# National **Quality Improvement Conference**

Improving Diabetic (DM) patient care for those discharged from KTPH Emergency **Department (ED) by ensuring they are** followed up by our Primary Care Provider (PCP) or Specialist Outpatient Clinic (SOC)\*

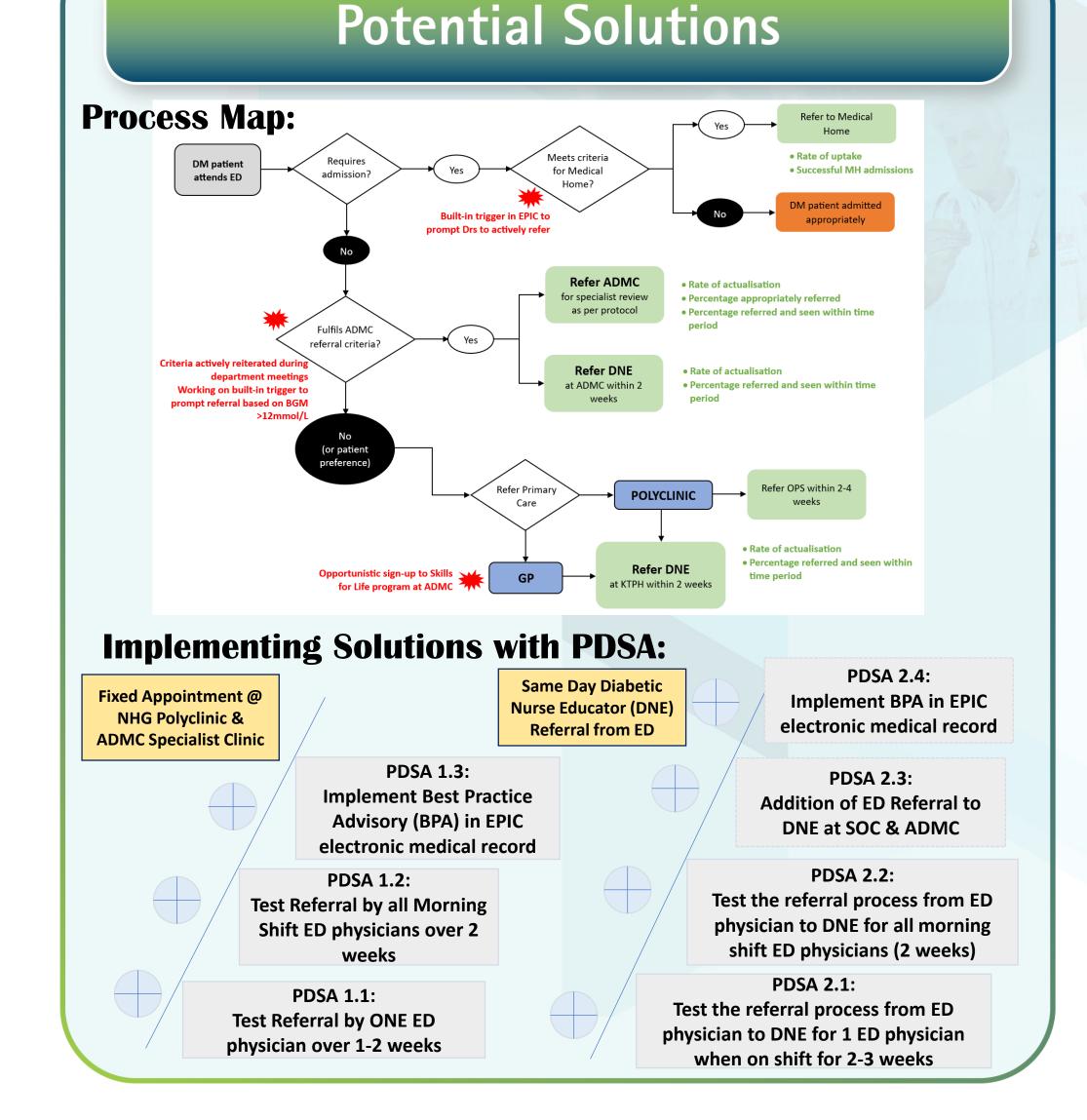
\*KTPH SOC @ two locations –SOC & Admiralty Medical Centre (AdMC)

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### **Problem Statement**

- **Regular follow-up with primary or specialist care has** been shown to improve outcomes in the management of chronic medical conditions like Diabetes.
- A telephone survey of discharged ED DM patients over • a 4-week period showed the actualisation (patient turn up) rates for primary care provider (PCP) / specialist outpatient clinic (SOC) follow-up was only



31%.

Referral	Total	Actualised	Actualisation Rate
ADMC	3	1	33%
Polyclinic	9	3	33%
GP	2	1	50%
Nil	1	-	-
Total	16	5	31%

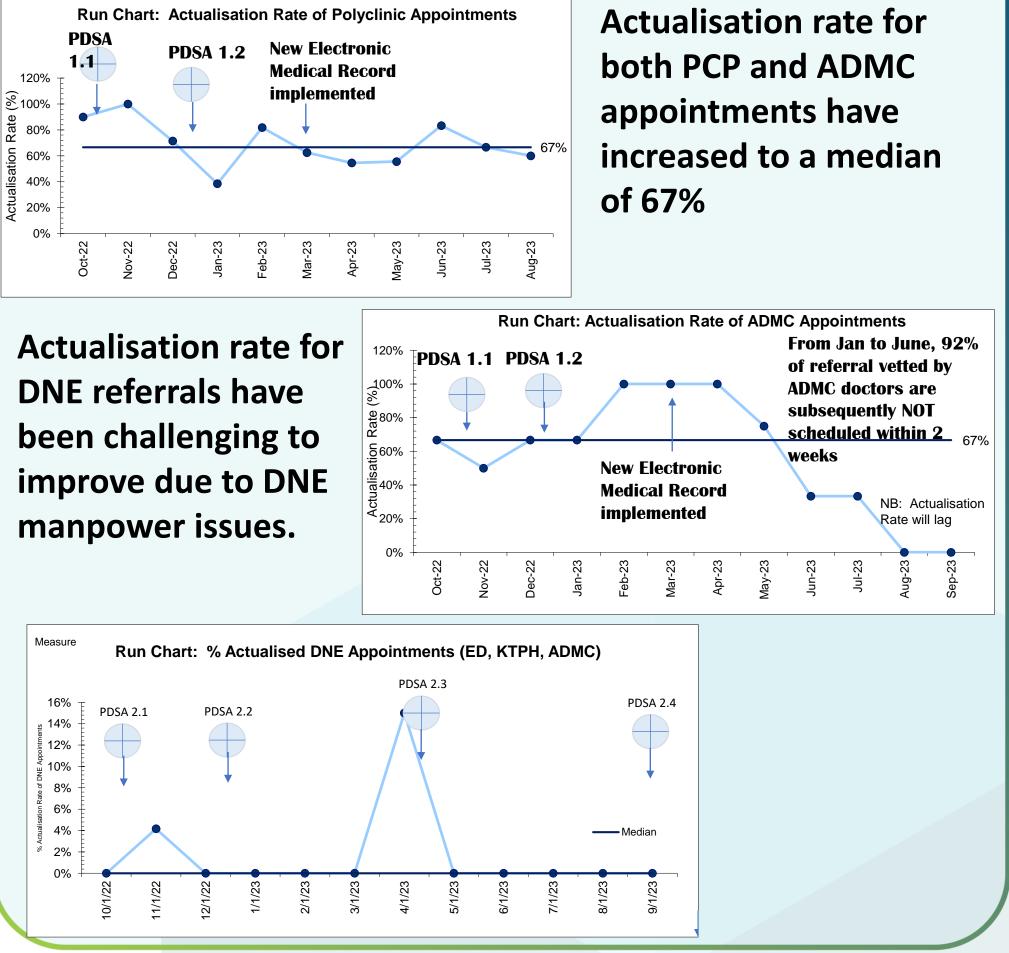
## **Project Aim**



Increase the actualisation rate of follow-up of patients with diabeticcomplaints with related their primary care provider or specialist clinic within 2 weeks from 31% to 80% by September 2023.

#### Lessons Learnt

#### **Outcomes & Impacts**



- Implementing new workflows at a system level takes the buy-in and cooperation of multiple partners at various levels
- is imperative that the environment and It infrastructure is first habitable before interventions can take flight
- Given the challenging and busy environment that is the ED, interventions have to be simple and efficient to encourage uptake and ensure success
- Incorporating decision rules into the electronic health record system has been helpful in ensuring continuity and harmonization of care for our patients
- The ED has never worked as a silo as such, lacksquareinvolvement and support of community partners is imperative in the successful discharge and follow-up of patients outside of an acute care setting