Promoting Manageable Workloads Project

Phase 2 - Preferred Practice Guidelines for BC Paediatric Therapists

December 2008

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Abbreviations

BCASLPA	British Columbia Association of Speech-Language Pathologists and Audiologists
BCSOT	British Columbia Society of Occupational Therapists
CASLPA	Canadian Association of Speech-Language Pathologists and Audiologists
CYSN	Children and Youth with Special Needs
CDC	Child Development Centre
EIT	the Early Intervention Therapy program (provides OT, PT, and SLP)
OT	Occupational Therapy / Occupational Therapist
MCFD	Ministry of Children and Family Development
PT	Physiotherapy / Physiotherapist
PABC	Physiotherapy Association of British Columbia
PPTC	Provincial Paediatric Therapy Consultant
SAT	the School-Aged Therapy program (provides OT and PT)
SLP	Speech-Language Pathology / Speech-Language Pathologist

Executive Summary

This Preferred Practice guidelines document is intended to assist therapists, administrators, managers and funders involved in the delivery of paediatric therapy services work towards manageable workloads. It presents monthly workload ratios and caseload ranges for British Columbia (BC) paediatric therapists and describes caseload management factors and workload management strategies to consider.

Workload ratios and caseload ranges provide a reference point that can assist in the development of a balanced and manageable workload for paediatric therapists. These preferred practice guidelines are an important strategy to address the recruitment and retention of occupational therapists (OTs), physiotherapists (PTs), and speech-language pathologists (SLPs) delivering paediatric therapy services to the children and families of BC. For more information on recruitment and retention initiatives related to paediatric therapy in BC, visit www.therapybc.ca.

The guidelines are based on the literature regarding therapy workload and were informed by the paediatric therapy community in BC. Consultation was conducted with therapists providing Early Intervention Therapy (EIT), School-Aged Therapy (SAT) and public health SLP services. Some feedback was also provided by therapists and program administrators from tertiary settings[1], executive directors of agencies, and from regional and provincial Ministry of Children and Family Development (MCFD) staff. Thus, the preferred practice guidelines are most applicable to EIT and SAT programs (school district SLP was not considered), and with special consideration could be used to inform paediatric therapy services provided in other settings.

A summary of the preferred paediatric therapy practice guidelines for the EIT and SAT Programs is presented in the Workload Ratios and Caseload Size table below. The workload ratio represents the percentage of time spent on client related tasks, compared to non-client related tasks. Client related tasks include assessment, intervention, and consultation activities including but not limited to preparation, documentation, and travel specific to a client. Non-client related activities are integral to the functioning of an agency's operation but do not involve the delivery of services to a client. Caseload size ranges include figures for children considered 'active,' indicating that they have received some level of service that month and figures for children considered 'inactive,' indicating that they are being monitored by the therapist, but did not require any level of service that month. Figures are presented for full-time therapists in a clinical position and those in a 'sole-charge' therapist position. This document considers a 35 hour week to be full-time.

[1] Tertiary services refers to the provincial 'sub-specialized,' one of a kind services that are not replicated in every community such as the Positioning and Mobility Team, Vision Team and Inpatient Severe Brain Injury Program at Sunny Hill Health Centre for Children.

Workload Ratio and Caseload Size

	Early Intervention Therapy		School-Aged Therapy	
	Clinical Therapist	Sole-charge Therapist	Clinical Therapist	Sole-charge Therapist
Workload Ratio (% of time spent on client related vs. non-client related tasks)*	70% : 30% to 80% : 20%	65% : 35% to 75% : 25%	70% : 30% to 80% : 20%	65% : 35% to 75% : 25%
Caseload Size (# of children receiving service per month)	30 – 40	25 – 35	50 – 65	45-55
	20-25 active 10-15 inactive	*15-20 active 10-15 inactive*	*25-35 active 25-30 inactive*	*20-25 active 25-30 inactive*

* *Travel time is accounted for in both the percentage of time used to conduct client related activities and non-client related activities.*

A number of factors need to be considered when establishing a caseload size. This includes but is not limited to: the range and complexity of needs of the individual children and families, the needs of the community, the service delivery model adopted by the agency (e.g., emphasis on prevention services would increase the percentage of time spent on non-client related activities), the number and distance between the various community settings where therapy services are to be provided, documentation requirements and methods, and the amount of experience of the therapist.

Special consideration is required for therapists acting as department heads or program managers, and part-time employees. Suggested guidelines for the proportion of time assigned to administrative and management duties are offered for therapists who split their time between clinical services and the administrative activities that come with managing a department or program area (e.g., supervision, hiring, organizational duties). Some practical suggestions are provided to assist with mitigating the issue of non-client related activities dominating a part-time therapist's workload.

The "Phase 2 – Preferred Practice Guidelines for BC Paediatric Therapists" is a tool that supports manageable workloads and is intended to work within the context of a variety of caseload management strategies. Such strategies include waitlist and caseload prioritization tools (clinical decision making matrix, intervention intensity rating), the effective use of therapist assistants and administrative support, efficient documentation methods and the use of technology to support the client and non-client related activities.

Background

The project "Promoting Manageable Workloads for Paediatric Therapists in BC" was initiated in 2005 as part of the 2005-2006 work plan of the Office of the Provincial Paediatric Therapy Consultant, which is funded by the Ministry of Children and Development (MCFD). Phase 1 of the project consisted of a survey and literature review, and addressed topics such as service delivery, referral management, caseload management, workloads, and communications. This resulted in a greater understanding of the caseloads therapists in British Columbia currently face and some of the strategies BC agencies use to help manage workload; it also includes findings from the literature regarding workload management. The report *"Promoting Manageable Workloads for Paediatric Therapists in BC"* (Stewart, 2006) was produced and included six recommendations. The action plan stemming from these recommendations is presented in a separate document *"Phase 1 Recommendations Discussion"*, and is available at www.therapybc.ca.

Phase 2 of the project involved the development of preferred practice guidelines in the areas of workload ratios and caseload size, which are presented in the Preferred Practice Guidelines section of this document. A workload ratio contrasts the amount of time spent performing client specific vs. non-client specific tasks and monthly caseload describes a recommended total number of children receiving services from a paediatric therapist for a one month period, which is based on similar caseload ranges provided in the literature. All of these terms are defined in detail in the Definitions section on page 6.

The purpose of this document, *"Phase 2 – Preferred Practice Guidelines for BC Paediatric Therapists"* is to guide and inform workload management practice in community-based therapy settings such as the home, child care centres, child development centres (CDCs), pre-schools, and schools. It is intended to assist therapists, program administrators, and managers involved in the delivery of paediatric therapy services work towards manageable workloads for therapists. However, this tool may also be a useful resource for paediatric therapists working in other programs (e.g., public health speech, school district speech services).

Development Process of Phase 2 - Promoting Manageable Workloads Project

The Promoting Manageable Workloads project thus far has focused on therapy services funded in full or part by MCFD. Future paediatric promoting manageable workload initiatives will seek input from paediatric therapy representatives from all service sectors, including education, and will be guided by the Children and Youth with Special Needs Framework for Action - a cross-ministry initiative that is working towards improved access, effective services and coherent systems for the services and supports for children and youth with special needs and their families.

This Preferred Practice Guidelines document includes feedback from representatives of all three EIT disciplines (OT, PT, and SLP), and OT and PT from the SAT program. In addition, OTs and PTs employed by school districts and health unit SLPs receiving a portion of their funding from MCFD participated in this project. The sample included staff therapists, therapists with administrative responsibilities, and therapists in sole-charge positions. Therapists working in larger tertiary centres also had the opportunity to provide feedback. School district SLPs were not included in the initial or second phase of the Promoting Manageable Workloads project.

Monthly caseload figures were first discussed in the document *"Promoting Manageable Workloads for Paediatric Therapists in BC"* (Stewart, 2006). Using these monthly caseload figures as a starting point, further dialogue occurred through small focus groups comprised of paediatric therapists and agency therapy department managers. Telephone interviews assisted in ensuring a representative sample of paediatric therapists had the opportunity to provide feedback to this phase of the project. A draft of this report was also disseminated via the Provincial Paediatric Therapy Councils to allow therapists not able to participate in the focus groups to provide further feedback. Feedback was also sought from school district administration, executive directors of agencies delivering paediatric therapy services, Ministry of Health prevention managers, and regional MCFD managers of Children and Youth with Special Needs (CYSN) programs and services.

The following communities hosted a focus group:

1. Prince George
2. Williams Lake
3. Kamloops
4. Penticton
5. Vernon
6. Abbotsford
7. Surrey
8. Vancouver
9. Parksville
10. Victoria

Discussions typically took place at an agency such as a local child development centre. Host agencies extended the invitation to participate throughout their surrounding area, and this resulted in the majority of sessions having representation from additional communities as well. Jason Gordon, the Provincial Paediatric Therapy Consultant (PPTC) directed sessions, which consisted of the following:

- A PowerPoint presentation that reviewed findings from the final report: *"Promoting Manageable Workloads for Paediatric Therapists in BC"* (Stewart, 2006).
- Discussion of phase 1 recommendations.
- Discussion regarding 'preferred practice' guidelines for workload ratios and monthly caseload figures.

Why Preferred Practice Guidelines?

The current situation surrounding recruitment and retention of therapists to work in paediatric settings in BC is in crisis. Cameron, McLean & Namazi (2001) discussed how caseload size and lengthy waitlists are directly related to therapist 'burnout' and job dissatisfaction. Furthermore, it has been reported that only 20% of SLPs, 40% of PTs, and 30% of OTs felt that their workload allowed for the ability to provide an adequate level of service to their clients (Stewart, 2006). Such factors may lead therapists to leave public agencies for the private sector where they can have more control over their caseloads, or leave paediatric practice area altogether.

An aging workforce is an added pressure on the delivery of paediatric therapy services. Professional association surveys from both the Physiotherapy Association of BC and the BC Association of Speech Language Pathologists and Audiologists demonstrate that one-third of the paediatric PT and SLP work force will be retiring within the next five years (PABC, 2007; BCASLPA, 2007), and a survey from the BC Society of Occupational Therapists demonstrates 16% of OT's will be retiring within the next five years (BCSOT and POTC, 2008). Successful recruitment of therapist training program graduates into paediatrics will be vital to offset the portion of the workforce approaching retirement. Therapists with difficult to manage workloads are less inclined to be supervisors for students taking clinical practica, thus decreasing the availability of paediatric therapy learning opportunities for students. In addition, all three therapy disciplines (OT, PT, SLP) are now trained at a Masters degree level, with graduates expecting a balanced workload that allows for a 'best practice' approach to service delivery and a work environment that is supportive of research.

Therapists, administrators and managers responsible for the delivery of paediatric therapy in BC currently have little reference to what resembles a manageable workload. All three national therapy professional associations (Canadian Association of Occupational Therapists, Canadian Association of Physiotherapists, Canadian Association of Speech-Language Pathologists and Audiologists) have produced documents discussing workload, but only the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) document takes the step of identifying a recommended caseload range. [2]

Preferred practice guidelines surrounding workloads have the potential to improve therapy services on two levels:

1. Therapists – A manageable caseload allows therapists to deliver a more adequate level of service to individual clients, reflecting a 'best practices' approach. Manageable workloads allow therapists to offer the appropriate number of treatment sessions and the time required to adequately plan an effective intervention session, communicate with colleagues regarding a

[2] Pollard, 2006; Management Dimensions & D. Parker-Taillon and Associates, 2005; and CASLPA, 2003.

particular client or recent developments within the profession and attend continuing education. Opportunities for continuing education and research support therapists in the adoption of best practices and the development of innovative techniques to improve therapy services. This supports a work environment that is attractive to the recruitment and retention of therapists.

2. Therapy Agencies and Funders – An understanding of what is considered to be a manageable workload for paediatric therapists can assist agencies and funders in the planning of therapy service provision, such as in the allocation of resources and staffing.

Definitions

The Canadian Institute for Health Information (CIHI) is a not-for-profit, independent organization providing analysis and data on the health of Canadians. Where possible, definitions used in these guidelines reflect those of CIHI.

Client related tasks – Includes all assessment, intervention, and consultation activities specific to a client that directly relate to delivering service to a client, including travel to provide service to or on behalf of a client (CIHI, 2008)

Examples of client-related tasks include:

- Assessment – screening, initial intake activities, initial assessment, re-assessment, outcome evaluation
- Intervention – functional activity and activity/ability training, the provision of equipment and assistive devices, counseling/facilitation of support, intervention planning, service recipient advocacy, service recipient education,
- Consultation/Collaboration – consultation, client conferences, team meetings
- Other – travel time, documentation specific to a child

Consultation is an increasing component of a therapist's workload, particularly with the number of different service providers often involved with a child (behavior interventionists, teachers, therapist assistants, education assistants, Infant Development Program consultants, Supported Child Development Program consultants, other therapy disciplines, etc.). Effective communication is essential for the successful delivery of care to a child and involves consulting with a variety of professionals face-to-face, by phone, or via a written report.

Client related tasks also include 'Direct Therapy', 'Equipment Prescription, Loan and Adaptation' and 'Group Therapy', which are types of intervention services as described in the *"Early Intervention Therapy Program Guidelines"* (MCFD, 2008). Direct and group therapy are also described in the *"Program Guidelines: School-Aged Therapy*

Program – Occupational Therapy and Physiotherapy" (Ministry of Health and Ministry Responsible for Seniors, 1995).

Non-client related tasks – Activities that are integral to the functioning of an agency's operation, but do not involve the delivery of services to service recipients (CIHI, 2008).

Examples of non-client related activities include: meetings, program evaluation, cleaning and maintaining equipment, accreditation tasks, continuing education, research, prevention activities, travel time and other non-client specific tasks.

Active caseload – The number of children on a therapist's caseload that directly or indirectly received any level of service during a one month period (i.e., assessment, intervention and/or consultation).

Inactive caseload – The number of children on a therapist's caseload that did not receive any type of service during a one month period; however, they still have therapy related needs or concerns regarding their development and as a result are being ***monitored*** by the therapist. The *"Early Intervention Therapy Program Guidelines"* (MCFD, 2008), further define monitoring and indicate that this allows for the identification of children who may benefit from intervention at a later date.

Caseload – The total number of children that comprise a therapist's caseload (sum of inactive and active caseloads).

Sole-charge – A single therapist who is responsible for providing service to a population and who may also be responsible for managing and administering the services. This person is not directly supervised by a senior therapist from the same discipline. This definition is independent of definitions used in collective agreement language (union contracts).

Workload – The total amount of work related responsibilities. Includes all client-related and non-client related activities.

Workload ratio – The percentage of work time a therapist spends performing client specific vs. non-client specific tasks.

The Ministry of Children and Family Development developed a 'Catalogue of Services and Sub-services' to assist with the standardization of contract language.[3] The definitions for the preferred practice guidelines are not to be confused with those used for contracting purposes. In addition, agencies contracted by MCFD to provide EIT and/or SAT services report to the ministry on indicators related to accessibility and utilization

[3] Consultation, coordination, intervention (and the sub-service therapeutic intervention/treatment), linking/brokerage and training/education are considered the primary services of the Early Intervention Therapy and School-Aged Therapy Programs.

through the Children and Youth with Special Needs Service Indicators Reporting Framework (SIRF).[4] SIRF is not intended to capture all of the work done by service providers, but rather focuses on the time spent directly with a client, either in person or on the telephone. In recognition of the SAT Program's primarily consultative service delivery model, some SAT indicators focus on consultative services. It is acknowledged that all client-related activities are vital to the delivery of services to individual children and families, and that non-client related activities support an important and necessary component of service delivery.

Preferred Practice Guidelines

Overview

An effective ratio of client-related to non-client related activity ensures a good balance in a therapist's workload. Therapists need to effectively provide services to children and families, and have sufficient time to participate in program planning, staff meetings and continuing education/professional development activities.

It is important to recognize that therapists with a predominance of non-client related activities have a decreased ability to provide service to clients. Balancing the different types of non-client related activities is critical to ensure that these necessary tasks are not overlooked, while at the same time ensuring that there is a balance between these and the delivery of client related services. For example, there are some non-client related activities that assist agencies and therapists in evolving their service delivery models to meet the needs of the communities they serve (e.g. – program planning). Others are more general in nature but necessary (e.g., cleaning and inventory of equipment, administrative tasks), and some are more meaningful and contribute to the delivery of quality services and job satisfaction (e.g., professional development opportunities).

The potential benefits of having caseload guidelines to assist in the development of a manageable workload include a therapist's improved sense of providing an effective level of service and greater job satisfaction. This in turn has the potential to increase the recruitment and retention of more therapists to paediatric practice. Further, guidelines can assist agencies and funders in the identification of communities/agencies requiring more resources, including appropriate staffing levels. When circumstances dictate that agencies are unable to provide staffing levels to meet the demand for service (e.g., difficulty recruiting vacant therapy positions), therapist caseloads above recommended guidelines should trigger the implementation of additional caseload management strategies.

[4] SIRF also includes indicators for the Supported Child Development Program and Infant Development Programs.

The suggested workload ratio figures provided are intended to offer an appropriate balance between client related and non-client related workload activities. For the purpose of these guidelines, a full-time therapist refers to a clinician working a 35 hour week.

EIT Preferred Practice Guidelines

The Early Intervention Therapy Program provides community-based services (OT, PT, SLP and family support) to children between birth and school entry who have, or are at risk for, a developmental delay and/or disability, and their families and communities (MCFD, 2008). Services and supports include:

- screening;
- referral;
- assessment;
- family education and support;
- service planning;
- direct therapeutic intervention;
- consultation;
- monitoring;
- transition planning, and;
- community training.

Workload Ratio

The workload for a full-time clinical paediatric EIT therapist with no administrative responsibilities is:

70%-80% of a therapist's time to be spent on client-related activities

20%-30% of a therapist's time to be spent on non-client related activities

Note: Some work settings may include a significant 'prevention' component as part of their service delivery model (e.g. public health unit SLPs). Prevention activities would be considered non-client related since they are not specific to a particular client. Thus, therapists involved in prevention type activities will likely spend a higher proportion of their time relative to the recommended range for non-client related activities, and in no way should the suggested range be interpreted as meaning to limit prevention type activities. Examples of prevention activities

include parent education/community education workshops, and participation in health fairs to screen toddlers for the need for service.

Caseload Size

The monthly caseload range for a full-time clinical EIT therapist with no administrative responsibilities and a workload percentage of 70% to 80% for client related activities is

Total Caseload: **30 – 40 children**

Caseload breakdown: **20-25** children considered 'active.'
10-15 children considered 'inactive.'

SAT Preferred Practice Guidelines

The School Aged Therapy Program provides OT and PT services to school aged children with a developmental delay or disability. The primary goals of SAT services are to help children achieve their educational goals and attain their greatest potential for independent functioning. Typical services include screening, assessment, intervention, consultation, and education and training to parents, school staff and, occasionally, community support personnel. SAT therapists are also involved in referral to other professionals, and in transition planning.

SAT requires collaboration among therapists, families, teachers, and educational assistants. Although the title of the program implies services are delivered in the school setting, the scope of the program also includes home and community settings.

The SAT Program is jointly funded by school districts and MCFD. Speech-Language Pathology services for school-aged children are the sole responsibility of school districts.

Workload Ratio

Non-client related activities such as program planning and continuing education are equally as important in the school-aged setting as in the early intervention setting, thus the SAT workload ratio guideline is similar to EIT. The workload for a full-time clinical paediatric SAT therapist with no administrative responsibilities is:

70%-80% of a therapist's time to be spent on client-related activities

20%-30% of a therapist's time to be spent on non-client related activities

Caseload Size

The monthly caseload range for a full-time clinical SAT therapist with no administrative responsibilities and a workload percentage of 70% to 80% for client related activities is

Total Caseload: 50-65 children

Caseload breakdown: **25-35** children considered 'active.'
25-30 children considered 'inactive.'

SAT therapists have a larger caseload figure than EIT therapists. The larger figure for inactive caseload is due to the SAT Program supporting children throughout their entire elementary and secondary school career, a much longer time frame when compared to the birth to school entry mandate of the EIT program. In addition, the increased use of a consultative service delivery model in SAT results in a larger active caseload.

Sole-Charge Therapists

BC's unique geography and sparse, broad population distribution presents many rural areas with additional challenges in the delivery of paediatric therapy services. In many cases, therapists offering services in such areas do so in a 'sole-charge' position. As a result, they often are also responsible for managing and administering the program.

The rural nature of many of these positions typically results in a caseload spread out over a large catchment area, and therapists often struggle to find time for non-client related activities such as program planning and professional development. This lack of time for professional development is of particular concern for sole-charge therapists in consideration of the professional isolation and lack of continuing education opportunities available to rural therapists. A manageable workload will assist therapists working in sole-charge positions to pursue the supports required to address their professional development needs. This can improve retention of therapists in such vital positions, which are often a rural community's only access to therapy service.

Workload Ratio

The workload for a full-time clinical therapist in a sole-charge position is:

65% - 75% of therapist's time to be spent on client-related activities

25% - 35% of therapist's time to be spent on non-client related activities

The increased workload proportion for non-client activities for sole-charge therapists (up to 35%) is to reflect the additional time required to administer, develop, and enhance programs, and pursue professional development opportunities.

Caseload Size

Caseload guidelines for sole-charge therapists should be considered ***maximum ranges*** only. In some instances a sole-charge therapist may have a caseload of less than the suggested range; however, due to the rural nature of the caseload, a full-time position is still required to effectively deliver service.

EIT Program

Total Caseload: 25-35 children

Caseload breakdown: **15-20** children considered 'active.'
10-15 children considered 'inactive.'

SAT Program

Total Caseload: 45-55 children

Caseload breakdown: **20-25** children considered 'active.'
25-30 children considered 'inactive.'

Factors Influencing Caseload Size

There are several factors that need to be considered when building a caseload. The preferred practice guidelines offer a caseload size range but there are child, family, community, agency and therapist related factors that influence a therapist's ability to operate within a preferred practice caseload range. The following list describes such factors.

1. Child and Family Factors

- Complexity and the number of areas to address and support for the child (e.g., feeding, seating, behavior, computer access, home equipment, joint contractures).
- Current and future equipment needs (prescription, fabrication, fit, training and monitoring of devices)
- Complex health needs that require consultation with a variety of team members and tertiary services.
- Developmental and environmental transitions (e.g., transition to Kindergarten, transition to competitive employment and adult services, transition to a new school or home environment)
- Child's health status (i.e., deterioration or progressive illness), Pre and/or post surgical rehabilitation needs
- Communication and language services for the child and/or family (i.e., sign language, interpreters)
- Family's level of involvement and need for ongoing information and training to help them understand and support their child's needs
- Intensity and frequency of intervention required (e.g., one-time splint fabrication vs. comprehensive developmental and functional assessment).

2. Team Factors

- Availability of a person to coordinate services with the family
- Size and variety of team members, including private practitioners
- Number of different agencies providing services to the child and family
- Amount and frequency of training the intervention team requires

3. Service Delivery Model Factors

- Emphasis on prevention activities at the community level involves a greater amount of time spent on population based services and therefore would necessitate a smaller caseload range.

- Emphasis on direct service delivery to the child in the form of one-to-one direct therapy, group therapy, treatment blocks (set amount of time such as 6 to 8 weeks) and/or ongoing weekly sessions

4. Service Delivery Environment Factors

- Number of environments where therapy services are delivered (e.g., homes, child care settings, schools, recreation centres)
- Distance between the various locations where therapy services are delivered (i.e., amount of time to get to multiple environments for the children and families on a caseload)

5. Therapist Skill Level Factor

- Level of experience to address a range of child and family needs (i.e., new graduate or new to paediatrics)

6. Documentation and Administration Factors

- Amount of detail required for reports (e.g., comprehensive assessment report vs. a screening note)
- Availability of report templates and standard handouts/training materials
- Data collection (e.g., SIRF) for the agency and for funding sources

Examples of Caseload Size Varying from the Preferred Practice Guidelines

The following examples are meant to demonstrate how factors such as those described in the previous section can influence the ability of a therapist to manage a workload.

Example #1: An EIT therapist in a rural setting

An EIT therapist working in a rural setting has a large catchment area and spends approximately one-third of his or her typical workday traveling to family homes to deliver service. In addition, the majority of this therapist's caseload consists of children with a number of areas to address. These children frequently require the therapist to research and apply for equipment funding, provide lengthy direct therapy sessions, and conduct frequent discussions with specialists and other health care providers. In this scenario, the therapist may not be able to provide an adequate level of service and effectively manage a caseload within the recommended range of 30-40 children given the extensive travel demands and the number of children with complex needs. Consequently, consideration must be given to implementing additional workload strategies to support this therapist. For example, this therapist could benefit from increased administrative support to research and apply for equipment funding. In addition, there may be some children on his/her caseload that could have appropriate aspects of the intervention plan delivered through the use of support personnel such as a therapist assistant. This would

free up more of the therapist's time to consult with specialists and other health care providers.

Example #2: A SAT therapist in a large urban area

A SAT therapist with limited experience in paediatrics working in a large urban centre is responsible for providing service to children in eight different schools. The large travel distances between schools and the notorious traffic in this urban centre are frustrating and time-consuming, yet unavoidable. In this scenario, the therapist may not be able to provide an adequate level of service and effectively manage a caseload within the recommended range of 50 to 65 children - given the travel demands combined with his/her limited experience. As a result, a smaller caseload size than the recommended range may be needed to allow for the time needed to perform other client related tasks (assessment, intervention, consultation, documentation).

Other Scenarios in Paediatric Therapy Settings

The two main scenarios where the preferred practice guidelines do not directly apply are to department heads/program managers and part-time employees. A description of factors to consider for therapists in such situations is described below.

Therapists with Administrative and Management Responsibilities

In many agencies therapists act as department heads and/or program managers. These therapists typically split their time between providing clinical services, planning and developing programs, and supervising other therapy staff. The focus group discussions revealed how, in many instances, the clinical time of this type of therapist was used to perform intake assessments, consultations, and other clinical duties designed to assist the department manage large caseloads and waitlists. Therapists in this group are typically assigned a portion of a full-time equivalency (e.g., 0.4 FTE) for their administrative duties, and their remaining time (e.g., 0.6 FTE) is for clinical responsibilities. Several therapists in this group expressed concern with their ability to sufficiently provide management type duties (e.g., program planning, outcome measurement, mentoring of less experienced therapists) given the pressure to provide clinical services within the limited FTE allocated to do so.

Below are suggested guidelines for the proportion of time assigned to administrative and management duties for therapists who split their time between these duties and clinical services, based on the number of staff being supervised. These guidelines are based solely on feedback received through focus group discussions.

# of staff supervised	*Equivalent FTE for management duties*
12 or more	1.0 FTE
6-10	0.75 FTE
3-5	0.6 FTE
1-2	0.4 FTE

The development of preferred practice guidelines for therapists with administrative and management responsibilities is beyond the scope of this project; however, it is recommended that such guidelines be developed in the near future.

Part-Time Employees

Another typical scenario in the delivery of paediatric therapy services is the presence of part-time employees. It is recommended that agencies have an approach in place for part-time employees to ensure an appropriate workload for client related and non-client related tasks. Otherwise, non-client related activities may dominate a part-time therapist's workload.

For example, over the course of a month, a 0.4 FTE may attend a 3 hour general staff meeting and a 2 hour department meeting, and spend 6 hours at a continuing education opportunity. This represents 11 hours of non-client related activity, which is 20% of his/her workload (11 hours / 56 hours), and does not take into account other important non-client related tasks such as professional development, prevention type activities, program evaluation, and accreditation tasks.

Although non-client related activities often dominate a part-time employee's workload, it is important to include them in staff and department meetings, and provide opportunities for continuing education. Alternate means of participating in meetings is one suggestion and could take the form of messaging systems to deliver and receive feedback from part-time employees regarding meeting agenda items not requiring a group discussion. In addition, meeting agenda items requiring staff participation/feedback could all be grouped together and part-time employees could attend only that particular portion of the meeting, allowing more time to perform clinical duties. Part-time therapists are a vital part of an agency and these suggestions in no way imply that they do not participate in staff meetings, but rather suggest ways to gain efficiencies and maximize their time spent providing therapy to children.

Additional Workload Management Strategies

The focus group discussions revealed several excellent examples of strategies BC agencies are currently using to assist therapists in managing large caseloads. The following list provides a few examples.

1. Use of therapist assistants

Several agencies are using therapist assistants to support the delivery of therapy services. Resources describing the appropriate use of therapist assistants in paediatric therapy settings can be found at: http://www.therapybc.ca/pptc_updates.php

2. Enhanced administrative support for therapists

Some agencies are supporting therapists by having administrative staff perform tasks such as preparing child/family written handouts and other education materials, appointment scheduling, travel planning, photocopying, equipment cleaning, preparing materials, shopping for therapy supplies, and treatment room preparation.

3. Efficient documentation methods

Several agencies are using standardized forms and drop-down menus to expedite documentation processes.

4. Increased use of technology

Some agencies are using email systems to reduce on the number of meetings needed, and computer generated exercise programs specific to paediatrics to expedite the creation of home exercise programs.

Caseload Management Strategies

Another strategy to offer a more comprehensive means of providing caseload guidelines is to utilize some type of intervention intensity system or clinical decision-making matrix tool. There are several references in the literature to such systems (Fortune & Ryan, 1996; Hunt, 2001). This Preferred Practice Guidelines document utilizes tangible caseload figures generally understood by all paediatric therapy stakeholders; however, agencies may choose to supplement the preferred practice guidelines with some form of a clinical decision-making matrix or intervention intensity guide. A project is currently underway to develop an eLibrary of such tools, including their benefits and limitations.

Summary

The development of the preferred practice workload and caseload guidelines is an important step in ensuring children and youth with special needs have adequate and equitable access to therapy services regardless of the community in which they live. In addition, these guidelines support a work environment that should improve the recruitment and retention of therapists to paediatric therapy programs and services. Therapists, agencies and funders involved in the delivery of paediatric therapy services can use these guidelines to assist in the recognition of excessively large caseloads and prompt the implementation of additional strategies to support manageable workloads. The development of an evaluation framework of the preferred practice guidelines is currently being considered in order to determine the impact of these guidelines.

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