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, ie 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 clinincal need, protocol, order of presentation) Please provide as much information as you can.

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Example

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*

Referral Category	Number
URGENT	
SEMI-URGENT	
NON-URGENT	

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) ________________
- ☐ Age ________________
- ☐ Condition ________________
- ☐ Referral Source ________________
- ☐ Insurance Status ________________
- ☐ District/Organisation Policy ________________
- ☐ Other ________________

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 ________________

Example

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
- ☐ Private Practice
- ☐ Blue Care
- ☐ St Vincent's Nursing Service
- ☐ St Luke's Nursing Service
- ☐ Cerebral Palsy League
- ☐ Commonwealth funded (eg More Allied Health Services program)
- ☐ Education Department
- ☐ Other (please specify) ______________________

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).

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

- ☐ Community need
- ☐ Service not provided locally elsewhere
- ☐ Departmental priority
- ☐ Historically provided
- ☐ District/Facility priority or policy
- ☐ Staff specialist/interest area
- ☐ Other (Please state) ______________________

Example

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.

Service/Program	Priority

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.

Program/Service e.g Chronic Pain Program does not follow chronic disease self-management model	**Reason** Community pressure and time limitations

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)

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Example

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)

OUTPATIENTS	No. patients on waiting list	Average wait for treatment
URGENT		
SEMI-URGENT		
NON-URGENT		

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

☐ Refer back to clinic / referral source

☐ Refuse further appointments

☐ Phone patient for reason for DNA/FTA

☐ Book another appointment

☐ Other. (Please state) ____________

Example

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?

Reason	Number
An appointment was made	
Treatment was no longer needed	
Client unable to be contacted	
Client seen by another service	
According to DNA policy	
Other (Please specify)	

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

Example