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Improving the communication between care providers of individuals who may require joint replacement surgery – A framework for referral

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Project team

- Investigators
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  Melissa Morgan (Project Officer)
- Joint Replacement Waiting List Working Group
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- RACGP
  Morton Rawlin, Amy Jasper
- Commonwealth Department of Health and Ageing
  Michael Fisher, Isolde Kauffman, Narelle Moody

Background

- Commonwealth Department of Health and Ageing funded project
- RACGP leadership
- One of six working groups
- Link to National Action Plan for Arthritis and Musculoskeletal Conditions

Project objective:

To specify the information required in referrals to public hospital orthopaedic outpatient departments in order to streamline the care and prioritisation of individuals who may require joint replacement surgery

Relevance to general practice

- Arthritis and musculoskeletal conditions frequently managed by GPs
  - 12% problems managed in 2003-04 (AIHW, 2005)
- Musculoskeletal Surgical referrals common among GP encounters
  - 12% of surgical referrals were for knee arthritis/pain
  - 10% of surgical referrals were for hip arthritis
- BEACH data (April 1998-March 2001), Gruen et al, 2004

Why is a referral framework needed?

- Prevalence of chronic bone and joint conditions projected to rise with ageing of population
- ~60,000 joint replacements per year
  - many more referrals for assessment
- Length of waiting time for joint replacement surgery in Australian public health care system one of most lengthy in developed world
- Long waiting times lead to
  - worsening of mobility & health-related quality of life
  - Deconditioning
Why is a referral framework needed?

- Current system may not be equitable
  - Quality of referral from GP to orthopaedic outpatient departments may affect patient care (content, legibility)
  - Informal prioritisation systems for orthopaedic assessment and surgery may vary between hospitals
  - Women and poorer people on waiting lists have worse initial disease (in public system)
- Arthritis more frequent in women and poorer people

Methods

- National working group with key stakeholder representation convened
  - Scoping document prepared
  - Review of relevant literature, guidelines and programs
  - Consensual approach used to draft framework including standard referral form incorporating validated prioritisation tool
- Planned extensive stakeholder consultation & piloting of framework

Results

Decision pathway – conceptual basis for referral framework

- Highlights key considerations in the decision to refer for orthopaedic assessment:
  - need for joint replacement surgery
  - fitness for surgery
  - willingness to undergo surgery

Results

Standard referral form developed

- based on SIGN guidelines
- consensus approach to information parameters included
- inclusion of a validated tool to assist the prioritisation of patients for assessment and surgery

Multiattribute Arthritis Assessment and Prioritisation Tool (MAPT)

- Developed by the University of Melbourne with Victorian Department of Human Services
- Embodies criteria surgeons consider for placement on joint replacement waiting lists
- Provides an indication of severity of arthritis
- Enables prioritisation of hip and knee orthopaedic outpatient appointments and assists prioritisation for surgery
Results

Referral framework

• Articulates the need for good communication between multidisciplinary care providers and between the GP and the patient
• Highlights the role of the multidisciplinary team in optimising management prior to assessment and surgery
• Links to chronic disease items on MBS

Implications for practice

The GP has a central role in the referral framework:

• Optimising conservative management
• Initial assessment of the severity of the patient’s arthritis
• Assessment of the patient’s willingness for surgery
• Assessment of fitness for surgery & stabilisation of co-morbidities
• Liaison with multidisciplinary care providers
• Regular clinical review of the patient

Potential barriers to incorporation of the standard referral form into practice

• Multiple referral forms for various conditions may not be practical
• Standardised referral forms may already be in use in some settings
• Need multi-level support for use of the form - health system, hospital, GP and patient

Conclusions

• Need for surgery, willingness to have surgery and fitness for surgery are factors the GP should consider when deciding to refer
• A standard referral form will facilitate equitable prioritisation of individuals with arthritis requiring orthopaedic assessment for possible joint replacement surgery
• Communication between the multidisciplinary care providers is an important part of optimising conservative management

“Ensuring the right person accesses the right care at the right time…..”

Thank you

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