

**ACREU**



Arthritis Community Research & Evaluation Unit

**ARTHRITIS COMMUNITY RESEARCH &  
EVALUATION UNIT (ACREU)  
University Health Network**

# **WAIT LISTS AND WAIT TIMES FOR COMMUNITY-BASED ADULT REHABILITATION IN ONTARIO**

**MARCH 2006**

*Prepared by:*

Laura Cook  
Michel Landry  
Cheryl A. Cott

*With contributions from:*

Kathleen Sheridan  
Crystal MacKay

**In partnership with the Mental Health and  
Rehabilitation Reform Branch, Ministry of Health and  
Long-Term Care**

**\*Address for correspondence:**

**Arthritis Community Research &  
Evaluation Unit (ACREU)  
Toronto Western Research Institute  
399 Bathurst Street  
MP-10<sup>th</sup> Floor, Suite 316  
Toronto, ON M5T 2S8  
Tel: (416) 603-6269  
Fax: (416) 603-6288  
[www.acreu.ca](http://www.acreu.ca)**

*Working Report 2006-02*



**University Health Network**

Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

# TABLE OF CONTENTS

<b>1</b>	<b>INTRODUCTION.....</b>	<b>1</b>
1.1	Background and Rationale .....	1
1.2	Purpose and Objectives.....	2
<b>2</b>	<b>LITERATURE REVIEW (Phase 1).....</b>	<b>4</b>
2.1	Search Strategy .....	4
2.2	Search Results .....	6
2.2.1	Measurement of Wait Times and Wait Lists .....	7
2.2.2	Extent of Wait Times .....	7
2.2.3	Wait Time Management Methods.....	8
2.2.4	Wait Time Perceptions .....	9
<b>3</b>	<b>KEY INFORMANT INTERVIEWS (PHASE 2).....</b>	<b>11</b>
3.1	Methods.....	11
3.1.1	Sampling and Recruitment .....	11
3.1.2	Procedure.....	12
3.2	Analysis .....	12
3.3	Results.....	13
3.3.1	Wait Time and Wait list Measurement .....	13
3.3.2	Wait Time and Wait list Management.....	13
3.3.3	Wait Time and Wait list Perceptions .....	16
<b>4</b>	<b>SURVEY OF COMMUNITY-BASED REHABILITATION SETTINGS IN ONTARIO (PHASE 3) .....</b>	<b>19</b>
4.1	Method.....	19
4.1.1	Sampling .....	19
4.1.2	Questionnaire Development.....	21
4.1.3	Procedure.....	23
4.2	Analysis .....	23
4.3	Results.....	24
4.3.1	Response Rate.....	24
4.3.2	Description of settings Service Provision (Figure 1) .....	25
4.3.3	Wait Lists.....	30
4.3.4	Wait Times .....	33
4.3.5	Wait List Management.....	39
<b>5</b>	<b>DISCUSSION.....</b>	<b>45</b>
5.1	Demand for Service .....	45
5.1.1	Chronic Conditions .....	45
5.1.2	Hospital Outpatient Services .....	46
5.2	Service Capacity.....	48
5.2.1	Staffing .....	48
5.2.2	Hours of Operation/Service Availability .....	49
5.2.3	Settings .....	49
5.3	Study Limitations .....	49
<b>6</b>	<b>CONCLUSIONS AND RECOMMENDATIONS .....</b>	<b>51</b>

## APPENDIX

Appendix A .....	58
Appendix B .....	61

## FIGURES

Figure 1: Rehabilitation Service Provision by Setting.....	25
Figure 4: Service Availability by Clinical Setting (OT and PT combined) (n=214)....	29
Figure 5: Percentage of People Waiting for Community-based Occupational Therapy by Setting, December 2005 .....	30
Figure 6: Percentage of People Waiting for Occupational Therapy Services by Condition, December 2005 .....	31
Figure 7: Percentage of Clients Waiting for Community-based Physiotherapy, .....	32
Figure 8: Percentage of Clients waiting for Physiotherapy Services by Condition, December 2005 .....	33
Figure 15: Top 5 Most Frequently Used Methods to Prioritise Wait Lists by Setting	40
Figure 16: Methods Used For Management (n=214) .....	41
Figure 17: Effectiveness of Management Techniques (n = 214).....	42

## TABLES

Table 1: Characteristics of Literature Used in Review .....	6
Table 2: Characteristics of the Key Informants .....	13
Table 3: Measures used in questionnaire .....	22
Table 4: Survey Response by Setting.....	24
Table 5: Response Rate by LHIN .....	24

## **ACKNOWLEDGEMENTS**

We would like to thank the key informants who willingly shared their perspectives on wait lists and wait times for community-based rehabilitation.

We would also like to thank Amy deHueck for sharing with us her experiences with the survey she conducted on wait times for hospital outpatient physiotherapy. In addition, we would like to thank all of the staff at ACREU who assisted with this project.

We would like to acknowledge the Mental Health and Rehabilitation Reform Branch of the Ministry of Health and Long-Term Care for their support of this project.

*The opinions, results and conclusion are those of the authors and no endorsement by the Ministry of Health and Long-Term Care is intended or should be inferred.*

## **LIST OF TERMS AND DEFINITIONS**

### **Community-Based Rehabilitation**

In this report, community-based rehabilitation settings include publicly and privately funded settings where rehabilitation can be accessed by community dwelling individuals. Included are private clinics, Designated Physiotherapy Clinics (formerly known as Schedule 5 Physiotherapy Clinics), Community Care Access Centres, Community Health Centres, Hospital Outpatient Rehabilitation Departments and The Arthritis Society Consultation and Rehabilitation Services.

### **Community Care Access Centres (CCAC)**

CCACs provide in-home health care services (including occupational therapy and physiotherapy) and access to long-term placement within communities throughout the Province of Ontario. All services provided by Community Care Access Centres are funded by the Ministry of Health and Long-Term Care. Anyone can refer a client to a CCAC, such as the client themselves, a family member, caregiver, friend, physician or other health care professional <sup>1</sup>.

### **Community Health Centres (CHC)**

Community Health Centres are delivered through publicly funded (MOH-LTC), community governed, not for profit organisations that provide primary health care, health promotion and community development services, using multi-disciplinary teams of health providers. These teams sometimes include occupational therapists and physiotherapists. Services are designed to meet the specific needs of the community surrounding the CHC. In many communities, CHCs provide their programs and services for people with difficulties accessing the full range of primary health-care services<sup>2</sup>.

### **Designated Physiotherapy Clinics**

Formerly known as Schedule 5 OHIP Physiotherapy Clinics, these clinics are funded by the Ontario Ministry of Health and Long-Term Care through the Ontario Health Insurance Program (OHIP). In order to be eligible for this service, one must meet at least one of the following conditions: 1) be either under the age of 20 or aged 65 and over; 2) a resident of a long-term care home at any age; 3) requiring physiotherapy services in home or after being hospitalised at any age, or, 4) a participant of the Ontario Disability Support Program, receiving Family Benefits and Ontario Works at any age<sup>3</sup>.

### **Hospital Outpatient Rehabilitation Departments**

Many hospitals offer outpatient occupational therapy and/or physiotherapy services. These services are usually funded through the hospital's global budget. However a few clinics throughout Ontario hospitals exist as for-profit business entities or have contracted services to external providers.

### **Occupational Therapy (OT)**

Occupational Therapists are health professionals who help people or groups of people of all ages assume or reassume the skills they need for the job of living. OTs work with clients to help identify barriers to meaningful occupations (self care, work and leisure). While enabling clients to change these barriers, occupational therapists fulfill the roles of therapist, educator, counsellor, case manager, resource developer, policy analyst and advocate<sup>4</sup>.

### **Physiotherapy or Physical Therapy (PT)**

Physiotherapists are first contact, autonomous, client-focused health professionals trained to: improve and maintain functional independence and physical performance; prevent and manage pain, physical impairments, disabilities and limits to participation; and promote fitness, health and wellness<sup>5</sup>.

### **Private Funding**

Private funding is derived purely from private sources and are not regulated by the provincial government. Some examples are private third party insurance such as casualty or extended health coverage and out-of-pocket payments directly from the client or their family. In some cases programs are funded through private sources, but the fee structure is regulated in some way by the provincial government. Examples are the Workplace Safety & Insurance Board (WSIB) and the Motor Vehicle Accident (MVA) insurance.

### **Public Funding**

Public sources of funding are finances derived purely from federal, provincial or municipal governments. In Ontario, public sources for funding rehabilitation services include (but are not limited to) global budgets provided to hospitals and institutions, Community Care Access Centres (CCAC), and direct funding from the Ministry of Health and Long-Term Care.

### **Rehabilitation**

Rehabilitation is a goal-oriented process that enables individuals with impairment, activity limitations and participation restrictions to identify and reach their optimal physical, mental and/or social functional level through client-focused partnership with family, providers and the community. Rehabilitation focuses on abilities and aims to facilitate independence and social integration.

### **The Arthritis Society Arthritis Rehabilitation and Education Program**

This is a specialised program of The Arthritis Society where occupational therapists, physical therapists and social workers, who work throughout the province of Ontario and have advanced training in the assessment and management of arthritis. Patients may self-refer or be referred by a physician. Service is provided through clinics or if indicated, home visits can be arranged. This program is covered by the Ontario Health Insurance Plan<sup>6</sup>.

**Wait List**

The number of people waiting for community-based rehabilitation services.

**Wait Time**

Wait time refers to the length of time between when a patient is enrolled on a waiting list and when the service is received. There are divergent opinions as to the precise moment at which an individual begins “waiting” for services, however in general, wait time refers to the time between first contact with a provider and the time of assessment.

# **EXECUTIVE SUMMARY**

## **COMMUNITY-BASED REHABILITATION WAIT TIMES**

Recent attention to wait times for surgical and diagnostic services indicates a positive commitment toward timely access to health care. Concerns regarding wait times are not restricted to medical assessment and treatment, but also extend along the continuum of care to community-based rehabilitation. As the demographic characteristics of Ontario's population change, timely access to community-based rehabilitation is becoming increasingly difficult to ensure. The aging population, increased prevalence of chronic disease, and the transfer of care from inpatient to community-based settings are likely to affect wait times and wait lists for community-based rehabilitation, and may have long-term consequences for the health care system. Examining wait lists and wait times for community-based rehabilitation will provide an understanding of the current status of rehabilitation services in Ontario and initiate discussion regarding ways to ensure timely access for Ontarians requiring community-based rehabilitation.

## **OBJECTIVES**

This study describes the extent, measurement methods, management and perceptions of wait lists and wait times for occupational therapy and physiotherapy in community-based rehabilitation settings in Ontario. The specific research objectives are to:

- Establish the extent of wait times and wait lists for community-based occupational therapy and physiotherapy in Ontario
- Determine if wait times and wait lists vary according to setting and diagnostic group
- Describe the wait list management methods used in community-based rehabilitation settings in Ontario
- Identify the perceived cause and impact of wait lists and wait times for community-based rehabilitation

## **METHODS**

The study was conducted in three phases using a mixed methods approach. In Phase 1 an extensive literature review of the scientific and grey literature was conducted to identify the extent, measurement and management of wait lists and wait times for community-based rehabilitation. In addition, the literature was examined to identify perceptions of wait lists and wait times for community-based rehabilitation from the perspectives of both the health care provider and the

client. In Phase 2, key informant interviews were conducted in order to obtain information on the extent, management and perceptions of wait lists in community-based rehabilitation in Ontario. The results of Phase 2 were used to help guide sampling strategies and the development of the study questionnaires for Phase 3 of this project, in which all publicly funded community-based rehabilitation settings in Ontario were surveyed. This survey was conducted to determine the extent of wait lists and wait times for community-based rehabilitation by setting and condition, and, to describe current wait list management strategies and their perceived effectiveness. These investigative techniques served to gather a variety of data in a short time frame and help to define a broad spectrum of views on the topic of community-based rehabilitation wait times and wait lists.

## **SUMMARY OF RESULTS FROM EACH PHASE:**

### PHASE 1 - Literature Review

- There is a scarcity of literature on wait lists and wait times for community-based rehabilitation settings
- The extent of wait lists and wait times for community-based rehabilitation settings is uncertain given inconsistent methods of measurement
- Management methods for wait lists and wait times vary among settings and are generally not evidence based
- Providers report problems meeting demand and managing capacity for community-based rehabilitation settings

### PHASE 2 – Key Informant Interviews

- Wait times and wait lists are not an issue for the private sector
- Increased demand for services with limited capacity contributes to the increasing length of wait lists and wait times
- Wait time measurement varies between and within publicly-funded settings
- The most commonly reported methods for wait list management are: caseload prioritisation; changes in rehabilitation and administrative practice, and policy implementation
- Effective wait list management strategies involve efficient, innovative and ethical processes that respond to client need
- Community-based rehabilitation wait times are thought to affect the health care system by increasing health care costs; interrupting in the continuity of care, and, increasing the degree of disability among those waiting

## PHASE 3 – Survey of Ontario Community-Based Rehabilitation Settings

- Hospital outpatient departments have the largest staff complement for community-based PT but at the same time have the largest wait lists and longest wait times
- Most community-based rehabilitation settings are open Monday to Friday during the day, and very few settings are available beyond these hours of operation
- The majority of people waiting for community-based rehabilitation services have chronic musculoskeletal conditions.
- Frequently used methods of wait list management at community-based settings include self management, regular audit of wait lists and referral to other clinics
- Increasing staff complement, only accepting in-house referrals, use of rehabilitation assistants and use of evidence-based benchmarks are considered to be very effective methods to manage wait lists for community-based rehabilitation

## CONCLUSIONS AND RECOMMENDATIONS

Overall, the results from this study indicate that wait times and wait lists for community-based rehabilitation vary based on setting and condition. Most notably, wait lists and wait times are the longest for people with chronic musculoskeletal conditions who are waiting for hospital outpatient PT. This suggests that current publicly-funded community-based rehabilitation capacity is not adequate to meet the demands from specific client populations, in specific settings.

In order to further understand this complex relationship the following is recommended:

- 1) Further research should examine the long-term effect of wait lists and wait times for community-based rehabilitation on client outcomes and continuity and transition of care. Research also needs to be conducted to understand how wait lists and wait times affect aggregated health care cost and societal burden.
- 2) A more robust understanding must be gained regarding client perspectives of wait lists for community-based rehabilitation. We restricted our study to publicly funded settings; however, there are numerous (perhaps 1,500) of community-based rehabilitation settings in the private sector. In light of this, one must question: to what extent are Ontarians willing (and able) to access these privately-funded community-based rehabilitation settings?

- 3) Prioritisation based on acuity for community based rehabilitation services is commonly practiced in all settings. However, definitions of acuity vary between and within settings. Individuals with less acute conditions often have the longest wait times. Evidence based benchmarks for wait times need to be established to ensure that people with chronic conditions do not wait beyond a reasonable time.
- 4) Utilisation of currently untapped capacity needs to be considered in order to mitigate wait times and wait lists for vulnerable or marginalised populations such as those with chronic conditions and those unable to access privately funded rehabilitation. This could be accomplished, for example, by expanding current hours of operations of publicly-funded community-based rehabilitation settings to include evenings and weekends. Settings such as Community Health Centres need to be considered as sites for rehabilitation expansion, particularly for populations with chronic conditions. These expansions in service would require more investment in financial and health human resources.

In conclusion, this study provides one of the first overviews of wait lists and wait times for adult rehabilitation in community-based settings within the Province of Ontario. It also provides preliminary data upon which to build future projects that examine wait lists and wait times for community-based rehabilitation. As the Ontario population continues to evolve, it is important that the existing health care system also evolve, in order to ensure timely access to quality health care.

## **STRUCTURE OF THE REPORT**

This report has six sections. Section one presents the background information, rationale and objectives of the project. Section two presents the methods and results of Phase 1 of this study. This involved a review of the relevant literature in the area of wait times and wait lists in community based rehabilitation. Section three outlines the methods and results for Phase 2 (key informant interviews) of the study. Section four provides an overview of the methods and results for Phase 3 (survey of community-based rehabilitation settings) of the study. Section five presents key implications and section six provides concluding remarks and recommendations.

# INTRODUCTION

## 1.1 Background and Rationale

Access remains a defining element of Canadian health care. However as the demographic and epidemiological characteristics of the population change, *timely* access is becoming more elusive and difficult to ensure. Multiple demands on the current health care system are being felt across the spectrum of health care service delivery with much attention toward wait times for surgical and diagnostic services. In November 2004 the Ontario Ministry of Health and Long-Term Care (MOH-LTC) announced Ontario's Wait Time Strategy as a response to public demand for wait list resolution<sup>7</sup>. This strategy was designed to improve access to health care, specifically in the areas of cancer surgery, selected cardiac procedures, cataract surgery, hip and knee total joint replacements, and diagnostic scans (MRI and CT scans). Although, this attention towards wait times for health services may represent a commitment toward system wide wait time management, there remains little attention to wait times for health care services beyond these selected areas. Some contend that community care wait lists are overshadowed by surgical and medical waiting times, thereby preventing community rehabilitation services from addressing wait time issues<sup>8</sup>. Others argue that "the success in the 5 priority surgical and medical areas is coming at the expense of longer wait times in other areas" along the health care continuum<sup>9</sup>.

The changing demography of Ontario's population, in combination with changes to current provincial health care delivery, underscores the need to more fully understand community-based rehabilitation wait times and wait lists. The aging population, increased prevalence of chronic disease, and the transfer of care from inpatient to community-based settings are likely to have an impact on wait times and wait lists for community based rehabilitation with potential long-term consequences for the health care system.

Chronic disease places a significant demand on the health care system with diseases such as cardiovascular disease, diabetes, cancer, obesity and respiratory conditions accounting for 46% of the global burden of disease<sup>10</sup>. Some chronic conditions are more likely than others to be associated with disability (e.g. arthritis, musculoskeletal disorders, stroke) and therefore are more likely to require ongoing rehabilitation intervention to optimise a person's ability to function in the community. As care is increasingly shifted to the community in an attempt to reduce the pressure on hospitals by decreasing hospital lengths of stay, additional demand on community-based rehabilitation services has resulted<sup>11</sup>. Given the increasing prevalence of individuals with chronic diseases requiring rehabilitation, and the progressive shift toward community care, it is foreseeable that an already overburdened health care system will be further challenged. This

could ultimately lead to longer wait times and increased wait lists for access to community-based rehabilitation services.

This study flows from research conducted by the Arthritis Community Research and Evaluation Unit (ACREU) in partnership with the Mental Health and Rehabilitation Reform Branch (MHRRB) of the MOH-LTC on Adult Rehabilitation and Primary Health Care in Ontario<sup>12</sup>. This earlier study identified funding source, wait times and wait lists as barriers to accessing community-based rehabilitation services, especially physiotherapy. Physicians and nurse practitioners cited wait times as the second most common barrier to referring patients to rehabilitation. Wait times for physiotherapy were significantly longer in publicly-funded compared to privately-funded practices settings, and in the North compared to other regions of Ontario. Despite these findings regarding the importance of wait times, geographical challenges and fiscal barriers to accessing rehabilitation, a number of questions remained unanswered. The purpose of this study is to address some of these limitations.

## **1.2 Purpose and Objectives**

The purpose of this study is to describe the extent, measurement methods, management and perceptions of wait lists and wait times for occupational therapy (OT) and physiotherapy (PT) across community-based rehabilitation settings in Ontario. The specific research objectives include:

1. To determine the extent of wait times and wait lists for community-based PT and OT in Ontario.
2. To determine if wait times and wait lists vary according to setting and diagnostic group.
3. To describe the wait list management methods currently being used in publicly-funded community-based rehabilitation settings in Ontario.
4. To identify the perceived causes and impacts of wait lists and wait times for community-based rehabilitation.

The study was conducted in three phases using a mixed methods approach. In Phase 1 an extensive literature review of the scientific and grey literature was conducted in order to identify the extent, measurement and management of wait lists and wait times for community-based rehabilitation. In addition, the literature was examined to identify perceptions of wait lists and wait times for community-based rehabilitation from the perspectives of both the health care provider and the client. In Phase 2, key informant interviews were conducted in order to obtain information on the extent, management and perceptions of wait lists in community-based rehabilitation in Ontario. The results of Phase 2 were used to

help guide sampling strategies and the development of the study questionnaires for Phase 3 of this project, in which all publicly funded community-based rehabilitation settings in Ontario were surveyed. This survey was conducted to determine the extent of wait lists and wait times for community-based rehabilitation by setting and condition, and, to describe current wait list management strategies and their perceived effectiveness. These investigative techniques served to gather a variety of data in a short time frame and help to define a broad spectrum of views to establish general perspectives on the topic of community-based rehabilitation wait times and wait lists. The University Health Network Research Ethics Board approved all phases of this study in 2005.

# LITERATURE REVIEW (PHASE 1)

## 2.1 Search Strategy

A review of the literature for the years 1990 to 2005 was conducted to examine the extent, measurement and management of, as well as, perceived reasons for wait times and wait lists in community-based rehabilitation settings. For the purpose of this literature review, rehabilitation referred to PT and OT. Articles pertaining to the provision of rehabilitation in outpatient clinics, homecare, community care, and hospital outpatient rehabilitation departments serving the adult population were included. Searches were restricted to English language journals. Due to limited information on the topic of community-based rehabilitation and wait times, literature pertaining to medical and surgical wait times was also searched in order to explore the topic of wait times from other sectors of the health care system. This component of the search was limited to those articles with a broad scope and did not focus on a particular discipline within medicine or surgery. Literature relating to medical or surgical specialities was excluded. The following databases were searched (\* indicates sources in which relevant information was found):

- Medline\*
- CINAHL\*
- EMBASE\*
- AgeLine\*
- Cochrane Library of Systematic Reviews
- International Campbell Collaboration
- OTDbase\*
- PEDro\*
- PsychINFO
- Combined Health Information Database
- REHABDATA
- Centre for International Rehabilitation Research and Exchange

The following outlines the terms used in the literature search:

### Wait Times

Waiting time, wait time, wait list, wait list were used for the key word search of the literature. In addition, the MeSH terms wait lists, appointment and schedules, organization and administration, supply and distribution, utilization, trends, referral and continuity of patient care were also applied to the search strategy. Various forms of truncation were also used and included: wait\*, refer\*, util\*.

## **Community-Based Rehabilitation**

Rehabilitation, OT, OT service, occupational therapist, PT, physiotherapists, and physical therapy service were used to locate articles pertaining to community-based rehabilitation. The combination of these key words with the 'or' conjunction was used to capture all articles relevant to community-based rehabilitation. Several truncated keywords were applied and included: rehab\* occupational therap\*, physical therap\* or physiother\*. In addition, health care delivery and health care deliv\* were also used. Community-based rehabilitation terms were used in conjunction with the wait time terms using the Boolean operator, "and".

## **Community-Based Rehabilitation Setting**

The MeSH headings: community health services, community-based rehabilitation, home health care, home care services, outpatients, and outpatient services were applied depending on the database searched. Several truncations of the community-based rehabilitation setting were used as key word to broaden the search.

## **Access to Care**

For this search, the keywords for community-based rehabilitation and wait times were used in conjunction (i.e. using the AND operator) with the keywords access\*, access to care, health services accessibility, health resource utiliz\*, discharge destination, health care access\*, health care deliv\*, deliv\* of healthcare, health care ration\*, health care distrib\*, resource allocat\*, prior\*, direct access, continuity of patient care and strateg\*.

## **Grey Literature**

Grey literature was also searched for information on wait times and community-based rehabilitation and included government and nongovernmental technical reports, documents and conference proceedings. Furthermore, the search included the government websites of Canada, Australia, New Zealand, Scandinavian countries, the United Kingdom (UK) and the United States (US). Internal ACREU databases were searched for relevant articles. ACREU working reports were also included in the literature.

The following web sites were also searched for information on wait times and community-based rehabilitation (\*indicates sources in which relevant information was found):

- [www.opa.on.ca](http://www.opa.on.ca) (Ontario PT Association)
- [www.PT.ca](http://www.PT.ca) (Canadian PT Association)
- [www.collegept.org](http://www.collegept.org) (College of Physiotherapists of Ontario)\*
- [www.apta.org](http://www.apta.org) (American Physical Therapy Association)
- [www.caot.org](http://www.caot.org) (Canadian Association of Occupational Therapists)\*
- [www.osot.on.ca](http://www.osot.on.ca) (Ontario Society of Occupational Therapists)
- [www.coto.org](http://www.coto.org) (College of Occupational Therapists of Ontario)
- <http://www.gtarehabnetwork.ca/home.asp> (GTA Rehab Network)\*

## 2.2 Search Results

The review resulted in only nine articles, published in peer-reviewed journals that pertained to community-based rehabilitation and wait times. The majority of the peer-reviewed articles focused on wait times and PT practice. Research methods included surveys, chart review, and semi-structured interviews. Only two of the peer-reviewed articles were Canadian. There were six relevant reports found in the grey literature on wait lists, wait times and rehabilitation. Several articles were obtained on the subject of medical and surgical wait times that included 13 peer-reviewed articles and seven reports from the grey literature. (see Table 1)

**Table 1: Characteristics of Literature Used in Review**

<b>Type of Article</b>	<b>Number</b>
<b>Physiotherapy</b>	<b>9</b>
Peer Review	5
Grey Literature	4
<b>Occupational Therapy</b>	<b>2</b>
Peer Review	2
<b>Rehabilitation – General</b>	<b>6</b>
Peer Review	3
Grey Literature	3
<b>Wait Time – general surgical / medical</b>	<b>20</b>
Peer Review	13
Grey Literature	7
<b>Total articles retrieved</b>	<b>37</b>

### **2.2.1 Measurement of Wait Times and Wait Lists**

Methods used to measure *wait times* are not standardised<sup>13</sup>. There is significant variation regarding determining the timing of the referral process, when it begins and when it ends; and thus, can lead to different understandings of the extent of wait times and wait lists<sup>14;15</sup>. Such discrepancies in the measurement of wait times can lead to an accrued difference in overall wait times of 200 to 300 percent<sup>16</sup>. Further, multiple waits can occur along the continuum of care, starting with the first visit with the primary care practitioner, to the date of surgery, and beyond to the wait for rehabilitation and community services.

*Wait lists* are commonly defined as a roster of patients awaiting a particular health service<sup>17-19</sup>. However, interpretation of these measures can vary depending on the context. Wait list size was defined as the average number of patients waiting per full time equivalent staff in a survey of Canadian teaching hospital outpatient PT clinics<sup>15</sup>. In contrast, others have defined wait lists as the absolute number of people waiting for community-based rehabilitation services<sup>20</sup>. A number of studies suggest caution when using wait lists as a measure of timely access. These lists can be misleading as a number of patients on the list may no longer require service due to death, deterioration in health status, movement to another community, receipt of the service elsewhere, resolution of symptoms or inappropriate initial placement on the list<sup>21</sup>.

### **2.2.2 Extent of Wait Times**

#### **Physiotherapy**

The majority (84.4%) of community-based physiotherapists (including those in publicly and privately funded settings) in Ontario reported average wait times of seven days or less from receipt of referral to when the patient was assessed<sup>12</sup>. In a recent study of adult rehabilitation and primary health care, wait times were shorter in privately funded practice settings compared to publicly funded settings; and acute patient populations as compared to those with chronic conditions<sup>12</sup>. The College of Physiotherapists of Ontario reported that patients waited on average 10 days longer for urgent PT outpatient care through hospitals than through community PT clinics<sup>22</sup>.

A recent report by the provincial auditor of Ontario indicated that 14.9% of all people waiting for community care services were waiting for PT<sup>20</sup>. Exploration of community rehabilitation wait times revealed “patients awaiting publicly-funded care in the home often waited longer than 2 weeks”<sup>22</sup>. In contrast, others have reported that 75% of patients received home care within 4 days of discharge from post acute care institutions<sup>14</sup>.

## **Occupational Therapy**

Over half (60.1%) of community-based occupational therapists reported average wait times of one week or less from receipt of referral to when they first see a patient in a recent study of rehabilitation and primary health care<sup>12</sup>. An Ontario audit of community-based health care services that determined 45.6% of all people waiting for community health care services were waiting for home based OT<sup>20</sup>. The one peer-reviewed article that we found reported a mean wait time for OT home assessment to be 16 weeks with subsequent wait times for the acquisition of adaptive devices recommended after initial assessment ranging from less than one week to 11 weeks<sup>23</sup>.

### **2.2.3 Wait Time Management Methods**

The most commonly reported management strategies employed in rehabilitation, medical and surgical settings include:

- Centralised wait list management systems
- Prioritisation
- Practice adjustment

#### **Centralised Wait List Management Systems**

The use of a central referral system allows for the triage of patients to the appropriate service, ensuring there is no duplication of referrals and that appropriate referrals are received and managed through a systematic process<sup>24</sup>. Centralised systems facilitate wait list management by redirecting referrals to clinicians with shorter waiting times<sup>7;25</sup>. In the UK the use of centralised systems reduced wait times for PT from 16 to four weeks and decreased non-attendance rates from 18 to two percent<sup>26</sup>. The Provincial Auditor of Ontario recently recommended the establishment of consistent policies for maintaining centralised wait lists for community rehabilitation services in lieu of the common practice of maintaining separate lists by individual service providers<sup>20</sup>.

An essential component of the centralised wait list management strategy is the need to perform regular audits to ensure patients are listed appropriately<sup>19;25;27;28</sup>. Wait lists may be inflated by 20-30% due to a change in condition, if the patient has died or moved out of the jurisdiction, has changed their mind regarding the procedure, or, has had symptom resolution<sup>18</sup>.

#### **Prioritisation**

Prioritisation of wait lists is accomplished by organising patients according to level of urgency or acuteness<sup>15</sup>. Referral intake is an important step to ensure the accuracy of wait list placement. A study examining the accuracy of referral

priorities for OT within the UK indicated 56% of low priority cases were inappropriately prioritised, with a tendency to underestimate an accurate level of priority<sup>29</sup>. While many agree that patients should be prioritised on a wait list based on need and that this prioritisation should be based on the best possible evidence<sup>7;9;21;25;27;30-32</sup>, few organisations implement evidence-based practice for prioritisation within rehabilitation settings<sup>13</sup>.

## **Practice Adjustment**

Screening patients for group interventions such as education programmes or exercise classes is another option to manage wait lists<sup>22;33</sup>. It has also been reported that involvement in PT clinical education can improve clinic productivity by increasing the number of new patients and the number of treatments per patient<sup>34</sup>. Further, participation in PT student education can increase overall productivity by 47% when PT students are on clinical placements and thus decrease the extent of wait times and wait lists for patients awaiting treatment<sup>35</sup>. However, one could argue that implementation of such a strategy could inappropriately transfer the burden of wait lists to rehabilitation students.

### **2.2.4 Wait Time Perceptions**

Perceptions of wait times and wait lists for health care services have been modestly addressed in the literature from the perspectives of both the health care provider and the patient waiting for health care services.

#### **Provider Perceptions**

A survey conducted in the UK of PT outpatient managers reported that 84% of PT departments felt they had difficulty managing their volume of referrals and that physiotherapists believed the causes of wait lists were due to increases in referral level; increased awareness of the benefits of PT and a lack of appropriate resources<sup>15;33</sup>. In Ontario, it has been argued that wait lists exist because of insufficient capacity of rehabilitation clinics to accommodate client demand due to staffing resources and lack of physical space<sup>13</sup>. Furthermore, it is reported that clinicians believe there may be few resources available for complex client needs, thereby creating a backlog of complex patients waiting for rehabilitation<sup>13</sup>.

Providers also perceive that if wait lists are based on patient need alone, then patients with more chronic conditions and members from vulnerable groups may never be considered troubled enough to get to the top of the list<sup>21;27</sup>.

## Public Perceptions

Although public perceptions have not been well addressed in the literature, a common public perception that is reported is the concern of deterioration of health while waiting for a procedure<sup>36</sup>. In contrast, a study of OT services in the UK revealed that the majority of clients typically do not complain about the wait times, despite an average wait of 16 weeks for community OT assessment<sup>23</sup>. Most clients were unaware of how wait lists were created and managed<sup>36</sup>. Others suggest that long waiting times are the main reason why Canadians report they would be willing to pay for treatments outside the public health care system<sup>19</sup>. In contrast to the perception that wait times evoke negative opinions, some members of the public believe there is some benefit to wait lists as it allows patients the time to decide that they may not want the intervention they are waiting for and subsequently allows time for symptom resolution or conservative treatment<sup>21;37</sup>.

### Summary of Literature Review:

- There is a scarcity of literature on wait lists and wait times for community-based rehabilitation settings
- The extent of wait lists and wait times for community-based rehabilitation settings is uncertain given inconsistent methods of measurement
- Management methods for wait lists and wait times vary among settings and are generally not evidence based
- Providers report problems meeting demand and managing capacity for community-based rehabilitation settings

## **KEY INFORMANT INTERVIEWS (PHASE 2)**

The purpose of Phase 2 was to conduct key informant interviews in order to obtain information on the extent, management and perceptions of wait lists in community-based rehabilitation in Ontario. The results of this phase were intended to guide sampling strategies and aid in the development of the survey for Phase 3 of this project.

### **3.1 Methods**

#### ***3.1.1 Sampling and Recruitment***

A purposive, snowball sample of health care providers, involved in community-based rehabilitation, were invited to participate as key informants in this study. The purpose of the sampling was to ensure that key informants represented a range of community based rehabilitation settings, geographic settings and health professions. Key informants were identified by the researchers as known experts and/or were in a position to discuss current issues surrounding wait times and wait lists in community-based rehabilitation. These individuals were identified through existing and emerging contacts with professional associations, rehabilitation academics and service delivery organisations.

The sample consisted of managers and senior therapists engaged in work in the following community-based rehabilitation settings in Ontario:

- Private Clinics/Practices
- Designated Physiotherapy Clinics (formally known as Schedule 5 OHIP PT Clinics)
- Community Care Access Centres (CCAC)
- Community Health Centres (CHC)
- Hospital Outpatient Rehabilitation Departments (OPD)
- The Arthritis Society: Arthritis Rehabilitation and Education Program (AREP)

In order to provide a balanced representation of all community-based rehabilitation settings, three key informants from the private sector were interviewed. These participants agreed unanimously that wait times and wait lists are not critical for private sector community-based rehabilitation services because the competitive nature of the business precludes the existence of this type of barrier. Furthermore, these key informants emphasised that the responsiveness of private sector rehabilitation practice allows for the adjustment of hours of operation and staffing levels in order to manage periods of high service demand. Because of these differences, we focused our research on the public sector.

### **3.1.2 Procedure**

The research team contacted potential participants by telephone or e-mail to determine interest in receiving information about the study. Potential participants who expressed interest in the study were then sent an information letter and consent form that described the purpose of the study and the nature of the request for their participation. The letter also informed potential participants that a research associate would contact them either by telephone or through electronic mail to answer any questions they may have about the study and to request their participation. Participant consent was obtained prior to commencing the interview.

A semi-structured interview guide was developed for this study based on review of recent national and international peer reviewed and grey literature on the topic of waiting times and rehabilitation (Phase 1 of the study). Questions regarding wait time and wait list measurement, management of wait lists, as well as perceptions on the impact of community-based rehabilitation wait times and wait lists on the health care system were posed to key informants. Some examples of these questions included, “do you have a wait list for community-based rehabilitation services at your clinical setting?” and “please indicate how your clinical setting defines wait time for community based rehabilitation services” (see Appendix A for the key informant interview guide). Informants were probed as necessary to expand on the themes of interest. A Research Associate with a Masters level education and a background in rehabilitation conducted the interviews. An interview lasted approximately one hour.

Interviews were conducted either over the telephone or face to face, depending on feasibility of travel and time constraints. Data were collected during the key informant interviews using written field notes and audiotape. Audiotapes were not transcribed but were used as a supplement to field notes during summarisation of the interview.

## **3.2 Analysis**

Data were categorised to identify key elements of wait times in primary care rehabilitation. These categories included: techniques used to measure wait times and wait lists; management strategies for community-based rehabilitation wait times and wait lists, as well as perceptions regarding the impact of wait times and wait lists with respect to the health care system in Ontario. Interview data were categorised to identify key findings from each question posed to the key informant.

### 3.3 Results

In total 23 potential key informants were approached for participation. Of these, 15 consented to participate. Nine interviews were conducted in-person and six interviews were conducted over the phone. Reasons for non-participation were non-response to request for participation (n=5) or decline of the interview (n=3). Table 2 provides a summary of the setting and location the key informants represented.

**Table 2: Characteristics of the Key Informants**

Setting	Number	Geographic Representation
Private Practice	3	Urban (2) Remote (1)
Hospital OPD	6	Urban (4) Rural (1) Remote (1)
CCAC	3	Urban (1) Remote (2)
CHC	2	Urban (1) Rural (1)
The Arthritis Society AREP	1	Urban
<b>Total</b>	<b>15</b>	

#### 3.3.1 Wait Time and Wait list Measurement

In general, no standardised method to measure wait times was evident from the interviews, both between settings and also within settings. The majority agreed that the wait time started at the point when the referral was received, however many variations were used to describe when the wait time ended. For some, the wait ended when the client attended their first appointment whereas others indicated that the wait ended when the client was booked into the schedule, regardless of when they actually attended their appointment. Other key informants indicated that they did not measure the *time* people were waiting for services, but only the *number* of people waiting.

#### 3.3.2 Wait Time and Wait list Management

The most frequently reported management methods were caseload prioritisation; changes in rehabilitation approach and administration practice; and attendance policy implementation.

## **Prioritisation**

The majority of key informants reported using level of acuity to prioritise clients. Acuity was largely established at the point of referral intake, and was dependent on the completeness and accuracy of the referral to decide how clients should be prioritised while waiting for services. Clients were placed into one of a number of categories that described the elapsed time since the onset of the impairment to the point of the rehabilitation referral. These usually included acute, sub-acute and chronic categories. For example, those with acute conditions, such as a recent fracture or stroke would have a higher priority than those with chronic conditions such as osteoarthritis or fibromyalgia. As with definitions of wait times, the definitions used to determine level of acuity varied from setting to setting and also within settings.

Another common prioritisation method described by key informants, especially hospital OPDs, is referral source. This prioritisation technique streams clients into one of two wait lists that include in-house referrals and community referrals. In most cases in-house referrals have a higher priority than community referrals. In some cases, key informants from hospital rehabilitation OPDs reported having to refuse all community referrals in order to manage high volumes of referrals from in-house physicians and surgeons.

## **Changes in Rehabilitation Approach**

A number of key informants reported recent implementation of group interventions for patients with similar needs who did not necessarily need a one-on-one appointment with a rehabilitation professional. Others described a shift of practice towards a self-management model to address patients with chronic conditions. Key informants believed these changes in approach ensure efficient use of practitioner time and allow clients to gain control over their conditions. This consequently reduces the frequency and duration of rehabilitation and will ultimately impact on wait lists and wait times.

A number of key informants described the use of an “assessment blitz” to deal with long wait lists. This was accomplished by one or two therapists dedicating scheduled time for clients to be assessed and provided with a home program. Based on this initial assessment, clients would either return to the wait list or be discharged, depending on the client’s needs. If they were returned to the wait list, key informants reported that they would be better prepared for treatment when offered an appointment and in some cases less debilitated compared to their initial assessment.

## **Changes in Administrative Practice**

Several key informants reported the use of regular wait list audits to determine if patients waiting for rehabilitation services continue to need these services; had

sought treatment elsewhere; had moved away from the rehabilitation clinic, and so forth. Others described the importance of efficient referral intake by staff to ensure that referrals are complete and accurate in order to appropriately prioritise patients for wait list placement. In addition to referral intake, participants reported the use of referral output to private clinics with shorter wait times or no wait list as an administrative technique to manage wait lists.

Key informants were also asked if they used management systems that involved centralised wait lists or computerised wait lists. The majority of respondents had not implemented management strategies such as centralised or computerised wait lists. However, some participants from health care institutions with multiple treatment sites reported the use of an informal centralised system that would provide patients with an option to be on wait lists at each site of the institution. Others also described informal methods of centralised systems such as collegial working relationships amongst therapists working within a region in order to redistribute wait lists.

### **Attendance Policy**

Many key informants reported the use of attendance, cancellation, and no-show policies as a method to ensure efficient use of schedules. Others described the use of guaranteed maximum wait times as a method to manage extensive wait lists. This would allow patients to move up prioritisation levels, despite their level of acuity.

### **Components of an effective management system**

The majority of key informants identified the following components as important to an effective wait list management system:

- Prioritisation for rehabilitation services based on need
- Efficient intake processes that ensure referrals are accurate and complete
- The use of non-traditional rehabilitation interventions that emphasise health promotion, disease prevention and early intervention strategies to address the chronic disease population
- Centralised intake process
- Regular audit of wait lists
- Accountability and transparency of wait list management methods.
- Realistic waitlist management strategies that respond to individual needs

### **3.3.3 Wait Time and Wait list Perceptions**

#### **Cause of wait lists**

The majority of key informants described the cause of wait lists to generally be rooted in two main themes. These were 1) increasing demand for services; and, 2) decreased capacity to provide services.

#### **Increasing demand for services due to the aging of the population**

Key informants attributed the increasing demands for community-based rehabilitation services to several factors. A number of participants reported the population growth over the age of 65 years is having a significant impact on the demand for community-based rehabilitation services. This issue was frequently raised from key informants representing the rural regions of Ontario where much of the population is elderly with chronic conditions. Furthermore, key informants from the more rural areas felt that the aging population, particularly those aged 80 years and older, had less access to privately funded health care and were more reliant on the publicly-funded system. It was believed that this resulted in an increased number of people waiting for publicly funded community-based rehabilitation services.

Key informants representing remote areas of Ontario expressed similar concerns. However these key informants generally attributed demographic changes to issues concerning the determinants of health, including socioeconomic status (SES), education and housing. Key informants reported that individuals with lower SES, less education and poor housing tend to have chronic health problems and would likely need to seek health services from the publicly funded system, thereby putting greater demand on community-based rehabilitation services.

#### **Decreased capacity due to lack of funding and human resources**

The majority of participants indicated that lack of funding for rehabilitation services was a significant variable affecting wait times and wait lists. This was frequently reported by those working in hospital outpatient rehabilitation departments, who cited that rehabilitation services are funded through hospital global budgets and the provision of outpatient rehabilitation services is at the discretion of the hospitals corporate management. Many key informants reported that the trend toward the closure of hospital outpatient rehabilitation departments, in combination with the partial delisting of Designated Physiotherapy Clinics has put pressure on the existing hospital outpatient rehabilitation services. It was felt that these hospital OPDs have limited capacity to take up the volume of individuals seeking community-based rehabilitation services.

The lack of health human resources is a particular concern for key informants in the rural and remote regions of the province who indicated that a larger client to therapist ratio makes recruitment and retention of rehabilitation staff difficult. Subsequently, this problem has an impact on the ability to provide timely access for rehabilitation services.

### **Rehabilitation wait times and the impact on the health care system**

When asked to describe the impact of wait times and wait lists on the health care system, responses from key informants can be categorised into the following:

- Greater amounts of disability
- Increased health care costs
- Interruption in the continuity of care

Many of the key informants agreed that prolonged wait times would lead to greater amounts of both short term and long term disability from a population perspective contributing to a general decrease in productivity and quality of life. Clients who continue to wait for community-based rehabilitation services may continue to lose function and require greater effort and cost to regain mobility when they are seen by a rehabilitation professional. Further, long wait times and wait lists could disrupt the continuum of care by causing delays in the transitional phases of care from rehabilitation settings to homecare to community-based outpatient rehabilitation.

### **Opinions for Wait Time and Wait List Reform**

When asked what would be required for wait time and wait list reform for community-based rehabilitation, participants provided the following suggestions:

- There is a need to align rehabilitation services to the changing population by increasing the role of rehabilitation in health promotion, disease prevention and early intervention strategies in order to prevent the excess need for rehabilitation services by individuals with chronic disease.
- There is a need to start exploring alternative ways to deliver rehabilitation services that use existing public resources more efficiently and provide rehabilitation in an efficient and timely manner.
- It is important to consider the barriers to accessing care (e.g. personal finances, transportation, availability of skilled professionals) and the effect these have on wait times.
- There is a need for a standardised way to collect wait time data in community-based rehabilitation settings in order to produce meaningful information that accurately assesses service demand and capacity.

## **SUMMARY OF KEY INFORMANT INTERVIEWS**

- Wait times and wait lists are not an issue for the private sector
- Increased demand for services with limited capacity contributes to the increasing length of wait lists and wait times
- Wait time measurement varies between and within publicly-funded settings
- The most common methods for wait list management are: caseload prioritisation; changes in rehabilitation and administrative practice, and policy implementation
- Effective wait list management strategies involve efficient, innovative and ethical processes that respond to client need
- Community-based rehabilitation wait times are thought to affect the health care system by increasing health care costs; interrupting in the continuity of care, and, increasing the degree of disability among those waiting

# **SURVEY OF COMMUNITY-BASED REHABILITATION SETTINGS IN ONTARIO (PHASE 3)**

## **4.1 Method**

Phase 3 involved a cross-sectional self-administered survey of all publicly funded community based rehabilitation settings.

The purpose of Phase 3 of this project was to:

- Establish the extent of wait lists and wait times in community based rehabilitation by setting and by condition
- Describe current wait list management strategies and their perceived effectiveness

### **4.1.1 Sampling**

Unlike our previous research in which we surveyed individual practitioners, the unit of analysis for Phase 3 of this study was the site or the practice setting (e.g. clinic, department). Questionnaires were mailed to managers or senior therapists in the following community-based rehabilitation sites in Ontario:

- Designated Physiotherapy Clinics
- Community Care Access Centres
- Community Health Centres
- Hospital Outpatient Rehabilitation Departments
- The Arthritis Society AREP

Given the relatively small number (N=374) of publicly funded community-based rehabilitation settings, we decided to survey all sites that provide OT and/or PT services to adults (age 19 years and older). Community-based rehabilitation services provided through mental health institutes or institutes that provided rehabilitation to children and/or adolescents, as well as, specialty ambulatory programs (such as amputee programs or hand clinics) were excluded.

A number of strategies were used to identify all the sites and key contact persons that provide publicly-funded community-based rehabilitation in Ontario:

#### **Designated Physiotherapy Clinics:**

Information pertaining to Designated Physiotherapy Clinic contact information is within the public domain and was accessed through the MOH-LTC website.

Ninety-three clinics throughout the province of Ontario were mailed an information letter and questionnaire.

### **Hospital Outpatient Occupational Therapy and Physiotherapy:**

Hospital contact information was downloaded from the Ontario Hospital Association website. All hospitals, excluding mental health hospitals and children's hospitals, were contacted by telephone to identify if outpatient rehabilitation services were provided at the institution. For those facilities that provided these services (n=208), contact information for the person in charge of wait list management was obtained and a questionnaire was sent directly to the identified contact person.

### **Community Care Access Centres:**

There are 42 CCACs that fund community rehabilitation services throughout the province of Ontario. Contact information was obtained from the Ontario Association of CCACs website. Each CCAC was contacted by telephone to identify the person in charge of wait list management to ensure that the appropriate personnel received the questionnaire. As noted from the key informant interviews, almost all CCACs have divested their professional services. However, for the purposes of this study, only the CCACs, and not the providers were surveyed since most CCACs monitor their wait lists and wait times for their jurisdiction. Furthermore the logistics involved in obtaining provider information for all the CCAC jurisdictions in Ontario were not feasible and thus beyond the scope of this study.

### **Community Health Centres:**

There are 55 CHCs throughout the province of Ontario, however there are only three CHCs that provide OT and seven CHCs that provide PT. Contact information for these health professionals was obtained from the College Occupational Therapists of Ontario and the College of Physiotherapists of Ontario.

### **The Arthritis Society Arthritis Rehabilitation and Education Program (AREP):**

The Arthritis Society provides rehabilitation services to five Ontario regions: North, South East, South West, Central West/South, and, Central East/Toronto. The Arthritis Society key informant indicated that the regional directors of client services manage the wait lists for their corresponding regions, with the exception of a few therapists practicing within the regions who manage their own wait list. Contact information for the regional directors was obtained from the Senior Director of Client Programs. Contact information for the individual therapists who manage their own wait list was obtained from the director of client services for

each region. In total there are five regional directors of client services and 16 individual therapists working for the Arthritis Society AREP that were surveyed for the project.

#### **4.1.2 Questionnaire Development**

The literature review and discussions with the MOH-LTC revealed a suitable survey instrument/questionnaire was not available for the purpose of this study. Therefore, results of the literature review, combined with the information obtained from the key informant interviews were used to guide the development of the questionnaires for Phase 3 of the study.

Key informants from Phase 2 of the study were asked if they would review the questionnaire and make suggestions for revisions with respect to clarity, scope of questions, and ease of completion of the questionnaire. Key informants provided feedback pertaining to face and content validity, clarity, relevance and format of the questionnaire. Relevant modifications were made to the questionnaires based on the key informant's feedback. If there were significant discrepancies among the key informants' recommended revisions, they were contacted by the study coordinator for verification of further recommendations for changes.

From the key informant interviews it was clear that there were sufficient differences between settings to require a specific version for each setting. Subsequently four versions of the questionnaire developed:

1. Hospital OPDs/CHCs/The Arthritis Society where managers/senior therapists are responsible for both OT and PT services
2. Hospital OPDs/CHCs/The Arthritis Society where managers/senior therapists are responsible for only OT services
3. Hospital OPDs/CHCs/The Arthritis Society/Designated Physiotherapy Clinics where managers/senior therapists are responsible for only PT services
4. CCACs where managers are responsible for both OT and PT services

Each version of the questionnaire, although tailored to a particular setting, contained similar questions to allow comparisons across settings. Questions incorporated nominal, discrete and continuous measurement scales. Respondents were given an opportunity to provide any additional information regarding community-based rehabilitation wait time and wait lists with one open ended question at the conclusion of the survey. See Appendix B for the questionnaire used to survey hospital OPDs/CHCs/The Arthritis Society where managers/senior therapists are responsible for both OT and PT services. Table 3 contains the measures used in the questionnaire.

**Table 3: Measures used in questionnaire**

Measure	Operationalized as...	See question(s) # in survey
Service Provision*	OT PT	Q1
Setting	CCACs CHCs Designated Physiotherapy Clinics Hospital Outpatient PT Clinics The Arthritis Society AREP	Q2
Funding Source*	Hospital Funded through global budget Third party billing Ministry of Health and Long-Term Care Other sources	Q3
Staffing	Number of Full Time Equivalent staff who are involved with direct patient care for community-based rehabilitation services. This was used as a proxy for size of clinical setting.	Q4
Service Availability	Days of the week (Monday-Sunday) that rehabilitation service is available Hours of the day services is available (daytime hours=7:00am to 5:00pm; evening hours=after 5:00pm)	Q5
Wait Lists	The number of people waiting for community-based rehabilitation services. Please note that the number of people waiting for rehabilitation services, or the wait time for rehabilitation services was a proxy for the existence of a wait list by service.	Q7 Q10a)
Wait Time	The average number of days people are waiting for community-based rehabilitation from the date the referral is received to the date a client attends his/her first appointment or as "other" (respondent specific)	Q12 Q13a)
Condition Specific Wait List and Wait Time	Hip fracture Other acute musculoskeletal (MSK) (e.g. soft tissue injuries, sport injuries, fractures excluding hip fractures) Total joint replacement Other chronic MSK (e.g. arthritis, low back pain, chronic soft tissue problems, osteoporosis) Acute stroke Chronic stroke Other neurological conditions (e.g. brain injury, spinal cord injury, neurodegenerative diseases)	Q10b) Q13b)
Methods to prioritize wait lists	A list of 10 ways of prioritizing wait lists was provided. Respondents were asked which they had ever used and which they used most frequently	Q. 9a) Q. 9b)
Management Strategies* (based on literature review and key informant interview)	A list of 14 management strategies was provided. Respondents were asked which they have used in the past, currently used or never used.	Q14-column A
Effectiveness of Management Strategies	Very effective; somewhat effective; not at all effective	Q14-column B

\*Not mutually exclusive

### **4.1.3 Procedure**

Potential participants were mailed an information letter, a questionnaire and a prepaid postage return envelope. Return of a completed questionnaire implied informed consent. A Modified Dillman approach was used to maximize the response rate for the questionnaires<sup>38</sup>:

- 1) Questionnaires were mailed to all study participants and return envelopes were coded to identify those participants did not respond.
- 2) Three weeks after the initial mailing, a second information letter, a second questionnaire and a prepaid return envelope a letter were sent to all non-respondents, reminding them to complete the questionnaire and thanking them if they had already returned it.

## **4.2 Analysis**

The data from the questionnaires were entered into a database management system (Access for Windows 2000). To ensure data quality, a process of double data entry was undertaken. This process involved entering raw data on at least two occasions by different data entry personnel and comparing differences in data files. Any differences were reconciled with the source data and the process continued until there were no discrepancies between databases. Descriptive statistics were used to describe the study sample, to summarize results from the study questionnaires and to address the study objectives. Cells sizes less than five were excluded from analyses involving frequency counts due to reasons pertaining to confidentiality. Statistical Analysis Systems (SAS) Version 9.1 was used for all analyses.

## 4.3 Results

### 4.3.1 Response Rate

A total of 221 surveys were returned prior to the cut off date of January 12, 2006. Of these, seven surveys were labelled “return to sender”. The overall response rate of eligible questionnaires was 57.2% (214/374). Table 4 summarises the response rate according to each setting.

**Table 4: Survey Response by Setting**

Setting	Total Questionnaires Sent	Total Eligible Questionnaires Returned	Response Rate
CCACs	42	19	45.2%
CHCs	10	7	70.0%
Hospital OPDs	208	122	58.7%
Designated Physiotherapy Clinics	93	47	50.5%
The Arthritis Society AREP	21	19	90.5%
Total	374	214	57.2%

There was fair representation from settings within provincial Local Health Integration Networks (LHINs) with a response rate of 40% or higher (see Table 5). The exception to this was Waterloo Wellington that had a response rate of 23.1% (3/13).

**Table 5: Response Rate by LHIN**

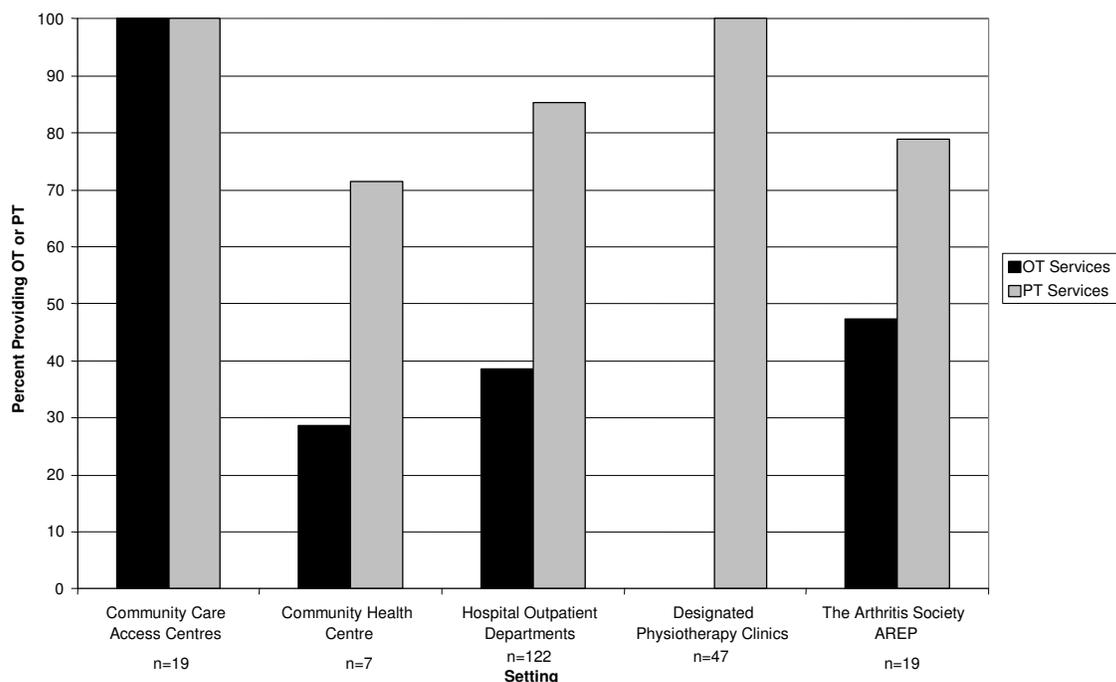
LHIN	Total Questionnaires Sent	Total Eligible Questionnaires Returned	Response Rate
Erie St Clair	21	11	52.4
South West	42	25	59.5
Waterloo Wellington	13	3	23.1
Hamilton Niagara Haldimand Brant	45	28	62.2
Central West	16	9	56.3
Mississauga Oakville	11	8	72.7
Toronto Central	46	21	45.7

Central	23	15	65.2
Central East	24	13	54.2
South East	18	9	50.0
Champlain	38	25	65.8
North Simcoe Muskoka	16	7	43.8
North East	42	27	64.3
North West	19	13	68.4
Total	374	214	57.2

### 4.3.2 Description of settings Service Provision (Figure 1)

The majority of respondents indicated they offered PT services (88.8%), while approximately a third (36.0%) indicated they offered OT services. When service provision was examined by setting, all CCACs offered both OT and PT services. For the remaining settings, a higher proportion of PT services were offered compared to OT services.

**Figure 1: Rehabilitation Service Provision by Setting**



## **Funding Source**

All settings reported they received some form of public funding either directly through MOH-LTC or through Hospital Global Budgets. In addition to public funding sources a small percentage of respondents reported they also received funding from private sources such as motor vehicle accident insurance, Workplace Safety and Insurance Board (WSIB) and private insurance. The exception was Designated Physiotherapy Clinics that reported 60% of their additional funding came from these private sources.

## **Full Time Equivalent (FTE) Staffing Allocation**

The distribution for FTE staffing was not normally distributed, making statistical estimates describing central tendency, such as means, inappropriate. Instead, box and whisker plots of FTE allocation by service are presented in order to adequately and easily compare staffing complement between rehabilitation settings.

The black line inside the box reflects the median FTE complement (50% of responses above the line and 50% below). The upper and lower outlines of the box represent the 75<sup>th</sup> and 25<sup>th</sup> percentile scores, respectively. The whiskers extending from both ends of the box display the minimum and maximum FTE complement for each setting. Circles represent the outliers with FTEs greater than values between 1.5 and 3 box lengths from the upper edge of the box.

## Occupational Therapy Full Time Equivalent Allocation by Setting (Figure 2)

The staffing complement of OTs in hospital OPDs is between 0.3 and 4.0 with half of the settings having only 1 FTE. Although there are fewer AREP settings (n=8) than OPDs (n=44), half of AREP have 2 FTEs. There is a total of 1.6 FTE for OT at CHCs, working in two settings. The majority of the CCAC settings that responded to this survey have divested their rehabilitation services to other providers. For the three non-divested CCACs there is, on average, 4.2 OT FTEs.

**Figure 2: Occupational Therapy Full Time Equivalent Allocation by Setting**

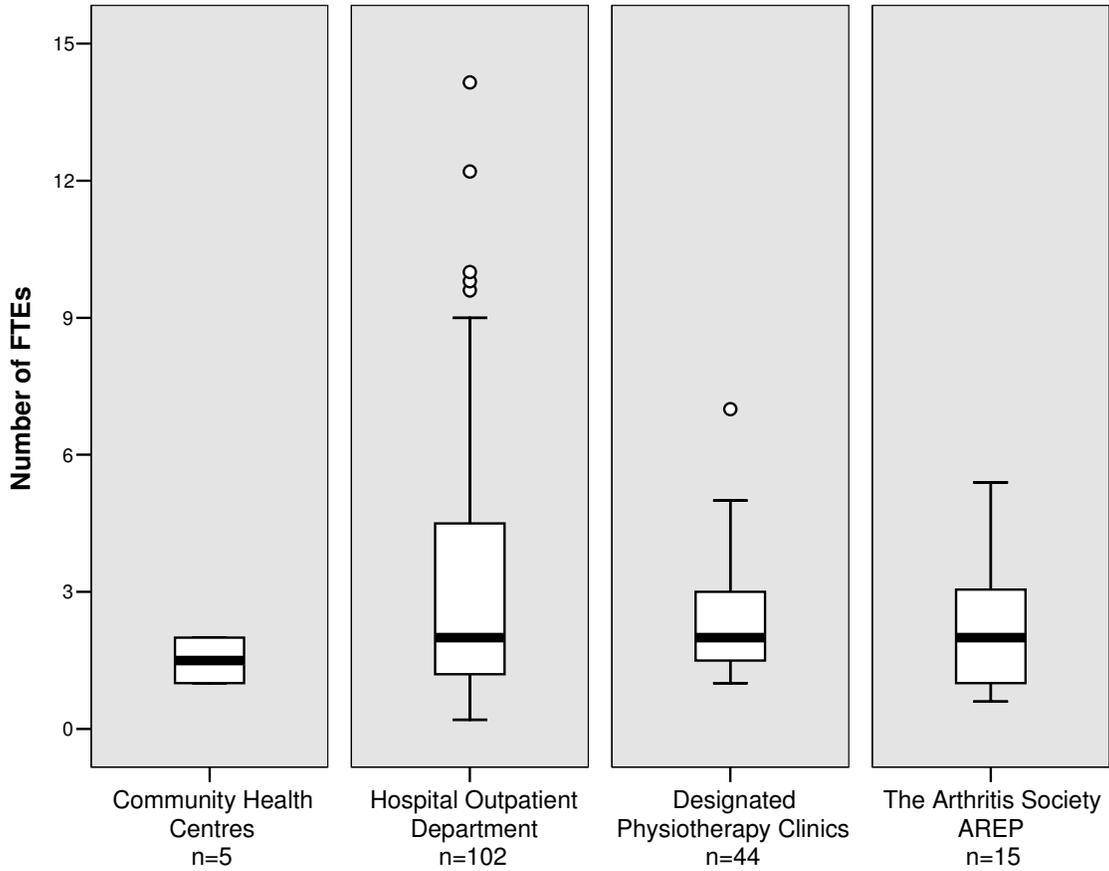


\*Community Care Access Centres and Community Health Centres not presented due to cell size < 5

### Physiotherapy Full Time Equivalent Allocation by Setting (Figure 3)

Although the average size of the PT settings is larger than for OT, most of the settings are still relatively small with a median of less than 3 FTEs. The exception is Hospital OPDs, the largest of which reported 14.2 FTE for PT. Of the three CCACs that continue to provide direct service, the FTE allocation for PT range from 0.8 to 6.4.

Figure 3: Physiotherapy Full Time Equivalent Allocation by Setting

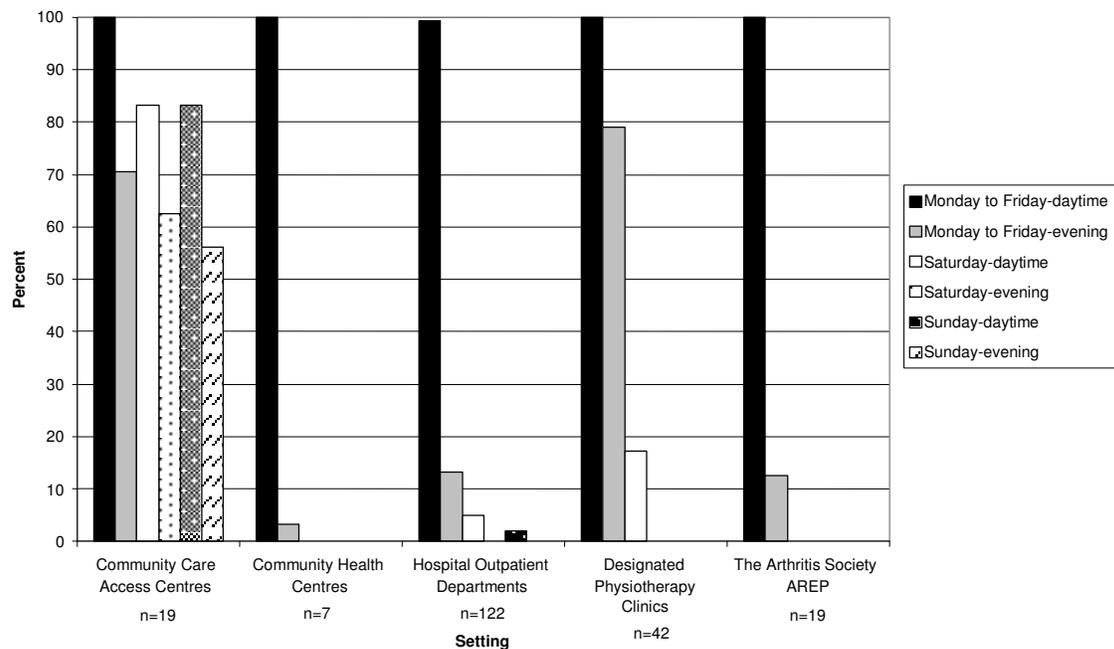


\*Community Care Access Centres not presented due cell size < 5

## Hours of Operation (Figure 4)

Figure 4 illustrates the hours of operation that PT and OT services are available at the various settings. While all settings provide service Monday to Friday between 7:00 am and 5:00 pm, less than 20% provide services on evenings or weekends. The exceptions are CCACs, most of which report they provide service outside of the traditional Monday to Friday daytime hours, and, Designated Physiotherapy Clinics of which 79.1% report offering PT services Monday to Friday evenings. There is little difference in hours of operation for OT and PT so they are not reported separately.

**Figure 4: Service Availability by Clinical Setting (OT and PT combined) (n=214)**



### 4.3.3 Wait Lists

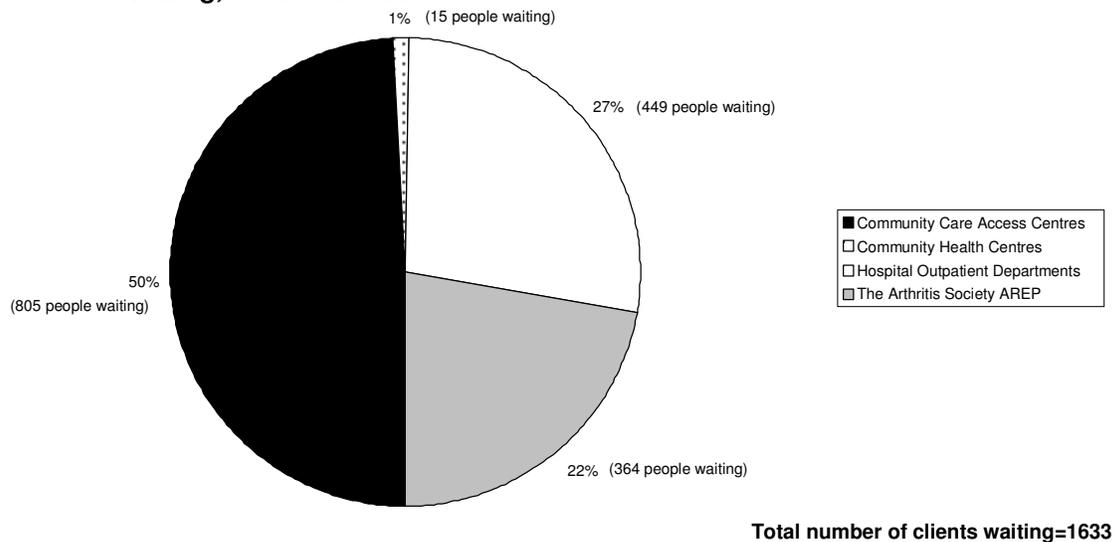
Overall 73.7% of respondents (OT and PT combined) reported having a wait list at their clinical setting.

#### Occupational Therapy

Almost all (8 of 9) of The Arthritis Society AREP sites have a wait list for OT while just over half (55.3% or 26 out of 47) of hospital OPDs report a wait list. Less than a third (31.6% or 6 of 19) of CCACs report a wait list for OT. Results for the CHCs are not reported since the sample size is so small.

Figure 5 illustrates the proportion of all clients waiting for OT by setting. In total, 1633 patients were waiting for OT in those settings that responded to the survey in December, 2005. The greatest number of people waiting for OT is at CCACs, accounting for almost 50% of all people waiting for OT. Of the remaining people waiting, approximately half are waiting for hospital outpatients (27.5%) and half for the Arthritis Society AREP (22.3%).

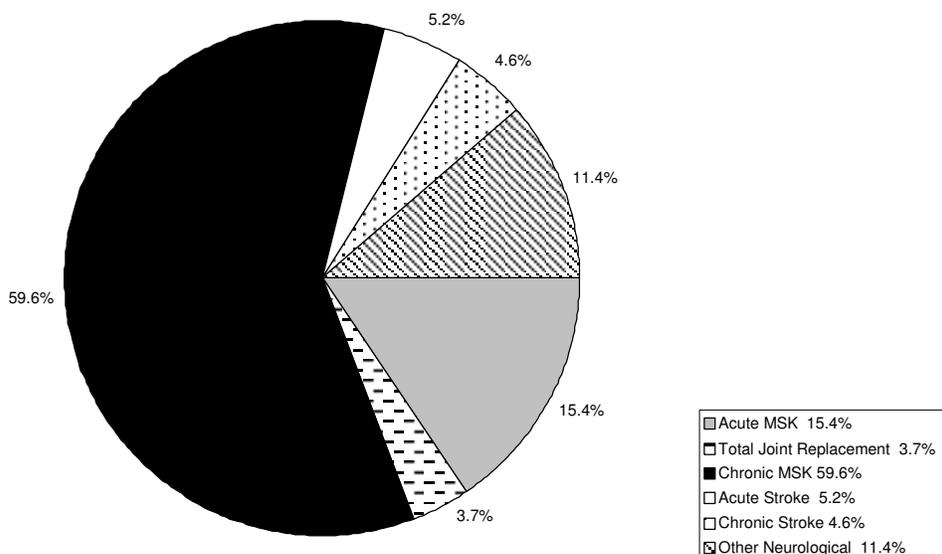
**Figure 5: Percentage of People Waiting for Community-based Occupational Therapy by Setting, December 2005**



## Who is Waiting for Occupational Therapy?

Figure 6 shows the overall distribution of the number of people waiting for OT by condition. More than half (59.6%) of people waiting for OT have chronic musculoskeletal (MSK) conditions, followed by, acute MSK (15.4%) and other neurological conditions (11.4%).

**Figure 6: Percentage of People Waiting for Occupational Therapy Services by Condition, December 2005**



## **Physiotherapy**

Eighty-four of 104 hospital OPDs (80.8%) and 13 of 15 (86.7%) of AREP settings reported having a wait list for PT services. In contrast only 12 of 47 Designated Physiotherapy Clinics (25.5%) and 4 of 19 CCACs (21.1%) reported having a wait list for PT.

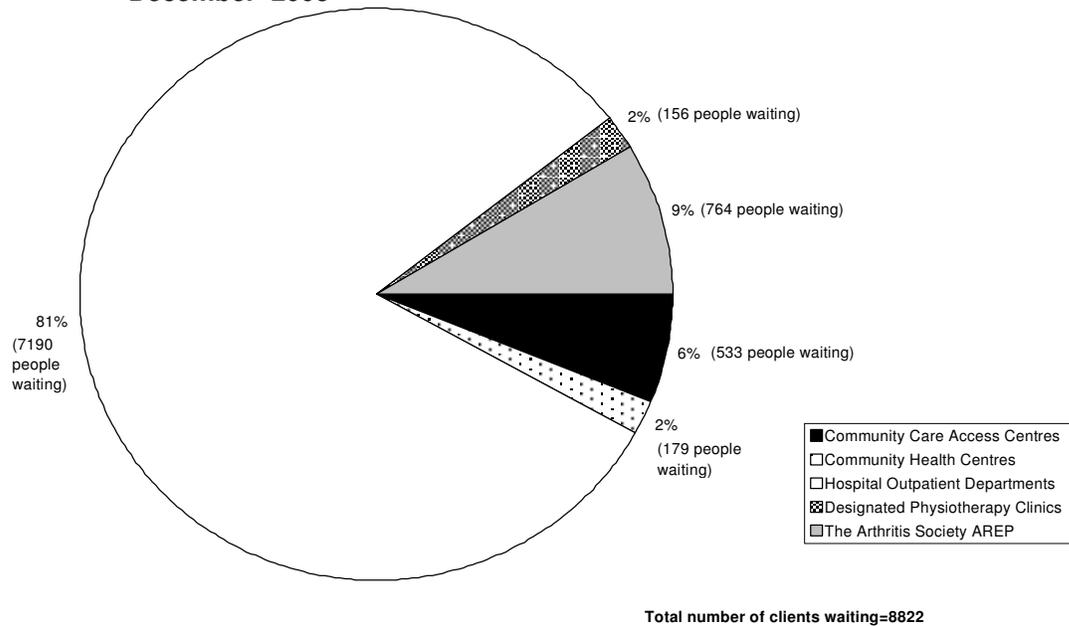
The respondents from Designated Physiotherapy Clinics explained in the comments section that they could not be competitive if they had a wait list. As one said, “We cannot afford to keep people waiting and people cannot afford to be kept waiting for treatment.” However, they also commented that they had seen a change in their wait lists since the delisting. As one said, “Since physio was delisted we have not had a wait list but often clients are turned away because they don’t fall into our OHIP funded category and have no private funds.”

Three CHCs report having a wait list for PT, but in some respects wait lists for rehabilitation in CHCs is a moot point, given that out of 55 CHCs in Ontario only 3 provide OT and 7 PT. For most CHCs therefore, there is not even a wait list to join. For those CHCs that do provide rehabilitation services, there is a

constantly increasing demand. Respondents report trying to utilize group programming and limiting from whom they will accept referrals. However, as one respondent commented, “Strategies and inventiveness to address wait lists and wait times are ultimately limited by sheer numbers of referrals and lack of staff.”

Figure 7 shows there were 8822 clients waiting for PT in December 2005 in the settings that responded to the survey. Of these, the majority (81.5%) were waiting for PT at hospital OPDs. Less than 2% of people waiting for PT were waiting for treatment at a Designated Physiotherapy Clinic.

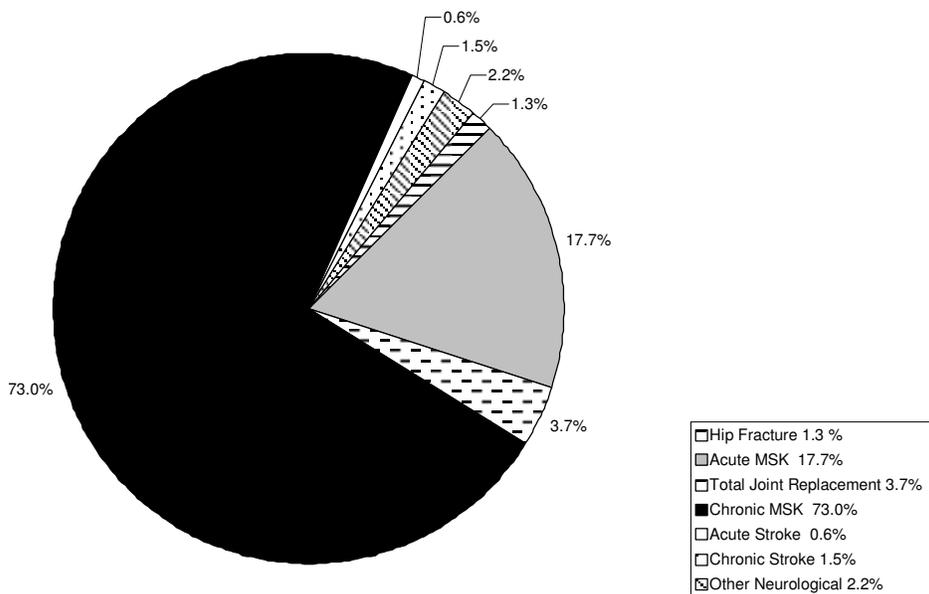
**Figure 7: Percentage of Clients Waiting for Community-based Physiotherapy, December 2005**



## Who is Waiting for Physiotherapy?

As illustrated in Figure 8, almost three quarters (73.0%) of all people waiting for PT have chronic MSK conditions with the next most frequent condition waiting for PT being acute MSK conditions (17.7%). The remaining conditions (hip fracture, total joint replacement, stroke and other neurological conditions) represent less than 5% each of the total number of people waiting for PT services.

**Figure 8: Percentage of Clients waiting for Physiotherapy Services by Condition, December 2005**



### **4.3.4 Wait Times**

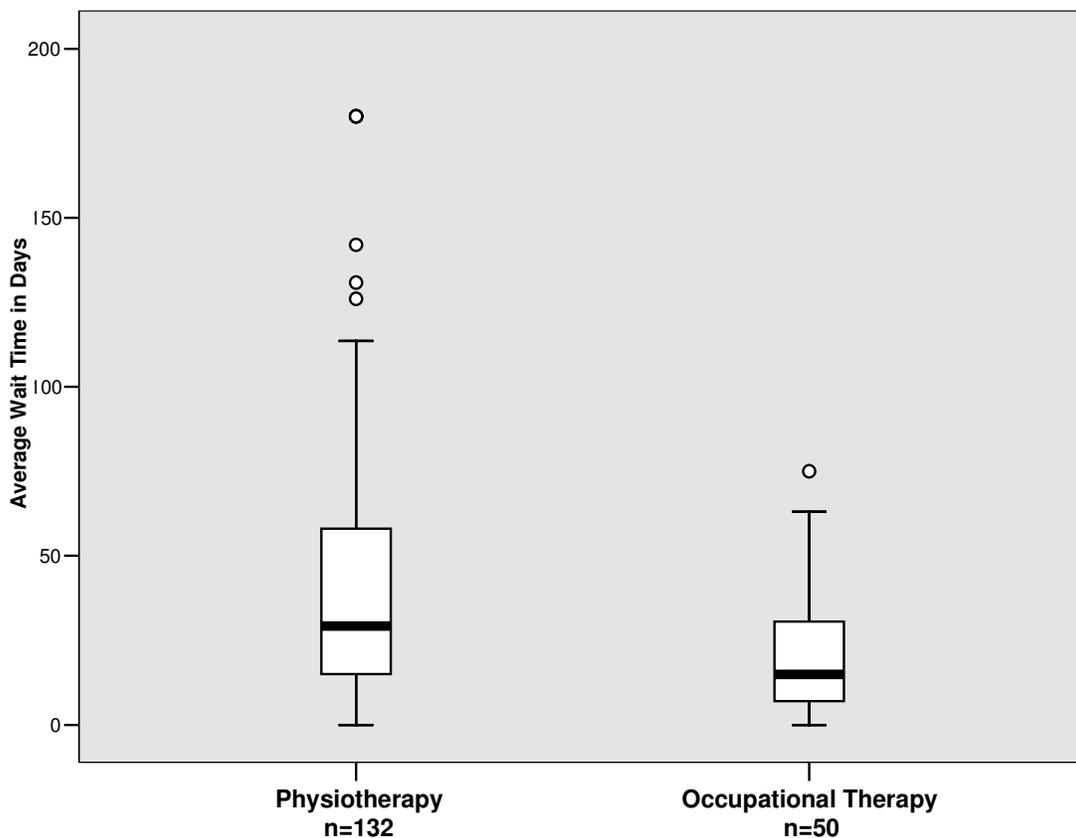
There was greater standardisation of wait time definition across settings than originally hypothesised from the key informant interviews (Phase 2). Wait times were defined by 93% of respondents using the standard definition (“time from the date the referral is received to the date a client attends his/her first appointment”).

Wait time distribution for this study is not normally distributed, making statistical estimates describing central tendency, such as means, inappropriate for the wait time data. Therefore box and whisker plots were used to present the wait times data. The box and whisker plots display the distribution of wait times for community based community-based rehabilitation in Ontario for December, 2005. The black line inside the box reflects the median wait time, indicating that 50% of rehabilitation settings are below the line and 50% of settings are above. Similarly, the upper and lower outlines of the box represent the 75<sup>th</sup> and 25<sup>th</sup> percentile scores, respectively. The whiskers extending from both ends of the box display the minimum and maximum rehabilitation wait times. Circles

represent the outliers with wait times greater than values between 1.5 and 3 box lengths from the upper edge of the box. Extreme wait times that are more than 3 box lengths from the upper edge of the box have been removed from the graph due to concerns regarding data quality.

Figure 9 presents the distribution of average wait times for PT and OT services for those settings reporting a wait list in December 2005. In general, wait times for PT are longer than OT wait times. Further, maximum wait times for PT are almost twice as long compared to maximum wait times for OT (114 days compared to a maximum of 63 days waiting for OT).

**Figure 9: Average Wait Time (Days) for Rehabilitation Services\*, December 2005**

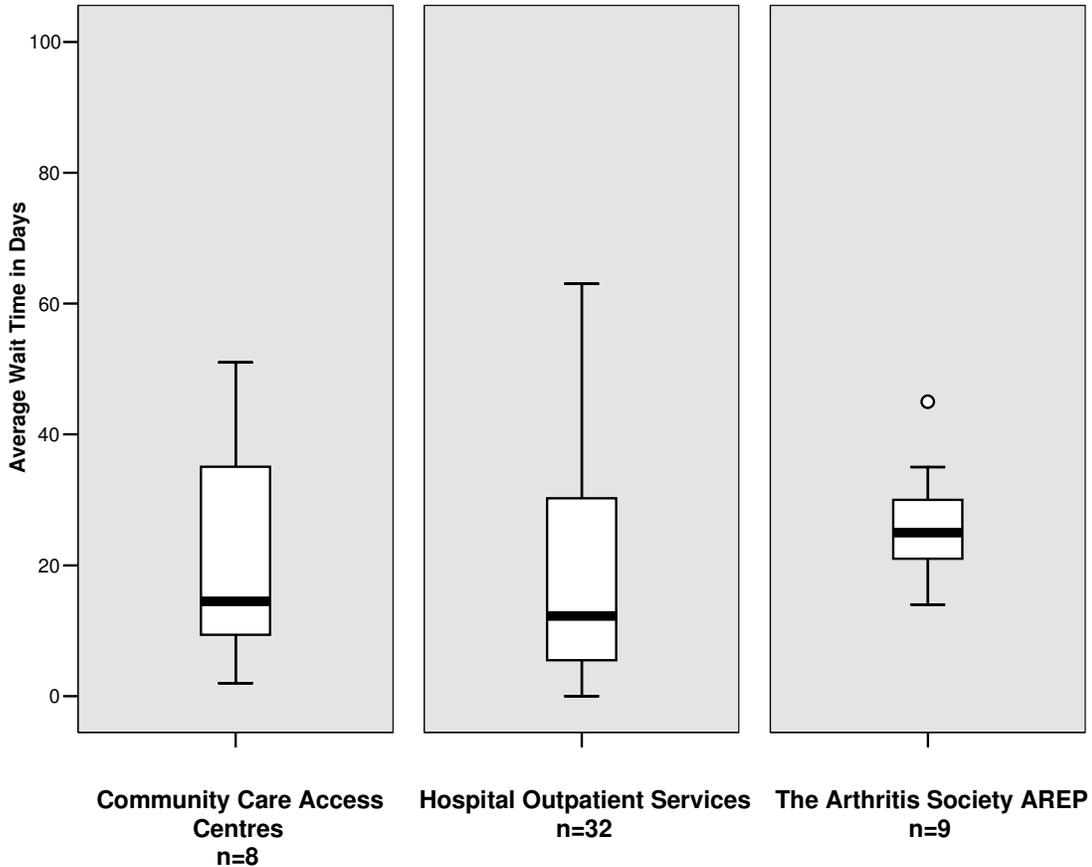


\*Wait times of respondents who indicated they had a wait list

## Occupational Therapy Wait Times by Setting (Figure 10)

CCACs and hospital outpatient services show a similar distribution of wait times, with median wait times of 14.5 and 12.3 days respectively, however, hospital OPDs have a longer maximum wait time compared to CCACs (63 days versus 51 days, respectively). The Arthritis Society AREP have a much longer median wait time of 25 days, with a smaller overall distribution.

Figure 10: Average Wait Time (Days) for Occupational Therapy\*, December 2005

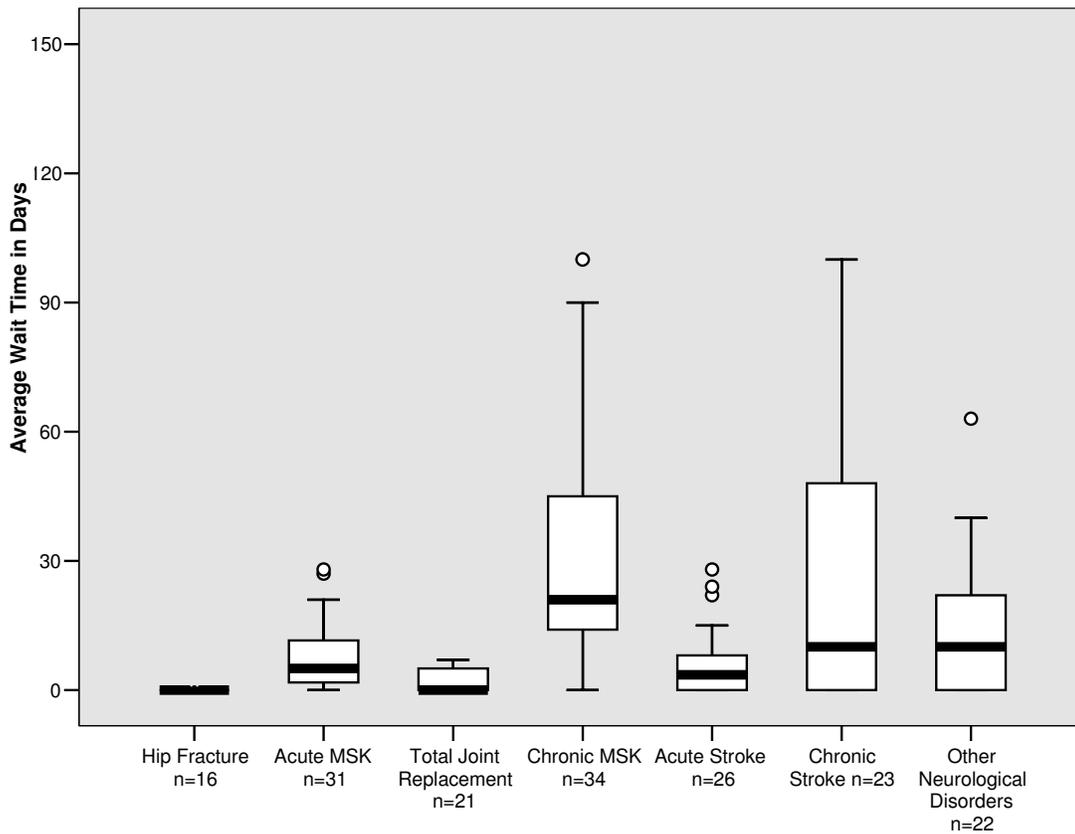


Wait Times of respondents who indicated they had a wait list

## Occupational Therapy Wait Times by Condition (Figure 11)

The longest wait times for OT occur for the people with chronic stroke (median=10 days, maximum=100 days) and chronic MSK (median=21 days, maximum 90 days).

**Figure 11: Average Wait Times (days) for Occupational Therapy\*, December 2005**

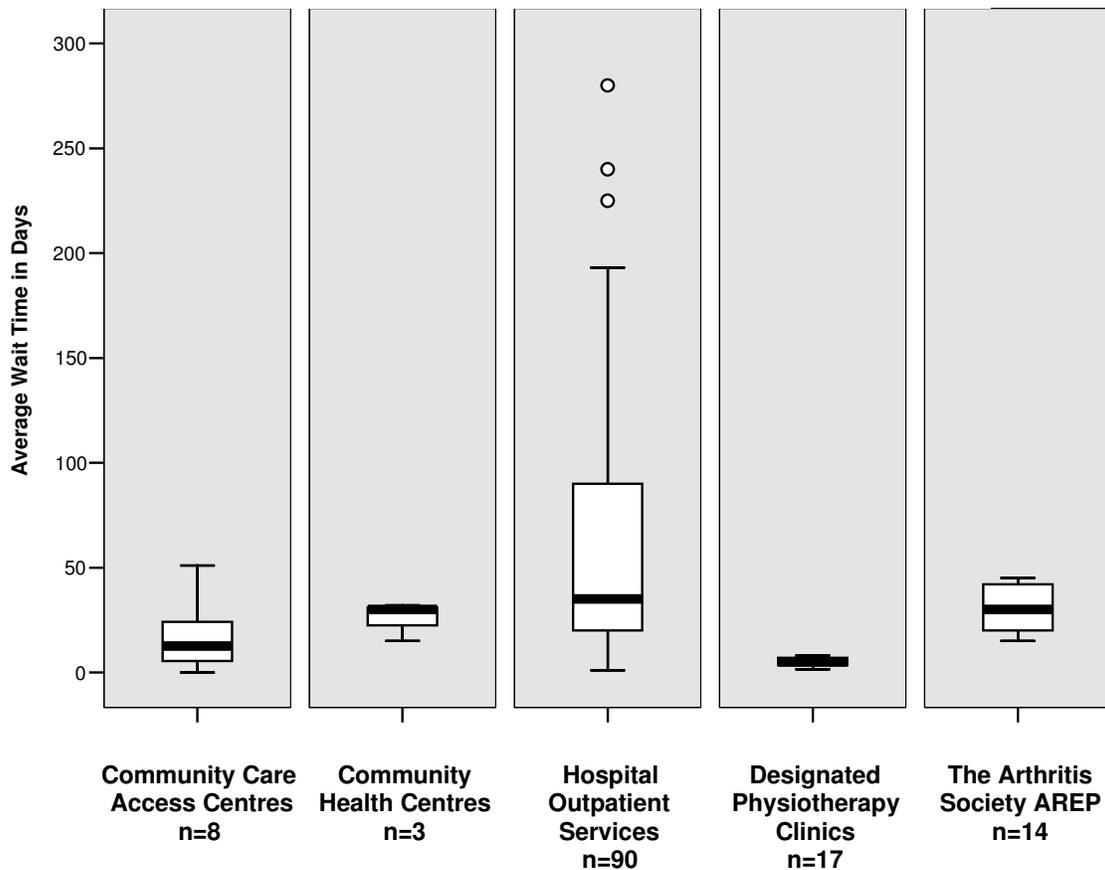


\*Wait times of respondents who indicated they had a wait lists

## Physiotherapy Wait Times by Setting (Figure 12)

The few Designated Physiotherapy Clinics that have a wait list also have the shortest wait times with a median wait time of 5 days, and a maximum wait time no greater than 8 days. In contrast, 50% of patients waiting for PT in hospital OPDs are seen in 35 days with the remaining 50% sometimes waiting up to 193 days.

**Figure 12: Average Wait Time (days) for Physiotherapy\*, December 2005**

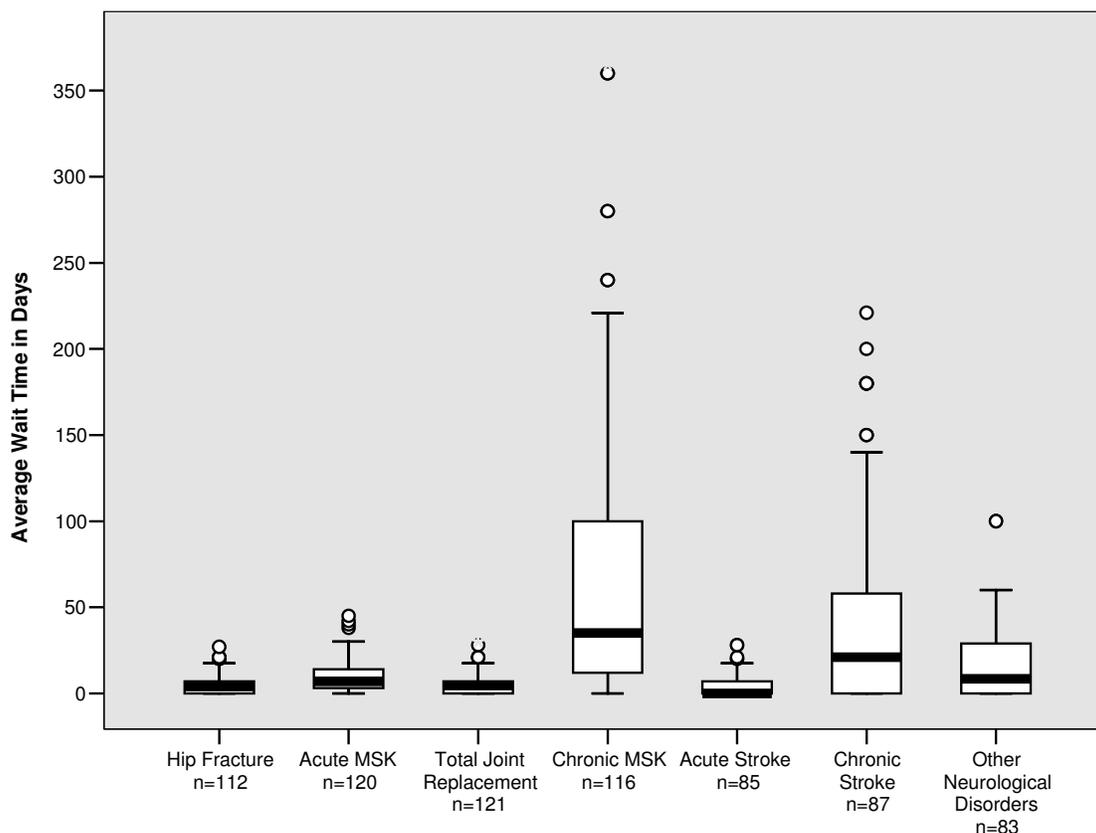


\*Wait times of respondents who indicated they had a wait list

### Physiotherapy Wait Times by Condition (Figure 13)

As with OT, people with chronic conditions are waiting the longest for PT services. Half of patients with chronic MSK conditions wait up to 35 days for PT services, however, people with these conditions can wait up to 221 days. Similarly, half of individuals waiting with chronic stroke wait 21 days for PT services, with the remaining half waiting up to 140 days. Acute conditions such as hip fracture, total joint replacements, other acute MSK conditions and recent stroke have a much shorter wait times with most being seen within 30 days.

**Figure 13: Average Wait Time (days) for Physiotherapy by Condition\*, December 2005**



\*Wait times of respondents who indicated they had a wait list

### 4.3.5 Wait List Management

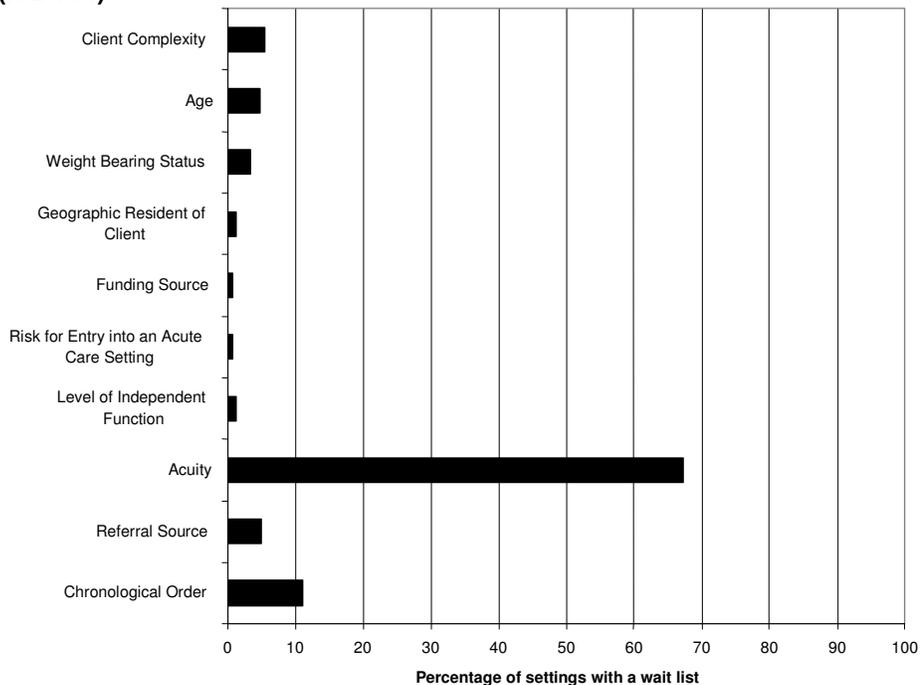
The majority of respondents had either a formal or informal process to track wait lists or wait times with less than 10% of respondents reporting no process for tracking wait times or wait lists.

#### Most Frequently Used Methods for Prioritising Wait Lists (Figure 14)

All settings reported using a variety of methods to prioritise wait lists. While respondents report using many of the methods at some time, the most frequently used methods of prioritisation are by acuity (99.3%) and by chronological order (71.7%).

**Figure 14: Most Frequently Used Methods To Prioritise Wait Lists**

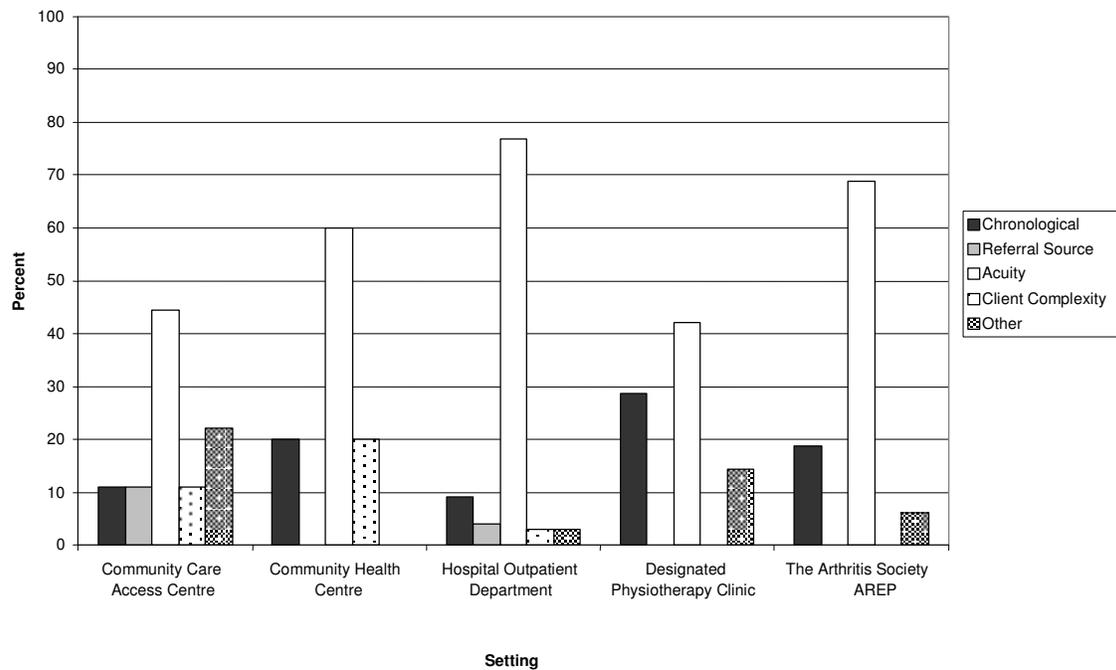
(n = 144)



## Most frequently used methods by setting (Figure 15)

Acuity is the most commonly used method of prioritisation overall. Comments from respondents highlight chronic conditions having the least priority. For example, one respondent comments in the open-ended data, “We will put re-referrals for the same person and the same condition (especially if it is a chronic condition and physio didn’t help the first time) at the bottom of the wait list.”

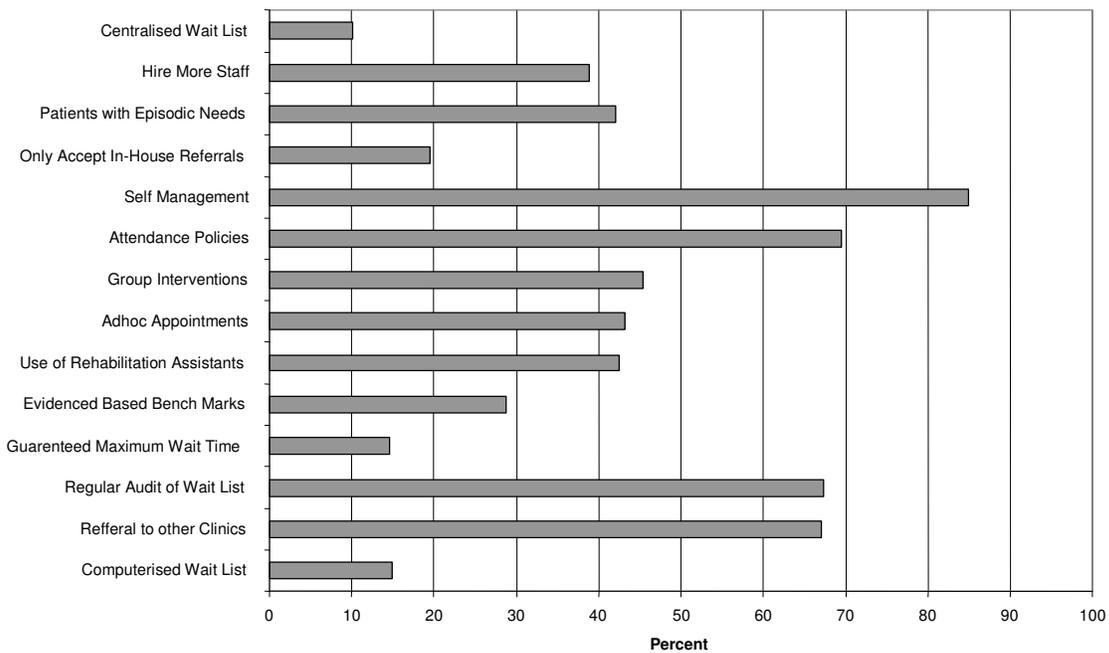
**Figure 15: Top 5 Most Frequently Used Methods to Prioritise Wait Lists by Setting**



## Methods for Managing Wait Lists (Figure 16)

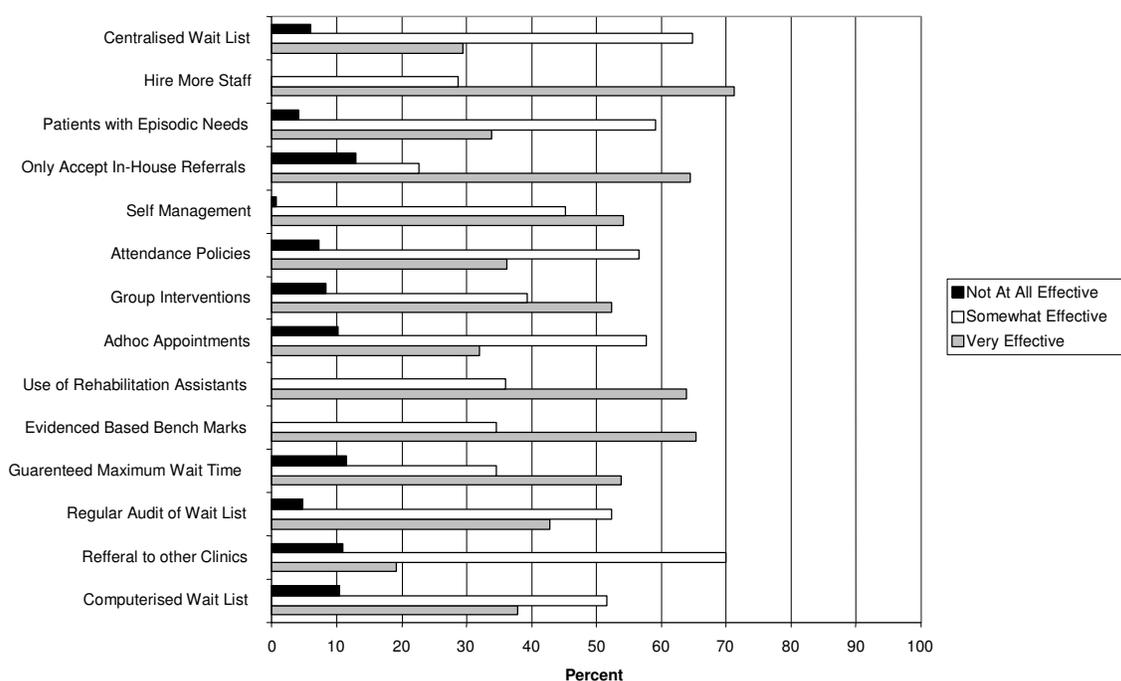
The most common methods currently used or used in the past by respondents to manage wait lists are presented in Figure 16. Self-management methods (85%) were the most commonly used management methods followed by the use of attendance policies (69.5%), regular wait list audits (67.3%) and referral to other clinics (67.0%). The least common methods to manage wait lists included the use of a computerised wait list management system (14.8%), guaranteed maximum wait times (14.5%) and centralised wait lists (10.1%).

**Figure 16: Methods Used For Management (n=214)**



We also asked respondents how effective they found these wait list management strategies to be (see Figure 17). Interestingly, self-management, attendance policies, regular wait list audits and referrals to other clinics were identified as the most commonly used management methods, however, these were not the methods they identified as most effective. Over half of respondents (54.2%) reported that self-management is an effective wait list management strategy whereas only about a third (36.3%) found attendance policies to be effective. Not surprisingly, hiring more staff was seen as the most effective method (71.2%) followed by the use of evidence-based benchmarks (65.4%), only accepting in-house referrals (64.5%) and the use of rehabilitation assistants (64.0%).

**Figure 17: Effectiveness of Management Techniques (n = 214)**



## Management of wait lists at hospital outpatient departments

While most settings reported similar ways of managing and prioritising wait lists, there are some particular issues for hospital OPDs. As can be seen from the results so far, the issues of wait lists and wait times are particularly significant for respondents in hospital OPDs. Many respondents in these settings described the challenges they face when dealing with large wait lists. “You do the best you can with the ever decreasing resources giving some attention to those that have greater potential for rehabilitation. The rest either wait or get nothing.”

The most commonly used wait list management strategies used by hospital OPDs included prioritising wait lists by acuity or referral source, encouraging clients to utilise other community-based services, and educating referral sources.

Many hospital OPDs described putting clients with chronic MSK conditions at the bottom of the list. As one reported, “We have closed our wait list and no longer accept chronic referrals (only acute referrals and specialty programs accepted).”

Encouraging patients to utilise other rehabilitation services by providing information about other PT clinics is often used but is limited in its effectiveness due to either the lack of other publicly-funded options or inability of clients to pay due to lack of private insurance. This was particularly true in rural and remote areas. As one rural hospital OPD stated, “Geographically we are quite ‘isolated’. For much of our clientele, a private clinic would be over 50 km away...So we’re it.” The partial delisting of Designated Physiotherapy Clinics has also limited the options available. “We used to refer patients to Designated Physiotherapy Clinics ...but this is very limited now due to changes in Ministry of Health Guidelines.” As one respondent concludes, “Many patients are denied treatment as a result (because) they cannot afford private. “

Hospital OPDs are in a relatively unique position in that they do not receive their funding directly from MOH-LTC, rather they receive their funding through their hospital’s global budget. As a result, they are more limited than other settings in their ability to utilise various wait list management strategies. Whereas a Designated Physiotherapy Clinic has the option to hire more staff to meet wait list demands, a hospital OPD must compete with other services for funding within the hospital. As one respondent states, “We continue to put in increased staffing requests but have been restricted by the hospital budget.” As another says, “We have discontinued seeing or accepting referrals for chronic musculoskeletal disorders since we can’t see them in a timely manner anyway. We don’t have the ability to hire more staff. Our priority is to support post-total joint replacements and acute orthopaedic injuries (within 6 weeks).”

Further, some respondents report that in response to the need to balance budgets, many hospitals are considering reducing outpatient rehabilitation services in order to save money. In some of these situations, the hospital OPD represents the only publicly-funded outpatient rehabilitation service in the region (often rural or remote), leaving huge issues of access for Ontario residents to community-based rehabilitation in these areas.

## **SUMMARY OF SURVEY RESULTS**

- Hospital outpatient departments have the largest staff complement for community-based PT but at the same time have the largest wait lists and longest wait times
- Most community-based rehabilitation settings are open Monday to Friday during the day, and very few settings are available beyond these hours of operation
- The majority of people waiting for community-based rehabilitation services have chronic musculoskeletal conditions
- Frequently used methods of wait list management at community-based settings include self management, regular audit of wait lists and referral to other clinics
- Increasing staff complement, only accepting in-house referrals, use of rehabilitation assistants and use of evidence-based benchmarks are considered to be very effective methods to manage wait lists for community-based rehabilitation

## DISCUSSION

The purpose of this study was to describe the measurement, extent, management and perceptions of wait times and wait lists for PT and OT across community-based rehabilitation settings in Ontario. The findings present a snapshot of the status of wait lists and wait times in Ontario for December 2005. It also raises important issues for future research on timely access to community-based rehabilitation in Ontario. This section summarises and discusses key findings, identifies strengths and limitations of the study, and offers directions for future research.

### 5.1 Demand for Service

The results of this study illustrate there is considerable demand for community-based rehabilitation service, however, the magnitude of wait lists and wait times indicate that demand exceeds the current capacity to provide community-based rehabilitation in a timely manner. It is apparent from the results of this study that there is a disproportionate demand from people with chronic conditions, and large wait lists and wait times for hospital outpatient rehabilitation services.

#### 5.1.1 Chronic Conditions

People with chronic MSK, chronic stroke and other neurological conditions comprise the majority of people waiting for community-based rehabilitation. In addition, people with these diagnostic conditions have the longest wait times. The presence of extensive wait lists and wait times suggests limited capacity in the health system to address the needs of clients with these conditions. This has varying implications as chronic diseases (including chronic MSK conditions) make up the majority of health related problems for Canadians<sup>39;40</sup>. Adding to this is the fact that the aging population also experiences conditions of a chronic nature. Recent population data from British Columbia indicate a three to 10 fold increase in the prevalence of chronic disease such as COPD, diabetes, osteoarthritis and hypertension between the ages of 50 and 75 years<sup>41</sup>. Compounding these figures are current population projections of approximately 3.2 million seniors making up 20.3 percent of the Ontario population by the year 2028<sup>42</sup>. These facts, combined with the knowledge that the presence of chronic conditions in the elderly can lead to progressive disability, suggest a future increase on the demand of community-based rehabilitation services.

The results from this study indicate that managers and senior therapists recognise that people with chronic conditions make up the majority of rehabilitation wait lists. As a result, they have implemented various strategies to mitigate wait lists and wait times through the use of self management techniques for chronic disease. Self management emphasise the client's role in managing their illness through collaboration with their health care professions<sup>43</sup>. The

benefits of self management are well documented throughout the literature. Improvement in health behaviours, self-efficacy, health status and cost-effectiveness has been demonstrated through chronic disease self management programmes with rheumatoid arthritis, osteoarthritis and COPD<sup>44-48</sup>. Therefore alternative treatment techniques specifically aimed at the chronic disease population may be a viable option for wait list management.

The results from this study also suggest the need to explore further the role of rehabilitation practice in prevention which would minimise the number of people requiring service and ultimately reduce current wait lists for rehabilitation services. Traditionally, rehabilitation has focused on the post-acute and chronic phase of injury<sup>49</sup>. However, recently there has been a move by rehabilitation professionals toward the practice of health promotion and disease prevention especially for chronic disease. An example of this can be found in the effectiveness of falls prevention programmes, the concept of “prehab”, workplace safety programmes and wellness programmes<sup>50-54</sup>. As more rehabilitation professions begin to focus on health promotion and disease prevention, it is plausible that wait lists and wait times could be managed more effectively through the prevention of both acute and chronic conditions.

### **5.1.2 Hospital Outpatient Services**

Findings from this study indicate that Ontario hospital OPDs have the largest wait lists and the longest wait times compared to other settings that provide community based community-based rehabilitation services. This is of concern given the recent partial delisting of publicly funded PT services in Ontario. In order to be eligible for services in the newly termed “Designated Physiotherapy Clinics”, residents must meet one of the following criteria: 1) aged 64 and over; 2) aged 19 years or younger; 3) reside in a long-term care facility; 4) require PT at home post-hospitalisation; or, 5) receive social benefits.

The logic of delisting a publicly-funded service such as the Schedule 5 clinics (Designated Physiotherapy Clinics) is that clients will access other publicly-funded services such as home care or hospital OPDs; utilize private insurance to pay for PT services; or pay out of pocket. The findings of this study place many of these assumptions in question. It would appear to be unlikely that hospital OPDs have the capacity to absorb more clients given their current wait lists. This is of particular concern when the hospital outpatient setting is the only publicly-funded option available within a given community setting. Furthermore, vulnerable members of the population, especially those with chronic conditions, who do not have access to privately funded rehabilitation, will be forced to wait for rehabilitation services from hospital OPDs, thereby limiting their access to timely rehabilitation services. In fact, many respondents report hospital outpatient services being cut back or the criteria for access being changed to exclude clients with chronic conditions or referred from extra-hospital sources. Some hospital OPDs report only accepting in-house referrals; others report referring

clients on to other clinics, which may or may not be publicly funded. Vulnerable and marginalised members of the population, especially those who are elderly or underemployed, and/or with chronic conditions are unlikely to have the option to utilise private insurance or pay out of pocket.

The vulnerability of public funding for community-based rehabilitation services reflects the ambiguity of the Canada Health Act (CHA) with respect to “medically necessary” services<sup>55</sup>. The CHA stipulates that residents shall receive, at no direct cost, all medically necessary services provided by physicians, and/or in hospital<sup>56</sup>. There is ambiguity regarding the degree to which ‘non-core’ services such as PT are publicly insured. In general, provincial governments are not required to insure PT services, particularly those in the community and they therefore have the option to make policy changes to public funding for community-based PT. Although PT is specifically mentioned (albeit briefly) in the CHA, OT is not, and is therefore in an even more ambiguous situation.

Evidence from this study suggests that some of the methods being employed by hospitals to manage extensive wait lists could be further limiting access to community-based rehabilitation. Some hospital OPDs report only accepting in-house referrals; others report referring clients on to other clinics, which may or may not have publicly funding. This practice, although necessary for some settings, may create additional strain on wait lists and wait times outside of some hospital catchment areas by adding further strain on the publicly funded community clinics. The effect is an increase in already lengthy wait lists and wait times.

Demand on hospital outpatient rehabilitation departments can also occur due to the range of services that are often offered by hospital rehabilitation departments. In many cases, hospital outpatient rehabilitation departments coexist with an inpatient counterpart. When there are inpatient staff shortages, often it is the outpatient staff that must be reallocated to cover inpatient services. This further contributes to the limited capacity for hospital outpatient rehabilitation departments to service the population and ultimately impact the extent of wait lists.

The high demand on hospital outpatient rehabilitation departments requires immediate attention in order to alleviate extensive wait lists and long wait times. Alternative and innovative solutions need to be explored to ensure that people seeking publicly funded rehabilitation are able to access appropriate and timely services. Future research is warranted that examines current hospital funding formulas and how they may be adjusted to consider the number of people on wait lists and the wait time. Ontario’s implementation of LHINs may address these issues in specific regions of the Province; thereby, accurately reflect the demand for hospital based outpatient rehabilitation.

## 5.2 Service Capacity

The presence of a wait list for a particular service implies demand for that service. In order to meet such demand, it is necessary for a service provider to have adequate capacity. Capacity for rehabilitation services generally involves the distribution of resources in the form of staffing levels, hours of operation and the utilisation of settings where rehabilitation services take place.

### 5.2.1 Staffing

Approximately 39% of respondents identified they have hired additional staff as a method to manage wait lists. Of these, 85% felt it to be a very effective method to manage and reduce wait lists for community based primary health care rehabilitation services. This strategy is predominately used by Designated Physiotherapy Clinics, as these settings have greater autonomy over resources to increase capacity in the form of health human resources. The majority of settings, other than Designated Physiotherapy Clinics, receive the majority of their operating funds either directly from the MOH-LTC or they receive a fixed proportion of global budgets to operate rehabilitation services. According to key informants, limitations in budget autonomy have a significant impact on the setting's ability to adjust to demand through the increase of full time equivalent staff.

Based on the findings from this study, it is difficult to assess if the full time equivalent distribution of occupational therapists and physiotherapists represent adequate human resource allocation to community-based rehabilitation. There is little information found in the literature pertaining to the distribution of occupational therapists and physiotherapists across Ontario. However, a recent study examining PT human resource distribution in Canada indicated that Ontario's ratio of physiotherapists to 10, 000 population grew by only 2.2% despite provincial population growth of 17.9% between 1991 and 2000<sup>57</sup>. Other studies indicate problems with hospital PT staffing. The Ontario Hospital Association listed PT having the highest vacancy rates in its member's hospital, suggesting a gap between the supply and demand for PT services<sup>58</sup>.

In order to address the limited information available on rehabilitation staffing levels, further research is necessary to determine the effect of increasing community-based rehabilitation health human resources may have on the reduction of wait lists and wait times.

### **5.2.2 Hours of Operation/Service Availability**

With the exception of Designated Physiotherapy Clinics and CCACs, most settings only provide service Monday to Friday from 7am to 5pm. In most cases it is these same settings that have the greatest number of people waiting for rehabilitation services for the longest amount of times. This gap in service availability represents an opportunity for the redistribution of care over additional hours and days throughout the week. It is a reasonable prediction that the expansion of existing hours of operation would increase access to clients seeking primary health care rehabilitation services and ultimately decrease wait lists and wait times. However, such an expansion in services would require more investment in health human resources.

### **5.2.3 Settings**

Under utilisation of settings that offer community-based rehabilitation services is an area that warrants attention. Notable from the onset of this project was the substantial lack of CHCs that offer community-based rehabilitation services with less than 20% (10/55) of all CHCs offering either OT or PT. The under-utilisation of these settings presents another opportunity to expand community-based rehabilitation and increase capacity. Furthermore, the CHC model offers a systems approach to organised primary health care, disease prevention and health promotion that is ideal for chronic disease management. This makes CHCs well positioned to take on a portion of existing wait lists for rehabilitation from settings such as hospital outpatient rehabilitation departments. Since CHCs have been providing primary care for more than 30 years, the model is well established to meet the needs of the community and can adapt its service accordingly<sup>59</sup>. In order to address the rehabilitation wait lists problem, it is critical to explore CHCs as a potentially cost-effective option to alleviate some of the wait list burden of other community-based rehabilitation settings.

## **5.3 Study Limitations**

The extent of wait lists and wait times for community-based rehabilitation in this study are likely underestimated due to the exclusion of specialty ambulatory rehabilitation services (e.g. amputee programmes and hand clinics) and other members of the rehabilitation team. Furthermore, this study only examined wait lists and wait times for adult rehabilitation.

Although we had a very good response rate to the survey in all settings, there is the potential for response bias. It is not clear if the non-responders did not participate in the survey because they did not have a wait lists and were therefore not interested in participating in the survey, or, if that they did have wait lists but were reluctant to participate.

It was not possible given the time available to complete this project to fully analyse the data by geographic region or by LHIN. Due to the variable response rate by various settings with each LHIN, this kind of analysis will require weighting and mapping to determine differences in wait times and wait lists by LHIN. We recommend that this level of analysis be completed as a second phase to this report.

## CONCLUSIONS AND RECOMMENDATIONS

Overall, the results from this study indicate that wait times and wait lists for community-based rehabilitation vary depending on setting and condition. Most notably, wait lists and wait times are the longest for people with chronic musculoskeletal conditions who are waiting for hospital outpatient PT. This suggests that the current publicly-funded community based rehabilitation capacity is not adequate to meet the demands from specific client populations, in specific settings. In order to further understand this complex relationship the following is recommended:

- 1) Further research should examine the long-term effect of wait lists and wait times for community-based rehabilitation on client outcomes and continuity and transition of care. Research also needs to be conducted to understand how wait lists and wait times affect aggregated health care cost and societal burden.
- 2) A more robust understanding must be gained regarding client perspectives of wait lists for community-based rehabilitation. We restricted our study to publicly funded settings; however, there are numerous (perhaps 1,500) of community-based rehabilitation settings in the private sector. In light of this, one must question: to what extent are Ontarians willing (and able) to access these privately-funded community-based rehabilitation settings?
- 3) Prioritisation based on acuity for community based rehabilitation services is commonly practiced in all settings. However, definitions of acuity vary between and within settings. Individuals with less acute conditions often have the longest wait times. Evidence based benchmarks for wait times need to be established to ensure that people with chronic conditions do not wait beyond a reasonable time.
- 4) Utilisation of currently untapped capacity needs to be considered in order to mitigate wait times and wait lists for vulnerable or marginalised populations such as those with chronic conditions and those unable to access privately funded rehabilitation. This could be accomplished, for example, by expanding current hours of operations of publicly-funded community-based rehabilitation settings to include evenings and weekends. Settings such as Community Health Centres need to be considered as sites for rehabilitation expansion, particularly for populations with chronic conditions. These expansions in service would require more investment in financial and health human resources.

In conclusion, this study provides one of the first overviews of wait lists and wait times for adult rehabilitation in community-based settings across the Province of Ontario. It also provides preliminary data upon which to build future projects that examine wait lists and wait times for community-based rehabilitation. As the Ontario population continues to evolve, it is important that the existing health care system also evolve, in order to ensure timely access to quality health care.

## REFERENCE LIST

- (1) Rahim A. (personal communication). North York Community Access Centre. 2006. 12-4-2005.
- (2) Association of Ontario Health Centres. Association of Ontario Health Centres 2006 Available from: URL:  
[http://www.aohc.org/aohc/index\\_e.aspx?DetailD=9](http://www.aohc.org/aohc/index_e.aspx?DetailD=9)
- (3) Ministry of Health and Long-Term Care. Physiotherapy services in designated clinics for social assistance recipients. Ministry of Health and Long-Term Care 2006 Available from: URL:  
<http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/3000/bul3069.pdf>
- (4) Ontario Society of Occupational Therapists. About occupational therapists. Ontario Society of Occupational Therapists 2006 Available from: URL:  
<http://www.osot.on.ca/eng/aboutot.asp>
- (5) Canadian Physiotherapy Association. What is physiotherapy? Canadian Physiotherapy Association 2006 Available from: URL:  
<http://www.physiotherapy.ca/wahtis.htm>
- (6) Wahidi I. (personal communication). The Arthritis Society Arthritis Rehabilitation and Education Program. 2006.
- (7) Ontario Ministry of Health and Long-Term Care. Ontario's Wait Time Strategy. Ontario Ministry of Health and Long-Term Care 2004 Available from: URL:  
[http://www.health.gov.on.ca/transformation/wait\\_times/wt\\_data.html](http://www.health.gov.on.ca/transformation/wait_times/wt_data.html)
- (8) Young J, Turnock S. Community care waiting lists and older people. *BMJ* 2001;322(7281):254.
- (9) The Wait Time Alliance. No more time to wait: toward benchmarks and best practices in wait time management. The Wait Time Alliance 2005 March Available from: URL:  
[http://www.eyesite.ca/pdf/no\\_more\\_time\\_to\\_wait.pdf](http://www.eyesite.ca/pdf/no_more_time_to_wait.pdf)
- (10) The World Health Organization. Facts related to chronic diseases. World Health Organization 2006 [cited 5 A.D. Dec]; Available from: URL:  
<http://www.who.int/dietphysicalactivity/publications/facts/chronic/en/>
- (11) Ontario Ministry of Health and Long-Term Care. Results Ontario-Better Health. Ministry of Health and Long-Term Care 2005 January [cited 2005 Dec]; Available from: URL:  
<http://www.resultsontario.gov.on.ca/scripts/ho.asp>

- (12) Cott C, Devitt R, Falter L, Soever L, Wong R. Adult rehabilitation and primary health care in Ontario: A preliminary report. 2004. Toronto, Arthritis Community Research and Evaluation Unit.
- (13) GTA Rehab Network. Measuring and managing supply and demand: A waiting list information management proposal for musculoskeletal rehabilitation in the Greater Toronto Area. GTA Rehab Network 2003 May [cited 2005 Jul]; Available from: URL: <http://www.gtarehabnetwork.ca/downloads/rpt-waitlist-2003.pdf>
- (14) Chesworth BM, Speechley M, Hartford K, Crilly R. Home care after hip fracture in a health planning region. *Can J Public Health* 2001;92(5):380-4.
- (15) Christie HJ, Gobert AD, Matthew E, Rousseau DC, Webber SC. Waiting List Management Strategies for Outpatient Orthopaedic Physical Therapy. *Physiotherapy Canada* 47[3], 191-206. 1997.
- (16) Rachlis M. Prescription for excellence: How innovation is saving Canada's health care system. Toronto: Harper Collins Publishers Ltd; 2004.
- (17) Hadorn DC. Setting priorities for waiting lists: defining our terms. Steering Committee of the Western Canada Waiting List Project. *CMAJ* 2000;163(7):857-60.
- (18) McDonald P, Shortt S, Sanmartin C, Barer M, Lewis S, Sheps S. Waiting lists and waiting times for health care in Canada: More management!!! More money??? Health Canada 1998 July Available from: URL: [http://www.hcsc.gc.ca/english/media/releases/waiting\\_list.html](http://www.hcsc.gc.ca/english/media/releases/waiting_list.html)
- (19) Romanow R. Building on values: The future of health care in Canada. Health Canada 2002 [cited 2005 Jul]; Available from: URL: <http://www.hc-sc.gc.ca/english/care/romanow/hcc0086.html>
- (20) Auditor General of Ontario. 2004 Annual report of the Auditor General of Ontario. Office of the Auditor General of Ontario 2004 [cited 2005 Jul]; Available from: URL: [http://www.auditor.on.ca/en/reports\\_2004\\_en.htm](http://www.auditor.on.ca/en/reports_2004_en.htm)
- (21) Shortt SE, Shaw RA. Equity in Canadian health care: does socioeconomic status affect waiting times for elective surgery? *CMAJ* 2003;168(4):413-6.
- (22) Nayler M. Quality Management Program. College of Physiotherapists of Ontario 2003 June [cited 2005 Jul]; Available from: URL: [http://www.collegept.org/college/content/pdf/en/QM\\_Evaluation\\_Executive\\_Summary.pdf](http://www.collegept.org/college/content/pdf/en/QM_Evaluation_Executive_Summary.pdf)

- (23) Nocon A. GP's Assessments of People Aged 75 and Over: Identifying the Need for Occupational Therapy Services. *British Journal of Occupational Therapy* 1993;56(4):123-7.
- (24) Maddison P, Jones J, Breslin A, Barton C, Fleur J, Lewis R, et al. Improved access and targeting of musculoskeletal services in northwest Wales: targeted early access to musculoskeletal services (TEAMS) programme. *BMJ* 2004;329(7478):1325-7.
- (25) Sanmartin C, Shortt SE, Barer ML, Sheps S, Lewis S, McDonald PW. Waiting for medical services in Canada: lots of heat, but little light. *CMAJ* 2000;162(9):1305-10.
- (26) Pattinson J. Primary care. Central reservations. *Health Serv J* 2003;113(5838):30-1.
- (27) Elwyn GJ, Williams LA, Barry S, Kinnersley P. Waiting list management in general practice: a review of orthopaedic patients. *BMJ* 1996;312(7035):887-8.
- (28) Sullivan T, Baranek PM. First do no harm: Making sense of Canadian health care reform. Vancouver: UBC Press; 2002.
- (29) Wright C, Ritson E. An Investigation into Occupational Therapy Referral Priorities within Kensington and Chelsea Social Services. *British Journal of Occupational Therapy* 2001;64(8):393-7.
- (30) Decoster C. Measuring and managing waiting times: what's to be done? *Healthc Manage Forum* 2002;15(2):6-50.
- (31) Meiland FJ, Danse JA, Wendte JF, Gunning-Schepers LJ, Klazinga NS. Urgency coding as a dynamic tool in management of waiting lists for psychogeriatric nursing home care in The Netherlands. *Health Policy* 2002;60(2):171-84.
- (32) Western Canadian Waiting List Project. From chaos to order: Making sense of waiting lists in Canada-final report. Western Canadian Waiting List Project 2001 March [cited 2005 Jul]; Available from: URL: [http://www.wcwl.org/media/pdf/library/final\\_reports.2.pdf](http://www.wcwl.org/media/pdf/library/final_reports.2.pdf)
- (33) Rastall M, Fashanu B. Hospital Physiotherapy Outpatient Department Waiting Lists. *Physiotherapy* 2001;87(11):563-72.
- (34) Holland KA. Does Taking Students Increase Your Waiting Lists? *Physiotherapy* 1997;83(4):166-72.
- (35) Ladyshevsky RK, Bird N, Finney J. The impact on departmental productivity during physical therapy student placements: An investigation

- of out-patient physical therapy services. *Physiotherapy Canada* 1994;45:94-8.
- (36) McGurran J, Noseworthy T. Improving the management of waiting lists for elective healthcare services: public perspectives on proposed solutions. *Hosp Q* 2002;5(3):28-32.
- (37) Lewis S, Barer ML, Sanmartin C, Sheps S, Shortt SE, McDonald PW. Ending waiting-list mismanagement: principles and practice. *CMAJ* 2000;162(9):1297-300.
- (38) Dillman DA. *Mail and telephone surveys: The total design method*. New York: Wiley; 1978.
- (39) Health Canada. *Arthritis in Canada: An ongoing challenge*. 2003. Ottawa, Health Canada.
- (40) Perruccio AV, Badley EM, Guan J. *Burden of Disease. Arthritis and related conditions in Ontario: ICES research atlas*. 2nd ed. Toronto: Institute for Clinical Evaluative Sciences; 2004.
- (41) BC Ministry of Health Services. *Prevalence rate of people with specific chronic disease, by gender and age group: British Columbia, 2002/2003*. BC Ministry of Health Services 2004 March [cited 2006 Feb]; Available from: URL: [http://www.health.gov.bc.ca/cdm/research/cdm\\_cases\\_age\\_02-03.pdf](http://www.health.gov.bc.ca/cdm/research/cdm_cases_age_02-03.pdf)
- (42) Ontario Ministry of Finance. *Update to Ontario population projections 2001-2028*. Ontario Ministry of Finance 2006 [cited 2004 Oct]; Available from: URL: <http://www.gov.on.ca/FIN/english/demographic/demog02e.htm#I15>
- (43) Lorig KR, Sobel DS, Ritter PL, Laurent D, Hobbs M. Effect of a self-management program on patients with chronic disease. *Effective Clinical Practice* 2001;4(6):256-62.
- (44) Brooks G. Physical activity counseling beyond the workout. *Cardiopulmonary Physical Therapy Journal* 2005;16:5-10.
- (45) Damush TM, Weinberger M, Perkins SM, Rao JK, Tierney WM, Qi R. Randomized trial of a self-management program for primary care patients with acute low back pain: Short term effects. *Arthritis and Rheumatism* 2003;49:179-86.
- (46) Gallefoss F, Bakke PS. How does patient education and self-management among asthmatics and patient with chronic obstructive pulmonary disease affect medication? *American Journal of Respiratory Critical Care Medicine* 1999;160:2000-5.

- (47) Hammond A, Young A, Kidao R. A randomized controlled trial of occupational therapy for people with early rheumatoid arthritis. *Annals of Rheumatic Diseases* 2004;63:23-30.
- (48) Heuts PHTG, de Bie R, Drietelaar M, Aretz K, Hopman-Rock M, Bastiaenen CHG. Self-management in osteoarthritis of hip or knee: a randomized clinical trial in a primary healthcare setting. *Journal of Rheumatology* 2005;37:543-9.
- (49) Powell N. Rugby injuries: Patterns and prevention. *Physiotherapy in Sport: The Journal of the Association of Chartered Physiotherapists in Sports Medicine* 1998;21(4):5.
- (50) Beaton-Starr M. Carpel tunnel syndrome and the workplace: An occupational therapy approach to prevention. *Work* 1992;2(4):61-6.
- (51) Campbell AJ, Robertson MC, Gardner MM, Norton RN, Buchner DM. Falls prevention over 2 years: a randomized controlled trial in women 80 years and older. *Age and Ageing* 1999;28(6):513-8.
- (52) Carter N, O'Driscoll M. Life begins at forty! Should the route to promoting exercise in elderly people start in their forties? *Physiotherapy* 2000;86(2):85-93.
- (53) Gill TM, Baker DI, Gottschalk M, Peduzzi PN, Allore H, Van Ness PH. A prehabilitation program for the prevention of functional decline: Effect on higher-level physical function. *Arch Phys Med Rehabil* 2004;85(7):1043-9.
- (54) Jaffe ER. Medical consumer education: Health promotion in the workplace. *Occupational Therapy in Health* 1989;5(4):5-24.
- (55) Government of Canada. C-6. Canada Health Act: Revised Statutes of Canada, 185. 1984.
- (56) Deber RB. Getting what we pay for: Myths and realities of the Canadian health care system. *Health L Can* 2000;21(1):9-56.
- (57) Landry MD. Physical therapy human resources in Canada, 1991 to 2000. *Physiotherapy Canada* 2004;56:39-42.
- (58) Ontario Hospital Association. Considering a career in a hospital? Ontario Hospital Association 2006 Available from: URL: [http://www.oha.com/clinet/OHA/OHA\\_LP4W\\_LND\\_WebStation.nsf/page/Considering+a+Career+in+a+Hospital](http://www.oha.com/clinet/OHA/OHA_LP4W_LND_WebStation.nsf/page/Considering+a+Career+in+a+Hospital)
- (59) Watt S, Browne G, Gafni A. Community care for people with chronic conditions: An analysis of nine studies of health and social utilization in Ontario. *Clinical Medicine* 2004;4(4):336-42.



## **Appendix A**

### **Key Informant Response Template**

#### **Ontario Rehabilitation Wait Times: Perceptions, Management and Measurement in Community-based Rehabilitation**

---

##### **KEY INFORMANT INFORMATION**

**Name:**

**Date (dd.mm.yy):**

**Position:**

**Setting:**

**Population serviced:**

**Address:**

**Phone:**

**Fax:**

**Email:**

##### **INTERVIEWER INFORMATION**

**Name:**

**Date of Interview (dd.mm.yy):**

**Date of Interview summary (dd.mm.yy):**

#### **A. Overview of Study**

- Purpose
- Objectives

#### **B. Questions from Participant and sign Informed Consent**

### **C. Interview Questions**

For the following set of questions about rehabilitation wait times, please consider a 'typical' month in your clinical setting. In other words, think of an average month, or a month where your supply of human resources and the demand for services are representative of an average month.

- 1. How long is your waiting list for physiotherapy? How long is it for occupational therapy?**
  - 2. How has your waiting list changed over the last 2 years?**
  - 3. Describe how you or your clinic/practice currently measure waiting times and waiting lists for rehabilitation services? [*measurement*]**
  - 4. Describe how you or your clinic/practice manages wait times for rehabilitation services? [*management*]**
  - 5. What factors do you feel contribute to an efficient wait list management system? [*management*]**
  - 6. In your opinion, what factors are important to consider in the development of a reliable and valid method to measure waiting times? [*measurement*]**
  - 7. What do you believe to be the cause of wait lists in your clinical setting/practice?**
  - 8. How do you think waiting times and waiting lists for rehabilitation impact on the transition from inpatient to home/community? [*perceptions*]**
  - 9. How do you think rehabilitation wait lists impact the health care system? [*perceptions*]**
  - 10. How do you think changes to the current health care system to shorten wait times for surgical and diagnostic interventions will impact on the extent of your waiting lists? [*perceptions of transition*]**
  - 11. Who would be the best person to target for our survey to inform us about wait times in community-based rehabilitation?**
- D. Is there anything that you would like to add with respect to waiting lists and waiting time in community-based rehabilitation that has not been discussed?**

- E. Recommendations for sampling strategies for different disciplines and sectors.**
- F. If you were to be surveyed on wait times, would you prefer to receive the questionnaire by mail or by electronic format?**
- G. Invitation to participate in review of draft of questionnaire.**

## **Appendix B**



University Health Network

Toronto General Hospital | Toronto Western Hospital | Princess Margaret Hospital

# **Waiting Lists and Wait Times: A Survey of Primary Care Adult Rehabilitation in Ontario**

Principal Investigator: Cheryl Cott PT, PhD

Study Coordinator: Laura Cook BScPT, MHSc  
tel: 416-603-5800 ext 3174  
toll free: 1-866-827-6183  
fax: 416-603-6288  
email: [laura.cook@uhnres.utoronto.ca](mailto:laura.cook@uhnres.utoronto.ca)



***Thank you for taking the time to complete this questionnaire. Your responses are important to us. For the purposes of this questionnaire, the term “primary care rehabilitation services” will encompass adult (18 years and older) occupational therapy and physiotherapy delivered in outpatient or community based settings. It does not include specialty ambulatory programs or day hospitals.***

***While your clinical setting may have diverse and varied practices, please think of a typical month which best characterises your setting as a whole when completing this questionnaire.***

***This survey has four sections:***

***Section A: Demographics***

***Section B: Wait Lists***

***Section C: Wait Times***

***Section D: Management of Waiting Lists and Wait Times***

***All responses will remain confidential and results will be presented in aggregate form only. Neither you, nor your organisation will be identified in any way. Your participation is voluntary and you may chose to refrain from answering some or all questions posed in the questionnaire. By returning the completed survey to the study coordinator, you are implying consent to participate in this project.***

## Section A: Demographics

The following set of questions will help us to classify your clinical setting.

1. Please indicate which primary care rehabilitation service(s) are available at your clinical setting (**check all that apply**):

- <sub>1</sub> Occupational Therapy  
<sub>1</sub> Physiotherapy

2. Which of the following categories best describes your clinical setting? (**Please check only one.**)

- <sub>1</sub> Hospital Outpatient Department  
<sub>2</sub> Schedule 5 OHIP Physiotherapy Clinic  
<sub>3</sub> Community Health Centre  
<sub>4</sub> The Arthritis Society Consultation and Rehabilitation Services  
<sub>5</sub> Other (please specify):

---



---



---

3. Please specify the type of funding for your clinical setting (**check all that apply**):

- <sub>1</sub> Hospital funded (through global budget)  
<sub>1</sub> Third party billing  
<sub>1</sub> Ministry of Health and Long-Term Care direct funding  
<sub>1</sub> Other (please specify):

---



---



---

4. Please indicate the number of full time equivalents (FTEs) who are involved with direct patient care for primary care rehabilitation services. If a staff group is not at your setting, please check "Not Applicable".

Staff Group	# FTEs Allocated	
Physiotherapists	_____ FTEs	<input type="checkbox"/> <sub>888</sub> Not Applicable
Occupational Therapists	_____ FTEs	<input type="checkbox"/> <sub>888</sub> Not Applicable
Physiotherapy Assistants	_____ FTEs	<input type="checkbox"/> <sub>888</sub> Not Applicable
Occupational Therapy Assistant	_____ FTEs	<input type="checkbox"/> <sub>888</sub> Not Applicable
Kinesiologists	_____ FTEs	<input type="checkbox"/> <sub>888</sub> Not Applicable
Other (please specify): _____	_____ FTEs	
Other (please specify): _____	_____ FTEs	

5. When are primary care rehabilitation services available at your clinical setting? (**Please circle the correct response**)

	<b>Daytime hours</b> (e.g. between 7:00am to 5:00pm)		<b>Evening hours</b> (e.g. after 5:00pm)	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<b>Monday to Friday</b>	1	2	1	2
<b>Saturday</b>	1	2	1	2
<b>Sunday</b>	1	2	1	2

6. Now we would like to ask you about the flow of clients through your clinical setting. Please complete the following table while thinking about a typical month which best characterises your practice as a whole.

	<b>Average number of referrals received during a typical month (from all sources)</b>	<b>Average number of clients discharged from treatment during a typical month</b>	<b>Average number of <u>new assessments</u> during a typical month</b>
<b>Physiotherapy</b>	_____ (#) <input type="checkbox"/> <sub>777</sub> Do not know	_____ (#) <input type="checkbox"/> <sub>777</sub> Do not know	_____ (#) <input type="checkbox"/> <sub>777</sub> Do not know
<b>Occupational Therapy</b>	_____ (#) <input type="checkbox"/> <sub>777</sub> Do not know	_____ (#) <input type="checkbox"/> <sub>777</sub> Do not know	_____ (#) <input type="checkbox"/> <sub>777</sub> Do not know

## Section B: Wait Lists

*Now, we would like to know about the **number of people waiting** for primary care rehabilitation services at your clinical setting.*

7. Do you have a wait list(s) for primary care rehabilitation services at your clinical setting?  
<sub>1</sub> Yes (**Please proceed to question 8**)  
<sub>2</sub> No (**Please skip to Section D, page 9**)
8. Do you have a process in place to track the number of people waiting for services at your clinical setting?  
<sub>1</sub> There is a *formal process* in place (process has been formally addressed by the organisation and guidelines, policies and/or procedures exist)  
<sub>2</sub> There is an *informal process* in place (process occurs but is not specified in a written guideline, policy or procedure)  
<sub>3</sub> There is no process in place
- 9 a) Do you have a method to prioritise your wait list?  
<sub>1</sub> Yes (**Please proceed to question 9b**)  
<sub>2</sub> No (**Please skip to question 10a**)

9 b) Please complete the following chart regarding the methods used to prioritise your wait list.

Management Method	Please indicate if you use the following methods to prioritise your wait list(s)		Please indicate <b>the most frequently used method</b> to prioritise your wait list(s) ( <b>check only one</b> ).
	Yes	No	
<b>Chronological (first come, first served)</b>	1	2	<input type="checkbox"/> <sub>1</sub>
<b>Referral source (e.g. in-house, community, self-referral)</b>	1	2	<input type="checkbox"/> <sub>1</sub>
<b>Acuity of injury/disorder</b>	1	2	<input type="checkbox"/> <sub>1</sub>
<b>Level of independent function</b>	1	2	<input type="checkbox"/> <sub>1</sub>
<b>Degree of risk for entry into the acute care setting</b>	1	2	<input type="checkbox"/> <sub>1</sub>
<b>Funding source for treatment</b>	1	2	<input type="checkbox"/> <sub>1</sub>
<b>Geographic location of the client's residence</b>	1	2	<input type="checkbox"/> <sub>1</sub>
<b>Weight bearing status</b>	1	2	<input type="checkbox"/> <sub>1</sub>
<b>Age</b>	1	2	<input type="checkbox"/> <sub>1</sub>
<b>Client complexity</b>	1	2	<input type="checkbox"/> <sub>1</sub>
<b>Other (please specify): _____</b>			<input type="checkbox"/> <sub>1</sub>

10a) In **total**, approximately how many clients are currently waiting for primary care rehabilitation services? (If you have more than one wait list for physiotherapy and occupational therapy, please provide a sum total of all wait lists combined for each discipline).

<b>Physiotherapy</b>	<b>Occupational Therapy</b>
_____ # waiting for Physiotherapy	_____ # waiting for Occupational Therapy

10b) Please complete the following table regarding the number of people waiting for primary care rehabilitation services with the conditions listed below. If a particular condition is not seen by either physiotherapy or occupational therapy, please check the “Not Applicable” box. If you do not have a wait list for a particular condition, and the condition is seen at your clinical setting, please indicate with “0”.

<b>Condition</b>	<b>Condition is seen at this setting?</b>		<b>Number of clients waiting for <u>Physiotherapy</u></b>	<b>Number of clients waiting for <u>Occupational Therapy</u></b>
	Yes	No		
<b>Acute Musculoskeletal</b>			_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable
Hip Fracture	1	2		
Other Acute Musculoskeletal (e.g., soft tissue injuries, sport injuries, fractures)	1	2	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable
<b>Chronic Musculoskeletal</b>			_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable
Total Joint Replacement	1	2		
Other Chronic Musculoskeletal (e.g., arthritis, low back pain, chronic soft tissue problems, osteoporosis)	1	2	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable
<b>Neurological</b>			_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable
Acute Stroke	1	2		
Chronic Stroke	1	2	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable
Other Neurological (e.g., brain injury, spinal cord injury, neurodegenerative disease)	1	2	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable
<b>Other:</b> _____			_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable
<b>Other:</b> _____			_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable
<b>Other:</b> _____			_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ (#) <input type="checkbox"/> <sub>888</sub> Not Applicable

## Section C: Wait Times

Now, we would like to know about **the length of time people are waiting** for primary care rehabilitation services at your clinical setting.

11. Do you have a process in place to track wait times at your clinical setting?

- <sub>1</sub> There is a *formal process* in place (process has been formally addressed by the organisation and guidelines, policies and/or procedures exist)
- <sub>2</sub> There is an *informal process* in place (process occurs but is not specified in a written guideline, policy or procedure)
- <sub>3</sub> There is no process in place

12. Please indicate how your clinical setting defines wait time for primary care rehabilitation services (**please check either A or B**).

- A) <sub>1</sub> Time from the date the referral is received to the date a client attends his/her first appointment
- B) <sub>2</sub> Other (Please specify):

**When the wait time starts:**

---



---



---

**When the wait time stops:**

---



---



---

13a) Based on the definition in question 12, what is the average wait time for primary care rehabilitation services? (**If you have more than one wait list for physiotherapy and occupational therapy, please provide an average of all wait lists combined for each discipline**).

Physiotherapy	Occupational Therapy
_____ average wait time (in days)	_____ average wait time (in days)

13b) Please complete the following table regarding the length of time people are waiting for primary care rehabilitation services with the conditions listed below. If a particular condition is not seen by either physiotherapy or occupational therapy, please check the “Not Applicable” box. If you do not have a wait list for a particular condition, and the condition is seen at your clinical setting, please indicate with “0”.

Condition	Approximate wait time in days for <i>Physiotherapy</i>	Approximate wait time in days for <i>Occupational Therapy</i>
<b>Acute Musculoskeletal</b>	_____ days	_____ days
Hip Fracture	<input type="checkbox"/> <sub>888</sub> Not Applicable	<input type="checkbox"/> <sub>888</sub> Not Applicable
Other Acute Musculoskeletal (e.g., soft tissue injuries, sport injuries, fractures)	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable
<b>Chronic Musculoskeletal</b>	_____ days	_____ days
Total Joint Replacement	<input type="checkbox"/> <sub>888</sub> Not Applicable	<input type="checkbox"/> <sub>888</sub> Not Applicable
Other Chronic Musculoskeletal (e.g., arthritis, low back pain, chronic soft tissue problems, osteoporosis)	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable
<b>Neurological</b>	_____ days	_____ days
Acute Stroke	<input type="checkbox"/> <sub>888</sub> Not Applicable	<input type="checkbox"/> <sub>888</sub> Not Applicable
Chronic Stroke	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable
Other Neurological (e.g., brain injury, spinal cord injury, neurodegenerative disease)	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable
<b>Other:</b> _____	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable
<b>Other:</b> _____	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable
<b>Other:</b> _____	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable	_____ days <input type="checkbox"/> <sub>888</sub> Not Applicable

## Section D: Management of Waiting Lists and Wait Times

*We previously asked how your wait lists are prioritised. Now we would like to know how wait times and wait lists are currently **managed** at your clinical setting.*

14. Please complete **Column A** by indicating which of the strategies listed you currently use, have used in the past, or have not used to manage your wait lists. For each strategy you currently use or have used in the past, please indicate in **Column B** how effective you have found the strategy.

	Column A			Column B		
	Which of the following strategies listed you have used, or currently use, to manage your wait lists?			How effective did you find the strategy for managing your wait list(s)?		
	Circle all that apply					
	Currently Use	Have used in the past	Have Not Used	Very Effective	Somewhat Effective	Not at all Effective
Computerised wait list software package	1	2	3	1	2	3
Refer clients to another rehabilitation facility	1	2	3	1	2	3
Routinely audit wait list to determine if clients waiting for assessment continue to require rehabilitation services	1	2	3	1	2	3
Guaranteed maximum waiting times	1	2	3	1	2	3
Evidence based benchmarks for wait list management	1	2	3	1	2	3
Rehabilitation assistants	1	2	3	1	2	3
“Ad-hoc” appointment to start the patient on a simple home program while they are waiting for assessment	1	2	3	1	2	3
Group intervention rehabilitation	1	2	3	1	2	3
Strict enforcement of attendance policies	1	2	3	1	2	3
Provide education to clients regarding self-management	1	2	3	1	2	3

