Subject: Provision of Assistive Devices and Durable Medical Equipment

Dear Sir/Madame;

On behalf of the contributing individuals and organizations identified herein, we wish to draw attention to ongoing concerns affecting people with disabilities and seniors. We are pleased to submit the enclosed 'White Paper' offering comments and recommendations relating to current practices and programs.

In preparing this document, each contributing organization has gathered input from its members working in a variety of roles relating to the provision of assistive devices and durable medical equipment across BC. Consumers have provided input through Disability Alliance BC and through Spinal Cord Injury BC. Occupational therapists, health care professionals most involved with assessment and recommendation of assistive devices, have provided input through the Canadian Association of Occupation Therapists, BC Chapter (CAOT-BC). Professionals involved with individuals living in care

homes have provided input through BC Care Providers Association. Organizations supplying medical equipment in communities across BC have provided input through the Home Medical Equipment Dealers Association and through the BC Association for Individualized Technology and Supports for People with Disabilities.

Our purpose in exploring current practices and collaborating with affected groups is to impact future government actions. These include program planning and requests for proposals (RFP's) to be developed for provision of goods and services within the categories of assistive devices and medical equipment used by people living at home, in assisted living or in long-term care.

In proactively bringing this document forward now, government planners and program funders will have ample time to review ideas and recommendations and take appropriate action in advance of developing program proposals for the future provision of these goods and services across BC.

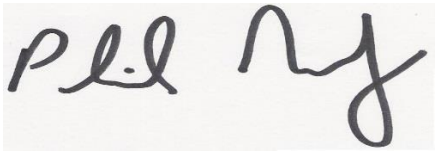
Regards;

Daniel Fontaine, CEO
BC Care Providers Association (BCCPA)
Metrotower 1, 1424-4710 Kingsway, Burnaby, BC, V5H 4M2
e-mail: dfontaine@bccare.ca Ph: (604) 736-4233 ext. 229

Ruth Marzetti, Executive Director
BCITS Technology for Living, BC Association for Individualized Technology and Supports for People with Disabilities
Provincial Respiratory Outreach Program (PROP)
Technology for Independent Living (TIL)
103 – 366 East Kent Ave S. Vancouver, BC, V5X 4N6
e-mail: rmarzetti@bcits.org, Ph:604 301 4201

Giovanna Boniface, Managing Director for BC
Canadian Association of Occupational Therapists (CAOT-BC)
PO Box 30042 RPO Parkgate Vlg, North Vancouver, BC, V7H 2Y8
e-mail: gboniface@caot.ca, Ph: (604) 765-9605

Jane Dyson, Executive Director
Disability Alliance BC
204-456 W. Broadway, Vancouver, BC V5Y 1R3
e-mail: jwd@disabilityalliancebc.org Ph: (604) 875-0188



Robert Boscacci, President, Phil Mundy, Executive Director,
Home Medical Equipment Dealers Association of British Columbia (HMEDA)
5810 Highbury Street, Vancouver, BC, V6N 1Z1
e-mail: robert@hmebc.com, Ph: (604) 821-0075, info@hmeda.com Ph: 778 239 9233

Chris McBride, PhD, Executive Director
Spinal Cord Injury BC
780 SW Marine Drive, Vancouver, BC, V6P 5Y7
Executive Directors Council
e-mail: CMcBride@sci-bc.ca, Ph: 604-326-1226

Discussion and Recommendations for Improvements for Future Assistive Devices and Durable Medical Equipment Delivery in BC

Executive Summary

BC's Ministry of Health (MOH), Ministry of Social Development and Poverty Reduction (MSDPR), Ministry of Children and Family Development (MCFD), WorkSafeBC, and the Insurance Corporation of BC (ICBC) each play a role in providing assistive devices for people with disabilities and seniors.

Community partners directly involved in service delivery, and organizations representing people who receive assistive devices have collaborated in drafting this report, providing recommendations as to how BC might improve medical equipment provision programs in the future.

Assistive device programs exist in every Canadian province and territory. Some are operated by the provincial MOH and some through provincial ministries delivering social safety net services. Equipment delivery systems generally involve client needs being assessed by a qualified prescriber (normally an occupational therapist and/or physiotherapist and/or a physician) working with home medical equipment (HME) providers. Equipment recommendations are submitted to funders who pay part of, or all, costs. Some provinces provide universal funding for all their citizens. BC's government ministry programs currently provide limited funding for mobility equipment, focusing on individuals receiving income support payments, that exclude students, working adults, and individuals over the age of 65. BC crown corporations (ICBC and WorkSafeBC) provide equipment funding as part of injury compensation programs.

BC's MOH operates two programs through regional health authorities. One of these focuses on provision of equipment for individuals with limited resources and newly released from hospital. This program is currently in the process of changing to more closely reflect best practice equipment assessment and prescription process. Regional health districts are encouraged to continue working to complete this transition.

The other MOH program is a new initiative where MOH has provided a grant to the BC Care Providers Association (BCCPA) for the development and management of a new province-wide Seniors Safety and Quality Improvement Program (SSQIP). This new initiative funds publicly subsidized residential care providers with equipment to enhance senior safety and quality of life.

As both MOH programs are either in the process of changing, or have been very recently launched, it is recommended that MOH and its partners continue these efforts and take steps to monitor future client and care-giver outcomes.

BC's Procurement Services manages a Master Standing Agreement (MSA) with the MSDPR, MCFD, WorkSafeBC, and ICBC. The two ministry programs provide assistive devices as part of the province's social safety net for people needing assistance. The two crown corporations provide equipment as part of injury compensation programs.

The current MSA has been in-place for at least ten years. Procurement BC manages a process where HME providers periodically compete for the right to offer equipment provision services in regions across BC. In developing this White Paper, clients, prescribers and equipment providers have identified concerns and made recommendations intended to improve client outcomes and program efficiencies.

The following paragraphs will outline specific recommendations.

One set of rules
The current MSA has four different sets of rules. When planning future MSA contracts, ensure funding stakeholders agree to a common set of rules governing supply of products and services. Clearly documented, commonly applied rules will be easier to understand and apply, benefiting clients, prescribers and providers.

Timely access to the right equipment
Steps taken to simplify and clarify funding rules and eligibility requirements will have a positive impact on processing speed. Time and effort will be saved if funders better-define the kinds of equipment within the scope of programs, providing direction well in advance of prescribers and HME providers assessing clients. This will reduce costs and delivery time.

Eliminate funding caps
Cost containment can be achieved through the contract tendering process where bidders submit a list of goods and services and discount offered relative to a manufacturer's suggested retail price (MSRP). Adding funding caps in addition to already agreed-upon discounts, especially after the start of a contract, is unreasonable and must not continue.

Varying basic and essential needs require more choice
Programs need to be more inclusive, recognizing the importance of mental health and well being, and the need for clients to actively participate in community. The current system arbitrarily outlaws some devices prescribers consider critical to a client's independence.

Fast-track low cost equipment
If equipment costing under $500 can be provided using a verbal authorization or equivalent means 'on the spot', the number of home visits will be cut in half and the client will have the benefit of receiving their equipment immediately.

Provide funding for batteries
When providing powered mobility, batteries should be listed as a separate line item and charged at MSRP less the contracted discount offered by contractors. This will allow contractors to provide batteries with a warranty matching the manufacturers warranty period.

Contractors' labour rate
Contractors need to bid labour pricing at a rate they can support within their operation and should bid a labour rate they will charge when supplying services.

Emergency repair service
Contracts must provide a more efficient means of authorizing emergency repairs. Leaving clients unable to use equipment for 3-4 weeks or longer while awaiting repair approval causes great hardship and puts client safety as well as their equipment at risk.

Access to a prescriber
Future MSA contracts should include government ministries procuring qualified prescribers to support MSA client assessments. WorkSafeBC and ICBC currently have contracted prescribers to ensure this task is completed for injured workers and injured drivers. The same support should be afforded clients without timely access to prescribers through the public system.

In conclusion, new MOH initiatives launched through the health regions and in collaboration with organizations such as BCCPA will hopefully improve outcomes for low-income individuals leaving hospital and for provincially supported seniors living in care. Furthermore, future MSA agreements could become a key component in BC's advertised "home first" provision of health care which holds that

residents should remain in their home as long as possible to reduce the costly prospect of hospital stays and/or building and operating more tertiary care facilities.

Physiotherapists and occupational therapists form the core of prescribers already charged with making decisions that directly affect the likelihood of a person being able to stay home and utilize a more basic level of care through provision of equipment. Working together with HME providers, future MSA contracts offer an opportunity to expand on this delivery model and save cost to our healthcare system at the same time.

Background - National Landscape

Data from the Canadian Survey on Disability (2012) indicates that nearly 3.8million community dwelling Canadians experience some form of disability. Of those, 8% use a wheeled mobility device, and a further 10% report a need for one (but do not currently have one). Of the 10% who have an unmet need, the most common identified need is for a mobility scooter (60%). (Giesbrecht EM, Smith EM, Mortenson WB, Miller WC (2017). Needs for mobility devices, home modifications, and personal assistance among Canadians with disabilities. Health Reports. 28(8): 9-15)

Approximately 1.2% of BC community dwelling individuals (about 46 000 people, not including residential care or any group living arrangement) require a wheelchair for daily mobility. (Smith EM, Giesbrecht EM, Mortenson WB, Miller WC (2016) The prevalence of wheeled mobility device use among community dwelling Canadians. Physical Therapy Journal. 96(8): 1135-42)

All provinces and territories across Canada offer some form of provincially sponsored funding aimed at supporting goods and services needed by people with disabilities and seniors. Provincial health ministries may provide funding to all citizens, or the provincial ministry overseeing the social safety net will target funding toward individuals unable to independently purchase equipment. For example:

- In Quebec, Regie de l'assurance maladie (RAMQ) offers a universal program, providing a limited range of needed equipment for individuals covered by the Health Insurance Plan.
- In Ontario, the Ministry of Health operates the Assistive Devices Program (ADP), also a universal program. Residents pay 25% of the cost of equipment with ADP funding the balance. Once provided, the resident owns their equipment. Individuals receiving disability support payments and children have no co-pay requirement and have 100% of the cost of their device covered.
- In Alberta, the Ministry of Health operates the Alberta Aids to Daily Living program (AADL). Residents pay 25% of the cost of new equipment, to a maximum of $500. Residents can apply for full cost subsidy if unable to fund their portion of cost. When no longer needed, equipment is returned to provincial inventories held at various locations (home medical equipment (HME) providers) across the province where it can be refurbished and redeployed.

Provinces use professionally trained prescribers, usually occupational therapists (OTs) and/or physiotherapists (PTs) and/or a physician to determine individual need and to provide home medical equipment. In BC, 90+% of assistive devices are prescribed by OT's working together with HME providers. Various products are first tested by the client. The goal is to find a device, or combination of devices, that allows the client to avoid or reduce health risks, accomplish tasks independently, get back to work and/or regain access to their community.

Best practice in equipment provision has been investigated and reported by BC health authorities, ICBC, and WorksafeBC. The following summary provides an overview;

Evidence-informed Equipment Prescription

Best practice for equipment prescription is an individualized process that utilizes the expertise of regulated health care professionals in the context of an interprofessional, team-based approach. Evidence-informed equipment prescription prevents under- and over-prescribing by matching individuals with the most appropriate device for their unique needs (Greer, Brasure, & Wilt, 2012).

According to current research (Karmarkar, et al., 2012; Khasnabis & Mines, 2012; EnableNSW and Lifetime Care & Support Authority, 2011), this best practice leads to:

- ✓ Better outcomes such as improved mobility or skin health,
- ✓ Maintained or improved functional ability,
- ✓ Increased engagement in daily activities, and
- ✓ Increased quality of life.

Evidence-based best practice guidelines for equipment prescription include a comprehensive collection of services including assessment and client evaluation, equipment selection and trial, equipment delivery, equipment training, and outcome measurement and equipment monitoring (National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance, 2014; Greer et al., 2012, Mortenson, Miller, Backman, & Olifee, 2012; Requeio, Furumasu, & Mulroy, 2015).

As an example, in the best practices for wheelchair prescription, various sources recommend interprofessional collaboration (as well as collaboration with the client and their family) in equipment prescription and outline similar steps in this process:

1. Assessment – includes a thorough assessment of client (noting physical, cognitive, and developmental functional abilities), environment, and equipment features;
2. Fitting/Trialing – clients trial equipment to ensure proper fit and function; wheelchairs must provide adequate support and feature appropriate measurements for seat depth and width and backrest height; and adjustments may need to be made for pressure ulcer prevention or to address functional needs;
3. Provision – includes choosing equipment with appropriate design and features for their users and environments, and training users;
4. Monitoring/evaluation – after equipment has been ordered, ongoing monitoring and evaluation ensures reliability and safety of the equipment, adequate fit for environmental and functional needs, and ongoing maintenance needs (Enable NSW and Lifetime Care & Support Authority, 2011; Khasnabis & Mines, 2012).

BC's Current Funding Programs

BC funds provision of assistive devices primarily through the following avenues:

- **Avenue 1 -Ministry of Health** - funded through Regional Health Authorities by the (MOH).
- **Avenue 2 – Procurement Services Master Standing Agreement** - funded through a collaboration of MSDPR, MCFD, WorkSafeBC, and ICBC via a Master Standing Agreement (MSA).

Avenue 1 - Ministry of Health

For many years, BC's MOH has provided direct funding to the Red Cross HELP program to assist health regions with patient discharges from hospital. Red Cross warehouses a variety of devices at locations across the province, using a mix of volunteers and paid staff to loan equipment to patients leaving hospital in need of an assistive device. Regional health authorities are currently in the process of updating this delivery system toward evidence informed equipment prescription. OT Practice Coordinators working in the Vancouver Coastal Health region report a variety of concerns regarding delays in placing people into their community.

- There is no consistent process for equipment justification. OTs must write letters to justify funding. The process is time consuming, inefficient and the responses are inconsistent.
- There is insufficient opportunity for equipment rental when equipment is needed for short-term use.
- There is little consideration of the need for community access. For example, items such as ramps are not made available. Scooters are very difficult to justify under the current rules.
- There is little consideration for caregiver safety, whether it be family or employed care givers. These concerns are critical when patient lifts, wheelchairs and adjustable beds are being used.

The MOH is currently working to improve this delivery system by exploring contracts with qualified HME providers across the province working in collaboration with prescribing therapists to provide equipment required upon hospital discharge as patients transition out of hospital care. Health regions have been in the process of engaging with HME providers for equipment delivery since early 2017.

Once a new system is in place, the health regions will complete this transition. It is anticipated that patient discharges will improve when prescribers begin working with professional equipment providers who assist with equipment selection, installation, user training and maintenance.

MOH recently launched a project in collaboration with the BC Care Providers Association (BCCPA) whereby publicly funded long-term residential care providers can apply for a grant to fund equipment through a Senior Safety and Quality of Life Program (SSQIP).

For targeted individuals already living in one of these care homes, funds are now beginning to flow that will provide a range of assistive technology devices as well as safety related equipment. A full description of the project and a list of equipment fundable via this program can be viewed here http://bccare.ca/programs/ssqip/. BCCPA is hopeful that this project will be extended in the future.

Comments and Recommendations – MOH

Currently, updates are being made to the MOH program designed to help individuals being discharged from hospital to procure equipment, but this process is not yet complete. The transition to using professionally trained staff to prepare, maintain and refurbish equipment being loaned is anticipated to produce notable benefits. Best patient outcomes are achieved when prescribing therapists work in collaboration with knowledgeable HME providers who can assist with equipment trials and the maintenance of equipment over the longer-term. When operated in collaboration with prescribing therapists and HME providers, loan equipment will be targeted to individuals unable to self-fund the rental or purchase of needed equipment. Others may be directed toward rental or direct purchase as needed, potentially reducing the cost to MOH.

The new MOH funding for BCCPA to manage the Senior Safety and Quality Improvement Program (SSQIP) is currently available to publicly funded residential care providers in BC. The needs assessment conducted by BCCPA identified over $26 million dollars is required by residential care providers, while the available funding for SSQIP is currently $10 million. The recommendation is to expand SSQIP funding to meet all equipment needs as identified by the residential care sector. In addition, expanding the equipment program funding to other sectors such as Assisted Living will further enhance senior safety and quality of life needs.

Avenue 2 - Procurement Services - Master Standing Agreement

For more than ten years BC has operated a provincial Master Standing Agreement (MSA) where four funding stakeholders contract together for provision of durable medical equipment for their respective clients. The MSA includes following Ministries and entities:

1) Ministry of Social Development and Poverty Reduction (MSDPR)
2) Ministry of Children and Family Development (MCFD)
3) WorkSafeBC
4) Insurance Corporation of BC (ICBC)

For funding stakeholders, the contract provides a vehicle for BC's Procurement Services to arrange supply of equipment at competitive prices across all regions of the province and to ensure consistent conditions around supplier participation. For contractors, the agreement provides access to an identified market, consistency of terms for supply and assurance of payment for goods provided. The contract provides funding for such items as;

- Manually operated and powered wheelchairs
- Patient lifting devices
- Specialized mattresses, pressure relieving support surfaces and adjustable beds
- Toileting and personal care devices

Operationally, clients arrange for an assessment by an OT, most frequently conducted at the client's home or at an (HME) provider location. Working with the assistance of one or more HME providers, the therapist develops recommendations for equipment. A request is submitted to one of the four funding stakeholders who review and decide if the equipment will be provided and funded under the MSA. Supplied items must include a two-year all-risks warranty supported by the HME provider.

Some equipment provided is of a universal design and can be used by most clients without fitting or customization. Specialized wheelchairs, lifting slings, some support surfaces and a variety of other items must be fitted specifically for an individual client, requiring added time and attention on the part of the therapist and HME provider during assessment and delivery stages. These items also require ongoing monitoring and maintenance provided by the HME provider through the life of the product. The price of some of these items can range from hundreds of dollars to $15,000 or more. It is important to ensure ongoing maintenance and repair are part of the delivery system.

Equipment provision must include training by knowledgeable suppliers related to use and maintenance of devices. For equipment used by residents of care homes, staff are involved in monitoring equipment to be sure it can be kept operating properly over the long term.

MSA contracts have been awarded via a bidding process managed by BC Procurement Services. Contracts have typically been for a two-year period plus extensions at the option of Procurement Services. Contracts are normally awarded to at least a few suppliers in each health region to ensure sufficient access for all residents within each region of the province.

The current MSA, signed by contractors in August 1, 2014, was originally set to terminate on August 31, 2016. BC Procurement Services has enacted two of its three options to renew and has extended the contract to August 31, 2018. If the Province exercises the last renewal option, the present agreement will expire August 31, 2019.

Comments and Recommendations – MSA Agreement

One Master Standing Agreement, but four sets of rules

The current MSA has been written primarily from the perspective of someone who is servicing clients of the MSDPR, and to a lesser extent the MCFD. These Ministries have different objectives for their clients compared with the other two significant entities, WorkSafe BC and ICBC.

The intention of the MSA is to provide goods and services for people needing support across the province, but rules relating to eligibility, level of funding and equipment selection are different for each funding stakeholder. This makes it difficult for clients, prescribing therapists and equipment providers to deliver goods and services efficiently. Overall quality can be improved if funders agree on a common set of goals and objectives and a common operational process. The current mosaic of criteria, rules, contractor redirection and changing contract interpretation is counterproductive. The result is delays in delivery of service and increased costs for all parties.

Recommendation – When planning future MSA collaborations, ensure funding stakeholders agree to a common set of rules governing supply of products and services. It is understood that the two ministry funding programs are part of BC's social safety net, while the two crown corporation funders are operating injury compensation programs. Regardless, clearly documented, commonly applied rules will be easier to understand and to implement, which benefits clients, prescribers and providers.

Timely access to Equipment as Recommended by the Prescriber

The purpose of the MSA is to ensure people with disabilities across BC have timely access to mobility equipment, durable medical products, and appropriate services. Some recipients report they feel this is not being achieved. The delivery system has been implemented in a way that results in some clients having to travel great distances to access a provider, when often there is a home medical equipment provider located much closer to where they live. Once a provider is engaged, in many cases delivery is unacceptably slow. Slow administrative processes, and funding program staff member questioning therapist prescriptions are significant factors that delay equipment provision. Prescribers are the primary decision makers when choosing what equipment is needed, yet Disability Alliance BC (DABC) members report that questioning therapist prescriptions increases waiting periods by as much as 10 months before critically needed equipment is provided.

Example – Processing delays and approving equipment other than equipment trialled by the client

In most cases, when a consumer is identified as in need of a device potentially funded under the MSA, a PT or OT (prescriber) and HME provider (contractor) meet with the client to determine what device might provide a 'best-fit' solution. Once the complexity of need is assessed and a potentially optimal device is identified, an equipment trial confirms suitability. Following a successful equipment trial, the prescriber provides a written recommendation for the device. The contractor then submits a quotation for the funding of the recommended device.

Disability Alliance BC reports it is becoming commonplace for MSDPR to request a second (or in some cases a third or fourth) quotation for equipment that has not been assessed by a therapist, trialed with the client, or recommended for provision to that client.

This situation raises the following concerns:

- The contractor receives an approval for a wheelchair that was not trailed by the client.
- The approved wheelchair does not match the wheelchair approved and recommended by the prescriber in their letter of recommendation.

- Th funder has ignored clinical expertise of the therapist prescriber and the trial experience, approving funding for something that has not been recommended or expected by the client.
- The contractor does not know if the untested product will work for the client. Regardless, the contractor will be expected to deliver the untested product and provide warranty support.
- The client has consulted with the prescriber and contractor in choosing a suitable device. They have tested the device to ensure suitability, but they receive a different device without being consulted.

Over the past three years, DABC reports an increased number of appeals related to the delivery of equipment that differs from that prescribed by a therapist. For example, last year a DABC advocate assisted an individual who had been assessed by an OT and then applied for a $10,700 wheelchair but was instead granted a $3,500 scooter. The funding adjudicator had contacted the client's OT and convinced her to support the client for a scooter instead of a wheelchair. With DABC assistance the client eventually received the therapist-recommend device following an appeal.

The equipment trial system has evolved over many years and has worked well when the client, prescriber and contractor work as a team in selecting equipment to be trialed. In this example, the prescriber's clinical recommendation and client's choice of equipment were not followed. The contractor is then put into a situation where they are expected to provide equipment without the benefit of a trial. Clients, prescribers, and contractors cannot be expected to take responsibility for a product that is not working as anticipated if the equipment has not been trialed by the client or recommended by the prescriber.

Recommendation –Simplify and clarify funding rules and eligibility requirements to see a positive impact on processing speed. This recommendation is essentially an extension of the previous recommendation suggesting a common set of rules for the four funding stakeholders. Furthermore, if funders can better define the kinds of equipment within the scope of programs and provide this direction well in advance of prescribers and HME providers beginning client assessment, significant time and effort might be saved, reducing costs and delivery time for all concerned.

One specific way to reduce processing time and to avoid trialling equipment that can not be provided, is for funders to provide therapists and HME providers with a specific list of products eligible for funding. If an approved list of equipment can be developed, clients, prescribers and HME providers will be better able to choose appropriate equipment meeting a client's needs as well as meeting the Funder's criteria.

Funding Caps for Specific Kinds of Equipment

Funding caps have been used to limit funding for some types of equipment. In many cases there is no possibility of supplemental funding arranged by the client and their health care workers. As a result, either no equipment is provided, or less costly but inappropriate equipment is provided and not used by the client.

Example – Funding cap on ceiling lift installations

Ceiling lifts are an important piece of equipment enabling caregivers, therapists and families to safely lift users out of bed and transfer onto other pieces of equipment. These lifts are often the most important piece of safety equipment in a client's home.

Currently, ceiling lifts are provided using a funding cap set at a maximum rate of $4,200 for 2 pieces of track, portable motor, a reacher, and two slings.

Ceiling lift costs have increased but the funding cap has not changed since 2010. A survey of supplier pricing data shows that from 2010 to 2016 the cost of materials has increased 19.72%. Installation requires two certified technicians. Trained and certified ceiling lift technicians are difficult to find and require compensation rates that reflect specialized skill. A typical installation requires two technicians working six hours, totaling twelve hours of labour. Using the current MSA rate of $80 per hour, installation labour cost to the provider will total $960.These increasing costs have led some contractors to stop providing these products for ministry funded clients.

Example - Funding cap on powered scooters

Under the current contract, funding for powered scooters has been set at $3,500 for most scooters and $4,500 for bariatric scooters. This amount includes two sets of Group 22 batteries (for which the cost is mentioned in 'Providing batteries at no cost' below).

Many scooters are currently well above the $3,500 cap. A review of MSRP for products commonly provided in BC shows prices range between $3,900 - $5,000 for mid-size scooters with batteries, or $5,700 - $6,150 for bariatric scooters including batteries. As MSRP continues to rise, contractors will no longer provide scooters under the funding cap.

Example - Replacement battery price cap

Batteries are an essential component of important medical equipment and on average need to be replaced every three to four years. Since 2010 contractors have seen battery costs increase each year at a rate exceeding inflation. During this same period the MSA funding limit has been unchanged. Contractors have great difficulty providing batteries to clients within this funding limit.

The current MSA contracted price is not sustainable. Contractors must provide replacement batteries at a price of $450.00, including installation. Labour needed to remove the old batteries, install new batteries and perform the required battery load test, as well as pay an associated disposal fees for the used batteries is charged at the labour rate of $80.00 per hour and results in a margin of under 2%.

Considering that the contractor will need to do an initial client visit, conduct an assessment, provide a quotation for the battery replacement, then go back to the client's home to provide the new batteries and process an invoice for work done, the cost of replacing batteries exceeds $450.

Recommendation – Funding caps should be eliminated. Cost containment can and is being achieved through the contract tendering process where bidders submit a list of goods and services and discount offered relative to MSRP. Adding funding caps in addition to already agreed-upon discounts, especially after the start of a contract, is unreasonably arbitrary.

Varying basic and essential needs require more choice

The current MSA offers a variety of funding criteria, rules and operational traditions. When we fail to understand the changing needs of our clients, or we simply ignore realities that affect part of the client group, the goal of facilitating access to a more normal life and access to community is unattainable.

Examples of client-specific situations that are not allowed consideration;

- Bariatric clients are unable to get approval for larger-sized equipment including wheelchairs, scooters and beds. Justification for beds excludes consideration of sexual health and its impact on mental health and overall well-being.
- MSDPR will not fund the provision of a ramp, regardless of cost. A ramp may enable a client to access a part of their home or provide ingress/egress from the home. Individuals unable to obtain this device are effectively shut-in and/or are wholly reliant on searching out alternative funding through other community services.

Recommendation - Programs need to be more inclusive and recognize the importance of mental health and well-being, the need to actively participate in the community and the need to conduct basic, every day activities. Enacting this recommendation will ensure the assistive devices provided are more likely to be used as intended, enabling clients to more fully engage in the community.

Provision for Low Dollar Amount Requests

When working with MSDPR clients, low dollar value requests for basic equipment have long been handled using the same process as is used with more complex equipment such as mechanical lifting devices and manual and powered wheelchairs. Clients, prescribers and contractors feel the process likely costs the system more than the value of the goods or services received.

In the case of MSDPR, equipment requests are channelled through the Health Assistance Branch for authorization. A therapist and contractor employed by a Health Authority must visit the client for an initial assessment and then complete a trial of the equipment prior to the prescriber recommendation, contractor quotation and subsequent approval. The Health Assistance Branch requires 1-3 months to review and approve provision of the device. Once authorization is received, the contractor must coordinate with the client (and sometimes prescriber) to go back to install equipment in the client's home.

Recommendation - Equipment of $500 or less should be provided using verbal authorization or equivalent means that could be done 'on the spot'. Two full length home visits could be replaced by one, and clients would benefit by receiving equipment immediately. The risk to clients would decrease compared to the current system where a client can await authorization for months. Consider granting these items automatic approval if recommended by an authorized prescriber.

Providing Batteries at No Cost

In the current contract, when supplying powered wheelchairs and scooters to SDSI and MCFD funded clients, power wheelchairs and scooters must be provided with batteries supplied at no added cost by the contractor. When a contractor purchases a powerchair or scooter from a manufacturer, batteries are never included in their price.

In all normal commercial sales of powered products, batteries are supplied and invoiced as a separate line item when invoicing.

Under the current contract, contractors must purchase batteries and install them into the units. SDSI then requires the contractor to warranty these batteries for two years. Often during the 2-year warranty period a contractor must replace batteries that are worn out. This mixing of two different products with very different life cycles creates problems for contractors trying to manage delivery and ongoing servicing of equipment.

Recommendation - Batteries should be listed as a separate line item and charged at MSRP less a contracted discount offered by contractors for powered mobility equipment. This change will facilitate contractors providing batteries with an appropriate warranty period matching the battery manufacturers warranty period. If a future contract requires batteries to be supplied with a longer warranty period, listing batteries separately will ensure contractors can plan to supply more than one set if required to meet the extended warranty time.

MSA Labour Rate

The current labour rate set in the MSA is $80/hour for service work and has not changed since 2014. Contractors report their costs in maintaining trained/certified technicians are increasing at a rate higher than the inflation rate.

Recommendation – In future bidding, contractors need to bid labour pricing at a rate they can support within their operation. In future bid documents, contractors should bid a labour rate they will charge when supplying services. Funding stakeholders will then evaluate each contractor's bid accordingly when selecting suppliers. This change will enable bidders to bid more competitively on original equipment supply knowing they will no longer have to subsidize artificially low labour rates during the contract term.

Provision of Emergency Services and Services Following the Two-Year Warranty Period

According to the current MSA contract, "The contractor should not perform any repair or service work on mobility devices or durable medical equipment after the expiration of coverage period for manufacturer's warranty without the receipt of a draw down".

Provision of medical equipment is quoted to each funder, including repair of mobility equipment outside of the two (2) year warranty period and repairs to other medical equipment (including emergency repairs) as required by clients. Quotations are done after an assessment by a contractor and sent to each funder for review. Historically, quotes for repairs for medical equipment have taken anywhere from 3-4 weeks. In recent years this has increased to 2-3 months to get work approved by some funders. During this waiting period, clients are unable to use their equipment.

Providing emergency repairs becomes more challenging when dealing with clients who have ongoing mental health issues. MSDPR clients have a higher frequency of damaging equipment, not related to typical wear-and tear activities, but due to uncontrollable frustration, lashing out, or other factors not likely to be attributable to poor product design or manufacture.

Contractors struggle with contract wording as clients often require emergency repairs after the two-year warranty expires. Examples include:

- a flat tire outside and far from home
- batteries in a powerchair have become discharged and the client cannot leave their home
- hospital bed is stuck in the upright position
- lifting system has stopped working and caregivers are using emergency services such as fire department to get client in and out of bed
- MSDPR client has broken something on their wheelchair making it unusable in it's current state

While the current contract explicitly states that following the two-year warranty period contractors must refrain from performing emergency services without prior authorization, urgent needs of clients

often require contractors to violate this rule to ensure client safety and continued access to their community.

Most contractors view their role in supplying equipment as a vital part in maintaining or promoting clients' participation and functioning in the community. When something goes wrong, a good contractor wants it fixed as quickly as possible. In the past, contractors have felt obligated to do the work and then issue quotes to funders requesting approval for the emergency repairs. Funders approved these quotations and contractors subsequently billed for the work done. In recent years contractors have noticed with increasing frequency that they are no longer receiving approval for work done on an emergency basis. In some cases, approvals are granted, but the approval is for less than the number of hours that had been required to complete the work.

DABC echoes concerns around the length of time it takes to get needed repairs approved. Clients can wait 3 – 4 weeks or longer and are unable to use equipment vital to their ability to participate in their community. The current contract process relating to post-warranty repairs is unmanageable, poses a risk for clients and must be changed to reflect the need to keep clients safe and keep their equipment operating.

Recommendation - Future contracts must provide a more efficient means of authorizing emergency repairs. Leaving clients unable to use equipment for 3-4 weeks or longer while awaiting repair approval causes great hardship and puts client safety as well as their equipment at risk.

Future MSA's could include a list of emergency repairs that can be undertaken without need for a preauthorization. There must also be a mechanism ensuring authorization for the completed repair is assured. A schedule of pre-authorized repairs could be developed along with the funded amounts.

Timely access to an occupational therapist

As per best practice guidelines, effective equipment provision requires the expertise of therapists (OTs or PTs) to ensure optimal health outcomes and prevent equipment abandonment (Houghton, Campbell, & CPG Panel, 2013; Wound, Ostomy and Continence Nurses Society, 2016; Greer et al., 2012; Clark et al., 2011; Di Marco, A., Russell, M., & Masters, M., 2003). However, access to occupational therapy services in BC is not always timely, and often unavailable.

Many issues influence access to occupational therapy services – delays in the public sector, seasonal staffing changes, and widespread shortages in OTs in BC contribute to long wait times and leave many citizens paying out-of-pocket for occupational therapy services. The distribution of OTs in BC varies, and one estimate suggests only 5% of OTs work in rural communities in Canada (Canadian Association of Occupational Therapists, 2011). A national physician survey indicates 61.6% of BC physicians are unsatisfied with access to publicly funded OTs (The College of Family Physicians of Canada, Canadian Medical Association, & The Royal College of Physicians and Surgeons of Canada, 2013). Depending on the client, wait times to see an OT in BC range from just over 4 months in the Northern Health Authority to more than a year in the Vancouver Coastal Health Authority (Provincial Advocate for BC Association for Child Development & Intervention).

Given the value of therapist expertise in ensuring prescribed equipment helps individuals achieve the best health outcomes, timely access to occupational therapy services is critical.

Recommendation - Private insurers such as WorkSafeBC and ICBC currently contract OTs to assess, trial, prescribe, and monitor equipment for their clients. Public service delivery would be more efficient if the MSA procured a list of qualified OTs or PTs to support clients accessing services through the public system.

Conclusions

Conclusions on MOH Program

Anticipated benefits of the updated MOH program will flow from the change to using professionally trained staff to recommend, provide, maintain and refurbish equipment being loaned.

The MOH grant provided to BCCPA to manage the Senior Safety and Quality of Life Program (SSQIP) will enhance the provision of needed equipment for seniors in publicly funded residential care homes.

Conclusions on Procurement Services – MSA Program

When planning future MSA collaborations, ensure funding stakeholders agree to a common set of rules to govern the supply of products and services, resulting in the process becoming easier to understand and apply, benefiting clients, prescribers and providers.

Steps need to be taken to simplify and clarify funding rules and eligibility requirements. Significant time and effort will be saved, reducing costs for all concerned, if funders are able to better define the kinds of equipment within the scope of programs and provide this direction well in advance of prescribers and HME providers beginning client assessment.

One possible way to speed up processing might be for funders to provide therapists and HME providers with a specific list of products eligible for funding. If an approved list of equipment can be developed, clients, prescribers and HME providers will be better able to choose appropriate equipment meeting a client's needs as well as meeting the funder's criteria.

Cost containment can and is being achieved through the contract tendering process where bidders submit a list of goods and services and discount offered relative to MSRP. Adding funding caps in addition to already agreed-upon discounts, especially after the start of a contract, is unreasonably arbitrary.

Programs need to be more inclusive, recognising to the importance of mental health and well being, the need to actively participate in the community and the need to conduct basic, every day activities. Including these considerations in decision-making will ensure the assistive devices provided are more likely to be used as intended, enabling clients to more fully engage in the community.

If equipment costing under $500 could be provided using a verbal authorization or equivalent means that could be done 'on the spot', time and cost savings will be achieved. Clients will have the benefit of receiving their equipment immediately. Clients will be at reduced risk compared to the current system where they can be left waiting for authorization for months.

Power wheelchair batteries should be listed as a separate line item and charged at MSRP less a contracted discount offered by contractors for powered mobility equipment. This change will facilitate contractors providing batteries with an appropriate warranty period matching the battery manufacturer's warranty period.

Contractors should bid a labour rate they will charge when supplying services. Funding stakeholders will then evaluate each contractor's bid accordingly when selecting suppliers. This change will enable

bidders to bid more competitively on original equipment supply knowing they will no longer have to subsidize artificially low labour rates during the contract term.

Future contracts must provide a more efficient means of authorizing emergency repairs. Perhaps future MSA's might include a list of emergency repairs that can be undertaken without need for a preauthorization. There must also be a mechanism ensuring authorization for the completed repair is assured. Perhaps a schedule of pre-authorized repairs might be developed along with the funded amounts.

Finally, future MSA agreements could become a key component in BC's advertised "home first" provision of health care which holds that residents should remain in their home as long as possible to reduce the costly prospect of hospital stays and/or building and operating more tertiary care facilities.

New MOH initiatives initiated through the health regions and in collaboration with organizations such as BCCPA will hopefully improve outcomes for provincially supported seniors living in care.

PTs and OTs form the core of prescribers already charged with making decisions that directly affect the likelihood of a person being able to stay home or utilize a more basic level of care through provision of equipment. Working together with home medical equipment providers, future MSA's offer an opportunity to expand on this delivery model while simultaneously saving cost to our healthcare system. We must seize this opportunity to make the process of equipment provision efficient, cost-effective, and capable of truly improving the lives of citizens who need home medical equipment.

References

Canadian Assistive Devices Association (CADA). Assistive Devices, Proactive Solutions for Ontario's Seniors and Persons with Disabilities, April 2018, www.cadaonline.ca

Canadian Association of Occupational Therapists (CAOT). (2011). CAOT position statement: Health human resources in occupational therapy. Retrieved from: https://www.caot.ca/document/3694/H%20-%20Health%20Human%20Res%20in%20OT.pdf

Clark, F., Jackson, J., Carlson, M., Chou, C.P., Cherry, B.J., Jordan-Marsh, M., Knight, B.G., Mandel, D., Blanchard, J., Granger, D.A., & Wilcox, R.R. (2012). Effectiveness of a lifestyle intervention in promoting the well-being of independently living older people: Results of the Well Elderly 2 randomised controlled trial. *Journal of Epidemiology and Community Health, 66*(9), pp. 782-790.

The College of Family Physicians of Canada, Canadian Medical Association, & The Royal College of Physicians and Surgeons of Canada. (2013). National Physician Survey. Retrieved from http://nationalphysiciansurvey.ca/wp-content/uploads/2013/10/2013-ByProvince-ENr.pdf

Di Marco, A., Russell, M., & Masters, M. (2003). Standards for wheelchair prescription. *Australian Occupational Therapy Journal, 50*(1), 30-39. doi: https://doi.org/10.1046/ j.1440-1630.2003.00316.x

EnableNSW and Lifetime Care & Support Authority. Guidelines for the prescription of a seated wheelchair or mobility scooter for people with a traumatic brain injury or spinal cord injury. EnableNSW and LTCSA Editor, 2011, Sydney.

Greer, N., Brasure, M., & Wilt, T.J. (2012). Wheeled mobility (wheelchair) service delivery: Scope of the evidence. *Annals of Internal Medicine, 156*(2), 141-146. Doi: 10.7326/0003-4819-156-2-201201170-00010.

Houghton, P.W., Campbell, K.E., and CPG Panel (2013). Canadian best practice guidelines for the prevention and management of pressure ulcers in people with spinal cord injury: A resource handbook for clinicians. Retrieved from: http://onf.org/system/attachments/168/original/Pressure_Ulcers_Best_Practice_Guideline_Final_web4.pdf

Karmarkar, A. M., Dicianno, B. E., Graham, J. E., Cooper, R., Kelleher, A., & Cooper, R. A. (2012). Factors associated with provision of wheelchairs in older adults. *Assistive Technology, 24*(3), 155-167. 10.1080/10400435.2012.659795

Khasnabis, C. & Mines, K. (2012). Wheelchair service training package: Basic level. Retrieved from: http://apps.who.int/iris/bitstream/10665/78236/1/9789241503471_reference_manual_eng.pdf

Mortenson, W.B., Miller, W.C., Backman, C.L., & Oliffe, J.L. (2012). Association between mobility, participation, and wheelchair-related factors in long-term care residents who use wheelchairs as their primary means of mobility. *Journal of the American Geriatrics Society, 60*(7), 1310-1315.

National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers: Quick Reference Guide*. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.

Requejo, P.S., Furumasu, J., & Mulroy, S.J. (2015). Evidence-based strategies for preserving mobility for elderly and aging manual wheelchair users. *Topics in Geriatric Rehabilitation, 31*(1), 26.

Wound, Ostomy and Continence Nurses Society – Wound Guidelines Task Force (2016). Guideline for prevention and management of pressure injuries (ulcers). *Journal of Wound, Ostomy, and Continence Nursing, 44*(3), 241-246. Doi: 10.1097/WON.0000000000000321