Summary Report: **Integration of Care**

Perspectives of Home and Community Providers

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Executive Summary

The Change Foundation's 2007-2010 strategic plan identified integration as a topic that presented a significant opportunity to assist the newly created Local Health Integration Networks meet their mandates and to help improve health care in Ontario. One of the first initiatives in The Change Foundation's strategic plan was a survey and series of focus groups with patients and their family caregivers to understand their perspectives and experiences of integration in health care. In the context of these results, The Change Foundation decided in 2009 to explore the perspectives and experiences of health and social service providers in the home and community sector.

This report represents the results of surveys conducted with
Regulated Health Professionals (RHPs):

- Registered nurses (RNs)
- Registered practical nurses (RPNs)
- Rehabilitation therapists (occupational therapists (OTs), physiotherapists (PTs), speech language pathologists (SLPs)
- Dieticians (DTs)
- Social workers (SWs)
- Respiratory therapists (RTs)
- Pharmacists (medical equipment and supplies) (PHs)

Personal Support Workers (PSWs), and
Care Coordinators:

- CCAC case managers and system navigators
- Care coordinators in provider organizations
- Intake coordinators and order processors (medical equipment and supplies)

Demographics

The provision of care in the community is largely a female driven workforce. Of the 630 respondents to the surveys, 94.0% were female.

Similar to other sectors of healthcare, the community care workforce is aging. Two-fifths of respondents were over the age of 50. Amongst these groups, 40 to 50 percent of case managers, social workers, registered nurses, speech language pathologists, and personal support workers were over the age of 50.

Ninety-seven percent of respondents are Canadian by birth or naturalization. Proportionately fewer personal support workers (65.1%) than care coordinators (87.7%) and regulated health professionals (75.6%) are Canadian by birth. The majority of professionals speak English and the majority did not experience a language barrier with their last client. French was the first language of 5.6% of respondents and 3.7% currently speak it at home, which is approximately the same proportion of Franco-Ontarians according to the 2006 census.

Home and community care providers are experienced workers in the home care and other sectors. Almost one-third and three-fifths of respondents have worked in their profession for more than 20 years and ten years

respectively. Proportionately more RHPs (66.1%) than care coordinators (50.0%) and PSWs (55.2%) have worked more than ten years in the profession. One-half of all respondents had worked in the home and community sector for more than 10 years. Almost all (99.0%) had experience working in other sectors, particularly the acute care sector (47.3%), physician's offices/family health teams (39.4%), complex continuing care/chronic care facilities (19.8%), and rehabilitation facilities (18.3%). Slightly more than three in five work in both rural and urban areas.

More than one in ten (13.9%) of all respondents work for more than one organization, particularly RHPs (20.7%) and PSWs (16.9%) compared with care coordinators (7.5%). This may reflect either the shortage of professionals or the inability to find sufficient work hours with one agency. More than one-half (55.1%) of all respondents work for large organizations with over 100 employees. Proportionately fewer PSWs (31.0%) than care coordinators (62.5%) and RHPS (55%) work for large organizations.

Slightly over two-thirds of respondents work less than 40 hours a week, and less than one-third (31.8%) work 40 or more hours a week. While the high percentage working part-time may reflect personal preferences and availability, it may mean that providers are not receiving benefits earned by their full-time counterparts. Almost two-thirds of respondents (64.6%) work only during the week, with proportionately more coordinators (81.8%) than RHPs (57.2%) and PSWs (26.7%) working only weekdays.

Perceptions of Integration

Meanings of Integration offered by respondents highlighted four factors which are presented in order of the frequency with which they were mentioned in 1) client-focused care (CCs, RHPs, PSWs); 2) coordinated, multi-disciplinary care (CCs, RHPs, PSWs); 3) improving access/availability/one-stop shopping for clients (CCs), and better communications/availability of physicians 24/7 (RHPs, PSWs).

Some of these factors were supported in a rating and ranking of 10 factors provided to respondents. *Actively involving the client in the care plan*, *Receipt of information promptly about care plans and care plan changes,* and *Good communications amongst providers* were, in order, the three factors rated most highly by all respondents. Care coordinators and RHPs rated these three factors in the same order. For PSWs *Receipt of prompt information about care plans or care plan changes* was the most important factor, followed by *Good communications amongst providers*, and *Actively involving the client in the care plan* and *ensuring that their role was understood by other providers*. PSWs' ratings may reflect the extent to which they feel part of a team and the extent to which they feel that some of their work is not appropriate for their skill levels.

In choosing the top three factors amongst the ten above, *Actively involving the client*, *Having good communication with other providers* and *Having complete information from other providers* were ranked by all respondents in order as the top three factors.

Conversely, the potential effects of poor coordination and integration as rated by all respondents reflected the important factors involved in integration. *Poor client understanding of provider roles and the care plan* was viewed by all as the most likely impact of poor coordination. The second and third most important factors varied amongst the respondents. Care coordinators and RHPS rated *Waste of human and other resources* as the second most important impact, while PSWs rated *Risks to the client's health and well-being* as second. RHPs and PSWs rated

Clients not following the care plan as the second most likely effect, while CCs and also RHPs rated *Risks to the client's health well-being* as the third most likely impact of poor coordination and collaboration.

These results show that respondents see 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 communications amongst providers are also viewed as key to integration. Risks to the client's health, poor client understanding of roles of providers and the care plan which in turn can result in a risk to the client's health, and a waste of resources were all seen as likely effects of poor integration.

Working with Clients

In keeping with the importance of client-focused care in integration, all respondents said that the need to be respectful of clients' needs and preferences was most important in order to establish a good relationship with clients. Other factors important in establishing a good client relationship included: providing assessments in a timely manner, and being the client's regular provider of care.

The vast majority of respondents (98.8%) were able to establish a good working relationship with their last client. Insufficient time, missing information, client dementia, and non person to person contact were given as reasons contributing to poor client relationships. Despite developing good relationships with their last client, 10% of respondents experienced a language barrier.

Despite a focus on the client and his/her family in developing the care plan and treatment, almost 30.4% of clients are having difficulty understanding the role of other providers, and 8.9% had no to little understanding of their care plans. Although professionals can rely on family members in this regard, and indeed the majority of respondents (79.0%) find it easier to provide care when a family caregiver is involved, they also indicated that 3.4% of family members had no to little understanding of care plans. A greater focus on clear descriptions and explanations of treatment plans for clients and family caregivers may be required.

Views on Care Plans

While good communications amongst providers and the prompt receipt of good information were rated by professionals as the second and third most important factors in providing integrated care, a little more than one-quarter of respondents (26.8%) were not happy with the amount of information they were provided for their first visit with their clients. Insufficient information on the client's medical history, difficulty obtaining information from physicians and hospital discharge summaries, and problems with the Client Health and Related Information System were cited as reasons. Furthermore, almost one-third (31.6%) of RHPs and two out of five (39.2%) care coordinators had to contact another health provider for more information - RTs, PTs, DTs, SWs and PHs more often contacted other providers for more information about their client and test results than other providers. Furthermore, nearly 60% of pharmacists said they did not have enough client information to determine possible drug interactions. Pharmacists indicated they experienced some difficulty contacting other providers.

Duplication of information and assessments is a concern expressed by many clients, further highlighting the lack of communication and collaboration amongst providers. Almost two-thirds of regulated health professionals (65.4%)

- proportionately more SWs, PTs, RTs, DTs and OTs - said they had asked their last client to repeat some or all of their health and care history. One-quarter of RHPs – proportionately more RNs and SLPs – who saw the question as applicable, said they had to repeat an assessment or test on their last client. [Care coordinators and personal support workers were not asked these questions.] Not only does this highlight a possible lack of sufficient information, it also corroborates one of the reasons clients cite for the lack of integrated care.

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 professionals' 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. Changes in care plans need to be communicated to providers promptly for seamless care. A little less than one-half of RHPs (46.8%) and one third of PSWs (37.1%) said that the treatment plan for their last client changed. Of those respondents 8.5% of RHPs and 12.5% of PSWs said they were not informed of the change. [Care coordinators were not asked this question.] Moreover, almost one-third of all respondents (30.9%) – 29.1% of care coordinators, 32.6% of RHPs, and 10.0% of PSWs – said they were not informed in a timely manner when their client was moved from the home into the hospital or a long term care (LTC) facility. Almost one-half of care coordinators (48.3%) and regulated health professionals (48.0%) did not know if there was a single person responsible for communicating information to the receiving facility. Furthermore, when their clients returned to their home, roughly one-third of all respondents – proportionately more care coordinators (35.8%) than RHPs (27.1%) and PSWs (18.4%) – did not receive information about the care plan promptly.

As noted earlier, home care clients frequently have multiple providers who are not onsite at the same time. Collaboration requires the sharing of these treatment plans. In this regard, almost one-half of all respondents (45.3%) – 38.3% of care coordinators, 54.0% of regulated health professionals, and 56.7% of personal support workers – said they did not have access to the treatment plans of other providers. Two-fifths of RHPs and one-third of PSWs said they had not reviewed other providers' treatment plans. Unavailability of plans, lack of time, lack of authority, confidentiality, and reliance on clients to provide the information were given as reasons for not reviewing other providers' treatment plans.

With respect to the provision of care, almost one fifth (17.4%) of all respondents said that care was not started at the right time for their last client. Twenty-one percent of care coordinators compared with regulated health professionals (4.7%) believed the delay in service was due to their own organization. [PSWs were not asked this question.] The majority of all respondents (84.5%) said the care plan took into consideration the client's mobility and living environment. Approximately 9 in ten RHPs and PSWs believed that consideration was given to having the same provider for each visit. [Care coordinators were not asked this question.] Similarly, 9 in ten of all respondents said the care plan took into consideration the time of day for service appropriate for clients or their caregivers. Approximately one in ten of all respondents said the client did not have either the necessary medical equipment or supplies for their care. Finally, one in ten of all respondents said the client was not receiving adequate nutrition.

Because of the isolation of the home as a care environment, it is important that clients have opportunities for redress for any lack they perceive in their provider or treatment plan. It is incumbent on the home care provider to inform the client of this process. However 13.8% of all respondents did not know if such a process existed and 6.8% said that there was no process available for client feedback. Proportionately more PSWs than care

coordinators and regulated health professionals did not know of a process (20.7%) or said there was no process (9.2%).

The isolation of the home as a care environment can also be of concern to providers who are exposed to difficult or abusive clients, communicable diseases, aggressive pets, smoke, and bed bugs. One in ten (9.6%) of all respondents said that their last client was a potential risk to their health and safety, and 38.9% of these individuals said they were not informed of that risk. Similarly one in ten (10.2%) of all respondents said that their client's home was a potential risk to their health and safety, and 51% of them said they were not informed of this risk.

Working with Other Providers

Respondents were asked a number of questions with respect to their knowledge of, and their ability to work with other providers. In order to collaborate on care, providers at a minimum must know who else is providing care to their client. A little over 5% of RHPs and 16.1% of PSWs did not know who was organizing their client's care. [Care coordinators were not asked this question.] Twelve percent of all respondents, and particularly PSWs (18.8%), did not know who the primary health care or social service provider was for their last client. Five percent of all respondents did not know who the primary family caregiver was. Slightly less than one-fifth of all respondents (17.2%), and particularly PSWs (25.6%), did not know if their client had other providers and 12.4% of all respondents did not understand the role of other providers. Almost one in ten of all respondents (9.2%) did not know if the client had a family physician. A small percentage of all respondents (4.1%) did not know who to call for professional help.

There also appears to be no consistent source for learning about a client's other providers. The client is most often the source of this information. Similarly, one-third of all respondents (34.4%) have relied on the client to pass on messages or health information to other providers. Regulated health professionals (44.9%) more often use this method of information transmission than care coordinators (29.6%) and personal support workers (18.4%). The accurate conveyance of information may break down if providers do not communicate directly with each other. Lack of communication can also often lead to a waste of resources. Four in ten of all respondents (41.4%) said they have arrived at an appointment to find that the client was not available.

One measure of collaboration is the extent to which providers feel that they are able to suggest changes to care plans. In this regard one-half of RHPs and PSWs said they wanted to suggest changes and in almost all cases they conveyed the suggestion.

The majority of all respondents (93.8%) said they were able to use all the skills from their training that were needed and appropriate for their client. Reasons for not being able to work to their full competencies had to do with a limit in resources, time, and unwillingness of other providers to allow them to use their skills. Allowing providers to work to their full competency can improve job satisfaction, efficiency and effectiveness.

When asked how well they worked with the other providers of care to their client, a majority of all respondents (92.5%) said they felt they worked well with the other providers. Despite the fact that they felt they worked well with others, 23.5% of all respondents did not feel as though they were a part of a multidisciplinary team. Ironically, this was particularly more true for care coordinators (23.1%) and regulated health professionals (28.2%) than for personal support workers (9.4%). The majority of all respondents (94.1%) felt that their training adequately

prepared them to work in teams. One mechanism for collaboration is joint visits or teleconferences. However, only 63.5% of care coordinators and 50.9% of regulated health professionals had organized such meetings. [PSWs were not asked this question.]

Reasons offered for not feeling as though they were part of a team included not being valued, lack of expectations for collaboration, fragmented communications and connections, not having the time or being reimbursed for collaboration, and a division amongst disciplines. Good integration depends on open communications. This requires that employers convey through the allocation of time and resources an organizational expectation and the value of good communications, coordination and collaboration.

Respondents' Recommendations for Improvement

When given a list of 14 strategies for improving integration, all respondents gave the following three factors the highest ratings in order: *Having the appropriate provider providing care*, *Developing strategies to promote the health of the client and prevent decline and illness*, and *Ensuring providers work to the full extent of their training*. When asked to rank the 14 strategies in terms of importance against each other, respondents chose *Strategies to promote the health of the client and prevent decline and illness, Having the appropriate type of provider providing care,* and *Providers working to the full extent of their training*.

When asked to write one thing they would change to improve client's care in the home and community care system, respondents raised funding issues, client care issues, issues regarding working with other providers, system-level issues, and work and workplace issues. Funding issues were most often raised by regulated health professionals. Client care issues were most often raised by care coordinators. Work and work place issues were most often raised by personal support workers.

Amongst all the suggestions mentioned by respondents, *Increased funding, resources, and staff* was the most frequently mentioned recommendation, followed by *Better collaboration with other providers,* and *Better information systems.*

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. [a]

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. [b]

 In response to these reforms The Change Foundation's 2007-2010 strategic plan[c] 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.[d]

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 was 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 were 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 experiences 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

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

[b]   Ontario Local Health Integration, *About LHINs.* http://www.lhins.on.ca/aboutlhin.aspx?ekmensel=e2f22c9a_72_184_btnlink

[c]   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

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

overall coordination of their care. These problems and concerns were exacerbated at points of transition.[e] A summary of the report can be found on The Foundation's website.

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 included 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.

1.0 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

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[e]   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

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 be administered to registered nurses, registered practical nurses, physiotherapists, occupational therapists, speech language pathologists, 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 intake coordinators and 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.

Research[f] 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

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[f]   Tversky, A., & Kahneman, D. (1974). Judgment under uncertainty: Heuristics and biases. *Science*, *185*, 1124–1131.
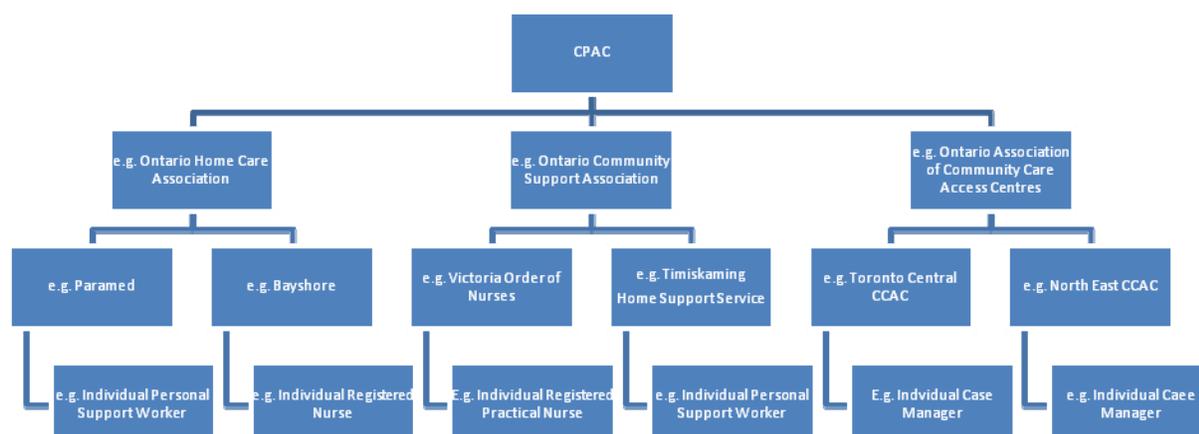
To determine the perceptions of all people who provide health care and social services to clients/patients in the community, it would be ideal to have contact information for all such providers. Providers would be categorized by type, e.g. case managers, service coordinators, registered nurses, personal 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 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
Regulated Health Professions		
Registered Nurses	6500	300
Registered Practical Nurses	1600	200
Physiotherapists		100
Occupational Therapists	1000	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**

Personal Support Workers	**20,000**	**300**
Care Coordinators		
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. [g]
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 (minimizes 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 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 or 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

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[g] 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 51social 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.

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÷140x100) 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 ÷ 140 x100) 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 ÷ 140 x100). 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 ÷ 140 x 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 possible, 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, and those 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 details the results from the Care Coordinators:
- CCAC Case Managers and System Navigators
- Care Coordinators from OHCA and OCSA member organizations
- Intake Coordinators and Order Processors from medical supplies and equipment organizations

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

This report is the comparison report providing a summary of results from all of the surveys for Home and Community Providers including the regulated health professionals, the care coordinators and personal support workers.

2.0 Results

2.1 Response Rate

All together 2,020 surveys were distributed to home and community providers: 662 to Care Coordinators, 1,058 to Regulated Health Professionals, and 300 to Personal Support Workers. Of the 2,020 distributed surveys, 630 were returned for an overall response rate of 31%. Specifically, the response rate across the three types of surveys varied, with Care Coordinators returning proportionately more surveys than Personal Support Workers and Regulated Health Professions: Care Coordinators, 44.9%[i]; Personal Support Workers, 30.0%; and Regulated Health Professionals, 23.0%[ii]. Within each survey type, the rate of response varied. See Table 3.

Table 3: Response Rates

Care Coordinators	No. Surveys Sent	No. Surveys Received	Response Rate (%)
CCAC Case Managers	300	138	46.0
OHCA/OCSA Service Coordinators	300	132	44.0
Medical Supplies/Equipment Order Processors	62	27	43.6
Total	662	297	44.9
Regulated Health Professionals	**No. Surveys Sent**	**No. Surveys Received**	**Response Rate**
Registered Nurses	300	70	23.3
Registered Practical Nurses	200	44	22.0
Physiotherapists	100	37	37.0
Occupational Therapists	100	43	43.0
Speech Language Pathologists	100	6	6.0
Social Workers	100	20	20.0
Dieticians	100	10	10.0
Respiratory Therapists	50	5	10.0
Pharmacists	8	8	100.0
Total	1058	243	23.0
Personal Support Workers	**No. Surveys Sent**	**No. Surveys Received**	**Response Rate**

Personal Support Workers	300	90	30.0
Total	300	90	30.0
Grand Total	**2020**	**630**	**31.2**

3.2 Demographics

Of the 630 respondents, 592 or 94.0% were female: 96% of care coordinators; 92.2% of regulated health professionals; and 92.2% of personal support workers. The female and male respondents were proportionately distributed across the three types of care coordinators. Of the 18 male RHP respondents, 5 were pharmacists, 4 were OTs and PTs each, 3 were RNs, 1 was an RPN, and 1 was a social worker.

Almost 60% (58.5%) of respondents were 50 years of age or younger; 41.4% of respondents were over 50 years old. See Table 4. Half (50.7%) of the case managers were over the age of 50 compared with 36.4% of service coordinators and 25.9% of order processors (see Care Coordinator Technical Report). RNs, RPNs, SWs, SLPs and PTs were older than the other RHP groups. A little over 50% (55%) of SWs, 52.9% of RNs, 50% of SLPs, 46.5% RPNs, and 37.8% of PTs were over the age of 50 (see Regulated Health Professionals Technical Report). Fifty-five percent of PSWs were 50 years of age or younger; 41.6% of respondents were between the ages of 51-65.

Table 4: Age of Respondents (years)

All Providers	Age Groups	Percent
	16-20	0.3
	21-30	9.4
	31-40	22.5
	41-50	26.3
	51-65	39.2
	>65	2.2
Care Coordinator	**Age Groups**	**Percent**
	16-20	0.3
	21-30	8.4
	31-40	23.2
	41-50	25.9
	51-65	40.7
	>65	1.3
Regulated Health Professionals	**Age Groups**	**Percent**
	16-20	
	21-30	11.6
	31-40	24.0
	41-50	24.8
	51-65	36.4
	>65	2.9
Personal Support Workers	**Age Groups**	**Percent**
	16-20	1.1

	21-30	6.7
	31-40	15.7
	41-50	31.5
	51-65	41.6
	>65	3.4

To put this into context, according to the TD Financial Group, 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.[h] Another survey found that the percent of nurses in Canada over the age of 50 in 2005 was 37%.[i] Based on age alone, education and health care appeared the most vulnerable to incipient retirement in 1999.[j] The age distribution of the community care sector raises a need for attention: an aging population may increase the demand for health services, particularly care in the community for chronic diseases.

Almost four in five providers (79.9%) were Canadian by birth, 16.9% were naturalized Canadians, and 3.5% were new immigrants or citizens of other countries. Proportionately more care coordinators (87.7%) than regulated health professionals (75.6%) and personal support workers (65.1%) are Canadians by birth. Table 5 shows the breakdown by type of respondent.

Table 5: Citizenship of Survey Respondents (%)

	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
Canadian by birth	79.9	87.7	75.6	65.1
Canadian Naturalized	16.9	10.5	18.6	31.5
Other Country	3.5	1.7	5.8	3.4
Total	100.3	99.9	100.0	100.0

English was the first language of 83.3% of all survey respondents, and French was the first language of 5.6% of all respondents. Table 6 shows the breakdown by types of respondents.

Table 6: First Language or Respondents

Language	All Respondent	Care Coordinators	Regulated Health Professionals	Personal Support Workers
English	80.7	82.7	80.2	75.3
French	4.6	5.8	3.7	3.4
Other	12.1	10.5	13.6	13.5
English + French	1.0		1.2	3.4
English + Other	1.6	1.0	1.2	4.5

[h] TD Bank Financial Group, The Changing Canadian Workforce. March 8, 2010. http://www.td.com/economics/special/ff0310_canlab.pdf

[i] Canadian Nurses Association, 2005 Workforce Profile of Registered Nurses in Canada. http://www.cna-nurses.ca/CNA/documents/pdf/publications/workforce-profile-2005-e.pdf

[j] MacKenzie A., H. Dryburgh, 2003. *Perspectives on Labour and Income.* The Online Edition, Vol 4, No 2. http://www.statcan.gc.ca/pub/75-001-x/00203/6449-eng.html

Total	100.0	100.0	99.9	100.1

While English was the first language of 83.3% of all respondents, 92.9% spoke it at home: 93.9% of care coordinators, 92.1% of regulated health professions, and 92.1% of personal support workers spoke English at home. While French was the first language of 5.6% of all respondents, 3.7% spoke it at home: 3.8% of care coordinators, 3.3% of regulated health professions, and 4.4% of personal support workers currently spoke French at home. Table 7.

Table 7: Respondents Language Spoken at Home (%)

Language	All Respondent	Care Coordinators	Regulated Health Professionals	Personal Support Workers
English	91.0	92.2	91.3	86.5
French	3.4	3.8	3.3	2.2
Other	4.0	3.1	4.5	5.6
English + French	0.3			2.2
English + Other	1.6	1.7	0.8	3.4
Total	100.0	100.8	99.9	99.9

Two-fifths (42.3%) of all respondents had at minimum a baccalaureate; 33.7% had a diploma, 11.0% had a certificate, and 9.3% had some college- or university- level training. The regulated health professionals had higher levels of education (89.7% had at least a diploma) compared with care coordinators (77.2%) and personal support workers (34.8%).[iii] See Table 8.

Table 8: Education Level of Respondents

Education	All Respondent	Care Coordinators	Regulated Health Professionals	Personal Support Workers
Some High school	0.3			2.2
High School	3.4	4.4		9.0
Some Coll./Univ	9.3	9.2	2.9	27.0
Certificate	11.0	9.2	7.4	27.0
Diploma	33.7	36.9	29.8	33.7
B.A./BSc.	32.7	34.9	41.7	1.1
M.A./MSc./MSW	9.3	5.4	17.4	
PhD	0.3		0.8	
Total	100.0	100.0	100.0	100.0

Registered nurses comprise almost one-third of the home and community work force. When asked to indicate their current major profession, 32.4% of all respondents indicated that they were registered nurses.[iv] See Table 9.

Table 9: Major Profession of Respondents

Type of Professional	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
Registered Nurse	32.4	45.1	28.8	
Nurse Practitioner	0.5	1.0		

Advanced Practice Nurse	10.2	6.4	18.1	1.1
Registered Practical Nurse	14.3	3.4		
Personal Support Worker	7.6	1.7	17.7	88.9
Occupational Therapist	6.0	0.3	15.2	
Physiotherapist	1.0		2.5	
Speech Language Therapist	5.7	5.4	8.2	
Social Worker	1.0	0.3	2.1	
Respiratory Therapist	4.1		4.1	
Dietician	1.3		3.3	
Pharmacist	1.0	1.0		3.3
Home Support Worker	2.2	3.0		5.6
Community Support Worker	14.9	31.6		
Other	0.5	0.7		1.1
Total	100.0	100.0	100.0	100.0

Respondents were asked what service they currently and predominantly provided. If they provided more than one service, they were asked to rank order them according to the frequency in which they provided the service. On the whole, each of the respondents was providing services for which they were trained. All regulated health professionals said the most frequent service they provided was one that was regulated. Personal support workers predominantly provided personal support and homemaking and community support services. A number of respondents indicated that they provided more than one type of service; i.e. 194 (30.8%) said they provided 2 types of services; 80 (12.7%) provided three different services; and 39 (6.2%) provided four different services.[v] See Table 10.

Table 10: Most Frequent Service Provided (%)[1]

Most Frequent Service Provided	All Respondents	Regulated Health Professionals	Personal Support Workers
Nursing	17.6	40.3	2.2
Personal Support	20.2	4.5	85.6
Physiotherapy	6.0	14.8	
Occupational Therapy	7.0	17.7	
Speech Language Pathology	1.0	2.5	
Social Work	3.8	8.2	
Respiratory Therapy	1.0	2.1	
Dietetics	1.6	4.1	
Case Management/ Coordination	27.3	1.6	
Pharmacy Services	1.7	3.3	
Medical Equipment Supply	2.1		
Medical Supply	0.6		
Homemaking Services	1.1		4.4
Community Support Services	4.3		5.6

|			
Other	4.3	0.8	1.1
Missing	0.5		1.1
Count	630	243	90
Total	100.0	100.0	100.0

1. Data for Care Coordinators are not included because it is likely that they misunderstood the question. Slightly over one-half (56.6%) of care coordinators said they provided some form of service coordination or case management. However, 43.4% indicated that they performed some other function. It is likely that in the latter percentage, care coordinators were actually providing coordination services for that particular function rather than the function itself.

The majority (64.4%) of respondents worked in both urban and rural areas; 30.0% worked only in urban areas; and 5.5% worked only in rural areas. See Table 11.

Table 11: Respondents' Geographic Area of Practice (%)

Geographic Area of Practice	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
Urban	30.0	24.4	35.3	34.5
Urban & Rural	64.4	68.1	62.2	57.5
Rural	5.5	7.1	2.5	8.0
Count	623	295	241	87
Total	100.0	100.0	100.0	100.0

Fifty-three respondents (8.5%) indicated that they worked in more than one CCAC catchment area, and 22 respondents (3.5%) did not know their catchment area. Figure 2 indicates the percentage of respondents working in each of the 14 different CCAC areas of the province. Proportionately more survey respondents came from the Champlain CCAC, the Hamilton Niagara Haldimand Brant CCAC, and the South West CCAC.

Figure 2: Percent of Respondents by CCAC Catchment Area
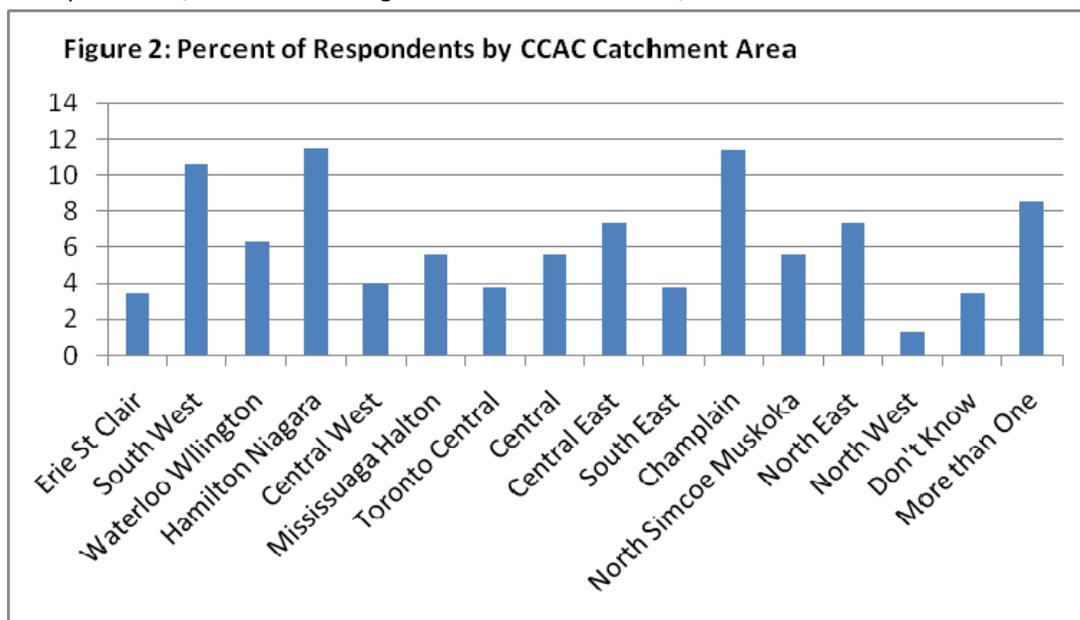
Eighty-seven respondents (13.9%) indicated that they were working for more than one organization. Not surprisingly, proportionately more RHPs (20.7/20.6%) and PSWs (16.9%) worked for more than one organization than care coordinators (7.5%).[vi] More than half (55.1%) worked for an organization with more than 100 employees/contract staff; 16.3% worked for an organization that had between 51-100 employees; and 15.9% worked for organizations that employed under 50 employees. Proportionately fewer PSWs (31.0%) than care coordinators (62.5%) and RHPs (55%) worked for organizations with more than 100 employees/contract staff.[vii]

Almost two-thirds (64.6%) of all respondents worked only during the week, while 35.2% worked both during the week and weekends, and 0.2% worked only weekends. The majority (81.8%) of care coordinators worked only during the week, while 17.2% worked both during the week and weekends. Slightly more than one-half (57.2%) of regulated health professionals worked only during the week, while 42.8% worked both during the week and weekends. Almost three-quarters (73.3%) of PSWs worked both during the week and on weekends. The others only worked Monday to Friday.

A little over three-quarters (77.1%) of all respondents worked only days; 11.8% worked days, evenings and nights; and 9.2% worked days and evenings. Proportionately more care coordinators (89.2%) and RHPs (75.3%) than PSWs (42.2%) worked only days. Proportionately more PSWs (25.6%) than RHPs (8.6%) and care coordinators (4.7%) worked only days and evenings.

Over two-thirds of all respondents (68.2%) worked less than 40 hours a week, and approximately one-third (31.8%) worked 40 or more hours per week. One-half of all respondents worked between 30-39 hours a week. Proportionately fewer PSWs (69.3%) than care coordinators (88.1%) and RHPs (77.4%) worked 30 or more hours per week. See Table 12.

Table 12: Hours of Work per Week by Type of Respondents (%)

Hours Worked Per Week	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
<10 hours	1.0	0.3	1.2	2.3
10-19 hours	4.0	2.0	7.0	2.3
20-29 hours	13.8	9.5	14.4	26.1
30-39 hours	49.4	60.9	39.5	38.6
≥40 hours	31.8	27.2	37.9	30.7
Count	625	294	243	88
Total	100.0	100.0	100.0	100.0

Almost one-third (31.9%) of all respondents had been working in their profession for more than 20 years and over one-quarter (26.8%) had worked between 11 and 20 years. Proportionately more regulated health professionals (66.1%) than care coordinators (55.2%) and personal support workers (50.0%) had worked in their profession for more than 10 years.[viii] See Table 13.

Table 13: Number of Years Worked in Their Major Profession (%)

Years in Profession	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers

< 1 Year	5.1	4.7	6.2	3.3
1-5 Years	19.6	20.7	15.3	27.8
6-10 Years	16.6	19.3	12.4	18.9
11-20 Years	26.8	22.0	28.1	38.9
>20 Years	31.9	33.2	38.0	11.1
Count	627	295	242	90
Total	100.0	100.0	100.0	100.0

One-half (50.8%) of all respondents had worked in the community for more than ten years, and 29.8% had worked for five years or less in the community. Proportionately more care coordinators (23.9%) than regulated health professionals (11.5%) and PSWs (12.2%) had worked in the community for more than 20 years.[ix] See Table 14.

Table 14: Number of Years Respondents have provided Services in the Community (%)

Years in Profession	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
< 1 Year	6.5	5.5	8.2	5.6
1-5 Years	23.3	16.4	28.4	32.2
6-10 Years	19.2	21.2	18.9	13.3
11-20 Years	33.4	32.8	32.9	36.7
>20 Years	17.4	23.9	11.5	12.2
Count	626	293	243	90
Total	99.8	99.7	100.0	100.0

Almost all respondents (99.0%) had worked previously in other sectors of care. The 'other' sector of care most frequently checked off by respondents was the acute care sector (47.3%), followed by a physician's office/family health team (39.4%), complex continuing care/chronic care facilities (19.8%), and rehabilitation facilities (18.3%).[x] See Figure 3.

Figure 3: Percentage of Respondents Previously Worked in Other Sectors
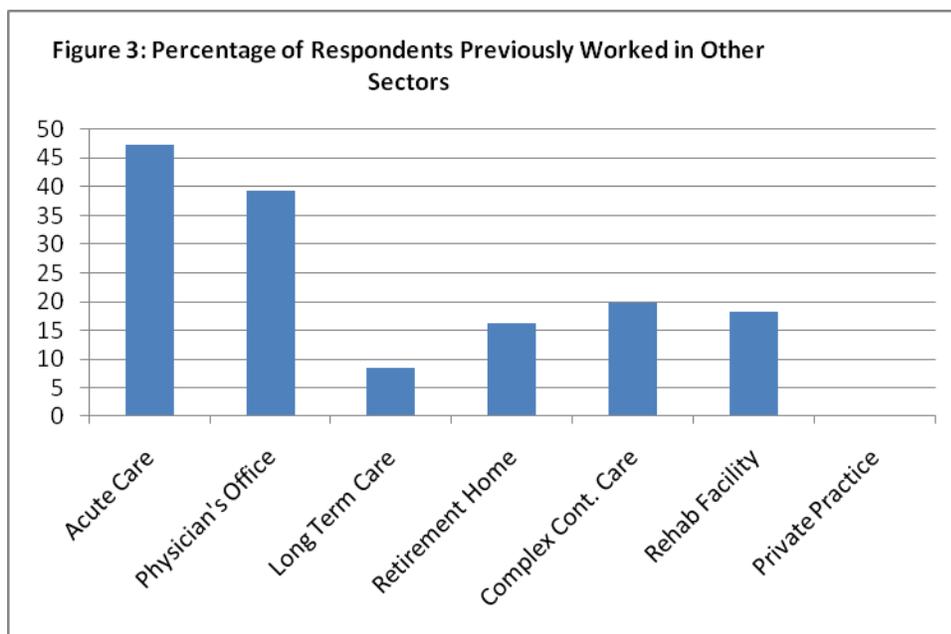
3.3 Definitions and Perceptions of Integration

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.*[k]

3.3.1 Perceptions of Integration

Respondents were asked what integration of health care services for clients meant to them in their own words. There was quite a bit of congruence amongst the different type of respondents. Of the 630 respondents, 479 (76.0%) answered the question: 220/297 (74.1%) care coordinators, 201/243 (82.7%) regulated health professionals, and 58/90 (64.4%) personal support workers. An analysis of their responses shows that the most frequently mentioned feature of well-integrated care is that it be client focused – 69.1% of all respondents mentioned it: 72.7% of care coordinators, 69.2% of regulated health professionals, and 55.2% of personal support workers.

The feature mentioned second most often by all respondents was *Coordination/Working Together/ Multidisciplinary Care/ Continuity of Care*, i.e. by 39.5% of all respondents (36.4% of care coordinators, 42.8% of regulated health professionals, and 24.1% of personal support workers).

The feature mentioned third most often varied by the type of provider. *Improving access/availability/one-stop shopping* was mentioned third most often by all respondents (20.3%) and care coordinators (31.4%). However,

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

regulated health professionals and personal support workers mentioned *better communications/availability of physicians 24/7* - 26.9% and 22.4% respectively.

Table 15 lists all of the features mentioned by all respondents and their count.

Table 15: Views of Features that Comprise Integration

Category	All	CC	RHP	PSW
Client Focused	331	160	139	32
Coordination/Working Together/ Multidisciplinary Care/ Continuity of Care	189	89	86	14
Better Communications/24-7 availability of FPs	79	21	54	13
Better Information Systems	63	26	34	3
Seamless / Seamless Transitions	63	31	32	
Access/Availability/One-stop	97	69	27	1
Best Quality of Care/ Effective Care	55	24	21	10
Timely	36	14	19	3
Client at Home/Community Care	45	16	18	11
Holistic Care/Health Promotion-Disease Prevention	44	28	15	1
Common Goals	21	8	12	1
Family Involvement/Support	21	6	11	4
Understand/Respect each other's Roles	24	10	8	6
Better Use of Resources/ Decreased intake time and more service/ Decreased Cost of Care	17	12	4	1
Equitable Care	13	9	3	1
Better use of skills	3		2	1
Deliver care in appropriate setting	1		1	
Consistency of services	3	2	1	
Decreased layers of bureaucracy	2	2		
Evidence-based	2	2		
Accountable	1	1		
No. of Respondents who answered question	479	220	201	58

3.3.2 Factors Important to Integration

Respondents 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 16, most respondents 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 = 37.390; df=9,590; p<.001). Consistent with respondents' own description of well-integrated care, client participation in care planning and considering their goals was the most supported factor (M=4.77), followed by the receipt of information promptly (M=4.74), and good communications amongst providers (M=4.67) by all respondents. Care coordinators and regulated health professionals rated these three factors in the same order. While personal support workers rated these factors in their top three, it was in a different order. Receipt of prompt information was rated first, followed by good communication amongst providers, and actively involving the client/family caregiver in assessment and care. Personal support workers also rated another factor as highly – Ensuring that their role in delivering care is understood by other health and social

service providers. Having shared values with other providers received the least support from all providers. See Table 16.

Table 16: Importance of various factors in the coordination of health and social services (Means)

Factors	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
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.	4.77	4.82	4.80	4.54
Having good communication about the client with other health and social service providers.	4.67	4.68	4.70	4.60
Having complete information about the client from other health and social service providers.	4.55	4.55	4.57	4.50
Receiving information promptly about the care plan or changes in the client's health status.	4.74	4.71	4.79	4.67
Having shared values about care provision with other health and social service providers.	4.27	4.32	4.21	4.30
Having good working relationships with other health and social service providers	4.54	4.55	4.55	4.49
Having a clear understanding of the individual roles and responsibilities of the care plan	4.53	4.54	4.53	4.49
Ensuring that your role in delivering care is understood by other health and social service providers	4.56	4.53	4.58	4.60
Having ready access and availability to health and social service providers.	4.54	4.54	4.61	4.36
Having available and reliable technology to support the transfer of information.	4.43	4.43	4.47	4.32

Respondents were also asked to rank the 3 factors that were most important in providing coordinated health and social services. This analysis is different from the ratings above in that in the ranking exercise respondents were asked to compare each strategy with all the others and to rank them accordingly. In the former exercise, respondents were rating each strategy on its own merits on a scale from one (not very important) to five (very important). Out of 630 respondents, 491 did the rankings correctly. It is likely that those who did not do this exercise correctly were confused by the difference between rating and ranking the factors. The results presented here are for the 491 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 17. Care Coordinators and regulated health professionals ranked these three factors in the same order. However, PSWs ranked *Receiving information promptly about the care plan or changes in the client's health status* as the third most important factor

instead of *Having complete information about the client from other health and social service provider.* See Table 17.

Table 17: Ranking of Factors (Percentage of All Respondents)

Factors	1st	2nd	3rd
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.	67.0	11.8	6.9
Having good communication about the client with other health and social service providers.	6.9	23.8	20.0
Having complete information about the client from other health and social service providers.	9.2	16.3	12.0
Receiving information promptly about the care plan or changes in the client's health status.	4.9	14.7	17.1
Having shared values about care provision with other health and social service providers.	0.8	3.7	4.3
Having good working relationships with other health and social service providers	2.6	3.9	10.0
Having a clear understanding of the individual roles and responsibilities of the care plan	1.8	8.6	7.5
Ensuring that your role in delivering care is understood by other health and social service providers	0.8	2.4	3.9
Having ready access and availability to health and social service providers.	3.5	9.2	9.2
Having available and reliable technology to support the transfer of information.	2.0	4.5	7.7

3.3.3 Impact of Poor Coordination and Collaboration

All respondents were asked to rate in terms of importance a number of effects that are likely to arise from poor coordination and collaboration amongst providers on a scale from 1 (not very likely) to 5 (very likely). All respondents rated the 7 factors on average from 3.54 to 3.89 on a scale between 1 and 5. There are significant differences in the ratings of the 7 factors ($F = 26.386$; $df=6,536$; $p<.001$). Table 18 shows the ratings for all respondents and for the three different types of respondents. There is unanimity amongst the care coordinators, regulated health professionals and personal support workers in rating *Poor client understanding of roles and care plans* as the most likely effect from poor coordination and collaboration amongst providers. The three different types of respondents, however, varied in what they saw as the second and third most likely effects from poor coordination and collaboration amongst providers. Care coordinators and regulated health professionals rated *Waste of human and other resources* as the second most likely effect, while PSWs rated *Risks to the client's health and well-being* as their second choice. Regulated health professionals and personal support workers rated *Clients not following the care plan,* while care coordinators and regulated health professionals rated *Risks to the client's health and well-being* as the third most likely factor to occur from poor coordination and collaboration.[xi] See Table 18.

Table 18: All Respondents' Ratings of Likely Effects from Poor Coordination and Collaboration amongst Providers (Scale (1) very unlikely to (5) very likely).

Likely Effect of Poor Coordination and Collaboration amongst Providers	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
Waste of human and other resources	3.91	3.98	4.0	3.57

Poor client understanding of roles of health and social service providers and care plan	4.08	4.15	4.1	3.89
Clients not following the care plan	3.83	3.84	3.9	3.70
Poor understanding amongst health and social service providers of each others' roles	3.79	3.94	3.7	3.54
Poor understanding amongst health and social service providers about the care plan	3.85	3.95	3.8	3.55
Risks to the client's health and well-being	3.92	3.97	3.9	3.77
Risks to the health and social service provider's safety and well-being	3.47	3.50	3.4	3.66

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 (78.4%) properly ranked the possible effects of poor coordination. *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 19.

Care coordinators ranked the same three factors in order as did all respondents, i.e. *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*.

Regulated health professionals ranked the same three factors but reversed the second and third factors, i.e. *Risks to the client's health and well-being* was rated the most likely factor to result from poor coordination and collaboration, followed by *Waste of human and other resources* and *Poor client understanding of roles of health and social service providers and care plan*.

Personal support workers ranked the same top two factors but said the third most likely risk from poor coordination and collaboration amongst providers was that *Clients would not follow the care plan*.

Table 19: All Respondents' Rankings of Top 3 Likely Effects of Poor Coordination and Collaboration amongst Providers (Percentage of Respondents ranking each factor first, second, or third)

Likely Effect	1st	2nd	3rd
Waste of human and other resources	19.6	14.2	19.0
Poor client understanding of roles of health and social service providers and care plan	21.7	19.4	13.2
Clients not following the care plan	8.9	16.4	12.8
Poor understanding amongst health and social service providers of each others' roles	6.3	10.7	17.6
Poor understanding amongst health and social service providers about the care plan	3.8	12.6	14.4
Risks to the client's health and well-being	37.2	11.3	9.5
Risks to the health and social service provider's safety and well-being	2.0	14.2	9.7

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. Respondents 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.[xii] 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, 4.65), and *being the client's "regular" provider of care as much as possible* (mean, 4.47). These three factors were the same for care coordinators, regulated health professionals and personal support workers. *Being of the same ethnic origin* was the least important factor (mean, 1.96) for all respondents and for each of the three sub groups of respondents. See Table 20. There are significant differences in the ratings of the 8 factors (F=634.558, df=7,567, p<001).

When ranking each of the 8 factors against each other, all respondents as well as the three subgroups ranked these three factors in the same order of importance, except that PSWs ranked *Being the client's regular provider of care* second and *Providing client assessment and care in a timely manner* third. See Table 21.

Table20: Factors important in establishing a good relationship with clients (1=not very important, 5 = very important) (Mean response)

Factors	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
Being respectful of the client's needs and preferences where possible	4.90	4.90	4.91	4.90
Being of the same ethnic background as the client	1.96	2.05	1.79	2.16
Speaking the same language as the client	3.26	3.29	3.19	3.38
Providing client assessment and care in a timely manner	4.65	4.68	4.65	4.53
Being the client's "regular" provider of care as much as possible	4.47	4.53	4.46	4.33
Being considerate of the client's preference for the time care is provided	4.10	4.03	4.10	4.32
Being considerate of the client's financial situation	3.73	3.83	3.77	3.27
Getting along with the client's family caregivers	4.10	4.06	4.23	4.15

Table 21: Top 3 factors in establishing a good relationship with clients

Factors	1st	2nd	3rd
Being respectful of the client's needs and preferences where possible	77.7	15.7	4.6
Being of the same ethnic background as the client	0.6	0.6	0.4
Speaking the same language as the client	1.6	7.0	4.7
Providing client assessment and care in a timely manner	13.7	41.9	16.8
Being the client's "regular" provider of care as much as possible	5.1	21.9	34.6
Being considerate of the client's preference for the time care is provided	0.2	3.5	12.7
Being considerate of the client's financial situation	0.4	1.8	5.9
Getting along with the client's family caregivers	0.6	6.3	17.8

Respondents were asked a series of questions about the provision of care and their relationship specifically with *their last client*. The vast majority (98.8%)[i] indicated that they were able to establish a good working relationship with their last client. The following were offered as reasons 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. However, 10.3% of providers did experience a language barrier with their client. 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. Where clients had other providers, respondents stated that only 55.0% of their clients understood the role of other providers, while 30.4% said their client did not understand the roles of other providers, and 14.6% did not know. See Table 22.

Table 22: Working with Clients (Percent answering yes to the questions)

Question	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
Were you able to establish a good working relationship with your last client?	98.8	98.0	99.1	98.9
Did you experience a language barrier with your last client?	10.3	7.9	10.7	13.9
Did your last client understand the roles of their other providers?	55.0	47.7	54.9	77.6

With respect to whether the last client understood the care plan developed for them, only 40.6% of providers indicated that their client had a complete understanding while 37.0% had some understanding, and 8.9% indicated little or no understanding of the plan (Table 23). Approximately three-quarters (74.8%) of case managers and service coordinators, 80.6% of regulated health professionals, and 77.2% of personal support workers 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%) of care coordinators, 6.5% of regulated health professionals, and 8.8% of personal support workers said their last client had no or little understanding of their care plan (see Technical Reports).

Respondents indicated that family caregivers understood the client's care plan somewhat better than the client. Of those clients who had family caregivers, respondents indicated that 52.0%, 32.2% and 3.4% of family caregivers had complete, some, and little or no understanding respectively. Care coordinators, regulated health professionals, and personal support workers did not differ appreciably in their responses. This may be one of the reasons why four out of five (79.0%) respondents find it easier to provide care when a family caregiver is involved.[xiii] See Table 23.

Table 23: Working with Clients and Family Caregivers (Percent Ratings on a scale of 1 to 5)

Question	1 No	2	3	4	5 Complete

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[i]   Pharmacists and order processors who rarely come into contact with clients were not asked this question.

	Understanding				Understanding
Did your last client understand his/her care plan?	4.1	4.8	13.4	37.0	40.6
Did the family caregivers of your last client understand the client's care plan?	0.8	2.6	12.4	32.2	52.0
	1 Much More Difficult				5 Much Easier
Is it easier to provide good health care when there is a family caregiver involved?	0.8	1.6	18.6	24.9	54.1

3.5 Views on Care Plans

When working in the home and community, providers are rarely in situ at one time. As a result, clear, appropriate and adequate information is key for providers to do their work. A little over one-quarter (26.8%) of all respondents were not happy with the amount of information they were provided with on their first visit with their client: 24.2% of care coordinators[xiv], 34.2% of regulated health professionals, and 15% of personal support workers. 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.

In fact, almost one-third (31.6%) of regulated health professionals and two in five (39.2%) care coordinators said they had to contact another health and social service provider for client information or diagnostic test results.[xv] Personal support workers were not asked this question.

Clients/patients have reported concerns about the duplication in assessment of their condition and requirement to repeatedly provide the same information to different providers. Regulated health professionals were asked if they had asked their last client to repeat any of their care history. (Care coordinators and personal support workers were not asked this question.) About 65 (65.4%) percent of RHPs had asked their last client to repeat some or all of their health and care history. Proportionately more social workers, physiotherapists, respiratory therapists, dieticians, and occupational therapists asked clients to repeat their health or care history. See Table 24.

Table 24: Regulated Professionals – Asking Clients to Repeat their Health/Care History

Professional	1 Yes	Percent (%) Yes	2 No	Total
RN	36	55.4	29	65
RPN	13	33.3	26	39
OT	29	76.3	9	38
PT	33	91.7	3	36
SLP	3	50.0	3	6
SW	18	90.0	2	20
DT	7	77.8	2	9
RT	3	75.0	1	4
Total	142	65.4	75	217

Only regulated health professionals were asked if they had to repeat any diagnostic tests or assessments. Of those who felt the question was applicable, one-quarter (25.4%) of the respondents said they had to repeat an assessment or test for their last client. Although two-thirds of SLPs said they repeated tests, there were only a total of 6 who responded to the survey. On the other hand, 44.4% of RNs said they repeated tests with their last clients, much higher than other professionals, except for SLPs (66.7% or 4/6). Dieticians and respiratory therapists were the only regulated professional that did not need to repeat tests with their last client. Pharmacists were not asked this question. See Table 25.

Table 25: Regulated Professions – Repeating Tests/Assessments

Profession	Did you have to repeat any assessments or diagnostic tests?			
	1 Yes	%	2 No	Total
F RN	28	44.4	37	65
T RPN	4	12.9	27	31
OT	8	20.0	32	40
PT	6	16.7	30	36
SLP	4	66.7	2	6
SW	3	16.7	15	18
Diet	0		9	9
RT	0		4	4
Total	53	25.4	156	209

Changes in care plans need to be communicated to providers promptly for seamless and appropriate care. Regulated health professionals and personal support workers (but not care coordinators) were asked if the treatment plan for their last client ever changed and if so, were they informed of the change in a timely manner. A little less than half of the regulated health professionals (46.8%) and 37.1% of the personal support workers said that the treatment plan did change for their client. Of those respondents who had indicated there was a change in treatment for their last client, 8.5% of regulated health professionals and 12.5% of personal support workers said they were not informed of the change. See Table 26.

Multiple providers often treat a client. Often the different providers have their own treatment plans and document them. Some leave them in the client's home. Others do not. It is widely believed that the sharing of information amongst providers is central to integrated care. Respondents were asked if they had access to the treatment plans of other providers. Almost one-half (45.3%) of all respondents indicated that they did not have access to other providers' plans: 38.3% of care coordinators, 54.0% of regulated health professionals, and 56.7% of personal support workers said they did not have access to treatment plans of other providers.[xvi] See Table 26.

The regulated health professionals and personal support workers were asked if they reviewed the plans of other providers. While 60% of RHPs said they did review the plans, 40% did not.[xvii] Two-thirds (66.1%) of personal support workers reviewed the treatment plans of other providers and one-third did not. The reason overwhelmingly given by regulated health professionals for not reviewing the care plans of other providers was that they were not available. The respondents also said they relied on the client to inform them of the care of other providers, or that there simply was not enough time to review the plans. Another somewhat common theme is that providers worked for other agencies, private organizations, or were from a different discipline from the respondent and therefore, their plans were not available. Personal support workers' reasons for not reviewing the

plans included: the treatment plans were not in the homes; the client threw the care plans out; the PSW believes they do not have the authority without permission to look at the treatment plans of other providers; that providers write up reports for the agency every 3 months (the implication being that the reports of other providers can be reviewed at that time or that the plans of other providers are only available at that time); or plans are confidential and are only to be reviewed by the client, primary caregiver, and the agency. See Table 26.

Table 26: Respondents' Views on the Availability of Information about their clients (%)

Question	Answer	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
Were you satisfied with the information provided on your first client visit?	No	26.8	24.2	34.2	15
Did you have to contact another provider for client information or diagnostic test results?	Yes		39.2	31.6	Question not asked
Did the treatment plan of your last client change?	Yes		Question not asked.	46.8	37.1
Were you informed of the change in a timely manner?	No			8.5	12.5
Did you have access to the treatment plans of other providers	No	45.3	38.3	54.0	56.7
If your client had other providers, did you review their plans	Yes		Not asked	60.0	66.1

Respondents were asked to comment on the care plan for their last client. With respect to access and quality of service, 17.4% of all respondents believed that services did not begin at the right time for the client: 18% of care coordinators, 22.0% of regulated health professionals, and 3.4% of personal support workers.[xviii] See Table 27. Regulated health professionals and care coordinators were asked to what extent the delay in services was due to delays within their own organization.[m] Only 4.7% of RHPs but 21.1% of care coordinators believed the wait was due to delays in their organization, while 26.8% of RHPs and 24.0% of care coordinators believed the wait for service was due to delays with other providers/organizations. 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.[xix] See Table 27.

The majority of all respondents (88.4%) felt that the care plans took into consideration the client's mobility: 92.8% of care coordinators, 77.1% of regulated health professionals, and 75.3% of personal support workers. Of the 9.6% of all respondents who said the care plan did not consider the client's mobility or location, 3.8% were care coordinators, 9.6% were regulated health professionals, and 9.9% were personal support workers.[xx] See Table 27.

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[m]   PSWs were not asked this question.

Clients have indicated a preference for having the same provider attend to their care as much as possible. Almost 9 in 10 regulated health professionals (88.6%) and personal support workers (91.1%) believed that attempts were made to provide the client with the same provider for each visit.[n] Proportionately more RNs (11.9%) and OTs (7.5%) than their other colleagues thought that their organization did not try to provide the same provider. See Table 27.

It was believed by a majority (88.4%) of all respondents that care plans did give consideration of the time of day for service to clients: 85.1% of care coordinators, 90.4% of regulated health professionals, and 92.2% of personal support workers.[xxi] See Table 27.

A little over one in ten (11.4%) of all respondents said that their last client did not have the necessary equipment for their care: 5.7% of care coordinators; 17.9% of regulated health professionals[xxii]; and 5.7% of personal support workers. 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%). One in ten respondents (10.3%) said their last client did not have the necessary medical supplies for care: 7.6% of care coordinators; 13.3% of regulated health professionals; and 6.9% of personal support workers.[xxiii] See Table 27.

Nine in ten respondents (91.9%) said the client was receiving adequate nutrition; 3.9% said they were not receiving adequate nutrition, and 4.2% did not know. Proportionately fewer care coordinators (88.2%) than regulated health professionals (95%) and personal support workers (94.3%) thought the client was receiving adequate nutrition. See Table 27.

While almost four-fifths (79.4%) of all respondents indicated that there were ways for clients to provide systematic feedback on services, 13.8% did not know of such a process, and 6.8% indicated there was no process for feedback. 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. While four-fifths (81.5%) of regulated health professionals indicated that there were ways for clients to provide systematic feedback on services, 13.0% did not know of such a process, and 5.3% indicated there was no process for feedback.[xxiv] One-fifth (20.7%) of PSWs were not aware of any mechanisms for clients to provide feedback on the service they received and almost one-tenth (9.2%) said that no mechanisms were available. Although this does not mean that mechanisms were not available, it is clear that at least 20% of respondents were not able to inform clients about them. See Table 27.

Table 27: Respondents' 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?	75.2	17.4	7.5	100.1
Did the care plan take into consideration client mobility, and accessibility to service?	88.4	7.3	4.3	100.1
Did the care plan try to provide the client with the same	88.6	7.3	4.1	100.4

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[n]   Care coordinators were not asked this question.

provider as much as possible?				
Did the care plan consider the time of day for service convenient for the client?	88.4	7.3	4.3	100.0
Did the client have the necessary equipment for care?	86.2	11.4	2.4	99.9
Did the client have the necessary supplies for care?	83.8	10.3	5.9	100.0
Was the client receiving adequate nutrition?	91.9	3.9	4.2	100.1
Are there processes or mechanisms for clients to provide systematic feedback on the services they receive from you?	79.4	6.8	13.8	100.0

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.[o] In regulated and controlled environments or LTC facilities, regulated health professionals have reported physical, verbal and sexual abuse and racism. It has been reported that providers in the home and community care perceived that the risk of injury from client physical aggression is higher than in a "typical" workplace.[p] (Source??).

Almost one in ten respondents (9.6%) indicated that their last client was a potential risk to their health and safety. Of these respondents, 38.9% or 21 individuals were not informed of the potential risk prior to their first visit. Approximately one in ten (10.2 %) of respondents indicated that their last client's home was a potential risk to their health or safety, and of these respondents, 51% were not informed of the risk prior to their first visit.

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.[xxv] 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. Of these 20 respondents, 7 were not informed of the risk prior to their first visit.

Approximately 8% of regulated health professionals indicated that their last client was a potential risk to their health and safety. Of these 18 respondents, all were informed of the potential risk prior to their first visit. Almost 10% of respondents indicated that their last client's home was a potential risk to their health or safety, and of these 18 respondents, only 1 was not informed of the risk prior to their first visit. Six out of 7 pharmacists said they rarely or never are told if the client is a potential risk to health or social service providers who go into the home. Similarly 6 out of 7 pharmacists said that they are rarely or never told if the client's home is a potential risk to health and social service providers who go into the home.

Approximately 14% of PSWs indicated that their last client was a potential risk to their health and safety. Of these 13 respondents, only 41.6% were informed of the potential risk prior to their first visit. A much smaller percentage (5.7%, n=5) of PSWs indicated that the last client's home was a potential risk to their health or safety, and of these five, three were not informed of the risk prior to their first visit.

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[o] 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%2008.pd

[p] Ontario Home Care Association and Ontario Community Support Association, 2008. *Response to the Ontario Ministry of Labour Consultation on Workplace Violence Prevention*. October 2008.

Respondents indicated actual risks to them from clients included verbally abusive alcoholic clients, exposure to contagious diseases such as MRSA, and second hand smoke. With respect to the health and safety hazards of the home, respondents said they have been exposed to bed bugs, aggressive dogs, icy sidewalks, unclean homes which can contain animal excrement.

3.6 Working with Other Providers

Respondents 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. Knowledge of other providers can help in better planning client visits to avoid overlaps. The regulated health professionals and personal support workers were asked if they knew who was responsible for organizing their last client's care. (Care coordinators were not asked this question.) While 5.6% of RHPs did not know who was organizing their client's care, 16.1% of PSWs said they did not know. Twelve percent (12.2%) of all respondents said they did not know who the primary health care or social service giver was for their last client: 8.9% of care coordinators; 13.3% of regulated health professionals[xxvi]; and 18.8% of personal support workers. Approximately 5% of all respondents did not know who the primary family caregiver was: 3.1% of care coordinators; 5.6% of regulated health professionals; and 7.1% of personal support workers.

Slightly less than one-fifth (17.2%) of all respondents did not know if their last client had other providers: 22.3% of care coordinators; 8.9% of regulated health professionals[xxvii]; 25.6% of personal support workers.[xxviii] Of all respondents, 12.4% did not understand the roles of other providers: 12.3% of care coordinators; 12.1% of regulated health professionals; and 13.9% of personal support workers.

Almost one in ten (9.2%) of all respondents were not aware if their last client had a family physician: 10.6% of care coordinators; 5.1 % of regulated health professionals; and 15.7% of personal support workers.[xxix] 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.

A small percentage of all respondents (4.1%) did not know who to call for professional help with respect to the care of their last client: 5.8% of care respondents[xxx]; 2.6% of regulated health professionals[xxxi]; and 2.3% of personal support workers. See Table 28.

Table 28: Respondents' Knowledge of Other Providers and Back-Up

Working with Other Providers	Answer	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
Are you aware whether your last client had other providers?	No	17.2	22.3	8.9	25.6
Are you aware if your last client had a family physician?	No	9.2	10.6	5.1	15.7
Do you know who is responsible for organizing your last client's care?	No		Not asked	5.6	16.1

Do you know who the primary health or social service provider was for your last client?	No	12.2	8.9	13.3	18.8
Do you know who the primary family caregiver was for your last client?	No	4.7	3.1	5.6	7.1
Do you know who to call for professional help if you need it?	No	4.1	5.8	2.6	2.3
Do you have a clear understanding of the roles of other providers working with your last client?	No	12.4	12.3	12.1	13.9

Respondents 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. A little more than one-half (55.9%) find out about other providers from their clients or family caregivers. Other sources of information about other providers in order of frequency include the employing organization (35.4%), available records (21.9%), and other providers (14.7%). All respondents, with the exception of personal support workers, found out about other providers from their clients and family caregivers. Personal support workers most often found out about other providers from their employer and then from clients/family caregivers.[xxxii] See Table 29.

Table 29: Respondents' Sources of Knowledge of Other Providers

Source of Knowledge of Other Providers	%[1]
From Clients or Family Caregiver	55.9
From Employing Organization	35.4
Available Records	21.9
Other Providers	14.7

1.Percentages add up to more than 100% because some respondents ranked 2 or more sources as their number one source.

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, respondents were quite positive in their responses. For those whose clients had other providers, a majority (92.5%) felt that they worked well with other providers. However, 7.5% of all respondents (7.0% of care coordinators, 9.1% of regulated health professionals, and 4.5% of personal support workers) felt they did not work well in a coordinated way with other providers.[xxxiii] See Table 30.

Despite feeling they worked well with others, 23.5% of all respondents said they did not feel part of a team with other health and social service providers: 23.1% of care coordinators; 28.2% of regulated health professionals; and 9.4% of personal support workers.[xxxiv] See Table 30. Reasons given for not feeling part of a multidisciplinary team included:
- Feeling that community providers are not as valued;
- not necessary because communication with the case manager was very good;
- a lack of connections;
- fragmented communications;
- lack of time to communicate with others;
- work largely in isolation/a vacuum;

- lack of reimbursement for team work (don't get paid for team meetings);
- no expectation to communicate and coordinate; and
- disciplines are too divided and some are valued more than others;

A little more than five percent (5.9%) of all respondents said that their training had not prepared them to work with other providers: 5% of care coordinators; 6.9% of regulated health professionals; and 3.0% of personal support workers.[xxxv] A number of respondents said that their experience in the field more than their formal education prepared them to work as a team. See Table 30.

Six percent of all respondents said they were not able to use all the skills from their training that were needed and appropriate for their last client: 5.7% of care coordinators; 11.5% of regulated health professionals; and 3.4% of personal support workers. See Table 30. In response to why they were not able to use all their skills appropriate to their last client, care coordinators 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. The most frequent response as to why respondents were not able to use all their skills had to do with limits in the budget for the client. Other reasons given included:
- Insufficient time allowed for visit (e.g. they were doing other menial tasks such as housekeeping),
- minimal number of visits allowed,
- general lack of resources – i.e. lack of supplies, minimal equipment or the home was not well enough equipped,
- minimal information,
- unwillingness of other providers (e.g. general practitioner) to allow respondent to use skills, or unwillingness of caregiver to allow respondent to use all required skills.

Regulated health professionals and personal support workers were asked if they were requested to perform a delegated task with the last client. More than four in ten (42.7%) of personal support workers and 9.5% of regulated health professionals were asked to do so and almost all were adequately prepared to undertake the task.[xxxvi] See Table 30.

When asked if they had ever planned joint visits or teleconferenced with other providers (other than family physicians) to discuss their client's care, 36.5% of care coordinators and 49.1% of regulated health professionals said they had not.[xxxvii] More social workers (63.2%), PTs (61.2%), OTs (55.3%), and RNs (54%) than other professionals organized team conferences. Speech language pathologists (16.7%, n=1), pharmacists (28.7%) and respiratory therapists (25%, n=1)) less often planned joint meetings or teleconferences. A little less than one-half (44.4%) of respondents had contacted the family physician. Respiratory therapists (75.0%, n=3), RNs (66.7%), dieticians (50.0%), and RPNs (42.9%) more often had contacted the family physician than the other professional providers. See Table 30.

Regulated health professionals and care coordinators were asked if their last client had a family physician, had they ever had a reason to contact the physician. A little less than one-half (44.4%) of RHPs had contacted the family physician.[xxxviii] A little more than one-third (35.7%) of care coordinators had contacted their last client's physician. See Table 30.

One measure of collaboration is the extent to which providers feel that they are able to suggest changes to care plans. Once again with respect to their last client, 49.3% of regulated health professionals and 50% of personal

support workers indicated that they wanted to suggest a change in the care plan.[xxxix] In almost all cases, RHPs and PSWS conveyed the suggested change. See Table 30.

Another indication of coordinated action is the extent to which clients are available at the appointed time. Four in ten (41.4%) of all respondents said they have met their appointment, only to find that the client was not available: 38.3% of care coordinators; 42.7% of regulated health professionals; and 45.3% of personal support workers.[xl] Respondents indicated that the client has often slept in, forgotten the appointment, 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. See Table 30.

Of those who found the question applicable to their last client, 34.4% of all respondents relied on the client to pass on messages or health information to other providers. Proportionately more RHPs (44.9%) than care coordinators (29.6%) and personal support workers (18.4%) had relied on clients to convey information to their other providers. [xli] See Table 30.

Table 30: Working with Other Providers (%)

Question	Answer	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
Did you feel you worked well in a coordinated way with other health and social service providers?	No	7.5	7.0	9.1	4.5
Did you feel part of a team with other health and social service providers?	No	23.5	23.1	28.2	9.4
Do you think your formal education/ training prepared you to work collaboratively with other providers in the community?	No	5.9	5.0	6.9	3.0
Were you able to use all the necessary skills from your training with your last client?	No	6.2	5.7	11.5	3.4
Were you asked to perform a delegated task with your last client?	Yes		Not asked	9.5	42.7
Have you ever planned joint visits or teleconferenced with other providers (other than family physicians)?	No		36.5%	49.1	Not asked
If your last client had a family physician, did you have reason to contact the FP?	Yes		35.7	44.4	Not asked
With respect to your last client, have you ever wanted to suggest a change in the care plan?				49.3%	50%
Have you ever arrived at an appointment	Yes	41.4	38.3	42.7	45.3

to find that the client was not available?					
Did you rely on the client to convey information to other providers?	Yes	34.4	29.6	44.9	18.4

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. Respondents were asked a number of questions regarding the last home care client they had who had to go into a hospital or some other care facility while they were providing care to that client. Of all the respondents who said the question was applicable, more than one-quarter (27.9%) said they were not informed of the decision to move the client in a timely manner: 29.1% of care coordinators; 32.6% of regulated health professionals; and 10.0% of personal support workers. This may account for the fact that many respondents had indicated that, with respect to their last client, they have arrived to find that the appointment with the client had been cancelled. Roughly one-half of care coordinators (48.3%) and regulated health professionals (48.0%) did not know if there was a single person communicating the information to the receiving facility. When their client returned home from the facility, roughly one-third of all respondents (30.9%) did not receive information about the care plan promptly: 35.9% of care coordinators; 27.1% of regulated health professionals; and 18.4% of personal support workers.[xlii] See Table 31.

Table 31: Transitions from Home to Hospital/LTC Facility back to Home (% of respondents)

Question	Answer	All Respondents	Care Coordinators	Regulated Health Professionals	Personal Support Workers
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?	No	27.9	29.1	32.6	10.0
When this client was transferred, did you know if there was a single person in charge of communicating all necessary information to the facility?	No		48.3	48.0	Not asked
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?	No	30.9	35.9	27.1	18.4

3.8 Recommendations for Improvement

Respondents 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 1) *Having the appropriate type of provider providing care*, 2) *Developing strategies to promote the health of clients and prevent their decline or illness*, 3) *Ensuring that providers work to the full extent of their training,* and 4) *Having CCAC case managers in all hospitals*. Care coordinators, regulated health professionals and

personal support workers rated these three factors most highly and in the same order (PSWs ranked the 2nd and 3rd factor higher than the 1st). The strategies seen as least likely to make an improvement were pay-for-performance payment schemes, the provision of training on the roles of other health and social service providers, and the provision of training on the different parts of the health care system. These differences were statistically significant (F=53.774, df=13/480, p<001). See Table 32.

Table 32: Respondents Rating of Strategies to Improve the Integration of Care (Mean Response)

Strategies	All Respondents	Care Coordinators	Regulated Health Professional	Personal Support Workers
Ensuring providers work to the full extent of their training	4.63	4.46	4.80	4.74
Developing strategies to promote the health of the client and prevent decline and illness	4.64	4.50	4.82	4.74
Having the appropriate type of provider providing care	4.79	4.66	5.00	4.68
Having CCAC case managers in all hospitals	4.58	4.51	4.78	4.24
Integrating the Family Physician into the care plan	4.38	4.31	4.53	4.26
Assigning CCAC case managers to Family Health Teams	4.17	4.11	4.21	4.18
Electronic health records	4.35	4.33	4.51	4.13
More portable information technology, e.g. handheld devices, laptops	4.04	3.94	4.30	3.84
Training in communication skills	4.13	4.10	4.06	4.39
Training in how to manage conflicts with patients or other health and social service providers	4.13	4.12	4.06	4.37
Training in the roles of other health and social service providers	4.00	4.01	3.97	3.89
Training regarding the various parts of the health care system	4.00	4.00	4.00	3.87
Training for health and social service providers in how to work together effectively	4.20	4.16	4.16	4.37
Implementing a payment scheme based on performance	3.49	3.26	3.71	3.42

All respondents were also asked to review the 14 above strategies and rank the top 3 amongst them. This analysis is different from the ratings above in that in the ranking exercise respondents were asked to compare each strategy with all the others and to rank them accordingly. In the former exercise, respondents were rating each strategy on its own merits. Of the respondents who did the ranking correctly, *Developing strategies to promote health of the client and prevent decline and illness* was ranked as the number one strategy to improve the integration of health care followed by *Having the appropriate type of provider providing care*, and *Providers working to the full extent of their training*. See Table 33.

Care coordinators and regulated health professionals ranked *Strategies to promote the health of the client and prevent decline and illness* and *Having the appropriate type of provider providing care* as the most important and second most important strategy. Regulated health professionals however, ranked *Electronic health records* as the third most important strategy. Personal support workers agreed with care coordinators on the most important strategy for improving the integration of care, namely, *Strategies to promote the health of the client and prevent decline and illness.* However, their second and third most important strategies were *Providers working to the full extent of their training,* and *Training in communications skills* respectively.

Table33: Respondents' Rankings of 14 Strategies to Improve the Integration of Care (Percentage of Respondents ranking each factor first, second, or third)

Strategies	1st	2nd	3rd
Providers work to the full extent of their training	13.2	11.7	7.2
Strategies to promote the health of the client and prevent decline and illness	22.6	9.1	9.8
Having the appropriate type of provider providing care	10.9	14.7	12.5
Having CCAC case managers in all hospitals	1.5	1.9	3.4
Integrating the Family Physician into the care plan	3.8	6.4	5.3
Assigning CCAC case managers to Family Health Teams		2.3	3.0
Electronic health records	10.9	10.2	6.8
More portable information technology, e.g. handheld devices, laptops	5.3	9.4	6.8
Training in communication skills	3.4	1.9	1.9
Training in how to manage conflicts with patients or other health and social service providers		2.6	3.0
Training in the roles of other health and social service providers	1.5	1.1	4.5
Training regarding the various parts of the health care system		1.1	3.4
Training for health and social service providers in how to work together effectively	2.3	2.6	5.7
Implementing a payment scheme based on performance	1.1	0.8	1.9

When asked what one thing they would change to improve clients' care in the home and community care system, 475 of the 630 respondents provided suggestions, some more than one suggestion, ranging from funding issues; client care issues; issues regarding working with other providers; system-level issues; and workplace issues. See Table 34.

Issues regarding funding were the most frequently mentioned (35.8% of all respondents) and included the need for increased funding and resources; the need for consistent, equitable or stable funding; and an increase in accountability and the development of outcome measures. See Table 35.

Suggestions about improving client care were mentioned by 39.2% of all respondents and included: increasing the comprehensiveness of care and developing common care plans; more timely access to care; greater access to care and one-stop shopping; improving the quality of care/client-focused care; increasing certain types of services, e.g. palliative care, home drug checks, respite care, and other non-medical related care; decreasing the number of providers and increasing the consistency of providers going into the home; and increasing the involvement of family members and reducing language barriers. See Table 35.

Issues regarding working with other providers were mentioned by 30.5% of all respondents and included: better collaboration and respect amongst providers; improving the coordination and provision of medical supplies and equipment; and greater integration of family physicians and CCAC case managers into the home. See Table 35.

System-level issues, mentioned by 18.7% of all respondents, and involving the entire home and community care system or health care system included: better information systems; better links between sectors; an increase in focus of health promotion, disease prevention, and injury prevention; the development of more supportive housing and alternatives to home care, such as clinics and outpatient care; the de-privatization of home care and a re-evaluation of the effectiveness of the home care model; reducing the number of structural levels in home care, i.e. the need for LHINs, CCACs, etc.; and the introduction of different reimbursement models, such as pay for performance or the choice of providers by clients. See Table 35.

Workplace or workers' issues, mentioned by 20.8% or all respondents, included: adequate remuneration; decreased case loads and increased time with patients to accomplish all that is required; more education/training and better use of provider skills; less travelling; reduction in administrative work such as paper work, duplication; and an improvement in workplace health and safety issues in the home. See Table 35.

Funding issues were most often raised by regulated health professionals (57.4% of all RHPs); in particular increasing funding and resources (53.8% of all RHPs). Client care issues were most often raised by care coordinators (42.2% of all care coordinators), in particular improving access to care or one-stop shopping models (11.7% of all care coordinators). Work and Workplace issues were most often mentioned by personal support workers (52.6% of all PSWs), in particular decreased workloads/increased client time/better use of provider skills (23.6% of all PSWs). See Table 34.

Table 34: Type of Suggestions Raised by the Different Type of Providers (%)

Suggested Strategy	All Respondents N=475	Care Coordinators N=223	Regulated Health Professionals N=197	Personal Support Workers N=55
Funding	35.8	24.2	57.4	5.5
Client Care	39.2	42.2	41.6	18.2
Working with Other Providers	30.5	28.7	33.5	27.3
System-Level	18.7	7.2	32.5	16.3
Work and Workplace	20.8	19.3	13.7	52.6

Amongst all the suggestions provided by all respondents, increased funding was mentioned most often (33.7%), followed by better collaboration with other providers (16.0%), and better information systems (12.8%). Table 35 provides the numbers and percentages of all respondents who suggested each of the strategies for improvement.

Table 35: Improvements suggested by All Respondents

Suggested Improvements/Changes	No. of Respondents (Total =475)	Percent
FUNDING		
Increase Funding/ More Resources/ More Staff	160	33.7

Consistent/equitable/stable funding	7	
Increase accountability/ introduce more outcome measures	3	
Total	170	35.8
CLIENT CARE		
Single Comprehensive Care/common care plans	43	
More timely care	31	
Improve access to care/one-stop shopping	36	
Greater consistency of providers/services, fewer providers in the home	14	
Improve quality of care/continuity of care	13	
Client focused care	12	
Increase non-medical/health care	15	
Introduce home Med checks	2	
Increase family member involvement with care	3	
Increase assistance with language barriers	2	
Increase respite care	5	
Increase palliative care	1	
Increase care based on need	9	
Total	186	39.2
WORKING WITH PROVIDERS		
Better collaboration with other providers	76	16.0
Greater respect and understanding for providers' roles, judgment, processes amongst providers	38	
Greater integration of FPs and CCAC case managers into the home	12	
Improve provision of supplies/equipment	9	
Total	145	30.5
SYSTEM ISSUES		
Better Information Systems	61	12.8
Better links between sectors of care	13	
More health promotion/disease prevention/fall and injury prevention	6	
Reduce the number of structural levels in care provision	6	
De-privatize community and home care	5	
More supportive housing/more alternatives to home care e.g. clinics, outpatient care	4	
Re-evaluate effectiveness of the CCAC model	4	
Greater Accountability; Pay for performance	2	
Money follows clients	6	
Total	89	18.7
WORK ISSUES		
Adequate pay for community providers	29	
Better budgeting/less travelling	10	
More education and training of employees	15	
Decrease case load/increase client time/better use of provider skills	29	
Improve administration/reduce paper work/reduce duplication	7	
Improve workplace health and safety in the home	5	
Better hours of work/more stable hours of work	4	
Total	99	20.8

This concludes the report comparing the results from the surveys of regulated health professionals, personal support workers, and care coordinators.

Endnotes

i   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).

ii   Of the 300 surveys sent to registered nurses, 70 surveys were returned for a response rate of 23%. A little over one-fifth (22.0%) of registered practical nurses responded to the survey (n=34/200). Of the 300 surveys sent to rehabilitation professionals, 86 were returned with a response rate of 29%. The response rates varied across the three rehabilitation therapists (43% occupational therapists, 37% physiotherapists, and 6% speech language pathologists). SLPs were low probably because of the sampling methodology and the overestimation of the number of speech language pathologists working in sampled association member organizations. The response rate for social workers and dieticians was 20% and 10% respectively. Once again, the low rate of return for dieticians was probably due to the sampling methodology and the overestimation of such professionals in sampled member organizations. The response rate for respiratory therapists and pharmacists were 10% and 100% respectively.

iii   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.

Nearly 60% (59.7%) of respondents had at minimum a baccalaureate. A little over one-half (58.6%) of Registered Nurses had either a certificate or diploma in nursing. Proportionately more respondents from the three rehabilitation therapies and social work had post graduate education than those from nursing (SW – 90%; SLP – 66.6%; PT -25.6%; OT – 16.2%; RN -7.4%).

iv   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%; 1.0% PT; 6.1% SW). 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). 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.

Ninety percent of PSW respondents indicated that their major profession was personal support worker. The remaining respondents indicated that they were community support workers, home support workers and one was a registered practical nurse.

[v]   Case management, service coordination or order processing is only one of the duties performed by care coordinators, 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%). CCAC case managers most frequently provided case management services (87.5%, n=119). OHCA/OCSA service coordinators to this survey did not predominately provide case management or service coordination. The following services were most frequently provided by care coordinators from OCHA/OCSA organizations: 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%) said they most frequently provided general order processing or medical equipment supply order intake; while almost one-half (48%, n=13) predominantly provided pharmacy services. Other services provided by medical equipment/supply order processors included nursing, respiratory therapy, and community support services.

Three RNs, one RPN, one OT, and 4 social workers were also providing case management services in addition to the services for which they were trained; 2 RNs and 4 RPNs were providing personal support services; one OT was working in the area of medical equipment supply; 1 RN was providing homemaking services and 1 was providing community support services; 1 RPN was providing dietetic services; 1 RN was providing occupational therapy services, and one pharmacist was providing dietetic services. It is possible that some of the respondents who indicated that they were providing services below their level of training were actually providing case management for those services.

Most (86.6%) PSWs said they predominantly provide personal support services to clients. Others indicated their predominant service was community support services (5.6%) or homemaking services (4.5%). Although only one respondent was trained as a registered practical nurse, 2 respondents said they provided nursing services. If respondents indicated they provided more than one service, homemaking services was the most often listed (45.5%), 5.6% provided physiotherapy, and 1% provided dietetic services.

[vi]   The proportion of particular regulated health professionals that worked for more than one organization varied. Forty percent of dieticians worked for more than one organization compared with 35.1% of PTs, 25% of SWs, 20.5% of RPNs, 18.6% of RNs, 12.5% of Pharmacists and 11.6% of OTs. Respiratory therapists and speech language pathologists only worked for one organization.

[vii]   Six in 10 care coordinators (62.4%) said they worked for an organization with more than 100 employees/contract staff; 15.9% 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.

More than half (55.0%) of the regulated health professionals worked for an organization with more than 100 employees/contract staff; 14.8% worked for organizations that employed under 50 employees.

[viii] 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.

A greater percentage of physiotherapists (56.8%), social workers (55.0%), pharmacists (50%) and nurses (44.3%) had worked over 20 years in their profession compared with the other professional groups (RPNs (19.5%), OTs (18.6%), SLPs (33.3%), and DTs (20.0%)).

One-half of PSWs had worked in their current profession for 10 years or less, while 38.9% had worked for 11 to 20 years and 11.1% had worked for over 20 years in their profession.

[ix] Two-thirds of case managers had worked in the community sector for 11 or more years, whereas approximately one-half (48.5%) of service coordinators and one-third (37.0%) of order processors had worked as long in the community.

[x] The sector of care most frequently checked by care coordinators 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%).

The sector of care most frequently checked by regulated health professionals was the acute care sector (59.7%), followed by a physician's office/family health team (57.6%), retirement homes (28.0%) and long term care facilities (20.2%).

Almost one-quarter of PSWs (23.3%) had worked in no other sectors of care. Almost two-thirds had worked in long term care facilities, retirement homes or in complex continuing care. A little less than 10% had worked in the acute care sector.

[xi] Approximately half of RNs (48.5%), OTs (53.5%), PHs (50%, n=4), and RTs (50.0%, n=2) saw a waste of human and other resources a very likely effect of poor coordination and collaboration. Poor client understanding of the roles of providers and their care plan was seen as a very likely effect by at least half of SWs (57.9%), OTs (55.8%) and RTs (50.0%, n=2). Three-quarters of RTs (n=3) and 41.7% of PTs said that poor coordination and collaboration are very likely to lead to clients not following their care plan. Respiratory therapists (50%, n=2), and SWs (45.0%) more often than other providers said that a very likely effect was poor understanding amongst providers about their roles. Three-quarters of RTs (n=3), and approximately one-third of SLPs (40%, n=2), OTs (37.2%), SWs (36.8%), and RNs (35.4%) felt that a very likely effect amongst providers is a poor understanding of the care plan. Risks to the client's health and well being was seen as a very likely effect of poor integration by 75% of RTs (n=3), 62.5% of PHs, and 54.6% of RNs. Finally, 75% (n=3) of RTs and 31.3% of nurses saw risks to the health and safety of providers as a very likely risk of poor integration.

Because it was assumed that pharmacists rarely and infrequently interacted directly with clients, pharmacists were not asked questions about factors important in establishing a good working relationship with clients. They were, however, asked the frequency of their client interactions. Their response ranged from 2% to 100% with a mean response of 66.6% (SD=33.4%). The low end frequency of 2% skews the mean because 7 of the 8 respondents interacted with clients a minimum of 50%, 3 of whom interacted almost 100% of the time.

The majority of all care coordinators (82.4%), 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% of order processors found it easier to provide care with a family member involved.

The regulated health professionals that found it much easier to provide care when a family caregiver was involved were, in order of frequency:80.2% of Regulated Health Professionals found it easier or much easier to provide care when a family caregiver was involved (RTs (100.0%, n=4), PHs (75.0%), SWs (65.0%), OTs (60.5%), PTs (56.8%), RNs (51.5%), RPNs (51.2%), SLPs (50.0%), and DTs (40.0%)).

Only 6.8% of PSWs respondents found it much more difficult or difficult to provide care to clients when the family caregiver was involved; whereas, two-thirds (66.6%) found it easier or much easier to provide care with family caregiver involvement.

28.1% of case managers and 20.0% of service coordinators were not happy with the information provided on their first visit with the client.

Proportionately more case managers (42.9%) than service coordinators (34.9%) said they had to contact other providers.

Almost one-third (31.6%) of the regulated health professionals said they had to contact another health and social service provider for client information or diagnostic test results. Seventy-five percent of RTs (n=3), 47.2% of PTs, 40% of DTs, 36.8% of SWs and 36.2% of RNs contacted another provider for client information and test results. Only one of three RTs said they had to contact their employer for additional client information.

A little more than one-third (37.5%, n=3) of pharmacists said that they had to contact someone for further information in at least 5 of the last 10 orders/referrals/prescriptions they processed. When pharmacists had to contact another professional for further information, 50% (n=4) said they were able to make contact in a timely manner most of the time, and the other 50% indicated they were able to make contact in a timely manner some of the time. Overwhelmingly (87.5%, n=6), the reason that pharmacists were not able to contact another professional in a timely manner was that they had left a message for the other professional but the person did not get back to the pharmacist in time.

Pharmacists indicated that in 42.4% (SD= 23.8%) of all their referrals, orders or prescription they received, they had to get further information or clarification before completing the order. Pharmacists were asked to rank order the reasons why they needed to obtain further information. The highest ranked reason for needing more information was that the client information provided was incomplete, followed by incomplete drug information,

and inaccurate client information. In fact, they indicated that in between 1% to 15% of all their cases the client is not at home when the order is delivered. Pharmacists were further asked whom they typically contact for further information. By far, pharmacists most often contact the Case Manager (M=68.9%, SD=38.3%). See Table 17. Over half of the pharmacists (57.1%, n=4) said they were not able to access client information to determine drug interactions.

Table 17: Whom Pharmacists Contact for Further Information (%)

Person Contacted	Mean	SD
Physician	13.7	14.1
Case Manager	60.9	38.3
Nurse	8.6	13.1
Pharmacist	6.0	9.2
Care Recipient	3.8	6.3
Family Caregiver	7.4	12.4

[xvi] 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).

The frequency with which the different regulated health professionals said they did not have access to other providers' treatment plans is as follows in order: RTs (75.0%; n=3), PTs (70.0%), OTs (61.5%), and SWs (57.9%), RNs (53.2%), RPNs (37.1%), DTs (33.3%), and SLPs (25.0%).

[xvii] Of the regulated health professionals, proportionately more DTs (75%), SLPs (75%, ¼) RPNs (73.3%) and RNs (62%) reviewed the treatment plans of other providers compared with PTs (57.7%), SWs (55.6%), OTs (43.3%), and RTs (33.3%).

[xviii] Amongst regulated health professionals, proportionately more social workers (40%) and the three rehabilitation therapists (SLPs – 33.3%, OTs – 30.2%, PTs – 27.0%) believed that services did not start at the optimum time for the client.

[xix] 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.

Proportionately more respiratory therapists (50.0%), social workers (45%), OTs (34.9%), PTs (29.7%), and RNs (26.5%) believed delays were due to other providers/organizations. Pharmacists were asked what percent of all their referrals/orders/prescriptions did not meet the CCAC requirement of being delivered on time. Fifty percent of pharmacists said that all of them had been delivered on time. The remaining pharmacists indicated that between 2% to 10% of orders did not meet the time requirement. Overwhelmingly, pharmacists said that delays were due to problems with the order rather than delays in their organizations.

[xx] Amongst the regulated health professionals, a little over one-fifth of RTs (25%; n=1), RNs (24.6%), SWs (23.5%), and OTs (20.5%) said that the care plan did not consider the client's mobility and location.

[xxi] Amongst care coordinators, 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.

Amongst the regulated health professionals, RNs (9.0%) more often than other providers believed that organizations did not consider the time of day convenient to the client.

Half of those regulated health professionals who said the client did not have the necessary equipment were occupational therapists and a little under one-fifth were physiotherapists. All RTs (n=4) who answered the question said that they have arrived at the client's home to find that the appropriate equipment was not available to provide their care. All RTs (n=4) also said that they have arrived to find that the client or family caregiver had not been adequately trained to use the equipment.

Amongst regulated health professionals, 19.7% of RNs, 18.8% of SWs, and 15.8% of OTs said that their clients did not have the necessary medical supplies.

A higher proportion of RPNs (14%) than other providers indicated that there were no feedback mechanisms for clients or they did not know if there were (25.9%). Other providers who said there were no mechanisms were SLPs (16.7 %, n=1), and SWs (11.1%), or were not aware of feedback mechanisms were OTs (16.3%), SWs (11.1%), and PTs (10.8%).

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.

Amongst the regulated health professionals, the respondents from the three rehabilitation therapists more often said they did not know who the primary health and social service provider was for their client.

Six of the 7 pharmacists said that they knew who the primary health or social service provider was at least 50% of the time. The pharmacists we surveyed worked for medical equipment and supplies providers and got involved when the CCAC requested equipment or supplies. Most home care clients probably have community pharmacists who take care of their other prescription needs. However, 75% (n=6) of pharmacists said that they rarely or never knew if the client had another pharmacists. When they requested information from another pharmacists, only 62.5% (n=5) said that it was easy or very easy to obtain that information.

Pharmacists were specifically asked the frequency of their interaction with nurses, physicians, case managers and others across all referrals. They said they interacted with Case Managers approximately 45.8% (SD=37.0%) of the time, with nurses 17.6% (SD=17.4%) of the time, with physicians 9.6% (SD=10.3%) of the time and with no one 22.8% (SD=34.5%) of the time.

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%).

Proportionately more service coordinators (20.2%) than 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.

Amongst the regulated health professionals, more OTs and SLPs than any other provider type did not know whether their client had a family physician. Fifty percent (n=4) of pharmacists rarely or never knew if the client had a family physician.

[xxx]   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.

Of the seven pharmacists who answered the question, four knew who to call for professional help in 8 or 10 of the last 10 cases. The other 3 pharmacists only knew who to call for help in 0 to 2 of the last 10 cases.
[xxxi]

[xxxii]   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.

[xxxiii]   A little over one in ten (11.7%) of service coordinators compared with 3.2% of case managers felt they did not work well with other providers.

[xxxiv]   More than twice as many service coordinators (33.7%) compared with case managers (14.6%) did not feel part of a multidisciplinary team.

SLPs (66.7%, n=4), OTs (43.6%), SWs and (38.9%) most often said they did not feel part of a multi-disciplinary team. Similarly, four of 8 pharmacists said that they only felt part of an interdisciplinary team in less than 5 of their last 10 cases.

[xxxv]   13.4% of order processors, 6.1% of case managers, and 4.5% of service coordinators said their training did not prepare them to work in teams

[xxxvi]   Only one RN and one PSW did not feel adequately prepared to undertake a delegated task.

[xxxvii]   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.

More social workers (63.2%), PTs (61.2%), OTs (55.3%), and RNs (54%) than other professionals organized team conferences. Speech language pathologists (16.7%, n=1), pharmacists (28.7%) and respiratory therapists (25%, n=1) less often planned joint meetings or teleconferences.

[xxxviii]   Respiratory therapists (75.0%, n=3), RNs (66.7%), dieticians (50.0%), and RPNs (42.9%) more often had contacted the family physician than the other professional providers.

xxxix   Registered nurses (64.2%) and RTs (75%, n=3) much more often than other providers said they wanted to suggest changes to the care plan. The percentage of other providers who wanted to suggest changes varied from 25% (DTs) to 44.4% (SWs). Five out of six pharmacists wanted to make changes to the care plan and three of the five actually made the suggestion.

xl   Of those care coordinators who said that the client was not there at the appointed time, 51.1% were service coordinators and 27.9% were case managers. For a similar question asked of order processors, 25% said that the clients in their last 10 case was 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.

xli   Proportionately more case managers (53.7%) than service coordinators (46.3%) relied on clients to transmit information to other providers. Over one-half of physiotherapists (54.3%) and registered nurses (51.5%) relied on clients to convey information to other providers, followed closely by OTs (46.2%), dieticians (44.4%), RPNs (36.8%), and SWs (30.0%).

xlii   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.