

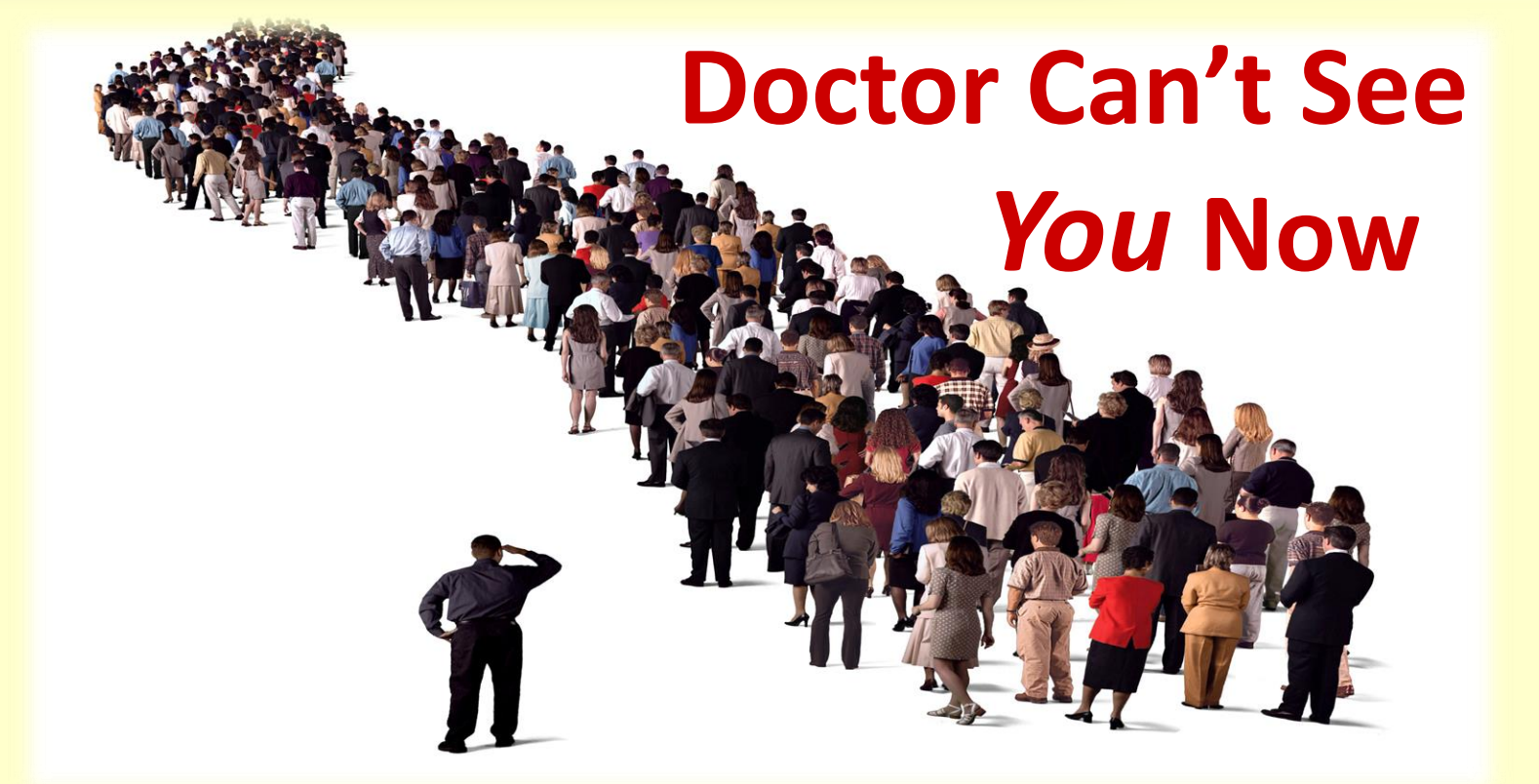
ENABLING SHARED DECISION MAKING

Active Clinical Referral Triage (ACRT) and Opt-in

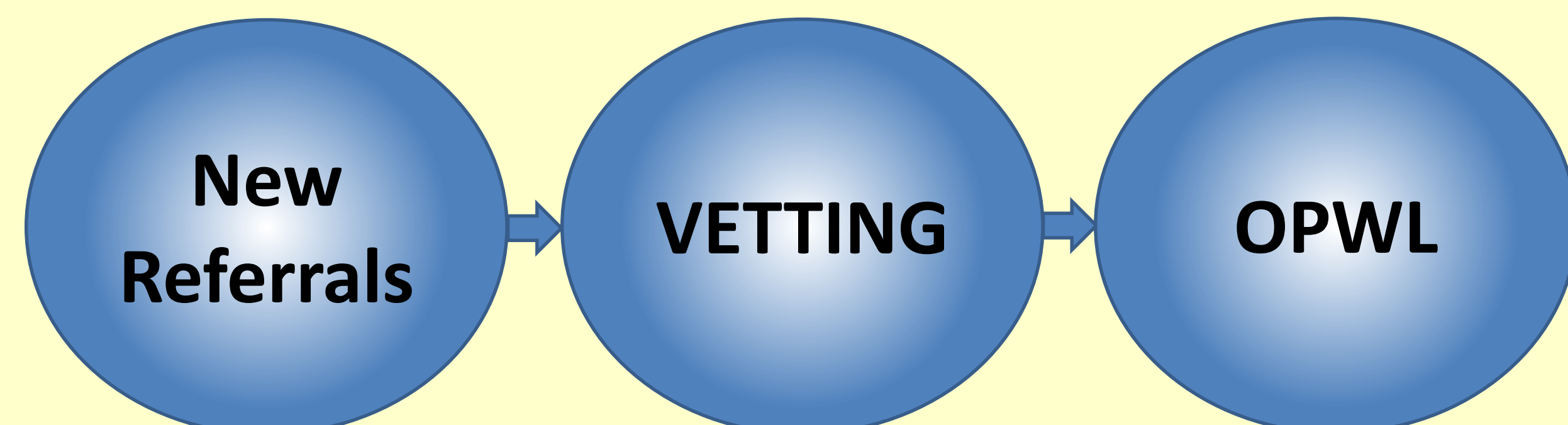
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Outpatient Waiting Lists (OPWL) for face-to face (F2F) review are problematic

- People routinely wait for months after referral to hospital for a F2F OP appointment¹
 - appropriate management of their condition is therefore delayed
- No clinical information is usually sought or provided until individuals are physically seen
- Patients, friends and family experience unnecessary anxiety and uncertainty²



Traditional Pathway



> 95% patients referred to secondary care
- routinely added to the OPWL after vetting

- The initial F2F assessment in secondary care routinely duplicates the history taking / examination process
 - **despite** the accessibility of electronic patient records / lab results / imaging
- 40-80% of the information provided at a F2F attendance may be forgotten immediately by the patient³, which is of particular importance for informed consent
- Evidence-based pathways are often underutilised⁴
 - resulting in unwarranted variation at the F2F review⁵
- OP Waiting List targets are regularly breached requiring Waiting List Initiatives

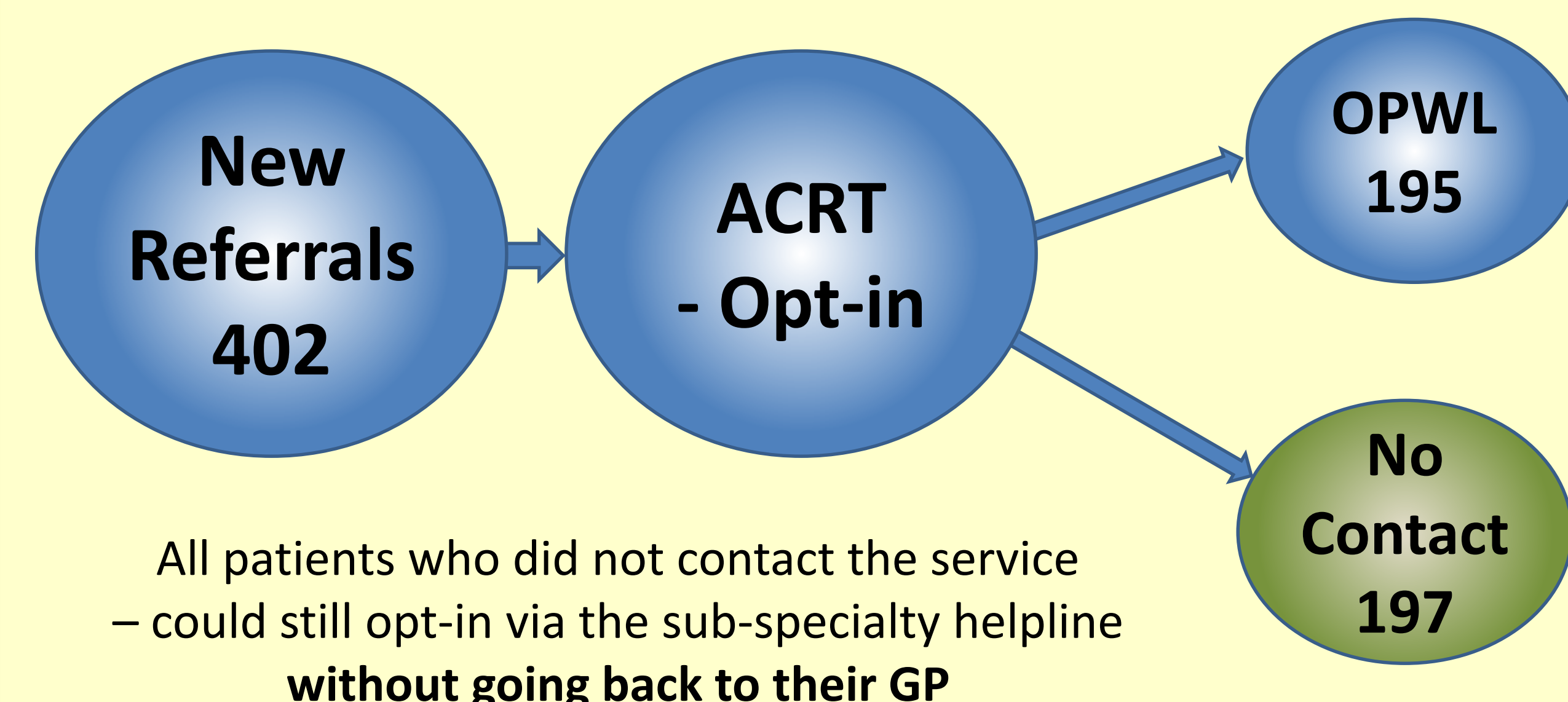
ACRT (Enhanced vetting) on receiving every referral

- A Senior Clinical Decision-maker reviews **all** the electronic patient records (including imaging, lab results)⁶
- Triages using clear, evidence-based, locally agreed pathways
 - including a new **Opt-in** process with the aim of improving an individual's knowledge and shared decision making
- Clinical information leaflets are supplied to appropriate people informing them about their condition and options, thus enabling patient engagement including self-care⁸
- A sub-specialty helpline provides the patient with the opportunity for clarification, discussion and advice i.e. a virtual attendance - and the patient can opt-in for a F2F consultation as required



F2f appointment
- only if adds value for the patient

Results of an Orthopaedic ACRT / Opt-in pilot : GRI May 2017 – May 2018



Patient Questionnaire (n=150)

- Understood the information and process $p = 0.235$ (ns)
 - 94% of the patients who opted-in were satisfied
 - 89% of the patients who did not opt-in were satisfied

Effect of Deprivation

- On matching postcodes against the Scottish Index of Multiple Deprivation
 - no statistical difference between the two patient groups

CONCLUSIONS

- Prompt provision of written information for new patients after referral, with the choice to opt-in, was demonstrated to be a safe, efficient and effective system
 - patients understood the leaflets and engaged satisfactorily with the process
- The patients who had chosen to attend for a F2F review could reflect on the relevant information, enhancing the informed consent process
- Clinical leaflets served as consensus documents to agree standardised protocols for the management of specific conditions, reducing unwarranted variation
- Only 48.5% of selected patients with 5 conditions chose to opt-in for a F2F consultation within a year i.e. the size of an OPWL can be **significantly reduced** - **merely** by providing clinical information and sharing decision making

ACRT / Opt-in checklist

- **All Clinicians in a local unit**
 - agree standardised, evidence-based patient leaflets
 - assign ACRT time in the appropriate clinicians' job plans
- **Managers / Administrators**
 - establish admin process for sending out leaflets / opt-in
 - insert an ACRT / opt-in outcome in the current vetting options for accurate data collection / audit

References

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