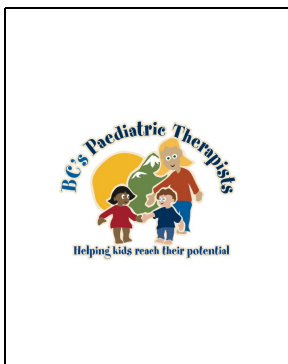




## **Promoting Manageable Workloads Project**

### **Final Report**

**November 2006**



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October 26, 2006

### ***Promoting Manageable Workloads for Paediatric Therapists in BC***

#### Letter of Introduction to the full Project Report

In the 2005-2006 work plan of the Office of the Provincial Paediatric Therapy Consultant in British Columbia, the importance of promoting manageable workloads for paediatric occupational therapists, physical therapists, and speech language pathologists was identified. A project was commissioned to recommend Provincial Guidelines for manageable workloads for therapists practicing in paediatric settings that recognizes discipline-specific service delivery trends, and accounts for child, family, and community factors.

With direction from the Provincial Paediatric Steering Committee, the project was developed to include a literature review of caseload guidelines, waitlist management strategies, and service delivery models; a review of relevant initiatives at the provincial, national and international levels; and, proposed common definitions for discussing caseloads and waitlists that has relevance to occupational therapists, physical therapists, speech language pathologists, employers, and funding sources.

The Final Report covers the topics of Service Delivery, Referral Management, Caseload Management, Workloads, Communications, and Recommendations. The format for each topic covers the relevant terminology, findings from the literature, the provincial perspective from the survey of February 2006, and recommended guidelines. The appendices cover the survey results, detailed examples of systems in use in other jurisdictions, and sample forms and tools.

The following are a summary of the recommendations provided at the conclusion of this report:

1. Establish provincial consensus
2. Field test new guidelines
3. Develop and implement a waitlist prioritization/outcome measurement tool
4. Develop a province-wide information-sharing strategy
5. Develop a provincial paediatric therapy community of practice strategy

## 6. Develop useful and meaningful recording methods

Throughout the course of the project, the realization of the complexity of the concept of manageable workloads was deepened. It is a topic that eludes a simple solution, and is common to paediatric therapists worldwide, and to professional disciplines as diverse as nurses, social workers, and public defenders.

I wish to offer my sincere appreciation to the many individuals who contributed their expertise and energy to this project: Alison Stewart, Project Leader and Author; Ann Harmer, Editor, Bluff Hollow Editing Services; BC Ministry of Children and Family Development, Children and Youth with Special Needs Branch for funding support to commission this project; the Provincial Steering Committee for direction and feedback throughout the project; the small group participants who provided feedback on the draft of this manuscript; and to the many participants who shared their experience during the provincial survey process. The combined effort of everyone has created a comprehensive report that can be used to guide the direction of practice for paediatric therapists in BC.

The plan is to widely distribute the ***Promoting Manageable Workloads for Paediatric Therapists in BC Final Report*** to therapists, agencies, and stakeholders; welcome feedback; participate in discussions across the province; and determine the next phases to move forward with provincial guidelines for manageable workloads for paediatric therapists.

Please feel welcome to direct your comments, feedback, ideas, suggestions or requests to me. I look forward to our anticipated dialogue.

Sincerely,

Christie Diamond  
Provincial Paediatric Therapy Consultant

# **Promoting Manageable Workloads In British Columbia**

***Caseload and Waitlist Management  
For Pediatric Speech Language Pathologists,  
Physiotherapists, and Occupational Therapists***

May 1, 2006  
Office of the Provincial Pediatric Therapy Consultant  
[www.therapybc.ca](http://www.therapybc.ca)

Submitted to  
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## BACKGROUND

The Office of the Provincial Pediatric Therapy Consultant, British Columbia, has identified the importance of promoting manageable workloads for pediatric therapists (pediatric speech language pathologists, physiotherapists, and occupational therapists) in British Columbia. The Provincial Consultant is part of an interdisciplinary approach to addressing issues in therapy services for children in British Columbia, particularly that of recruitment and retention of pediatric therapists.

The Provincial Consultant's vision is to make British Columbia the province of choice for pediatric therapists, thus significantly enhancing therapy services available to children and families in BC. To this end, the Provincial Consultant commissioned this project, the objectives of which are:

1. To propose common definitions for discussing caseloads and waitlists that have relevance to speech language pathologists, physiotherapists, occupational therapists, employers, and funding bodies.
2. To conduct a literature review of manageable workload, caseload guidelines, service delivery models, and waitlist management strategies.
3. To conduct a province-wide survey of BC's pediatric speech language pathologists, physiotherapists, and occupational therapists, and administrators of agencies that provide these services.
4. To investigate, compile information, and establish contacts with relevant initiatives at provincial, national, and international levels to inform the development of provincial guidelines.
5. To recommend provincial guidelines for manageable workloads for speech language pathologists, physiotherapists, and occupational therapists in pediatric settings that recognizes discipline-specific service delivery trends and account for child, family, and community factors.

### **Standard Terminology**

Currently the terms and definitions used by pediatric therapists throughout British Columbia are far from uniform across centres and regions. Multiple meanings significantly confuse the discussion around the topics of caseload and waitlist management.

Standard terminology would reduce confusion by improving consistency in reporting and promote the ability to share common information across centres and funding bodies, despite location or differences in service delivery or discipline. This could assist in the

reporting of standardized health indicators to measure local outcomes, compare provincial systems' performance, and provide information of allocation of resources, provided the significant differences between regions and systems were well recognized.

Standard terminology improves communication among therapists within a facility/system, assists executive directors when planning services and budgetary/staffing allocations, and helps support more effective coordination of services and systems when reporting to accreditors and funding agencies.

The Canadian Institute for Health Information (CIHI) — whose members include the national physiotherapy and occupational therapy associations — collects data on various health issues across Canada, used for analysis and research to improve health care. For data to be useful, measures must be consistent. For example, wait times are measured in different ways and therefore cannot be compared across centres, communities, or provinces. Many of the definitions used by CIHI relate to medical interventions. Where possible, the list of standard terminology in this report includes the applicable CIHI terminology available to date.

The Ministry of Children and Family Development is currently developing a glossary of terms for children and youth with special needs, to provide a common understanding of the descriptions of services and programs. (The glossary of terms is not yet published, but is available for reference.) The glossary also describes the contract and reporting language associated with these programs, supports, and services and is intended to support those involved with managing associated contracts. The definitions used in this report represent a compilation of terms from the Ministry's glossary as well as terminology gathered from the provincial survey of pediatric therapists (see Provincial Perspective, page 3).

### **Literature Review**

In the available literature, the topic of manageable workloads is closely related to workload, caseload management, service delivery, and waitlist management. Proposed solutions for reducing caseload sizes, waitlists, and wait times include using various service delivery models, grouping work activities, and dedicating additional resources.

Although the literature is not always focused on pediatrics or pediatric therapy, many characteristics are applicable to speech language pathologists, physiotherapists, and occupational therapists. The literature suggests strategies to improve these interrelated areas, many of which do not focus on acquiring more human resources, but on working more efficiently and using available resources and professional knowledge to support clinical decisions. In some cases, allocation of funding needs to be considered as a solution in addition to alternative strategies.

The literature refers to a national trend toward transdisciplinary care.

The literature supports continuing development of clinical reasoning skills and knowledge

if therapists are to manage caseloads and waitlists with expertise.

*Please see Appendix A, Literature Review.*

## **Provincial Perspective**

To better understand workload issues facing pediatric speech language pathologists, physiotherapists, and occupational therapists in British Columbia, a provincial perspective was needed. This project focuses on workload issues pertaining to caseload and waitlist management, which are best reported from the therapists and administrators who are providing this pediatric service.

### **Data Collection**

A survey of pediatric therapists was conducted in the Spring of 2006. To obtain information on the provincial perspective, the following methods were used: Telehealth (videoconferencing) sessions, face-to-face interviews, telephone interviews, and an online survey. Requests for participation were sent to all directors/administrators of BC Association for Child Development and Rehabilitation agencies and all provincial council regional representatives for speech language pathology, physiotherapy, and occupational therapy. One regional representative from each discipline participated in the survey. Some of the Telehealth participants participated in the survey as well.

Telehealth sessions took place through the Provincial Health Services Authority and the Vancouver Island Health Authority. Consistent topics and questions were presented and discussed with each site.

The videoconferencing took place in Prince Rupert, Terrace, Kitimat, Dawson Creek, Fort St John, Prince George, Kamloops, Port Hardy, Abbotsford, and Chilliwack.

Face-to-face interviews took place in Vancouver, Surrey, and Nanaimo. Please refer to Figure 1, British Columbia Survey Respondents and Interview Locations.

Of 66 surveys sent to participants online, 57 were returned. The survey topics were consistent with those presented in the videoconferences.

### **Figure 1**

# British Columbia

## Survey Respondents & Interview Locations



- Interview Locations
- Survey Respondents
- ● Survey Respondents & Interview Locations



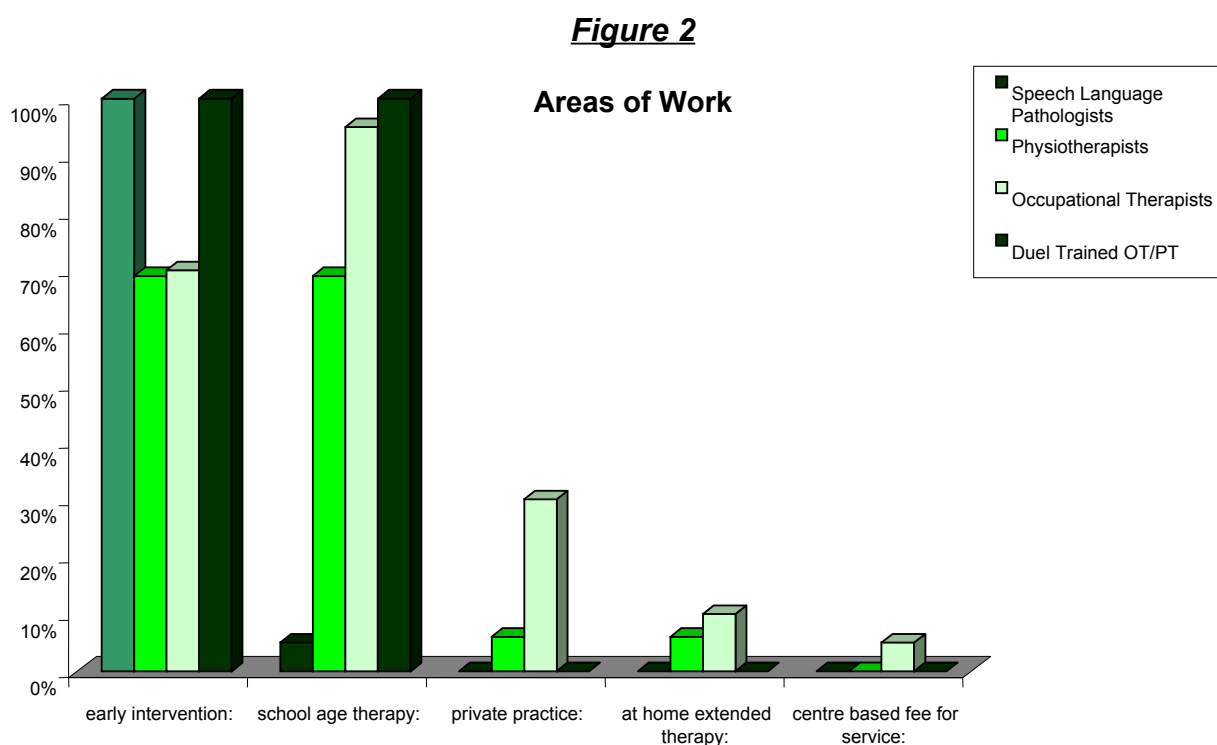
## **Analysis**

The Telehealth sessions and face-to-face interviews provided valuable qualitative information. Discipline-specific filters were added to eliminate any differences. As many therapists work in both early intervention and school therapy, the filters were not effective to single out differences in these two areas of work. The school environment was referenced often. The survey provided quantitative, multiple-choice answers and qualitative information with open-ended answers. Most questions offered opportunity for open comments.

*Please refer to Appendix B , Survey Summary Results.*

Fewer therapists in positions funded solely by the Ministry of Health or the Ministry of Education responded than did therapists in positions funded by the Ministry of Children and Family Development (MCFD) or jointly funded by MCFD/Education.

Participants reported not always having time to foster relationships with therapists working in other systems in their communities. Figure 2 indicates the survey respondents' areas of work. Participants representing speech language pathology, physiotherapy, and occupational therapy worked in a variety of areas, but were not evenly distributed.



It became apparent while collecting data that many terms have different meanings to therapists in BC. Examples include: screening, consultation, waitlist, monitoring, waitlist

prioritization, caseload weighting, direct treatment, and indirect treatment. Service delivery terms were not well understood across disciplines and were not included in the analysis. The terms “delegation” and “therapeutic activities” were not well understood, and therefore the data relating to these was not fully analyzed.

### **Recommended Guidelines**

Guidelines for caseload and waitlist management will help promote manageable workloads for practising pediatric speech language pathologists, physiotherapists, and occupational therapists in British Columbia. The guidelines suggested in this report reflect the information collected from BC’s pediatric therapists and from the literature search.

Where possible, the suggested guidelines have universal potential across disciplines and agencies, for example, early intervention through a child development centre or health unit, therapy provided through the school, or a service delivered through private practice. Where differences may exist among service providers, various strategy options — recommendations only — are presented. Review of the interrelated topics, adapting them to specific settings, as well as consensus and field testing, would be needed across a wide section of practitioners, administrators, funders, and parents, to establish the most useful practice guidelines.

## SERVICE DELIVERY

### Terminology

#### Service level

##### **Active service**

The child is currently receiving therapy intervention of any kind.

##### **Inactive service**

The child is on a waitlist and is not receiving any therapy service. The child may have received some service in the past, such as an initial therapy consultation and comprehensive assessment, but now remains on the waitlist with no active therapy intervention.

##### **Discharged/File Closed**

No contact is planned. The child has been removed from the agency's system and services are terminated. The child may or may not have received active therapy intervention. The child may be re-referred for another service in the future.

#### Service delivery methods

##### **Initial service**

Initial service is the first contact by a therapist of the discipline the child has been referred to. A different therapist may provide intervention at a later date.

##### **Intake screen**

An intake screen determines the child's eligibility for service, establishes very general family priorities, and determines what general services would be beneficial for the child. The face-to-face family meeting can be completed by a social worker, a family support worker, a school-based team, or a therapist. A decision on which therapy discipline will first see the child and on relevant community resources is often made at this time. A developmental history and screening tool may be administered (such as the Ages and Stages Questionnaire) to provide further information.

##### **Initial therapy consultation**

An initial therapy consultation is the first initial contact(s) by the therapist with the child and family to obtain informal descriptive information about a child's performance, to estimate further needs and referrals. It is aimed at determining the caregiver's priorities regarding the child's therapy needs and at providing some immediate suggestions to the family, based on the therapist's clinical expertise. This service might require several contacts and in some cases it may be the only service provided. In some settings, the therapist takes the child on caseload at this point. The child may return to the waitlist after the initial therapy consultation (adapted from: BC Ministry of Children and Family

Development, pending).

### **Consultation to community or team**

Therapy information is provided on a specific topic not related to a specific child.

### **Consultation to child**

A child-specific consultation is focused on a specific topic requested for a specific child. It includes an assessment, followed by provision of individualized therapy information. It can include a consult to the child's general team to provide information on improving the child's functioning within that environment.

A child-specific consult can also include writing educational goals for the child's individualized educational program (IEP). The therapist is responsible for teaching an intervention plan, collaborating with the family, educators, and caregivers. The intervention is provided by someone other than the therapist, while the therapist is responsible for monitoring the outcome of the intervention. If further suggestions are required, another consult is requested.

### **Assessment**

An assessment includes a standardized assessment of presenting problems and/or informal clinical observation/family interview with the child, family and/or school. Assessment occurs prior to intervention of any form, even if it is very informal. An assessment involves gathering information and the formulation of strengths/needs/diagnosis, using sound clinical reasoning. The assessment results form a baseline of performance, making recommendations and/or an intervention plan and identifying desired outcomes of intervention.

Assessment can be comprehensive or focused on the family/teacher/education assistant's current highest priority. It can be part of an ongoing treatment program. For example, during a block of therapy, assessment may take place to explore how the family and child respond and to determine the most effective method of intervention or any need to alter the intervention.

### **Treatment**

Treatment is any direct or indirect activity specific to a child, carried out by a therapist and focused on the achievement of the child's specific therapy goals. Treatment follows an assessment, with goals and a treatment plan identified by combining the child's and family's needs and abilities with the assessment results. Goals can be created from an integrated service plan and/or more detailed discipline-specific areas.

Treatment is a professionally recognized approach that applies accepted theories, principles, and techniques designed to achieve recovery and rehabilitative outcomes for the persons served (Commission on Accreditation and Rehabilitation Facilities, 2005).

### **Direct treatment**



Direct treatment follows assessment and includes evidence-based treatment intervention, directly related to the goals identified, provided by the therapist with the child present. This can take place in a variety of formats, such as one-on-one or in a group setting, with a single discipline, or in conjunction with other professionals (transdisciplinary, multidisciplinary, or interdisciplinary) or community partners. The therapist makes clinical decisions to determine the method, frequency, and duration of treatment, using clinical practice guidelines, recognized outcome measures, and facility guidelines or protocol.

### **Indirect treatment**

Indirect treatment includes child-specific activities focused on the treatment goals, with the child often not present. These activities can include training/coaching parents, caregivers, and education assistants and others; meeting with the child's team or community agencies; fabrication of splints; setting up a computer; sourcing and adapting equipment; preparation of materials for a session; creating home programs; child-specific phone calls; report-writing; and travel to the child's appointment location.

### **Monitoring**

Following an assessment, a child is monitored periodically, using clinical judgment, to determine if the child is continuing to develop appropriately or is at risk and needs further services. If a home program is provided, another person within the child's natural environment is trained by the therapist to carry out the plan. The therapist remains responsible for the plan, initiating and remaining in regular contact with the person who carries out the monitored program, to adapt it as needed. (Adapted, BC Ministry of Children and Family Development, pending)

### **Support personnel supervision**

Supervision follows delegation of a discipline-specific function/task to therapy support personnel. The therapist is responsible for the supervision of the individual performing the task and for the professional services delegated to the support person. The delegation of function is in accordance with the guidelines of the therapist's membership in the appropriate professional college.

## **Service delivery models**

### **Consultative**

This is a process in which a service provider uses her/his expertise to assist other adults in meeting the needs of children with special needs. It includes teaching adults to implement specific intervention strategies as well as monitoring adults who are involved with the implementation of intervention programs (BC Ministry of Children and Family Development, pending).

**Collaborative**

*Interdisciplinary:* A variety of disciplines participate in the assessment, planning, and/or implementation of a person's program. There must be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals (Commission on Accreditation and Rehabilitation Facilities, 2005).

*Multidisciplinary:* Several disciplines coordinate efforts to achieve a common goal; however, the contributions drawn from different disciplines are largely complementary and not integrative (BC Ministry of Children and Family Development, pending).

*Transdisciplinary:* Instead of working in parallel, service providers collaborate across levels of analysis and intervention to develop a comprehensive understanding of the problem at hand. (BC Ministry of Children and Family Development, pending).

**Related Terms****Clinical reasoning**

Clinical reasoning is known as the thought process that guides practice.

**Evidence-based practice**

Evidence-based practice is the formulation of treatment decisions using the best available research evidence (Egan, M., Dubouloz, C.J., vonZweck, C., & Vallerand, J. 1998).

**Outcomes**

Outcomes can be person-referenced (results for people) or system-referenced (results for the service delivery system). Person-referenced outcomes are results in terms of change or maintenance of attitudes/values, knowledge, skills, functioning, behaviour, status, and/or circumstances. Results can be positive or negative, intended or unintended, or direct or indirect. Outcomes can occur over time, and one outcome may lead to another, later outcome. Outcomes are often used to meet reporting requirements and to clarify what is trying to be achieved (BC Ministry of Children and Family Development, pending).

**Service need**

Service need refers to the type of service or intervention the child is thought to need, for example, pre-kindergarten assessment, feeding assessment, seating and mobility trials/prescription, regular treatment, or consultation for a specific topic.

## **Literature Review**

### **Service delivery models outlined in the literature that pertain to pediatric speech language pathology, physiotherapy, and occupational therapy**

Health Canada (2005) supports interdisciplinary collaboration because of staff shortages, limited financial resources, rural geography, and otherwise heavy workloads. Health Canada reports considerable agreement on the benefits of interdisciplinary collaboration when using clear objectives and role clarity. Health Canada goes on to state, in a snapshot report of Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP), “As long as there is perception that time is being taken away from service delivery by already overburdened health professionals, it will be difficult to generate enthusiasm for undertaking organizational change to support greater interdisciplinary collaboration.”

EICP is a federally funded initiative with participation from physiotherapists, speech language pathologists, and occupational therapists. Many other health care providers are participating collaboratively to improve the primary health care system (Primary Health Care 2005).

Numerous sources discuss the value of collaborative consultation and interdisciplinary teamwork, whether the organization is blessed with full staffing or not. Collaborating with other disciplines reportedly brought a richer service for the child and family, was time effective, and was a more holistic approach for many families.

School-based therapy services in Ontario were described by the Research Alliance for Children with Special Needs (2005). Collaborative consultation models appeared to be a key feature, but creative solutions were needed to free up sufficient time for therapists and teachers to actually meet. Frequent consultations and adequate follow-up were required to ensure success. Flexibility to use direct therapy within a consultative model may be beneficial, especially around the time of initial assessment, when determining effective strategies.

Interdisciplinary and transdisciplinary service delivery models were referenced in the literature, but more often, consultative vs. collaborative were mentioned. Gerlach & Zeidler (2004) reported on community-based models, outreach models, and tertiary-based models of service delivery when discussing early intervention programs for aboriginal children.

*Please refer to Appendix C, Examples of Service Delivery Systems in the Literature.*

### **Issues around service delivery models in the provision of pediatric therapy**

#### **Changing model of care**

Much of the literature suggests organizational environments are continually changing. Therapists need to be aware of these changes, understand them, and plan accordingly to ensure they are working within an appropriate service delivery model. Due to these dynamic environments, service delivery models are evolving, and therapists need to continually reflect on principles of best practice (Dunn 2000).

Canada's health care system is currently undergoing and planning significant changes that affect British Columbia's communities, such as the move to the primary care model with interdisciplinary and transdisciplinary services (Harvey 2005, Health Canada 2004, Health Human Resources 2005, Langlois 2005, Smadu 2005).

Primary health care centres are being developed across Canada. The approach is thought to be very comprehensive, whereby the roles of all professionals are enhanced. Each site may have a team of direct providers and a network of other providers, which could include a speech pathologist or a physiotherapist or an occupational therapist. The focus is on prevention/promotion and capacity-building within the community. The concept is based on four "pillars":

- information (electronic records)
- access (24/7)
- healthy living (prevention/promotion)
- collaborative interdisciplinary teams (efficiency, teamwork, and information-sharing).

Health care providers work together to improve continuity of care, reduce duplication, and ensure individuals have access to appropriate health professionals. Patients are part of the team and are empowered to make their own health decisions (Primary Health Care 2005).

#### **New models of service delivery**

The Pew Health Professions Commission (Center for Health Professions 1999) reports that the workplace is demanding new professional skills and new configurations of staff. The commission also defines 21 competencies for the 21<sup>st</sup> century, understanding how the nature of health professions is changing in today's "health care vortex." As the primary health care model becomes more prevalent, therapists will be required to provide a new and different model of service delivery.

The additional time required to learn about and develop competence in new methods of providing clinical service may affect a therapist's workload.

#### **Awareness of population and funding trends**

The evolution of a profession is related to its ability to match the needs of society with planned, appropriate responses to those needs (Boshoff 2003, Hertzman 2005, Center for Health Professions 1999, Canadian College of Health Service Executives 2002,

Parker-Taillon 2003). Therapists are often urged to participate with their administrations in anticipating change and in planning for adapting to service delivery strategies. Therapists are informed through professional associations and colleges, professional journals, and networking, but they have few opportunities to learn about forthcoming changes in government policy and funding.

The Canadian Association for Occupational Therapists (CAOT) reported a need for baseline data before becoming involved in deployment issues of human resource management. CAOT also noted a real need to examine the population health needs first, to assess the need and placement of occupational therapy services as well as to address funding issues (Health Canada 2004).

Population studies have been difficult to find but are pertinent to this topic. Hertzman's Early Development Index (2005) helps illustrate limited regional differences; however, it does not include children with a "low incidence" designation, such as those with physical disabilities.

Environmental mapping acknowledges local community needs in conjunction with organizational and district priorities to facilitate optimal planning and allocation of resource. Planning, implementation, and evaluation of service delivery in a coordinated approach across the region help match staff skills and service needs. (Tweedale et al, 2003)

### **Terminology**

Service model terminology overlaps and is inconsistently described. Some examples include: one on one, direct-individual, direct-group, consultative, collaborative, multiple models, parent education, multidisciplinary, transdisciplinary, interdisciplinary, case management, team, and monitoring.

### **Client need**

Child and family-centred care was referenced in the literature in most articles; however, the choice of individual service delivery is based on a variety of factors, such as the service to be delivered, the convenience of location, and the availability of transportation. The context of the children's needs in relation to their functional ability to participate in their environment is also a factor.

### **Large caseloads**

Heavy caseloads are referenced frequently in the literature. They affect service delivery choices by limiting time available for providing services to clients. It is relevant to reflect on current practice and consider ways to address these environmental and client demands (Boshoff, Alant, & May 2005).

### **Staffing approach/allocation**

The Canadian Alliance of Physiotherapy Regulators and the Canadian Physiotherapy Association recommend a national physiotherapy human resource planning initiative to ensure an adequate supply of physiotherapists. They propose a supply and demand analysis, national database, and analysis of the labour market and the impact of current

health care system changes.

Multi-skilling, delegation of function, assistants

The service delivery model selected depends upon the delegation of function and the provider of the service, whether it is a therapist, a multi-skilled therapist, (Salvatori 1997, Boshoff, et al 2005), a clinical specialist therapist, a trained supported child development worker, an infant development worker, a therapy assistant, a teacher, or an education assistant (Boshoff, Alant & May 2005).

The Canadian Association for Occupational Therapists supports the inclusion of rehabilitation or therapy assistants, OT aides, OT assistants, OT technicians, care aides, case management assistants, educational assistants, vocational assistants, health care assistants, health care workers, nurses' aides, nursing assistants, teacher assistants, vocational therapists, and many others, in the delivery of occupational therapy services where the contributions of those individuals will enhance the services' effectiveness (Health Canada 2004).

The Canadian Physiotherapy Association reported on primary health care activities in Saskatchewan. There, physiotherapists have had an opportunity to work the full scope of practice as well as working in health promotion and disease prevention in interprofessional health programs (2005).

The Canadian Physiotherapy Association reported on the use of physiotherapy support workers, who now have one to two years of college training. They have developed an essential competency profile, as there are currently no standards, and the profession is not yet formalized. Physiotherapists would need to take the extra time to supervise and have direct responsibility for this worker (Canadian Physiotherapy Association 2002)

The Alberta Physiotherapy Association (2005) has clearly delineated expected responsibilities of the therapist and the support personnel, as well as what is beyond the scope of practice for both.

Following a community needs assessment, the Nunavut Region has planned to introduce a community therapy assistant position. These assistants will be trained as support workers to physiotherapists, speech language pathologists, and occupational therapists. They will function as interpreters and "cultural brokers." They will be responsible for following up on a client's individual therapy program, but they are not empowered to assess or change a program. They have a five-year strategy to better anticipate health care changes and predict the best way to provide improved care (Health Canada 2004).

Therapy services in Rankin Inlet team with public health workers to complete annual preschool screenings (Health Canada 2004).

Nurse practitioners are gaining more recognition for their specialty knowledge and are being encouraged to work to the full capacity of their training, as reported in New Brunswick's Primary Care Collaborative Practice Project (Health Canada 2004).

A National Recruitment and Retention Project (NRRP) in the UK suggests using support workers in physiotherapy and occupational therapy. There was no mention of speech language pathology (Health Canada 2004).

#### Key worker

CanChild reported on the “key worker” service delivery model (Drennan, Wagner & Rosenbaum 2005). It was found that key workers provide a single point of contact for families and can help coordinate a child’s care across systems, such as education, health care, financial, recreational, social, and transportation. The main concept is to empower parents to help provide effective care coordination. This is in contrast to case coordination, which provides coordination only in one system. Case coordination in the traditional sense does not typically individualize approaches for different families based on specific needs, nor does it take steps to empower parents. As reported in the literature, key workers are often described as pediatric therapists, teachers, or psychologists.

#### Integrated case management

The Ministry of Children and Family Development (1999) described integrated case management as an approach to help raise standards to a “corporate parenting” level by setting outcome objectives for children and linking them to types of parenting actions most likely to lead to success.

#### **Type of service**

The service delivery model selected can depend on the specific therapy intervention planned, such as prevention/promotion, neurodevelopmental treatment, post-operative rehabilitation, transition planning, and goal-setting, as well as the length and intensity of service.

Specialty clinics are described in the literature as a way to provide services while being much more efficient with the health human resources. Examples of specialty clinics described in the literature are a wound care clinic in BC and a home care clinic in the UK (Health Canada 2004). There are also specialty clinics by diagnosis, such as BC Children’s Hospital neuromuscular clinic and spinal cord clinic, and by specialty service in pediatrics, such as Sunny Hill Health Centre for Children’s assistive technology resource team in British Columbia.

#### **Service delivery methods**

Service delivery models vary, depending on service delivery methods, such as assessment, consultation, treatment, group meetings, parent education, mentoring support personnel, screening, monitoring, planning intervention, education, coaching, report writing, prescribing equipment, writing letters of justification, case conferencing, participating in teams, and liaising with parents, teachers, involved professionals, support personnel, equipment dealers, and supervising assistants.

### **Service locations**

Selection of service delivery model depends on location of service, such as home, group home, hospital, school, preschool, daycare, child development centre, clinic, or community program. There is less choice in service delivery models in rural areas or when geographic distance separates appointment locations. Some therapists believe the consultative model is being implemented too often with a school or home program, simply because it allows them to service more clients. School therapists believe that, though they are using it, the consultative model has some drawbacks in that teachers and parents often need more support than the therapist can provide. Speech language pathologists working with young children and therapists in the schools believe that direct service to clients is being sacrificed due to heavy caseloads and limited resources. (CASLPA, 2003, Boshoff, Alant, & May 2005).

Telehealth is used across BC and other provinces, particularly in rural areas, to foster team approaches and to provide service to children or education to therapists closer to home. It also saves financial resources by reducing travel costs, both for therapists who might otherwise travel to remote communities, and for families who would travel to larger centres. Many communities are unaware of this service, available free or for only a nominal charge (Health Canada 2004).

### **Therapist support**

Choosing a service delivery model also depends on how much support the therapist has when providing the service. Speech pathologists' satisfaction with service delivery models in providing service to children under six was significantly related to whether caseload guidelines were in place (CASLPA 2003).

The Nova Scotia Department of Health Continuing Care has piloted a decision support tool, Minimum Data Set 2.0 (MDS), to better identify care needs and allocate resources by tracking changes in care over time (Health Canada 2004).

### **Evidence-based Information**

The Canadian Healthcare Association (CHA) reported on the need to use evidence-based approaches with Canadian-based research to document and provide evidence that innovative practices are reliable and effective (Health Canada 2004). The LTC Priority Project (Ministry of Health and Long Term Care 2002) uses client assessment protocols, outcome measures, quality indicators, case mix, and a method of assigning priority levels to assist in providing evidence for service delivery caseload and decision support.

### **The need for change in service delivery**

In a participatory research project, Boshoff, Alant & May (2005) reported that half the participants perceived a need for change. Participants also foresaw difficulties in facilitating change, particularly in mobilizing resources and the inability of upper management to recognize the need for change.



**Are service delivery models the same for speech language pathology, physiotherapy, and occupational therapy?**

All of the models discussed would be applicable to speech language pathologists, physiotherapists, and occupational therapists. Therapists use a variety of service delivery models in their practices. There was little reference in the literature as to when specific service delivery models should be used. Therapists would like to be able to do more direct treatment. They prefer using practice guidelines and the opportunity to choose what they believe is the most effective service delivery model, not just the one they have time for. This can help promote a manageable workload.

## REFERRAL MANAGEMENT (Waitlist Management)

### Terminology

#### **Referral management**

Referral management relates to how a referral is managed from the time it is received to the time the child receives services.

#### **Waitlist**

A waitlist refers to a list of children waiting for a service that is not yet available. In some settings where only one type of service delivery is available, there may be only one waitlist, for example, a consultation waitlist in schools. In other settings offering a variety of service delivery options, there may be more types of waitlist. Examples are listed below.

#### **Waitlist types**

Agencies maintain waitlists in different ways. Meaningful waitlist records would describe the actual service the child is waiting for, the number of children waiting, the services they are waiting for, including the service delivery method, wait times, and staffing required. The following waitlists could be maintained:

- *initial therapy consultation waitlist*: a list of children waiting for an initial consultation from a therapist.
- *assessment waitlist*: a list of children waiting for a comprehensive assessment. Some of these children may have received an initial therapy consultation.
- *treatment waitlist*: a list of children who have received a discipline-specific assessment and are now waiting for ongoing direct and/or indirect therapy intervention.
- *consultation waitlist*: a list of children who have received an initial therapy consultation and require an additional consultation from a speech language pathologist, physiotherapist, or occupational therapist.

#### **Wait time**

Wait time is the time from the date a specific service was requested to the date the child starts receiving that *specific* service. A true wait time does not refer to the time from referral to provision of an initial service if that service was not identified as being required for the child. The child may have received the initial therapy consultation within the three-month limit for initial service contact, but is still recorded as waiting until the requested service begins.

**Waitlist prioritization method**

Waitlist prioritization method is a strategy used to determine the priority of service for specific clients waiting for service. A child's need could outweigh those of children on the active caseload. The therapist uses clinical judgment and a priority ranking of each referral to determine the order of the waitlist. Agencies use many different prioritization methods. For example, priorities can be ranked by:

- urgency of need
- type of service requested
- service level
- numerical value placed on a combination of factors
- child's age
- date of service request/referral
- level of severity
- complexity of family need
- family's priority of need
- expected predicted outcome of service requested vs. family request.

**Literature Review****Relevant issues presented in the literature that reference waitlist management****Expectations for service**

Canadians have a legitimate expectation that their publicly financed health care system provides timely access to care based on relative need (Canadian Medical Association 2005).

Waiting time for rehabilitation services must be reduced. Empowered parents appear to manoeuvre within the system to reduce waiting times for their children (Feldman, D.E., Champagne, F., Komer-Bitensky & Meshefedjian 2002).

**Variation in reporting of wait times**

Survey participants reported variations in wait times for an assessment from 7 to 200 days. It was unclear whether this was a true discrepancy or a variation in the method of reporting the actual wait time period. For intensive and specialized services, there is a relationship between inadequate resources and long waiting lists and unduly long wait times, (Boshoff, Alant & May 2005, Canadian Medical Association 2005, CASLPA 2003, BC Aboriginal Child Care Society 2003).

**Strategies to measure wait time benchmarks**

Wait time Code: "rights"/benefits to each party in achieving the performance goals and "responsibilities"/actions that need to be completed by each party to achieve the benchmark. (Wait time Alliance, 2005).

4M Toolbox: strategies to mitigate, measure, monitor, and manage wait times. This is the cornerstone for evidence-based decision-making and for assessing system performance (Wait time Alliance, 2005). When measuring wait list times, consideration should be given to:

- supply-based barriers: an insufficient supply of health human resources, a lack of infrastructure, and poor system coordination
- demand-side issues: health promotion to help reduce the need and therefore the demand for service
- lack of data: limited information available to measure and monitor the extent of wait times and to determine progress

### **Prioritizing service**

Waitlist management necessitates ethical decision-making when prioritizing interventions or creating internal rules to ration service, using information available in the health care ethics literature. A uniform criterion can be developed to guide therapists in their decision-making to determine if there is a child at risk on the waitlist. A numerical value or criterion could be used to determine risk. The uniform criterion could be related to the child's age, as is the case in South Australia (Boshoff, Alant & May 2005), or location, need, severity, or resources (CASLPA, 2003). In the Children's Community Therapy Service in Queensland, Australia, families are prioritized based on age of client, capacity to make improvement through therapy, and geographical location. It was unclear how the client was assessed on capacity to make improvement through therapy.

### **Providing service while client is on the waitlist**

It has been noted that some children receive service while on the waitlist. Therapists can provide a screening, followed by a home program for the family to carry out while the child is on the waitlist. In Victoria, Australia, parents are given a strategy or exercise to work on while their children are on the waitlist, which could be eight weeks for physiotherapy or occupational therapy, and six months for speech language pathology. Parents are referred to an "initial support group," which assists them in taking appropriate actions, even though the child may be on the wait list. Broad educational issues are addressed (Department of Disability, Housing and Community Services 2004).

### **Outcome indicators**

CanChild Centre for Childhood Disability Research (Drennan, Wagner, & Rosenbaum 2005) discusses using national outcome indicators for decision-making in pediatric rehabilitation. CanChild has launched Bluewirecs, an intranet website for Ontario subscribers, to provide up-to-date research information on outcome measurement. They currently use the Gross Motor Function Measure (GMFM) and Sweden's Manual Ability Classification system (National Perinatal Epidemiology Unit 2004). The National Reporting System at CIHI uses the WeeFim II (Uniform Data System 2003). Rosenbaum & Plews (2005) presented on the importance of systematic assessment of children and their families as a provincial strategy for outcome measurement to describe the population to be served, evaluate change over time, relate issues to one another, explore

the impact of childhood disabilities, and undertake cost-benefit analyses. Using outcome indicators could help determine which type of issue would benefit from which type of service, service delivery model, and method.

### **Waitlist strategies**

Many waitlist strategies are in use. The 12 most common are described in detail in Appendix D, with the exception of “by date of referral”:

- severity levels (Manitoba 2000)
- priority ratings (Manitoba 2000, Priority Rating Project 1997, Western Canada Waitlist Project, 2005 Nova Scotia 2003)
- standard treatment outcome measurement (Manitoba 2000)
- integrated service delivery system (MACS 2005)
- performance goals/benchmarks for service (Wait Time Alliance 2005, Nova Scotia 2003)
- intake screening service (Hunter slp project 2004)
- agency penalty if target wait time exceeded (Tasmania 2004)
- non-numerical priority rating (IDP BC 2004)
- urgency rating (SCDP 2005)
- consistent wait time definition (Nova Scotia 2003)
- by date of referral (common strategy).

*Please refer to Appendix D, Examples of Waitlist Systems.*

### **Limited relevant references**

The bulk of information in the literature on waitlists refers to surgical waitlists, such as the Alberta Waitlist Registry (2005). Sobolev (2004) noted less urgent cases had a significant chance of receiving service ahead of more urgent cases in part because of cancellations and delays in scheduling. Recommendations were made to prioritize clients at admission and to include protocols for queuing more urgent cases over the course of waitlist time.

### **Limited references on funding allocation**

No references were found on funding allocations and wait times applicable to pediatric therapy in BC.

A measurement system is used to prioritize referrals and services fairly. There is wide inconsistency in strategy. There should be evidence of service effectiveness and risks involved for each wait or lack of service. This helps to understand who should be waiting, for what and why, and when they should be discharged or if the service should be changed.

**Are relevant waitlist management strategies described in the literature, applicable to speech language pathology, physiotherapy, and occupational therapy?**

Yes. Most of the waitlist strategies are pertinent to speech language pathology, physiotherapy, and occupational therapy.

A specific strategy for prioritizing waitlists must be clearly outlined and described for use with speech language pathologists, physiotherapists, and occupational therapists. The strategy must incorporate aspects of human functioning and disability, to capture the interactive relationship between health conditions and contextual factors as described in the International Classification of Functioning, Disability and Health (ICF) (Stewart & Rosenbaum 2003). ICF delineates health condition, body structure and function, activity participation, and environmental and personal factors. A child's capacity (best performance under ideal conditions) and performance (usual performance under typical conditions) must also be identified. Some investigators (Missiuna & Pollock 2000) have focused on developing tools to describe the child's participation level as a means of evaluating the effectiveness of interventions. This approach can guide clinical thinking when reviewing a case to prioritize service need, service level, and service delivery method and model

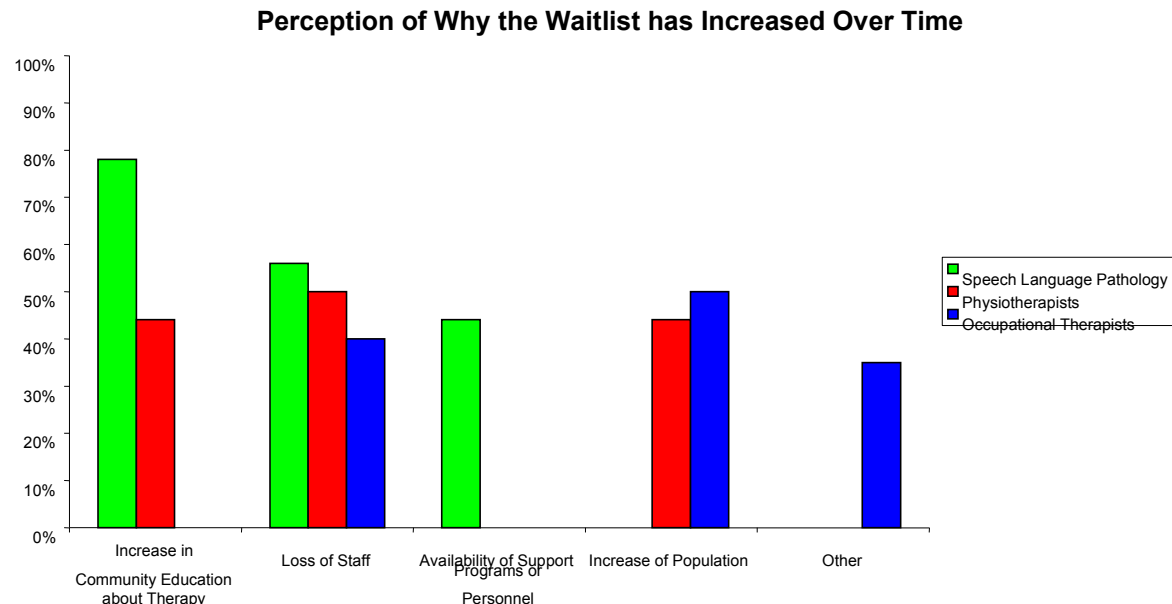
## **Provincial Perspective**

### **Waitlist influences**

Therapists, centres, and parents across BC struggle with increasing waiting times for pediatric speech language pathology, physiotherapy, and occupational therapy; many children's needs don't even "rank" to get on a waitlist. As shown in Figure 2, therapists attribute these increases to: greater education within the community about therapy, especially that provided by speech language pathologists; loss of staff; availability of support programs or personnel; and an increase in population.

### **Inaccurate waitlist reporting**

In some cases, there is no actual waitlist at all. Some therapists working in private practice in BC report they have no waitlists, and have job satisfaction. Some therapists report they do not have waitlists, or their centres have a "no waitlist policy". These latter centres may also have staff shortages or limited resources, which was often reported by therapists as "watered down" service.

**Figure 2**

Other therapists report, “We technically have no waitlists,” and each child is seen within one month to determine what need the parents see as a priority and to provide strategies to deal with that need. However, by report, therapists keep waitlists within their own caseloads for these children to be seen for direct intervention. These children are not reported as waiting.

### **Inconsistent waitlist description**

Many therapists posed the question, “When does the waitlist date actually start?” It appears the most common date is when the child was originally referred to the service, whether it was at their centre or not. It is unclear if the same procedure is followed within the school system.

### **Population changes not meeting staffing requirements**

Therapy survey respondents who have worked in the same regions over time reported their waitlists continue to grow, despite management strategies; the full-time equivalents do not always match the area’s population growth or the change in diagnosis patterns. Respondents reported that referrals have more than doubled in the past two to three years. For speech language pathology, children are reported as being referred earlier, with increasingly complex cases, and are therefore on long waitlists despite innovative strategies to address the situation.

### **Haste in adding new positions without the research**

Another reported influence on ever-increasing waitlists is the addition of staff without research into how such an allocation would translate into new therapy roles. This could be related to using funding (especially one-time funding) to increase staffing levels

without allowing adequate time for planning.

### **Consistent difficulty with staff recruitment and retention**

This has been reported across the province, but it is most prevalent in the rural and more remote areas. It was suggested that rural incentives — in education, salary, and benefits — be made more attractive to encourage therapists to relocate to rural areas.

### **Increase in public awareness about therapy**

An increase in new referrals was reported as being due to increased public understanding about child development, therapies, children with physical needs in the school, and what therapy can do.

### **Feelings of moral obligation**

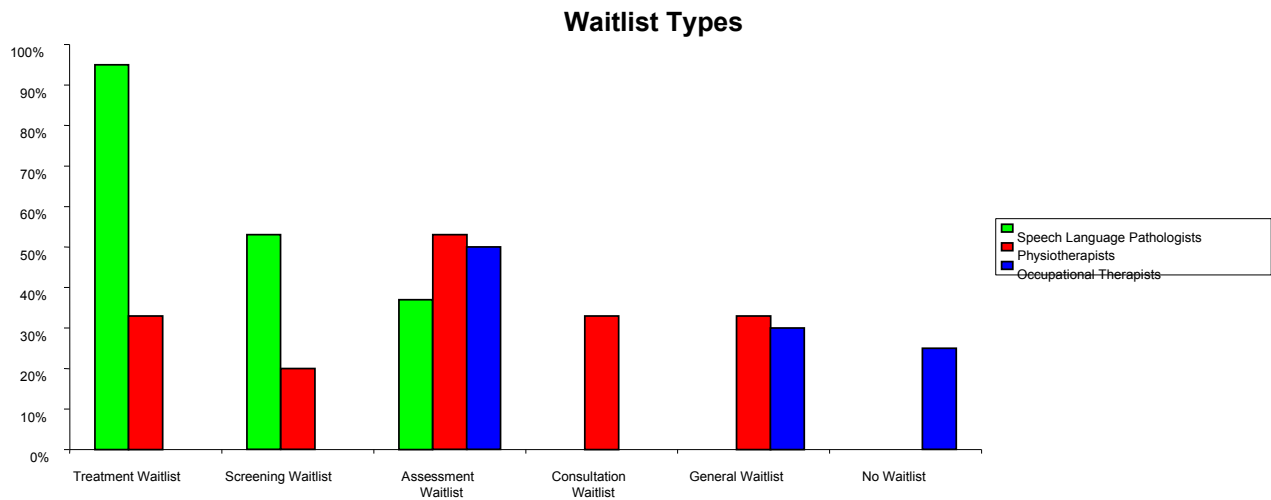
Many therapists determine individually when to take on a new client. Many reported they do this because they feel morally obligated to do so, rather than having time on their caseloads.

### **Waitlist types**

Therapists reported using several different waitlists, formal or informal, depending on the procedures at their places of work. These included most of the service delivery options: intake consultation, assessment, treatment, group treatment, specific parent/child program, consultation, and monitoring. As indicated in Figure 3, a treatment waitlist was the most common for speech language pathology, while an assessment waitlist was the most common for physiotherapy and occupational therapy.

The definitions for these service delivery areas were well described within the centres and well understood by those using them. However, these service delivery methods are not well defined universally and vary dramatically between employers and therapists. This makes it extremely difficult to report accurately on waitlists and to discuss waitlists across the province.



**Figure 3**

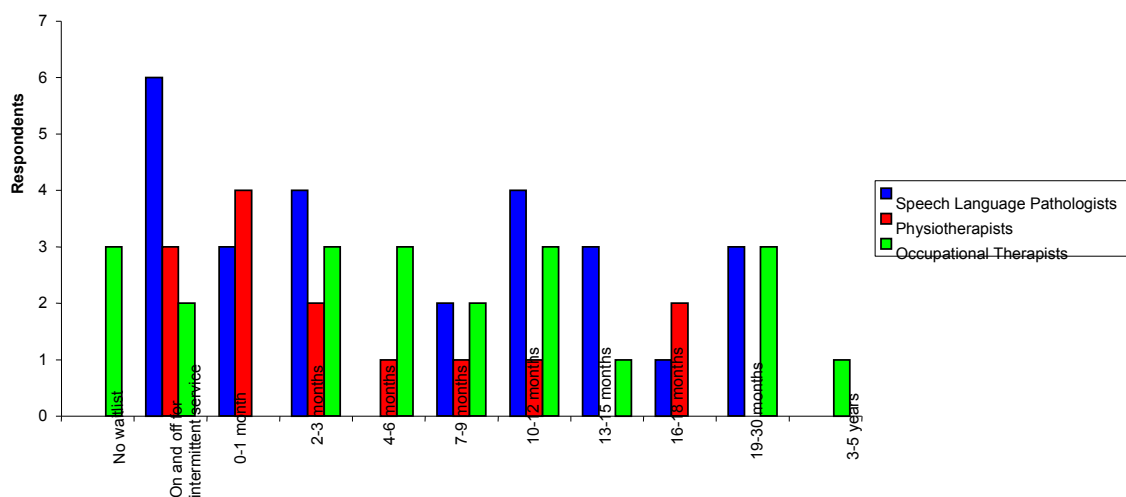
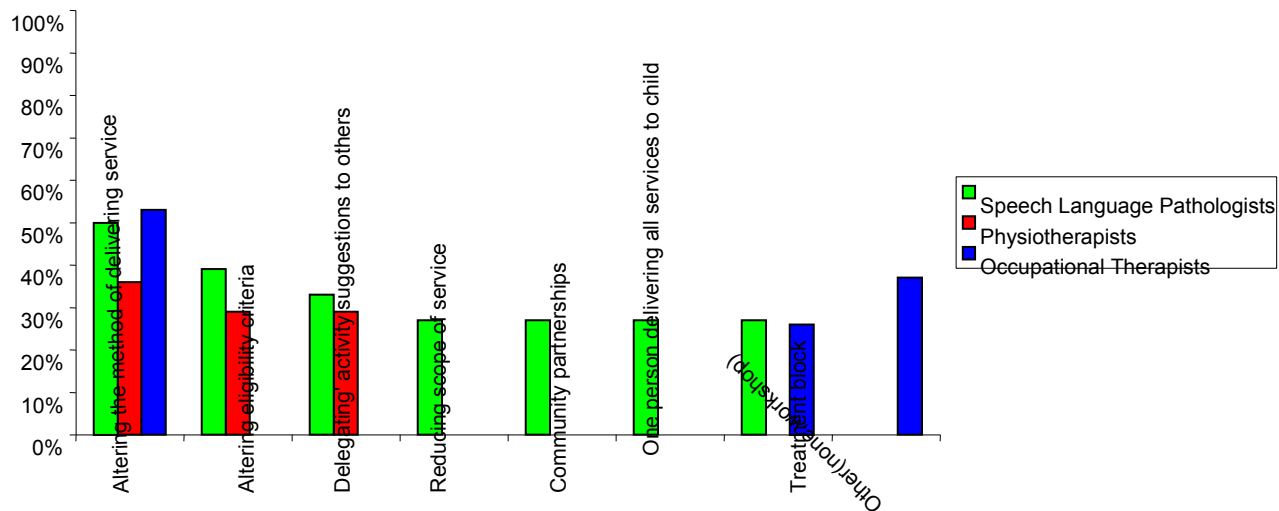
### **Waiting times**

Therapists reported that parents feel “entitlement” to full service after enduring a long waitlist. Again, reporting when a child is actually on and off the waitlist is not consistent across the province. Figure 4 demonstrates the waitlist times reported; it appears that speech language pathologists most often use intermittent service with children on and off the waitlist.

### **Waitlist management strategies**

Therapists across BC have tried many strategies to decrease their waitlists; please refer to Figure 5. Altering the service delivery method was reported by fewer than 50% of respondents. Other effective strategies (without involving increases in staff) included: altering eligibility criteria, delegating activity suggestions to others, and reducing the scope of service. Therapists also found the following effective: treatment blocks, consultation with family or caregivers about activity suggestions or treatment ideas, one person delivering all services to the child, community partnerships, and workshops for the school and community.

“Waitlist consults” are completed by the child’s designated “primary therapist” (determined at the screening) in at least one centre. There is a four-hour minimum for this consult, including all service, documentation, and travel time. One agency reported this was an effective way to reduce the waitlist and address the family’s primary issue with the child. After this consult, the child could return to the waitlist, if still needed. This centre employs a waitlist database system to pull all the information together, across disciplines, and uses online reporting.

**Figure 4****Length of Time on Therapy Waitlist****Figure 5****Most Effective Strategies Used to Reduce Waitlist**

Some centres reported success with the use of therapy aides, primarily by speech pathologists. However, their supervision required a lot of time. Other centres lost funding for their aide position(s), or have never had the opportunity to consider one.

Therapists' responses in the areas of providing consultation and discussing delegation of activity suggestions to others (rather than providing direct treatment) led to the following concerns:

- no time and difficult to provide adequate training, supervision, and support to the other person providing the intervention
- depends on the experience and skill level of the person working with the child; that person may not know how to modify or adjust the intervention
- varies according to the difficulty of the intervention.

Several centres reported that, because of high numbers of children on the waitlists, children moving into the area would have their original dates of referral considered, but not necessarily honoured.

Some therapists reported finding no effective strategy to reduce waitlists. Others were unsure if their strategies had been effective, as no outcome measures were used to measure effectiveness.

Formal outcome measures are widely used for system or centre performance, usually associated with accreditation or Ministry of Children and Family Development performance measures. Examples of outcome measures include satisfaction surveys, reports on whether the child's goals were met, and whether the child was "seen" within three months of referral date. Many therapists mentioned they were considering how to fit more formal outcome measures into their practices.

*Please refer to Appendix E, Additional Detail on Waitlist Reduction Strategies Used in BC.*

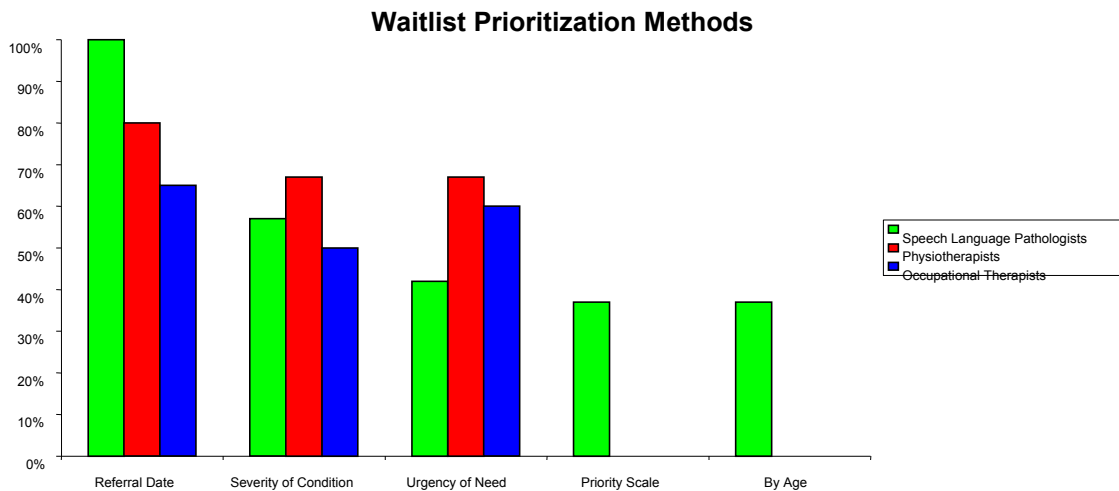
### **Waitlist prioritization**

Waitlists are often prioritized to minimize the waiting time for children thought to need therapy the most. Waitlist prioritization overlaps somewhat with caseload weighting. Waitlist prioritization addresses the child's entry point into service, focusing on the referral priority and on the child's specific condition. Caseload weighting refers to the entire service intervention process of the child's case, including family and community supports. A waitlist prioritization scale or method rates a child's referral priority and assigns a numerical value or category with guidelines attached for maximum wait times, for benchmarking.

Methods most commonly used by therapists in BC to prioritize waitlists include: by

referral date, by severity of condition, and by urgency of need. (Please refer to Figure 6). Only speech language pathology survey respondents reported using age to prioritize children on their waitlists. Other methods reported include: referrals prioritized by schools, prioritization by safety and accessibility, by the months prior to kindergarten entry, and by family and team members' availability, as well as considering feeding and swallowing issues, and whether intervention would make a significant difference.

**Figure 6**



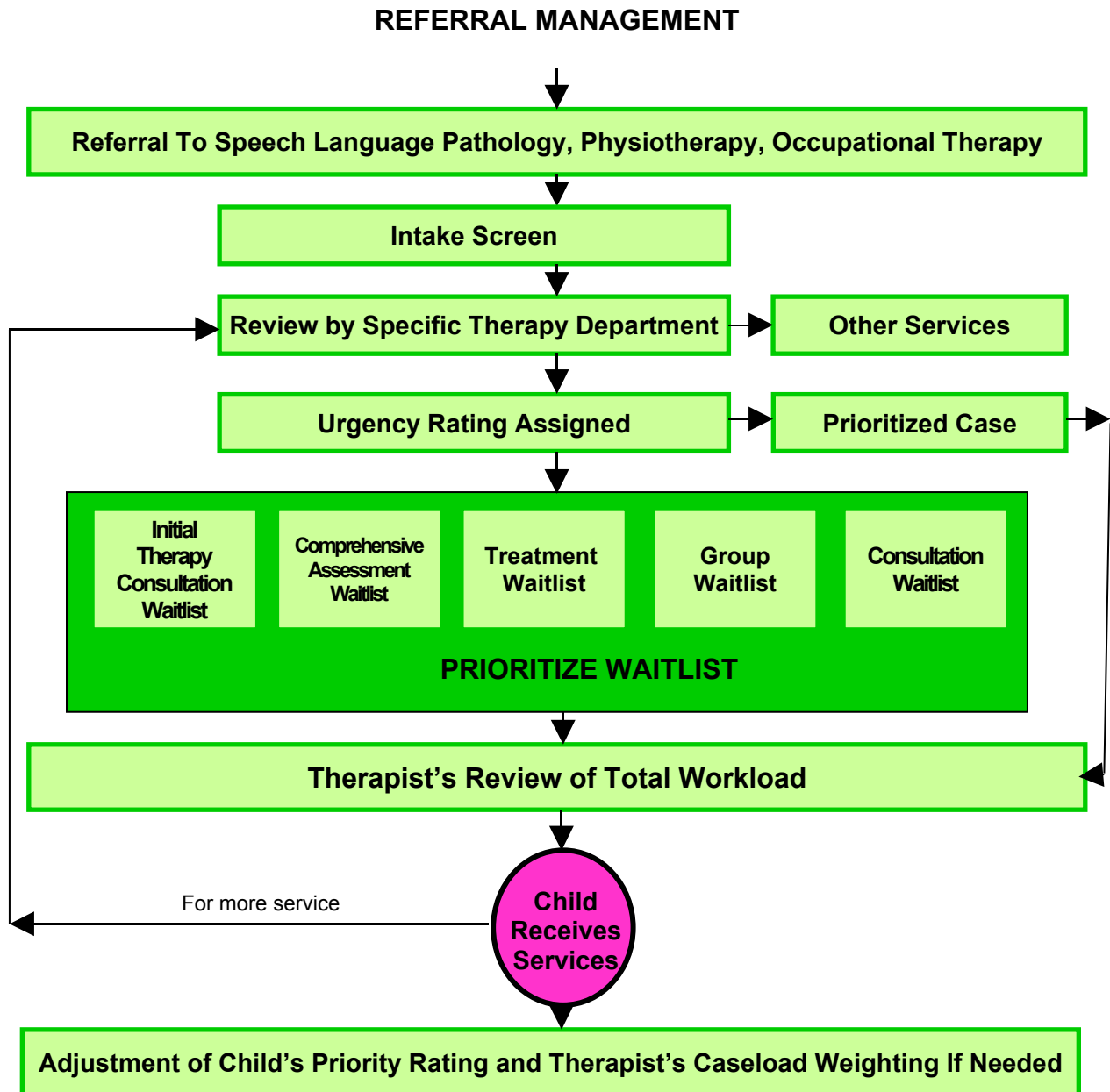
Some prioritization scales or tools are in use in BC. Most are customized to the service and agency to reflect the philosophies and uniqueness of the organization and staff. Examples include: 2-category systems, 5-point priority intervention criteria for school consultation, 3-tier urgency rating, Manitoba Outcomes Measurement.

*Please refer to Appendix F, Examples of Waitlist Prioritization Methods Used in BC.*

## **Recommended Guidelines**

A referral management process (also known as a waitlist management process) is suggested in Figure 7, to help provide consistency across agencies in areas such as reporting, resource allocation, equity, and procedure.

Figure 7



**Referral management process****Step 1: Initial referral**

The child is referred to speech language pathology, physiotherapy, and/or occupational therapy. The date of the referral is recorded. A waitlist prioritization method is used to determine the priority of service for specific clients waiting for service. The therapist uses clinical judgment and a priority ranking of each referral to determine the order of the waitlist.

**Step 2: Intake screen**

An intake screen is completed to gather information from the family and is often completed by a family service worker, social worker, or school district personnel. The team member completing the intake screen may present additional community resources to the family at this time. Eligibility is determined.

**Step 3: Review by specific therapy department**

The referral is then reviewed by the specific therapy department — an initial service — to determine the issues and suitability of the referral. The family is referred on to other services, if appropriate. At this stage, the specific therapy department proposes the service delivery method, such as initial therapy consultation or group treatment.

**Step 3A: Urgency rating assigned to determine waitlist or immediate service need**

The specific therapy department applies an urgency rating scale, using a numerical system, to determine if the case is urgent and needs immediate intervention. Without considering the related factors around a child's referral, an urgent referral may be missed, potentially putting the child at risk. The related factors linked to the child's referral include:

- 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 3B: Child receives urgent service**

If the case is urgent, the child's referral moves onto a therapist's total workload, which the therapist considers when deciding to initiate the new case. When the therapist decides to take the child onto the active caseload, the child is ready to receive service.

**Step 4: Child's case is prioritized and moved onto the waitlist**

If the child's case is determined not to be urgent, then the referral moves to a waitlist of the service delivery method proposed. If the status of urgency is 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 urgency and date of referral.

#### **Step 5: Child receives service**

When a therapist has time available from the total workload to add a child to the caseload, the child is removed from the waitlist and put onto a therapist's caseload for active service. This date is recorded as the end of the wait time. The time between the date of the referral and the date active service began is considered the wait time.

Following initial service consultation with the child, the therapist may wish to review his or her caseload and rebalance it as more detailed information becomes available regarding the complexity of the child's case.

#### **Step 6: Child returns for more service**

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

#### **Comments**

While on the waitlist, the child can receive services. Some children receive an initial service consultation then go back onto the waitlist to receive further consultations until a therapist is available to provide the service identified, such as individual treatment. A waitlist recording form can 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, therapists should be able to tell families that, although their children are waiting a long time, evidence shows that children who receive a certain therapy have better outcomes, with certain responses, and will be able participate more fully in childhood activities.

#### **Waitlist recording**

Agencies collect different information for different purposes, such as staffing allocation, service planning, and resource allocation. Funding sources often ask agencies to provide specific information to justify funding. Some agencies manage large waitlists over long periods, representing large numbers of children, families, issues, and expectations for service. It is imperative that therapists, supervisors, and administrators keep track of referral information in a consistent manner. A universal waitlist recording method, applicable to all parties and not time-intensive, would result in consistent reporting across the province, helping validate the wait and the service.

An appropriate form will record the reason for referral, urgency rating, service need identified, service delivery method proposed, frequency of intervention expected, waitlist type, waitlist priority, services the child received while on the waitlist, and the wait time for service.

*Please refer to Appendix G, Waitlist Recording Form.*

**Recommended waitlist prioritization strategies**

Each referral, representing a unique child and family situation, must be carefully considered in relation to the others on the waitlist. A waitlist prioritization method is used to determine the priority of service for specific clients waiting for service. The therapist uses clinical judgment and a priority ranking of each referral to determine the order of the waitlist.

*Please refer to Appendix H, Principles of Prioritization Strategy*

Among the numerous strategies that rank waitlist priorities, two options — By Date of Referral and Urgency Rating, and By Date of Referral and Level of Participation — are presented on the following two pages of this report. These tables are designed to be clipped and used for future reference.



**Waitlist Prioritization Strategy #1: *By Date of Referral and Urgency Rating******By Date of Referral*****For use by**

Speech language pathologists, physiotherapists, and occupational therapists

**Description**

The waitlist is prioritized by the date listed on each referral. The date is recognized throughout the province.

**Limitations**

By prioritizing waitlist cases totally by referral date alone, some children could be at risk of developing secondary impairments. Children with urgent concerns would not be identified to receive intervention (Bartlett and Palisano 2000). Delays can occur at various points along the referral process; as an example, if the date of the referral predates the date the referral arrived to the discipline, unfair prioritization of children waiting can result. However, the wait time recorded would be accurate for the child.

***By Urgency Rating Scale*****For use by**

Speech language pathologists, physiotherapists, and occupational therapists.

**Description**

The child's referral is rated from 0 to 3, using a scale that considers factors such as family support and the effect of the child's health condition on his or her activity participation. A resulting score represents the urgency of the referral. Intervention timelines are suggested, but such timelines cannot be outlined as a universal measure; agencies, disciplines, funding allocations, and service models vary widely across the province, and each service provider must develop its own definitions.

*Please refer to Appendix I, Rating Urgency for Intervention Scale.*

**Limitations**

Initial interventions for "fast track" and "urgent" will be determined by individual agencies, making comparison between agencies difficult. Urgency ratings, though on a numerical scale, still have a great deal of subjectivity.

**Waitlist Prioritization Strategy #2: *By Date of Referral & Level of Participation******By Date of Referral*****For use by**

Speech language pathologists, physiotherapists, and occupational therapists

**Description**

The waitlist is prioritized by the date listed on each referral. The date is recognized throughout the province.

**Limitations**

By prioritizing waitlist cases by referral date alone, some children could be at risk to develop secondary impairments. Children with urgent concerns would not be identified and receive intervention (Bartlett and Palisano 2000). Delays can occur at various points along the referral process; as an example, if the date of the referral predates the date the referral arrived to the discipline, unfair prioritization of children waiting can result. However, the wait time recorded would be accurate for the child.

***By Level of Participation Scale*****For use by**

Speech language pathologists, physiotherapists, and occupational therapists

**Description:**

Levels of severity, functional independent participation, or performance can be used as a pre-test to determine who may need therapy first. These measures can also be used as a post-test following intervention to provide an outcome measure of service. Recorded over time, this information can help provide data for development of evidence-based clinical practice guidelines and possible prognosis of treatment outcomes.

Evidence-based rehabilitation focuses on using research evidence, in partnership with clinical knowledge, and information from clients and their families to make decisions about rehabilitation service provision. This combination of information enables therapists to work together with families to make the best use of knowledge (Sackett 1996).

A numerical value can be applied to level of participation, using the Level of Participation Scale. This records the child's independence, how much supervision the child requires, and if the child requires a helper. The child's typical performance in environments that are not adapted are recorded, as well as the child's capacity for perform under ideal conditions. Also reported are the child's health condition, contextual factors, and environmental and personal factors. This information could be very useful in planning programs and services, especially for community-based programs, in addition to being a method to measure functional change.

*Please refer to Appendix J, Level of Participation Scale.*

**Limitations**

Functional independence measures (for example, GMFM, WeeFIM, Measuring Children's Abilities), though widely available, may not be present at an agency or incorporated into clinical practices.

## CASELOAD MANAGEMENT

### Terminology

**Caseload size**

Caseload size refers to the number of children on a therapist's individual caseload who are receiving both direct and indirect services. Often, caseload size is referred to as the caseload of a full-time equivalent (FTE) therapist, unless otherwise specified. The number takes into account direct and indirect activities toward managing the caseload and daily workload tasks.

**Caseload composition**

Caseload composition refers to the range of cases on a therapist's caseload. Examples of this range include diagnoses, service need, severity of condition, complexity of case, location of service provided, and frequency of service.

**Balancing caseload**

Balancing a caseload refers to weighing details about a child's case and assigning a value relating to the time required to deal with the case. The value can be numerical, a level, or a rating. A standard system is often used within the same facility, with guidelines for values for an FTE, to ensure therapists have equitable and reasonable case mixes and sizes.

**Caseload management**

Caseload management is the management of the volume and type of clinical cases to whom an individual therapist is responsible for providing service.

**Caseload range**

Caseload range includes diagnosis, type of service required, severity of child's condition, complexity of child's case, location of service provided, and frequency of service.

**Caseload weighting**

Caseload weighting refers to reviewing the parameters around the child's case and assigning a value, often using a prioritization tool. The value is often numerical (1–5) or reported as a level or rating (for example, low to high need). This essentially allows the values to be compared and prioritized. Children have different needs at different times of their lives and therefore the rating would reflect that.

**Severity of condition**

This term is used to refer to the child's level of functional independence to participate in an activity, often obtained by using such functional measures as the GMFM, WeeFIM or the Measuring Children's Abilities scale.

**Functional independence**

Functional independence refers to the child's performance and capacity for independence in a particular activity within a given environment. It considers the

relationship between the child's health condition and the contextual factors of that environment, for example, if it is barrier-free or not. Functional independence is often determined by a functional assessment measure. These measures vary in description, but relate to how much assistance is required for the child to participate in an activity.

### **Complexity of case**

Complexity of case refers to the compilation of a variety of factors, such as urgency of need, type of service requested, child's level of independence, complexity of family need, and family's priority of need.

## **Literature Review**

Caseload assignment and management involves the productive and efficient use of time and resources to maximize and achieve successful client outcomes. The systematic synthesis of client and service information should help design effective and efficient service delivery. Such a service delivery system should accomplish positive outcomes within available health agency resources and professional guidelines (Cavouras 2003, Parker-Taillon 2005). Organizations have a responsibility to construct clear local strategies to develop and maintain a framework for practice (Dube & Davis 2005).

Historically, there is no provincial or national method for defining caseload client severity and priority levels, nor a consistent way of determining outcomes for intervention (Manitoba Education, Training and Youth 2000). In British Columbia, there is a need to identify a consistent method of caseload rating, caseload selection, and measurement of outcomes for intervention (Cameron, McLean & Namazi 2001).

CAOT conducted an environmental scan of international associations in occupational therapy and speech language pathology for information on caseload assignment and management in Australia, New Zealand, the UK, and the USA. Among the available caseload management tools, the Wigan Method and the Maroondah Approach to Clinical Services (MACS) were identified and will be described later. The American Occupational Therapy Association (AOTA) reported difficulty in providing guidelines regarding caseload, because they would vary depending on the acuity of the condition, type of services provided, and nature of the setting. AOTA also indicated that health service organizations, school systems, and state departments of education may have their own policies (Parker-Taillon 2005).

*Please refer to Appendix K, Examples of Caseload Systems in the Literature*

### **Issues that influence caseload management for pediatric speech language pathologists, physiotherapists, and occupational therapists**

#### **Caseload factors in pediatric therapy**

Parker-Taillon (2005) cites seven potential factors to consider when building a caseload:

- contact frequency: measures service demand

- response difficulty: measures client need and level of individual service required
- intervention type: reflects the range of evidence-based interventions
- competence/seniority: reflects the range of skills and experience affecting caseload capacity
- caseload maturity: considers the greater burden of work required earlier than later in the process
- location of clients: considers the geographic distribution of client caseload
- roles other than case management: considers the non-caseload responsibilities.

*Please refer to Appendix L, Caseload Factors in Pediatric Therapy..*

### **Caseload size**

The Canadian Association of Speech Language Pathologists and Audiologists (CASLPA), the Canadian Association of Occupational Therapists (CAOT), and the American Speech-Language and Hearing Association (ASHA) are the only national agencies that have documented caseload guidelines for pediatric physiotherapy, speech language pathology, or occupational therapy. ASHA's guidelines pertain to school therapy.

No references found in the literature search alluded to an ideal caseload size without considering the clients on the caseload. CASLPA (2003) conducted a survey of speech language pathologists who work with children under six years of age. It reported that the average caseload for a full-time equivalent therapist was 46. CASLPA recommended that caseloads for full-time speech language pathologists working with children under six should be between 26 and 30 clients.

The CASLPA survey found that the average caseload size of speech language pathologists who work with school-age children was 65. CASLPA recommended that the caseload for a full-time equivalent speech language pathologist working in the schools should be 36.

Speech language pathologists in private practice suggest they have more work satisfaction because they feel more "in control" of the work they do.

Numerous references suggest using multi-skilled therapists and support staff, personnel substitution, and therapy assistants (Boshoff, Alant & May 2005) as a way to reduce large caseload sizes.

No caseload guidelines were found for physiotherapists in the literature search of materials in the public domain. Guidelines may be available for members of the physiotherapists' professional organization.

## Caseload assignment

CAOT's document *Toward Best Practices for Caseload Assignment and Management for Occupational Therapy in Canada* (Parker-Taillon 2005) is complete and addresses not only caseload management for occupational therapists, but also for physiotherapists and speech language pathologists. The entire document is a critical reference to the topic of caseload assignment. CAOT notes that in the past, caseload models for occupational therapy in Canada tended to focus on caseload guidelines based on averages for indicators that reflected the work actually being done. The report notes, "The trend now appears to be toward using more of a population based approach that seeks to understand and quantify workload using health human resources in relation to the needs of a specific population." (Parker-Taillon 2003, Center for Health Professions 1999, Canadian College of Health Services Executives 2002, Health Canada 2005). The PEW Health Professions Commission (1999) reported on the importance of aligning the configurations of staff and size of the health care workforce with the needs of the public.

CAOT (Parker-Taillon 2005) reports no clear direction for caseload management in occupational therapy in Canada and suggests that research and development is definitely required. CAOT suggests using workforce management and caseload information to launch these projects, with the following guiding principles:

- evidence-based therapy
- cost effectiveness
- accountability
- professional leadership and expert judgment
- comprehensiveness
- flexibility.

Parker-Taillon (2005) also suggests an approach to caseload management that includes three considerations:

Meaningful data will be needed, with measurements in reliable and computerized formats. Database systems are needed to provide accurate, reliable, timely, and accessible real-time information. Management information systems can provide this information.

### Population-specific

The findings suggest that retrospective data is more valid and reliable when considered in relation to clinically relevant and appropriate case groups. These groups can be identified by data availability and caseload sensitivity. CAOT suggests considering such factors as population characteristics, access and demand patterns, and service delivery approaches to specific populations and population outcomes.

Context-specific

Review of client outcomes is important to allow caseload reassignment.

In 2005, CAOT put forward five recommendations for caseload assignment and management, including developing an inventory of caseload practices, holding a consensus workshop, commissioning research, developing framework that integrates evidence-based practice to shape best practices, and conducting more research to evaluate the impact of caseload management practices, all to be completed in three years.

When determining caseload size, many variables need to be considered, including the service delivery model used (Johnson 1996). There are many combinations of service delivery within a caseload, and a client's service may involve spending differing amounts of time, such as monthly monitoring vs. weekly direct treatment. Because of this variation, no direct interpretation can be made regarding a specific caseload number (Boshoff, Alant & May 2005).

**Caseload composition (client mix or case mix)**

A "head count" of case files or even of individual service users or families is not usually a good indication of the actual work involved. Numbers alone do not accurately reflect actual workload. The composition or case mix of a caseload should always be taken into consideration.

A population-based approach to case mix in British Columbia could consider the urban vs. rural services available, geographic isolation, and concentrations of children with similar issues (such as complex developmental and behavioural challenges, with the resulting need for assessment and treatment). Health indicators, therefore, would be different for different regions.

Travel time cannot be overlooked in a province with both rural and urban areas. The focus on the caseload composition would be different for different regions.

The number of clients accepted onto a caseload should be based on the complexity and severity of needs and on standard service protocols that are regularly monitored and reviewed. A more complex caseload requires extra time and responsibility; consideration should then be given to hiring a case coordinator/manager. (Dube and Davis 2005, Department of Disability, Housing and Community Services 2004).

Clear, consistent weighting systems help provide some equity between workers. A weighting system can be developed for each case and therefore each worker's caseload.

A weighting system can be used to:

- agree upon appropriate weightings for each therapist, given his or her level of experience and expertise
- define and assign the type of caseload to help the worker's professional development

- keep a watchful eye on potential stress levels; a preponderance of work with high weightings in one category may indicate potential stress levels better than a count of allocated files
- predict changes in weightings to help formulate professional interventions and intended outcomes (Electronic Library for Social Care [ELSC] 2005).

Some teams/organizations have developed their own caseload management systems by discussing definitions and arriving at consensus. This can create custom criteria to suit the type of service delivered. ELSC (2005) described subdividing a worker's effort into the following three components, with detailed, sequential definitions for each:

- complexity (number of other professionals/agencies involved)
- risk (urgency and status of client/situation [static or changeable], which contribute to professional anxiety), and
- travel (time/distance).

The Queensland Education department chose factors to consider when determining a workload/caseload (Department of Disability, Housing and Community Services 2004). These include the number of students, number of facilities, nature of student disabilities, number of educational teams across facilities, distance and travel time between the facilities, and the model and frequency of other therapies the children are receiving.

In Manitoba a need was identified for a consistent method of caseload rating, caseload selection, and measurement of outcomes from intervention (Robertson 2005). Such a mechanism would assist speech-language pathologists in clinical decision-making, enhance quality assurance, assist transition planning, and provide consistency among clinicians and agencies.

Furthering their attempts at consistency of measurement, the Manitoba Speech and Hearing Association developed an interactive website database to allow speech language pathologists to input caseload information and generate reports regarding caseload composition, severity levels, priority ranking, and outcomes from intervention.

Caseload management is a complex topic. The need for a caseload management framework is widely accepted within the professions of speech language pathology, physiotherapy, and occupational therapy. Evidence-based practice with clinical reasoning and accountability will add to the development of best practices. Caseload guidelines that focus on composition rather than size are more useful. Guidelines should be flexible to allow for individual diversity of service delivery models, disorder and severity of the child, and the work setting (CASLPA 2003). Some organizations are attempting to quantify caseload composition for their specific environments.



**Do caseload guidelines exist that can be applied across the three therapy disciplines?**

The issues around caseload size, assignment, and composition appear to be consistent across all three disciplines. It is unclear from the literature if the same caseload guidelines can be applied to speech language pathology, physiotherapy, and occupational therapy.

## **Provincial Perspective**

Caseloads are reviewed by size, composition, and weighting.

### **Caseload size**

It appears from the survey results that, although a range of ideal caseload sizes was reported, there was some consensus across the three therapies for ideal caseload size ranges for early intervention. There was not a wide range of respondents working in school-age therapy; therefore, the ideal caseload recommendations for this age group are less well researched.

There is no provincial definition for the term “caseload.” Therapists asked such questions as: “Is a child I monitor once every six months on my caseload?” or “Is a child considered active if I gave him some situational ideas in a preschool?” A child is often reported as receiving “direct” or “indirect” service, on “active” or “inactive” service, “on block” or “off block,” on or off the caseload, or back on the waitlist. A province-wide definition would be useful so therapists could discuss caseloads equitably.

### **Current perspectives on caseload size in BC**

Therapists report that the current caseload size is very high. Caseloads range between 15 and 200, depending on the service delivery model and location of service. Therapists who provide consultation only, such as in a school district, report much higher caseloads than therapists in early intervention, who are expected to provide a full range of service for children before entry into kindergarten. This full range is expected to include screening, assessment, treatment, monitoring, and consultation.

Many therapists report they are pressured to provide service within three months or less. This pressure could be from attempts to meet the Ministry of Children and Family Development 2006–2008 performance measure, “Percent of children under six with special needs receiving an early intervention therapy within three months of service request.” Therapists report caseload sizes have increased to meet this goal, and with the limited human resources present, the service becomes so “watered down,” the therapist feels it is much less effective. Therapists report a desire to cap caseload size and provide a service that is best practice. For many, the effect would mean an increase in the waitlist.

### Ideal caseload size

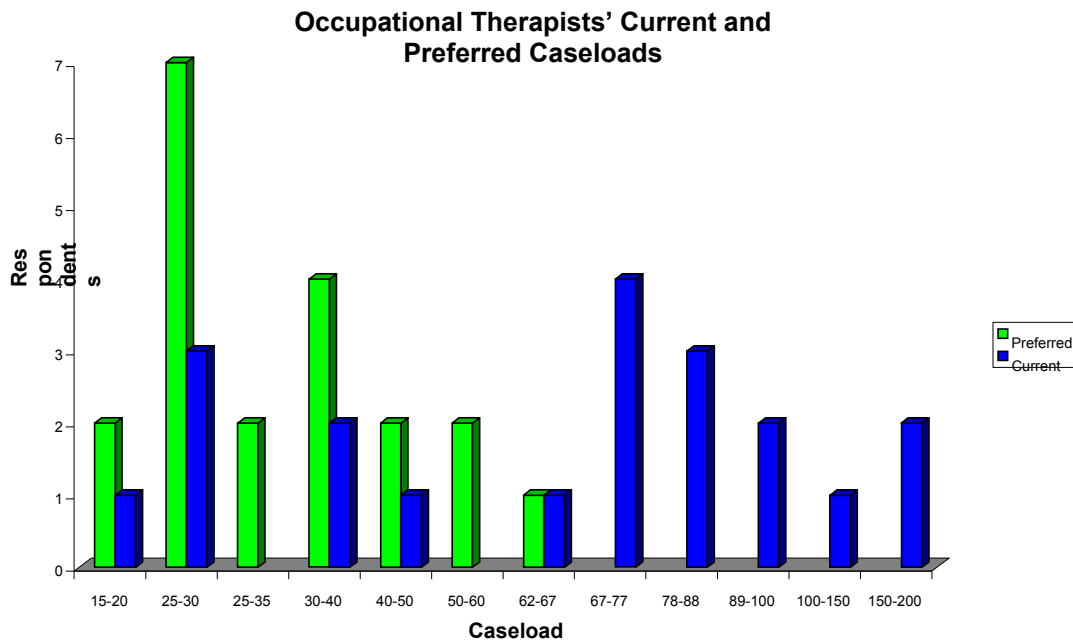
Therapists most commonly believed an ideal caseload would be 25–30, to provide a more adequate service. This was true of speech language pathologists, physiotherapists, and occupational therapists. (Please refer to Figures 8, 9, and 10.)

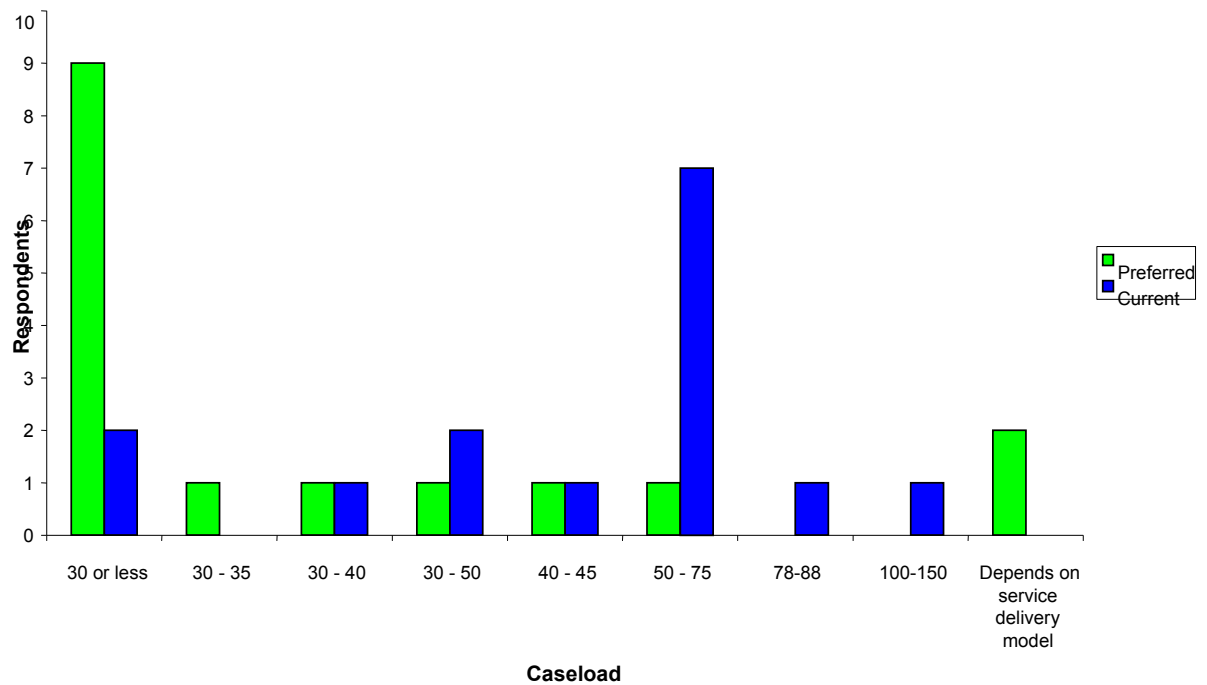
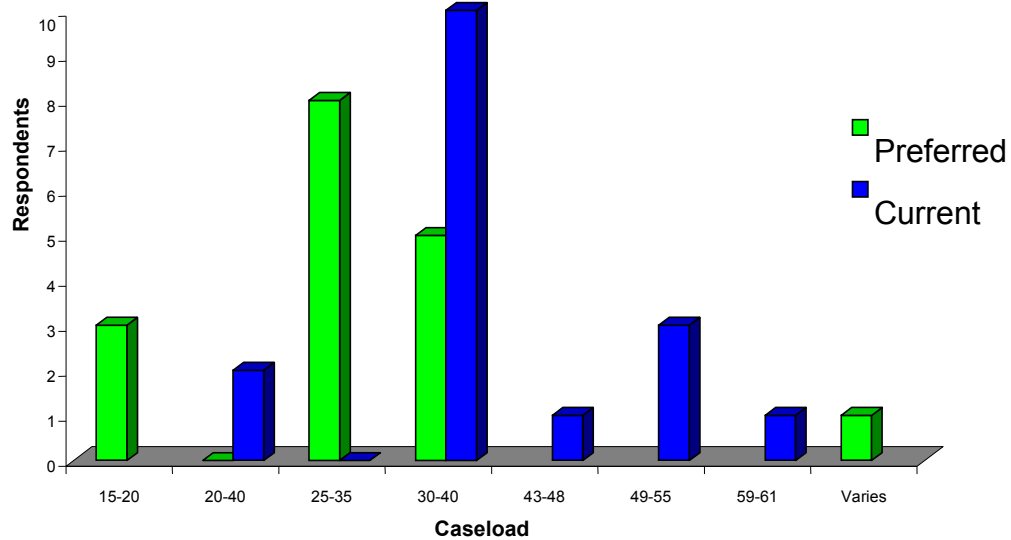
Some school therapists who provided consultation only believed a caseload of 60 would be manageable.

Therapists reported that a caseload cap would help promote not only improved service for the child, but also job satisfaction and some equity among staff.

It is important to note that caseload size alone is not necessarily indicative of the number of children being seen or needing to be seen. It could include cases seen weekly, with heavy family and community involvement, and cases that are only monitored once every three months. Caseload size alone does not account for individual differences within cases that may allow a higher or lower caseload, such as travel distance and time involved in specific intervention, such as serial casting.

**Figure 8**



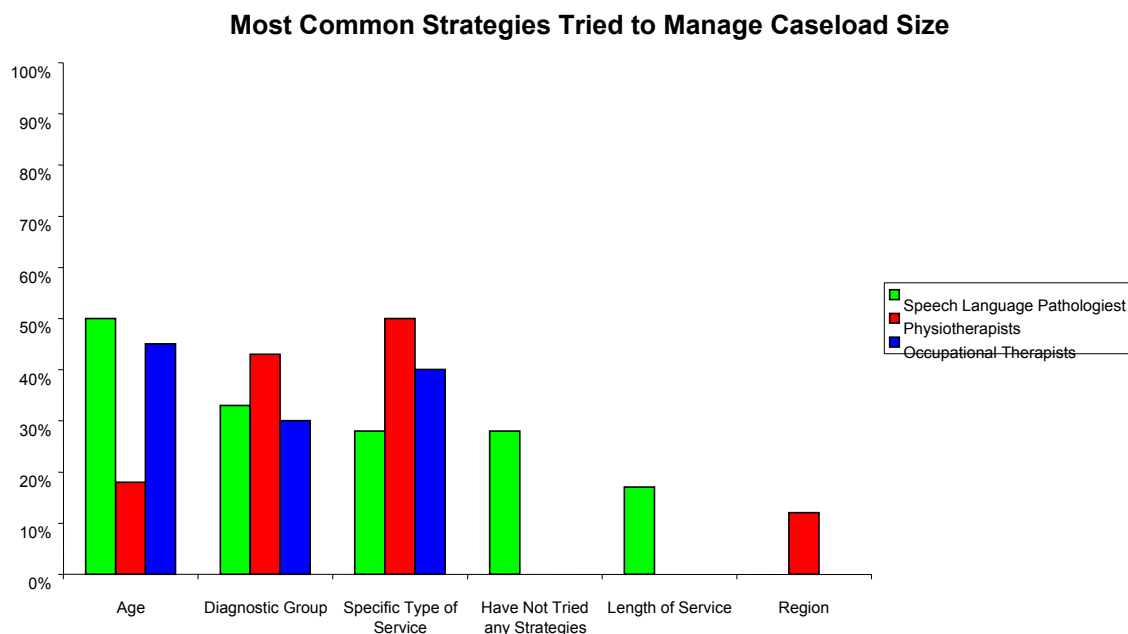
**Figure 9****Physiotherapists' Current and Preferred Caseloads****Figure 10****Speech Language Pathologists' Current and Preferred Caseloads**

## Strategies to manage caseload size

Therapists in BC try many strategies to manage the size of their caseloads, to provide a quality service for fewer children rather than disjointed services and what they view as less effective services to a larger number of children. Therapists reported this is related to their feelings of job satisfaction. (Please refer to Figure 11, Most Common Strategies Tried to Manage Caseload Size.)

The most common strategies include: limiting the service by age (speech language pathology, occupational therapy), diagnostic group (speech language pathology, physiotherapy, occupational therapy), or by specific type of service offered (physiotherapy, occupational therapy). Altering the service delivery method — for example, monitoring — providing group treatment instead of one-on-one treatment, or treatment block were also common strategies. Other therapists tried prioritizing cases based on functional need or a numerical value.

**Figure 11**



At least one centre is reviewing, but not yet using, the quota system described by the David Thompson Health Region in Alberta, which calculates caseload based on a formula of caseload cap, funded time for service, direct and indirect percentages:

- caseload cap x direct service % = maximum number of direct clients
- Caseload cap x indirect service % = maximum number of indirect clients

A formula including the average number of attendances per day, averaged over a year for the FTE and adding in percentages for travel and documentation time, is used by at least one centre.

In larger centres, children are sometimes allocated to therapists based on limiting factors, such as type of service required, diagnosis, age, and location of service. This allows a therapist to become more proficient and efficient in a smaller number of service areas. Small group intervention is used more with this strategy. In smaller communities, where sole charge therapists are common, this is not possible unless more than one part-time therapist is present.

In rural communities, where travel to a home visit can take two hours, and in dense urban communities where traffic is heavy, therapists often either limit service to more local children or allocate by region to save on travel time, where possible.

A team approach is used in most centres. This shares the load and can provide a broader service. The primary therapist may shift over time.

Collaborative arrangements have been made with speech language pathologists in some local health units and child development centres. Several situations have been reported: the health unit speech language pathologist sees children from a specific region or children requiring only a specific type of service, or the health unit therapist functions essentially as a member of the child development centre.

Some centres and clinics have caseload caps and guidelines that state a new client cannot be added to the caseload until an existing client is discharged. These centres report longer waitlists, and therapists report less job dissatisfaction.

Other centres discharge a child when the original referral priority has been achieved. The child can go back on the caseload (or waitlist) for another issue. The original date of referral is recognized. Children can come on and off service frequently. It has been reported that families anxious about their children being discharged feel calmer knowing they can come back. A percentage of families reportedly do not come back.

Therapists reported using clinical decision-making when deciding whether or not to discharge a child from their caseload. Some of the factors in these decisions include:

- child's development is within typical range or has plateaued
- child appears to need a break from therapy, is moving, or is leaving the funded system
- family is satisfied with progress
- family priorities have changed
- family objectives have been met (or not)
- child fails to meet minimum attendance guidelines
- child's functional goals have been met
- no request for service has been received for a year

- child is able to access school curriculum with dignity.

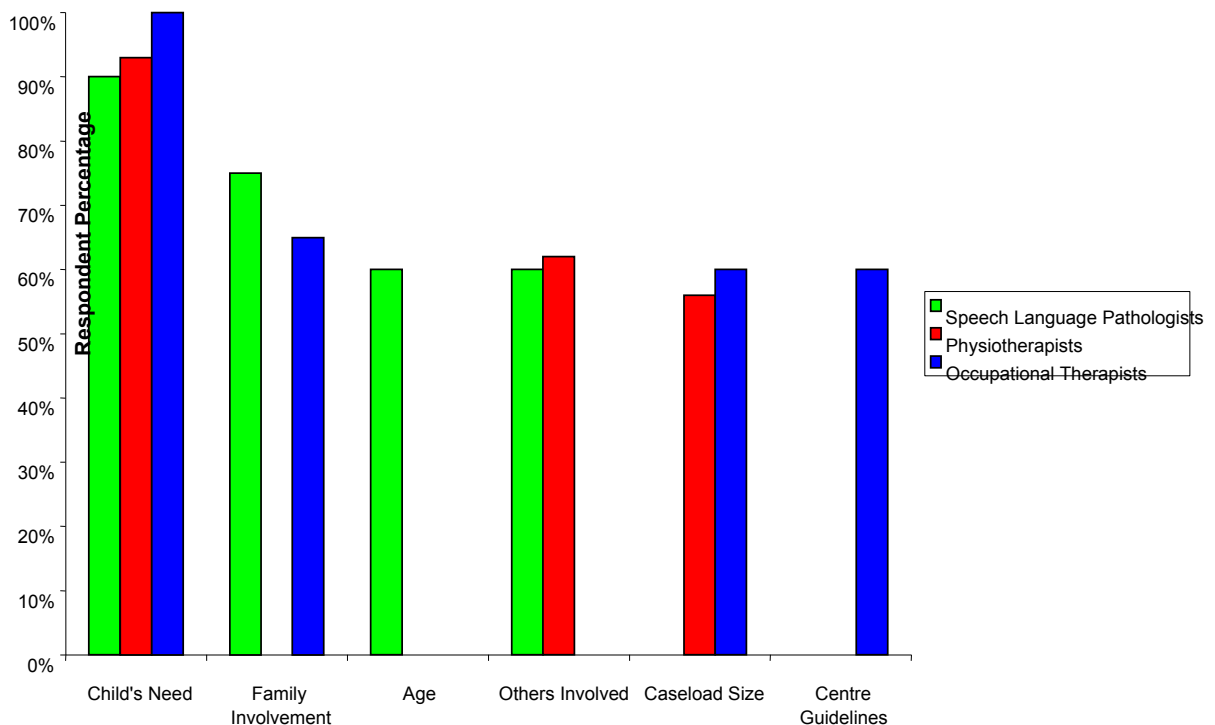
### **Caseload composition**

Across BC, therapists' caseloads are primarily comprised of children with a wide range of diagnoses, severity of conditions, and service needs. When more than two therapists are present, a therapist's caseload is sometimes comprised of children with a smaller range of need.

Therapists report becoming overwhelmed by high caseloads. This is most prevalent when the numbers are too high, or when a higher proportion of children and families require more in-depth service. Therapists state they often must decide whether to provide that in-depth service, forcing cancellation or limiting of another child's service to accommodate the new referral, or to continue providing a service that is not meeting the child's and family's need. Figure 12 indicates the factors therapists consider when choosing a service delivery method.

**Figure 12**

#### **Factors Therapists Consider when Choosing Service Delivery Method**



Constant rescheduling reportedly occurs for some therapists around the province, as

they try to decide what service delivery choice to make for the children they see. One therapist remarked, “I am trying to manage an active caseload of 25 clients, many of whom have high needs, while trying to address the assessment waitlist and monitor the clients on the therapy waitlist.”

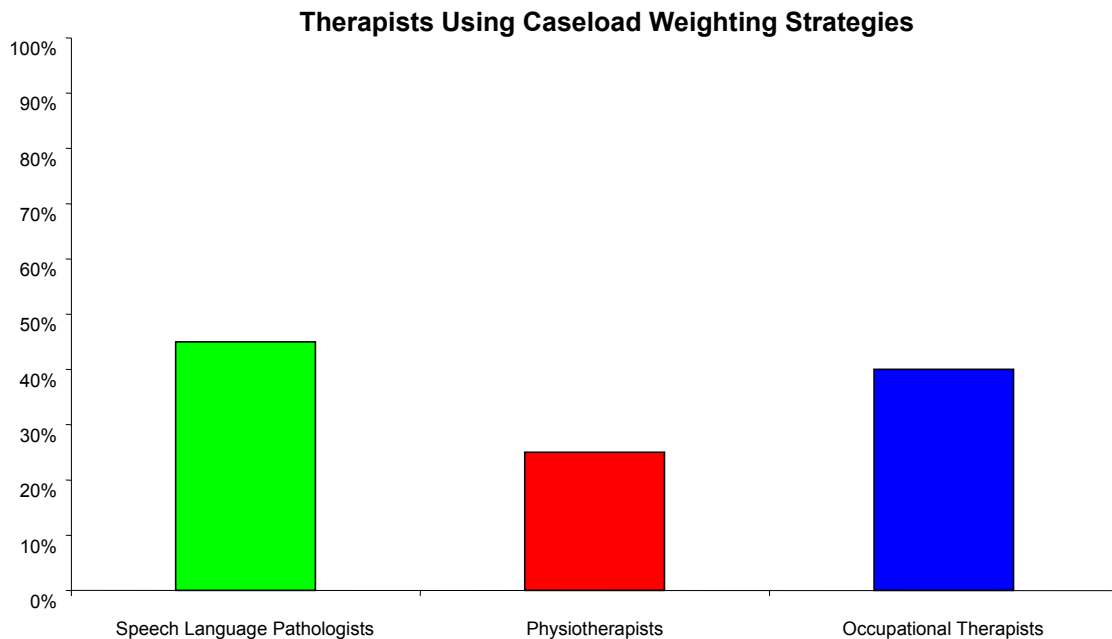
### **Caseload weighting**

Weighting a caseload ensures the therapist is aware of and can predict how much time the child needs. Weighting helps justify a lower caseload size if the children referred have a higher rating. Caseload weighting also helps provide some workload equity among staff at the same centre.

*Please refer to Appendix M, Examples of Caseload Weighting Strategies Used in BC.*

Fewer than half of the survey respondents are currently using a caseload weighting system. (Please refer to Figure 13.) Some use a standard method, such as a 2-, 3-, or 5-tier rating system, or an informal method. Some speech language pathologists use the Manitoba Outcomes Measures System (MOMS). Some centres used MOMS to develop clear guidelines around the general areas of service expected to be provided for a child with a specific priority rating. At least one centre reported that when staffing levels decrease, the centre shifts from caseload weighting to prioritization by date of referral only.

**Figure 13**



Several centres use an intervention intensity model, which has the following features:

- 100 points assigned to one FTE, with a 10-point leniency if the therapist is new to pediatrics or the agency
- intervention intensity rating assigned to each child.

Concern was raised regarding weighting children's needs, as high-incidence children, for whom intervention could have the most positive impact, are often not eligible, as they are "not severe enough."

It was also reported that some parents advocate for a set level of service with a set minimum hours of service per week, instead of having the level of service match the actual need of the child.

### **Recommended Guidelines**

Therapists must be able to review their caseloads at any time to determine if, by taking on another case, they can still provide adequate service to their existing caseloads as well as to the new client.

Unmanageable caseloads have been reported around the province and appear to be clearly linked to retention difficulties. Caseloads should be limited, as is practical within the setting and philosophy of the agency in which the therapists work. This could help ensure quality service while allowing therapists to feel good about what they do, thus helping prevent professional burnout.

It is important that therapists and administrators within the same agency meet and establish consensus on the most effective strategy for managing caseloads, to provide equity and an ability to work together from the same perspective.

#### **Caseload size**

Providing guidelines for maximum caseload size is a task not to be taken lightly. Giving suggestions for caseload numbers, without considering who those children are, what they need, and how they need the service delivered, does not provide an actual representation of workload.

A number of factors must be considered when deciding if a therapist has time for an added case. The most obvious are frequency of service (once a week or once every six months, for example) and service delivery options (direct one-to-one treatment vs. a transdisciplinary consultation, for example). However, some therapists and administrators would rather have a range of caseload sizes to use as a guideline to help negotiate for more staff and/or to explain the long waitlists.

Caseload size ranges could be developed into guidelines for speech language pathology, physiotherapy, and occupational therapy if they were also closely associated



with some related factors.

*Please refer to Appendix N, Related Caseload Factors.*

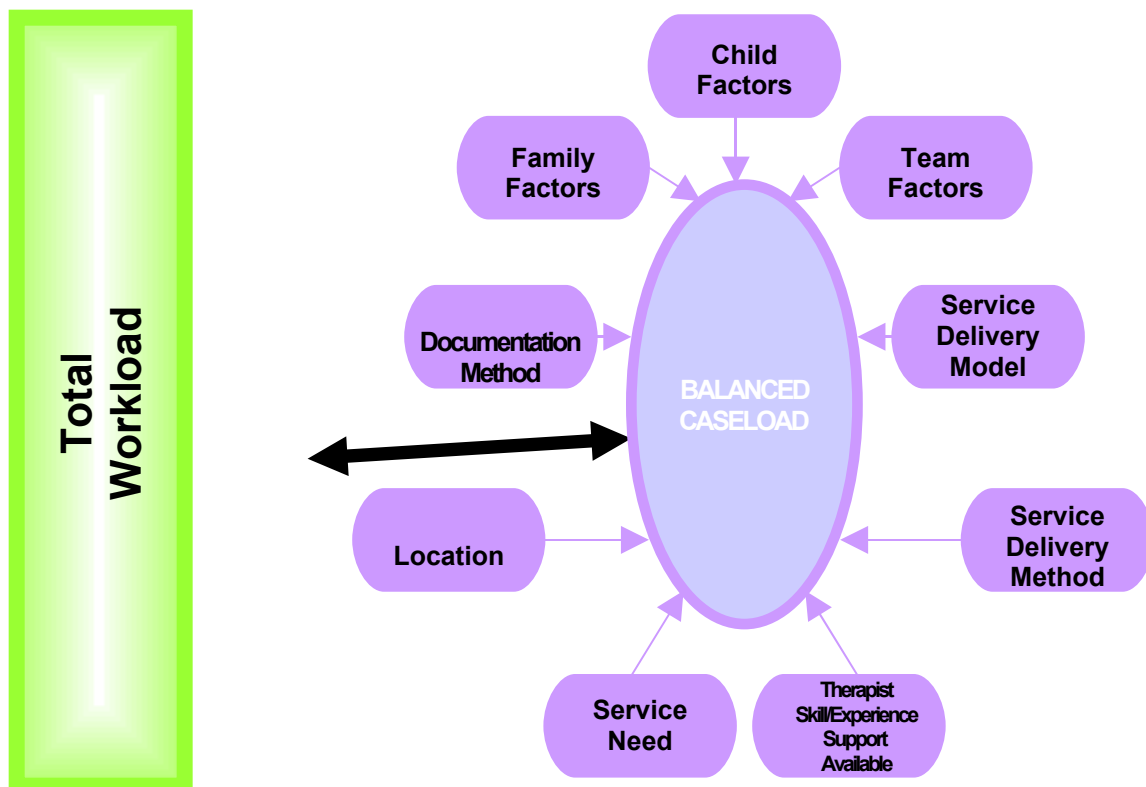
Early intervention and school-age therapy would also need to be considered separately, as these are very different services because of funding inequities and service delivery models.

### **Caseload composition**

With increasing service demands, only the more complex cases are being seen, reducing the variety of cases composing a caseload.

**Figure 14**

### **BALANCING YOUR CASELOAD**



**Balancing caseload**

“Balancing a caseload” refers to weighing details about a child’s case and assigning a value for the time involved in dealing with the case. This value is balanced with and against those of other children on the therapist’s caseload to promote an evenly balanced caseload, leading to a manageable workload.

The value can be reported as an estimation of complexity or as a numerical level or rating that refers to the estimated time needed to work with a specific child with a specific referral issue. A standard system is often used within the same facility, with guidelines for the suggested values for an FTE staff therapist to ensure equitable and reasonable caseload composition and sizes.

Further, this information is balanced with the therapist’s total workload activities, for example, half a day a week on accreditation duties. If the therapist does not consider the total workload when building and maintaining a caseload, there is a real danger of over-scheduling and burnout.

To balance a caseload effectively, a therapist must consider not just adding the new case and figuring a caseload total, but all the related factors around a case. Please refer to Figure 14, Balancing Your Caseload.

**Caseload recording**

It can be a challenge to keep track of a caseload, both for the therapist and for the immediate supervisor. It can be equally challenging to ensure caseloads are somewhat equitable for therapists in the same agency. A recording form may help track caseloads, especially over time. The sample caseload recording worksheet, included as an appendix, records the number of cases seen, location of service, how many are receiving differing amounts of intensity, and other work activities that require the therapist’s time.

*Please refer to Appendix O, Caseload Recording Worksheet.*

When balancing a caseload, numerous related factors must be considered to determine when a therapist has actual time to dedicate to a new case. Regular rebalancing is important, as cases fluctuate in their complexity and time needs. Cases can be heavier at the beginning or later, as a child deteriorates or transitions to kindergarten or adult services.

To review the complexity of a referred or new case, and balance it with the other active cases, one must consider the time needed to address the related factors around the child’s referral.

### **Recommended caseload strategies**

The following caseload balancing strategies, applicable to a variety of settings, are recommended for flexible solutions.

#### **Strategy #1: Balancing Caseload by Size and Related Factors**

##### **For use by**

Speech language pathologists, physiotherapists, occupational therapists

##### **Description**

The caseload is balanced by not exceeding a suggested number of cases. The Provincial Consultant for Pediatric Therapists suggests the following (with close consideration of the related caseload factors listed in Appendix N):

Early intervention therapy:

*suggested caseload size: 25–30 for 1 FTE*

School age therapy:

*suggested caseload size: 36-60 per 1 FTE*

*Please refer to Appendix P, Caseload Size Worksheet.*

##### **Limitations**

Using caseload size alone has significant limitations. It does not take into account the complexity or related factors of a case, nor does it consider the therapist's total workload expectations.

*Please refer to Appendix O, Caseload Recording Worksheet.*

#### **Strategy #2: Balancing Your Caseload by using Flexible Service Delivery Models**

##### **For use by**

Speech language pathologists, physiotherapists, occupational therapists

##### **Description**

Flexible service delivery models are used to provide service, rather than a one-size-fits-all approach. Models that use a more integrated approach are often considered.

The child may be receiving several single-discipline therapy sessions per week. The family may be spending three hours per week at the centre. A transdisciplinary model can reduce the number of hours at the centre by integrating several therapies, perhaps delivering these in a child's natural environment.

Not all children need direct one-on-one treatment to provide the best outcome. Providing your expertise and training for family members, education assistants, supported childcare workers, and infant development workers, as well as other therapists on your team, may result in a broader base of intervention throughout the child's day. This model can increase intervention opportunities in the child's natural environment.

##### **Limitations**

This strategy is difficult if the therapist is inexperienced, or if it occurs in a location where there is little support from other disciplines.

### Strategy #3: Balancing Your Caseload by Intervention Intensity and Related Factors

#### For use by

Speech language pathologists, physiotherapists, occupational therapists

#### Description

The intervention intensity model involves rating a child's case on a numerical point system as well as assigning a number value, reflecting the time involved, to other clinical services the therapist may provide. For example, monitoring a child once every three months would be assigned a point value of 1, whereas weekly intervention would be assigned a point value of 4. Other clinical services, such as coordination of a visiting clinic or group, or department leadership responsibilities, can be given point values to reflect the actual time involved.

Each centre must customize this model, assigning points for each clinical service offered. The centre then determines how many points relate to a full caseload for one FTE, considering the total workload expectations. For example, if the total point value for an FTE is considered 100, or 100%, and department leader responsibilities amount to 60% of the therapist's time, then the responsibilities of the department leader would total 60 points, leaving 40 points for other activities.

It is important to consider the total workload in these equations. For example, a centre may determine that the maximum amount of clinical time will be 60%, to allow time for other workload activities. In this case, the maximum number of clinical points for a therapist would total 60.

*Please refer to Appendix Q, Intervention Intensity Guide.*

#### Limitations

Each centre customizes this system, so it is difficult to compare its use between centres. Otherwise, the limitations are minimal.

### Strategy #4: Balancing Your Caseload by Using Session Numbers

#### For use by

Speech language pathologists, physiotherapists, occupational therapists

#### Description

Numbers of clinical sessions are determined for each FTE. A session refers to an open clinical appointment related to a child on the caseload.

The open session time can be filled with a direct intervention session, such as direct treatment. It could also be filled with an indirect intervention session, such as preparation, documentation, treatment planning, research, travel time, meeting, and communication with other team members. Each centre defines the appropriate number of clinical sessions, taking into account each therapist's total workload requirements. Currently, this indirect time is often fitted around direct appointment times or in spots where appointments have been cancelled, taken home and completed on unpaid time, or never completed.

For example, if a centre determines 60% of the therapist's time is directed to clinical time, and a therapist works 37.5 hours per week (with one hour for lunch and breaks), and session times are one hour, then an FTE therapist would have time for approximately 17 sessions per week. But to do the proper calculation, one would need to factor in holiday time and stat holidays, which can be 28 days per year for a therapist who has four weeks' vacation time and eight stat holidays. A centre would need to consider this and lower the weekly session numbers relative to that therapist's employment details. In the above example, the therapist's average could drop to 10.4 sessions per week.

#### Limitations

The calculations required to determine a therapists' number of clinical sessions can be perceived as complex.

### Other ways to assist therapists to manage their caseloads

#### Hiring rehabilitation assistants

Rehabilitation assistants can help a therapist in those activities that are time-consuming and take away from direct clinical intervention time. Rehabilitation assistants can be a welcome addition to a department by, for example, providing clinical support, preparing materials, locating and organizing equipment and resources, finishing splints, and adapting equipment. Supervising therapists must allocate time for supervision to ensure the rehabilitation assistant is working safely.

#### Reallocating administrative tasks

In the survey, many therapists listed administrative tasks as being very time-consuming, reporting that they lacked not only the time, but the skill to perform many of these tasks efficiently. Reallocating some administrative time to the therapy departments would help free up clinical intervention time. Administrative tasks include preparing written handouts, education materials, and flyers; photocopying and laminating; locating and creating visual supports; and scheduling. As additional examples: administration can create text

reports from worksheets filled in by hand with clinical data; administrative departments have the skill to develop computerized systems, such as “drop-down” menus, from content provided by therapists, to shorten the time required to generate reports; administrative staff or rehabilitation assistants have the expertise to insert graphics and customized digital photos into treatment programs and reports, using the content provided by the therapist.

## WORKLOAD

### Terminology

#### **Total workload**

Workload refers to all the activities a therapist performs, not only in direct service, but also the indirect activities that promote professional discipline-specific development for improving service and outcomes, as well as administrative tasks required by the employer, accreditor, professional college, or facility as part of the therapist's professional role.

#### **Manageable workload**

A manageable workload should be defined as the amount of work that can be completed in a reasonable number of hours, and tasks that can be accomplished without undue pressure.

### Literature Review

Manageable workloads are considered directly related to effective recruitment and retention of pediatric therapists (New Brunswick Physiotherapy Association 2005, Cameron, McLean, & Namazi 2001).

For most pediatric therapists, having a sustainable workload is an important aspect of a quality work life. Having too much work can create stress, affecting health and well-being over time. How a therapist perceives whether the workload is manageable or not is related to that therapist's perception of the quality of care he or she provides. Determining a reasonable workload is the subject of ongoing discussions and negotiations between many professions and agencies. Manageable workloads have been identified as being interrelated with service delivery, caseload size, and composition, as well as waitlist management.

Many external and internal factors affect a therapist's perceptions of and abilities to maintain a manageable workload. Therapists are expected to provide clinical service within external structures, such as specific models of service delivery, regulations, codes of ethics, standards of practice, funding limitations, and specific staffing. Therapists must balance these external structures with other factors, such as total workload (direct and indirect time), workplace responsibilities, and workplace flexibility. To promote manageable workloads, pediatric therapists require skill and support to ensure an equal balance in all areas.

**What influences manageable workload in pediatric speech language pathology, physiotherapy and occupational therapy?**

## External factors

Pediatric therapists often work with large caseloads and are pressured to provide more and more clinical service, as many children are often waiting for service. Therapists work within a framework of professional regulations, quality standards, and current knowledge.

A number of external factors affect therapists' ability to manage their work, especially if time is not allocated to these important components of professional practice.

### Caseload/waitlist size

Manageable workloads are a factor in the retention of pediatric therapists; a plan was created for recruitment and retention of pediatric therapists in British Columbia (Cameron, McLean & Namazi 2001). The authors of this report stated, "Therapists, senior therapists, and senior administrators overwhelmingly listed caseload size and lengthy waitlists as factors significantly contributing to 'burnout' and dissatisfaction with the job, thereby leading to people leaving their jobs or their profession." They went on to discuss that overwhelming caseloads and large waitlists result in frustration, anger, and dissatisfaction among families whose children are waiting for therapy services, or those who can't get the appropriate level of service for their children. They stated that this presents "an ethical dilemma, especially in the face of the extensive body of research, which demonstrates that early intensive intervention works."

A 2005 initiative of Health Canada, Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP), discusses heavy workloads and staff shortages, especially in northern and rural communities, which face a high turnover rate and burnout. Health Canada went on to report that health professionals are demanding a more balanced lifestyle with less strain at the workplace.

### Regulation

Therapists are required to ensure their practices provide quality service, performed competently and ethically, with adequate and appropriate knowledge of therapeutic techniques. To work within their profession, therapists must work under the regulations set forth by their respective professional colleges or associations. These groups develop, establish, and maintain programs and standards of practice and promote continuing competence among members. The *Regulated Health Professions Act* (Government of BC 1996) granted self-regulation in the provision of health services, to protect the public. This act mandates quality assurance and continuing competence as essential components of regulation for all health professions. Occupational therapy and physiotherapy are regulated health professions in BC.

The PEW Commission (Center for Health Professions 1999) suggests reforming the ways in which health care professionals are regulated to promote responsive independence and competence while protecting the public from harm.

### Quality

Each health care profession develops standards of practice to ensure the quality of professional services and to promote continuing competence among members, to help protect the public. A standard of practice helps a therapist measure the degree to which a service provided meets the profession's expectations for acceptable quality. Accountability for competence of performance is shared not just by the individual



therapist, but also by the regulating body, the academic community, the national and provincial professional associations, the practice setting, and the employer, to name a few.

Quality services are referenced against quality management frameworks, standards of practice, clinical practice guidelines, and professional codes of ethics. The College of Physiotherapists of Ontario developed a publicly accessible quality management framework in 2003 to promote quality practice and to support registrants in ongoing efforts to apply knowledge, skills, and judgment, and to ensure competence. This framework focuses on competency reflection and integration, competency assessment, and competency improvement. Many colleges and professional organizations have such guidelines, but many are not publicly accessible. Quality assurance accreditors do review overall therapy services at accredited agencies.

Therapists may feel unsettled around self-assessment of competence. The American Speech-Language-Hearing Association (ASHA) has a publicly available code of ethics to help guide professionals. This code cannot determine if a given practitioner is competent to perform a clinical procedure or participate in a particular area of clinical practice, but it can assist the practitioner in making this determination. Therapists who have established competence still have an ethical responsibility to evaluate outcomes of their actions. As stated in the ASHA Code of Ethics, Principle of Ethics I, Rule G, “Individuals shall evaluate the effectiveness of services rendered . . .” (Mustain 2003). Therapists should be recognized when reporting a lack of competence to perform a service or when making recommendations about ethical or ineffective outcomes of services. The lack of support, time, or recognition can affect therapists’ ability to manage their workload.

### Education

Therapists must keep up to date with a large amount of information. This requires time and resources, which can affect a therapist’s ability to manage workload.

Opportunities for various types of professional development are important for the retention of therapists in British Columbia as well as for the “provision of ethically sound therapy services based on current ‘best practice’” (Cameron, McLean & Namazi 2001). Therapists have an ethical responsibility to continue professional development throughout their careers, to assess personal competence and client benefit. William Mustain, in an article for the *ASHA Leader Online*, stated that acquiring new knowledge and skills is necessary to assure that our dynamic professions continue to meet their ethical responsibilities to engage in lifelong learning (Mustain 2003). Therapists will often be called upon to develop clinical skills beyond those developed during undergraduate and graduate training. The Pew Commission (Center for Health Professions 1999) reported that health professionals must ensure their education and training efforts are consistent with the changing demands of the care delivery system.

Therapists listed time, funding, and availability of courses as factors to consider when pursuing educational opportunities. Therapists in rural locations reported that geographic isolation makes professional development a challenge; greater travel costs and travel time can limit essential professional growth and peer support. Suggestions included videoconferencing, circulating videotapes, provincial coordination of professional development, and mentoring. Telehealth and online education has been used effectively to reduce isolation and provide access to professional education (Health Canada 2004).

According to the College of Physiotherapists of Ontario (2003), “It is estimated that the half-life of health care knowledge is two years.” This means that two years from the day a therapist graduates, half the information that therapist learned is obsolete. Professional development is essential for therapists to remain current on the changing knowledge in pediatric rehabilitation. This knowledge should evolve into best practice, leading to efficient, effective provision of therapy services in British Columbia (Cameron, McLean, & Namazi 2001).

### Ethics

Therapists are responsible for adhering to and promoting ethical practice. When becoming professionally registered, therapists accept fundamental ethical principles to fulfill their obligations to clients, the profession, and society. Each professional organization has guidelines for appropriate conduct in situations of uncertainty, and these serve as a basis for reflection and self-evaluation (College of Physiotherapists of Ontario 2005, Canadian Occupational Therapy Association of British Columbia 2005, Physiotherapy Association of British Columbia 2005, British Columbia Association of Speech Language Pathologists and Audiologists 2005, Mustain 2003).

### Workload measurement data

Data on manageable workloads is necessary to inform and support therapists’ clinical decision-making.

The Canadian Institute for Health Information (CIHI) is developing new national supply-based databases for occupational and physiotherapists (2005). Speech language pathologists were not mentioned in the CIHI literature.

Health Canada’s EICP examines forecasting models for health human resources (2005). The report states that these models are still in their infancy and tend not to be accurate at present, due to poor data sources and shifts in disease burden, factors that lead to difficulty in accounting for changes in the practice environment, budgets, hiring, and distribution. The CIHI will help provide a framework for collecting this information, with the exception of that relevant to speech language pathology (2005).

Benefits of being part of these new national health human resources databases, as reported by CIHI, include:

- participating in the development of national standards for health human resource information — for internal and external use
- standardizing data information — for use across jurisdictions
- collating of quality information — for research and planning
- providing annual profession-specific analysis of the data collected within the database
- increasing exposure of the profession at provincial, national, and territorial levels.
- informing policy-makers and promoting evidence-based solutions to health human resource issues.
- enabling more comprehensive research studies on the profession
- providing supply-based data to better plan for the profession.

### Health human resource planning

The government of Saskatchewan has developed an integrated health human resource plan (Ward, 2005) to address issues of quality of care, workplace environment, education and training, evidence-based planning and roles, responsibilities, and relationships at work.

The plan, not yet implemented, includes broad categories, such as:

- experimentation and flexibility of new strategies
- a common set of guidelines and definitions, e.g., staff mix, scope of practice, competencies
- information sharing, data linkages, coordination between educational institutions and workforce needs
- improved access to professional development

The plan suggests the following implementation strategies:

- develop an interprovincial exchange of information related to health human resources
- create common definitions
- create a provincial health human resource body comprised of all stakeholders.

The Canadian Physiotherapy Association (CPA) reports on desired outcomes of healthy human resource approaches: integrated, interprofessional service, based on population needs, utilizing full scope of practice and ensuring maximum access (2006). Because primary care includes health promotion and disease prevention, the CPA also suggests paying more attention to needs-based approaches that reflect a population's demography, culture, geography, and epidemiology.

CIHI also maintains health personnel databases on a number of health care professions in Canada. The type of information maintained on each profession varies, depending on availability of data. Most of the data is supplied by national or provincial regulatory/licensing authorities, professional organizations, governments, and educational institutions. The data includes quantitative information.

### **Internal factors**

Several internal factors appear to affect a therapist's perception of a manageable workload:

#### High caseloads

Job satisfaction is related to the opportunity to provide quality care. An emphasis on quantity versus quality reduces job satisfaction. There appears to be a correlation between high caseloads and lower perceptions of job satisfaction, thereby preventing therapists from providing the quality of care they desire and are trained to provide (New Brunswick Physiotherapy Association 2005), and self-perception of decreased clinical effectiveness (King, LeBas, & Spooner 2000). High caseloads have been reported to be related to a risk of burnout, stress, and increased sickness levels in community mental health nurses (Dube & Davis 2005) and therapists.

### Activities

Workload management expands the focus beyond client-therapist treatment and acknowledges that the therapist operates within a professional environment of some complexity as a member of an organization. It takes into account indirect work, such as meetings, professional development, education, teaching, mentoring, personal needs, innovation, documentation, travel, telephone and email communication, clinical supervision, and consultation with staff. All work settings have a large contingent of indirect activities.

Because of staff shortages and increasing waitlists for pediatric therapists in British Columbia, therapists have limited time for management duties such as mentorship, supervision of best practice, and encouraging staff progress toward professional goals, to name a few. Therapists in management are instead performing significant direct client service as well as basic management activities such as hiring, performance reviews, resource development, and purchasing, (Cameron, McLean & Namazi, 2001).

### Workplace flexibility

In the UK, Allied Workers found that financial incentives alone do not attract and retain workers. Workers found flexible hours, assistance with travel, and daycare, measures that reduce stress in the workplace, were more attractive incentives. (Health Canada, 2004).

### Time

Generally, a manageable workload means having enough time to do a job well, being able to balance work and personal life, and not feeling constantly stressed.

Cameron, McLean and Namazi (2001) also discovered that many therapists in British Columbia are spending significant time doing “non-therapy” (indirect) work that could easily be carried out by a support person. Non-therapy work significantly reduces the time therapists have for direct client care and reduces the number of clients that can be seen. In their 2001 report, Cameron, McLean and Namazi recommended providing core funding for therapy aides and administrative support, to promote retention of pediatric therapists in British Columbia.

Estimating how much and what type of indirect responsibilities are required for a particular position allows the therapist to determine the time and resources required to complete this indirect, but necessary, work. This allows team members to share tasks while maintaining differing spheres of responsibility and expertise, such as school-age vs. early intervention service.

Reviewing total workload helps:

- identify the overall pattern and rate of work
- estimate appropriate timescales and apportioning of necessary activities
- determine most effective use of time and effort
- allow resource allocation to be fairly measured (eLSC 2005).

Activity measurement

Workload management can encompass workload measurement. One such system is described as Management Information System (MIS) (Connell 2005). CIHI coordinates maintenance of a comprehensive MIS in Canada, which includes national workload measurement systems and reporting frameworks. CIHI currently collects information for physiotherapists and occupational therapists, but not for speech language pathologists. In 1996, CIHI suggested a framework with MIS revisions that could be used by a variety of disciplines reporting to a single manager. The provinces and territories decide on the information to be reported to CIHI, which compiles the database. This workload measurement system is often referred to as WMS.

WMS classifies workload data into two categories of workload unit (activities that fulfill the primary service mandate of the workplace): service-recipient activities (such as assessment, therapeutic intervention, and consultation) and non-service recipient activities (such as research, teaching, organizational, and professional activities). Therapists record their own statistics as to how they use their time. The objective of WMS is to collect information that can be tracked, to help determine budgets, resource allocation, and staff and skill mixes, to assess productivity, to estimate full-time equivalent staffing, and to track referrals and wait times. Organizations need clear definitions of all aspects of the workload, so that statistics can be collected accurately. Implementation and data reporting takes time. The data collected should inform decisions (Health Canada 2004). This data is often used for funding allocation, so it is important that the information collected is appropriate, meaningful, and useful.

It is well documented that there is a significant nursing shortage in Canada. Health Canada (2004) funded a project of the Canadian Nurses Association's Canadian Nursing Advisory Committee, with the intention to study nursing workload measurement tools as a way to provide better decision support. The findings included the fact that 50% of nurse employers in Canada are not using workload measurement tools.

No information in the literature referred to manageable workloads in British Columbia while working in different systems (early intervention vs. school vs. hospital) or under different funding agencies (such as the Ministry of Children and Family Development and Community Living British Columbia). The literature reviewed did not discuss differing factors affecting manageable workloads among speech language pathologists, physiotherapists, and occupational therapists.

**Are manageable workload issues the same for all three therapy disciplines?**

Yes, it appears the same issues relating to manageable workloads apply to speech language pathology, physiotherapy, and occupational therapy.

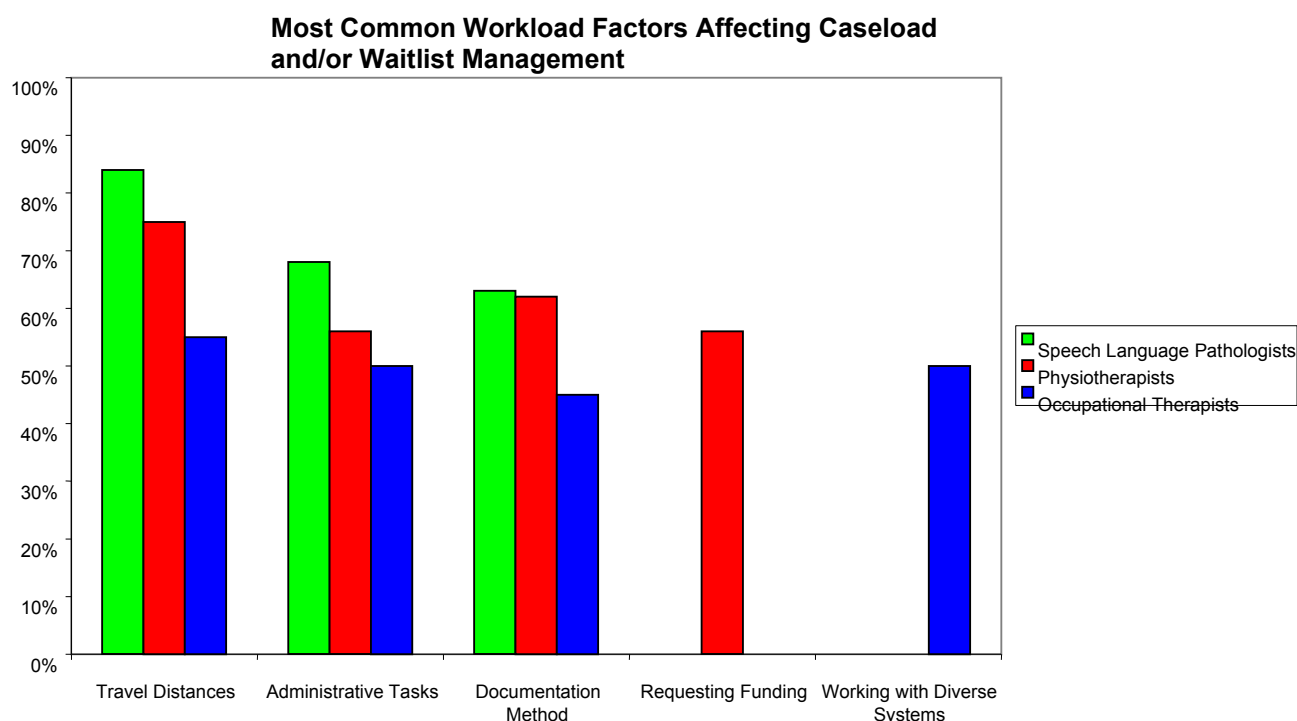
**Provincial Perspective**

Therapists reported a lack of time to complete all of the activities expected of them. They reported stress related to long waitlists, high caseloads, and a lack of time to provide adequate service. In some situations, chronic staff shortages, due to inadequate

resources for the population size and need, or chronic vacant positions in more rural locations, were perceived to contribute to the problem. Therapists In some communities reported insufficient time to add student placements to their already full schedules, limiting the learning opportunities for potential new pediatric therapists.

Many of the tasks therapists are required to do during their workdays affect their ability to manage their caseloads and reduce the size of their waitlists. (Please refer to Figure 15.) The most common workload factors are: travel distances, administrative tasks, documentation, requesting funding, and working within diverse systems in early intervention and school-age therapy.

Therapists' daily workloads appear to compound the difficulties in managing their caseloads and waitlists, especially when considering travel distances. Administration tasks and documentation methods are also reported by speech language pathologists, physiotherapists, and occupational therapists as having an effect on workload. Physiotherapists are challenged by the time it takes to request funding, and occupational therapists are challenged by working in diverse systems in early intervention and school age therapy.

**Figure 15**

*Please refer to Appendix R, Workload Factors Affecting Caseload and Waitlist Management — Additional Responses of Survey Respondents*

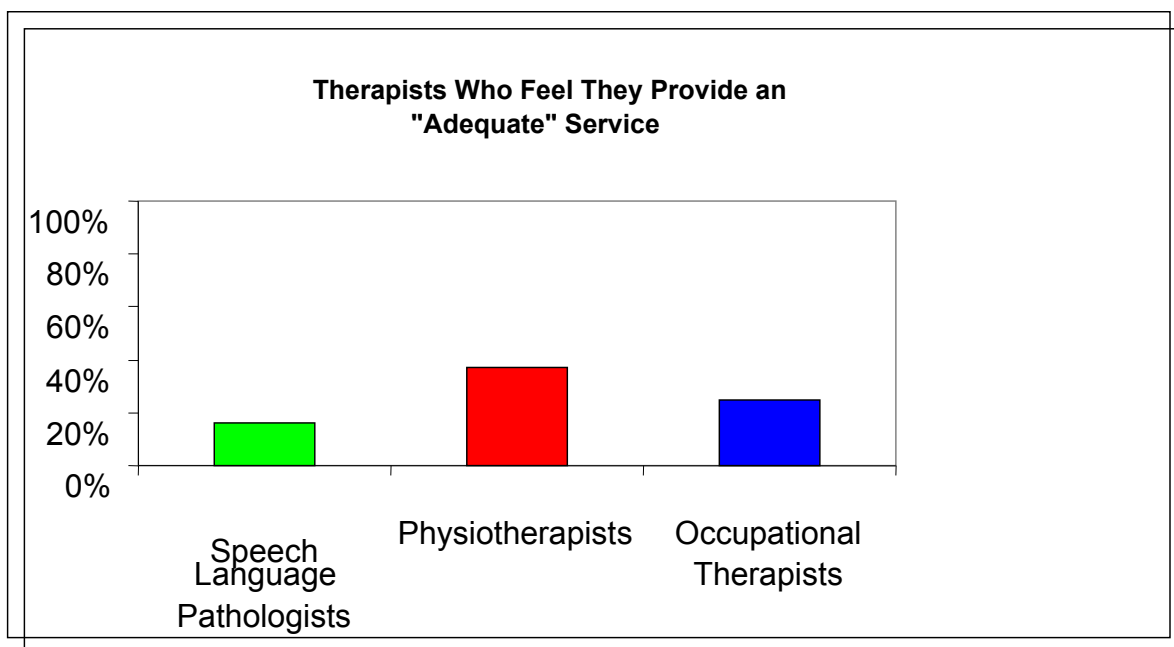
### **Adequacy of Service**

Many therapists feel they are unable to provide an adequate service with the resources they are currently working with. Many reported they lack job satisfaction because they are unable to provide the service they feel is best practice. Please refer to Figure 16.

The most common wish reported included more resources for new positions, including therapists, therapy assistants, and clerical staff. Therapists reported wanting at least half again as many therapists in new positions. For example, if a centre has four full-time equivalents (FTEs), they would like two new positions.

Other suggestions that did not necessitate acquiring new positions included: shifting resources between disciplines, regions, and systems; support by private insurance companies, reducing overlapping scopes of practice, basing practice on outcome measures, initiating effective recruitment and retention strategies, and utilizing more clerical support. Other examples included: sharing of resources, such as handouts, clinical practice guidelines, and education provided by bigger centres; access to more and better technology for documentation and time management; use of supported prioritization tools; and guidelines for caseload and waitlist management.

**Figure 16**



*Please refer to Appendix S, Resources Needed in BC to Provide More Adequate Pediatric Service.*

Therapists reported many possibilities for positive change if they had these new resources, including: smaller caseload sizes and reduced waiting times for children and families; increase in the range of service delivery options; increase in the frequency and length of service; increase in community education about prevention and about the therapies themselves.

## **Recommended Guidelines**

### **Total workload**

To promote a more manageable workload, we must first recognize all the functions a therapist is expected to perform. Most are related to clinical intervention, but may not be valued as activities to be scheduled and planned for. Therapists must be able to schedule time for the work expected of them, to provide adequate, or even better, quality service for children.

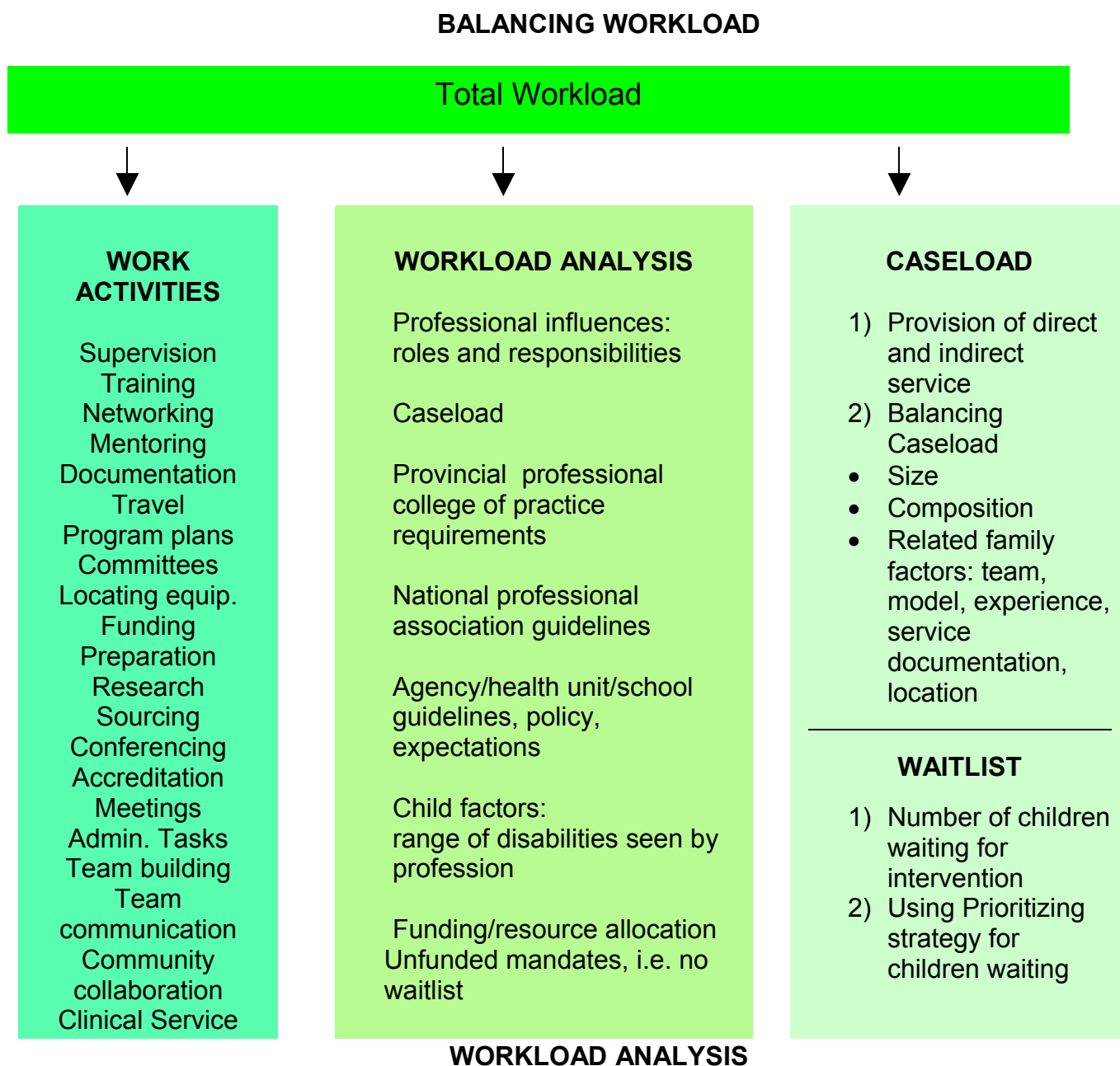
Figure 17, Total Workload Activity Examples, presents examples of workload activities. These, represented by dark green squares, are usually related to clinical intervention. On a daily basis a therapist performs many direct and even more indirect clinical intervention activities that should be accounted for when balancing caseloads, recording statistics, staff allocations, and additional projects. Activities represented by the rounded, light green boxes are supporting activities for the clinical intervention. Agencies should review the tasks a therapist currently performs and consider which could be done more effectively by another employee. Many tasks could be performed by a “less costly” and often more capable employee, in effect allowing more clinical time.



**Figure 17**

**Balancing workload**

“Balancing workload” refers to balancing work activities, workload analysis, caseload, and waitlist, all part of the total workload (please refer to Figure 18). Work activities include supervising students, sitting on committees, mentoring, and attending conferences. Workload analysis involves considering why activities may need to be completed in a specific way, for example, to comply with the practice requirements of the provincial professional college, or for agency policy (please refer to Figure 19). Caseload management and waitlist or referral management are considered in this balancing act. As these are all interrelated topics, it is difficult to look at one in isolation.

**Figure 18**



Adapted from ASHA, 2002, III, pp. 411.

It is important to be aware of and analyze the factors that can affect a therapist's workload or ability to provide what the therapist considers an effective service. Therapists are accountable to their regulatory colleges, boards, or associations. These organizations are responsible under provincial legislation for "serving and protecting the public." They do this by ensuring their members are qualified and follow clearly defined standards of ethics and practice, and they keep their members up to date on new developments in professional practice. This public service and protection is provided by the professions themselves (Healthcare Professionals of British Columbia 2006). Therapists must work within standards of practice that program administrators may not be aware of when asking a therapist to perform a specific activity.

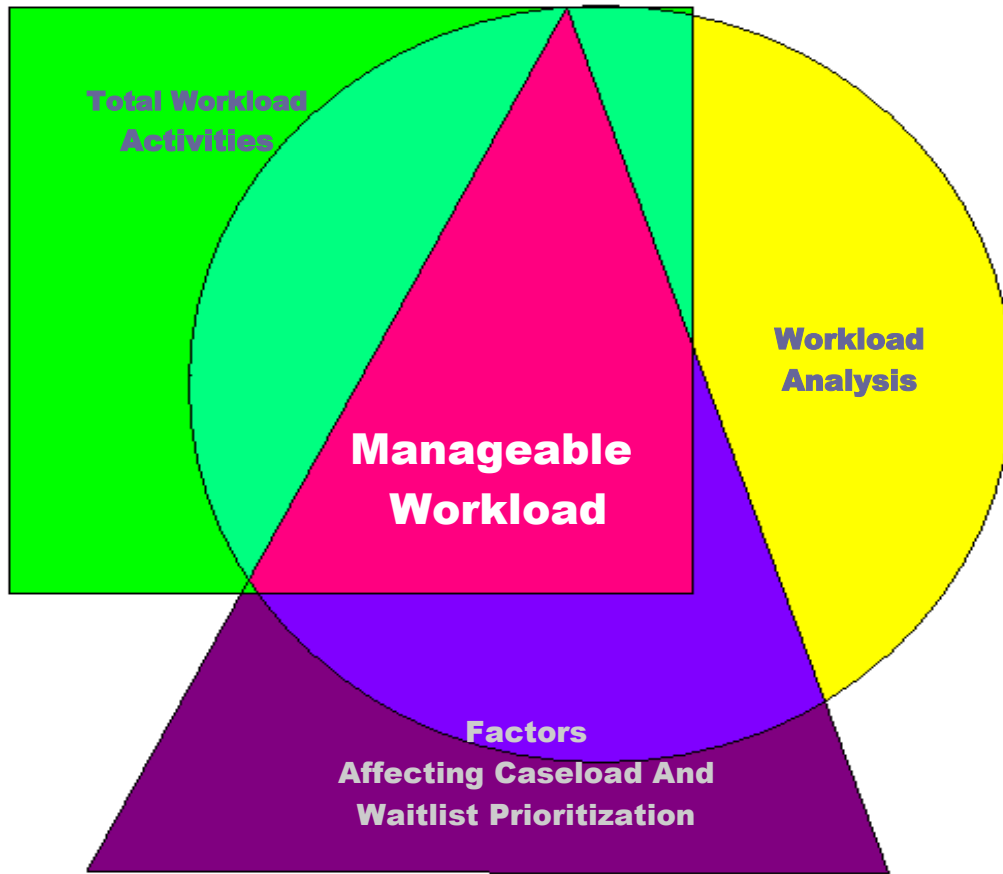
Employing organizations may also establish parameters for service delivery. As an example, a therapist may be told not to carry a waitlist past a specific time period. The work is then conducted within an atmosphere of servicing many children with minimal involvement, rather than servicing a few with a strong intervention focus. In another example, a therapist may work within both early intervention and school-age populations, with different funding agencies and allocations. The therapist may provide “full service” to young children and no service or limited service when the child enters kindergarten or is of kindergarten age.

Therapists in BC would prefer to participate in decisions that affect management of their own workloads, such as those regarding funding mandates, service limitations, agency policy, national guidelines, college requirements, and caseload management. Therapists would like to make decisions on service provision with evidence-based practice choices that have strong outcomes, rather than with what many refer to as inadequate “crowd control.”

There is a variety of different funding arrangements and systems, with many different interpretations of service provision across the province. It is therefore important that therapists have some flexibility to work effectively within different systems while still maintaining strong professional standards and competencies.

A manageable workload is a complex concept. It involves the interrelationship among total workload, workload analysis, and the factors affecting caseload and waitlist prioritization. A balance among all of these areas creates a greater opportunity for a manageable workload. Figure 20, Manageable Workload, illustrates this concept.

**Figure 20**



## COMMUNICATION

### Literature Review

Practice communities are networks of people who collaborate to work, plan, share ideas, and learn from one another in a physical or virtual space (Fordis, et al 2005, Headrick, Wilcock, & Bataldan 1998, Ho, et al 2003, Johnson 2005). A community of practice can relate to a particular topic, such as swallowing disorders or assistive technology, and its members may be from a variety of disciplines, including parents.

One of the most important functions of communities of practice is peer-to-peer knowledge development as members share particular issues and interests, fostering a community spirit. A desire to share experiences, learning, and insights hold a community of practice together. It provides a venue to discuss evidence-based practice, competencies, and expectations, define ethical best practices, and support critical thinking. It also provides a method of developing practice guidelines. Province-wide communities of practice would provide therapists with a unique perspective of BC.

Although communities of practice are similar to teams and work groups, some important features set them apart:

- Team relationships are established when an organization assigns people to be team members. Community of practice relationships are formed around practice: largely informal, voluntary, and self-organizing.
- Leadership relationships within a team are often “top-down” hierarchies. Leadership relationships in a community of practice develop around members’ interaction and expertise.
- Teams often have goals, missions, and fixed timelines, which may be established by people not on the team. Communities are primarily responsible to their members.
- Teams rely on work and reporting processes that are organizationally defined. Communities develop their own processes.

Communities of practice that make use of technology-assisted communications can overcome restrictions of geography and scheduling. Typically, the communications are computer-based, real-time, online meetings that allow easy access for all and can also include face-to-face member meetings.

A community of practice strategy allows a means for members to quickly receive up-to-date information about new developments in professional practice and universal funding or about mandate changes, whether from a regulatory college, board, association, or other source, and it provides a method for members to discuss the implications for practice.

### **Provincial Perspective**

Therapists reported difficulty working in diverse systems at the same time. Pediatric programs are funded by the Ministry of Children and Family Development, the Ministry of Health, and the Ministry of Education, but other funding sources provide services, too. These systems can have different approaches, service delivery methods, funding sources, allocations, procedures, staffing, and reporting requirements. Changes may apply to only one of the systems.

Therapists often feel uninformed and reported a lack of communication with peers, even in the same community. There is a need for enhanced communication among those involved in providing, receiving, planning for, administering, and funding pediatric services. Information should flow at regular intervals on potential changes that could affect any administrator, provider, or receiver of these services, where appropriate, with an established mechanism to ensure feedback. A province-wide information-sharing strategy would establish a communication link among funding sources, agency service providers, therapists, parents, and caregivers. This link could provide timely information and promote collaboration and partnerships across the province of British Columbia.

## SUMMARY

Many pediatric therapists in British Columbia struggle with managing their workloads. Many therapists do not feel they have the time or support to address their total workload, especially the necessary indirect time. Terminology, graphic representations, and definitions have been presented to help explain the interrelationship of total workload activities, workload analysis, and factors influencing caseload and waitlist issues, all in an effort to describe a manageable workload.

Therapists described long waitlists. It was clear there were inconsistencies in reporting and waitlist structure. Standard terminologies, suggestions for referral management, and waitlist prioritization strategies have been recommended. Photocopiable forms have been created.

Large caseloads have been reported across the province, with little opportunity for flexible service delivery methods. This report suggests standard terminologies and strategies for balancing caseloads.

The recommendations presented are meant to be flexible, applicable to speech language pathology, physiotherapy, and occupational therapy in diverse settings.

The following recommendations address the broader issues of collaboration, consensus, outcome measures, and information sharing to further promote manageable workloads for pediatric therapists in British Columbia.



## RECOMMENDATIONS

Many of the following recommendations will require coordination, meetings, planning and long-range support. These recommendations, if carried out, will improve the quality of pediatric service in British Columbia while addressing the broader issues of delivering pediatric service in a province where size and diversity present their own challenges. The provincial consultant and the steering committee may need to discuss the viability of taking on any of the recommendations, or to prioritize them, based on the many projects already under way. Creative solutions for financing could be proposed, with input from professional therapy associations, colleges, and other related stakeholders.

### **1. Establish provincial consensus**

It is recommended that the Office of the Provincial Consultant and the Steering Committee create a focus group to establish provincial consensus on balancing workload, waitlist prioritization strategies, and development of reporting guidelines. The focus group should include representatives of: therapists practising in speech language pathology, physiotherapy, and occupational therapy; administration of child development centres; health units; school districts; private practices; funding agencies in health and education; and parents of children receiving therapy services. Representation should also include individuals with experience in rural and urban communities, early intervention, school-age, and adult transition services, with support from focus group members, funding agencies and employers.

### **2. Field test the new guidelines**

It is recommended that, after the focus group reaches consensus, the Office of the Provincial Consultant create a working group, representing a range of therapists and communities, to field test the initial suggested guidelines over a period of 4–6 months. The guidelines would cover:

- caseload size recommendations with related factors
- standard terminology
- referral management process
- urgency rating scale
- waitlist recording form
- levels of participation scale
- waitlist prioritization strategies
- caseload balancing strategies.

Feedback should include comments on how useful, meaningful, reliable, and valid the tools are. The tools would then be adapted as necessary for use across BC, and the sharing of experiences would assist in developing a new communication strategy.

### **3. Develop and implement a waitlist prioritization/outcome measurement tool**

It is recommended that a working group be formed to develop a clinical functional waitlist prioritization/outcome measurement tool for use by pediatric speech language pathologists, physiotherapists, and occupational therapists in BC. Representation on this group should include providers of these three branches of pediatric therapy; parents of children receiving therapy services; individuals with experience in rural and urban communities, early intervention, school-age, and adult transition services; agencies funded by the Ministry of Health, Ministry of Education, and Ministry for Child and Family Development; and privately funded agencies. Funding would be required to develop the tool. The working group would use the feedback obtained from the focus group described in Recommendation 2 to develop and implement this tool.

### **4. Develop a province-wide information-sharing strategy**

It is recommended that the TherapyBC website be more widely advertised and used to provide province-wide communication among therapists, agency directors, school districts, health units, funders, and related parties, to provide timely updates on new developments. Additional funds would be required to develop the capacity of the website.

### **5. Develop a provincial pediatric therapy community of practice strategy**

We recommend that a facilitator locate target communities and potential members across the province, develop and distribute resource information about communities of practice, arrange online support and technology for the communities to interact, and coordinate online real-time sessions and face-to-face member meetings. Funding would be required to support the facilitator.

### **6. Develop useful and meaningful recording methods**

It is recommended that representatives of funding agencies, service-providing agencies, and therapists meet to establish consensus on what information is useful to collect, how it can be collected in a time-efficient manner, what can be collected for future research, and how such information relates to that forwarded to the Canadian Institute for Health Information (CIHI).

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## Appendix A

### LITERATURE REVIEW

The literature review gathered information on caseload and waitlist management to promote manageable workloads in the following four main areas:

- **Manageable Workload**  
What is a manageable workload? What influences manageable workload in pediatric speech language pathology, physiotherapy, and occupational therapy? Are the manageable workload issues the same for all three therapy disciplines?
- **Caseload Management**  
What is caseload management? What issues influence caseload management for pediatric speech language pathologists, physiotherapists, and occupational therapists? Are there caseload guidelines that can be applied across the three therapy disciplines?
- **Service Delivery**  
What is a service delivery model? What are the service delivery issues pertaining to pediatric speech language pathology, physiotherapy and occupational therapy?
- **Waitlist Management**  
What is a waitlist management strategy? What issues influence waitlist management? Are relevant waitlist management strategies described in the literature that are applicable to speech language pathology, physiotherapy, and occupational therapy?

For this project, the following sources were searched for relevant information:

- databases such as Ebsco Host Research, academic search premier, health business, psychology and behavioral sciences, nursing and allied health, biomedical reference, Medline, PubMed, Cochrane Library, Best Evidence, CINAHL, PEDro, Physiobase, NNLM, ProQuest Health Management, Health Web
- bibliographies
- publications
- search engines such as Google, Yahoo, Colossus, Alta Vista
- electronic libraries
- related websites and discipline-specific websites such as the Canadian Association for Speech Language Pathology and Audiology, Canadian Physiotherapy Association, Canadian Association of Occupational Therapists, American Speech Language Hearing Association, American Physiotherapy Association, and American Occupational Therapy Association. Numerous sites were unavailable due to protected, member-only admission.

Search topics included:

- caseload management
- workload management
- caseload guidelines
- waitlist management
- priority-setting
- access to health services
- service delivery models
- clinical decision-making
- evidence-based practice
- outcome measures
- health human resource management
- speech language pathology standards of practice
- physiotherapy standards of practice
- occupational therapy standards of practice
- critical appraisal
- clinical practice guidelines
- quality improvement
- quality management
- rehabilitation practice management
- health care ethics.

## Appendix B — Survey Summary Results

### Pediatric Therapy Caseload and Waitlist Management Survey

Provincial Pediatric Therapy Advisory Committee [www.therapybc.ca](http://www.therapybc.ca)

SERVICE DELIVERY		
<b>1. I work in:</b>		
	Response Percent	Response Total
early intervention	80.70%	46
school age therapy	52.60%	30
private practice	14%	8
at home program	7%	4
centre-based fee for service	1.80%	1
<b>Total Respondents</b>		<b>57</b>
(skipped this question)		0
<b>2. I work in the following teams:</b>		
	Response Percent	Response Total
Interdisciplinary	25%	6
<b>Multidisciplinary</b>	<b>54.20%</b>	<b>13</b>
Transdisciplinary	8.30%	2
Integrated Service	16.70%	4
No team	29.20%	7
All of the above	12.50%	3
Other:	4.20%	1
The most effective to me is:	33.30%	8
<b>Total Respondents</b>		<b>24</b>
(skipped this question)		33
<b>3. I provide therapy service using the following service delivery methods:</b>		
	Response Percent	Response Total
intake	68.40%	39
general screening	66.70%	38
kindergarten	24.60%	14
<b>assessment</b>	<b>98.20%</b>	<b>56</b>
monitoring	87.70%	50
<b>consultation</b>	<b>98.20%</b>	<b>56</b>
ongoing treatment	82.50%	47
treatment block	50.90%	29
cycling treatment	26.30%	15
group treatment	59.60%	34
parent education	50.90%	29

promotion of my		28.10%	16
community education		70.20%	40
Other (please		10.50%	6
<b>Total Respondents</b>			<b>57</b>
(skipped this question)			0

**4. The following descriptive statement(s) for the term 'screening' best suit my understanding within therapy practice. 'Screening' is a process to gather**

	Response Percent	Response Total
what services are needed for the child	24.60%	14
what are the child's areas of need	40.40%	23
eligibility of service	22.80%	13
if indepth assessment is	36.80%	21
<b>All of the above</b>	<b>56.10%</b>	<b>32</b>
None of the above	1.80%	1
Or please provide an alternate suggestion:	14%	8
<b>Total Respondents</b>		<b>57</b>
(skipped this question)		0

**5. The following statements regarding the term 'assessment' best suit my understanding in my therapy practice:**

	Response Percent	Response Total
<b>The term</b>	<b>86%</b>	<b>49</b>
Assessment must include a standardized	5.30%	3
<b>Assessment can include many forms of evaluation with analysis of information based on sound clinical reasoning.</b>	<b>86%</b>	<b>49</b>
A therapist MUST assess a child prior to providing intervention of any	43.90%	25
all of the above	8.80%	5

none of the above	0%	0
Or Provide an alternate suggestion:	15.80%	9
<b>Total Respondents</b>		<b>57</b>
<b>(skipped this question)</b>		<b>0</b>

6. The following descriptive statements about the term 'monitoring' best suit my understanding within therapy practice:	Response Percent	Response Total
'Monitoring' is used to determine if the child is continuing to develop appropriately or is at risk and needs further services.	57.90%	33
Monitoring follows an assessment of the child, and the provision of a home program.	26.30%	15
A child is monitored with clinical observations.	47.40%	27
A child can be monitored through phone contact.	31.60%	18
The family and therapist set up a schedule for periodic monitoring	40.40%	23
All of the above	40.40%	23
None of the above	1.80%	1
Or please provide an alternate suggestion:	12.30%	7
<b>Total Respondents</b>		<b>57</b>
<b>Skipped this question</b>		<b>0</b>

7. The following descriptive statement(s) about the term 'consultation' best suit my understanding in therapy practice:	Response Percent	Response Total
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A consultation provides therapy information on a specific topic requested.	44.60%	25
Following assessment, a consultation can include a therapist providing instruction to someone else to deliver the service.	51.80%	29
<b>A child specific consultation includes a best practice assessment with a consult to the child's general team to provide information on improving the child's functioning within their environments. In this case, the intervention is provided by someone other than the therapist. The therapist is responsible for teaching an intervention plan collaborating with the family, educators, caregivers.</b>	<b>58.90%</b>	<b>33</b>
A team consultation involves providing general information on a specific topic, but not related to a specific child.	16.10%	9
Educational	33.90%	19
All of the above	35.70%	20
None of the above	0%	0














Or please provide an alternate suggestion	16.10%	9
<b>Total Respondents</b>		<b>56</b>
(skipped this question)		1

8. The following descriptive statements about the term 'treatment' best suit my understanding in therapy practice:		
	Response Percent	Response Total
Treatment can only include direct intervention with the child.	28.10%	16
Treatment can be direct or indirect intervention with the child. Give an example of indirect treatment:	64.90%	37
<b>Treatment involves setting goals identified by an assessment first, combining with child and family needs and abilities.</b>	<b>73.70%</b>	<b>42</b>
Treatment usually is started after case management with an integrated service plan meeting to set goals	24.60%	14
all of the above	7%	4
none of the above	0%	0
Or please provide a description:	47.40%	27
<b>Total Respondents</b>		<b>57</b>
(skipped this question)		0

9. The following factors are the top 5 most important in helping me pick the way I will deliver service:		
	Response Percent	Response Total
<b>child's need</b>	<b>94.70%</b>	<b>54</b>
family involvement	64.90%	37

location of child's home or program		12.30%	7
age of the child		47.40%	27
others involved with the child		57.90%	33
availability of child		33.30%	19
my available caseload size		28.10%	16
waitlist size		56.10%	32
centre guidelines		24.60%	14
all of the above		31.60%	18
none of the above		8.80%	5
Other (please		0%	0
Other (please		12.30%	7
<b>Total Respondents</b>			<b>57</b>
(skipped this question)			0

### CASELOAD MANAGEMENT

10. How many children are on the caseload of a full time equivalent therapist at your centre?		Response Percent	Response Total
24 or less		3.70%	2
25-30		11.10%	6
31-36		13%	7
<b>37-42</b>		<b>14.80%</b>	<b>8</b>
43-48		5.60%	3
49-55		13%	7
56-61		7.40%	4
62-67		3.70%	2
67-77		11.10%	6
78-88		5.60%	3
89-100		3.70%	2
100-150		3.70%	2
150-200		3.70%	2
greater than 200		0%	0
<b>Total Respondents</b>			<b>54</b>
(skipped this question)			3

11. In order to provide an adequate service, what do you think would be an ideal caseload number?		
<b>Total Respondents</b>		<b>54</b>
(skipped this question)		3

12. In an effort to manage my caseload, I have limited the parameters somewhat in the following areas by:		
	Response Percent	Response Total

age		37.70%	20
diagnostic group(s)		34%	18
need for specific			
type(s) of service		37.70%	20
specific region(s) in my community		17%	9
specific program(s) in my community		5.70%	3
all of the above		7.50%	4
none of the above		26.40%	14
Other (please)		17%	9
<b>Total Respondents</b>			<b>53</b>
(skipped this question)			4

<b>13. I "weight" the needs of children on my caseload to allow me to better manage it.</b>			
		<b>Response Percent</b>	<b>Response Total</b>
TRUE		38.20%	21
FALSE		20%	11
<b>This is how I do it:</b>		<b>41.80%</b>	<b>23</b>
<b>Total Respondents</b>			<b>55</b>
(skipped this question)			2

<b>14. How long do children typically remain on your caseload?</b>			
<b>Total Respondents</b>			<b>53</b>
(skipped this question)			4

<b>15. The following has been my most effective strategy to manage the size of my caseload:</b>			
<b>Total Respondents</b>			<b>50</b>
(skipped this question)			7

<b>16. I use the following to help me in my clinical decision making around when to discharge a child from my caseload:</b>			
		<b>Response Percent</b>	<b>Response Total</b>
child's age		56.40%	31
standardized		63.60%	35
need to reduce caseload		9.10%	5
need to see a more urgent case		10.90%	6
centre guidelines		29.10%	16
clinical practice		40%	22
outcome measures		10.90%	6
all of the above		5.50%	3

none of the above	1.80%	1
Other/Comment:	47.30%	26
<b>Total Respondents</b>		<b>55</b>
(skipped this question)		2

## SCOPE OF PRACTICE

<b>17. I am an:</b>		
	<b>Response Percent</b>	<b>Response Total</b>
occupational	36.40%	20
physiotherapist	29.10%	16
speech language pathologist	36.40%	20
<b>Total Respondents</b>		<b>55</b>
(skipped this question)		2

<b>18. I sometimes "delegate" therapeutic activities (non-direct therapy) to others because:</b>		
	<b>Response Percent</b>	<b>Response Total</b>
I do not have time to provide direct service to all of my clients otherwise	50.90%	27
I believe it is best practice	41.50%	22
I do not delegate therapy services to others	3.80%	2
Both of the above	13.20%	7
None of the above	0%	0
Other (please	37.70%	20
<b>Total Respondents</b>		<b>53</b>
(skipped this question)		4

<b>19. I sometimes "delegate" therapeutic activities (non-direct therapy) to:</b>		
	<b>Response Percent</b>	<b>Response Total</b>
child, family and caregivers	79.60%	43
therapy aides	35.20%	19
supported child care consultants	48.10%	26

infant development consultants		53.70%	29
teachers (preschool or school)		63%	34
teacher assistants		66.70%	36
family support workers		20.40%	11
other therapists		44.40%	24
behaviour interventionists		33.30%	18
social workers		1.90%	1
community programs		16.70%	9
Others (please specify)		7.40%	4
<b>Total Respondents</b>			<b>54</b>
(skipped this question)			3

<b>20. I feel the child is provided with an adequate therapy service when I delegate to others.</b>			
		<b>Response Percent</b>	<b>Response Total</b>
TRUE		18.50%	10
FALSE		22.20%	12
<b>comments:</b>		<b>59.30%</b>	<b>32</b>
<b>Total Respondents</b>			<b>54</b>
(skipped this question)			3

#### WAITLIST MANAGEMENT

<b>21. The following types of waitlists are maintained at my organization:</b>			
		<b>Response Percent</b>	<b>Response Total</b>
screening waitlist		28.30%	15
assessment waitlist		45.30%	24
<b>treatment waitlist</b>		<b>49.10%</b>	<b>26</b>
consultation waitlist		20.80%	11
general waitlist		26.40%	14
Other (please specify)		26.40%	14
<b>Total Respondents</b>			<b>53</b>
(skipped this question)			4

<b>22. The waitlist at my facility has changed over time for the following reasons:</b>			
		<b>Response Percent</b>	<b>Response Total</b>
loss of staff		47.20%	25

addition of new staff		26.40%	14
increased population of children in area		43.40%	23
decreased population of children		7.50%	4
increased education in community about therapy		47.20%	25
administrative		17%	9
availability of support		28.30%	15
accreditation		22.60%	12
none of the above		9.40%	5
Other/comments		32.10%	17
<b>Total Respondents</b>			<b>53</b>
(skipped this question)			4

23. The typical number of children on the waitlist for therapy services within my discipline is:		Response Percent	Response Total
0-10		27.50%	14
11-21		9.80%	5
22-32		11.80%	6
33-43		2%	1
44-54		9.80%	5
55-65		2%	1
66-76		7.80%	4
77-87		3.90%	2
88-98		5.90%	3
99-125		0%	0
126-150		3.90%	2
151-200		3.90%	2
greater than 200		11.80%	6
<b>Total Respondents</b>			<b>51</b>
(skipped this question)			8

24. The children remain on the waitlist typically for:		Response Percent	Response Total
children are on and off waitlist for intermittent service		20.40%	11
0-1 month		13%	7
2-3 months		16.70%	9
4-6 months		5.60%	3

7-9 months		7.40%	4
10-12 months		14.80%	8
13-15 months		7.40%	4
16-18 months		5.60%	3
19 months or more		5.60%	3
Other (please		33.30%	18
<b>Total Respondents</b>			<b>54</b>
(skipped this question)			3

25. How do you prioritize children on your waitlist?		Response Percent	Response Total
by referral date		81.10%	43
by age		24.50%	13
by severity of condition		56.60%	30
by prioritization scale		24.50%	13
by urgency of need		56.60%	30
by location of service		13.20%	7
by availability of skilled therapist in the area of need		9.40%	5
by complexity of family need		17%	9
Other (please		24.50%	13
<b>Total Respondents</b>			<b>53</b>
(skipped this question)			4

26. If you use a prioritization scale, please describe:		
<b>Total Respondents</b>		<b>16</b>
(skipped this question)		41

27. I often take children off the waitlist and provide service, even though I do not have time as I feel morally obligated to do so.			
		Response Percent	Response Total
TRUE		54.90%	28
FALSE		45.10%	23
<b>Total Respondents</b>			<b>51</b>
(skipped this question)			8

28. In order to reduce the waitlist, I/we have tried the following strategies:		
	Response Percent	Response Total



altering the eligibility criteria		37.30%	19
reducing the scope of service		41.20%	21
<b>altering the method of delivering the service</b>		<b>72.50%</b>	<b>37</b>
delegation of therapeutic activities to others		56.90%	29
innovative funding		13.70%	7
recruitment and retention strategies		17.60%	9
community partnerships		31.40%	16
use of key workers to provide a variety of therapies		15.70%	8
assessment block for a group of children		35.30%	18
Other (please )		39.20%	20
<b>Total Respondents</b>			<b>51</b>
<b>(skipped this question)</b>			<b>6</b>

29. Of the following strategies, I have found these most helpful in reducing the waitlist:		Response Percent	Response Total
altering the eligibility criteria		28%	14
reducing the scope of service		26%	13
<b>altering the method of delivering the service</b>		<b>46%</b>	<b>23</b>
delegation of therapeutic activities to others		24%	12
innovative funding		6%	3
recruitment and retention strategies		2%	1
community partnerships		16%	8

use of key workers to provide a variety of therapies	14%	7
assessment block for a group of children	10%	5
treatment block for a group of children	26%	13
Other (please	32%	16
<b>Total Respondents</b>		<b>50</b>
(skipped this question)		7

30. What type of support does the family receive while waiting on the waitlist?	Response Percent	Response Total
information related to the referral topic	68.80%	33
general child development information	54.20%	26
information about other programs available on site and in the community	62.50%	30
websites for parent-to-parent support	10.40%	5
websites for specific referral topic	18.80%	9
Other (please	66.70%	32
<b>Total Respondents</b>		<b>48</b>
(skipped this question)		9

31. Do you feel you are able to provide an adequate service with the resources you have available?	Response Percent	Response Total
yes	25.90%	14
no	77.80%	42
<b>Total Respondents</b>		<b>54</b>
(skipped this question)		3

32. In order to provide a more adequate therapy service, the following additional resources would help:		
<b>Total Respondents</b>		<b>48</b>
(skipped this question)		9

33. If you had these additional resources, what would you do differently that you are not able to do now?		
<b>Total Respondents</b>		<b>47</b>
(skipped this question)		10

### MANAGEABLE WORKLOADS

34. I find the following workload factors affect my ability to manage my caseload and/or waitlist:	Response Percent	Response Total
committee participation	48.10%	26
documentation method	55.60%	30
accreditation duties	38.90%	21
administrative tasks	57.40%	31
<b>travel distances</b>	<b>70.40%</b>	<b>38</b>
poor weather/driving	29.60%	16
sourcing clinical information	22.20%	12
lack of peer support	14.80%	8
preparation of materials for therapy sessions	44.40%	24
training new staff	33.30%	18
working within diverse systems of early intervention and school districts	33.30%	18
sourcing equipment	27.80%	15
requesting funding for equipment	33.30%	18
burnout	33.30%	18
all of the above	11.10%	6
none of the above	1.90%	1
Other (please	24.10%	13
<b>Total Respondents</b>		<b>54</b>
(skipped this question)		3

**APPENDIX C**

<b>EXAMPLES OF SERVICE DELIVERY SYSTEMS IN THE LITERATURE</b>
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Name/Location	Purpose	Components of System
<b>The Queensland Allied Health Demand Management Project (Tweedale, et al, 2003)</b>	To facilitate service planning, determination of service priorities, and management of caseloads.	<p><i>Environmental mapping:</i> acknowledges local community needs in conjunction with organizational and district priorities to facilitate optimal planning and allocation of resources</p> <p><i>Service definition roles and responsibilities:</i> allows planning, implementation, and evaluation of service delivery in a coordinated approach across the region, therefore matching staff skills and service needs</p> <p><i>Service strategies:</i> integrates strategies already in use with evidence-based practice to assist in the development of protocols for management of common conditions. The model uses the following 10 strategies:</p> <ul style="list-style-type: none"> <li>• ensure clinical effectiveness</li> <li>• ensure that skilled staff deliver service</li> <li>• determine level of urgency</li> <li>• utilize a multidisciplinary approach where appropriate</li> <li>• form client partnerships in decision-making around goals to be achieved, the intervention plan, and discharge</li> <li>• manage client and referrer expectations by offering the appropriate clinical service</li> <li>• incorporate self-management into the intervention</li> <li>• use active discharge planning</li> <li>• use waitlist management strategy</li> <li>• collect data</li> </ul>

Name/Location	Purpose	Components of System
<b>The Children's Community Therapy Service</b> Townsville, Queensland, Australia (Department of Disability, Housing and Community Services, 2004)	Cycles of service for caseload management	<p>Follows a two-month treatment cycle.</p> <p>At the end of each cycle, individual client needs as well as overall caseload are reviewed and adjusted. Another block of therapy appointments are scheduled, if necessary. This may result in an increase or reduction in frequency of service.</p> <p>Each six weeks, the service sets aside a week without clinical appointments, to plan, review needs, and meet with all families. This results in specific therapy goals and confirmation of appointments.</p>
<b>CCAC-LTC Priority Project (2002)</b> The Ministry of Health and Long Term Care in Ontario	To help with service delivery caseload implementation and decision support	<p>Assessments with a specific system, which includes assessment items, definitions, care planning protocols, and educational materials developed through extensive international research. The assessment results have the ability to generate:</p> <ul style="list-style-type: none"> <li>• client assessment protocols</li> <li>• outcome measures</li> <li>• quality indicators</li> <li>• case mix</li> <li>• method for assigning priority levels.</li> </ul>

**APPENDIX D**

<b>EXAMPLES OF WAITLIST SYSTEMS IN THE LITERATURE</b>
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Name/Location	Purpose	Components of System	Comments
<b>The Manitoba System</b> (Manitoba Education, Training and Youth 2000)	<p>To define standard severity levels, standard priority rating, and standard treatment outcome, and measurement to measure change in a client</p> <p>Assist in caseload prioritization and provide consistency across programs</p> <p>Improved communication could be a benefit to a consistent system</p>	<p>A severity and priority rating are assigned after assessment, at the beginning of intervention, and again at the end, after intervention.</p> <p>A manual provides detailed information, including an outcome summary form and the 12 functional communication measures.</p> <p>The Manitoba system reports on six levels of severity. There are detailed descriptors within each of 12 functional communication measure topics (such as pragmatics and articulation/phonology).</p> <p>Level 0: Independent            Level 1: mild            Level 2: mild-moderate            Level 3: moderate            Level 4: moderate-severe            Level 5: severe            Level 6: profound</p> <p>The Manitoba system also develops a priority rating, looking at related factors such as impact, reaction, motivation, support, and concomitant condition, as well as urgency and prognosis. A priority total is collected, and a priority</p>	<p>Initially, the ASHA Functional Communication Measures provided the best severity rating scale, while the Alberta Priority Rating Scale provided the best means of prioritizing individuals. Upon further review, it was determined that both of these tools would have to be adapted and revised to better capture functional change, add certain elements important in individual prioritization, and redefine terms to better reflect service delivery models. Later, information from the New Brunswick Priority Rating Scale made it even more functional in that it addressed the impact of the disorder on an individual's ability to function at home, school, work, or play. The final system, for children 0-21 years of age, was developed by speech</p>

Name/Location	Purpose	Components of System	Comments
		classification is made. This is paired with the intervention mode. Decisions are then made using the sum of all of this information.	language pathologists representing different settings, mandates and service delivery models.
<b>Maroondah Approach to Clinical Services (MACS)</b> (Department of Disability, Housing and Community Services 2004)	<p>To eliminate their therapy waiting list by integrating new clients into an existing caseload immediately</p> <p>Uses evidence-based practice and is thought to consider individual needs</p>	<p>Shares the responsibility between service provider and service user for therapy outcomes.</p> <p>The clinician and “the carer” (parents, grandparents, child care workers, teachers . . . ) are provided with training and guidelines for the implementation and participation in all therapeutic programs.</p> <p>Service delivery models are flexible, such as including individual blocks of therapy or group treatment.</p> <p>Therapy models are scheduled into a critical ration of appointments.</p> <p>Each clinician’s “timetable” will be different, based on individual work schedules.</p>	<p>MACS reports it can accommodate changing client and clinician needs by providing a frame for clinical development with scope to modify programming as necessary. Flexibility is present to adapt to changing clients and work environments, to maintain immediate access to service as soon as a client need is identified. It reports long-term change in “throughput” (clients through the system), claiming to treat more clients per quarter despite a loss of outpatient treatment hours. To use MACS, inservices are held, and licenses issued (Maroondah Hospital, 2005).</p> <p>It should be noted that MACS did not report the interrelationship between</p>

Name/Location	Purpose	Components of System	Comments
			clinical services provided, total workload, or caseload size or composition.
<b>Wait Time Alliance (WTA)</b> (Canadian Medical Association 2005)	<p>To improve health care</p> <p>Canadians have a right to timely, quality care.</p> <p>Must be developed from the patient's perspective</p> <p>Should be applicable across geographic areas</p> <p>Should be based on the best evidence with clinical consensus. Clinical judgment is important due to the lack of research evidence.</p> <p>Are dynamic, able to be refined following evaluation or when new technology is available</p> <p>Require ongoing input from frontline workers</p> <p>Are publicly accountable</p> <p>Are sustainable</p>	<p>Wait time benchmarks were set in each of the five specialty areas in December 2005 (cancer care, joint replacement, sight restoration, cardiac care, and nuclear medicine).</p> <p>A benchmark is a performance goal that reflects consensus on a reasonable wait time for the health service.</p> <p>The benchmarks were developed by using the best evidence available.</p> <p>Three urgency categories apply to the patient's need for service:</p> <ol style="list-style-type: none"> <li>1. Emergency</li> <li>2. Urgent</li> <li>3. Scheduled</li> </ol>	<p>Created in 2004, the formation of this alliance represents an "unprecedented effort" to bring together several national groups.</p> <p>It does not take into account the constraints on the system's capacity to achieve these benchmarks.</p>



Name/Location	Purpose	Components of System	Comments
	<p>Must not be achieved at the expense of reduced access to other health care services</p> <p>Implemented with guidelines and prioritization tools that are fair, equitable, and transparent to the patient</p>		
<p><b>Hunter Speech Pathology Access Project</b> (Department of Disability, Housing and Community Services 2004)</p>	<p>The project was initiated to reduce waiting times in Australia for service from 12 months to 6 weeks by exploring new work practices and service delivery models</p>	<p>Allocate sufficient assessment appointments each month to keep pace with the referral rate.</p> <p>Develop a staffing roster (or client referral system to other centres) which addressed any mismatch of local resources to conduct assessments. This ensured a more equitable distribution of referral volumes</p> <p>Expanded use of group interventions and home programs where clinically indicated. It was found that 30% could be assisted through a home program or did not require service.</p> <p>Post-assessment, the clients/families were:</p> <ul style="list-style-type: none"> <li>• aware of speech and/or language issues</li> <li>• informed of the recommended treatment</li> </ul>	<p>A drop-in intake screening service was tried and discarded. It is unclear why.</p>

Name/Location	Purpose	Components of System	Comments
		<ul style="list-style-type: none"> <li>provided with interim interventions where appropriate.</li> </ul>	
<b>Managing Demand in Tasmania</b> (Department of Disability, Housing and Community Services 2004)	Decreasing waitlists	There are penalties in relation to time on the waitlist from the contracting non-government organizations. The target groups are defined in priority. Looking functionally rather than demographically has allowed them to manage demand for service better. They use group intervention for some functional needs, rather than individual appointments.	There was no report on consequences for abandoning quality of service and shifting focus to waitlist reduction.

Name/Location	Purpose	Components of System	Comments
<b>Priority Rating Scale (PRS)</b>  (New Brunswick Health and Community Services 1997)	Enhance accountability  Increase objectivity  Support professional decision making  Promote consistency	<p>The PRS is a tool for the consistent prioritization of individuals requiring rehabilitation services. It was designed to help determine which individuals have a greater need for rehabilitation service relative to other individuals, to ensure equitable access to service.</p> <p>The total numerical score reflects a combined perspective of the individual's point of view, clinician's point of view, and objective information.</p> <p>The client-centred approach framework allows the following indicators to be measured:</p> <ul style="list-style-type: none"> <li>• impact of the primary presenting problem on function</li> <li>• predicted outcome of the rehabilitation intervention</li> <li>• impact of service delay.</li> </ul>	
<b>Infant Development Program (IDP) of British Columbia</b>	To ensure that families most in need of a service receive it first	A non-numerical priority rating is suggested.  Each child is prioritized with the	The rating appears based on qualitative clinical judgment.

Name/Location	Purpose	Components of System	Comments
(2004).		<p>following criteria:</p> <ul style="list-style-type: none"> <li>• transfer from another IDP</li> <li>• significant visual impairment</li> <li>• child's condition would deteriorate without intervention</li> <li>• child has a diagnosis</li> <li>• family has a high level of concern and/or need for information regarding the child's delay</li> <li>• child is showing significant delay in one or more skill area</li> <li>• child is at risk for delay.</li> </ul>	
<b>Supported Child Development Program (SCDP) (2005)</b>	<p>Suggested waitlist principles:</p> <ul style="list-style-type: none"> <li>• accountability</li> <li>• fairness and equity</li> <li>• access to information</li> <li>• openness</li> <li>• consistency.</li> </ul>	<p>Criteria:</p> <ul style="list-style-type: none"> <li>• service request date</li> <li>• urgency of need</li> <li>• age</li> <li>• intensity and nature of child's support needs</li> <li>• loss of daycare space</li> <li>• complexity of family needs</li> <li>• external supports available.</li> </ul>	
<b>Aboriginal Infant Development Program (2005)</b>	To be fair, flexible, accessible, and inclusive for all Aboriginal children and families in urban, rural, and	<p>Considerations:</p> <ul style="list-style-type: none"> <li>• the child is transferring from</li> </ul>	

Name/Location	Purpose	Components of System	Comments
	remote areas	<p>another program</p> <ul style="list-style-type: none"> <li>• significance of the child's delay or disability</li> <li>• the condition will deteriorate without service</li> <li>• the child has medical diagnosis</li> <li>• the family has a high level of concern</li> <li>• the child shows significant delays in 1+ areas</li> <li>• the child is at risk for delay.</li> </ul>	
<b>Provincial Wait Time Monitoring Project Steering Committee, Nova Scotia</b> (Health Care Human Resource Council 2003)	To recommend a standardized, province-wide approach to collecting and reporting wait-time information. The focus at that time was on orthopedic surgery, diagnostic services, and referrals from general practitioner to oncology, plastic surgery, and gastroenterology specialists.	<p>Working groups were formed to make recommendations on the following:</p> <p><i>Wait time definition:</i> specific start and end times for measuring wait times</p> <p><i>Priority bands:</i> categories that reflect the urgency level of the patients (not emergency cases). These are most often set as three categories.</p> <p><i>Priority tools:</i> consistent way to measure priority bands, such as checklists, priority scales, and tools already in use help prioritize patients by need</p> <p><i>Target wait times:</i> suitable time frames for service delivery</p> <p><i>Wait time data collection:</i> the systems used to report information</p>	

Name/Location	Purpose	Components of System	Comments
		<i>Data reporting:</i> how the wait time information should be reported to the public.	
<b>Chan &amp; Sheps (pending) Research Project</b>	Establish a valid measure, definition, and variation(s) of waiting list, wait time of early intervention services for preschool children in BC.	In process	

**Appendix E****ADDITIONAL DETAIL ON WAITLIST REDUCTION  
STRATEGIES USED IN BC****Speech Language Pathologists**

- implement train-the-trainer models
- include families in a more integral way in the therapy process
- rotate treatment blocks
- offer treatment/play groups
- see only children who have delays in more than one area
- see only children who are at risk, using the Ages and Stages Questionnaire
- advocate for services in our area (MLA, Minister Hagan)
- see children in pairs
- see children less frequently
- providing “breaks” for some children
- set up a treatment block for a group of children
- use one-time only funding to provide parent education courses and Intake consultations.
- backfill funds for short term contracts with private SLPs

**Physiotherapists**

- limit the service to a specific type of referral
- provide effective screening
- provide block therapy
- provide group therapy
- refer to private practitioners
- define waitlist
- contact parents by phone early
- see children on school therapy outside of school hours

**Occupational Therapists**

- Our administration has mandated we try strategies to reduce our waitlist with reducing parameters of service, even though we don't want to use them.
- We close the waitlist for half the school year while assessments are done.
- We define waitlist.
- We provide general inservices to teachers and teacher assistants regarding topics such as fine motor development and sensory based behaviours.
- Participating in school team discussions can reduce the number of students with less serious issues.

**Appendix F****EXAMPLES OF WAITLIST PRIORITIZATION METHODS USED IN BC**

<b>Name of Strategy</b>	<b>Description</b>
<b>2-Category System</b>	<p><b>Urgent</b>  <i>Service provided within two weeks, with ongoing intervention</i></p> <p>Feeding (e.g., aspiration risk), acute/subacute medical sequelae (e.g., primary respiratory complication), central nervous system dysfunction (e.g., significant neurological sequelae), palliative/degenerative, orthopedic/neuromuscular (e.g., torticollis), intervention (e.g., post-botox, rhizotomy), psychosocial (e.g., familial anxiety with multiple stressors, consult with social worker)</p> <p><b>Fast-tracked</b>  <i>Service provided within one to six months, with consultation to determine service need</i></p> <p>Infants under 12 months, feeding (e.g., g-tube to oral), orthopedic (e.g., spina bifida), psychosocial (multiple factors), intervention (e.g., transition planning, splinting)</p>
<b>5-point priority intervention criteria for school consultation</b>	<p>1 = children for whom safety is a concern</p> <p>2 = children for whom needs have been identified as urgent, as they are unable to function within their environments</p> <p>3 = children who need therapy intervention due to difficulty functioning within their environments</p> <p>4 = children whose program has been put in place and who need periodic review</p> <p>5 = children requiring assistance with a specific problem.</p>
<b>2-category system for use in school</b>	<p>1 = direct service          Definite diagnosis, such as cp, dcd, md, that interferes with educational program, students with severe sensory dysfunction, on at-home program, on set-bc.</p> <p>2 = indirect service, as time might be available, or provide inservices, written information, screening for category +1.</p> <p>Learning disabilities, mentally handicapped, fine and gross</p>



Name of Strategy	Description
	motor delays consistent with global delay, autism, poor writing and printing
<b>2-stage waitlist</b>	<p>I = initial consult waiting</p> <p>2 = regular service of some type, removed from waitlist. May return right back to waitlist when service is over, such as parent-child education group</p>
<b>3-tier Urgency Rating</b>	<p>R = regular, by date of referral</p> <p>Fast Track = 3–6 months</p> <p>Urgent = several weeks</p>
<b>Manitoba Outcomes Measures</b>	<p>The Manitoba Speech-Language Pathology Outcomes Measure is a comprehensive prioritization system with potential for customization for a wide variety of agencies and services. It has been developed solely for speech language pathology. The MSLPOM was designed to measure change in an individual's performance as a result of speech-language intervention by assigning a severity and priority rating at the beginning and ending of the intervention or at a later interval. It was also intended to assist in caseload prioritization and provide consistency across programs for rating individuals in terms of severity and in measuring outcomes. It has been field tested. At present, it is being used in an adapted way by a small number of speech language pathologists/agencies around the province. It is being used as a multi-tool, as it is being used in part as a waitlist prioritization capacity as well.</p> <p>Many speech language pathologists have customized the standard scale presented within CASLPA or are waiting for comments from the college prior to using it.</p>

**Appendix G****WAITLIST RECORDING FORM****Child's Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_**Date of Referral:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date:** \_\_\_\_\_**Reason for Referral:** \_\_\_\_\_**Urgency Rating:** \_\_\_\_\_**Service Need Identified (i.e., type of intervention)**  
\_\_\_\_\_  
\_\_\_\_\_**Service Delivery Method Proposed: (i.e. assessment, individual/group treatment, consultation)**  
\_\_\_\_\_**Frequency of Intervention Expected, if known: (i.e., weekly, twice a month, once a month, once every 6 months)**  
\_\_\_\_\_  
\_\_\_\_\_**Waitlist Type: (initial consult, assessment, individual/group treatment, consult)**  
\_\_\_\_\_**Date Child's Name Placed on Waitlist:** \_\_\_\_\_**Waitlist Priority:** \_\_\_\_\_**Date Child Received Service Identified:** \_\_\_\_\_**Services Child Received While on This Waitlist:** \_\_\_\_\_**WAIT TIME** \_\_\_\_\_

**Appendix H****PRINCIPLES OF PRIORITIZATION STRATEGY**

- **Accountability**  
Prioritization strategy is administered in a professional and ethical manner. Families have the right to expect that services and the manner in which they are delivered are consistent across the province.
- **Fairness and Equity**  
Placement of children and families on waitlists must be fair and equitable at all stages of the process.
- **Access to Information**  
Information about the waitlist process, including how to access it, decision-making stages, and procedures, as well as relevant policies, is made available and provided to individuals requesting the service.
- **Openness**  
The process is to be conducted in an open manner. Individuals will receive information at the time of initial referral for service regarding the range of services available and the limitations on service availability, as well as the length of the waitlists, and will be kept up to date.
- **Consistency**  
The same principles, criteria, and procedures for developing and managing waitlists are followed by all pediatric therapists.

Adapted from: Manitoba Speech-Language Pathology Outcomes Measure (2000). An Implementation Manual for Speech-Language Pathologists and Administrators, Manitoba Education, Training and Youth.

**Appendix I**

<b>RATING <span style="color: red;">URGENCY</span> FOR INTERVENTION</b> <b>EXAMPLE WAITLIST PRIORITIZATION STRATEGY</b>
--

	0	1	2	3	Total
<b>Consider referral issue and need for immediate intervention</b>  <b>Assign value 0–3</b>	Child does not require intervention or is ineligible	Timing of Intervention is not critical for the child. May be chronic condition.	Child needs to be seen as soon as possible but not necessarily immediately.	Child requires immediate intervention.	
<b>Consider impact of health condition on child's activity participation</b>  <b>Assign value 0–3</b>	No impact	Minimal impact	Impact evident in some but not all aspects of life	Significantly impacts on all aspects of life	
<b>Child and family reaction to referral issue/health condition</b>  <b>Assign value 0–3</b>	Not concerned	Somewhat concerned	Noticeably concerned	Extremely concerned	
<b>Child's motivation toward intervention</b>  <b>Assign value 0–3</b>	Not motivated	Questionable Motivation	Motivated	Highly motivated	
<b>Support offered by family/school/agencies/other</b>  <b>Assign value 0–3</b>	Extensive support	Adequate support	Limited support	No support system	
<b>Effect of other health issues on referral issue</b>  <b>Assign value 0–3</b>	None	Minimal impact	Noticeable impact	Significant impact	
<b>Factor Total</b>					
<b>Prioritize Intervention</b>	No service initiated.	By date of referral	Fast track	Urgent	

Adapted from: Manitoba Speech-Language Pathology Outcomes Measure (2000). An

Implementation Manual for Speech-Language Pathologists and Administrators, Manitoba Education, Training and Youth.

The scale is an example of a waitlist prioritization method, and has not been field tested. Each factor is given an urgency rating from 0 to 3, resulting in a total that represents the urgency of the referral, leading to a decision whether to prioritize intervention or not. This results in more objectivity and can potentially make the wait fairer and less stressful for the family and therapist.

## Appendix J

## LEVEL OF PARTICIPATION SCALE

Child's Name:

Date:

ACTIVITY:

1	2	3	4	5	6	7
Total assistance	Maximal assistance	Moderate assistance	Minimal assistance	Supervision for participation	Modified Independence with a device	Complete independence safely, on time
Child participates 0%+	Child participates 25%+	Child participates 50%+	Child participates 75%+	Child Participates	Child participates	Child participates
Helper needed	Helper needed	Helper needed	Helper needed	Helper needed	No helper needed	No helper needed

Description of child's typical performance:

Description of child's capacity under ideal conditions:

Describe:

- child's health condition
- contextual factors
- environmental factors
- personal factors

Adapted from:

1. CIHI (1997). National Rehabilitation Reporting System (NRS) Discharge Recording Form.
2. Manitoba Education, Training and Youth (2000). Manitoba Speech Language Pathology Outcomes Measure
3. Stewart, D. & Rosenbaum, P. (2003). International Classification of Functioning, Disability and Health (ICF), CanChild Centre for Childhood Disability Research.

**APPENDIX K**

<b>EXAMPLES OF CASELOAD SYSTEMS IN THE LITERATURE</b>
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Name/Location	Purpose	Components of System	Future Use/ Recommendations
<b>Caseload Management System for Community Occupational Therapists (Fortune &amp; Ryan, 1996)</b>  Initially developed in 1991 by occupational therapists from the Poplar Neighborhood Team in the London Borough of Tower Hamlets, London, England	<p>To ensure quality case interventions with a secondary benefit of addressing quantity of cases</p> <p>To improve services by reducing unnecessary cases, freeing time to work on complex cases and using expertise more efficiently</p> <p>To assist staff development</p>	<p>Accepts clinical reasoning as core</p> <p>Focuses on case complexity with differing levels of therapist experience</p> <p>Categorizes cases as simple quick (standard protocols, reasoning is procedural, familiar situation, limited time) simple long (same as above, but requiring more time) and complex (reasoning not procedural, individualized approach, clinical reasoning is creative, imaginative, intuitive, planning, intervention and documentation is time-consuming)</p> <p>Assigns a numerical weighting using established guidelines considering case complexity, level of therapist experience, and mix of caseload management and other professional responsibilities</p> <p>Establishes an individual caseload allowance for each therapist with a mix of simple and complex cases that do not exceed the maximum caseload allowance,</p>	<p>Need for ongoing and more formal evaluation</p> <p>System was not devised to apply to assistants</p> <p>Is suggested that model allows therapists to reflect critically, consider complexity and deal with practical issues</p> <p>Facilitates interacting and managing clients through a holistic approach</p>
<b>David Thompson Health Region,</b>	To allow flexibility in calculating the	The quota system has four “easy” steps:	“Percentages are flexible and can vary from month to

Name/Location	Purpose	Components of System	Future Use/ Recommendations
<b>Alberta, Illchuk &amp; Ward, (2005)</b>	maximum number of students to be seen directly and/or indirectly at any one time.	<p>1. Use your maximum active caseload (quota) for direct treatment and indirect treatment, i.e., 80 indirect, 40 direct.</p> <p>2. Take the amount of time given to each school and convert it into an FTE, i.e., 1 full day a week =.2 FTE.</p> <p>3. As a percentage, determine how your caseload will be split between direct and indirect treatment, i.e., 25% direct and 75% indirect treatment.</p> <p>4.To find the maximum number of students:</p> <p>Direct quota x FTE x direct service % = Max number of students to be seen</p>	month, depending on the needs of the particular school. Consider the amount of SLP assistant time available and the time needed for assessments and direct treatment versus consultation.”



Name/Location	Purpose	Components of System	Future Use/ Recommendations
<b>Manpower Measurement Model (Hollis and Kinsella, 1994)</b>	<p>To have agreed-upon staffing levels using staff input and data</p> <p>To identify staffing shortfalls, define staffing needs, and predict staffing requirements</p>	<p>Determine care groups receiving therapy.</p> <p>Calculate staff input hours per episode of care.</p> <p>Allocate time to specific parts of the therapy process (i.e., initial consultation, comprehensive assessment, consultation, group treatment, individual treatment, case coordination).</p> <p>Decide on the level of involvement of the therapist or assistant, based on professional standards</p> <p>Determine the time allocation to an episode of care. It must reflect the specific circumstances, such as travel time and related factors.</p>	<p>Includes therapy assistants and support personnel</p> <p>Takes into account total workload</p>

*“Components of System” continued on next page*

**Manpower Measurement Model —  
Components of System (cont'd)**

	Time Allocation	Therapist	Assistant	Carried Out by Support Staff
Intake Screen				
Initial consultation				
Comprehensive Assessment				
Individual Treatment				
Group Treatment				
Consultation to Child				
Consultation to Community				
Monitoring				
<b>Total</b>				

Determine the total treatment time per episode of care.

Calculate clinical time available per year in each care group.

*Continued on next page*

Number of hours worked per year, minus leave	Time available per year	% non-clinical time	<b>Total clinical hours available</b>
Therapist			
Therapy Assistant			

Calculate total episodes per year in each care group.

Total clinical time available	Total episodes of care per year	Total number of children to be seen

Determine required staffing levels, depending on total clinical time and total episodes per year in each care group, given the following considerations:

- Clinical staffing levels exclude non-clinical time and include all patient-related activities.
- Determination of clinical time available excludes annual and statutory leaves.
- Allocation of staff workload must relate to competence, experience, ongoing training and the clinical supervision available.
- Staffing levels are intended to include, not exclude assistants.

Adapted from Parker-Taillon (2005).

**APPENDIX L****CASELOAD FACTORS IN PEDIATRIC THERAPY**

<b>Advantages and limitations of seven factors to consider when building a caseload</b>		
<b>Factor</b>	<b>Advantages</b>	<b>Limitations</b>
<b>Contact frequency</b> <ul style="list-style-type: none"> <li>• Measure of service demand</li> </ul>	<ul style="list-style-type: none"> <li>• Routinely collected data</li> <li>• Index of time consumed by client</li> </ul>	<ul style="list-style-type: none"> <li>• Potential to encourage overservicing</li> <li>• Does not take into account duration of contact</li> </ul>
<b>Response difficulty</b> <ul style="list-style-type: none"> <li>• Measure of client need and level of individual service required</li> </ul>	<ul style="list-style-type: none"> <li>• Provides an index of expected time allocation</li> </ul>	<ul style="list-style-type: none"> <li>• High response difficulty does not always equate to workload</li> <li>• Response difficulty may be highly variable within caseload period</li> </ul>
<b>Intervention type</b> <ul style="list-style-type: none"> <li>• Reflects the range of evidence-based interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Recognizes variable time demands of different types of intervention</li> </ul>	<ul style="list-style-type: none"> <li>• May favour high-intensity interventions</li> </ul>
<b>Competence/seniority</b> <ul style="list-style-type: none"> <li>• Reflects the range of skills and experience that affect caseload capacity</li> </ul>	<ul style="list-style-type: none"> <li>• Makes higher performance demands on those best equipped to manage</li> </ul>	<ul style="list-style-type: none"> <li>• Little evidence that experience or seniority results in increased efficiency</li> <li>• Any efficiency benefit difficult to quantify</li> </ul>
<b>Caseload maturity</b> <ul style="list-style-type: none"> <li>• Considers the greater burden of work required earlier rather than later in the process</li> </ul>	<ul style="list-style-type: none"> <li>• Recognizes the increased work demands associated with new cases</li> </ul>	<ul style="list-style-type: none"> <li>• No basis for quantification</li> <li>• Fails to take into account other periods of increased workload</li> </ul>
<b>Location of clients</b> <ul style="list-style-type: none"> <li>• Considers the geographical distribution of client caseload</li> </ul>	<ul style="list-style-type: none"> <li>• Allows for travelling time</li> <li>• Recognizes inverse relationship between services provided by case manager and services available in the community</li> </ul>	<ul style="list-style-type: none"> <li>• Need for travel difficult to measure</li> <li>• Difficult to quantify additional service demand associated with working in rural areas</li> </ul>
<b>Roles other than case management</b> <ul style="list-style-type: none"> <li>• Considers the non-caseload responsibilities</li> </ul>	<ul style="list-style-type: none"> <li>• Recognizes multi-role functioning of pediatric therapist</li> </ul>	<ul style="list-style-type: none"> <li>• May reduce flexibility in staff deployment</li> </ul>

Adapted from Parker-Taillon (2005).

**Appendix M****EXAMPLES OF CASELOAD WEIGHTING STRATEGIES USED IN BC**

<b>Name of Strategy</b>	<b>Purpose</b>	<b>Description</b>	<b>Comments</b>
<b>Intervention Intensity Model</b>	<p>To ensure caseload is equitable across services and staff</p> <p>To identify staffing needs</p>	<p>100 points assigned to 1 FTE, with a 10-point leniency if new to pediatrics or the agency</p> <p>Each child is assigned an intervention intensity rating.</p> <p>60 points = department head</p> <p>20 points = equipment team</p> <p>5 points = casting and splinting program</p> <p>4 points = intense intervention (i.e., children who are medically fragile, post-surgical weekly service)</p> <p>3 points = moderate intervention (i.e., developmental delay of 1–2 years, 2 x month intervention)</p> <p>2 points = low intervention (i.e., global developmental delays, 1 x month intervention)</p> <p>1 point = monitoring, if you are case coordinator (i.e., children who have reached a plateau, 1 x each up to 6 months intervention)</p>	Used for OT/PT, not SLP
<b>Therapy involvement rating scale</b>	To determine caseload weighting for school-aged therapy.	<p>Scale with 0–5 values cross-referenced with a 6-point student need scale. Combinations of factors are computed and totalled. Suggestions for service recommendations are provided.</p>	Computer-based for OT ? PT

<b>Name of Strategy</b>	<b>Purpose</b>	<b>Description</b>	<b>Comments</b>
<b>3-tier priority</b>		<p>1. <i>most urgent</i> (direct intervention, highest priority: acute, post-surgical, major changes)</p> <p>2. <i>moderate urgency</i> (high priority: complex physical needs and those who require equipment)</p> <p>3. <i>least urgent</i> (generally requiring indirect intervention, lowest priority: gross motor problems who are able to function)</p>	<p>Reported by PT</p> <p>This reportedly makes it difficult to see children with disabilities such as hemiplegia who are basically functioning well.</p>
<b>5-point Scale</b>	To analyze caseload on a yearly basis	<p>5-point scale:</p> <p>5: highest need child and the therapist is the case manager, to:</p> <p>1: monitoring on a 3-month or less basis</p>	Reported by PT
<b>Squeaky wheel</b>	To weight caseload	To accept children on caseload whose parents strongly advocate for them	Reported by PT, OT
<b>Therapist decision on child need</b>	To weight caseload	Clinical decision by therapist	Reported by PT,SLP,OT
<b>Ad hoc</b>	To weight caseload	Inconsistent use of strategies	Reported by PT
<b>Original date of referral</b>	To weight caseload	Child is added to caseload only by date of referral	Reported by PT, OT
<b>By Manitoba outcome measures scale</b>	To weight caseload	Follow Manitoba scale for level of severity, priority, and prognosis	Reported by SLP
<b>High priority</b>	To weight caseload	Fluency, hearing loss, and swallowing are considered high priority	Reported by SLP
<b>Community agreed-upon list</b>	To weight caseload	Following the community's list of "priorities/urgent" needs	Reported by SLP
<b>By age</b>	To weight caseload	Older preschool children	Reported by

<b>Name of Strategy</b>	<b>Purpose</b>	<b>Description</b>	<b>Comments</b>
		receive more direct treatment time	SLP
<b>By progress</b>	To weight caseload	Children with mild needs who are showing good progress without intervention are monitored, if the families are in agreement with this service delivery option.	Reported by SLP
<b>2-point scale</b>	To weight caseload	1. safety issues, equipment needs, staff training 2. high incidence	Reported by OT for school based intervention
<b>By type of disability</b>	To weight caseload	Physical disability rates highest	Reported by OT for school-based intervention
<b>Priority of Intervention</b>	To weight caseload	Customized priority of intervention criteria	Reported by OT for use in school
<b>By number of areas affected</b>	To weight caseload	1. multiple areas of development affected (i.e., vision, self-care, gross-motor) 2. two areas of development affected 3. one area of development affected	Reported by OT
<b>Balance by Multiple Factors</b>	To weight caseload	Balance child's need, availability, and cooperation of family with the size of caseload and availability of treatment slot	Reported by OT

## **Appendix N**

### **RELATED CASELOAD FACTORS**

#### **Examples of Factors to Consider When Building Your Caseload**

##### **1. Child**

Will the child need more or less service in the immediate future? Will his or her condition be improving or deteriorating? Will the child be transitioning to a new environment? Will new teachers or caregivers need to be trained? Receiving a new piece of equipment that requires training? Undergoing surgery that needs intensive treatment?

##### **2. Family**

Does the family have additional needs, such as interpreters? Will you need to provide intervention in multiple settings, such as in families where there is a separation or respite situation? Does the family need additional information and training to help them understand their child's needs?

##### **3. Team/Community Need**

Will you be the service coordinator? Will the child have a large, small, or no team to coordinate with? Will the child have team members who do not work in your office?

##### **4. Service Delivery Model**

Will the intervention be provided in a consultative or collaborative model?

##### **5. Service Delivery Method/Length of Service**

How long will the child need service? Will the child need an assessment or consultation, then be discharged to kindergarten, or will the child be attending a group then discharged, or needing a rotating treatment block, or long-term weekly treatment?

##### **6. Location of Appointments**

Will the appointments be located conveniently across the hall from your office, or in a centre or school where you already see many children, or do you have to drive a long way to reach the appointment?

##### **7. Service Needed**

Is the child referred for a one-time service such, as a splint fabrication or developmental assessment, or a complex prescription with multiple appointments and liaising with other team members and tertiary facilities?

##### **8. Your Skill Level**

Do you have the experience and support available to provide the service requested? If not, is there someone else at your facility that does? Would it be more time efficient for the other staff member to provide this service? Can you organize your learning for this particular service through a mentoring situation with the other staff member or set it as a professional goal?

##### **9. Documentation method**

Does the case require a full, typed, comprehensive assessment, or will a handwritten triplicate form be enough? Do you have access to a computer-based system with drop-down menus for quick report development?



**Appendix O****CASELOAD RECORDING WORKSHEET**

Name: \_\_\_\_\_ Full time equivalent: \_\_\_\_\_

Date: \_\_\_\_\_

Active Caseload Size: \_\_\_\_\_  
 # seen on site: \_\_\_\_\_  
 # seen off site: \_\_\_\_\_  
 # seen in combination: \_\_\_\_\_

# receiving intense intervention (4 points each): \_\_\_\_\_  
 # receiving moderate intervention (3 points each): \_\_\_\_\_  
 # receiving low intervention (2 points each): \_\_\_\_\_  
 # receiving monitoring every 3 mos. or less (1 point each): \_\_\_\_\_  
 # receiving monitoring every 6 mos. or less (1/2 point each): \_\_\_\_\_

Number of Service Coordination Cases (1 point each): \_\_\_\_\_

Department Leader Responsibilities ( points): \_\_\_\_\_

Clinical Specialist (2 points): \_\_\_\_\_

# of once per week groups( points): \_\_\_\_\_

# of twice per week groups ( points): \_\_\_\_\_

# of once per month groups( points): \_\_\_\_\_

Coordination of the \_\_\_\_\_ program ( points): \_\_\_\_\_

Coordination of the \_\_\_\_\_ program ( points): \_\_\_\_\_

Participation in the \_\_\_\_\_ program ( points): \_\_\_\_\_

Participation in the \_\_\_\_\_ program ( points): \_\_\_\_\_

Adapted from the following sources: The Centre for Child Development, School District 33, Chilliwack, British Columbia, Fraser Valley Child Development Centre.

**Appendix P****CASELOAD SIZE WORKSHEET**

Name: \_\_\_\_\_ Full-Time Equivalent: \_\_\_\_\_

Date: \_\_\_\_\_

Record the number of children for the criteria below:

- ***On a monitoring schedule*** \_\_\_\_\_
  - Early intervention \_\_\_\_\_
  - School-age therapy \_\_\_\_\_
  - At-home program \_\_\_\_\_
  - Fee-for-service \_\_\_\_\_
- ***Receiving individual treatment*** \_\_\_\_\_
  - Weekly**
    - Early intervention \_\_\_\_\_
    - School-age therapy \_\_\_\_\_
    - At-home program \_\_\_\_\_
    - Fee-for-service \_\_\_\_\_
  - Twice a month**
    - Early intervention \_\_\_\_\_
    - School-age therapy \_\_\_\_\_
    - At-home program \_\_\_\_\_
    - Fee-for-service \_\_\_\_\_
  - Monthly**
    - Early intervention \_\_\_\_\_
    - School-age therapy \_\_\_\_\_
    - At-home program \_\_\_\_\_
    - Fee-for-service \_\_\_\_\_
- ***Enrolled in group treatment*** \_\_\_\_\_
  - Early intervention \_\_\_\_\_
  - School-age therapy \_\_\_\_\_
  - At-home program \_\_\_\_\_
  - Fee-for-service \_\_\_\_\_
- ***For periodic consultation*** \_\_\_\_\_
  - Early intervention \_\_\_\_\_
  - School-age therapy \_\_\_\_\_
  - At-home program \_\_\_\_\_
  - Fee-for-service \_\_\_\_\_

Total number of children on active caseload: \_\_\_\_\_

**Appendix Q**

<b>INTERVENTION INTENSITY GUIDE</b> For Pediatric Physiotherapy and Occupational Therapy	
Intense Intervention: <b>4 points</b>	Children who: <ul style="list-style-type: none"> <li>• are medically fragile</li> <li>• are post surgical</li> <li>• Demonstrate significant developmental delay more than 2 years for any area</li> <li>• Have ongoing equipment and positioning needs</li> <li>• Family has significant need for support and/or information</li> <li>• <i>Intervention of some form is provided weekly</i></li> </ul>
Moderate Intervention: <b>3 points</b>	Children who: <ul style="list-style-type: none"> <li>• are medically stable</li> <li>• demonstrate developmental delay of between 1 and 2 years for any area</li> <li>• have movement abnormalities</li> <li>• have equipment needs that are not changing rapidly</li> <li>• family has information and support needs</li> <li>• <i>Intervention is provided at least twice a month</i></li> </ul>
Low Intervention: <b>2 points</b>	Children who: <ul style="list-style-type: none"> <li>• have global developmental delays</li> <li>• are progressing at a slower rate but in keeping with their cognitive abilities</li> <li>• no movement abnormalities</li> <li>• minimal equipment needs</li> <li>• family requires a flow of information but is otherwise well supported</li> <li>• <i>Intervention is provided once a month or less</i></li> </ul>
Monitoring: <b>1 point</b>	Children who: <ul style="list-style-type: none"> <li>• have reached a plateau in their development</li> <li>• do not demonstrate significant change</li> <li>• Have been referred to adjunctive services</li> <li>• family calls with sporadic concerns</li> <li>• <i>Intervention provided once every 3 months or less</i></li> </ul>
Consultation: <b>½ point</b>	Children who: <ul style="list-style-type: none"> <li>• have environmental adaptation issues</li> <li>• have requests for a topic-specific issue</li> </ul>

Adapted from: The Centre for Child Development, School District 33, Chilliwack, and The Fraser Valley Child Development Centre

**Appendix R****WORKLOAD FACTORS AFFECTING  
CASELOAD AND WAITLIST MANAGEMENT:  
ADDITIONAL RESPONSES OF SURVEY RESPONDENTS**

- With the introduction of individualized funding for autism spectrum disorders, there appears to be a dramatic increase in parents of children with other diagnoses “fighting” for services for their children. The parents are requesting a set level of service/certain hours of service per week, instead of having the level of service match the actual need of the child. There has been a dramatic increase in the number of hours having to be spent by all levels of the team and administration in “putting out brush fires” instead of working collaboratively with parents to meet the needs of their children. If public funding is not provided to adequately meet the needs, we should stop pretending the needs can be met.
- Lack of understanding and support from the Director of Student Support Services for the unique role of therapists in the education setting.
- Shift from having school-funded positions to contracts with outside agencies that have recruitment and retention problems.
- Lack of support in the district for team-building between disciplines. There is a splintering of service, lack of coordination, and duplication of some tasks by resource teachers.
- Schools relying on OT/PT for medical information, support, and guidance with little concept of the issues. The OT/PT spend a lot of time in case management for the school-age child.
- Communication with a large number of people who do not work in a team perspective. This takes a lot of time.
- Funded family support systems would go a long way to decreasing the stress on therapists and providing a far superior support system to families.
- The perception that therapists will do whatever everyone else won’t do or doesn’t have time for, such as typing, printing, family support.
- Accreditation is of utmost importance, but also took away hours and hours from direct client service.
- Sole charge positions have a high contingent of administrative duties attached.
- Too many non-client meetings.
- Lack of ability to network with others and find therapists.

- Investigating changing referral service information, such as what the specialty clinics do in Vancouver and how to refer to them, and what the eligibility criteria are.
- Learning about different associations and their parameters.
- Availability and high cost of assessments and equipment for private therapists. Central loaner site needed.
- Personal cost for keeping education up to date. Need regional meetings to share information about courses attended.
- Not enough computers for staff to become proficient.
- Complex family and child factors.
- Inadequate access to interpreters.

**Appendix S**
**RESOURCES NEEDED IN BC TO PROVIDE MORE  
ADEQUATE PEDIATRIC SERVICE:  
SUMMARY OF SURVEY RESPONDENTS**
***Speech Language Pathologists***

- speech language pathology positions
- effective recruitment/retention strategy to attract strong professionals
- health authority support and recognition of caseload and waitlist difficulties
- clerical support to schedule appointments, groups, and contact families
- transportation for families to come to appointments
- adequate wages, especially to recruit new staff
- staff dedicated to resource development and materials
- therapy aides
- funding for materials, supplies, and equipment
- funding and time for continuing education, including training to offer to parent groups
- space
- team-building, stress reduction, mental health, morale boosting

***Physiotherapists***

- more physiotherapy positions
- additional school resources to allow therapists to provide services that carry over into the home
- caseload guidelines
- clerical assistance
- increased school therapy time
- trained rehabilitation assistants (e.g., equipment, maintenance, clerical, group assistance)
- increased administrative support
- supported prioritization tool
- ways to collect statistics that show the need for service
- more hours for service delivery choice
- waitlist management tool
- sharing of resources by bigger centres (handouts, education)
- provincial standardization of forms and handouts to help cut down on administrative time
- more recreation therapists
- therapy aide to implement bursts of treatment, group treatment blocks, book appointments, clean toys
- easier access to equipment; someone on staff to inventory, maintain, and acquire equipment.
- better funding for equipment to decrease time looking for funding and equipment

- not funded
  - better access to technology for documentation and time management
  - determine if therapy is part of the delivery system of care of children and family development and where overlapping scopes of practice are occurring and how it can be managed.
  - prevent communities from finding ways of “doing without” physiotherapy
  - more support for the team approach to care at an administrative level
  - ability to use flexible outcomes that support a team approach to care
  - additional occupational therapists
  - funding to be aligned with the socioeconomic level of specific communities.
- 

### ***Occupational Therapists***

- more occupational therapy positions
- have managers who are occupational therapists to increase understanding of our role
- provincial guidelines or expectations of OT services in schools and in the community
- more OT and less PT in the schools
- more direct relationship with school board
- better clerical support
- ensure ministry guidelines match the level of funding to meet the goal
- cap caseloads
- eliminate public funding of private therapists and add that to the contracted public services
- fund therapists at a competitive rate
- eliminate the expensive bureaucracy developed to manage individualized funding for private therapies and turn that funding over to the regions to include in therapy contracts
- full complement of staff in all departments to prevent OT from “covering” for them
- adequate funding for both “health” and “educational” needs in a ratio that meets the needs as they increase within a community
- occupational therapy services to be funded within a private insurance plan as with physiotherapy and massage
- increase benefits and wages to rural communities
- use therapy aides/assistants to provide help with preparing materials and resources required for therapy sessions
- provide more education
- provide more supplies

## **Therapists' responses as to what they would do differently with additional resources:**

### ***Speech language pathologists***

- see children sooner.
  - increase range of services
  - increase length of service for those who need it
  - decrease the waitlist
  - increase choice of service delivery method (i.e. ,direct intervention, follow-up to consultation, consults with preschools and daycares around a specific child)
  - community education
  - attend more professional development courses to improve programming and abilities
  - provide more formal documentation
  - travel less
  - timely assessments and an actual person to actually do the treatment after
  - reduce size of caseload
  - make sound decisions on a lower stress level
  - time to develop innovative solutions
  - individualized programming
  - increase productivity
  - bring more positive energy to work
  - not provide “watered-down” service
  - prevention-focused therapeutic groups
  - develop parent education opportunities
  - be able to listen more effectively to the family
  - allocate therapists differently (ongoing therapy staff and screening, monitoring, groups, and training)
  - more effective consultation to staff in other disciplines and community partners
  - provide best evidence-based practice for particular child with a particular diagnosis
  - build staffing to address minority issues
  - employ flexible staff to provide evening hours.
- 

### ***Physiotherapists***

- direct service to children 6–19 in rural areas
- see children with high incidence needs
- better planning of utilization of services
- increase parent and caregiver workshops
- more effective service with increase in direct and indirect service
- see school-aged children outside of school time
- pull resources together for schools and parents
- less time copying, filing, and mailing
- time to supervise rehabilitation assistant to run group program and routine



- exercise programs
  - decrease the child's burden on the health care system
  - increased support to children, families, caregivers, schools
  - would increase job satisfaction
  - more direct treatment
  - smaller caseload
  - ensuring the child is well positioned for function
  - measure strategies to see what works and what doesn't in terms of waitlist strategies
  - train more therapists
  - use the team more effectively
  - decrease wait times
  - do more outreach to reach children we are currently missing
  - more classes, such as for wheelchair use.
- 

### ***Occupational Therapists***

- problem-solve our way of providing more services more confidently with understanding of our roles; we could work on a uniform level throughout our region and accommodate the uniqueness of the populations in the different areas of the region we serve
- ongoing targeted education and training
- training and support for writing and motor programs, perceptual motor groups
- less time wasted on office clerk tasks
- see the children in a more timely manner
- provide treatment when necessary
- provide more quality, in-depth intervention.
- feel less stressed
- increased consultation to primary caregivers
- nothing
- screen all children within three months and provide appropriate general information
- do 4–6 diagnostic treatment sessions before transferring the skills and information to the teacher's assistant, parent, or classroom teacher
- provide more holistic service, not on only the one topic asked about
- better able to monitor development and the efficacy of our services
- better communication with families and schools
- not spend so much time on being creative about how to get paid and then more able to focus on treatment
- see children in their homes and daycares
- more parent education
- preventive/proactive public education
- provide best practice service, not just "adequate"
- increase frequency of service
- increase educational inclusion

- investigate the use of therapy aides
- learn to use outcomes measures
- discover evidence-based practice/clinical practice guidelines.

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