Community Eye Care (C-EYE-C) Model for Glaucoma and Diabetic Retinopathy
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- **specialist advice on healthcare innovation** – advising on the development, evaluation and adoption of healthcare innovations from optimal use through to disinvestment
- **initiatives including guidelines and models of care** – developing a range of evidence-based healthcare improvement initiatives to benefit the NSW health system
- **implementation support** – working with ACI Networks, consumers and healthcare providers to assist delivery of healthcare innovations into practice across metropolitan and rural NSW
- **knowledge sharing** – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement
- **continuous capability building** – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign.

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A priority for the ACI is identifying unwarranted variation in clinical practice and working in partnership with healthcare providers to develop mechanisms to improve clinical practice and patient care.

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**Produced by:** Ophthalmology Network

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- the Agency for Clinical Innovation (ACI) Ophthalmology Network Governing Body, including network managers Helen Badge and Sarah-Jane Waller
- representatives of the Western Sydney C-EYE-C steering committee
- the Westmead Eye Clinic clinical and administrative staff
- Western Sydney Local Health District Executive
- Associate Professor Andrew White, Head of Department Ophthalmology at Westmead Hospital and co-chair of the Ophthalmology Network
- Dr Michael Hennessy, Ophthalmologist, Co-Chair of the Ophthalmology Network
- Optometry NSW/ACT
- Dr Gerald Liew, Ophthalmologist, Westmead Hospital
- Belinda Ford, Service coordinator WSLHD and PhD student at the George Institute
- Professor Lisa Keay, Head of UNSW School Optometry and Vision Science.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-EYE-C</td>
<td>Community Eye Care project</td>
</tr>
<tr>
<td>Diabetes</td>
<td>A group of different conditions in which the body cannot maintain healthy levels of glucose in the blood. Glucose builds up in the blood leading to high blood glucose levels which cause the health problems linked to diabetes.</td>
</tr>
<tr>
<td>Diabetic retinopathy</td>
<td>A condition when the tiny blood vessels inside the retina at the back of the eye are damaged as a result of diabetes. This can seriously affect vision and in some cases cause blindness.</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>A group of eye diseases where vision is lost due to damage to the optic nerve. Glaucoma cannot be self-detected, and many people affected by glaucoma may not be aware of any vision loss. Glaucoma can occur at any age, but is more common in older people. There is no cure for glaucoma and vision cannot be regained, although early detection and adherence to treatment can halt or significantly slow progression.</td>
</tr>
<tr>
<td>NPDR</td>
<td>Non-proliferative diabetic retinopathy. Part of a grading scale for disease severity. There is mild, moderate and severe NPDR.</td>
</tr>
</tbody>
</table>
Introduction

The Community Eye Care (C-EYE-C) model of care is a service delivery model for those with, or at risk of developing, glaucoma and/or diabetic retinopathy to prevent avoidable vision loss and blindness.

This is achieved via improving access to appropriate management for people with, or at risk of, diabetic retinopathy and glaucoma. It is a collaborative care model for chronic eye-disease patients that shares care between local optometrists (private) and a public hospital eye clinic. The C-EYE-C model of shared care aims to streamline referral pathways and improve access to ophthalmology services for patients with chronic eye disease, ensuring timely and appropriate care is given.

The C-EYE-C model of care was developed after extensive consultation with optometrists, ophthalmologists, general practitioners (GPs), ophthalmic nurses, policy makers and health managers. The model was piloted at two sites within Western Sydney Local Health District to establish sustainability, examine patient and clinician satisfaction, and assess the potential impact on the current ophthalmology outpatient waiting times.
a. Increasing demand as population ages and associated increase in diabetic retinopathy and glaucoma

As the population ages, the prevalence of glaucoma in Australia is expected to increase to 379,000 by 2025. The number of people with diabetes in Australia is predicted to rise to 2 million people by 2025.¹ This is expected to substantially increase the number of Australians impacted by diabetic eye disease and resultant vision loss. Almost all those with type 1 diabetes and more than 60% of those with type 2 diabetes will develop diabetic eye disease within 20 years of diagnosis.¹

b. Demand on ophthalmology outpatient services is unsustainable with current workforce and resourcing

Current models place high demand on hospital outpatient departments. These models may become unsustainable with current workforce numbers estimates² and limited ophthalmology services available beyond metropolitan and large rural areas. These trends suggest that an increased number of ophthalmologists will be needed to meet growing demand. Optometrists have higher numbers and spread across rural and metropolitan areas providing greater opportunity for patient care activities.

c. Increasing health care costs to hospitals, patients and the community

Australian health system costs for the management of glaucoma are estimated to increase from $355 million to $784 million between 2005-2025 million, with total costs (health system costs, indirect costs and costs or loss of wellbeing) increasing from $1.9 billion to $4.3 billion.³

d. Glaucoma is the world’s leading cause of irreversible blindness, and poses serious public health concerns³

The social and economic impact of impaired vision makes improving access to specialist eye services an urgent priority.⁴ Compared to the general population, those with reduced vision are:

- twice as likely to experience a fall
- 4-8 times more at risk of experiencing a hip fracture
- at risk of hospitalisation and premature death (particularly senior populations)
- twice as likely to experience depression.

e. Current extended wait times for patients and patient dissatisfaction at long wait times

Inefficiencies of current/previous service models are illustrated by inconsistent quality of referrals and poor communication between referrers and public ophthalmology clinics. This has led to prolonged wait time for patients, resulting in complaints and the associated risk of adverse patient outcomes. The findings of the diagnostic phase of the C-EYE-C project were consistent with previous research demonstrating a high rate of inappropriate referrals to specialist eye clinics.⁵ Improving referral quality maximises existing capacity and ensures patients receive the level of care most appropriate to their needs.

f. C-EYE-C model allows early identification and intervention for patients in need of urgent care and is seen by patients as more user friendly than traditional appointments

The C-EYE-C model also demonstrated the need for clearly defined processes to allow the identification of people with an urgent need for specialist eye services in line with NSW Health’s ‘Right care, right place, right time’. During the C-EYE-C trial phase, seven patients received urgent care that would have otherwise been subjected to an average wait time of 389 days for a glaucoma appointment or 118 days for a diabetes appointment.
Outcomes from implementing C-EYE-C at Westmead Hospital

Reduction in patients having to attend hospital

Effective triaging means patients are seen by the most appropriate care-provider, increasing capacity in outpatient clinics for patients with more complex needs requiring specialist level care, and supporting patients who do not require this service to access local community-based management. In this case, 62% of patients avoided having to attend hospital.\(^7\)

Cost effective care for hospitals

A literature review on the cost effectiveness of monitoring glaucoma patients in a shared care model demonstrated that patients with a stable glaucoma can access faster assessment and management in a community setting rather than specialist level environment and still maintain good patient outcomes.\(^8\)

In 2017, the average cost of a new glaucoma patient referred to a C-EYE-C appointment was $133.60\(^7\) versus a hospital outpatient appointment at $171.\(^9\) This is a saving of 22% on patient care costs. It is estimated that a C-EYE-C model of care could save $37,400 per 1000 patients by providing new glaucoma patients with clinically suitable levels of care.

A reduction in patient waiting times, improved patient outcomes and patient preference of care

There was improved capacity in specialist outpatient clinic to see patients with higher clinical needs and translation into surgical management and revenue from additional clinical services. The C-EYE-C trial demonstrated 10 weeks of hospital outpatient appointments were freed for use by patients with higher clinical need with a significant reduction in waiting time of 9.8 months for first assessment for patients at risk of, or with, diabetic retinopathy and glaucoma, compared to hospital-based appointments.\(^7\)

Overall economic and social impact of chronic eye conditions is reduced by patients receiving earlier access to care improving quality of life and safety related to vision loss.\(^10\)

In surveys of both the ophthalmology clinic and the C-EYE-C clinic, there was no difference reported by patients in the level of care or the health professionals at C-EYE-C compared to hospital care (p=0.647). Patients in the C-EYE-C program reported higher satisfaction levels with car parking (61% vs 31%, p<0.001), appointments starting on time, (61% vs 4%, p<0.001) and privacy both during examination (100% vs 87%, p=0.009) and discussions with the health professional (100% vs 87%, p=0.001).

Patient feedback

‘I would definitely use this service again, because it’s convenient, it saves time, everybody is nice.’ – Patient


Improved integration and relationships between the primary and secondary health sector

The C-EYE-C model of care provides the opportunity for specialists and hospitals to work in collaboration with referrers and provide a collaborative service by qualified staff. This is supported in literature that improved communication can reduce inappropriate referrals to specialist clinics.\(^11\)

By improving communication between referrer and the clinic, and through jointly agreed standardised protocols, the C-EYE-C pilot agreement rates on the management of a patient were recorded at 83%. Oversight by ophthalmologists ensures that all patients have appropriate management and optometrists can improve their care through feedback.

Patient feedback

‘Patients are happy with the outcome, and it reduces the wait at the hospital. Collaborative care is the future for all chronic eye care issues in Australia.’ – Joe Nazarian, Optometrist
Patient journey under the C-EYE-C model of care

1. Patient presents to GP/optometrist with query re: glaucoma/diabetes

2. GP/optometrist refers patient to outpatient clinic

3. Patient’s paperwork is triaged by eye clinic

4. Patient triaged as suitable for C-EYE-C model

5. Patient sent appointment for C-EYE-C clinic

6. Patient assessed at C-EYE-C clinic with preliminary diagnosis by optometrist

7. Patient files are reviewed remotely by an ophthalmologist for confirmation of diagnosis and management

8. Patient managed at C-EYE-C or referred to hospital specialist clinic if needed

9. Patient follow up with local optometrist/GP and or specialist clinic as needed
# Key lesson for successful implementation of the C-EYE-C model

<table>
<thead>
<tr>
<th>Aim</th>
<th>Key lesson</th>
<th>Points to keep in mind in local implementation</th>
<th>Part of this document to support implementation/examples of implementation</th>
</tr>
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<tbody>
<tr>
<td>Support high quality referrals for patients with glaucoma and diabetic retinopathy criteria to ensure appropriate patients are referred to specialist eye clinics.</td>
<td>Define, agree and communicate with stakeholders regarding the service definition and criteria for inclusion and exclusion of the C-EYE-C clinic.</td>
<td>Minimum standards are needed for assessment to triage referrals to decide appropriateness for shared clinic versus needing to be seen in a hospital clinic. Criteria for community based eye clinic need to be agreed between specialist eye services and community provider. A process is needed for managing patients who do and do not meet the agreed criteria, and how this integrates with existing service policies and procedures. System is needed for triaging referrals – personnel, process, criteria for triage.</td>
<td>Appendix 1: Westmead Hospital Flow chart of process of C-EYE-C. Appendices 2-3: Template for shared eye care model referral triage process (based on Westmead Hospital C-EYE-C). Appendix 4: Shared eye care model clinical inclusion and exclusion criteria. Appendix 5-7: Optometrist assessment and ophthalmologist review, including diabetes and glaucoma pro forma. Appendix 9: C-EYE-C transfer of booking lists an notes to optometrists. Appendix 10: C-EYE-C file receipt and virtual review clinic booking.</td>
</tr>
<tr>
<td>Processes developed and endorsed to support safe and timely coordination of care between the hospital service and community based service.</td>
<td>Identify appropriate numbers of staff to implement and maintain the shared care model.</td>
<td>The C-EYE-C team in the proof of concept included: three community based optometrists (from two clinics), two optometry clinic administration staff (practice managers), one hospital service coordinator, two hospital based ophthalmologists (glaucoma specialist and retinal specialist). Identify equipment needs (See Appendix 12: Optometrist assessment for clinical requirements). Provide supervision and capacity building opportunities. Electronic receipt of patient files (from optometrist). Ophthalmologist ‘virtual’ review clinics. Quality assurance check and performance indicators.</td>
<td>Appendix 9: C-EYE-C transfer of booking lists an notes to optometrists. Appendix 10: C-EYE-C file receipt and virtual clinic review. Appendix 11: Sample patient letter including patient information and clinic map.</td>
</tr>
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| Ensure community staff employed to meet conditions of local health district for shared care including access to hospital electronic medical record (eMR) and patient data systems. | Agree on the roles and responsibilities of community and specialist eye services staff, including copies of optometrist registration and indemnity insurance  
Technology needed for sharing information including images and access to public health systems from community locations  
Contingent working status – state contingent worker guidelines allow the optometrist to log in and view patient status  
Local decision and approval needed at LHD/SHN level  
Secure electronic transfer needed.  
A service level agreement (SLA) is needed to outline the overarching governance of the partnership and activities, with the following:  
– ensure indemnity and insurances are in place  
– ensure patient confidentiality and privacy is maintained  
– describe the project, including purpose and need  
– outline shared care protocols, including testing and equipment requirements, referral pathways, transfer of information, record keeping  
– indicate expected patient volume  
– indicate timeframes of partnership  
– define the governance of the partnership, for example stakeholder steering committee, reporting requirements, and other milestones or deliverables  
– outlines and incentive payments (if negotiated – this will become a contract). | Appendix 3: Flowchart for C-EYE-C referral triage process  
Appendix 5: Template for shared eye care model patient assessment process |
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<tbody>
<tr>
<td>Appropriate community-based provider identified to partner with hospital.</td>
<td>Process map for patient journey in local clinic developed and implemented. Need for communication and implementation plan to be developed with local stakeholders and for potential consumers.</td>
<td>Established communication point for community stakeholders to reach service to address issues early, communicate with patients and collect data (hospital service coordinator)</td>
<td>Appendix 6: Template for shared eye care model Assessment pro forma variables (based on Westmead Hospital C-EYE-C) Appendix 13: C-EYE-C Coordinator position description</td>
</tr>
<tr>
<td>Consider capability development to ensure the local team has sufficient skills to implement change effectively.</td>
<td>Need for project sponsorship and project manager.</td>
<td>Gain executive support and establish governance framework Organise the implementation team Identify objectives and develop an appropriate implementation and communication plan Assess change readiness and needs Analyse activity and demand in your local service / district Gap analysis Determine needs for people, resources and equipment Develop and implement project plans Monitor and evaluate outcomes of implementation</td>
<td>The ACI Centre for Healthcare Redesign (CHR) provides capability development for the NSW Health workforce, enabling frontline staff to successfully redesign and improve service delivery across all aspects of the patient’s journey. See <a href="https://www.aci.health.nsw.gov.au/make-it-happen/centre-for-healthcare-redesign">https://www.aci.health.nsw.gov.au/make-it-happen/centre-for-healthcare-redesign</a></td>
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| Demonstrate improvement in agreed areas. | Need to agree evaluation plan associated with implementing the C-EYE-C model for patients with diabetic retinopathy and glaucoma. | Evaluation plans could consider:  
- types and numbers of referrals  
- types of appointments  
- change in waiting times from referral to clinic appointment (median and range) before and after implementation of shared care model  
- numbers of patients assessed for C-EYE-C including appropriate and inappropriate referrals  
- number referrals with adequate information for triage (considered high quality referrals)  
- demographic details of shared care model patients  
- management outcomes  
- glaucoma and diabetes assessment outcomes  
- patient reported outcome measures and patient experience measures. Patient experience data could be captured with support of the LHD Consumer and Community Participation Managers (or equivalent) or through accessing patient experience data from the Bureau of Health Information filtered by the relevant district/site. | For further information on types of program evaluation and key steps in undertaking an evaluation including suggested governance process, see Understanding Program Evaluation: An ACI framework on https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0008/192437/Framework-Program-Evaluation.pdf#zoom=100 |
Appendix 1: Westmead Hospital Flow chart of process of C-EYE-C

Local process maps should be developed to account for existing hospital and community services and processes to be accurately reported.

New GP/ Optometrist referral
Referral from GP/ Optometrist/ Hospital Dept.

Triage of referral letter
Suitable for C-EYE-C?

Yes

No

Westmead Eye Clinic
Waitlist/ Appointment

Follow up - Chronic patients

Eye Clinic

C-EYE-C review

C-EYE-C Appointment
- Assessment form
- OCT/ Photos/ HVF* Optometrist recommends patient management plan* (*As per glaucoma and DR screening guidelines)

Westmead Opthamologist review

Management outcomes

Eye Clinic

Eye Clinic

C-EYE-C
Appendix 2:
Template for shared eye care model referral triage process (based on Westmead Hospital C-EYE-C)

<table>
<thead>
<tr>
<th>Process name</th>
<th>[Name of shared care service] Referral Triage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared by</td>
<td></td>
</tr>
<tr>
<td>Prepared in consultation with</td>
<td></td>
</tr>
<tr>
<td>Sign-off date</td>
<td></td>
</tr>
<tr>
<td>Relevant team</td>
<td>Clinicians completing referral triage (i.e. CNC, NUM, RN, Fellow, Registrar)</td>
</tr>
</tbody>
</table>

**Rationale**

[Name of shared care service] is a community based model of care for the management of patients with low risk and stable glaucoma and diabetic retinopathy. Definitive clinical criteria have been developed for inclusion and exclusion in [Name of shared care service]. All new referrals to the eye clinic are triaged by a clinician to determine clinical urgency. This ensures that the right patients are assessed at [Name of shared care service], and those requiring more urgent or complex care are seen within the hospital. [Name of shared care service] clinical criteria align with National clinical management guidelines. NB: Conditions not suitable for [Name of shared care service] can be assessed under the [name of] Hospital Eye Clinic guidelines (as appropriate).

**STEP 1: Receipt of referrals**
- There is no direct referral from external providers to [Name of shared care service].
- Referral to [Name of shared care service] is processed through the existing eye clinic referral pathways (email, fax, letters or hand delivered).
- All referrals are documented by eye clinic administration team in the Referral Action Sheet [or other system as appropriate for local context].
- Administration team transfer new referrals to Clinical Nurse Consultant (CNC) [or other role as appropriate in local context] for review.

**STEP 2: Referral triage to determine clinical suitability**
- Clinical suitability for [Name of shared care service] appointments is determined based on the clinical inclusion and exclusion criteria tabled below.
- The CNC [or other role as appropriate in local context] triages all new referrals, and patients are allocated to an appointment category (triage outcome) based on clinical need and urgency.
- Referrals for [Name of shared care service] are marked on referral sticker.
- It is expected a large proportion of new referrals will go to [Name of shared care service].

**STEP 3: Ophthalmologist review for clinical suitability**
- As required, CNC consults with senior registrar to query suitability of referrals with unclear data against triage guidelines.
- CNC [or other role as appropriate in local context] identifies Glaucoma/Diabetes referrals and sends these for further triage by a specialist to query suitability of referrals with unclear data against triage guidelines.
- Referrals for [Name of shared care service] are marked on referral sticker.

**STEP 4: Triage outcomes**
- Referrals suitable for [Name of shared care service] will be updated in the Referral Action Sheet [or other system as appropriate for local context], and allocated a [Name of shared care service] appointment.
- All other referrals are assessed for suitability to hospital clinics (as per local guidelines) or allocated Not for Service.
Appendix 3: Flow chart for C-EYE-C Referral Triage Process

New referral received
From optometrist/GP

CNC/CNS triages referral
Consult with Senior Registrar if needed

Consultant review
All glaucoma referral assessed for clinical urgency

Triage outcomes
1. Not for Service
2. Eye clinic appointment
3. [Name of shared care service]
## Appendix 4: Shared eye care model service eligibility criteria (based on Westmead Hospital C-EYE-C)

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Stabile glaucoma:</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No change in the management of the patient’s glaucoma for 1–2 years</td>
<td>No retinopathy (diabetic screening)</td>
</tr>
<tr>
<td></td>
<td>No new progressive visual deterioration, such as a drop in acuity or progression of visual field defect over last 1–2 years</td>
<td>Mild non-proliferative diabetic retinopathy – microaneurysms only AND good vision (6/9 or better)</td>
</tr>
<tr>
<td></td>
<td>Stable intraocular pressure well controlled on current drug regime (monotherapy, e.g. Xalacom, Duotrav, ganfort)</td>
<td>Moderate non-proliferative diabetic retinopathy – microaneurysms and mild retinal pathology e.g. haemorrhages, cottonwool spots, AND good vision (6/9 or better)</td>
</tr>
<tr>
<td></td>
<td>No progressive optic disc thinning for 1-2 years. This should preferably be based on good quality optic disc photography or OCT</td>
<td></td>
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<tr>
<td></td>
<td>Monitoring for ocular hypertension</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion</th>
<th>Newly diagnosed glaucoma</th>
<th>Diabetic macular oedema or clinically significant macular oedema (new hard exudates)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Narrow angles, angle closure glaucoma requiring gonioscopy</td>
<td>Severe non-proliferative diabetic retinopathy – numerous microaneurysms, haemorrhages, reduced vision.</td>
</tr>
<tr>
<td></td>
<td>Unstable glaucoma</td>
<td>Proliferative diabetic retinopathy (PDR) – abnormal vascular proliferation is seen in one or more sites; iris, optic, or elsewhere</td>
</tr>
<tr>
<td></td>
<td>– Chronic or acute angle closure</td>
<td>Vitreous haemorrhage, pre-retinal haemorrhage, severe retinal haemorrhage</td>
</tr>
<tr>
<td></td>
<td>– Progressive optic nerve changes, expanding nerve fibre layer defect, enlarging cup, new disc haemorrhage, and rim thinning</td>
<td>Vision worse than 6/9 without clear reason, e.g. cataract</td>
</tr>
<tr>
<td></td>
<td>– Progressive visual field changes, progressive visual field defect, confirmed by repeat testing</td>
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<tr>
<td></td>
<td>– &gt;3mmHg IOP change from last visit (i.e. beyond regression to the mean)</td>
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<tr>
<td></td>
<td>– Clear VF (based on Hodapp Parish Anderson criteria - see Asia Pacific Glaucoma Guidelines Vol 3) or OCT progression on reliable testing (&gt;4 micron change on OCT) or photo disc changes, i.e. new notch or haemorrhage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IOP &gt;30</td>
<td></td>
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<tr>
<td></td>
<td>Complex ocular pathology/ secondary glaucoma (except for PXF or PDS)</td>
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<td></td>
<td>Monocular patients</td>
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<td></td>
<td>Visual field loss of ≥12dB or within 10 degrees of fixation</td>
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<td></td>
<td>Target IOP &lt;12mmHg</td>
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<td></td>
<td>Patients requiring surgery for glaucoma, e.g. trabeculectomy or tube implant</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional exclusion criteria</th>
<th>Patients requiring interpretation services (unless available at optometry clinic)</th>
<th>Diabetic macular oedema or clinically significant macular oedema (new hard exudates)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Justice Health patients</td>
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<td></td>
<td>Patients ineligible for Medicare, such as non-resident</td>
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<td></td>
<td>Patients with known infectious disease e.g. tuberculosis</td>
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<td></td>
<td>Patients unable to cooperate e.g. dementia</td>
<td></td>
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<tr>
<td></td>
<td>Hospital inpatients</td>
<td></td>
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<td></td>
<td>Patients &lt;16 years of age</td>
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</table>
Appendix 5: Template for shared eye care model patient assessment process (based on Westmead Hospital C-EYE-C)

<table>
<thead>
<tr>
<th>Process name</th>
<th>[Name of shared care service] Assessment process</th>
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</thead>
<tbody>
<tr>
<td>Prepared by</td>
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<tr>
<td>Prepared in consultation with</td>
<td></td>
</tr>
<tr>
<td>Sign-off date</td>
<td></td>
</tr>
<tr>
<td>Relevant team</td>
<td>Clinicians completing assessments (optometrists)</td>
</tr>
</tbody>
</table>

Rationale

[Name of shared care service] uses standardised assessments to ensure a high level of the service and consistency of patient information between service providers. [Name of shared care service] patients are referred from [name of] Hospital to partner optometrist service for a diabetes or glaucoma assessment, or both. Standardised assessment include completion of a clinical information on a template pro forma, and relevant testing and imaging.

Step 1: Clinical assessment and Imaging
Refer to [Name of shared care service] diabetes and glaucoma assessment templates, including standardised protocols for each of the [Name of shared care service] clinical assessment variables.

Step 2: Transfer to Hospital Eye Clinic
All patient files, including completed optometrist assessment forms and imaging are transferred to [name of] Hospital Eye Clinic electronically. Current process is via secure email. Patient files to be saved with a standardised naming convention using patient name and/or MRN, and/or date of birth.

Step 3: Ophthalmologist review of assessment
All patient files are reviewed at [Name of hospital] by an ophthalmologist for confirmation of diagnoses and management. Changes in management plan or diagnoses by the ophthalmologist are final.
Appendix 6: Diabetes form

C-EYE-C diabetes eye assessment report

Date: ___/___/___  □ F/U appointment

Patient name:  
Patient DOB:  
(Or place Patient Label here)

Optometrist name & Location

Patient information
- Diabetes mellitus
  □ Type 1  □ Type 2  Duration of diabetes (years) ____________
- HbA1c
  ____________ Date ____________
- Current diabetes therapy
  □ Diet  □ Insulin  □ Oral hypoglycaemic agents

Visual symptoms

Ophthalmic history

Medical history

Other history

Examination finding
- Visual acuity (best corrected)
  RE ____________ LE ____________
- IOP
  RE ____________ LE ____________ mmHg (normal 12-22mmHg)
- Rx/autorefraction
  RE S C A LE S C A Add: ____________
- Cataract
  RE Y / N LE Y / N

□ Dilated fundus examination performed  □ Fundus photograph attached
□ OCT performed  □ OCT attached

No diabetic retinopathy  □ RE □ LE
Non proliferative diabetic retinopathy
  □ Mild □ RE □ LE
  □ Moderate □ RE □ LE  □ Severe □ RE □ LE
Proliferative diabetic retinopathy  □ RE □ LE
Clinically significant macular oedema □ RE □ LE
OCT macular oedema □ RE □ LE
Other ____________  □ Unable to assess

Management Plan
- □ Discharge (local optometrist/GP)
- □ 6-month review C-EYE-C
- □ 12 month review C-EYE-C
- □ Review at (Name) Eye Clinic in ______ wks/mths  Reason: ____________
- □ Referred for treatment (private)
- □ Urgent ophthalmologist review (call registrar via hospital switch ph: XXXXXX)
  Comments ____________

Ophthalmologist remote assessment

Management plan  Diagnosis
□ Agree  □ Agree
□ Change: ____________ in ______ wks/mths  □ Change ____________

Comments ____________

Ophthalmologist name ____________ Signature ____________ Date ____________
Appendix 7: Glaucoma form

C-EYE-C glaucoma assessment report

Date: ___/___/___  □ F/U appointment

Patient name: 
Patient DOB: 
(Or place Patient Label here)

Optometrist name & Location

Patient information

Optical history

Comments:

History of eye trauma □  Family history of glaucoma □  Diabetics □  Autoimmune disease □

Medications: Steroids □  Antidepressants □  Alpha Antagonists □  Other Antihypertensive Drugs □  Topical treatment □

Visual acuity (best corrected)  □ 6/□

Rx/refraction  □ 6/□

Examination finding

Anterior chamber findings

Pseudo exfoliation (PXF) □  Pigment dispersion syndrome (PDS) □

CCT:  □ 6/□

AC (van Herrick):  □ 6/□

Intraocular pressure (IOP):  □ 6/□

Optic disc/cup disc ratio:  □ 6/□

□ OCT report attached

Time: __________

Visual field

□ HVF Report Attached

□ No visual field loss

□ Visual field loss <5dB not within 10° of fixation

□ Visual field loss >5dB <12dB not within 10° of fixation

□ Visual field loss >12dB within 10° of fixation

Final assessment

□ Low risk glaucoma suspect: Circle (A, B, C, D or E)

□ High risk glaucoma suspect: Circle (A, B, C, D or E)

□ Early glaucoma

□ Stable early glaucoma

□ Moderate glaucoma

□ Stable moderate glaucoma

□ Advanced glaucoma

□ Acute raised IOP

□ Other ____________________  □ Unable to assess

Management Plan

□ Discharge local optometrist/GP

□ 6-month review C-EYE-C

□ 12 month review C-EYE-C

□ Review at [Name] Eye Clinic in _________ weeks/months

Review reason:

□ Urgent Ophthalmologist Review (call Registrar via hospital switch XXXXXXX)

Comments: _____________________________________________________________

________________________________________

Ophthalmologist remote assessment

Management plan

□ Agree

□ Change: __________ in _____ wks/ mths

Comments: __________________________________________________________

Ophthalmologist Name________________________ Signature___________ Date_______
Appendix 8:
Template for shared eye care model assessment pro forma variables (based on Westmead Hospital C-EYE-C)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Descriptor</th>
<th>Assessment type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name and DOB</td>
<td>Minimum data for patient identification</td>
<td>Diab and Glau</td>
</tr>
<tr>
<td>Date</td>
<td>Date of assessment</td>
<td>Diab and Glau</td>
</tr>
<tr>
<td>Optometrist name and location</td>
<td>Identifies clinician and location of assessment</td>
<td>Diab and Glau</td>
</tr>
<tr>
<td>Patient information</td>
<td>Relevant details for patient optical and medical histories, medications, and other comments</td>
<td>Diab and Glau</td>
</tr>
<tr>
<td><strong>Examination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual acuity</td>
<td>Best corrected. Snellen</td>
<td>Diab and Glau</td>
</tr>
<tr>
<td>Rx/autorefraction</td>
<td>To determine if hypermetropic</td>
<td>Diab and Glau</td>
</tr>
<tr>
<td>Intraocular pressure (IOP)</td>
<td>Goldmann applanation, including time collected</td>
<td>Diab and Glau</td>
</tr>
<tr>
<td>OCT</td>
<td>Any machine RNFL and Macular</td>
<td>Diab and Glau</td>
</tr>
<tr>
<td>Cataract</td>
<td>identify if there is a cataract</td>
<td>Diab</td>
</tr>
<tr>
<td>Dilated fundus examination</td>
<td>Standard exam</td>
<td>Diab</td>
</tr>
<tr>
<td>Fundus photograph</td>
<td>Fundus in focus, and clear view of the disc for glaucoma</td>
<td>Diab</td>
</tr>
<tr>
<td>Pseudo exfoliation (PXF)</td>
<td>Y/N</td>
<td>Glau</td>
</tr>
<tr>
<td>Pigment dispersion syndrome (PDS)</td>
<td>Y/N</td>
<td>Glau</td>
</tr>
<tr>
<td>Central corneal thickness</td>
<td>Optical or ultrasound measurement</td>
<td>Glau</td>
</tr>
<tr>
<td>Anterior chamber (AC)</td>
<td>van Herrick, Gonioscopy is preferable</td>
<td>Glau</td>
</tr>
<tr>
<td>Optic disc/Cup disc ratio</td>
<td>Include notches, haemorrhages and wedge defects</td>
<td>Glau</td>
</tr>
<tr>
<td>Visual field</td>
<td>HVF SITA 24-2, Record MD field loss in dB and degrees of fixation</td>
<td>Glau</td>
</tr>
<tr>
<td>Final assessment</td>
<td>Diagnoses as per optometrist recommendation</td>
<td>Glau</td>
</tr>
<tr>
<td>Management plan</td>
<td>Management as per optometrists recommendation</td>
<td>Diab and Glau</td>
</tr>
<tr>
<td>Reason for review</td>
<td>If referred to Westmead then identify reason for review</td>
<td>Diab and Glau</td>
</tr>
<tr>
<td>Comments</td>
<td>As required</td>
<td>Diab and Glau</td>
</tr>
<tr>
<td>Ophthalmologist remote assessment</td>
<td>Confirmation of management plan and diagnoses, and any comments</td>
<td>Diab and Glau</td>
</tr>
</tbody>
</table>
Appendix 9:
[Name of shared care] transfer of booking lists and notes to optometrists

<table>
<thead>
<tr>
<th>Process name</th>
<th>[Name of shared care] transfer of booking lists &amp; notes to optometrists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared by</td>
<td></td>
</tr>
<tr>
<td>Prepared in consultation with</td>
<td></td>
</tr>
<tr>
<td>Sign-off date</td>
<td></td>
</tr>
<tr>
<td>Relevant team</td>
<td>Part A: Administration team; Part B: Eye clinic Nurses</td>
</tr>
</tbody>
</table>

Rationale

[Name of shared care service] is centrally coordinated by the [Name of hospital], including booking patients and patient file management. Governed by a SLA with [Name of hospital], [Name of shared care] optometrists conduct standardised assessments for [Name of hospital] patients. Regular and timely communication with optometrists is an essential component of [Name of shared care service] and collaborative care.

Appointment booking lists for [NAME OF SHARED CARE] clinics are prepared and sent to two weeks in advance to optometrists to provide enough notice for planning service delivery, and communicating effectively with patients who enquire about appointments. Appointment booking lists can be compiled by administration team following completion of booking.

Optometrists require relevant patient information, such as original referral details and previous eye examinations, to ensure effective care is provided to [Name of shared care] patients, as well as maintain continuity of care across [Name of shared care] and hospital-based eye services. The collation of patient files requires clinical acumen and should be undertaken by a clinical team member, such as a nurse or orthoptist.

Patient files are transferred to and received from [Name of shared care] optometrists using secure email. NB The method for transfer should be approved by [Name of hospital] privacy team and comply with privacy and confidentiality regulations. Standardised file naming conventions are in place so that optometrists can identify patient records.

Part A: Optometrist booking lists

Step 1: Prepare Excel spreadsheet

Open a new Excel spreadsheet to create booking sheet. Use the following file naming convention: CLINIC DD-DD MMM YYYY.xlsx (e.g. ClinicName 21-25 Aug 2017.xlsx).

Step 2: Search for clinic details in [Patient management system]
Step 3: Copy daily/weekly appointment list to Excel

*NB this may need to be repeated for each day of the week, and placed in the same Excel sheet.*

From iPM day list view: Press F2 button. The Print List Screen Window will pop up, and click Export to Excel.

![Excel sheet screenshot](image1)

An Excel sheet will open. *NB this cannot be saved to the share drive so information needs to be copied to the new Excel sheet prepared in Step 1.*

From the exported Excel sheet, highlight the cells with patient booking details. To copy, right click highlighted cells and select ‘Copy’ or Press Ctrl+C.

![Excel sheet screenshot](image2)

Go to the saved Excel sheet and paste the copied cells, right click Paste or Ctrl+V into cell B1.

![Excel sheet screenshot](image3)

Repeat the copy and paste for each clinic day. Doublecheck that the date of appointment is lined up next to the correct date entered in Column A.
Step 4: Delete additional details columns
For example delete columns labelled: Departed, Resources, Booked by. Click SAVE.

Step 5: Scan referrals for “New” patients.
Use booking list ‘Type’ column to determine if patients are New. For New patients gather referral letters in appointment Date order. Scan as one document. File naming convention:
ClinicName_New referrals_Dates, e.g. Blacktown_New referrals_19-23 Feb 2018.PDF

Step 6: Transferring Appointment booking list and patient files to Optometrists
NB Transfer of booking lists and patients files should use a secure email address [in accordance with local requirements]. The email subject should clearly state the information is for [Name of shared care service], the type of information contained, and relevant booking dates.
e.g. Subject: [Name of shared care] follow up - 19-23 Feb 2018 or [Name of shared care] Booking list 19-23 Feb 2018.

Part B: Compiling referrals and patients follow up notes

Step 1: Open relevant booking list
Step 2: Identify ‘follow up’ patients
Refer to the booking list column labelled ‘Type’. All patients listed as ‘follow up’ require clinical notes pulled and saved from the patient’s medical record for referral to the optometrist.
Refer to booking list Excel sheet column ‘Comments’ to identify patient clinical assessment type.

<table>
<thead>
<tr>
<th></th>
<th>Follow up from eye clinic</th>
<th>Follow up from CEYEC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaucoma patient</td>
<td>GLAU</td>
<td>GLAU CEYEC F/U</td>
</tr>
<tr>
<td>Diabetes patient</td>
<td>DIAB</td>
<td>DIAB CEYEC F/U</td>
</tr>
<tr>
<td>Both glaucoma and diabetes</td>
<td>GLAU + DIAB</td>
<td>GLAU + DIAB CEYEC F/U</td>
</tr>
</tbody>
</table>

NB Patients listed as Follow up with a comment ‘C-EYE-C Follow up-C-EYE-C F/U’ only require the previous C-EYE-C assessment to be pulled and saved from the medical records. All other follow up patients will require previous eye clinic notes related to their assessment type.

Step 3: Find notes
Open patient’s electronic medical record. Search Patient by MRN (refer to booking list). Find last encounter for appropriate eye assessment (either [Shared Care] or eye clinic appointment).
NB this may be several visits if patient’s tests and consultation with an ophthalmologist were at different appointments (e.g. visual fields then a follow up appointment with ophthalmologist).

Step 4: Save patient files (using print to PDF)
Open the file and select the Printer icon, then select Draft print and OK.
From the Print screen, select PDF Printer from the drop down (e.g. Adobe PDF) and click OK

The next screen will prompt you to save the PDF file.

Navigate to the appropriate clinic and week folder

Type the file name as outlined below:

<table>
<thead>
<tr>
<th>File type</th>
<th>Glau or Diab</th>
<th>File naming</th>
<th>E.g. File save name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress Notes, or consult, or CEYEC assessment</td>
<td>All patients</td>
<td>LASTNAME MRN (1)</td>
<td>SMITH 123456 (1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LASTNAME MRN (2)</td>
<td>SMITH 123456 (2)</td>
</tr>
<tr>
<td>Optical Coherence Tomography (OCT)</td>
<td>All patients</td>
<td>LASTNAME MRN (OCT)</td>
<td>SMITH 123456 (OCT)</td>
</tr>
<tr>
<td>Humphrey Visual Field</td>
<td>Glaucoma only</td>
<td>LASTNAME MRN (HVF)</td>
<td>SMITH 123456 (HVF)</td>
</tr>
</tbody>
</table>

If any files are not available, e.g. OCT or HVF, make a note in the Excel sheet next to the patient name. (Remember to save.)

Step 5: Repeat for all patients in the booking sheet
Repeat to collect all files for each patient listed in the booking sheet.

**Tips**

Once the first file has been saved the save option will automatically direct to the correct folder.
To save time, when you start typing a repeat file name, you can select the name as it drops down, but edit the text in the brackets.

Step 6: Notify Admin team when file collection is complete
Please notify Administration team when the files collection is complete. Admin team will transfer files to the optometrists prior to patient appointments using secure email. (See Section A, Step 6).
Appendix 10: [Name of shared care] file receipt and virtual review clinic booking

<table>
<thead>
<tr>
<th>Process name</th>
<th>[Name of shared care] File receipt and virtual review clinic booking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared by</td>
<td></td>
</tr>
<tr>
<td>Prepared in consultation with</td>
<td></td>
</tr>
<tr>
<td>Sign-off date</td>
<td></td>
</tr>
<tr>
<td>Relevant team</td>
<td>Eye Clinic Administration</td>
</tr>
</tbody>
</table>

**Rationale**

Complete [Name of shared care] assessment files are securely transferred electronically to [Name of hospital] eye clinic where the ophthalmologist will review and confirm diagnosis and management. A virtual clinic is set up in [name of booking system] to ensure recording and accountability of ophthalmologist review of patient files. Program performance measures, such as time to review, and file receipt data can be captured through patient management systems.

Arrival of patients at this clinic facilitates direct entry into the electronic medical records system by the ophthalmologist at time of file review. An administrative patient tracking sheet (yellow sheet) is prepared for the virtual clinic to facilitate booking of follow up appointments.

**Part A: Receipt of files and labelling**

**Step 1: Print and save patient assessments**

Accessing the [Name of shared care] secure email open and save all patient records in folders under relevant dates. Print all records in colour and double sided, or upload directly to patient medical record if the facility permits this.

**Step 2: Arrive/Depart patients in [Name of patient management system]**

Check patient files are complete and arrive and depart patients on day of booked optometrist appointment.

**Step 3: Print and attach appointment labels**

**Part B: Booking a virtual [Name of shared care service] review clinic**

**Step 1: Book patient (files only) into a virtual review**

Check patient details and confirm MRN on patient notes. Select the next available Virtual review clinic. Search for patient using patient MRN or name/ DOB.

**Step 2: Booking type**

Book under ‘Case Planning’ new slots.

**STEP 3: Select ‘Fin Class’**

This is OP No charge.
Part C: Preparing for virtual review clinic

Step 1: Prepare ‘yellow sheet’ for the virtual review clinic
You will need to create a Virtual ‘yellow sheet’ (see Appendix) to provide with the paper files to the reviewing doctor.
Open Yellow sheet template and enter the date of the review clinic e.g. 29/6/18, and the name of the reviewing clinician.

Step 2: Fill in virtual review clinic lists on the ‘yellow sheet’
Open the ‘Day Clinic List in iPM’

Clinic anywhere on clinic day list and Press F2 button. Then click Export to Excel.

Return to the yellow sheet template and highlight cells in the patient name and MRN. Note you will need to copy as many rows as there are patients booked in the review clinic, and then paste.

Tips
To copy use Control + C
To paste use Control + P. Print on yellow paper.
Step 3: Organise patient notes for review clinic
Organise a paper folder with patient notes for the ophthalmologist to review. [if uploaded directly in medical records the ophthalmologist can direct access from there.]

Step 4: Arrival of patients for virtual review
On the day of the virtual review clinic, organise patients so that the reviewing doctor can directly review/enter the notes in Powerchart.

Step 5: Departing patients in virtual review
At the end of the clinic, or on the following work day depart all patients.

Step 6: Send patient notes for scanning into electronic medical records

Part D: Processing follow up appointments

Step 1: Follow up booking – eye clinic
Check the ‘yellow sheet’ and book appointments for the patients requiring an eye clinic follow up (as per ‘yellow sheet’ instruction).

Step 2: Follow up bookings: return to [Name of shared care service]
Enter details of patients requiring follow up appointments for [Name of shared care service] in the [Name of booking system] wait lists so they can be booked for follow up at the correct interval.
# C-EYE-C follow up booking sheet

**CEYEC Review Clinic Date:**

**Review Ophthalmologist:**

<table>
<thead>
<tr>
<th>Patient details</th>
<th>Next appointment (Please tick)</th>
<th>Eye Clinic</th>
<th>Rebook</th>
<th>Discharge</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CEYEC</td>
<td>Next CEYEC</td>
<td>Eye Clinic</td>
<td>Rebook</td>
<td>Discharge</td>
</tr>
<tr>
<td></td>
<td>appt type</td>
<td></td>
<td>Other clinic: (Specify)</td>
<td>Wks/Mths (Specify)</td>
<td>GP/ optom</td>
</tr>
<tr>
<td>Patient Name</td>
<td>MRN</td>
<td>6-mth</td>
<td>Diab</td>
<td>GL</td>
<td>DR</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>12-mth</td>
<td>Glau</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
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<td>11</td>
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<td>12</td>
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<td>13</td>
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<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Booking and Administration purposes only.*
Appendix 11: Sample patient appointment letter

MRN: XXXXXXXXXXX
AUId: XXXXXXXXXXX

1 January 2017

FIRST NAME SURNAME
ADDRESS 1
ADDRESS 2
SUBURB  STATE  POSTCODE

Dear TITLE SURNAME,

Your doctor/eye care practitioner has referred you to the [Name of hospital].
[Name of hospital] has checked your referral, and you are suitable to attend our new [Name of shared care service] for assessment. Information on [Name of shared care service] is enclosed.

Your [Name of shared care service] appointment details:

DATE: DATE
TIME: TIME
Please allow up to 2 hours for your appointment as you will have multiple tests performed.
LOCATION: [Optometrist details] A map and directions are attached.

The following is required on the day of appointment:

• Medicare Card and/or DVA Card

Please be aware that it is possible that your pupils may be dilated with eye drops, which could affect your ability to drive for a period of time.

Should your clinical condition change or you have any concerns regarding your vision, please do not hesitate to attend your referring practitioner for advice. Changes in your condition or health may have implications on your appointment timing.

Please call XX XXXX XXXX to confirm your appointment, or if you have any questions or concerns.

Yours sincerely,

Eye Clinic, [Name of Hospital]
C-EYE-C Community Eye Care

What is C-EYE-C?
Westmead Eye Clinic is trialling a new Community Eye Care (C-EYE-C) assessment program that will help patients access the right services and shorten waiting times to get to hospital appointments.

Your C-EYE-C eye assessment will be at an optometrist clinic located in Blacktown. At this appointment an optometrist will test your eyes, and your results will then be checked by an eye doctor (ophthalmologist) from Westmead Hospital.

What happens after my appointment?
The optometrist and ophthalmologist will work together to decide if you need an appointment for further tests or treatment. Some people will not need any further appointments and can continue having regular eye checks with their local optometrist.

If you need further appointments, you will be notified by post. Further appointments may be located at Westmead Eye Clinic or a community eye care optometrist clinic in the area.
### Appendix 13: Example of the C-EYE-C Coordinator position description

<table>
<thead>
<tr>
<th>POSITION TITLE</th>
<th>C-EYE-C Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWARD</td>
<td>Does this role require Multiple Awards? ☐Yes ☐No</td>
</tr>
<tr>
<td></td>
<td>Award: Health Managers (State) Award</td>
</tr>
<tr>
<td></td>
<td>Classification:</td>
</tr>
<tr>
<td>SUPERVISORY</td>
<td>Does this role manage or supervise others? ☐Yes ☐No</td>
</tr>
</tbody>
</table>

**PRIMARY PURPOSE**
*Write one or two paragraphs describing the main purpose of the role and how it contributes to service needs. This answers the question "why does this role exist?".*

The Coordinator will deliver quality project management to support the eye clinic team to effectively implement and evaluate a service improvement project, including a new screening pathway. This project aims to improve patient outcomes, increase service efficiency, and reduce burden of disease for patients with chronic eye diseases.

3400 characters max.

**KEY ACCOUNTABILITIES**
*(Maximum 12)*

*Key accountabilities should be:*

- outcome focused, rather than process focused
- ordered in importance and/or frequency
- as specific to the role as possible while not detailing tasks.

- See Public Service Commission website for more information

- Manage assigned [Name of shared care project] from the concept phase to project closure to ensure it is successfully completed within scheduled timeframes, reach quality standards, and achieve agreed targets.

- Support services and/or operational functions of the eye clinic to identify and facilitate the implementation of initiatives aimed at improving both the patient experience and system performance to meet services demand and targets.

- Provide a range of project management services, preparation of detailed project documentation and plans including project scopes, briefs/discussion papers, and ethics applications.

- Review, monitor and provide progress reports on project plans, to ensure the successful delivery of [Name of shared care service] project on time and within budget.

- Meet all reporting requirements and deadlines.

- Identify and manage project risks, problems or conflicts including development and implementation of risk mitigation strategies.

- Develop, maintain and foster effective networks, relationships and partnerships with a diverse range of internal and external stakeholders, and work collaboratively with clinical teams to effectively manage system change.

3800 characters max.
**WSLHD Standard Key Accountabilities that apply to all managers**

**not to be removed except for the “optional” statement**

This section is in addition to the character count (3800) of the section above. These paragraphs can be moved up into the key accountabilities section above, however note that will impact character count in that section.

- Demonstrate relational leadership behaviours which shape a workplace culture embodying CORE values and continuous learning together with mutual respect, having a disposition of mindfulness in all actions with an awareness and application of the Code of Conduct.
- Ensure that all team members receive regular performance feedback, coaching for performance and formal review. Provide all team members with the opportunity to discuss and agree on a Work Plan for the year ahead, and a Development Plan which identifies areas for personal and professional development for the next 12 months.
- Manage all resources including finances/assets/leave balances) in a cost effective, transparent and accountable manner in accordance with all internal, legislative, audit, other compliance and Ministry of Health requirements.
- Promote and coordinate quality improvement and person centred care within the department, facility and district. Utilise key performance indicators that provide outcome measures. Include quality improvement, patient safety and consumer participation as standard agenda items at department meetings. Include consumers in the evaluation and planning of services. Ensure timely and accurate reporting and management of near or actual, incidents or patient safety concerns.
- Serve as a leader and support the organisation to achieve the aims of the safety management system, to establish and maintain a positive health and safety culture in the workplace and to consult with workers and others when making decisions that may impact upon the health, safety and welfare of those in the workplace.
- Risk management: Actively identify, communicate and escalate risks and understand their responsibility to manage these risks for the organisation. This responsibility includes the use of enterprise risk systems, and the review of adequacy and effectiveness or risk controls and treatment.
- Promote a positive risk culture where understanding, managing and accepting appropriate risk is part of all decision making processes.

**KEY CHALLENGES**

**2–3 key challenges**

A summary of the role’s key challenges, indicating the complexity of the role. These inform job evaluation and are an important consideration when selecting the capability levels required for the role.

- Manage projects and activities given tight timeframes, and the need to produce high quality outcomes and deliverables.
- Develop and maintain strong interpersonal relationships with eye clinic and external stakeholders to build capacity and effective project management focused on whole of departments outcomes as well as individual projects.
- Assist with developing new processes and change management change to enhance the projects.

*1000 character limit per challenge*
### WHO YOU ARE WORKING WITH

<table>
<thead>
<tr>
<th>Internal Relationships</th>
<th>WHO</th>
<th>WHY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outline 3 key internal stakeholders and customers</strong> the role is expected to interact with on a regular basis</td>
<td>Eye clinic nursing and allied health team</td>
<td>To promote a dynamic team and share knowledge within the department</td>
</tr>
<tr>
<td></td>
<td>Optometrists</td>
<td>To promote a dynamic team and share knowledge within and across the health system</td>
</tr>
<tr>
<td></td>
<td>Eye clinic administration team</td>
<td>To promote a dynamic team and share knowledge within the department</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External Relationships</th>
<th>WHO</th>
<th>WHY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outline 2 key external stakeholders and customers</strong> the role is expected to interact with on a regular basis</td>
<td>Agency for Clinical Innovation (ACI)</td>
<td>Report on project funding and deliverables and transfer of lessons learnt to develop innovative strategies</td>
</tr>
<tr>
<td></td>
<td>Stakeholder and consumers</td>
<td>To deliver patient centred care for people who attend our service.</td>
</tr>
</tbody>
</table>

### Financial delegation

- As per Delegations manual

### Job Requirements

**Vaccination Category:**
- □ A
- □ A High Risk
- □ B

**Information Sheet – Risk categorisation guidelines**

- □ National Criminal Record Check
- □ Aged Care Check
- □ Working with Children Check

**Is the position targeted to ‘eligible persons’ under the Government Sector Employment Rule 26 – please indicate below:**

| | Aboriginal / Torres Strait Islander |
| | Targeted |
| | Identified |

<table>
<thead>
<tr>
<th>Disability</th>
<th>Refugee</th>
<th>Gender</th>
<th>&lt;25</th>
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</table>
References


