

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

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# **Department of Geriatric Medicine**

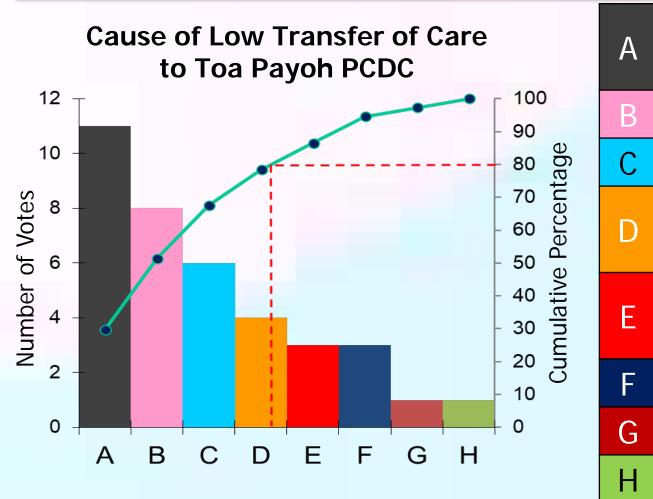


Adding years of healthy life

#### **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 the period of 6 months

|                | Tear                   | n Members         |                    |
|----------------|------------------------|-------------------|--------------------|
|                | Name                   | Designation       | Department         |
| Team<br>Leader | Dr Khin Khin Win       | Consultant        | Geriatric Medicine |
| Team           | Dr Noorhazlina Bte Ali | Senior Consultant | Geriatric Medicine |



#### **Pareto Chart**

Screening is doctors-dependent which is not priority work for doctor

B Poor publicity about PCDC to cognition service/clinic

C Patient/NOK prefers specialist care

Lack of involvement of PSA/Nurse in discharge process as it is not in their role and responsibilities

E Long consult time due to complex cases, so doctors are unable to screen during consult.

F Poor understanding of PCDC capability by doctors

G No visible checklist to refer in clinic

Patient/NOK's distrust in PCDC

| Members     | 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 &<br>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

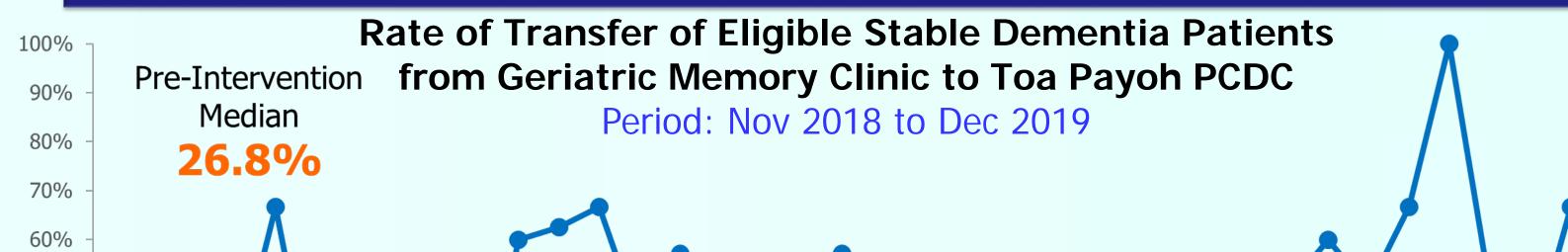
46.7%

c) Enable memory clinic to see complex cases

50% ¬

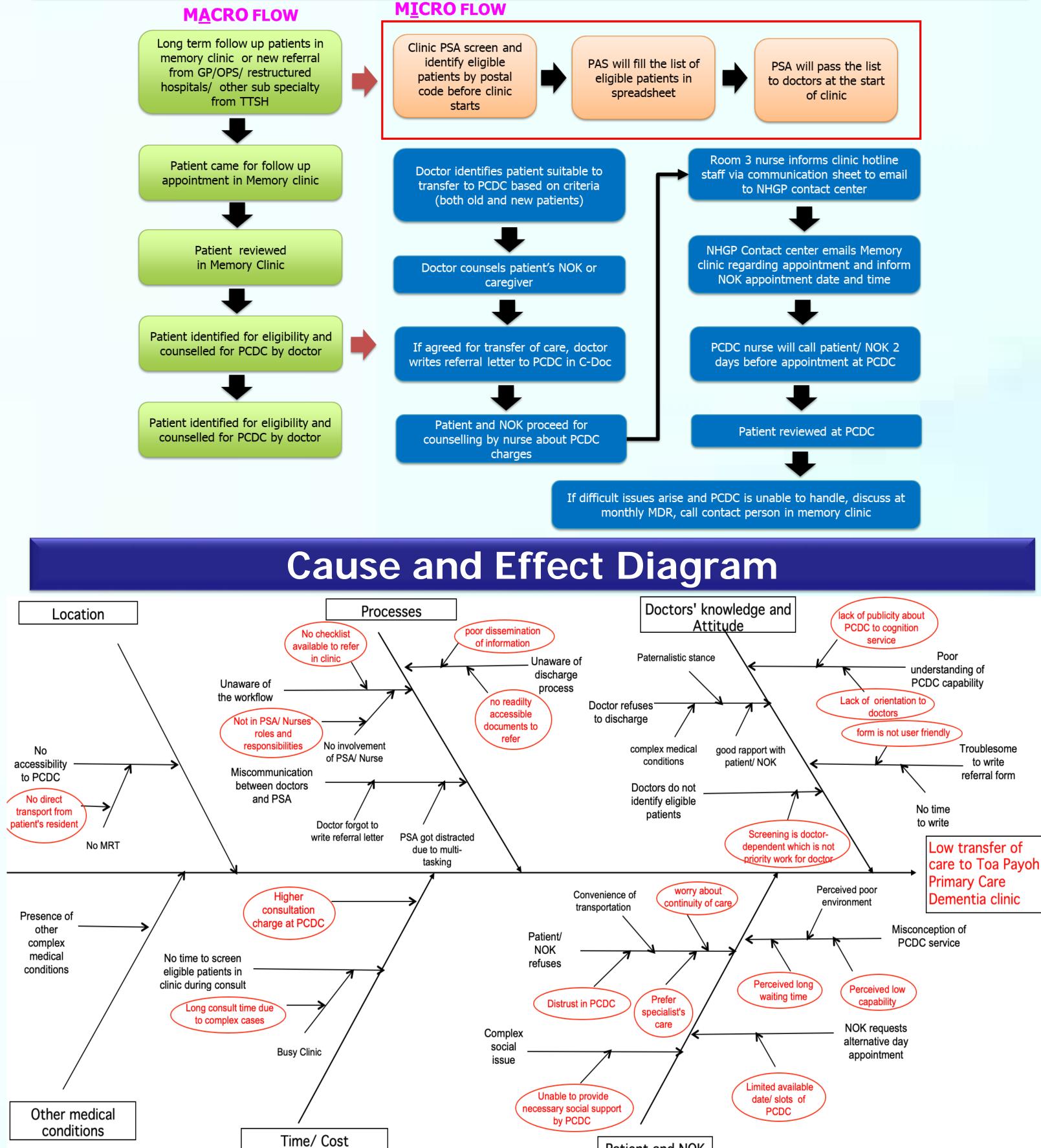
## **Current Performance of a Process**

| Implementation  |  |                        |  |  |  |  |  |  |
|---|--|------------------------|--|--|--|--|--|--|
| Root Cause  | Intervention   | Implementation<br>Date |  |  |  |  |  |  |
| Poor publicity about<br>PCDC to cognition<br>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-<br>dependent which is not<br>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<br>PSA/Nurse in discharge<br>process as it is not in<br>their role and<br>responsibilities | Memory clinic PSA were briefed regarding<br>the PCDC and instructed to do screening and<br>select the patients staying at Toa Payoh area<br>prior to start of clinic and pass the list to<br>doctors | 25 March 2019          |  |  |  |  |  |  |
| Results   |  |                        |  |  |  |  |  |  |





#### **Flow Chart of Process**



Patient and NOK

| 50%<br>40%<br>30%<br>20%<br>10% |                    |              | 1            |              |              |              |                              |              | <b>^</b>                     |              |                              |              |                              | V            |                              |              |                              |              |                              |              |              |              |                              |                              |              |              |              |              | •                            | F            | DOS.                         | Μ            | led          | rve<br>ian<br><mark>%</mark> |              | on           |              |              |              |
|---------------------------------|--------------------|--------------|--------------|--------------|--------------|--------------|------------------------------|--------------|------------------------------|--------------|------------------------------|--------------|------------------------------|--------------|------------------------------|--------------|------------------------------|--------------|------------------------------|--------------|--------------|--------------|------------------------------|------------------------------|--------------|--------------|--------------|--------------|------------------------------|--------------|------------------------------|--------------|--------------|------------------------------|--------------|--------------|--------------|--------------|--------------|
| 0%                              | Wk 18 <sub>2</sub> | Wk 3&4       | Wk 1&2       | Wk 3&4       | WK 1&2       | Wk 3&4       | Wk5 Wk1                      | Wk 2&3       | Wk4 Wk1                      | Wk 2&3       | Wk4 Wk1                      | Wk 2&3       | Wk 4&1                       | Wk 2&3       | Wk4 Wk1                      | Wk 2&3       | Wk4 Wk1                      | Wk 2&3       | Wk4 Wk1                      | Wk 2&3       | Wk 4&5       | Wk 1&2       | Wk3 Wk4                      | Wk1 Wk4                      | Wk 1&2       | Wk 3&4       | Wk 1&2       | Wk 3&4       | Wk5 Wk1                      | Wk 2&3       | Wk4 Wk1                      | Wk 2&3       | Wk 4&5       | Wk 1&2                       | Wk 3&4       | Wk 1&2       | Wk 3&4       | Wk 1&2       | Wk 3&4       |
|                                 | Nov                | Nov          | Dec          | Dec          | Jan          | Dec          | <br> Feb                     |              | <br> Mar                     | Mar          | Mar<br> <br>Apr              | Apr          | &<br>May                     | May          | <br> Jun                     | Jun          | Jul                          | Jul          | Aug                          | Aug          | Aug          |              | <br>Feb                      | <br> May                     | Jun          | Jun          | Jul          |              | Aug                          |              | <br>Sep                      | Sep          | Sep          | Oct                          | Oct          | Nov          | Nov          | Dec          | Dec          |
|                                 | Nov<br>Wk1&2       | Nov<br>Wk3&4 | Dec<br>Wk1&2 | Dec<br>Wk3&4 | Jan<br>Wk1&2 | Dec<br>Wk3&4 | Jan  <br>Feb<br>Wk5  <br>Wk1 | Feb<br>Wk2&3 | Feb  <br>Mar<br>Wk4  <br>Wk1 | Mar<br>Wk2&3 | Mar  <br>Apr<br>Wk4  <br>Wk1 | Apr<br>Wk2&3 | Apr  <br>May<br>Wk4  <br>Wk1 | May<br>Wk2&3 | May  <br>Jun<br>Wk4  <br>Wk1 | Jun<br>Wk2&3 | Jun  <br>Jul<br>Wk4  <br>Wk1 | Jul<br>Wk2&3 | Jul  <br>Aug<br>Wk4  <br>Wk1 | Aug<br>Wk2&3 | Aug<br>Wk4&5 | Sep<br>Wk1&2 | Sep  <br>Feb<br>Wk3  <br>Wk4 | Mar  <br>May<br>Wk1  <br>Wk4 | Jun<br>Wk1&2 | Jun<br>Wk3&4 | Jul<br>Wk1&2 | Jul<br>Wk3&4 | Jul  <br>Aug<br>Wk5  <br>Wk1 | Aug<br>Wk2&3 | Aug  <br>Sep<br>Wk4  <br>Wk1 | Sep<br>Wk2&3 | Sep<br>Wk4&5 | Oct<br>Wk1&2                 | Oct<br>Wk3&4 | Nov<br>Wk1&2 | Nov<br>Wk3&4 | Dec<br>Wk1&2 | Dec<br>Wk3&4 |
| Eligible for<br>discharge       | 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            |
| Actual<br>discharged            | 2                  | 0            | 4            | 2            | 4            | 2            | 0                            | 1            | 1                            | 1            | 6                            | 5            | 6                            | 3            | 4                            | 3            | 4                            | 3            | 4                            | 2            | 1            | 2            | 0                            | 0                            | 2            | 3            | 0            | 1            | 2                            | 3            | 6                            | 4            | 4            | 3                            | 1            | 3            | 4            | 1            | 3            |

Note: Temporary Holding Off Transferring Cases [Sep 2019 to Feb 2020] Restructuring of teams in PCDC and [Feb to Jun 2020] COVID-19 Outbreak

## **Cost Savings**

|  | Pre-<br>Intervention | Post-<br>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<br>(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)  | \$20 x 96            | 5 = \$1920                         |
| Cost savings in median salary of caregiver (Per Patient)<br>Assume no. of hours required to take day off = 4 hr (less 48 visits) |                      | hrs x 48 visits =<br>33.44         |
| Total Cost Savings (Annualized)  |                      | 920 + \$4,333.44 =<br><b>L3.44</b> |

#### **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**

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