

Who's next? Referral prioritisation criteria for home care occupational therapy

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Background/aims: Prioritising referrals on waiting lists is common practice in rehabilitation. However, little is known about the exact criteria that are used in home-based occupational therapy to determine the level of urgency. This study aimed to identify prioritisation criteria in home-based occupational therapy services in Quebec, Canada and to describe how they are used in practice.

Methods: A mail and telephone survey of 55 home care programmes across Quebec was conducted. Participants provided information about occupational therapy wait times and referral prioritisation tools and practices. A detailed quantitative content analysis compared the content of all referral prioritisation tools.

Results: This study identified 48 main categories of referral prioritisation criteria, but only nine of them were present in the majority of tools. Wait times vary greatly between priority levels, with a median of 2 days for urgent referrals and 20 months for low priority referrals. In general, problems related to safety and remaining at home are considered more urgent than problems related to independence, quality of life, and activities outside the home.

Conclusions: These findings highlight the need for more consistent and evidence-based prioritisation criteria for occupational therapy in home care in order to facilitate equitable access to these services.

Key words: ■ Occupational therapy ■ Waiting lists ■ Prioritisation ■ Home care ■ Access to care

Submitted 9 August 2013, sent back for revisions 31 October 2013; accepted for publication following double-blind peer review 25 November 2013

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Prioritising referrals on waiting lists is common practice in rehabilitation and in community occupational therapy (Wright and Ritson, 2001; Harries and Gilhooly, 2003; Swan et al, 2010; Harding et al, 2012; Drolet, 2013). Referral prioritisation, as opposed to a first-come-first-served approach, is generally accepted as an appropriate strategy to manage waiting lists in healthcare as it aims to minimise the negative impacts of waiting for services (Sobolev and Kuramoto, 2008; Curtis et al, 2010; Núñez et al, 2010).

Considering that delaying occupational therapy services can compromise the client's safety, health and community participation (Canadian Home Care Association, 2011), and can lead to hospitalisation or premature institutionalisation (Canadian Association of Occupational Therapists [CAOT], 2008), it is imperative to tailor wait times to the urgency of the client's need. As the demand for community rehabilitation services surpasses the supply of available resources, (Harries and Gilhooly, 2003; Carrier et al, 2010; Passalent et al, 2010), prioritising patients correctly is critical, since low-priority clients may wait for months or even years for services (CAOT, 2008; Carrier, 2009).

Some tools have been reported to assist in this referral prioritisation process for community occupational therapy (Leonard, 1993; Wright and Ritson, 2001; Harding et al, 2010; Swan et al, 2010). These tools usually consist of three or four priority levels with a short description of patient characteristics corresponding to each level, such as 'Priority 1: Clients who are most at risk and require an urgent assessment' (Harding et al, 2010), or 'Priority 2: Service user requiring general assessment, for example, difficulty with essential activities of daily living, but where no risk is indicated' (Wright and Ritson, 2001). Some tools assign a target wait time for each priority level. However, as the descriptions of each priority level in these tools are broad and poorly defined, it is not surprising that their predictive validity and/or inter-rater reliability are less than optimal (Leonard, 1993; Wright and Ritson, 2001; Harding et al, 2010). Furthermore, in Harding et al's study (2011), even a training programme did not lead to significant improvements in the tool's inter-rater reliability.

One occupational therapy referral prioritisation tool (Swan et al, 2010) distinguishes itself from the others by providing a more detailed description of each of the four priority levels as

well as numerous examples of types of referrals that would fit each priority level. This tool's development was based on a literature search and extensive discussion and collaboration with many community occupational therapists across different sites of the Interior Health Authority region of British Columbia, Canada (Swan et al, 2010). The thorough description of each priority level and the contribution of many clinicians to this tool's development seem promising in terms of clinical usefulness and effectiveness. Although the occupational therapists of this health region have reported satisfaction with this tool, no information has been published about its psychometric properties. It is also unknown whether this tool is used by home or community occupational therapy services outside the region where it was developed.

All in all, the scientific literature leaves us with some degree of confusion about which precise criteria should be used to prioritise home care occupational therapy referrals. In the absence of clear and objective guidelines to this effect, other factors can influence a therapist's decision to prioritise a referral, such as political pressures, the therapist's values and biases, or resource constraints (Grime, 1990). Moreover, therapists are not always aware of all the aspects that influence their decision about a referral's priority level (Harries and Gilhooly, 2010). The subjective nature of this decision can pose a threat to equity in access to care (Carrier et al, 2010), because the same client could be prioritised differently depending on who receives their referral. The need to facilitate fair access to home-based occupational therapy, requires clear and refined referral prioritisation criteria.

This study's general goal was to describe the referral prioritisation practices of home care occupational therapists in Quebec, Canada. We sought to identify referral prioritisation criteria, their prevalence and their relative priority levels. As secondary objectives, we aimed to define how the referral prioritisation tools had been developed and the associations between priority levels and wait times.

METHODS

The authors conducted a survey with the person who manages the occupational therapy waiting list in home care programmes across all Health and Social Services Centres (HSSCs) in the province. In Quebec, home care occupational therapy services are publicly funded and locally provided by the province's 94 HSSCs (Ministère de la santé et des services sociaux, 2008).

Recruitment

The authors contacted each of the HSSCs that had given institutional approval for the project by telephone to obtain the name of the person in charge of managing the home care occupational therapy waiting list. The authors mailed these potential participants an invitation letter, with a request to return the consent form and referral prioritisation tool in a prepaid envelope. Upon receipt of these documents, the participants were contacted to set a date for a telephone interview. Following the Dillman approach for survey design and implementation (Dillman, 2000), the authors sent non-respondents a reminder letter after 3 weeks, followed by a telephone reminder after another 3 weeks.

Data collection

This study used two sources of data: the referral prioritisation tools that the participants sent by mail, and a structured telephone interview lasting approximately 30 minutes. The interviews were conducted between September 2012 and June 2013. The interview questionnaire was composed of 30 questions, mainly in multiple choice or short-answer format. The closing question was open-ended and invited respondents to make general comments about waiting list management in their services. The questionnaire was pilot-tested with two home care occupational therapy waiting list managers and slightly adjusted for clarity. The interview questions pertained to their referral prioritisation tool and practices as well as current wait times for urgent, high- and low-priority levels. The interviews were audiotaped and the answers transcribed manually on the survey form by the interviewer.

Ethical aspects

The Centre for Interdisciplinary Research in Rehabilitation of Greater Montreal granted multi-centre ethical approval. Institutional approval from each of Quebec's 94 HSSCs was also sought. During data analysis, all identifying information was removed from the prioritisation tools and survey forms to ensure confidentiality. Participants received a thank-you letter and a results summary.

Data analysis

Data from the telephone interviews were analysed with descriptive statistics using SPSS version 19. The authors performed detailed quantitative content analysis of the referral prioritisation criteria from the prioritisation tools following a five-step process. See *Table 1*.

Table 1. Excerpt from data analysis spreadsheet for the “At risk of falls” subcategory

Tool #	Phrase	Priority level in tool	Calibrated priority level	Calibrated priority score
24	“Falls: Risk”	2 points in a tool where the highest score for any individual criteria is 10 points	4=low	4
26	“Risk of falls related to mobility, transfers or the environment”	Level 3 of a tool with 3 levels	4 = low	4
39	“At risk of falls”	Level 3 of a tool with 4 levels	3=moderate	3
45	“High risk of falls”	“Priority clients, Immediately assigned to therapist, no wait”	1=urgent	1
55
Average calibrated priority score:				3.12
Standard deviation:				1.02
Number of tools containing this subcategory:				26

Establish main prioritisation criteria categories

One author (MP Prud’homme) extracted each phrase textually from each tool and grouped them into main categories of prioritisation criteria (e.g. pressure sores, falls, caregivers) and noted the priority level of this phrase. For example, the phrase ‘high risk of falls’ was placed in a spreadsheet for the category ‘falls’ in the row for ‘tool #45’ then ‘priority clients, immediately assigned to therapist, no wait’. The categories were reviewed by a different author (MH Raymond), with groupings agreed upon after discussion.

Establish subcategories of prioritisation criteria

Different tools considered different aspects of prioritisation criteria, e.g. most tools considered falls, and the various phrases extracted from the tools referred either to frequent falls, recent falls, risk of falls, injury due to the fall. MH Raymond analysed the phrases of all main categories, and identified aspects that were present in at least 20% of the phrases, which were retained as a subcategory. In this example, the phrase ‘high risk of falls’ and its corresponding annotations was then moved to a new spreadsheet for the subcategory ‘at risk of falls’, along with the 25 other phrases pertaining to risks of falls in other tools.

Develop a calibration scale

To compare each priority criterion’s urgency level across tools across the tools, the research team developed a scale to calibrate measures for all

tools. The scale has four priority levels (1=urgent, 2= high, 3=moderate, 4=low) as this was both the mode and median number of priority levels per tool in our sample. To be considered level 1 (urgent), a tool’s priority criteria must be under a heading with the term urgent, specify that the referral will bypass the waiting list or have a target wait time of 1 week or less. Level 2 criteria (high) generally have a target wait time between 1–3 months. Level 3 criteria (moderate) have a target wait time between 3–6 months, and level 4 criteria (low) are contained under the lowest priority level (or lowest score) of each tool.

Convert each tool to the calibration scale

We then converted all tools in our sample to fit the calibration scale. In other words, we established a correspondence between each priority level of the tool (or each score, for tools with total scores) and the four levels of our calibration scale. For tools that did not already have four priority levels, levels were decided based on target wait times for each priority level (when available in the tool) and on actual wait times for high- and low-priority referrals, as mentioned in the telephone interview.

Two authors (MH Raymond and MP Prud’homme) converted the tools independently and initially obtained an 86% level of agreement (47/55 tools with identical conversions to the calibrated scale). Through discussion, a consensus was reached for all tools.

Score the subcategories of prioritisation criteria

In this step, all phrases within each subcategory of prioritisation criteria were assigned a score corresponding to their calibrated priority level. All level 1 (urgent) phrases were scored 1 point, phrases of level 2 (high) were scored 2 points, etc. MH Raymond calculated the average score, the standard deviation and the frequency for each prioritisation criteria subcategory.

RESULTS

Respondents

Sixty HSSCs gave institutional approval for the project and 55 home care occupational therapy waiting list managers participated in the survey (92% response rate). Participants’ job titles were Clinical Coordinator (n=23, 42%), Occupational Therapist Clinician (n=21, 38%), Program Manager (n=8, 15%), and other health professionals (n=3, 5%). The programmes where they worked had on average 3.9 (SD 2.7) full-time equivalent occupational therapists and served an

average population of 67 104 people (SD 49960). Fifty eight percent of surveyed programmes were set in an urban region, which is defined as having a population density of 400 people or more per square kilometer (Quebec Institute of Statistics, 2008). There was no significant difference between responding and non-responding HSSCs regarding urban or rural status ($X^2(1, n=94) = 0.174, P=0.676$).

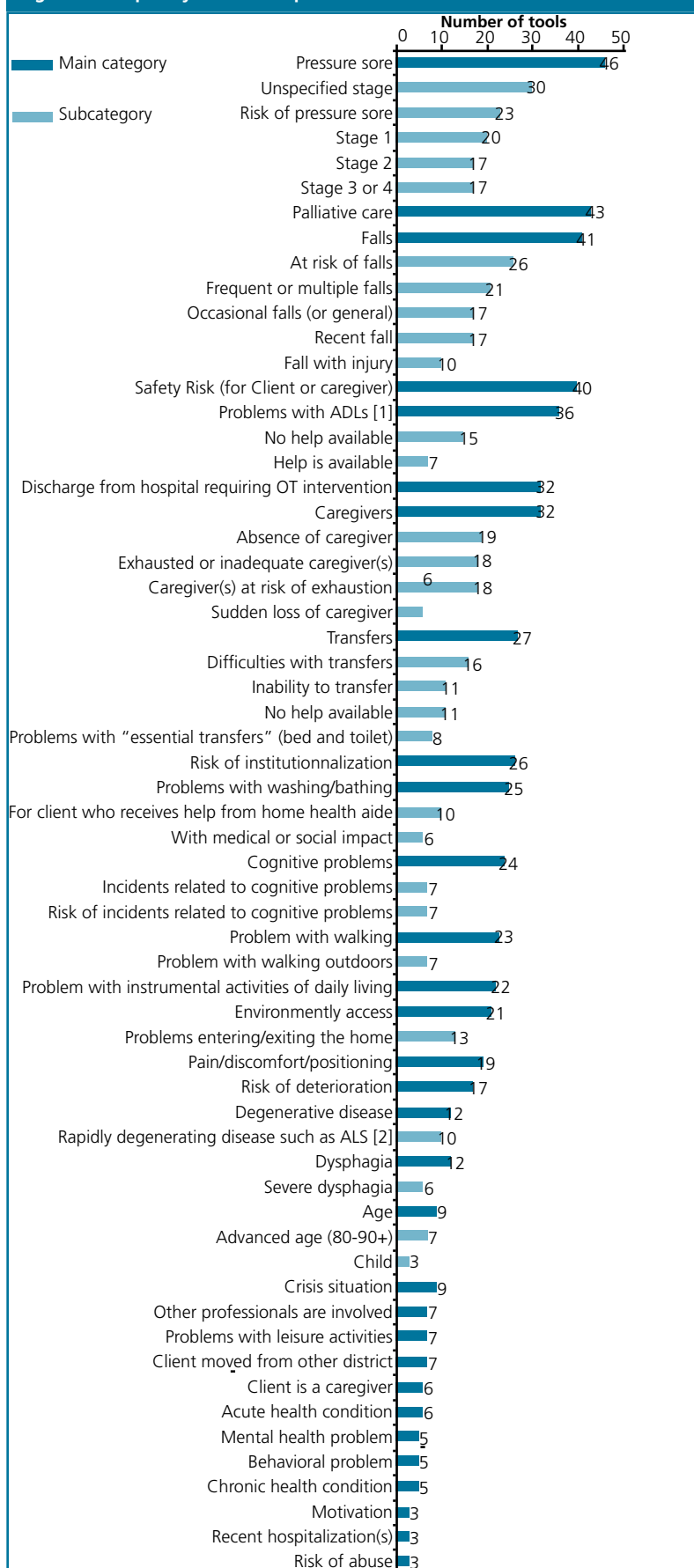
In general, respondents were quite preoccupied with the length of their waiting list, especially for low-priority clients, who experienced very long wait times. Most programmes were actively engaged in implementing or planning new ways of organising their services more efficiently, such as redefining the eligibility criteria for their services or increasing collaborations with support personnel. Some respondents also expressed dissatisfaction with their current referral prioritisation tool and hoped to develop a more objective and precise tool in the future.

Referral prioritisation tools

All surveyed programmes prioritised occupational therapy referrals rather than using a first-come first-served approach. No prioritisation tools were identical, although there were three ‘pairs’ of tools that were highly similar in format and content. Eleven programmes (20%) used a tool with a total score, and 41 programmes (75%) used priority levels. The three other programmes (5%) prioritised informally based on clinical judgment, without using a written tool. Nevertheless, these respondents were able to clearly state their priority criteria and the priority levels that they used, which was retained for analysis. The vast majority of the 52 written tools (88%) were specific to occupational therapy services, whereas 6% were used by both physiotherapy and occupational therapy, and 6% were used by all professions of the home care program. Of the 44 programmes using priority levels rather than total scores, three programmes used two priority levels, 14 used three priority levels, 23 used four priority levels, three used five priority levels and one program used seven priority levels.

These in-house prioritisation tools had mostly been developed through consultations and discussions with colleagues within the HSSC. Twenty-three respondents (42%) stated they had also consulted people from other HSSCs in developing their prioritisation tool. Most tools ($n=32, 62%$) had been revised at least once since their initial development. None of the respondents mentioned having consulted the scientific literature or service users in developing or revising their prioritisation tool.

Figure 1. Frequency of referral prioritization criteria: client's situation



Wait times per priority level

The median stated wait time for urgent referrals was 2 days (range 0–10 working days). These referrals were not present on the waiting list as they were immediately assigned to therapists. As most respondents did not have data on the mean or median wait time per priority level, we asked them the date of the highest priority referral and the oldest referral currently on their waiting list. The highest priority referrals on the waiting list represent level 2 (high) on our calibrated scale, whereas the oldest referral on the waiting list represents level 4 (low). The median wait for the highest priority referral on the waiting list at the time of the interview was 4 weeks (range 0–143 weeks). Median wait time for the oldest referral on the waiting list was 20 months (range 2 months to 9 years).

Referral prioritisation criteria

Two main types of prioritisation criteria were identified in the prioritisation tools: criteria pertaining to the client or their situation, and criteria pertaining to the type of service requested. For criteria pertaining to the client/their situation, 31 categories and 30 subcategories were identified. As for the criteria related to the type of service requested, 17 categories and two subcategories were identified. The prevalence of each main category and subcategory of criteria in the sample of tools is presented in *Figures 1*.

Figures 1 shows the calibrated priority levels of each subcategory of criteria in descending order of urgency, with the error bars representing the standard deviation of the score. In general, a higher consensus (lower standard deviation) is observed for the criteria on the upper and lower extremes of the graphs than for criteria in the middle of the continuum.

DISCUSSION

This study identified the prevalence and priority levels of referral prioritisation criteria used in 55 in-house tools in home care occupational therapy services in Quebec, Canada. The telephone survey also revealed how these tools were developed and how their priority levels impacted wait times. These findings are useful for occupational therapists and waiting list managers who wish to improve their current prioritisation tool by: verifying whether their tool contains most of the main criteria, and whether these criteria's priority levels are consistent with those of other home care programmes. The results may also be of use to health professionals who wish to refer clients to home-based

occupational therapy services, helping them understand which information is important to include on the referral.

Our findings substantiate the need for more consistent referral prioritisation criteria for home care occupational therapy. First of all, the fact that no two tools in our sample were identical illustrates the lack of consensus regarding prioritisation criteria. Furthermore, this study identified a sizable number of different main categories of prioritisation criteria across the 55 tools in our sample, yet only nine of these criteria were present in at least half the tools. Many prevalent main category criteria are inconsistent between the tools regarding which aspects (subcategories) of these criteria should be considered. For example, what is it about falls that should be taken into account when prioritising a referral? Do the falls need to be frequent or recent or is a mere risk of falling sufficient? Finally, some criteria, such as exhausted caregivers and advanced age, have a standard deviation well above one point on our 4-point scale, again reflecting divergent views on the priority levels of the various criteria.

The importance of establishing more definite criteria is compounded by the fact that prioritisation tools that are presently being used are not based on scientific evidence, as reported by the participants. Despite this lack of theoretical basis, clients of different priority levels are made to wait radically different amounts of time. An effort to base prioritisation criteria on the literature would increase the validity of referral prioritisation tools and improve equity of access to services. It may also help occupational therapists and waiting list managers feel more confident about their prioritisation tools and reduce the time they spend on revising their tools. In the field of rehabilitation, there are few studies on target wait times or the adverse effects of delayed intervention compared to certain fields of medicine (Ahn et al, 2011; Feldman et al, 2013). Similar studies in rehabilitation would definitely be of use to guide the establishment of referral prioritisation criteria. While literature searches on the functional impact, prognosis or factors influencing individual prioritisation criteria's outcomes would help to confirm or modify their priority levels.

Objective vs subjective criteria

Most of the prioritisation criteria in the tools relate to specific problems or types of requests (e.g. 'absence of caregiver', 'inability to transfer', 'request for scooter'), such as in the Swan et al (2010) tool. This is in contrast to the broader statements of priority level that other tools

available in the literature offer (Leonard, 1993; Wright and Ritson, 2001; Harding et al, 2010). Nonetheless, some criteria require more clinical judgment, e.g. 'crisis situation', 'risk of deterioration, and 'risk of institutionalisation'. Although these criteria are more subjective and possibly have a lower reliability and validity, they reflect the complex clinical reasoning underlying the decision about a client's priority level. As no single tool could contain all possible factors and interactions between factors that could affect the urgency of a referral, it is important to leave some room for clinical reasoning beyond objective and specific facts. This may be why Swan et al (2010) chose to call their tool 'priority guidelines'. Therefore, a combination of many precise and objective prioritisation criteria with a few criteria calling for advanced clinical judgment would seem to form a sound basis for referral prioritisation tools.

Values and prioritisation criteria

It is striking that in *Figures 1*, criteria pertaining to activities outside the home are systematically scored towards the lower end of the scale. In contrast, criteria pertaining to living and remaining at home are scored towards the higher end of the scale. Similarly, medical and safety issues take precedence over problems related to independence and quality-of-life.

At first glance, these dichotomies seem to clash with one of the core values of occupational therapy, namely occupational participation in activities that are most meaningful to the client, whatever those activities are and wherever they take place (Kielhofner, 2009; Drolet, 2013). However, priority levels need not be seen as a reflection of the actual importance of these activities or problems in clients' lives. Rather, priority levels merely speak to the time-sensitivity of the occupational therapy interventions that are required to address these problems. Consequently, to remain coherent with the value of occupational participation, waiting list managers should strive to ensure that clients with low-priority problems are not constantly pushed down the waiting list. Using maximum wait time targets for all priority levels may be one way of ensuring the needs of lower priority clients, which are just as important, are eventually addressed (Health Council of Canada, 2005; Núñez et al, 2010). However, if resources are consistently insufficient to meet these targets, it seems more honest to restrict service eligibility criteria than to place clients on a waiting list with a minimal chance of being seen within a reasonable time frame.

Limitations

This study surveyed the referral prioritisation tools and practices of 55 home care occupational therapy programmes across the province of Quebec, Canada. The prioritisation criteria this study identified are generally consistent with those of the Canadian tool by Swan et al (2010). However, the applicability of these findings to other regions is uncertain as prioritisation criteria may be contingent on local circumstances and services.

As for the calibrated priority levels of the different prioritisation criteria, we chose to report average scores and standard deviations rather than medians and quartiles, despite the use of an ordinal scale. We felt that medians and quartiles on such a small scale would not have offered enough discrimination between criteria to be useful in practice. However, due to methodological challenges involved in comparing tools of different formats, the average scores of the subcategories of prioritisation criteria should be interpreted with caution. For example, the target wait times for each priority level differed greatly between the different tools in our sample as they are dependent on each site's supply and demand and some tools did not specify target wait times. Similarly, it is uncertain whether the term 'low priority' in a tool with priority levels is conceptually equivalent to the score '0' of a tool using a total scoring system; all depends how low priority referrals are managed after they are prioritised. Due to the inherent complexity converting all tools to a calibration scale, this step was performed independently by two members of the research team to maximise the analysis' validity. Nonetheless, it may be wiser to consider the general ranking of the prioritisation criteria rather than their exact average scores.

Recommendations for future research

This study's results give a good indication of the types of information to consider when deciding on a referral's priority level for occupational therapy in home care. However, there is no guarantee that all clinically important factors are present or that their priority levels are appropriate in light of scientific evidence or clients' actual priorities.

Future research should aim to corroborate each of these prioritisation criteria using the available scientific literature. Further studies should also document the impact of waiting for specific occupational therapy interventions and involve other stakeholders, such as clients, in the determination of occupational therapy refer-

ral prioritisation criteria. These steps would aid the development of a formal referral prioritisation tool.

CONCLUSION

In summary, prioritising referrals on waiting lists for home-based occupational therapy services is a widespread practice in Quebec. Urgent referrals are generally seen in a matter of days while low-priority referrals wait for many months or even years to access services. Most programmes use a three or four level prioritisation tool that has been locally developed. Referral prioritisation criteria within these tools are abundant but diverge substantially across programmes. Further research is needed to come to a consensus on these criteria in order to promote fair access to occupational therapy services for community-dwelling persons experiencing loss of autonomy. **IJTR**

Conflicts of interest: None.

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KEY POINTS

- Many home care occupational therapy services in Quebec use referral prioritisation criteria, but there is a lack of consistency between tools.
- Prioritisation tools were developed locally through discussion with colleagues, but were not based on scientific evidence.
- There is a need to establish clear, consistent and evidence-based criteria to prioritise referrals for occupational therapy services in home care.
- Issues related to safety and remaining at home are considered more urgent than those around activities outside the home. This does not mean these issues are more important, but that the interventions are more time-sensitive.
- Waiting list managers should strive to provide services within a reasonable time frame for clients of all priority levels.

COMMENTARIES

Having a tool that helps occupational therapists correctly prioritise the need for home care services becomes critical since these services may improve health outcomes when delivered at the appropriate time. Tied to home-care services are goals to prevent re-hospitalisation, which is a high priority in medicine and government-funded services due to costs. Clearly, the authors document the importance of evidence-based prioritisation criteria that allow occupational therapy home-care services to address needs beyond medical emergencies and include quality of life domains.

As the authors of the current study highlight, more consistent prioritisation documentation is needed for continuity of care. In addition, occupational therapy process may need to reconsider the assessments used to determine functional capacity, which would contribute to the information that transfers to the prioritisation criteria.

Continued occupational therapy services in home care must use evidence-based assessments, and collaborate with the patient, carer(s), and other involved health professionals. Such an interdisciplinary approach to prioritising care after discharge, could establish better communication that may result in more of those involved knowing about the

available services and the value of occupational therapy; therefore, this could support the priority of need to address more than safety and falls, skin care, and carers' ability to assist with transfers. For example, if one cannot receive services to address quality of life issues, then depression may develop among discharged patients. Depression may lead to lack of care, which may then result in rehospitalisation. Findings suggest that depression continues to be under-detected in medically ill, homebound elderly patients. (Madden-Baer et al, 2013). If such needs beyond medical care can be addressed, this may reduce depression onset and stop a possible cycle of hospital readmissions.

This study found that problems related to safety and remaining at home are considered more urgent than those related to independence, quality of life, mental health, and activity engagement outside the home. It may be that some of the concerns about falls, safety, and readmission may be best addressed prior to discharge. For example, a pre-discharge home visit may assess safety and accessibility in the home (Wilson et al, 2011). Pre-discharge patient education programs may prevent misunderstandings about medications, teach signs of medical need, and assess carer competencies. Addressing such

issues pre-discharge may pave the way for home-care services to address other issues.

Madigan et al (2002) believe that studying which patients might be expected to achieve positive outcomes, and examining the integration of home healthcare with broader community-based services may help with prioritisation during home-care service evaluations. This current study contributes to educating health professionals who wish to refer clients to home-based occupational therapy services, helping them understand how to refer to occupational therapy. This study may help health professionals know which information is important to include on the referral, how to prepare a patient for discharge, and the need to standardise the prioritisation system.

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This paper identified that while health and social services centres used some formal management strategies, this was not consistent across the province. Regardless, these individual approaches may be more advanced than what occurs in other health-care systems internationally.

The findings demonstrated that current tools prioritise medical and safety issues over problems related to independence and quality of life. As suggested, this practice potentially clashes with core occupational therapy beliefs, which place emphasis on enabling meaningful occupations. In reality, this probably demonstrates the significant influence of health-care systems on occupational therapy practices and the potential impact of individual therapists' values. These discussions may help clinicians to reflect on their current management of waiting lists. We look forward to these important considerations being addressed in future publications.

The paper comments that none of the respondents mentioned consulting the scientific literature in developing their prioritisation tool. This raises questions about whether clinicians view waiting list manage-

ment as a clinical decision-making process or a purely operational process. In our opinion, these differing perspectives influence tool development and, ultimately, patient care. Prioritisation is one stage of the clinical decision-making process (Harries and Tomlinson, 2012); therefore, clinical reasoning should outweigh the operational influences on waiting list management.

The development of consistent evidence-based prioritisation criteria enables equity for patients across health services (Lowe and Barber, 2005). This criteria would aid clinical decision making, particularly for novice therapists, who may not have the clinical experience on which to make these decisions. We commend the authors for highlighting the value of consistent, evidence-based prioritisation practices. It is worth noting that, internationally, prioritisation tools will vary due to the influence of health-care systems on the nature of occupational therapy practice.

Thinking beyond this paper, it is important for clinicians to consider how referrals are received and that a complete picture is required for informed decision-making around prioritisation. For example, while

a referring health professional may list the clinical diagnoses and functional limitations, referral from a family member may provide a more comprehensive picture of the client's social context and the subsequent impact on quality of life. In line with occupational therapy ideology, therapists need to consider each aspect of the 'Person', 'Environment' and 'Occupation' (Law et al., 1996) to make informed decisions around prioritization.

Harries P, Tomlinson C (2012) Teaching young dogs new tricks: Improving occupational therapists' referral prioritization capacity with a web-based decision-training aid. *Scand J Occup Ther* **19**(6): 542–6

Law M, Cooper B, Strong S, Stewart D, Rigby P, Letts L (1996) Person-Environment-Occupation Model: A transactive approach to occupational performance. *Can J Occup Ther* **63**(1): 9–23

Lowe D, Barber LA (2005) Implementing a priority and waiting list system in an acute hospital setting. *Int J Ther Rehabil* **12**(7): 294–8

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