

# Sustainability Phase: Improving Percentage of Transfer of Care from Geriatric Memory Clinic to Primary Care Dementia Clinic



Adding years of healthy life

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### **Mission Statement**

To improve the percentage of transfer of eligible stable dementia patients from Geriatric Memory Clinic to Toa Payoh Primary Care Dementia Clinic (PCDC) from 24% to 75% over a sustained period

Team Members				
	Name	Designation	Department	
Team Leader	Dr Khin Khin Win	Consultant	Geriatric Medicine	
Team Members	Dr Noorhazlina Bte Ali	Senior Consultant	Geriatric Medicine	
	Dr Steven Chao	Family Physician	Toa Payoh Polyclinic	
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	Ms Deborah Lee	Management Associate	Clinical Standards & Improvement	
Sponsor	A/Prof Chan Peng Chew	Head of Department	Geriatric Medicine	
Facilitator	Adj A/Prof Julie George			

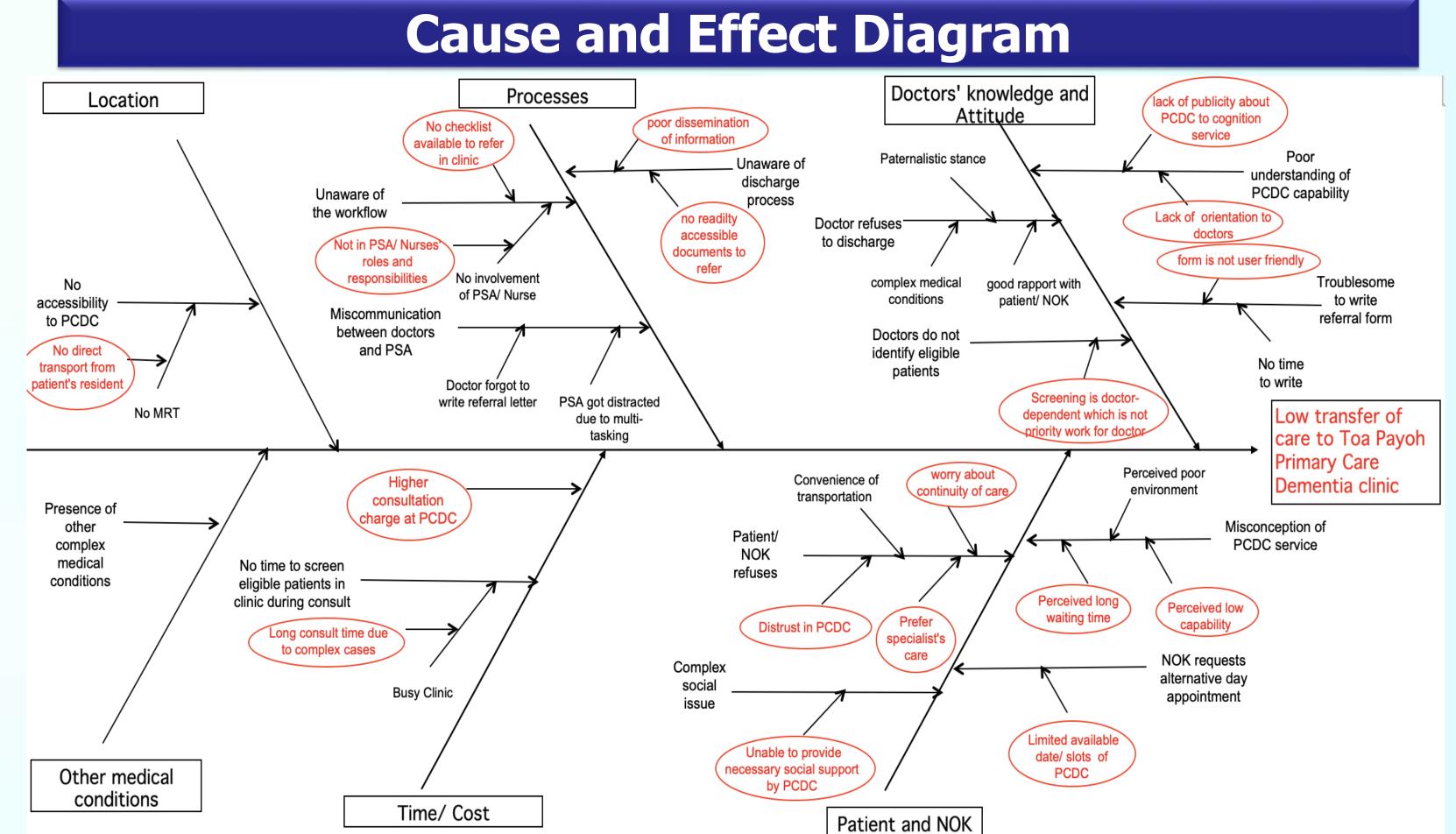
## **Evidence for a Problem Worth Solving**

- 1. Low rate of transfer of care from Geriatric Memory Clinic to Toa Payoh Primary Care Dementia Clinic (PCDC)
- 2. Why is it important to improve the right siting of the patients? As the population ages, the number of persons with dementia is expected to be increasing. So, it is important to:
  - a) Increase capacity building of primary care partners in dementia care
  - b) Right site the stable dementia patients with limited resources in tertiary care
  - c) Enable memory clinic to see complex cases

### **Current Performance of a Process** 46.7% Rate of Transfer of Eligible Stable 30.0% 27.3% **Baseline Dementia Patients** from Geriatric Median Memory Clinic to Toa 20% 12.5% 20.0% Payoh PCDC 23.6% Period: Sep 2018 to Feb 2019 Dec-18 Jan-19 Feb-19 Sep-18 Oct-18 Nov-18 No. of Patient eligible to be discharged **13 15** 20 11 10 **Actual No. of Patient discharged** 3

### **Flow Chart of Process MICRO FLOW MACRO FLOW** Long term follow up patients in Clinic PSA screen and memory clinic or new referral identify eligible PAS will fill the list of PSA will pass the list from GP/OPS/ restructured patients by postal eligible patients in to doctors at the start hospitals/ other sub specialty code before clinic spreadsheet of clinic from TTSH Room 3 nurse informs clinic hotline Patient came for follow up Doctor identifies patient suitable to staff via communication sheet to email appointment in Memory clinic transfer to PCDC based on criteria to NHGP contact center (both old and new patients) NHGP Contact center emails Memory Patient reviewed in Memory Clinic Doctor counsels patient's NOK or clinic regarding appointment and inform NOK appointment date and time caregiver Patient identified for eligibility and If agreed for transfer of care, doctor PCDC nurse will call patient/ NOK 2 counselled for PCDC by doctor days before appointment at PCDC writes referral letter to PCDC in C-Doc Patient identified for eligibility and Patient and NOK proceed for Patient reviewed at PCDC counselled for PCDC by doctor counselling by nurse about PCDC difficult issues arise and PCDC is unable to handle, discuss a

monthly MDR, call contact person in memory clinic



### **Pareto Chart** Screening is doctors-dependent which is not priority work for **Cause of Low Transfer of Care** doctor to Toa Payoh PCDC Poor publicity about PCDC to cognition service/clinic 10 Patient/NOK prefers specialist care Votes <sup>∞</sup> Lack of involvement of PSA/Nurse in discharge process as it is 60 not in their role and responsibilities 40 Long consult time due to complex cases, so doctors are 30 unable to screen during consult. 20 Poor understanding of PCDC capability by doctors No visible checklist to refer in clinic DEFGH H Patient/NOK's distrust in PCDC

Implementation				
Root Cause	Intervention	Implementation Date		
Poor publicity about PCDC to cognition service/clinic	<ul> <li>Reminder email was sent out to all doctors regarding PCDC clinic</li> <li>Flashcards with eligible criteria were pasted at clinic room computer as visual reminder</li> </ul>	11 March 2019		
Screening is doctors- dependent which is not priority work for doctor	Involved clinic room PSA to do screening and select cases according to postal code for all doctors	25 March 2019		
Lack of involvement of PSA/Nurse in discharge process as it is not in their role and responsibilities	Memory clinic PSA were briefed regarding the PCDC and instructed to do screening and select the patients staying at Toa Payoh area prior to start of clinic and pass the list to doctors	25 March 2019		

### Results Rate of Transfer of Eligible Stable Dementia Patients from Geriatric Memory Clinic to Toa Payoh PCDC Pre-Intervention Median Period: Nov 2018 to Dec 2020 **26.8%** Post-Intervention 30% Median 20% **50%** 10% 7 4 10 6 6 8 6 6 3 6 10 8 9 7 7 6 8 6 7 8 2 5 0 0 7 8 3 4 5 6 10 8 6 3 2 8 6 7 7 2 0 4 2 4 2 0 1 1 1 6 5 6 3 4 3 4 3 4 2 1 2 0 0 1 2 3 6 4 4 3 1 3 4 1 3 Note: <Temporary Holding Off Transferring Cases> [Sep 2019 to May 2020] Restructuring of teams in PCDC and [Feb to Jun 2020] COVID-19 Outbreak

Cost Savings					
	Pre- Post- Intervention				
% of eligible patients who are actually discharged (Median)	24%	55%			
Projected number of eligible patients who are actually discharged (average eligible patients per month $= 13$ )	3	7			
Different in number of patents who are discharged (Per Month)	4				
Different in number of patents who are discharged (Annualized)	4	8			
Number of clinic visits saved per annual (each patient requires 2 visits in 1 year)	48 x 2	2 = 96			
Cost savings from general polyclinic visits (Annualized)	\$6 x 96 = \$576				
Cost savings from less payment in PCDC per visit (Annualized)	\$4 x 96 = \$384				
Cost savings in transportation for clinic visits (Annualized)		= \$1920			
Cost savings in median salary of caregiver (Per Patient) Assume no. of hours required to take day off = 4 hr (less 48 visits)	\$ 22.57/ hr x 4 hrs x 48 visits = \$4,333.44				
Total Cost Savings (Annualized)		920 + \$4,333.44 = <b>L3.44</b>			

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## **Problems Encountered**

- 1. Matching of supply (available PCDC slots) and demand (number of eligible patients from Geriatric Memory Clinic suitable to transfer care to PCDC) and monitoring the status of the supply meeting the demand so that the transfer flow is not disrupted by inadequate PCDC slots.
- 2. Achieving confidence of family and caregiver of patients on capability of the family physicians in taking care of persons with dementia.
- 3. Improving the consistent awareness of doctors in Geriatric Memory Clinic on PCDC and the importance of right siting of the stable dementia patients from tertiary clinic to Primary Care Clinic.

- Strategies to Sustain Screening of suitable patients to be transferred to PCDC since first visit as a routine
- 2. Continue involvement of transdisciplinary staffs (clinic PSA) in screening process

process

3. To continue training and capacity building of primary care partners through regular multidisciplinary rounds and cases discussion to enable them to provide quality care to persons with dementia in the community