions, community partners come on board as well and work in a mutually beneficial manner.

For referrals to Hua Mei Clinic's Case Management service, GPs can email to **hmcm_comsa@tsaofoundation.org** for more information.

Reference:
1. Primary Care Medical Home - https://pcmh.ahrq.gov/page/defining-pcmh

Community of Care (CoC):

Working Hand in Hand to Improve Lives for All

A CARE PARTNERSHIP BEYOND WALLS

Emerging prevalence of chronic and long-term care needs due to Singapore's ageing population has brought about greater social isolation and associated health risks. Addressing the need for continuous post-discharge care close to home is the CoC, a structured framework commissioned by the Agency for Integrated Care (AIC), or holistic care within the neighbourhood which supports ageing in place.

To find out more about the CoC, we chat with leaders from Tan Tock Seng Hospital Community Health Team (TTSH CHT), National Healthcare Group Polyclinics (NHGP) and AWWA, who have been reaching out to seniors at 16 HDB blocks and one private estate in Ang Mo Kio since April 2020, when the initiative began.

Describing social and health aspects of care as being "fragmented" in the early years, AWWA Centre Manager, Ms Mahes noted that non-medical aspects of care often influenced patients' health outcomes – resulting in unnecessary hospital readmissions or so-called "frequent flier" patients who lacked the proper follow-up care. The CoC hence provided timely care intervention as ***"a multi-disciplinary comprising medical, nursing, life health service"*** beyond hospital walls and out into the community.

Agreeing, Ms So from AWWA flagged another issue – the lack of social resources for some patients who "don't know how they can go about getting health and social support" and would often fall through the cracks, since they tend to be socially isolated. By picking up on ***those who "urgently require help so we can quickly intervene"***, preventive care is achieved.

PIECING TOGETHER CLIENT PROFILES FOR HOLISTIC CARE

The interplay of the patient's medical and social dimensions is key in providing holistic care, as per George Engel's biopsychosocial model of care, and CoC has truly embraced this!

Engaging our stakeholders and tackling the intertwining issues together lie at the heart of the CoC initiative – TTSH CHT plays a bridging role between acute healthcare and primary care providers, while community partners such as AWWA act as the team's "ears and eyes on the ground", as shared by Ms How. This enables them to efficiently reach those who urgently require health and social support, by escalating the right care plans:

Joint home visit can be conducted by TTSH CHT and community partners to understand and address the CoC client's needs.

"By trying to push forward a medical appointment for the patient, we see that care can be provided faster in a seamless manner."

Indeed, empowering the disadvantaged is a passionate cause for AWWA. Their CoC team had gone door-to-door as part of their outreach efforts in September 2020, engaging and profiling residents to onboard the programme, when pandemic restrictions still allowed.

Since May 2021, seniors were profiled using a community screener tool set up by the AIC and recommended for A (active ageing), B (befriending needs) or C (care and support). AWWA would also receive requests from organisations including the Silver Generation Office to connect with clients who have high care needs, not forgetting those whose caregivers are facing difficulties in caring for them.

As Dr Valerie Teo acknowledges, unity is strength, and having many heads (and hands) come together allowed the clients' social and medical issues to be better resolved:

"Having this close communication working on the same plan where the patient is involved in...allows us to then chip away at some of the concerns... and challenges that he faces. And that way he is then more empowered to manage his health better and to stay well in the community."

A COHESIVE COLLABORATION

For now, monthly virtual meetings have become the norm for the tripartite CoC partners, who remain committed to keep one another informed and check in on their clients. Such discussions offset burdens for each partner by channelling client profiles to the right places while comprehensive evaluations ensure that appropriate care interventions and referral decisions are made.

Each care provider plays to their respective strengths. AWWA's staff, volunteers, and even seniors check in on the clients at home or in the community to ensure that they are well, easing NHGP to focus on ensuring patients' chronic conditions are being well-managed. Through information sharing across the CoC, the knowledge of every client's underlying conditions allows primary caregivers to provide "care in the right context".

Despite healthcare needs often falling on medical professionals such as NHGP and TTSH, a more dynamic approach allows for patient-centred, individualised care. Thus, in situations where social issues surface, AWWA would then step in to manage the care.

"The real beauty of this partnership is really to allow all of us to be able to openly discuss to see what is most beneficial for the patient and then for that team to step up..."

As geographically close nodes in the community, NHGP also collaborates by helping clients navigate through the system, "[guiding] their concerns about where to go and who they should consult", further shortening the care management timeline, shared Dr Teo. Side-stepping a one-size-fits-all approach has allowed the multi-disciplinary team to exercise agility in response to different needs of the clients.

EVERY SUNSET BRINGS A NEW DAWN

Illustrating this is a particular story of 75-year-old Mr Tay, who came under CoC's care after his discharge from IMH in February 2021. A multi-pronged approach was taken due to the patient's relapses and medical risks, on top of his history of depression. Exhibiting struggles with compliance, the senior Mr Tay had turned down medication and rejected all help at one point.

Despite interventions by different services, progress had been dismal – until the CoC's case discussions was followed up by AWWA's unyielding engagement efforts, which successfully convinced Mr Tay to visit AWWA's Rehab and Day Care Centre twice weekly. This proved to be a turning point and his progressive improvements in medication compliance.

Primary care doctor reviewing a patient. (Photo taken during pre-COVID-19)

Ms How recalled how the team "could not [achieve] any breakthrough" to get Mr Tay on track with his health initially, and was later thrilled to see "support starting to fall in place for him. Subsequently, he allowed us to bring forward his specialist appointment to resolve his hearing deterioration issues, which was cause for celebration. Gratefully, Dr Teo also shared how care intervention was simultaneously provided to Mr Tay's elderly sister, who also had pressing healthcare needs including cognitive impairment and short-term memory:

"The whole team is very proactive in trying to find the right fit of support... that's really what healthcare is about - managing [our client] in the context of their family."

HOPES FOR A MORE ROBUST CoC

When it comes to measuring the success of their care provision, each stakeholder has their own envisionment.

For AWWA, Ms Mahes was happy to see clients maintaining their status on the clinical frailty scale, while TTSH CHT's Ms How observed satisfactory compliance rates in her clients, in addition to them being equipped with better knowledge of available healthcare channels they can approach:

"Many times when residents require help, it is good enough that they know how to and will reach out to someone."

For Dr Teo, she finds joy in patients successfully "graduating" from the programme, and enjoying an improved quality of life, thus putting the brakes on recurrent admissions into healthcare institutions.

With the partnership progressing well, Ms Mahes brought up an envisioned next step – for more primary care physicians and GPs to come onboard CoC and be part of the healthcare journey. This way, more "seniors can be connected with a structured health and social care network that promotes active ageing with better lifestyle choices, via a coordinated approach to detect and respond to any biopsychosocial issues at an early stage", thus empowering residents to live well and age gracefully within their community.

If you are a GP practising in the Central Zone in Singapore and would like to find out more about collaborative opportunities in CoC, email us at **gp@ttsh.com.sg**.

Don't des(s)ert your health!

Healthy tweaks you can make for that perfect healthy and delicious dessert

Festive seasons are never complete without hearty meals and desserts! Here are some fuss-free ways to prepare a healthier dessert, while not compromising on taste!

Emily Yeo
Dietitian, Department of Nutrition & Dietetics
Tan Tock Seng Hospital

Swap the butter

Butter is commonly used in baked products to add a delightful aroma as well as to create a light and fluffy texture. However, it is high in saturated fats which are not heart-healthy. For the same mouthfeel, swap one cup (225g) of butter with:
- ¾ cup (180ml) of healthier plant-based oil (e.g. canola oil) or
- Plain Greek yogurt using a 1-to-1 replacement ratio (if using reduced fat Greek yogurt, add ¼ cup (80g) of unsweetened apple purée to add moistness and flavour)

Reduce sugar intake

Try using 80% of the sugar content stated in the ingredient list when making your dessert. Be adventurous by replacing at least 50% sugar with heat-stable non-caloric sweeteners such as stevia. Adding spices like cinnamon can also enhance flavour without the caloric load.

Experiment with wholemeal flour

Compared to white flour, wholemeal flour provides more micronutrients and fibre. For a start, try replacing ⅓ of white flour in the recipe with your preferred wholemeal flour, and gradually increase the proportion of wholemeal flour over time to get accustomed to the taste.

OATMEAL WALNUT CARROT CAKE

Preparation: **15 min**

Cook time: **35 min**

Serves: **20 slices (approx.)**

Serving size: **50g (1 slice)**

Nutrition information Per serving (50g)	
Energy (kcal)	123
Protein (g)	3.8
Carbohydrate (g)	9.8
- of which added sugars (g)	0
Fats (g)	6.8
- of which saturated (g)	1.1
- of which trans (g)	0
- of which cholesterol (mg)	19
Dietary Fibre (g)	2.2
Sodium (mg)	118

Wet Ingredients

- 2 large eggs
- 340g reduced fat plain Greek yogurt
- 35g stevia
- ¼ cup unsweetened apple purée (80g)
- ¼ cup canola oil
- 1 tsp vanilla essence
- 2¼ cup carrots, finely grated (310g)

Dry Ingredients

- 1½ cups ground oats (or oat flour) (150g)
- 1 cup quick oats (90g)
- 1 tsp baking powder
- 1 tsp baking soda
- ½ tsp salt
- 1½ tsp cinnamon, ground
- ¼ tsp nutmeg, ground
- ¼ tsp ginger, ground
- ½ cup chopped walnuts (65g)

Method:

1. Preheat the oven to 350°F (180°C).
2. For wet ingredients: In a big bowl, beat the eggs and add Greek yogurt, stevia, apple purée, canola oil, vanilla, and whisk to combine. Next, add the grated carrots and stir until well-mixed.
3. For dry ingredients: In a separate bowl, add the ground oats, quick oats, baking powder, baking soda, cinnamon, nutmeg, ginger, salt and walnuts.
4. Add dry ingredients in batches into the bowl of wet ingredients, stirring mixture slowly with a fork until smooth. Avoid overmixing the batter to ensure the cake has a fluffy texture.
5. Pour batter into an 8 by 8 inch prepared baking dish, smooth the top and bake at 350°F (180°C) for 35 to 40 minutes.
6. Remove from oven and let it cool completely in a cooling rack. Transfer to a cutting board and slice. Best to consume warm.

*Stevia to honey conversion varies from brand to brand, please refer to product information to ascertain the suggested amount to to replace with ½ cup of honey.

3 Steps for referring patients to TTSH

Here's a comprehensive chart listing the steps to refer **non-subsidised patients and patients under the Community Health Assist Scheme (CHAS)** to Tan Tock Seng Hospital (TTSH).

Step 1 PREPARE

Before you contact TTSH

1. Get patient's full name, NRIC, date of birth and contact number

2. Check if patient has CHAS/MG/PG card

3. Prepare documents:

For CHAS referral:
(i) CHAS Cover Note and
(ii) Referral Letter

For non-subsidised referral:
(i) Referral Letter only

Step 2 CONTACT

TTSH Appointment Hotline: 6357 7000

1. Advise which clinic you are referring your patient to

2. **For CHAS referrals only**
Email referral documents to referrals@ttsh.com.sg**

For non-subsidised referrals
Call TTSH at 6357 7000 to provide patient's details

Step 3 INFORM

Inform patient after confirming appointment details*

1. Inform patient Specialist Outpatient Clinic name, date and time of appointment

2. Remind patient to bring necessary documents for their appointment

*To ensure that your patients are seen promptly at TTSH, triaging may be conducted by our staff. Our staff will get back to you with an appointment date within 3 to 5 working days.

**Please retain a copy of the documents for reference purpose.

We thank you for your kind understanding.