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Perceptions of Otolaryngologists on Single-Entry Models for Managing Wait Times in Community-Based Health Care in Ontario: A Qualitative Study

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Abstract

Importance. Long wait times for medical care have been exacerbated following the pandemic in many health systems. Single-entry models (SEMs) have been proposed as a strategy to manage growing surgical backlogs and increase timeliness and quality of care by creating a single queue and centralizing the referral triage process.

Objective. The primary objective was to evaluate the perceptions of SEMs among community otolaryngologists for managing surgical backlogs. The secondary objectives were to better understand their experiences with the current system and to investigate their recommendations for implementing an SEM.

Design. Interpretive Description.

Setting. Ontario, Canada.

Participants. Nine community-based otolaryngologists.

Intervention/Exposures. Not available.

Methods. Virtual semi-structured interviews were conducted with study participants. Data were independently analyzed using inductive and deductive methods by multiple team members. Results were triangulated, and a final coding framework was developed collaboratively from which themes were identified.

Main Outcome Measures. Perceptions of SEMs as well as recommendations for design and implementation.

Results. Three thematic domains and 9 subdomains were identified from our interview data: (1) factors affecting the utility of SEMs; (2) opinions and buy-in of physicians; and (3) opportunities to improve equity.

Conclusions and Relevance. We identified a number of factors that should be considered in supporting community-based otolaryngologists to adopt SEMs as a strategy for ensuring timely and equitable access to care. Clinical leaders and specialty organizations play a pivotal role for such changes to succeed. Implementing SEMs may be an important step toward increasing equity, quality, efficiency, and cost-effectiveness in otolaryngology.

Keywords

health policy, clinical research, quality of life, health services, pediatrics, outcomes/cost-effectiveness, clinical, allergy/rhinology

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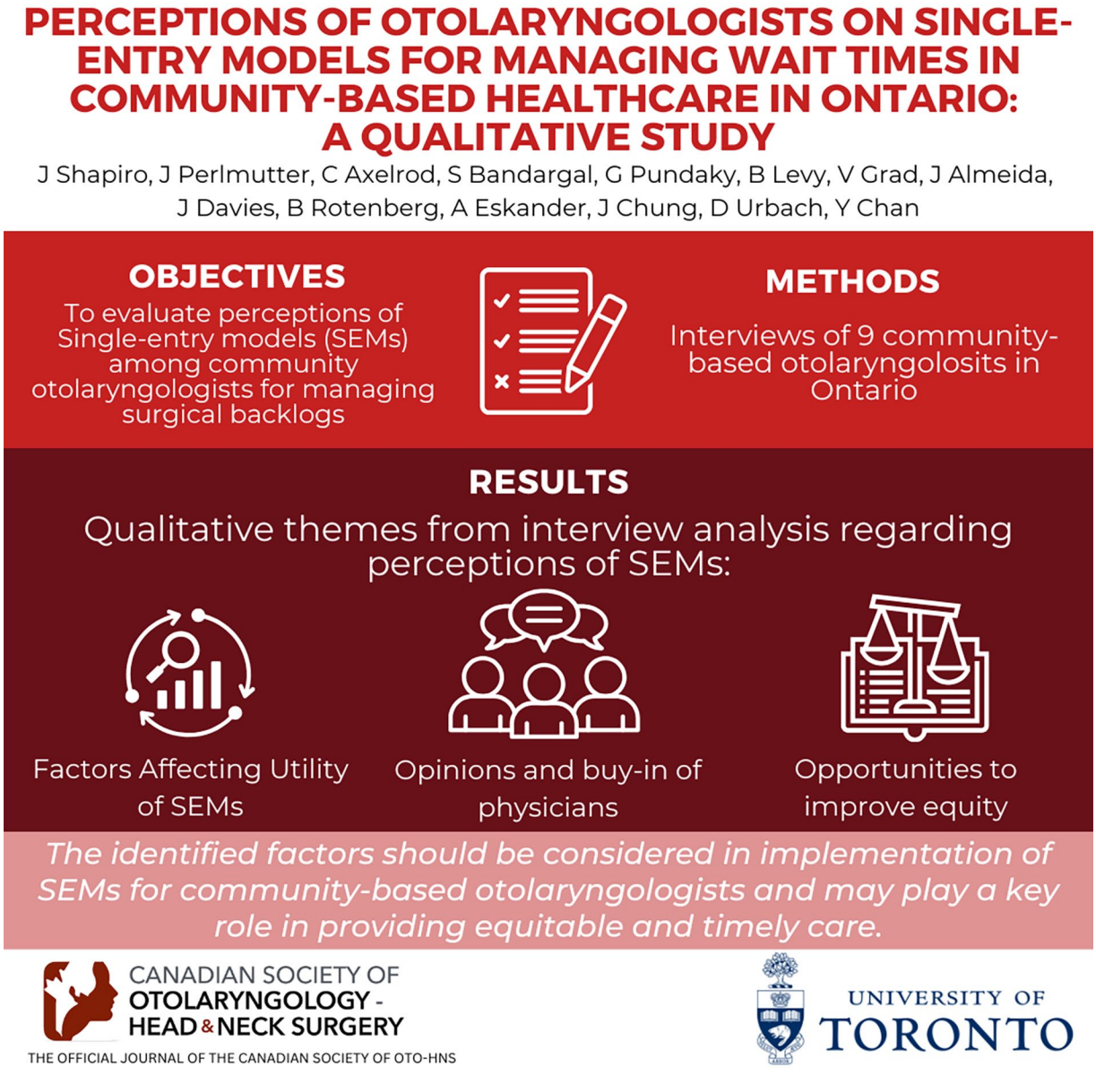
Graphical Abstract



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Introduction

Long wait times for medical care have been exacerbated across medical disciplines in many countries in the aftermath of the COVID-19 pandemic, and otolaryngology—head and neck surgery (OHNS) is no exception.[1-3] Our specialty faces a need for innovative strategies to manage worsening backlogs.[4] The problem is particularly acute for patients requiring high-volume procedures such as tonsillectomies or myringotomies. Traditional models of health care delivery are characterized by individual physicians managing their own waitlists, maximizing physician autonomy. However, these models prevent universal coordination of surgical referrals, reduce physicians' productivity by adding to their workload, and lack a reliable triage process to maximize patient outcomes.[5] Patient care is suffering due to increasingly contributing to poor efficiency at a system-wide level.[5]

Single-entry models (SEMs) have been proposed as a strategy to manage the long and highly-variable wait times resulting from growing surgical backlogs.[5,6] SEMs centralize the referral triage process by funneling patients into a single queue using objective criteria.[7-9] Patients are then prioritized and allocated to see the first available health care provider.[8] Such a system can be designed to ensure that patients are served based on medical necessity, rather than factors such as socioeconomic status or geographical location.[9] These models have been endorsed by national medical organizations, and provincial governments have increasingly allocated funding to developing SEMs.[7-9]

Preliminary findings from recent studies indicate that SEMs can reduce wait times and increase the timeliness and quality of care, with 1 review reporting a 57% decrease in wait times for surgical referrals.[9-11] The recent implementation of an SEM for hip and knee replacement surgery in Winnipeg improved streamlining of referrals, access to care, and monitoring of surgical outcomes.[6] However, these studies revealed that the implementation of SEMs was limited by a lack of physician buy-in, driven by concerns about efficacy, autonomy, and billing practices.[5] Otolaryngologists need not look beyond their own practices to grasp the mounting problem of lengthening wait times. The benefits of SEMs may be most pronounced in community settings, where the majority of care in OHNS is provided. However, review of the literature yielded no studies evaluating centralized intake in general otolaryngology. As such, we sought to evaluate the perceptions of SEMs for managing surgical backlogs among community otolaryngologists.

Methods

This research project received ethics approval from the University of Toronto Research Ethics Board (Protocol #00044197).

Study Design

This work is grounded in the qualitative research methodology of interpretive description. Such an approach allows us to explore the perceptions and experiences of community otolaryngologists regarding the utility of SEMs, for the purpose of generating practical knowledge for stakeholders involved in the development of SEMs.[2,8,22] Interviews were conducted and transcribed using Zoom (Copyright ©2024 Zoom Video Communications, Inc).[3,12]

Data Collection

We invited community-based otorhinolaryngologists from Ontario to participate in semi-structured interviews. Participants were recruited by purposive and snowball sampling. Interviews were conducted by J.S. and S.B. in English between January and March 2024 and lasted 20 to 30 minutes each. Interviewers were trained based on the recommendations of McGrath et al, including steps to minimize unconscious bias, and reviewed methods to address ethical tensions according to Schmid et al.[13,14,15] There were no prior relationships between interviewers and participants. Inclusion criteria included all practicing otolaryngologists in Ontario outside of academic hospitals. Exclusion criteria included otolaryngologists currently practicing within academic hospitals, those not actively practicing, and those unable to participate in an English-language interviews. Recruitment concluded when interviews no longer generated novel insights (ie, saturation was achieved). A hybrid data/inductive thematic saturation model was employed, where the depth, breadth, and consistency of themes reviewed after each interview to evaluate whether further data collection would yield new information.[16] Once it was evident that additional interviews were not contributing novel themes or insights, the recruitment process was concluded.[16]

Interview questions were designed by the research team based on literature review, consultation with content experts, and modification of interview guides used in prior related research carried out by several coinvestigators on our team.[17] Semi-structured interviews were transcribed using Zoom, and transcripts were verified for accuracy by G.P. Study participants were also invited to review the transcripts to confirm accuracy. Supplemental Appendix 1 contains our semi-structured interview guide.

Data Analysis

Two researchers (C.A. and J.P.) independently analyzed data using inductive and deductive methods.[16] An a priori coding framework was utilized, generated based on findings from prior SEM research, and novel codes were also created where the data required it.[18] The NVivo 14 software was used for coding.[19] The researchers triangulated their findings iteratively and with a third researcher, J.S., developed a final

Table 1. Demographics of the 9 Community Otolaryngologists Who Participated in the Semi-Structured Interviews Regarding SEMs.

Participant	Practice years of experience (<20, 20-30, >30)	Working or retired	Practice location (GTA, other)	Previous experience with SEMs (yes, no)
P1	20-30	Working	Scarborough	No
P2	N/A	Working	Peterborough	Yes
P3	20	Working	Brampton	No
P4	<20	Working	Niagara	No
P5	20-30	Working	Kitchener	No
P6	N/A	Working	Scarborough	No
P7	<20	Working	Stratford	No
P8	<20	Working	Mississauga	Yes
P9	<20	Working	Mississauga	No

Abbreviations: GTA, greater Toronto area; N/A, not available; SEM, single-entry model.

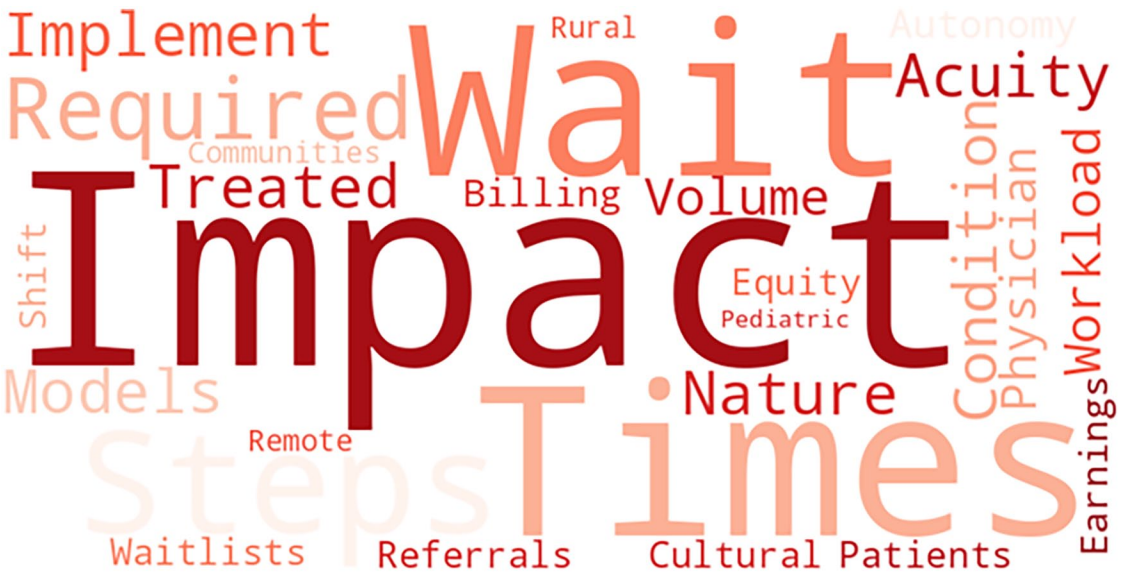

Figure 1. Key themes and frequencies across interviews.

coding framework from which themes were identified. Validity was established through data source, investigator, and theoretical triangulation.[16] Finally, the coding framework was finalized with the research team.

Results

We contacted 14 individuals, of whom 9 agreed to be interviewed for the study. The demographic details of study participants, including practice locations, years of experience, and previous experiences with SEMs, are displayed in Table 1. All participants were practicing otolaryngologists in Ontario; 3 also served as hospital administrators. The majority of participants (7/9) did not have previous experience with SEMs. The majority of participants (6/9) practice in the greater Toronto area. Figure 1 outlines the thematic domains and subdomains, as well as their relative frequency during interviews.

We identified 3 thematic domains from our interview data, each containing several subdomains (coding tree in Supplemental Appendix, available at 2). These domains included the following: (1) factors affecting the utility of SEMs; (2) opinions and buy-in of physicians; and (3) opportunities to improve equity.

Thematic Domain #1: Factors Affecting the Utility of SEMs

Wait times. Most participants believed that the primary metric for evaluating the utility of SEMs should be their impact on wait times. Further, the impact of the pandemic has exacerbated the already saturated waitlists of many otolaryngologists. As 1 participant noted, "I think the wait times have been historically long but not as long as they are now. There are added demands for the health care system with an increase in the population and stagnant resources" (P9). Participants

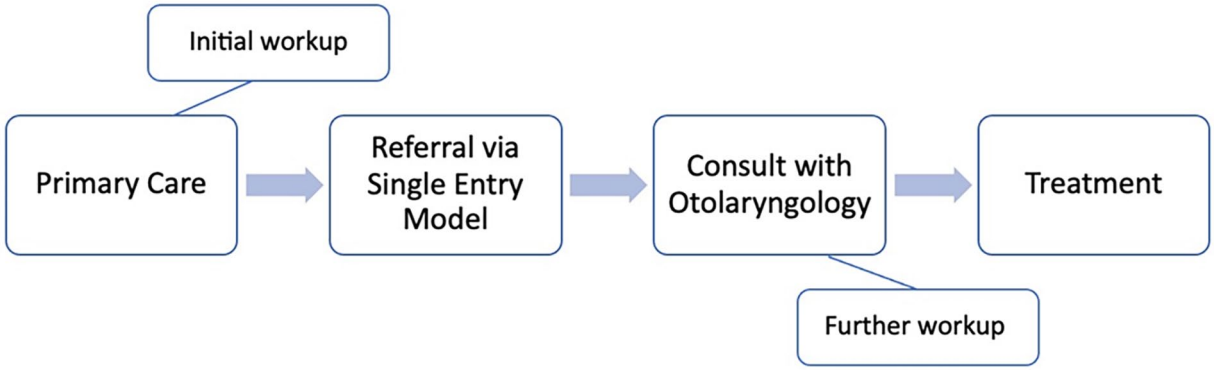

Figure 2. Example of patient flow through a SEM. SEM, single-entry model.

expressed that SEMs can potentially reduce wait times for initial consultations and surgical procedures. Another participant highlighted the issue of isolated waitlists, stating, "I think that there is some value in a SEM. If you're trying to reduce wait times, the thing is like all of each, separate surgeon—we're all basically in silos, and nobody knows what everybody else is, except maybe the chief of the division. Everybody else does not know what everybody else's waitlist is and what their OR availability is" (P1).

Steps required to implement models. Many participants noted that systemic reform must be implemented to facilitate the successful implementation of SEMs. This should include the allocation of adequate funding for adequate training to facilitate the triage process. Financial incentives for participation, such as fair consultation fees and subsidized clinic overheads, are also necessary to engage overworked surgeons. As 1 participant noted, "By basically increasing funding to cases that have traditionally had longer waitlists, this may drive the inherent willingness for surgeons to potentially operate on them more from a realistic perspective" (P6). Centralized electronic medical records should also be utilized to facilitate smooth referrals and yield accessible patient information. One participant suggested starting in larger centers: "I think starting in the biggest centers . . . I assume there's a lot more anonymity . . . And then if there was success and uptake there, then maybe it'd be seen in a positive light" (P2). Additionally, fostering buy-in from stakeholders through open communication, addressing concerns, and demonstrating the model's efficacy with data is critical. Figure 2 demonstrates a patient referral's journey through a proposed SEM.

Acuity and nature of condition being treated. Participants agreed that triaging within SEMs should prioritize patients based on the severity of their conditions rather than on a first-come, first-served basis. They also emphasized that SEMs would be most effective for procedures that are "general high volume," low morbidity, and require minimal follow-up (P2). Participants also stressed the importance of maintaining quality of care: "What needs to be prioritized? I think we have to prioritize not only the timeliness of care but also the quality of care. So not just that the patient is able to kind of see the first available individual. But the caveat is that they're seeing equally qualified specialists" (P5).

Thematic Domain #2: Opinions and Buy-In of Physicians

Impact on volume and workload. Participants believe that buy-in from surgeons to adopt a SEM model could be hindered by the fear their volumes of practice might lose direct referrals based on reputation and existing long waitlists, which some view as a metric for their success. Alternatively, newer surgeons with shorter waitlists may benefit from this system by gaining equitable access to patients. SEMs may also alleviate some of the administrative burdens and improve work-life balance by centralizing referrals. One participant noted: "As physicians switch to thinking about their quality of life, thinking about their work-life balance, no longer wanting to be available 365 days a year, wanting to share the load a bit and to have a life outside the office—I think that having a centralized referral model is better for these reasons. I think it will eventually lead to better work-life balance and quality of life for us" (P1).

Impact on physician autonomy. Participants believe that buy-in to adopt a SEM model will be hindered by fear of disruption to their control over case selection and lead to unfair distribution of cases. Many fear that without careful management, SEMs might result in some surgeons receiving a disproportionate number of lower paying or less desirable cases. "People have different niches and some people really like doing certain things for a variety of reasons. I just don't see that [SEMs] would be something that [those specialists] would be interested in at all" (P1). Another participant expressed concerns about fairness: "I think it's going to come down to—are things falling through the cracks? Do I still have autonomy over my practice? Am I going to get left with all these crappy cases and all the good ones are cherry-picked up by other people? These types of typical insecurities that people have" (P3).

Impact on billing and earnings. Participants suggest that buy-in to adopt SEMs may be limited by the increasing financial strain and workloads they already face due to low reimbursement rates and rising costs. The complexity and inadequacy of current physician fee codes in Ontario, coupled with fears of inequitable case distribution, may exacerbate the current strain faced by otolaryngologists if a SEM system were adopted. "Surgeons are running small businesses" (P3). Another participant highlighted the potential benefits for newer surgeons: "For surgeons, it's good because if you join a practice, and you've been there for six months, and your waitlist is still short, because the established surgeons are getting the lion's share of all the referrals, but you do your fair share of call—that's not really fair either . . . . So, I think it would only make it more fair, not less, if that makes sense" (P3).

Cultural shift regarding referrals and long waitlists. Participants highlighted that many surgeons take pride in having long waitlists and view it as a sign of their positive reputation among referring physicians. This cultural norm may pose a barrier to the implementation of SEMs, which will likely reduce these waitlists. Referrals based on personal connections and word-of-mouth were also seen as deeply-ingrained practices that could resist change. One participant noted their desire for a shift in this cultural norm by stating, "I'm sure there are places where people are anxious that their wait times are short and patient volumes are small to meet what they want. I'm sure. But in most places, there's more than enough work to go around, so we just need to be not worried about our referral patterns and hoarding that. We should be trying to spread it out as much as possible, I think" (P4). The implementation of SEMs would require a cultural shift such that maintaining a long waitlist is no longer equated to a desirable career accolade.

Thematic Domain #3: Opportunities to Improve Equity

Equity among patients in rural or remote communities. Participants recognize that SEMs could enhance patient equity by ameliorating disparities in access to care, particularly for those in rural or remote areas, where wait times can be excessively long. Implementing SEMs could facilitate a more equitable distribution of health care resources, ensuring rural patients do not experience longer wait times than their urban counterparts. However, challenges such as managing follow-up care and the feasibility of patients traveling to distant regions for procedures remain concerns. "Definitely [SEMs are beneficial for] the province, because I do know that there are some areas in the province where the wait list is one to two years to see an otolaryngologist—primarily in underserviced areas in rural Ontario. Because I actually see patients from those areas who come to me, they contact us when their wait time is unacceptably long" (P1).

Equity among pediatric patients. Participants highlight that pediatric cases often "slip through the cracks," (P4) with children being referred to neighboring hospitals due to long wait times. SEMs could streamline these referrals, ensuring timely and efficient care, particularly for pediatric otolaryngological issues such as snoring and sleep disordered breathing. "I can tell you that from our own institution, we do see slippage of pediatric patients who are referred to neighboring jurisdictions or neighboring hospitals like Trillium or Humber or elsewhere, simply because they just cannot be seen and dealt with in a reasonable amount of time" (P1). However, there is concern about how to fairly prioritize pediatric cases over adult cases and incentivize surgeons to take on more pediatric patients, as these decisions can be highly subjective and practitioner-dependent.

Discussion

In this study, we evaluated the perceptions of community-based otolaryngologists in Ontario on the role of SEMs in managing wait times within their practices and specialty. The following thematic domains were identified from analysis of study data: (1) factors affecting the utility of SEMs; (2) opinions and buy-in of physicians; and (3) opportunities to influence equity.

SEMs are receiving increasing recognition as an effective approach to tackling wait times in multiple health disciplines.[10,11,20] Studies have shown promising results with respect to reducing variation in overall wait times to assessment and surgery.[9,11] In fact, when designed to incorporate interdisciplinary health care teams, central intake models may even increase the appropriateness of referrals that are seen by physicians.[7,20]

These models have been endorsed by national medical organizations including the Canadian Medical Association, and provincial governments have allocated increasing funding to the development of SEMs in recent years.[6,8,21] This top-down approach has created an environment ripe for individual departments and health systems to design SEMs that address concerns in their local jurisdictions and specialties.[8,22]

Recent studies further bolster the case for SEMs across surgical and medical specialties.[11,22] Some of the positive effects observed after SEM implementation include increased efficiency and reduced wait times without compromising the quality of care.[11,20,22] As part of a study examining the role of SEMs in head and neck oncology, our research team recently interviewed head and neck surgeons across 8 head and neck cancer centers in Ontario.[22] Participants believed that SEMs could increase equity, quality, and timeliness of care for patients in their practices. Within the subspecialty of head and neck oncology, surgeons had valid concerns about the suitability of SEMs given the complexity of care and level of expertise necessary for treating these malignancies. Likewise, a revision frontal sinus surgery may not have the same suitability for standardization as a tonsillectomy. Alternative models to improve the current wait times have been trialed with varying success and also merit further exploration, such as eliminating the referral process entirely or utilizing urgent care models for minor ENT

ailments. For instance, bypassing traditional referral pathways via self-referral or direct-access may streamline care for certain conditions but has been compromising continuity of care and perpetuate inequity of outcomes.[21] Similarly, urgent care services could help address wait times by providing timely access if used for high-volume, low-complexity conditions. However, in reality these models have been shown to worsen wait times and overextend the resources of community sites as patients may present with conditions better managed by primary care providers or other specialists.[22]

Surgeons in our study endorsed SEMs as an innovative solution for managing wait times, particularly for high-volume, low-variation, low-acuity, and low-complexity surgeries. This is congruent with evidence across other surgical specialties.[6,23] Concerns over bureaucratic and technology demands to facilitate SEM implementation were acknowledged by participants, especially related to initial setup and ongoing management. However, several instances of SEM implementation in other specialties suggest that these challenges can be mitigated with thoughtful design and robust supportive infrastructure.[24] Physician and patient buy-in are critical, and aligning these models with stakeholder needs is essential for their success.[6] Overall, participants unanimously agreed that community-based practices, where the bulk of health care is delivered, would benefit from the adoption of SEMs for certain procedures and presentations.

Our study has several limitations. Firstly, the small number of study participants. However, this is common in qualitative research, and we attained a representative sample of otolaryngologists from across Ontario. Surgeons of various ages and backgrounds from rural, urban and suburban communities were represented, and saturation was achieved before recruitment was completed. The geographic restriction to 1 province was also a limitation in this study. However, Ontario is Canada's largest province and health care system. Evaluating the perspectives of subjects within 1 health system increased the likelihood of achieving saturation with a reasonable number of study participants. Further, all provincial health systems are structured according to the principles laid out in the *Canada Health Act*, and the study results should be generalizable to a large degree to other jurisdictions in Canada and beyond.

The small but growing body of evidence on SEMs increasingly demonstrates that central intake improves patient outcomes and boosts system-level performance. We are currently developing additional research protocols to study SEMs, which incorporate both qualitative and quantitative methods. Future research to study and describe the perspectives of other key stakeholders, such as referring physicians and patients, is also warranted. Various OHNS departments in which study investigators practice have moved or are considering moving to centralize referral intake for endocrine surgery, pediatric otolaryngology, or broader applications. Preliminary studies are currently underway to measure changes in wait times, case volumes, and patient-reported outcome measures after SEM implementation. Future studies could also provide further data on how SEMs can maximally improve efficiency, equity, and outcomes within OHNS.

Conclusion

Otolaryngologists need not look beyond their own practices to grasp the mounting problem of lengthening wait times. SEMs offer a practical, evidence-based approach that may help distribute patient flow through health systems more efficiently. Community-based otolaryngologists should consider adopting SEMs as one strategy for ensuring timely and equitable access to care. However, clinical leaders and specialty organizations must play a pivotal role for such transformative change to succeed. Implementing SEMs may be an important step toward increasing equity, quality, efficiency, and cost-effectiveness in our specialty.

Declaration of Conflicting Interests

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Supplemental Material

Additional supporting information is available in the online version of the article.

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