Improving Wait Times in the Referral-Consultation Process

WCWL Priority Referral Scores

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Taming of the Queue VI

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Outline

- Access to medical subspecialties
  - Medical Access to Services Grant
  - Western Canada Waiting List Project
- Methods
  - Literature reviews
  - Deliberative process
  - Criteria, levels & weights
- Examples
- Testing
- Next Steps

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Rationale

- Increasing pressure from primary care referrals to medical specialists
- Constrained supply of specialists & primary care providers
- Priority-setting systems for referrals needed
- Referral information needs vast improvement
- CHR – Department of Medicine/Family Medicine
  - **Improve access & flow through medical specialties (Alberta Health & Wellness – medical access to services grant)**
- WCWL – an established group of investigators with a record for development & testing of tools to improve access

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Referral Tool Development

- Objective: to develop priority-setting referral tools for use by primary care providers when referring to medical sub-specialties

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Medical Specialists – Choices for (PRS)

- Single-entry model for referrals
- ‘Rapid-response’ clinics
- Clinical champion for tool development
- Demonstrable need (i.e. long waiting times)
  - Rheumatology, Nephrology, Geriatrics & Gastroenterology

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General Methodology

- Literature review
- Tool formulation – clinical deliberative process
- Tool testing – specialists & primary care providers
- Implementation with evaluation

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Panel Set-up & Support

- 4 – 5 specialists
- 3 – 4 family physicians
- 1 nurse practitioner
- 1 specialist as co-chair
- 1 general practitioner as co-chair

Facilitator & Support: Dr. Ray Naden & Alison Barber
New Zealand

1,000 minds ® Software

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Literature reviews

- Broad search for any existing priority referral criteria
- Some criteria for specific conditions
  e.g., early RA, frailty scale
- Nothing to address the scope of practice

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Methodology

- Two two-day working meetings
- Discuss actual case scenarios & rank order using clinical judgement
- Distill criteria that affect urgency of referral
- Identify Emergency situations
- Assign weights
- Compare ranking with PRS vs clinical ranking

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Sample case scenario

- Reason for referral: elevated creatinine
- Problem list: 10-month history hypertension. BP 174/78

Hemoglobin	120	Macrosopic (dipstick)	
MCV	86	pH	6.0
Platelet	330	Leukocyte	Neg
Sodium	137	Nitrite	Neg
Potassium	4.9	Protein	Neg
Chloride	105	Glucose	Neg
Albumin	38	Blood	Large
eGFR		Random PCR	0.01
6 wks ago	38		
1 yr ago	>60		

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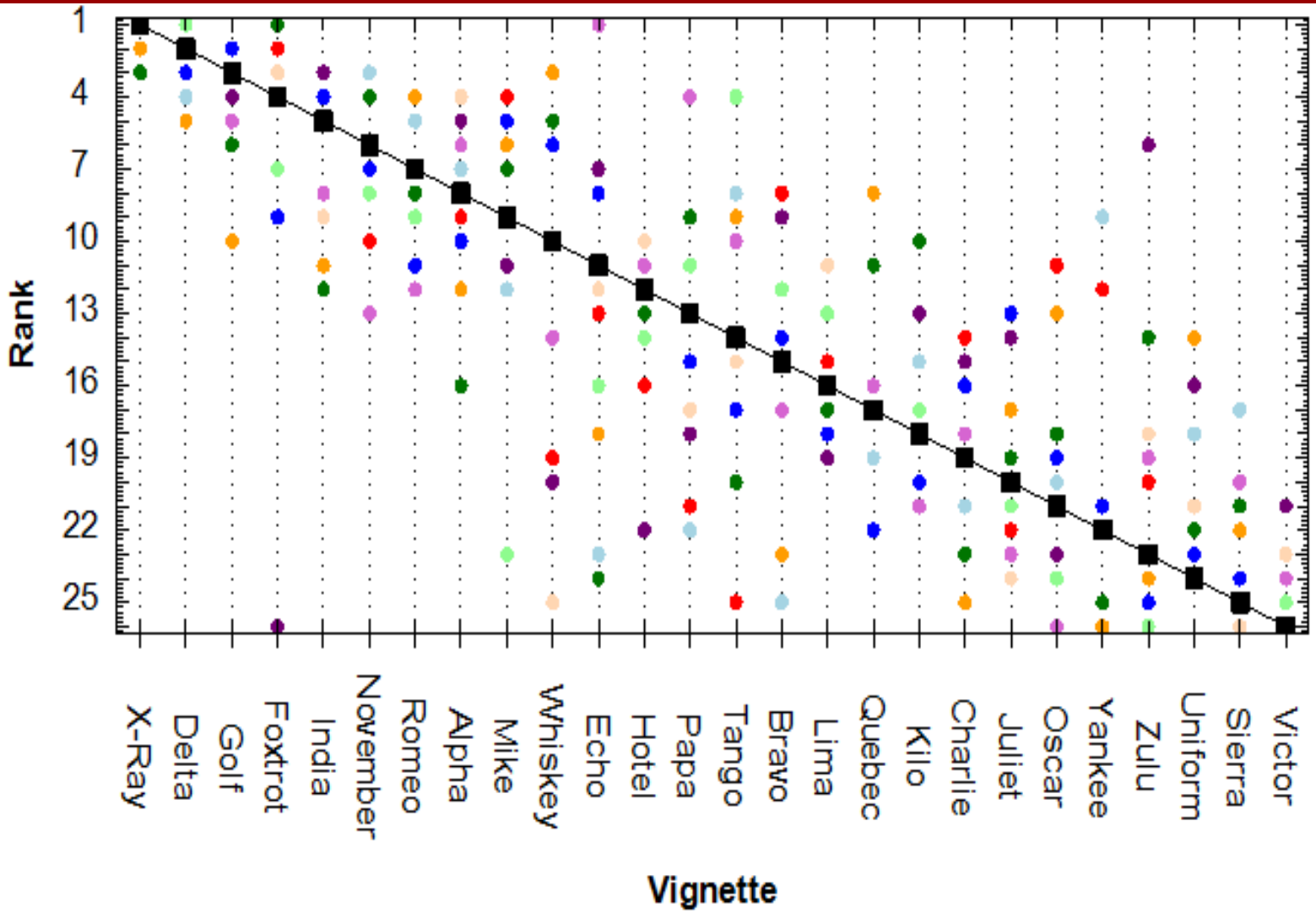
Clinical Ranking of Rheumatology Cases



Methodology

- What caused people to rank differently?
- What are the salient features that affect **priority** for referral?
- Elicit criteria and categories

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Methodology: Domains & Criteria

- Current state of patient
- Risk of progression
- Ability of patient to benefit by seeing the subspecialist

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How can we compare?

- People can only pay attention to 2 or 3 salient features
- 1000Minds ® software helps
- Presents pair-wise comparisons
  - if a>b and b>c, then a>c

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Methodology: Weighting

All else being equal, which is more urgent?

- Potential risk to others – Yes
- Severely disabled functional status

OR

- No potential risk to others
- Vulnerable or mild to moderate functional impairment

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Methodology: Weighting

All else being equal, which is more urgent?

- GFR < 15 with K+ < 6.0
- Recurrent symptomatic episodes of urolithiasis

OR

- GFR 15-29 with K+ 6.0-6.5
- Stones with single kidney

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Results – Rheumatology PRS

DOMAINS (3)	CRITERIA (8)	LEVELS
Current state of patient	Self reliance/ independence	4
	Limit to usual role/work	4
	Pain	2
Potential/ threat of progression	Currently receiving steroids	3
	Complexity management /risk due to comorbidities	2
	Inflammatory markers	2
	Evidence progressive major organ involvement	2
Delta benefit	Evidence of active inflammatory arthritis	3

1. Self reliance/independence	%
• No significant or meaningful impact	0.0
• Significant but not requiring assistance	6.1
• Requiring increased assistance in current environment	7.6
• At risk of or recently requiring increased level of care in new environment	20.2
2. Limitation to usual role/work	
• No significant or meaningful limitation	0.0
• Chronic (>6 months) significant limitation	3.8
• Some recent limitation	8.4
• Recently unable to perform usual role/work	14.1
3. Pain	
• No significant pain or pain controlled effectively	0.0
• Pain is not effectively controlled	6.1
4. Receiving Glucocorticosteroid for rheumatological condition	
• No	0.0
• Yes < 25 mg prednisone (or equivalent) per day	4.9
• Yes ≥ 25 mg prednisone (or equivalent) per day	12.9

5. Complexity of management/risk due to PRE-EXISTING comorbidities	%
• No	0.0
• Yes	8.4
6. Evidence of PROGRESSIVE major organ involvement probably related to reason for referral	
• No	0.0
• Yes	20.5
7. Inflammatory markers ESR >30 OR +ve C-Reactive Protein OR platelet count >400,000 x 10^9/L	
• No or not assessed	0.0
• Yes	5.3
8. Active Inflammatory arthritis features – joint swelling OR morning stiffness of joints or spine OR MCP/MTP joint involvement	
• No (with or without positive Rheumatoid factor	0.0
• Yes without positive Rheumatoid factor	8.7
• Yes with positive Rheumatoid factor	12.5

Additional Considerations

- Identify Emergency scenarios – do not fill out PRS
- Clear explanatory notes required for all criteria and levels within criteria

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Reliability testing

- Separately for specialists and family physicians
- Rank order cases
- Rate cases using PRS
- Repeat in six weeks

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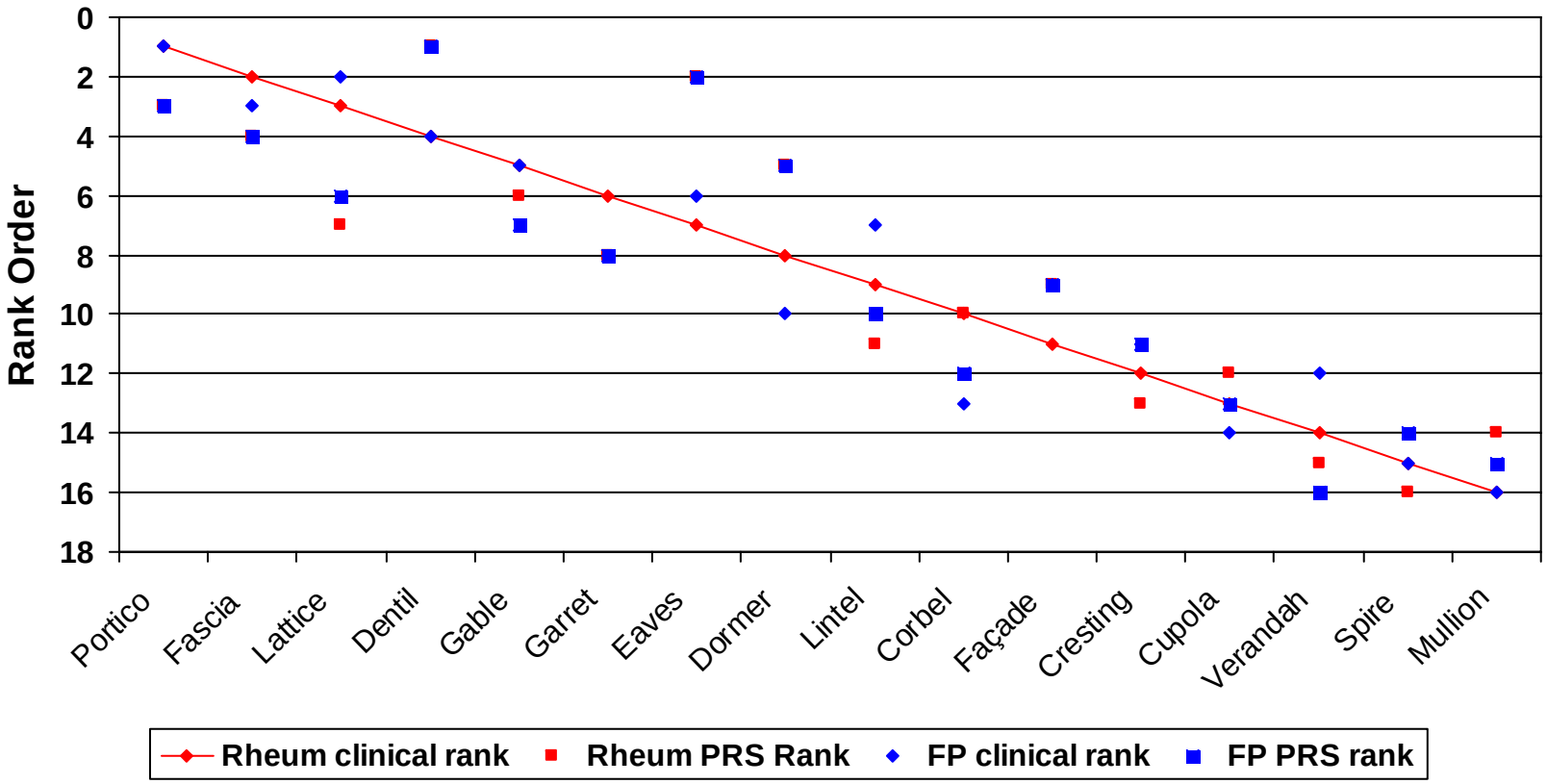
Clinical and PRS rank order of cases

Rheumatologists and Family Physicians



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WCWL - PRS

Medical Specialties Chosen - Stage

- Rheumatology
  - Testing nearing completion
- Geriatrics
  - B version for testing
- Nephrology
  - B version for testing
- Gastroenterology
  - Formulation of B version nearing completion

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Conclusions & next steps

- Clinical coherent, reliable, valid measure of urgency for referral
- Pilot-testing of Rheumatology PRS
- Finalize criteria for Gastroenterology
- Reliability testing of other tools

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