Specialist clinics improvement and innovation strategy
Report on projects funded in 2009
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Introduction

The Victorian public hospital’s specialist clinics strategic framework, published in February 2009, provides policy direction for the planning, organisation and delivery of public hospital specialist clinics in Victoria. The three key objectives of the framework are to ensure timely access, maintain patient focus and provide sustainable services.

In March 2009, the department invited health services to submit proposals for funding to undertake projects to support innovation and service improvement in specialist clinic services within the objectives of the strategic framework.

In April 2009, three health services, St Vincent’s, Mercy Health and Western Health, were selected to participate in the Victorian public hospitals specialist clinics redesign project. The project aimed to improve the quality of specialist clinic service delivery by optimising the flow of patients and the patient’s experience during their journey. The project focused on the specialty areas of maternity, orthopaedics, gastroenterology and urology.

This report provides a summary of the improvement and redesign projects undertaken by Victorian health services in 2009. The purpose of the report is to share and support the work and innovations occurring in Victorian specialist clinics.
A. Improvement projects

1. Referral management and triage

Good referral management practices are important to ensure that patients receive timely access to appropriate specialist clinic services. The improvement projects summarised in this section demonstrate how the implementation of standardised referral and triage management processes can minimise repeated handling of referrals and improve wait list management.

Alfred Health: Management of specialist clinics referrals

Rationale
The aim of the project was to redesign the external referral management process to achieve:

• 100 per cent referrals progressing to triage with complete patient and referrer information
• 100 per cent referrals recorded electronically within 24 hours of receipt
• 100 per cent acknowledgement of receipt of referral within three days of receipt
• 0 lost referrals.

Prior to the project, systems for initial management of referrals were all paper based. There were multiple referral entry points and multiple handoffs (up to six staff were involved from receipt of referral to appointment scheduling). The ‘first time’ quality of referrals was variable, and there was no mechanism for acknowledging referral receipt to either the patient or referrer. These issues contributed to:

• delays of up to 14 days before referrals were registered electronically
• more than 1000 ‘work in progress’ paper referrals being managed at any given time
• inability to account for missing referrals
• an estimated 50 duplicate referrals being processed per week
• rework associated with incomplete patient and referrer information
• difficulty in measuring service demand.

Actions and outcomes
Processes for receipt of new external referrals have been redesigned in order to achieve:

• electronic registration of referral at point of receipt and referral documentation scanning into CERNER clinical system
• an administrative tollgate for patient information at receipt of referral
• communication of receipt of referral to patient and referrer.

At the completion of the project:

• 100 per cent of referrals were acknowledged within three days of receipt
• the time from receipt of referral to electronically recording the request reduced from seven days (median) to all referrals within 24 hours
• approximately 8 hours and 45 minutes clerical/nursing/medical time was saved each week on processing duplicate referrals
• ‘missing’ referrals were eliminated (electronic report showed all referrals pending action)
• complete patient and referrer information was entered into the IT system at receipt of referral.

Sustainability and next steps
Sustainability of the reforms will be achieved by:

• embedding changes in standard work practices through auditing, ongoing training and education, and processes for evaluating staff feedback
• implementation of visual management tools and automated reports to highlight when the new work standards are not met.

Opportunities for ongoing improvements to referral management identified as part of this project were:

• electronic triaging
• electronic ordering of internal follow-up appointments
• electronic ordering of diagnostics
• scheduling workflows, including day of clinic workflows.

**Austin Health: Referral and care pathways for neck and lower back pain**

**Rationale**

Patients with neck and lower back pain are referred to a number of different specialities including neurosurgery, orthopaedics, rheumatology and neurology. Both the neurosurgery and orthopaedic clinics have a physio-led clinic running concurrently.

The project aimed to streamline referral processes and the management of referrals for patients with neck and lower back pain.

**Actions and outcomes**

A new model of care was implemented in which most patients referred to orthopaedics and neurosurgery clinics were seen by a physiotherapist, with only a few patients seeing the surgeon initially.

The new referral pathway includes a referral template designed to obtain more detailed information regarding a patient’s condition. This more detailed referral information is used to ensure referrals are triaged appropriately and streamed to the most appropriate specialist, thus reducing the waiting time for new appointments. Lower back and neck pain referrals are not accepted until a questionnaire is completed.

This model:

• streamlines the referral process
• provides referrers with a management and referral pathway for these conditions
• ensures appropriate evidence-based investigations have been undertaken prior to referral
• ensures that best use is made of community based services, where available.

**Sustainability and next steps**

Resources have been made available through reallocation of duties to ensure that obtaining and reviewing the questionnaire is part of the referral management process for lower back and neck pain.

However, the completion of the ‘lower back and neck questionnaire’ remains resource intensive as general practitioners (GPs) do not send it in with the initial referral. The questionnaire has recently been made available in a word document in response to feedback from GPs who currently complete the referral electronically.

**Goulburn Valley Health: Management of patients waiting for specialist paediatric consultations**

**Rationale**

The main aim of the project was to improve the management of patients waiting for specialist paediatric consultations at Goulburn Valley Health. Waiting lists were audited, families were communicated with prior to their appointment to lay the groundwork for the specialist medical assessment, and patient focused booking was introduced. A second aim was to improve the appropriateness and quality of referrals to specialist paediatric clinics.

Specific objectives of the project were to:
• identify any children or families with special needs, deterioration of symptoms, or no longer requiring appointments
• provide culturally sensitive information to families to reinforce the need for follow up of children’s health conditions
• review current clinic schedules and booking times so that paediatricians can reach productive outcomes in one appointment rather than repeated short consultations
• formalise a policy on leave notification by the clinicians attending specialist paediatric clinics
• develop and implement ‘paediatric referral criteria’ for local GPs wishing to refer children to Goulburn Valley Health.

**Actions and outcomes**

The Paediatric intake referral nurse (PIRN) contacted families of children on the waiting list either face to face or over the telephone (with the support of on-site or telephone interpreters if necessary) or via their GPs.

This process revealed a proportion of families no longer requiring an appointment because the child was now well or had been seen privately, as well as a group of patients that had moved from the area and could not be contacted.

The process enabled the PIRN to:

• provide reassurance to families that they had not been forgotten
• obtain preliminary information to support the medical assessment
• re-evaluate the child’s condition and escalate the urgency of the appointment if required
• where necessary, advise families to return to their GPs for further follow up prior to the specialist appointment
• provide other information/advice as per the PIRN’s scope of practice.

Other initiatives undertaken as part of the project were:

• screening of patient referrals from community GPs
• collaboration between hospital specialists and relevant community stakeholders to identify the specific needs of local refugee groups
• audits of specialist schedules and appointment times.

As part of the efforts to improve referrals, the PIRN, in consultation with a paediatrician, now returns any inadequate referrals with a letter requesting -as appropriate -more relevant details, pathology, medication, and/or management undertaken in the community prior to the appointment.

Information on Goulburn Valley Health’s paediatric services was sent to the local Division of General Practice for inclusion in its monthly magazine. Issues raised in the article included the appropriateness of requests for assessment of children’s behaviour and development, and the need for referrers to document relevant medical, psychosocial, and cultural issues in the referral letter.

The assessment of the needs of refugee communities has enabled more appropriate patient communication to address the high DNA rates in this patient group. One initiative implemented to meet the cultural and linguistic needs of refugee communities was to mail out hospital letters and envelopes with pictorial information.

The audits of schedules and appointment times have resulted in each of 16 different paediatric outpatient clinics running a purpose built schedule.

**Sustainability and next steps**

The position of PIRN has been included in Goulburn Valley Health’s budget as a permanent part-time role and will therefore continue beyond the project. This will ensure that day to day management of patient focused bookings and referrals will continue.

The development of criteria for paediatric referrals has commenced but is not yet complete due to the demands of other prioritised initiatives. Work is ongoing in this area.
Northern Health: Best access first go; improving referrals to medical clinics

Rationale
Prior to the ‘Best access first go’ project, GP referrals to Northern Health’s specialist medical clinics were often incomplete and/or inappropriate. This resulted in:

- additional workload for intake staff in contacting GPs for missing information
- incomplete and/or duplicate triage of referrals
- delay in patient assessment and treatment while waiting for diagnostic testing to be undertaken
- delays in patient access due to long waiting lists and inappropriate triaging.

The project objectives were to:

- provide accessible, user friendly clinical referral management guidelines to assist GPs in making complete and appropriate referrals, and thereby:
  - reduce the need for secondary triage by Northern Health staff
  - ensure that patients are allocated to the right clinical specialty at the right time
  - improve the management of waiting lists for Northern Health’s specialist clinics.
- provide an accessible, functional and contemporary web portal to facilitate GP access to information about Northern Health’s specialist clinics.

Actions and outcomes
Consultations were held to determine GP perspectives and requirements regarding referrals, and their needs for information about specialist clinics.

Subsequently, the Victorian Statewide Referral Form (VSRF) was established as the preferred template for referrals and detailed clinical referral guidelines were developed for the following specialist medical clinics:

- gastroenterology
- ophthalmology
- orthopaedics
- renal
- urology.

The development of referral guidelines for a further three specialties (neurology, rheumatology and obstetrics) is in progress.

A methodology has been established to facilitate the successful development of guidelines, and this has helped to engage consultants from different specialties in the guideline development process.

Input from the GP consultations is also being used in the redevelopment of the webpage for Northern Health’s General Practice Liaison (GPL) Unit. The redevelopment, which will be launched in November, aims to improve the webpage content and make it easier for GPs to find referral information.

Sustainability and next steps
Referral guidelines for the remaining three clinics will be completed and published on the GPL website. By having a ‘critical mass’ of guidelines on the website, and a central point for document control and ongoing communication of referral-related information, it is expected the website will become the primary source of information for GPs wishing to refer patients to Northern Health specialist clinics.

A publicity campaign will be conducted to ensure that GPs in the Northern Health catchment are aware of Northern Health’s new web portal and the referral resources.

A GP education session will be held on the 26th October along with an evaluation of the project.

Subject to the availability of funding, a second stage of the project is planned focusing on an additional eight high demand clinics in collaboration with North East Melbourne Integrated Cancer Services (NEMICs). This will use processes and methodologies developed in the first stage of the project. The second stage to be continued by GP liaison will also include:
• a GP ‘Communication and Assertive Referral Management’ initiative which will form a part of the triage reform project (to be driven by outpatients & specialist clinics)
• expand web page content to include referral information for continuing care ambulatory and community services
• complete web page development
• a formal launch of the new referral guidelines.

Peter MacCallum Cancer Centre: Referral management and triage improvement

Rationale
The Peter MacCallum Cancer Centre identified a number of issues relating to the patient registration process. These issues included an inability to monitor the movement of referrals through the triage and appointment booking processes, lack of standards around these processes, and an inability to collect performance data.

The aim of the project was to improve the process of referral management and triage.

Actions and outcomes
The following initiatives were successfully introduced:
• centralised documentation of referrals
• standard clerical triage guidelines
• standard process for managing and responding to new referrals
• standard system for tracking referrals throughout the triage, appointment booking and registration processes
• redefining roles and responsibilities within the outpatient department.

These initiatives resulted in:
• 80 per cent of all new patient referrals being processed within two weeks of their receipt
• prompt identification of overseas patients to support timely management by the overseas patient coordinator
• improved data collection and reporting against monthly performance indicators.

Sustainability and next steps
To embed the successful outcomes of the project into day to day work practices, the hospital is exploring IT solutions to support electronic management of all referrals to specialist clinics.

The current capacity of clerical resources to manage the new referral management and triage processes will also be evaluated.

Royal Children’s Hospital: Access to specialist clinics

Rationale
The aim of the project was to identify causes of service inefficiency that impact on patient access to specialist outpatient clinics.

The Royal Children’s Hospital (RCH) identified a number of barriers to patients accessing specialist outpatient clinics in a timely and equitable way. These included underutilisation of available appointments, extensive waiting lists, incomplete referrals, inconsistent approaches to triage, and lack of standardised discharge protocols.

Actions and outcomes
To address these barriers, the following initiatives were successfully introduced:
• a standard access process to manage and triage new referrals
• a standard process to better manage patients who fail to attend appointments
• comprehensive discharge guidelines
• a GP education program.

Sustainability and next steps
Once endorsed by senior management, the standardised access procedure will be embedded into the organisation-wide access policy.

To further support access to its specialist clinics, the Royal Children’s Hospital is planning to work with its GP Liaison Unit to update pre-referral guidelines. This work will focus on plastics, general paediatrics and general surgery clinics.

Patient focused bookings will also be trialled to improve patient access and minimise failure to attend rates.

Royal Women’s Hospital: Establishment of a clinic access centre

Rationale
The Royal Women’s Hospital (RWH) identified significant flaws in the process of triaging women to appropriate clinics. These included:

• triaging to the wrong clinic or subspecialist clinic • opportunities for errors, duplications and delays in making appointments
• long waiting times for appointments
• lack of communication with patients and their GPs.

Actions and outcomes
The Clinic Access Centre was established to provide a central point of intake for all referrals and entry of these referrals into the hospital’s iPM patient records management system.

Two dedicated clerical staff were initially assigned to the Clinic Access Centre in September 2009; this was increased to three staff in March 2010. Functions of the centre include:

• electronic registering of patient referrals or information updates in the iPM
• triage of referrals by clinicians within agreed timelines
• appointment booking or follow up of referrals for further information as directed by the clinician.
• managing the ‘Referred for Clinical Management list’ (referrals accepted but awaiting an appointment)
• phone enquiries.

After its establishment in September 2009, the Clinic Access Centre was receiving, on average:

• 400 referrals per week by fax and mail
• 700 telephone enquiries per week, including calls to follow-up referrals, appointment scheduling, and general enquiries.

As of September 1st the Royal Women’s Hospital no longer accepted self referrals for maternity bookings, and all referrals needed to come from a GP. Therefore there was an increase in the volume of enquiries during this change over period.

The implementation of electronic logging of referrals into the iPM has meant that:

• there is now a system for tracking referrals, and referrals can be accessed quickly if required
• multiple referrals are no longer received for the same patient
• patients and referrers are advised that the referral has been received (KPI 48 hrs), and are later sent another letter with appointment details
• iPM reports can be generated to identify volumes of referrals and patient details (Referred for Clinical Management reports).

The project also included:

• improved communication with referrers through:
  – enhanced information on the Royal Women’s Hospital website
– a communication strategy undertaken by the GP Liaison Officer, who initiated contact with approximately 600 of the Royal Women’s Hospital’s accredited shared care affiliates
– development of flow charts and telephone scripts for Clinic Access Centre staff to advise referrers of the changed processes
– development of referral guidelines and a referral template for GP’s.
• development of triage guidelines for all specialist clinics, which set out the patient criteria for each clinic and the clinical indications associated with different levels of urgency. The guidelines will be available via the hospital’s intranet site by November 2010
• expansion of the hospital’s existing nurse-led clinics, with further clinical sessions set up for nurse practitioners to see women in the Gynaecology Assessment Clinics.

Sustainability and next steps
Key performance indicators (KPIs) have been developed for the Clinic Access Centre, and weekly data is produced via the iPM. The measures include:
• number of referrals received by each clinic/team per week
• number of referrals accepted
• number of maternity referrals rejected due to local area boundary limits introduced in 2008 (women’s health referrals are accepted regardless of postcode)
• average days from receipt of referral to logging in iPM and sending of an acknowledgement letter
• average number of days from logging in iPM to appointment being made and letter sent with appointment date
• number of pregnancy referrals accepted, but currently awaiting a confirmed appointment date
• average number of days from receipt of referral to the date of clinic appointment
• self referral rate for women’s health services.

2. Streamlining clinic processes
Streamlining the specialist clinic patient journey necessitates standardisation of clinic processes to ensure that the capacity of services matches demand. This is important to reduce waiting times, and maximise patient outcomes and satisfaction of specialist clinic services.

The improvement projects discussed in this section provide examples of ways in which standardising appointment booking systems, patient communication processes and discharge protocols can minimise inefficiencies thereby increasing capacity for service delivery within existing resources.

Ballarat Health: Patient focused booking in medical clinics

Rationale
Medical clinics at Ballarat Health had a thirty per cent ‘did not attend’ (DNA) rate, the highest of all clinical specialties.

The medical clinics provided poor service coordination for patients, and accounted for 30–60 per cent of all patient complaints regarding long waiting times for specialist clinic appointments. GPs and other referring healthcare providers had low levels of satisfaction with the medical clinics.

The purpose of the project was to provide a patient-centred approach to appointment scheduling in order to improve waiting times, reduce DNA rates, reduce administrative burden on clinic staff, and improve patient and referrer satisfaction.

Actions and outcomes
Key actions undertaken as part of the project were:
• an audit of clinic waiting lists to remove patients no longer requiring appointments and to validate clinical and demographic information
development of a referral pathway, with all referrals containing inadequate information returned to GP for completion of further clinical details needed for appropriate triage of the referral
• implementation of phone calls to all urgent patients to negotiate appointment times
• commencement of booking appointments a maximum of four weeks in advance only, with patients contacted via an ‘invitation for appointment’ letter to negotiate an appointment time with the clinic
• improved written communication with GPs.

Sustainability and next steps
Sustainability of the project outcomes will be achieved by:
• development of system support resources, such as instruction and orientation manuals
• implementation of patient experience surveys
• staff education.
Opportunities for ongoing improvements identified as part of this project were:
• development of a lead nurse role with responsibility for referral management
• further staff education in the information technology systems.

Bendigo Health: Standardising appointment booking and discharge processes

Rationale
In order to address the lengthy waits for new patients to access specialist clinics, Bendigo Health’s project aimed to increase capacity within existing resources via new processes for managing bookings and the utilisation of standardised discharge protocols. The specific objective of the project was to decrease the number of ‘review’ patients in specialist clinics, thereby creating capacity to see an increased number of new patients.

Actions and outcomes
Key actions included:
• introduction of patient focused bookings in ENT, orthopaedic and urology clinics. This includes a 16 week booking horizon (beyond which no appointments are made), which decreases the chances of patients forgetting their appointments and failing to attend
• introduction of a new process in which demographic data is routinely checked at each appointment to ensure that subsequent patient communication goes to the right address
• development of a paper-based discharge slip to be completed by medical staff during the consultation and encourage a ‘discharge discussion’ with patients
• introduction of discharge procedures requiring patients to report back to reception to allow them to be discharged
• implementation of discharge protocols in general surgery clinics
• collection of data, such as new to review ratios and discharge rates, to support performance monitoring.

The introduction of patient focused booking has supported wait list auditing. This had greatest impact on ENT wait lists, where at least 50 per cent of the patients contacted for appointments failed to respond or cancelled their referral and were subsequently removed from the waiting list.

The initiatives introduced in the project were successful in creating additional capacity for new patients and, as a result, the number and proportion of new patients is trending upward in the identified clinics.

Sustainability and next steps
Collection of meaningful data has assisted in the management of Bendigo Health’s specialist clinics, and will be monitored on an ongoing basis.

The HealthSmart patient management system is currently being introduced hospital-wide: the data items identified in this project have been added into the suite of data management tools for the outpatient’s area.

Patient focused booking is being rolled out across all clinics in a planned way.
Melbourne Health: Renal clinic redesign

Rationale
The aim of this project was to redesign processes within the renal clinic to improve patient access and flow, reduce waiting times and congestion, and improve the patient experience.

The need for redesign work was demonstrated by:

- increasing workloads
- poor IT resources
- cramped working conditions
- poor physical environment and decor
- poor patient satisfaction
- lack of a clear governance structure for management of the clinic and monitoring of clinic performance.

Actions and outcomes
The diagnostic phase of the project identified that constraints in the physical environment and problems in the organisation of work were impacting on patient flow and resource allocation.

Key actions included:

- transfer of pathology collection to the pathology department
- introduction of online pathology test reviews with resultant reduction in paper use
- tailored pathology viewing screens for medical staff
- altered reception desk to allow greater access and reduce bottlenecks in patient and staff flow
- replaced static examination couches with height adjustable models
- restructured staff profile to match workloads and types.

The outcomes of the project were:

- improved patient flow
- need for clinic leadership role identified.

Sustainability and next steps
Sustainability of the project outcomes will be achieved employing a clinic coordinator to maintain and drive change and embed the improvements as core business.

Southern Health: Transcription services improvement

Rationale
The aim of Southern Health’s improvement project was to update and streamline medical transcription processes to ensure the timely transfer of information between specialist clinics and general practitioners.

Specific problems addressed by the project included:

- a large number of cumbersome and inefficient internal processes
- a large backlog of work
- IT system inefficiencies
- the high number of corrections required to transcribed materials
- poor communication between transcription services and medical staff
- low staff morale.
Actions and outcomes

As part of the project:

- processes, forms, templates and guidelines relating to transcription services were updated, streamlined and standardised
- an additional typist was recruited
- the IT system was upgraded with a new server, up to date software, new computers and monitors
- KPIs were developed in accordance with benchmark industry standards for the quality and timeliness of transcription services. As a result of these initiatives, the turnaround time for letters dropped from six weeks to two weeks and there was improved communication with GPs and other referrers.

Sustainability and next steps

Sustainability of the project outcomes will be achieved by regular performance audits and embedding of new business rules and processes into the core business of the transcription services.

Opportunities for ongoing improvements identified as part of this project included the expansion of the transcription service’s expertise to other areas of Southern Health.

St Vincent’s Health: SMS appointment reminders

Rationale

The objective of this project was to test the effectiveness and impact of using SMS technology to remind patients of upcoming appointments.

The project complemented the redesign demonstration project being conducted by St Vincent's Health (STV) in its orthopaedic, urology and gastroenterology clinics. These clinics incorporated both high and medium flow clinics and patients represented broad cultural backgrounds. Prior to commencement of the project, the average DNA rate for these clinics was between 20 and 40 per cent.

Actions and outcomes

Message Media, a Melbourne based company, was engaged to provide an SMS reminder desktop product and deliver related staff training and support.

A multidisciplinary working group, with representatives from relevant management, clinical and operational areas at STV, was established to oversee the testing of the SMS reminder system and to consider issues relating to data extraction, data integrity and patient privacy.

Patient information posters were published in the month preceding the trial. All patients were informed when making an appointment that an SMS reminder would be sent, unless they opted out.

The Specialist Clinics clerical team began sending SMS messages during April 2010 to patients attending the selected clinics. The messages were sent in the week before the patient’s scheduled appointment. A dedicated telephone line was used to receive calls from patients who needed to advise of their inability to attend or reschedule appointments.

The primary impact measure used to determine the impact of the pilot was a comparison of pre and post implementation DNA rates. A review of patients’ responses to their sent texts provided additional feedback on the merits of the project. Feedback from staff was also used to determine issues associated with the process of sending out the SMS messages.

DNA rates for each clinic decreased between March and May 2010, from the starting point of 20-40 per cent across the nominated clinics to 5-37 per cent. There was an average decrease in DNA rates of 33 per cent.

Sustainability and next steps

The next steps are to undertake a comprehensive review process with a view to introduce SMS reminders as a fully integrated function of specialist clinics at St Vincent’s Health.
There will be ongoing review of the system and its impact on the efficiency of services to ensure the improvements and patient acceptability seen to date are sustained over time.

The following opportunities for further improvements were identified through the project:

- enhancements to scheduling templates
- review of booking systems to incorporate patient choice for appointment scheduling
- extension of the SMS appointment reminder system to recall patients needing review or follow-up.

**Western Health: Improving the management of referrals and booking systems**

**Rationale**
The rationale for this project was demonstrated by the following problems affecting Western Health’s specialist clinics:

- high numbers of poor quality and incomplete referrals
- long waiting times for non urgent patients
- uncertainty about the true number of patients waiting for non urgent appointments, due to unaudited wait lists
- cumbersome and inconsistent booking systems
- high DNA rates
- low new versus review patient ratios in clinics.

**Actions and outcomes**
Key achievements as part of the project were:

- initial work towards the establishment of a centralised booking system:
  - through the development of a robust referral receipting process
  - telephone upgrade in progress.
- reduction in non urgent wait list numbers through auditing of waiting lists:
  - 80 per cent of non urgent waiting lists audited.
- development of guidelines for managing missed appointments:
  - departmental guidelines are in place
  - posters are in all consult rooms
  - patient letter templates include a notation about missed appointments
  - patient information brochure.
- enforcement of the clerical and clinical first time quality checks on all referrals:
  - departmental guidelines for clerical and clinical first time quality checks
  - triage slip identifies staff member who undertook each first time quality check.
- collection of data to monitor new versus review patient ratios:
  - installation of Tableau software has assisted in the collection of new and review patient statistics
  - new scheduling templates going forward ensure a suitable number of new patient slots are available.

**Sustainability and next steps**
There will be ongoing reinforcement and periodic auditing of the new guidelines and procedures, and the changes will be reinforced through further documentation and staff training. A change implementation group that involves all levels of staff within the Outpatient Service will be established. One of the roles of this group will be to progress the centralised booking service.
3. Redesigning care pathways

There is growing recognition that improvement in patient flow in specialist clinics requires consideration of the whole patient journey. This facilitates efficient use of resources and ensures that patients’ care is provided in the most appropriate setting. The development and implementation of care pathways early in the patient journey has the potential to reduce unnecessary review appointments and empowers staff to discharge patients where clinically appropriate. The following improvement projects are examples of how the implementation of care pathways can improve timely and appropriate access to specialist services.

Austin Health: Improving patient access for neurological conditions through referral guidelines and discharge pathways

Rationale

Key issues affecting general neurology outpatient clinics included:

• the number of referrals exceeded the number of discharges
• consultant neurologists were spending large amounts of time triaging outpatient referrals, although most referrals can be triaged by a nurse if they contain appropriate information
• patients were often attending scheduled appointments without their CT scan images, leading to further delays in definitive diagnosis and management.

The project aimed to improve referral processes and facilitate discharge of patients who could be effectively managed by their GPs following initial assessment, diagnosis and development of a management plan.

Actions and outcomes

The following resources for referrers have been developed as part of the project:

• additional guidelines and procedures to enhance the quality of referrals so that urgent problems are triaged appropriately
• a ‘headache tips’ information sheet, which provides practical information to help GPs manage patients with headache and describes features of headaches that would indicate the need for urgent assessment
• a ‘headache referral fax back form’ to request the essential information required for triage of referrals for patients with headache.

A new process has been introduced for referral of a patient because of concerns about an abnormality on brain imaging:

• the referring doctor is asked via a ‘fax back request form’ to forward copies of the imaging on CD or as hard copy: this information is then uploaded to the Austin Hospital’s PACS imaging system to ensure that it is available at the time of clinical assessment
• the imaging and clinical information provided by the referrer is formally reviewed at the Austin’s neurovascular or neurology/neurosurgery radiology meeting, where decisions are made regarding the patient’s urgency and need for further imaging
• feedback is provided to the referrer and any necessary further imaging is organised prior to the patient’s scheduled outpatient appointment (in consultation with the patient by phone).

Other initiatives included:

• development of formal guidelines for triage of neurology outpatient referrals, to facilitate nurse-led triage
• development of guidance for junior medical staff about the criteria for discharge from neurology clinics and the information that should be provided to referrers at the time of discharge
• development of an information sheet, ‘Discharging patients from neurology outpatients’, for neurology HMOs and registrars
• introduction of a policy of ‘no review appointments unless approved by a consultant neurologist’— meaning that HMOs and registrars need to consider the reasons for review (and whether any outstanding follow up could be undertaken by the patients GP) and the appropriate time interval until review.

The new resource and processes ensure that:
• patients are provided with appointments in line with the true urgency of their problem
• the referrer receives rapid expert feedback about the level of concern associated with abnormal CT findings and how these will be further investigated
• patients do not need to attend for additional unnecessary outpatient appointments
• appropriate patients are seen in stroke or neurosurgery clinics rather than in general neurology.

Sustainability and next steps
The work involved in managing referrals across all outpatient clinics has become too great for one individual. Therefore, while the Outpatient GP liaison nurse will continue to work closely with the neurology unit, the clinic nurse and clerical lead within the neurology portfolio will become involved in managing neurology referrals, including medical imaging requests and inappropriate referrals.

Discharges from the neurology clinic will be monitored monthly for the next six months to evaluate the effectiveness of the ‘Discharging patients from neurology outpatients’ information sheets for HMOs and registrars.

Austin Health: Examination of GP needs for after hours clinical advice

Rationale
The Department of Health’s Specialist clinics access guidelines recommend that specialist clinics should provide extended hours telephone information and support.

This purpose of this project was to determine whether there was a need to extend the hours of operation of Austin Health’s Specialist Clinics Call Centre to provide after hours information and advice to GPs.

Actions and outcomes
The hours of operation of Austin Health’s Specialist Clinics Call Centre were extended into the evenings between Monday and Friday and on Saturday mornings to allow GPs to access specialist clinics for urgent appointments. The extended hours complemented the operating hours of Community Medical Centres.

The extended hours of operation were advertised in GP Divisions’ newsletters and through Austin Health’s GP Liaison Officer.

During the extended the hours, Austin Health’s GP liaison nurse was available to provide clinical advice and had authority to overbook specialist clinics.

The extended hours of operation were trialled for an eight week period. In this period, there were no out of hours phone calls from GPs.

Austin Health contacted local GPs during the trial period to ensure they were aware of the extended operating hours. Feedback received from GPs indicated that the ‘in hours’ service was sufficient.

Sustainability and next steps
The extended hours for the Specialist Clinics Call Centre were not continued as the trial showed that GPs require an ‘in hours’ service only.

Barwon Health: Pathways for orthopaedic trauma patients referred from the ED

Rationale
The aims of Barwon Health’s project were to establish pathways for management of orthopaedic trauma patients referred from the emergency department (ED) and to promote planned and timely discharge of these patients from the specialist clinic.

The rationale for the project was that:
• the ED triage process was leading to patients being seen too early and ‘wasting’ their specialist clinic appointment
• patient uncertainty about the purpose of the specialist review was contributing to high DNA rates
• specialist clinic staff were reluctant to discharge patients from the clinic due to lack of awareness of other services that could care for the patient and a desire to bring the patient back for review ‘just in case’
• GPs were re-referring discharged patients or asking for ‘extra’ appointments due to uncertainty about management protocols for orthopaedic trauma
• there was poor communication between the clinics and GPs
• clinics were overbooked and had long waiting lists.

Actions and outcomes
Key actions undertaken as part of the project were:
• implementation of new ED processes, including a standardised pathway for urgent orthopaedic trauma patients
• establishment of electronic referrals from the ED
• daily triage of ED referrals
• development of a clear patient journey for trauma patients, which promotes timely discharge from the clinic with an avenue for streamlined re-entry
• implementation of a manual patient management template with populated patient data and tick boxes for planned care. The template is used by nursing and clerical staff to facilitate patient care and clinic flow
• development commenced on an electronic version of the template
• implementation of compulsory communication with referring doctors for all new patients.

Key outcomes following implementation of the above actions are summarised below:
• As a result of enhanced communication with GPs and patients, 92 per cent of referring doctors received communication about the plan of care for new patients.
• The development of a standardised trauma care pathway covering presentation to ED to discharge from the specialist clinic led to improved utilisation of available resources.
• One hundred per cent of ED referrals were triaged and booked in a clinically appropriate timeframe.
• One hundred per cent of patient notes were documented on the new form, eliminating the need for dictation of letters.

Sustainability and next steps
Sustainability of the project outcomes has been achieved by closing other pathways for referral and management of trauma patients from the ED and embedding the new practices as policy.

The opportunities for ongoing improvements identified as part of this project were:
• roll out of electronic communication to GPs across other specialties
• development of patient journey pathways across other orthopaedic specialties, and urology.

Royal Victorian Eye and Ear Hospital: Community eye care partnership

Rationale
The funding for the RVEEH improvement project was used to support the sustainability of a model of shared care which was developed in the Community Eye Care Partnership (CECP), which will conclude in November 2010. The model of care focuses on strengthening the interface between Specialist Clinics, general practice and community setting to improve the continuum of care.

The improvement project aimed to address the:
• discharge of patients to their GP and community eye care provider for ongoing eye care management in real time
• time consuming patient selection processes of the demonstration project model
• time consuming, labour intensive processes used in managing the patient flows through the CECP project
• communication between consultants and community practitioners.

Actions and outcomes

Implementation is expected to be completed by November 2010. However, the key strategies to achieve the desired outcomes are:

• establishment of sub working groups; referral pathways, training; and recruitment review
• development of an implementation plan; based on the following five staged approach:
  – develop agreed clinical guidelines used in patients shared care
  – develop standardised documentation to assist with the discharge process
  – train staff in the process and identification of patients suitable for discharge
  – review and edit CECP training modules
  – monitor and evaluate the initiative.
• identification of pilot clinics and clinical leads
• relocation of orthoptic clinics to improve access to medical consultants and patient flow
• development of a communication strategy, including online access via RVEEH GP resource webpage to the continuum of care guidelines and documentation.

The following key actions were implemented as part of the Specialist Clinics Improvement and Innovation Strategy improvement project:

• establishment and embedding of a streamlined process for identifying and discharging patients suitable for management by community and hospital linked practitioners
• establishment and embedding of a streamlined process for improved communication between Specialist Clinics and general practice and community
• maintenance of relationships with hospital linked community practitioners who will continue to service the needs of patients with the targeted eye diseases of AMD and glaucoma suspects.

Sustainability and next steps

It is planned that the continuum of care model will become business as usual for the management of patients in the hospital’s Specialist Clinic setting.

Werribee Mercy Hospital: Elective surgery patient journey

Rationale

The purpose of this project was to review and redesign the elective surgical patient journey at Werribee Mercy Hospital (WMH).

Issues the project was designed to address included:

• improving the communication with local GPs about the services provided at the Werribee Mercy Hospital, to reduce patients being referred for surgical management out of the area
• providing public hospital clinics for general surgery assessment to improve access for people in the community to have surgery locally.
• improving patient pre-admission management to ensure appropriate patients who had been reviewed, managed and prepared for surgery could be operated on at WMH.
• changing the current processes relating to referral of patients to the elective surgery waitlist and pre-operative patient management and communications.

Actions and outcomes

Key improvements implemented as part of the project are described below.

Improved communication with local GPs
Visits were made to approximately 12 local GP practices, and information about WMH surgical services was mailed out to all GP practices in the area. As a result, the hospital has experienced an increase in referrals to the surgical clinics. The MBS-billed clinics were operating at approximately 75 per cent capacity on completion of the project, up from 50 per cent previously. Additional clinics commenced in February 2010, provided by a second staff surgeon.

**Improved referral management and appointment booking in MBS clinics**

A dedicated fax machine was installed for all referrals to MBS clinics in the consulting suites offices. This has simplified the referral process and ensured that patients can be booked into clinics in a timely manner.

Training for clerical staff was provided to streamline appointment booking processes.

**Improved surgical pre-admission processes**

Key improvements included:

- establishment of an Elective Surgery Access team and office
- mapping and redesign of processes relating to pre-admission communication between the surgeon, patient and hospital
- revision of templates for patient letters, in line with the requirements of the elective surgery access policy
- commencement of a centralised booking process for operating theatres
- development of a pre-admission nurse role and recruitment to this role.

**Sustainability and next steps**

To ensure sustainability of the project outcomes, the consulting suites manager will disseminate regular information updates to local GP practices.

Initial discussions have commenced, and there will be further discussions with local GP practices with a view to implementing a consistent referral form.

A range of audit and data collection processes will be put in place to support monitoring of:

- utilisation of MBS-billed surgical clinics
- compliance with the Department of Health’s Elective Surgery Access Policy
- VMO surgeons’ compliance with process changes.

Weekly meetings to review surgical activity and plan theatre lists for the following week will continue, and monthly meetings will be established to review the appropriateness of theatre utilisation, and examine scheduling concerns, referral and wait list issues.

Pre-admission protocols will be developed, and surgical registrar trainees will be given a greater role in the provision of pre and post operative management through an ‘outpatient model’ of service.

### B. Redesign project

**Rationale**

The ‘project set-up’ and ‘diagnostics’ phases of the project indicated that more capacity could be delivered within existing resources; however this would require significant and fundamental change to the way people performed their work.

**Actions and outcomes**

The project was undertaken using a five stage redesign methodology. In addition to project set-up and diagnostics, the stages were: intervention; sharing key learnings; and sustainability through continuous improvement.

For the intervention period, three high level targets were established relating to timely access, patient focus and service sustainability. These were:
• timely access: an increase in the number of patients waiting in clinic for less than one hour from time of appointment to review by specialist
• patient focus: an increase in positive comments from patients
• sustainability: agreement, reporting and sharing of performance metrics to use as a basis for improvement.

A range of interventions to improve the patient journey were implemented at each of the three sites. While some of the interventions addressed specific organisational arrangements, many of the successful interventions are potentially transferable to other health services. They include:

• referrals being processed when they are received, and nurse triaging by reallocation of clerical work, ensures new referrals are receipted efficiently
• ensuring templates align with actual clinic start time reduces intra-clinic waiting for patients and is the first step in engaging doctors to address capacity issues
• a floor coordinator/information nurse role ensures a safe environment for patients and better queue management
• creating a communication hub by using a whiteboard to detail clinic activity for the day promotes team work and provides a mechanism for measuring actual capacity
• clinic kick start meetings involving all staff improves communication across the team
• producing a weekly activity report that details planned capacity, actual activity, and ‘did not attend rates’ means that all staff are aware of the opportunities for increasing activity within existing capacity.

ThincLean has produced an evaluation report describing the project outcomes and major achievements against the project aims and high level targets. Highlights include:

• St Vincent’s Health:
  – aim to achieve 80 per cent of orthopaedic clinic patients seen within one hour (baseline 55 per cent)
  – use of activity boards to support kick start meetings with medical staff arriving closer to clinic start time
  – the development of an activity report communicated to the team and clearly visualising the opportunity for increasing activity within existing agreed capacity.

• Western Health:
  – all referrals receipted and nurse triaged within three days (baseline: urology = 73 days, orthopaedics = 126 days)
  – templates aligned with doctors’ arrival times for urology clinic, resulting in 71 per cent of patients seen in less than one hour (baseline 38 per cent)
  – introduction of the floor coordinator resulted in a 6 per cent decrease in the amount of time spent by the phone clerk on clinically related calls.

• Mercy Health:
  – the implementation of a 36 week midwife visit resulted in 22 new appointment slots in medical staff templates.

Sustainability and next steps

The final report on the project identified a series of ‘transferable learnings’ that could be considered by all health services. Key messages from the project are noted below:

• Undertaking redesign in specialist clinics is a significant and complex task, with many challenges that are unique to the specialist clinic environment. Dedicated executive sponsorship and involvement is vital to support the team in navigating these complexities and challenges.
• Specialist clinics require high quality, strategic leadership, with clear lines of accountability and reporting within the health service and the support of a multidisciplinary leadership team.
• The specialist clinic pathway includes two high volume journeys, namely the pre-clinic journey from referral to appointment, and the intra-clinic patient visit. It is these two journeys that should dictate the organisation of processes and work in specialist clinics, and in these areas that redesign initiatives should focus.
• Workforce roles and responsibilities should be reviewed to ensure the right staff are doing the right jobs and to make best use of available skills and expertise. Currently at many health services, nurses spend large
amounts of time managing patient flow and supporting doctors with administrative tasks. The work of junior doctors may add minimal value to patients or senior colleagues.

- High levels of administrative work occur within the specialist clinic environment with large variation in practice between sites. Redesign of administrative processes is a fundamental element of specialist clinics improvement work.
- A role to manage demand and capacity is required in all specialist clinics. Currently, there is a lack of ownership of the clinic wait list and wait list management, including regular auditing and reporting, may be inadequate.

The Department of Health’s Redesigning Hospital Care Program is using the lessons and outcomes from the demonstration project in further programs of work. The Royal Children’s Hospital has commenced an ‘Improving the outpatient experience in orthopaedics’ project. Alfred Health has begun work on reducing patient waiting times in specialist clinics. Eastern Health is undertaking a program of work to develop a better understanding of specialist clinics access, quality and safety, patient and staff experiences and demand and capacity management. These health services are using Lean Applications expertise, learned from the consultants who worked on the initial project.

The department’s Specialist Clinics Program has established a networking forum to bring together key staff involved in the management and operation of specialist clinics. These forums provide an opportunity to share experiences in redesigning the specialist clinic environment.

A planned Specialist clinics improvement guide, to be produced by the Specialist Clinics Program in 2010-11, will incorporate learnings of the Specialist Clinics Redesign Demonstration Project.