

Integration of Care:
Perspectives of Home and Community Providers:
Personal Support Workers

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Executive Summary

As already known, personal support work is a female-driven profession. It is also an aging profession. Given that these workers do considerable lifting in the provision of care, this may become an issue. The majority of PSWs speak English and the majority did not experience a language barrier. While French was the first language for only 3.4% of respondents, the proportion is not too different from the proportion of Franco-Ontarians according to the 2006 census.

Ontario PSWs are experienced workers in the home and community sector as well as other sectors, particularly the long term care sector. Almost half of the respondents provided more than one service. Other than personal support, PSWs most often provided homemaking services as well. Half of personal support workers have worked in their profession for over ten years and approximately one-half had worked in the community for over ten years, a little over three-quarters had experience working in other sectors, and over half work in both rural and urban areas.

The majority of respondents worked for only one organization. Three-quarters worked both during the week and on weekends and less than half worked only during the day. Less than one-third worked a 40 hour week. While the high percentage working part-time may reflect personal preferences and availability, it may mean that PSWs are not receiving benefits earned by their full-time counterparts.

Client focused care is highly valued by care coordinators and is seen as integral to integration. The meaning of integration offered by respondents highlighted four factors, in order of frequency: client-focused care (55.2%), providers working together/multi-disciplinary teams (24.1%), and better communications (22.4%). When presented with a fixed list of factors important to providing integrated care, PSWs chose receipt of prompt information, good communications amongst providers, client participation in care planning, and ensuring that PSW roles are understood by other providers. PSWs saw the greatest risk of poor coordination and collaboration amongst providers as being poor client understanding of the care plan and providers' roles and the risk to the client's health and well-being.

Almost all PSWs said they were able to establish good relationships with their last client. Nevertheless, 14% of PSWs experienced a language barrier with their last client. In establishing a good relationship with clients, their responses highlighted the need to be respectful of clients' needs and preferences, providing assessment in a timely manner, and the desirability of the continuity of providers. According to PSWs, however, despite a focus on the client and his/her family in providing care, PSWs said that their clients are having difficulty understanding the role of other providers (11.8% of PSWs), and had minimum understanding of their care plans (22.1% of PSWs). Although home care workers can rely on family members in this regard, and indeed the majority of PSWs find it easier to provide care when a family caregiver is involved, they also indicated that one in ten family members had no to some understanding of the care plan. A greater focus on clear descriptions and explanations of treatment plans may be required.

The receipt of good communications amongst providers was rated by PSWs as the second most important factor in providing integrated care. Poor understanding amongst health and social service providers about the care plan was the second most cited risk for poor coordination and collaboration amongst providers. However, 15% of PSWs were not satisfied with the information provided to them before their visit to the client, 15.9% said the care did not start at the optimum time for the client, 9.9% believed the care plan did not consider the client's mobility or home environment, and 5.7% and 6.9% respectively indicated that the client did not have the necessary

equipment or supplies. Anecdotal evidence has suggested that due to breakdown in information, timeliness in information transmission, and the accuracy of information transmitted, clients do not receive the appropriate equipment and supplies. Almost one-third of PSWs was not aware of any formal mechanisms for client feedback on their care or said there were none.

Home care clients frequently have multiple providers who are not onsite at the same time. Yet 24 of every 100 PSWs were not aware of their clients' other providers, 19 of 100 did not know who the primary health or social service provider was, and 16 out of 100 did not know who was responsible for organizing their client's care. There also appears to be no consistent source for finding out about other providers. The client is more often the source of this information than available records or other providers.

Quality care usually requires understanding and integrating the care provider by others. For this reason, care plans are left in the clients' homes in convenient locations for review by other providers. However, only 43.3% of PSWs had access to the treatment plan of other providers, and less than half of those actually reviewed those plans. PSWs gave numerous reasons for not reviewing the treatment plans, including lack of authority and missing treatment plans.

While it may not be critical to know who else is providing care and what the overall care plan is, it is conceivable that the integration of care may likely be improved with this knowledge and understanding, i.e. clear documentation and a process of routine review of these documents by all providers. Despite these issues, almost all PSWs knew who to call for professional help regarding their client, thereby minimizing any safety issues that may arise.

PSWs, on the whole, were quite positive about how well they worked with other providers. The majority felt their training had prepared them for collaborative work and on the whole they felt part of a team. When appropriate and necessary, they felt able to make suggested changes to the care plan. However, a large majority of PSWs report not being informed of changes to treatment plans. One in ten were not informed in a timely manner of a decision to move a client to hospital or to a LTC facility, and almost one in five did not receive prompt information about the care plan when the client was returned to the home. Moreover, despite the positive view of working with other providers, PSWs did not always communicate directly with other providers. Almost one-fifth of them said they had asked their client to convey messages or health information to other providers, which raises the possibility of error in information transmission.

When given a list of strategies for improving integration, PSWs chose strategies to promote the health of the client and to prevent decline and illness, providers working to the full extent of their training, and training in communications skills. When asked what one thing they would change to improve client's care in the home and community care system, PSWs most frequently mentioned decreasing their caseloads in order to spend more time with each client, followed by better collaboration with other providers, and better information systems.

1.0 Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.0 Methodology

2.1 Development of the Surveys

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

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

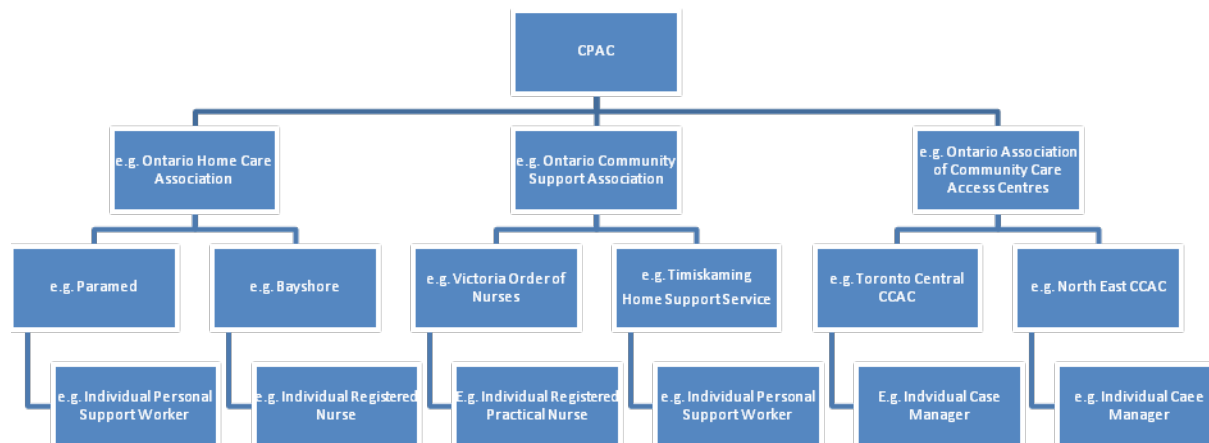
Research⁶ has shown that unusual events or problems tend to be more salient in people’s minds and remembered. As a result, these events are given more weight in questions that elicit overall perceptions or ask respondents to reflect on the “typical case”. To avoid this bias, the questions in the five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

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

2.2 Sampling

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.3 Limitations

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

Assumptions

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

Process

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

Distribution

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

Responses

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

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

2.4 Reporting Results

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

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

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

The second report – this report - details the results of Personal Support Workers (PSWs). Personal Support Workers provide services to people who need help with their daily needs. Ultimately, the goal of the Personal Support Worker is to improve the individual's overall quality of life and assist them with their Activities of Daily Living (ADLs). PSWs are the largest class of workers in the home care system. They provide care and assist clients of all ages, and their families/caregivers, with tasks of daily living, personal care and hygiene, restorative/activation activities and home management activities. PSW activities are supportive and non-medical in nature and typically, they provide care that clients could be expected to perform by themselves if physically and/or cognitively able.⁸

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.

3.0 Results

3.1 Response Rate

Of the 300 surveys that were sent out to Personal Support Workers, 90 were returned for an overall return rate of 30%.

3.2 Demographics

⁸ OHCA Position Statement. *The Personal Support Worker in Home & Community Care*.
<http://www.homecareontario.ca/public/docs/papers/2007/July/ohca-personal-support-worker-in-home-and-community-care.pdf>

Of the 90 respondents, 83 or 92.2% were female. Fifty-five percent of respondents were 50 years old or younger; 41.6% of respondents were between the ages of 51-65.

The majority of respondents (65.2%) were Canadian by birth. While English was the first language of 75.3% of respondents, 86.5% currently spoke English at home. French was the first language of 3.4% of respondents and 2.2% currently spoke it at home.

Roughly one-third each – 33%, 27%, and 27% – had a diploma, a certificate, or some college/university training respectively. One respondent had a baccalaureate. Ninety percent indicated that their major profession is personal support worker. The remaining respondents indicated that they were community support workers, home support workers and one was a registered practical nurse.

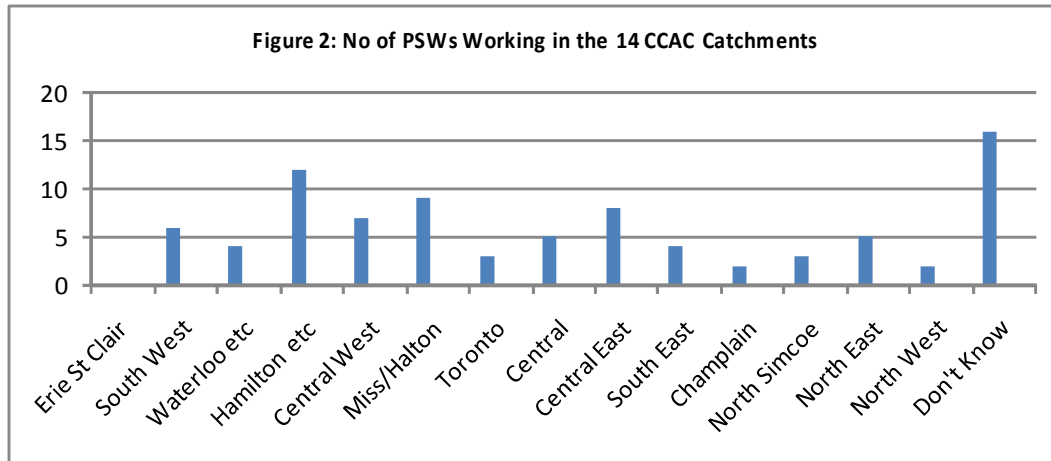
Respondents were asked to indicate which services they predominantly provide to clients. If they provided more than one service, they were asked to rank order them in order of frequency performed. Most (86.6%) respondents said they predominantly provide personal support services to clients. Others indicated 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, home making services was the most often listed (45.5%), 5.6% provided physiotherapy, and 1% provided dietetic services.

One-half 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. Similarly, 51.1% had worked for ten years or less in the community; 36.7 % had worked for 11 to 20 years; and 12.2% had worked for over 20 years in the community. While 23.3% had worked in no other sectors, 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.

Over one-half (57.5%) of respondents worked in both urban and rural areas, approximately one-third (34.5%) worked only in urban areas, and 8.0% worked in rural areas only. While 11.6% of respondents did not know in which CCAC catchment area they worked, the others were spread out in the fourteen areas. Figure 2 shows in which CCAC area the respondents who answered the question correctly worked.

The majority (83.1%) of respondents worked for only one organization. Nearly one-third (31%) worked in organizations with more than 100 employees, 18.4% in organizations with 51 to 100 employees, and 17.2% in organizations with 11 to 50 employees. Thirty percent did not know the size of their employer organization.

Almost three-quarters (73.3%) worked both during the week and on weekends. The others only worked Monday to Friday. Less than half (42.2%) worked only during the day. The others worked a combination of days and evenings and nights. Approximately one-third (30.7%) worked 40 or more hours a week; while 69.3% worked part-time (38.6% worked 30 to 39 hours a week, and 26.1% worked 20 to 29 hours a week).



3.3 Definitions and Perceptions of Integration

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

3.3.1 Perceptions of Integration

All Personal Support Workers were asked what integration of health care services for clients meant to them in their own words. Of the 90 PSWs who responded to the survey, 58 (64.4%) answered this question. An analysis of their responses shows that the most frequently mentioned feature of well-integrated care is *Client-Focused Care* (55.2%), followed by multidisciplinary *Coordination/Working Together/Multidisciplinary Care/Continuity of Care* (24.1%), and *Better Communications/24-7 Availability of FPs* (22.4%). See Table 3.

In their own words, personal support workers said:

An easy system of access for clients to have help at their grasp without going through a lot of effort to contact people at different levels of an organization. Integrated care would have different types of care providers working together in some kind of very organized manner.

Good communication between all the professionals involved in the client's care is the most important part of good coordinated community care. Such e.g. [examples] are; weekly reporting on all clients, possibly through fax or telephone.

Good coordinated community care and integrated care should reflect as a respectful partnership involving client, personal care workers and client's family, coordinating with doctor, nurses, pharmacist, physio and occupational therapy as well as social worker.

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

Where all levels of the “team” communicate on an equal level. Sometimes I feel a lot of work is put on us because we are lowest rung on ladder.

Table 3: Personal Support Workers’ Views of Features that Comprise the Integration of Health and Social Services

Category	Count (No. of Respondents)	Frequency (% of Respondents)
Client Focused	32	55.2
Coordination/Working Together/ Multidisciplinary Care/Continuity of Care	14	24.1
Access/Availability/One-stop	1	1.7
Seamless/Seamless Transitions		
Holistic Care/Health Promotion-Disease Prevention	1	1.7
Better Information Systems	3	5.2
Best Quality of Care/Effective Care	10	17.2
Better Communications/24-7 availability of FPs	13	22.4
Client at Home/Community Care	11	19.0
Timely	3	5.2
Better Use of Resources/Decreased intake time and more service/Decreased Cost of Care/One assessment tool	1	1.7
Understand/Respect each other’s Roles	6	10.3
Equitable Care	1	1.7
Common Goals	1	1.7
Family Involvement/Support	4	6.9
Better use of skills	1	1.7
Deliver care in appropriate setting		
Consistency of services/Standardized Care		
Decreased layers of bureaucracy		
Evidence-based care		
Accountable		
Don’t Know		

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 4, most respondents found all of the factors to be very important in the provision of care although there are significant differences in the ratings of the 10 factors ($F = 3.215$; $df = 9,72$; $p < .003$). The receipt of information promptly ($M=4.67$), good communications amongst providers ($M=4.60$), ensuring that PSW roles were understood by other providers ($M=4.60$), and client participation in care planning and considering their goals ($M=4.54$) were the factors that received the most support from respondents. Having shared values with other providers and available and reliable technology for information transfer received the least support.

Table 4: Importance of Various Factors in the Coordination of Health and Social Services

Factors	Mean
Actively involving the client/family caregiver in the assessment and care planning and considering the client/family caregiver’s goals and needs in the care plan.	4.54

Having good communication about the client with other health and social service providers.	4.60
Having complete information about the client from other health and social service providers.	4.50
Receiving information promptly about the care plan or changes in the client's health status.	4.67
Having shared values about care provision with other health and social service providers.	4.30
Having good working relationships with other health and social service providers.	4.49
Having a clear understanding of the individual roles and responsibilities of the care plan.	4.49
Ensuring that your role in delivering care is understood by other health and social service providers.	4.60
Having ready access and availability to health and social service providers.	4.36
Having available and reliable technology to support the transfer of information.	4.32

Respondents were also asked to rank the 3 factors that were most important in providing coordinated health and social services. Forty-seven of the 90 respondents answered this question correctly. *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 most support as the most important factor in providing coordinated care. *Having good communications with other providers* was ranked second in importance. *Receiving information promptly about the care plan or changes in the client's health status* was ranked third by PSWs. See Table 5.

Table 5: PSW Ranking of Top 3 Factors (Percentage of Respondents Ranking Each Factor First, Second, or Third)

Factors	1 st	2 nd	3 rd
Actively involving the client/family caregiver in the assessment and care planning and considering the client/family caregiver's goals and needs in the care plan.	48.9	19.1	10.6
Having good communication about the client with other health and social service providers.	8.5	31.9	2.1
Having complete information about the client from other health and social service providers.	12.8	10.6	12.8
Receiving information promptly about the care plan or changes in the client's health status.	14.9	19.1	25.5
Having shared values about care provision with other health and social service providers.	2.1	6.4	2.1
Having good working relationships with other health and social service providers.	4.3	6.4	6.4
Having a clear understanding of the individual roles and responsibilities of the care plan.	4.3	2.1	6.4
Ensuring that your role in delivering care is understood by other health and social service providers.	2.1	6.4	2.1
Having ready access and availability to health and social service providers.	2.1	4.3	6.4
Having available and reliable technology to support the transfer of information.	2.1		2.1

3.3.3 Impact of Poor Coordination and Collaboration

PSWs 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). PSWs rated the 7 factors in Table 6 below from 3.54 to 3.77. *Poor client understanding of roles and care plans* received the highest rating (M=3.89), followed by *Risks to client's health and well-being* (M=3.77), and *Clients not following care plans* (M=3.70). These differences are not statistically significant (F = 0.985, df = 6/61, p < 0.44). See Table 6.

Table 6: PSW Ratings of Likely Effects from Poor Coordination and Collaboration amongst Providers

Effect	Mean Response
Waste of human and other resources	3.57
Poor client understanding of roles of health and social service providers and care plan	3.89
Clients not following the care plan	3.70
Poor understanding amongst health and social service providers of each others' roles	3.54

Poor understanding amongst health and social service providers about the care plan	3.55
Risks to the client's health and well-being	3.77
Risks to the health and social service provider's safety and well-being	3.66

PSWs were further asked to rank the top 3 of the 7 effects that were most likely to occur from poor coordination and collaboration amongst providers. Forty-nine (54.4%) of PSWs properly ranked the possible effects. *Risks to the client's health and well-being* was rated the most likely factor to result from poor coordination and collaboration, followed by *Poor understanding amongst health and social service providers about the care plan* and *Clients not following the care plan*. See Table 7.

Table 7: PSW Rankings of Top 3 Likely Effects of Poor Coordination and Collaboration amongst Providers (Percentage of Respondents ranking each factor first, second, or third)

Effect	1 st	2 nd	3 rd
Waste of human and other resources	8.7	21.7	52.2
Poor client understanding of roles of health and social service providers and care plan	33.3	26.7	33.3
Clients not following the care plan	40.0	35.0	15.0
Poor understanding amongst health and social service providers of each others' roles	16.7	33.3	33.3
Poor understanding amongst health and social service providers about the care plan	46.7	40.0	13.3
Risks to the client's health and well-being	66.7	15.2	12.1
Risks to the health and social service provider's safety and well-being	16.0	44.0	32.0

3.4 Working with Clients

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. The factor that received the greatest support was *Being respectful of the client's needs and preferences where possible* (M=4.90), followed by *Providing client assessment in a timely manner* (M=4.53), and *Being the client's "regular" provider of care as much as possible* (M= 4.33). *Being of the same ethnic origin* was the least important factor (2.16). (See Table 8). The differences across the factors were statistically significant (F=37.676, df=7/66, p<.001).

Table 8: Factors Important to PSWs in Establishing a Good Relationship with Clients (1 = not very important, 5 = very important)

Factors	Mean Response
Being respectful of the client's needs and preferences where possible	4.90
Being of the same ethnic background as the client	2.16
Speaking the same language as the client	3.38
Providing client assessment and care in a timely manner	4.53
Being the client's "regular" provider of care as much as possible	4.33
Being considerate of the client's preference for the time care is provided	4.32
Being considerate of the client's financial situation	3.27
Getting along with the client's family caregivers	4.15

Fifty-four of the 90 PSWs appropriately ranked the top three of all the 8 above factors in relation to each other that were important in establishing good working relationships with their clients. The top three factors more or less mirrored the ranking of the factors done in isolation of each other, except that the second and third most important factors were reversed. See Table 9.

Table 9: PSWs' Ranking of Top 3 Factors in Establishing a Good Relationship with Clients (Percentage of Respondents ranking each factor first, second, or third)

Factors	1st	2 nd	3 rd
Being respectful of the client's needs and preferences where possible	85.2	7.4	3.7
Being of the same ethnic background as the client	3.7	1.9	5.6
Speaking the same language as the client	3.7	13.0	5.6
Providing client assessment and care in a timely manner	27.8	14.8	42.6
Being the client's "regular" provider of care as much as possible	1.9	25.9	20.4
Being considerate of the client's preference for the time care is provided	5.6	16.7	22.2
Being considerate of the client's financial situation	3.7	1.9	3.7
Getting along with the client's family caregivers	1.9	9.3	25.9

All (98.9%) but one PSW indicated that they were able to establish a good working relationship with their last client. The majority (86.0%) did not experience a language barrier with their last client. Only 77.6% of PSWs said their last client understood the roles of other providers, while 11.8% indicated that the client did not understand the different roles. See Table 10.

Table 10: PSWs- Working with Clients

Question	Yes	No	Don't Know	Total
Were you able to establish a good working relationship with your last client?	98.9	1.1		100.0
Did you experience a language barrier with your last client?	13.9	86.0		99.9
Did your last client understand the roles of their other providers?	77.6	11.8	10.5	99.9

PSWs were asked to rate the understanding of the care plans of their clients and their caregivers. A little over one-fifth (22.1%) of PSWs said their clients had either no, little or some understanding of their care plans. However, respondents found that client family members had better understanding of care plans – only one-tenth (11.6%) had no, little or some (ratings 1 to 3) understanding. This may be why PSWs found it easier to provide care to clients when a family caregiver was involved. Only 6.8% of PSW 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. This difference is significant ($\chi^2=42.250$, $df=1$, $p<.001$). See Table 11.

Table 11: PSW - Working with Clients and Family Caregivers (Percent Ratings on a scale of 1 to 5)

Question	1 No Understanding	2	3	4	5 Complete Understanding
Did your last client understand his/her care plan?	4.4	4.4	13.3	26.7	51.1
Did the family caregivers of your last client understand the client's care plan?	1.2	2.3	8.1	31.4	57.0
	1 Much more difficult	2	3	4	5 Much easier
Is it easier to provide good health care when there is a family care giver involved?	3.4	3.4	26.4	27.6	39.1

3.5 Views on Care Plans

Respondents were asked to comment on the care plan for their last client. Most PSWs (85.6%) were satisfied with the information provided to them before their first visit to their last client. A little over one-third (37.1%) said that the treatment plan for their last client has changed over the course of their involvement, but not all (15%) were informed of this change. Only 52.8% of PSWs said they had access to the treatment plans of other providers, while 40.3% said they did not have access, and 6.9% did not know if they had access to care plans of other providers. Moreover, of those who knew of the client’s other providers, only two-thirds (66.1%) reviewed their treatment plans.

A little over four-fifths (84.1%) of respondents felt that service was started at the right time to provide maximum benefit to the client, 12.5% did not know if service was started at the optimum time, and 3.4% believed that service was not started at the right time. While 75.3% of respondents believed that the care plan took into consideration the client’s mobility and accessibility to services (e.g. home access ramps, transportation) and 14.8% did not know, 9.9% of PSWs felt that the plan did not consider the client’s mobility and home environment, or available transportation. Slightly over 90% believed the care plans tried to provide the same service provider at each visit and took into consideration times convenient to the client for service. Slightly over one-twentieth (5.7% and 6.9%) of PSWs indicated that their clients did not have the necessary equipment and necessary supplies to provide their care respectively. A little over 5% said their clients did not have adequate nutrition or did not know if they had adequate nutrition. 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 30% of respondents were not able to inform clients about them. See Table 12.

Clients frequently have multiple providers. However, as stated above, only 52.8% of PSWs said they had access to the treatment plans of other providers, and of those, only 66.1% reviewed those plans. The reasons given for not reviewing the plans of other providers 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.

Table 12: PSW Comments on Client Care Plans

Service to Clients	Yes	No	Don't Know	Total
Were you satisfied with the information provided to you before your first visit with your last client?	85.6	14.4		100.0
Did the treatment care plan for your last client change?	37.1	62.9		100.0
If the plan changed, were you informed of the change?	85.0	12.5	2.5	100.0
Did the PSW have access to the treatment plans of other providers?	52.8	40.3	6.9	100.0
If the client had other providers, did the PSW review the treatment plans of other providers?	66.1	33.9		100.0
Was service started at the right time to provide maximum benefit to the client?	84.1	3.4	12.5	100.0
Did the care plan take into consideration client mobility, and accessibility to	75.3	9.9	14.8	100.0

service?				
Did the care plan try to provide the client with the same provider as much as possible?	91.1	4.4	4.4	100.0
Did the care plan consider the time of day for service convenient for the client?	92.2	3.3	4.4	100.0
Did the client have the necessary equipment for care?	93.2	5.7	1.1	100.0
Did the client have the necessary supplies for care?	90.2	6.9	2.8	99.9
Was the client receiving adequate nutrition?	94.3	3.4	2.3	100.0
Are there processes or mechanisms for clients to provide systematic feedback on the services they receive from you?	70.1	9.2	20.7	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.¹⁰ In regulated and controlled environments or LTC facilities, PSWs have reported physical, verbal and sexual abuse and racism. Almost all personal support workers in LTC facilities have experienced some form of violence, and nearly half experience physical violence on a *daily* basis.¹¹ Indeed, 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.

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.

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. While roughly three-quarters (74.4%) of PSWs were aware of their last client’s other providers, almost one-quarter (25.6%) of PSWs were not. Approximately 16% were not aware if their last client had a family physician. Approximately 16% did not know who was responsible for organizing their last client’s care plan, and almost one-fifth (18.8%) did not know who the primary health or social provider was. More (92.9%) knew who the primary family caregiver was. Nevertheless, almost all (97.7%) PSWs knew who to call for professional help with respect to the care of their last client. Fourteen percent indicated they did not have a clear understanding of the role of their last client’s other providers. See Table 13.

Table 13: PSWs Knowledge of Other Providers and Back-Up

Working with Other Providers	Yes	No	Total
Are you aware whether your last client had other providers?	74.4	25.6	100.0

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

¹¹ A Banerjee, T Daly, H Armstrong, P Armstrong, S Lafrance and M Szebehelym 2008. *“Out of Control”: Violence against Personal Support Workers in Long-Term Care*. February 23, 2008. http://www.psno.ca/pdf/Out_of_control___english.pdf

Are you aware if your last client had a family physician?	84.3	15.7	100.0
Do you know who is responsible for organizing your last client's care?	83.9	16.1	100.0
Do you know who the primary health or social service provider was for you last client?	81.2	18.8	100.0
Do you know who the primary family caregiver was for your last client?	92.9	7.1	100.0
Do you know who to call for professional help if you need it?	97.7	2.3	100.0
Do you have a clear understanding of the roles of other providers working with your last client?	86.1	13.9	100.0

PSWs were asked how they routinely find out about their clients' other providers. Eighty-eight of the 90 respondents answered this question. While 80% are informed of other providers by their employer, 70% obtain this information from the client or the family caregiver. Only one-third learn about other employers from available records which includes the treatment care plans, and one-fifth (21.1%) from other providers. See Table 14.

Table14: PSW Sources of Knowledge of Other Providers

Source of Knowledge of Other Providers	%
From Employing Organization	80.0
From Clients or Family Caregiver	70.0
Available Records	33.3
Other Providers	21.1

PSW respondents were asked a number of questions regarding how well they worked with other providers of their last client. On the whole in this dimension, PSWs were quite positive in their responses. For those whose clients had other providers, the vast majority (95.5%) of PSWs felt that they worked well with other providers and 90.6% felt that they were part of a team with other providers. Almost all (97.6%) said that their training had prepared them to work with other providers. Almost all (96.6%) said they were able to use all the skills from their training that were needed and appropriate for their last client. A little over two-fifths of PSWs (42.7%) said they were asked to perform a delegated task from another provider and of those, almost all (97.0%) felt adequately prepared to do so.

One measure of collaboration is the extent that PSWs feel that they are able to suggest changes to care plans. Once again with respect to their last client, 50% indicated that they wanted to suggest a change in the care plan and 92% of these 50% actually made the suggestion. The accurate conveying of information may break down if providers do not communicate directly with each other. Almost one-fifth (18.4%) of PSWs said that they had asked their last client to convey messages or health information to other providers.

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. PSWs were asked a number of questions regarding the last home care client they had who had to go into hospital or some other care facility while they were providing care to that client. Only 49 of 90 PSWs answered these questions. Ten percent (n=5) of PSWs said they were not informed of the decision to move the client in a timely manner, one PSW could not recall, while the remaining 87.8% (n=43) were informed in time. When clients returned to their home from the other care facility, almost one-fifth (18.4%) of PSWs did not receive information about the care plan promptly.

3.8 Recommendations for Improvement

PSWs 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 ensuring that *providers work to the full extent of their training* (M=4.74), *developing strategies to promote the health of clients and prevent their decline or illness* (M=4.74), *ensuring that the appropriate type of provider provides the needed care* (M=4.68), and *training providers in communication skills* (M=4.39). The strategies seen as least likely to make an improvement were *pay-for-performance payment schemes*, *the provision of training on either the health care system or the roles of other health and social service providers*, and *the provision of portable information technology*. These differences were statistically significant (F=4.753, df=13/25, p<001). See Table 15.

Table 15: PSWs Rating of Strategies to Improve the Integration of Care

Strategies	Mean Response
Providers work to the full extent of their training	4.74
Strategies to promote the health of the client and prevent decline and illness	4.74
Having the appropriate type of provider providing care	4.68
Having CCAC case managers in all hospitals	4.24
Integrating the Family Physician into the care plan	4.26
Assigning CCAC case managers to Family Health Teams	4.18
Electronic health records	4.13
More portable information technology, e.g. handheld devices, laptops	3.84
Training in communication skills	4.39
Training in how to manage conflicts with patients or other health and social service providers	4.37
Training in the roles of other health and social service providers	3.89
Training regarding the various parts of the health care system	3.87
Training for health and social service providers in how to work together effectively	4.37
Implementing a payment scheme based on performance	3.42

PSWs were also to review the 14 above strategies and rank the top 3 amongst them. Of the 45 PSWs that did the ranking correctly, *health promotion and disease/decline prevention* was ranked as the number one strategy to improve the integration of health care followed by *providers working to the full extent of their training*, and *training in communication skills*. See Table 16.

Table 16: PSW Rankings of 14 Strategies to Improve the Integration of Care (Percentage of Respondents ranking each factor first, second, or third)

Strategies	1st	2 nd	3rd
Providers work to the full extent of their training	43.8	31.3	12.5
Strategies to promote the health of the client and prevent decline and illness	60.0	16.7	23.3
Having the appropriate type of provider providing care	19.2	42.3	26.9
Having CCAC case managers in all hospitals	12.5	37.5	
Integrating the Family Physician into the care plan		28.6	42.9
Assigning CCAC case managers to Family Health Teams			
Electronic health records		25.0	25.0
More portable information technology, e.g. handheld devices, laptops		16.7	50.0
Training in communication skills	30.8	23.1	23.1
Training in how to manage conflicts with patients or other health and social service		25.0	50.0

providers			
Training in the roles of other health and social service providers	14.3		14.3
Training regarding the various parts of the health care system		14.3	42.9
Training for health and social service providers in how to work together effectively	8.0	25.0	25.0
Implementing a payment scheme based on performance	14.3	14.3	28.6

When asked what one thing they would change to improve client’s care in the home and community care system, 55 of the 90 personal support workers provided suggestions ranging from funding issues; work issues; client care issues; issues regarding working with other providers; and system issues.

Issues specific to work issues were the most frequently mentioned (52.6% of respondents) and included decreasing case load and increasing time with clients, adequate pay for community providers, better education and training for providers, improving workplace health and safety, and better and more stable hours of work.

Suggestions about improvements in working with other providers were mentioned next most frequently (27.3% of respondents) and included efforts for better collaboration, and greater respect and understanding of each other’s roles, judgement and ways of working.

Suggestions for improving client care were mentioned by 18.2% of respondents and included providing care based on need, plus a number of other suggestions.

System issues were mentioned by 16.3% of personal support workers; in particular, developing better information systems.

Funding issues were mentioned by only 5.5% of respondents with an increase in funding, resources and staff being the only recommendation made.

Amongst all the suggestions, decreased case loads and increased time with clients was mentioned most frequently (23.6%), followed by better collaboration with providers (18.2%) and better information systems (14.5%). See Table 17.

Table 17: Improvements Suggested by PSWs (Numbers and Percent who Mentioned Improvement)

Suggested Improvements/Changes	Number (n=223)	Percent
Funding		
Increase Funding/ More Resources/More Staff	3	5.5
Consistent/equitable/stable funding		
Increase accountability/introduce more outcome measures		
Total	3	5.5
Client Care		
Single Comprehensive Care/common care plans	1	1.8
More timely care	1	1.8
Improve access to care/one-stop shopping	1	1.8
Greater consistency of providers/services, fewer providers in the home		
Improve quality of care/continuity of care		
Client focused care		
Increase non-medical/health care	1	1.8
Introduce home Med checks		

Increase family member involvement with care	1	1.8
Increase assistance with language barriers	1	1.8
Increase respite care		
Increase palliative care		
Increase care based on need	4	7.3
Total	10	18.2
Working with Other Providers		
Better collaboration with other providers	10	18.2
Greater respect and understanding for providers' roles, judgment, processes amongst providers	5	9.1
Greater integration of FPs and CCAC case managers into the home		
Improve provision of supplies/equipment		
Total	15	27.3
System Issues		
Better Information Systems	8	14.5
Better links between sectors of care		
More health promotion/ disease prevention/fall and injury prevention		
Reduce the number of structural levels in care provision		
De-privatize community and home care		
More supportive housing/more alternatives to home care, e.g. clinics, outpatient care		
Re-evaluate effectiveness of the CCAC model	1	1.8
Greater Accountability; Pay for performance		
Money follows clients		
Total	9	16.3
Work Issues		
Adequate pay for community providers	6	10.9
Better budgeting/less travelling		
More education and training of employees	6	10.9
Decrease case load/ increase client time/better use of provider skills	13	23.6
Improve administration/reduce paper work/reduce duplication		
Improve workplace health and safety in the home	2	3.6
Better hours of work/more stable hours of work	2	3.6
Total	29	52.6

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