Allocation of Rehabilitation Services for Older Adults in the Ontario Home Care System

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ABSTRACT

Background: Physiotherapy and occupational therapy services can play a critical role in maintaining or improving the physical functioning, quality of life, and overall independence of older home care clients. Despite their importance, however, there is limited understanding of the factors that influence how rehabilitation services are allocated to older home care clients. The aim of this pilot study was to develop a preliminary understanding of the factors that influence decisions to allocate rehabilitation therapy services to older clients in the Ontario home care system, as perceived by three stakeholder groups.

Methods: Semi-structured interviews were conducted with 10 key informants from three stakeholder groups: case managers, service providers, and health system policymakers. **Results:** Drivers of the allocation of occupational therapy and physiotherapy for older adults included functional needs and postoperative care. Participants identified challenges in providing home care rehabilitation to older adults, including impaired cognition and limited capacity in the home care system. **Conclusions:** Considering the changing demands for home care services, knowledge of current practices across the home care system can inform efforts to optimize rehabilitation services for the growing number of older adults. Further research is needed to advance the understanding of, and optimize rehabilitation service allocation to, older frail clients with multiple morbidities. Developing novel decision-support mechanisms and standardized clinical care pathways for older client populations may be beneficial.

Key Words: delivery of health care; geriatrics; home care services; occupational therapy; rehabilitation.

RÉSUMÉ

Contexte : les services de physiothérapie et d'ergothérapie peuvent jouer un rôle essentiel dans le maintien ou l'amélioration du fonctionnement physique, de la qualité de vie et de l'autonomie des personnes âgées recevant des soins à domicile. Or, malgré l'importance des services de réadaptation à domicile, les facteurs qui influencent leur attribution auprès de cette clientèle sont mal connus. Cette étude pilote visait à mieux comprendre les facteurs qui influencent les décisions concernant l'attribution de services de réadaptation auprès des clients âgés au sein du système de soins à domicile de l'Ontario, tels que perçus par trois groupes d'intervenants. **Méthodes :** nous avons réalisé des entrevues semi-dirigées auprès de 10 informateurs-clés appartenant à trois groupes d'intervenants : des gestionnaires de cas, des fournisseurs de services et des responsables des politiques au sein du système de santé. **Résultats :** les facteurs influençant l'attribution des services d'ergothérapie et de physiothérapie aux personnes âgées comprenaient les besoins fonctionnels et les soins postopératoires. Les participants ont relevé les défis que pose la prestation des soins de réadaptation à domicile aux clients âgés, tels que l'altération de la fonction cognitive des clients et la capacité limitée du système de soins à domicile. **Conclusion :** compte tenu de l'évolution de la demande pour les soins à domicile, une bonne connaissance des pratiques actuelles à travers tout le système de soins à domicile peut guider les efforts visant à optimiser les services de réadaptation pour le nombre croissant de personnes âgées. Il faudrait approfondir les recherches afin de mieux comprendre la clientèle âgée frêle et multimorbide et d'optimiser l'attribution des services de réadaptation. Il pourrait y avoir lieu de mettre au point des mécanismes de soutien à la prise de décision et des plans de traitement normalisés pour les clients âgés.

The home health care system in Ontario provides an assortment of services to a large number of individuals in home settings. In 2013–2014, it provided 699,000 clients with 38 million hours of a variety of therapeutic and support services, including nursing, homemaking, meal delivery, transportation, physiotherapy, and occupational therapy; the majority (56%) of the clients were

aged 65 years or older.¹ The province's health care systems have been regionally organized into 14 Local Health Integration Networks (LHINs) to allow each geographic region to plan and fund their health services and integrate them into their own communities. In each LHIN, Community Care Access Centres (CCACs) work as a single entry point for persons requiring home care

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services. Case managers at the CCAC determine who is eligible for home care services, then arrange for health care providers—nurses, physiotherapists, social workers, registered dietitians, occupational therapists, speech therapists, and personal support workers—to provide the necessary care and support services.

Rehabilitation therapy services in home care systems can help older adults improve or maintain their physical functioning, quality of life, and overall independence—all of which can extend the time that they are able to remain in their communities and out of hospitals and long-term-care homes.^{2,3} Research has demonstrated that rehabilitation services provided in home-based settings, including occupational therapy and physiotherapy, can achieve health outcomes for older persons that are similar to or better than those achieved by inpatient services.^{4–12}

Despite this evidence, however, older home care clients who could benefit from rehabilitation services do not necessarily receive them. In Ontario, Hirdes and colleagues¹³ found that more than two-thirds of older home care clients who were assessed as having rehabilitation potential were not provided with occupational therapy or physiotherapy. Moreover, investigators have found substantial disparities in the allocation of rehabilitation therapies^{14,15} and home care¹⁶ across the 14 health regions in Ontario. Unfortunately, decisions related to the frequency and volume of rehabilitation services in home care are often constrained by economic factors and not always determined solely by a client's actual or perceived needs.¹⁷ Standardized care processes, also known as care pathways, have been developed in Ontario to define best practices or essential care components for a few specific client populations (e.g., those recovering from hip or knee surgery).¹⁸ However, for other client populations, such care pathways have yet to be developed.

Because the population is aging and the associated chronic conditions and disabilities are increasing, the demand for rehabilitation services is expected to rise.¹⁹ The growing importance of rehabilitation services for this aging population has created a need to know more about how these services are allocated to older adults to modify the home care system to meet their changing needs. The aim of this qualitative pilot study was to develop a preliminary understanding of the factors that influence how rehabilitation therapy services are allocated to older clients in the Ontario home care system.

METHODS

Design overview

On the basis of the interpretivist paradigm,²⁰ this qualitative study used one-on-one, semi-structured interviews with stakeholder groups in the Ontario home care system. Ethics clearance for this study was obtained from the University of Waterloo's Office of Research Ethics.

Before each interview, participants were briefed on the purpose of the study, the presence of a digital recorder, and their right to withdraw participation or data at any time. Furthermore, all participants were advised of the confidentiality and anonymity of their responses.

Participants

A stratified purposeful sampling approach²¹ was used to select participants for the study from three stakeholder groups: (1) CCAC case managers, (2) service providers, and (3) health system policymakers. The case manager stratum was chosen because of its role in decision making. In the Ontario system, CCAC case managers (also known as care coordinators) are responsible for making all decisions related to the allocation of services for home care clients. The second stratum included employees of rehabilitation service provider organizations—that is, occupational therapists and physiotherapists providing therapy services to home care clients. The third stratum included policymakers from provincial and regional health authorities, who have a systems perspective on home care in Ontario and who may be involved in setting home care policies and funding levels. Individual participants were recruited by means of a standardized email message from the lead author and through an announcement in a research group newsletter. Participants for the study were selected from major urban centres and from health regions that provide both urban and rural services.

Data collection and data analysis

Before the interviews took place, all participants provided informed consent. Semi-structured interviews took place both face to face and by telephone. Each interview was 1–2 hours long and was digitally recorded for transcription purposes. All interviews were conducted by the first author and took place in English. An interview guide (see Appendix 1) consisting of open-ended questions was used to facilitate the discussions between the interviewer and each participant.

All interview data were examined using a framework analysis approach.²² Framework analysis was chosen because it is well suited for applied research projects that include specific a priori questions and topics and a purposeful sample.²² In this type of analysis, interview data are analyzed and categorized into key issues and themes using five steps: (1) familiarize, (2) identify a thematic framework, (3) index, (4) chart, and (5) map and interpret.^{21,23} An external company transcribed the digital recording verbatim after each interview.

The lead author read each transcript carefully to become thoroughly familiar with the data. During this initial examination, we took notes to develop a basis for future coding using QSR NVivo 8 (QSR International Pty Ltd., Doncaster, Victoria, Australia). Once all interviews had been conducted and transcribed and we had familiarized ourselves with the data, we developed a

preliminary thematic framework consisting of the themes and sub-themes that had emerged across all interviews. The lead author then reviewed the transcripts and used NVivo to code the text on the basis of the thematic framework. We used several strategies to reinforce the rigour of the study, including cross-checking full transcripts against the original audio files for quality and completeness, reflexive note-taking throughout the data generation and data analysis process, and member checking by following up with participants and circulating the summary report.^{21,23} All transcripts were anonymized and stored on a secure server.

RESULTS

In total, we interviewed 10 individuals for this project: 3 CCAC case managers, 3 service providers, and 4 policymakers. All participants were female; 5 of the 6 participants from the case managers and service providers strata worked in regions containing both urban and rural areas, and the 6th participant worked primarily in an urban setting. Each policymaker had expertise and knowledge related to the entire provincial system. All participants were well acquainted with the Ontario setting, having worked in their positions for an average of 8.3 years. (The case managers averaged 5.6 y, the service providers 6.7 y, and the policymakers 11.5 y.) Places of employment included CCACs, rehabilitation service provider organizations, a university, and a patient-advocate agency.

Two main themes and eight sub-themes emerged from the data (see Box 1), all of which are supported by the framework analysis and participant quotes that follow.

Theme 1: Drivers of rehabilitation therapy service allocation

Functional needs and risk

Most of the participants, particularly the case managers, noted that rehabilitation therapy services are provided to older adults on the basis of their functional needs, irrespective of their medical conditions. These functional needs are assessed by case managers using the provincially mandated interRAI Resident Assessment Instrument—Home Care (RAI-HC) information system.²⁴ The RAI-HC is a comprehensive assessment instrument that case managers use to identify the preferences and needs of all long-term (>6 mo) home care clients in the province of Ontario. Case managers then use that information, along with their case notes and clinical expertise, to decide which services to allocate to clients.

It's totally based on their functional needs, not about diagnosis. So we don't have any category that says, you know, this client has MS or has, I don't know, any other kind of issue—dementia, Alzheimer's—and then they automatically get service. They have to actually have a functional need, and then they get occupational therapy or physiotherapy. (case manager 1)

Box 1 Main Themes and Sub-Themes Resulting from the Semi-Structured Interviews

Theme	Sub-themes
Drivers of rehabilitation therapy service allocation	Functional needs and risk
	Postoperative care and clinical care pathways
	Reactive approach
	Case managers and decision-support systems
Challenges of providing rehabilitation therapy services in home care	Cognitive impairment and multiple morbidity
	Providing rehabilitation in rural regions
	Interdisciplinary communication
	Home care system capacity

The risk of adverse events was also noted as an important driver for allocating both occupational therapy and physiotherapy services. These therapies are often used to ensure that clients are safe in their homes and to improve their mobility to reduce the risk of adverse events, such as falls. Therefore, occupational therapists and physiotherapists tend not to be used in their traditional roles of helping clients attain their best possible level of functioning; instead, home care rehabilitation providers primarily help clients avoid using acute care services in the immediate future.

It is more managing the symptoms and making sure that they are safe at home, and then that's all the visits or the time that you are there for allows you to do. (rehabilitation provider 1)

When the decision has been made to provide rehabilitation services to a home care client, that client receives a priority classification, which indicates to the service provider the time frame that he or she has to provide services. This priority system classifies individuals on the basis of risk status and urgency of receiving care.

Postoperative care and clinical care pathways

Although the decisions to provide services were reported to be based primarily on clients' functional needs, participants indicated that physiotherapy services are predominantly provided to clients for postoperative care after receiving a knee or hip replacement. For these types of clients, care pathways have been developed in Ontario that guide the planning of care and specifically include community-based physiotherapy.¹⁸ Multiple participants mentioned that occupational therapy is used in the home care system primarily to evaluate home safety and determine the need for medical equipment.

Our occupational therapy—unfortunately, right now it's really focused on just home safety and equipment purposes. (case manager 2)

For certain disease diagnoses and clinical issues in the Ontario home care system, clinical care pathways

that involve rehabilitation therapy services (e.g., hip replacement, knee surgery) are relatively well established. For older clients with these issues, care pathways allow case managers to make relatively simple decisions about how to allocate rehabilitation services. However, for frail older persons, the development of care pathways has been complicated by clinical complexity, multiple morbidity, heterogeneous needs, and an unpredictable clinical course. Without established care pathways, decisions about providing rehabilitation services to frail older adults can be difficult and are based on an individual case manager's clinical expertise and past experiences.

For the most part, the path or the journey of fractured-hip patients is fairly predictable. For sure, total hip and knee replacement patients, we know their path. I mean, they're on a clear clinical care pathway. They're very predictable. And stroke patients are also fairly predictable. It's those other patients. It's the medically complex, the frail elderly that we don't necessarily know what their outcome is going to be, and we don't have a clear sense of their trajectory. (health systems policymaker 3)

Reactive approach

Participants also spoke about how rehabilitation services in home care are targeted more toward individuals who have had an acute injury or illness rather than those with slowly declining health and mobility resulting from long-term, chronic illnesses. Rehabilitation therapy services are thought to be used in a reactive way and were reported to be primarily focused on clients who have recently been released from acute care facilities, whereas clients with chronic conditions and long-term functional impairments are often considered to be a low priority for therapy services. Typically, home care clients do not receive therapy services until after they have had some sort of an acute incident (fall, hip fracture) or after a knee or hip replacement.

It is sort of like a Band-Aid approach. You kind of go in, and you treat issues that you could have prevented if you got the services beforehand. (rehabilitation provider 1)

Case managers and decision support systems

In Ontario, CCAC case managers make the decisions about how to allocate home care services. One issue that was raised by both case managers and service providers was the impact of a case manager's training on the decisions he or she makes about what services to provide to a client. For example, many case managers have a background in nursing; as a result, they are likely to approach decisions about allocating home care services from a nursing perspective. This can affect how they perceive a client's needs and how they believe his or her needs should be addressed by service providers. Furthermore, the interviews revealed that case managers' familiarity with the availability of services in their region

can affect their decisions to provide occupational therapy and physiotherapy services. If case managers are not familiar with how rehabilitation therapy services can be used for their clients' issues, or what services are available in the community, they may not allocate rehabilitation services to their clients, even though their clients may benefit from them.

So often what happens is, case managers will do one of two things. They will either under-service that client because [of] their lack of knowledge related to the rehab component, or over-service as a means of compensating, to make sure that every *i* is dotted and *t* is crossed. (case manager 3)

We are also struggling with how do you identify who gets rehab because everyone has a different appreciation of rehab ... because not all the case managers are rehab professionals, and even within rehab professionals, it depends on what population you have worked with. (case manager 2)

Participants in this study made it clear that the current clinical assessment protocols (CAPs), a set of decision support tools in the RAI-HC information system, are not currently used by case managers to guide decisions related to rehabilitation services because they are perceived to have poor sensitivity and specificity. Essentially, because the care population typically consists of older adults with functional impairments, many, if not most, home care clients are classified as being likely to benefit from rehabilitation therapy services. As a result, the CAPs are not considered to be helpful to case managers when they are making their decisions.

I think that for [decision support], the more specific the better because it helps to guide case managers, especially if they don't have a therapy background. (health systems policymaker 4)

Theme 2: challenges of providing rehabilitation therapy services in home care

Cognitive impairment and multiple morbidity

Although the interviews contained no references to cognitive impairment as an outright barrier to clients receiving rehabilitation therapy services, participants mentioned that declining cognition affected decisions about allocating physiotherapy because of its very nature. Much of physiotherapy is self-directed and requires a client to practise a programme that a therapist has developed. This can be challenging for a client if he or she has a cognitive impairment and if a caregiver is not available or capable of assisting in rehabilitation therapy activities.

Well, a lot of the programming is self-directed, so if they can't follow an exercise program, it's limited to what we can offer them through the CCAC framework. (rehabilitation provider 2)

The service providers in this study indicated that multiple morbidity and frailty have to be considered when providing services to older clients because they affect exactly what type of therapies are provided, how they are provided, and their effectiveness and efficiency.

As we look at the new senior population, you know this: Most of them have comorbidities. Not one person has one condition. So how do we provide rehab to these individuals? Is it based on diagnosis anymore? Or do we start to look at our approach based on the function of the client? (case manager 2)

Providing rehabilitation in rural regions

For clients who live in rural areas, it can be challenging to find professionals who are able and willing to provide services to them. If professionals do not reside in that rural area, they have to travel there to provide care; this raises problems of availability, transportation time, and the timeliness of the services they can provide.

There is a huge challenge in terms of having professional services available in some of those more isolated areas.... So professionals going into some of these areas that are just not popular places to practise, you have a lot of trouble servicing clients. (rehabilitation provider 1)

Interdisciplinary communication

An additional challenge that was discussed involved communication among different rehabilitation professionals and between them and the case managers. Communication between these groups is difficult because these professionals often work for different agencies and are rarely in a client's home at the same time. Therefore, if any issues come up during treatment or assessment, communication with the other members of the client's care team can be difficult and time consuming.

Home care system capacity

The participants noted that one of the most common challenges of providing rehabilitation therapy services to older clients lies in the lack of resources in relation to increasing demand, need, or both. The population is aging, so many home care clients have mobility and functional independence issues. Because the home care system lacks resources, however, many older individuals do not receive occupational therapy or physiotherapy despite their actual or perceived needs.

The system is working so that everybody can't have a prevention rehab because we don't have enough resources. (health systems policymaker 2)

Many of those resources that typically would have been allocated to community-dwelling residents were now being used up front for getting people home quicker. (health systems policymaker 1)

Multiple participants spoke to the fact that home care should not be considered as the only point of access to

health, medical, and support services. Older clients can obtain occupational therapy and physiotherapy from community-based services (e.g., outpatient clinics, group settings) and by paying providers privately. Therefore, case managers must also be able to provide information to home care clients so that they can find outpatient programs in their communities.

And just because you are in the community, does that mean that that should be a home care client? Or should we be exploring other types of creative outlets to provide people with rehab, such as a community centre? (case manager 2)

DISCUSSION

The primary objective of this study was to develop a preliminary understanding of the factors that influence how rehabilitation therapy services are allocated to older clients in the Ontario home care system. The results highlighted client-level drivers of rehabilitation service allocation, issues related to case manager decision making, and the challenges of providing services in rural areas.

Although older adults' health profiles are often complex,²⁵ decisions about providing occupational therapy and physiotherapy are generally made on the basis of a client's functional needs. By focusing on functional needs, rehabilitation therapy services can be allocated in a way that is thought to be more client centred than disease focused. However, this is not how best practices and care pathways are often developed because they tend to be based on specific conditions (e.g., stroke, total knee replacement).²⁶ Clinical care pathways exist for rehabilitation services for some medical conditions in older adults, and they involve allocating occupational therapy and physiotherapy.¹⁸ However, no care pathways or evidence bases currently exist for frail older persons, which makes it challenging for case managers to make decisions, especially case managers with less experience with older frail populations.²⁷

Cognitive impairment is often referred to as a challenge for geriatric rehabilitation.²⁸ According to the participants, cognitive decline tends to affect decisions related to allocation only if the impairment is severe and only if a client does not have caregivers who can assist with his or her exercises. For clients with mild to moderate cognitive impairment, improvements in decision support tools and care pathways may help case managers determine who would gain the most from, and could adhere to, rehabilitation services.

On the basis of the interviews, the study participants appeared to have a limited understanding of system trends that are associated with allocating rehabilitation services in home care, including the population characteristics of older rehabilitation users. Because the demand for rehabilitation services is expected to rise,¹⁹ it will

be increasingly important for health care managers and policymakers to improve their knowledge of population characteristics and how the system functions for older adults. This will enable them, in their capacity planning, to decide how to allocate limited resources and meet the changing needs of the province's population.

The results of this study indicate that rehabilitation services in the Ontario home care system are used primarily for post-acute care and to attempt to avoid taxing the health care system. This finding is not entirely unexpected because it concurs with the results of other Ontario-based research studies.^{29,30} Our findings add to a growing body of literature that demonstrates that people with chronic conditions have trouble accessing rehabilitation therapy services, despite their functional needs. As stated in a 2015 report from the Ontario Health Coalition,³¹ the provincial home care system is struggling to support post-acute care patients on the one hand and, on the other, longer term care for older adults and persons with disabilities and chronic illnesses. Although it may appear too costly to provide rehabilitation therapy services to individuals with chronic conditions, these services have great potential to affect future health care use and indirect societal costs.³ Again, this calls for a mechanism to more clearly identify those clients who would gain from and adhere to rehabilitation services.

Several participants indicated that the home care system is not the only option for older adults who live in the community and need rehabilitation therapies. Occupational therapy and physiotherapy can be provided by paying providers privately and accessing community-based services (e.g., outpatient clinics, group settings). For example, there have been recent initiatives throughout Ontario to establish community-based exercise programs for people with neurological conditions.^{32,33}

Participants also indicated an interest in seeing enhanced decision support systems for rehabilitation therapy services in home care. Using the routinely collected RAI-HC data, researchers and the CCACs could develop decision support systems to identify individuals who would have the greatest trouble accessing community-based services (e.g., those who are homebound or severely immobile or those who live in regions in which physiotherapy is not available in the community). Also, because the health care of older adults is sometimes complex, decision support systems may improve the efficiency of rehabilitation services by helping to identify older adults who would benefit the most from receiving occupational therapy, physiotherapy, or both.³⁴ Furthermore, decision support systems may also improve the consistency of decision making across case managers and CCACs.

This study is not without limitations. First, it was conducted in Ontario, and the results may not be generalizable to other jurisdictions. The sample represented three different perspectives and multiple health regions in the southern, more heavily populated part of the province.

The challenges of providing home care in rural areas of Canada have been discussed in the literature,^{25–27} and a few of the participants from more rural regions spoke to this issue. In addition, this study did not include any interviews with stakeholders from the northern health regions (North West LHIN and North East LHIN), whose size and larger proportion of remote and rural clients magnify these issues. As a result, this study would have benefited from including additional informants from the two northern LHINs, and further studies are encouraged to focus on therapy services in the northern and rural parts of the province.

An additional limitation is that the analyses were conducted by a single individual. The reason for this approach was that the work was conducted as part of a PhD dissertation project. Despite these limitations, however, enough data were collected in this pilot study to reach saturation.

CONCLUSIONS

This study yielded insights into the factors that drive how occupational therapy and physiotherapy are allocated to older adults in the Ontario home care system. The participants identified a series of challenges when providing home care rehabilitation to older adults, and they highlighted the need for novel decision support systems and care pathways that can accommodate the clinical complexity of frail older adults. Although financial constraints limit the amount of rehabilitation that can be offered to older adults, knowing what the characteristics of the client population are and how the current system works can inform policymakers and aid in the development of new provincial policies, resulting in a system that is more responsive and preventive.

With large amounts of electronic health data available for older clients, researchers can use quantitative analyses to build on these results to help improve the efficiency and effectiveness of the limited number of resources allocated to rehabilitation services. Because the number of older adults in Ontario is increasing drastically, even minor changes to the provincial system can have a huge impact on overall costs, efficiency, and, most important, the well-being of older home care clients.

KEY MESSAGES

What is already known on this topic

Physiotherapy and occupational therapy services are critical components of any home health care system. These services can be used to maintain or improve the physical functioning, quality of life, and overall independence of older home care clients. In Ontario, not everyone who could benefit from rehabilitation receives rehabilitation services, and disparities exist across the health regions of the province. With the aging of the population, the demand for services is expected to rise.

What this study adds

This study provides an overview of the factors that influence how rehabilitation therapy services are allocated to older clients in the Ontario home care system. The study highlights how client characteristics and case manager decision making can have an impact on rehabilitation service allocation. We also identified some of the challenges in providing these services, including cognitive impairment and multiple morbidity in older clients, difficulties involved in providing home care services in rural areas, interdisciplinary communication, and the discordance between home health care system resources and the increasing demand from an aging population.

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APPENDIX 1—INTERVIEW GUIDE

INTRODUCTION

Thank you for agreeing to participate in this research project. The overall purpose of this dissertation project is to enhance understanding of the provision of rehabilitation services in the Ontario Home Care System. Interviews are being conducted with key informants to gain varying perspectives that can be used to inform the analysis of a large provincial data repository.

This interview will consist of a discussion on rehabilitation service provision in home care and will be guided using the open-ended questions found in the table below. These questions have been organized into three sections based upon the Andersen and Newman Framework of Health Services Utilization. The interview will last approximately 1 hour and will be tape recorded for transcription purposes. All discussion will be anonymized, and your participation is greatly appreciated.

Organized by the Andersen and Newman framework	Open-ended questions
Need factors	What are the different types of clients that receive rehabilitation services? What type of clients could benefit from rehabilitation services but don't receive it?
Enabling factors	Describe how the provision of OT and PT services is decided for home care clients. What kinds of system or environmental factors impact the provision of rehabilitation services?
Predisposing factors	Do factors such as age and gender play any role in the provision of rehabilitation therapy service? Similarly, do factors such as ethnicity, culture, occupation, and education level impact the provision of rehabilitation services?

OT = occupational therapy; PT = physiotherapy.

ADDITIONAL PROBES ORGANIZED BY STRATUM

Strata	Probes
CCAC case managers	<p>What role does multi-morbidity play in the decision for rehab therapies?</p> <p>What patterns have you noticed in terms of rehabilitation outcomes for older adults in home care?</p> <p>How much of a role does geography play in the provision of services? How is volume/rate determined? Frequency?</p> <p>Who is most likely to benefit from rehab services? Who is least likely to benefit?</p> <p>How is the type of therapy services determined?</p> <p>How do you prioritize clients? Prioritize services offered to individuals?</p> <p>How does the utilization and outcomes of rehabilitation services differ across LHINs?</p> <p>How do regional characteristics (e.g., population density, OT/PT staffing levels) impact the provision and outcomes of rehabilitation services?</p> <p>How do rehabilitation services vary over the course of a budget year?</p> <p>Do differences in service provision impact outcomes for subgroups such as persons with stroke or MSK disorders?</p> <p>What are the profiles of home care clients who receive/do not receive rehabilitation services?</p> <p>Does cognitive impairment (or other geriatric syndromes such as frailty or incontinence) affect rehabilitation outcomes?</p> <p>What are the common chronic disease clusters associated with rehabilitation service use and non-use?</p> <p>Can RAI-HC data be used to identify and prioritize home care clients of varying need of rehabilitation services?</p>
Service providers	<p>What role does impaired cognition play in the rehabilitation therapies for older adults in home care?</p> <p>How do multi-morbidities impact rehabilitation services?</p> <p>How is the type of therapy services determined?</p> <p>How does the utilization and outcomes of rehabilitation services differ across LHINs?</p> <p>How do regional characteristics (e.g., population density, OT/PT staffing levels) impact the provision and outcomes of rehabilitation services?</p> <p>How do rehabilitation services vary over the course of a budget year?</p> <p>Do differences in service provision impact outcomes for sub-groups such as persons with stroke or MSK disorders?</p> <p>What are the profiles of home care clients who receive/do not receive rehabilitation services?</p> <p>Does cognitive impairment (or other geriatric syndromes such as frailty or incontinence) affect rehabilitation outcomes?</p> <p>What are the common chronic disease clusters associated with rehabilitation service use and non-use?</p> <p>Can RAI-HC data be used to identify and prioritize home care clients of varying need of rehabilitation services?</p>
Policymakers/administrators	<p>How is the type of therapy services determined?</p> <p>How do you prioritize clients? Prioritize services offered to individuals?</p> <p>How do the utilization and outcomes of rehabilitation services differ across LHINs?</p> <p>How do regional characteristics (e.g., population density, OT/PT staffing levels) impact the provision and outcomes of rehabilitation services?</p> <p>How do rehabilitation services vary over the course of a budget year?</p> <p>Do differences in service provision impact outcomes for sub-groups such as persons stroke or MSK disorders?</p> <p>What are the profiles of home care clients who receive/do not receive rehabilitation services?</p> <p>Does cognitive impairment (or other geriatric syndromes such as frailty or incontinence) affect rehabilitation outcomes?</p> <p>What are the common chronic disease clusters associated with rehabilitation service use and non-use?</p> <p>Can RAI-HC data be used to identify and prioritize home care clients of varying need of rehabilitation services?</p>

CCAC = community care access centres; LHIN = local health integration networks; OT/PT = occupational therapy/physiotherapy; MSK = musculoskeletal; RAI-HC = Resident Assessment Instrument – Home Care.