

Department of Health

health

Victorian public hospital specialist clinics

Discharge guidelines

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1. Introduction

Demand for public hospital specialist clinics (outpatient) services is growing, driven by an ageing population, the increasing burden of chronic disease and rising community expectations. In addition, changing hospital practices have led to much shorter inpatient stays for many medical and surgical conditions and a focus on managing patients on a non-admitted basis where possible. Therefore, as well as experiencing growth in overall demand, specialist clinics now need to manage higher acuity patients and more complex clinical interventions.

The *Victorian public hospital specialist clinics strategic framework*, published in February 2009, recognises that access to specialist clinics can affect patient outcomes and influence demands on other parts of the health care system. Improved access to specialist clinics is needed to ensure timely medical or surgical intervention, where appropriate, and to enable patients with less severe conditions to receive early advice on their treatment options.

To help health services meet these challenges, the Victorian Government is supporting innovation and good practice in the management of specialist clinic resources. The Department of Health has supported reform of specialist clinic processes through specific funding for improvement projects and through a number of broader programs, including the Redesigning Hospital Care Program. There are now many examples of good practice in the system.

Timely discharge of patients is critical to ensuring appropriate use of specialist clinics' services, streamlining patient flow, and increasing the capacity of specialist clinics to treat new patients. Given the high demand for specialist clinic appointments and specialists' time, it is essential that patients are brought back for review only when clinically necessary. Although some complex and rare conditions will require lifelong involvement of specialists, most patients need specialist care for a limited period and should be discharged to other service providers, such as GPs, as soon as clinically appropriate. While patients remain in the system unnecessarily, they take up appointment times that could be used to improve access for new patients.

Recent reviews, reform projects and consultation processes have identified a number of strategies to improve rates of discharge from specialist clinics. These include reducing unnecessary appointments, monitoring discharge rates, developing clear criteria for discharge, and making it easier for specialists to prepare discharge documentation.

About specialist clinics

Public hospital specialist clinics provide planned non-admitted services that require the focus of an acute hospital setting to ensure the best outcome for patients. Services tend to require:

- specialised staff skills and expertise
- specialised technology, infrastructure and/or facilities
- linkages to other specialised services.
- Specialist clinic services provide:
 - medical, nursing and allied health assessment, diagnosis and treatment
 - specialist management of chronic and complex conditions, often in collaboration with community-based healthcare providers
 - pre and post hospital care
 - maternity care
 - related diagnostic services such as pathology and imaging.

Patients are referred by general practitioners (GPs), other community-based healthcare providers, and specialists and other clinicians in the emergency department, inpatient units and other areas of the hospital. Patients may also access services through self-referral for clinical specialties such as maternity services.

Reasons for referral include:

- to obtain a definitive diagnosis of a health problem
- to obtain specialised treatment for a medical problem and/or a plan for ongoing management of the condition
- to assess the patient's need and priority for surgery
- to obtain a second opinion
- to participate in a shared care arrangement with a GP for the management of chronic conditions
- to obtain specialist allied health services that are not available in the community or which the patient cannot afford to access in the community
- to meet patients' expectations that their condition should be reviewed or managed by a specialist.

Current challenges

Currently, members of the community may not be aware that Victorian public hospital specialist clinics provide assessment and treatment that requires the focus of an acute setting and which is limited to the period that specialised expertise is required. Health services may need to actively manage the expectations of both patients and referrers.

The ability of specialist clinics to discharge patients often depends on the availability of, and linkages with, a range of community based services. GPs have a key role in providing follow-up and ongoing care to patients who have been assessed and/or treated in specialist clinics. Other services that may be important in ensuring continuity of care for patients discharged from specialist clinics include allied health professionals and community based sub-acute, social support, and aged care services.

Problems in the continuity and coordination of care between acute hospitals and other healthcare services are well documented.¹ One issue is that some service types have limited capacity, creating difficulties in discharging patients from hospital services. Another issue is that sharing of patient information between hospitals and community based services can be fragmented, slow or non-existent. Key developments addressing these problems are noted below under 'Opportunities for change'.

As well as issues concerning the broader healthcare system, there are specific challenges in the management of specialist clinic resources. While there is growing recognition that improvements in patient flow and discharge practice require consideration of the whole patient journey, the specialist patient pathway is often viewed as a set of discrete stages; namely referral, triage, assessment, treatment, review and discharge.

In a 2008 review exploring the use of patient care pathways in public hospital specialist clinics, conducted on behalf of the (then) Department of Human Services, the following findings relating to discharge were reported:

- There is little 'visibility' of the patient's journey once the patient is referred to the specialist clinic, and little integration between specialist and primary care. For example, pathways for discharge referrals and other referrals from specialist clinics may be undefined and clinicians may not be aware of resources in the community that could assist with the provision of care.
- Some specialist clinics staff lack confidence in the GP/primary care sector capacity to manage the transfer of care, do not know if the patient has a GP, or believe the patient will not get access to the GP/referring doctor in a timely manner.
- Some patients perceive that their conditions can be managed indefinitely by outpatient departments, and may use specialist clinics as a source of primary care because they believe hospital services provide the best quality care.
- There is limited information available to support decision making about how often patients should be reviewed.
- Junior medical staff may lack support and authority to make decisions about discharge.
- Time pressures impact on capacity of medical staff to prepare discharge letters, including a discharge management plan.

¹ See, for example, National Health and Hospitals Reform Commission. *Beyond the blame game: accountability and performance benchmarks for the next Australian Healthcare Agreements*. Canberra: Commonwealth of Australia, 2008.

A specialist clinics profiling exercise conducted by Department of Health staff in 2009 looked at whether health services had formal guidelines to support discharge from specialist clinics. Of the seventeen health services that participated in the profiling exercise, only four had documented discharge guidelines (a further seven were planning or working towards the development of discharge guidelines). Three of these four services reported poor compliance with and difficulty enforcing their discharge guidelines.

Opportunities for change

The renewed impetus and increased investment in reform of Australia's health sector will bring many opportunities to improve health services' ability to discharge patients from specialist clinics.

As part of the Council of Australian Government's National Health and Hospitals Network (NHHN) Agreement, the Commonwealth Government has reaffirmed its commitment to strengthening primary health services, and improving their integration with other healthcare providers. The Commonwealth's development of primary care services will focus strongly on evidence-based management of chronic disease, supporting patients to manage their conditions, and supporting GPs as members of the healthcare team.²

Service options and continuity of care for patients discharged from hospital have already been strengthened by Victorian Government initiatives to better manage vulnerable people with chronic diseases in community settings and by recent investments in sub-acute ambulatory care services. Additional funding as part of the National Partnership Agreement on Hospital and Health Workforce Reform (the agreement) will deliver further increases in the volume and quality of these services. The Victorian Government also provides specific funding for acute/primary care liaison, notably through the hospital-based General Practice Liaison Program. Further, the involvement of many hospitals in Victoria's Primary Care Partnerships (PCPs),³ and the use of PCP service coordination tools by some health services, has improved communication with primary health and other community-based services.

Implementation of the agreed NHHN reforms will require clearer delineation of the role of hospital and community-based services. For example, the agreement commits the Commonwealth Government to funding, over time, up to 100 per cent of the national efficient price of 'primary health care equivalent outpatient services' provided to public patients.

The reforms will be supported by large-scale ICT (Information, Communication and Technology) initiatives to enable electronic transfer of patient information and other mechanisms for strengthening coordination between hospital and community based services.

The commitment to collection of patient level data about non-admitted hospital patients will enable centralised monitoring, at both a state and national level, of access to specialist clinics: this will require services to focus on reducing waiting times and improving the flow of patients through specialist clinics.

² Australian Government Department of Health and Ageing, 2008, *Towards a national primary healthcare strategy: a discussion paper from the Australian Government*. Canberra: Commonwealth Government of Australia.

³ As part of the Primary Care Partnerships Strategy, a range of Victorian Government-funded services, including primary care and community support services, HARP, palliative care, and post-acute care services, are mandated to use a common set of service coordination tool templates to share referral and other key information about clients. For further information go to <www.health.vic.gov.au/pcps/>.

About the guidelines

The guidelines are targeted to Victorian public health services, particularly the managers and clinical staff of specialist clinics. They will also be made available to general practitioners, through General Practice Victoria.

The Department of Health's Specialist Clinics Reform Program has developed the guidelines in collaboration with an expert working group. Members of the working group are listed on page 3.

The specific purpose of the guidelines is to:

- provide a consistent understanding of key issues and challenges that impact on specialist clinics' discharge practices
- identify good practices and innovations already occurring in the Victorian hospital system and in other jurisdictions
- reinforce existing departmental policies relating to the appropriate use of hospital services and timely linkages to community based services
- clearly outline the department's expectations of health services in the development and implementation of specialist clinics discharge protocols and practices
- provide authority to local policies and protocols.

The document complements the *Victorian public hospitals specialist clinics access guidelines*, which the department released in September 2009. As with the access guidelines, a self assessment tool based on a quality improvement framework will be developed to assess the implementation of the discharge guidelines and inform service planning.

The guidelines are a 'living document' and will be updated to reflect any broad changes in the department's policy or funding framework.

2. Discharge principles

The specialist clinics discharge guidelines working group has defined a series of ‘best practice’ principles that should underpin the development of discharge policies, protocols and practices. These are outlined below.

Communication and collaboration

1. Patients are involved as partners in their own care.
2. The role of the specialist clinic as a provider of acute, time limited care is communicated to patients, referrers and specialist clinic staff.
3. The role of the GP as the primary carer and central to the outpatient episode is communicated to the patient.
4. The GP and the specialist clinic work in partnership to share the care of patients with complex and chronic conditions.
5. Health services keep the patient's GP informed of the patient's care in specialist clinics.
6. Specialist clinics facilitate connections with primary care and other community-based services so that patients receive appropriate post-discharge care.
7. There are effective processes in place to support the transition of care between specialist clinics and community based care.
8. Patients who do not have a GP are encouraged to obtain one.
9. There are effective processes in place to support the efficient transfer of information between specialist clinic staff, both intra-clinic and inter-clinic.

Care pathways and processes

10. Discharge policies, protocols and practices are sensitive to the needs of different patient cohorts and individual patients. It is recognised that some patients will require long term specialist clinic care.
11. Discharge planning commences as part of the initial assessment.
12. Standardised discharge protocols and criteria are developed to promote consistency of practice between specialists and to reinforce the appropriate use of specialist clinic resources.
13. There are clearly defined pathways for specialist clinic patients, highlighting critical points for timely and clinically appropriate discharge from specialist clinics.
14. There are mechanisms for streamlined re-entry to the clinic for the same problem once a patient has been discharged.

Staff roles and responsibilities

15. Senior clinical staff take responsibility for discharge practices.
16. Staff are supported to discharge patients appropriately.

Service monitoring

17. Specialist clinics collect and monitor information on discharge rates and related aspects of service demand and capacity.

3. Discharge standards

The following section outlines the department's expectations in relation to discharge from specialist clinic services. It presents guidelines for:

- communicating with patients
- strengthening linkages with primary and community care
- streamlining the patient journey
- discharge planning and documentation
- using data to monitor and improve discharge practice
- using the workforce effectively to support discharge.

Notes and examples relevant to these six areas are also provided.

Communicating with patients and carers

Guidelines

Patients and, where applicable, their carers are encouraged to participate in decision making about the patient's treatment and care.

Patients and carers are provided with accessible, easy to understand information about the patient's condition and how health outcomes can be optimised.

Patients and carers are provided with written and verbal information on the role of the specialist clinic at their first appointment. This highlights:

- the acute, specialist and time limited nature of the specialist clinic intervention
- the role of the patient's GP as the primary carer
- the likely outcome of the patient's specialist clinic journey.

Discharge information is provided to the patient in easy to understand terms.

Processes for collecting and sharing patient information are open and transparent.

Notes

There is a growing burden associated with chronic disease and all health professionals have a role in helping patients better understand and take more responsibility for managing their own health.

There is now considerable evidence that involving patients in their own care not only enhances patient and clinician satisfaction, but can be effective clinically and economically.⁴ Patients' understanding of and commitment to care plans can have a significant bearing on their outcomes: this can in turn lead to better use of resources. For example, the need for routine specialist review of some conditions may be reduced by ensuring that patients can recognise the 'trigger events' that should prompt them to seek care from a GP.

Family members and other carers are often key partners in the patient's treatment and care: where appropriate, they should receive information about the patient's condition, and support to participate in care planning and delivery.

⁴ See Department of Human Services. *Doing it with us not for us: Participation in your health service system 2006–09*. Melbourne: Victorian Department of Human Services, 2006, <www.health.vic.gov.au/consumer/>.

As well as providing general information and encouraging participation in decision making, it is good practice, where appropriate, to copy the patient into written correspondence between health professionals about his or her care. This practice is policy in the United Kingdom's National Health Service (NHS), where patients receive a copy of all communication about their care, unless they choose to opt out of receiving letters. Sharing written information with patients improves the process of discharge, and would allow patients to share in the responsibility for their ongoing care.⁵

Patient expectations of their specialist care can be managed by providing timely written and verbal information on the role of the specialist clinic and the time limited nature of specialist input. The reasons for discharge should be made clear to the patient.

Example

In 2008 the department released information for consumers titled *About public hospital outpatient services: frequently asked questions*. This information has recently been updated to include a section to make patients aware of the acute and time limited nature of specialist clinic intervention, and to reinforce the important role of the GP as the primary carer.

The updated version of 'frequently asked questions' is available on the Department of Health's website at <www.health.vic.gov.au/outpatients/resources>.

5 Burkey, Y et al, 1997, *Long term follow up in outpatient clinics: the view from the specialist clinic*, Journal of Family Practice Vol 14 No 1, Oxford University Press, UK.

Strengthening linkages with primary carers and the community

Guidelines

The health service works in partnership with local primary and community providers to ensure appropriate referral and care coordination processes are in place.

Specialist clinics staff have access to and knowledge of services available in the community that can provide ongoing patient care at the completion of an acute episode.

The specialist clinic utilises the skills and knowledge of their General Practice Liaison Officer (GPLO), or engages with their local division/s of general practice, to strengthen and streamline communication about patient care.

Once a patient has been assessed in a specialist clinic, information is provided to the referrer about the patient's plan of care.

There are effective systems and processes for communicating discharge information from specialist clinics to community based health care providers.

Specialist clinic staff provide education and ongoing support to GPs and other community providers to encourage knowledge transfer and enable patients to be cared for in the community where possible.

There are documented processes in place for shared care arrangements, where appropriate, between hospital specialists and providers in the community.

GPs and other healthcare providers are advised of how they access post-discharge specialist advice on the patient's management, including re-referral for the same condition if necessary.

Notes

GPs and other community based healthcare providers have a key role in the provision of follow-up and ongoing care to patients who have been treated in hospital. Strengthening primary and community health services, and improving their integration with the acute health sector, is a key policy objective for the healthcare system.

It is the responsibility of health service staff to maintain knowledge of the resources in the community that can provide ongoing care for the patient at discharge, and to be aware of how these resources can be accessed. The Human Services Directory (HSD)⁶ provides accurate and up-to-date information about health, social and disability services in Victoria.

Specialist clinic services can support GPs as members of the healthcare team. The Department of Health) has published a resource guide *Working with general practice*,⁷ which provides a framework for a coordinated approach to underpin collaborative work with general practice.

The role of GPLOs in health services is to build strong working relationships that promote collaboration and partnerships between general practice and services provided by the hospital. GPLOs should be engaged in the development of local specialist clinics discharge policies and protocols to ensure these are sustainable and consistent with statewide initiatives.

⁶ Available at <www.humanservicesdirectory.vic.gov.au>.

⁷ Department of Human Services, 2009, *Working with general practice*, Department of Human Services position statement and resource guide, Melbourne, Victoria.

Having access to a GP is critical to a successful discharge from the specialist clinic. Specialist clinics are encouraged to identify key nursing staff who can assist the patient to navigate the service system and access local general practitioners.

Discharge of patients to the care of a GP or other healthcare provider can be supported by processes to ensure timely re-access to the specialist clinic if the patient needs to be re-referred for the same condition. GPs should receive information about how to re-refer the discharged patients if required.

Effective communication of patient information between service providers, subject to relevant privacy and confidentiality requirements, is a prerequisite for care coordination and continuity. Both the Victorian and Commonwealth governments are investing in large-scale ICT initiatives to support electronic information transfer.⁸ The national e-health strategy includes a proposed individual electronic health record that could be accessed by healthcare providers and patients themselves. This will potentially revolutionise the way in which patient care can be coordinated across healthcare settings, including public and private services within and across all states and territories.

Examples

GP posters

Both St Vincent's Hospital and the Royal Children's Hospital display posters in their specialist clinic waiting rooms outlining the importance of having a local GP for improved health care. The poster encourages those patients who do not have a GP to find one. The posters are attached in Appendix 1.

Community Eye Care Partnership

The Royal Victorian Eye and Ear Hospital (RVEEH) Community Eye Care Partnership (CECP) has developed a model of collaborative care between the RVEEH and primary eye health care practitioners. The initiative aims to assist with the effective use of resources, strengthen links between primary, secondary and tertiary sectors and improve working relationships between providers.

The continuum of care model involves the RVEEH referring stable patients within three diagnostic groups (age-related macula degeneration, diabetic eye disease, and glaucoma), who have mild disease, to either a GP or optometrist practitioner pilot site for monitoring. New patients referred to the RVEEH with one of these specified conditions attend the outpatient clinic for an initial assessment by an ophthalmic consultant. Suitable patients who consent to participate in the pilot are referred to their closest community practitioner for further assessment and ongoing management. Results of the patient assessment and details of the care plan are sent to the RVEEH for inclusion in the patient's medical record.

The patient is discharged from the RVEEH outpatient clinic with streamlined pathways for re-referral and priority assessment if the patient's condition deteriorates or the community practitioner is concerned.

8 See <www.health.vic.gov.au/ictstrategy/>.

Integrated Diabetes Education and Assessment Service (IDEAS)

The specialist endocrinology clinic at Eastern Health has developed a cooperative model of care known as the Integrated Diabetes Education and Assessment Service (IDEAS). This service is a collaborative and integrated team approach between Eastern Health and Whitehorse Community Health Service (WCHS) to optimise the management of patients with diabetes. The consultant and registrar from the endocrinology clinic at Eastern Health run one clinic session per week from the WCHS, where patients also have access to a multidisciplinary team and health management education. The model encourages close links with GPs and facilitates discharge from the clinic through early referrals to community services and patient education in disease self-management.

Peter MacCallum Cancer Centre (PMCC) Late Effects Clinic

The PMCC Late Effects Clinic provides care for long-term survivors of cancer. The clinic provides a multidisciplinary approach to the surveillance of late side effects of cancer therapies, and the management of these complications. Guidelines have been developed to provide a framework for stratifying patients to long term follow-up, either in the Late Effects Clinic for the most complex patients, discharge back to their GP with guidelines for surveillance for the less complex patients, or a 'shared care' model with a combination of Late Effects Clinic review at less frequent intervals and GP review in the interim. The clinic is also exploring methods for education and inclusion of GPs in teleconferencing.

Streamlining the patient journey

Guidelines

Patient journeys through specialist clinics are actively managed to ensure the most efficient use of specialist services and the provision of care in the most appropriate clinical setting.

Services consider adopting a generic system for grouping patients according to the complexity of the clinical and administrative processes needed to manage their condition.

Standardised care pathways are developed for high volume conditions.

Determination of the patient's care pathway occurs early in their specialist clinic journey, either at triage or the first assessment.

All pathways are flexible and responsive to any clinical deterioration or change in the individual needs of the patient.

Notes

There is a cohort of patients who, because of the complex nature of their conditions, will never be suitable for discharge from specialist clinic care. However, failure to discharge patients when it is clinically appropriate and where there is capacity for a GP or other community provider to meet the patient's needs means that specialists are less available to treat more complex patients.

A care pathway is a concept that embeds guidelines, protocols and locally agreed evidence-based patient-centred best practice into everyday use for individual patients in the form of planned care.⁹

As well as pathways that are specific to particular clinical conditions, generic pathways have been proposed that stream all patients according to the length and nature of their likely involvement with specialist clinics (see table 1 on page 16 and figure 1 on page 17).

Adherence to standardised care pathways that are determined early in the patient journey:

- facilitates the development of a clear management plan that can be communicated to the patient and GP at the first assessment
- facilitates up front allocation of resources
- reduces the number of unnecessary review appointments
- promotes consistency of practice between specialists.

Care pathways developed in the United Kingdom incorporate alternative outpatient discharge procedures designed to reduce the number of outpatient follow-up appointments. These pathways may specify 'no follow-up', 'patient-initiated follow-up' or 'follow-up in primary care', depending on the patient's clinical needs. This approach has been developed in response to evidence that, in some cases, regular outpatient follow-up has no clinical benefit.

⁹ Welsh Assembly Government, 2005, *A guide to good practice: Elective Services, Tools and Techniques to enable NHS trusts to improve the delivery of healthcare*, NHS, Wales.

In Victoria, funding has been provided under the Specialist Clinics Improvement and Innovation Strategy and the Redesigning Hospital Care Program to help health services examine and redesign specialist clinics pathways and processes. The department is working closely with health services involved in these projects to ensure that learning is shared across all health services.

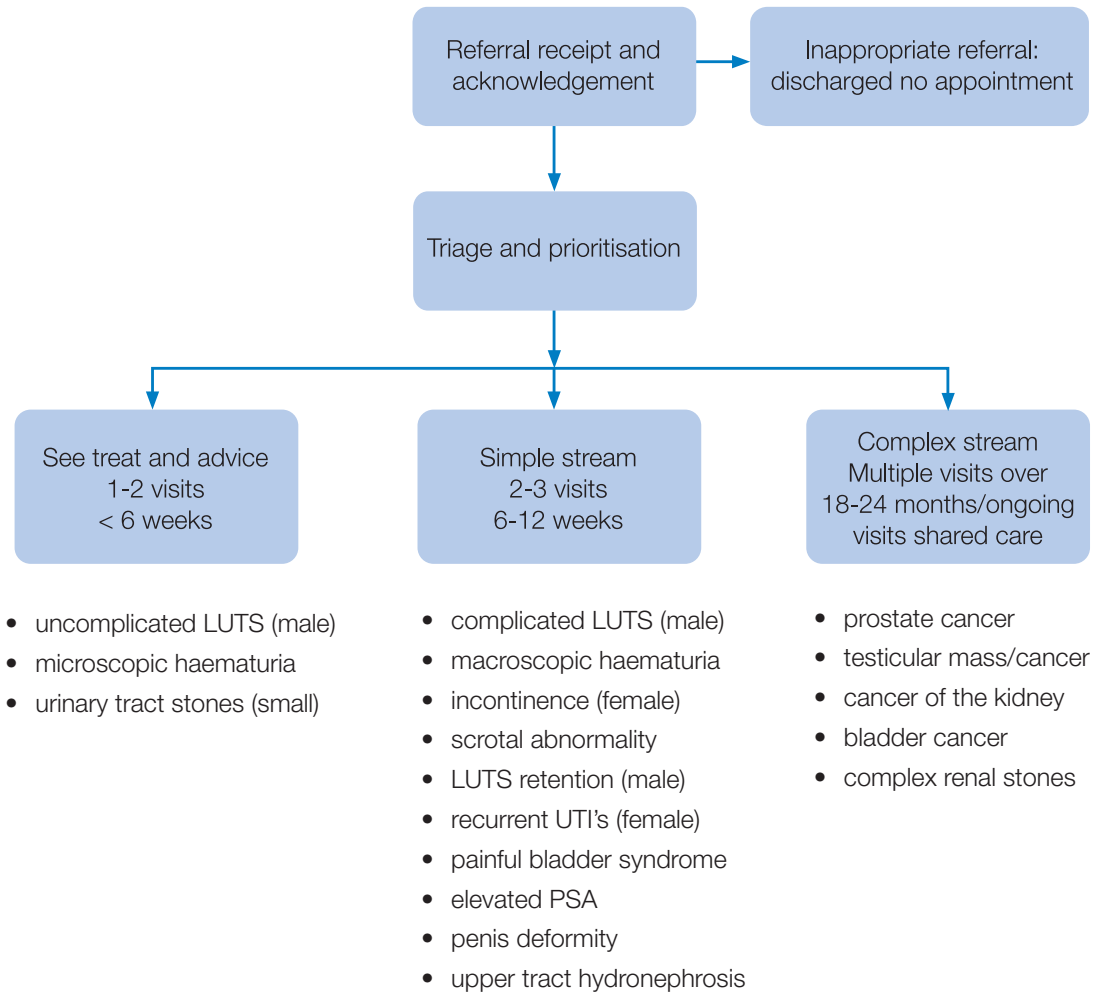
Table 1: Generic stream definitions¹⁰

Stream	Definition
'See treat and advise'	1 Visit only: relatively minor matters, patient given an opinion and/or minor treatment and discharged with advice, without review or follow-up. May be treated in nurse practitioner/allied health professional led clinics. Discharged to GP.
'Simple'	2-3 visits: patients attend to receive diagnostic testing and specialist appointment for opinion and possible treatment. May attend a follow-up appointment before being discharged to a GP.
'Complex'	Multiple visits: patients who have complex conditions, rare conditions and/or complex co-morbidities and who may require multidisciplinary care and multiple reviews. May be discharged to GP once stabilised with preferential access to return to clinic. Some patients may never be discharged, although there may be a shared care arrangement between the specialist clinic and the GP.

Figure 1 shows how the streaming definitions described in table 1 could be applied practically in a urology clinic.

¹⁰ Adapted from recommendations of Sano Consultancy, *Generic Outpatient Care Pathway Template*, Melbourne, Victoria, 2008.

Figure 1: Mapping the patient journey in a urology clinic¹¹



¹¹ Sano Consultancy, 2008, *Generic Outpatient Care Pathway Template*, Melbourne, Victoria.

Examples

Barwon Health care pathways

Barwon Health has developed a range of guidelines to define care pathways for particular patient groups. These include:

- a trauma pathway for trauma patients referred to specialist clinics from the emergency department (see Appendix 2a)
- Surgical review guidelines, in which particular surgical procedures are linked to target times for post-surgery review and discharge from the specialist clinics (see Appendix 2b)
- a process for review of arthroplasty patients; this includes a patient self-assessment questionnaire that is mailed to the patient or administered over the telephone.

Guidelines for consistent follow-up of upper GI cancer, including timelines for referral back to GP

The Western and Central Melbourne Integrated Cancer Service (WCMICS) is a collaboration between PMCC, Royal Melbourne Hospital, Royal Women's Hospital, Western Health, and Werribee Mercy Hospital. The WCMICS has adopted an evidence based, standardised program for the management and follow-up of patients with upper GI cancer.

The guidelines were developed in response to the need to minimise unnecessary specialist follow-up while ensuring early recognition and treatment of recurrences, late toxicities or second malignancies.¹² The aim of the guidelines is to indicate when it is appropriate for the GP to monitor the patient. Key benefits include consistent follow-up and improved care coordination, as well as a decreased burden on WCMICS cancer services through the standardisation of follow-up management. The guidelines provide an example of how resources can be effectively managed in the care of a complex patient cohort.

The protocol currently used by PMCC is provided in Appendix 3.

St Vincent's diabetes clinic discharge guidelines

St Vincent's Health has established clinical discharge guidelines for their diabetic clinic. The guidelines provide clearly defined and easy to follow pathways for discharge and planning of follow-up care. Junior doctors are empowered to initiate discharge using the guidelines. The guidelines are provided in Appendix 4.

¹² Western & Central Melbourne Integrated Cancer Service, 2008, *Development of guidelines for consistent Upper GI cancer follow-up, including timeframes for discharge back to GP: an upper GI Tumor Group Project*, Melbourne, Victoria.

Discharge planning and documentation

Guidelines

A routine formal discharge planning process is documented in the patient's medical record and followed.

The use of standardised discharge processes across clinics and specialties is encouraged.

Discharge planning commences as part of the first assessment in collaboration with the patient and/or carer.

Specialist clinics staff have access to timely, up to date patient information to facilitate discharge planning.

Processes are in place to ensure that making and sending discharge documentation is as straightforward as possible.

Standardised templates for discharge letters and other communications are available to promote efficiency and consistency of practice.

Discharge letters and other information is prepared and sent to GPs or other relevant healthcare providers within one week of the patient being discharged from the specialist clinic.

There are documented processes for streamlined re-access into the specialist service if the condition of a discharged patient deteriorates or if the GP is concerned.

Notes

Discharge planning is a critical link between the acute specialist intervention and the primary care and community sector, and should be viewed as an integral part of specialist clinic care.

Effective discharge planning enables seamless transfer of care and promotes better outcomes for the patient. Referrals to community providers, such as GPs and allied health professionals in community health centres, should be initiated, completed and forwarded as early as possible to ensure the patient is not disadvantaged by waiting for ongoing care and that discharge is not delayed unnecessarily.

Information on discharge planning within the specialist clinics should be included in the orientation of new clinical staff.

Generic care pathways should include discharge criteria and management plans to reduce the number of unnecessary review appointments.

One of the deterrents to discharge is cumbersome, poorly communicated and time consuming processes. For example, the efficiency of the medical transcription service within a health service impacts on the timeliness of the transfer of patient information to the GP.

Services should review their current processes and practices to assess their effectiveness, and identify potential areas for improvement. Standardisation of processes and templates will help streamline discharge activity and reduce duplication of effort. Information technology (IT) issues that impact on the ability of staff to generate timely discharge information should be assessed and addressed.

Examples

Alfred Health discharge sheet: orthopaedic clinic

To reduce the burden of paper work associated with the discharge process, and to encourage transfer of information to the GP, the orthopaedic clinic in the specialist consulting suits at The Alfred have introduced an electronic, one page format letter and tick sheet that is completed by staff at the end of the medical consultation and faxed to the GP. The letter includes the progress note to avoid duplication of work. Discharge rates have shown an upward trend, and the electronic letter format is now being developed for several other specialist units. A copy of the letter template is provided in Appendix 5.

Southern Health review of medical transcription service

Southern Health recently reviewed its medical transcription service in specialist clinics. The review identified a number of opportunities for service improvement to streamline processes, reduce the backlog of letters, and ensure communication with GPs is timely. The transcription system was audited, templates were standardised and guidelines and protocols for the transcription staff were reviewed and updated. The service was also realigned under a new unit. A business case for an updated IT software system was successful. These changes resulted in a four week reduction in turn around time for discharge letters.

Barwon Health re-referral processes

Barwon Health specialist clinics have a number of processes which allow streamlined re-referral of patients for the same condition. Prior to discharge, patients are provided a 'window' of time in which they can return to the clinic as a review patient for the same condition. The patient is discharged once this window has passed if they have not initiated a review.

South Australian 'active discharge' policy

In 2005 the South Australian Government commenced the implementation of an Active Discharge Policy in outpatient clinics.¹³ Under the policy, discharge planning commences at the first consultation, and an agreed patient pathway is developed during this initial assessment. The process identifies issues relevant to each patient's discharge back to the referring practitioner, and initiates action to address these issues so that discharge is not delayed. Patients are discharged from specialist clinics when the episode of care is completed or when another service provider can more appropriately provide the care.

¹³ Government of South Australia, 2005, *Improving the delivery of outpatient services*, Adelaide, SA.

SOS appointments

Many outpatient departments in the NHS in Wales now use self-referral for follow-up rather than fixed appointments. The so called 'SOS' appointments have been very effective in reducing unnecessary review appointments and 'did not attend' (DNA) rates.¹⁴ The SOS system is used

to advantage in the following scenarios:

- **Recurrent problems:** This is the most common use of SOS appointments in Wales, allowing patients with conditions that flare up from time to time to have rapid access to an appointment when the problem recurs.
- **Procedure follow-up:** Informing the patient about the progression of recovery through a care pathway, and allowing the patient to make an appointment quickly if there is a deviation or if they are concerned, reduces unnecessary reviews (where the patient attends to report no further problems). Patients on a normal recovery path do not take up clinic time, thus improving clinic capacity to see those patients who are experiencing problems.
- **Chronic condition monitoring:** Some patients with chronic conditions are also allocated SOS appointments where monitoring can be undertaken in part by the patient. Less frequent review can then occur. To ensure that patients understand what events require specialist reassessment, laminated cards with the events that should lead to an SOS appointment and instructions on how to make the appointment are provided to the selected patients.

The selection of appropriate patients and conditions is essential to successful and safe implementation of SOS appointments and similar processes. Clinicians must balance the benefits of such initiatives with the role that a periodic review appointment (or shared care structure) may have in reinforcing patient compliance with management and monitoring.

¹⁴ Welsh Assembly Government, 2005, *A guide to good practice: Elective Services. Tools and Techniques to enable NHS trusts to improve the delivery of health care*, NHS, Wales.

Using data to monitor and improve discharge performance

Guidelines

Health services monitor specialist clinics performance through a range of key performance indicators (KPIs). Monitoring of each speciality includes, but is not limited to, the following:

- new to review ratios¹⁵
- discharge rates
- waiting times from receipt of referral to first appointment
- number of patients on the waiting list.

In addition to monitoring these high level KPIs, specialist clinics conduct regular internal audits to assess the effectiveness and efficiency of discharge processes.

Staff receive regular, easy-to-understand information about the performance of specialist clinics.

Notes

Without sound data it is difficult to measure the effectiveness and efficiency of specialist clinic services, set clear targets for improvement, or evaluate the outcomes of improvement work. Collecting and communicating discharge performance data is a key strategy in improving the rate of appropriate discharge from specialist clinics.

Data should be collected to provide a clear understanding of specialist clinics' demand and capacity, including activity levels, rates of discharge and the backlog of work. The provision of such information to specialist clinics' staff provides an opportunity for them to see how their discharge practices impact on patients who need services.

In addition to monitoring of key data, there should be regular auditing of specialist clinics discharge practices. The audits could include, for example:

- turn around time for medical transcription of discharge letters
- number of correctly completed discharge forms
- number of re-referrals for the same condition.

The department is moving towards being able to monitor specialist clinics performance at a central level. A specialist clinics minimum data set has been developed and piloted. The pilot indicated that specialist clinics data collection was deliverable; however, there is a need to:

- further consider information technology capability and other resourcing requirements
- consider whether the proposed dataset optimally supports the requirements of the National Reform Projects.

¹⁵ The VINAH definition of a 'new' patient is:

- new to the specialist clinic
- not new to the specialist clinic, however all contacts of the previous episode completes and was discharged
- new referral for a patient to a specialist clinic, for a different condition.

Note: if the referral is renewed to continue an episode of care, the patient is not a new patient.

Once these issues are resolved and a patient level data collection is implemented, it will be some time before data could be of sufficient reliability to allow monitoring and reporting of performance at a statewide level. In the interim specialist clinics are encouraged to develop systems to collect and monitor performance data across as many areas as possible.

Example

Austin Health discharge awareness campaign and data monitoring

The Austin Hospital conducted a discharge awareness campaign (see Appendix 6), using visual reminders to medical staff about discharge of appropriate patients back to their primary carer.

As part of this work, the service developed a visual management tool to allow staff to easily see the number of referrals received compared with the number of patients discharged, and the impact this has on the length of the waiting list (Appendix 7).

Using data in this way has been a powerful tool in improving discharge rates from high volume clinics. Overall, specialist clinics discharge rates at Austin Health have increased from 6.9 per cent in 2005 to 15 per cent in 2009.

Using the workforce effectively to support discharge

Guidelines

Health services engage clinical leaders in creating cultures that encourage and support staff to discharge patients appropriately from specialist clinics.

Health services demonstrate effective and efficient use of human resources to support timely discharge and improve patient flow through specialist clinics.

Opportunities are explored to improve discharge rates and practices through workforce role redesign and enhanced practice of allied health and nursing staff.

Junior medical staff are supported to initiate discharge for less complex patients.

Processes exist for regular consultant review of longer stay or more complex patients to determine suitability for discharge.

Notes

The commitment of specialists and the presence of strong clinical leadership are critical to effective discharge practice. Health services are expected to create cultures that encourage clinicians' input to policy, procedures and the management of resources.

Studies have shown that some junior medical staff may lack the confidence to make decisions about discharging patients from specialist clinics and have a tendency to bring patients back when in doubt.¹⁶ The use of protocols that make it explicit when patients should be brought back, or offered an SOS appointment, as discussed on pages 14 and 16, may empower junior staff to make appropriate discharge decisions for less complex patients.

Where consultant review will be required in order for the patient to be discharged, scheduling of patients should take into account the need to return the patient for consultant review after a set number of follow-up appointments. This has been successfully implemented in Western Australia, with all patients returning for their third follow-up appointment reviewed by a specialist for assessment for discharge. An operational directive issued by the Western Australia Department of Health states:

'Patients attending for their third follow-up appointment (fourth appointment) shall be scheduled to see their treating specialist...Before re-appointing to further visits, due consideration should be given to the purpose, need and expected outcome of the visit. Hospitals may exercise discretion in the case of referrals for chronic conditions'.¹⁷

16 Faulkner, A et al, 1995, *Outpatients revisited: subjective views and clinical decisions in the management of general surgical outpatients in south west England*, Journal of Epidemiology and Community Health, 49:599-605, UK.

17 Department of Health, Government of Western Australia, 2008, *Specialist Outpatient Services Access Policy-Metropolitan Health Services Operational Directive*. Perth, WA.

Other possible workforce strategies for improving discharge practice include:

- Regular case conferences to review case notes and educate more junior team members about the appropriate clinical circumstances for discharge.
- Limiting the number of allied health follow-up appointments for certain conditions to ensure that planning for discharge is a consideration at the first appointment, and treatment focuses on patient education about how to self manage the condition.

Examples

Royal Melbourne Hospital (RMH) cardiology clinic medical orientation

As part of their orientation to the cardiology clinic, registrars and residents are provided with information on the types of patients who can be appropriately discharged, and are empowered to initiate discharge for these groups. This creates capacity for new referrals as patients are no longer reviewed inappropriately or at unnecessarily short intervals. The introduction of discharge guidelines as part of clinic orientation has also led to a reduction in clinic overbooking. An excerpt of the orientation material is provided in Appendix 8.

Austin Health nurse led review of post operative general surgical patients:

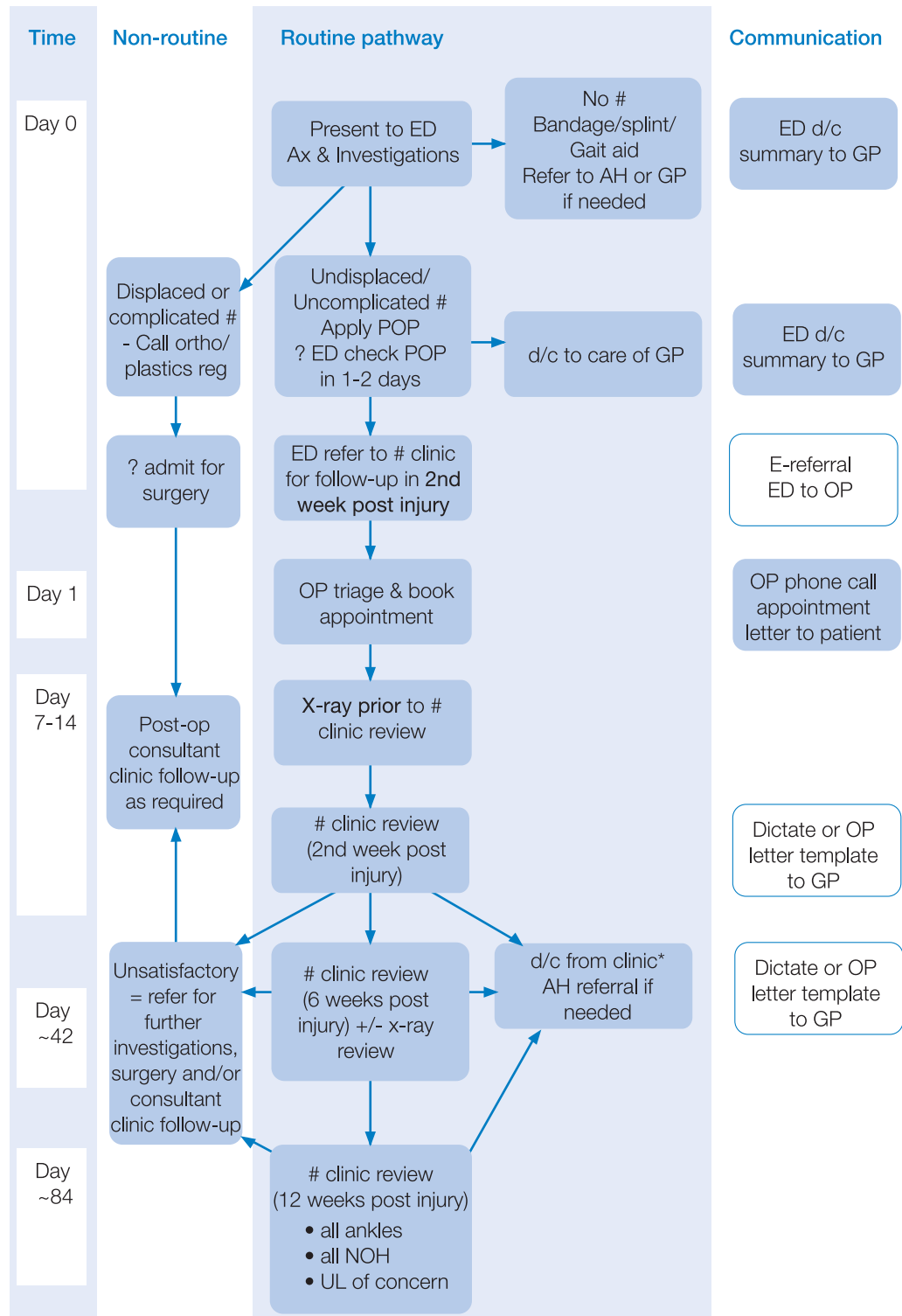
The post operative review of patients who have undergone uncomplicated procedures (such as removal of ingrown toenails, hernia repair, removal of benign breast lump, cholecystectomy and pilonidal sinus surgery) is conducted by a division one registered nurse. The nurses have authority to discharge patients to the care of the GP using a discharge template designed by the head of the unit. Patients are informed prior to their surgery that they may see a nurse for the post operative review. The model empowers surgeons to make the clinical decisions at point of surgery about which patients are suitable for nurse led clinic follow-up.

Alfred Hospital physiotherapy-led orthopaedic screening clinic

Advanced practice musculoskeletal physiotherapists assess patients who have been referred into the Orthopaedic Unit. The physiotherapist screens appropriate referrals and determines if they require review by an orthopaedic surgeon or would benefit from conservative management from a physiotherapist. The physiotherapists are able to formulate management plans and discharge patients who do not require surgical opinion. Overall capacity of the clinic is increased, and waiting times to the first appointment are reduced. The surgeon's time is spent seeing higher acuity patients who require surgical expertise, and throughput for patients requiring surgical review is increased.

Appendix 2: Barwon Health care pathways

(a) Trauma patients referred from the emergency department



* patient can be referred by GP or AH if there are clinical concerns, functional problems, excessive pain or radiological problems.

(b) General surgery outpatient review guidelines

Post operative diagnosis	Clinic	First appointment	Second appointment	Aim
Uncomplicated cholecystectomy	Discharge clinic	2-6 weeks	Nil	Discharge
Appendicectomy	Discharge clinic	2-6 weeks	Nil	Discharge
Hernia	Discharge clinic	2-6 weeks	Nil	Discharge
Haemorrhoidectomy	Discharge clinic	2-6 weeks	6 weeks	Discharge
Carpal tunnel syndrome	Discharge clinic	2-6 weeks	Nil	Discharge
Hiatus hernia / Laparoscopic fundoplication	Consultant clinic	2 weeks	6 weeks	Discharge
Scope (no Biopsy)	Nil	Nil	Nil	Surveillance scopes as per guidelines
Colonoscopy / Gastroscopy / biopsy / Polypectomy	Discharge clinic	2 weeks	Nil	Surveillance scopes as per guidelines
Colorectal cancer	Consultant clinic	4 weeks	3/12 & 6/12	Colorectal follow-up strategy
Colorectal (benign) with Hartman's or stoma	Consultant clinic	4 weeks		Discharge 6 weeks post stoma closure
Oesophageal / Gastric cancer	Consultant clinic	2-4 weeks		Follow-up Strategy
Breast cancer	Consultant clinic	2 weeks		Breast follow-up strategy T
Thyroid / Parathyroidectomy	Consultant clinic	2-4 weeks		Endo follow-up strategy

Appendix 3: Peter McCallum Cancer Centre upper GI cancer follow-up guidelines

Guidelines

These guidelines aim to streamline follow-up care. They are not a mandatory protocol.

These guidelines may be varied in accordance with patient or clinician preferences, clinical indications, geography and convenience. If the patient is on a clinical trial the trial protocol will supersede these guidelines.

Follow-up frequency

Oesophageal, Gastric, Pancreatic and Hepatic cancer	
Yrs 1-2	3 monthly
Yrs 3-4	6 monthly
Yrs 5-9	Annual
Yr 10+	Discharge to GP

Disciplines providing follow-up:

Patients will be seen by no more than two treating clinicians that alternate appointments.

In most situations a surgeon will be one of the clinicians providing follow-up. Patients often require a surgical procedure even if surgery was not part of their primary treatment, such as endoscopy or dilation for oesophageal patients. If a patient has radiotherapy as part of their treatment, a radiation oncologist should be one of the clinicians providing follow-up in order to monitor radiation toxicities.

Tests to be ordered

		Oesophageal cancer	Gastric cancer	Pancreatic cancer	Hepatic cancer
Blood tests	CEA	No	No	No	No
	CA19- 9	No	No	At each visit	No
	AFP	No	No	No	At each visit
Imaging	CT	No	No	No	6 monthly
	PET	No	No	No	No
Endoscopy	Post chemo RT & 12 months post treatment (optional)	No	No	No	No

Other points

The guidelines will be reviewed every 12 months at the Upper GI tumour group meetings, to alter the guidelines according to new evidence.

Revision Date: November 2009.

Appendix 4: St Vincent's Health diabetes clinic discharge guidelines¹⁸

Discharge guidelines

The following are guidelines only. The decision to discharge is always at the discretion of the consultant endocrinologist concerned, in consultation with the patient and the diabetes educator

Condition	Management/Discharge guide
Well controlled (HbA1c <7%), no or minimal diabetes complications	Discharge to GP. Ensure enrolled in retinal screening programme
Well controlled (HbA1c <7%), but with one or more established diabetes complications of mild severity	Annual clinic review
Moderate control (HbA1c 7-8%), or one or more established diabetes complications of mild to moderate severity	Six monthly clinic review
Poor control (HbA1c >8%), or presence of moderate to severe diabetes complications	Three monthly clinic review
Very poor control (HbA1c >10%) for >18 months despite optimal management and advice including Restoring Health*	General Medicine clinic. Aim is to provide complication screening and optimise vascular risk factors
Established vascular disease and/or multiple medical problems, diabetes at least moderately controlled (HbA1c <8%)	General Medicine clinic + Restoring Health. Aim is to provide comprehensive general medical care and complication management, prevent hospital admission

*St Vincent's HARP stream

¹⁸ Developed by Dr Warrick Inder, Head of Endocrinology, St Vincent's Hospital, Melbourne.

Appendix 5: Alfred Health orthopaedic clinic discharge sheet

Specialist Consulting Clinics

The Alfred

Commercial Road Melbourne 3004

Phone: 9076 2025 Fax: 9076 6938

E-Mail: outpatient@alfred.org.au

Dear Doctor,

Today, your patient had an Attendance at Orthopaedic Outpatient Clinic

Date: / /

☐ Consultant 1 ☐ Consultant 2 ☐ Consultant 3 ☐ Consultant 4 ☐ Consultant 5

☐ Consultant 6 ☐ Consultant 7 ☐ Consultant 8 ☐ Consultant 9 ☐ Consultant 10

☐ Other _____

For reception staff (Circle): Day: Mon Tues Thurs Friday Orthopaedic Outpatients / Fracture Clinic
With the diagnosis of:
Progress note:

And the management plan is:

☐ **Discharge** from the Orthopaedic Clinic back to your care

☐ On the **waiting list** for _____

☐ **Referral** to:

☐ Physiotherapy

☐ Other medical clinic _____

☐ Other allied health _____

☐ **Review** in : ____ weeks / months (circle one) with:

☐ Bloods ☐ MRI scan ☐ X-ray

☐ CT scan ☐ Interpreter _____

Seen by: signature: _____ print name: _____

Appendix 6: Austin Health discharge awareness campaign



REMEMBER YOU CAN DISCHARGE PATIENTS BACK TO THEIR PRIMARY CARE PROVIDER

Austin Health OUTPATIENTS DEPARTMENT

CLINIC _____
 UR # _____
 NAME _____

FOLLOW UP ACTION:

☐ **DISCHARGE** (Doctor, please place this card in Discharge box for clerk to Discharge Pt on Med7194)

☐ **Next Appointment**
 _____ weeks/months or (date) _____
 Doctor, what is the acceptable time frame if this date is already booked out?:
 _____ weeks/months before this date to
 _____ weeks/months after this date

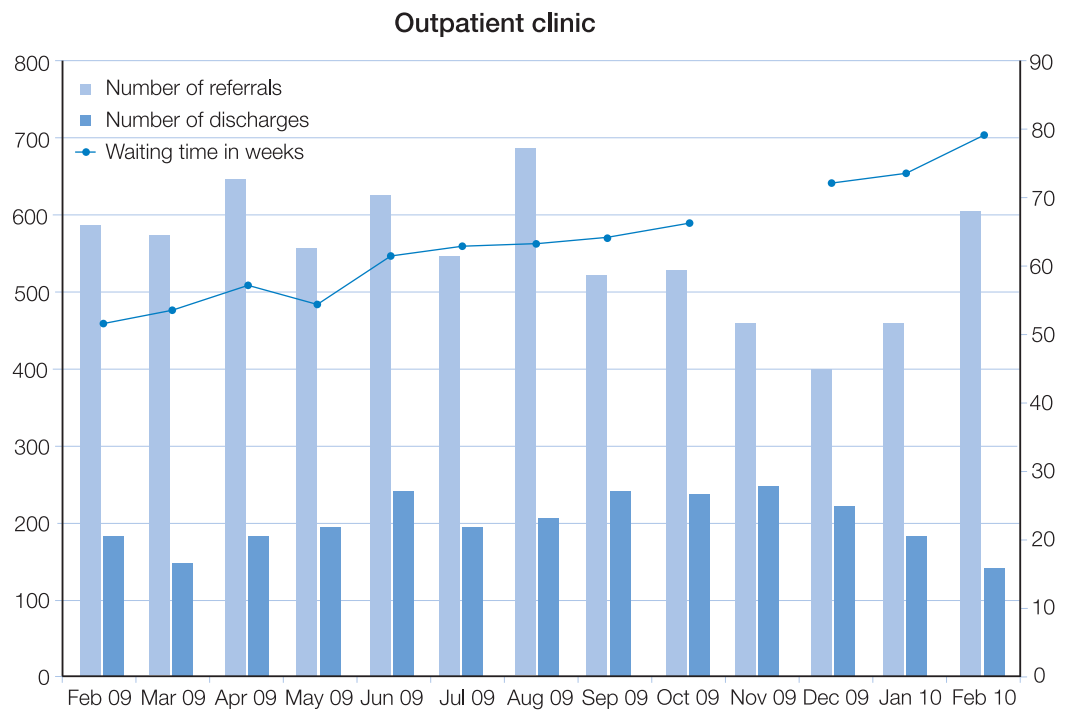
☐ **TRANSPORT** ☐ **INTERPRETER**
 You must take this slip to the clinic desk in order to book your next appointment.

Please fill out the appropriate box on the Appointment Slip

And place in the tray located on your desk.

This will help clerical staff to discharge them from the system

Appendix 7: Austin Health visual management tool



Appendix 8: Royal Melbourne Hospital cardiology clinic medical orientation

The following is an excerpt from the Royal Melbourne Hospital cardiology clinic's medical orientation manual:

'Some patients are inappropriately brought back to the Clinic after inpatient admission, for example patients from the country, other hospital, consultants' rooms etc. You can prevent this by appropriate referral from the ward.

Many patients can be discharged from the clinic. These include patients eight weeks after uncomplicated bypass surgery or PCI and patients with stable hypertension, arrhythmias or angina. Patients with prosthetic valves should have an echo within six months of surgery. Stable prosthetic valves can be then discharged to the care of their GP with a letter suggesting follow-up echo in five years time.

Patients who need to be followed in the clinic include those with unstable symptoms or unresolved diagnostic issues. Patients with chronic un-operated valve lesions need to be followed with regular (usually annual) echocardiograms to determine the optimal time for surgery. Patients with severe cardiac failure need to be followed up in Cardiac or Cardiomyopathy Clinic.'

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