Non-contact first specialist appointments are safe

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New models of care are required to provide greater access and flexibility in the delivery of specialist advice for patients referred from primary care settings. Non-Contact First Specialist Assessments (NCFSAs) provide such a model and offer an opportunity to improve access to specialists when resources are limited.¹

NCFSAs involve specialist assessment of a patient without them being present. The specialist develops a plan of care after review of the patient’s records and test results. This consists of a written clinical summary, treatment goal and planned actions, with clearly identified responsibilities for the parties involved. The plan of care, along with any other necessary advice, is then sent to the primary care provider, and patient if appropriate, and should be available in the patient’s records.

In this edition of the Journal, Cariga and colleagues report the findings of an extensive assessment of NCFSAs in a mid-sized regional New Zealand hospital.² A total of 222 of 1107 (20%) referrals made to the neurology outpatient clinic over a 12-month period were triaged by a neurologist to NCRSA. NCFSAs were more likely in patients with non-serious disorders and took approximately 15 minutes to complete. The rates of re-referral, patient admission to hospital and delayed or missed diagnosis were recorded at 1 and 6 months.

The main finding of the study is that NCFSAs were safe. At 6 months, 11% of patients had been re-referred, most of whom were subsequently triaged to a clinic appointment, and 6% were admitted to hospital (none with a neurological condition).

Reassuringly, only 1 of the 222 patients had an adverse outcome and this may have been avoided with improved documentation in the original referral. The authors speculate that the number of adverse events would have been at least as frequent if the patients had been triaged into face-to-face appointments given the local waiting time of six months for a clinic appointment. That NCFSAs are safe is reassuring. In selected patients, NCFSAs provide advantages over face-to-face clinic visits and should not be seen as an inferior form of consultation. Primary care providers and patients often have specific and simple questions of specialists.

Headache syndromes were the most frequent condition triaged to NCFSA in this study. Patients with headache often want reassurance that their symptoms are not an indication of an underlying sinister disorder (rarely the case) and a clear plan for symptom management. Generic recommendations for conditions such as headache tailored to an individual patient help even further and often reflect the advice that would have otherwise been given in a clinic visit.

NCFSAs also facilitate more rapid access to specialist opinions. Waiting times from referral to diagnosis, assessment or treatment are reduced, as are travel costs and time spent by patients at outpatient appointments. The equivalent of just under one specialist clinic per fortnight was freed up in the reported study. In a District Health
Board with only two neurologists, this represents a significant saving and means that patients with more serious conditions can be seen in a more timely manner.

NCFSAs provide new challenges to inter-professional relationships and a change in the relationship between primary and secondary health care providers is required. Specialists need to trust GPs to include all relevant information on referrals and that treatment plans and recommendations will be followed. General practitioners need to be reassured that face-to-face assessments will be expedited if the patient does not follow the expected clinical course. This requires improved communication and may mean the provision of specialist advice hotlines for GPs.

From a management point of view, NCFSAs cannot be used simply as a way to save money. The time commitment was still one third of that taken to see patients in face-to-face clinics and it is important that the specialist is allocated the time and funding to do the job properly. Specialists also need to have access to investigations for NCFSA patients in a reliable and timely manner.

When done well, NCFSAs should be good for patients and their health professionals, and lead to more efficient use of limited health care resources. Cariga and colleagues should be congratulated for providing some solid data to support this option for patient care.

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