ASSESSMENT OF 30 MCQs

FPSC No : 70
MCQS ON MANAGING COMPLEX PATIENTS IN FAMILY MEDICINE SETTINGS
Submission DEADLINE: : 12 September 2017, 12 NOON

INSTRUCTIONS

- **To submit answers to the following multiple choice questions, you are required to log on to the College Online Portal (www.cfps2online.org)**
- **Attempt ALL the following multiple choice questions.**
- **There is only ONE correct answer for each question.**
- **The answers should be submitted to the College of Family Physicians Singapore via the College Online Portal before the submission deadline stated above.**

1. Mr S is seeing you today requesting some blood tests ordered by the hospital. He was recently discharged for the problem of fluid overload. The memo states that a full blood count and a renal panel should be done within 3 days of discharge and that the patient had requested earlier discharge against medical advice. The following best describes the next mode of action:

A. Order a full blood count and renal panel.
B. Explore the reason for discharge against medical advice.
C. Review patient's adherence to medication and fluid restriction.
D. Screen for social and psychological factors that may impact care.
E. All of the above.

2 For successful management of a complex patient in the home care setting,

A. Only patient activation is required.
B. Only system activation is required.
C. Both patient and system activations are required.
D. Both patient and system activations are not required.
E. None of the above.

3. Which of the following term is most useful for the purpose of creating a roadmap for the clinical management of patients with many diseases?

A. Multimorbidity.
B. Co-morbidity.
C. Frailty.
D. Disease burden.
E. Mortality.

4. Which of the following examples is not considered transitional care?

A. Discharge from the acute hospital to home.
B. Transfer from high-dependency ward to the general ward.
C. Discharge from community hospital to nursing home.
D. Discharge from the acute hospital to community hospital.
E. None of the above

5. The proposed SBAR4 model is:

A. A new model for inter-professional communication.
B. A new model in the theory of consultation.
C. A framework for understanding and managing patients with co-morbidities.
D. A novel method of developing treatment options for patients with multi-morbidities.
E. A system for understanding patients' ideas, concerns, and expectations.

6. SBAR4 provides a framework for managing a complex case with bio-psycho-social components. What does the R4 represent?

A. Reasons, Reluctance, Readiness, Recommendation.
B. Reliability, Resources, References, Responsibility.
C. Reassurance, Reliability, Responsibility, Reconciliation.
D. Recommendation, Resources, Responsibility, Relationship.
E. Reasons, Recommendation, Reconciliation, Resources.

7. What are the responsibilities of the Family Physician when taking care of a patient with complex comorbidities?

A. Identify the patient's medical problems and refer to specialists subsequently.
B. Coordinate the different team members with a common goal of holistic care.
C. Activate EASE programme to ensure patient receive financial subsidy.
D. All of the above.
E. None of the above.

8. For a single elderly who is socio-economically disadvantaged and requires home modifications such as grab bars and ramps, which of the following schemes is most suitable?

A. Senior activities centre.
B. Housing Development Board's Enhancement for Active Seniors Programme.
C. Senior mobility fund.
D. SG enable fund.
E. Assistive technology fund.

9. A 70-year-old male was brought to your clinic by his wife. For the past 1 year his care needs have increased to the point that his wife who is the main caregiver is no longer able to cope. They live in a 3-room fully paid HDB flat and have no children. They get by with vouchers given by the CDC and public assistance handouts. His wife is requesting Voluntary Nursing Home placement. He is assessed to have an RAF of Category III. Based on this category he is likely to be:

A. Wheelchair-bound/bed-bound.
B. Incontinent in both bowels and urine.
C. Requiring total assistance in all his ADLs.
D. Independent in ADLs.
E. Able to ambulate with quad stick.

10. The patient in the case study had moderate to diarrhoea which was found to be caused by *Clostridium difficile*. Which of the following is the antibiotic of choice for this infection?

A. Rifaximin.
B. Fidaxormicin.
C. Rifampicin.
D. Vancomycin.
E. Metronidazole.

11. Mdm A is a poorly controlled diabetic who presents with an HbA1C reading of 13 percent today. She reports that she has not taken her medications for 2 weeks now. Which of the following best describes the next mode of action:

A. Advise her to take her medications daily.
B. Refer her to a medical social worker.
C. Explore the reasons for non-adherence to medications.
D. Explore the reasons for non-adherence to medications and screen for other factors such as financial problems and mood disorders.
E. Engage her to develop a medication plan for improved adherence to medications.

12. Assessment in the SBAR4 framework refers to:

A. Reviewing the medical history.
B. Listing down the medical and social problems.
C. Formulating the problem list .
D. Formulating the problem list, and identifying the contributing social, behavioral, and psychological factors.
E. Identify the comorbidities and the social, behavioral, and psychological factors; formulate the problem list; and identify the stakeholders for the problems identified.

13. In the acronym SBAR, "S" represents which aspect of the communication?

A. Solving the problem that is most important.
B. Moving the patient to the right site of care.
C. Explaining the reason why the patient is encountered in the care process.
D. Listing all problems in a systematic manner.
E. Listing all the treatment options that are suitable for the patient.

14. Relationship in the SBAR4 framework refers to

A. The relationship between the patient and the provider.
B. The relationship between the comorbidities.
C. The relationship between the primary care provider, patient, caregivers, care team members, and community service providers.
D. The relationship between the primary care provider and the hospital specialists.
E. None of the above.

15. Ms S is a hypertensive and a poorly controlled diabetic. She presents today with high blood pressure of 220/110mmHg and a headache. She has not taken any medication for the past month. The following best describes the next mode of action.

A. Refer her to the A&E.
B. Explore reasons for non-adherence to the medication,
C. Establish a therapeutic relationship and arrange follow up.
D. A & B.
E. All of the above.

16. The elements of the SBAR model of communication include the following:

A. S for Situation.
B. S for Summary.
C. S for Solution.
D. S for Surveillance.
E. S for Scenario.

17. Which of the following is not effective in the transitional home care for complex patients?

A. Reviewing and consolidating post-discharge follow-up.
B. Communication between the inpatient nurse and home nursing foundation.
C. Understanding patient's preference, values and goals

with regard to his health.

D. Assessing patient's knowledge of his medication dosages.

E. Reviewing the patient 1 month after discharge from the acute hospital.

18. What are the important components of the social history the Family Physician should consider when taking care of a patient with complex comorbidities?

A. Caregiver stress, financial situations, community resources.

B. Means test, MSW referral, family tree.

C. Home environment, occupation, medical certificate.

D. Post-discharge placement, medisave balance, follow-up plans.

E. Senior mobility fund, pre-existing insurance policy, MSW referral.

19. A home-bound patient requires an assessment for the use of a personal mobility device such as an electric scooter for community ambulation. Which of the following healthcare workers is most suited for this task?

A. Occupational therapist.

B. Speech therapist.

C. Medical social worker.

D. Physiotherapist.

E. Nurse.

20. Multimorbidity can be defined as:

A. The co-occurrence of inter-related illnesses in an individual.

B. The prevalence of different types of chronic diseases in a community.

C. The total disease burden in a community.

D. The presence of multiple risk factors that predispose to ill health.

E. The co-existence of 2 or more chronic diseases in an individual.

21. Singapore's population is rapidly ageing, it has been estimated that by the year 2030, the population above 65 will reach one million. Many are also living alone because of changing family structures, resulting from personal preferences or unfortunate circumstances or others. From the year 2000 to the year 2014 the elderly population living alone has:

A. Doubled.

B. Remained stable.

C. Decreased by half.

D. Tripled.

E. Quadrupled.

22. Referrals for most of the services in the ILTC have to be placed in the AIC IRMS system. When the service provider receives the application, they assess the patient's eligibility by using some form of assessment. What is the assessment that they use?

A. Resident Assessment Form.

B. Braden's score.

C. ADL score.

D. IADL score.

E. CAM score.

23. When a patient with complex comorbidities is discharged from the hospital, how should the Family Physician coordinate the post-discharge follow-up?

A. Provide a memo to the patient's primary care physician.

B. Discharge the patient to Family Medicine Clinic in the hospital instead of the patient's primary care physician.

C. Secure all the specialists' outpatient appointments and provide memo to the patient's primary care physician.

D. Consolidate all the specialists' outpatient appointments and cancel the unnecessary specialists' outpatient appointments.

E. Take responsibility for overall care plans for the patient and consolidate all the specialists' outpatient appointments.

24. A 64-year-old single who lives alone in a 1-room rental flat is referred to the family medicine department for transitional homecare. He has no regular income and relies on his savings for subsistence. What percentage subsidies is he likely to be entitled to if he is means tested?

A. 50%.

B. 75%.

C. 30%.

D. 60%.

E. 80%.

25. A 56-year-old was recently admitted for a stroke to the National University Hospital and later to St. Luke's for rehabilitation. After rehabilitation he still has residual left hemiplegia and needs 1 person's assistance to ambulate. He will need a motorised wheelchair to help him move around in the community. Where can you apply to help him get some subsidies for his purchase of the wheelchair?

A. SMF funding.

B. SG Enable.

C. CDC.

D. Member of Parliament.

E. Social Services Office.

26. By 2030, what is the proportion of the population who will be 65 years and older?

A. 9%.

B. 15%.

C. 19%.

D. 30%.

E. 38%.

27. Which of the following factors is MOST LIKELY to result in a nursing home placement of an elderly family member?

A. Presence of caregiver.
B. Stroke.
C. High Barthel Index Score.
D. Lower-limb amputation.
E. Hospital admission for falls.

28. When managing a patient with complex comorbidities, what should the Family Physician do to ensure best outcomes for the patient?

A. Explore ICE, refer for specialist reviews, and provide detailed discharge memo to patient's primary care physician upon discharge.
B. Utilise SBAR4 in order to have a comprehensive and integrative approach to managing the patient's needs
C. Explore ICE, refer for specialist reviews, and provide detailed discharge memo to Family Medicine Clinic upon discharge instead.
D. Utilise SBAR4 in order to determine if specialist reviews are needed and refer as necessary.
E. Take overall responsibility for patient's care and do not discharge back to patient's primary care doctor.

29. The Resident Assessment Form (RAF) classification is used to help allocate elderly people to nursing homes. Which of the following pairing of RAF Category and nursing home type is CORRECT?

A. Category II — Nursing Home sometimes.
B. Category I — Day Care Centre.
C. Category III — Sheltered Home.
D. Category IV — Sheltered Home.
E. Category I — Nursing Home.

30. The enhanced nursing home standards cover 3 domains of care. Which of the following is one of these 3 domains?

A. Medications.
B. Governance and organisational excellence.
C. Nursing procedures.
D. Infection control.
E. Advance care planning.

FPSC No. 69
"Updates in Rheumatology"
Answers to 15 MCQ Assessment

1. E	11. D
2. A	12. D
3. C	13. C
4. B	14. D
5. A	15. E
6. A	
7. C	
8. E	
9. D	
10. E	