Tan Tock Seng HOSPITAL
National Healthcare Group

A PUBLICATION FOR PRIMARY CARE PHYSICIANS

GP BUZZ

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JANUARY-JUNE 2021

ORGANISING PREVENTIVE CARE

MOTIVATING PATIENTS IN THE BATTLE AGAINST DIABETES

CARDIOVASCULAR PREVENTION: FACING THE DIREST CONSEQUENCES

SUPPORTING GPS WITH CENTRAL HEALTH'S HEALTH COACHES

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JANUARY - JUNE 2021

About the Cover Page:

PREVENTIVE CARE: GETTING MORE ORGANISED

By **Dr Wong Chia Siong**,
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Tan Tock Seng Hospital

Dr Eng Soo Kiang,
Clinical Lead,
Central North Primary Care Network

Broadly, preventive care refers to the scope of activities intended to reduce disease occurrence among patients. These activities include risk assessment, screening, vaccinations and lifestyle interventions.

Currently, preventive care is mostly delivered in an opportunistic and fragmented manner. Typically, the physician tries to find an opportunity to bring up preventive care during a medical consultation. There is therefore limited risk assessment guideline present for preventive care, and the risk-benefit of screening or interventions are usually not discussed. Multiple providers now offer health screening packages. While the results may be discussed with the patient, the screening results may not be returned to the primary care physician for entry into the medical record or for further intervention.

The approach to preventive care should be better organised to feature proactivity and personalisation. For example, residents can be scheduled to attend dedicated preventive care visits where validated assessment tools are used to measure and communicate risk. The physician can then refer eligible residents for community-based intervention, such as smoking cessation or physical activity programmes. These preventive care visits can be enabled by a data registry that helps track, schedule, and evaluate care activities.

Currently, the National Health Service (NHS) in the UK has implemented a Health Check programme that is anchored by their General Practitioners (GP). Residents aged 40 to 74 are invited to undergo regular screening to identify those with chronic diseases and risk factors. The screening is accompanied by structured risk assessment and a set of recommended interventions. The health checks are free for residents, GPs are reimbursed for health checks, and there is a data platform to support scheduling, data sharing, and systematic implementation of health checks. There are definitely learning points in this programme that we can adopt locally.

Primary care provides holistic, continuous, and relationship-based care to residents, and is thus a key setting to deliver preventive care. In this issue of GPBUZZ, we highlight some of Central Health's preventive care activities. These include our screening programmes, which remain a key preventive care tool through early disease detection, as well as structured programmes in the community that targets weight management and frailty prevention. We welcome collaborations and look forward to partnering with you in this very important area of care. GPBUZZ

ANCHORING PRIMARY CARE IN THE COMMUNITY WITH ANG MO KIO SPECIALIST CENTRE

Amidst safe-distancing and proper contact-tracing protocols, TTSH welcomed General Practitioners (GPs) across Central Zone for three Continual Medical Education (CME) sessions conducted at our new care site, Ang Mo Kio Specialist Centre (AMKSC). The CME – 'Anchoring Primary Care in the Community with Ang Mo Kio Specialist Centre' – covered topics on developing holistic and shared care models with GPs in the community.

The topics discussed include:

- Applying a biopsychosocial model to care for the community with the Community Health Team (CHT)
- Enhancing Diabetes Mellitus (DM) care in the community through a trans-disciplinary approach on medication, nutrition, podiatry and nurse education
- Managing common musculoskeletal conditions such as osteoarthritis knee and lower back pain within the primary care setting
- Anchoring eye care with GPs

Principal Occupational Therapist, Ms Janis Yeo, demonstrating devices such as wrist brace and splint used during patient's treatment at the iMSK care clinic at AMKSC.

Dr Vivien Yip, Consultant from the Department of Ophthalmology, explains to GPs the types of eye assessments conducted at AMKSC.

Following the CME, GPs were brought around AMKSC on a guided tour of the centre's facilities. This tour aimed to introduce new services at the centre that GPs can have direct access to. As AMKSC provides allied health support, GPs remain to be the primary provider of healthcare for their patients.

GP referred services available at AMKSC	Subsidised (CHAS)	Non-Subsidised
Pharmacy • Medication Review • Smoking Cessation	✓	✓
Community Eye Clinic • Consultation with Optometrist	✓	✓
Diabetes Mellitus • Consultation with Endocrinology Specialist	✓	To refer, email referrals@ttsh.com.sg
Physiotherapist or Occupational Therapist Session for the following conditions: • De Quervain's Tenosynovitis • Carpal Tunnel Syndrome • Trigger Finger/Thumb • Non-specific Lower Back Pain • Osteoarthritis Knee	✓	✓
Endoscopy • Colonoscopy • Gastroscopy		✓

With these services, AMKSC serves to support primary care in the community and take care of patients together with the GPs. GPBUZZ

FOR DIRECT REFERRALS TO SERVICES AT AMKSC

Step 1: Call the appointment line: 6554 6500

Step 2: Email your referral documents with CHAS referral form to: AMK_Specialist_Centre@ttsh.com.sg

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

Take Charge of Your Patients' Health

One of the core values of preventive care is to take care of one's health even when one is healthy and one such way is through health screenings. Health screenings allow residents to gain a better understanding and awareness of their health, even if the resident feels healthy. They allow for the early detection of illnesses and make timely treatment possible.

We all know how important health screenings are. However, taking care of one's health should not stop there. Going a step beyond screening is to follow up with more healthy activities upon receiving the results of the screening.

Enter the Campaign on Chronic Disease Screening & Follow-up Care in the Neighbourhood. In this upcoming campaign, Tan Tock Seng Hospital's (TTSH) Community Health Teams (CHT) collaborated with Health Promotion Board's (HPB) Screen for Life (SFL) to help residents access chronic disease screening with their preferred neighbourhood GP clinic. Following the screening is a management of residents' health through regular follow-ups and advice on lifestyle changes.

As part of TTSH's continuing care for the residents, the teams are set on supporting GPs and helping the community lead a healthier lifestyle through early detection and prevention of chronic diseases. GPBUZZ

SUPPORT US IN ADDING YEARS OF HEALTHY LIFE

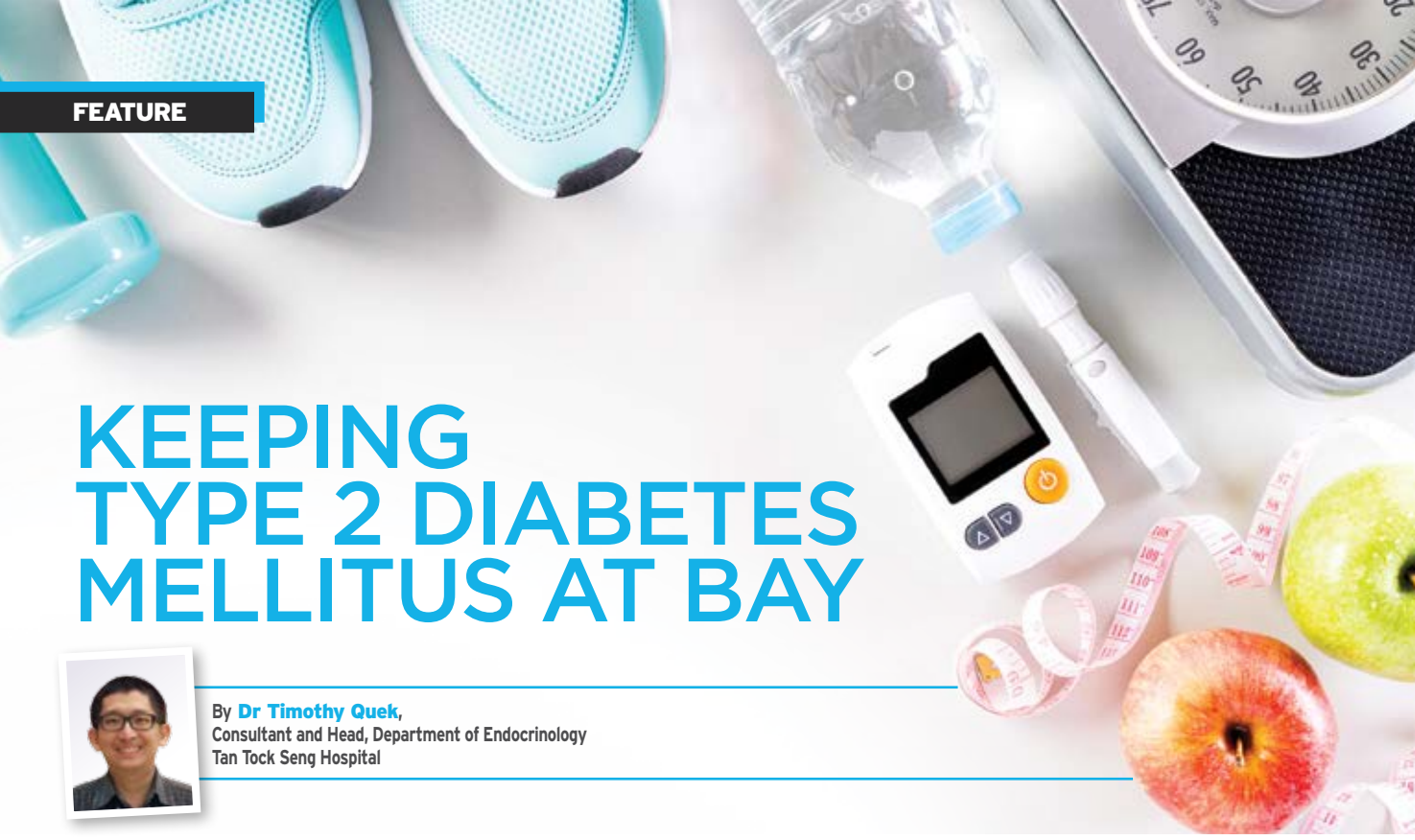
Campaign on chronic illness screenings and follow-up care will be implemented in the following regions:

If your clinic is located in any of these locations and you would like to find out more about how you can play a role in this campaign, email gp@ttsh.com.sg.

CME (JANUARY – JUNE 2021)

TITLE	CME POINTS	DATE	TIME	VENUE	REGISTRATION DETAILS
GP Webinar Workshop by NHG Eye Institute	2 CME Points	19 June 2021, Saturday	2.00pm to 4.00pm	Online webinar	**For further enquries or registration, email us at eye@ttsh.com.sg**

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



KEEPING TYPE 2 DIABETES MELLITUS AT BAY

By **Dr Timothy Quek**,
Consultant and Head, Department of Endocrinology
Tan Tock Seng Hospital

In Singapore, more than 1 in 8 adults suffer from Diabetes Mellitus[1], and prevention of Type 2 DM (T2DM) is one of the main thrusts of the strategic framework to combat diabetes in our local population.

There are many risk factors for T2DM, including non-modifiable risk factors such as age and family history; as well as modifiable risk factors like high body fat percentage, sedentary lifestyle, and unhealthy dietary habits rich in refined grains, sugar-sweetened beverages and red / processed meat[2].

Despite the many risk factors, intervention trials have indicated that preserving normal glucose levels in patients at high risk of T2DM is achievable[3] through lifestyle interventions, medications and metabolic surgery[4].

Lifestyle Interventions: Lifestyle interventions include changes to diet and physical activity to achieve and maintain body fat reduction and body weight. These have been shown to reduce the incidence of T2DM in several randomised controlled trials, with the effect persisting over long-term follow-up[5-7].

Medications: Among pharmacological interventions, metformin is well-known and effective, particularly in younger and obese populations, although less effective than lifestyle interventions[7-8]. Other pharmacological interventions that have been studied include pioglitazone and acarbose[4].

Metabolic surgery: Metabolic (or bariatric) surgery has also been shown to greatly reduce the incidence of T2DM among obese subjects[9], and is an important option to induce weight loss, particularly in the very obese.

Although a significant proportion of T2DM is preventable, initiating and maintaining these interventions can be difficult. These interventions require trust between doctor and patient, and an in-depth knowledge of the family and social set-up.

The family physician is therefore well placed to initiate preventive strategies for patients and families at high risk of T2DM, as members from the same household often develop a deep relationship with the same physician for many years. GPBUZZ

The Department of Endocrinology in TTSH also provides services as a one-stop facility for Diabetes Mellitus (DM) care. To refer your patients, please email referrals@ttsh.com.sg.

Reference:
1. International Diabetes Federation (Ed.). IDF Diabetes Atlas. 8th ed. Brussels, Belgium, International Diabetes Federation, 2017.
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6. Li G, Zhang P, Wang J, et al. Cardiovascular mortality, all-cause mortality, and diabetes incidence after lifestyle intervention for people with impaired glucose tolerance in the Da Qing Diabetes Prevention Study: a 23-year follow-up study. Lancet Diabetes Endocrinol. 2014 Jun;2(6):474-80. doi: 10.1016/S2213-8587(14)70057-9.
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MOTIVATING PATIENTS TO BETTER THEMSELVES IN THE BATTLE AGAINST DIABETES

By **Melissa Ho**,
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Department of Nutrition and Dietetics,
Tan Tock Seng Hospital

By **Rethinam Ganesan**,
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Department of Physiotherapy,
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Patients need to adopt a healthier lifestyle to prevent the onset of diabetes, manage diabetes and/or metabolic syndrome. However, many patients struggle with making diet and exercise changes as this usually requires modifying their lifelong habits.

Adopting a fear strategy to warn residents about the consequences of poor lifestyle choices may result in resistance or avoidance to change. Patients need to be equipped with the right strategies and resources to initiate the lifestyle change they need. Therefore, a professional should consider techniques such as affirmation, reflective listening and asking of open-ended questions. These techniques will help to enhance a patient's confidence, develop coping strategies and encourage self-management of their condition.

Studies have shown that a lifestyle intervention comprising of both an exercise regime and dietary changes is paramount to enhance outcomes of prevention and management of diabetes.

Behavioural change techniques include addressing **capabilities(C)**, providing **opportunities(O)** or initiating **motivation(M)** to facilitate change. It is important to identify which stage of change a patient falls under to engage in meaningful conversation. The strategies explained in the next page could be used interchangeably for the various stages of change depending on patient's needs.

In summary, it is important for patients to realise that they are on a lifelong journey of prevention and management of diabetes. This requires healthcare professionals to provide their patients with the adequate skills and knowledge to ensure achievable and sustainable change to improve their well-being. GPBUZZ

STAGES OF CHANGE IN DIETARY AND EXERCISE BEHAVIOURS

STAGE OF CHANGE	DIETARY BEHAVIOURS	EXERCISE BEHAVIOURS
(Pre)contemplation and preparation	• Explain the benefits of keeping an ideal body weight and making dietary changes (**M**) • Identify causal factors that pose challenges to healthy eating (**O**,**M**) • Recognise motivation factors that support dietary changes (**O**,**M**)	• Explain the benefits of exercise (**M**) • Identify barriers to the uptake of an exercise programme (**O**,**M**) • Identify and recognise motivational factors to support adaptation of an exercise programme (**O**,**M**)
Action and maintenance	• Provide education on healthy dieting (**C**) • Discuss available healthier options to choose when eating out (**C**,**O**) • Explain healthier cooking methods and strategies (**C**,**O**) • Identify suitable and convenient dietary alternatives to lower calories, fat, cholesterol and improve post-prandial hyperglycaemia (**C**,**O**) • Plan and agree on specific, achievable dietary changes with meal plans (**C**,**O**,**M**)	• Provide knowledge on the different exercises one can consider as part of an exercise regime (**C**) • Impart knowledge on the strategies to avoid hypoglycaemia during and post exercise (**C**) • Plan and agree on specific and attainable goals for exercise (**C**,**O**,**M**) • Devise an exercise regime to ensure compliance and sustainability (**C**,**O**,**M**)
Relapse (Remember to acknowledge efforts to empathise with patient rather than reprimand)	• Encourage self-monitoring strategies like regular weight tests, and tracking food intake with blood sugar diaries that builds self-efficacy (**C**,**O**) • Provide more support with suitable apps, lifestyle programmes, technology and relevant referrals (**C**,**O**) • Involve family members in meal planning (**C**,**O**,**M**) • Celebrate the success of newly established healthy eating habits (**C**,**M**)	• Provide adequate support through the use of technology and social system (**O**,**M**) • Encourage self-monitoring strategies such as heart rate and weight monitoring to ensure target exercise gains are achieved (**C**,**O**,**M**) • Celebrate the success of newly established exercise habits (**M**)

C: Capabilities **O**: Opportunities **M**: Motivation

EMPOWERING SENIORS TO BE STEADY LAH!

By **Chng Pey Ling**,
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Tan Tock Seng Hospital

By **Lim Biyu**,
Senior Physiotherapist, Department of Physiotherapy,
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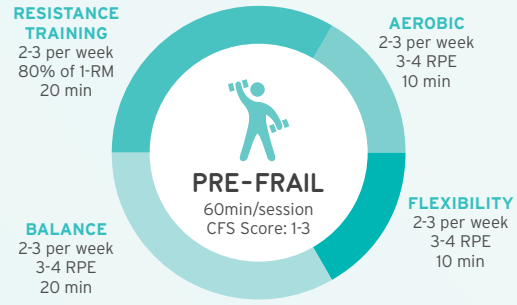
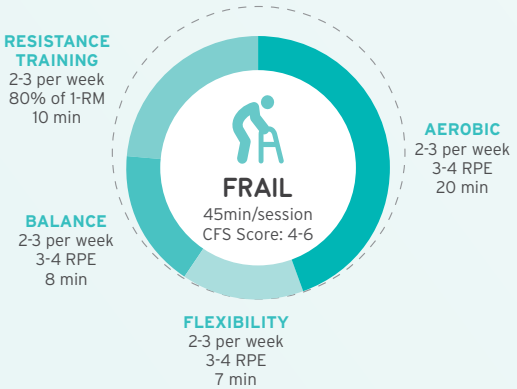
Frailty is a state of increased vulnerability with limited reserve capacity within the individual's major organ systems. This leads to reduced capability to withstand stress such as trauma or disease, which increases the risk of dependence and disability[1]. In the primary care practice setting, you may assess your patient's frailty status with the Clinical Frailty Scale (CFS)[2] (right).

Frailty is bi-directional: with appropriate intervention, it can be reversed[3]. This is especially so when the patient has a low CFS score of 1 to 4. At this stage, the role of GPs is crucial in managing and guiding their patients to improve their CFS score. Such appropriate intervention includes exercise and nutrition.

Current exercise guidelines to reverse frailty recommend a combination of aerobic, resistance, balance, and flexibility exercises[4]. The following pie charts further exemplify these recommendations:





CLINICAL FRAILTY SCALE

1 VERY FIT
People who are robust, **active**, motivated, **exercise regularly** and are among the fittest for their age.

2 FIT
People **without active diseases** but are not as fit as those in category 1.

3 MANAGING WELL
People with **well controlled symptoms** but are not regularly active.

4 VERY MILDLY FRAIL
People who are not dependent but have **symptoms** that limit activities.

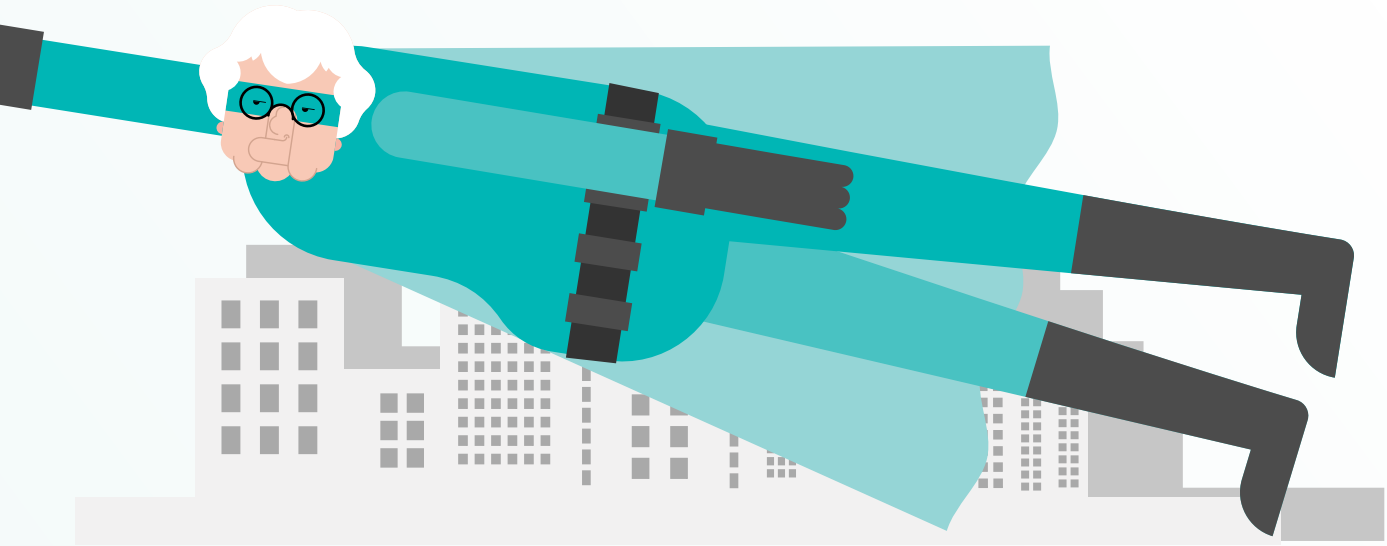
5 MILDLY FRAIL
People who require help with **High Order IDALs**.

6 MODERATELY FRAIL
People who require **assistance** for **all living activities**.

7 SEVERELY FRAIL
People who are **completely dependent** on others for **all aspects of living**.

8 VERY SEVERELY FRAIL
People who are **completely dependent** and approaching **end of life**.

9 TERMINALLY ILL
People who are approaching **end of life** with a **life expectancy** of less than 6 months.



Adequate protein intake also plays an important role in preserving lean muscle mass, which is essential in managing frailty. It is recommended, where possible, to consume 25-30g of good quality protein in one main meal to optimise muscle protein synthesis. Some examples to achieve 25-30g good quality protein in one meal include:

1 bowl of sliced fish soup noodle + 1 egg

1 plate of rice with vegetables and fish + 1 cup of low-fat milk or low-sugar soy milk

Inadequate energy and protein intake can lead to unintentional weight loss and loss of muscle mass and strength, which may in turn result in poor physical function, exhaustion and reduced physical activity. These are all important determinants of physical frailty.

Having your patients participate in programmes specifically designed for frailty will help to slow down or reverse frailty in a structured and targeted manner. Therefore, TTSH's Central Health has designed a community programme, "Steady Lah", for two different groups of older adults. "Steady Lah" Level 1 targets older adults with CFS score of 1 to 3 while Level 2 targets older adults with CFS score of 4 to 6. The programme's key areas of focus include:

- Increasing physical fitness through practice of strengthening and balance-specific exercises,
- promoting adequate nutrition intake for stronger muscle and bones through practical nutrition tips, and
- promoting self-management strategies through personalised goal-setting. GPBUZZ

Scan this QR code to register your patients for the "Steady Lah!" programme!

Reference:
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CARDIOVASCULAR PREVENTION: FACING THE *DIREST* OF CONSEQUENCES

By **Dr Tan Chong Keat**,
Associate Consultant, Department of Cardiology
Tan Tock Seng Hospital

"I will prevent disease whenever I can, for prevention is preferable to cure."

So goes the time-tested adage, mentioned in the modern Hippocratic Oath by Louis Lasagna. Despite being ubiquitous, prescribing and adopting such wisdom remains a major challenge in our fast-paced lifestyles, whether we are physicians or patients. Being diagnosed with Cardiovascular (CV) diseases with prior lack of primary prevention measures would usually leave patients with a familiar feeling of regret, often summarised by the phrase "I should have known."

In the latest 2019 American Colleague of Cardiology / American Heart Association (ACC/AHA) Guideline on the Primary Prevention of Cardiovascular Disease, recommendations are made on CV prevention and Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment. Most of these recommendations rely on the persistence of physicians' 'nagging' and constant emphasis on lifestyle changes with an adoption of healthy habits. Based on these recommendations, I would propose a simple framework: "**DIREST**". This framework may aid with patients' day-to-day encounters, reminding us of the direst consequences presented by CV diseases.

DIET

In 1826, Anthelme Brillat-Savarin wrote: "Tell me what you eat and I will tell you what you are." This line has eventually grown in popularity, through its colloquialised form: "You are what you eat." A diet that emphasises the intake of vegetables, fruits, nuts, whole grains, and fish, and replacement of saturated fat with dietary monounsaturated and polyunsaturated fat is recommended, along with minimising intake of processed meats, refined carbohydrates and sweetened beverages. By adhering to such a healthy diet, one can then become healthy themselves.

INSIGHT

Health literacy, amongst all the points stated here, is the most important. Only with good insight via proper counselling would patients be able to "buy in" on the other proposed measures. Time should ideally be allocated to every patient encounter to facilitate patient activation.

RISK ASSESSMENT

The use of the Framingham score has, in recent years, been increasingly replaced by the Pooled Chort Risk Equation that predicts the 10-year ASCVD risks. It is recommended as a routine assessment for asymptomatic adults aged 40 to 75. Furthering this, depending on the risk profile, the coronary artery calcium score may be utilised to further assist with risk stratification and therapy.

ENCOURAGE EXERCISE

The word "encourage" can also refer to "giving courage". Physicians can assist to overcome the oft-quoted excuse, "easier said than done." Weekly recommended exercise includes at least 150 minutes of moderate intensity exercise, such as brisk walking and recreational swimming, or 75 minutes of vigorous intensity exercise, such as jogging and swimming laps.

SMOKING

The advice with the highest yield if heeded, smoking cessation is an action that brings many benefits that are not only limited to the cardiovascular system. Studies have shown that smokers are more likely to quit after 6 months if physicians give strong advice to quit, compared to smokers who are not given any advice at all.

TREATMENT OF CV RISK FACTORS

Chronic diseases such as hypertension, hyperlipidemia, diabetes mellitus, and obesity are well-known risk-enhancers to CV diseases. Management of these conditions should follow best medical practices and aggressive control, especially for patients with high ASCVD risks.

Although patients should be responsible for their own health, physicians too have always played a major role. Instead of having patients proclaim "I should have known," physicians can share similar responsibilities such that we too will not end up saying "*We* should have told you." GPBUZZ

Scan this QR Code to find out more about TTSH's Community Wellness Programmes to prevent chronic diseases.

Caring As One: Supporting Our GPs Through The Efforts Of Our *Health Coaches*

Who are the Health Coaches of Tan Tock Seng Hospital (TTSH)?

TTSH Health Coaches are our hospital's health ambassadors whose efforts find themselves placed at the heart of preventive care. As part of TTSH's Community Health Teams (CHT), our Health Coaches encourage healthier active living and a culture of health ownership among residents. They offer personalised guidance and motivate participants to make sustainable lifestyle changes through exercise and diet, further contributing to our guiding values to do with preventive care.

The work of the Health Coaches includes outreach to communicate key messages on preventive care, understanding residents' needs and providing experiential group-based activities that impart practical skills and knowledge to empower residents for lifestyle change. Their work supports primary care physicians, complementing their clinical management through the provision of lifestyle interventions.

Who can attend the programmes under Health Coaches?

All are welcome to participate in programmes organised by our Health Coaches. Through these programmes, participants are welcome to work together towards achieving healthier and more active lifestyles for themselves, while receiving care from their primary care physicians.

How do I register my patient for Health Coaching programmes?

1. Referrals can be made by preparing the relevant patient-related documents. and calling the CHP appointment hotline at 9657 1102.
2. The accompanying documents can be sent via email to chp@ttsh.com.sg. GPBUZZ

Scan this QR Code for more information on Health Coaches and the types of preventive care programmes they provide.

» Health Coaches leading different exercises and guiding the residents along.

» Health Coaches delivering health talks that educate residents on practical skills to keep healthy and consistent.

« Health Coach identifying healthier food options with participants during the 'Walking Foodpidea' programme.

OUR HEALTH COACHES' GUIDE TO HEALTHIER LIVING

The prevalence of chronic diseases has most definitely increased over the years. Today, 1 in every 4 Singaporeans aged 40 years and above presents with chronic diseases. One factor that remains unchanged is how healthy dieting and leading an active lifestyle are key to preventing such chronic disease. Healthy eating is not difficult, it involves just a matter of making the right choices and eating the right portions! You can refer to the following quick and simple guide developed by the Health Promotion Board (HPB), for an example of what a healthy, daily meal would look like.

Diet and exercise go hand-in-hand to prevent chronic diseases. Exercise is defined as any movement that makes your muscles work and requires your body to burn calories and exercising regularly can improve your quality of life. Everyone is encouraged to do 150mins of moderate intensity exercise per week.

Before you start doing the exercises, always ask yourself these questions:

- Are you feeling well?
- Have you taken your medication?
- Have you had any falls over the last 6 months?
- Were you ever hospitalised at any time during the past 6 months?

This is to ensure that you are in a good condition before starting exercise. Not to forget, always ensure safety first by doing proper warm up and cool down. Doing a proper warm up can prepare your body for exercise by raising your body temperature and increasing blood flow to your muscles. After exercising, do a cool down to bring your body temperature back to normal and avoid straining your muscles. If you experience any pain, rest. However, seek medical attention if the pain persists.

Lastly, there are so many ways to exercise. Before you start planning your exercise routine, consider the 4 following types of physical activities that you should engage in, and the benefits they provide. GPBUZZ

DIET

WHOLEGRAINS

- Aim for 1/4 of the plate
- Choose more wholegrains such as brown rice, wholemeal bread and oats. These help to lower risk of chronic disease!
- Avoid cereals that are high in sugar or flavoured bread e.g. (chocolate flavoured bread).

MEAT & OTHERS

- Aim for 2-3 servings per day. 1 serving should come from dairy products.
- Avoid processed meats that are high in salt.
- Choose low-fat options (lean meat and low-fat milk).
- Promote good heart health by having 2 servings of fish (particularly oily fish) per week.

EXERCISE

ENDURANCE

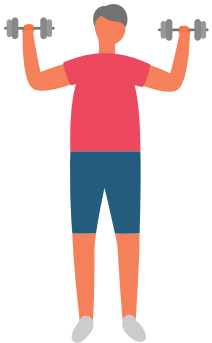
Endurance activity is often associated with aerobics exercises. At the same time, it can delay or prevent from heart diseases and diabetes.

Examples: Brisk Walking, Jogging, Dancing, Swimming

STRENGTH

As you age, you will lose muscle mass, however by doing strength exercises, it can maintain your muscle strength. Strength exercise can also facilitate your daily tasks like carrying groceries, going up the stairs and standing up from the chair.

Examples: Using resistance band or lightweights



My Healthy Plate is designed by Health Promotion Board for Singaporeans

VEGETABLES & FRUITS

- Aim to fill half your plate with vegetables for each meal.
- Aim for 2 servings fruit per day.
- Good sources of fibre, vitamins and minerals!
- Helps in controlling blood pressure, cholesterol and blood sugars.
- Always try to choose a variety of colours!

COOKING

- Use healthier methods like boiling, steaming, baking or grilling.
- If frying is necessary, choose healthier methods like stir-frying or dry-frying. Avoid excessively deep-fried food.

FOODS HIGH IN FAT, SUGAR AND SALT

- Consume foods like these sparingly.
- They increase the risk of health problems like obesity, high blood pressure, high cholesterol and high blood sugar.

FLEXIBILITY

Stretching exercises are encouraged as they can improve your flexibility. These will help you move more freely and make it easier for you to reach for items, in the even you accidentally drop them.

Examples: Static stretching

BALANCE

Improving your balance will make you feel steadier on your feet and help you prevent falls. Lower body strength can also help to improve your balance.

Examples: Balancing on one leg for 20 seconds while holding onto support.

Scan this QR Code to exercise along with the Health Coaches and learn more about their deliciously healthy recipes!

USEFUL RESOURCES

To request for more materials on our community wellness programmes, email chp@ttsh.com.sg.

Madam Chua Lye Soon's Journey as An Active Senior

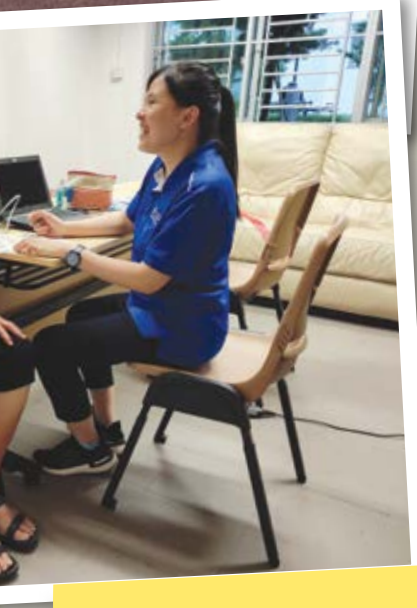
Discussing with Mdm Chua her health goals and ambitions...

Since 2019, Tan Tock Seng Hospital's (TTSH) Health Coaches have worked with residents to aid them in achieving their personal health goals. This support is given through health coaching services that are based on the principles of motivational interviewing and experiential group-based activities. These activites seek to impart practical skills and knowledge to empower residents to live healthier, more active lifestyles. Since then, many residents have benefitted from these services and activities provided at more than 60 CHPs located across the Central Zone.

One such resident is Madam Chua Lye Soon, a 76-year old senior who first visited our Community Health Post (CHP) at SilverACE@Whampoa Senior Activity Centre (SAC) in January 2018. Mdm Chua's main concern and goal was to manage her cholesterol levels. To help her achieve her goals, the Health Coaches started working with Mdm Chua in setting small action plans to increase her exercise frequency and improve her diet. She also started monitoring her own blood pressure daily, from the comfort of her own home. Through this close and nurturing relationship, the Health Coaches ensured that Mdm Chua managed to improve her cholesterol levels, and to a point where her medicine dosage was subsequently reduced by her doctor.

A second concern Mdm Chua wanted to work on, was the pain she experienced in her knee. This was causing her difficulty with climbing stairs. To help her improve her leg strength, the Health Coaches encouraged Mdm Chua to participate in the Steady Lah! Programme, where she learned simple exercises that focused on strength and balance, as well as on how to prepare healthier and more nutritious meals to maintain one's bone and muscle health. After the 12-week programme, Mdm Chua's gait speed had improved significantly.

The start of a healthier lifestyle!

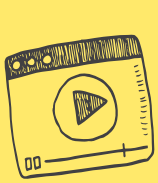


She expressed a reduction in the pain she was experiencing, and that she can now walk and climb stairs with more ease. Her knowledge increased, along with her overall confidence. She also became more independent and showed more initiative during her daily activities.

Being very enthusiastic and motivated, Mdm Chua was nominated by her peers in the Steady Lah! Programme to be a Peer Support Leader (PSL). PSLs play an important function as extenders of the Health Coaches, working closely with them to continue motivating their fellow peers for health maintenance. As a PSL, Mdm Chua has been guided by fellow Health Coaches to lead weekly exercises with her peers at the SAC. In turn, she also encourages them to maintain healthy lifestyles, beyond their completion of the 12-week programme.

Even despite the COVID-19 pandemic and restrictions placed on physical gatherings and activities, Mdm Chua and the Health Coaches did not relent on their goals. The Health Coaches succeeded in guiding Mdm Chua, and her own success is largely due to the open mindset that she kept towards learning new technological skills. Mdm Chua also received training on how to use ZOOM, so she could use the video conferencing application to actively participate in virtual activities organised by the Health Coaches.

Mdm Chua's journey is just one among the many examples of heart-warming success stories that come as a result of the relationships between residents in the community and the Health Coaches. In this journey towards preventive care, Mdm Chua's story is a testament to how it takes an entire village, consisting of people such as GPs and Health Coaches, to take care of the residents within our larger Singaporean community. GPBUZZ



Watch Mdm Chua's interview on Channel 8 news for her journey with our Health Coaches!

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.