Use of Rehabilitation Assistants in Home Care

February 2023

HOME CARE ONTARIO

TABLE OF CONTENTS

Rehabilitation Assistants in Home Care

In Canada, Rehabilitation Assistants work directly under the supervision of the Regulated Health Professions of Physiotherapy, Occupational Therapy and Speech Language Pathology.

In this document, the term Rehabilitation Assistant is used to refer to Physiotherapist Assistant (PTA), Occupational Therapist Assistant (OTA) and Communication Disorders Assistant (CDA).

The objective of this resource is to provide background information concerning the benefits and considerations to effectively utilize Rehabilitation Assistants in the Home Care setting.

Background

The majority of Ontarians wish to remain in their home and "age in place."[1] The provision of therapy in the home is recognized as an effective method to support clients to maintain or improve their strength, mobility and independence in function. The increased awareness of the benefits of rehabilitation for an aging and medically complex population is growing and the demand for rehabilitation services has increased (Home Care Ontario, 2016).

Workforce capacity issues have affected all aspects of the health care system. With the rising demand for therapy services and the limited number of therapists available, models of care need to expand to include trained and skilled Rehabilitation Assistants, working under the direct supervision of the treating therapist.

In 2013, Physiotherapist Assistants (PTAs), were introduced to provide therapy services in Retirement Home settings by the Community Care Access Centres (CCAC)[2, 3]. Since that time several Home and Community Care Support Services (HCCSS) Programs in the province of Ontario have expanded the use of PTAs to include the use of OTAs and CDAs (Rehabilitation Assistants).

Rehabilitation Assistants support clients to receive more robust, responsive and cost-effective care. The use of the Rehabilitation Assistant adds additional health human resource capacity to support the delivery of comprehensive rehabilitation service plans. This enhanced capacity is necessary to support the growing waitlists for clients due to the increasing difficulty of recruiting OTs, PTs and SLPs.

Clients receiving therapy at home achieve improved function to meet their goals, prevention of functional status decline and increased capacity to age in place.

In addition, system outcomes can include:

- **Reduced hospital lengths of stay**
- **Preventing institutionalization**
- **Lower utilization of costly health services**
- **Preventing hospitalization**
- **Improved care for caregivers[4] (RCA, Nov., 2020)**

1. https://www.homecareontario.ca/docs/default-source/position-papers/2021-09-29homecarestudy.pdf?sfvrsn=8
2. http://healthcareathome.ca/southwest/en/news/Documents/OACCAC-Whitepaper-CCAC-Backgrouder-FINAL.pdf
3. https://www.homecareontario.ca/docs/default-source/position-papers/position-papers/ontario-home-care-overview.pdf?sfvrsn=4
4. RCA - Community-Based Rehabilitation: Providing High-Value Rehabilitative Care in the Community Part 2: In-Home Rehabilitation White Paper (2020)

Client Populations

Clients who access therapy at home through HCCSS are typically not able to access outpatient therapy services for a variety of reasons, or have rehabilitation goals that are best met in the home setting.

The Rehabilitation Care Alliance 2020 paper **"Community Based Rehabilitation, Providing High Value Rehabilitative Care in the Community Part 2: In-Home Rehabilitation"** organizes models of care by three categories. These include: Prevention / Restorative care, Rehabilitation Post injury /illness and Maintenance of progressive / chronic conditions.

Prevention / Restorative in-home rehab care is focused on maintaining or preventing decline in functional status and enhancing capacity for clients to remain at home. Seniors with multiple co-morbidities and complex health needs would benefit from this model of care, including falls prevention and cardiac care initiatives.

In-home **post-injury/illness rehabilitative** models of care provide rehabilitation for clients following injury (i.e., fractures and soft tissue injuries), surgical procedure or sudden onset, life-altering disability. The focus is to reach and maintain maximum function and potential. Stroke rehabilitation is included in this model of care.

In-home rehabilitative models of care for **progressive/chronic conditions or maintenance** address the needs of clients living with a chronic disease/condition or experiencing an exacerbation or worsening of symptoms. Therapy services support goals of maintaining independence to manage safely at home. Clients living with Multiple Sclerosis, COPD, Rheumatoid Arthritis and ALS are examples of who would benefit from this model of care.

Who Is a Rehabilitation Assistant?

Who Is a Rehabilitation Assistant?

Rehabilitation Assistants have graduated from a relevant two-year College program, or may have equivalent relevant training and experience. A Rehabilitation Assistant completes care that is assigned under the direction and supervision of a Regulated Health Professional. Rehabilitation Assistants are not Regulated Health Professionals in Ontario.

Client care is the responsibility of the supervising therapist including; obtaining consent, assessment, treatment planning and discharge planning. Rehabilitation Assistants do not replace therapists but augment the treatment provided by the Occupational Therapist, Physiotherapist and Speech Language Pathologist in the home.

5. https://www.ontario.ca/laws/statute/91r18

Roles and Accountability

Therapist

The titles Physiotherapist, Occupational Therapist and Speech Language Pathologist are protected under the Regulated Health Professions Act (RHPA).[5] They have a legislated scope of practice, specialized training and education, and are regulated by their respective professional Colleges.

As regulated health professionals, therapists are required to comply with Regulations under the RHPA and professional standards of practice established by their respective Colleges, including the Standards for use of Rehabilitation Assistants.

Within the practice of the Occupational Therapist, Physiotherapist and Speech Language Pathologist, they must obtain informed consent, complete professional assessments, develop treatment plans and determine appropriate discharge planning. The therapist must also make the clinical decision when assignment of care to the Rehabilitation Assistant is appropriate.

Rehabilitation Assistant

When aspects of client care can be assigned, the Rehabilitation Assistant completes the treatment delegated by the supervising therapist. These therapy tasks may include implementing home treatment/exercise programs (HEP), providing patients with support to improve activities of daily living (ADLs), managing safe mobility and improving functional independence. Rehabilitation Assistants may also assist with cognitive and communication treatment programs. All activities are specified by the supervising therapist and aligned with client-centred goals.

The Rehabilitation Assistant requires the direction of the supervising therapist to implement the treatment plan, and to progress or modify client treatment plans. The Rehabilitation Assistant cannot complete the client assessment, interpret findings, create treatment plans or discharge clients.

The supervising therapist maintains sole accountability for client assessment, treatment progression and instructions provided to the Rehabilitation Assistant. As a result, there is a requirement and expectation for collaboration and timely communication between the supervising therapist and the Rehabilitation Assistant throughout the service delivery. Joint visits are a critical component of supervision.

Supervision/ Assignment

Regulatory Colleges require that the supervising therapist ensure that the Rehabilitation Assistant has the skill and knowledge to competently carry out the assigned service plan. (COTO, CPA, CASLPO).

"Regardless of the OTA's training, it is the accountability of the supervising OT to ensure the OTA is competent to safely, effectively and ethically deliver the assigned OT service components." [6]

"The SLP must ensure that the support personnel has the knowledge, skill and judgement to provide the intervention assigned." [7]

"The PT must ensure that the PTA has the knowledge, skills and judgement to perform a treatment prior to the assignment of care." [8]

The supervising therapist is required to take into consideration several factors when determining the level of supervision required, including:

- Knowledge, skill, ability and judgement of the Rehabilitation Assistant
- Complexity of client condition
- Degree of risk associated with the treatment[9]

Essential components of supervising a Rehabilitation Assistant include:

- Consistent communication between the supervising therapist and the Rehabilitation Assistant throughout service delivery
- Completion of client reassessment by the therapist throughout treatment as required
- Observation of the Rehabilitation Assistant in completion of tasks as required
- Joint visits between the therapist and Rehabilitation Assistant to support the above

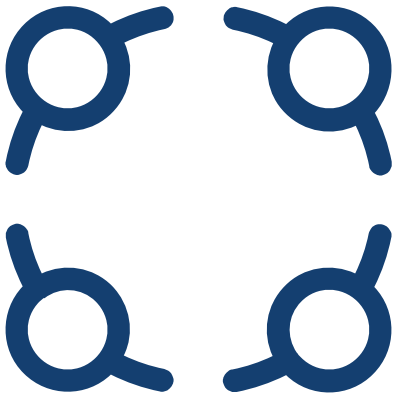
6. COTO Standards for the Supervision of Occupational Therapist Assistants, June 2018
7. CASLPO Position Statement - Use of Support Personnel by Speech Language Pathologists (2017)
8. College of Physiotherapists of Ontario (2010). Physiotherapists Working with Physiotherapist Support Personnel; Guide to the Standards for Professional Practice
9. COTO Standards for the Supervision of Occupational Therapist Assistants, June 2018

Communication and Consent

Rehabilitation Assistant

All Regulatory College Standards require that informed consent is obtained from clients or their Substitute Decision Maker (SDM) by the registered therapist and must include consent to use the Rehabilitation Assistant in the provision of care.

'The College of Occupational Therapists expects the OT to "obtain informed consent from the client or SDM by providing specific information to enable the client's understanding of the role and activities that the OTA will perform."' [10]



When assigning OT, PT or SLP service components, the therapist will evaluate and communicate risk, implementing strategies to minimize any potential harm to the client, the Rehabilitation Assistant and others. (2018, COTO).

The Rehabilitation Assistant must be able to communicate with, and access their supervising therapist about changes in the client's status.

"Effective communication between the PT and PTA is vitally important to ensure effective care and client safety."[11]

10. Home Care Ontario & Ontario Physiotherapy Association: Physiotherapist Assistants in Home Care, 2016.
11. CPA - Description of Physiotherapist Assistants and Essential Competency Profile for PTAs in Canada (2012).

Service Guidelines

Rehabilitation Assistants as an extension of PT, OT and SLP services have been introduced in Ontario's home care sector as a way to provide more robust client therapy services in the home and as a strategy to provide enhanced therapy services to clients and maximize treatment outcomes.

Guidelines for the utilization and service availability of Rehabilitation Assistants must be consistent, standardized and informed by best practice. Currently, there is variability across HCCSS with respect to therapy guidelines and benchmarks. In some parts of Ontario, therapy visit allocations are limited (e.g. four consultation visits maximum) and are not based on client complexity or clinical needs. The implementation of a model of care that achieves client outcomes must include Rehabilitation Assistants that are supervised by therapists. This requires the appropriate allocation of therapy resources.

Introducing Rehabilitation Assistants requires that:

- Guidelines are clinically relevant and represent client need
- Adhere to the Regulated Health Professional College guidelines

HCCSS Regions with service provider organizations utilizing Rehabilitation Assistants in their in-home therapy teams recommend that it is essential for service plans to have:

- Visits authorized for the Rehabilitation Assistant distinct from the supervising therapist
- The number of visits for each to be fluid and flexible based on client need, as assessed by the supervising therapist
- Recognition that Rehabilitation Assistant visits and supervising Therapist visits may occur at the same time
- An appropriate ratio of Rehabilitation Assistant to Therapist visits based on the model of care
- Delivery of therapy services (virtual vs in-person) as determined by the Therapist

These recommendations serve to clarify communication, accountability and expectations for the HCCSS Care Coordinator, therapist, Rehabilitation Assistant and client.

Training / Core competencies

Supervising Therapists are responsible to ensure the Rehabilitation Assistant has the knowledge and skills required to deliver the assigned service components. The service provider organization is responsible to ensure the necessary training is provided to support competency in the community. There are established core competencies for assistants outlined by the respective professional associations. [12, 13]

Considerations for Recruitment and Retention

The compensation for the Rehabilitation Assistant working in the community needs to be equitable in comparison to the hospital and long-term care employment settings. It is a valuable position that needs to be reimbursed accordingly to acknowledge the quality of care required and support retention.

The challenges of the cost of travel and rural geographies also need to be addressed within the service model. The cost of travel is an inherent cost of delivering home care service and a significant factor in rural areas.

12. CPA - Description of Physiotherapist Assistants and Essential Competency Profile for PTAs in Canada (2012).
13. CAOT Practice Profile for Occupational Therapist Assistants (2018)

Home Care Ontario Recommendations:

1

Roles, responsibilities and expectations for intervention provided by Rehabilitation Assistants and the supervising therapist are clearly understood by care coordinators, providers, clients and families (Home Care Ontario, 2016).

2

Evidence/best practices are incorporated appropriately in the delivery of in-home therapy in the home care environment when utilizing Rehabilitation Assistants (Home Care Ontario, 2016).

3

Sufficient therapy resources must be in place in order for the therapist to fully utilize the Rehabilitation Assistant to achieve desired client outcomes. Traditional consultative models do not support the utilization of Rehabilitation Assistants.

4

Service models must include compensation for the necessary communication and supervision between the supervising Therapist and the Rehabilitation Assistant.

5

Models of care and funding must allow for joint visits and flexibility for adequate levels of supervision based on professional assessment, client need and regulatory college guidelines for practice (Home Care Ontario, 2016).

6

Therapy visits must be authorized for the Rehabilitation Assistant distinct from the visits being authorized for the supervising therapist assignment and accountability.

7

Reassessments by the supervising Therapist must be completed regularly as indicated by client need, to monitor progress and modify treatment plans assigned to the Rehabilitation Assistant.

8

Technology must be available for Virtual Care to facilitate communication and supervision within this Model of Care (Home Care Ontario, 2016). Incorporating technology will allow for direct supervision to be completed virtually which expands therapy capacity while maintaining quality of care.

9

Compensation must be equitable with hospital, LTC and Private Sector.

10

There must be a critical volume of patients to sustain multiple Rehabilitation Assistants across the region in order to reduce travel time and reduce transportation costs.

11

Travel costs and rural geography must be incorporated into resource planning and allotted to the Rehabilitation Assistant visit cost.