Specialist clinics access policy: list of key changes from draft to final version

What hasn't changed?

Key processes and timeframes, as proposed in the draft document, remain the same. These are summarised below:

Summary of key processes and timeframes

Process	Section	Timeframe
Referral screening (identification of referrals that are in the wrong place or missing required information, and contact with referrers if necessary)	6.1	Within **three working days** of referral receipt
Closure of referrals pending further information and reconsideration	6.3 and 6.4	Within **thirty days** of requesting additional referral information, where the referrer has not responded
Referral acceptance/rejection	6.6 and 6.7	Within **five working days** of receiving a referral containing necessary referral information
Referral acknowledgement The referral acknowledgment conveys information to the referrer about the referral outcome (e.g. acceptance or rejection) or requests additional information	6.8	Within **eight working days** of referral receipt
Clinical prioritisation	7.3	Within **five working days** of receipt of referral containing necessary referral information
Addition to waiting list/offer to book appointment/or scheduling of urgent appointment	8.1	Within **three working days** of referral acceptance and clinical prioritisation
First appointment for urgent patients	7.1	Within **thirty days** of referral receipt
Patient notification of new appointment date where health service has cancelled scheduled appointment	9.6	Within **five working days of cancellation**
Communication with referrer about the findings of initial assessment/treatment*	10.3	Within **five working days** of completed initial assessment/ treatment
Discharge summary sent to referrer and/or other provider*	10.3 and 11.2	Within **five working days** of discharge from the clinic

* The revised policy outlines circumstances in which the health service may apply discretion to this requirement

What has changed and why?

A range of clarifications and changes have been made in response to consultation feedback. These changes and the reasons for them are described below (in the left and right hand columns, respectively).

Title

The term 'specialist outpatient clinics' is replaced with 'specialist clinics'	The Commonwealth has adopted the term 'specialist outpatient clinics' to refer to a broad range of non-admitted services, including specialist mental health and sub-acute services, endoscopy, chemotherapy etc.

General

Requirements to communicate with the patient's 'referrer' or 'referring practitioner' have been replaced with the 'referrer and/or the patient's usual GP' where appropriate.	To allow hospitals to decide whether it is more appropriate to communicate with the referrer and/or the patient's usual GP.

Section 1: Introduction

The revised policy outlines an implementation and monitoring approach: • health services to be compliant by 1 July 2015. • department to establish performance indicators and associated benchmarks; these to be developed in 2013-14, and tested during 2014-15 prior to 1 July 2015 implementation.	To respond to health services' request for information about the status of the policy and how it will be monitored.
A summary table of key business processes and timeframes has been inserted.	To respond to stakeholder requests for an overview of key policy requirements.

Section 4: Scope

Scope of the policy defined as: • All health services in-scope to report specialist clinics data through VINAH MDS. • Most clinics that can be classified under the Tier 2 '20' and '40' codes (full list of in-scope clinics attached to policy) used for national activity based funding (ABF) • MBS clinics where clinics the hospital controls the patient record.	To respond to stakeholder requests for greater clarity about the scope of the policy. To remove reference to the VACS funding system, which has been replaced by ABF.

• Most internal referrals excluded from the mandatory scope of the referral and waiting list sections of the policy. • Health services are encouraged to implement consistent processes for internal referrals.	To respond to feedback that aspects of the policy would create unnecessary communications and other processes if applied to internal referrals. To limit the potential for onerous accountability requirements.

Section 5: Pre-referral communication

Implementation guidelines:	
• Referral content is now described as 'details that health services may require' rather than 'suggested basic referral content', and a fuller list of possible referral items is shown.	To respond to stakeholder feedback about items that different clinics may require. To respond to stakeholder feedback that it is not useful to ask referrers to indicate urgency as this is a decision the specialist clinics should make, based on a high quality referral.
• 'Urgency flag' has been removed from the list.	
• A number of items have been added to the list of referral content including: Medicare number, NHI, indigenous status, physical examination results, relevant social history or special needs, allergies or warnings.	
• Clinical information has been reorganised to highlight the need for clarity around the reason for referral.	
• The 'Victorian Statewide Referral Form' has been changed to the 'General Practice Referral Template'.	To reflect the name change from VSRF to GPRT.
• A description of the NeHTA e-referral program has been added.	To alert reader to national work on e-referral.
• Added to health services 'website information for patients': details on what the patient can expect, including an explanation that, in general, public hospitals do not enable a choice of individual specialist and details about how patients can reschedule or cancel their appointment.	To respond to stakeholder feedback on the type of information patients require.

Section 6: Receiving and managing referrals

Sections 6.1-6.9: • Re-ordered sections.	To better align with health services' referral management processes.
6.3 Referrals requiring further information or reconsideration: • Wording changes to clarify the process for managing these referrals • Method of contacting the referrer changed to 'by telephone or in writing'.	Clarification.
6.5 Transfer of referrals to other services: • Added the requirement to obtain the patient's consent to transfer their referral from one health service to another.	To respond to legal advice about the need to seek patient consent to transfer information.
6.6 Referral acceptance: • Section 6.8 in the consultation draft has been removed, and policy content on advice to patients included in section 6.6.	Clarification.
6.7 Rejected referrals: • Removal of 'patient not contactable' as a reason for referral rejection. • Qualified the requirement that health services provide information about alternative services or management advice.	Original text caused confusion, as according to the access policy 'logic', the patient would not have been contacted at this stage. To respond to stakeholder feedback that it is not always possible, nor the role of the hospital, to provide this information.
6.8 Acknowledgement to referrers: • Wording changes to clarify the purpose of the 'referral acknowledgment.' • Added the 'request to reconsider' as a possible response by the health service to the referral.	Clarification. To outline a complete list of possible responses to the referral.
6.9 Patient registration: • Changed the term 'register' to 'generate a UR number or medical record'.	Clarification.
Implementation guidelines: • Wording changes to make it clearer that screening is an administrative function. • Addition of 'good practice' advice that health services should keep sufficient information about the referral to answer follow-up queries in the event referrals are rejected or returned to the referrer for	Clarification.

more information or reconsideration. • Addition of advice about whose role it is to obtain a patient's consent to transfer their referral. • New paragraph inserted to explain the circumstances in which health services may ask referrers to reconsider referrals.	

Section 7: Clinical prioritisation

7.1 Statewide clinical priority categories: • Timeframe for urgent appointments changed from '30 working days' to '30 days'	To correct error in draft document and inconsistency with the flow diagram in Appendix 1.
7.2 Clinical prioritisation in individual specialties: • Noted that patients should be assigned to a priority category based on their clinical need and related psychosocial factors.	To respond to stakeholder feedback that the need to consider psychosocial factors be stated explicitly.
7.4 Re-prioritisation: • Requirement to contact patients and referrers has been deleted and is now discussed in the implementation guidelines.	To avoid mandating communications that may be not be necessary in some cases.
Implementation guidelines: • An acknowledgement has been added that 'some clinics may be better suited to consultant-led triage'.	Clarification.

Section 8: Managing waiting patients

8.3 Record keeping and validation: • The requirement to keep records of all postponed appointments has been limited to hospital-initiated postponements and failure to attend scheduled appointments.	To avoid mandating potentially onerous and impractical record keeping requirements.
8.4 Removal of patients from the waiting list: • The requirement for the treating specialist to agree to the removal from the waiting list of new patients who fail to attend two first appointments has been removed. • New statement inserted that, 'patients are considered to be waiting until such time that they are seen for their first appointment or removed from the waiting list…'	The requirement was considered unworkable and unnecessary, since the patient would not yet have been seen by or known to the treating specialist To promote consistency across hospitals in how 'waiting patients' are defined.

• Hospitals have been advised to exercise discretion in removing patients from the waiting list in particular circumstances.	To respond to stakeholder concerns that patients may be removed from the waiting list despite hardship, misunderstanding or other extenuating circumstances.
8.5 Suspension of patients from the waiting list: • This section has been removed.	To avoid potentially onerous and impractical waiting list management requirements.
8.6 (now 8.5) Pooling and redistribution of waiting lists: • The sentence stating that 'specialists may agree to pooling' has been replaced with a sentence indicating that pooling of waiting lists should occur for public patients unless there are clinical reasons why patients should see a particular doctor. • A statement on pooling for patients attending review appointments has been added. • In relation to MBS-billed patients being able to be seen by different practitioner than the one named on their referral, the revised text notes this may occur 'under certain circumstances'	To promote greater efficiency in the management of public hospital outpatient waiting lists, and ensure patients are seen in the shortest possible time. To clarify that pooling is not appropriate/ expected for review patient appointments. To ensure that health services are aware of the circumstances in which patients may see a different doctor to that on their named referral. The revised access policy refers the reader to the Department of Health's MBS resource kit for further details.
Implementation guidelines: • Advice that the health service has a duty of care to inform the patient of any risks to their health of not receiving treatment for their condition has been removed. • Advice for the hospital to contact the referrer where patients decline, repeatedly reschedule or fail to attend their appointments has been qualified.	To respond to stakeholder feedback that it may impractical or inappropriate for the hospital to counsel the patient if they choose not to proceed with treatment or are unavailable. To limit the need for follow-up to patients who do not attend for treatment *and* who are urgent or have high-level clinical needs. To avoid potentially onerous and impractical waiting list management requirements.

Section 9: Appointment scheduling and booking

9.1 Selection of patients for appointments: • 'Patient availability' added as a factor hospitals should consider when booking appointments.	To be consistent with the requirement to offer patients a choice of appointment, outlined in section 9.2.
9.2 Booking appointments: • Qualifications have been added to the policy on patient focussed booking, to outline circumstances in which this requirement may be waived.	To avoid mandating processes in circumstances in which they will be impractical to implement (for example, where patients need treatment at pre-determined intervals, involuntary or statutory patients).

9.4 Clinic schedules: • The revised text notes that booking templates should allow for appointments of different lengths.	To recognise that appointment durations will vary according to the complexity of a patient's needs.
9.4 New and review appointments: • The reference to other appointment purposes has been removed.	The code set for appointment purpose is outlined in the VINAH MDS manual.
9.6 Health service initiated postponements: • Clarification to text to make it clear that rescheduling is to the next available appointment, and these patients do not take priority over other patients whose appointment has already been scheduled. • Re-imbursement of costs required only where this is appropriate.	Clarification
9.7 Failure to attend appointments: • The policy statement on failure to attend for all patients has been separated into two statements for 'new' and 'review' patients. • Revised text indicates that patients who fail to attend two consecutive review appointments may only be discharged from the clinic with the approval of their treating specialist. • Statement inserted on advising the referrer/and or the patient's usual GP (and the patient, where contactable) when patients are removed from the waiting list. • New policy requirement to advise the referrer/and or the patient's usual GP (and the patient, where contactable) that the patient has been discharged from the clinic after failing to attend appointments.	Clarification It is appropriate to seek the approval of the treating specialist before discharging a patient who is known to the clinic, and has failed to attend two appointments. To be consistent with section 8.4.
Implementation guidelines: • Advice on facilitating communication between patients and specialist clinics has been added. • The revised text suggests that it may be necessary to inform patients who decline, repeatedly reschedule or fail to attend their appointment of any risks to their health of not receiving treatment.	To respond to stakeholder feedback that it can be difficult for patients to contact specialist clinics to reschedule their appointment.

Section 10: Patient flow and care coordination

10.3 Coordination with general practitioners and other community providers: • Additional statement on discharge communication • Qualifications introduced to the policy on communication of assessment and discharge information to referrer.	To be consistent with section 11.2 and emphasise the need for communication at assessment and discharge. To account for situations in which it would not be appropriate or necessary to communicate with the referrer (for example, where it may be preferable to contact the patient's usual GP) and to avoid mandating potentially unnecessary or duplicative communications. To respond to stakeholder feedback that, for maternity patients, it is more appropriate to send a summary of the birthing episode than to communicate on discharge from specialist clinics.
Implementation guidelines: • The revised text encourages hospitals to develop innovative models that assist patients to access community-based health and support services. • A new section on care coordination has been added. The section on, 'Collaboration with general practitioners and other primary care providers' has been moved to section 10 from section 5 (Pre-referral communication).	To respond to stakeholder feedback that specialist clinics need to create more effective linkages with community health services. To respond to stakeholder requests to emphasise the role of specialist clinics in providing long-term management of patients with chronic and complex conditions. To recognise that collaboration with GPs and primary care providers needs to occur throughout the patient's specialist clinic journey.

Section 11: Discharge

11.2 Discharge documentation • The revised text notes that the need to communicate with the referrer, usual GP and/or other relevant healthcare providers is subject to the qualifications in section 10.3.	To be consistent with section 10.3.
Implementation guidelines: • Additional text to note that not all patients will be suitable for discharge from specialist clinics.	To respond to stakeholder feedback that the document should have a stronger focus on patients with chronic and complex needs.

Section 12: Performance monitoring

Implementation guidelines • Updated information on the Government's plans to publish waiting list and waiting time data, and the development of other KPIs for the purpose of monitoring the access policy.	To respond to stakeholder requests to clarify this.