



LIGHTER LIFE: ENABLING BETTER WEIGHT MANAGEMENT FOR PEOPLE LIVING WITH CHRONIC ILLNESSES WITH A FOCUS ON DIABETES

A COMPREHENSIVE CHANGE PACKAGE

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EXECUTIVE SUMMARY

Lighter Life is a structured, multi-component weight management programme designed for individuals with chronic conditions, particularly diabetes, delivered in primary care and community settings. Developed and tested by NHG Polyclinics under the National Diabetes Collaborative Phase 2, the programme addresses the gap between excess weight and chronic disease outcomes by combining behaviour change strategies, peer support, medication review, and clinician-led referrals.

Since its introduction, Lighter Life has been scaling across all NHG Polyclinics and refined through more than 20 PDSA cycles. These iterations strengthened enrolment processes, enhanced patient engagement, and optimised medication and educational tools. The programme resulted in a 6-fold increase in enrolment of eligible patients, with 33% of all participants achieving at least 5% weight loss, an improvement in average HbA1c% and strong qualitative improvements in self-efficacy, clinician engagement, and programme integration.

This playbook provides all the tools, workflows, and tested strategies needed to replicate Lighter Life with minimal contextualisation.

PATIENT'S STORY: LIVING WITH EXCESS WEIGHT AND COMORBIDITIES

Mr S., a 56-year-old gentleman, joined the Lighter Life programme in November 2024. He was overweight with a BMI of 26.1 kg/m². He had struggled with his weight for multiple years, tried multiple diets but his weight loss had always rebounded after initial weight loss. He went out of his way to join the Lighter Life programme because he was convinced by his primary care doctor that this programme would help him on his weight loss journey and prevent and delay further chronic disease complications. He even encouraged his direct supervisor to join him on this programme so that they can make work arrangements to attend this programme together.

Mr S. remained participative and enthusiastic throughout the programme and remained a constant peer supporter to his fellow cohort mates. Through Lighter Life, he has achieved a stellar reduction in body fat mass of 4kg over 6 months and had a BMI reduction from 26.1 to 24.2 kg/m².

Even after the programme, he remains as an active alumnus and peer ambassador for Lighter Life, organising gym sessions and giving advice to the wider community of Lighter Life participants.

BACKGROUND: THE OBESOGENIC DIABETES CARE CHALLENGE

There is strong evidence that patients with pre-diabetes^{1,2} and patients with diabetes³ can significantly benefit from weight loss through structured weight management programmes. Weight loss in patients with pre-diabetes has shown to prevent or delay the progression to Type 2 diabetes^{1,2}, while weight loss in patients with diabetes will have overall improved glycaemic and chronic disease control^{3,4,5} and eventually prevent end stage organ failure. This may in turn lead to lower healthcare consumption and an overall reduction in healthcare cost.

There is increasing prevalence of obesity in Singapore since 2013. Based on 2024 National Population Health Survey, the obesity prevalence is 12.7% in Singaporeans aged 18 to 74 years old, up from 10.6% four years ago. There is also increasing diabetes prevalence in Singapore. There are over 400,000 people living with diabetes and this number is projected to reach 1 million by 2050⁶. Given that weight loss is a proven factor in improving overall glycaemic control, it is critical to address the problem of obesity in those living with diabetes.

In daily practice, weight management remains under-addressed. Primary care providers often face time constraints, uncertainty about referral pathways, or discomfort discussing weight due to stigma concerns. In Singapore, structured weight loss services are often siloed and vary by provider site. Referral systems are inconsistent, and services typically focus on individual diet counselling without addressing behaviour change, peer support, or medication-induced weight gain. Cultural stigma and fear of judgement further reduce patient engagement⁷.

Group-based weight programmes offer a viable alternative. Literature from international studies shows they are more effective than individual counselling for achieving weight loss and are more resource efficient. Peer support, shared learning, and accountability strengthen patient motivation and enable long-term change^{8,9}.

Lighter Life was designed to close these gaps. It embeds referral into clinical workflows, supports patient education through group sessions, and fosters patient empowerment through peer interaction. Its design is aligned with Singapore's broader push toward integrated, preventive care and anchored by primary care and community under the Healthier SG vision.

PROBLEM STATEMENT: ADDRESSING CRITICAL GAPS IN CARE

The critical gaps in addressing obesity in patients living with diabetes are multifaceted.

Clinician Constraints

Addressing and managing obesity remains to be challenging in the tight clinical consultations today. The main constraints are as follows:

- Lack of time in a busy consultation with many urgent issues to discuss with patient
- Variable experience in bringing up weight management in an appropriate, effective, and sensitive manner.
- Variable knowledge of resources available for patients to achieve desired weight loss
- Inconsistent referral and enrolment processes when clinicians often lack simple, embedded workflows to refer patients to weight management programmes.

Patient Factors

- Lack of social support
- Physiological limitations to exercise
- Low health literacy
- Hesitation to engage as patients may feel discouraged, especially after previous failed weight loss attempts
- Concerns about cost, time, and weight stigma

Institutional Factors

- Obesity is currently not a key performance indicator tracked routinely
- Existing interventions are fragmented and there is no clear and systematic approach to obesity management. Most services focus on diet or physical activity in isolation, and few integrate behavioural strategies, or peer support.
- Programmes are not sustainably embedded. Current weight loss initiatives are often dependent on temporary funding, siloed staff, or pilot-phase enthusiasm.

The Lighter Life programme was designed to overcome these obstacles and serve as a resource for clinicians to refer motivated patients who are ready for action and provides the knowledge and social support necessary for effective weight loss. It provides a low-friction referral process, builds motivation through peer support, uses real-time feedback to adapt delivery, and integrates directly into primary care clinical operations.

STRATEGIC OUTCOMES AND MEASUREMENT STRATEGY

Lighter Life's Targets in the National Diabetes Collaborative Phase 2 period

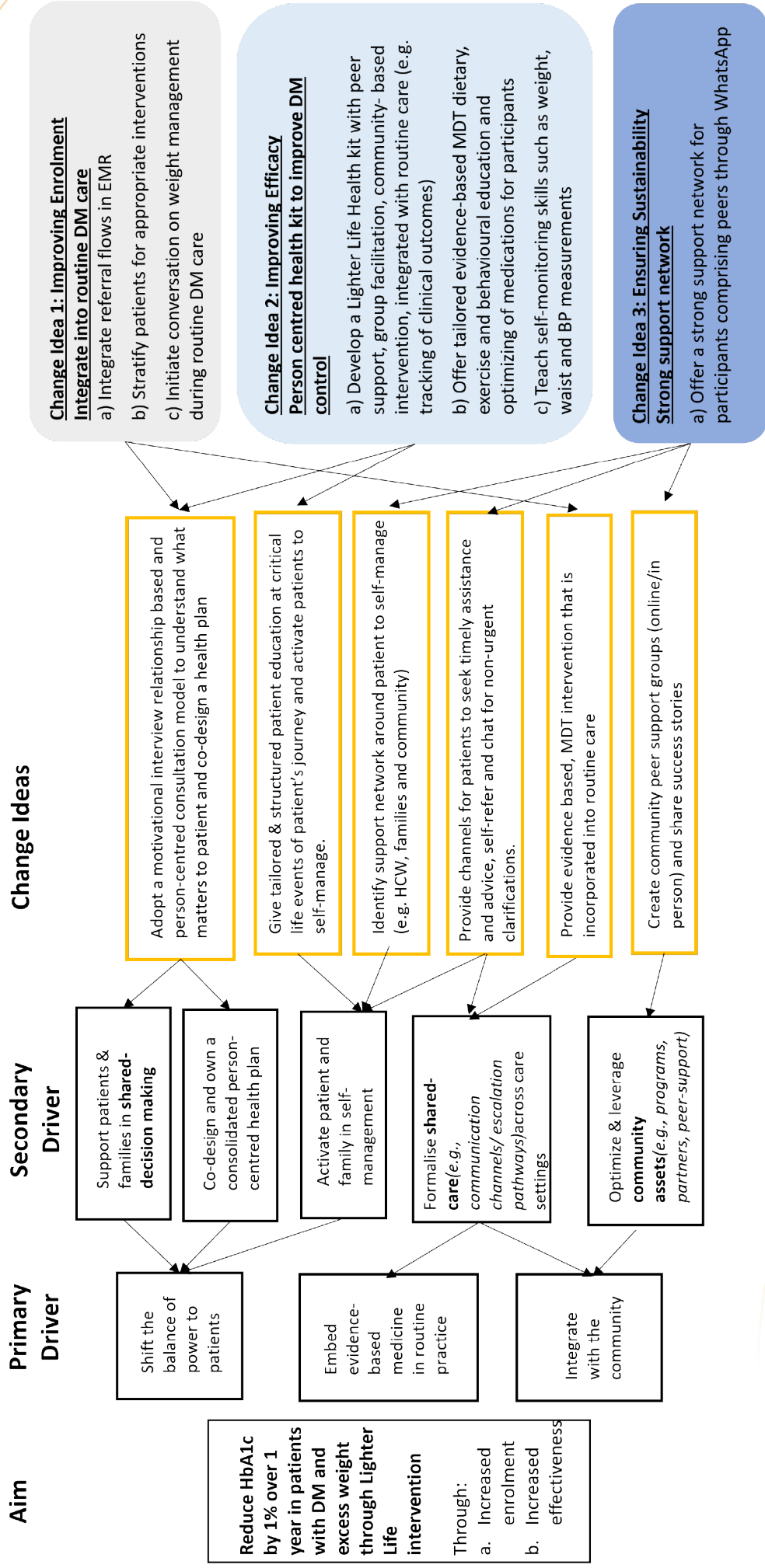
1. Increase % of patients with DM in Lighter Life achieving $\geq 5\%$ weight loss to 30% from a baseline of 18% by March 2025.
2. Reduce HbA1c by 1% over 1 year in patients with DM from baseline of 7.4% HbA1c and excess weight through Lighter Life by March 2025.
3. Increase in enrolled eligible overweight/obese* patients with DM into Lighter Life to 120 patients from a baseline of 17 patients[^] by March 2025.

*Overweight in Asians = BMI 23.1kg/m² to BMI 27.4kg/m². Obese in Asians = BMI >27.5kg/m²

[^]Baseline DM target based on eligible DM patients from 1 Oct 2021 to 31 Aug 2023

S/N	Measures	Operational Definition
Outcome		
1	Percentage of patients with 5% weight loss	% of overweight LL participants with DM achieving $\geq 5\%$ weight loss at 6 months (No of LL DM participants achieving $\geq 5\%$ weight loss at 6 months / No of LL DM participants)
2	Average HbA1c Improvement	Sum of total HbA1c of LL participants per month / Total no of LL participants per month
3	No. patients with weight loss	No of participants who achieved any weight loss
Process		
4	No. of eligible overweight/obese patients with DM referred to Lighter Life	No of patients with diabetes, and BMI ≥ 23 to 32.4kg/m ² who are referred to Lighter Life
5	No. of eligible overweight/obese patients with DM enrolled in Lighter Life	No of patients with diabetes, and BMI ≥ 23 to 32.4kg/m ² who are referred and enrolled in Lighter Life
6	No. of overweight/obese patients with DM who drop out of programme	No of patients with diabetes, and BMI ≥ 23 to 32.4kg/m ² who are enrolled in Lighter Life and attended 1 out of 7 group sessions.
Balancing		
7	PREM	Patient Reported Experience Measure
8	Hypoglycaemia occurrence	Number of patients with hypoglycaemia episodes
9	Patient satisfaction	Percentage of Lighter Life patients who would recommend the programme to others

THEORY OF CHANGE



LIGHTER LIFE PROGRAMME

Lighter Life is a structured multi-component six-month, group-based weight management programme tailored for patients with chronic conditions. Anchored within primary care, it combines medical supervision with behavioural and social support, delivered through **three key components**:

Component 1: Group-Based Shared Learning and Personal Progress

Interactive, multidisciplinary sessions form the backbone of Lighter Life. They equip participants with evidence-based knowledge, practical skills, and confidence to manage weight in the context of chronic disease. The hybrid and structured format - in-person, online, and experiential sessions, ensures both accessibility and depth.

- Hybrid format: Starts with an in-person session to build trust and cohesion, followed by online sessions for convenience and family involvement.
- Structured sessions: Three-hour blocks combining knowledge, discussion, and practice, covering topics such as weight management, nutrition, physical activity, and relapse prevention.

Component 2: SMART Goal-Setting and Personal Action Plans

Knowledge is translated into sustained change through personalised SMART goal-setting. Participants learn to set realistic goals tailored to their circumstances, supported by facilitators who ensure progress is reviewed and barriers are addressed. This process helps participants transform intentions into practical, achievable commitments tailored to their individual life circumstances.

Component 3: Peer Support and Community Engagement

Sustained change is reinforced through strong social networks that extend within and beyond each cohort. Dedicated WhatsApp groups, wider community linkages, and peer-led activities create a dynamic environment of accountability and encouragement. By combining motivation with collective ownership, peer networks transform social support into a powerful driver of long-term weight management success.

Summary

Together, these three components create a comprehensive model that integrates medical, behavioural, and social dimensions of care. This design ensures Lighter Life is both impactful for individuals and scalable across institutions.

IMPLEMENTATION PHASES

Phase 1: Identification and Referral

Systematic Patient Identification:

SmartPhrase in EPIC EMR: Clinicians use a SmartPhrase embedded in EPIC to screen patients based on inclusion/exclusion criteria.

Target population:

Inclusion Criteria	Exclusion Criteria
Adults aged 18–64	Recent stroke or IHD (within 6 months), or on anticoagulants
BMI between 23–32.4 kg/m ²	Cognitive/psychiatric conditions or deemed unfit for exercise
Diagnosed with diabetes, hypertension, knee osteoarthritis, or asthma	Significant sensory impairments
	Non-English speaking or unable to use a smart-phone/device

Multiple Referral Pathways:

- Clinician Referral via EPIC: Direct submission for eligible patients.
- Self-Registration: Public-facing webpage allows patients to register interest independently.

Phase 2: Recruitment and Enrolment

Eligibility Verification and Outreach:

- The Lighter Life team contacts referred/self-registered individuals to confirm eligibility and interest.

Enrolment Support:

- Information Pack: Includes programme overview, expectations, and logistics.
- Pre-Programme Questionnaire: Completed prior to the first session to assess baseline status and readiness.

Phase 3: Programme Delivery

Session Structure:

Six sessions over six months, each lasting 3 hours:

- Welcome (10 min): Establish group norms and rapport
- Education Lecture (90 min): Core curriculum on lifestyle and condition management
- Exercise Segment (20 min): Guided physical activity
- Goal Setting & Planning (60 min): Development of SMART goals and action plans

Session Logistics:

- Venue Requirements: Comfortable space with AV equipment
- Virtual Option: Consider Zoom Healthcare for remote delivery
- Materials: Standardized handouts, goal templates, and resource lists

Facilitator Model:

- Led by trained lay facilitators with support from allied health professionals as needed

Phase 4: Follow-Through and Monitoring

Facilitators track:

- Progress on SMART goals
- Weekly self-monitoring metrics
- Updates to individual action plans

Documentation:

- Standardized notes in EMR to ensure continuity and accountability

Outcome Tracking:

- Integrate follow-up assessments (e.g., weight, blood pressure, HbA1c) to measure impact

Phase 5: Peer Support and Sustainability

Digital Community Engagement:

- Online Platforms: WhatsApp or other secure messaging apps to foster peer encouragement and accountability
- Participant-Led Initiatives: Encourage sharing of tips, recipes, and success stories

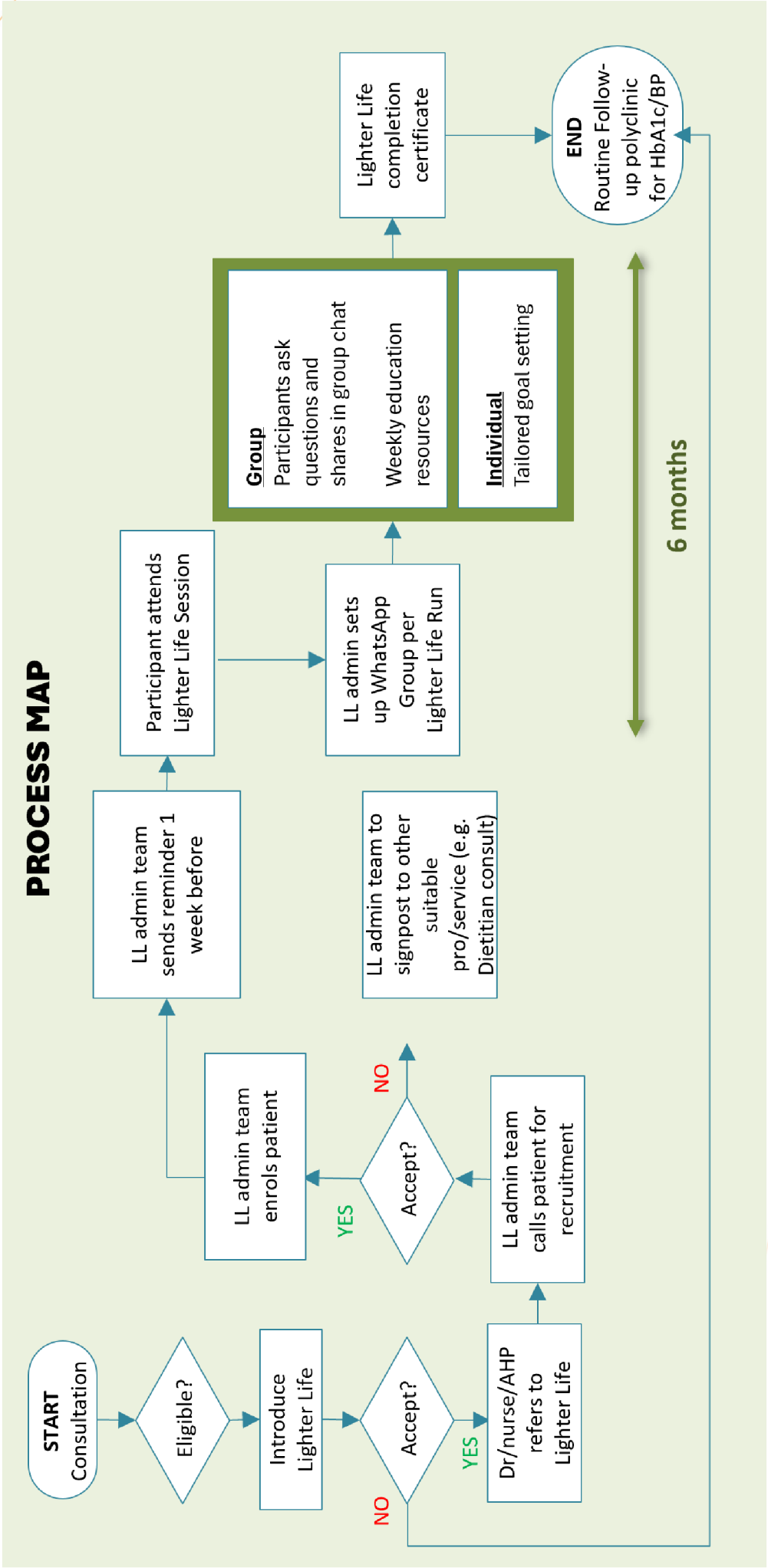
Recognition and Empowerment:

- Celebrate milestones and completion with certificates or shout-outs in the group

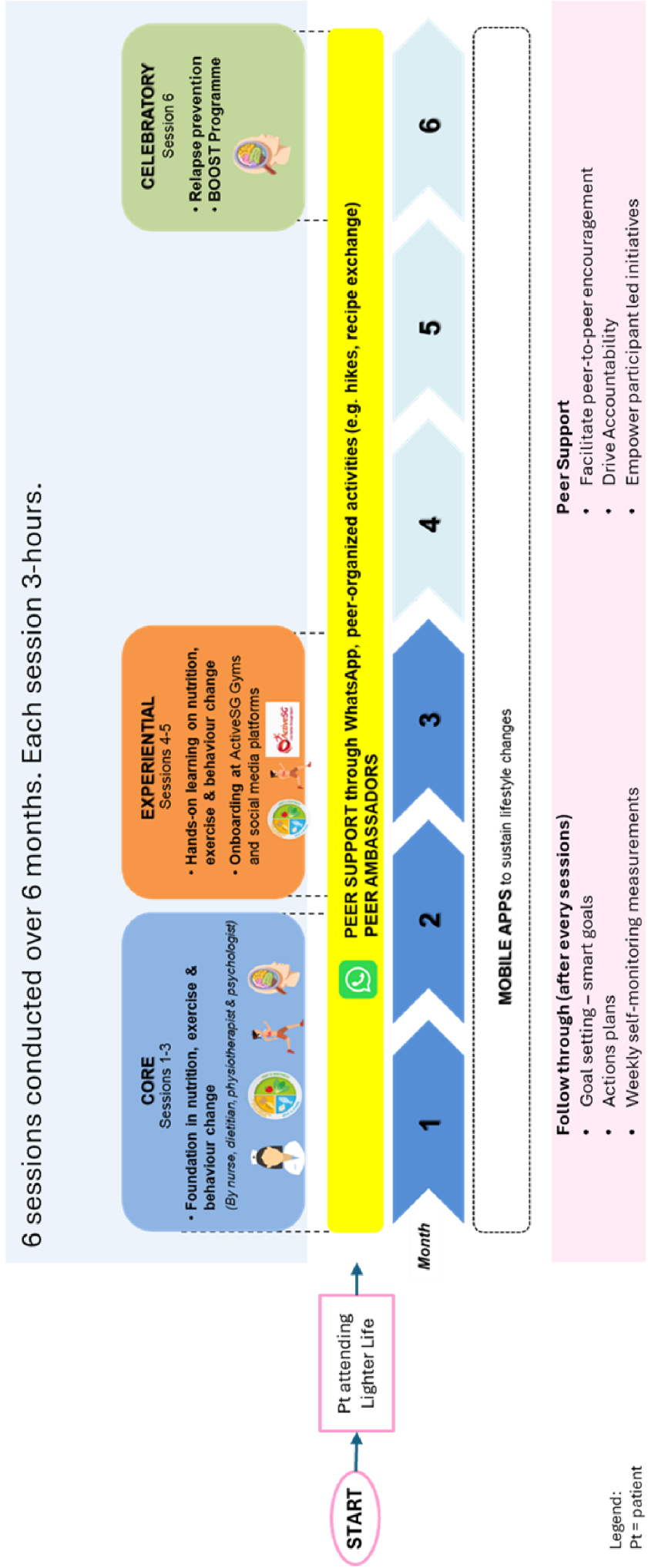
Quality Assurance:

- Feedback Surveys: Post-session evaluations to improve delivery and content
- Continuous Improvement: Use feedback to refine future cohorts

RECRUITMENT PROCESS



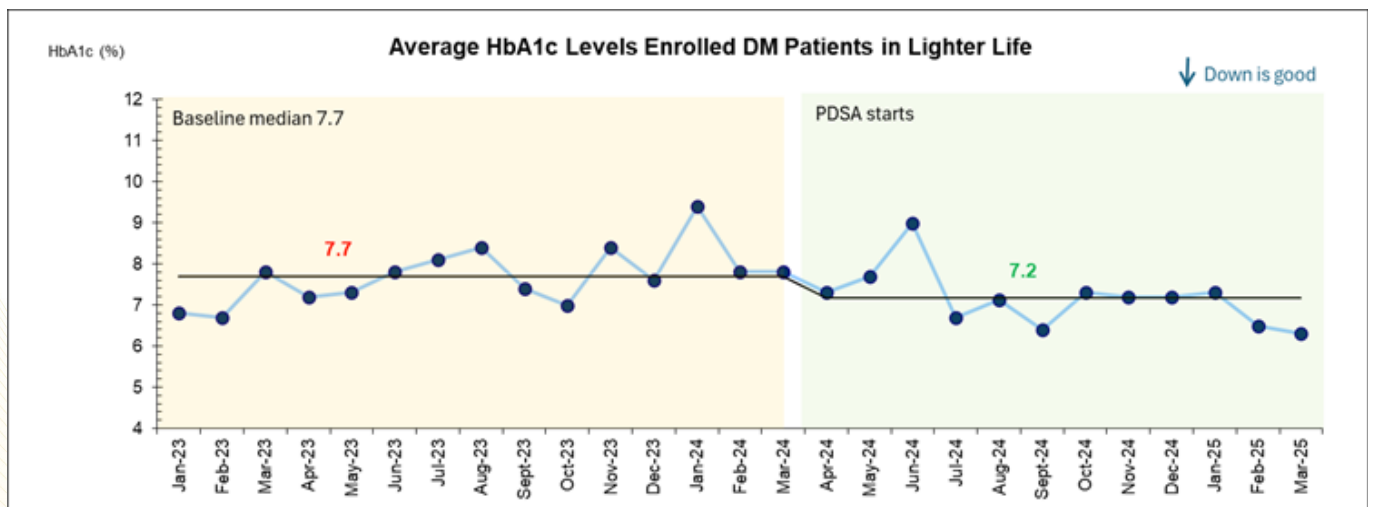
PATIENT EXPERIENCE



RESULT AND IMPACT

Key outcomes achieved:

1. HbA1c decreased by 0.5% in enrolled patients with diabetes
2. 33% of patients with diabetes achieved $\geq 5\%$ weight loss after the programme
3. 79% of patients with diabetes achieved any weight loss after the programme
4. Number of eligible patients with diabetes referred to Lighter Life increased from a median of 4 per month to 21 per month
5. Number of eligible patients with diabetes enrolled to Lighter Life increased from a median of 1 per month to 3 per month



ROLES AND RESPONSIBILITIES

A strategic partnership of key stakeholders drives Lighter Life's success through clearly defined roles and integrated workflows. This framework ensures seamless delivery and optimal outcomes.

Role	Time Needed	Key Tasks	Resources
Care Team (Doctor, Care Managers, Allied Health Professionals)	1 to 2 hours per week (referrals)	<ul style="list-style-type: none"> Identify and refer eligible patients to Lighter Life 	<ul style="list-style-type: none"> Access to Epic SmartPhrase and e-Order referral templates Intranet resources Program orientation
Lecturers (Allied Health Professionals, Care Managers)	1 to 2 hours per session	<ul style="list-style-type: none"> Deliver standardised education session Conduct Q&A during sessions Prepare session slides/materials aligned with curriculum 	<ul style="list-style-type: none"> Standardised lecture slides Session outlines Access to pre-recorded material
Facilitators (Allied Health Professionals, Lay Health Coaches)	3–4 hours per week (session facilitation, WhatsApp support, documentation, clinical queries)	<ul style="list-style-type: none"> Facilitate group discussions and interactive elements (e.g. Zoom polls) Guide patient goal setting and document progress. Manage WhatsApp support groups 	<ul style="list-style-type: none"> Facilitation handbook Training courses
Project Team (Family Physician, Manager, Executive)	2–3 hours weekly for oversight and coordination	<ul style="list-style-type: none"> Coordinate recruitment and operations Oversee clinical, operational and data management for monitoring and reporting 	<ul style="list-style-type: none"> Lighter Life implementation playbook

SCALABILITY & ADOPTION: PATHWAYS FOR INSTITUTIONAL IMPLEMENTATION

Lighter Life was designed as a structured, modular weight management programme that can be flexibly implemented across healthcare institutions. Using the **RE-AIM** framework, this section outlines how institutions can successfully adopt, implement, sustain and evaluate Lighter Life at scale.

Reach

Scaling begins with ensuring that all eligible patients can be systematically identified and engaged.

- EMR integration: Referral pathways in EPIC NGEMR embed Lighter Life into clinical workflows.
- Multiple entry points: Clinician referrals and self-registration webpages reduce barriers and increase inclusivity.
- Targeted outreach: Outreach to underrepresented groups (e.g., younger adults, lower health literacy) expands programme equity.

Effectiveness

Adoption must maintain fidelity to the programme's evidence-based components while demonstrating measurable patient outcomes.

- Core content delivery: Institutions should deliver the three programme components, group-based learning, SMART goal-setting, and peer support, with fidelity.
- Outcome tracking: Monitor weight change, HbA1c, blood pressure, and self-efficacy as primary indicators of impact.
- Qualitative insights: Collect feedback on patient motivation, empowerment, and satisfaction to supplement quantitative measures.

Adoption

Institutional uptake depends on leadership support, alignment with organisational priorities, and capacity-building within care teams.

- Leadership buy-in: Senior management commitment is critical to embed Lighter Life as part of chronic disease pathways.
- Staff facilitation model: Nurses, Allied Health Professionals and health coaches can be trained as facilitators, minimising the need for new hires.
- Multidisciplinary involvement: Physicians, dietitians, physiotherapists and psychologists, enhance programme credibility and ensure holistic care.

Implementation

Institutions can adapt delivery formats and operational models to their resources and patient populations.

- Flexible formats: Programmes can be delivered in-person, virtually, or hybrid, expanding accessibility for patients with mobility or scheduling challenges.
- Institutional readiness models:
 - Basic model: Monthly sessions led by existing staff, supported by digital peer groups, with a lead monitoring progress.
 - Intermediate model: Increased frequency, diversified facilitators, structured content libraries, and interactive check-ins.
 - Advanced model: Full integration into chronic disease management pathways, expanded across multiple clinics or regional networks, supported by continuous data use.
- Peer support networks: WhatsApp groups and community-based engagement sustain motivation and accountability.

Maintenance

Sustainability is achieved by embedding Lighter Life into routine workflows and building a culture of continuous improvement.

- System integration: Referral, documentation, and follow-up embedded within EMR systems ensure long-term consistency.
- Cross-institutional learning: Regular forums and communities of practice enable best-practice exchange and collective problem-solving.
- Patient and community engagement: Patient champions, family involvement, reinforce and sustain lifestyle changes beyond the clinical setting.
- Continuous improvement: Feedback surveys, outcome monitoring, and QI cycles refine the programme over time and demonstrate ongoing impact.

Summary

By applying the RE-AIM framework, institutions can approach scalability systematically: reaching more patients, ensuring programme effectiveness, securing adoption, enabling flexible implementation, and sustaining impact through continuous learning and community engagement.

CONCLUSION

Lighter Life has shown that structured, group-based weight management can be embedded within primary care to deliver meaningful outcomes for patients with chronic conditions. Its design, combining medical oversight, behaviour change strategies, and peer support, provides a replicable and scalable model of care.

By refining the programme through repeated Plan-Do-Study-Act cycles, the team has demonstrated not only effectiveness but also adaptability and sustainability across diverse settings. This positions Lighter Life beyond a pilot initiative: it is a tested framework ready for wider adoption.

Scaling Lighter Life nationally offers a timely opportunity to strengthen chronic disease management, reduce obesity-related complications, and ease long-term healthcare costs. With strong leadership support, EMR integration, and cross-institutional collaboration, Lighter Life can move from project to practice, becoming a routine, sustainable part of chronic disease care under Healthier SG.

OUR TEAM

TEAM LEAD



Dr Donna Tan
Team Lead
Deputy Director, Clinical Services,
Family Physician Associate
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TEAM MEMBERS



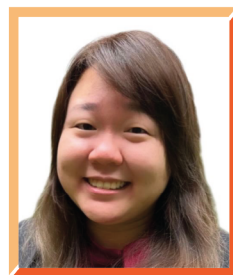
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ANNEXES

LIGHTER LIFE BROCHURE



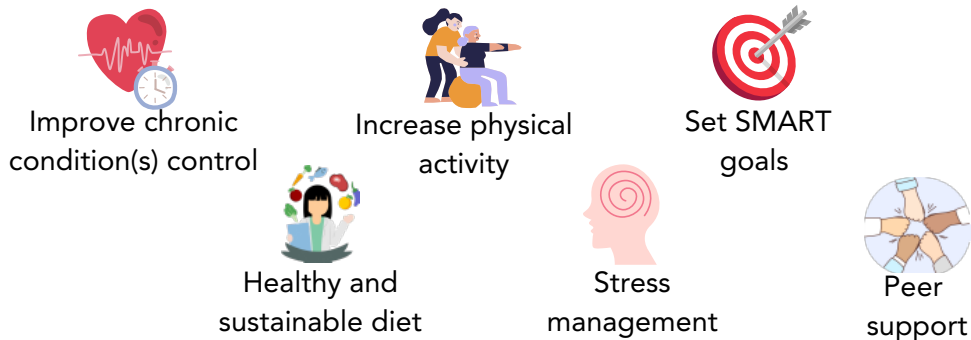
What is Lighter Life?

- ▶ Lighter Life¹ is a 6-month structured group weight loss² programme
- ▶ Interactive in-person and online group learning sessions
- ▶ Targeted practical advice from the dietitian, physiotherapist, and psychologist
- ▶ Support through mobile chat group
- ▶ 1-year follow up measurements after the start of programme

Am I eligible?³

- ✓ are 18 - 69 years old **AND**
- ✓ are overweight (with a BMI of 23-39.9 kg/m²) **AND**
- ✓ have an existing chronic condition such as diabetes or high blood pressure
- ✓ are on regular follow-up with a primary care doctor

How will Lighter Life benefit me?



How much does it cost?

\$ \$60
Rebate of \$30 if goal achieved⁴

Note:

1. Lighter Life is conducted in English.
2. Individual results vary.
3. Eligibility and acceptance into the programme are subject to NHG Polyclinics' final decision.
4. Achieve at least 5% weight loss.

Register your interest TODAY



Frequently Asked Questions (FAQs)

- ▶ **I have more questions regarding Lighter Life. Who can I contact?**
 - ▶ Email nhgp.lighter.life@nhghealth.com.sg
- ▶ **Can my family members/friends participate in the group sessions?**
 - ▶ They are welcome to register as a participant if they are eligible.
- ▶ **Should I inform my doctor that I have joined Lighter Life?**
 - ▶ Please inform your doctor that you have joined Lighter Life.
- ▶ **Is Lighter Life part of my chronic care plan?**
 - ▶ Yes. Achieving and maintaining a healthy weight is part of the holistic care plan for chronic conditions.
- ▶ **Is there a make-up session if I miss one?**
 - ▶ There are no make-up sessions if you miss any of the sessions. However, you will receive the materials at the following session.
- ▶ **Are there extra fees?**
 - ▶ Separate fees apply for ActiveSG activities and additional dietitian, physiotherapist or psychologist consultation, if needed.

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