The multi-factorial origin of lengthy wait times for colonoscopy in the public sector

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Current status

• Difficult to separate colonoscopy and upper GI endoscopy statistics – patients are referred for either or both

• Endoscopy lists are put together on the basis of:
  – Urgency (Categories 1 – 3)
  – Time already waited (“First on, First off”)
  – Ability to contact patient
  – Time until procedure (upper ‘scope easier than colonoscopy if time is short)
Current status

• OPH currently has (upper and lower)
  – 119 Cat 1 (<30 days) and
  – 1310 Cat 2 (31 – 90 days) and
  – 1047 Cat 3 cases (91 – 365 days) on its W/L

• Longest wait for Cat 2 = 1259 days
• Longest wait for Cat 3 = 1580 days

• App. 25 cat 1 colonoscopy requests per week
Current status

• SCGH – app. 100 referrals per week

• > 2,400 cases awaiting endoscopy

• Colonoscopy
  – Cat 1: 313 cases
  – Cat 2: 425 cases
  – Cat 3: 456 cases
Current status

• Capacity for public colonoscopy around Perth???

• OPH
  – 7 endoscopy lists per week
  – maximum 40 colonoscopies per week
  – will increase as second suite returns after April
Why the long wait?

Demand exceeds capacity
Factors driving demand up

- GI complaints are ubiquitous
- Colonoscopy is a precise diagnostic tool
- Previously used GI investigation (barium enema) is now obsolete and unobtainable
- Alternative GI investigations (CT imaging) are less precise, less versatile and difficult to access
- Patients demand access regardless of indication
- Access in “private” is brisk regardless of indication
- Colonoscopy is all we’ve got!
Factors driving access down

- Finite number of colonoscopy suites
- Finite number of endoscopists
- Urgent cases bumping elective cases
- Expensive and resource-sapping investigation
- Inefficient utilisation of existing suites
  - No shows
  - Late cancellations
  - No preps
Is this as good as it gets?

• Can’t stop people presenting with GI symptoms

• Can’t ignore GI symptoms when present

• Number of endoscopists/endoscopy suites limited by finite public funds
What is the strike rate of public hospital colonoscopy?

- <2% colonoscopies (all categories) identify CA (OPH)
- <5% colonoscopies (all categories) identify CA (SCGH)
- Numbers are even less amongst Cat 2 and Cat 3 cases
- The vast majority of those currently waiting on public endoscopy wait lists >90 days have not got significant/serious GI pathology
The problem with lengthy wait times

• A small number of people with significant/serious pathology will have delayed diagnosis and worse outcomes
• A much larger number of people will be anxious about their health for longer than ideal
• Long wait times increase the likelihood of no shows and cancellations
• The raw data create the impression of a system that is unable to cope
What bits can we fix?

(i) Referral control

(ii) Clerical and administrative factors
(i) Referral control

• Refining the indications

• Modifying the triage
Refining the indications

• The first thing to remember is that colonoscopy is really only an *investigation*.

• The second thing to remember is that it is an especially labour-intensive, resource-sapping and costly investigation.

• The indications for colonoscopy need to be refined – not everyone with GI symptoms who “ideally” we would have colonoscoped can actually get one.
Indications for colonoscopy

1. Change in bowel habit with alarm symptoms at any age (weight loss, severe pain, anaemia, palpable mass)
2. Patient >40yr reporting rectal bleeding with a change in bowel habit towards looser or increased frequency of stools for 6 weeks or more
3. Patient >60yr with rectal bleeding for >6 weeks and no change in bowel habit or anal symptoms
4. Change in bowel habit >6 weeks without alarm symptoms in patient aged >60yr
5. Positive FOBT result (including NBCSP participants)
6. Unexplained iron deficiency anaemia in men or non-menstruating women
7. Abnormal CT/Barium imaging (suspected cancer/large polyp >2cm)
8. Active inflammatory bowel disease or diarrhoea where endoscopy is indicated to progress management
Modifying the triage

• Current
  – Category 1: <30 days
  – Category 2: 31 – 90 days
  – Category 3: 91 – 365 days*

• Proposed
  – Staged colonoscopy: polyp F/U, cancer surveillance
  – Colonoscopy required: book <60 days
  – Clinical review required by referrer: up to 6 months

* 366 in leap years
(ii) Clerical and administrative factors

• Smarten up the referral please!

• Bring clerical processes into the 21\textsuperscript{st} century
(ii) Clerical and administrative factors

Smarten up the referral please!

- Does the patient really want the procedure?
- Are the telephone contact details current and correct?
- Has the patient also been referred to another endoscopy provider (private/public)?
- If the patient does not speak English, have the contact details of someone (friend/relative) who does been provided?
Clerical and administrative factors

Bring clerical processes into the 21st century

– Has the patient been spoken to and the date confirmed prior to booking?
– Has an appropriately timed reminder been sent?
– Has the patient confirmed that they will be attending?
– Have appropriate efforts been made to back-fill cancellations?
– Has appropriate funding been applied to clerical support?
– Have patients who do not want or need the procedure been removed from the wait list?
Lengthy waiting lists for colonoscopy

- Inevitable consequence of demand > supply
- Worse in appearance than in clinical reality
- Reflect correctable flaws in the current system
- Improvement requires change by referrers, by facilities and by the system that funds them
What needs to be done

Them

• Appropriate funding for clerical and clinical requirements

• Funding formula to attract and retain endoscopists
What needs to be done

Us

• Triage of referrals that reflects the current reality

• Booking procedures that reflect the arrival of the telephone
What needs to be done
You

- Preparedness to undertake clinical review in 6 weeks – 6 months for many patients rather than refer all immediately
- Much greater attention to administrative detail (contact details!!) when completing the referral
- Do NOT book the patient into multiple public waiting lists