Waiting list management practices for home-care occupational therapy in the province of Quebec, Canada

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Abstract

Referral prioritisation is commonly used in home-based occupational therapy to minimise the negative impacts of waiting, but this practice is not standardised. This may lead to inequities in access to care, especially for clients considered as low priority, who tend to bear the brunt of lengthy waiting lists. This cross-sectional study aimed to describe waiting list management practices targeting low-priority clients in home-based occupational therapy in the province of Quebec, Canada, and to investigate the association between these practices and the length of the waiting list. A structured telephone interview was conducted in 2012–2013 with the person who manages the occupational therapy waiting list in 55 home care programmes across Quebec. Questions pertained to strategies aimed at servicing low-priority clients, the date of the oldest referral and the number of clients waiting. Results were analysed using descriptive statistics and non-parametric tests. The median wait time for the oldest referral was 18 months (range: 2–108 months). A variety of strategies were used to service low-priority clients. Programmes that used no strategies to service low-priority clients (n = 16) had longer wait times (P < 0.0001) and a greater number of people on the waiting list (P = 0.006) compared with programmes that applied a maximum wait time target (n = 12). In conclusion, diverse strategies exist to allocate services to low-priority clients in home-based occupational therapy programmes. However, in programmes where none of these strategies are used, low-priority clients may be denied access to services indefinitely.

Keywords: health services accessibility, home-care services, occupational therapy, referral prioritisation, rehabilitation, waiting lists

Introduction

In recent years, much attention has been given to reducing waiting lists in healthcare (Health Council of Canada 2007, Willcox et al. 2007, Kreindler 2010). However, the great majority of these initiatives have targeted surgical and medical services, while home and community care waiting lists have received less consideration (Shamian et al. 2006, Passalent et al. 2010). At the same time, home and community care...
are taking on a growing importance in the healthcare scene (Canadian Home Care Association 2007), and it has been argued that reducing waiting lists in the overall healthcare system will not be feasible without a sufficient focus on home and community care (Shamian et al. 2006).

Rehabilitation services in home care contribute to the efficiency and effectiveness of the healthcare system by helping clients either regain or maintain their independence and remain at home as long as possible (Canadian Home Care Association 2011). Home-based occupational therapy is specifically aimed at maximising independence and ensuring safety in activities of daily living for clients and their caregivers (Carrier et al. 2010). Typical interventions include home modifications, provision and training in the use of assistive devices, and the teaching of strategies to enhance safety and performance in daily activities (Steultjens et al. 2004, Craig 2012).

In the past decade, access to home-based occupational therapy in the province of Quebec, Canada, has been compromised due to a persistent shortage of occupational therapists (von Zweck 2008) coupled with an increased demand in services related to the ageing population and the shift from hospital to ambulatory care (Ordre des Ergothérapeutes du Québec 2005, Canadian Association of Occupational Therapists 2008). The gap between demand and available resources has been recognised (Office des Personnes Handicapées du Québec 2009). Clients can wait for months or even years for home-based occupational therapy services (Raymond et al. 2013), and instances where clients die while on the waiting list are increasing (Carrier 2009). Such excessive wait times compromise clients’ rights to access services (Carrier et al. 2010) and often generate stress and anxiety for clients (Kreindler 2008, Ní Shiotcháin & Byrne 2009). Delayed access to occupational therapy also hinders the possibility of providing prevention and health promotion interventions before accidents happen (Sackley et al. 2009), and may lead to increased utilisation of other services during the waiting period (Canadian Association of Occupational Therapists 2008).

To minimise the negative impacts of delayed access to services, referral prioritisation, sometimes called triage, is common practice in rehabilitation (Rastall & Fashanu 2001, Harding et al. 2010, Passalent et al. 2010, Swan et al. 2010). Based on factors such as severity of symptoms, risk of deterioration and likelihood of benefiting from the intervention, clients are assigned a priority score or category which determines the relative speed at which they will receive the service. Prioritisation of referrals is generally recognised as a fair means of allocating resources in healthcare when demand exceeds supply (Sobolev & Kuramoto 2008, Curtis et al. 2010, Núñez et al. 2010) by tailoring wait times to the urgency of clients’ needs. However, waiting list prioritisation has some shortfalls, namely a lack of standardisation in the manner of prioritising referrals (Carrier et al. 2010, Curtis et al. 2010) and ensuing difficulties with reliability and validity of prioritisation tools (Harding & Taylor 2013).

One drawback of waiting list prioritisation that is less widely acknowledged is the lack of clear guidelines for managing the waiting list in accordance with clients’ priority levels. One study of prioritisation practices in community rehabilitation found very limited correlation between priority levels and actual wait times (Harding et al. 2012), which suggests that referral prioritisation alone may not be sufficient to guide waiting list management effectively. More importantly, wait times depend on the rules that are used to order the allocation of referrals after they have been prioritised (Sobolev & Kuramoto 2008), which is sometimes called the queuing discipline (Green 2006). While these rules may seem obvious at first glance, the literature offers varying standpoints on the subject.

In the most basic form of prioritisation, referrals in a given priority category are selected for services on a first come, first served basis, and clients of a higher priority category take precedence over lower priority categories, meaning that lower priority referrals are only selected if there are no higher priority referrals on the waiting list (Green 2006, Sobolev & Kuramoto 2008). However, when high-priority clients are numerous, this rule can prohibit access for low-priority clients who may endlessly be postponed (Ní Shiotcháin & Byrne 2009). Other authors recommend applying pre-established maximum wait times for each priority level (Patrick & Puterman 2008, Núñez et al. 2010), thus preventing eternal waits for low-priority clients. Yet, when resources are largely insufficient to meet demand, this is easier said than done. Valente et al. (2009) and Davis and Johnson (1999) propose a dynamic system whereby clients progress up the waiting list at different speeds, depending on their initial priority score, until they reach the top of the list. However, these systems require specialised software, and we are not aware of any reports of their application to rehabilitation or home care.

The heterogeneity in waiting list management practices can lead to inequities, especially for low-priority clients who tend to bear the brunt of lengthy waiting lists (Rastall & Fashanu 2001). When monitoring waiting lists in healthcare, the Health Council
of Canada (2005) recommends reporting not only average or median wait times but also the ‘wait list tail’, i.e. the longest waiters. Although these clients’ needs may be less time-sensitive, they are not necessarily less important than those of clients with more urgent needs (Health Council of Canada 2005). Accordingly, our study focused on the longest waiters for home-based occupational therapy services, whose access may be compromised due to lengthy wait times and unstandardised prioritisation or waiting list management practices.

Therefore, the main objective of this study was to describe waiting list management practices targeting low-priority clients in home-based occupational therapy in Quebec. A secondary objective was to investigate associations between these management practices and the length of the waiting list.

**Methods**

We conducted a telephone survey of home care programmes across the province of Quebec by interviewing the person who manages the occupational therapy waiting list. We aimed to sample one home care programme in each of Quebec’s 94 health and social services centres. Multicentre ethical approval was obtained through the Centre for Interdisciplinary Research in Rehabilitation of Greater Montreal. Each health and social services centre in Quebec includes one or more (average: 1.7) different home care programmes covering distinct territories. We randomly selected one home care programme in each of the centres that had given institutional approval, based on the fact that waiting list management practices are similar, if not identical, across programmes within one health and social services centre.

Data collection took place between September 2012 and June 2013. We contacted home care programmes by telephone to obtain the name of the person who manages the occupational therapy waiting list. These persons were sent an invitation letter and were asked to return a written consent form as well as their referral prioritisation tool, if they used one, by mail in a prepaid envelope. Non-respondents were sent a reminder letter after 3 weeks, and were contacted by telephone after another 3 weeks if they had not responded. If the person still did not reply or was unable or unwilling to participate, the procedure was repeated in another home care programme in the same health and social services centre, when available.

After receiving the informed consent form and prioritisation tool by mail, we conducted a structured telephone interview with each participant. The interview questionnaire was based on the relevant literature on referral prioritisation and waiting list management in rehabilitation and home care, as well as literature on survey development and administration (Dillman 2000, Bourque & Fielder 2003). It was pilot tested with two home-based occupational therapy waiting list managers and adjusted accordingly. Questions were mainly of multiple-choice and short answer form, and included descriptions of their referral prioritisation tools and practices, the number of people on the waiting list, the number of therapists (full-time equivalents), average wait time if available, the date of the oldest referral on the waiting list (excluding any clients who were not currently available for services, e.g. hospitalised) and waiting list management practices for low-priority referrals. For this study, we considered that waiting list management practices included the queuing discipline as well as any other strategies aimed at allocating services to low-priority clients. The interviews were audiotaped and the answers were transcribed on the survey form by the interviewer, referring to the recording as needed for verification.

Data on waiting lists and management practices were first analysed using descriptive statistics. Because participants did not have information on their mean or median wait times, the length of the waiting list was represented by the wait time for the longest waiter presently on the list (i.e. the wait list tail) and the total number of people waiting. Wait times were obtained by calculating the time difference between the date of the client’s referral to occupational therapy and the date of the study interview. The number of people waiting was divided by the number of occupational therapists (full-time equivalents) to account for the large variation in size of the home care programmes in terms of staffing and the size of the population that they covered. The number of occupational therapists is highly associated with the size of the population served by the home care programme (Spearman’s $\rho = 0.90, P = 0.000$).

To investigate associations between management practices and the length of the waiting list, management practices were considered as the independent variable and were categorised into four main groups. Analytical reasoning guided the identification and categorisation of management practices into these four groups by the research team, based on the nature of strategies used to service low-priority clients and the frequency distribution of each strategy. The dependent variables pertain to the length of the waiting list, operationalised by the maximum wait time and number of people waiting per full-time therapist. The association between management practice groups
and the length of the waiting list, in terms of wait times and number of people waiting, was analysed using the non-parametric Kruskal–Wallis test for independent samples due to the non-normal distribution of the data. All statistical analyses were performed using IBM SPSS Statistics Version 19.0 (IBM Corp. 2010).

Results

Respondent characteristics

Sixty health and social services centres gave institutional approval for the project. Of these, 55 people responded to the survey (91.7% response rate). Respondents’ job titles were clinical or professional co-ordinator (n = 23, 41.8%), occupational therapist clinician (n = 21, 38.2%), programme manager (n = 8, 14.5%) and other healthcare professionals (n = 3, 5.5%). Collectively, these participants managed the occupational therapy waiting list for 42.3% of existing home care programmes in Quebec. The territories covered by each participating home care programme served a population of 67,070 people on average (SD: 49,995 people). These home care programmes had an average of 3.9 occupational therapy full-time equivalents (SD: 2.7), excluding occupational therapy professional co-ordinators.

Of the participating programmes, 58.2% were localised in an urban setting as opposed to a rural setting, which is defined as having a population density of less than 400 people per square kilometre (Quebec Institute of Statistics 2008). Persons aged 65 years or older, who account for a large portion of the clientele in home-based occupational therapy, constituted on average 14.9% of the population of the surveyed programmes (SD: 2.9%) (Santé et Services Sociaux Québec 2006). There was no significant difference between responding and non-responding health and social services centres with respect to urban status [χ²(1, n = 94) = 0.174, P = 0.676] or percentage of the population aged 65 years and over [two-sample t(92, n = 94) = 0.272, P = 0.786].

Length of waiting lists

Wait times for the oldest referral on the waiting list ranged from 2 to 108 months (9 years), with a median of 18.0 months (interquartile range: 11.0–32.0 months, n = 55). The full distribution is presented in Figure 1. In 35 programmes (63.6%), the wait time for the oldest referral exceeded 12 months. Of note, most programmes (n = 43, 78.2%) performed waiting list audits regularly or occasionally, to ensure that all referrals on the waiting list remained appropriate over time. Therefore, the data presented here are not likely to represent persons who have moved, died or otherwise do not require services any more.

The number of people on the waiting list ranged from 2.9 to 130.0 people waiting per full-time equivalent therapist (median = 23.4, interquartile range = 13.8–38.0, n = 54). The distribution is presented in Figure 2.

A substantial correlation was found between the wait time for the oldest referral and the number of people waiting per full-time therapist (Spearman’s ρ = 0.58, n = 55, P = 0.000).
Referral prioritisation practices

All respondents prioritised referrals on their waiting list. Fifty-two of the fifty-five programmes (94.5%) used an in-house referral prioritisation tool; the three others informally prioritised referrals based on clinical judgement. These prioritisation tools comprised either two \( (n = 1) \), three \( (n = 14) \), four \( (n = 22) \) or up to seven priority categories \( (n = 4) \). The remaining programmes used a cumulative point system with a continuous score to express priority level \( (n = 11) \).

The vast majority of prioritisation tools had been developed within the participant’s own home care programme, sometimes in consultation with other home care programmes (for 42% of tools). None of the participants reported using consultation with service users, research evidence or testing psychometric properties (e.g. test–retest or inter-rater reliability) when developing the tool.

According to the 52 referral prioritisation tools provided, common low-priority referral criteria included functional independence or quality of life issues where safety is not at risk, and difficulties with the following activities: outdoor mobility and transportation, leisure, instrumental activities of daily living (IADLs) and entering and exiting the home due to architectural barriers. A detailed description of the referral prioritisation criteria in these tools is provided in another report (Raymond et al. 2013).

Waiting list management policies and practices for low-priority referrals

Thirty of the fifty-five programmes (54.5%) had a maximum wait time policy for low-priority referrals. These target maximum wait times had a median of 12 months (range 2 weeks to 24 months, interquartile range 5–12 months). In terms of actual practice, 12 participants stated that this target was often attained (40.0%), 2 participants (6.7%) claimed that it was sometimes attained and 16 respondents (53.3%) reported that it was rarely attained. In the 18 programmes where the target was not often attained, the research team considered that the target policy was not sufficiently applied in practice to reflect the programme’s management practices for low-priority referrals. Therefore, these 18 respondents, as well as the 25 respondents who did not have maximum wait time targets for low-priority referrals, were asked to explain which strategies, if any, were used in practice to give access to services to clients in low-priority categories. Sixteen programmes did not use any strategies. In those cases, low-priority clients simply waited until there were no higher priority clients on the waiting list, or were reprioritised to a higher category if the waiting list manager was informed that their condition had deteriorated. The 27 other programmes identified at least one strategy (see Table 1).
Strategies for referrals (see Table 1). In Group 1 (waiting list management practices for low-priority clients) we categorised the 55 programmes into four mutually exclusive groups according to their main type of practices and the length of waiting lists. We also expressed concern regarding the length of the waiting list, and the situation seems to have deteriorated considerably since then.

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Number of programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1: No strategies</strong></td>
<td>16</td>
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<tr>
<td>Low-priority clients must wait until there are no higher priority clients on the waiting list</td>
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<td><strong>Group 2: Maximum wait time targets (often respected)</strong></td>
<td>12</td>
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<tr>
<td>Low-priority clients are seen after a predetermined amount of time (median 12 months, range 2-24 months), regardless of other clients on the waiting list. In practice, this maximum wait time target is respected most of the time</td>
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<td><strong>Group 3: Informal efforts</strong></td>
<td>12</td>
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<tr>
<td>Waiting list manager tries to assign low-priority cases to therapists whenever possible even if there are higher priority clients on the waiting list, depending on clinical judgement and available resources, but has no formal rule to do so. No other strategies are used</td>
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<tr>
<td><strong>Group 4: Other strategies</strong> (some programmes use more than one strategy)</td>
<td>15</td>
</tr>
<tr>
<td><strong>Moving up in the waiting list:</strong> Referrals are moved up one priority level in the waiting list after a predetermined amount of time (range 3-12 months, median 6 months)</td>
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<td><strong>Dedicating staff (ongoing):</strong> Certain staff members are dedicated to low-priority referrals for a certain number of days per week (range 1-3 days per week in total per programme) on an ongoing basis</td>
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<td><strong>Dedicating staff (short term):</strong> Short-term or contractual staff are dedicated to low-priority referrals, or students or new staff take low-priority referrals for training purposes as they are usually less complex than high-priority referrals</td>
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<td><strong>Periodic efforts:</strong> Managers/teams decide to assign some or all of their low-priority referrals on an annual (n = 2) or seasonal (n = 1) basis, or periodically dedicate a time slot to specific types of low-priority referrals (e.g. power mobility clinics every 6 months) (n = 1)</td>
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<tr>
<td><strong>Visual reminders:</strong> Waiting list manager highlights the referrals that have surpassed the maximum wait time target</td>
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<tr>
<td><strong>Target date:</strong> Waiting list manager assigns referrals in the order of targeted date (which is a function of priority level and date received) as opposed to only considering priority level</td>
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</table>

**Relationship between waiting list management practices and the length of waiting lists**

We categorised the 55 programmes into four mutually exclusive groups according to their main type of waiting list management practices for low-priority referrals (see Table 1). In Group 1 (n = 16), no strategies were applied. In Group 2 (n = 12), maximum wait time targets were established and were often attained. In Group 3 (n = 12), informal efforts were made to assign low-priority referrals to therapists whenever possible despite there being higher priority referrals on the waiting list. This was based on the waiting list manager’s clinical judgement, and there was no systematic rule or procedure to guide the decision. All remaining programmes (n = 15) used other specific strategies to allocate services to low-priority clients, such as dedicating staff to low-priority referrals, making periodic efforts, etc. Given the small number of respondents using each of these strategies, they were categorised together in Group 4.

Wait times for the oldest referral for each of these groups are presented in Figure 3. A statistically significant difference was found [H(3) = 24.43, P = 0.000] between Groups 1 and 2. The statistical difference between these two groups was present even when the outliers of the full distribution were removed from the analysis [n = 52, H(3) = 21.05, P = 0.003].

The number of people on the waiting list for each of the four groups is presented in Figure 4. Again, a statistically significant difference was found [H(3) = 20.24, P = 0.006] between Groups 1 and 2. When the outliers of the full distribution were removed from the analysis, this difference remained significant [n = 50, H(3) = 16.01, P = 0.037]. Furthermore, with these outliers removed, a statistically significant difference was found between Groups 2 and 3 [n = 50, H(3) = 16.17, P = 0.04].

**Discussion**

The results of this study confirm that low-priority clients on home-care occupational therapy waiting lists in the province of Quebec can wait for a very long time, with a median wait time of 18 months for the oldest referral on the waiting list. These wait times far exceed those that have been described previously. A survey conducted in 1998 with 249 home-care occupational therapists in Quebec indicated that most programmes had a wait time of under 3 months for non-urgent referrals, with only 14% of programmes exceeding 6 months (Hébert 2000). At that time, most respondents already expressed concern regarding the length of the waiting list, and the situation seems to have deteriorated considerably since then.
Because our study focused on the longest waiters, wait times reported here do not represent the typical wait for home-based occupational therapy services. Nonetheless, these results still may not reflect the longest possible wait for low-priority referrals. In more than a quarter of the surveyed programmes, no strategies are used to allocate services to low-priority clients, and so wait times are allowed to grow indefinitely as long as there are higher priority referrals on the waiting list. In programmes where the longest wait time exceeds 2 or 3 years, it is reasonable to conceive that these clients may in fact never get their turn to access services. This constitutes a threat to universal access to healthcare, which is an essential component of health equity according to the World Health Organization (2013) and is a main principle of the Canada Health Act (Government of Canada, 1985).
Regarding waiting list management practices, many of the strategies evoked by our participants echo those reported by other surveys in outpatient rehabilitation. In Rastall and Fashanu’s (2001) survey of outpatient physiotherapy departments in the United Kingdom, some programmes allocated time slots or dedicated staff to low-priority referrals. A small portion of participants in the Passalent et al. (2010) Ontario survey also reported using guaranteed maximum wait times to manage their waiting lists in outpatient rehabilitation. While these studies addressed the perceived effectiveness of waiting list management strategies, our findings provide empirical data on their association with the length of waiting lists. The results suggest that programmes that do not use any strategies to allocate services to low-priority referrals have significantly longer waiting lists than programmes that consistently use maximum wait time targets, both in terms of actual wait times and number of people waiting. Given the cross-sectional nature of this survey, it is not known whether programmes that meet their wait time targets are able to do so because they have less people waiting in the first place, or if the smaller number of people waiting is the effect of consistently conforming to maximum wait time targets. Some of our respondents suggested that low-priority referrals tended to be less complex and thus faster to treat than high-priority referrals. This might explain the association that we found between shorter maximum wait times and less people on the waiting list in our study. If this is true, servicing low-priority clients more often might be a way of reducing the number of people on the waiting list. However, further research is needed to confirm this.

Some discrepancies were found between intended waiting list management policies and actual practice. While more than half of our sample reported having maximum wait time policies for low-priority referrals, less than half of these reached their targets most of the time. It is possible that staff shortages and increasing demand for services have gradually rendered these targets too difficult to attain, and that some providers have abandoned the policy instead of redefining a more realistic target. This ambivalence may also reflect the controversy about maximum wait times that is reported in the literature about waiting list management for elective surgeries. On the one hand, the use of targets can be effective in reducing wait times, especially if these targets are achievable and are enforced by upper management with financial incentives, such as rewards or penalties (Kreindler 2010). On the other hand, the use of wait time targets can lead to ethical dilemmas because they can contradict clinical priorities by delaying services for clients with more urgent needs (Siciliani & Hurst 2005, Council of Europe 2012, Santé et Services Sociaux Québec 2012). Consequently, some providers may see maximum wait time targets as a threat to their professional autonomy (Kreindler 2010), especially if they did not set the target themselves.

In practice, deciding on which clients to select from the waiting list according to their priority level is no easy task, especially considering that the effects of delaying occupational therapy services in home care are not well documented in the literature. It may be difficult to visit a client in need of home adaptations for fall prevention ahead of an elderly person with dementia living alone and who repeatedly leaves the stove on or forgets their medication. However, waiting list managers should keep in mind that the reliability and the validity of referral prioritisation tools in rehabilitation is less than optimal (Leonard 1993, Wright & Ritson 2001, Harding & Taylor 2013), and that determining priority levels can be quite subjective in nature (Grime 1990, Carrier et al. 2010). In contrast, time already spent on the waiting list is an objective fact. Therefore, it seems wise to give some weight to the amount of time already spent on the waiting list when selecting the next client to service, as opposed to solely assigning referrals on the basis of their priority level. The ‘Target date’ strategy presented in Table 1 seems to be a simple way of combining both priority level and time spent waiting when selecting referrals. This strategy consists of defining a target maximum wait time for each priority level, and upon reception of the referral, determining the target date to see the client according to their priority level. For example, an urgent referral received today could be targeted for this week, whereas a low-priority referral received today could be targeted for 1 year from now. Although there is no guarantee that the target will be met, by sorting the referrals in the order of target date instead of ordering them by priority level, low-priority clients have less chance of being constantly pushed to the bottom of the waiting list.

If using any such strategies to service low-priority clients is consistently impossible because it seriously compromises the safety of higher priority clients, programme managers should reconsider the scope and range of services that they are realistically able to provide. This may require a broader reflection on alternative ways of organising services to meet the needs of community-dwelling persons who are experiencing loss of autonomy. For example, in home-based occupational therapy, skill mix is increasingly being used. This allows home health aides to make recommendations for bathing equipment in certain cases, freeing
occupational therapists for more complex tasks (Guay et al. 2010, 2014). Furthermore, in a large urban community rehabilitation centre, a new intervention consisting of immediate appointments without waiting lists significantly reduced wait times without adverse effects on clients or staff (Harding et al. 2013a, b).

Limitations

The main limitation of this study is that it focuses only on the longest waiters, i.e. the ‘tail’ of the waiting list, and thus does not give a full representation of wait times for home-based occupational therapy in Quebec. This is due to the fact that the respondents of our survey, i.e. the person managing the waiting list, did not have data on mean or median wait times for their services. This brings into question how managers can effectively monitor their waiting lists without having such basic information on hand. Nonetheless, the fate of the longest waiters in the queue should not be overlooked (Council of Europe 2012), especially as long wait times can undermine the public’s confidence in the healthcare system (Siciliani & Hurst 2005).

This study was also limited by its cross-sectional design, which precludes us from drawing any conclusions about the effects of waiting list management practices on the length of waiting lists. The small number of programmes that use the strategies grouped in the ‘other’ category (Group 4) also does not allow to study their individual associations with the length of the waiting list. Nevertheless, we hope that the results will broaden waiting list managers and decision-makers’ perspectives on some types of strategies that can be used. Finally, although the participation rate was high (91.7%) among the 60 people that we approached for the study, there are 34 other health and social services centres in Quebec that were contacted but did not give institutional approval for the project. It is not known whether this was due to lack of time, unwillingness to divulge their waiting list data or for other reasons, but in any case there is a possibility of differences between our sample and the target population which may affect the generalisability of the results.

In sum, this study demonstrates that although maximum wait time targets are associated with shorter waiting lists and wait times in home-based occupational therapy, their use remains limited. To provide clear recommendations on the use of maximum wait time targets and other strategies aimed at servicing low-priority clients, further research is needed to document the clinical effects of these strategies and the consequences of waiting for home-based occupational therapy.

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Competing interests

The authors declare that there is no conflict of interest.

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