We're Chronically Understaffed:

A Report on Public Rehabilitative Care in BC

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Contents

Introduction

Public rehabilitative care is at a tipping point in British Columbia.

This research report examines the state of public rehabilitation services for patients requiring therapy from debilitating illness, chronic disease, injury or recovering from surgery. Specifically, rehabilitative care includes, but is not limited to, physical therapy for strength and to enable movement, occupational therapy for the skills necessary for everyday living, and speech and language therapy for communication and swallowing. Rehabilitative care provides essential therapies to foster wellness, quality of life, and optimize and maintain functional abilities. Rehabilitative care is essential public health care.

Rehabilitative and prehabilitative[1] care is provided by health science professionals including physiotherapists, occupational therapists, and speech-language pathologists. They work with a team of other health science professionals as well as assistive and support staff, nurses, care aides, and physicians. Rehab professionals provide care across the health care system in inpatient and outpatient hospital settings, primary care teams, home and community care for seniors and people with disabilities, non-profit agencies, and Child Development Centres. And while this report focuses specifically on physiotherapy, occupational therapy, and speech and language therapy, rehabilitative care involves mental health professionals, respiratory therapists, recreational therapists, art and music therapists, dietitians, social workers, audiologists, among other professional disciplines.

However, these specialized services have been eroded over several decades. The result is staffing shortages, a lack of services in many communities, and long wait times for patients and clients, including children and their families. The staffing shortages crisis is taking a toll on patients and frontline professionals. In a 2020 survey of HSA members, 65 per cent reported shortages in their professions and 53 per cent said their department has a patient waitlist. Most concerning, 42 per cent said they are considering leaving public practice due to unmanageable workload.

These challenges have been acknowledged by government and employers, but limited action has been taken.

In 2017, the Ministry of Health identified four health science “priority professions” experiencing labour market challenges, including recruitment, retention, and shortages.[2] This initial list has since expanded. Today, the Ministry of Health has agreed to expand the list to 14 priority health science professions, including physiotherapists, occupational therapists, and speech-language pathologists. This is the result of work carried out by the Recruitment and Retention Committee negotiated into the Health Science Professionals Bargaining Association collective agreement, which governs health science professionals providing services in acute and community settings.

In 2020, the BC government committed to improving workforce planning with the creation of the new Allied Health Policy Secretariat in the Ministry of Health. This new branch is engaging in the first-ever provincial allied health consultation, which includes health science professionals as well as other occupations outside of nursing and medicine. Since the fall of 2018, the BC Ministry of Health has also provided two rounds of professional development funds totalling $6 million for health science professions facing shortages and other challenges. While these are welcome steps, much more still needs to be done to address the challenges outlined in this report.

Drawing on interviews and focus groups with 46 frontline professionals, as well as statistical analysis, this report documents the current state of public rehabilitative care in BC with a focus on physical, occupational, and speech and language therapies. This report finds that access to public rehabilitative care has been deteriorating, and significant policy attention is required to rebuild these services.

1 Prehabilitative care or prehabilitation refers to care initiated before surgery that is intended to strengthen physical, mental, nutritional health and wellbeing so that patients are better prepared for surgery and experience fewer complications and a faster recovery. Prehabilitation can help reduce length of hospital stay and readmission.

2 BC Ministry of Health, 2017.

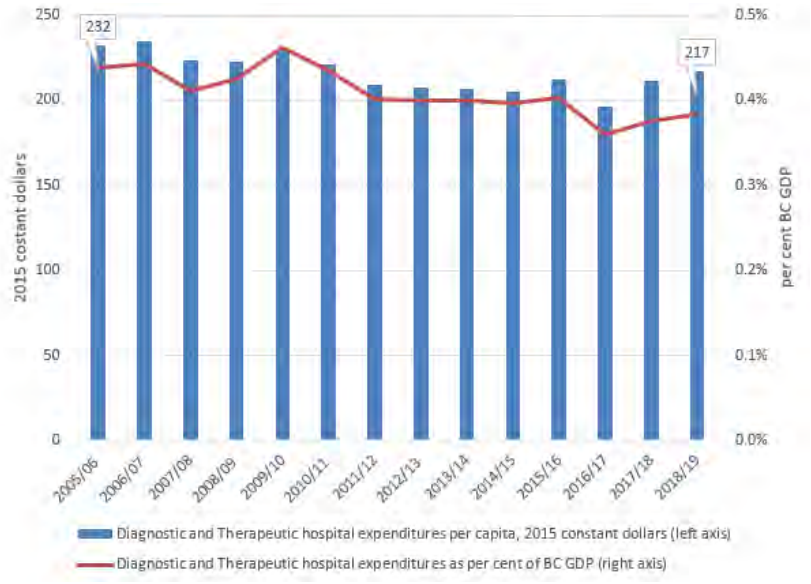
Policy and Funding Context

The erosion of public rehabilitation services has multiple causes. Funding cuts and health services restructuring beginning in the 1990s brought reductions in public rehabilitation as well as program closures.[3] Despite some of the admirable goals of a "closer to home" policy agenda and the de-institutionalization of care, many services were in fact lost as the promises for greater home and community-based care went unfulfilled.

The Canada Health Act and BC Hospital Insurance Act require medically necessary physician and hospital services to be publicly funded. However, as governments look to reduce public expenditures, one of the main ways is to remove health care services from the hospital setting so that certain services can be rationed or user fees introduced. In this way, health care privatization – and the downloading of health care costs onto families and individuals – often occurs by cutting services, failing to properly fund them, or contracting out services to private, for-profit providers.[4]

In some cases, user fees may be introduced or patients are expected to pay out-of-pocket for the full treatment that may have been provided at no cost in the hospital setting. As this report will show, rehabilitative therapy is increasingly limited to the inpatient setting in BC with very limited outpatient therapy provided. In other cases, health authorities pay for patients' post-operative therapy in the private sector. In many of these settings, private clinics may charge patients for additional services or equipment that would be covered had it been provided in the hospital setting. Put simply, health care privatization is a shift away from the principles of universal, not-for-profit provision and public accountability.

Figure 1: Public hospital diagnostic and therapeutic funding in BC (inflation adjusted), 2005/06 to 2018/19



Source: Author's calculations from CIHI (2020d). GDP and inflation figures from CIHI 2020 NHEX Appendices A, B, D.

Figure 1 shows the trend in declining investment in public rehabilitative care. Between 2005/06 and 2018/19, inflation-adjusted per capita funding for hospital diagnostic and therapeutic services declined from $232 to $217. This decline occurred at a time when the seniors population grew significantly. In the last two years, there has been an increase in per capita funding, but when adjusted for inflation, it remains below funding levels in the mid-2000s. In addition, funding as a share of BC's GDP declined from 0.44 per cent in 2005/06 to 0.38 in per cent in 2018/19.

This report examines the consequences of declining per capita funding for therapy services from staffing and patient care perspectives. The result of declining real funding has been reduced access to public rehabilitative care in most regions of the province.

3 Cohen & Pollak, 2000.
4 Armstrong et al., 1997.

Methods

This research draws on academic and policy literatures, health authority and Canadian Institute for Health Information (CIHI) data, and interviews and focus groups with frontline professionals. Semi-structured interviews were conducted with 34 participants and two focus groups with a total of 12 participants from mid- to late-2019. In total, 15 physiotherapists, 14 occupational therapists, 14 speech-language pathologists, one social worker, and two family physicians working in long-term care participated.

> “The staffing shortages crisis is taking a toll on patients and frontline professionals.”

Participants were recruited through HSA’s magazine *The Report*, social media, email, and website. An effort was made to ensure balanced professional and regional representation (see Appendix A: Research Participants). All participants were offered, and all requested, pseudonyms to protect their identity. Semi-structured interviews, lasting 40-60 minutes on a range of topics, were conducted by phone and in-person. Upon completion, participants received a $40 honorarium. Interviews and focus groups were recorded, transcribed, and manually coded and analyzed for recurrent and emerging themes. Thematic saturation was achieved in the interviews, and key themes were validated by focus group participants.

Rehabilitative care is essential public health care

The Canada Health Act is the foundational legislation that establishes and maintains public health care in every province. It requires that provincial governments provide medically necessary care “provided to inpatients or outpatients at a hospital […] for the purposes of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability[.]”[5] Specifically, it sets out minimum legislative requirements for the provision of rehabilitative care by provincial public health care systems.

Rehabilitation therapy is provided by a range of different health care professionals. This report focuses on three professions and therapeutic domains:

- **Physiotherapists** are regulated professionals “with a significant role in health promotion and treatment of injury and disease” with the goal of “getting [patients] to a place where [they] can be at [their] best functional capacity, maintaining that and then helping [them] to prevent future injuries.”[6] Physiotherapy involves hands-on treatment, including manual therapy, therapeutic massage, and the use of machines. Physiotherapy supports all age groups, especially older adults, to improve and maintain physical mobility within their home and community, prevent falls, optimizes patients for surgery and support recovery, and provides non-opioid pain management strategies. With an aging population, it is estimated that 20 to 30 per cent of all GP consultations involve musculoskeletal complaints. Physiotherapists are clinical experts in this area and can rapidly assess patients for surgery or non-operative therapy.[7]

- **Occupational Therapists** are regulated professionals “that help to solve the problems that interfere with a person’s ability to do the things that are important to them – everyday activities like self-care (getting dressed, eating, moving around the house), being productive (going to work or school, participating in the community), and leisure activities (sports, gardening, social activities).” Occupational Therapists are “trained to understand not only the medical and physical limitations of a disability or injury, but also the psychosocial factors that affect the functioning of the whole person – their health and their wellness.”[8] Occupational therapy helps people of all ages and dis/abilities to adapt their environment to maintain functionality and participation and support quality of life (physical and psychological).

- **Speech-Language Pathologists** are regulated professionals “who have training and expertise in evaluating, diagnosing, and treating a wide range of speech, language, communication, and swallowing disorders. Speech-

5 Canada Health Act, s. 2 https://laws.justice.gc.ca/eng/acts/C-6/FullText.html . Under the Canada Health Act, a “hospital” includes “any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care[.]”

6 Canadian Physiotherapy Association, http://physiocanhelp.ca/what-is-physiotherapy/what-physiotherapists-do/

7 Jordan et al., 2005.

8 Canadian Association of Occupational Therapy, https://www.caot.ca/site/aboutot/whatisot?nav=sidebar

language pathologists work with people of all ages, from newborns to seniors."[9] Speech-language therapy is critical to evaluating and treating individuals for speech, language, and swallowing disorders that can result from strokes, degenerative diseases (e.g., Parkinson's or dementia), traumatic brain injury (including overdose-induced), certain cancers, and head and neck surgeries. Speech-language pathologists help children and their families with age-appropriate communication skills, which are foundational to cognitive development, education, and social and emotional development.

These rehabilitation professions, among others, play critical roles supporting individual and population health. When rehabilitation is equitably accessible to all, it has the potential to address chronic disease, injury recovery, episodic disabilities, and the growing public cost pressures of an aging population with multimorbidities.[10]

Addressing health inequalities requires equitable access to rehabilitative care

Forty-four percent of adults 20 and older have at least one of ten common chronic conditions, which increases to 73 per cent of adults 65 and older.[11] Many of these chronic diseases are preventable or manageable with appropriate therapies and supports.

However, many British Columbians, especially those who lack access to private extended health insurance, also lack access to rehabilitative care that could help them avoid developing debilitating disease or manage their condition and avoid hospitalization. Falls are a major cause of injury, disability, hospitalization, and premature death for seniors in Canada. As the Public Health Agency notes, "[i]n 2017/18, approximately 350,000 (or 5.8 per cent) reported a fall-related injury in the past 12 months [and] almost two-thirds were women."[12]

The Health Officers Council of BC – an organization comprised of public health physicians – has produced some of the most comprehensive research on health inequalities[13] in BC. In 2008, the Council found that "there is a relatively large number of disadvantaged people in the province – the unemployed and working poor [and] children and families living in poverty […] all of whom experience significantly lower levels of health than the average British Columbian."[14] The Council's 2013 report concluded that the substantial differences in life expectancies between the wealthiest and poorest segments of the population had increased – a trend that demonstrates that the health gap between higher and lower income groups is widening in BC.[15]

Poverty and income inequality as well as access to health services produce health inequalities. This issue is particularly a concern for seniors, especially as senior women living alone have experienced greater poverty in BC since the mid-1990s.[16] This is particularly troublesome since many seniors cannot afford out-of-pocket health care expenses. A 2015 BC Seniors Advocate survey found that 65 per cent of seniors with a low income (less than $30,000 per year) did not have extended private health coverage, compared to 40 per cent of middle-income seniors ($30,000 to $60,000 per year). Thus, these seniors – disproportionately women living alone – are likely to lack access to preventative therapy that may help them prevent falls, hospitalization, and long-term care.

With BC's seniors population projected to dramatically increase over the next 20 years (Table 1), BC should urgently address the gap in public rehabilitative care in order to prevent widening health inequalities.

Table 1: Increase in population 65 and older by health region, 2021 to 2041

Fraser	80%
Interior	32%
Northern	62%
Vancouver Coastal	65%
Vancouver Island	36%
British Columbia	57%

Source: Calculated from BC Stats PEOPLE 2020 projections (accessed June 15, 2021)

9 Speech and Hearing BC, http://speechandhearingbc.ca/professional/careers/.
10 Canadian Working Group on HIV and Rehabilitation and Wellesley Institute, 2021.
11 Public Health Agency of Canada, 2019; 2020b.
12 Public Health Agency of Canada, 2020a.
13 Health inequalities refer to observed differences in health by population groups (e.g., income).
14 Health Officers Council of BC, 2008, p. 8.
15 Health Officers Council of BC, 2013, p. 12
16 Ivanova, 2017.

These health inequalities are not inevitable, and result from various socio-economic determinants of health as well as access to health services. Addressing these health divides can reduce public health care costs (i.e., hospitalization), increase economic productivity (i.e., rehabilitation can support greater employment participation), and improve population health outcomes. Re-focusing rehabilitation services around health promotion and restorative care – which means ensuring that services are available *before* individuals find themselves requiring acute inpatient care – would improve health outcomes and the health system burdens that result from the lack of preventative care.

Research evidence shows that health science professionals (also called allied health professionals) have an important role to play addressing health inequalities.[17] Physical and occupational rehabilitation can have a positive impact on the functional abilities of older adults to maintain independence and avoid the need for more costly health services.[18] Speech-language pathologists' management of swallowing disorders reduces morbidity, mortality, and length of hospital stay while also improving quality of life.[19] In addition, speech and language therapy is critical in supporting young children and youth develop communication skills necessary for success in school and employment.

Improving public access to rehabilitative care would go a long way in addressing health equity.

COVID-19 and rehabilitative care

Although interviews and focus groups for this research report were conducted before the pandemic, COVID-19 has exacerbated pre-existing issues documented in this report.

COVID-19 has significantly increased demand for acute and outpatient rehabilitation. Rehabilitation professionals including physiotherapists, occupational therapists, speech-language pathologists, respiratory therapists, social workers, and dietitians – as well as physicians, support staff, nurses, medical laboratory and medical imaging technologists – are essential in providing care to patients who are hospitalized, intubated, and/or requiring critical care.

Patients admitted to inpatient rehabilitation after hospitalization have had deficits in mobility, cognition, speech and swallowing, and have benefited significantly from therapy.[20] Physiotherapists assess and manage neurological, musculoskeletal and cardiorespiratory complications. They may be involved in specific patient positioning, suctioning, mobilization (including ambulation and range of motion), strengthening and balance exercises, and airway clearance techniques. Early mobilization results in decreased length of stay in ICU, decreased overall hospital stay, prevents ICU-related complications, and improves function and quality of life. Occupational therapists work with inpatients to carry out activities of daily living and develop treatment plans to rehabilitate physical, cognitive, psychosocial, and developmental impairments. For patients who have been intubated or receiving high-flow oxygen, speech-language pathologists play a critical role assessing and treating patients transitioning from tube feeding to eating and drinking by mouth.

In addition to inpatient care, outpatient rehabilitation is necessary for recovery of hospitalized COVID-19 patients and for patients who suffer from "Long COVID". Long COVID refers to symptoms persisting more than four weeks after the period of acute illness is over (also called sequelae). Long COVID can affect adults and children who are hospitalized as well as those who suffered mild or moderate acute illness at home. Frequent symptoms after six months include fatigue, post-exertional malaise, and cognitive dysfunction, with "prolonged multisystem involvement and significant disability."[21]

A recent UK survey conducted by the Office of National Statistics found that an estimated 962,000 people living in private households in the UK (1.5% of the population) were experiencing long COVID. Of these, 385,000 had experienced symptoms longer than one year. Symptoms adversely affected day-to-day activities of 634,000 people (65.9% of self-reported long COVID), with 178,000 (18.5%) reporting their ability to undertake their day-to-day activities had been "limited a lot".[22] Emerging evidence suggests that 10 to 15 per cent of children infected suffer from Long COVID.[23] Although similar data have not been collected in Canada, prevalence of Long COVID is expected to be similar.

COVID-19 has increased the demand for public rehabilitative care for patients suffering from acute illness and Long COVID. The pandemic has also increased demand for rehabilitative care for people with long-term conditions and frailty have deteriorated while seniors' programs were limited or closed, and for the growing number of individuals with brain injury resulting from opioid overdose as drug poisoning deaths have increased during the pandemic.

17 Ford et al., 2021; Fowler Davis et al., 2016.
18 Wilson, 2013.
19 Hindle et al., 2015, p. 14.
20 Olezene et al., 2021.
21 Davis et al., 2021, p. 1.
22 Office of National Statistics, 2021.
23 Lewis, 2021.

In response, BC has opened four COVID-19 Recovery Clinics in the Lower Mainland for patients suffering from Long COVID.[24] These clinics are important; however, increased access to public rehabilitation services for Long COVID and other rehabilitation needs are required province-wide.

24 Post-COVID-19 Recovery Clinics, http://www.phsa.ca/our-services/programs-services/post-covid-19-recovery-clinics.

Key Findings

Access to public rehabilitative care stagnant or declining in most regions

Access to publicly funded and provided physiotherapy, occupational therapy, and speech and language therapy is stagnant or declining in most BC communities. Drawing on CIHI and health authority data, the following sections analyze trends related to public access to rehabilitation.

Physiotherapy

Total workforce

In BC, there were 3,915 physiotherapists in 2019 or 78.4 physiotherapists per 100,000 population.[25] This includes all registered physiotherapists in the province, including those who work in the public, non-profit, and private sector.

Table 2: Physiotherapists per 100,000 population by province (public and private sectors), 2019

	Number of physiotherapists	Number per 100,000
Nova Scotia	754	78.5
British Columbia	3,915	78.4
New Brunswick	567	73.6
Alberta	3,086	71.6
Prince Edward Island	104	67.9
Ontario	9,532	66.6
Quebec	5,424	64.6
Saskatchewan	746	64.2
Manitoba	814	60.2
Newfoundland & Labrador	300	57.1

Source: CIHI, 2020a, Tables 1-10

Physiotherapists by sector of employment

BC had the smallest share – 33 per cent – of physiotherapists working in the public sector among the provinces with available data (Table 3).

In BC in 2019, 64 per cent of physiotherapists worked in the private sector, including self-employment. Saskatchewan (53%), Newfoundland and Labrador (52%), Manitoba (48%), Alberta (47%), and New Brunswick (42%) had a greater share of physiotherapists working in public practice.

BC has the second-highest number of practicing physiotherapists per capita, compared to other provinces (Table 2), and yet the fewest working in the public sector among provinces with available data (Table 3). This misdistribution of physiotherapists is contributing to declining access to public physiotherapy in many communities – an issue identified by many frontline physiotherapists in the interviews and focus groups.

> “BC has the second-highest number of practicing physiotherapists per capita compared to other provinces, and yet the fewest working in the public sector among provinces with available data.”

25 2019 is the most recent year available. CIHI, 2020, Table 10.

Table 3: Percentage of physiotherapists by sector of employment, 2019

	% in public sector	% in private sector
Saskatchewan	53%	44%
Newfoundland and Labrador	52%	48%
Manitoba	48%	48%
Alberta	47%	52%
New Brunswick	42%	56%
British Columbia	33%	64%

Source: CIHI, 2020c, Table 2
Note: Provinces with available data are included. Percentages may not sum to 100% as some data do not specify sector. Private sector includes self-employed.

Most concerning, a declining share of physiotherapists in BC are working in public practice. In fact, between 2010 and 2019, the share of physiotherapists in the public sector declined from 48 to 33 per cent (Table 4). Put another way, in 2010 a greater share of physiotherapists was working in public practice than in the private sector, but by 2019, the share working in private practice accounted for a much greater share: 64 per cent of the total workforce.

Table 4: Physiotherapists per 100,000 population by sector of employment in BC, 2010 to 2019

Year	Population	Total physio-therapists	Per 100,000	Number in public sector	Per 100,000	% public sector	Number in private sector (includes self-employed)	Per 100,000	% private sector
2010	4,465,546	2,857	64.0	1,381	30.9	48%	1,305	29.2	46%
2011	4,502,104	2,900	64.4	1,356	30.1	47%	1,327	29.5	46%
2012	4,566,769	2,972	65.1	1,344	29.4	45%	1,373	30.1	46%
2013	4,630,077	3,101	67.0	1,338	28.9	43%	1,510	32.6	49%
2014	4,707,103	3,206	68.1	1,337	28.4	42%	1,538	32.7	48%
2015	4,776,388	3,321	69.5	1,443	30.2	43%	1,581	33.1	48%
2016	4,859,250	3,404	70.1	1,436	29.6	42%	1,637	33.7	48%
2017	4,929,384	3,587	72.8	1,397	28.3	39%	1,519	30.8	42%
2018	5,010,476	3,771	75.3	1,386	27.7	37%	1,689	33.7	45%
2019	5,090,955	3,885	76.3	1,292	25.4	33%	2,490	48.9	64%

Source: CIHI, 2020c, Table 2 and BC Stats population estimates
Note: Percentages may not sum to 100% as some data do not specify sector. There was a significant change in reporting of employment sector between 2018 and 2019, which suggests a reclassification of data from "not stated" to "private" and therefore the significant increase in private sector practice in 2019 should be interpreted with caution.

In absolute terms, BC lost 89 public practice physiotherapists between 2010 and 2019 (Table 4). On a per capita basis, the number of physiotherapists in the public sector declined from 31 per 100,000 in 2010 to 25 per 100,000 in 2019 (Table 4). During the same period, the rate of physiotherapists increased in the private sector from 29 to 49 per 100,000 population, with an absolute increase of more than 1,000 physiotherapists working in the private sector. The findings are troubling when comparing the share of public practice physiotherapists in BC compared to other provinces with available data.

Public physiotherapy access rate by region

The public physiotherapy access rate – calculated as funded physiotherapist full-time equivalent (FTE) per 100,000 population – reveals low baseline staffing levels generally, and inequities in the provincial distribution of public physiotherapists, specifically (Table 5). This measure is useful as it accounts for changes in access to public physiotherapy (employed by health authorities) relative to population growth.[26]

- BC had an access rate of 17.5 full-time equivalent (FTE) physiotherapists to 100,000 people in 2018.
- BC and all health regions, except for Northern Health, experienced a decline in access from 2012 to 2018.

26 Please note that this calculation does not include physiotherapists employed by non-health authority organizations in the broader public sector.

- Northern Health saw an increase in access, but had comparatively much lower access rates in 2012 and 2018 to begin with (and less than half of Vancouver Coastal Health in 2018).

Table 5: Public physiotherapy access rate in BC, 2012 to 2018

	Population		Physiotherapist FTE		Physiotherapy Access Rate (FTE per 100,000)		Access Rate Change,
	2012	2018	2012	2018	2012	2018	2012 to 2018
Fraser Health	1,672,799	1,872,846	206.91	213.23	12.4	11.4	-8%
Interior Health	725,918	796,391	154.9	166.6	21.3	20.9	-2%
Northern Health	285,197	296,431	27.53	35.50	9.7	12.0	24%
Vancouver Coastal Health	1,123,333	1,210,265	311.66	309.93	27.7	25.6	-8%
Vancouver Island Health	759,522	834,543	155.0	154.0	20.4	18.5	-10%
British Columbia	4,566,769	5,010,476	856.0	879.3	18.7	17.5	-6%

Source: Freedom of Information requests and BC Stats population estimates (accessed June 14, 2021)
Note: Vancouver Coastal Health includes Providence Health Care

Occupational Therapy

Total workforce and sector of employment

In 2019, BC had 2,491 registered occupational therapists or 50 per 100,000 population working in public, non-profit, and private sectors (Table 6).

Along with Ontario, BC stands out for a relatively high share of self-employed occupational therapists at 15 per cent of the total workforce (Table 7). While sector of employment data are unavailable, the comparatively higher share of self-employed occupational therapists suggests a higher percentage work in private practice settings compared to some other provinces with available data including Alberta, Saskatchewan, Manitoba, and Nova Scotia.

Table 6: Occupational therapists per 100,000 population by province (public and private sectors), 2019

	Number of occupational therapists	Number per 100,000
Quebec	5,560	66.3
Nova Scotia	571	59.5
Alberta	2,260	52.5
New Brunswick	403	52.3
Manitoba	690	51.0
British Columbia	2,491	49.9
Prince Edward Island	70	45.7
Ontario	6,235	43.5
Newfoundland & Labrador	215	40.9
Saskatchewan	359	30.9

Source: CIHI, 2020a, Tables 1-10

Table 7: Percentage of occupational therapists self-employed, 2019

	% self-employed
Ontario	17.7%
British Columbia	15.4%
Saskatchewan	7.3%
Alberta	7.0%
Manitoba	6.3%
Newfoundland and Labrador	6.2%
Nova Scotia	6.1%
Prince Edward Island	5.7%

Source: CIHI, 2020b, Table 2

Public occupational therapy access rate by region

The public occupational therapy access rate – calculated as funded occupational therapist FTE per 100,000 population – reveals low baseline staffing levels generally, and inequities in the provincial distribution of public occupational therapists, specifically

(Table 8). This measure is useful as it accounts for changes in access to public occupational therapy (employed by health authorities) relative to population growth.[27]

- In BC, occupational therapy access increased marginally from 18.4 to 19.1 FTE per 100,000 population (4 per cent) between 2012 and 2018.
- Fraser Health (the most populous health region) had the lowest occupational therapy access rate in 2018 (12 FTE per 100,000), followed by Northern Health at 12.2 FTE per 100,000 population.
- Vancouver Coastal Health had the highest occupational therapy access rate of 30.1 FTE per 100,000 – more than double that of Fraser and Northern Health.
- All health authorities increased access to public occupational therapy between 2012 and 2018 with the exception of Vancouver Coastal Health. However, as noted, some health regions – namely Northern, Fraser, and Interior Health, had very low access rates to begin with.

Table 8: Public occupational therapy access rate in BC, 2012 to 2018

	Population		Occupational Therapist FTE		Occupational Therapy Access Rate (FTE per 100,000)		Access Rate Change, 2012 to 2018
	2012	2018	2012	2018	2012	2018	
Fraser Health	1,672,799	1,872,846	183.88	224.56	11.0	12.0	9%
Interior Health	725,918	796,391	108.1	128.5	14.9	16.1	8%
Northern Health	285,197	296,431	29.04	36.10	10.2	12.2	20%
Vancouver Coastal Health	1,123,333	1,210,265	337.1	364.0	30.0	30.1	0%
Vancouver Island Health	759,522	834,543	182.0	206.0	24.0	24.7	3%
British Columbia	4,566,769	5,010,476	840.1	959.1	18.4	19.1	4%

Source: Freedom of Information requests and BC Stats population estimates (accessed June 15, 2021)
Note: Vancouver Coastal Health includes Providence Health Care.

Speech and Language Therapy

Total workforce

In 2019, there were 1,371 registered speech-language pathologists working in all sectors (public, non-profit, and private) in BC – or 27.5 speech-language pathologists per 100,000 population (Table 9). BC had the second-lowest number of speech-language pathologists (all sectors) per capita in Canada.

Table 9: Speech-language pathologists per 100,000 population by province (all sectors), 2019

	Number of speech-language pathologists	Number per 100,000
Nova Scotia	337	35.1
Quebec	2,937	35.0
Alberta	1,505	34.9
Saskatchewan**	382	32.9
New Brunswick	250	32.4
Prince Edward Island*	48	31.3
Manitoba	396	29.3
Newfoundland & Labrador	148	28.2
British Columbia	1,371	27.5
Ontario	3,276	22.9

*Counts may be understated due to the unregulated status of the profession.
**2018 is the most recent year available.
Source: CIHI, 2020, Tables 1-10

27 Please note that this calculation does not include occupational therapists employed by non-health authority organizations in the broader public sector.

Public speech and language therapy access rate by region

The public speech and language therapy access rate – calculated as funded speech-language pathologist FTE per 100,000 population – reveals extremely low baseline staffing levels in BC and across all health authorities (Table 10). This measure is useful as it accounts for changes in access to public speech and language therapy (employed by health authorities) relative to population growth.[28]

Specifically, the trends show:

- In BC, the public speech and language therapy access rate remained stagnant (a marginal increase from 4.9 to 5 FTE per 100,000 population). The provincial access rate demonstrates that funded baseline staffing is extremely low.

- The access rate declined in Interior Health and Vancouver Island Health, with an absolute decline in the number of speech-language pathologist FTE on Vancouver Island.

Table 10: Public speech and language therapy access rate in BC, 2012 to 2018

	Population		Speech-Language Pathologist FTE		Speech and Language Therapy Access Rate (FTE per 100,000)		Access Rate Change, 2012 to 2018
	2012	2018	2012	2018	2012	2018	
Fraser Health	1,672,799	1,872,846	58.4	73.6	3.5	3.9	12%
Interior Health	725,918	796,391	32.6	35.1	4.5	4.4	-2%
Northern Health	285,197	296,431	14.7	15.9	5.1	5.4	4%
Vancouver Coastal Health	1,123,333	1,210,265	72.3	82.7	6.4	6.8	6%
Vancouver Island Health	759,522	834,543	47.0	44.0	6.2	5.3	-15%
British Columbia	4,566,769	5,010,476	225.0	251.3	4.9	5.0	2%

Source: Freedom of Information requests and BC Stats population estimates (accessed June 15, 2021)

Note: Vancouver Coastal Health includes Providence Health Care

Furthermore, Speech and Hearing BC estimates that the province funds just under 165 FTE speech-language pathologists serving the toddler and preschooler population, which leaves nearly half of publicly funded therapists with unmanageable caseloads of over 80 children. Te recommended caseload is 25-40 children.[29]

The BC Association for Child Development and Intervention has raised similar concerns. In its survey of publicly funded Child Development Centres and non-profit agencies, it found that the average wait time following referral for speech and language therapy is about 180 days.[30]

In conclusion, the physiotherapy, occupational therapy, and speech and language therapy access trends show the ongoing erosion of public rehabilitation services. This is the result of a lack of funding, severe public sector recruitment and retention challenges created by a vicious cycle of shortages, and a provincial policy approach that has favoured private-pay rehabilitative care over public care.

Private-pay therapy is unaffordable for many, and lack of public rehabilitation widens health inequalities

The erosion of public rehabilitative care has laid the foundation for a significant market for private-pay rehabilitation services. However, the research literature and interviews with HSA members tell us that privately funded health care creates barriers to access necessary care for lower income and marginalized populations.[31] As well, private-pay health care does not reduce wait times in the public system. It has the opposite effect: it pulls limited professionals out of the public system to the private sector, where professionals can earn higher incomes with reduced workloads.[32]

In 2019, approximately 3.5 million (out of 5 million) BC residents had extended health insurance that might help cover the cost of private-pay rehabilitation therapy.[33] However, many British Columbians who are moderate and low income, especially seniors and populations who are disproportionately impacted by chronic disease, are unable to afford private-pay

28 Please note that this calculation does not include speech-language pathologists employed by non-health authority organizations in the broader public sector.
29 Speech and Hearing BC, n.d.
30 BC Association of Child Development and Intervention, 2020, p. 6.
31 Canadian Foundation for Healthcare Improvement, 2012.
32 Canadian Foundation for healthcare Improvement, 2005.
33 Canadian Life and Health Insurance Association, 2020.

rehabilitative care.

In interviews and focus groups, HSA members expressed concerns that private-pay therapy is unaffordable for many patients:

> *"I feel like it would also be nice if we had more physiotherapists that we could offer more outpatient services for people who need them and can't afford private practice. […] I mean with outpatient we only see hip and knee replacements and everyone else has to go to private. Lots of people aren't able to afford private so they can't go to physio they might not be getting exercises that can help rehab whatever injury they have or to keep them fit and active. So even with that little bit of education, with other adults if they keep moving and they have exercises to do at home, they can stay at home longer, they can be healthier longer, but if they don't have access to any of that then they often end up in the hospital." (Ingrid, PT)*

> *"Yeah and I think because right now publicly funded actual rehab is extremely limited right now and extremely difficult to access. For example, for post-stroke patients it's really only the cream of the crop, the ones for the highest potential for improvement, the smallest number of comorbidities, all those sorts of things that are accepted into actual inpatient rehabilitation, there's still some opportunity for outpatient rehabilitation, but it's still really kind of a picking of […] the most quality patients to take into those programs. And hence you've seen a proliferation, I suppose might be one of the words we could use of actual specialized, private neuro-therapy clinics around – not just BC but other places as well – but you know, over the last ten years in Vancouver the number of private PT clinics that specifically specialize in neuro rehab has just grown tremendously and that's just kind of […] in response to there's a huge population of patients there that aren't able to access publicly funded services but would still benefit to some level. […] And once again those private options would not be available to someone who was on fixed income – those types of things – no health insurance to help pay for that sort of stuff. Especially with the neuro rehab…the extra time and equipment and things that go on to that…there's a higher level of cost that's being paid out for that type of rehab." (David, PT)*

> *"[P]articularly if we look more at the outpatients in terms of the Interior Health has a very restricted list of who I can see, and so that limits who can access the program here. And often times I'm the one who has to tell a client I'm sorry, yes I realize you don't have any money to go to private but you don't fit the criteria here so we cannot see you. So you always have to wonder who treats that person who might only need, not a lifetime of PT but one or two appointments just to set them in the right direction. And so there is definite inequality, at least in this health region." (Kim, PT)*

> *"Most of the clients we see obviously here they don't have the financial means to go privately for an assessment. $2,000 for a psych assessment… for a speech assessment so that's why they've been waiting this long for public services for kids to be assessed, so yeah, I definitely see that every day." (Catherine, SLP)*

Access to public rehabilitative care is an essential part of our public health care system and necessary for improving health equity.

Government and employer data show professional shortages in the public system

The public and non-profit sectors are facing severe shortages of health science professionals, including physiotherapists, occupational therapists, and speech-language pathologists. Ministry of Health, Health Employers Association of BC (HEABC), and HSA data indicate that professional shortages have reached a crisis point. In addition to the trends discussed above, there are a number of additional concerns:

- Based on the most recent data provided (2018) by HEABC, the net inflow for physiotherapists and occupational therapists has been negative (and worst for physiotherapists).

- According to HEABC data, there are projected demand-supply gaps for physiotherapists and occupational therapists, which increase from 2018 to 2023.

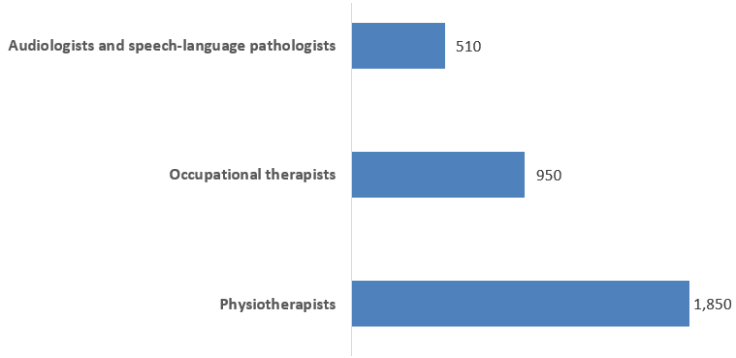
- HEABC-designated "Difficult-to-Fill"[34] and "Not-Difficult-to-Fill"[35] vacancies have been trending up for physiotherapists and occupational therapists since 2014.

34 Job vacancies that are unfilled for 90 days from the initial posting date (internal/external) and are advertised externally.

35 Job vacancies that are either filled within 90 days or no longer advertised.

- PTs, OTs, and SLPs are among the Ministry of Advanced Education and Skills Training's "high opportunity occupations" with hundreds and thousands of job openings between 2019 and 2029 (Figure 2).

Figure 2: Job openings forecast by BC government, 2019-2029



Source: BC Labour Market Outlook (2019 Edition)

Professional shortages undermine the conditions of work and the conditions of care

The conditions of the work are the conditions of care.[36] Shortages – including low baseline staffing levels and unfilled vacancies – undermine the conditions of work and the quality of care. The next four sections describe the different ways shortages materialize and the effect this has on working conditions and quality of care.

Shortages undermine care quality, scope of practice, and the potential of restorative care

Shortages make it very difficult for frontline professionals to help patients benefit from the full potential of rehabilitative and restorative care, which requires therapists to work to their full scope of practice and have adequate time with patients. There are different models and types of rehabilitative therapy depending on the context and condition. For some patients, intense therapy may be required. For others, less-intensive therapy over a longer period may provide greater benefit and help individuals develop a restorative plan that focuses on maximizing quality of life at their optimal level of functioning.

However, rehabilitation professionals are constrained in both their ability to provide the type of intensive therapy many patients would benefit from and ongoing outpatient therapy (an issue addressed in subsequent sections). Many interviewees and focus group participants expressed deep concerns and moral distress about the effect of shortages and understaffing:

> *"I find that when we're chronically understaffed or just have this very low baseline of staffing, patient care is definitely impacted. We see our patients on a priority basis as well, and our strategy is to provide compensatory strategies. We hardly ever have the chance to go in to a situation with a patient who has dysphasia, and actually provide dysphasia therapy. wW say, you have trouble swallowing, this is going to be the easiest texture, we put them on like let's say a puree diet, and then we leave them. And we go to the next patient and we do the same thing with the next patient, where I feel like that's doing them a disservice because they're not going to eat the puree, they're not going to drink the thickened fluids, but yet we are not really giving them any way to get better. So we leave these patients on these modified diets and then they get dehydrated and then it becomes more urgent and then what are we really doing to help them at that point?" (Jeanne, SLP)*

> *"I would probably say very little is working. Once again, I think there's very few people that got into the profession to do what they're doing in the hospital. […] I think the hope would be that if there could be more opportunities to expand the sort of rehab coverage of things. You know, to have more sort of Holy Family or GF Strong type [services]. Or even more hospital-based outpatient programs to be able to do stuff. It's a little bit of a catch-22 in a way of because of the sort of limiting of the scope sometimes. You know that's all other people see of what PTs do and so they start to think that that's all the PTs can do. And so they don't necessarily see all the advanced stuff that we are capably trained to do and do in private sector. And it's kind of the same thing. You know just too for all of my colleagues like the OTs… people start*

36 Armstrong & Armstrong, 2019; Berwick, 2003.

to think that that is all OTs do… is give people wheelchairs, when their skillset is so much more varied and advanced and that, but they're just sort of never given the opportunity to do that stuff with the mandate of the hospital." (David, PT)

"Especially for PT, as I've mentioned it's so difficult to access, so we have, I would say 10 per cent of the people who are admitted to a nursing home have some real rehab potential, where there's a chance that they could regain function that they had lost. So not everybody, like a small percentage. But our PTs they have so many people assigned to them and they can't keep up, and they also are very specifically limited to assessment." (Rivka, Family Physician in Long-Term Care)

"Well, certainly I have a patient who recently was in hospital for a long time after a fall and fracture and that person came home, was bed-bound for the first while, but has been able to mobilize from the point of view of her specialist and yet I think PT is only just starting now and that's four or five weeks later. So I think that would be an example where, in the interim muscle mass is lost even further because they remained in bed. More at risk of falling, and in fact this person has had a fall since going home. Luckily no major injuries but it's a very precarious situation and hopefully now the system is responsive but I suspect that there's quite a lot of those instances where it's just very challenging to get timely access when the greatest chance of rehab can happen." (Anastasia, Family Physician in Long-Term Care)

Interviews and focus groups reveal the extent of moral distress that is experienced on a daily basis on the frontlines of rehabilitative care. Moral distress arises when health care providers are trying to provide the intensity of care required by patients in order to achieve optimal clinical outcomes, and yet are prevented by institutional constraints from doing so.

As workloads increase, managers often respond to unmanageable workload by restricting the type or amount of therapy that can be provided to patients, which in turn limits therapists' scope of practice. This response becomes a self-reinforcing cycle of reducing job satisfaction and driving therapists from public practice as the work becomes increasingly narrow:

"…I think one thing that we're seeing in Vancouver Coastal Health is that it just starts to impact folks' job satisfaction and so with that, I would agree in terms of the narrowing of scope and so I think definitely as an employer, a health authority would be able to say you, "now we want to pay you to do 'x' part of your scope." That is well within an employer's ability to do that but I think some of the consequences of that is just the job satisfaction for clinicians, their desire to stay within any given position if they find it becoming quite boring or redundant, there's a greater impetus to leave that role and we end up – our current state right now is we have a lot of clinicians who are very well skilled, who will work part-time in public to sort of have the good benefits of that, but then will really seek their career satisfaction in a part-time private position." (Selma, OT)

"Here it's a divide or breakdown between knowledge and translation. I can speak from an OT perspective… what I've found is the practice is more…antiquated to a degree. This purpose in many clinical settings from acute care where I worked briefly, is I would it describe….or even in community…in many aspects I would describe that practice [is] more of technical work rather than therapeutic. Meaning the therapist is working more of technician rather than a clinician. […] [T]he way it's structured requires really some transformation." (Irfan, OT)

"…definitely we're short all over but a lot of the response in a lot of ways has been to really sort of limit the scope for what the PTs are doing, to sort of pull workloads into what is able to be provided by the staffing levels. And so […] we don't see everybody on all the units and […] you know there's much, much more that we could be doing. But it's simply not the priority and it's a little bit of a catch-22, you know we don't have the staffing levels necessarily to do that service anyways [...] [T]here's just much less opportunity to really work on higher level goals and a lot of it sort of boils down to simple transfers in and out of bed and maybe a little bit of walking plus or minus stairs […] The position has become much less about sort of rehabilitating people and much more just about getting people out of the hospital. And community positions which I've worked in in the past are much more now about keeping people out of the hospital as opposed to necessarily getting them better. Some of the outpatient programs in a few of the rehab units from GF Strong or Holy Family Hospital being kind of the last couple, sort of places where sort of actual rehab work is still sort of going on." (David, PT)

"…I feel that it's related to time constraints so the higher priority issues come to the fore and the more I guess less acute issues or issues that require more focus over a longer duration. They go by the wayside so I can't do everything that I am confident to do because of time constraints." (Bob, SLP)

The inability to provide the care that is required also makes team-based care very difficult. Despite the aspirational goal of team-based care, severe understaffing makes this idea very difficult in practice. Since rehabilitation professionals are not consistently able to be present for care team and discharge planning meetings to ensure that their input is consistently provided, the quality of care suffers:

> *"It's very tricky to do the team-based collaborative work that I think I'm passionate about my profession doing. And I think how we're most effectively used is in both complex team assessment of what the person's situation and function is, how they're recovering and then how we can make the best possible successful discharge plan. So I think hopping around to all these different floors made it almost impossible to participate in family team meetings. And because of that you didn't build up the same kind of closer relationships with like, the charge nurse and the doctor involved and if you're not building that relationship – like they barely care about your opinion anyways and if they have no idea who you are they're like "well, they're not here let's just discharge" or whatever. So I think the quality of patient care definitely suffers with having so few OTs per many different floors, different programs." (Susan, OT)*

Long wait times and increased length of hospital stay

Large patient caseloads place therapists in the difficult position of trying to provide optimal care despite severe understaffing and shortages. Interview and focus group participants stated that they cope with this situation by trying to provide as much intensive therapy for patients as quickly as possible. Heavy workload demands in the acute setting and understaffing mean that many rehabilitation professionals are not able to provide ongoing therapy in either inpatient, outpatient, or community settings, which would improve patient outcomes. There is too much pressure to move onto the next patient.

Interview and focus group participants explained how this contributes to long wait times and a lack of rehabilitative care for the highest acuity patients as well as lower acuity patients who might benefit most from ongoing outpatient therapy:

> *"I was recently working a split position where 0.6 of time was spent, not with inpatients but in a rehab program where it operates much like an inpatient stay where the patient comes every day, and receives very intensive therapy and I often felt that I was pressured to see more of those patients than my caseload target [and] would be to the detriment of the number of clients that I was able to see for my other more traditional outpatient caseload. I hadn't even realized that the target caseload size was, but I realized that I had been seeing you know, 30% more than the target caseload for the inpatient program, which meant that I wasn't getting through the outpatient waitlist as quickly as I would like to." (Ella, SLP)*

> *"…we just got just a tiny little bit of FTE to tackle our communication caseload and I feel so silly calling people from like, 2014 referrals. From 2014! And I'm embarrassed to even call, and people are so angry and shocked. And really – it feels awful! Because I'm trying my best here, at least I'm calling you! Like, significant situations that have been untouched for years." (Jeanne, SLP)*

> *"…unfortunately we don't have outpatient services or even waitlists, we stopped that a long time ago because there was no point, we'd never get to it but with this whole waitlist – I mean, the way we are managing our inpatient load, which at 2.2 FTE we really aren't managing for the whole hospital well, is unofficially we've created a waitlist for inpatients as well and so when we have patients come in we prioritize them based on the information on the referral and often times we just never get to even some of our inpatients cause we never get that far down." (Stella, SLP)*

Staffing shortages and the inability to provide timely care often means that patients have longer hospital stays because it takes longer for therapy to begin. This has implications for the entire health care system:

> *"…sometimes people just stay in the hospital longer if we're short staffed and not able to get to all of our top priorities… maybe they could go home pending an occupational therapy assessment, but we don't have – there's enough people that are in that situation – that we aren't able to get to them. And so probably increasing time in the hospital which isn't always pleasant for patients but it's also not ideal for the health authority and how much that costs." (Ann, OT)*

> *"So for example, this week, the other OT is on vacation for a whole week and there's been no coverage for the past three days, so I'm basically doing the work of 2.0 – full-time. And yeah, 18 clients, so maxed out, and it's just not possible to get to everybody. So a lot of people who are expecting at least an hour of therapy a day, they're just getting the bare minimum, like maybe me being able to do wheelchair seatings, splinting, discharge planning […] But for those intense like visual assessments, cognition, upper extremity*

treatments – they're not being seen. So definitely affecting the discharge timing. People are staying longer in hospital just because it's going to take them longer to get to the level to where they're independent." (Michaela, OT)

Shortages cause burnout and impede public sector recruitment and retention

In a 2020 survey of HSA members, 65 per cent reported shortages in their professions and 53 per cent said their department had a waitlist. Most concerning, 42 per cent told us they are considering leaving public practice due to unmanageable workload. Similar themes were identified in another survey of 123 private practice occupational therapists (conducted in 2014/15) published in the *Canadian Journal of Occupational Therapy.* They attributed their private practice preference to large public caseloads leading to burnout as well as a lack of understanding of the clinical role of OTs within health authority leadership.[37]

These two surveys are consistent with interviews and focus groups conducted for this report:

"From my experience increasing FTE would be huge. We have students that come and see us working like dogs with not updated equipment and it's not a glamorous looking situation. And they're like, "okay thanks for the experience but I don't want to work like that," and then they leave. So I would say increasing funds for equipment or education and increasing FTEs." (Jeanne, SLP)

"I'm just back from my summer vacation […] I took 3 weeks off and because the caseload demands have changed somewhat in terms of me doing more swallowing, when I came back, it was pretty clear that not having anybody to backfill, […] it was a problem. And actually it's not just me. I think that even my colleagues in rehab, they had trouble covering. They normally have coverage. We don't have enough bodies, we don't have casual staff to do backfill." (Tamara, SLP)

"I work as a casual and five years ago when the staffing was better, I felt more comfortable going in because there was a lot more support for me, so we had more shifts where I could pick up a shift where there was another PT on that same unit. And the worse the staffing gets, the less comfortable I feel going in because it's harder and harder to connect with colleagues when I need a bit of support because I'm not there every day. And so I find that it's kind of a bad cycle but the more they need casuals there I think for some of us the less likely we are to pick it up. Because it used to be that I always had somebody come if they had a bit of time, they would come to my area and say I can see a patient for you, or I can see somebody with them if I needed some support or what have you and I feel like now that a lot of those double coverage shifts are just gone, it's much harder to do that. It's sort of sad, the more they need the casual, the less appealing it is for me to go in." (Serafina, PT)

"I can certainly speak to high turnover. […] I'm new this year I feel like we have gained and then lost people. It's almost cyclical. I can say that we have often quite a bit of moral distress when we let people go out back to community. We have one community SLP for the greater Vancouver area, so – we know her, she has a wait list in the hundreds. She barely gets to see people for things like communication therapy, a lot of the time it feels as if she's just able to put out fires barely, as opposed to actually any therapeutic visits." (Rosanna, SLP)

"It's a mix of a few experienced OTs with a lot of young OTs and after a year being off coming back, I could see their spirit has really, really dampened and it's really sad to see. It's like we've hardened these people who are great OTs, who are wonderful to work with, creative – are on their way to being excellent experts as OTs, and to see this glimpse in their eyes that are no longer sparkling, really upsets me. So it's not just a patient's clinical outcome, it's our mentality, to hear one of my colleagues – a few of them going through an anxiety attack last year – is upsetting. And I certainly feel myself coming back, like I'm experienced, why am I feeling like crap every day after work? Yeah I get tired but tired is different from not feeling fulfilled." (Betty, OT)

For Tina, a full-time OT, who provides therapy for 105 predominantly frail elderly long-term care residents, she expressed concern about taking vacation only to come back to unmanageable workload because no one would continue seeing her patients:

37 Kobbero et al., 2018, p. 62.

"[T]his past summer, where I had two weeks off…first of all I wasn't really wanting…comfortable with taking the full two weeks off because I knew there was nobody to take on my caseload. So then that puts an impact on me because I'm at home but I'm knowing that I'm coming back to piles upon piles of work." (Tina, OT)

Chronic unfilled vacancies

Chronic unfilled vacancies remain an ongoing challenge facing the rehabilitation professions, which makes already low staffing levels even worse. Persistent unfilled vacancies are particularly concerning because it means that funded positions are going unfilled for a variety of reasons, including higher wages and lower caseloads in the private sector and limited clinical leadership opportunities in the public sector (see subsequent sections). Many rehabilitation professionals expressed concerns about the vacant positions going unfilled for weeks, months, and even years. Sometimes chronic vacancies result from recent graduates entering public practice and quickly exiting:

"...we've had a vacant job posting now for a while […] but it's been vacant for almost a year, nine months it's been vacant, yes. And no one applied for it." (Patricia, PT)

"I'm an OT and my first job out of school ... I was filling a role that was vacant for 18 months and there was no other – it was in LTC and there was no other OT working in LTC in Prince George. So yeah it's like all over. And Prince George constantly has vacant roles. And then I came to [this town] and my role was vacant for five months and there were no other public OTs in this town. There's private OTs. So yeah, it's very prevalent. I'm in the Northern Health Authority and […] the NHA has 35 OT roles and close to 15 of them are vacant. So […] there's a lot of vacancies and you feel it in every authority. Like every hospital you go to." (Deliah, OT)

"At the site where I work which is a trauma centre we had over eight vacancies in PT. That was primarily due to restructuring and poor management which caused a huge exodus of most of our staff. We also have very few casuals which doesn't help with staffing either. With respect to patients and just getting used to working short, it is to their disadvantage cause you're just doing patchwork. We only see patients on a priority basis, so unless you're a new assessment going home, progressing in some ways, unfortunately you get left on the back burner. So as a clinician it's hard because it's difficult to say to people, 'we just can't see you today because there's such a push to get people out of the hospital and out of those acute care beds.' But as therapists we feel we're just scratching the surface of what we can truly be providing to or patients because we are so short staffed." (Anita, PT)

Long-term vacancies sometimes result in permanent staffing cuts.

"I've been a PT in FHA in the same site for over 20 years and I would say chronic unfilled vacancies has been a theme that has been with me throughout my career, and even as recently as two weeks ago, we had two of our positions just removed because they were unfilled and so they were seen as sort of easy to take away when they have to cut budgets." (Christina, PT)

The result is rehabilitation services have even more severe staffing shortages and, as caseloads increase, more professionals in the public system leave. It is a vicious cycle.

BC is not training enough rehabilitation professionals

Over the last three years, there have been encouraging steps towards creating new post-secondary training opportunities for health science professionals, including 40 new physiotherapy and 24 occupational therapy training seats across the province.[38] These are important steps, but the shortages have become so great from many years of failing to expand training that BC needs to continue and accelerate expansion of rehabilitationtraining programs across the province.

As Tables 11 and 12 demonstrate, BC falls far below other provinces when it comes to in-province training and retention of physiotherapists and occupational therapists trained here. For physiotherapists, only 47 per cent of BC graduates were registered to practice in the province – significantly below the second-lowest (Alberta at 68 per cent).

38 Ministry of Advanced Education, Skills and Training, 2019. There are currently 80 first-year physiotherapy seats in BC. This will increase to 120 first-year spaces, with full expansion expected by September 2022. The First 20 seats will be at UBC Vancouver, followed by Fraser Valley. The most recent increase was in 2008. In occupational therapy, there are 48 first-year seats in BC. This will increase to 72 first-year seats with the first eight at UBC Vancouver (Sep. 2020) and 16 through a joint UBC/UNBC initiative (Sep. 2022). The most-recent increase was in 2009.

For occupational therapists, the percentage of OTs who trained in BC and are registered to practice here is even lower at 44 per cent. Again, this is significantly below Alberta at 61 per cent. This tells us that we are not training enough of these professionals in-province nor are we retaining the professionals we train in public practice.

However, training more therapists alone will not be enough. For example, the majority of UBC physiotherapy graduates each year go into private practice. There is currently no UBC public practice program stream nor are there public sector recruitment strategies in place such as tuition remission in exchange for a commitment to public practice for several years. Increasing the supply of new therapists trained in BC is not a long-term solution if the majority do not choose – or cannot be retained in – public practice. As the above and subsequent sections identify, new graduates are not entering and practising in the public system for a variety of reasons.

Table 11: Percentage of physiotherapists registered to practice in province of graduation, 2019

	%
Manitoba	93
Ontario	87
Saskatchewan	86
Quebec	83
Nova Scotia	80
Alberta	68
British Columbia	47

Source: CIHI, 2020c
Note: Only provinces with available data are shown.

Table 12: Percentage of occupational therapists registered to practice in province of graduation, 2019

	%
Quebec	93
Manitoba	93
Ontario	88
Nova Scotia	77
Alberta	61
British Columbia	44

Source: CIHI, 2020b, Table 3
Note: Only provinces with available data are shown.

Public rehabilitation budgets are not increasing with patient demand

Interview and focus group participants consistently reported that even as health authorities see demand for rehabilitation services increase, staffing levels are stagnant, and in some cases, rehabilitation funding is getting cut. At the same time, the growth of private-pay rehabilitation clinics has grown significantly. This issue was raised across in communities across the province:

> *"I've worked with Island Health and it's just been interesting to see as the program grows and demand grows, how funding does not grow and we're often told to show that there's a need and show that there's – you know, build your wait list and that sort of thing and then the funding will come and you sort of don't see that happening." (Melody, PT)*

> *"So whenever programs need to have cost-saving measures, we tend to be the ones that are first looked at, because we are such a small portion of the team. For example, I remember about maybe 12, 13 years ago Cardiology decided that they didn't feel like they needed to fund physiotherapy anymore, because they had to make a cut, so they cut the physio technician out of the program. Yet, now they are still asking us to see the Cardiology patients, even though they are not funding it. And as professionals, we still see them, but at a cost of adding extra work load on us." (Teresa, PT)*

> *"I have essentially no ability to see the outpatients that are being referred to me. So individuals are waiting on that outpatient list for over a year and counting. And a lot of those conditions' best practice guidelines dictate that those people should be seen within the first six months because that's when the best recovery – the best treatment gains are for those conditions. And then recently my workload hours were cut due to*

Island Health budget reasons." (Bob, SLP)

"Well there's definitely less PTs. Since I started we are now not quite 3 FTE, and I think when we started here we were about 8 FTE. So there's been a dramatic decrease in the number and yet private clinics here in town have grown exponentially. If there's five people working in public practice, there's 25 in private practice in my little town." (Kim, PT)

Limited or no opportunities for clinical leadership and career advancement

Limited opportunities for clinical leadership and career advancement within health authorities was a persistent theme that emerged from interview and focus group participants. Health care is no longer a doctor and a nurse. It takes a team of health care providers, with specialized training, to provide patient care. For many years, physicians were the only health care profession that had clinical leadership opportunities in health care. Those opportunities later followed in nursing. With advances in technology in medical imaging and laboratory science, as well as the importance of therapeutic professions and social-behavioural care, health care requires clinical leadership from health science and rehabilitation professionals.

In addition to the need for greater clinical leadership from these professions, the research literature demonstrates that clinical leadership and job satisfaction are critically important to fostering organizational cultures that empower frontline professionals to work to their full potential and improve the quality of care. In other words, health care workers who find joy in their clinical practice and have leadership opportunities are more likely to dedicate their career to public practice and working to improve the public health care system.[39] From an organizational and employer perspective, improving the conditions of work also improves the conditions and quality of care, resulting in fewer medical errors, better patient outcomes, and cost-savings.[40]

The vast majority of interview and focus group participants indicated a deep frustration about the lack of clinical leadership and career advancement opportunities as well as dissatisfaction with workplace culture and management that does not often understand or recognize their clinical contributions:

"I'm thinking about how outpatient services or specialist services were protected in other places that I've worked and I think that by comparison one way that it really worked was people had things like incentives to specialize, there were career ladders where you could move up through them, for example, you could move from a junior to a senior to clinical specialist and I think that creating progression in that way also helps to protect more specialist work and obviously I see it from a much more junior perspective, but I do wonder sometimes if there would be a way to create more reward for specialist work, it could be more protected. ... that really, really resonates with me, and I it think what that then creates when we're all "jack-of-all-trades" is we have very little time to do things that could eventually improve patient care like have protected time to do research or network – what it creates is a very poor set of circumstances where were just trying to put out fires as opposed to working to create more specialized structures that could ultimately then improve patient care." (Rosanna, SLP)

Interviewees also expressed frustration that many leadership roles are reserved for nurses or physicians without any clinical rationale, despite rehabilitation professionals' expertise in health promotion and disease prevention:

"[T]here's minimal opportunity to participate in program development and to do any of that level of stuff. There's not necessarily a ton of interest in the allied health section of things [from senior health authority leadership], that it's still very dominated by doctors and nurses and still very based around accommodating their needs […] [O]ur best funded program is the hip and knee surgical program to make sure beds are cleared and people are out. While they still haven't particularly […] even thought [about] the research [which] would say that a robust attempt at lifestyle modification – losing weight, exercising – would prevent a lot of those surgeries from even happening. […] But as opposed to the nursing situation where there's like – there are particular jobs you can take to ladder yourself up into all sorts of different roles. There's just nothing like that. It's really become a real leap between sort of the clinical positions and the leadership positions. With very little means of sort of transitioning people into being prepared for those types of roles. There's also a lot of roles that don't necessarily require technical expertise that have been basically locked down and identified as nursing roles only, that you need to be a nurse to apply for these roles even though there's not necessarily anything about the role that would really dictate you have to be a nurse to do that." (David, PT)

39 Perlo et al., 2017.
40 Berwick, 2003.

In other cases, rehabilitation departments and programs report to nurses and physicians in the health authority leadership structure, despite the fact that health science and rehabilitation professionals are the clinical experts:

> *"[I]n [my health authority] […] my physio manager reports to a nurse […]who's in charge of allied health. […] I don't understand why so many leadership positions go to nurses when other disciplines are also really competent to be leaders." (Dinah, PT)*

The lack of clinical leadership and career advancement opportunities has implications for the quality of care and the potential for restoring the function of patients, especially older adults with frailty, who could potentially retain greater independence if rehabilitation professionals had the staffing levels to also provide clinical education to the health care team:

> *"You know the restorative care model – and I've definitely been at the places where some of that has been quite successful. And you know the sort of care is trying […] have them doing as much for themselves as they possibly can, and that's everybody's job, not just an allied health job. So yeah, getting more of the other staff – whether it's nurses or care aides or things like that, doing walks that are within the patients capability and having them do that with them and you know, not feeding them, but getting them to feed themselves as much as they're able to and sort of helping as much as they can with bathing and toileting and all those sorts of things so that when I come in, I can actually work on exercises and work on other activities to help people get better as opposed to sort of going through the basic tasks that, in a lot of ways are kind of going to maintain a person where they're at." (David, PT)*

Despite a strong desire among HSA members for professional development and clinical leadership opportunities, interviewees consistently expressed concern with the difficulty getting management approval for education leave (a collective agreement right) due to heavy workloads and a lack of staff to backfill.

In sum, participants expressed concerns about limited or no opportunities for clinical leadership and career advancement without having to leave clinical practice entirely. HSA members suggested increasing the number of clinical educator and professional practice lead roles, and the need to ensure that health science and allied health professionals have career ladders within health authorities at senior leadership levels. Many wanted opportunities so that they are not forced to exit public practice if they want to pursue clinical leadership opportunities. Interviewees believed addressing the lack of clinical leadership opportunities would help address public practice recruitment and retention.

Pressure to discharge from hospital, but lack of ongoing outpatient rehabilitation

Rehabilitation professionals expressed concerns that the overriding objective in the acute care setting is often to discharge patients as quickly as possible. This stems from the fact that BC and Canada have fewer acute care beds per capita compared to other OECD jurisdictions[41] an issue exacerbated by the lack of prevention-focused community alternatives including public home and community care.[42] It also reflects the lack ongoing outpatient rehabilitation services that can help patients, especially seniors, maintain independence with supports and avoid hospitalization.

Within this context, interviewees expressed concern about the pressures to discharge patients without patients having access to ongoing rehabilitative care:

> *"[…] there's a little bit of a disconnect between, you know as far as sort of hospital metrics go, length of stay and out of the hospital and that sort of it doesn't necessarily impact that but it would come back to, oh – this is a person that probably could transfer again or walk again or do these sorts of things if they had enough sort of resources […]" (David, PT)*

> *"And so it's the same thing at our hospital where some days only the priority ones, people being discharged will be seen, and so a lot of those ones that would really benefit from ongoing therapy – OT or PT – I guess I'm speaking for both of us in the acute care setting. Like we end up only seeing the highest priorities but then by the time you get to the priority two or three, they've changed in their acuity so there's this ongoing kind of cycle of not being able to intervene and prevent a pressure wound before it develops, or people getting deconditioned because they're not going to be discharged within the next week." (Daisy, OT)*

41 Canadian Institute for Health Information, OECD Interactive Tool: International Comparisons – Peer Countries, British Columbia, https://www.cihi.ca/en/oecd-interactive-tool-international-comparisons-peer-countries-british-columbia (accessed June 16, 2021).

42 Longhurst, 2017.

Outpatient rehabilitation is limited or non-existent in most communities

The erosion of public rehabilitative care and outpatient closures is the result of inadequate funding and staffing levels as demand for services grow. In addition, the lack of a provincial approach to rehabilitative care means that outpatient rehabilitation is limited or non-existent in most communities.

As the previous section revealed, many patients are discharged from inpatient care without access to ongoing public outpatient therapy. Many cannot afford to pay privately for therapy that could help them restore function and quality of life, and help them to avoid hospitalization:

> *"I think the biggest thing that I see is that they don't have the physiotherapy intervention when they are in the hospital, then they don't learn what they can best do to continue on with their recovery when they are home. So this will mean either a greater disability or not as much recovery, even in the long run, or it will mean more inpatient and/or emergency room admissions when they are not able to self-manage. I'm thinking about our COPD folks that they couldn't do and learn to be able to self-manage, but we often don't have the time to actually teach them the self-management skills. In particularly all the orthopedic admissions, or the frail elderly admissions, when we are just running to get them good enough to get home, but then the services aren't available when they are home, to keep them going. There aren't the outpatient or home help services available for them to be able to access once they are home, or they don't have the finance to get in, or the organizational skills with their mental health or cognition problems to come back in or to carry out their exercise program, so then they get weaker and frailer, rather than stronger. Or they end up with permanent disabilities from their hip surgery that could've been avoided if they had been able to stay in hospital a little bit longer, or had daily outpatient rehab. That's a big thing that we push for around here, is a day program. We kind of have an adult day program, but it's not an exercise based individual based program, so we always think an outpatient daily program would help..." (Yolanda, PT)*

> *"So we only provide services to adults in the acute care setting, we don't provide outpatient services, there actually are no outpatient services in or for speech pathology or dysphagia, they would have to hire privately, and there's only one SLP I know of in the North that does private work. [...] [W]e've now had to make a change to that as well because we are feeling so overwhelmed that we can't provide 6-8 weeks of rehabilitation, which is a typical rehab scheduled follow, we can now do a general communication screening, do some patient identified goals or patient-led goals, and then we develop a home program for them and do a therapy session to show them how it's done, and then one follow-up session and that's it, that's all we can provide because we're not able to see everybody, and there will be people who won't get that service if we do anything longer, whether [we're] bringing in casual employees or not." (Jenny, SLP)*

> *"….the other thing that comes up is also services outside of the hospital; so there's no outpatient occupational therapy available in [our city], so if individuals have something like a stroke and maybe their deficits aren't super significant that they would require going to inpatient rehab where they have to go to a different city for that but if they have some maybe fine motor deficits, there isn't anyone that we can refer them to outside of the hospital so we would either keep them in the hospital when that's the only thing they need which doesn't really make sense for how much it costs to have someone in the hospital, but it also means that someone would go home with some residual deficits and not have the support from the community to work on that." (Ann, OT)*

> *"So even though our staff positions are generally filled, like the permanent positions, there just doesn't seem to be enough funding for the demand for the service. So for example, there's no outpatient OT. So if someone goes home post-stroke, the hospital here, like we don't have a rehab unit and if they can't go to Kelowna or Vancouver for rehab, they're discharged home from here and there's so much pressure to discharge them as soon as possible. And sometimes too early. And it's a real struggle because you know that, wow – they could really use some upper extremity rehab, but we just don't have an outpatient OT, we have very limited outpatient neuro and orthopedic PT. So you just feel so bad that you're not going to be able to give them the treatment that some would really benefit from. There's so much pressure to discharge, and then we know that once they're gone, the outpatient services just aren't enough." (Daisy, OT)*

> *"And then I guess the other thing that comes up is also services outside of the hospital; so there's no outpatient occupational therapy available in [my town on Vancouver Island], so if individuals have something like a stroke and maybe their deficits aren't super significant that they would require going to inpatient rehab where they have to go to a different city for that but if they have some maybe fine motor deficits, there isn't anyone that we can refer them to outside of the hospital so we would either keep them*

in the hospital when that's the only thing they need which doesn't really make sense for how much it costs to have someone in the hospital, but it also means that someone would go home with some residual deficits and not have the support from the community to work on that." (Karen, OT)

"I can definitely speak to the being short-staffed issue, and it's more-so that rather than being short-staffed, is that there aren't enough positions available to fill the need, both within the acute care setting and within the rehabilitation setting and that's just inpatients, when we talk about outpatients, there is no outpatient care whatsoever for SLP and often, like what resonate with in terms of what others have said is that we have patients who the only thing potentially holding them in the hospital is their swallowing and then it becomes a matter of discharge planning going ahead because for whatever reason and then we have to discharge a patient from our swallowing caseload, knowing they're not fully rehabilitated, knowing services in the community are extremely minimal." (Stella, SLP)

Some hospitals may notionally offer outpatient therapy, but understaffing and heavy inpatient workloads mean that therapists are not able to see outpatients:

"…often due to short staffing situations in acute care, our outpatient services are often looked at as easy wins to pull either staff into unfilled acute positions or sometimes from a budget perspective, if there's a budget crunch things will get prioritized to acute care and we'll see losses in outpatient services...the outpatients is the first to go, even though long-term for patient and client benefits is where you might see the greatest gains." (Selma, OT)

"So I work primarily inpatient, but we also have outpatient feeding team, and so a lot of our kids when they get discharged home, we need to keep seeing them. Because of their background, premature or what not, they will take priority over the waitlist, for the general children who get referred to the outpatient services, the waitlist is incredibly long. So usually, I would say probably 6-8 months. (Emira, SLP)

"So that region itself has pretty much no outpatient services. And my client base, depending on what the caseload is like in the hospital, is always the outpatients that get cut. So inpatients take the priority over an outpatient generally." (Annika, SLP)

"I can't speak to all outpatient services but I can say that for the patients that we try to discharge, whether it's to rehab or PATH or, to any sort of service outside of the initial acute setting. Often there's a long waitlist just because they are also overwhelmed by workload as well. And they're also only seeing priority patients. I can remember when patients used to go home after, say knee replacements or shoulder replacements, and you'd have PT at home immediately, doing exercises with them. They'd be able to go to rehab within days of being discharged. Whereas now, sometimes people have to wait weeks before they can actually get into outpatient PT. They're given their little program to do at home, but are we actually benefitting the patient by taking all these services out of these areas where we know that they can benefit?" (Serafina, PT)

And yet, as Sandra states, the lack of outpatient programs means that many patients could in fact be discharged sooner if ongoing care could be provided on an outpatient basis:

"I know we hang on to patients longer than we should like ones that have had strokes for example, because there's no outpatient neuro to follow up with them. So I want to make sure that they have their equipment, I want to make sure that they have all the skills and home exercise programs and everybody's up to speed where if there was that direct translation and the outpatient neuro program could pick them up they'd be discharged sooner." (Sandra, OT)

RebalanceMD and the privatization of outpatient rehabilitation on the South Island

Established in November 2012, RebalanceMD is a for-profit, investor-owned, Victoria clinic receiving public funding to provide musculoskeletal care including pre- and post-op services. Royal Jubilee Hospital ended public provision of post-operative hip/knee replacement rehabilitation following Island Health's decision to privatize publicly funded post-operative rehabilitation. If additional visits are required, patients must purchase services privately. RebalanceMD provides private-pay services in addition to third party insured services (e.g., WorkSafeBC) – replicating a business model common among private surgical clinics in which clinics access both public and private funding (and attempt to sell private-pay services to publicly funded patients who come through the clinic's doors).

As a for-profit company, RebalanceMD continues to grow at the expense of public outpatient rehabilitation. Most hip and knee surgery patients in Greater Victoria are now sent for post-operative physiotherapy at RebalanceMD. Between 2015/16 and 2019/20, RebalanceMD increased its annual funding from VIHA from $689,000 to $1.23 million – an increase of 78 per cent over five years.[43] In 2020, a private equity acquired a majority interest in RebalanceMD with an investment "which will provide significant capital for growth through the opening of new clinics, initially in BC and Alberta and, over the longer term, throughout Canada."[44] These are public dollars that are going to an investor-owned corporation and not going into public rehabilitation services.

The RebalanceMD business model is focused on maximizing profits and physician remuneration rather than optimizing the scope of practice of rehabilitation professionals who could be safely and rapidly assessing potential surgical candidate or supporting non-surgical patients with self-management (it is estimated that 10-50 per cent of orthopedic referrals do not require surgical opinion or placement on a surgical consult waitlist). RebalanceMD providers, including physicians and non-physicianspredominantly have sports medicine backgrounds rather than expertise in geriatric rehabilitation and chronic disease management, unlike rehabilitation professionals in the public system. This raises concerns about RebalanceMD's ability to meet the prehabilitation and post-operative needs of the South Island's growing senior population.

In contrast, public health care systems, including our own, have made efforts to optimize the scopes of practice for rehabilitation professionals, which also helps enable physicians and surgeons to work at the top of their scope and consult with more complex patients. There have been promising efforts at the VCH Rapid Access Spine Clinic, VCH OASIS Clinic, and other examples internationally that demonstrate how rehabilitation professionals can help reduce wait times and provide appropriate pre- and post-op care as well as ongoing self-management supports for musculoskeletal conditions which do not require surgery.[45]

Public pediatric therapy services are understaffed and have long wait times

Non-profit Child Development Centres (CDCs) provide therapy and services to more than 15,000 children and youth and their families. CDCs serve children with physical, behavioural, neurological and developmental disabilities, including cerebral palsy, Down syndrome, autism, fetal alcohol spectrum disorder, and other mental health and behavioural issues. CDCs provide Early Intervention Therapies for children with disabilities from birth to age five, enabling these children to participate in school and in their communities.

Early Intervention Therapies include speech and language therapies to help develop the ability to communicate, physiotherapy to improve mobility and coordination, and occupational therapy to enable children to manage a variety of daily living activities. Early Intervention Therapies also include the use of infant development consultants during the first three years of a child's life. They help parents develop the many skills needed to care for a child with a disability. Child development consultants work with child care centres and preschools so that children with disabilities are able to participate in these programs.

Most early intervention funding is provided by the Ministry of Children and Family Development (MCFD) through the Children and Youth with Special Needs (CYSN) funding stream, which includes Early Intervention Therapies, Infant Development, Supported Child Development and School Age Therapies. A lack of funding for early intervention therapists means that CDCs have long waits for children and families trying to access therapy. In one northern CDC, for example, there are nearly 250 children on the waitlist trying to access Early Intervention Therapies, and as a result, children are going to school without ever receiving assessments.

43 Calculated from Vancouver Island Health Authority's Payments to Suppliers statements for fiscal years 2015/16 to 2019/20.
44 CAI Capital Partners, 2020.
45 Longhurst et al., 2016; Scottish Government, 2014.

As the BC Association for Child Development and Intervention (BCACDI) has noted, from 2008 to 2016, there were no increases in the Early Intervention Therapies budget provincially. In 2016, the program saw a small increase. And although budget consultation reports in 2018, 2019, and 2020 each made specific recommendations to increase investment in early intervention services, increased funding was not provided. As a result, Early Intervention Therapies continue to have the longest wait times province-wide.

Waitlists mean children don't get the care they need when they need it. For example, clinical guidelines for children document the essential need for early interventions by rehabilitation professionals. Failure to do so can result in additional health challenges for children as they attempt to navigate life in the community and at school.

- In the North region, the average wait time for speech therapy is 335 days.
- In the Vancouver-Coastal region, the average wait for occupational therapy is 180 days.
- In the Fraser region, the average wait time for physiotherapy is 151 days.[46]

There is an urgent need to increase staffing levels in the Early Intervention Therapies program. There are simply not enough therapists to ensure that children with disabilities will have access to publicly funded care.

Top-down management culture and limited professional recognition impedes team-based care

Many frontline rehabilitation professionals expressed concerns about the top-down management culture in health authorities and the limited clinical recognition they receive. Many felt that managers as well as nurses and physicians did not often understand the scope of practice among PT, OT, and SLP – or had particularly narrow or outdated views about the role of these disciplines. Some research participants had positive things to say about managers who were strong advocates for rehabilitative (as opposed to highly medicalized) approaches to care. These managers often had rehabilitation backgrounds.

Generally, there was a widespread feeling of frustration that health authority management and senior leadership do not often listen to frontline rehabilitation professionals before implementing changes to care delivery models. Many felt this reflected the lack of understanding of their clinical expertise:

> *"[U]pon discussion with other colleagues, it really comes down to management, where if management advocates for OT, then great, if management didn't – which happened a lot of other teams – then they get cut. Which is kind of scary because, I don't know exactly the process they use, but I do believe that the managers have a really, really important role in advocating. And so if the management doesn't believe in OT then, and so that kind of speaks to being able to have a manager where they are able to come in and talk to their employees, get to know them, have like a good working environment where they feel like they have the time for that and then so that can kind of establish and support that relationship. […] And mainly the things I've noticed […] at [my program], [which] underwent a lot of changes in service delivery, management structure – they call it integration – a lot of things change in the area, not just our area, but all the teams that we work with and so it's like a huge disruption in service delivery and also for our clients. And we felt that – well, I felt it was managed in a very – it could have been managed better. And it's unfortunate because [it was] big project and I think they had a lot of time to plan it out but it wasn't implemented well – or it could have been implemented better. And so that definitely caused a lot of issues for us – there was a lot of staff that left, a lot of turnover, clients were really confused about what was happening. Staff were confused as well, so it was like nobody really knew what was going on. And our rehab team was almost disintegrated from the mental health team, which we felt was quite a big hit to some of our clients." (Lee, OT)*

> *"Yeah, I think that sometimes it means that they don't get a referral when it would be appropriate or they might refer to us when we're not the best discipline to address something. Most often, I guess an example that comes to mind is in terms of cognitive assessment and cognitive rehab that often times, especially working with an older population, the inclination is to refer someone to a geri-psychiatrist to better assess their cognition when we are trained in a lot of those assessments and can provide lots of input on how someone's cognition is affecting their day to day abilities and how they might function safely at home or not. So I feel like sometimes, actually tying back in to your last question … maybe sometimes our input isn't taken as seriously because they might not understand our level of training in that area. And are waiting for the input of a specialist that can take sometimes months to come and provide that." (Ann, OT)*

46 BC Association for Child Development and Intervention (2019), Submission to the Select Standing Committee on Children and Youth.

Compensation

Low compensation in the public sector was consistently raised by interview and focus group participants. Many members spoke about compensation in relation to practice conditions, job quality, and career advancement. New graduates are attracted to private practice for the combination of reduced caseloads, more therapeutic time with patients, and higher compensation in a province where the cost of living is very high.

> *"One part of it would be a higher pay […] Yup that's one of the big issues right now. And you know, the public system and the private system have always sort of, there's been points in time when the pay gap was bigger and there's points in time when the pay gap is more minimal. But I think after the limited raises we've gotten over the last 10 years it's really at a point where working in the private sector you can make enough money that you can basically make your own pension and pay for your own health benefits and still be ahead of the public system. Or you can translate that into making the same money working less hours for sort of work-life balance […] within the context of generally more rewarding sort of clinical work and more sort of autonomy and sort of respect for knowledge within the caseload. And being able to bring all of your knowledge to your caseload. […] So there's a lot more of an ability to see the patient from the start to the finish. And to be able to do so in a much more self-directed manner – in collaboration with the patients themselves. And at a much better remuneration than the public system. And so there's a little bit more of having your own caseload and much more control over the care plan direction. Whereas sometimes within the public system there'll be situations where I don't necessarily, you know, I don't know if this person should be discharged but they are going to be discharged so I will do what I can to mitigate risk of them going home." (David, PT)*

Therapists are deeply committed to their patients, teamwork, and public health care

Despite the very challenging working conditions that public practice therapists face, interview and focus group participants are deeply committed to their patients and profession, teamwork, and public health care. They constantly navigate the challenges of working with very limited staff and equipment resources while working to provide the best care they can.

> *"I think that's why I do like working in public rather than private because […] people don't have to pay to come here and so they're able to access the resources they need, generally. There's other factors as well. So I like doing that. What works for me in the public sector is, well it's generally that teams are interdisciplinary, so there's, like, I enjoy working – like talking to the doctors here, talking to the case managers, just because we all provide a different perspective and we're all kind of there, along with the client on different journeys during their recovery, and so I think that's so important. I enjoy working with other professionals as well. Whereas in other sectors you might be working with solely with OTs or solely with PTs [...]" (Lee, OT)*

> *"I really like getting to help people with chronic conditions that really feel like they have no hope left and you get to go in and help maintain their life and still find ways to fulfill their passions." (Deliah, OT)*

Differences in practice environments between rural and urban communities was a prominent theme. Many therapists working in smaller hospitals and clinical settings valued the ability to be more responsive to patient needs and the ability to provide outpatient care. While workloads were demanding in all settings, frontline therapists in smaller communities generally had opportunity for more diverse clinical practice and greater teamwork and communication with other health care professionals in the hospital and community:

> *"I think a lot of physios like an outpatient role because it's nice to talk to people who are cognitively intact and can do exercises.The reason I stayed in that crazy job for a long time is because I had a little bit of outpatient and could have formal conversations with people. […] [S]o having more outpatient services that people can even do part-time would keep people in public practice." (Dinah, PT)*

Team-based models of rehabilitative care

Although public rehabilitation in BC has been eroded over the last 30 years, there are examples of effective, team-based programs. There is also no shortage of ideas for re-imagining rehabilitative care that better meets the needs of patients and also creates rewarding practice opportunities for frontline therapists. The following care models range from primary care with a strong rehabilitation orientation to specialized musculoskeletal (p)rehabilitation programs to system-wide public clinical pathways for musculoskeletal conditions in Ontario and Scotland:

- **VCH Home Visits to Vancouver's Elders (Home ViVE)** is an integrated hospital-based outreach primary care program for homebound elders that has shown positive outcomes in its ability to stabilize emergency department visit and hospital admission rates. The Home ViVE team includes physiotherapists, occupational therapists, family physicians, nurse practitioners, nurses and administrative staff. Services include "planned regular home visits, responsive daytime and after-hours care for emergencies, and nursing, physical and occupational rehabilitation services as needed. The team holds regular meetings to discuss both individual patients and service quality more generally."[47] An important aspect of this program is the ability for rehabilitation professionals to communicate with physicians and nurse practitioners through a shared electronic medical record, which facilitates team-based care planning, clear communication, and recognition of each team member's clinical contributions.

- **Child Development Centres (CDCs)** provide specialized, publicly funded services to children with a wide range of physical, neurological and developmental disabilities (such as cerebral palsy, Down syndrome, autism and fetal alcohol spectrum disorder), as well as mental health and behavioural issues. Approximately 30 non-profit CDCs in BC provide multidisciplinary therapy and integrated services to more than 15,000 children and their families. CDCs specialize in providing services to children from birth to school entry (usually age 5), and some CDCs also serve school-aged children. CDC services are essential to enable children with special needs to participate in child care and preschool programs, as well as to make a successful transition into the K-12 school system, and have better outcomes later in life. Despite the essential role of the Early Intervention Therapy program (PT, OT, SLP) in helping children with disabilities, the lack of funding and professional shortages mean that many children do not receive therapy at the stage when they would benefit most, and in some cases, "age out" of the program before receiving therapy.

- **Long-term care provided by health authorities and non-profit organizations**, where seniors benefit from having access to a broader team of rehabilitation professionals than for-profit seniors long-term care (LTC) homes. Public and not-for-profit care homes perform better based on a number of quality indicators including staffing levels, staffing mix, and transfers to emergency.[48] In a study of nursing home characteristics associated with resident transfers to emergency department, "results showed that higher total direct-care nursing hours per resident day, and presence of allied health staff – disproportionately present in publicly owned facilities – were associated with lower transfer rates."[49] BC's Seniors Advocate also found contracted not-for-profit LTC homes compared to for-profit ones put more public funding into direct care and to be more efficient with public dollars even when receiving, on average, the same funding.[50]

- **VCH Osteoarthritis System Integration Service (OASIS)** is a made up of three clinics (Vancouver, Richmond and North Shore) for surgical and non-surgical patients with osteoarthritis. The clinics were established to provide central intake and triaging to support rapid access to appropriate care for surgical patients while also adopting a primary care approach to support non-surgical patients (and primary care physicians) with education and self-management supports. The clinics were initially staffed with physiotherapists, occupational therapists, dietitians, and administrative staff.[51] Nearly half of all patients referred to OASIS as surgical candidates by their family doctor were ultimately found to be better suited for non-surgical treatment.[52] Without OASIS, 1,955 patients between 2012 and 2015 would have been inappropriately placed on an orthopedic surgeon's waitlist, increasing waits for those in urgent need and unnecessary public costs for surgical consultations. The Scottish NHS visited BC to learn from OASIS in order to inform its musculoskeletal services redesign work (see final bullet).[53] ,

47 McGregor et al., 2018.
48 Ronald et al., 2016.
49 McGregor et al., 2014.
50 Office of the Seniors Advocate, 2020.
51 Longhurst et al., 2016, pp. 34-36.
52 Longhurst et al., 2016, p. 35
53 Personal communication, Cindy Roberts, former Director, Musculoskeletal Programs & Special Projects, VCH.

OASIS has not been optimized to play a more significant role in reducing orthopedic surgery wait times and providing patients with much faster access to non-operative therapy for the upwards of 50 per cent of patients who typically do not require surgery.[54] If the original vision for OASIS could be fully realized across all health authorities, it would operate similar to NHS Scotland's musculoskeletal clinical pathway where patients can self-refer for publicly funded low-intensity rehabilitative therapy in an outpatient setting.

- **Vancouver Coastal Health (VCH) Rapid Access Spine Triage Program** was established to address long wait times for non-emergent spinal conditions.[55] Physiotherapists with advanced training in neuro-musculoskeletal conditions, working in a collaborative manner with spine surgeons, serve as the patient's first point of clinical contact, enabling patients to be assessed much faster for possible surgery or non-surgical therapy. Only about 10 per cent of patients require surgery. This means that many patients previously waited for a surgical consult when what they needed was a physiotherapist to help manage their condition early in symptom onset when non-operative care can be most effective.

- **Toronto Academic Pain Medicine Institute** is a network of five hospital-based outpatient pain clinics that provide patients access to a team of occupational therapists, physiotherapists, psychologists, social workers, pharmacists, doctors, nurses, and chiropractors.[56] The clinics provide shared care with patients' primary care providers. Therapy provided by rehabilitation professionals helps patients self-manage their pain as well as support opioid management and tapering off opioid use. As the host hospital for the clinical network, Women's College Hospital offers pain education classes, self-management group program, physiotherapy and exercise group programs, mental health therapy programs, and pharmacy consultation.

- **Ontario's Rapid Access Clinics for Musculoskeletal Care** are a provincial network of clinics in every health region that provide a central point of contact for patients to be assessed by a health care provider with specialized training in their condition, often a physiotherapist.[57] Patients are seen at a Rapid Access Clinic within four weeks and provided with a treatment plan, and referred to a surgeon if they are a surgical candidate. Currently, these clinics focus on low back pain and hip and knee arthritis – some of the most common musculoskeletal conditions that can most often be supported by a team of rehabilitation therapists through self-management.

- **Community Health Centres in Canada and the US** are non-profit primary care organizations that provide integrated multidisciplinary and interprofessional health care and social services.[58] One of the unique features of the model is its strong focus on the social determinants of health and preventing acute illness among groups who are more likely to experience poor health and suffer from chronic conditions, including low-income people, ethno-cultural communities, Indigenous peoples, and frail seniors. Many CHCs integrate rehabilitative care into their primary care services.

- **NHS Scotland's Musculoskeletal (MSK) Pathway** provides standardized national-level (e.g., provincial) guidelines that all regional health boards must implement.[59] As the Nuffield Trust, a leading UK health policy institute notes, "Innovative use of other professionals to deal with GP shortages extends across Scotland. Almost all health boards now allow patients to refer themselves to physiotherapists rather than GPs for certain musculoskeletal conditions, and this has been incorporated into the NHS 24 helpline."[60] In Scotland, there is a national standard that patients will wait no longer than four weeks for allied health professional musculoskeletal treatment, which means that health boards must properly fund physiotherapy and occupational therapy staffing, among other rehabilitation professions.

54 See Downie et al., 2019.
55 Vancouver Coastal Health, 2018.
56 Toronto Academic Pain Medicine Institute, https://tapmipain.ca/. See also Thacker et al., 2021.
57 Rapid Access Clinics for Musculoskeletal Care, https://www.hqontario.ca/Quality-Improvement/Quality-Improvement-in-Action/Rapid-Access-Clinics-for-Musculoskeletal-Care. See also CBC News, 2019.
58 Longhurst & Cohen, 2019.
59 Scottish Government, 2014.
60 Dayan & Edwards, 2017, p. 34. NHS 24 is a 24-hour health care helpline similar to BC 811.

Conclusion and Recommendations

The erosion of public rehabilitative care did not emerge overnight. However, the neglect of these public health care services has now reached a point where urgent provincial action is required to avoid the further deterioration of care.

With an aging population, increasing demand for musculoskeletal care and pain management, and the acute and post-acute rehabilitation required for COVID-19 patients, public rehabilitative care is needed now more than ever.

And yet, BC faces widespread understaffing and professional shortages, a lack of services in many communities, and long wait times. It is taking a toll on patients, families, and frontline therapists. It is placing a greater burden on emergency services, acute, and long-term care because patients do not have access to preventative therapy in the first place.

Interviews and focus groups with frontline speech-language pathologists, occupational therapists, and physiotherapists, as well as statistical analysis, document the negative consequences for patient care resulting from staffing shortages and a lack of provincial focus on improving access to public rehabilitative care.

The following recommendations would begin to address the report's findings.

Immediately address professional shortages and increase clinical leadership opportunities in the public sector

The Ministry of Health, Health Employers Association of BC (HEABC), and health authorities need to work with HSA and the Health Science Professionals Bargaining Association (HSPBA) to address worsening professional shortages in the public system, including unfilled vacancies and longstanding understaffing.

Through the negotiated Recruitment and Retention Committee, the HSPBA recommended immediate steps that could be taken to address worsening shortages. Unfortunately, at the Recruitment and Retention Committee, HEABC (representing health authority employers) and the Ministry of Health did not support these recommendations.

HSA recommends a suite of complementary strategies that would improve working conditions, address wage inequities with the private sector, and provide new clinical leadership opportunities.

- **Fill existing vacancies**: Fill already posted vacancies that remain unfilled using market adjustment to support recruitment efforts. Extend market adjustments to all 14 priority health science professions, including OT, SLP, and PT.

- **Increase baseline staffing levels** in order to reduce workload concerns, expand clinical leadership opportunities, all of which will help recruit more new graduates and encourage those in private practice to enter public practice. This should include a review of "Difficult to Fill" positions in each health authority that were eliminated from budgets over the last five years and re-posting those positions. Increasing staffing levels will also improve working conditions, job quality and satisfaction, and support a higher level of retention of rehabilitation therapists. Declining access to public physiotherapy, occupational therapy, and speech and language therapy needs to be reversed.

- **Provide market wage adjustments** for the Ministry of Health's 14 priority health science professions, including speech-language pathologists, occupational therapists, and physiotherapists, in order to recruit new graduates and private practice therapists into the public system and retain existing therapists.

- **Provide provincial funding for province-wide and health authority-directed recruitment incentives** and a return of service for those not currently employed in the public sector as well as loan forgiveness, travel and relocation expense reimbursement, housing stipends for relocation, and providing housing in communities with housing shortages.

Increase post-secondary training opportunities for rehabilitation professionals

Over the last three years, encouraging steps towards creating new training opportunities for Health Science Professionals have been taken, including 40 new first-year Physiotherapy and 24 Occupational Therapy training seats across the

province.[61] These are important steps, and BC needs to continue to invest in post-secondary training opportunities and capacity in the other professions facing severe shortages. However, increased training alone will not be enough. It must be accompanied by innovative incentives to bring new graduates into public health care, and strategies to maintain and increase existing staffing levels.

Expanding post-secondary training capacity for public-sector shortage professions is one important part of addressing the crisis. However, a high percentage of new graduates, especially in rehabilitation professions, pursue private practice. Therefore, increasing post-secondary training capacity remains a partial solution if very few of these new gradates are pursuing public practice for a variety of reasons, including compensation, working conditions, and clinical leadership and practice opportunities.

Specifically, HSA recommends:

- Ongoing seat expansion for physiotherapy, occupational therapy, and speech-language pathology programs, including possible expansion of programs beyond UBC Vancouver and UBC-UNBC cohorts so that more professionals can train in communities across the province.

- Introduction of public practice streams with tuition remission for return-of-service to encourage PT, OT, and SLP recruitment into the public health care system.

- Through a health equity lens, review current curriculum and program design so that it can better showcase and encourage working in the public health care system.

Rebuild public outpatient rehabilitative care across the province

Frontline therapists were unanimous in raising concerns about the erosion of public outpatient care in communities throughout the province over many years, and the negative consequences for patient care. Many expressed concerns that many patients would benefit significantly from ongoing outpatient therapy, but understaffing and large caseloads limit the ability to provide the ongoing therapy that clinical guidelines recommend.

> *"I would say when I first started […] about 20 odd years ago, we did a lot of the rehabilitation on-site, but of course health care has changed since then, and seems like we have been offloading follow-ups to the community, without adequate ways, in my opinion, of funding those resources. A lot of families are really stuck with their options. A lot of it truly is private-pay options, which a lot of the time families cannot afford, because rehabilitation in pediatrics is long-term, it's not just one- or two-off thing, sometimes it is multi-month or multi-year rehabilitation, and sometimes benefits are weekly, some are weekly based on certain conditions, and I think it is cost-prohibitive, and also the public services that are out there right now, such as Child Development Centers, other community hospitals, they are at capacity as well."*

There is also a deep sense of dissatisfaction with the inability to see outpatients because of unmanageable inpatient workloads. Many therapists feel that expanding outpatient services would increase job satisfaction and help attract and retain staff in the public sector, enable therapists to work to full scope of practice, create new clinical leadership opportunities, and ultimately improve the quality of care.

Therefore, HSA recommends:

- The Ministry of Health, health authorities, and Ministry for Children and Family Development, in partnership with HSA and the HSPBA, work to develop a provincial plan to rebuild public outpatient rehabilitation services in the province, starting immediately with expanding services at hospitals and Child Development Centres by filling vacancies and increasing baseline staffing (see above recommendations).

61 Ministry of Advanced Education, Skills and Training (2019). This will increase to 120 first-year spaces, with full expansion expected by September 2022. The First 20 seats will be at UBC Vancouver, followed by Fraser Valley. The most recent increase was in 2008. In occupational therapy, there are 48 first-year seats in BC. This will increase to 72 first-year seats with the first eight at UBC Vancouver (Sep. 2020) and 16 through a joint UBC/UNBC initiative (Sep. 2022). The most-recent increase was in 2009.

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Appendix A: Research Participants

Interior Health

Alice, OT

Susie, OT

Annika, SLP

Michaela, OT

Kim, PT

Jeanne, SLP

Daisy, OT

Northern Health

Aggie, PT

Jenny, SLP

Sandra, OT

Patricia, PT

Deliah, OT

Stella, SLP

Penny, PT

Vancouver Island Health

Melody, PT

Tina, OT

Karen, OT

Chuck, SLP

Robert, OT

Ann, OT

Ingrid, PT

Lower Mainland (Vancouver Coastal and Fraser Health)

Susan, OT

Tamara, SLP

Dinah, PT

Lee, OT

Emira, SLP

Yolanda, PT

Catherine, SLP

Celina, SLP

David, PT

Heidi, OT

Lena, PT

Teresa, PT

Alexandria, SLP

Irfan, OT

Anita, PT

Serafina, PT

Selma, OT

Rosanna, SLP

Gillian, PT

Christina, PT

Ella, SLP

Darlene, Social Worker

Anastasia, MD (Family Physician in Long-Term Care)

Rivka, MD (Family Physician in Long-Term Care)

Appendix B: Participant responses by theme

Professional shortages

"…often due to short staffing situations in acute care, our outpatient services are often looked at as easy wins to pull either staff into unfilled acute positions or sometimes from a budget perspective, if there's a budget crunch things will get prioritized to acute care and we'll see losses in out-patient services...the out-patients is like the first to go, even though long-term for patient & client benefits is where you might see the greatest gains." (Selma, OT)

"I just wanted to add that there's very much awareness of just how awful it is, I think we have 0.2 SLP in [our community] for our long-term care and were trying to work on some research to demonstrate that there is so much more of an increased need so it's nice to hear that other people who are aware of it." (Rosanna, SLP)

"I can definitely speak to the being short-staffed issue, and it's more-so that rather than being short-staffed, is that there aren't enough positions available to fill the need, both within the acute care setting and within the rehabilitation setting and that's just inpatients, when we talk about outpatients, there is no outpatient care whatsoever for SLP and often, like what resonate with in terms of what others have said is that we have patients who the only thing potentially holding them in the hospital is their swallowing and then it becomes a matter of discharge planning going ahead because for whatever reason and then we have to discharge a patient from our swallowing caseload, knowing they're not fully rehabilitated, knowing services in the community are extremely minimal." (Stella, SLP)

"Working up North I also know that it can be quite challenging to get people to fill the positions. But there are also definitely positions that are needed; we don't have an adult SLP. We have huge numbers of diabetes and other comorbidities and we have one dietitian to cover the hospital, the community, approximately five villages that we support. And so there's definitely vacancies but there are also lack of positions available as well." (Penny, PT)

"I've been a PT in [my health authority] in the same site for over 20 years and I would say chronic unfilled vacancies has been a theme that has been with me throughout my career, and even as recently as two weeks ago, we had two of our positions just removed because they were unfilled and so they were seen as sort of easy to take away when they have to cut budgets." (Christina, PT)

"I was recently working a split position where 0.6 of time was spent, not with inpatients but in a rehab program where it operates much like an inpatient stay where the patient comes every day, and receives very intensive therapy and I often felt that I was pressured to see more of those patients than my caseload target [and] would be to the detriment of the number of clients that I was able to see for my other more traditional outpatient caseload. I hadn't even realized that the target caseload size was, but I realized that I had been seeing you know, 30% more than the target caseload for the inpatient program, which meant that I wasn't getting through the outpatient waitlist as quickly as I would like to." (Ella, SLP)

"And I think sometimes people just stay in the hospital longer if we're short staffed and not able to get to all of our top priorities that maybe they could go home pending an occupational therapy assessment, but we don't have – there's enough people that are in that situation that we aren't able to get to them. And so probably increasing time in the hospital which isn't always pleasant for patients but it's also not ideal for the health authority and how much that costs." (Ann, OT)

"And I have essentially no ability to see the outpatients that are being referred to me. So individuals are waiting on that outpatient list for over a year and counting. And a lot of those conditions, best practice guidelines dictate that those people should be seen within the first six months because that's when the best recovery – the best treatment gains are for those conditions. And then recently my workload hours were cut due to Island Health budget reasons." (Bob, SLP)

"Most of the time we're required to see the dysphagia patients first because that's what's actually going to lead more directly to longer hospital stays because they see, oh somebody's sick they get pneumonia, that's more urgent, you have to see that right away so the communication usually gets pushed to the back burner and we usually don't ever end up with time to address that sort of thing so it's usually dealing with the urgent kind of crisis stuff first and then never getting time to deal with other things and even still, that band-aid solution really makes sense and we get used to that being the way it is, so seeing for somebody for an assessment, making a quick recommendation, even for dysphagia, and not having the time to really go through rehab exercises with them or follow-up with them on any regular basis, it's really doing the minimum in that sense." (Alexandria, SLP)

"…feeding tubes that go in unnecessarily, patients that will be NPO if they come in on a Friday afternoon, until SLP comes back and if I'm away, that doesn't happen. OT does do a bit of coverage for me but they're caseload is ridiculous as well. So those are folks that don't hit the radar, and so feeding tubes that go in or repeated pneumonias – yeah just sort of the lack of ability to follow that patient out into the community consistently. Definitely. And I would say for our communication folks as well, that their end outcome is lower than if they were in a location where they could have continuous, ongoing supports." (Annika, SLP)

"I – like some of the other therapists – work in two parts, like two different jobs, so I work half-time on an inpatient ward and half-time on an outpatient ward and some of the OTs, PTs, and SLPs are like that too. So we rob our outpatient jobs to work with the in-patient children, and so it's – I mean my bosses know it, I think other people, supervisors know it, but there's so much work to do on the in-patient ward." (Darlene, SW)

"So I work primarily inpatient, but we also have outpatient feeding team, and so a lot of our kids when they get discharged home, we need to keep seeing them. Because of their background, premature or what not, they will take priority over the waitlist, for the general children who get referred to the outpatient services, the waitlist is incredibly long. So usually, I would say probably 6-8 months." (Emira, SLP)

"…sometimes people just stay in the hospital longer if we're short staffed and not able to get to all of our top priorities that maybe they could go home pending an occupational therapy assessment, but we don't have – there's enough people that are in that situation that we aren't able to get to them. And so probably increasing time in the hospital which isn't always pleasant for patients but it's also not ideal for the health authority and how much that costs." (Karen, OT)

"…you have to prioritize them, which patients you can see, which patients you can't, um, for example we have a moment there has been in two units, two physios away for whatever reason, and then there is only one physio trying to cover two units, helping that extra or the casual so again, we both are prioritizing so you can't see some patients…" (Lena, PT)

"So for example, this week, the other OT is on vacation for a whole week and there's been no coverage for the past three days, so I'm basically doing the work of 2.0 – full-time. And yeah, 18 clients so maxed out, and it's just not possible to get to everybody. So a lot of people who are expecting at least an hour of therapy a day, they're just getting the bare minimum, like maybe me being able to do wheelchair seatings, splinting, discharge planning, rooms. But for those intense like visual assessments, cognition, upper extremity treatments – they're not being seen. So definitely affecting the discharge timing. Like people are staying longer in hospital just because it's going to take them longer to get to the level to where they're independent." (Michaela, OT)

"...we've had a vacant job posting now for a while, but I just learned while I was off here...but it's been vacant, it's been vacant for almost a year, nine months it's been vacant, yes. And no one applied for it." (Patricia, PT)

"Especially for PT, as I've mentioned it's so difficult to access, so we have, I would say 10 per cent of the people who are admitted to a nursing home have some real rehab potential, where there's a chance that they could regain function that they had lost. So not everybody, like a small percentage. But our PTs they have so many people assigned to them and they can't keep up, and they also are very specifically limited to assessment." (Rivka, Family Physician in Long-Term Care)

"we don't have a lot of support or mentorship or coaching around how to improve service and how to cope with the demands in the most efficient way and I suppose we're trying our best as individuals, but there's little structure of support. And usually when we ask for more support in terms of coverage or an extra person, it's usually we don't have that money or we don't have that – a lot of push back, so. Sometimes you walk away thinking I could have done a lot more to support these kids…" (Robert, OT)

Outpatient neuro clinic closed for two years because of short staffing (Sandra, OT)

"I know as a Speech Pathologist, I'm quite frustrated with the lack of resources. […] I don't manage all of the swallowing because it's just too difficult because I'm only around for 3 days a week. So it kind of between myself and Occupational Therapy." (Tamara, SLP)

105 predominantly frail elderly residents and one full-time OT:
"like this past summer, where I had two weeks off – first of all I wasn't really wanting, comfortable with taking the full two weeks off because I knew there was nobody to take on my caseload. So then that puts an impact on me because I'm at home but I'm knowing that I'm coming back to piles upon piles of work." (Tina, OT)

"We are the ones that actually get them out of the hospital. Whether that be OT, OT for equipment, PT for movement, Dieticians, Social Workers, what not. So I think that's the piece that they don't quite remember, so to speak. That's impactful. So we can actually cause a cancellation of surgeries, which we never like to do, but it has happened in the past because we just can't get kids help because of the sheer shortage of therapists. And yeah like I said, we also look at some of these kids who are on our waitlist. We know we should be seeing them earlier, according to the Gold Standard."

"So whenever programs need to have cost-saving measures, we tend to be the ones that are first looked at, because we are such a small portion of the team. For example, I remember about maybe 12, 13 years ago Cardiology decided that they didn't feel like they needed to fund physiotherapy anymore, because they had to make a cut, so they cut the physio technician out of the program. Yet, now they are still asking us to see the Cardiology patients, even though they are not funding it. And as professionals, we still see them, but at a cost of adding extra work load on us, even though they we are still seeing them." (Teresa, PT)

"I think the biggest thing that I see is that they don't have the physiotherapy intervention when they are in the hospital, then they don't learn what they can best do to continue on with their recovery when they are

home. So this will mean either a greater disability or not as much recovery, even in the long run, or it will mean more inpatient and/or emergency room admissions when they are not able to self-manage. I'm thinking about our COPD folks that they couldn't do and learn to be able to self-manage, but we often don't have the time to actually teach them the self-management skills. In particularly all the orthopedic admissions, or the frail elderly admissions, when we are just running to get them good enough to get home, but then the services aren't available when they are home, to keep them going. There aren't the outpatient or home help services available for them to be able to access once they are home, or they don't have the finance to get in, or the organizational skills with their mental health or cognition problems to come back in or to carry out their exercise program, so then they get weaker and frailer, rather than stronger. Yeah. Or they end up with permanent disabilities from their hip surgery that could've been avoided if they had been able to stay in hospital a little bit longer, or had daily outpatient rehab. That's a big thing that we push for around here, is a day program. We kind of have an adult day program, but it's not an exercise based individual based program, so we always think an outpatient daily program would help..." (Yolanda, PT)

"At the site where I work which is a trauma centre we had over 8 vacancies in PT. That was primarily due to restructuring and poor management which caused a huge exodus of most of our staff. We also have very few casuals which doesn't help with staffing either. With respect to patients and just getting used to working short, it is to their disadvantage cuz you're just doing patchwork base work. We only see patients on a priority basis, so unless you're a new assessment going home, progressing in some ways, unfortunately you get left on the back burner. So as a clinician it's hard because it's difficult to say to people, we just can't see you today because there's such a push to get people out of the hospital and out of those acute care beds. But as therapists we feel we're just scratching the surface of what we can truly be providing to or patients because we are so short staffed." (Anita, PT)

"I'm an OT and my first job out of school ... I was filling a role that was vacant for 18 months and there was no other – it was in LTC and there was no other OT working in LTC in Prince George. So yeah it's like all over. And Prince George constantly has vacant roles. And then I came to [this town] and my role was vacant for five months and there were no other public OTs in this town. There's private OTs. So yeah, it's very prevalent. I'm in the Northern Health Authority (NHA) and we have I think like the NHA has 35 OT roles and close to 15 of them are vacant. So it's just – yeah – there's a lot of vacancies and you feel it in every authority. Like every hospital you go to." (Deliah, OT)

"I worked on my own for the whole [region] for ten years. Now we have so many SLPs in the area that are hungry for work and there's no positions to put them into. So we kind of have flip flopped into kind of the opposite situation where we could happily use more FTE and more help. We have people available we just don't have the funding." (Jeanne, SLP)

"I work as a casual and five years ago when the staffing was better, I felt more comfortable going in because there was a lot more support for me, so we had more shifts where I could pick up a shift where there was another PT on that same unit. And the worse the staffing gets, the less comfortable I feel going in because it's harder and harder to connect with colleagues when I need a bit of support because I'm not there every day. And so I find that it's kind of a bad cycle but the more they need casuals there I think for some of us the less likely we are to pick it up. Because it used to be that I always had somebody come if they had a bit of time, they would come to my area and say I can see a patient for you, or I can see somebody with them if I needed some support or what have you and I feel like now that a lot of those double coverage shifts are just gone, it's much harder to do that. It's sort of sad, the more they need the casual, the less appealing it is for me to go in." (Serafina, PT)

Professional shortages: Impact on patient care

"There is no one really available for my vacation. I've reduced it by a week so I'm supposed to be away for two weeks and there will be not outpatient service for the next 2 weeks due to staffing shortage." (Kim, PT)

"So the main impact is on the ward – on the acute care, the joint replacements have priority. Sometimes the frail and elderly people won't get seen that often." (Aggie, PT)

Didn't have enough time to support stroke patients to ensure they were ready for discharge; not enough caseload capacity for frail seniors (Heidi, OT)

"some things that might happen are, people getting discharged that we're not aware of, so going home on unsafe diets or their facility not necessarily getting the updates. Other things we tend to see happen when were short-staffed is those lower priority patients, so those would tend to be somebody who – let's say, need their diet upgraded, if they're on thick liquids for too long... we might run the risk of them becoming dehydrated and if were not able to see them as quickly as we should see them, it may negatively impact intakes, which can be pretty important if they're trying to heal and get well in the hospital or lead to dehydration, but those people just tend to be lower on the priority list." (Alexandria, SLP)

"Well certainly I have a patient who recently was in hospital for a long time after a fall and fracture and that person came home, was bed bound for the first while, but has been able to mobilize from the point of view of her specialist and yet I think PT is only just starting now and that's four or five weeks later. So I think that would be an example where, in the interim muscle mass is lost even further because they remained in bed. More at risk of falling and in fact this person has had a fall since going home. Luckily no major injuries but it's a very precarious situation and hopefully now the system is responsive but I suspect that there's quite a lot of those instances where it's just very challenging to get timely access when the greatest chance of rehab can happen." (Anastasia, Family Physician in Long-Term Care)

"So that region itself has pretty much no outpatient services. And my client base, depending on what the caseload is like in the hospital, is always the outpatients that get cut. So inpatients take the priority over an outpatient generally." (Annika, SLP)

"So our caseload really fluctuates, obviously depending on time of year, right now like I said, it's been increasing quite a bit, so [we've] been having to call in quite a few casual staff because there might be you know, 15 people we haven't been able to get to yet and they've been waiting weeks, so let me see here, [we've] got – so we have 28 people right now and let me see – 7 of them we haven't been able to see, last week I think I was 11 or 12 that we hadn't seen yet, but then I had called in a few casual employees and we were able to bring that back down[...] So we only provide services to adults in the acute care setting, we don't provide outpatient services, there actually are no outpatient services in or for speech pathology or dysphagia, they would have to hire privately, and there's only one SLP I know of in the North that does private work. [...] [W]e've now had to make a change to that as well because we are feeling so overwhelmed that we can't provide 6-8 weeks of rehabilitation, which is a typical rehab scheduled follow, we can now do a general communication screening, do some patient identified goals or patient-led goals, and then we develop a home program for them and do a therapy session to show them how it's done, and then one follow-up session and that's it, that's all we can provide because we're not able to see every body, and there will be people who won't get that service if we do anything longer, whether [we're] bringing in casual employees or not." (Jenny, SLP)

"And then I guess the other thing that comes up is also services outside of the hospital; so there's no outpatient occupational therapy available in [my town on Vancouver Island], so if individuals have something like a stroke and maybe their deficits aren't super significant that they would require going to inpatient rehab where they have to go to a different city for that but if they have some maybe fine motor deficits, there isn't anyone that we can refer them to outside of the hospital so we would either keep them in the hospital when that's the only thing they need which doesn't really make sense for how much it costs to have someone in the hospital, but it also means that someone would go home with some residual deficits and not have the support from the community to work on that." (Karen, OT)

"It's very tricky to do the team-based collaborative work that I think I'm passionate about my profession of doing. And I think that's how we're most effectively used is in both complex team assessment of what the person's situation and function is, how they're recovering and then how we can make the best possible successful discharge plan. So I think hopping around to all these different floors made it almost impossible to participate in family team meetings. And because of that you didn't build up the same kind of closer relationships with like, the charge nurse and the doctor involved and if you're not building that relationship – like they barely care about your opinion anyways and if they have no idea who you are they're like "well, they're not here let's just discharge" or whatever. So I think the quality of patient care definitely suffers with having so few OT per many different floors, different programs." (Susan, OT)

1 SLP for 500 residential facilities with 500 beds, 12 patients across four sites (60 patients)
"…what we're noticing from acute care that is that push to have people out, out of acute care as quickly as possible. And so were' getting people barely stabilized and they've often have not had a chance to really recover. So I think I think a lot of it is just poor communication. Umm, and what happens is we have these families who are just so often times distraught and you don't' kwon

what's happening, nothings been done, they haven't even had a chance to get out of bed and try walking or try exercising or anything like that. They come and they haven't eaten, they have a tub feed, are they going to be able to eat again? So a lot of that hasn't been communicated when they've left the hospital. […] I'm just back from my summer vacation, so I have a lot of seniority so I booked off 3 week...So and that's something that I'm entitled to. So you know, I took 3 weeks off and because the caseload demands have changed somewhat in terms of me doing more swallowing, when I came back, it was pretty clear that not having anybody to backfill, for backfill, it was a problem. And actually it's not just me. I think that even my colleagues in rehab, they had trouble covering. They normally have coverage. We don't have enough bodies, we don't have casual staff to do backfill." (Tamara, SLP)

"Sometimes with time, sometimes, I don't want to say cut corners, but we just don't provide as full of a service as we know we could do if we had the time. If we didn't have those extra three or four patients waiting for us to be seen. Umm, so we do see the patients. Do we provide the, what should be done? Not always, to be honest. We are aware of that, which again adds a lot of pressure on us, because we do want to provide the optimal care. But we do do our best." (Teresa, PT)

"So for myself and my colleagues, particularly those who are working, say in the ICU, when we are short just like everyone's short with the priority patients, if the priority for that patient is necessarily, say a respiratory issue, our goal for that day is probably going to be to do some chest therapy or mobilize them. And if their secondary issue would be say, a range of motion or something like that, that was probably going to get delayed because the imperative thing is to get them up, try to get them off the vent, try to get them more independently breathing would be a priority over range of motion. So then unfortunately for them, once they're going through the acute care system, maybe by the time they get to the ward or they go to the community, the range of motion that they could have been doing early on, they might be at a disadvantage with some contractures, or less return from a hemiplegic arm because at that time, the priority is to get them off the ventilator as opposed to say maintaining range. So that to me is always heartbreaking because I want to be able to spend an hour with every patient, but when you have 30 or 40 people on your caseload and you're there for 10 hours, that's just not possible." (Anita, PT)

"I find that when we're chronically understaffed or just have this very low baseline of staffing, patient care is definitely impacted. We see our patients on a priority basis a well, and our strategy is to provide compensatory strategies. We hardly ever have the chance to go in to a situation with a patient who has dysphasia, and actually provide dysphasia therapy. We go in, we say, you have trouble swallowing, this is going to be the easiest texture, we put them on like let's say a puree diet, and then we leave them. And we go to the next patient and we do the same thing with the next patient, where I feel like that's doing them a disservice because they're not going to eat the puree, they're not going to drink the thickened fluids, but yet we are not really giving them any way to get better. So we leave these patients on these modified diets and then they get dehydrated and then it becomes more urgent and then what are we really doing to help them at that point?" (Jeanne, SLP)

"And so it's the same thing at our hospital where some days only the priority ones, people being discharged will be seen, and so a lot of those ones that would really benefit from ongoing therapy – OT or PT – I guess I'm speaking for both of us in the acute care setting. Like we end up only seeing the highest priorities but then by the time you get to the priority two or three, they've changed in their acuity so there's this ongoing kind of cycle of not being able to intervene and prevent a pressure wound before it develops, or people getting deconditioned because they're not going to be discharged within the next week." (Daisy, OT)

"I can't speak to all outpatient services but I can say that for the patients that we try to discharge, whether it's to rehab or PATH or, to any sort of service outside of the initial acute setting. Often there's a long wait list just because they are also overwhelmed by workload as well. And they're also only seeing priority patients. I can remember when patients used to go home after, say knee replacements or shoulder replacements, and you'd have PT at home immediately, doing exercises with them. They'd be able to go to rehab within days of being discharged. Whereas now, sometimes people have to wait weeks before they can actually get into outpatient PT. They're given their little program to do at home, but are we actually benefitting the patient by taking all these services out of these areas where we know that they can benefit?" (Serafina, PT)

"In our community we follow up with our discharges at home and if they transfer to other hospitals, and basically a lot of times we are asked – well when will you follow up? And we have literally no idea. Because we also have to triage them with all the acute stuff that comes in to the hospital. So if someone goes home on a PEG tube, and has just started to swallow in the hospital, it's kind of – it just feels sick to not have a set up plan for them. […] I don't know why I didn't even think to share this, but we just got just a tiny little bit of FTE to tackle our communication caseload and I feel so silly calling people from like, 2014 referrals. From 2014! And I'm embarrassed to even call, and people are so angry and shocked. And really – it feels awful! Because I'm trying my best here, at least I'm calling you! Like, significant situations that have been untouched for years." (Jeanne, SLP)

"Yeah so just to speak to the tensions around people's expectations of you and the discrepancy of between being able to actually fulfill those versus reality. So even

though our staff positions are generally filled, like the permanent positions, there just doesn't seem to be enough funding for the demand for the service. So for example, there's no outpatient OT. So if someone goes home post-stroke, the hospital here, like we don't have a rehab unit and if they can't go to Kelowna or Vancouver for rehab, they're discharged home from here and there's so much pressure to discharge them as soon as possible. And sometimes too early. And it's a real struggle because you know that, wow – they could really use some upper extremity rehab, but we just don't have an outpatient OT, we have very limited outpatient neuro and orthopedic PT. So you just feel so bad that you're not going to be able to give them the treatment that some would really benefit from. There's so much pressure to discharge, and then we know that once they're gone, the outpatient services just aren't enough." (Daisy, OT)

"I am an OT not an SLP by background, but one thing we are seeing a lot of in our long-term care facilities is that we're hearing a lot about challenges accessing SLP services both in acute care as well as in out-patient settings but after that as well in our long-term care both our owned and operated and our contracted sites, and from a profession practice lens you see some pretty concerning practices come about when you don't have access to appropriate services, so you end up having other disciplines pursue activities that you would never see in a setting that would be appropriately staffed so folks that are practicing either outside a scope or really pushing the lines of what would be considered in scope out of scope for certain disciplines." (Selma, OT)

"I can certainly speak to high turnover. I can say that there are, I'm new this year I feel like we have gained and then lost people it's almost cyclical. I can say that we have often quite a bit of moral distress when we let people go out back to community. We have one community SLP for the greater Vancouver area, so – we know her, she has a wait list in the hundreds. She barely gets to see people for things like communication therapy, a lot of the time it feels as if she's just able to put out fires barely, as opposed to actually any therapeutic visits." (Rosanna, SLP)

"…even in the acute system, rather than have the time to devote to each patient in terms of helping them rehabilitate their swallow, in terms of swallow rehabilitation exercises, even having other staff available like 1:1s to guide them through meals, follow their strategies, it's very, very difficult and so often we also have to modify a diet and then with just the premature discharge home that happens with people, patients with dysphasia often go home on quite limited diets that are impractical and it doesn't necessarily have to be that way for them because if they had undergone a course of therapy, they likely could be on a higher grade diet that's more reasonable…" (Stella, SLP)

"I work in out-patient physio but we don't have any community physio so once someone goes home from in-patient hospital they basically have to try and battle in to come and see me. There isn't any community physio, but we've got two community OTs but no acute OTs. So, it's just quite an imbalance and we spend a lot of time trying to work out how to get around things, it often doesn't feel like really good quality supported discharge, it's more like trying to make them safe with the little that we have…" (Penny, PT)

"I would say the lack of services in the community makes it very, very difficult as inpatient therapists, knowing the waitlist, knowing the reality of what's available in the community especially when we're pushed really hard to get people out of the hospital and were told that these people could be better supported at home. But knowing the reality of what's out there in the community and by out-patient services it's really distressing for us to be forced to push them out knowing there's not much out there for them and then the other issue was the really long waitlist that makes it really hard to provide effective treatment for patients who wait a really long time to get to your service and when early intervention is key, that's a real issue and for me, partially working in pediatrics I wanted to highlight too that there's a real lack of services for kids that sort-of age-out of the pediatric system…" (Christina, PT)

"…of course I'm always striving to follow best practices but because of lack of outpatient resources or long waitlists, I know I' m not able to always offer best practice, so for example, if you have a client or patient with dysphasia, you should do everything possible before modifying their diet, like the diet texture, for example swallowing exercises but if there's no out-patient services available well I might just have to modify that person's diet to make them as safe as possible, knowing that they're not going to receive any other interventions that will offer them best care." (Ella, SLP)

"But because I often find that 80-90% of my caseload might be putting out fires in terms of educating LPNs on the swallow screening tools or answering the 10 referrals for swallowing, which are basically nursing education, I don't have as much time in my day, and I often feel like there can be mixed messages from leadership sometimes where there is an expectation that we're doing these very high level therapy, and getting everything done in terms of total patient needs being met, but also our caseloads don't really make that really fit to achieve and sometimes the answer, you know, you see it in younger therapists that are spending much more time in the jobs than we're paid for, so people sort of do overtime on a daily basis and that's not a good answer." (Rosanna, SLP)

"I just wanted to add just for this question that unfortunately we don't have outpatient services or even waitlists, we stopped that a long time ago because there was no point, we'd never get to it but with this whole waitlist – I mean, the way we are managing our inpatient load, which at 2.2 FTE we really aren't managing for the whole hospital well, is unofficially we've created a waitlist

for inpatients as well and so when we have patients come in we prioritize them based on the information on the referral and often times we just never get to even some of our inpatients cause we never get that far down." (Stella, SLP)

"But our issue really has been that we've been included and we've advocated for physiotherapy positions or other positions and then they're posted and then they go unfilled because of the shortages, then the next time these things come up they're not likely to post again because they couldn't fill the position last time…" (Christina, PT)

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Lack of public rehabilitation and socio-economic and health inequalities

"…particularly if we look more at the out-patients in terms of the Interior Health has a very restricted list of who I can see, and so that limits who can access the program here. And often times I'm the one who has to tell a client I'm sorry, yes I realize you don't have any money to go to private but you don't fit the criteria here so we cannot see you. So you always have to wonder who treats that person who might only need, not a lifetime of PT but one or two appointments just to set them in the right direction. And so there is definite inequality, at least in this health region." (Kim, PT)

"...unfortunately some of our clients don't get the equipment and things they need because they don't have the money to rent it or buy it. And not all equipment we can rent for hygiene reasons, or things like that. Or there is a delay, if they are say a client on Persons with a Disability, because you have to go through an approval for funding, and doing that through the ministry is not always the speediest process, so yeah people with money who can afford to buy equipment or place their Mom or Dad in a private care facility until the subsidized one becomes available, for sure they have an advantage." (Alice, OT)

"…access to um you know programs promoting health all cost money. So whether it's at a gym, accessing to a gym, education programs for cardiac rehab or chronic management and lot of those programs there's cost to them and some people can't afford it." (Patricia, PT)

"I think so because often times our residents who come into our facilities who are um, on the lower end of the socioeconomic spectrum, they often don't have family who can come in to support them. And to provide them with you know, sometimes even basic things like a toothbrush, toothpaste, a shave. You know, those residents that we see who may have come from you know a downtown east side often don't have those things." (Tamara, SLP)

"I definitely work with a lot of people who are very low income, being in the mental health realm of their lives, they pretty much haven't had you know good paying jobs, and their living off of the social welfare system and they don't get all the equipment that they deserve because they don't have the money. We do get things from the Ministry, we do get things from little bits here and there but you come in with somebody who has a lot of money and their family is just like – whatever they want, get them. So I feel that equipment wise we definitely see inequality between the different socioeconomic populations." (Tina, OT)

"I see people that don't get enough food, I see people who don't have adequate housing or sometimes no housing. I'm working with a fella right up on our unit. He lived in a tent on the side of the mountain here in [my community] for a year before he got into an apartment. Affordable housing is a huge, huge, huge issue. People are living in conditions that are horrendous. A lot of people have to live in the little motels. There's no kitchens, there's no cooking, and sometimes they are stuck inside their apartment because all the apartments around here that have stairs, or the motel have the stairs. If they get injured or disabled or have a bad back, they can't get up and down their stairs, so they can't get food. ... They can't afford their medications. So we send them home, and try to get medications and they can't afford them. So they are having to choose between food and shelter and medications. They can't access transportation to be able to get to, for example, physiotherapy. So yeah, it would be great for them to be able to come to have therapy to help them recover, but they can't actually afford to get here. There is very limited bus service here, almost none, so that's not even an option for them." (Yolanda, PT)

"…when I go to refer clients back and they're in their home communities, there's not always necessary somebody who can follow up with them after they've received like an intensive bout of treatment in Vancouver, so I often feel like things are just left hanging. [...] I think the biggest thing that I would want to communicate to everybody is that communication is a basic human right that all people should have access to and as others in the group have mentioned, communication often takes a back-seat to swallowing which is often seen as a more immediate concern, that's I guess my biggest concern I'd like to share with the higher ups." (Ella, SLP)

Patients impacted by inability to pay privately (out-of-pocket) for therapy

"…in terms of like the private service provision, you know just speaking from my own experience here in [my community in the North], we currently have one SLP who sees adult patients privately and again the private rate for an SLP is over $100/hour, so to have someone pay for that to get the intensity of services they need either for dysphasia or for communication therapy you could look at, I mean, how could anyone afford that if they don't have some other funding. So often times, are patients who are discharged who haven't had thorough rehabilitation can't afford to go privately and even in the private sector it might not be available every day for the intensity that they need…" (Stella, SLP)

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"And then they say they can't pay the bills and a lot of them don't have extended health so they can't go to private practice where they would get – I mean the private practice has probably a week's wait. They have two full time PTs. But yeah, by the time they get to see us a lot of people say they can't afford to get the private practice so they have to sit on our wait list..." (Aggie, PT)

"Most of the clients we see obviously here they don't have the financial means to go privately for an assessment. $2,000 for a speech assessment so that's why they've been waiting this long for public services for kids to be assessed so um yeah, I definitely see that every day." (Catherine, SLP)

"…there's a little bit of a disconnect between, you know as far as sort of hospital metrics go, length of stay and out of the hospital and that sort of it doesn't necessarily impact that but it would come back to, oh – this is a person that probably could transfer again or walk again or do these sorts of things if they had enough sort of resources…" (David, PT)

"I have a patient right now and I've been waiting to hear back, so I've got some frail senior patients who are still living in the community, and their ability to walk around their apartment is essential, obviously. And how much of a freaking hassle it is to get them on the radar of the health authority run community outreach services. Which, I can only imagine, it must be because they're so overworked. The RN access is a little bit better like for wound care or that kind of thing. But PT and OT is, like I've called about this particular guy, I called on Friday, I said my need was urgent. I left my cell phone number. I called again on Monday, and I called again on Tuesday – I did not call yesterday but I'm just noticing that I still have not heard back. And so my problem is, is that this guy that I think maybe he might have the financial resources, but first of all to have that conversation with him is super awkward. He knows how urgent this is. He's freaking out about it because he does not want to go to a nursing home. And for me to say, oh yeah you know, I'm sorry the system's so broken right now but so far 3 urgent phone messages that I have left with the person who's supposed to be responding about this request, haven't been returned – do you have some spare cash where you could see somebody? And I don't even know who to refer him to in the community because I need to have a PT that has a specialization in frail elders, which, I don't know – maybe all PTs know how to look after frail elders, but I'm suspecting not. I think that most of the private providers in the community are more oriented towards sports related injuries and weight loss associated programs and that kind of thing. So I would have to potentially have to ask him to spend his money on a service that I don't know if it's adequate for what he needs." (Rivka, MD, Family Physician in Long-Term Care)

"I cover multiple sites, I get a lot of questions as to you know can my mom or dad, grandfather, can they get speech therapy? And right now the way my caseload is, I can't even do that. I can do an assessment and I can provide some recommendations and I can say in my documentation that this person would benefit from something. But due to caseload demands, I can't do that. So I have to you know, if somebody is absolutely desperate for their dad to try some kind of speech therapy, they have to look privately." (Tamara, SLP)

"Some examples – we are now being told that we can't supply any specialty equipment anymore. And for us, that makes it hard because all of the sudden if someone has a pressure ulcer on their coccyx and they're in a wheelchair, all of a sudden I'm telling the family they have to go out and purchase a row-how cushion that's going to be $800-$900 because we can no longer provide one." (Tina, OT)

"I would say when I first started, way back when, about 20 odd years ago, we did a lot of the rehabilitation on-site, but of course health care has changed since then, and seems like we have been offloading follow-ups to the community, without adequate ways, in my opinion, of funding those resources. A lot of families are really stuck with their options. A lot of it truly is private-pay options, which a lot of the time families cannot afford, because rehabilitation in pediatrics is long-term, it's not just one- or two-off thing, sometimes it is multi-month or multi-year rehabilitation, and sometimes benefits are weekly, some are weekly based on certain conditions, and I think it is cost-prohibitive, and also the public services that are out there right now, such as Child Development

Centers, other community hospitals, they are at capacity as well. They used to be able to take on our, we have kids, and now they are also declining them now because the waitlist is too long, and they can't service them as well, which pushes the families to seek out more private-pay services" (Teresa, PT)

Interviewer: For your more affluent clients do you ever see them giving up on Health Authority waitlists? And seeking out private care?
Yolanda (PT): All the time. Yeah.

"…in terms of like the private service provision, you know just speaking from my own experience here in Prince George, we currently have one LP who sees adult patients privately and again the private rate for an SLP is over $100/hour, so to have someone pay for that to get the intensity of services they need either for dysphasia or for communication therapy you could look at, I mean, how could anyone afford that if they don't have some other funding. So often times, are patients who are discharged who haven't had thorough rehabilitation can't afford to go privately and even in the private sector it might not be available every day for the intensity that they need…" (Stella, SLP)

Long wait times for public rehabilitation

"Our wait list is 25 weeks so a lot of people now are going over to the private practice." (Aggie, PT)

"Yeah and I think because right now publicly funded actual rehab is extremely limited right now and extremely difficult to access. For example, for post stroke patients it's really only the cream of the crop, the ones for the highest potential for improvement, the smallest number of comorbidities, all those sorts of things that are accepted into actual inpatient rehabilitation, there's still some opportunity for outpatient rehabilitation, but it's still really kind of a picking of sort of, the most quality patients to take into those programs. And hence you've seen a proliferation, I suppose might be one of the words we could use of actual specialized, private neuro-therapy clinics around – not just BC but other places as well – but you know, over the last ten years in Vancouver the number of private PT clinics that specifically specialize in neuro rehab has just grown tremendously and that's just kind of, you know, in response to there's a huge population of patients there that aren't able to access publicly funded services but would still benefit to some level. You know, some of those, once again, may be in the style of somebody who is needing a full ceiling lift, to being a one person assist transfer, or you know – wheelchair-bound for mobility to being able to walk indoors with a gate aid. It's different things like that, maybe not always the huge dramatic increases there. And once again those private options would not be available to someone who was on fixed income – those types of things; no health insurance to help pay for that sort of stuff. Especially with the neuro rehab; the extra time and equipment and things that go on to that, you know, there's a higher level of cost that's being paid out for that type of rehab." (David, PT)

"I've worked with Island Health and it's just been interesting to see as the program grows and demand grows, how funding does not row and we're often told to show that there's a need and show that there's – you know, build your wait list and that sort of thing and then the funding will come and you sort of don't see that happening." (Melody, PT)

"I know we hang on to patients longer than we should like ones that have had strokes for example, because there's no outpatient neuro-thing to follow up with them. So I want to make sure that they have their equipment, I want to make sure that they have all the skills and home exercise programs and everybody's up to speed where if there was that direct translation and the outpatient neuro program could pick them up they'd be discharged sooner." (Sandra, OT)

"I think it's a common theme, is that everyone is getting stretched, which again creates longer wait times. Which results in some honestly negative consequences." (Teresa, PT)

Rural and urban differences

Ability to see patient right from the beginning to the end, and see them at their home with the OT; benefit of small community hospital and diversity of work (Aggie, PT)

"…yeah often times I see it with people who've had a stroke or have had a fracture and maybe they could go home with a certain level of mobility, but really they should continue working on that to progress but there isn't the resources [in rural communities], there's no one to send them to. So I would say there's a significant difference, yeah." (Ann, OT)

"…talking to [colleagues in rural areas there is] a really dramatic difference between the services they provide and what we provide here, but even here across the different sites, I mean I don't consider [this community in the Fraser Valley] being that rural but compared to some of the other bigger sites for instance Surrey, there's a big difference in the services that are provided, they're able to provide a lot more services than we can here." (Alexandria, SLP)

"…there's only one outpatient physiotherapist, and I'm the outpatient OT, I'm only 0.2 FTE here in the rural setting. Coming from [a larger centre] there's a full-time OT who does outpatient neural rehab, mind you they have a much larger population. But yes, access to us, often I'll hear from patients "Oh it's going to take that long to get in" or "Can I be seen 3 times a week?" and that's just not the reality here. I mean thankfully we do have some OT, but for example we have no Speech Pathologist, people have to travel to [a different community] if they want to see a Speech Pathologist. Or we have to send people away to go seek out private OT or Physio. " (Alice, OT)

"…so we have a lot of new grads coming here but…for example there's a position in [this rural community] that an SLP was put in as a new grad, and there has been 3 or 4 of them rotate through this position, it's not surprising, they are tasked in a single role to cover acute care, long-term care, community and children's programs at the health units, so that's four jobs in one, that one new grad is supposed to do. And then unfortunately they don't have a team down there to be their support…and then it's just a revolving door in terms of services and now that positon has been vacant now for over a year. So those are the type of challenges we get in those types of communities." (Jenny, SLP)

"Yeah I think that's a big one that I find really difficult to having no outpatient occupational therapy. I do find that there's a lot of people and I think that kind of ties in with that social inequality piece. That you have to travel three hours to go to any long-term rehab facility. And so you have to meet certain requirements to be an inpatient and they're a little bit looser to be an outpatient, but the reality of someone making that journey is unlikely and so I think to not have any – like you have home and community care but they're really looking at a safety perspective, they don't really do active rehab, to work on improving things or kind lf making sure they're safe at home, making sure they have the equipment that they need." (Karen, OT)

"So with our geographical area, it's definitely limited to how much access people get. For example, people in Valemount and McBride, there's no therapists out there. So that is a huge issue in accessing services if you needed OT or a PT you probably would have to take the northern health bus to PG. Other places like Fort St. James which is about 45 minutes away from Vanderhoof, there's only one community therapist in Vanderhoof and she goes out there once a month for a day. Some of the other more rural, reserves for example, it might be every few months. So it is tricky and then like, Haida Gwaii, it's its own entity. They have Prince Rupert therapists going out there but again it's very limited, it's very sporadic." (Sandra, OT)

"…well geographical location for sure is another major determinant whether or not we can, the ease of finding qualified [pediatric] rehabilitation specialists, a lot of times we are told, well can't they see an adult clinic as well? Well no, not really. We tried that and we get all these phone calls from the adult clinics saying "we don't know what to do with them, we've never seen this before, what should we do?" so we do spend time again, out of our day fielding their calls." (Teresa, PT)

"I would say as a new grad, a lot of us, yeah tons of vacant, rural OT jobs where you're probably the only OT in the community and those are probably the most vacant jobs in the north." (Deliah, OT)

Public sector working conditions

"It's a mix of a few experienced OTs with a lot of young OTs and after a year being off coming back, I could see their spirit has really, really dampened and it's really sad to see. It's like we've hardened these people who are great OTs, who are wonderful to work with, creative – are on their way to being excellent experts as OTs, and to see this glimpse in their eyes that are no longer sparkling, really upsets me. So it's not just a patient's clinical outcome, it's our mentality, to hear one of my colleagues – a few of them going through an anxiety attack last year is upsetting. And I certainly feel myself coming back, like I'm experienced, why am I feeling like crap every day after work? Yeah I get tired but tired is different from not feeling fulfilled." (Heidi, OT)

"Here it's a divide or breakdown between knowledge and translation. I can speak from an OT perspective…what I've found is the practice is more…antiquated to a degree. This purpose in many clinical settings from acute care where I worked briefly, is I would it describe….or even in community…in many aspects I would describe that practice more of technical work rather than therapeutic. Meaning the therapist is working more of technician rather than a clinician. […] [T]he way it's structured requires really some transformation." (Irfan, OT)

"Well there's definitely less PTs. Since I started we are now not quite 3 FTEs, and I think when we started here we were about 8 FTEs. So there's been a dramatic decrease in the number and yet private clinics here in town have grown exponentially. If there's 5 people working in private practice, there's 25 in private practice in my little town." (Kim, PT)

"And I think for our clients and also for employees it's really important to have a good environment of work and I find that sometimes it's lacking in areas of VCMH, so that's why I wanted to participate." (Lee, OT)

"I feel like in public health care there's always the intent to do the best that we can, to provide really thorough services and there's a really great team environment, so when someone's in the hospital they do get access to everybody and everybody works together, so that's one of the benefits of being – at least in the hospital, I cant' speak for outside of the hospital in public health, I think really the main thing I would change is more staffing. And I feel like a lot of the maybe frustrations or issues that do arise usually boil down to not having enough staff in all areas, because it all impacts each other, if nursing is low on staffing then that impacts us, and if we're low on staffing than that impacts them." (Alexandria, SLP)

Interviewer: Right, and I'm wondering, do you yourself have coverage when you're away?
Jenny, SLP: No. We don't have any coverage and there's actually no relief budget for any coverage across all of the allied health disciplines.

Interviewer: And do you have coverage when you're away – if you need to take a sick day or you're feeling a bit burned out and you need to use up your vacation time?
Robert, OT: No, none. It's really sad. I really admire my work and I'm really passionate about it. But I won't take time off at Christmas because I kind of worry about the patients that will come in and the low staffing that we have. And I pride myself in trying to gain more knowledge and experience around different conditions and practice areas, so like burns and orthopedics which technically isn't my role but when staffing is short and you have kids who are in crisis, like they need a splint, like I want to be competent and I want to be able to support that family during that time of need especially. And then vacation, it's dumped on a counterpart or when my colleague goes off she has 8 weeks of vacation and I only have 4, and I have to compensate for her 8 weeks which I feel is very unfair, so I pick up two caseloads.

"Okay so various programs I know over the years have kind of gone by the wayside. We did have a return to work program, and that disappeared. We had an arthritis program. That disappeared. We had a much more prevalent splinting, and we still have it but it's only one day a week and it's also combined with burns, which is only one day a week service. MS program – it was still running but it hasn't had consistent coverage – would be another one in the last little while because we have been short staffed. Those would be kind of the big areas. And I don't know if this would relate or not, but I've also lost space" (Sandra, OT)

"I think having, as a younger person and as a parent of young kids, it felt super, like I was so burnt out with full time work and there was very few opportunities for part time work. I think that's one of the biggest problems of public sector jobs right now and why I see so many people going private. And the flexibility – having any flexibility – or what you would consider like job perks in the public sector. So not being able to job share easily or not being able to access a three day a week job, is the difference between staying in the public sector or leaving and going private for most of the people I know." (Susan, OT)

"So I have been hesitant to take a student over the past few years because we simply don't have an office space. There is no office for the two to three rehab assistants and then a part time PT and a part time OT at our residential care facility so we have no office. And we managed to get a computer, we're required to chart on a computer so we have one computer to share between up to four staff members on a given day, in no office. So we come to work and there's been residents peeing in the garbage can beside our desk. So things like that I feel like I can't bring a student into that environment because I don't have a private work space where you can do things really confidentially. We're right next to a resident room, so phone conversations can be easily overheard. And so we've been trying to create an office space, but it's sort of like trying to extract water from a stone because it's an old building and there just isn't the physical space for it

so we were trying to get an accordion door just to cordon off this little corner that we found for our computer and our desk but we're running into, "oh well that's now a capital funding grant" and it's been years and we still don't have a way to close the door and lock it and have a private office space." (Daisy, OT)

"I'm the casual and so I have some other jobs that I'm kind of comparing it to but when I go in to the acute care position and at lunch time the PTs are literally siting on desks to eat their lunch because there's not enough room around the table for people to sit or, you know, I – I mean it sounds like silly things but you just look around the work environment or recently there was a sort of a shuffle and PTs ended up having to re-apply for positions that meant that people weren't working their areas of expertise and I just think, add all those things up it doesn't make you feel like your role is valued by that organization. And with such a shortage in each of these professions, we have choices to go elsewhere. So if the culture at the organization doesn't feel like the PTs/OTs/SLPs are valued then I think it makes it very easy to look elsewhere for employment." (Serafina, PT)

"…I think one thing that we're seeing in Vancouver Coastal Health is that it just starts to impact folks' job satisfaction and so with that, I would agree in terms of the narrowing of scope and so I think definitely as an employer, a health authority would be able to say you know we want to pay you to do 'x' part of your scope, like that is well within an employer's ability to do that but I think some of the consequences of that is just the job satisfaction for clinicians, their desire to stay within any given position if they find it becoming quite boring or redundant, there's a greater impedance to leave that role and we end up – our current state right now is we have a lot of clinicians who are very well skilled, who will work part-time in public to sort of have the good benefits of that, but then will really seek their career satisfaction in a part-time private position." (Selma, OT)

What would you change about public practice?

"When I was doing private practice I took on a contract for an independent school and I did that for a couple of years and then I picked up a few school aged clients on the side on top of that. And what worked with that was I liked the autonomy of being able to schedule your day. What I didn't like about that was I felt like I was always on call, whether it was a phone call or an email and I'd like to be able to turn it off at 4:30 kind of at the day's end."

" And I think, that's what I see is a major flaw in the public system. And it's really I think impact patient care. Now I cannot quantify it but it seems to me that is one of the reasons why we have watered down the scope of practice in many professions. To keep it least common denominator. So in community and in acute care, really the primary focus or the primary practice of OT is pretty much equipment. Wheelchairs, toilet seats etc." (Irfan, OT)

"I think in the public sector, cuz actually what I've encountered in VCH is managers and directors are stretched thin, very thing. They have multiple portfolios, multiple teams to manage and it's hard for them and then that kind of filters down to supervisors and then filters down to employees, because the managers can't really provide the support they should be giving to the employees and that also affects client care. So I think in general having a healthy work environment for leadership, will definitely be helpful for employees in general. As I've made discussions to my previous colleagues about this, I think that's what kind of it filters down to, the managers are very stressed and I think they try to well but they don't have enough time to and we kind of have seen the differences between a manager that's all supportive versus manager that isn't and how it affects the team overall. Then we would be provided – I don't know if it's better training, but being able to kind of restructure the work a bit more; hire more people if possible, to take on these portfolios or teams but that would be beneficial." (Lee, OT)

"I think the key point really would be that you have a group of professionals that are not feeling completely valued lots of times in their professional work and in their ability to be the profession that they thought they would be when they went to school. It's not coming out as the same and it's usually because of a lack of resources and increased pressure and that sort of timeline and time crunch and we all see sort of extra meetings. Extra meetings and extra management, not the frontline people. The decisions are being made by the people that are too far removed from the frontline to know what's going [...]" (Annika, SLP)

"I work a lot with recruiters on recruitment and retention pieces and I know that they're out there trying to recruit them and I think the biggest thing is, if we had appropriate numbers and supports in place for when we

do hire people, that's the biggest thing, I think it's the retention piece that's the issue here, you know, if we can get a new grad to come through we need to support them, their families, their partners, everybody. We had a new grad come through, be overwhelmed in her job and then her husband wasn't satisfied in his and no one really – abandoned, all of a sudden she left and now that position is vacant for years. So I think it's the retention part they really have to focus on and I think if they had better numbers in terms of best practice and you know, general standards, I think that would be more helpful." (Jenny, SLP)

What is working well in public practice?

"I would just echo the comments said already, I think when you see examples of really strong team-based in action it's just so inspiring and you see the amazing outcomes that are achieved for patients and families. When it works well, it's an incredible thing." (Selma, OT)

"I do really love my work and I love being a speech language pathologist and I admit that it does have its challenges from the administrative level that I've spoken of, but I do love the work that I do and just it's so multifaceted and I particularly benefit a lot and my work is enriched by our allied health team, the physiotherapists, the occupational therapists, the registered dietitians who I could just, because we have such a good working relationship just pop over and ask them to see a patient for positioning so that they could eat safer and they're supported and just the openness that other members of the allied health team have in terms of being a team member and helping out and that's working phenomenally well and I think that is something that definitely keeps me loving my job and also the difference that is made in each patient's life…" (Stella, SLP)

"I really love my job, I love the patients that I see and the variety and the challenge of the job but I think what has really kept me in my position for so long is the strength of the team around me and I think that really sets a tone, so the relationships within the team, the way we're able to support each other and learn from each other and just really having a real culture of learning and always striving to provide the best care we can within our limited resources…" (Christina, PT)

Team rounds – teamwork (Heidi, OT)

Work 6 month rotations: inpatient, outpatient, extended care/community (Kim, PT)

"I think that's why I do like working in public rather than private because there's no – like people don't have to pay to come here and so they're able to access the resources they need, generally. There's other factors as well. So I like doing that. What works for me in the public sector is, well it's generally that teams are inter-disciplinary, so there's, like, I enjoy working – like talking to the doctors here, talking to the case managers, just because we all provide a different perspective and we're all kind of there, along with the client on different journeys during their recovery, and so I think that's so important. So I enjoy working with other professionals as well. Whereas in other sectors you might be working with solely with OTs or solely with PTs and physical health and what not, so I enjoy working with a team of other professionals." (Lee, OT)

"A big reason why I chose this job was just that there was lots of other people to ask questions to and get support from. I've been working for almost 4 years but that's still pretty new in the career so I really appreciate

having people to go to to ask questions. [...] So I really do appreciate in the public system that people can access items that they need and care that they need without that cost being a barrier and even though I only see it in a fairly minor way, there can be really tricky cases where you know what someone needs and you can't give it to them until you can figure out that financial piece." (Karen, OT)

"There's many things that are working for us. I would say my biggest thing is that we're a centralized department that have some really great resources, have some really great therapists and we share the load. The drawbacks are that we definitely don't have enough staffing. So our hospital is, at any point, I'm going to say 15 to 30 percent over capacity. And we don't increase the staffing levels to reflect that." (Sandra, OT)

"Support I would say is a big one. I think that's a big draw for me, being a new graduate, is publicly I have my co-worker, I have connections in the rest of the [region] as well as the Professional Practice leader, so that's a big one as well. A major plus would be access to funded education…" (Susie, SLP)

"what works is me having a team approach. When staffing levels are good, having that team approach between the Speech Therapy, and the Occupational Therapy, and the Care Aids, and the Physicians, and the whole team working together in a small community. It works a lot better because there's only one hospital, we all meet together every morning. All the home support people come, it's a really great team approach." (Yolanda, PT)

"I love seeing those firsts. Whether it's the first time someone takes a breath on their own, or sits up by themselves, or starts walking. Just those minute first changes, I love those things." (Anita, PT)

"I really getting to help people with chronic conditions that really feel like they have no hope left and you get to go in and you get to go in and help maintain their life and still find ways to fulfill their passions." (Deliah, OT)

"I love the variety and the acuity of the patients." (Jeanne, SLP)

"I love my hospital days because of all the interactions with the team members and they physicians and I think the private practice clinicians miss out on a lot of that. It's difficult for them to get access to information, being part of the team." (Daisy, OT)

"For me, it's about the team. I love to have that ability to connect with my PT colleagues, and then in the actual practice setting to just be able to function as part of a team. I find that really a richer experience where you kind of know the patient better when you're hearing the whole team's approach as opposed to just as a PT working in isolation." (Serafina, PT)

Teamwork

"Well I noticed it big time around discharge planning. Like that was what really bothered me is that discharge planning on the psyche unit would often involve – are they stable on their meds? Great. Discharge. So without any appreciation of like, what about their transportation, where are they going to live? And I mean the social works would totally pipe in sometimes about housing, but often it was a more complex situation, so they'd be couch surfing, or they maybe had a friend they could stay with. Like, you could sometimes cobble something together, or – but there just wasn't enough time to figure out – "so how are you actually going to live when you're outside of the hospital"?" (Susan, OT)

I think it takes someone at like a team leadership level to sometimes be able to sort of set the stage through a facilitation type role to help the team move in positive ways in terms of interdisciplinary collaboration and shared learning and so the example from the geriatric assessment program that was provided is the idea around – sound likes you had two physicians maybe, who were very strong drivers in helping set the stage, in helping facilitate the opportunities for this collaboration and education to happen and I think the tricky thing that we're seeing, at least for Vancouver Coastal Health is that there's inconsistencies across the different programs and sites around the availability and I guess strength of folks who would maybe within those positions of leadership to help provide that facilitation." (Selma, OT)

"In the hospitals, part of it is due to a cycle because we don't have enough time to attend certain things, or always give input. Again, that could affect how often we are invited to give input and to be present for things like family meetings, right? Because there is just simply not enough time for us to be everywhere." (Susie, SLP)

"In a small hospital like this, I feel it's not as much of an issue because again, you get to know everybody personally and a small staff. You're working together closely, I have a good chance to work with other team members and teach them. Most of them are open to that kind of team work together. In the larger facilities, I believe it's a huge problem because there's such a low staffing level for Physio's. They don't have time to do any of that education, but there's 10 million nurses changing everywhere. You don't really have the chance to build relationships with the people you're working with, they are changing all the time, and you're not really there much with them. I feel that that is a big issue in the larger areas." (Yolanda, PT)

"I think all of us as allied health professionals are very well respected in our teams, not only within the fact that we do something different then say the bedside nurse or the doctor. They recognize that our skillsets are different – they often realized that we're the ones that take that more time with the patient one on one. We probably know things about them that the nurse that's with them for the whole shift doesn't know. I think they understand what we bring to the team, they understand that we communicate generally better within our allied health groups, and that we bring so much valuable information to the team that is essential beyond just their medical picture. I can't say that there's anyone I've met in my career that doesn't respect our role, but they might want to try and - maybe they might confuse our roles, but I think they respect the fact that we are there and they appreciate the skillset that we do bring to our jobs and to our multidisciplinary teams." (Anita, PT)

"I would agree there's a lot of, at the risk of, I don't want to try to polarize the professions, but there's a lot of kind of nursing monopoly I find. Like for example in other provinces, OTs and PTs can be community case managers, but here in BC you have to be a registered nurse. I hope this isn't too much of a tangent but yeah, sorry I'm losing my train of thought. But there does seem to be a disconnect between the decisions that are made at the upper level and then us being consulted on the front. Certainly that's my experience. There's been an improvement though, I've noticed but there are the creation of some of the allied health directors, I've noticed that some of them are OTs and so it's great, so that part is good." (Daisy, OT)

Private sector/private practice working conditions

"So there's a lot more of an ability to see the patient from the start to the finish. And to be able to do so in a much more self-directed manner – in collaboration with the patients themselves. And at a much better remuneration than the public system. And so there's a little bit more of having your own caseload and much more control over the care plan direction. Whereas sometimes within the public system there'll be situations where I don't necessarily, you know I don't know if this person should be discharged but they are going to be discharged so I will do what I can to mitigate risk of them going home." (David, PT)

"Like when you're working in the private sector you're not working in the ICU, you're not working in the emergency department, you're not working on a great big stroke rehab unit and seeing patients like every day gaining back a skill like, couldn't hold a fork yesterday but can hold it today. The things that we learn in school and then when you're in the private sector, you're just taking one little slice of that pie basically and doing that. When there is so much more than that. And the general pubic doesn't understand the scope of what we are trained or capable of doing as therapists. And we get marginalized to "oh I know – you're a physio – you treat sprained ankles". (Kim, PT)

"What's working for me is the amount of time I get to spend face-to-face with the client, much more than they would experience in the public setting, in terms of frequency and intensity of therapy that can be increased. Which of course, has greater outcomes on their improvements. Privately there can be a little more flexibility in terms of what I can work on, or seeing people in their homes instead of having them come to me. Privately as well, I can access quite a range of, I guess, messes, but maybe don't have to be a standard protocol, that I can be a little bit more creative in terms of what I am doing, which can be nice." (Susie, SLP)

Recommendations to address recruitment and retention challenges

"Yeah we always have like a vacancy that will go on for months and months and months. More incentive – especially to get new grads up here. […] And maybe making the wages the same as what they'd be in private practice or equivalent and then some of the new grads probably wouldn't go strait into the private practice." (Aggie, PT)

Mentorship: "So to attract more people I think proper mentorship would be also good. I'm looking at some of our new staff here and she's stressed every day. She's staying late every day, and yes, it's a learning for her but it's also I feel that I don't think she had proper mentorship. And again I'm not trying to disrespect my practice leader, I know she works hard but she's part time, I know she went from a .8 to a .6 or whatever it is that they cut from her." (Heidi, OT)

"I would say it would be nice if there were just more SLP positions because even as a new grad just trying to enter the health region with a casual or a temporary positions, north of the Mallahat there are not enough positions to even keep someone sustained. There's just not enough people that can actually go on leave or switch positions to have that turnover. So it's hard just to really bring people to the area because there's just no opportunity to bring them in the first place." (Bob, SLP)

Wage - making more than $10/hr more in Ontario just out of school (Catherine, SLP)

"One part of it would be a higher pay is definitely going to – yup that's one of the big issues right now. And you know, the public system and the private system have always sort of, there's been points in time when the pay gap was bigger and there's points in time when the pay gap is more minimal. But I think after the limited raises we've gotten over the last ten years it's really at a point where working in the private sector you can make enough money that you can basically make your own pension and pay for your own health benefits and still be money ahead of the public system. Or you can translate that into making the same money working less hours for sort of work-life balance and all sort of within the context of generally more rewarding sort of clinical work and more sort of autonomy and sort of respect for knowledge within the caseload. And being able to bring all of your knowledge to your caseload." (David, PT)

"I think one thing that drives people out of public a lot is the really, the extreme rigidity around vacations and days off. Because I'm the only physio here I get to take vacation whenever I want. But every other place that I've ever worked, when there's multiple physios you can't have more than one off at the same time, and there's a whole complicated system and there's 3 rounds of vacation planning and it all happens like….your 2019 vacation is completely locked in within the year of 2018.

And there's absolutely no changing it for any reason. Like one physio was asked to go help with some Olympics things and they wouldn't let her change her vacation even though it worked fine for the department." (Dinah, PT)

Wage - making less than in Sask. despite higher cost of living; more educational opportunities (Ingrid, PT)

"I would say having an educator role, that would be helpful. Having clinical site leads across Northern Health. So I am one of two chiefs and then there's somebody who manages PT and OT up in Rupert, but that is it. So if you're in the community you're either a Grade II or they've kept some of the therapists as Grade I in long term care and draw a little doted line to me. I would say, to have somebody to at least go to especially if you're in Burns Lake or Kitimat, like you would just feel more supported. I know they've lost a lot of therapists over the years because they get new grads out there with no support. So definitely more support either educator wise or just even having somebody they can go and talk to that actually understands their role. And with the school coming I think it will probably get a little bit easier with this respect, but we're not probably doing as good of a job advertising the fact that if you're a UBC grad with BC provincial loans, if you come up north you get some loan forgiveness." (Sandra, OT)

"Obviously some more positions available, maybe a little bit more awareness of our roles? I know that's also on us as well, but having some support maybe, showcasing or having whatever, Speech Month. Having a little more publicity, maybe. What else to attract us hmm… I would say having systems in place that value the input of a Speech Pathologist. So including us in things like rounds, including us even in the paper work, and having thought for SLP on the patient's board. Right next to PT and OT, things like that, where for certain patient's that's very much a part of their care plan. Just being acknowledged a little bit more, in addition to having more positions available, and having more time for patients." (Susie, SLP)

"It's really that recognition, so if we could have more laddering of Clinical Specialists and Clinical Educators that would be fantastic. I know that would go a long way in retaining I would say senior staff. It's also a good selling point for newer staff, newer grads as well
"Another thing from a physio point-of-view is in other provinces, they have something called the Physiotherapy Practitioner, there are a lot of studies out there right now that show the benefits of having a Physiotherapy Practitioner, it's sort of like a Nurse Practitioner, but a Therapy Practitioner. Studies have shown, the research shows, it decreases wait times, I approve patient quality of care, because they are seen quicker, ups surgery times, so overall everyone is very pleased the data is very positive for having Physiotherapist Practitioners in other provinces, Alberta is one of them, Ontario is another one of them. For some reason our province is a little bit slow, actually I don't even know if it is on their radar right now, because they are really focused in on Nurse Practitioners right now. Yeah, so it definitely would go a long way to attract newer staff and newer grads to the public sector" (Teresa, PT)

"…having better baseline staffing levels, and having a recognition of the role that Physiotherapists can play in the hospital, on a medical floor, instead of just "Okay, the Physio is there to get them out of bed and walk them down the hall and send them home". There's so much more. Scope of practice. That's the phrase I've been looking for. There's a huge scope of practice that Physiotherapists could bring to the healthcare team, both in the hospitals, but also having access to those community resources, so that I know that if I send somebody home, they have access to continuing rehab in the community. That's actually a big source of job satisfaction for the hospital Physio's because then you know that they are not just abandoned into nothing out in the community. That does make a big difference to your inpatient sense of satisfaction too. So staffing levels in and scope of practice, ability to actually do the job you were trained to do and have respect within the team as to what your role is, and having the staffing levels in the community to have the confidence that people are going to get what they need once they are discharged." (Yolanda, PT)

"My recommendation would be a way to get new graduates in to public practice. I can't speak to the other disciplines but I know currently in PT they are creating a northern corhort to try and have students who are going to school up north stay up north. Another idea could be that when you have your class, that you have patients who are also in, say, a public practice cohort. So they agree to work for two or three years in public practice upon graduation, and then they could have a benefit like a tuition refund or some sort of initiative or incentive to want to be in pubic practice. Because unfortunately now, the pull is towards private practice." (Anita, PT)

"I'm with them in saying I think we need more students graduating from BC. We only have I think 75 – not it's even less – OT roles a year – 50 I think? So NHA recruits in [out of province], that's where I was recruited from. So I think we just need – the northern OT program could probably expand double to what they're proposing and we still wouldn't be able to fill all the roles. I guess the trouble is that, you know, even if they increase the new grads and they had better exposure to acute care and I'm not sure who it was that just said that, if they continue to come in and see PTs/OTs/SLPs who are you know, working like dogs and can't provide the treatment they want then they still might not choose to go there. So I think some of the stuff that's kind of eroded over the last five years seems to me even just the way – maybe the value that is put on kind of the working conditions for some allied health in terms of – you know I'm guessing that it varies from health authority to health authority, but just some of the management that [the other member] was talking about around how the PTs are treated by management

and even down to things like how much physical space they're allotted for a department so that you can have those kind of meaningful connections and so on. And so I think if we don't look at even what the working environment looks like, we can continue to turn out more grads but if we don't – if it's not a more appealing place to be to work, we're not going to retain them. ... I'm a new grad, I graduated in 2018 and NHA tried really hard for me. They actually did have a mentor OT paired with me for probably the first three months. … But having the mentorship from her has actually made me quite loyal to Northern Health because I also call on her quite frequently for guidance. And so I think the health authorities know about this, it's just finding the people to do the mentorship is another tough challenge. I think there's a big turnover. I think there's a lot of people at the end of their careers, and a lot of people starting off so it's just kind of hard for the people ending their careers to leave either management roles or leave their clinical practices." (Deliah, OT)

Challenges created by dual practice (working in public and private sectors)

"Officially not, but we do have casuals that I call in on a regular basis, but basically because I have not been fully staffed in two years. So officially I have my ex-boss that comes in one day a week to work on the pre-surgical screenings for hips and knees, and I have access to, I just hired somebody last week, who is working privately on the side. Well he's working privately – that's his main job but he's going to do some casual hours for me, when available. And I have somebody else that's working a .5 position that's also doing private, so he's maybe giving me a day here and there. So my pool is very small." (Sandra, OT)

Scope of practice, clinical specialization, and clinical leadership

"I would say, what others have said definitely resonates with me, I feel like in Northern Health and acute care, as an SLP, our scope of practice is extremely narrow for example, we see a patient who has a stroke and they have difficulties with swallowing, difficulties with their voice, difficulties with their language, difficulties with their speech and cognitive communication, so you're having a hard time communicating with them that you know you can only help with their swallowing because there just isn't time and there isn't the services available in the hospital to help with all the other areas…" (Stella, SLP)

"I would totally agree with what [the other focus group participant] has said, that resonates with me with our small team where OTs and physios, and as I said, it would be lovely to have SLPs, but we're managed by an OT, our manager's great, I feel very much listened to, very much supported and I think if we come up with little ideas to improve the department, she's always very much open to it and very much supports us in that however, it concerns me with some of the visions for the future, as how it might move forward it seems to be favoring quite large general teams which maybe you would be managed by someone not with an allied health background and it would look a bit more like our community structure which speaking to our community OTs, I don't think they feel particularly supported or there's not really much/any mentorship for them and I think it would be a shame if the team become wider in general with less communication and less support for each other because I feel like how we have it now works very well."

"I'm lucky enough in my position to have been able to have some career progression but I think positions like mine are fairly rare and hard to carve out. I was lucky to have a PPL who just took it upon herself to kind of change funding around/use the funding she had to create sort of supervisor positions which are sort of like clinical specialists, but I think that really talks to the issue of working to working to full scope, I think so many – and I can speak from a physio perspective but I'm sure it's the same in OT and SLP – so many of our therapists are not working to full scope because there's no time or space for them to actually work to full scope because there's so much of the kind of general things that need to be done, that we're seeing we're not even able to cover that, so why would we sort of let someone take on an advanced scope." (Christina, PT)

"I feel that others definitely see me as just for swallowing assessments, I very rarely see a referral if ever for any communication needs even though I know there are patients who would benefit from intervention regarding their communication…" (Ella, SLP)

"When I'm in the hospital I know my position and my position is that I am a discharge planner. On a lucky day

I get to be an OT to some stroke patients but mostly I'm a discharge planner. And I'm full aware of that, which is why I at one point I needed this private work because I need to feel that what I went to school for I'm still able to use." (Heidi, OT)

"Um, yeah I have a great team I have a really, really awesome professional practice leader. We have monthly SLP meetings where we do pro-D's so one of us will give a presentation on whatever they've learned, whatever conference they've attended – and then we kind of all discuss that. So the big change for us now - are we all using the term developmental language disorder and just making sure – we're using it correctly. So we have a lot of discussion about new research and changes that would benefit our practice." (Catherine, SLP)

"I would probably say very little is working. Once again I think there's very few people that got into the profession to do what they're doing in the hospital. I think, from my end right now, the easy part for me is I get to work as a casual and basically collect a full time income and so there's sort of structural benefits to me that way. Theoretically there are opportunities for advancement within the system, but that's a different topic that I have a different answer for. I think the hope would be that if there could be more opportunities to expand the sort of rehab coverage of things. You know, to have more sort of Holy Family or GF Strong type set ups. Or even more hospital-based outpatient programs to be able to do stuff. Like I think there's also been – it's a little bit of a catch 22 in a way of because of the sort of limiting of the scope sometimes. You know that's all other people see of what PTs do and so they start to think that that's all the PTs can do. And so they don't necessarily see all the advanced stuff that we are capably trained to do and do in private sector. And it's kind of the same thing. You know just to for all of my colleagues like the OTs that people start to think that that is all OTs do is give people wheelchairs when their skillset is so much more varied and advanced and that, but their just sort of never given the opportunity to do that stuff with the mandate of the hospital." (David, PT)

"…that's why they like private practice because it provides other practice opportunities and ability to see patients over a longer course of care." (Annika, SLP)

"Yeah, I think that sometimes it means that they don't get a referral when it would be appropriate or they might refer to us when we're not the best discipline to address something. Most often, I guess an example that comes to mind is in terms of cognitive assessment and cognitive rehab that often times, especially working with an older population, the inclination is to refer someone to a geri-psychiatrist to better assess their cognition when we are trained in a lot of those assessments and can provide lots of input on how someone's cognition is affecting their day to day abilities and how they might function safely at home or not. So I feel like sometimes, actually tying back in to your last question … maybe sometimes our input isn't taken as seriously because they might not understand our level of training in that area. And are waiting for the input of a specialist that can take sometimes months to come and provide that." (Ann, OT)

"[...] definitely we're short all over but a lot of the response in a lot of ways has been to really sort of limit the scope for what the PTs are doing, to sort of pull workloads into what is able to be provided by the staffing levels. And so it's kind of the case of like, you know like we don't see everybody on all the units and it's like, you know there's much, much more that we could be doing. But it's simply not the priority and it's a little bit of a catch 22 of, you know we don't have the staffing levels necessarily to do that service anyways [...] That there's just much less opportunity to really work on higher level goals and a lot of it sort of boils down to simple transfers in and out of bed and maybe a little bit of walking plus or minus stairs if somebody has stairs in their home to go to that ah … the position has become much less about sort of rehabilitating people and much more just about getting people out of the hospital. And community positions which I've worked in in the past are much more now about keeping people out of the hospital as opposed to necessarily getting them better. Some of the outpatient programs in a few of the rehab units from GF Strong or Holy Family Hospital being kind of the last couple, sort of places where sort of actual rehab work is still sort of going on." (David, PT)

"But that's why I left acute. Because I did not feel that I was practice, that I'm allowed or have the room to practice." (Irfan, OT)

"Yeah definitely a lot more bandaid solutions over at [our program] especially after integration. I think before it was quite well functioning where – I mean the case managers would be the one putting out some of the fires and then we would work with them sometimes, but we'll work more so on the goals and the rehab piece. Whereas afterwards, since we're kind of our own separate team and rehab group now, we definitely do find we do a lot of crisis management and a lot of times also the clients see us more than they see their primary care physician over at the primary care team. So when they have a crisis they will call us. And also we work with clients a lot on anxiety management and distress ?? [50:27] and so when something happens where they're highly distressed they call us. And so yes, I do find that now with that new structure and the new way of doing, we do find we are in crisis management a lot and putting out the fires and case management things that is not in our scope and that's one of the reason why we did grieve our position because we find we're doing a lot of case management and all that stuff. And then because of that sometimes we can't provide services for our OT scope, it's just kind of yeah, putting out fires." (Lee, OT)

"I would say that we don't have enough time to address communication needs here, so no we don't really get to practice all of our communication skills." (Alice, OT)

"I feel like in school we kind of touched on all of these topics, but it's been a while since I graduated and so I think keeping up with the practice – that's the main challenge. So you know globally that the clinical pathway is this, but we're so far behind because we have no staffing and no space, and no access that we're not even able to practice what we know is evidence based." (Celina, SLP)

"No, for example if I hadn't decided to put in the speech clinic on Wednesdays, we would be doing zero speech and language and cognition therapy, we would be handing somebody […] a couple of handouts and giving some brief verbal education to the family but other than that we would just be managing dysphagia because that is more critical in terms of life and death obviously than speech and language." (Jenny, SLP)

"I think a big part of our training and one of the things I mentioned before was like, working with people to do things that meat something to them. So full activities, things that improve their quality of life. And I think in the hospital setting, typically we're looking at – what's the minimum they need to be able to get back home safely? As opposed to, what things would they need to do to be happier or to have more meaning in life or to have a better quality of life. And that we don't always get to do that kind of rehab." (Karen, OT)

"I'm a bit biased because I am an OT but we work so well with teams and we're often good at communicating and like really bringing the whole picture to other professions that usually don't see like a muscle or a joint or a skin condition where we literally see the whole picture, we address homes, we address social situations and I feel like, yeah, families really struggle with that because they're like what's an OT and you're really having to advocate for your role. And then you're kind of limited cuz now I can't do that, literally like "I'm the person that makes splints".

"As I've said in the past we are skill based now, we are literally offering what we can in a limited amount of time so the scope of practice, we as OTs are one of the broadest professions and it's so sad when you see what's going in to such specific areas because of such demand and need rather than we can work on this and really grow with the kid or individual. I feel very limited like they see me as a shoemaker because that's all I make is splints." (Robert, OT)

"Am I working under my full scope? I would say no. I think we, as Physiotherapists, we can do more, if given the opportunity and the chance to. I've been meeting with some Surgeons and some Medical Directors this week actually, in regarding expanding our Physiotherapy role within the Orthopedic clinic, uhh, so far it's in the preliminary stages, it's not going too far unfortunately, umm, but again with all the literature that I've presented and read, you know, Physiotherapy can have a big impact on the care of the flow of patients through a certain clinic, through an orthopedic clinic." (Teresa, PT)

"This is something that Physiotherapists in acute care hospitals go into private practice. Because they can see that they could work to their full potential, but can't because of the work load. Even at baseline staffing levels, Physio's are not happy with the level of qualification that they could use. All the knowledge and all the skills that we get trained to have, and in many areas of acute care you can't use them. So lots of younger Physio's want to go off where they can work with fuller, um, up to their capacity." (Yolanda, PT)

Consider allowing PTs to refer to imaging (Ingrid, PT)

"As therapist you know because we've been pigeon holed to do this very minimal [44:41 inaudible]. And I think that's connected to the bigger picture that I've been describing. To change the system to make OT an OT, to move them from one place to another, you….it's not convenient for the authorities to have special, to have that kind of system. You know because they just want to move people from one spot to another, not worrying to much about skills, you know? So what is the lowest common denominator is equipment. You cannot hurt too many people delivering walkers and ah….you are paying so much money for not really getting the services that you're paying for. So you might as well just put vendor machines to give you equipment." (Irfan, OT)

"In some of the bigger centres, where I didn't work but as a student, they would kind of have lunch learning sessions. And it would be on your own time you didn't get paid for that you had to eat your lunch during it but they would kind of do a quick in-service on different things to keep you up to date and I would say that's something, and that's maybe not for the public sector as a whole but the public sector in a northern community that I don't think we have access to as much of that education that would I think improve our work." (Karen, OT)

More education dollars (Aggie, PT)

More pro-d opportunities, lunch and learns, in-service, longer practicuum placements (Ann, OT)

More opportunity to engage in learning of clinical innovations and support/time to do this. (Chuck, SLP)

No requirement currently for OTs to take continuing education; could work for 30 years without any continuing education. Need to mandate continuing ed. (Irfan, OT)

I think a bit more training the dysphagia area in terms of the time they a lot with all the things we have to cover over the two years. Yeah that's pretty much it, in terms of the grand scheme of things. (Alice, OT)

"The students are doing better but I don't feel like there's enough motivation to do well because with the clinical practicums at UBC, they're not pass/fail. You basically just have to complete your time. And I feel like because

there isn't that graded component, people don't take the internships as serious as they should." (Celina, SLP)

"But really we don't have time to advertise and show and, as a tertiary hospital we really should be the leading pediatric department – like educate people and bring people in and really say this where best practice comes from and this is why we support people in the community but we can't. And I think just personally for me I just love education and professional development and learning that piece and if I see a ladder and growth, I really want to strive on that. If I can see it, I can get up in more of a tiered system in a sense of professional development and education was part of that where you can really see your rewards coming in and you can really see how much progress you've made in a year or two years or three years. You don't really get that support currently. And then of course I would say salary but that's a no-brainer." (Robert, OT)

"Other pieces I think are professional development opportunities as well. I just remember having to jump through so many hoops to … it was a little easier on mental health to be honest. Like the manager there was – and because we had a nurse educator on they psych ward who was there for the nurses but she was awesome in encouraging like discussion on articles, and doing sort of more team-based education stuff and I did get to do a couple of courses when I was in mental health to build my confidence which was great. But I think easily accessing education dollars and leave was a challenge. Which is also a potential recruitment problem." (Susan, OT)

"I would also say more variety in practicum, so having access to all these positions I'm in now would be nice as a student. I know it's a little bit limited sometimes, yeah, just setting it up is difficult on its own, I get that. It would have been really valuable to have maybe even more clinical experience, it wouldn't have to be a full practicum, but just being able to see a range of what's out there." (Susie, SLP)

"…more discussion and exposure about public sector versus private sector. They get a lot of education from private sector Physios, and they don't do an awful lot about social determinants of health, they don't do an awful lot about what a well-functioning public sector could do, and the importance of having universal public health care as a policy issue. " (Yolanda, PT)

"I'm in the community and there's no OT in the hospital here. Our hospital only has [less than 30] acute beds. So I kind of do become the jack of all trades generalist OT. So equipment prescription is a big part of my job but I do remedial dysplasia management. I do a lot of, like I get to coordinate with the clinicians in town and tell them about my different skillsets. Like concussion management is in my scope and I get to make splints. So I do feel like my scope is well understood among my team and like I do get to use my skillset quite well." (Deliah, OT)

"I think we hear from people sometimes like, the students that do, you know, placement in public practice and then they leave with the impression that all you do is walk people." (Serafina, PT)

"Yeah at our site we're encouraged to take education and we're given, it's not necessarily hard to get the time to go, but we struggle with getting funding that we're contractually allowed to have through our collective agreement. That's our biggest thing. They encourage you to stay abreast of practice, they encourage you to go but then they won't necessarily help you with the funding to go get it. So like why offer it if you're not willing to facilitate us going, which is extremely frustrating." (Anita, PT)

"I don't know if access to professional development has been a part of the conversation, but I just know that where I am, I'm running into all kinds of challenges with that because I've been wanting to take this dysphasia workshop that's two days offered in Vancouver once every year or two or whatever, but first of all finding the funds, as a single parent I just can't afford to pay for these courses and the travel and the lost work time and the child care, and so I applied for the HSA professional development fund but by the time I had applied and found out about the course, I wasn't eligible because there was just too much demand for it and then we don't have any kind of really good funding in place for professional development. And so I think that's one of the issues I just want to draw attention to. Especially rural places."

Clinical leadership and career advancement

Lack of public sector leadership opportunities (Aggie, PT)

"I think just in terms of that opportunities for career laddering, I would say again I feel very fortunate that I've had the opportunity to do some career laddering but it's definitely been a hard, sought out path, and I definitely hear that from a lot of my colleagues in a sense that Vancouver Coastal Health is going through some fairly significant structural changes that have really taken away opportunities for our frontline staff to pursue career laddering, so I really loved hearing [from another focus group participant] around like the model in the UK, I think that's something that we used to have, probably not as well developed but something similar to that, probably around 8 years ago, where we saw more like clinical specialist positions, providing some supervision and caring the caseload. Our current structure […] one of the things that's problematic is that our sort of clinical leadership no longer carry any type of caseload so our ability to maintain, I would say the confidence of the staff that we are supporting is limited in the sense that we're not necessarily practicing what we're preaching a lot of the times anymore so yeah I don't think we've landed on the best model to meet both client and patient needs as well as supporting our staff in their sort of career progression and also their sort of faith in their leadership team." (Selma, OT)

"I'm just reflecting on what everyone's been saying and it really resonates with me and I'm thinking about how outpatient services or specialist services were protected in other places that I've worked and I think that by comparison one way that it really worked was people had things like incentives to specialize, there were career ladders where you could move up through them, for example, you could move from a junior to a senior to clinical specialist and I think that creating progression in that way also helps to protect more specialist work and obviously I see it from a much more junior perspective, but I do wonder sometimes if there would be a way to create more reward for specialist work, it could be more protected. ... that really, really resonates with me, and I it think what that then creates when we're all "jack-of –all-trades" is we have very little time to do things that could eventually improve patient care like have protected time to do research or network – what it creates is a very time poor set of circumstances where were just trying to put out fires as opposed to working to create more specialized structures that could ultimately then improve patient care." (Rosanna, SLP)

"I think that really resonates with me having worked in the UK, there was a really clear structure as to how you would progress as previously mentioned about how you'd be a certain band or level and you'd start off, and then you'd interview for another job like to be slightly more senior, and as you go you can specialize more so, for example with physio, you do your junior rotations in lots of different areas for four to six months at a time and then you interview and go for like a band 6 which is the next level up to specialize in maybe, rehab, musculoskeletal, respiratory, or something like that, and then once you get one of those jobs you rotate around the different specialties within that specialty so for example, physio musculoskeletal outpatients, you'd pool rehab, hand therapy, scar management etc. and then you'd interview and go to the next level so there'd be a real clear progression where'd you'd get more and more specialized and I feel like that isn't so much the case where I'm working now, there is – you're just expected to be a generalist for the age of 8 to I don't know, as old as people get, in every single aspect; stroke, vestibular, respiratory, cardiac rehab, musculoskeletal – and it's very difficult and it's challenging and it's interesting, and I do like the variety but you feel very much like a generalist all the time with no progression, there's no other job to go to once you're – there's just one manager role and that's it so there isn't any progression and incentive maybe to stay in that one position for years." (Penny, PT)

"Again, I don't know that we're often sought out for our opinions. And when our opinions are sought out, they may not materialize. For example, again a year or two before I went on mat leave our hospital was re-designing. I'll give you two scenarios. One scenario is that we're redesigning one of the units to be a behavioural cohort to model one after Surrey and the manager there was very inclusive and certainly included OTs, SWs to get feedback, I was even able to get my rehab assistant and we went there and we didn't just go there but we also then supported a report to our manager. But then to come back and say, yup, no, funding is the same and the things that we asked for – I don't maybe 5%, 10% was followed through but the rest of it was just actually no – that TV room that we're thinking about, we're not actually having a TV room it's just going to be a patient room cuz we need that room. I find that often times some of the leaders are aware to include us but I find it's superficial, it's just to look good." (Heidi, OT)

"One there's minimal opportunity to participate in program development and to do any of that level of stuff. There's not necessarily a ton of interest in the allied health section of things, that it's still very dominated by doctor's and nurses and still very based around accommodating their needs, you know, like our best funded program is the hip and knee surgical program to make sure beds are cleared and people are out. While they still haven't particularly – you know – even thought the research would say that a robust attempt at lifestyle modification – losing weight, exercising – would prevent a lot of those surgeries from even happening." (David, PT)

"I mean that's one of the reason I moved out of…because I tried to do that in acute care and I was pretty much shown the door." (Irfan, OT)

"upon discussion with other colleagues that it really comes down to management, where if management

advocates for OT, then great, if management didn't – which happened a lot of other teams – then they get cut. Which is kind of scary because, like I don't know exactly the process they use, but I do believe that the managers have a really, really important role in advocating. And so if the management doesn't believe in OT then … and so that kind of speaks to being able to have a manager where they are able to come in and talk to their employees, get to know them, have like a good working environment where they feel like they have the time for that and then so that can kind of establish and support that relationship.

Interviewer: Overall do you feel like there are enough clinical leadership opportunities for OTs?
Interviewee (Lee, OT): No. I think there could be more. I think I'm really happy that we have clinical resource therapists and also a practice leader, to support OTs. I think in general OTs, I guess for ourselves, we have the opportunities for further leadership development, not specifically an OT though, so I don't find a lot of OTs in management or leadership, actually. So even if there is no specific carved out OT roles, having maybe an OT practice leader or someone to encourage people to take on leadership positions would be beneficial.

"Yes and no, I mean we get to determine our clinical day to day and what we're doing and our procedures in that sense and in following research, our department is pretty good about working together and that sort of thing. But on a bigger level anything really big or significant is a bit more limited, like in terms of if we wanted to start let's say a stroke group on outpatients, it's not quite as easy to get that done, because we can't quite change the department set-up necessarily but there's still a voice there to advocate for those sort of things." (Alice, OT)

Not enough opportunities (Annika, SLP)

"Because I've also worked in Australia and Hong Kong, I know that the SLP system over there is very structured. It's very tiered-based, and so you have a chance to move kind of up, if you will. But whereas I find with Vancouver, everything is flat and so even though at the moment and even when I was at Coastal, it was quite a specialized position requiring advanced certifications in different areas, it wasn't valued. You were just seen the new grad. Almost like we could just hire a casual as a new grad and you could be replaced. That's kind of the impression that I got. [...] Yeah there isn't a lot that kind of keeps people in the system for that reason. And there are some really good therapists that have gone on and left the system for that reason. Also just thinking about my time at VGH was just some ludicrous explanation for training. So there's an area of training that would be helpful for all of us, but the practice leader decides that we need to do it by seniority which makes no sense. And so until the person ahead of you is trained, you're not even allowed to start practicing or even observing. And I think it's very difficult in this kind of environment when you're seen as a generalist when the position really requires specialized clinical skills. And also I find with the position that I'm in now, we don't have a practice leader that is an SLP and so there's no advocacy and there's no one representing us at the table. So we're basically just on our own. [...] But people become quite jaded and because there isn't initiative to move forward, and there are no positions to move into – maybe one if someone retires in the next like, 40 years – so it makes it very challenging to come to work sometimes because what's the point? " (Celina, SLP)

"you do kind of max out at some point, right? So, you know, because most of us, we have two supervisors and one CPL and the vast majority of us are Grade 1 Clinicians. So, you can have 20 years' experience and still be a Grade 1 Clinician. So, you know, you can take on students, you can try different initiatives, but other than that if you don't want to go the supervisory route, there isn't a lot of opportunity for mobility or challenge I would say. [...]but just looking at our structure of, for example our pay, when I started working, I worked in the States first, and then I came here. I was however old I was, maybe 30, and I was already at the top of my pay skill, right? And so it's very challenging to know that you put in so much time and you go to courses and you specialize your training and, you know, for example that there are only 2 or 3 of us in the whole province that do what I do, but yet, for the rest of my career, I still will only get paid at a Grade 1 Level. [...]" (Emira, SLP)

"Yeah, and I know Northern Health too is making a lot of changes in terms of management models, they're looking at going to a model where we are kind of decentralized and we are just kind of teams underneath nursing units, that being said then the clinicians won't have the support that they need – you know you really do need a department and you need a lead for each clinician or each area, you know OT, PT, RD, and SLP – we really do need leads and almost like a safe meeting place for all the clinicians to come back to and bounce ideas off of, you really need a lead who has a really good understanding of all the various disciplines too so I see some issues with that. I also know that, that's plan, like the program management model hasn't worked in the south, so I'm not quite sure why they're trying it here, even now on the new floor that they're saying is program managed, it's not, all the chiefs are just taking over and doing what they already do so they think it's working but it's not, but don't want to here it's not working." (Jenny, SLP)

Interviewer: Do you feel like your skills, expertise and scope of practice is well understood by other professions, team members, clinical managers or department managers?

Interviewee (Karen, OT): No, I don't.
Interviewer: And does this lack of understanding have an effect on the quality of care that patients may receive?
Interviewee (Karen, OT): Yeah, I think that sometimes it means that they don't get a referral when it would be appropriate or they might refer to us when we're not

the best discipline to address something. Most often, I guess an example that comes to mind is in terms of cognitive assessment and cognitive rehab that often times, especially working with an older population, the inclination is to refer someone to a geri-psychiatrist to better assess their cognition when we are trained in a lot of those assessments and can provide lots of input on how someone's cognition is affecting their day to day abilities and how they might function safely at home or not. So I feel like sometimes, actually tying back in to your last question … maybe sometimes our input isn't taken as seriously because they might not understand our level of training in that area. And are waiting for the input of a specialist that can take sometimes months to come and provide that.

Interviewer: Do you think there are enough clinical leadership opportunities for OTs?
Interviewee (Robert, OT): Oh there's none! In terms of OT I have one professional practice lead and that's it and that PPL doesn't even seem like and exciting job to me. Like I would love to be a clinical educator I like passionately read up about medical teaching and especially like the masters I'm doing. There's a lot about training staff, making more support and structures to encourage staff retention and encourage staff growth but I think there's a clinical educator at VGH but there's none for us. Not even like a dual PT-OT-1. It's so sad I feel like yeah there's no like and even management I feel I don't again I hope I'm not going to cross the street but it seems like a very nursing dominated thing and if you love the job like leadership stuff or like growth and that stuff it seems they always identify you need to have a nursing background or with leadership experience and we can't get that because there's no opportunities for us. "I'm currently doing the masters in rehab program at UBC and it's great, I really love it. And I sought it out because I felt like my department didn't offer a lot of education. But I think it's great that I did it but in the end I think it's so sad because there's no hierarchy or growth after it. Like if you've learned and developed your practice of service and still an OT 2. Not really going to help me grow or get more pay per se."

"It's either you're a Grade I or you're a Grade 6 – my level. There's no in-between. In the acute hospital setting, which I feel like – Grade I's, like I was a Grade I for multiple, multiple, multiple years, and it would be nice because I came from the UK working there where there was many different Grades and everybody supported each other in a different level. And there's not really an opportunity in this hospital, where it's either you're a Grade I or you're a Grade 6 so that's limited." (Sandra, OT)

"Fraser Health is like this massive, top down, corporate run business model structure. So frontline workers were never invited or encouraged to participate in any decision making. Especially non-nurses and non-doctors. And so, I don't know, like the rehab department is always in the business in any hospital I've ever worked in. [laughter] And so I think especially for allied health there's just this sense that we're totally not valued in the acute care, even though I think clinically we offer an amazing amount to clients. So I think better relationship building with allied health professions and understanding and recruiting for positions like educator roles, manager roles, like more leadership opportunities I think would also go further in both shifting culture but also valuing those different professions better." (Susan, OT)

Experience working in a smaller community hospital: "Yeah, we have pretty consistent meetings in which we are reflecting on our practices, what caseload pressure looks like, and also discussing across sites what is happening. We are trialing different messes, to try and combat the struggles of each fight, and then inputting them across sites if it's something that works well. [...] As of now, the biggest barrier to actually having more clinical education leadership experiences would be not having the time for them." (Susie, SLP)

"one thing that constantly comes up is the lack of laddering. Where you just have nowhere to go upwards in terms of leadership positions. That's something that many senior clinicians have voiced their dissatisfaction about, because after five years, you're pretty much at the top of your pay scale, you're the top of your profession, so to speak. Right? I know that other centers maybe have clinical supervisors, maybe multiple ones, but there aren't that many out there. And then there's professional practice leads. There's really not much ability to, or opportunity to keep moving up, and to be recognized for your expertise. It doesn't have to be leadership per se, but even a clinical specialist position would be amazing, because again working in a very specialized area such as pediatrics or oncology" (Teresa, PT)

"Probably in a bigger center there might be some, but I know there's very limited opportunity to, like the clinical specialist positions, that has been something that Physio's have asked for, to have more of. People designated as Clinical Specialists, and have that as part of their role, and have some time designated to be a Clinical Specialist. I know that's been a part of the contract negotiations for a really long time. That's not something that has ever happened, but, you know it's not just about more of an administrative ladder, like becoming a supervisor, becoming a department head. It's that clinical side of leadership and clinical educator stuff that is very few and far between." (Yolanda, PT)

"I think it doesn't also have to be that the jump has to be straight from clinical to management. There could be other steps in our practice structure that would be enticing I think to some front line staff. Some people are huge clinicians, it's a given, that's why we got into this profession for sure. Some people like to do research. There could be research positions. Some people are great at being educators. They could be the educator or the regional educator. Some people love having students, they could have a position totally dedicated to students. But there's really no variety as much depending

on where you work. So like the only options shouldn't be just clinical, maybe you're a practice lead manager, there needs to be other things to reflect also some of the interests that people might have. Like we could all need a resource specialist. If you look at the nurses, they have CNEs, they have CREs, they have all these different people that are resources to them." (Anita, PT)

"I've worked in my community for about 13 years now and I've noticed a lot of improvements since there's been the creation of OT professional practice leaders in IHA. And then prior to that it was OTs working in isolation reporting to nurses. And often the scope of practice would be defined by the nurse manager and we'd be asked to be putting in all of the short term home support, authorizations – or something like that. But since the creation of a structure that had OT professional practice positions, there has been a gradual, an increase in funding, and it's been great in many regards because the patients are getting more and more acute as well too I'm noticing. ... But a lot of colleagues don't realize that we're also assessing cognition and perception and all of those brain functions that impact a person's function. And so our professional practice leader started with doing some in-servicing to the doctors about cognition and OT cognitive assessments. And so it's great, and then all of a sudden we get a ton of referrals and now you're in a situation of having to manage that and, you know apologizing for the wait time, or whatever. And then in my position on an orthopedic ward we're funded for a half day, and so I find myself kind of repeating the same "well we are funded for only a half of a day and I will do my best to get to these priorities" and whatever. And so I just find myself repeating that and there seems to be this gradual increase in awareness among the other team members that know the OT isn't there full time. And I was realizing I don't think they realized that all of these part time positions, how part time they are. ... Like this position that I'm in, I will probably be in for the rest of my life. [laughs] There just has not been a lot of; like when the new community programs come out, allied health is not really involved. So you see things like that where they hire ten new nurses and no one else. So you're like, well there's no other opportunities – I'm just going to be doing this for my career. ... Well I feel like there's a lot of us that have a lot of different skillsets that are not being utilized but because we are allied health, we are not even considered for positions." (Deliah, OT)

Restorative care and realizing the full potential of rehabilitation

"You know the restorative care model – and I've definitely been at the places where some of that has been quite successful. And you know the sort of care is trying to bring back a little bit of the best way of us helping people is to have them doing as much for themselves as they possibly can, and that's an everbody job, not just an allied health job. So yeah, getting more of the other staff – whether it's nurses or care aides or things like that, doing walks that are within the patients capability and having them do that with them and you know, not feeding them, but getting them to feed themselves as much as they're able to and sort of helping as much as they can with bathing and toileting and all those sorts of things so that when I come in, I can actually work on exercises and work on other activities to help people get better as opposed to sort of going through the basic tasks that, in a lot of ways are kind of going to maintain a person where they're at." (Karen, OT)

"I agree, I think prevention is key and at the moment we just seem to be trying to put out fires there isn't enough staffing, there aren't enough people available for example, to help with prevention, so education, drop-ins once a month for people to participate in, just having more dietitians to help people with dietary advice and education on how to prevent the big ones like diabetes, heart disease, and also after someone's had something like a CABG having a cardiac rehab to support them, we just don't have the prevention measures in place right now." (Penny, PT)

"Some of the limitations I've run into quite a bit is we do not have enough Home Health Workers, like the IHA home support, that can come into a person's home four times a day to help them, to keep them at home. So, if the home support is not available, and many can't afford to hire services privately, then unfortunately sometimes by default the clients have to go into assisted living or long-term care." (Michaela, OT)

"I think any aspect where you can enable somebody to take care of themselves is beneficial. Giving them the tools to be able to recognize when things are going well or when things are not going well and to make changes or to contact the right person benefits them in the long run, it maintains their health and it maintains their mental wellness as well. And empowering anybody to take care of their own self is beneficial rather than creating that patient and mentality of I need to be cared for. It's just a different mind-set and I think rehab does a good job of encouraging people to do their best to the best of their ability whether or not if that looks the same as it did a month ago or not. But it's definitely a different mind-set then when you're in hospital and being cared for by a nursing staff." (Annika, SLP)

"Yeah. I would say not having enough therapeutic resources in long-term care is a huge one. Like for

speech for example, where I was, I was there only one day a week. When you're covering an entire long-term care facility, a lot of these people have really significant, or could really benefit from a lot of therapy and intervention, but when you're only there one day a week, it's nearly impossible. So, you know, I used to work before I worked here, I worked in the States. I worked in a long-term care facility, and my job was full-time and there was two of us. And so, it was a really big change to see how it was when I came here, because you know I was looking at all these patients who could really benefit from so much intervention and therapy, but they weren't getting it because they had to prioritize the urgent ones. A lot of the time they get discharged from the hospital and end up in long-term care, but they are still a really good rehab candidate. But because they are perceived as long-term care, there just aren't the services that are there. [Pause] That is very challenging, because they could really regain a lot of independence, umm, you know, maybe not to live independently, but they could regain a lot of independence. But if they don't have the rehab to get to that point, then they are only going to decline." (Emira, SLP)

"…it was determined that he would be wait listed for long term care and then typically when something like that happens, they drop down to the bottom of our priority list, simply because it's a hospital. We have to focus on getting people well and home and so people that are waiting in the hospital for long term care don't end up being higher priority. But then they don't get rehab service and there's not like, in Campbell River there isn't any kind of like, slow stream rehab or like transitional care or sub-acute care that they could go to where they would still get more service. So I feel that if we had more staffing then people could continue to get treatments that even if they wouldn't have a big effect from it, it might still have an impact on their quality of life." (Karen, OT)

"I would say about 80 percent seniors there. And a lot of people coming back like, like kind of like a revolving door, just cuz they're going home with minimum home supports. They're not really able to provide what they're saying in terms of having home health coming three times a day let's say. A lot of people are kind of slipping through the cracks and then they're not having any of the assisted living for these people so they go home and a lot of them are coming back worse than when they left in a short time. [...] Not able to manage their insulin and home health won't provide any insulin physical assistance. Yeah. They get the education but if they can't physically can't do it themselves they have to rely on family and a lot of our seniors that come in are actually living alone and the family is working so just not available to help in the day when they really need it. And then of course they have so many wounds as well coming in so I think that's really just a poor diabetes management and seniors too aren't moving around and not getting out much, they just stay in their house trying to cope and yeah. That's probably a major issue for them. Getting worse health wise and coming in to us." (Michaela, OT)

"So doing that bridge to the – I think we're such an ideal profession to be in that sort of bridge to the community. But it's often nurses who are in the role of community liaison role. And that's like all of the managers I ever worked with were all nurses and all of the like – and that I think is shifting a little bit but very minimally and I think it's actually – like I think doctors and nurses have worked together for so long and they come from a very medical perspective. ... And so there is more, especially with I think nursing has more awareness that you have to think about the whole person and transportation and housing and that they have a support system, etc., etc. But still nurses are trained in a very medical model like pretty narrow scope of assessment and recovery I would say. So because there's so few OTs compared to like nurses and doctors and our role isn't well understood by the general public. ... But also in physical medicine like people not understanding that after major surgery – like who would be getting their groceries – like I don't know. Just kind of basic life skill things. So it was challenging to always feel that doctors, like when doctor's wanted to discharge, whether we had been able to do a kitchen assessment or not, or do a cognitive assessment or not. They were just discharged either way." (Susan, OT)

"Once they come to long term care, I don't think people realize that there's just not those services. So they see that there's physiotherapy, there's occupation, oh look there's speech therapy too. But they're not, usually they don't realize that we're only there on, well for me only there on certain days. There may be a fulltime occupational therapist, but they can only do certain things as well. We're actually, as the allied health professional, rehab professionals, we're actually not doing rehab therapy! It's like for me, it's like we're just plugging holes."
"I think with a lot of the seniors are caring for now, I just don't see how they would be able to um really thrive in a place like this dementia village that you know, these dementia villages that everybody wants to build. Because they're just too frail." (Tamara, SLP)

"There's only so much you can do with a little bit of once a week home physiotherapy. We can't do that forever, so their access to community programs. There might not be community programs, but even just their access to public physiotherapy programs can be difficult with not a lot of transportation around here. Maybe their difficulty getting in and out of the house. Maybe they don't have family that can help them get here. Then we are definitely wanting to progress them from therapy, actual physiotherapy, to community programs. So access and affordability of any community program is often an issues. Transportation and affordability." (Yolanda, PT)

Top-down management culture

"Yeah I think more so, especially with changes that are big that's going to affect the community as a whole, being able to reach out to the community members to people who actually work in the communities, like health care workers, OTs, nurses – all of them – and also even clients – to see, how can we improve service delivery? I feel like they try doing that during integration but not really and then they provide all these changes and then it happened afterwards when everyone was yelling at them saying it's not working. But anyways, being able to gather more community input when making changes." (Lee, OT)

"…I know that my old manager had a great understanding, we have a new manager who recently started who has no clinical background, so it's going to be very difficult for her to gain that understanding, especially when they're working below executives who have absolutely no clue what we do in a day or what our job entails or any of the difficulties we're having, you know they receive a briefing note but we just get them sent back to us asking them to redo them every 6 months because they're outdated which is not the best use of our time but that's really their only involvement. [...] I think if they had a better understanding of not only patient needs but what we're able to do for the patients, as well as how we're able to impact readmission to hospital and things like that, which is all money, money is what talks to them, I think that they might advocate for more SLP positions. [...] We really don't have a lot of control over anything that we do in executive or any of the decisions that are made up there, I have tried to interact with you know, at management conferences and things like that, with even I sat next to the COO and this like that and just kind of described experience that I had in Ontario that I feel would work really well here but the time to listen to any of that[.]" (Jenny, SLP)

"…I don't know if coming from [the UK] we have a very clear, definitive role in essence you get a job and this is your role. But ever since I moved to Canada, like even when you apply for a job it's so vague – it's like "you're working for children". But you're like, is it rheumatology, is it brain injury or is it orthopedics – you don't have a clue on the job description. But then you get into the role and they're like, oh you work in neuro and you're like, okay great, so what's that? And they're like well, it's neuro you don't really have … when I first started I had a manual left on a desk and like, sorry I couldn't do any one on one days but I had to move back to the other place so, here's a book and a ?? [19:05] page of what I'm should do. And so it's kind of in a sense it's you're trying to figure it out as you go and you don't really have that support. […] Our scope is so limited that we can't even branch out into areas like – well maybe I should learn about this because it's an area that keeps coming up for me cause now with what we're doing it's so narrow we won't even grow differently or branch into another area or try to learn some bit because we know our skillbit. It's like that's what we do. We just do splints. And that's what we're here to do and are expected to do and so when other exciting things come up we're just kind of like well – I rarely see them and I don't know if that's between these lines but there's no encouragement to seek professional development that way unless it's out of your own passion or interest."

Interviewer: Do you ever feel like you ever have the ability to inform program design or delivery based on new models of care in OT that are guided by research or cutting edge practices?

"No. It's so sad we built this brand new hospital and there was not one OT consulted around environment design and we're brilliant at that: how to set up toilets and showers and stuff and then we get in there and none of it works for kids that actually need it.

"…a lot of the people that are above me don't have clinical experience, so that's also a bit of a barrier. And they don't understand our roles. So the mentality is that we're not doing enough, but I personally feel that we're doing a lot with what little we've got." (Sandra, OT)

"As I talk to a lot of them as a Steward, don't feel like what we do is valued from the eyes of the employer. Some simple things, some very, very simple things such as, umm, Nursing Week, you know this facility hired a poet to make a lovely online poetry reading about Nursing and how great, and how amazing they are, which they are. They had coffee carts rolling around, they had lunches for them, they had executive walk around Nurses with their coffee carts and then when it came to either Physiotherapy Week or Occupational Therapy Week, there's silence, there's nothing that is on the internet. There's not site wide messages about Therapy Week, it's something that we have to take on ourselves to promote. I would say a handful, I would say they have a better understanding than others, but I would say as an overall whole I don't believe that people who make those decisions have a full appreciation of what we can bring to the team and to the patients based on their decision making, based on how they are re-jigging programs I guess? Reform programs? So no, I don't think they have an understanding of the full scope of what we can offer." (Teresa, PT)

"But historically, no we weren't given much of a voice in to how our department runs. It was very much a top down directive, mainly directed by HR or directors who don't actually have any insight into what allied health did. When we ended up with our over 30 people leaving our department, it was due to the fact that the manager at the time wanted to create a department and scheduling that was very similar to a nursing model that would not work with what the rehab staff actually had to do. It wasn't until it was a complete disaster that then our opinions were valued. So I think now they're more understanding that the frontline people know what their skillsets are, they're working, they understand what the needs are, they understand probably more than the

people that are crunching the numbers what the FTE needs are, what those types of things are. But sometimes it's unfortunately too late. So I'm hoping that those few steps that we've taken forward can continue on. But I feel it always seems that we're there when it's already falling apart and it would be more beneficial in the front stages when you're asking about changes, when you're thinking about developing things, that the people who it's going to affect the most should be included in those initial conversations." (Anita, PT)

"I see upper management is rarely allied health." (Deliah, OT)

"I think we're definitely underutilized in the strategic planning of things for sure." (Jeanne, SLP)

"I would say for the Vancouver Coastal Health perspective, I would say the one that you posted Interviewer, resonates with the bulk of the staff that I work with just feeling sort of excluded from the decision making process, not a lot of opportunity for input, seems to land on a lot of unintended consequences from decisions that were made without input from the staff that ultimately impact patient care and staff morale in a negative way…" (Selma, OT)

"…this current question just spoke to me in terms of having managers or senior leadership with an allied health background, more and more of what I'm seeing here, is that we have people who – positions that are open and often times, people who fill them have no allied health background whatsoever and maybe not even very much of medical background be that nursing or whatnot and so often these positions do get filled with people who just don't have that experience in terms of clinical work and for an example, we had one of our rehab managers, rather our only rehab manager, who was manager of the rehabilitation department and SLP and OT, we are fell under that, and he left that position and it was opened for a very long time and it was a pretty – I mean a very good position, but it wasn't filled for a long time and they took that posting down and I think it was several months it was not filled, and then someone was subsumed into that position who has no allied health background whatsoever, and I think that's because there wasn't competition. [...] I wanted to say that within our SLP department and our chief SLP who is also an SLP, and she is the manager of two other SLPs, myself and my colleague, so in terms of our SLP department definitely from us two SLP clinicians, speaking to our manager of our department who is an SLP herself, ways to improve our services are definitely taken into consideration for example our swallow screen, our communication screen, looking at educational in terms of during better speech and hearing month in May, things like that within our small department definitely there's a lot of improvements that are taken and put into effect, but I have to say that's where it stops, anything above that like on a more global level in a way that [our health authority] is administering rehabilitation services and allied health, I would say definitely I don't feel heard at all and I don't feel that they necessarily reach out to ask input when making decisions that would impact patient care as it relates to our scope of practice, often there is a very top-down versus bottom-up[.]" (Stella, SLP)

"I definitely agree with what Interviewee 4 said, again it is difficult up North to staff some of the positions so for example we have case managers who are LPNs completing the RAI, making complete decisions of whether people are accepted into long-term care or not and one of the LPNs has never worked clinically as a LPN and there's also with our long-term care unit the manager, again, has only worked in research and not so much with clients and in a clinical sense. So there's definitely been a lot of staff turnover and like everyone else is saying, it's not always maybe the person with the qualifications that was initially requested filling the roles." (Penny, PT)

"I had a personal experience with our arthroplasty here, we were working with surgeons to create an arthroplasty clinic where a physiotherapist would be working to advanced scope, in an advance scope roll or to full scope to work on triaging patients for surgery of no surgery and it just ended up falling apart partially because the surgeons just said, you know, you can't even get physios to fill your general position so how are we going to get a physio in this position, which is kind of counterintuitive cause there's lots of physios who probably – that would've been a coveted position, but that's kind of how it's seen around the health authority I think, is that we can't even get therapists to fill the basic positions so how would we have people working at full or advanced scope." (Christina, PT)

"I also often feel that my clinical expertise is not considered in the way that programs and ways of doing things a managed an example would be that recently myself and some of my colleagues brought to the attention of our manager that our usual process of receiving referrals and how we prioritize them was not efficient and was not allowing us to offer best care to our patients and we all kind of felt that our clinical judgements were based on how things should be done – we're ignored, we're pretty much told this is the way we're doing it, and a lot of us felt very unheard and I think it is definitely something that I think about when I think about how I want to future of my career to go because I don't feel like I am able to always offer the best care within the confines of the management." (Ella, SLP)

Other comments

Move away from narrow curative approach to providing minimal intervention but looking at restorative philosophy: "Yes, yes! Because the atmosphere there isn't about discharge, discharge, discharge – it was about okay you have a one week or a two week stay and you got to – and I won't call it rehab because supposedly isn't on rehab but the intensity is about restoring what you would normally do at home. And in that there were groups so it was socialized so it was great. Nurses mentality was to think from a restorative perspective. I love my nurses and I don't mean anything, but there was less of a "let's be a robot A,B,C,D, but more about, hey you know what – this person likes to paint her nails, maybe I'll bring in a nail polish and they can sit there and do that. Which again, administrators are like, great, you can do this you can go home, you know? I think we are now pushed to think acute care is – in for a medical reason, and once your medical reason's dealt with out you go. It doesn't matter if you can't walk; we'll give you a wheelchair. And I'm being facetious there but it's kind of, we're basically – what is the minimal that they need to do in order to go home? What is the minimum? They can walk to the bathroom? Great they can go home now. Never mind about anything else because anything else we can put in support for." (Heidi, OT)

Every province except for BC and NS provide outpatient PT for people receiving cancer treatment (Dinah, PT)

Do inpatient and outpatient rotations - diversity of practice opportunities (Ingrid, PT)

"Lack of consistency of services offered across sites: "… what's most frustrating as a clinician is just the lack of consistency of services across sites, even within major areas like [xyz hospital] is in [port moody] that's not remote, but the services provided there are way below the services provided at other sites." (Alice, OT)

"I think having home and community care workers integrated as part of the health care team, giving them agency to make recommendations, to chart clinically on a shared electronic record that all members of the team are able to access and write into, I think would be a huge, huge piece of the puzzle. And allowing the hospital system and that electronic record to talk to each other. So that if someone ends up in the hospital, one could easily see what were the events leading up to a hospital visit. And vice a versa, when someone arrives back in community, you can easily go back to the hospital system and understand what their course in hospital was. So I think that record integration and then integrating all members of the team and giving – you know the members of the team that are most at point of care really, who are the home and community care workers more agency to speak up to provide their observations and to be heard I think would be very revolutionary and transformative. And then to involve families and patients in defining what their goals are." (Anastasia, Family Physician in LTC)

"But I know Cranbrook is having a really hard time recruiting and it's a sole charge position with a casual – they do have someone that's there, so there would be somebody else there to bounce ideas off of, but you're coming to a position, and a position that's been vacant numerous times over the last couple of years, on your own." (Annika, SLP)

"Well, we need outpatient resources, it's completely ridiculous not to have any outpatient resources, no transition of care, to refer to an occupational therapist, I know I've said it a couple of times now, they won't get to them or they won't actually – I heard – (cutting out – 33:42) – throwing out the (??) referrals, which is illegal, they've been doing because they will not see those people or get to them or nor do they have it within their capacity to do that – so outpatient programs is a huge, huge gap and we really do need more bodies, FTEs, individuals to be able to provide accurate and best rehab services here. For us to see someone in the rehab department who's had a recent stroke and we get there organized and under control we really don't have the ability to do a lot of the therapies we need to even for dysphagia, let alone speech and language or cognitive realms." (Jenny, SLP)

"We're Chronically Understaffed": A Report on Public Rehabilitative Care in BC
Published by Health Sciences Association of British Columbia
October 2021

The Health Sciences Association of BC (HSA) is a democratic union that represents more than 20,000 health science and social service professionals in over 250 acute and community settings across BC including hospitals, long-term care homes, child development centres, mental health programs, and community social service agencies.

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Acknowledgements: Thank you to HSA members and other clinicians who participated in this research project. This project would not have been possible without their involvement.

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