Connecting the dots

National Healthcare Group Polyclinics (NHGP) is working to establish medical-social connections to holistically care for chronic patients who require more than just clinical care. Chong Jeen Ktong, 82, is one such patient who has benefited from such efforts.

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Due to an ageing population and smaller family units where care support is sometimes lacking, NHGP is working with community and social providers to holistically care for chronic patients with multiple care needs.

One such collaboration involves Thye Hua Kuan Moral Charities (THKMC) and Ang Mo Kio Polyclinic. Since last year, the two jointly provide interventions that look into medical, psychosocial and functional needs of NHGP patients.

Dr Djoni Huang, Deputy Head of Ang Mo Kio Polyclinic, who is also the Assistant Director of Patient Empowerment & Community Engagement (PEACE) department of NHGP, says that medical care accounts for only about 20% of what affects people’s health. Other factors that play a much bigger part – such as diet, exercise, stress, compliance to medication and home environment – are what doctors have little control over.

Chong Jeen Ktong, 82, is a regular patient at NHGP who has benefited from the collaboration. He suffers from multiple ailments including hypertension, asthma, lower limb weakness, and benign prostatic hyperplasia. He operated a stall in a coffee shop from 1988 to 1998 but had to stop due to health reasons.

During one of his regular consultations in September 2013, Dr Huang noticed that Mr Chong had been admitted to the emergency department seven times and hospitalised three times within span of a year. Later, he found out that Mr Chong – who was wheelchair-dependent – was hindered by a couple of stairs at the doorstep of his home. When he needed to go the hospital, he would call for an ambulance to transport him using a stretcher. It was equally challenging for him to go to the polyclinic.

His wife, aged 75, also faced challenges as a caregiver. She stopped working in late 2013 after her knee operation.

Dr Huang believed one way to help Mr Chong improve his mobility issue was to encourage him to stay active. Dr Huang, together with a caseworker from THKMC, made a home visit to learn more about Mr Chong’s situation.

In November 2013, Mr Chong started having a turnaround in his situation when NHGP’s financial counsellor helped him apply for Medifund assistance.

Three months ago, with the help of THKMC, Mr Chong started going for rehabilitation at a day care centre manned by the Asian Women’s Welfare Association (AWWA).

Despite hesitations over the arrangement, Mr Chong soon got used to the routine. Aside from making friends at the centre, Mr Chong has seen improvements in his mobility and is now less dependent on the wheelchair. He is able to move around more confidently with a walking frame and desires to be more mobile on his own in the neighbourhood. He even took part in the activities organised by the centre, such as a recent visit to Chinatown to soak into the festive mood, something he was unable to do for many years.

His wife’s load has lessened as he is well-taken care of at the rehabilitation day care centre.

Furthermore, as most of Mr Chong’s specialist outpatient visits at the hospital are now consolidated, he can visit the polyclinic for many of his conditions and does not need make unplanned visits to the hospital.

“There are many providers in the community who could help look into these non-medical issues. As a primary care provider, our role is to help connect the dots, engaging suitable community providers to look into the different needs to complete the big picture of health,” Dr Huang explains.
NHGP goes mobile

To improve patient experience and convenience, NHGP launched a mobile application on 15 December 2013. The application allows patients to make same-day appointments for doctor consultations and nursing services such as wound dressing. Using the application, patients can also reschedule selected appointments like vaccinations, make enquires, give feedback, refill their medication, and obtain information on NHGP’s various services.

Ang Chee Chiang, Director, Operations at NHGP pointed out that NHGP’s Contact Centre receives about 600 calls from patients making same-day appointments every day. With this additional portal for appointment booking, NHGP hopes to make it more convenient for patients and encourages them to call-in instead of just walking in. Coming by appointment helps patients better manage their time as patients can come to the clinic nearer the timing given.

“The application has a simple user interface, and only three steps are required to make an appointment. To date, about 250 patients use the mobile application every month to make same-day appointments. “I am grateful for the mobile appointment booking system because it has helped me save time by not having to sit down and wait in the clinic before getting to consult the doctor,” Benson, one of NHGP’s patients, said.

Fall prevention talk for the public

On 16 January 2014, NHGP’s Corporate Development division invited members of the public to Toa Payoh Polyclinic for a falls prevention talk cum volunteer orientation programme. Through the event, NHGP equipped participants with knowledge on how they can protect their loved ones from fall-related injuries, and offered them opportunities to help others who are at risk of falling.

In an ageing society, NHGP aims to empower community members in falls prevention. Studies have shown that falls are prevalent among the elderly; some reported that as high as one-third of those aged 65 and older experiencing a fall each year.

In addition to a talk conducted by NHGP’s Volunteer Programme Coordinators Connie Wee and Sim Mong Kheng, two volunteers, Gina Ang and Sunny Soo, were invited to share their volunteering experience at NHGP.

The participants were also given an opportunity to tour the Ageing-In-Place (AIP) studio. Located at Toa Payoh Polyclinic, the AIP studio is a replica of a studio apartment that showcases a variety of strategic home modifications to help the elderly or persons with fall risks live safely and independently at home.

Left: Sunny Soo, one of NHGP Falls Ambassadors
Bottom: Volunteers Gina Ang and Sunny Soo sharing their volunteering experience at NHGP with the participants
Right: NHGP Health Promoter Amy Tan conducting an educational tour at the AIP Studio
Tossing up good fortune for 2014

To welcome the New Year with a great start, three batches of NHGP Family Medicine Residents, enrolled between 2011 and 2013, had an enjoyable Lo-Hei cum dinner at Khoo Teck Puat Hospital after the second Residency Didactic Seminar on 20 January 2014. This was the first time the residents had a formal gathering with all the core faculty members, polyclinic heads and NHGP’s senior management team, providing an ideal opportunity for networking and bonding.

A/Prof Chong Phui-Nah, Senior Director, Primary Care Academy and Family Medicine Development division of NHGP, gave a speech to wish them success in all areas of their residency.

Chronic Disease Management course for nurses and AHPs

As chronic diseases become more prevalent and complex, there is an increasing need to adopt an inter-professional collaborative approach in managing these diseases. As nurses and allied health professionals (AHPs) play a critical role in these processes, Primary Care Academy organised a nine-week Chronic Disease Management course from 22 January 2014 for 19 nurses and AHPs from NHGP.

The course equipped participants with essential skills and knowledge to better manage chronic diseases. The topics covered include: concept and principles of chronic disease management, health promotion, and health education; pathophysiology of chronic diseases; medical and nursing management and pharmacotherapy of common chronic diseases; and self-management skills.

PCA participates in National Life Saving Day

Yeoh Hui Ling, Trainer of Primary Care Academy (PCA), and Wendy Ong, Senior Staff Nurse of Woodlands Polyclinic, recently represented PCA as instructors in the fourth National Life Saving Day. The event was by the National Resuscitation Council on 19 January 2014 at Republic Polytechnic.

With the aim of raising awareness of the need to save lives and increasing the numbers of trained and confident life-savers in the community, the event saw some 3,000 community members participate in mass cardio-pulmonary resuscitation and automated external defibrillator training sessions.

Spreading joy to the elderly at Casa Clementi

Some 30 elders from the Lion Befriender Activity Centre at Casa Clementi received goodie bags sponsored by staff from Clementi Polyclinic on 15 February 2014.

On that Saturday afternoon, 22 staff from the clinic volunteered to help pack and distribute the goodies. The staff also visited the homes of the elders who could not be present at the activity centre. The elderly expressed their gratitude for the visit.

“All of us felt that the session was meaningful as we could go beyond the four walls of our polyclinic to reach out to the less fortunate people in our neighbourhood,” said Seah Hui Min, Deputy Head Nurse, Clementi Polyclinic, NHGP.
**Impact of care provided by APNs in primary care**

Carolyn Chan, an Advanced Practice Nurse (APN) in NHGP, led a research study involving APNs who co-manage patients with high blood pressure and hyperlipidaemia. Her study showed that APNs are effective in helping patients manage chronic diseases such as high blood pressure and hyperlipidaemia.

**What inspired you to take on this research project?**
APNs have been co-managing patients with high blood pressure and hyperlipidaemia since 2009. We did the study to see how well these chronic conditions are managed through this service, and evaluate the impact of care provided by APNs, in the primary care setting.

**Tell us more about your research project.**
This is a retrospective cohort study. We reviewed about 250 medical records of patients with high blood pressure and hyperlipidaemia, who had at least two consultations with us (APNs) between November 2009 and May 2011. We compared their average blood pressure and cholesterol level measured during their first consultation with the APNs against the levels measured after 12 months of follow-ups.

**How do you counsel patients during consultations?**
I monitor their blood pressure and cholesterol levels, and follow up on their conditions. I will also ask patients about their medical history, and take time to understand their lifestyle – such as their dietary and exercise regime, and whether they drink or smoke. Based on this information, I will set personalised targets for their blood pressure and cholesterol levels, and advise them on lifestyle and dietary modifications. I also recommend appropriate medication, which is first endorsed by doctors.

**What are the findings of your research?**
Under the management of APNs, patients saw significant improvements in the blood pressure and low-density lipoprotein (LDL) cholesterol levels. This shows that collaboration between doctors and APNs results in effective management of chronic diseases such as high blood pressure and hyperlipidaemia. Lifestyle and health education are also important when it comes to managing chronic diseases.

**Was the research published?**
We did a poster presentation at the Singapore Health and Biomedical Congress 2013 and won the Silver Award.

**How many APNs participated in the research?**
A total of three APNs from NHGP were involved in this research.

**Why are you interested in research?**
Research keeps me abreast of updates in patient care and helps ensure that I practise evidence-based nursing.

**What is the process for APNs and nurses to initiate research? Where does funding come from?**
Doing research is part of NHGP nurses’ continuing career development. It’s also part of the curriculum under the Master of Nursing programme. In addition to the Clinical Research Unit, there is a nursing research team at NHGP that oversees research undertaken by nurses. For APNs, we can also initiate research projects by discussing with our supervisors what we plan to examine, how we hope to go about implementing the study and so forth. For research projects led by NHGP nurses, funding is available for projects approved by the National Healthcare Group’s Domain Specific Review Board. Nurses can also apply to various organisations such as National Medical Research Council (NMRC) for research grants.

**Now that the research study has proven this programme’s effectiveness, will the programme be expanded?**
Yes, we are looking to expand this programme. Currently, there are chronic disease management services by APNs in three NHGP polyclinics: Bukit Batok, Choa Chu Kang, and Jurong Polyclinics. We are in the midst of training four APN interns. They will start this service in another four clinics after they are certified.

**Ms Carolyn Chan**
Ms Chan graduated from the National University of Singapore (NUS) in 2009 with a Master of Nursing. She was from the third batch of nurses who had completed this degree at NUS. She is now an APN at Jurong Polyclinic.

An APN is a Registered Nurse who has completed a Master’s Degree in Clinical Nursing. APNs’ advanced nursing education and clinical training in the diagnosis and management of medical conditions allow them to apply a thorough medical approach with a special nursing focus.

Ms Chan specialises in chronic disease management. She also manages common acute conditions such as upper respiratory tract infection, gastroenteritis, and tension headache. During her consultation with patients, she performs duties such as interpreting laboratory test results, performing physical examinations, ordering laboratory investigations and making diagnosis. Ms Chan also educates patients about their medical condition, monitors and assesses changes in their condition, plans follow-ups and furnishes medications. As most of her patients are follow-up cases referred to her by doctors, Ms Chan communicates her patients’ condition with their respective physician in charge to ensure that patients are provided with the best care.

With APNs like Ms Chan around, patients at NHGP can be assured that their health needs are met. The inter-professional collaboration between APNs and doctors also helps improve patient care in NHGP.
On 15 January 2014, a dialogue session at Toa Payoh Polyclinic with Dr Douglas Eby, Vice President of Medical Services at Southcentral Foundation (SCF), attracted about 50 NHGP staff.

Dr Eby shared how the Alaska-based SCF’s “Nuka” system is doing more with less. Here are the key learning points from the session.

**Why learn from Nuka**

SCF is a non-profit healthcare organisation established in 1982 to improve the health and social conditions of Alaska Native and American Indian people, and empower individuals and families to take charge of their lives. SCF calls its healthcare system “Nuka” – a native word for strong living things.

From a modest beginning with a budget of USD3 million and fewer than 100 staff, SCF now operates on a USD277 million budget, employs 1600, and serves some 60 000 Alaska Native and American Indian in Anchorage, the neighbouring Matanuska-Susitna Valley, and 55 rural villages. It offers 65 programmes aimed at reducing domestic violence, suicide, obesity, substance abuse, diabetes, heart disease, and other ills.

Since its major restructuring in 2002, SCF has cut hospital emergency room visits by 42%, hospital days by 36%, specialty care by 58% and routine doctor visits by 30%, all of which have cut costs.

The organisation also has made headway on its core goals. Binge drinking, strokes, heart disease and cancer rates have plunged among Anchorage-area Natives to be on par with the national average.

Such success has caught the eyes of the world, placing Nuka on the proverbial map as a best practices model for healthcare delivery.

They keys to SCF’s improvement journey and success can be distilled down to (a) customer ownership and (b) relationships.

**“Customer ownership” the most important piece in the chain**

“If you could own completely your healthcare system, what would you do as a customer-owner?” Dr Eby explained that “customer ownership” is the most important piece in redesigning the tribal healthcare system.

SCF underwent a system transformation beginning 1999, when the Alaska Native leaders were given full ownership and management of the system from the federal Indian Health Service.

The shift to customer ownership has resulted in a very different reframing of the tribal healthcare system. Along with this new customer-owner status came responsibilities to make informed choices on priorities for the healthcare system and to work to sustain it for future generations.

What followed was a customer-driven overhaul of healthcare delivery, philosophy and values.

With customer-owners originating from more than 200 tribes in Alaska alone, SCF works in partnership with many different cultural groups. To ensure the organisation is capturing feedback from this diverse customer base, it offers a range of options for customer-owners to be heard and responded to – some examples include personal interaction with staff, comment cards, special events, surveys, a 24-hour telephone hotline and online form, focus groups and advisory committees.

SCF’s board of directors and advisory boards are comprised solely of Alaska Native customer-owners, representing a number of different tribes. Customer-owners have also established careers in more clinical and non-clinic roles at SCF.

**Control: Who really makes the decision?**

SCF’s key insight is that patients control their health. Traditional Western medicine pours most of its resources into perfecting what it can control, treating patients with injuries or illnesses demanding precise care – stitching cuts, repairing hearts and hips, prescribing medicines. Eby compared this with throwing rocks at a target. With enough practice, you can hit the target every time because you’re in control.

But this measured care accounts for only about 10% to 20% of what affects people’s health, Eby said. Diet, exercise, stress, work, sleep, lifestyle are controlled by patients. They decide whether to take their prescriptions, quit smoking, exercise. Affecting their health on these fronts, Eby said, is more like throwing a bird at a target.

To get the bird to go where you want it to, you need to understand the bird, identify the motivators and attractors. Thus, SCF built its healthcare system based on relationships.

“Relationship is THE core clinical service we offer and the key set of skills we train every person on,” Eby explains.
**Relationship-based operational principles**

Indeed, relationships are the core priority of how SCF designs services and facilities, improves flow, decreases waste, measures success, and recognises and rewards excellence. To do this, SCF adopts the “relationship-based operational principles” (see box below).

These principles influence everything from strategic planning to employee hiring practices, facility design, job progressions, information support, quality improvement, financial structures, work flow across the boundaries and more.

When care is needed outside of the team, the handoff is immediate and the customer is returned to the team promptly.

**Removing barriers of space and time**

One of the areas where SCF has worked hard to remove barriers is in the design of its physical spaces. “Every wall is movable because we believe that space should not limit what you do,” Eby said.

SCF believes that its physical space should help raise the esteem, pride, dignity, and self-worth in people – as people with higher self-esteem do better in life including managing their own health outcomes.

In that light, SCF is built not just as a medical facility, but a social centre for Alaska Natives as well. The building is filled with sun and native art, inviting people for socialising. Patients come with their families to meet doctors in talking rooms. Larger family rooms are created to emphasise the importance of the family unit in the journey to wellness. This environment removes hierarchical barriers, promotes full transparency, and supports SCF’s philosophy of building strong relationships.

To address the barrier of access, SCF has been offering same-day access with 70% to 80% of appointment slots open on any given day when that day starts. About two-thirds of the teams also give out their direct phone lines so customer-owners have easy access. Teams manage what they can over the phone, and if someone needs to be seen, he or she can be scheduled on the same day with any member of the team, depending on the nature of the problem. The parallel processes remove the bottleneck, shifting the work to where it’s most appropriately and cheaply done. Teams also use phone and email as needed.

**Workforce focus**

The organisation’s executive leaders act as role model for relationship-building behaviours for the rest of the workforce. These behaviours include sharing personal stories, inviting inquiry and questions, admitting mistakes and celebrating successes. A 3-day mandatory Core Concepts (see box below) training, led by the president/CEO, helps employees understand how their relational style impact others, how their experiences affect how they approach and build relationships, and how to articulate and respond to story in everyday work and life.

**Core Concepts**

**Work together in a relationship to learn and grow**
- Encourage understanding
- Listen with an open mind
- Laugh and enjoy humour throughout the day
- Notice the dignity and value of ourselves and others
- Engage others with compassion
- Share our stories and our hearts
- Strive to honour and respect ourselves and others

Over a decade of performance measurement data has shown that the relationship-based “Nuka” System of Care has effectively broken down barriers – of space, attitude, language and time – that previously stood in the way of better health and wellness.

To read more about Southcentral Foundation, you may visit their website at https://www.southcentralfoundation.com/nuka/

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**Integrated care team**

In care delivery and coordination, small, integrated primary care teams have been established to work with the customer-owner to build a trusting, accountable, and long-term relationship. Each team has a doctor with one or two medical assistants – a nurse who focuses on care coordination and an administrative assistant who provides care management support.

Recognising that behavioural issues are an important component of health, SCF also incorporates behaviourists into the primary care team.

The objective is for customer-owners and their families to see the same team every time, and for teams to see only their panel, which is equally important. This allows teams to be responsible and accountable. Each integrated team’s panel size is about 1,200 individuals.

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**Reference**

About Pioneer Generation Package

About 450,000 older Singaporeans will be eligible for the Pioneer Generation Package, Prime Minister Lee Hsien Loong said at the Pioneer Generation tribute at the Istana on 9 February 2014. The Pioneer Generation Package honours and recognises the contributions of the Pioneer Generation in the early years of our nation-building. This package will provide the Pioneer Generation with a greater peace of mind that their healthcare costs will be taken care of in their golden years.

WHO IS ELIGIBLE?
Singapore citizens who meet the following two criteria will be eligible for the Pioneer Generation Package:

- Aged 16 and above in 1965 (born on or before 31 December 1949), which means those aged 65 and above in 2014
- Obtained citizenship on or before 31 December 1986.

WHAT ARE THE BENEFITS?
The package provides the following three forms of benefits, which the members of the Pioneer Generation will enjoy for life:

OUTPATIENT CARE
50% off the net bill for subsidised services at Specialist Outpatient Clinics (SOCs) (see subsidy rates in Table 1 below) and polyclinics.

Pioneer Generation Disability Assistance Scheme will provide cash assistance of $1,200 a year to help those with moderate to severe functional disabilities. (Require hands-on assistance with at least 3 Activities of Daily Living).

The subsidies for SOC and polyclinic services, as well as disability assistance, will be implemented in September 2014. The additional CHAS benefits will be implemented in January 2015.

MEDISAVE TOP-UPS
Annual Medisave top-ups of $200 to $800 for life, with older cohorts of the Pioneer Generation enjoying a larger top-up.

Table 2: Lifetime Annual Medisave Top-up for Pioneer Generation

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<th>Annual Top-up</th>
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<td>65 – 69 (1945 – 1949)</td>
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MEDISHIELD LIFE
- Subsidy for their MediShield Life premiums starting from 40% at age 65, rising to 60% at age 90.
- More details will be provided after the MediShield Life Review Committee has finalised benefits and corresponding premiums later in 2014.

To get to know more about the Pioneer Generation Package, visit http://www.singaporebudget.gov.sg/budget_2014/pgp.aspx

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