

Diabetes 1-2-3

Community Diabetes Management Programme to support GPs & your patients

July 2025

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EatWiseSG lead - NUHS

Background

Context on the programme

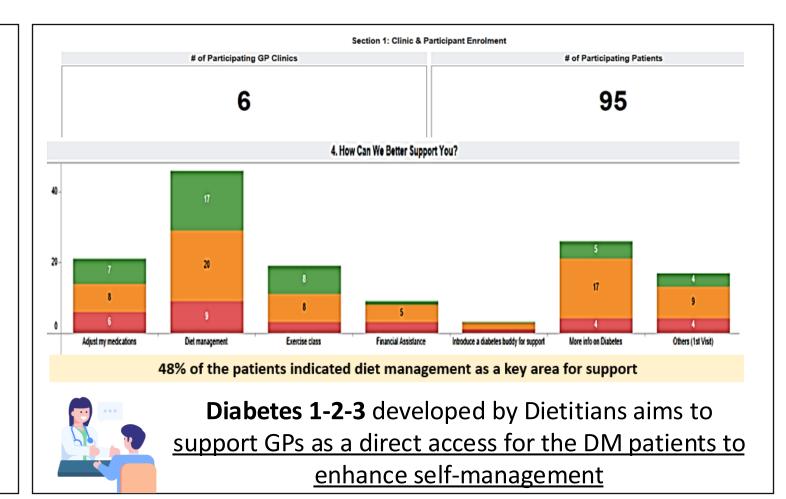
400kDiabetic patients in Singapore¹

1 in 3

Singaporeans have lifetime risk of developing diabetes²

How is this relevant?

- GPs have increased patient load with HSG
- More diabetic & chronic patients to be managed in primary care setting



¹ Data from National Population Health Survey, 2022

² Speech from World Diabetes Day, MOH, 2023

Diabetes 1-2-3 Programme

Objective	Empower patients with self-management (DSM) skills to optimise diabetes management through sustenance of healthier diet & lifestyle through multilevel support in the community	
Mode of delivery	 Group setting (10-15pax) face-to-face (F2F) 2 physical workshops & 2 follow-up sessions 	
Conducted by	Dietitian	
Workshop Dates	Thursday AM (Mandarin) Saturday AM (English) Team will also hold Mandarin workshops on Saturday based on demand (11 October 2025)	
Venue	Block 463 Clementi Ave 1, #01-18, Singapore 120463 (NUHS community site)	
Criteria	 18 – 75 year old Singaporean citizens or PR Diagnosed with diabetes No CKD Patients encouraged to attend workshop together with 1 family member/caregiver 	



Components of Diabetes 1-2-3







1) Diet & lifestyle management

2) Selfmonitoring 3) Medication adherence

End Goal

Empower patients to manage their diabetes & related conditions sustainably

DM 123 Curriculum

Workshop details: Workshop 1 (Theory)	Duration
Chapter 1: Understanding Diabetes	1 hour
Share their diabetes journey	
What is Diabetes?	
 Consequences of uncontrolled diabetes 	
 Type & Amount of carbohydrates 	
 Hypoglycemia management 	
 Importance of self-monitoring 	
 Common Diabetes myths 	
Break – Learn about suitable snacks (Part I) + BSL checks (self)	30mins
hanter 2: Understanding Hypertension & Cholesterol	
Chapter 2: Understanding Hypertension & Cholesterol	1 hour
What is hyperlipidemia and hypertension	1 hour
 What is hyperlipidemia and hypertension Types of fats and their dietary sources 	1 hour
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 What is hyperlipidemia and hypertension Types of fats and their dietary sources Sources of dietary cholesterol How to reduce salt consumption? Importance of fiber Self-monitoring tools for diabetes, BP Homework to prepare for Workshop 2 Start using diet, exercise, and blood sugar monitoring tool for self-monitoring. 	1 hour
 What is hyperlipidemia and hypertension Types of fats and their dietary sources Sources of dietary cholesterol How to reduce salt consumption? Importance of fiber Self-monitoring tools for diabetes, BP 	1 hour

Workshop details: Workshop 2 (Practical)	Duration
Chapter 3: Diet Management for Diabetes - Practical	1 hour
 Energy balance concept Making Healthier Choices (Eating out & food preparation) Art of Portion control Understanding Food Label 	
Break – Learn about suitable snacks (Part II) + BSL checks	30mins
Chapter 4 Putting it all together- Practical (1 hour)	1 hour
 Getting ready for change Setting SMART goals Redesigning your lifestyle Tools for self-monitoring Support for your diabetes journey (after the program) (By the NUHS Community Care team & the NUHS Primary Care Network) 	
Post workshop questionnaire	30 mins

DM 1-2-3 Highlights



Pan fried tofu patties with vegetables, egg white omelette with mushroom & broccoli, low GI fruits and cherry tomatoes



Air-fried salmon, black pepper mushrooms, Lettuce wraps with braised mushroom and tofu tofu, omelette as a soba/quinoa salad

Highlight 1: Educational Tea Break

Healthy, tasty meals prepared by dietitians suitable for diabetic patients

- Practical way to understand carbohydrate portions
- Helpful for patients to taste & sharing recipes

Highlight 2: Post-programme walking group

Patients started a walking group to motivate each other to increase physical activity

- Encouraged patients who found it hard to start
- Peer support helped keep them motivated









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+ Healthy Recipe Book created by AH & the community



Results from 2024 Pilot

Small pilot group of 20 participants

Measure	Overall
HbA1C	-0.9% mean reduction
Weight Loss	Range between <u>2.7 – 7kg</u>
LDL Results	1.11 mmol/L mean reduction
Self reported Diabetes Evaluation Tools	



Self reported Diabetes Evaluation Tools		
Diabetes Self-Management Questionnaire Revised (DSMQ –R)	0.5 median increase (better self reported <u>Eating Behaviour</u> , <u>Glucose Monitoring</u> , <u>Physical Activity</u>)	
Diabetes-Related Nutrition Knowledge Questionnaire (DRNK-Q)	25% increase in overall score (Increased nutrition knowledge on <u>Nutrition Content of Food</u> , <u>Health Food Choices & Safety</u> , <u>Food Label Reading</u>)	
Diabetes Empowerment Scale Short Form (DES-SF)	7% increase in overall score (Reported <u>better insight on necessary skills</u> to bring about lifestyle changes, and felt more <u>in control of disease management</u>)	

Mr H's Story

Diabetic patient for 10 years – was referred from Anchor Health Family Clinic

Q: What were some of your biggest challenges before joining? And how did it affect your daily life?

Mr H: I had <u>issues losing weight</u> and controlling my diabetes for **10 years**. I can't seem to bring my diabetes (HbA1c levels) down to below 8% or <u>even lose weight or even start to exercise</u>.

Q: What changes have you noticed in your health, mindset or daily habits since joining? Any improvement in your diabetes?

Mr H: I am now more mindful about my carbohydrate intake, aiming to do my 10,000 steps, and I am consistent in checking health app on my phone, and choosing the healthier choice when eating out.

I have reduced from 9.6 (Feb 24) > 7.1 (Sept 24) > 6.7 (March 25)

Q: What are the main features of this programme you find helpful?

Mr H: Learning from the dietitian how to eat & what to eat, and how to adjust from what I am eating, how & when to monitor my diabetes, how it's important to have a goal and to start with baby steps to get to where I need to.

Having **peer support** from the participants to share their learning points have been useful. Catherine has also started a walking group because I have no walking kakis. All these help me to have more confidence in managing my diabetes & weight.

Publicity Flyers

Diabetes 123

A Dietitian-Led Diabetes Programme (NEW)

Diabetes 123 is a programme developed by dietitians designed to empower people with the basic skills of managing diabetes and enable them to nurture good habits and choices for a healthier diet and lifestyle.

Beyond the workshops, participants will be supported by healthcare professionals and/or health peer volunteers, depending on their diabetic condition and level of management.

The programme will include:

- 2 workshops (1 theory + 1 practical)
- 2 follow-up sessions
- 2 educational tea breaks

Terms & Conditions:

- For Singapore Citizens/PRs aged 18 to 75 with diabetes
- · Able to attend any of the listed runs:

Batch 1 (Mandarin)		
Thurs, 14 Aug 2025	Thurs, 28 Aug 2025	
2 – Spm	2 – 5pm	
Batch 2 (English)		
Sat, 13 Sept 2025,	Sat, 27 Sept 2025	
9am – 12pm	9am – 12pm	
Batch 3 (Mandarin)		
Sat, 11 Oct 2025	Sat, 25 Oct 2025	
9am – 12pm	9am – 12pm	

Workshops will be held at Block 463
 Clementi Ave 1, #01-18, Singapore 120463

All information retains in course of the Date of window and may be extinct to the own without writing

Scan the QR code to find out more & sign up:







糖尿病 123

由专业营养师所特制的新项目

糖尿病 123 是一个由营养师专设的项目, 旨在通过培养更健康的饮食和生活方式, 让居民增强管理糖尿病的基本技能。

除了这两堂作坊之外,参与者将根据他 们的糖尿病状况及管理,得到医疗保健 专业人员和志愿者的支持。

这个项目包括:

- ☑ 一堂理论作坊和一堂实习作坊
- ☑ 两个健康复诊
- 六个月的个性化支持由国立大学医学组织的护士、营养师和护理协调员团队提供

参与者需要符合以下条件:

- 18至75岁患有糖尿病的新加坡公民或永久居民
- · 能参与两堂作坊和两个健康复诊:

8月(中文)

星期四,2025年8月14日 星期四,2025年8月28日 下午二点至下午五点 下午二点至下午五点

9月(美文)

星期六 2025年9月13日 星期六 2025年9月27日 上午九点至中午十二点 上午九点至中午十二点

10月(中文)

星期六 2025年10月11日 星期六 2025年10月25日 上午九点至中午十二点 上午九点至中午十二点

 地址 Block 463 Clementi Avenue 1, #01-18, Singapore 120463

* 好有信息否切要担约定案确无法、如有变更、更不关行通知。

扫描二维码了解更多及报名:



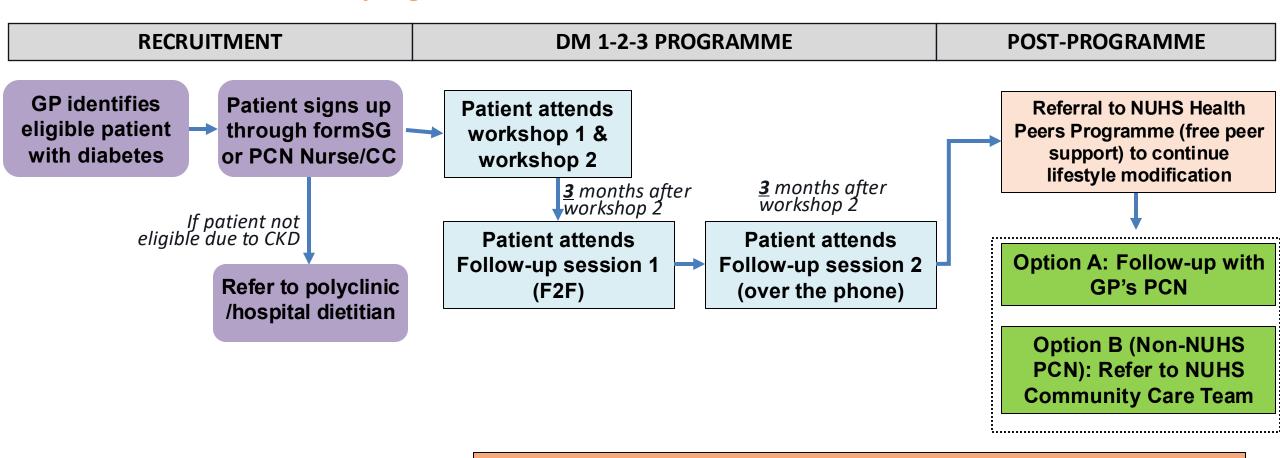


举办机构:



Flow of Programme

Breakdown of how the programme works



After programme ends, NUHS will email GPs to close the loop and inform GPs of their patients' results & progress





Update on the Eatwise SG Initiative

Community Dietetics and Nutrition (COMDAN) Workgroup 23 Oct 2024

What is EatWise SG?

EatWise SG is an initiative designed to enhance access to appropriate dietetic and nutrition care where they live, helping individuals achieve better health outcomes. This initiative addresses critical unmet nutrition care needs, including:

- Inadequate dietetic support
- Under-recognition of malnutrition
- Lack of care continuity for individuals with metabolic diseases, frailty, and malnutrition

EatWise SG Model of Care

Right siting care by the appropriate trained care providers

FUTURE

Referral/

Escalation/

Handover

Protocol

Risk stratified approach to community-based integrated nutrition care

Tier 4: complex/ acute

Tier 3: With

nutrition-related

conditions.

Moderate/high

risk

 Patient receive personalized nutrition assessment/intervention

 Supported by acute hospital DT/ Specialist DT in teambased management @SOC

+/- support by Primary /Community DT

T4: Hospital Dietitians

- Patients receive personalized nutrition assessment/intervention
- Supported by Primary Care/Community Dietitians +/- co-managed with Specialist Dietitians
- 1-1 consult / telehealth/ centre based e.g. SSAs/CCOs

tion-

Tier 2: With nutritionrelated conditions. Wellcontrolled Low risk T3: Community / Primary Care Dietitians

 Patients receive basic nutrition interventions

Non-Dietitian Healthcare providers

+/-TransD

T2: Community/Primary Care Nurse & Primary Care Physicians & GPs

> intervention or selfempowerment resources

- Non-healthcare providers i.e. lay extenders, PA, volunteers, etc
- Preventive group sessions/ activities

Tier 1 : No/Low nutrition-related risk



T1: Care Coordinators

COMDAN Subgroup Composition

Subgroup 1 - metabolic conditions (Obesity, Diabetes)

Role	Name	Designation/institution
Co-leads	Dr Nelson Wee	Dy Hd (Primary Care and FP), Healthway Medical Group
	Dr Han Wee Meng	Hd/Snr Pr DT, KKH
Members	Ms Janie Chua	Pr DT, NUP
	Ms Kala Adaikan	Hd/Snr Pr DT, SGH
	Ms Pauline Xie	Pr DT, NHGP
	Ms Lim Siew Choo	Pr DT, SHP
	Ms Stephanie Teo	CN/Dy GCN, SHP/SingHealth
	Ms Marine Chioh	AD(PCCD), AIC
	Ms Ong Li Jiuen	Hd/Sr Pr DT, CGH
	Ms Koh Pei Ling	Actg Hd/Pr DT, WHC
	Dr Cindy Ng	Snr Pr PT, SGH
	Jamie Kok	Snr Pod, NUH
	Dr.Swiatha	East Coast Family Clinic,
	Dr Sujatha	Frontier PCN
Secretariat	Ms Chan Yu Leng	M(CAHOO)
	Ms Fionn Chua (MOH PTPS)*	Snr DT, CGH
	Ms Carmen Wong (MOH PTPS)*	Snr DT, SKH
	Ms Melissa Ho (MOH PTPS)*	Snr DT, TTSH

Subgroup 2 - Frailty/Malnutrition/Enteral Nutrition

		-
Role	Name	Designation/institution
Co-leads	Dr Ng Lee Beng	Snr Consultant, SGH
	Ms Catherine Koh	Hd/Snr Pr DT, AH
Members	Ms Ng Puay Shi	Hd/Pr DT, TTSH
	Ms Chow Pek Yee	Hd/Pr DT, KTPH
	Ms Jesslyn Chong	Hd/Pr DT, NTFGH
	Ms Fong Yoke Hiong	AD Nursing, Tsao Foundation
	Ms Precilla Lai	APN, HNF
	Ms Tan Kim Fong	Pr DT, NUH
	Ms Phoebe Tay	Pr DT, SKH
	Ms Kua Pei San	Snr DT, SCH
	Ms Wong Yuefen	Pr DT, NHGP
	Dr Ng Joon Hwee	Stat Medical @ Hougang
Secretariat	Ms Chong Hui Hsien (MOH PTPS)*	Pr DT, CGH
	Ms Tan Chew Sia (MOH PTPS)*	Sr DT, KTPH
	Ms Fionn Chua (MOH PTPS)*	Snr DT, CGH
	Ms Cheryl Zhang	SM(CAHOO)

Eatwise SG Resource Package Restricted

To address the key gaps, the COMDAN Workgroup has developed a comprehensive resource package to empower healthcare providers to provide quality nutrition care in primary care and the community. The resource package includes:

- EatWise SG care model, referral and escalation criteria have been approved by DGH in Jan 2024. They map out how nutrition care should be delivered across settings, a tiered framework for nutrition care needs and the types of patients that should be seen at each tier (See Annex A for details in the referral and escalation frameworks).
- Training curricula for Tier 1 (lay extenders) and Tier 2 (non-dietitian healthcare professionals including Doctors and Community Nurses) providers to equip them with the knowledge and skills to provide nutrition advice/support and intervention at the appropriate level
- Clinical Nutrition Management Guidelines (CNMGs) to provide healthcare professionals including GPs and community nurses with recommendations on how to nutritionally manage metabolic conditions and malnutrition / enteral nutrition;
- A curated list of patient education materials to serve as a common nutrition care resource with harmonized and quality nutrition information
- Guidelines for the provision of quality meals to improve the standards of meals in residential homes or by meal providers

Why EatWise SG Matters to You

- Enhance Your Practice: Gain access to evidence-based resources to elevate your practice
- Improve Patient Outcomes: Collectively tackle malnutrition, metabolic diseases, and frailty with targeted diet interventions.
- Streamline Care Continuity: Benefit from clear referral pathways and interprofessional collaboration.

Home > Guidelines >

EatWise SG for Healthcare Providers: Enhancing Community-Based Nutrition Care

Guidelines

EatWise SG for Healthcare Providers: **Enhancing Community-Based Nutrition** Care

Professionals Allied Health Professionals Doctors Nurses 11 June 2025

EatWise SG is an initiative designed to enhance access to appropriate dietetic and nutrition care in the community, helping individuals achieve better health outcomes closer to home.

EatWise SG for Healthcare Providers: Enhancing Community-Based Nutrition Care | Health Professionals Portal

Short Survey for GPs Help us support you better



Thank you.

























