Clinical **Excellence** Division
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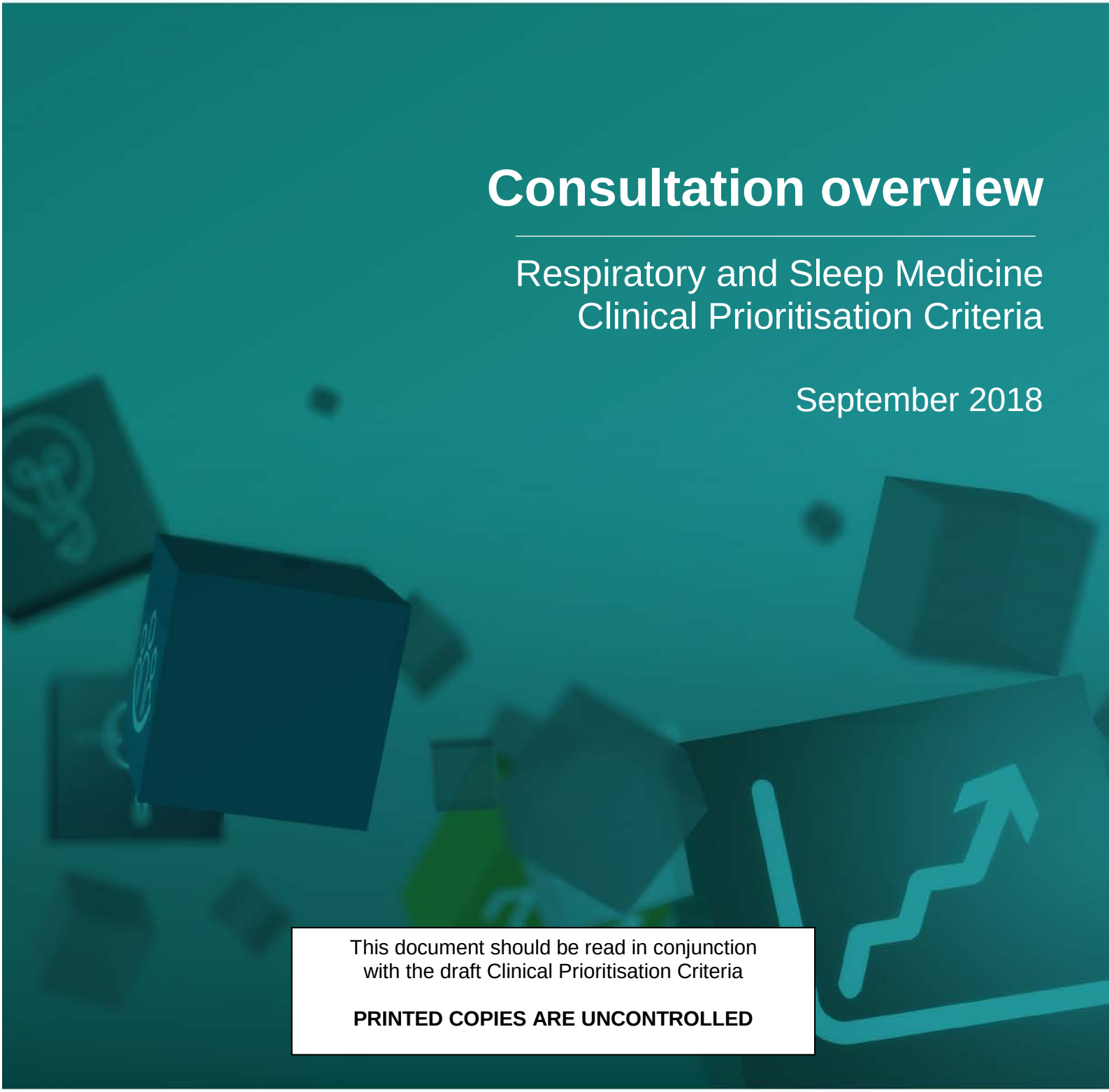
# Consultation overview

## Respiratory and Sleep Medicine Clinical Prioritisation Criteria

September 2018



This document should be read in conjunction with the draft Clinical Prioritisation Criteria

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**Consultation overview: Respiratory and Sleep Medicine Clinical Prioritisation Criteria**

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# Purpose

This consultation overview has been prepared to accompany the draft Clinical Prioritisation Criteria (CPC) for Respiratory and Sleep Medicine and provide a useful overview during the CPC development and consultation process.

# Introduction

CPC are clinical decision support tools that will help ensure Queensland patients are assessed in order of clinical urgency. They will be used by both referring practitioners when referring patients to specialist outpatient services and specialist outpatient services when determining how quickly the patient should be seen (urgency category).

CPC have been developed to improve the patients' specialist outpatient experience. CPC aim to support:

- equitable assessment of patients regardless of geographical location within Queensland
- the provision of specialist outpatient appointments in order of clinical urgency
- ensuring patients are ready for care at their first specialist outpatient appointment
- improved referral and communication processes between referrers and specialist outpatient services.

Importantly, CPC will assist rather than replace clinical judgment and decision making.

CPC will integrate into local care pathways, or HealthPathways so that GPs and other referring practitioners and their patients can be sure that referral to a public medical specialist service is appropriate, regardless of whether that specialist service is available in their local area.

The implementation of CPC may mean that some patients will be offered appropriate care in a different setting or appropriate care with an alternative health care provider (for example allied health or nurse led clinics) rather than waiting to be offered a specialist outpatient appointment.

# CPC development

Clinical Advisory Groups (CAGs) are utilised for each specialty area. Guided by a clinical lead, the CAGs provide expert clinical advice to inform the development of the relevant CPC. This is important to ensure the criteria are clinically relevant and credible.

CAG membership includes general practitioners (GPs), medical specialists, nurses and allied health professionals. A list of current CAG participants is listed in Appendix 1.

The development process can be broadly described in the below diagram. As the CPC progress through the development and consultation process, different groups of stakeholders may be invited to participate.

The content in the attached draft has been drawn from existing guidelines implemented in some Queensland Hospital and Health Services (HHSs), in other Australian jurisdictions or internationally. The draft CPC should be seen as a starting point only with outcomes of the consultation and testing a key input to the final content.

## CPC format

The draft CPC attached to this overview is not the final format or layout for the CPC. The CPC will be published to the CPC website (https://cpc.health.qld.gov.au/) and will also be integrated into the HealthPathways platform. Once the CPC has been finalised by the CAG, the website will be the source of all truth.

HealthPathways is a web-based information portal that provides pathways for assessment, management and referral of patients and assists clinicians to navigate the patient through the complex local health system. HealthPathways is designed to be used at the point of care, primarily for general practitioners, but is also available to specialists, nurses, allied health and other health professionals.

### In scope conditions

The conditions for which criteria are to be developed are determined by the CAG. This may not be a comprehensive list of all conditions (symptoms, diagnoses) seen by specialists in that area; however, will typically be the most common conditions presenting for first specialist outpatient appointment.

Where available this will be informed by data on presenting conditions; however, statewide data for outpatients is not currently able to be interrogated at this level.

Conditions and interventions can be added (or removed) in future reviews and updates of the CPC.

### Paediatric conditions

Historically in CPC development, the CPC Paediatric Advisory Group (PAG) considered the most common paediatric presentations for each specialty, those conditions where there was potential to receive unnecessary referrals and those conditions where there may be a waiting list to be reviewed in outpatients. This advice was provided to the CAG, and the list of conditions was expanded or reduced in consultation with the PAG. Consideration was also given to whether paediatric conditions (those unique to children) or conditions commonly impacting children could suitably be addressed or included in the draft CPC or warrant development of a specific paediatric CPC for that specialty.

In early 2017, the PAG closed as they had fulfilled their terms of reference. From this point forward, all new CPCs developed will include the following clinicians as invited stakeholders so that they may contribute as they see fit:

- members of the now closed PAG
- members of the Statewide Child and Youth Clinical Network.

Each CAG must have a paediatric representative to provide advice from a paediatric perspective.

## Purpose of referral and outpatient criteria

The information in the draft CPC for Respiratory and Sleep Medicine is intended to assist:

- GPs and other referring practitioners to identify the point at which a patient may benefit most from a first referral to specialist outpatient services, the information necessary to support the referral, and how quickly the patient may be seen.
- Appropriate HHS staff to make transparent and equitable decisions on when referrals should be accepted and the timeframe for first appointment.

# Consultation questions

To assist in providing feedback on the draft CPC, please consider the following general questions.

1. Are the criteria clinically appropriate and evidenced-based?
2. Have only the minimum criteria necessary for triaging been included?
3. Is the CPC applicable across the state? i.e. referral into tertiary facilities to rural facilities.
4. Do the criteria adequately and appropriately differentiate triage categories?
5. Is there any other relevant information that should be considered or incorporated into HealthPathways?

## Other useful information

In the course of engaging with stakeholders about CPC more information has been sought on a number of topics. This information is provided in the appendices.

- Appendix 2: General referral information
- Appendix 3: Urgency categorisation
- Appendix 4: Named referrals
- Appendix 5: Scope of publicly funded services

## How to provide feedback

Feedback on the draft CPC may be provided via email to CPC@health.qld.gov.au, by the date requested in the accompanying email.

## Contact us

Email: cpc@health.qld.gov.au

Phone: (07) 3234 1813

# Appendix 1 Clinical Advisory Group (CAG)

The following clinicians nominated to participate in the development of the CPC. Participation was voluntary and members contributed as and when able.

| Name | Position | HHS | Role ID |
|---|---|---|---|
| Dr Michael Bint<br>***Clinical Lead*** | Director of Respiratory Medicine,<br>Sunshine Coast University Hospital | Sunshine Coast HHS | Medical |
| Dr Aalia Thasneem | Respiratory and Sleep Physician,<br>Ipswich Hospital | West Moreton HHS | Medical |
| Dr Anthony (Tony) Parente | General Medicine Physician, Staff Specialist<br>Gold Coast Hospital | Gold Coast HHS | Medical |
| Dr Caroline Yates | General Practitioner, Inala | Brisbane | Medical |
| A/Prof Craig Hukins | Director, Department of Respiratory and Sleep Medicine,<br>Princess Alexandra Hospital | Metro South HHS | Medical |
| Dr David Kilner | Sleep and Respiratory Physician,<br>Lady Cilento Children's Hospital | Children's Health Queensland | Medical |
| Dr Deanne Curtin | Thoracic and Sleep Physician,<br>Director of Sleep Disorders Centre,<br>The Prince Charles Hospital | Metro North HHS | Medical |
| Dr James Brown | Director of Thoracic Medicine,<br>Cairns Hospital | Cairns and Hinterland HHS | Medical |
| Dr Krishnan Rajkumar | General Practitioner | Gold Coast | Medical |
| Dr Megan France | Senior Thoracic and Cystic Fibrosis Physician<br>The Prince Charles Hospital | Metro North HHS | Medical |
| Dr Michael Fanning | Respiratory and Sleep Physician,<br>Mater Health Services | Mater Health Services | Medical |
| Dr Ramaa Puvvadi | Paediatric Respiratory Fellow, Respiratory and Sleep Medicine,<br>Lady Cilento Children's Hospital | Children's Health Queensland | Medical |
| Dr Salim Memon | General Medicine Physician, Staff Specialist<br>Gold Coast Hospital | Gold Coast HHS | Medical |
| Dr Sian Hebron | General Practitioner, Noosa | Sunshine Coast | Medical |
| Anne-Marie Scriven | Clinical Nurse,<br>Ambulatory Care Service | Sunshine Coast HHS | Nurse |

| | | | |
|---|---|---|---|
| Caroline Rae | Clinical Nurse Consultant, Cardiac/ Respiratory, Medical Outpatients<br>Toowoomba Hospital | Darling Downs HHS | Nurse |

# Appendix 2 General referral information

The introduction of CPC does not remove the need for each referral to contain general information about the referring practitioner and general demographic and clinical information about the patient.

Consistent with the Queensland Health Outpatient Services Implementation Standard and literature on necessary content for good quality referrals, Queensland HHSs typically request the information below in every referral.

During initial consultations on CPC, suggestions have been made by GPs and HHS staff on clarifying information that would be useful to facilitate shared care and improve the prioritising and scheduling of outpatient appointments and further interventions. These items are marked with an asterisk (*).

| **Patient's demographic details** | |
|---|---|
| • Full name (including aliases)<br>• Date of birth (and country of birth)<br>• Residential and postal address, (including if resides at an aged care facility)<br>• Telephone contact number/s – home, mobile and alternative<br>• Email address | • Medicare number (where eligible)<br>• Name of the parent or caregiver (if appropriate)<br>• Preferred language and interpreter requirements<br>• Patient's Aboriginal and Torres Strait Islander status<br>• Name of delegate and contact details (Department of Corrective Services) |
| **Referring practitioner details** | |
| • Full name<br>• Full practitioners address<br>• Contact details – telephone, fax, email | • Provider number<br>• Date of referral<br>• Signature (hard copy or via an approved electronic method) |
| **Relevant clinical information about the condition** | |
| • Presenting symptoms (evolution and duration)<br>• Physical findings<br>• Details of previous treatment and outcome (including systemic and topical medications prescribed and outcomes of previous treatment)<br>• All conservative options that have been pursued unsuccessfully prior to referral<br>• Body mass index (BMI)[i]* | • Details of any associated physical factors which may affect the condition or its treatment (e.g. diabetes, body mass index)<br>• Current medications and dosages<br>• Drug allergies<br>• Alcohol, tobacco and other drugs use[ii]*<br>• A comprehensive capture of information in relation to CPC where applicable |
| **Reason for referral** | |
| • To establish a diagnosis | • Reassurance for GP/second opinion |

| | |
|---|---|
| • For treatment or intervention not otherwise accessible to the patient<br>• For advice regarding management<br>• To engage in an ongoing shared care approach between primary and secondary care | • Reassurance for the patient/family<br>• For other reason (e.g. rapidly accelerating disease progression) |
| **Clinical modifiers** | |
| • Impact on employment<br>• Impact on education<br>• Impact on home<br>• Impact on activities of daily living functioning – low/medium/high | • Impact on ability to care for others*<br>• Impact on personal frailty or safety*<br>• Identifies as Aboriginal and/or Torres Strait Islander |
| **Other relevant information** | |
| • Willingness to have surgery (where surgery is a likely intervention)<br>• Choice to be treated as a public or private patient | • Compensable status (e.g. DVA, Work Cover, Motor Vehicle Insurance, etc.)<br>• Any special care requirements where relevant (e.g. tracheostomy in place, oxygen required) |

# Appendix 3 Urgency categorisation for outpatients

There is currently no national standardised categorisation for the first outpatient appointment. In Queensland, categorisation has been aligned to national elective surgery categorisation with public outpatient referrals services triaged into one of three urgency categories as defined in the Outpatient Implementation Standard: Timeframes for appointment are from the date that the referral has been validated and accepted by the relevant outpatient department.

| Category 1 | Category 2 | Category 3 |
|---|---|---|
| • Appointment **within** 30 days | • Appointment **within** 90 days | • Appointment **within** 365 days. |

The urgency category should be appropriate to the patient and their clinical situation as indicated by CPC where appropriate, or as per endorsed local triaging guidelines. It must not be influenced by the perceived or actual availability of resources.

The clinical situation is taken to encompass the patient's medical condition and the patient's life circumstances, including issues related to activity limitations, restrictions in participation in employment and other life situations and access to carer and other supports.

# Appendix 4 Named referrals

Named referrals are not required when referring to a public outpatient service. However, where a patient chooses to be treated as a private patient a named referral is required in order to meet the requirements of the National Health Reform Agreement and Medicare Benefits Schedule (MBS).

Most publicly employed specialists have access to Granted Private Practice (also known as a right of private practice) as part of their employment arrangements. These arrangements provide patients with a choice of treating doctor and in turn, enable staff specialists to earn additional income through private practice. Granted Private Practice is a fundamental component of medical workforce recruitment and retention strategies, further benefiting patients in terms of the quality and range of public hospital services available.

If a referred patient chooses to be seen in a private clinic operating from a public health service, the patient (or the HHS, with the patient's consent) needs to obtain a named referral from the referring practitioner. It should be noted that in almost all cases where a patient chooses to be treated as a private outpatient they are bulk billed and therefore have no out of pocket expenses.

The requirements of the National Health Reform Agreement are reflected in the Queensland Health Outpatient Services Implementation Standard as follows:

| National Health Reform Agreement | Queensland Health Outpatient Services Implementation Standard |
|---|---|
| G17(c): referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services.<br><br>G19: An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:<br><br>a. there is a third-party payment arrangement with the hospital or the State or Territory to pay for such services; or<br><br>b. the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient. | 5.5.2: All referrals to a private (including bulk-billed) outpatient service will be to a named specialist / consultant with a right of private practice.<br><br>5.5.3: All hospitals will ensure that patients are provided with the option to attend a public or private (including bulk-billed) outpatient service.<br><br>• Referral pathways will not be designed nor controlled so as to deny access to free public hospital outpatient services.<br><br>• Referrals to a named specialist will not be a prerequisite for access to outpatient services. |

Within the public system, named referrals sometimes occur between public specialists, for example referring to a sub-specialist. This can assist in ensuring referrals within or between specialties are appropriately directed; however, is not a requirement to access the publicly funded services. A named referral would only be required if the specialist or sub-specialist is exercising a right of private practice and the patient chooses to be treated as a private patient.

# Appendix 5  Scope of publicly funded services

As is the case in other state public health systems in Australia and internationally, not all types of health services are publicly funded in the Queensland health system.

The Queensland Health Scope of Publicly Funded Services Policy outlines the broad intent and principles to inform the types of services that are appropriate for public funding, and the Guideline specifies the out-of-scope services, the operational management of the policy and managing exceptions to the policy.

The intent of the Scope of Publicly Funded Services Policy is to ensure public resources are allocated where the health benefit or health need is greatest.

Typically, but not always, out-of-scope services are services that if undertaken in a private facility would not attract a Medicare Benefit (e.g. cosmetic surgery). Other services currently listed as out-of-scope, regardless of whether they attract a Medicare Benefit, include:

- varicose veins (except where there is significant dysfunction or disability, or venous ulcers)
- vasectomies and reversal of vasectomies
- laser refraction.

Exceptions can always be made where a procedure is clinically indicated, and this can be approved at the local HHS level.

# References

[1] Queensland Health (2017). *Outpatient Services Implementation Standard*. Standard # QH-IMP-300-1:2016. Retrieved 16 January 2017 from https://www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf

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[1] Queensland Health (2011). *Scope of Publicly Funded Services.* Policy # QH-POL-336:2015. Retrieved 16 November 2015 from https://www.health.qld.gov.au/system-governance/policies-standards/doh-policy/policy/qh-pol-336.pdf

[1] Queensland Health (2011). *Publicly Funded Services Guideline.* Guideline # QH-GDL-336-1:2015. Retrieved 16 November 2015 from https://www.health.qld.gov.au/system-governance/policies-standards/doh-policy/guideline/qh-gdl-336-1.pdf

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[i] Centres for Disease Control and Prevention. *Body Mass Index: Considerations for Practitioners.* Retrieved 26 February 2015 from http://www.cdc.gov/obesity/downloads/BMIforPactitioners.pdf

[ii] Lynn Bickley, Peter G. Szilagyi (2012) Bates' Guide to Physical Examination and History-Taking (11th ed). Philadelphia, PA Lippincott Williams & Wilkins