Professional Ethics in Rehabilitation Network
Réseau sur l'éthique professionnelle en réadaptation

# Toolbox of wait list management strategies in rehabilitation

PERN is a research group studying various aspects of ethics in rehabilitation. In recent years, we have studied access to public outpatient physiotherapy and home-based occupational therapy services in the province of Quebec. Our results show that **equitable and timely access** to these services can sometimes be problematic. Many clinicians and wait list managers find it difficult to meet the needs of their clientele with **limited resources**, and there is **no standardized way of managing wait lists**.

This toolbox contains wait list management strategies that were mentioned by participants in our studies or that stem from our results. The list provides an overview of the different strategies that can be used, as well as considerations related to their application. It is designed so that users can add their reflections and comments as they go along, especially when using it to assess the situation in their own practice setting. These strategies should be viewed as **tools to consider** and **may or may not be applicable to your setting**.

We hope this toolbox is useful in **guiding your reflection** on wait list management.

**Don't forget:**

*Every wait list management strategy has its advantages and disadvantages.*

***Professional judgment** should always prevail in using these strategies.*

| Wait list management strategies | Presently used | Not applicable in our setting | Worth considering in our setting | Comments and reflections |
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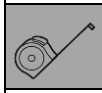
|  **At time of referral** | | | | |
| **Improve referral forms**<br>• Ask more specific questions on the referral form to decrease time spent obtaining required information when receiving the referral.<br>➢ But keep in mind that the person referring may not have the same professional knowledge as you do, so the requested information cannot be too specific. | ❒ | ❒ | ❒ | |
| **Seek the patient's perspective**<br>• Call or meet the patient to obtain their views on their problem and expectations for treatment.<br>➢ More patient-centred but time-consuming.<br>➢ Can be done systematically or occasionally, for referrals that are less straightforward. | ❒ | ❒ | ❒ | |
| **Inform the patient or person referring about expected wait times**<br>➢ Increases transparency.<br>➢ Wait times may be difficult to estimate and may increase frustration if wait times exceed estimation or are expected to be long. | ❒ | ❒ | ❒ | |
| **Do an in-person screening with an intervention before putting the person on the wait list**<br>• Establishes a more accurate priority level, and offers a short intervention (e.g., exercise program, education or advice) to help prevent deterioration during the waiting period.<br>➢ Associated with shorter wait times in outpatient physiotherapy departments in Quebec.<br>➢ Some outpatient physiotherapy departments stopped using this strategy when the number of new patients became too high and it became too time-consuming. | ❒ | ❒ | ❒ | |

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| **Redirect patients elsewhere**<br>• To optimize use of resources and decrease wait time for the patient, if resources are available elsewhere.<br>➢ May be done with or without placing the patient on your wait list, in the hope of obtaining the fastest service for them.<br>➢ May promote the use of private healthcare services, if referral is oriented to private service providers.<br>➢ May entail a risk of conflict of interest, if you or your service's employees have relationships with the other provider. Providing several resources can reduce this risk. | ❒ ❒ ❒ | |
| **Restrict access for certain categories of referrals**<br>• E.g., from a specific referral source, for a specific type of problem or for non-urgent patients.<br>➢ May be indicated if resources are systematically insufficient to meet all patient needs.<br>➢ Formally excludes certain clienteles but prevents putting people on a wait list with very low or no chance of being seen.<br>➢ May not be well received by patients or population. Need to check if acceptable according to governmental/ institutional laws and policies. | ❒ ❒ ❒ | |
| **Create a separate wait list for certain categories of patients or referral sources (e.g., patients from in-house physicians or with a certain diagnosis)**<br>• Dedicate stable resources to the separate wait list.<br>➢ May help respect continuity of care or contractual agreements with referral sources.<br>➢ May create ethical tensions because these patients could be favoured with respect to patients on the "regular" wait list. | ❒ ❒ ❒ | |

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| **Strategies related to prioritization** | | | | |
| **Prioritize referrals according to urgency**<br>• Usually in 3 or 4 categories; patients within each category are seen in chronological order of arrival on the wait list.<br>➢ Very common strategy; generally seen as fair as it adjusts wait times to urgency of patient need or risk.<br>➢ Prioritization criteria are not standardized across sites.<br>➢ Even when using referral prioritization tools, prioritization is complex and subjective. | ❒ | ❒ | ❒ | |
| **Apply maximum wait times for each priority category**<br>• Ensures low priority referrals are not recurrently pushed back.<br>➢ Associated with lower maximum wait times and less people on the wait list in home-based occupational therapy in Quebec.<br>➢ Seeing low priority patients based on maximum wait times may compromise the timely uptake of high priority patients if resources are too limited.<br>➢ Easier to apply if referrals are sorted in order of target date to be seen, instead of by priority level.<br>➢ Automatic reminders can also help, e.g., computerized wait list that highlights referrals that will soon reach their target date. | ❒ | ❒ | ❒ | |
| **Move referrals up one priority level after a predetermined amount of time**<br>• E.g., Priority 4 becomes Priority 3 after 6 months, and so on.<br>➢ As an alternative to using maximum wait times per priority category.<br>➢ Easier with a computerized wait list where this can be programmed automatically. | ❒ | ❒ | ❒ | |

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| **Seek potential service users' opinions about your prioritization criteria**<br>• Seek feedback about your prioritization tool from your institution's users' committee, community organizations, or patient partners.<br>➢ Although potential service users do not have all the necessary information to make resource allocation decisions, they have a distinct expertise that might help you view your services in a new light. | ❒ ❒ ❒ | |
|  **During the waiting period** | | |
| **Monitor the wait list closely**<br>• Program computerized wait list to obtain instant information on number of patients waiting, mean and maximum wait times for each priority level and for the whole wait list.<br>➢ Gives important feedback to help guide wait list management.<br>➢ May initially require help from information technology services. | ❒ ❒ ❒ | |
| **Regularly audit the wait list**<br>• Call back all patients on wait list to see if they still need services and if their needs have changed. Reprioritize the referral accordingly.<br>➢ Time-consuming; sometimes done by staff on "light duties".<br>➢ May reassure patients that they have not been forgotten, or revive frustration with long wait times.<br>➢ Particularly indicated for vulnerable clienteles at risk of deterioration or who may not be able to call back if their needs change. | ❒ ❒ ❒ | |
| **Request new referral after predetermined amount of time to maintain place on the wait list**<br>• As an alternative to auditing the wait list.<br>➢ May save time for your service but time-consuming and burdensome for the referral source and/or patient.<br>➢ May block access for vulnerable patients or increase patient frustration with wait times. | ❒ ❒ ❒ | |

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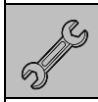
| **Provide patients with information or education during the waiting period**<br>• May help prevent deterioration or prepare them for the upcoming intervention.<br>➢ Can be done in person (e.g., group sessions) or in writing (e.g., pamphlet for a specific diagnosis or problem).<br>➢ Consider clinical risks vs. benefits of providing general information to patients before full assessment. | ❒ | ❒ | ❒ | |
|  **During clinical intervention** | | | | |
| **Teach self-management strategies to patients**<br>• May require lower frequency of visits than passive treatments.<br>• May also prevent new referrals in the future for same needs. | ❒ | ❒ | ❒ | |
| **Use group interventions**<br>• To optimize use of time.<br>➢ Consider the clinical appropriateness of a group intervention for the patient's individual needs.<br>➢ Consider whether the volume of patients with similar intervention needs is sufficient. | ❒ | ❒ | ❒ | |
|  **Strategies related to patient flow** | | | | |
| **Set goals for uptake of new patients in a given time period**<br>• Ensures regular uptake of new patients.<br>➢ Could be stressful for staff or seen as a threat to professional autonomy.<br>➢ May be more successful if therapists set their own goals.<br>➢ For more information about this strategy, see the "suggested reading" section at the end of this document. | ❒ | ❒ | ❒ | |

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| **Dedicate resources to patients who have been on the wait list for the longest time**<br>• Set aside one therapist, a certain amount of days per week, or specific time slots, for the oldest referral(s) on the wait list (as opposed to highest priority referrals).<br>➢ Ensures low priority referrals are eventually seen.<br>➢ Can be done on an ongoing basis, or periodically.<br>➢ May compromise the timely uptake of high priority patients if resources are very limited or demand is high. | ❒ ❒ ❒ | |
| **Revise professional caseload regularly**<br>• Therapists make sure to discharge patients as appropriate, to make room for new patients.<br>➢ Can be facilitated by establishing formal criteria for discharge. | ❒ ❒ ❒ | |
| **Set a limit for the number of treatment sessions**<br>➢ Distributes resources more equally between patients but means that certain patients' needs will not be fully met.<br>➢ May be seen as a threat to professional autonomy. | ❒ ❒ ❒ | |
| **Apply an attendance policy**<br>• Discharge patients who cancel appointments more than a set number of times to make room for new patients.<br>➢ May be difficult to apply systematically.<br>➢ Inform patients of the policy in advance.<br>➢ Consider reasons for cancellation and respect patients' limitations.<br>➢ May disadvantage vulnerable clienteles. | ❒ ❒ ❒ | |
|  **Broader strategies** | | |
| **Invest in health promotion and prevention strategies**<br>• Educate the public to engage in healthy behaviours and reduce need for services in the future.<br>➢ Requires a shift to a population-based approach that may not be traditionally implemented in individual rehabilitation services.<br>➢ Impact is difficult to measure in the short term but may be effective in the long term. | ❒ ❒ ❒ | |

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| **Advocate for patient/population needs and for increased resources**<br>• Create opportunities to advocate to your institution or government.<br>➢ Partnerships with external bodies may help.<br>➢ If possible, use data available in your setting to demonstrate unmet needs of patients/population.<br>➢ If possible, use research results to support advocacy efforts (for example, to demonstrate the cost-effectiveness of the service and effectiveness of early intervention). | ❒ ❒ ❒ | |

Do you have other ideas? Join the discussion on our Facebook page: www.facebook.com/PERN.ca/

**References from our research group:**


1. Deslauriers S., Raymond M.H., Laliberté M., Lavoie A, Desmeules F., Feldman D.E., Perreault K. (2016) Access to publicly funded outpatient physiotherapy services in Quebec: waiting lists and management strategies. *Disability and Rehabilitation*. Available at: http://dx.doi.org/10.1080/09638288.2016.1238967
2. Laliberté M, Feldman DE, Williams-Jones B, Hunt M. Operationalizing wait lists: strategies and experiences in three Quebec outpatient physiotherapy departments. *Physiotherapy Theory and Practice,* 2017, in press.
3. Raymond, M.H., Demers, L., Feldman, D.E. (2016).Waiting list management practices for home-care occupational therapy in the province of Quebec, Canada. *Health and Social Care in the Community*, 24(2), 154–164. Available at : http://onlinelibrary.wiley.com/doi/10.1111/hsc.12195/abstract;jsessionid=EB8B36295CA8135951C880E439EA94EA.f04t04
4. Raymond, M.H., Demers, L., Feldman, D.E. Differences in waiting list prioritization preferences of occupational therapists, elderly people and persons with disabilities: a discrete choice experiment. *Archives of Physical Medicine and Rehabilitation*, 2017, in press. Available at: http://dx.doi.org/10.1016/j.apmr.2017.06.031


**Suggested reading:**


1. Harding, K. E., S. G. Leggat, B. Bowers, M. Stafford and N. F. Taylor (2013). Reducing Waiting Time for Community Rehabilitation Services: A Controlled Before-and-After Trial. *Archives of Physical Medicine and Rehabilitation,* 94(1): 23-31.
2. Harding, K. E., N. F. Taylor, B. Bowers, M. Stafford and S. G. Leggat (2013). Clinician and patient perspectives of a new model of triage in a community rehabilitation program that reduced waiting time: a qualitative analysis. *Australian Health Review*, 37(3): 324-330.


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