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Interview with Dr Hayden Bosworth

By Dr Jeremy Lim, Editorial Board Member

Dr Hayden Bosworth is the Co-Director of the Center for Health Services Research in Primary Care, and Senior Career Awardee at the Durham Veterans Affairs Medical Center. He is a Research Professor in the Department of Medicine, Division of General Internal Medicine, Research Professor in the Department of Psychiatry and Behavioral Sciences, Research Professor in the School of Nursing at Duke University Medical Center, and Adjunct Professor in the Department of Health Policy and Administration in the School of Public Health at the University of North Carolina at Chapel Hill. Dr Bosworth has published over 150 articles that examine the role of patient characteristics and social environment among individuals' coronary heart disease, stroke, and hypertension. He has received funding from the VA, National Institutes of Health, and various

foundations to develop and evaluate interventions to improve health behaviors and self-management among individuals with chronic diseases in cost-effective ways.

During his visit to Singapore at the invitation of Duke-NUS Health Services and Systems Research programme, SingHealth Centre for Health Services Research and the Chapter of Public Health and Occupational Medicine physicians, Academy of Medicine Singapore, Dr Bosworth discussed various studies evaluating different models to reduce the impact of chronic disease and the policy implications of these programs. *SMA News* caught up with Dr Bosworth to learn more about how health services research can impact on chronic disease management and integrating care across the continuum and how clinicians and health services researchers can work together optimally.

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JL: You mentioned in your plenary lecture at the Public Health and Occupational Medicine conference that it takes 15 to 20 years for a best practice to become mainstream, but the Veteran Affairs Medical Centre (VA) seems to be one happy exception to this – why is this so?

HB: The VA is still a work in progress, but was probably one of the first to realise the length of time needed from discovery to implementation, and to act on it. A significant problem is the reimbursement system for both doctors and patients, which tends to encourage the maintenance of status quo. Financial incentives are not in the VA

that will be powered to detect actual events for cardiovascular disease self-intervention management. The fact that we are able to bring together representation from about 10 different sites is remarkable, and based solely on the idea that we are trying to improve healthcare outcomes. Also, we do not have to worry about reimbursements.

JL: Why is it so difficult for research to be translated into practice?

HB: We are not well-trained to disseminate research findings. We worry about publications and when we publish, the assumption is that one can pick up a journal or article and it will be clear what

into practice. Are there any issues on the part of the healthcare providers?

HB: We had already briefly discussed the barriers caused by reimbursement systems. The key component in translating research into practice is communicating with clinicians and other healthcare providers, and solving problems that matter in the clinics. Researchers should not stay in their ivory towers, but should instead try to help those in the clinical front lines in their struggles. Participatory research in which there is strong community engagement is a phenomenon that is developing, and I think that it is a good place to start.

JL: As a non-doctor, you engage with doctors to solve problems. Could you share with us some thoughts on how doctors can optimally work with non-doctors in areas like research or clinical care?

HB: As a non-clinician, it was essential that my work involve a number of clinicians both within research and when going to clinics. A little financial incentive really goes a long way – if I can offer clinicians \$2,000 over two years to cover food or travel expenses as a token of appreciation to be allowed to use their clinics or enrolling their patients, this ‘greases the wheel’. Once we are in, our goal is to demonstrate that our efforts do not negatively impact clinical care; more often than not, physicians forget that we are even there. Once the trust and relationship are built up, things get much easier. We also need to show that the research helps patients, and how we can reduce disease rates or improve care.

One challenge goes back to reimbursement: There have been physicians who comment that although they appreciate our work in patient self-management, they are reimbursed based on the number of hospitalisations; our programme may reduce this, and hence their income. My response is that our efforts may reduce hospitalisations, but this may also allow the increase of the



Photo credit: Changi General Hospital

system; providers do not have to deal with the issue of reimbursement, which is a significant problem on the fee-for-service side. This is similar to some of the problems that Singapore struggles with, and this is a huge barrier. Once this barrier is removed, it is likely to facilitate things.

The other issue is that the VA puts money into centres of excellence that focus on how to improve healthcare delivery, and to answer questions that both the VA and health services would like and need to address. Hence, there is incentive to cross-collaborate between the VA centres of excellence and the larger healthcare system. For example, we are now putting together a study with 3,000 to 4,000 veterans

to do. Even when I give presentations, I am struck by the queries on what I did and what my training consisted of – I don't have enough time to go into all these details! In this regard, I think that there is a lot that we do not have the opportunity to circulate. Perhaps, we get too caught up in reinventing the wheel as opposed to trying to cross-collaborate, and building upon what has already been done. Unfortunately, often times in research and academia, we live in silos and are competing against everyone for the same funds; this disincentivises cross-collaboration.

JL: On the part of the academics, we can do a better job in disseminating knowledge that is easily translatable

patient pool, enable the doctors to see more complex patients and bill for more problems. It is a significant issue.

On the fee-for-service side, it has been difficult, but on the Medicaid system (public health insurance for low income citizens), it has not been a problem at all. Typically we would trial a new health services intervention in the VA system which is not based on financial incentives, and then bring the same intervention into the Duke health system – a fee-for-service model – and see how it works in a different and more challenging reimbursement framework.

JL: On the issue of the fee-for-service model, VA physicians do not worry about reimbursement. That being the case, what attracts some of the best doctors to the VA?

HB: This may be due to intellectual curiosity. Physicians can't cover their salary on VA grants, but they can buy up their clinical time. So from that perspective, if a problem is consistently seen in a certain number of patients, the VA presents an opportunity to learn more about this observation and conduct some research to address the problem. Also, this opens the possibility for cross-collaboration, and on a higher level, allows them to directly create an impact. I think physicians who come into, or are affiliated to the VA are interested in "paying it forward" – they want to make a difference. The VA also has a long history of training and many physicians who enter the VA provide training to medical students, residents, and so on.

JL: As a health services researcher, what advice do you have regarding engaging clinicians here in Singapore? What do we also need to know so as to produce a fruitful relationship?

HB: I'm not sure how many opportunities for health services research there are in Singapore, but I see a lot of excitement and a need for increased methodology and training.



Photo credit: Changi General Hospital

I think there is a skill in learning how to communicate to the media, and they are not the enemy. We joke that if an article ends up in the *New York Times*, it implies that the article has made it big, almost like being published in the *New England Journal of Medicine*.

Firstly, researchers must know the role of health services research, and why it is a helpful field. It is very easy for people to think of basic and clinical research, but it is another issue to think of health services research. There has to be cross-education and learning how to speak together, similar to physicians having to communicate to their diverse pool of patients. There is a fundamental need to communicate, and one way we do it is by trying to get information out into environments that the clinicians are reading, for example in the form of journals and conferences.

In the US, we are perhaps a little further down the road from where you are, where we have convinced clinicians that there is a reason for health services research. Our focus is on struggling with clinicians to address the issues that are most important to them, as well as their patients.

JL: In this regard, what do you tell a new clinician who asks what health services research is, and why he/she should bother?

HB: (*laughs*) I have not experienced that question in a while! Part of the answer is familiarising the clinician in health services research and why it is relevant, and making the benefits personal; be it improving the quality of life of the patient or reducing cost for the healthcare system, as well as benefiting the local clinician.

We tend to forget the role of the patient and their perceptions. Particularly in areas like psychiatry and mental health, physicians may need to look to health services research as outcomes like depression are not directly observable. All these measurement issues are aspects that we deal with in health services research, and where we have expertise in.

JL: What do you see as the role of health services researchers?

HB: We can dispel rumours and false accusations, as well as use data to demonstrate benefits or costs. I think part of our role as health services researchers is to learn about health policies and engage the media. We are not doing a good job in communicating in health policies, how to change or reform them.

JL: How do you think a better job can be accomplished?

HB: We can always have a 20-page write-up, but I think what we need are accurate sound bites. I'm not sure what it is like in Singapore, but Americans only look at sound bites; nobody will look at the details so things get misconstrued very easily.

As researchers, we have to do a better job in learning how to communicate – in the US, most will live in their ivory towers and publish their journals, and this is what they are being encouraged to do! I think there is a skill in learning how to communicate to the media, and they are not the enemy. We joke that if an article ends up in the *New York*

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Times, it implies that the article has made it big, almost like being published in the *New England Journal of Medicine*.

JL: You run a health services research centre; what would you set as performance metrics for your researchers?

HB: The VA does a nice job of addressing performance metrics and every year I have to produce an annual report on what we have accomplished: publications, presentations, grants, money brought in and so on. The report also includes a section on impact, where we have to come up with six examples like books, peer-reviewed publications, conferences or media reports.

It is a vague form of measurement, but I think this has pushed us to look at impacts, and made us rethink how we are doing things. For example, writing a book directed at physicians with treatment options and recommendations, to be placed in their laboratory coats. Engaging colleagues to contribute to writing different chapters will also engage many people.

JL: You have been in Singapore for about a week; do you have any observations about the country and the healthcare system?

HB: It's been a fascinating week. The speed at which Singapore has changed its emphasis from acute to chronic diseases is impressive and Singapore seems nimble enough to make changes, whereas it takes a lot longer in the US. We go in four year blocks, and I think Singapore's infrastructure and technology will encourage much more innovativeness. There were many interesting questions asked, and I think there was also a sense of frustration that we experienced. This is actually good as it means there is impetus to change.

I was just walking around earlier on, and seeing all these technological innovations. I think we have to build upon these, and yet not overly rely on them because of their extremely rapid changes. Infrastructure-wise, there are



Photo credit: Changi General Hospital

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more advances that can be accomplished in Singapore. I cannot comment on the clinician issue and their training, but the lack of a strong primary care setting here is similar to what we see in the US, and we would be interested to know more about how this issue is being handled by relying on allied health and nursing personnel.

JL: Can you share with us your comments on the role of technology in chronic disease management?

HB: I was recently involved in a workgroup with the National Institutes

of Health (NIH), and I think the take-home message is that we must be flexible with the mode of administration of interventions. These can include cell phones or the internet, and will allow patients to get information the way that they want and need. What I worry about is the material or content – the technology is just one tool that we are using, and it does not matter what type of technology is utilised. To me, that is the direction we need to head.

I think that technology is fundamental for self-monitoring, and this is something we have to be mindful of. No matter how frequently a patient comes in to see a doctor, there is still a role of responsibility for the patient and I think we can see more improvement when the patients feel that they have a sense of control over their own health.

One thing we learned about bringing IT into healthcare was that it was important to have clinicians' feedback on their likes and dislikes. We had one project where we had some people in academia creating a widget, but they weren't working with programmers and people who create interfaces. We did not engage stakeholders in a manner we should have and observed disappointing results.

JL: Thank you for your time, and we look forward to welcoming you back to Singapore soon. 