Access to occupational therapy in home care:

Will low priority referrals ever get their turn?

Marie-Hélène Raymond, OT(C), Ph.D. Student

Debbie Feldman, pht, Ph.D.

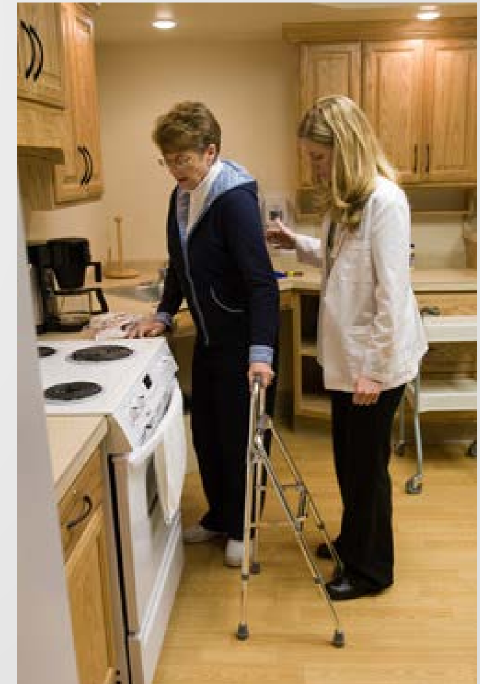
Louise Demers, OT(C), Ph.D.

Université de Montréal

marie.helene.raymond@umontreal.ca

Background

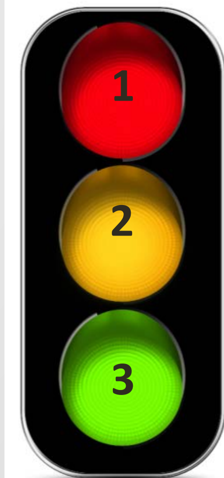
- General preoccupation for access to health care and waiting list reduction.
- Rehabilitation services in home care have an important role in the health care system: helping clients remain at home as long as possible (Canadian Home Care Association, 2011).
- Occupational therapist's role in home care:
  - Maximize clients' independence;
  - Ensure safety in activities of daily living.
  - Typical interventions:
    - Home adaptations
    - Assistive devices
    - Teaching strategies



- Increasing demand and staff shortages ➔

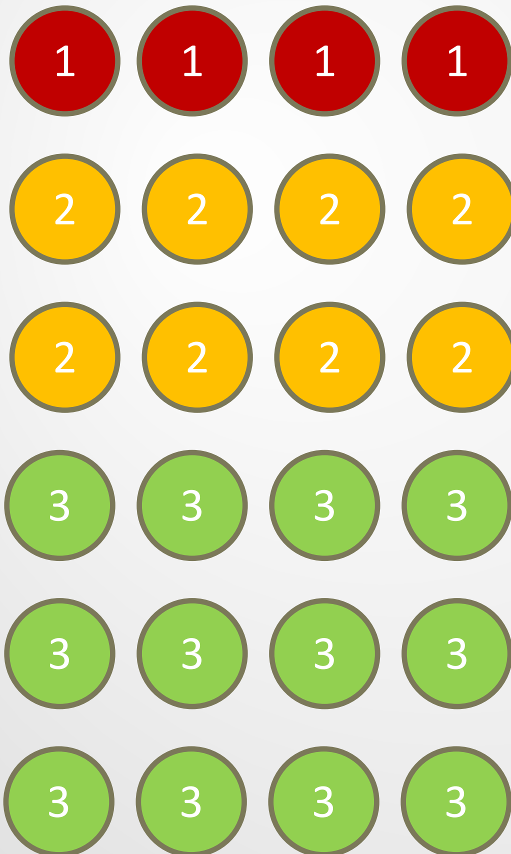
  Excessively long waiting lists
  - Months or years
  - Instances where clients die while on the waiting list are increasing (Carrier, 2008).

- Referrals are prioritized according to urgency level
  - Seen as a fair means of allocating scarce resources according to need (Curtis et. al, 2010; Nunez et. al., 2010; Sobolev &Kuramoto, 2010).
  - Lack of clarity and standardization in practices (Carrier et. al., 2010; Ní Shiothcháin et. al., 2010).



Referral prioritization

- "Queueing discipline": Rules for selecting referrals from the waiting list after they have been prioritized.



- Referrals are selected on a "first come first served" basis within each priority category.
- Basic or "traditional" prioritization: referrals of higher categories take precedence over lower categories
  - Risk for lower priority patients to be postponed indefinitely.
- Establish maximum wait time targets for each category
  - May be hard to meet if demand largely surpasses supply.

Low priority clients

- This lack of standardization can create inequities, especially for low priority clients who tend to bear the brunt of long waiting lists (Rastall & Fashanu, 2001).
- The needs of low priority clients may be less time-sensitive, but they are no less real than those of higher priority clients (Health Council of Canada, 2005).

Study objectives:

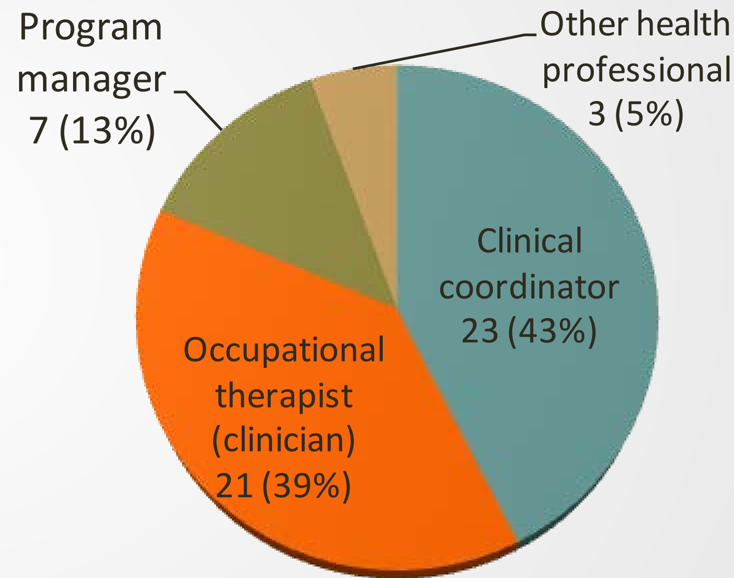
1. Document wait times and waiting list management practices targeting low priority clients in home-based occupational therapy in Quebec.
2. Investigate associations between these management practices and the length of the waiting list.

Methodology

- Survey design
- Structured telephone interview with the person who manages the occupational therapy waiting list in home care programs across Quebec (2012-2013)
- 59 of Quebec's 94 Health & Social Services Centres gave institutional approval for the project.

Study participants

- 54 participants (92% response rate)
- Job titles:

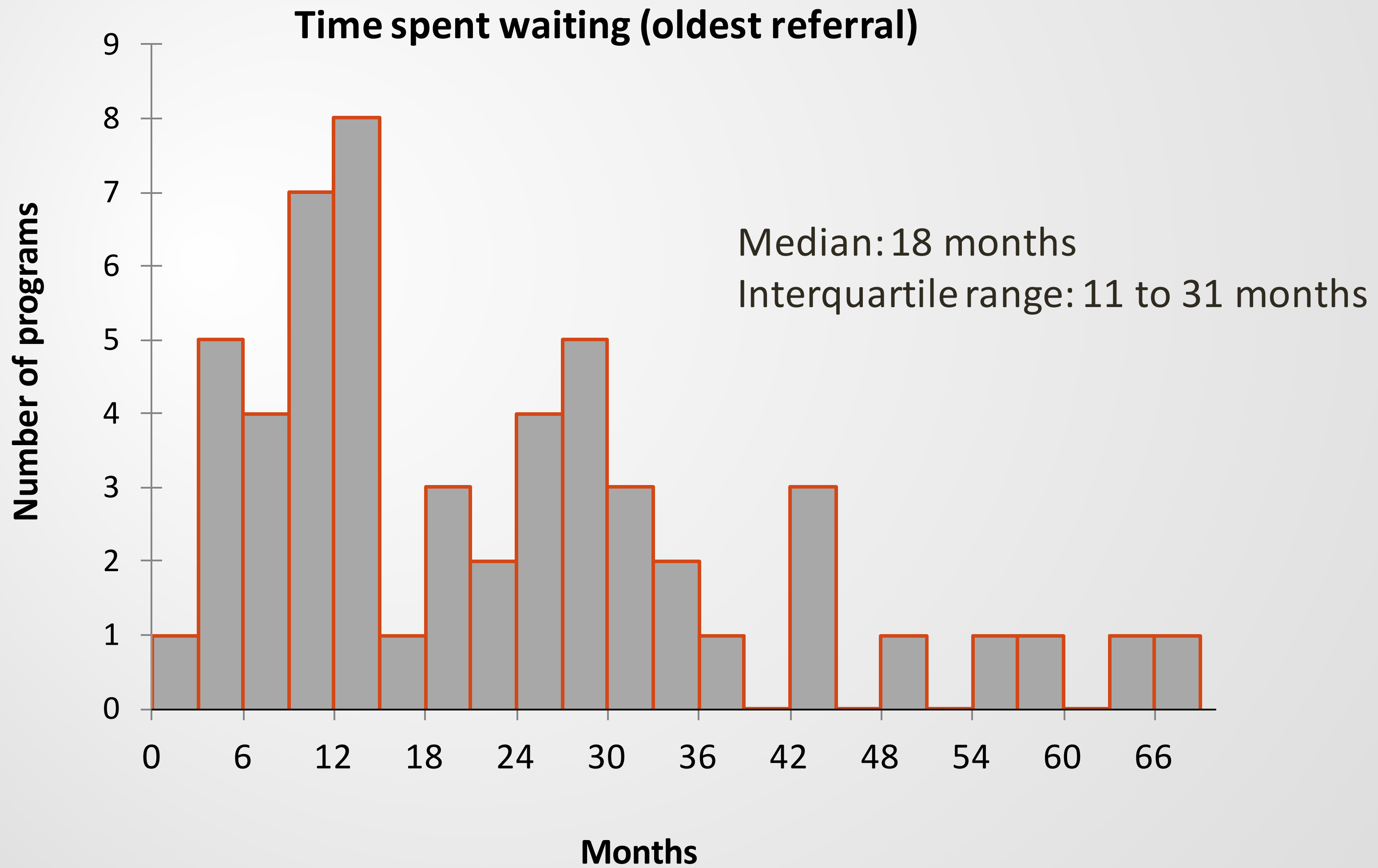


- Average of 3.9 full-time occupational therapist per program (S.D. 2.7 therapists).
- Wide variation in the size of the population covered by each program (average: 68 000 people, S.D. 50 000 people).

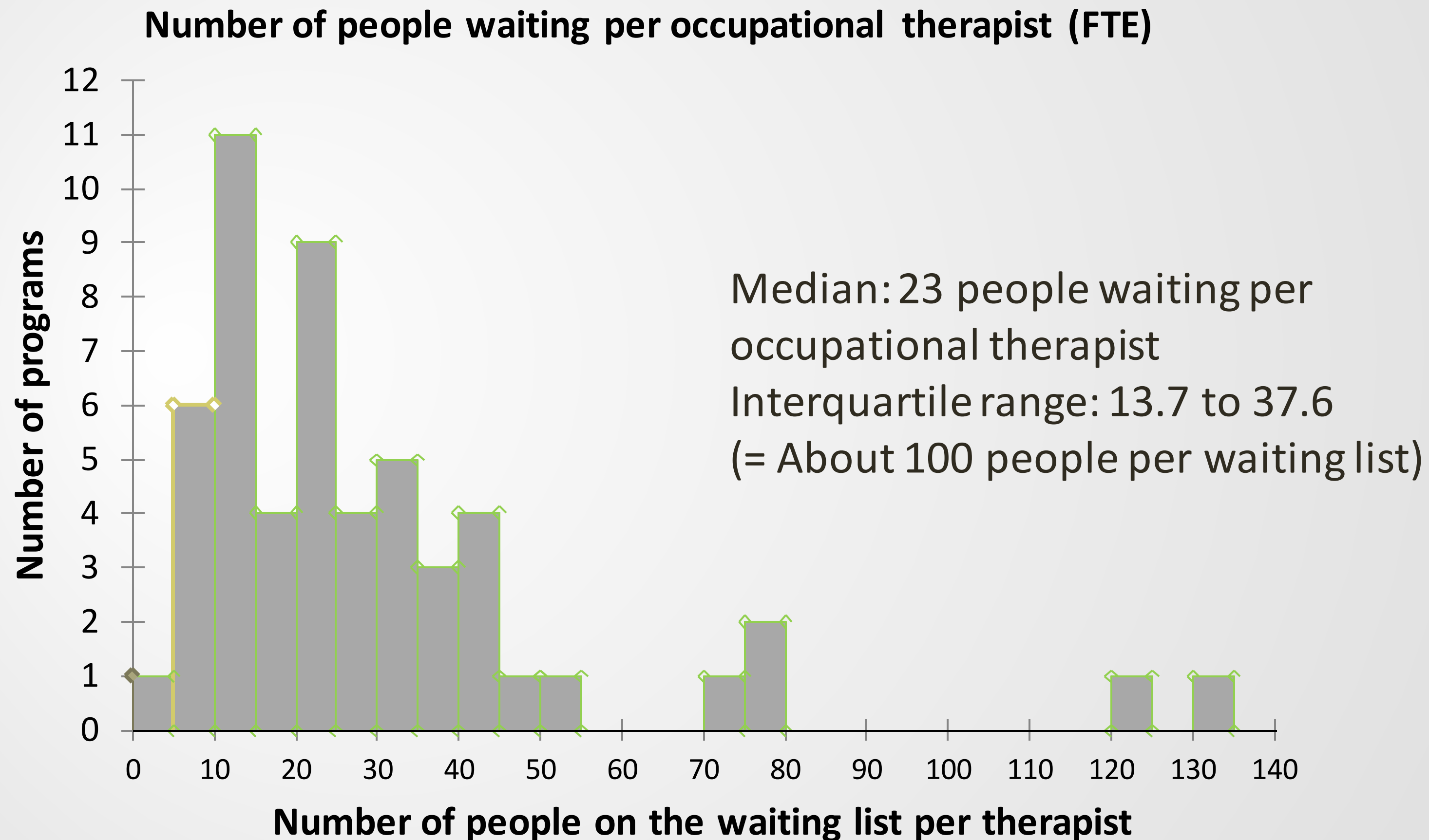
Prioritization practices

- All 54 programs prioritize referrals
- In-house prioritization tools (48 different tools)
- Common low-priority referral criteria:
  - non-acute health conditions;
  - functional independence or quality of life issues where safety is not at risk;
  - difficulties with : outdoor mobility, bathing, and entering and exiting the home due to architectural barriers, leisure;
  - interventions aimed at prevention and health promotion.

Length of waiting lists



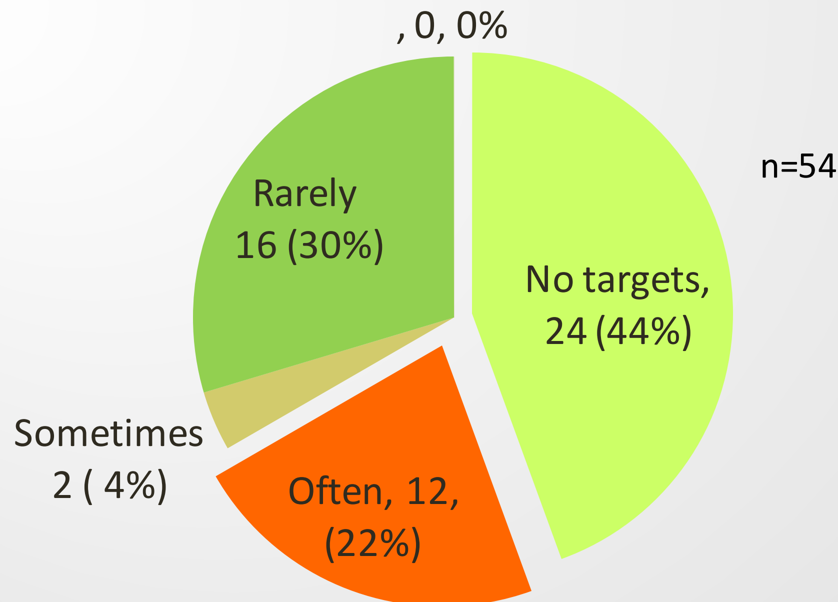
Length of waiting lists



- Substantial correlation (Spearman's ρ=0.56, $p < 0.001$) between maximum wait times and number of people on the waiting list per therapist.

Target maximum wait times

- 30 of 54 programs (56%) have target maximum wait times for low priority referrals.
- Median target: 12 months (range 2 weeks to 24 months)

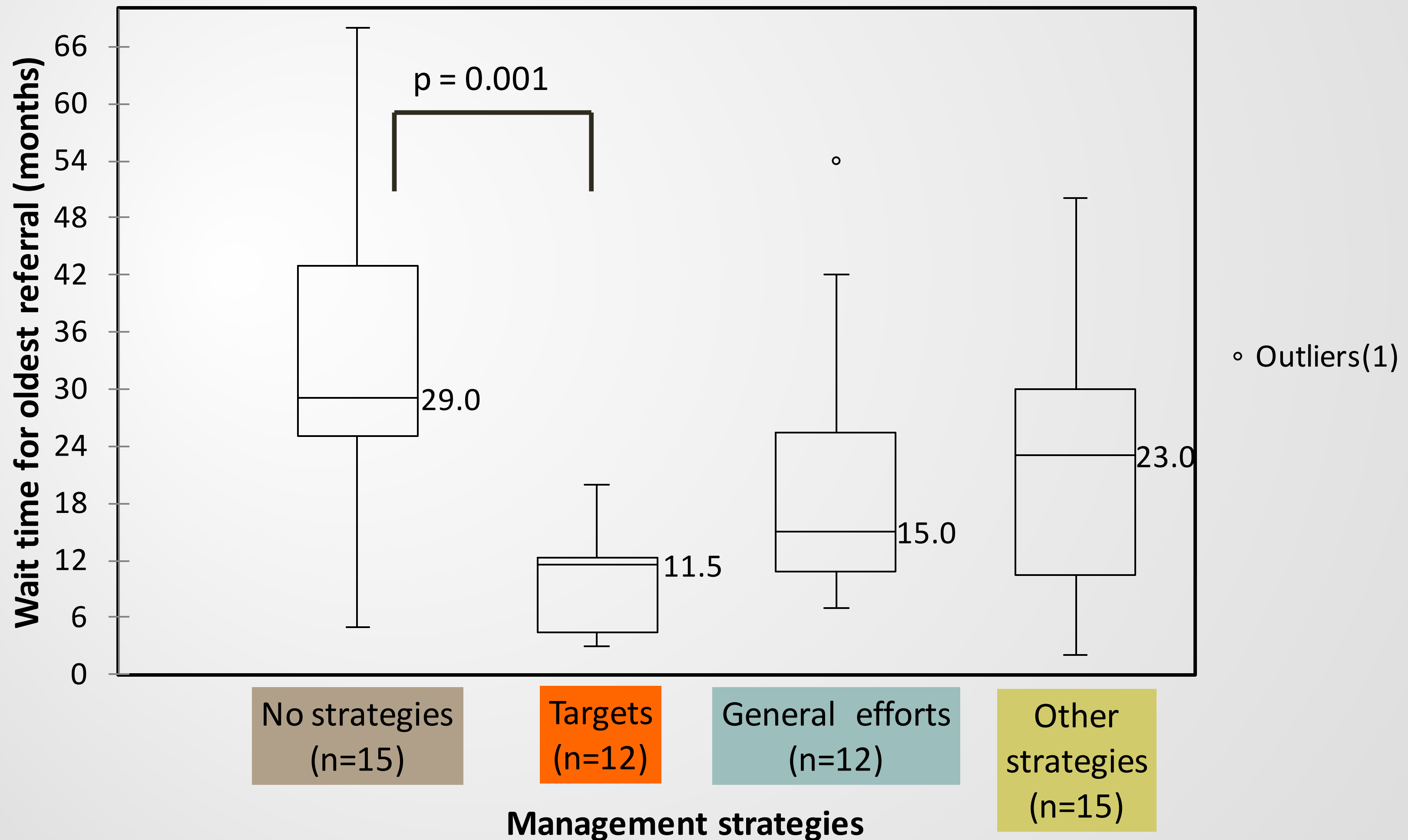


Management strategies for low priority referrals

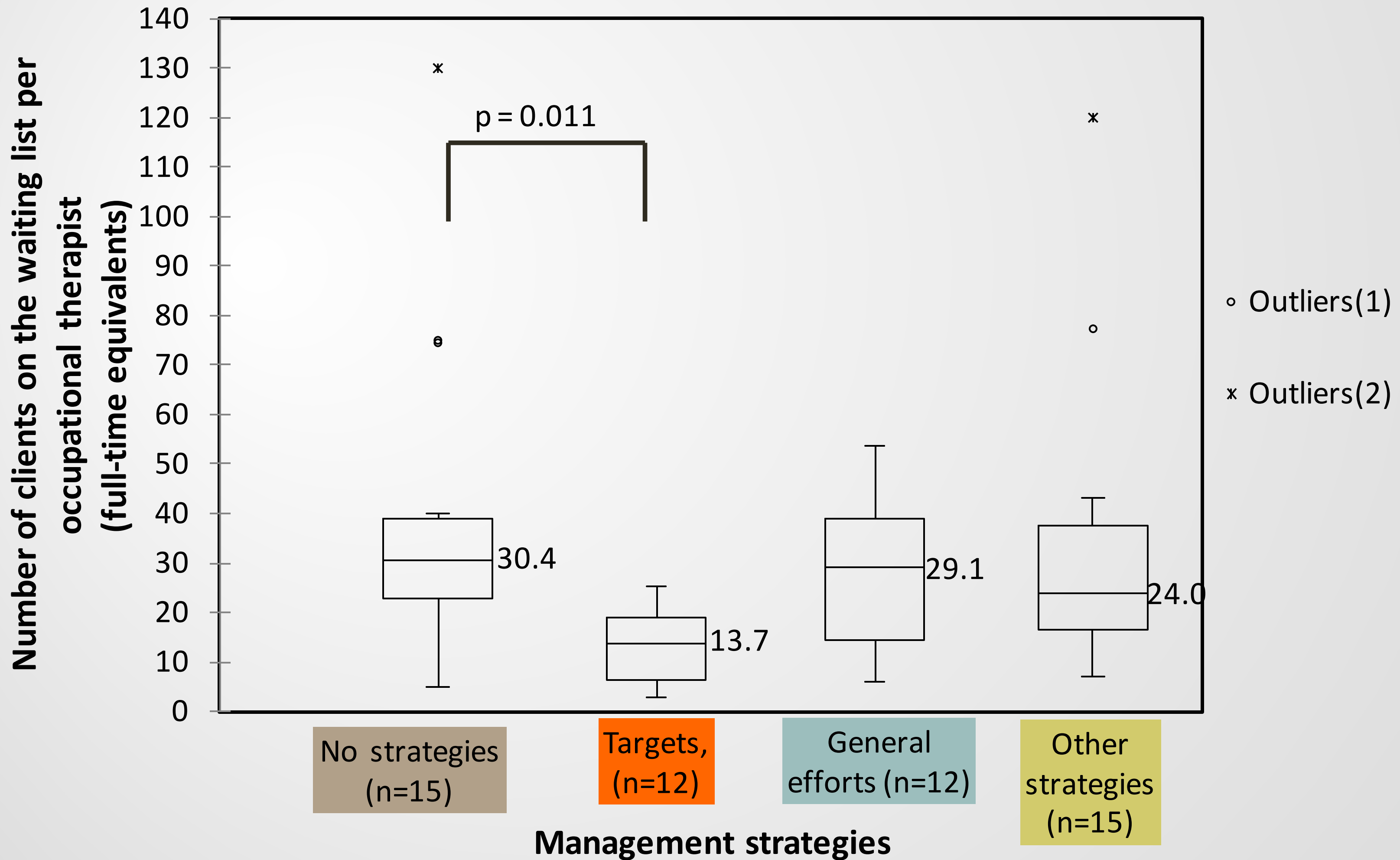
Do you use any strategies to allocate services to low priority clients?
n=54

Other strategies	n
Moving up in the waiting list	5
Dedicating staff (ongoing)	4
Dedicating staff (short term)	4
Periodical efforts	4
Highlighting "overdue" referrals	2
Assigning referrals in order of targeted date as opposed to priority level	1

Maximum wait times in relation to management strategies for allocating services to low priority clients



Number of clients on the waiting list in relation to management strategies for allocating services to low priority clients

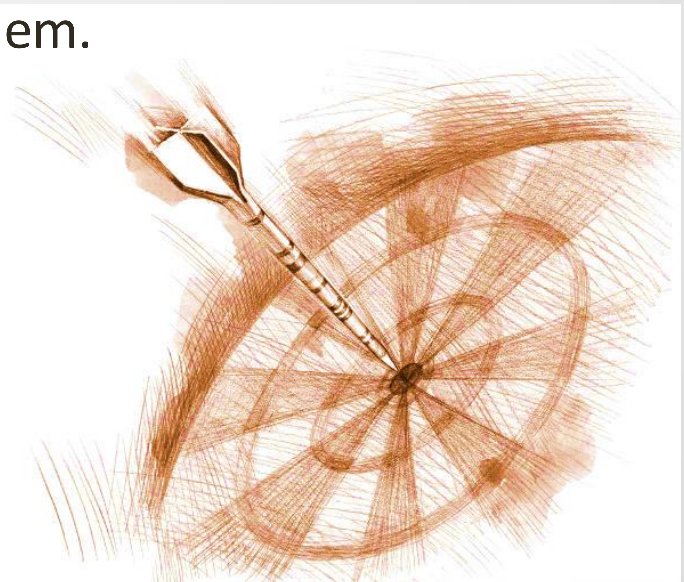


Implications

- Equity in access to home-based occupational therapy in Quebec is often compromised for low priority clients due to:
  - Excessively long wait times (Accessibility)
  - Exclusion from services (Universality)
- In absence of management strategies dedicated to low priority clients, these clients may never get their turn.
- Important to investigate management practices for low priority clients in waiting lists for elective health services.

Implications

- Target maximum wait times:
  - Discrepancy between intentions and actual practice.
  - More than half our sample had targets, but less than half of these reached their targets.
  - Perhaps the targets became too hard to reach.
  - Important to redefine more realistic targets in times of shortage instead of abandoning them.



Implications

- Difficult to select a low priority client from the waiting list due to fear of delaying services for high priority, “at-risk” clients.
- However, determining priority level is somewhat subjective, and the reliability and validity of available tools are less than optimal (Harding et. al, 2011 , Wright & Ritson, 2001; Leonard, 1993, Grime, 1990).
- In contrast, time spent on waiting list is an objective fact and should be considered when selecting a referral for services.

Conclusion

- Management practices dedicated to low priority clients can pose a threat to equity, accessibility and universality.

- Many different strategies are available to dedicate some services to low priority clients.

- We hope that waiting list managers for elective health services can be inspired by these strategies in order to manage their waiting lists more equitably.

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Acknowledgements

Fonds de recherche
Santé

Office des personnes
handicapées

REPAR
FRQS

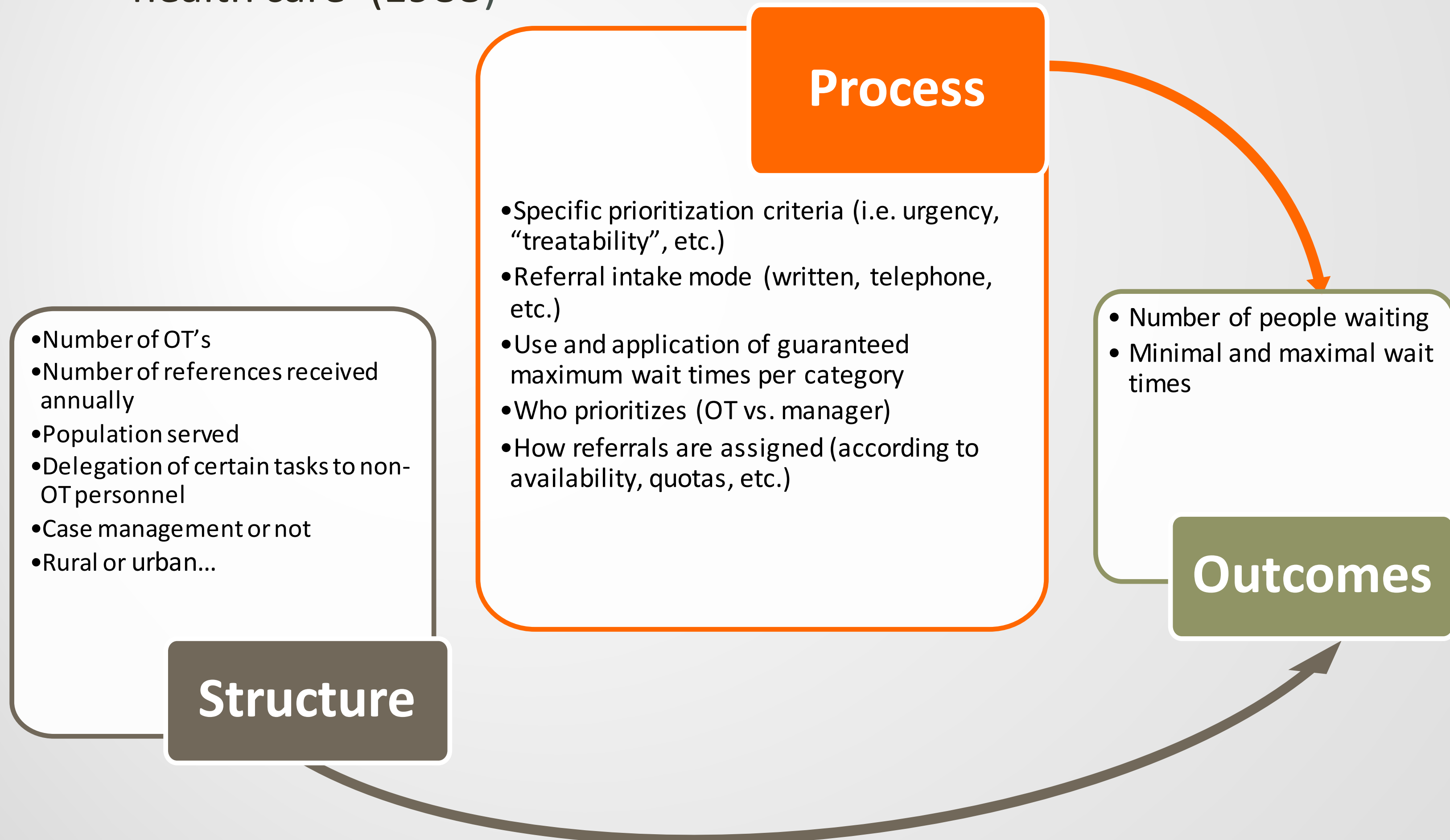
RÉSEAU PROVINCIAL DE RECHERCHE
EN ADAPTATION-RÉADAPTATION

Centre de recherche interdisciplinaire
en réadaptation du Montréal métropolitain

The Canadian
Occupational
Therapy
Foundation

Theoretical framework

- Frame of reference : Donabedian's writings on quality assessment in health care (1988)



Respondents vs. non-respondents

	Responding Health and Social Services Centres (n=54)	Non-responding Health and Social Services Centres (n=40)	p	Statistic
Urban status	59.3%	52.5%	p=0.514	X^2 (1) = 0.427
Percentage of the population aged 65 and over	Average = 14.9% (S.D. = 2.9%)	Average = 15.2% (S.D. = 3.8%)	p=0.644	Two-sample t (92) = 0.464

Statistical analyses

- <u>Length of waiting lists:</u>
  - A substantial correlation was found between the wait time for the oldest referral and the number of people on the waiting list per full-time occupational therapist (Spearman's $\rho = 0.56$, $n=54$, $p < 0.001$).

- <u>Kruskall-Wallis tests:</u>
  - Relationship between management practices (Groups 1 to 4) and wait time for the oldest referral:
    - A statistically significant difference was found ($H(3) = 23.38$, $p=0.001$) between groups 1 and 2.
  - Relationship between management practices (Groups 1 to 4) and number of people on waiting list per occupational therapist:
    - A statistically significant difference was found ($H(3) = 18.95$, $p=0.011$) between groups 1 and 2.

Limitations

- Cross-sectional design: no conclusions about effectiveness of management strategies (causality).
- Focus on low priority clients: does not reflect typical wait times for all clients.
- Possibility of differences with 40 non-participating health and social services centres which limits generalizability of findings.