Measuring and Managing Supply and Demand: A Waiting List Information Management Proposal for Musculoskeletal Rehabilitation in the Greater Toronto Area

May 2003
MEASURING AND MANAGING SUPPLY AND DEMAND: A WAITING LIST INFORMATION MANAGEMENT PROPOSAL FOR MUSCULOSKELETAL REHABILITATION IN THE GREATER TORONTO AREA

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EXECUTIVE SUMMARY

In May 2001, Network members identified waiting lists as one of the most frequently experienced barriers to accessing rehabilitation. While the problem was experienced to varying extents across Network member organizations, not being able to determine the exact nature and extent of waiting list issues was commonly shared across the system. The need for a reliable and ongoing method of collecting, monitoring and responding to waiting list information was identified and included in the GTA Rehab Network Operating Plan for 2001-2003. A task group was struck in October 2001 to prepare the following proposal for a waiting list information management system.

Mandate and Deliverables

The mandate of the waiting list information management task group was to: “Explore the feasibility of a waiting list information management system for rehabilitation in the GTA”. The requested deliverables included: (1) a “model for waiting list information management with appropriate feedback and consensus” (2) a “recommendation to Coordinating Council on the feasibility of a standardized waiting list information management system for rehabilitation in the GTA” (GTA Rehab Network Operating Plan 2001-2003)

Overview of Approach

1. Expert consultations and publications were obtained from organizations that have expertise in the area. These included: Toronto Acquired Brain Injury Network; the long term care waiting list management system through an expert at the North York Community Care Access Centre; Canadian Institute of Health Information’s National Rehabilitation Reporting System; the Joint Policy and Planning Committee; and the Cardiac Care Network. Twenty-one published articles were also reviewed. Two of these articles were literature reviews.

2. Selection of a conceptual framework published by the Joint Policy and Planning Committee as a basis for development of the proposal.

3. Feasibility studies involve three elements: process, technical, and economic feasibility assessments. This project focuses only on the process feasibility element. Examining the technical and economic feasibility of the proposal is beyond the scope of this report and will occur as next steps.

4. Establishment of principles for the development and operation of the model.

5. Development of a survey based on the types of processes and decisions that may lead to waiting list information.

6. Identification of issues in waiting list information management through a survey designed to explore the decision-making processes and parameters that influence the generation of waiting list information.
7. Development of propositions to address the issues identified in the survey. A stakeholder feedback session was held to discuss the survey issues and to gain feedback on the propositions and therefore, their process feasibility. The propositions were then modified based on feedback from Network members and incorporated into the overall proposal.

Musculoskeletal (MSK) Rehabilitation as Prototype for the Waiting List Proposal

- Musculoskeletal rehabilitation represents a large proportion of rehabilitation cases and projections indicate an increase in need in the future (Jaglal et al, 2001).
- The Network has an MSK Best Practices Task Group that is examining best practices for triage, care and outcome measurement.
- There are already stroke, acquired brain injury and cardiac activities in place.
- Pediatric, spinal cord and burn rehabilitation require a different approach because of the distinctive nature of the rehabilitation process and the current service delivery models that exist for these populations.
- It was determined that a cross-population waiting list proposal was unrealistic and not feasible given the time frame.

Exploring the Issue: Five types of waiting and other confounders

A survey was conducted on the processes and decisions that influence the generation of waiting list information. Thirty of thirty-five Network members involved in the provision of MSK rehabilitation participated in the survey. The results showed a current lack of differentiation between the following reasons a patient may wait for rehabilitation:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Delay in referral response because of no agreed upon response time</td>
<td>Process issue</td>
</tr>
<tr>
<td>2. Patient not yet ‘ready’ for rehabilitation because ‘ready for rehab’ is poorly defined or not transparent</td>
<td>Clinical issue</td>
</tr>
<tr>
<td>3. Insufficient capacity at the location to which the referral is sent because of staffing, resource, or physical space issues, causing a patient to wait for the next available bed of space. (program exists but unable to accommodate at given time)</td>
<td>Resource issue</td>
</tr>
<tr>
<td>4. Inability to meet complexity of client needs because of program design causing an inability to place the patient in the system. (program does not exist)</td>
<td>Placement issue</td>
</tr>
<tr>
<td>5. Patient needs are met but patient chooses to wait for preferred choice</td>
<td>Policy issue</td>
</tr>
</tbody>
</table>
It is recognized that issues 3 and 4 above are not always cleanly divided. However, differentiating between these five types of reasons for waiting is important if we are to take appropriate action to address waiting list issues. Current waiting lists do not make these differentiations.

In addition, other confounders found through the survey include the following:

- Not all organizations collect waiting list information for inpatient, ambulatory and in home rehabilitation, therefore, not all patients waiting for rehabilitation are captured.

- Where organizations have waiting lists, they may track waiting lists differently, resulting in information that is incommensurable across organizations.

- Patients with referrals to multiple programs appear on more than one waiting list, often with no communication between facilities when the patient is accepted and no longer needs to be placed.

- Patients placed on waiting lists may not be appropriate candidates for rehabilitation. This may be caused by different planning parameters for sending a referral, criteria for assessing the client, and possible confusion about the admission criteria at the responding organization.

**Propositions for Addressing Issues**

Following the analysis of the survey results, fourteen propositions were developed for addressing the issues noted. These propositions were presented to Network member representatives on December 3, 2002. The following themes summarize feedback from the day:

- **Support for propositions that:**
  - Propose standardizing forms, definitions, communication protocols, and referral and response expectations between different organizations
  - Promote transparency of information and processes

- **Lack of support for propositions that:**
  - Attempt to dictate organizational processes i.e., how assessments or admissions should be made
  - Limit choice i.e., the number of referral locations to which a referral should be sent

- **Emphasis on including outpatient and in home rehabilitation issues in discussions**
Waiting List Information Management Concept

- The information traveling between referrers of musculoskeletal patients and responders will be streamlined through standard forms and processes for:
  - Sending a referral
  - Responding to a referral
  - Recording the response to a referral and the subsequent impact on the referring organization
  - Updating responders on any changes in patient status

- Referral forms will be designed in a manner reciprocal to the admission criteria template that is also in development. This will enable better profiling of the patient, ensure complete information, and facilitate matching between the patient and the program.

- If the forms are web-based, the referrer and responders will have the potential to speak to each other in real time.

- Their responses will be coded, recorded and communicated according to commonly agreed upon definitions for accepted, admitted, wait listed, and refused.

- At designated points, information from the referral forms can be obtained to provide waiting list information that differentiates between the five types of waiting identified in the survey.

- At the same designated points, all Network members also record capacity in the system. Capacity is described using the elements of the admission criteria template.

- By linking waiting list information and available capacity, as well as by differentiating between the five types of waiting through coding on the forms, Network members will have reliable data to advocate for unmet needs and improvements in access.

Recommendations

- Develop common referral, response, and status update forms and processes
- Agree on common definitions and use of words accept, admit, wait list and refuse
- Invest in automation of referral, response and update forms
- Separate types of waiting into different lists
- Designate days where all the data is collected in a snapshot
- Work towards a real time system
- Form a steering committee to oversee enable implementation
- Support use of the admission criteria as a mechanism to monitor capacity
- Develop a marketing plan to ensure understanding and dissemination of proposal
- Support research in MSK best practices to assist in triage and prioritization and support research on clinical indicators for ready for rehabilitation.
Implementation Plan

Months 1-2:  
- Conduct costing and feasibility study for electronic, web-based forms and develop thorough understanding of privacy legislation issues
- Establish task groups and steering committee to implement recommendations
- Develop common forms for referral, response and update forms and establish referral process protocols.

Months 3-4:  
- Conduct further consultation with community hospitals whose referrals are principally within their own organization to determine whether standardized forms can be used or if alternatives to gathering information on these patients need to be pursued.

Months 6-9:  
- Implement forms as pilot and begin data collection. At the end of the trial period set date on which to match supply and demand to get comparable waiting list information
- Develop automation infrastructure after a technological and economic feasibility study has been conducted.

Months 9-12:  
- Follow up results of pilot and complete automation

Challenges and Opportunities

As a result of consultation with over forty individuals from across the Network, this proposal captures a number of viewpoints, concerns and challenges. While care will be required in order to overcome challenges in implementation, the benefits to the system will be worthwhile. In addition to the vision articulated later in this report, implementation of this proposal will enable:
- Improved service for patients through transparency of process and availability of services.
- Improved access through better data for local and system planning and policy development and the ability to problem solve collectively.
- Enhanced communication and better integration using standard forms and processes.
- Increased ability of all Network members to meet the system integration and change indicators on the rehabilitation balanced scorecard
- Ability to integrate and learn from similar initiatives which are also being proposed for stroke and which have been proposed for traumatic brain injury through the rehabilitation reform pilot project in Ottawa-Carleton.

Finally, this initiative is reflective of the spirit of integration and collaboration that exists among the providers of rehabilitation in the Greater Toronto Area. It is expected that implementation of the proposal and the lessons learned in its development will lead to a more integrated, accessible, and responsive rehabilitation system for the patients, families, and providers of the Greater Toronto Area.
I. INTRODUCTION

1. Purpose of this Report

This report satisfies the mandate of the waiting list information management task group whose objective was to explore the feasibility of a waiting list information management system for rehabilitation in the GTA. The report proposes a waiting list information management model based on the literature and expert consultations; principles for waiting list information management; a survey on the processes and decisions that influence the generation of waiting list information; a number of propositions to address the issues identified; and stakeholder feedback on the propositions made.

2. Organization of the Report

The next section of this report (section II) provides background on the initiative, a vision for the expected outcomes and a summary of the literature and the expert consultations. It concludes with the rationale for focusing on the MSK population as a prototype for the proposal.

Section III reviews the approach taken to develop the proposal and to assess its feasibility. This is followed by the analysis in section IV, which summarizes a survey conducted to assess the processes that generate waiting list information across the GTA; propositions to address the issues that could be included in a waiting list information management proposal; and stakeholders’ reactions to those propositions.

The actual proposal is described in Section V along with a review of the vision, principles for proposal development and a number of scenarios to describe how the system works. This is followed by specific recommendations required for implementing the proposal; a timeline; and some concluding remarks on the benefits, challenges, and next steps.

II. BACKGROUND

1. Objectives and Inception of the Initiative

In May 2001, GTA Rehab Network members identified waiting lists as one of the most frequently experienced barriers to access. While different organizations experience waiting list problems to varying extents, the problem of not knowing whether we have a waiting list problem is shared across the system.

Waiting lists are not only indicators of access. They are tools to assist us in understanding patient flow and capacity. Without this tool, we are unable to project when waiting list problems will occur or to ensure that our system is operating with the appropriate resources.

As such, a waiting list information management task group was struck to develop a proposal for waiting list information management and to study its feasibility.
2. Vision and Expected Outcomes

The waiting list information management proposal was developed for GTA Rehab Network member organizations with a view to attain the following vision for the rehabilitation system:

*A rehabilitation system in which at any given point in the future we know…*

- Who is waiting for what services, where, when, why and for how long
- What services are available, where, for whom, and how many
- How information travels between those providers who are referring patients and those who have services to offer.

*A rehabilitation system in which as a collective voice for rehab we can…*

- Identify system issues by using reliable data to monitor and advocate responsibly for unmet patient needs
- Track not only those patients who we reach but also those to whom we cannot offer services
- Total the access issues across different organizations to paint a regional picture and a picture for rehabilitation in the Greater Toronto Area

*A rehabilitation system in which publicly funded providers of rehabilitation can…*

- Share information about their programs and services in a commonly understood and valued manner
- Research and explain options to their patients and can tell them how the “system” works
- Transfer information in a quick, common, and streamlined fashion
- Market services appropriately to avoid lag periods of unwanted excess capacity or backlog periods of too much demand

*A rehabilitation system in which all rehab patients in the GTA understand…*

- Where and why they may be waiting for a service
- If, and for how long, they will wait for services and what the process will be like

*A rehabilitation system in which the public and funders can be assured that…*

- Our system is appropriately funded and operating without bottlenecks
- Providers are actively improving access and advocating for unmet needs
3. Literature Review and Expert Consultations

Expert consultations and publications were obtained from organizations that have expertise in the area. These included: Toronto Acquired Brain Injury Network; the long term care waiting list management system through an expert at the North York CCAC; Canadian Institute of Health Information’s National Rehabilitation Reporting System; the Joint Policy and Planning Committee; and the Cardiac Care Network of Ontario.

a. Expert consultations/publications

Toronto Acquired Brain Injury Network:
- Need for trust; separate project into pieces; focus on processes; automate wherever possible; incorporate waiting list data elements as part of the referral process

National Rehabilitation Reporting System:
- Data on who waits will become available retrospectively; two data elements on waiting included in NRS will provide diagnoses but not reason for waiting. Somewhat subjective measure; inpatient only; data elements are not always mandatory.

Joint Policy and Planning Committee:
- Designing a waiting list information management system for rehabilitation is very different than for other types of care due to the number of players and clinical conditions and how we characterize ideal rehabilitation candidates; model published linking supply and demand; learning from Ontario Wait List Project

Long Term Care Waiting List Management:
- Iron out the wrinkles up front; acknowledge complexity; involve software savvy people in discussions to know what’s technically feasible; acknowledge the impact of legislation in making it happen

b. Literature review

A review of 21 articles on waiting lists, two of which were published literature reviews, was conducted. The articles included background material for the Western Canada Waiting List Project and the Ontario Wait List Project. Few articles addressed waiting list information in home or rehabilitation settings. None of the articles provided a model for rehabilitation waiting list information in particular, however, a number of lessons can be applied to the development of a waiting list information management proposal. The major themes and sources are summarized below. Not all articles reviewed are included in this summary (see References)

Definitions of waiting lists (Hadorn, 2000; Pope, 1993; Smith, 1994)

Several authors discuss definitions of waiting lists. Waiting lists occur when demand for a service exceeds supply. They are usually rosters of patients awaiting a particular service. In Morris et al, waiting lists are defined as the length of time between when a
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A patient is enrolled on a waiting list and when the service is received. This may be a function of how patients enter the list and how services are delivered.

**Impact of referral processes on wait list information** (Stevenson, 1996; Cromwell et al, 1999; Goddard and Tavakoli, 1998; Western Canada Wait List Project, 2001; Lewis et al, 2000; Bamji, 2000)

A number of articles and sources discuss the relationship between the referral process and waiting list information. These articles look at the way in which demand for services “flows”. They also discuss flow and stock models, where waiting lists result either when demand exceeds supply overall or when at a specific time, demand for a particular service causes a temporary backlog. Some of these articles also show that increases in supply or capacity do not necessarily alleviate waiting list problems, because of the tendency to fill the new supply with more referrals.

**Suggestions for how to measure waiting lists** (Pope, 1993; Decoster, 2002; Lewis et al, 2000; Smith 1994; McDonald et al, 1998)

A few articles provide suggestions on how to measure waiting lists. It is noted that parameters of measurement differ across different waiting lists and even across cases within a single wait list. One recommendation is to look at the time within which a given percentage of patients are seen.

Another suggestion is to look at post referral times to get a valid indication of how long patients are waiting. While inpatient waiting lists are valid indicators of waiting, post referral times give a clearer indication of how long people actually wait. The literature also describes three types of lists: a deferred list, which includes patients who are under social or medical constraint hence, affecting the admission decision; a true waiting list, which does not have a priority sequence, but brings patients to the front of the queue once they reach a maximum waiting time; and a planned repeat waiting list for patients whose care is planned over a series of admissions.

The article by Carolyn Decoster goes as far as reviewing different approaches to waiting list measurement which include surveys, administrative data analysis, hospital booking systems, registries, and priority scoring systems. Her article reviews the advantages and disadvantages of each method.

**Causes of waiting lists** (Lewis et al, 2000; Sanmartin et al, 1992)

Two articles discussed determinants of waiting lists. Determinants of waiting lists included whether the organization was a teaching or a non teaching hospital, the number of beds that it had, and the number of cases or procedures performed. By contrast, it was found that patient characteristics of income, education, and sex were not associated with waiting times. No general theoretical frameworks exist that outline a comprehensive range of factors that affect waiting lists and their size. Factors found to affect waiting lists include patient choice, physician referral patterns and global budgets.
Importance of waiting lists (Western Canada Wait List Project, 2001; Lewis et al, 2000; Lewis and Sanmartin; 2000; McDonald et al, 2000)

A number of articles showed that waiting lists are indications that the system is not running costly excess capacity and predictors for the flow of services.

Use of technology in measuring waiting lists (Kent 1999; Cromwell et al, 1999; Stewart 1998)

Several articles discuss the use of technology such as hand held computers, to provide waiting list information to providers. It was shown that these devices often help to change referral behaviour because they present real time waiting information. They also discuss how technology enables transparency and the subsequent effect that transparency has in improving practices.

Problems with waiting lists (Pope, 1993; Decoster, 2002; Kent 1999; Western Canada Wait List Project, 2001; Lewis et al, 2000; Trevor, 1994; Bamji, 2000; McDonald et al 1998; Sanmartin et al, 2000)

Several articles have been published stating the problems with waiting lists. The most common problem is the difference in start times and definitions of waiting lists. Another problem is the appropriate placement of patients on waiting lists. For example, Morris et al found that 20-30% of patients are inappropriately placed on a waiting list.

Approaches to dealing with waiting lists (Pope, 1993; McDonald et al, 1992; Decoster, 2002; Sanmartin et al, 2000)

The literature proposes the following methods of dealing with waiting lists:

- Standardizing assessment procedures to determine needs
- Increasing capacity
- Changing funding methods
- Developing practice guidelines for monitoring patients on lists
- Reducing the demand for the service
  - Conduct list audits and continually reassess patients on the list
- Prioritize the patients awaiting the service
  - Match place in queue with clinical urgency
  - Coordinate the list
- Reorganizing patterns of care
  - Put in place methods to reduce missed appointments
  - Redirect referrals to areas with shorter waiting lists
  - Redirect specialist physician visits
Public perceptions of waiting lists (Pope, 1993; Rafferty et al, 2002; McGurran et al, 2002)

While waiting lists are often perceived as undesirable, studies have shown that the public does not mind waiting if there is fair treatment, clear expectations of wait times, clarity of process and appropriate management of the symptoms or pain in the interim. How patients feel about waiting can often be linked to cultural differences. Studies have discussed the notion of patient involvement in prioritization. For example, patients waiting treatment may cede their place in the queue to a person who in their judgment requires more immediate care. This introduces a number of ethical and logistical issues.

Meaning of Feasibility Study (Information System Management Module)

An information management module was found that discussed the meaning of a feasibility study. Feasibility studies need to be considered in terms of the following:

- Process feasibility: The effect the system will have on the people who are going to use it and in turn, the effect the people will have on the system
- Technical feasibility: The availability of equipment, software and know how to develop a system that responds to a user request
- Economic feasibility: The cost of developing and using the system

4. Rationale for Focusing on the Musculoskeletal Population

Recognizing that a waiting list information management system could not realistically focus on all patients simultaneously, the musculoskeletal (MSK) rehabilitation population group was selected as an area for focus for several reasons.

Data from the recent report “Epidemiological Variables and Utilization in Rehabilitation in Ontario” (Jaglal et al, 2001) showed that a third of all inpatient rehab cases fall into five MSK Diagnoses.

The Chronic Pain and Geriatric populations are two groups that were identified as requiring attention (GTA Rehab Network, 2001). These population groups have significant number of service providers who are not Network members. As such, focusing on these populations is difficult. However, since MSK often includes chronic pain and geriatric populations, some of these needs may be captured under an MSK.

Rehabilitation Pilot Projects already exist for stroke, ABI/MS, and cardiac rehabilitation. The Toronto Acquired Brain Injury (ABI) Network successfully addresses waiting list information management for ABI clients that require inpatient rehabilitation. The burns population is small, focused, and waiting for rehabilitation has specific clinical implications. Spinal cord, respiratory and pediatric rehabilitation are offered at only a limited number of Network member organizations and do not pose the same inter-organizational issues.
III. APPROACH

1. Overview of Approach

- Expert consultations and literature review
- Selection of a conceptual framework published by the Joint Policy and Planning Committee.
- Decision to focus feasibility on extent to which Network members would support propositions making up the waiting list information management proposal\(^1\)
- Establishment of principles for the operation and development of the model
- Development of a survey based on hypothesized patient flow maps on the types of processes and decisions that may lead to waiting list information
- Identification of issues through the survey and development of propositions to address those issues.
- Held a stakeholder feedback session after the survey, to validate the issues and gain feedback on the propositions and therefore, their process feasibility
- Modification of propositions and principles based on feedback and incorporation into overall proposal.

2. Expert Consultations and Literature Review

Expert consultations and publications were obtained from organizations that have expertise in the area. These included: Toronto Acquired Brain Injury Network; the long term care waiting list management system through an expert at the North York CCAC; Canadian Institute of Health Information’s National Rehabilitation Reporting System; the Joint Policy and Planning Committee; and the Cardiac Care Network.

A review of 21 published articles on waiting lists was also conducted. Two of the articles reviewed were literature reviews conducted by the Western Canada Wait List Project and the Ontario Waiting List Project. Few addressed waiting list information in home or hospital-based rehabilitation settings. None provided a model for rehabilitation waiting list information in particular.

3. Conceptual Framework and Linkage with Admission Criteria Template

The task group began by adapting the conceptual framework for waiting list information that was developed by the Joint Policy and Planning Committee framework of waiting list information as a basis for the proposal. The framework for waiting list information developed by the JPPC requires the linkage of three components in order to obtain waiting list information. The first component is the list of who is waiting. In this section of the framework, a listing of who is waiting, where, when and for how long is required. How we operationalize “who” i.e. all those of a certain diagnosis, with special needs, of a particular age group etc, is up to the users of the information.

\(^1\) Economic feasibility will depend on implementation decisions and can be tailored to a budget
The second requirement is to match the list of who is waiting for services to the list of services available. What services are available will be detailed using organizations’ admission criteria. A separate project has been initiated by the GTA Rehab Network to have all organizations articulate admission criteria using a standard template with common definitions and entries. The template allows us to ensure a thorough understanding of what services are available.

To connect the list of patients waiting to the services available, a third requirement is clarity and consensus on common communication processes between those who may have patients waiting for rehabilitation and those who may have services to offer them. This requirement has led to the founding premise of the proposal:

If we can streamline the processes by which referral and referral response information travels and is recorded, and if we can clarify the definitions, expectations, and starting points, reliable waiting list information can be obtained.

Figure 1: Framework for the conceptualization of waiting list information
adapted from the Joint Policy and Planning Committee*

*adapted from Markel F., in Rafferty et al, 2002
4. Patient Flow Maps

Following the notion of improved processes as a means of generating better waiting list information, a number of hypothesized patient flow maps were drawn to determine the locations and decisions that may impact the generation of waiting list information. It was recognized that some organizations’ referrals occur internally while some occur between organizations.

5. Survey Development and Analysis

Using the patient flow maps, the task group developed a questionnaire to explore issues relating to the decisions and processes that influence the generation of waiting list information. A questionnaire (Appendix A) was developed based on the patient flow maps and was piloted by task group member organizations. Of the possible 35 respondents, only 30 (86%) responded to the questionnaire due to an error in the mailing lists. Feedback was invited separately from the organizations that did not submit data for this reason. The survey responses were analyzed for issues influencing waiting list information generation. Results are presented in Section IV.

6. Proposition Development

Based on the issues identified through the survey, fourteen propositions were developed which would form the structural and process components of a waiting list information management system. (See Section IV)

7. Stakeholder Feedback Session

A session was held on December 3, 2002 to share the starting hypotheses, model, objectives, survey results and propositions. Over 40 representatives from 30 Network member organizations attended. Delegates were asked to accept, reject or modify each of the 14 propositions. The session allowed the task group to explore the process feasibility of the propositions, which would constitute key elements of the proposal. A summary of the session results is included in Section V. (See Appendix B for detailed notes).

8. Principles for Development and Implementation

Based on the initial problem, the literature review, industry consultations and principles for the use of admission criteria, the waiting list information management task group developed a number of principles for the model. After the survey and stakeholder feedback sessions, these principles were revised. Part of the feasibility of the proposal relies on ensuring that the principles articulated in this proposal are adhered to in both system development and implementation.

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2 The GTA Rehab Network Admission Criteria Task Group developed principles for use of the admission criteria template that is in development for use across the region.
IV. ANALYSIS: SURVEY RESULTS AND PROPOSITIONS

This section of the report has four subsections. The first provides an overview of the results of the survey on decision-making processes and parameters that influence the generation of waiting list information. The second lists the fourteen propositions developed to address the issues noted. The third section is a summary of feedback given by Network members on the fourteen propositions. The fourth section links the issue, specific propositions, feedback from Network members, and conclusions drawn. It also contains the figures noted in the first section.

1. Summary of Survey Results and Observations

- **When does the referral process start?** There is lack of agreement on when the referral application process should begin. This leads to different understandings of waiting and confusion between multiple referrers and acceptors. (Figures 1 and 2)

- **What is meant by “ready for rehabilitation”?** A lack of indicators on when a patient is “ready for rehab” could result in confusion when a referring facility attempts to move an acute care patient into a rehab program or service. (Figure 3)

- **What happens if you occupy a bed/space waiting to become ready for rehab?** The absence of a step down or convalescence unit among acute care or rehab providers means that patients “waiting to become ready” for rehab may be posing as “bed blockers”. This confounds the waiting lists issue for rehabilitation. (Figure 4)

- **What is the protocol and policy on patient choice?** Differing patient choice protocols, such as whether a patient helps to select referral destination, honouring the order of their choices, resolving issues, and accepting the first available bed, confound waiting list information (Figure 5)

- **What decision-making processes influence waiting list information?** There are a number of different decision-making processes used by Network member organizations to refer, accept and admit patients. The processes themselves have implications for what type of information is generated. Looking at standardizing the processes should enable smoother flow of information, resulting in better waiting list information. (Figure 6)

- **When should referring organizations receive a response for a patient who meets the criteria but for whom space is not available?** When a patient is found to be a suitable candidate for rehabilitation, but a bed or space is not available, organizations respond to the referrers in one of two ways: they either tell the referrer that the patient has been wait listed or they defer a response until a bed or space becomes available, at which point they provide an ‘accepted’ decision. These two different approaches cause confusion in waiting list information. Consensus on one protocol needs to be established. (Figure 7)

- **What happens if the patient’s condition changes?** Organizations accepting rehabilitation patients have acknowledged that referrers often appropriately inform
them of changes in patient conditions. This is a positive finding in our system but there are still areas for improvement. Common protocols for updating patient information may be helpful in this regard (Figure 8) as incomplete information will confound waiting list data.

- **How are MSK patients prioritized?** When patients finally do get on a waiting list, most organizations prioritize the patients in one of two fashions: either according to the current mix of patients at the facility or chronologically. Few organizations use measured criteria for prioritization. This raises the question of required research and best practices. (Figure 9)

- **How long does it take to hear back regarding a referral?** When an organization receives a referral, most organizations provide a response to the referring organization within one day. A small group requires 2 to 6 days to respond. No organizations reported taking more than one week to respond to a referral. (Figure 10)

- **Once accepted, when does the patient get admitted?** When an organization decides to accept a patient, the time frame within which the patient is actually admitted to the facility varies. For inpatients, the response time is mostly 1-2 days. For outpatients, it is more than a week. For home care, it varies (Figure 11)

- **What does accept, reject or wait list a referral mean to the referrer and to the responder?** A possible confounder of waiting list information occurs when there is a lack of clarity on what happens in each of the following scenarios: patient meets criteria and capacity exists; patient does not meet criteria but capacity exists, patient meets criteria but no capacity exists; patient does not meet criteria. Use of the responses “accept”, “wait list”, and “decline” need to be defined very specifically to understand the true meaning of “wait listed” and “accepted”. These terms confound waiting list information. Most organizations report designated protocols for these instances (Figure 12, 13 and 14)

- **Are there currently waiting list information management systems in place?** Most organizations already have their own approach to waiting list information management. It is important to bear this in mind when looking at standardizing processes. (Figure 14)

These problems suggest the following reasons a patient may be placed on a waiting list:

<table>
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<tr>
<th>Reason</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay in referral response because no agreed upon response time</td>
<td>Process issue</td>
</tr>
<tr>
<td>Patient not yet ‘ready’ for rehabilitation because ‘ready for rehab’ is poorly defined or not transparent</td>
<td>Clinical issue</td>
</tr>
<tr>
<td>Insufficient capacity at the location to which the referral is sent because of current resource issues i.e. staffing, equipment, physical space etc.</td>
<td>Resource issue</td>
</tr>
<tr>
<td>Inability to meet complexity of client needs because of program design</td>
<td>Placement issue</td>
</tr>
<tr>
<td>Patient needs are met but patient waits for preferred choice</td>
<td>Policy issue</td>
</tr>
</tbody>
</table>

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GTA Rehab Network
2. Summary of Propositions

After analyzing the survey responses to determine the above noted issues, the task group formulated the following propositions as possible solutions based on their discussions, literature review and consultations.

**Proposition I:** A waiting list information management system should establish commonly agreed upon parameters between the organizations referring and those accepting patients, on when the referral process should begin, and on the number of organizations to which a referral is sent.

**Proposition II:** A waiting list information management system requires clarity on what is meant by “ready for rehab” and the difference between those waiting for programs/services and those who are waiting to become eligible for programs/services.

**Proposition III:** A waiting list information management system should be built with the involvement of patients.

**Proposition IV:** A waiting list information management system should include the premise that patients accept the first available bed or space, regardless of whether it is their first, second, or third choice of referral location.

**Proposition V:** A waiting list information management system should have as a tenet, a mechanism for collaborative problem solving, such as a regional ombudsman for addressing problems that span multiple organizations and regions.

**Proposition VI:** A waiting list information management system should seek standardization in the processes that influence the generation of waiting list information (e.g. use of an admissions committee).

**Proposition VII:** In situations where the patient is “accepted” but no space/bed is available, the applicant organization should be informed and give an approximate wait time for a bed or space to become available.

**Proposition VIII:** A waiting list information management system should contain a standard form for reporting changes in patient status after the original referral has been made.

**Proposition IX:** A waiting list information management system should include an investment in best practice research/consensus with respect to patient prioritization.

**Proposition X:** A waiting list information management system should allow providers to understand the time frame in which organizations will provide a response to a referral.

**Proposition XI:** A waiting list information management system should provide consensus on the meanings of “accepted” and “admitted”.

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*GTA Rehab Network*
Proposition XII: A waiting list information management system should include a mechanism for sharing current capacity information.

Proposition XIII: A waiting list information management system should provide organizations with a simple and effective means of providing and receiving information on the status of referrals.

Proposition XIV: A waiting list information management system should establish response protocols, which help create standards on how an organization responds to the following scenarios:
   a) Patient meets criteria but no capacity exists
   b) Patient does not meet criteria but capacity exists
   c) Patient does not meet criteria and no capacity exists
   d) Patient meets criteria and capacity exists

3. Summary of Stakeholder Feedback on the Propositions

On December 3, 2002, representatives from across Network member organizations were invited to give feedback on the fourteen propositions proposed above. Five tables consisting of over forty representatives from across the continuum and across the Greater Toronto Area were asked to come to consensus on whether they would accept, reject or modify each proposition. The following themes summarize feedback from the day (see Appendix B) for a complete summary:

- Support for propositions that:
  - Propose standardizing forms, definitions, communication protocols, and referral and response expectations between different organizations
  - Promote transparency of information and processes

- Lack of support for propositions that:
  - Attempt to dictate organizational processes i.e., how assessments or admissions should be made
  - Limit choice i.e., the number of referral locations to which a referral should be sent

- Emphasis on including outpatient and in-home rehabilitation issues in discussions
4. Linking the Survey Results, Propositions and Next Steps

This section of the report provides the linkage between the survey response, the proposition developed to address it, the results of the stakeholder feedback session, a summary of participant comments on the proposition and the conclusion that the task group would take forward into the waiting list information management proposal.

Each sub-section begins with a problem statement as identified by the survey, the data that supports the problem, the propositions proposed to address it, stakeholders’ responses to the proposition, comments made at the survey follow up day and the conclusion that the waiting list information management task group took forward into the proposal.

a) When does the referral process start?

**Problem:** There is lack of agreement on when the referral application process should begin. This leads to different understandings of waiting and confusion between multiple referrers and acceptors (Figures 2 and 3).

**Proposition I:** A waiting list information management system should establish commonly agreed upon parameters between the organizations referring and those accepting patients, on when the referral process should begin, and the number of organizations to which a referral is sent.

**Feedback:**
Table 1 ✔ Table 2 ✔ Table 3 ● Table 4 ● Table 5 ✔

(✔ = accept  ✗ = reject ● = modify)

**Comment:** The idea of a common point in care at which to begin the referral process was supported in principle. Tables requesting a modification to the proposition were concerned about specifying the number of organizations to which a referral is sent. Additional comments included linking to the admission criteria template and being careful in implementation.

**Conclusion:** Proposition is supported in principle if the idea of specifying the number of organizations to which a referral is sent is removed, implementation considerations are made and linkages to the admission criteria template are considered.
Figure 2: When does the referral process start?

In advance of patient being ready to transfer
When the patient is clinically ready
Varies according to referring organization pressures
Varies according to accepting organization practice

Organizations referring acute care patients
Organizations referring rehab patients
Organizations accepting rehab patients

Figure 3: If the referral is made in advance of the patient being ready to transfer, how far in advance is the referral made?

2+weeks 1-2 weeks 3-5 days 1-2 days

Organizations that refer acute patient
Organizations that refer rehab patients
Organizations that accept rehab patients
b) **What is ready for meant by “Ready for Rehab”?**

**Problem:** A lack of indicators on when a patient is “ready for rehab” could result in confusion when a referring facility attempts to move an acute care patient into rehab. (Figure 4)

**Proposition II:** A waiting list information management system requires clarity on what is meant by “ready for rehab” and the difference between those waiting for programs/services and those who are waiting to become eligible for programs/services.

**Feedback:**
Table 1 ✔️ Table 2 ✔️ Table 3 ✗ Table 4 ✔️ Table 5 ✔️
(✔️ = accept  ✗ = reject  ✗ = modify)

**Comments:** Proposition supported in principle. Modification suggested is to ensure that the data is objective and not confounded by subjective definitions of ready for rehab. Link to admission criteria recommended.

**Conclusion:** Data clarity, objectivity supported. Organizational definitions and clinical definitions of ready for rehab need to be considered in tandem.

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![Figure 4: Are the indicators that prompt a rehabilitation referral made on a case by case basis or are they applied according to written criteria?](image-url)
c) What happens if you are waiting to become ready for rehab?

**Problem:** The absence of a step down or convalescence unit among acute care or rehabilitation providers means that patients “waiting to become ready” for rehab may be posing as “bed blockers”. This confounds the issue of waiting lists for rehabilitation. (Figure 5)

![Figure 5: Do you have access to a step down unit?](image)

**d) What is the protocol and policy on patient choice? - Patient involvement, use of an ombudsman, first available bed policy**

**Problem:** Differing policies and protocols on patient choice are confounders in waiting list information. These include policies on patient choice, accepting the first available bed, and patient participation. (Figure 6)

**Proposition III:** A waiting list information management system should be built with the involvement of patients

**Feedback:**
Table 1 ✔  Table 2 ✔  Table 3 ✗  Table 4 ✔/✗  Table 5 ✔
(✔= accept  ✗= reject  ✗/✔= modify)

**Comments:** The involvement of patients needs to be clarified in this proposition. Is the idea to involve the patients in the waiting list decisions or in the development of the system? In principle, it’s a good idea; the question is how this is done.

**Conclusion:** The idea of client centeredness needs to be maintained as well as a realistic view of feasibility.
Proposition IV: A waiting list information management system should include the premise that patients accept the first available bed or space, regardless of whether it is their first, second, or third choice of referral location.

Feedback:
Table 1 ✔ Table 2 ⚪/ₓ Table 3 ⚩ Table 4 ✔ Table 5 ⚪/ₓ

(✔ = accept  ✗ = reject  ○ = modify)

Comments: There was no consensus on this proposition. Concerns included encouraging gaming in the system, infringing on managerial choice and limiting the flexibility needed to meet patient needs. Suggestions were to collect data to determine to what extent such a policy was necessary and that it might be a down the road solution. Those who accepted the proposal felt that implementing a first available bed policy was appropriate and in the best interests of the system as a whole.

Conclusion: There is a careful balance to be struck between system thinking and patient centeredness, between standardization and provider autonomy. Making decisions of this nature may be a future solution, but is not feasible at this point, based on overall feedback. Taking an incremental and phased approach may be worth considering.

Proposition V: A waiting list information management system should have as a tenet, a mechanism for collaborative problem solving, such as a regional ombudsman for addressing problems that span multiple organizations and regions.

Feedback:
Table 1 ✔ Table 2 ⚪ Table 3 ✔ Table 4 ⚩ Table 5 ✗

(✔ = accept  ✗ = reject  ○ = modify)

Comments: The concept of ombudsman was not well received. Concerns about infringing on organizational autonomy, duplication, resource use and regionalization were cited as reasons against such an idea. What was supported was the idea of regional problem solving mechanism that could take system issues brought forward through the system and address them.

Conclusions: The idea of collective problem solving is supported, if care is maintained not to infringe on organizational autonomy or to impose decisions on an organization.
Figure 6: Patient participation in choice of facilities, rank ordering of choice, informing accepting facilities of the patient's preferences, and presence of patient ombudsman?

- Ombudsman at organization referring rehab patient
- Inform organizations of rehab patient choice
- Rank ordering of choice at organizations referring rehab patients
- Patient participation at organizations referring to other rehab facilities
- Ombudsman at organization referring acute care patient
- Inform organizations of acute care patient choice
- Rank ordering, organizations referring acute care patients
- Patient participation, organizations referring acute care patients

e) **Should we have standard protocols and processes?**

**Problem:** There are a number of different decision-making processes used by Network member organizations to refer patients. This causes differences in the way information flows. (Figure 7)

**Proposition VI:** A waiting list information management system should seek standardization in the processes that influence the generation of waiting list information.

**Feedback:**
Table 1 ✗ Table 2 ● Table 3 ✔ Table 4 ● Table 5 ✔
(✔ = accept  ✗ = reject  ● = modify)

**Comments:** The system should not seek standardization necessarily but agreement on timely protocols and procedures. The actual process should be the decision of the organization, so long as it achieves the desired outcome.

**Conclusion:** Respect the balance between standardization and organizational autonomy. Strive for smooth transitions rather than standardization.
f) **When is a response to a referral provided?**

**Problem:** When a patient is found to be a suitable candidate for rehabilitation, but a bed or space is not available, organizations respond to the referrers in one of two ways: they either tell the referrer that the patient has been accepted and give them a wait time, or they tell them the patient is accepted when the bed or space is available. These two different approaches cause confusion in waiting list information. Consensus on one protocol needs to be established. (Figure 8)

**Proposition VII:** In situations where the patient is “accepted” but no space/bed is available, the applicant organization should be informed and give an approximate wait time for a bed or space to become available.

**Feedback:**
Table 1 ✔ Table 2 ✔ Table 3 ✔ Table 4 ✔ Table 5 ✔
(✔ = accept ✖ = reject  ● = modify)

**Comments/Conclusion:** Accepted as written
g) How do we do on updating accepting organizations on changes in patient status?

Problem: Organizations accepting rehabilitation patients have acknowledged that referrers often appropriately inform them of changes in patient conditions. This is a positive in our system but there are still areas for improvement. Common protocols for updating patient information may be helpful in this regard (Figure 9).

Proposition VIII: A waiting list information management system should contain a standard form for reporting changes in patient status after the original referral has been made.

Feedback:
Table 1 ✔ Table 2 ✔ Table 3 ✔ Table 4 ✔/● Table 5 ✔
(✔ = accept  ✗ = reject  ● = modify)

Comment/Conclusion: Accepted as proposed
h) **How are MSK patients on waiting lists prioritized?**

**Problem:** When patients finally do get on a waiting list, most organizations prioritize the patients in one of two fashions: either according to the current mix of patients at the facility or chronologically. Few organizations use measured criteria for prioritization. This raises the question of required research, best practices etc. (Figure 10)

**Proposition IX:** A waiting list information management system should include an investment in best practice research/consensus with respect to patient prioritization

**Feedback:**
Table 1 ✔ Table 2 ● Table 3 ✔ Table 4 ✔ Table 5 ✔
(✔= accept ✖= reject ●= modify)

**Comments:** There is concern about mandating best practices that are not feasible for all organizations.

**Conclusion:** Develop consensus and support for implementing best practices.

![Figure 10: If you have a waiting list for rehabilitation, how do you prioritize patients?](image-url)
i) How long does it take to hear back after a referral has been made?

Problem: When an organization receives a referral, most organizations provide a response to the referring organization within one day. A small group requires 2 to 6 days. No organizations take more than one week to respond (Figure 11).

Proposition X: A waiting list information management system should allow providers to understand the time frame in which organizations will provide a response to a referral.

Feedback:
Table 1 ✔ Table 2 ✔ Table 3 ✔ Table 4 ✔ Table 5 ✔
(✔= accept ✖= reject ●= modify)

Comment/Conclusion: Accept

Figure 11: Within what time frame do you provide a response to the referring facility?
j) Once accepted, when does the patient get admitted?

Problem: When an organization decides to accept a patient, the time frame within which the patient is actually admitted to the facility varies. For inpatients, the time frame for a response is most often, 1-2 days; for outpatient, it is more than a week; and for home care it varies (Fig. 12)

Proposition XI: A waiting list information management system should provide consensus on the meanings of “accepted” and “admitted”.

Feedback:
Table 1 ✔ Table 2 ✔ Table 3 ● Table 4 ✔ Table 5 ✔
(✔= accept ✗= reject ●= modify)

Comment: Accept with some clarification in wording

Conclusion: Clarify the use of the meaning of accept, admit, reject and wait list.

![Figure 12: Once a decision is made to accept a patient, the expected time frame within which the patient is likely to be admitted to rehabilitation?](image)

k) Accept, Reject or Wait List? No space? Wrong type of patient?

Problem: A possible confounder of waiting list information occurs when there is a lack of clarity of what happens in each of the following scenarios: patient meets criteria and capacity exists; patient does not meet criteria but capacity exists, patient meets criteria but no capacity exists; patient does not meet criteria. Use of the responses accept, wait list, and decline need to be defined very specifically to understand the meaning of wait listed and accepted if solutions are to be sought (Figure 13). Most organizations report designated protocols for these instances (Figure 14 and 15)
Proposition XII:  A waiting list information management system should include a mechanism for sharing current capacity information.

Feedback:
Table 1 ✔ Table 2 ✔ Table 3 ✔ Table 4 ✔ Table 5 ✔
(✔= accept  ✗= reject  ●= modify)

Comments: The proposition is generally accepted, but there are some concerns about how we really measure and record the capacity as well as concerns about insufficient capacity currently in the system

Conclusion: Ensure that capacity issues are not minimized. Support development of tools, such as the admission criteria template.

Proposition XIII: A waiting list information management system should provide organizations with a simple and effective means of providing and receiving information on the status of referrals.

Feedback:
Table 1 ✔ Table 2 ✔ Table 3 ✔ Table 4 ✔ Table 5 ✔
(✔= accept  ✗= reject  ●= modify)

Comment/conclusion: Accept proposition but ensure patient confidentiality issues are carefully addressed.

Proposition XIV: A waiting list information management System should establish response protocols which help create standards on how an organization responds to the following scenarios:
a) Patient meets criteria but no capacity exists
b) Patient does not meet criteria but capacity exists
c) Patient does not meet criteria and no capacity exists
d) Patient meets criteria and capacity exists

Feedback:
Table 1 ✔ Table 2 ✔ Table 3 ● Table 4 ✔ Table 5 ✔
(✔= accept  ✗= reject  ●= modify)

Comment/conclusion: Accepted with comment to clarify what we mean by capacity
I) My process versus a standard process?

**Problem:** Most organizations have discussed and come to consensus on an approach for waiting list management for rehabilitation within their own organization. It is important to bear this in mind when looking at standardizing processes. (Figure 15)

**Comment:** Given that most organizations have discussed and come to consensus on their own approach for waiting list information management, it will be important to keep this in mind as we move forward. This was not presented as a proposition but factored into the analysis.
Summary

This section presented the survey data, observations and conclusions. Stakeholder feedback to the problems identified and the proposed solution were also presented. This approach was integral to ensuring that the waiting list information management proposal addresses the appropriate issues in a manner that is consistent with the needs and interests of our stakeholders. It also allowed us to determine what elements should be included in the waiting list information management proposal.
V. PROPOSED MODEL

1. Vision

The waiting list information management system was developed with a view to attain the following vision:

A rehabilitation system in which at any given point in the future we know…

- Who is waiting for what services, where, when, why and for how long
- What services are available, where, for whom, and how many
- How information travels between those providers who are referring patients and those who have services to offer.

A rehabilitation system in which as a collective voice for rehab we can…

- Identify system issues by using reliable, responsible data to monitor and advocate for unmet patient needs
- Track not only those patients who we reach but also those that we don’t
- Sum or total the access issues in individual organizations to paint a regional picture and then a picture for rehabilitation in the Greater Toronto Area

A rehabilitation system in which publicly funded providers of rehabilitation can…

- Share information about their programs and services in a commonly understood and valued manner
- Can easily research and explain options to their patients and can tell them how the “system” works
- Can transfer information in a quick, common, and streamlined fashion
- Have services appropriately marketed to avoid lag periods of unwanted excess capacity or backlog periods of too much demand

A rehabilitation system in which all rehab patients in the GTA understand…

- Where and why they may be waiting for a service
- If and how long they will wait for services and what the process will be

A rehabilitation system in which the public and funders can be assured that…

- Our system is appropriately funded and operating without bottlenecks
- Providers are actively improving access and advocating for unmet needs
2. Principles for Development and Implementation of the Proposal

The following principles for the development and implementation of the proposal are based on a review of the literature, consultations with experts, the survey results and stakeholder feedback.

- **Continuous communication:** The waiting list information management proposal facilitates communication through standard forms and communication protocols. This includes communication between different types of providers, different types of facilities and organizations from across the continuum, and between patients and providers.

- **Cross continuum participation and inclusiveness:** While the Network cannot mandate participation in the system, mechanisms will be created to encourage and enable open communication and feedback and to create incentives for participation. It is acknowledged that different stakeholders may perceive the recommendations differently. The intent however is a system that produces information potential so useful all Network members choose to participate.

- **Client-family centeredness:** A waiting list information management system should involve patients and families as per the principles of client-family centered care which include: open and consistent communication between all parties; continuous provision of information to clients and family members so they are able to make informed decisions; and partnerships with clients and families that are mutually respectful, encouraging, empowering and based on equality (Toronto ABI Network, 2000).

- **Research and reality based:** The waiting list information management model should consider both the evidence in the academic literature as well as the operational realities experienced by Network members. It should enable the right person, at the right place and at the right time to perform functions considering both academic research and operational realities.

- **Transparency:** A waiting list information management proposal is one in which any data collected has definitions and collection protocol expectations which are made explicit, so that patients and providers alike can make the assumption that they have all the information that they need to move patients in a seamless, coordinated, and appropriate fashion through the system.

- **Confidentiality:** A waiting list information management system should allow Network members to come to agreement on the extent to which organization-specific and patient-specific information is shared and the manner in which this is done.

- **Evolution of data quality, completeness and meaning:** A waiting list information management proposal needs to be developed in small steps over time. Its implementation is not linear. It is important however, in the development of the system, that there be short term wins along the way.
Flexible standardization: Ensures that the process is not so specialized or rigid that it creates rather than fills gaps.

Population focused: Recognizing that the literature has shown the effectiveness of a system that can prioritize across different populations on the same waiting list (Sanmartin et al, 2000), this proposal remains focused on one population, the musculoskeletal rehabilitation population, as a starting point. Although clinical differences between populations are recognized, it is hoped that this proposal can be modified and adapted to suit the needs of different populations.

Respect for diversity: While all organizations share membership in the GTA Rehab Network, this proposal recognizes the distinctiveness and unique characteristics of each member. The intent of the waiting list information management system is not to prescribe practices for organizations but to stimulate practices that will be commensurable and transparent across the system (Purtilo, 1992).

System’s approach: Builds on other tools and integrates with other initiatives to create a linked system within the GTA.

Accountability for reasonableness: Waiting list issues have within them contrasting views on distributive and procedural justice. Resolution of such philosophical issues in a diverse sector may not be possible. To address this, the ethics approach of the proposal is contained in the framework of accountability for reasonableness (Norman et al, 1997) which says that all decisions are made public (within the limits of respect for confidentiality of patient and organizational information); applied equitably and consistently; that there is always a method for recourse; and that the rationale for the decisions are stated.

Long-term vision with near term returns: This is the first time publicly funded rehabilitation providers in the GTA propose a model that involves all provider organizations. This will require time, trust and dialogue to make all the pieces work. However, short-term returns will also be accomplished by beginning the recommendations required not only to implement the model but also to improve the processes of communication between referrers and responders.

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3 Purtilo, 2002
4 Supported through consensus day feedback to Propositions V and VI
3. Concept Description

- The information traveling between referrers of musculoskeletal patients and responders will be streamlined through standard forms, and processes for:
  - Sending a referral
  - Responding to a referral
  - Recording the response to a referral and the subsequent impact on the referring organization
  - Updating responders on any changes in status

- Referral forms will be designed in a manner reciprocal to the admission criteria template that is also in development. This will enable better profiling of the patient, ensure complete information, and facilitate matching between the patient and the program.

- If the forms are web-based, the referrer and responders will have the potential to speak to each other in real time.

- Their responses will be coded, recorded and communicated according to commonly agreed upon definitions for accepted, admitted, wait listed, and refused.

- At designated points, information from the referral forms can be obtained to provide waiting list information that differentiates between the five types of waiting identified in the survey.

- At the same designated points, all Network members will also record capacity in the system. Capacity is described using the elements of the admission criteria template.

- By linking waiting list information and available capacity, as well as by differentiating between the five types of waiting through coding on the forms, Network members will have reliable data to advocate for unmet needs and improvements in access.

<table>
<thead>
<tr>
<th>The model does propose to…</th>
<th>The model does not propose to…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardize processes, forms and communication protocols and definitions to eliminate bottlenecks and the five confounders noted</td>
<td>Attempt to centralize MSK referrals</td>
</tr>
<tr>
<td>Differentiate between the five types of waiting that have been noted as confounders to current waiting lists</td>
<td>Dictate how organizations should manage their waiting lists</td>
</tr>
<tr>
<td>Match supply and demand at snapshots and then possibly in real time</td>
<td>Increase data collection initiatives or propose a survey to collect retrospective data</td>
</tr>
</tbody>
</table>
4. Understanding the Model: Case Study

This section provides a case study that brings the proposal out of the conceptual and onto the realm of the day-to-day operations of the system. The section has two purposes: To operationalize the concept and to provide background for a future technical and economic feasibility study that will need to be conducted as next steps.

Scenario: A referral is accepted at one organization, wait listed at a second and rejected at a third organization: How would the waiting list information management system work? How would this enable rehabilitation providers to differentiate between the five types of waiting and obtain reliable waiting list information?

A patient’s rehabilitation need is identified.

A provider at a Network member organization determines that his or her patient should be referred for rehabilitation. For the purpose of this scenario, we will assume the referral is being sent to three Network member organizations. Referral outside of the Network membership is beyond the scope of this project.

A rehabilitation referral form is completed.

The referrer completes a standardized online (electronic) form that contains entries that allow for a clear description of the patient and his or her needs. The referral form also mirrors the types of entries that an organization would use to articulate admission criteria to the program. This ensures that a profile of the patient is complete and that it consists of information required to match the patient to the service. Careful exploration is required to ensure that this electronic transfer of information does not violate any privacy legislation or compromise the confidentiality of patient information.

We begin tracking the time it takes to receive a referral response.

Once referred, the patient is considered to be waiting for a response. The patient’s name is placed on a “referred list” which sits only at the organization which has made the referral for that patient. This allows us to monitor how long the patient is waiting for a response, one of the five types of waiting which were identified through the survey.

The responding organizations complete on line response forms with their responses.

Once the organizations that have received the referral review the referral form, within a designated time frame, each makes a decision on whether the organization will “accept”; “wait list” or “refuse” the referral. Each of the terms accept, wait list, and refuse have common and standardized meanings. For example, the term ‘wait list’ might only be used if the patient meets the criteria for rehabilitation but the organization does not currently have space to accommodate the patient. It would not be used to denote the response of an organization to a patient who has to wait for the medical condition to stabilize before being admitted. Similarly, the term accepted, is not used if the organization does not have the capacity to admit the patient.
Option 1: The referral is declined by one or more organizations

The organization that declines the referral, checks off the reasons for which the referral is declined. To enable a quick response to the referring organization, possible reasons are provided as check box options. Analyzing the reasons for which referrals are declined in tandem with the services available in the system will enable us to monitor what services are needed but not available. It is important to note that from the perspective of the referring organizations, patients who are declined admission to a rehabilitation program, may still be viewed as waiting for rehabilitation. It is important that our waiting list information management system differentiates between waiting for a bed or space to become available versus waiting for the patient’s status to change in order to meet the admission requirements of the available beds or spaces in the system. In the first case, the solution might be an increase in quantity of existing beds or services. In the second case, the solution might be a change in the nature of services available.

Option 2: The referral is wait listed by one or more organizations

The organization that has wait listed the patient, has essentially decided that the patient meets the admission criteria, but physical space issues, staff resources; bed availability or other related capacity issues prevent an admission. The organization provides a ‘wait listed’ response through the electronic form. This will include an estimate of how long the wait will be. Once the bed or space becomes available, a message is sent to the referring organization. The process that occurs at that point would be similar to what happens if the organization had provided a response of patient ‘accepted’.

The system should also have the following attributes:
1. There must be a mechanism to flag patients who are on more than one waiting list
2. There must be a mechanism to remove patients from other waiting lists once a bed or space becomes available.
3. If the patient is offered a bed or space but has the option of continuing to wait until the preferred location becomes available, the system must be able to move the patient’s name onto a ‘patient choice’ waiting list or at least to identify the cause of waiting accordingly. This is the fourth type of waiting list identified through the survey.
4. It is possible that an unanticipated change in the status of the patient being referred for rehabilitation occurs during the waiting period. For this purpose, the system must contain a mechanism for updating the organization on the patient status and making modifications to the waiting lists.

Option 3: The referral is accepted by one or more organizations

This response ultimately concludes the waiting period. It is recommended that the term accepted be used only when an organization is prepared to admit a patient and when the patient meets the admission criteria. The organization, which decides to accept a referral, sends this notification electronically to the referring organization. The patient’s name is removed from all other lists. To enable this, the referring organization sends an electronic
response to the other organizations to which it has sent the referral to inform them the patient has been accommodated in the system.

**Obtaining the waiting list information**

Assume now that the referral forms have been used for three consecutive months. The entries on the referral forms should allow us to obtain the following information for a designated period:

1) A count of patients who have waited a designated amount of time for a response to a referral
2) A count of patients, and their characteristics, who have been declined rehabilitation
3) A count of patients who were once on a waiting list and who have since been admitted, and the length of time between being placed on the waiting list and being admitted for care

**Matching the information to capacity**

As previously discussed, to truly measure waiting lists, we need to ensure that our waiting lists are presented in light of the capacity in the system. It is recommended that on designated days, the waiting list information obtained through the database be matched to available capacity. Traditionally, assessing capacity in the system has been confounded by our inability to categorize and describe programs and services commensurably. The GTA Rehab Network has prepared a draft template that will allow organizations to articulate their programs, services and admission criteria in commensurable terms. These templates will allow a measure of capacity in the system.

The measures of capacity will be dynamic since on a daily basis patients enter and leave the system. At the beginning, capacity will be measured on designated days i.e. on a designated day, an organization will post the number of available beds and spaces, the template entries will describe what types of patients can be accommodated in these beds or spaces. Since the referral forms are developed to mirror the admission criteria template, we should be able to look at what services are out there, relative to what types of patients are waiting or are declined rehabilitation.
VI. RECOMMENDATIONS

The basis of the waiting list information management proposal is the premise that by streamlining the processes that generate waiting list information, we will have greater consistency in collection and reporting of information. Network members have shown support for the standardization of communication protocols and processes that influence the generation of waiting list information (see feedback to Propositions I, VI, VII, VIII, X, XI, XIII, XIV in section IV and in Appendix B). This section contains both the process and outcome recommendations required to implement the proposal.

Framework for the conceptualization of waiting list information adapted from the Joint Policy and Planning Committee*

Summary of recommendations
- Develop common referral, response, and status update forms and processes
- Conduct technical and economic feasibility of automating the system
- Agree on common definitions and use of words accept, admit, wait list and refuse
- Invest in automation of referral, response and update forms
- Separate types of waiting into different lists
- Designate days where all the data is collected in a snapshot
- Work towards a real time system
- Form a steering committee to oversee implementation
- Support use of the admission criteria as a mechanism to monitor capacity
- Develop a marketing plan to ensure understanding and dissemination of proposal
- Support research in MSK best practices to assist in triage and prioritization and research on clinical indicators for ready for rehabilitation.

*adapted from Markel F., in Rafferty et al, 2002
Recommendation 1: Develop a common referral form which allows members to communicate and record referrals expeditiously (supported by response to Propositions VII, XIII, XIV) and that provides the following:

a) Information on the patient, filled into a form that mirrors the entries on the proposed admission criteria template. This allows for a patient description in a manner comparable to the admission criteria and ensures appropriate and sufficient information is provided.

b) Ability to communicate the referral to multiple organizations

c) Ability to place the patient’s name and referral date onto a referral list that measures how long it takes to get a response to a referral and then to remove the name from the referral list once a response is obtained.

d) Enables the referrer to provide responding organizations with simple reports on changes in patients status, including movement to another facility (Proposition VIII)

e) Establishes commonly agreed upon parameters between organizations referring and those accepting patients on when the referral process should begin (Proposition I) to allow clear differentiation between patients waiting for rehab beds/spaces and those waiting to become ready for rehab (Proposition II)

Recommendation 2: Develop a common referral response form and protocols that allow members to respond and record decisions to applicant organizations in common ways (Proposition VII, XIII, XIV). The following must be included or must accompany the forms:

a) Commonly shared definitions and uses of the words “accepted”, “admitted”, “refused”, and “wait listed” (Proposition XI)

b) A method to record each of the following decisions: (Proposition XIV)
   - Patient meets criteria but no capacity exists
   - Patient does not meet criteria but capacity exists
   - Patient does not meet criteria and no capacity exists
   - Patient meets criteria and capacity exist

    c) Reasons for which the patient is declined where that is the case

    d) Expected wait time if applicable (Proposition VII)

    e) How the applicant organization should expect to receive information on the status of their referral and on who to contact

    f) Establish commonly shared expectations for when a response to a referral may be received.
Recommendation 3: Conduct a technical and economic feasibility study on automating the referral and response forms and processes. If feasible, automate the referral, response and patient update forms so that transfer of information occurs in real time. (Proposition XII)

Recommendation 4: Select days in which across the system, snapshots of patients awaiting rehabilitation are matched to capacity determined from across the system. Increase frequency of snapshots and work towards a real time system.

Recommendation 5: Conduct further discussion with the community and other hospitals to determine best manner of collecting information on patients who are referred within the same organization.

Recommendation 6: Support and promote use of the admission criteria template not only an admission criteria tool, but as a program description tool to be incorporated as part of the model.

Recommendation 7: Develop a marketing and communication plan so that rehabilitation professionals understand not only the recommendations but also the model envisioned.

Recommendation 8: Establish a steering committee to monitor and evaluate implementation of the waiting list information management proposal:

a) To ensure that the development and implementation of the waiting list information management proposal occurs in a manner consistent with the principles established

b) To ensure that all of the recommendations are implemented with a view to achieving the model described.

c) To determine, in collaboration with specific working groups, if and when patient/family/public representation is required in the development of protocols for the waiting list information management system and to facilitate this participation in a responsible fashion. (Proposition III)

d) To determine how section I of the model, about who is waiting for what, where, when and why will be operationalized for Network purposes i.e. how do we define “who”: diagnoses, age, special needs, etc.

e) To assist the working groups proposed in recommendation 2, disseminate, gain support and implement the outcomes of the decisions made.

f) To determine and organize the manner and days upon which demand information will be obtained from the database and matched to existing capacity.

g) To monitor and assess overall return on investment from the perspective of those entering the data, Network members in general, and the Network as a whole and to address any concerns and suggestions as they arise.
h) To determine when data is sufficiently available/mature and to establish a task group or committee responsible for data review, analysis and collaborative problem solving of issues that become apparent. (Proposition V)

i) The steering committee must also ensure that the following specific confounders to waiting list information are addressed:
   - Patients waiting because of capacity issues versus who is waiting because of choice issues. This will require re-examine the first available bed issue.
   - Patients waiting for rehabilitation vs. patients waiting to become ready for rehabilitation
   - Facilities declining patients because of lack of capacity versus declining patients because of admission criteria issues

**Recommendation 10:** Support best practice research/consensus with respect to patient prioritization (Proposition IX) for the MSK population. These practices should not be mandated but should be available, explained, and encouraged. This will influence and enable decisions on prioritization practices, beyond simple chronological prioritization, should Network members decide that this is a desirable direction in which to move.

**Recommendation 11:** Encourage further research into the appropriate indicators for “ready for rehab”. In the meantime, support the admission criteria task group’s approach of encouraging transparent and available organization specific definitions of available for rehabilitation.
VII. IMPLEMENTATION PLAN

Months 1-2:  ▶ Conduct costing and feasibility study for electronic forms and develop thorough understanding of privacy legislation issues
             ▶ Establish task groups and steering committee. Steering committee to oversee connection of all the forms
             ▶ Conduct further consultation with community and other hospitals whose referrals are principally within their own organization to determine whether standardized forms can be used or if alternatives to gathering information on these patients needs to be pursued.

Months 3-4:  ▶ Develop common referral, response and update forms and establish referral process protocols.

Months 6-9:  ▶ Implement forms as pilot and begin data collection. At the end of the trial period set date on which to match supply and demand to get first true waiting lists
             ▶ Develop automation infrastructure after a technological and economic feasibility study has been conducted.

Months 9-12: ▶ Follow up results of pilot and complete automation
VIII. CONCLUDING REMARKS: CHALLENGES & OPPORTUNITIES

This initiative involved over 40 individuals from across the Greater Toronto Area Rehabilitation System. As a result, the project was able to capture a diversity of viewpoints, preferences, and concerns.

Through our consultations, we acknowledge that the proposal poses the following challenges that must be kept in mind throughout the implementation period.

- Patient choice and first available bed policies will have an impact on individual patient and system waiting times.
- Automation will require careful feasibility assessment
- Need to consider how collection of comparable waiting list information can be collected in situations where patients are referred to different programs within the same organization.
- Different organizations will perceive different benefits and incentives in participating.

The benefits of the proposal however, will likely exceed the challenges. In addition to achieving the vision described in the report, the proposal will lead to:

- Improved service for patients through transparency of process and availability of services.
- Improved access through better data for local and system planning and policy development and the ability to problem solve collectively.
- Enhance communication and better integration using standard forms and processes.
- Ability of all Network members to meet the system integration and change indicators on the rehabilitation balanced scorecard
- Ability to integrate and learn from similar initiatives which are also being proposed for stroke and which have been proposed for traumatic brain injury through the rehabilitation reform pilot project in Ottawa-Carleton.

Finally, this initiative is reflective of the spirit of integration and collaboration that exists among the providers of rehabilitation in the Greater Toronto Area. It is expected that implementation of the proposal and the lessons learned in its development will lead to a more integrated, accessible, and responsive system for the rehabilitation for patients, families and providers in the Greater Toronto Area.
IX. REFERENCES


Stewart, J. (1998). Winnipeg software designed to give FPs access to specialist advice. Canadian Medical Association Journal. 159, 9, 1161-1162


X. TASK GROUP MEMBERS

Chair of Task Group:
Ms. Georgia Gerring (Chair), Toronto Rehabilitation Institute

Task Group Members:
Ms. Heather Brien, Toronto Community Care Access Centre
Ms. Tina Demmers, Lakeridge Health
Ms. Charissa Levy, GTA Rehab Network (Executive Director)
Ms. Rika Vander Laan, GTA Rehab Network (former Executive Director)*
Ms. Dawn Prentice, Halton Healthcare Services
Ms. Judi Ritchie, Southlake Regional Health Centre
Ms. Tina Saryeddine, GTA Rehab Network
Ms. Jacqui Telfer, The Scarborough Hospital
Ms. Fern Teplitsky, Toronto District Health Council
Ms. Rose Edwards, St. John’s Rehabilitation Hospital*
Ms. Louise Howcroft, St. Michael’s Hospital*

Chair of Clinical Committees:
Mr. Malcolm Moffat, GTA Rehab Network
Ms. Mimi Lowi-Young (past Clinical Committees Chair)*

Project Coordinator:
Ms. Tina Saryeddine, Project Coordinator/Planner

* left the task group/respective organizations during course of task group work
XI. ACKNOWLEDGEMENTS

The Network would like to thank the following individuals for their advice and expertise in helping the task group to formulate its proposal:

Mr. Geoffrey Cole, North York Community Care Access Centre
Ms. Charissa Levy and Ms. Rika Vander Laan, Toronto Acquired Brain Injury Network.
Ms. Janice Miller, Canadian Institute for Health Information
Ms. Caroline Rafferty, Joint Policy and Planning Committee

We also thank the organizations that completed the survey and the following individuals who participated in the stakeholder feedback session on December 3, 2002:

Ms. Peggy Arden, Baycrest Centre for Geriatric Care
Ms. Eleanor Leggat, Bloorview McMillan Children’s Centre
Ms. Kim Sterling, Bridgepoint Health
Ms. Mary Murphy, Central Emergency Network
Ms. Nadia Linok, Community Care Access Centre of Halton
Ms. Maureen Lynn, Etobicoke Community Care Access Centre
Ms. Charissa Levy, GTA Rehab Network (Executive Director)
Mr. Malcolm Moffat, GTA Rehab Network
Ms. Tina Saryeddie, GTA Rehab Network (Project Coordinator)
Ms. Dawn Prentice, Halton Healthcare Services
Ms. Sharon Cardiff, Humber River Regional Hospital
Ms. Sang Choi, Credit Valley Hospital
Ms. Karyn Lumsden, Credit Valley Hospital
Ms. Tina Demmers, Lakeridge Health
Dr. Mark Mason, Lakeridge Health
Ms. Terri Stuart McEwan, Markham Stouffville Hospital
Ms. Carole Moore, Markham Stouffville Hospital
Ms. Susan Way, Mt. Sinai Hospital
Ms. Anna Rozenberg, Mt. Sinai Hospital
Ms. Jennifer Scott, North York Community Care Access Centre
Ms. Sandy Bleeman, North York General Hospital
Ms. Heather Reid, Rouge Valley Health System
Ms. Linda Moore, Rouge Valley Health System
Ms. Lynn Douglas, Scarborough Community Care Access Centre
Ms. Jacqui Telfer, The Scarborough Hospital
Ms. Riki Yamada, Southlake Regional Health Centre
Ms. Elaine Fockler, Southlake Regional Health Centre
Ms. Riki Yamada, Southlake Regional Health Centre
Ms. Judi Ritchie, Southlake Regional Health Centre
Ms. Annette Marcuzzi, St. John’s Rehabilitation Hospital
Ms. Margaret Furman, St. Joseph’s Health Centre
Ms. Shelly Sinyard, St. Joseph’s Health Centre
Ms. Brenda Johnson, St. Michael’s Hospital
Ms. Ellen Valeau, Sunnybrook & Women’s College Health Sciences Centre
Ms. Patti Timbers, Sunnybrook & Women’s College Health Sciences Centre
Ms. Catherine Cotton, The Scarborough Hospital
Ms. Heather Brien, Toronto Community Care Access Centre
Ms. Shauna Beard, Toronto East General & Orthopaedic Hospital
Ms. Iris Hogan, Toronto Rehabilitation Institute
Ms. Kathy Eliott, Trillium Health Centre
Ms. Nadia Woloshyn, Trillium Health Centre
Ms. Maria Martinez, University Health Network
Ms. Vilma Rusac, West Park Healthcare Centre
Ms. Rena Postoff, West Park Healthcare Centre
Ms. Evelyn Kirijewski, William Osler Health Centre
Ms. Carol Cober, York Central Hospital
Ms. Brenda Andrachuk, Community Care Access Centre of York Region

Finally, we thank the following individuals and groups for their advice and support:

Mr. David Garlin, GTA Rehab Network
Mr. Robert Jessop, GTA Rehab Network
Dr. Mark Mason and members of the Admission Criteria Task Group
Ms. Judy Moir, GTA Rehab Network/Toronto ABI Network
Ms. Mary Murphy and members of the Central Emergency Post Hospital Working Group
Ms. Patty Aird, GTA Rehab Network
Ms. Tina Sutherland, Toronto Rehabilitation Institute
INSTRUCTIONS

Thank you for your participation in the GTA Rehab Network’s Waiting List Information Management Survey. The objective of the survey is to explore the decision making processes and parameters that influence waiting list generation at Network member organizations in the Greater Toronto Area.

Responses from Network members will be collated and presented for discussion at a fall consensus-building workshop. As the intent is to examine common trends and parameters, no organization specific data will be presented or shared. You will be contacted at a later date concerning the time and place of the session.

This survey should be answered considering experience with hip fracture, hip replacement, and knee replacement patients. Please complete the survey by following the instructions below:

1. Answer all questions in consideration of your hip fracture, hip replacement and knee replacement patients.

2. Only complete sections relevant to your organization by noting the instructions below and at the beginning of each section.

3. Use your mouse and keyboard to complete each question or print the survey and complete it by hand. You will receive both an electronic and paper version.

4. You may check more than one answer for each question

The following provides a summary of which sections you will need to complete. Some organizations will need to complete the entire survey.

- If your organization refers hip fracture, hip replacement, and knee replacement patients from acute care beds, programs, or services to inpatient, outpatient, or home care rehabilitation programs or services, please complete Section A. The estimated time to complete this section is 5-10 minutes.

- If your organization refers hip fracture, hip replacement, knee replacement patients from rehab beds, programs, services to other inpatient, outpatient, or home care rehabilitation programs or services, please complete Section B. The estimated time to complete this section is 5-10 minutes.

- If your organization accepts hip replacement, knee replacement, and hip fracture patients for rehabilitation to inpatient, outpatient, or home care programs or services, please complete Section C. The estimated time to complete this section is 10-15 minutes.

PLEASE RETURN THIS SURVEY TO THE GTA REHAB NETWORK BY EMAIL TO SARYEDDINE.TINA@TORONTOREHAB.ON.CA OR BY FAX ATTENTION TINA SARYEDDINE GTA REHAB NETWORK (416) 591-6812 BY AUGUST 28, 2002

GTA Rehab Network
SECTION A: The following questions are to be completed by organizations that refer hip fracture, hip replacement, and knee replacement patients from ACUTE CARE beds, programs, or services to inpatient, outpatient, or home care REHABILITATION programs or services. This section is most appropriately completed by those who refer patients in acute care to rehab. If this section is not applicable to your organization, GO TO PAGE 6.
Section A: For organizations referring hip fracture, hip replacement and knee replacement patients from acute care beds, programs, or services to rehab beds, programs, or services.

Please identify the respondent for this portion of the survey

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You will be invited to a problem solving session in October.

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1. When does the referral process normally begin (you may check more than one)
   a. [ ] in advance of the patient being ready to transfer/begin service
   b. [ ] when the patient is deemed clinically ready for rehabilitation
   c. [ ] organizational pressures cause us to vary in our approach
   d. [ ] different organizations require us to approach the referral process differently

Other (specify) / Comments:

2. If the referral for rehabilitation is made in advance of the patient actually being ready for transfer/begin service, when does the referral process begin?
   a. [ ] more than 2 weeks in advance of anticipated transfer date/service beginning
   b. [ ] between one and two weeks of the anticipated transfer date/service beginning
   c. [ ] three to five days before the anticipated transfer date/service beginning
   d. [ ] one or two days before the anticipated transfer date/service beginning
   e. [ ] not applicable (N/A)

Other (specify) / Comments:

3. Do you have access to a convalescence/step down unit
   a. [ ] Yes
   b. [ ] No

Other (specify) / Comments:

4. The indicators that prompt a rehabilitation referral are
   a. [ ] selected on a case by case basis
   b. [ ] applied across all patients according to written criteria

If you have written criteria please describe or indicate if attached:

Other (specify) / Comments:
5. To how many organizations/programs is the referral sent?
   a. ☐ 1-2
   b. ☐ 3-4
   c. ☐ 5 or more
   Other (specify) /Comments:

6. Please rank order with 1 most important and 8 least important, the considerations that influence your choice of referral location?
   ______ historical relationship between facilities/agencies/programs
   ______ admission criteria
   ______ flexibility of the program with respect to accommodating timing etc.
   ______ geographic location
   ______ referral destination’s waiting list length
   ______ patient/family preference
   ______ physician preference
   ______ program complexity
   Other (specify) /Comments:

7. Do the patient and family participate in the choice of facilities/programs to which referrals are made?
   a. ☐ Yes
   b. ☐ No
   Other (specify)/Comments:

8. Does the patient rank order his or her choice of facilities/programs?
   a. ☐ Yes
   b. ☐ No
   c. ☐ N/A
   Other (specify)/Comments:

9. Are the patient’s order of choices and referral locations specified on the application form to other organizations/programs?
   a. ☐ Yes
   b. ☐ No
   c. ☐ N/A
   Other (specify) /Comments:
10. Do inpatients have the option of waiting in hospital for the preferred choice?
   a. ☐ Yes
   b. ☐ No
   c. ☐ N/A
   Other (specify)/Comments:

11. If an inpatient has the option of waiting in hospital for the preferred choice, do you charge the patient for the hospital stay?
   a. ☐ Yes
   b. ☐ No
   c. ☐ N/A
   Other (specify)/Comments:

12. Do you have a patient ombudsman/representative who will appeal the admission/waiting decision or advocate for the patient should he or she be dissatisfied with the waiting time or the facility’s/program’s response?
   a. ☐ Yes
   b. ☐ No
   Other (specify)/Comments:

13. If the patient is accepted for rehabilitation, do you usually experience barriers in moving the patient out of your facility and into the rehab facility/program?
   a. ☐ always
   b. ☐ usually
   c. ☐ seldom
   d. ☐ never
   Please list the types of barriers experienced
SECTION B: This section is to be completed by organizations that refer hip fracture, hip replacement, and knee replacement patients in a rehab bed, program or service to other inpatient, outpatient, or home care rehabilitation programs or services. The section is best completed by those who discharge rehab patients home or to other rehab programs/services. If this is not applicable to your organization, GO TO PAGE 10.
Section B: For organizations/programs referring hip fracture, hip replacement, and knee replacement patients from rehab beds, programs, services to OTHER rehab beds, programs or services.

Please identify the respondent for this portion of the survey

| **Organization** |  
| **Name of respondent** |  
| **Telephone number** |  
| **Email address** |  

You will be invited to a problem solving session in October.

| **Preferred time of day** | AM | PM |  
| **Preferred day** | MON | TUE | WED | THUR | FRI |  

1. When does the referral process normally begin (you may check more than one)
   - [ ] in advance of the patient being ready to transfer/begin service
   - [ ] when the patient is deemed clinically ready for rehabilitation
   - [ ] organizational pressures cause us to vary in our approach
   - [ ] different organizations require us to approach the referral process differently
   - Other (specify)/Comments:

2. If the referral for rehabilitation is made in advance of the patient actually being ready to transfer/begin service, when does the referral process begin?
   - [ ] more than 2 weeks in advance of anticipated transfer date/begin service
   - [ ] between one and two weeks of the anticipated transfer date/begin service
   - [ ] three to five days before the anticipated transfer date/begin service
   - [ ] one or two days before the anticipated transfer date/begin service
   - [ ] not applicable (N/A)
   - Other (specify)/Comments:

3. Do you have access to a convalescence/step down unit
   - [ ] Yes
   - [ ] No
   - Other (specify)/Comments:

4. The indicators that prompt a rehabilitation referral are
   - [ ] selected on a case by case basis
   - [ ] applied across all patients according to written criteria
   - If you have written criteria please describe or indicate if attached:
   - Other (specify)/Comments:
5. To how many organizations/programs is the referral sent?
   a. [ ] 1-2
   b. [ ] 3-4
   c. [ ] 5 or more
   Other (specify) /Comments:

6. Please rank order with 1 most important and 8 least important, the considerations that influence your choice of referral location?
   ______  historical relationship between facilities/agencies/programs
   ______  admission criteria
   ______  flexibility of the program with respect to accommodating timing etc.
   ______  geographic location
   ______  referral destination’s waiting list length
   ______  patient/family preference
   ______  physician preference
   ______  program specialty
   Other (specify) /Comments:

7. Do the patient and family participate in the choice of facilities/programs to which referrals are made?
   a. [ ] Yes
   b. [ ] No
   Other (specify)/Comments:

8. Does the patient rank order his or her choice of facilities/programs?
   a. [ ] Yes
   b. [ ] No
   c. [ ] N/A
   Other (specify)/Comments:

9. Are the patient’s order of choices and referral locations specified on the application form to other organizations/programs?
   a. [ ] Yes
   b. [ ] No
   c. [ ] N/A
   Other (specify) /Comments:
10. Do inpatients have the option of waiting in hospital for the preferred choice?
   a. [ ] Yes
   b. [ ] No
   c. [ ] N/A
   Other (specify)/Comments:

11. If an inpatient has the option of waiting in hospital for the preferred choice, do you charge the patient for the hospital stay?
   a. [ ] Yes
   b. [ ] No
   c. [ ] N/A
   Other (specify)/Comments:

12. Do you have a patient ombudsman/representative who will appeal the admission/waiting decision or advocate for the patient should he or she be dissatisfied with the waiting time or facility’s/program’s response?
   a. [ ] Yes
   b. [ ] No
   Other (specify)/Comments:

13. If the patient is accepted for rehabilitation, do you usually experience barriers in moving the patient out of your facility and into the rehab facility/program?
   a. [ ] always
   b. [ ] usually
   c. [ ] seldom
   d. [ ] never
   Please list the types of barriers experienced:
SECTION C: This section is to be completed by organizations that accept hip fracture, hip replacement, and knee replacement patients for inpatient, outpatient, or home care rehabilitation programs or services. If this section does not apply to your organization, please ensure that you have completed either or both of Sections A and B and return the questionnaire by fax to GTA Rehab Network, Attention: Tina Saryeddine, (416) 591-6812 or by email to: saryeddine.tina@torontorehab.on.ca
Section C: For organizations that accept hip fracture, hip replacement, or knee replacement patients to a rehabilitation program or service.

Please identify the respondent for this portion of the survey

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1. When should the application process for your rehabilitation services occur

   a. [ ] in advance of the patient being ready to transfer/begin service
   b. [ ] when the patient is deemed clinically ready for rehabilitation
   c. [ ] we have no particular expectations and deal with issues ad hoc

Other (specify)/Comments:

2. If you answered (a) to question 1, how much in advance do you expect to receive the referral?

   a. [ ] more than 2 weeks in advance of the anticipated time of transfer/start of service
   b. [ ] between one and two weeks of the anticipated transfer date/start of service
   c. [ ] organizational pressures cause us to vary in our approach
   d. [ ] we have no particular expectations and deal with issues ad hoc
   e. [ ] N/A

Other (specify)/Comments:

3. Do you have a formal admissions committee that meets to make the decisions on each application?

   a. [ ] Yes
   b. [ ] No

Other (specify)/Comments:

4. Do the meetings of the admissions committee occur:

   a. [ ] on an ad hoc, as needed basis
   b. [ ] at a preset and regular time
   c. [ ] a combination of a and b
   d. [ ] N/A

Other (specify)/Comments:
5. In the event that an application is made and the patient is found to be a suitable candidate, but a bed/space is not available:
   a. [ ] the applicant organization is informed and given an approximate wait time
   b. [ ] the applicant organization is informed once a bed/space becomes available
   c. [ ] N/A

Other (specify)/Comments:

6. In the event that a patient’s condition changes in the wait period are you:
   a. [ ] always informed
   b. [ ] usually informed
   c. [ ] seldom informed
   d. [ ] never informed
   e. [ ] varies depending on the applicant organization
   f. [ ] N/A

Other (specify)/Comments:

7. If you manage a waiting list for your rehabilitation services do you prioritize patients (you may check more than one response):
   a. [ ] chronologically
   b. [ ] according to the mix of patients currently at the facility
   c. [ ] according to a measured criteria, i.e. results of an assessment tool etc.
   d. [ ] varies
   e. [ ] N/A

Please specify any assessment tools that you are using:

Specify circumstances that would cause an exception to the prioritization process

8. Within your organization/program, have you ever discussed and come to consensus on your approach to waiting list management for rehabilitation
   a. [ ] Yes
   b. [ ] No

Other (specify)/Comments:
9. Consider the scenario: you receive an application (referral) and
   I. the patient MEETS the admission criteria
      II. capacity (space/staff/resources) EXISTS to accept the patient

   a) Within what time frame do you provide a response to the referring facility
      a. □ within one day
      b. □ within 2-6 days
      c. □ within 7-14 days

      Other (specify)/Comments:

   b) Is there a designated protocol for communicating the response
      a. □ Yes
      b. □ No
      c. □ N/A

      Other (specify)/Comments:

   c) Once a decision is made to accept a patient, the expected time frame within which the patient is likely to be admitted to an inpatient program:
      a. □ Immediately
      b. □ within 1-2 days
      c. □ within 3-6 days
      d. □ more than one week
      e. □ N/A

      Other (specify)/Comments:

   d) Once a decision is made to accept a patient, the expected time frame within which the patient is likely to be admitted to an outpatient program:
      a. □ Immediately
      b. □ within 1-2 days
      c. □ within 3-6 days
      d. □ more than one week
      e. □ N/A

      Other (specify)/Comments:

   e) Once a decision is made to accept a patient, the expected time frame within which the patient is likely to be admitted to a home care program:
      a. □ Immediately
      b. □ within 1-2 days
      c. □ within 3-6 days
      d. □ more than one week
      e. □ N/A

      Other (specify)/Comments:
10. Consider the scenario: your organization receives an application (referral) and
   I. the patient DOES NOT meet admission criteria BUT
   II. unused capacity (space/staff/resources) exists

   a) Would your organization tend to:
      a. [ ] accept the patient/application
      b. [ ] wait list the patient/application
      d. [ ] refuse the patient/application
      e. [ ] N/A

   Other (specify)/Comments:

   b) Is there a designated protocol for communicating the response
      a. [ ] Yes
      b. [ ] No
      c. [ ] N/A

   Other (specify)/Comments:

11. Consider the scenario where you receive an application (referral) and
   I. the patient DOES meet admission criteria BUT
   II. NO current capacity (space/staff/resources) exists

   a) Would your organization tend to:
      a. [ ] accept the patient/application
      b. [ ] wait list the patient/application
      c. [ ] refuse the patient/application

   Other (specify)/Comments:

   b) Is this response ALWAYS communicated
      a. [ ] Yes
      b. [ ] No
      b. [ ] N/A

   Other (specify)/Comments:

   c) Is there a designated protocol for communicating the response
      a. [ ] Yes
      b. [ ] No
      b. [ ] N/A

   Other (specify)/Comments:
12. Consider the scenario where you receive an application (referral) and
   I. the patient DOES NOT meet admission criteria AND
   II. NO current capacity (space/staff/resources) exists

   a) Would your organization tend to:
      a. [ ] accept the patient/application
      b. [ ] wait list the patient/application
      c. [ ] refuse the patient/application
      d. [ ] N/A

   Other (specify)/Comments:

   b) Is this response ALWAYS communicated
      a. [ ] Yes
      b. [ ] No
      c. [ ] N/A

   Other (specify)/Comments:

   c) Is there a designated protocol for communicating the response
      a. [ ] Yes
      b. [ ] No
      c. [ ] N/A

   Other (specify)/Comments:

13. Please rank order the importance (with 1 most important and 10 least important) each of the following patient attributes on your waiting list and prioritization decisions:

   ____ Age
   ____ Resources
   ____ Incontinence
   ____ Cognition
   ____ Behaviour
   ____ Diagnoses
   ____ client complexity
   ____ weight bearing status
   ____ preferences of physician/patient/family
   ____ patient location at time of application

   Other (specify) /Comments:
THANK YOU.  
You have completed this survey.

Please fax the completed survey:  
Attention: Tina Saryeddine,  
GTA Rehab Network 11th Floor  
(416) 591-6812  
OR  
Email it to:  
saryeddine.tina@torontorehab.on.ca
APPENDIX B:  Notes from survey follow up day

Notes: MSK Waiting List Information Management Survey Follow Up Session

Notes from Tuesday, December 3, 2002
12:30–4:00
St. John's Rehabilitation Hospital
Grassett Hall
### APPENDIX B: Waiting List Information Management Task Group Survey

#### PRESENT

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baycrest Centre for Geriatric Care</td>
<td>Ms. Peggy Arden</td>
</tr>
<tr>
<td>Bloorview MacMillan Children’s Centre</td>
<td>Ms. Eleanor Leggat</td>
</tr>
<tr>
<td>Bridgepoint Health</td>
<td>Ms. Kim Sterling</td>
</tr>
<tr>
<td>Central Emergency Network</td>
<td>Ms. Mary Murphy</td>
</tr>
<tr>
<td>Community Care Access Centre of Halton</td>
<td>Ms. Nadia Linok</td>
</tr>
<tr>
<td>Credit Valley Hospital</td>
<td>Karyn Lumsden</td>
</tr>
<tr>
<td>Credit Valley Hospital</td>
<td>Ms. Sang Choi</td>
</tr>
<tr>
<td>Etobicoke Community Care Access Centre</td>
<td>Ms. Maureen Lynn</td>
</tr>
<tr>
<td>GTA Rehab Network</td>
<td>Ms. Charissa Levy</td>
</tr>
<tr>
<td>GTA Rehab Network</td>
<td>Ms. Tina Saryeddine</td>
</tr>
<tr>
<td>Halton Healthcare Services Corporation</td>
<td>Ms. Dawn Prentice*</td>
</tr>
<tr>
<td>Humber River Regional Hospital</td>
<td>Ms. Sharon Cardiff</td>
</tr>
<tr>
<td>Lakeridge Health Corporation</td>
<td>Ms. Tina Demmers</td>
</tr>
<tr>
<td>Lakeridge Health Corporation</td>
<td>Dr. Mark Mason</td>
</tr>
<tr>
<td>Markham Stouffville Hospital</td>
<td>Ms. Terri Stuart McEwan</td>
</tr>
<tr>
<td>Markham Stouffville Hospital</td>
<td>Ms. Carole Moore</td>
</tr>
<tr>
<td>Mt. Sinai Hospital</td>
<td>Ms. Susan Way</td>
</tr>
<tr>
<td>Mt. Sinai Hospital</td>
<td>Ms. Anna Rozenberg</td>
</tr>
<tr>
<td>North York Community Care Access Centre</td>
<td>Ms. Jennifer Scott</td>
</tr>
<tr>
<td>North York General Hospital</td>
<td>Ms. Sandy Bleeman</td>
</tr>
<tr>
<td>Rouge Valley Health System</td>
<td>Ms. Heather Reid</td>
</tr>
<tr>
<td>Rouge Valley Health System</td>
<td>Ms. Linda Moore</td>
</tr>
<tr>
<td>Scarborough CCAC</td>
<td>Ms. Lynn Douglas</td>
</tr>
<tr>
<td>Southlake Regional Health Centre</td>
<td>Ms. Riki Yamada</td>
</tr>
<tr>
<td>Southlake Regional Health Centre</td>
<td>Ms. Elaine Fockler</td>
</tr>
<tr>
<td>Southlake Regional Health Centre</td>
<td>Ms. Judi Ritchie*</td>
</tr>
<tr>
<td>Southlake Regional Health Centre</td>
<td>Ms. Elaine Fockler</td>
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<tr>
<td>Southlake Regional Health Centre</td>
<td>Ms. Riki Yamada</td>
</tr>
<tr>
<td>Southlake Regional Health Centre</td>
<td>Ms. Nadia Woloshyn</td>
</tr>
</tbody>
</table>
APPENDIX B: Waiting List Information Management Task Group Survey

<table>
<thead>
<tr>
<th>Hospital/Center</th>
<th>Contact Person</th>
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<tbody>
<tr>
<td>St. John’s Rehabilitation Hospital</td>
<td>Ms. Annette Marcuzzi</td>
</tr>
<tr>
<td>St. Joseph’s Health Centre</td>
<td>Ms. Margaret Furman</td>
</tr>
<tr>
<td>St. Joseph’s Health Centre</td>
<td>Ms. Shelly Sinyard</td>
</tr>
<tr>
<td>St. Michael’s Hospital</td>
<td>Ms. Brenda Johnson</td>
</tr>
<tr>
<td>Sunnybrook &amp; Women’s College Health Sciences Centre</td>
<td>Ms. Ellen Valeau</td>
</tr>
<tr>
<td>Sunnybrook &amp; Women’s College Health Sciences Centre</td>
<td>Ms. Patti Timbers</td>
</tr>
<tr>
<td>The Scarborough Hospital</td>
<td>Ms. Catherine Cotton</td>
</tr>
<tr>
<td>The Scarborough Hospital</td>
<td>Ms. Jacqui Telfer*</td>
</tr>
<tr>
<td>Toronto Community Care Access Centre</td>
<td>Ms. Heather Brien*</td>
</tr>
<tr>
<td>Toronto District Health Council</td>
<td>Ms. Fern Teplitsky*</td>
</tr>
<tr>
<td>Toronto East General &amp; Orthopaedic Hospital</td>
<td>Ms. Shauna Beard</td>
</tr>
<tr>
<td>Toronto Rehabilitation Institute</td>
<td>Ms. Iris Hogan</td>
</tr>
<tr>
<td>Trillium Health Centre</td>
<td>Ms. Kathy Eliott</td>
</tr>
<tr>
<td>University Health Network</td>
<td>Ms. Maria Martinez</td>
</tr>
<tr>
<td>West Park Healthcare Centre</td>
<td>Ms. Vilma Rusac</td>
</tr>
<tr>
<td>West Park Healthcare Centre</td>
<td>Ms. Rena Postoff*</td>
</tr>
<tr>
<td>West Park Healthcare Centre</td>
<td>Ms. Vilma Rusac</td>
</tr>
<tr>
<td>William Osler Health Centre</td>
<td>Ms. Evelyn Kirijewski</td>
</tr>
<tr>
<td>York Central Hospital</td>
<td>Ms. Carol Cober</td>
</tr>
<tr>
<td>York Region CCAC</td>
<td>Ms. Brenda Andrachuk*</td>
</tr>
</tbody>
</table>

*members of task group

WELCOME AND INTRODUCTIONS

Mr. Malcolm Moffat, Chair of the Clinical Committees and GTA Rehab Network Coordinating Council member welcomed attendees to the MSK Waiting List Information Management Survey Follow Up day. In his address, Mr. Moffat noted that the GTA Rehab Network is a forum for collaboration and consensus building. The Network is committed to understanding the needs of its membership and to acting in a responsive and responsible fashion.

Mr. Moffat expressed thanks on behalf of the Network to the clinicians and administrators who took of their time to participate in both the survey and the follow up session. He then introduced Ms. Georgia Gerring, Chair of the Waiting List Task Group, Ms. Charissa Levy, Executive Director, and Ms. Tina Saryeddine, Project Coordinator/Planner.
OBJECTIVES

Ms. Georgia Gerring gave an overview of the session. The following were covered in the presentation, a copy of which is available at www.gtarehabnetwork.ca. The presentation included the following:

Objective

To discuss propositions that relate to factors affecting waiting list information generation and management which will be included in a waiting list information management proposal.

Situating the problem

While not all Network members experience waiting list problems for their patients, the inability to quantify and articulate waiting list problems exists across the system. The development of a waiting list information management system is intended to improve: access, accountability, and advocacy.

Nature of Council Proposal

The proposal to Council will contain two parts:

- Improvements in processes that influence waiting list information
  - If we can streamline the processes by which referral information travels and clarify the definitions, expectations, and starting points, a waiting list information management system will be simplified.
- Investments in system management
  - Explore the feasibility of investing in information system development that will capture or enable transmission of the information required
  - Build on existing available information systems and coordinate with activities such as the National Rehabilitation Reporting System

Model Overview

The proposal will be aligned with a model for waiting list information management that was published by the Joint Policy and Planning Committee\(^5\) (below). The objective is to eventually know: who is waiting for what, where, when and why (Section I) and to be able to link this with what services are available where (Section IV). The proposal will contain a series of recommendations in four main areas of the JPPC model that was published earlier this year including: What is the queue process and priority setting approach? (Section II); How does information flow between the people doing the priority setting and those people who are waiting? (Section III); How does the information flow between people doing the priority setting and the services available? (Section V).

---

Break Out Discussions

All attendees participated in break out groups to discuss each of the propositions. Individuals were asked to consider whether they accepted, rejected or wished to modify the proposition. Each table recorded a consensus position and if applicable, reasons for rejecting or accepting the propositions. The discussions were facilitated by Ms. Heather Brien, Ms. Dawn Prentice, Ms. Judi Ritchie, Ms. Fern Teplitsky, and Ms. Jacqui Telfer.

Discussion Outcomes

In this portion of the meeting, the consensus of each table on whether to accept, reject, or modify the proposition was shared. The qualifying comments which were recorded on flipcharts appear below.

The outcomes from each table are summarized as follows:

✔ = accept  ✗ = reject  • = modify.

<table>
<thead>
<tr>
<th>Proposition</th>
<th>Table</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROPOSITION I:</strong> A waiting list information management system should establish commonly agreed upon parameters between the organizations referring and those accepting patients, on when the referral process should begin, and the number of organizations to which a referral is sent.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 4 5</td>
<td>✔ ✔ • • ✔</td>
</tr>
<tr>
<td><strong>PROPOSITION II:</strong> A waiting list information management system requires clarity on what is meant by &quot;ready for rehab&quot; and the difference between those waiting for programs/services and those who are waiting to become eligible for programs/services.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 4 5</td>
<td>✔ ✔ • ✔ ✔</td>
</tr>
<tr>
<td>Proposition</td>
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<td>----------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>PROPOSITION III:</strong> A waiting list information management system should be built with the involvement of patients</td>
<td>✔ ✔ ✗ ✔ / ✗</td>
</tr>
<tr>
<td><strong>PROPOSITION IV:</strong> A waiting list information management system should include the premise that patients accept the first available bed or space, regardless of whether it is their first, second, or third choice of referral location.</td>
<td>✗ ✗ ✗ ✔ / ✗</td>
</tr>
<tr>
<td><strong>PROPOSITION V:</strong> A waiting list information management system should have as a tenet, a mechanism for collaborative problem solving, such as a regional ombudsman for addressing problems that span multiple organizations and regions.</td>
<td>✗ ✗ ✔ ✗ ✗</td>
</tr>
<tr>
<td><strong>PROPOSITION VI:</strong> A waiting list information management system should seek standardization in the processes that influence the generation of waiting list information (e.g. use of an admissions committee).</td>
<td>✗ ✗ ✔ ✗ ✗</td>
</tr>
<tr>
<td><strong>PROPOSITION VII:</strong> In situations where the patient is &quot;accepted&quot; but no space/bed is available, the applicant organization should be informed and give an approximate wait time for a bed or space to become available.</td>
<td>✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td><strong>PROPOSITION VIII:</strong> A waiting list information management system should contain a standard form for reporting changes in patient status after the original referral has been made</td>
<td>✔ ✔ ✔ ✔ / ✗</td>
</tr>
<tr>
<td><strong>PROPOSITION IX:</strong> A waiting list information management system should include an investment in best practice research/consensus with respect to patient prioritization</td>
<td>✔ ✗ ✔ ✔ ✔</td>
</tr>
<tr>
<td><strong>PROPOSITION X:</strong> A waiting list information management system should allow providers to understand the time frame in which organizations will provide a response to a referral</td>
<td>✔ ✔ ✔ ✗ / ✗</td>
</tr>
<tr>
<td><strong>PROPOSITION XI:</strong> A waiting list information management system should provide consensus on the meanings of &quot;accepted&quot; and &quot;admitted&quot;.</td>
<td>✔ ✔ ✗ ✔ ✔</td>
</tr>
<tr>
<td><strong>PROPOSITION XII:</strong> A waiting list information management system should include a mechanism for sharing current capacity information.</td>
<td>✗ ✗ ✔ ✔ ✔</td>
</tr>
<tr>
<td><strong>PROPOSITION XIII:</strong> A waiting list information management system should provide organizations with a simple and effective means of providing and receiving information on the status of referrals.</td>
<td>✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td><strong>PROPOSITION XIV:</strong> A waiting list information management system should establish response protocols which help create standards on how an organization responds to the following scenarios a) Patient meets criteria but no capacity exists b) Patient does not meet criteria but capacity exists c) Patient does not meet criteria and no capacity exists d) Patient meets criteria and capacity exists</td>
<td>✔ ✔ ✗ ✔ ✔</td>
</tr>
</tbody>
</table>
Closing Remarks

Ms. Georgia Gerring and Ms. Charissa Levy provided an overview of the results. It was noted that while there were a number of elements which required modifications, a focus on common methods of communication was commonly valued. The task group will continue developing the proposal with this feedback. A final report is anticipated for presentation to Council in March 2003.

Supplementary Information for Appendix B

Qualifying Statements for propositions: Flipchart themes.

✔ = accept  ✗ = reject  ● = modify

| PROPOSITION I: A waiting list information management system should establish commonly agreed upon parameters between the organizations referring and those accepting patients, on when the referral process should begin, and the number of organizations to which a referral is sent. |
|---|---|---|---|---|
| ✔ | ✔ | ● | ● | ✔ |
| Summary of stakeholder comments: The idea of common time to begin the referral process was supported in principle. Tables requesting a modification to the proposition were concerned about specifying the number of organizations to which a referral is sent. Additional comments included linking to the admission criteria template and being careful in implementation. |
| Carry forward: Proposition supported in principle if the idea of specifying the number of organizations to which a referral is sent is removed, implementation considerations are made and linkages to the admission criteria template are considered. |

| PROPOSITION II: A waiting list information management system requires clarity on what is meant by "ready for rehab" and the difference between those waiting for programs/services and those who are waiting to become eligible for programs/services. |
|---|---|---|---|---|
| ✔ | ✔ | ● | ✔ | ✔ |
| Summary of stakeholder comments: Proposition supported in principle. Modification suggested is to ensure that the data is objective and not confounded by subjective definitions of ready for rehab. Link to admission criteria recommended. |
| Carry forward: Data clarity, objectivity supported. Organizational definitions and clinical definitions of ready for rehab need to be considered in tandem. |
PROPOSITION III: A waiting list information management system should be built with the involvement of patients.

<table>
<thead>
<tr>
<th>Table 1</th>
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</table>

Summary of stakeholder comments: The involvement of patients needs to be clarified in this proposition. Is the idea to involve the patients in the waiting list decisions or in the development of the system? In principle, it’s a good idea, the question is how this is done.

Carry forward: The idea of client centeredness needs to be maintained as well as a realistic view of feasibility.

PROPOSITION IV: A waiting list information management system should include the premise that patients accept the first available bed or space, regardless of whether it is their first, second, or third choice of referral location.

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<tr>
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<td>✔️</td>
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</tbody>
</table>

Summary of stakeholder comments: There was no consensus on this proposition. Concerns included encouraging gaming in the system, infringing on managerial choice and limiting the flexibility needed to meet patient needs. Suggestions were to collect data to determine to what extent such a policy was necessary and that it might be a down the road solution. Those who accepted the proposal felt that implementing a first available bed policy was appropriate and in the best interests of the system as a whole.

Carry forward: There is a careful balance to be struck between system thinking and patient centeredness, between standardization and provider autonomy. Making decisions of this nature may be a down the road the solution, but is not feasible at this point, based on overall feedback. Taking an incremental phased approach may be worth considering.

PROPOSITION V: A waiting list information management system should have as a tenet, a mechanism for collaborative problem solving, such as a regional ombudsman for addressing problems that span multiple organizations and regions.

<table>
<thead>
<tr>
<th>Table 1</th>
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Summary of stakeholder comments: The concept of ombudsman was not well received. Concerns about infringing on organizational autonomy, duplication, resource use and regionalization were cited as reasons against such an idea. What was supported was the idea of regional problem solving mechanism that could take system issues brought forward through the system and address them.

Carry forward: idea of collective problem solving but no infringing on organizational autonomy or imposition of decisions from external body.
APPENDIX B: Waiting List Information Management Task Group Survey

**PROPOSITION VI:** A waiting list information management system should seek standardization in the processes that influence the generation of waiting list information.

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</table>

**Comments:** The system should not seek standardization necessarily but agreement on timely protocols and procedures. The actual process should be the decision of the organization, so long as it achieves the desired outcome.

**PROPOSITION VII:** In situations where the patient is "accepted" but no space/bed is available, the applicant organization should be informed and give an approximate wait time for a bed or space to become available.

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Accepted.

**PROPOSITION VIII:** A waiting list information management system should contain a standard form for reporting changes in patient status after the original referral has been made.

<table>
<thead>
<tr>
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Accepted.

**PROPOSITION IX:** A waiting list information management system should include an investment in best practice research/consensus with respect to patient prioritization

<table>
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**Comments:** Modify to take into concerns about mandating best practices, the investment it requires and the changing nature of best practice work.

**PROPOSITION X:** A waiting list information management system should allow providers to understand the time frame in which organizations will provide a response to a referral

<table>
<thead>
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Accepted.
### PROPOSITION XI:
A waiting list information management system should provide consensus on the meanings of "accepted" and "admitted".

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<tr>
<th>Table 1</th>
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Accepted with some clarification in wording.

### PROPOSITION XII:
A waiting list information management system should include a mechanism for sharing current capacity information.

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</tbody>
</table>

Comments: Generally accepted, but some concerns about how we really measure and record the capacity. Concerns about insufficient capacity currently in the system.

### PROPOSITION XIII:
A waiting list information management system should provide organizations with a simple and effective means of providing and receiving information on the status of referrals.

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</table>

Comment: Need to ensure patient confidentiality is respected.

### PROPOSITION XIV:
A waiting list information management system should establish response protocols which help create standards on how an organization responds to the following scenarios:
- a) Patient meets criteria but no capacity exists
- b) Patient does not meet criteria but capacity exists
- c) Patient does not meet criteria and no capacity exists
- d) Patient meets criteria and capacity exists

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Table 2</th>
<th>Table 3</th>
<th>Table 4</th>
<th>Table 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>✔️</td>
<td>●</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

Accepted with comment to clarify what we mean by capacity.