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On April 1, 2009, AHS brought together 12 formerly separate health entities in the province: nine geographically based health authorities (Chinook Health, Palliser Health Region, Calgary Health Region, David Thompson Health Region, East Central Health, Capital Health, Aspen Regional Health, Peace Country Health and Northern Lights Health Region) and three provincial entities working specifically in the areas of mental health (Alberta Mental Health Board), addiction (Alberta Alcohol and Drug Abuse Commission) and cancer (Alberta Cancer Board).
Role Clarity:
An Interprofessional Perspective

Health Systems and Workforce Research Unit
Alberta Health Services, Calgary Health Region

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Acknowledgements

The following research has involved the commitment and continued collaborative efforts of many health care providers, administrators, research staff and other colleagues in Calgary. This work began with early discussions and subsequent focus groups completed as part of the study *Improving Quality of Care through Process Improvement: Redesigning Patient Assessment Processes*, which was completed in 2007. That project raised questions about clarity of interprofessional roles and suggested that further exploration was needed. The findings presented in this report arise from more recent efforts aimed at clarifying the roles of health professionals – one using care scenarios to discover the “thought processes” of various health care providers as they responded to questions about the care of a hypothetical patient and the other involving members of the interprofessional team who were invited to join a focus group to discuss findings arising from the care scenario exercise. We appreciate the willingness of providers and their managers to take time away from their hectic schedules to help us along the journey toward improving role clarity as a means of achieving effective collaboration in health care delivery.
Background

The growing shortage of health professionals and concurrent underutilization of many health care providers is placing increasing pressure on health care agencies’ ability to provide timely access to needed services. Consequently, many organizations are exploring the implementation of new service delivery models based on the principles of collaborative practice, to achieve optimal utilization of the health workforce, strengthen the provision of safe and high quality care, improve retention and enhance patient and staff satisfaction. **Collaborative practice** is commonly defined as “an interdisciplinary process for communication and decision-making that enables the separate and shared knowledge and skill of the care providers to synergistically influence the client/patient care provided.”¹ To guide development of its workforce optimization initiative, the Calgary Health Region defines collaborative practice as “care providers working together to contribute their knowledge and skills to patient care in a process of continuous communication and shared decision-making among patients/families and all of the care providers who are involved in a patient’s care to achieve outcomes that could not have been achieved by any one care provider working alone.”²

Effective collaborative practice requires that all members of the team have a strong sense of professional identity and are confident about the distinct role they play in care delivery. Research examining nurses’ (Registered Nurses [RNs], Licensed Practical Nurses [LPNs] and Registered Practical Nurses [RPNs]) and other providers’ perception of their roles has been conducted by the Health Systems and Workforce Research Unit [HSWRU] since 2003. This research has highlighted considerable role confusion within the three occupational nursing groups as well as between nursing and other health care professionals. It was found that most health care providers have a tendency to describe who they are as professionals (i.e. the role they are educated and authorized to perform) by reference to the tasks and activities they perform in enacting their respective roles. Given the substantial overlap that exists in the tasks or activities (e.g. medication administration, group therapy, patient assessment) performed by many health care providers, this approach to discussing professionals’ contribution to health care delivery results in substantial role ambiguity and in what some providers perceive as excessive duplication of effort. Few health care providers seem able to clearly articulate how differences in education, knowledge or expertise across professional groups

² Workforce Optimization Initiative [Web link to additional information and resources]

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does, or should influence decisions about the appropriate number and mix of personnel needed to optimize patient health outcomes and promote effective and efficient use of all health care providers. It is reasonable to assume that overcoming excessive role ambiguity could potentially help decrease inefficiency in service delivery. Ideally, all health care providers should be supported in fully enacting the roles they are educated and legislated to perform. However, in order to optimize the utilization of all members of the health care team, it is necessary to clearly articulate how the shared and distinct “knowledge and skill of care providers ... synergistically influence the client/patient care provided.”

Purpose

In an attempt to help clarify interprofessional roles, HSWRU conducted a small study with the goal of answering the question: “How do we make explicit the distinct roles of various members of the health care team, in a manner that helps leaders / managers make informed decisions about the optimal number and type of health providers needed to effectively and efficiently achieve intended patient/population (e.g. self-care capacity), provider (e.g. job satisfaction) and system (e.g. sustainability) outcomes?” It was hoped that by asking various members of the health care team to reflect on a specific care scenario (Appendix A), the manner in which they described assessment, planning, and intervention would begin to highlight differences in the “thinking processes” (i.e. the application of professional knowledge) that would then draw a distinction between providers. In the end, the study raised more questions than were answered.

A brief summary of the project and key questions that arose from the study are described below. Issues arising from this and other research conducted by the HSWRU are discussed concurrently, as a means of encouraging dialogue about approaches that must be taken to overcome the current ambiguity that exists among health professional roles. The goal in achieving role clarity is effective utilization of all health care workers, improved patient/population health outcomes, enhanced job satisfaction, and a sustainable health care system.

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Study Approach

A volunteer sample of health care providers (N=23) working in acute care (Geriatric Assessment and Rehabilitation Unit [GARP], in-patient neurology unit) and in the community (Carewest, Home Care) were invited to participate in a small exploratory study. Individual face to face interviews were conducted with participants representing a variety of professional disciplines. Interview questions related to one of two scenarios (geriatric chronic disease or Guillian-Barre syndrome) that described health issues in a hypothetical patient followed from admission to an emergency department, through to an in-patient unit, rehabilitation service, and eventually discharged to their home (Appendix A). The Geriatric Case described a married diabetic male living in a rural setting, admitted for treatment of an infected wound. The Guillian-Barre Case involved a 30 year old female with pneumonia and related complications, who was discharged from the Emergency Department to her parents’ home.

Subsequent to analysis of the interview data, a focus group involving a cross section of health care providers (e.g. Occupational Therapist, Recreation Therapist, Respiratory Therapist, Pharmacist, Social Worker, Health Care Aide etc.) was held to clarify questions that had arisen during the analysis and to bring additional perspective to the researchers’ interpretation of the data.

In the section that follows key themes that arose from the study are discussed. Representative quotes emanating from the interviews and the subsequent focus group are presented to better understand key issues that must be resolved in order to optimize the utilization of all members of the health care team.

Issue #1:

Are there opportunities to enhance health system performance (i.e. to use providers more efficiently) by eliminating overlap or duplication of effort in the delivery of care?

One of the key role functions of all managers is organizing, which involves determination of the number and type of providers needed to achieve strategic goals established at the unit, program or departmental level. It is difficult for managers to plan for and implement the “right” staff mix unless they understand the distinct contribution that various members of the health care team make in meeting the needs of patients and families. Previous research conducted with RNs, LPNs, and RPNs...
revealed substantial role ambiguity that contributed to perceived underutilization of all three groups of nurses and to potentially less than optimal patient health outcomes. The tendency of nursing providers and other health professionals to describe their roles (i.e. what they are educated and legislated to do) by making reference to the tasks and activities they perform is problematic given the overlap that exists in the tasks/activities performed by many health care providers. In order to overcome the role ambiguity that is inherent in this approach to defining health care professionals’ contribution to client/patient care, it is critical to better articulate what distinguishes one type of professional from another based on their knowledge and to identify where overlap exists.

A key question that must be answered when assigning patient care to more than one type of provider is what significant added benefit each brings to patients and families. If one professional group is as effective as another in achieving intended outcomes, then it could be argued that efficiency in service delivery demands that the lower cost provider be assigned to deliver care, all else being equal. The quotes that follow reflect some of the ambiguity inherent in determining whether different professionals add unique value when providing care or whether potentially avoidable duplication of effort occurs.

i. Perspectives of interview participants

Assessment:

- So if he’s driving a wheelchair, is he going to be safe driving the wheelchair? Can he use his walker properly? Does he know where things are in space, so he doesn’t have to look at it all the time? (Occupational Therapist [OT])
- And looking at adaptations, if getting to the pool does the seating work to get up and get dressed? What footwear needs to be safe because balance is impaired? What is your ability in that actual task of swimming? (Rec Therapist)
- So again, assessing him for mobility aids and safety on stairs, level and uneven surfaces. And again, I would consult the OT. (Physiotherapist [PT])

Wound care:

- They’d bring in wound care nurses to assess his foot and look at the treatment, because he could lose his foot. (RN)
- But he could be assessed by a nurse or a physio. The nursing end of it would cover more the dressings and the medication that is going on. The physio do kind of—they will do some of that as well, but they could do the direct debridement of the ulcer. Sometimes they’ll do some hydrotherapy of the ulcer. (PT)
- And because he’s got a wound that’s not healing, I would actually think that maybe this would be a good time to intervene with some therapy for sleep apnea … And what we have
found is people that have wounds that don’t heal, a month later, they’re all healed up. (Respiratory Therapist [RT]).

ii. Perspectives of focus group participants

It was difficult for participants to spontaneously and explicitly describe what they perceived was the distinct role of each of the professions represented in the focus group. The difficulty that providers face in describing their roles raises questions about the way in which they are socialized into their roles. Do professionals understand the philosophical and theoretical basis of their respective disciplines upon entry to practice, or do they come to understand their roles as a result of the sum of the courses and clinical experiences to which they are exposed throughout their program of studies? Do student practicum experiences provide sufficient opportunity to integrate theory into practice, or is the focus primarily on developing competency in skillful performance of a variety of tasks? Does the “role modeling” that students see during their practicum experiences predispose them to valuing the tasks and activities that they see “expert” practitioners performing? Since students see few examples of interprofessional collaborative practice in the clinical environment, is it surprising that they have little understanding of the roles of their professional colleagues?

Despite the inability to articulate differences in professional knowledge (i.e. in roles), most providers could readily describe how their respective roles are enacted (i.e. what they actually do) in practice. Participants noted that PTs primarily address functional impairment with a view to helping clients/patients achieve their maximum physical potential, whereas OTs complement the work of PTs by enabling individuals to adapt to their physical and social environment as optimally as possible despite physical, cognitive and/or psychological limitations. OTs describe their “value added” as helping individuals achieve their personal health and work-related goals subsequent to an illness or injury. The role involves reviewing what a person can or cannot do in relation to activities of daily living, in order to ensure safe discharge home or recommend a different level of care. Recreation Therapists further complement the service of PTs and OTs by focusing on leisure, healthy lifestyles, and connecting people with community resources (e.g. transportation, bridge clubs, etc.) that allow them to take full advantage of the potential to improve their quality of life. Rec Therapists lack the depth of assessment skills of OTs and speech language pathologists [SLPs], but work closely with those professionals in helping individuals return to the lifestyle and leisure activities that were of interest to them prior to their illness or injury. Participants noted that while these three roles are distinct, they are not without overlap and “grey areas.”
Role overlap also occurs between OTs and SLPs and at times with psychologists and/or social workers [SW]. Both OTs and SLPs assess and manage patients with cognitive impairment, although the roles become more “fuzzy” when dealing with patients who suffer from short term memory loss or attention deficit. While SLPs primarily focus on the relationship between cognitive impairment and the ability to communicate, OTs focus on helping patients return to optimal performance of activities of daily living. Assessment by OTs may be carried out to determine how cognitive impairment may impact activities of daily living, while a more in-depth assessment by a psychologist may be required to determine an individual’s capacity to return to work. Some, though not all SWs also perform cognitive assessment provided they have additional training that is specifically related to the nature of the job they perform.

It was clear from the focus group discussion that for the most part, health care professionals perceive little difficulty in sorting out who will perform what activities for which patients. Although there was no discussion specifically related to the process of decision-making, it seems that an explicit understanding of how differences in knowledge and skill account for how different professionals ought to be utilized does not factor into the process. As noted by one of the focus participants, “SW, OT and Psychology ... the overlap is huge and we expect that. What do you need to know to do this job ... and none of the professions own knowledge. What are the restricted activities, what can you learn to do this job, how much training is involved? Certainly not every Social Worker needs to know cognitive assessment. It varies depending on the area you work in, the knowledge you will have and how you’re going to apply it.”

As this quote implies, continuing education provides opportunities to cross-train providers from a variety of health professions to perform specific tasks or activities associated with particular program or service needs, which may well contribute to role ambiguity in practice. Regardless of similarities or differences in the foundational or core knowledge that distinguish disciplines during the “pre-service” phase of professional education, focus group participants explained that additional skills or activities can be performed with equal competence by a variety of professionals, provided they have access to on-the-job training, post graduation. If that is indeed the case, should the following questions not be asked?
Do educational programs provide sufficiently different theoretical knowledge to justify the number of distinct professional groups that currently work within the health care system?

In light of increasing cost constraints and faculty shortages, could or should some professionals programs be merged to reduce the number of distinct professional groups whose knowledge base reflects substantial content overlap?

Are the right people being involved in decision-making about the content and duration of educational programs? Who determines whether there is excessive duplication in the foundational knowledge taught across health professions and whether that contributes to unnecessary duplication in the practice setting?

In prior research conducted by HSWRU, considerable duplication in conducting and recording patient assessments was reported by a number of health care providers. Nurses often mentioned that assessment was a means of “getting to know” the patient and therefore they needed to conduct their own assessment of that patient’s status, regardless of what another nurse may have documented on the patient’s chart. They also noted that “the need” to repeat assessments performed by another provider was in part a function of workload (e.g. “I know that OT did an assessment, what did they do? Oh, I don’t know, I’m so busy”), but also reflected a lack of trust among providers within and/or across professions.

- *We’re wondering sometimes about the trust ... you know, the physician asks the same questions, multiple nurses ask the same questions and the patient gets tired ... They’re tired of telling you the same story over and over again.* (Process mapping focus group)
- *There could be a number of consultations ... they could be assessed by OT, PT, speech, dietary and social work.* (Process mapping focus group)
- *I looked through the chart and the client history was there four hundred times. Four hundred times! The physio would write it and the OT would write it and speech would write it and the nurse would write it ... and the resident would write it and on and on. And the same history was repeated!* (Process mapping focus group)

Participants in the “process mapping” focus group acknowledged that the potential for considerable overlap in assessments exists as a result of “grey areas” or role overlap across many occupational

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4 HSWRU (2007) Improving Quality of Care through Process Improvement: Redesigning Patient Assessment Processes (not published)
groups. Participants also confirmed that the “sequential” nature of referrals from one professional to another without the benefit of face to face consultation about care plans is one factor leading to duplicate assessments. A number of other factors influence duplication in care, thus inhibiting efficient utilization of providers. For example, patient care records and policies related to documentation that vary across settings (e.g. “Home care will have their own, long-term care will have their own and when a client is going from one facility to the next, you have to repeat that assessment”) and reporting requirements can be perceived as unnecessarily adding to repetition of information that may not improve delivery of care (“… the implementation of this whole MDS [clinical documentation system]. You repeat the assessment ... you do it initially when they come, you repeat the assessment every three months and then, if there’s a change in status or if the client has been to the hospital, you repeat it again”).

Observations
Substantial overlap in roles and unnecessary duplication of effort among providers not only threaten sustainability of the health care system, but also hinder effective long term health human resources [HHR] planning. It is difficult, if not impossible to forecast the future need for different types of health care providers by making reference to the type of activities (e.g. cognitive assessment, functional assessment, and wound management) performed by various members of the health care team. It would seem more effective to clarify what the differences are in the core knowledge of various providers in order to determine how changing health care needs might influence the need for various types of providers over time. For example, health policy increasingly focuses on the importance of promoting health, preventing disease and injury, and enhancing self-care capacity among patients and families. The promotion of health and well-being underpins the practice of certain health professionals (e.g. RNs and health educators) whose education is heavily focused on enabling them to perform health promoting functions as part of their role. Other providers play a stronger role in the medical management of patients through episodes of illness and rehabilitation (e.g. physicians and PTs). Yet other providers are highly skilled in the application of technology (e.g. radiation technologists).

Rather than focusing on the overlap that exists in the performance of tasks (e.g. medication administration) or activities (e.g. cognitive assessment) among providers, might it not be more fruitful to discuss future HHR planning alongside patient or population needs based forecasting? As the
population becomes increasingly culturally or economically diverse and social patterns change (e.g. more single parent families) what influence will that have on the need for more social workers, psychologists or other mental health workers? Are differences in education and professional knowledge currently reflected in the utilization of the health workforce? Recently completed research further examining the utilization of nursing roles (e.g., RNs, LPNs, and Health Care Aides [HCAs]) in acute care suggests they are not.  

**Issue #2:**

**How do managers determine which provider might be most appropriate (i.e. most effective in achieving intended outcomes) when several providers seem to focus on similar aspects of assessment and/or patient care needs?**

Interview participants were asked to describe their response to the care issues outlined in the case scenarios (Appendix A) in order to help clarify the distinct contributions that each professional makes in the provision of care. It was assumed that differences in role enactment would emerge as different professionals responded to the same care scenario, but data analysis revealed inherent challenges in clearly articulating differences in roles.

- *And we’ll still be assessing like how he’s doing with his own care, own washing ... and get him stronger; get him more independent, so he’s doing everything for himself.* *(RN)*
- *So it’s assessment of ADLs, which is activities of daily living and how well she can get her own clothes on, how well she can brush her teeth and brush her hair and things like that. And how well she’s able to manage outside of the hospital world?* *(LPN)*
- *We just more focus on the leisure and recreation part of it, as opposed to physio, right? Or the activities of daily living, which really, that’s where a lot of the overlap keeps happening between PT/RT and OT ... the activities of daily living.* *(Rec Therapy)*
- *Occupation therapy would still be involved with regard to his activities of daily living (OT).*
- *Again, any equipment needs to facilitate those ADLs. And looking at his function with regard to being in his environment."* *(PT)*

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i. Perspectives of focus group participants

Focus group participants found it difficult to express what differentiates them from other providers when asked how they might articulate what their distinct or specialized role is in order to help colleagues better understand how to effectively utilize them.

*It is difficult for any one person to articulate on behalf of their profession. Even with a lot of the managers that we work under, there is not a lot of clarity of what the role of each professional is. Professional practice committees where professional practice leaders are chairs would be a great resource [in helping to clarify roles].*

Most focus group participants agreed with the premise that decisions about assignment of care to a particular type of professional are often based on their own or managers’ assumptions about what is the role of that provider, rather than on a clear understanding that a particular type of professional knowledge might be more beneficial to patients in a given situation. Consequently, referrals are often made “sequentially” from one provider to another, often inappropriately, thus placing an unnecessary burden on professionals who already feel overworked. This creates frustration and no doubt contributes to job dissatisfaction among providers, with negative implications for the quality of patient care. A comment made by one focus group participant clearly reflects the underutilization of professional skills and knowledge that results from lack of knowledge about colleagues’ professional roles.

*...Some team members may request a specific “test” be done on a patient and treat other disciplines as technicians. For example, a decision has already been made to discharge a patient to long term care and the date is arranged. As the LTC facility needs a score regarding the mental status, the OT is asked to complete the MMSE or the pharmacist may ask for this score so that Aricept can be prescribed. No other functional information is wanted / desired or requested and will not change discharge plans. Thus, OTs are often saying no to these requests, as they do not utilize any particular OT skills, will not affect outcomes and any other member of the team can do the MMSE. However, they are often being “bullied” into doing this. If there is no need for any overall functional review or recommendations, then OT services do not seem to be indicated. It would be like us trying to tell physicians (or any other discipline) which test they should perform. The perspective has to be considered that too many requests are being made of other professionals, when they will have no ultimate impact on pre-determined recommendations, and these disciplines are trying to say no, but to no avail.*

The quotes presented below demonstrate how ambiguity in professional roles contributes to unnecessary referrals that are costly in terms of both wasted professional time and over-utilization of finite health care services.
• A lot of times, even the physicians don’t really know what each of us provides and what our role is. So they just cover the bases… *(Rec Therapist)*

• When the word medication comes up, it seems like it is an automatic referral. It is typical for us that when a patient cannot afford their medications, we are asked to do something. We cannot address financial issues and do not know the resources out there. *(Pharmacist)*

• In home care, many times people are referred to me because they want to lose weight, but are not at a stage in their care where I can manage or help them. *(Dietician)*

• In acute care, inappropriate referrals happen a lot. An example for us is where a stroke patient in the hospital is put onto a feeding tube and a referral for a swallowing assessment is sent to Speech. With the person essentially unconscious the referral does not make sense. People seem to focus on what they do and remove themselves from some responsibility ... and pass on a referral regardless if the timing is wrong. *(SLP)*

• Again, a psychiatrist would be called in as well, because a psychiatrist would probably be the first line of attack, in terms of capacity say. The psychiatrist may say: “Well, I recommend neuropsych testing to clarify this issue.” I would be called in then. Occasionally, I’m called in first line. I’m never sure why. I’m never sure when they do that why they did that. Why they wouldn’t go through the psychiatrist first. I’m not always clear why. *(Psychologist)*

Many focus group participants reported that they receive a large number of referrals from other professional colleagues. In many cases however, the reason for the referral is unclear or so much “irrelevant” information is provided that it is more expedient for that provider to conduct his/her own assessment of the patient’s needs than to try to determine why the patient was referred to begin with. Clearly, role ambiguity is not only inefficient, but it may also result in incorrect assessment of a patient’s needs and may result in less than ideal health outcomes.

**Unanswered Questions**

Given the overlap that exists in activities performed by various occupational groups, the following questions seem to beg for an answer:

- How do managers make informed decisions about how many of each type of professional is needed to meet patient health needs at any given time?
- How are decisions made about what is an appropriate staff mix now and in the future, given current and future patient and population health needs?
- Do we know if or how patient health outcomes are influenced by the different types of professionals involved in the delivery of care? If not, how do we judge the impact on quality of care when different professionals are assigned to manage the care of a particular patient?
For example, will the plan of care emerging from an assessment of patient health needs be the same regardless of who conducts the assessment? If we assume that the knowledge base of a psychologist or psychiatrist is substantially different from that of a registered psychiatric nurse, would it not be reasonable to assume that some patients might benefit more from an assessment conducted by one provider versus another?

The quotes below provide some insight to the questions posed above:

- *Anyone can do the screen. The MMSE, the mini-mental state examination. So a screen would be done on initial assessment for sure by whoever does the initial assessment (OT).*
- *So if his complaints are anxious complaints, then of course, looking at social work and psych. Perhaps they don’t have enough supports in the home, so kind of looking to see. Social work is certainly involved with that. Looking at what the next plan would be. (PT)*
- *So this scenario didn’t really talk about what his cognitive status is. We assume he’s intact and competent. That would be assessed. But exactly who assesses and who intervenes is quite grey to me. But it is potentially the role of the OT, but also psychology and psychiatry. I think social work can do some cognitive assessments to an extent. So that is an area, to me, that is quite grey. (OT)*

If the expectation is that outcomes will likely be the same regardless of which professional provides the care the key question becomes why do we need several different types of professionals in the workforce and different approaches to educating them? Having the right person perform the right work for the right reason and in the right setting is an important principle of the workforce optimization initiative in the Calgary zone, but should the decision of what is right be made on a case by case basis, and if so, how does that reconcile with the need for long-term needs based health human resources planning, another feature of the workforce optimization initiative? From a sustainability perspective, if it is difficult to differentiate the contribution of one provider versus another (e.g. SW, OT, RPN) should we not simply educate more of the least costly provider and perhaps have fewer of those who are more costly?
Issue #3:

Are there “missed opportunities” to utilize health care providers more effectively and efficiently?

A recurrent theme emerging from analysis of the interview data was the recognition that more could be done to enhance service delivery and improve quality of care if providers were encouraged to consider patient health needs along the entire continuum of care. This perception of “missed opportunities” to make a difference was reinforced by focus group participants, who identified a number of “structural” issues that contribute to ineffective use of health care professionals. Providers from in-patient, out-patient, community or continuing care settings seldom, if ever, have an opportunity to discuss patient health care needs with each other. In addition, many are unaware of the services provided by professional colleagues working in settings other than their own. As a result, care may be provided in one setting when it would be more appropriate to refer the patient to another setting. “You cannot do it all in an acute care hospital and need to ask where should we provide care rather than where can we provide care?”

- Talking about wellness to a 65 or 70 year old patient who just fractured their hip ... their concern is about how am I going to get to my house, how am I going to go pee, how am I going to shower? They are not going to have full function or weight bearing for 6 weeks. So it is not a great time to talk about exercise or smoking cessation. If we could have something in place 6 weeks after that would be great ... as well as before the fracture. (PT)

- In the discharge summary check list, education is checked off as being done. However everyone got 5 minutes and took it on the last day. And that was not about the patient getting educated. That was about us filling a need of yes I have to go in and do this education. That patient did not get any of the information because they were constantly bombarded with information and it was not focused on them. Addressing health care not only in acute care but transitioning in community with proper supports so that patients get the appropriate person at the appropriate time. (RT)

As reflected in the above quotes, focus group participants agreed that patient / family needs could be better met if there were opportunities for relevant members of the health care team to meet occasionally to discuss care plans, particularly when care needs are complex and multiple health care providers are involved. Unfortunately, most participants reported those opportunities are rare, given that case conferencing across boundaries (e.g. acute care, community care) is not expected practice among professionals.
I do not think we do that with families let alone with each other because it becomes a referral and referral and referral. I might read this provider’s referral and they might read mine, and this is how it goes down the line. We don’t actually meet and talk as a group, so we miss a lot of things that way. In many cases we treat symptoms a lot of times rather than the person where there are other issues going on that are not my area of expertise (RT)

In home care this is particularly true. There is a huge issue with a lack of accessibility to other providers especially given the hours we work. We are not in the clinic from 9-5. As a result of our role we develop particular relationships with patients where they may tell you so much more than they tell a nurse or physician. However in attempting to pass on that referral there is no direct access to OT or Dietary, etc. So our referral goes to the RN and we don’t know where it goes [from there]. (HCA)

Focus group participants indicated that they did not know who in the organization was responsible for making short or long term decisions about the type and number of health professionals needed to meet patient health care needs, or understand the process of how those decisions are made. Nonetheless, it was clear that in many cases there was a perceived mismatch between the needs of patients and the availability of the right type of provider to meet those needs.

Well, ideally, you’d want him to see a dietician, but you know they don’t have that kind of stuff anymore. They just focus more on a real critical kind of needs, not just general diabetic kinds of things. So who else? (RN)

In long term care there is little respiratory therapy support and it has completely overwhelmed people. We had completed case reviews of patients in the care facilities. There were patients diagnosed with COPD or asthma who were visually short of breath and who complained of shortness of breath and there was such complacency ... “that is just Bob”. However in going back through his chart Bob used to be on medications for his breathing but those had not been ordered since he came here. (RT)

We often get referrals for Rec Therapy in acute care, and although there is a role for us we do not have funding for Rec therapy in acute care. (Rec Therapy)

Sometimes people would refer but think that we are swamped and so won’t refer. This is not an acceptable reason but it is sometimes what we act on ... Maybe it would be better to have some RNs and Dieticians to work in the diabetic area than some where else. (RT)

Summary

If we aim to achieve effective and efficient utilization of the health workforce, it is crucial that we understand the distinct and shared contributions made by various members of the health care team. The growing shortage of health professionals and recent economic downturn will place increasing pressure on health care organizations to manage their resources efficiently and effectively.
Results from the current study have validated findings from earlier research suggesting that role ambiguity is a significant issue across the professions and has highlighted the need to improve the utilization of health human resources by clarifying professional roles. It is difficult, if not impossible to make appropriate decisions regarding the number and type of health care providers required to address current and future patient health care needs without explicit knowledge of the contribution that each provider makes to achieving intended patient health care outcomes. Failure to address the current ambiguity that exists across provider roles will make it difficult for health care leaders to demonstrate accountability for the quality and sustainability of the health care system.

**Next Steps**

This report summarized the reflections of the research team involved in collecting and analyzing data obtained from a variety of projects conducted over time. It was important that those who provided the information have an opportunity to confirm, contest or alter the interpretations made of the views they expressed. Feedback has been received from those who chose to comment on the issues and questions raised in this report. We will now follow through with a recommendation made by one of the participants – that we invite professional practice leaders (including academic faculty members) to come together to help us better articulate similarities and differences in the roles of interprofessional team members.
Appendix A. Patient Case Study Scenarios

Guillain Barre

PATIENT PRESENTS

Chris, a previously healthy 30 year old female was admitted to the hospital on May 10th, 2006 with a diagnosis of pneumonia, upper respiratory track infection, and progressive lower extremity weakness.

She reports that she has been having progressively more difficult time walking and just feels weak. She presents with a two-week history of tingling in her hands and feet which progressed to her inability to stand independently. Chris was diagnosed with Guillain-Barre on admission.

Having the information above, what would your assessment of Chris involve? What would your plan of care be for Chris and what treatment would you suggest or directly provide? If providing the treatment, is it carried out independently or as per a physician order? Would you consult any other discipline at this point?

On her 3rd day of hospitalization, Chris was unable to move her extremities and displayed laboured breathing.

At this point, what would your assessment of Chris include, what would be your plan for care and what treatment would you suggest or directly provide?

Chris is admitted to the ICU on the 4th day of hospitalization and placed on a ventilator.

At this point, what would your assessment of Chris include, what would be your plan for care and what treatment would you suggest or directly provide?

Chris has an extended ICU stay, and is removed from the ventilator after 21 days of mechanical ventilation. Her tracheostomy tube remains open and patent. She’s discharged to a rehabilitation unit for further management.

At this point, what would your assessment of Chris include, what would be your plan for care and what treatment would you suggest or directly provide?
After 6 weeks of hospitalization, Chris is transferred to a Rehabilitation Center for evaluation and a treatment plan by the rehabilitation team.

As a member of the rehabilitation team, what would your assessment include, what would be your treatment plan be for Chris? Would you consult any other discipline at this point?

After 2 months of rehabilitation, the plan is to discharge Chris to her parent’s home.

What would your discharge assessment include at this time? What is your plan for care and what treatments would you suggest or directly provide? Which disciplines would you include in the discharge discussions?

Chris is discharged to her parents home. Her tracheostomy continues to be open and patent. She is ambulatory for short distances with some assistance. She requires a walker for distances greater than 25 feet. She needs a wheelchair for mall shopping.

What would your continued assessment of Chris include? What is your plan for care and what treatments would you suggest or provide to Chris at this time?
Geriatric Case Study

Mr. Jones is a 65 year old who resides with his wife in a 2-storey farmhouse on a large acreage.

He has a 15 year history of type 2 diabetes, complicated by retinopathy, peripheral and autonomic neuropathy, coronary artery disease and peripheral vascular disease. He has had amputations of two of his toes and right forefoot. In addition, he has had a CABG X 4. He received a Kidney transplant 5 years ago. Prior to his transplant, Mr. Jones had a history of hypertension. Since his transplant, Mr. Jones has had orthostatic hypotension, controlled by making postural changes slowly, sleeping with the head of the bed raised, and a high salt diet. Due to his kidney transplant, he's also on $1200.00 per month worth of immunosuppressive drugs, which are partially covered by insurance.

He has a long smoking history, starting at an age of 12 but quit his 1 to 1.5 pack a day habit about 10 years ago. He has a persistent cough but does not complain of chest pain or shortness of breath. His wife reports that he's occasionally restless when he sleeps and snores throughout the night. He sleeps best propped up with two pillows.

He complains that his feet has been numb but denies any pain with ambulation. He reports that he has never fallen but recognizes the potential seriousness of a fall. Due to his current medical status, Mr. Jones no longer works. His wife has since returned to as a clerk in the evenings. This arrangement allows her to take care of Mr. Jones during the day and allows her to bring him to his frequent medical appointments.

Hospital Admission:

Mr. Jones was seen in the Emergency Department for what looked like an infected right foot. He had an ulcer on his right foot that was not healing, it looked badly swollen and erythematous and draining green purulent material. He had a large blister over the metatarsal plantar aspect of the foot and arrived in ED with a temperature of 38 degrees Celsius.

At this point, would you or should you be brought into the care of Mr. Jones? If you are brought in to care for Mr. Jones, what would your assessment include and why. What would you plan on doing with the information from your assessment (ie. Directly provide treatment to Mr. Jones, make recommendations, consult another service or provide treatment to Mr. Jones after an order from the Physician).

Mr. Jones was admitted for further evaluation and treatment. He was started on antibiotics and had his plantar space of his right foot incised and drained. The purulent material was sent for cultures.

Culture Results: Staph. Aureus, Strep. Intermedius and Strep. Constellatus
At this point, would you or should you be brought into the care of Mr. Jones? If you are brought in to care for Mr. Jones, what would your assessment include and why. What services would you provide to Mr. Jones? What would you plan on doing with the information from your assessment (ie. Directly provide treatment to Mr. Jones, make recommendations, consult another service or provide treatment to Mr. Jones after an order from the Physician)?

Mr. Jones right foot is amputated 8 inches below his knee. No intra or post-operative complications are noted.

At this point, would you be involved in the care of Mr. Jones? What would your care include? What would your assessment include and why. What interventions would you provide Mr. Jones, if any and who would you consult, if any?

3 Days post surgery, Mr Jones was able to transfer to his wheelchair with minimal assistance. He is able to do his own oral and hair care. Is able to wash his upper body and able to feed himself. He is able to dress his body independently but required some assistance to dress his lower body due to fatigue from exertion and trunk instability. He required total assistance with all other lower body care such as bathing, toileting and changing of wound dressing. The surgical site remained clean and dry and only slightly edematous, with the skin pink and cool to the touch. He reported feeling tired with very little exertion such as sitting on the edge of the bed. He is also complaining of poor sleep and reports that he often has headaches when he wakes up and has a tendency to fall asleep in the middle of the afternoon.

How would you be involved in the care of Mr. Jones at this point. What would your assessment include and why? What other disciplines do you think should be or would be involved in his care at this time?

An interprofessional team is now needed to plan Mr. Jones discharge to a rehabilitation facility.

Team members from what services should be involved with this planning? Provide a brief rationale for why you think each of the members should be involved (ie. How will they contribute to the team).

Mr. Jones is transferred to the rehabilitation facility 12 days post-op. His orders included:

- Medications: Immunosuppressants, Aspirin, Multi-Vitamin, Fludrocortisone, Proton pump inhibitor, stool softener, magnesium oxide and insulin.
- 2400-calorie diet with 3 gm sodium, 3 meals/3 snacks per day.

Team members from what services should be involved with Mr. Jones care at the rehabilitation facility and why? What would your assessment/evaluation of Mr.
Jones include at this point and why? What kind of services would you likely be providing to Mr. Jones?

The team has done a great job with Mr. Jones and the plan now is to discharge him home in 10 days.

Team members from what services should be involved in planning Mr. Jones discharge and why. What would your plan for treatment be for Mr. Jones for the following 10 days and what would you be concerned with once he returns home?

During a short outing to the shopping center with his care aid, Mr. Jones reported experiencing mild distress regarding the amputation of his lower right leg, although he remains comfortable with his decision. He acknowledged distress regarding his decline in physical functioning in recent years and his increasing need to depend on others for assistance, particularly since the amputation. He also expressed concern regarding the impact his medical problems are having on his wife.

How would you be involved in Mr. Jones care at this point? What would your assessment/evaluation involve and why? What would your interventions be, if any?

HOME MANAGEMENT

Mr. Jones is discharged home after 8 weeks at the rehabilitation facility. During his last week there, he experienced a temporary loss of coordination of his right hand and a short spell of slurred speech. Investigations showed that Mr. Jones had a transient ischemic attack (TIA). Upon discharge, he was tolerating weight bearing on his prosthesis for less than 30 minutes. Using a roller walker Mr. Jones could ambulate independently for less than 20 feet before having to rest because of SOB and fatigue. His diabetes continues to be poorly controlled causing worsening of his vision, sensation and reflexes. Mrs. Jones continues to work in the evenings.

What would your assessment/evaluation of Mr. Jones include at this point and what would be your treatment plan? What services would you provide Mr. Jones, in any?