



Ontario Society of
Occupational Therapists

Occupational Therapy in Ontario Long-Term Care Homes

Strategies to achieve capacity
to meet resident needs

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Introduction

The Ontario Society of Occupational Therapists (OSOT) is the voluntary professional association of Ontario occupational therapists. Over 4000 members strong, the Society serves a mission to both serve and represent members and to promote and position occupational therapy to contribute effectively to the health and well-being of Ontarians and to the quality outcomes and efficiency of the province's health care system.

Occupational therapists (OTs) are regulated health professionals who assist people to overcome or minimize barriers to managing the day to day tasks, activities and interactions (occupations) of their lives when health related issues limit function. OTs work with clients across the lifespan and work across the continuum of our public health care system – from primary care to long-term care. Occupational therapists bring to their practice a masters prepared education that provides a focus in both physical and mental health with unique attention to functional capacity, performance and engagement in occupation.

Occupational therapy has a relevance and importance in long-term care homes who are legislatively directed to engage a restorative care approach that promotes resident well-being and quality of life in an environment that is recognized to be their home. While occupational therapy services are directed to promote resident function and engagement, the profession also makes meaningful contribution to the prevention of risks such as falls, pressure wounds, depression, or responsive behaviours of residents with severe dementia.

Resident access to occupational therapy services has been severely restricted by funding changes resulting from the Physiotherapy Funding Reform initiatives of 2013. This document represents a solutions-focused effort of the Ontario Society of Occupational Therapists to work with the Ministry of Health and Long-Term Care to identify appropriate service delivery levels and models of care and service delivery for occupational therapy services in order to restore service access in Ontario's 634 long-term care homes.

To the extent that has been possible, the Society has undertaken the following activities to support development of this document:

- Literature search and review related to OT services in long-term care homes
- Review of related data that is accessible to the Society
- Consultation with OT professional associations across the country
- Consultation with stakeholders – Ontario Long-Term Care Association, Ontario Physiotherapy Association
- Consultation with OSOT members who have experience working in long-term care homes and/or expertise in issues of relevance to residents of LTCHs.

Background

Occupational therapists have been important health care team professionals in Ontario's long-term care homes for many years. The OT's unique scope of practice and skillset is particularly relevant amongst clients whose functional capacity is typically on a downward trajectory with barriers to function arising as a result of the often multiple chronic and progressive conditions they live with. The LTC sector's goals and commitments to promote a home environment that supports residents to live to their fullest potential with a meaningful quality of life is well served by the occupational therapist's expertise and focus of practice.

In the past decade, the profession has experienced unprecedented challenge in maintaining a presence and viable role in long-term care homes. Since 2005, OHIP-funded Designated Physiotherapy Clinics (DPCs) have provided most physiotherapy services in LTC Homes on a fee-for-service basis funded by OHIP. Contracts between LTC Homes and the DPCs initially provided for the provision of physiotherapy services, however, over time these contracts were extended to include other services such as staff education and certification in restorative techniques and workplace injury prevention, consultation and support for falls prevention, wound care, pain management and other required programs, therapeutic exercise equipment and supplies, and specialized assessments and services including Assistive Devices Program and occupational therapy and speech language pathology.

Occupational therapy services funded by the DPCs were limited predominantly to assessments of clients with complex seating and mobility needs that would result in an application to the [Assistive Devices Program](#). Access to OT services that addressed the full scope of practice and contribution of the profession was severely limited. CIHI data on therapy utilization, 2011 – 2012 identifies that only 3% of Ontario LTC Home residents accessed OT, as compared to 80% who accessed physiotherapy services. In other provinces, the long term care utilization rates for physiotherapy and occupational therapy were 11%, 8.4% respectively.¹

The Physiotherapy Funding Reform initiative announced in April 2013 and implemented commencing August 21, 2013 effectively removed the existing access to OT services in long-term care homes. Although the MOHLTC identifies that it was expected that homes were funding OT services from their Program and Support Services Budget, this had not been the case in the vast majority of homes for many years. When new physiotherapy contracts were directed and implemented with restrictions to provide only physiotherapy services, access to OT services was lost. Consultation with the Ontario Long-Term Care Association and Ontario Association of Non-Profit Homes and Services for Seniors identifies that their members report that there is not sufficient resource in their Program and Support Services Budget to pay for OT services.

Occupational therapy remains an important professional service for residents of long-term care homes. The [Long-Term Care Homes Act](#), 2007, requires all homes in Ontario to ensure that restorative care

¹ *Physiotherapy Provision in Long Term Care: Issues & Recommendations, OLTC, May 2013, p. 4, Retrieved from http://oltca.com/system/files/Policy/Therapies_Health/Physio%20Backgrounder_June%2006.pdf*

approaches are integrated into the care that is provided and coordinated to ensure that residents are able to maintain or improve their functional and cognitive capacities in all aspects of daily living, to the extent of their abilities. Indeed, access to necessary occupational therapy services for residents who have need is also enshrined in the *Act, 2007*. Presently over 76,000² Ontarians who call a long-term care home their home do not have reasonable access to occupational therapy services when they need them. Many who have need may not have access at all.

What is Occupational Therapy?

Occupational Therapy is defined in the *Occupational Therapy Act, 1991* as follows;

*The practice of occupational therapy is the assessment of function and adaptive behaviour and the treatment and prevention of disorders which affect function or adaptive behaviour to develop, maintain, rehabilitate or augment function or adaptive behaviour in the areas of self-care, productivity and leisure.*³

Occupational therapists (OTs) are uniquely concerned with people's ability to manage everyday activities viewed as an outcome of the interaction between personal characteristics (e.g. abilities and skills) and the physical, socio-cultural and organizational contextual features that they live within. It is the goal of occupational therapy to enable clients' ability to function to their fullest potential to enable engagement in activity that is meaningful to them. Occupational therapists understand that engagement in meaningful occupations contributes to health and well-being. Occupational therapy is a client-centred profession that engages clients in all aspects of OT assessment, treatment planning and interventions, focuses on individual needs and priorities, addresses the client as a person with a wholistic approach to care, and takes a strengths based approach to maximizing an individual's ability to function as independently and with as rich a quality of life as possible.

Occupational Therapy in Long-Term Care Homes

Occupational Therapists (OTs) work with residents of long-term care homes to promote their optimal function and engagement in activities of daily living, those day to day basic living skills (self care, mobility, participation in social or leisure activities, etc) that give purpose, accomplishment, independence and meaning to one's life.

Resident-focused occupational therapy interventions are targeted to:

- prevent de-conditioning and promote sustainable levels of function for as long as possible

² Health Quality Ontario, retrieved from <http://www.hqontario.ca/public-reporting/long-term-care>

³ Occupational Therapy Act, 1991, retrieved from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91o33_e.htm

- restore function when impaired by periodic injury, illness or other factors
- promote adaptation when cognitive abilities are impaired in order to improve function and/or reduce behavioural episodes related to loss of independence or control
- improve quality of life and engaged participation in the restorative care environment and activity of the home
- assess and intervene to mitigate resident risk relating to
 - cognitive behavioural status which may result in wandering, outbursts, etc.
 - falls
 - skin breakdown and other wounds associated with poor skin integrity
 - use of restraints
 - environmental accessibility
 - mental health status
- adapt or modify the resident’s living environment to optimize function and safety

While it is difficult to find a formal definition of restorative care in Ontario long-term care homes, the Ministry’s [A Guide to the Long-Term Care Homes Act, 2007 and Regulation 79/10](#) describes restorative care in this way;

Restorative care helps residents improve or maintain their ability to perform activities of daily living. Restorative care includes promoting continence and increasing muscle strength and balance. Integrated restorative care approaches can also help reduce falls and the use of restraints. A restorative care approach promotes independence, health and well-being, and improves quality of life.

Occupational therapy is well aligned with the philosophic orientation of a restorative care

approach to resident care as enshrined in the [Long-Term Care Homes Act, 2007](#). With a focus on the whole person – their physical, cognitive and mental health function in the context of their environment - occupational therapists address many of the most complex and challenging issues residents present. OTs work as members of interprofessional teams, bringing their unique skillsets and competencies to resident-focused care and contributing and consulting to the problem solving, treatment planning and day to day resident care. An OT perspective and participation on key policy and program committees within a home is a valued addition in such areas as falls prevention, wound care and prevention, restraint reduction programs, pain management, etc.

While occupational therapists working in long-term care homes focus on resident needs, an outcome of OT service intervention can be the reduction of nursing staff requirement for day to day resident care.

Occupational therapists practice with a holistic person-centred approach to care and their services include;

- assessment
- enabling strategies
- consultation

that is focused on, but not limited to, the core domains of:

- activities of daily living – self care, engagement in meaningful activity
- integration of adaptive equipment & environment modification to promote safe function
- mobility and seating
- cognitive function and dementia care
- behavioural support
- restraint reduction
- falls prevention
- pressure wound prevention and management
- resident and family education
- staff consultation/training
- links to community resources as appropriate

Which residents can benefit from occupational therapy services?

The *Long-Term Care Homes Act* provides for access to OT services based on assessed resident need. Not all residents of a long-term care home will require OT services. OSOT identifies 3 types of resident for whom OT services are appropriate and for which a framework for OT service delivery is required.

1. Short-stay residents with needs for low intensity rehabilitation to achieve/restore independent function with a goal of discharge to community-based living.

2. Long-stay residents with needs for assess and restore interventions to achieve optimal independent function, maximizing resident ability and addressing safety and risk management.

3. Long-stay residents with needs for OT interventions to maintain and prevent/delay decline in function or to promote effective adjustment to the trajectory of functional decline that may be realistic for residents.

While not identified in the current mix of Long-Term Care Home residents, the potential for LTC Homes to provide meaningful respite care solutions for families caring for loved ones at home may present yet another category of resident for which OT has particular relevance. In a short term respite stay, an occupational therapy assessment of current function, equipment needs, accessibility requirements in the home, etc. may identify needs and opportunities for improvement that, if provided within the respite visit, could promote optimal function, facilitate caregiver management at home, reduce risks in the home environment, etc.

Within the context of a service delivery model for each of the resident need type identified above, occupational therapists bring unique expertise and focus of attention to;

1. Activities of Daily Living

- promoting optimal levels of safe engagement in resident self care and the day to day activity/life within the home.

2. Seating and Mobility

- to promote independent mobility where possible
- to facilitate resident participation in day to day activity/life within the home
- to effectively position residents to prevent skin breakdown,
- manage pain/promote comfort

3. Cognitive Assessment & intervention

- Assessing cognitive skills & identifying implications for functions and safety
- Identifying strategies to address and prevent responsive behaviours
- Safety and risk management strategies

While the needs of each type of resident vary and may be addressed in different service delivery models, OSOT identifies the following core principles that would be common to the care delivery model for all resident types in need of OT services;

- OT services will be goal directed and documented on the resident care plan
- OT services will be individualized based on the OT's assessment of identified needs and resident potential
- OT services will be delivered in a holistic, person-centred approach
- OT services will be evidence-informed
- OT services will be directed and overseen by a registered occupational therapist and delivered in a service delivery model that is directed to effectively meet treatment goals, employing an efficient mix of OT, OT Assistant and nursing staff support.
- Education is a component of OT care – teaching residents, family, LTCH staff approaches, techniques that are resident appropriate and promote independent function, progress toward identified goals and/or resident safety and risk management
- Families, caregivers are partners in care
- OTs will participate actively as members of the interprofessional care team to assure collaborative care and effective communication

- Residents will be discharged from the occupational therapy service when treatment goals are achieved or when the resident's status precludes reasonable participation in therapy or has deteriorated to a level where functional goals are no longer relevant.

The following pages detail proposed OT service delivery frameworks to address each level of resident need for occupational therapy, identifying;

- Targeted residents for referral/eligibility for service
- OT interventions appropriate for this target group of residents
- Reporting and accountability
- Service delivery requirements and resources

1. Short-stay residents with needs for low intensity rehabilitation to achieve/restore independent function with a goal of discharge to community-based living.

Target Residents

- Residents admitted for slow stream rehabilitation or convalescent care further to hospitalization for an injury, illness, surgery or debilitating health event
- Short stay residents admitted for up to 90 days to restore capacity to manage in the community
- Residents assessed to be medically stable to participate in low intensity rehabilitation
- Residents assessed to have reasonable potential for functional improvement

Occupational therapy services to achieve/restore functional independence

- Comprehensive occupational therapy assessment upon admission
- Individualized treatment planning focused on achievement/restoration of functional independence in activities of daily living which will include self care activities and may (depending on the community discharge environment) include homemaking and IADLs
- Goal oriented OT plan is developed in collaboration with the resident and in consideration of their discharge environment
- Family/caregiver consultation/education to support effective discharge planning and transition to community - residents and families are partners in care
- OT treatment plans are documented in the plan of care as a component of an interdisciplinary rehabilitation program of care
- Interventions may include specialized attention to:
 - Seating and mobility assessment to determine appropriate equipment needs
 - Cognitive assessment and retraining
 - Splinting to promote functional recovery or positioning
- Appropriate linkage with community support services to facilitate smooth, effective discharge transitions

Reporting/Accountability

- Regular reporting of progress toward goals in resident record (weekly/monthly)
- Participation of OT in resident care team meetings
- Discharge from service as goals are achieved

Service Delivery requirements

- Time-bounded, resident - centred, goal directed occupational therapy services will be directed and primarily implemented by a registered occupational therapist
- OT Assistant required to support efficient delivery of occupational therapy services when skill practice is required and the resident's response to treatment is relatively predictable
- Equipment to support active low intensity OT rehabilitation services would include: wheelchairs, walkers, ADL assistive devices (tools for grooming and dressing, commodes, raised toilet seats, transfer boards, bath seats, transfer aids, splinting supplies and fabrication resources, etc.)

2. Long-stay residents with needs for assess and restore interventions to achieve optimal independent function, maximizing resident ability and addressing safety and risk management.

Target Residents

- Long-stay residents who have experienced a de-stabilizing episode such as a fall, illness, admission to acute care, pressure wound, etc. which has resulted in an episodic decline in functional ability
- Newly admitted residents who experience a period of de-stabilization adjusting to a new environment.
- Residents assessed to have potential for restorative interventions to regain function

OT services to restore functional independence or previous functional status

- Occupational therapy assessment upon referral
- Individualized treatment planning focused on restoration of optimal functioning after a period of de-conditioning, with a focus on activities of daily living which will include self care activities and ability to participate in meaningful occupations/activities within the home
- Goal focused treatment plans targeted to advance function are documented in the plan of care as a component of the resident care plan
- Family/caregiver and nursing staff consultation/education to support transfer of restorative gains to day to day routine
- Interventions may include specialized attention to the following needs that are specific to the episodic event that impacted function;
 - Seating and mobility assessment to determine appropriate equipment needs
 - Cognitive assessment and retraining
 - Splinting to promote functional recovery or positioning
 - Wound care and pressure relief
 - Pain management
 - Falls prevention
 - Mental health issues

Reporting/Accountability

- Regular reporting of progress toward goals in resident record (weekly/monthly)
- Participation of OT in resident care team meetings
- Discharge from service as goals are achieved

Service Delivery requirements

- Episodic, resident-centred, goal directed occupational therapy services will be directed and primarily implemented by a registered occupational therapist
- OT Assistant required to support efficient delivery of OT services as skills practice is likely required with this long stay resident who is likely dealing with multiple chronic conditions
- Equipment to support active restorative OT services would include: wheelchairs, walkers, ADL assistive devices (tools for grooming and dressing, commodes, raised toilet seats, transfer boards, bath seats, transfer aids), pressure relief options (cushions, mattresses), splinting supplies /equipment

3. Long-stay residents with needs for OT interventions to maintain function or to prevent/delay decline or to promote effective adjustment to the trajectory of functional decline that may be realistic for residents.

Target Residents

- Long-stay residents who experience increasing problems managing their self care, mobility and/or activity routines
- Residents experiencing an increase in the number of falls, behavioural incidents, or an increase in cognitive difficulty, symptoms of depression, social withdrawal, physical decline involving change in muscle tone or joint range of motion or contracture

Occupational therapy services to maintain functional status or assist resident/staff to adjust to functional decline while optimizing safe, functional performance.

- Occupational therapy assessment upon referral
- Individualized treatment planning focused on prevention of complications and risks resulting from functional deterioration, delaying functional decline in activities of daily living as long as possible and assisting residents and staff to adjust to changing functional ability
- Treatment plans are goal focused and are documented in the plan of care as a component of the resident care plan
- Family/caregiver and nursing staff consultation/education to support transfer of functional maintenance strategies and/or adjustments to functional decline
- Interventions as per resident need which may include specialized attention to:
 - Seating and mobility assessment to determine appropriate equipment needs
 - Cognitive assessment and interventions such as behaviour management strategies
 - Splinting to promote positioning and prevent contractures
 - Wound care and pressure relief
 - Pain management
 - Falls prevention
 - Mental health issues

Reporting/Accountability

- Regular reporting of progress toward goals in resident record (weekly/monthly)
- Participation of OT in resident care team meetings
- Discharge from service as goals are achieved or resident status deteriorated to level that functional goals are no longer appropriate

Service Delivery requirements

- Episodic, resident - centred, goal directed occupational therapy services will be directed and primarily implemented by a registered occupational therapy
- OT Assistant important when maintenance or skills practice is required
- Equipment to support active restorative OT services would include: wheelchairs, walkers, ADL assistive devices (commodes, raised toilet seats, transfer boards, bath seats, transfer aids, etc.), pressure relief options (cushions, mattresses), splinting supplies/equipment

Activities of Daily Living

Activities of Daily Living (ADL) for residents in LTC include dressing, hygiene, toileting, and feeding activities. Because ADL tasks are performed by an individual employing his or her entire scope of abilities, other elements of a resident's function can have significant impact on their ability to perform ADL tasks; i.e. mobility to transfer to toilets, positioning in wheelchair to provide postural support and positioning adequate to participate in ADL tasks, such as feeding.

An occupational therapist assesses a resident's ability to perform ADL tasks;

- The resident's cognitive ability to perform the ADL task must be assessed including attention to; their ability to take initiative, knowledge of and ability to plan the steps of the task, awareness of safety concerns, ability to remember and complete the steps of a task
- The resident's physical abilities to perform the ADL task must be assessed with attention to; sitting balance, standing balance or bed mobility movements and the active limb movement or range of motion necessary to perform the ADL task.

If limitations in the resident's active range of motion or cognition are present, a treatment plan must be developed to remediate and correct the dysfunction. If the resident's potential to correct the dysfunction is unlikely due to the level of physical or cognitive dysfunction or deterioration, then opportunities to compensate for, or to accommodate the dysfunction, must be explored and trialed. This may include adaptive motor or cognitive techniques to compensate for the cognitive or physical dysfunction, the use of adaptive devices (for example; buttonhook, sock aid, long handled shoehorn, raised toilet seat, walker or wheelchair), and/or the introduction of environmental supports and cues to enable engagement in ADLs.

The resident's whole function must be considered when considering adaptive devices. For example a wheelchair and seating system is not solely a mobility device.

- When appropriately seated in a wheelchair and seating that has been prescribed and built to suit a resident's functional goals, a resident's ability to perform multiple ADL tasks can be enhanced. For example appropriate positioning in a wheelchair to accommodate kyphosis can reduce a resident's back and neck pain, facilitating their ability to engage with others socially when their face is in a neutral position. As well, compensation of kyphosis through a wheelchair and seating system, can facilitate a resident's ability to feed themselves or be fed.
- A wheelchair and seating system may also provide pelvic and core support which result in a more upright and midline trunk support which enables bilateral arm and hand function. Appropriate seating in a wheelchair may reduce abnormal tone and posturing and facilitate a resident's ability to function in ADL.
- A wheelchair and seating provides mobility but may allow a confused client at risk for falls, the spontaneous ability to be safely and independently mobile while sitting in the wheelchair;

reducing the risk of falls and injury. It allows a resident with functional cognition to compensate for a physical disability and provide them with independent mobility and the ability to move freely within and without the LTC facility.

- A wheelchair may provide support, prevent injury, and reduce pain for physical dysfunction; an amputation, a flaccid upper extremity and/or a subluxed shoulder.
- Appropriate seating in a wheelchair can assist in preventing and/or healing wounds due to sitting and pressure.

A resident must be able to learn and intentionally alter his behaviour to remediate function in ADL. If a resident is unable to alter his behaviour, then the environment and interactions with staff must be altered to meet the resident's functional needs. In LTC the parameters for environmental change and staff change (behaviour and staffing ratio) vary by facility and must be considered when a resident's ADL function is being assessed.

Seating & Mobility Services

The Ontario Long-Term Care Association identifies that approximately 57% (49,000) of Ontario LTC residents who are assessed annually use a wheelchair. These numbers generate a high volume of seating and mobility assessments both on resident admission and as function deteriorates. Although not all seating and mobility assessments will result in an application for funding from the province's Assistive Devices Program, OLTC notes that they estimate approximately 28,000 ADP Assessments (OLTC's term) were conducted in 2011-12⁴. Occupational therapists are the predominant provider of assessment of complex seating and mobility needs of LTCH residents. This population typically presents with multiple chronic

diseases resulting in physical and cognitive limitations, risks to skin integrity, pain, etc. OTs bring unique skills and competence to this assessment/prescription process that add value, contribute to quality of care and deliver outcomes that effectively address needs of both the resident and the home and its staff. Occupational therapists provide comprehensive assessments that address;

- the resident's physical mobility needs
- the functional skills that a seating/mobility system can impact (performance of ADLs, transfers, participation in daily home activities, etc.)
- the impacts of cognitive dysfunction on the use of the device,
- the potential impacts on resident care,

⁴ *Physiotherapy Provision in Long Term Care: Issues & Recommendations, OLTC, May 2013, retrieved from http://oltca.com/system/files/Policy/Therapies_Health/Physio%20Backgrounder_June%206.pdf.*

- the potential for appropriate seating/mobility to address behavioural issues that may be exacerbated by factors such as discomfort, lack of independent mobility, or pain
- pressure relief options to prevent skin breakdown
- the impacts of the environment in which the resident needs to function or be cared for on their use and mobility within their seating system

Many occupational therapists who have been working in the LTC sector are ADP Authorizers and can complete ADP applications for funding on behalf of eligible residents.

Appropriate seating and mobility is foundational to the achievement of many of the goals of homes focused on restorative care and the principles of the *Long-term Care Homes Act, 2007*, including:

- enabling maximal independence in mobility and transfers
- effective, support positioning to enable maximal function including – ADL skills such as feeding, grooming, participation in day to day activities of the home
- positioning for support, comfort, pain reduction
- falls prevention
- prevention of skin breakdown due to pressure
- prevention of contracture or deformity
- restraint reduction
- reduction of responsive/aggressive behaviours that may result from discomfort, lack of independent mobility, control, etc.
- support to resident care by staff

OT service delivery models need to address the significant demands for complex seating and mobility solutions in LTC Homes. Seating and mobility solutions for clients with complex needs

are not inexpensive and skilled assessment and prescription is an investment in appropriate use of public funds in addition to the goal of best supporting resident comfort, mobility and function. Occupational therapists identify that assessment times will vary depending to assure client centred approaches, availability of trial equipment, etc. A range of 3 – 4.25 hours (+ any extended trial time) is projected for an average assessment where there are no unforeseen complications. A detailed breakdown of an OT Seating and Mobility Assessment is presented in Appendix I.

Cognitive Assessment & Intervention

7% of seniors living in a residential care home have a diagnosis of Alzheimer's disease and/or other dementia⁵, and 70% of all individuals diagnosed with dementia will die in a long-term care home.⁶

These numbers speak to the need for skilled staff to care for persons living in our nursing homes. It is not just frailty and physical complexity of residents. Many residents in long-term care will be admitted with dementia; others will develop signs of cognitive decline during the time they live in our nursing homes. Staff need to understand what the functional implications are for the individuals they care for. Progression of neurocognitive disorders such as dementia also means that staff must be prepared to deal with end of life issues for these residents.

Occupational therapists are trained to fully assess the individual. Their scope also includes adult education principles so they are ideally suited to support staff at the bedside, who will ultimately be responsible for daily care.

Maximizing remaining strengths of persons with dementia can enhance quality of life and contribute meaningfully to restorative care programs. Fostering a measure of independence can contribute to reducing unwanted/undesirable behaviours for persons with cognitive decline. Being able to facilitate success in simple daily tasks can reduce frustration and enhance well-being.

Responsive behaviours

Many individuals with cognitive decline will demonstrate behaviours that are framed as 'responsive', meaning that the person is responding to something going on within or around him/her. It can be something negative or something that is confusing to the person. Determining what is causing the behavior can be a complex process. Understanding the person, his/her strengths and remaining abilities, being able to step back and examine the environment, as well as having a sense of who this person was, are all key components of a good behavioural assessment. Occupational therapists bring these assessment skills and foci to the LTCH Team.

Thorough assessment of the person (physically, cognitively & emotionally) as well as the environment (physical and social) is the first step in putting good behavior management plans in place. For persons with dementia, being uncomfortable can be the primary trigger for responsive behaviours. Properly seating someone who is losing mobility can increase their comfort, reduce pain, contribute to improved

⁵ Canadian Institute for Health Information, *Caring for Seniors with Alzheimer's Disease and Other Forms of Dementia*, August 2010.

⁶ Mitchell S, Teno J, Miller S, Mor V: *A national study of the location of death for older persons with dementia*. JAGS 2005, 53:299-305.)

continence and skin integrity. Individualized programming can enhance remaining abilities through meaningful engagement. One's ability to participate in activities within the home to the potential of their ability reinforces cognitive skills, provides for social interaction and, when activities are well matched to ability and prior interests, can provide meaningful enrichment of their lives.

OT versus OTA ... who does what, how do they work together

Occupational therapist assistants work under the supervision of occupational therapists to support their work with clients whose abilities to function and adapt have been impaired by illness or injury, mental health disorders, developmental disorders, social disabilities or aging.

Occupational therapy support personnel are not qualified occupational therapists but are individuals who have the job-related competencies to support occupational therapists in delivering occupational therapy services. The work of support personnel is supervised by an occupational therapist ([CAOT Position Statement Support Personnel in Occupational Therapy Services, 2011](#)). In Ontario, OT Assistants are educated within the Colleges of Applied Arts and Technology system and through a variety of private colleges. The OSOT has supported the [Occupational Therapist Assistant and Physiotherapy Assistant Program Standard](#), Ministry of

Training, Colleges and Universities, June 2008, which guides OTA and PTA programs offered through Ontario Colleges of Applied Arts and Technology.

Occupational therapists' work with support personnel in Ontario is guided by the following professional resources:

- [Practice Profile of Support Personnel in Occupational Therapy, 2009](#), Canadian Association of Occupational Therapists,
- [Support Personnel in Occupational Therapy Services \(2011\)](#), Position Statement of the Canadian Association of Occupational Therapists,
- [Standards for the Supervision of Support Personnel, 2011](#), College of Occupational Therapists of Ontario

Occupational therapist assistants may support occupational therapy service delivery in a variety of ways, including but not limited to:

- gather relevant materials in preparation for client treatment and education
- implement treatment plans designed by occupational therapists for individual clients and groups
- maintain and promote a positive attitude toward clients and their treatment programs
- help clients learn skills needed for daily living (self-care, productivity and leisure)

- help clients maintain or improve performance in moving, thinking and social-emotional areas
- assist in completing splints and creating or repairing assistive devices
- educate clients on the proper use of wheelchairs
- assist in educating clients regarding joint protection techniques and energy conservation
- lead or participate in treatment groups
- observe and document client behaviour, and report to the supervising therapist
- prepare, clean, maintain, adjust and make minor repairs to equipment
- maintain inventories, and order supplies and equipment
- schedule appointments and collect statistics
- support collaboration with the client, occupational therapist and inter-professional team.

Occupational Therapist Assistants (OTAs) have been a missing resource in service delivery models in Ontario long-term care homes because OT service levels have been so low that they have precluded realistic engagement of support personnel. An OT working in a home only 3

hours per week has neither time to assign OT components to an OTA nor reasonable capacity to supervise implementation of the assigned therapy components. Furthermore, recent service access restrictions imposed by physiotherapy providers, effectively restricted access to OT services to the provision of seating and mobility assessments for the purposes of seating system prescriptions. This is a component of OT intervention that would not be assigned to a support worker.

The potential to engage new service delivery models for OT services in LTC Homes provides an opportunity to consider the effective mix of professional and support personnel to meet service needs with high quality and efficiently delivered OT services.

Essential Determinants of Quality OT Services

Occupational therapy services for residents of long-term care homes may be delivered in a variety of models of practice and through various funding models. Service delivery models should be directed by and tailored to meet the needs of residents. The Ministry of Health and Long-Term Care has requested input and advice regarding service delivery models for occupational therapy in LTCHs. It is recognized that the primary goal for considering access to OT services in Ontario long-term care homes is to meet the needs of residents and to promote function and engagement in the activities of their daily living for as long as possible. To this end, efficient, effective occupational therapy service delivery models that can deliver quality care are critical.

Based on our review of evidence, including prevalence, as well as current and potential service delivery models, the Ontario Society of Occupational Therapists has identified the following factors as important determinants of quality occupational therapy services.

1. Recognition of the College of Occupational Therapy of Ontario Standards of Practice.

Ontario occupational therapists' regulated practice is directed by the standards of practice and guidelines of the College of Occupational Therapists of Ontario which works to both serve and protect the public interest with goals to assure competent, safe OT services for all Ontarians. Service delivery models must acknowledge implications of these standards on issues such as, assessment protocols, treatment follow-up, documentation, supervision of support personnel, managing conflict of interest, etc. The profession's standards are accessible at www.coto.org.

2. A reasonable ratio of OT hours to number of beds, consistent in each LTC home across the province that is determined in consultation with the profession.

While OTs have much to offer residents of long-term care homes and can impact outcomes relating to key provincial measures (ADL, falls, pressure sores, cognitive function, use of restraints), absence of a sufficient resource of OT service precludes meaningful contribution. This situation has been evidenced in the recent past when OT services were rationed by Designated Physiotherapy Clinic providers. OSOT notes from consultations with OTs in other Canadian provinces that the ratio of PT:resident and OT:resident is far closer than in the recent Ontario experience. The literature has supported the benefit of a ratio of 1:50 OT/resident beds.⁷ This is borne out in the CIHI data. Residents, the resident care team and the health care system should see value adding OT services. OSOT has recommended a ratio consistent to the PT ratio be considered for occupational therapy (ie. \$750/bed/year)

3. Service delivery and funding models that embrace an appropriate mix of professional OT and OT Assistant personnel.

Many components of OT treatment with complex residents require repetition, practice and supervision that is most effectively delivered by support personnel who are trained to work under the supervision of an OT to achieve OT treatment goals. Models that promote the collaborative work of OTs and OTAs can maximize the service reach of the profession and promote cost-efficiency and effectiveness of service delivery models. Utilization of OT support personnel is directed by professional standards relating to assignment of tasks, supervision, etc.

4. Consistency of OT personnel working within a home is assured to enable development of relationships with residents, staff and to promote consistency and continuity of approach and care.

The benefits of having dedicated occupational therapy staff working within a home are far reaching for the therapists, the resident, the home staff and the programs and services delivered. The engagement of multiple therapists on a per visit/referral basis prohibits the development of relationship, knowledge of home policy/procedure and day to day routines, the ability for OTs to be useful for more spontaneous requests, problems, etc.

⁷ Giesbrecht, EM; Morenson, WB; Miller, WC. (2012) Prevalence and facility level correlates of need for wheelchair seating assessment among long-term care residents. *Gerontology*, Volume 58 (4), 378-84.

5. A clear referral and/or re-referral process that is recorded on the resident's chart or care plan.

Accountability for service delivery must begin with clear referral processes that provide for accurate tracking of identified need for assessment/intervention. OSOT members working in LTC Homes presently identify a diversity of referral approaches many of which are verbal and seldom reported in the resident care plan.

6. Expectation, access and time allocated/compensated to provide an OT record on each resident's electronic chart, which documents all follow-up to a referral including assessment, OT Treatment goals, and progress notes of progress toward and achievement of those goals.

7. Regular and appropriate utilization of outcome measures and evaluation tools to accurately and objectively track and measure volume and outcomes of OT services provided.

Occupational therapy services provided in LTC Homes are poorly identified and measured in the present RAI-MDS (see Appendix III). Meaningful measures of volume utilization and achievement of treatment goals is both reasonable to expect and critical to validate the value of the OT interaction.

8. Expectation and capacity for completion of an OT initial assessment for each newly admitted resident.

Engagement of a restorative care approach in long-term care homes requires an effective baseline of staff and independent function and identification of potential for improved function in daily living skills within the home. This is best provided by an occupational therapist. Admission to a LTC Home may have the impact of de-stabilizing an individual's ability to function which should be addressed in a timely manner to assure the resident is enabled to be optimally engaged in self care and activity within safe limits. The OT's assessment enables not only the resident but also nursing staff and other program staff to engage collaboratively in the achievement and maintenance of a resident's optimal function.

9. Appropriate levels of funding to enable service delivery models that allow for OT referral to address changing resident status, enabling both the resident and staff to adjust/adapt to altered levels of function (e.g. Limited transfer skills following a fall, increasingly difficult responsive behaviours, feeding difficulties).

OSOT has positioned 3 types of resident need for OT services. It should be recognized that long-stay residents may have fluctuating or periodic needs for OT services. To address these intermittent needs for service to address/resolve problems or to re-engage function/participation after an episodic event, funding and service delivery models need to provide for such fluctuations in resident need.

10. Support of active participation of OT on the resident's Care Plan Team.

Interprofessional collaborative care is diminished when Team members are not engaged as active participants in the resident care plan team. OT participation in Team meetings, family meetings, etc. promotes integration of care, timely adjustment of care plans, etc. Models of service delivery that do not enable OTs to function as members of the care team, diminish the capacity of the therapist to provide services efficiently and to contribute effectively to interprofessional care.

11. Support of active participation of OT on home program committees for which OT has a professional contribution to bring – e.g. inclusion as a member of the Wound Care Committee, the Restorative Care Committee, Falls Prevention Committee, Restraint Reduction Committee, Responsive Behaviours/BSO team, etc.

This can be an effective way to maximize the contribution of the OT professional perspective to these important programmes which are intended to promote the home’s ability to prevent incidents and promote safe, person-focused care across the resident population.

12. Expectation and support for OT to be available as a professional resource to nursing home staff, residents, and their families, when appropriate.

Funding and service delivery models support efficient use of OT resources when they provide for opportunity for OT personnel to function as a resource to nursing home staff in addition to their resident-focused care. Use of an on-site resource to support staff development relating to OT related foci (e.g. transfer training, behaviour management strategies, use of assistive devices, seating & positioning, etc.), to provide patient/family education programs, and to support collaborative solutions-focused issue management are complementary services an OT can provide in addition to direct resident-focused care, when appropriately resourced.

13. Provision for space individual and/or group OT interventions within the facility.

Accommodation for treatment space for OT services must be addressed in funding/service models. A high percentage of an OT’s resident focused interventions can and should occur in the environment in which the resident needs to function (his/her room, dining room, washroom, activity room, etc.), however, this must be accommodated within nursing staff schedules, routine home timetables, etc. in order to be effective. Working space for OTs to address record keeping, indirect treatment (equipment researching, telephone contact, etc.) must be addressed.

14. Provision of a budget for equipment and supplies to provide a full scope of practice (ie. adaptive equipment, splinting materials).

OT equipment requirements in LTC Homes are typically not significant, however, resources for assessment wheelchairs and mobility devices, assistive devices, etc. as well as materials to support splinting, positioning, etc. must be accessible.

15. Compensation for professional occupational therapy services and support personnel are competitive and fairly recognize all direct and indirect care time.

The LTC Homes sector has had challenge in attracting and retaining professionals under the former service delivery model through DPCs. It is recognized that payment of OTs under this system came out of a clinic’s profits. OT services are most cost-effectively and efficiently delivered when the sector can attract and retain experience and expertise. Funding models that minimize the third party “middleman” can best ensure that limited resources are paid directly for OT services.

16. Opportunities for the OT to engage in continuing professional education.

Occupational therapists embrace a professional responsibility to maintain currency of practice

knowledge and competence. Funding and service delivery models need to accommodate reasonable expectation for support to such activity – funding support, leave time for supported activity, invitation to participate in home wide education programs, etc.

17. Support for and expectation of OT participation in the supervision of student OTs and OTAs completing clinical fieldwork in the long term care home.

The development of skills and expertise across health professions treating seniors and those in long-term care homes is a need identified in Ontario.⁸ Past funding models for OT have precluded the engagement of student fieldwork opportunities for OT students because OT hours were so limited. The absence of OTAs in the sector speaks for itself. Service delivery and funding models that are targeted to invest in the development of human resource and expertise in the sector will provide for the development of student fieldwork opportunities in the sector and the engagement of a LTCH's OT in fieldwork supervision. While there is a time demand for fieldwork supervision, this investment is often offset by the access to increased OT resource that student fieldwork brings to an organization.

Appendix III provides insights from occupational therapists who have worked in long-term care homes in the province and share experience and example of the unique working environment

that is a long-term care home. These perspectives highlight the importance of addressing determinants of quality occupational therapy services.

Models for Engaging OT Service

Key determinants for delivery of quality and timely occupational therapy services have been identified. OSOT would suggest that any service access model that addresses these determinants can be acceptable to the profession. This notwithstanding, a variety of service access/funding models exist and, at the Ministry's request, a review of these options is presented, identifying the strengths and potential limitations of each. The following options for service access have been considered:

- Employment model – OT and OTA personnel employed directly by the LTC Home
- Direct Contract model – OT and OTA personnel contracted directly by the LTC Home
- Contract with Service Provider Organization – LTC Home Contracts a Service Provider Organization to provide OT and OTA personnel
- CCAC provides OT and OTA personnel
- Family Health Team related to LTC Home provides access to OT and OTA personnel
- Seniors Expert Team funded by LTC Home or LHIN provides access to OT and OTA personnel

⁸ [Living Longer, Living Well](#), Report submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to Inform a Seniors Strategy for Ontario, Samir Sinha, December 2012

Employment Model

Description	
<p>Occupational Therapist(s) (OT) and Occupational Therapist Assistant(s) (OTA) are employed by the LTC Home through the operating budget. A dedicated OT budget assures access to service and accountability to provincial funding. Funding is determined based on the size and case mix of the home in relation to the approved OT Service Models as per approved MOH guidelines. Service accountabilities are clearly to the Home as are employee related accountabilities. As staff of the home, OT personnel are subject to all policy and procedure of the Home, serve the interests of the home and its residents.</p>	
Strengths of this Model	Limitations of this Model
<ul style="list-style-type: none"> • OT has consistent presence in the home functioning as an integrated member of the multi-disciplinary care Team • Operational processes such as electronic referrals & documentation are standardized & streamlined • Formal and informal relationship with staff and residents and their families is facilitated when viewed as part of the staff team • Role description can be driven by Homes needs and enable comprehensive utilization of the OT scope of practice. • Flexibility of use of OT resource is best supported by employment model • Participation on resident care program Committees such as Skin & Wound Care, Restraint Reduction, Responsive Behaviours, Contenance Care, Restorative Care, etc. can be built into role descriptions bringing expertise to this program work • Staffing model enables effective utilization of OT support personnel to effect efficient service delivery models • Appropriate resourcing of OT services in an employment model can facilitate staff training/education/consultation roles • OT personnel are compensated as employees with appropriate benefits, holidays, etc. – more competitive to other sectors. • OT personnel are afforded a sense of job security as an employee not as evident in contracted models • OT personnel are covered by LTCH WSIB • Stable employment option may lend to effective recruitment and retention of OT 	<ul style="list-style-type: none"> • LTC Homes manage OT human resources – hiring, orientation, performance review, etc. as with all other employees – some increase of demand in this regard • Coverage for vacations and sick time is limited assuming small numbers of OT personnel limiting potential for shared coverage – potential for some gap in service • Costs of this model tend to be perceived to be higher as a result of employer costs, benefits, etc. on top of salary. However, costs of contracted options should be comparable to accommodate payment in lieu of benefits, paid vacation, etc. • Employment models may be subject to union terms and conditions which may impact recruitment, termination, HR management flexibility

<p>personnel</p> <ul style="list-style-type: none"> • Home has control over employee selection, development and termination • Supervision of OT/OTA students is facilitated by employment model that supports clinical education 	
<p>Discussion</p> <p>An employment model for OT service access is deemed to best address the key determinants of quality OT service delivery identified by OSOT. OTs and OTAs employed in a home are truly integrated into the life and work of the home, engaging as full members of care teams, in program development for which they share ownership, interacting regularly and effectively with nursing staff to foster transference of therapy goals and achievements, etc. The capacity to work effectively with OT support personnel is an important attribute that is facilitated by this model. Employment models offer more security to professionals and are attractive for recruitment purposes. Present exemplars of employment models for OT service delivery provide evidence that staff can be flexibly deployed to meet the emergent needs of residents and staff, care plan meetings, program planning, etc.</p>	

Direct Contract Model

Description	
<p>Occupational Therapist(s) (OT) and Occupational Therapist Assistant(s) (OTA) are contracted by the LTC Home through the home’s operating budget. The contractual relationship exists between the home and the OT and/or OTA directly. A dedicated OT budget assures access to service and accountability to provincial funding. Funding is determined based on the size and case mix of the home in relation to the approved OT Service Models as per approved MOH guidelines. Service accountabilities are clearly defined in the contract, identifying the number of OT service hours to be provided and service expectations. OTs and OTAs function as independent contractors and provide services in the home as directed by a negotiated, time-bounded contract.</p>	
Strengths of this Model	Limitations of this Model
<ul style="list-style-type: none"> • Contractual engagement of OT personnel may reduce demand on LTCH human resource staff – hiring, benefits administration, etc. • Inviting proposals for contract staff promotes competitive bidding within a defined quality framework • Affords LTCH opportunity to recruit, select, orient and manage contracted provider(s) which can promote attention to team-building, fit and desired skillset. • Direct contract with service providers eliminates fees for service provider organizations – larger percentage of budget goes to direct service provision • Can assure consistent OT personnel who can 	<ul style="list-style-type: none"> • Contract negotiation and administration required annually • Less flexibility in use of OT resources than in employment model – contract defines focus of work • Hourly rates for OT personnel may be perceived high to accommodate compensation in lieu of benefits, WSIB coverage, etc. but this becomes essential to attract quality applicants • Private practitioner access to WSIB coverage is onerous and expensive • Level of engagement of contract staff in the “life” of the organization and its staff may be diminished.

<p>have longstanding relationship with home, residents and staff, and familiarity with policies, routines and schedules of the home</p> <ul style="list-style-type: none"> • OTs are regulated and practice to standards of practice which can guide contracting home in the event of concern re performance to contract expectations • Contract can provide for OT participation in resident care, program development, Committee participation, etc. to meet the needs of the home • Contract may require OT personnel to cover their own absences (vacation, sick time) minimizing the HR administration and loss of access that may be inherent in an employment model • Addresses situations where a small number of hours is required of OT personnel more cost-efficiently than employment model – e.g. enrolment in benefit program 	<ul style="list-style-type: none"> • Contracts of OTs and OT support personnel need to promote appropriate working relationships and accountability • Contracting OTs may have multiple contracts which limits flexibility of access or change in access over time. • Individual OT personnel are responsible for engaging their own professional development, quality assurance activities, etc. to meet professional standards and service quality expectations. • Access to OT services during periods of vacation or sick time may be at risk • Provisions for equipment and supplies to support OT interventions needs to be addressed in contract
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Discussion

Contractual models to engage OTs and OTAs directly can be structured to address most of the key determinants of quality OT service delivery identified by OSOT. Homes may identify a risk in having to supervise contracts but OTs are regulated health professionals and can be expected to perform to professional standards. Contracting directly with the OT provider eliminates costs associated with a health service provider organization but the services that may be provided for by these companies need to be addressed within the contract with an OT....e.g. clarifying how services to cover vacation/sick time may/may not be provided. OTs working in this model will expect a higher hourly rate than an employed OT to adjust for loss of benefits, vacation time, costs of independent practice. OTs working in this model have a high degree of identification with the home, key contract accountabilities with management as well as the care team. Contracts tend to structure roles more tightly than a role description of an employee so need to address fulsome scope of OT to ensure the fulsome benefit of the profession’s contribution is achieved.

Contract with Health Service Provider Organization

<p>Description</p> <p>Occupational Therapist(s) (OT) and Occupational Therapist Assistant(s) (OTA) are contracted by the LTC Home from an Health Service Provider (HSP) organization and funded through the home’s operating budget. A dedicated OT budget assures access to service and accountability to provincial funding. Funding is determined based on the size and case mix of the home in relation to the approved OT Service Models as per approved MOH guidelines. Service accountabilities are clearly defined in the contract, identifying the number of hours of OT service to be provided and service expectations. OTs and OTAs are contracted as independent contractors by an HSP who contracts to provide OT services to</p>

the home as defined by the contract. An HSP may provide only OT personnel or may be a multi-disciplinary provider who contracts a variety of professional services to the home. Services are contracted through a regular and transparent RFP process.

Strengths of this Model	Limitations of this Model
<ul style="list-style-type: none"> • Recruitment, contracting of, and management of contracts for OT personnel is the responsibility of the HSP minimizing demands on LTCH human resource staff • Inviting proposals for contract staff promotes competitive bidding within a defined quality framework • May allow LTC H to contract with a single provider for multiple professional/non-professional services minimizing contract management obligations. • Can assure consistent OT personnel who can have longstanding relationship with home, residents and staff, and familiarity with policies, routines and schedules of the home • Contract can provide for OT participation in resident care, program development, Committee participation, etc. to meet the needs of the home • HSP responsible to provide consistent coverage across all weeks of the contract term, covering vacation, sick time, etc. • HSP may be able to provide a variety of specific OT skillsets through its personnel resources to provide expertise to meet varied needs of the home • HSP provides orientation, supervision, professional development opportunities and performance/quality review services • Addresses situations where a small number of hours is required of OT personnel more cost-efficiently than employment model – e.g. enrolment in benefit program • May provide practice options for OT personnel – i.e. contract with HSP for work in a variety of practice settings • HSP provides opportunities for mentorship, professional development, clinical networking, support for dealing with difficult situations, etc. 	<ul style="list-style-type: none"> • Contract negotiation and administration required annually • Less flexibility in use of OT resources than in employment model – contract defines focus of work • Hourly rates for OT personnel may be perceived high to accommodate compensation in lieu of benefits, WSIB coverage, in addition to the HSP administrative services costs • Private practitioner access to WSIB coverage is onerous and expensive • Level of engagement of contract staff in the “life” of the organization and its staff may be diminished. • LTCH may not be aware of significant differences between the administrative support of various HPSs and focus on negotiating a lower hourly rate which could compromise the quality of OT service and administrative support. • Provisions for equipment and supplies to support OT interventions needs to be addressed in contract • HSPs have a history of negotiating inappropriately low rates for OT services which has seriously impacted the professional and the ability to attract and retain experienced therapists and LTC expertise • RFP processes can be expensive and may unintentionally rule out broader participation of smaller or not-for-profit therapy provider agencies or individuals

Discussion

Contractual models engaging OT service providers through a service provider organization can be structured to address most of the key determinants of quality OT services identified by OSOT. Past

experience of OTs engaged in homes through this model has provided evidence of the risks that can arise in this model – high percentage of hourly rate for OT service to HSP (e.g. 30%) without concomitant service for this fee resulting in less investment in direct OT services, HSPs have history of negotiating extremely low rates with professionals they contract. Provisions for transparency and guidelines for contracts could combat some of these pitfalls. Contracts tend to structure roles more tightly than a role description of an employee so need to address fulsome scope of OT to ensure the fulsome benefit of the profession’s contribution is achieved. It is expected that the hourly rate for OT services is highest in this model as the home would be paying for OT services (which would need to address an hourly rate to be competitive to an employment model) as well as the HSP services. There needs to be a clear value-add to engage an HSP versus contracting OTs directly.

CCAC provides OT and OTA Personnel

Description	
<p>Occupational Therapist(s) (OT) and Occupational Therapist Assistant(s) (OTA) services are accessed through the local CCAC. Eligible services and resident eligibility criteria is clearly defined and supported by the LHIN. Service commitments are covered by the CCAC budget. Service components and programs of care to be delivered by the CCAC are clearly defined. OT personnel are contracted to CCAC Health Service Providers who are contracted by the CCAC. OT services are accessed on a referral basis. CCAC OTs provide visit based services to meet needs of referred residents as per service contracts between the home and CCAC.</p>	
Strengths of this Model	Limitations of this Model
<ul style="list-style-type: none"> • No demand on LTCH to be providers of OT services – minimizes demand on LTCH • Budget allocation for OT services is outside of LTC Home 	<ul style="list-style-type: none"> • visit based service delivery model is expensive due to the time required to travel to see one resident and the resulting low number of clients that can be seen in a day. • Visit based service delivery model can be inefficient – e.g. if resident not available when OT visits, visit is not useful • Delays in access to OT services as a result of referral delays, determination of CCAC client priority, etc. • “single problem” referral based model limits access to OT service for flexible attention to resident needs • OT scope of practice becomes directed by referral, not resident need • OT interventions are provided in an episodic manner by different OTs with no follow-up of a resident’s a resident’s continuing need • Limitation of CCAC visits (e.g. 3 visits) precludes reasonable engagement in restorative therapy, complex seating/mobility assessment and

	<p>evaluation, etc.</p> <ul style="list-style-type: none"> • Visit limitations (e.g. 3 visits) restrict potential to assign OT treatment components to support personnel with supervision • CCAC visit limits may preclude flexibility to attend care conferences, family meetings, engage in follow-up to treatment interventions, etc • OT is not part of resident care team, opportunities to promote integration of care are minimized • OT resource is not accessed to support LTCH staff adjustment to resident changes in function, consult to program development, etc. • CCAC visit payment model does not cover documentation, indirect time to resource equipment prescription, consultation with other team members, etc. • CCAC documentation structures and expectations are not integrated with LTCH resident records
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Discussion

OSOT is not supportive of a CCAC delivered access to OT services. Disadvantages and weaknesses outweigh the potential strengths of this model. Past experience with CCAC delivered models have been fraught with low and fluctuating service levels that are at risk as CCACs cut services to manage annual budgets. A visit – based model is expensive and a significant barrier to quality, team based care which is critical to restorative care in LTCHs and minimizes opportunities for service efficiencies utilizing OT support personnel. Few of the key determinants of quality OT service delivery identified by OSOT are addressed effectively by this model.

Family Health Team or Geriatric Expert Team Delivered OT Services

<p>Description</p>	
<p>A future model might include OT services provided in a long-term care home through a Family Health Team or LHIN supported Geriatric Expert Team that is centred in the home or close by. A FHT servicing the primary care needs of the residents of a LTCH could employ an OT(s) to meet the identified needs of residents. Service allocation is determined based on the size and case mix of the home in relation to the approved OT Service Models as per approved MOH guidelines. A LHIN funded expert team might be situated in a LTCH and provide services to residents as well as to seniors with complex needs living in the community. Service allocation to the home would be Service allocation is determined based on the size and case mix of the home in relation to the approved OT Service Models as per approved MOH guidelines.</p>	
<p>Strengths of this Model</p>	<p>Limitations of this Model</p>
<ul style="list-style-type: none"> • Links primary care and ongoing care needs of 	<ul style="list-style-type: none"> • Additional rostered patients of FHT may

<p>residents in LTCHs</p> <ul style="list-style-type: none"> • Population focused model would be best realized with a Geriatric Expert Team • Depending on resource allocation, FHT/Expert Team OT can provide resource to complex seniors living in community in addition to LTCH – situates LTCH as hub of expertise for complex seniors care • Budget allocation for OT services is outside of LTC Home – LHIN funds FHT or Expert Team • Clear processes for referral/communication/charting, etc. would need to be addressed to marry two presently separate systems • Opportunity for focused interprofessional team • Can assure consistent OT personnel who can have longstanding relationship with home, residents and staff, and familiarity with policies, routines and schedules of the home • Recruitment, for OT personnel is the responsibility of the FHT/Team minimizing demands on LTCH human resource staff • OTs are employees of FHTs – job stability/security vs contract 	<ul style="list-style-type: none"> • distract attention from LTCH residents • Documentation systems of FHTs are not integrated with LTC Homes • Primary care sector salaries are below profession’s average – challenge to recruitment • Limits engagement of OT in LTCH program development, staff development, etc. unless these components are clearly identified in shared relationship • Teams do not presently exist in relationships with LTC Homes • 30 – 40 of nearly 200 Family Health Teams in the province presently have access to OT services.
<p>Discussion</p> <p>The integration of community focused services for seniors with complex needs and services for residents of LTC Homes is attractive to contemplate. It is not a present reality so this model of service access is difficult to project. Appropriately resourced, FHT or Geriatric Expert Team models could address many of the key determinants of quality OT service identified by OSOT. The advantage of dedicated teams of experts would be magnified in communities where smaller LTCHs might share access to expertise through a team. Provisions to ensure consistent OT presence to a consistent standard of care (hours of service, etc) within a LTCH would be important when a team that serves a broader community population. Teams situated within LTCHs that have community outreach services attracts team professionals with unique expertise and interest in addressing the needs of seniors and positions the LTCH as a community/regional resource.</p>	

In summary....

Evaluative data or outcome data for varied access models for OT service delivery in LTC Homes has not been available to the Society. OSOT has considered a number of OT service access options. Most present both strengths and limitations. The Society is prepared to support any access model that can meaningfully address determinants for quality OT service delivery identified on page 19.

Based on our analysis, service access through the Community Care Access Centre model is the only model that cannot be supported unless there is significant policy reform to enable alternative models of care through CCAC providers. A model of service access through a Family Health Team or Geriatric

Expert Team has interesting potential for the future but is not seen to be a reasonable option in the short term. These structures presently do not exist in relationship with LTC Homes.

Models that support access to OT services through external contracts, either directly with an OT or through a health service provider have many attractive features that may reduce administrative demands on homes. Structuring of contracts to assure appropriate service levels and to provide for integration of contracted staff into the care team, care planning meetings, program development and consultation roles would address many of the potential limitations. Occupational therapists express concern, based on past experience, that these models must

fairly compensate independent contractors (addressing payment in lieu of benefits, paid vacation, etc.) in order to maintain a competitive compensation model that will attract and retain professionals. Contracts with third party health service provider organizations must reflect the additional costs of utilization of the services of the HSP (e.g. staffing orientation/training, scheduling, payroll, etc.) above and beyond the cost of the OT service so as to ensure that these costs are not subtracted from the compensation level available for OT personnel.

An employment model of OT service access is identified as the preferred model. This model clearly situates a funding envelope for OT staff in the home and allows for the greatest flexibility and integration of OT services within the care team, special programs, etc. It also affords the most security and sense of engagement within the home for OT staff which are deemed important attributes of an access model to attract and retain staff. Most importantly, this model is deemed to have the most potential to deliver ready and appropriate OT supports for residents of long-term care homes when they need it.

Compensation of Occupational Therapy Personnel

Occupational therapists work across the health system. To promote the LTC Homes sector, compensation levels for OT personnel should be fair and competitive in order to attract competence and inspire the development and retention of expertise.

OSOT's annual compensation data reflects the most common hourly compensation level amongst employed occupational therapists is \$36 - \$42/hour (\$64,000 - \$75,000 / annum). Experienced OTs and those who bring additional skills to their work are generally compensated at higher levels. In addition, typical compensation packages include extended health benefits, paid vacation, statutory holidays, sick time, some professional development funding/time support, etc.

Occupational Therapy Assistants typically earn \$20 - \$25/hour.

While service access models may vary (employment versus contract), OSOT asserts that compensation rates be comparable and equitable across models. The hourly rate for the service will need to be adjusted for the service access model. For example, an independent contractor paid the same hourly rate as an employee is taking home considerably less (after business costs, self insurance, etc.) and an

OT contracted to a health service provider who takes a percentage of the OT rate could be taking home far less again. Transparent attention to compensation models is important.

Funding for OT services must recognize the need to compensate OT personnel for their time spent in both direct and indirect resident care. High levels of indirect time spent to support

direct interventions such as wheelchair assessment/prescription is typical amongst the LTC resident population and will include task such as family consultation, staff training, team meetings, contacting powers of attorney, etc. in addition to documentation and reporting requirements.

OT Service Delivery Models that make appropriate use of OT Support Personnel can maximize the investment of OT budget allocations. Appropriate use and supervision of support personnel is guided by standards and factors noted on page 17.

Determining Appropriate Ratios for OT/Beds

Access to OT services must be restored to support maintenance and improvement of residents' functional status and quality of life and to enable long-term care homes to more effectively achieve their mandate to deliver restorative care.

Notwithstanding the above assertion, OSOT positions that it is insufficient to restore OT services to levels provided by the DPCs prior to August 22, 2013. The unusual service provision model allowed to exist over the past 7 – 8 years has eroded access to OT services and reduced access to minimal levels. Review of CIHI data for Ontario LTC Homes in comparison to other jurisdictions in Canada reveals that the relative mix of physiotherapy, occupational therapy and speech language pathology vary considerably from other jurisdictions (Table 1). Occupational therapy services are reported to be received by less than 3% of residents in Ontario homes as compared to an average of 8.6 % in other provinces. On the other hand, physiotherapy services have been received by over 80% of Ontario residents of LTCHs compared to an average of 11.2% in other provinces. Clearly the balance of OT, PT and SLP services needs to be addressed. Residents of Ontario's long-term care homes have diminished access to services needed to optimize their functioning and quality of life.

Table 1 - Therapy Utilization 2011 – 20132 (CIHI)

Therapies	Assessed Residents Receiving Therapies ≥15 Minutes within 7 Days of Assessment				Relative Mix of Therapy Services by Setting and Jurisdiction		
	CCC - Ontario	LTC - Ontario	LTC - Other Provinces		CCC - Ontario	LTC - Ontario	LTC - Other Provinces
	%	N	%	%	%	%	%
Speech	15.2	392	0.4	0.3	7.2	0.4	0.6
Occupational	62.4	3,079	3.0	8.6	29.4	3.2	20.0
Physical	73.3	81,320	80.4	11.2	34.5	85.2	26.2
Respiratory	10.5	839	0.8	0.4	4.9	0.9	0.9
Psychological	14.6	1,463	1.4	0.4	6.9	1.5	1.0
Recreational	36.5	8,355	8.3	22.0	17.2	8.8	51.3
TOTAL (N)	(19,352)	(101,112)		(37,035)	100	100	100

Note: Duration and intensity of therapies varies by sector and jurisdiction. Rates are based on residents who were assessed with the RAI-MDS 2.0© assessment instrument in 2011–2012 and received a minimum of 15 minutes of therapy at least once in the seven days prior to the assessment.

Source: Continuing Care Reporting System, 2011–2012, Canadian Institute for Health Information.

Ontario utilization data is collected through the RAI-MDS 2.0. OSOT has identified to the MOHLTC concerns about the accuracy of the OT data this tool reflects. A number of limitations relating to the tool’s sensitivity in accurately reflecting time-bounded episodic care, interventions that take less than 15 minutes, and assessment or indirect treatment time which are integral elements of OT service, result, in our opinion, in an under-representation of even the limited time afforded by the DPCs and the value that occupational therapy services contribute to residents of long-term care homes. OSOT has made previous representations to the MOHLTC regarding the limitations of the RAI-MDS 2.0 as a meaningful measurement for OT – see Appendix III. These inaccuracies of utilization data compound our assertion that funding for OT services must extend to serve beyond the 3% of residents identified in current measurement data.

In the absence of good provincial data, the Society has looked to other provinces for insights. Consultation with provincial service providers in Alberta and Manitoba identify that where funding models provide for a single budget for OT and PT, it is not uncommon for Homes to allocate a higher percentage of the budget for occupational therapy which is perceived to have a greater relevance and value to residents and the health and safety outcomes homes strive to deliver. Indeed, even the CIHI data reflected in Table 1 identifies that across the country the relative mix of therapy services places OT and PT significantly closer together than in Ontario. These reports give some basis of assumption that building a funding model based on a bed:OT ratio that is close or the same to that of physiotherapy is not unreasonable.

OSOT proposes that occupational therapy be funded to an equivalent level to physiotherapy in Ontario long-term care homes. A budgetary allocation of \$750 per bed per year (\$2.05/bed/day) would allow homes and occupational therapists to engage appropriate and individualized services for residents with need over the course of a year, recognizing that needs may vary over the course of the year and that within the case mix resident need will vary from minimal OT requirement to complex need.

An allocation of \$750/bed/year would provide homes the capacity to secure OT services in a cost effective human resource mix that has not been feasible in present day minimal hour contracts. Occupational therapists would be able to extend the reach of their services in cost efficient models utilizing OT support personnel, home appropriate mixes of full and part time staffing, etc. A home of 200 beds, for example, could consider a full or part time OT and up to 2 OT assistants. This is consistent with reports of staffing ratios we have accessed in Manitoba and Alberta. The potential for an OT to add *real* value by being in the home each day (as opposed to a few hours each week) is a significant return for the investment of such funding.

The results of an Alberta study⁹ explored the outcomes relating to enhancing access to OT and PT in a 200 bed long-term care facility to a ratio of 1:50 beds. Results showed that enhanced OT/PT services were more effective at promoting, maintaining or limiting decline in functional status at 6, 12 and 18 months compared to a control group that had a ratio of 1: 200. Specifically, residents in the enhanced group performed better on self-care tasks (e.g. feeding, grooming, bathing, dressing, toileting) mobility, communication, cognition and psychosocial adjustment. As well, even though the PT/OT costs were 4 times higher for the enhanced group than the control group, a cost analysis suggests that the enhanced group required less caregiver involvement and less overall care delivery resources – at a cost savings of \$283 per bed per year. While this is but an example, it gives good rationale for clearly targeting for a reasonable access to occupational therapy services for those residents deemed to have need.

Conclusion

Ontario's long-term care resident is promised access to necessary occupational therapy services. Across the province today, access to OT services is at best scarce and often absent in homes. Attention to the re-establishment of OT services in LTCHs since the August 2013 PT Funding changes has been slow and stymied to date. The Ministry of Health and Long-Term Care has requested of the Ontario Society of Occupational Therapists identification of those residents that can benefit from OT service and interventions and has requested input and recommendations for service delivery models for occupational therapy.

OSOT has identified 3 types of resident need that can be effectively addressed by appropriately resourced OT services in a home and has presented the unique perspective and range of services occupational therapist provide to address resident needs and potentials and to support the goals and work of the resident care team.

OSOT has reviewed 6 service delivery options for occupational therapy services in long-term care homes, identifying pros and cons of each model. A listing of key determinants for the delivery of quality

⁹ Przybylski, B.R., Dumont, D., Watkins, M.E., Warren, S.A., Beaulne, A.P & Lier, D.A. (1996). Outcomes of enhanced physical and occupational therapy service in a nursing home setting. *Archives of Physical Medicine and Rehabilitation*, 77, pp. 554-561

occupational therapy services provides insight to factors that must necessarily be explored in determining best options for service delivery. The Society identifies that an employment model with a designated funding base meets the most criteria for effective service delivery.

OSOT has identified a need for critical review of ratios of OT service to resident beds as a component of the exploration of service delivery models. Current RAI-MDS is faulty in relaying the true utilization of OT in Ontario homes (prior to August 2013 and at present) and nation-wide and international data would suggest more equalized ratios of OT and PT need to be considered.

Occupational therapists are vested in providing quality services in long-term care homes and expect to see their services measured for impact on the quality indicators on which long-term care homes are measured. The profession believes it can contribute significantly to components of *Function, Safety and Quality of Life* indicators, enabling homes to more effectively reach performance targets. And most importantly, to give indication that residents of long-term care homes are accessing the services and supports that they need and are able to experience a quality of life that engages their strengths and capabilities in ways that are meaningful to them.

Appendix I

Occupational Therapy Mobility and Seating Assessments, Components & Timeframes

Occupational therapists (OTs) play a significant role in the assessment for and prescription of seating and mobility devices and systems for residents in Ontario’s long-term care homes when their comprehensive assessment of the resident identifies such need. Most OTs working in this sector are “Authorizers” registered with the province’s Assistive Devices Program Mobility Devices Program. Occupational therapists are ideally suited to conduct mobility and/or seating assessments for the residents of long-term care homes. An OT’s mobility assessment will address not only the physical needs of the resident but also factors that relate to seating and mobility solutions including; cognitive function, responsive behaviours, independence in activities of daily living, and environmental accessibility factors and considers the impact of seating systems on transfers and nursing care. These considerations contribute to quality outcomes.

The following table identifies key components of the OT’s Mobility and/or Seating Assessment and identifies an average time required for each component. A total of 3 – 4.25 hours/assessment is a projected average for a typical, uncomplicated Mobility and/or Seating Assessment for a walker or wheelchair from start to finish. While OTs identify that many assessments can be accomplished in this timeframe, assessment of residents who present complex physical/functional impairments which require that a prescription accommodate physical deformities, specific ADL concerns/needs (toileting, feeding), specific environmental needs, etc. will require more time and visits.

Occupational Therapy Seating and Mobility Assessment	Estimated Time (min)
Acquiring Consent <ul style="list-style-type: none">• Initial contact with client/Power of Attorney(POA)• Explanation of OT role and responsibility• Explanation of client role and responsibility• Brief review of ADP eligibility criteria• Initial assessment scheduled as a joint visit if POA is available.	15

<p>Initial assessment</p> <ul style="list-style-type: none"> • Review of consent forms <ul style="list-style-type: none"> ○ OT role and professional responsibilities, confidentiality ○ Client role and responsibilities ○ Goal of intervention ○ Reason for referral ○ Expected outcome with benefits and risks ○ Review of systematic assessment approach • Review of ADP eligibility criteria and Vendor Choice if ADP application is required. • Completion of Occupational Therapy Functional Assessment Form • Discussion with client and/or POA clinical observations, clinical reasoning and intervention plan • OT to order necessary equipment for trial 	<p>70 to 90</p>
<p>Equipment delivery, set-up and trial</p> <ul style="list-style-type: none"> • Joint visit will be conducted by vendor and OT. • The vendor is expected to deliver and set-up the equipment for trial. • The client is expected to trial the equipment within a time frame mutually agreed upon between the client, the vendor and the OT. • Time frame of equipment trial can range from 1 week to several months depending on the complexity of the client’s seating. 	<p>30 – 60</p> <p>Or more depending upon length of trial</p>
<p>Follow Up(s)</p> <ul style="list-style-type: none"> • The OT will follow-up and monitor the client’s seating once the equipment has been delivered. • The OT will collaborate with the client/POA and the vendor regarding the appropriateness of the equipment and whether any modifications have to be made. • This process continues until the client’s seating and mobility goals have been reached. • The OT will review if the goals of the intervention plan were not achieved • Elderly clients, especially those with neurodegenerative diseases or other progressive illnesses, will have changes in their condition over time that may warrant seating modifications. Regular access to OT will be important in order to identify these changes and address them in a timely manner. • If the OT is regularly on site, multiple follow-ups will typically require less time as a result of familiarity with the resident, the home, communication processes, etc. 	<p>35 – 45</p> <p>Or more depending on the complexity of the seating and mobility goals.</p>

<p>Discharge process</p> <ul style="list-style-type: none"> • The equipment delivery will be completed by the vendor once the client agrees that the recommended equipment meets their needs and once the client has endorsed the “Confirmation of Delivery” form confirming that the equipment is satisfactory and that the OT’s intervention plan has been successfully accomplished • The ADP application form is signed by the client/POA • The OT completes the ADP application form • The ADP application form is mailed by the OT 	<p>30 – 45</p>
<p>Mobility Goals & Outcomes Evaluated</p> <ul style="list-style-type: none"> • The client is safe with independent ambulation and indoor/outdoor mobility; independent or assisted mobility in a wheelchair • The client has increased sitting tolerance • The client has decreased fatigue and is able to participate in ADL’s • The client has improved (or maintained) skin integrity • The client has improved postural support and a more functional position when sitting in the wheelchair, including accommodation of kyphosis, corrective or accommodative support for physical deformities due to contracture, increased or decreased muscle tone, etc. 	
<p style="text-align: right;">Total</p>	<p>3 – 4.25 hr</p> <p>In addition to any extended trial times, etc.</p>

Appendix II

OSOT Positions on Inadequacies of the RAI

Occupational Therapy concerns re. RAI-MDS data and coding in Ontario Long-Term Care Homes

June 2013

The issue...

The Ministry of Health and Long-Term Care reports that current RAI-MDS data reflects that within Ontario Long-Term Care Homes less than 5% of residents are receiving occupational therapy services. This data provides the only formal indicator of utilization of OT in LTC Homes and may be used to project funding required to support access to OT services after the Physiotherapy Funding Reform initiative is implemented. These figures are concerning to occupational therapists for a number of reasons;

- The RAI-MDS data does not reflect the anecdotal experience of OTs working in LTC Homes who know that they see more than 5% of the residents in the homes that they serve.
- RAI-MDS data does not capture a true picture of OT services currently delivered in Ontario long-term care homes because of the manner in which data is collected and limitations imposed by the data collection systems for the RAI-MDS.
- Measurement and use of the what OT services are currently provided LTC Homes as an indicator of what is needed is inappropriate because the current service delivery model is a supply directed model as opposed to a more appropriate needs based model. Designated Physiotherapy Clinics (DPCs) that provide OT services without charge impose significant limitations on the provision of OT services. It is the position of the Ontario Society of Occupational Therapists that this results in an under-utilization of OT services as compared to resident need.

Recommendations...

1. MOHLTC meet with OSOT and CIHI to discuss utilization of RAI-MDS in Ontario LTC Homes as a measure of OT utilization in order to identify issues and potential solutions.

2. MOHLTC undertake a jurisdictional review of utilization levels of OTs in other Canadian provinces or international jurisdictions.
3. MOHLTC explore the feasibility of alternative funding models to OT to allow for the short term transition to program based funding through the PSS budgets of the homes and allowing for a more appropriate determination of need for OT services in LTC Homes.
4. MOHLTC explore the feasibility of piloting an alternate funding model for OT in designated LTC Homes across the province which would enable Homes to secure OT services under contract on the basis of a ratio of OT services/bed. These pilot sites could contribute to evaluation of need and impact of OT services in Ontario LTC Homes.

Background

Implementation of the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0) was initiated in the province of Ontario in June 2005 to improve the care of residents in LTC homes by standardizing the assessment and care planning process. RAI-MDS is a system that aims to gather definitive information on resident care, focusing on a resident’s strength, abilities and preferences. It recognizes the additional elements of care that can improve the resident’s quality of life and enables measurement of all care activities as often as an assessment is undertaken. It is intended to assist healthcare providers in developing individualized care plans. As of September 2009, all Ontario LTC Homes converted to use the RAI-MDS. The RAI MDS is completed for each resident upon admission and thereafter quarterly and annually or when a resident experiences significant change in health status.

In recent years, occupational therapy services provided to residents in Ontario long-term care homes have been delivered by Designated Physiotherapy Clinics who have contracts to deliver OHIP funded physiotherapy services in the home. Occupational therapy services have been offered to homes without charge, as a value add service to their physiotherapy contract. Prior to the emergence of this practice (which OSOT had reported to the Ministry of Health as early as 2009), OTs were largely contracted directly or employed by long-term care homes. Some CCACs provided OT services in some communities.

Under the auspices of the DPC, the OT role has become effectively consultative and generally restricted to periodic interactions with residents to address episodic issues such as mobility needs or pressure relief. OTs are not involved in initial assessments (or subsequent formal reassessments) of residents and are seldom identified on the resident’s care plan. Many OTs are present in homes less than 1 day per week because this is the maximum number of hours for which the contracting DPC will engage their services.

Challenges to capturing accurate data for OT utilization in long-term care homes

with the RAI-MDS

OSOT asserts that data retrieved from the RAI-MDS relating to OT utilization is suspect for the following reasons:

- I. **RAI-MDS arbitrarily sets a treatment time as being valid only if it is 15 minutes or longer.** In the current service delivery model for OT in Ontario LTC Homes, this requirement is problematic for the profession of occupational therapy.
 - a) As a result of current service delivery models, large caseloads and the consultative nature of Occupational Therapy LTC practice (impacted by limited funding), treatments (direct time) are often, of necessity, short in order to allow the OT to treat as many residents as possible in a workday (usually one day or less per Nursing Home per week) and to spend the time for necessary indirect and non-resident time tasks.
 - b) The College of Occupational Therapists of Ontario states that it is the responsibility of the Occupational Therapist to determine the appropriate length of each treatment. Because of the physical, cognitive or behavioural limitations of LTC clients, it is often inappropriate to attempt to treat a resident for 15 minutes or more.

The arbitrary 15 minute treatment time that RAI-MDS demands, leaves an OT with no choice but to code treatments that lasted 0-14 minutes as, for example, “0” visits “10” minutes; which likely does not register as one valid treatment.

- II. **RAI-MDS does not allow for the collection of data related to indirect treatment time**
Notwithstanding the RAI-MDS may not well capture the current OT interventions occurring with residents, it also does not capture (by intent) the indirect treatment time spent without a resident present but necessary to the accomplishment of treatment goals and outcomes.

Required indirect OT treatment includes:

- Documentation,
- Communication with Power of Attorney or Substitute Decision Maker for informed consent regarding treatment and equipment trials and costs (e.g. wheelchairs, seating, walkers, splints, adaptive aids); discussion of ADP program and funding; vendor choice,
- Communications with vendors regarding equipment
- Completion of Assistive Devices Program forms (30 minutes to 1 hour)
- Exploring, advocating, and accessing supplementary or extended health funding for equipment (i.e. the 25% client cost for wheelchairs, orthopedic shoes, splints not covered by ADP)

- Communication with the team members to facilitate integration of treatment goals/accomplishments into restorative care approach

These activities are not recorded as occupational therapy activities even though they are critical to the accomplishment of treatment goals and outcomes and utilize OT hours.

II. **Because of the episodic and consultative nature of Occupational Therapy in LTC, RAIMDS does not reliably record direct OT treatments during the quarterly reviews.**

The list of residents reviewed in any of the 13 weeks of each quarter does not necessarily correspond to any of the residents that an OT may treat during their workday. (usually 7 hours or less (one day or less per nursing home) each week) An OT may see 20 clients in a 7 hour day at one LTC home but find that not one of them is on the list for the 7 day Observation period that week.

By way of another example, an OT may have treated a client during one week, spending 45 minutes adjusting a wheelchair. During the next week the resident did not receive OT treatment while waiting for additional equipment to arrive. This week may have been the Observation Period. The following week the resident may receive 30 minutes treatment when the equipment arrives and is adjusted. In this case, measurement for the quarter will “incorrectly” identify through the RAI-MDS stats record that the resident has not received any OT treatment during the entire quarter.

Current Service Delivery Models do not support representation of actual need for OT Services

In most LTC Homes in Ontario, access to OT services has been brokered as a value-add service by a physiotherapy service provider. Providing OT services without cost to homes has resulted in a supply driven model of OT service delivery to homes rather than one driven by need. Many OTs working in homes report that OT referrals are not documented in the Plan of Care.

Volumes of OT work are driven by the PT service provider who, without compensation for this service, sets limits on the amount of time OTs may be contracted for. OSOT believes these limits are artificially low. OTs report that while visiting a home (often related to an ADP authorization referral), the volume of informal verbal referrals and requests for resident attention is significant. While therapists may attempt to address these requests they are limited in the number of hours that they can spend in the home and this often results in the short consultative resident visits described above. If LCTHs funded OT that was required and these referrals were documented in the plan of care, visibility of the profession’s need and utility would look different.

A recent OSOT survey identified that over 65% of referrals for OT services in long-term care homes were to address ADP seating and mobility assessments. While this survey did not

capture data from every OT working in LTCHs, the message is compelling. Of the OT services captured in the present RAI-MDS data (quantified as serving 3% of residents), the majority is focused on this one unique aspect of OT intervention. OSOT positions that occupational therapists should be engaged in long-term care homes to address a variety of resident needs including; ADL and restorative care assessments and training, dementia care and support to management of responsive behaviours, restraint reduction, falls prevention, pressure and wound prevention and management, staff support, etc. Limitations in the amount or number of hours of OT services that DPCs have been willing to provide without cost to LTC Homes has restricted utilization and visibility of OT for these services.

Appendix III

Insights into the Idiosyncratic factors relating to the provision of OT services in LTC Homes

The following insights are offered by experienced OTs who have worked in long-term care homes and are offered to lend perspective to some of the recommendations and challenges relating to occupational therapy service delivery in homes.

Providing OT services in a LTC facility is extremely different than providing OT services in a clinic setting or an acute care setting.

- **The LTC facility is a resident's home and a resident's function within his home is a paramount consideration;** any OT interaction has to occur within the framework of the resident living in his home. This is typically a cultural requirement of the LTC facility, but also often a functional requirement for a resident, as disruption of routine can be very disturbing to a resident with dementia and may result in agitation, distress, or exacerbation of behaviours. OT assessment/Rx is best performed at the convenience of the resident and staff, with consideration that a resident's involvement in programs within the LTC facility is not disrupted.
- **Referrals for OT services assessment/Rx are often problem-oriented and may come from the physician, nursing, multidisciplinary team members, the resident and family.** When OT services are not effectively resourced with a home, it is likely impossible for OTs to perform comprehensive, holistic admission assessments.
- **OT services in LTC are performed at bedside because there is usually no Therapy room, especially in older LTC facilities.** Considerable indirect time is spent moving through the LTC facility to locate residents, move them into private areas for assessment/Rx and attempting to access residents at times when they are available and willing to be assessed/Rx'ed (ie. waiting for a resident to be toileted, or returning afterwards, etc.). In current service provision models, OTs do not have support staff to assist in the time and cost effective transport of residents to the OT. **It takes time to bring the OT to the resident rather than bringing the resident to the OT, as in a clinic model.**
- **Scheduling of Therapy Interventions is challenging in the residential environment.** Mealtimes are structured and unless the OT is involved in assessment/Rx of a resident's feeding skills, residents are typically not to be disturbed at mealtimes. Feeding assessment/Rx is best scheduled during established mealtimes and is not easily done at other times. This is problematic when an OTs presence in the home is limited to specific hours and can result in long delays to access of important solution focused services.

Many residents rest/sleep in bed after lunch and therefore, are unavailable for assessment/Rx of mobility and seating, transfers, toileting, wheelchair mobility, and ADL tasks such as dressing,

hygiene. Therefore the most functional time to have direct access to LTC residents for assessment/Rx is the few hours between the end of breakfast and before lunch; typically from 9am-1pm. The time in the morning before breakfast is a very task oriented time for nursing, when PSWs are washing, toileting, dressing and transferring residents in preparation for breakfast. This morning time is the most functional time to assess and treat dressing and hygiene skills, but typically because of the business of the PSWs and their 8:1 to 15:1 ratios of care, OT interventions with respect to ADL have to be negotiated in advance to avoid antagonizing nursing staff.

To effectively manage time and provide as much OT service as possible, **an OT typically assesses/treats directly as many residents as possible in the 3-4 available morning hours.** The afternoons, when residents are less accessible, are spent performing indirect treatment components; charting, calls to vendors and Power of Attorneys, consultation with staff, etc. For example, in a 7 hour day, 20-25 residents may be assessed/treated/followed and require **approximately 4 hours direct time and approximately 3 hours indirect time.**

OTs performing comprehensive seating and mobility assessment/Rx's (re. ADP and non-ADP) usually have to schedule time to spend with the Equipment Vendor Sales Reps to review, request, adjust, prescribe equipment. This typically also falls within the morning hours available for assessment/treatment and reflects many of the previously mentioned residents assessed/treated in the mornings.

An OT's participation in Care Conferences, Committee meetings, etc. may fall in prime treatment periods resulting in an unretrievable loss of active assessment/treatment time that day.

- **OTs report that in a typical 180 bed LTC facility, there may be between 6-10 new problem-based referrals each week in the current (recent past) system.** Based on the experience of access and use of OT services delivered through Designated Physiotherapy Clinics, approximately 60% of referrals are for seating and mobility (ADP) needs assessment/Rx (as the device addresses mobility, safety, positioning, pressure relief, fall prevention issues) and approximately 40% may be about other issues concerning existing mobility and seating devices and ADL tasks (feeding, toileting, transfers, dressing), safety, pressure relief, and falls prevention, etc. Typically, 1-2 of the referrals are developed on the day of the OT visit due to acute resident's needs; acute dysfunction, falls, behaviours, etc. OTs note that referral for use of OTs for functional restoration, modification of ADL levels, etc. has been restricted by the limited parameters for referral to DPC provided OT services.
- **OT's often struggle to have access to a computer and phone to perform the necessary indirect tasks such as charting on the electronic record, and making often lengthy calls to Power of Attorneys, etc.**
- **Existing models of access to OT services do not allow OT's the option of supervising OTA's to provide assigned treatment components.**

The only way that an OT can effectively assess/Rx/follow 20-25 residents in 7 hour day is to have an OT onsite, who has the flexibility to access residents when they are available. A CCAC model of single problem referred OT visits cannot provide this flexibility and responsiveness to residents' needs within the culture and framework of the functioning of a LTC facility.

Appendix IV

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