Orthopedics Clinic
Access

DEM Rounds May 16 2017. Paul Keyes
Perspective

- Emergency
- Orthopod
- Emergency Admin
- Clinic Admin
Orthopedics Clinic

- May 2016
- 3 different referral processes
- Variable adherence to any protocols by various surgeons, variable clinic appointments between surgeons
- Difficult implementation by administrative staff
- Variable forces driving chaos
Literature review

• Cochrane review. Available 2014

• Interventions to improve outpatient referrals from primary care to secondary care Akbari et al.

• Objectives—To estimate the effectiveness and efficiency of interventions to change outpatient referral rates or improve outpatient referral appropriateness.

• 17 studies with 23 separate conclusions

Cochrane Database Syst Rev. Author manuscript; available in PMC 2014 September 15.
Conclusions:

- Ineffective strategies included: passive dissemination of local referral guidelines (two studies), feedback of referral rates (one study) and discussion with an independent medical adviser (one study).

- Generally effective strategies included dissemination of guidelines with structured referral sheets (four out of five studies) and involvement of consultants in educational activities (two out of three studies).

- There are a limited number of rigorous evaluations to base policy on.
Clinical forces

- Appropriate ED management (+/- admission) then appropriate Clinic and/surgical management
- Timely referral for possible surgical cases
- ERP requirement for reliable follow-up of all appropriate cases
- Need for re-assurance of safe guards to consultation process
- Desire to see appropriate patients in clinic, not in ED in week following call.
Administrative forces

- Emergency department
  - Simple one system process for all referrals
  - A definitive time/place process so that patients know follow-up BEFORE leaving the ED, and chart documents same
  - Ability to refer specialty specific consults to field subspecialists
  - A re-affirmation of local best practice in consultation standards
Administrative Forces

- Orthopedics
  - Equal sharing of ED consults/workload
  - Orthopod-on-call responsible to see/care for ALL referrals made from ED during their respective call periods
  - Flexibility to see consults where/when it works best for the orthopedic surgeon, but assuming responsibility for follow-up if the clinic moves form Clinic 1-SJRHI
  - Essential demographic provision for EVERY consult
  - Appropriate sorting of “in ED” consults from clinic consults
  - Appropriate sorting of Emergent/urgent/elective and specialization specific consults
Rationalization of processes

- Single consult entry point re-affirmed: admin support SJRH ED
- Clinic 1 staff directed to supply ED with only “physician on call that day” clinic book
- All emergent consults go to physician on call that day in ED, Urgent consults in clinic-within a week.
- All Orthopods provide a minimum of 12 clinic appointments per call day in the following week. If orthopod away, they are responsible to direct clinic to provide covering physician’s clinic book to ED with same space provisions
Rationalization of processes

- Every consult is entered by ERP into I3 and printed to accompany copy or ED chart and is placed in clinic book, with a patient sticker placed on clinic appointment sheet.

- Non-urgent consults are faxed to orthopedic surgeons offices for triage and cue placement with all other primary care referrals.

- If subspecialty specific consult requested, then this is faxed to the orthopod of choice’s office. If urgent, then the orthopod on call will sort/laterally refer consult in clinic that week.
Program Goals

- Happy ERP’s….. Happy Orthopedic surgeons
- Patients get timely care by orthopedics
- Continuity of care
- Minimization of risk to patients/referring/receiving physicians
- Orthopedics gets flexibility as to location of consult provision
- Equitable sharing of consults/workload
- All vital information provided to satisfy Medicare audits
Resources required

- Time... Physicians, nurse managers, clerical support
- Ability to step back and identify what the “wants” are of various groups
- Work with the clinic and admin staff, including an audit and crisis management availability to ensure process works
- Follow-up ability with all groups to re-evaluate and trouble shoot problems
Outcomes

• **Issues Orthopedics - None to date from Dept head**
  • For monthly Ortho Dept meetings
  • …updates as they arrive....

• **Issues Emergency perspective:**
  • Improper clinic books in ED
  • Referral to subspecialty group missing required DI
  • Initially issues with booking slot adequacy
  • ERP’s would like consultation report copied back to them.
Outcomes

- Collaborative approach ED and ortho
- Single process for all orthopedic referrals
- Identical sorting of: In ED, Clinic, Ortho office/subspecialty referrals
- Legible, billable consults
- Timely and appropriate consultations/assessments
- Orthopod flexibility as to site of consultation/clinic
- Appropriate chain of responsibility from Consult to consultant evaluation