

Redesigning care to improve the waiting time for shoulder patients accessing Orthopaedic Outpatients

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Outline

- Beginnings of Physiotherapy-led clinics
- Clinic processes
- Outcomes
- Guidelines for referral to surgeon /injections
- Key changes
- Barriers and enablers

Historical Background

United Kingdom

- European working time directive 1993
- Medical staff <60hrs per week
- Fewer medicos available to provide services
- Unacceptable waiting times for surgical consultations
- NHS needed to think broader about roles – role redesign

Australia

- 10 years behind UK
- Structure and funding different – State & Commonwealth government shared responsibilities and larger private health sector
- Long waits for surgical consultations
- Auditor General's report 2006: Access to specialist medical outpatient care identified as an issue

DHS Initiative -Better Skills Best Care

- 2004 - Encouraged health services to explore new and redesigned work roles
- Address workforce and service delivery issues
- Supporting change in health and roll out of initiatives
- 18 pilots
- Pilot in ED at RMH to run physiotherapy primary contact role – now ongoing 7 day service

Productivity Commission report 2005

Recommendations:

1. Services should be delivered by staff with the most cost-effective training and qualifications to provide safe, quality care
2. A realignment of existing health workforce roles, or the creation of new roles, to make optimal use of skills and ensure best health outcomes



Other factors to consider

- Ageing population - increase in chronic disease
- Long waiting times for outpatient appointments¹
 - Patients' condition may deteriorate / become chronic²
 - Suboptimal management in the treatment of chronic conditions
- Low conversion to surgery rates for specific patient groups eg LBP
- Physiotherapists have expertise in assessment, differential diagnosis and management of musculoskeletal conditions



"Age? You mean now or when we first sat down?"

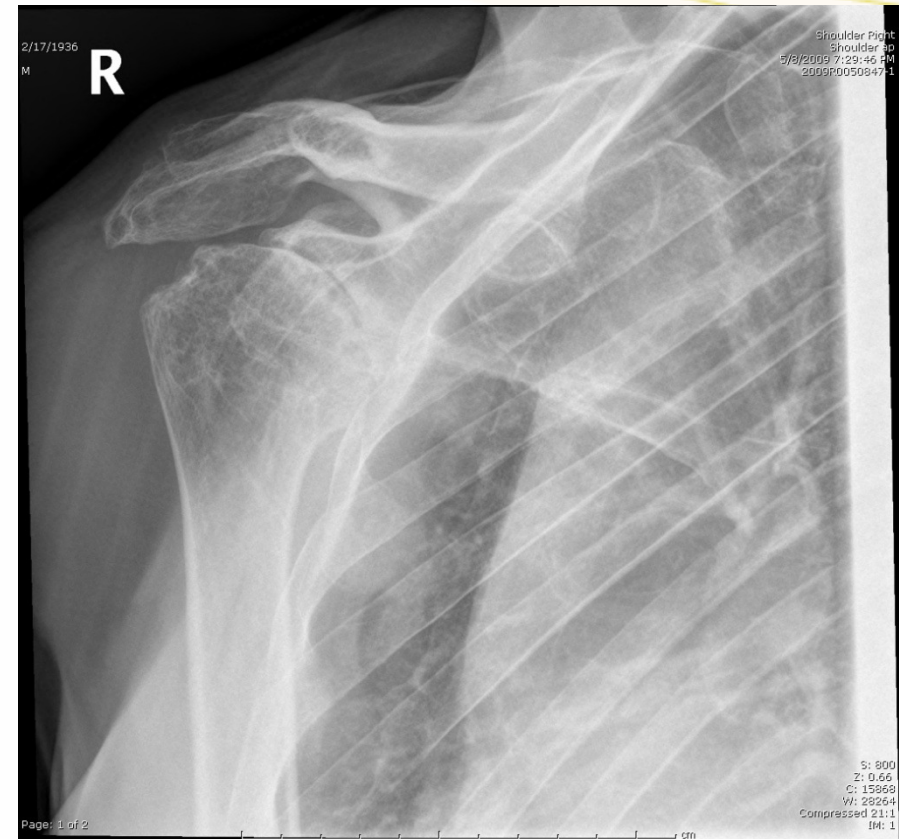
Physiotherapy-led Clinics

- Clear benefits reported ³⁻⁸
 - Reduced waiting time for treatment
 - Prevention of chronicity
 - Avoidance of surgery
 - Efficient and cost-effective approach to patient care
 - High level of patient satisfaction
 - High level of GP / surgeon / staff satisfaction

Shoulder Clinic

- Began March 2008
- Initially ran fortnightly, now weekly
- Co-located with shoulder surgeon
- Set up as a triage/ consultant clinic
eg assessment only

- Triage criteria:
 1. Shoulder pain
 2. Rotator cuff injury



Exclusion criteria

1. Suspected tumour or malignancy (unexplained weight loss, malaise, unremitting non mechanical pain, any mass or unexplained swelling)
2. Suspected infection (fevers, malaise, non-mechanical pain)
3. Suspected inflammatory disease (prolonged morning stiffness, skin rash, multiple joint pains) eg RA
4. Unreduced dislocation (history of trauma / epileptic fit / electric shock) or recent dislocation
5. Chest pain with arm pain
6. Fractures

Patient triaged to Shoulder Clinic -Outpatient appointment booked

Patient consents to mgt

Assessment → diagnosis

Management plan

Referral for conservative mgt

Referral to surgeon

Review at 3-4/12

deteriorated

improved

Continue with conservative management - discharge

Outcomes

- 150 new patients to date have been assessed
- Demographics: mean age 57 yo, 70% female
- Only 27% have had any recent previous conservative management
- 33% were discussed or referred to surgeon
 - 67% patients were managed by Shoulder Clinic

Pathology	Percentage of overall (%)
Rotator cuff*	70
Cervical spine ref	4
Osteoarthritis (GH and AC)	4
Frozen shoulder	4
Cervical spine with definite RC symptoms	5
Chronic pain	5
Spontaneous recovery	3
Other diagnoses **	7

*inclusive of tears, impingement, calcific tendinopathy

**include clicking scapula, shoulder instability, biceps pathology, AC injury and clavicle osteolysis

Outcomes of initial assessment

- Referrals to Physiotherapy 93%
- Hydrotherapy 5%
- Chronic Pain 2%
- Referred for further Ix 16%
- Referred to surgeon 22%
- Discharged 4%

Outcomes of surgeon review

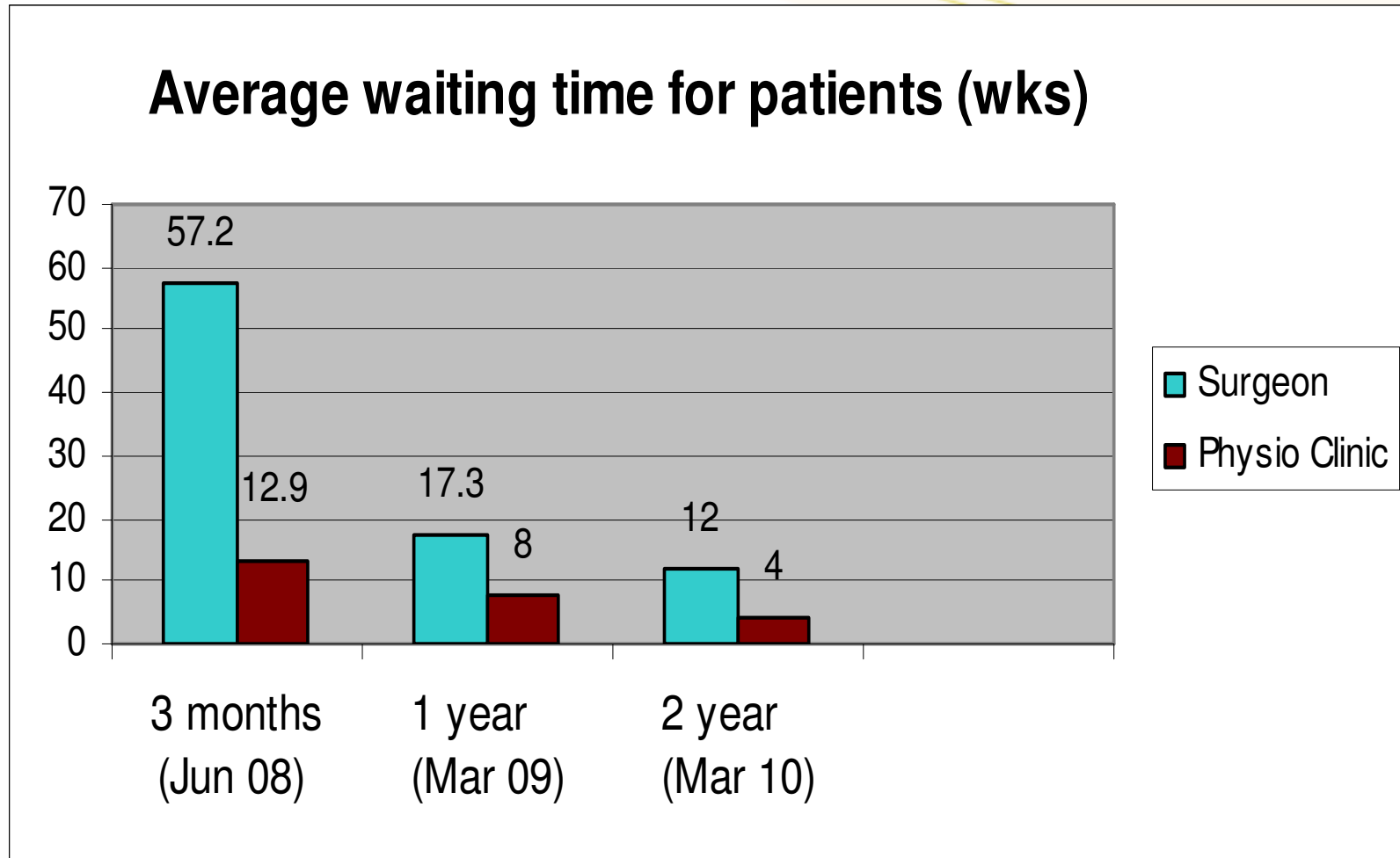
- 24 patients referred to surgeon at initial assessment
 - 14 offered CSIs with 3 patients refusing
 - 5 waitlisted for surgery and 1 declined
 - 4 referred for medicolegal or wrong joint
 - 5 patients continuing to be monitored by ortho
- 13 referred at 3/12 RV
 - 4 CSIs offered with 2 patients refusing
 - 7 waitlisted for surgery and 2 declined
 - 4 continuing to be reviewed by ortho

3/12 RV - Outcomes of Conservative Management

Physiotherapy N=100	Improved and DC	32%
	Some improvement-more Rx required	7%
	No change – no Rx yet	6%
	No change-no further mgt wanted	5%
	No change –referred to surgeon	12%
Hydrotherapy N=5	No improvement	20%
Chronic pain program N=2	No change-no further mgt	100%



Outcomes –reduction in waiting time



- All patients requiring surgical assessment were fast tracked to an orthopaedic appointment within six weeks of initial assessment
- Appropriateness of referral to surgeon
 - Conversion to surgery - 80% on waitlist

Referral guidelines to surgeon

- Reduced shoulder ROM with less than 90 degrees elevation and restricted by pain
- Red flags
- Limited improvement in condition despite appropriate treatment
- Severe degenerative changes of either the acromioclavicular or glenohumeral joint with associated pain and restriction of movement
- Acute tear of rotator cuff – pt young and active or older patient with good anatomy
- Bankart lesions
- ?Acromial osteophytes with associated symptoms
- Patient booked incorrectly or requesting medicolegal documents
- Patient requesting to see a surgeon

Guidelines for injections

- Failure to improve with conservative management
- Poor sleep pattern – regular night pain in combination with restricted function
- Pt not scheduled for surgery in the next few months
- Definitive diagnosis eg. AC vs subacromial source

Key changes implemented

1. Clear protocols / guidelines developed in consultation with orthopaedic surgeon
 - Inclusion / exclusion criteria
 - Risk management (red and yellow flags)
 - Discharge policy
2. All new referrals to orthopaedics are triaged by a senior physiotherapist
 - 80-90 new referrals received each week
 - Approximately 25-35% triaged to physiotherapy-led clinics

3. Senior physiotherapists can now order X-rays
4. Clinic co-location
 - close liaison / communication with surgeon
 - order investigations (CT, MRI etc)
 - can organised immediate review / future ortho appt

Barriers to Physiotherapy-led clinics

- Medical modelling – medically centred
- Funding
 - Doesn't attract same fee for service (Allied Health VACS (\$59) vs. Medical VACS (approx \$167) per occasion of service)
 - Recurrent clinic funding
- Space
- Patient and GP expectations
- Staffing - expertise
- Community resources



What? I'm behind the barriers, aren't I?

Key Enablers for Success

- A medical champion is essential
- Issues with current service – opportunity for improved service delivery
- Suitably qualified / experienced physiotherapy staff are required
- Clear protocols must be developed in conjunction with medical staff to ensure the safe and effective management of patients
- Established relationships alongside specialists working in clinic
→co-location of clinics
- Frees up medical workforce for roles that only they can provide

Summary

- Collaborative approach
- Understand your role
- Improvement in career path
- Physiotherapy often first-line treatment BUT
 - not effective with all patients
- Management rather than treatment – 67% of patients managed exclusively by Shoulder Clinic
- Effective strategy to address long waits for specialist consultation

Acknowledgements

- Christine Frith, Senior Physiotherapist
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