West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

ALTERNATIVE PATHWAYS FOR NEW PATIENTS (ADPF No. 34)

FINAL PROJECT REPORT

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TABLE OF CONTENTS

WCDHB REGION **1**

ALTERNATIVE PATHWAYS FOR NEW PATIENTS PROJECT **1**

THE URGENT COLONOSCOPY PATHWAY **1**

Background *1*

The Alternative Pathway *2*

Funding *2*

Findings *2*

Conclusion *4*

THE CATARACT PATHWAY **4**

Background *4*

The Alternative Pathway *5*

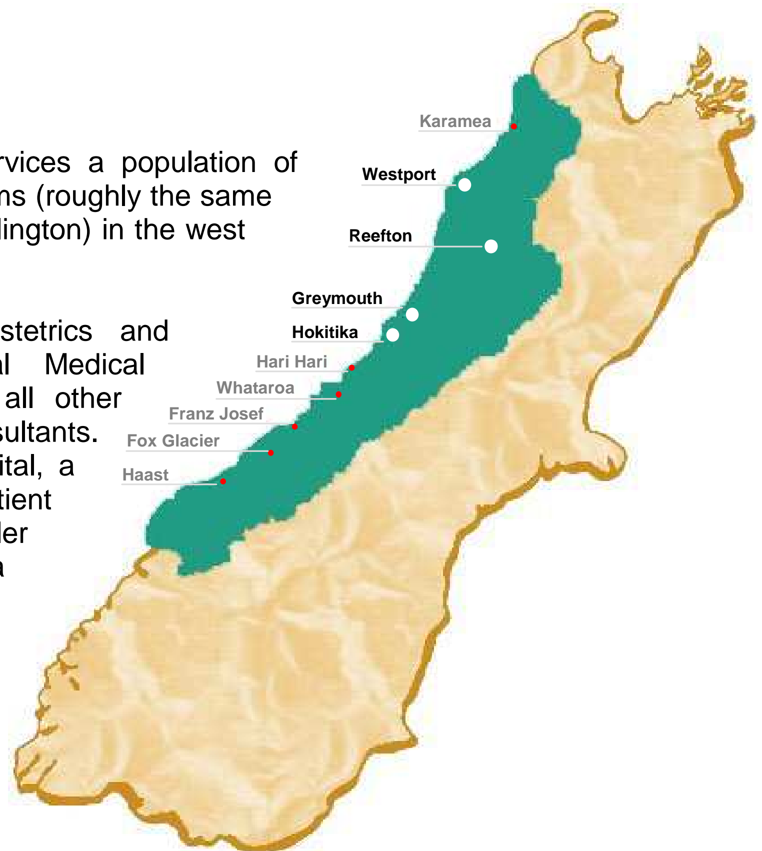
Funding *6*

Findings *6*

Conclusion *7*

APPENDIX 1 – Urgent Colonoscopy Referral Tool
APPENDIX 2 – Cataract Referral Tool
APPENDIX 3 – Urgent Colonoscopy Alternative Pathway, Patient Journey Map
APPENDIX 4 – Cataract Alternative Pathway, Patient Journey Map

WCDHB Region



The West Coast District Health Board services a population of around 30,000 spread over an area of 600kms (roughly the same distance as that between Auckland and Wellington) in the west of New Zealand's South Island.

WCDHB provides General Surgery, Obstetrics and Gynaecology, Orthopaedic and General Medical services with in-house consultants while all other specialties are covered by visiting consultants. Surgery is provided from Grey Base Hospital, a secondary level facility, with outpatient appointments also provided from Buller Hospital, Reefton Hospital and the Hokitika Health Centre.

There are around 30 General Practitioners on the West Coast with most based in the main centres of Westport, Reefton, Greymouth and Hokitika.

Alternative Pathways For New Patients Project

The aim of the Alternative Pathways For New Patients project was to develop and formalise processes around alternatives to the traditional FSA pathway encompassing the virtual FSA and direct access to treatment concepts. The virtual FSA approach can be incompatible with volumes-based funding and produces barriers to efficiency in service delivery. The project would consider alternatives to the current volumes based funding mechanism where appropriate to provide greater opportunity for efficiency at service level without loss of funding or reduction in contract volumes.

The project would initiate pilots in General Surgery (a service provided by WCDHB consultants) for urgent colonoscopy, and Ophthalmology (a service provided by visiting consultants) for cataract.

Work on the project began in November 2006 with an expected completion date of 30 June 2007. An application to extend the completion date to 28 September 2007 was granted due to delays caused by project staff vacancies and in order to collect additional data.

The Urgent Colonoscopy Pathway

Background

The West Coast has the highest incidence of colorectal cancer in New Zealand. WCDHB maintains a waiting list of around 400 surveillance colonoscopies with approximately 300 new referrals for colorectal conditions each year (30% total referrals to General Surgery). WCDHB General Surgeons note that West Coast patients diagnosed with colorectal cancer often present late and at an advanced stage of disease.

Patients referred to WCDHB requiring colonoscopy follow the same pathway as that for any elective surgical patient with the referral being prioritised, the patient placed on the outpatient waiting list, seen in clinic (FSA), and then placed on the surgical waiting list. Under this structure

patients can wait up to eight months from referral to procedure, particularly those in the semi-urgent and routine groups.

Ways of reducing the number of new patient clinic attendances and improving waiting times for scope patients have been considered for some time. The Alternative Pathways pilot provided an excellent opportunity to trial the virtual FSA and direct access concepts for the colonoscopy pathway.

The project team agreed that the trial would best be conducted with patients requiring urgent colonoscopy as this group was considered to be provided the most benefit from the direct access concept, particularly considering the high incidence of colorectal disease on the West Coast.

The Alternative Pathway

The virtual FSA method was provided by way of a criteria based referral tool (Appendix 1) which allowed patients to be reviewed by a surgeon and anaesthetist via a paper-based exercise and directly wait listed for surgery. The tool was released for use by GPs on 7 March 2007 and was also made available for use by hospital consultants and junior doctors in all wards and outpatient departments at all WCDHB facilities.

Desired outcomes for the trial were a maximum waiting time of 28 days from referral to procedure with the ultimate goal of 14 days.

The referral tool was developed by WCDHB's General Surgeons and Anaesthetists in consultation with GPs. Education sessions were held with GPs to increase knowledge and awareness of colorectal disease and endoscopy.

The GP, at the time of consultation with the patient, completes the tool and provides the patient with information on the procedure and anaesthesia. The referral is then faxed directly to Grey Hospital surgical waiting list where it is entered into the patient management system and forwarded to the Anaesthetist and General Surgeon for review.

The referral is assessed as to the patient's suitability for direct access and whether a clinic appointment or further investigations may be required. Patients who are suitable for direct access are placed on the surgical waiting list and booked into the next available scope session. Patient notes are reviewed by the Surgeon and Anaesthetist when the patient is booked for surgery and a brief interview is conducted with the patient on the day of surgery.

If the referral is assessed and an appointment is required the referral is sent to the outpatient department or pre-assessment clinic for booking into the next available slot.

To ensure that all care necessary to ensure patient safety was being provided through the alternative pathway a patient journey mapping exercise was undertaken for the traditional pathway to identify activities in the outpatient component that still needed to occur through the direct access method. A patient journey map for the urgent colonoscopy alternative pathway is included in Appendix 3.

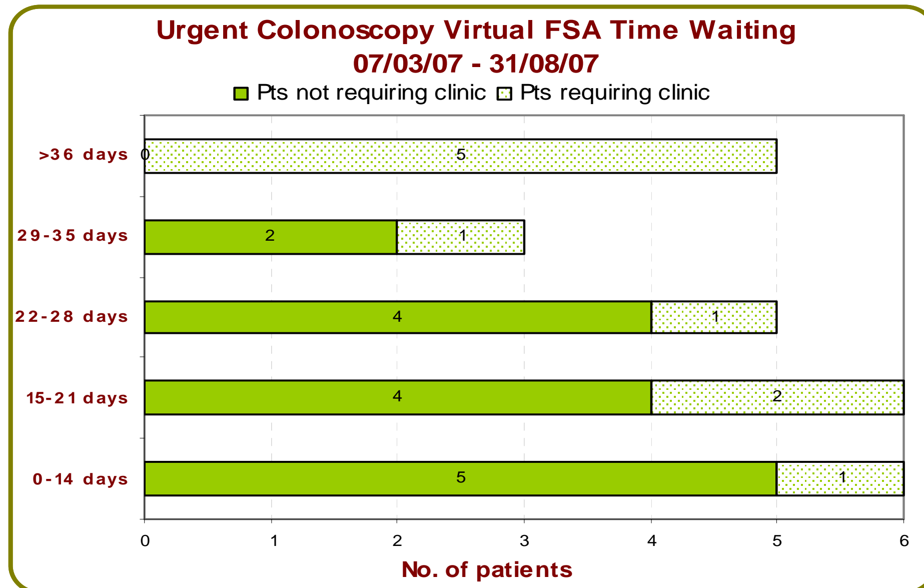
Funding

Various funding mechanisms were considered for patients referred using the direct access referral tool, however it was considered that the FSAs freed up by use of the virtual FSA method could offset overproduction or allow a drop in outpatient access thresholds for General Surgery.

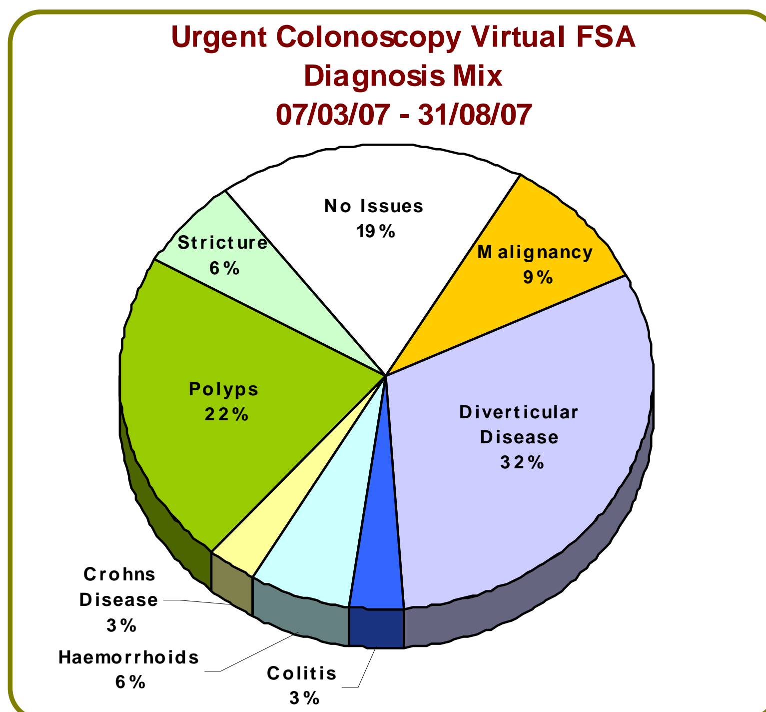
Findings

From 7 March to 31 August 2007, 34 direct access referrals for urgent colonoscopy were received. Of those five were assessed as requiring a surgical clinic appointment and six were assessed as requiring a pre-assessment clinic appointment.

Average waiting time for a patient requiring urgent colonoscopy referred through the traditional pathway is 104 days from date of referral to procedure. Average waiting time from referral to procedure for patients referred with the direct access tool during the pilot who did not require a clinic appointment was 19 days from referral to procedure, a reduction in average waiting time of 85 days. Average waiting time from referral to procedure for patients referred with the direct access tool who did require a clinic appointment (surgical or pre-assessment) was 42 days, a reduction of 62 days.



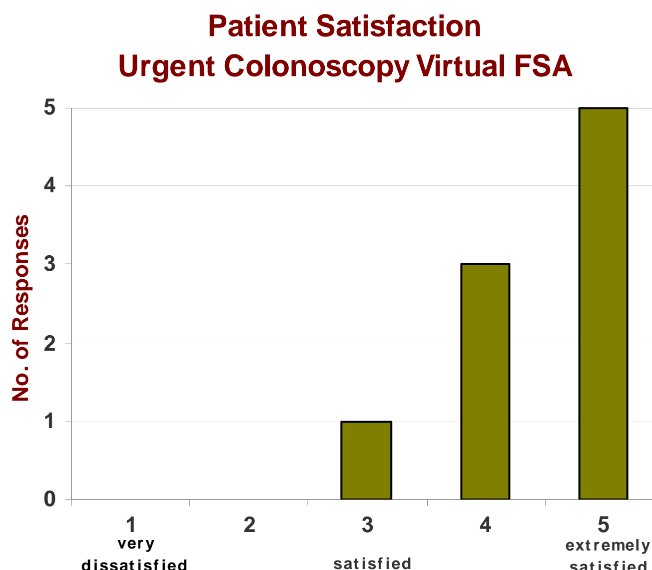
The following chart displays the mix of diagnoses from procedures performed.



The procedure completion rate for direct access patients was 87.5%. Three cases were not completed due to complications during the procedure.

Patients were supplied with a questionnaire to rate satisfaction with their treatment and the adequacy of the information provided. At the time of writing nine questionnaires had been returned with five patients selecting a satisfaction rating of 5 – extremely satisfied.

GPs also expressed satisfaction with use of the tool and have reported positive feedback from patients referred through the direct access method.



Conclusion

The direct access referral tool for urgent colonoscopy has proven to be an efficient and safe method of assessing patients using the virtual FSA concept. WCDHB is implementing the tool on an ongoing basis and work is already underway to further develop the tool to encompass all priorities of scope including gastroscopy, and expansion of the concept to other procedures or diagnostics such as DHB funded mammogram.

The Cataract Pathway

Background

At WCDHB Ophthalmology services are provided on a visiting basis by two separately contracted private Ophthalmologists. One consultant services the Buller district in the north based from Buller Hospital and the other covers the Grey and Westland districts in the south based from Grey Hospital. WCDHB does not have the equipment to perform Ophthalmic surgery on the West Coast and patients requiring a procedure receive treatment from the contracted consultants at their practices in Nelson and Christchurch respectively. Some patients can also have their procedure on the mobile surgical bus when it visits Westport.

Approximately 70% of all referrals to Ophthalmology are made to Grey Hospital. Both the Grey and Buller regions receive approximately the same number of referrals for cataract (36 in Buller and 44 in Grey over the course of the pilot), which accounts for around 20% of referrals to Ophthalmology in Grey and 50% of referrals to Ophthalmology in Buller.

From March 2004 to July 2007 WCDHB experienced difficulty in maintaining consistency of consultant cover in Ophthalmology. Clinics held over this period focussed on follow-up appointments and new patients with urgent priority. By 30 June 2006 the Grey Hospital FSA waiting list had grown to 182 patients, 51 waiting over six months with approximately 20 of those waiting from 12 to 24 months. The average waiting time for a patient requiring cataract surgery from referral to procedure for the 05/06 year was 400 days. In July 2006 93 patients were removed from the outpatient waiting list, half of which were patients waiting for cataract assessment.

When a long term arrangement was made with a visiting Ophthalmolgist for the Grey district in July 2006 various ways of reducing clinic load while ensuring patients requiring cataract surgery still

received treatment were discussed. Investigation of the virtual FSA concept was the preferred option.

The Alternative Pathway

The Grey Hospital visiting Ophthalmologist worked with local Optometrists and GPs to develop a referral tool based on the national scoring tool for cataract surgery for use as a direct access referral tool.

Desired outcomes for the trial were a reduction in waiting time to less than six months (180 days) for 90% of patients, greater certainty of treatment status or eligibility for treatment for patients and reduction in the number of FSAs required whilst retaining a high level of access to the visiting service.

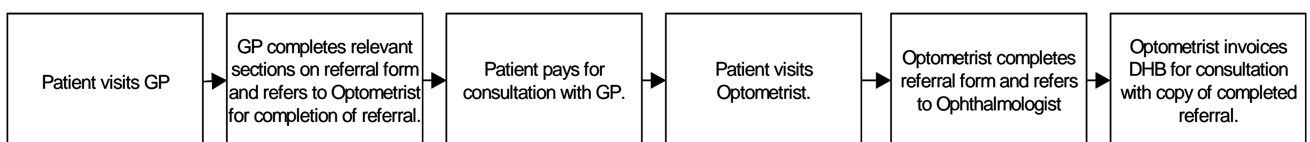
A series of consultation and education sessions were held with the visiting Ophthalmologist, GPs and Optometrists regarding cataract and the presence of other eye disease and medical conditions that may compromise referral using the direct access method.

The pilot began in November 2006 with GPs referring patients potentially requiring cataract surgery to Optometrists who would then assess the patient using the national scoring tool for cataract and refer to Ophthalmology for paper-based review by the visiting Ophthalmologist. Only patients without other eye disease or significant medical issues, and with the ability to travel for surgery were eligible for referral using this method.

This process was effective as an alternative to clinic assessment, however there was confusion amongst GPs and Optometrists as to what criteria or score needed to be met for a patient to receive direct access to the surgical waiting list. There were also issues regarding sufficient information on medications & co-morbidities that could present a problem at the time of surgery.

It was also reported by GPs, Optometrists and WCDHB Social Workers that additional financial strain on patients in meeting the cost of both a GP and Optometrist appointment was an issue. There was also a need for delivery of information regarding travel and accommodation subsidies for patients travelling to Christchurch for cataract surgery that was not covered by the paper based exercise.

Further consultation with Optometrists and GPs led to further development of the referral tool (Appendix 2) based on the national CPAC tool for cataract with information on co-morbidities, travel and surgical thresholds included. Patients referred with the tool who had followed the appropriate process would be entitled to a free consultation with their GP or Optometrist depending on which provider they presented to first, as per the following process. The revised tool and subsidy arrangement was made available in May 2007.



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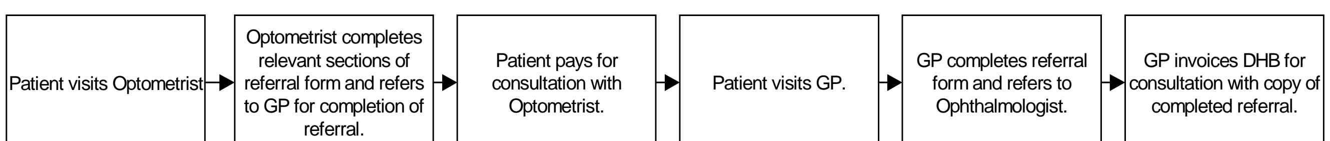


A patient journey map for the cataract alternative pathway is included in Appendix 4.

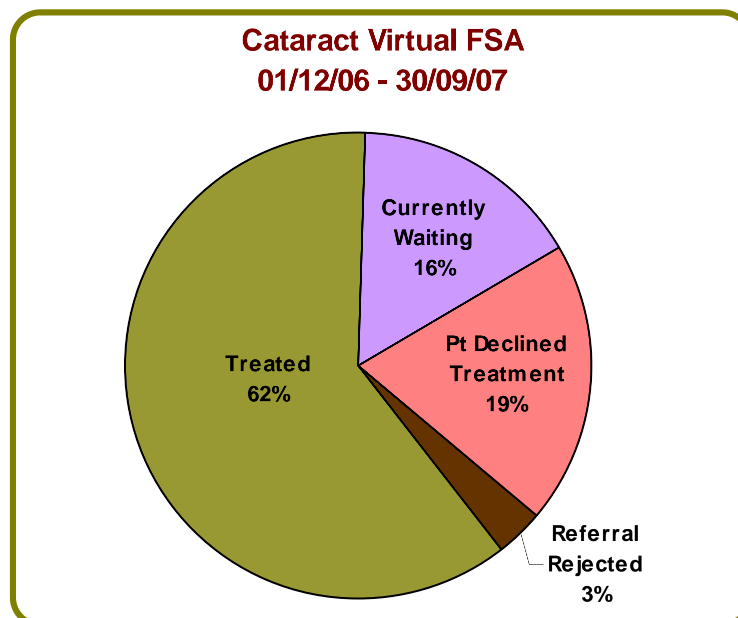
Funding

The virtual FSA concept for Ophthalmology has reduced the number of FSAs required, however the service does still incur a cost for the visiting Ophthalmologist to review referrals and make arrangements for patients requiring surgery that would ordinarily occur at a clinic appointment. There is also a cost for patients who are eligible for a subsidised consultation with their GP or Optometrist. At the time of writing only four claims have been made for subsidised consultations.

A proposal to create a separate line item in the provider contract for Ophthalmology virtual FSAs at a reduced rate to that of a traditional FSA is being considered but will not be implemented until the number of virtual FSAs can be predicted with more certainty.

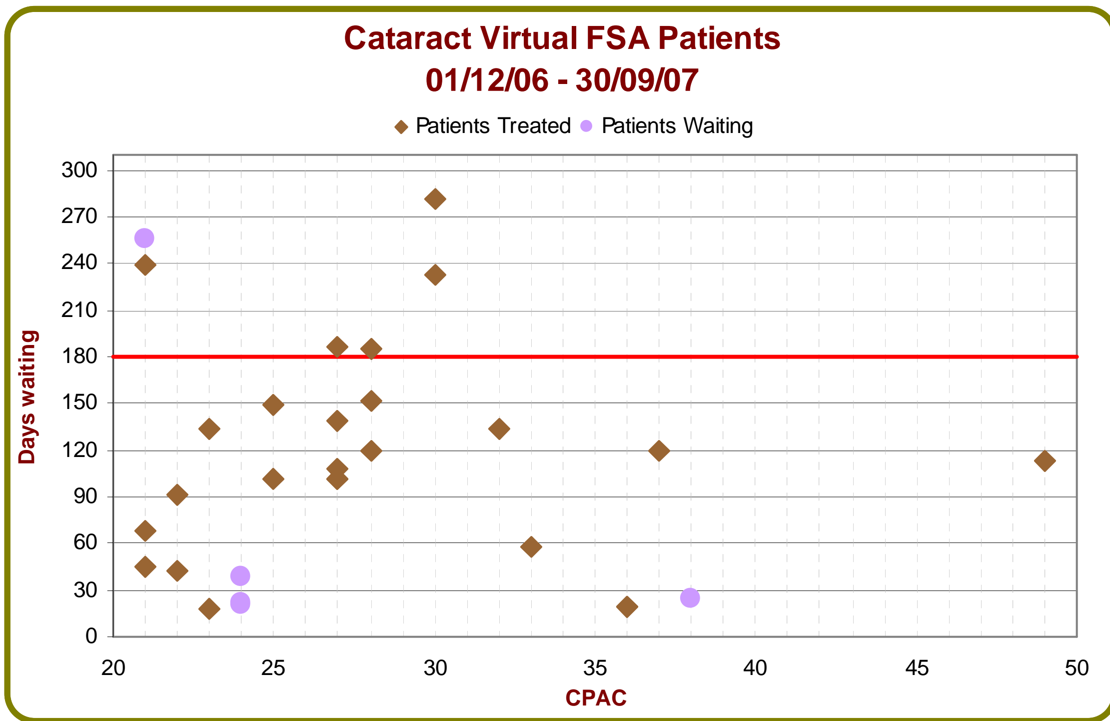
Findings

From 1 December 2006 to 30 September 2007, 44 patients were referred for cataract surgery using the pilot referral tool. None of these patients were assessed as requiring a clinic appointment before being wait listed for surgery. Only five referrals through the traditional pathway for cataract surgery were received during this period.



The surgical treatment threshold for cataract surgery over the course of the pilot was a CPAC score of 21 points. Only one patient scoring below the surgical threshold was referred using the virtual FSA method during the pilot. This indicates that clarity of treatment status has been improved at the primary level. GPs and Optometrists have reported that the referral tool has provided a greater sense of certainty for patients regarding eligibility for surgery at the time of consultation.

Average waiting time from referral to procedure for patients referred through the alternative pathway was 118 days. Of the patients who received surgery during the pilot 80% were treated within six months.



Travel for Ophthalmic surgery has been a difficult issue for West Coast patients. Information on travel and accommodation assistance is included on the referral tool and GPs and WCDHB Social Workers noted that this improved the experience for many patients as there had previously been uncertainty over eligibility for assistance and the process for making a claim.

Conclusion

The direct access referral tool for Ophthalmology is being implemented by WCDHB on an ongoing basis with review of primary care subsidies in six months if required and possible inclusion of a separate line item in the provider contract for the 08/09 year if considered viable.

APPENDIX 1

Urgent Colonoscopy Referral Tool

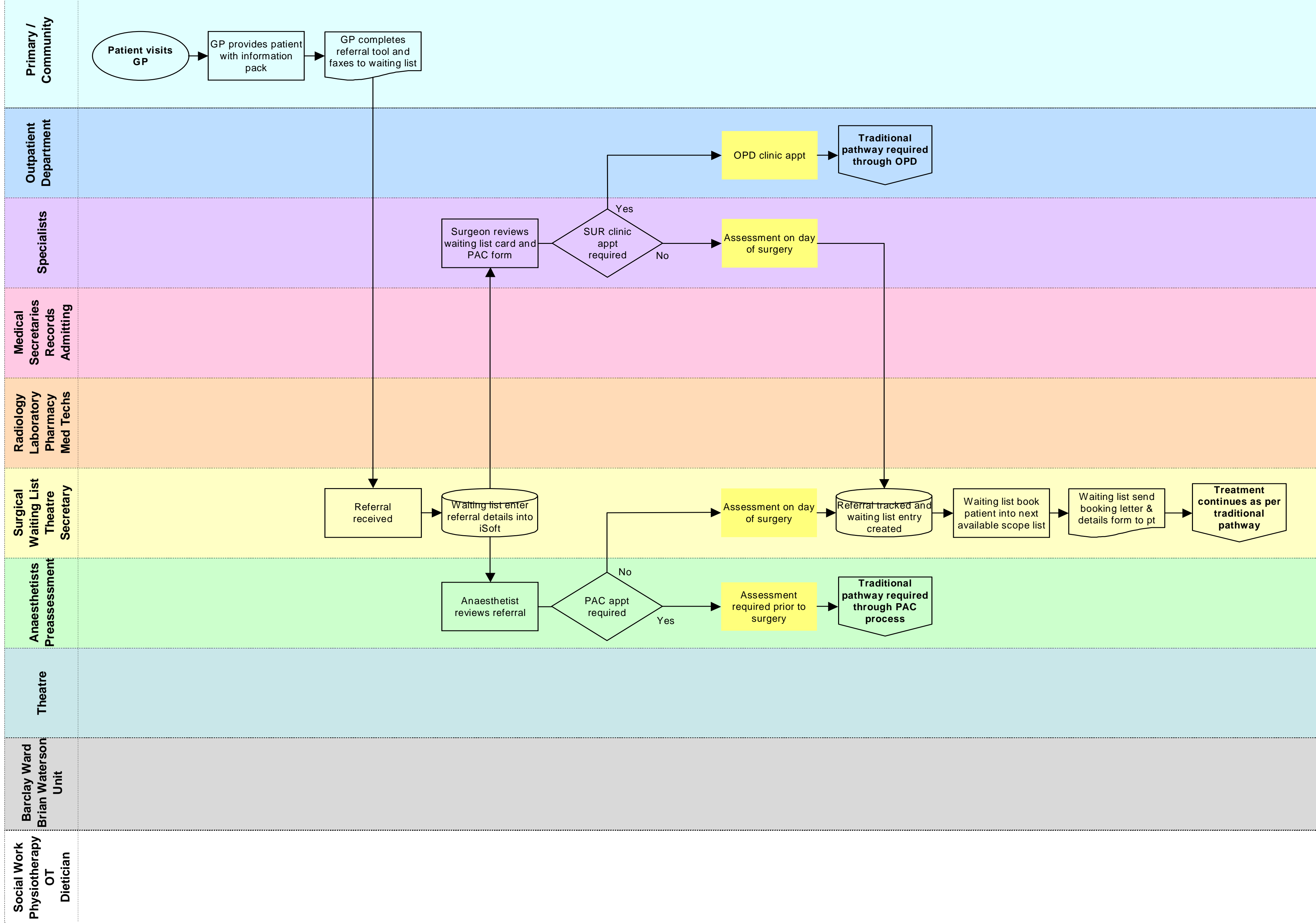
APPENDIX 2

Cataract Referral Tool

APPENDIX 3

Urgent Colonoscopy Alternative Pathway

Patient Journey Map

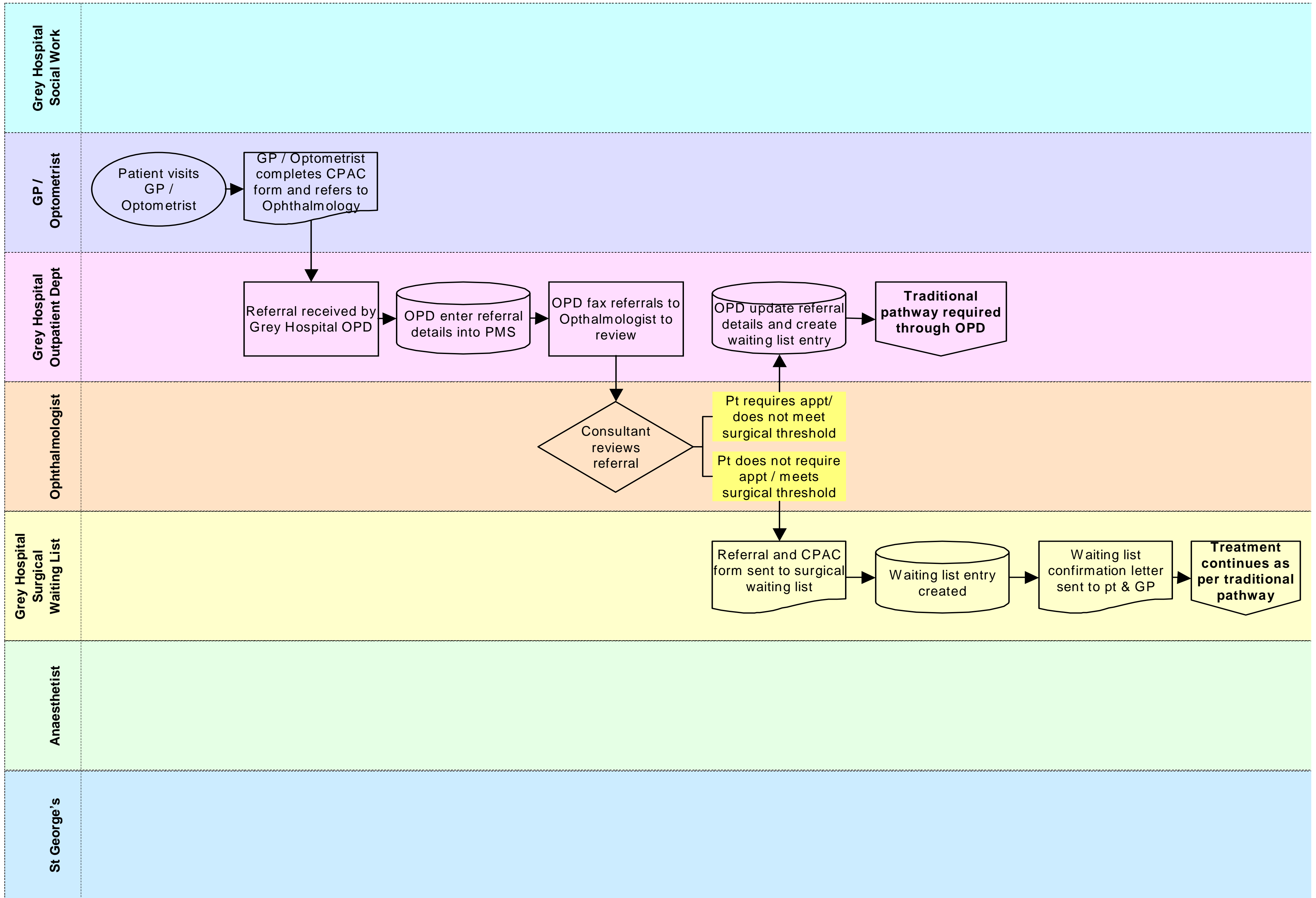


Primary / Community
Outpatient Department
Specialists
Medical Secretaries Records Admitting
Radiology Laboratory Pharmacy Med Techs
Surgical Waiting List Theatre Secretary
Anaesthetists Preassessment
Theatre
Barclay Ward Brian Waterson Unit
Social Work Physiotherapy OT Dietician
Patient visits GP
GP provides patient with information pack
GP completes referral tool and faxes to waiting list
OPD clinic appt
Traditional pathway required through OPD
Yes
Surgeon reviews waiting list card and PAC form
SUR clinic appt required
No
Assessment on day of surgery
Referral received
Waiting list enter referral details into iSoft
Assessment on day of surgery
Referral tracked and waiting list entry created
Waiting list book patient into next available scope list
Waiting list send booking letter & details form to pt
Treatment continues as per traditional pathway
No
Anaesthetist reviews referral
PAC appt required
Yes
Assessment required prior to surgery
Traditional pathway required through PAC process

APPENDIX 4

Cataract Alternative Pathway

Patient Journey Map


Grey Hospital Social Work
GP / Optometrist
Grey Hospital Outpatient Dept
Ophthalmologist
Grey Hospital Surgical Waiting List
Anaesthetist
St George's
Patient visits GP / Optometrist
GP / Optometrist completes CPAC form and refers to Ophthalmology
Referral received by Grey Hospital OPD
OPD enter referral details into PMS
OPD fax referrals to Opthalmologist to review
OPD update referral details and create waiting list entry
Traditional pathway required through OPD
Consultant reviews referral
Pt requires appt/ does not meet surgical threshold
Pt does not require appt / meets surgical threshold
Referral and CPAC form sent to surgical waiting list
Waiting list entry created
Waiting list confirmation letter sent to pt & GP
Treatment continues as per traditional pathway