

## **Integration of Care:**

### **Perspectives of Home and Community Providers**

#### **Regulated Health Professionals:**

**Registered Nurses, Registered Practical Nurses, Physiotherapists, Occupational Therapists,  
Speech Language Therapists, Social Workers, Dieticians, Respiratory Therapists, Pharmacists**

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## Executive Summary

Regulated health professionals in the home and community care sector, with the exception of pharmacists, are women. Overall, these professionals span the age ranges, with 60% under the age of 50 and 40% older than 50. Nurses, social workers and physiotherapists were older than the other professionals. The majority of professionals speak English and the majority did not experience a language barrier. French was the first language of 4.9% of participants and 3.3% currently spoke it at home, which is approximately the same proportion of Franco-Ontarians according to the 2006 census.

Ontario regulated professionals are experienced workers in the home and other sectors, and in both urban and rural areas. Almost forty percent have worked in their profession for twenty years, particularly PHs, PTs, SWs and RNs. Over 40% had worked in the community for over ten years. All had experience working in other sectors, and over one-quarter had worked in more than one other sector, particularly the acute care sector. Over 60% work in both rural and urban areas.

One-fifth of professionals work for more than one organization, particularly dietitians and physiotherapists. This may reflect either the shortage of professionals or the inability to find sufficient work hours with one agency. Respiratory therapists and SLPs worked for only one organization. Almost two-thirds of respondents worked less than 40 hours a week. While the high percentage working part-time may reflect personal preferences and availability, it may mean that professionals are not receiving benefits earned by their full-time counterparts.

The meaning of “integration” offered by respondents highlighted four factors: client-focused care; collaborative, multi-disciplinary care; good communications amongst provider; and support by good information systems. These factors were supported in a rating and ranking of 10 factors. Professionals put the highest value on client-focused care, followed by good communication amongst providers, and prompt and complete client information. Professionals clearly value client-centred care and see it as integral to integration. However, despite being one of their most mentioned factors in the open-ended question, *having good information technology to support the transfer of information* did not rank as highly in the forced choice question. It is possible it was implied in good communication, and prompt and complete information.

Conversely, the potential effects of poor coordination and integration as rated by professionals reflected the important factors involved in integration. *Poor client understanding of provider roles and the care plan, clients not following care plans, and risks to client’s health and well being* were the first and third most highly rated impacts of poorly integrated care. *Waste of human and other resources* was the second most highly rated factor.

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 continuity of providers. Despite a focus on the client and his/her family in providing care, almost 30% of clients are having difficulty understanding the role of other providers, and almost one-fifth had no to little understanding of their care plans. Although professionals can rely on family members in this regard, and indeed the majority of professionals find it easier to provide care when a family caregiver is involved, they also indicated that a little less than one in 20% 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.

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-third of

professionals were not happy with the information they received about their clients on the first visit. Furthermore, one-third had to contact another health provider for more information. RTs, PTs, DTs, SWs and PHs more often contacted other providers for more information about the client and test results. 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 the other provider. Nearly one-half of professionals indicated that the care plan for their client changed while they were involved with the client, and almost one in ten were not informed of the change. One-third of respondents said they were not informed in a timely manner when their client was moved from the home into hospital or a LTC facility. Furthermore, when their clients returned to their home, over one-quarter did not receive information about the care plan promptly. Obtaining client health and test information from other providers, being informed of changes to treatment or care plans, and the ability to reach the other providers in a timely fashion are key, as we have seen, to 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.

Duplication of information and assessments is a concern expressed by many clients, further highlighting the lack of communication and collaboration amongst providers. A little over 6 out of 10 professionals asked their clients to repeat some or all of their personal history. Proportionately more rehabilitation therapists, social workers and dietitians asked clients to repeat their history. Either pertinent information is not being collected by case managers at the initial assessment or there is a lack of trust of information collected by other professionals. One-quarter of respondents said that they also had to repeat an assessment or test on the client. Proportionately more nurse and speech language pathologists repeated tests.

As noted earlier, home care clients frequently have multiple providers who are not onsite at the same time. Collaboration requires the knowledge of the existence of other providers. In this regard, over 90% professionals, with the possible exception of pharmacists, knew if their client had other providers or a family physician, knew who was organizing their client's care plan, knew who the family caregiver was, and knew who to call for professional help. However, a little over one in ten professionals indicated that they did not understand the role of the other providers. 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 the employing organizations, available records or other providers.

For this reason, care plans are left in the clients' homes in convenient locations for review by other providers. However, over one-half of respondents indicated that they did not have access to the treatment plan of other providers, and less than half of those actually reviewed those plans. The most frequent mentioned reason for not reviewing the treatment plans was simply that they were not available. Other frequently mentioned reasons were that providers relied on clients to provide them with the necessary information or that there was insufficient time to review plans. This lack of critical information or the receipt of potential misinformation from clients, once again can lead to poor quality care and adverse events. At best, it may not be critical to know who else is providing care or what the overall care plan is. However, clear documentation of plans, availability of these documents, and time to review them is likely to improve the integration of care.

In responding to questions about their clients' care plans, more than one in five professional providers, more notably social workers and the rehabilitation therapists, said that the care did not start in time. Over one-quarter, particularly RTs, PTs, OTs, SWs, RNs and PHs, believed the wait for services was due to delays in organizations other than their own. These are largely professionals, with the exception of pharmacists and social workers, who may require medical equipment and supplies to provide care. Almost one in five and a little more than one in ten

respondents said that the client did not have the necessary equipment and medical supplies to provide care. All respiratory therapists said that all clients did not have adequate training to use their equipment.

Almost one in five respondents believed that the care plan did not take into account the client's mobility or home environment. However, over four out of five health professionals felt that their organizations tried to provide the client with the same provider for each visit and was considerate of the time and day of the visits. Although four-fifths of respondents knew of mechanisms for clients to provide feedback on their care, the fact that 13% did not know of such mechanisms and 5% said there were no mechanisms require correction.

A little more than nine out of ten respondents said that their training had prepared them to work with other providers. Although health professionals were quite positive about how well they worked with other providers, less than three-quarters felt they were part of a multi-disciplinary team. Only about one-half had ever planned joint visits or teleconferenced with other providers, and less than one-half had ever contacted the client's family physician. In particular, SWs, OTs, PHs and SLPs more often said they did not feel part of a team. Reasons offered for not feeling 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. Furthermore, health professionals did not always communicate directly with other providers. Almost one-half 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. Good integration depends on open communications, and requires from employers both organizational expectations and being valued in terms of the allocation of time and resources.

A little less than 9 out of 10 respondents said they were able to use all the skills from their training that were needed and appropriate for their last 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 given a list of 14 strategies for improving integration, the regulated health professionals gave the following three factors the highest ratings: *having the appropriate provider providing care, developing strategies to promote the health of the client and prevent decline and illness, and having providers work to the full extent of their training.* When asked to rank the 14 strategies in terms of importance, respondents chose *Strategies to promote the health of the client and prevent decline and illness, Having the appropriate type of provider providing care, and the Development of electronic health records.* Once again, respondents emphasized client-focused care, prompt and reliable communications, and the appropriate provider working to their full capacity.

When asked what one thing they would change to improve client care in the home and community care system, *Increased funding, resources, and staff* was the most frequently mentioned change, followed by *Better information systems, Single Comprehensive Care/common care plans, and Better collaboration with other providers.*

## 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.<sup>1</sup>

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.<sup>2</sup>

In response to these reforms The Change Foundation's 2007-2010 strategic plan<sup>3</sup> 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.<sup>4</sup>

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.<sup>5</sup> A summary of the report can be found on The Foundation's website.

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

<sup>2</sup> Ontario Local Health Integration, *About LHINs*. [http://www.lhins.on.ca/aboutlhlin.aspx?ekmensele=e2f22c9a\\_72\\_184\\_btnlink](http://www.lhins.on.ca/aboutlhlin.aspx?ekmensele=e2f22c9a_72_184_btnlink)

<sup>3</sup> 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>

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

<sup>5</sup> 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](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.

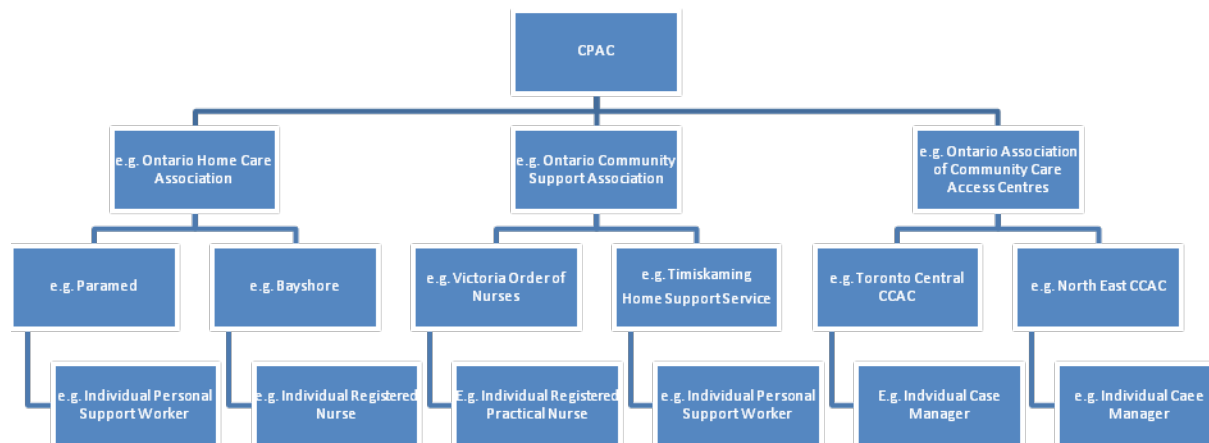
Research<sup>6</sup> has shown that unusual events or problems tend to be more salient in people’s minds and remembered. As a result, these events are given more weight in questions that elicit overall perceptions or ask respondents to reflect on the “typical case”. To avoid this bias, the questions 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

<sup>6</sup> 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
<b><i>Regulated Health Professions</i></b>		
Registered Nurses	6500	300
Registered Practical Nurses	1600	200
Physiotherapists	1000	100
Occupational Therapists		100
Speech Language Therapists		100
Dieticians <sup>1</sup>	?	100
Social Workers <sup>1</sup>	?	100
Respiratory Therapists	50	50
Pharmacists <sup>2</sup>	8	8
Subtotal	<b>9,158</b>	<b>1,058</b>
<b><i>Personal Support Workers</i></b>	<b>20,000</b>	<b>300</b>
<b><i>Care Coordinators</i></b>		
CCAC Case Managers	3650	300
Service Coordinators	4550	300
Intake Order Processors	62	62
Subtotal	8,262	662
<b>Total</b>	<b>~37,420</b>	<b>2,020</b>

1. CPAC was not able to identify an estimate of the population of dieticians and social workers for their organizations.<sup>7</sup>
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

<sup>7</sup> 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 <sup>a</sup>
2 to 9 locations/branches	24	17%	25.5 <sup>b</sup>
10 to 20 locations/branches	26	18.6%	28 <sup>c</sup>
21 and over location/branches	75	53.6%	80 <sup>d</sup>
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 - this report - details the results from the surveys of the Regulated Health Professionals. A regulated health professional is member of a self-governing college established under the *Regulated Health Profession Act, 1991* and includes:

- 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.

## 3.0 Results

### 3.1 Response Rate

Although these surveys were distributed only to the regulated health professionals, 13 participants indicated that they were members of an unregulated profession (personal support worker, home support worker, and other). In reviewing the data, the 10 individuals who had checked off personal support worker or home support worker had diplomas or some university training. For purposes of analyses, it has been assumed that they are RPNs who were working as personal support workers and home support workers. Two of the surveys sent to pharmacists were completed by certified pharmacy technicians. These latter two surveys were coded as "pharmacists". The final "Other" category was a Certified Occupational Health Nurse (RN). This respondent was coded as a RN for analysis purposes.

Of the 1,058 surveys that were sent out to the regulated health professionals (nurses, rehabilitation therapists, social workers, dieticians, respiratory therapists, and pharmacists), 243 were returned for an overall return rate of 23%. However, the return rate varied considerably across professional groups. 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=44/200). 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 because of 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. See Table 3.

**Table 3: Response Rates of Regulated Health Professionals**

Regulated Health Professionals	No. Surveys Sent	No. Surveys Received	Response Rate
• Registered Nurses	300	70 <sup>1</sup>	23.3
• Registered Practical Nurses	200	44 <sup>2</sup>	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 <sup>3</sup>	100.0
Total	1058	243	23.0

1. One respondent identified him/herself as a Certified Occupational Health Nurse (RN)
2. 10 respondents indicated their major profession as personal support or home support workers, although they were sent the Regulated Health Professionals Survey. I have assumed for purposes of analysis that they are RPNs because they have indicated they have either some university training or a diploma.
3. Two of Regulated Health Professional respondents identified themselves as certified Pharmacy technicians. I have assumed for analysis purposes that they are pharmacists.

### 3.2 Demographics

Of the 243 respondents, 224 or 92.2% were female. Of the 18 male respondents, 5 were pharmacists, 4 were OTs and PTs each, 3 were RNs, 1 was an RPN, and 1 was a SW. Sixty percent of respondents were 50 years old or younger; 36.2% of respondents were between the ages of 51-65, and 2.9% were over the age of 65. See Table 4. RNs, RPNs, SWs, and SLPs were older than the other professional groups - a little over 50% (55%) of SWs, 52.9% of RNs, 50% of SLPs, 46.5% RPNs were over the age of 50.

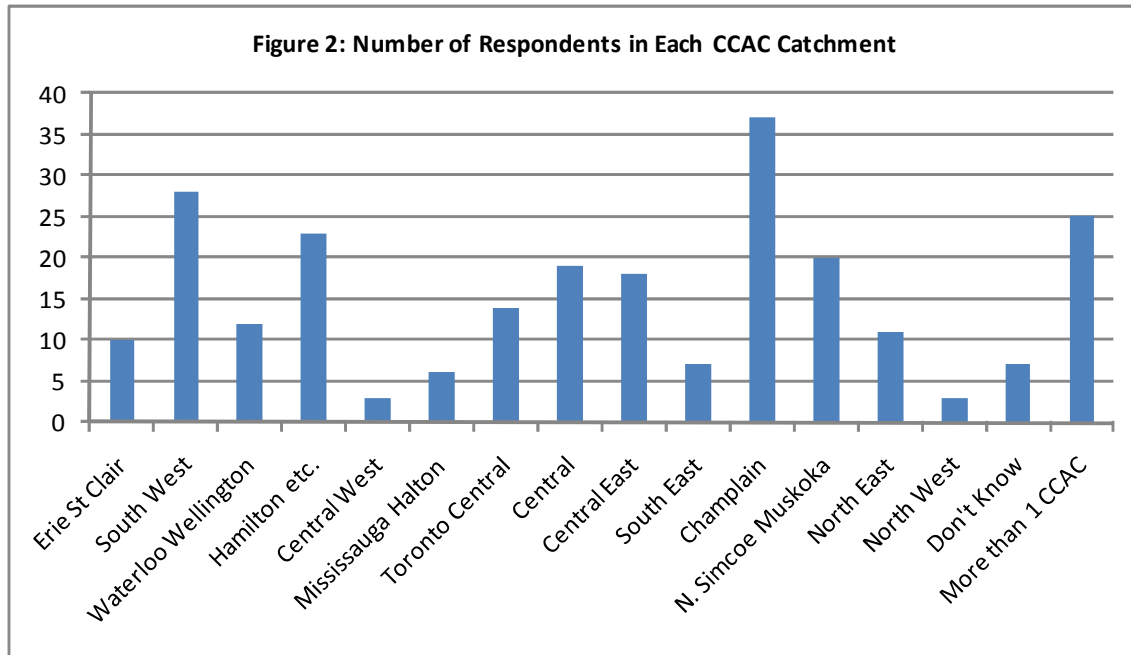
**Table 4: Age of Participants (years)**

Age Groups	Frequency	Percent	Cumulative Percent
21-30	28	11.9	12.2
31-40	58	23.9	34.3
41-50	60	24.7	59.6
51-65	88	36.4	96.5
>65	7	2.9	99.6
Missing	1	.3	100.0
Total	243	100.0	

The majority of participants (75.7%) were Canadian by birth, 18% were naturalized Canadians, and 5.8% were immigrants. While English was the first language of 81.1% of participants, 91.8% currently spoke English at home. French was the first language of 4.9% of participants and 3.3% currently spoke it at home. Nearly 60% (59.7%) of participants 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 participants 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%).

On the whole, each of the participants was providing services for which they were trained. A number of participants indicated that they provided more than one type of service; i.e. 26 (10.7%) said they provided 2 types of services; 8 (3.3%) provided three different services; and 2 (0.8%) provided four different services. In particular, 3 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 participants who indicated that they were providing services below their level of training were actually providing case management for those services.

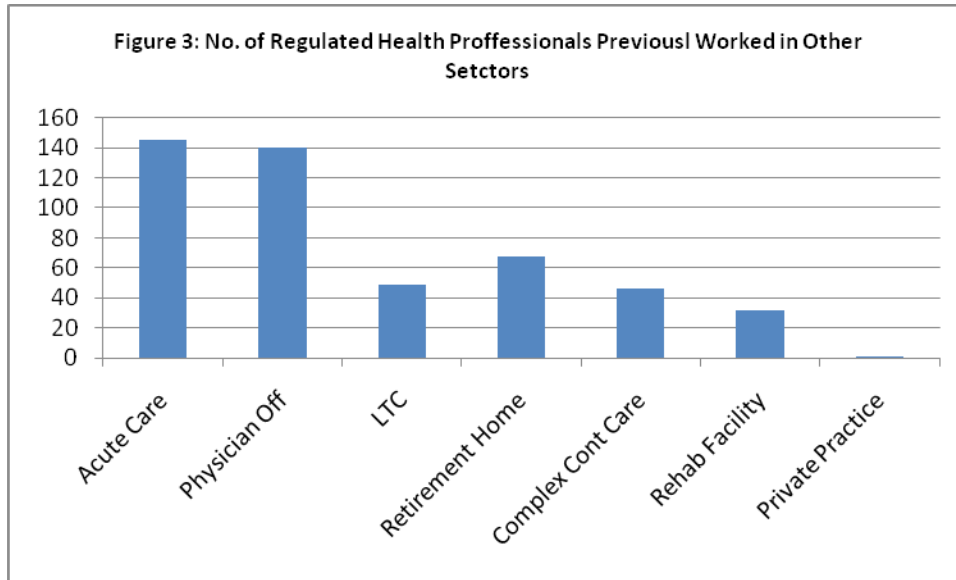
The majority (61.7%) of participants worked in both urban and rural areas; 35.0% worked only in urban areas; and 2.5% worked only in rural areas. Twenty-five participants (10.3%) indicated that they worked in more than one CCAC catchment area, and 7 respondents (2.9%) did not know their catchment area. Figure 2 indicates the number of participants working in each of the 14 different CCAC areas of the province.



Forty-nine participants (20.7%) indicated that they were working for more than one organization. More than half (54.7%) worked for an organization with more than 100 employees/contract staff; 14.8% worked for organizations that employed under 50 employees. The proportion of particular professionals that worked for more than one organization varied. Forty percent of dietitians 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. Slightly more than one-half (57.2%) of participants worked only during the week, while 42.8% worked both during the week and weekends. Approximately three-quarters (75.3%) worked only days. Almost two-thirds of participants (62.1%) worked less than full-time, and one-third (37.9%) worked 40 or more hours per week.

Almost forty percent (37.9%) of participants had been working in their profession for more than 20 years, and over one-quarter (28.0%) had worked between 11 and 20 years. 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%)). Forty-four percent of participants had worked for 11 or more years within the community care sector, and 30.6% had worked for 5 years or less in the sector. All participants had worked previously in other sectors of care. Over one-quarter (28.4%) had worked in more than one sector. The most frequently listed other sector of care 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%).

**Figure 3: No. of Regulated Health Professionals Who 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.*<sup>8</sup>

#### 3.3.1 Perceptions of Integration

Respondents were asked what integration of health care services for clients meant to them in their own words. Of the 243 regulated health professionals who responded to the survey, 201 answered this question. An analysis of their responses shows that the most frequently mentioned feature of well-integrated care is that it be client focused – 69.2% of respondents mentioned this. See Table 5.

*Taking into account the client's needs and wishes in the care plan, or having client participation in their care*

*Care that is based on client's needs not the cost of the care*

The next three features of well-integrated care in order are providers working together/multidisciplinary care (42.8%),

*Planning as a team, team-based care*

better communications amongst providers (26.9%),

*More communication with CCACs*

<sup>8</sup> The Change Foundation, *2010-2013 Strategic Plan: Hearing the stories, changing the stories*. June 2010. <http://www.changefoundation.ca/docs/2010strategicplansummary.pdf>. pg.5.

*Communication between involved services, between health care and social services*

and better information systems (16.9%).

*Improving the health care information system, e.g. standardized system of records, integrating all records for a patient, universal charting*

*Sharing client information between service providers*

Table 5 lists all the features mentioned by respondents and their frequency.

**Table 5: Regulated Health Professionals' Views of Features that Comprise Integration**

Category	Count (No. of Respondents)	Frequency (% of Respondents)
Client Focused	139	69.2
Coordination/Working Together/ Multidisciplinary Care/Continuity of Care	86	42.8
Better Communications/24-7 availability of FPs	54	26.9
Better Information Systems	34	16.9
Seamless/Seamless Transitions	32	15.9
Access/Availability/One-stop	27	13.4
Best Quality of Care/Effective Care	21	10.5
Timely	19	9.5
Client at Home/Community care	18	9.0
Holistic Care/Health Promotion-Disease Prevention	15	7.5
Common Goals	12	6.0
Family Involvement/Support	11	5.5
Understand/Respect each other's Roles	8	4.0
Better Use of Resources/Decreased intake time and more service/Decreased Cost of Care	4	2
Equitable Care	3	1.5
Better use of skills	2	1.0
Deliver care in appropriate setting	1	0.5
Consistency of services	1	0.5

### 3.3.2 Factors Important to Integration

Participants were asked to indicate how important a list of 10 factors was in the provision of coordinated health and social services on a scale from 1 (not very important) to 5 (very important). As can be seen in Table 6, most participants found all the factors to be very important in the provision of care although there are significant differences in the ratings of the 10 factors ( $F = 20.528$ ;  $df = 9,224$ ;  $p < .001$ ). Consistent with respondents' own descriptions of well-integrated care, client participation in care planning and considering their goals was the most supported factor, followed by the receipt of information promptly, and good communications amongst providers. Having shared values with other providers received the least support.

**Table 6: Importance of Various Factors in the Coordination of Health and Social Services for Regulated Health Professionals**

Factors	Mean
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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.	4.80
Having good communication about the client with other health and social service providers.	4.70
Having complete information about the client from other health and social service providers.	4.57
Receiving information promptly about the care plan or changes in the client's health status.	4.79
Having shared values about care provision with other health and social service providers.	4.21
Having good working relationships with other health and social service providers.	4.55
Having a clear understanding of the individual roles and responsibilities of the care plan.	4.53
Ensuring that your role in delivering care is understood by other health and social service providers.	4.58
Having ready access and availability to health and social service providers.	4.61
Having available and reliable technology to support the transfer of information.	4.47

Participants were also asked to rank the 3 factors that were most important in providing coordinated health and social services. Out of 230 respondents, 195 did the rankings correctly. The results presented here are for the 195 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 7.

**Table 7: Ranking of Factors (Percentage of Participants)**

Factors	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>
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.	69.7	10.3	4.1
Having good communication about the client with other health and social service providers.	7.2	24.6	20.5
Having complete information about the client from other health and social service providers.	8.2	19.5	13.3
Receiving information promptly about the care plan or changes in the client's health status.	5.1	15.4	15.4
Having shared values about care provision with other health and social service providers.	0.5	2.6	4.1
Having good working relationships with other health and social service providers.	1.5	2.6	10.3
Having a clear understanding of the individual roles and responsibilities of the care plan.	0.0	7.7	6.2
Ensuring that your role in delivering care is understood by other health and social service providers.	0.5	2.6	4.1
Having ready access and availability to health and social service providers.	3.6	6.7	11.3
Having available and reliable technology to support the transfer of information.	2.6	6.2	7.7

### 3.3.3 Impact of Poor Coordination and Collaboration

Regulated health professionals 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). Respondents rated the 7 factors on average from 3.4 to 4.1 on a scale between 1 and 5 (Table 8). There are significant differences in the ratings of the 7 factors ( $F=15.007$ ,  $df = 6/209$ ,  $p < .001$ ).

**Table 8: Regulated Health Professionals' Ratings of Likely Effects from Poor Coordination and Collaboration amongst Providers (Scale (1) very unlikely to (5) very likely).**

Effect	Mean Response
Waste of human and other resources	4.0

Poor client understanding of roles of health and social service providers and care plan	4.1
Clients not following the care plan	3.9
Poor understanding amongst health and social service providers of each others' roles	3.7
Poor understanding amongst health and social service providers about the care plan	3.8
Risks to the client's health and well-being	3.9
Risks to the health and social service provider's safety and well-being	3.4

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 the 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.

Respondents were also asked to rank the top 3 of the above 7 effects that were most likely to occur from poor coordination and collaboration amongst providers. Almost four-fifths of respondents (79.9%) properly ranked the possible effects. *Risks to the client's health and well-being* was rated the most likely factor to result from poor coordination and collaboration, followed by *Waste of human and other resources* and *Poor client understanding of roles of health and social service providers and care plan*. See Table 9.

**Table 9: Regulated Health Professionals' Rankings of Top 3 Likely Effects of Poor Coordination and Collaboration amongst Providers (Percentage of Participants ranking each factor first, second, or third)**

Likely Effect	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>
Waste of human and other resources	22.4	15.6	14.6
Poor client understanding of roles of health and social service providers and care plan	18.8	22.9	12.5
Clients not following the care plan	12.0	16.1	14.1
Poor understanding amongst health and social service providers of each others' roles	4.2	10.4	20.8
Poor understanding amongst health and social service providers about the care plan	4.7	12.0	15.1
Risks to the client's health and well-being	35.9	10.9	9.9
Risks to the health and social service provider's safety and well-being	1.0	10.4	8.9

### 3.4 Working with Clients

As demonstrated above, the relationship between the client/family caregiver and the individual provider is considered key in the provision of integrated care. Participants were asked to rate the importance of each of 8 factors in establishing a good relationship with their clients on a scale from 1 to 5 where 1 was not very important and 5 was very important. The factor that received the greatest support was *Being respectful of the client's needs and preferences where possible* (mean, 4.91), 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, 4.46). *Being of the same ethnic origin* was the least important factor (mean, 1.79). (See Table 10). There are significant differences in the ratings of

the 8 factors ( $F=377.377$ ,  $df=7,223$ ,  $p<001$ ). When ranking each of the 8 factors against each other, participants ranked these three factors in the same order of importance. (See Table 11).

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.

**Table10: Factors Important in Establishing a Good Relationship with Clients (1 = not very important, 5 = very important)**

Factors	Mean Response
Being respectful of the client’s needs and preferences where possible	4.91
Being of the same ethnic background as the client	1.79
Speaking the same language as the client	3.19
Providing client assessment and care in a timely manner	4.65
Being the client’s “regular” provider of care as much as possible	4.46
Being considerate of the client’s preference for the time care is provided	4.10
Being considerate of the client’s financial situation	3.77
Getting along with the client’s family caregivers	4.23

**Table 11: Top 3 Factors in Establishing a Good Relationship with Clients**

Factors	1st	2 <sup>nd</sup>	3 <sup>rd</sup>
Being respectful of the client’s needs and preferences where possible	79.2	15.7	2.0
Being of the same ethnic background as the client			
Speaking the same language as the client		5.1	4.1
Providing client assessment and care in a timely manner	15.2	46.2	17.3
Being the client’s “regular” provider of care as much as possible	4.1	20.8	28.4
Being considerate of the client’s preference for the time care is provided		3.6	17.3
Being considerate of the client’s financial situation		1.1	7.1
Getting along with the client’s family caregivers	1.0	6.6	22.8

Participants were asked a series of questions about the provision of care and their relationship specifically with *their last client*. The overwhelming majority (99.6%) indicated that they were able to establish a good working relationship with their last client. However, 10.7% of providers did experience a language barrier with their client. Where clients had other providers, only 54.9% of respondents stated that their client understood the role of other providers, while 16.9% did not know if their client understood and 28.2% of respondents stated that their client did not understand the role of other providers. See Table 12.

**Table 12: Working with Clients (Percent)**

Question	Yes	No	Don’t Know	Total
Were you able to establish a good working relationship with your last client?	99.6		0.4	100.0
Did you experience a language barrier with your last client?	10.7	88.4	0.9	100.0
Did your last client understand the roles of their other providers?	54.9	28.2	16.9	100.0

With respect to whether the last client understood the care plan developed for them, only 44.2% of providers indicated that their client had a complete understanding (5) while 36.4% had some understanding (4), and 6.5 % indicated little (2) or no understanding (1) of the plan. Of those clients who had family caregivers, providers indicated that 48.1%, 34.3% and 3.3% of family caregivers had complete, some, and little or no understanding respectively. Despite the fact that the proportion of clients' and family caregivers' understanding of the care plan did not differ appreciably, the majority of providers found it easier to provide care when a family caregiver was involved (56.1% much easier; 24.1% somewhat easier). See Table 13. The professionals that found it much easier to provide care when a family caregiver was involved were, in order of frequency: 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%).

**Table 13: 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?	5.2	1.3	13.0	36.4	44.2
Did the family caregivers of your last client understand the client's care plan?	1.4	1.9	14.3	34.3	48.1
	1 Much More Difficult				5 Much Easier
Is it easier to provide good health care when there is a family care giver involved?	0.4	1.7	17.7	24.1	56.1

Clients/patients have reported concerns about the duplication in assessments of their condition and requirement to repeatedly provide the same information to different providers. About 65 (65.4%) percent of participants 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 had asked clients to repeat their health or care history. See Table 14.

**Table 14: Regulated Professionals – Asking Clients to Repeat their Health/Care History**

Professional	Yes	Percent (%) Yes	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

Of those who felt the question was applicable, one-quarter (25.4%) of the participants 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, which was a much higher proportion than other professionals, except for SLPs (66.7% or 4/6). Dieticians and respiratory therapists were the only regulated professionals that did not need to repeat tests with their last client. Pharmacists were not asked this question. See Table 15.

**Table 15: Regulated Professions – Repeating Tests/Assessments**

Profession		Did you have to repeat any assessments or diagnostic tests?			
		Yes	%	No	Total
R	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

Of those who found the question applicable to their last client, 44.9% relied on the client to pass on messages or health information to other providers. Over one-half of physiotherapists (52.8%) and registered nurses (51.6%) relied on clients to convey information to other providers, followed closely by OTs (46.2%), dietitians (44.4%), RPNs (36.8%), and SWs (30.0%). See Table 16.

**Table 16: Regulated Professions (D16) – Relying on Client to Convey Information**

Profession		Have you ever relied on last client to convey messages/health info to other providers?			
		Yes	%	No	Total
	RN	34	51.6	31	65
	RPN	14	36.8	24	38
	OT	18	46.2	21	39
	PT	19	52.8	16	35
	SLP	1	16.7	5	6
	SW	6	30.0	14	20
	RT	0		4	4
	Diet	4	44.4	5	9
Total		97	44.9	119	216

Given these findings, it is not unexpected that a little over one-third (34.2%) of respondents were not happy with the information provided to them before their first visit with clients. In fact, almost one-third (31.6%) of respondents said they had to contact another health and social service provider for client information or diagnostic test results. Seventy-five percent of RTs (3/4), 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 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 the referrals, orders or prescriptions they receive, 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

Changes in the client’s care plan need to be communicated to providers promptly for seamless and appropriate care. A little less than half of the respondents (46.8%) said that the treatment plan did change for their client; a further 1.3% did not know if the plan had changed. Of those respondents who had indicated that there was a change in treatment for their last client, 8.5% said they were not informed of the change. See Table 18.

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. Over one-half (54.0%) of respondents indicated that they did not have access to other providers’ plans. See Table 18 The frequency with which the different providers 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%), SWs (57.9%), RNs (53.2%), RPNs (37.1%), DTs (33.3%), and SLPs (25.0%). Respondents were asked if they reviewed the plans of other providers. While 60% said they did review the plans, 40% did not. 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%). The reason overwhelmingly given for not reviewing the care plans of other providers is that they are 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. See Table 18.

**Table 18: Reasons Given by Regulated Health Professionals for Not Reviewing the Care Plans of Other Providers**

Reasons	Count
Plans not available	42
Ask the client what other providers are doing or the client is aware	7
Not enough time to review charts as well	6
Care provided by another company so access is not available or communication is lacking	5
Other providers work for private companies and therefore don’t have access	3
My portion of care is not dependent on others’ plans	3

Don't have access because of privacy/confidentiality issues	2
Can contact the CM if I need information	2
It's not always necessary to review plans	2
Other provider is from the same agency	1
Communications are verbal	1
No opportunity for paid communication	1
Only nursing and personal support are in home care plans	1
Rely on client/family member to convey information to other providers, my plans are not available	1
No need to review	1
Others' notes are incomprehensible	1
Information that is provided is very basic	1
Don't have access to provider plans from different disciplines	1
Hard to contact other providers. Call not always returned	1

### 3.5 Views on Care Plans

Respondents were asked to comment on the care plan for their last client. With respect to access and quality of service, 22.0% of participants believed that services did not begin at the right time for the client. See Table 15. Proportionately more social workers (40%) and the three rehabilitation therapists (SLPs – 33.3%, OTs – 30.2%, PTs – 27.0%) believed this to be true. However, only 4.7% believed the wait was due to delays in their organization, while 26.8% believed the wait for service was due to delays with other providers/organizations. See Table 15. 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/order/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.

Almost 18% (17.9%) of respondents said that their last client did not have the necessary equipment for their care; half of those were occupational therapists and a little under one-fifth was 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. A little over 13% (13.3%) of participants said their last client did not have the necessary medical supplies for care (RNs – 19.7, SWs – 18.8% and OTs – 15.8% said that their clients did not have the necessary medical supplies) and 9.4% did not know if their client had the right supplies. Eight out of 219 (3.7%) respondents indicated that their last client was not receiving adequate nutrition and a further three (1.4%) did not know. See Table 19.

The majority (77.1%) felt that the care plans took into consideration the client's mobility and location and 16.7% believed it did not. 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. Clients have indicated a preference for having the same provider attend to their care as much as possible, and 88.6% of providers believed that attempts were made to provide the client with the same provider for each visit. 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. It was believed by the vast majority (90.4%) that care plans did give consideration of the time of day for service to clients. RNs (9.0%) more often than other providers believed that organizations did not consider the time of day convenient to the client. While four-fifths (81.5%) of respondents indicated that there were ways for clients to provide systematic

feedback on services, 13.0% did not know of such a process, and 5.5% indicated there was no process for feedback. See Table 19. A higher proportion of RPNs (14%) than other providers indicated that there were no feedback mechanisms for clients or they did not know if any were available (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%).

**Table 19: Regulated Health Professionals' 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?	65.8	34.2		100.0
Did you have to contact another health or social provider for client information or diagnostic test results?	31.6	68.4		100.0
Did the treatment care plan for your last client change?	46.8	51.9	1.3	100.0
If the plan changed, were you informed of the change?	91.5	8.5		100.0
Did you have access to the treatment plans of other providers?	46.0	54.0		100.0
If the client had other providers, did you review the treatment plans of other providers?	60.0	40.0		100.0
Was service started at the right time to provide maximum benefit to the client?	73.7	22.0	4.3	100.0
Did the client have to wait for service because of delays in your organization?	4.7	84.5	10.8	100.0
Did the client have to wait for service because of delays with other health and social service providers?	26.8	54.0	19.3	100.1
Did the care plan take into consideration client mobility, and accessibility to service?	77.1	16.7	6.3	100.1
Did the care plan try to provide the client with the same provider as much as possible?	88.6	7.3	4.1	100.4
Did the care plan consider the time of day for service convenient for the client?	90.4	5.9	3.7	100.0
Did the client have the necessary equipment for care?	80.1	17.9	1.9	99.9
Did the client have the necessary supplies for care?	77.3	13.3	9.4	100.0
Was the client receiving adequate nutrition?	95.0	3.7	1.4	100.1
Are there processes or mechanisms for clients to provide systematic feedback on the services they receive from you?	81.5	5.5	13.0	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.<sup>9</sup> 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.

<sup>9</sup> 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.puno.ca/pdf/ohca-ocsa%20response%20to%20the%20consultation%20on%20workplace%20violence%20prevention-oct%202008.pdf>

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 the 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 are rarely or never 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.

### 3.6 Working with Other Providers

Participants were asked a number of questions with respect to their knowledge of and their ability to work with other providers. Integration of care across providers and time requires the knowledge of other providers providing care to the same client. On the whole, the respondents were aware of and understood the roles of other providers. Only one pharmacist had a clear understanding of the roles of other providers in all of their last 10 cases. Four of seven pharmacists said they had no understanding of the roles of other providers in all of their last 10 cases.

Nine out of ten (91.1%) regulated health professionals were aware of their last client’s other providers. There were no meaningful differences across professional types. Six out of 7 pharmacists said they did not know if any of their last 10 clients had other health and social service providers. Approximately 95% of all regulated health professionals were aware if their last client had a family physician. 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.

Approximately 95% of regulated health professionals knew who was responsible for organizing their last client’s care plan, and almost 87% knew who the primary health or social provider was. 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. A majority (94.4%) knew who the primary family caregiver was, and almost all professionals knew who to call for professional help with respect to the care of their last client. 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. Twelve percent of all regulated health professionals indicated that they did not have a clear understanding of the role of their last client’s other providers. Approximately 15% of RNs, SLPs, and SWs and roughly 10% of dieticians, OTs and RPNs said they did not have a clear understanding of the roles of other providers working with their client. See Table 20.

**Table 20: Regulated Health Professionals’ Knowledge of Other Providers and Back-Up**

Working with Other Providers	Yes	No	Total
Are you aware whether your last client had other providers?	91.1	8.9	100.0
Are you aware if your last client had a family physician?	94.9	5.1	100.0
Do you know who is responsible for organizing your last client’s care?	94.4	5.6	100.0
Do you know who the primary health or social service provider was for you last client?	86.7	13.3	100.0
Do you know who the primary family caregiver was for your last client?	94.4	5.6	100.0
Do you know who to call for professional help if you need it?	97.4	2.6	100.0
Do you have a clear understanding of the roles of other providers working with your last client?	87.9	12.1	100.0

On average, 57.9% (SD=27.1%) of pharmacists knew who the primary health or social service provider was. 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 pharmacist. When they requested information from another pharmacist, 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.

Respondents were asked how they routinely find out about their clients' other providers. Of those who answered the question correctly, a little more than one-half (54.3%) 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 (32.9%), available records (27.1%), and other providers (8.2%). See Table 21.

**Table 21: Regulated Health Professionals' Sources of Knowledge of Other Providers**

Source of Knowledge of Other Providers	%
From Clients or Family Caregiver	54.3
From Employing Organization	32.9
Available Records	27.1
Other Providers	8.2

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, regulated health professionals were quite positive in their responses. For those whose clients had other providers, a majority (91.1%) felt that they worked well with other providers. However, only 71.8% felt that they were part of a team with other providers. SLPs (66.7%, n=4), OTs (43.6%), SWs and (38.9%) most often said that 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. Reasons given for not feeling part of a multidisciplinary team included:

- 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;

When asked if they had ever planned joint visits or teleconferenced with other providers (other than family physicians) to discuss their client's care, only one-half (50.9%) of regulated health professionals said they had. 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.

A little more than nine out of ten respondents (93.1%) said that their training had prepared them to work with other providers. A little less than 9 out of ten respondents (88.5%) said they were able to use all the skills from their training that were needed and appropriate for their last client. Similarly, 6 out of 8 pharmacists said they were able to use all the needed skills from their training in the last 8 or all of their last 10 cases. The most frequent responses as to why they were not able to use all their skills had to do with limits in 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 provider (e.g. general practitioner) to allow respondent to use skills, or
- unwillingness of caregiver to allow respondent to use all required skills.

Only about 10% (9.5%) of respondents said they were asked to perform a delegated task from another provider and of those, only one did not feel adequately prepared to do so and that was an RN.

One measure of collaboration is the extent to which professionals feel that they are able to suggest changes to care plans. Once again with respect to their last client, 49.3% indicated that they wanted to suggest a change in the care plan and all but one of those who wanted to suggest a change actually made the suggestion. 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.

The accurate conveying of information may break down if providers do not communicate directly with each other. Almost one-half (49.0%) of respondents said that they had asked their last client to convey messages or health information to other providers. Almost fifty percent of RNs (51.5%), PTs (54.3%), OTs (46.2%), and dieticians (44.4%), one-third of SWs (30.0%), RTs (33.3%, n=1) and RPNs (26.8%), and 17% of SLPs relied on their clients to forward 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. Respondents 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. One-third (32.6%) of the regulated professionals said they were not informed of the decision to move the client in a timely manner. This may account for the fact that 42.7%

of respondents had indicated that, with respect to their last client they worked with, they have arrived to find that the appointment with the client had been cancelled. Roughly one-half (48%) did not know if there was a single person communicating the information to the facility. When their client returned home from the facility, over one-quarter of respondents (27.1%) did not receive information about the care plan promptly. See Table 22.

**Table 22: Transitions from Home to Hospital/LTC Facility back to Home**

Question	Yes (%)	No (%)	Don't Remember (%)	Total (%)
Thinking of the last client you had who had to go to hospital or some other care facility, were you informed of this decision in a timely manner?	64.8	32.6	2.6	100.0
When this client was transferred, did you know if there was a single person in charge of communicating all necessary information to the facility?	44.8	48.0	7.2	100.0
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?	69.3	27.1	3.6	100.0

Pharmacists (87.5%) more than any other profession said they were not informed in a timely manner that their client was transferred to a hospital or facility, followed by RTs (75.0%, n=3), and OTs (50%). See Table 23.

**Table 23: Respondents who said “No” to “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?”**

	RN	RPN	OT	PT	SLP	SW	RT	DT	PH
Count	20	9	21	7	1	8	3	0	7
%	31.3	20.5	50.0	18.9	25.0	40.0	75.0	0.0	87.5

With the exception of RPNs and DTS and PTs, at least 50% of regulated health professionals did not know if a single person was responsible for communicating all necessary information to the facility. Respiratory therapists (75%, n=3) and SWs (63.2%) more often than the other professionals said they did not know. See Table 24.

**Table 24: Respondents who said “No” to “When this client was transferred, did you know if there was a single person in charge of communicating all necessary information to the facility?”**

	RN	RPN	OT	PT	SLP	SW	RT	DT	PH
Count	33	13	22	17	2	12	3	4	0
%	51.6	34.2	53.7	46.0	50.0	63.2	75.0	40.0	0.0

More than any other professional, SWs (35.0%), RNs (31.8%) and OTs (29.3%) said that they did not receive information about the care plan promptly when their client returned home. See Table 25.

**Table 25: Respondents who said “No” to “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?”**

	RN	RPN	OT	PT	SLP	SW	RT	DT	PH
Count	21	10	12	9	1	7	0	1	0
%	31.8	23.3	29.3	24.3	20.0	35.0	0.0	10.0	0.0

### 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 *Having the appropriate type of provider providing care* (M=5.00), *Developing strategies to promote the health of clients and prevent their decline or illness* (M=4.82), *Ensuring that providers work to the full extent of their training* (M=4.80), and *Having CCAC case managers in all hospitals* (M=4.78). The strategies seen as least likely to make an improvement were pay-for-performance payment schemes (M=3.71), the provision of training on the roles of other health and social service providers (M=3.97), and the provision of training regarding the various parts of the health care system (M=4.00), communication skills (M=4.06) or how to manage conflicts with patient or other providers (M=4.06). These differences were statistically significant (F=25.376, df=13/182, p<001). See Table 26.

**Table 26: Regulated Health Professionals' Rating of Strategies to Improve the Integration of Care**

Strategies	Mean Response
Providers work to the full extent of their training	4.80
Strategies to promote the health of the client and prevent decline and illness	4.82
Having the appropriate type of provider providing care	5.00
Having CCAC case managers in all hospitals	4.78
Integrating the Family Physician into the care plan	4.53
Assigning CCAC case managers to Family Health Teams	4.21
Electronic health records	4.51
More portable information technology, e.g. handheld devices, laptops	4.30
Training in communication skills	4.06
Training in how to manage conflicts with patients or other health and social service providers	4.06
Training in the roles of other health and social service providers	3.97
Training regarding the various parts of the health care system	4.00
Training for health and social service providers in how to work together effectively	4.16
Implementing a payment scheme based on performance	3.71

The regulated professionals were also asked to review the 14 above strategies and rank the top 3 amongst them. Of the respondents who 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 having the appropriate type of provider providing care, and training in electronic health record. See Table 27.

**Table 27: Regulated Health Professionals' Rankings of 14 Strategies to Improve the Integration of Care (Percentage of Participants ranking each factor first, second, or third)**

Strategies	1st	2 <sup>nd</sup>	3rd
Providers work to the full extent of their training	10.4	9.9	7.8
Strategies to promote the health of the client and prevent decline and illness	23.4	9.9	9.9
Having the appropriate type of provider providing care	12.0	16.1	15.6
Having CCAC case managers in all hospitals	2.1	2.1	4.2
Integrating the Family Physician into the care plan	5.7	7.8	5.7
Assigning CCAC case managers to Family Health Teams	2.6	4.2	6.8

Electronic health records	14.6	12.5	7.3
More portable information technology, e.g. handheld devices, laptops	6.8	12.0	7.8
Training in communication skills	3.1	0.5	1.6
Training in how to manage conflicts with patients or other health and social service providers		2.1	2.1
Training in the roles of other health and social service providers	1.6	2.6	5.7
Training regarding the various parts of the health care system	0.5	1.6	3.1
Training for health and social service providers in how to work together effectively	2.6	2.6	6.3
Implementing a payment scheme based on performance	1.0	0.5	2.1

When asked what one thing they would change to improve clients' care in the home and community care system, 197 of the 243 professionals provided many suggestions ranging from funding issues; work issues; client care issues; issues regarding working with other providers; and system issues.

Issues regarding funding were the most frequently mentioned (57.4% of 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 28.

Suggestions about improving client care were mentioned by 41.6% of 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.

Issues regarding working with other providers were mentioned by 33.5% of 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.

System-level issues, mentioned by 32.5% of respondents, involve the entire home and community care system or health care system, and 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; 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.

Workplace or workers' issues, mentioned by 13.7% of 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 work place health and safety issues in the home. See Table 28 for a summary of all the suggestions by order of the frequency with which they were mentioned.

Amongst all the suggestions, increased funding was mentioned most often, followed by better information systems, single comprehensive care, and better collaboration amongst providers.

**Table 28: Improvements suggested by Regulated Health Professionals**

Suggested Improvements/Changes	Count (n=197)	Frequency
<b>Funding</b>		
Increase Funding/ More Resources/ More Staff	106	
Consistent/equitable/stable funding	5	
Increase accountability/introduce more outcome measures	2	
Total	113	57.4
<b>Client Care</b>		
Single Comprehensive Care/common care plans	29	
More timely care	17	
Improve access to care/one-stop shopping	9	
Greater consistency of providers/services, fewer providers in the home	7	
Improve quality of care/continuity of care	6	
Client focused care	5	
Increase non-medical/health care	3	
Introduce home Med checks	2	
Increase family member involvement with care	1	
Increase assistance with language barriers	1	
Increase respite care	1	
Increase palliative care	1	
Total	82	41.6
<b>Working with Other Providers</b>		
Better collaboration with other providers	28	
Greater respect for providers' roles, judgment, processes amongst providers	12	
Greater integration of FPs and CCAC case managers into the home	10	
Improve provision of supplies/equipment	6	
Total	66	33.5
<b>System Issues</b>		
Better Information Systems	35	
Better links between sectors of care	7	
More health promotion/disease prevention/fall and injury prevention	5	
Reduce the number of structural levels in care provision	4	
De-privatize community and home care	3	
More supportive housing/more alternatives to home care e.g. clinics, outpatient care	3	
Re-evaluate effectiveness of the CCAC model	3	
Greater Accountability; Pay for performance	2	
Money follows clients	2	
Total	64	32.5
<b>Work Issues</b>		
Adequate pay for community providers	9	
Better budgeting/less travelling	5	
More education and training of employees	2	
Decrease case load/increase client time/better use of provider skills	3	
Improve administration/reduce paper work/reduce duplication	3	
Improve workplace health and safety in the home	3	
Better hours of work/more stable hours of work	2	
Total	27	13.7

This concludes the report on the Regulated Health Professionals' perceptions and experiences of integration in the health care system.