Dr Foo Jong Yi, Dr Lai Weina, Dr Edmund Chan and Dr Tieh Suat Ying receiving tips from Dr Loo Yuxian during a tutorial.

EC: The examination is a long journey. It is good to start early and be consistent.

CM: How has your own FM journey been since you joined Outram Community Hospital?

WN: I am grateful to be guided by good tutors and helpful colleagues. They are always willing to help make sure that we are on the right track. I am also glad that there are ample opportunities to practise for physical examination in the community hospital setting.

JY: The opportunity to practise Family Medicine in a community hospital setting has been a very good experience for me. I got to learn many new things and become a better family physician.

EC: Since joining Outram Community Hospital, it has helped me focus on each patient's holistic wellbeing and his interaction with the community, thereby providing person-centred care that I can be proud of.

CM

What is iPCARE?

Interview with A/Prof Lee Kheng Hock and Dr Andrew Wong

College Mirror (CM): How did this idea come about?

Dr Andrew Wong (AW): iPCARE stands for Integrated Primary Care for At Risk Elderly. The programme aims to re-connect patients who are discharged from community hospitals back to the GPs in their neighbourhood. The community hospital will continue to support the patients and the GPs with case management and other backend support.

Many of our patients from the community hospitals are elderly and possess multiple comorbidities, spanning bio-psycho-social domains. Though stable upon discharge, they have ongoing complex care needs and are at a high risk of deterioration, especially upon the initial weeks to month of discharge. Functional decline, worsening disease trajectory, falls and increased caregiving burden are just some examples of the ordeals our patients face. This may necessitate subsequent trips to the emergency department and this put a strain on our healthcare system.

From case studies, our team realised that many of the problems our patients face can be averted if they are reconnected to good primary care provided by private GPs practicing in the community. All they needed was some additional resources and support such as case-management, allied health, nursing and peer support by family physicians working in community hospitals.

CM: What did your team do to make this happen?

AW: My team consists of 3 case-managers who are registered nurses, a physiotherapist, a medical social worker and an administrative assistant. All recruited patients will be given a 24/7 helpline to our BVH healthcare team and be tagged to a case-manager who will contact them 1-3 monthly post discharge until they have been re-connected to a GP. During this transitional period, the team will help to sort out their medical issues, engage in health coaching, home safety review, assess caregiving competencies and reduce unnecessary medications. This may take the form of home or clinic visits. Our wound nurse and therapists are also engaged to sort out their nursing and therapy needs accordingly. All these are done in preparation for transition to primary care provided by a GP.

(continued on the next page)

(continued from Page 11: What is iPCARE?)

A/Prof Lee Kheng Hock (LKH): The team had developed a successful working relationship with nearby GPs in the vicinity of our community hospital. Many of them find this to be a meaningful project and allow them to bring their professional skills to help patients with complex care needs. Once we identified a GP practice that may potentially take over the care of our patient, our case-managers will personally introduce our patient to the doctor and provide a handover dossier that define the ongoing care needs to the GP and other information needed for joint care of the patient. After a successful handover, case-management by the community hospital will continue for these patients and the GPs will be updated regularly by our case managers and through multidisciplinary meetings.

CM: Any feedback from the GPs?

LKH: We are encouraged that our program is well received by the GPs. Most felt that with this additional support provided by community hospitals, they are empowered to do more for their patients and now know how their patients are faring the community. Many are happy that they can bring the full range of their professional competencies to help these patients who would otherwise have to turn to the hospital or the A&E. The good primary care that can be provided by GPs are so much more cost effective for the patients as well as for the healthcare system.

CM: Anything else that will be good to bring to light?

LKH: One of main barrier to the empowerment of our GP colleagues in the community is the cost of medication. The programme is able to help negotiate this barrier through medicine reconciliation, deprescribing as well reducing the out of pocket payment by patients through the optimization of drug subsidies.

新闻 联合早报 NEWS 10-03-2019

观明医院年长病患出院后 转介家庭医生管控慢性病

观明医院在前年初推行综合基层医疗计划，至今年1月底已与24家私人家庭医生诊所合作，协助36名患复杂共存病症的病患能继续在社区里管控慢性疾病。

叶伟强 yeowq@sph.com.sg

……位于后港、隶属新加坡保健服务集团的社区医院——观明医院在前年初推行综合基层医疗计划（Integrated Primary Care for At-Risk Elderly，简称iPCARE），至今年1月底已与24家私人家庭医生诊所合作，协助38名患复杂共存病症的病患能继续在社区里管控慢性疾病。……

观明医院为iPCARE计划诊所医生提供多种资源

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An article featuring iPCARE on Lianhe Zaobao on 10th March 2019

▲ Home visit conducted for one of our frail patients

◄ Medicine delivery and reconciliation performed by our case-manager

■CM