Process for patients triaged as non-urgent to access specialist appointments at an Australian public hospital

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Abstract

**Background**
The length and duration of waiting lists to access specialist clinics in the public system is problematic for Queensland Health (QH), GPs and patients. Therefore, QH is collaborating with GPs to reduce the number of patients on the wait list by trialing a recently developed referral management process.

**Discussion**
Strategies implemented to date include: GP audit of patients on 'long wait' list; inclusion of patients in the process by allowing them to choose if the appointment is required and for them to update their clinical information; and collaboration between GPs and consultants to develop a template of minimum clinical information to accurately triage and maximise conservative management prior to referral. Via this new process 6885 patients have been contacted, 633 patients have been seen by public hospital consultants at specially arranged clinics and 197 have required intervention.

**Summary**
Since the start of this process in 2008, the wait time to access a specialist appointment has reduced from eight to two years. The process described here is achievable within the routine of the referral centre and identifies the small number of people on the long wait list in need of intervention.
Process for patients triaged as non-urgent to access specialist appointments at an Australian public hospital.

Background
This article describes the development of a service model to allow patients with non-urgent referrals to be seen at a public hospital specialist outpatient clinic. To access outpatient specialist clinics, patients must obtain a referral from a GP which is sent to the hospital where the referral is triaged prior to delegating appointments. The triage system prioritises referrals depending on clinical criteria with the most urgent assigned Category 1 and least urgent, Category 3. Queensland Health (QH) recommended timeframes for patients to be seen from date of receipt of the referral are 30, 90 or 365 days for Category 1, 2 or 3, respectively. However, for various reasons, The Townsville Hospital (TTH) often does not have the capacity to meet these criteria. This results in a wait list of patients from Category 2 but mostly from Category 3 for which wait times extend beyond two years. These ‘long wait’ patients are unlikely to be seen unless their condition deteriorates and an updated referral upgrades them to a Category 1. The administrative difficulties associated with long wait lists, plus the potential of patients in need of procedures masked by inadequate referral information warranted a review of referral processes.

TTH gained negative attention as having the second longest list of patients waiting for specialist appointments in the State. To address this issue, TTH collaborated with the GP Liaison Officer from the local Division of GPs (Townsville GP Network) to ensure cooperation from both primary care and hospital staff. The overall process included two strategies: 1) to provide access to appointments for patients who have been on the wait list greater than two years by updating their referral using a specifically designed referral template, and 2) to streamline the process of new referrals coming into the system. The second strategy was considered necessary to ensure the number of new referrals entering the system does not overwhelm the hospital’s capacity and develop into another long wait list. Here we describe the first strategy: the process to target long wait referrals where ‘long wait’ was defined as two years or older.

Discussion
Long wait times to access specialist outpatient consultations and associated procedures are endemic in public hospitals in Australia(1) and overseas.(2-4) Numerous detrimental factors come into play when wait lists become onerously long, including additional administrative support(5) and increased mortality and morbidity rates.(6) Wait lists are inflated by patients that have not been investigated thoroughly prior to referral reducing capacity for accurate triaging. (7) To improve clinical management of patients on waiting lists, innovative models of care have been widely adopted including the Orthopaedic Physiotherapy Screening Clinic, nurse practitioner first contact clinics and a remote rheumatology outpatient clinic.(5) The
process we are developing addresses wait times to access specialist clinics in public hospitals that is acceptable to both GPs and specialists, includes the patient, and educates GPs on the minimum amount of data required to triage the patient. Once GPs are provided with information about waiting times, their willingness to change their referral practice rises.(8) Inclusion of patients in the decision making process and the subsequent removal of patients from the wait list for non-response was preceded by an extensive media campaign which has resulted in negligible community backlash.

Participants
The overall coordinator for the process was the Townsville GP Network’s GP Liaison Officer. Key hospital staff included the Nurse Unit Manager of Surgical Special Clinics, and the Executive Director of Medical Services. The referral templates were developed in collaboration between TTH consultants from the relevant specialty and the GP Clinical Reference Group (GP-CRG) from Townsville GP Network. The process was advertised and marketed extensively throughout the local GP community via education sessions and GP letters. Patients were indirectly included in the process through the media campaign associated with the project and directly included via a letter from TTH to allow them to determine if they considered they still required the specialist appointment. Patients increasingly want greater involvement in making decisions regarding their care (9) and as it is generally accepted for patients to initiate care, it should also be accepted that patients can withdraw from care.

Sequence of events
Our first attempt to address long wait referrals was not successful. In this first attempt, a list of long wait patients was sent to the referring GP to confirm if the referral was still current. This process proved time consuming for GPs and practice managers due to difficulty of data retrieval within practices and transiency of the patient and GP populations. Further, the additional workload was contrary to our aim of implementing a change process with minimal impact on current work practices.

Overwhelming negative feedback from hospital staff regarding referral content prompted the GPLO to conduct an audit on incoming referrals to help guide future interventions. Findings from the audit indicated many referrals contained clinical information up to eight years old and only 25% contained complete and appropriate information to adequately triage patients. Information regarding referral validity is limited, but is suggested in MBS Schedule (Note G6.1) to be 12 months. Poor quality referrals present a dual risk management issue. If high risk patients are ranked low on the triage scale, negative outcomes may result before the appointment date.(6) Conversely, if low risk patients are seen urgently, it may inappropriately delay high risk patients. One solution is to improve the adequacy of the information contained in the referral to enhance appropriate triaging.(2, 3) Therefore, we developed a referral
template containing a minimum data set (MDS) for each of the specialties. For the long wait process, the MDS was used to update clinical information and to ensure all appropriate investigations had been performed.

To develop the MDS, a search of the grey literature showed numerous resources had already been developed in Australia.(10-12) Using these resources, and input from the consultant from the relevant specialty, all information potentially required for a referral was drafted into a template. This draft was refined at a meeting to ensure it met triage requirements for the relevant consultant and be of acceptable length for GPs to complete in a standard consultation. Further refinement continued using a Delphi process, where the draft was emailed between the two groups until a consensus was reached. We have now developed templates for all specialist clinics at TTH. The templates are also available as a direct electronic referral document for registered GPs from their desktop to TTH via Townsville GP Network.

The process to provide an appointment for long wait patients in Category 2 and 3 has evolved over time with the current process shown in Diagram 1. Patients on the long wait list are sent a letter directly from TTH clearly advising two options. Option A advises patients to ‘Take no action’ if the referral is no longer required and option B advises them to update the referral by presenting the referral template (included in the patient letter) to their GP within three months. Patients are advised in this letter that their name will no longer remain on the wait list if they choose Option A. Patients are sent a reminder letter after two months. The three month timeframe was chosen on the basis of review for chronic conditions and to avoid an increased work load for GPs. The GP then returns the referral to the TTH referral centre so that an appointment can be arranged. All patients whose referrals returned in the long wait process are given an appointment.

Evening information and education sessions by relevant specialists are held at regular intervals to advise local GPs of the new referral template and MDS. They are also provided information on conservative management strategies by appropriate allied health professionals (e.g. senior musculoskeletal physiotherapist). Additional awareness strategies included presentations, education sessions and newsletters to practice managers and practice nurses. Importantly, the general community was informed of the process via local print, TV and radio. GPs were provided with a copy of the referral template prior to the first mail out to patients and a downloadable version was available on the Townsville GP Network website. A good working relationship and an open communication policy with TTH referral centre staff were essential to the success of this process.

Outcomes
The first trial of the long wait process was conducted in 2008. In August of that year, 872 long wait orthopaedic patients were sent letters asking them to update their clinical information if they still wanted the appointment. A total of 101 patients responded, all of whom were seen at specially arranged clinics. This resulted in 16 procedures, confirming our belief there were patients on the long wait list in need of intervention who had little likelihood of being seen unless their condition deteriorated and an updated referral allowed them to be triaged to Category 1.

In 2009, letters were again sent to orthopaedic long wait patients (562) and also patients on the long wait list for ENT (1095), neurosurgery (544), urology (699), and general surgery (1241). A total of 532 patients updated their clinical information as a result of these letters. Again, all of these patients were seen at specially arranged clinics. The numbers of surgical interventions resulting from these appointments are: ENT 16; neurosurgery 1; orthopaedics 14; urology 8 and 138 for general surgery. At the end of 2009 the wait time for these clinics was 2 years for orthopaedics, ENT, neurosurgery, urology and 1 year for general surgery.

In 2010 it is planned to conduct the long wait process on the specialties of orthopaedics, ENT, neurosurgery, urology, general surgery, vascular surgery and ophthalmology. By the end of 2010 we expect the wait time to be one year for neurosurgery and urology, 18 months for orthopaedics and ENT and 2 years for ophthalmology. To date, a total of 6885 letters have been sent to long wait patients, 633 patients have responded by updating their clinical information and of those, 197 have required an intervention.

**Summary**

Since 2008, we have successfully integrated the long wait process into the routine running of the surgical clinics, demonstrating it can co-exist with normal referral centre workflow. It includes the patient, hospital and GPs in the process and is achievable and cost effective in identifying the small number of people on the long wait list in need of procedural intervention. Over the last three years this process has reduced wait times from 8 to 2 years and has given us confidence to move forward in the referral reform agenda until wait times are within acceptable levels. Out of the total 6885 letters sent there has been a conversion rate to procedural intervention varying between 1-10% and 6261 patients removed from the long wait list. This process has provided an equitable system for ‘long wait’ patients to access a public hospital specialist clinic appointment and subsequent procedure if required.
References

First patient letter plus referral template from TTH

Visit GP – fill in MDS

Second patient letter from TTH

Patient contacts TTH for referral

Patient advises reason for no longer wanting appointment

Visit GP – fill in MDS

TTH Referral Centre

Fax

No response

Patient’s name no longer held on wait list

'Man long wait' appointment

Surgical procedure

Discharge

Months 1-2

Month 3

Months 4-6
Additional files provided with this submission:

Additional file 1: BMC HSR cover letter.doc, 24K
http://www.biomedcentral.com/imedia/1689813894395150/supp1.doc