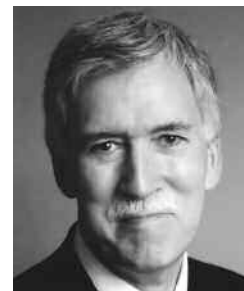


Improving Access to Rheumatology Care: A Continuing Challenge



More effective disease modifying and biologic drugs for rheumatoid arthritis (RA) and the documented benefits of early treatment have created a priority for rapid access to rheumatology consultation^{1,2}. Unfortunately, long wait times preclude such care in many communities, and the projected deficit of rheumatologists in the United States relative to demand is expected to worsen this access problem³. A common response among rheumatologists has been to identify these “early arthritis patients” and schedule them preferentially.

The report by Thompson and Graydon in this issue of *The Journal* describes a process for triaging the urgency of referrals, and assesses its performance⁴. Each referral during a 4-month pilot test was stratified from high to low urgency by the practicing rheumatologist based on the information provided by referring providers. Then these patients were stratified again after their rheumatology consultation, and the 2 rankings were compared.

Long wait times to appointments averaging 48 days occurred in their “urgent” group, and delays were even longer in others, documenting the problem they were attempting to solve. The mean interval of 7 months from onset of patients’ symptoms to their appointment was as troubling, even more so because 31% of their patients turned out to have inflammatory arthritis.

The performance of their triage process was also unsettling; only 59% of patients considered urgent after consultation had been assigned that priority initially. At the same time, other patients with an incorrect urgent grade at triage occupied early appointments that may have been better used for the truly urgent patients that they were unable to identify. While the problem in some misclassified patients was a worsening of their disease during their prolonged waits, the primary difficulty was a lack of necessary history and examination data in referring physicians’ evaluations; only musculoskeletal pain and laboratory tests were consistently reported. In any case, this commonly used triage approach did not solve the problem at hand.

The authors’ commitments to addressing their wait time, and their use of clinical process improvement methods, are to be commended. It is important that they measured the per-

formance of their process rather than just implementing it and accepting whatever happened. The negative result of this first Plan-Do-Study-Act cycle provides a basis for their performing additional tests of change to either refine their triage process or evaluate other approaches to improving this practice’s access. Their discussion thoughtfully reviews the access literature and considers the pros and cons of alternative possibilities. Their report not only informs other rheumatologists dealing with similar concerns, but it also demonstrates the power and efficiency of process improvement methods in changing complex clinical processes for the better.

Simple clinical criteria have been validated for identifying those patients who may have early inflammatory arthritis⁵, but it is clear that referring physicians do not use them, and that high variance is the rule in primary care assessment of musculoskeletal symptoms. The authors’ findings resonate with all rheumatologists in this respect, and in my opinion they correctly discard the expectation of improving referring physician performance through education. It is widely recognized that improving the performance of individual physicians rather than redesigning the processes themselves cannot resolve system-level problems with quality of care⁶.

Referral decisions would be more likely to improve, as the authors indicate in their discussion, through system-level use of well trained mid-level providers to evaluate and coordinate care for patients with persisting musculoskeletal symptoms using standardized protocols at a central location. To be acceptable to primary physicians in the US, this approach would need to be reconciled somehow with the traditional role of primary care in coordinating referrals and the widely advocated decentralized “medical home” paradigm⁷. The effectiveness of nurses coordinating chronic disease care within systems based on interdisciplinary algorithms has also been reported^{8,9}. Other approaches to improving new patient access mentioned by the authors include an alternative use of triage to eliminate unnecessary consultations¹⁰ and use of advanced access methods to eliminate unnecessary work and backlog¹¹. These processes free rheumatologists to see all necessary consults in a more

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timely fashion up to the point where capacity mandates adding providers, but they are unacceptable in fee-for-service environments because maintaining open access threatens revenues.

Taking a broader view, we must recognize that access to rheumatology care is but one example of disordered patient flow through highly variable, weakly-integrated health systems, and that this problem is a major contributor to the waste, ineffectiveness, and high costs of healthcare and to suboptimal disease outcomes⁶. The same access problems that affect arthritis patients affect those with all chronic diseases, and these problems will not be resolved unless the referral interface is redesigned across specialties, systems, and diseases.

The primary care-medical specialist interface is a critical area for improving chronic disease care, as the authors have recognized. Referral decisions are often driven by patient demand and enabled by accommodating providers rather than being based on rational criteria, data, and need. Specialists who have the knowledge to contribute to more appropriate decisions too often accept the decisions of others, and view unacceptable wait times as inevitable. Equally disturbing is the high percentage of patients who are not referred until after their "window of opportunity" has closed. Clinical process improvement methods are well suited for addressing referral problems^{12,13}, but the shared responsibility for doing this must first be acknowledged by both specialists and our primary care colleagues. For improvement to happen, we must decide together who is going to do what for whom, and then design processes that achieve these goals.

The recently published report of the American College of Rheumatology (ACR) Manpower Task Force documents the likelihood of growing rheumatology supply-demand problems. These will certainly undermine our patient care mission and render rheumatologists irrelevant if we do not move decisively to address them⁴. The Task Force concluded that it will not be possible to improve access through expanding training programs, because no number of rheumatologists practicing as we do now will be sufficient. We recognized that much of rheumatologists' work is unnecessary, is performed inefficiently, and could be done better in other ways than it is now during physician-patient encounters. We recommended practice redesign, process standardization and efficiency, expanded team care, and involvement of other providers as approaches to focusing rheumatologists on our core roles as diagnosticians and problem solvers for patients with serious rheumatic diseases.

Pay-for-performance programs may also penalize rheumatologists financially for suboptimal disease outcomes related to delayed care. The ACR Quality Measures Subcommittee is developing computer-based tools to facilitate practices monitoring and improving the care of rheumatic disease patients. Measuring performance, using quality improvement methods, and sharing important findings broadly across our specialty are all essential to improvement.

Quality performance indicators based on medical evidence will equip rheumatologists to respond to pay-for-performance programs. Measuring our access to necessary care and continuously improving it should become a priority as well. The ACR annual meeting and other initiatives provide opportunities for rheumatologists to become involved in this important and rewarding work and to share our results. We owe this to the patients we serve.

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