

Synergise

Inspiring A Healthier Community

Managing
Chronic
Kidney Disease

03

Given a Shot
in the Arm

04

Co-designing
Better Care
for Diabetes

05

Tripartite
Collaboration at
Nursing Homes

06



Synergy is what like-minded partners unified by a common purpose can achieve. We chose the name 'Synergise' for our first eNewsletter for community partners because we wanted this to symbolise a cohesive eco-system of partnerships working together to become more effective in nurturing positive care outcomes for the communities we serve.

We have been hearing the need for improved communication between partners in the western community. Last year at the annual Partners' Engagement event, we asked, and you responded to the call for collaboration towards this end. Our heartfelt thanks to each of you who have stepped up and got involved!

From the first workshop to the editorial meetings, the tremendous enthusiasm shown to make 'Synergise' work for everyone was gratifying and energising, especially the free flow of ideas and the responsiveness to be co-editors. It is a reflection of how we collaborate to achieve our vision of A Healthy Community.

In this special launch issue of 'Synergise', we turn our focus to one of the more prevailing issues that plague residents – Chronic Diseases.

Chronic diseases are long-term medical conditions needing on-going medical care and concurrent personal efforts in lifestyle changes for better control. Examples include diabetes, hyperlipidemia, hypertension, heart disease, stroke, asthma etc. We are also witnessing a greater awareness of chronic mental health issues such as depression. An important consideration in management of chronic diseases is the need for recognition that the patients and caregivers are unique individuals who have their own aspirations, as well as innate capabilities and limitations. Thus, an individualised person-centred approach is important. Many of them need additional support beyond medication prescription, including help with adopting and sustaining lifestyle changes in exercise and dietary management, navigation through the various components of healthcare system for their health needs as part of disease progression.

In this issue, you will find short write-ups that touch on many of the above components that are so important to the overall care of chronic diseases, testament to the many initiatives taken by the National University Health System (NUHS) and so many partners to bring health to the population.

We look forward to having 'Synergise' reach everyone in our regional health eco-system in the west and take this opportunity to invite more partners join us as we work on future editions in the coming year.

We want to hear from you so connect with us!

The Synergise Editorial Team
Email: rhs@nuhs.edu.sg

Editorial Team

Joanne Yap (NUHS RHSO)

Lakshmi K.S. (Active Global Home & Community Care)

Josephine Leong (Econ Healthcare)

Shawn Wee (Lions Befrienders)

Ong Si Jie (Lions Befrienders)

Hanis Farhannah (Lions Befrienders)

Arlene Tan (NUHS RHSO)

Fiona Foo (NUHS RHSO)

Leow Yu Zhen (REACH Community Services)

Adrian Tan (SG Assist)

Brenda Lee (Stroke Support Station)

Siti Hosier (Vanguard Healthcare)

Eswari Annavee (Viriya Community Services)






Tan Zhiwei (Viriya Community Services)

Managing Chronic Kidney Disease

Chronic Kidney Disease (CKD) often goes unnoticed among the elderly. In home care, nursing homes, and ambulatory clinics, healthcare providers often juggle a myriad of issues, e.g. hypertension, stroke, diabetes, dementia, and caregiver stress, with CKD in the background.






CKD presents unique challenges in the elderly population, particularly those with coexisting conditions like hypertension and diabetes. Age-related changes in kidney function, and existing medical conditions, can complicate diagnosis and treatment. A physician will want to prevent further renal injury, treat underlying conditions, and reduce protein elevation.

Lifestyle changes can help. These include:

-  Limiting protein intake to 0.8-1.3 grams/kg/day, unless contraindicated
-  Regular physical activity may slow CKD progression
-  A plant-based diet, avoiding highly processed foods
-  Consider sodium bicarbonate for acidosis management
-  Blood pressure control through a low-salt diet, exercise, and medications (ACE inhibitors, ARBs, diuretics)



Managing CKD complications:

-  Fluid overload: Limiting fluid, salt and using diuretics
-  CKD-mineral bone disease: A low-phosphate diet, phosphate binders, activated vitamin D can help
-  Anemia: Beneficial to use iron supplements and erythropoietin stimulating agents
-  Electrolyte disturbances: Low potassium diet, diuretics and bicarbonate may help
-  Uremia: Subtle symptoms like poor appetite, nausea, itch or sleep wake reversal may occur

Lifestyle modifications is important, and a tailored approach considering factors such as age, underlying conditions and individual preferences is key to managing CKD.

Contributed by **Home Nursing Foundation**



Contribute your organisation's stories to our eNewsletter!

You can

- share your initiatives and experiences
- profile your organisation and the work that you do in the community
- feature best practices and collaborative opportunities

Write in to us today!

Chronic Disease Management: Given a Shot in the Arm through **Community Collaboration and Partnerships**

When the updated service requirements for Active Ageing Centre (AAC) 2.0 (Transition) were announced in April 2024, the Community Care Division at ECON worked with colleagues at the NUHS Community Health Post (CHP) and partners at 1doc to formalise their collaboration.

A Memorandum of Understanding between ECON and 1doc was inked on 30 July 2024 to tap on the clinical expertise of 1doc's team of family physicians to optimise the wellness of seniors and manage stable chronic conditions in the community. 1doc's health optimisation programme integrates medical expertise with fitness and nutrition. To sustain our seniors' engagement,

both teams at ECON and 1doc will activate Health Coaches to connect with the seniors and their families to introduce the use of 1doc's 'digital twin' to manage their health and/or stable chronic conditions. We hope the gamification of learning and adoption will incentivise the community to use technology to empower their health self-management. We are also concurrently studying the feasibility of installing 1doc's Robot Pharmacy at the AACs.

Conversations are on-going to jointly serve identified seniors and their families so that in addition to supporting the management of their chronic conditions, colleagues at the NUHS CHPs located in the neighbourhood can also be roped in to help seniors navigate the spectrum of evolving needs through the different stages of their vitality and frailty.

The journey has been both humbling and inspiring. We are optimistic that Synergise will help link us with different providers so that together, we can impact lives positively.

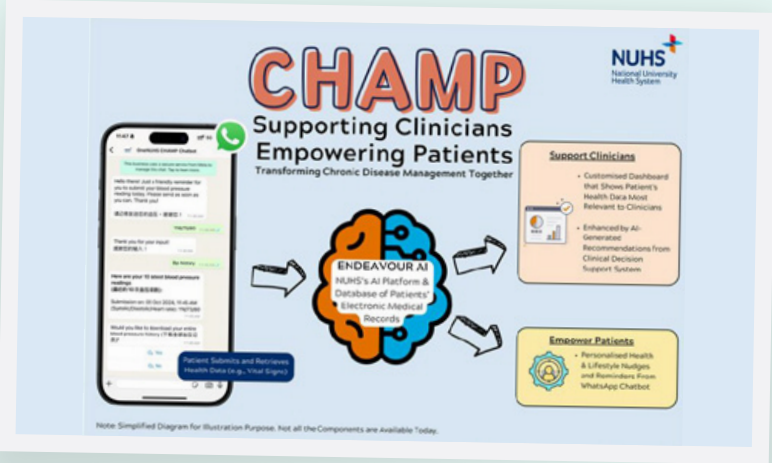
Contributed by **Econ Healthcare**



NUHS CHAMP

CHAMP, developed by NUHS, is a population-based Chronic Disease Management Programme aligned with the Ministry of Health's (MOH) Healthier SG strategy. It aims to promote healthier living through seamless chronic disease monitoring.

CHAMP empowers patients through submission of vital sign readings (e.g., blood pressure, heart rate) effortlessly via a WhatsApp-powered chatbot. In addition to receiving timely, relevant, and personalised health and lifestyle nudges to improve health, patients are also able to retrieve and download submitted readings anytime through the CHAMP chatbot. This helps clinicians to access submitted readings and make quick, informed decisions



aligned with the latest clinical guidelines. Launched in FY23, CHAMP has since onboarded 12 GPs and 114 patients.

Contributed by **RHSO Primary Care & Partnership**

Co-Designing Better Person-Centered Care to **Achieve Optimal Control of Diabetes**

Actively involving patients in knowing about and managing their own chronic condition is a crucial yet often neglected component of successful care. To optimise Diabetes care amongst GP patients, NUHS embarked on a patient-centric Quality Improvement (QI) project in April this year. The project team is co-led by Dr Kwong Kum Hoong (Family Physician, Anchor Health Family Clinic) and Dr Franco Wong (Consultant, Jurong Polyclinic), together with a multidisciplinary team (nurse, dietitian, care coordinators and administrators) across various NUHS Regional Health System Office (RHSO) divisions.

Applying a rigorous QI methodology, the project team co-designed and tested with six GP partners within the NUHS Primary Care Network (PCN) a short questionnaire where patients are first activated to identify any gaps in their Knowledge, Attitude and Practice (KAP) on their self-management of Diabetes. Then, using the patient responses in the questionnaire, GPs could better facilitate discussions with patients on their preferred Health Plan interventions, which are then tailored to address

gaps in their KAP. To optimise and leverage on the available network of community resources, patients may also receive basic health coaching from PCN Care Coordinators (CCs), in-depth Diabetes counselling by PCN nurses, peer support from health volunteers as well as referrals for exercise programmes run by Active Ageing Centres or the Health Promotion Board.

One of Dr Kwong's patients who received additional Diabetes Mellitus (DM) education materials and basic dietary advice from the PCN CCs showed an improvement in his blood sugar level (HbA1c) from 10.9% to 8.9% within six months. Over 90 Diabetes patients have since been engaged as part of the pilot project and will continue to be monitored for improvement in their blood sugar level (HbA1c).

Contributed by **NUHS RHSO**



Using the KAP questionnaire allows the discussion with patients to be more focused and targeted. I'm also glad that my patients now have a network of support to help them better manage their Diabetes."

Dr Kwong Kum Hoong
Family Physician, Anchor Health Family Clinic



Tripartite Collaboration for Patient-Centric Geriatric and Palliative Care at Nursing Homes

In alignment with MOH's National Strategy for Palliative Care to enable Nursing Home residents to receive good quality care and demise in their desired care setting, NUHS has collaborated with our community partner, St Luke's Hospital (SLH), to bolster and augment support to Nursing Homes through capacity and capability building.

Through this partnership, the Nursing Home Support Team Plus (NHST+) programme was established and currently supports All Saints Home (ASH) in Jurong East in both geriatric and palliative care. In this pioneering care model, palliative care is integrated with chronic disease care, where the programme reviews a patient's illness trajectory as a continuum and incorporates a risk-stratified matrix that facilitates better anticipatory care planning and timely serious illness conversations with both patients and caregivers.

The NHST+ journey with ASH began in October 2023, where the teams from SLH and ASH first determined the suite of services to be provided, such as tailored training, on-site medical reviews, multidisciplinary meetings and escalation pathways. SLH recently completed the on-site training modules on general end-of-life care topics for more than half of the ASH care staff, with plans

for appointed ASH staff champions to receive further hands-on training, as well as palliative and dementia care attachments at SLH. ASH nursing staff will also receive training by SLH's Speech Therapists on management of residents with swallowing difficulties.

"Since we began our collaboration, the hospital admission rate has reduced significantly. We have also noted an increased awareness of palliative care amongst our nurses and enhanced nursing outcomes. We look forward to future training and collaborations with SLH to enable our residents to live out their last days with dignity," said All Saints Home's Nurse Manager Ng Zheng Yuan.

The positive feedback from the ASH team serves as both an encouragement and a call to continue support for our Nursing Home partners. By maintaining a collaborative approach and building on the strengths of the care model, NUHS aims to further strengthen our partnerships to improve the quality of care provided to our Nursing Home residents.

Contributed by **RHSO Clinical Services & Governance Division, St Luke's Hospital and All Saints Home**



Empowering Female Stroke Survivors through Adaptive Makeup

Stroke survivors from Stroke Support Station (S3) collaborated with The Style Atelier (TSA) to conduct adaptive makeup workshops at S3's Jurong Point and Enabling Village centres. Designed exclusively for women affected by stroke, the adaptive makeup workshop programme designed by TSA aims to boost self-esteem and confidence by teaching tailored makeup techniques that accommodates the unique challenges of stroke recovery.



Recognising the physical challenges faced by stroke survivors, everyday makeup techniques are adapted for one-handed application by simplifying steps and using innovative tools. Participants can learn new ways to apply makeup such as using the back of their hand as a palette and opting for push-dispenser products instead of those with screw-caps. Such practical adjustments empower women to regain a sense of independence and control over their appearance. To enhance the learning experience, TSA reached out



to Tarte Cosmetics, Dermalogica and Embryolisse Singapore, who generously provided makeup and skincare products, allowing participants to experiment with the new techniques learned.

Beyond makeup skills, the workshop also focused on mental resilience. Participants are introduced to simple yet effective strategies to shift their perspective from adversity to opportunity. By fostering a positive mindset, these women are encouraged to view their experiences as catalysts for personal growth and empowerment.

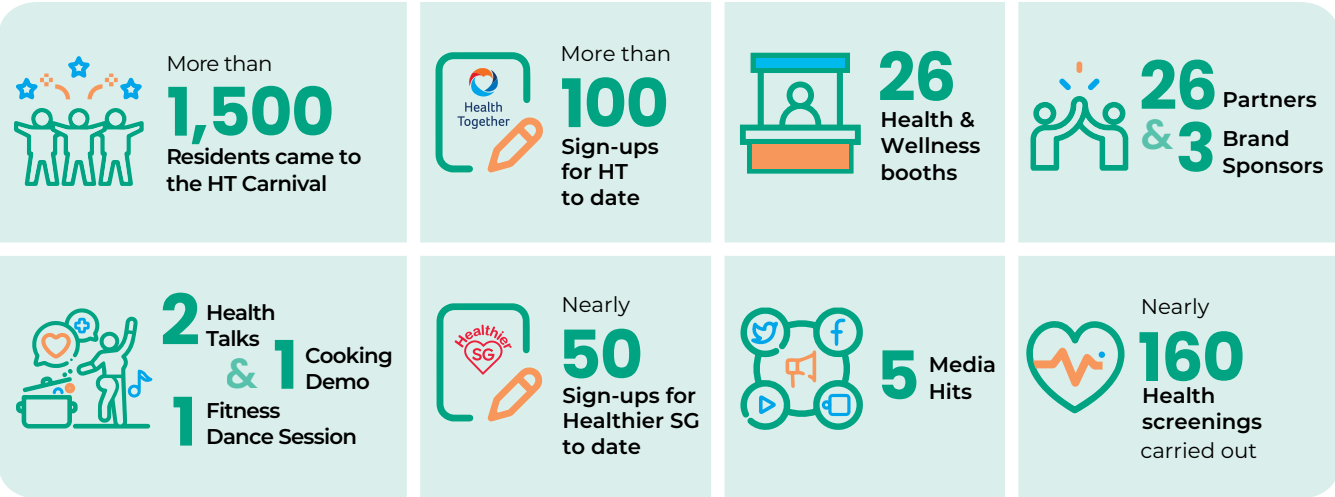
Through this initiative, S3 and TSA have created a supportive environment where stroke survivors can not only enhance their appearance, but also cultivate a positive outlook. By addressing both physical and emotional needs, the workshop empowers women to embrace life after stroke with confidence and resilience.

Contributed by **Stroke Support Station**

NUHS Health Together Carnival



Our third and largest Health Together Carnival to date took place on Saturday, 12 October, at Jurong Spring Community Centre. Co-organised with People's Association, the event was graced by four Grassroots Advisers — Mdm Rahayu Mahzam, Minister of State for Ministry of Digital Development and Information and Ministry of Health, as well as Adviser to Jurong GRC GROs, alongside three other Grassroots Advisers including Mr Shawn Huang, Senior Parliamentary Secretary for the Ministry of Finance and Ministry of Education; Dr Tan Wu Meng; and Dr Hamid Razak.



Events Calendar

Walk for Wellness Virtual Challenge

organised by Stroke Support Station

The [Walk for Wellness Virtual Challenge](#) is designed to inspire stroke survivors to take charge of their health and wellness. Participants can set their own pace and track their progress using the [My Virtual Mission](#) app, all while being part of a supportive community. With exciting milestone rewards such as exclusive finisher t-shirts, medals, and supermarket vouchers, this initiative encourages stroke survivors to stay active and celebrate their achievements. **Registration for the challenge ends on November 24, 2024**, and it is open to all individuals affected by stroke.

24 September – 24 December 2024

Grant A Wish Campaign

organised by Nursing Home Foundation

This Season of Giving, join Home Nursing Foundation (HNF) in fulfilling the wishes of their underprivileged patients by providing essential items like daily necessities, medical supplies and household appliances. Your generosity can bring warmth and joy to those in need this festive season. Simply scan the QR code to donate and help make their Christmas wishes come true.



1 November – 31 December 2024

NUHS GP Engagement Chinese New Year Lohei 2025

organised by NUHS Regional Health System Office

To welcome the Year of the Snake, this annual CNY Lohei event will be the first NUHS GP engagement for 2025. The event is a networking opportunity for GPs and a chance to catch up with members of the NUHS leadership team.

Saturday, 18 January 2025 | 1.00pm to 4.00pm
Venue: To be confirmed



We would like to hear your feedback on the first issue of Synergise!