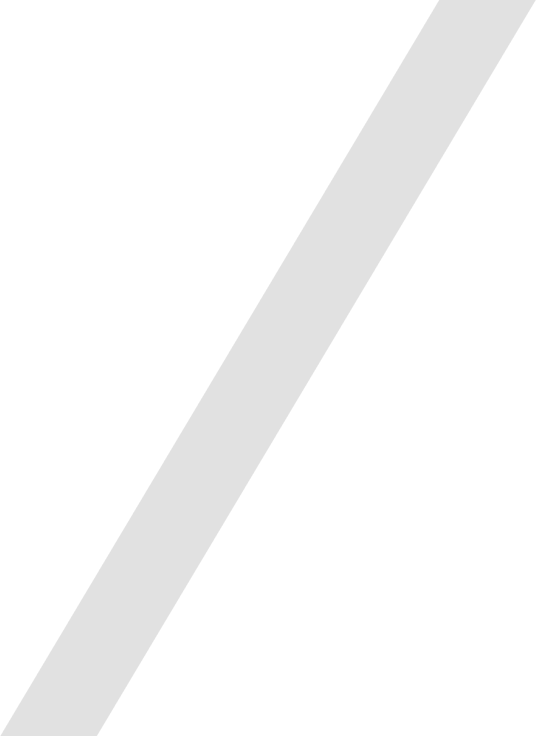
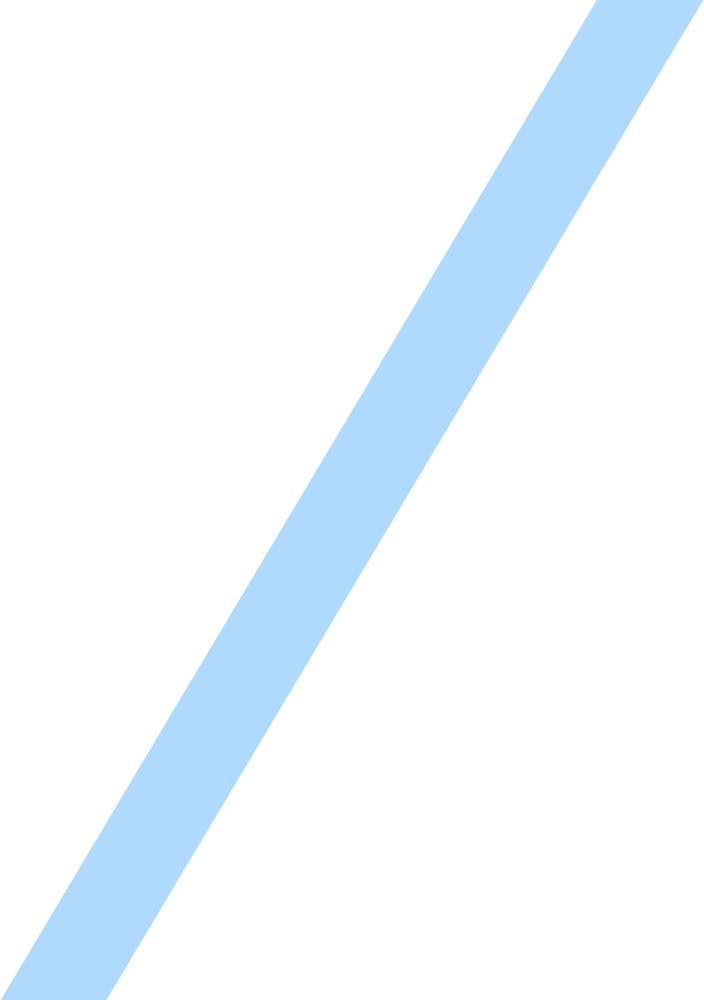
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| Rural Older Adult Transitions in Care |

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| Laura Poulin  2022 |  |





Report for Haliburton Highlands Health Services & Seniors Care Network

Published 2022

Trent Centre for Aging & Society

Trent University

Peterborough, Ontario

Canada

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\*Please note that some parts of this report were included in a submission to Health Standards Organization to help inform the National Standards of Long-Term Care in Canada.

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The logo contains a red canada flag

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**Abbreviations**

# Glossary of Terms/Abbreviations

ADL - Activities of Daily Living

CIHR - Canadian Institutes of Health Research

FTC - Failure to Cope

HHHS - Haliburton Highlands Health Services

IADL - Instrumental Activities of Daily Living

LHIN - Local Health Integration Network[[1]](#footnote-1)  
IV - Intravenous

POA - Power of Attorney

SCN - Seniors Care Network

SDM - Substitute Decision Maker

TCAS - Trent Centre for Aging & Society

WHO - World Health Organization

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**Glossary of Terms**

# Glossary of Terms/Abbreviations

Activities of Daily Living - A term used to describe the competencies required to independently care for oneself including but not limited to: eating, bathing, mobility, etc.

Alternate Level of Care - A designation given to patients in hospital when their acute medical needs have stabilized but they cannot be discharged as they are awaiting a ‘bed’ in another sector.

Bed Flow, Systems Flow, Patient Flow - The movement of patients through the health care system. This movement can be between care sectors or between departments/services in one organization. For example, the flow of patients from the emergency department into acute care.

Biomedical Model - The dominant model used in Westernized medicine where health is defined based on the absence of illness. This model focuses on disease, diagnoses and physical aspects of health rather than acknowledging the ways that sociocultural and psychosocial factors influence health.

Continuum of Care - An integrated system of care that is provided to patients over time and which may include many health and social services from different sectors (Swan, Haas & Jessie, 2019).

Follow-Up - Making contact with patients after discharge to identify barriers to successful transitions to other care settings and to ensure the provision of on-going support.

Holistic Care - Encompassing sociocultural, psychosocial, biological/medical, spiritual and personalized constructions of health into the care provided.

Identity - A term used to describe the factors that shape an individual and their ways of life including but not limited to rurality, gender, sexuality, ethnicity, etc.

Older Adult Health Construction - The contributing factors that shape interpretations and presentations of older adult health.

Informal Caregiver - Any person that has a connection to a patient and provides support for their health and care including but not limited to: family, friends, neighbours, colleagues, community members, etc. The level of support provided by each informal caregiver ranges greatly and is not necessarily on-going.

Instrumental Activities of Daily Living - A term used to describe the competencies required to independently care for oneself in the community, including but not limited to: grocery shopping, preparing meals, housekeeping, taking medications, etc.

# Glossary of Terms/Abbreviations

Length of Stay - The total number of days a patient has resided in hospital, including the number of days spent in the emergency department.

Linear Algorithm of Care - a set of rules that determine if a patient qualifies for discharge resources.

Local Health Integration Network - Prior to 2021, the government of Ontario established Local Health Integration Networks (LHINs) to act as regional authorities to coordinate, integrate and fund health services at a local level including hospitals, community health centres, long-term care homes, mental health and addictions agencies and community support service agencies.

Patient-Centred Care - A range of activities from a patient’s involvement in front-line care to the public’s involvement in developing health policy (Higgins et al., 2016). Health professionals, administrators, educators and policy makers have all developed different meanings of this term to shape research, policy and practice (Higgins et al., 2016). Whole-system patient-centred care identifies the common goal of streamlining services to personalize care provision (i.e. a focus on patient’s goals, needs and preferences) across the care continuum (Flumian, 2018; Khan et al., 2018).

Power of Attorney - A legal document that gives the authority for another person to make decisions regarding property, finances and medical care if a person has been deemed incapable of doing so. Power of Attorney papers are divided by 1) finances, property and estate and 2) personal/medical care.

Psychosocial Aspects of Health - Mental, emotional, social and spiritual aspects of health.

Quality of Life - The World Health Organization defines quality of life as “an individual’s perception of their position in life in the context of culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (WHO, 2012, p.11).

Relational Care - Developing care that reflects local strengths and is flexible to adapt to the diverse needs, preferences and goals of patients.

Rural Care Context - Elements of the rural community and the health care system that influence the health and care of patients.

Rurality - a term used to describe how facets of local contexts influence residents’ lives, perceptions, wants, needs, actions and attitudes. Rurality encompasses the connection between residents and the places that they live.

# Glossary of Terms/Abbreviations

Social Determinants of Health - Social and economic factors that influence health such as income, education, social status, ethnicity, gender, etc. (Canadian Public Health Association, 2021).

Social Positioning - The societal status of an individual based on the social stratification of society.

Social Stratification - The idea that systems and structures of society are designed to advantage certain sub-populations which leads to the hierarchal ranking of people based on income, age, race, education, gender, etc.

Systemic inequities - The way certain subgroups of people in society are disadvantaged due to engrained structures, systems and processes. For example, health and care inequities between patients exist in health care due to engrained facets of health care provision that disadvantage certain populations based on gender, ethnicity, sexuality, socioeconomic status, age, etc.

# Glossary of Terms/Abbreviations

Substitute Decision Maker - a person that by law is entitled to make decisions regarding property, finances and medical care if a person has been deemed incapable of doing so and in absence of Power of Attorney papers. A hierarchy of substitute decision makers is designated under the Ontario’s Health Care Consent Act (Speak Up Ontario, 2021).

Transfer Events/Transitional Care Events - Admissions or discharges of patients.

Transitional care - is a model of care that employs a collaborative and streamlined approach to care for patients across care settings to ensure coordination and continuity of care (Hirschman et al., 2015). The benefits of this model have been linked to improving the health outcomes and quality care of patients, while also contributing to increased health system efficiencies such as reducing readmissions and overall health care costs (Hirschman et al., 2015).

Transitions - The experiences of patients as they interact with the health care system over time and care setting.

Urban Centrism - The dominance and prioritization of systems, structures and processes that more readily align with and provide support for populations in urban centres.

## The “Rural Older Adult Transitions in Care” project explored the influence of older adult health construction and the rural care context on the experiences of older adults as they transferred between:

## a hospital and a long-term care home or

## a hospital and a residential home in the community

## The results provide insight into the ways in which rural care settings both enhance and inhibit older adult health during transitions in care. Quality rural older adult transitions in care in Haliburton County depend on rural health care providers leveraging the strengths of rural communities and redressing macro approaches to care, such as:

## a multi-coloured illustration on a city grey and green picture of a hospital bed

## Urban Centrism Bed Flow Prioritization

## illustration of a pink heart with a heart monitoring line through it Picture of an older person and health care staff a broken chain

## Biomedical Dominance Systemic Inequities Sectored Divisions

## These features of the health care system do not allow rural care providers the flexibility to adapt care to the goals, needs and preferences of rural older patients or leverage local strengths that could improve rural older adult transitions in care.

## To all of the participants, thank you for your openness and willingness to participate and for sharing your personal experiences with me. I hope that by sharing your stories and your words that it will compel others to recognize the strengths of rural communities and acknowledge the importance of your experiences across the care continuum.

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# Executive Summary

**Aligning Health Care Services with Older Populations & Rural Communities**

# Findings

# Findings

**Appreciating how Older Adults Define their Health**

In Ontario, health care services do not align with the ways that older adults define their health. While older adult health is holistic, interconnected, fluctuating, conflicted, unpredictable and unique, health services rigidly focus on macro system goals. For example, biomedicine is prioritized in the current structures (e.g., target health outcomes, quality indicators, funding allocation as well as provincially and professionally driven priorities) that guide the provision of care, which results in little support for health beyond physical and medical care. As a result, front-line staff face moral dilemmas during transitions in care as they attempt to navigate the divergence between macro system goals and the personal goals of their patients. These dilemmas put pressure on older adults and their families to accept the misaligned care options available, which increases responsive behaviours, decreases mental and physical health and/or leads to the decline of formal services (“refusal of care”). Consequentially, these macro driven health services make it very difficult for front-line staff to foster patient-and-family-centred transitions in care.

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| The 6 Ways that Older Adults Define their Health |
| **Holistic-** health is physical, psychological, social, spiritual and reflective of both individual identities as well as the social determinants of health. |
| **Interconnected**- factors that construct health are interdependent and cannot be treated or cared for separately. |
| **Fluctuating-** Individuals definitions of health and care change over time in response to their health presentations (e.g. physical/cognitive abilities, diagnoses, responsive behaviours), values, preferences, social networks, identities and the social determinants of health. |
| **Conflicted-** Individuals may define their health one way, but their actions may reflect other priorities. These conflictions can result from individual autonomy to prioritize other aspects of life (e.g. older adults may identify that exercise is important to maintain ‘good health’, but choose not to) or from societal inequities that act as barriers to pursuing ‘good health’. |
| **Unpredictable**- Trajectories of health are not always predictable. As such, identifying the type of care older adults will need in the future is also not predictable. |
| **Unique**- Older adults do not prioritize their health and care needs in the same way. Similarly, trajectories of health and care are not experienced in the same way. |

# Findings

# Findings

In rural communities, this macro approach to care counters the strengths of rural care provision by reinforcing rather than attending to the barriers of providing care to rural older populations. This section therefore presents the engrained nature of biomedicine, bed flow prioritization, sectored divisions, urban centrism and systemic inequities that overshadow the strengths of rural communities to attend to the complexity of rural older adult health during transitions in care.

**Biomedicine**

# Findings

# Findings

Support for the social determinants of health is required to provide quality care to geriatric populations across the care continuum. Many older adults indicate how the smaller, intimate feel of their rural community helps to provide holistic care as they transition between care settings. On the other hand, the biomedical model that is engrained in provincial health care practice impedes rural health care providers to leverage the strengths of their communities and attend to older adult health beyond biomedical care. While attention to physical and psychological health is important to rural older populations, these aspects of health are only essential to them to maintain their current lifestyles and/or pursue quality of life. Biomedical prioritization within health care then overshadows the strengths of rural communities and undermines the support required by rural older adults to maintain holistic aspects of their health during transitions in care.

Consider these examples of how biomedicine is engrained into transitions in care:

* *Required Reporting/Documentation:* Health care documentation typically only records the biomedical aspects of a patient’s health and care. In contrast, psychosocial patient information is often collected inconsistently and is rarely passed on to other internal or sector staff.
* *Staffing Considerations*: Staffing models and base education of health professionals is rooted in biomedicine. While attempts have been made to leverage other types of professional staff and training opportunities, many front-line staff still indicate that they do not feel comfortable talking about or providing interventions for psychosocial aspects of health during transitions in care.
* *Quality Management*: The patient data tracked by the LHIN to support quality management focuses predominantly on biomedical diagnoses. For example, readmission data is collected only for certain types of medical diagnoses rather than recognizing the influence of multi-morbidities and the social determinants of health.
* *Health Professional Regulatory Bodies*: Health professional regulatory bodies stipulate best practices and documentation requirements that are dominated by biomedicine.

Due to the prioritization of biomedicine in the design of our health care system, front-line staff have little time in their daily routines to actively dedicate to older peoples’ pursuit of quality of life or the social determinants of health. This focus of care then creates tension between front-line staff, informal caregivers and older patients as well as health system inefficiencies during transitions in care.

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# Findings

# Findings

**The Case of Data Management & Information Exchange**

Formal health care providers have extensive knowledge on the social determinants of health and patient-centred communication, yet documentation and information exchange during transitions in care more readily reflect other aspects of care provision. Specifically, data management and communication processes in health care prioritize biomedicine, risk management/liability and professional obligations. Psychosocial information on patients (e.g., preferences, informal caregivers other than the Power of Attorney/Substitute Decision Maker and family dynamics) is then not provided during transitions in care, which results in front-line staff not feeling comfortable providing care with the information that they receive from other sectors. In addition, front-line staff maintain that the information that they receive on patients is not always accurate due to the minimization of certain types of information (e.g., responsive behaviours). As such, front-line staff spend an exorbitant amount of time re-collecting and/or synthesizing the patient information that they need to provide care after a patient transfer.

These aspects of data management contribute to older adults and their families frequently having to repeat information that they have already provided to other internal staff or to health professionals from other care sectors (e.g., family physician, acute care staff, community care staff or LHIN staff). In particular, older adults and their families repeat their personal health and care information: 1) upon entry into a new care setting, 2) after a staff shift change, 3) when meeting a new staff with a different professional designation and 4) when meeting a staff who is visiting from a different sector. Even though older adults and informal caregivers repeat this information frequently, they still do not feel that they are involved in the formation of their plans of care. Addressing the inefficiencies that impact the management of patient information both within and between care settings then needs to be addressed to improve transitions in care.

**“I’m not sure that physical health is more important than mental health. I don’t know which is more important, but I don’t think you can separate them. You can’t feel physically well if you are mentally unwell and vice versa. Services really shouldn’t be geared to one or the other.” (Informal caregiver - Community 57)**

**Bed Flow Priorities**

# Findings

# Findings

Rural health care staff go beyond their front-line roles to attend to the needs and preferences of older patients during transitions in care. For example, formal and informal family meetings, attention to the ‘smaller aspects of care’ (e.g., getting blinds for a patient who is having a hard time sleeping in a bright room) and enhanced communication between rural health professionals foster high quality care of rural older adults between care settings. On the other hand, bed flow priorities overshadow the efforts made by rural health care providers by establishing a utilitarian rather than an individualized approach to transitions in care. Specifically, bed flow prioritization focuses on the efficient flow of patients through the health care system which results in the expedited admissions and discharges of rural older adults to free up ‘beds’ in other areas of the health care system. This approach focuses transitions in care on the efficient turn-over of patients, which places pressure on rural older adults to accept care options that do not fit their individual needs, goals and preferences (e.g., long-term care options out-of-county, home care that does not fit their rural lifestyles, etc.)

Consider some examples of how bed flow priorities are engrained into transitions in care:

* *Provincial Initiatives:* Bill 7 requires older patients designated as Alternate Level of Care in hospital to accept any long-term care bed available within a 70 or 150 kilometre radius depending on where they reside in Ontario. This bill overrides older peoples’ autonomy and displaces them from their informal caregivers and communities.
* *Funding Allocation:* Long-term care funding is based on maintaining maximum occupancy levels in long-term care homes resulting in the expedited discharges and admissions of older residents.
* *Quality Management:* Quality indicators in hospital focus on reducing Length of Stay and Alternate Level of Care rates, which focuses transitions in care on the discharge of older patients.
* *Staffing Considerations*: Admission, discharge and bed flow coordinators are common in both hospital and long-term care settings.

Bed flow priorities are particularly detrimental in rural communities where home care services are not as reliable or as readily available as in urban centres. These conditions result in unsafe discharges, the frequent readmissions of older adults back to hospital as well as tensions between front-line staff and informal caregivers/older adults. Interestingly, this focus on bed flow priorities also leads to rural health system inefficiencies. The Table following outlines these connections. Realigning health care provision to better support rural older patients and their families during transitions in care then may help increase rural health system efficiency.

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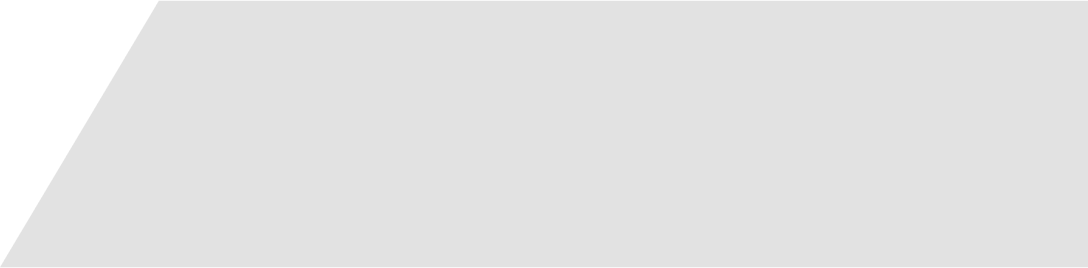
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# Findings

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| **Barriers to Patient Flow** | | |
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| **Identified Barrier to Patient Flow** | Impact on Older Adults' Transitional Care Experiences | Participant Quotation |
| **Family Tensions** | * Longer wait in hospital * Frequent readmissions | “A non-supportive family or a family who are just there to give you grief, antagonists, trouble makers.” (Front-Line Staff-Acute Care 20) |
| **Caregiver Burn-Out** | * Longer wait in hospital * Frequent readmissions * Moving out-of-county to obtain adequate levels of care * Accepting long-term care earlier than needed | “Family factors are also a huge barrier to discharges. Caregivers are often burnt out and push for their loved ones to stay in hospital because they feel they can’t manage them at home. They worry about taking them home and we have to provide a lot of support for them to take them home.” (Front-Line Staff-Acute Care 10) |
| **Limited Home Care Services** | * Longer wait in hospital * Frequent readmissions * Accepting long-term care earlier than needed * Moving out-of-county to obtain adequate levels of care * Complacency in just accepting the home care services available  FindingsFindings | “Staffing shortages in the community is delaying discharges because they need home care and we don’t have the hours in the community on a consistent basis. Often this means that older adults have to come back to hospital and keep coming back to the hospital because of the lack of home care.” (Front-Line Staff-Acute Care 19)  “They don’t have the staff to fulfill the hours, it’s a strain on the families and then they put them on the list for long-term care when maybe if they had more support at home they wouldn’t have to.” (Front-Line Staff-Long-Term Care 65) |
| **Biomedical/Episodic Focus of Care** | * Frequent readmissions * Moving out-of-county to obtain adequate levels of care * Accepting long-term care earlier than needed * Complacency in just accepting the home care services available | “If they don’t have a lot of support, transportation, limitations in financing or an understanding of their meds they’ll often come back.” (Front-Line Staff-Acute Care 44)  “Usually in acute care they’re just trying to get them out quickly and get the next person into the bed and this means we aren’t able to take into account all the aspects of a persons’ home life that is not helping this person thrive.” (Front-Line Staff-Acute Care 5) |
| **Lack of Insight & Individualized Health Experiences** | * Frequent readmissions * Complacency in just accepting the home care services available | “They don’t accept that they need long-term care even though they are in hospital often. Revolving door in and out.” (Front-Line Staff-Acute Care 16) |
| **Aversions to Long-Term Care** | * Longer wait in hospital * Complacency in just accepting the home care services available | “We have had a few patients live in hospital, but it’s because patients and caregivers have refused to go home or take a bed in long-term care and that’s why they stay in hospital.” (Front-Line Staff-Acute Care 10) |
| **Logistical Aspects of Discharges** | * Longer wait in hospital | * “When patients go home this can be complicated because there are a lot of things that need to be put in place to get that patient home. Equipment, services, home assessments etc. these all delay how long a patient is in hospital.” (Front-Line Staff-Acute Care 32) |
| **Cognitive Impairments/ Responsive Behaviours** | * Longer wait in hospital * Frequent readmissions * Moving out-of-county to obtain adequate levels of care * Accepting long-term care earlier than needed * Complacency in just accepting the home care services available | * “I have become a little more selective in my acceptance process, especially if there are behaviours. I have done some rejections and then I get challenged. I need to make sure I am saying something and reject them due to behaviours. I don’t think it is on staff or administration, but there is this underlying pressure knowing that patients are not getting the appropriate care they need because of behaviours, that they will just live in hospital and not get the supports they need.” (Administrator/Manager 78) |

# Findings

# Findings

**Consider this: The Moral Dilemmas Navigated by Rural Front-Line Staff**

Rural front-line staff face moral dilemmas as they try to navigate the individual needs of their patients and the macro priorities of the health care system. On one hand, emergency and acute care services are not designed to support non-biomedical health, which challenges front-line staff to care for complex geriatric patients (e.g. those with social needs, multiple-morbidities, chronic conditions & responsive behaviours) that stay in hospital. On the other hand, health providers indicate that home care services in rural areas can cause harm to older people due to the inadequacy of home care and community services in rural areas. Hospital staff are then tasked with whether to discharge a patient home knowing that they likely will not cope and will be readmitted back to hospital or keeping them in hospital knowing that the biomedical focus of these services will result in their health decline.

**Consider this: Health Professional Language Used to Safeguard Against the Impacts of Macro Care Provision**

The language used by front-line staff to describe patients acts as a safeguard to protect them from macro driven priorities of care that are out of their control. For example, front-line staff use language such as, ‘bed’, ‘social admit’, ‘FLC’, ‘ALC’ and ‘new admit’ to describe older patients in their care. These descriptors reflect bed flow priorities and/or highlight those patients that do not readily align with the biomedical focus of care.

In addition, prominent language in health care such as ‘live at risk’ or ‘care refusal’ place judgements on older adults whose definitions of health are not biomedically focused or who are averse to the biomedical or limited care options provided. For example, if an older adult chooses to go back to their community home even though health professionals are recommending long-term care, we indicate that they are ‘living at risk’ rather than prioritizing other aspects of life beyond physical and medical health. This language focuses on the actions of the older person rather than acknowledging the systems, processes and practices that do not fit older adult’s definitions of health or their individual needs and preferences.

**“The CCAC put pressure on me to put more long-term care homes on our list. It is only because I am a strong advocate that I haven’t. It’s a lot of pressure when that is not what we want.” (Informal caregiver -Community 33)**

**“My number came up so I had to move, otherwise someone else would take the bed and then you have to go on the bottom of the list if I didn’t want to go. Then I don’t know how long it would take to get in again, so there was a lot of pressure.” (Older Adult - Long-Term Care 27)**

**“Last Wednesday the LHIN called me and said there was a bed available and I had 24 hours to decide. 24 hours later she was at long-term care. It’s all been so quick so you review and review in your mind all the things you have to do. You have to make all these decisions so quickly and set things up so fast.” (Informal caregiver - Long-Term Care 75)**

# Findings

# Findings

**“Family has 48 hours to get out of the room, but when we are talking about funding there is a timeline.” (Administrator/Manager 78)**

**Sectored Divisions**

HHHS represents a progressive rural health system that has embraced integrated care to redress many of the barriers of providing care in less populated areas. Sharing staff between emergency and acute care to overcome human resource deficits and pooling resources to provide transportation services for medical appointments are just two examples of innovations that have been generated to enhance the care provided to local residents. In addition, the smaller community fosters enhanced interpersonal relationships between sector staff, which contributes to an informal communication network that improves rural older adult transitions in care. Even over the duration of the project, front-line staff worked together to generate new methods to provide better support for older patients with responsive behaviours transitioning into long-term care. Despite these resounding efforts of rural care providers, governmentally determined care sectors impede Haliburton County’s pursuit of fully integrated health and social services. These sectors result in divisions that compartmentalize the care provided to older adults and their families across the care continuum.

Consider some examples of how sectored divisions are engrained into transitions in care:

* *Funding Allocation:* Diverse funding sources and restrictions on the way that funding can be used to provide care impede the ability of HHHS to support a continuum of care.

# Findings

# Findings

* *Staffing Considerations:* Front-line staff are allocated by sector rather than deployed to areas of the health system in greatest need.
* *Quality Management:* Each sector has different approaches to quality management. For example, the accreditation process for hospitals and long-term care are separate and there is no accreditation body that focuses on the care of patients between sectors.
* *Jurisdictional Barriers:* Patients in long-term care do not have access to health professionals in the community and vice versa.

In rural communities, sectored divisions contribute to redundant processes, inhibit collaboration and act as a barrier to rural health systems integration. This divisive approach to care makes human resource deficits and service limitations in rural areas more pronounced by restricting the innovation of rural care providers. Sectored divisions are particularly detrimental to older adults who are discharged back to their rural homes due to the need for increased support immediately after hospital discharge and the lack of specific support provided to assist older adults in their rural homes (e.g., taking garbage to the dump, cutting fire wood, plowing driveways, etc.). Although rural health professionals often try to keep older patients in hospital longer and informally follow up with patients in the community, many older adults still struggle to cope after getting home and are often readmitted back to hospital as a result.

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# Findings

# Findings

**“Staff don’t seem to have any information. It’s frustrating because if they would look back at her medical history or looked at her old charts they would know that she doesn’t respond to that kind of antibiotic.” (Informal caregiver - Community 57)**

**“They can’t see the social worker or the geriatric psychologist. We still can’t share those services because they are driven by the government and the different funding sources don’t allow for it.” (Administrator/Manager 50)**

**Urban Centrism**

# Findings

# Findings

Rural communities are unique with a diverse range of resources, supports, advantages and challenges, however, these contextual features are rarely considered during older adult transitions in care due to the macro focus of service provision. While rural communities can provide an intimate and supportive culture, public health services are not incentivized to collaborate with private, secular, non-secular and research entities that are dedicated to the on-going improvement of local areas. This macro focus of care rarely fits the needs of rural communities due to the lack of consideration of human resource deficits, limited housing options, large travel distances, socio-demographics, socio-economics and the high cost of living in rural areas. As such, macro driven care leads to health inequities and access issues in rural regions due to the inability to leverage the strengths of local communities. Although rural care providers routinely adapt and innovate to overcome barriers to rural older adult transitions in care, provincially driven care models reinforce structures, processes and services that do not work in rural regions.

Consider how urban centrism is engrained into transitions in care:

* *Structures of Care:* Home care provision does not take into account geographical features (e.g., long driving distances, incremental weather etc.) which result in urban home care models that are ineffective in rural regions. This contributes to care inadequacies, high turnover rates and patients early entry into long-term care.
* *Care Environments*: The communal care environments in long-term care greatly contrast rural older adults’ prior lifestyles resulting in care aversions and declined services.
* *Funding Allocation:* Food costs in rural communities are significantly higher than in urban centres, however, these additional costs are not considered in the funding allocated to rural long-term care homes resulting in the food provided to rural residents being of lower quality.
* *Service Allocation:* The number of provincially allocated long-term care beds in rural areas is disproportional to the needs of older adults in rural regions. Many older adults must then access long-term care and/or assisted living outside of their communities, culminating in the displacement of older people and the requirement of additional resources to access care (e.g. travel time, finances & transportation access). Similarly, large catchment areas result in a lack of support from geriatric specialists since out-of-county services prioritize patients closest to where services are located.

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* *Provincial Support for Responsive Behaviours:* Ministry interventions for responsive behaviours such as 1:1 staffing undermine regional human resource challenges. While Behavioural Supports Ontario staff have been important to reduce responsive behaviours in hospital and long-term care, BSO staff in rural regions are typically shared between facilities, which counters best practice models of care that highlight the importance of consistent support.

# Findings

# Findings

For rural older adults and informal caregivers discharged back to the community, narratives of non-existent, inconsistent and impractical home care services are reflective of urban models of care. For rural older adults moving into long-term care, the communal and fast-paced care environments of these facilities greatly contrast residents’ previous lifestyles. Since these health care services do not allow rural older adults to maintain their rurality, aversions to care (‘care refusals’) are common during rural older adult transitions in care. The ability to adapt health care provision to local contexts is then paramount to ensure patient-centred care that considers the diverse regions in Canada in which older adults live.

**“It’s getting use to living with so many people after living on your own for so long. It’s hard. It’s really hard and there’s not support for that.” (Informal caregiver - Long-Term Care 87)**

**“They [residents in long-term care] don’t get fresh fruit and veggies because we pay more for shipping up here.” (Administrator/Manager -Long-Term Care 78)**

**“The ministry does provide 1:1 for behavioural patients, but you have to have the staff to do 1:1 and it’s a process to fill out the application and it is a real challenge to fill those shifts. If those transfers came with extra resources it would be different.” (Front-Line Staff - Long-Term Care 37)**

**Systemic Inequities**

# Findings

# Findings

Contemporary health care structures and processes engrain health and care inequities into practice through the establishment of macro driven care that is not adaptable to the diverse needs of rural older populations. For example, the high cost of living in rural areas (rent, food and transportation are proportionally more expensive in rural and remote regions when compared to the average household income) and long travel distances limit the amount and type of care that can be provided to rural older adults with lower financial means. These features of the rural care context result in older adults with lower financial means experiencing inequitable access to care, which restricts their ability to age-in-place.

**Consider this: Systemic Ageism in the Health Care System**

Senior Friendlymodels are emerging in health care, however, these initiatives are ineffective within broader systems that devalue older adults’ needs and preferences. Specifically, the prioritization of biomedicine, sectored divisions and patient flow internalizes ageism within the health care system. This approach to care positions older patients as an impediment to systems efficiency rather than as clients to be served. This rhetoric is so engrained that older adults, themselves, are concerned about their strain on the system and experience deflation when they fail to fit the services provided (Banerjee, 2015). The consequences of ageism are then cyclical: older adults avoid reaching out for support until the point of crisis, which increases the cost of care (Clarke et al., 2017; Levy et al., 2020) and perpetuates the stigmatization of older populations. Micro-aggressions towards older adults are then common in health care settings, not because health professionals are inherently ageist, but because older adults’ multi-morbidities, chronic conditions, social needs, cognitive impairments and responsive behaviours are hard to manage within services that are not designed to support geriatric patients.

Consider how systemic inequities are engrained into transitions in care:

* *Long-Term Care Bed Allocation*: Long-term care homes are prescribed a ratio of private, semi-private and basic beds. This bed allocation system results in rural older adults with lower financial means only being placed on the basic bed waiting list. This approach then results in older adults with lower financial means waiting longer for long-term care services in county and/or being pressured to move out-of-county to obtain timely access to long-term care.
* *Community Health Care Access:* Due to large driving distances and the cost of travel in rural areas, older adults with lower financial means are more likely to forego medical treatment, not attend health appointments, regularly accept long-term care services prior to requiring 24-hour support and/or are pressured into accepting care outside of their home communities.

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# Findings

# Findings

* *Lack of services available for older patients:* the lack of long-term care beds available in Ontario engrains ageism into front-line practice as older adults are required to plan for their potential future care needs. For example, older adults must put their names on long-term care wait-lists prior to needing 24-hour support in an attempt to avoid the 2-3 year wait time to access these services. Planning for potential future losses, however, is not expected of any other age category. This approach to wait-lists results in older adult health decline either due to older people waiting for services that they need or due to accepting a bed out of fear that another bed will not become available.

**“In this particular case he was able to afford to live in his home and we were able to pay for a full-time caregiver. That meant that he had three square meals a day. She would bring him a newspaper. Check in on him. Do laundry, housekeeping. That allowed him to maintain his independence, but not everyone has that luxury.” (Informal caregiver -Community 73)**

**“Patients that are moving from hospital are the patients on the private list. This is an example of where money matters.” (Front-Line Staff - Acute Care 32)**

**Consider this: 2 Loopholes to Skip the Long-term Care Queue**

To avoid the impact of extended wait-times for long-term care, two loopholes are sought out by applicants to circumvent the social stratification of the admissions process. First, applicants can pay for a private room temporarily upon admission and then be placed on an internal transfer list for a basic bed. Since the wait-list for private beds is typically less than the wait-list for semi-private and basic beds, this loophole helps older adults to gain entry into long-term care faster. Second, older adults can be placed on a crisis list which allows them to be prioritized entry into long-term care above others who are on the wait-list. Interestingly, those applicants who put their name on the wait-list for long-term care ahead of time wait longer in hospital as a result.

**“It’s not fun getting older because you have to do what other people want you to do instead of what you want to do. I have no more home. He said this is my home and I said not in my brain.” (Older Adult -Long-Term Care 83)**

# Findings

# Findings

**“BSO was supposed to be put in place to combat wait-times for long-term care, but as someone pointed out BSO is not going to help with wait-times when there are no beds to go to. They can help stabilize a patient through interventions that work for behaviours, but if patients aren’t able to move out of hospital because there are no beds in long-term care, that’s the real problem.” (Front-Line Staff - Acute Care 45)**

**“There is something wrong with the way the wait-list to get into long-term care is done. It’s like patients put their name down because they know that the wait is so long, but then patients aren’t ready when their name comes up. A lot of times people come to long-term care earlier than they use to and this decreases their life span because they don’t know when the next bed will come available.” (Front-Line Staff - Long-Term Care 36)**

**“As you age, you feel that you are being ignored and that your issues are not as important as those people who are 30-40 and that it’s expected that you will decline. It’s throughout the system, it starts with doctors and goes all throughout from nurses to care workers.” (Informal caregiver - Community 46)**

**“There is a pressure on older adults as the health system describes them as bed blockers.” (Informal caregiver - Community 54)**

**Experiences of Older People and their Caregivers**

# Findings

# Findings

**Tensions between People**

The misalignment between macro health systems and the needs and preferences of older populations generates tensions between people during transitions in care. These tensions greatly contrast the intimate feel and strong interpersonal relations between rural residents, which is one of the greatest strengths of rural care provision in Haliburton County. While older adults and informal caregivers outline the superiority of support that they receive from rural health professionals, many older patients still feel frustrated by their needs and preferences not being met during transitions in care.

**System goals versus patient/informal caregiver goals**

Health system goals foster a utilitarian approach to care rather than an individualized approach. This discrepancy causes tensions between front-line staff and older patients/informal caregivers during transitions in care due to services that are not designed to address older peoples’ needs and preferences, offer ‘choice’ or prioritize quality of life. While rural health professionals acknowledge the need to foster patient-centred care, many identify that this approach to care is not possible within the current priorities that are valued within the health care system.

**Professional goals versus patient/informal caregiver goals**

Health professionals have an extensive amount of knowledge on the interventions needed to make people physically well. These professional goals can conflict with older patients/informal caregiver’s goals that more often focus on maintaining quality of life. As such, tensions can arise between health professionals who are trying to share their expertise and older adults/informal caregivers who do not wish to pursue physical/medical care goals.

**Service/care decline (‘care refusal’)**

Due to the prioritization of health system goals (e.g., biomedicine, bed flow, etc.), older adults and their informal caregivers decline care/services during transitions in care. This generates tensions between older adults, informal caregivers and front-line staff.

**Conflict over care authority**

Tensions over who has authority over care, property and estate occur during transitions in care between informal caregivers as well as between informal caregivers and older adults. These tensions are complicated by a patient’s capacity, role re-negotiations within the family structure and legal designations of authority over care and finances (e.g., Power of Attorney/Substitute Decision Maker/ Public Guardian and Trustee). These tensions are particularly prominent in rural areas due to the lack of social care professionals to help older adults and their informal caregivers mediate these challenging conversations.

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# Findings

# Findings

**Antagonism between health professionals in different care settings**

Rural health professionals have strong interpersonal relations that are enhanced by an informal network of communication in Haliburton County. On the other hand, large catchment areas for specialized services and a lack of services allocated to the county for complex geriatric patients (e.g., responsive behaviours, addictions, social determinants of health etc.) foster antagonism and distrust between rural health professionals in different care sectors. Specifically, complex geriatric patients are often caught in limbo between care services as they do not readily fit the mandates of any of the rural services provided. This causes tension between health professionals in different care settings over who is most capable of providing care for geriatric patients with complex needs.

**Increasing Choice to Decrease Aversions to Care**

# Findings

# Findings

Fears of dependency and losing autonomy frequently impact patient engagement during transitions in care. While rural care providers are knowledgeable in patient-and-family-centred approaches to care, contemporary health care systems do not provide opportunities for rural older adults to exercise their autonomy. For example, once an older adult requires a set number of personal care hours their only option (if they are not affluent) is to accept a bed in long-term care. Certainly, moving into long-term care is not experienced by older patients as a ‘choice’, but as a threshold in which a person’s physical care needs surpasses what can be provided for in their community. Since older adults fear dependency and losing their autonomy, this lack of care options deters older adults from accessing formal services until a point of crisis. In rural communities, aversions to long-term care settings are particularly strong as accepting care is connected with losing their ability to maintain their rural lifestyles. Even older adults with severe cognitive and physical impairments who are no longer capable of making the decision about moving into long-term care have strong aversions to accessing these services. To increase patient engagement during transitions in care it is then vital to expand the care options available to older people and their informal caregivers so that they can actually make choices that impact their care.

**“My mom would never have agreed to go into a home. There is no long-term care application. Never in a million years would she agree to go into long-term care.” (Informal caregiver - Community 56)**

**Consider this: Ableism Limits Care Options**

Long-term care facilities indicate that older adults have a right to smoke, yet residents are permitted to smoke only if they can get to the designated smoking area safely or if someone can assist them. The biomedical focus of formal care, however, does not allow front-line staff to prioritize assisting residents outside to smoke even if the older resident indicates that smoking is an important aspect of their quality of life. This approach to care engrains ableism[[2]](#footnote-2) into front-line practice by taking away residents’ choices due to physical and cognitive impairments.

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**“We have three gentlemen in here that smoke, but when they move in here we don’t allow them to smoke unless family take them. (Front-Line Staff - Long-Term Care 40)**

**Consider This:** **Risk or Pursuit of Quality of Life**

# Findings

# Findings

Current care practices in long-term care stipulate that older adults can consume solid food even if they have been prescribed a puree diet. This resident is said to be choosing to “live at risk”. This use of language, however, places judgment on residents who prioritize other aspects of health over their physical health or who would rather choose death over losing their quality of life. In this case, health care practice defines these actions as a form of risk whereas residents connect these actions with their pursuit of life.

**The Emotional Overlay of Health and Care**

# Findings

# Findings

Older adults and their informal caregivers have emotional responses to transitions in care due to experiences of loss in later life. Health system priorities, however, undervalue these experiences of loss, which leaves rural health professionals little time to provide emotional care to older patients and their families. The 7 Ds model below outlines the common experiences of older adults and their informal caregivers during transitions in care.

**“They don’t recognize that needing more care means you are moving away from someone you have lived with for 23 years.” (Informal caregiver - Long-Term Care 26)**

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**The 7 Ds: The Emotional Overlay of Transitions in Care**

# Findings

# Findings

**Detachment**

Older adults and informal caregivers describe discharges as being a detached experience. While many older adults and their informal caregivers identify concerns about discharge (e.g., how they will cope, if their health will continue to decline, what long-term care will be like), bed flow priorities and sectored divisions result in hospital staff not supporting older people after discharge. For example, follow-up with patients in the community or in long-term care are rare, yet older adults who receive follow up after discharge describe how this support enhances their care experiences.

**Displacement**

# Findings

# Findings

Older adults experience displacement during transitions in care from the intimate social networks that they previously maintained. In the community, older adults must re-negotiate their relationships with their neighbours, spouses and adult children in response to the additional time and energy required to manage their ADLs/IADLS after hospital discharge. In addition, some adult children or spouses may be taking on caregiver roles for which they are not accustom. When older adults move into long-term care, sentiments of displacement become more pronounced as older adults are required to live apart from their spouses and are estranged from other family members, neighbours, acquaintances and/or religious communities. For example, long-term care services limit impromptu social interactions with neighbours, which affects older resident’s relationships with these individuals. Similarly, even though older patients may receive regular visits from close family and friends, there is a lack of intimacy and a decreased frequency of social interaction with these individuals, which permanently alters their close relationships. In rural communities, older adults are frequently required to move out of county to access long-term care services, further limiting their connection to their loved ones and communities. Older adults and their caregivers then grieve the new parameters of their relationships during transitions in care.

# Findings

# Findings



Rural older adults experience displacement as a relinquishing of their ruralityas many older adults must move out-of-county to access long-term care services. Rural residents in long-term care experience both physical and psychological health decline due to being physically and emotionally displaced from their intimate social networks.

**Dispossession**

Older adults moving into long-term care must give up their property, estate and personal possessions. In rural communities, dispossession is expedited due to the high cost of living and the high cost of care in these areas. For example, many informal caregivers struggle with transportation costs to visit loved ones in long-term care and/or afford accommodation in rural areas. These circumstances then result in joint property and estate being sold upon their spouses’ entry into long-term care to afford these additional costs. Older adults grieve these losses as many have accumulated personal belongings over their lifetime that hold sentimental value to them and they connect these possessions with aspects of their lives that they must leave behind.

**“Patients feel they have been stripped of all the things in their life. They have everything at home and they are limited in what they can bring here. They had a whole different life and it can be hard to accept care. It’s almost like they are being stripped of everything when they come through those doors.” (Front-Line Staff-Long-Term Care 61)**

# Findings

# Findings

**Dependency**

Older adults feel as though requiring care means they are forgoing their autonomy and their independence. Since older adults identify and value independence as an inherent part of their identities, many older adults are responsive to care or avoid asking for help which leads to the crisis nature of hospital and long-term care admissions. In long-term care, older residents are also triggered by other residents who exhibit severe cognitive and physical disabilities that they are not a custom to. These daily interactions with other residents result in older people self-reflecting on what they have lost and their proximity to end of life.

**“To make this better people have to recognize that it isn’t just a move. It’s not you supply me with a bed and meals and care and I’m good. It’s a huge mental process. I don’t know how long transition is, but I know I am still in it.” (Informal caregiver - Long-Term Care 90)**

**Decline**

Older adults experience transitions as a decline of their holistic health which results in them grieving aspects of their life that they can no longer live. Certainly, physiological and psychological aspects of health become more pronounced, leaving little time and energy for other aspects of their lives that they once enjoyed. Informal caregivers are also deeply impacted by the decline of their loved one’s health and grieve the former relationship that they once shared. Despite the extent of these emotions, informal caregivers rarely share these experiences with formal health professionals and many informal caregivers indicate that they do not have the time or energy to participate in the current formal support programs that are made available to them.

**“It’s a grieving process. You have to get use to a whole new life. I am not better in here. They keep saying I’m better in here. And they say I need to be here because of my health needs, but I don’t think so.” (Older Adult - Long-Term Care 27)**

# Findings

# Findings

**Death**

Transitions in care are connected with the processing of mortality. For older adults moving into long-term care, many residents have difficulty processing that this will be their last move as well as the eminency of end of life. Older adults reflect on their lives, their memories, their achievements and their regrets as they transition. While older adults require support for these losses, palliative and bereavement services are only initiated at end stages of life, if they are initiated at all (Gallagher & Passmore, 2020).

**Consider this: Bed Flow Prioritization Overshadows Loss of Life**

Language used in health care such as ‘open bed’ or ‘discharge’ describe an older adult’s death. This language illustrates the lack of attention to the losses experienced by front-line staff, other patients and informal caregivers due to the prioritization of patient flow during transitions in care.

**“Who knows maybe in a couple of weeks I’ll feel better about it, but it’s hard to know and I keep coming back here, that I am here for good. I am here permanently. I’m too old. I am going to die here for sure. This is where you come to die.” (Older Adult - Long-Term Care 83)**

**Valuing Older Peoples’ Experiences of Health & Care Over Time & Place**

Older adults experience health and care as a process over time that is not restricted by any one care setting. In contrast, health care services fixate on transfer events (e.g., admissions & discharges). The provision of task-based care then becomes a common feature of transitions in care as health professionals try to attend to the long list of logistical requirements that are connected to resident transfers in and out of their care settings. As such, older adults and their families are overwhelmed during transitions in care that are not adequately supported over time and place.

# Findings

# Findings

**Consider This: Older Adult Transitions into Long-Term Care**

The admissions and discharges of residents are expedited to free up ‘beds’ in other areas of the health care system and to ensure that adequate operational funding for the long-term care home is maintained (as operational funding is directly linked with resident occupancy rates). As such, the move into long-term care is experienced as a hastened process since life altering decisions are having to be made quickly to ensure the efficient turn-over of residents. Patient discharges after death are also problematic, as families are expected to collect the older persons’ belongings quickly, undermining the bereavement experiences of family members who have just lost their loved one.

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**Five Common Experiences of Rural Older Adult Transitions in Care**

There are five common experiences of transitions in care that lead to the health decline of rural older patients: 1) long wait-times in hospital, 2) frequent readmissions, 3) accepting long-term care services earlier than requiring 24-hour care, 4) moving out-of-county to obtain adequate levels of care and/or 5) complacency with home care services that do not fit their needs. These experiences are most common for geriatric patients with complex needs (e.g., responsive behaviours, social needs, addictions etc.) and reflect the influence of macro driven aspects of transitions in care outlined in this report (e.g., sectored divisions, bed flow, biomedical prioritization, etc.).

**Consider This: Information Relayed to Older Adults & Their Families about Discharge & What to Expect**

# Findings

# Findings

Older adults and their family members experience information overload during transfer events (such as admissions and discharges), but rarely retain this information due to the overwhelming nature of these experiences. To address this communication breakdown, health care services provide numerous pamphlets, however, the majority of this information is never read. On the other hand, older adults are given very limited information on discharge details (e.g., times/dates) or what life will actually be like once they move into long-term care or back to their residential homes. This lack of information results in negative experiences of older adults in their new care setting. While older adults and their families indicate that they do not need any more information prior to hospital discharge, they often identify questions retrospectively that they would have asked. The methods used to familiarize older patients with what to expect after discharge therefore need to change to support older adults to feel comfortable as they transition between care settings.

*3 Things Older Adults & Their Families Need to Know Prior to Moving into Long-Term Care*

1) Bed allocation is based on availability rather than compatibility with roommates.

2) Some residents have significant cognitive impairments. As such, they may wander into other resident’s rooms or take items that do not belong to them.

3) There are restrictions on the types of personal belongings that can be brought into long-term care.

**“At first when you start needing care there are so many people coming in giving you information and that’s confusing. It’s too much information and you don’t really understand how to access all the different kinds of supports and services and what’s available.” (Informal caregiver - Long-Term Care 21)**

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# Findings

# Findings

**“There needs to be support before they get here. A lot [of residents and family members] have only been given a pamphlet or talked briefly with CCAC, but not given support with the actual process.” (Front-Line Staff - Long-Term Care 35)**

**“The staff knowing that she needed to have her [taken out to maintain anonymity] with her and the staff member going over to check on her the day of admission really helped. He was able to help with her transition. This helped to situate her, especially to have that staff that she knew. It didn’t feel like they were passing her off, it was just about the patient. It was very personal care and that’s the best. It was huge to have that person she knew there and help her settle.” (Informal caregiver - Long-Term Care 75)**

**Involving Everyone in Caring for Rural Older Adults**

# Findings

# Findings

Informal caregivers play a pivotal role in caring for older populations, especially in rural communities. In Haliburton County, religious groups provide many transitional care supports such as transportation, friendly visiting, recreation opportunities, emotional care and home maintenance. Despite many types of informal caregivers, the legal designation of Power of Attorney (POA) and Substitute Decision Maker (SDM) places the majority of older adult care provision on a few individuals. As a result, POAs/SDMs with health concerns, those with family commitments, those who are older and those who are employed full-time struggle to support their loved ones during transitions in care. In rural communities, the strain placed on rural caregivers is heightened due to the prevalence of older populations and youth out-migration that leads to older informal caregivers supporting other older adults. Since older caregivers rarely cope with these additional pressures, caregiver burn-out leads to early entry into long-term care as well as increased use of emergency and acute care services in rural communities. Older adults without POAs/SDMs struggle the most during transitions in care due to a lack of support beyond biomedical care provision. Acknowledging the full extent of an older person’s informal care network and generating new methods to support informal caregivers is then pivotal to generate patient-and-family-centred transitions in care.

**“Patients end up relying really heavily on neighbours, but when you aren’t the POA you aren’t part of the circle of care. I think we need to involve everyone in the plan including neighbours and friends.” (Informal caregiver - Community 54)**

**“She never wanted to move into long-term care and it is the hardest thing knowing that we are going against what she wanted.” (Informal caregiver - Long-Term Care 87)**

**“He’s screaming in the middle of the night and calling me crying. It’s been incredibly stressful to manage.” (Informal caregiver - Long-Term Care 89)**

## Older Adult Health

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# Recommendations from the Participants

* **There needs to be better recognition that health is an on-going experience that cannot be compartmentalized by setting or professional discipline**

*“It’s like when you are in hospital it is marked as just one incident in your overall experience. Their needs to be better reflection on what happens before a patient is admitted, while they are in hospital and after a patient is discharged.” (Informal caregiver-Community 54)*

## Holistic Patient-Centred Care Provision

* **Health services need to reflect: care beyond physical/medical conditions, health prevention, chronic care management & individual patient’s needs**
* **A care transition is not ‘just a transfer’, but a huge life change**

*“I think we are still disease-focused and focused on medical issues, but we can see how these other things play into it.” (Front-Line Staff-Hospital 15)*

*“There should be more attention put on preventative care for older adults. A lot of seniors come in with on-going chronic issues, but asides from primary care they don’t really qualify for any other kind of service up here.” (Front-Line Staff-Hospital 29)*

*“Sometimes we get so caught up in care, we forget the human piece of things. This hospital has not embraced person and family-centred to the extent that we could or should.” (Administrator/Manager 6)*

*“What the system doesn’t recognize is that this is a huge life change. They support you when you are having a baby, but don’t support you during this.” (Informal caregiver-Long-Term Care 26)*

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Continuity of Care

# Recommendations from the Participants

* More effective information transfer is needed between care settings
* Collaborative care planning with patients and informal caregivers is ideal
* Follow ups after hospital discharge is wanted
* Informal caregivers that are not the POA are an untapped resource

*“The sentiment behind collaborative care planning is amazing to create a continuum of care, but most that exist do not benefit both health professionals and patients. It means that information on these care plans is not helpful for either the patient or the service provider and so they are shelved, but there can be joint care planning that could be effective for both.” (Administrator/Manager 4)*

*“I want them to do the follow-up. Allot of times people say if you don’t hear from us then everything is great. I don’t agree with that. I shouldn’t have to call to see if the test was good, bad or ugly.” (Older Adult-Community 68)*

*“Rural is different. Patients end up relying really heavily on neighbours, but when you aren’t the POA you aren’t part of the circle of care. I think we need to involve everyone in the discharge plan including neighbours and friends.” (Informal caregiver-Community 54)*

## Rural Care Context

* There is a need for alternative housing options between community and long-term care and a staff member that supports transitions between care settings would be helpful
* Technology is underutilized
* Increased use of respite beds in the county would assist with older adult transitions into long-term care

# Recommendations from the Participants

*“I would choose to add something between home and long-term care. There needs to be some kind of transition housing so that people have options. So that there is maybe a lower staffing ratio, but like apartment buildings so that there is extra help.” (Front-Line Staff-Long-Term Care 80)*

*“I think it would be great to have a case manager that follows patients and helps with these transitions and provides information on a client. Like a community oriented GEM nurse that could float between acute care and community.” (Administrator/Manager 4)*

*“In rural areas we are very behind on technology and this needs to change to help our care…Technology can be very transformative to support older adults, but right now it is not making it into mainstream health care of the elderly.” (Administrator/Manager 6)*

*“I think it might be better if patients transition to long-term care slowly. Allow them to stay for a bit and get use to the routines. That way when people get fully admitted they aren’t as uncomfortable with the move.” (Front-Line Staff- Long-Term Care 80)*

## Recommendations for HHHS

# Recommendations for HHHS

**Develop Mutually Beneficial Partnerships**

* Use the rural community inventory to develop mutually beneficial partnerships with private businesses, not-for-profits and informal community groups to enhance transitions in care (e.g., attention to holistic aspects of health, rural tasks required to age in place, follow up between care settings, what to expect after discharge, etc.) and to fill in the gaps in publicly available services (e.g., limited specialized services, human resource barriers, accessible/affordable housing, stratified care options, etc.).
* Some partnership considerations have been proposed within these recommendations to act as a starting point.

**Increase Support for Psychosocial & Holistic Aspects of Health**

* Consider partnering with Seniors Care Network to provide front-line staff training on Comprehensive Geriatric Assessments as well as on navigating difficult conversations related to the social determinants of health and mediating conflict over care authority (e.g., POA/SDM, etc.).
* Consider partnering with the local high school (have students use their 40 volunteer hours) to develop and continually update a community inventory of the public, private, not-for-profit and informal groups available to support the social determinants of health in Haliburton County. This resource can help front-line staff to direct older patients and their caregivers to non-biomedical supports. The rural community inventory can be used as a starting point to develop this resource.

**Common Digital Care Plan**

* Consider partnering with University IT or engineering departments to have students develop a common digital care plan for Haliburton County that can be used by all sectors to reduce repetitive patient information collection and inaccuracies (e.g., intersectoral collaborative care planning) within and between care settings. This care plan could be continually adjusted to reduce repetitive information collection on patients and generate front-line work routine efficiencies. If older patients/informal caregivers also had access to view and add to this common care plan this tool could increase access to personal health and care information during transitions in care.

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# Recommendations for HHHS

* Consider adapting the Comprehensive Geriatric Assessment to fit the Haliburton context to act as the base for this digital care plan.

**Explore Diversity in Haliburton County**

* Collaborate with the Trent Centre for Aging & Society (TCAS) to explore demographic information of populations other than the dominant norm within Haliburton County. Determine how marginalized populations experience health and care in Haliburton County and additional supports that may be required to support these older patients during transitions in care.

**Collecting Data to Support Macro Systems Change**

* Collaborate with a researcher at TCAS or U-Links Centre of Community Based Research to develop a whistle blowing system that allows all administrators/managers, health professionals, older patients and informal caregivers to anonymously record facets of care that impede the autonomy and agency of rural older adults during transitions in care.
* Collaborate with a researcher at TCAS or U-Links Centre of Community Based Research to develop a whistle blowing system that allows all administrators/managers, health professionals, older patients and informal caregivers to anonymously record facets of care that are ineffective and/or lead to inefficiencies during transitions in care.
* Collaborate with a researcher at TCAS or U-Links Centre of Community Based Research to develop a whistle blowing system that allows all administrators/managers, health professionals, older patients and informal caregivers to anonymously record facets of care that limit the flexibility of rural health professionals to attend to individualized or holistic aspects of rural older adult health.

# Recommendations for HHHS

* Ensure that these whistle blowing systems leverage technology to ensure that they do not put additional strain on front-line staff and that they seamlessly fit into staff work routines.
* Create a local communication strategy with seniors’ advocacy groups and the Seniors Care Network to routinely present these findings to governing bodies (municipal, provincial and federal). In this communication strategy provide recommendations that synthesize the findings from this project and the findings from the whistle blowing systems developed. This data can assist health care providers in Haliburton County to advocate for change and to reallocate funding to support the mutually beneficial partnerships proposed.

## Recommendations for SCNRecommendations for SCN

* Work with Haliburton County to support the development of a whistle blowing system that allows administrators/managers, health professionals, older patients and informal caregivers to anonymously record aspects of health care provision that impede the autonomy and agency of rural older adults during transitions in care.
* Work with care providers in Haliburton County to support the development of a whistle blowing system that allows administrators/managers, health professionals, older patients and informal caregivers to anonymously record aspects of health care provision that are ineffective and/or lead to inefficiencies during rural older adult transitions in care.
* Work with care providers in Haliburton County to support the development of a whistle blowing system that allows administrators/managers, health professionals, older patients and informal caregivers to anonymously record aspects of health care provision that limit the flexibility of rural health professionals to individualized or holistic aspects of rural older adult health.
* Adapt the whistle blowing systems created to support their use in other rural communities. Recording this data throughout the CELHIN will help support the need for macro health systems transformation.
* Work with care providers in Haliburton County and other rural communities to develop a communication strategy to advocate for macro health systems change in rural communities. Provide recommendations that synthesize the findings from this project and the findings from the whistle blowing systems developed.
* Support research on the diversity within and between rural older populations to establish how marginalized populations experience health and care in rural communities.
* Provide Comprehensive Geriatric Assessment education to rural health professionals in Haliburton County to increase comfort in collecting and transferring information beyond biomedical health and care.

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* Recommendations for SCNProvide education to rural health professional on navigating difficult conversations related to the social determinants of health and mediating conflict over care authority (e.g., POA/SDM, etc.).

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## Other Useful Resources

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1. Please note that at the time that this research was conducted the LHINs were designated as regional health authorities in the province of Ontario. The Ministry of Health was in the process of reorganizing health care into Ontario Health Teams at the time that this report was published. [↑](#footnote-ref-1)
2. Ableism is discrimination towards people with physical/cognitive impairments by favouring able bodied people. [↑](#footnote-ref-2)