Ontario Society of Occupational Therapists

RESPONSE TO HOME AND COMMUNITY CARE REVIEW

STAKEHOLDER SURVEY QUESTIONS

NOVEMBER 7, 2014

The Ontario Society of Occupational Therapists (OSOT) is pleased to have opportunity to contribute to the Home and Community Care Expert Group's review of Ontario's current home and community care system. OSOT is the voluntary professional association of over 3900 Ontario occupational therapists. 55% of OSOT members report working in the community. While this figure represents both publicly funded and private practice, it is good evidence of the profession's relevance and visibility in the community where clients live, manage their lives, maintain relationships, work and play. From an OT's perspective, the community is the environment in which people engage in the occupations of their life. We relay perspectives of a profession engaged in the present home and community care sector. At the same time, all occupational therapists, work with clients whose health care trajectory can (and usually should) interact with the home and community care system. To this end, we represent inputs from occupational therapists (OTs) working across the private and public health care systems, in hospitals, in community health centres, in Family Health Teams, in long-term care homes, in clients' homes and workplaces.

What is occupational therapy?

Occupational therapy is a profession rooted in the evidence and understanding of the importance of engagement in meaningful occupation to health and well-being. People experience life, relationships, their environment and their role in their communities through purposeful activities of daily living. Our capacity to engage in those activities that we need and want to do (self care, leisure, work, etc.) contributes to our sense of well-being, to our sense of self and pragmatically to our capacity to be independent, contributing members of our communities. Our ability to engage in our life occupations can be interrupted by injury, disease, aging, mental health issues, etc. When people experience barriers to managing and engaging in occupations, occupational therapists are the primary health professional that assists them to regain skills or modify the task or environment to enable them to participate actively in those occupations that are important to them.

While occupational therapists work in a health system largely framed in a medical model, the OT's engagement with their client is not as much about cure or symptom management as it is about functional skill development, restoration, adaptation and/or maintenance. The profession's focus on function that is both meaningful and important for a person to be able to engage in is relevant in the hospital as one prepares for transition home, but it is ever more

relevant in the community where people live and function in their own environments. The potential value of a community based health care system that truly supports people to restore function lost to periodic injury, illness, mental health issues, etc. is enormous to both consumers of services, anxious to be able to manage to their fullest potential and to the goals of system affordability and sustainability. The occupational therapist's movement into primary care in Community Health Centres or Family Health Teams has provided a context for OT to demonstrate value in health promotion, chronic disease management and enablement of functional ability and safe participation in activities of daily living for Ontarians living independently but with vulnerabilities resulting from disability, chronic disease, mental health issues, aging, etc. For all of these reasons, the profession has applauded the increased attention and policy talk focused on transitioning health care focus to the community

Question 1

What are the three greatest sources of frustration for individuals in need and their families/unpaid caregivers who are receiving home and community care?

While the best source of input to this question would be from consumers who are fully informed and aware of options and services and processes that might be available to serve their needs, OSOT is pleased to represent comments forwarded by occupational therapists working in the sector and observations of the profession from a systems perspective.

1. **<u>Issues relating to access to necessary services</u>**

Ontario's home and community care client has changed over the years, and somewhat dramatically in recent years. Not only is the general population served older and consequently presenting a range of needs and issues unique to a senior demographic, but in addition, shifting policy and funding issues have resulted in earlier discharges from hospital to home, resulting in an increasingly acute client population. Both these situations create challenges and new demands for necessary services in the community. At the same time, CCACs report 101% growth in the volume of client served since 2003/4. Sectoral funding has not increased concomitantly to the same levels. These factors contribute to many of the access issues reported which include:

- **Mis-management of client expectations in transitions from hospital to home** – reports are not uncommon of patients and families being led to believe that certain services would be available in the community to support safe discharge, only to find that these services are not accessible in their community or the delay in access to these services results in difficulty managing. For example, the recommendations of a hospital based OT and case coordinator that a CCAC OT would perform a home assessment and arrange for appropriate modifications and equipment and provide transition support consultation/education is followed by discharge and a 3 – 4 week delay in access to a CCAC OT who has 1 visit which precludes meaningful consultation/education and follow-up to recommendations re home accessibility/modification.

- **Restricted access to rehabilitation professionals and supports to restore functional capacity post injury, illness or periodic decline across Ontario CCACs** – access to therapy services (OT, PT, SLP) focused on functional restoration are extremely limited, if not absent across all CCACs. Clients arriving home in acute conditions are most typically supported with nursing and PSW supports from which they are never weaned. A focus on restoration or rehabilitation has been lost in Ontario's community sector. In many CCACs a referral to an OT or a PT may be made with limited visits (often 1 – 2 visits). Such visit limitations restrict a professional's focus to consultative advice and provide for little by way of follow-up, reinforcement of advice, etc. Clients expecting "treatment" are frustrated that they simply get advice or a prescription for equipment. The result is a system that supports a dependency model where clients are cared for in their homes. Regretfully, this not only perpetuates costs over the long term but also ignores a significant body of research that would suggest that people can and want to remain as independent as possible.

- **Insufficient access to care deemed necessary by consumers** – clients and caregivers report frustration that they cannot access more care. In a system that does not empower and enable individuals or their families or caregivers to learn or regain skills to do more for themselves, access to PSW supports is deemed critical and inadequate.

- **Lack of consistency of access to care for clients throughout the year –** in virtually all CCACs a lack of consistent access to services throughout the fiscal year is absent. An annual cycle of fluctuation resulting in typically more restricted access in the third and fourth quarters is common. In some cases this may totally restrict service access. It would appear that therapy services are particularly vulnerable to these fluctuations.

- **Lack of consistency of access to services across LHINs –** it is evident to consumers and health care providers that access to services across LHINs is not equitable. It is understandably frustrating to consumers to learn that they may have access to fewer services, hours of service or community based options outside of the CCAC than residents of other jurisdictions in the province. While regionalized planning has intended to allow for planning to meet more localized needs, when the result is inequitable access to services the public deems important it is frustrating to taxpayers. CCAC provider agencies report variability in their contracts for services from CCAC to CCAC that support this consumer perception.

- **Wait lists for services –** timely access to services is not guaranteed, resulting at times in expenditures that are not fruitful because needs have changed. Waitlists are perhaps most evidence in school-based support services where priority given to this care envelope by CCACs varies and some children are on waitlists for services such as occupational therapy for 2 years.

- **Lack of access to out-patient post-surgical services or rehabilitation services –** over the last 10 years, hospital out-patient services have diminished significantly resulting a paucity of access in many communities to publicly-funded community based services that are treatment focused. Patients discharged from hospital further to surgeries, strokes, etc. who require ongoing rehabilitation services and who are not homebound are not eligible for CCAC services. Except for some physiotherapy services there are no publicly funded community rehabilitation services for OT, SLP, dietetics, etc. This disconnect is most obvious in the area of hand therapy further to surgery. Our health system pays for expensive surgical interventions targeted to improve all important hand function but then does not provide access to the very therapy that would enable functional recovery. Hand patients in most communities are expected to pay private therapy services for their hand rehabilitation. This is restrictive for some and particularly troublesome because extended health insurance policies typically do not cover occupational therapy services. Similar access issues exist for those who are discharged from hospital rehabilitation units and who should benefit from transitional continuity of service or to those who do not need in-patient rehabilitation services but would benefit from community based OT treatment.

- **Lack of access to and integration of mental health services** - linkages with mental health services and the home and community care sector

- **Access to family and caregiver support services –** family and caregivers have varying skills in managing the needs of those they care for and experience limited support to services that are directed to support or consult to them. Access to services or contacts with service providers at times when family can be present is a frequent request shared by members. Some report that even discharge from hospital to home could be more client-centred with scheduling to enable family member participation. Increased access to respite services would more effectively support families to assume caregiving roles.

- **Inequitable or lack of access to primary care services that promote maintenance of functional status as clients age or live with chronic disease -** except for some physiotherapy services and services offered through some Family Health Teams (FHTs), access to rehabilitative professions and mental health professions is lacking in the primary care system. As the populations ages, health services that serve to promote and maintain function and safe, independent self management become a critical component of a community based system that aims to support people to age at home. Family physicians not tied to FHTs have nowhere to refer clients who may benefit from supports such as occupational therapy home safety assessments, memory clinics, post driving cessation groups, etc. While engagement of occupational therapists in 40 – 50 FHTs across the province are beginning to give evidence of the impactful difference access to OT or other interprofessional team members can make, this represents access for a small number of Ontarians.

- **Accessibility of community supports and services in rural Ontario –** for clients who can be well served by community based social or day programs, accessibility can be an issue for residents of rural Ontario. Distances and locations of programs and services may prohibit participation when transportation systems, companion support, etc. are not in place. Concerns have been articulated that regionalization of care coordination has diminished the knowledge of Care Coordinators about local community options.

2. Communication issues

While not unexpected in the complex world of home and community care, communication issues are a frustration reported frequently. These issues identify and underline the lack of integration of systems of the province's health care system and potentials for duplication of effort and service. Common frustrations identified include:

- **Lack of fulsome information about the home and community care sector and what resources are accessible to whom and when –** clients are often unaware of resources that might be accessible to them simply because they have not been informed and don't know what to ask for. The maze of home and community care services can be overwhelming to many clients/families, particularly when cultural or language factors impede ready understanding.

- **Conflicting messaging amongst care providers about access to care, processes for engaging service, etc. -** is most common between hospital to home transitions and highlights breakdowns in communication across sectors, however some clients report poor communications relating to who or when someone is coming to address their needs or scheduling of multiple professionals.

- **Repetitive requirements for personal information sharing and assessment -** clients are often assessed with similar questions and physical tests by a variety of professionals leading them to perceive little communication amongst engaged health care providers. The frustration of repetitive/duplicative sharing of information over and over is only overshadowed by the perception that if communications aren't flowing between providers with assessment/interview data then what happens when there is a serious problem or issue that needs to be addressed.

- **The lack of universally accessible common medical record or mechanisms for interprofessional team meetings or communications** is a frustration shared by health providers and clients. Detailed notes are maintained by individual providers and are seldom shared with a broader team. In fact, funding models de-incentivize many providers from communicating with other professionals such as the family physician, another therapy provider, etc. because face to face time with the client is what is paid for. Clients can experience repetitive assessments and perceive little interprofessional collaboration in their care.

3. **System navigation issues**

Understanding and navigating the scope of the home and community care sector is overwhelming and confusing. Issues raised include:

- There is no one place or person from which to access information that clearly identifies services, eligibility criteria, etc. CCAC Client Care Coordinators are perceived to be gatekeepers to CCAC services, not coordinators of care in a broader sense.

- Family physicians are often unable to identify where to go for resources and information leaving patients to fend for themselves

- Care Coordinators are reportedly difficult to reach as a result of busy caseloads resulting in limited access to navigational supports and information.

Question 2

What can be done to address these frustrations?

- **Stability of funding is critical to provide an underpinning to coordinated care and system planning.** CCACs, community care providers and clients need to know that a consistent level of service can be delivered and accessible throughout the year. Funding mechanisms need to ensure that funding can fairly follow the patient in ways that assure equitable access to appropriate services. Stability of funding is also critical to assure potential to maintain an experienced and ready workforce. The frequent periods of insufficient work has resulted in sectoral erosion of therapy service resources in recent years.

- **Effective investment in the home and community care sector is critical –** transitions to community based care have not been adequately matched with fiscal investment. Transforming a system has inherent start-up costs but these funds have not flowed to facilitate engagement and implementation of true innovation. Instead limited financial investment has likely not kept pace with population growth and service demands let alone provided for meaningful change management processes, piloting or trialling new service delivery options, etc.

- **There is a need to clearly define the core elements of the home and community care system and how these interact or are integrated to address a broad range of needs** from those who are well but vulnerable to decline (e.g. seniors, people living with chronic disease, etc.), to those with incidental or periodic care needs who have potential

to restore function and ability to self manage, to those with complex care needs who are dependent upon others for care, and those with acute nursing care needs. Mental health and behavioural support services need to be considered. Related eligibility criteria and mechanisms for access to appropriate services are necessary. Clear articulation and policy direction re relationships and referral patterns within the home and community care services and hospital and primary care sectors are critical to facilitate systemic integration and access to appropriate services for clients who move from one sector to another. Coordinated system wide planning is required. Core services as defined above need to be transparent and accessible across community sectors in all parts of the province.

- **Access to community based rehabilitation services are critical to support a restorative care approach from hospital to home and from primary care incident back to self management.** Currently CCACs are not providers of rehabilitative/restorative services in a meaningful way. A shift in service focus to enable attention to patients' restorative potential requires an upfront investment but can result in longer term savings, improved quality of life and diminished caregiver stress and burden. If CCACs are not the organization through which rehabilitative care services are accessed, then alternate structures or locations that can appropriately serve clients needs need to be identified, structured and funded.

- **Establish accessible community based rehabilitation services for clients who can attend clinics or locations outside of their home.** This provides the potential to remove the burden on CCAC services and to improve restorative and/or preventative/health promotion aspects of community care. For example, interprofessional clinics that provide access to a team of providers who bring or develop expertise in the scope of their services – e.g. dementia care, falls prevention, hand therapy, management of COPD, etc. and can provide resource to the community at large. This may engage incentives for local PT clinics to engage other health professionals, the development of interprofessional programs in community centres, or retirement homes. True interprofessional care is less costly (shared locations, more efficient coordination of care) and effective (better communication, integrated planning and problem solving) and addresses the frustrations of clients who deal with multiple providers who are not well linked or co-located. With the growing demand for seniors services, investment in Seniors Centres of Excellence or Seniors Service Hub might provide a foundational base for access to a variety of primary and restorative care services targeted to seniors. At the same time as meeting service access needs, such modelling may serve to attract and retain clinical experts who lend strength to the community based system.

- **Evidence based protocols should be employed consistently across the province's community sectors** assuring consistent access to best practice and utilization of service delivery models proven to work. While regional independence in developing and trialling new methods lends to innovation and evaluation, proven methods should be

shared broadly, built into best practice and effectively funded, enabling all Ontarians to gain from such practices.

- **Improve health information sharing amongst providers and ensure linkage with primary care system.** Processes and technology need to be leveraged to assure effective interprofessional care planning and communication and to effectively engage patients and caregivers in their care planning and implementation.

- **Achievement of a simplified one-stop access point for information and resources relating to home and community care is necessary** to more effectively enable clients/families to navigate and participate actively in their care decisions. Technology may be a longer term support but in the interim clarity of a primary system navigation support professional is important. This function needs to be accessible to clients but also to referral sources who may include family physicians and other primary care and community care providers.

- **Engagement of technologies that can reasonably bring health care into the home without provider presence should be explored** to determine if there are more cost efficient methods for delivering high quality health care and that can increase accessibility by both serving more clients and serving more clients who are living remotely. For example, consultations with clients, caregivers, family or other health professions via skype, tele-monitoring systems, use of mobile technologies to access best evidence, expert advice, etc.

- **Investment in reducing caregiver burden to promote family participation in caring for loved ones.** Access to more readily available respite options, consultation to address a family member's changing health or functional status, financial supports to modify homes and secure equipment that is appropriate to support caregiving (beyond a tax credit which provides benefit to those most able to pay for renovations) could all be considered as investments in managing care at home.

Question 3
What are the home and community care sector's three greatest successes?

1. **Increasingly acute and complex clients are being managed safely in the community facilitating earlier discharge from hospital.** While care paths and access to services may not be ideal, better management of ALC days and hospital costs promotes savings that are critical to achieve to contemplate reinvestment in the community sector.

2. **Some CCACs have engaged innovative programs to address clients' needs and budget challenges and have seen promising rewards for their innovation.** For example, the CW CCAC engaged a Home Independence Program designed to maximize clients' long-term independence and quality of life by refocusing CCAC services to a more restorative care approach as opposed to a caring for and maintaining approach. In this model rehab professionals (OT and/or PT) worked in a team with a PSW early in the client's care plan of CCAC services with goals to; identify client potential for restoration of function, introduce restorative approaches to achieve improved function, and consultation to the PSW re how best to promote restoration, achievement and then maintenance of new levels of independence. Investment in upfront costs (of therapist time and some increased time for PSW (more time to assist someone to do for themselves than to do for them) appear to have paid off in the outcomes relating to patient independence, confidence, ability to reduce CCAC services and longer term costs of PSW support. These results appear similar to studies of the Home Independence Program offered through Silver Chain and evaluated in Australia in 2010 and 2012.

3. **Engagement of rehabilitation professions in primary health care roles where the focus is on promoting and preserving function and self management amongst community dwelling persons have begun to demonstrate effective outcomes.** For example, OTs have been funded to work in Family Health Teams since 2010. Although still not present in over half of FHTs, OTs engaged in these primary care organizations are demonstrating impacts, particularly with those populations most vulnerable to functional decline – the elderly, those with early dementia, people living with mental illness or who are isolated and at risk of depression, etc. The Toronto based House Calls program is another primary care initiative that demonstrates the benefits of engaging a restorative, health promotion approach to management of vulnerable, frail seniors living independently. These programs underline the potential for investment in the primary care sector to significantly support and minimize demand on the home and community care sector. While OTs might argue that sectoral delineation is outdated…..funding mechanisms tend to separate components of care along the care continuum. The opportunities to mimimize sectoral boundaries by bringing components of a restorative approach to primary care could be important.

Question 4
How can we build upon these successes?

- Sharing evaluations and data of new innovative approaches across CCACs and LHINs is critical. Uptake of new innovations may require policy direction and funding allowances as transition and change has a cost. Review international models of restorative

community-based care for potential fits for Ontario's system.

- Increase engagement of therapy professions in primary care options such as FHTs, Community Health Centres, House Calls and other accessible programmatic options that could be accessed by patients of non-FHT/CHC/House Call physicians. Invest in the capacity of the system to keep people well and able to function as independently as possible for as long as possible so as to reduce demand on the more treatment and care driven aspects of the home and community care system.

- Evaluate real fiscal impacts of earlier discharge from hospital to the community with a goal to transferring savings to the community sector. For years community based providers have heard that budgets would shift from hospital to community. Little real traction on this promise has been observed and felt.

Question 5

What are three specific changes you believe would increase the coordination and integration of services (e.g., hospital transitions, primary care, home and community care, social services) for individuals in need and their families/unpaid caregivers so that they can be active participants in planning and managing their own care and be well supported in that role?

1. **Clarify roles and services and clear eligibility criteria for service components/organizations that are consistent across the province.** Consumers and health providers both within and outside of the home and community care sector need to be able to know when and how to access services that can be accessible in the right place, at the right time, for the right person (that meets the eligibility criteria). Inconsistencies of access across the province magnify confusion amongst providers and users. For example, clarity re what services are provided by hospitals, CCACs, primary care organizations, community care organizations, etc. in the community sector is needed. When it is clear who does what and with whom, coordination, integration and system navigation by consumers and providers is easier. Gaps in service can then be more effectively identified and addressed in a timely manner.

2. **Achieve a reliable, easily accessible, common health record** that can be accessed and utilized across organizations and settings. Lost time and diminished quality of care that may result from inefficient or ineffective communication across professionals or organizations working with a client should be spared. Policy frameworks that enable electronic health information sharing should be a priority, ultimately providing opportunity for improved coordination of patient care, sensitive attention to privacy and protection and diminished administrative burdens

3. **Addressing the need for comprehensive system navigation support** is critical to enabling clients and their families to be and feel more engaged in managing and supporting their own care. Shifting health services into the community imposes high expectation upon families and caregivers to both support and pay for services. To assume these responsibilities, people need to feel they can make informed decisions. Informed decisions require access to necessary information about service options, caregiving expectations, etc. While these expectations may be reasonable and achievable over time, the system needs to invest in supports to caregivers and nurture a culture where families see and expect their roles for caregiving to be within a range of normal activities of family life. Effective system navigation support is a good place to start.

Question 6

What are three specific ways that providers of home and community care could better meet the needs of individuals in need and their families/unpaid caregivers?

1. **Support restoration and enabling of self management for as long as possible –** today's home care system is largely focused on caring for clients as opposed to focusing on enabling clients to resume activities of daily living and to manage as independently as possible in their own home. Public consultations, CARP and other seniors' organizations repeatedly identify that seniors today want to be independent, want to maintain control over their own health and life activities and to minimize burden to family and loved ones. A focus on restorative care is congruent to these ideals and further serves individuals and their families by reducing the long-term reliance of many home and community care clients on care and its inherent costs, thereby allowing the system's resources to stretch further to serve more people in need. This strategy is well applied in the primary care system, the hospital system and in the home and community care sector. True integration of the primary care sector can extend a focus to health promotion, education and maintenance of independent living skills. Policy direction to engage such a shift in thinking can give rise to service delivery options that currently don't exist, for example, community hubs of excellence for seniors care or, (as in Denmark) semi-annual home-based assessments of older community-dwelling individuals that focus on functional ability, welfare, life content, home conditions, potential for self management , medication review, etc. in an effort to ensure that as problems arise they are identified and addressed expediently, minimizing any restriction to function and long-term reliance on the system before it is necessary.

2. **Interprofessional collaboration promotes quality care, could diminish unnecessary duplication of assessment, interaction with the family, and might result in fewer but more effective interactions with a client and their family.** Frontline clinicians position that the current system de-incentivizes collaborative care, largely because providers

seldom see each other, have limited access to shared records and are not compensated to be in communication with each other. Reframing care to be more collaborative may include: team or joint assessments (either in person or remotely), team conferencing and care planning, collaborative record sharing, shared responsibility for skills shared across scopes of practice enabling the "present" provider to engage in activities to meet client needs when they arise, use of support personnel as may be appropriate when intervention timelines permit, development of community based specialist teams or interprofessional programs, and true engagement of the client and family and the family physician as team members.

3. **Development of excellent resources and supports to caregivers and family members.** While the above two suggestions relate, specific attention to supports and services for caregivers seems paramount to more effectively enable families to assume the increasing demands of a health system focused on keeping people living as well as possible at home. Education (online and community based), support networks, access to respite care, equipment when needed, ready access to community supports when needed, supports for behaviour management, etc. are opportunities to effectively support these important partners of the home and community care system

Question 7

Health care consumes a significant portion of the provincial budget, and these costs are growing. What innovations and new approaches to care delivery could be made to maximize the value of our investment in home and community care? Where are the greatest opportunities for impact?

- **Focus on primary care and access to restorative/maintenance supports to prolong safe, independence and self management to minimize dependence on supports as long as possible.** Prevention of functional decline for as long as possible is a win/win strategy for consumers and the system alike. Reducing burden of demand on care support services, when one is enabled to remain well and able, ensures that resources can be spent on those with greatest need. Increased engagement of therapy professionals such as OTs in Family Health Teams, Community Health Centres and House Calls can provide resource within the primary care system to meet the challenges of a restorative system approach.

- **Explore feasibility of expansion of Home Independence Program across CCACs to introduce assessed attention to client ability to regain function and maintain higher levels of independence and/or participation in daily living skills and activities.** Providing a means through which appropriate levels of PSW support are engaged in models that promote client participation have been seen to reduce overall dependence on home care supports over a longer period of time.

- **Investment/development in effective supports to clients and families dealing with cognitive decline, dementia, behaviour management challenges.** While early impacts of memory loss, dementia, behavioural changes and/or mental health issues are challenging for clients and families, having support to develop effective management strategies, comfort and confidence in addressing the emerging challenges and awareness of communities resources, programs and services to address needs of family members with these challenges can be the difference between a family coping or not and a loved one able to remain in their familiar surroundings or not. As the numbers of people living or likely to be living with dementia or other cognitive deficits is expected to grow, investment in evidence informed programs and services for this population would be strategic. Memory clinics, driving cessation programs, day programs (an example might be the Toronto based Woodgreen Community Centre's Seniors Programs. The learnings to date from the Behavioural Supports Ontario (BSO) initiative should be carefully evaluated for further development and saturation of resource into the primary and community sectors. Occupational therapists have much to offer in the management of dementia, impacts on management of daily living occupations and responsive behaviour management. The profession would advocate for increased representation of OT in the BSO program so that ongoing program development can benefit from the professional insights of more diverse interprofessional teams.

- **Engage community-based clinic/program models for interprofessional rehabilitative care.** Strategically, a negative impact of early hospital discharges and rationalization of hospital funded services such as out-patient rehabilitation, has been the resultant lack of access to important rehabilitation services, no longer available in the hospital environment but not available in the community. Occupational therapy, for example, except as delivered by the CCAC (or in some FHTs) is not accessible as a community-based service ..... unless a client is able to pay. Access to a community based location where a variety of professionals might practice, provides therapy resources that can assure that the hospital based investment (surgery, short stay admissions, etc.) are realized with meaningful outcomes and that clients are provided with appropriate and necessary services to enable to get on with their job of living.

Question 8

Please comment on any additional issue that is not addressed in the above questions but that you feel will help the Expert Group develop its recommendations.

Refocusing home and community care to a "restorative paradigm"

OSOT positions that if Ontario is to meet the growing needs of our aging population in times of fiscal restraint we need to look at how we deliver community services. Our existing community care system works to effectively turn those with health problems into long-term consumers of nursing and personal support services. Our present model appears to work on the assumption

that Ontarians who have been discharged from hospital or are assessed to be eligible for home care require ongoing care. In a number of other jurisdictions, such as Australia, the United Kingdom, Denmark, and the US, there has been a growing realization that we can achieve better quality of life for clients and their families, and better performance for the system as a whole, if we focus more on helping people regain or retain their independence, for as long as possible. This underlines a dual focus on improved client outcomes and reduced cost.

Emerging models suggest that community models that focus on a restorative approach can improve client functionality, ease caregiver burden and reduce, or delay the need for home care services. These restorative models deploy interprofessional teams to work with clients and their caregivers to assess what can be done to allow individuals to continue to live independently for as long as possible. Appropriate supports, such as necessary home modifications or time-limited restorative therapy, are then provided. Because of the profession's training, expertise and outlook OTs are ideally suited to operate within such a paradigm. In all the jurisdictions we've reviewed, OTs are an integral component of interprofessional teams focused on delivering restorative home care services.

We believe there is a significant incentive for both individuals and the system to find ways to help maintain and restore function more effectively and OSOT is committed to working with partners across the health system to develop and test the effectiveness of restorative models.

Promoting Age-friendly Communities

OSOT applauds the government's current Action Plan for Seniors which calls assertively for attention to the creation and maintenance of age-friendly communities. A home and community care system that is focused on maintaining health, well-being and meaningful participation in the community can only be successful in an environment where Ontarians living with health challenges are not further compromised by inaccessibility, lack of appropriate transportation or housing options, social exclusion, etc. These community factors are critical considerations, especially if community based treatment or education programs are to be successfully promoted and utilized. A wonderful community hub of services and resources to support seniors and their caregivers is terrific unless getting to the hub for those no longer able to drive is a barrier. Housing options which provide for a range of increasingly supportive options within an accessible community that promotes integration of older people into the fabric of community life is foundational support to enabling independence or function/participation to one's potential for as long as possible. We urge attention to accessibility requirements for new residential builds designed to be marketed to seniors, to ensure that principles of universal design create environmental contexts that promote ease of function for people of all abilities and their caregivers.

Shifting Public Attitudes and responsibilities for care

Occupational therapists understand that shifting to a restorative paradigm is bigger than just changing how things are done. Currently clients and families get and expect "care"... and they want more...on an ongoing basis. A shift to restorative approaches requires attention to

changing public expectations and attitudes to their own roles and responsibilities in care and restorative approaches. The good news is that evidence suggests that this is in keeping with what seniors are articulating as their vision. Families may need more convincing that the supports they want for their loved ones to be able to be as safely independent as possible will be there. Exploration of alternative payment models that may provide options for self managed care for those who so choose may be enabling as self-managed models may, in fact, allow for more care/service as a result of lower consumer costs. Visible efforts to support families and caregivers to navigate the health care system, to access services, to be supported to accommodate aging parents (e.g. renovation subsidies, work leaves, access to respite care, etc.), to be supported to be "healthy" caregivers themselves would be valuable strategies to contribute to positive attitudinal shifts to caregiving responsibility.

Assuring public Accountability

The suggestion that the public share more in the provision of informal care and/or financial share of formal support will draw to attention the need for transparent public accountability in the home and community care sector. This notion of transparency has been challenged in recent years with queries regarding the percentage of budget funds that find their way to direct client care. At a time of systemic review and invitation for innovation and new ideas, this issue needs to be addressed because at the same time that innovation and new ideas are invited, there are cautions about sustainability, growing service demands and limited fiscal resource. The complexity of the business models engaged between CCACs and service provider organizations is significant and difficult to both understand and judge from the outside. It is hoped that a review of the home and community care system will address opportunities for new innovation as well as the challenge of proving that the "old" is working as well as it can and producing the same bright outcomes we hope to see new innovation deliver.