Author’s response to reviews

Title: Quality and Continuity of Information Between Primary Care Physicians and Rheumatologists

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Author’s response to reviews:

Re: Manuscript BRHM-D-18-00064

Response to reviewers’ comments

January 6, 2018

Dear Jennifer Barton

Thank you for the opportunity to revise and resubmit our manuscript entitled "Quality and Continuity of Information Between Primary Care Physicians and Rheumatologists" (BRHM-D-18-00064) to BMC Rheumatology. We thank the reviewers for their thoughtful review. We have revised the manuscript as suggested and respond below to each of the reviewers’ comments.

Sincerely,

Jessica Widdifield
REVIEWER 1: COMMENTS TO THE AUTHOR

Reviewer reports:

This retrospective chart review describes characteristics of consultations from PCP to Rheumatologists between 2000-2013 in Ontario, Canada. The manuscript is well written, however, could use clarification in the following areas:

1. The abstract and introduction refer to quality of consultation letters. It would be helpful to provide a definition or framework for evaluating quality in this context.

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AUTHOR REPLY:

Unfortunately, there is no definition of a high quality consultation letter in the context of rheumatology (to our knowledge). We evaluated quality using a selection of criteria reported by Berta et al. for minimum essential elements in consultation reports essential to achieving good continuity of information.


ACTION TAKEN:

In the limitations section after the sentence: “Furthermore, we did not scrutinize the quality of consultation letters as thoroughly as the contents of referral letters.” We have now added: “In the context of rheumatology, there is lack of consensus on what defines a high quality consultation letter and we only assessed some general components of what is recommended to be included in general consultation letters (24).”

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2. In the introduction (to enhance rationale for this study), consider adding several sentences about how early referral and treatment are critical for rheumatic diseases.

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AUTHOR REPLY/ ACTION TAKEN:

Thank you for this suggestion.
In the introduction we have added: “In Canada, rheumatology is one of the most frequent non-surgical specialty referrals (12). Timely access to rheumatology care is a challenge that has significant implications for patient outcomes, as early diagnosis and intervention improve long-term outcomes particularly for systemic inflammatory conditions.”

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3. What are the clinical implications of this research specifically in Rheumatology? See #2 above for suggestion on framing.

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AUTHOR REPLY/ACTION TAKEN:

In addition to improvements to the introduction undertaken to comment #2 above, we have added into the introduction: “Systemic inefficiencies in the traditional referral process as a result of poor communication may delay access to rheumatology specialist care and impede accurate and rapid diagnoses and treatment.”

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4. For data abstraction, please clarify who determined the clinical diagnosis if a consultation note was not received?

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AUTHOR REPLY:

As reported in the methods “an independent abstractor (J.W.) also performed double data abstraction related to assigning patients to diagnostic categories.” The entire medical record was reviewed. The majority of patients that did not have a consultation were for non-systemic rheumatic diseases (e.g. OA or fibromyalgia) or for whom a diagnosis by a rheumatologist was not required (e.g. fertility or neurological issues or abnormal lab results in the absence of symptoms).

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5. On page 5, lines 27-29, the investigators state that if multiple conditions were present, "they were assigned to the most serious complaint requiring consultation." Who determined this and how?
AUTHOR REPLY:
The most serious complaint requiring consultation was the primary reason for referral. For example, if the referral note stated that the patient has new-onset inflammatory arthritis and an established diagnosis of osteoarthritis, the primary reason for referral was inflammatory arthritis, and NOT OA.

ACTION TAKEN:
In the methods, we have clarified this as now stated: “If patients exhibited multiple conditions, they were assigned to the most serious complaint requiring consultation (primary reason for referral).”

6. The statistical analysis section can be expanded. More detail is needed about statistics to match the results reported.

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AUTHOR REPLY/ ACTION TAKEN:
We have added to this section:

“We assessed the frequency of general details provided on referral letters (patient history and laboratory results), details of symptoms provided on the referral letter, actual diagnostic imaging performed on the patient in contrast to what was reported on the referral letter, and details and timeliness of consultation letters.”

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7. Please verify if/that duplicate referrals were removed.

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AUTHOR REPLY:
It is unclear whether the reviewer is referring to duplicate referrals that are sent at the same time to 2 or more separate rheumatologists or duplicate re-referrals at different points in time.

The entire medical record was screened to determine if the referral identified was a re-referral. We only assessed the first referral (so duplicate referrals were not assessed on the same patient).
8. Do the investigators have any data about the PCPs? For a study about characteristics of referral it would be helpful to know more about those referring (i.e. How many years in practice, panel size, community vs academic setting, population served).

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AUTHOR REPLY/ACTION TAKEN:

We have revised the section on Participants to state: “At the time of study, 168 PCPs from across Ontario were included in the EMRALD data set: 32 rural, 39 suburban, and 97 urban. The mean duration of EMR use in our sample was 5 years (range 2-25). Our sample of PCPs was slightly younger with mean (range) age of 47 (28-69) years, in comparison to all Ontario PCPs [with a mean (range) age of 52 (27-79) years]. Our PCP study population also comprised more females (56% vs. 41% for all Ontario PCPs). The mean number of years in practice was 15 for our PCP participants in comparison to 19 years for all Ontario PCPs.”

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9. Overall, it is impressive that ~70% consultation letters were returned within 30 days of consultation.

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AUTHOR REPLY:

While an established benchmark does not exist, 100% of consultation letters should be returned within 30 days.

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10. 17% referrals did not result in a rheumatology consultation (page 8, line 12). Please provide more detail, if available, for why this is the case. Were these referrals particularly sparse? Would be helpful to know if and how these referrals differed from the others.

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AUTHOR REPLY/ACTION TAKEN:

We have expanded on this sentence as follows:
“In our sample, 415 referrals (17%) did not result in a rheumatology consultation, with 68 (1.6%) patients having evidence that they subsequently cancelled or missed their consultation appointment and only 87 patients (2.1%) having explicit documentation of a rheumatologist declining to see the patient (the majority were for non-systemic inflammatory conditions). Among these 87 declined referrals, the main reasons provided by rheumatologists for declined referrals were that they did not provide consultations specific to the referral (26.4%), or that a consultation was not required (24.1%). Among 19 (21.8%) of declined referrals, no reason was provided.

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11. How do these results inform practice in other health care systems?

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AUTHOR REPLY:

At present, there is no consensus on the use of standardized forms for referral letters or for consultation letters in the context of rheumatology. Our results will hopefully provide an impetus to stimulate efforts in this area.

The presence of comprehensive and easily accessible information in referrals letters is likely to impact on the decision-making process for patient appointments, regardless of whether the type of health care system.

ACTION TAKEN:

We have modified this paragraph in the discussion as follows:

The presence of comprehensive and easily accessible information in referrals letters is likely to impact on the decision-making process for patient appointments, regardless of the type of health care system. In many countries, a traditional PCP-to-rheumatologist referral process occurs in which new patients are referred directly to a specific rheumatologist(21).

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12. Please clarify what are the clinical implications from this research?

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AUTHOR REPLY:
Deficits in communication and information transfer between PCPs and rheumatologists can have implications for patient safety and continuity of care. As our conclusions states: “the under reporting of key information within rheumatology referral letters and delay of receipt of consultation letters may represent a lost opportunity for coordination and continuity of rheumatology care, and may ultimately affect the quality of care.”

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13. Page 9, lines 43-51: please move this paragraph to prior or expand to make this its own paragraph.

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AUTHOR REPLY:

This paragraph previously stated:

“Indeed, a recent survey of Canadian rheumatologists identified that one-third of new referrals were deemed to be of poor quality, and another third were of moderate quality, making it difficult to triage patients appropriately, resulting in requests for more information contributing to delayed or declined consultations (7).”

ACTION TAKEN:

We have expanded on this paragraph to state: “As a result, the majority of rheumatologists surveyed (75%) in this prior study were not satisfied with the completeness of information provided by the referring physician, as missing information resulted in wasted time and repeat consultations to retrieve additional laboratory test results to facilitate diagnosis and treatment(7).”

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14. The authors suggest on page 9, line 58 (and again in final paragraph of discussion) that improved "referral process could improve physician satisfaction and quality of patient care." The current research does not directly address physician satisfaction or quality of patient care.

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AUTHOR REPLY/ACTION TAKEN:
We have revised this to state “Future efforts to improve the referral process could ultimately improve both physician satisfaction and quality of patient care.” While our research does not directly address this, it underscores the rationale for this study.

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REVIEWER 2: COMMENTS TO THE AUTHOR

This is very interesting article about a very important problem seen in clinical practices. The conclusions are supported by the descriptive data of this study. More importantly, I think that the authors delineated very well the limitations of the study, which gives the reader a clear understanding of how should the data be interpreted and in which context (e.g. single-payer system, retrospective limitations, and risk of misclassification).

Here are my comments:

1. This study was conducted in a single-payer system, which as the authors mentioned, access to rheumatologists depends on referrals. In the discussion they also mentioned that adoption of referral templates have been problematic. Does this mean in Canada in particular or in another country, or private insurance system like the U.S.?

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AUTHOR REPLY:

While this is beyond the scope of the current study, adoption of referral templates is likely to be universally problematic, unless strictly endorsed by the rheumatology professions, PCPs, and health care systems.

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2. It would be interesting to describe if there has been any policy implementation regarding referrals in this public system, as we could assume that since the system is public, policy changes could be easier or less problematic. Regardless, it would be interesting to have a little bit more background on these areas of the single payer system as other countries health care systems where the health care system is mainly private. I think that adding these details in the manuscript will increase the significance of the manuscript, especially when there are skepticism about single-payers system in the U.S. Highlighting or even comparing the findings of this study with
studies conducted in private health care systems will show the reader that this may not be a problem of a single-payer system, but that exist at different levels in different systems.

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AUTHOR REPLY/ACTION TAKEN:

In addition to the similar revisions suggested by reviewer 1,

In the methods we have added:

“During the study period, there was no policy implementation regarding rheumatology referrals in this setting.”

We have modified 2 paragraphs in the discussion as follows:

“Our study, … reinforces findings from previous Canadian and international reports from single rheumatology centers that referral letters lack potentially important details (7, 15-20).” We have cited both Canadian and international studies.

“The presence of comprehensive and easily accessible information in referrals letters is likely to impact on the decision-making process for patient appointments, regardless of the type of health care system. In many countries, a traditional PCP-to-rheumatologist referral process occurs in which new patients are referred directly to a specific rheumatologist(21).” We have referenced a US study “Harrington JT, Walsh MB. Pre-appointment management of new patient referrals in rheumatology: a key strategy for improving health care delivery. Arthritis Rheum. 2001;45(3):295-300.”

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Thank you to the reviewers for providing us with an opportunity to improve our manuscript.