



Department of Health
Government of Western Australia

AMBULATORY SURGERY INITIATIVE 2006-07 INFORMATION PACKAGE

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Version 2

(Endorsed by Dr Mark Salmon, Executive Sponsor of the Ambulatory Surgery Initiative)

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1. Introduction

Demand for State funded health services is estimated to increase rapidly over the next decade, and doubling by 2016, with most of the growth being in same-day services. This escalating demand, driven largely by a growing and ageing population, together with advances in medical technologies and changes in clinical practice, is leading to an increasing number of procedures being referred for treatment in non-admitted settings.

Despite very considerable efforts to meet this demand, waiting times are increasing for specialty services such as day procedures, particularly for those with non-urgent status. To meet this challenge, innovative and collaborative approaches to providing services are required. The Ambulatory Surgery Initiative (**ASI**) is one such approach.

The ASI provides patients who have been, or are likely to be waiting for surgery for more than clinically desirable periods of time with faster access to treatment. By increasing clinical throughput, the ASI will reduce waiting times for elective, non-admitted procedures and reduce the overall number of patients waiting for these procedures.

Procedures conducted within the scope of the ASI are extra work, on top of regular day procedure activity.

Those patients who are 'ready for surgery' are now being offered the option of having their procedure done at an earlier date at one of the participating hospitals.

2. The Ambulatory Surgery Initiative

The ASI commenced in July 2004 at the Osborne Park Hospital and Armadale Kelmscott Memorial Hospital. Since then it has been introduced to Fremantle/Kaleeya, Bentley, Swan, Kalamunda and Broome hospitals. Further expansion will see the initiative at more hospitals, including Joondalup and Peel Health Campuses.

Specialties performed under the ASI include gastroenterology, ophthalmology, urology, gynaecology and general surgery. Specific procedures include colonoscopy, gastroscopy, cystoscopy, cataract extraction, Lletz procedures and the removal of minor skin lesions. Planning for the introduction of other procedures, including pain management procedures, minor ear nose and throat, minor orthopaedic and minor plastic procedures, is underway.

Patients, through their GPs, can access the ASI when they choose the option of being referred to specialists working in a private capacity at one of the participating hospitals. Patients do not incur any out-of-pocket expenses as medical fees are directly billed to Medicare. This approach is consistent with the Australian Health Care Agreement between the Commonwealth and Western Australia.

Participating hospitals provide the nursing staff, theatre facilities, non-medical staff, equipment, consumables and prostheses as required. The ASI benefits the health system as a whole by using otherwise spare physical capacity within the secondary hospital system. As ASI involves the treatment of patients at low risk, the number of cases able to be treated per session is also typically greater than standard lists. These factors all combine to make the ASI an efficient tool for increasing clinical throughput and minimising waiting times for patients.

3. Medical Indemnity and Protocol

Information regarding the medical indemnity provided to clinicians participating in the ASI is available on the Department of Health website at <http://www.health.wa.gov.au/indemnity>. This website also provides information on the 'Protocol' which gives effect to the State Government's commitment to and support for the ASI.

4. ASI Procedures

Once the health service has identified they have spare theatre time and clinicians who have expressed interest in doing extra work, the next step is to identify which procedures would be appropriate to undertake at that facility within the scope of the ASI. The following guidelines have been established to assist health services make such a decision. ASI procedures should:

- Have a length of stay of several hours only
- Be performed under local or regional anaesthetic or light sedation *
- Be associated with low risk
- Be associated with a rapid recovery
- Have the capacity to have high volume throughput
- Not require hospital doctor assistance
- Have the relevant Medicare (non-inpatient) item number/s available
- Preferably have substantial waiting times, which require additional work to be done over and above standard lists
- Have the potential for improved service delivery.

* The ASI is better suited to procedures performed under local anaesthesia or sedation that can be provided by clinicians. There is, however, scope for some minor procedures that require general anaesthesia (or where there is a possibility it will be necessary to convert the local anaesthesia to a general anaesthesia) provided it is clinically safe to allow the patient to go home within a few hours post procedure. These procedures will require the additional services of a specialist anaesthetist or a suitably trained and credentialed GP anaesthetist.

5. What is the process for clinicians?

Once the health service has offered theatre time to clinicians to conduct ASI work, there are a few administrative steps that need to be addressed. The following is a checklist for doctors preparing to commence ASI lists:

- 5.1 Apply for Medicare provider number if you don't already have one for the site in which you intend to conduct ASI work.** If you already have a provider number for the proposed site, you will not require an additional, ASI-specific provider number. If you intend to conduct ASI work at multiple sites, you will need a provider number for each.

The contact telephone number regarding provider numbers is 9214 8133 and the application form is to be faxed back to 9214 8201. Application forms are available at <http://www.medicareaustralia.gov.au>

5.2 Complete the Medical Indemnity and Protocol Registration forms (relating to the Ambulatory Surgery Initiative) and submit it to the participating Health Service prior to the proposed commencement date.

The terms and conditions of the Indemnity and Protocol Registration are available at <http://www.health.wa.gov.au/indemnity>.

5.3 If your health service manually processes the Medicare benefits, please provide your new provider number to the clerical staff to enable your payment.

5.4 If your health service is using the Fast Claim software, you are required to use the HIC Online system instead of the manual forms. This system is more efficient and usually results in payment within approximately three days.

NB: To register for HIC Online, you are required to submit contact details through the web based facility and to print, sign and return the HIC Online Agreement to Health eSignature Authority (HeSA). You will also be required to complete and submit a HIC Online Banking Details form. This should be submitted with the signed HIC Online Agreement.

Practice sites may choose either or a combination of the following:

* Option A: Location and Individual Certificate.

* Option B: Location Certificate only.

Currently, all ASI sites have chosen Option B, as they have found this to be the most practical alternative.

It usually takes two weeks from the time HeSA receives the paper work for the clinicians to be registered on-line and where appropriate, for clinicians to receive their individual certificates.

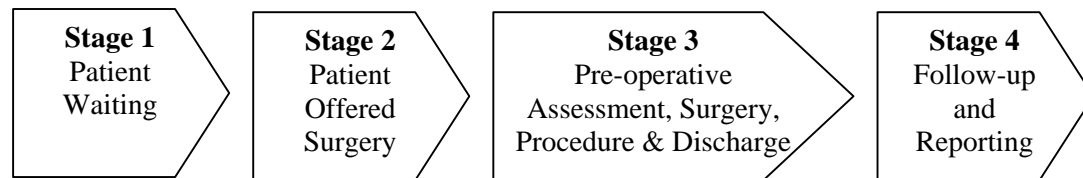
5.5 The ASI recognises the private relationship between the clinician and the patient. Payment systems are available to allow clinicians to direct bill Medicare (ie accepting 85% of the Medicare schedule fee as full payment).

5.6 At the time an appointment is made for an ASI procedure the patient is to be advised of the financial charges that will be made by the treating medical practitioner and whether these are fully covered by Medicare.

5.7 It is the clinician's responsibility to ensure the booking clerk is aware of any charges for any pre or post procedure consultation. The patient must be fully informed of the extent of these charges at the time the booking is made.

5.8 Clinicians are referred to the Operational Circular 2086/06 www.gp.health.wa.gov.au/asi/publications/ which sets out the approved business rules applying to the ASI in public hospitals. It is strongly recommended that medical practitioners participating in the ASI familiarise themselves with this material.

6. The Journey



6.1. Stage 1: Patient waiting

6.1.1. Patients are clinically assessed by a general practitioner (or other doctor working in a private capacity or agency external to the hospital system) and then either:

- a) referred directly to a clinician participating in ASI or;
- b) referred to a public hospital waiting list according to their category type. Category 1 refers to patients whose optimum surgery time is 30 days. Category 2 refers to those whose optimum surgery time is 90 days and Category 3 for patients whose optimum surgery time is 365 days.

6.1.2. For waitlisted patients, an assessment is made as to suitability for treatment under the ASI.

6.1.3. The hospital clerk or the clinician's clerical staff contacts eligible patients by phone and offers the patient the opportunity to have their procedure done under the ASI. If verbal consent is given, the patient is sent an information package.

6.2 Stage 2: Patient offered surgery

6.2.1. Once verbal consent has been given by the patient to the hospital clerk, the patient is then sent an information package. This package is designed to:

- Explain the ASI;
- Ascertain if they still wish to have surgery (or whether they have already had surgery);
- Inform them of their opportunity to participate in the ASI. Before the patient signs the Patient Option form they would need to agree to:
 - be transferred to a hospital that will undertake their surgery.
 - obtain a named referral from their General Practitioner (or another doctor working in a private capacity or agency external to the hospital system) to the participating clinician.
 - be clinically reviewed (if necessary) to ensure that their previous clinical diagnosis is still accurate and they are suitable for surgery.

The patient must also be informed that if they choose not to have the elective surgery under the ASI, they will be managed according to the usual public wait list process.

- 6.2.2. Once the patient decides on this option the patient is given an appointment for the procedure, including the location, surgeon, dates and times for pre-operative assessment, operating sessions and follow-up appointments (if required). Under this Initiative, prospective patients must be referred to a named clinician and not to a generic hospital clinic. Clerical staff at each site may undertake this step.

6.3 Stage 3: Pre-operative Assessment, Surgery and Procedure

- 6.3.1. If the patient has difficulty attending the scheduled appointment, hospitals will need to reschedule the appointment depending on when a suitable time is available. If, after three attempts to schedule a procedure booking, the patient still has not proceeded to surgery, the offer to have the procedure done under the ASI should be withdrawn.
- 6.3.2. If for any reason the patient does not progress to surgery from the pre-operative assessment or there is clinical uncertainty whether or not to proceed, it is suggested that a clinician-to-clinician conversation takes place so that the patient receives consistent advice.
- 6.3.3. Patients are required to arrange for their own transport to and from the hospitals.
- 6.3.4. Before the procedure the administration clerk creates a physical medical record for the patient along with their medical history and a copy of the named referral to the clinician.
- The patient episode data must ensure appropriate recording of ASI activity occurs This requires the patient to be waitlisted, admitted and discharged through a patient administration system. The episode of care is to be clinically coded using ICD10 and submitted to the Department of Health Hospital Morbidity Data System (HMDS).
 - At hospitals using TOPAS, the administration clerk creates a referral in the TOPAS Waitlist and ATD Modules. The financial election of PR will be used for all ASI patients. TOPAS functionality prohibits the use of this financial election for any other admission.. ASI cases will be isolated by the use of the financial election-type code for reporting purposes.
 - The administration clerk may hold the patient's Medicare card until after surgery.
- 6.3.5. After the procedure:
- The clinician documents the procedure/s undertaken, including the Medicare Item number/s to be claimed (check lists with tick boxes for item numbers may be developed for this purpose).
 - The administration clerk imprints the Medicare Assignment form with the patient's details and ensures the patient signs the Medicare form before they leave, ensuring the patient's Medicare card is returned to them.
 - Where a patient is unable to sign the form, the signature of a parent, guardian or other responsible person is acceptable. The reason the patient is unable to sign should also be stated.
 - In the absence of a 'responsible person' the patient signature section should be left blank and, in the section headed 'Practitioner Use', an

explanation should be given as to why the patient was unable to sign eg. pt unconscious, pt had injured hand etc. This also needs to be signed by the doctor.

- If a patient leaves without signing, the patient voucher should be printed and mailed to the patient for signing. Billing cannot occur until the voucher is returned.
- Where online billing is in place, there is no requirement to send in the hard copies to Medicare Australia. At the close of business each day, the administration clerk prepares and transmits claims directly to Medicare Australia. It is recommended that a weekly reconciliation of patients with MBS items is conducted.
- The administration clerk removes patients from TOPAS waiting list.

6.4 Stage 4: Follow Up and Reporting

- 6.4.1. Cataract patients are seen by the Ophthalmologist the day after the procedure. Endoscopy patients need to see their GP after the procedure.
- 6.4.2. The accuracy of the weekly reports needs to be authenticated by the medical director at each hospital.
- 6.4.3. In addition, monthly reports on ASI activity and expenditure will be generated and forwarded through the Executive Sponsor for presentation to the Director General and Minister for Health. The number of procedures undertaken at each site is reported and the monthly reports assist in understanding the variance of expenditure at the health service level, and also facilitate the payment process for procedures.