STAT

Specific Timely Assessment and Triage

Handbook second edition

Eastern Health

LA TROBE UNIVERSITY

K. E. Harding, A. K. Lewis, D. A. Snowdon, N. F. Taylor & the STAT Research Group

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Clinicians and consumers are gratefully acknowledged for their insightful comments that are used through this handbook to illustrate challenges and benefits of the model. These comments have been drawn from interviews, focus groups and surveys within the context of research related to the STAT model and waiting for health services in a variety of settings.

Part 1: Theory and evidence

Background

Waiting for care is an issue at every stage of the health continuum, from ambulance arrivals to access to aged care beds

Elective surgery wait lists and long waits in emergency departments often hit media headlines, but clients (or patients) also often wait for long periods for outpatient and community healthcare services. These services provide access to a wide range of care providers, including medical and nursing specialists, allied health professionals and multidisciplinary teams. Typically these services are provided over a series of appointments, and provide planned rather than emergency services. Sometimes referred to as ambulatory care, this part of the health system provides important care for follow-up of acute care episodes, management of long term conditions, rehabilitation and preventative healthcare. Effective ambulatory care is vital to maintain flow through the healthcare system, keep people out of hospital and maximise participation and quality of life.

> "MY DOCTOR WAS THE ONE WHO TOLD ME TO GO TO EMERGENCY. HE SENT ME WITH A LETTER THAT SAID LOOK, I REFERRED THIS PATIENT TO YOU 3 YEARS AGO AND SHE STILL HASN'T HEARD ANYTHING AND SHE'S TO BE SEEN ASAP."

However, high demand and long wait lists for these services have a significant impact on the health sector and the individuals in need of care. In some cases, people experience deterioration in their condition while on wait lists.

For others, excessive wait time can lead to reduced engagement or a missed opportunity to intervene at a key moment in a person's healthcare journey (Lewis, Harding et al 2018). Waiting has also been linked with anxiety and decreased levels of participation in employment and community activities (Harding, Lewis et al 2023).

Traditional strategies used to manage demand and why they don't work

Strategies commonly used for managing demand in healthcare services can often be ineffective or only successful under particular circumstances. One common approach to managing demand in health services is the "triaged waiting list": referrals are received, given a priority rating according to protocol (based on urgency or risk) and put onto a waiting list (Figure A). New clients are offered an appointment as others are discharged, but the people on the waiting list are essentially, "out of sight, out of mind." Once in a while, the waiting list is perceived to be too long; there is an urgent "blitz" effort to reduce it, resulting in a short term improvement before things return to normal. There are a number of pitfalls with this approach.

Heavy reliance on **triage systems** is common in waiting list management. However, there is minimal evidence that traditional triage systems improve patient flow, and they often show low levels of reliability. The validity of triage processes is also difficult to establish; there is often no 'gold standard' to assess whether those who have been allocated the highest category have the most urgent needs.

Part 1: Theory and evidence

The concept of urgency or priority is dependent on the values of those making the decisions, often needing to weigh up competing factors. For example, a person may be unlikely to benefit from treatment, but have a carer experiencing a high degree of stress and few options for alternative services.

Another problem with traditional triage systems is that they only weigh up the needs of clients at the point of access, without considering the relative need for follow-up appointments for those already in the system. For example, if Fred and Maria are referred to a service at the same time, both are given a triage category that determines who is seen first. Prioritisation protocols may help the clinic staff to make an objective decision that Maria should receive an earlier appointment than Fred. However, in the meantime Jane, an existing client, gets offered a sixth appointment with no capacity within the system to weigh up whether this is a more important use of the clinic's resources than the first appointment for Fred. People who have already made it past the access hurdle tend to be given automatic priority for review appointments without consideration for overall service demand.

Finally, triage systems with no mechanism for moving low priority referrals up the queue also run the risk of creating situations where the lowest priority referrals will never be seen, as those considered higher priority constantly displace those deemed to have less urgent needs.

Wait lists can create an expectation of waiting and generate work that doesn't add value: Implementing triage systems, fielding questions from waiting clients and monitoring those on the list take time. Meanwhile, service providers put time and energy into defining triage categories or designing extra services to support people while they wait, rather than addressing the fundamental question of why people are waiting in the first place.

The injection of resources to boost supply of health services without any change in service delivery can work in the short-term, but unless something is done to address underlying causes wait lists will grow back when resources return to normal levels. A study published by Kenis in 2006 in the Netherlands, for example, describes a $3 billion investment in excess of normal health funding for waiting list reductions, which had no lasting impact. The number of people waiting for care five years later remained unchanged, suggesting that resources alone are not adequate to achieve lasting reductions in waiting times. There is a need for a fundamental change in the way that services are delivered in order to have a sustainable impact on reducing wait lists.

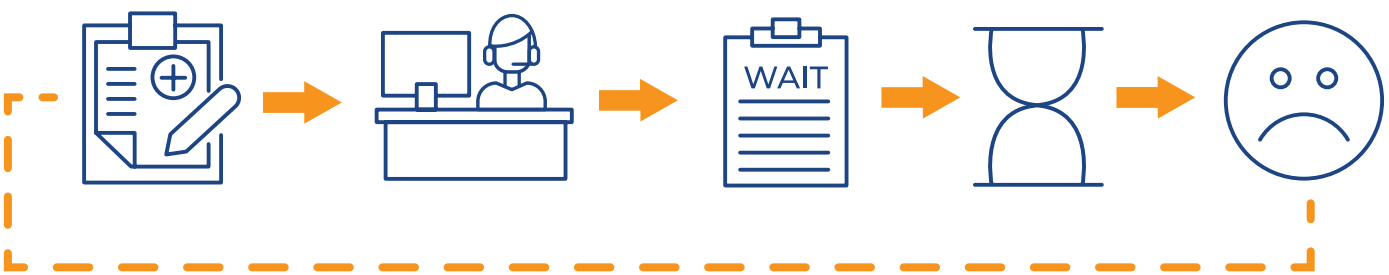


Figure A: The "Triaged Waiting List" A common demand management approach in ambulatory, outpatient and community health services.

Part 1: Theory and evidence

What can be done to reduce waiting time?

There is good evidence that changes to access and triage processes can contribute to reduction of waiting times and improved patient flow (Kreindler 2008).

> "THEY WERE WAITING ANYWHERE BETWEEN 8-14 WEEKS. THAT'S BEEN STOCK STANDARD WAITING TIME OVER THE LAST THREE OR FOUR OR FIVE YEARS."

+ **Identify whether there is a true imbalance between supply and demand, targeting interventions accordingly.** Some wait lists continually grow over time, as the number of referrals seen consistently exceeds the number of clients who can be seen. Others, however are stable over time; the number of referrals is roughly equal to the number of clients being discharged, but an ongoing backlog leads to constant delay (Figure B). In these situations a targeted, short-term strategy to reduce the backlog will be key to getting the service back on track, with only relatively small changes required to service delivery to ensure flow continues at the rate of demand.

Triage systems are only needed when demand exceeds supply

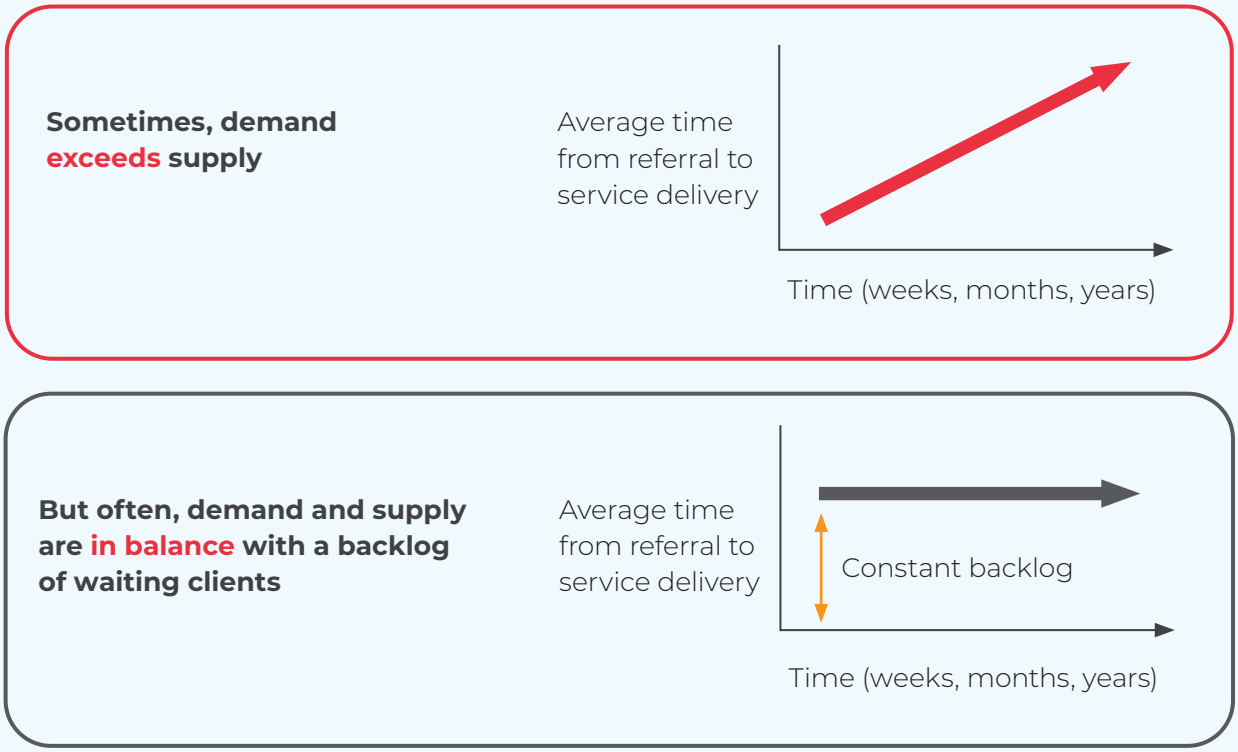


Figure B: Supply and demand relationship in health services

Part 1: Theory and evidence

- **Reduce complexity in access, triage and booking processes.** Eliminate duplication, provide simple checks of eligibility and keep triage to a minimum. Where triage processes are used, there is evidence that a simpler system, such as using only two categories for 'urgent' and 'routine' cases, is just as effective and more reliable than a more complex, multi-category system.

- **Integrate triage with initial assessment and early intervention.** To make a decision about triage (what services are required, by whom and in what time frame), healthcare providers need access to sufficient information. In emergency departments a triage nurse collects this information; in outpatient and community services it is usually obtained through referral information, supplemented by talking to the client or those involved in their care. If a problem is identified through this process that can be addressed quickly using the skills of the triaging health worker, it is better to intervene immediately, rather than placing the person on a waiting list to be reassessed in the future.

IF THE BACKLOG CAN BE REDUCED OR ELIMINATED, WITH A SYSTEM PUT IN PLACE TO KEEP UP WITH DEMAND, IT IS POSSIBLE TO PREVENT WAITING LISTS FROM BUILDING UP AGAIN.

- **Reduce the backlog.** Fewer people waiting means less time spent managing the wait list. A one-off targeted intervention to reduce an existing wait list is often an essential part of an effective waiting list reduction strategy. However, it is only likely to lead to sustained change when coupled with other strategies that address underlying imbalances between supply and demand to maintain patient flow.

> "THE BOOKING TASKS ARE REDUCED BECAUSE THE LIST IS CLEANER. THERE'S NO WAITLISTING ANYMORE... PREVIOUSLY I MIGHT WAITLIST THEM AND THEN SEND A LETTER SAYING THEY'D GET AN APPOINTMENT IN FUTURE BUT, GIVEN THE NEW MODEL I CAN SEND THEM OUT AN APPOINTMENT DATE."

Part 1: Theory and evidence

What is STAT?

Specific Timely Assessment and Triage (STAT) is an alternative model for access and triage that brings evidence-based principles into one package with a clear, step-by-step implementation process.

STAT is a way of organising access into a service by preserving sufficient new appointments to see all new patients for an initial assessment in a timely way without using a waiting list. Triage decisions are then made in relation to further care, considering patient need in the context of service demand (Figure C).

STAT works best in reducing waiting times for health services that share the following key characteristics:

1. The service is provided to the majority of clients over more than a single occasion of service, so that there is some flexibility in how the service is delivered. For example, there is potential for design of care pathways for clients requiring different intensity of service.

2. The relationship between supply and demand is relatively stable. This is indicated by wait lists that may be long, but have not changed significantly over time (see Figure B). Services with constantly increasing waiting times are likely to need a preliminary intervention, such as tightening of referral criteria or increasing supply, to achieve some degree of balance before STAT can be successfully implemented.

"STAT" IS AN ABBREVIATION OF THE LATIN WORD STATUM, MEANING "IMMEDIATELY", AND IS COMMONLY USED IN MEDICAL SETTINGS TO MEAN "URGENT" OR "RUSH".

Principles of STAT

The letters of the STAT acronym provide an overview of key elements of the model.

S = SPECIFIC – Clinicians schedule a specified number of protected appointments in their weekly schedule for the specific purpose of assessment of new referrals. The number of these appointment slots is based on the typical demand for the service, obtained through analysis of historic service data.

T = TIMELY – Upon referral, clients are immediately booked into the next available assessment appointment. There is no need for a protocol-based triage system and clients are not placed on a wait list. The aim is to accept clients into the service and provide an appointment within a single point of contact (whether it be a letter or phone call), resulting in a person-centred service that minimises duplication.

A = ASSESSMENT – Early assessment provides the clinician with a complete picture of the client's needs, and the client with access to information and reassurance that their needs will be addressed. In many cases it is will be possible to provide advice, referral to other services or initiate some early treatment during this first contact. Direct, early contact with a clinician avoids the problems associated with low reliability of triage processes that depend on information in written referrals.

T = TRIAGE – Clinicians triage the client at the point of care, taking into consideration the relative priority of the new referral and the people already under their care. Triage is still important but the focus is now on "Triage for ongoing services" rather than "Triage for access." For this to work well, service providers need a range of pathways through which to direct client care. Rather than a standardised "one size fits all" model of care, for STAT to be most effective a range of alternatives need to be available to choose from. For example, low intensity self-management strategies or group programs for those with lower levels of need, through to intensive one-to-one treatment for those with more complex issues.

Part 1: Theory and evidence

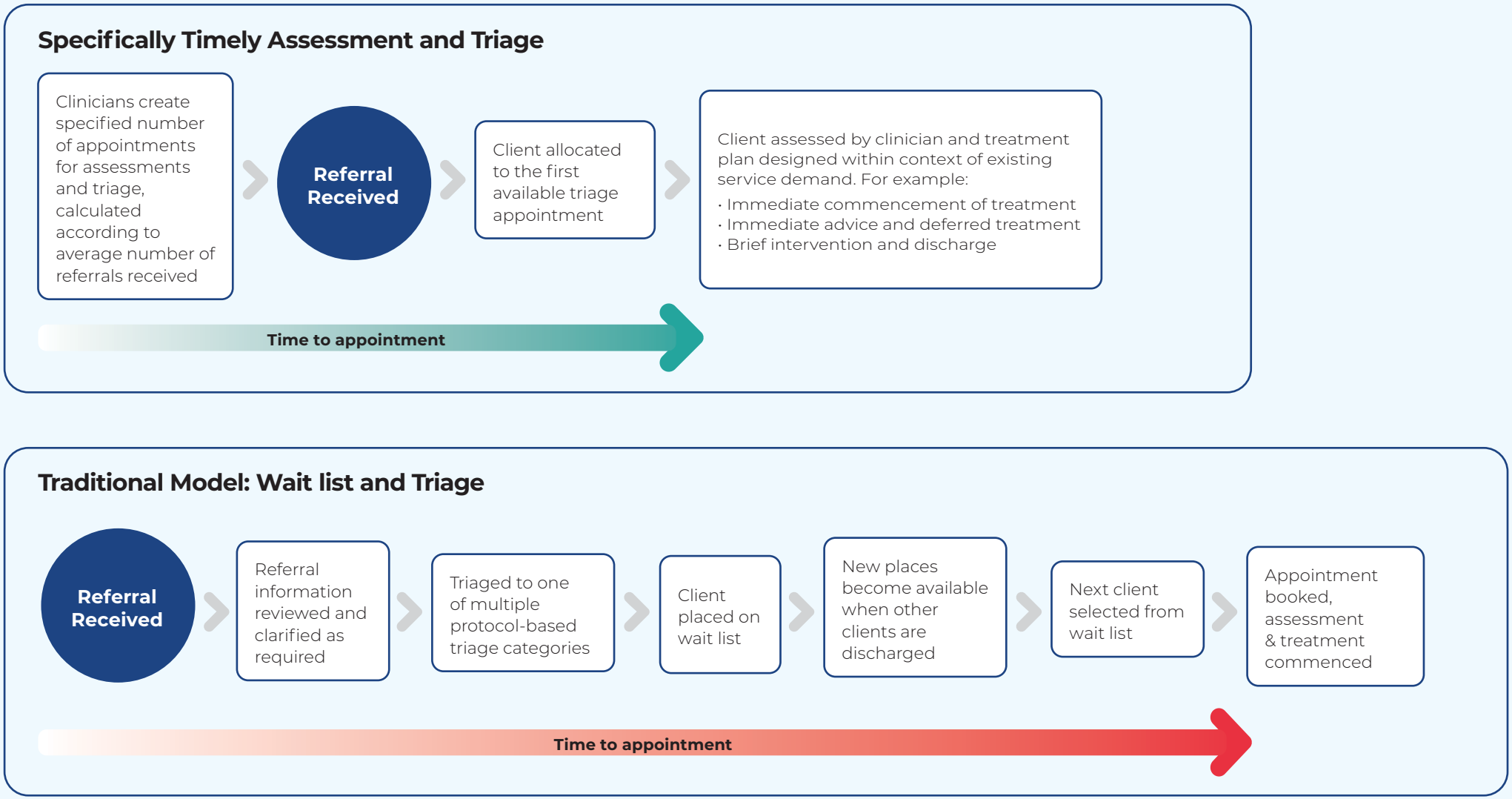
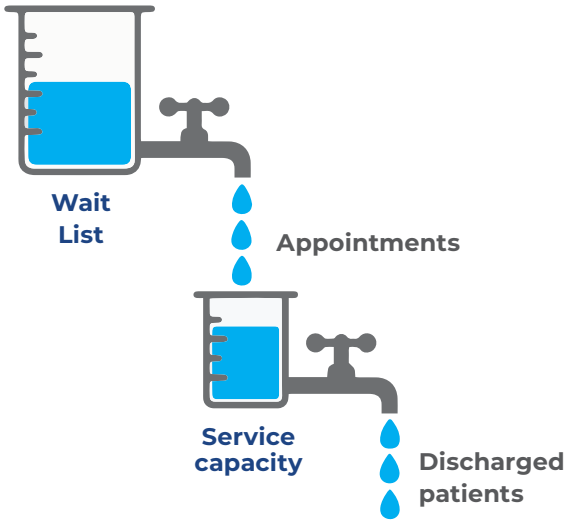


Figure C: Triage models – STAT vs Wait list and Triage

Part 1: Theory and evidence

Another way to think about the STAT model is to compare it to a system of flowing water. The system has an upstream tank that represents the wait list, connected by a tap to a bucket that represents the service capacity.

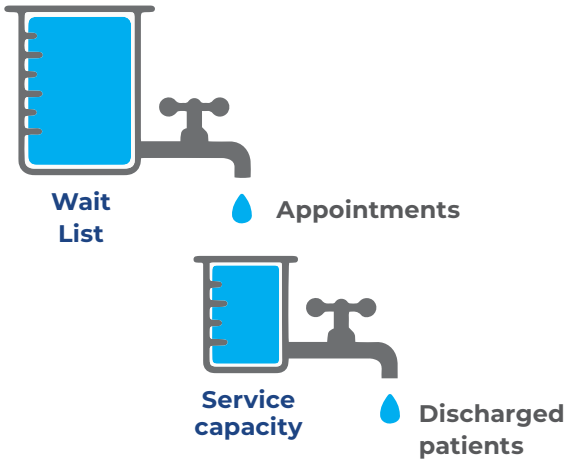
A stream of water that constantly fills up the tank represents new referrals. Clients are 'discharged' by a tap releasing water from the service bucket. When the taps are all flowing at an equal rate, everything is nicely in balance.



However, if the service capacity bucket starts to fill up, something needs to change.

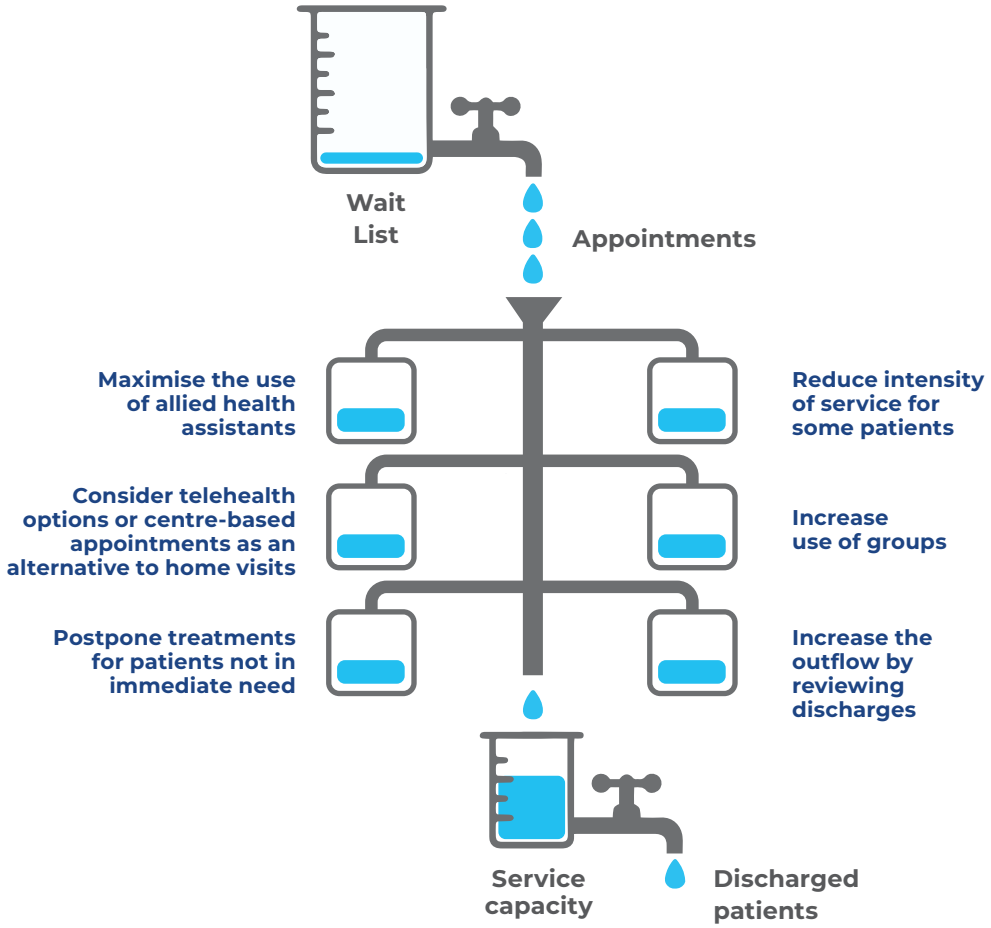
The simplest solution is to slow down the flow from the wait list tank and the service capacity bucket. This is the strategy used with the traditional 'wait list and triage' model.

This restores the balance, but it isn't great for the people who are waiting.



Part 1: Theory and evidence

STAT provides an alternative solution. Instead of turning off the supply tap, we keep up with the flow from the wait list and get creative about finding other ways to relieve the pressure. Some examples are shown below.



STAT can only work if the flow into the wait list tank is not excessively higher than the maximum possible outflow from all other possible sources. If a service has had relatively stable wait lists in the past (even if the list has been long over an extended period), this is a good indication that flow rates in and out are quite similar.

However, if the inflow constantly exceeds the maximum possible outflow, the wait list "tank" will continue to fill faster than it can be emptied. If this is the case, an "upstream" intervention might first be needed to limit flow into the service in first place. This might be achieved by tightening referral criteria for example, or reconsidering the services that can realistically be offered with the available resources.

It is surprisingly common in health services for supply and demand to be better matched than they first appear. That is, the wait list "tank" is large and constantly full, but the "water level" doesn't change much over time. If a service has had relatively stable wait lists in the past (even if the list has been long over an extended period), this is a good indication that flow rates in and out are quite similar. In this case, a one-off, targeted period of intervention may initially be needed to "drain the tank", to reduce the existing wait list. Then, once the backlog is cleared, the STAT model maintains the flow and prevents the wait list "tank" from filling back up.

Part 1: Theory and evidence

Benefits of the STAT model

- **Triage and initial assessment are combined at the first appointment.** Combining triage with initial assessment avoids situations where identified needs are put on hold or must be handed over. The clinician conducting the assessment has the opportunity and expertise to act on the issues that arise without delay.

- **Ongoing service decisions are made in the context of current demand.** Whereas traditional wait list and triage systems tend to 'hide' people on wait lists so that they are 'out of sight, out of mind' to clinicians, STAT ensures that clinicians always have a current picture of the people who are in need of their service.

  This means that clinicians must actively prioritise how they allocate their treatment time, with the ultimate aim of spreading their resources so that they provide the greatest good to the greatest number of people.

- **Clients with minor needs can be treated promptly and discharged.** In traditional triage models, people with minor needs are often given low triage priority and made to wait long periods for treatment. Addressing the needs of these clients quickly and then discharging or referring on, is both efficient for the service and good for the person seeking care. In addition, some clients and service providers can feel that a certain level of service may be needed to justify a long wait, creating a reluctance to refer on or discharge quickly, even if the service is unlikely to be of significant benefit.

- **Treatment resources are actively managed and allocated according to need.** Traditional wait list and triage systems often prioritise referrals at the point of access, but then offer a relatively standard episode of care once the person has entered the service.

  For example, a physiotherapy clinic might typically offer an assessment, followed by weekly review appointments for a specified number of weeks or until goals are met.

  A key component of STAT is that decisions about service provision are made in the context of demand. Clients with capacity for self-management, or less likely to benefit, may require fewer appointments, making room for others who might benefit from a more intensive service. Flexible and innovative models of care will help to manage demand for treatment or therapy.

- **Supply and demand is balanced and transparent.** Balance is achieved by scheduling a set number of new assessments each week that are carefully calculated according to the historical demand of the service. The time from referral to service provision is always transparent, as it is defined by the time to the next available appointment, rather than a number on a waiting list.

- **More time spent with clients and less time on administration.** The removal of unnecessary triaging steps and processes associated with managing and monitoring wait lists increases time available to be spent with clients.

- **Alignment to strategic directions in healthcare.** Strategic directions and values underpin delivery of healthcare at organisational and policy levels. STAT aligns with values such as client-centred care, high-quality care, responsiveness and agility, and timely and equitable access to services. The model also incorporates transparency and accountability of service providers. The Victorian Department of Health Demand Management Toolkit for Community Health (2023) provides a good example of alignment between the STAT model principles and healthcare strategy.

Part 1: Theory and evidence

STAT works: The Evidence

STAT has been tested in multiple trials. After initial indications of success in two single-site pilot studies, the model was tested in a fully-powered multi-site trial.

Further trials have been conducted in medical outpatients and paediatric community health services, and we have evidence from a survey of more than 50 service providers across Victoria, Australia, suggesting that the model is being successfully implemented beyond trial settings. The following section provides an overview of what we have learned so far about implementing STAT, and a summary of key studies contributing to the STAT evidence base can be found on page 16.

Less waiting

Trials of the STAT model have consistently reduced waiting time, with reductions typically in the order of 30-40%. For example, following implementation of STAT in a community rehabilitation setting, median waiting time reduced by 40% compared to a control service (Harding 2013). A trial in outpatient physiotherapy showed 22% reductions overall with much larger reductions for those in the low priority category (Harding 2015). These results were replicated in a stepped wedge cluster randomised controlled trial involving 8 services and more than 3000 patients (Figure D and E), where a reduction in waiting time of 34% could be attributed to the intervention (Harding 2018). A subsequent implementation study involving five paediatric community health services recorded a 35% reduction in waiting time and halved the number of children on wait lists (Harding 2023). A project to implement STAT virtually eliminated a waiting list of 600 people in a medical outpatient clinic (Lewis 2020).

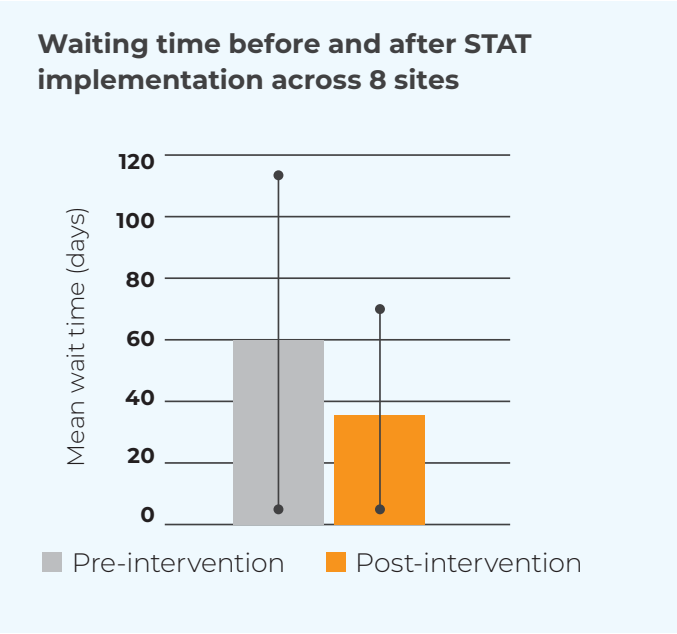


Figure D: Findings from a multi-site trial of STAT in community outpatient services (Harding et al, 2018)

Reduced variability in waiting time

Another significant finding in trials of the STAT model is that it has consistently led to reductions in unwanted variation in waiting time. By booking everyone in for a timely first appointment regardless of the nature or perceived urgency of their presenting issue, no one is left languishing as a "low priority" on a long wait list. Clients with less need can be expected to receive a less intensive intervention, but the services they are eligible for are still provided promptly. Reduced variation has been seen consistently across all trials of the STAT model, as indicated by a decrease in the interquartile range or standard deviation of waiting time data.

> "FOR THE URGENT ONES, I DIDN'T NOTICE A BIG WAIT, BUT THERE WERE CERTAINLY A LOT OF ROUTINE PRIORITY PATIENTS WHO HAD BEEN WAITING AROUND FOR A VERY LONG TIME."

Part 1: Theory and evidence

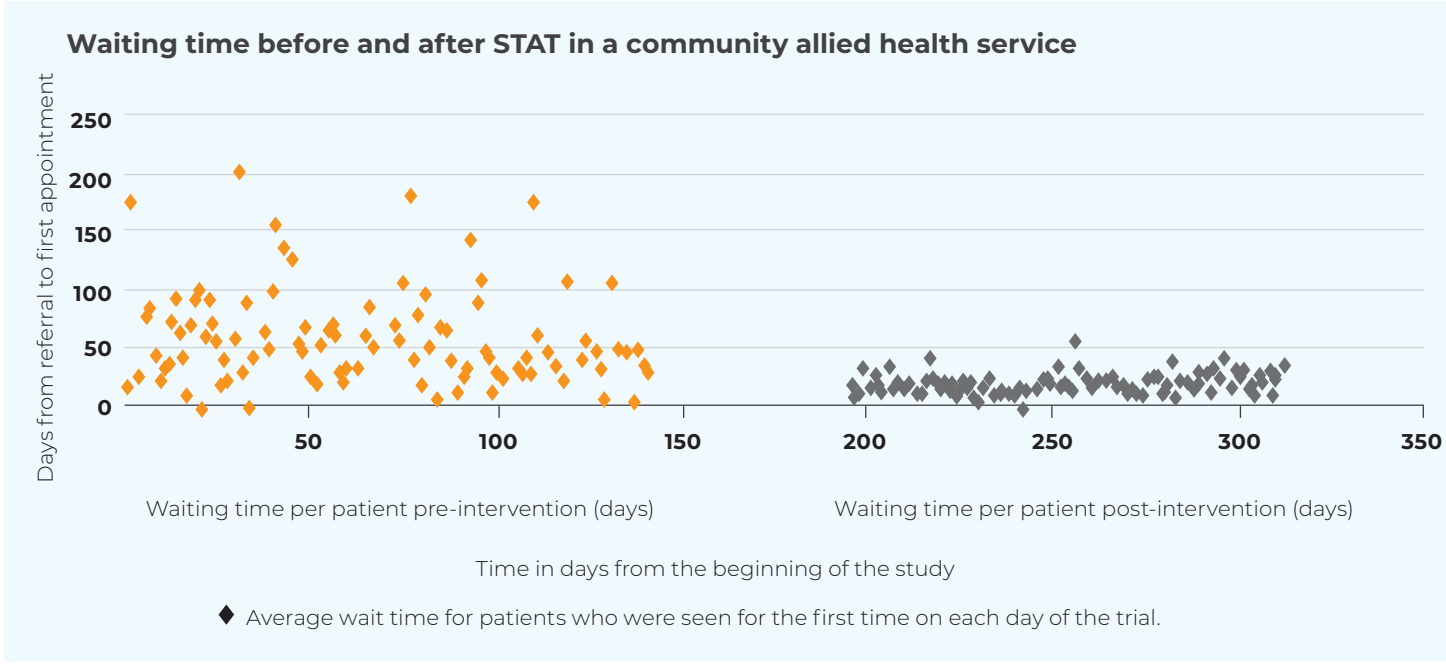


Figure E: Days waited at one site in one site of a multi-site trial (Harding et al 2018).

Staff perspective

Participants in two qualitative studies (Harding, Snowdon et al 2019; Harding, Taylor et al 2013) involving interviews with staff who have implemented STAT have reported improvements in efficiency, transparency and fairness in workload allocation as benefits of the model. Allocating set numbers of appointments for new clients in clinician diaries at the point of referral saves time in contacting clients, and ensures that work is distributed fairly across the team. In the words of one clinician "It is definitely a lot more efficient processing referrals; a lot less time consuming. All those processes have been more streamlined."

Participants in these studies also described challenges in the startup period and maintaining flow through the service. Management of review appointments was sometimes difficult, and this was a source of stress for some participants

> "WAITING TIMES NOW REDUCED TO 2-4 WEEKS FOR INITIAL ASSESSMENT. IT WAS 6-12 MONTHS FOR PRIORITY THREES PREVIOUSLY."

> "NOW WE PRIORITISE THE PATIENTS WHO HAVE NEVER HAD ACCESS TO PHYSIO, AS OPPOSED TO PRIORITISING THE ONES ALREADY IN THE SERVICE. IT'S A REALLY GOOD WAY OF SHIFTING MINDSET."

in these studies. The findings highlight that implementing STAT is not always easy, and that adequate support of clinicians to adjust to changes in processes – particularly in relation to review appointments – is essential to the success of the implementation.

In general, both clinical and administrative staff were more likely to have a positive view of the model if they were aware of access issues and felt responsibility for those who were not receiving timely care. Staff who felt the "burden" of the waiting list tended to be actively seeking to improve their service model, and valued the changes that implementing STAT pushed forward in their workplace.

Part 1: Theory and evidence

Reduced waiting is better for clients

Studies conducted by our team, as well as prior evidence from the literature, establishes a clear link between reduced waiting time and improved outcomes. Our team conducted a systematic review of the literature that demonstrated associations between shorter waiting times for community based health services and improved health outcomes, with the strongest evidence in the fields of musculoskeletal conditions and cardiac rehabilitation (Lewis, Taylor et al 2018).

This finding was also supported by a qualitative study (Harding, Lewis et al., 2023) in which consumers waiting for outpatient healthcare were asked about their experiences. They talked about deteriorations in their health conditions, fear and anxiety. Most of all they wanted efficient referral and appointment processes and access to clear and timely information about what was happening with their care, so that they could make a plan.

> "IF WE WERE TOLD UP FRONT IT WAS GOING TO BE X AMOUNT OF TIME, AT LEAST I FEEL AS THOUGH I COULD HAVE MADE AN INFORMED DECISION ABOUT HOW I WANTED TO PROCEED."

Sustainability of the STAT model

Sustaining interventions in healthcare is challenging, but two trials conducted to date with the STAT model have shown that improvements can be maintained. The first followed up services that participated in the stepped wedge cluster randomised controlled trial at 1 year (Harding 2020), and the second looked at two year outcomes after applying STAT principles to an epilepsy outpatient clinic (publication pending).

Both studies found reductions in waiting times were largely maintained, although there were some threats to sustainability identified. STAT is not a silver bullet or a "set and forget" model. However with the right conditions and monitoring in place it has the potential to reduce wait lists and stop them growing back over long periods of time.

Return on investment

A health economics evaluation using a return on investment approach conducted alongside a stepped wedge cluster randomised controlled trial provided evidence that implementing STAT represented a good return on investment for health services (Snowdon 2021). A modest upfront investment to implement the model and reduce the existing backlog is likely to be offset by savings associated with improved efficiency and reduced waiting time.

Application to a range of health services

STAT works across a range of services, and can be implemented beyond trial settings. In contrast to other strategies designed to reduce waiting time, STAT has not been designed for a single sector of the health service. Trials have been conducted community health settings, paediatric services, multi-discplinary specialist clinics, allied health outpatient services and specialist medical outpatients. In addition, a follow-up survey of service providers who attended STAT training showed that more than half of respondents had either implemented the model or were in the process of doing so, providing evidence that this approach can be applied to a variety of services outside of trial settings.

Part 1: Theory and evidence

Summary of STAT trials

Trial Setting	Design	Key findings	Publications
Community rehabilitation program	Before and after trial with a control service n= 971 patients	Waiting time reduced by 43% at intervention site, no change at control Well received by staff, some challenges identified	Main paper: *(Harding, Leggat et al, 2013)* Staff and patient perspectives: *(Harding, Taylor et al, 2013)*
Outpatient physiotherapy clinic	Before and after trial, n=1428 patients	Waiting time reduced by 22%, reduced variability (IQR range reduced from 11-33 days to 9-21 days)	Main paper *(Harding & Bottrell, 2015)*
Mixed services: community health, multi-disciplinary clinics, allied health outpatients	Stepped wedge cluster randomised controlled trial with 8 services, n=3116 patients	Waiting time reduced by 34%, reduced variability (interquartile range (IQR) 19-86 to 13-48) Well received by staff, some challenges identified Good return on investment Mostly sustained at 12 months	Main Paper: *(Harding, Leggat et al, 2018)* Staff perspectives: *(Harding, Snowdon et al, 2019)* Economic Analysis: *(Snowdon, Harding et al, 2021)* Sustainability: *(Harding, Snowdon et al, 2020)*
Paediatric therapy in community health	Implementation trial with 5 sites, n=2564 children	33% reduction in waiting time (from median 57 to 38 days) Total number of children waiting reduced from 335 to 112 after initial backlog reduction No impact on employee satisfaction	Main paper *(Harding, Lewis et al, 2023)*
Specialist medical outpatient clinic	Time series analysis over 28 months with process evaluation and two year follow-up	Waitlist reduced from 616 patients to 11 No change in median waiting time for those seen, but all patients offered appointments instead of urgent patients only and variation in waiting time reduced Largely sustained at 2 years	Main paper: *(Lewis, Taylor et al, 2023)* Backlog reduction process: *(Lewis, Taylor et al, 2020)* **Additional papers (sustainability and process evaluation) in progress. Check website for updates*
Mixed services that had staff attend STAT training	Survey of workshop participants, 3-12 months after attending training	58% of respondents reported that they had implemented STAT or were in the process of doing so Barriers to implementation included existing waiting list and lack of resources	Main paper *(Harding, Lewis et al, 2021)*

Part 2: Implementing STAT

The implementation process for the STAT model is broken down into 5 steps.

Steps to implementation:

1. Gather data
2. Calculate demand
3. Reduce backlog
4. Create appointments
5. Establish a new workflow

Part 2: Implementing STAT

Step 1: Gather data

The first step in implementing STAT is to develop a good understanding of service demand (Refer to Figure B, p 6).

You need to know the number of people who are requesting access to your service, whether this number fluctuates in a predictable way during the year and what is happening to the waiting list over time. That is, has the number of people waiting increased, decreased or remained the same? (Refer to Figure B, p 6)

It is best to collect data over at least one year to be able to see seasonal fluctuations in demand. Two or three years' data can be very useful for seeing patterns in demand, provided that there haven't been other significant changes during that period that have impacted on the service. For multidisciplinary services, it is often useful to break the data down by discipline.

Data required to calculate demand:

- The number of referrals per week/month/year.
- Predictable fluctuations in demand – for example, paediatric services may be influenced by school holidays, respiratory services influenced by winter flu season, and so on.
- The number of clients who miss appointments – sometimes known as the 'failed to attend' (FTA) rate or 'did not arrive/attend' (DNA) rate. Missed appointments create additional demand, as these clients use two appointments rather than one to receive an initial assessment.
- The number of referred clients who are never seen, either because they are rejected by the service or they decline the service before receiving an appointment. These will be counted in referral data, but don't need to be counted in demand data as they don't actually require a service.
- The average time from referral to first appointment, broken down into time periods if possible. Although not strictly required to calculate demand, this data is very useful as a baseline measure to track your progress over time.
- In multi-disciplinary services, it is often useful to break the data down by discipline. More information on calculating demand in multi-disciplinary services can be found on page 21.

You will also need an estimate of the supply available:

The overall equivalent full-time (EFT) staff providing the service of interest.

- Note whether staff are part-time or full-time.
- Predictable service disruptions or fluctuations. For example, do you have periods of low activity or high leave? Does your service shut over the Christmas holidays, or do you have a lot of staff with children who take leave during school holiday periods?
- Supply constraints due to other factors, such as availability of rooms, cars or equipment.

Preliminary questions to ask yourself based on initial data collection:

- Has the average waiting time changed over time? If it has increased substantially, you may need to review the balance between the supply and demand for the service before proceeding with STAT. If it has remained reasonably stable (less than 10 percent increase annually), you are ready to proceed to the next step in the process.
- Do you have the data you need to have a good understanding of your service's supply and demand? If not, how can you get it? Accurate data will make the next stages of implementation much easier and increase your chances of success.

Part 2: Implementing STAT

Step 2: Calculate demand

The next step in the introduction of STAT is to determine how many new assessment appointments are required to keep up with demand.

The key principle is to determine the demand and divide this by the available supply. Demand in this case is defined as the number of referrals over a given time period (for example referrals received per week or per month; choose a time frame that makes sense for your service) and supply is typically expressed as the number of full-time equivalent staff providing the service (although there may be some services where it is more appropriate to think of supply as the number of available clinic sessions, for example). This will establish the number of new appointments required per unit of supply (a full-time staff member, for example) to meet service demand, without having to put new referrals onto a waiting list.

Once this number is known, it is necessary to allocate this demand across the service in a practical way. For example, consideration may need to be given to the time fraction of clinicians, with pro rata allocation to part-time clinicians. Clinician experience and seniority may also have an impact; more experienced clinicians may be able to handle a larger caseload, or alternatively may have less time allocated to clinical work, leading to a smaller allocation of new appointments than their more junior colleagues.

Adding a buffer

Everyone is entitled to annual leave and there will be times when a scheduled appointment is unavailable due to professional development or staff illness. These are normal conditions when delivering health services and should not be considered an aberration when they occur. Rather than constantly trying to 'catch up' when a staff member is away, STAT works best when additional appointments are built into the system to allow for these normal variations.

It is possible to work this out very accurately for individual services, taking account of usual work days for part-time staff to accurately allow for public holidays, checking historical rates of unplanned leave and so on. However, an addition of 15 percent above the number of calculated STAT appointments is a good "rule of thumb" to allow for a sufficient buffer to comfortably compensate for these predictable 'lost' appointments. In small services with a number of part-time staff, public holidays (depending on days of the week typically worked) and unplanned leave can have a greater impact and a larger buffer may be required.

Failure to attend rates

Consider the rate at which clients fail to attend appointments and the policies for dealing with this. In services that have a high FTA rate, and clients who don't attend are routinely offered new appointments, extra new client spots will be required to compensate. Services with a low FTA rate or strict policies that limit rebooking of these appointments will not need to make such significant adjustments.

Part 2: Implementing STAT

Worked Example

Let's imagine a service that has 4 full-time clinicians and 1 part-time clinician. The service receives 775 referrals per year, but an average of 55 referrals are either rejected or withdraw without receiving an appointment. On average, 10% of clients don't attend their first appointment and are offered a second one.

Step 1: How many new referrals require appointments?	775 – 55 = 720
Step 2: What is the impact of people who don't attend? 72 clients (10% of 720) use two appointments instead of one.	720 + 72 = 792
Step 3: How many new appointments are needed each week to see new clients at the rate of demand To provide a buffer and allow for leave and public holidays, inflate this number by 15%	792 ÷ 52 = 15.2 15.2 x 1.15 = 17.5
Step 4: Calculate allocation for the equivalent of one full-time clinician Round up to a practical figure to work with	17.5 ÷ 4.5 = 3.9 (round to 4)
Step 5: Decide on a practical allocation within the context of the service	Eg. 4 new clients per week for full-time, 2 for part-time clinician
Or use this formula, where: N = Total referrals received annually R = Number of referrals rejected or withdrawn each year F = Number of additional appointments to compensate for non-attendance S = Supply – total full-time equivalent of staff available to supply the service	$\frac{(N-R+F) \times 1.15}{52 \times S}$ = weekly demand $\frac{(775-55+72) \times 1.15}{52 \times 4.5}$ = 3.9

What if the final number is unachievable?

What happens if the number of appointments required exceeds a realistic workload for clinicians? We can't create more hours in the day, and introducing STAT is not about making people work harder.

If the final number is unachievable, the service has a true imbalance between supply and demand and compromises will need to be made.

These decisions can be difficult and should involve organisational leaders and policy makers, not just left to clinicians. For example, the Community Health Demand Management Toolkit published by the Victorian Government gives advice on decisions about supply of services when resources are limited. (Department of Health Victoria, 2023)

Part 2: Implementing STAT

Options to consider

Reduce demand

- Tighten referral criteria: You may not be able to provide all the services to all the people that you would like to, so think about what your core business really is. Perhaps it is better to decline services to some people, so that those with greater need can get a bigger slice of the pie.
- Divert some clients elsewhere: What other services are available? Is anyone else offering similar services that could help some clients instead?
- Educate referrers about service constraints. They may reconsider the threshold for referral of clients with lower level needs if they have a better understanding of demand.

Increase supply

- Look for efficiencies – are there ways to work smarter? For example, can you provide some services using telehealth to reduce travel time, or schedule clients with similar needs together into a dedicated clinic, streamlining set up and resource preparation?
- Review your models of care. For example, weigh up the alternatives of providing a little less service or treating more people in groups, versus having some people wait a long time for treatment. Perhaps neither is ideal, but which is the lesser evil?
- Can failure to attend policies be tightened, or other strategies such as SMS reminders be used to reduce non-attendance rates?
- Make a case for expanding the service. This is not a quick fix but now you have the data required to put forward a strong argument.

Retain a waiting list

- This is often the default position and might sometimes be the only option. Sometimes service providers may decide that there is no better alternative. However the important thing is that a decision to retain a waiting list is an active decision – made after weighing up all the options – not an automatic default.

Calculating demand for multidisciplinary services

Some healthcare organisations offer a multidisciplinary service, in which clients might be referred to either a single discipline or multiple disciplines. In some cases, health professionals may want to refer to each other.

Essentially there are two approaches to managing this situation.

1. Treat the service as a single, multi-disciplinary entity, where clients receive one assessment appointment as an entry point to the service and are then referred internally to specialist disciplines as required. This works well in services where the model of care provides for a standard assessment for all clients, with this generic work shared between members of the team.

2. Treat the service as a number of co-located but separate, discipline-based entities. Calculate the number of assessment appointments required by a single discipline. On referral, clients can be booked for assessment with one or more disciplines. There may also be opportunities for intra-team referrals to book clients in for assessment with colleagues in the same way that appointments are allocated for new clients to the service. In this case, Internal demand is also accounted for when calculating the number of new appointments required by each discipline.

Part 2: Implementing STAT

Step 3: Reduce backlog

The backlog of clients currently on the waiting list needs to be addressed before the STAT model can be successfully introduced.

STAT is very effective at maintaining flow into the service at the rate of demand, but if there is already a long backlog of waiting clients, time from referral to first appointment will stabilise, but not improve. To achieve ongoing improvements in access, the existing backlog needs to be substantially reduced or ideally eliminated.

Backlog reduction should be viewed as a targeted, "one-off" intervention carried out over a limited time frame. The aim is to reduce the size of the existing waiting list, so that STAT can do its work to keep things that way.

Start by agreeing on an ideal 'target time' from receipt of referral to first appointment, based on clinical evidence and consultation with service users. In a perfect world, what would be the ideal time between referral and first appointment? The answer to this question will vary from service to service. For example, people accessing a service as part of a hospital discharge plan might typically need a week to settle in at home before their first appointment. A service that provides developmental assessment for preschool children may consider three to four weeks to be ideal, given the condition is unlikely to change over that time period and parents may need time to plan appointments. A modest lead time into the next available appointment isn't a bad thing, as it provides both services and clients sufficient time to be able to ensure that appointments can be consistently filled.

There is no "one size fits all" to backlog reduction. Solutions will be unique to each service, with the aim to reach the 'ideal' target time for referral to first appointment before progressing to Step 4.

Bottle necks within each service must be identified and addressed, and service providers need to work together to create targeted strategies that are likely to make the biggest impact on reducing the number of clients waiting to be seen. A one-off injection of funds over a short period to prepare for commencement of STAT can be extremely useful in this process, and far better use of funds than an isolated investment to reduce backlogs with no plans to maintain flow in the future.

Some backlog reduction strategies that have been successful in other services we have worked with include:

+ Waiting list audits. This is probably the single most effective strategy we have used in terms of value for time invested. Contacting the clients on your waiting list to see if there are some people who no longer require the service will usually result in many being removed. In a study done by our team in an epilepsy outpatient clinic, of roughly 600 clients on a waiting list only 11 % were identified as actually needing an appointment after a waiting list audit (Lewis, Taylor et al 2020).

> "WE CERTAINLY HAD AN ISSUE WITH A LARGE NUMBER OF UNADDRESSED REFERRALS. WHAT WE WEREN'T CLEAR ON WAS TO WHAT EXTENT WE HAD A LARGE NUMBER OF PEOPLE AWAITING CARE, OR WE HAD A LARGE NUMBER OF REFERRALS TO BE DEALT WITH FOR PEOPLE WHO DIDN'T NEED CARE."

Part 2: Implementing STAT

- ‘Blitz clinics’: As a team, set aside days to assess clients on the waiting list. Consider having the whole team clear their diary for a day or two, put on lunch and follow up with a planning meeting to share the assessment outcomes and decide how to manage the clients who need appointments. If you can turn this into an “event” where everyone is working together on a common goal, you have a good chance of getting buy-in from staff.

- Clear the decks in preparation: Have all staff review their caseloads with a focus on discharge before addressing the backlog. This will create space to absorb new clients from the waiting list as you work through your backlog.

- Additional short-term supply to address key areas: This can be a very useful strategy if any additional resources are available, and is most efficiently achieved if you have part-time staff members willing to work additional hours for a temporary period. No training, no onboarding, no orientation – every extra hour you pay for can go straight to additional services.

- Additional services outside of normal business hours for a temporary period: This strategy isn’t always practical and will only be an option if you have additional resources available, but can be worth considering where an infrastructure issue is causing a bottleneck. For example, where there is a lack of space or specialised equipment for assessment, a few Saturday clinics might be useful to provide a temporary increase in supply.

- Take advantage of seasonal fluctuations: Sometimes referral data indicates a time of year when there is typically a lull in referrals. For example, elective surgery slow-downs over Christmas might lead to a lull in orthopaedic rehabilitation referrals in January, or children may be less likely to be referred by educators towards the end of the school year. Anticipating these natural downturns and timing your introduction of STAT may make this temporary low more permanent.

- Temporarily suspend other activities to focus on the waiting list for a defined period: Every health service has regular non-clinical activity – meetings, professional development, quality projects etc. Consider setting aside a couple of weeks where these activities are replaced by a concerted effort to bring people in from the waiting list.

- Other ideas: Think outside the box!

It’s important to involve the whole team, including administrative and intake staff, when coming up with strategies and to stress the ‘one-off’ nature of this intervention to clear the backlog. Staff will be willing to take on extra clients or temporarily reduce time spent on other activities if they know why they are doing it and how long it will go on for. When given the opportunity, staff will often come up with the best ideas about how to achieve backlog reductions. Once underway, provide regular updates to track progress – share the numbers on the list and progress towards targets, and plan a celebration when you meet your goal.

> “I’VE GOT OTHER WORK THAT I’M DOING NOW WHICH IS MORE CONSTRUCTIVE FOR THE TEAM. I’M NOT JUST SITTING THERE MANAGING A WAIT LIST.”

Part 2: Implementing STAT

Step 4: Create appointments

STAT works on the principle that appointments are 'ready and waiting' in clinicians' diaries to be allocated to new clients.

Electronic diaries are ideal for creating appointments for new clients, with the specified number of recurring time slots for new clients clearly indicated.

Clinicians generally have the freedom to schedule their own days and choose when they would like to schedule appointments for new clients, although there may be some constraints to scheduling within individual services. For example, lack of availability of cars for home visits, or restrictions on clinic rooms may limit when appointments can be scheduled.

Flexibility in setting up diaries is quite acceptable, so long as the correct number of new client appointments is available over a week or month.

MON	TUES	WED	THUR	FRI
New client			New client	
New client			New client	
	New client			
New client	New client			
	New client		New client	
			New client	

Additional rules regarding scheduling might be agreed upon, related to issues such as:

+ Reallocation of unused appointments: For example, if a new appointment has not been filled three days prior to the appointment, you may want a rule that allows the clinician to fill it for another purpose.

+ New appointment slots: These can be moved around within a given timeframe, but not completely removed from the schedule. Some services have found flexibility around periods of leave to be helpful, by moving new patient appointments from the week prior to a period of leave (when clinicians are focusing on discharges and handovers) to their week of return (when they are rebuilding their caseload).

+ Reservation of appointments for specific categories of clients: For example, your service may need to allocate space specifically for different clinical or funding streams, or for emergency assessments.

+ Seasonal variations: All clinicians might be expected to add one additional new patient slot in winter months for a service that receives additional referrals at this time of year. Non-clinical work, such as project or quality activities, might be scheduled around this time to support the service to manage known variations in demand.

+ Accrued days off: If your organisation offers accrued days off, you will need to allow for this. You could inflate your buffer, or ask staff to move their assessment slots to avoid missing these appointments when they plan an accrued day off.

Part 2: Implementing STAT

Step 5: Establish a new workflow

Once you have gathered data, understood your demand, reduced the backlog and created space for new appointments, it's time to make changes to your workflow.

Workflow changes changes will need to occur across four distinct stages of service delivery: The access and booking process, initial assessment, service delivery and transition out of the service.

Streamline the access and booking process

A key aim of STAT is to minimise processes performed prior to the client attending their initial appointment so that the client gets in front of a clinician as quickly and efficiently as possible.

Start by identifying the processes that must be performed prior to the initial appointment. There are likely to be some essential administrative steps, such as registering the client on databases. Remember that if everyone gets early access to an appointment there is no need to spend time prioritising clients (determining when clients should be seen), but screening for eligibility (should this client be seen by this service?) remains important. However, make sure that these processes are not so onerous that time would have been better spent assessing the occasional person who slips through rather than ensuring 100% accuracy on eligibility assessment.

Minimise completion of tasks that are not necessary prior to seeing the client and, in particular, those likely to be duplicated during the first assessment. For example, it may be necessary to ask a potential new patient about the history of their condition if this information is required to establish eligibility for the service. However, if eligibility has already been established, such questions will be asked by the assessing clinician at the first appointment and gathering and documenting this information in detail at the point of acceptance to the service may not add any value to the patient journey.

Once a referral is received and deemed eligible for the service, the intention is that clients are booked into the first available appointment, which should now be within an acceptable timeframe. Ideally, the client should receive an appointment time as part of their first contact with the service. This may negate the need for other correspondence, such as a letter confirming receipt of a referral.

Completion of a process map, identifying all current processes in the patient journey to their first assessment can be very helpful. Once the process map is complete, ask yourself which tasks could be reduced or eliminated if there was no waiting list (Figure F).

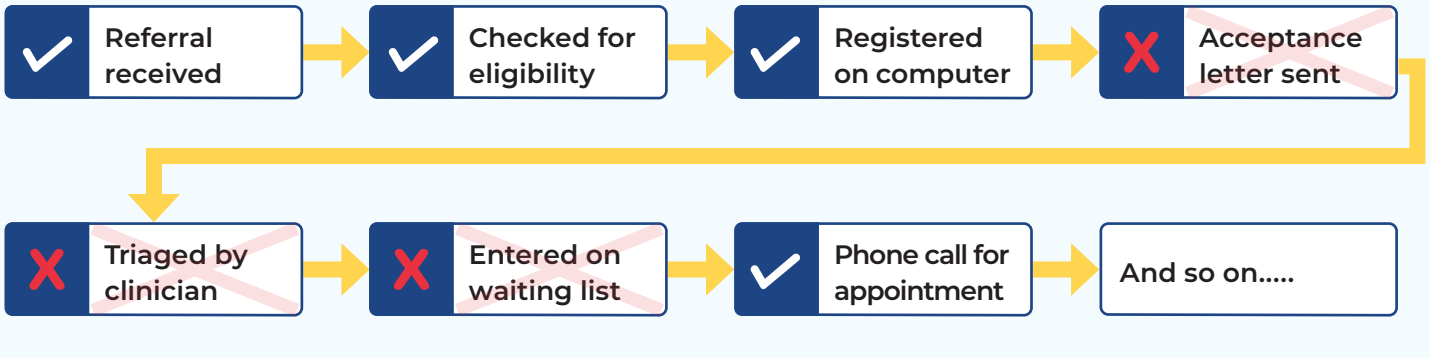


Figure F: Example of a process map noting steps that could be eliminated in a service operation without a waiting list

Part 2: Implementing STAT

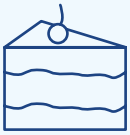
The first appointment

Under the STAT model, the first appointment has multiple purposes.

+ Assessment: The clinician finds out about the needs of the client, and the client learns more about the service. This interaction provides much more information than a written referral, and enables the clinician to gain a broad understanding of the client's situation. This doesn't just include clinical needs, but also provides insights into factors such as social support, health literacy and motivation, which may influence the intensity of services required or suitability of different care pathways.

+ Early advice or initial treatment: Sometimes it doesn't take a lot of time to make a difference. We know that the things people want most in terms of access to services, are information, communication and the ability to make a plan. Providing some initial information about their condition, lifestyle or exercise advice, referrals to other services, and a plan for the next steps will go a long way.

+ Triage for further care: Following this initial interaction, a decision will need to be made about future care. What can and should be offered depends not only on patient need but also on the resources available for distribution among all the people who are looking to access the service.



Your service as a cake

Think of your service as a cake, and your clients as guests at a party. In a traditional "waitlist and triage" our guests line up at the door. They come in one at a time, and are served a piece of cake. Those already inside are offered additional helpings until their needs have been satisfied, then they leave and a new guest is granted entry and a piece of cake. With the STAT model, your guests enter the party at the rate of arrival. They each get a small piece of cake, but whether they get a second helping or a bigger slice depends not just on how hungry they are, but how big the cake is and how many guests are at the party.

> "I THINK THAT YOU'RE PUTTING PATIENTS MORE AT RISK BY HAVING THEM WAIT THREE WEEKS WITHOUT CONTACT. I FEEL COMFORTABLE TO KNOW THAT WE HAVE SEEN SOMEONE AT LEAST AND BEEN ABLE TO GET THEM STARTED ON THEIR REHAB."

Part 2: Implementing STAT

Planning and delivering care

Triaging and, to some extent, rationing services is made easier for clinicians when services are able to offer a number of different care pathways tailored for different levels of need.

After assessment, clinicians should not feel under any obligation to see the client immediately for intensive, ongoing care, however a secondary waitlist for treatment should be avoided. A key part of adapting to the STAT model is for clinicians to actively consider the appropriate intensity and timing of further services for new clients, based on client need and available resources.

This will be challenging at first, particularly in services where clinicians are accustomed to providing a 'standard' package of care. However, active development of 'pathways of care' at a service level will make this easier.

The options available will vary from service to service, but some possibilities might include:

+ **Brief intervention or reassurance and discharge or referral on:** In services with long wait lists, clinicians can be reluctant to offer only a single occasion of care. They may feel that if a patient has waited six months to see them, they need to make the service worth waiting for, regardless of the client's needs. However, with rapid access to an initial appointment it is much more acceptable to discharge after a single assessment.
+ **Access to self-management resource:** Motivated clients may go a long way with good information and support for self-management. Setting up pathways to make this possible (by exploring apps, online resources, or open access education groups, for example) may help to free up resources for others with higher levels of need.
+ **A low intensity treatment pathway:** At the initial STAT appointment the clinician has the opportunity to fully understand the client's needs and determine the most appropriate pathway. For example, can the client be treated as part of a group? Could they be offered a couple of sessions with subsequent telephone follow-up? Could another less specialised team member or health assistant provide or support appropriate care?
+ **Immediate commencement of treatment:** Some clients will require immediate commencement of regular or intensive treatment. Early face-to-face assessment determines the client's needs so that resources can be allocated accordingly.

> "YOU MIGHT JUST HAVE TO BE A BIT MORE CREATIVE WITH YOUR SESSION, SHOWING THEM HOW THEY CAN PROGRESS A BIT FURTHER INDEPENDENTLY…BUT THE PRO IS THAT WE ARE SEEING MORE PEOPLE SOONER, WHICH I THINK IS MORE OF A PRIORITY."

Part 2: Implementing STAT

Managing care with STAT: an example

Let's imagine a situation where Fred, Maria, Jane and Deng are referred to a service at the same time. Under a traditional 'wait list and triage' system, Maria and Fred were deemed to be 'Priority 1' and Jane and Deng are given 'Priority 3' and put on a waiting list. As each get their turn to enter the service, they go on a schedule of weekly therapy for the standard period of eight weeks. For Maria and Fred this happens without delay, Jane and Deng wait four months. When they eventually commence, it is doubtful whether Jane and Deng need the full program but they are offered it anyway since they have waited a long time for their place.

Under the STAT model, all four clients are offered a first appointment within a relatively short period of time. This is possible because sufficient appointments for new clients have been protected in the schedule to accommodate the expected number of new clients. None have received a triage category, and only limited information has been collected so far to check eligibility.

Following the initial assessment, Maria is identified as having urgent needs and commences with twice-weekly therapy for three weeks, later reduced to once a week as she improves. Fred's needs were not as extensive as might have been expected from the referral, but he goes onto a weekly schedule with a plan to review in four weeks.

Deng turns out to be very capable and motivated. He can be given a home program with fortnightly review. Jane's needs are less aligned with the goals of the service, but she is given some advice and reassurance, referred to a health education and exercise group in her local community and leaves happy.

The example is simplistic, but it illustrates how decisions about priority are shifted from access to ongoing management. All four clients received similar access to the service with minimal waiting time, but priority decisions were still made in relation to their care. While many service providers already make decisions about discharge and frequency of services the STAT model places a stronger emphasis on this process.

If new clients continue to enter the service at a steady rate, there will be times when review appointments need to be rationed, and clinicians will need to make tough decisions about who needs the service least. Although this may not be ideal, we are essentially balancing the relative disadvantages of excessive wait times with compromises on service provision for some clients during high demand periods.

Part 2: Implementing STAT

Exit from the service

In order to maintain a steady flow of clients through the service, exit of clients (discharge or separation) from the system must keep up with the rate of entry. For clinicians, it is always easier to keep seeing the clients who are already known than beginning again with new ones. Most health professionals are also highly motivated by building relationships with their clients and want to provide the best possible care. Clients who are benefitting from a service may also be reluctant to be discharged. All these factors mean that it is tempting to prioritise clinic time for those in the system, rather than those who are "out of sight, out of mind" on the waiting list even if those who are waiting are in much greater need than those in the later stages of treatment.

The process of discharge is made much easier if the exit strategy is being planned before a person even enters the service. To promote effective discharge:

+ Be clear about the core business of the service, with clear guidance for all clinicians about its limits.

+ Identify options for clients to transition to if needed. For example, community based services through local gyms, senior citizens centres or neighbourhood houses, or explore support services provided through condition-specific advocacy groups and foundations.

+ Set clear, time limited expectations. For example, rather than telling a family their child will "start speech pathology next week", instead offer a place in a "6 week block of speech therapy". This doesn't preclude the offering of a subsequent block, but sets up an opportunity to review and make an active decision about need for further care.

+ Set clear treatment goals and stick to them.

+ Partner with your clients and their other care providers. Promote self-management, communicate with colleagues (such as the local doctor) and actively work towards independence from the service.

+ Enable re-entry. Fear about a client being able to get back into the service if something changes is a barrier to discharge. By reducing or eliminating your waiting list and keeping pace with demand, clients who need to return should be able to access the service in a timely manner.

Ongoing monitoring of the supply/ demand balance

STAT is not a "set and forget" model. It is necessary to continually monitor the number of new appointments available and measure them against the incoming referrals. A lack of balance between referrals and available appointments could suggest a need for adjustment to your original calculations, or an indicator that something has changed.

A benefit of the STAT model is that it is relatively easy to see when things are out of balance. When there are more referrals coming in than scheduled appointments, the time to the next available appointment increases. If there are more appointments available than referrals coming in, there will frequently be empty slots.

Part 2: Implementing STAT

If there is a consistent problem with insufficient appointments, you need to find out why. This is likely to require exploration of your clinic data to investigate the problem.

- Has there been an increase in the number of referrals received? If so, can you see why? For example, are more referrals coming from a new source? Has a neighbouring service closed? Is it a consistent upward trend, or does there seem to have been a "blip" that might represent a normal fluctuation that will balance out over time?

- Has there been a reduction in supply? Are all appointments consistently filled? How many are being lost to non-arrivals? Is there a vacant position or someone on extended leave beyond what was accounted for in your calculations?

The first step in managing these issues is to recognise them early, before you are back to having a massive waiting list. A good strategy is to decide up front on a 'tipping point', triggering a pre-defined process to review the data and respond accordingly. For example, you might decide your ideal time to first appointment is four weeks.

Once the time to the next available appointment exceeds 6 weeks, the intake team notify a designated senior clinician to manage the data review and response.

Disruptions to supply, such as prolonged staff vacancies, can result in a waitlist returning after you have successfully implemented STAT. Rather than continuing to accept referrals and placing them on a waitlist, be proactive with planning and modify your model of care to offer a reduced service until your EFT is filled. For example, you may only offer assessment and online education or referral on until successful recruitment.

> "WE REGULARLY MONITOR THE TIME TO FIRST APPOINTMENT. OUR TEAM IS CREATIVE AND INNOVATIVE ABOUT IMPROVING MODELS OF CARE AND CAN BE FLEXIBLE DEPENDING ON OUR AVAILABLE RESOURCES."

Part 2: Implementing STAT

Tips for success

Follow good principles of change management. STAT may require a significant change to both clinical practice and administration processes. Staff members who feel included in decision-making are empowered to work creatively to meet the challenges; and staff members who have a good understanding of the reason for change manage the transition well.

Provide good leadership. Managers, team leaders and influential staff members need to create the conditions that guide the team towards a shared goal to reduce waiting time. Endorsement and sign off from senior managers will help the organisation make the shift to a more accessible service. Project leaders need to provide information, support team members and be open to suggestions.

Align proposed changes with your organisation's strategic focus. Equitable access, timely service, client safety, reduction in clinical risk, client-centred care and financial responsibility are examples of how STAT can contribute to the advancement of a healthcare service. Bringing the organisational plan to the forefront assists in ensuring support from executive, managers, team members and consumers in creating a drive to change.

Involve and value your administrative staff. The role of administrative staff and, in particular, the person who makes the bookings and manages the clinicians' diaries, is very important. The roles for these staff members may change significantly, although ultimately STAT should make their work easier and more efficient. This group is likely to be able to make a very positive contribution to the process, so make sure that they have a seat at the table.

Clarify and monitor your eligibility criteria. STAT ideally negates the need for triage prior to allocation of an appointment but determination of eligibility remains important. Use the opportunity to review eligibility criteria and make sure these criteria are consistently followed. Many services suffer eligibility creep where criteria gradually expand and increase pressure on supply.

Streamline processes right across the service. Many processes in healthcare settings have developed over time in response to changing requirements. There are sometimes layers of tasks that were introduced in the past that are no longer required. Take a fresh look at the processes, what they add and whether they are still necessary. Ask: 'Why do it we do it this way?', 'Is there another way?'

Part 2: Implementing STAT

Tips for success

Prepare the team for a transition period. During the transition from the current model to STAT, there will be an overlap of the 'old way' and the 'new way'. Clinicians will have clients from their 'pre-STAT' caseload for a period of time while taking on clients as per the STAT diary. This transition can be aided by good preparation, involving staff in the planning of backlog reduction strategies, providing feedback on progress (such as updates on the length of the waiting list), and reassuring staff of the temporary nature of the effort. A preparatory discharge blitz can ease the transition. Short term additional resources can also be very useful during this period.

Prepare for a different way of managing caseloads. With STAT, staff will be asked to place higher priority on those clients who have not yet been seen, and think carefully about distribution of resources to those who are already engaged with the service. People will need support to get used to the idea of distributing resources according to need, particularly when that means some clients receive less than they used to. However, remember that on the flip side, all clients are receiving benefits from faster access to care.

Build a case for change. Staff awareness of the existing waiting list has been shown to be a factor associated with a positive response to STAT. Therefore exposing people to the waiting list issue may help to build a case for change. For example, consider rotating clinical staff through intake roles, or add a waiting list report as a standard agenda item to team meeting to raise awareness.

Part 2: Implementing STAT

Conclusion

Lengthy waiting times for care in an outpatient or community setting are challenging to many clinicians, administrators and managers. Delays in access to care for these services have been associated with poorer patient outcomes, anxiety, and service inefficiencies. The STAT model provides an alternative option to the management of wait lists, addressing patient flow by reducing complexity in booking systems, combining triage with initial management, and actively managing the relationship between supply and demand. This handbook is the result of research which has shown that the STAT model works where key principles are followed and team members and leaders are ready and willing to change.

The STAT research team is proud to provide this handbook as a resource to those who wish to take the plunge and try the STAT model. This body of work has been made possible by a partnership between La Trobe University and Eastern Health, with support from the Victorian Department of Health, the Eastern Health Foundation, the Medical Research Future Fund and the National Health and Medical Research Council.

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