MANAGING COMPLEX PATIENTS IN FAMILY MEDICINE SETTINGS

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"I'm not telling you it's going to be easy. I'm telling you it's going to be worth it!"

The above quote by Art Williams says it all. Family physicians deal with complex care for our complex patients because it is worth it. It does not take a genius to see that the patients these days are a lot more complex than they used to be. Or could it be that such patients have always existed from time memorial but it is only with recent decades that there is more awareness of an increasing gap in our healthcare system and the patients that we hope to serve?

One wise family physician told me that our patients no longer suffer from "1M" but "3Ms" nowadays. Most patients in their younger years and initial presentation of diseases, usually come to us with only 1M, i.e. a **Medical** issue. As years pass by, that 1M undergoes mitosis and spawns 3Ms – such patients develop **Multi-morbidities**, with issues existing in **Multiple dimensions in the bio-psycho-social realm,** transiting through **Multiple settings** ranging from primary care, acute hospitals, community hospitals, home care, and nursing homes.

Multi-morbidities are an issue in themselves because such patients usually have many specialists onboard to manage their conditions, and while there is deep expertise in each specialty care, the diversity sometimes causes unexpected outcomes such as fragmentation of care. Issues existing in multiple dimensions mean physicians alone can no longer resolve the patients' problems, and an expanded circle of healthcare professionals, including our allied health professionals, are called upon to the mammoth task. Care that spans multiple settings means that healthcare professionals in the hospital alone, or primary care alone, can no longer adequately care for the patients in silos, but need to coordinate with each other so that the ball is not dropped and the transitional bridge is strong for care to be handed over seamlessly.

So what started off as a simple and straightforward 1M variable, has morphed into an extremely complex 3M healthcare equation with so many variables and moving parts. As our family medicine discipline envisaged helping each and every patient, and rescuing a fragmented healthcare system, we were forced to evolve from an old system where a general practitioner sees his patients alone in his solo practice, aided by a clinic assistant in a pen and card system. Modern family physicians find themselves embedded in multiple settings from hospitals to primary care, needing to practice in team-based care alongside our allied health professionals, and requiring greater knowledge and skills in managing complex patients. It was supposed to be a task that required decades to establish, but it was only put together in the past decade or so, and looking back, we have accomplished a lot of evolution in a relatively shorter period of time. With increasing awareness by our Ministry of Health of the ever-increasing needs of our patients, the emphasis now is to boost family medicine in primary care and other settings to cope with this silver tsunami. More and more resources have been poured into family medicine and primary care in the form of portable subsidies, primary care networks, formation of team-lets for holistic care of such patients, and widening the pipeline for training of aspiring family physicians. I am happy to report that this issue has beautifully illustrated the work done by family physicians as described above, through the articles put forward by the various authors.

Unit 1 by A/Prof Lee Kheng Hock and Dr Low Lian Leng crystallised a holistic approach to caring for patients with complex co-morbidities, which is useful for family physicians in clinical practice. It integrated the commonly used SBAR with Pendleton's 7 tasks into a new SBAR4 comprehensive model which, if applied skillfully, will enable complex patients with multi-morbidities to be managed appropriately in the context of the patient's family and community.

Unit 2 by Dr Xu Bangyu described a patient who had suffered a stroke as an initial presentation in the acute hospital and was managed by his team in a community hospital. In the true spirit of family medicine and holistic care, the team picked up an entire stew of issues along the way that did not present themselves during the previous acute admission, including poor rehabilitation progress; high fall risk; frailty; osteoporosis; vitamin D deficiency; various cardiovascular risk factors including diabetes mellitus, hypertension and hyperlipidaemia; depression; and adverse social circumstances. Dr Xu's team managed the patient holistically during the community hospital admission and transited the patient back to primary care for long-term care.

Unit 3 by A/Prof Goh Lee Gan brought out the important role played by nursing homes in the care of elderlies in Singapore, especially for those who are wheelchair bound or bed-bound, with the need for as many as 15,600 nursing home beds by 2020. The SBAR4 tool is useful for clerking nursing home patients and this case described a patient who became bed-bound after hospitalisation for pneumonia due to deconditioning.

Unit 4 by Dr Agnes Koong described a patient with renal failure and cardiomyopathy who had recurrent admissions to the hospitals, and the various challenges faced by her in the course of managing the patient in the primary care setting. More and more patients suffer from end-organ failures as a result of disease progression, and they often run into acute exacerbations that are distressing to the patients and their family members who may feel inadequate in dealing with such disturbing symptoms. It takes a well-trained family physician in a team-let setup to confidently manage such patients and their families in the community.

Unit 5 by Dr Tay Wei Yi and Dr Low Lian Leng illustrated the use of the SBAR4 framework in the approach and management of a home-bound patient during the transitional

care period for problems of recurrent fluid overload as well as a clavicular fracture sustained after a fall. A single patient was used to illustrate the longitudinal development of medical, functional, and social problems that Family Physicians, as experts in person-centred, primary, continuing and comprehensive care in the community, should be confident in managing in the domiciliary setting.

Unit 6 by Miss Christine Hindarto and Dr Matthew Ng described in detail how medical and social care can be bridged. This unit is an update on this topic by both authors and should be read together with the authors' previous two articles published in the Singapore Family Physician: SFP 2015, 41(1); 32-45 and SFP 2016:42(4):39–54. With an increasing number of community services to tap into, the multi-disciplinary team members are now more involved in care planning, defining care goals and coordinating such healthcare and psychosocial care services, thus increasing their ability to provide a smoother transition from hospital all the way to the community. Useful lists of home care services, centre-based services, residential-based services, AICare link locations and contact numbers in the community have been provided. Miss Hindarto and Dr Ng highlighted that the problem is not a lack of services in Singapore, but rather too many targeted help schemes with varying criteria and limiting conditions attached. The application process is daunting, leading to the applicants giving up rather than following through.

Readings 1–5 focus on important components in the management of complex patients: a team-based whole-person intervention model of care; need for a comprehensive geriatric assessment; recognition of the impact of multimorbidity; utilising the validated Clinical Frailty Scale (CFS) to screen for frailty; and using the Screening Tool for Older Persons Prescriptions (STOPP) and Screening Tool to Alert doctors to Right Treatment (START) to identify potentially inappropriate prescribing.

Reading 6 talks about how primary care needs to evolve in order to care for an increasing population that is high-needs and high-cost (HNHC), requiring a disproportionate share of resources and straining traditional office-based primary care practices. The strategy being put forward includes complex case management and specialised clinics focused on HNHC patients. In specialised clinics for HNHC populations, care for HNHC patients must be transferred to a multidisciplinary team that can offer enhanced care coordination and other support, thus producing more substantial benefits.

Reading 7 talks about the increasing burden of dementia in Australia and the important role that GPs play in diagnosing and managing them. Recommendations that are of greatest relevance to GPs in the Cognitive Decline Partnership Centre's Clinical practice guidelines and principles of care for people with dementia are discussed in this reading.

Reading 8 describes transitions in care from hospital to primary care for older patients with chronic diseases which encompass education on self-management, discharge planning, structured follow-up and coordination among the different healthcare professionals. A systematic review was done and significantly better outcomes were observed in transitional care compared to usual care with a lower mortality rate, a lower rate of ED visits, a lower rate of readmissions and a lower mean of readmission days. They concluded that transitional care improves transitions for older patients and should be included in the reorganisation of healthcare services.

Reading 9 was written by a task force of clinical researchers and discussed the transformation of nursing homes to settings in which the residents and those living in neighboring communities could benefit from staff expertise to enhance quality of life and maintain or slow functional decline, in order to generate a new paradigm.

Reading 10 describes a new integrated approach to the management of high-risk respiratory patients incorporating specialist and primary care teams' expertise. Patients were reviewed at joint clinics by primary and secondary care professionals. In the 9-month follow-up there was an increase in inhaled corticosteroid prescriptions, a reduction in short-acting β2-agonist prescriptions, a reduction in acute respiratory exacerbations, in unscheduled GP visits, and acute respiratory hospital admissions. Healthcare costs were also reduced. The study concluded that patients with respiratory disease in this region at risk of suboptimal outcomes, when identified proactively and managed by an integrated team, had improved outcomes without the need for hospital referral.

PRISM 1 by Dr Lim Lay Khim and Dr Tay Wei Yi describes a patient who developed acute upper gastro-intestinal bleeding soon after the initiation of haemodialysis. The article also discusses the evidence showing an increased risk that haemodialysis poses to the development of peptic ulcer disease in end-stage renal failure patients. The possible mechanisms, as well as the acute and chronic management in such patients are presented. As the incidence and prevalence of chronic kidney disease and end-stage renal failure increases, Family Physicians should take note of this increased risk of potential gastrointestinal bleeding in their patients.

PRISM 2 by Dr Julio Tan describes a case of a 5-year-old girl who presented with atypical rash and weakness, which took 8 weeks to diagnose as juvenile dermatomyositis before treatment was started. Such cases, though rare, may occasionally turn up in a family medicine practice and a high level of suspicion and prompt recognition is required in order to institute timely treatment. This case hopes to raise our awareness of such cases and their atypical presentation.

Finally, The CASE RECORDS OF FAMILY MEDICINE is a newly created series to encourage submissions from family medicine teaching programmes and family medicine departments to submit cases of learning value to the Singapore Family Physician. It differs from the PRISM series in requiring a short literature review on the latest evidence/guidelines (related to diagnosis and/or management) of the case, or to highlight the gaps of knowledge if such evidence is lacking. Author(s) should also suggest ways to apply the new knowledge in clinical practice or to highlight the limitations of its applications, if any. Cases discussed during peer review learning and family medicine grand ward round teachings are just some examples that are suitable for this series. More details on the