

COMPLEX CARE

Dr Luke Low

SFP2016; 42(4): 3-4

It is a blessing and a curse all at the same time, for family physicians to work in hospitals. On the one hand, we are in a unique position to manage such hospitalized patients, their families and care-givers during their great times of need and crises. On the other hand, these patients really require a lot of resources involving multi-disciplinary team members usually led by medical such as family physicians, involving nurses, physiotherapists, occupational therapists, speech therapists, pharmacists, medical social workers, patient navigators and dietitians. Any weak link in the whole chain of the care plan have dire consequences for the patient, and they invariably run into crises again, get readmitted or suffer further morbidity and mortality as a result. Such complex care planning involve high stakes and family physicians, though in an excellent position to help such patients and their families, also require the necessary knowledge, skill sets and tools in order not to fail their patients. Very much the same can be said for family physicians who work in primary care, as they will frequently encounter patients who have been discharged from the hospitals back into their care. No longer can primary care constraint themselves only to seeing patients with acute or simple chronic medical conditions. We are often called to rise up to the face the challenge of the silver tsunami and the ageing population, along with the long list of problems that each and every one of them bring along for the consultation. Over the decades, the polyclinics have been evolving themselves from dealing with acute, episodic encounters to their current capabilities in managing chronic and continuing care, with adequate allied health services all under one roof. Some of the polyclinics even manage their complex patients in teamlets in order to encounter that these patients with problems spanning across the bio-psycho-social domains have their needs comprehensively assessed and managed by each and every member of the multi-disciplinary teamlet. If you think that it is impossible for solo clinic practices to have the resources to manage these patients, think again. In recent years, many allied health services have been made more accessible to small clinic practices via Community Health Centres (CHCs) or direct access services in polyclinics or hospitals. This has enabled many ageing patients to continue seeing their familiar neighbourhood family physicians without having to transfer to the polyclinics or acute hospitals, while not compromising on chronic care standards.

The College of Family Physicians is happy to present this upcoming Family Practice Skills Course on Complex Care,

which has tapped on many of our local experts in this field. The course strives to deliver the broad framework as well as the detailed skill sets required for family physicians to deliver such crucial complex care regardless of the setting of care; primary care, intermediate and long term care (ILTC) or transitional care.

Unit 1 by Dr Ng Wai Chiong skilfully proposed how primary care can be bolstered to cope with our ageing population's needs. Some of the Primary Care Practice Models for frail seniors include the Patient-Centred Medical Home (PCMH), age-friendly Primary Health Care Centre and Home-based Primary Care, and such a full spectrum model delivers care to elderly patients with varying functional status ranging from the community ambulant ones to the homebound or bedbound ones in the appropriate settings, to ensure that even homebound patients receive optimal standard of care. Some of the guiding principles of their care included patient-centredness, comprehensiveness, coordination, accessibility and commitment to quality and safety. It is an ideal state which if applied appropriately, supported and funded well, can truly enable patients requiring complex care to be cared for wherever they wish to be.

Unit 2 by A/Prof Lee Kheng Hock and Dr Low Lian Leng crystallizes a holistic approach to caring for patients with complex co-morbidities, which is useful for family physicians in clinical practice. It aims to integrate the commonly used SBAR with Pendleton's 7 task into a new SBAR4 comprehensive model which if applied skilfully, will enable complex patients with multi-morbidities to be managed appropriately in the context of the patient's family and community.

Unit 3 by Dr Adrian Tan sheds light on the care and assessment of complex patients in our local home care setting, especially helpful for homebound patients with complex chronic conditions, frail patients and dying patients. In order to understand and care for such complex patients, we need to have assessments involving multi-disciplinary team members, comprehensive evaluation of bio-psycho-social domains, coordination of various healthcare professionals across settings and ensuring that care is delivered in a continuing and timely fashion. Some of the benefits of home care to patients include accessibility, convenience, comfort, reduction of nosocomial infections and personalized care. However, home care faces many challenges, some of which include lack of funding, manpower and resources, low efficiency, reliance on caregiver competence and sustainability.

Unit 4 by Dr Tay Wei Yi and Dr Low Lian Leng focuses on care transitions in complex patients. Patients who transit across care settings are at constant risk of falling through the cracks during such critical and stressful moments for themselves, their families and care-givers, and awareness of this vulnerability as well as the importance of managing care transitions skilfully cannot be over-emphasized. Case studies were used to illustrate

LUKE LOW SHER GUAN
Associate Honorary Editor
Singapore Family Physician

the execution of care transitions in practice, ensuring good coordination and continuity of care plans. The results of good transitional care may include reducing hospital readmission rates and length of stay, while increasing quality of life and patient satisfaction. Hospital pre-discharge planning and immediate post-discharge follow-up in the community are crucial in ensuring success, and family physicians play a key role in such transitions through continuing family medicine training, changes in systems of care and increased collaboration across various family medicine settings.

Unit 5 by Dr Farhad Vasanwala showcases what a family physician in a small clinic practice is able to access in term of allied health services in order to achieve the ideal multi-disciplinary team care for his patients with chronic medical conditions. The recent years in Singapore have seen the advent of CHCs and how they have empowered small clinics to better manage their patients without having to refer them to polyclinics, as would have been the case just under a decade ago. The recent portable healthcare subsidies including the Community Health Assist Scheme (CHAS) and Pioneer Generation (PG) schemes have also enabled patients to receive subsidized care at their preferred family clinics and CHCs, thus ensuring more affordable care by family physicians in private clinics.

Unit 6 by Miss Christine Hindarto and Dr Matthew Ng describes in detail on how medical and social care can be bridged. With an increasing number of community services to tap into, the multi-disciplinary team members are now more involved in care planning, defining care goals and coordinating such healthcare and psychosocial care services, thus increasing their ability to provide a smoother transition from hospital all the way to the community. Useful lists of home care services, centre-based services, residential-based services, AICare link locations and contact numbers in the community have been provided.

A/Prof Goh Lee Gan has also graciously selected ten papers for our readings. In the areas of post graduate training, one of the author elegantly illustrated how complex care training is incorporated as part of their residency training. In the realm of primary care, some GPs go through workshops in care for multi-morbidities which improves their knowledge and confidence. Another article described how primary care for the older adults is challenging in itself and requires much more time and effort to sort their problems out. Huge paradigm shifts from the traditional biomedical care model to a Person-Centered Care (PCC) to better manage elderly patients with chronic conditions and functional impairment was also described. The proponents for PCC advocated the domains of such care to include holistic or whole-person care, respect and value, choice, dignity, self-determination, and purposeful living, something that is meaningful to incorporate in our daily practice, no matter how challenging it may be. Another study explored how community living older adults may benefit from integrated care. Older adults in the intervention group reported a higher level of perceived quality of care than those in the control group, and the advantages were clearer for patients who are frail and with complex care needs. One article studied and analyzed the various characteristics and contextual factors that contribute to patients presenting with complex care needs, so

that care plans can be better tailored to deal with these factors. Another author showed how a telephone support programme can help patients at risk of readmissions.

Our team also received two original articles by our local authors. Dr Elin Lee, Dr Chris Tsoi and Dr Ong Chooi Peng presented a case report on a middle-aged Chinese gentleman with a rare occurrence of post-stroke delusional disorder that presented and was managed in the community setting in Singapore. Though cerebrovascular diseases are common, post-stroke delusional disorders are uncommon, and family physicians should be aware of uncommon presentations of common diseases so as to better manage patients who present so atypically. In another article, Dr David Cheong did a narrative review looking at the management of nasal foreign bodies (FBs) in children in general practice. Whether the removal of such FBs is successful or not depends on preparation and correction selection of technique, and the author concluded that such FBs can be safely removed in the general practice so long as the above work is done well.

On that final note, two new associate honorary editors have joined the Singapore Family Physician editorial team. Dr Low Sher Guan Luke is a fellow of the College, College Council member, and is currently working in Sengkang Health, SingHealth. Walking off the beaten path, Dr Low has seen his fair share of frail and elderly patients with multi-morbidities who have been caught up in hospital readmissions and thus unable to be cared for in the community. Together with fellow family medicine physicians in the department, they believe in helping to transit each and every patient, empowering them and their care-givers, with a dream that they remained cared for in the community and age in place. He believes strongly in good care transition and collaboration with partners in primary care in order to make this dream a reality. Dr Valerie Teo is a Family Physician, Associate Consultant who practices at Ang Mo Kio Polyclinic, National Healthcare Group Polyclinics and serves as their Deputy Head. She attributed that the path she took was influenced by the positive and comprehensive care her family had with their family doctor. The personal connections and experiences she gets to share with her patients make each day a fulfilling one. She aspires to be like her mentors who have helped to shape and guide the path she is on today, hopes to be part of the Family Medicine journey and mission to provide her patients with a personal, positive and comprehensive experience and also to be a part of the journey that our future generations of doctors and family physicians are on. Both Dr Low and Dr Teo are involved with teaching at both undergraduate medical students as well as post graduate doctors who are embarking on their journeys in Family Medicine.

There are many believers in “No Pain, No Loss” and far fewer believers in “No Pain, No Gain”. Our editorial team strives to adopt the “No Pain, No Gain”. As our journal aims to be indexed in PubMed Central and various bibliographic databases, we are working hard with authors to improve the quality for each and every issue. The College would like to encourage residents and family physicians to contribute original articles and case studies with valuable learning points to the PRISM section of the Singapore Family Physician. Patient details should be de-identified and consent obtained for publication of the case study.