

Integration of Care: The Perspectives of Home and Community Providers

June 2011



THE CHANGE FOUNDATION

HEALTH CARE DESERVES
OUR FINEST THOUGHT

About The Change Foundation

The Change Foundation is an independent policy think tank, intent on changing the health-care debate, health-care practice and the health-care experience in Ontario.

A charitable foundation established in 1996 and funded through an endowment, The Change Foundation leads and leverages research, policy analysis, quality improvement and strategic engagement to enable a more integrated health-care system in Ontario designed with individuals and caregivers top of mind.

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“Today, more than ever, Ontarians are receiving, in their homes and communities, care that was previously provided in the hospital.”

2009–2010 CCAC Quality Report

INTRODUCTION

Why we did this survey

In 2008, The Change Foundation conducted a series of focus groups with patients who were frequent users of the health-care system, and family and friend caregivers of people with multiple chronic conditions. In those discussion groups, we heard that patients and informal caregivers had concerns about the delivery of health-care services ([The Puzzlemaker](#)). These concerns included:

- a lack of coordination and communication among health-care providers—in particular, in the connecting of the hospital-care process with the home-and-community-care process—which left them feeling frustrated, confused and forgotten;
- a lack of confidence that necessary information had been transferred from one provider to another or one setting to another, which left them worrying and wondering who was responsible for what; and
- being asked to repeat tests and assessments, and provide the same medical histories and symptom reports to a series of providers. This left them wondering about waste, inefficiency and potential risks to their health.

The Foundation wanted to hear from providers who deliver home care and support services in the community. What does integrated care mean for them? From their perspective, what are the components of a well-integrated system, and the barriers to integrated health-care delivery? What is their experience in working with patients/clients and their caregivers? How do their experiences, and their views about a well-integrated health system, compare with those of patients/clients? How could they contribute to an integrated health system and what could be done to improve integrated care?

For those who are interested in detailed data and/or data specific to the various provider groups, four technical reports are available. There are three provider technical reports—for the [regulated health professionals](#), [care coordinators](#), and [personal-support workers](#)—and a [comparative summary report](#) analyzing the responses of all provider groups.

Who we worked with

The Change Foundation worked with the Community Provider Associations Committee (CPAC), an umbrella group of associations that includes the majority of organizations providing home and community care in the province. CPAC includes:

- 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 Services (OACRS);
- Alliance of Professional Associations for Community-Based Therapy Services (APACTS); and
- Medigas, representative of Medical Equipment and Supply Vendors.

CPAC provided assistance in project and survey development, and provided mechanisms for accessing home and community providers in their membership.

Who we heard from

We wanted to hear from the range of providers who deliver home care and support services in the community.¹ Surveys were developed and distributed to the following providers:

- regulated health professionals (RHPs)—specifically registered nurses, registered practical nurses, occupational therapists, physiotherapists, speech-language pathologists, dietitians, social workers, respiratory therapists and pharmacists;²
- care coordinators (CCs)—including Community Care Access Centre (CCAC) case managers/system navigators (all of whom are regulated health professionals, but have been grouped with other coordinators for the purposes of this survey), care coordinators employed by provider organizations, and intake coordinators and order processors in organizations providing medical equipment and supplies; and
- personal support workers (PSWs).

Table 1: Distribution and response rates

	Surveys Distributed	Response Rate
RHPs	1,058	23%
CCs	662	45%
PSWs	300	30%
TOTAL	2,020	31%

Surveying providers in the home and community sector has its unique challenges. The response rates were relatively low but sufficient for analysis. The regulated health professions had the lowest response rate and the rates for specific regulated professions varied, with speech-language pathologists, dietitians and respiratory therapists registering response rates that were too low to allow for meaningful interpretation (see the technical reports for details).

How we did it

An effort was made to have consistency in questions across all versions of the survey. Questions were modified, when necessary, to reflect the types of interaction that different provider groups have with patients/clients and their family and friend caregivers.

The survey asked providers to answer questions based on the interactions they had with their “last” client. We know from research that unusual events or problems tend to be more salient in people’s minds and more likely to be remembered (Tversky and Kahneman, 1974), so these events tend to get more weight when respondents are asked to reflect on the “typical case.” With a focus on their last client, this bias was minimized.

Different versions of the survey were pilot-tested with members of each of the targeted provider groups. Based on the results of the pilots and comments from the respondents, the survey was further refined and finalized.

¹ Primary care physicians were not targeted in this survey as there are existing survey initiatives with this provider group.

² This survey included pharmacists filling orders and prescriptions for medical equipment and home-care supplies in CPAC member organizations. The total number of participating pharmacists was eight, which represents 60% of the pharmacists in the province who provide this service.

The sampling process was complicated by the fact that contact information for individual home-care and community-based support service providers was not available. The process to randomly select organizations and branch offices, and to get a random sample of individual providers within these locations, is described in the technical reports, as are the limitations of the sampling and distribution methodology.

FINDINGS

This section summarizes results from the surveys. Throughout the report we will use “caregiver” in reference to family and friends who provide informal caregiving, and “provider” to refer to the survey respondents (paid caregivers).

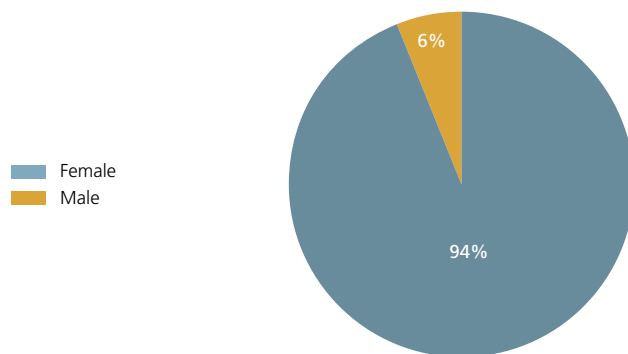
Our intent in presenting the survey results is to identify areas for quality improvement—areas of focus to improve performance. The survey data were generally positive. Our interest was to look at “opportunities”—even though they may be in the minority of cases—where attention could be focused to change practice in order to improve the experience of individual clients and their informal caregivers.

Demographics

Care in the home and community is provided by a largely female workforce (Table 2).

- 94% of respondents were female (Table 2). The percentage was highest in care coordination—96% of respondents—compared with 92% of regulated health professionals and personal support workers (PSWs). These high rates are consistent with a recent Canadian Research Network for Care in the Community survey of PSWs (CRNCC, 2009)—97% were female.³

Table 2: Gender

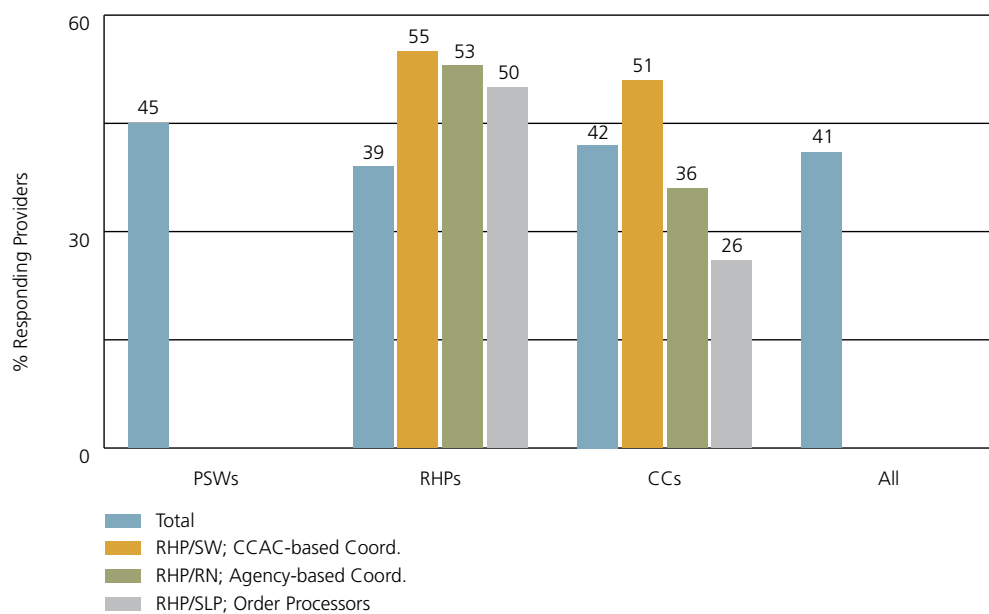


- The home and community care workforce is aging (Table 3).
- Two-fifths of respondents (41%) were over the age of 50.
- There was a significant difference in age for the various groups of care coordinators—51% of CCAC coordinators were over 50, compared with 36% of agency-based service coordinators and 26% of medical equipment and supplies order processors.

³ This survey included PSWs in all sectors—65% identified that they worked in the home and community sector, 28% in multiple settings and 7% in the long-term care and hospital sectors.

- In the regulated health professions, more social workers (55%), registered nurses (53%) and speech-language pathologists (50%) reported being over the age of 50, compared with 39% of respondents from the regulated health professions as a whole.
- Just under half of PSWs (45%) were over the age of 50. Again, this is consistent with the recent CRNCC (2009) survey of PSWs, which found 45% of respondents to be over 50. This is of particular concern given that these workers do considerable lifting in the provision of care.

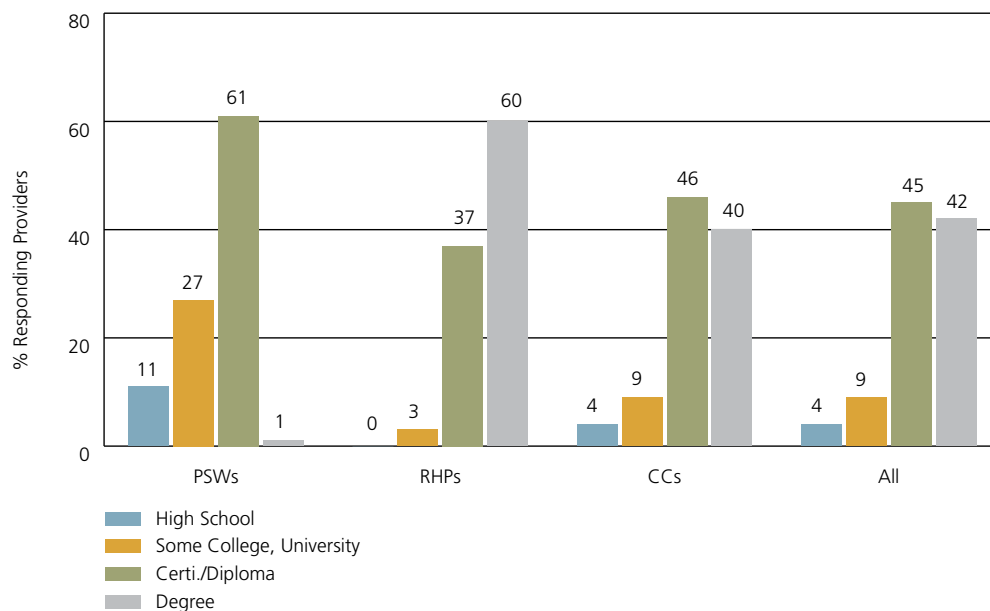
Table 3: Over the age of 50



Home and community care workers have varying levels of educational achievement (Table 4).

- Two-fifths (42%) of respondents had at minimum a baccalaureate (33% a B.A. or B.Sc., and 9% an M.A., M.Sc. or M.S.W.); almost half (45%) had a certificate or diploma; and almost one in ten (9%) of the rest had some college-or university-level training.
- Three-fifths of PSWs (61%) had a certificate or diploma; three-fifths of regulated health professionals (60%) had a degree (42% had a post-secondary degree and 18% had a graduate degree).
- As expected, the regulated health professionals had higher levels of education (90% had at least a diploma) compared with 77% of care coordinators (recognizing that care coordinators are a diverse group) and 35% of PSWs. (See technical reports for breakdown of numbers.)

Table 4: Education



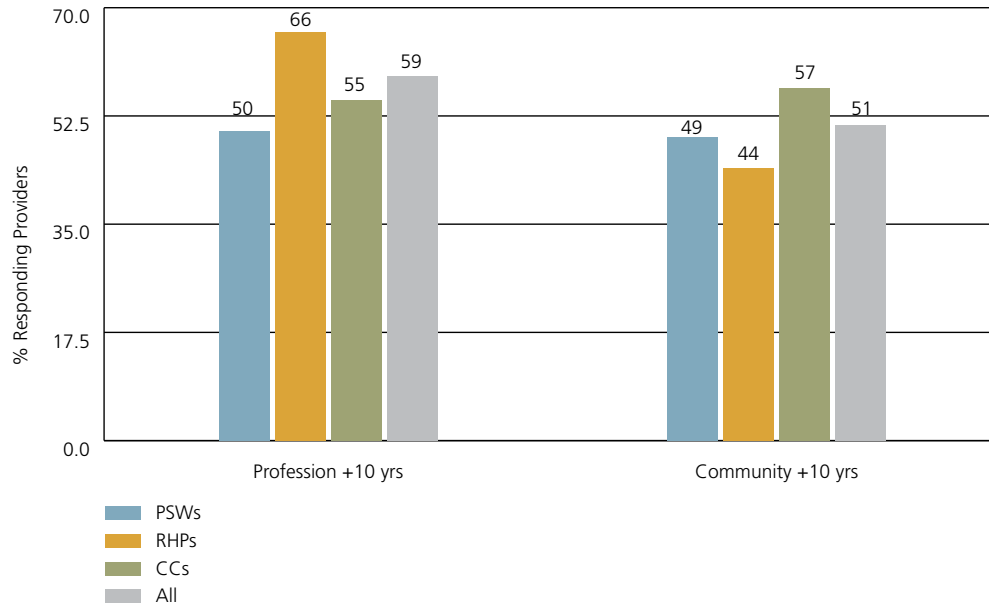
Experience in their profession and in the sector

- Home and community care providers are experienced (Table 5).

Three-fifths of respondents (59%) had been working in their profession for more than 10 years—and 32% of these had been doing so for more than 20 years.

- Proportionately more regulated health professionals (66%) than care coordinators (55%) and PSWs (50%) had been working in their profession for more than 10 years.
- In the regulated health professions, almost two-fifths of respondents (38%) had been working in their profession for more than 20 years. There was variance among the professions: physiotherapists (57%), social workers (55%), pharmacists (50%) and nurses (44%) were far more likely to have been working for more than 20 years in their profession than respondents in other professional groups (registered practical nurses—20%, occupational therapists—19%, speech language pathologists—33% and dietitians—20%).
- More than half (51%) of respondents had been working *in the home and community sector* for more than 10 years.
 - Care coordinators had more experience in the community sector—i.e., more than 10 years experience—than the PSWs and the regulated health professionals (57% compared to 49% and 44% respectively).
- Almost all respondents (99%) had experience working in other sectors—experience in:
 - the acute sector (47%),
 - physicians' offices/family health teams (39%),
 - complex continuing care/chronic care facilities (20%), and
 - rehabilitation facilities (18%).

Table 5: Experience in the profession and in the sector



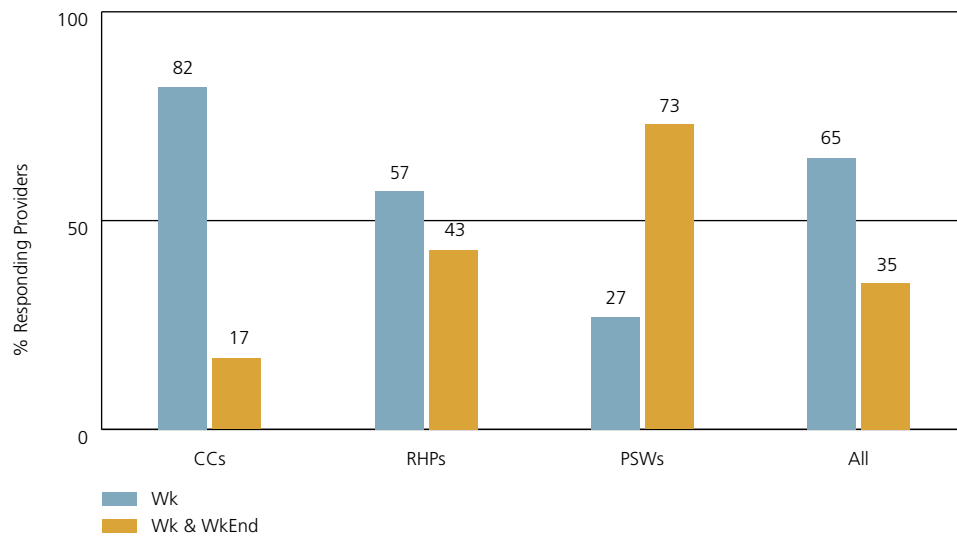
Employment hours and circumstances

- Community-based providers work both during the week and on weekends; however, more are likely to work Monday to Friday 9 to 5, with the exception of PSWs.
 - Two-thirds of respondents (65%) worked Monday to Friday only, while one-third (35%) worked both during the week and on weekends (Table 6).

There were notable differences between the provider groups:

- 82% of care coordinators worked only during the week, while 17% worked both during the week and on weekends;
- 57% of regulated health professionals worked only during the week, while 43% worked both during the week and on weekends; and
- 27% of PSWs worked only during the week, while 73% worked both during the week and on weekends.

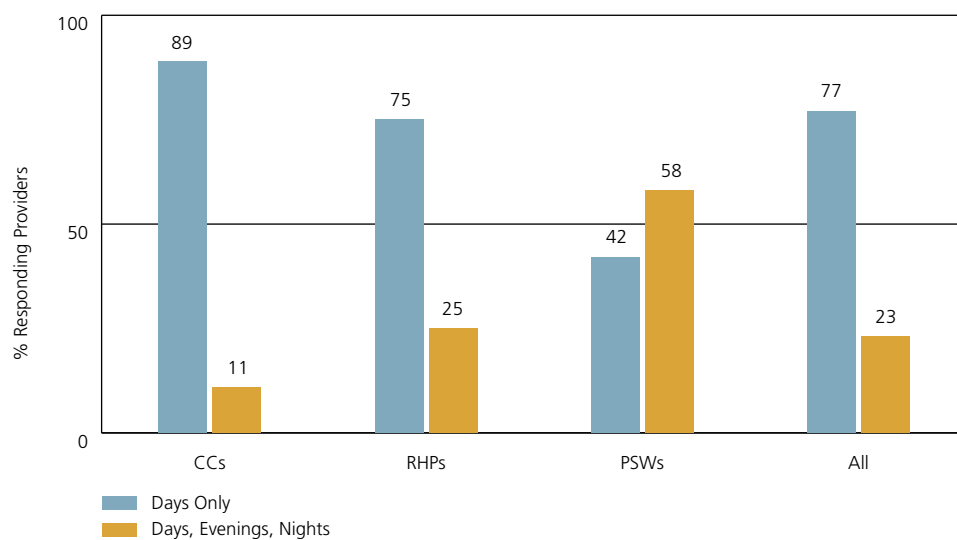
Table 6: Days of work



Three-quarters (77%) of respondents worked only daytime hours (Table 7). Again, there were differences between the provider groups:

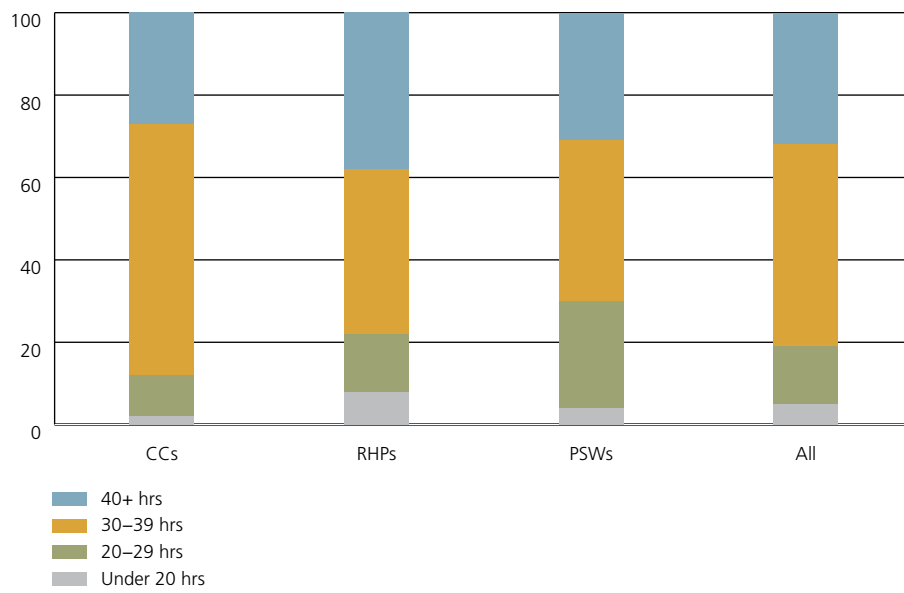
- 89% of care coordinators worked only days;
- 75% of regulated health professionals worked only days; and
- 42% of PSWs worked only days.

Table 7: Hours of work



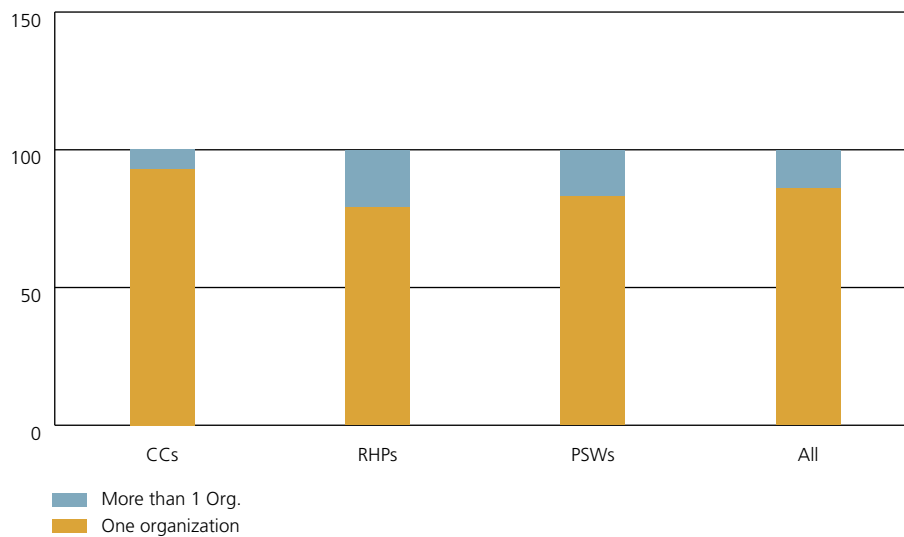
- Over two-thirds of respondents (68%) worked less than 40 hours a week (Table 8):
 - Almost three-quarters of care coordinators (73%) worked less than 40 hours per week.
 - More than two-thirds of PSWs (69%) worked less than 40 hours per week.
 - Almost two-thirds of regulated health professionals (62%) worked less than 40 hours per week.
 - Fewer PSWs (70%) worked 30 hours or more per week compared to care coordinators (88%) and regulated health professionals (78%).

Table 8: Hours per week



- Most respondents—86%—reported working for one organization (Table 9). However, more than one in 10 (14%) of respondents worked for more than one organization. This was more often true for regulated health professionals and PSWs (21% and 17% respectively) than for care coordinators (7%).

Table 9: Number of employers



Working with clients and their caregivers

The relationship between the client, their caregiver and the individual provider is a key component of integrated care. The vast majority of survey respondents—99%—reported that they were able to establish a good working relationship with their last client.

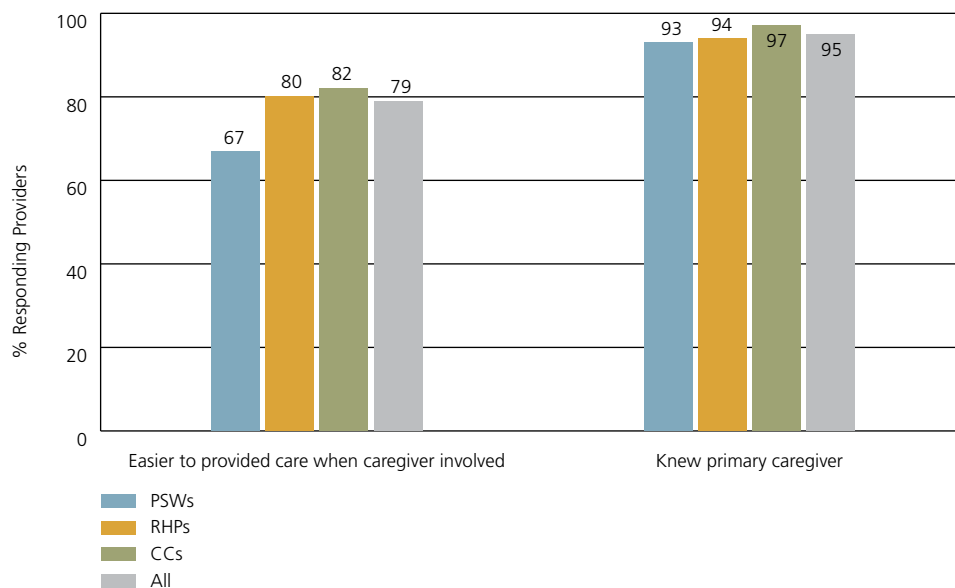
Respondents were asked to rate and rank factors that help to establish a good relationship with clients and their caregivers. The highest rated and ranked factors—consistently across the provider groups—were:

- being respectful of the client’s needs and preferences where possible;
- providing client assessment and care in a timely manner; and
- being the client’s “regular” provider of care as much as possible.

Nine of 10 regulated health professionals (89%) and PSWs (91%) believed that attempts were made to provide the client with the same provider for each visit. (Care coordinators were not asked this question.)

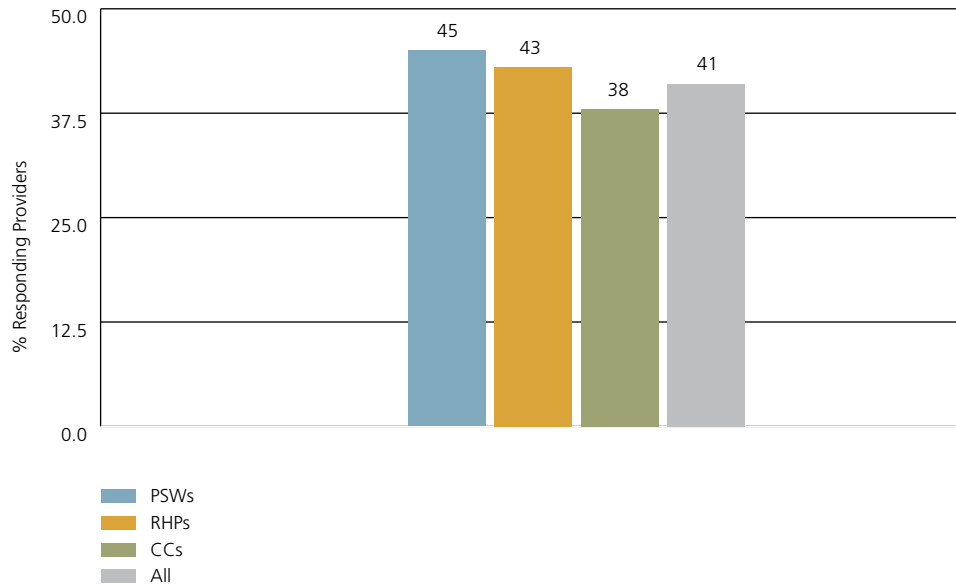
Four out of five respondents (79%) reported that it is easier to provide care when a caregiver is involved (Table 10). There was variance between the provider groups, with care coordinators valuing caregiver involvement the most (82%) and PSWs valuing it the least (67%). This variance might be because PSWs often replace caregivers—being assigned to relieve a caregiver who may be absent, resting or taking a break from caregiving—or perhaps PSWs view caregivers as “interfering” or directing their work, whether appropriately or inappropriately. The vast majority of respondents (95%) knew who the primary caregiver was—97% of care coordinators, 94% of regulated health professionals and 93% of PSWs.

Table 10: Caregiver involvement



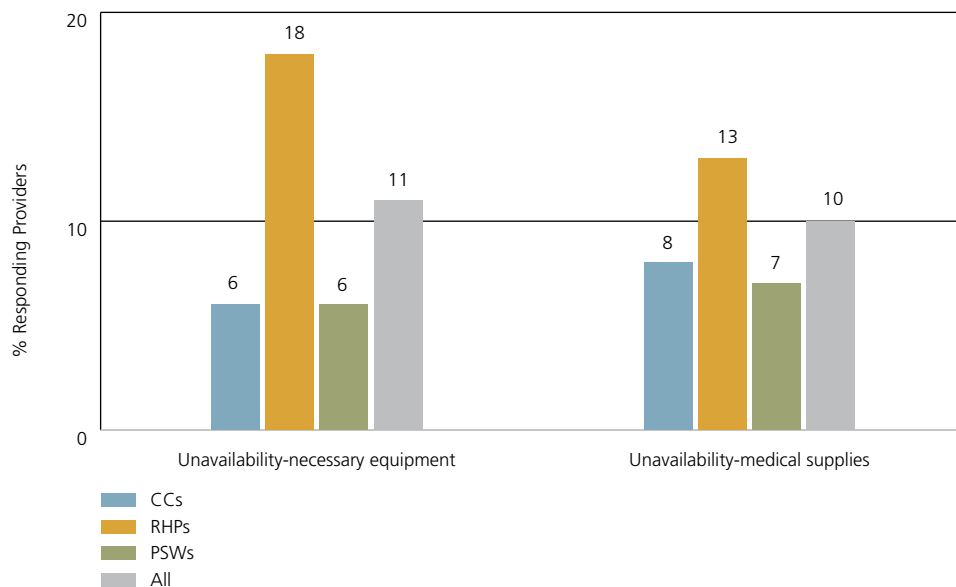
An indicator of coordinated care is the extent to which clients are available for scheduled appointments. Two in five respondents (41%) reported that they have arrived at scheduled appointments to find that the client was not available—38% of care coordinators, 43% of regulated health professionals, and 45% of PSWs (Table 11). Reasons cited included that the client had slept in, forgotten the appointment, or was confused given the number of services.

Table 11: “Missed” scheduled appointments



Respondents reported that in nine out of ten cases, their last client had the necessary equipment and medical supplies for their care. However, one in 10 respondents reported that the necessary equipment (11%) or medical supplies (10%) were not available for their last client (Table 12). Regulated health professionals—primarily occupational therapists, physiotherapists and respiratory therapists—were most likely to report that necessary equipment and medical supplies were not available (i.e., 18% and 13%).

Table 12: Unavailability of equipment and medical supplies



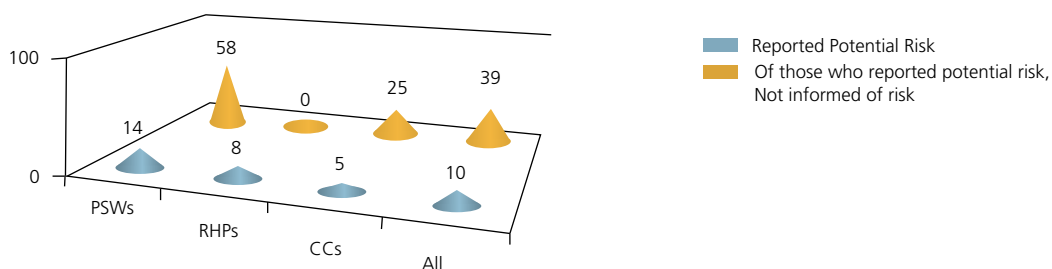
Pharmacists were asked what percentage of all their orders did not meet the CCAC requirement of being delivered on time—50% reported that all orders had been delivered on time. The remaining 50% indicated that up to one order in 10 (10%) did not meet the time requirement. The overwhelming response from pharmacists was that delays were due to problems with the order rather than delays in their organizations. Respiratory therapists reported that they found clients or caregivers had not been adequately trained to use the equipment.

Medical equipment and supply order processors were asked in what percentage of the last 10 orders was the delay due to the CCAC—almost one-fifth of respondents said that none of the delays were due to the CCAC, and 13% said the CCAC was responsible for the delay in all their orders. For delays that 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 was the requirement for further information or clarification, followed by problems with electronic transmission of information, and delays in receiving clarification/information.

Providers were asked if the care plan took into consideration the client's mobility and the accessibility of services. Four percent of care coordinators—i.e., the personnel who assess the client and develop the care plan—said the plan did not take client mobility and service accessibility into consideration. This compares to 10% of PSWs and 17% of regulated health professionals who responded that the care plan did not take these factors into account.

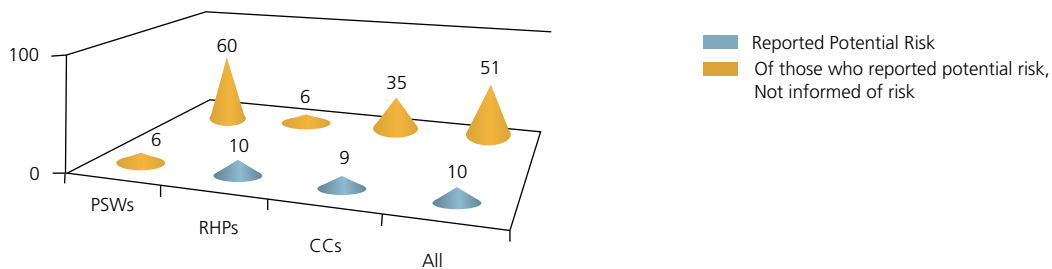
One in 10 respondents reported that their last client was a potential risk to the respondent's health and safety (Table 13). Of this 10%, 39% said they were not informed of the risk prior to their first appointment. The types of risk included: verbally abusive alcoholic clients, exposure to contagious diseases such as MRSA, and second-hand smoke. There were differences among the provider groups: regulated health professionals who reported that their last client was a potential risk to their health and safety had been informed in all cases; care coordinators were not informed in one out of four cases (25%); and PSWs were not informed in almost three out of five cases (58%).

Table 13: Client is a potential risk to health and safety



Similarly, one in 10 respondents reported that their last client's home posed a risk to their health and safety (Table 14). Of this 10%, 51% said they were not informed of the risk prior to their first appointment. Examples of the types of risk included exposure to bedbugs, aggressive dogs, icy sidewalks and unclean homes. Again, there were differences in whether the provider was informed of the risk prior to the first appointment: regulated health professionals were informed in most cases (94%); care coordinators were not informed in one-third of cases (35%); and PSWs were not informed in the majority of cases (60%).

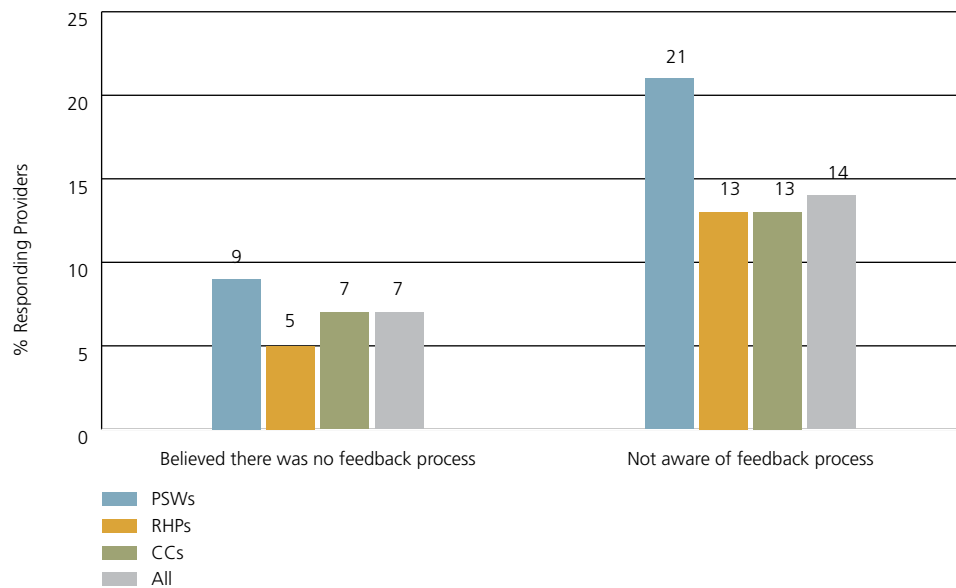
Table 14: Home is a potential risk to health and safety



Respondents were asked about the process for clients to provide feedback on services received (Table 15). This survey question was not designed to determine whether feedback mechanisms were available for clients, but rather whether the provider was aware of their existence. Fourteen percent of respondents were not aware of a feedback process, and a notably higher percentage of PSWs were not aware of the process (21%). In addition, 7% of respondents believed there was no process available for clients to provide feedback on services received. Combining those who were not aware of a feedback process for clients (14%) and those who believed there was none (7%), one can conclude that at least one in five respondents (21%) were not able to inform clients about mechanisms they could use to give feedback. The combined totals broken down by provider groups: 30% of PSWs, 18% of regulated health professionals, and 20% of care coordinators as a whole and 17% of CCAC case managers.⁴

⁴ The care coordinator response rate includes responses from CCAC case managers, provider-based service coordinators and medical equipment and support intake order processors.

Table 15: Process to provide feedback on services



Access to information and communication between providers

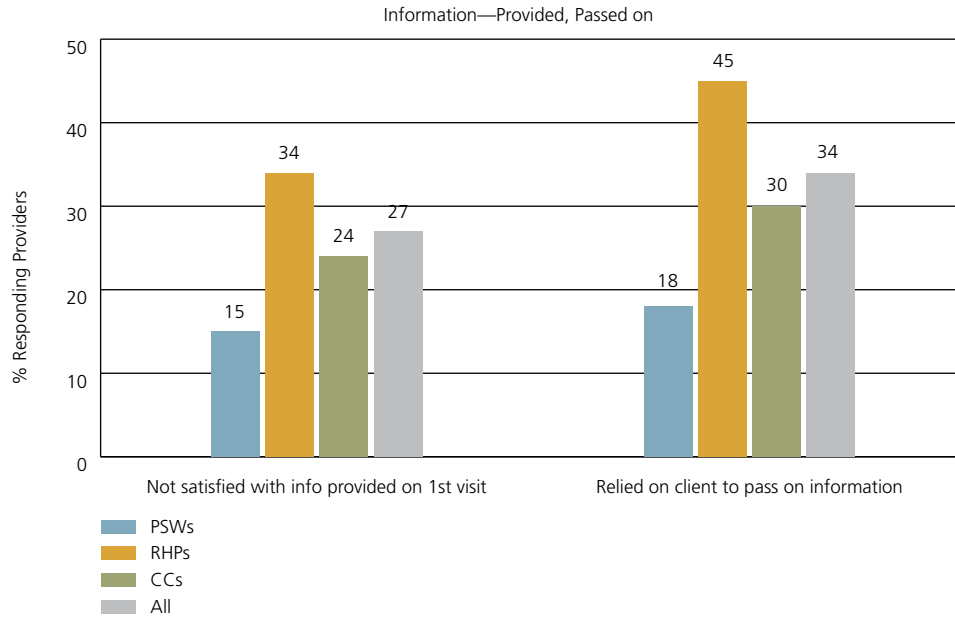
Timely access to quality information and the sharing of information among providers is central to the provision of integrated care.

More than a quarter of respondents (27%) were not satisfied with the information they were given for their first visit with their client (Table 16). There was some variance between the provider groups—34% of regulated health professionals, 24% of care coordinators, and 15% of PSWs were not satisfied. Respondents elaborated:

- There was often insufficient information on a client's medical history.
- It was often difficult to get information from family physicians.
- Hospital discharge summaries were not available.
- There were concerns about the usefulness and operability of the Client Health and Related Information System (CHRIS).

More than a third of community providers (34%) relied on the client to pass information on to other providers (Table 16). Again, there was variance between the different provider groups: proportionately more regulated health professionals (45%) than care coordinators (30%) and PSWs (18%) had relied on clients to convey information to other providers.

Table 16: Transfer of information

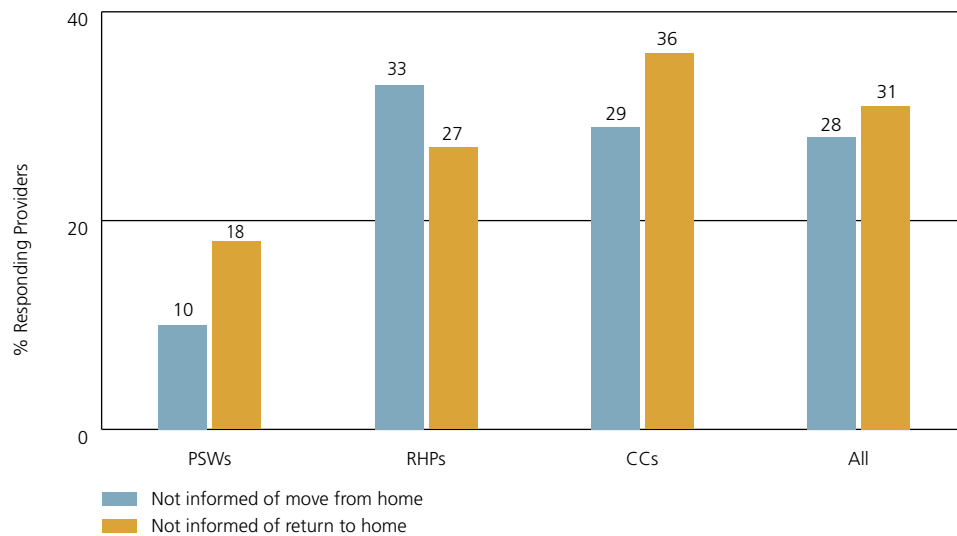


Transitions between sectors—for example, from hospital to home, from primary care to specialty care—have been identified by patients and their caregivers, providers and service organizations, and policy- and decision-makers as an area where care is less than seamless, resulting in poor coordination and integration of care. More than a quarter of respondents (28%) were not informed in a timely manner when a client to whom they were providing care was moved from home to hospital or to another care facility (Table 17). There was variance among the provider groups, with a third of regulated health professionals (33%), 29% of care coordinators, and 10% of PSWs not being informed in a timely manner. It is interesting to note that PSWs were the group most likely to be informed in a timely manner—perhaps because they tend to have more frequent contact with clients and usually know more about what is going on in the home than do those who are responsible for the care plan or clinical care (i.e., care coordinators and regulated health professionals). In the regulated health professions there was a wide range of responses. Pharmacists were the most likely to report that they were not informed of these transitions (86%), while registered nurses were not informed almost one-third of the time (31%). Physiotherapists were least likely to report that they were not informed (19%).

Almost half of care coordinators and regulated health professionals (48%) did not know if there was a single person in charge of communicating all necessary information to the facility (PSWs were not asked this question).

When the client returned home from the facility, almost one-third of respondents (31%) did not receive information about the discharge care plan promptly—36% of care coordinators, 27% of regulated health professionals, and 18% of PSWs (Table 17).

Table 17: Clients moving between home and hospital or other care facility



Almost a third (32%) of regulated health professionals and two-fifths (39%) of care coordinators had to contact another health or social service provider for client information or diagnostic test results (PSWs were not asked this question).

Over half of responding pharmacists (57%) reported that they did not have enough client information to determine possible drug interactions. More than a third of pharmacists (38%) said they had to contact someone for further information in at least five of the last 10 orders/referrals/prescriptions they had processed.⁵ Half of them (50%) said they were able to make such contact in a timely manner most of the time, and 50% said they were able to do so “some of the time.” When contact was not made on time, pharmacists reported that it was overwhelmingly (88%) due to a lack of response, or a late response, by the other professional to a message left by the pharmacist.

One-quarter of responding medical equipment and supply order processors said they needed to get further information or clarification on at least 50% of all orders. Seven out of 10 order processors (70%) had to contact another provider for more information in up to six of the last 10 cases, and 30% reported that they had to contact another provider in three or more cases. One-quarter (27%) of respondents said they were able to contact the other provider in a timely manner; 39% said they were only able to contact the other person in a timely manner in less than half of the last 10 cases; and 15% were not able to contact the other person in a timely manner in any of the last 10 cases. The most frequently cited reason was that the person did not return the order processor’s call.

Almost two-thirds (65%) of regulated health professionals reported that they asked their last client to repeat some or all of their health and care history. A quarter of respondents (25%) had to repeat an assessment or test for their last client. (Care coordinators and PSWs were not asked these questions.)

⁵ Pharmacists’ key contacts are case managers or nurses.

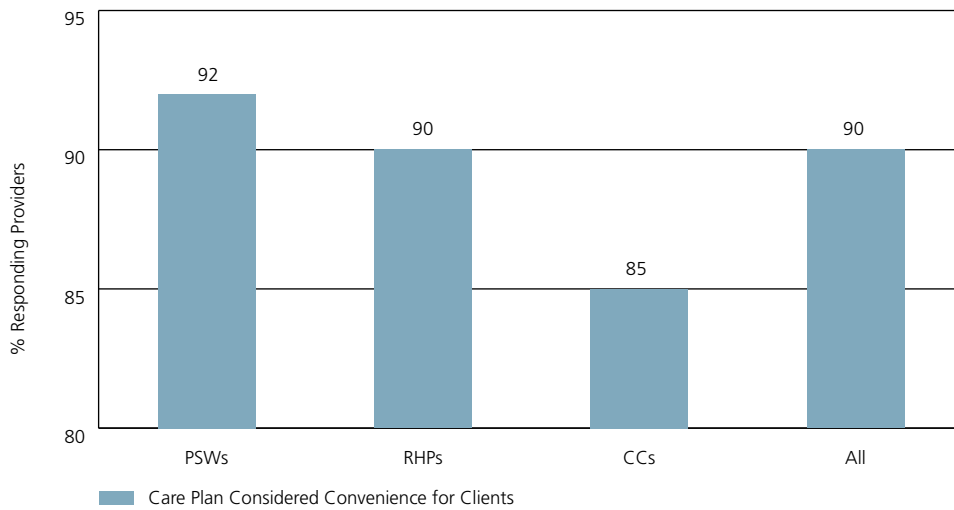
“It is each agency doing their own thing, their own agenda, their own paperwork. Patients are over-assessed.”

—Survey respondent

In the home and community sector, a client typically receives a range of services and supports from multiple providers. Moreover—unlike in other sectors of care such as hospitals and long-term care facilities—home and community care providers are transient. As a result, when there is ambiguity as to what a particular provider prescribed or did, it is not a matter of going down the hall to check. Accordingly, **care plans** in the home are a tool to facilitate communication between the provider and the client and caregiver, as well as communication between providers.

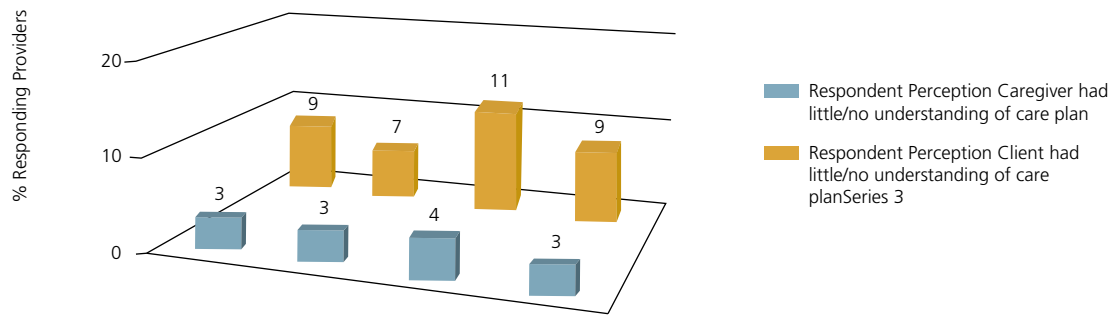
Respondents were asked whether “care plans considered the time of day for service convenient for the client” (Table 18). Nine out of 10 respondents (85% of care coordinators, 90% of regulated health professionals and 92% of PSWs) believed that care plans did give consideration to the time of day convenient for the client. Of note, 65% of order processors reported that orders took into consideration the time of day for service that was convenient to the client or family caregiver.

Table 18: Care plans considered time of service that was convenient for client



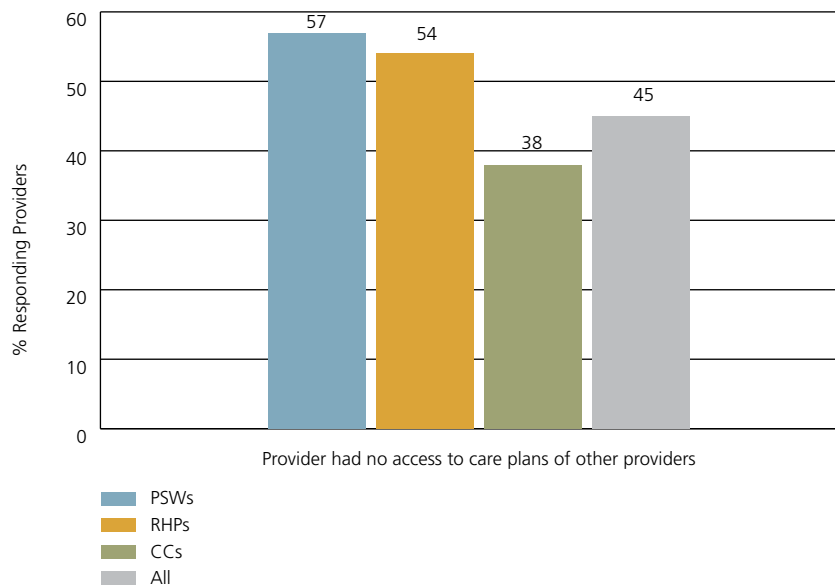
Respondents were also asked for their perception of whether their last client and his or her caregiver understood their care plan (Table 19). Almost one respondent in 10 (9%) felt that their client had little or no understanding of the plan. The perception of respondents was that the caregiver understood the client’s care plan somewhat better than the client did—i.e., only 3% felt that the caregiver had little or no understanding of the plan. This may be one of the reasons respondents find it easier to provide care when a caregiver is involved (see Table 10). It would be interesting to compare these relatively impressive numbers with those for patients who are leaving the hospital and whether they understand their discharge care plans.

Table 19: Care plans—respondents’ perception of caregiver and client understanding



Respondents were asked if they had access to the care plans of other providers (Table 20). Almost half of respondents (45%) indicated that they did not have access to other providers’ plans—38% of care coordinators, 54% of regulated health professionals and 57% of PSWs.

Table 20: Care plans—access to care plans of other providers



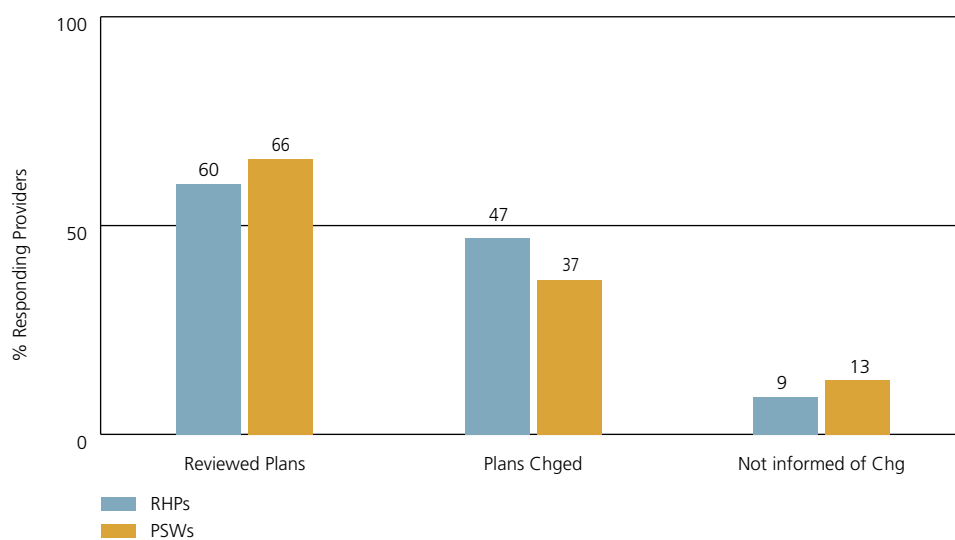
An additional question was asked of the regulated health professionals and PSWs: if their client had other providers, did they review the plans of the other providers? (Table 21). Although the majority of respondents did review the care plans of other providers, it is of note that four out of 10 regulated health professionals (40%) and one-third (34%) of PSWs did not. Reasons given for not reviewing the plans of other providers included:

- The plans were not available—either the plans were not in the home or other providers worked for other agencies or were from a different discipline.
- They relied on the client to inform them of the care of other providers.
- There was not enough time to review plans.

- Some PSWs elaborated that they felt they did not have the authority, without permission, to look at the plans of other providers; or that the plans were confidential and to be reviewed only by the client, primary caregiver and employing agency.

Almost half of the regulated health professionals (47%) and more than a third of the PSWs (37%) said that the treatment plan for their last client changed during the course of their contact with the client. In those cases where the treatment plan did change, one respondent in 10 was not informed of the change in a timely manner—9% of regulated health professionals and 13% of PSWs (Table 21).

Table 21: Care plans—reviewed plans, plans changed, not informed of change



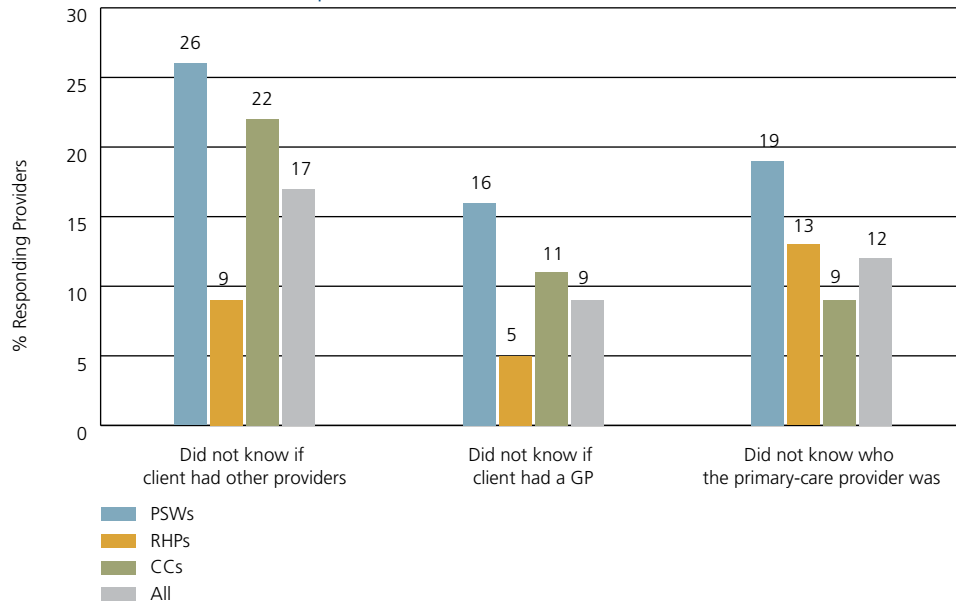
Working with other providers

Integration of care requires that community providers are aware of the other providers their client is receiving services and care from, are knowledgeable of the role of other providers, and can work effectively with other providers.

Almost one in five respondents (17%) did not know if their last client had other providers (Table 22). There was variance between the provider groups—more than a quarter (26%) of PSWs did not know if the client had other providers, while less than one in 10 (9%) of regulated health professionals were not aware.

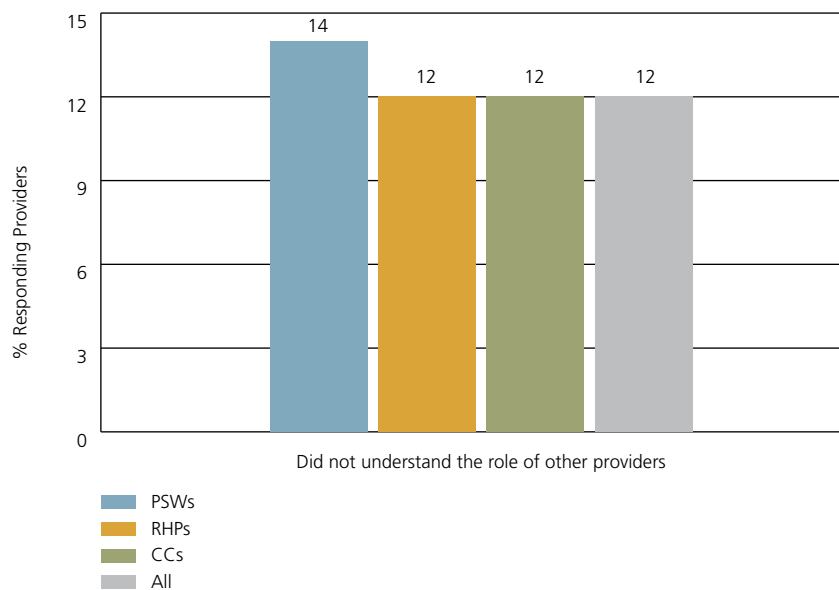
Almost one in 10 respondents (9%) did not know if the client had a family physician/GP, and more than one in 10 (12%) did not know who the primary health or social service provider was for their last client (Table 22). Again, there was variance between the provider groups, with PSWs more likely to report that they did not know whether the client had a family physician or GP (16%) or did not know who the primary care provider was (19%). Of regulated health professionals as a whole, 95% knew whether their last client had a family physician/GP; but only half of the pharmacists (50%) knew.

Table 22: Awareness of other providers



More than one in 10 respondents (12%) did not understand the role of other providers (Table 23), with 14% of PSWs reporting that they did not understand the role of other providers.

Table 23: Understanding the role of other providers



The majority of respondents—94%—felt that their training had prepared them well to work with other providers (Table 24). A number of respondents noted that their experience in the field, more so than their formal education, had prepared them to work as part of a team.

The majority of respondents—93%—also felt that they worked well with other providers (Table 24). However, despite feeling that they were trained well for team work and that they worked well with others, almost a quarter of respondents (24%) reported that they did not feel part of a team with other health and social service providers. Of note, PSWs were more likely to feel part of a team—nine out of 10.

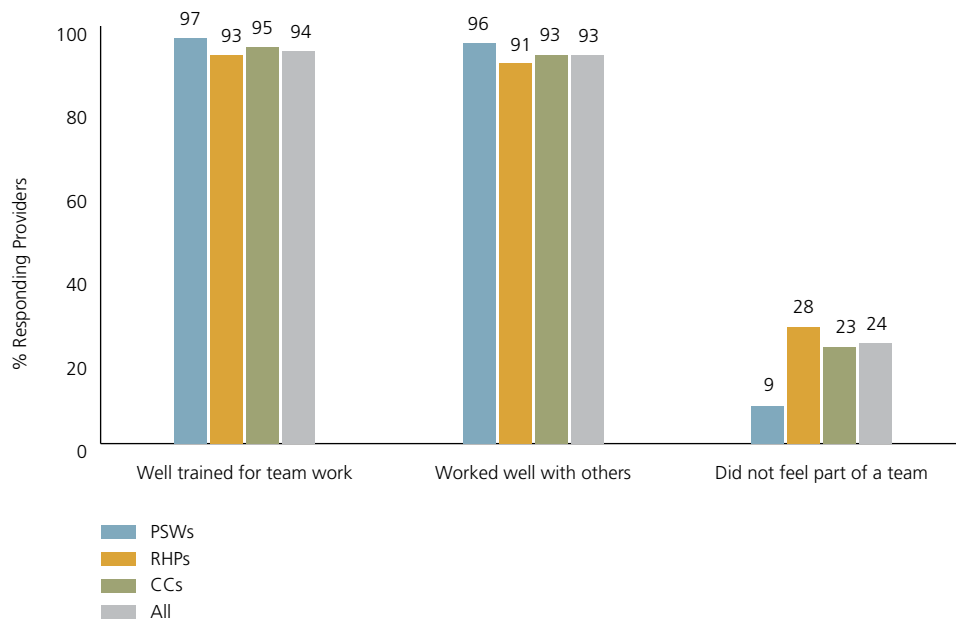
“Sometimes it is difficult to get information from other organizations; it is frustrating to have my work duplicated by agencies I have referred [clients] to.”

—Survey respondent

Respondents elaborated on reasons for not feeling part of a multidisciplinary team:

- a feeling that community providers are not valued;
- a sense that disciplines are too divided and that some are valued more than others;
- a lack of time to communicate with others;
- absence of reimbursement for the time required (i.e., not paid for team meetings); and
- working largely in isolation, with no expectation to communicate and coordinate with others.

Table 24: Working as part of a team



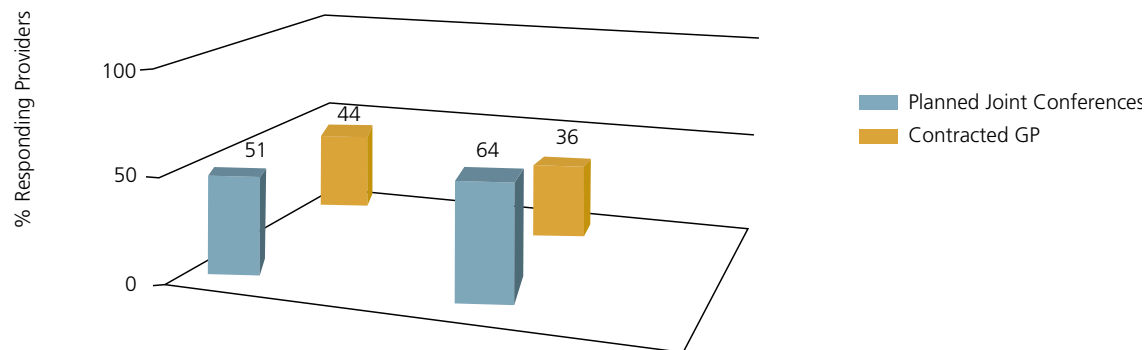
The regulated health professionals and care coordinators were asked whether they ever planned joint visits or teleconferences with other providers (other than family physicians) (Table 25). Just over half (51%) of regulated health professionals and almost two-thirds (64%) of care coordinators replied that they did. Accordingly, almost half of regulated health professionals (49%) and more than one-third of care coordinators (36%) did not. What we can't determine from the questions asked and response categories offered is whether joint visits or contacts with other providers were required and didn't happen, or whether joint visits or contacts were made when it wasn't required.

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

—Survey respondent

Regarding contact with family physicians/GPs, less than half of regulated health professionals (44%) and just over a third of care coordinators (36%) had contacted their last client's family physician/GP (Table 25). The majority of respondents—56% of regulated health professionals and 64% of care coordinators—reported that they did not contact their last client's family physician/GP.

Table 25: Planned joint conferences/visits, contacted GP



Views on integrated care

The survey of community-based providers also included qualitative data. Providers were asked to describe, in their own words, what integration of health-care services for clients meant to them. An analysis of responses found significant congruence among the different provider groups. The most frequently mentioned features included:

“Integration of health care services is taking into account the client's needs and wishes in the care plan, or having client participation in their care.”

—Survey respondent

- Care should be “client-focused”—69%.
- Care should be “coordinated,” “multidisciplinary”; there should be “continuity of care” and a “working together”—40%.
- Care should be “accessible,” “available”; there should be “one-stop shopping”—20%.
- Community-based providers were asked to rate and rank factors in the provision of integrated and coordinated care. There was significant consistency between the rating and ranking results, and significant congruence among the different providers. The highest rated and ranked factors by respondents were:
 - actively involving the client/caregiver in the care plan, and considering their goals and needs in care planning;
 - receiving information promptly about the care plan or changes in the client’s health status;
 - having good communication about the client with other health and social service providers; and
 - having complete information about the client from other health and social service providers.

PSWs also rated “ensuring that your role in delivering care is understood by other providers” in their top two ratings.

Similarly, respondents were asked to rate and rank the effects that are likely to result from poor coordination and collaboration among providers. They viewed the most likely effects of poor coordination and collaboration among providers as being:

- poor client understanding of the roles of service providers and care plans;
- risks to the client’s health and well-being;
- waste of human and other resources; and
- clients not following the care plan.

STRATEGIES FOR IMPROVEMENT

Understanding the perspectives and experience of community-based providers—i.e., care coordinators, regulated health professionals and personal support workers—in the delivery of care in the community is an important input to understanding and improving the experience of individuals and their caregivers. The Change Foundation offers its commentary on the survey results and presents recommendations for further action.

The survey data were generally positive. Our commentary and recommendations are offered in the spirit of quality improvement. Are there areas—even though they may be in the minority of cases—where there is room for improvement; where attention could be focused to change practice to improve the experience of individuals and their caregivers?

Survey respondents clearly articulated that client-focused care, working well with other providers, prompt and complete information, effective communication with the client and with other providers, and timely assessment and care are highly valued. They view client involvement and client-focused care as integral to a well-coordinated system of care. Prompt information about care plans and changes to plans, having complete information from other providers, and good communication among providers were viewed as key to integration.

However, analysis of the quantitative data indicates that there is a gap between community providers’ ideals and their reality. The majority of respondents would like to provide client-focused care. However, providers in the home care and community support sector are working within a broader health-care delivery system that has evolved over time and undergone significant change. Based on what we have heard from individuals and their caregivers, it is a delivery system still not known for its client-focused orientation.

Four predominant themes emerged from our analysis of the survey responses—human resources strategy development, operational design improvements, information exchange and communication improvements, and improved linkages with primary care.

1. A human resource strategy for the community sector is urgently needed to ensure that the workforce is valued, supported and sustained.

The **aging workforce** in the community sector is not unique. Rather, it is consistent with other sectors of health care and the broader economy. A recent TD Financial Group report (TD, 2010) concluded that more than a third of the entire Canadian labour force is preparing to retire over the next two decades, representing one of the most significant shifts in the workplace seen in the last half-century. A Canadian Nurses Association survey found that the percentage of nurses in Canada over the age of 50 in 2005 was 37% (CNA, 2005). Of note, though, a Statistics Canada report has concluded that—based on age alone—education and health care appear to be the sectors most vulnerable to retirement losses (MacKenzie and Dryburgh, 2003).

The community sector workforce is an **experienced workforce**. However, it is likely that experienced (and aging) community care providers will be leaving the sector and the workforce at a time when policy shifts are increasingly moving care delivery models into the community, and demographics are pointing to aging populations and increasing demands for care in the community.

Workers in the community sector have **varying education and training experience** given the nature of their work in the home and community. PSWs play a much more prominent role in this sector. Note that the Community Provider Associations Committee (our partner in the survey) estimates that 20,000 PSWs are employed by its member organizations to provide services and supports in the home—by far the largest provider group in the sector.^{6,7} (This estimate does not include private arrangements between families and PSWs.) PSWs typically provide non-professional services involving personal assistance with daily activities including personal care and home management, as well as practical tasks (e.g., medication reminders) and social connectedness. The scope of this work requires varying levels of knowledge and skills. The relationship between the personal support worker and the client and caregiver is of key importance; PSWs often provide the largest part of client care, and close bonds frequently develop.

With the exception of PSWs, community-based providers work mostly during the **daytime on weekdays**. However, daytime hours during the week may not be convenient or sufficient for clients and their caregivers. This is especially true for high-needs clients who may find it difficult to access services past 5 p.m. on Friday. These survey results are consistent with research into the accessing of medical care without going to a hospital emergency department, i.e., two-thirds of Canadians (65%) have reported that accessing care in the evenings, on weekends and on holidays is somewhat or very difficult (Health Council of Canada, 2010). The survey results indicate that 24/7 accessibility of services in the community sector is highly dependent—not surprisingly—on PSWs.

It is not clear from the survey questions asked whether the high percentage of **part-time workers** reflects personal preferences or unavailability of full-time positions (and with the benefits received through full-time employment). Similarly, although most respondents reported working for one organization, it is not clear whether those who were working for more than one were doing so because of personal preference or an inability to find sufficient work hours with one agency. However, a recent Canadian Research Network for Care in the Community survey of PSWs found that almost half of respondents (46%) reported that “too few hours” was a major challenge they faced with their employer—the second-highest response after “pay is too low” at 64% (CRNCC, 2009). Similarly, the Community Support Service Health Human Resource Report noted that over 50%

6 The estimated number of registered nurses in the sector was 6,500; registered practical nurses—1,600; and physiotherapists/occupational therapists/speech-language therapists—1,000.

7 The Canadian Institute for Health Information does not report on the number of PSWs in their workforce reporting (see CIHI, 2008).

of staff are part-time, with direct service workers and PSWs being the most affected (Ontario Community Support Association, 2010). This report concluded that “a part-time employment model is having an adverse effect on the abilities of agencies to attract the right front-line staff as well as retain them.”

Availability of part-time work may reflect both a business and client services strategy by agencies. One of the issues in home care is that most if not all clients want to get out of bed, be toileted and have their meal between 7 and 9 a.m., and then the reverse at night. Part-time workers make it possible to meet client needs on a more timely basis.

A strategy to retain and grow the human resource component of the community sector is urgently needed. Health Force Ontario human resource planning has focused on physicians and nurses in a range of practice environments.⁸ To date, it has not included the full range of providers in the community sector.

Admittedly, HR planning for the community sector may be particularly challenging for a number of reasons. First, the system pays hospital workers more than community-based workers. Emerging data confirm the long-suspected movement of workers from the community sector to better-paying jobs with better benefits and pensions in the hospital sector. As the community sector grows, workers will be asking for greater parity with the hospital sector.

Second, the predominance of women in the community sector is a complicating factor for HR planning. Recent data confirm that women are more likely than men to be informal caregivers—57% compared to 43% (Cranswick and Dosman, 2008). The looming pressures of informal caregiving for an aging population will have an impact on the largely female workforce in the community sector.

Third, an HR strategy will need to address the challenge of how to make a PSW career attractive for the long term. Remuneration for the position—in essence the value assigned to the work—is low.

⁹ As well, there are currently few opportunities for advancement or specialization within the personal support worker role. Finally, there are basic working-condition issues that need to be addressed in order to influence the view of personal support as a rewarding career (e.g., accountability framework for travel and compensation, scheduling standardization, standard and enhanced training opportunities). A further consideration is that PSW positions are often entry points to employment for new immigrants. An HR strategy has to address issues related to an immigrant workforce.

A human resource strategy must also address provider education/training requirements and enforcement. For PSWs, the minimum training requirement is a certificate program that is offered through four recognized categories of training organizations (community colleges, private career colleges, board of education and not-for-profit training organizations). With multiple training environments and the lack of oversight responsible for the enforcement of training standards, there is a wide variance in skill sets from one PSW to another, making it difficult to be sure of the abilities of a particular employee

“A dual labour force has emerged—there’s disparity between the hospital and community sector in terms of wages and benefits, and therefore, movement tends to be ‘one way’ from the community to hospitals.”

—Healthcare of Ontario Pension Plan (HOOPP), 2010

8 The Health Force Ontario website refers to hospitals, long-term care, primary care, public health, home care/CCAC, hospice and office/clinic care as practice environments.

9 The Community Support Service Health Human Resource Report (Ontario Community Support Association, 2010) reported that the median salary of full-time PSWs was \$29,000—the lowest salary of the 14 distinct positions defined for the survey.

(PSNO, 2010). A training curriculum was developed by the Government of Ontario and the Ontario Community Support Association (OCSA). The latter, with its personal-support stakeholders, launched a voluntary provincial accreditation program in 2010—the PSW Education Program Accreditation (PEPA). PEPA offers great promise in improving the consistency of skills and competencies of PSW graduates in the future. Given the important role that PSWs play in the sector, accountability and quality assurance of their training should be a priority.

Finally, a human resource strategy must ensure that scope of practice guidelines and directives are in place and are appropriate for the various providers in the sector. We need to ensure that the workforce is optimally deployed, with all occupations able to utilize all of their knowledge, skills and experience. Should scope of practice be determined increasingly by demonstrated and regularly monitored competency assessments and performance reviews, and less by formal educational credentials earned at the very beginning of a career? PSWs are more likely than other providers to be working evenings and nights and providing services on the weekends—are there “nursing” tasks that could be safely undertaken by PSWs? Are there more appropriate tasks that nurses should focus on?

If PSW training standards were enforced, scope of practice adjustments for PSWs and nurses could be made with more confidence. We want PSWs to be as capable as possible to deliver care and support, and to know when a higher level of care is required. Scope of practice issues need to be seriously explored in a framework of concern for what is best for the client and their caregivers, rather than with an orientation that seeks to protect the interests of one provider group over others, or to minimize costs at the expense of quality and safety.

“The PSW training curriculum includes training in monitoring, identification of client changes and appropriate communication and documentation of these changes. However, many agencies send regulated professionals to do frontline assessment, or discount PSW-communicated observations of a changed condition.

Routine bowel procedures are typically performed by visiting or shift nursing programs even though a PSW, who is already providing other care, could be trained to provide the bowel routines in stable clients; the end result could be improved continuity of care and a freeing up of nurses to perform tasks that must be performed by a nurse.”

—Personal Support Network of Ontario, 2007

The Canadian Home Care Human Resources Study (CACC, 2003) presented findings, recommendations and strategies related to supply and characteristics of the home-care workforce: education and training, wages and benefits, the nature of work, and the recognition and image of the sector and its workers. Both this report and the Community Support Service Health Human Resource Report (OCSA, 2010) are important resources with useful information to support the development of a human resource strategy in Ontario.

Recommendations

At the provincial level:

- Develop a human resource strategy for the community sector—a strategy that addresses the unique challenges of the sector (e.g., predominance of women, pay and benefits differentials with other sectors, part-time employment model) and the reliance on PSWs (i.e., how to make it an attractive career, accountability and quality assurance of training, etc.). Consideration of the provincial PSW Education Program Accreditation (PEPA) as mandatory for all training organizations in Ontario should be undertaken as a quality assurance component of the strategy. A scope of practice review, involving key stakeholders, should be undertaken as part of the development of a human resource strategy for the sector.

At the agency level:

- Review and revise agency policies and care approaches to ensure that community providers work to their full scope of practice where appropriate and needed.

2. The operational design of home care and community support services needs to better reflect the needs of clients.

Survey respondents consistently reported that they were able to establish good working relationships with individual clients. This is in keeping with what we heard from individuals and caregivers in the focus groups—i.e., in a one-on-one relationship, the care experience is positive. It is beyond this relationship between the individual provider and the client that problems start to emerge.

The part-time employment model—in addition to impacting the ability of agencies to attract committed staff—also impacts their ability to provide services that meet the needs of clients. The community sector is recognized for offering a better work-life balance, compared to the shift work required in hospitals. However, we know from our focus groups with individuals and caregivers, and from other sources,¹⁰ that people—particularly those with high needs—often cannot access the services and support they need after hours and on weekends. We need to better understand the extent of need for after-hours care in the community. What percentage of this need goes unmet due to lack of workers, employee and employer preferences regarding part-time hours and weekday/daytime shifts, etc? How many more people could stay at home longer if community provider organizations actually provided more after-hours services?

The vast majority of survey respondents believe that attempts are made to send the same provider to a client for each visit. This is inconsistent with what we heard from individuals and caregivers in the focus groups. They reported that different providers were often sent from one visit to the next, making it difficult to establish relationships. This inconsistency in findings between the two groups invites further exploration.

The survey findings imply that at least one in five respondents was not able to inform clients and caregivers about mechanisms to provide feedback on services. Of CCAC case managers, 17% were not aware of these mechanisms for clients to provide feedback. This is particularly surprising given that all CCACs are using a common client satisfaction survey designed

¹⁰ The Toronto Star's "Begging for Care" series on issues in home care in Ontario by reporters Theresa Boyle and Moira Welsh (Feb 18–26, 2011); see: <http://www.thestar.com/news/article/945070—senior-leaves-nursing-home-with-help-of-home-care>

to compare the quality of care and experience of clients and caregivers across the 14 CCACs. ¹¹ Consistently informing clients about feedback mechanisms should be a standard component of service delivery. These feedback mechanisms must be structured so that clients have an opportunity to provide meaningful feedback on their care experience, which will be a key input into service quality improvement. ¹²

The survey data raise questions that need to be further explored. What do we know about the health and safety issues of home-care staff? How can we better ensure their health and safety? Why are scheduled appointments missed? Why are required equipment and supplies not always available? Why are clients and caregivers not always appropriately trained to use equipment and supplies?

The survey results also suggest that some administrative and operational processes are in need of improvement. We need better processes and protocols to ensure that:

- scheduled appointments are not missed;
- medical equipment and supplies are available as required;
- clients and caregivers are appropriately trained to use the equipment/supplies; and
- providers are informed of potential hygiene and safety risks with clients or in clients' homes.

There are pockets of innovation, e.g., call-in-advance protocols that reduce the waste of resources and client and provider inconvenience associated with missed appointments. These innovative processes and protocols need to spread throughout the sector.

“To facilitate care at the right place at the right time, the Government of Ontario should ensure that structures and processes are in place so that patients, especially those with complex care needs, have their care connected across the continuum.”

—OHA and OACCAC, 2011

Recommendations

At the provincial level:

- Undertake an analysis of the extent of need/demand for after-hours care in the community sector and its alignment with the employment model in the community sector, particularly as it compares to other sectors of the health-care system. Key issues such as equity, fairness and client preferences and needs will have to be addressed. (This analysis will be linked to the development of a human resource strategy in the community sector.)

At the agency level:

- Develop and share administration processes and protocols to improve the care experience for clients and providers (e.g., scheduling protocols, provider-assignment protocols, equipment and supply order and usage protocols, risk-assessment and notification protocols and client-feedback protocols).

¹¹ Client and Caregiver Experience Evaluation Survey referenced in the 2009–2010 CCAC Quality Report.

¹² Feedback reported on client satisfaction surveys may be suspect as clients may be afraid to report problems, given concerns that their service may be compromised.

3. Information flow and communication among providers and with individuals and their caregivers must be improved.

The survey responses point to clear concerns about the lack of information and quality of information exchanged between providers, and about the extent and quality of communication between them. Clearly, the provision of well-integrated and high-quality care is compromised when:

- providers themselves are not always satisfied with the information they are given to support their work with clients;
- providers may have to rely on clients and their caregivers to relay information to other providers (especially worrisome when there is a perception that clients and caregivers don't always understand their care plans);
- providers are not always informed when their client has been transferred to another sector for care, or has returned home from a care facility;
- providers are not always informed about changes to the client's care plan;
- a series of providers may be asking clients and caregivers to repeat the same health-care history; and
- care plans—which are intended to serve as a tool to facilitate communication between providers, clients and caregivers—are not always accessible, understandable and valued by all providers.

In this regard, community care is no different from other sectors of the health-care system. Almost a quarter of Canadians (23%) have reported that their regular doctor did not seem to be up-to-date about care they had received from a specialist, and more than one in 10 (12%) reported that medical records or test results were not available at the time of a scheduled appointment (Health Council of Canada, 2010).

These situations are consistent with those that The Change Foundation heard about from individuals and caregivers. Focus group participants identified serious concerns about the duplication in assessments of their condition, requirements to repeatedly provide the same information about their health condition and their care history to different providers, and worries that providers were not communicating among themselves.

The lack of information and delay of information transfer is not surprising given the history of information technology development in the community sector. Typically, information management systems in hospitals and the community sector and between organizations within the community sector cannot talk to each other. There is limited access to technology in the sector, with, for example, very few provider organizations giving hand-held technology to staff. There are small-scale innovations,¹³ and plans for a common platform in CCACs to track client information and care plans.¹⁴ But in general, the use of technology in the sector has not been well-supported.

In the absence of integrated information systems, we need to better understand the root causes of information redundancies and misalignments between providers, and how information moves from hospitals and CCACs to the front line.

The potential for error is huge and the potential impact on the quality of care cannot be ignored. The quality and flow of information and communication between providers and with individuals and their caregivers is an area that is ripe for quality

13 One CCAC is experimenting with eShift technology that connects a PSW in the home with a registered nurse via a web-enabled iPhone (CCAC, 2010).

14 The Client Health Related Information System (CHRIS) is a web-based system designed to provide CCAC case managers and administrators with a common system to enter and track client information and care plans. All CCACs are expected to use CHRIS by the end of 2011, an achievement viewed as a major step toward a common electronic record for each CCAC client. CHRIS is starting to connect CCACs to other parts of the health system including hospitals and family physicians (CCAC, 2010).

improvement and care-delivery re-design. In many cases, relatively simple changes in processes and protocols could improve the information flow and communication among providers—which would in turn have a positive impact on the experience of both clients and providers. Existing innovations need to spread throughout the sector. In other cases, care delivery re-design will need to be undertaken.

Recommendations

At the provincial level:

- Pursue innovative care delivery and funding initiatives—such as the Integrated Client Care Project (ICCP). ICCP is testing new ways to improve the home-care experience for clients and caregivers, providers of care and the system that pays for the care; there are plans to move in the direction of a single contract to a lead provider agency to coordinate services based on client needs, where payment will be based on client complexity and needs.
- Support IT infrastructure development that will facilitate information exchange and communication between providers across the sectors of care, and with individuals and their caregivers.
- Develop common health records and care plans designed to improve information exchange and communication between providers, and with clients and caregivers. Standard components of the common care plan should include information on other providers (e.g., contact information), up-to-date client information (e.g., most-recent assessments, diagnostic tests and client mobility restrictions), and a standard process to provide timely care plan updates.

At the CCAC level:

- Develop and share processes and protocols to support information and communication exchange (e.g., protocols for access and review of care plans, assessments and diagnostic tests; changing care plans; informing clients and caregivers about their care plans; and notification of client transitions).

At the agency level:

- Promote and foster a team culture among providers within the agency and with providers in other organizations and other sectors. (This recommendation is linked to the training and scope of practice issues discussed under the human resource strategy recommendation.)

4. Linkage between home and community services and primary care must be improved.

The survey responses indicate that information exchange and communication between providers in the home and community sector and the primary care sector has room for significant improvement. High quality care and a positive experience are jeopardized when home and community providers do not know if their client has other providers—including whether they have a family physician/GP or primary care provider.

To some extent, it is not surprising that community providers were often not aware if their client had a family physician/GP or primary care provider. Community Health Centres (CHCs) are currently the only primary care delivery model with a formal accountability agreement with LHINs. Family Health Teams (FHTs) are not accountable to the LHINs but they do

“Physicians—even those associated with Family Health Teams—operate autonomously from the LHINs, even though they are the primary point of contact for health care for many Ontarians.”

—OHA and OACCAC, 2011

have some administrative infrastructures. The remaining primary care physicians are functioning independently of accountability agreements with the LHINs or the administrative infrastructures of the FHTs. CCACs are accountable to the LHINs and are responsible for coordinating care in the community. However, there is not a formal process for interaction between the CCACs and the full range of primary care delivery models. For example, it appears that there is some interaction between the CCACs and the FHTs—i.e., CCACs have case managers in some (or all, depending on the CCAC) of the FHTs in their LHIN¹⁵—however, interactions between CCACs and solo practice family physicians/GPs appears to be intermittent at best.

At the provider level, what can we do to encourage regulated health professionals and care coordinators to plan joint visits/teleconferences, or contact the client's GP/family physician? What is the current standard process for arranging joint teleconferences/visits or contacting family physicians/GPs, and can there be improvements to that process? What can the community sector do to enable more effective communication and more effective working relationships between providers within the sector and with providers in the primary care sector? Should this be reflected in care plans and appropriately remunerated?

We need to ask the tough questions. How do we better link the clinical/medical history and the nursing knowledge in the primary care sector with the case management expertise, administrative structure and knowledge of local resources of the community sector? Is the separation between primary care and home and community care meeting the needs of individuals and their caregivers? Whose responsibility is it to ensure overall planning and accountability across the continuum of care, including home and community care and primary care?

The primary care sector and the home and community care sectors have evolved in Ontario as they have due to a series of circumstances and decisions. There is a gap between the sectors and until more formal accountability systems are established, the primary care sector and the home and community sector will be challenged by this disconnect. Do we need to consider a next iteration of a primary care/community care administrative infrastructure and governance model? Perhaps we start with CHCs and FHTs and build from there.

The Ontario Hospital Association (OHA) and the Association of Community Care Access Centres (OACCAC) have recently proposed that the planned legislative review of LHINs should include an examination of how physicians can be better integrated with LHINs, CCACs, hospitals and community-based health providers (OHA and OACCAC, 2011). As well, we can learn from existing models of care that are designed to integrate primary, secondary, tertiary and community care, promote local input and planning, improve quality, and establish systems for shared accountability and performance measurement—e.g., Accountable Care Organizations in the U.S. come to mind. Given that we can't start from scratch, the recommendations are predicated on knowing what needs to be done balanced against the existing system design.

Recommendations

At the provincial level:

- Undertake an analysis of the formal and informal relationships and linkages between the primary care sector and the home and community care sector with a goal to create a more integrated care pathway for the benefit of the patient/client.

At the agency level:

- Promote and support a team culture with providers in the primary care sector, including a review of the current process for joint visits/teleconferences, and a review of how care plans can facilitate communication with primary care providers and link medical/clinical history with case management expertise.

15 As confirmed by the Ontario Association of Community Care Access Centres.

CONCLUDING NOTES

“The quality problems occur typically not because of failure of good will, knowledge, effort or resources directed to health care, but because of fundamental shortcomings in the way care is organized.”

—U.S. Institute of Medicine (2001)

The Change Foundation has heard from patients and clients, their family and friend caregivers, and now from community-based home care and support service providers. The Foundation has taken part in a number of quality improvement initiatives for people who are making transitions between health-care sectors, such as moving from hospital to long-term care or home care. These initiatives have involved CCAC coordinators, nurses, PSWs, discharge planners and therapists, working within individual organizations and working together to improve the experience of patients/clients and their caregivers.

The Change Foundation will continue to engage with individuals, caregivers and providers to better understand the challenges being faced and to explore potential solutions. It is becoming increasingly clear what the problems and shortcomings are within our system. The solutions will range from fairly simple changes to more complex re-direction of policy. We want to work with patients and clients, their family and friend caregivers, and providers to make changes that will improve the quality of services, and improve the experience of everyone involved.

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Vision

To be Ontario's trusted advisor advancing innovative health policy and practice.

Goal

To improve the experience of caregivers and individuals as they move in, out of, and across the health-care system over time.

The Foundation will adopt a participatory approach to the following four methods: research, policy analysis, quality improvement, and engagement.

Mission

To make caregivers and individuals in need of health care part of the health-care discussion about how to find solutions to improve their experiences.

To stimulate new ways of thinking, behaving, and interacting to foster improved health care for people, especially when they are in transitions.

To generate robust and independent research and policy analysis of health-care issues related to improving the experience of individuals and caregivers as they navigate the health-care system.

To lead informed discussion and strategic engagement with the stewards, stakeholders and users of the health-care system.

Mandate

To promote, support and improve health and the delivery of health care in Ontario.

Values

Excellence. We strive for excellence in all we do. **Innovation.** We take innovative approaches in developing new ideas. **Collaboration.** We work in partnership with others to achieve success. **Inclusivity.** We strive to include all voices and views.

Contact us

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