Acta Scientific Gastrointestinal Disorders

Volume 1 Issue 1 September 2018

Research Article

Utilization of an Urgent Gastroenterology Clinic for Patients Seen in the Emergency Room or Urgent Care Centre

Khurram J Khan[1]*, Wasel Kabir[2], Baha Alazzoni[3], Houssein Fergani[1], Subhas C Ganguli[1], Subash Jalali[1], David G Morgan[1], Robert Spaziani[1] and Keith Tsoi[1]

[1]Faculty, Division of Gastroenterology, McMaster University, Hamilton, Ontario, Canada

[2]Research staff, St Josephs' Healthcare Hamilton, Hamilton, Ontario, Canada

[3]Resident, Department of Medicine, McMaster University, Hamilton, Ontario, Canada

***Corresponding Author:** Khurram J Khan, Associate Professor, Faculty, Division of Gastroenterology, McMaster University, Hamilton, Ontario, Canada.

Received: May 31, 2018; **Published:** August 28, 2018

Abstract

The Canadian Association of Gastroenterology reports that wait times to see a gastroenterologist are too long, even for urgent problems. A weekly urgent GI clinic (UC) started in March 2014 to improve timely access for patients. The clinic only accepted referrals from the emergency room (ER) and urgent care clinic.

Methods: Retrospective review of patients booked in UC at St Josephs' Healthcare Hamilton between March and October 2014. Demographics, reasons for referrals, duration of symptoms, previous gastroenterology visits, and utilization of endoscopy and clinic resources were collected. Patients who missed their appointment were also reviewed.

Results: Between March and October 2014, 119 patients were seen in the urgent GI clinic and 118 were reviewed. The average age of the patient was 52.9 years. The mean duration of symptoms was 23.4 weeks, but 59% of patients had more acute symptoms for 1 week or less when presenting to ER or urgent care. Common reasons for referrals included lower GI bleeding (31%), abdominal pain (25%), upper GI bleeding (13%), anemia (5%), and dysphagia (3%). A high proportion (71%) were booked for endoscopic tests, and 52% were booked for a follow-up appointment. Thirty-seven patients were absent for their appointment and 22/37 (59%) were contacted with 10 electing not to re-book, 6 were re-booked, 3 were seen as inpatients, and 3 were seen by another outpatient gastroenterologist.

Conclusion: The urgent clinic provides a useful mechanism to book subacute GI illnesses in a timely fashion. Further optimization is needed to reduce incidence of missed appointments.

Keywords: Urgent Clinic; Missed Appointment; Utilization; Gastroenterology Clinic

Introduction

In a new ranking from 2017, Canada's health-care system is third-last of developed countries [1]. The weaknesses centre on patient wait times in emergency rooms (ER) and time to see specialists. The ER often serves as backbone for health care emergencies when alternatives are not available or attainable. However, a London, Ontario study found that up to 13% of people with mental health and addictions needs presented to the ER for stressors such as housing, finances, and legal issues suggesting that many individuals may not require emergency medical services from the ER [2].

Other factors driving ER visits include the availability of patients' family practitioners and access to specialists [3]. Waiting time for referral by a general practitioner to consultation with a specialist had increased from 9.4 weeks in 2016 to 10.2 weeks 2017 [4] despite $4.2 billion spent by the Federal government on the Wait Times Reduction Fund [5]. Urgent care centers were established for treatment of urgent, but non-life threatening illnesses or injuries and also reduce the burden on ER while providing timely care to patients.

The Canadian Association of Gastroenterology (CAG) has been concerned about patients' suboptimal access to digestive health care for many years. Patients are dissatisfied with their wait time reporting an impaired quality of life and decreased work productivity due to their digestive illness [6]. A systematic evaluation of Canadian wait times for patients with digestive disease showed median total wait time for all referrals of three months. The median total wait time for patients who have no alarm features is longer than four months, with one-quarter of patients waiting nearly nine months [7]. Furthermore, wait times in 2012 for gastroenterology services continued to exceed recommended targets, remained unchanged since 2008 and exceeded wait times reported in 2005 [8].

Further straining the healthcare system are patient misutilization of resources including failure to attend (FTA) and cancellations of scheduled clinic visits. FTA regular clinic visits was reported in the literature to be 5 - 39% [9-12]. Surprisingly, similar behaviours have been reported in urgent clinic referrals and follow ups. An estimated 240 million USD worth of appointment time with GPs is lost each year in the United Kingdom [13]. Absenteeism was related to different factors including transportation to clinics, parking fees, forgetting appointments and/or resolution of patients concerning symptoms [14,15].

An urgent Gastroenterology clinic started at St Joseph's Healthcare Hamilton to improve timely access (within 3 weeks) for patients seen in the emergency room (ER) and urgent care clinic with a capacity of 6 patients per week. The utility of the clinic, appropriateness of referrals and utilization of endoscopy resources were reviewed. Also reviewed were patient factors for missed appointments to appreciate how gaps could be filled and efficiency improved.

Methods

The urgent gastroenterology clinic at St Joseph's Healthcare Hamilton was started in February 2014 and designed to accommodate referrals from St Joseph's emergency and urgent care centres that required more timely assessment. Referral guidelines were recommended and included patients not known to a gastroenterologist presenting with subacute gastrointestinal bleeding, dysphagia, or suspected new diagnosis of inflammatory bowel disease. Referrals were requested by telephone to the gastroenterologist on-call and approved. The clinic was attended by a senior gastroenterology resident and staff person, and up to 6 consultations were booked per week in a single half-day clinic.

A six-month retrospective review of all cases booked in the urgent GI clinic was conducted as part of a quality assessment review for the clinic. The referral letters were reviewed for appropriateness based on indication. The patient charts were reviewed to determine demographic factors, duration of symptoms, whether they had previously seen a gastroenterologist, utilization of endoscopy resources and requirement for ongoing follow up. Patients who missed their appointment also had their referral letters reviewed and demographic factors collected. The clinic attempted to call patients who missed to document reason for absence, and offer another appointment and this data was also reviewed.

Result

Between March and October 2014, 119 patients were seen in the urgent GI clinic and 118 were reviewed. The average age of the patients attending was 52.9 years, and 57% were females. The mean duration of symptoms was 23.4 weeks, but 59% of patients had more acute symptoms for 1 week or less when presenting to ER or urgent care (See table 1). The reasons for referrals included lower GI bleeding (31%), abdominal pain (25%), upper GI bleeding (14%), inflammatory bowel disease (6%), diarrhea (6%), anemia (5%), and dysphagia (3%) (See table 2).

	Attended n = 118	Absent n = 37
Age (mean years)	52.9	51.0
Female (%)	57	43
Duration of Symptoms (mean weeks)	23.4	28.2
Symptoms for 1week or less (%)	59	56

Table 1: Baseline characteristics.

	Attended n = 118 (%)	Absent n = 37 (%)
Lower GI bleeding	31	24
Upper GI bleeding	14	22
Abdominal pain	25	16
Dysphagia	3	8
Anemia	5	5
Inflammatory bowel disease	6	5
Diarrhea	6	8
Other	9	11

Table 1: Reasons for referrals.

Of the 118 patients seen and reviewed, 42% had previously been seen a gastroenterologist. Moreover, 46% had recently visited the ER or urgent care. A high proportion (71%) was booked for endoscopic tests after the consultation, and 52% were booked for a follow-up appointment.

During the same period of March and October 2014, 37 patients (25%) were absent for their appointment to the urgent GI clinic. The average age of those patients was 51 years, and 43% were females (See table 1). The reasons for referrals included lower GI bleeding (24%), upper GI bleeding (22%), abdominal pain (16%), dysphagia (8%), diarrhea (8%) anemia (5%) and inflammatory bowel disease (5%) (See table 2). The mean duration of symptoms was 28.2 weeks, but 56% of patients had more acute symptoms for 1 week or less when presenting to ER or urgent care.

Several attempts were made to contact patients for rebooking their appointment, and 22/37 (59%) were reached. Of the 22 patients, 10 elected to cancel without rebooking, 3 were seen as inpatients, and 3 were seen by another outpatient gastroenterologist. Only 6/22 (27%) were rebooked to another urgent clinic appointment.

Discussion

Timely access to a specialist for patients with sub-acute gastroenterology illness was facilitated by opening an urgent clinic space. A six month review of the cases referred to the clinic provides an insight into some of the difficulties facing the Canadian health care system like accessibility, resource consumption, and misutilization.

Although guidelines were developed for appropriate reasons for referrals, many referrals were sent outside the guidelines like abdominal pain (31%) and diarrhea (6%). The reasons for why the guidelines were not followed were not explored but may highlight a desire of the physician or patients to get specialist access soon [16].

Also, many referrals were sent to address chronic symptoms with the average symptom duration being 25 weeks. The average was skewed by a few outliers with chronic symptoms, but when reviewed further, more than half the patients seen in the clinic had symptoms for only 1 week or less. Newer symptoms by themselves may not necessitate an urgent clinic, and following guidelines about which symptoms should prompt an urgent referral should be further emphasized.

Of the 6 spots per week opened for urgent referrals, the utilization was only 4.5 spots per week on average. Most of this gap was due to missed appointments. Although FTA and cancellations of outpatient appointments appears to be a minor issue day to day, it will affect the efficiency of the Canadian healthcare system in the long term as many of these patients will be rebooked.

Studying the reasons behind missed appointments may allow for interventions to reduce this problem. In our experience, almost half (10/22) patients cancelled without rebooking but the exact reason was not known. Factors from the literature that could increase absence rates included difficulty in getting to the clinic, parking fees, forgetting appointments and/or resolution of patients concerning symptoms [14,15]. We found an association between longer duration of symptoms and worse attendance rate. We suspect one of the other challenges with acute presentation of symptoms is that they may be transient and resolve after the emergency visit. Finding ways to allow patients to cancel appointments for transient symptoms and open up the space for other patients would also be useful [17,18].

Many interventions were developed to improve attendance rates including telephone and mail reminders [19]. Identifying patients with previous No-Shows as "high-risk" for absenteeism and overbooking the clinic when they are visiting is a frequently used temporary strategy [18].

On the other hand, outpatient management may not have been suitable in some cases and better selection criteria of the referral should be attempted. Three patients in our study were admitted to hospital despite being referred through the urgent clinic referral stream. Deferring "emergent" patients to the urgent clinic as opposed to being seen directly in the emergency room must always be taken with caution.

Another surprising factor was the high number (42%) of patients seen in the urgent clinic that already were seen by a gastroenterologist. We did not explore if the previous visit was for a different reason. Regardless, appropriate follow-up could be directed to the patients' previous gastroenterologist who knows the patient already to avoid a "second opinion" use of the clinic.

The urgent clinic's endoscopy utilization rate was especially high (71%) but this is not surprising given the most common reason for referral was lower GI bleeding. If an urgent clinic will lead to substantial endoscopy resource requirement, then this must be considered in the development of such clinics in the future. Moreover, we did not explore the urgency of the endoscopy and this may also be a factor for future research and planning.

Conclusions

In conclusion, urgent Gastroenterology clinics provide a useful method to see subacute digestive health illnesses in a timely fashion. However, further work must be done to improve the efficiency of the clinic including referral criteria that include duration of symptoms, a strategy to deal with missed appointment and a way to direct patients to the care of their own gastroenterologist if they have one. Challenges include high endoscopy utilization of the urgent patients, and the need for clinic follow-ups. Our urgent GI clinic now screens all referrals for appropriateness, and does not see patients seen within the past year by another gastroenterologist. Follow-up data will hopefully demonstrate reduction in absence rate with this new strategy.

Bibliography

1. Sarnak DO., *et al*. "International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care". MIRROR. Based on Commonwealth Fund analysis (2017).

2. Coristine R., *et al*. "Mental Health Triage in the ER: a qualitative study". *Journal of Evaluation in Clinical Practices* 13.2 (2007): 303-309.

3. "Sources of Potentially Avoidable Emergency Department Visits Report" (2014).

4. B Barua. "Waiting Your Turn: Wait Times for Health Care in Canada, 2017 Report". Fraser Institute (2017).

5. Archived - Where Your Tax Dollar Goes (Department of Finance) (2005).

6. Paterson WG., *et al*. "Wait times for gastroenterology consultation in Canada: The patients' perspective". *Canadian Journal of Gastroenterology* 24.1 (2010): 28-32.

7. Armstrong D., *et al*. "Access to specialist gastroenterology care in Canada: The Practice Audit in Gastroenterology (PAGE) Wait Times Program". *Canadian Journal of Gastroenterology* 22.2 (2008): 155-160.

8. Leddin D., *et al*. "The 2012 SAGE wait times program: Survey of Access to GastroEnterology in Canada". *Canadian Journal of Gastroenterology* 27.2 (2013): 83-89.

9. Collins J., *et al*. "Why outpatients fail to attend their scheduled appointments: a prospective comparison of differences between attenders and non-attenders". *Australian Health Review* 26.1 (2003): 52-63.

10. Loccoh EC., *et al*. "Prevalence and risk factors associated with non-attendance in neurodevelopmental follow-up clinic among infants with CHD". *Cardiology in the Young* 28.4(2018): 554-560.

11. Kaplan-Lewis E and Percac-Lima S. "No-Show to Primary Care Appointments: Why Patients Do Not Come". *Journal of Primary Care and Community Health* 4.4 (2013): 251-255.

12. Mohamed K., *et al*. "A Quality Improvement Project to Reduce the 'No Show' rate in a Paediatric Neurology Clinic". *BMJ Quality Improvement Reports* 5.1 (2016).

13. Beecham L. "Missed GP appointments cost NHS money. According to a survey by the Doctor Patient Partnership (DPP)". *British Medical Journal* 319.7209 (1999): 536.

14. Campbell JD., *et al*. "The no-show rate in a high-risk obstetric clinic". *Journal of Women's Health and Gender-Based Medicine* 9.8 (2000): 891-896.

15. Murdock A., *et al*. "Why do patients not keep their appointments? Prospective study in a gastroenterology outpatient clinic". *Journal of the Royal Society of Medicine* 95.6 (2002): 284-286.

16. Boissin C., *et al*. "Adherence to Referral Criteria at Admission and Patient Management at a Specialized Burns Centre: The Case of the Red Cross War Memorial Children's Hospital in Cape Town, South Africa". *International Journal of Environmental Research and Public Health* 14.7 (2017): E732.

17. Lee CS and McCormick PA. "Telephone reminders to reduce non-attendance rate for endoscopy". *Journal of the Royal Society of Medicine* 96.11 (2003): 547-548.

18. Reid MW., *et al*. "Preventing patient absenteeism: validation of a predictive overbooking model". *American Journal of Managed Care* 21.12 (2015): 902-910.

19. Lin H and Wu X. "Intervention Strategies for Improving Patient Adherence to Follow-Up in the Era of Mobile Information Technology: A Systematic Review and Meta-Analysis". *PLoS One* 9.8 (2014): e104266.

Volume 1 Issue 1 September 2018