A News Bulletin by NUHS Communications

SHAPING MEDICINE, TRANSFORMING CARE
THROUGH INNOVATION IN CLINICAL CARE

New Initiatives for NUHS Clinics and Community Partners to Improve Diabetes Care

NUHS has set up a new **Centre of Excellence in Chronic Disease Prevention and Management** to carry out research and develop innovative programmes to help patients with chronic non-communicable diseases such as diabetes and cardiovascular disease. This was announced at a media briefing on World Diabetes Day, 14 November, ahead of a community health event which included a Primary Care Network (PCN) GP symposium held on Sunday, 17 November.

Organised by Diabetes Singapore, and supported by NUHS, the weekend public event was an opportune platform for NUHS to share with GPs our strategies and initiatives for the betterment of diabetes care in the western region and potentially across Singapore. It was graced by Mr Edwin Tong, Senior Minister of State, Ministry of Law and Ministry of Health, and attended by over 600 people who came to NTFGH for onsite health screening and to attend public education talks.

Year of Care programme at NUH

Led by Prof Tai E Shyong, Centre Director and Senior Consultant, Division of Endocrinology, NUH, this new Centre of Excellence oversees the "Year of Care" programme at NUH. More than 200 patients have been enrolled since it was first trialled in NUH in January 2018. The outcomes of 67 of these patients showed positive results: 28% had improved engagement and motivation to take action; and the proportion of patients who achieved an ideal target for their glucose control increased by 2.5 times after one year in the pilot programme.

"The centre believes that the solution lies with an 'engaged and activated individual' (aka 'patient') collaborating with an 'engaged and activated provider' to achieve the best outcome. Living well with diabetes requires the active participation of patients," said Prof Tai, "The Year of Care programme is a tried-and-tested collaborative model which has proven effective in delivering managing and improving outcomes for people living with diabetes in the UK. We adapted this into our protocol and made good progress in coming up with a more engaged, collaborative and consultative approach to help patients live better with diabetes."

The innovative diabetes care model takes on a more collaborative patient-centred approach in supporting patients living with diabetes. Under this approach, doctors, nurses and other healthcare providers are trained to use techniques to uncover patients' true motivations and goals. It also provides tools for healthcare professionals to actively involve patients in developing a plan of action to support them in their self-management of diabetes.

PACE-D programme at NUP

Since March 2019, the programme has been running at 4 NUP sites under the name, Patient Activation Through Community Engagement/Empowerment for Diabetes Management (PACE-D), to convert every patient encounter into a communication-focused experience. Led by Dr Tan Wee Hian, Family Physician & Associate Consultant, NUP, the programme aims to recruit 6,000 patients over 3 years, where half of the patients will receive their test results prior to their visit and undergo a more collaborative consult with the doctors and nurses of their care team. NUP will review its success before possible expansion to all of its polyclinics.

PDSA model for NUHS PCN GPs

On the GP front, to help our PCN partners improve their clinical care quality, NUHS has set up a chronic disease registry, to track the progress in chronic disease management of its patients who have chosen to base their care at partner GP clinics.

With this registry, NUHS introduced the Plan, Do, Study, Act (PDSA) model to GPs who usually work in silos. The guide works by cycles and will lead GPs through a cycle of:

- comparing their patients' progress with patient data from the polyclinics
- analysing their clinical outcomes and process indicators, and
- subsequently establishing processes to achieve improved clinical goals.

Said Prof Doris Young, who leads the PDSA model, "Private GPs in Singapore can play a bigger role in chronic disease management, while we seek to drive more clinical improvement in primary care outcome." Prof Young is also the Head of NUHS Family Medicine.

Added Dr Ho Han Kwee, Director of NUHS Primary Care Partnerships, "Diabetes patients should have a regular family doctor to look after their health needs. Their regular family doctor will be able to link them up with relevant hospital specialists at the appropriate time. The NUHS PCN offers residents in the west an alternative option of 71 different locations near their homes. These PCN partners are supported by NUHS nurses and coordinators, as well as the PDSA framework of regular clinical quality tracking and improvements."