

Integration of Care:

Perspectives of Home and Community Providers

Care Coordinators:

**CCAC Case Managers, Service Coordinators, Intake Coordinators,
System Navigators, Intake Coordinators/Order Processors**

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Executive Summary

Care coordinators are predominantly women. Although approximately 60% of the coordinators are under the age of 50, case managers as a group are older than service coordinators and order processors with half of them being over the age of 50.

The majority of coordinators are Canadian by birth and 9 in 10 speak English at home. Approximately 4% of respondents spoke French at home which is approximately the same proportion of Franco-Ontarians according to the 2006 census.

Case managers have higher educational levels with 6 in 10 having a baccalaureate compared with one-quarter of service coordinators and one-tenth of order processors. Given the roles and responsibilities of case managers versus the other two types of coordinators/processors, this may not be inappropriate. The majority of case managers are members of a regulated profession, predominantly nursing, compared with approximately one-third of service coordinators and one-fifth of order processors.

The majority (93.6%) of care coordinators worked for one organization and six in ten worked for large organizations with 100 employees/staff. Proportionately more case managers than service coordinators and order processors worked for large organizations. Care coordinators are predominantly part-time workers with seven in ten working part-time. While working part-time may reflect personal preferences, it does mean that these coordinators probably do not have the advantage of benefits. Proportionately more order processors have full-time work – two-thirds of order processors compared with less than one-fifth of case managers and less than one-third of service coordinators worked full-time.

On the whole, this is an experienced group of providers. However, case managers have been working in their profession longer than service coordinators and order processors – 50% of case managers compared with 18% of service coordinators and order processors have worked for more than 20 years in their profession. This is not surprising given that case managers have probably practiced as regulated professionals before assuming the case management responsibilities.

Potentially, experience in other sectors of care should improve the integration of services since coordinators would benefit from the knowledge of the roles, responsibilities and processes of these other sectors. All coordinators have had experience in other health care sectors, predominantly the acute and primary care sectors.

Client focused care is highly valued by care coordinators who see it as integral to integration. The meaning of integration offered by respondents highlighted four factors, in order of frequency: client-focused care (72.7%), providers working together/multi-disciplinary teams (36.4%), better access/availability of care/one-stop shopping (31.4%), and seamless care/seamless transitions (14.1%). When presented with a list of factors important to integration, care coordinators still chose client-focused care as the most important factor, followed by good communications amongst providers, and receipt of prompt information. Having shared values with other providers and understanding of one's role by other providers were ranked the lowest factors in the coordination of health and social services.

Conversely, the potential effects of poor coordination as rated and ranked by coordinators inversely reflected the important factors in integration. Poor client understanding of providers' roles and care plans and risks to the client health and well-being were highly rated, along with waste of resources.

The vast majority of coordinators indicated that they were able to establish a good relationship with the client. In establishing a good relationship with clients, coordinators' responses highlighted the need to be respectful of clients' needs and preferences, providing assessment in a timely manner, and the desirability of continuity of providers. Similar ethnicity between client and providers was seen as the least important factor. Despite the fact that only one in ten coordinators said they experienced a language barrier, they reported almost 30% of clients as having difficulty understanding the role of other providers, and almost one-fifth had no to little understanding of their care plans. Although coordinators can rely on family members in this regard, and indeed the majority find it easier to provide care when a family caregiver is involved, they also indicated that a little more than 15% of family members had little or some understanding of care plans. A greater focus on clear descriptions and explanations of treatment plans for clients and family caregivers may be required.

Although on the whole case managers and service coordinators are aware of the risks to health and safety posed by their client or their homes, one-half of order processors said they did not know of potential risks to be able to inform the driver or provider going to the home. More effort should be made to inform order processors of potential client and home risks.

Quality of service depends on timely service, which in turn relies on good coordination and communication. Almost one-fifth of case managers and service coordinators believed that services did not begin at the right time for their client. Ten percent of case managers and service coordinators said they were not able to arrange medical equipment and supplies in a timely manner. One-fifth said that the wait for service was due to delays in their own organization compared with one-quarter who said that delays were due to other providers.

Although coordinators said that client-focused care was the most important factor in good integrated care, 85% of case managers and service coordinators and 65% of order processor said that the care plan gave consideration to the time of day for service that was convenient to the client or caregiver. Only 6 in 10 case managers and service coordinators said that the care plan took into consideration the client's ability to pay.

While four-fifths (79.8%) of all care coordinators, including order processors, indicated that there were ways for clients to provide systematic feedback on services, 12.5% did not know of such a process, and 7.1% indicated there was no process for feedback.

Good communications amongst providers and the prompt receipt of good information were ranked by coordinators as the second and third most important factors in providing integrated care. Almost 40% of case managers and service coordinators said they did not have access to treatment plans of other care providers; proportionately almost twice as many service coordinators than case managers. Almost one-quarter of care coordinators were not satisfied with the information provided to them before their first visit with the client; 28% of case managers and 20% of service coordinators. Almost 4 in 10 case managers and service coordinators had to contact another provider for further information and 7 in 10 order processors had to contact another provider for information in anywhere from one to six of the last ten orders.

One-quarter of order processors had to get further information on at least 50% of their orders – usually because the information was incomplete or inaccurate. Order processors most frequently needed further information on medical equipment and supplies orders. When they did need to contact other providers for information, only one-quarter were able to do so in a timely manner, most often because the person contacted did not return the call in time. As a result, for the last 10 orders, only one-half of order processors were able to fill all the orders in the time

frame specified. There were more delays experienced in filling orders for medical equipment and supplies. A little over one in ten order processors said the delay in processing all of the last 10 orders was due to the CCAC.

Almost one-third of care coordinators said they were not informed in a timely manner when their client was moved from the home into a hospital or a LTC facility. Furthermore, when their clients returned to their home, three in ten care coordinators did not receive information about the care plan promptly.

Obtaining client health and test information from other providers, being informed of changes to treatment or care plans, and the ability to reach the other providers in a timely fashion are key, as we have seen, to coordinators' views of what comprises quality integrated care. Deficiencies in these areas merely frustrate providers and can lead to risks to clients' health and well-being.

Home care clients frequently have multiple providers who are not onsite at the same time. Collaboration requires the knowledge of the existence of other providers. In this regard, over 90% of care coordinators knew who the primary health or social service provider was, who the primary family caregiver was, whether the client had a family physician, and who to call if they needed professional help regarding their client. However, this means that less than 10% did not. Over one fifth did not know whether the client had other non-CCAC providers, three times as many service coordinators than case managers. The most frequent source of information about the existence of other providers is the client or family care giver, especially for case managers.

Working together in multidisciplinary teams was one of the major factors according to care coordinators in the provision of well integrated care. In this regard, care coordinators felt that their formal training had prepared them for collaborative work. The majority of case managers and service coordinators felt they worked well with other providers. However, twelve percent and 3 percent of service coordinators and case managers respectively did not share this feeling. While three-quarters of case managers and service coordinators said they felt part of a team with other providers, one-third of service coordinators and 15% of case managers did not feel part of a multidisciplinary team. Only 64% of care coordinators had planned joint meetings or teleconferences with other providers. Two-thirds of order processors compared with one-third of case managers and service coordinators had not planned joint meetings or teleconferences. Another indication of coordinated action is the extent to which clients are available at the appointed time. Almost 40% of case managers and service coordinators said the client did not meet the appointment. Three-quarters of order processors said that in their last ten orders, between one and five clients were not there at the appointed time.

When given a list of 14 strategies for improving integration, care coordinators gave the following three factors the highest ratings: *having the appropriate provider providing care, having case managers in hospitals, and developing strategies to promote the health of the client and prevent decline and illness*. When asked to rank the 14 strategies in terms of importance, respondents chose: *Strategies to promote the health of the client and prevent decline and illness, Having the appropriate type of provider providing care, Providers working to the full extent of their training, and Electronic health records.*

When asked what one thing they would change to improve client's care in the home and community care system, *Increased funding, resources, and staff* was the most frequently mentioned change, followed by *Better collaboration with other providers, and Improved access to care/one-stop shopping*.

1.0 Introduction

The health care system in Ontario, like many others, is largely a loose confederation of institutions, contractual arrangements, informal referrals and individual practitioners. Each has their own business requirements and obligations, challenges and information systems. Reimbursement rewards behaviours that further isolate each institution as they maximize their own interests and often work at cross purposes with others.¹

In March 2006, the Ontario Government created fourteen Local Health Integration Networks (LHINs), not-for-profit corporations, whose main roles are to plan through community consultations, fund and integrate health care services locally for hospitals, community care access centres (CCACs), community support services, long-term care, mental health and addictions services, and community health centres.

This was part of the Government's major transformation of the health care system. Pivotal in this transformation was the idea that care should reflect the distinct needs of a specific community, and be planned, coordinated and funded within that community. These reforms to health care recognized the importance of *integration* in the provision of high quality care, the creation of a system of care, and ultimately the sustainability of health care financing.²

In response to these reforms The Change Foundation's 2007-2010 strategic plan³ identified integration as a topic that presented a significant opportunity to help improve health care in Ontario. The plan had three strategic priorities – integration, quality improvement in home and community care, and informed public dialogue. To ground the integration research agenda, a conceptual framework was developed which included the following elements: the patient perspective; the provision of care; governance structure and authority; funding mechanism and incentives; performance management; and information management. The new 2010-2013 strategic plan adds a more tightly focused goal to improve the experience of individuals and caregivers as they move in, out of, and across Ontario's health care system over time and as their health changes.⁴

In exploring the first element of the 2007-2010 strategic plan, the patient perspective, The Foundation conducted a review of the literature. Much has been written about the challenges, barriers and opportunities for the integration of services, but what was lacking is the perception and understanding of integration from the perspective of patients and their caregivers. As a result The Foundation held ten focus groups with patients who are frequent users of the health-care system (minimum of six interactions within the previous year), and caregivers of people with multiple chronic conditions. Respondents were asked about their experience in navigating Ontario's health system. Feedback from focus group respondents highlighted issues related to service repetition, redundancy and delay, worries about communication between providers, and concerns about the overall coordination of their care. These problems and concerns were exacerbated at points of transition.⁵ A summary of the report can be found on The Foundation's website.

¹ Berwick, D., B. James, M. Coye (2003). Connections between Quality Measurement and Improvement. *Medical Care*. 41(1), Supplement. Pp I-30 to I-38.

² Ontario Local Health Integration, *About LHINs*. http://www.lhins.on.ca/aboutlhlin.aspx?ekmensele2f22c9a_72_184_btnlink

³ The Change Foundation, *2010-2013 Strategic Plan: Contemplating the way we change, changing the way we think*. May 2007. <http://www.changefoundation.ca/docs/TCFstratplan2007-2010.pdf>

⁴ The Change Foundation, *2010-2013 Strategic Plan: Hearing the stories, changing the stories*. June 2010. <http://www.changefoundation.ca/docs/2010strategicplansummary.pdf>

⁵ The Change Foundation, *Who is the Puzzle maker? Patient / Caregiver Perspectives on Navigating Health Services in Ontario*. http://www.changefoundation.ca/docs/ChgFdn_Puzzle_Web.pdf

The Change Foundation felt that it was important to understand what integration meant to the providers of care within the health care and social services system. Working with the Community Provider Associations Committee (CPAC), The Foundation decided to begin the exploration of providers' perspectives on integration through a survey with health and social service providers who work in the community. CPAC includes:

- the Ontario Association of Community Care Access Centres (OACCAC);
- Ontario Home Care Association (OHCA);
- Ontario Community Support Association (OCSA);
- Community Healthcare Providers' Network (CHPN);
- Ontario Association of Children's' Rehabilitation Centres (OACRC); and
- Alliance of Professional Associations for Community-based Therapy Services (APACTS).

The members of each association in CPAC were organizations that provided home and community health care and social services in Ontario. The associations in CPAC included the majority of organizations providing home and community care in the province. In some instances, CPAC associations include organizational members who represent a variety of provider groups who may also be represented in other associations. For example, both the OHCA and the OCSA have home care nurses and personal support workers within their membership; rehabilitation therapists are members of OHCA and APACTS.

The role of CPAC in the project was to assist in project and survey development, and to provide mechanisms for accessing providers in their membership. The target group for the surveys included case management staff and providers working in the home and community sector. Specifically:

- CCAC Case managers/system navigators
- Community support service coordinators
- Home care nurses (registered nurses, advanced practice nurses, registered practical nurses)
- Personal support workers
- Rehabilitation therapists (occupational therapists, physiotherapists, speech language pathologists)
- Social workers
- Dieticians
- Community pharmacists
- Respiratory therapists
- Medical equipment and supply intake coordinators/order processors

Although primary care physicians are another key target group, it was felt that there were existing survey initiatives underway and therefore, they did not need to be part of this set of surveys.

2.0 Methodology

2.1 Development of the Surveys

A review of the health integration academic and grey literature was conducted to determine the issues, challenges and opportunities identified in the field. Based on the evidence found and the results of The Foundation's work on the perception and experience of integration of health care from the point of view of client/patients and their caregivers, a draft survey was developed for review. With the advice of the CPAC members it was decided that three different types of surveys should be developed – one for regulated health professionals, one for personal support workers, and one for case managers/ intake or service coordinators/ order processors. The survey for regulated health professionals would go to registered nurses, registered practical nurses, physiotherapists, occupational therapists, social workers, dieticians, respiratory therapists, and pharmacists. The survey for care coordinators would go to CCAC case managers and system navigators, care coordinators within organizations providing care, and to order processors in organizations providing medical equipment and supplies. The demographic section in each type of survey was identical.

An effort was made to have some consistency in questions across all surveys with modifications for particular groups. For example, the survey for pharmacists was modified to reflect the fact that pharmacists who were involved with processing prescriptions and orders for medical equipment and home care medical supplies often did not interact directly with recipients of care. Similarly, unlike CCAC case managers and care coordinators within home care provider organizations, order processors or intake coordinators within organizations providing medical equipment and supplies rarely had contact with recipients of care. In both the case of pharmacists and order processors, their direct contact clients were on the whole CCAC case managers or family physicians. As a result the variations introduced for pharmacists and order processors resulted in five different surveys and five processes for distribution of surveys.

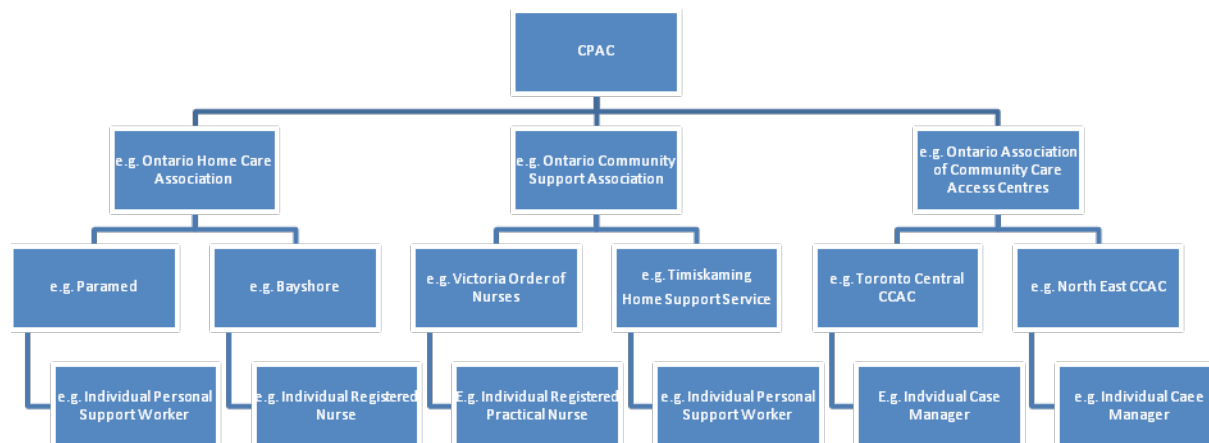
Research⁶ has shown that unusual events or problems tend to be more salient in people’s minds and remembered. As a result, these events are given more weight in questions that elicit overall perceptions or ask respondents to reflect on the “typical case”. To avoid this bias, the questions in the five surveys focussed on the participating provider’s interaction with his or her last client/case. With a randomly selected sample and a large enough sample, the occurrences of events, problems or issues should reflect the actual frequency of events.

With input from The Change Foundation and CPAC, the 5 different surveys were refined and pilot tested in the field with 5 members of each of the targeted professions listed above. The surveys took on average 30 minutes to complete by respondents. Based on the results of the pilots and the comments of the respondents, the surveys were further refined and finalized.

2.2 Sampling

To appreciate the sampling process adopted, it is necessary to understand the relationship between the members of CPAC, their member organizations, and the individual providers whom we were trying to survey, as well as the limitations on accessing these individual providers. Figure 1 schematically displays these relationships.

Figure 1: Relationship of CPAC Members to Individual Staff/Contract Employees



To determine the perceptions of all people who provide health care and social services to clients/patients in the community, it would be ideal to have contact information for all such providers. Providers would be categorized by type, e.g. case managers, service coordinators, registered nurses, personal support workers, etc. Surveys would then be sent to a randomly selected sample of the different types of providers. This approach would require each CPAC member to ask their member organizations to provide a list of their staff/contract employees. For privacy

⁶ Tversky, A., & Kahneman, D. (1974). Judgment under uncertainty: Heuristics and biases. *Science*, 185, 1124–1131.

reasons as well as placing an undue burden on its members, CPAC decided that contact information for all home and community care individual providers could not be made available.

A different approach to determining the population and sampling procedure was adopted. Each of the Associations in CPAC provided rough estimates of the total number of each type of individual provider in the employ of their members to determine the size of the overall population of individual provider types. Table 1 provides a summary of the estimates for each provider type. This provided a guide as to how many of each type of provider to sample or send surveys. Some of the provider types, e.g. dieticians, respiratory therapists were oversampled to ensure a large enough cell size for analysis. To achieve the number of completed surveys for each type of provider, twice as many surveys were sent to each provider type. Because of the limited number of pharmacists, respiratory therapists, and order processors for medical equipment and supplies organizations, all were sampled.

Table 1: Estimated Population and Sample Size of Home and Community Providers

Type of Provider	Estimated Population	Sample Size
<i>Regulated Health Professions</i>		
Registered Nurses	6500	300
Registered Practical Nurses	1600	200
Physiotherapists	1000	100
Occupational Therapists		100
Speech Language Therapists		100
Dieticians ¹	?	100
Social Workers ¹	?	100
Respiratory Therapists	50	50
Pharmacists ²	8	8
Subtotal	9,158	1,058
<i>Personal Support Workers</i>	20,000	300
<i>Care Coordinators</i>		
CCAC Case Managers	3650	300
Service Coordinators	4550	300
Intake Order Processors	62	62
Subtotal	8,262	662
Total	~37,420	2,020

1. CPAC was not able to identify an estimate of the population of dieticians and social workers for their organizations. ⁷
2. Pharmacists in this survey only included those filling orders and prescriptions for medical equipment and supplies in organizations of CPAC member associations.

A random sample is defined as a sample in which each person of interest has an equal chance of being asked to fill out the questionnaire. However, in almost any situation, compromises must be made between choosing a true 'random' sample and what is practical. In designing a method of sampling it is necessary to arrive at a compromise that maximizes efficiency (minimize complexity and burden), but does not forfeit in any obvious way the randomness of the sample. As indicated above, contact information for all home and community providers was not

⁷ After the surveys went out, data collected and analysed and report written, the OHCA contacted 40 of their member organizations to enquire on the number of dieticians and social workers employed by them. Twenty-four organizations responded. In total there were 39 dieticians and 51 social workers in their employ who provide direct home care services. Based on this information, the 100 surveys that went out to dieticians and social workers each were over-estimated.

available. The next best option – a list of all organizations in the province providing these services – was used to select individuals. Knowing the numbers of each type of provider within each organization would be desirable; however, it was not feasible to determine these numbers. Some of these organizations are large and have more than one location and some are single location organizations. The larger organizations are spread out across the province. As a result, to be able to sample the number of providers in each organization proportional to their size, it was assumed that the branch locations of a large organization were equivalent to each other and to single location organizations.

Organizations were grouped into one-location organizations, organizations with 2 to 9 branches, organizations with 10 to 20 branches, and organizations with 21 and more branch locations. However, organizations did not necessarily provide all services. The types of services - e.g. nursing, physiotherapy, occupational therapy, dietetics, social work, etc. – provided by each organization were determined. It was assumed that all branches of an organization provided the same array of services. Lists of organizations and their branches providing each type of service were developed, i.e. separate lists were developed for nursing, physiotherapy, social work, etc. The proportion of the total number of organizations providing a particular service for each size category was determined. The number of surveys determined for each type of individual provider was determined for each size category of organization. For example, see Table 2 for determining how to sample RNs from OHCA organizations.

Table 2: Determining the Number of Surveys to be sent to OHCA Organizations for RNs

Category of Organizations	Number of Locations Per Category	Proportion of All OHCA Organizations	Number of Surveys to be sent to RNs
Only one location	15	11%	16.5 ^a
2 to 9 locations/branches	24	17%	25.5 ^b
10 to 20 locations/branches	26	18.6%	28 ^c
21 and over location/branches	75	53.6%	80 ^d
Total	140	100%	150

- a. 15 members have only a single location. These represent 11% of the 140 locations ($15 \div 140 \times 100$) with nursing staff. 11% of the 150 surveys for nurses to be distributed to these locations is 16.5 (17) surveys.
- b. Members with 2 to 9 locations in total have 24 locations which represent 17% of the total 140 locations ($24 \div 140 \times 100$) with RNs. 17% of the 150 surveys to be distributed to these locations for RNs is 25.5 (25) surveys.
- c. Members with 10 to 20 locations in total have 26 locations which represent 18.6% of the 140 locations ($26 \div 140 \times 100$). 18.6% of the 150 surveys to be distributed for RNs to these locations is 28.
- d. Members with 21 to 32 locations in total have 75 locations which represent 53.6% of the 140 locations ($75 \div 140 \times 100$). 53.6% of the 150 surveys to be distributed for RNs to these locations is 80.

To reduce burden on both the associations and their member organizations, a random sample of “locations” was chosen (e.g. by a random number generator) in each size grouping of organizations and an approximate equal number of surveys was sent to each. As a result, each “location” only had to distribute between 4 to 10 surveys. Organizations were drawn randomly from each size category until all the surveys had been allocated for that size category.

Hard copies of the surveys were sent to the chosen organizations. It was critical that providers within each chosen location were selected randomly or in a way that did not leave the decision up to any person who might – for understandable reasons – try to choose individuals strategically. To ensure that individual providers were chosen in a manner that would be unlikely to differ in a material way, chosen organizations were instructed to select individuals whose last name began with a particular randomly chosen letter, going down the alphabet until all

surveys had been allocated. Each selected organization was given a different letter of the alphabet. Individual providers were instructed to return their surveys directly in self-addressed, prepaid postage envelopes to The Change Foundation.

Individual providers were told that participation in the survey was voluntary; all information provided in the survey would be confidential; no one but the researcher, Dr. Patricia Baranek, would see individual survey results; and only aggregate results (i.e. the sum total of responses to a question) would be reported in order to protect the anonymity of individuals.

2.3 Limitations

The assumptions, sampling process and distribution of surveys adopted may pose some limitations to the results as follows:

Assumptions

- CPAC member organizations and their staff/contract employees are representative of all home and community care providers in Ontario.
- The number of sites of multi-site organizations was a proxy for the size of the organization and its number of employees
- The size of one-off organizations was the same as each branch office or large, multi-site organization.
- The types of services provided by organizations were garnered from their websites or from the organization's association. The types of services provided were used as proxies for the types of providers employed/contracted by the organization. For example, if the organization provided nutritional counselling, it was assumed that they employed a dietician/nutritionist. If the organization was selected to distribute a survey to a dietician and in fact, the organization did not employ/contract with a dietician, the survey would not be completed and would affect the response rate for dieticians.
- It was assumed that organizations gave out the surveys to the appropriate personnel indicated in the covering letter. For example, it was assumed that respondents from the Regulated Health Professionals surveys who indicated that they were personal support workers or home support workers were in all likelihood registered practical nurses. Similarly, it was assumed that respondents who indicated that they were pharmacist technicians were pharmacists.

Process

- Because a list of all potential respondents (providers) was not available nor was working directly with provider organizations, there were a number of steps in the process of sampling where errors of omission or commission could occur.

Distribution

- It was assumed that organizations gave out the surveys to the appropriate personnel indicated in the covering letter. Those respondents from the Regulated Health Professionals surveys who indicated that they were personal support workers or home support workers were coded as registered practical nurses, or who indicated that they were pharmacist technicians were coded as pharmacists.

Responses

- The response rates were lower than expected but sufficient for analyses. The number of responses for some of the professional providers, e.g. speech language pathologists, dieticians, and respiratory therapists were too low for meaningful interpretation. Results for these professional groups are reported but should be viewed conservatively. In those instances where results for these professions are provided, both the percent responding and the actual count will be reported.

- In most cases the responses are based on the respondent's perceptions or recall, which may be biased or faulty.

2.4 Reporting Results

Because of the complexity of the surveys and the number of different types of respondents, the reporting of results has been broken down into four reports.

The first report details the results from the surveys of the Regulated Health Professionals:

- Registered Nurses (RNs),
- Registered Practical Nurses (RPNs)
- Physiotherapists (PTs)
- Occupational Therapists (OTs)
- Speech Language Pathologists (SLPs)
- Dieticians
- Social Workers (SWs)
- Respiratory Therapists (RTs)
- Pharmacists

The second report details the results of Personal Support Workers (PSWs).

The third report – this report - details the results from the Care Coordinators:

- CCAC Case Managers and System Navigators
- Care/Service/Intake Coordinators and System Navigators from OHCA and OCSA member organizations
- Intake Coordinators and Order Processors from CHPN member organizations that provide medical supplies and equipment

Finally, the fourth report provides a comparison of results from the three reports where possible.

When reporting data for all the respondents to this survey, the term 'care coordinator' will be used to refer to the combination of the three types of coordinators listed above. When specifically referring to the coordinators from the three different types organizations, the terms 'case managers' will be used for CCAC case managers, 'service coordinators' will be used for OHCA/OCSA care coordinators, and 'order processors' will be used for intake coordinators from medical equipment and supplies providers.

3.0 Results

3.1 Response Rate

Of the 662 surveys that were sent out to the care coordinators, 297 were returned for an overall return rate of 44.9%. The return rates did not vary much across the different types of care coordinators. Of the 300 surveys sent to CCAC Case Managers, 138 surveys were returned for a response rate of 46.0%. Of the 300 surveys sent to OHCA and OCSA Service Coordinators, 132 were returned with a response rate of 44.0%. The response rate for intake coordinators and order processors from medical supplies and equipment organizations was 43.6% (27/62). See Table 3.

Table 3: Response Rate from Care Coordinators

Participant Type	# of Surveys Distributed	No. of Surveys Returned	Valid Percent of Distributed Surveys per Professional Group
CCAC Case Managers	300	138	46.0%
OHCA/OCSA Care Coordinators	300	132	44.0%
Medical Supplies/Equipment Processors	62	27	43.6%
Total	662	297	44.9%

3.2 Demographics

Of the 297 respondents, 285 or 96% were female. The female and male respondents were proportionately distributed across the three types of care coordinators. While almost 60% of respondents were 50 years old or younger, 42% of care coordinators were over the age of 50. See Table 4. Half (50.7%) of the CCAC case managers were over the age of 50 compared with 36.4% of OHCA/OCSA service coordinators and 25.9% of medical equipment and supplies order processors. [Note: data not included in table]

Table 4: Age of Care Coordinators

Age Group (Years)	Frequency	Percent	Cumulative Percent
16-20	1	.3	.3
21-30	25	8.4	8.7
31-40	69	23.2	31.9
41-50	77	25.9	57.8
51-65	121	40.7	98.7
>65	4	1.3	100.0
Total	297	100.0	

The vast majority of participants (87.5%) were Canadian by birth. While English was the first language of 82.2% of participants, 90.9% currently spoke English at home. French was the first language of 5.7% of participants and 3.7% currently spoke it at home.

A little over one-third (34.9%) of care coordinators had a baccalaureate. Over one-half (54.0%) of case managers had bachelor's degrees compared with 19.8% of service coordinators and 11.1% of order processors. The educational level of the order processors varied from some high school to a bachelor's degree, with the majority (44.4%) having a diploma. See Table 5.

Table 5: Educational Levels of Care Coordinators

Provider Type	High School	Some College/ University	Certificate	Diploma	BA/BSc	MA/MSc/ MSW	Total ¹
Case Managers		3	3	48	74	9	138
Service Coordinators	7	20	22	49	26	7	130
Order Processors	6	4	2	12	3	0	27
Total	13	27	27	109	103	16	295

1. There were two missing responses.

When asked what their major profession was, 46.1% of care coordinators said they were registered nurses; 6.4% were registered practical nurses, 5.4% were social workers, 3.4% were personal support workers, 4.0% were community workers or home care workers, and 0.3% (n=1) was a respiratory therapist. A little less than one-third

(31.6%) indicated ‘other’ and wrote in case manager, service coordinator, client service specialist, etc. The majority (94.2%) of case managers said they were members of one of the regulated health professions – registered nurse, registered practical nurse, occupational therapists, and social worker. The remaining 5.8% wrote in their function, i.e. case management, and in one instance, the respondent was an elementary school teacher. Approximately one-half (49.6%) of service coordinators had indicated ‘other’ and wrote in either some form of coordination or administrative title such as director. Compared with case managers, only 34.4% of service coordinators were members of a regulated health profession (RN, 14.5%; RPN, 13.0%; PT, 1.0%; SW, 6.1%). The remaining service coordinators indicated they were either home or community support workers (9.2%) or personal support workers (6.9%). Almost one-fifth (18.5%) of order processors were members of a regulated health profession (RN, 7.4%, n=2; RPN, 7.4%, n=2; Respiratory therapist, 3.7%, n=1; Personal support worker, 3.7%, n=1). The remaining 77.8% of order processors said they were ‘other’, e.g. supply clerk, mobility rental coordinator, customer service, data entry, pharmacist technician, home healthcare/equipment manager, or clerk. See Table 6.

Table 6: Care Coordinators’ Major Profession

Profession/Type of Care Coordinator	Case Manager (%)	Service Coordinator (%)	Order Processor (%)
Registered Nurse	84.7	14.5	7.4
Registered Practical Nurse		13.0	7.4
Personal Support Worker		6.9	3.7
Occupational Therapist	3.6		
Physiotherapist		1.0	
Social Worker	5.8	6.1	
Respiratory Therapist			3.7
Home or Community Support Worker		9.2	
Other	5.8	49.6	77.8
Total	99.9	100.3	100.0

Care coordinators were asked which services they currently and predominantly provided directly to clients. If they provided more than one service, they were asked to rank order them in terms of frequency of provision. From the results, it is clear that case management, service coordination or order processing is only one of the duties performed by these respondents, and not necessarily the most frequently provided service by individual respondents. The most frequently provided service by care coordinators was predominately case management, intake coordination, or system navigation (57%). The other services that were ranked first in terms of frequency of provision included personal support (13.2%), community support services (8.1%), homemaking services (7.5%), and pharmacy services (4.4%). See Table 7. CCAC case managers most frequently provided case management services (87.5%, n=119). OHCA/OCSA service coordinators who responded to this survey said they did not predominately provide case management or service coordination. Only 49 or 37.1% of service coordinators said they provided case management/service coordination. The remaining 62.9% of services provided by service coordinators from OCHA/OCSA organizations were: service/intake coordination (37.1%), personal support (25%), homemaking services (16.7%), and community support services (12.1%). There was also considerable variability in the most predominant service provided by respondents who did some order processing for medical supplies and equipment suppliers. Only 7 respondents (25.9%) respondents said they most frequently provided general order processing or medical equipment supply order intake, while almost one-half (48%, n=13) predominately provided pharmacy services. Other services provided by medical equipment/supply order processors included nursing, respiratory therapy, and community support services. See Table 7.

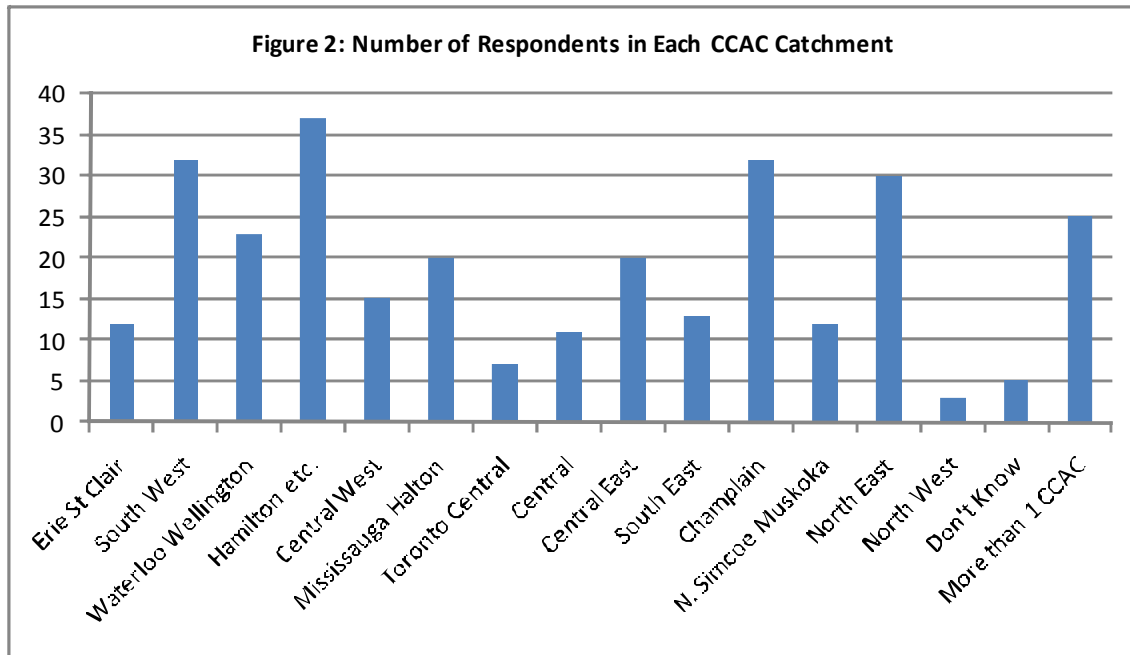
Table 7: Most Frequently Provided Service by Different Care Coordinators

Profession	Case Managers	Service Coordinators	Order Processors	Total
Nursing	4	5	2	11
Personal support	6	33		39
Physiotherapy	1	1		2
Occupational Therapy	1			1
Speech Language Pathology				
Social Work	1	3		4
Respiratory Therapy Services			1	1
Dietetics				
Case Mmt. /Intake Coord. /System Navigation	119	49		168
General Order Processing			3	3
Pharmacy Services			13	13
Medical Equipment Supply Order Intake			4	4
Medical Supplies Order Intake		3		3
Homemaking Services		22		22
Community Support Services	4	16	4	24
Total	136	132	27	295

Of the 295 respondents who answered this question, 59.3% said they provided only one service; 41.4% provided 2 services; 20.0% provided 3 services; and 11.9% provided 4 services. More interestingly, of the 59.3% of respondents who said they provided *only one* service, 29.1% said they provided case management, intake coordination or system navigation. A further 17.7% said they provided personal support services, 5.7% provided pharmacy services, 4.6% nursing services, 2.9% homemaking services, and 2.9% community support services. Those respondents who said they predominantly provided services other than case management, i.e. intake coordination, system navigation, general order processing, medical equipment order intake or medical supplies order intake, were probably listing the services for which they coordinate services or take orders. For example, respondents who said they provided pharmacy services may actually have been processing orders to fill various prescriptions, or those respondents who said they predominantly provided homemaking services were more likely coordinating services for homemakers.

The majority (67.7%) of coordinators worked in both urban and rural areas; 24.2% worked only in urban areas; and 7.1% worked only in rural areas.⁸ While the majority of care coordinators worked in one CCAC catchment area, 22 respondents (7.4%) indicated that they worked in more than one and five participants (1.7%) did not know which CCAC catchment area they worked in. Figure 2 shows the number of participants working in each of the 14 different CCAC areas of the province.

⁸ The total does not add up to 100% because there was missing data for 3 participants.

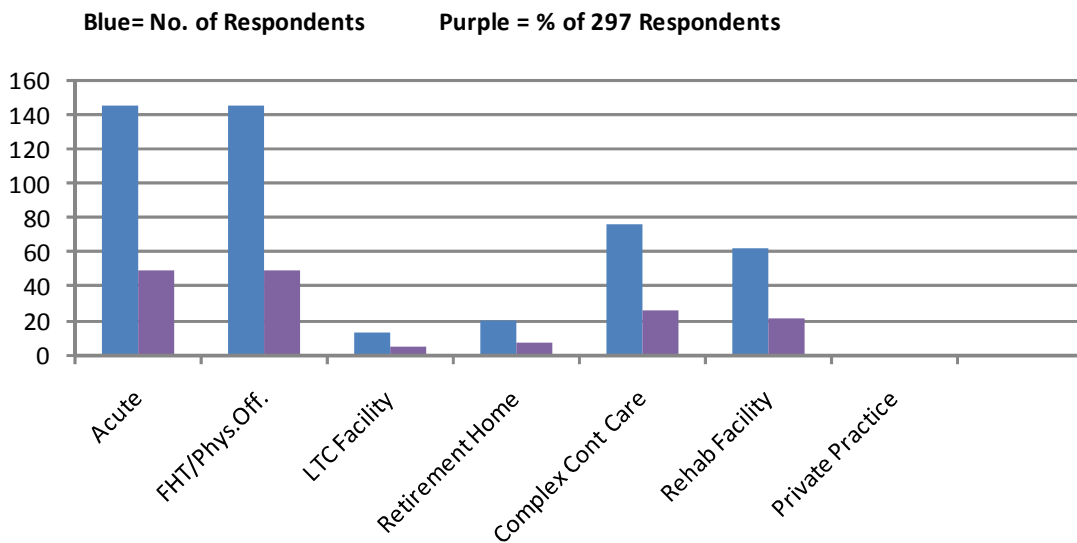


While 93.7% of care coordinators worked for only one organization, 7.5% (n=22) indicated that they were working for more than one. Of these 22, 14 were case managers, 5 were service coordinators, and 3 were order processors. Six in 10 respondents (60.9%) said they worked for an organization with more than 100 employees/contract staff; 14.9% worked for organizations that employed under 50 employees. Not surprisingly, 84.4% of case managers worked for organizations with more than 100 employees, compared with 47.7% of service coordinators, and 20.0% of order processors. The majority (81.8%) of care coordinators worked only during the week, while 17.2% worked both during the week and weekends. Almost 9 in 10 (89.1%) worked only days. Approximately seven in 10 (72.1%) worked part-time, and one in three (26.9%) worked 40 or more hours per week. Two-thirds of order processors compared with 1 in 5 (18.2%) case managers and 28.7% of service coordinators worked full time (≥ 40 hrs/wk).

One-third (33.0%) of participants had been working in their profession for more than 20 years, 21.9% had worked between 11 and 20 years, and 44.4% had worked 10 years or less. Proportionately more case managers had been in their current profession the longest – 50% of case managers had worked in their profession for more than 20 years compared with 18.2% and 18.5% of service coordinators and order processors respectively. Seventy percent of order processors had been employed in their profession for 10 years or less compared with 54.6% of service coordinators and 29.7% of case managers. Over 50% of participants (55.9%) had worked for 11 or more years within the community care sector, and 21.6% had worked for 5 years or less in the sector. While two-thirds of case managers had worked in the community sector for 11 or more years, approximately one-half (48.5%) of service coordinators and one-third (37.0%) of order processors had worked as long in the community.

All care coordinators had worked previously in other sectors of care. The most frequently listed other sector of care was the acute care sector (48.8%) and physician's office/family health teams (48.8%), followed by complex continuing care/chronic care (25.6%) and rehabilitation facilities (20.9%). See Figure 3.

Figure 3: No. & % of Respondents Who Had Worked in Other Sectors



3.3 Definitions and Perceptions of Integration

The Change Foundation has defined a well-integrated health care system from the patient perspective to mean *the process makes sense to you. It gives you confidence that all the providers you interact with are complementing each other's efforts, are respectful of each other's contributions, and are working together in your best interest.*⁹

3.3.1 Perceptions of Integration

All Care Coordinators were asked what integration of health care services for clients meant to them in their own words. Of the 297 care coordinators who responded to the survey, 220 (74.1%) answered this question. An analysis of their responses shows that the most frequently mentioned feature of well-integrated care is that it be client focused – almost three-quarters of care coordinators (72.7%) mentioned it.

Client and family actively involved in health care decisions. Health care information shared amongst client's health care team with client consent. Client able to choose who their health care team is. Client understands who does what on their HC Team. (CCAC case manager)

Integrations means – quality controlled, less fragmented, coordinated which is client centred promoting goal setting with client's participation, sharing relevant information which impacts on care planning. Mutual respect for all community providers with circle of care. (OHCA/OCSA service coordinator)

⁹ The Change Foundation, *2010-2013 Strategic Plan: Hearing the stories, changing the stories*. June 2010. <http://www.changefoundation.ca/docs/2010strategicplansummary.pdf>. pg.5.

Client or patient centred care addressing all the needs of the client/patient i.e. physical, mental and emotional with better coordination of health and social services. (Order processor)

The next three features of well-integrated care mentioned by care coordinators in order are:

Providers working together/multidisciplinary care (36.4%);

Agencies working together. Eliminate the 'silo' way that agencies have operated in for years. (CCAC case manager)

All health care services work together and share pertinent information to give the client the best care possible. (OHCA/OCSA service coordinator)

An integrated care would include open dialogue between all parties involved in care (i.e. client, caregiver, provider of service, Pt, Dts, etc.). If all people involved are in communication the process would be smoother. Of course, there are many other factors and systems that would have to be in place but communication is a great start. (Order processor)

Better access/availability of care/one-stop shopping (31.4%);

One-stop shopping – Health and social services working collaboratively to meet client needs. Referral for health care and social services through one agency. (CCAC case manager)

All services are amalgamated under one umbrella where it is possibly more accessible for people to access the services required, i.e. nursing, PSW/homemakers, companions, transportation. (OHCA/OCSA service coordinator)

All health services would be handled by one agency and would coordinate the services for each client. Therefore a patient would not have to contact more than one agency to help with all of their health care services. (Order processor)

Seamless/seamless transitions (14.1%);

Smooth transition between care partners with minimal upset to the client. All systems coordinate for easy transition between health and social services. (Order processor)

A seamless system where medical needs and social needs are considered of equal importance. All providers work together to support client's well-being. Service providers have opportunities to meet, learn together and develop respect for one another. (OHCA/OCSA service coordinator)

Client would be able to transition smoothly from hospital to the community with all services in place. One case manager would coordinate all services, funding and health

care would save time and resources in clients being able to access what they need.
(CCAC case manager)

Client would have one person to contact from referral to discharge of services. It would be seamless for client. Open communication between hospital/CCAC/social services in community. (CCAC case manager)

Table 8 lists all the features mentioned by respondents and the frequency with which they were mentioned.

Table 8: All Care Coordinators Views of Features that Comprise the Integration of Health and Social Services

Category	Count (No. of Respondents)	Frequency (% of Respondents)
Client Focused	160	72.7
Coordination/Working Together/ Multidisciplinary Care/Continuity of Care	80	36.4
Access/Availability/One-stop	69	31.4
Seamless/Seamless Transitions	31	14.1
Holistic Care/Health Promotion-Disease Prevention	28	12.7
Better Information Systems	26	11.8
Best Quality of Care/Effective Care	24	10.9
Better Communications/24-7 availability of FPs	21	9.6
Client at Home/Community care	16	7.3
Timely	14	6.4
Better Use of Resources/Decreased intake time and more service/ Decreased Cost of Care/One assessment tool	12	5.5
Understand/Respect each other's Roles	10	4.6
Equitable Care	9	4.1
Common Goals	8	3.6
Family Involvement/Support	6	2.7
Better use of skills		
Deliver care in appropriate setting		
Consistency of services/ Standardized Care	2	0.9
Decreased layers of bureaucracy	2	0.9
Evidence-based care	2	0.9
Accountable	1	0.5
Don't Know	4	1.8

3.3.2 Factors Important to Integration

Participants were asked to indicate how important a list of 10 factors was in the provision of coordinated health and social services on a scale from 1 (not very important) to 5 (very important). As can be seen in Table 9, most participants found all the factors to be very important in the provision of care although there are significant differences in the ratings of the 10 factors ($F = 18.747$; $df = 9,276$; $p < .001$). In order of frequency, client participation in care planning and considering their goals, the receipt of information promptly, and good

communications amongst providers were the factors that received the most support from participants. Having shared values with other providers received the least support. See Table 9.

Table 9: All Care Coordinators’ Ratings of Factors Important in the Coordination of Health and Social Services

Factors	Mean
Actively involving the client/family caregiver in the assessment and care planning and considering the client/family caregiver’s goals and needs in the care plan.	4.82
Having good communication about the client with other health and social service providers.	4.68
Having complete information about the client from other health and social service providers.	4.55
Receiving information promptly about the care plan or changes in the client’s health status.	4.71
Having shared values about care provision with other health and social service providers.	4.32
Having good working relationships with other health and social service providers.	4.55
Having a clear understanding of the individual roles and responsibilities of the care plan.	4.54
Ensuring that your role in delivering care is understood by other health and social service providers.	4.53
Having ready access and availability to health and social service providers.	4.54
Having available and reliable technology to support the transfer of information.	4.43

Participants were also asked to rank the 3 factors that were most important in providing coordinated health and social services. Out of 297 respondents, 249 (83.8%) did the rankings correctly. The results presented here are for the 249 respondents who understood the question. More than any other factor, *Actively involving the client/family caregiver in the assessment and care planning and considering the client/family caregiver’s goals and needs in the care plan* received the most support as the most important factor in providing coordinated care. *Having good communications with other providers* and *having complete information about clients from other providers* were the second and third most important factors respectively. See Table 10.

Table 10: All Care Coordinators’ Ranking of Factors Important in the Coordination of Health and Social Services (Percentage of Participants)

Factors	1 st	2 nd	3 rd
Actively involving the client/family caregiver in the assessment and care planning and considering the client/family caregiver’s goals and needs in the care plan.	68.3	13.1	9.5
Having good communication about the client with other health and social service providers.	6.4	21.7	19.3
Having complete information about the client from other health and social service providers.	9.2	14.9	10.8
Receiving information promptly about the care plan or changes in the client’s health status.	2.8	13.3	16.9
Having shared values about care provision with other health and social service providers.	0.8	4.0	4.0
Having good working relationships with other health and social service providers.	3.2	4.4	10.4
Having a clear understanding of the individual roles and responsibilities of the care plan.	2.8	10.4	8.8
Ensuring that your role in delivering care is understood by other health and social service providers.	0.8	2.8	3.2
Having ready access and availability to health and social service providers.	3.6	12.0	8.0
Having available and reliable technology to support the transfer of information.	1.6	4.0	8.8

3.3.3 Impact of Poor Coordination and Collaboration

Case managers, service coordinators, and order processors were asked to rate the likelihood of 7 listed potential impacts of poor coordination and collaboration on a scale from 1 (not very likely) to 5 (very likely). Respondents’

ratings show that the most likely impact of poor coordination and collaboration is *Poor client understanding of roles of health and social service providers and care plans* (mean = 4.15), followed by *Waste of human and other resources* (mean = 3.98), and *Risks to the client health and well-being* (mean = 3.97). There are significant differences in the ratings of the 7 factors ($F = 14.607$; $df = 6,254$; $p < .001$). See Table 11.

Table 11: All Care Coordinators' Ratings of Likely Effects from Poor Coordination and Collaboration amongst Providers (Scale (1) very unlikely to (5) very likely)

Effect	Mean Response
Waste of human and other resources	3.98
Poor client understanding of roles of health and social service providers and care plan	4.15
Clients not following the care plan	3.84
Poor understanding amongst health and social service providers of each others' roles	3.94
Poor understanding amongst health and social service providers about the care plan	3.95
Risks to the client's health and well-being	3.97
Risks to the health and social service provider's safety and well-being	3.50

Respondents were also asked to rank the top 3 of the above 7 effects that were most likely to occur from poor coordination and collaboration amongst providers. Almost four-fifths of respondents (79.9%) properly ranked the possible effects. *Risks to the client's health and well-being* was rated the most likely factor to result from poor coordination and collaboration, followed by *Poor client understanding of roles of health and social service providers and care plan* and *Waste of human and other resources*. See Table 12.

Table 12: All Care Coordinators' Rankings of Top 3 Likely Effects of Poor Coordination and Collaboration amongst Providers (Percentage of Participants ranking each factor first, second, or third)

Likely Effect	1 st	2 nd	3 rd
Waste of human and other resources	20.6	13.8	21.3
Poor client understanding of roles of health and social service providers and care plan	24.1	17.4	12.3
Clients not following the care plan	5.1	17.0	13.0
Poor understanding amongst health and social service providers of each others' roles	7.9	10.7	16.2
Poor understanding amongst health and social service providers about the care plan	4.0	12.6	14.2
Risks to the client's health and well-being	36.8	11.9	9.5
Risks to the health and social service provider's safety and well-being	1.6	15.4	9.1

Care coordinators offered the following comments to support their rankings with respect to the ill effects of poor coordination and collaboration:

Client can become frustrated and decline care if inconsistent – loss of trust. (Case Manager)

Duplication of roles for clients continues. This is a huge cost to health tax dollars. Process set out makes it very time consuming and often too many people working on the same matter → causes human error, which is a detriment to client. (Case Manager)

Many clients are confused by all the services coming into their homes. Many multidisciplinary teams don't even look at notes from other providers and

clients usually don't experience the best health or social outcomes. Communication and understanding roles and care plans is vital in making health outcomes positive. (Service Coordinator)

Waste of human resources as each agency does an intake and assessment. It would be wonderful if we were all the same and that they could be shared....It makes the client at times overwhelmed. (Service Coordinator)

3.4 Working with Clients

As demonstrated above, the relationship between the client/family caregiver and the individual provider is considered key in the provision of integrated care. Participants were asked to rate the importance of each of 8 factors in establishing a good relationship with their clients on a scale from 1 to 5 where 1 was not very important and 5 was very important. The factor that received the greatest support was, *Being respectful of the client's needs and preferences where possible* (mean, 4.90), followed by *providing client assessment in a timely manner* (mean, 4.68), and *being the client's "regular" provider of care as much as possible* (mean, 4.53). *Being of the same ethnic origin* was the least important factor. (See Table 13). These differences are significant ($F = 288.131$, $df = 7,264$, $p < 0.001$). When ranking each of the 8 factors against each other, participants ranked these three factors in the same order of importance. (See Table 14).

Table 13: All Care Coordinators' Ratings of Factors Important in Establishing a Good Relationship with Clients (1 = not very important, 5 = very important)

Factors	Mean Response
Being respectful of the client's needs and preferences where possible	4.90
Being of the same ethnic background as the client	2.05
Speaking the same language as the client	3.29
Providing client assessment and care in a timely manner	4.68
Being the client's "regular" provider of care as much as possible	4.53
Being considerate of the client's preference for the time care is provided	4.03
Being considerate of the client's financial situation	3.83
Getting along with the client's family caregivers	4.06

Table 14: All Care Coordinators' Rankings of Top 3 Factors in Establishing a Good Relationship with Clients

Factors	1st	2 nd	3 rd
Being respectful of the client's needs and preferences where possible	74.8	17.6	6.7
Being of the same ethnic background as the client		0.4	0.8
Speaking the same language as the client	2.5	7.1	5.0
Providing client assessment and care in a timely manner	15.5	41.6	16.8
Being the client's "regular" provider of care as much as possible	6.7	21.8	42.9
Being considerate of the client's preference for the time care is provided	0.4	2.9	8.0
Being considerate of the client's financial situation		2.5	5.5
Getting along with the client's family caregivers		5.5	11.8

Participants were asked a series of questions about the provision of care and their relationship specifically with *their last client*. The majority of these questions were only asked of the case managers and the service coordinators since the order processors had little direct interaction with clients. A different set of questions were

asked of them specific to the role they play and the tasks they perform. It will be specifically stated whenever order processors were asked the same questions as case managers and service coordinators. In all other instances, the results refer to only case managers and service coordinators.

The vast majority (98.1%) of case managers and service coordinators indicated that they were able to establish a good working relationship with their last client. Care coordinators offered the following reasons in general for not being able to establish good client relationships: insufficient time; missing information; client has dementia or is in crisis; or contact is brief and often by phone. One in 10 (7.9%) care coordinators did experience a language barrier with their client. Twice as many case managers (n=16) as service coordinators (n=8) said they experienced a language barrier with their last client, but these differences are not significant. Respondents said that the reasons that they did not experience a language barrier was that officials, volunteers or family members were able to translate, the respondent herself had capability in the client’s language, and often speaking slowly, distinctly and using simple words and constructions works well. See Table 15.

Table 15: Case Managers and Service Coordinators: Working with Clients (Percent)

Question	Yes	No	Don't Know	Total
Were you able to establish a good working relationship with your last client?	98.1	0.8	1.2	100.1
Did you experience a language barrier with your last client?	7.9	92.1		100.0
Did your last client understand the roles of their other providers?	47.7	38.0	14.2	99.9

Approximately three-quarters (74.8%) of case managers and service coordinators said that their last client had either complete or a lot of understanding of the care plan developed for them. A little over one in ten (11.2%) indicated that their last client had little or no understanding of the plan. Of those clients who had family caregivers, 84.2% of case managers and service coordinators indicated that the family caregiver had complete or a lot of understanding of the client’s care plan, and 3.4% said the family caregiver had little understanding of the care plan. The majority of all coordinators (81.7%) including order processors who were also asked this question believe it is much easier or easier to provide care when a family caregiver is involved – 60.3% of case managers, 50.4% of service coordinators, and 72.0% found it easier to provide care with a family member involved. Furthermore, less than half (47.7%) of care coordinators said their clients understood the roles of other providers.

Table 16: Case Managers and Service Coordinators: Working with Clients and Family Caregivers (Percent Ratings on a scale of 1 to 5)

Question	1 No Understanding	2	3	4	5 Complete Understanding
Did your last client understand his/her care plan?	3.1	8.1	14.0	41.1	33.7
Did the family caregivers of your last client understand the client’s care plan?		3.4	12.3	30.6	53.6
Table Case Managers, Service Coordinators, and Order processors: Ease of Care Provision with Family Caregiver Involved.					
Is it easier to provide good health care when there is a family care giver involved?	1 Much more difficult	2	3	4	5 Much easier
		1.0	16.9	24.8	56.9

Despite the fact that care coordinators indicated that some portion of their clients did not understand their care plans or the roles of other providers, 29.6% of care coordinators relied on the client to pass on messages or health information to other providers. Proportionately more case managers (53.7%) than service coordinators (46.3%) relied on clients to transmit information to other providers. These differences are significant ($\chi^2=11.81$, $df=2$, $p<.003$)

Providing care in someone's home does not always meet the safety standards of regulated workplaces, or allow for oversight. Home care workers sometimes have to work with difficult or abusive clients or in unclean or hazardous environments, e.g. aggressive pets, smoke.¹⁰ In regulated and controlled environments such as hospitals and LTC facilities, providers have reported physical, verbal and sexual abuse and racism. It has been reported that providers in the home and community care perceive that the risk of injury from client physical aggression is higher than in a "typical" workplace. Home and community organizations try to inform their employees or volunteers of such risks. Often these risks are not known until the first visit or the risk levels change over the course of care.

Of the 239 case managers and service coordinators for whom the question was applicable, 5% said that their last client was a potential risk to their health and safety. Respondents indicated that actual risks to them included verbally abusive alcoholic clients, exposure to contagious diseases such as MRSA, and second hand smoke. Of these 12 respondents, 3 were not informed of the potential risk prior to their first visit and one could not remember. Of the 214 for whom the question was applicable, 9.4% considered the client's home a risk to their health and safety. Respondents said they have been exposed to bed bugs, aggressive dogs, icy sidewalks, and unclean homes which can contain animal excrement. Of these 20 respondents, 7 were not informed of the risk prior to their first visit.

Order processors were asked in how many of the last ten cases was the client a potential risk to the health or safety of the driver or provider who was sent out. Fifty percent of the order processors said they didn't know; 34.6% said none of the clients in the last ten cases was a risk; 11.5% (n=3) said only one client in the last ten orders was a risk. A similar response was given for how many in the last 10 orders was the client's home a potential risk to the driver/provider.

3.5 Views on Care Plans

Respondents were asked to comment on the care plan for their last client. With respect to access and quality of service, 18.0% of participants believed that services did not begin at the right time for the client. One-fifth (21.1%) of care coordinators stated that the client had to wait for service because of delays in their own organization. Of those 21.1% of coordinators who said that the delays were due to their own organization, 24.8% of them were CCAC case managers compared with 17.1% service coordinators. Almost one-quarter (24.0%) of respondents felt that the wait for service was due to delays with other service providers; approximately 24% of both case managers and service coordinators believed delays were due to other service providers. See Table 17.

Nine out of ten case managers and service coordinators for whom the question was relevant indicated that they were able to arrange necessary equipment for their client in a timely manner (90.5%), and were able to arrange medical supplies for their client in a timely fashion (90.5%).

¹⁰ Ontario Home Care Association and Ontario Community Support Association, 2008. *Response to the Ontario Ministry of Labour Consultation on Workplace Violence Prevention*. October 2008.
<http://www.psno.ca/pdf/ohca-ocsa%20response%20to%20the%20consultation%20on%20workplace%20violence%20prevention-oct%202008.pdf>

A little less than 90% said that clients were receiving adequate nutrition. Over 90% (92.8%) of respondents said that the care plan took the client’s mobility and location into consideration, and 85.1% said the plan gave consideration to the time of day for service convenient to the client. (When asked the same question, only 65.4% of order processors said the order took into consideration the time of day for service that was convenient to the client or family caregiver.)

Of those case managers and service coordinators who said it was applicable, only 60.5% said that the care plan took into consideration the client’s ability to pay for services not covered by the government; 68.8% of case managers compared with 51.5% of service coordinators said the plan took into payment considerations. See Table 17.

While four-fifths (79.8%) of all care coordinators including order processors indicated that there were ways for clients to provide systematic feedback on services, 12.5% did not know of such a process, and 7.1% indicated there was no process for feedback. See Table 17.

Table 17: Case Managers and Service Coordinators’ Comments on Client Care Plans

Service to Clients	Yes	No	Don’t Know	Total
Was service started at the right time to provide maximum benefit to the client?	73.4	18.0	8.6	
Did the client have to wait for service because of delays in your organization?	21.1	77.0	2.0	
Did the client have to wait for service because of delays with other health and social service providers?	24.0	63.0	13.0	
Were you able to arrange the necessary equipment in a timely manner?	90.5	5.7	3.8	
Were you able to arrange the necessary medical supplies in a timely manner?	90.5	7.6	1.9	
Was the client receiving adequate nutrition?	88.2	4.2	7.6	
Did the care plan take into consideration client mobility and accessibility to service?	92.8	3.8	3.4	
Did the care plan consider the time of day for service convenient for the client?	85.1	9.9	5.0	
Did the care plan take into consideration the client’s ability to pay for services not covered by the government?	60.5	22.0	18.5	
Are there processes or mechanisms for clients to provide systematic feedback on the services they receive from you?	79.8	7.1	12.5	
Did you have access to current treatment/care plans of other health and social service providers?	61.7	38.3		
Were you satisfied with the information provided to you before your 1 st visit with the client?	75.8	24.2		
Did you have to contact another provider for client information or diagnostic test results?	39.2	60.8		

Case managers and service coordinators were asked a number of questions regarding the adequacy and quality of information they received about the client. Of the 266 respondents who answered this question, 13.5% said it was

not applicable to their last client. Almost 17 percent (16.9%) of service coordinators and 10.3% of case managers said the question was not applicable. Of those respondents who said the question was applicable to them, 61.7% said that they had access to the current treatment/care plans of other care providers and 38.3% said they did not have access to the plans. Proportionately almost twice as many service coordinators than case managers said they did not have access to plans of other providers (27% of case managers and 50.9% of service coordinators). Conversely, a higher proportion of case managers than service coordinators said they had access to treatment plans (73% of case managers versus 49.1% of service coordinators). Respondents indicated that even though the treatment plans of other providers are in the home, the client does not always consent to make them available. See Table 17.

Case managers and service coordinators were asked if they were satisfied with the information provided to them prior to their first visit with the client. Almost one fifth (17.9%) said the question was not applicable to their last client – 15.6% of case managers and 20.5% of service coordinators. Of those who said the question was applicable to them, three-quarters (75.8%) were happy with the information provided – 80.0% of service coordinators and 71.9% of case managers. For those for whom the question was applicable, almost one-quarter (24.2%) were not content with the information provided before their first visit – 28.1% of case managers and 20.0% of service coordinators. Respondents stated that there was often insufficient information on a client’s medical history and that it was often difficult to get information from family physicians or that discharge summaries from hospitals were not available. A few respondents mentioned the need to contact OTs and PTs for reports. Some said that CHRIS (Client Health and Related Information System) was helpful, others said it was not. See Table 17.

Case managers and service coordinators were asked if they had to contact another health or social service provider to obtain more client information or diagnostic test results. A little over ten percent (12.5%) of respondents said the question did not apply to them – proportionately more service coordinators (17.8%) than case managers (7.4%) said the question did not apply to their last client. Of those respondents who said the question was applicable, almost 4 in 10 (39.2%) had to contact another provider for further information – proportionately more case managers (42.9%) versus service coordinators (34.9%) said they had to contact other providers. See Table 17.

In developing the survey for the medical equipment and supplies order or intake processors, we heard that their biggest concern was incomplete information and difficulty in getting a timely response to their queries. As a result, a number of questions focused on this aspect of their work. One-quarter of all order processors said, in general, they needed to get further information or clarification on at least 50% of all orders in order to fill the order. With respect to their last 10 orders, 69.2% of respondents said they were satisfied with the last 8 to 10 orders. However, only 11.5% (n=3) said they were satisfied with all orders. Order processors were asked to rank the reasons why they were not satisfied with the information in their last 10 orders in order of frequency. Respondents, for whom the question applied and who answered the question correctly, said the number one reason for requesting information/clarification was that the information was incomplete, followed by the information being inaccurate. See Table 18.

Table18: Order Processors’ Reasons for Non-Satisfaction with Provided Information (Rankings 1 to 4)

Reason for Non-Satisfaction with Provided Information	1 st	2 nd	3 rd	4 th
Information was incomplete	62.5	12.5	4.2	4.2
Information was inaccurate	20.8	29.2	8.3	12.5
Equipment/supplies was inappropriate	16.7	25.0	25.0	4.2
Equipment/supplies was contraindicated		12.5	16.7	16.7

Order processors were asked, in general, for what types of orders or referrals did they typically require clarification or further information. Orders for medical equipment, medical supplies, and oxygen were most frequently cited as ones requiring further information. See Table 19.

Table 19: Percent of Order Processors Requiring Information or Clarification on Types of Orders

Type of Order/Referral	Percent
Medical Equipment	66.7
Medical Supplies	51.9
Drugs	14.8
Infusion Supplies	18.5
Oxygen	22.2

They commented that most orders lack height and weight or equipment specifications. Delivery fees or a contact person is often missing for the client. As one respondent put it,

Accurate, detailed, complete info is essential to delivery of appropriate [equipment] to clients. This prevents confusion, multiple interruptions to client/caregivers, and improves client safety for clients. Seamless services should be everyone's goal.

Of the last 10 orders, 29.6% of order processors said they did not have to contact another health care provider for more information. Conversely, 70% had to contact another provider in 1 to 6 of the last 10 cases. Thirty percent said they had to contact another provider in 3 or more cases. Specifically, with respect to the last 10 orders, the most frequent reasons for contacting another provider were for more client contact information or correct/sufficient product information. See Table 20.

Table 20: Rank Order Reasons for Contacting another Provider in the Last 10 Orders/Referrals

Reason	1 st	2 nd	3 rd	4 th
Client health information	19.4	9.5	9.5	9.5
Client contact information	42.9	23.8	14.3	
Delivery dates and/or times		33.3	14.3	14.3
Correct or sufficient product information	28.6	19.0	14.3	14.3

Order processors were asked if they needed to contact another provider for information in the last 10 orders, how many times were they able to reach that person in a timely manner. A little over one-quarter (26.9%) of respondents said that they were able to contact the other provider in a timely manner; 38.5% said that they were only able to contact the other person in a timely manner in less than half of the last ten cases; 15.4% (n=4) were not able to contact the other person in a timely manner in any of the last 10 cases. Respondents were asked to rank the reasons from a list for why they were not able to make contact. The most cited reason was that the person did not return the order processor's call, followed by no answer. See Table 21.

Table 21: Ranking of Order Processors' Reasons for Not Making Contact with Other Provider

Reason	1 st	2 nd	3 rd
There was no answer	29.1	16.7	12.5
I left a message but the person did not get back to me in time	54.2	16.7	4.2
My message was lost		8.3	8.3

All order processors said they were, in general, able to fill their orders within the time frame specified in the order at least 80% of the time. Only 14.8% said they were able to fill all their orders within the timeframe specified one hundred percent of the time. Specifically for the last 10 orders, 51.9% said they were able to fill all ten orders in the time frame specified. Respondents said they experience more of a delay in filling orders for medical equipment followed by medical supplies. See Table 22.

Table 22: Order Processors’ Rank Ordering of Types of Referrals for which They Experience Most Delay

Type of Referral	1 st	2 nd	3 rd	4 th	5 th
Medical Equipment	37.5	25.0	4.2	8.3	
Medical Supplies	25.0	8.3	12.5		
Drugs	16.7	4.2	4.2	4.2	
Infusion Supplies	12.5	12.5	4.2		
Oxygen					4.2

Almost two-thirds of order processors said that the delay in their last 10 orders was never due to problems in their own organization. Respondents were asked in what percentage of the last ten orders was the delay due to the CCAC. Almost one-fifth of respondents said that in their last 10 orders none of the delays was due to the CCAC and 12.5% of respondents said that the CCAC was responsible for the delay in all their orders. If delays were due to problems with other organizations, order processors were asked to rank order the cause of the delays from a specified list. The most frequent cause of delay is the requirement for further information or clarification, followed by problems with the electronic transmission of information, and delays in receiving clarification/information. See Table 23.

Table 23: Order Processors’ Ranking of Causes of Delay in Last 10 Orders

Cause of Delay	1 st	2 nd	3 rd	4 th	5 th
Order required clarification or further information	66.7	25.0	4.2		
Difficulty in reaching the appropriate person for information	12.5	8.3	33.3	8.3	4.2
Delay in receiving clarification/information		33.3	20.8	8.3	
Original time frame was unrealistic	8.3	16.7		12.5	16.7
Problems with electronic transmission of information	20.8	12.5	8.3	20.8	8.3

3.6 Working with Other Providers

Participants were asked a number of questions with respect to their knowledge of and their ability to work with other providers. Integration of care across providers and time requires the knowledge of other providers providing care to the same client. For the 246 case managers and care coordinators who said the question was applicable, 91.1% said they knew who the primary health or social service provider was; 8.9% did not. Almost all (96.9%) of the respondents knew who the primary family caregiver was. Of the 233 respondents for whom the questions were applicable, 22.3% said they did not know if the client had other non-CCAC providers. Almost three times as many service coordinators than case managers did not know if the client had other non-CCAC providers (32.1% vs.13.2%). Respondents indicated that it would be helpful to know of other providers so that they do not overlap in visits. Often respondents ask the client or the family caregiver if there are others providing services. However, at times the client gets confused as to who is providing what service. A little over one in ten (12.3%) care coordinators – case managers (9.3%), service coordinators (16.5%), and order processors (7.6%, n=2) – said that

they did not have a clear understanding of the roles of the other health and social service providers who were also working with their client. A majority (94.2%) said they knew who to call if they required professional help regarding concerns about their client, which meant that 5.8% did not. Proportionately twice as many service coordinators (7.8%) than case managers (4.0%) did not know who to call for professional help or advice. One of these respondents said, *“This is very worrying. Needs addressing.”* Similarly, the majority (92.6%) of order processors knew who to call if they had concerns about an order or referral. See Table 24.

Ten percent (10.6%) of case managers and service coordinators were not aware if the client had a family physician. Proportionately more service coordinators (20.2%) versus case managers (1.5%) did not know if the client had a family physician. Respondents indicated that on the whole family physicians are often listed as a contact on the client’s file. Proportionately more case managers (48.9%) than order processors (30.8%) and service coordinators (22.0%) have contacted the family physician about their client’s care or condition. Respondents indicated that it is often difficult to contact the family physician or have them return their calls. Others stated that they rely on clients to keep their physicians informed, or that the respondent contacts the physician associated with the program rather than the family physician. See Table 24.

Table 24: Case Managers and Service Coordinators’ Knowledge of Other Providers and Back-Up

Working with Other Providers	Yes	No	Total
Do you know who the primary health or social service provider is?	91.1`	8.9	100.0
Do you know who the primary family care giver is?	96.9	3.1	100.0
Are you aware whether your last client has non-CCAC providers?	77.7	22.3	100.0
Are you aware if your last client had a family physician?	89.4	10.6	100.0
Do you know who to call for professional help if you need it?	94.2	5.8	100.0
Do you have a clear understanding of the roles of other providers working with your last client?	87.7	12.3	100.0

Case managers, service coordinators, and order processors were asked how they routinely find out about their clients’ other providers. They were asked to rank order four potential sources of client information in terms of frequency. Of those who answered the question correctly, more than one-half (57.7%) said the most frequent way of finding out about other providers is from their clients or family caregivers. Other sources of information about other providers in order of frequency include the employing organization (39.6%), other providers (19.2%), and available records (15.3%). See Table 25.

Table 25: All Care Coordinators’ Sources of Knowledge of Other Providers

Source of Knowledge of Other Providers	%
From Clients or Family Caregiver	57.7
From Employing Organization	39.6
Other Providers	19.2
Available Records	15.3

The number one source of client information for case managers was the client or family caregiver; for service coordinators, it was the client/family caregiver or the employing organization; and for order processors it was other providers. See Table 26.

Table 26: The Number One Source of Client Information by Type of Care Coordinator.

#1 Source of Knowledge of Other Providers/ Type of Providers	Case Managers (%)	Service Coordinator (%)	Order Processors (%)
From Clients or Family Caregiver	64.2	51.8	47.4
From Employing Organization	31.6	51.5	21.4
Other Providers	8.2	25.7	60.0
Available Records	15.2	39.0	16.7

Respondents were asked a number of questions regarding how well they worked with the other providers of their last client. On the whole in this dimension, case managers and service coordinators were quite positive in their responses. For those whose clients had other providers, a majority (93%) felt that they worked well with other providers. A little over one in ten (11.7%) of service coordinators compared with 3.2% of care managers felt they did not work well with other providers. Qualitative comments, however, indicated that in general home care is not well coordinated –

It is each agency doing their own thing, their own agenda, paperwork and issues. Patients are over-assessed!!

Sometimes it is difficult to get information from other organizations clients? have been referred to – it is frustrating to have my work duplicated by agencies I have referred to.

Despite the majority feeling that they worked well with other providers, only 76.9% of case managers and care coordinators said that they felt that they were part of a team with other providers. More than twice as many service coordinators (33.7%) compared with case managers (14.6%) did not feel part of a multidisciplinary team. Some of the comments included:

I feel belittled.

I almost never feel that I am part of a circle of care! There is an obvious disconnect.

I believe I work well and communicate well with CCAC service providers. There is less communication with hospitals and physicians.

When asked if they had ever planned joint visits or teleconferenced with other providers (other than family physicians) to discuss their last client’s care, 63 (21.5%) case managers, service coordinators, and order processors said the question was not applicable. Of those who said the question was applicable, 63.5% said they had, and 36.5% had not planned joint visits or teleconferences with other providers. Two-thirds (65.0%) of order processors compared with 32.5% of case managers and 35.4% of service coordinators said they had not planned joint visits. Conversely, about two-thirds of case managers and service coordinators have organized joint visits or teleconferences compared with one-third of order processors.

Another indication of coordinated action is the extent to which clients are available at the appointed time. Case managers and service coordinators were asked if they have ever arrived to find that their last client was not available. About one-quarter said the question was not applicable to them – 31.8% of service coordinators and

19.0% of case managers. Of those for whom the question was applicable, 38.3% said they had found the client not available at the appointed time – 1.5% (n=3) said they could not remember and 60.2% said that the client did meet the appointment. Of those who said that the client was not there at the appointed time, 51.1% were service coordinators and 27.9% were case managers. Respondents indicated that the client has often slept in, has forgotten, gone out and not informed them, or was confused due to the number of service providers they have. A number of respondents said that their organization has a protocol for the provider to call in advance of going to the appointment with the client. For a similar question asked of order processors, 25% said that the clients in their last 10 cases were always there at the appointed time; 37.5% said that between 1 or 2 clients in their last 10 cases were not there; and 37.5% said that between 3 and 5 clients in their last 10 cases were not present.

All care coordinators were asked if their formal education or training had prepared them to work collaboratively with other health and social service providers. Almost ten percent (9.9%) said the question was not applicable to them – 15.3% of service coordinators, 15.4% of order processors, and 3.7% of case managers said the question was not applicable. Of those who said the question was applicable, 95.0% said that their training prepared them for collaborative work and 5.0% said that it did not – 13.4% of order processors, 6.1% of case managers, and 4.5% of service coordinators. A number of respondents said that their experience in the field more than their formal education prepared them to work as a team.

Case managers and service coordinators were asked if they were able to use all the needed and appropriate skills from their training (4.3% said the question was not applicable). Of those who said the question was applicable, more than nine out of ten (94.3%) said they were able to use all the necessary and needed skills from their training. In response to why they were not able to use all their skills appropriate to the last client, respondents indicated that as assessors or coordinators they are not able to use their “hands on” training or often they do not deal directly with the client.

3.7 Transitions

Transitions from one sector of care to another, e.g. from home to hospital or vice versa, have been identified in the literature as areas where care is less than seamless, resulting in poor coordination. Case managers, service coordinators and order processors were asked a number of questions regarding the last home care client they had who had to go into hospital or some other care facility while they were providing care to that client. Of the 95.2% (n=278) of respondents who said the question was applicable, almost one-third (29.1%) said they were not informed of the decision to move the client in a timely manner. This may account for the fact that 38.3% of case managers and service coordinators had indicated that, with respect to their last client they worked with, they have arrived to find that the appointment with the client had been cancelled. Roughly one-half (48.3%) did not know if there was a single person communicating the information to the facility. When their client returned home from the facility, one-third of respondents (35.9%) did not receive information about the care plan promptly. See Table 27.

Table 27: Transitions from Home to Hospital/LTC Facility back to Home

Question	Yes (%)	No (%)	Don't Remember (%)	Total (%)
Thinking of the last client you had who had to go to hospital or some other care facility, were you informed of this decision in a timely manner?	68.3	29.1	2.5	100.0
When this client was transferred, did you know if there was a single	43.5	48.3	8.2	100.0

person in charge of communicating all necessary information to the facility?				
Thinking of the last client who returned back into your care from hospital or some other care facility, did you receive information about the care plan promptly?	60.0	35.9	4.1	100.0

A much greater proportion of order processors (68.0%) than service coordinators (30.1%) and case managers (20.8%) said they were not informed in a timely manner that their client was transferred to a hospital or facility. Similarly, proportionately more order processors (69.6%) than service coordinators (51.2%) and case managers (41.6%) did not know if a single person was responsible for communicating all necessary information to the facility to which the client was transferred. Lastly, more order processors (45.8%) than service coordinators (38.3%) and case managers (31.7%) said they did not receive information about the client’s care plan promptly when the client returned home. See Table 28.

Table 28: Percent of Care Coordinators Who Said ‘No’

Questions	Case Managers	Service Coordinators	Order Processors
Thinking of the last client you had who had to go into hospital or some other care facility during your plan of service, were you informed of this decision in a timely manner?	20.8	30.1	68.0
When this client had to go into hospital or some other care facility, did you know if there was a single person in charge of communicating all necessary information to the facility?	41.6	51.2	69.6
Thinking of the last client you had who returned back into your care from hospital or some other care facility, did you receive information about the care plan promptly?	31.7	38.3	45.8

3.8 Care Coordinators’ Recommendations for Improvement

Case managers, service coordinators and order processors were asked to rate a number of strategies or initiatives that would improve the provision of integrated health care on a scale from 1 (not very helpful) to 5 (very helpful). The factors that received the highest ratings were: *Having the appropriate type of provider providing care* (M=4.66), *Having case managers in all hospitals* (M=4.51), *Developing strategies to promote the health of clients and prevent their decline or illness* (M=4.50), and *Ensuring that providers work to the full extent of their training* (M=4.46). The strategies seen as least likely to make an improvement were: *Implementing a pay scheme based on performance* (M=3.26), *More portable information technology* (M=3.94), *Training regarding the various parts of the health care system* (M=4.00), and *Training in the roles of other health and social service providers* (M=4.01). These differences were statistically significant (F=30.884, df=13,221, p<001). See Table 29.

Table 29: All Care Coordinators Ratings of Strategies to Improve the Integration of Care

Strategies	Mean Response
Providers work to the full extent of their training	4.46
Strategies to promote the health of the client and prevent decline and illness	4.50
Having the appropriate type of provider providing care	4.66
Having CCAC case managers in all hospitals	4.51

Integrating the Family Physician into the care plan	4.31
Assigning CCAC case managers to Family Health Teams	4.11
Electronic health records	4.33
More portable information technology, e.g. handheld devices, laptops	3.94
Training in communication skills	4.10
Training in how to manage conflicts with patients or other health and social service providers	4.12
Training in the roles of other health and social service providers	4.01
Training regarding the various parts of the health care system	4.00
Training for health and social service providers in how to work together effectively	4.16
Implementing a payment scheme based on performance	3.26

All care coordinators were also asked to review the 14 above strategies and rank the top 3 amongst them in order of importance in improving the provision of integrated care. Of the respondents who did the ranking correctly, *Strategies to promote health and disease decline/prevention* was ranked as the number one strategy to improve the integration of health care, followed by *Having the appropriate type of provider providing care*, *Providers working to the full extent of their training* and *Electronic health records*. See Table 30.

Table 30: All Care Coordinators' Rankings of 14 Strategies to Improve the Integration of Care (Percentage of Participants Ranking Each Factor First, Second, or Third)

Strategies	1st	2 nd	3rd
Providers work to the full extent of their training	13.4	9.6	6.7
Strategies to promote the health of the client and prevent decline and illness	30.1	12.9	7.2
Having the appropriate type of provider providing care	13.9	18.2	10.5
Having CCAC case managers in all hospitals	4.8	7.7	8.6
Integrating the Family Physician into the care plan	4.3	10.5	8.6
Assigning CCAC case managers to Family Health Teams	2.9	7.7	5.7
Electronic health records	6.2	4.8	12.4
More portable information technology, e.g. handheld devices, laptops	1.0	3.8	7.2
Training in communication skills	3.3	3.8	3.8
Training in how to manage conflicts with patients or other health and social service providers	1.4	3.8	6.2
Training in the roles of other health and social service providers this one is higher than electronic health records	6.7	3.3	5.3
Training regarding the various parts of the health care system	1.4	2.9	3.3
Training for health and social service providers in how to work together effectively	7.2	8.1	8.1
Implementing a payment scheme based on performance	1.0	1.0	0.5

When asked what one thing they would change to improve client's care in the home and community care system, 223 of the 297 care coordinators provided many suggestions ranging from funding issues; work issues; client care issues; issues regarding working with other providers; and system issues.

Issues specific to client care were the most frequently mentioned (42.2% of respondents) and included improving access to care and a one-stop shopping approach; single comprehensive care plans; and greater consistency and fewer providers in the home.

Suggestions about improvements in working with other providers was mentioned next most frequently (28.7% of respondents) and included efforts for better collaboration, and greater respect for and understanding of each other's roles, judgement and ways of working.

Funding issues were mentioned by 24.2% of respondents with an increase in funding, resources and staff most frequently mentioned.

Workplace issues were mentioned by 19.3% of respondents; adequate pay and decreased workloads and caseloads allowing for more client time being most frequently mentioned.

System issues were the least frequently mentioned (7.2% of respondents). Within this category, better information systems was most frequently mentioned.

Amongst all the suggestions, increased funding was mentioned most often (22.9%), followed by ways to improve collaboration amongst providers (17.0%), and improving access to care or a one-stop shopping approach (11.7%). See Table 31.

Table 31: Improvements Suggested by Care Coordinators (Numbers and Percent who Mentioned Improvement)

Suggested Improvements/Changes	Number (n=223)	Percent
Funding		
Increase Funding/ More Resources/ More Staff	51	22.9
Consistent/equitable/stable funding	2	
Increase accountability/introduce more outcome measures	1	
Total	54	24.2
Client Care		
Single Comprehensive Care/common care plans	13	
More timely care	13	
Improve access to care/one-stop shopping	26	11.7
Greater consistency of providers/services, fewer providers in the home	7	
Improve quality of care/continuity of care	7	
Client focused care	7	
Increase non-medical/health care	11	
Introduce home Med checks		
Increase family member involvement with care	1	
Increase assistance with language barriers		
Increase respite care	4	
Increase palliative care		
Increase care based on need	5	
Total	94	42.2
Working with Other Providers		
Better collaboration with other providers	38	17.0
Greater respect and understanding for providers' roles, judgment, processes amongst providers	21	
Greater integration of FPs and CCAC case managers into the home	2	
Improve provision of supplies/equipment	3	
Total	64	28.7
System Issues		
Better Information Systems	18	
Better links between sectors of care	6	

More health promotion/disease prevention/fall and injury prevention	1	
Reduce the number of structural levels in care provision	2	
De-privatize community and home care	2	
More supportive housing/more alternatives to home care, e.g. clinics, outpatient care	1	
Re-evaluate effectiveness of the CCAC model		
Greater Accountability; Pay for performance		
Money follows clients	4	
Total	16	7.2
Work Issues		
Adequate pay for community providers	14	
Better budgeting/less travelling	5	
More education and training of employees	7	
Decrease case load/increase client time/better use of provider skills	13	
Improve administration/reduce paper work/reduce duplication	4	
Improve workplace health and safety in the home		
Better hours of work/more stable hours of work		
Total	43	19.3

This concludes the report on the results from the survey of care coordinators' perceptions and experiences of the integration of health care.