

Triage of Rheumatology Referrals by an Advanced Practice Physiotherapist Facilitates Wait Time Benchmarks

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Background:

Improved access to rheumatologists and initiation of disease-modifying anti-rheumatic drugs for patients with suspected inflammatory arthritis (IA) and connective tissue disease (CTD) has been shown to decrease disability, improve functional outcomes and prevent disease progression. As such, there has been a focus on identifying patients with IA and CTD and reducing wait times for access to rheumatology through improved triage processes and efficiency (1). Some Canadian centers reported wait time from referral to initial consultation at over 13 months (2), which is inconsistent with CRA wait time benchmarks.

Objective:

To determine if both centralized triage of rheumatology referrals by an Advanced Practice Physiotherapist (APP) and the introduction of quality improvement initiatives would facilitate achievement of wait time benchmarks. Quality initiatives included priority assignment of referrals, booking templates, and monthly audits as indicators against benchmarks.

Methods:

In 2012, all incoming referrals were screened by several rheumatologists to determine possible diagnoses and need for urgent assessment. A non-standardized process was used to direct booking of the initial consult.

In April 2013, WCH Rheumatology developed benchmarks based on literature review and initiated centralized triage by an APP :

Urgent:- 24-48 hours

Priority 1 (suspected IA or CTD): 31 days

Priority 2 (tendonitis, osteoarthritis, gout): 90 days

Priority 3 (chronic pain, fibromyalgia): 240 days

A database to track referrals and monthly audits was established to evaluate wait times for priority patients and identify opportunities for quality improvement.

In 2014, the Canadian Rheumatology Association(CRA) outlined wait time benchmarks for inflammatory and connective tissue disease to improve patient outcomes.

Comparison of wait times for inflammatory arthritis (IA) and connective tissue disease (CTD) from 2012 to 2014 was conducted:

- A retrospective chart extraction for all new patient consults from September to November 2012 was performed.
- January to March 2014 referrals new patient consults were extracted from the established database.
- Date of receipt of referral and date of initial consults were obtained. The standardized priority ranking algorithm utilized in 2014 was applied to the 2012 referrals by a rheumatologist.
- Priority 1 patients were classified as IA/CTD
- Priority 2 and 3 patients were classified as non-IA
- Exclusion criteria:
 - Urgent referrals were not included as they commonly bypass the central triage process
 - Duplicate /cancelled referrals and those with incomplete information

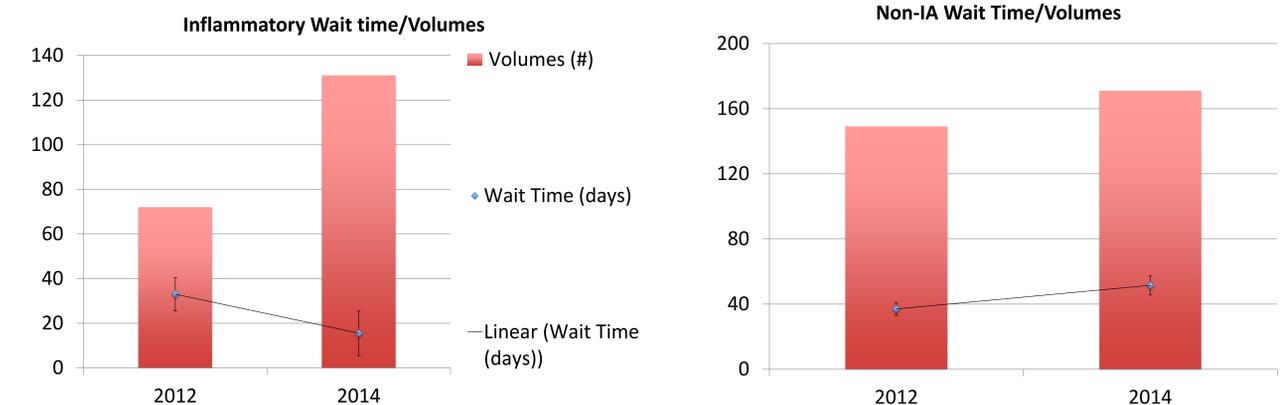
References:

1. Thompson, A. 2010. Referral and triage in rheumatology: accelerating the spectrum of care Rheumatology National Grand Rounds
2. Carpenter T, Katz S. 2014. Review of a rheumatology triage system: simple, accurate, and effective Clinical Rheumatology

Results:

A total of 558 referrals were evaluated, with 11 (2%) urgent and 24 (4%) had insufficient information/duplicate. In 2012 a total of 227 referrals were received compared to 331 in 2014.

Wait times for IA/CTD went from 33 to 15.5 days with the institution of a centralized triage system. Wait times for non-IA went from 37 to 51.5 day during the same time period.



Conclusion:

Triage of rheumatology referrals by an APP is effective in improving wait times for rheumatology assessment. Centralized triage, booking templates, monthly auditing, and the implementation of benchmarks facilitated decreased wait times for inflammatory arthritis and connective tissue disease.

Strengths: The sample size was large and the study was completed in a large urban general rheumatology practice that is reflective of a typical practice.

Limitations: This was a retrospective study. Multiple quality improvement initiatives were implemented simultaneously and it is difficult to ascertain if all strategies were effective and which ones had the most impact on the outcome.

Future Directions: Evaluate referral information and assessment diagnosis by rheumatologist to determine what referral information increases the probability of a IA/CTD. This will aid both referring physicians and rheumatology triage.