RESEARCH ON THE RUN

Health and Care Experiences

Improving continuity of care for older adults by optimizing home and community care partnerships

In this study, the client experience of transitions between home and community support services will be examined with the goal of improving information sharing, care management and continuity of care for older adults.

Key considerations

Home care and community support agencies typically deliver complementary services that assist individuals to remain in their homes; however little information is formally shared between these organizations.

Transitions between home care and community support services are fluid and can occur in either direction.

Overall management and coordination of home and community care services often falls upon the client and their caregiver, without consideration of their capacity or desire to fulfill this role.

Project overview

To remain living in their communities, many older adults receive care from several organizations, each providing a specific aspect of the care required. Often these services span the home care and community support sectors. Overall management and coordination of these services often falls upon the client and their caregiver, without consideration of their capacity or desire to fulfill this role. In this study, the client experience of transitions between home and community support services will be examined with the goal of improving information sharing and care continuity for older adults. In collaboration with clients, caregivers, frontline providers and home and community support organizations, the current processes in community care transitions will be described and the circumstances necessary for optimal transitions will be identified. New shared processes for care transitions will be developed and tools required to support these transitions will be adapted or created as necessary.

What we will do?

Phase 1: Identify Current Practices

First, to identify any existing processes or tools used to support transitions and information sharing in the community, a review of the academic and grey literature will be conducted. Then, to describe the current structures and processes of community care transitions and shared care in Ontario, the research team will conduct focus groups with providers and interviews with clients and caregivers. Three process mapping sessions with home care, community support and Local Health Integration Network staff will be held. Information gained from these sessions will be used to build a picture of the parallel processes taking place across the three care settings. Key touchpoints, where clients interact with service providers, will then be identified and client interviews will be conducted to understand any positive or negative experiences felt by clients and caregivers during these touchpoints.

Phase 2: Participatory Design of Community Transition Tools and Processes

In this phase, knowledge gained in phase one will be used to develop or adapt a tool/ tools to support information sharing across home and community care organizations and to develop a shared process to provide a more seamless care experience across organizations. Four half-day workshops will be held with clients, caregivers, care providers and home and community support organization management to collaboratively identify key principles to guide service design, develop shared tools and processes and operationalize results.

Phase 3: Pilot Testing and Evaluation

In the final phase, the new tool/tools and shared processes will be trialed with two organizations in one region to evaluate both care provider and client and caregiver experiences with the new tool/tools as well as the feasibility and effectiveness of the new processes for transitions in community care.

What do we expect to find?

In this project we expect to:

1. Describe the client journey through the home and community care system.
2. Identify and describe ideal continuity of community-based care from the client and caregiver perspective.
3. Develop a tool/tools to support information sharing between home care and community support agencies

involved in shared care and/or community care transitions for older adults.

4. To develop shared processes to improve transitions between community-based care agencies.
5. To understand the acceptability of using these tools and processes in practice.

Innovative approach:

A participatory approach was chosen for this project in order to develop a community transition process which is acceptable to all stakeholders and appropriately addresses any gaps in current processes identified in Phase 1. Harnessing the expertise of clients, caregivers, frontline providers and community support organizations to design the information sharing tool/tools and develop the shared processes will allow researchers to challenge assumptions and consider alternative perspectives regarding what is important to share and how information should be shared.

IMPACT: How will we move Knowledge to Action?

All outputs of this project will be made publicly available through the SE Research Centre website and shared directly with partner organizations involved in the development and testing of shared tools and processes. Through partnerships with provincial home care and community support associations, we hope to be able to broaden our reach to home and community support organizations who were not directly involved in the project. Additionally, results of this work will be shared with the wider research community through conference presentations and the development of peer-reviewed publications.

Who are our collaborators?

The SE Research Centre is partnering with SE Health to leverage their considerable experience mobilizing communities, nurturing partnerships and facilitating community-led development. Additionally, to capture the perspectives of organizations varying in size, location, target populations and resources, the SE Research Centre is engaging home and community support organizations from across Ontario. These organizations bring unique experiences which will assist the research team in developing a robust, adaptable solution which can be applied broadly.

Ottawa West Community Support (OWCS) and VHA Health & Home Support are engaged project partners in the Ottawa region and members of the study advisory committee. OWCS is a non-profit outreach ministry of Christian Churches in the West End of Ottawa, that provides practical support that assists our clients to remain living at home, in a manner which respects their dignity and worth. VHA Health & Home Support is a community support services provider which provides home support, attendant care and nursing services to individuals in the community with palliative, acute and chronic care needs. These organizations provide vital insight into successes and challenges facing the independent living sector as well as provide strategic linkages to other community support organizations through the Champlain Community Support Coalition in the Ottawa region.

Able Living Services Thrive Group and Circle of Care are engaged project partners in the Greater Toronto and Hamilton Area and members of the study advisory committee. Able Living Services is part of Thrive Group, a not for profit organization that provides a wide range of independent living support solutions, including in-home services and communal living options, for seniors and individuals with disabilities. Circle of Care, a part of the Sinai Health System, is a not-for-profit organization providing both

home health care and community support services. Circle of Care serves the diverse population of the Toronto region by providing targeted programs including language-specific care, supports for Holocaust survivors, caregiver support services and a range of programs for individuals living with Alzheimer's disease and related dementias.

Community Services for Independence Northwest (CSINW) is the final member of our advisory committee, representing the unique perspective of an organization providing care in Ontario's north. CSINW is a not-for-profit, charitable organization serving persons with a disability and seniors in Thunder Bay and Northwestern Ontario. CSINW provides access to barrier-free housing, support care services and recreation programs for seniors and persons with disabilities.

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How was this research funded?

For more information about this project, please see our webpage:

https://www.saintelizabeth.com/Services-and-Programs/Research-Centre.aspx

About the Saint Elizabeth Research Centre

SE Health has made a strategic commitment to research – $13 million over 13 years. The SE Research Centre conducts impact-oriented health services research and evaluation to synthesize, generate, translate, adapt and directly apply scientific evidence in the design, delivery and evaluation of person- and family-centred health and social care services.

At the SE Research Centre, we study the needs of people, their caregivers, and healthcare providers, to develop innovative solutions to tough health and social care problems.

The SE Research Centre has four fields of research and evaluation: *Aging in Society; Dying, Death and Grief; Health and Care Experiences; and Models of Care Delivery*

We see possibilities everywhere.