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1. **Introduction**

The Central Adelaide Local Health Network (CALHN) is one of five Local Health Networks (LHNs) in South Australia, and serves 27% of South Australia’s population. The new Royal Adelaide Hospital (RAH) Model of Care (MoC) promotes a patient centred approach to service provision and is underpinned by some basic system principles e.g. physical design and environment, behaviours, attitudes and the general culture of the organisation and its staff. The overarching principles have four key aspects:

- Safe care
- Healing environment
- Holistic patient care
- The patient journey.

A MoC for the CALHN Specialist Outpatient and Ambulatory Care Services in the new RAH has been developed that aligns to the above principles.

The current RAH Specialist Outpatient Clinics and Ambulatory Care Services provide the highest level of patient activity within CALHN. The ways in which clinics provide a service will be challenged by the changing health needs of South Australians and changes in health care delivery.

To this end, and consistent with the vision articulated in the SA Health Care Plan, CALHN has embarked on a journey to change its approach to health care and the way it delivers health care services into the future.

2. **Purpose**

The purpose of this paper is to describe the CALHN Specialist Outpatient and Ambulatory Care Services MoC. There have been planning workshops, presentations and discussions with clinical teams and administrative staff to collaboratively develop the MoC. This also follows the consultation process about the Outpatients Governance Framework in June 2015. Related documents about this process can be found on the new RAH consultation intranet page.

This paper starts the next part of the consultation process about these functions and the imminent changes due to the new RAH infrastructure. The CALHN Specialist Outpatient and Ambulatory Care MoC will streamline the patient journey to provide timely access to appropriate services, through the implementation of the Patient Services Teams and the roll-out of the Patient Queueing and Wait Management System.

The Specialist Outpatient and Ambulatory Care Services MoC will undergo continuous improvement and staff will continue to be engaged in further iterations, up to and beyond the opening of the new RAH.

3. **Current Model**

CALHN Specialist Outpatient and Ambulatory Care Services is the largest public facing service within CALHN. Specialist Outpatient and Ambulatory Care Services at the current RAH provide a number of hospital and statewide services across a large variety of clinic settings. A number of these services support tertiary clinics within the RAH, and play critical roles in the state’s cancer and blood disorders management, renal services, ongoing care for complex trauma, burns and spinal care management, and complex elective surgery.

Several services within the Specialist Outpatient and Ambulatory Care Services model also deliver hospital admission avoidance care as well as complex disease management.
The RAH receives referrals to the various services from both internal and external referral bases. These services are currently delivered in multiple locations across the site and occur across an excess of 400 rooms.

The current patient journey follows a referral to a clinic, which is then triaged and an appointment made. Letters are sent to patients stating the time, date and clinic area to attend. In some areas, clinic attendance is confirmed either via a phone call or SMS, prior to the scheduled appointment.

The appointment requires a patient to attend clinic in a specific location, e.g. orthopaedics level 3 Theatre Block, where a patient will present to the clinic at the reception desk, and wait in a designated waiting area adjacent to the clinic consultation rooms until the health care professional is ready to assess the patient. When finished the patient may require further investigations or other appointments or maybe discharged back to their primary health care provider. The patient is then directed back to the reception desk.

If another appointment is required, the administration staff at the reception desk of the clinic makes these arrangements with the patient at the time of the clinic attendance. There may also be engagement with other services on the day of appointment for investigations such as imaging or pathology, which may be planned or ad hoc.

The current model places a significant burden on the ‘front desk’ to provide support to manage registration of appointments, check and update demographics, manage re-appointments, book investigations, monitor did not attends, follow up missing information in case notes, billing answer phones and other face-to-face enquiries. In some cases the current model also relies on ad hoc clinic flows, rather than planned clinical pathways, that have historically evolved and not enabled clear resource planning, nor offered a patient-centred experience. A variety of models of care are currently in place across the outpatient clinics and may be single discipline consults, multi-team consults, or multidisciplinary consults in nature.

Poorly articulated clinical pathways currently contribute to inefficiencies in many clinics, one outcome of which is poor access to clinics contributing to long waiting lists. Accountability for the management of the clinics, the use of resources and the patient-centeredness of the models of care is fragmented and there is opportunity for better alignment to the SA Health policy framework and operational documents.

4. Rationale for Change

Design of the new RAH

A fundamental rationale for change to the MoC is the new RAH functional design. In the new RAH, outpatients will be co-located with shared clinical spaces across 6 wings. The physical design of the outpatients area in new RAH requires changes to the way outpatient services are delivered and ways of working for staff. This includes the way patients are prepared prior to clinics, the way patients will experience their clinic appointment, and the way staff will provide clinical services to their patients.

The Specialist Outpatient and Ambulatory Care Services should only be used for patients requiring an outpatient or ambulatory care services in that clinical areas agreed service profile, with a scheduled appointment for a clinic. No admitted inpatients should be managed in the outpatient setting.

Patient Queueing and Wait Management System (PQWMS)
PQWMS has been purchased to support the patient flow between the waiting areas, wings and rooms and medical imaging. PQWMS is a “check in” service based on appointments made in Enterprise Patient Administration System (EPAS) / Enterprise System Medical Imaging (EMSI). It provides a virtual waiting room for each clinic and communicates to patients via TV screens in the hospital or via SMS to the patient directly.

**Patient Journey**
Currently there are various practices in place due to the location of services and the way they are delivered. The proposed new model will enable a consistent patient centred approach to the patient journey.

The key to the Specialist Outpatient and Ambulatory Care Services model is the coordinated pre-arrival management of the patient clinical and demographic information to facilitate a productive appointment with a clinician, without the need for duplication or rework. This work needs to be supported by combined administrative and clinical teams (the Patient Services Teams), with local knowledge of the clinics.

5. **Future Model**
The following section refers to the future model by describing the physical design of the new RAH, the PQWMS, the Patient Services Team and the five phases of patient journey. This section is supported by information contained in Appendix A “Outpatient and Ambulatory Care Services Phases of the Patient Journey” and Appendix B “CALHN Specialist Outpatient and Ambulatory Care Services roles and responsibilities”.

1.1 **Physical design**
The Specialist Outpatient and Ambulatory Care Services will occupy most of the layout of level 3 at the new RAH (see diagram 1) i.e. in areas 3C, 3E, 3F, and 3G.

**Diagram 1: Level 3 floorplan at the new RAH**

The internal layout of the wings is comprised of treatment rooms, clinic consult rooms, utility rooms, work spaces and storage spaces for stock items etc. (see diagram 2).
There are some small internal sub-wait areas inside the wings that will be used to facilitate patient flow between the consult and treatment rooms. To maintain a patient centred environment, all clinical interactions with the patient will be undertaken in the rooms, and not in the corridors or the waiting areas, as this is considered public space.

Diagram 2: Outpatient wing floor plan

The Specialist Outpatient Services will be consolidated to 6 wings across level 3 of the new RAH, with some clinic locations specified by infrastructure requirements, whilst the remaining areas having generic clinic functionality. The wings comprise of 78 consult rooms and 54 treatments rooms (i.e. 13 consult rooms and 9 treatment rooms per wing). There are three reception desks that service the six wings and there will be space for up to three administrative staff at each desk.

The Day Medical Unit is adjacent to the Specialist Outpatient Service wings and contains the SA Pathology phlebotomy area. Day Medical contains consult and treatment rooms with the addition of treatment chairs. Day Medical is serviced by a single reception desk at the front of this area.

The Cancer Day area is adjacent to ‘wing 1’ of the Specialist Outpatient Service wings and is serviced by a single reception desk with space for up two administrative staff. Cancer Day contains consult and treatment rooms as well as isolation rooms for immunocompromised patients. Cancer Day has treatment chairs for treatment therapies.

Located on level 3 is one of the Distributed Medical Imaging services designed to support the Specialist Outpatient and Ambulatory Care Services. It is anticipated that as a result of co-location, there will be a higher degree of collaboration across all services. Distributing Medical Imaging has been the subject of a
separate consultation process. Documents relating to this process can be found on the new RAH consultation intranet page.

5.1 Patient Queueing and Wait Management System (PQWMS)
Each step of the patient appointment journey is supported by the PQWMS and supports both patients and clinicians to navigate the appointment journey as well as optimise the preparation required for the patient and the service delivery at the time of appointment. Scheduling of appointments will be done in EPAS which interfaces with the PQWMS, and will be the ‘source of truth’ for patient outpatient clinic and ambulatory care appointments.

Patients may arrive via a number of entry points to the Specialist Outpatient and Ambulatory Care Services areas in level 3, either through the front entrance, the eastern entrance off the plaza adjacent to the SAMHRI complex, or via a number of public lifts throughout the level 3 concourse that connect to the car parking below.

At each entry point, patients will be able to ‘check in’ for their appointment using the PQWMS kiosk, similar to an electronic ‘check in’ at an airport. The kiosk then advises staff that a patient has arrived at the hospital. Patients will be supported at the ‘check in' kiosks by volunteers trained to assist patients in how to use the system. The patient may either scan the appointment letter, or their Medicare card at the kiosk.

Further information about the next steps for the appointment, e.g. preferred waiting location, the need to present to a specific reception desk for further appointment instruction etc., is displayed on the kiosk screen. There will be multiple languages available to display information for patients at the kiosk, based on current linguistic groups accessing services at the RAH.

Patients may choose to be either issued a printed ticket at the PQWMS kiosk about their appointment and where to go, or to receive further information via a SMS text, at which point they will be required to enter their mobile phone number into the PQWMS kiosk.

Patients will be ‘called’ to their consult room by the PQWMS, either via SMS or reference to the ticket issued at the kiosk. This ticket reference will be subsequently displayed on a number of the public information displays (TV screens scattered throughout the level 3 concourse). It does not display any patient information, just a queue reference number.

5.2 Patient Services Teams (PSTs)
The PST is a combined clinical and administrative team designed to support timely management of patient registration, referrals and appointments, and communication with patients, servicing specific groups of clinics therefore not generic in nature. The teams will report through the Specialist Outpatient and Ambulatory Care Governance model (as per the consultation process about the Outpatients Governance Framework in June 2015). Each team will have local knowledge of specific clinic requirements to enable a well-coordinated and structured patient journey and understanding of clinic service profiles. The PSTs will have the opportunity to work together across the clinics to help facilitate planning of patients with multiple appointments across multiple clinics.

Administrative staff
The new RAH was designed to support direct patient facing clinical functions, with “back of house administrative functions” housed off site using ICT support functions such as EPAS to deliver services remotely. Having regard to this, the
PST “pre-arrive” functions (refer to 5.4.1 and Appendix B) will not be located at the new RAH site. The location of “pre-arrive” functions is still to be determined and there will be further communication with staff about this once a decision has been made.

PST staff will perform both “pre-arrive” functions off-site and “arrive/departure” (reception) functions at the new RAH. This will mean that they will rotate work locations to perform duties as per their job and person specification. Further information about the spit of duties is contained in Appendix B.

It is recognised that there are number of operational arrangements that need to be worked through for the “pre-arrive” function to successfully support the new RAH from an alternative location, this includes: the provision of full SA Health network access, including but not limited to telecommunications, EPAS, PQMWS, and OACIS; implementation of processes to facilitate management of referrals electronically enabling timely triaging and communication between PST and medical staff located at different sites; the provision of transport for staff between sites during the day where required, for example nursing staff in PST may be required to perform “pre-arrive” functions in the morning and attend a clinic at the new RAH later that day. The decision regarding the location of “pre-arrive” functions will have regard to a number of factors including being located in reasonable proximity to the new RAH.

If there are any changes to rosters for administrative staff arising from the proposed model, this is will be subject to a separate consultation process with affected staff and their representatives, as required.

For administrative staff, the information arising from this consultation process, will also inform the development of specialised Outpatients responsibilities and functions in the Standard Competency Based Role Descriptors currently being developed, as outlined in the new RAH Administration Services consultation process. The new RAH Administration Services consultation process also discussed the Administration Professional Workforce Stream (APWS), the ‘Central Governance, Local Management’ administrative model for the new RAH and Principles of Professional Practice, which will also apply to Outpatients administrative staff. Documents relating to the new RAH Administration Services consultation process can be found on the new RAH consultation intranet page. Further information and/or consultation with affected staff and their representatives will be undertaken in relation to the implementation of the new RAH Administration Services consultation process as required.

Clinical staff

Nursing and Allied Health Professional roles as part of the PST will support triaging of referrals and support to efficient clinics by providing direct clinic advice to patients as well as directly liaising with clinicians in determining specific appointment requirements or requests for further clinical information from referrers and other healthcare providers. Senior Nursing and Allied Health Professionals will commence triaging of the simple referrals and escalating the more urgent or complex referrals to medical staff. They will assist in extracting further information from referring agents if referrals do not provide all relevant
information to enable triaging and subsequent appointment management. Referral management and triaging will be in line with SA Health policies, clinic specific guidelines and best practice.

The PST clinicians will have the local knowledge of their clinics and support from medical staff as required. The Nursing and Allied Health clinical roles will be most likely work on a rotational basis through the PSTs and clinics, and only be provided by senior clinical staff who have had appropriate training in triaging of referrals within a discrete scope of clinic services.

The allocation of clinical staff over the five phases of the patient journey will depend on specific clinic requirements and have regard to staff preferences.

5.3 Five phases of the Patient Journey

The future MoC and service delivery is designed on five key phases in the patient appointment process:

1. Pre-arrive
2. Arrive
3. Service delivery
4. Orders and requests
5. Departure

Appendix A outlines the five phases of the patient journey diagrammatically.

5.3.1 Pre-arrive – What happens before the patient comes to the appointment

The pre-arrive process is outlined in Figure 1 (Appendix A).

Referral management processes will be similar to practices currently undertaken at ‘live’ EPAS sites within SA Health. The PST supporting the clinics across Outpatients will undertake training in order to best manage the referrals that are made to CALHN for specialist services, including validation of referral against service model, seeking further information from referrer when required (e.g. patient demographics), seeking information on tests already undertaken etc.

Triaging of appointments will be undertaken by clinicians (nursing, medical and Allied Health Professionals), who will ascertain the time intervals in which a patient requires an appointment. Patients will be contacted by the clinic relevant PST to arrange appointments and commence the appointment preparation process. Patients will also be asked about preferred contact methods to best support timely provision of information for example; demographics checked and updated; any special circumstances regarding the appointment e.g. do they require an interpreter; mode of arrival e.g. via barouche from SAAS; and if they have any further appointments to be made. Patients will also be sent further information about their appointment and about the experience of attending the new RAH facility. The system that will be used to support appointment booking will be EPAS, which interfaces with the PQWMS. This way, EPAS becomes the ‘source of truth’ for all appointments required at the new RAH.

EPAS will have specific letters generated regarding patient appointments but if a patient appointment is urgent (generally within 7 days from triaging of the referral) the PST will organise the appointment via telephone due to uncertainty of mail delivery times.

Patients will also be able to receive SMS text reminders 24-48 hours prior to their appointment.

5.3.2 Arrive – When the patient arrives at the new RAH for their appointment
The arrive process is outlined in Figure 2 (Appendix A).

The PQWMS is designed to support patients and clinicians with the flow of patients through the appointment process. Public Information Display screens (TV screens), Patient Queueing Kiosks and volunteers provide additional support to facilitate timely progress of the clinic appointment schedule on the day with timely clinician and patient flow.

A patient requiring an Outpatient service will be required to register their arrival and “check in” if they have an appointment. There will be a number of PQWMS Kiosks where they can either scan their appointment letter or swipe their Medicare/DVA card. The patient can choose to be issued a printed ticket with a reference number, which is later used to notify them to specific locations during their journey via monitoring the TV screens located on the level 3 area, or sent to them via SMS text message if the patient has a mobile phone.

There will also be a number of administration staff located at designated reception desks across the outpatient wings who can assist with registering the patient’s arrival. Volunteers will be available to assist patients to use the Kiosk. The use of Volunteers in this manner is similar to the way volunteers currently assist patients find their way around the hospital now.

**Requirement for an interpreter**
A patient who has a scheduled appointment on Level 3 of new RAH arrives and needs to be matched with appropriate interpreter will be directed through PQWMS to the nearest outpatients reception desk to complete this process.

**Requirement for a barouche**
A patient arriving on a barouche will be directed to the nearest reception desk where they can be directed to an available consult room/internal waiting space in the wing in preparation for their appointment. During the Pre-Arrive process, the patient’s mobility will be ascertained and appointments for patients who require mobility equipment will be spread across the day.

**Late arrivals**
If the Patient arrives after the start time of their scheduled appointment, then the PQWMS will direct the patient to the nearest reception desk for confirmation that they can still be seen that day, or re-scheduled.

5.3.3 **Service Delivery – What happens to the patient during the appointment**
The service delivery process is outlined in Figure 3 (Appendix A).

There will be no major changes to the clinical components of service delivery during the appointment. Health care providers will use PQWMS to notify patients they are ready for service rather than walk out into the corridor to physically call the patient. Following notification the patient will receive a SMS or their ticket number will be displayed on the screen in the local waiting area, asking to patient to proceed directly in to the clinic room.

5.3.4 **Requests and Orders – Does the patient need further investigations**
The service delivery process is outlined in Figure 4 (Appendix A).

During the patient appointment a clinician may request further diagnostic tests, e.g. pathology, imaging, or treatments (e.g. physiotherapy) as part of the current or next appointment/s. These will be ordered through EPAS and will need to be demarcated between what is urgent that requires the patient to remain at the hospital for immediate follow up in clinic, or whether this in formation or treatment is required prior to the next scheduled appointment.
Referral to other services may also be activated at this stage of the appointment and may also instigated discussions with fellow clinicians as how to next proceed with a clinical pathway. If the patient requires assistance moving from one location to another (e.g. requires assistance with a wheelchair), this can be arranged prior to the appointment, and supported by Spotless staff. Any new requirements can be arranged contemporaneously by the PST through a direct notification using the PQWMS internal messaging. The appropriate supports will then be arranged as required via a web portal booking procedure to order an Orderly (Spotless staff) or via telephone call to the Spotless Help Desk to organise the Orderly.

If the patient is unwell and requires admission, the patient admission processes will be followed through coordination with the Patient Flow Team and the admitting clinical team.

1.1.5 Departure – When the appointments are complete

The service delivery process is outlined in Figure 5 (Appendix A).

Once the appointment is completed, there are alternative pathways to follow at this time:

- If the appointment is billable, the patient will need to proceed to the clinic reception desk to sign the Medicare form, or relevant paperwork.
- If an urgent appointment is required, the patient will present to the clinic reception desk to have this arranged; if the follow-up appointment is not urgent, the patient will be contacted by the PST to arrange this and other potential appointments.
- If the patient is not billed for this occasion of service and already has appointments made, they leave the area without any further actions to follow.

Once the clinician has completed the service, they will use the PQWMS to notify that the service is complete. If the patient is being discharged from the service, then this will also need to be noted in the clinical record and managed in EPAS, as a discharge. The PQWMS does not provide discharge functionality; its function is to support patient flows throughout the clinic processes.

It is anticipated that discharge letters will be managed in a similar way to those currently planned with the implementation of EPAS at The Queen Elizabeth Hospital. In the absence of this functionality being available ‘day 1’ at the new RAH, business as usual processes will apply.

5.4 Benefits of the future model

It is expected the new model will decrease bottlenecks at reception desks, improve the flow of patients waiting and decrease the length of time waiting for the appointment, improve timeliness of clinics and ensures patient have access to the right care in the right place in the hospital. Many of the expected benefits are anticipated to be delivered as the result of the new environment and the ICT systems (PQWMS). Further to this, improved coordination and preparation of patient appointments including internal and external communications will streamline the patient journey.

It is also expected that the MoC will enable improved compliance with SA Health Specialist Outpatient Clinics policies and guidelines.

5.5 Implementation of the future model

The new MoC for Specialist Outpatient and Ambulatory Care Services will start at
the new RAH on day one. For this to occur work needs to commence now to refine the model and determine more of the detail which will ensure patient safety and timely access to services. It will be useful to implement some of concepts in the current RAH, although the physical design and available technology may limit how much can be tested. Consideration will be given to trialling aspects of the model with specific clinics in the current RAH where possible.

Due to the configuration of clinics and co-location of services in the new RAH, new clinic schedules and templates will be developed with clinicians supported by Central Adelaide LHN Business Rules. A copy of the Business Rules are contained in Appendix C. It is noted these will apply across Central Adelaide and will be implemented in a staged approach across sites.

The new Specialist Outpatient and Ambulatory Care Services MoC will undergo continuous improvement through the transition period and after the move to the new RAH.

5.6 Related change processes
The MoC for the Specialist Outpatient and Ambulatory Care Services has interdependencies with the development of Direct Access / Admissions, the model for the Acute Assessment Unit (AAU), the new RAH Administration Services consultation process, the rollout of EPAS and the management of medical records in the new RAH. These matters will be the subject of separate consultation processes.

5.7 Implications for not undertaking the change
A change to the MoC for the Specialist Outpatient and Ambulatory Care Services is needed due to the design of the new department and the need to improve the patient experience and business efficiencies.

6. Feedback
This proposal provides more detail in relation to the new MoC for the Specialist Outpatient and Ambulatory Care Services at the new RAH. There are still details that need to be determined and your feedback, suggestions and questions will assist in further refining the new model.

Feedback can be provided via survey monkey at https://www.surveymonkey.com/r/newRAHOPDMoC or in writing to Workforce Workstream, new RAH Program, Level 8, Emergency Block, Royal Adelaide Hospital, Adelaide, SA 5000.

Feedback is due by 12 August 2016.

In particular we are seeking responses to the following questions:

1. Do you have any feedback in relation to the Specialist Outpatient and Ambulatory Care Services Consultation Paper? If yes, please provide your feedback in the box below.

2. Do you have any specific feedback in relation to the Patient Services Teams (PSTs) as described in the consultation paper? If yes, please provide your feedback in the box below.

3. What else would you like to know about Specialist Outpatient and Ambulatory Care Services at the new RAH?
7. **References**

- Model of Care for Major Hospital SA Health
- SA Health policy directive Specialist Outpatient Services (eA523220)
- South Australia’s Health Care Plan 2007 – 2016
Figure 1: Pre-Arrive

OUTPATIENTS GENERAL – ‘TO BE’ CONCEPT – PRE ARRIVE

Start of Specialist Outpatient & Ambulatory Care Service (SOACS)

Referral to CALHN

Fax / Referral form / M60 / OACIS/Phone call followed up by faxed referral form

Patient Services Team (PST) – clinic specific validation of referral

Referral has enough info, fits service delineation, LHN specific

Yes

No

Referral does not have enough info and / or doesn’t fit service delineation, not LHN specific

Check UR, history, demographic update etc.

CAT 1 – Within 30 days
CAT 2 – 30 – 90 days
CAT 3 – Within 365 days

Rapid Access i.e. within 72 hours.
- Hospital clinician to discuss with referring clinician.
- Preloading diagnostics
- Referral form faxed in

Hospital clinician advises referring clinician of appointment

Hospital clinician notifies PST to schedule appointment

Patient receives phone call from PST to negotiate appointment (and appointment letter if Cat 1 – 3)

Appointment is scheduled on EPAS

Interpreter Booked (if required) Identify SAAS barouche transfer, bariatric, wheelchair, mobility, custody

Medical records notified to send notes for appointment

Patient receives confirmation SMS text 24 hours prior to appointment

From receipt, referral should be appointed or wait listed within 5 working days.

Referral returned to referrer for further information or advising CALHN unable to accept referral

Huddle to occur day before clinic. This is to discuss numbers of clinic, notes prepped, referrals ready and interpreters, special cases prepped correctly and staff available so as to avoid patient delays / clinic efficiency for staff.

Patient is scheduled an appointment per SA Health Category Guidelines or is booked to Waiting List

PST admin staff register referral onto EPAS/ Medicare checks

PST sort referral form into Clinic ‘folders’ for clinical triaging

Patient services Team (PST) – clinic specific validation of referral

Outcomes

Interpretation

- Identification and accommodation of patient needs
- Access to interpreter services
- Increased patient understanding
- Improved patient satisfaction
- Enhanced communication between patient and healthcare provider

Validation

- Verification of referral details
- Confirmation of patient eligibility
- Identification of any scheduling conflicts
- Ensures that the patient receives the appropriate level of care

Appointment Scheduling

- Arranges appointments for the patient
- Ensures timely access to care
- Facilitates patient follow-up and continuity of care

Referral Management

- Tracks the progress of referrals
- Monitors referral process and outcomes
- Helps to identify any issues or delays

Patient Experience

- Provides a positive experience for patients
- Ensures that patient needs and preferences are considered
- Promotes patient satisfaction and retention

Efficiency

- Increases process efficiency and effectiveness
- Reduces wait times for patients
- Enhances clinic capacity and resource utilization

Appendix A – Specialist Outpatient and Ambulatory Care Services Five Phases of the Patient Journey
Figure 2: Arrive

OUTPATIENTS GENERAL – ‘TO BE’ CONCEPT - ARRIVE

Patient arrives at Way Finding kiosk and is directed to Patient Queue Wait Management System (PQWMS) kiosk

SAAS patient transfers travel direct route from Ambulance Bay via lifts to local reception area of required clinic.

Patient checks into PQWMS kiosk by scanning either:
- Medicare card
- DVA card
- Appointment letter barcode

Mobile number for SMS notifications is registered

Ticket number is printed and patient waits in appropriate waiting area

Patient monitors for SMS notification and/or display screens for ticket number when appointment / clinician ready

Patient notified to progress to local waiting area via PQWMS 15 minutes prior to appointment time

Clinician notifies patient to come directly to clinic room via PQWMS

Ideally the patient will arrive at SOAS with all investigations undertaken in community etc. but if required, to be undertaken prior to appointment at SOAS.
Figure 3: Service delivery

**OUTPATIENTS GENERAL – ‘TO BE’ CONCEPT - SERVICE DELIVERY**

**Service Delivery**

- Patient Assessment/Evaluation
- Care Plan
- Treatment/Procedure
- Documentation in Medical Record/EPAS
- Communication
- Update

**Systems used**

- PQWMS
- OACIS / EPAS
- Medical Records
- EPLIS
- ESMI

Health care professional notifies patient to come directly to clinic room via PQWMS

Patient arrives in consult room for assessment
Figure 4: Requests and Orders

OUTPATIENTS GENERAL – ‘TO BE’ CONCEPT

Requests & Orders

Health Care Professional prints off request form from EPAS and gives to patient

- Medical Imaging required

- SA Pathology required

- Pharmacy required

- Unplanned Admission required

- Planned admission required

- Orth DX

- Allied Health

Immediate (during service)

- Non Urgent

- Non Urgent

- Script generated by Health Care Professional

- Refer to separate Bed Flow Process

Patient gives RFA pack and consent to Admin

Non Urgent

- Imaging requested by clinician via EPAS order

- Performed in Imaging prior to next OPD appointment

- Performed in SA Pathology as advised by clinician and prior to next appointment

- Patient goes to Pharmacy to collect medication

- Technical Suites Flow

Complete RFA pack

RFA pack delivered to Booking Officer to arrange admission

- Discharged home and patient re-presents as booked for inpatient admission

Urgent bloods taken in clinic per current clinical practices

Samples sent via internal pneumatic tube; results available on EPLIS.
## Figure 5: Departure

### OUTPATIENTS GENERAL – ‘TO BE’ CONCEPT

<table>
<thead>
<tr>
<th>Departure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage Medicare billing</td>
</tr>
<tr>
<td>Health Care Professional advises local reception admin staff of item number to be billed via internal message on PQWMS</td>
</tr>
<tr>
<td>Patient presents to local reception desk</td>
</tr>
<tr>
<td>Local reception admin staff prints DB4</td>
</tr>
<tr>
<td>Patient signs DB4 form</td>
</tr>
<tr>
<td>Administrative staff changes appointment status on PQWMS to complete and checks the patient out in EPAS</td>
</tr>
<tr>
<td>Manage Discharge Summary/ Letter</td>
</tr>
<tr>
<td>Health Care Professional to produce discharge summary / letter to referrer &amp; patient</td>
</tr>
<tr>
<td>Health Care Professional to dictate letter and transcription occurs as organised</td>
</tr>
<tr>
<td>Letter transcribed by typist / transcription service</td>
</tr>
<tr>
<td>If transcribed letter requires signature when approved</td>
</tr>
<tr>
<td>Generate and print or email letter and send to referrer</td>
</tr>
<tr>
<td>Generate and print letter for case notes (if not loaded into EPAS)</td>
</tr>
<tr>
<td>File any papers in case notes</td>
</tr>
<tr>
<td>Change location of case notes to Central Medical Records (track medical records)</td>
</tr>
<tr>
<td>Case notes into trolley to return to medical records</td>
</tr>
<tr>
<td>Case notes transported to medical records</td>
</tr>
<tr>
<td>Receive case notes and track into medical records</td>
</tr>
<tr>
<td>Discharged</td>
</tr>
</tbody>
</table>

If additional OPD appointments are required that are not already bundled and booked for the patient, this will be managed by communication from the clinician to the PST via the PQWMS whiteboard messaging function. The pre-arrival process then starts again.

Appointments clinically required from the OP clinic within 48 hours will be managed by the PST at the local reception desk.

Regular 6 month intervals of wait list audits conducted.

Discharge Pathway

FTA Pathway

Patient

Administration / Reception

Patient Services Team

Clinician / Health Professional
## Appendix B – CALHN Specialist Outpatient and Ambulatory Care Services roles and responsibilities

<table>
<thead>
<tr>
<th></th>
<th>Pre-arrive</th>
<th>Arrive</th>
<th>Service Delivery</th>
<th>Orders and Requests</th>
<th>Departure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT</strong></td>
<td>I am contacted by the Patient Services Team (either via telephone or letter) – Administration / Nursing Coordinator / Allied Health – about my details, my supports, my health, any tests I’ve had done recently, how I feel, and they make all the predicted appointments I need for the care I need.</td>
<td>I arrive at the hospital close to my appointment time.</td>
<td>I will be asked many times for confirmation of my identity; if I'm having treatment I will also have an identification band placed on my wrist.</td>
<td>My doctor may suggest I have some blood tests or x-rays / scans before my next appointment, but I don't have to have these done at the hospital; I can do these closer to home.</td>
<td>My doctor and nurse tell me to take care and will see me on my next appointment as already arranged (but this may not be necessary as I have been discharged back to my local doctor). The hospital doctor will email my GP / send a letter to let them know of my progress. The reception staff will ask me to sign the Medicare form before I leave. If I need further or different appointments, the administration staff will advise the Patient Services Team to contact me to arrange.</td>
</tr>
</tbody>
</table>
Compensation cards / Private Insurance information and where I need to go when I get to the hospital and contact details in case I have any questions before I get there. I get a text message in the days leading up to the appointment to remind me to confirm my attendance. I will also get a reminder to make sure I get my blood tests or x-rays done before I have my appointment. I can also look at the new RAH website for information that helps me manage my outpatients and ambulatory care visits and any other useful health information.

If I need blood tests / x-ray done at the hospital before or after my appointment, I will be scheduled to attend SA Pathology / Medical Imaging for investigations.

PATIENT SERVICES TEAM

Review referrals
Triage facilitation of
Assists patient 'check in' if required

be ready for me.
rooms.
If I need to ask a question I can write it down so as I can ask the staff.

their care, management and advice and return to my GP for ongoing management.
I can get my prescription filled at the new RAH pharmacy or my local pharmacy but understand there will be a cost at either choice.

Receive information from Clinicians
| **NURSING COORDINATOR** | referrals as per SA Health guidelines and clinical area directives  
Contact referring agent if further details are required to assist the clinician to triage referral.  
Screening of referrals appropriate for Specialist Outpatient and Ambulatory Care service involvement or for referrals that do not meet service profiles  
Care planning – initiate clinical pathway  
Initiate discharge planning  
Communication with other Outpatient & Ambulatory Care units  
Communication with inpatient units, as required |  | respect to further care or future appointment requirements.  
Commence admission process if patient requires admission from Specialist Outpatients & Ambulatory Care services |
|---|---|---|---|
| **CLINICAL SERVICES COORDINATOR** | Equipment check to ensure that anything required for clinic functionality is present and operational  
Ensure clinical elements are provided  
Assists patient ‘check in’ if required | Staff allocation  
Clinical standards  
Daily coordination  
Feedback to Patient Services Team | Interprets orders and requests for both patients or staff if required |
| **NURSING – GENERALIST DUTIES** | Assists patient ‘check in’ if required  
Ensure clinical elements are provided | Clinic room set-up.  
Additional assessments, update care plan as required,  
Assists medical staff with orders or requests i.e. undertake wound dressings, | Directs patient to other areas i.e. medical imaging, pharmacy, SA Pathology, other |
| NURSING – SPECIALIST i.e. CLINICAL PRACTICE CONSULTANT / NURSE PRACTITIONER | Assist with triage of referrals.  
Assist manager other requests – directed to GPs.  
Screen Screening of referrals appropriate for Specialist Outpatient and Ambulatory Care service involvement or for referrals that do not meet service profiles.  
Triaging of referrals Advanced assessments | Prompt attendance at clinic at scheduled time | Additional assessments.  
Review/ update care plan.  
Feedback to Patient Services Team.  
Preparation of inpatient admission, if required.  
Assists specialist teams with Code Black, Code Blue/MET call | Discharge letter and commence communication with GP about follow up.  
Update EPAS / case notes |
| Care planning | Initiate Discharge planning. |
| Inpatient Admission planning, as required |

| ADMINISTRATI ON STAFF | Primarily undertaken when located off-site. |
| Registration of referral details on EPAS / PAS. |
| Book the appointments as ordered by the clinical staff. |
| If no appointment made add patient to the booking queue |
| Update patient demographic. |
| Package bookings |
| Send patients the information packs required for their appointment. |
| Contact patient 48-72 hours before appointment to confirmation attendance. |
| Ring patient to check demographics and |

| Primarily undertaken when located at new RAH. |
| Meet and greet the patient. |
| Confirm Interpreters arrived at clinic as required. |
| Monitor the FTA data and escalate to the clinicians. |
| Print patient labels / wrist band as required |

| Primarily undertaken when located at new RAH. |
| Assist the clinicians with bookings of follow up or urgent investigations |

| Primarily undertaken when located at new RAH. |
| Billing. |
| Liaise with Patient Services Team about future bookings / next appointments |
| **MEDICAL STAFF (INCLUSIVE CONSULTANT, FELLOW, REGISTRAR, RESIDENT MEDICAL OFFICER, INTERN)** | confirm appointment if patient appointment is a rapid assessment appointment or a country patient if within 5-10 days (to allow for Australia Post delivery schedules).  
Maintain waiting lists.  
Book the interpreter if required via EPAS as well as booking schedule.  
Monitor the MDT room bookings for multi-consults | | | |
| | Assist the nursing and administration staff triage the complex referrals.  
Screening of referrals appropriate for Specialist Outpatient and Ambulatory Care service involvement or for referrals that do not meet service profiles.  
Contact GPs if further information is required to enable triage to occur. | Prompt attendance at clinic at scheduled time.  
Call patient into the consult / treatment room via the Patient Queue Wait Management System or verbal call. | Examination / assessment of patient.  
Clinical documentation of findings in EPAS / case notes.  
Review/ update care plan on EPAS / case notes | Order any further requests / investigations as required – if internal the majority of requests for imaging or pathology will be via EPAS.  
Instruct nursing staff as required to undertake dressings, minor procedures, medication administration  
Order discharge medications | Complete billing order.  
Communication with GP via discharge summary letter.  
Feedback to Patient Services Team |
| ALLIED HEALTH PROFESSIONAL (PHYSIOTHERAPY, OCCUPATIONAL THERAPY, SOCIAL WORK, DIETETICS, SPEECH PATHOLOGY, AUDIOLOGY, ORTHOTICS & PROSTHETICS, PHARMACISTS) | Assist the Patient Service Team with triage of referrals. Screening of referrals appropriate for allied health involvement or for referrals that do not meet service profiles. Communication with other Specialist Outpatient & Ambulatory Care units/community providers Communication with inpatient units. Prompt attendance at clinic at scheduled time. Examination / Assessment. Review/ update. Documentation of care plan and treatment. Order investigations or treatment as per diagnostic recommendations Order prosthetics as required. Order other treatment modality as required. Referral to community provider. Complete Discharge Letters. Update EPAS / case notes. Feedback to Patient Services Team. |
| VOLUNTEERS | Liaise with Patient Services Team, as required Meet and greet the patient and visitors. Assist patients with patient queuing kiosk (stationed across the level 3 footprint). Assist patients with directions etc. as required. Provide escort assistance/ direction, as appropriate. Provide escort assistance / direction, as appropriate. Feedback to Patient Services Team, as appropriate. |
Appendix 3 – Central Adelaide LHN Specialist Outpatient and Ambulatory Care Business Rules

Specialist Outpatient and Ambulatory Care Services

Central Adelaide Local Health Network Business Rules

In accordance with the SA Health Specialist Outpatient Services Policy Directive (2012)
1. Introduction

This paper details the business rules set by the CALHN Specialist Outpatient and Ambulatory Care Governance Committee regarding the utilisation and management of Specialist Outpatient and Ambulatory Care Services across CALHN.

The CALHN outpatient service delivery model is based on the SA Health Specialist Outpatient Services Policy Directive (2012) and its associated guidelines\(^1\), which includes the primary principles of:

- **Community needs** – System is designed to meet the health needs of patients, their families and the community.
- **Whole of system approach** – Supports an integrated approach to the promotion of healthy lifestyles, prevention of illness and injury and diagnosis and treatment of illness across the continuum of care.
- **Preventative approach** – Focus on the prevention of disease and injury and the maintenance of health as distinct from simply focussing on the treatment of illness.
- **Engaging Clinicians** – Clinician engagement is vital in ensuring that an initiative is viable, responsive and effective.
- **Improve timely and equitable access** – Strategy aims to reduce wait times in regards to access to service and ensures accessibility to all who require the service regardless of place of residence.
- **Culturally Respectful** – Ensure the service is responsive to the cultural needs of Aboriginal people and people from culturally and linguistically diverse backgrounds.

Outpatient and Ambulatory Care services are scheduled appointments that do not require an overnight stay. CALHN will provide these services within a single service, multi-site framework.

CALHN Specialist Outpatient and Ambulatory Care Services will be primarily located across Level 3 of the new Royal Adelaide Hospital (nRAH) and in various locations at The Queen Elizabeth Hospital (TQEH). These services include clinic support, consultation clinics, ambulatory day care, and multidisciplinary clinics for all CALHN Clinical Directorates.

2. Background - Assumptions from the functional brief new RAH

In preparation for transition to the new RAH, these business rules have been developed as an extension from the assumptions made as part of the design of the building.

The new RAH Functional Brief outlines the outpatient care requirements for the patient journey, including the following requirements:

- The development of strong links and well developed open communication systems with primary health care services.
- The provision of timely patient access to specialist consultation, specialist Allied Health therapy, diagnostic modalities and treatments.

\(^1\) Referral to Specialist Outpatient Services Guideline; Emergency Department referrals to Specialist Outpatient Services Guideline; Active Discharge from Specialist Outpatient Services Guideline; Patient Focused Booking System Guideline; Medicare Billing for Private Non-admitted Patients in SA Health Outpatients Clinics Policy.
The use of multidisciplinary clinics and telemedicine to facilitate seamless patient care planning and integrated care (within the Facility and across care providers).

Ensuring the avoidance of unnecessary admission of patients to inpatient units for treatment.

The new RAH Functional Brief also outlines the following assumptions for Consultation Room utilisation in the Outpatient Wings (new RAH = 78 consult rooms):

- Hours of operation 6.5 hrs/day
- 5 days per week
- 48 weeks per year
- New cases allocated 30 minute
- Review cases allocated 15 minute
- The 08/09 data gave a new to review ratio of 16:84 (average of 1:5 including chronic disease review’s)

Due to having other dedicated spaces outside of the outpatient wings, the following data was removed from the modelling of consultation spaces available in the new RAH:

- telephone calls
- inpatient consultations
- outreach services
- radiation oncology, cancer day, nuclear medicine, hyperbaric, dermatology (day only) scopes (procedural) and burns.

Some of these assumptions formed the foundation of the CALHN business rules as documented below. Some changes were made, including implementing the SA Health guideline for new : review ratio and extending the hours of operation. This will ensure patients have timely access to outpatient services.

### 3. CALHN Business Rules

The following business rules have been developed using the SA Health Specialist Outpatient Services Policy Directive 2013 and associated guidelines.

#### 1.2 Hours of Operation

Clinic times at the new RAH will be available over a 9 hour day synchronised with the Technical Suites i.e. 2 x 4.5 hour clinic sessions - 0800 – 1230hrs and 1300 – 1730hrs.

The QEH will continue to operate Monday to Friday 0730 – 1730hrs i.e. 2 x 4 hour clinic sessions - 0800 – 1200hrs and 1300 – 1700hrs.

#### 1.3 CALHN Clinic Template Structure

All generic clinic templates will have the following principles:

- Clinics will run 5 days a week, 48 weeks a year
All new cases allocated 30 minute slots
All review cases allocated 15 minute slots
New:Review ratio of 1:3 and or in accordance to the SA Health guidelines.

To ensure flexible use of the spaces, clinics may apply to change the clinic’s start and finish times. Changes to the above can be sought in the form of a business case to the Chief Operating Officer via the Nursing Co-Director for Specialist Outpatient and Ambulatory Care Services. This includes the need for longer consultations and amendment of times for example complex medical might require 45 minutes for initial consultations.

At the new RAH, clinics will be allocated a number of sessions according to the percentage of total actual activity reported YTD 2014-2015 and include the following:

- Face to face OPD appointments will be provided in level 3 OPD
- Weekend capacity is yet to be determined
- Rooms will be scheduled to allow flexible use of rooms and growth.
- Nursing and Allied Health will be scheduled in in treatment rooms where required.
- Capacity for rapid access.

Post relocation to the new RAH, the above operating hours will be reviewed as part of an evaluation process.

1.4 Service Access rules:

Referrals

SA Health has released two guideline documents for referrals to Outpatient services:- “Referral to Specialist Outpatient Services” and “Emergency Department referrals to Specialist Outpatient Services”. Central Adelaide is committed to implementing the processes and recommendations within these documents in order to provide a consistent, timely and patient focussed Outpatient service.

As per the guidelines, access to an Outpatient service requires a referral from an appropriate registered health practitioner. After receipt and processing of the approved referral the patient will be provided with an appointment at a facility that is closest to their usual place of residence and offers the required service.

Should a referral be received for a service that is not provided, a letter will be forwarded to the referring practitioner and patient notifying them that the service is not available and they are required to make alternative arrangements for patient care.

CALHN will not accept referrals that do not meet minimum requirements as per clinical unit service profiles, and the Patient Services Team will work with Referrers to ensure compliance so that patients are not disadvantaged.

Referrals for Specialist Outpatient & Ambulatory Care Services remain valid for a single course of treatment for specified periods (3 months, 12 months, or ongoing) as indicated by the referral. Where a referral is for a chronic or long term condition that will exceed beyond 12 months, this should be indicated by the referring health care professional, i.e. wording must indicate that the referral is valid for an indefinite period and compliance with Medicare rules.
If an interpreter is required, the initial patient referral should state that an Interpreter may be required. Interpreting services will be provided as per CALHN Policy OWI 03878 and in line with SA Health Policy Language Services Provision: Operational Guidelines for Health Unit.

As per best practice guidelines, referrals must be received and registered within 2 days triaged within 5 (Figure 1).

**Figure 1 – Referral management**

![Referral management diagram]

Communication with patients, referrers, CALHN and SA Health at time of writing these business rules are exploring opportunities for electronic communications between CALHN and referrers.

CALHN Outpatients aim to have referral information sent to both patient and referrer within 5 days of receiving the referral. In special circumstances i.e. when a referral is accepted and the patient appointment needs to be within 10 days the P.S.T will contact the patient via phone to inform them of their appointment time, due to the timeline of mail delivery.

### 1.5 Appointments:

The Patient Focused Booking System Guideline (SA Health) will be used to by CALHN Specialist Outpatient and Ambulatory Care Services to provide a consistent approach to the management of patient bookings for specialist outpatient clinic appointments. It aims to ensure timely and efficient access to services for all patients while minimising inefficiencies and rework created by cancelled lists and non-attendance of patients at a booked specialist outpatient appointment.

Patient appointments will be allocated specific amounts of time: New cases allocated 30 minute slots, Review cases allocated 15 minute slots. The templates will be designed to support this configuration of appointments; appointment times of different duration will require approval and be supported by best practice. Where changes are required, the specific clinical units will need to determine the appropriate appointment length of time (as previously indicated) for new and review appointments, and these will be built into the clinic template.
Notification
As per SA Health Specialist Outpatient Services Waiting List Management Policy Guideline, patients registered on Specialist Outpatient & Ambulatory Care Services waiting lists will be formally notified of:

> Placement on the wait list
> Appointment offer
> Postponement / reschedule of appointment
> Failure to attend (FTAs) for a confirmed appointment
> Removal from the waiting list.

Regular wait list audits must be undertaken as per the SA Health guidelines.

Patient appointments will not be booked for periods extending greater than 365 days from the appointment date. For such re-occurring requests, the clinician should consider discharging the patient back to the primary health care provider where they can be re-referred if required.

FTAs will managed as per the SA Health guidelines Specialist Outpatient Services Waiting List Management Policy Guideline,

Selection of patients from the Specialist Outpatient & Ambulatory Care Services wait list on the basis of clinical urgency and waiting time will assist in maximising the number of patients seen within the recommended timeframes.

Please note: Follow up appointments for patients in the custody of the Department for Correctional Services (DCS) will be managed by the SA Health Policy Directive: Prisoners – Care and Treatment in SA Health Services.

Flexibility of room (both consult and treatment) use will be required as part of work practice to allow for the anomaly patient or clinical situation that arises i.e. transplant teams may need 3-4 rooms to prepare the patient for assessment and management.

Appointment Ratio
In line with SA Health policy, the new to review ratio for Outpatient appointments is 1:3. It is recognised that certain cohorts of patients will require additional appointments (where long term follow up of patients with chronic disease), other examples, of patients are:

> With unresolved clinical issues relating to reason for referral
> Who require monitoring of potentially harmful therapies that cannot be undertaken in other settings by other services
> With complex conditions that are unable to be safely treated by another service
> Who are enlisted in a funded and approved research protocol.

However, patients should only ever be re-appointed following review by a senior decision maker, and such documented in the patient record.

Staff booking patient appointments will adhere to the clinic’s schedule template. For reporting consistency and integrity, only new patients will be booked into new patient time slots, and review patients into review time slots.
1.6 **Treatment**

*In Clinic*

Patients seen in Outpatient clinics will have senior clinical decision makers involved in their care from the initial consultation in order to develop a care management plan.

Following the initial consultation the patient may be:

- Returned to the referring practitioner with recommendations for ongoing management
- Returned to the referring practitioner with recommendations for referral to an alternate specialist
- Listed for elective admission
- Provided a follow up appointment in Specialist Outpatient & Ambulatory Care Services; or
- Admitted to hospital.

Specialist Outpatient & Ambulatory Care Services will be evidence based with due consideration of treatment options. All treatment options will be discussed with, and only occur, once consent of the patient, guardian or attorney has been provided.

If the patient required clinical treatment consisting of administration of General Anaesthetic or sedation, the patient will be transferred to the RAH technical suites or TQEH theatres for the procedure/treatment.

*Admission to Hospital*

- As per SA Health’s directive re: the implementation of a [Direct Admissions process](#), CALHN Outpatient services will utilise CALHN’s processes to admit patients directly to the required Unit.
- Admitted inpatients will not be transferred to the Specialist Outpatient & Ambulatory Care services area for treatment, unless there is specific infrastructure not available in the inpatient setting and needs approval by the Patient Services Team and activity captured appropriately in the PAS, e.g. Ophthalmology equipment.
- Patients requiring future admission will need to be added to appropriate waiting lists after specific criteria and processes are fulfilled as per CALHN Technical Suites service delivery guidelines.

*Discharge / Transfer of Care from Outpatients*

- Specialist Outpatient & Ambulatory Care Services will deliver coordinated care, clinical follow up and appropriate discharge planning (refer Active Discharge from Specialist Outpatient Services Guideline) to support all parts of the patient journey.
- Discharge planning will commence at the initial consultation and will continue at each appointment.
- A discharge / transfer summary will be provided to the referring practitioner and the ongoing service provided as appropriate and CALHN policy as outlined in the NSQHSS Standard 6 Clinical Handover.
- Clear discharge criteria will promote consistency of practice and aid decision making across all employees working in the specialty.
- The discharge is to be recorded in the electronic system and documented in the medical record, with a discharge / transfer summary communicated to the referrer and the patient’s GP.
1.7 Clinic Administration

Co-operative Arrangements
> In situations where Specialist Outpatient & Ambulatory Care Services are provided through a cooperative arrangement between facilities (e.g. outreach services) a service agreement will clearly identify the service with the responsibility for each aspect of clinical and administration service provision.

Clinic Review
> Clinical units providing Specialist Outpatient & Ambulatory Care Services with CALHN need to regularly review clinics and ensure they are in line with the Clinical Service Profile.
> If change of clinic information and clinic number is required this must be discussed with the CALHN Specialist Outpatient & Ambulatory Care Services Clinical Operations Lead for consideration.

Clinic Scheduling
> The clinical space in the new RAH (i.e. Consult and Treatment rooms in the wings) will be for clinical face to face consultations and examinations. All other non-face-to-face activity i.e. virtual clinics, phone calls, case note reviews and telehealth consults must be undertaken in Blue Space or specific telehealth locations.
> Clinic times will commence at the agreed start times, i.e. Clinic A is scheduled to commence at 0800 as the first scheduled appointment, the treating clinician must be ready to commence assessment of that patient at 0800 so as the next scheduled patient is not be disadvantaged, and the clinic runs to time.
> Clinics will finish according to allocated time, i.e. 1230pm, enabling efficient transition of the clinic room to the next clinic session.
> By enabling clinics to start and finish on time, clinics will not be:
  - Over booked
  - Scheduled against conflicting arrangements (i.e. theatre lists, unit meetings)
  - Capacity for emergent cases (rapid access) will be embedded into the template, and kept available for urgent reviews or emergent new patients until 72 hours for clinics.
> Where possible, appointment times should be arranged to facilitate patients being seen by the same clinician or specialist team.
> Senior decision makers (consultants) are to be available in person during all clinics.
> Where possible appointment times are to be allocated in a patient focussed manner, especially to facilitate coordination of appointments across multiple clinics.

Patient Records
> For day 1 of operation at new RAH, both electronic medical records and paper-based case notes will exist. More detail will be provided.
> TQEH will have EPAS, as well as access to historical paper records, as required.

Staff Leave
> Staff must follow the leave management process that is in accordance with industrial and HR requirements from SA Health.
> If sick or unplanned leave is required all endeavours must be made to cover clinics so as patient appointments can be maintained.

1.8 Clinic specific reporting and KPI's

Measurement of ‘Specialist Outpatient Services’ performance will be based on the SA Health Specialist Outpatient Services Policy Directive (2012) and will include the following CALHN KPIs:

<table>
<thead>
<tr>
<th>Specialist Outpatient and Ambulatory Care KPI's</th>
<th>System</th>
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<tbody>
<tr>
<td>Referral Management (fig 1)</td>
<td>EPAS</td>
</tr>
<tr>
<td>Room Utilisation</td>
<td>EPAS/PQWMS</td>
</tr>
<tr>
<td>New : Review Rates</td>
<td>EPAS</td>
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<tr>
<td>Waitlist</td>
<td>EPAS</td>
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<td>Fail to attends (FTAs)</td>
<td>EPAS</td>
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<tr>
<td>Productivity and patient throughput</td>
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<tr>
<td>Clinic cancellations –</td>
<td></td>
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<td>Clinic start / finish times</td>
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</table>