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Specialist Consulting Clinics Reform at The Alfred

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DoH Innovation showcase, February 2010

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Overview

- Background
- Overview of Redesigning Care
- Framework for redesign – our roadmap
- Case study
  - Redesigning Referral management
- Next steps
- What have we learnt

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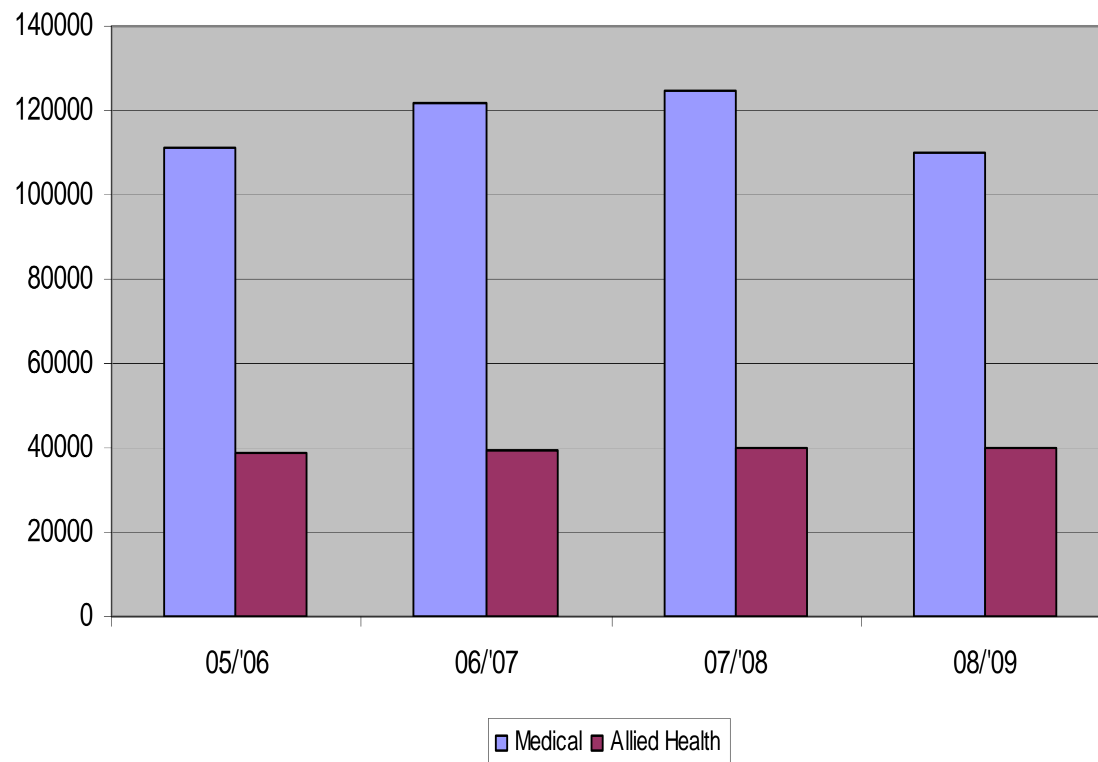
About the Alfred’s Specialist Consulting clinics

- Provider of full range of Specialist Consulting Services (excluding paediatric and gynaecological) for people living in the inner south-eastern suburbs of Melbourne

- Major provider of Specialist Consulting Services for designated statewide services, including Adult Major Trauma; Burns; and Statewide Elective Surgery



Drivers for change

- Drivers:-
  - Increasing demand
  - Sub-optimal capacity utilisation (FTA's, cancellations, reschedules)
  - Long queues and wait times
  - Inefficient paper based systems
  - Significant duplication and rework
  - Inability to communicate effectively to referrers and patients
  - Patient, staff, referrer dissatisfaction
  - Others…

In the context of…

- Data – paucity, and poor data quality
- History of improvement initiatives fragmented, variably implemented, and variably sustained
- Improvements from service provider perspective; as opposed to patient focused
- Service ‘evolution’ vs. ‘design’
- Culture of ‘just fix it’ – reactive; improvements isolated, with limited understanding of broader system implications

Redesigning Care in the Specialist Consulting Clinics

- Redesigning Care in The Alfred's Specialist Consulting Clinics is a comprehensive program of work aimed at redesigning referral management, triage and scheduling processes; and improving patient flow within the specialist consulting clinics. The program commenced in January 2008.
- Executive ownership & Operational management commitment
- Commitment to in-depth redesign, across all clinics – transformational change as opposed to quality improvement projects
- Alfred Centre Stage 2

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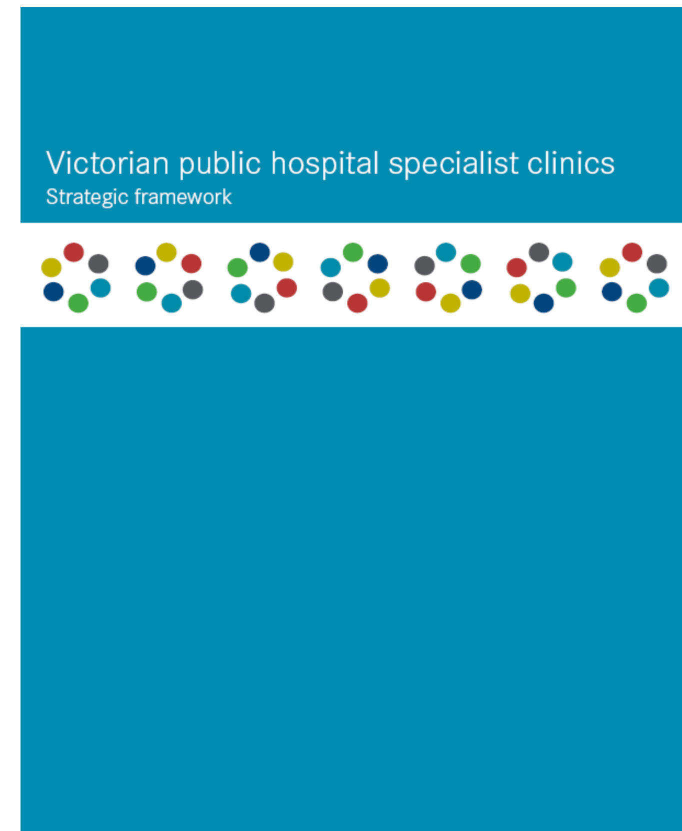
Policy context - Victorian Public Hospital Specialist Clinics Strategic Framework (Feb 2009)

Five high impact service improvements to be delivered by the Specialist Clinics improvement and Innovation Strategy are:

1. increased capacity for new patients
2. individualised appointments for all patients
3. patient journey standards
4. local specialist clinic telephone services 'Infolines'
5. better monitoring of services.



Good foundations

- GP referral guidelines across most clinics
- Priority system for referral management
- KPI establishment
- Elective Surgery pathways (part of Perioperative redesign for Alfred Centre Stage 1)

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Improvement initiatives

- ‘Redesigning Care’ program initiatives
- Increasing MBS billed Specialist Consulting Clinics
- GP liaison and referral guidelines
- Alfred Centre Stage 2 planning
- Amenities upgrade
- Medical Record Scanning
- Ambulatory Diabetes framework
- Workforce innovations

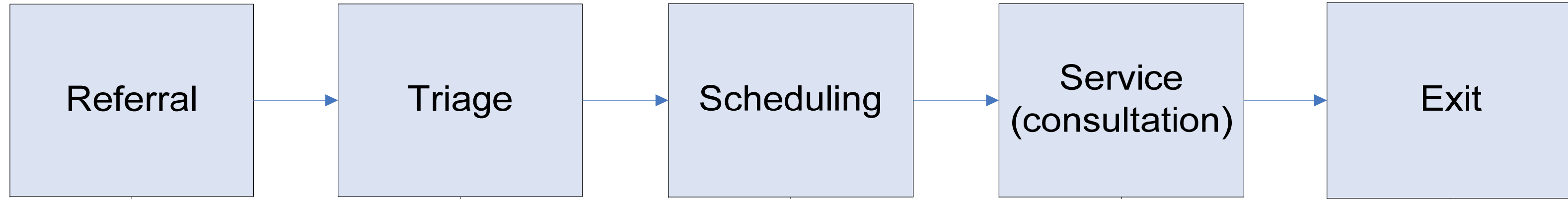
Aims of Redesigning Care program

1. **Improve timeliness of care for patients**
   - Reduce queues
   - Reduce wait times
2. **Improve capacity to manage demand**
   - Reduce FTA’s; cancellations; reschedules
3. **Improve patient and staff satisfaction**
4. **Improve quality and safety outcomes for patients**
   - Right patient, right clinic, right information, right time

Redesigning Care in the Specialist Consulting Clinics (cont)

- Thorough diagnostic work undertaken early 2008 within Diabetes (Medical) and Orthopaedics (Surgical) Specialist Consulting Clinics. This consisted of:-
  - value stream mapping with staff
  - direct observation and patient tracking
  - analysis of available data
  - Patient satisfaction monitoring – ongoing

Patient Journey:



	Referral	Triage	Scheduling	Service (consultation)	Exit
Current state issues:	- Difficult to measure demand - Multiple referral entry points - Batching: processing delays - No communication to patient/referrer - Duplicate work in progress referrals - Variable referral quality - Paper based	- Paper-based: no e-record - Batching: processing delays - Multiple handoffs - Lost referrals?? - Variable information quality - Which referrals to triage? - Compliance to referral guidelines? - Appropriateness of referrals?	- Inaccurate scheduling: wrong clinic/doctor/date - Multiple entry points - Demand & capacity pressures - Slots may not reflect actual demand - Cancellations - Reschedules	- Long queues - Long wait times to consultation - Fail to attends (FTA's) – wasted capacity - Rework: delays - Patients not seen in order of appointment - Communication to patients and between staff difficult - Variable availability of patient history/investigations - Patient/staff satisfaction	- Variability in discharge/ referral/review practices - Inability to link consultation to patient's 'episode of care' - Variable communication to patients and referrer
Opportunities:	- Administrative toll-gates eg referrer, patient details - Document scanning – electronic workflow; referral information readily available to all - Electronic registration of referral - record referral activity and capability to measure demand - Confirmation of referral receipt to patient and referrer	- Clinical toll-gates eg. investigations, diagnosis - Standard work – protocol-driven triage; increase application of referral guidelines - Electronic workflow - increase timeliness of referral triage - Separate referral streams - Alternate workforce models eg stream coordinators	- 'Patient focused booking' - Confirmation of appointment with patient and referrer - Separate streams for scheduling - Patient stream coordinators - 'Real-time' demand and capacity analysis to inform Schedule build	- Minimise waiting - Reduce wasted capacity - Improve flow coordination - Patient information readily available on patient arrival - Patient flow coordinators - Improve communication to patients - Standard work for reception, check-in, missing histories, FTA, review appointment processes etc	- Develop discharge and review guidelines - Consultations linked to patient's 'episode of care' - Confirmation of consult outcome with patient and referrer - Measure review appts; cross-specialty referrals; discharges - Reduce variability in practice
Metrics:	- Time from referral receipt to complete registration of referral - Demand measures (i.e. # of referrals by specialty type) - Referral quality eg. internal and external	- Time from referral to triage - Standard work – application of referral guidelines	- Time from triage to scheduling - Time from referral to appointment - Demand measures (i.e. requests by slot type) - Cancellation rates - Reschedule rates - New to review ratios	- Time from patient arrival to patient information available - Appointment time to patient seen time - Patient and staff satisfaction - Waiting times - FTA rates	- Number of appointments per patient/clinic/episode of care - # patients discharged - monitor cross-specialty referrals - monitor # review appointments (+/- KPI's)
Benefits:	- Improved first-time quality of referral information - Reduced duplicate referrals and rework - Improved communication with patient and referrer - Improved timeliness - reduced delay to triage - Demand measurement capability by specialty - No lost referrals - First-in-first-out (FIFO) processing - Referral information readily available to all	- Improved first-time quality of clinical information - Reduced handoffs and rework - No lost referrals - Right patient; right clinic - Increased timeliness of referral triage; reduced delay to scheduling - Appropriate clinical investigations complete - improved FIFO processing - Patient information readily available electronically	- Reduced rework i.e. FTA's, cancellations, rescheduling - Increased clinical awareness and ownership of demand/capacity issues - Right patient; right time - Improved access - Improved clinically appropriate timing of scheduling - Schedule to reflect actual demand - Capacity issues visible	- Reduced queuing & waiting time for patients - Reduced rework - Increased clinical ownership of patient flow - Appropriate clinical information for consultation - Improved patients seen in order of appointment - Patient demographic information readily available on patient arrival - Improve communication to patients - Improve pt/staff satisfaction	- Reduced rework - Increased capacity for new patients - Increased clinical ownership of demand/ capacity issues - Eliminate unnecessary return appointments - Capacity issues routinely monitored and visible - Improved communication with referrer and patient

Specialist Consulting Clinics Planning Principles DRAFT v.5-01.07.09

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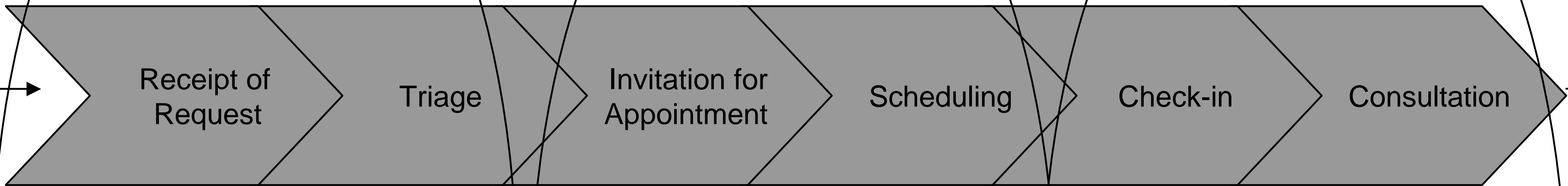
External referral (from community)

Internal cross-specialty referral

Internal home specialty request

Other referral

Discharge



Receiving officer

- All internal requests made electronically
- All external referrals electronically registered and scanned
- Receipt of referral communicated to patient and referrer
- Tollgate: patient registration data complete
- Tollgate: referrer details complete

Nurse Coordinator (unit-specific)

- Eligibility criteria applied (clinical and catchment)
- Referral guidelines to inform clinical priority of new referrals (including cross-specialty and frequency of review appointments
- Tollgate: clinical information & investigations to inform triage are complete
- Tollgate: diagnosis captured
- Tollgate: streamed to right clinic & right priority

Nurse Coordinator (unit-specific)

- Patients identified to fill schedule by FIFO (first-in, first-out) principles per clinic and priority stream
- Invitation to make non-urgent appointments sent to patients, with indicative timeframe and investigations required
- Urgent appointments scheduled immediately
- Tollgate: investigations to inform consultation identified & communicated

Scheduling Clerk (unit-specific)

- All appointments made in consultation with patient (face-to-face or phone)
- Urgent and time-critical appointments scheduled immediately
- Non-urgent appointments scheduled on reply from patient to invitation
- Protocols for following up non-replies
- Scheduling outcomes communicated to patient and referrer
- Tollgate: investigations to inform consultation identified & scheduled
- Tollgate: all patient information complete

Reception clerk & Clinic nurse

- Electronic check-in with assistance as required
- Electronic way-finding
- Tollgate: Pre-consultation investigations / work-up coordinated

Clinician

- Patients seen in appointment time order
- Consultation 'outcome' captured electronically (i.e.. review, discharge, referral)
- Communication of 'outcome' to patient and referrer

- Electronic workflow across whole of patient pathway
- Standardised care processes across whole of patient pathway
- Role redesign emphasises flexibility, multi-skilling and new skills to support patient pathway
- Buildings and facilities support flow across the patient pathway

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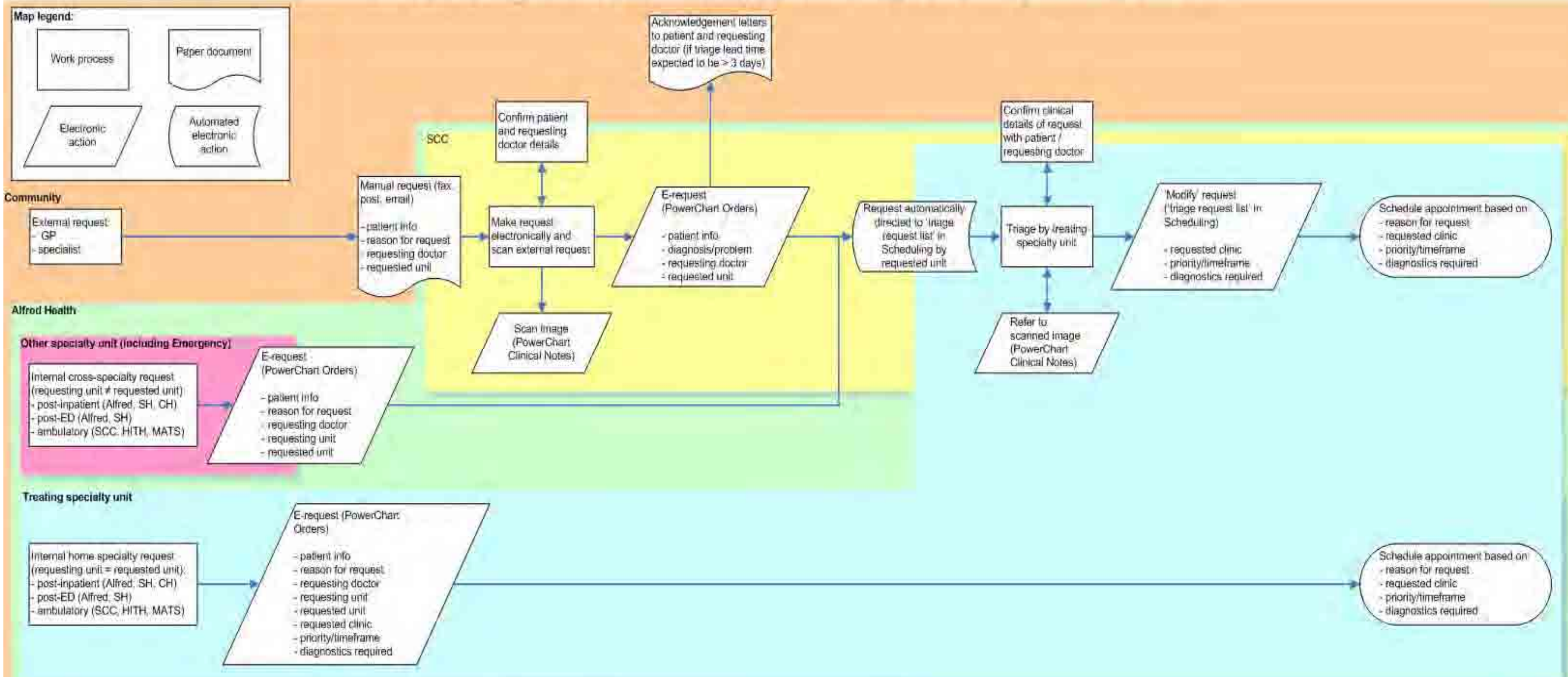
The Alfred Specialist Consulting Clinics - Request Management Workflows



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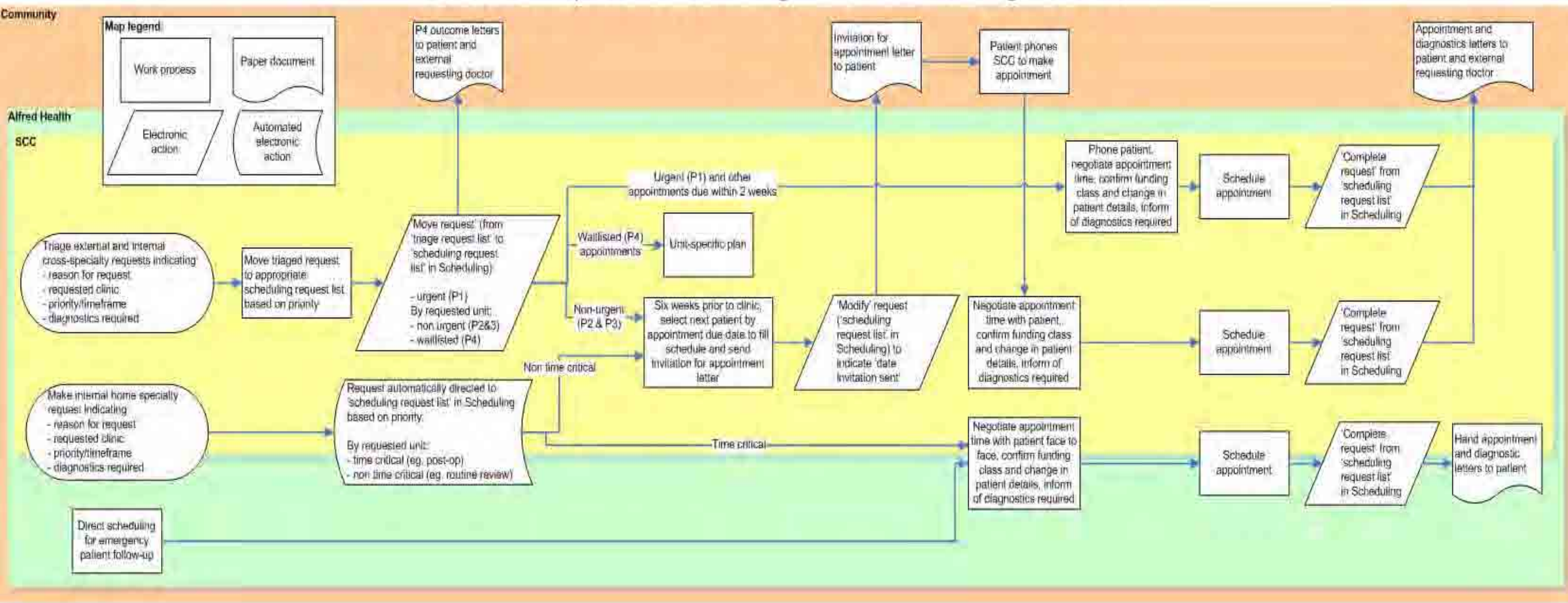
The Alfred Specialist Consulting Clinics - Scheduling Workflows



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Redesigning Referral Management

Case study

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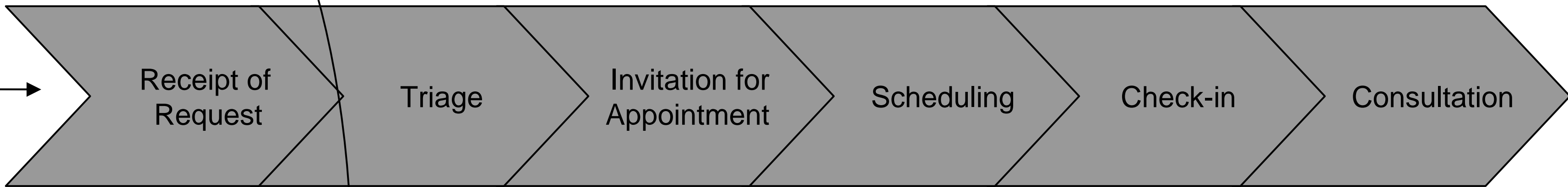

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The problems

- Manual, paper based systems.
- Estimated > 1000 'work-in-progress' referrals being managed at any given time
- Delays of up to 14 days before referrals are 'registered' i.e. awaiting scheduling of appointment (NB ‘priority’ referrals within 24 hours)
- Duplicate referrals being processed (est. approx. 50 p/week) due to
  - no mechanism to track work-in-progress (WIP)
  - delays to referral ‘registration’
  - no communication mechanism to referrer or patient (19% (n=154) newly referred patients were sent communication within 3 days)

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The problems

- Variable 'first-time' referral quality
  - 39% (n=154) external referrals received with complete patient information
  - 91% (n=154) external referrals received with complete referrer information
- Multiple handoffs (up to 6 staff from receipt of referral to appointment scheduling)
- Inability to account for missing referrals
- Difficult to measure demand
- Batching and processing delays within process

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Proposal

Redesign current processes for receipt of referrals in order to achieve:

- Electronic registration of referral at point of receipt; referral documentation scanning into PowerChart
  - Targets:-
    - 100% of ‘external’ referrals registered and scanned within < 24 hours
    - Eliminate duplicate work in progress referrals
    - Eliminate ‘missing’ referrals

- Administrative tollgate for patient and referrer information at receipt of referral:-
  - Target:-
    - 100% referrals to have complete patient and referrer information prior to being processed

- Communication of receipt of referral to patient and referrer
  - Target:-
    - 100% referrals acknowledged within 3 days of receipt

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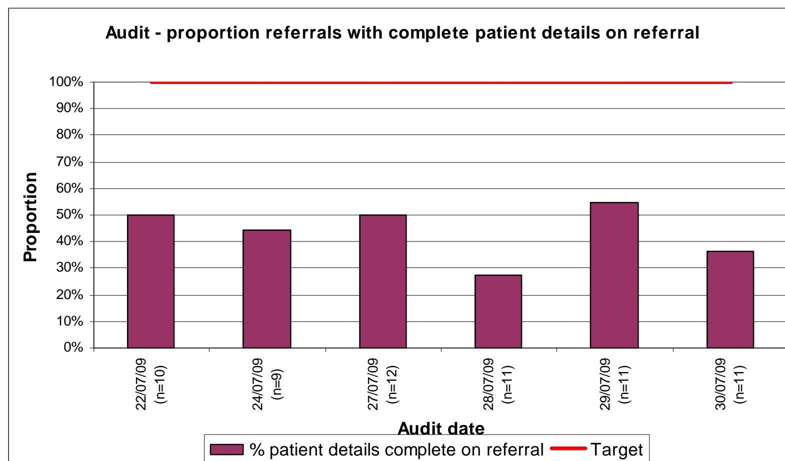
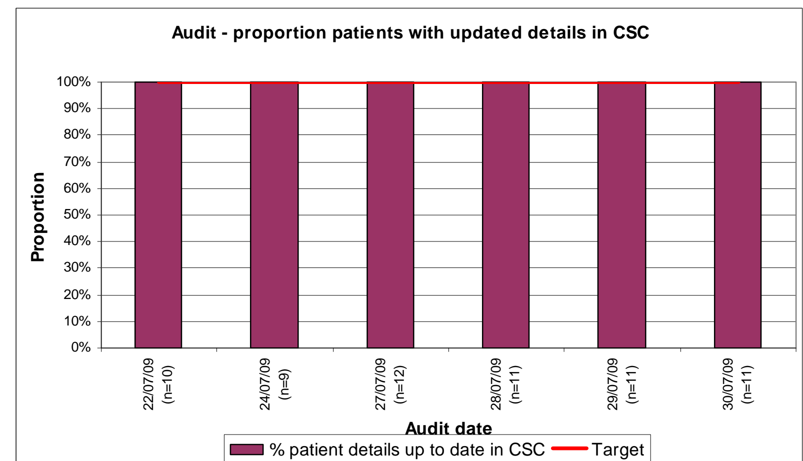
Benefits realised (cont)

- Eliminate ‘missing’ referrals
- Improved efficiency of ‘downstream’ processes (eg patient check-in, scheduling etc) resulting from accurate data capture ‘up-front’

Incoming quality on referrals received



Output quality in patient registration system



Benefits realised (cont)

- Time from receipt of referral to electronically recording the request:
  - Reduced from 7 days (median) to 1 day
- More timely communication with patients and referrers
  - 100% newly referred patients receive either acknowledgement of receipt of referral or appointment letter within 3 days (previously 19%)
- Improved, timely data capture to measure (and respond to) changing patterns of demand
- Provides start point for electronic workflow (esp. triage and scheduling)
- Since ‘go-live’, approx 183 hours of rework saved (Medical, Nursing, Clerical) through identification of duplicate referrals at point of recepit

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Next steps

- Referral and Request Management workflows
  - Electronic workflow for internal referrals
- Scheduling workflows
  - Patient centred scheduling
- Day of clinic (i.e. intraclinic) workflows
  - Undertake detailed diagnostic work
  - Reduce patient wait times
  - Reduce clinic ‘overruns’
  - Comprehensive demand & capacity analysis and schedule review
- Diagnostic services
  - Ortho/Radiol interface
    - E-requests
    - Schedule interface
  - Patient flow (ACS2)
- Performance monitoring and reporting systems

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What have we learnt?

- Complexity +++
- Importance of thorough diagnostics to ensure we're working on the right things
  - Takes time & focused effort
  - Work on root cause redesign vs. symptoms/effects of problems
  - Understanding and balancing the need for quick wins to maintain staff engagement (esp. clinicians)

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What have we learnt

- strong and visible leadership has been critical
- Document standard work +++ - create a baseline for continuos improvement
- ACS2 has helped to concentrate our attention
- Persistency and constancy of purpose
- assume nothing – understand and acknowledge the local context (i.e. clinic by clinic)

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Thank you

Comments / Questions

Acknowledgements

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