AIC SAYS

Making Diabetes Care a Team Effort

by the Agency for Integrated Care



Managing diabetes requires more than clinical treatment alone. The reality is that social determinants of health and the socioeconomic realities that patients face outside the clinic dictate up to 80% of their chronic disease control, while clinical interventions account for just 20%.[1]

Yet many of these influences can be difficult to address during a typical GP consultation.

"In primary care, we all operate within finite time and dispense medical advice and therapy in time blocks. We cannot expect dramatic outcomes from short clinical encounters," Dr Roy Teow, Family Physician and Clinical Lead of SingHealth Delivering on Target (DOT) Primary Care Network (PCN), reflects.

"Lifestyle and social prescribing can help bridge that gap and facilitate an ongoing action-reflection cycle," Dr Teow shares. "While nurse counselling sessions are similarly time-constrained, we aim to improve our patients' mindsets through incremental encounters."

"Acknowledging this limitation may drive a shift away from our traditional, solo practice-centric GP model toward a more well-rounded, sustainable and scalable team-based care model," he continues.

In conjunction with World Diabetes Day, Dr Teow and Ms Teo Rui Ying, a Nurse Counsellor with SingHealth DOT PCN, share how team-based care helps patients turn treatment plans and lifestyle recommendations into lasting changes that support better diabetes control.

A partnership beyond the GP consultation

"Time and cost are our biggest constraints as a GP. Trying to deliver a comprehensive education package at the exact point of diagnosis almost always leads to information overload for the patient, and it severely disrupts a busy clinic schedule," Dr Teow shares.

"The PCN care team helps me deliver complex care without bottlenecking my clinic operations," he continues. "The nurses take over the time-intensive therapeutic education that we cannot fit into the same consult."

To make support more accessible for patients while minimising disruption to clinic operations, Dr Teow suggests: "We try to bundle nurse counselling with Diabetic Retinal Photography (DRP) and Diabetic Foot Screening (DFS) appointments. I would also refer patients to group diabetes counselling sessions conducted over Zoom, where lifestyle education can be broken down into digestible parts."

Nurse counsellors can also use social prescribing to connect patients with resources such as Active Ageing Centres (AACs), community exercise programmes, and Community Mental Health Intervention Teams (COMIT), depending on their needs.

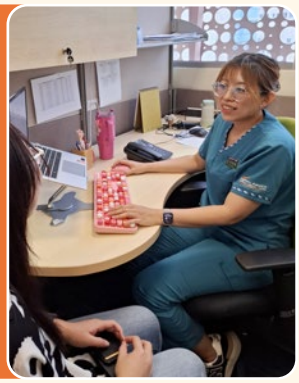
"From the patient's perspective, it can be experienced as one unified care plan even though the appointments take place on different dates," Dr Teow added.

Turning advice into action

Within this model, the GP and nurse counsellor work together to help patients turn care plans into action.

"GPs prescribe the treatment plan, and nurse counsellors help patients make that plan work in their everyday lives. Together, we're not just managing chronic diseases; we're empowering patients to live healthier and more meaningful lives."

- Ms Teo Rui Ying, Nurse Counsellor, SingHealth DOT PCN



Communication is key. Clinical information from the GP helps Ms Teo tailor her counselling, while insights gained during counselling can uncover barriers that might otherwise go unnoticed.

"After we complete our reports, we send them back to the GP with updates on the patient's progress, challenges and goals. This helps ensure that we are communicating the same messages," Ms Teo says.

This creates an action-reflection cycle. Patients test strategies discussed during counselling and return to reflect on what worked and what did not.

While patients who engage in counselling may already be more motivated, Dr Teow observes a notable change in how they approach their care: "They shift from being passive to now active partners in their own health outcomes."

Understanding the person behind the condition

Ms Teo notes that many patients may already know what to do to manage their condition but struggle to put that knowledge into practice. Counselling provides a safe space where patients feel supported rather than judged or lectured.

She remembers a patient, Mr Tan (not his real name), who was referred by Dr Teow for nurse counselling. Despite years of medication adjustments and regular follow-up, the patient's diabetes remained poorly controlled. He was initially guarded and saw little value in counselling.

Use HealthierSGEventsGoWhere to help your patients find suitable Community Lifestyle Activities

[1] Magnan S. Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives. 2017. https://nam.edu/perspectives/social-determinants-of-health-101-for-health-care-five-plus-five/

"After spending time listening to him, I learnt that his challenge was not a lack of knowledge about diabetes. However, he had recently retired and was struggling with the loss of routine and purpose. He shared that one of his biggest fears was becoming a burden to his children," Ms Teo recalls.

"I think this is a concern for many older people. They worry not only about their own suffering but also about the effect on the whole family," Ms Teo reflects. "Instead of focusing solely on maintaining his blood sugar, we tried to add a bit of social prescribing around maintaining his independence and being able to enjoy time with his family."

By connecting health goals to what mattered most to him, self-management became more relevant and achievable. Following the counselling, the patient became happier and more motivated to manage his health.

Making healthy habits stick

Ms Teo believes that lasting behaviour change is more likely when patients choose goals that are meaningful and achievable within the context of their own lives. Her approach reflects the principles of Lifestyle Medicine, which focuses on helping patients build sustainable habits that fit naturally into their daily routines.

Ms Teo recalls another patient, a widow who struggled with motivation after losing her husband. Through their conversations, Ms Teo learnt that the patient used to enjoy walking in the park with her late husband. Together, they then set small yet meaningful goals as a start.

"She started with a few short walks each week in a place that held memories of her husband, creating a positive association with exercise," Ms Teo says. "Over time, she shared that her walks had become more regular and she felt happier. Eventually, she joined a walking group."

Dr Teow admits that long-term change is difficult unless the patient genuinely buys into the process and repeats it daily.

"One concept we try to teach is habit stacking," Dr Teow shares. "Instead of carving out an entirely new block of time for lifestyle change, we look for ways to attach a small adjustment to a routine the patient already has, such as doing a quick stretch after taking their morning medication or choosing to take the stairs instead of the lift when heading home."

Starting early for better outcomes

"I would encourage more referrals for nurse counselling, particularly early referrals for newly diagnosed patients. The earlier we engage them, the greater the opportunity we have to correct misconceptions, build trust and support meaningful improvements in diabetes or chronic disease management," Ms Teo encourages.

Over time, Ms Teo sees patients become more confident in managing their health: "They are no longer making changes only because the doctor or nurse told them to. They want to make the changes for themselves. That is patient empowerment."

For Dr Teow, how GPs position the service matters. While a small co-payment may increase resistance to enrolment, it can also strengthen patients' commitment to follow through on agreed goals.

"We recognise that the GP does not control the whole picture. However, our recommendations often carry the most weight with our patients. We should therefore frame nurse counselling not as an optional add-on, but prescribe it as a medical necessity," Dr Teow suggests.

Case Study: Team-based Care in Action



Patient Profile: Mr Tan

- Has Type 2 diabetes
- Overweight
- Retired and struggled with loss of routine and purpose

GP Review

During a routine review, Dr Teow noted that Mr Tan's diabetes and weight remained suboptimal. Dr Teow then referred Mr Tan to the PCN nurse for lifestyle counselling and social prescribing support.

Nurse Counselling

The nurse explored Mr Tan's lifestyle habits, challenges and understanding of his condition. Together, they set goals to:

- Reduce sugary drinks
- Walk 30 minutes, 2-3 times weekly
- Achieve gradual weight loss

Social Prescribing

To support these goals, Mr Tan was linked to community exercise programmes through the Healthy365 app. Mr Tan also discussed challenges adjusting to retirement. Strategies were explored to help him establish a structured daily routine and engage in meaningful activities.

Follow-Up with PCN Nurse

During follow-up sessions, the nurse reviewed Mr Tan's progress, reinforced goals and addressed barriers to lifestyle change. Updates on Mr Tan's progress were shared with Dr Teow to support coordinated care.

Follow-Up by the GP (3 months later)

At the follow-up, Dr Teow reviewed Mr Tan's clinical progress alongside updates from the nurse.

After three months, beyond the clinical improvements and gradual weight loss, Mr Tan reported healthier eating habits, a more active lifestyle and greater confidence in managing his condition, demonstrating how coordinated support can help patients translate health goals into sustained lifestyle change.

"By embracing this team-based model, we acknowledge that while our clinical time is finite, our impact does not have to be. We must build stronger partnerships between healthcare and community resources. We are equipping our super-ageing population with the exact tools and community support they need to maintain their health and independence outside of our clinic walls."

- Dr Roy Teow, Family Physician and Clinical Lead of SingHealth DOT PCN

