

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

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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

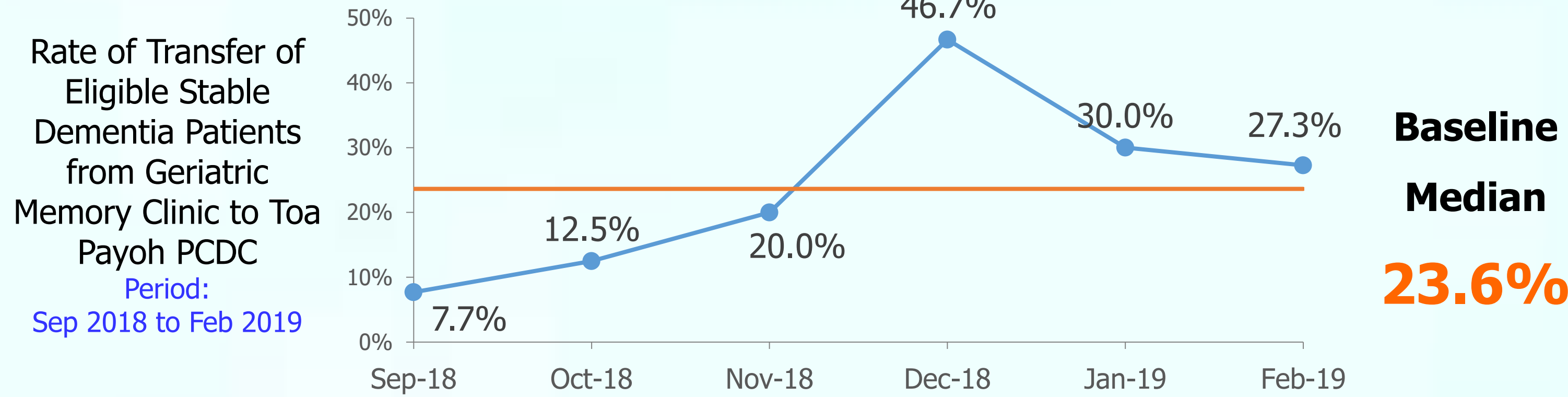
Team Members

	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
	Ms Goh Gek Hum	Senior Staff Nurse	Geriatric Medicine
	Ms Lee Yew Lay	Senior PSA	Geriatric Medicine
	Ms Pearlyn Goh	Executive	Ops DICC
	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

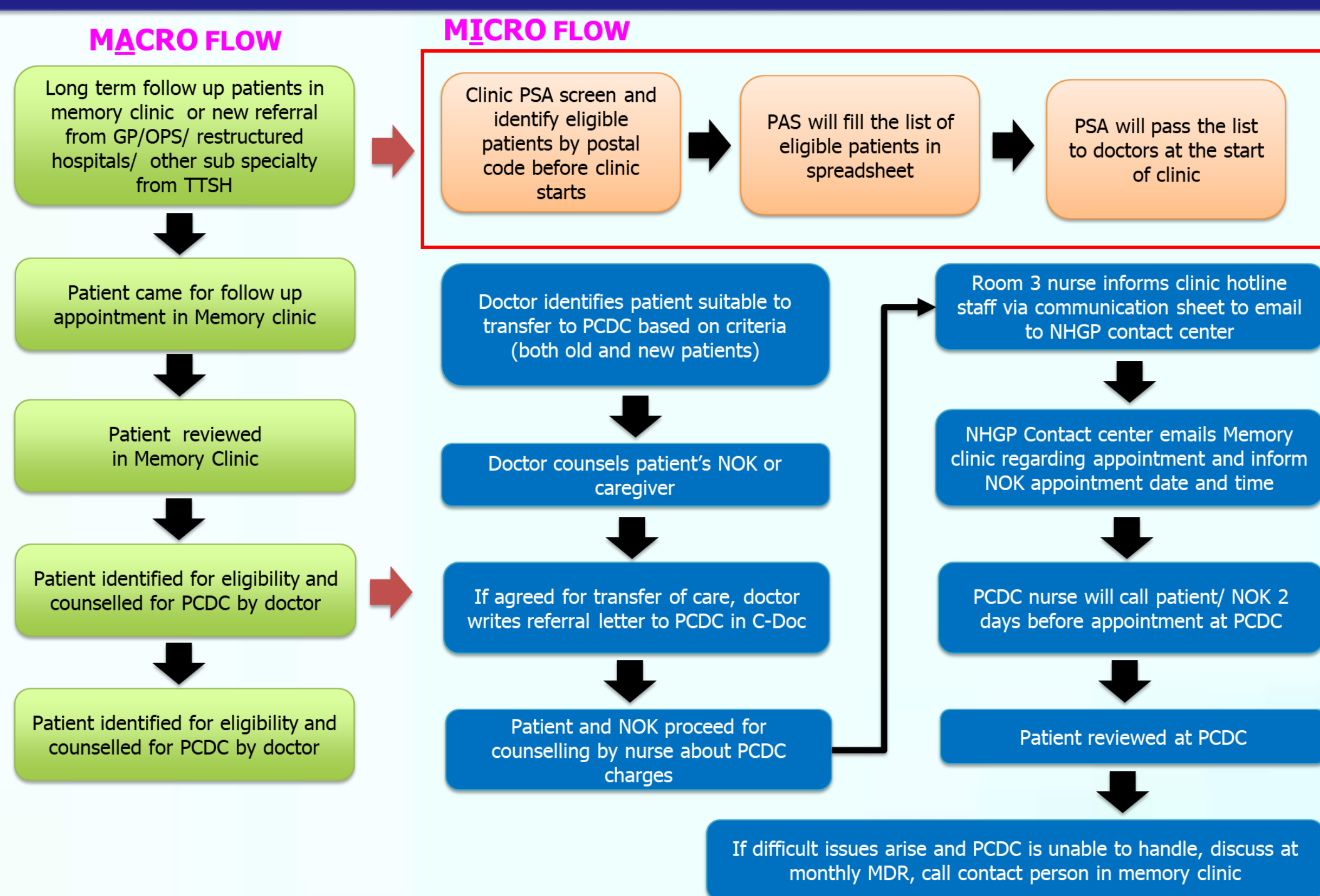
- Low rate of transfer of care from Geriatric Memory Clinic to Toa Payoh Primary Care Dementia Clinic (PCDC)
- Why is it important to improve the right siting of the patients?
As the population ages, the number of persons with dementia is expected to be increasing. So, it is important to:
 - Increase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

Current Performance of a Process

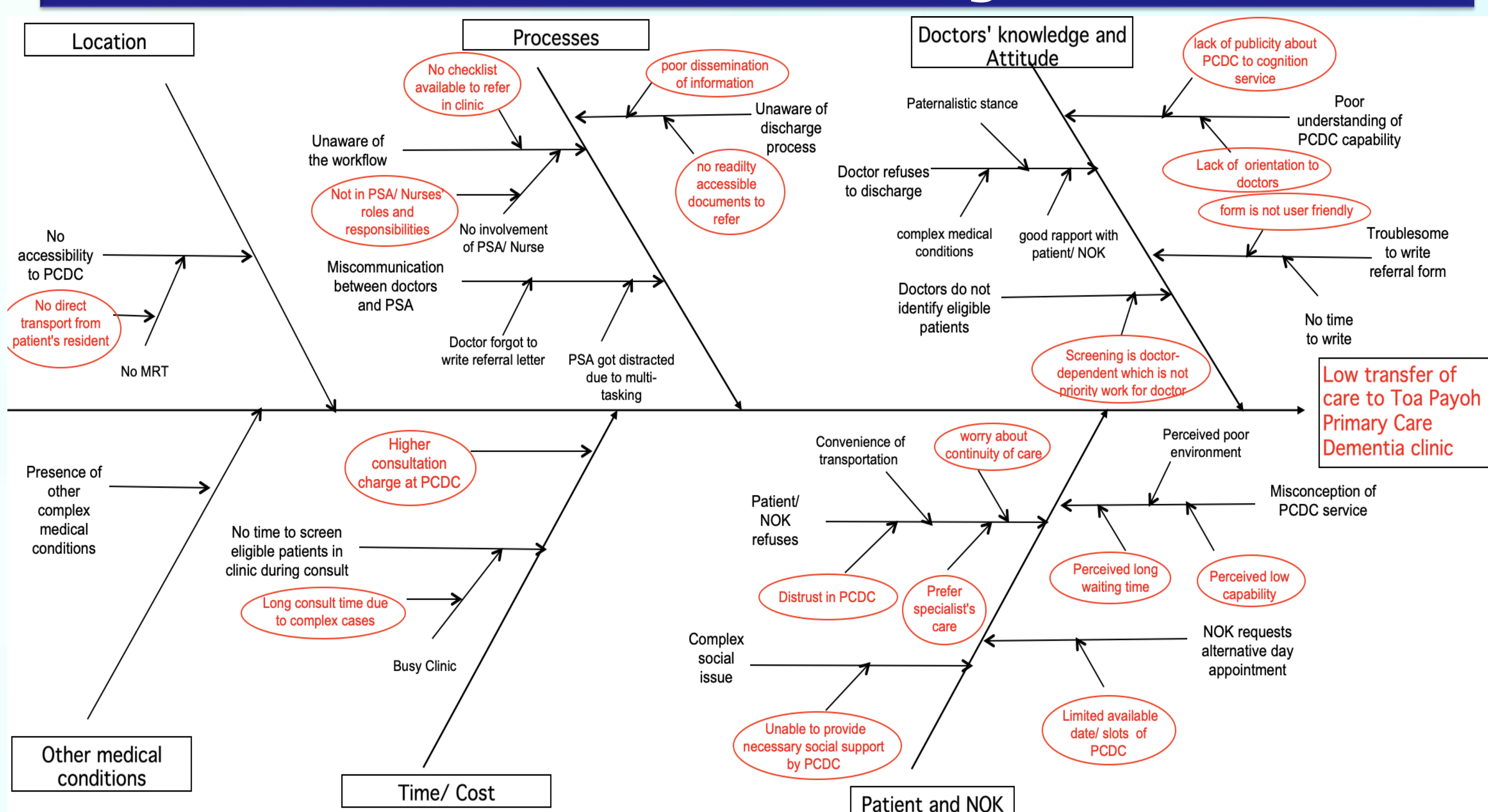


No. of Patient eligible to be discharged	13	8	10	15	20	11
Actual No. of Patient discharged	1	1	2	7	6	3

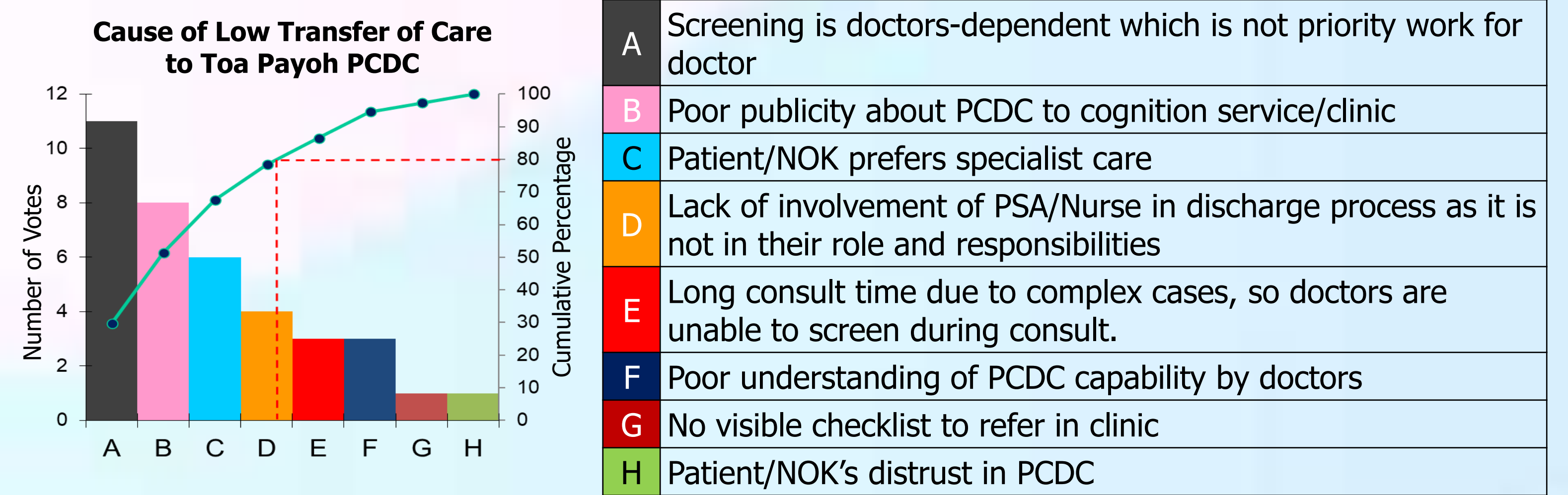
Flow Chart of Process



Cause and Effect Diagram



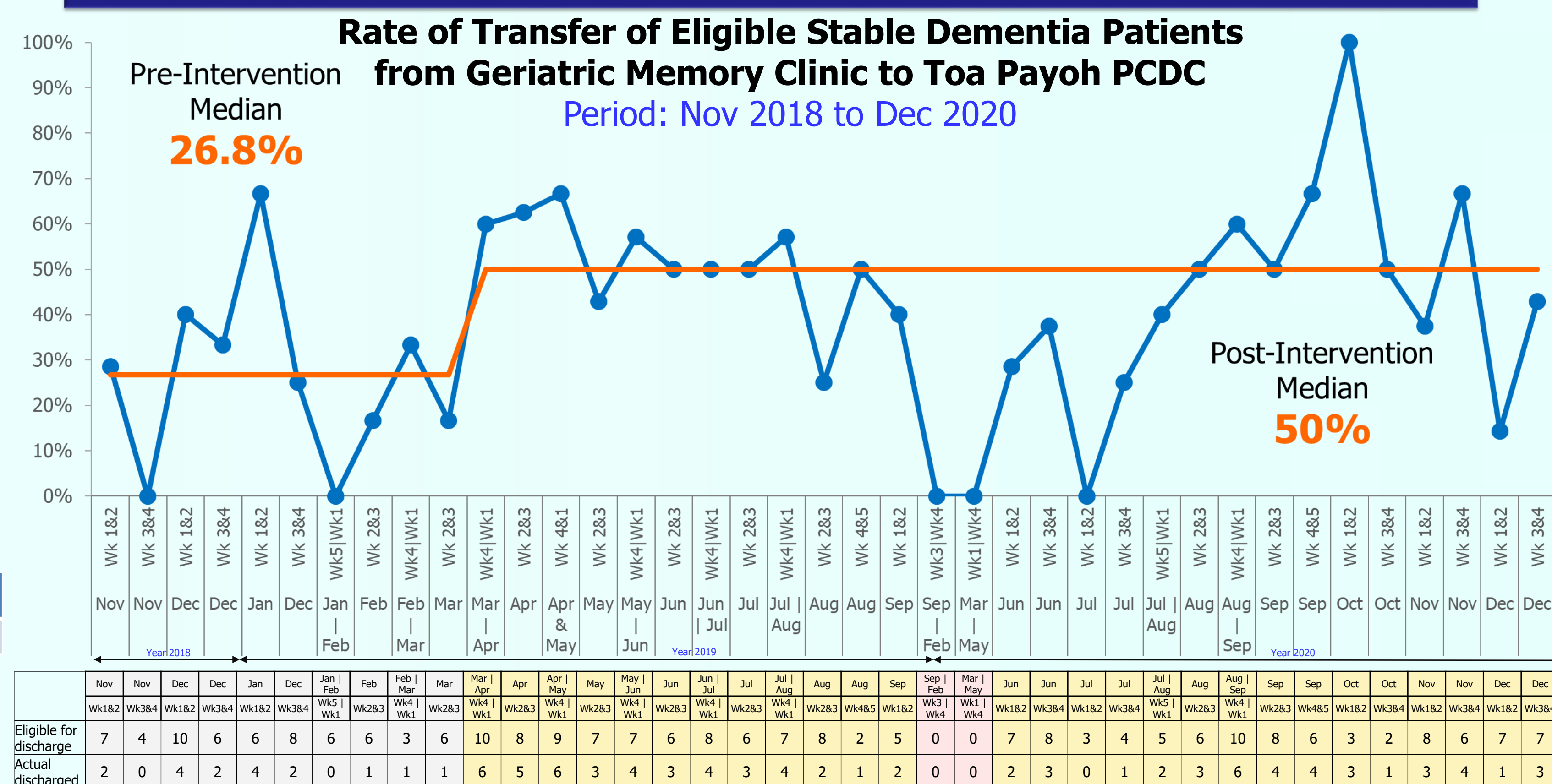
Pareto Chart



Implementation

Root Cause	Intervention	Implementation Date
Poor publicity about PCDC to cognition service/clinic	<ul style="list-style-type: none"> Reminder email was sent out to all doctors regarding PCDC clinic Flashcards with eligible criteria were pasted at clinic room computer as visual reminder 	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



Cost Savings

	Pre-Intervention	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)		48
Number of clinic visits saved per annual (each patient requires 2 visits in 1 year)		48 x 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)		\$20 x 96 = \$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)		\$576 + \$384 + \$1920 + \$4,333.44 = \$7,213.44

Problems Encountered

- 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.
- Achieving confidence of family and caregiver of patients on capability of the family physicians in taking care of persons with dementia.
- 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 process
- Continue involvement of transdisciplinary staffs (clinic PSA) in screening process
- 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