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COURSE BROCHURE

AI for Chronic Disease Management Training Course

7 – 11 December 2026
Singapore

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Registered in the United Kingdom and Saudi Arabia

AI for Chronic Disease Management Training Course

Ref: 90_2269 **Date:** 7 – 11 December 2026 **Location:** Singapore **Fees:** 9300 GBP

AI for Chronic Disease Management is a 1-week training course for care managers, population health leads, specialist nurses and digital health managers, ending with a long-term conditions care model for one patient panel. Diabetes, heart failure and COPD fill clinic lists and emergency beds, and prediction now lets care teams reach the right patients before they deteriorate. Jupiter Prime Training runs this AI for Chronic Disease Management course.

Why AI for Chronic Disease Management Matters Now

Ageing populations and rising diabetes and heart failure prevalence stretch clinic capacity. Patients now share glucose, weight and oxygen readings from home devices, creating more signals than nurses can read. Payers and hospital boards want fewer avoidable admissions and readmissions. A service that stratifies its panel, monitors remotely and personalises care plans keeps people stable at home; one that does not reacts late, crowds emergency departments and loses patient trust. The course draws on ISO/IEC 42001 for AI management and the NIST AI Risk Management Framework NIST AI RMF for testing risk scores on real patient groups.

Who Gains Most from AI for Chronic Disease Management

- Care managers who coordinate follow-up for high-risk patients
- Population health staff who segment patient panels and target outreach
- Specialist nurses who review home readings and adjust treatment
- Digital health staff who run remote monitoring platforms
- Primary care leads who answer for admission and readmission rates

A clinic network or hospital outreach service gains most when care managers, specialist nurses and its digital health staff attend together and agree one escalation route for every risk alert.

AI for Chronic Disease Management Capabilities

Participants work with anonymised patient panels and home monitoring streams to decide who needs a call today, who needs a plan change and who can safely wait.

- Assess risk stratification models against local admission history — population health leads
- Design remote monitoring thresholds and alert routes — specialist nurses
- Specify deterioration and readmission predictions for discharge planning — ward and transition teams
- Build personalised care plan triggers from patient goals and readings — care managers
- Calculate outcome improvement with matched comparison groups — service commissioners
- Communicate risk scores and self-management advice to patients — families and carers

Key AI for Chronic Disease Management Terms

- Risk stratification — sorting a patient panel into risk tiers so care effort goes first to those most likely to deteriorate.
- Remote patient monitoring — collecting readings such as glucose, blood pressure or oxygen from patients at home for clinical review.
- Readmission prediction — estimating the chance a discharged patient returns to hospital within a set period.
- Care plan personalisation — adjusting goals, medication reviews and contact frequency to one patient's risk and preferences.
- Alert fatigue — clinicians ignoring warnings because too many low-value alerts arrive.
- Patient activation — a person's knowledge, skill and confidence in managing their own long-term condition.

AI for Chronic Disease Management Day by Day

Day 1: Long-Term Conditions and Care Pressures

- Chronic Disease Burden Mapping — Diabetes, Heart Failure and COPD Pathways
- Care Model Review — Where Prediction Changes Follow-Up
- Primary Care and Hospital Outreach Cases — Early Lessons
- Patient Panel Data Sources — Records, Pharmacy and Home Devices
- Equity Check — Patients Missing From Digital Data

Day 2: Stratifying Risk Across Patient Panels

- Risk Stratification Models — Tiers for Outreach Priority
- Admission and Readmission Prediction — Discharge and Follow-Up Choices
- Model Calibration on Local Patients — Trusting the Scores
- Social and Behavioural Factors — Beyond Clinical Variables
- Caseload Allocation — Matching Care Managers to Risk Tiers

Day 3: Remote Monitoring and Early Warning

- Home Monitoring Streams — Glucose, Weight, Blood Pressure and Oxygen
- Deterioration Alert Thresholds — Balancing Sensitivity and Alert Fatigue
- Wearable Signal Quality — Missing and Noisy Readings
- Nurse Triage Workflows — Who Reviews Which Alert
- Escalation Pathways — Telephone, Clinic or Emergency Response

Day 4: Personalised Care and Measuring Outcomes

- Care Plan Personalisation — Goals, Medication Review and Contact Frequency
- Patient Engagement Messaging — Nudges for Self-Management
- Outcome Evaluation Design — Matched Comparison Groups
- NIST AI RMF Measure Function — Bias Across Patient Groups
- ISO/IEC 42001 Controls — Ownership and Change Records

Day 5: Practising the Long-Term Conditions Care Model

- Pathway Maps and Data Sources From Day 1 — Scope
- Stratification and Caseload Rules From Day 2 — Outreach Priorities
- Monitoring Thresholds and Escalation From Day 3 — Alert Design
- Care Plan and Evaluation Measures From Day 4 — Outcomes
- Long-Term Conditions Care Model — Service-Ready Panel Plan

Applying AI for Chronic Disease Management After the Course

- Stratify one practice or clinic panel of diabetes or heart failure patients and compare the top risk tier with patients currently receiving active follow-up.
- Review one month of remote monitoring alerts, classify those that led to action and adjust thresholds that produced the most noise.

AI for Chronic Disease Management Questions FAQ

What is AI for chronic disease management and why does it matter now?

AI for chronic disease management is the use of risk scores, remote monitoring and prediction to guide care for long-term conditions. It matters now because demand outpaces clinic capacity and home devices produce more readings than staff can review.

Which roles gain most from AI for chronic disease management training?

Care managers, population health staff, specialist nurses and digital health staff gain most. Primary care leads also benefit, since they answer for admissions and outreach coverage.

How does AI for chronic disease management differ from a course on wearable health technology?

It centres on care decisions for whole patient panels rather than device design. You stratify risk, set alert thresholds, personalise care plans and evaluate outcomes.

What do you bring back from AI for chronic disease management training?

You bring back a long-term conditions care model for one patient panel, covering stratification rules, monitoring thresholds, escalation routes, care plan triggers and outcome measures.

AI for Chronic Disease Management: The Way Forward

The long-term conditions care model informs the first service decision: which patients receive proactive outreach this month and how alerts reach the right clinician. Care managers, specialist nurses and digital health staff use it together. After the first quarter, revisit calibration and alert volumes, because patient mix, devices and seasonal illness patterns shift the risk picture.