

# A triage approach to managing a two-year waiting list in a chronic pain program

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**OBJECTIVE:** Individuals with chronic pain referred to specialist chronic pain management programs frequently wait months to years for assessment and care. In the authors' pain management program, approximately 600 patients are on the waiting list. An innovative recommendation program to encourage and educate referring physicians to continue active care of pain during this waiting period was developed.

**METHODS:** All referrals to the Queen Elizabeth II Health Sciences Centre's Pain Management Unit for a one-year period were reviewed and triaged as either 'regular waiting list' or 'fast track'. Patients in the fast track group were seen within four months and required limited interventions or were urgent in nature. The regular waiting list group waited up to 27 months for assessment and development of a treatment plan. Treatment recommendations were faxed to the referring physician. A follow-up questionnaire was sent to each physician to assess whether these treatment recommendations were useful.

**RESULTS:** Recommendations were faxed for 297 patients. One hundred forty-nine physicians returned the follow-up questionnaire. Ninety-five physicians used the recommendations and 68 patients followed the recommendations. Seventy-nine physicians felt that the recommendations were helpful to them in their care of the patient. For 39 patients, the recommendations were helpful. The most frequently used recommendations were those on medications (eg, tricyclic antidepressants, anticonvulsants, nonsteroidal anti-inflammatory drugs and controlled-release opioids). Other modalities included participation in an interdisciplinary group program and physiotherapy.

**CONCLUSIONS:** A triage review process with recommendations faxed to referring physicians was developed and put into action for one year. The recommendations were used by 32% of the physicians (64% of responding physicians). Fifty-three per cent of responding physicians felt that the recommendations were helpful in the care of their patient. This process led to a benefit in care, as perceived by the physician, in 26% of patients (of physicians who returned the questionnaire [13% of all patients]) on the waiting list for a tertiary care pain management unit.

**Key Words:** *Chronic pain; Multidisciplinary pain program; Triage; Waiting list*

Many patients with chronic pain have to wait several months, and sometimes up to two or more years, to be seen for assessment in a pain management program. The Pain Management Unit at the Queen Elizabeth II Health Sciences Centre (QEIIHSC) in Halifax, Nova Scotia, has approximately 600 patients with chronic pain on its waiting list for assessment. Many of these

## Une démarche de triage pour gérer une liste d'attente de deux ans dans un programme de douleur chronique

**OBJECTIF :** Les personnes souffrant de douleurs chroniques orientées vers des programmes spécialisés de prise en charge de la douleur attendent souvent des mois et même des années pour être évalués et soignées. Dans le programme de prise en charge de la douleur des auteurs, plus de 600 patients figurent sur la liste d'attente. Un programme de recommandation novateur a été mis sur pied afin d'encourager et d'informer les médecins orienteurs pour qu'ils poursuivent les soins actifs de la douleur pendant la période d'attente.

**MÉTHODOLOGIE :** Tous les aiguillages à l'unité de prise en charge de la douleur du *Queen Elizabeth II Health Sciences Centre* pendant une période d'un an ont été évalués et triés pour faire partie de la « liste d'attente ordinaire » ou de la « voie rapide ». Le groupe de patients sur la voie rapide était vu dans un délai de quatre mois et avait besoin d'interventions limitées ou urgentes. Le groupe sur la liste d'attente ordinaire a attendu jusqu'à 27 mois avant d'être évalué et de profiter d'un plan de traitement. Les recommandations de traitement ont été télécopiées au médecin orienteur. Un questionnaire de suivi a été envoyé à chaque médecin afin qu'il évalue si les recommandations de traitement étaient utiles.

**RÉSULTATS :** Des recommandations de traitement ont été télécopiées à l'égard de 297 patients. Cent quarante-neuf médecins ont renvoyé le questionnaire de suivi. Quarante-vingt-quinze avaient utilisé les recommandations, et 68 patients les avaient respectées. Soixante-dix-neuf médecins trouvaient qu'elles leur avaient été utiles dans leurs soins au patient. Pour 39 patients, elles avaient aussi été utiles. Les recommandations les plus utilisées avaient trait aux médicaments (p. ex., antidépresseurs tricycliques, anticonvulsifs, anti-inflammatoires non stéroïdiens et opiacés à libération contrôlée). D'autres modalités incluaient la participation à un programme de groupe interdisciplinaire et à de la physiothérapie.

**CONCLUSIONS :** Un processus d'analyse par triage accompagné de recommandations télécopiées au médecin orienteur a été élaboré et mis en œuvre pendant un an. Les recommandations ont été utilisées par 32 % des médecins (64 % des médecins traitants). Cinquante-trois pour cent des médecins traitants étaient d'avis qu'elles étaient utiles dans leurs soins aux patients. Ce processus a favorisé une amélioration des soins, selon la perception du médecin, chez 26 % des patients (de médecins qui avaient renvoyé le questionnaire [13 % de tous les patients]) sur la liste d'attente d'une unité de prise en charge de la douleur de soins tertiaires.

patients wait for more than two years to be seen by a specialist physician following referral by their primary care physician.

There is very little information available on how to manage long waiting lists and what type of care should be provided to these patients while they wait for their assessments. As Arnesen et al (1) noted, when resources are constrained, it is inevitable to

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**TABLE 1**  
**Recommendations suggested to and used by physicians**  
**(n=297)**

Recommendation	Suggested	Used
Add to current therapy	228	NA
Physiotherapy	68	19
Immediate-release opioids	11	5
Controlled-release opioids	52	12
Tricyclic antidepressants	184	57
Anticonvulsants	100	34
Other medications	60	27
Group program	134	34

NA Data not collected

ration according to assessment of priority. Other programs, such as a breast cancer clinic, have developed triage processes for appointment stratification (2). In addition, an orthopedic outpatient referral clinic has suggested that general practitioners would value easier telephone access to consultants for management advice, and that an alternate source of management advice might enable more effective use of specialist orthopedic resources (3).

To properly manage our waiting list, we initially developed a triage process whereby patients were categorized into three groups. The first group consisted of patients who needed to be assessed urgently, and the second group consisted of patients who required limited interventions over a short period of time and did not require the interdisciplinary components of our program; both of these groups were usually seen within one to four months and were referred to as 'fast track' referrals. The third group required comprehensive assessment and interdisciplinary management of their chronic pain (the 'regular waiting list'). Patients from this last group typically waited up to two to two-and-a-half years from referral to assessment. We were very concerned about the feedback we had received from these patients saying that they had not received active care from their primary care physicians during this waiting time.

Davies et al (4) reported in 1993 that the local target for referral to outpatient appointment in five pain clinics associated with teaching hospitals in Scotland was nine weeks. However, the actual waiting time varied between three and five months, and this was considered to be too long. It is clear that in many pain management programs in Canada, the waiting time from referral to assessment is too long and typically ranges from six months to two years.

It is currently estimated that up to 29% of the Canadian adult population suffers from chronic pain and, as the population ages, the proportion of individuals with chronic pain will increase because older age groups are associated with an increased prevalence of chronic pain (5). Thus, unless resources change, wait times from referral to assessment for patients with chronic pain will increase.

Because it appears that many patients do not receive ongoing care from their primary care physicians, the Pain Management Unit at the QEIIHSC decided to enhance the triage process, as part of a quality improvement initiative, for those patients placed on the regular waiting list by developing a feedback process to the referring physician as to possible therapeutic modalities that might be considered while patients wait for assessment in the unit.

## METHODS

From December 1, 2002 to November 30, 2003, all referrals to the Pain Management Unit at QEIIHSC were triaged by one of two authors (AJC, IB) to two triage paths: fast track or regular

waiting list. After referral, each patient on the regular waiting list was asked to complete a Pain Evaluation Questionnaire. The information from the referring physician and the Pain Evaluation Questionnaire was then reviewed by one of two authors (AJC, IB). Recommendations about possible care were entered on a form (Appendix 1) that was then faxed to the referring physician so that these recommendations might be used while the patient was waiting for an assessment.

Approximately three months after these recommendations were sent by fax, a second form (Appendix 2) was sent to the physician to obtain feedback about whether the recommendations had been used in the care of their patient, whether the recommendations had been useful in this care and whether the physician thought this process was helpful in the management of the patient.

## RESULTS

Recommendations were faxed to the referring physicians of 297 patients (167 women, 128 men). One hundred forty-nine physicians (50%) returned the follow-up questionnaire asking whether the recommendations had been used and whether they had been useful in the care of the patient. Ninety-five of the physicians (64%) who returned the follow-up questionnaire had used the recommendations (32% of all physicians who had been sent recommendations). Thirty-five physicians (23%) indicated that they did not use the recommendations. According to the physicians, 68 patients (46%) had followed the recommendations provided (23% of all patients for whom recommendations had been provided). Seventy-nine physicians (53%) felt that the recommendations were useful in their care of the patient; these physicians also noted that for 39 patients (26% of those patients whose physician responded) the recommendations were helpful. Thus, at least 13% of patients had benefited from the recommendations provided to their physicians before their assessment in the unit.

The most frequently suggested recommendations to the referring physician are listed in Table 1. For almost one-quarter of patients (23%), it was not possible to provide recommendations, either because of inadequate information or because the patient had already used most available modalities. The most often recommended medications included tricyclic antidepressants (62%), anticonvulsants (34%) and controlled-release opioids (18%). For almost one-half of the patients (45%), participation in a group pain self-management program was recommended, and physiotherapy was recommended for 23% of patients.

The recommendation most frequently used by the 95 physicians who used the recommendations and returned the follow-up questionnaire, involved prescribing medications. These included tricyclic antidepressants (n=57), anticonvulsants (n=34), controlled-release opioids (n=12) and other medications (n=27) (which consisted primarily of nonsteroidal anti-inflammatory medications). Other modalities that were recommended and used included participation in a group pain self-management program provided by the author's unit (n=34) and physiotherapy (n=19) (Table 1). More than one-half (53%) of the physicians who returned the follow-up questionnaire said that the recommendations were helpful to them in the management of their patients.

## DISCUSSION

The present project was initiated because of concern that many patients were not receiving ongoing care for their chronic pain while awaiting assessment in a chronic pain program. In addition, it was felt that some pain management techniques could be used by primary care physicians for their patients if

the physician was provided with recommendations by specialists who care for patients with chronic pain.

The response rate from the physicians surveyed was quite high for this type of survey (fax/mail), and almost two-thirds of those physicians who replied had used the recommendations. More importantly, 68 of 95 patients (72%) had followed the recommendations initiated by the physician and 39 patients (41%) had experienced benefit.

It has previously been demonstrated that changing the way consultations between general practitioners and specialists are handled can improve patient satisfaction, reduce the number of tests and investigations ordered, and result in improvements in the patient's health status one year after referral (6,7). In addition, there are often substantial communication deficiencies in patient referral, which, if addressed, may lead to improved patient care (8).

Additional possible benefits are the ongoing education of physicians about treatment modalities for chronic pain and the possibility that some patients may not need care through a pain management program if the recommendations made result in benefit to the patient.

### CONCLUSION

The present study found that a triage review process with faxed recommendations to referring physicians was effective. The recommendations were used by 32% of physicians (64% of responding physicians). This process led to a benefit, as perceived by the physician, in 13% of all the patients on a waiting list for an interdisciplinary pain management unit. Waiting lists of a year or longer for chronic pain services are unacceptable, but are currently the reality in most academic pain centres across Canada. Until improved resources for patients with chronic pain become available, this type of innovative program may allow a minority of patients to benefit while waiting for assessment and care.

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### APPENDIX 1



Capital Health

QE II Health Sciences Centre  
Pain Management Unit

### Interim Recommendations to Referring Physician

FAX to # \_\_\_\_\_ Number of Pages \_\_\_\_\_  
HCN: \_\_\_\_\_

Dear Dr. \_\_\_\_\_:

You have recently referred your Patient \_\_\_\_\_ to the Pain Management Unit. A Unit physician has reviewed your referral and to enhance the efficiency of patient care, we are requesting that you consider some interim recommendations. There will be a follow-up faxed to you in **12-16 weeks** to assess whether these recommendations have been useful to you.

Based on the information provided by you and your patient, you may wish to consider the following recommendations whilst your patient is waiting to be seen at the Pain Management Unit:

**Maintain Current Therapy**

**Maintain Current Physiotherapy: OR consider**

Details: \_\_\_\_\_

**Maintain Current Pain Medication: OR consider**

**Change/add the following medications:**

Opioid     IR     CR     Tricyclic

Antiepileptic agent     Other

Details: \_\_\_\_\_

**Refer for Psychological Assessment/Care**

Locally     Group Program

Details: \_\_\_\_\_

**Other Recommendations:** \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### APPENDIX 2



Capital Health

QE II Health Sciences Centre  
Pain Management Unit

### Follow up to Faxed Recommendations

FAX to # \_\_\_\_\_ Number of Pages: \_\_\_\_\_  
HCN: \_\_\_\_\_

Dear Dr. \_\_\_\_\_

On \_\_\_\_\_ we faxed a list of recommendations for care to you for your patient \_\_\_\_\_, whom you have

referred to the Pain Management Unit. In order to assess the usefulness of the recommendations provided we would ask that you **please complete the following and return by Fax to \*-\*-\*-\*\*\*.\*\*\*\* as soon as possible.**

**Thank you.**

**Did you use the recommendations in the care of your patient? Yes  No**   
**If no, please state reason(s):** \_\_\_\_\_

**If yes, did the patient follow the recommendations? Yes  No**   
**If no, please state reasons:** \_\_\_\_\_

**Where the recommendations helpful to your patient? Yes  No**   
**Comments:** \_\_\_\_\_

**Where the recommendations useful to you in the care of your patient? Yes  No**   
**Comments:** \_\_\_\_\_

**Additional information / Comments: (Please use additional sheets if required)**  
\_\_\_\_\_  
\_\_\_\_\_



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