Outpatients: Accelerating Flow and Improving Service Integration

19-20 October 2015
Royal on the Park, Corner Albert & Alice Streets
Brisbane QLD Australia
A seminar for everyone committed to outpatient service improvement and integration across settings:

1. Reconciling demand and capacity to drive throughput and reduce wait lists
2. Improving referrals, referral management, bookings and scheduling etc
3. Successful pathways that cover the continuum of care from referral to discharge
4. Innovations in service and care integration
5. Clinical redesign and flow improvement strategies
6. Patient focused models of care
7. Stakeholder engagement strategies that have delivered demonstrable outcomes for outpatients
8. Information technologies as a tool for supporting the integrated delivery of efficient outpatient services

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Health IQ has being partnering with Australian hospitals since 1996, with unique focus on helping them gain visibility of their internal capacity to meet patient demand. Key among our solution suite is Queue Manager.

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### Session 1: Outpatients Reforms: What's in it for patients?

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*Chair: Prof Donald MacLellan, Director, Surgery, Anaesthesia and Critical Care<br>NSW Agency for Clinical Innovation*
Day 1: Monday 19 October 2015

Session 2  Improving Efficiency with Centralised Referral Initiative

Chair  Ila Stuer, A/Assistant Nursing Director, Outpatient Coordinator
Royal Brisbane & Women’s Hospital, QLD

11.20-11.40  Developing Statewide Clinical Prioritisation Criteria – the story so far
Jody Paxton
Manager, Clinical Prioritisation Criteria Project
Queensland Health

Brigid Philip, Senior Planning Officer, Queensland Health

11.40-12.00  Centralised referral management – a tale of two Metro’s
Part One: Metro North Hospital and Health Service
Nicole Payne
Assistant Director of Nursing, Specialist Outpatients,
Clinical Operations Strategic Implementation (COSI)
Metro North Hospital and Health Service, QLD

Miranda Thompson, Project Manager, Central Patient Intake Project, Katherine Baxter,
Project Officer, Central Patient Intake Project, MNHHS; Wendy Haynes, Project Officer (CNC),
Central Patient Intake Project, MNHHS, QLD

12.20-12.40  Central Referral Hub
Angelina Zande-Wilkins
Director/Assistant Director of Nursing
Primary Care Partnerships Unit
Metro South Health, QLD

Carly Phillips
A/NUM Central Referral Hub
Primary Care Partnerships Unit
Metro South Health, QLD

12.40-12.55  Questions to Speakers

12.55-13.55  Lunch
Session 3  Streamlining Administrative Functions to Improve Efficiency

Chair  Jody Paxton, Manager, Clinical Prioritisation Criteria Project, Queensland Health

13.50-14.10  Metro South Electronic Internal Referral (e-Blue Slip)
Jennifer Brownlea, Michelle Reynolds, Kerry Spillane, Raksha Trengove, Tamara Wylie
Metro South Health Business Practice Improvement Officers (BPIO)
Metro South Health Primary Care Partnerships Unit, QLD
Additional Author: Angelina Zande-Wilkins

14.10-14.30  Streamlining allied health led outpatient clinics in preparation for centralised access
Raisa Shaikh
Allied Health Informatics Advisor, Clinical Manager of Nutrition and Diatetics
Monash Health, VIC

14.30-14.50  Ambulatory Referral Management System (ARMs)
Lloyd Wright
Data Administrator, Central Referral Hub
Metro South Health, QLD

Danielle Lemon
Director Support Officer
Primary Care Partnerships Unit
Metro South Health, QLD

14.50-15.10  The Kids Rehab eMR Project - Improving non-clinical support systems for clinicians working in an ambulatory outpatient setting.
Lynn McCartney
Clinical Nurse Consultant, Cerebral Palsy & Movement Disorder Service, Kids Rehab
The Children’s Hospital at Westmead, NSW

15.10-15.20  Questions to Speakers

15.20-15.40  Afternoon Tea
Session 4  Outpatient Check In and Data Quality

Chair  Julie Faoro, Director Development and Operations, Change Champions Health Innovation Network

15.40-16.00  The introduction of a patient self-check in and SMS calling system (QFlow).
Stephen Tucker
Manager, Specialist Clinics
Royal Children’s Hospital Victoria

Britta Saunders
NUM, Specialist Clinics, Royal Children’s Hospital Victoria, VIC

16.00-16.20  Patient self check-in and ELECTRONIC calling reduces in-clinic waiting time
Colleen Jackson
Quality and Projects Manager, Specialist Clinics
Austin Health, VIC

16.20-16.40  A Team Approach to Data Quality
Shane Downey
Manager Data Services
Mater Health Services, QLD

Susan Gardiner
Practice Manager, Ambulatory Services
Mater Health Services, QLD

16.40-16.50  Questions to Speakers

16.50  Close of Day 1

19.00 for 19.30  There’s No “I” In Team Dinner
The Avro Room, Royal on the Park
Session 4A  Models of Care

Chair  Char Weeks, Director of Innovation, Change Champions Health Innovation Network

15.40-15.55  Allied Health Specialist Outpatient Clinics: New models of care to enhance care, drive throughput, and reduce wait lists
Michelle Stute
Allied Health Workforce Development Director
Metro North Hospital and Health Service, QLD

Marita Plunkett, Allied Health Workforce Development Officer, Royal Brisbane and Women’s Hospital,
Prof Tracy Comans, Metro North Hospital and Health Service District and Menzies Health Institute, Queensland,
Griffith University, Dr Simon Finigan, Research Coordinator Allied Health Professions, Royal Brisbane and Women’s Hospital, Maree Rayner, A/ Program Manager Neurosurgery/Orthopaedic Physiotherapy Screening Clinic and Multidisciplinary Service, Royal Brisbane and Women's Hospital, Dr Merrilyn Banks, Director Research, Allied Health Professions, Royal Brisbane and Women's Hospital, Peter Buttrum, A/Director Allied Health Professions, Royal Brisbane and Women’s Hospital, QLD

15.55-16.10  From hand maiden to autonomous practitioner-Development of nurse clinics at ManukauSuperClinic
Sandy Ryan
Nurse Educator Ambulatory Care
Counties Manukau Health, NZ

16.10-16.25  Can we improve the flow for patients referred to Gynaecology / Urogynaecology outpatients with incontinence or pelvic organ prolapse?
Helen Edwards
Physiotherapist Advanced, Continence & Women’s Health
Metro North Health, QLD

Janelle Greitschus, Physiotherapist Advanced, Continence & Women’s Health, RBWH, Metro North Hospital & Health Service, Jennifer Nuicfora, Physiotherapist Advanced, Continence &Women’s Health, RBWH, Metro North Hospital & Health Service, Sonia Sam, GPSC Project Officer, RBWH, Metro North Hospital & Health Service, Suzanne Kuys National Head of School of Physiotherapy, ACU, Brisbane, QLD, Christopher, Weekes, SMO Obstetrics & Gynaecology, Caboolture Hospital, Metro North Hospital & Health, Service, Queensland Health

16.25-16.50  Questions to Speakers and Close of Day 1

19.00 for 19.30  There’s No “I” In Team Dinner
The Avro Room, Royal on the Park

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Session 5

Chair  
Lauri O’Brien, Principal Redesign Consultant, Health Services Innovation Tasmania, UTAS

09.00-09.30  
**Keynote Address**  
Integration and Acceleration—lessons from 10 years of Redesign in NSW  
Raj Verma  
Director Clinical Program Design and Implementation  
NSW Agency for Clinical Innovation

09.30-10.10  
**One Health Service**  
Susan Langdon  
General Practice Liaison Officer  
Mackay Hospital and Health Service, QLD

10.10-10.30  
**Specialist Outpatient Services (SOS) Project**  
Sarah Jane Waller  
Senior Project Officer, Outpatient Services  
NSW Ministry of Health

Additional Authors:  The Specialist Outpatient Services Steering Committee

10.30-10.50  
**Consumer to Consumer Outpatient Experience Surveyor Program (C2C Program)**  
Mellita Kimber  
Consumer Engagement Coordinator, SALHN  
SA Health, Southern Adelaide Local Health Network (SALHN)

Co- contributor: Catherine Hughes, SALHN

10.50-11.05  
**Questions to Speakers**

11.05-11.25  
**Morning Tea**
Session 6  Redesign and Change Management for Flow Improvement

Chair  Julie Faoro, Director Development and Operations, Change Champions Health Innovation Network

11.25-11.45  Out of the box-creating ambulatory rehabilitation efficiency
Ann Coe and William Dang
Rehabilitation Day Therapy Unit, Internal Medicine Services
The Prince Charles Hospital, QLD

Leah Thompson, Manager, Research and Quality, The Prince Charles Hospital, QLD
Ann Finnomore, Nadine Tallon, John Deeth, Ling Lan
Rehabilitation Day Therapy Unit, Internal Medicine Services
The Prince Charles Hospital, QLD

11.45-12.05  Using a Rapid Improvement events to kick start reforms in Outpatients.
Lauri O’Brien
Principal Redesign Consultant
Health Services Innovation Tasmania, UTAS

Additional Author: Di Mulcahy, Clinical Redesign Program Officer, Health Services Innovation Tasmania, UTAS

12.05-12.25  Camera Rolling! Our innovative marketing approach for clinical redesign of outpatients
Catherine Hughes
Manager Strategic Projects Unit
SA Health, Southern Adelaide Local Health Network

12.25-12.30  Poster Presentation
Establishing a combined hand therapy unit at the Royal Adelaide Hospital
Nicola Williams
Principal Physiotherapist, Outpatients & Specialty Services, Physiotherapy Department
Royal Adelaide Hospital (RAH), SA

Janelle Hill
Senior Occupational Therapist, Occupational Therapy Department, RAH, SA

12.30-12.45  Questions to Speakers

12.45-13.45  Lunch
Day 2: Tuesday 20 October 2015

Session 6A  Integration with General Practice and Clinic Redesign

Chair  
**Char Weeks**, Director of Innovation, Change Champions Health Innovation Network

11.25-11.45  Back Pain Assessment Clinic: Shifting a Tertiary Spinal Service Into Primary Care  
*Adam de Gruchy*  
Advanced Practice Physiotherapist in Orthopaedics, Neurosurgery and Emergency Medicine  
Royal Melbourne Hospital, VIC

11.45-12.05  Evaluation of a pilot project to increase access to allied health services in four rural communities in South West Victoria  
*Jacinta Bourke*  
Regional Manager- Geelong  
Western Victoria Primary Health Network, VIC  
*Natalia Haugh*, Primary Care Consultant- Population Health Planning, Western Victoria Primary Health Network,  
*Monica Murnane*, Primary Care Consultant- GP Data & Business Modelling Western Victoria Primary Health Network,  
*Kay Widdicombe*, Allied Health Manager, Colac Area Health, VIC,  
*Lyndall McNeil*, Primary Care Consultant, Western Victoria Primary Health Network

12.05-12.25  Turning off allergies with your GP – a model of shared care  
*Pam Hudson*  
Allergy Clinical Practice Consultant  
Flinders Medical Centre, SALHN  

Additional Authors:  
*Sue Mattschoos*, Clinical Practice Consultant, SALHN  
*Anthony Smith*, Clinical Head of Department-Allergy Clinical Immunology Service, SALHN  
*Catherine Hughes*, Principal Coordinator, Southern Adelaide Health Alliance, SALHN  
*Christopher Yuen*, Medical Student, School of Medicine Flinders University, SA

12.25-12.45  Urology Outpatient Clinic Template Redesign  
*Sally Kruger*  
Service Development Officer, Operational Performance and Improvement  
Ballarat Health Services, VIC  

*Dennis O’Leary*, Project Officer, Operational Performance and Improvement, Ballarat Health Services, VIC  
*Rowena Clift*, Executive Director, Operational Performance and Improvement, Ballarat Health Services, VIC

12.45-12.55  Questions to Speakers

12.55-13.45  Lunch
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Practice and Process Outpatient Coordinator  
Royal Brisbane & Women’s Hospital, Metro North Hospital & Health Service, QLD |
| 14.05-14.30 | Public Hospital Long Wait Outpatient (OPD) Care Improvement                     | Anthony Kiosogolous  
Consultant Urologist  
QEII Jubilee Hospital, Metro South Health, QLD  
Jennifer Ashton  
Nurse Unit Manager – Specialist OPD  
QEII Jubilee Hospital, Metro South Health, QLD |
| 14.30-14.50 | Decreasing Lost Capacity – Fail to Attends (FTAs), Patient Initiated Postponements (PIPs) and Cancellations | Susan Fiori  
Administration Manager, Specialist Clinics, Access and Demand  
Austin Health, VIC |
| 14.50-15.10 | Royal Reduction: Complexities of reducing outpatient waiting lists by 50% in a tertiary hospital | Carmen Mauchline  
A/A Nursing Director, Outpatient Coordination  
Royal Brisbane and Women’s Hospital, QLD |
| 15.10-15.30 | Questions to Speakers                                                          |                                                                            |
| 15.30-15.45 | Afternoon Tea                                                                  |                                                                            |
Session 8  A Futurist Perspective on Service Delivery for Outpatients

Chair  
John Hallett, Data Integrity Officer, NSW Ministry of Health

15.45-16.15  Closing Address  
Prof Stephen Duckett  
Director, Health Programs  
Grattan Institute, VIC

16.15  Close of Seminar
09.05-09.35  **Opening Address**

*Michael Zanco*

Executive Director, Healthcare Improvement Unit  
Healthcare Research and Innovation Branch  
Department of Health, Queensland Government

**Bio**

Michael Zanco is the Executive Director, Healthcare Improvement Unit within the Clinical Excellence Division. Michael has over twenty eight years experience working for Queensland Health and has dedicated his working life to improving the quality and delivery of public health services in Queensland.

In his current role, Michael has responsibility for leading health system reforms and policy initiatives that improve patient access to hospital services across a broad range of areas such as specialist outpatients, emergency departments and elective surgery.
Keynote Address

Achieving Compliance with the Specialist Clinic Access Policy

Sharon Walsh

Director Outpatient Transformation

The Royal Melbourne Hospital, VIC

Bio

Sharon Walsh is a nurse by background who completed her training in South Africa but has spent the bulk of her career working in the UK and Australia. She worked clinically for a number of years but eventually moved into the area of clinical governance. Key achievements in this field have included leading key organisation wide projects (e.g. Surgical Safety Compliance and Global Trigger Tool Program), the co-writing of key organisational strategies (e.g. Safety First Strategy) and leading organisation accreditation. In 2014 Sharon moved back into an operational role managing the Outpatient Department at Melbourne Health where the preparation for compliance with the Victorian Specialist Clinics Access Policy was one of the drivers for change. She has recently stepped into the role of Director Outpatient Transformation which is a 2 year project aimed at implementing sustainable improvements in the outpatient setting.
Keynote Address
Keeping the line moving—an interplay of interventions
The outpatient in focus approach of SALHN

Catherine Hughes
Manager, Strategic Projects
Southern Adelaide Local Health Network, SA

Bio
Qualifying as a pharmacist, Catherine Hughes was the first Director, Country Pharmacy Services SA Health overseeing operations at 58 Hospitals and implemented Pharmaceutical Reform in country SA. Seeking the opportunity to make health-system-wide impacts she left pharmacy to become Manager, Strategic Projects Unit for Southern Adelaide Local Health Network. This has resulted in her leading a suite of reform projects including implementing changes to Outpatients, pathology, transport, aged care, ACAT and partnerships with primary care.
Developing Statewide Clinical Prioritisation Criteria – the story so far

Jody Paxton
Manager, Clinical Prioritisation Criteria Project
Queensland Health

Brigid Philip, Senior Planning Officer, Queensland Health

Bio

Jody Paxton has over 25 years clinical experience and currently works for Queensland Health as the Manager for the implementation and evaluation of the Clinical Prioritisation Criteria Project. Jody has a Masters in Health Care Research and is a Lecturer for the School of Medicine at Griffith University. She is also currently supervising numerous research projects at the Gold Coast University Hospital.

Abstract

With patient demand exceeding finite public resources, effective and efficient management of patient referrals is critical to ensure equitable, transparent and safe access to an initial medical or surgical specialist outpatient appointment. Yet currently there are no standardised criteria for prioritising patient access to public specialist care, nor for specifying the minimum information required in a referral request.

Whether a patient is referred to a specialist, how urgent the referral is considered (prioritisation), and how long a patient waits for an initial appointment can depend on location, specialty and the healthcare professionals involved.

In 2014, Queensland Health commenced the Clinical Prioritisation Criteria (CPC) project. The CPC project aims to develop, implement and evaluate standardised criteria to enable equitable access to public medical and surgical specialist services, with a primary focus on outpatients but also through to intervention. The CPC project is informed by international and local work; however, appears unique in scope and scale.

CPC are being developed by Clinical Advisory Groups currently comprising over 280 clinicians including Allied Health Practitioners, General Practitioners, Nurses and Medical Specialists who consider the evidence on best practice from referral through to specialist care. The CPC project currently includes the development and testing of CPC for conditions across 11 specialities with additional specialities to be addressed in subsequent project phases.

A robust project evaluation is embedded in the project design and will inform project improvements and phase two development and implementation.

This presentation will describe Queensland’s experience of convening the Clinical Advisory Groups and the process of developing CPC. It will also describe the planning process for implementing and evaluating CPC, including the key performance indicators to measure the safety, effectiveness and efficiency of CPC.
Centralised referral management – a tale of two Metro’s

Part One: Metro North Hospital and Health Service

Nicole Payne
Assistant Director of Nursing, Specialist Outpatients, Clinical Operations Strategic Implementation (COSI)
Metro North Hospital and Health Service, QLD

Miranda Thompson, Project Manager, Central Patient Intake Project, Katherine Baxter, Project Officer, Central Patient Intake Project, MNHHS; Wendy Haynes, Project Officer (CNC), Central Patient Intake Project, MNHHS, QLD

Abstract

Metro North Hospital and Health Service (MNHHS) is comprised of over 50 Outpatient and Allied Health Specialties across 5 facilities (of which 2 provide tertiary services). Previously referrers to MNHHS had to struggle with multiple referral entry points, variation in referral processes and complex communication pathways. Within MNHHS, there was limited transparency related to monitoring of referrals against established benchmarks and standards. In 2013, MNHHS submitted and was approved for Health Innovation Funding to implement a Central Intake Model (CIM) with a single point of entry for referrals to Specialist Outpatient and Allied Health Services within MNHHS. On 28 January 2014, the single point of entry for referrals was achieved with the commencement of the Central Patient Intake (CPI) Unit. At the same time a MNHHS Gastroenterology Referral Hub was also established.

MNHHS is the largest health service in Queensland and was the first to adopt a HHS wide central intake model supported by electronic Referral Management processes (there have been long standing central intake that supports 1 or 2 facilities). Prior to implementation, engagement was held with General Practitioner Liaison Officers and the Metro North Medical Local to ensure uptake of the CIM by MNHHS referrers would be successful. The CPI Unit was established around a predominantly administrative model with limited clinical review. To coincide with the implementation of the CPI Unit, the internally developed electronic referral management solution R-Track was deployed across all MNHHS Specialist Outpatients & Allied Health areas. This allowed for the electronic receipt, allocation and tracking of all external referrals received by MNHHS.

Results: Initial uptake of the CPI Unit saw 12,798 external referrals received in February 2014 (the first full month of operation). Since commencement of the CPI Unit on 28 January 2014, a steady increase has been recorded each month to the number of referrals received. In March 2015, the CPI Unit recorded its highest number of referrals received to date with 17,187 recorded for the month. Implementation of the Central Intake Model across MNHHS is ongoing, with full implementation scheduled for June 2016.

Lessons learnt: The reduced implementation planning time prior to the CPI Unit commencing operations resulted in a number of lessons learnt. One significant lesson learnt was the importance of documented referral allocation pathways from the CPI Unit across MNHHS. The reduced lead in time resulted in a decreased ability to conduct comprehensive engagement, resulting in the requirement for extensive consultation post-implementation by a unit that was managed by an Administrative Practice Manager, with overall clinical governance yet to be established.
12.20-12.40  Central Referral Hub

Angelina Zande-Wilkins
Director/Assistant Director of Nursing
Primary Care Partnerships Unit
Metro South Health, QLD

Carly Phillips
A/NUM Central Referral Hub
Primary Care Partnerships Unit
Metro South Health, QLD

Bio

Mrs Angelina Zande-Wilkins has been employed by Queensland Health since 1983 and holds a Bachelor of Business of Health Administration, Bachelor of Nursing and currently undertaking Master of Nursing (Leadership). Currently in the position of Director/Assistant Director of Nursing with an area of responsibility of Outpatient Reform, Angelina’s significant achievement in the past 15 months has been the planning and implementation of the Metro South Health Central Referral Hub to standardise management of outpatient referrals and improve data capture and reporting capabilities across the Health Service. Angelina is an Associate fellow of ACHSE, a member of the QUT Alumni and Queensland Nursing Union.

Abstract

The Metro South Health Central Referral Hub is a patient centred, dynamic and sustainable multidisciplinary service that will improve access to the right service at the right time, enhancing an integrated partnership approach between community, primary, and secondary care. Dedicated clinical and administrative resources provide the skills and knowledge to educate and provide advice to referrers regarding available services and waiting times for appointments in the Metro South Hospital and Health Service.

The service provides the infrastructure to develop, control, monitor and standardise consistent processes for referral management, assessment, correspondence and direction to appropriate and/or alternative community service ensuring patient safety throughout the process. The ‘No Wrong Door’ philosophy will promote confidence in the system and ensure all patients are receipted and actioned.

Benefits will be realised through:

1. Consistent, streamlined and standardised process
2. Simplifying the referral process for General Practitioners; improved satisfaction
3. Ensuring adequate information contained in referral to safely categorise
4. Load sharing across the HHS
5. Identifying alternative pathways if appropriate
6. Ensuring the initial new case attendance is a clinical consultation and not an administrative appointment.
7. Reduce patient duplication on outpatient waiting lists across the HHS
Metro South Electronic Internal Referral (e-Blue Slip)

Jennifer Brownlea, Michelle Reynolds, Kerry Spillane, Raksha Trengove, Tamara Wylie

Metro South Health Business Practice Improvement Officers (BPIO)

Metro South Health Primary Care Partnerships Unit, QLD

Additional Author: Angelina Zande-Wilkins

Abstract

Metro South Health Electronic Internal Referral (e-Blue Slip) is a web based application for internal referrals to Outpatient services, developed to ensure a standard, consistent practice across Metro South Health (MSH) hospitals and compliance with referral management and documentation. Internal referrals account for approximately 20-25% of all outpatient referrals received monthly within MSH facilities. The quality of clinical information, incomplete patient demographics and legibility of the referrals varies, delaying patient triage, categorisation and appropriate appointment scheduling. Paper based internal referrals were routinely completed manually and submitted via internal mail, fax or by hand delivery. These manual methods are time consuming and increase the risk of referrals being lost, delayed in transit or caught in a loop of redirection until the referral reaches the correct department.

In 2012, the Ambulatory Care Program team worked with the PAH Clinical Informatics team to develop a cost effective application for electronic internal referrals to replace the paper based system. The electronic referral was to provide a complete, legible referral both clinically and administratively in a timely manner ensuring the referral is directed to the correct specialty without delay. e-Blue slip was initially trialled in the ED at the PAH. Outpatient scheduling coordinators reported improved data quality allowing more efficient processing of referrals. With the success of the trial, e-Blue slip was rolled hospital wide at the PAH. The application is currently used within two of the major MSH hospitals, shortly to be implemented across all the MSH hospitals, and have had a significant impact, including:

- Nil lost/delayed referrals
- Improved referral quality to triage and categorise referrals
- Reduced turnaround time for processing referrals
- Reduced patient safety risks due to incomplete or lost referrals delaying triage, appointment allocation and patient treatment
- Better outcomes for patient due to timely appointments and treatment
- GP details captured ensuring clinical monitoring of patients while waiting for outpatient appointment

A number of key lessons learnt in the e-Blue slip implementation were:

- Ongoing education/promotion - imperative for uptake
- Improving accessibility to e-Blue slip, eg availability of computers, desktop icon, network login
- Establishing the inclusions / exclusions – prevent scope creep
- Interim measure – no funding for enhancements
- Remove all paper referral forms – will be used if still around
- Resistance of some users due to aversion to technology
- Change in process – referrals previously completed by Admin staff in some areas, now a clinician responsibility
- Differing referral processes within facilities
Streamlining allied health led outpatient clinics in preparation for centralised access

Raisa Shaikh
Allied Health Informatics Advisor, Clinical Manager of Nutrition and Diatetics
Monash Health, VIC

Bio

Raisa Shaikh works as the Allied Health Informatics Advisor and Clinical Manager of Nutrition & Dietetics at Monash Health (VIC). She has completed her bachelor’s degree in Nutrition & Dietetics and post graduate certificate in Palliative care in Aged Care (2006). She is also in the process of completing her Masters in Health Service Management (2015). Within her role of the Allied Health Informatics Advisor she has been involved in the development of the Allied Health DATA strategy for Monash Health. Raisa has finalised concise rules on how and what was recorded to measure clinical care and with Monash Business Intelligence unit (MBI) has developed easy to read and accurate in-patient reports. Raisa has also ensured that all Allied Health outpatient tier 2 specialist clinics are set up as per the DoH rules to ensure the readiness of Allied Health at Monash Health for the Activity based funding (ABF) and to meet the DoH key Access policy processes.

Abstract

Background: The Department of Health (DoH) published a Specialist Clinic Access Policy in August 2013. In March 2014, Monash Health performed a high level mapping and gap analysis for the relevant Monash Health Allied Health led outpatient clinics against the relevant DoH policy driven processes. Subsequently a project lead was employed in the Workforce Innovation, Strategy, Education and Research (WISER) Allied Health Unit at Monash Health. The purpose of this project lead was to identify the key gaps for Allied Health and align with the DoH processes ahead of June 2015 when these processes are set to become Key Performance Indicators (KPIS). Simultaneously the same project for Medical and Nursing led clinics was allocated to the Monash Health Director of Performance portfolio.

Project Aims: To map and streamline processes for all allied health led outpatient clinics such that they comply with DoH policy and provide a clear and consistent picture of activity. To design a streamlined process such that audit of compliance with the DoH processes is clear, simple and sustainable.

Methodology: All allied health led outpatient clinic processes were mapped and one standardised process was designed. A twelve week trial of this standardised process took place from November 2014 to February 2015. This was the first of its kind for allied health in Victoria.

Evaluation: A multipronged approach to evaluation included; administration data entry over the course of a twelve week trial; a medical record audit of 182 patient files; an online staff survey; Business Intelligence Unit (MBI) KPI reports; GP feedback; an issues log kept during the trial.

Deliverables Achieved: One streamlined process for pre-referral information, registration of referrals, acceptance and rejection of referrals and initial appointment bookings; A successful twelve week trial of a single point of administration and access for each site; Standard Referral form and Allied Health letter templates; Medical Record Audit establishing 100% compliance with all administrative based KPIs and 60% compliance with two clinical based KPIs around initial and discharge findings letters; Allied Health inclusion in MBI generated KPI reports; Business case for ongoing administrative resources required to meet DoH KPIs.

Conclusion: In order for the Allied Health led outpatient clinics at Monash Health to meet the DoH KPIs, an increase in administrative resource is required. There is an option as to whether this additional resource is kept internally or placed in a centralised access unit as per medicine and nursing led clinics.
Ambulatory Referral Management System (ARMs)

**Lloyd Wright**
Data Administrator, Central Referral Hub
Metro South Health, QLD

**Danielle Lemon**
Director Support Officer
Primary Care Partnerships Unit
Metro South Health, QLD

**Bio**

**Lloyd Wright** has been employed by Queensland Health for 9 years. During this time he has worked in several system management roles. He is currently the Data Administrator for the Metro South Health Central Referral Hub, supporting the Ambulatory Referral Management System. Lloyd’s primary task within this role is the design and testing of enhancement for the ARMs application.

**Danielle Lemon** has been employed by Queensland Health since 2010 and holds a Certificate III in Business and Medical Administration. She is currently in the position of Director Support Officer with responsibility to support the Primary Care Partnerships Unit Director in the Metro South Health Outpatient Reform. Danielle has been involved in the planning and development of the Ambulatory Referral Management System (ARMs) used within the Metro South Health Central Referral Hub which standardises management of outpatient referrals.

**Abstract**

The Ambulatory Referral Management System (ARMs) was developed specifically for the Metro South Health Central Referral Hub to support the provision of a patient centred, dynamic and sustainable multidisciplinary service. The clinician led application began development in October 2013 by the Metro South Health Clinical Informatics Technology Service in conjunction with the Metro South Health Central Referral Hub clinical project team. The need for a centralised application for outpatient referrals was identified in the project to ensure patient safety and efficient delivery of referrals to outpatient services. The application was to be purpose built to service the individual needs of each facility within the Hospital Health Service. As ARMs would be the base tool for the staff operating within the Metro South Health Central Referral Hub servicing multiple facilities, it was imperative that there was one application for all Metro South Hospitals. Prior to the implementation of ARMs, referrals were managed independently by each Metro South Health facility. This opened the way for GP’s to refer their patients to multiple Metro South Health facilities creating duplication and increasing waiting times. The Metro South Health Central Referral Hub staff utilise ARMs in conjunction with other hospital scheduling systems to identify these patients already listed at multiple facilities.

Since the implementation of ARMs, the following results have been identified;

- Reduction in duplicate referrals
- Increase in efficiency of receiving, inputting and assigning referrals to services
- Patient safety ensured by minimising delay in referral registration thereby reducing the risk of misplaced referrals
- Consistent feedback provided to the patient regarding their referral progress

Many HHS’s from around QLD, Melbourne, Perth, Darwin and SA have visited the Hub and are considering ARMs implementation as a form of referral and triage management.
The Kids Rehab eMR Project - Improving non-clinical support systems for clinicians working in an ambulatory outpatient setting.

**Lynn McCartney**
Clinical Nurse Consultant, Cerebral Palsy & Movement Disorder Service, Kids Rehab
The Children’s Hospital at Westmead, NSW

**Bio**

*Lynn McCartney* is a Clinical Nurse Consultant with over 20 years’ experience working in the specialty of paediatric rehabilitation. As well as her specific clinical role working with children and their families with disabilities, Lynn has an interest in team processes and service delivery models to improve quality patient care in the ambulatory setting. Lynn was the clinical lead on this project to lead a department through a significant process of change.

**Abstract**

Kids Rehab and the Electronic Medical Record (eMR) Unit at the Children’s Hospital at Westmead have collaborated to develop an electronic workflow in the patient eMR to standardise referral management, document clinical assessments, intervention and outcomes, and streamline communication about patient management plans and rehabilitation goals. The project aimed to improve clinical documentation in the patient eMR, reduce duplication of patient data into different systems and capture mandatory activity reporting. Kids Rehab is the first department in this hospital to build their workflow into the eMR through a custom designed system that combines information from PowerChart, Patient Management, Scheduling, an existing patient database and paper records. The build consists of template forms, automated letters, collection of clinical activity for activity based funding requirements, and data for third party billing requirements as a real-time byproduct of clinical documentation.

In August 2013 a multidisciplinary project team was established to progress the project. Sponsorship support from the Head of Kids Rehab and the eMR Manager ensured the project was prioritised without reducing clinical services. The team met regularly to discuss form design and workflow processes. Forms were trialled within the PowerChart ‘BUILD’ environment to limit risks in the live PowerChart system and familiarise the project team with PowerChart functionalities. As part of the implementation strategy significant time was given to training clinicians prior to the July 2014 go-live date.

**Results:** Prior to the project, there was only one electronic form available for clinical documentation in the eMR. Six months prior to go-live there were 2089 ad-hoc entries for Kids Rehab patients in PowerChart. In the 6 months post go-live, 3549 ad-hoc entries have been made, a 70% increase in accessible clinical documentation in the eMR.

There has been a 30% increase in mandatory ABF reportable activity in the 6 months post go-live. A monthly data report built into the new system allows tracking of clinical activity to specific patient groups to facilitate service planning and ensure resources are being directed appropriately.

A post-implementation staff survey identified positive aspects to the new documentation system: 1) the collaboration and support given to clinicians by the eMR Unit 2) effective communication about the aims and objections of the project along the way 3) the training offered by the Kids Rehab project team who were familiar with clinical needs in developing the system.

**Lessons Learnt:** The collaboration of clinicians with IT professionals became a rewarding aspect of this project as it integrated team members with a clinical focus with those skilled in system programming components. Regular consultation of the design work occurred at Kids Rehab clinical team meetings to showcase forms and obtain feedback. In this way all staff, not just the project team maintained engagement in the project which facilitated a smooth implementation and has built capacity in the new workflow system.
The introduction of a patient self-check in and SMS calling system (QFlow).

Stephen Tucker
Manager, Specialist Clinics
Royal Children’s Hospital Victoria

Britta Saunders
NUM, Specialist Clinics, Royal Children’s Hospital Victoria, VIC

Bio

Stephen Tucker has been the operational manager of Specialist Clinics at RCH for 2 years. He was previously associate program director for Specialist Clinics at Eastern Health, and prior to that worked in both a management and clinical capacity as a podiatrist.

Abstract

The Royal Children’s Hospital provides over 240,000 specialist clinic consultations per year, with all patients attending with at least a parent and or carer and often accompanied by siblings and other family members. This activity was leading to long queues at appointment desks and overcrowded waiting areas.

To overcome the queuing and crowding in the waiting areas an innovative patient check-in, calling and patient follow up system was put in place.

Patient queuing and calling systems have been introduced into other hospitals, but I believe that RCH is the 1st hospital to link the system with SMS messages, that advise the patient when the clinician is ready for them, and instructs them which clinical room to proceed to. A mobile phone App has also been developed for patients to check upcoming appointment, as well as check in from near the hospital via their phone. The check-in system also includes a post consultation form which is completed by the clinician, and provides information to clerical and billing staff regarding the outcome of the appointment.

A project manager was appointed, and steering committee formed. The steering committee was responsible for decision making and sign off for all design aspects. Clinic patient flow was observed and modified to optimise the calling system. At go-live additional human resources were in place aid the transition to a new system for clinicians, who despite our best effort did not all attend training.

Results:

- After some initial issues, and required refinements fewer patients are queuing on arrival.
- Families are happier to leave the clinic area while waiting for an appointment.
- Patients requiring follow up appointments are no longer lost.
- Results of patient satisfaction survey across specialist clinics indicates improved satisfaction with clinics operations.
- Staff have been able to be reallocated to other tasks.

Lessons learnt:

- Lack of fully functioning test environment before go-live caused some early glitches
- Don’t expect clinicians to attend training
- Be very specific in the functional brief provided to vendor.
Patient self check-in and ELECTRONIC calling reduces in-clinic waiting time

Colleen Jackson
Quality and Project Manager, Specialist Clinics
Austin Health, VIC

Bio

Colleen Jackson has completed a Masters in Nutrition and Dietetics, further studies in research methods, and has over 18 years of experience as a clinician. As a senior dietitian, she fulfilled an operational leadership role where she monitored performance and implemented changes aimed at improving the efficiency and quality of clinical care. More recently she has focused on project co-ordination and service redesign on a broader scale.

Abstract

Background: Specialist Clinics at Austin Health has introduced an electronic queue management system known as Q-Manager. The first of its kind in Victoria, the innovative system allows patients attending Specialist Clinics to check themselves in. Following patient check-in, clinicians are required to call and complete their consultations electronically. This provides a platform whereby in-clinic wait time and clinician consultation time can be measured and addressed through the analysis of data that was not available previously. The initial implementation occurred at the Austin campus in October 2012 followed by a progressive roll out of the system at the Heidelberg Repatriation Hospital campus by September 2014.

Objectives
- To address in-clinic wait times
- To improve check-in efficiency
- To ensure ongoing integrity of patient records
- To reduce overcrowding and noise in waiting rooms

Methods:

Reports extracted from the Q-Manager system are able to determine the usage of self check-in machines by patients and the compliance of clinicians with electronic calling and completing. Where a clinic is compliant with calling and completing, median wait time has been established and reported monthly. Additional observational data was collected in the clinic waiting room before and after implementation of Q-Manager. The site of this data collection was Ground Floor Tobruk, Heidelberg Repatriation Hospital. 66 patients waiting in Clinic B-Orthopaedic Surgery 3 were observed.

What did not work:
- Limited screen sensitivity of check-in machines
- Ticket printer issues

In-clinic wait times

Clinic appointment schedules are reviewed regularly together with the Q-Manager reports. This has enabled improvements in scheduling appointments to achieve the 20-minute wait time target.

Example - APGASTRO clinic where the wait time was reduced by starting the clinic later and spreading out the appointments. By improving the clinic’s patient wait times, median wait time has dropped from 33 minutes (Oct 2012) to 26 minutes (May 2014)

Lessons Learnt
- Signage delays & variation challenging
- Difficult to engage clinicians to ‘complete’ consultation
- Consumers wanting to know more – what is my wait time?
- Training requirements need to be mandatory
- Technical requirements (e.g. automated rebooting)
A Team Approach to Data Quality

Shane Downey
Manager Data Services
Mater Health Services, QLD

Susan Gardiner
Practice Manager, Ambulatory Services
Mater Health Services, QLD

Bios

Sue Gardiner, Practice Manager/BPIO, Mater Health Services
Sue is the Practice Manager for Ambulatory and Outpatient Services at Mater Health Services South Brisbane. In 2012, as part of the initial BPIO team, she was tasked with the preparation for patient level reporting of non-admitted patient activity. Sue’s prior role of Nurse Unit Manager in the service has also given her an in depth understanding of the clinical demands on the service. She is passionate about promoting data quality; which in turn enables accuracy of reporting, a shared understanding of the service’s business, and most importantly, ensuring that care delivery is maximized to patients in need.

Shane Downey, Data Services Manager, Mater Health Services
Shane is a dedicated and outcome focused Information Technology and business professional with an extensive track record of achieving business outcomes. He is recognized for significant contributions to a variety of organizations over a career spanning some 20+ years, including land information management, banking and insurance, finance and wealth management, retail, manufacturing, and healthcare. Shane possesses strong leadership and management practices, with a collaborative approach to achieving and exceeding goals, and mentoring and coaching to foster a culture of teamwork, enterprise and innovation.

Abstract

The introduction of the national pricing model for public outpatient services (what is referred to as Activity Based Funding or ABF) represented a real challenge to an organization using best-of-breed health solutions. With data and information being captured in several key systems (i.e. separate Patient Administration Systems (PAS) for insured and non-insured patients, theatre booking and management systems, pathology, pharmacy, and oncology – the list goes on) how could Mater Health Services (MHS) meet this new requirement to provide accurate Patient activity data within the required timeframes? Our solution was to leverage our existing clinical data integration middleware platform, and utilising the principles and practices of Master Data Management, MHS have established a centralised ABF repository for reporting of all outpatient services. The benefits of this approach include a reduction in the amount of time required to prepare statutory reporting, a reduction in the amount of data quality errors, and opportunities for providing value added services.

Team Project Award Winner, 2014 Data Quality Asia Pacific Awards
Allied Health Specialist Outpatient Clinics: New models of care to enhance care, drive throughput, and reduce wait lists

Michelle Stute
Allied Health Workforce Development Director
Metro North Hospital and Health Service, QLD

Marita Plunkett, Allied Health Workforce Development Officer, Royal Brisbane and Women’s Hospital,
Prof Tracy Comans, Metro North Hospital and Health Service District and Menzies Health Institute, Queensland,
Griffith University, Dr Simon Finnigan, Research Coordinator Allied Health Professions, Royal Brisbane and Women’s Hospital,
Maree Raymer, A/ Program Manager Neurosurgery/Orthopaedic Physiotherapy Screening Clinic and Multidisciplinary Service, Royal Brisbane and Women’s Hospital, Dr Merrilyn Banks, Director Research, Allied Health Professions, Royal Brisbane and Women’s Hospital, Peter Buttrum, A/Director Allied Health Professions, Royal Brisbane and Women’s Hospital,QLD

Bio
Michelle Stute is an Occupational Therapist with a Masters in Health Services Management. Michelle’s current role is an Allied Health Workforce Development Director with Metro North Hospital and Health Services. In recent years her work has focussed on supporting allied health teams to implement new allied health-led models of care to reduce wait times, provide patient enhanced care and support full and advanced scope roles for allied health practitioners.

Abstract
In 2014, Metro North Hospital and Health Service (MNHHS) located in Brisbane had over 34 000 people waiting for their first appointment with a surgical specialist. Innovative, feasible models were required to achieve MNHHS’s goal of a 50% reduction in long waits within a 12 month period. Allied Health Practitioners (AHPs) are able to screen and manage a variety of conditions in several specialty areas and therefore this represented a significant opportunity to develop new, enhanced models of care. Ten new models of care were developed to provide allied health first contact care to suitable patients on six surgical specialty waiting lists. The specialties involved were: ear, nose and throat (ENT); orthopaedics; plastic surgery; gynaecology; urology; and neurosurgery. The aim of this study is to present the development and progress of AHP led models of care within MNHHS.

How is it innovative? Some of the service models developed were the first of their kind within MNHHS. Some built on established AHP led services in orthopaedics/ neurosurgery while others had exemplars in other states, or were the first known examples nationally. There is no known common data collection framework for this range of AHP specialist clinics.

Implementation: What worked and what did not work: AHPs worked closely with relevant stakeholders across multiple surgical specialties to redesign clinical pathways and governance. A rigorous service evaluation and reporting framework based on prior research in orthopaedic outpatient services was established to closely monitor outcomes and demonstrate productivity and efficiency.

Results: The new models were operationalised from March 2014. The process followed has ensured strong stakeholder support for these models. Crucial to demonstrating their value is data collected according to the reporting framework which includes throughput, waiting times, clinical outcomes, patient experience, service utilisation, safety and discharge outcomes. This data will be reported six monthly to relevant stakeholders to ensure the services are meeting MNHHS objectives.

Lessons learnt: This project highlights the need to have proposals drafted and stakeholders engaged to quickly respond to funding opportunities to meet organisational priorities. Financial data including cost and revenue projections is frequently requested, but has been weak in many allied health submissions to date. This project offers a rigorous reporting framework that may assist others to demonstrate the value of AHP led services as a strategy to drive throughput, reduce wait lists and provide patient focussed care.
From hand maiden to autonomous practitioner-Development of nurse clinics at ManukauSuperClinic

Sandy Ryan
Nurse Educator Ambulatory Care
Counties Manukau Health, NZ

Bio

Sandy Ryan is the Nurse Educator for ManukauSuperClinic, providing professional development and education for staff working in outpatients. Sandy has been nursing for over 30 years with experience in Surgical, Plastics and Intensive Care nursing. She has completed her Masters in Health Science and has an Advanced Nursing Postgraduate certificate. Sandy has a passion to promote nursing and encourages nurses to maintain a strong professional focus and ensure the patient experience is optimized.

Abstract

Nurse Clinics were established to provide a sustainable framework for the delivery of improved patient care in outpatients within Counties Manukau Health (CMH) across a variety of services. The wound nurse clinic in the Plastic-Hand surgery service was the first clinic to be established using the framework, which has now extended to both medical and surgical sub-specialties at the ManukauSuperClinic.

Nurse-led Clinics are an established method of service delivery in many areas of New Zealand and internationally. However we have introduced Nurse Clinics where the registered nurse has their clinic alongside the medical team and manages patients within a plan of care and their scope of practice as an RN working to Nursing Council New Zealand (NCNZ) competencies. The clinics are evidence based and utilise nursing knowledge to deliver holistic care to meet the patients/family/whanau needs. Nurse Clinics provide effective use of clinical resources and work collaboratively alongside medical colleagues not in exclusion. Nurse Clinics provide a career path for nurses to advance their professional practice onto nurse specialist and nurse practitioner pathways.

When capacity issues continue to put pressure on services to meet targets, the nurse clinic helps reallocation of patients to be seen as follow-up and following the plan of care directed by the clinician, thus the nurse clinic enables clinicians to see more urgent cases and improves First Specialist Appointment time lines and helps meet the Ministry of Health initiatives of patients to be seen within four months from time of referral.

There has been improved patient flow in the clinic, with better utilisation of resources and greater nurse autonomy. What was initially a quality improvement project, the nurse clinic concept has become an accepted and established part of clinical practice for outpatients. Concepts from change management were employed to help staff adjust to working in an autonomous fashion rather than be the hand-maiden for the doctor and we have seen nurses develop to nurse specialist and potential nurse practitioner level easily. There is a reduction in patient wait times during clinic waiting and patient experience is positive.

The templates for the policies, procedures and guidelines allow the local services to individualise the entry and exit criteria to meet their service requirements. Nurse clinics are a proven method of health care delivery that provide quality outcomes for patients/family and their whanau.
Can we improve the flow for patients referred to Gynaecology / Urogynaecology outpatients with incontinence or pelvic organ prolapse?

**Helen Edwards**

Physiotherapist Advanced, Continence & Women’s Health
Metro North Health, QLD

**Bio**

**Helen Edwards** is a titled APA Continence & Women’s Health (C&WH) Physiotherapist. In her current role as a Clinical Physiotherapist Advanced she is the lead clinician in the Gynaecology Physiotherapy Screening Clinic (GPSC) at Caboolture Hospital. She is currently involved in a research project with RBWH looking at the effectiveness of a GPSC in improving health outcomes and access to care for women on Gynaecology waiting lists. This project has been supported by a novice research grant awarded by Health Practitioner Research Scheme 2015.

**Abstract**

This project involved reviewing the process for managing patients referred to Gynaecology/Urogynaecology for urinary / faecal symptoms as well as pelvic organ prolapse (POP). Funding was obtained through Metro North Resource Committee Surgical Avoidance Clinics project, to establish Gynaecology Physiotherapy Screening Clinics (GPSC) at Royal Brisbane and Women’s Hospital (RBWH) and Caboolture Hospital in March 2014. GPSC targets women who have been referred to outpatients with urinary or faecal incontinence, frequency, urgency or POP. These women were facing lengthy delays (up to 12 months) prior to any intervention with conditions that have a significant impact on their physical, psychological and social wellbeing. Conservative management has been recommended as first line treatment in many of these conditions before any surgical intervention, and pelvic floor muscle training has also shown significant benefits with POP and for women undergoing surgery for POP and/or urinary incontinence.

The concept of Physiotherapy led screening clinics in Orthopaedics has been well established and is widespread across Queensland, however Gynaecology physiotherapy screening clinics have not been tried previously in Queensland Health, or interstate at the time of project commencement. The GPSC clinics include a lead Physiotherapist (C&WH), as well as treating Physiotherapists and a Continence Nurse Advisor (Caboolture Hospital). Referrals to Gynaecology/Urogynaecology outpatients are screened by the Gynaecologist, or the lead Physiotherapist as being suitable for GPSC. Those patients are then offered an appointment in GPSC and a comprehensive initial assessment is undertaken by the lead Physiotherapist. If appropriate, conservative management is then implemented. Following treatment the patient is either removed from the waiting list, remains to await Gynaecology/Urogynaecology review, or recategorised for earlier review. Case conference occurs with the consultant as necessary, which allows concerns to be raised, earlier review initiated or additional investigations organised as appropriate. GPSC clinics also work closely with the patients General Practitioner which allows medication trials if appropriate. Initially category 2 and 3 patients were included at RBWH however this was later modified to category 3 patients only at both sites.

- Establishment of GPSC appears to allow patients access to earlier treatment;
- Gynaecology appointments after GPSC are more efficient – patient has already completed conservative management, investigations completed where appropriate and decisions regarding surgery are often able to be made at the initial visit;
- A significant number of patients seen in the GPSC were able to be removed from the waiting list reducing the demand for outpatient appointments;
- Provision of timely, appropriate conservative management is also likely to improve surgical outcomes;
- Early initial screening identifies women who require earlier intervention and more urgent review than initially indicated on the referral.

This is currently in progress – a novice research grant has been awarded by Health Practitioner Research Scheme to formally evaluate the effectiveness of GPSC in improving health outcomes and access to care.

**References**

1) Milsom I et al, 2013 ‘Epidemiology of Urinary Incontinence (UI), and other Lower Urinary Tract Symptoms (LUTS), Pelvic Organ Prolapse (POP) and Anal Incontinence (AI)’. In 5th International Consultation on Incontinence, Paris, European Association of Urology.
Tuesday 20 October 2015

09.00-09.30  **Keynote Address**

Integration and Acceleration—lessons from 10 years of Redesign in NSW

Raj Verma
Director Clinical Program Design and Implementation
NSW Agency for Clinical Innovation

Bio

**Raj Verma** has been involved in working with clinicians, managers, executives and patients in improving health systems since 1995. Raj has delivered many large scale projects through structured project management, significant stakeholder engagement, and a focus on deliverables and results.

Raj has worked to improve the efficiency and effectiveness of health care services through new models of care at almost every point of the patient journey, including models of Emergency Care, redesigning Hospital in the Home services, implementation of Medical Assessment Units, safe clinical handover, Rehabilitation Redesign, Improving Patient and Staff Experience program and creating the NSW Patient Experience Survey.

He has been involved in running and sponsoring the NSW Centre for Healthcare Redesign Diploma Program (Redesign School) since its inception in 2007.

Raj gained his initial clinical experience working as a hospital Medical Laboratory Scientist at Royal Darwin Hospital. Raj is passionate about improvement and innovation.

Twitter: @raj_verma1
Bio

Sue Langdon, General Practice Liaison Officer (GPLO) for the Mackay Region, BA Nursing, Midwife, GradDip Quality, MBA. She has worked in many areas and positions in Canada and Australia as a clinical nurse and in senior management positions. The last ten years in Aboriginal health in Torres Strait, Northern Territory and Kimberley’s in Western Australia as a Senior Manager. She has a proven record in quality, integration, implementation and evaluation. I have set up new services in rural area, built on services in larger regional hospitals to managing geographically isolated health services. Sue commenced in July 2014 in the GPLO position in Mackay, with a passion to improve integration and coordination of care between primary and secondary care. The combination of her experience with that of the enthusiastic team in Mackay has allowed for adoption of fresh and innovative approaches to integrations.

Abstract

Over the last year Mackay Hospital and Health Service in partnership with the Medicare Local, (now the Primary Health Network) worked together to break down the barriers between hospital and primary care, looking at the system silos both internally and externally. We focused on integration, communication, improve connectivity between GPs and hospital and build relationships.

The main tools used to build links between services and to confirm the value of local expertise, to support integration were project to reduce outpatient long wait and the establishment of the Mackay HealthPathways.

By working together we have developed solution orientated approach were all have an equal voice and are considered fundamental to how we support the Patient on their journey.
10.10-10.30 Specialist Outpatient Services (SOS) Project

Sarah Jane Waller
Senior Project Officer, Outpatient Services
NSW Ministry of Health

Additional Authors: The Specialist Outpatient Services Steering Committee

Bio

Sarah Jane Waller worked at St Vincent’s Hospital for over 7 years with an array of hats including Operating Theatres NUM, A/Nurse Manager Peri-Operative Services, A/Waitlist Manager and A/Nurse Educator Peri-Operative Services before being seconded to the Ministry of Health in 2013 to the Surgical Access Line. She has co-ordinated many projects at a local level and enjoyed the learning curve of contributing to State wide initiatives. In her current role she is co-ordinating the Specialist Outpatient Services Project which, for the first time in NSW, will provide a policy for Outpatient services together with supporting material for hospitals. “Be stubborn about your goals and flexible about your methods” has enabled her to maintain her focus on improving patient access to the public health system whilst negotiating the inevitable barriers that all projects face.

Abstract

Why? Issues at a NSW hospital were reported in the media in mid-2013. A letter from the hospitals’ eye clinic stated “that due to high demand there is approximately a 2.5 year wait for an appointment”. When investigated further, it became clear that there was an issue with the reliability of data reported for Specialist Outpatient Services (SOS) including waiting times. This highlighted a lack of a SOS Framework and clear policy statement about the scope of SOS.

What Where and When? The development of:

- A Specialist Outpatient Services Framework
- A SOS implementation Toolkit
- For NSW public hospital in 2015.

Is it Innovative? For the first time in NSW, hospitals, clinics, staff, referrers have a SOS Framework containing roles and responsibilities explaining expectation and protocols for Specialist Outpatient Services promoting service integration and timely patient access.

Results: All sites now report Outpatients wait time information and the numbers of patients waiting for an appointment to the Ministry of Health quarterly. Since the original request for Outpatients wait time data in 2013 there has been a refocussing of SOS in NSW resulting in local attention to Outpatient clinics. Consequentially there has been a marked decline in the numbers of patients waiting for an appointment through the introduction of auditing processes and the introduction of a SOS KPI in to the Service agreements with the Local Health Districts and Specialty Health Networks (LHDs/SHNs) that monitors the numbers of patients waiting longer than 365 days for an appointment. Sites are addressing their processes to improve services through the utilisation of the SOS Toolkit which provides a dashboard of indicators that demonstrate a “healthy” Outpatients clinic.

Lessons Learnt:

- Do not reinvent the wheel – NSW is the last Australian state to embrace a SOS Policy; network with interstate colleagues to learn what works.
- Just because the wheel has been around for years; don’t expect the locals to embrace it – Entrenched practices in NSW clinics however convoluted and impractical are still their own practice. The importance of effective change management and demonstrating the “what’s in it for me” in order to sustain the change.
- Not all wheels are the same – Overarching principals need to be centrally driven but locally led and implemented to ensure successful integration.
- It’s better to beg forgiveness than ask permission – never underestimate the power of the informal network to get things done.
Consumer to Consumer Outpatient Experience Surveyor Program (C2C Program)

**Mellita Kimber**

Consumer Engagement Coordinator, SALHN
SA Health, Southern Adelaide Local Health Network (SALHN)

**Co-contributor:** **Catherine Hughes**, SALHN

**Bio**

**Mellita Kimber** is the Consumer Engagement Coordinator for Southern Adelaide Local Health Network in SA Health. She has been working in Consumer Engagement for eight years. Her role is to work closely with both staff and community to increase knowledge and skills in community participation; promote, recruit and support consumer representatives and build capacity and provide on-going support for a culture of consumer centred care. She is a member of the International Association for Public Participation and has completed their Certificate in Consumer Engagement and Online Engagement.

**Abstract**

The C2C Program is an innovative program established by SALHN on 1 July 2014 and is based on consumer led interviewing of patients. It presents an opportunity for consumers to share their outpatient experiences in order to assist the organisation to collect both qualitative and quantitative data to drive and support patient centred care and safety & quality reform initiatives. It is a robust program that includes processes that manage all areas of the program including: recruitment, orientation, training, management and reporting. These processes were established to enable the program to be implemented to across multiple sites. The key aim in developing the processes was to ensure that there was constancy in training and orientation but opportunity to make site specific adjustments.

To ensure the success of the program, it was important to have a multidisciplinary approach; the following stakeholder groups were engaged from the survey tool development to pilot program design, implementation and in the program’s evaluation: Consumers; Clinician’s; Administrative Staff– Clinical Governance, Outpatients and Department of Health. The strength of this program has been the collaborative engagement approach. This program has enabled us to increase the engagement of consumers from culturally and linguistically diverse backgrounds: 33% of consumers identified as being from a CALD background; 10% were from non-English speaking backgrounds and 3% were Aboriginal or Torres Strait Islander Background. Outcomes from this program have been driven by two sources, consumer suggestions and data. Key outcomes from the program have included:

**Consumer Driven:**
- development of a volunteer concierge service;
- waiting time boards;
- re-design of patient friendly waiting areas including toys for children and improved privacy
- review of Patient Information;
- Consumer led appointment booking, offering consumers more choice;

**Data Driven:**
- Governance process being established for review of Consumer feedback and monitoring of quality improvement outcomes;
- establishment of project Groups set up to educate Consumers about the Charter of Rights and consumer feedback mechanisms;
- introduction of Customer Service Training with Consumers involved in the facilitation.

Whilst improving the experience of consumers and/or carers this program also positively impacted on:

- Consumer Surveyors by providing them with a sense of achievement by meaningfully contributing to the collection of consumer stories and data and the development of skills and knowledge relating to health administration and project management.
- Staff by offering real time feedback and data which has led to a sense of achievement and work satisfaction, whilst also offering opportunities to develop new skills through supporting the implementation of projects.
Tuesday 20 October 2015

11.25-11.45 Out of the box-creating ambulatory rehabilitation efficiency
Ann Coe and William Dang

Rehabilitation Day Therapy Unit, Internal Medicine Services
The Prince Charles Hospital, QLD

Bios
Ann Coe has extensive experience in rehabilitation and aged care since 1999. Since 2007, she has overseen and supported the delivery of service at RDTU with a focus on quality patient centred care. Ann has a Bachelor of Nursing and a Bachelor of Education (Hons) - Adult and Community Learning. She has a special interest in multiple sclerosis and has been a member of the Australian Rehabilitation Nurses Association (ARNA) since 2006. William Dang has worked across multiple services within TPCH since 2007. From 2011, he has provided inpatient and outpatient occupational therapy within the Internal Medicine Service. He has a special interest in the area of upper limb hypertonicity management. William has a Bachelor of Occupational Therapy (QLD), and previously received practice commendations for the ongoing clinical education of occupational therapy students.

Abstract
Ambulatory rehabilitation plays a significant role in the process of community integration for patients transitioning from a hospital admission. However, there is limited literature available on general ambulatory rehabilitation models of care nationally and internationally. There is also a knowledge gap in terms of the common quality outcome and performance indicators for the measurement of an ambulatory rehabilitation service. The Rehabilitation Day Therapy Unit (RDTU) at The Prince Charles Hospital has been providing ambulatory rehabilitation services since the year 2000. This initiative aims to describe how using clinical redesign methodologies can improve efficiencies of the service through evaluation of the current model of care, diagnostic identification of gaps in service provision, and establishment of solutions to enhance the patient experience.

Method: Six (6) members of the RDTU MDT (multidisciplinary team) participated in a series of workshops developing skills in project management and clinical redesign following successful application to the Queensland Institute of Clinical Redesign (QuICR) school. The workshops commenced in May 2014 and completed in February 2015. During this time, a literature review was completed, evaluation of the current model of care, and benchmarking performed. The project was conducted in five stages involving project planning, diagnostic mapping, solution design, implementation and sustainability.

Results: In the planning stage, the need to improve the patient journey was identified as the highest priority. In the diagnostic phase, the redesign team analysed five (5) years of local data collected within ambulatory rehabilitation and completed surveys and workshops with internal and external stakeholders. Results highlighted that inconsistent referral pathway and management led to prolonged patient journey and time delay in service delivery. From the diagnostic phase, the team transitioned to solutions design phase and proposed solutions pertaining to defining the service profile, model of care, knowledge of service, referral process, triage of referrals and engagement of consumers. The implementation phase was carried out by focusing on referral process through streamlining of referrals by employing an electronic referral system for internal referrals and central patient intake system for external referrals. As a result, we have achieved: (1) referral intake has been shortened from previous 3-5 days to current within 24 hrs on average; (2) referrer acknowledgement within 48 hrs, which was not previously a routine process; (3) booked appointments available within 2 weeks; (4) simplified journey of referral to flow through to end point from previous 26 steps to the current new process for 13 steps; (5) having a clinical nurse as one gatekeeper at entry point of referral processing for triaging then passing onto the administration officer for acknowledgement and bookings has created a time efficiency of between 4 -7 days; (6) created clinical care efficiency by saving previous bookings and meeting time for clinical care, which equates to 2 extra therapy sessions now available.

Summary: The RDTU team has successfully participated in a clinical redesign project addressing the ambulatory rehabilitation service in the Rehabilitation Day Therapy Unit. Improvement in the referral process has achieved clinical efficiency. Next step moving forward is sustainability, aiming to maintain the efficiencies achieved and progress other carparked initiatives. This will be an open-ended process requiring MDT team members’ involvement and is cost neutral without extra resource. Re-evaluation of established services will rely upon support from the MDT members to enable standardised high quality service provision. The further research study on the efficiency of ambulation rehabilitation services will help us achieving a successful service model in the future.

Acknowledgements: We gratefully acknowledge all the support provided by Ms Leah Thompson, Dr Keren Harvey, Mr. Kevin Clark and Mr Andy Carter.
Using a Rapid Improvement events to kick start reforms in Outpatients.

Lauri O'Brien
Principal Redesign Consultant
Health Services Innovation Tasmania, UTAS

Additional Author: Di Mulcahy, Clinical Redesign Program Officer, Health Services Innovation Tasmania, UTAS

Bio
Lauri O'Brien has over 30 years’ experience in the health care sector as a midwife, senior clinician, clinical governance and change management roles in South Australia and interstate.

Her role in Health Services Innovation Tasmania is predominantly mentoring and enabling the Program Officers across the state to implement change using predominantly the Lean methodology has seen her facilitate widescale projects which have large cultural and change management component.

Abstract
As part of the Clinical Redesign program care across Tasmania, Outpatient waiting lists was seen as a substantial issue. For surgical patients this had the potential of being a gate keeping exercise before many proceed to the surgical waitlist.

We used a Rapid Improvement model, which entailed choosing five units to begin with, based on size of wait list, missed opportunities such as cancellation rates and Did Not attend rates and the willingness of clinicians to engage in this 6-8 month redesign program. Neurosurgery, Ophthalmology, ENT, Plastics and Gastroenterology came together in March 2015 for a two day workshop and presented their prepared homework of their current state. By the end of the two days, we had mapped the patient journey, identified the opportunities, undergone some lean training including visual management and started an action plan to reform each specialty. The ability to cross pollinate across each unit as they presented their ideas was invaluable. The units were supported by a Clinical Redesign program officer and Clinical Services Officer

Outcomes included introducing nurse led clinics and telehealth, standardising referrals, reviewing of letter generation in ipm (IT system) to improve communication to referring GPs, triage practices and Did not attend processes, clerical auditing of wait lists, redefining core business, different “on the day” models to enhance flow and sharing care with Gp’s and other clinicians outside of the Acute care system.

Part of the redesign process included visibility of services on a public website and the average wait times per category for each specialty. There has been strong collaboration with GP liaison and Primary Health Tasmania (formerly TML) which has given a pathways for socialization of the activity as it progresses per specialty.
Camera Rolling! Our innovative marketing approach for clinical redesign of outpatients

**Catherine Hughes**
Manager Strategic Projects Unit
SA Health, Southern Adelaide Local Health Network

**Bio**
Qualifying as a pharmacist, Catherine Hughes was the first Director, Country Pharmacy Services SA Health overseeing operations at 58 Hospitals and implemented Pharmaceutical Reform in country SA. Seeking the opportunity to make health-system-wide impacts she left pharmacy to become Manager, Strategic Projects Unit for Southern Adelaide Local Health Network. This has resulted in her leading a suite of reform projects including implementing changes to Outpatients, pathology, transport, aged care, ACAT and partnerships with primary care.

**Abstract**
The SALHN, like many other jurisdictions is burdened by an inability to turn the tides on increasing referral numbers, growing waiting lists and untamed growth in occasions of service in outpatients and frustrated clinicians. With pockets of specialties devoted to implementing outpatient redesign, the network was far from a critical mass to boast system-wide reform.

We wanted to inspire Heads of specialty units (HoU) to commit their team to the clinical redesign approach so in late in 2013, developed an innovative marketing strategy by creating a 15-minute documentary on outpatient reform with the stars being the Specialists from SALHN. To do this we engaged specialties who were “just getting started”, “on the journey” and those “already seeing results”. We asked them to share their motivations, outcomes as well as the challenges. They were encourage to be honest with their colleagues about what would be necessary to foster change and to explain not just what they did but how they did it. GPs from the region were also involved to add perspectives as to why reform would be important for them and their patients and suggesting some of the changes they would like to see.

Alleviating the concerns for participants of misrepresentation in editing and justifying why we taking a non-traditional approach was the greatest hurdle. This required building considerable trust between the project team and clinicians, as well as significant editing oversight to preserve integrity of the messaging.

The documentary was shown at the two major hospital campuses of the LHN in a grand round supported by a Q&A session with the HoU from within the video.

The attendance, especially by senior medical staff was extraordinary, keen to catch a glimpse of colleagues on the big screen. Even more positive was the level of engagement in the Q&A session and the resulting interest of new HoU in developing their outpatient reforms.

In reflection on all of the reform strategies within SALHN over the last two years this was the tipping-point for building awareness and priority for outpatient service redesign. SALHN now has 40 specialties with referral and triage and condition management guidelines for GPs on the internet and has seen massive growth in clinician led reforms for shared-care models, and reconfiguring outpatient service delivery.

*The documentary will be aired as part of the presentation of this abstract at the conference paired with a short introduction and opportunity for questions*
Establishing a combined hand therapy unit at the Royal Adelaide Hospital

Nicola Williams
Principal Physiotherapist, Outpatients & Specialty Services, Physiotherapy Department
Royal Adelaide Hospital (RAH), SA

Janelle Hill
Senior Occupational Therapist, Occupational Therapy Department, RAH, SA

Bio
Nicola Williams is the Principal Physiotherapist, Outpatients & Specialty Services at the Royal Adelaide Hospital (RAH). Nicola has gained extensive experience in the management of hand and upper limb conditions and is currently involved in developing a combined hand therapy unit at the RAH. Nicola recently had the opportunity to work within a combined hand therapy unit in the United Kingdom where she was able to gain invaluable experience to assist in this process.

Abstract
Background
Hand therapy at the Royal Adelaide Hospital (RAH) has traditionally required patients to attend either the Physiotherapy or Occupational Therapy Department or both, depending on their presentation or assessed needs.

Problem
The current provision of hand therapy across the two departments has created some duplication and inconvenience to patients. In a health climate where there is growing demand for outpatient services, ambulatory reform continues to be a priority for SA Health. The provision of an efficient and patient-centred hand therapy service is vital.

Intervention
The new RAH is scheduled to open in 2016 and will have a single hand therapy space. This has provided the impetus to develop a combined hand therapy unit staffed by both physiotherapists and occupational therapists, where both disciplines will be integrated to deliver an efficient and patient-centred service. In Australia and overseas there are combined hand therapy units in use, however, a literature search failed to find any reports of the process of developing a combined hand therapy unit. The process of developing a combined hand therapy unit at the current RAH in readiness for the move to the new RAH will be presented.

Conclusion
Learnings from the change process and future integration plans will be discussed.
**Background:** Low back pain (LBP) is the most prevalent musculoskeletal condition in the community and places great demands on hospital specialist services and primary care. Currently patients with LBP can wait more than 2 years for an outpatient appointment with the neurosurgery or orthopaedic spinal surgery clinic at Melbourne Health (MH). However, the evidence indicates that only a small percentage of patients have conditions that require or will benefit from spinal surgery. Delays in initiating appropriate non-surgical management can lead to deterioration and the increased risk of chronic symptoms and poorer health outcomes.

**BAC model:** The Back pain Assessment Clinic (BAC) model and care pathways were developed in collaboration with rheumatology, neurosurgery, orthopaedic spinal surgery, pain services and physiotherapy at MH. The BAC commenced in 22 July 2014 supported by Workforce Innovation Grant pilot (WIGP) funding from the Department of Health and Human Services (DHHS) and is one of the first primary care-based, tertiary back pain clinics in Australia. Clinics are located within primary care services. The clinic is staffed by two advanced musculoskeletal physiotherapists and a rheumatology registrar that work under the supervision of a rheumatologist, to screen patients for ‘red flag’ causes of LBP and to develop a comprehensive management plan. In the pilot phase of the project, a fortnightly central triage process was established involving representatives from neurosurgery, orthopaedic spinal surgery, rheumatology and physiotherapy reviewing all incoming spinal referrals to determine the most appropriate care provider, which for the majority (≥70%) translated to assessment and management in the BAC. Referrals are excluded from the BAC in the presence of ‘red flag’ or if there is a high likelihood of surgical intervention. The central triage process has now been streamlined to the rheumatologist undertaking all spinal triage. This was based on the pilot data that showed good agreement amongst all 4 clinicians. Patients assessed in the BAC as requiring non-surgical management are given priority access to enhanced community services, while those requiring neurosurgical, orthopaedic spinal surgery, rheumatology or pain services are fast-tracked for review within 12 weeks of referral.

**BAC evaluation:** The evaluation report of the BAC pilot showed very positive results. To date, the BAC has removed all (n=522) ‘in-catchment’ MH neurosurgery and orthopaedic spinal surgery waiting list patients. The majority of the referrals seen in the BAC were from neurosurgery (n=429, 83%), followed by orthopaedic spinal surgery (n=68, 13%) and rheumatology or chronic pain services (n=25, 4%). Forty eight per cent (n=250) were existing waiting list patients and 52% (n=272) were new referrals. Patients are seen in the BAC within 10 weeks of referral and attendance rates have been high (>85%). Fifty per cent of patients were referred for conservative management in primary care settings and commenced therapy within 2 weeks of referral. Twenty three per cent of patients were referred for further investigations (MRI (7%), x-ray (7%), bone scan (5%), and CT (1%)). In contrast to the neurosurgery clinics which routinely refer every patient presenting with a spinal issue for an MRI scan, the reduction in MRI ordering for patients seen during the BAC pilot represents a saving of $90,000 in MRIs alone to the health system. Only three per cent of patients seen in the BAC were referred for a surgical opinion. This indicates that the vast majority of patients can be appropriately managed in the BAC and do not require surgery. There have been very high levels of patient satisfaction and strong surgeon support for the BAC model. There have been no patient complaints or adverse incidents.

**Projected BAC activity:** The initial pilot phase looked at ‘in-catchment’ referrals only, but the model has now been extended to all appropriate spinal referrals to MH. The Victorian Department of Health has now granted funding for MH to act as a mentor site to roll out this model of care to another 2 health services, 1 metropolitan and 1 rural.
Evaluation of a pilot project to increase access to allied health services in four rural communities in South West Victoria

Jacinta Bourke
Regional Manager- Geelong
Western Victoria Primary Health Network, VIC

Natalia Haugh, Primary Care Consultant- Population Health Planning, Western Victoria Primary Health Network, Monica Murnane, Primary Care Consultant- GP Data & Business Modelling
Western Victoria Primary Health Network, Kay Widdicombe, Allied Health Manager, Colac Area Health, VIC, Lyndall McNeil, Primary Care Consultant, Western Victoria Primary Health Network

Bio
Jacinta Bourke has spent the last 22 years in the design, implementation and evaluation of health programs and services. More recently Jacinta has focussed on developing her skills in Population Health planning with a focus on disease streams and place based interventions. Much of Jacinta’s professional practice has been in rural areas and Jacinta is committed to working collaboratively to develop models that provide rural and remote communities with choice and access to evidence based care as close to their home as possible.

Abstract

Background: Based on the identification of an allied health service delivery gap by local rural health services and general practices, Barwon Medicare Local (BML) developed a Medicare Benefits Schedule (MBS) funded model implementing a multi-disciplinary approach to diabetes care in rural communities. A team of allied health providers (diabetes educator, podiatrist, dietitian) contracted through Colac Area Health (CAH) provided face to face and tele-health visits in four rural communities in South West Victoria from 1 Feb-30 June 2015. This model was an innovative approach to utilising existing resources within CAH to fill service needs in nearby rural communities using established relationships with general practices and MBS items to privately fund clinician time for patients on Chronic Disease Management plans. This project was evaluated by BML in June to assess barriers and enablers to implementation, client and GP satisfaction and short term effectiveness.

Method: A mixed methods evaluation design was used. Service utilisation data was collected from CAH and general practices and survey data was collected from clients (n=20) and general practices (n=5) involved. A focus group was undertaken with the allied health providers (n=3) and an interview conducted with CAH.

Findings: Across the four communities there was an increase in the number of; individual clients seen, occasions of service, tele-health services delivered and claims for chronic disease management MBS items. All clients surveyed were satisfied with the services and would use them again in the future. GPs were satisfied with the level of support, information and engagement received throughout the project. Allied health providers and GPs outlined the benefit of the project in delivering services closer to people homes. Key enablers included; champion GPs to drive the project, quality of resources and support provided by BML, opportunities created for a more collaborative model of care and willingness of clinicians to undertake the work and travel. Keybarriers included; short project timeframe, slow uptake of GPs in generating referrals, lack of patient knowledge regarding GP management plans, incomplete referrals, poor scheduling of appointments and staff turnover.

Lessons Learnt: Evaluation data collected was used to inform recommendations to guide development of the project for a further 12 months, during which time further evaluation including the financial sustainability of this model will be undertaken. Understanding the barriers and enablers to this model will be crucial in determining its potential replicability in other rural areas where gaps in service delivery have been identified.
Turning off allergies with your GP – a model of shared care

Pam Hudson
Allergy Clinical Practice Consultant
Flinders Medical Centre, SALHN

Additional Authors: Sue Mattschoss, Clinical Practice Consultant, SALHN
Anthony Smith, Clinical Head of Department - Allergy Clinical Immunology Service, SALHN
Catherine Hughes, Principal Coordinator, Southern Adelaide Health Alliance, SALHN
Christopher Yuen, Medical Student, School of Medicine Flinders University, SA

Bio
Over the last 11 years Pam Hudson has played a key role in developing a regional ACI service, in response to a 400% increase in referrals to a fragmented ACI service. In conjunction with the Head of the ACI Service, Pam has developed a business plan and secured a specialised multidisciplinary team to provide coordinated care to paediatric and adult patients with allergic and immunological disease. This has been achieved through working within the SA Health strategic plans and being willing to trial new models of care and reflecting on the success and failures. Recently they have refined the tertiary services provided and developed ACI referral guidelines to direct our consumers.

Abstract
With growing outpatient service demand and fixed resources the allergy and clinical immunology service (ACIS) at Southern Adelaide Local Health Network (SALHN) formalised a new business model of care in the delivery of immunotherapy (IMT) outpatient services. ACIS engaged and worked collaboratively with General Practitioners (GPS) to define a shared care model for IMT delivery. This included an acute phase treatment (0-12 weeks) within the acute hospital and an IMT maintenance phase (3-5 years) in community general practice. This enabled:

- patients to receive safe, ongoing care with their GP closer to home, providing continuity of care and flexibility in appointment times
- GPs greater accessibility to specialist allergy clinicians and ongoing education
- Built trust between specialists and GPs
- Increased capacity for a growing specialist outpatient service

Innovative: Through collaboration and engagement between specialists and GPs, a vision for an integrated model of care has delivered an existing primary care service model into a shared care model. This was achieved without new infrastructure and costs, delivering patient satisfaction and continuity of care.


Results: (as at June 2015)

117 patients were involved in IMT from January to June 2015
80% patients met criteria for shared care
79% of patients who met the criteria have been transferred to maintenance shared care with the remaining 21% undergoing the acute IMT phase
97% patients were very satisfied with the program and happy to receive ongoing IMT injections at their GPs
92% of GPs felt that the program helps build patient/nurse/GP relationships and continuity of care
The new shared care model is now embedded as a standardised practice within ACIS and has increased OPD service capacity by 10 appointments/year for 77 patients (n=770)

Lessons Learnt: Clinicians often have innovative and creative ideas, however there needs to be investment into supporting clinical vision towards achieving new models of care through change management processes.
Bio

Sally Kruger currently works in the Service Redesign and Innovation Unit at Ballarat Health Services where she applies her project and change management skills to analyse, identify and implement strategies to improve services and achieve better outcomes for patients.

She has worked on the Cardiac Clinical Facilitator Project with the Department of Health Victoria, resulting in a new model of care for patients presenting with ST elevation myocardial infarction. She is now leading the program to bring about change aimed in improving the experience for patients seeking Specialist Clinics Services.

Sally has also completed a Foundation for Improvement Science course. She recently became a member of the School for Health and Care Radicals, convened by Helen Bevan at the NHS, where she has achieved Certified Change Agent status.

Abstract

At Ballarat Base Hospital a 38 patient Urology Outpatient four hour clinic template was based on booking patients to arrive within the first 90 minutes of the clinic commencing. Apart from the time patients arrived and left the clinic no other touch times were collected. Inevitably, such a design resulted in long delay times leading to a poor patient experience and an overcrowded patient waiting room.

One of our innovations was to engage an experienced Facilitator from the NHS to provide a two day workshop to build up a project redesign with the goal being to improve the overall experience for both patients and staff involved in the clinic.

The basis of the redesign was a value stream map which we developed based on observing the clinic in action and collecting time stamp data associated with the touch points for patients attending the clinic. Using the value stream map we sat down with the Outpatient Team and came up with a proposed template that was designed to ensure that no patient should wait longer than 30 minutes.

Through a series of meetings the team developed a confidence that the basis of the redesign would reduce work and actively began to embrace the change. This alteration in attitude plus an improved understanding of how existing information technology could support the change contributed significantly to the success and ongoing sustainability of the project.

The outcome of the redesign has been a greater than 50% reduction in patient waiting time, a less crowded waiting room with high levels of patients satisfaction reflected from patient’s surveys.

Major learnings have been the importance of engaging the staff early on so that they take ownership and run with the change process and a recognition that existing information technology is not being used to its capability.

It is our intention to role this concept out to all other Outpatient Clinics.
Outpatient waitlist auditing – shifting towards a “patient-centric experience”

Benjamin Reid
Practice and Process Outpatient Coordinator
Royal Brisbane & Women’s Hospital, Metro North Hospital & Health Service, QLD

Bio

Ben is the Royal Brisbane & Women’s Hospital (RBWH) Practice & Process Outpatient Coordinator, a role that ensures consistent and ‘best practice’ administrative outpatient processes are maintained and developed across the entire facility. The RBWH holds approximately 500,000 outpatient occasions of service every year and incorporates a variety of outpatient clinics, including centralised and decentralised models, ranging from facility-based to remote offsite locations. Ben has a tertiary background in Psychology and has previously worked within outpatient clinics as a senior administration officer and administration manager.

Abstract

Clean and transparent outpatient specialist waiting lists within a public hospital facility are of paramount importance in order to ensure that patient care is always prioritised, whilst resources and public funds are appropriately managed and allocated. The outpatient specialist waiting lists at the Royal Brisbane & Women’s Hospital (RBWH) presented with a significant number of patients waiting longer than the clinically recommended timeframes for non-urgent conditions (Category 2 and Category 3). Recent government directives outlined the need to reduce the numbers of patients waiting for outpatient appointments by 50% by the end of the previous financial year.

Regular waitlist auditing is a requirement under the Outpatient Services Implementation Standard (OSIS). Due to variety of historical reasons this has not been consistently and regularly performed at the RBWH, resulting in a wait list that is not clean and more than 25,000 patients waiting longer than clinically recommended for an outpatient new case appointment. The RBWH initiated the development of a ‘centralised’ audit team to make contact with all non-urgent patients across the facility waiting longer than the clinically recommended timeframe. In addition, a ‘rolling audit’ model was developed, whereby all patients who become a ‘long waiting patient’ on a daily basis, would be contacted by the audit team. This contact involves sending a ‘patient friendly’ letter to ensure that the hospital has the most up-to-date demographic information as well as requesting a response from the patient as to whether they still require an appointment for the referred condition.

To ensure accurate reporting and tracking of patients through the ‘audit process’, a comprehensive audit database was developed. This was done to ensure many benefits, including patient visibility, audit reporting, transparency of the audit process and reporting for outpatient waitlist reduction targets.

Patient feedback regarding the new audit process has been overwhelmingly positive and patients are appreciative of the regular personal contact and concern from the hospital. Patients are given the opportunity to discuss additional hospital queries and advice is provided when prompted, such as what to do when a medical condition has deteriorated whilst awaiting an appointment.
**Public Hospital Long Wait Outpatient (OPD) Care Improvement**

*Anthony Kiosogolous*
Consultant Urologist
QEII Jubilee Hospital, Metro South Health, QLD

*Jennifer Ashton*
Nurse Unit Manager – Specialist OPD
QEII Jubilee Hospital, Metro South Health, QLD

**Bios:**

**Dr Anthony Kiosogolous** is a Urological Reconstructive Surgeon at QEII & RBWH in Brisbane QLD. He is a Senior Lecturer University of Queensland Department of Medicine and involved in the Royal Australian College of Surgeons State Committee. Dr Kiosogolous is a research/review of three international urological journals. **Jennifer Ashton** RN BN holds a Grad Cert Perioperative Nursing and MACCYPN

**Abstract**

The purpose of the project was to identify patients who required review or who could be removed from the Urology wait list for Category 2 and 3 OPD appointments. A database was established and managed by both Nursing and Medical staff. Nursing staff contacted patients via telephone with a script approved by the Consultant. Based on the conversation, the patient’s referral and medical record were reviewed by the Consultant. If the patient no longer required care, a discharge letter was dictated by the Consultant to the General Practitioner.

Patients were scheduled to temporary Consultant-led clinics and at this point, assessment, further investigations and/or reassurance provided and discharge letters completed.

Results from the initial nurse telephoning screening are as follows:

- Discharge 30 - 40% of patients
  - 1/3 uncontactable (2 x calls, 3 x letters, including to the GP)
  - 1/3 already treated
  - 1/3 problem resolved.

Results from the chart review and clinic appointment are as follows:

- All patients were appropriately categorised as Category 2 and 3 (benign conditions)
  - 5 - 10% converted to surgery
  - 40-50% required further investigations for lower urinary tract systems and review appointments
  - 1 of 1000 patients was referred to the Colorectal Service for advice
  - 40% of patients were discharged

**Lessons Learnt**

- Long waits for patients can be prevented by undertaking pre-screening to improve utilisation in clinics
- Send investigations to patients prior to their appointment
- Send out a pre-screening history questionnaire
- Nurse Led Clinics to improve streaming of appropriately screened and prepared patients
- Principal House Officer Led Clinics to see patients and if anything difficult to review with the Consultant
- Improve the referrals from the General Practitioners though a proforma to the GP’s in the catchment area outlining specific information required.
Decreasing Lost Capacity – Fail to Attends (FTAs), Patient Initiated Postponements (PIPs) and Cancellations

Susan Fiori
Administration Manager, Specialist Clinics, Access and Demand
Austin Health, VIC

Bio

Susan Fiori has a Bachelor of Business and a Masters in Engineering with twenty five years experience working in IT Infrastructure (process reengineering), Property Management, Not-for-Profit, Health and Community Services, and private consultancy. Susan currently manages the administrative operation and clerical teams for Austin Health’s Specialist Clinics - which is one of the largest comprehensive outpatient service providers in Victoria.

Abstract

Austin Health had 254,967 outpatient attendances last financial year. This was an increase of nearly 27% / 68,631 attendances in three years. Even though we had an increase of attendances, we decreased our Failed to Attends (FTAs) from 13.8% to 11.6% in the same period. This reduction was contributed to the introduction of the Patient Choice Booking (PCB) system that placed patients on a wait list and, when an appointment became available within a four week window, invited patients to contact the hospital to make their appointment. When PCB was introduced there was a significant FTA decrease however over the last two years the FTA rate has remained stagnant at around 11.6% / 33,354 patients per annum. An FTA is a lost appointment and increases our waiting list and operating costs. We introduced SMS reminders resulting in only an additional 0.1% decreased with significant costs. In an attempt to further reduce FTAs, we undertook extensive unit auditing and found:

- patients were unable to get through to our busy call centre within an appropriate time frame to advise they couldn’t attend or needed to change their appointment;
- there was no notification procedure to cancel outpatient appointments while the patient was an inpatient;
- patients receiving mail notification of an urgent appointment scheduled date did not receive that notification, due to postage speed, until after the appointment date; and
- patients simply didn’t understand the impact on not turning up for their appointment.

As a result:

- we redesigned our Call Centre, now answering 88% of the 17000 calls we receive each month within 5 minutes increased from only 37% twelve months earlier;
- we introduced email and web-form contact pathways receiving 1000 email requests a month answering all emails within 1 business day;
- we now capture inpatient with outpatient appointment daily reporting to enable outpatient appointment management;
- patients are now phoned if an urgent appointment is schedule for within 2 weeks;
- we are about to embark on a “Let Us Know If You’re Not Going to Show” patient communication campaign to increase the value of patient appointments.

At the end of March this year, we also extended the booking horizon from 4 to 6 weeks to accommodate ward/inpatient discharge follow-up appointments. Clinical units have also been encouraged to manage their wait lists, including increasing appointment offers and overbookings, complete GP referral guidelines to direct what patients they do and don’t see, and manage FTAs by discharging patients who fail to attend or cancel multiple times. In order to aim for a 5% FTA target, which is formally reviewed monthly with dashboard reporting, we need to move away from costly paper based and manual appointment management and notification.
Royal Reduction: Complexities of reducing outpatient waiting lists by 50% in a tertiary hospital

Carmen Mauchline
A/A Nursing Director, Outpatient Coordination
Royal Brisbane and Women’s Hospital, QLD

Bio
Carmen Mauchline is an A/Assistant Nursing Director responsible for coordinating outpatients across all services delivered by the Royal Brisbane and Women’s Hospital. The organisation has 28 decentralised outpatient departments and one central outpatient department that services more than 12 specialist services. Carmen has been working in service delivery of outpatient and elective surgical services for the past 6 years and has particular focus and achievements in waiting list management and strategy.

Abstract
In June 2014 the Metro North Hospital and Health Service committed to reducing the number of patients waiting longer than clinically recommended by 50%. The initiative was tied to our purchasing agreement with Queensland Health and was based on an initial 20 784 patients waiting longer than clinically recommended at the Royal Brisbane & Women’s Hospital (RBWH). The target therefore was to reduce to less than 10 392 patients waiting longer than clinically recommended by the 30th June 2015.

Such a target had never been attempted before now in the delivery of outpatient services.

The project commenced in July 2014, employment of multiple project teams in various departments reported to a business analyst. The project officer’s skill set was not outpatient based and the organisational structure was fractured. The organisation had a lot of experience in managing government targets including National Elective Surgery Targets (NEST) and National Emergency Access Targets (NEAT) and very little experience managing outpatient targets. There was an apparent ‘culture shock’ when the volume of patients through the service was demonstrated in relation to emergency services, elective surgery and inpatient activity and in addition the understanding of demand verses capacity was limited. Data and reporting in outpatients is complex and misunderstood so this to added to the problem.


Opportunities for Improvement: include: *Governance, *Direction, *Commence with capacity and work backwards (physical and human resource availability), *Specialist workforce does not grow on trees, *Building organisational outpatient knowledge and expertise

What we did well:
Innovate – *allied health pathways, *alternate models of care, *trying something different – group appointments for surgical candidates,*clean up, cleanse the waiting list make sure patients require there appointments before offering them

Partner with consumers, primary health and interdisciplinary colleagues

Results:
11 745 patients waiting longer than clinically recommended or 43% reduction

Lessons Learnt:
Clearing an outpatient wait list is costly, New Case Capacity needs to be > Demand, For every new case - you need the expected review case capacity. If patients require elective surgery – you need operating capacity, If additional rooms are required you need capacity and support to run these, Clear and consistent governance and leadership, Consistent executive lead to support project and overcome challenges with competing targets, Changes in leadership = expanded scope of project, Changes in leadership = change in target, Innovation is required to overcome: Specialist workforce shortages, Capacity for expansion of services, Medium and long term planning needs to coexist to ensure sustainable change.
Closing Address

Prof Stephen Duckett
Director, Health Programs
Grattan Institute, VIC

Bio

Stephen Duckett is Director of the Health Program at Grattan Institute. He has a reputation for creativity, evidence-based innovation and reform in areas ranging from the introduction of activity-based funding for hospitals, to new systems of accountability for the safety of hospital care. An economist, he is a Fellow of the Academy of the Social Sciences in Australia and of the Australian Academy of Health and Medical Sciences.
Lisa Broad
Lisa Broad is Practice Manager for the Surgical Outpatients Services at Caloundra and Nambour. She also manages the Specialist Outpatients Department (SOPD) with the many service group clinics at Caloundra (Medical, Gynae, Surgical and Allied Health Service Clinics).

Julie Faoro
Julie Faoro is experienced operations and development director with particular expertise in the initiation, creation and implementation of innovative service models, stakeholder engagement, operations and sound working knowledge project and change management methodologies. Julie has enjoyed a 25-year plus career within the Victorian public health system with senior management positions held at tertiary and regional health services. With this expertise, she has been invited to join the new look Change Champions Health Innovation Network in 2016 as Director, Operations and Development.

John Hallett
John Hallett (B. App. Sc. (Health Information Management), Grad. Dip. (Information Technology)) is a Data Integrity Officer within the NSW Ministry of Health, responsible for co-ordinating data collection and information management improvement projects to support elective surgery and outpatients waiting lists, community health, community transport and former Home and Community Care. John has a passion for health information management to support clinicians in the timely and accurate collection of information as a by-product of their day-to-day clinical care. John has over 20 years’ experience working in Health, at both Local Health District and State levels, where he has been responsible for information management, data quality and developing and implementing source system and data warehouse solutions for oncology, drug and alcohol, aged care, community health, community transport and elective surgery and outpatients waiting lists. John is a former President of the Health Information Management Association of Australia (NSW Branch), Employment Information Adviser of the Australasian Health and Research Data Managers’ Association and community radio broadcaster.

Prof Donald MacLellan
Prof Donald MacLellan BSc, MD, MBA, FRACS was born in Scotland and obtained his science and medical degrees at Glasgow University. He moved to Australia in 1978 was awarded the FRACS in 1984, an MD through the University of Melbourne in 1985. He completed an MBA through Monash University in 2002. In 1991, he was appointed to the Chair of Surgery, University of Melbourne and in 1996 he became the Inaugural Professor of Surgery, University of Sydney in Canberra. In 2002, he joined Hunter Area Health Service and undertook various senior management roles and was also appointed Conjoint Professor, Faculty of Health, University of Newcastle. From 2005 to 2012, Prof. MacLellan was in the NSW Department of Health and had responsibility as NSW Director of Surgery for all aspects of the surgical patient journey from pre-admission to discharge. Major reforms of surgical service delivery occurred under his leadership and were recognised on receiving the NSW Premier’s Public Sector Silver Award (2006). In 2012, Professor MacLellan was appointed as Director of Surgery, Anaesthesia and Critical Care in the NSW Agency for Innovation. In this new position, he will continue to enable clinicians to improve patient outcomes through the design and implementation of innovative Models of Care.

Lauri O’Brien
Lauri O’Brien has over 30 years’ experience in the health care sector as a midwife, senior clinician, clinical governance and change management roles in South Australia and interstate.
Her role in Health Services Innovation Tasmania is predominantly mentoring and enabling the Program Officers across the state to implement change using predominantly the Lean methodology has seen her facilitate widescale projects which have large cultural and change management component.
**Jody Paxton**

Jody Paxton has over 25 years clinical experience and currently works for Queensland Health as the Manager for the implementation and evaluation of the Clinical Prioritisation Criteria Project. Jody has a Masters in Health Care Research and is a Lecturer for the School of Medicine at Griffith University. She is also currently supervising numerous research projects at the Gold Coast University Hospital.

**Ila Stuer**

Ila Stuer is the Clinical Nurse Consultant, Elective Surgery Coordinator, at the Royal Brisbane and Women's Hospital. Ila's professional experience includes orthopaedic and outpatient nursing. In her current position, Ila enthusiastically supports elective surgery and outpatient service integration. Ila holds a Master of Health Management, which includes a study area of outpatient referral management and referral pathways. In collaboration with senior clinicians, Ila researched and developed the RBWH's Specialist Outpatient Services referral and management guidelines.

**Char Weeks**

Char Weeks has been at the helm of Change Champions for over 10 years. Previously she was a Board Member and Executive Director of the Australian Resource Centre for Health Care Innovations. Char is passionate about innovation and improvement in health care and managing change effectively. In 2016, she will co-lead the transformation of Change Champions into a membership driven organisation, Change Champions Health Innovation Network. In her spare time, Char is a certified executive and resilience coach, a member of the Community Advisory Committee and a member of the Partnering with Consumers Working Group at St Vincents Hospital Melbourne, VIC. She also visits psychogeriatric patients with her dog, Goliath.
Change Champions & Associates Health Innovation Network coming in 2016