Executive Summary

Dietitians of Canada’s (DC) Ontario Primary Health Care Action Group surveyed DC members working in primary health care settings in spring 2012 to:

- Describe the current dietetic workforce in Ontario primary health care (PHC)
- Identify factors supporting integration of PHC dietitians in the health system
- Assess job satisfaction and compare satisfaction with previous dietetic workforce surveys

Two hundred and twenty-nine responses were received to the electronic survey. Highlights of the results include:

- 63% of respondents work full-time for one employer
- 51% of respondents have worked in dietetics for over 6 years.
- 16% of respondents have been in their current position for more than 5 years
- 85% of respondents agreed that nutrition care is integrated within their organization
- Poor integration of primary health care with acute care, homecare, and long term care is perceived
- Overall job satisfaction is high, yet lower than satisfaction reported in 2009
- 87% of respondents are not satisfied with compensation
- 26% of respondents are planning to leave their current position within the next year, with another 20% undecided
- 23% plan to leave their current position within 2 – 5 years
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- Tracy Hussey, Hamilton FHT and Chair DC ON PHCAG
- Paula Brauer, Professor University of Guelph and member of the DC ON PHCAG
- Marg Alfieri, Centre for Family Medicine, Kitchener FHT and executive member of the DC ON FHTRDN
- Deb McKinley, Couchiching FHT and executive member of the DC ON FHTRDN
- Adijatukubra Musa, North York FHT and Co-Chair of the DC ON FHTRDN
Introduction

Registered Dietitians (RDs) practice in primary health care settings throughout Ontario, including Family Health Teams, Community Health Centres, 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. In addition, all Ontario DC members were sent information about the survey to allow members who self-identified as working in primary care settings to provide a survey response. This included members working in Community Health Centres (CHC), private practice and public health (PH).

Response

A total of 229 responses were received, from Family Health Teams (n=148), Community Health Centres (n=57), Other (n=24). An accurate response rate cannot be calculated because the total number of members who self-identify as working in primary healthcare is not known. Based on the College of Dietitians of Ontario Annual Report 2011-12, 577 Registered Dietitians work in Family Health Teams, Family Health Networks, and Community Health Centres. Approximately 73% of Registered Dietitians in the province are members of DC.

Responses were received from dietitians in every LHIN in the province, with a range of 7 – 23 responses from each LHIN.
Results

Full-time and Part-time Work

Sixty-three percent of respondents worked full-time (>36 hours/week) for one employer. Half of the respondents that worked part-time (18 – 35 hours/week for one employer) indicated that it was because no full-time work was available, while the remainder did so for personal/family reasons. Seventeen respondents indicated that they worked full-time in a collection of part-time positions.

Experience

Approximately half (100/206) the respondents had been working in dietetics for 5 years or less (see Figure 1). Experience specifically in PHC settings was, as expected, limited for the FHT setting due to the relative newness of the model in Ontario. For CHC and other PHC settings, the majority of respondents also reported working in those settings for <10 years.

Twenty-five percent of respondents had been in their current position less than one year, while 59% 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 new to the profession. As many FHTs and CHCs employ only one dietitian, linkages to other RDs for mentoring may be particularly important. Given the range and complexity of patients that may be counseled by PHC RDs, some experience would be ideal. 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 (DC PHCAG, 2010).

Figure 1: Years of Practice as a Dietitian

![Years of Practice as a Dietitian](chart)

Wait Times
For urgent referrals, the majority of clients are able to access the dietitian within 1 – 2 weeks. However, for a few respondents the reported wait time was more than 3 weeks. For non-urgent referrals, the majority of clients were able to book appointments within three weeks, but almost 20% waited for greater than 4 weeks.

Analysis of the acceptability of these wait times is difficult as there is no consensus on acceptable wait times for dietitian referrals, nor consistent definitions of urgent vs. non-urgent referrals. It would appear that the majority of wait times are within customary lengths, however with increasing interest in advanced access and same-day appointments throughout PHC, a 1 week wait may be seen as excessive. For long term lifestyle change, such as counseling for weight management, wait times of 1 week are not necessarily an issue, however for nutrition issues related to acute conditions faster access may be needed. Further exploration of the impact of wait times on clients is needed, as well as investigation of the reasons for lengthy wait times reported by some respondents.

**Scope of Practice**

Three quarters of the respondents felt that they were able to work to their full scope of practice. For those that reported not being able to work to full scope, the most common reasons were inability to order laboratory work, and to adjust insulin. Barriers identified were laws and regulations, and organizational policies. The College of Dietitians of Ontario has submitted a proposed regulation to the Ministry of Health and Long Term Care regarding ordering of laboratory tests; legislative approval for this process was obtained in 2010 but implementation requires the appropriate regulations to be in place. During the scope of practice review for dietetics process in 2008, insulin adjustment was proposed, however this was not widely supported at that time. Many RDs currently do adjust insulin as part of their practice under other authorizing mechanisms such as medical directives or delegation. Continued review of this issue is needed to support patient-centred care.

Other barriers identified to working to full scope of practice include lack of time and lack of understanding of the RD’s role or competencies by other health professionals including physicians. This may point to a need for further education and team development initiatives.

For respondents who reported being asked to perform duties outside of their scope of practice, insulin adjustment and ordering of laboratory work were again mentioned multiple times. One respondent raised the issue of communicating a diagnosis, a concern that was broadly discussed during scope of practice consultations in 2008. Since communicating a diagnosis is a controlled act not granted to dietitians, a referral to a dietitian for diabetes counseling (for example) when the person has not been informed that they have diabetes, requires care to ensure the counseling does not take the form of communicating a diagnosis. The College of Dietitians of Ontario has provided some guidance for these scenarios (CDO, 2006).
Interprofessional Collaboration and Integration Within the Health System

The vast majority (85% 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). 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 2). Similarly, integration of dietetics care with non-dietetics practitioners outside of primary health care 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 2: Integration of Primary Care with Other Providers and Settings

The majority (78%) of respondents cited informal conversations as the means to achieving integration. While this can have positive outcomes, it also points to the lack of a systems approach to integration, and relies on individual practitioners’ capacity and willingness to share the required information. Informal conversations are not necessarily recorded in a medical record, and may be subject to individual interpretation. Shared electronic health records and formal discharge/transfer notes were cited as supports to integration by 53% and 46% of respondents, respectively, and 40% of respondents noted that diabetes collaboratives supported integration of care. In response to the open-ended question about supports required to improve integration, 41 of the 67 respondents mentioned communication supports through shared electronic health records or traditional discharge summaries/access to notes.
The need for a standardized systematic approach to integrating dietetics care is needed to ensure transfer of key information to all practitioners involved in the care of the individual.

Other challenges to interprofessional collaboration and integrated care were also found within the comments provided. Lack of information sharing, ranging from physicians to dietitians in other settings, were cited by several respondents, for example “Buy in from MD’s regarding importance of non-MD health professionals in the care of patients/clients” and “territorial RDs are an issue”. Lack of time to communicate and develop relationships that would promote integration was also mentioned. Despite the positive views of integration of care, there remains work to be done at individual levels and system-wide to encourage care that seamlessly manages transitions through the system.

Work Satisfaction

Most of the respondents felt that they are “somewhat” (53%) or “very” (34%) valued at their workplace. This is almost identical to the results of the 2009 Dietetic Workforce Survey (55% somewhat, 33% very).

Influences on Work Satisfaction 2012 Compared to 2009

Questions measuring work satisfaction were included in the 2009 Ontario Workforce Survey, and were repeated in the 2012 survey to gauge changes in dietitians’ satisfaction with their work. The 2009 survey includes responses from all areas of dietetic practice, while the 2012 results are specific to the PHC setting. The majority of respondents are generally satisfied with their work, colleagues, and employers, consistent with 2009 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 3 – 7 below. Results are shown using a traffic light analogy as depicted in the 2009 survey results.

Overall job satisfaction, relationship with dietitian colleagues, and interprofessional relationships were all rated less positively in 2012 than in the 2009 survey. Autonomy of practice, opportunities for personal growth, and recognition from supervisors and peers were also satisfactory to a smaller proportion of the respondents in 2012. Workload and work-life balance show improvement in satisfaction levels from 2009 to 2012 responses. 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. 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. Opportunities for, and access to funding for, personal and professional development, are rated more satisfactory in 2012; this may be related to opportunities with the Allied Health Professional Development Fund, or may reflect PHC setting priorities on professional development of staff.

Dietitians in this survey are not satisfied with their opportunities for advancement, and the 2012 results show a greater proportion are dissatisfied. The implications of this dissatisfaction, and opportunities to ameliorate, should be further investigated. Career progression and opportunities for advancement have been reported as important to overall job satisfaction in other studies of health professionals (Cody, Ferguson & Desbrow, 2011).
Turnover of dietitian colleagues and training of new colleagues show increasing dissatisfaction in 2012 compared to 2009. This supports the reported issues raised by the PHCAG, and aligns with the results of the intention to leave question.

![Figure 3: Satisfaction with job and employer](image)

![Figure 4: Work schedule and workload](image)
Figure 5

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Figure 6

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Percentage of Respondents
- Dissatisfied
- Neutral
- Satisfied
Compensation

Sixty percent of respondents working full time for one employer reported income of $55001 – $65000. An additional 20% reported $65001 – $75000, and 10% reported $45001 – $55000.

The vast majority (87%) of respondents (148/170) who answered this question in 2012 stated that they are not satisfied with their compensation. Reasons for this dissatisfaction are perceived inequity with wages paid to other health professionals with similar education, training, and competencies, and inequity with dietitian positions in other sectors such as acute care. This can be compared to 2009, when 65% of respondents from all practice settings felt they were not adequately compensated.

Wage rates for dietitians in FHTs are based on the Ministry of Health and Long Term Care’s Guide to Interdisciplinary Provider Compensation (MOHLTC, 2010).

Dissatisfaction with compensation was apparent at all levels of reported income; of the 41 respondents who reported annual income of >$65000, only 9 felt that they were paid a fair wage. For the 124 respondents reporting income <$65000, seven individuals felt they were paid a fair wage.
Intention to Leave Current Position

Respondents were asked about their plans to leave their current position within the next year, next 2 – 5 years, or beyond 5 years. Significant numbers of respondents plan to leave their current position to pursue other employment, and a large proportion are undecided (see Figure 8). The small numbers of dietitians planning to retire within the next five years is to be expected given the large proportion of respondents in this survey that are new to the profession. This contrasts with the findings of the 2009 workforce survey and the overall Canadian dietetic workforce meta-analysis which showed up to 50% of current members of the profession exiting due to retirement by 2018 (Dietitians of Canada, 2009a and 2011).

In the lower income group, 27% of respondents reported intention to leave their current position within one year to pursue other employment, and 19% within 2 – 5 years. For dietitians reporting income >$65000/year, 18% plan to pursue other employment within one year, and 9% in 2 – 5 years.

Intention to leave was similar between FHT and CHC respondents for the medium term, but differed for <1 year and >5 years. Leaving current position to pursue other employment within the next year was indicated by 22% (FHT) and 32% (CHC), in 2–5 years by 19% (FHT) and 20% (CHC), and beyond 5 years by 17% (FHT) and 4% (CHC).
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:

- Follow up on practitioners’ intent to leave their current position
- Factors which influence the “undecided” group toward staying or leaving their current position
- Effects on client outcomes and practitioner satisfaction related to dietitians working at full scope of practice
- Relationship between wait times and client satisfaction and health outcomes
- Continued efforts to build high-functioning primary health care teams
- Effect of compensation dissatisfaction on recruitment and retention of RDs in PHC
- Systems approaches to integrating primary health care with other sectors of the health system
References


