

Patient Focused Bookings



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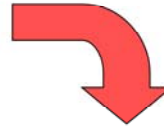


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Auditor General's report (2006)
Access to Specialist Medical Outpatient Care



Outpatient improvement
and innovation strategy



Victorian public hospital specialist clinics
Strategic framework





Victorian Public Hospital Specialist Clinics *Strategic Framework:*

3 objectives of the framework :

- Timely access
- Patient focus
- Sustainable services



Funding outpatient improvement and innovation





Specialist Clinics Web site:

<http://www.health.vic.gov.au/outpatients/index.htm>



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IMPLEMENTATION OF PATIENT FOCUSED BOOKING ROYAL MELBOURNE HOSPITAL

Leonie Carberry, Manager, Specialist Clinics, RMH



VIDRL

Passion for Caring - Achieving the Extraordinary



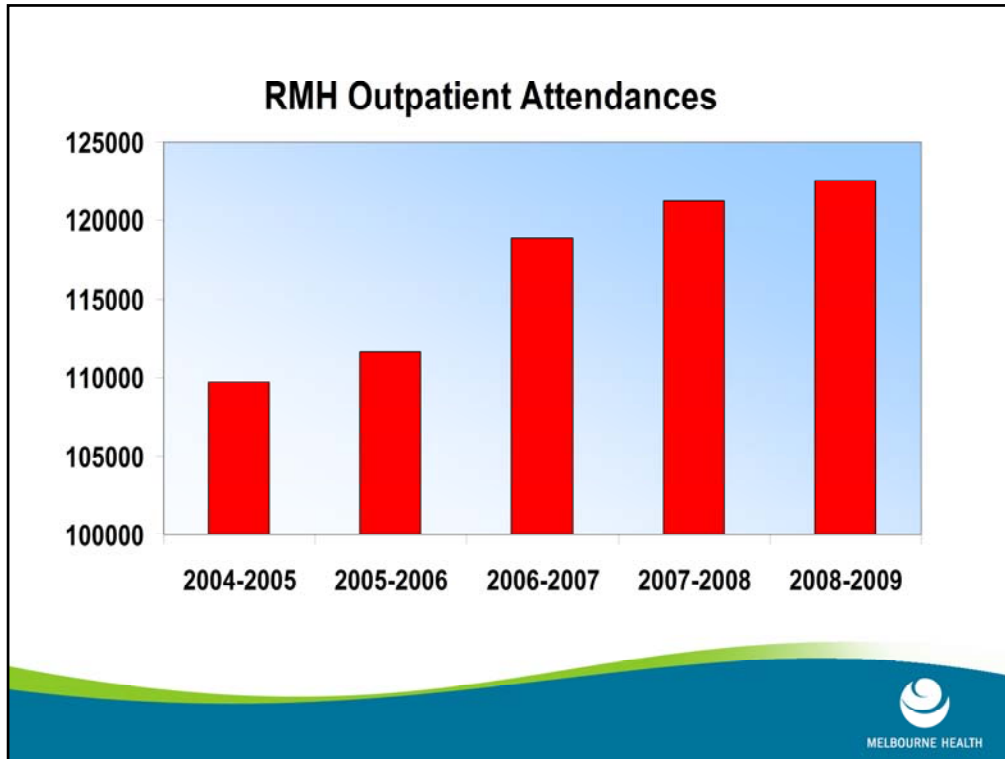
Royal Melbourne Hospital Specialist Clinics

- 125,225 Attendances
- 23,714 New Attendances
(2008 – 2009)



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Tertiary hospital



Increasing attendances up 12%

Project funding from DHS to address areas of need and introduce initiatives.

Recognising the importance of referrals we chose to target referral management and booking systems.

KEY ISSUE

- Inefficient Booking System
- All patients sent an appointment
- Fully booked future clinics
- Rebooking cancelled patients = overbooking
- Inefficient use of capacity
- Minimal patient choice



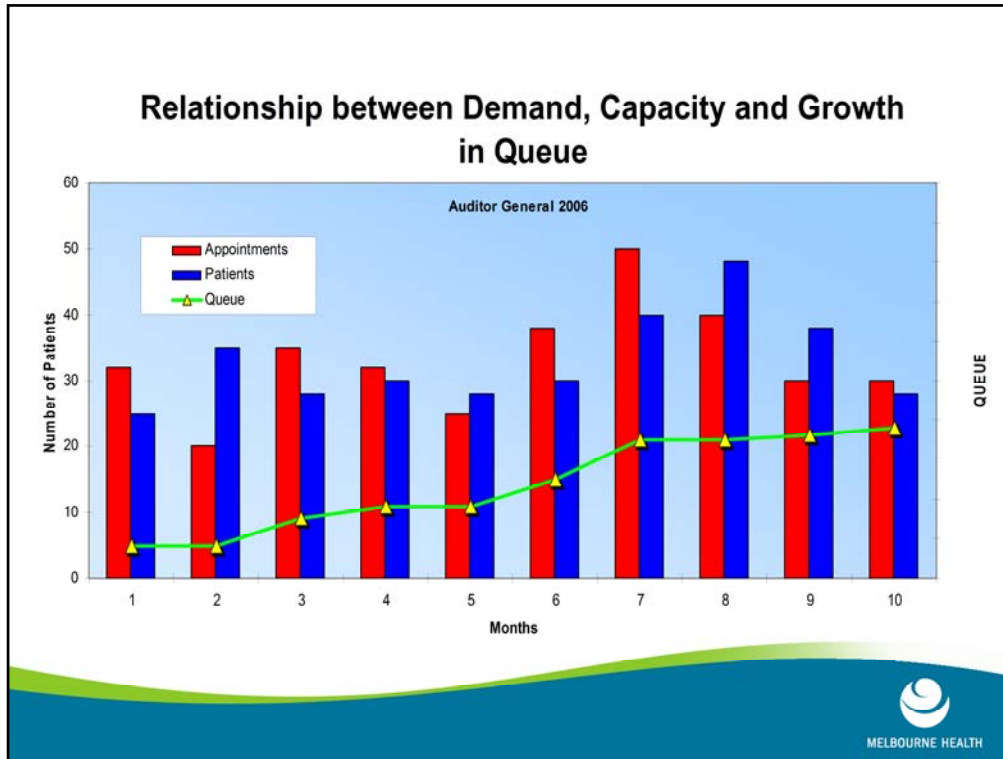
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Our practice had been to send all new patients an appointment urgent and routine. This resulted in clinics that were fully booked for months for many clinics.

So even with the required 6 weeks notice of doctor cancellation, new patients needed rescheduling into clinics already booked.

Patients were not consulted about the suitability of the appointment time and our switch was kept busy rescheduling.

We first needed to understand our demand and to achieve this we set about centralising our referral entry.



As the Victorian AG stated in his report “Access to specialist medical outpatient care 2006”

If demand for outpatient services is greater than available capacity, then patients will have to wait to see a specialist. However, lack of capacity is not the only factor that can cause waiting times to grow. Even if *average* capacity matches *average* demand, a mismatch between daily demand and daily capacity can cause queues.

This happens because when demand exceeds capacity, appointments are postponed and those patients increase the queue. This excess demand is carried forward. However, when capacity is underutilised because it exceeds demand (for example, when booked patients “fail-to-attend”), this saving cannot be carried forward. Capacity is reduced when clinics are cancelled, but referral volume is independent of this

METHODOLOGY

- Steering Group and project team
- Literature search and consultation
- Patient/booking list audits
- Lean Principles applied



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PATIENT FOCUSED BOOKING

AIM

- ↑ Patient choice
- ↑ Capacity by controlling flow
- ↓ New “Did Not Attend” rate
- ↓ Overbookings



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These aims are directed at NEW patients at this point.

Increase patient choice by allowing them to tell us which dates suited, within the limits of clinic and priority, close to the date rather than months in advance

Applying the AG theory and matching demand and capacity. By not booking appointments and having patients choose their appointment time we would expect increased compliance and the data from the UK backs this up

Because we can reschedule patients who have been cancelled into empty clinics, along with quarantined spots for urgent patients we have drastically reduced overbooking of new patients

HOW

- Pilot clinic/unit
- Consultant agreement
- Review capacity & demand
- Access policy and Action Cards
- Audit of patients waiting



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We chose orthopaedics as our trial, but included the Cardiac clinic as we had been progressing to this model prior to the commencement of the project.

Clinicians were without exception open to the logic of PFB and we soon had other units requesting to use this model

We looked at average referrals per unit and used the number of new slots based on 42 weeks a year. For most units projected capacity exceeded demand, yet we still have waits!!

We formalised an Outpatient Access Policy and developed Action Cards to guide clerical processes.

And then began a major audit of patients with future orthopaedic appointments.

HOW

- Electronic referral entry
- Two triage categories
- Urgent patients contacted & booked
- Non-urgent patients no longer booked



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All referrals are entered onto HOMER – soon to be Healthsmart

Orthopaedic Triage is done by our specialist physiotherapists, and consultants in other units.

Referrals are triaged as Urgent (no of weeks spec) or non-urgent

Urgent patients rung

HOW

- Information letter to non-urgent patients
- Information letter to referring practitioner
- Offer letters sent ~ 4 weeks ahead
- Hold if clinic full or cancelled
- Ensure unused capacity filled



Non-urgent patients are no longer booked but notified that they will be contacted 4 weeks prior to their appointment.

The referring doctor is also notified at this point either of the urgent appointment or the new 'booking system.

Orthopaedic patients wait by specialty, so we have lists for Hip & Knee, Spinal, Shoulder, Foot & Ankle etc.

Having patients listed but not booked enables us to adjust the demand flow to align with capacity with the aim of avoiding the queues caused by mismatch.

So if a clinic is cancelled no appointments are offered. When clinics are open, every slot is filled and DNAs are minimal as the appointment is made recently and agreed by the patient. This should mean that the yearly capacity is fully utilised.

Outpatient Forward Booking Report

ORTH8B - ORTHOPAEDIC FRIDAY AM MR. B									
Doctor	Week Ending								
	30 Aug 09	6 Sep 09	13 Sep 09	20 Sep 09	27 Sep 09	4 Oct 09	11 Oct 09	18 Oct 09	25 Oct 09
BEIA New	4	3	3	1	0	1	0	0	0
BEIA Review	12	11	13	10	5	3	7	1	0
Total	16	14	16	6	10	4	8	1	0

To assist us in monitoring our capacity, we are fortunate to have future booking reports available on line and updated daily.

Here we see a clinic which is open for the next few weeks, with a cancelled clinic late October.

The new capacity is 4 patients per week. We have booked 4 weeks out, but left some Urgent capacity. If this is not filled after triage the week before we contact the next patient on the list until the slot is filled.

If we are able to do this all year, we should keep up with our referrals as we know that our capacity = demand

OUTCOMES

↑ New Patients

↓ New DNA

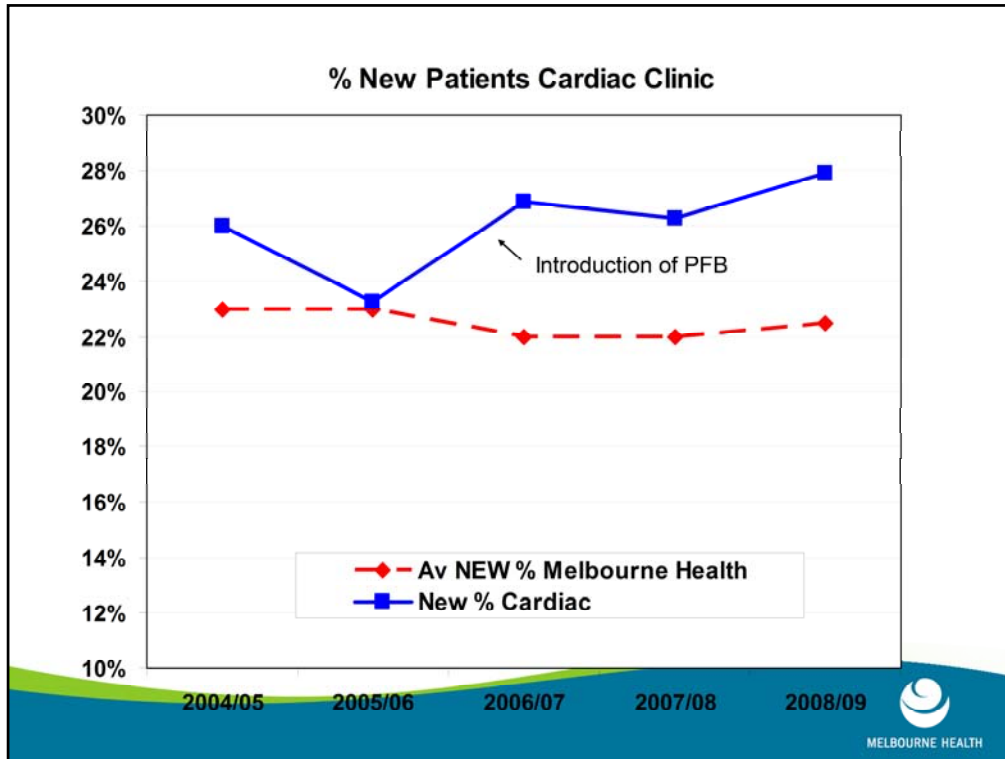
↓ Patients waiting

↓ Patient rescheduling



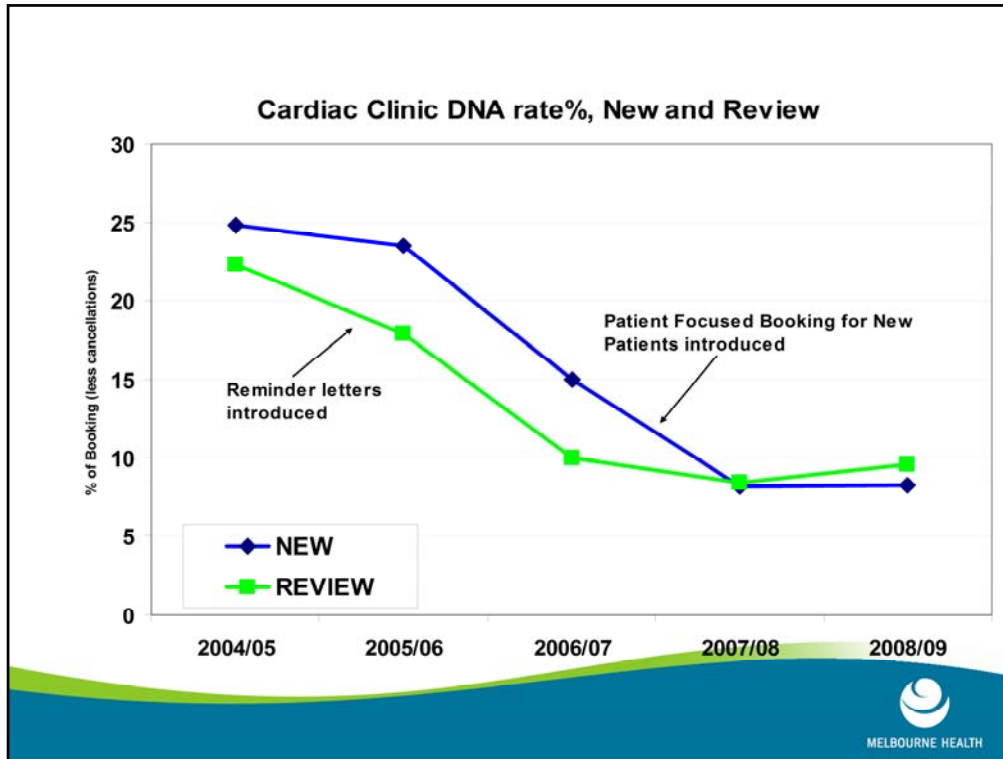
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It is now 2 years since commencement and does have a lead time roughly equal to the current wait. What we are beginning to see is



Cardiac clinic are increasing their percentage of new patients seen.

The wait time for a non-urgent referral remains at 3 months, but there has been a 26% increase in referrals and no increase in capacity.



The pattern across Melbourne Health is for a higher rate of New DNA % compared with review patients. With PFb we are seeing the rate of new DNA decrease which means reduced wasted capacity.

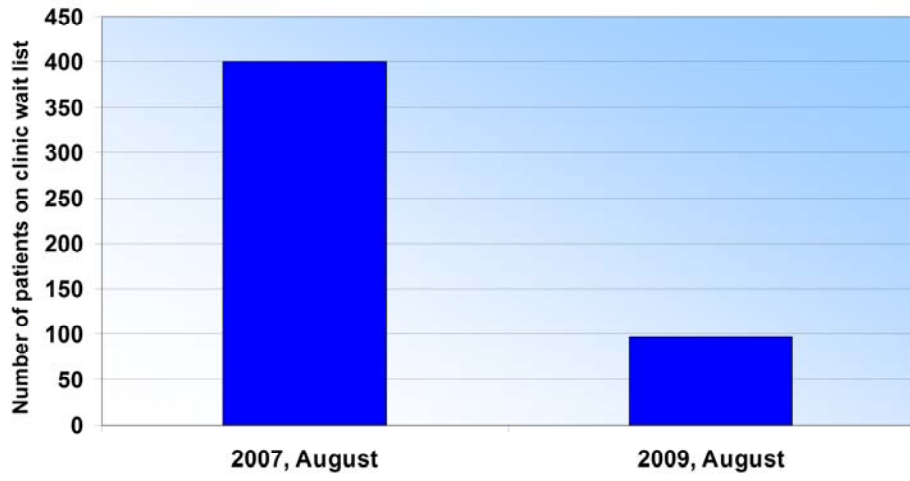
ORTHOPAEDIC OUTCOMES

- ↓ Wait times for access to all orthopaedic specialties
 - Hip/Knee from 4 months to 4 weeks
 - Shoulders from 10 months to 3 months



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Patients Waiting for First Specialist Orthopaedic Foot Consultation



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ORTHOPAEDIC OUTCOMES

Multiple interventions

- Orthopaedic wait list project
- Physiotherapy Triage of referrals
- Additional consultants

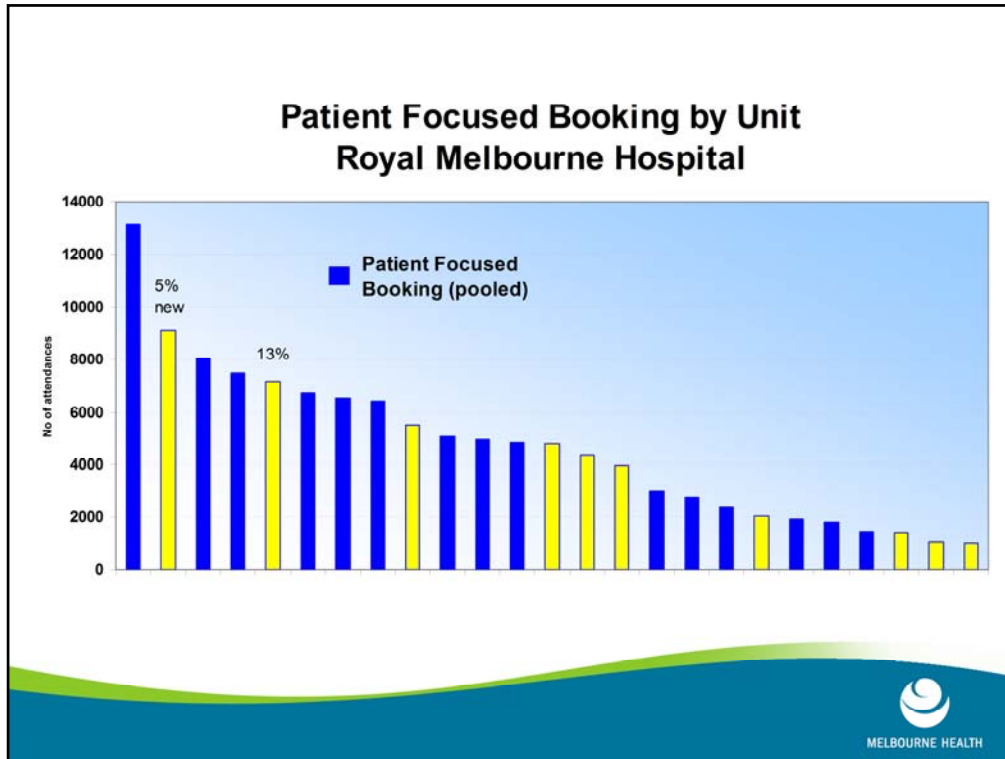


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The improvements in Orthopaedics have been marked, mostly due to

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-
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Patient Focused Booking complements these initiatives and ensures efficient use of available resources.



We have now introduced this system to ~ 60% of clinics and hope to reach 100% within a year.

Not all clinics have long enough waits to justify holding patients but we will still send these patients an offer of appointment rather than a premade appointment therefore ensuring that all patients have choice.

LESSONS LEARNT

- Monitoring essential
- Dynamic Templates (schedules)
- Responsive switchboard
- Regular rolling audits



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Monitoring – Wasted capacity is a no-no!!

Templates or Schedules need to be adjustable at short notice. Clinics may be nicely balanced for a while and then we notice either they are getting shorter and could manage some extra new patients, or getting clogged down, and we can reduce for a while.

We also benefited from the AGs advice to have realistic templates. If a clinician sees 12 patients per session according to attendance data, then no point having 6 slots. Results in overbooking and double booking which reduces flow.

We have increased our switch by about .5, less than we thought but fewer patients are calling to reschedule unsuitable appointments. However this may need to increase and is being monitored.

We also audit our lists while we still have some long waiters. We do not do this where wait is less than 4 months as the offer letters act as an audit tool

FUTURE

- All patients to have choice
- ↑ Discharge Rate
- ↓ Reviews
- Electronic receipt of referrals
- Electronic storage of referrals



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OP management systems can control the flow of non-urgent new patients but it rests with the clinicians to manage the reviews.

Where numbers are high can be reduced by increased discharge or increasing the interval of time for review.

We are working with DoH to address barriers to electronic receipt of referrals, which will eliminate the need to physically store and retrieve referrals.



Which will make our team very happy!!