

Caseload Management Planning Tool

ONLINE SURVEY REPORT

Purpose:

An online questionnaire was created to survey members of the Canadian Association of Occupational Therapists, the Canadian Physiotherapy Association and the Canadian Association of Speech-Language Pathologists and Audiologists concerning elements of the caseload management planning tool (hereafter called the Tool). The purpose of the survey was to seek stakeholder input to guide the development of the Tool and to confirm its relevancy and usefulness in diverse practice environments. The information derived from the survey will be used to further refine the Tool and to guide the communication strategy to promote its use.

Method:

Members of the three partner associations were sent an email message concerning the Tool with a link to the electronic survey. The survey was opened on February 1, 2010 for a period of four weeks; it was closed on March 1, 2010. The survey was available in both official languages.

Results:

A total of 2921 respondents answered the survey in English, while 159 responded in French, giving a total of 3080 responses out of a potential number of 22,000 (9000 CAOT, 10,000 CPA, and 4250 CASLPA members), indicating a response rate of 14%. The numbers in each section of the questionnaire vary as all respondents did not answer every question. The findings are as follows:

I. Demographic Information

1. Professional Identity

Professional identity	Number	%
Occupational therapist	994	32%
Physiotherapist	608	20%
Speech-language pathologist	1448	47%
Support personnel -OT	3	1%
Support personnel - PT	5	
Support personnel - SLP	7	
Other	15	
Total	3080	100%

Almost half the respondents were speech-language pathologists (47%) followed by occupational therapists (almost one-third of respondents) and physiotherapists (20%). The high representation of speech-language pathologists could reflect the importance of this project in the eyes of this profession. The lower representation of physiotherapists may be indicative of the large proportion of this group working in the private sector who does not view the Tool as being of relevance in this sector of practice. Included in the Other category were: educators, administrators, program facilitators, rehabilitation and therapy assistants.

2. Province/Territory of Residence

Province/territory of residence	Number	%
British Columbia	553	18
Alberta	445	15
Saskatchewan	159	5
Manitoba	143	5
Ontario	1124	37
Quebec	153	5
New Brunswick	137	4
Prince Edward Island	22	1
Nova Scotia	154	5
Newfoundland & Labrador	106	4
Yukon	16	1
Northwest Territories	10	0
Nunavut	9	0
Total	3031	100

There was geographical representation of respondents from each province/territory in Canada. Understandably, the provinces with the largest number of association members were most highly represented in the survey respondents as follows: Ontario (37%); British Columbia (18%); Alberta (15%); the Atlantic Provinces (14%); Saskatchewan and Manitoba (5%) and the Territories (1%).

3. Primary Professional Role

Primary professional role	Number	%
Clinician	2491	76
Administrator/manager	228	7
Professional leader	127	4
Educator	64	2
Researcher	32	1
Consultant	245	7
Other	89	3
Total	3276	100

The large majority of respondents were clinicians (over two-thirds) which is representative of the professional profile of members of the three professional associations. This strong representation of clinicians could also reflect the relevance and importance with which this group views this project. In addition to administrators and consultants (both 7%), professional leaders, educators and researchers also were represented in the survey participants (7%). The Other category (3%) included: retired individuals, case managers, unemployed professionals, students, regulators and those with combined roles.

4. Primary Client Group

Primary Client group	Number	%
Pediatrics	1308	40
Adults	815	25
Seniors	464	14
Mix of client groups	575	17
Not responsible for client care	124	4
Total	3286	100

There was marked representation from professionals working with pediatric aged clients (40%), followed by those involved with adults (25%) and the senior population (14%). Seventeen per cent of respondents had a mixed client case load while only 4% were not responsible for client care. The strong representation of respondents working with children may be indicative of the challenges this sector is experiencing with caseload management where client need surpasses the available human resource complement to provide service. This phenomenon is supported in the literature (see Background Paper, 2009).

5. Place of Employment

Place of employment	Number	%
Hospital	854	25
Rehabilitation centre	384	11
Community Practice	621	19
School Care	527	16
Private practice	534	16
Educational Institution	168	5
Other	276	8
Total	3364	100

One quarter of all respondents worked in hospital settings (25%), followed by community practice (19%), school care and private practice (16%), rehabilitation centres (11%) and educational institutions (5%). Other (8%) sites of employment include: long-term care, preschools, public health agencies, research centres, government agencies, consultants, and industry.

Summary of Section I Demographic Information

There was approximately a 14% response rate to the Caseload Management Planning Tool survey. Respondents included representatives from the three professional groups and all geographical regions of Canada. The greatest proportion of participants was clinicians working with children (40%) and adults/seniors (39%), in hospital (25%), community (19%) and school care and private practice (16%).

II. Caseload Management Planning Tool Questions

1. Are you aware of the caseload Management Planning Tool initiative?

	Number	%
Yes	858	29
No	2105	71
Total	2963	100

If yes, how did you hear about this project?

	English	
	Number	%
Email	675	59
Newsletters	246	21
Association web sites	270	22
Conferences	22	1
Word of mouth	111	9
Other	59	4
Total	1383	

Despite regular communications by the three professional associations, less than one-third (29%) of survey respondents were aware of the Caseload Management Planning Tool project. Those who were familiar with the project cited email correspondence (59%), association web sites (22%), newsletters (21%) and word of mouth (9%) as being their primary sources of information. Other mechanisms that informed respondents of the project included: association activities, through this survey, colleagues, and professional meetings.

2. What do you think is the most important purpose of a Caseload Management Planning Tool?

	Number	%
Human resources planning	454	12
Effective caseload planning	1773	49
Recruitment & retention of health care providers	342	9
Improving client outcomes	983	27
Other	94	3
Total	3646	100

Approximately half the respondents (49%) indicated that in their view, the main purpose of the Tool was effective caseload planning, followed by improving client outcomes (27%) and human resources planning (12%), recruitment and retention (9%). Other suggested uses included: facility planning, providing quality care, funding, efficiency, and managing limited resources. It is notable that many respondents saw the Tool as having an important impact on client outcomes.

3. Rate the usefulness of a Caseload Management Planning Tool in your practice setting.

	Not at all useful			Very useful				
Score	1	2	3	4	5	N/A	Total	Mean
Number	97	160	424	645	885	437	2648	4.15
Percent	(4%)	(6%)	(16%)	(24%)	(33%)	(17%)	100%	

While there was a range of responses from not at all useful to very useful, 57% of respondents indicated that in their view the Tool would be useful or very useful in their practice setting.

4. What would be the main use of a Caseload Management Planning Tool in your practice setting?

	English	
	Number	%
Effective caseload planning	1821	54
Improving client outcomes	783	23
Human resources planning	419	12
Recruitment & retention of health care providers	227	7
Other	141	4
Total	3391	100

Over half of respondents indicated that within their practice setting, the Tool's main utility would be directed towards effective caseload planning (54%), followed by improving client outcomes (23%) and human resources planning (12%) and retention (7%). Other uses suggested by survey participants included: facility planning, setting priorities, educational training, and advocacy related to the components of quality care and the need for time on the part of the provider.

5. The proposed Caseload Management Planning Tool would use a client classification system which is based on the World Health Organization (WHO) International Classification of Functioning, Disability and Health (ICF) to facilitate information collection and benchmarking.

	Number	%
Are you using the ICF classification system in your practice?		
Yes	407	15
No	2240	85
Total	2647	100
Would you need training in the use of this classification?		
Yes	2137	82
No	466	18
Total	2603	100

Respondents indicated that only 15% were familiar with the ICF Classification System and over 80% supported the need for training in this evaluation checklist. While the WHO ICF is an accepted evaluation tool used worldwide, most of the respondents to this survey are not using the ICF in their practice. This finding has important implications for promoting the widespread use of the Tool.

6. The proposed Caseload Management Planning Tool would also rate clients by the intensity and complexity of the interventions required. Would this rating be useful to your caseload planning?

	Number	%
Yes	2370	90
No	262	10
Total	2632	100

Survey participants indicated that the Tool’s capacity to rate the interventions of clients by complexity and intensity would be of value in caseload planning.

7. The proposed Caseload Management Planning Tool would determine an estimate of the time and the number of visits required by clients of similar clinical groupings. What resources would you use to determine these estimates?

	Not at all useful				Very useful	Total	Mean
	1	2	3	4	5		
Research Evidence	82 (3%)	158 (6%)	440 (18%)	829 (34%)	955 (39%)	2464	3.95
Retrospective data	63 (3%)	110 (5%)	498 (20%)	1039 (42%)	741 (30%)	2451	3.91
Expert Opinion	46 (2%)	130 (5%)	517 (21%)	1010 (41%)	740 (30%)	2443	3.93
Focus groups	165 (7%)	359 (15%)	674 (29%)	733 (31%)	428 (18%)	2359	3.54
Other	63 (29%)	7 (3%)	28 (12%)	40 (18%)	75 (35%)	213	3.06

When survey respondents were asked what resources they would use to estimate the intervention times required by clients, they rated research evidence, expert opinion and retrospective data as being their main sources of information. Focus groups were seen as being of slightly lesser importance. Other resources cited by respondents include: client outcomes, patient satisfaction, provider clinical experience and expertise, and external specific data.

8. In your clinical setting, what would be a reasonable percentage of the total work time that is not related to direct or indirect client care (such as meetings, administration, research, etc.)?

	Number	%
5%	315	12
10%	689	27
20%	820	32
30%	528	20
Other	219	8
Total	2571	

Survey respondents indicated that 20% (32% of responses), 10% (27% of responses) and 30% (20% of responses) of their work time was a reasonable amount of their day not allocated to client care. The range of values cited by participants extended from 0% to 100%. The Tool proposes that when calculating clinicians' time available for client care, 20% of work time be allocated to not client related to activities. This value is supported by survey respondents.

9. One step of the proposed Caseload Management Planning Tool would compare the therapist's time available for client care (all aspects of client care both direct and indirect) to the time required for clients' interventions. This would determine the number of clients that an individual therapist can manage effectively. Would you find it useful to have a Caseload Management Planning Tool that carries out this function?

	1 (not at all)	2 (somewhat)	3 (useful)	4 (very useful)	Total	Mean
Number	123	523	839	1029 (40%)	2508	3.39
Percent	(4%)	(21%)	(33%)			

Seventy-three percent of respondents indicated that in their practice setting, a Tool that determined the number of clients that an individual therapist could effectively manage would be a useful (33%) or very useful (40%) element in their practice.

10. How should a final Caseload Management Planning Tool be shared with the three professions? Check all that apply.

	Number	Rank
Email	2073	1
Newsletters	1202	5
Association web sites	1808	2
Conferences	1156	6
Instructional teleconference	1395	3
Webinar	1208	4
Total	2536	

Respondents indicated that the most effective communication mechanism to promote the use of the Tool would be email, association websites, teleconferences, webinars, newsletters and conferences in that order. Other suggestions included: hard copy, departmental meetings, promote to managers, online educational modules, workshops, multipronged dissemination approach, and volunteer contact at each site. This finding has important implications for dissemination of the Tool.

11. The proposed Caseload Management Planning Tool offers opportunities for sharing information and benchmarking. What processes would facilitate this outcome?

	Number	Rank
Teleconferences	1475	2
Chat rooms	520	5
Sessions at conferences	1333	3
Newsletters	1132	4
Websites	1872	1
Total	2500	

Other: webbased of teleconference, conferences too limiting, linkages, networking

Mechanisms to promote sharing of information and benchmarking recommended by respondents include: websites, teleconferences, conference sessions, newsletters and chatrooms. This finding has implications for the promotion of use of the Tool to promote benchmarking and sustainability.

Summary of Section II. Caseload Management Planning Tool Questions

The majority of survey respondents expressed their support for the development of a Caseload Management Planning Tool. They indicated the Tool would be useful in their practice setting for: determining the number of clients that an individual therapist could effectively manage (effective caseload planning); improving client outcomes; and human resources planning, recruitment and retention. Respondents indicated that very few (15%) were familiar with the ICF Classification System and the majority supported the need for training. The resources respondents would use to estimate the intervention times required by clients included: research evidence, expert opinion and retrospective data. Survey respondents indicated that 10 to 30% of their work time was a reasonable amount of their day not allocated to client care.

Despite regular communications by the three professional associations, less than one-third of survey respondents were aware of the Caseload Management Planning Tool project. For future information sharing and promoting use of the Tool, respondents recommended the use of email (electronic communications), association websites and teleconferences, and to a lesser extent conferences and newsletters.

Recommendations for the Tool based on survey results:

- **Provide training for the use of the ICF checklist**
- **Continue to use 20% as the total work time not allocated to client care**

- **Use electronic communication, association websites and teleconferences to disseminate information related to the Tool**
- **Use the same communication mechanisms to promote use of the tool and benchmarking practices**

Additional Comments:

A large number of respondents provided additional comments related to the Tool and its use. Comment themes included:

- This is much needed and overdue. Thank you for taking on this initiative.
- Patient treatment is a function of clinician expertise, patient compliance, and nature of dysfunction. It involves physical treatment, educating the patient, supervision. Suggesting time frames would end up being a tool used by insurance companies to dictate payment schedules.
- Not only should the complexity and location of patients/clients be a factor, the work processes also impact the workload capabilities. An offshoot of this initiative might be a sharing of Tips and Tools for efficiencies that might be value added to clinicians.
- The planning tool would likely not be relevant – elite athletes, outpatient ortho, private practice school setting, health promotion, consultative practice.
- It is important that administrators understand this tool. I think this information would be very useful to help advocate for more staff as there is no set standard for appropriate caseload sizes.
- The CMPT would be a good tool to use but it may not change the underlying pressure to garner as many attendances as possible.
- I have found that the ICF is quite cumbersome to use, I am a little skeptical that this tool will be widely adopted
- This is a great idea, but a hefty piece of work! Much needed initiative- I am looking forward to the final product.
- I think the biggest stumbling blocks for this type of thing is time away from patients. It cannot be too exhaustive or time consuming or won't get used in the clinical setting
- A tool like this can be very useful for our practices if it gives clear direction as to how much time is appropriate for various activities, patient contact activities, indirect patient activities and non-patient activities. It will need to be stressed that any benchmarks presented are guidelines only based on averages.
- The tool needs to be quick and easy. Make the system computer based and easy to read.
- Have you considered any potential negative effects of implementing a CMPT?
- It would be important to have discussions with representatives from provincial organizations, associations, service providers re: current caseload management standards
- A caseload management tool that could be used by OT's, PT's AND SLP's would be an incredibly valuable resource in this time of crazy caseloads when we are attempting to do more and more inter- and transdisciplinary service delivery...It would help us be more objective and realistic in

caseload planning, advocate for increased personnel/funding, and, possibly, prevent burnout. It would be particularly helpful if it allowed me to prioritize but also manage my caseload.
