



## Referral and Information Centre

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# Acknowledgments and Advisors

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# Executive Summary

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Patients, carers and consumers of health care services are becoming more knowledgeable in their understanding of their health needs. Information technology and modern communications systems has provided access to a broad range of health resources. Patients, carers and their families often 'research' their health conditions to gain additional information to assist in the management and prevention of further problems. Over the last five years there has been an increase in the number of internet and telephone based human service information repositories.

Highly trained staff are able to deliver safe and effective health care services and information using these modern communications and information technology. Although they are highly specialised undertakings, they have proven their ability to operate effectively and safely (Latimer et.al., 2004). Internationally they are a popular and effective method of delivering health care advice and information without time or geographic restrictions.

The Hunter New England Area Health Service (HNE) established a Referral and Information Centre (RIC) for the Greater Newcastle Cluster of community health services. The RIC aims to improve access to timely, safe, consistent and appropriate level health care information, support and advice to clinicians and the community.

This partnership of skilled staff and sophisticated technology allows HNE to provide an effective information and referral system that meets the needs of patients, carers and clinicians. Using clinical support systems, combined with quality improvement processes and detailed reporting, RIC staff are able to effectively and collaboratively work with patients, carers and clinicians to provide appropriate referral and health care information. The RIC offers patients and carers improved access to timely, safe, consistent and appropriate levels of health care support and services.

# The Need for Change

## Jenny's Story

### Jenny's Story Prior to RIC

Jenny lives in a small seaside township, has three teenage children and provides support and assistance to her elderly parents Bridget and Joseph who live nearby. Joseph recently returned home from hospital where he was being treated for cancer and his health has continued to deteriorate. Bridget wants to care for her husband at home for as long as possible but she is quite frail and needs Jenny to help her with domestic chores and the care of her husband.

Jenny's parents are ill and frail.

Jenny wants to support them to stay in their home. This is Jenny's story prior to RIC.

*This is a real story, only the names have been changed.*

Recently Jenny visited her GP in distress as Joseph was in severe pain and has been constipated for six days. As he weighs 80 kg, Jenny is unable to lift him or help him with his personal hygiene needs. Bridget's health is also rapidly deteriorating under the strain of caring for her husband. Jenny took a day off work and spent the whole day telephoning community based services to try and get some domestic support and palliative care for Joseph. After ringing one service she was transferred to five different people before she was told that her parents weren't eligible for their type of service because they lived in the wrong area. Jenny was very frustrated and distressed.

Jenny's GP made a referral for the palliative care service to visit Joseph to help him with his pain. After several phone calls the GP's nurse rang Jenny to say that she had been able to arrange for some support to help with Joseph's personal hygiene. In the meantime Jenny continued to ring around to try and access some other support. Eventually she was able to have Joseph's name put on a 12 week waiting list for an occupational therapy assessment.

## Jenny's Journey



Jenny lives in a small seaside town, has three teenage children and supports her elderly parents Bridget and Joseph.



Joseph is being treated for cancer. He has been discharged home but is continuing to deteriorate. Bridget is frail but wants to care for Joseph at home. Jenny wants to support her parents and help them to stay in their home.



Recently Jenny visited her GP in some distress. Joseph is in severe pain, unable to get out of bed without help and has been constipated for six days.



Jenny took the day off work and spent the day telephoning around to try and get some nursing assistance and palliative care for Joseph. She was unsuccessful and became very frustrated and distressed.

### What is wrong about this story?

- Multiple access points to obtain services.
- Long waiting lists leading to extra strain on Jenny's family.
- No coordination of care and services.
- Jenny was unable to support her mother's desire to nurse her father at home.

Despite both Jenny and her GP making numerous phone calls they were unable to obtain any further help for Bridget and Joseph. In the meantime Jenny rearranged her work roster and other family commitments so she could be with Bridget and Joseph when the nursing staff visited. By the time she had made numerous phone calls to her GP, the palliative care service and the community health centre Jenny wondered whether it was worth all the effort. Despite Jenny and her GP's efforts to locate some help for her parents, they were unable to. A week later Joseph was admitted to a nursing home as Jenny and Bridget were unable to care for him at home.



Jenny's GP made a referral for the palliative care service to visit and help Joseph with his pain. After several phone calls the GP's nurse rang to say that she had been able to get some domestic support to help with Joseph.



Jenny continued ringing services to obtain further support. Eventually she was able to have Joseph put on a 12 week waiting list for an occupational therapy assessment to help get him out of bed.



Jenny and her GP were unable to access any other support for Bridget and Joseph despite numerous attempts. A week later Joseph had to be admitted to a nursing home to be cared for.

# Background to the Model



*Jenny needed rapid assistance to support her ageing parents, while still providing care for her three children.*

*As Australia's population ages, Jenny's story will increasingly become usual. The large number of health and community services available - both known and unknown to Jenny and her parents - demonstrate the need for central information and referral points.*

*A central point can rapidly determine need, mobilise services, and organise comprehensive assessment to plan for ongoing support and care.*

Access to better information increases confidence about health decisions leading to better care and reduced costs. Jenny and her family needed to be fully informed prior to discharge from hospital about the care choices available.

A central point can also help patients, families and carers decide on the best model of care, whether medical treatment, home treatment or community services.

The need to change traditional access methods, provide robust information and rapid technological changes are driving development of new models of health care. Modern telecommunications and information technology are pivotal tools for delivery of these new models (Kassirer,1995). Combined with highly skilled clinical staff, these call centre based services are proving to be a safe, effective and popular with patients, carers and the community. Although these centres may have different forms and functions, they can operate effectively as either stand alone services or within the context of local community services. Standalone services operate with nurses undertaking triage and/or providing accessible advice using proprietary software (Turner et.al., 2002). Others operate with nursing providing a single integrated access and referral point using locally developed protocols to provide information and referrals.

These services can offer better access to health care services for patients without time or geographic restrictions (Dale et.al., 2004) and opportunities for coordination and support for clinicians. In the United Kingdom, the NHS Direct service is proving its worth as a strategy to improved access to health care information. A review of Australian established services for the Australian Health Ministers Ministerial Council has reported high levels of

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consumer satisfaction (ACIL Tasman, 2004). Regional, rural and remote communities are reporting benefits because of the ease of telephone access and because it allows them to access services without disrupting their employment and caring responsibilities.

In 2003, the HNE established the Referral and Information Centre (RIC) to service the Greater Newcastle Cluster of Community Health Care Services. The RIC is able to provide a single integrated access point and accurate and consistent information to consumers and clinicians. It is a service delivery solution that addresses the changing health care environment and enhances the delivery of health care services to patients, carers and clinicians.

# Referral and Information Centre

## Jenny's New Story

### Jenny's Story with the RIC

Jenny lives in a small seaside township has three teenage children and provides support and assistance to her elderly parents Bridget and Joseph who live nearby. Joseph recently returned home from hospital where he was being treated for cancer, but his health continues to deteriorate. Bridget cares for her husband but she is frail and needs Jenny's help with the domestic chores and to support her as she cares for Joseph. Jenny's support helps her parents to maintain their independence.

Jenny assists and supports her frail parents in their home.

Jenny needs to access some domestic assistance and nursing support to help maintain her parents in their own home.

This her story under the RIC Model of Care.

*This based on a true story. Only the names have been changed.*

Recently Jenny visited her GP because Joseph who weighs 80 kg needs help to get out of bed. Jenny and Bridget are not physically strong enough to help him. Joseph is now in severe pain and been constipated for over six days. Bridget's health is also rapidly deteriorating under the strain of caring for her husband. Jenny's GP rang the RIC to access some nursing assistance for Jenny and her parents.

After talking to the GP the RIC nurse rang Jenny directly to find out further information. Based on this information and using the assessment protocols for each discipline the RIC nurse arranged for a community nurse to assess the level of assistance required for personal care and help with his constipation. An urgent referral was also made for a physiotherapist to do a mobility assessment and an occupational therapist to do a Home Mobility Assessment. The RIC nurse asked the GP for a direct referral so that the RIC nurse could complete a service request for the palliative care team. This meant that Joseph could access the palliative care services immediately.

By the end of the day the RIC nurse has been able to identify and arrange access to range of locally based services and support mechanisms to help Jenny to support her parents comfortably in their home.

## Jenny's New Story



Jenny lives in a small seaside township, has three children and supports her elderly parents Bridget and Joseph.



Joseph is being treated for cancer. He is at home now but continues to deteriorate. Bridget is frail but wants to care for Joseph at home with Jenny's help and support.



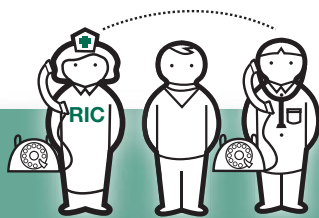
Recently Jenny visited her GP as she needs some help for Joseph as he is in severe pain and has been constipated for six days. He weighs 80 kg and Jenny is unable to get him out of bed. The GP rang the RIC to access some help for Joseph, Bridget and Jenny.

## What's good about this service:

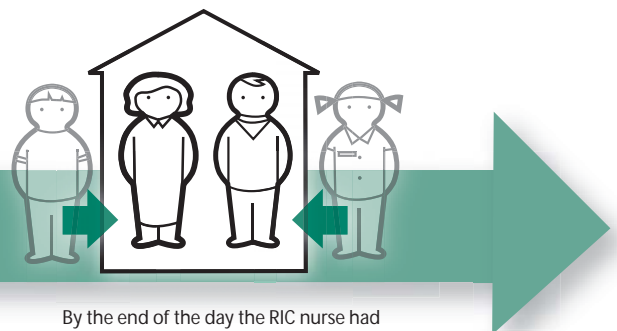
- Jenny's GP only had to make one phone call to access a range of locally based services.
- Services were arranged consistent with agreed clinical protocols.
- Jenny and her parents were able to quickly have services in place to help them through their crisis.
- Jenny was able to balance her caring responsibilities with her employment and family commitments.



After talking to the GP, the RIC nurse spoke directly to Jenny at home. The RIC nurse arranged for a community nurse to visit to assess the level of assistance that Joseph needed.



The RIC nurse contacted the GP for a service request referral to the palliative care team. She also arranged for both a physiotherapist and occupational therapist to visit and do Mobility and Home Modification assessments.



By the end of the day the RIC nurse had identified and accessed a range of locally based services and support mechanisms to help Jenny to support her parents comfortably in their home.

### Martin's Story with the RIC

Recently I was feeling very down and felt like I was at the end of my rope. A lot of really bad things seemed to be coming together. I contacted Centre-link and spoke to one of the staff members there. She contacted the Referral and Information Centre (RIC) in an effort to help me obtain counselling for myself. The Centre-link person said that the RIC would contact me shortly for more details. I didn't believe her, so I just went home feeling even worse than before.

That afternoon to my surprise someone from the RIC called me. The RIC nurse told me that her name was Theresa. Even though I was quite emotional on the phone Theresa listened to my story. Theresa sounded as if she really cared and wanted to help even though she explained that I didn't fit the criteria for Community Health counselling. I really responded to Theresa's personal approach. As I have a long history of substance abuse Theresa felt it would be better in the first instance for me to see a Drug and Alcohol counsellor. Theresa explained that the Drug and Alcohol counsellor could refer me back to Community Health at a later date if other counselling issues outside Drug and Alcohol remained.

I was asked if I would consider seeing a Drug and Alcohol counsellor and when I agreed I was put on hold while Theresa contacted the service. They were able to arrange an appointment for the next morning. I really believe that Theresa cared about my call and she made a real effort to get me the right help and arrange an appointment. She spoke to me with compassion and I told my wife when I got off the phone that I felt like a great weight was off my shoulders.

Although I was very emotional when the RIC first contacted me, I felt a lot better after the call. I have since had a session with the counsellor who has since referred me to the Mater Hospital Drug and Alcohol unit. I have a long haul ahead of me but I am now on the road to recovery.

### What's good about this story

- Martin was contacted promptly and listened to sympathetically.
- Martin was given assistance in accessing the right service, when he needed it.
- The RIC nurse was able to use approved protocols and a single database to make a correct and prompt appointment for Martin.

# The Hunter New England Referral and Information Centre

*The RIC provides a single, integrated access into the Community Health Network of the Greater Newcastle Cluster of the HNE. The philosophy of RIC is to enhance existing services by improving and integrating access for both clinicians and consumers.*

Operating in conjunction with clinic home visiting services, it provides accurate and consistent information to consumers and clinicians in the HNE and facilitates referral to community services. It aims to provide a central referral point for both clinicians and residents to assist them to access these services. The RIC focuses strongly on meeting the diversity of needs, both cultural and geographic, of HNE Health service partners and consumers.

## The aims of the RIC are to:

- Provide a single point of contact for safe and consistent high quality customer focused services for the region.
- Ensure consistency of service provision and thereby reduce clinical risk.
- Improve the region's capacity to monitor the impact, value and cost of services.
- Improve data collection methodologies and technologies to support future planning for the community and its needs.
- Improve overall client and customer satisfaction.
- Facilitate effective integration of systems and services.
- Provide a succinct record of the relevant clinical information to allow for prioritisation and allocation of services.

## RIC Outcomes

The intended outcomes of the RIC are to provide choice, confidence, education, consistent and safe health advice, and better integration between services for both clinicians and the community.

HNE has migrated many of its services into this centralised model. The service functions both as an end service that provides first call resolution for callers and also as a 'linkage information service' between health consumers and health service providers. The services included in the RIC have similar aims and are focussed around the requirement to centralise contact within the community while delivering appropriate access to clinical and community care. The RIC provides a central intake point for the Greater Newcastle Cluster services in the HNE to:

- Provide clear and consistent information to consumers by appropriately trained and skilled staff.
- Provide efficient, streamlined access to services.
- Coordinate the referral process.

# Keys to Success

## Enhancing Services

The RIC aims to improve the care journey of patients and to support clinicians in their roles of health care providers. It is a community based program that operates between 8:30 am to 5:00 pm five days a week to coordinate care between the patient, clinicians and health funded and NGO provided community services.

The RIC has been particularly successful at enhancing the delivery of available services. The RIC is able to assist in alternate clinical and non-clinical community services e.g. other geographic areas, transport and support services, in the HNE region. It is able to direct and coordinate between services and users and provide advice that reflects the local services. Clinicians use the RIC to find out about other services within a particular area or discipline without having to maintain their own repository of accurate and up to date information. At times the RIC receives calls for services not in the scope of its core business. These out of scope calls are also linked to appropriate services to enhance customer service.

## Referrals and Intake

RIC staff are able to provide information and make referrals to some CARE network clinicians including:

- Community Nursing Service
- Physiotherapy
- Occupational Therapy - Home Modifications
- Speech Pathology
- Psychology
- Social Work
- Aged Care Assessment Team
- Equipment Services
- Rehabilitation Services
- Palliative Care Outreach Services
- Day Centres.

## Telephone system

HNE has migrated the switchboards from many services into the centralised RIC model. The RIC has a single contact number with access also available via fax and e-mail. An interpreter service is available on request. The migration to a single telephone number allows:

- a standardised call handling process
- consistent treatment of callers
- adequate training of phone operators
- first call resolution in the majority of cases
- a single transfer to the most appropriate resource if required
- utilisation of a robust information system.

The telephone runs on a queue system, with the system automatically indicating which operator is ready for calls. All calls automatically default to the operator who has been free for the longest amount of time. If no one is free the caller is automatically moved to the queue system. Alarms are automatically generated when a person has been waiting in the queue for more than two minutes. Callers are given a choice as to remain on line or leave a message for a clinician to return the call at the next earliest time.

### **Service Directory**

The RIC utilises a service directory that is available to all HNE staff via the intranet. This directory has:

- Access and entry details for services in plain language and 'look up' and 'find' features.
- Provides links to private services, Commonwealth Government Carelink, carer and support services, transport information, other HNE services and the NSW Health website.

### **Planned Implementation**

The RIC implementation has been planned, staged and incremental. Starting with the migration of services from a single community health service the RIC individually and incrementally rolled out the migration to all the Greater Newcastle Cluster services. This allowed the RIC staff to identify the gaps and strengths of each service and to isolate any difficulties during the service migration process.

### **Staffing**

The RIC requires clinical staff to facilitate telephone referrals from a central location using robust and sophisticated information technology. To achieve this the RIC is staffed with highly trained nurses - primarily enrolled nurses. Successful RIC staff must not only have an understanding and knowledge of clinical practices and processes but must also have highly developed listening skills, an ability to extract stories from callers, be able to think laterally and solve problems all within the context of using complex technical skills in the operation of the computer and telephone system.

A buddy system operates so that new and less experienced team members are supported within the team. This helps build collaboration and communication between the staff and ensures support within the team.

### **Continuity of Service**

The RIC has staff relief built into each FTE position, sharing a relief position with a community health centre. Every twelve months an expression of interest is

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advertised to provide a pool of interested relief staff. This has allowed the community health nurses to obtain a good understanding of the role of RIC and the services that may be available within their community. There is also potential to develop a casual, short term, relief staffing opportunities.

## Clinical Streams / Information

Being able to provide consistent and safe information is a key component of the RIC success. This has been possible because of the collaboration between the RIC and the relevant disciplines within the HNE. The key participants and decision makers within each discipline of the HNE have worked collaboratively to identify and obtain agreement on the specific criteria for service requests for their discipline.

The criteria - inclusion and exclusion - are specific for each discipline and it is these decision makers who must review and update their criteria. This means that each discipline has provided the information about what needs to be asked to make a referral. The RIC provides the relevant health care and service information within the agreed criteria for each discipline. If there is a grey area the RIC staff negotiate directly with the clinicians concerned. This helps in the delivery of the single call resolution for the callers. The RIC also provides feedback to clinicians when they make a referral to the RIC.

## CHIME

The RIC uses the Community Health Information Management Enterprise (CHIME) system to provide consistent, universal service request and clinical information across the Newcastle cluster.

The RIC established standard referral business rules within CHIME that are now used across the community health service network. This has helped to improve the consistency and quality of referrals across the service network. Since its establishment, the RIC has developed CHIME clinical note templates that determine what clinical information needs to be captured in order for the treating clinicians to determine priority of need for their clients. RIC has also used the diary features of CHIME allowing close monitoring of RIC activities to improve and refine the service. CHIME is used to:

- Track referrals, appointment and service contacts.
- Improve service planning and targeting.
- Improve understanding of the health care needs of the community.
- Minimise duplication and improve functionality.
- Information management across services.
- Provide data to measure outcomes and improve reporting at the local, state and national levels.

## Physical Space

In order to deliver safe, high quality, up to date and timely advice and information the HNE installed sophisticated communication and information technology support systems within the RIC. It is based in a physically secure area that has a resilient power system to support the installed technology. In anticipation that the RIC call volumes and scope will increase over time to suit the wider HNE, it has an inbuilt capacity to scale up as needs require.

Another aspect of the RIC physical space is the environment in which it is housed. Important features are the purposely chosen call centre chairs and desks. These accommodate multiple users and facilitate free sharing of knowledge amongst colleagues along with the ready access to resources.

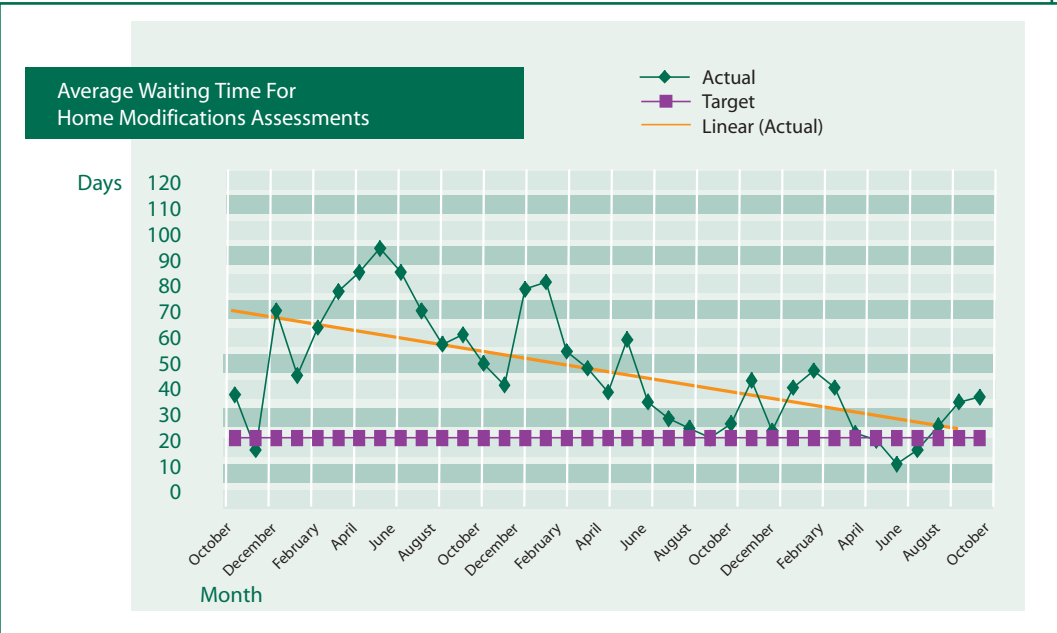
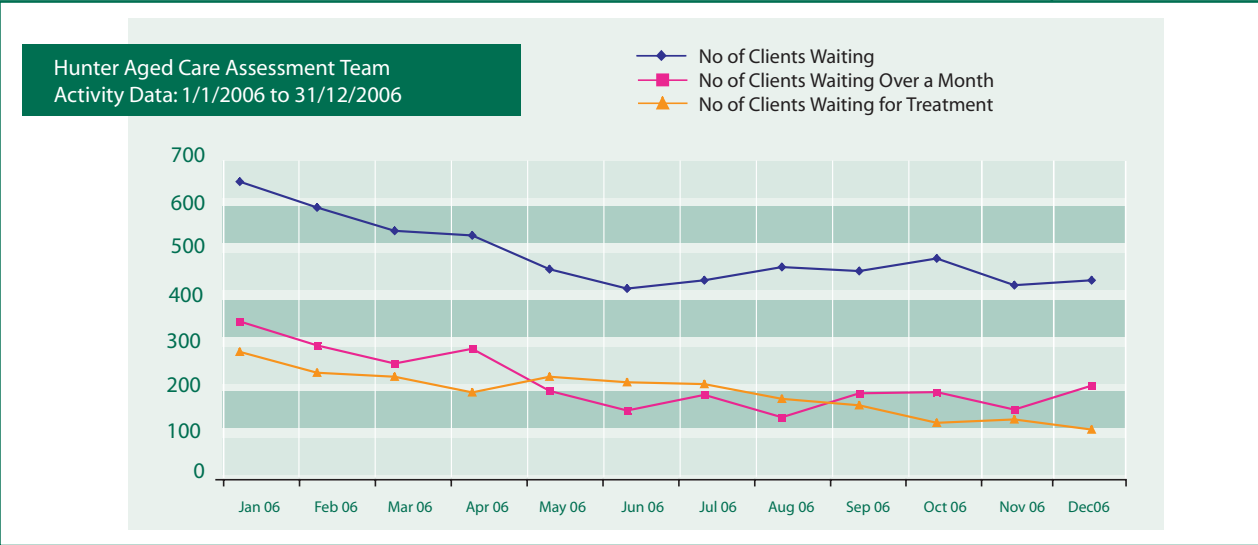
## Key Performance Indicators

Each month the RIC averages 1200 incoming calls, 1500 referrals and over 2300 contacts. The RIC achieves an error rate of less than 1% in each of its referrals consistent with its Key Performance Indicator (KPI). Errors in referrals may be geographic, meet the exclusion criteria for a discipline or be a referral to the wrong discipline. If a referral is inappropriate the clinician is able to reject the referral and the RIC must rectify the referral. The RIC provides monthly reports to the area health service on this KPI.

# Benefits of a Referral and Information Centre

## A Referral and Information Centre:

- ✓ Satisfies a demand from clinicians and consumers for information and reassurance.
- ✓ Provides a safe and effective clinical and community advisory service that operates within consistent clinical guidelines and protocols.
- ✓ A single entry point for callers where the person taking the call 'owns the call'.
- ✓ One of a suite of effective tools used to assist in the reduction of waiting list times for services such as ACAT and Occupational Therapy.
- ✓ Implementation of standard referral business rules across the community health service network.
- ✓ Provides a repository of locally based services and supports across a wide geographic area.



# Implementing RIC

## Process Map

Visit the online version of this process map on the ARCHI website at [www.archi.net.au/elibrary/build/moc](http://www.archi.net.au/elibrary/build/moc)

Here you will be able to access more information on each of the steps in implementing the model. You will have access to tools and templates as well as hints and lessons learned by others who have implemented the model.

	Planning Where are you now?
<b>Governance</b>	<ul style="list-style-type: none"> <li>• Identify leaders.</li> <li>• Develop a process map.</li> <li>• Establish a steering committee.</li> <li>• Develop an evaluation framework.</li> </ul>
<b>Patient Journey</b> How do patients flow through the model	<ul style="list-style-type: none"> <li>• Map the patient journey including care and/or family perspective.</li> </ul>
<b>Policies and Protocols</b>	<ul style="list-style-type: none"> <li>• Identify policies, protocols and guidelines applicable to the RIC.</li> <li>• Clearly identify gaps in existing resources that may limit service implementation.</li> <li>• Review and/or develop agreements with GPs, other clinicians, health care and community organisations.</li> </ul>
<b>People</b> Understand who the staff are, how they function and what role they play in the patient journey	<ul style="list-style-type: none"> <li>• Stakeholder analysis.</li> <li>• Develop staff profile.</li> <li>• Identify existing teams to build capacity.</li> <li>• Learn and understand role of all team members.</li> </ul>
<b>Resources</b>	<ul style="list-style-type: none"> <li>• Survey current resources.</li> <li>• Understand current systems.</li> <li>• Define service succinctly and clarify potential overlaps with existing programs.</li> </ul>
<b>Communication</b>	<ul style="list-style-type: none"> <li>• Develop communication plan.</li> <li>• SESIAHS Lessons Summary - Communication</li> </ul>

	<b>Preparing Make it happen</b>	<b>Operationalise Make it stick</b>
	<ul style="list-style-type: none"> <li>• Develop a Governance Plan.</li> <li>• Establish clinical reference groups.</li> <li>• Recruit a project officer.</li> <li>• Develop Key Performance Indicators (KPIs).</li> <li>• See SESIAHS Lesson Summary Management.</li> </ul>	<ul style="list-style-type: none"> <li>• Monitor and evaluate against the KPIs.</li> </ul>
	<ul style="list-style-type: none"> <li>• Describe the ideal patient journey using the RIC.</li> </ul>	<ul style="list-style-type: none"> <li>• Regularly monitor and remap the patient experiences. Include the experiences of carers and/or families.</li> </ul>
at ,	<ul style="list-style-type: none"> <li>• Develop policies, protocols and guidelines.</li> <li>• Establish clear referral processes.</li> <li>• Identify the care pathways that will be used.</li> <li>• Seek endorsement via the clinical reference groups for the referral pathways.</li> <li>• Identify barriers and potential resolution strategies.</li> </ul>	<ul style="list-style-type: none"> <li>• Go live!</li> <li>• Implement and monitor compliance with all policies and protocols.</li> <li>• Refine the protocols and processes as required.</li> </ul>
	<ul style="list-style-type: none"> <li>• Develop competencies and position descriptions.</li> <li>• Engage key stakeholders such as GPs, Community Health Care service managers, NGO providers.</li> <li>• Implement a training and education program for RIC staff.</li> <li>• See the SESIAHS Lessons Learnt - Cultural.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a review process.</li> <li>• Mentor staff to sustain implementation and achieve best practice.</li> <li>• Celebrate achievements.</li> </ul>
	<ul style="list-style-type: none"> <li>• Deliver required resources.</li> <li>• Ensure that technological resources are scalable for future expansion.</li> <li>• Ensure site is physically secure.</li> </ul>	<ul style="list-style-type: none"> <li>• Monitor resources use.</li> <li>• If necessary reallocate resources to sustain implementation.</li> <li>• See SESIAHS Lessons Summary - Performance</li> </ul>
on.	<ul style="list-style-type: none"> <li>• Implement the communication plan.</li> <li>• Talk about your project at every opportunity.</li> <li>• Identify how the results of the communication plan will flow back to the project.</li> </ul>	<ul style="list-style-type: none"> <li>• Review and revise the communication plan as goals are achieved.</li> <li>• Celebrate successes!</li> </ul>

# Resources

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