Tan Tock Seng HOSPITAL
National Healthcare Group

A PUBLICATION FOR PRIMARY CARE PHYSICIANS

GPBUZZ

MCI (P) 013/05/2022
JAN - JUNE 2023

THE PARADIGM SHIFT OF HEALTHIER SG

MANAGING CDMP CONDITIONS – GPs AND SPECIALISTS

SUPPORTING A HEALTHIER SG THROUGH COMMUNITIES OF CARE

Scan the QR code using your smartphone to view GPBuzz on the TTSH website, or visit **https://delivr.com/2KB6V**

THE GPBUZZ EDITORIAL TEAM:

Ms Evelyn Tan
Ms Lynn Lee
Ms Vanessa Leong
Ms Jeslyn Woon
Ms Khairah Rohaizad

ADVISORY PANEL:

Professor Chin Jing Jih
Associate Professor Thomas Lew
Adjunct Associate Professor Ian Leong
Adjunct Associate Professor David Foo
Adjunct Associate Professor Chong Yew Lam
Ms Doreen Yeo
Ms Hoi Shu Yin

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EDITOR'S NOTE

A Healthier SG with Central Health: Are You Ready?

Around this time last year, everyday felt like a tightrope walk with uncertainties and frustrations as we did our best to deal with the ever-evolving COVID-19 situation. Fear and frustrations came forth, but also inspiring stories and the proverbial silver lining, as we now see how moments of crises created opportunities for us to identify key gaps in the way care was delivered. In particular, we saw how it was pertinent for the local healthcare landscape to shift from being reactive to proactive. Born from a vision to strengthen the sustainability of our healthcare model, Healthier SG was launched.

Come second half of the year starting July, eligible residents will receive an invitation from Ministry of Health (MOH) to enrol with a Healthier SG clinic of their choice. The Healthier SG roadmap places an emphasis on empowering Singapore residents to achieve better health and improve their quality of life, while healthcare providers such as GPs, community providers and hospitals will form Communities of Care (CoC) to anchor support for residents to take charge of their own health, and enjoy more years of healthy life.

Delivering person-centred care to residents is a shared responsibility, and Central Health will support family doctors to care for our residents together. This GPBUZZ issue pays tribute to our community through this trying period, and offers a closer look into the upcoming (and uplifting!) partnership between GPs, community partners, and Central Health.

The transformation of the healthcare environment will need the joint effort of family doctors, community partners, and hospitals. Central Health is committed to walking this journey with our GPs and community. Let us work together to form a network of care in your neighbourhood, and spark important conversations as we navigate this journey forward. To Healthier and Happier Communities!

Together, we are not waiting for what comes next; we are helping to close the loop - and to create new frontiers.

Yours Sincerely,
Ms Loh Shu Ching
Executive Director
Division for Central Health
Tan Tock Seng Hospital & Central Health

Singapore Patient Conference 2022 Highlights -

Building Healthier and Happier Communities

At the annual Singapore Patient Conference (SPC) 2022 last November, we heard from change leaders in the community about how everyone has a role to play in creating healthy and happy communities. From designing better living spaces to ground-up movements that spread kindness, the abundant display of passion and camaraderie around us that kindle the 'kampung spirit' in our communities has been most inspiring.

Through a sharing by Singapore Patient Action Awards (SPAA) 2022 Recipient, Dr Alvin Lum, Deputy Director of Mental Health-General Practitioners (MH-GP) Partnership Programme, Institute of Mental Health, we gained further insights on how a strong partnership between GPs and healthcare institutions can strengthen the drive towards community-based mental healthcare. The ongoing MH-GP Partnership Programme, in particular, aims to connect stabilised patients with GPs to ensure continuity of care at the residents' doorstep.

As healthcare providers, it is instrumental to tap on the strengths of both residents and healthcare professionals to magnify our efforts in improving population health. Through the skills and experience of our doctors, and the cooperation of all stakeholders, we can empower everyone to build one cohesive, healthy community.

Plenary Presentation by Our Speakers (from left to right):
Ms Sherry Soon (Be Kind SG),
Mr Michael Leong (SAA Architects Pte Ltd),
Mr Azaree Atan and Ms Evon Chua (Yishun Health)

Sharing by Dr Alvin Lum, 2022 Singapore Patient Advocate Award Recipient at Singapore Patient Action Awards 2022 Ceremony

RECAP EVENT HIGHLIGHTS

Hear more from these leaders through the full event highlights of the SPC Main Conference and SPAA Ceremony:

https://for.sg/spc-videos

EMBARK ON THE SPAA JOURNEY

Nominations for SPAA 2023 are now open. Nominate an inspiring patient, caregiver, volunteer group or community initiative today:

www.spaa.com.sg

Singapore Patient Action Awards 2022 Recipients, Nominators and VIPs

TTSH Annual GP Lohei Luncheon and CME Highlights 2023

LEAPING IN 兔 A HEALTHIER NEW YEAR!

The Primary Care Partners Office just celebrated a Happy New Year to(兔) gether with our GP partners, welcoming the Year of the Rabbit! This year, we have invited Central Health GPs, TTSH clinicians and Community Health Teams to come together to bask in an atmosphere of festivity and building network of care. The day started with the Lo Hei segment, where everyone earnestly tossed the rainbow platter for good fortune, health and bountiful returns.

Dr Tang Kong Choong, Deputy CEO, Tan Tock Seng Hospital [third from the right] & Adj A/Prof David Foo [first from the left] having Lohei with our esteemed GPs

Adjunct Associate Professor David Foo, Clinical Lead for Primary Care, shared on the plans that Central Health has in store to support GPs in the upcoming Healthier SG initiative. He highlighted the importance of Central Health partnership with GPs, which would complement Healthier SG in supporting the 'One Resident, One Family Doctor' vision. Adj A/Prof David Foo extended his gratitude to our Primary Care Partners for their continued trust and collaboration in these programmes, which include Community Right-Siting Programme, GP*Next*, and Community Health Screenings.

TTSH Health Coach explaining to GPs on how health plan works

Adjunct Assistant Professor Jerome Goh, Clinical Director Division for Central Health, started off the Continuing Medical Education (CME) session, '**Navigating Around Communities of Care in Central Health**', by sharing the biopsychosocial model of holistic healthcare which is an important aspect in Healthier SG. Introducing Central Health's Communities of Care (CoC), Adj Asst Prof Jerome Goh emphasised the importance of GPs being connected with other community and healthcare providers in a place-based model to develop a network of care for their residents closer to home.

GPs' firsthand experience with mobility aid devices to understand how it may benefit patients with mobility issues

Following were presentations by various healthcare professionals from the Community Health Team (CHT) – Ms Sharinah Parveen (Health Coach), Ms Foo Shi Hui (Senior Occupational Therapist), and Mr Su Qing Feng (Assistant Nurse Clinician). They shared in great lengths about how they can work hand-in-hand with GPs in caring for the patients in the community setting. This includes health coaching tips to encourage motivation in patients to make lifestyle changes, home assessments by Occupational Therapists (OTs) to assess patients' functional needs, and case management by nurses to connect patients to health and social care and support in the community to stabilise these needs. The day ended with a bustling marketplace where OTs demonstrated mobility devices and GPs tried their hand at developing their own health plans with the Health Coaches.

At the CME, we have heard GPs sharing their challenges faced in caring for patients in the community, which allowed TTSH to better understand how we can amplify the support provided to primary care partners. The event provided a unique opportunity for our GPs and CHT, to learn and understand the importance of each and everyone's role in the population health landscape. In 2023, we look forward to meeting more GPs in Central Health through upcoming neighbourhood CME events, and to introduce community partners in the area to build a collaborative CoC.

If you are a GP practising in **Ang Mo Kio**, **Bishan**, **Geylang**, **Hougang**, **Novena**, **Kallang**, **Serangoon** or **Toa Payoh**, email **gp@ttsh.com.sg** to be added into our mailing list and get updates on our latest developments in TTSH and the community we serve.

One-stop Community Health Club

Wellness Hub Launched to Improve Residents' Health

The Jalan Kayu residents who completed their chronic illness group coaching sessions

Members of JKCHC are encouraged to monitor their health closely and the club offers health programmes to keep them active

Prime Minister Lee Hsien Loong and Jalan Kayu MP, Ms Ng Ling Ling with the GP Clinic partners

Located at Serangoon North Ave 4, the newly launched Jalan Kayu Community Health Club (JKCHC) offers residents aged 40 and above access to health screenings and healthcare programmes to promote early detection of diseases and encourage residents to take charge of their health.

Some of the programmes offered at Jalan Kayu Community Health Club include:

- TTSH Community Health Programmes and Activities
- Crochet Art
- Chinese Calligraphy
- IMDA Digitech Workshops
- Outdoor Discovery Walk
- Resistance Band Workshop

With more than 30,000 residents in Jalan Kayu meeting the age requirement, its Grassroots leaders see the importance of setting up a health-centric club in which healthcare partners, namely Tan Tock Seng Hospital and GP Clinics such as Frontier Healthcare Group, Phoenix Medical Group, The Pinnacle Family Clinics (Serangoon North and Buangkok) and The Family Physician Clinic, collaborate with one another to support residents' health.

This new initiative will allow partnering GP clinics to interact with residents outside of their clinic settings and better understand their health needs.

With the upcoming Healthier SG, the JKCHC also serves as a foundational puzzle piece to prepare family doctors in Jalan Kayu for the transformation ahead.

If you are a GP or community provider within the Jalan Kayu Health Network and would like be involved, please contact **gp@ttsh.com.sg**

Our **Jalan Kayu** Health Network

phoenix medical group
MWS COVENANT FAMILY SERVICE CENTRE
Club HEAL
HOME NURSING FOUNDATION
ANGLICAN CARE CENTRE
TAI PEI SOCIAL SERVICE
Pinnacle Family Clinic
FRONTIER HEALTHCARE
INSTITUTE OF MENTAL HEALTH
SATHYA SAI SOCIAL SERVICE
SUNLOVE ABODE FOR INTELLECTUALLY INFIRMED LTD
Jalan Kayu Community Health Club
The Family Physician Clinic

Good health brought to you by:
CENTRAL HEALTH — Building Health Together With You
Jalan Kayu Community Health Club

CME & GP Events

1. GP Symposium: Updates on Gastrointestinal & Liver Diseases

Date & Time of Event	Organising Department	No. of CME Points Awarded	Registration Details
Saturday, 29 Apr 2023, 1.00pm – 4.30pm	Gastroenterology & Hepatology Dept @ Tan Tock Seng Hospital	2 CME Points (Subject to SMC approval)	**Venue:** Tan Tock Seng Hospital, Theatrette, Level 1 To register, please scan the QR code. For queries, contact: Chiang Han Fong 6357 7897 | Han_fong_chiang@ttsh.com.sg

2. Enhancing Recovery After Surgery – Safer Surgery, Stronger Recovery

The Perioperative Recovery Office will be organising a 3-day event from 25th to 27th May 2023 to raise awareness of the TTSH Enhanced Recovery After Surgery (ERAS)® programme. Held in conjunction with Global Surgery Day on 25 May, this event aims to highlight the importance of patients' health maintenance before and after surgery in order to recover better and faster.

The ERAS® Roadshow will be held at TTSH Atrium, and is open to the public.

To register, please scan the QR code or visit https://for.sg/w1qslz

See you there!

Day	Time	Programme	Venue
Thursday, 25 May 2023	All Day	ERAS® Roadshow	TTSH Atrium, Level 1
Friday, 26 May 2023	All Day	ERAS® Roadshow	TTSH Atrium, Level 1
	8.00am – 1.00pm	**Multidisciplinary Perioperative Care Forum** *Pending CME accreditation A half-day seminar involving Perioperative Care Teams from Public Healthcare Institutions & Primary Care Physicians. **Highlights** 1. Key aspects of perioperative care from public healthcare institutions 2. Primary Care perspective on caring for surgical patients	CHI Hall 1, Level 2
Saturday, 27 May 2023	All Day	ERAS® Roadshow	TTSH Atrium, Level 1
	9.00am – 12.00pm	ERAS® Public Forum Expert advice on staying fit and healthy for disease prevention and surgical recovery.	CHI Auditorium, Level 5

3. General Practitioner Workshop on Ophthalmology

Date & Time of Event	Organising Department	No. of CME Points Awarded	Registration Details
Saturday, 24 Jun 2023, 2.00pm – 3.30pm	NHG Eye Institute @ Tan Tock Seng Hospital	1 CME Point	Registration link: https://for.sg/dn9mgq Email: eye@ttsh.com.sg

The Paradigm Shift of Healthier SG

Adj A/Prof David Foo,
Clinical Lead, Primary Care,
Division for Central Health
Tan Tock Seng Hospital

"It is better to die than to fall ill in Singapore" – a street talk amongst Singapore residents. As one develops some form of chronic disease, a considerable amount of financial and socio-economic burden amplifies. Whilst medical research and technology have improved leaps and bounds to decrease mortality and morbidity downstream, it is timely to focus on upstream strategies to prevent or delay the onset of common chronic illnesses.

The main and central character in delivering such pre-emptive care is our trusted Family Doctor – a general practitioner who embraces primary care efforts to promote holistic health in our communities. Our family doctors are more than equipped with the tremendous breadth of knowledge in delivering care from cradle to grave. In our new paradigm shift in Healthier SG, our primary care physicians provide the residents with much needed coordinated care, in addition to strategising an appropriate and personalised health care plan for the enrolled and empowered individuals. Albeit this will take several years in the making, following through a preventive care plan to its potential will undoubtedly bend and reduce the chronic disease curve and burden.

This is an exciting and challenging way forward. Without our family doctors being the key to Healthier SG, this transformation cannot and will not happen.

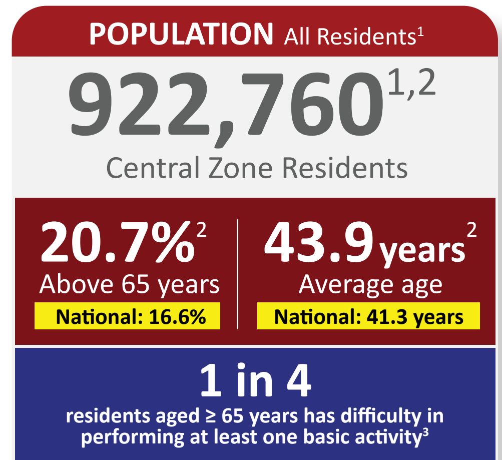
In the upcoming series of feature articles, we will be sharing more about the various ways Central Health will partner and provide support to GPs in Healthier SG. We will also illustrate how community partners can come together to form Communities of Care (CoC) with GPs.

We look forward to partnering our Family Doctors in this quest for a Healthier SG!

THROUGH THE NUMBERS: PAINTING A PICTURE OF CENTRAL ZONE

With the launch of Healthier SG in 2022, the Ministry of Health has emphasised the key role that family physicians play in delivering preventive care. Being a key priority for Central Health, the Primary Care Partners Office is committed to fostering close, long-term collaborations with our primary care partners. Through trusted and continuous relationships with their family physicians, we hope that Central residents will enjoy more years in good health.

While most are aware of Singapore's ageing population, this phenomenon is more pronounced in the Central zone. Around 922,700 residents live in the Central zone, which spans across seven subzones – Ang Mo Kio, Bishan, Geylang, Hougang, Kallang-Novena, Toa Payoh, and Serangoon – accounting for 23% of the total Singapore resident population. In 2022, more than 20% of the residents in Central zone were above 65 years old, which was higher than the national figure of 16.6%, while the average age of Central residents was 43.9 years, compared to the national average of 41.3 years.[1,2]



The residents' healthcare needs will continue to grow as the population ages. According to Census 2020, around one in four Central residents who are aged above 65, would encounter some difficulty in performing at least one of these basic activities - seeing, hearing, mobility, remembering, self-care, or communicating.[3]

While these statistics help us to understand the Central population's needs better, beyond these numbers are individual residents of whom we hope, with the support of their dedicated primary care physicians and their community, can be further activated to pursue better health.

The proportion of elderly residents living in Central Health is above the national average. Thus, Central Health and community partners such as GPs, hold important roles to play in providing our ageing population a supportive environment for active ageing.

References:

[1] Residents refer to Singaporean citizens and permanent residents, excluding foreigners

[2] Singapore Residents by Planning Area/Subzone, Age Group, Sex and Type of Dwelling, Department of Statistics, June 2022

[3] Singapore Census of Population 2020 Statistical Release 2: Households, Geographic Distribution, Transport and Difficulty in Basic Activities. Department of Statistics, Ministry of Trade and Industry

Back in Control:
"Red Flag Signs" for Emergency Care

Dr John Chua,
Consultant,
Emergency Medicine,
Tan Tock Seng Hospital

At the forefront of Community Health, GPs play an important role as the first point of contact to care for their patients' minor emergencies and triage for necessary ED interventions. One of the common minor emergencies frequently seen by GP includes the debilitating health problem of low back pain (also known as lumbago). Low back pain is the world's most common cause of absence from work, according to a 2020 study, and can affect people of all ages and background. GPs are able to diagnose and manage low back pain effectively, and assess when it is necessary to refer a patient to the Emergency Department (ED) for further evaluation and treatment.

Management of Low Back Pain: A Suggested Approach

The first step in managing low back pain is to perform a thorough evaluation of the patient's symptoms and medical history. This may include taking a detailed history of the patient's pain, physical examination, and imaging tests such as X-rays, MRI or CT scans. Once the diagnosis has been made, the GP should then determine the best course of treatment for the patient, which may involve a combination of non-pharmacological and pharmacological interventions. Referral to a spine specialist can also be considered.

Pharmacological treatments	Non-pharmacological treatments
Analgesia such as paracetamol, NSAIDs, or even opioids	Heat or ice therapy, use of a lumbar brace, exercise, and physical therapy

Recognising the "Red Flags": Specific Causes

In some cases, however, low back pain may be indicative of a more serious underlying condition that requires immediate medical attention. For example, low back pain can be a symptom of Spinal Cord Compression, which can cause paralysis or death if left untreated. Other serious conditions that may result in the common ailment include spinal fractures, tumours, infections, and abdominal aortic aneurysm.

Therefore, it is important for GPs to be able to recognise the signs and symptoms of these serious conditions, and to refer a patient to the ED for further evaluation and treatment. Some of these red flags include:

- Sudden, severe, or worsening pain in the lower back
- Numbness, tingling, or weakness in the legs or feet
- Loss of bladder or bowel control
- Difficulty standing or walking
- Unexplained loss of appetite/weight, or active/recent malignancy
- A fever or other signs of infection (e.g. pyelonephritis, history of IV drug abuse)

Treatment Approaches & Diagnostic Roadmaps for GPs in Central Health

Consider referring when a patient is experiencing persistent low back pain that is not responding to their prescribed treatments, as this may indicate a more serious underlying condition. Depending on the suspected underlying condition, the urgency of the referral will be determined, whether an immediate ED referral is warranted or if an appointment with a Spine Specialist clinic should be scheduled.

With the **GP*First* programme** for TTSH ED launching in July 2023, patients who have first consulted their GPs before being subsequently referred to ED will be entitled to a $50 rebate on their ED fee and be accorded higher priority to be seen in the ED.

TTSH ED also runs the **GP*Next* programme**, which allows patients with stable conditions to be discharged with a referral to GPs for further management, while given an open appointment date with the appropriate specialist clinic as a safety net. For patients seen in TTSH ED with benign causes of low back pain, they can be discharged via GP*Next* to their GPs and given an open date appointment with the Orthopaedic Spine clinic.

In conclusion, low back pain is a common presenting complaint that can have a significant impact on an individual's quality of life. Majority of these patients can be managed adequately by GPs although some patients with persistent stable symptoms may need a referral to a spine specialist. If red flags are present, a referral to the ED is advised.

To find out more about **GP*First* & GP*Next***, please contact **gp@ttsh.com.sg**

FEATURE

Managing CDMP Conditions – GPs and Specialists

Featuring Diabetes Mellitus (DM)

With Singapore's fast-ageing population, one in three individuals in Singapore is now at risk of developing diabetes,[1] one of the 23 conditions under the Chronic Disease Management Programme (CDMP).

Considering the criticality in lowering the diabetes burden, Ministry of Health declared a War on Diabetes (WoD) in April 2016, which called for a nationwide effort to jointly engage in community-based initiatives for diabetes prevention.[2]

RELIANCE ON THE ALLIANCE: TOWARDS CONNECTED CARE

To delve deeper into chronic disease management, we had an exchange with **Dr Timothy Quek Peng Lim, Head of Endocrinology at TTSH**, and his father – **Dr Quek Meng Poo, a General Practitioner (GP) at Premier Clinic & Surgery** to better understand the relationship and interaction between the two professions.

Senior Consultant & Head of Endocrinology, Tan Tock Seng Hospital (TTSH)

Dr Timothy Quek

Dr Quek Meng Poo

General Practitioner, Premier Clinic & Surgery

As a GP who treats common health concerns and an endocrinologist specialising in all-things diabetes, both field experts shed light on co-managing patients' conditions from the perspective of their differentiated roles in our healthcare system. Being in the heart of the neighbourhood, GPs remain as the first point of contact for most patients to seek medical advice. Opportunities for collaboration arise when GPs refer patients with less common subtypes of Diabetes Mellitus (DM) or poorly-controlled DM to the specialist.

While specialist referrals should be made whenever necessary for appropriate and timely care, chronic disease management continues to rely on patients' strong foundation of trust in their family doctors. DM, like many other chronic conditions, are best managed within the primary care setting where possible, to reduce patients' uncertainties. To optimise care access for patients with DM in the community, family doctors are further supported by nurse counsellors in Primary Care Networks (PCN) and the multi-disciplinary Community Health Teams (CHT) at TTSH.

STEPS IN THE RIGHT DIRECTION

> *"Due to the increase in publicity on screening and health management, more patients have come to us for screening under Screen For Life (SFL)."*
>
> *– Dr Quek Meng Poo*

Generally, most patients with diabetes are well-managed at primary care settings. However, the occurrence of an acute health event, or a sudden or major life change may trigger episodes of poor control of their diabetes. Such patients may then require timely and targeted referrals to specialist care and intervention to help manage their condition. Once these patients are stabilised, they can then be transferred back to their family physicians for continued follow-up.

Unlike most acute medical cases which can be treated with a single course of treatment, management of diabetes mellitus is a journey that is undertaken between the patient and the healthcare team. Hence, a good rapport between the patient and his/her primary care physician is essential.

Regular screening allows for early detection and prompt treatment of chronic conditions. Individuals with symptoms or risk factors for DM, should consult their family doctor to be screened for DM. If diagnosed with DM, it is crucial to make adjustments to one's diet and lifestyle, take appropriate medications, and undergo regular screening for eye, foot and renal complications.

TAKING ON DIABETES IN A NEW LANDSCAPE

As dedicated, longitudinal care advocates, GPs play a vital role in the communities' chronic care needs, including motivating their lifestyle and behaviour adjustments, while specialists' input and expertise are invaluable in scenarios requiring "stepped up" care for the patient, who will benefit greatly from education, consultation, and supervision at the specialist level. Together, GPs and specialists' effective co-management of patients is key to improving outcomes for those with chronic conditions.

Aligning with the move towards Healthier SG, TTSH's CHT offers a one-stop service, with a network of allied healthcare professionals and community partners. As part of the extended care team, these individuals provide personalised medical services, including health checks, nursing care, medication advice and many other resources that boost the patients' **well-being across the care spectrum.**

HAVE A PATIENT WHO REQUIRES FOLLOW-UP INTERVENTION?

You may refer suitable patients to TTSH's CHTs for diabetes care interventions at: https://for.sg/referttshcht

Flip to page 18 to discover Central Health Support for GPs, and page 20 for an overview of services at Ang Mo Kio Specialist Centre!

References:
[1] Ministry of Health, 2021. *Speech by Mr Ong Ye Kung, Minister For Health, At World Diabetes Day 2021.*
[2] Ministry of Health, War On Diabetes, https://www.moh.gov.sg/wodcj

Towards a Healthier Singapore:

Relationship at the Centre of Care

Adj Asst Prof Jerome Goh,
Clinical Director, Division for Central Health
Tan Tock Seng Hospital

Healthier SG enables every resident to be connected with a family physician. Through this unique relationship built on trust and familiarity, a health plan is developed and tailored to meet the residents' health goals, based on their clinical needs and **what matters to the resident**.

Our ageing population would see more chronic and complex illnesses, requiring a slew of interventions to strengthen the biological, psychological and social aspects of care. TTSH and Central Health, alongside our community partners in each neighbourhood, will support our General Practitioners by bringing together primary care providers and making a wider suite of services accessible, so that the delivery of care can be comprehensive and connected.

Social prescribing, where healthcare professionals refer patients for non-medical interventions and support in the community, can improve health outcomes. However, some patients may face challenges adhering to medications prescribed, or lifestyle changes that are important in managing their chronic illnesses optimally.

Addressing treatment readiness using personalised motivational interviewing approaches make it more likely for residents to adhere to their health plans, for example, through evoking reasons for a change, determining the best change for them, setting short term behavioural goals, or skills building.

You could also adopt a 'What Matters To You' conversation methodology with the residents, to find out what really matters to them, to motivate their behavioural change. Community health teams, comprising nurses, therapists and health coaches, could also assist GPs in ensuring residents stay healthy and age well in their communities.

Flip to Page 22 for a rundown of the Central Health services & resources available!

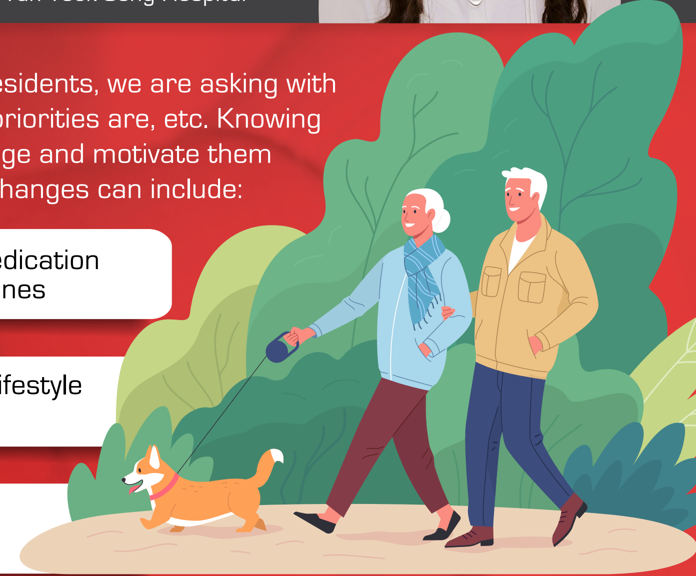
What Matters

to the Residents instead of 'What is the matter with them?'

Dr Huang Wanping,
Principal Psychologist
Head, Department of Psychology
Tan Tock Seng Hospital

By having a 'what matters' conversation with the residents, we are asking with intent to find out what they care about, what their priorities are, etc. Knowing what really matters to our residents, helps us engage and motivate them towards positive behavioural change. Behavioural changes can include:

1. Replacing unhelpful behaviours (such as medication or treatment non-compliance) with helpful ones
2. Shoring up protective factors (e.g., healthy lifestyle habits, regular exercise and balanced diet)
3. Equipping with skills and knowledge to cope well with problems



Ultimately, we aim to align behaviours with what matters. This is how we operationalise person-centred care:

First, we make an effort to understand what matters to our patients, prioritise what they value, engage them to work collaboratively on outcomes that matter most to them. They guide us on how we can tailor our interventions to help them achieve what matters to them. To kick-start a What Matters conversation, we may ask, **"Can you please share with me, at this stage in your life right now, what are your priorities? What's important to you?"** Common responses from our seniors may include, "being independent", "not being a burden to my family", "my relationships with loved ones...".

Next, we connect the dots and let them know that staying healthy equates to being able to achieve all that. With health, they can be independent, continue to do the things they enjoy and spend time fruitfully with loved ones.

After eliciting What Matters, to help translate words into actions, we ask, "**What needs to happen, what can you do now (through choices and actions) to achieve what matters to you?**". This may involve taking small but important steps, such as taking medication as prescribed daily to keep chronic diseases under control, so as to stay healthy and get to enjoy the things that matter to them. Some patients may require customised information, such as applying the principle that humans are loss-averse, to understand the full impact of non-compliance - deterioration of health, potential hospitalisation, deconditioning, needing a caregiver, perhaps even nursing home placement should their family not be able to manage, which is the opposite of what matters to them.

The key ingredient necessary for success is good rapport, hence relationship-based care underlies what we do. To sum up, our care encounters start with an intentional conversation to find out what matters to our patients, so as to effectively engage and motivate them towards positive behaviour change, to achieve what truly matters and enable them to live and age well in place.

Interested to learn more about the 'What Matters' conversation? Email **gp@ttsh.com.sg** to indicate your interest.

FEATURE

Supporting a Healthier SG through

Communities of Care

As part of Healthier SG, residents are encouraged to enroll with a family doctor to work together in partnership on a health plan that helps improve and care for residents' health in the long term. To provide the appropriate support for residents with more complex needs, this care relationship is further supported by a network of partners, comprising of TTSH Community Health Teams (CHT) and other health and social care providers such as Active Ageing Centres, day rehabilitation centres, home care partners, the Silver Generation Office, grassroots and social service offices, as part of a Community of Care (CoC)*.

A REWARDING COLLABORATION BETWEEN PARTNERS: A CASE ILLUSTRATION

Dr James, a General Practitioner practising in Aljunied, has been regularly managing Mr Wong's chronic conditions. Noting that Mr Wong lives alone with only a helper and had poorly-controlled blood pressure, Dr James submitted a referral to TTSH CHT to review Mr Wong's care at home.

With inputs from Dr James, TTSH CHT co-developed a plan to oversee Mr Wong's adherence in taking his medication, guided his helper to monitor Mr Wong's blood pressure and coordinated a referral to Harmony Active Ageing Centre. Located conveniently near his home, Mr Wong participates regularly in Harmony Active Ageing Centre's active ageing programmes such as morning exercises and group outings, which keeps him socially and physically engaged.

Today, Mr Wong's blood pressure is better controlled. He continues to be supported by the network of CoC partners, alongside Dr James who regularly monitors and manages his health.

Fellow GPs can also connect with partners like TTSH CHT and Harmony Active Ageing Centre to help follow through on patients' health plans. In this instance, the multi-disciplinary team supported Dr James in following through on Mr Wong's condition and encouraging Mr Wong to lead a healthier lifestyle.

**CoC refers to Central Health's place-based care model which brings together a network of partners to actualise community-based care.*

Refer your patient to TTSH CHT at:
https://for.sg/referttshcht

For more details and how you can get connected to a CoC in your neighbourhood, kindly contact us at **gp@ttsh.com.sg**

Central Health Support for GPs

With Healthier SG, GPs have an expanded role in helping residents take charge of their health and eventually become the first point of contact for residents and oversee their healthcare. Central Health aims to build and expand the following services and resources that will support GPs to fulfil their role as residents' primary care provider.

Pharmacy Support Hotline

TTSH Pharmacists provide support to Central Health GPs for drug advice such as drug interactions, dosing for renal- or liver-impaired patients.

Call or **WhatsApp 9820 8387**
9am to 5pm
(Mon – Fri,
except public holidays)

Relationship Managers

Your dedicated Relationship Managers (RM) will be your point of contact for queries relating to Healthier SG, Primary Care Network, Communities of Care and referrals to TTSH and Central Health residents' to support you in caring for your patients.

Know your Central Health RMs from the TTSH Primary Care Partners Office:

WhatsApp us at **9727 1081** or email **gp@ttsh.com.sg**

Jeslyn Woon

Lynn Lee

Evelyn Tan

Vanessa Leong

Community Health Teams (CHT)

Multi-disciplinary teams providing interventions and case management/coordination including:

- Lifestyle programmes
- Health coaching
- Stabilisation of clinical needs
- Coordination of health and social care support services

Scan QR code or visit **https://for.sg/referttshcht** to refer.

Community of Care (CoC)

A network of health and social service providers to coordinate and collaborate care for residents living within neighbourhoods in Central Health.

Contact **gp@ttsh.com.sg** for collaboration opportunities.

Coordinating Advisory Care Team (CoACT)

Clinical advisory group comprising a team of specialists across clinical disciplines to enable bilateral communications and collaboration between hospital specialists and GPs.

Contact us at **gp@ttsh.com.sg**.

Health Kampung

Resource for social, health and lifestyle activities in the neighbourhood.

***Coming soon**

Advance Care Planning (ACP)

Help your patients make care plans in the event that they are seriously ill and unable to make decisions for themselves. ACP discussions allow your patients to voice out their personal care preferences and reduce unnecessary stress for their loved ones while making critical decisions in times of crisis.

To refer your patient for ACP conversations, email **acp@ttsh.com.sg** or call **6359 6411/6410**.

Visit **https://for.sg/ttshacp** for more information.

Overview of Services at Ang Mo Kio Specialist Centre

Ang Mo Kio Specialist Centre is located at 723 Ang Mo Kio Ave 8, Singapore 560723

Refer to the 3-step referral process at back cover or scan QR code for more details on the full services. See CHAS column for the CHAS-subsidised services.

Care Model	Services provided	CHAS
Community Audiology	Services include: • Hearing Diagnostic Package (Otoscopy Image, Audiogram and Audiologist Report) • Audiogram • Tympanogram • Acoustic Reflex Test • Hearing Aid Evaluation and Fitting (if indicated and when required) • Senior Mobility and Enabling Fund (SMF) for hearing aid purchase (if Household Means Testing (HHMT) and assess-ment criteria are fulfilled)	• Direct GP referrals for audiology services will be non-subsidised for the time being
Trans-disciplinary Diabetes Care	• Diabetic Eye Screening • Diabetic Foot Screening and Podiatry Services • Physiotherapy and Exercise education • Diabetes Clinical Educator Services (Diabetes Nurse/ Pharmacist/Dietician) • Specialist Endocrinology Consult Services	• CHAS referral only for Specialist Endocrinology Consult Services • Direct GP referrals for other ancillary services will be non-subsidised for the time being
Integrated Musculoskeletal Care	**Occupational Therapy:** Hand/wrist osteoarthritis, e.g. education, splint provision and treatment of common hand/wrist/elbow repetitive strain injury, such as trigger digits, carpal tunnel, De Quervain's tenovaginitis, wrist pain, and osteoarthritis hands **Physiotherapy:** Rehabilitation of common musculoskeletal pain/injuries, e.g. ankle sprain, osteoarthritis knee (OA knee), Plantar fasciitis, mechanical neck/back pain, etc.	• CHAS referrals to Allied Health Professionals will be eligible for outpatient subsidies for selected musculoskeletal conditions • Direct referrals to PT and OT
Community Eye Clinic	EYE@AMKSC provides services for concerns including: blurring of vision of four weeks or more, persistent redness of the eyes, which may be coupled with mild pain or ocular discomfort, glaucoma suspects with screening evidence of glaucoma	• CHAS Subsidised

TTSH-GP Partnership Programmes

Encompassing full-spectrum care from preventive to chronic care, Healthier SG will see the family doctor co-create a health plan with the resident, and offer medical expertise through recommended lifestyle adjustments that take residents' health goals into consideration.

Anchoring the Healthier SG framework, Central Health-GP Partnership Programmes will actionise the overarching vision of 'One Singaporean, One Family Doctor' through diverting patients to their enrolled GP – to ensure that suitable care is delivered to residents while working towards stronger awareness of timely preventive care, to enable both early interventions, as well as the appropriate transition of care from acute and specialist care, back into the community.

Preventive Care Programmes

Screen for Life (SFL)

To promote cardiovascular and cancer screening in residents, TTSH-Central Health is collaborating with Community Partners, Health Promotion Board (HPB) and GP Partners to direct residents to do screening and chronic care follow-up at the clinic.

GP Partners can come on board the Open Government Products (OGP) Health Appointment System* to manage patients' Screen for Life appointments and post-screening reviews.

*The Health Appointment System (HAS), powered by Open Government Products, links residents with GP clinics to facilitate higher rates of preventive care appointments, such as health screenings and vaccinations.

Acute & Chronic Care Programmes

GPFirst (Pre-Emergency Care)

Patients are triaged by General Practitioners (GPs), and patients with conditions requiring further care are appropriately diverted to TTSH Emergency Department (ED).

GPNext (Post-Emergency Care)

Patients with minor or low-acuity conditions are appropriately transited from TTSH Emergency Department (ED) to GPs for follow-up review and care.

CRiSP* Total Discharge

Patients with stable, chronic conditions are discharged from Specialist Outpatient Clinics (SOCs) for continual follow-up at GPs.

CRiSP* Shared Care

Patients under Shared Care are co-managed between TTSH Specialists and GP Partners, after a shared consensus as:
• Single disease track, or
• Primary condition managed by specialist; stable secondary condition managed by primary care

*Community Right-Siting Programme (CRiSP)

During the course of residents' care, family doctors may also tap on these services with the residents' health condition in mind:

A. Use Central Health's e-referral system^ to refer patients to specialist hospital services

B. Refer to Tan Tock Seng Hospital's Community Health Teams (CHT) for health and social service: **https://for.sg/referttshCHT** (Scan the QR Code)

C. Encourage patients to sign-up for programmes via the Health Kampung^ in the NHG Health mobile app

D. With GPs' recommendations, patients can attend activities and receive health and social support at Active Ageing Centres (AACs) near them

^ Coming soon in Q3 2023.

FOR MORE INFORMATION

To find out more about our partnership programmes, please contact TTSH Primary Care Partners Office (PCPO) at gp@ttsh.com.sg.

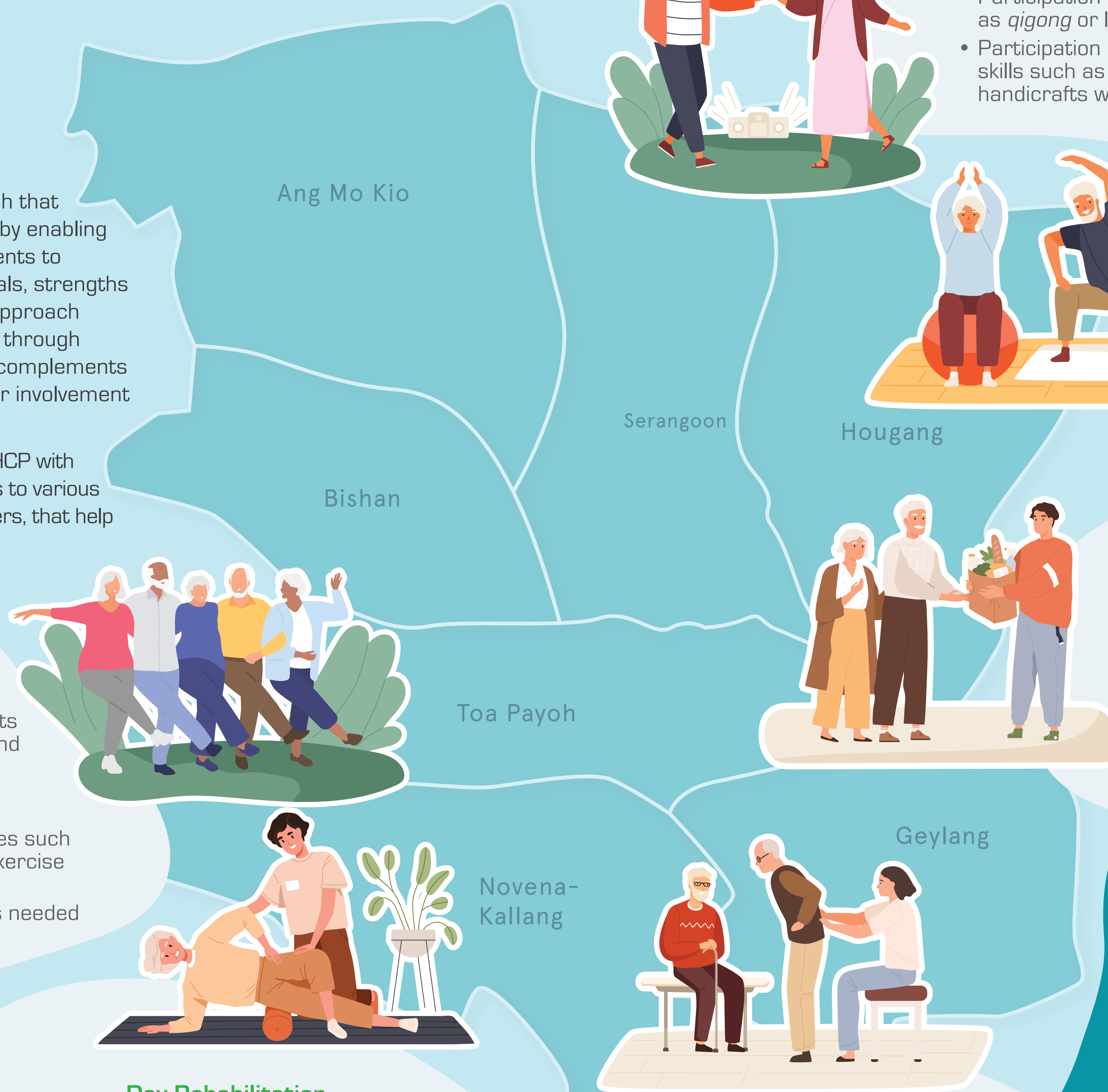
Social Prescribing to Support a

Healthier SG in Central Health

What can I Social Prescribe to residents?

Social prescribing is a holistic healthcare approach that bridges the gap between medical and social care by enabling healthcare professionals (HCPs) in connecting clients to programmes chosen based on their interests, goals, strengths and location within their local communities. This approach aims to empower clients in improving their health through participation in meaningful activities that not just complements their clinical treatments but also strengthens their involvement and connection in their community.

Based on the health/care plan co-developed by the HCP with the patients, the HCP could "social prescribe" clients to various activities, offered across different community partners, that help sustain and enhance the overall health plan.



Active Ageing Centres (AACs)

Drop-in centres that serve as go-to-points for seniors to build social connections and take part in recreational activities

Examples of Activities/Services:

- Participation in Active Ageing Programmes such as karaoke, arts and craft, cooking and exercise programmes
- Befriending services for social support as needed
- Information on schemes, grants and support

Day Rehabilitation Centres (DRCs)

Centres providing therapy for patients with conditions that have affected their ability to do everyday things like walking around or going to the bathroom

Examples of Activities/Services:

- Rehabilitative services aimed at regaining function such as physiotherapy

Community Centres/ Community Clubs

Centres run by the People's Association that provide common spaces for gathering and social bonding

Examples of Activities/Services:

- Participation in interest groups such as *qigong* or line dancing
- Participation in courses to learn new skills such as cooking workshop or handicrafts workshops

ActiveSG Facilities and Active Health Labs

Sports and gym facilities

Examples of Activities/Services:

- Self-directed sports / exercise activities
- Guided fitness and health assessments and workshops focusing on moving better, eating better and resting better

Family Service Centres

Community-based social services that provide support for low-income and/or vulnerable individuals and families with social and emotional issues

Examples of Activities/Services:

- Case management and coordination of holistic support by Social Work Practitioners for clients to help them achieve stability, self-reliance and social mobility

Community Health Team

Multi-disciplinary care team support for health engagement, care coordination and ageing in place

Examples of Activities/Services:

- Health Coaching
- Occupational Therapy
- Community Nurse

To support GPs in social prescribing, the role of a Community Care Integrator (C2i) has been established within the TTSH Community Health Teams (CHT). A C2i may help to facilitate engagements with clients referred by GPs to better understand What Matters to them and help to recommend and navigate the available local community programmes to complement their medical treatment.

Get in touch with and partner our CHTs to build a healthier, happier community today!

To find your nearest community partner, please scan the QR code

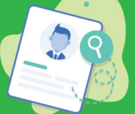
3 Steps for referring patients to Ang Mo Kio Specialist Clinic

Here's a comprehensive chart listing the steps to refer **non-subsidised patients and patients under the Community Health Assist Scheme (CHAS)** to Ang Mo Kio Specialist Centre (AMKSC).

Step 1 PREPARE

Before You Contact AMKSC

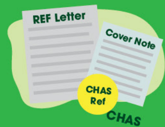
1. Get patient's full name, NRIC, date of birth and contact number.



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

Appointment Hotline AMKSC: 6554 6500

1. Advise which clinic you are referring your patient to

2. **For CHAS/ non-subsidised referrals**
Email referral documents to AMK_Specialist_Centre@ttsh.com.sg**

Step 3 INFORM

Inform patient after confirming appointment details*

1. Inform patient of AMKSC's address (723 Ang Mo Kio Ave 8 Singapore 560723), date and time of appointment.

2. Remind patient to bring all necessary documents for their appointment.

*To ensure that your patients are seen promptly at AMKSC, 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.