SPINAL CORD INJURY ONTARIO | LÉSIONS MÉDULLAIRES ONTARIO

Jan. 22, 2016

The Honourable Eric Hoskins
Minister of Health and Long-Term Care
Government of Ontario

Dear Minister Hoskins,

Spinal Cord Injury Ontario is pleased to provide feedback on your Patients First Proposal. Thank you for reaching out to our community and enabling us to offer a unique perspective on health care services.

We are excited to work with you to achieve integrated and coordinated community health services that are flexible, reliable and affordable. Through the support of the LHIN, Spinal Cord Injury Ontario presently addresses gaps in continuity of care through the following provincial services delivered from our 16 regional offices: Peer Support, Regional Navigation Supports, and Information and Education. We offer Employment Services and Attendant Services in the Greater Toronto Area.

We believe our organization is well positioned to assist you in reaching the goals you have outlined in your proposal. We are keen to work together on a solution that will deliver the highest quality of care to people with spinal cord injuries and other physical disabilities.

I hope that the following submission will lead to further discussions so that we can work together to achieve outstanding community health care for people with spinal cord injuries and other physical disabilities.

Sincerely,

Dr. Stuart Howe
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PATIENTS FIRST

Strengthening Community-Based Health Services for People with Spinal Cord Injuries in Ontario

Response to the MOHLTC Discussion Paper released December 17, 2015.

Submitted January 22, 2016

SPINAL CORD INJURY ONTARIO

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Who We Are

Spinal Cord Injury Ontario is an ongoing, life-long resource for people with spinal cord injuries, their friends, families and service providers that starts at the onset of injury and carries through acute care, rehab and then into the community. Our organization assists people in rebuilding their lives. We have been strengthening our expertise since 1945 when our organization was started by returning WWII veterans with spinal cord injuries. We are no strangers to the health care sector. In fact, we even built Lyndhurst Rehabilitation Centre and ran it until 1999. Today, we provide community support services to the SCI community across Ontario. From our beginnings, Spinal Cord Injury Ontario has been a leader in client rehabilitation, service and community re-integration – a time honoured legacy that continues today.

The Issue

Too often, as the Minister of Health and Long-Term Care has identified, health care services can be fragmented, uncoordinated, and unevenly distributed across the province. Our organization has observed our health care system falling short for the people who need it most.

Often people with spinal cord injuries fall between the cracks as we are a small population with diverse needs. We are the 6% of Ontarians who rarely have access to a primary health care provider. The specialization of services and rehabilitation required for people with spinal cord injuries, coupled with highly complex and changing chronic conditions, can create less than adequate community-based health care. In turn, there is an unnecessary expense to the health care system because of the need for emergency care. Had community supports been available, trips to the emergency room could have been likely avoided.

Our Focus

To support people with spinal cord injuries, their friends, families and service providers, our organization aims to:

1. Improve the consistency of accessible services regardless where you live in Ontario
2. Provide fair, accessible, integrated, and equitable primary care services
3. Expand the role and scope of non-regulated health care professionals in the community
4. Foster community and patient engagement (alternative – Integrate and engage people with SCI in health services)

How We Can Help

We believe that the evidence and experience we have from our years of providing service can be used to create better community-based health services and cost savings. We support self-directed services and can assist in bringing our client-focused model further into a community service delivery model.

We have consulted with our own community in order to provide feedback regarding your proposal. Our community includes our clients, members, volunteers, staff, researchers, policy makers and other service providers and health care professionals.

We also consulted directly with our partners Ontario Neurotrauma Foundation www.onf.org and the Ontario Spinal Cord Injury Solutions Alliance http://alliance.sciontario.org/node/74 who are essential to the successes outlined below and invaluable in developing and implementing new opportunities provincially.

Report Structure

This document outlines how we can help Ministry strengthen patient-centred health care. In response to your proposals, we offer 1) our perspective on what has worked well and are success stories to build; and 2) potential opportunities for further success. In the footnotes, we offer a point person or resource to further discuss potential opportunities.

PROPOSAL # 1: More Effective Integration of Services and Greater Equity

Successes to build on:

1. Self-directed consumer health care system navigation (e.g. SCI Pilot in HNHB Demonstration Project).
2. Family health team integration of services (e.g. Waterloo Kitchener Mobility Clinic)[1]
3. Integration of specialized services from acute to community (e.g. skin flap surgery proof of concept project - TCLHIN collaboration between St Michaels Hospital, University Health Network, and Spinal Cord Injury Ontario)
4. Chronic pain management program (e.g. Toronto Rehab LEAP)[2]
5. Self-directed care and direct funding models (e.g. success with attendant services)[3]
6. Identify vulnerable and medically complex population support (e.g. TCLHIN focus on most vulnerable and complex populations)

Potential opportunities:

1. Build a complex needs health link across Ontario to ensure equity of service provision.[4]
2. Develop a provincial community based long-term ventilator support program[5]
3. Implement evidence based best practices for prevention and treatment of pressure ulcers across all community services providers[6]
4. Expand the role and scope of non-regulated health care professionals to provide specialized attendant services supporting a faster and more efficient transition from acute care and rehab into the community[3]
5. Maximize the utilization of remote access technology in the community such as telehealth, tele-monitoring, OTN etc. for consultation, assessment and recommendations in the community sector[7, 8]
6. Maximize the Assistive Devices Program with integrated home and community support services[9]

[1] Waterloo Kitchener Mobility Clinic
[2] Toronto Rehab LEAP
[3] Attendant Services
[4] Complex Health Needs Link
[5] Ventilator Support Program
[6] Pressure Sore Best Practices
[7] Pressure Sores Guide
[8] Pressure Sores Webcast
[9] Assistive Device Program

PROPOSAL #2: Timely access to primary care, and seamless links between primary care and other services

Successes to build on:

1. Educational credits for Primary Care Providers (e.g. Spinal Cord Injury Actionable Nuggets) [10]
2. Family Health Teams accessibility strategy (e.g. Primary Care Accessibility Initiative) [11]
3. Spinal Cord Injury standardized clinical pathways
4. Continuity of services after discharge from rehab to primary community care (e.g. Family Health Network between Hamilton Health Sciences, Ontario Neurotrauma Foundation, The Mobility Clinic, and Spinal Cord Injury Ontario).

Potential opportunities:

1. Improve access to primary care providers by removing physical barriers (e.g. accessible office space, appropriate examination tables)
2. Enhance primary care providers' specialized knowledge the needs of individuals with physical disabilities [10]
3. Provide incentives for extended visit time for client with complex medical needs
4. Develop infrastructure to support access to primary care such as expanded inter-disciplinary teams in family health teams and health links
5. Expansion of the circle of care to community providers
6. Develop provincial patient satisfaction surveys and publish comparator data by LHIN and sub-LHIN regions

[10] Actionable Nuggets
[11] Primary Care Accessibility Initiative

PROPOSAL #3: Strengthen accountability and integration of home and community care. Transfer direct responsibility for service management and delivery from CCACs to the LHINs

Successes to build on:

1. Alignment of Client Data Management Systems (e.g. CBI initiative in the TCLHIN)
2. Strengthening of transfer of knowledge from specialized clinical settings to community services providers (e.g. implementation of best practice guidelines for pressure sores management project) [12]
3. Identification of variety of populations' need and development of continuum of care pathways (e.g. best practices in acute care, rehabilitation and community for reduction of pressure sores) [12]
4. Transfer of funding envelop from one sector to the other supporting alignment of resources along continuum of care (e.g. sharing of funding between three institutions to solve surgical recovery issue in the community - St Michaels, Toronto Rehab Institute, Spinal Cord Injury, Center for Independent Living Toronto)
5. Leverage current client satisfaction surveys from community organizations (e.g. standardized a provincial client satisfaction survey reflecting all phases of the continuum of care)

Potential opportunities:

1. Service to follow the patient along the continuum of care ensuring no service interruptions during transitions. Attendant Services providers can play an active role in rehab, long-term care, convalescent care, and acute care [13]
2. Interdisciplinary teams to include community service providers to anticipate and coordinate community supports well prior to discharge
3. Direct communication access between front line providers and specialized clinical settings. Review of the case coordinators' intermediary role
4. Provide support for self-directed care rooted in independent living philosophy for consumer across the continuum of care
5. Engage consumers in early discussion of what constitutes quality of care along the continuum care and especially when returning in their community

[12] Pressure Sore Best Practices
[13] Attendant Services

A PATH FORWARD

Successes to build on:

1. Community-based disability organizations are the most reliable voice for people with disabilities and broker conversations between consumers and decision makers. Large emphasis on consumer choice and direction must continue to be a part of this restructuring process. Not only does consumer engagement add value to service delivery, it prepares people to become active participants in their health care, and maximizes their own health outcomes. This is a critical component in building a successful path forward [14]
2. Creation of strong Community of Practice Networks leverages experience and expertise of clinicians, researchers and consumers to inform decision makers in the delivery of innovative and cost effective services across the continuum of care. It provides capacity building provincially to address equity and standardization of best practices. Examples include Ontario SCI Research Network[15], Neurological Health Charities of Canada[16], GTA Rehab Network - Spinal Cord Injury Rehab Definitions Framework[17], Spinal Cord Injury - A Manifesto for Change[18], Independent Living Service Providers of Ontario[19]

Potential opportunities:

1. Engagement of stakeholders including leaders in clinical services and service delivery as well as consumers at tables of influence from the conception of the model(s) to implementation
2. Consider the maintenance of parallel systems while transitioning into an evolving system
3. Consider linking MSAA agreements to metrics reflecting improved integration and client satisfaction results. Metrics could include: flow through the continuum of care, wait times, hospital or rehabilitation centers re-admission, gap in services, access to primary care
4. Develop provincial standards for data collection and IT compatibility for data sharing. Include ability for comparison and linkages across organizations for a particular patient/client as well as accounting for regional diversity
5. Opportunity for ongoing assessment of outcomes through MSAA metrics, performance indicators, satisfaction surveys, crowd sourcing for public opinion gathering.

[14] Strategic Plan of the Ontario Spinal Cord Injury Solution Alliance
[15] Ontario SCI Research Network
[16] Neurological Health Charities of Canada
[17] GTA Rehab Network
[18] SCI Manifesto for Change
[19] Independent Living Service Providers of Ontario

Conclusions

As the Ministry continues conversations about the Patients First Proposal in a variety of forums, our community would like to continue to be engaged. Our contribution and focus of expertise is the following:

1. Heighten the consistency of accessible services regardless where you live in Ontario
2. Provide Fair, Accessible, and Equitable Primary Care Services
3. The role of Non-Regulated Health Care Professionals in the Community
4. Welcome Consumer Engagement

For further details in relation to this submission or other opportunities to engage our community, please contact Peter Athanasopoulos 416-422-5644 x260; **petera@sciontario.org**