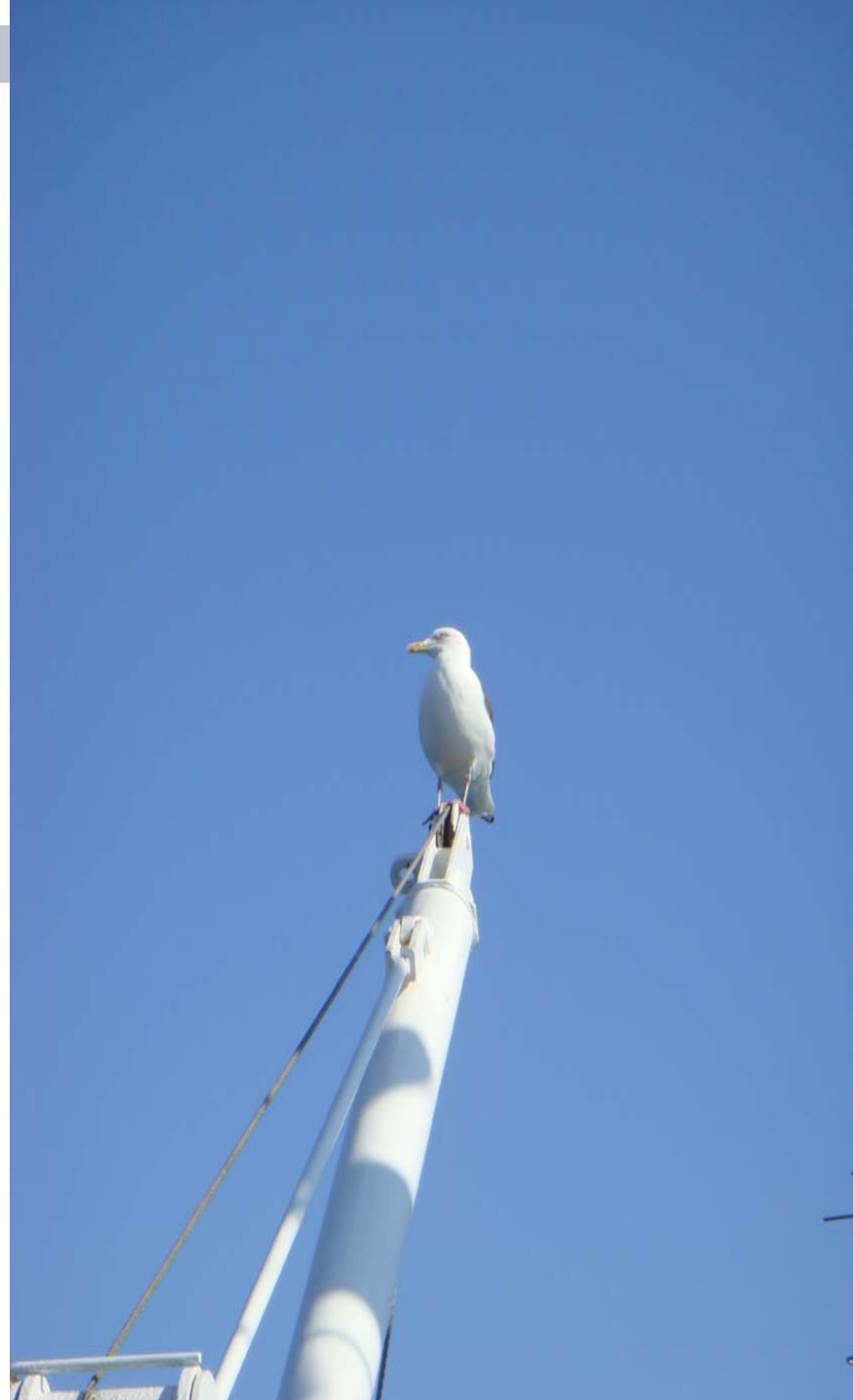
# *Studying referral rate & rate of inappropriate referral in Caritas Medical Center Family Medicine Training Center 2007*

SC Young

6th May 2008



“整形外科新症 最長輪候**124**周 (明報)

03月 28日 星期五 05:05AM

- 專科輪候時間有惡化趨勢。
- 醫管局大會討論08/09年度工作計劃指出，在2000年，外科、內科、矯形及創傷外科平均輪候時間約5星期，
- 但2006年輪候時間平均爲10至17星期。”

“不推醫療融資 專科輪候長3倍 (明報)

03月 17日 星期一 05:05AM

- 醫療融資諮詢文件指出，7年後公立醫院內科（糖尿、高血壓）專科門診的輪候時間，會由現時20星期增至76星期，
- 白內障手術則由現時3年延長至6年”

**The secondary care in public sector is really overloaded**

**Primary care doctors must take an active gate keeping role to reduce burden in secondary care**

# Objectives

1. To assess referral rate & referral pattern
2. To assess rate of inappropriate referral
3. To review and suggest on measures to improve the appropriateness

## Method

- **Cross-sectional study**
- **reviewing 190 referrals out of 4843 consultations**
- **from 5th to 31st March 2007 (4 week period)**

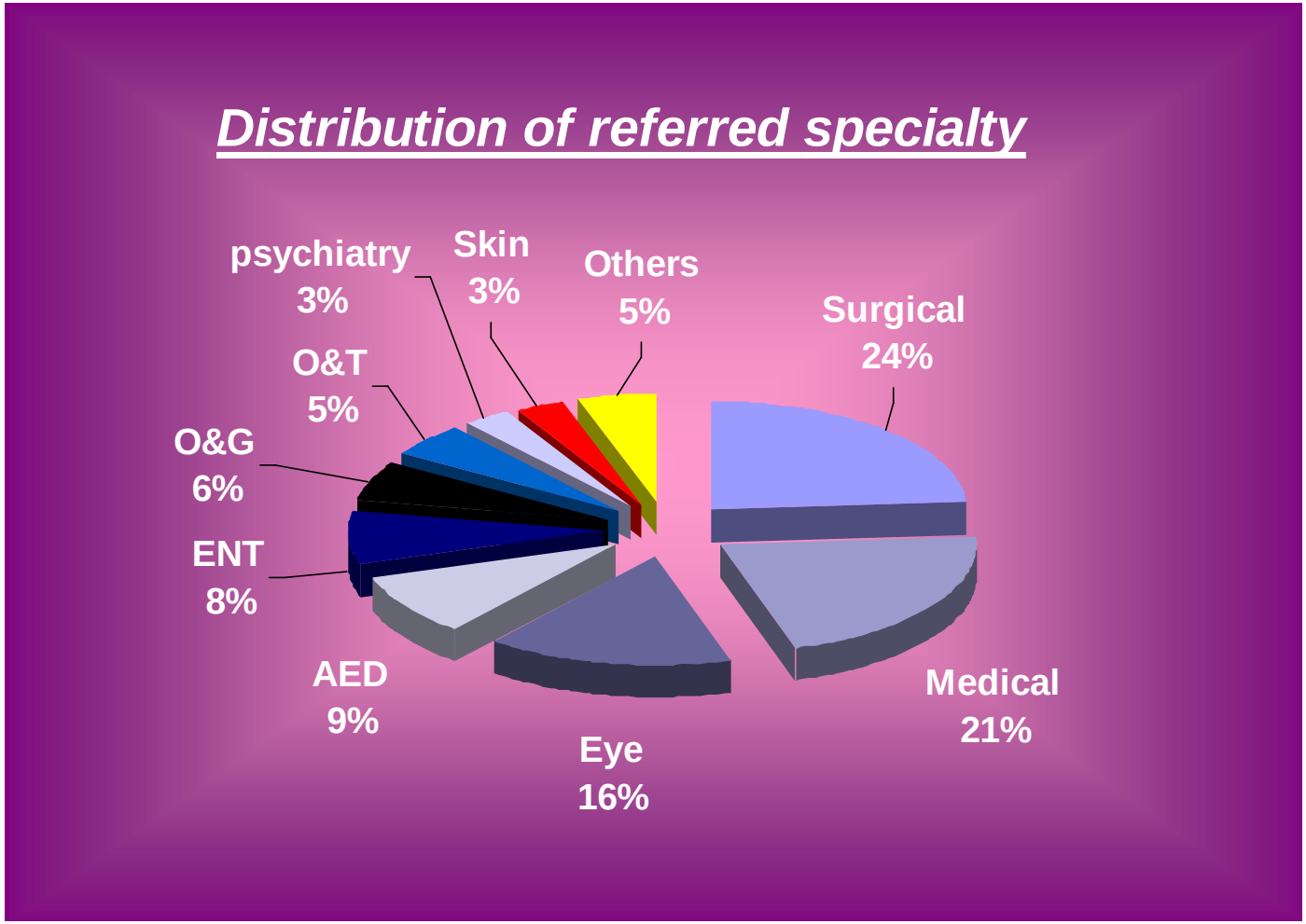
- **Referrals to paramedical specialties or for advancement of appointment were excluded**

## Method

- 171 referrals were reviewed
- Each referral letter being evaluated by 2 family medicine specialists
- A third family medicine specialist would be asked to assess cases with any discrepancy between the former 2 specialists

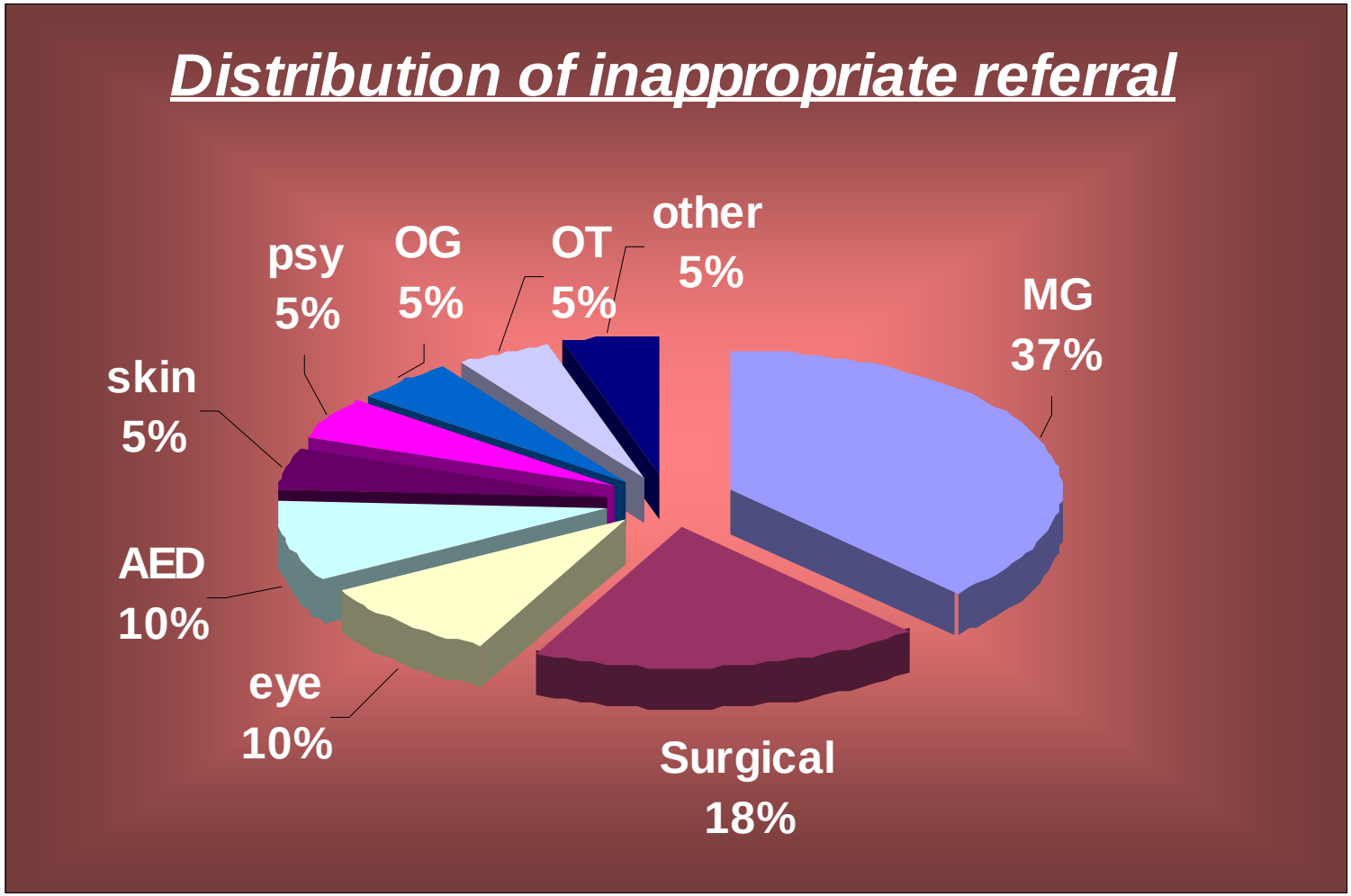
# Result

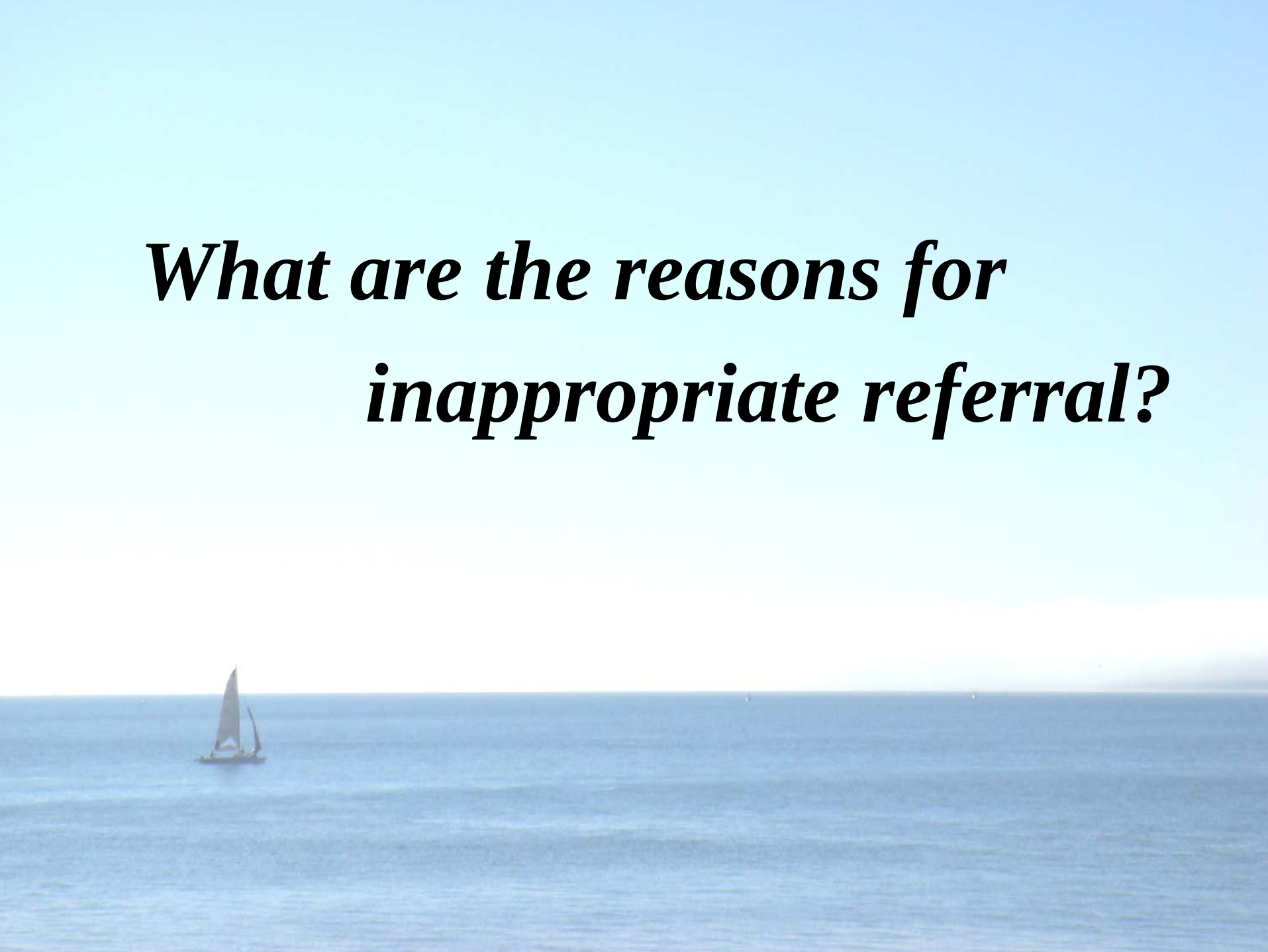
## The referral rate in our study was 3.5%



# Result

## The rate of inappropriate referral was 12.9%




*What are the reasons for inappropriate referral?*

# Inappropriate referral to MOPD

| | ***Reasons for referral*** | ***Reasons for inappropriate referral*** |
|---|---|---|
| 1. | Dyspepsia for 1/12 failed H2 blocker | No trial of PPI before referral |
| 2. | Dyspepsia for 6/12 with peptic ulcer features | No trial of PPI before referral |
| 3. | Recurrent reflux for 2/12, patient anxiety | No trial of PPI before referral |
| 4. | Incidental murmur found on lady with dizziness | Inadequate clincal information and doctor's knowledge |

# Inappropriate referral to MOPD

| | ***Reasons for referral*** | ***Reasons for inappropriate referral*** |
|---|---|---|
| 5. | Incidental finding of raised ALP in a lady with poor DM control | Inadequate clinical assessment & problem solving skill |
| 6. | Rt side numbness for 6/12 ? CVA | Inadequate clinical assessment & problem solving skill |
| 7. | Snoring for 20 yrs, ?OSA | Inadequate clinical information |
| 8. | Newly DX DM, start on statin | Poor communication skills |

## Reasons for inappropriate referrals were categorised into

- Inadequate clinical information provided and doctors' knowledge
- Failed in trial of available resources in primary care setting
- Lack of communication and problem solving skill in handling patient's anxiety


*Any way to improve*
*inappropriate referral ?*

***Active local educational interventions involving secondary care specialists shown impact on referral rate***

**Interventions to improve outpatient referrals from primary care to secondary care**

***Grimshaw, JM***

***Cochrane Database of Systemic Reviews***

***Volume (4) 2007***

# The Hong Kong College of Family Physicians

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| | |
|---|---|
| **Speaker(s):** | Dr Ai Hiu Fay, Dawn Teresa, Dr Peter J Lin, Prof Peter Yan, Prof Brian Tomlinson, Dr Benjamin Cheah, Dr Irwin C A Chung |
| **Fees:** | Members : Free Non-Members : HK$300 HKAM Registrants : HK$150 |

| | |
|---|---|
| **Date:** | Sunday, March 16, 2008 |
| **Topic/ Programme:** | Management of Peripheral Arterial Disease for Primary Care |
| **CME Points:** | 2 |
| **Time:** | 1:00 -4:00 pm |
| **Main Organizer:** | HKCFP |
| **Venue:** | Pearl Ballroom, 2/F., Eaton Hotel, 380 Nathan Road, Kowloon |
| **Speaker(s):** | Dr. Chiu Kai Ming, Leo - Specialist in General Surgery, Central Vascular Clinic Dr. Siu Kam Wang - Specialist in Radiology, Hong Kong Baptist Hospital Dr. Fong Ka Yeung, Jason - Specialist in Neurology, Private Practice Dr. Kwok On Ki, Angel - Associate Consultant, Dept of Anaesthesiology, Kwong Wah Hospital |
| **Fees:** | Members : Free Non-Members : HK$300 HKAM Registants : Hk$150 |

**HKCFP CME Calendar**

◀ 2008 ▶ HKCFP ◀ March ▶

| Su | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | | 1 |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 30 | 31 | | | | | |

**Effective if referral guidelines are constructed with**

- **Secondary care providers**
- **Reflect local circumstances & address local barriers**

**Interventions to improve outpatient referrals from primary care to secondary care**

***Grimshaw, JM***

***Cochrane Database of Systemic Reviews***

***Volume (4) 2007***

# Management guideline on Dyspepsia

By Guideline Working Group of KWC FM & PHC

Draft 6 Jul 07

A working group in the Dept of KWC FM & PHC was convened in May 2007 to review management strategies for dyspepsia, based on a review of the latest evidence and best clinical practice.

## General approach to dyspeptic patients in GOPC

1. In primary care, described symptoms of dyspepsia are a poor predictor of significant disease or underlying pathology (e.g. peptic ulcer, GERD, dysmotility, functional dyspepsia).[1]
2. While the grouping of patients according to symptom clusters is of little value in predicting underlying structural disease or in guiding initial management, this does not detract from the importance of careful clinical evaluation.
3. Clinical evaluation is important in excluding cardiac, hepato-biliary causes, and for exploring the psychosocial factors that often have a major impact on the success of management.
4. Although **alarm signs and symptoms** (i.e. unexplained weight loss, repeated vomiting, progressive dysphagia, iron deficiency anemia, jaundice, an epigastric mass) are only weak predictors of major pathology,[2,3] they are almost always present in dyspeptic patients with upper GI cancer. They raise the index of suspicion and are therefore used **as indicators for referral**.[5]
5. Routine endoscopic investigation of patients of any age presenting with dyspepsia and without alarm signs is **not necessary**.[5]
6. Indications of prompt OGD:

   i) patients of any age with dyspepsia when presenting with any of these **alarm signs or symptoms** (i.e. unexplained weight loss, repeated vomi

# *Use of in-house second opinion and other intermediate primary care based alternatives to outpatient referral appear promising*

- 20-30% referral rate could be reduced

**Interventions to improve outpatient referrals from primary care to secondary care**

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***Volume (4) 2007***

# 醫管局推出家庭醫學專科門診 (FMSC)

- 二〇〇五年十二月一日開始，十八間家庭醫學專科門診診所啓動
- 診所由家庭醫學專科醫生管理及主診，處理一些病情較爲復雜及需專科診治及支援的病人
- 家庭醫學專科診所主要負責分流病人，接收由專科門診、私家醫生及急症室等轉介的非緊急病症，縮短輪候時間，中心亦會將合適的病人轉介至私家醫生。

# *Enhancement of primary care capacity may be useful*

- for example enhancing the services provided before a referral (e.g. providing access and skills in minor operations)

**Interventions to improve outpatient referrals from primary care to secondary care**

***Grimshaw, JM***

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***Volume (4) 2007***

**From our studies,**

**On review inappropriate referrals, trainees did not understand reasons of inappropriateness**

**→ Feedback from family medicine specialist, discussion of inappropriate referred case will be beneficial**

## *Conclusion*

- **Primary care doctors' pivotal role in gate keeping helps in releasing referral load in secondary care**

- **Secondary care provider involvement can make a significant improvement in referral rate**

- **Enhancing primary care training and capacity helps to improve rate of inappropriate referral**


*Thank you*