

The Dietitian Workforce in Ontario Primary Health Care Survey Report

September 2015

Executive Summary

Dietitians of Canada's (DC) Ontario Primary Health Care Action Group surveyed DC members working in primary health care settings in spring 2015 to:

- Describe the current dietetic workforce in Ontario primary health care (PHC)
- Assess job satisfaction and compare satisfaction with previous dietetic workforce surveys
- Investigate use of outcome measures by PHC RDs
- Assess scope of practice issues

403 responses were received to the electronic survey. Highlights of the results include:

- 87% of respondents are not satisfied with compensation.
- 35% of PHC RDs intend to leave their current position within the next two years, and another 50% are undecided. Only 22% plan to stay in their current position beyond the next two years.
- Many RDs feel undervalued at their workplace.
- 93% of respondents agreed or strongly agreed that nutrition care was integrated with other providers within their organization.
- Poor integration with other sectors (acute care, LTC, homecare, public health) is perceived.
- The major work activity is Medical Nutrition Therapy for Chronic Disease Management, and RDs perceive the impact of their practice is significant in this area.
- Due to lack of resources (time and FTEs), RDs are not practicing to their full scope which includes prevention and promotion activity.
- Preceptoring and mentoring of interprofessional learners and fellow RDs is part of many PHC RD's practice.

Acknowledgements

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The following Registered Dietitians provided additional support in the development and analysis:

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Introduction

Registered Dietitians (RDs) practice in primary health care settings throughout Ontario, including Family Health Teams, Community Health Centres, Nurse Practitioner-led clinics, and other settings. Health human resources challenges within the sector, including recruitment, retention, and job satisfaction, have been identified by Dietitians of Canada Ontario Primary Health Care Action Group (PHCAG). PHC RDs were surveyed in an attempt to describe the current workforce and roles of the RD, and to identify factors that support integration of primary health care RD roles into the health system. Workplace satisfaction was assessed by repeating questions from the Ontario Dietetic Workforce Survey (Dietitians of Canada, 2009a, 2011).

Methods

An electronic survey was developed with input from members of the PHCAG and communicated to DC members through the Family Health Team (FHT) RD electronic listserve and the Community Health Centre (CHC) RD Ontario Action Group. In addition, all Nurse Practitioner-led clinics (NPLC) were contacted electronically to reach any RDs working at NPLC that do not belong to the FHT RD electronic listserve.

Response

A total of 403 responses were received, from Family Health Teams (n=207), Community Health Centres (n=162), NP-led clinics or Family Health Organizations (n=34). Although accurate response rates were unable to be determined for all sectors, the FHT RD listserve reaches 350 members, with the 207 FHT responses reflecting a 59% response rate.

Responses were received from dietitians in every LHIN in the province, with a range of 7 – 36 responses from each LHIN.

Results

Full-time and Part-time Work

Sixty-six percent of respondents worked full-time (>36 hours/week) for one employer, slightly higher than the 63% reported in the 2012 survey. The survey also explored the reasons for part-time work--23% of the respondents that worked part-time (18 – 35 hours/week for one employer) or casual indicated that it was because no full-time work was available. This is a positive change from the 2012 survey where 50% of part-time employees did so due to lack of full-time work, instead of for personal preference.

Experience

The responses showed that dietitians with less than 5 years of experience continue to make up the greatest proportion of the PHC workforce. Compared to the 2012 survey, there has been some aging of the workforce as shown by the shift to greater numbers in the 6 – 10 years experience category, and a decline in RDs with 20+ years experience, likely reflecting retirements or movement to other sectors such as acute care or LTC (Figure 1). A similar distribution of experience was shown in all sectors.

Seventeen percent of respondents had been in their current position less than one year, while 50% reported 1 – 5 years. Only 16% of respondents had been in their current position for more than 5 years.

These findings have implications for professional development and support for dietitians new to the PHC setting as well as those new to the profession. Since many FHTs and CHCs employ only one dietitian, linkages to colleagues for mentoring is particularly important. The profession's continuing education opportunities, the list serves for FHTs and CHCs and the professional Networks provide this mentoring. The job profile for PHC RDs developed by DC's Ontario PHCAG advises that 3 – 5 years experience in clinical nutrition and counseling experience is needed to deliver high quality nutrition services (DC PHCAG, 2010). Unfortunately, low compensation rates set by the Ontario government's Guide to Interdisciplinary Provider Compensation (Ministry of Health and Long Term Care, 2010) for dietitians working in PHC have defined the dietitians' role as entry level; thus, contradicting the depth and breadth of experience needed to provide optimum service, retain providers in the roles long-term and add further workload to mentors within the sector.

Dietitians with less than 5 years of experience continue to make up the greatest proportion of the PHC workforce.

Figure 1: Years of Practice as a Dietitian

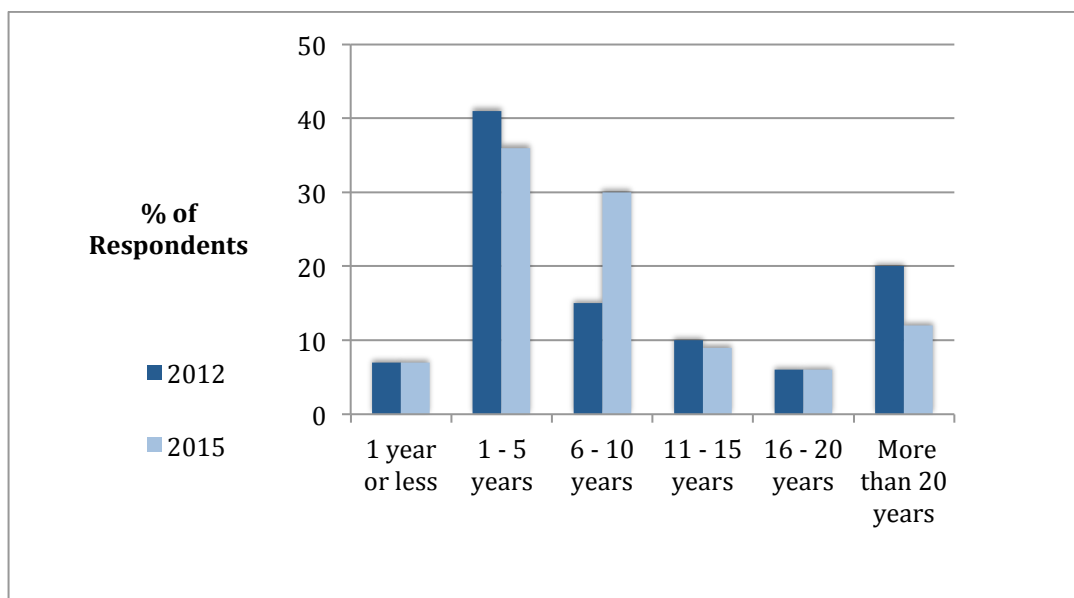
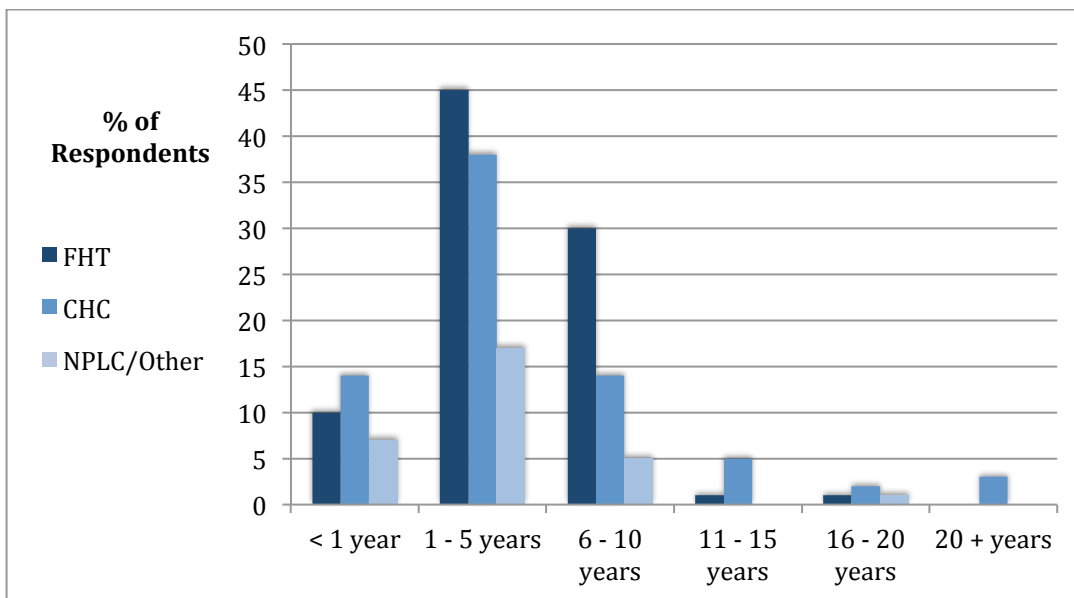


Figure 2: Years of Practice by PHC Setting



Additional Certification and Training

More than 87% of PHC RDs have advanced training, with 34% holding a Master's degree and 54% specializing in diabetes education (Certified Diabetes Educator credentialing). Registered Dietitians also reported attaining certification as lactation consultants, personal trainers, and in motivational interviewing techniques.

RDs in primary care are advocating for nutrition screening within family practice for populations at increased nutritional risk such as children and seniors. Within PHC, 27% of RDs have completed training on screening tools including Nutri-step®, a validated tool to identify toddler/preschooler feeding issues, and Subjective Global Assessment (12%), a validated tool to identify level of malnutrition within seniors.

Ten percent have completed training in Nutrition Cognitive Behaviour Therapy (Nutrition CBT) to become Craving Change facilitators, a program aimed at helping individuals identify the internal (thoughts, emotions, mood) and external (environment, family, friends, work) factors that influence their food choices. These additional qualifications bring value to their clients and the health system, yet are not often reflected in the compensation.

Job Vacancies

There were 41 unfilled RD positions reported in the survey, 22 at FHTs, 18 at CHCs, and 1 at a NPLC/FHO. This question was not asked in the 2012 survey, and there is no available data to compare these vacancies. The self-reported data is limited due to the inability to know if the same positions were reported by more than one person, nor were reasons provided for the vacancies (e.g. unable to fill due to lack of appropriate compensation or rural location). Dietitians of Canada continues to advocate for national data collection on RD workforce supply and demand to provide a clearer picture of workforce requirements. At present, there is no system of tracking vacant positions for dietitians in PHC or other sectors.

RD Activities — Medical Nutrition Therapy and Health Promotion/Disease Prevention

Medical Nutrition Therapy (MNT) is the application of food and nutrition expertise to provide care for a variety of conditions and illnesses to improve health and quality of life. Medical Nutrition Therapy is an evidence-based nutrition service provided by RDs to prevent, delay or manage diseases and conditions. Components of MNT include personalized, in-depth assessment, nutrition diagnosis and intervention treatment plan, and evaluation of response to the interventions. MNT is typically provided over multiple visits to positively impact nutrition behaviours and allow for continued monitoring of the patient. MNT is one application of the Nutrition Care Process, which is made up of nutrition assessment, nutrition diagnosis, intervention, and monitoring/evaluation (Dietitians of Canada, 2010).

Respondents were asked to report the percentage of time that they spent performing:

1. Medical Nutrition Therapy for *chronic disease management* (e.g. diabetes, cardiovascular disease, chronic renal disease)
2. Medical Nutrition Therapy for *episodic care* (e.g. infant failure to thrive, lactation, anemias, Irritable Bowel Syndrome)

3. Health promotion and disease prevention activities (e.g. diabetes prevention, osteoporosis prevention, senior wellness, healthy lifestyle classes, general wellness counselling, cooking demonstrations, non-clinical infant feeding instructions)

Figures 3, 4, and 5 depict the composition of workload — the majority of RDs are spending the bulk of their time in Chronic Disease Management activities, with over half of respondents reporting more than 70% of their practice is Medical Nutrition Therapy for CDM.

The majority of RDs are spending the bulk of their time in Chronic Disease Management activities.

- 80% reported that less than 20% of their time is involved in episodic care (e.g. Anemia, failure to thrive, Irritable bowel syndrome), yet evidence is strong that nutrition therapy from a RD can improve health outcomes in these conditions)
- 75% of RDs reported only 30% of their time was spent on disease prevention and health promotion such as nutrition counseling to prevent diabetes, metabolic syndrome, osteoporosis, malnutrition, and child obesity despite strong evidence supporting the benefits of nutrition counseling for these at risk populations
- Most respondents perceive that they have substantial impact on chronic diseases and conditions, as shown in the Impact on Selected Conditions section on page 13.

These results suggest a lack of time and priority for planning and implementing health promotion and disease prevention activities targeting vulnerable populations at risk of future disease (e.g. malnourished senior at risk of future falls and hospitalization, young child at risk of obesity).

Figure 3: Prevalence of Chronic Disease Management as Proportion of RD Workload

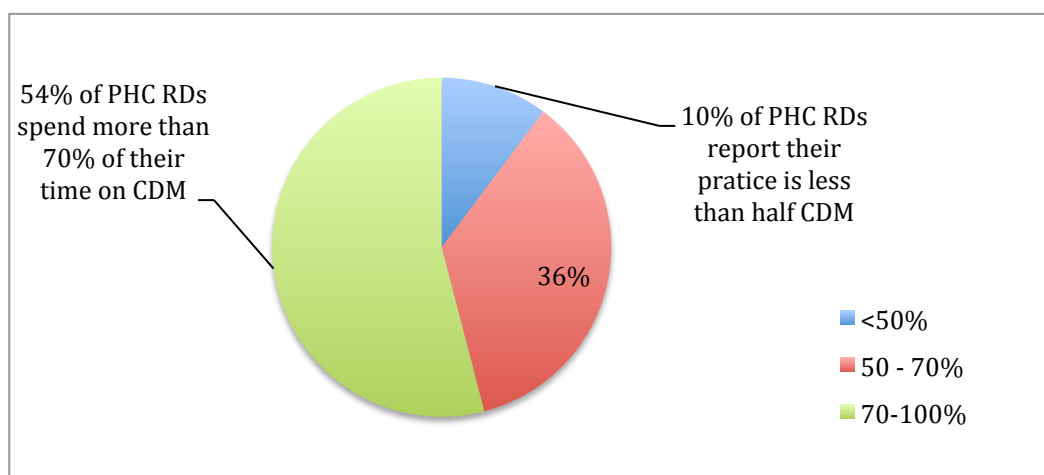


Figure 4: Prevalence of Episodic Care as Proportion of RD Workload

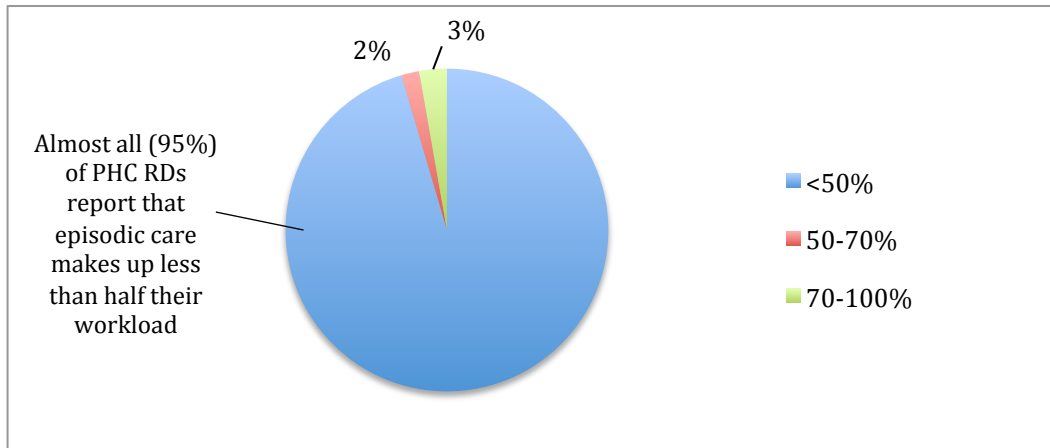
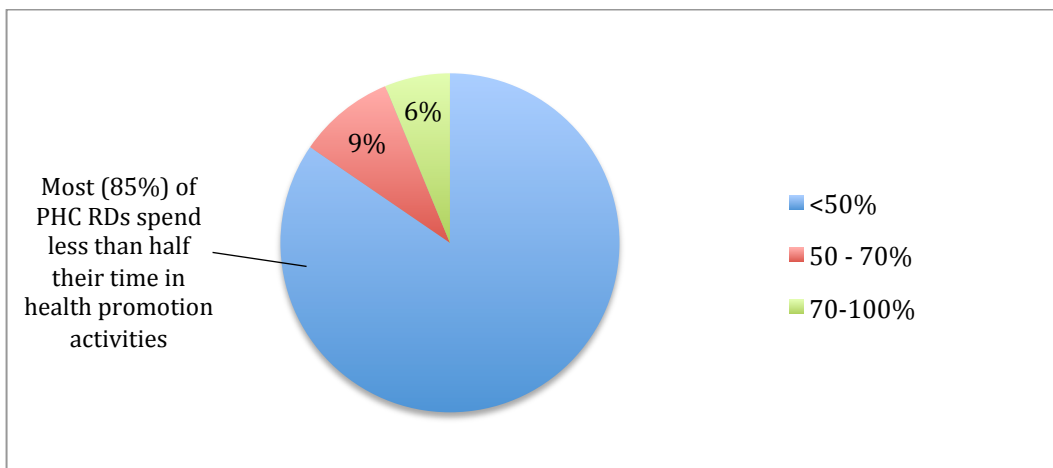


Figure 5: Prevalence of Health Promotion Activities as Proportion of Workload

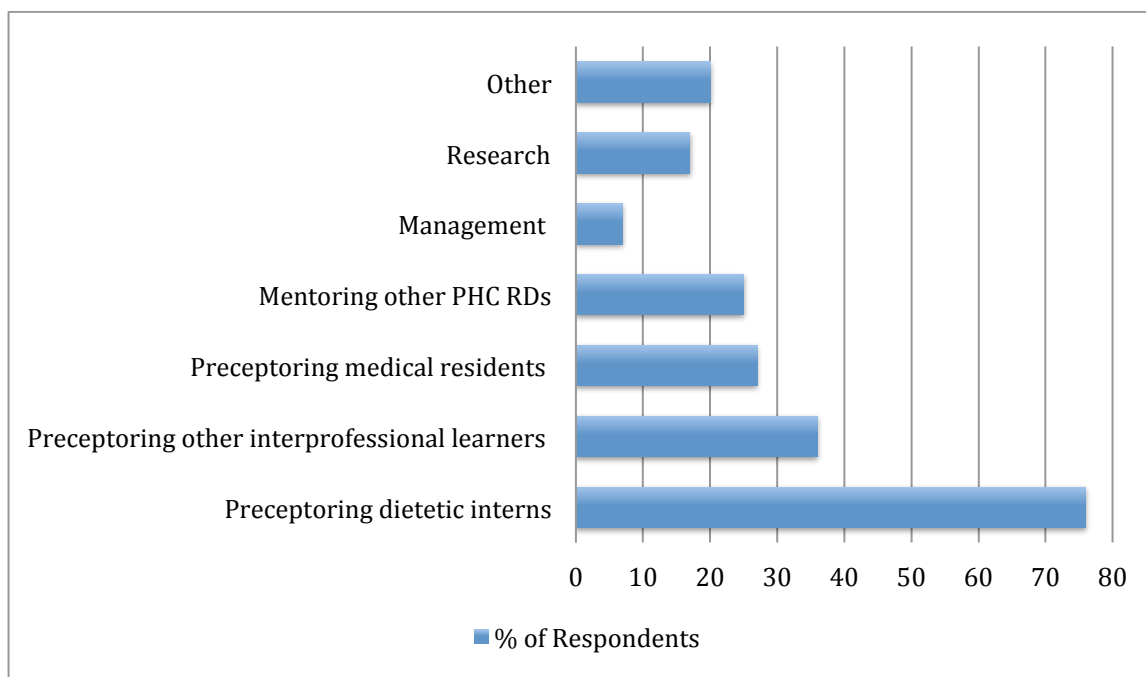


Other Activities (Preceptoring, Mentoring, Quality Improvement, Research)

In addition to the primary roles providing Medical Nutrition Therapy and Health Promotion/Disease Prevention activities, RDs act in many other capacities within the PHC setting, as shown in Figure 6. The preceptoring and mentoring roles are essential to the development of new professionals in dietetics and other health professions, for example medical residents, nursing, pharmacy, and mental health students.

The high percentage of PHC RDs providing mentoring and preceptorship supports the need for 3 – 5 years experience recommended by the PHCAG for the position. The impact of preceptoring on workload must also be considered, as studies have shown that time requirements are a major issue for both students and preceptors (Taylor and Hassberg, 2010; Wiseman, 2013), with one study showing an average impact of 1.2 additional hours per day required for clinical care when training a medical student (Ricer and Van Horn, 1997).

Figure 6: Other Activities Reported



The “Other” category of activities reported included quality improvement and workplace wellness, and broader leadership roles beyond the PHC organization, such as Regional Coordinator for the Baby Friendly Initiative, and Clinical Advisory Group for the Association of Ontario Health Centres.

Almost 20% of PHC RDs are involved in some form of clinical research as lead or co- investigators looking at outcomes of nutrition services, feasibility studies and the impact of service on health outcomes, clinical practice, and education of health professional students.

Several respondents indicated they have management roles, with the most frequently mentioned as Coordinator of the Diabetes Education Program. Other management roles reported were Interprofessional Practice Team Lead and Allied Health Supervisor. Dietitians working in PHC settings have the skills and training to succeed in leadership roles; inability to move to these roles is highlighted as a source of job dissatisfaction (see page 19).

Referrals to Dietetic Services

Dietitian services in PHC settings are most often accessed by clients through referral from another healthcare provider, most often the physician or Nurse Practitioner. In some settings, clients can request an appointment with the dietitian directly, often called self-referral. Respondents were asked to quantify the number of clients who were referred and the number who self-referred. Responses showed that the vast majority of dietitians’ clients are referred by other practitioners, and also highlighted that the source of referral is not tracked in many organizations.

Approximately half of respondents felt that a referral-based system (where patients see the RD based on referral from other healthcare provider) allowed adequate access to patients who would benefit from RD services. However, forty-two percent felt that the referral-based system was not adequate to ensure that patients who should receive RD services have access.

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Written responses provided to this question highlighted inconsistencies in referral

“I don't think some doctors know of which patients are appropriate for an RD referral. There is confusion surrounding our scope of practice. It would depend on the Doctor and their knowledge and experience working with RDs.” and capacity issues “not enough time to see all the patients that are referred - there was need to cut back on referrals as RD hours could not accommodate”

Inappropriate referrals, either under- or over- referring, points to the need for more communication and education with healthcare team members on the scope of dietetic practice, and establishing systems so that consistent and appropriate referrals are made.

In the hospital setting, research has found that over 60% of patients who would have benefitted from a referral to the dietitian, were not identified through traditional methods that relied on physician and nurse judgment or diet type (Keller et al 2014). If similar rates are found within the primary care setting, there are likely many patients that are not directed to the dietitian.

Decreasing referrals due to lack of capacity in RD services is a disturbing finding, and the extent of this problem is unknown. RDs report that family physicians stop referring to the RD in order to avoid overwhelming the service or because they feel the wait times are too extensive, leading to concerns of restricted access to nutrition counseling for patients who would benefit. Inconsistencies in referral rates makes it difficult to establish staffing standards for RD services in PHC settings, and lack of access to services affects patient health.

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Lack of Authorization to Order Appropriate Laboratory Tests

In 2011, legislative amendments were made under Bill 179 to authorize RDs to order lab work (blood and urine analysis), however regulatory amendments required to support this change have been delayed and the final authorizations have not been implemented. Lab values are an important tool for assessing nutritional status and determining response to nutrition interventions. Registered Dietitians in PHC settings use blood values to determine the course of Medical Nutrition Therapy. Currently, the RDs can be authorized through a delegation of authority such as a medical directive, or can make recommendations to the physician or NP and have the lab orders written by the other provider. Both of these work-arounds are an inefficient use of resources that impact both providers and patients.

To determine the scope of this issue, RDs were asked about the mechanism used and number of lab tests that they currently order, and what changes they anticipate if regulatory amendments authorize RDs to independently order lab tests.

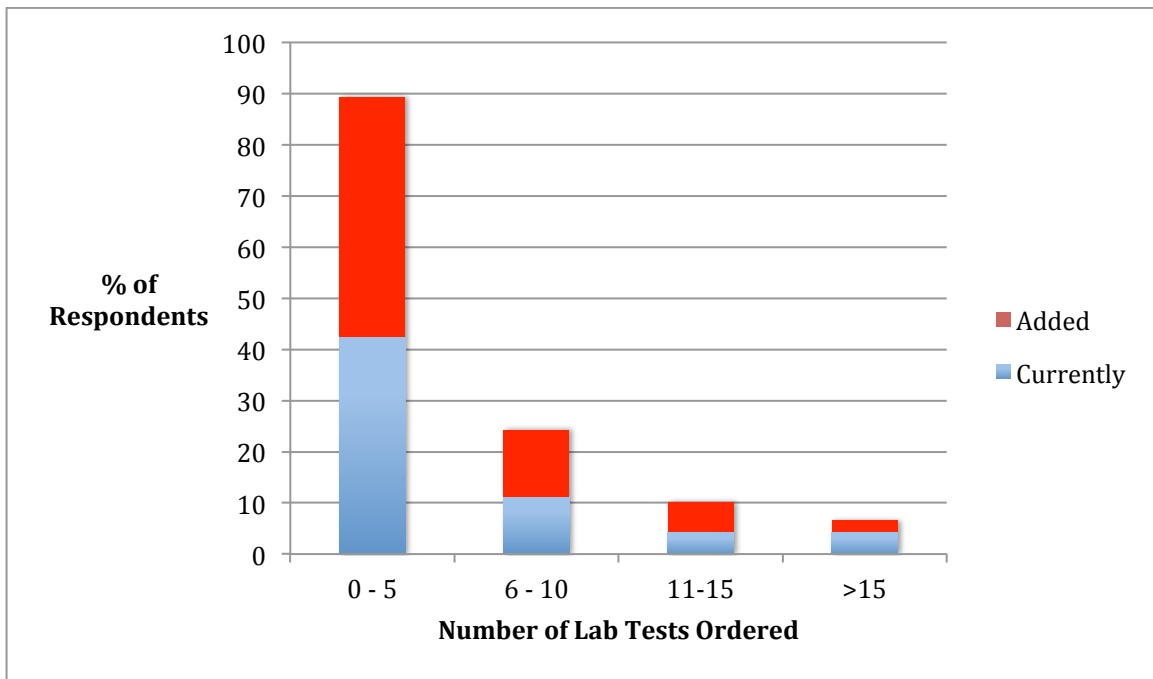
- 27% are currently using a medical directive or other authorization mechanism
- 32% order labs through making recommendations to the MD or NP
- 41% do not currently order labs.

Although the survey did not ask PHC RDs why they did not order lab work for their clients, the likely reasons are that the available lab reports in the medical record are sufficient to base Medical Nutrition Therapy decisions, or that the responsibilities or client population does not require additional lab data. Other potential reasons include too much time to have to find MD/NP for signature, or workplace policies preventing RDs from ordering.

As shown in Figure 7, the number of lab tests currently being ordered would be increased slightly if independent authorization was available for RDs, with the vast majority of respondents indicating that they would order 1 – 5 additional lab tests per week. One respondent commented that additional tests would be ordered, “to comply with best practice guidelines”. This suggests that best practice guidelines for some conditions are currently not being met for some patients, a situation that could be rectified by completing the regulatory changes to enable independent ordering of lab tests by dietitians.

- A possible scenario is a patient with diabetes who should have blood glucose testing completed every six months and blood lipids tested annually according to Canadian Diabetes Association Best Practice Guidelines. Dietitians rely on the results of these tests to monitor the effectiveness of medical nutrition therapy. If the tests are not ordered by another primary care practitioner, the dietitian should be able to order them independently.
- Another scenario is a patient with potential nutritional deficiencies that other clinicians may not be able to identify e.g. suggested testing for potassium and serum B12 levels in a patient with hypertension and reflux disease on Hydro-chlorothiazide.

Figure 7: Lab Tests Currently Ordered and Expected Increase with Authorization



Time Spent Seeking Authorization for Lab Tests

Forty-five percent of respondents indicated they spend less than 15 minutes per patient to obtain authorization from other providers (MD/NP) for lab tests. However, an additional 20% spent 16 – 30 minutes per patient, and 14 respondents indicated even longer times. The potential impact on patient flow and decreased capacity is immense, affecting service delivery (reducing the number of patients that are able to be seen) and patient quality of care. The economic impact of these delays is also significant: using the midpoint salary for FHT RDs of \$60,000, this inefficiency results in \$1885 - \$3770 cost per year for each dietitian affected.

Interprofessional Collaboration

Interprofessional collaboration is highly rated, with 93% of respondents reporting that their PHC setting is interprofessionally collaborative, (43% very, 50% somewhat). Almost all (96%) worked on a weekly basis in direct patient care with Nurses, Physicians (84%) and Social Workers/Mental Health Workers (78%). Pharmacist and RD collaboration on a weekly basis in direct patient care was reported by 44% of respondents, and 11% each for Physiotherapy and Occupational Therapy. Kinesiologists and Chiropractors were also identified as partners in direct patient care for many RDs, along with Health Promoters, Physical Activity Counsellors,

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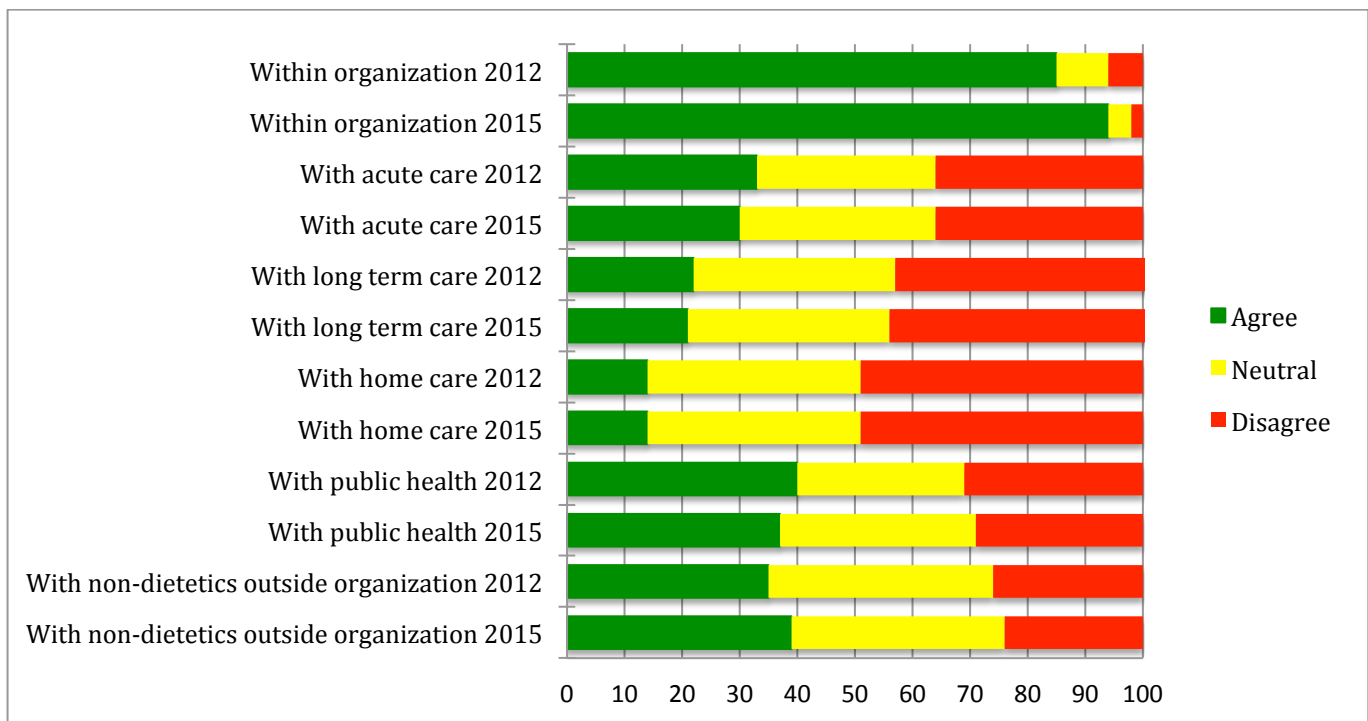
and Community Health Workers. Interprofessional collaboration has been promoted as a cornerstone of primary health care, so this is a very positive finding.

Interprofessional Collaboration and Integration Within the Health System

The vast majority (93% of respondents) agreed or strongly agreed that nutrition care was integrated with other providers within their organization. This is a very positive finding that indicates that interprofessional care within the PHC setting is progressing well, which is fundamental to patient care (Dietitians of Canada, 2009b), and reflects an increase from the 2012 survey when 85% agreed or strongly agreed.

Further questions on integration, however, point to the continued “siloing” of healthcare settings that is reported as a major issue within Ontario. Dietetics care in primary health care was not seen to be well integrated with acute care, homecare, or long term care settings by the majority of respondents; integration with public health was rated slightly higher (see Figure 8). Similarly, integration of dietetics care with non-dietetics practitioners outside of primary healthcare was rated highly by 35% of respondents. This could include professions such as Occupational Therapy, Speech-Language, or other regulated and non-regulated health professions.

Figure 8: Integration of Primary Care with Other Providers and Settings



Time Spent on Integration of Care

Successful team-based care requires adequate time to communicate between providers. The greatest proportion of respondents (45%) indicated that they spent between 1 and 3 hours each week in team meetings, case conferences, and other activities to support integration of care. Somewhat fewer (38%) spent less than 1 hour per week, and 13% indicated 3 – 5 hours per week. Only 4% indicated they spent more than 5 hours per week in integration activities. For RDs working part-time, the amount of time spent on team meetings and other integration activities represents a higher proportion of their total work time; for example, 24% of the respondents who spent 3 – 5 hours per week on integration of activities were RDs working less than full-time hours. Team communication and integration is an essential part of high quality interprofessional care, and sufficient time needs to be allocated within the PHC setting to accomplish these activities.

Health Links

Health Links is an initiative of the Ontario Ministry of Health and Long Term Care, intended to facilitate coordinated care planning for high users of the health system, including the frail elderly and those with multiple complex conditions. As of June 2015, Health Links have been established in 69 Ontario communities; the designated coordinating agency is typically a primary care setting (FHT or CHC), hospital, or Community Care Access Centre.

Only 19% of RD respondents indicated they were involved in their local Health Link. Comments provided showed that there was a wide range of involvement, from “available on referral” to “1 day every other week”. Several respondents said that although their organization was involved, the RD had not been identified to provide services or participate in coordinated care planning. Given the importance of nutrition care in chronic and complex conditions, RDs should be part of every Health Link.

Recent studies by the Canadian Malnutrition Task Force showed that 1 out of 2 seniors are malnourished on entry to hospital, worsen during their stay and have a very high 30-day re-admission rate (Allard et al, 2014, Keller et al, 2014). RDs need to be involved in the Health Links initiative to help teams identify and correct malnutrition, prevent further weight loss and decline, and reduce hospitalization rates. Dietitians are encouraged to advocate within their own organizations to increase access to dietitian services for Health Link clients. In addition, education and promotion of the Health Links initiative should stress the importance of involving all professionals, including dietitians, in local planning.

Given the importance of nutrition care in chronic and complex conditions, RDs should be part of every Health Link.

Outcome Data

Survey respondents were asked whether their PHC organization was collecting outcome data on a range of conditions. The top conditions for outcomes data are:

- Diabetes (being collected by 78%)
- Hypertension (41%)
- Dyslipidemia (38%)
- Weight (31%)
- Craving Change programs (31%)

At the lower end, only 15% are collecting outcome data on home visits, and 9% on seniors' care.

Thirteen percent of respondents indicated that no outcome data was being collected; approximately twice the number of CHC respondents were not collecting outcomes, compared to FHTs.

Barriers cited for outcome data collection were:

- time (77%)
- knowledge of data collection (58%)
- support from management (31%)
- personal interest (10%)
- additional barrier mentioned most frequently in the open-ended response was electronic medical record limitations.

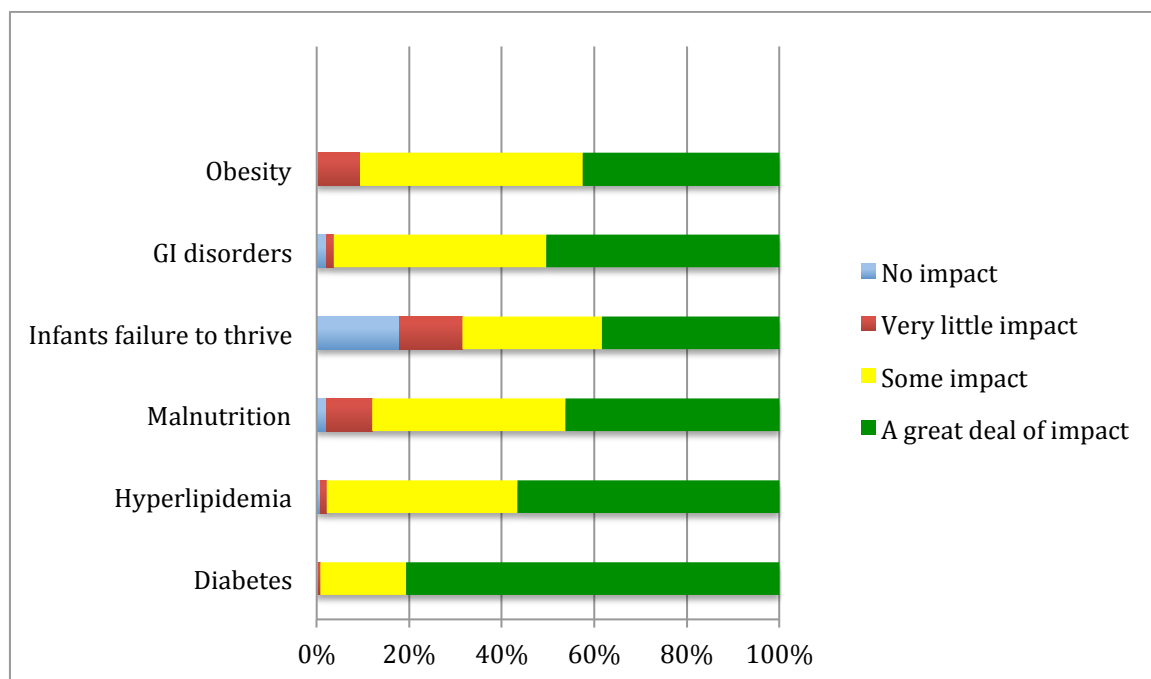
Dietitians of Canada's Ontario Primary Health Care Action Group (PHCAG) is advocating for outcome measurement across PHC and provides workshops and resources for PHC RDs to implement in their practice. Building the evidence base for dietetic interventions in primary care will enable the health system to achieve the best value for dollars spent.

Impact on Selected Conditions

Survey respondents were asked to rate their *perceived* impact on various clinical conditions that are commonly treated with Medical Nutrition Therapy. As shown in Figure 9, the dietitians felt that their work had significant impact on all of the clinical conditions, particularly in diabetes and gastrointestinal disorders. The least successful impact appeared to be failure to thrive in infants. The reasons behind these perceptions were not explored in this survey.

Dietitians felt that their work had significant impact on all of the clinical conditions.

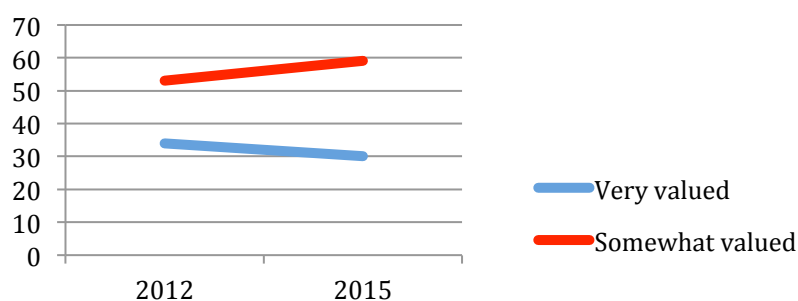
Figure 9: RDs' Perceived Impact on Selected Conditions



Work Satisfaction: Fewer Feeling Valued

Most of the respondents felt that they are “somewhat” (59%) or “very” (30%) valued at their workplace. Compared to the results of the 2012 and 2009 Dietetic Workforce Surveys, fewer RDs feel very valued in their workplace. The causes for this decrease may include lower compensation than other PHC professionals, and dissatisfaction with other job attributes.

Figure 10: RDs' Perception of Feeling Valued in the Workplace



How valued do you feel at work?	Very much	Somewhat
2015	30	59
2012	34	53
2009	33	55

Compared to the results of the 2012 and 2009 Dietetic Workforce Surveys, fewer RDs feel very valued in their workplace.

Influences on Work Satisfaction 2015 Compared to 2012 and 2009

Questions measuring work satisfaction were included in the 2009 Ontario Workforce Survey, and were repeated in the 2012 and 2015 surveys to gauge changes in dietitians' satisfaction with their work. The 2009 survey includes responses from all areas of dietetic practice, while the 2012 and 2015 results are specific to the PHC setting.

The majority of respondents are generally satisfied with their work, colleagues, and employers, consistent with 2009 and 2012 survey results. However, a number of dietitians reported dissatisfaction with various aspects of their work, and in some cases the proportion of "satisfied" responses has decreased from 2009 levels, as shown in Figures 11 – 16. Results are shown using a traffic light analogy as depicted in the 2009 survey results.

Overall, the greatest proportion of "dissatisfied" responses (>15% of respondents) were found in the areas of:

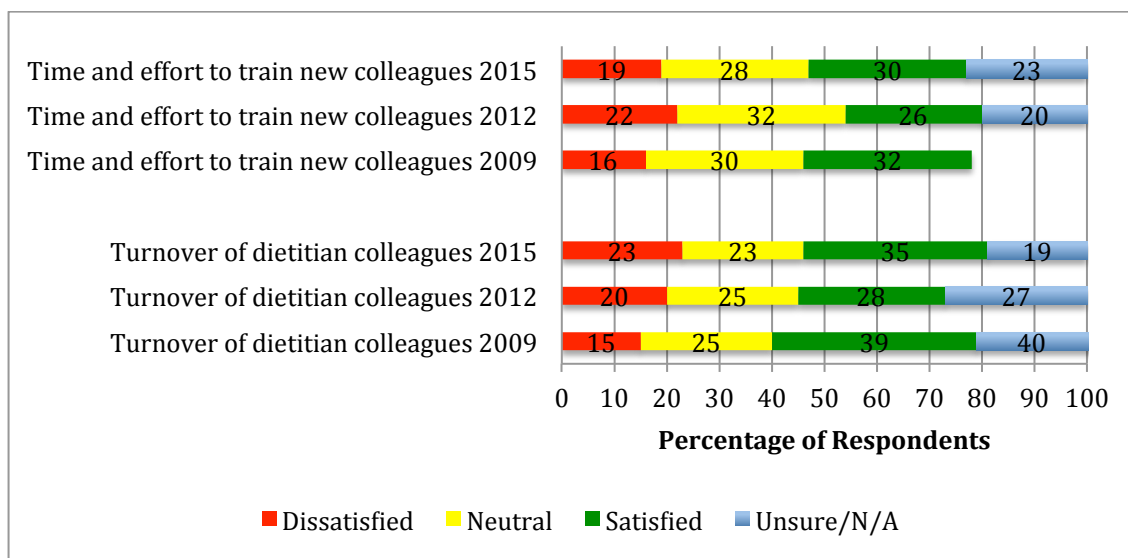
- Turnover of dietitian colleagues
- Time and effort to train new colleagues
- Ability/skill set to move into other roles
- Opportunities for growth
- Opportunities for professional advancement
- Recognition from supervisors and peers
- Benefits
- Funding for personal development

Relationships with dietitian colleagues and satisfaction with employer show continued slight decreases. Workload, work schedule and work-life balance show continued improvement in satisfaction levels, while satisfaction with work flexibility decreased. The care delivery model shows much higher satisfaction in the 2012 survey; this may be due to the responses in 2009 representing many different practice settings with various models of care, although continued improvement in 2015 responses is also seen. Interprofessional team delivery models such as FHTs and CHCs have been tied to higher levels of work satisfaction in healthcare providers, which may be reflected in these results.

Dietitian Turnover and Training of New Colleagues

Turnover of dietitian colleagues and training of new colleagues show increasing dissatisfaction in 2012 compared to 2009 but the 2015 results showed an increase in those satisfied as well as dissatisfied. The survey results support the anecdotal reported dissatisfaction with the "revolving door" of new graduates who train in PHC settings then leave for other sectors when positions become available at higher salary ranges.

Figure 11: Satisfaction with Turnover and Training



Overall job satisfaction, relationship with dietitian colleagues, and interprofessional relationships were all rated less positively in 2012 than in the 2009 survey, however the 2015 responses show improvement to 2009 levels in overall job satisfaction, with an improvement in interprofessional relationships that is still lower than 2009.

Figure 12: Satisfaction With Job and With Employer

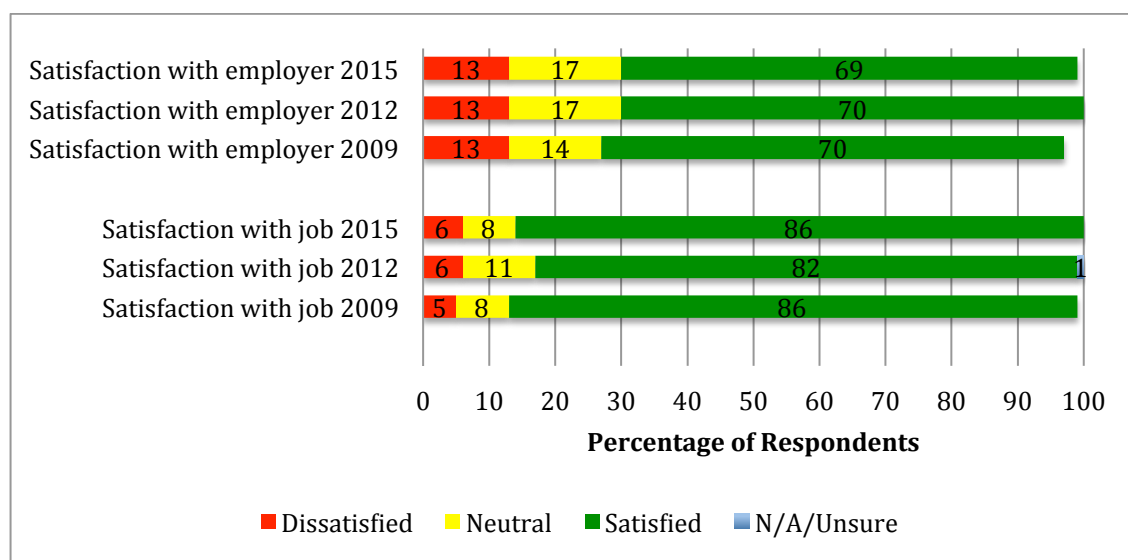
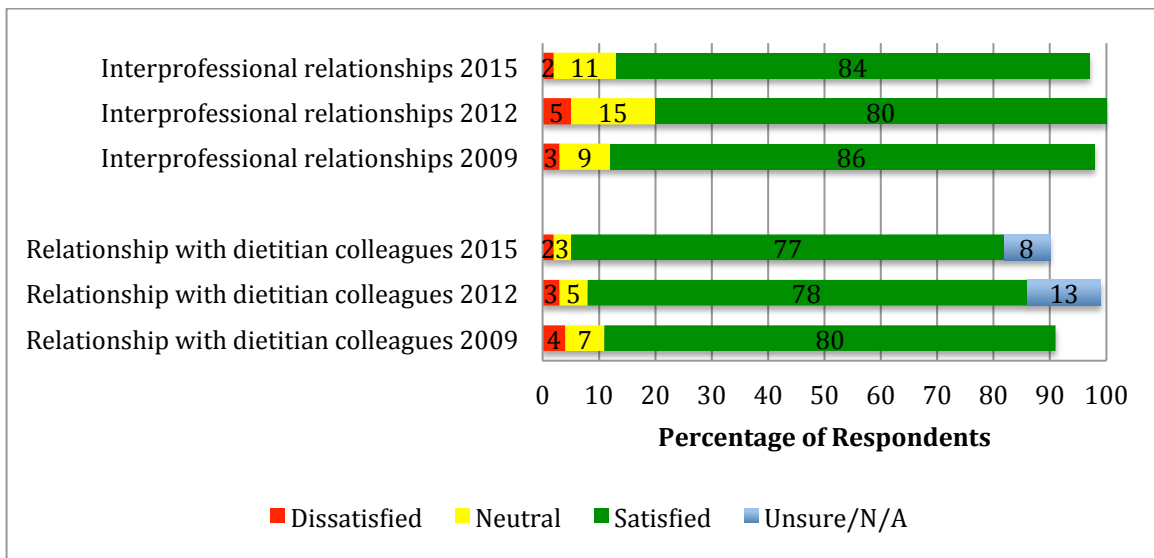
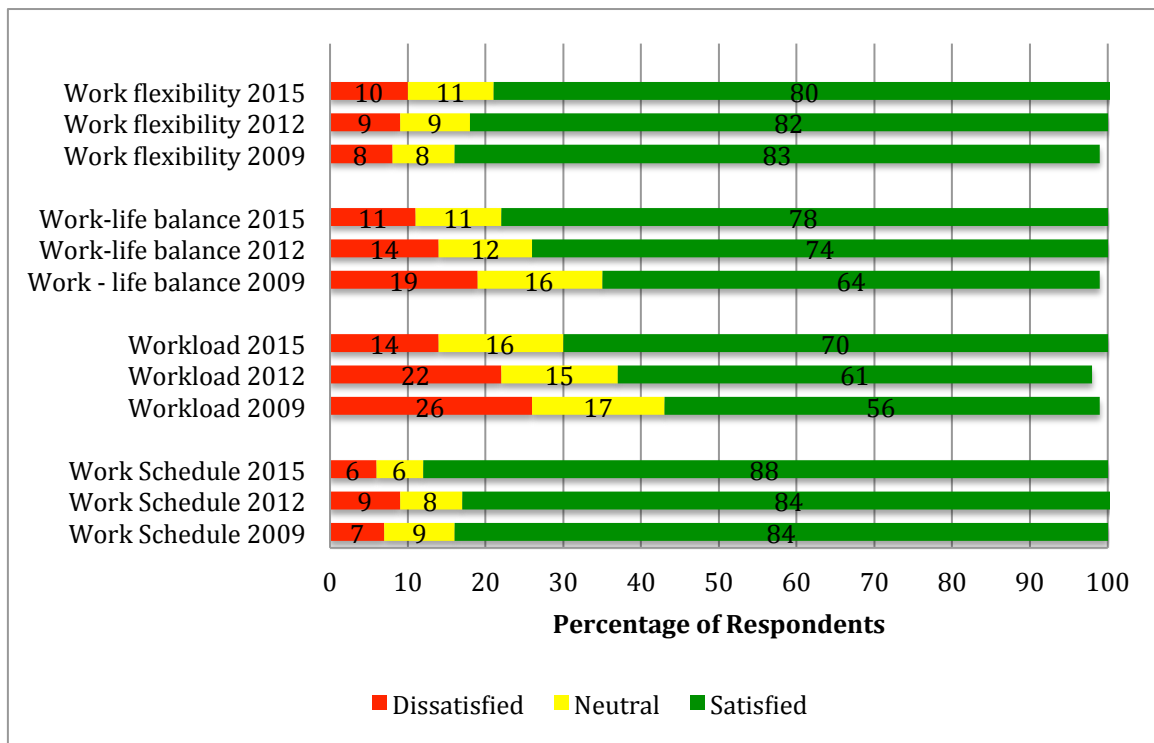


Figure 13: Satisfaction With Work Relationships



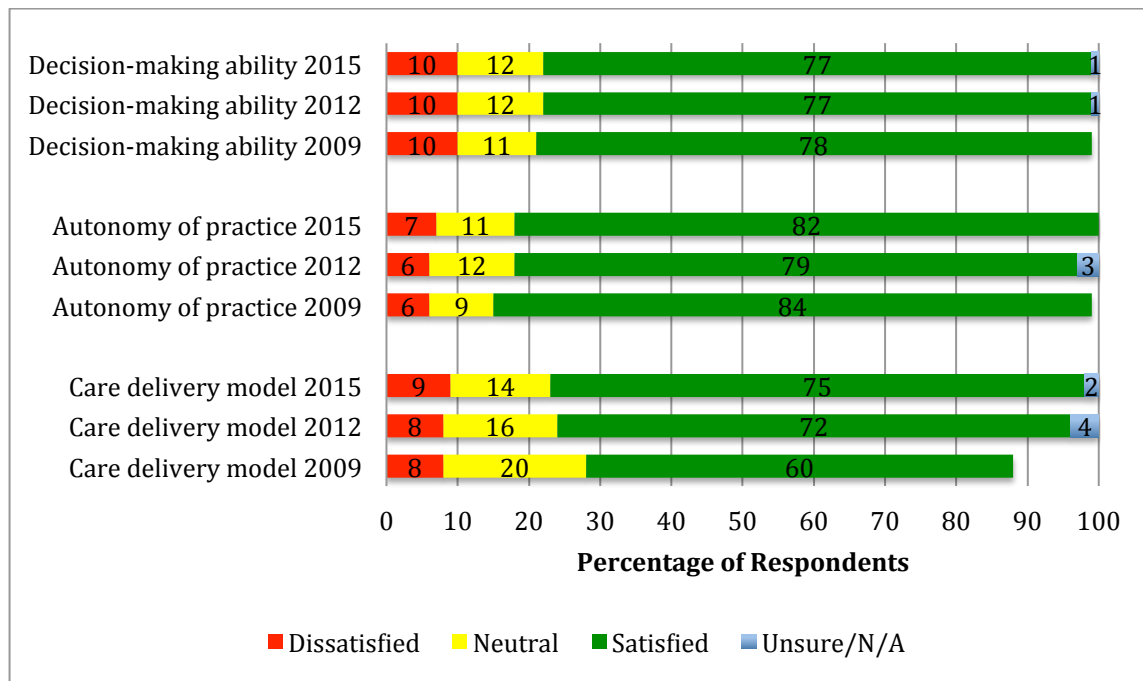
* The 2009 survey did not include the Unsure or N/A option

Figure 14: Satisfaction with Work Flexibility, Work-Life Balance, Workload and Schedule



* The 2009 survey did not include the Unsure or N/A option

Figure 15: Satisfaction with Decision-Making, Autonomy, Delivery Model



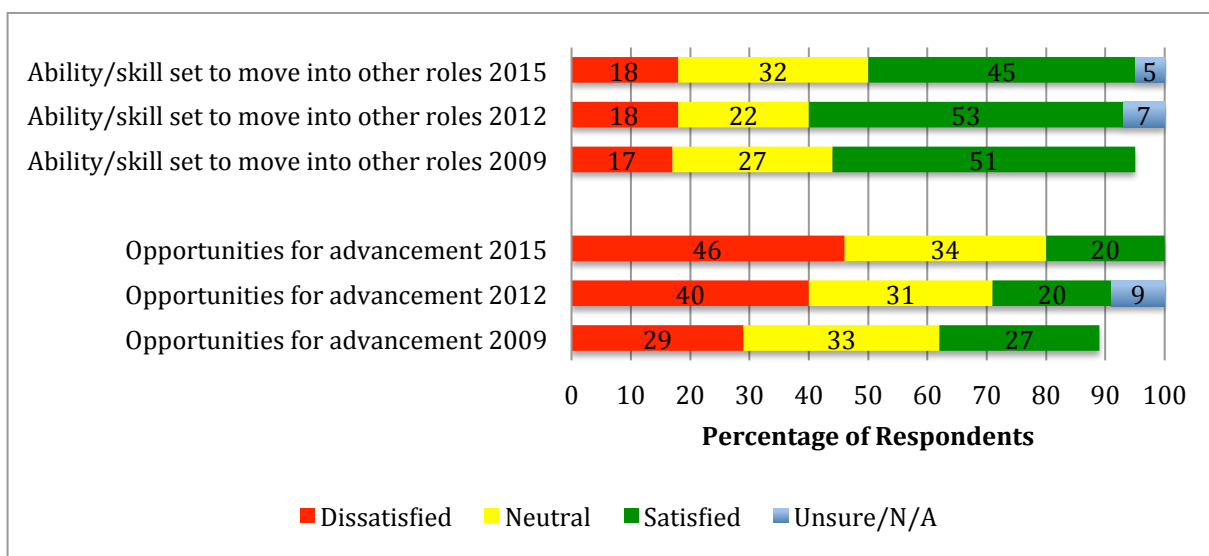
* The 2009 survey did not include the Unsure or N/A option

Limited Opportunities for Advancement

Dietitians are increasingly dissatisfied with their opportunities for advancement, as shown by a 6% increase in the proportion of respondents selecting dissatisfied or very dissatisfied in 2015 compared to 2012. A related measure of satisfaction, the ability to move into other roles in the PHC setting, remained steady in the dissatisfied category (18% of respondents) but showed substantial decrease in the proportion of respondents who rated this factor satisfactory.

Dietitians are increasingly dissatisfied with their opportunities for advancement.

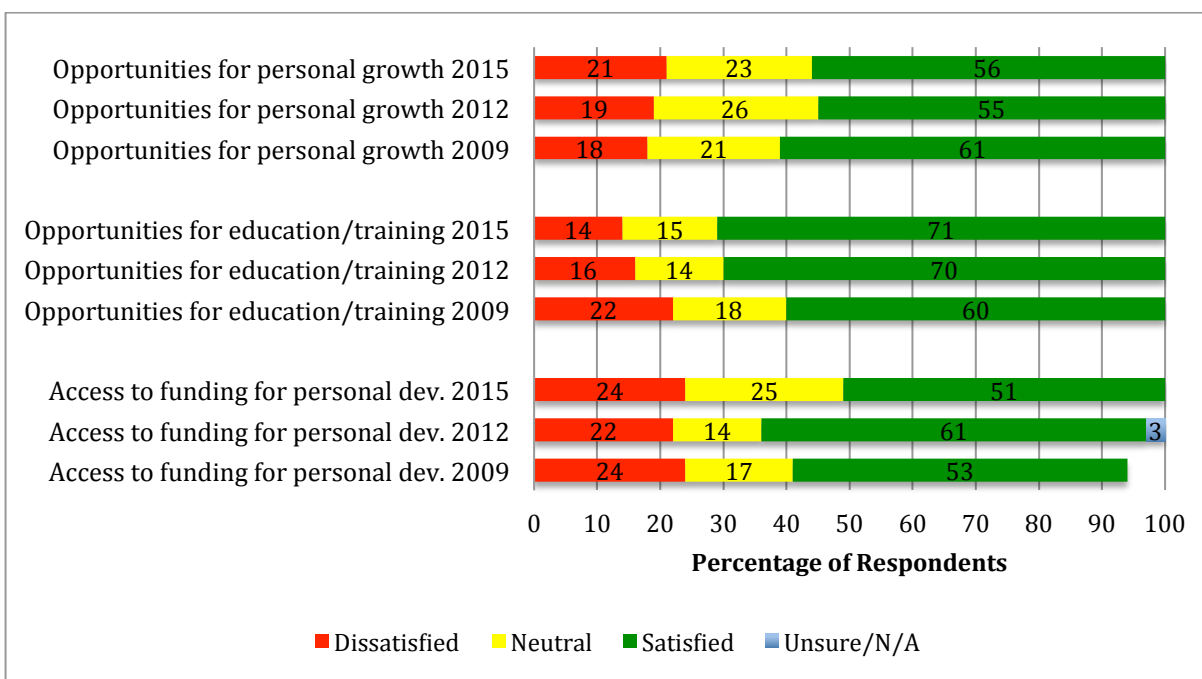
Figure 16: Satisfaction with Opportunities for Moving to Other Roles/Advancement



Education, Training, and Personal Development

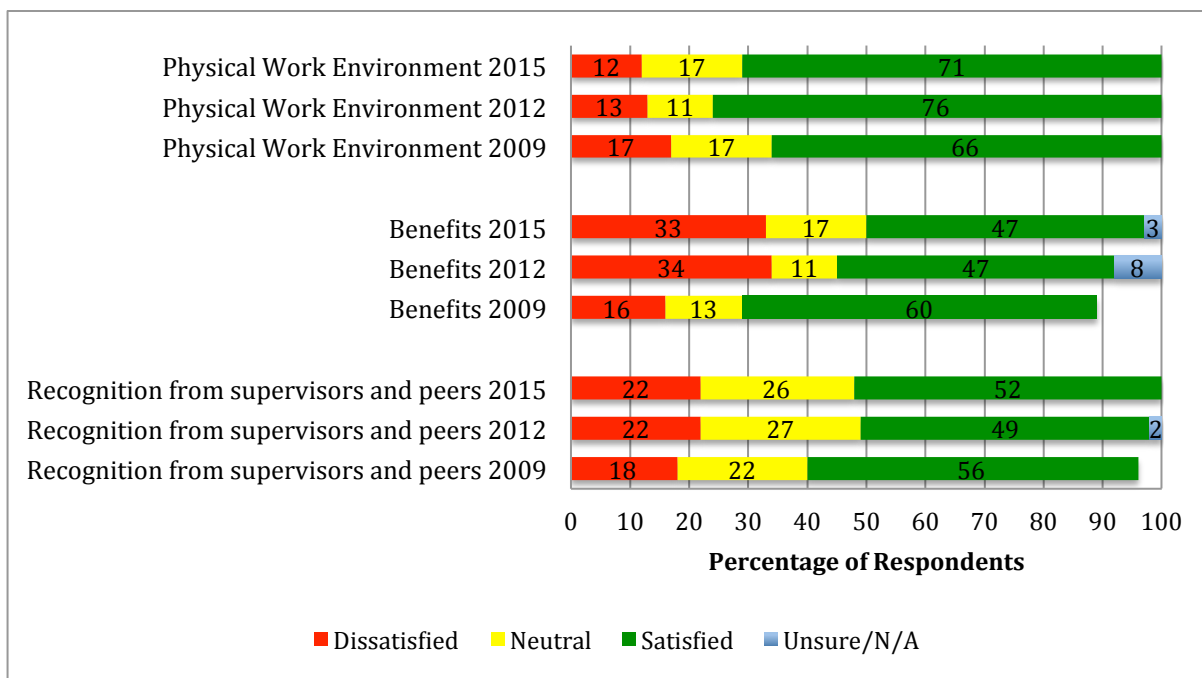
Respondents to the survey were slightly more positive about their opportunities for education and training in 2015 compared to 2012, and substantially more positive when compared to 2009. Opportunities for personal growth were also rated similarly in 2012 and 2015, with slightly more than half the respondents satisfied with their opportunities, however the 2009 survey showed more positive results. Access to funding for personal development is rated much less positively in 2015 than in 2012, with the proportion of respondents that are satisfied dropping from 61% to 51%. Although the Allied Health Professional Development Fund is still available to support reimbursement for continuing education, the fund has been over-subscribed in recent years and has been unable to meet demand. The decrease in satisfaction may also reflect smaller budgets available at the individual FHT or CHC level.

Figure 17: Satisfaction with Opportunities for Growth, Education/ Training, Funding for Development



* The 2009 survey did not include the Unsure or N/A option

Figure 18: Satisfaction with Work Environment, Benefits, Recognition



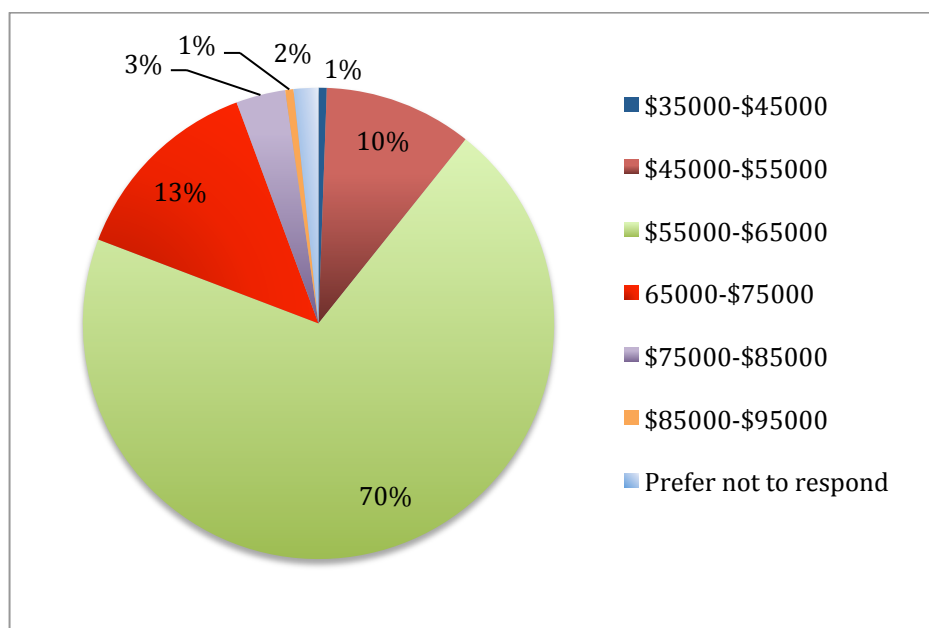
* The 2009 survey did not include the Unsure or N/A option

Compensation

Fifty-four percent of all respondents, 71% of those working full-time hours, reported annual income of \$55001 – \$65000, consistent with the current wage rates for dietitians in FHTs based on the Ministry of Health and Long Term Care's *Guide to Interdisciplinary Provider Compensation* (MOHLTC, 2010), as shown in Figure 19.

The most common salaries for part-time positions (18 – 35 hours per week) was reported as \$25000-\$35000 (n=18), \$35001-\$45000 (n=18), \$45001-\$55000 (n=15), and \$55001-\$65000 (n=13).

Figure 19: Reported Annual Salary for Full-time Positions



Eighty-seven percent of respondents (235/271) stated that they are not satisfied with their compensation. This is the same proportion of respondents (148/170) as in 2012. In the 2009 survey, 65% of respondents from all practice settings felt they were not adequately compensated.

The 2015 survey provided an open text box for respondents to explain their perception of their pay level. A total of 235 responses were given; the most prevalent reasons are inequity with wages paid to other health professionals with similar education, training, and responsibilities (131 responses) and inequity with dietitian positions in other sectors such as acute care and public health (109 responses). Twenty-nine responses also cited wage freezes and no increase for several years as a major reason for dissatisfaction with compensation.

Dissatisfaction with compensation was apparent across most levels of reported income, with the majority (56% of dissatisfied respondents) in the \$55001 – \$65000 annual salary range. Only 8 respondents in total felt they were being paid a fair wage.

Eighty-seven percent of respondents (235/271) stated that they are not satisfied with their compensation.

Compensation Inequity Between Professionals and Between Sectors

Two major reasons exist for the dissatisfaction reported – inequity within the PHC settings among different professionals, and inequity between the community/PHC settings and other health system sectors. The Ministry of Health and Long Term Care’s *Guide to Interdisciplinary Provider Compensation* (MOHLTC, 2010), classifies Registered Dietitians in salary band 7 despite recommendations provided by the Hay Group in 2009 and 2012 that RDs belong in the same classification as other similar health professions such as Occupational Therapists, Physiotherapists, and Registered Nurses. This error has not been corrected despite the ongoing advocacy of organizations such as the Association of Ontario Community Health Centres (AOHC), and the Association of Family Health Teams of Ontario (AFHTO) who state in their 2013 report *Toward a Primary Care Recruitment and Retention Strategy for Ontario: Compensation Structure For Ontario’s Interprofessional Primary Care Organizations*:

In 2004 when the first CHC compensation structure was developed with the MOHLTC, the dietitians and health promoters were placed in band 8. In 2006, MOHLTC decided to place the dietitians and the health promoters in the wrong pay band without supporting documentation. The Hay Group’s evaluation of the dietitian and health promoters consistently has placed them in the same pay band as other health professional roles, i.e., physiotherapists, occupational therapists, speech therapists and social workers. The 2012 Primary Care Compensation Report reaffirms that the Dietitians and Health Promoters should be in band 8.

Inequity between sectors of the health system is an acknowledged issue, and is highlighted by the discrepancies between community-based PHC and acute care sectors in RD wages. According to data collected by Dietitians of Canada’s Clinical Nutrition Leaders Action Group, average hospital RD annual salaries are approximately \$79,000. This is supported by the comments by respondents in this survey, such as:

- “I took a \$10,000 pay cut per year to move from a hospital based position to a CHC based position.”
- “Not comparable to other RDs in my community – avg \$8 less/hr”
- “RDs in hospitals get paid 10\$ more an hour”
- “\$20,000 pay cut from when I worked in the hospital setting. No HOOP”
- “While I love my work I do often look for postings elsewhere because the pay is so much lower at the CHC.”

“I took a \$10,000 pay cut per year to move from a hospital based position to a CHC based position.”

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Other Forms of Compensation

The survey asked the PHC RDs if they received any other forms of compensation. The most common response (n=143) was employer-paid PEN[®] subscription. The Practice-Based Evidence in Nutrition system is a knowledge translation and decision support tool for RDs that is available through Dietitians of Canada; an individual subscription for DC members is \$60 per year (\$500/year for non-members) and site licenses are also available. Although PEN subscriptions are valuable to the individual RD, the actual dollar value of this benefit is low for employers, assuming the RD is a DC member. In the additional comments, one respondent stated that the employer paid one subscription to be shared between 6 dietitians.

Membership fees for the College of Dietitians of Ontario and Dietitians of Canada were reported as paid by 18 respondents each. This was not limited to full-time employees, as 5 people who reported working part-time had the CDO registration paid, and 7 part-time people had DC membership paid.

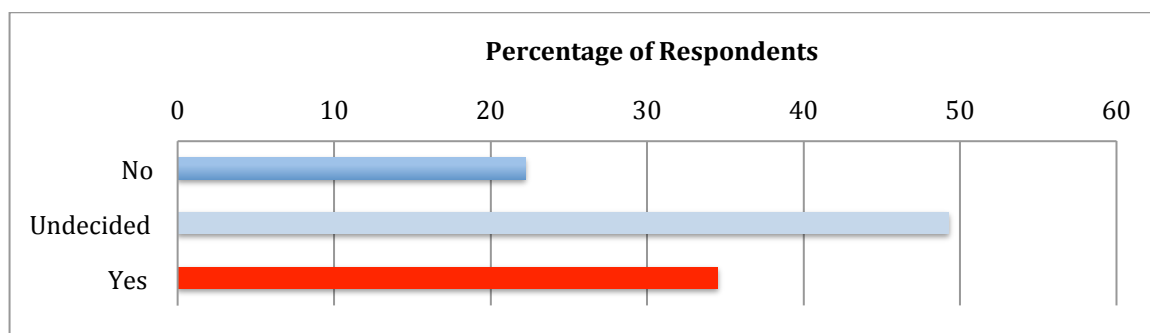
Full-time employees were more likely to report additional vacation time (n=12), professional development funds (n=10), and representing their PHC at conferences or presentations (n=20). Four people reported that their employer contributed to HOOPP and two noted that their liability insurance was paid.

Intention to Leave Current Position

Respondents were asked about their plans to leave their current position within the next 2 years, and their reasons for doing so. Twenty-eight percent of respondents plan to leave their current position within two years to pursue other dietetics employment. An additional 3% are planning to leave the profession of dietetics for other employment, and 4% to return to school or pursue a new area of study. Almost half (49%) are undecided about leaving their current position, and only 22% felt they would not be leaving their current position within 2 years. Compared to the survey results in 2012, fewer respondents are planning to stay in their current position in the short term (30% in 2012).

Compared to the survey results in 2012, fewer dietitians plan to stay in their current position in the short term.

Figure 20: Intention to Leave Current Position within 2 Years



The proportion of respondents planning to leave their position within the next two years varied somewhat between different income levels – within the \$55,001-\$65,000 annual income, 19% stated they were not planning to leave (less than the proportion overall) while those reporting annual income >\$65,000 were more likely to plan to stay (36%). Those who responded that they felt “very” or “somewhat” valued at their workplace were also more likely to stay in their current position, compared to those who reported feeling less valued.

Future Considerations

Primary health care settings are foundational in the Ontario healthcare system, and Registered Dietitians in these settings are instrumental in enabling patients to achieve their health goals through Medical Nutrition Therapy. Ongoing monitoring of workforce demographics and job satisfaction can be used to strengthen positive outcomes of nutrition programming in primary health care. Specific areas which require further investigation and action include:

- Effect of compensation dissatisfaction on recruitment and retention of RDs in PHC
- Mentoring and support to retain new graduates within PHC and manage risk associated with fewer years of clinical experience
- Follow up on practitioners' intent to leave their current position
- Factors which influence the "undecided" group toward staying or leaving their current position
- Regulatory amendments to finalize independent ordering of laboratory tests by RDs
- Consistent collection and use of outcome measures
- Continued efforts to build high-functioning primary health care teams
- Systems approaches to integrating primary health care with other sectors of the health system
- Adequate staffing of RDs in PHC settings to accomplish both Medical Nutrition Therapy and health promotion activities
- Creation of new roles and opportunities for advancement
- Ongoing advocacy efforts to raise awareness of the contributions of Dietitians in Primary Health Care towards Better Health, Better Care and Better Value.

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