Appendix 9  Baseline Service Profile Questionnaire

Managing Demand on Allied Health Services - Baseline Service Profile Questionnaire

Date: __________________  District: __________________  Service: __________________

Please answer all questions in relation to your service, i.e., the services provided by the staff within your department. Please write N/A if a question is not applicable.

Thank you for your assistance.

PART 1: Demographics

Question 1
a) Professional Staff
FTE Establishment __________________________  Actual Number of staff ______________

b) Assistant Staff (OO staff)
FTE Establishment __________________________  Actual Number of staff ______________

c) Assistant Staff (AO staff)
FTE Establishment __________________________  Actual Number of staff ______________

Question 2
How many out-patient/community client referrals does your department/service receive per month, on average?

________________________________________

Question 3
Do you prioritise your referrals?  Yes ☐  No ☐

If so, how do you do this? (Eg. by clinical need, protocol, order of presentation) Please provide as much information as you can.

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________
Question 4
Please indicate the number of urgent and non-urgent out-patient/community client referrals received per month according to categories used by your service. eg. urgent, semi-urgent, non-urgent

<table>
<thead>
<tr>
<th>Referral Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>URGENT</td>
<td></td>
</tr>
<tr>
<td>SEMI-URGENT</td>
<td></td>
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<tr>
<td>NON-URGENT</td>
<td></td>
</tr>
</tbody>
</table>

Question 5
Who can refer to your service?

- Hospital Doctor
- Other Hospital Staff
- GP
- Other (Please specify) ______________________________
- Allied Health Professionals

Question 6
On what grounds do you refuse referrals? (Please provide details).

- Geographic (postcode) ______________________________
- Insurance Status ______________________________
- Age ______________________________
- District/Organisation Policy ______________________________
- Condition ______________________________
- Other ______________________________
- Referral Source ______________________________

Question 7
Which of the following patients are eligible for treatment at your health care facility? Please tick all relevant categories.

- Public patient
- Private patient referred from private clinic in your facility
- Private patient external to Queensland Health
- Compulsory Third Party Insurance
- DVA
- WorkCover
- Other (please specify) ______________________________

Question 8
What type of referrals do you accept?

- Written - post
- Written - fax
- Verbal - face to face
- Phone
- Other ______________________________

Toolkit for Managing Demand on Allied Health Community and Outpatient Services 2005
Question 9
Are client required to attend your service face-to-face prior to getting an appointment/being placed on your waiting list?  
Yes [ ]  No [ ]

Question 10
What other services provided by your discipline (or service) are available in your geographical District?  
(Tick all relevant)

[ ] None  [ ] Cerebral Palsy League
[ ] Private Practice  [ ] Commonwealth funded (eg More Allied Health Services program)
[ ] Blue Care  [ ] Education Department
[ ] St Vincent’s Nursing Service  [ ] Other (please specify) ____________________________
[ ] St Luke’s Nursing Service

Part 2: Patient Population

Question 11
a) Please list specialised outpatient/community programs within your service? eg Women’s health, Hands, Diabetes, Cardiac, Chronic Pain, Neurological, Lymphoedema, Cardiorespiratory. (Include Multi-disciplinary services).

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

b) Why does your department provide these program/s? (Tick all applicable)

[ ] Community need  [ ] District/Facility priority or policy
[ ] Service not provided locally elsewhere  [ ] Staff specialist/interest area
[ ] Departmental priority  [ ] Other (please state) ____________________________
[ ] Historically provided
**Question 12**
a) Please list any programs or services currently not provided that you feel are important to patient needs in your District and indicate if they would be high, medium or low priority.

<table>
<thead>
<tr>
<th>Service/Program</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

b) Please indicate why these programs/services are not currently provided. (tick all applicable)

- Staff resources
- District Policy
- Equipment/finance resources
- Other (Please state) ____________________________

**Question 13**
Please list any programs or services that do not follow a best practice model, or would be a lower priority than services not currently provided. Give reasons for provision of these services.

<table>
<thead>
<tr>
<th>Program/Service</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g Chronic Pain Program does not follow chronic disease self-management model</td>
<td>Community pressure and time limitations</td>
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</tbody>
</table>

**Question 14**
Please indicate the types of intervention your service uses

- Individual
- Case Management
- Group
- Self-Management
- Team
- Triage
- Review at Future Date

**Question 15**
How does your department determine if an outpatient/community client is ready for discharge from your service? (please give details)

__________________________________________________________________________
__________________________________________________________________________
PART 3: Waiting List Management

**Question 16**
Do you have a service waiting list? Yes □ No □ (go to question 21)

**Question 17**
Why does your service have a waiting list?
□ Demand for services □ Visiting / outreach service □ Other (please state) __________________________

**Question 18**
Who coordinates the waiting list? (please tick)
□ Administration staff □ Manager
□ Allied Health Assistant □ Other (please state) __________________________
□ Clinician
Comments: ____________________________________________________________

**Question 19**
How many patients are on the waiting list? What is the approximate average length of time from receiving a referral to the patient commencing treatment? (as at the day of completing this survey)

<table>
<thead>
<tr>
<th>OUTPATIENTS</th>
<th>No. patients on waiting list</th>
<th>Average wait for treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>URGENT</td>
<td></td>
<td></td>
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<tr>
<td>SEMI-URGENT</td>
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<tr>
<td>NON-URGENT</td>
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</tbody>
</table>

**Question 20**
What percentage of your outpatients / community clients FTA (fail to attend) or DNA (did not attend) per month within your service? ________ %

**Question 21**
How do you manage FTA or DNA patients? (please tick all applicable)
□ Advise patient of DNA / FTA policy at time of booking appointment
□ Phone patient for reason for DNA/FTA
□ Refer back to clinic / referral source
□ Book another appointment
□ Refuse further appointments
□ Other. (Please state) __________________________
**Question 23**
Do you routinely allocate appointment slots for new patients only? Yes ☐ No ☐

**Question 24**
Approximately how many referrals per month are removed from the waiting list?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>An appointment was made</td>
<td></td>
</tr>
<tr>
<td>Treatment was no longer needed</td>
<td></td>
</tr>
<tr>
<td>Client unable to be contacted</td>
<td></td>
</tr>
<tr>
<td>Client seen by another service</td>
<td></td>
</tr>
<tr>
<td>According to DNA policy</td>
<td></td>
</tr>
<tr>
<td>Other (Please specify)</td>
<td></td>
</tr>
</tbody>
</table>

**Part 4: Quality Management**

**Question 25**
Does your department have a process or mechanism for collecting patient feedback? Yes ☐ No ☐

**Question 26**
Do you have a process or mechanism for monitoring the impact of your service on patients / clients? Yes ☐ No ☐

**Question 27**
Do you perform goal setting with your clients? Yes ☐ No ☐

**Question 28**
Does your department have a process or mechanism for collecting referrer feedback? Yes ☐ No ☐

**Question 29**
What method of activity / statistics collection do you currently use? (tick all applicable)

☐ Manual paper collection      ☐ No formal system
☐ Electronic data collection   ☐ None collected