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Integrated Care

Speech by Ms Yong Ying-I, Permanent Secretary (Health), at Agency for Integrated Care's (AIC) Inaugural Asian Conference on Integrated Care, on 25 February 2011

During the conference, the Permanent Secretary (Health) shared the Government's philosophy behind its support for integrated care.

"Integrated care landscape in Singapore

The landscape for integrated care is changing rapidly in Singapore. The Government has supported long term, aged care and the voluntary welfare sector clear through sizeable top-ups for Medisave, Eldercare Fund and Medifund. A $10m fund to support functional mobility of seniors was announced in the Budget. Training and development of medical social workers came in for special mention, with their having a significant share of a $20m development fund. A huge $1bn Community Silver Trust fund to enable matching grants for donations to the healthcare and social care charity sector was also announced. The secondment of professional staff from the public sector for deployment stints in healthcare entities in the VWO sector have begun on order to ensure that they are staffed up adequately with quality manpower.

The development of the non-acute sectors is crucial to greatly enable integrated care to happen. Acute-centric, hospital-based systems are not sustainable solutions to cope with rapidly ageing populations and the increasing prevalence of chronic diseases. Having strengthened the entities in the non-acute sector, the focus of efforts and of this conference was to discuss how the providers can come together to provide coordinated, coherent, high quality care. The end-goal is to create an environment where Singaporeans can move seamlessly across providers, without repeated testing, duplicative care or falling through the cracks. This will allow chronically-ill patients, frail elderly and even the well to receive the care and attention they need, where they need it the most, at a price that they can afford. Each country's approach differs due to their different starting points and socio-political context. But the underlying objectives are similar – balancing quality, accessibility and cost. So are the challenges in trading off multiple objectives that can be in conflict.

Ms Yong Ying-I, Permanent Secretary (Health). Photo courtesy of AIC.

Singapore's approach to integrated care

Key thrust 1: "From disease to wellness"

"We want to keep Singaporeans healthy so that they do not come into the healthcare system in the first place, especially the high cost acute sector. Other than Health Promotion Board's prevention and education efforts, we are helping Singaporeans detect and treat diseases early through health screening, in GP clinics and in the community such as at NTUC's Wellness Centres. Our Restructured Hospitals are helping the frail elderly and patients with chronic diseases manage their medical conditions better so that they stay well. In recent months, Changi General Hospital launched its chronic disease prevention programme called Eastern Community Health Outreach (ECHO) to help families in the Eastern part of Singapore access low cost screening and healthy lifestyle activities. It is also running a nurse-led call centre that supports discharged chronic disease patients on an ongoing basis to manage their condition at home, so as to avoid unnecessary visits to the hospital. When my Minister visited the Disease Management Unit operation at CGH, he coined an additional term "from disease to wellness". He said we should also think "from programme to population".

(continued on page 10)

Current State of Integrated Primary Care in Singapore

by Dr Wilson Eu, Editor

Post-GE2011, we welcome Minister Gan Kim Yong to the Ministry of Health. We should also acknowledge the vast and meaningful contributions of Mr Khaw Boon Wan to the work of Family Physicians in Singapore especially in espousing the One Family Physician for every Singaporean mantra.

Indeed well trained, connected and empowered Family Physicians are the value players in any health ecosystem. We are more available than any SOC in the hospital or Polyclinics, offer more bang for the healthcare dollar than any doctor in an AMC or RH in tackling acute and chronic conditions and offer similar outcomes from tertiary institutions.

Indeed well trained, connected and empowered Family Physicians are the value players in any health ecosystem.

Integrating care and right-siting patients has been a key MOH initiative for many years. There has been much progress achieved in the field of ILTC (Intermediate and Long Term Care) sector involving Community Hospitals, Nursing Homes, Home Care and so forth.

In this issue, we would like to look specifically at a few of the current right siting programmes that are being carried in a number of hospitals that involve right siting stable patients to private practitioners. Each individual Regional Hospital and Academic Medical Centre has developed its own programme. The disease conditions to be right sited, recruitment of patients and primary care doctors, reporting requirements for clinical outcomes, payment for services are all different. We hope to bring the relevant features of the programmes in a few short paragraphs in order to facilitate understanding of the work that is done.

The big picture of MOH's philosophy behind its support for integrated care was given by the PS (Health) during the first Asian Conference on Integrated Care organized by the Agency for Integrated Care in Feb 2011. This speech sets out in broad strokes the aims and intentions of the Ministry in transforming the care of all Singaporeans in the face of a rapidly ageing population often dubbed a "silver tsunami".

Many family physicians have prepared themselves for the change.

We will cover Changi General Hospital, Singapore General Hospital and National University Hospital. Similar programmes at KKH, KTPH, IMH and TTSH will be covered in later issues.

We hope this would improve our awareness of the different measures that are currently in place, specifically looking at right-siting from the SOCs to the private FPs. This may prompt further discussion on how to move the processes forward and at an accelerated pace. Barriers such as drug pricing, maintaining cost subsidy and achieving patient buy-in are tackled differently by the different institutions. Dr Michael Yee, a solo FP, teacher to numerous cohorts of undergrad and post-grad students in FM, offers his views on the issue of integration. I believe his views do resonate well with current opinion amongst family physicians.

Much has been done. Many of us have attended numerous feedback sessions, focus groups meetings and been part of committees looking at various aspects of making right-siting work. Yet, there is a long journey ahead: to go beyond pilot scale projects, engaging the greater body of practicing FPs and making a significant change in the numbers of patients with chronic medical conditions seen in primary care outside of the polyclinics.

Much needs to be done to engage the media on the work that is done in FP clinics. There remain occasional opinion makers in the media who promote the notion that patients with chronic illnesses should be channeled to polyclinics and that private clinics should see acute coughs, colds and acute diarrheal episodes. Just as during SARs and the last global influenza epidemic, to manage the oncoming silver tsunami requires all primary care practitioners to be involved. All primary care doctors in Singapore need to be successfully integrated with the secondary and tertiary care communities.

Patients need to see and understand that care at the SOC is not "special" and often times, unnecessary. Payment, subventions and subsidies must dovetail with the message that the best bang for the buck as for chronic care is not in the SOCs but in the community.

Many family physicians have prepared themselves for the change. As at end 2010, about 500 Family Physicians have taken the Graduate Diploma in Family Medicine, over 320 have obtained MMed(FM) degrees and nearly 100 have obtained Fellowships in Family Medicine. These doctors practice in both the private and public health sectors. They represent primary care physicians who will form the bulk of the Family Physicians Register. We look forward to the work of the AIC in making the ideals of Primary Care Integration into everyday programmes that benefit our patients especially the elderly. We look forward to the promise that the National EHR (Electronic Health Record) holds in advancing communication between institutions, caregivers and patients. And we look forward to care for our patients in an environment that values our input and empowers patients and caregivers alike. ■CM

this issue >>

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Primary Care Integration Programmes at Regional Hospitals

by A/Prof Goh Lee Gan, President, College of Family Physicians Singapore

Integration across the whole system

One of the desired attributes of healthcare delivery is integration of care across acute tertiary care, intermediate and long term care (ILTC) and primary care.

We have had several years' experience working on the Integration of care now. We are beginning to make this work. Nevertheless integration is a difficult word to operationalise because there are barriers to be overcome, mindsets to be synchronized so that we are all on the "same page". Notwithstanding the difficulties, various primary care integration programmes introduced by the various regional hospitals are experiencing varying degrees of success. It would be useful to share experiences with one and another and out of such sharing, best practices can emerge. This is the idea behind this issue of the College Mirror.

Evergreen barriers and solutions

Integration programmes need to take a systems approach to begin to wear down the barriers. There are the usual evergreen barriers and solutions are described here:

Drug costs – Most of the regional hospitals have extended their assistance in reducing the costs of drugs to patients by charging them at the hospital pharmacy rates. This is really a help in the short run.

Mindset change – This is a tough barrier to breach. Patients need a mindset change that their family doctors can look after their medical conditions.

Patient safety and confidence – To ensure patient safety, and to acquire confidence in patient care skills, there is a need to make use of CME sessions to impart and share experiences on patient care skills. Care studies are very useful in this context. An expert and a learner can engage on the same platform and share what can be done to grapple with diagnostic, follow-up and management issues. This is being actively done by some disciplines e.g., asthma care, rheumatology, and others.

Other solutions

Then there other strategies we learn along the way:

The idea of "flip flop" – the patient who is stable but who may become less stable can be managed through a system of alternating family doctor and specialist the visits. In this way, patients who are stable but may change in stability can be safely managed. And patients will feel confident too.

The care co-ordinator – for shared care to succeed, the care co-ordinator is all important. This person oversees that the whole system is moving seamlessly, detect concerns, hiccups and jams early so that corrective and enabling actions can be made to restore the system again.

Sustaining the shared care system

Based on a paper by Blashki G et al published in the Australian Psychiatry Sep 2005; 13(3), titled Primary Care Psychiatry: taking consultation liaison psychiatry to the GPs, there are three important points in right siting to remember. It does not matter whether it is right siting psychiatry care or diabetes care, or asthma care, or rheumatology care. The principles are the same. There are three principles to apply:

(1) Understand the GP context – provide him or her with timely care information – tasks of the specialist who is hosting the right siting programme

(2) Provide clinical support – such as availability of a hotline help – and make it really accessible

Patients need a mindset change that their family doctors can look after their medical conditions.

(3) Provide effective training content and resources – such as print-based material or online patient education materials, tools and patient worksheets – these can be on the hosting regional hospital's website – and passwords can be used if they are for the GPs only and no passwords if they are also suitable for patients.

Conclusions

We probably know enough to make shared care work. Sharing experiences and best practice is the way forward. There is however the need to engage the patient, the system, and ourselves to meet the common end in mind – seamless care at the right time, right place, and right price. CM

Current Right-siting Programmes at CGH, SGH and NUH

by Dr Kelvin Goh, Editorial Board Member,
Dr Wilson Eu, Editor, and
Dr Michael Yee, Editorial Board Member

A. RIGHT-SITING PROGRAMMES AT CHANGI GENERAL HOSPITAL

Over the past two years, in the eastern part of Singapore, Changi General Hospital (CGH), together with Polyclinics and St Andrew's Community Hospital, have renewed the drive towards engaging family practice stake holders. This engagement has resulted in close collaboration on projects and programs to right site patients to local family physicians; forming integrated care programs for the community in the east to manage chronic and long term diseases.

This Integrated Care is a multi-faceted health care programme focusing on addressing the entire disease management process. This includes early detection and prevention, coordinated follow-up care in partnership with healthcare providers, integrated care pathways and timely intervention.

The programmes available are:
1. General Practitioner Chronic Care Programme (GPCCP)
2. Community Health Centres (CHC)
3. Disease Management Unit (DMU)
4. Eastern Community Health Outreach (ECHO)

1. General Practitioner Chronic Care Program (GPCCP)

This programme was started in year 2008 to discharge clinically stable chronic disease patients from CGH SOCs. Disease Groups under GP Chronic Care Program are:
- Diabetes Mellitus
- Ischaemic Heart Disease
- Heart Failure
- Asthma

Patients are enrolled into the programme via pre-determined criteria (Annex 1, page 7). GPCCP Care Coordinators are located in the Specialist Clinics and their role is critical in ensuring the success of transferring care to the family GP. They counsel patients of the programme's details, select the clinic in the GPCC network and work closely with the Family GPs to ensure that the patients follow up with their treatment plan. Patients will receive timely reminders from the Care Coordinators to go for their follow-up review with their Family GPs. In the event that a patient's chronic disease condition deteriorates and warrants Specialist's attention, the Family GP can arrange for the patient to be seen by the CGH Specialist through the Care Coordinator.

After the first consultation, clinical reporting back to CGH takes the form of faxing back a simple Patient Med Assessment Form (first visit) or Update Form (subsequent visits). GPCCP will reimburse the GP $70 for the first patient visit. If the patient chooses to follow up with the GP, the GP is further reimbursed $30 to defray administrative cost of faxing updates back to CGH. The first visit is free to the patient. On subsequent visits the patient pays the clinic's usual consultation charges. Both subsidised and non-subsidised patients have been right-sited in this programme. Subsidised patients can continue to receive their chronic medications at CGH Pharmacy. All other medications and additional tests are payable at the clinic's prevailing rate. Through this scheme CGH has successfully right sited over 400 patients in the last two years.

2. Disease Management Unit (DMU)

The DMU focuses on helping prevent complications from chronic and long-term diseases and helping patients better manage their medical conditions. The two key elements of the DMU are a team of trained, dedicated DMU nurses and technology in the form of an electronic Patient Relationship Management system (PRM). DMU nurses utilise the PRM system to deliver personalised follow-up care via phone with their patients. This enables them to be more confident and effective in managing their medical conditions over the longer term. DMU started in June 2010 and has been steadily reaching out to diabetic patients in its Diabetic programme. Currently there will be up to ten dedicated nurse tele-carers. DMU works with Community Health Centre (CHC), to further strengthen disease management at the community level.

Currently, DMU is mainly targeted at diabetic patients. It will be extended to the following chronic and long term diseases: Chronic Obstructive Lung Disease, Ischemic Heart Disease, Heart Failure, Stroke and Hip Fracture and Stroke.

Don't be caught off guard if your patient tells you that the DMU nurse asked her to seek help at your clinic for optimisation of her diabetes. In the pipeline, DMU will also reach out to GPs in the east and support GPs to manage patients with chronic and long term diseases well so that the patients can remain healthy within the community.

3. Community Health Centre (CHC)

The CHCs help strengthen disease management at a community level by supporting and complementing clinical care provided by primary care GPs in eastern Singapore. They are set up in the neighbourhood to provide patients with convenient access to health monitoring and counseling services at affordable rates, to help them monitor and manage their chronic and long term disease.

The first CHC is located in Tampines. GPs in the vicinity can refer patients with chronic diseases for essential healthcare support services. The rates charged are very competitive and the unit is helmed by senior nurses and allied health professionals.

Common services utilized by GPs include the following:
- Digital Diabetic Retinal Photography - $12
- Diabetic Foot Screening - $14
- Diabetic Nurse Counseling Service - $15

The CHC is located at:
Blk 866 Tampines Street 83, #01-231
Singapore 520866
Tel: 67826885; Fax: 67823531

4. Eastern Community Health Outreach (ECHO)

ECHO is Singapore's first community-based disease prevention program which aims to achieve the following:
- Facilitate early detection of chronic disease
- Provide timely intervention
- Prevent and delay onset of disease diabetes, hypertension and hyperlipidemia

This program has started in May this year in Changi Simei area for 1,500 residents. It is designed to target Singaporeans and permanent residents aged 18 years and above with no known chronic disease. The conditions targeted are obesity, diabetes, hypertension and hyperlipidemia.

Collaborating with Changi Simei grassroots organisations, ECHO@ Changi Simei provides community-based health screening and lifestyle intervention workshops and activities for participants. The activities include primary and secondary prevention measures from exercise classes, brisk walking interest groups, healthy cooking and healthy living classes targeted at families.

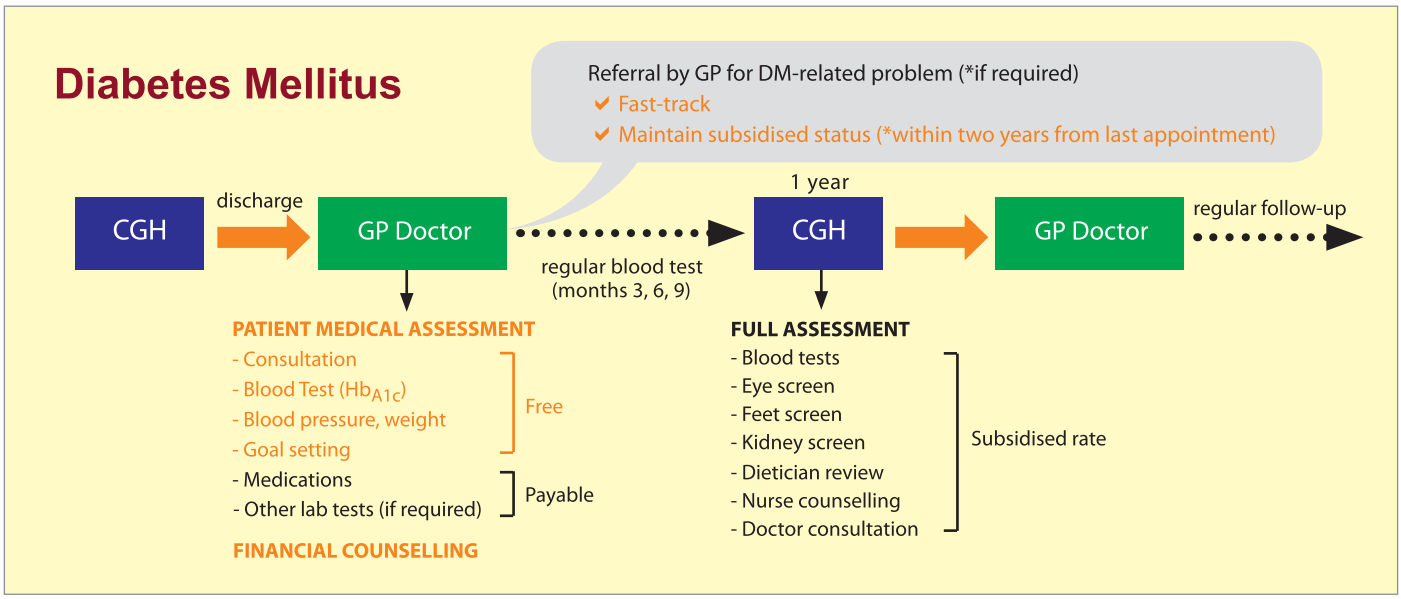
Dedicated ECHO coordinators will ensure residents receive timely interventions, support and motivation for healthy lifestyle changes.

Participants from 18-34 years old will undergo blood pressure and BMI measurements for $2. Those above 35 will have their blood pressure, BMI, cholesterol and fasting glucose for $10. Newly diagnosed patients will be referred to their GPs in addition to follow up by ECHO coordinators. GPs will also be able to refer their ECHO patients to the DMU Diabetes programme if appropriate, for follow-up by DMU nurses.

B. SINGAPORE GENERAL HOSPITAL: DOT (DELIVERING ON TARGET) PROGRAMME

The Singapore General Hospital (SGH) DOT Programme was launched on 20 August 2005 as a pilot programme to demonstrate a new model for cost-effective, integrated and community-based care for diabetes. It was initiated and led by Dr. Daphne Khoo, Head of Endocrinology at SGH and Director of Quality Management in SingHealth. Since its launch, more than 2,000 chronic patients have been right-sited to

Figure 1: Patient Counselling Flowchart



primary care. The number of active GPs under the DOT programme is expected to increase to 140 over the next three years.

The DOT Programme uses a multi-pronged approach at community level, benchmarked against evidence-based best-practice clinical guidelines. DOT currently covers the following diseases:

- IHD from National Heart Centre
- Asthma from SGH Resp Clinic A
- Diabetes from SGH Diabetes Centre
- Chronic Renal Disease from SGH Renal Clinic M

The DOT Optimisation Programme (DOT OP)

This is the backbone of the DOT programme. It seeks to set standards of care via care outcomes of actual patients and to equip and support GPs to better manage their diabetic patients.

The DOT OP requires each participating GP to:

A. Enrol three patients with diabetes into the programme and work towards achieving the prescribed DOT performance measures i.e. provide the history and management review of three of their patients with chronic diseases whom they managed for a year each, to demonstrate their commitment and level of care.

B. Attend four modular sessions organised by SingHealth (DOT Symposia). A DOT Blackboard (IT) Training Programme has been developed covering the four modular sessions. GPs who wish to join can now attend 50% of the modular sessions by attending two CME Symposia sessions, and the other 50% of their training via the Blackboard Training which incorporates e-assessments.

C. Sign up three of their enrolled patients for three customised education and counselling sessions conducted by nurse educators from the Diabetic Society of Singapore. This ensures that DOT accredited GPs are aware of the community health resources that need to be tapped in order to provide adequate care for the chronic illnesses. This emphasises the importance of maintaining linkages and network with other health workers.

This framework for the assessment of care outcomes was set in place

Annex 1: GP Chronic Care Programme - Diabetes Mellitus

Clinical Management Team

1. Dr Richard Chen, MBBS, MRCP (UK)
   Consultant, Head of Endocrinology
   Director, Diabetes Centre
2. Care Coordinators:
   Ms Joanna Teo,(O) 68504571 (HP) 81258443 (Office hours)
   Ms Xiao Ting Ting, (O)68504571, (HP) 96450287 (Office hours)
   Ms Wong Kah May, (O)68504571, (HP)9113 9964 (Office hours)
3. Specialist Outpatient Clinic:
   Diabetes Centre, CGH (Basement 1)

Enrolment Guidelines (Mth 0)

Fixed Criteria:

1. Creatinine less than 200 8mol/L
2. No recent recurrent admissions
3. No active ulcerative foot disease requiring podiatry services

Ideal Criteria:

4. No admissions with HHNK, DKA, hypoglycaemia within the last year
5. HbA1c < 8.0% on 2 occasions
6. BP < 140/90mmHg in the last 6 months
7. LDL < 3.4 mmol/L
8. Require minimum medication adjustment to reach target
9. Minimal or controlled microvascular complications
10. Stable co-morbidities

First GP Visit – Patient Medical Assessment (Mth 3)

1. Please refer to Patient Medical Assessment (PMA) Form
2. Scheduled lab test for DM first visit: serum HbA1c
3. Financial counselling
4. GP to fax PMA Form and Patient Medical and Clinical Update Form with lab results back to CCC (Fax no: 67866195)
5. The PMA is free-of-charge to the patient
6. GP will be reimbursed $70 for the PMA and the above lab test
7. An additional $30 will be provided for GP (to defray administrative costs) if patient chooses to continue chronic care with GP and provides consent on the PMA Form
8. CGH will process payment on basis of completed PMA and lab test result
9. Medications and additional lab tests (if any) are payable by the patient

Subsequent Follow-up with GP (Mth 6, 9)

1. Please refer to Patient Medical and Clinical Update Form
2. Patient to be followed up at months 6 and 9
3. Month 6 review: Weight, blood pressure, serum HbA1C, LDL, smoking status (number of cigarettes/day)
4. Month 9 review: Weight, blood pressure, serum HbA1C, smoking status (number of cigarettes/day)
5. GP to fax Patient Medical and Clinical Update Form back to CCC at months 6 and 9

First Year Assessment (appointment date pre-fixed by CCC)

FA includes serum HbA1c, lipid profile, fundal photography, feet (monofilament test) and nephropathy (serum Cr and microalbuminuria) checks, dietician and diabetic nurse counselling, and clinical consultation. Results will be given to patient to carry back to GP.

from the outset to ensure that GPs who are accredited as DOT GPs provide good ambulatory care for diabetes with proven outcomes.

The SingHealth Chronic Disease Management Office (CDMO)

In April 2008, SingHealth set up its Chronic Disease Management Office (CDMO). Staff of CDMO includes Right Siting Officers (RSOs) who are stationed in the Outram Campus CDM SOCs and to whom the SOC Clinicians refer their clinically stable patients. The RSOs take over from the busy Clinicians to counsel and follow up clinically stable patients and right site them to primary healthcare. The close follow-up and liaison by the RSOs with the right sited patients and the DOT GPs stretches over one year at least.

CDMO reviewed the SHS Right Siting Programme (DOT) and drew up the following key initiatives:

- **Subsidised Drug Delivery Programme**, whereby patients could continue to receive their drugs at the same charges as at the subsidised SOCs. The DOT GPs fax the patient`s prescriptions to the respective hospital`s pharmacy. The patient`s medications would then be couriered to the patients home. The courier charge is $8 for each trip.
- **Diagnostic Tests Incentive Programme**, under which right sited patients receive vouchers to cover the lab tests. The patients are required to pay the GPs a fixed phlebotomy charge of $15.
- **An Allied Healthcare Incentive Programme**, under which right-sited patients with diabetes receive free vouchers which cover the annual eye and foot screenings. In addition, a diabetes education service which covers diet, lifestyle modification, medication and insulin therapy and skills, provided by a diabetes nurse educator. This diabetes education service is sponsored by Johnson & Johnson.

The Allied Healthcare Services are provided by the Diabetic Society of Singapore (DSS)'s mobile diabetes bus or at the DSS's static diabetic centres or the CGH Community Health Centres (CHC).

DOT GPs would charge their patients $25 for the first consultation and $21 at the follow up visits which should be at three-monthly intervals each. This does not include a separate phlebotomy charge if blood tests are needed during the visit.

DOT GPs should agree to use the three SHS Incentive Programmes for the next two years. Each DOT GP will receive $600 worth of educational tools and meters from CDMO.

C. NATIONAL UNIVERSITY HOSPITAL SHARED CARE PROGRAMME

The National University Hospital (NUH) has chosen to tackle the issue of integrated care in a context and problem based manner. A committee involving the Family Medicine Division meets regularly to discuss the issue of right siting and shared care. We shall take a look at the rheumatology shared care programme as an example of how shared care is tackled in NUH. This is a joint project of the Division of Family Medicine and the Division of Rheumatology. The focus of this project is the shared care of stable patients with rheumatic conditions with the family doctor.

Through focus group discussions between family doctors, specialists, conversation with patients and their family members, the following problems were identified and various steps taken to minimize these shortcomings where possible:

(a) **Drug costs** – recurrent cost to patients can be significant in the provision of quality care of rheumatoid arthritis, but less so for patients with gouty arthritis. Thus arrangements have been made with the pharmacy to supply the medicines at hospital pharmacy rates and thus remove one big barrier.

(b) **Disincentive for patients to see the family doctor** – these are groups of patients like those with CSC cards, where subvention is obtained only if patient is seen in a hospital SOC.

(c) **Mindset change** – patients need a mindset change to shift their care provider to the family doctor. This is facilitated by a care co-ordinator who explains to the patients and reduces their concerns.

For the less stable patients two other strategies have been added:

(d) **The idea of "flip-flop" partnership** – the patient who is stable enough consults the family doctor once and sees the hospital specialist at the next visit. This works out well for conditions where there may be some instability from time to time and where blood monitoring is necessary. The suitable prototype condition for this scheme is rheumatoid arthritis.

(e) **The idea of sit-in sessions by the family doctor** – so that the expectation of care and processes may become more familiar.

The rheumatology conditions that are suitable for shared care in order of ease of implementation are: gouty arthritis, osteoarthritis, osteoporosis, ankylosing spondylitis, rheumatoid arthritis, and systemic lupus erythromatosus.

Care pathways for rheumatoid arthritis, systemic lupus erythromatosus are as follows:

(i) The stable patient is given the option to participate in shared care. The care co-ordinator helps to reduce the barrier of concern by explanation, and the reassurance that the patient can connect back to the co-ordinator if there are concerns;

(ii) Patient agreement;

(iii) The patient is given the family doctor's location, telephone number, and appointment date, and information including a care plan to be take to the family doctor;

(iv) The family doctor is notified of the patient's appointment and details clarified with the care-coordinator;

(v) During each visit, necessary blood tests are done. After clinical assessment, and if these are stable the patient is informed and medications replenished through the NUH pharmacy.

For conditions like gouty arthritis, osteoporosis, and osteoarthritis, where the stability of the condition is greater, the patient can be discharged to the family doctor. The parameters to aim for are reduction of attacks, reduction of uric acid level to <360 mmol/l in order that dissolution of tophi will begin to take place, and shrinkage of tophi over time which may take two years or more. There is a big pool of patients with gout who are not given allopurinol.

There is a need to educate patients that allopurinol is necessary to reduce the store of uric acid and subsequently tophi in the body. This will ensure a better acceptance of allopurinol. The principle is to started low (e.g. 100 mg om), and go slow (e.g. add slowly, e.g. 50 mg or 100 mg every three months or so and build up to 400 mg or even 500 mg over time).

Patients need a mindset change to shift their care provider to the family doctor. This is facilitated by a care co-ordinator who explains to the patients and reduces their concerns.

The idea aims to avoid an acute flare of gouty attack in starting treatment and the potential consequent loss of confidence on the treatment. It should be reiterated that patient education is all important and their fears need to be addressed conclusively.

GPs are free to charge their usual charges for both consultation and investigations. There is a recommended standard pricing of $28 for consultation. Blood monitoring of patients on disease modifying drugs at GP clinic; results communicated to patients by telephone. Prescribing rights given to GP-prescriptions are faxed to NUHS pharmacy, and dispensed medications couriered to patients.

The patient sees the rheumatologist and GP on alternate visits unless the patient is deemed so stable that he/she may be discharged completely.

Transitioning care

NUHS family medicine clinics: Supervised by the rheumatologist.

Two roles:

- Stable patients who need time to get used to the idea of shared care in the community.
- CSC holders/ patients whose medical bills are paid by their companies only if they are seen in restructured hospitals

The patient sees the rheumatologist and GP on alternate visits unless the patient is deemed so stable that he/she may be discharged completely. As of end of March 2011, 67 patients (from October 2010 to March 2011) are participating in shared care in the community; 139 are being seen in the NUHS Rheumatology- Family Medicine clinic with 46 discharges out to the community.

Other shared care programmes

Other shared care programmes between the hospital specialist departments and family doctors include renal shared care, asthma shared care and the NHG DOT programme for diabetes mellitus.

Summary

There are significant differences in the scope of the various right-siting programmes currently being carried out by CGH, SGH and NUH. These include differences in the recruitment criteria of doctors, chronic disease entities right-sited, payment quantum, reporting criteria of clinical indicators to ensure standards of care are maintained and even the amount of hand-holding that a patient might expect during the process.

These differences reflect the complexity that is inherent in providing quality, accessible and affordable long –term care. Rising patient expectations and valid patient concerns regarding costs further enhances the challenge that faces all stake holders in finding equitable solutions. Thus Regional Hospitals are rolling out different solutions to meet different needs.

Common enablers:

- Well trained right-siting officers, care coordinators.
- Continuing access to subsidized drugs and tests.
- Access to named-specialist and other allied health support via phone, on-line or joint-clinic arrangements.

Common barriers:

- Patient and specialists' concerns and expectations regarding care in the community.
- Costs of drugs and investigations
- Access to various subvention sources.

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and Ms Lok Sun Sun, Primary Care Integration, CGH.

CM

from page 1, "Integrated Care"

He challenged CGH and our other regional health systems to look at how to scale their excellent programmes serving small groups so that they can support their regional constituents as a whole.

Key thrust 2: "From provider to patient"

We must also plan the delivery of healthcare services with the patient in mind. This sounds obvious but all of you know that implementing a hassle-free, patient-centric system of care is challenging. Seamless care within the acute hospital is hard enough. Seamless care beyond the hospital across a network of primary care and ILTC providers requires the various parties to look beyond organisational boundaries, professional cultures and business models to structure care based on what is best for patients and the system. This patient-centric ethos extends to clinical leadership, coordination of treatment plans, quality evaluation, sharing of medical information and daily operations.

The Government's restructured acute hospitals are leading the efforts in their respective Regional Health Systems (RHS). The logic behind the RHS is that each of these should be anchored by an acute hospital, with a network of community hospitals, nursing homes and community services to support the frail elderly, mentally ill and other vulnerable patients. The collaborations have started, all over the island. The best known ones are those between the restructured hospitals and their partner community hospitals – CGH and St Andrews' Hospital; NUH and St Luke's Hospital; Tan Tock Seng Hospital and Ren Ci; SGH and Bright Vision Hospital. Our hospitals are also working with other entities in their regional systems. For example, TTSH has worked with a few nursing homes on fall-risk assessments and coaching of high-risk seniors to improve balance. Khoo Teck Puat Hospital is working with St Joseph's Home on tele-consultation. This has helped the nursing homes avoiding costly admissions to the hospital.

Patient-centric care would not be possible without AIC playing its role as national care coordinator. Its Aged Care TransitION (ACTION) teams within the acute and community hospitals help patients with complex medical and social needs transit smoothly from the hospitals back to their homes and communities. To date, AIC has helped over 15,000 patients receive good quality intermediate and long-term care after discharge from the acute hospitals.

The end-goal is to create an environment where Singaporeans can move seamlessly across providers, without repeated testing, duplicative care or falling through the cracks.

Good patient-centric care is also about empowering patients and their families to make informed choices about the care services they should access. I am very happy that AIC is making this process easier by rolling out the Singapore Silver Pages, the first of its kind ILTC portal here. The Silver Pages features a Self-Assessment Tool to help patients and their families estimate their care needs, an Eldercare Service Locator, a product directory of medical consumables and assistive devices, an online helpdesk and other useful resources.

Key thrust 3: "From institution to home"

Third, we are taking a home-centric approach to care. The priority of our healthcare institutions should be to get patients well again so that they can go home. To make this happen, acute hospitals, community hospitals and nursing homes are thinking hard about helping patients maintain contact with their families by explaining the patient's care plans and goals, facilitating family visitations and home leave arrangements.

These institutions are also addressing gaps in service planning, capabilities and resources that currently hinder patients from returning home. We are supporting home care providers such as the Home Nursing Foundation (HNF) and Touch Community Services to expand their capabilities and staffing. HNF is now working on a pilot with TTSH where a HNF nurse joins some ward rounds in TTSH. This allows her to speak to and better understand the needs of patients who require HNF services post-discharge. This way, patients, families, home care nurses and other personnel like physiotherapists and medical social workers, are all better prepared for the patients' eventual transition home. We have also set up an Expert Panel on Nursing Homes to advise us on improving the rehabilitative capabilities of nursing homes, so that patients can benefit from effective rehabilitation and are able to return home eventually.

Key thrust 4: "From isolation to integration"

This covers a broad range of concepts, such as structuring of services so that each provider does not deliver care in an isolated way. Beyond the obvious patient flows across institutions that I have talked about, I also hope that institutions within each Regional Health System can share staffing and capabilities more effectively. Shared group procurement is an obvious area to work together on; another area is pharmacy where smaller community

institutions and nursing homes may not need nor be able to afford a full-time pharmacist on-site. With part-time deployment possibilities, as well as tele-pharmacy, it should be possible to use scarce manpower more effectively. Guardian Pharmacy has been using tele-pharmacy for some time now, and has shown that it can work.

MOH and AIC as enablers

As our healthcare providers continue to take meaningful steps forward, MOH and AIC will support you in your efforts. MOH and AIC will invest in long term capacity and capabilities, including infrastructure, professional manpower and information systems.

In infrastructure, you will have already read about our plans to build more third-generation community hospitals like Yishun and Jurong Community Hospitals next to our restructured hospitals. We also plan to augment primary care, nursing home, hospice, home care and community care capacity to facilitate right-siting. Recognising that fund raising to build physical infrastructure is challenging for VWOs to do, we will fund the development of new infrastructure like nursing homes (subject to availability of funds). We had announced earlier the building of six new nursing homes for the VWOs to run.

We are also stepping up efforts to train and recruit quality healthcare professionals for the acute and ILTC sectors. We are expanding local training pipelines in all major healthcare professions, not just for public sector needs, but for national needs in the private and VWO sectors as well. For example, more local undergraduate programmes are being developed in medicine, nursing and allied health. We are giving out significant numbers of scholarships in professions where we are short, including pharmacy, physiotherapy, clinical psychologists, medical social workers, and even health economists etc. We have already begun helping VWOs in the ILTC sector recruit professional manpower and are considering seconding public sector professionals to them. AIC's Learning Institute is also rolling out several training programmes to raise the capabilities of the ILTC sector. AIC will develop a national care assessment tool and it is also guiding VWOs on quality assurance frameworks. MOHH with IHIS (Integrated Health Information System) will take on the challenge to develop the various IT projects.

MOH will also develop the key information systems for institutions outside the public sector. We are working with community hospitals on their electronic medical records needs and administration support IT infrastructure. Likewise, IT for primary care GP clinics and community care providers. These will all need to ride on top of the National Electronic Health Records system rolling out in the next few months. We are also very keen on trying out teleheath options where patients can consult their providers on the phone, via the TV or over the internet. Frail and recovering patients can be monitored by sensors and equipment that can send data to healthcare providers remotely.

The national healthcare financing framework is also being progressively redesigned to support the structural changes we are proposing. For instance, last year, we raised Medisave withdrawal limits for patients at community hospitals and day rehabilitation centres. We allowed Medisave for health screening, outpatient treatment of chronic diseases, and for home palliative care. We recognise that healthcare financing influences institutional business models, and these in turn will have a huge impact on whether care is effectively integrated.

Closing

In closing, I would say that we can certainly do more to make our system better. But I think we can be very proud of what we have already achieved. I am confident that we can realise our vision of integrated care, taking the next five to ten years to scale up our ideas. Singapore's size is often a disadvantage, but in this case, it can be an advantage as we can get everyone involved together in the same hall to brainstorm. Our fundamentals are right, giving us room to gear up and restructure our financing to support our goals. And most importantly, we have the right people – dedicated professionals and volunteers with the values, commitment and passion, anchored by the Singapore ability to get organised and get things done well. The number of people here today for this inaugural conference is testament to that.

I look forward to benefitting from your sharing at this conference. May I wish all attendees a fruitful and enjoyable experience.

Thank you. ”

CM

We are expanding local training pipelines in all major healthcare professions, not just for public sector needs, but for national needs in the private and VWO sectors as well.

The Mindset for Integrated Care

by Dr Michael Yee, FCFP(S), Family Physician in private practice, Editorial Board Member

The case for integrated care

Many of our patients have experienced, and lamented on, the state of disorientation in the body organ-oriented compartmentalised healthcare in Singapore, leading to inefficiencies and inconvenience to the end users of our national healthcare system. To add to these conventional issues is the biased health subvention policy leading to unnecessary overcrowding and misuse of specialist departments. There is a lack of continuing care as patients jump from one institution to another. Holistic care is often an afterthought. Medical cost is artificially inflated as patients get channeled from one specialist to another, often unnecessarily and unknowingly.

The public in fulfilling its economic compulsion tries to game the system, leading to further wastage. Amidst the lack of bearing, the media has started to lobby its own agenda on the healthcare system, in the process disparaging the private primary care physicians.

Theoretically, these problems would lead to sub-optimal health outcomes. Is there a purpose of this borborygmus? All these serious issues could be a thing of the past if a system of seamless integrated care can be put in place.

What have we been up to?

From a public health policy perspective, there is great potential for a small country like Singapore to lead the developed world in the area of integrated care. The Health Minister has clearly articulated his preference for a general practitioner (GP) for every citizen. To that end, the Ministry of Health (MOH) now has a Primary and Community Care Division. The Agency for Integrated Care (AIC) has also been established to spearhead the operational issues of integrated care in Singapore.

As part of a collective effort to dispel the image of an under qualified family doctor, the College with its various like-minded partners have put in place a comprehensive plethora of Continuing Medical Education (CME), certification and degree programmes to cater to all levels of academic expertise and professional development. The Family Physician Register (FPR) should leave nobody in doubt as far as the resolve of the GP community to make the mark. Restructured hospitals have set up Family Medicine Departments within the hospital itself and gaining prominence. Special corporate units have started to appear in hospitals and polyclinics to handle shared care programmes.

There is consensus that a well-established general discipline like Family Medicine should be the vital fulcrum that is necessary to bring about such an integrated health care system. Not surprisingly, the various Family Medicine Departments in our restructured general hospitals have been working overtime with the issues of shared-care and step-down-care.

Are we merely building castles in the air, an elusive utopia? Can one be blamed for being pessimistic, judging from the track record of healthcare reform in this instance?

Despite the hard work behind the scenes, it is evident to the ordinary GP that progress in this area has been excruciatingly slow. For the longest time, health authorities, public health institutions, restructured hospitals, polyclinics and private practitioners have been grappling with various schemes to operationalise the talk. Are we merely building castles in the air, an elusive utopia? Can one be blamed for being pessimistic, judging from the track record of healthcare reform in this instance? But I certainly believe that the hurdles are surmountable. So why have these efforts come up short of expectations? As with many testing issues, it probably has more to do with the 'heartware' rather than the 'hardware'. I see three mindset prerequisites:

1. Mutual trust
2. Money for quality
3. Momentum to change

Mutual trust

There remains a significant mutual distrust among the various stake holders. However, there are probably more in common among restructured hospitals, polyclinics and private practitioners than we care to imagine in the area of right-siting, shared-care, step-down-

care and other processes or programmes associated with integrated care. In fact, restructured SOC and even the polyclinics are anxious to offload suitable patients to GPs given the unsustainable workloads and drain on resources. Patients prefer the personal attention, convenience and stable long-term professional relationship in the community. Trained family physicians are keen to play their part as counselor, caregiver, patient advocate, gatekeeper and care coordinator. But, some specialists continue to doubt the reliability of GPs despite the affirmative academic and professional recognition.

There must be acceptance that a generalist will not have as deep a knowledge based as a sub-specialist, in the same manner the specialist does not have the broad-based skills and abilities of a family physician. It would be foolhardy to focus on our mutual shortcomings instead of capitalizing on each one's strengths. Detractors of the concept of GP as the gatekeeper and coordinator of healthcare have advocated a special force of lay patient coordinators dealing with individual diseases, ironically, attempting to integrate care in a silo mindset. The system of 'physician assistants' and 'barefoot doctors' that are being practiced in large countries like the US and China might not be suitable in a small well-connected city state like Singapore with an evenly distributed GP network servicing every nook and corner conceivable. The improved undergraduate medical training programme, putting more emphasis on Family Medicine and the new residency programme, which facilitates useful interactions, holds great promise of a beginning of a new era of cultivated mutual understanding.

Rome was not built in a day. Trust takes time to cultivate. Past contentious behavior towards GPs such as the infamous handling of the SARS crisis, the maid examination issue and the appeal for GPs to help with narcotic addiction only to be blamed for the increase addiction of narcotic alternatives, has sullied good professional relationships. All these dealings still reside in the collective memory of GPs who went through the distressing experience. Despite the reality that the misuse of treatments and procedures is hardly confined to family doctors, GPs are still being targeted. The misuse of addictive medicines and misuse of unproven therapeutics should be more effectively dealt with systemically as a national healthcare problem rather than by the convenient finger-pointing against family doctors as a whole.

Indeed it can easily be surmised that the media has a hidden vested interest, as alternative medicine and other pseudo-scientific health products and services, represent a huge potential source of advertising revenue. As a fraternity, family physicians would need to continue to stay disciplined and avoid endorsing such unproven therapies for the short-term profit, despite their media induced popularity.

The ship of a general practitioner is, in fact, built and sails very differently with that of a specialist's. For integrated care to succeed, the media must stop portraying GPs as inferior cousins to our specialist. With positive public portrayal of private clinics with respect to government owned healthcare establishment, patients shall gradually gain faith in their GPs. Small private GP clinics must not be unflatteringly compared to government owned institutions. Instead, ethical professional behavior must prevail.

Healthcare must be viewed as an essential investment with the ultimate aim of more happiness, prosperity and progress for all citizens, regardless of the cliché.

Money for quality

If we are indeed interested in real results, we would need to put our money where our words are. We should be worrying more about paying for quality rather than guarding of our national healthcare purse strings and recovery of the disbursed healthcare subsidy.

Integrated care is an attempt at improving the quality of care through better holistic care, continuing care, co-ordinated care and more efficient allocation of healthcare resources. Better quality of care for the patient that would inevitably translate to more costly, but better health. Healthcare must be viewed as an essential investment with the ultimate aim of more happiness, prosperity and progress for all citizens, regardless of the cliché. The government must start putting appropriate expansionary healthcare budget and reap the future manifold benefits.

While the public demands affordable healthcare, few are in favour of low quality health provision. To this end, GPs should certainly give themselves a pat on the back as one of the most efficient return on healthcare resources invested, putting its main effort in inexpensive low tech solutions, preventive care and wide accessibility, compared with the wasteful glamorous high tech white elephants that benefit only a few rich clients. The misplaced haughtiness in our low healthcare spending must be replaced with a more realistic allocation of our GDP in healthcare. If that means spending proportionately less

on other areas like housing, transport and defence, it would be a welcomed bonus. From the recently ended election campaign rallies and social media vibes, there was widespread agreement that the population has a willingness to spend more on healthcare.

If the government is serious about encouraging patients to patronize privately-owned GP clinics to solve the problems of right-siting, shared-care, step-down-care, and other processes leading to a truly integrated seamless healthcare system, they would have to start providing subvention where there are real benefits to patients in terms of improvements in quality, effectiveness and allocation efficiencies. They must not just consider how health subvention can be directly recovered through polyclinics and subsidised SOCs only. This is not an argument for social welfare, but an appeal for shrewd allocation of healthcare resources. There must be courage enough to dismantle and reform the biased subvention system favouring government owned institutions. Instead, subvention should ideally go to where the public health needs are regardless of ownership of the healthcare facility.

Putting resources to institutes with better outcomes is also flawed as more resources would logically improve outcomes when applied, putting institutions already receiving subvention at an unequal footing. All manner of schemes and rhetoric would not be able to solve the problem at hand if the archaic system of biased health subsidy continues to skew demand and disrupt continuing care. The system of CSC and other scheme also biased towards government owned healthcare institution must likewise stop. Instead, patients should be given the freedom to choose in a level playing field, which would lead directly to free market driven optimal efficiency.

Momentum to change

Two years after the AIC was incorporated and tasked to support the growth and development of the primary care and step down care sector, there are few new plans for how to integrate primary care to the national healthcare system. The AIC must take the initiative and engage GPs to work on a systematic plan for integrated seamless healthcare system and provide the leadership that is required to drive this essential piece of healthcare reform. Understandably, the AIC should try its best to avoid false starts. Past efforts have heralded false dawns, only to get entangled in the prohibitive administrative red tape. Taking too long or not taking any new initiatives, however, is not acceptable. This inertia to act would only put them in a bad light with regards to the lack of direction.

Meanwhile, various health establishments are rolling out individual schemes and programmes. Some might achieve limited success, but none would be able to help Singapore achieve the type of seamless integrated care without an overarching coordinating body to direct the vision. This lack of leadership should be rectified urgently.

For the family physician, there is a need to continue to upgrade ourselves to prepare to take part in the next wave of change. With each steady step, we shall surely get to where we want to go. As the saying goes, it is always darkest before dawn. If we want to play an active role in the new seamless integrated healthcare system we need to be willing to assume the role of a healthcare coordinator and gatekeeper. There could be additional responsibilities, but given the right attitude and genuine support, we would no doubt be able to handle the challenge.

If we want to play an active role in the new seamless integrated healthcare system we need to be willing to assume the role of a healthcare coordinator and gatekeeper.

We do not know what exactly healthcare in the 21st century would evolve into, but the possibilities are decidedly hopeful if each level of change agent play their part to make it a better world for our children and our own aged existence in the future. Family physicians should be well-poised to take a leading role in this seamless integrated healthcare system. If we are able to hold on to this vision, we may one day achieve the truly seamless integrated healthcare system.

Conclusion

In summary, we can leverage on our strengths and leave out futile blaming that drains our energy.

The name of the game should not be to provide less and recover more funds, but more efficient and appropriate use of healthcare dollar and reap real health benefits.

All this discussion on a national healthcare system would indeed become hot air if we lull ourselves into inertia by staying in our comfort zones. Opportunities could be turned into success if we seize the chance, let us take this opportunity to lead the world in integrated care. ▮CM

Tattoo Removal
Yellow Ribbon Project Volunteer

by Dr Jonathan Pang, Honorary Secretary, 22nd Council, College of Family Physicians Singapore

When I first learnt how to use a laser machine some 10 to 15 years ago, it was merely an extension of my surgical skills from simple blade cutting to electrosurgery using a cautery machine for some moles, lumps and bumps(minor surgery in the office or clinic setting).. Lasers were supposed to be more precise with less lateral damage to surrounding skin. Of course, the interest developed further and I went on to learn about other types of lasers over the years.

Never in my mind did it occur that to me that I could make use of the skill learnt to do volunteer work, especially at the Changi Prison Complex, to help remove tattoos or make the tattoos of some of the prison inmates lighter or less obvious. The project that I am involved in was first mooted by a company in Singapore selling laser machines. They came up with the idea of doctors volunteering their time to help the prison inmates remove their tattoos as part of the Yellow Ribbon Project (YRP).

The inspiration behind the YRP came from a 1973 Tony Orlando and Dawn hit song entitled "Tie a Yellow Ribbon Round the Ole Oak Tree". It was actually depicting a released prisoner's desire and hope for forgiveness and acceptance from his loved ones and the community to set him free! The goals of the YRP are – 3 'A's:

1. To create Awareness of giving second chances to ex-offenders.
2. To generate Acceptance of ex-offenders and their families into the community
3. To inspire Community Action to support the rehabilitation and reintegration of ex-offenders.

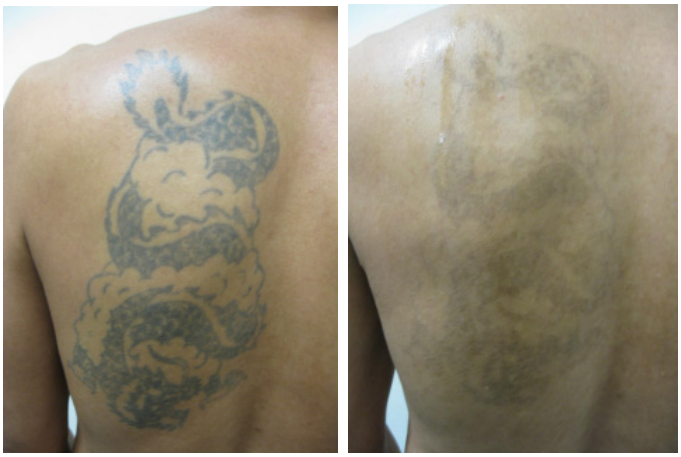
They create a ripple effect in enlarging the pool of people and organizations in supporting this cause.

The principal overseas supplier of the laser machine kindly consented to the suggestion by the local Singapore Company in this very meaningful endeavour. I agreed to help out when approached by them as I thought that it was a very meaningful way of returning something back to society and helping the prison inmates who were about to be released in the near future. They needed some doctors who were trained in the use of lasers and also willing to spare some time. The project started in June 2009 and was planned to last 6 months. Depending on the acceptance of the Prison authorities and the supplier, it was to continue if both parties felt it worthwhile to carry on. It eventually progressed to become a 2 year project, now into the fourth and final phase of the project.

We initially started with six volunteers, General Practitioners, who are ALL members of the College of Family Physicians Singapore (CFPS).

We took turns to go the Changi Prison and treated more than 200 inmates over this period. Some of them have relatively small tattoos (size of a thumb) while others have the whole body almost totally covered with tattoos. The initial aim was to treat those areas that were exposed as it would make their appearance at job interviews a disadvantage. Not all potential employers can accept ex-offenders into their fold. There have been an increase in the numbers who are hiring ex-inmates; this is a good sign as it means that the YRP has succeeded in creating more second chances for these ex-inmates. Singapore Corporation of Rehabilitative Enterprises (SCORE) is a statutory board that takes care of the rehabilitation of the prisoners through inmate-run enterprises in the Prisons. Many of them have acquired new skills which will help them find a new job upon release. There are also many who have decided to take up study courses to upgrade themselves. All these will help to increase their chances of being employed and become a useful member of our society.

I have enjoyed my interaction with the inmates. Many of them regret their folly during their teenaged years when they started the tattoos on their bodies. They have all realized their folly and will not be tattooed again and they have also told me that they



will ask their friends and relatives not to do any tattoos. I have also counseled them on the risk of contracting communicable diseases such as HIV, Hepatitis B or Hepatitis C through contaminated instruments used in the process. There is, of course, the pain and discomfort of the tattoo needling itself as well as when the tattoos are removed by laser. We also managed to listen to some of their personal testimonies that they and their families were thrilled to be given the chance to help remove or lighten the tattoo.

The project is coming to the end of the fourth and final phase. From the initial 6 general practitioners, we have some who have stopped and new ones join us. There were a total of 11 general practitioners and four dermatologists who have come on board over the last two years, some tried out one phase, some two and some three phases while three of us, GPs and also members of CFPS have been the only ones to be involved in all four phases. There are now seven GP's and three dermatologists taking turns to do the tattoo removal two times a week. The local company and the Prison authorities would like to invite more doctors who can do lasers to volunteer their time to help these inmates who are in need. Interested doctors can contact the local personnel, Irene at 96705256 or Kelvin at 96613538.

Reference: The YRP story by Tan Sheer Leen of SCORE. ■CM

Family Practice Skills Course **Management of Functional Decline in Older Adults**

The College of Family Physicians Singapore would like to thank **Health Promotion Board (HPB)** and the Expert Panel for their contributions to the Family Practice Skills Course on "Management of Functional Decline in Older Adults", held on 12-13 March 2011.

Expert Panel:

Dr Wong Sweet Fun, Senior Consultant, Department of Geriatric Medicine, Khoo Teck Phuat Hospital

Dr Terence Tang, Senior Consultant, Department of Geriatric Medicine, Khoo Teck Puat Hospital

A/Prof Lynne Lim, Senior Consultant, Department of Otolaryngology - Head, Neck Surgery, National University Hospital & National University of Singapore

Dr Ong Pui Sim, Senior Consultant, Psychogeriatrics, Changi General Hospital

Dr Au Eong Kah Guan, Medical Director and Senior Consultant, Singapore International Eye Cataract Retina Centre, Mount Elizabeth Medical Centre

Dr Wong Mun Loke, Deputy Director, Youth Health Programme Development, Health Promotion Board

Chairpersons:

Dr Tan Boon Yeow, St. Luke's Hospital
Dr Michael Wong, Khoo Teck Phuat Hospital

Reflections of a Family Physician

by Dr Peter Moey, MCFP(S), Family Physician

Battered and worn down by the toils of Housemanship from 2001 to 2002, like many others, I sought to never again do anything as tedious. I accumulated a list of "relaxed" Medical Officer (MO) postings, (from a mix of hear-say and actual MO feedbacks). For the following five years of governmental bond as a Medical Officer, I planned to sail down the list of "relaxed" MO postings. Then, a relaxed career of "Locum GP" after the bond sounded like a career I could "work" towards. Life would be good henceforth!

However, there was a dilemma whether I would be able to perform competently as a "Locum GP". With knowledge and experience limited to Medical School and Housemanship, I did not feel adequate to handle the myriad of medical conditions in general practice. The only thing I felt competent about was venepuncture, cannula insertion and administering intravenous medication. Moreover, as a doctor, one would always be asked by friends and relatives for advice. It would be good to be able to help them in more depth. Plus, for me, one of the initial reasons for doing Medicine was also to bring medical aid to places that are deprived. All in all, it seemed like a disservice to people and patients if I continued to practice when I felt inadequate about myself.

I tried to find a "balance" between training and not getting into the "toils of Housemanship" again. I figured that since I did Medicine, Obstetrics and Gynaecology, and Orthopaedics in Housemanship, I needed at least to do Paediatrics and Surgery. Looking through my list of "relaxed" MO postings, "Paediatric Surgery" appeared to be a solution, where I can learn about Paediatrics (and get familiar with Paediatric dosing of medications/antibiotics) and surgery (post-operative care, wounds and dressings). I was fortunate to be able to do a posting in Paediatric Surgery. Subsequently, I chose, and again was fortunate to get, a posting in Rehabilitation Medicine. It turns out that knowledge about Community Hospitals/Resources acquired during that posting proved more useful to my practice subsequently, than I had initially thought.

However, almost a year into Medical Officership, I still did not feel adequate to function as a "Locum GP". There were still many medical conditions/situations, where I would feel helpless. Especially as a solo doctor in a clinic, where people would wait and pay for advice and medication, I could not risk letting them down and betray their trust. Although many of my contemporaries started taking up lucrative locum slots the moment they had "license" to, I was not confident to do so. Many of them were surprised when they ask me to "cover" their locum slots, as they had something urgent, only to find out that I do not do locum jobs. Many then tried to re-assure me that it is not difficult and that I will learn as I go along. If in doubt, one can usually follow the regular doctor's previous prescription, or ask the clinic assistant what the regular doctor always gives. Some clinics have a list of medications for common conditions that we can follow. As a last resort, we can call the regular doctor for advice. But inside me, I still did not feel ready for it.

Sensing that I am missing out on the lucrative "locum business", I decided to train myself and do a posting which would bring me closer to my career of "Locum GP". So I gritted my teeth and put "Accident and Emergency" in my next posting. I thought it would be as close as it gets to learning about General Practice and a little more, even though it was way out of my list of "relaxed" MO postings. I had mixed feelings when I finally got the posting as the anticipation of going back to "toils of housemanship" surfaced in my mind. The A&E night-shifts turned out to be a little reminiscent of housemanship (especially at 5-6am) and the day-shifts were non-stop action packed, sometimes lasting even 1-2 hours after the official time to end work. However, I felt a leap forward towards being a competent "Locum GP". I was able to administer digital block, perform toilet and suture to lacerations, do manipulation and reduction of Colles' fractures, administer intramuscular injections (which previously were always done by nurses), examine eyes with fluorescein stain (and even slit-lamp), amongst acquiring other skills

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which I felt were what a competent GP should have. However, every time I saw a child appear down in my patient list, I felt a little flutter in my tummy, and I often hoped that the patient might somehow miraculously disappear from my screen before I reached him/her; perhaps cancelled consult or up-triaged or something. Afterall, if he/she was not here for a Paediatric Surgical condition, I would not have been exactly sure what to do, without consulting the Senior doctor on duty.

Removal of foreign bodies from ears and noses became my favorite procedure, just as the Quire Hook became my favorite instrument.

After a while, I decided that this would not do. I had to confront my fear face-to-face and overcome it. There will be no Senior doctor when I become a "Locum GP". Thus, although it was not in my list of "relaxed" MO postings, I bravely chose Paediatric A&E (or Children's Emergency). I figured there is no better way to learn about children than to handle nothing but children conditions for 6 months. For some strange reason, I seemed to always get the posting of my choice. For some stranger reason, I always get mixed feelings when I get the posting I want. Anyway, in Children's Emergency, I soaked up knowledge about all the common Paediatric conditions from the Department's Guidebook, lectures and advice from Senior doctors during work. I was thrilled to be able to become familiar with the approach to the various acute problems of children, which I was a little hazy about before. I became fluent with all the Patient Education Pamphlets to advise parents on discharge. Words like bronchiolitis and croup became more than theoretical words from a medical textbook as I learnt how to manage them confidently. Removal of foreign bodies from ears and noses became my favorite procedure, just as the Quire Hook became my favorite instrument. Other useful procedures acquired at the posting included reduction of pulled elbows and putting on backslab.

It was then that I realised the importance and value of training. Although I told myself after the tormenting MBBS, that I will never in my life sit for another exam, I signed up for the Master of Medicine (Family Medicine) [MMed (FM)]. I figured that since I had to be bonded for the next few years anyway, it would be great if I could make use of that time to train myself to become a competent "Locum GP". Perhaps, I would have a higher chance of getting more postings of relevance if I went into a training program. Besides, a series of lectures and tutorials would push me to update myself in areas where I might not have a chance to do a posting in eventually. I was not sure if I would eventually complete the Master program or clear the exam, but whatever I could learn from the postings, lectures and tutorials would definitely be good for my intended "Locum GP" career.

In the meantime, I still have not caught on to the lucrative "Locum business". Despite having experience in handling acute problems, I still was not sure what to do at the Primary Care level. I recalled some of the common discharges I have made to Polyclinics/GP for follow-up. I realised that I was not exactly sure how I would have followed up should they appear to me! This was especially so with the chronic conditions such as titrating medications for hypertension and diabetes mellitus. Besides, I was not exactly sure of the exact diagnostic criteria for hypertension, diabetes mellitus and hyperlipidaemia. Asthma and the titration of inhaled corticosteroids was also not something learnt in the A&E. Thus, despite hearing much about the dreaded workload of the Polyclinics and having to be there for 1 year in the final year of the MMed (FM) program anyway, I chose to do a posting in Polyclinic next, as I was keen to polish up my knowledge in chronic conditions, and finally join my friends who were becoming rich with all the "Locum slots". Not surprisingly, I got the posting and the mixed feelings (especially about the infamous workload).

The first few days in Polyclinic were an eye-opener. Despite my experience in Adult and Children's A&E, the learning curve was still extremely steep. For the acute cases, in the Polyclinic, going through the whole comprehensive checklist for every presenting symptom (as I did in the A&E) was neither going to be viable for the workload nor necessary. I was barely able to finish the cases assigned to me despite the number of cases being much reduced, compared with my other experienced colleagues. A mentor who patiently and meticulously went through all my case notes for the first few days introduced me to the "red flags" and "time as a tool" approach to deal with some problems. A 20-minute consult with one and a half pages of history and physical examination for a simple headache was simply not going to work. As for the chronic conditions, I spent the evenings for the first few days reading up on the medications (such as the indications and contraindications for the various anti-hypertensives and their side effects) and risk stratification for lipids and the target levels for the various risk profiles. I also had to quickly get familiar with the protocol of diabetes mellitus management, so as to fit in the overall scheme of things in the Polyclinic. Amongst the confusion in the first few days in Polyclinic, I was so happy whenever a child comes with a fever or a baby comes with neonatal jaundice. Finally, here is something I have become so comfortable with, a far cry from the time I was working at the Adult A&E.

A mentor who patiently and meticulously went through all my case notes for the first few days introduced me to the "red flags" and "time as a tool" approach to deal with some problems.

As time passed in the Polyclinic posting, I felt more and more confident. The workload in Polyclinic, though high, did not turn out as bad. Besides, as far as I could, I would fill up gaps in my knowledge. During off-days, I would return to the Polyclinic and follow the nurses in the vaccine room (to learn how to given vaccines, the checklists

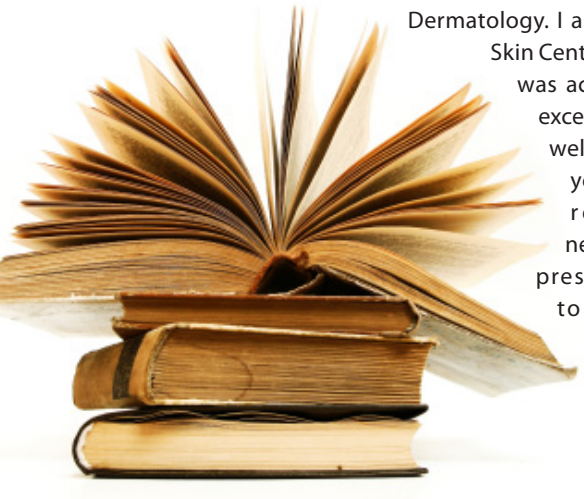
before doing so and the standard post vaccine advice), nurse counselors (on systematic counseling of chronic conditions such as diabetes and dietary advice) and developmental assessment. I also picked-up new procedural skills such as ear syringing and insertion of IUCD. Finally, I felt ready to embark on my "Locum GP" career. But ironically , I still did not have time for any locum work: around that time, I got attached to a lovely girl, who is now my wife!

Finally, when I went back to the Polyclinic as Family Physician, I had new found skills to deal with the various dermatological problems.

The next few years saw me going through 6-monthly rotations such as cardiology and psychiatry. I realised that I have once more gained new insights when I went back to the Polyclinic. For instance, I was more confident when I see a patient with psychiatric conditions and was able to take a full psychiatric history with corroborative history, as time occasionally permits. The only regret I had then was that the 6-month postings were too long and the exposure breadth was not wide enough. Some popular postings were also "out-of-reach", such as Dermatology. Fortunately, my organisation arranged sit-in sessions in Specialist Clinics according to individual MMed trainee's needs. So for me, I had morning attachments such as Sports Medicine, Breast Clinic and Dermatology (which I missed out in my training journey), while some of my other fellow trainees got other sit-in sessions in Specialties which they have missed out, such as Psychiatry. This helped in filling-in gaps in training, which would not have otherwise been possible had I not been a trainee.

With fist clenching determination, I completed the 5 case write-ups, performed a Clinical Audit and wrote-up my Practice Profile for the MMed (FM). Then, to prepare for the MMed exam, I went through the Clinical Practice Guidelines (CPG) from Ministry of Health (MOH), the latest Singapore Family Physician (SFP) articles from College of Family Physicians (CFPS), and finally the MMed (FM) notes (skipping those topics for which newer articles were available from CPG or SFP). The group of MMed trainees also went through the various systematic clinical examinations (which many of us have become strangers with since MBBS) and tutorials with hospital specialists. Finally with divine intervention, I passed the MMed (FM).

However, training did not end there. Amongst other personal aspirations to be fulfilled, I wanted to also apply to do a Dermatological posting. Despite finishing the MMed (FM), I wanted to be even more familiar with Dermatology. I applied to National Skin Centre and fortunately, was accepted. It was an excellent posting as I (as well as other MOs and young dermatology registrars) saw newly referred cases, presented each case to the specialists, and got instant feedback on our differentials, investigations and management plan. In addition, there were assigned sit-in sessions at the various sub-specialty clinics where more complicated cases were seen. As a bonus, I was attached and worked in Department of Sexually Transmitted Infections Control (DSC) where I became familiar with diagnosing and treating the various Sexually Transmitted Infections.



Finally, when I went back to the Polyclinic as Family Physician, I had new found skills to deal with the various dermatological problems. Even when referring to DSC, I was able to provide practical advice to patients such as not passing urine for four hours before consult, opening hours, appointment system and location details.

Training never ends. Since then, I have gone on to attend courses such as Medical Pedagogy, Qualitative Research and Evidence Based Medicine as sponsored by my organisation. I have also been given the opportunity to co-author in a Medical Missions Handbook, conduct research and work with Disease Management Unit (DMU) to integrate chronic disease care. I will be enrolling into the Family Medicine Fellowship Programme to further my training in Family Medicine.

Looking back at my training, I noticed that while it was something invaluable, there were some regrets. For instance, the 6-monthly postings were too long and did not cover enough breadth. Some missing training then had to be filled-up by my organisation, or even by myself. Also, I have come to Polyclinic after Specialist postings for 3 times and found that each time, there were some issues in Polyclinic, related to the Specialty, which I would have liked to consult the Specialists while I still had access to them; such as the management of certain conditions, given the limitations of diagnostic tests or medications in the Polyclinic.

Recently, I was introduced to the Family Medicine Residency Program. I am glad that the issues with training which I faced are being addressed. There are 3-monthly relevant Postings instead of the previous 6-monthly ones. Every week, right from year 1, each trainee returns to the Polyclinic to see patients in their own respective clinics. This would help develop the primary care perspective and ensure relevance of the specialty posting. While the eight postings will not be able to cover everything, workshops will be planned to fill-up any potential gaps in training. A mentor in Family Medicine would be assigned to trainee's right from the start of the program, instead of the Final Year of training as previously. This is a good step forward in Family Medicine training. Hopefully, the need to fill-in gaps in training by individual doctors themselves would be a thing of the past. While I cannot reverse time and be born later to enter this exciting Residency Program, those who are keen and eligible should grab the chance to apply for it.

So whatever happened to my "Locum GP" career? That would have to wait. As for now, I have not finished my training in Family Medicine... nor do I think I would in the near future... CM

Report Adverse Events to Health Products

by Ms Belinda Tan, Senior Regulatory Specialist, Health Sciences Authority (HSA)

The national adverse event (AE) monitoring system for health products is administered by the Vigilance Branch of the Health Sciences Authority (HSA). It is a surveillance system supported by healthcare professionals, who actively report adverse reactions of health products observed in clinical practice.

An adverse event (AE) is defined as any untoward medical occurrence that may present during treatment with a health product but which does not necessarily have a causal relationship with this treatment. It excludes AE caused by accidental or deliberate overdoses and medication errors.

REPORT YOUR SUSPICION

Report your suspicion of any serious and unexpected adverse events to marketed health products. Health Products include:

- Prescription drugs and over-the-counter (OTC) medicines
- Vaccines and other biologics
- Medical devices
- Complementary medicines such as traditional Chinese medicines, Malay traditional medicine, and Health Supplements
- Cosmetics

In particular, please report:

- All serious and non-serious adverse events to newly marketed health products;
- All serious adverse events to established drugs, even if the reactions are well known. This allows us to give advice on how the drug can be used more safely in clinical practice;
- All unexpected events to established drugs, i.e. adverse reactions that are not listed in the product package insert or labelling;
- All serious adverse events to complementary and herbal remedies.

HOW TO COMPLETE AN ONLINE AE FORM?

You can complete an AE form to tell us about a suspected adverse reaction to any health products. Report online at **www.hsa.gov.sg/ae_online**. Alternatively, paper form can be downloaded on this website or obtained by contacting the Vigilance Branch of HSA at tel: 6866 3538/3539. Do not be put off from reporting if you don't have all the information. Additional information can be provided at a later date.

KEY INFORMATION REQUIRED

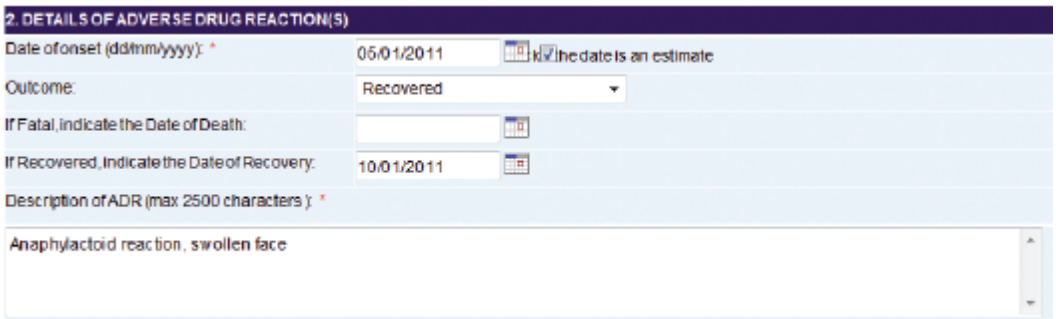
Four key information should be provided in an AE report. It will take you less than ten minutes to fill in the following:

1) Suspected AE/ Adverse Drug Reaction

Please provide details of the adverse reaction. Information on date of onset and outcome help in the assessment of the causal relationship between the reaction and the product. If you are uncertain of the date of onset for the adverse reaction, providing an estimate is acceptable.

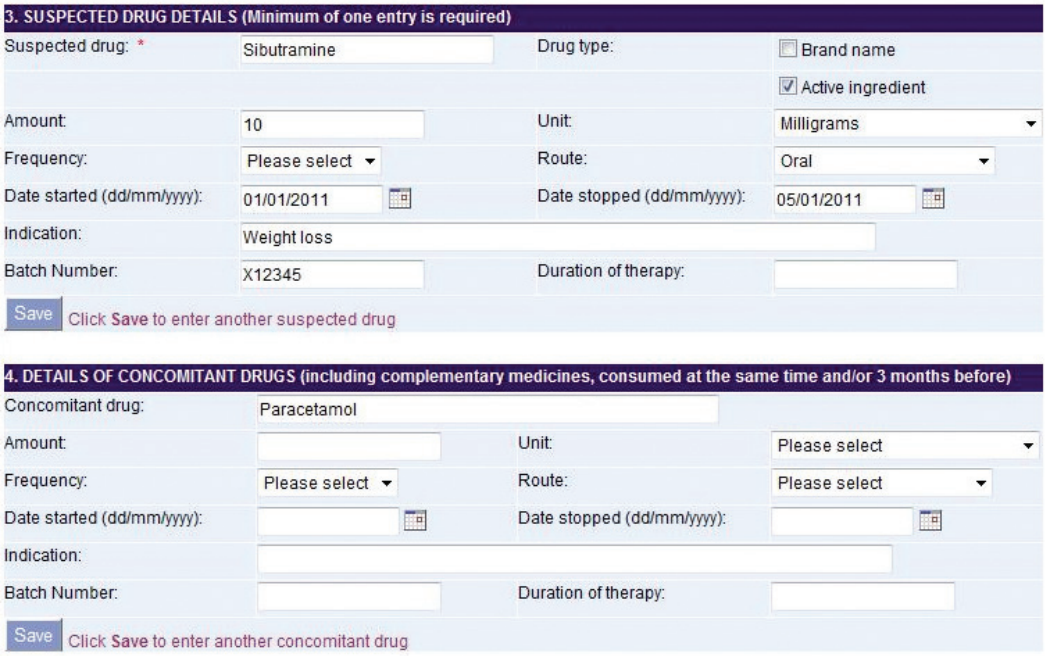
An example of a completed Adverse Drug Reaction (ADR) form is given.

Fields marked * are mandatory



2) Suspected Health Product/ Drug

The name of one or more suspect health product(s) thought to have caused the adverse reaction is required. If possible, please provide the brand name in case it is a brand specific AE. The batch number is important for detection of potential batch defects, particularly for vaccine. Other relevant information such as medical history and details of concomitant drugs/supplement are value-added information useful for our assessment.

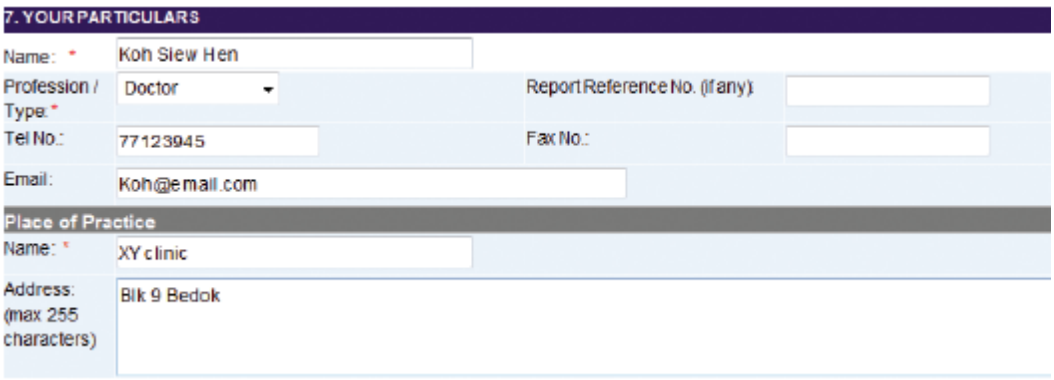


3) Patient Particulars

At least the age, sex and ethnic group of the patient should be provided. Identification number is not a mandatory field, but it will help us identify duplicate reports. Please be assured that patient particulars are kept in strict confidence.

4) Reporter Particulars

Your contact details must be provided. These are held in strict confidence and you will be contacted only if additional information is required. Please provide your email address if you want to receive an acknowledgement of your report.



HSA encourages all healthcare professional to report AEs experienced by your patients that may be related to a health product. There have been examples of astute family physicians who have assisted us to promptly detect safety concerns of health products. You could be one of them and your report is helping to safeguard public health. ■CM

Family Practice Skills Course #42

New Horizons in Hypertension

Sat-Sun, 15-16 October 2011
2.00pm-5.45pm
College of Medicine Building, Auditorium (Level 2)
16 College Road, Singapore 169854

TOPICS

Unit 1: Overview & Epidemiology of Hypertension in Singapore
Unit 2: Assessment of Hypertension & Cardiovascular Complications
Unit 3: Peripheral-vascular & Cerebrovascular Complications
Unit 4: Renovascular Complications
Unit 5: Behaviour Modification
Unit 6: Therapeutic Consideration

WORKSHOPS

1: Global Assessment on Cardiovascular Risks
2: DASH Diet Application

SPEAKERS

A/Prof Terrance Chua Siang Jin
Dr Goh Ping Ping
Dr Chadachan Veerendra Melagireppa
Prof A Vathsala
Dr Tan Yew Seng
Dr Akira Wu
Ms Gladys Wong

** All information is correct at time of printing and may be subject to changes.*

☐ **SEMINARS** (2 Core FM CME points per seminar)
Seminar 1 • Unit 1-3: Sat, 15 October 2011 (2.00pm - 4.15pm)
Seminar 2 • Unit 4-6: Sun, 16 October 2011 (2.00pm - 4.15pm)

☐ **WORKSHOPS** (1 Core FM CME point per workshop)
Workshop 1: Sat, 15 October 2011 (4.30pm - 5.45pm)
Workshop 2: Sun, 16 October 2011 (4.30pm - 5.45pm)

*Registration is on first-come-first-served basis. Seats are limited. Please register by 30 September 2011 to avoid disappointment.

☐ **DISTANCE LEARNING MODULE**
(6 Core FM CME points upon attaining a minimum pass grade of 60% in MCQ Assessment)
• Read 6 Units of study materials in The Singapore Family Physician Journal and pass the MCQ Assessment.

This Family Practice Skills Course is jointly organised and supported by the **College of Family Physicians Singapore** and **Novartis (Singapore) Pte Ltd**

NOVARTIS

REGISTRATION

FREE REGISTRATION for College Members!

NEW HORIZONS IN HYPERTENSION
Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1 (Sat)	☐ FREE	☐ $20.00
Seminar 2 (Sun)	☐ FREE	☐ $20.00
Workshops (Sat-Sun)	☐ FREE	☐ $40.00
Distance Learning (Journal)	FREE	☐ $40.00
	TOTAL	

☐ I attach a cheque for payment of the above, made payable to: **College of Family Physicians Singapore**.*

Cheque number: _____

Signature: _____

*Registration is confirmed only upon receipt of payment. The College will not entertain any request for refund due to cancellation after the registration is closed OR after official receipt is issued (whichever is earlier).

Name: Dr _____

MCR No: _____

(For GDFM Trainee only) *Please indicate:* ○ 2010 Intake ○ 2011 Intake

Mailing Address: (*Please indicate:* ○ Residential ○ Practice Address)

_____

_____

_____ **E-mail:** _____

Tel: _____ **Fax:** _____

Note:
Any changes to the course details will be announced via e-mail. Kindly check your inbox before attending the course. Thank you.

Please mail the completed form and cheque payment to:
College of Family Physicians Singapore
16 College Road #01-02, College of Medicine Building, Singapore 169854

Or fax your registration form to: **6222 0204**

Family Medicine Commencement Ceremony 2011

Saturday, 25 June 2011
2.00pm - 3.30pm

Tea Reception

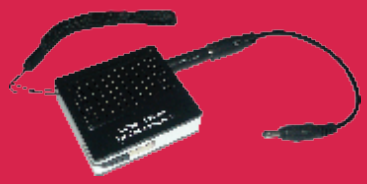
3.30pm - 4.00pm
Outside Auditorium (Level 2)

CFPS 40TH Annual General Meeting

Saturday, 25 June 2011
4.00pm - 6.00pm
Auditorium (Level 2)

Shaw Foundation
Alumni House
11 Kent Ridge Drive
Singapore 119244

USB Phone Charger



College Members who attend the AGM will receive a limited edition door gift, while stocks last!

Family Practice Skills Course #43

Cardio-Metabolic Update

Sat-Sun, 22 - 23 October 2011
2.00pm - 5.45pm
Venue: To be confirmed
(Please visit www.cfps.org.sg for venue details)

TOPICS

Unit 1: Cardio-Metabolic Diseases – An Overview
Unit 2: Rationale for Combination Therapy in Lipid Management Strategy
Unit 3: Evidence on Treating Dyslipidemia in High Risk Patients
Unit 4: The Science of Incretin Biology: Can the Course of Disease be Altered?
Unit 5: Managing the Obese Diabetics
Unit 6: Rethinking the Strategies in Hypertension Management

WORKSHOPS

1: Screening & Risk Assessment for Cardio-Metabolic Patients
2: A Diabetic's Diet

SPEAKERS

A/Prof Goh Lee Gan
Dr Raymond Lee
Dr Yong Quek Wei
Dr Chia Su-Ynn
Dr Tham Kwang Wei
Dr Akira Wu
Ms Teo Soo Lay

** All information is correct at time of printing and may be subject to changes.*

☐ **SEMINARS** (2 Core FM CME points per seminar)
Seminar 1 • Unit 1-3: Sat, 22 October 2011 (2.00pm - 4.15pm)
Seminar 2 • Unit 4-6: Sun, 23 October 2011 (2.00pm - 4.15pm)

☐ **WORKSHOPS** (1 Core FM CME point per workshop)
Workshop 1: Sat, 22 October 2011 (4.30pm - 5.45pm)
Workshop 2: Sun, 23 October 2011 (4.30pm - 5.45pm)

*Registration is on first-come-first-served basis. Seats are limited. Please register by 7 October 2011 to avoid disappointment.

☐ **DISTANCE LEARNING MODULE**
(6 Core FM CME points upon attaining a minimum pass grade of 60% in MCQ Assessment)
• Read 6 Units of study materials in The Singapore Family Physician Journal and pass the MCQ Assessment.

This Family Practice Skills Course is jointly organised and supported by the **College of Family Physicians Singapore** and **Merck Sharp & Dohme (I.A.) Corp. (Singapore Branch)**

MSD

REGISTRATION

FREE REGISTRATION for College Members!

CARDIO-METABOLIC UPDATE
Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1 (Sat)	☐ FREE	☐ $20.00
Seminar 2 (Sun)	☐ FREE	☐ $20.00
Workshops (Sat-Sun)	☐ FREE	☐ $40.00
Distance Learning (Journal)	FREE	☐ $40.00
	TOTAL	

☐ I attach a cheque for payment of the above, made payable to: **College of Family Physicians Singapore**.*

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Signature: _____

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Name: Dr _____

MCR No: _____

(For GDFM Trainee only) *Please indicate:* ○ 2010 Intake ○ 2011 Intake

Mailing Address: (*Please indicate:* ○ Residential ○ Practice Address)

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_____ **E-mail:** _____

Tel: _____ **Fax:** _____

Note:
Any changes to the course details will be announced via e-mail. Kindly check your inbox before attending the course. Thank you.

Please mail the completed form and cheque payment to:
College of Family Physicians Singapore
16 College Road #01-02, College of Medicine Building, Singapore 169854

Or fax your registration form to: **6222 0204**