SUBMISSION TO THE SENIORS CARE STRATEGY

October 2012

ONTARIO PHYSIOTHERAPY ASSOCIATION

Ontario Society of Occupational Therapists

EXECUTIVE SUMMARY

The Ontario Physiotherapy Association (OPA) and Ontario Society of Occupational Therapists (OSOT) take this opportunity to share perspectives of occupational therapists (OTs) and physiotherapists (PTs) on how best the professions can support the evolution of a senior care system that achieves government goals, meets the needs of aging Ontarians and their families, and is sustainable into the future. Throughout this paper, we will be focusing on several key principles pertaining to the role of OT and PT in senior care:

- Seniors in Ontario would be best served by an integrated health system that responds to their needs across the continuum of care. While OTs and PTs are present in a variety of sectors across this continuum, access to needed services is neither standardized nor optimized.
- Seniors are best served by a system that is truly interprofessional and can draw on the expertise, knowledge and skills of a variety of health care providers, assuring the right professional, at the right time, in the right place. PTs and OTs are key members of an interprofessional team whose goal is to promote independence in the community, maintenance, restoration and improvement of functional status.
- System navigation is important in order to be able to effectively facilitate access for seniors and their families to the services they need along the health care continuum.
- Access to OT and PT services is critical to promote the "assess and restore" philosophy, enabling seniors to regain or maintain independence.

With these principles in mind the OPA and OSOT make the following recommendations:

Primary Care

1. Increase access to OT and PT in existing senior-focused primary care services to take advantage of an enriched capacity to better meet the needs of seniors with the right professional, at the right time, in the right place.

2. Establish an interprofessional, team based model of senior focused primary care to serve communities that are not well resourced with FHTs and/or CHCs. OSOT and OPA propose the development of interprofessional Seniors Centres or Centres of Excellence.

3. Promote interprofessional House Call Teams to address the needs of vulnerable seniors for whom access to primary care services is limited because of mobility or transportation issues.

4. Develop senior-friendly system navigation supports for seniors and their families that will promote awareness and utilization of the full range of primary care services and supports available in their community and ensure a platform for systemic linkage and coordination with other sectors of the health care system when needs arise.

5. Assure targeted services for and recognition of the needs of caregivers

6. Develop a senior-friendly health policy framework that extends commitment to a cross-ministerial approach to enabling seniors to age at home.

Outpatient/Clinic Based Services

7. Place a moratorium be called on any further reductions of out-patient rehabilitation services within hospitals.

8. Identify gaps in out-patient/clinic based publicly funded OT and PT and take steps to address these gaps within the health system.

9. Consider Seniors Centres of Excellence as a potential model through which access to publicly funded OT and PT targeted to address incidental and episodic illness/injury of seniors.

Emergency and Acute Care

10. Develop and implement a senior's interprofessional expert team including OT and PT in acute care hospitals that can coordinate the care needs for seniors in emergency/acute care and facilitate transitions on discharge.

11. Develop provincial discharge planning best practices to which hospitals and discharge communities are held accountable by LHINs.

Home Care – CCAC Services

12. Increase to adequately resource therapy services that support a true assess and restore model to address the rehabilitation needs of CCAC clients.

13. Engage rehab professionals as initial assessors of care needs with respect to personal care, homemaking/housekeeping, etc. to ensure that PSW care plans promote and support an individual's capacity to care for themselves.

Long-Term Care Homes

14. Develop and implement a funding system for OT and PT in LTC homes that ensures protected, predictable and accountable funding linked to health and system outcome goals, and allows for identification of rehabilitation potential and facilitates as much independence as possible for residents of LTC.

15. Ensure adequate OT and PT resources to meet the needs of residents of LTC homes with a commitment to review resource requirements should new roles for LTC homes be considered such as slow stream rehabilitation.

OPA and OSOT share a vision for a health system that provides accessible community based rehabilitation services for seniors that are close to home and delivered by professionals who share experience in geriatric rehabilitation. Numerous studies have shown that access to physiotherapy and occupational therapy can reduce hospital length of stay, promote self-management, improve function and increase independence in the most vulnerable senior populations.

The province's primary health care system needs to address senior-focused health promotion services, interprofessional primary care that is based on an "assess/restore" approach, and system navigation services that facilitate seniors' and their families' efficient access to the services they need. All primary health care services must be integrated with the other sectors of the health system such as emergency/acute care and home care to allow for seamless transitions for seniors moving through the system.

INTRODUCTION

The Ontario Physiotherapy Association (OPA) and the Ontario Society of Occupational Therapists (OSOT) are professional associations that represent physiotherapists and occupational therapists in Ontario (see appendix A for more information on our organizations). Together OPA and OSOT are pleased with this opportunity to provide input to Ontario's Senior Care Strategy and to highlight the contributions our professions make and can make at all levels of the health system to support the goals of this strategy.

To truly meet the health needs of Ontario's Seniors we need to consider not only how our health system can provide the *right* care, at the *right* time, in the *right* place by the *right* professional in response to an incident or illness, but also how our system promotes, restores and maintains health and active engagement in self-care, health management, and family and community life. Further, our health system needs to more effectively address a balance between meeting care needs and providing access to a rehabilitation approach that promotes safe independence and function that actually minimizes reliance and dependence on care. This balance allows for a normalized life style, one that not only meets the basic needs of living independently, but also allows for choices for activities that bring quality of life and joy to living at home in the community. Whether that is the ability to work in an adapted community garden or to spend the afternoon with friends playing bridge, seniors should have the opportunity and the resources to do more than just 'stay in their homes'.

Occupational therapists (OTs) and physiotherapists (PTs) understand this premise well. The promotion of independent, active participation in activities that are meaningful to people is central to occupational therapy. The physiotherapist's focus on diagnosis and interventions to maintain or restore physical function in the domains of cardiorespiratory, neuromuscular and musculoskeletal, is driven by the same goal to promote independence and safe mobility.

We believe that in addition to more effectively meeting the needs and expectations of seniors, our suggestions promote significant opportunity for health system efficiency, costs savings and sustainability.

A vision for seniors' health care that embraces the following core principles is shared by OPA and OSOT:

- Senior Care is holistic and deals with the whole person, the context of their lives, and their goals, not just the impairment or illness
- Senior Care recognizes the unique complexities of health problems for this population
- Senior Care values and engages health professionals with specialized expertise who focus with skill and knowledge on the needs of vulnerable and complex seniors
- Senior Care is addressed and coordinated across the continuum of care spanning from prevention to palliation – a true systemic approach is needed
- Senior Care integrates "assess/restore" frameworks/approaches across all components of the health care continuum, promoting health, well-being and enabling highest levels of function/independence in whatever living environment a senior resides
- Senior Care empowers seniors to make choices and to self-manage
- Senior Care is family-focused and families and/or caregivers are considered as part of the client dynamic, included in care strategies, and honoured as critical partners in seniors' health & well-being

- Senior Care supports a focus on normalizing aging, since aging is a natural process and shouldn't be medicalized unnecessarily
- Senior Care is comprehensive in approach and integration, focuses on the broad determinants of health, and will engage several ministries of the provincial government (e.g. health and long-term care, municipal affairs and housing, transportation, finance) whose mandates impact on healthy aging and capacity to support seniors to live independently at home
- Senior Care is equitably accessible to Ontarians across the province with the reasonable expectation that core provincial standards will assure seniors' access to high-quality core services regardless of where they live
- Senior Care is both evidence-based, constantly evolving as we learn more, and innovative in approach
- Senior Care is supported by a commitment to shift public attitudes and expectations from the expectation that one can be "cared for" to an expectation of shared responsibility for safe, community based living throughout the senior years

With this broad vision in mind, OSOT and OPA take this opportunity to share perspectives of OTs and PTs on how best the professions can support the evolution of a senior care system that achieves government goals, meets the needs of aging Ontarians and their families, and is sustainable into the future.

Throughout this paper, we will be focusing on several key principles pertaining to the role of OT and PT in senior care:

- Seniors in Ontario would be best served by an integrated health system that responds to their needs across the continuum of care. While OTs and PTs are present in a variety of sectors across this continuum, access to needed services is neither standardized nor optimized.

- Seniors are best served by a system that is truly interprofessional and can draw on the expertise, knowledge and skills of a variety of health care providers, assuring the right professional, at the right time, in the right place. PTs and OTs are key members of an interprofessional team whose goal is to promote independence in the community, maintenance, restoration and improvement of functional status.

- System navigation is important in order to be able to effectively facilitate access for seniors and their families to the services they need along the health care continuum.

- Access to OT and PT services is critical to promote the "assess and restore" philosophy, enabling seniors to regain or maintain independence.

CURRENT SYSTEM – GAPS AND RECOMMENDATIONS

PRIMARY CARE

Ontario's seniors need a robust, coordinated, and accessible primary health care system that is incented to be "senior-friendly". This system needs to address senior-focused health promotion

services, interprofessional primary care that is based on an "assess/restore" philosophy, and system navigation services that facilitate seniors' and their families' efficient access to the services they need. OSOT/OPA assert that an "assess/restore" philosophy has a prominent place in primary care, assuring that all professionals are engaged in assessment with a view to restoring health, well-being and function when a change or decline is noted. In this way, deterioration of health status is minimized and the likelihood of ER visits or hospital admissions is reduced. Integration of primary health care services with the other sectors of the health system such as emergency/acute care and home care is paramount in facilitating seamless transitions for seniors moving through the system.

Physiotherapists and occupational therapists have much to offer a primary care system that works to enable seniors to age in their homes. Access to OT and PT assists in early identification of and attention to risk factors, access to education, chronic disease self-management programs, and facilitates links to appropriate treatment programs in the community. Key services include:

- Assessment and diagnosis of physical and functional status
- Health promotion - development and delivery of community programs in population health/health promotion/disease/injury prevention related to issues that affect mobility, function (physical and mental health) and safety
- Chronic disease management
- Assessment and treatment of incontinence
- Falls prevention/home safety assessments/home modification
- Cognitive assessment/strategies/memory clinics
- ADL assessment and restoration/adaptation
- IADL assessment and restoration – managing finances, driving/transportation, meal preparation, managing medications etc
- Driver evaluation/screening
- Education and training for caregivers – caregiver support
- System navigation and liaison with community programs and services such as Meals on Wheels

These roles focus on prevention of incidents that trigger engagement of other sectors of the health system, assist in the early identification of risk factors and strategies to minimize or ameliorate these risks, and the restoration of function and independence when challenged by health related issues.

OTs and PTs working in partnership with other primary health care providers are often working with those seniors who are at the "fringe" of stability. While they do not require intensive or ongoing services, they require more than the basics of primary care "check–ups". Responding to this increased need not only makes a difference in the health and quality of life of the individual, but also prevents deterioration that requires institutional care. These clients tend to be the 6% of a physician's practice that consume 33% of primary care resources[1]. Furthermore, this group of able, but vulnerable, clients cause stress to family members and burden caregiver supports when issues are not addressed. **Addressing the needs of these vulnerable clients achieves ER divergence, avoidance of hospitalization and reduction in need for long-term care.**

[1] Wallace, P. & Seidman, J. (2007) Improving population health and chronic disease management. In j. Dorland & M.A. McColl (Eds), *Emerging approaches to chronic disease management in primary health care.* Montreal: McGill-Queens University Press.

Ontario's health care system has experienced a significant loss of focus on a formalized team approach to care, especially in the community. Team care goes beyond having several different professions working with an individual senior and encompasses an investment in team discussion and planning to best meet the needs of the individual and the challenges of limited resources, and the sharing of the unique professional perspectives that team members bring to inform program planning and design. OPA and OSOT propose that truly integrated, team based care for seniors is the best and most efficient way to ensure that expertise and diversity of professional contribution are maximized. **In Ontario's present primary care system, Community Health Centres and Family Health Teams are two primary care models that promote inter-professional, team-based healthcare. Regretfully, occupational therapists and physiotherapists are not well utilized in these models at present**.[2] Occupational therapists have been funded to work in Family Health Teams since March 2010. Nevertheless, for a variety of reasons (largely related to whether FHTs have met roster growth targets for more IPs and the readiness/awareness of Teams to incorporate OT services in to the Team) there are currently under 40 of 200 FHTs in the province that provide access to even limited OT services. That said, the preponderance of OTs working in FHTs have a focus on seniors. To date, physiotherapists have not been funded to work in FHTs, so their potential to contribute has not been realized. Of the 74 primary CHC sites across the province only 13 offer the services of a physiotherapist, and only 5 or 6 engage OT services.

Notwithstanding that FHTs and CHCs have limited access to OT and PT services, most Ontarians continue to link to a primary health care model that has no access to the benefits of an interprofessional team. This is in contrast with trends seen internationally where a review of literature found at least 10 countries that have rehabilitation professionals including OT and PT in their primary health care teams[3] and recent developments in Alberta where physical and occupational therapists are included in the list of eligible professions for the recently developed primary care networks.[4] Family physicians working in traditional practices have no publicly funded therapy resource in primary care. Even where outpatient or clinic services are accessible, they do not provide primary care services such as screening, falls prevention and education programs for self-management of chronic diseases. In addition, CCAC services are not extended to clients who are not homebound and do not engage a primary care focus. **OT and PT services in a primary care context are largely inaccessible to Ontarians.**

Community based programs targeted to meet the health and wellness promotion needs of older persons are increasingly important contributors to our primary health care system. Programs such as seniors' fitness programs, adult day programs, seniors' clubs and associations can provide meaningful support to formal healthcare services. These programs may engage OTs and/or PTs for service delivery, but more likely they engage professionals for consultation. Currently there are many examples of these programs developed by OTs and PTs, or with OT and/or PT consultation, that are delivered through community organizations or facilities. For example, trained personnel at the YMCA provide education and exercise programming specifically to meet the needs of independent adults/seniors within certain diagnostic groups. The program has been developed by PTs who assess/screen for admission, train the personnel to deliver the programs and act as a liaison for questions or specific concerns during the

[2] McColl MA, Aiken A, Birtwhistle R, Corbett S, Schroder C, Schaub M. Why are there no rehabilitation professionals in family health teams? Final report to Ontario Neurotrauma Foundation and Ontario Rehabilitation Research Advisory Network. 2009.
[3] Richardson J, Letts L, Wishart L, Stewart D, Law M, Rehabilitation in primary care: National and international experiences and training requirements, 2006.
[4] Government of Alberta, Alberta Health Services, Alberta Medical Association, Primary Care Initiative Policy Manual, Version 10.1, June 17, 2008 accessed at http://www.albertapci.ca/Resources/guideandreference/Documents/27.PCIPolicyManualv10.1June2008.pdf

delivery of the program. In Toronto, a Seniors Day Program that targets clients living with dementia is delivered by non-professional staff, but clients are assessed by an occupational therapist who identifies strengths and abilities and recommends strategies for engaging the individual, managing behaviour issues, etc.

It is our assessment that the following gaps in the primary care system in Ontario represent significant barriers to achieving a coordinated approach to seniors' health:

- A senior-focused orientation that promotes the development of expertise and resource development unique to this population
- Access to interprofessional services in a truly team-oriented and integrated manner for all Ontarians
- One stop access for information and resources to support seniors and their caregivers'/families' ability to navigate and access the system
- System navigation resources that cross health sector boundaries
- Policy supports external to healthcare that would complement and enable success in aging at home strategies – e.g. housing and assisted living for seniors, accessible design requirements, aging driver policies, transportation planning, etc.

Recommendations

OSOT and OPA applaud the government's commitment to the development of a robust Seniors Health Care Strategy and hope for significant attention to opportunities to improve primary health care for this population. To support this focus, we assert that there is need to increase access to OT and PT services in the primary care system. Rehabilitation services focused on maintaining function and engagement in meaningful occupation, supporting chronic disease management, or living with mental illness or dementia are important contributions to a primary care system that focuses, not only on the prevention and treatment of illness, but also on an "assess/restore" approach that requires attention to the setbacks and functional challenges that seniors may experience as they age. Existing models of CHCs and FHTs utilizing therapy services are examples of the value the professions can bring. However, there needs to be equitable and available access to these services to achieve the goal of supporting seniors to age at home. In light of the divergent evolution of primary care models in the province and the unique challenges related to urban and rural communities, it is unlikely that a "one size fits all" model of senior focused primary care will work for all. To this end, the OPA and OSOT offer the following recommendations:

1. **Increase access to publicly-funded OT and PT in existing senior-focused primary care services to provide an enriched capacity to better meet the needs of seniors with the right professional, at the right time, in the right place.**

OT and PT services in Family Health Teams, Community Health Centres, and in community based senior support programs adds value, enabling attention to physical, cognitive, mental health and functional status that focuses on maintenance or restoration of health for the seniors these organizations serve. Policy direction will be required to enable achievement of this goal for PT to be funded in FHTs. Health system funding reallocation will be required to promote this objective. We posit, however, that cost savings in ER divergence, reduced hospitalization and the potential to increase the number of patients a physician or Team can manage in their practices are all factors that speak to the fiscal practicality of such a funding reallocation. Engagement of rehabilitation professionals in (or consulting with)

community based senior focused programs can be an economical way through which to deliver programs, however, such strategies will require true system integration and support of various funders to ensure that service duplication is avoided and equity of access is protected.

2. Establish an interprofessional, team based model of senior focused primary care to serve communities that are not well resourced with FHTs and/or CHCs. OSOT and OPA propose the development of interprofessional Seniors Centres or Centres of Excellence.

OPA and OSOT propose that truly integrated, team based care for seniors is the best and most efficient way to ensure that expertise and diversity of professional contribution are maximized. To this end we propose consideration of a model that promotes the concept of a "Seniors Centre of Excellence". A "centre of excellence" has the potential to be a physical centre providing access to services that are specialized to meet the needs of seniors and to be a virtual "centre of excellence" that can serve as a resource to health services across the continuum of care, to communities, families, etc. A "centre of excellence" becomes just that, as it attracts professionals with interest and expertise to meet the needs of seniors and who, when working together, bring the strength of interprofessional resource to enrich innovation, to promote research and evaluation, to support education and clinical fieldwork of health professionals, and to be an excellent resource to the broader health care community.

A Seniors Centre of Excellence may provide direct services in a community setting, visiting services to clients who are homebound, or consultation with health system providers, community planners, families, etc. Without duplicating services that exist in the community, such a centre can serve to increase the community's capacity to support seniors to age at home. Staffed with a team that includes, for example, dietitians, physiotherapists, occupational therapists, nurses and physicians, these centres would provide a hub and team to provide consultation, assessment, population health programs and interventions to address needs for:

- Early risk identification and screening programs
- Assess and restore – maintaining and returning to independence
- Secondary health promotion and disease prevention – preventing further injuries, decreasing exacerbations of episodic illnesses such as arthritis and COPD
- Chronic Disease Management – including self management programs
- Falls prevention programs
- Incontinence assessment and treatment
- Wound Care
- Mental health services
- Dementia screening and consultation services
- Home safety and accessibility assessment/consultation
- Caregiver support and education – helping them help themselves and to help enable independence in those they care for.

As a hub of professional expertise, Centres of Excellence, could co-habit with existing community based services and programs targeted to seniors in community centres, seniors health centres, etc. Such a model might be a practical community based access point particularly in urban communities. Centres of Excellence might reside with Regional Geriatric Programs, in Elderly Person Centres, in Family Health Teams or long-term care homes. Location of such a centre should be in a natural hub, facilitated by local transportation routes. In rural settings, a Centre of Excellence might be a travelling team or a

service hub that provides resource for home visits or outreach programs on a regular schedule similar to outreach health services delivered in northern Ontario. A range of options that would allow for the unique adaptation to meet a community's needs would allow for the most equitable access to expertise, services and consultation across the province. The size and population of the community will determine how many centres or home visit teams are required.

The reorganization of senior-focused resources (both HR and funding) to enable a Centre of Excellence model would allow for minimum impact to the financial demands of senior-focussed care, while optimizing the utilization of health human resources and expertise to address the needs of this population. We believe that focussed interprofessional attention to the primary care needs of seniors, enabling this cohort to manage safely and in good health in their homes for a longer period of time, will support cost savings throughout the health care system. Reduced dependence upon the family doctor for non-medical resources and interventions, reductions in ED visits and subsequent admissions, delayed or averted need for long-term care residency and promotion of overall health amongst this growing cohort will serve the health system well.

While we have used the title "Centre of Excellence", it is our opinion that it is the structure and commitment to provide a hub of expertise focused on senior care that are most critical. The naming of a "centre of excellence" is chosen to indicate a vision that is, in our opinion, important – our health system needs to invest expertise and focused services, targeted to promote health and well-being and to enable seniors to live as independently as possible before and after health incidents. We aspire to deliver "excellence" to Ontarians and we believe that interprofessional, collaborative, hubs of professionals who share a passion for seniors care in all its complexity is the best way to achieve this. Further, we assert that promoting a community resource with a focus of expertise will build health human resource expertise and capacity for effective population needs assessment, programme development and evaluation, and knowledge generation and exchange.

Centres of Excellence cannot live in the health system as separate entities. They need to be integrated with other services provided through the primary care system, hospitals, CCACs and long-term care homes. Professionals working with seniors in these systems may indeed be members of the Centre of Excellence Team or participate in advisory networks that ensure that systemic integration of services and care for seniors is efficient and effective so that seniors' experience of care in their community is positive and targeted outcomes are achieved.

3. Promote interprofessional House Call Teams to address the needs of vulnerable seniors for whom access to primary care services is limited because of mobility or transportation issues.

Ontario's Action Plan for Health Care makes a commitment to the provision of interdisciplinary House Calls for frail, vulnerable seniors who might otherwise not access primary care services. OSOT and OPA support this recommendation and are informed by the successes of early examples of this programming in the Toronto area where an OT and a PT have contributed to a House Calls program that supports older persons living at home. We assert that it is important program development and funding frameworks enable therapists to work with physicians as true team members. Seniors Centres of Excellence could be valued resources to these community based primary care teams.

4. Develop senior-friendly, culturally sensitive system navigation supports for seniors and their families that will promote awareness and utilization of the full range of primary care services and supports available in their community and ensure a platform for systemic linkage and

coordination with other sectors of the health care system when needs arise.

Seniors living with more complex issues in the community require a different kind of system navigation support. Care management services are needed as an enriching adjunct to primary care services for this population, ensuring that the multiple components of the health care system with which the senior interacts are in communication, are integrated to ensure that care is coordinated in a practical manner that promotes success, and that families and caregivers are well informed and appropriately engaged in care planning and decision-making. The linking of these coordinators with other segments of the health care system and especially the senior's primary care team is critical. Currently, clients who receive CCAC services have assigned Case Coordinators. Some suggest that care coordination makes most sense as a primary care function, managed by the primary care organization a person relates to (a physician's practice, a FHT, etc.). Regardless of where the role resides, it is imperative that it be defined in a consistent way with consistent accountabilities and linkages across the health care system. OTs and PTs have far too often witnessed the pitfalls of care coordination that does not cross sectoral boundaries, including poorly coordinated discharge processes for seniors from hospital to home, lack of communication to family physicians from the CCAC sector relating to client needs and progress, etc.

OSOT and OPA posit that case management services can be delivered by a variety of health professionals who have the skills and competence to do so – it is a role, not a profession. We position that this function is likely best performed for seniors by professionals who have expertise in senior care and are familiar with the unique attributes of seniors which may include memory or dementia issues, chronic disease, hearing or visual deficits, economic hardship, isolation, etc. OTs, PTs, SLPs, Dietitians, Social Workers, Nurses have demonstrated skill in case management and bring their unique professional perspectives to the role. OSOT and OPA posit that professionals who embrace an "assess and restore" philosophy are critical for these roles. This philosophy is embedded in the professions of OT and PT.

Seniors and their families need a single point of access for information about services and information to address their needs. While web-based technology solutions are expected, there is a present need to ensure that this information can be accessible to all. OSOT and OPA propose that this is a value of the endorsement of community Seniors Centres. These Centres can be resources for information and consultation that promote system navigation. To reduce duplication of effort and resources, Seniors Centres could also act as clearinghouses for community resources and information that is accessible to FHTs, CHCs, and family practice physicians and their patients.

The current and evolving 211 Community Connection service should be promoted and integrated into planning for seniors' health services and system navigation. To avoid parallel structures, we propose that Seniors Centres be engaged in consultation on the ongoing development of these resources. Information accessible through 211 should be consistent with that available through a Seniors Centre, CCACs and any other source of information for system navigation.

5. Assure targeted services for and recognition of the needs of caregivers

The capacity of many seniors to age at home will be dependent upon the support of spouses, families, and other caregivers. Caregivers need to be seen to be part of the solution and the strategy for seniors care in Ontario. However, they also need to be a group that is addressed by the strategy. Supports to caregivers, including access to good information and resources, effective support for system navigation, access to respite services, etc. are critical if our health system continues to rely on this cohort to assure success in our aging at home strategies. OTs and PTs would argue that a commitment to an

assess/restore philosophy across the continuum of care provides support and commitment to caregivers. OTs and PTs are excellent resources to caregivers, as they are the primary resources for assessment of function and capacity to self-manage and the providers of treatment, consultation and support to maintain function or restore to function when health incidents interfere. Pilot projects undertaken in the Mississauga Halton and North Simcoe CCACs have introduced a partnership of OTs and PSWs where CCAC client referrals are first assessed by an OT who can then educate, train and consult with assigned PSWs to ensure that care provided enables the individual to maintain or restore function and not simply "taking care of" the client. Early findings suggest that an investment in OT at the front end can reduce the intensity of PSW requirements over the longer term. An investment in rehabilitation services in the primary care system is a resource of value to seniors *and* their caregivers, and to the sustainability of Ontario's health care system. Proposed Seniors' Centres of Excellence can also be a resource to caregivers and assume some of this role.

6. Develop a senior-friendly health policy framework that extends commitment to a cross-ministerial approach to enabling seniors to age at home.

While government has made a commitment to a Seniors Health Care Strategy, OSOT and OPA urge consideration of the need for a more holistic approach to seniors' health. The broad determinants of health factor significantly in the experience of Ontario seniors. Economic vulnerability, access to affordable and accessible housing, driving and access to affordable transportation (especially when no longer able to drive), protection from elder abuse, access to community supports that enable socialization and meaningful participation in society, etc. are critical issues that need to be addressed in order to assure that health system efforts to support older persons to age in their homes can be successful. Rehabilitation professionals, occupational therapists in particular, are excellent resources to support policy development related to accessibility, aging drivers and transportation issues, and elder abuse strategies and engagement in meaningful occupation.

OUTPATIENT/CLINIC-BASED SERVICES

The gap between "available" and "accessible" is never more pronounced than in outpatient/clinic based rehabilitation therapy services for seniors.[5] There is a growing gap of accessible, publicly funded outpatient/clinic based therapy programs that serve the needs of seniors with both musculoskeletal conditions such as hip fractures as well as those with multiple co-morbidities or complex conditions such as Parkinson's, MS, ALS, cognitive impairments, mental health issues, amputations, COPD, arthritis.

In addition to continuing to promote the mobility of seniors able to travel to appointments outside the home, studies have demonstrated that outpatient/clinic services produce comparable outcomes to other settings such as home care or inpatient care but at a lower overall cost to the health system.[6] In a

[5] Ontario Physiotherapy Association, Position Statement: Access to Publicly Funded Physiotherapy in Ontario, September 2009 accessed at http://www.opa.on.ca/pdfs/position/access2physio_pos.pdf; and Ontario Physiotherapy Association, Ontario Society of Occupational Therapists, Bone and Joint Health Network Orthopaedic Expert Panel, Current State Review of Outpatient Rehabilitation Services Available at Ontario Acute and Rehabilitation Hospitals and Recommendations to Optimize the System, October 2011

[6] Pua Y-H, Ong P-H, Chong H-C, Lo N-N. Sunday physiotherapy reduces inpatient stay in knee arthroplasty: a retrospective cohort study. Archives of physical medicine and rehabilitation [Internet]. 2011 Jun 1 [cited 2012 Sep 11];92(6):880–5. Available from: http://www.archives-pmr.org/article/S0003-9993(11)00051-7/fulltext; and Chimenti CE, Ingersoll G. Comparison of home health care physical therapy outcomes following total knee replacement with and without subacute rehabilitation. Journal of

systematic review of acute exacerbations of COPD it was concluded that access to a community based multidisciplinary pulmonary rehabilitation program led to a reduction in hospital admissions, increased exercise tolerance and increased quality of life.[7] Outpatient rehabilitation is also key in reducing the cost of stroke on health care services. Outpatient therapy has been proven to improve outcomes and help maintain gains made in inpatient stroke rehabilitation in addition to allowing for early discharge home.[8]

Over the last decade there has been a progressive reduction/closure of outpatient services for both OT and PT in hospitals. This has increased the demand on home care services which has in turn increased the restrictions for eligibility for home care. A result of the lack of accessible, funded community-based rehabilitation services is that seniors find themselves in the position of waiting until they are impaired enough to meet the requirement of home care or admission to a long term care home, because that is the only way they can access the therapies they need to maintain and improve their function. **OPA and OSOT share a vision for a health system that provides accessible community-based rehabilitation services for seniors that is close to home and delivered by professionals who share experience in geriatric rehabilitation.**

Though currently those over 65 have access to clinic based services through Designated Physiotherapy Clinics the number of clinics was frozen in the late 1960's and there are only 93 clinics in Ontario. These are mostly located in highly populated centres in Southern Ontario leaving most seniors without access to these services. In addition, the low fee paid to DPCs from OHIP results in additional fees for non-insured services being charged the patients. These fees impose additional barriers to access for those who can't pay. Seniors presenting with multiple co-morbidities will have difficulty accessing specialized care within this model, again due to inadequate resourcing inherent in this fee for service model.

Currently there is no funding mechanism for publicly funded, clinic-based services for OT in the community.

Recommendations:

7. Place a moratorium be called on any further reductions of out-patient rehabilitation services within hospitals

Reductions in outpatient services are decisions made individually by hospitals facing financial challenges, often without a full understanding of the access problems created for seniors when these services are removed. With increasing gaps in access to medically necessary, publicly funded outpatient rehabilitation services across the province, initiating a province wide moratorium on any further reductions until accessible alternatives are in place (accessible geographically and economically) is critical.

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[7] Burtin C., Decramer M., Gosselink R., Jansens W. and Troosters T., Rehabilitation and acute exacerbations, European Respiratory Journal, 28(3), pp.702-712.

[8] Teasell R.W., Foley N., Salter K., Evidence based review of stroke rehabilitation (EBRSR), 2011, accessed at http://www.ebrsr.com/

8. Identify gaps in out-patient/clinic based publicly funded OT and PT and take steps to address these gaps within the health system.

A full picture of access issues faced by non-homebound seniors in our communities must inform any future decisions related to these services. As we continue to make decisions within silos, reducing outpatient services while increasing restrictions to access home care, seniors are being caught in the middle and many are going without needed care.

9. Consider Seniors Centres of Excellence as a potential model through which access to publicly funded OT and PT targeted to address incidental and episodic illness/injury of seniors.

Seniors Centres of Excellence proposed in the primary care section of this paper is a model to consider in developing access to multidisciplinary rehabilitation services in the community. As a centralized location for accessing services specializing in the needs of seniors, resources could be assigned to allow for incidental/episodic assessment and treatment by OTs and PTs for this population.

EMERGENCY AND ACUTE CARE

Studies show that early access to therapy in Emergency departments (ED) decreases the LOS without increases in adverse effects and facilitates return to function and to lower levels of care.[9]

Provision of OT and PT services in ED is already in place in a few Ontario hospitals. These organizations, such as London Health Sciences Centre, are beginning to report impacts that include:

- Reduced need for hospital admission as a result of setting up appropriate community supports
- Discharge from the ED possible as a result of provision of specific equipment recommendations to improve client safety and independence (or ease of caregiver support) in the home
- Prevention of secondary complications of an ED visit such as pressure sores, deconditioning, falls in the ED etc
- Facilitation of acute care hospital stays as a result of early initiation of treatment and discharge planning from the onset

Should admission to acute care be required, evidence shows that the following reduce impairments that can arise from hospitalization/immobilization and result in decrease LOS and return to lower levels of care:

- early access to assessment of physical and cognitive function by therapists,
- early mobilization,
- early functional restoration programs, and
- an assess and restore philosophy for care while in acute care.

[9] McClellan CM, Greenwood R, Benger JR. Effect of an extended scope physiotherapy service on patient satisfaction and the outcome of soft tissue injuries in an adult emergency department. Emergency Medicine Journal. 2006;23:384-387; and, Hoskins R. Evaluating new roles within emergency care: a literature review. International Emergency Nursing. 2010; doi:10.1016/j.iejj.2010.09.003; and, Taylor NF, Norman E, Roddy L, Tang C, Pagram A, Hearn K. Primary contact physiotherapy in emergency departments can reduce length of stay for patients with peripheral musculoskeletal injuries compared with secondary contact physiotherapy: a prospective non-randomised controlled trial. Physiotherapy. 2011;97:107-114.

In acute care, four trials comparing multidisciplinary clinical pathways for surgeries for hip fractures in the elderly showed that those who focused on more intensive PT and OT treatments post operatively than a standard approach demonstrated improved functional recovery following surgery and reduced length of stay in hospital.[10]

A recent program implemented in Brockville General showed that early, intensive therapy services for patients considered to be ALC increased independence and reduced LOS in ALC[11].
The most appropriate option for discharge should be considered based on the health status of the individual patient and resources available. Options for discharge include:

- Home First with enhanced services in home including rehabilitation therapies
- Home with access to outpatient/clinic based services or day hospitals
- Rehabilitation Centres
- Convalescent Care with access to rehabilitation therapies
- Long Term Care Home with access to rehabilitation therapies - e.g. slower stream rehab
- Long-term care Home as residence

Discharge planning should start at the time of admission to minimize the negative consequences of hospitalization. For discharge home and to provide a seamless transition the following activities, at the minimum, should be complete prior to discharge:

- Home Assessment
- Address access to short term equipment needs (gait aids, bathroom equipment)
- Care giver consultation/education/training – care, transfer, how to enable/promote independence/function

Home First programs integrating hospital and community based services can facilitate timely discharge from hospital while assuring adequate care supports and appropriate therapy to restore to maximum function and facilitate informed decision-making around discharge planning. Standardized discharge procedures should be used and allow for the effective link to the most appropriate level of care and community services.

Recommendations:

10. Develop and implement a senior's interprofessional expert team including OT and PT in acute care hospitals that can coordinate the care needs for seniors in emergency/acute care and facilitate transitions on discharge.

Therapy services are rare in Emergency Departments and are often not aligned to meet the specific needs of seniors. Access to OT and PT in the ED, however, shows promising impacts on admission diversion. Senior-friendly practices in EDs which identify patients for ED therapy assessment and intervention are recommended. Assigning and resourcing a specific 'Seniors Interprofessional Team' in acute care that provides consultation and links to the Centres of Excellence will increase coordination,

[10] Chudyk Am, Jutai JW, Petrell RJ, Speechley M., Systemic review of hip fracture rehabilitation practice in the elderly, Arch Phys Med Rehabili, 2009 Feb; 90(2) pp 246-262.
[11] Crawford H, Anderson S, TeKamp R, Chatzikiriakos V, Osborne D, Spring 2012. Enhanced Activation and Restorative Care, Healthcare Management Forum Volume 25, Issue 1, Pages 4-9

assist with accessing early mobilization and care and will assist in initiating discharge planning from the time of admission. Therapy services have experienced significant reductions in acute care in the last few years. These gaps often limit the options available for seniors at discharge from acute care often leading to prolonged stays in acute care or discharge to higher care levels such as rehabilitation centres. Addressing the HHR Gap will be critical to achieving the benefits of early assess and restore approaches.

11. Develop provincial discharge planning best practices to which hospitals and discharge communities are held accountable by LHINs.

OSOT and OPA urge the development of discharge planning best practices for senior patients, assuring consistency of approach and integration with primary care and CCAC sectors across the province.

HOME CARE – CCAC SERVICES

Therapists in home care, working through CCACs, are experts in assessment and interventions geared to increasing and maintaining independence and ensuring safety for seniors in the community. They provide the backbone of the intensive therapy programs currently part of strategies like 'home first'. Despite studies showing that improvements in function and independence can occur through home care OT and PT[12], there has been a progressive decrease in the number of OT and PT visits year over year and in seniors' access to these services. Data provided by CCAC's shows that despite an increase in the number of seniors receiving services from 07-08 to 09-10 of 5%, the number of visits for PT has dropped by 16% and for OT by of 31%. Nursing care increased by only 1%, but PSW visits increased by 19%.[13] In many cases the restrictions on the number of visits don't allow for assessment to be followed by adequate interventions and follow-up for the patient.

Investment in additional PSWs in some cases supports access to care. However, there is a need to ensure that appropriate levels of care are based on models that promote function/independence/self-direction. In other words, if we are not able to increase functional independence through rehabilitation, we are creating an increasing dependence on "care" provided by PSWs. Pilot projects undertaken in the Mississauga Halton, Central West and North Simcoe Muskoka CCACs where OTs /PTs complete an initial consultation to determine a plan of treatment and work with assigned PSWs to promote independence goals are showing that reduction in ongoing PSW care needs can be achieved over the short and long term. Unfortunately reductions in the number of rehabilitation professional visits and increasingly restrictive eligibility requirements for accessing home care rehabilitation are limiting access to these services and reducing the potential positive health and system outcomes they can achieve.

[12] Gillespie LD, Roberston MC, Gillespie WJ, Lamb SE, Gates S, Cummings RG, Rowe BH, Interventions for preventing falls in older people living in the community, Cochrane Database Systematic Review, 2009 Apr 15 (2).; and Beard J, Rowell D, Scott D, Van Beurden E, Barrett L, Hughes K, Newman B, Economic analysis of a community-based falls prevention program, Public Health, 2006 Aug: 120(8): 742-751, Epub 2006 Jul 5.; and Sherrington C, Tiedemann A, Fairhall N, Close JC, Lord SR. Exercise to prevent falls in older adults: an updated meta-analysis and best practice recommendations. *N S W Public Health Bull.* 2011a Jun;22(3-4):78-83.

[13] Ontario Association of Community Care Access Centres, accessed at http://www.ccac-ont.ca/Content.aspx?EnterpriseID=15&LanguageID=1&MenuID=1378

Recommendations:

12. Increase to adequately resource therapy services that support a true assess and restore model to address the rehabilitation needs of CCAC clients.

Seniors need more than assessment and consultation in their homes. Restrictions on eligibility for services and the number of visits should be evaluated based on the actual needs to the senior population. Seniors should never have to choose between living in their homes and moving to LTC homes because of the need to access rehabilitation services.

13. Engage rehab professionals as initial assessors of care needs with respect to personal care, homemaking/housekeeping, etc. to ensure that PSW care plans promote and support an individual's capacity to care for themselves.

LONG-TERM CARE HOMES

There are many needs for therapy to support care and management of complex health conditions of residents in long term care homes. Currently Long Term Care homes are viewed to be an 'end-point' in the health system journey. A destination that in turn becomes the residence for those who are admitted. **Studies show that these residents can benefit from the services provided by OT and PT, restore their function, maintain their ability to participate in their care and prevent further disability.** Services by OTs and PTs in LTC homes include:

- Assessment, diagnosis, risk identification for safety
- Interventions and programs to restore and maintain ambulation and self care function
- Pain management
- Seating and mobility
- Pressure relief/wound care
- Behavior management
- Staff support and consultation
- Restraint/PASD consultation
- Cognitive assessment
- Support to restorative care approach – ADL

In addition, as the health system evolves, new roles are being considered for LTC homes including a potential location for 'slow stream' rehabilitation and respite programs**. As these new roles for LTC are explored, an analysis of the additional needs for therapy services in LTC homes should be completed.**

At this time the funding system for PT and OT in LTC homes is complex. The *Long-Term Care Homes Act*, 2010 requires homes to ensure that OT, PT and SLP therapy services are arranged or provided for, but only PT services are required on-site.

PT services are currently funded through OHIP in long term care homes. There are two funding models for PT in the system; a fee for service model and an annual capitation model geared to the number of beds in a home. The majority of homes are funded via the fee for service model. The restrictions on

CCAC services and lack of funding in the LTC sector restricting availability of program funding have resulted in no funding mechanism for OT in LTC that provides consistent access to these services in this sector.

Recommendations:

14. Develop and implement a funding system for OT and PT in LTC homes that ensures protected, predictable and accountable funding linked to health and system outcome goals, and allows for identification of rehabilitation potential and facilitates as much independence as possible for residents of LTC.

15. Ensure adequate OT and PT resources to meet the needs of residents of LTC homes with a commitment to review resource requirements should new roles for LTC homes be considered such as slow stream rehabilitation.

CONCLUSION

OPA and OSOT share a vision for a health system that provides accessible community based rehabilitation services for seniors that is close to home and delivered by professionals who share experience in geriatric rehabilitation. Numerous studies have shown that access to physiotherapy and occupational therapy can reduce hospital length of stay, promote self-management, improve function and increase independence in the most vulnerable senior populations.

The province's primary health care system needs to address senior-focused health promotion services, interprofessional primary care that is based on an "assess/restore" approach, and system navigation services that facilitate seniors' and their families' efficient access to the services they need. All primary health care services must be integrated with the other sectors of the health system such as emergency/acute care and home care to allow for seamless transitions for seniors moving through the system.

Appendix A

The Ontario Society of Occupational Therapists

The Ontario Society of Occupational Therapists (OSOT) is the provincial professional association of over 3700 Ontario occupational therapists and occupational therapy students. OSOT relays and represents the insights and expertise of its membership to policy makers and stakeholders with a goal to contribute constructively to the evolution and development of Ontario's health care system. Solutions focused in approach, the Society addresses issues and opportunities for which occupational therapists can make meaningful contributions to improve quality and efficiency of experience of Ontario's health care system consumer. To further the profession's contribution to the health of Ontarians, OSOT is committed to the provision of professional development and practice support to promote practice excellence, integration of evidence into practice and a strong capacity to support interprofessional care.

Who are Occupational Therapists?

Occupational therapists are regulated health professionals who work with people of all ages whose lives and capacity to participate in the day to day life roles and activities that are meaningful to them have been, or may be at risk of being, disrupted by injury, illness, disability, social factors or aging. By looking at the whole picture – a client's psychological, physical, emotional, cognitive and social status and function, as well as the impacts of the environment and social context in which they need to function – occupational therapy assists people to achieve their goals, function at the highest possible level, maintain or rebuild their independence and participate in the everyday activities of life.

Occupational therapy is based in the expanding body of evidence that recognizes the importance of occupation (meaningful activity) as a determinant of health and well-being and its capacity to give meaning to life. Occupational therapists work with their clients to identify and resolve or minimize barriers to active participation in occupations such as self care, work, home management, community living, leisure, engaging in relationships, etc. A truly client centred profession, occupational therapy is directed by the client's determination of meaningful occupation and is delivered in an active partnership with the client.

To promote function and engagement in occupations, occupational therapists may; engage therapeutic treatment to restore function and/or promote recovery, engage their clients in learning alternate ways of doing things or employing compensatory techniques, introduce assistive devices or technology to accommodate a loss in function or ability, modify the environment to remove barriers to performance and /or participation or consult to family or caregivers who may support the individual's capacity to be as independent as possible. In so doing, occupational therapists enable their clients to live life to its fullest.

Educated at a Masters level, occupational therapists bring to their work a background in mental health, physical health, normal development, disability issues and cognitive function, enabling a holistic approach to client assessment and treatment. As mental health professionals, rehabilitation professionals, primary care professionals and consultants, occupational therapists are strong team players. Their focus on occupation is a natural interface with the foci of other team professionals in the same way that it is a catalyst for their interaction with other components of the health system. In fact, occupational therapists are integrally involved in transition points that people experience in their health

system journey as the occupational therapist's expertise in assessment and promotion of function and safe independence is critical for discharge and referral decision-making.

Occupational therapists are excellent clinicians but their team skills and problem solving orientation position them to be strong program designers, managers, consultants and corporate leaders. Over 5000 Ontario occupational therapists work in the primary care system in Family Health Teams, in acute care and hospital based rehabilitation, in community based out-patient services, in CCAC directed home care and school support services, in community based services funded by WSIB, Veterans Affairs and Ontario's auto insurance system, in long-term care homes and in private practices. Focused on how people are able to function at all levels of our health care continuum, occupational therapists have practical knowledge of system linkages and gaps and, we believe, useful perspectives to offer to the province's evolving healthcare system

The Ontario Physiotherapy Association

The Ontario Physiotherapy Association (OPA) is a dynamic health care professional organization with more than 5,500 members, divided into 16 geographic districts across the province.
OPA is committed to leadership in physiotherapy through the provision of advocacy, professional development and career support services for its members in order to provide quality physiotherapy to the citizens of Ontario. The vision of the OPA is: "Ontarians are Healthier and Stronger through Physiotherapy."

Who are Physiotherapists?

Physiotherapists are university-trained regulated health professionals who play an important role within the health care system by assessing and diagnosing diseases, disorders and dysfunctions within their scope of practice and developing and implementing effective treatment plans, including those that are specifically tailored to meet the needs of the frail and elderly population. The legislated scope of practice of physiotherapists in Ontario is:

> *The practice of physiotherapy is the assessment of neuromuscular, musculoskeletal and cardio respiratory systems, the diagnosis of diseases or disorders associated with physical dysfunction, injury or pain and the treatment, rehabilitation and prevention or relief of physical dysfunction, injury or pain to develop, maintain, rehabilitate or augment function and promote mobility. (Physiotherapy Act, 1991)*

Authorities available to physiotherapists include communicating a diagnosis, spinal manipulation, acupuncture, administering a substance by inhalation, tracheal suctioning and procedures related to the assessment and treatment of incontinence and pelvic pain. Authorities related to the ordering of certain diagnostic tests have been granted through Bill 179, but await the completion of regulations for proclamation and implementation.

Physiotherapists have a presence in all health care delivery streams in Ontario, namely: hospitals, long-term care facilities, home care, community-based clinics, schools, private practice clinics and primary care networks. Physiotherapists in Ontario are regulated under the Regulated Health Professions Act (RHPA) and licensed to practice by the College of Physiotherapists of Ontario. There are approximately 7,000 licensed physiotherapists in the province. The professional titles in Ontario for this leading rehabilitation health care professional are physiotherapist or physical therapist.

Physiotherapy is a drug-free health care practice. Physiotherapists work in partnership with individuals of all ages to break down the barriers to physical function whether that means working with patient's pre and post-surgery, helping patients come back from illness and chronic disease, injury, industrial and motor vehicle accidents and age related conditions. Physiotherapy is the treatment of preference for many who suffer from pain whether in the back or neck, or joint pain such as hips, knees, ankles, wrists, elbows or shoulders.

Physiotherapy has proven to be effective in the treatment and management of arthritis, diabetes, stroke and traumatic brain injury, spinal cord injury and a range of respiratory conditions offering those afflicted with tools and techniques to acquire and maintain an optimum level of function and pain free living.

Appendix B - Additional Bibliography

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