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At Home Program Medical Benefits

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Abstract

The At Home Program (AHP) Medical Benefits by the Ministry of Children and Family Development (MCFD) provides medical equipment to children and youth with support needs in British Columbia. However, there has been no formal evaluation of its effectiveness or the definitions of "basic" and "medically necessary" since its inception over 30 years ago. The number of children benefiting from AHP Medical Benefits has tripled in the past three decades. However, criticisms highlight inadequacies and outdated definitions, leading to inequities in accessing benefits. Studies show that children with medical complexity or neurodevelopmental disorders require more support, and caregivers often face burnout navigating the system. Three focus groups were conducted with healthcare providers and AHP Medical Benefits staff, revealing discrepancies in interpreting "basic" and "medically necessary" equipment. The adjudication process was critiqued for its length and lack of clarity, impacting access to benefits. In discussions, participants highlighted semantic hurdles, bureaucratic inefficiencies, and the need for clearer communication. Recommendations from focus group participants include clearer definitions, increased funding, and hiring healthcare professionals as AHP Medical Benefits staff. Frustration exists due to a lack of education and alignment between healthcare providers and AHP Medical Benefits staff. This research aimed to bridge this gap and improve policy alignment to better serve children and youth with complex needs. In conclusion, addressing the identified challenges and implementing the recommendations can lead to a more effective and equitable At Home Program Medical Benefits, ensuring better support for children, youth, and their families across British Columbia.

Keywords: At-Home Program, child welfare, medical benefits, eligibility, disability rights

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Introduction

The At Home Program (AHP) Medical Benefits is offered by the Ministry of Children and Family Development (MCFD) in British Columbia to provide medical benefits to children and youth with support needs. These benefits may include medical devices, transportation support, and additional healthcare coverage. The At Home Program Medical Benefits determines that children are eligible if they are dependent in a majority or all their activities of daily living (eating, dressing, toileting, and washing). Once children are determined eligible for the program, the adjudication process for the benefits requires the requested benefits be "basic and medically necessary" (such as to sustain life functions, support mobility, or to maintain proper bodily alignment). Recommendations are submitted by healthcare professionals to MCFD (Ministry of Children and Family Development, 2023). The number of children in BC utilizing the At Home Program Medical Benefits increased three times over the past three decades, from 1500 to approximately 4500 children (Representative for Children and Youth, 2020).

The Medical Benefits program has existed for more than 30 years. However, there has been no formal evaluation of the program and its effectiveness or the definitions of "medically necessary" and "basic." There has been criticism about the potential inadequacies and inequity of AHP Medical Benefits as children and youth and their family's needs have changed greatly since AHP Medical Benefits began and the definitions of "basic" and "medically necessary" may be outdated (Representative for Children and Youth, 2020).

Sponsored by MCFD and conducted by Master of Social Work students at the University of British Columbia, this research reviewed the current understandings of "basic" and "medically necessary" in the relevant academic and grey literature and via a brief jurisdictional scan. Focus groups with various professional stakeholders then explored whether the current definitions meet the needs of the children and youth and their families, as well as the service providers who access and interact with AHP Medical Benefits.

Literature Review

Definitions

The current definition of "medically necessary" is not clarified in provincial or federal legislation (Office of the Auditor General of British Columbia, 2014). However, current criteria include the maximum cost of equipment and services the system is willing to pay, what physicians can provide, what is scientifically proven to improve outcomes, and what is consistently funded from province to province. The current system assigns responsibility to the provincial health care systems to interpret "basic" and "medically necessary" to fit their own provincially run service delivery models (Forest & Stoltz, 2022). Further, there is a lack of transparency about "medically necessary" and like terms and definitions are not uniform or consistent across the provinces (Charles et al., 1997). Most programs seem to rely on other provincial or federal government caregiver benefits to fill that support gap within their services, including the AHP Medical Benefits (Ministry of Children and Family Development, 2023).

Other models of service provision exist. The Ontario Special Needs Strategy is based on the principles of family-centeredness, seamless information sharing, and inclusion. This model understands the family or caregivers are the best advocates for the children and youth accessing the services, second to the child or youth themselves (Ministry of Children, Community and Social Services, 2021). This means supporting the caregivers to achieve the best outcomes for the child or youth through preventative measures and interventions, which still aligns with the biomedical model, but also allowing the child or youth's caregivers to be involved in the care planning process.

Community Feedback

The literature includes some case examples and perspective from caregivers and community members on requesting provisions from the Medical Benefits program. Rud (2005) shared a story of a mother who applied for a therapeutic stroller for her son with Autism Spectrum Disorder (ASD). The mother considered the stroller to be an essential safety measure, as her son often became overstimulated and

displayed aggressive and unsafe behaviour. She had a recommendation from her occupational therapist stating the same. However, the application was rejected because the equipment was not part of the child's intervention plan. MCFD at the time required that funding for children under six must be "tightly tied to specific interventions and… as opposed to… general support" (Rud, 2005).

In another example, a mother whose son was born with a rare and complex developmental condition that caused him to be fully dependent, non-verbal, and use a wheelchair requested a standing frame that supports hip development and a comfort seat that maintains proper positioning. Both requests were denied as the cost exceeded funding caps, but these had not been updated for 30 years (Representative for Children and Youth, 2020). While there are some documents that support a push for "medically necessary" to include the provision of mental health as a medically necessary service, currently, access to these services is limited to the acute care setting within facilities, hospitals, or the private care market (Piturro, 2002; Thachuk, 2011).

Needs of Families

Studies show that children with medical complexity or neurodevelopmental disorders require more support in terms of access to healthcare (Cohen, 2011; Currie, 2023; Luymes, 2022). Caregivers for these children experience higher rates of burnout, connected in part to the requirements placed upon them to navigate the healthcare system (Currie, 2023). Additionally, Currie states that caregivers benefit from care coordination services. In 2022, MCFD released a service framework for children and families with support needs. The At Home Program Medical Benefits is included under this framework as a provincial service which provides equipment and medical supplies for children and youth with support needs. This document recognized the many barriers children and families face to access services, including the extensive process of diagnosis – which the At Home Program Medical Benefits requires for its users to request benefits (Ministry of Children and Family Services, 2022). The framework also indicates a primary service coordinator will be provided with a primary service coordinator for all children and families who are accessing multiple services. However, Luymes (2022) argues that even with this new framework, eligibility and available benefits are still unclear. While the implementation of this framework has been put on pause (Office of the Premier, 2022), the AHP Medical Benefits will be greatly impacted by this in the future.

Theoretical Frameworks

The AHP appears to be in line with the national standard of utilizing the biomedical model of care. The biomedical model understands health as the absence of disease, considering purely physical factors (Piturro, 2002; Thachuk, 2011). Children and youth eligible for AHP Medical Benefits may be receiving respite services that fall more into a biopsychosocial framework, but the AHP Medical Benefits assesses access to those benefits using a biomedical model of care (Farre & Rapley, 2017), as shown by the multi-step eligibility and adjudication process. Under the biomedical model, children and youth are required to have a diagnosis that firstly makes then eligible for the program, but also that makes them eligible for certain equipment. Presently, should the child or youth apply with a diagnosis that does not match the benefit they are requesting, their application for the benefit would get denied as it is not backed up by the descriptors of their initially disclosed diagnosis when accepted into the program (K. Chan, personal communication, November 2, 2023).

The social model of disability emphasizes disabilities not as an individual failure but rather as an impairment of society. The social model believes it is the way the environment and society respond to the impairment that defines disability (Barnes, 2020), including accessibility of services, environmental factors, and provider attitudes. Mauldin (2021) discusses the prevalence of bias within the medical field and argues that this bias – ableism – impacts access to services and benefits in the same way as racism or sexism by placing value, or lack thereof, on certain ideals and attributes.

The human rights model of disabilities further affirms that emphasizing impairment should not hinder human rights. Services should focus on removing barriers and consider securing fundamental and unconditional human rights so that regardless of social status, identity, physical condition, or any other status, all can enjoy equality in life (Degener, 2016). From a social work

perspective, human rights are a fundamental need. However, support is delivered by the AHP Medical Benefits based on the aforementioned eligibility criteria. Persad (2009) notes that it is impossible to decide how to allocate medical resources based simply on the idea of medical need, as providers will always consider additional criteria such as age, income, and life expectancy. Persad (2009) suggests an alternative decision-making framework, the complete lives system. The complete lives system considers how to save the most lives, support the most years of life, and prioritizes those between 15 and 40 years old, among other priorities (Kerstein & Bognar, 2010). However, Chen (2020) argues that even the move away from the simple idea of medical necessity will still result in discrimination, as quality-of-life metrics still unfairly target those with disabilities. She suggests that we move away from any model focusing on quality-of-life metrics and instead ensure that our decision-making models meet the guidelines set out by the UN Convention on the Rights of Persons with Disabilities (CRPD): "… reaffirm that every human being has the inherent right to life and [States] shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others" (United Nations Convention on the Rights of Persons with Disabilities, Article 10, 2006). Canada ratified this in 2010 (Robinson & Fisher, 2023). Chen (2020) argues that not providing access to medical equipment and treatment due to disability is discrimination.

These authors approach this research from a disability rights, human rights, and critically reflexive perspective.

Research Objectives and Questions

The research objective was to determine if the current structure and definitions for access and eligibility for equipment and supplies as part of the AHP Medical Benefits program serve the needs of service users. This was explored through three main questions: 1) How do providers who refer to At Home Program Medical Benefits interpret "basic" and "medically necessary" as it relates to equipment, supplies, and medical benefits?, 2) How do providers who refer to AHP Medical Benefits and AHP Medical Benefits staff use the definitions of basic and medically necessary to adjudicate benefits?, and 3) How is the current definition of "basic" and "medically necessary" meeting or not meeting the needs of the service users of the At Home Program Medical Benefits?

Methodology

Participants were invited to take part in focus groups through an email sent by the Ministry of Children and Family Development (MCFD) Research Sponsor. Invitations were sent to physical and occupational therapists (PT/OT), British Columbia Children's Hospital (BCCH) staff, and At Home Program (AHP) Medical Benefits staff. Inclusion criteria required that participants had experience working with families receiving AHP Medical Benefits and/or making or responding to recommendations for equipment and supplies through AHP Medical Benefits. Eligibility questionnaires and consent forms were provided for healthcare providers and AHP Medical Benefits staff during the first week of February 2024. Informed consent was received from all study participants through completion of the questionnaire. The study was approved by the University of British Columbia's (UBC) Behavioural Research Ethics Board (Ethics ID #H23-03409).

The healthcare provider enrolment was initially closed with 20 responses, but was reopened to allow for more responses as availability to attend the focus group was limited. The questionnaire was closed for the final time with 22 responses. From these questionnaires, seven participants were identified to attend focus groups in February 2024. All of these participants had over 10 years of experience.

The AHP Medical Benefits staff questionnaire was closed with five responses. From these responses, three participants were identified to attend a focus group in March 2024. All of these participants had under three years of professional experience. There was a total of 10 participants across all three focus groups.

Transcription for both healthcare provider focus groups was completed by Transcription Cosmos, and transcription for the AHP Medical Benefits staff focus group was completed by these researchers. Coding was then completed using codebook thematic analysis as

described by Braun and Clarke (2021). First cycle coding methods used included In Vivo coding, process coding, and versus coding (Saldana, 2021). Codes were then combined into themes that connected all three focus groups.

Findings

There are three main themes in our findings, including 1) Basic Vs. Beyond Basic, 2) Medically Necessary, and 3) Adjudication Process.

Theme 1: Basic vs. Beyond Basic

This theme captures the similarities and differences between how healthcare practitioners and AHP staff understood the reference to "basic" equipment.

For the interpretation of "basic", both parties shared a common understanding as the "most basic kind of barebones" that serves the minimal function. AHP Medical Benefits staff explained this using the metaphor of "A basic car that's gonna get you from A to B. It may not have a navigation system...You might not have your heated seats. So that's your basic vehicle," (Participant 9) adding that "basic components would be standard components" (Participant 8). While not disagreeing with this definition, most healthcare providers challenged that most equipment their clients need is not basic. One participant explained:

> I just think I have a problem with the word basic because the children that we work are not basic. So the children that qualify to get on to the At-Home Program to begin with have to have complex needs. So basic equipment often does not meet the needs of the kids that we are requesting this equipment for. - Participant 2

It was noted by AHP Medical Benefits staff that applications are adjudicated based on the least expensive equipment rather than based on what works best for the client.

> I'm sure that what they're recommending is what is gonna work best for that child but I have to look at it from a funding perspective and work within the parameters that I have. And that is. We don't fund Teslas as a backup devices. - Participant 8

Healthcare providers also criticized there being insufficient funds to purchase medically necessary equipment clients need. One participant mentioned:

> I think a lot of my families, a very common one is that it doesn't fund completely what they need. And if they're Indigenous then we can go with a lot of different funding sources. Or if they're really low-income, then you can go through Variety but only once a year. But our typical just managing middle-income kind of families, they're just out of luck. And to come up with an extra few thousand for every piece of equipment can start to be a challenge because they're also having to pay more for daycare and everything else. After all, most of these kids need one-on-one support. And if it's not available through supported child development, then they have to pay for that. So it's very costly for families. - Participant 3

It was also commented that some utilization of funds is ineffective.

> Sometimes if there's equipment required from other sources, the At Home Program will not want to maintain it. So when the wheelchair needs a repair, then we're kind of on the hook. And At Home Program would pay for a brand-new hospital bed or a brand-new chair rather than fixing less than a $100 repair on something that's provided from somewhere else. - Participant 1

Theme 2: Medically Necessary

This theme captions the different interpretations between AHP Medical Benefits staff and healthcare providers in terms of "medically necessary".

For the definition, AHP Medical Benefits staff referred back to and expanded the care metaphor used to understand "basic" equipment. One participant explained, "Let's say you've got a driver who struggles with navigation. You need that navigation system. So that's where you've got that increase. It's no longer basic, but it's necessary for that person" (Participant 9). Participant 8 adds on, "If you can justify why you are asking for it and it is for a medical reason and not for personal preference or because it will help the child with their independence and help them feel better in their everyday life, but it's not a medical necessity, then like that's generally where we wouldn't do it."

However, when asking about specific criteria, it was stated, "because every child's medical needs are different, so we don't have a standardized criteria"

(Participant 8), and "It depends on where they're at with their diagnosis and … what their needs are." (Participant 8). Healthcare providers expressed their opinion that the AHP Medical Benefit's interpretation "does not match with, I think, most clinicians' understanding of what medically necessary does mean" (Participant 5) and “it doesn’t reflect the lived reality of the clients and families we work with. It’s very outdated” (Participant 6).

Besides having a qualifying diagnosis, healthcare providers consider various criteria to justify equipment as being medically necessary, yet the equipment AHP Medical Benefits is offering fails to support children's functioning needs.

The first criteria that healthcare providers consider is whether or not the equipment is available commercially. Participant 1 states:

> School age children, a lot of the strollers, like feeding chairs, those kind of things are made for infants and toddlers. But when you get to be a school-age child’s age, and they don’t have those postural supports, they don’t make them commercially. So you’re going to have to ask for something more medically specific, and that requires funding from At Home Program, just to be able to function in daily participation and daily activities.

Participant 3 adds:

> Most of my clients have very complex needs that they don’t do well with, you know, they can’t just use crutches from Shopper’s Home Health. They can’t just use a basic aluminum walker that you buy at like Wal-Mart, right. A lot of them need fully supportive equipment. So exactly what Participant 1 said: it’s kind of like, well, their needs are so complex that we need the complex equipment that you’d go to At Home Program for that.

Healthcare providers also consider equipment that supports participation in the daily lives of these children, as demonstrated by this quote from Participant 2: “I think that we use our clinical judgement to decide when a kid needs equipment in their life to support their development and participation." Included in this consideration are discussions of their mobility and communication needs. Participant 3 shares:

> I have students that have spina bifida, so you know, they're paralyzed from the waist down. They have standing frames with giant mobile wheels, like a wheelchair, that they could be standing up and mobilizing around…They can use it in an environment at school, at home, with peers and so forth, right. But I've been asked so many times by At-Home Program, "We will not fund the wheels. We'll only fund the barebones frame, but not the wheels.” But I'm like, "Well, what's the point of getting the standing frame if there's no wheels? This child will not just stand in place." They’re too active and engaged. They want to participate.

Participant 2 adds, “We think of things that are not included beyond what we even talked about, like augmentative communication devices are not included. And it is medically necessary that a child has autonomous communication.”

The healthcare providers also noted considering things such as geographical location, caregiver needs, and future needs. They also shared that for them, it is often less important what a piece of equipment is intended to be used for than what it could be used for specifically for their identified client.

> We’re often justifying like the minimal medically justified piece of equipment and sometimes that is not the most basic, especially if there’s orthopaedic or neurological needs that we need to accommodate. One thing I’ve found in the past is that there’s often a holdup on the semantic or the description of things. And so for example, I had a student that was asking for an alternative positioning device for, and At Home program didn’t want to fund it because it was classified as a wheelchair. But we were wanting to use it for different properties and positioning needs, as an alternative positioning device, but because it was a – as described in the manufacturer’s – as a wheelchair, it wasn’t wanted to be funded because they already had a primary mobility device. So I think sometimes looking at more of the justification on why it’s needed, not necessarily the nomenclature of what it’s called, is more important to look at. – Participant 1

When exploring how the service providers and AHP Medical Benefits staff learn about the definition and

justification criteria for the program, it was reported that there is no formal training given to healthcare providers by MCFD or their schools. According to healthcare providers, knowledge was mostly learnt through knowledge exchange among colleagues and peers or experience in practice.

In terms of professional background, AHP Medical Benefits staff informed that they do not have any medical background, so they solely rely on detailed and accurate information from healthcare providers to facilitate the adjudication. The AHP Medical Benefits staff do have an Occupational Therapist as a consultant, but no Physiotherapy Consultant or medically trained staff on their team.

Theme 3: Adjudication Process

This theme captures the problems of the adjudication process. Both AHP Medical Benefits staff and healthcare providers raised concerns about the adjudication process as related to the justification of medically necessary.

Most of the healthcare providers expressed great frustration towards the adjudication process as a "long process" and "annoying", noting multiple back and forth requests for justification and quotes. For example, healthcare providers said:

> I find writing the letter is unhelpful because I don't think anyone actually reads the letter, because whenever they send you comments that they want more information, usually it's already in the letter and they haven't read it. They just – it's an automatic come back. They want more information. - Participant 7

Participant 5 shares:

> A lot of the process of writing the letter, depending on who it is on the other side that is reading it, and that has really changed over the years as to who it is that's making the decision on the other end, and whether or not they come back with completely inappropriate questions asking, "Well, why do they need this if they have this?" It's like, well, those are two very different things on that piece of equipment.

Healthcare providers also expressed feeling that the AHP staff question them heavily due to their own lack of understanding. They shared feeling a lack of trust, stating, "they need to trust us better, that we do know what we're talking about and nobody's trying to scam the system" (Participant 5).

On the other hand, AHP Medical Benefits staff explained the reason for the long process is because they have insufficient information to fully understand the client's condition. For example, Participant 8 shares:

> We always ask for more information to try to get the information we need from the therapist to make it a yes before we deny it. And I know that some therapists do get frustrated because they think that it's very clear in their justification.

They also said, "*We can't tell them what to say. We just have to ask questions to try to get the information and sometimes it works and sometimes it doesn't*" (Participant 8).

When discussing how the healthcare providers ensure they have a better assessment of needs for justification, they informed these researchers that they constantly discuss with cross professionals and communicate with families. Participant 4 shares:

> Many families take awhile to come around to maybe having a lift system in their house because they're used to carrying their child. So just being the person to not – yeah, to be there to have those conversations and like be there with the family and pros and cons and weighing things out I think also, but knowing that they are the ones that make the decisions for their child, and we are there to help support it and bring that knowledge we have.

In addition, healthcare providers and AHP Medical Benefits staff mentioned the lack of consideration for cultural support such as utilizing translators and intepretators throughout the application and adjudication process, which is needed for some cultural families.

It was also suggested that a demonstration and trial of equipment be conducted to help the families understand and better test whether the equipment fits the child. Participant 1 shares:

> So it's nice to do a trial, like a physical demo to have someone sit in a chair, and you could try propelling yourself instead of a chair that's set up for a caregiver to push you, for example. There's very different setups with those, and very different

pieces of equipment. So in order to have a clearer picture of what best suits that child's needs, the demo piece, and understanding that and families that don't speak English, having that interpreter there and being able to see it live, are a great combination for client-centred care and to inform a family's first decision-making.

Discussion

One of the main discoveries that came out of the discussions with the focus groups and the research in this study was that the current definitions and criteria being used by healthcare providers and At Home Program staff is not being interpreted in a streamlined and universally understood way. This finding is supported by the current literature that is available on the discourse regarding the efficacy of the definitions and use of the terms "basic and medically necessary". From these researchers observations and interpretation of the research data, these researchers believe this might be mitigated through the establishment of training programs in consultation with community health care providers and other shareholders.

The areas of concern raised by both AHP Medical Benefits staff and health care providers alike included a challenge of having complex referrals for children and youth to the program that were not needing "basic" equipment, but rather customized and specialized equipment. This supports the literature review findings that indicated studies show that children with medical complexity or neurodevelopmental disorders require more support in terms of access to healthcare (Cohen, 2011; Currie, 2023; Luymes, 2022).

Both health care providers and AHP Medical Benefits staff understood basic to be related to the value of cost of equipment. However, when applied to the child's needs they appeared to have differing interpretations.

When using the term basic, health care providers determined the equipment needs to be "basic" depending on the child's specific equipment care needs. The AHP Medical Benefits staff's interpretation prioritized the minimization of cost while attempting to meet the child's care needs. The term "basic" according to our literature review is understood to be defined as the least costly option.

The findings in these discussions support the findings of our literature review. There is no consistency nor clarity regarding how health care providers and AHP Medical Benefits staff are determining what is deemed and defined as "medically necessary" nor "basic".

These researchers observed a pattern of differing interpretations that impacted the efficacy of the program's capacity to meet the children and youth's identified needs. All stakeholders indicated a feeling of frustration with their respective system constraints, and limitations due to a lack of clarity in the application and adjudication process.

Both health care providers and AHP Medical Benefits staff would benefit from engaging in a joint conversation to establish a collaboratively developed tool for navigating the AHP Medical Benefits application and referral process, as it relates to a mutually understood definition of "basic" and "medically necessary".

Overall, participants stress the urgent need for streamlined processes, broader equipment, supplies and benefits coverage, and greater understanding of the challenges faced by families and healthcare professionals in navigating the system.

Limitations

There were some limitations in this study. First, there may be potential self-selection bias by the healthcare professionals and AHP Medical Benefits staff to participate in the focus groups due to time constraints of all parties. There were only a limited number of AHP Medical Benefits staff participating in the focus group, and minimal providers were able to participate. Researchers were not able to interview the AHP Occupational Therapist consultant, nor social workers and nurses who engage in the program to provide their comments, which limited the diversity in the data set.

Secondly, due to a lack of data resources and restrictions within MCFD, it is hard to access significant internal documentation and standard guidelines of the AHP Medical Benefits. The research relies heavily on the practitioners' interpretation.

Lastly, the At Home Program staff participants had between 1 and 3 years experience respectively, and

they may not be very familiar with the program compared to the healthcare providers.

Considerations

These researchers recommend that changes are made to the definitions of "basic" and "medically necessary". If possible, these researchers recommend these terms are removed from the At Home Program criteria fully, but recognize the potential difficulty of doing so. Clearer definitions would specify that equipment must be specifically proven to provide support based on the determined diagnosis of the identified child. The proof for this would be found through scientific evidence, such as research journals and case studies. It could also be specified that covered equipment will only include base components. For example, if a wheelchair is requested and approved, it will only include the base arms, base wheels, etc. Descriptions such as this would need to be written for each type of equipment.

As mentioned in the discussion, these researchers also note the implications for establishing trainings to support both healthcare providers and AHP Medical Benefits staff. For healthcare providers, these trainings could be implemented into their schooling. For certain providers, such as PTs and OTs, training should be included in mandatory classes. However, for providers such as social workers or nurses, these trainings might be made optional, depending on their identified area of interest. Additionally, these researchers endorse that a cross-professional training symposium be offered, perhaps for continuing education credit. These trainings would bring together both providers and AHP Medical Benefits staff to discuss current limitations, often observed issues, and proposed solutions.

Finally, these researchers believe that it would be highly beneficial for AHP Medical Benefits staff to have a medical background. Throughout this study, these researchers observed a lack of understanding from both sides of the referral process. These researchers suggest that if AHP Medical Benefits staff had a medical background, there would be less back-and-forth needed to gain understanding as to the justification of the need. This is in combination with the above suggestions will significantly streamline the process.

Conclusion

Overall, these researchers determined a heavy theme of frustration from both AHP Medical Benefits staff and healthcare providers. It appears that there is a lack of education and common understanding on both sides that is contributing to lower levels of client care and support.

In terms of defining "basic" and "medically necessary", these researchers found that while healthcare providers understand and acknowledge the definitions used by the At Home Program Medical Benefits and their staff, they do not agree that these definitions meet the needs of the children they work with. Both sides acknowledge that these definitions are heavily influenced by finances and this often leads to frustration for the healthcare providers, as they are viewing their client's needs from more of a holistic standpoint. Healthcare providers consider multiple factors such as participation, quality of life, and geographic location when interpreting the term "basic", while still acknowledging that the AHP Medical Benefits staff see this to mean the lowest financial cost.

This study determined that the current definitions do not meet the needs of service users, as the process takes a long time, often meaning that the needed equipment isn't available until it is no longer of use, as well as that service users do not receive support to participate fully in life or function at a reasonable level.

This research will contribute to potential changes to At Home Program Medical Benefits policy, and these researchers hope to see a new alignment between healthcare providers and AHP Medical Benefits staff in the context of "basic", "medically necessary", and the provision of medical benefits to children and youth with complex needs.

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Appendix 1: Healthcare Providers Focus Group Questions

1. What training and support are you given to help understand your role in working with families receiving Medical Benefits and making recommendations to the program?
2. The AHP defines "medically necessary" as a need directly related to the health condition or disability that qualifies the child or youth to be eligible for AHP Medical Benefits. The term "medically necessary" only applies to medical equipment and supplies under AHP criteria. What is your understanding of "basic" and "medically necessary" as they relate to the AHP?
3. What is the experience of applying for equipment and services under the Medical Benefits program like? What about the application process was helpful/unhelpful, and why?
4. How do you decide who to make an application for? What do you do or include in those applications to support the patient/client's case? Please maintain confidentiality of the client if you choose to share a case example using anonymized information (Do not use real names or reasonably identifiable information).
5. What measures do you have in place to ensure the accessibility of the medical equipment and benefits program to families with diverse needs or linguistic and cultural considerations, including throughout the application and assessment process?
6. How do you collaborate with families and other healthcare professionals to assess and determine the specific medical equipment needs of children and youth with special needs?
7. How do you respond to children and youth's evolving needs regarding equipment and supplies?
8. From your perspective, do you see any barriers that families routinely face to receiving Medical Benefits?

Appendix 2: AHP Staff Focus Group Questions

1. How do you go about the task of deciding eligibility for equipment and supplies under the AHP, and how do you ensure timely decisions? What specific criteria or guidelines do you use to assess eligibility for the medical equipment and benefits program for children and youth with special needs?
2. Have there been any formal or informal changes regarding adjudicating access to AHP Medical Benefits since you began in this role? What led to these changes?
3. How does your team try to understand the unique needs of each child, including identity and cultural diversity?
4. How are families supported to understand the criteria currently applied to Medical Benefits determinations? Please maintain confidentiality of the client if you choose to share a case example using anonymized information (Do not use real names or reasonably identifiable information).
5. What helps to promote equitable access or helps to reduce any potential bias in the adjudication process? Do you think any biases or structural barriers currently affect equitable access to equipment or supplies?
6. How are the input and recommendations from healthcare providers considered in the assessment process?
7. What is your perspective on the purpose and effectiveness of the current adjudication process for the AHP? What is working well? What aspects have you found challenging?