

Referrals

Peter von Eichstorff

Contents

- Literature search
- PBC Referral Report
- Questions
- Your tips
- Cochrane Review
- Joke

Question

- Please think of one unique trick of yours that prevents referral.

Referral Variability

Why do we refer the way we do?

- 25 fold variation between GPs
- Dr characteristics
- Organisational characteristics
- Patient's age
- Case mix
- Demographics?

■ *BMJ* 1997;314:1458 (17 May)

BMJ 1997;314:1458 (17 May)

General practice

The effect of deprivation on variations in general practitioners' referral rates: a cross sectional study of computerised data on new medical and surgical outpatient referrals in Nottinghamshire

Julia Hippisley-Cox, *lecturer in general practice*,^a **Carolyn Hardy**, *researcher in general practice*,^a **Mike Pringle**, *professor of general practice*,^a **Katherine Fielding**, *lecturer in medical statistics*,^b **Robin Carlisle**, *research lecturer in general practice*,^a **Clair Chilvers**, *professor of epidemiology*^b

^aDepartment of General Practice, Medical School, Queen's Medical Centre, Nottingham NG7 2UH, ^bTrent Institute for Health Services Research, Medical School, Queen's Medical Centre

Correspondence to: Dr Hippisley-Cox julia.h-cox@nottingham.ac.uk

Table 2 Univariate analysis for total, medical, and surgical referral rates and general practice characteristics

Variable	R ² (%)	Constant	B coefficient (95% CI)	P value
Total referral rates				
UPA(8) score	22.9	201.1	2.1 (1.5 to 2.7)	<0.0001
Singlehanded GP [*]	7.2	202.7	38.7 (18.1 to 59.6)	0.0003
Fundholder ^{**}	5.2	221.1	-47.3 (-77.1 to -17.50)	0.002
Medical referral rates				
UPA(8) score	31.8	117.6	2.5 (1.9 to 3.0)	<0.0001
Singlehanded GP [*]	5.6	123.4	35.3 (13.6 to 57.0)	0.002
Fundholder ^{**}	5.6	140.0	-48.5 (-78.2 to -18.8)	0.002
Surgical referral rate				
UPA(8) score	2.3	83.7	-0.3 (-0.6 to -0.01)	0.04
Singlehanded GP [*]	0.3	79.3	3.9 (-6.1 to 13.9)	0.44
Fundholder ^{**}	0.0	81.3	1.1 (-13.8 to 16.0)	0.89

CI=confidence interval; UPA(8)=underprivileged area; GP=general practitioner.

^{*}Relative to a baseline of practices with more than one doctor.

^{**}Relative to a baseline of non-fundholding practices.

- On multivariate analysis, where partnership size, fundholding status, percentage of men and women aged over 65 years were included, the UPA(8) score explained 29% and 35% of the variation in total and medical referral rates respectively. The addition of other practice characteristics to the analysis does not therefore explain much more of the variation than the UPA(8) score alone.

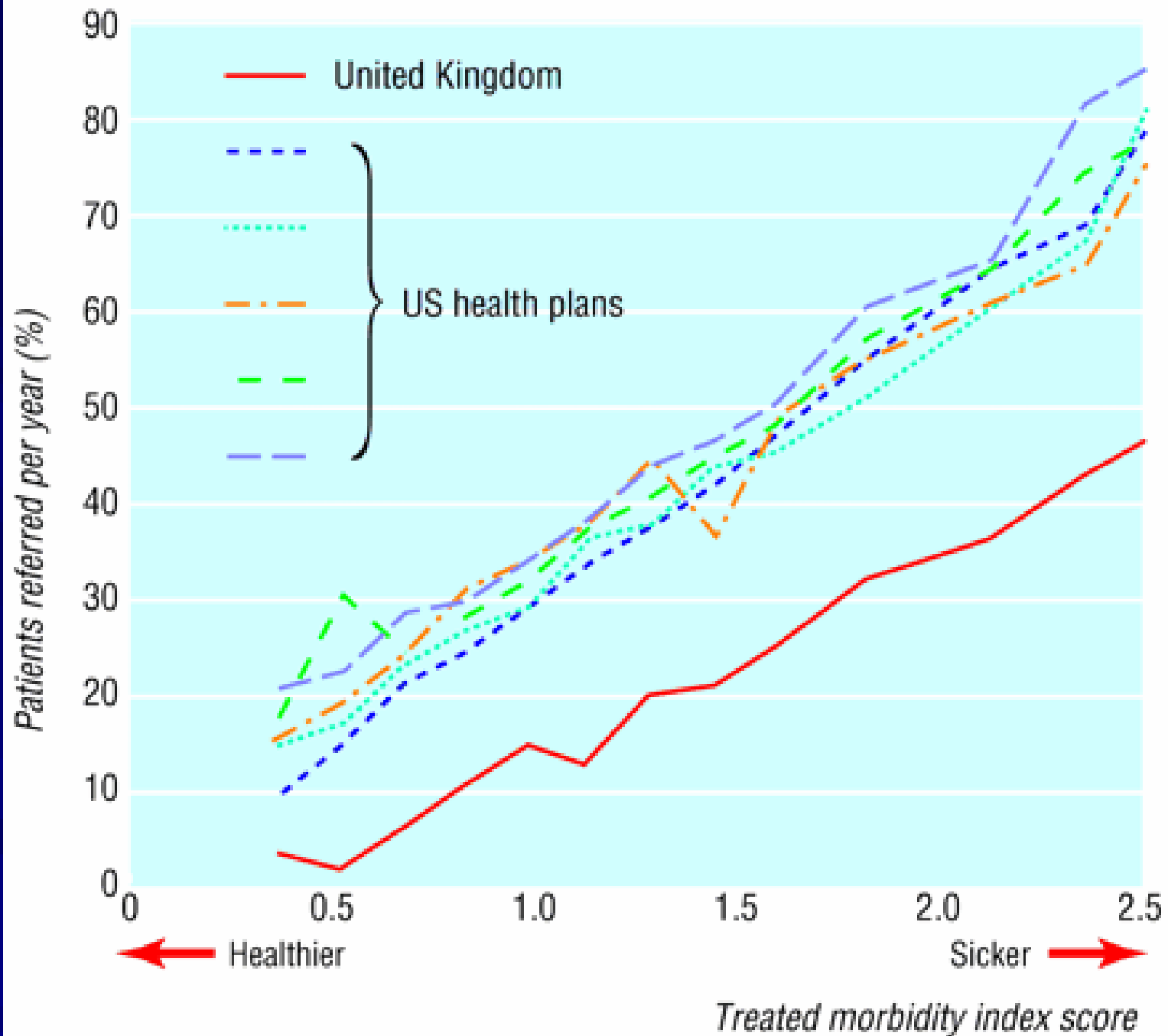
- our results are in broad agreement with recent work showing that morbidity, workload, and drug treatments in primary care increased with decreasing socioeconomic status.

BMJ 2002;325:370-371 (17 August)

Primary care

Comparison of specialty referral rates in the United Kingdom and the United States: retrospective cohort analysis

Christopher B Forrest, *associate professor of health policy and management and paediatrics*^a, Azeem Majeed, *senior lecturer in primary care*^b, Jonathan P Weiner, *professor of health policy and management*^a, Kevin Carroll, *specialist registrar in public health medicine*^c, Andrew B Bindman, *professor of medicine, epidemiology and biostatistics*^d.



Compared with US

- US 1 in 3 referred
- UK 1 in 7 referred
- Low availability of specialists in UK
- Waiting raises threshold in UK
- 2 fold difference for ill and well
- Less intensive / broader scope in UK
- Unlikely referral guidelines will help
- *BMJ* 2002;325:370-371 (17 August)

BMJ 2003;326:692-695 (29 March)

Primary care

Primary care in the United States

Primary care gatekeeping and referrals: effective filter or failed experiment?

Christopher B Forrest, *associate professor.*

Organisational Changes

- General practitioners' exclusive control of the referral process may change as nurse practitioners, nurse specialists, nurse consultants, and staff of NHS walk-in centres gain authority to refer patients. The US experience suggests that this may lead to a substantial increase in rates of referrals to specialists.

■ Andrew Bindman and Azeem Majeed

The main determinants of referral decisions

- prevalence of the presenting problems,
- the overall complexity of the patient,
- physicians' scope-of-practice,
- tolerance of clinical uncertainty,
- availability of specialists in the community.

Christopher B Forrest, Associate Professor
*624 N. Broadway, Rm 689, Johns Hopkins University, Baltimore,
MD 21205 USA*

Litigiphobia

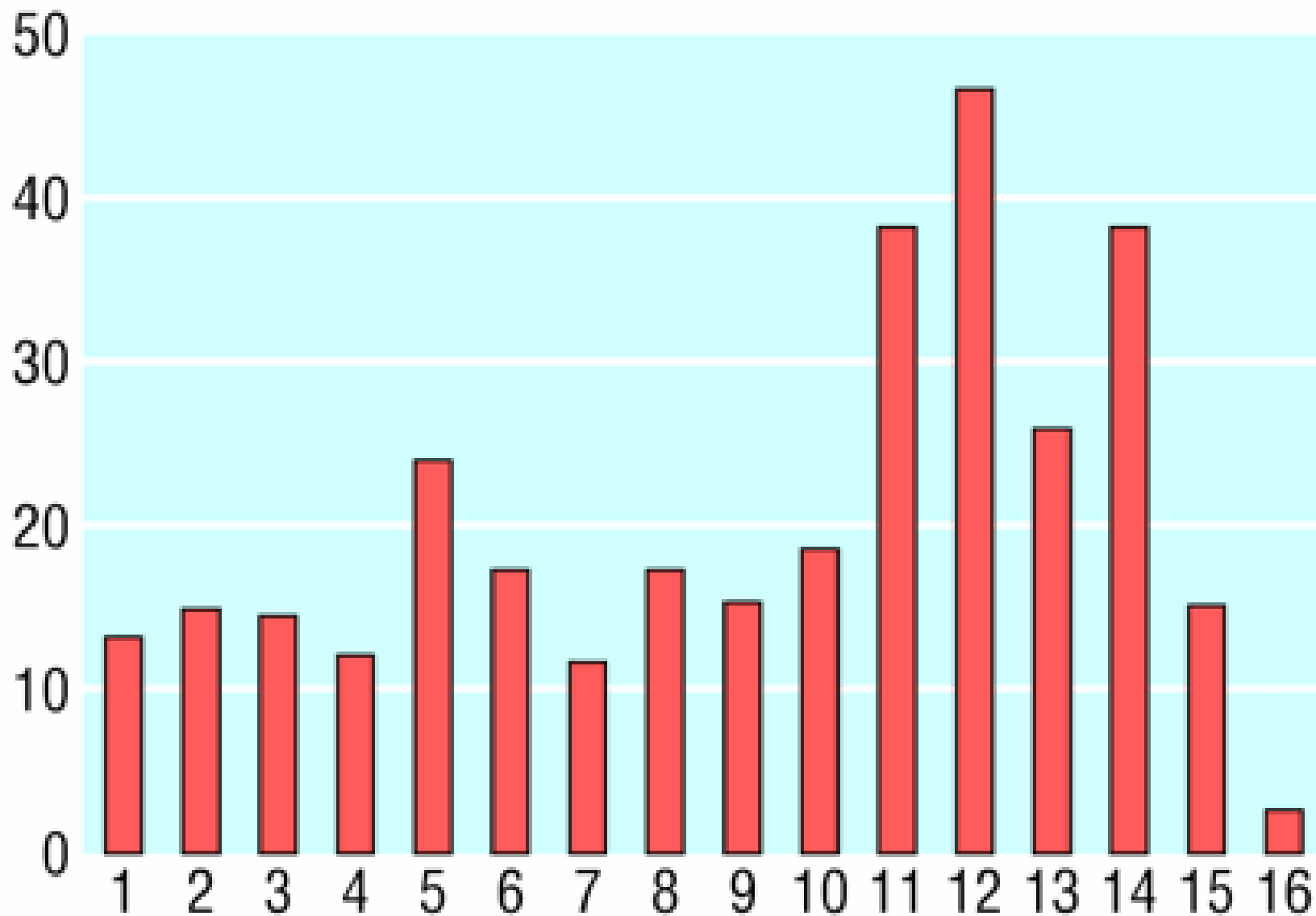
- The impact of physicians' fear of malpractice on referral rates has been studied in the US. Our group has examined thousands of referrals made by primary care physicians and the reasons for making those referrals. Concern about malpractice or "medico-legal" reasons was cited as a reason for referral in no more than 1 in 100 instances.

Dermatology referrals

- Vary from 2 - 47/1000
- 60% should be easily manageable by GP
- Lowest referring practice had clinical asst.
- All referrals triaged
- Similar in orthopaedics and cardiology
- **John F Navein**, *consultant in healthcare modernisation.*

Modernising Healthcare Partnership, Stratford-on-Avon CV37 7HU

Referral rate/1000



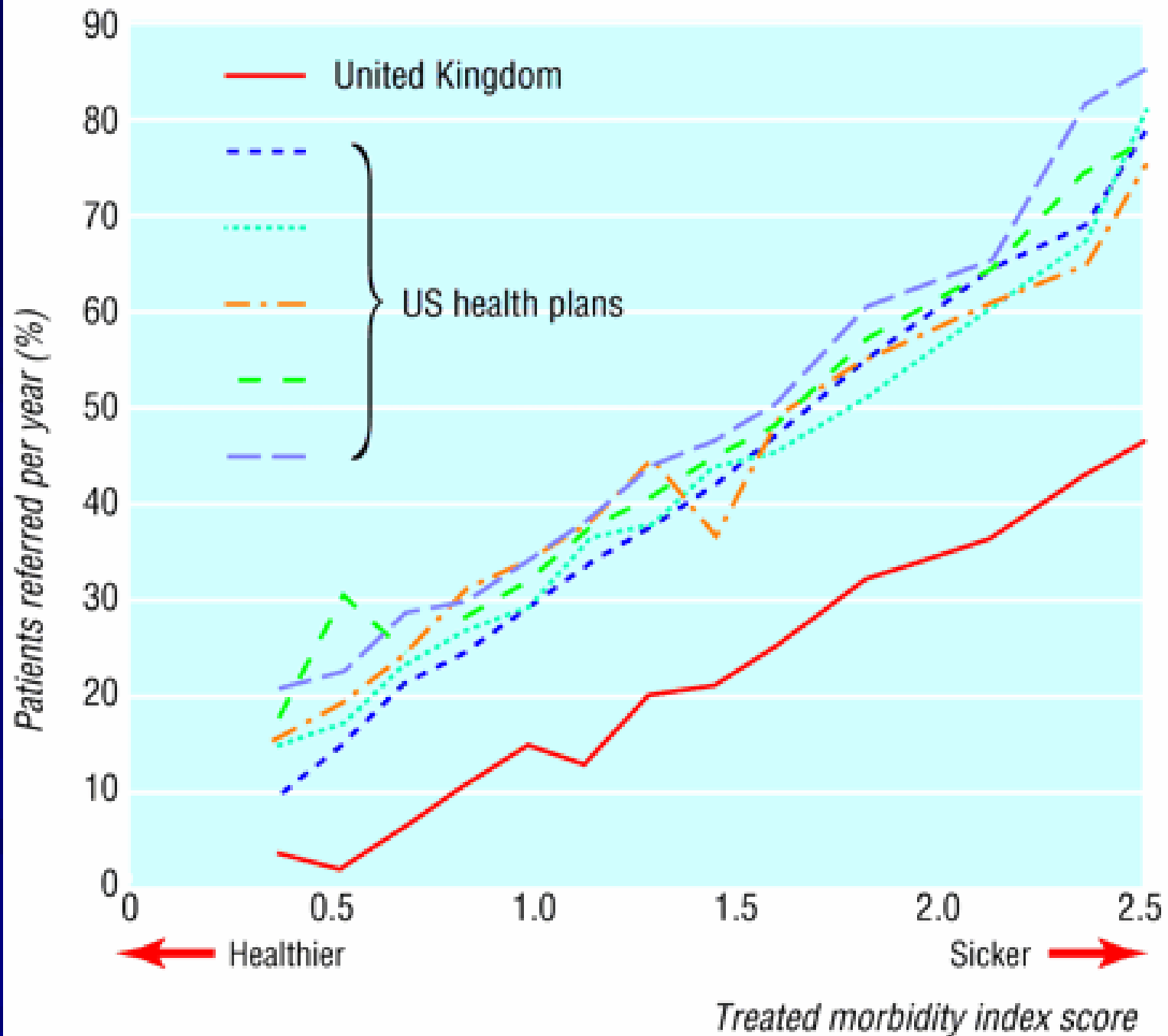
Practice No

Oxford City Picture

- City
- Practice
- GP and specialty

City Referral Rates

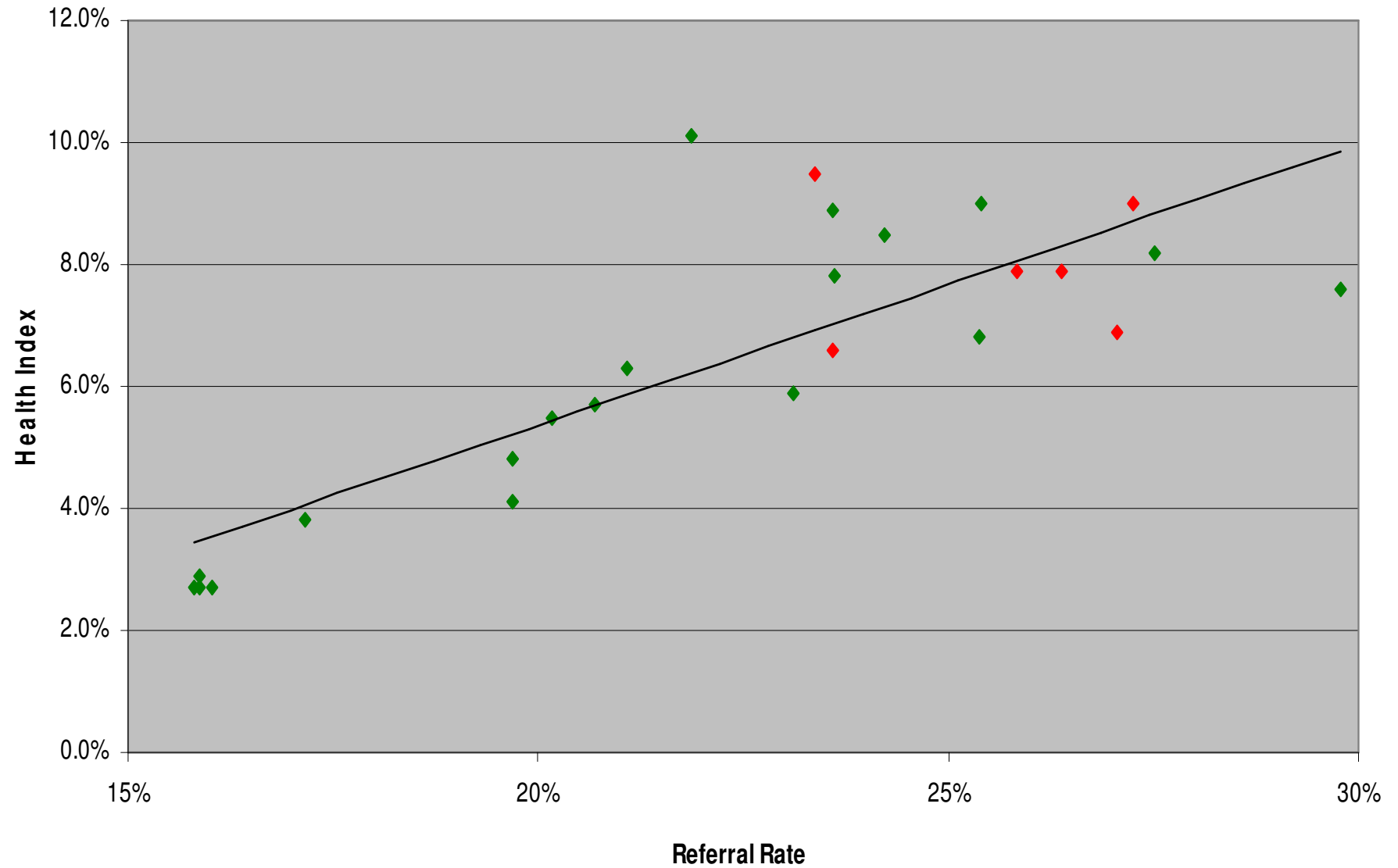
- Are linked to morbidity



Referral Rate (normalised by practice population)

v

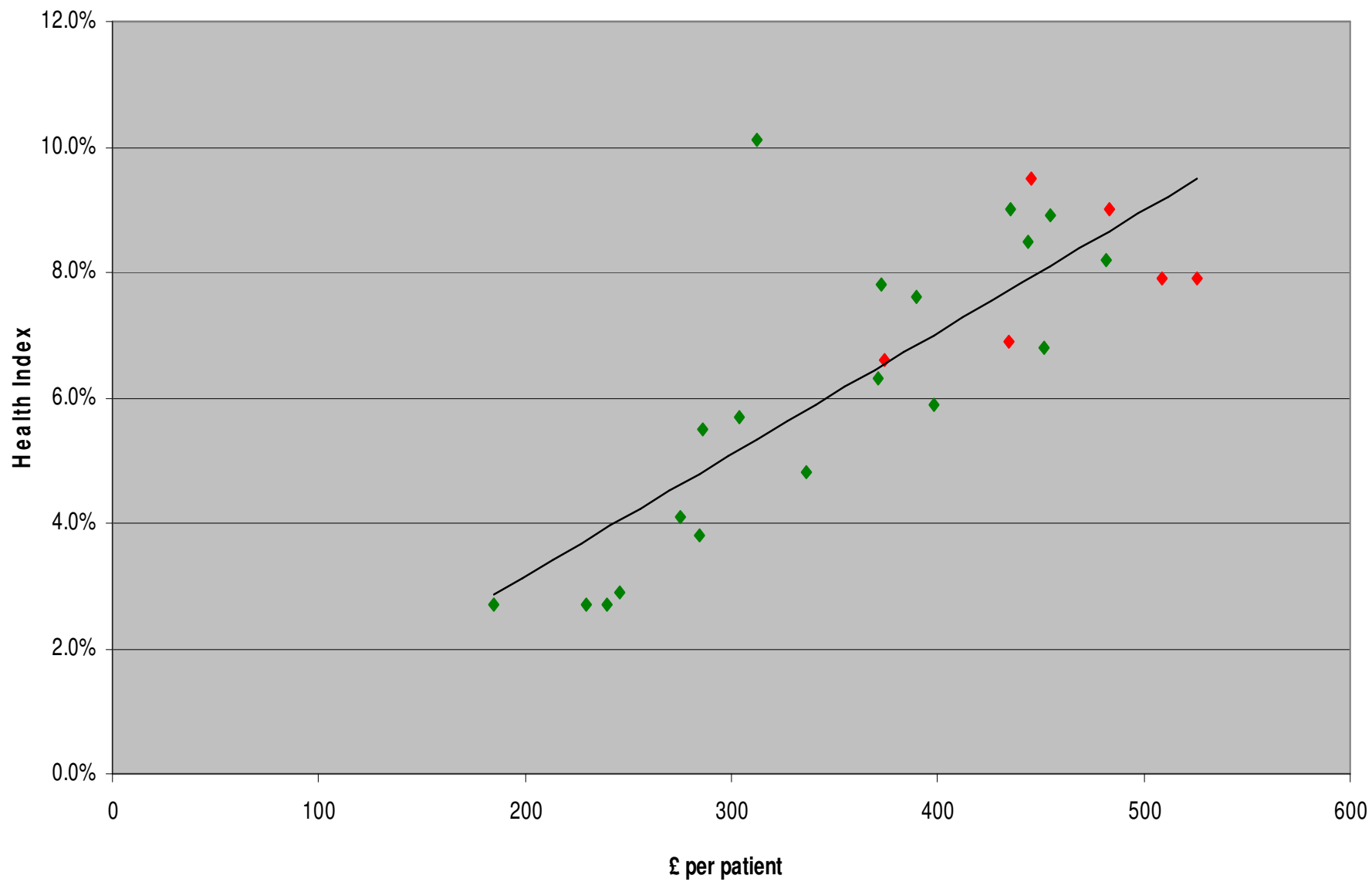
QOF Disease Prevalence (Cancer, CHD, COPD, DM)



Actual Spend, Q1 07/8 (normalised by practice population)

v

QOF Disease Prevalence (Cancer, CHD, COPD, DM)



Practice Referrals

- Thank you
- Consultation rates allow standardisation
- Referral rates of top 9 specialties
- PBC provides quarterly report

Quarterly Referral Report

- Referrals collated by Choose and Book
- Non CAB also coded
- Data up to date
- Data verified by smartcard
- Divided by consultation rate-standardised

Choose and Book

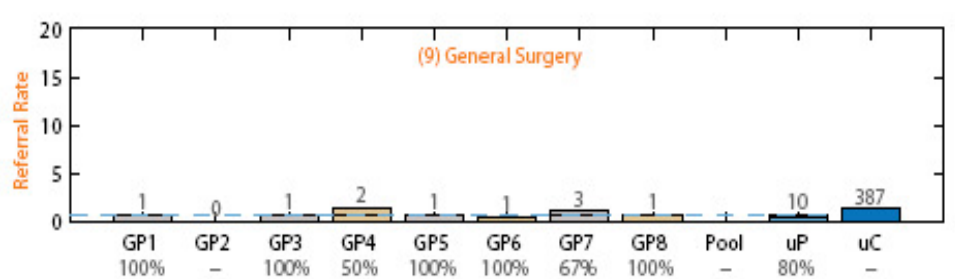
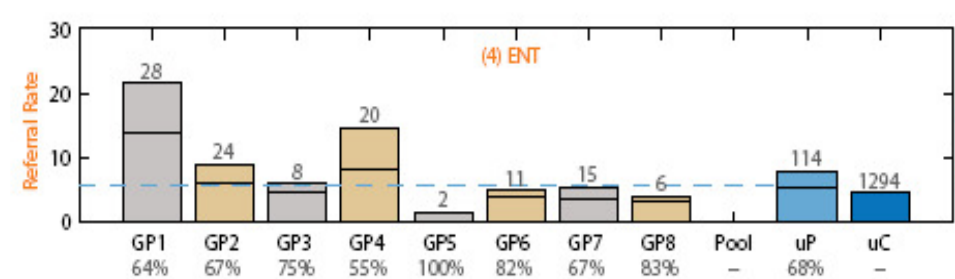
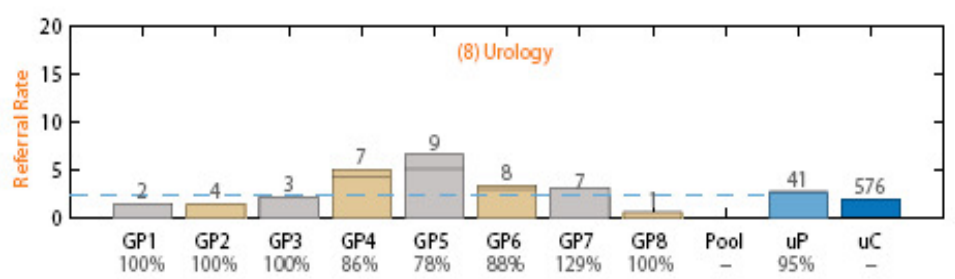
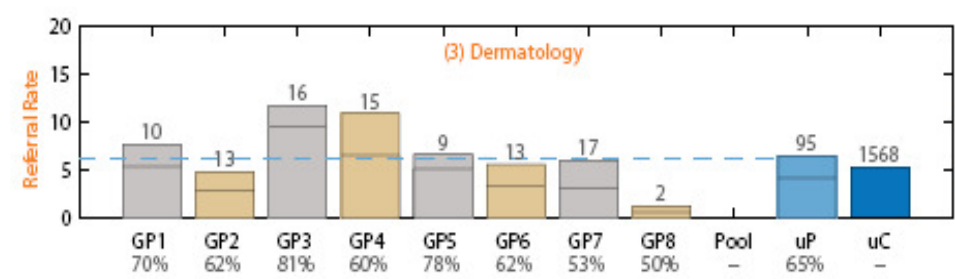
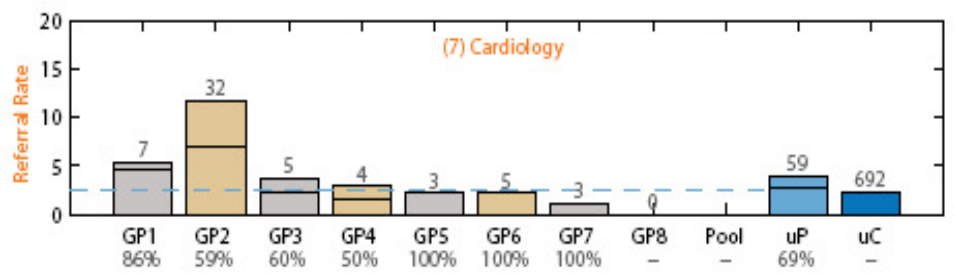
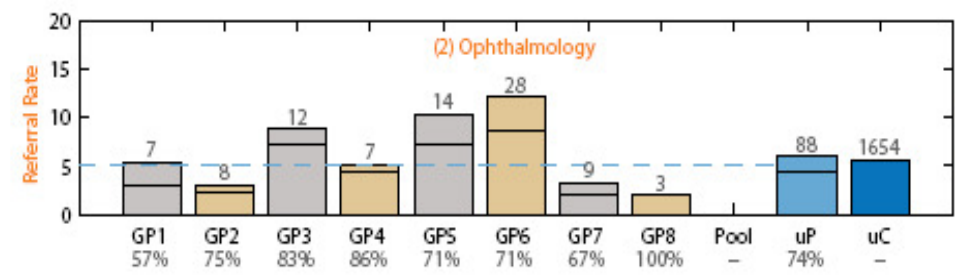
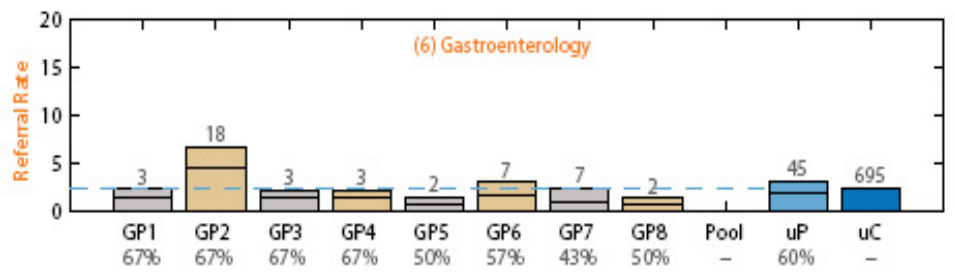
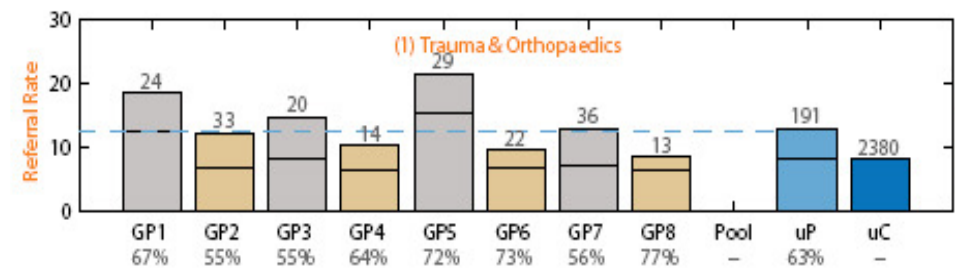
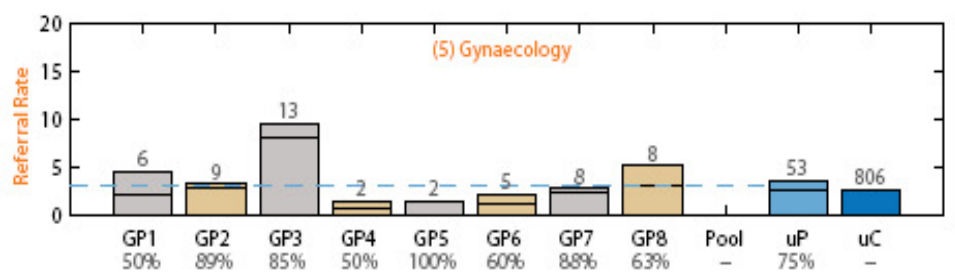
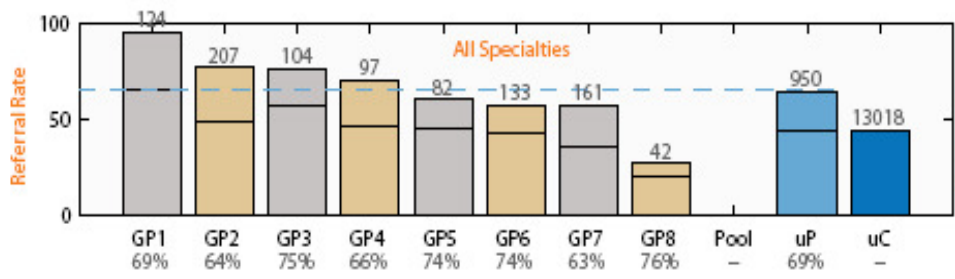
- GP refers
- Patient books or not (conversion rate)
- Receives appointment
- Attends appointment or not (dna rate)

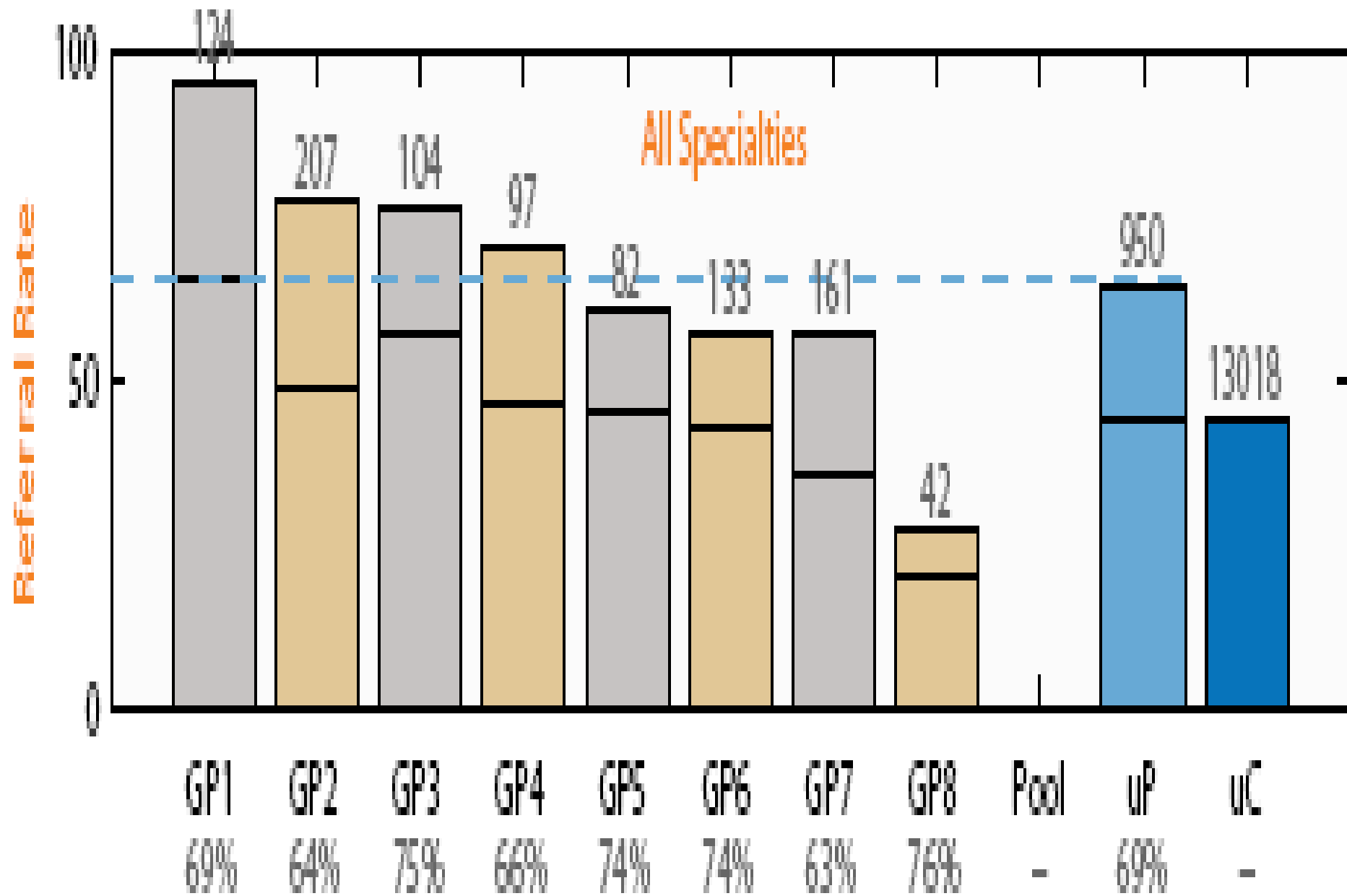
Conversion Rate Variables

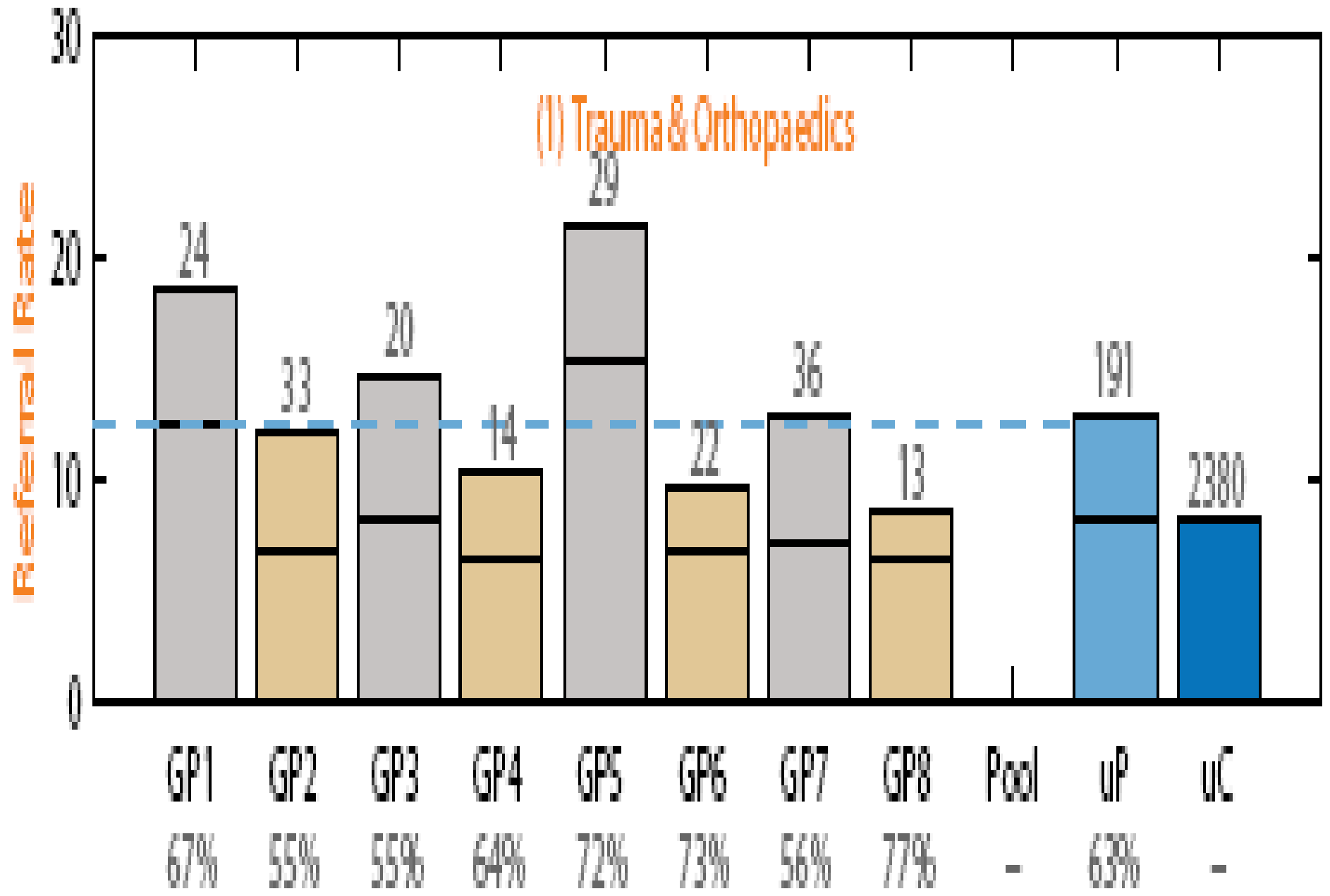
- Patient gets better
- Can't be bothered
- Doesn't understand, IQ, elderly
- Language problems
- Line engaged
- Referral was not agreed

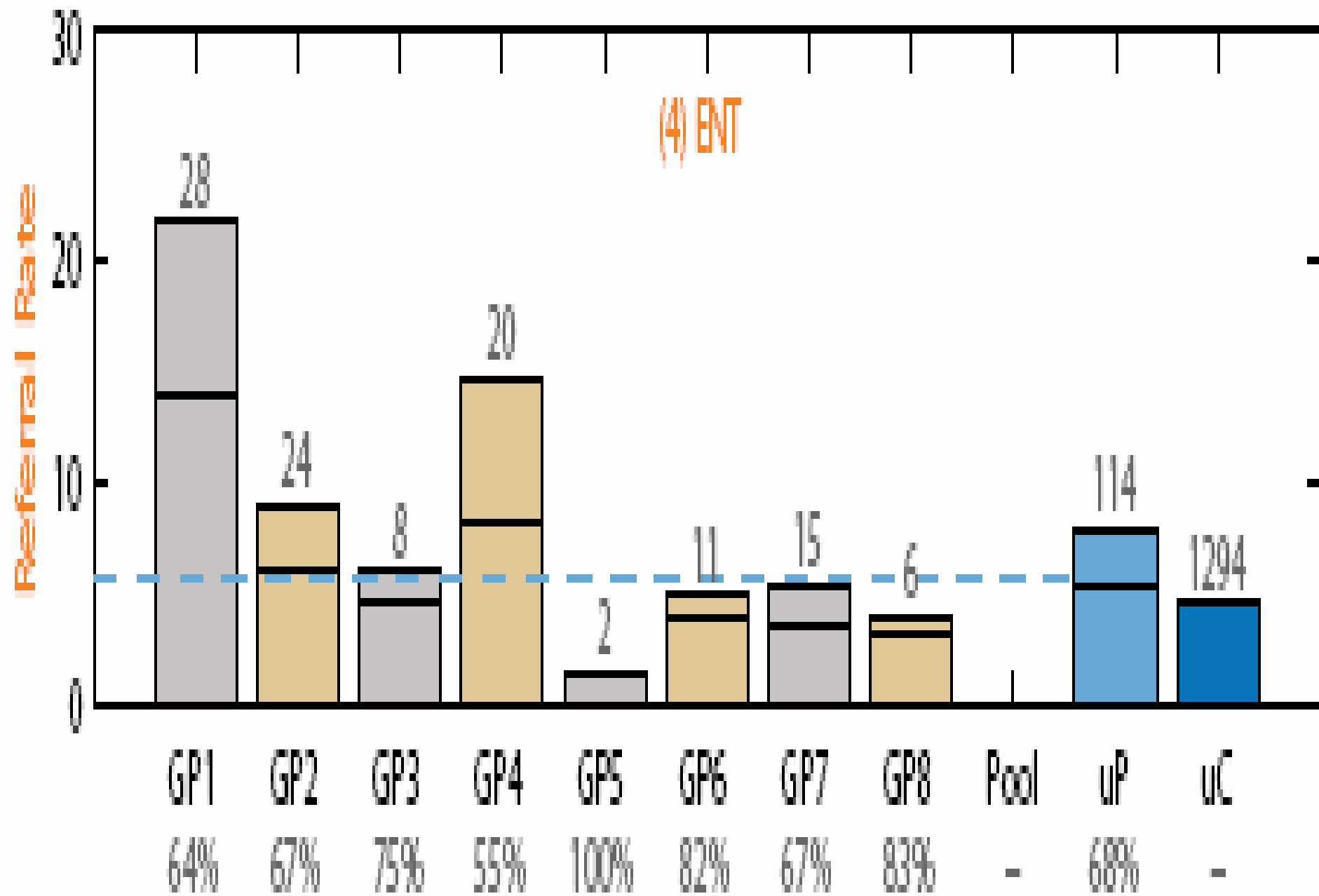
Referral Report Features

- Partners standardised referral rate
- Pool standardised referral rate
- Pool = locums, registrars, retainer etc
- Practice and consortium average
- Number of actual referrals
- Conversion rate

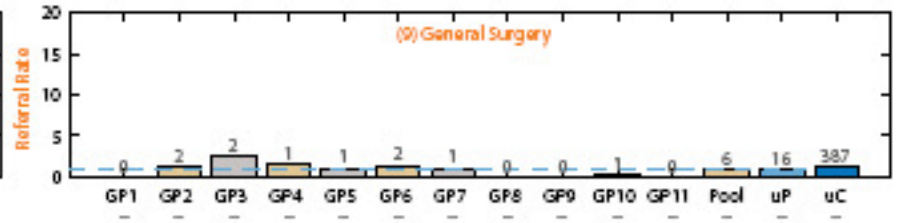
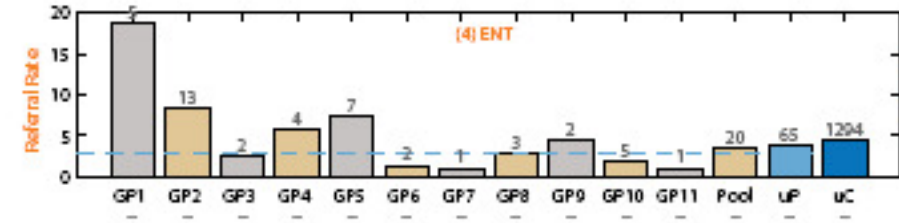
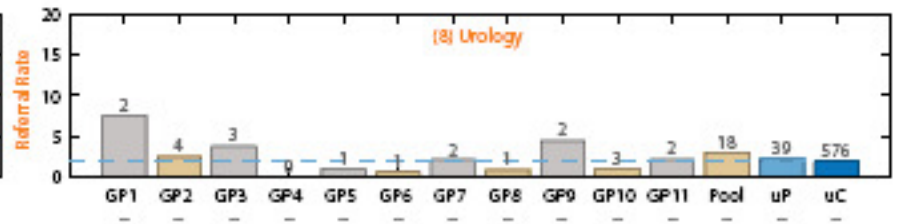
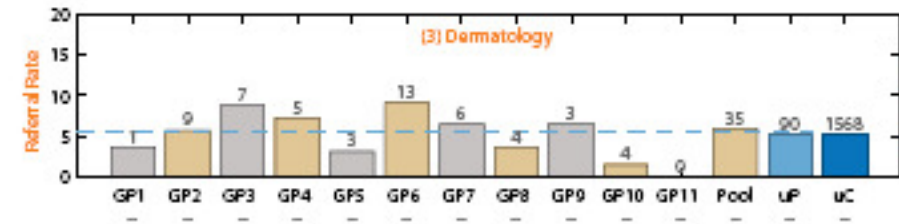
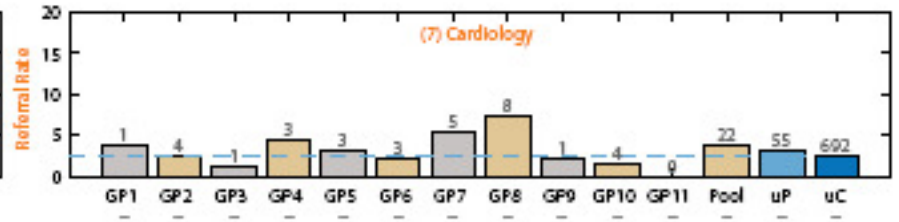
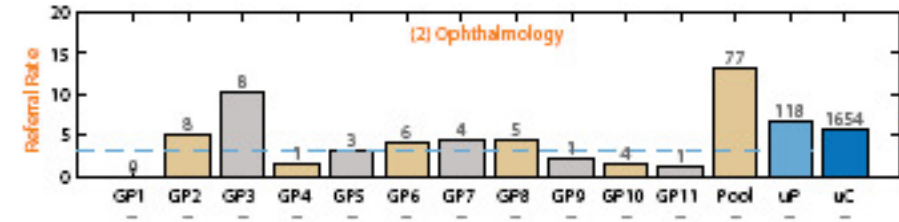
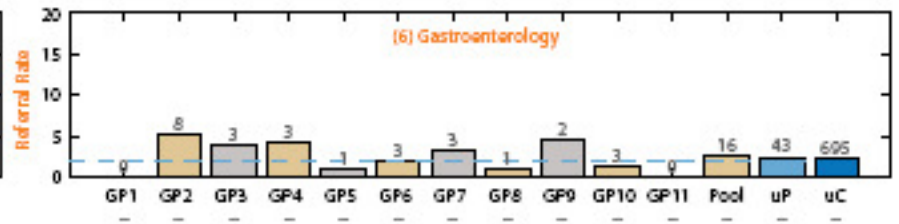
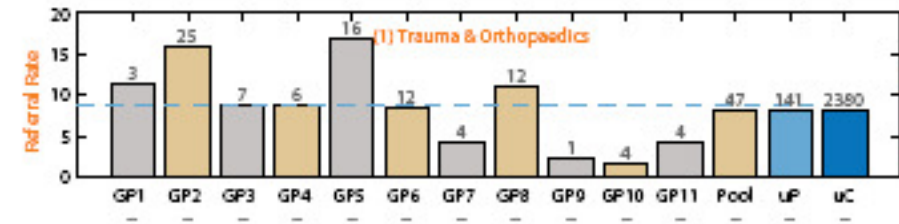
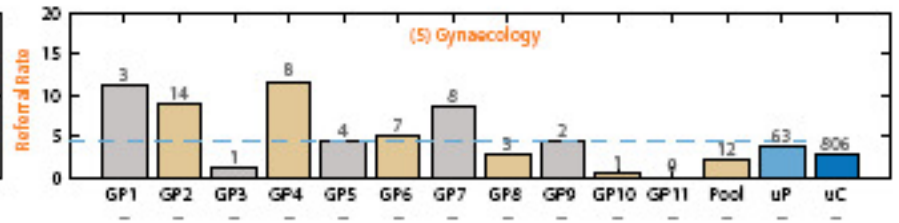
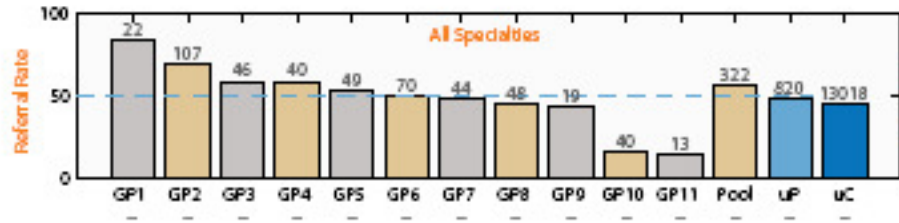




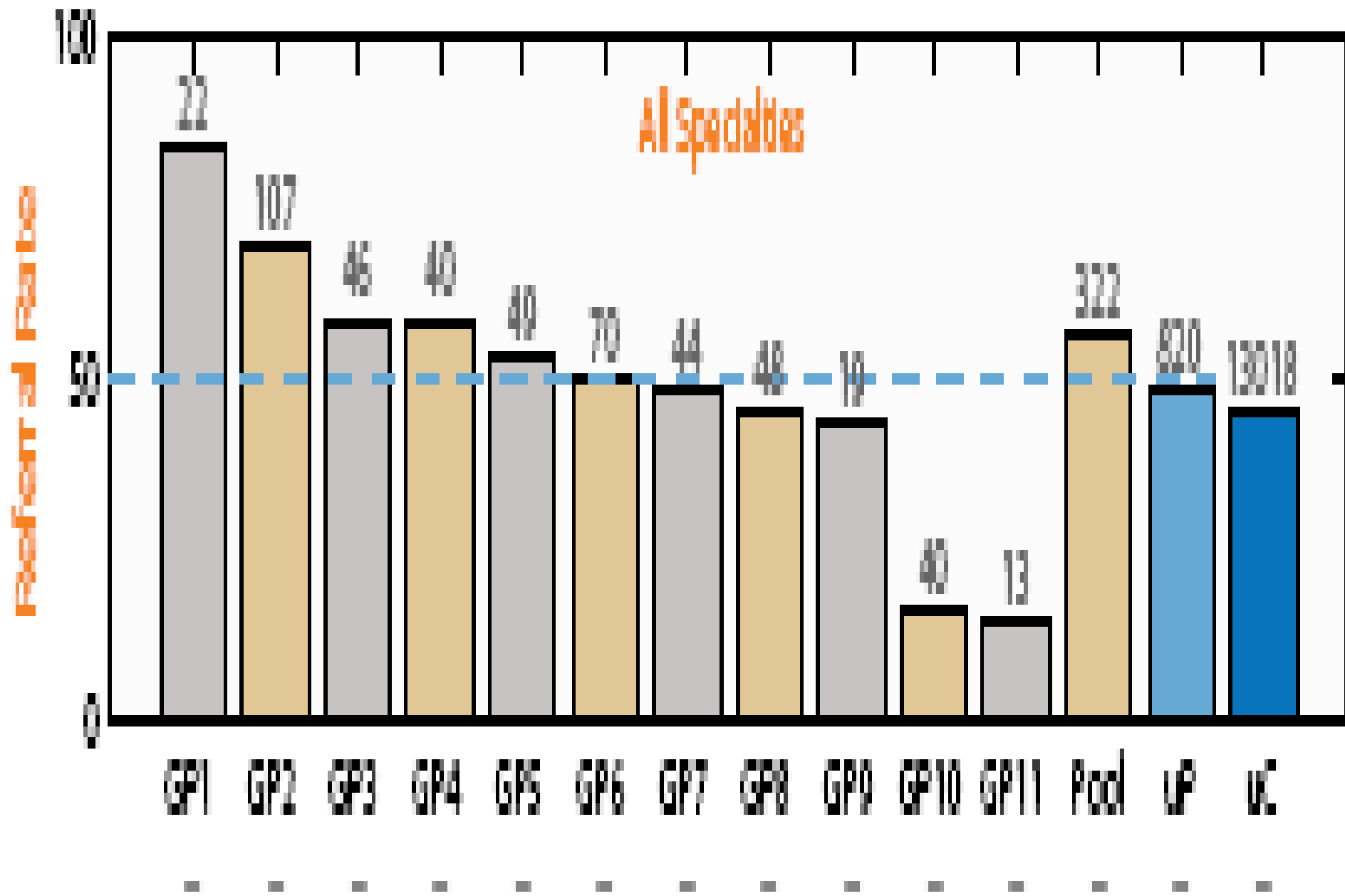




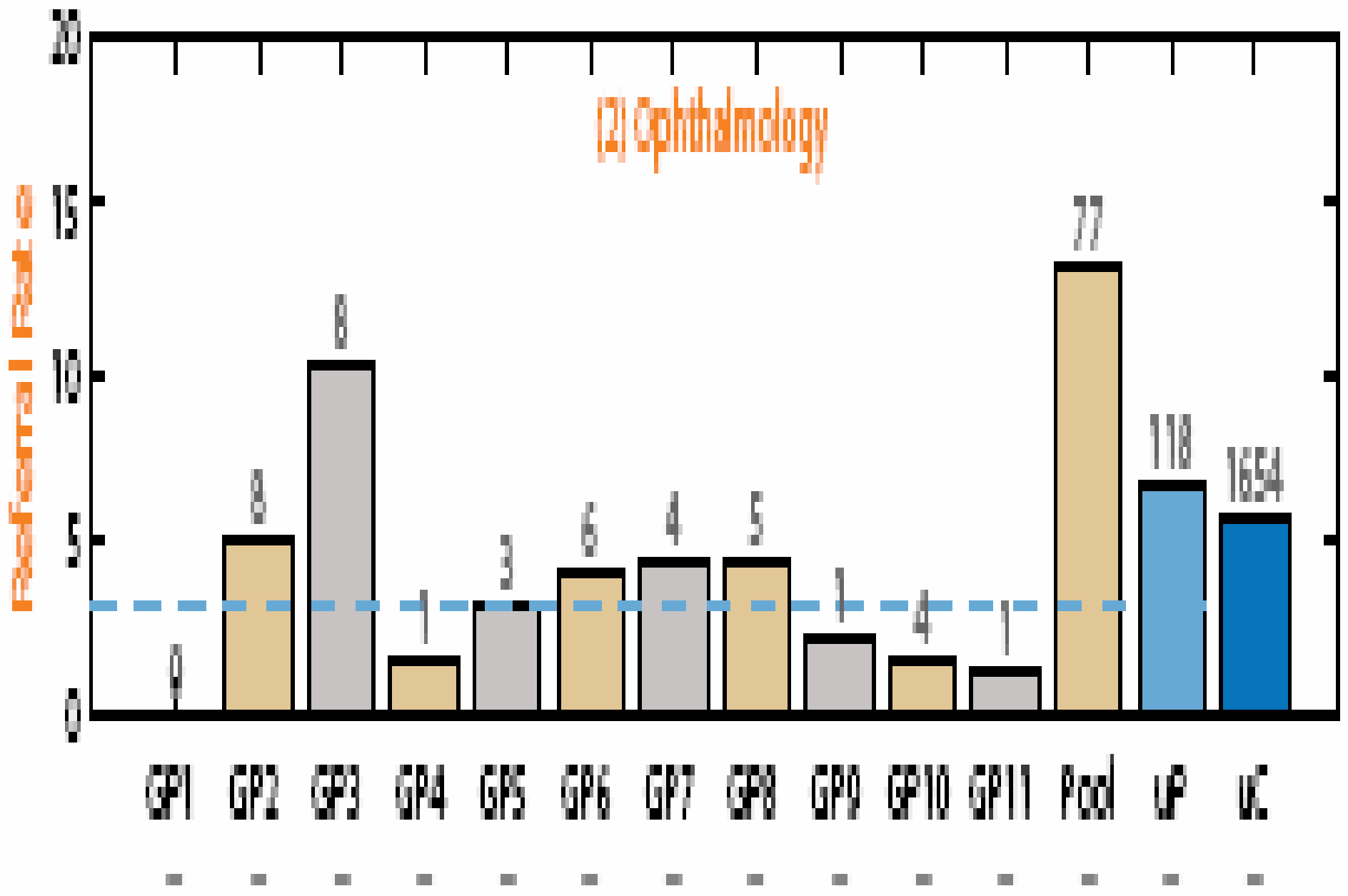
Clinician Profile, Practice Name (CODE), 5/2007 – 12/2007



Please refer to guidance notes for Interpretation, or email richard.gamuska@rns.net



(2) Ophthalmology



Cochrane Review

- Considerable evidence that the referral process can be improved

Objectives

- To estimate the effectiveness and efficiency of interventions to change outpatient referral rates...
- or improve outpatient referral appropriateness.
- Objectively measures provider performance or health outcomes

Results

- 17 Studies
- 9 evaluated professional education
- Ineffective
 - passive guideline dissemination
 - feedback of referral rates
 - discussion with medical adviser

Results

- 17 Studies
- 9 evaluated professional education
- Effective
 - guidelines + structured referral involving consultants in CME
 - organisational interventions

Organisational Interventions

- Family physician vs general internist
- Attachment of physiotherapist
- Requiring a second in-house opinion

all effective

Financial interventions

- Capitation to part fee-for-service
- Fee-for-service to capitation
- Fundholding
- Private referrals

Summary

- CME with secondary care specialists
- Referral sheets
- In-house second opinion
- Intermediate primary care based alternatives

Your suggestions?

GP or Travel Agent?

Soundings

Trisha Greenhalgh, professor of primary health care, University College, London







- The UPA(8) score had been calculated using a weighted average of the percentage of registered patients in each practice according to the electoral wards in which they lived.

Practice Profile, 5/2007 - 12/2007

