DEVELOPMENT OF A GYNAECOLOGY CARE COORDINATOR ROLE

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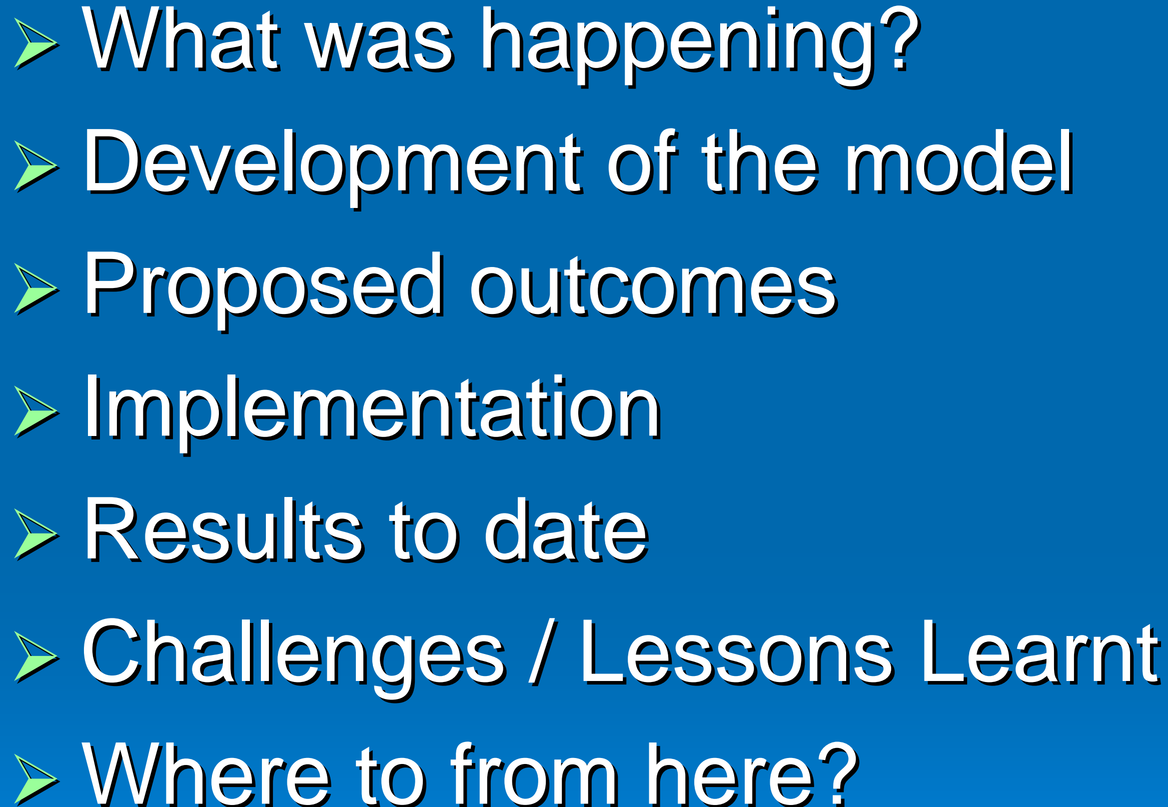
OVERVIEW



ABOUT US

- REDCLIFFE & CABOOLTURE HOSPITALS
  - Catchment area of over 200,000
  - Hospitals located 30 km’s apart.
  - Outpatients seen per annum
    - Redcliffe 35,000
    - Caboolture 16,000
  - 6.8% of the population is >65

WHAT WAS HAPPENING?

- Gynaecology: Clinics held both Redcliffe and Caboolture hospitals
- Demand for service:
- On a monthly basis central referrals receives on average 70 **new case referrals**, consisting of approximately 18% category 1, 40% category 2, and 42% category 3. Less than 50% of these patients are booked on receipt of referral.
- Conversion to theatre was around 1:4/5 for new patients, lower for reviews.
- FTA rate high around 15%

PATIENTS WAITING

		Total Cat 1	> 30 days	Total Cat 2	>90 days	Total Cat 3	>365days
Caboolture	**Aug-06**	**0**		**95**	**44**	**311**	**109**
Redcliffe		0		6		399	
Total waiting 06				***101***	***44***	***710***	***109***
Caboolture	**Aug-07**	**0**		**25**		**101**	**43**
Redcliffe		5	**2**	64	**5**	350	**124**
Total waiting 07		***5***	***2***	***89***	***5***	***451***	***167***

- Overall Reduction in patients waiting at both sites
- Waiting list equitably managed between sites.

HOW?

- Review of literature regarding case management within gynaecology.
- Consultation with QH facilities.
- Review of data within our facilities to determine potential improvements.
- Stakeholder consultation.
- Lean thinking principles / methodology introduced to reconfigure practices.

CARE CO-ORDINATORS AT REDCLIFFE AND CABOOLTURE

So what is a care co-ordinator?

The roles of these nurses at Redcliffe and Caboolture are continuing to grow, and currently include referral management, provision of direct patient care, including being a phone contact both for patients and GP's with enquiries, and liaison with district directors and consultants to provide a co-ordinated approach for patients throughout the continuum of care, including outpatients, theatre, and discharge.

IMPLEMENTATION

- Scope of the role defined – identify future directions for service.
- Improve clinical outcomes through timely categorisation of referrals and subsequent management of the patient through the service.
- Regular monitoring of patients waiting at both clinics, theatre and colposcopy.

Gynaecology

Emergency department referrals are appropriate for the following diagnoses:
Miscarriage Acute menorrhagia

Outpatient referrals are appropriate for the following diagnoses:	Please attach the copies of investigations to your referral:
Post menopausal bleeding	Ultrasound to assess endometrial thickness Mammogram Pap smear HVS/ endocervical swab
Ovarian Cysts	Pelvic ultrasound (TV if possible) Tumour markers – CA125, CA19-9, CEA, AFP, Beta HCG
Infertility	Pelvic Ultrasound Hormone profile, including 21 day progesterone, FSH, LH, prolactin, TFT'S Semen analysis
Heavy periods / Menorrhagia	Pelvic ultrasound FBC, TFT Pap smear
Abnormal Pap smear	Pap smear result
Post coital bleeding	Pap smear result HVS/endocervical swab
Cervical polyp	Pap smear result

Patients with the following diagnoses should <u>not</u> be referred to a Gynaecologist	***These conditions are best managed by:***
Reversal of sterilization	Alternate Private Practice
Absent Mirena threads	Pelvic ultrasound (see above for referral if u/s shows migrated)

- Care Coordinator is working with the consultant to refine guidelines.

RESULTS TO DATE

<u>Implemented</u>

- Referral Guidelines
- Nurse initiated investigations
- Categorisation Guidelines for Drs and CN CC
- Consistency across sites/Drs
- Commenced communication with GP /GP liaison
- Patient education
- SOPD linked to Elective Surgery

CLINICAL STAFF

- Business cases for equipment – successful → disposable speculum with lights; catheters
- Purchase of training equipment for use by Doctors and nursing staff.

PATIENTS

- Implemented the review / purchase of patient information pamphlets.
- Reviewing access to clinics / appointments, chart clinics.

Care Coordinator

- Changing established practice is difficult.
- Be prepared for competing priorities
- Marketing of the role is vital for ongoing support.

CHALLENGES / LESSONS LEARNT

Challenges / Lessons Learnt

- Working with two medical teams
- Understanding that processes / change management did not need to be the same both sites, simultaneously.
- Need to address the needs of consultants to engage them.
- Need for political savvy
- Have models of care / tasks identified as options, as it was difficult for some team members to 'look outside the square.'
- Using a project management methodology was important in achieving outcomes and not overextending the CN.

WHERE TO FROM HERE?

- Develop stronger links with local GPs
- Engage clients in the evaluation/ consideration of future changes.
  - **Clinic hours**
  - **Review of patient information**
- Expand links to community based services pre-consultation and post procedure.
- Work towards
  - **Health assessments prior to OT**
  - **Obesity / smoking etc.**
- Recruit a data manager
  - **Identify trends for Care Coordinator to action.**
  - **Review opportunities to alter clinic composition.**

Thank you