

# PROMs Policy Dialogue

3 Feb 2026

## Q&A

**Chair:** **Prof Nicholas Goodwin**  
NUS Centre for Research in Health Systems Performance (CRiHSP)

### Speakers

**Dr Albert Ty**  
Ministry of Health, Singapore

**Prof Jose M Valderas**  
NUS Centre for Research in Health  
Systems Performance (CRiHSP)

**Dr Brenda Reiss-Brennan**  
Intermountain Health, USA

**Ms Nidhi Swarup**  
Alliance of Patients' Organizations  
Singapore

**Ms Ai Ling Sim-Devadas**  
Office for Patient Engagement,  
Lee Kong Chian School of Medicine, NTU

**Ms Shikha Kumari**  
Value Driven Outcomes Office,  
National University Health System

### Talk-specific questions:

#### Talk 1 (Dr Albert Ty)

**Question:** If we modify and contextualize the PROM questions, which are validated, does it affect the accuracy and reliability of data collected? How can we mitigate this?

**Prof Valderas:** Completely agree with Dr Albert Ty, those changes need to be assessed to be able to appraise both the benefits and detrimental effects of the changes on metric properties.

**Prof Goodwin:** There is always a need for instruments like PROMs that have been developed in other cultures to be subject to validity testing where feasible, otherwise it is possible for the data collection to be unreliable or the questions misinterpreted. If PROMs are used without such validation (as is likely) then at least the caveats on data interpretation need to be clear.

**Question:** To validate PROMs is a long and tedious process but once validated can be use Singapore- wide, what is the MOH view on this (resources and manpower to do this in Singapore as a whole?)

**Dr Ty:** Identification of harmonized set of PROMs tools and subsequent validation to the Singapore context is indeed not a straightforward undertaking given the complexity of the healthcare system, evolving patient profiles and co-morbidities, and the resources needed. MOH is working with all the healthcare clusters (NHG Health, NUHS and SHS) on a national PROMs strategy to identify where resourcing is needed that MOH can support. However, this work must go in tandem with the important groundwork that respective healthcare organizations' must play in influencing health professionals' behaviour to adopt PROMs in their clinical decision-making process.

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## Talk 2 (Prof Jose M Valderas)

**Question:** Could you kindly share examples of patient-centred PROMS which may be correlated with therapist effectiveness? Would measures such as PHQ-9, when routinely monitored, reliably reflect therapist effectiveness on a session-by-session basis?

**Prof Goodwin:** Changes in PHQ9 scores over time can be used as a measure of therapy effectiveness, noting that other life factors and/or the way in which the tool is administered can influence results.

**Prof Valderas:** For efforts to embed this in routine practice, see NHS Talking Therapies (formerly IAPT) [\*\*\*NHS Talking Therapies data set reports - NHS England Digital\*\*\*](#)

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### Talk 3 (Dr Brenda Reiss-Brennan)

**Question:** Was there any Patient and Public Involvement component in the study? Really interesting initiative.

**Dr Reiss-Brennan:** Yes. From its inception patients, families, community and staff (operational, research, clinical) co-designed and monitored the MHI innovation in Primary Care and produced the multiple transparent data that was used for the retrospective evaluation.

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**Question:** How will we start the movement for better data collection and utilization/presentation when upgrades for dashboards etc. require cost outlay? It is 10 years before TBC could show savings. What were the measured variables that matter?

**Dr Reiss-Brennan:** Suggestion: Start with diverse governing stakeholders (representing local population to be cared for), build shared purpose and focused problem to solve, assess available resources needed include technology and workforce to deliver and assess iterative implementation steps. Yes, this is a long game building a normative culture for 'whole health' it is not the length in years but the quality over years and review of incremental ROI. Some of variables were detailed on the slides.

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**Question:** Could I have the reference for last Brenda's results? They are so interesting to me.

**Dr Reiss-Brennan:** Reiss-Brennan, B et al (2016) JAMA 316;(8) 826-834.

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## Talk 6 (Ms Shikha Kumari)

**Question:** Does NUHS have targets for response rates?

**Ms Kumari:** We have considered setting an overall PROMs response rate target, but it is challenging to establish a single benchmark. PROMs response rates vary significantly depending on several factors, including the type of instrument used (generic, condition-specific, micro, meso, or macro level), the collection methodology, and the technology platform employed.

At NUHS, we take a strategic approach by first identifying the aim and objective of each PROMs instrument. Based on these specific goals, we then select the most appropriate collection process and technology to achieve the required response rate for that particular context.

This tailored approach ensures that our response rate expectations are realistic and aligned with the intended use of the data, rather than applying a one-size-fits-all target that may not be appropriate across all our diverse PROMs initiatives.

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**General questions:**

**Question:** From a policy perspective, what measures are in place to ensure PROMs implementation is sustainable while minimizing administrative burden on providers and patients?

**Prof Valderas:** It depends on the country, the target population, the disease and the intended use (individual, group, population). Measurement systems based on Computer Adapted Testing are the state-of-the-art approach, but are not really used mostly because of limited understanding by stakeholders, more familiar with legacy measures (EQ5D, SF-36, etc.)

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**Question:** At current stage, do we have enough PROMs data to be incorporated into population health strategies?

**Prof Valderas:** We know that they provide information on user assessments of the impact of health systems that cannot be retrieved by other means (very solid empirical evidence).

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**Question:** Given the local context of largely not having patient's voice involve in actual clinical process change. Could you share your perspective on how PROMs can help cover that gap?

**Prof Valderas:** The very use of the instruments would shed light on how medical management impacts symptoms and function (the daily impact of disease and illness) in real terms. Physicians will need patient input into understanding patients' context and making sense of any gap, thereby increasing and promoting patient agency.

**Prof Goodwin:** To enhance the patients' voice, PROMs should be proactively used to support information sharing, health promotion, shared decision making and supported self-care. Patients should be engaged in the co-design and testing of PROMs tools.

**Ms Swarup:** Dedicating adequate time and employing accessible language when engaging with patients newly diagnosed with chronic conditions are essential strategies to ensure they comprehend the purpose of PROMs. Additionally, clinicians should support patients in articulating their challenges related to quality-of-life concerns and expressing their priorities regarding health outcomes.

**Ms Sim-Devadas:** Involving patient and caregivers in clinical process change is important and much needed. The challenge has always been how to bring patient and caregiver voices into these changes. PROMs (and PREMs) are two tools that provide the patient perspective in a structured form that is useful for any clinical process change. While the data from PROMS will be very useful, it should also be used together with other patient involvement methods to, involve patient and caregiver partners to co-design the system.

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**Question:** Given that we are at the stage of implementation/planning the roll-out of value-based care initiatives, how will PROMs data be used to inform policy decisions, such as benefit design, service prioritization, or resource allocation?

**Prof Valderas:** The priority would be to (quickly) accumulate empirical cross sectional and longitudinal evidence on PROMs to help understand individual and group trajectories in the local context and population.

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**Question:** I've found considerable resistance to change amongst senior consultants when it comes to adding PROMs into their regular activities, and recent graduates rarely mention PROMs when explaining their clinical reasoning. What is being done to train upcoming generations of physicians to incorporate PROMs into their clinical decision making in Singapore?

**Prof Luo Nan:** Good question! PROMs should be in the curriculum of medical schools. It is time now.

**Prof Valderas:** Completely agree with Luo Nan, same with clinical practice guidelines, which do not adequately distil specific impact of interventions on PROMs thereby obscuring rationale for a significant component of current care.

**Prof Goodwin:** The use of PROMs is linked to the wider need for clinicians to 'own the quality agenda' and to actively use data and information to identify and improve care. Training is one part of the solution, but support is also needed to implement quality improvements meaningful to the consultant / physician along with protected time and incentives.

**Ms Swarup:** Appropriate and Value-based Care (AVBC) needs to be embedded in medical education if we want a sustainable healthcare system. AVBC is about ensuring that every patient receives care that is both clinically effective and personally meaningful to their health journey.

**Dr Ty:** MOH has worked with the deans of the medical schools together with MOH colleagues to incorporate AVBC (which includes the more pervasive use of PROMs) in the National Outcomes Framework for Medical Graduates. This national framework guides medical school curriculum development and key competencies to prepare medical students for clinical work. MOH is also working to include this in residency training as well as in the curriculum for other healthcare professionals such as nursing, pharmacy, dentistry and allied health.

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**Question:** When does one make PROMs patient level (providers reviewing that prior to consulting their patients?) vs program level - which is useful? Will the patient level ones overwhelm the clinicians? How do we do this well?

**Prof Valderas:** This are not (necessarily) alternative options, the same measure may be used for all purposes (with possibly different indicators derived from the same core information being used at different levels). But they can be based on different measures if we for instance want to understand need based on a comprehensive measure but use screening instruments for case finding the individual level. Clinicians are used to incorporate new technologies. What is important is that there is careful implementation.

**Ms Swarup:** Singapore has 100 Patients' Organizations (POs) that can help introduce PROMs locally, as many patients are unfamiliar with them. By collaborating with clinicians, PO representatives can help design prompts that are customised to meet patients' needs and viewpoints within clinical environments, offering valuable perspectives in the process.

**Ms Sim-Devadas:** To encourage patients to embrace PROMS and to answer them truthfully, they need to see how it will help them in their care plan. If patients see that their responses to the PROMS questionnaire does not translate into any impact on their care, will they want to continue answering PROMS? Therefore, PROMS at patient level needs to be done well.

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**Question:** How do we manage the deluge of responses and information which a patient is asked to respond, such that they can focus on telling us the truth about what matters? Traditionally, our local patients do not seem to be truthful about responses to PROMS. Also, how do we train patients to respond well and truthfully?

**Dr Goldsmith:** A great place where Patient and Public Involvement (PPI) could be a valuable addition. Helping to sort out a better way that meets everyone's needs.

**Prof Valderas:** First thing is to understand why people would not trust the system so that the impression is that they do not provide valid answers. Not just a matter of training, need also to clarify incentives and barriers for effective engagement in PROMs data collection.

**Prof Goodwin:** Patients often do not see the value in responding to questions that will not be meaningful to their own care. There is also a highly positive bias, especially amongst older people, for people to give more positive answers than might be the reality. So the quality of the responses comes from the quality of engagement with patients themselves, which speaks to a strategic need for building trust and engagement, and to support shared decision making

**Ms Swarup:** There is a general perception that sharing the right information will translate to adherence to prescription medicines and lifestyle changes. The reality is far from it since the social determinants of care come into play. Behavioural Scientists, Patients and Clinicians can co-create prompts to be used when using PROMs. If patients feel safe, and respected for making certain decisions, and setting their outcome priorities, we can see better results with true shared decision-making.

**Ms Sim-Devadas:** As shared by my colleagues above, co-creating PROMS through PPI will help to create PROMS that addresses what matters to patients. Whether patients will answer truthfully or want to participate in PROMS, is also dependent on the value they see in answering them. If it impacts their personal care plan, their motivation to participate in PROMS and doing it truthfully increases. The issue here is trust and why does it matter for patients to participate in PROMS. It is not so much about “training” patients – but that they see the value in PROMS, and that this is communicated respectfully.

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**Question:** Interested to hear from the speakers how the incorporation of AI could impact PROMs implementation?

**Prof Valderas:** Optimization of data collection for patient benefit, efficient and timely data collection for system use, supporting interpretation of scores for patients, clinicians and other stakeholders, developing novel ways in which scores can be obtained.

**Ms Swarup:** AI notifications can empower patients' daily adherence to prescribed medicines, and lifestyle changes to achieve their set of outcomes. Compassionate messaging is crucial to encourage the patient to move on the path despite some pitfalls, missed meds, sub-optimal dosage taken, etc. Having a personal AI health buddy could work for some patients. Hearing from patients is vital.

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**Question:** In addition to PROMs and PREMs, patient preferences measures (PPMs) are also crucial to understand what matters to patients.

**Prof Valderas:** I would consider preference measures a subtype of PROMs. Some of them are based on psychometric measurement, others are based on preferences.

**Ms Sim-Devadas:** PROMS, PREMS and PPMs are important metrics to understand what matters to patients. But this should also be practiced with involving patient and caregiver partners in the conversation in developing and using these metrics. PPI (Patient and Public Involvement) should be included.

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**Question:** What if the patient and caregivers are in conflict of what matters / is meaningful? Or when the patients themselves are not eloquent enough / uncommunicative, which of their NOK do we take reference from? The concept of LPA is not yet widespread here. Secondly, what if patients' values conflict with evidence-based treatments, with no alternative? What if they value outcomes which they cannot afford?

**Prof Valderas:** They are entitled to those differences. PROMs may help illuminate those discrepancies that may go undetected. The problem will be there regardless of how we measure this.

**Ms Swarup:** Many important points have been brought up here.

1. The Patient's preference should be prioritized in my opinion since it is his/her life. Some level of 'mediation skills training' or counselling will be helpful. NOK needs to respect the patient's preferences.
2. LPA awareness is slowly growing yet not many people prepare for such a situation owing to our cultural background. Working with Patients' Organizations awareness amongst patients and their family members can be enhanced. In the situation when a patient is not eloquent enough, a safe environment can be created for the patient to share his/her appointed NOK to make decisions.
3. Listening with the 'intention to understand' the patients' perspective is a crucial first step. Once trust is built, the patient will be willing to listen to the explanation provided that is based on scientific evidence.
4. Lastly, all financial options need to be shared with the patient and family members to facilitate shared decision-making, without assuming that they can or can't afford.

**Ms Sim-Devadas:** I agree with the excellent points brought up by Ms Swarup.

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**Question:** So you have someone to collect PROMs? Or is the link sent and patient does on their own?

**Prof Valderas:** Both options are valid and have been implemented.

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**Question:** What is the proportion on who answers the PROMs question? Patient vs caregiver vs clinician?

**Prof Goodwin:** Patients themselves should be answering the PROMs questions directly, but in practice it is often the case that healthcare professionals, carers and family members who are directly involved in their care may actively support the process or even do so themselves. If so, they should have the necessary training and permissions.

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**Question:** Lots of PROMs are not locally validated. What is your view on this? Can we still use them in Singapore?

**Prof Valderas:** We are compiling a database of those with evidence of being ready for use in Singapore. For those for which aren't, if used, efforts should be made to collect the additional information that would facilitate assessment of those metric properties.

**Follow up question:** will this database be shared to all institutions?

**Prof Valderas:** It is our intent that this will be publicly available.

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**Question:** Given the long process required to locally adapt and validate PROMs, how should we balance this and clinician enthusiasm in implementing PROMs for their patients? Buy in will be lower if the process is too long/tedious

**Prof Valderas:** It may not need to be (that) long. If there are strong arguments for exploring the use, information should be collected alongside administered tools to support subsequent assessment. I note that the argument could be made about long evaluation of "effective" treatments coming in the way of adoption, but how do we establish they are effective in the first place.

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**Question:** How are PROMs data aggregated and analyzed at service or system level? How do we build a culture where PROMs are valued, nor seen as a tick-box exercise? What governance structures oversee PROMs use and interpretation?

**Prof. Valderas:** These are multiple complex questions that cannot be answered within this space. You can see an example of how this is done for instance in the OECD Report Does Healthcare deliver. [Does Healthcare Deliver? | OECD](#)

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**Question:** Joining from Toronto where it is well past midnight so my apologies if my question is not clear! Wondering if the PROM and PREM strategy in Singapore is focused on surgical/acute events or chronic longer term illness. If they are being collected at the point of care I assume this is hospitals? But a lot of care is delivered in primary care and I have not seen much PROM/PREM in primary care settings so wondering what your approach to this may be?

**Ms Swarup:** Currently they are being used in hospital settings but not across all disease areas. As Singapore is strong on promoting behaviours that could prevent health challenges, plus chronic illness care is becoming decentralized, I can foresee these tools being useful in primary care settings too.

**Dr Ty:** Part of the national strategy is to employ PROMs in primary and community care given that a significant portion of care is managed on an outpatient basis. PROMs become invaluable tools in determining whether patient's desired outcomes are being achieved beyond clinical management of the condition itself.

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