

Referral Path Management (RPM)

Overview: Schematic flow chart tracking the referral from the initial intake through to differing waitlists ending with active service, adapted from: Manitoba Speech-Language Pathology Outcomes Measure (2000). Urgency ratings are assigned to help determine the specific type of service delivery recommended for that referral for the child such as urgent service, fast track, by date of referral or no service needed. A form is provided to complete to determine an urgency rating. The rating helps determine the priority of intervention. A Waitlist Service Plan form is provided to record the details of the referral path. This form can be used to track wait time for a specific service request. The child can be re-referred for each issue. This method supports the maintenance of different waitlists to track the *type* of service the child is actually waiting for, such as treatment or consultation.

Uses: Suitable for most agencies and therapies dealing with longer waitlists, waiting times and those maintaining several waitlist types.

Benefits: This method is felt to be concise, provide consistency and equitable access to OT, PT or SLP and help prioritize the service by need, not date of referral with the urgency rating. Statistics for wait time can also be tracked over time with the included form.

Limitations: Would not be helpful for agencies without waitlists. Urgency ratings can have a great deal of subjectivity, but the RPM does consider and rate factors pertinent to the referral and can identify urgent cases that might otherwise be missed. Not field tested.

References:

- Stewart, A. (2006). Promoting Manageable Workloads Project Final Report, Office of the Provincial Paediatric Therapy Recruitment and Retention Coordinator, Therapy BC.
- Manitoba Speech-Language Pathology Outcomes Measure (2000). An Implementation Manual for Speech-Language Pathologists and Administrators, Manitoba Education, Training and Youth.

[Click here to view a flow chart](#)

The Process

Step 1: A child is initially referred for speech language pathology, physiotherapy, and/or occupational therapy. The date of the referral is recorded. This begins the child's wait time.

Step 2: An intake screen is completed to gather information from the family/teacher regarding the referral. The intake is often completed by a family service worker, social worker, school district personnel, or therapist directly. Additional community resources may be presented at that time. Eligibility is determined.

Step 3: The referral is then reviewed by the specific therapy department - an initial service - to determine the referral issues and suitability of the referral. The therapist contacts the family/teacher/other team members. The family is referred on to other services if appropriate.

Step 4: At this stage, the specific therapy department proposes the service delivery method to begin service such as initial therapy assessment, consultation or group treatment.

Step 5: The specific therapy department applies an urgency rating scale to assign a numerical system to determine if the case is urgent and needs immediate intervention or not. Without considering the related factors around a child's referral, an urgent referral may be missed, potentially putting the child at risk without receiving service earlier.

The related factors linked to the child's referral are also considered as part of the priority rating ([click here to view the Intervention Priority Rating form](#)), such as:

- impact of the child's health condition on the child's capacity to perform/participate in a variety of activities in a variety of environments
- child and family's reaction to the referral issue and child's health condition
- community family support available
- child and family's motivation for intervention
- effect of other health issues/concomitant factors on the referral issue/child's health condition.

Step 6: After totaling the intervention priority rate scale, this step involves using clinical decision-making to determine the child's priority of intervention in comparison to other children on the therapist's caseload. If the case is identified as urgent, the child's referral moves onto a therapist's total workload immediately. If it is considered to be a fast track case, then, the therapist considers his or her total workload to decide when the new case can be initiated. When the therapist has decided to take the child onto active caseload, the child is ready to receive service.

Note: Some agencies have one central waitlist. It can be difficult to keep track of how fast the waitlist will move as the number of names on the list may not reflect what the children are waiting for, and how long it will take to obtain it or be discharged from it. Other agencies may have 5 or more waitlists to help provide more accurate information, depending on the type of services the agency offers.

If the child's case is determined not to be urgent, then the referral moves to a waitlist of the service delivery method the agency offers. If uncertain, the child will be waitlisted for an initial service consultation where further information can be obtained. The child is prioritized on the waitlist by priority/urgency and date of referral.

When a therapist has time available from their total workload to add a child to their caseload, the child is removed from the waitlist and onto active service. This date is recorded as the end of the wait time. The time between the date of the referral and the date onto active service is considered the wait time. [Click here to view the Waitlist Service Plan form.](#)

Step 7:

If the child has received a service, but needs another, the child is referred back up the flow chart to the therapy department for review, an urgency rating is completed on the re-referral for waitlist prioritization and moved back on to the waitlist, for the process to continue again.

Wait time

During the wait time on the waitlist, the child can receive services. Some children receive an initial service consultation, then back onto the waitlist to receive further consultations until there is a therapist available to provide the service identified such as individual treatment. The child goes back onto the waitlist each time. The waitlist recording form can be filled out to provide more accurate wait time information. This will incur more paperwork, but will accurately reflect the number of children waiting, how long they are waiting, what they are waiting for, and what they receive while they are waiting.

Ideally, we should be able to tell families that though their child is waiting a long time, that the evidence shows that children who receive X therapy have better outcomes with X responses and can participate more fully in childhood activities and therefore, the wait for that specific therapy was worth waiting for!