Developing an integrated geriatric care planning approach in home care

by

Justine Lauren Giosa

A thesis
presented to the University of Waterloo
in fulfillment of the
thesis requirement for the degree of
Doctor of Philosophy
in
Public Health and Health Systems

Waterloo, Ontario, Canada, 2018

AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

EXAMINING COMMITTEE MEMBERSHIP

The following served on the Examining Committee for this thesis. The decision of the Examining Committee is by majority vote.

External Examiner   JILL CAMERON, PhD
                                       Associate Professor, Department of Occupational
                                       Science and Occupational Therapy, University of
                                       Toronto

Supervisor   PAUL STOLEE, PhD
                                       Professor, School of Public Health and Health
                                       Systems, University of Waterloo

Internal Member   SAMANTHA MEYER, PhD
                                       Assistant Professor, School of Public Health and
                                       Health Systems, University of Waterloo

Internal Member   KERRY BYRNE, PhD
                                       Adjunct Professor, School of Public Health and
                                       Health Systems, University of Waterloo

Internal-external Member   VANESSA SCHWEIZER, PhD
                                       Assistant Professor, Department of Knowledge
                                       Integration, University of Waterloo

ABSTRACT

Introduction

The demand for home care services in Canada is on the rise, as older adults wish to remain in their own homes as long as possible and deinstitutionalization of care continues to promise significant savings to the system (Better Home Care, 2016, p. 90). The provision of home care services to the older population is complicated by their increased likelihood to have two or more chronic health conditions and tendency to require care from multiple providers to meet their often complex physical, functional, social, cognitive and psychosocial needs (Health Council of Canada, 2012; Statistics Canada, 2015). In Ontario, home care service allocation, care planning and care delivery are further fragmented as a result of the multi-layered and complex funding and coordination model that exists across the province (Health Quality Ontario, 2012; Local Health Integration Networks, 2014a). More integrated care planning at the point-of-care has the potential to improve the delivery and experience of person- and family-centred geriatric home care (Harvey, Dollard, Marshall, & Mittinty, 2018). This study aimed to develop an implementation framework for a new integrated geriatric care planning approach, at the point-of-care in home care. Key objectives included: a) to investigate the geriatric assessment practices of point-of-care providers; b) to collect ideas from older adults and their family/friend caregivers for improving person-and family-centred goal-setting; and c) to co-design solutions for more integrated geriatric care planning with older adults, their family/friend caregivers and point-of-care providers.

Methods

The Medical Research Council (MRC) Framework for Developing Complex Interventions and the Co-creating Knowledge Translation Framework guided this study (Craig et al., 2013; Powell

et al., 2013). A sequential transformative mixed methods design from a pragmatic theoretical lens was applied, using an ideology of collective creativity to meaningfully engage older adults, their family/friend caregivers, and point-of-care providers (Creswell, Clark, Gutmann, & Hanson, 2003; Feilzer, 2010; Sanders & Stappers, 2008; Sanders & Stappers, 2012). Phase one data collection involved scoping the literature, clinical expert key informant interviews ($N = 7$) and a web-based survey of point-of-care providers ($N = 350$). Phase two data collection involved solutions-focused key informant interviews with older adults and their family/friend caregivers ($N = 25$). Quantitative data analysis involved psychometric testing and descriptive statistics. Qualitative data analysis involved inductive and deductive coding techniques and framework analysis (Gale, Heath, Cameron, Rashid, & Redwood, 2013; Lofland, Snow, Anderson, & Lofland, 2006). The data were brought together as an implementation framework during the interpretation phase of this research through a co-design workshop with older adults, their family/friend caregivers and point-of-care providers ($N = 19$).

Results

A new survey for assessing geriatric care assessment practices (G-CAP survey) was developed and demonstrated acceptable test-retest reliability ($M_{ICC} = 0.58$; $M_{kappa} = 0.63$), discriminative ($M t = 3.0$; $M p = 0.01$) and divergent/convergent ($M r = |0.39|$) construct validity for use with point-of-care nurses, occupational therapists and physiotherapists in home care. Survey data revealed that point-of-care providers use their observation and interview skills ($M = 4.50$ on a 5 point scale where 1= never and 5= often-always) far more often than standardized assessment tools for client assessment ($M = 1.72$) and rarely share assessment data with or receive assessment from other providers ($M = 3.75$; $M = 3.46$). Interview data indicated that older adults and their family/friend caregivers want to be engaged in conversations about their goals in

relation to their daily lives, personal background and medical history. An implementation framework for integrated geriatric care planning at the point-of-care emerged, involving three key influencing factors: 1) inclusive assessment practices; 2) dialogue-based goal-setting; and 3) flexible communication strategies.

Conclusions

Integrated care planning for service allocation and point-of-care delivery in geriatric home care would be better supported by assessment, goal-setting and communication practices that equally address the information needs and person- and family-centred care experiences desired by older adults, their family/friend caregivers and point-of-care providers in order to promote virtual home care teams. Future research should focus on prototyping strategies, technology, tools and evaluation criteria and measures to operationalize the implementation framework.

ACKNOWLEDGEMENTS

been a key driver of success in achieving an action-oriented study and outcomes. Thank you Dr. Holyoke for being a sounding board throughout this process and helping me to problem solve and develop creative solutions to ensure rigorous research in an applied health care setting.

I would like to acknowledge the older adults, family/friend caregivers and point-of-care home care providers who participated in this research study. From a lens of collective creativity, this study would not have been possible without their willingness to contribute knowledge, expertise and thoughtful ideas based on their lived experiences. I am confident in the success of the implementation phase of this research as a result of their participation.

This research study would not have been possible without the funding support I received from a) The Canadian Institutes for Health Research Canada Graduate Scholarship: Doctoral Award; b) The University of Waterloo: School of Public Health and Health Systems; and c) The SE Research Centre.

I am grateful to my colleagues in the Geriatric Health Systems Research Group for their constant support throughout my training, especially to Mrs. Sheila Bodemer for her constant encouragement and helping hand. I would also like to acknowledge my colleagues in the SE Research Centre and across SE Health for supporting this study.

Finally, I would like to thank my family, without whom I could not have accomplished this work. To my husband Andrew, thank you for believing in me and always pushing me to excel and pursue my dreams. To my daughter Olivia, thank you for being my source of inspiration for wanting to improve our health care system for future generations. To my parents and siblings, thank you for your patience, understanding and constant support on my post-secondary academic journey. Finally, to my grandparents, thank you for showing me the meaning of healthy aging and for driving my research passion to improve geriatric care.

DEDICATION

This thesis is dedicated to my precious daughter Olivia and the newest member of our family,

'Baby Boy Giosa' arriving in November, 2018.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

CHAPTER 1: INTRODUCTION AND OVERVIEW

The demand for home care services in Canada is on the rise, as older adults wish to remain in their own homes as long as possible and deinstitutionalization of care continues to promise significant savings to the system (Better Home Care, 2016). For example, the average daily cost of home care in Ontario is $42.00/ day versus $842.00/ day for hospital care and $126.00/ day for long-term care respectively (Home Care Ontario, 2017). While providing care at home is cheaper and receiving care at home is most preferred, the home care system in Ontario is challenged by increasing client complexity, an aging population, a complex and multi-layered structure, and limited resources (Ontario Home Care Association, 2018).

In 2014/15, approximately 70% of long-stay home care clients were categorized as complex, compared to less than 40% in 2009/10 (Auditor General of Ontario, 2015). In 2015, 729,357 people in Ontario received home care services and 63% of these services were provided to older adults aged 65 and older (Home Care Ontario, 2017). The provision of home care services to the older population is complicated by their increased likelihood to have two or more chronic health conditions and to require care from multiple providers to meet their often complex physical, functional, social, cognitive and psychosocial needs (Health Council of Canada, 2012; Statistics Canada, 2015). Older adults often report fragmented home care experiences plagued with poor communication, lack of consistency and limited family/friend caregiver support (Gill & Connelly, 2013; Giosa, Stolee, Dupuis, Mock, & Santi, 2014; Toscan, Mairs, Hinton, & Stolee, 2012). Allocation, planning and delivery of geriatric home care is further disconnected as a result of the multi-layered and complex funding and coordination model that exists across the province, resulting in a variety of providers working in isolation of each other to organize and provide care (Health Quality Ontario, 2012).

In 2017/18, Ontario invested $100 million into the home care system as part of a three year plan to invest $750 million in home care to help high needs clients and their family/friend caregivers access better and more types of care and support closer to home (Ministry of Health and Long-Term Care, 2016). Integrated care has been recognized as a major priority for improving care for community-dwelling older people living with multi-morbidity (Mittinty, Marshall, & Harvey, 2018). In home care, more integrated care planning at the point-of-care has the potential to improve the delivery and experience of person- and family-centred care (Harvey et al., 2018; Janse, Huijsman, Looman, & Fabbricotti, 2018).

Using a sequential, transformative mixed methods design from a pragmatic research lens and operationalizing collective creativity ideology, this research study aimed to develop a new integrated geriatric care planning approach at the point-of-care in home care (Creswell et al., 2003; Feilzer, 2010; Sanders & Stappers, 2008; Sanders & Stappers, 2012). Phase one (chapters 4, 5) involved scoping the literature, clinical expert key-informant interviews and the development and administration of a web-based survey on geriatric assessment practices to point-of-care providers. Phase two (chapter 6) involved solutions-focused key informant interviews with older adults and their family/friend caregivers to understand how goal-setting could be re-oriented around their needs and preferences. A co-design workshop was held with older adults, their family/friend caregivers and point-of-care providers in the interpretation phase of this study (chapter 7) to apply the qualitative and quantitative data through hands-on collaborative activities, and to populate an implementation framework for a new integrated geriatric care planning approach at the point-of-care in home care.

CHAPTER 2: BACKGROUND AND LITERATURE REVIEW

2.1 Introduction to Integrated Care

Integrated care is a buzz word in health care service delivery and reform strategies worldwide (Kodner, 2009) and has been called "a complex process, a fundamental principle" in health care today (Goodwin, 2013, p. 1). As an umbrella term, integrated care is used interchangeably with coordinated care or seamless care to describe a wide range of diverse efforts to address fragmentation within the health care system (Stein & Rieder, 2009; World Health Organization, 2016). While the concept of integrated care dates back to the early 1990s, it has multiple definitions, meanings and uses that are largely dependent on contextual factors such as the structure of the health system, the health care sector and even the population of patients and providers in question (Goodwin, 2013; Kodner, 2009; Valentijn et al., 2015). Definitions of integrated care also rely on the views of the stakeholders involved in the health care system of interest (World Health Organization, 2016).

Common among most conceptualizations of integrated care, is the recognition that it is a complex intervention that requires management and organizational support on macro (system), meso (organizational, professional) and micro (clinical) levels (Goodwin, 2013; Valentijn et al., 2015). For example, The World Health Organization (WHO) has broadly defined integrated health care service delivery as, "the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system" (World Health Organization, 2008, p. 4). Taxonomies of integrated care models reveal that the type of integration can be organizational, professional and/or functional; the breadth of integration can be vertical, horizontal or virtual; the degree of integration can range from cross-continuum to linked sectors, to coordination; and the

process of integration can be cultural, social, structural and/or systemic (Nolte & McKee, 2008; Shaw, Rosen, & Rumbold, 2011). For example, the Rainbow Model of Integrated Care has been used to explain the complexity and multidimensionality of integrated care (Valentijn, Schepman, Opheij, & Bruijnzeels, 2013). Table 2.1 outlines the six integrated care dimensions of the Rainbow Model on the macro, meso and micro levels of care (Valentijn et al., 2015; Valentijn et al., 2013).

Table 2.1 The integrated care dimensions of the Rainbow Model of Integrated Care

Level of Care	Dimension	Description
Micro	Clinical Integration	The coordination of person-focused care in a single process across time, place and discipline.
Meso	Professional Integration	Inter-professional partnerships based on shared competencies, roles, responsibilities and accountability to deliver a comprehensive continuum of care to a defined population.
Meso	Organizational Integration	Inter-organizational relationships (e.g., contracting, strategic alliances, knowledge networks, mergers), including common governance mechanisms, to deliver comprehensive services to a defined population.
Macro	System Integration	A horizontal and vertical integrated system, based on a coherent set of (informal and formal) rules and policies between care providers and external stakeholders for the benefit of people and populations.
Micro, Meso, Macro	Functional Integration	Key support functions and activities (i.e., financial, management and information systems) structured around the primary process of service delivery to coordinate and

		support accountability and decision-making between organizations and professionals in order to add overall value to the system.
Micro, Meso, Macro	Normative Integration	The development and maintenance of a common frame of reference (i.e., shared mission, vision, values and culture) between organizations, professional groups and individuals.

While defining these dimensions is a necessary step towards a more comprehensive understanding of integrated care, the key features of each dimension and how they are operationalized in practice, policy and research are still largely unknown (Valentijn et al., 2015). Evidence suggests that achieving integrated care in multi-layered delivery systems with diverse stakeholders, cultures, funding and governance is very challenging, which means there is no unifying solution to integrated care that will fit every situation (Goodwin, 2013; Wodchis, Dixon, Anderson, & Goodwin, 2015).

Successful integration models have been reported to be bottom-up in nature, driven by local needs and requiring the support and engagement of all stakeholders involved, including patients and their families (Goodwin, 2013; Wodchis et al., 2015). According to the National Collaboration on Integrated Care and Support (2013) "integrated care is not about structures, organizations or pathways, nor about the way services are commissioned or funded. It is about individuals and communities having a better experience of care and support, experiencing less inequality and achieving better outcomes" (Care Quality Commission, 2016, p. 8). The key difference between integrated care and the integration of care is that integrated care "imposes the patient perspective as the organizing principle of service delivery" (Lloyd & Wait, 2005, p. 7); whereas, integration refers to the tools, methods and processes to facilitate integrated care (Shaw

et al., 2011). Unfortunately, few studies have focused on the patient perspective of integrated care and there is limited understanding about the key elements of integrated care from a person- and family-centred lens (Mittinty et al., 2018). Most definitions of integrated care are process-based and/or from the perspective of health systems; however, the National Health Service (NHS) in England has uniquely adopted a user-led definition of integrated care, written in the patient voice: "I can plan my care with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes" (National Voices, 2013, p. 5). This definition of integrated care is person- and family-centred and emphasizes the patient and family/friend caregiver role as active participants in care (Singer et al., 2011). The present research study applied this user-led definition of integrated care and honed in on clinical, professional, functional and normative integration (Valentijn et al., 2015; Valentijn et al., 2013).

2.2 Home Care

2.2.1 Canada

Home care has been defined by The Canadian Home Care Association as "an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the informal (family) caregiver" (Canadian Home Care Association & Accreditation Canada, 2015, p. 2). The number of people receiving home care services in Canada has grown by 55% since 2008 due to the aging population and the de-institutionalization of care as a result of Canadians wanting to stay in their homes as long as possible and the government wanting to control health care spending (Canadian Nurses Association, 2018; Health Council of Canada, 2012). Over 1.8 million people received

publicly funded home care services across Canada in 2013, with 70% of these services being

provided to older adults aged 65 and older (Canadian Home Care Association, 2013). Home

care, is an "extended health service" and not covered in the Canada Health Act (Department of

Justice, 2011). There is wide variation in how each province and territory across Canada

allocates its publicly funded home care programs and services, including how much is covered,

who is eligible, and how the services are funded (Health Council of Canada, 2012). The

structure and organization of home care can have a significant impact on the experience of

integrated care for individuals and families at home. Integrated care is one of the key harmonized

principles of home care in Canada's Better Home Care Action Plan, defined optimally as:

"patients' needs are met through coordinated clinical and service-level planning and delivery

involving multiple health care providers and organizations" (Better Home Care, 2016, p. 7).

2.2.2 Ontario

Ontario home care provision is complex and multi-layered. At the system level, there are

14 Local Health Integration Networks (LHINs), which are each responsible for allocating funds

and coordinating all health care services within a region, including home and community care

(Local Health Integration Networks, 2014a). The LHINs employ care coordinators who are

responsible for assessing client needs, developing service goals, determining eligibility for

services and overseeing service delivery (Ministry of Health and Long-Term Care, 2015b).

While LHINs coordinate and allocate home care services, they do not provide them. Instead,

direct service provider agencies, of which there are more than 45 across the province, compete

for service contracts to deliver frontline care in each geographic region (Health Council of

Canada, 2012; Home Care Ontario, 2014). While technology and clinical advancements have

made home care services more accessible to older adults in terms of the breadth and complexity

of services available, home care service allocation has been described as overly bureaucratic, top-heavy and organized around system-generated goals and careful allocation of scarce resources (Baranek, Deber, & Williams, 2004; Ontario Health Coalition, 2015). All too often, Ontarians are not receiving the home care services they need or are receiving services that only partially meet their needs (Ontario Health Coalition, 2015). With over 100 different organizations working to deliver home care services across Ontario, it is not surprising that integrated care delivery has been cited as a major challenge within the sector (Health Council of Canada, 2012; Ministry of Health and Long-Term Care, 2015b). Clients, family/friend caregivers and point-of-care-providers alike are concerned with a lack of coordination and communication, and limited trust that important information is transferred and shared with those who need it most to plan and provide care (The Change Foundation, 2011). Further, clients and family/friend caregivers are often asked to repeat their medical information and history to multiple providers and participate in redundant assessments and tests, which causes confusion and frustration and raises questions about inefficiency and waste within the system (The Change Foundation, 2011).

2.2.3 Older Adults

It has been reported that 93% of Canadians aged 65 years and older live at home and wish to remain in their homes as long as possible (Canadian Institute for Health Information, 2011b). To achieve this goal, home and community care services are often needed for maintaining independence, completing daily activities and delaying entry into institutional care facilities (Health Council of Canada, 2012). In 2015, 729,357 people in Ontario received home care services and 63% of these services were provided to older adults aged 65 and older (Home Care Ontario, 2017). Older adult recipients of publicly-funded home care in Ontario are more likely to be female, over the age of 85 years, unmarried and have multiple complex conditions

along functional, cognitive and psychosocial dimensions (Coleman, 2003; Coleman & Boult, 2003; Covinsky et al., 2003; Health Council of Canada, 2012; The Change Foundation, 2008; Toscan et al., 2012; Welsh, Gordon, & Gladman, 2014). The three most common comorbidities faced by older adult home care recipients in Ontario are diabetes (26.4%), dementia (22.7%) and stroke (18.4%), and over one third of these recipients (38%) have high to very high needs (Health Council of Canada, 2012). As such, multiple types of point-of-care providers are needed to deliver comprehensive home care services to this population, including most commonly, personal support workers (74.0%), nurses (21.5%), physiotherapists (2.1%) and occupational therapists (1.5%) (Auditor General of Ontario, 2015; Health Council of Canada, 2012; The Change Foundation, 2011). What these providers do and how they work together to plan the point-of-care delivery of home care services to older adults is a key focus for this research study on integrated care.

2.3 Integrated Geriatric Home Care Planning

It has been suggested that home care can improve the health, well-being and care experiences of older adults and their families if it is person- and family-centred (Hollander, Liu, & Chappell, 2009). The philosophy of person- and family-centred care (PFCC) has been widely accepted as the gold standard of measuring health care experiences in home care, including that care demonstrates respect and dignity, promotes communication, supports participation and is delivered collaboratively (The Institute for Patient and Family Centred Care, 2010). Within the context of multi-morbid geriatric health issues requiring care from a range of providers working in isolation within a multi-layered home care system, it is not surprising that care experiences are often not aligned with key concepts of PFCC and that planning and delivery of care are fragmented, disconnected and task-oriented (The Change Foundation, 2011). While PFCC is

generally well defined as a philosophy of care, there is a dearth of evidence on how to operationalize it in practice, particularly in home care (Giosa, Holyoke, & Stolee, 2018). Adopting the NHS person- and family-centred definition of integrated care to guide this research study helps to hone in on the important concepts of integrated care according to clients and their family/friend caregivers and to identify opportunities for integrating methods, tools and activities that may be required to enhance not only service delivery but client and family/friend caregiver outcomes and experiences in geriatric home care (National Voices, 2013).

Service allocation, care planning and care delivery are distinct activities within the care process and should be linked in order for individuals to experience seamless care (Ministry of Health and Long-Term Care, 2017). Service allocation typically involves client assessment for eligibility of services according to criteria that are largely funding and resource dependent, but also meant to be informed by best-practice evidence for the treatment of relevant health conditions (Ministry of Health and Long-Term Care, 2015a). Care planning involves information gathering, emphasizing discussion and dialogue to develop a holistic picture of the client situation, setting goals for care, and action planning to meet these goals (NHS Foundation Trust, 2012). Care delivery includes the direct provision of care and support to clients and their family/friend caregivers, dictated by service allocation and also informed by the care plan (Ministry of Health and Long-Term Care, 2015a).

In Ontario home care, service allocation is distinctly completed by the LHINs and care delivery is distinctly carried out by point-of-care providers who work for direct service provider agencies (Local Health Integration Networks, 2014a). Unfortunately, there seems to be less clarity in terms of where the responsibility lies for completing care planning in home care. From the LHIN perspective, the individuals completing service allocation activities are called 'care

coordinators' who conduct standardized assessments of clients to determine their eligibility and designate appropriate services. Care coordinators then send a referral form to direct service provider agencies, including information on the focus of the intervention(s) and plan for service(s), which is often thought of and treated as synonymous with a care plan for home care, even though the goals of the two activities are different (Ministry of Health and Long-Term Care, 2015a; NHS Foundation Trust, 2012). Adding further confusion is that the standardized assessment tool used by the LHIN care coordinators to support service allocation was developed and intended to support point-of-care care planning and not only service allocation activities (Gray et al., 2009; interRAI, 2012). Point-of-care providers are given a limited time to provide services and support to individuals in their homes and are scheduled, monitored and paid according to the tasks they complete. Therefore, the focus of most point-of-care providers is on task-based service delivery rather than on active care planning, even though the latter is well within the scope of practice of any home care provider (Giosa, Holyoke, Bender, Tudge, & Gifford, 2015).

The present research study focused on improving clinical, professional, functional and normative integration (Valentijn et al., 2015; Valentijn et al., 2013) within the context of point-of-care home care planning for older adults aged 65 and older. Honing in on care planning at the point-of-care is aligned with the observation that successful integration strategies are bottom-up, and studying methods for improving integration at the system or organizational levels in this sector would not allow for the appropriate involvement of older adults and their family/friend caregivers in the process (Goodwin, 2013; Wodchis et al., 2015). This research adopted the NHS user-led definition of integrated care, which points to three key areas for further exploration within the context of integrated geriatric care planning, including: 1) assessment/ information

gathering; 2) goal-setting; and 3) interdisciplinary collaboration (Gill & Connelly, 2013; National Voices, 2013; Parsons et al., 2013; The Change Foundation, 2011; Toscan et al., 2012; Valentijn et al., 2015; Valentijn et al., 2013).

2.3.1 Assessment/ Information Gathering

As older adults are more likely to face multiple simultaneous health issues, information gathering and assessment are key activities for health care providers in the care planning process in order to develop a full and complete picture of the medical and social care needs of individuals and their family/friend caregivers and to understand how they manage and any risks within their home environments (Department of Health, 2014; Sahlen, Löfgren, Mari Hellner, & Lindholm, 2008). Critical to successful geriatric assessment is recognition that the health care of older adults requires more than just the traditional medical model of managing illness and disease and is impacted by physical, cognitive, affective, social, financial, spiritual and environmental factors (Ward & Reuben, 2018). Geriatric assessment in the home been found to be effective in reducing functional decline as well as overall mortality (Elkan et al., 2001; Huss, Stuck, Rubenstein, Egger, & Clough-Gorr, 2008). Home-based assessment has also been shown to increase sense of independence, safety and awareness and understanding of needs and available health services for both older adults and their family/friend caregivers (Rogerson, Weiss, & Phillips, 2006). Unfortunately, outside of these controlled research studies, little is known about the routine information being collected by point-of-care providers in home care and the precise tools and methods of information-gathering that are used in daily practice (Ontario Health Coalition, 2011; Parsons & Parsons, 2012).

2.3.2 Goal-Setting

Goal-setting is a broad term within geriatric care and varies depending on the level of

12

participation of older adults and their family/friend caregivers (Cheng, 2018). As the aim of home care is continuing to shift from enabling dependency to promoting independence, finding ways to encourage restoration, self-esteem and health related quality of life is growing in importance (Parsons, Rouse, Robinson, Sheridan, & Connolly, 2012). Engagement of older adults and their family/friend caregivers in the goal-setting process has been cited as a method for operationalizing shared decision-making in geriatric care (Schulman-Green, Naik, Bradley, McCorkle, & Bogardus, 2006). Mutual goal-setting with older adults has been shown to be an important motivational determinant for enhancing participation in self-management of illnesses and disease and has been demonstrated to improve physical and mental well-being (Cheng, 2018). Unfortunately, barriers to goal-setting in geriatric care have been cited by both patients and providers including that it is too time consuming, that clinical encounters are too symptom-focused, that there is a general disinterest in goals by both parties, and assumptions that all older adults' goals are the same (Schulman-Green et al., 2006).

2.3.3 Interdisciplinary Collaboration

Interdisciplinary collaboration involves health care providers from different disciplines working together in the delivery of care (Legare et al., 2013; Virani, 2012). Effective interdisciplinary collaboration requires providers to share common goals and has the potential to improve quality of care and better meet the needs of patients and their families by maximizing the knowledge and unique expertise that each team member brings to the care situation (Blewett, Johnson, McCarthy, Lackner, & Brandt, 2010; Nelson et al., 2014; Registered Nurses Association of Ontario, 2013; Virani, 2012). Formal information sharing (e.g., assessment data) and informal communication (e.g., opportunistic discussions) are two of the most important collaborative activities related to geriatric care planning in terms of developing a shared

13

understanding of the unique care situation (Campbell & Cole, 1987; Crawford, Omery, & Seago, 2012; Jordan et al., 2009; Lanham et al., 2009; Manojlovich, Squires, Davies, & Graham, 2015). Unfortunately, however, research has identified poor communication as a common barrier to integrated care experiences (Nelson et al., 2014; Toscan, Manderson, Santi, & Stolee, 2013). Further, as point-of-care providers in home care rarely have face-to-face contact with each other, information-sharing and communication are much more difficult in this sector than for health care providers who work together in institutional settings (Pinelle & Gutwin, 2002).

2.4 Summary and Implications

Integrated care is a key priority in health care today (Kodner, 2009); particularly in geriatric home care where older adults often have complex, multi-morbid health issues and require care from multiple providers (Ontario Health Coalition, 2011). The NHS user-led definition of integrated care points to assessment/information-gathering, goal-setting and interdisciplinary collaboration as activities for developing a more integrated geriatric care planning approach at the point-of-care in home care (MacAdam, 2009; National Voices, 2013; Nelson et al., 2014; Parsons et al., 2012).

CHAPTER 3: RESEARCH OBJECTIVES AND GENERAL METHODOLOGY

3.1 Research Objectives and Questions

The overall aim of this study was to develop an implementation framework for a new integrated geriatric care planning approach at the point-of-care in home care. Key objectives included:

a) To investigate the geriatric assessment practices of point-of-care providers;

b) To collect ideas from older adults and their family/friend caregivers for improving person-and family-centred goal-setting; and

c) To co-design solutions for more integrated geriatric care planning with older adults, their family/friend caregivers and point-of-care providers.

The following research questions guided data collection and analysis for each of the objectives:

a) What are the geriatric assessment practices of point-of-care nurses, occupational therapists (OTs) and physiotherapists (PTs) in home care?

b) How can geriatric client goal-setting practices be re-oriented around individuals' self-perceived goals, needs and preferences in home care?

c) What does an integrated geriatric care planning approach look like to older adults, family/friend caregivers and point-of-care providers in home care?

3.2 Conceptual Frameworks

The Medical Research Council (MRC) Framework for Developing Complex Interventions guided this study (Craig et al., 2013). Table 3.1 outlines the characteristics of a complex intervention according to the framework and the corresponding components of the integrated geriatric care planning approach that was developed in this study.

Table 3.1 Characteristics of a complex intervention according to the MRC Framework

Characteristics of a Complex Intervention According to the MRC Framework	Components of a New Integrated Geriatric Care Planning Approach in Home Care
• Several interacting components	• Assessment/ information gathering • Goal-Setting • Interdisciplinary collaboration
• Several difficult behaviours required by those delivering or receiving the intervention	• Use of standardized assessment tools • Use of clinical observation and interview skills • Goal-Setting • Documentation • Information-Sharing • Collaboration and communication
• Several groups or organizational levels targeted by the intervention	• Older adults • Family/friend caregivers • Point-of-care providers • Service provider organizations
• A variety of different outcomes of interest	• Clinical (e.g., wound healing time) • Experiential (e.g., patient satisfaction) • Economic (e.g., efficiency)
• Flexibility and adaptability according to unique contexts	• Physical home environment • Patient/ family/friend caregiver preferences • Family structure/ dynamics

The MRC Framework outlines four inter-related stages for developing complex interventions according to Figure 3.1 (Craig et al., 2013).
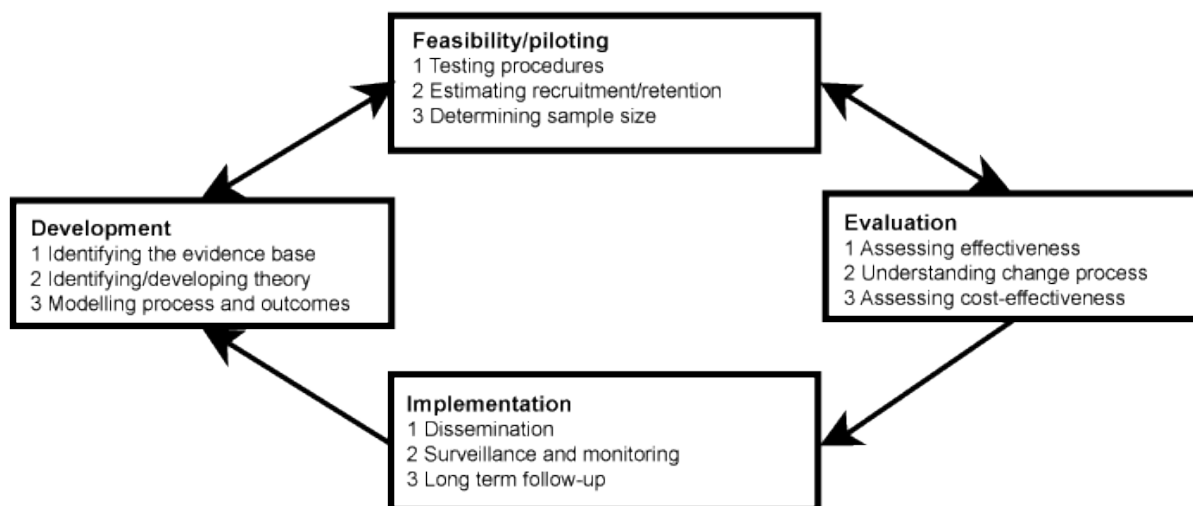
Figure 3.1 The MRC Framework for Developing Complex Interventions[1]

This study focused specifically on the *Development* stage of the framework, which has three steps: 1) Identifying the evidence base; 2) Identifying/ developing theory; and 3) Modeling process and outcomes (Craig et al., 2013). Identifying the evidence base and identifying/ developing theory for an intervention typically involves a review of the literature as well as primary research activities (e.g., consultation with relevant stakeholders) (Craig et al., 2013). Work to answer research questions a) and b) identified the evidence base and theory in this study. Modeling process and outcomes in intervention development involves considering implementation (e.g., Who will use this intervention? In what setting will it be used? What will be done? What are the facilitators and obstacles?) (Craig et al., 2013). Work to answer research question c) helped to model the process and outcomes for the intervention in this study.

While this research study focused on the *Development* stage of a complex intervention, this stage of the research was carried out with full recognition of its non-linear relationship and inter-connectedness with the other three stages to ensure that the framework for a new integrated geriatric care planning approach that emerged is sufficient to guide its testing, evaluation and

---

[1] This figure was reproduced with permission of the lead author (see Appendix A)

eventual scaled implementation (Craig et al., 2013).

　　While the MRC Framework for Developing Complex Interventions guided the stage of intervention development, the Co-Creating Knowledge Translation (co-KT) Framework guided the activities within this stage in order to facilitate collaborative knowledge development between the researchers and the stakeholders of geriatric care planning at the point-of-care (older adults, family/friend caregivers and point-of-care providers) (see Figure 3.2) (Powell et al., 2013). The co-KT Framework contends that knowledge creation must be iterative and supplemented by external evidence in order to develop interventions that address key health priorities of affected stakeholders (Powell et al., 2013). The co-KT Framework has five steps: 1) first contact between the researcher and study contexts (stakeholders) to frame the research issue through systematic data collection; 2) refinement of the research issue and knowledge by adding context through knowledge exchange events; 3) interpretation and analyzing the knowledge to inform the development of the intervention; 4) pilot testing and evaluation of the novel intervention; and 5) intervention adopted as regular practice. Work to address research questions a) and b) in the present study aligned with step one of the co-KT Framework in terms of systematic data collection through stakeholder surveys and interviews to refine and gather knowledge on the research issues around geriatric care planning in home care. Work to address research question c) in the present study aligned with step three in the co-KT Framework in terms of working collaboratively with stakeholders to interpret the data and develop an implementation framework through a co-design workshop. Steps four and five in the co-KT Framework will be the focus of future phases of this research in terms of developing and testing a pilot intervention from the emergent implementation framework for integrated geriatric care planning at the point-of-care in home care (see Figure 3.2).
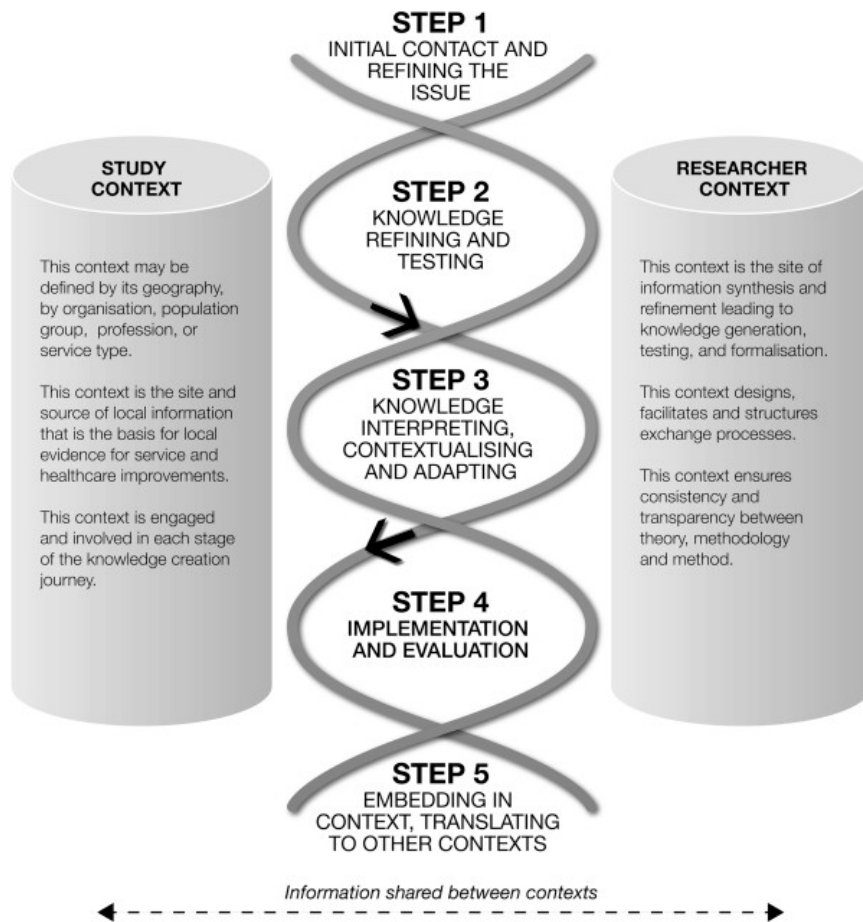
Figure 3.2. The Co-Creating Knowledge Translation Framework[2]

3.3 Meeting the Research Objective

The development of an implementation framework for a new integrated geriatric care

planning approach at the point-of-care in home care will provide service provider organizations

with detailed guidance for exploring the operationalization of the framework and developing a

pilot of the intervention for testing in real home care practice. Specifically, SE Health, a national

home and community care organization that has been in operation for over one hundred years, is

keen to be an early adopter of a new integrated geriatric care planning approach, and with the SE

Research Centre, has agreed to be a pilot test site in future stages of this research.

---

[2] This figure was reproduced with permission of the authors (see Appendix B)

3.4 Sequential Transformative Mixed Methods Design

This research study followed a sequential transformative mixed methods design (Creswell et al., 2003). In selecting this design, four factors were considered: 1) the implementation of data collection; 2) the priority given to qualitative and quantitative research; 3) the stage in the research process when qualitative and quantitative data are integrated; and 4) the potential use of an action-oriented or transformational approach/perspective in the research (Creswell et al., 2003).

In a sequential transformative design, the research study has two distinct data collection phases that follow one another, irrespective of whether the research begins with qualitative or quantitative data collection. Priority may be given to either qualitative or quantitative data in the research process, or the priority can be equally shared. In sequential transformative mixed methods research, the results of the two separate phases of inquiry are brought together in the interpretation phase. The overall purpose of a transformative design is to structure the research study in a way that aligns to the researcher's theoretical perspective, which is explicitly acknowledged in the research process (e.g., conceptual framework, ideology etc.) (Creswell et al., 2003).

Figure 3.3 outlines the specific sequential transformative design that was followed for this research study. Qualitative and quantitative data were given equal priority in the research. Each of the components in Figure 3.3 is discussed in detail in the sections to follow.

Phase One- Qualitative + Quantitative

What are the geriatric assessment practices of point-of-care nurses, occupational therapists and physiotherapists in home care?

Data collection

Data analysis

Results

1a) Survey Development

Scoping Literature Review

Key Informant Interviews: Providers ($N = 7$)

Psychometric testing (N T1 = 27; N T2 = 20)

Thematic analysis

Statistical analysis

Survey of Geriatric Care Assessment Practices that is valid and reliable for use with nurses, OTs and PTs in home care

1b) Survey Distribution

Broad Distribution of the Survey: Providers ($N = 303$)

Statistical Analysis

Descriptive statistics organized into themes around the geriatric care assessment practices of nurses, OTs and PTs

Phase 2- Qualitative

How can client goal-setting practices be re-oriented around individuals' self-perceived goals, needs and preferences in home care?

Data collection

Data analysis

Results

Key informant interviews: Older adults/family/friend caregivers (N=25)

Framework Analysis

Themes about how client goal-setting can be re-oriented around individuals' self-perceived goals, needs and preferences

Interpretation

What does an integrated geriatric care planning approach look like to system users in Ontario home care?

Co-design Workshop: older adults, family/friend caregivers, providers, ($N = 19$)

A framework for implementing an integrated geriatric care planning approach at the point-of-care in home care

Figure 3.3 Sequential transformative mixed-methods design

3.5 Theoretical Positioning

3.5.1 Pragmatism

A mixed methods way of thinking involves multiple ways of making sense of social phenomena in the world and multiple viewpoints on what information is important and valuable using both qualitative and quantitative methods (Greene, 2007). Critics of mixed methods research contend that qualitative and quantitative research paradigms are conflicting in nature. Quantitative research stems from positivist/ post-positivist thinking, where researchers believe in a singular reality that can only be discovered through objective research methods (Creswell & Plano Clark, 2007). On the other end of the spectrum, qualitative research aligns to constructivism, which positions subjective research inquiry as necessary to explore multiple realities (Creswell & Plano Clark, 2007).

Supporters of mixed methods research acknowledge that this research design does not fit within either the qualitative or quantitative epistemological stance. The most common alternative worldview associated with mixed methods research is pragmatism, where the researcher believes the appropriate methods to be used in a study are the methods best suited to generate solutions to real-world problems that can then be generalized to create positive changes in practice (Feilzer, 2010). In mixed methods research "pragmatism allows the researcher to be free of mental and practical constraints imposed by the forced choice dichotomy between post-positivism and constructivism" (Creswell & Plano Clark, 2007, p. 27).

The present research study to develop an implementation framework for a new integrated geriatric care planning approach at the point-of-care in home care was conducted from a pragmatic point of view. Using both qualitative and quantitative methods, the researcher identified evidence and theory to model integrated care planning factors, strategies, tools and

evaluation criteria that can be operationalized in real-world geriatric home care practice.

3.5.2 Collective Creativity

Within the pragmatic worldview, the researcher applied the ideology of collective creativity from the field of service design (Sanders & Stappers, 2008; Sanders & Stappers, 2012). Collective creativity explicitly acknowledges the expertise of system users in the research process, particularly when developing/designing new products, processes, interventions or changes in practice. This approach is premised on the fact that those who might be traditionally seen as the "end user" of a given product, process or intervention, should in fact be acknowledged as experts of their own unique experience and be consulted, involved and engaged in the design (Sanders & Stappers, 2012).

Collective creativity is similar to participatory research, whereby it brings together the perspectives of end-users/stakeholders and designers/researchers throughout the research process in an approach that is mutually beneficial to both parties (Bergold & Thomas, 2012). To operationalize the ideology of collective creativity in the field of design, generative research through co-design methods is applied (Sanders & Stappers, 2012). Figure 3.4 illustrates the differences in the roles of the user, researcher/designer (may be different people or the same person) in traditional research/design processes and co-creation using co-design methods. In traditional research methods the end-user is a passive object that is studied by the researcher who brings knowledge and theories to the process and develops more knowledge through observation of the user. This knowledge is then fed via a report to a designer who develops the product, process, intervention, etc. in isolation. In a co-design process, the end-user plays a large role in developing knowledge, concepts and ideas. The researcher/designer's role is to support the users by providing tools and methods for ideation to occur and then operationalizing the ideas (Sanders

& Stappers, 2008; Sanders & Stappers, 2012).
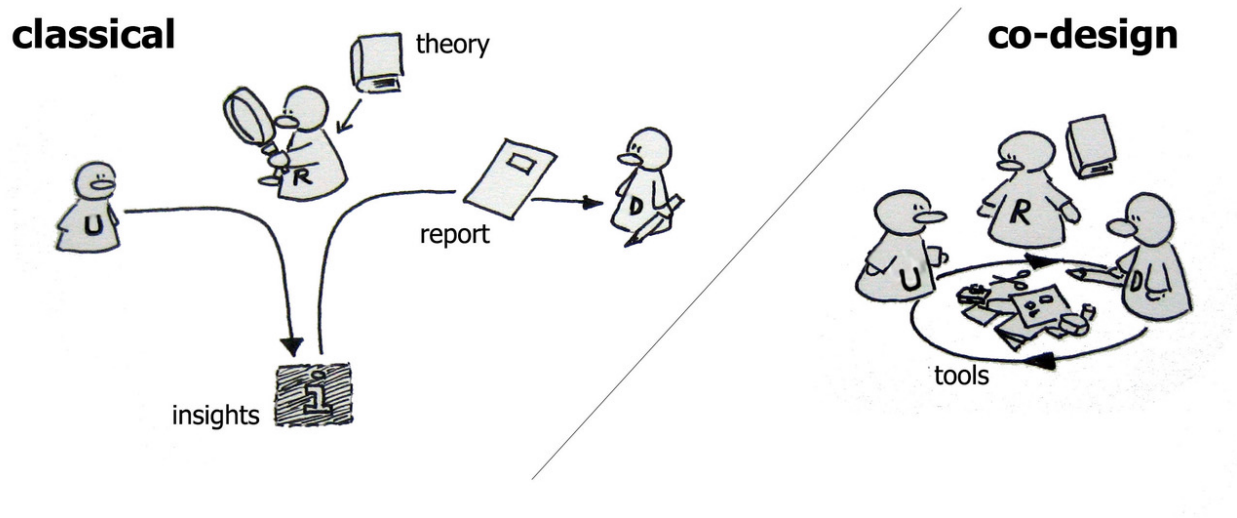
Figure 3.4 The role of users, researchers and designers in classic research versus co-design methods[3]

In terms of value, co-created solutions to real-world problems have a greater potential to be sustainable in the long-term (Sanders & Stappers, 2012). In this research study, collective creativity through co-design methods was implemented in both phases of data collection as well as the interpretation stage in the mixed methods design. In phases one and two, "end users" (i.e., older adults, family/friend caregivers and point-of-care providers) were consulted on their experiences and expertise in geriatric assessment and goal-setting using both qualitative and quantitative techniques. In the interpretation stage of the study, a co-design workshop brought together the researcher and end-users in a creative process that generated ideas, concepts and elements of a new geriatric care planning approach at the point-of-care in geriatric home care that informed the development of an implementation framework.

3.5.3 Ethical Considerations

Ethics clearance for this research study was granted by the University of Waterloo Office

---

[3] This figure was reproduced with permission of the authors (see Appendix C)

of Research Ethics (ORE #19586 & #22251). All survey, interview and co-design workshop participants received a study information letter prior to taking part in the study and were required to provide informed consent. All hard copy participant information collected for the purposes of the study is kept in a secure location at the University of Waterloo and all digital participant information is kept on the password encrypted hard drive of the primary study researcher's computer.

CHAPTER 4: DEVELOPMENT AND TESTING OF THE GERIATRIC CARE ASSESSMENT PRACTICES (G-CAP) SURVEY[4]

4.1 Abstract

Background

Older adults receiving home care often have complex needs which require care from a range of providers. While the RAI-HC tool is used to allocate services at the system level, little is known about how point-of-care providers collect the information they need to plan and provide care. The purpose of this pilot study was to develop and test a survey to explore the geriatric care assessment practices of nurses, occupational therapists (OTs) and physiotherapists (PTs) in home care.

Methods

Guided by the methods of Streiner and Norman (2008), multiple sources of information were used to develop the Geriatric Care Assessment Practices (G-CAP) survey—a 33 question, online, self-report tool exploring assessment and information-sharing methods, attitudes, knowledge, experience and demographic information. The survey was pilot-tested with point-of-care nurses, OTs and PTs at a single home care agency in Ontario, Canada ($N = 27$). Test-retest reliability ($N = 20$) and discriminative, convergent and divergent construct validity of the tool was explored.

Results

Test-retest reliability for subscales of the G-CAP survey was found to be acceptable within a population of interdisciplinary home care providers [ICC2 (A,1) (*M ICC* = 0.58), weighted kappa (*M kappa* = 0.63)]. Statistically significant differences between OT, PT and nurse responses [*M* t = 3.0; *M* p = 0.01] and moderate correlations between predicted related items [*M r* = |0.39|] indicated good survey construct validity in this population. Pilot participants specified that they

---

use their own clinical observation and interview skills far more often than standardized tools for geriatric assessment. Client input was indicated by pilot participants to be the most important source of information for goal-setting. A majority of pilot participants had heard of the RAI-HC; however, few used it. Pilot participants agreed they could use client information collected by others, but said they must conduct client assessments themselves to provide care and only sometimes share and rarely receive assessment information from other health care providers.

Conclusions

The G-CAP survey is reliable and valid for use with interdisciplinary home care providers. Additional exploration into the pilot findings related to geriatric assessment will be explored in the broad administration phase of the research.

4.2 Background

Older adults want to remain in their own homes as long as possible, and meeting their often compounding physical, functional, cognitive, and psychosocial needs with home care services is a key priority for Canadian health care (Better Home Care, 2016; Health Council of Canada, 2012). With the complexity of geriatric home care client needs and the number of different care providers potentially involved, a variety of information and data are required to plan and deliver effective home care services. How, when and who collects this information is very important to the experience of integrated care (Leatt, Pink, & Guerriere, 2000). To prevent duplication, repetition and frustration, a common assessment approach is preferred over each care provider completing their own assessment. This allows for the development of a comprehensive view of health care needs, while effectively reducing the demand on older adult home care clients and their family/friend caregivers to repeat their story and health history multiple times to different people (Baranek, 2010; Leatt et al., 2000; MacAdam, 2009).

A well-documented model for health care planning and delivery to older adults with complex health issues is the Comprehensive Geriatric Assessment (CGA). Often thought to be synonymous with specialized geriatric medicine, CGA emphasizes an interdisciplinary and multidimensional approach to assessment that requires all involved health care providers to input information on the functional, social and environmental factors related to an older individual's health, in conjunction with their diagnoses (Heckman, Gray, & Hirdes, 2013; Welsh et al., 2014). CGA has been used in a variety of geriatric care settings across the continuum of care. It has been most well established for use in hospital settings, with studies reporting its ability to predict adverse events (Avelino-Silva et al., 2014), lead to improved functional outcomes (Baztan, Suarez-Garcia, Lopez-Arrieta, Rodriguez-Manas, & Rodriguez-Artalejo, 2009; Ellis, Whitehead,

O'Neill, Langhorne, & Robinson, 2011) and decrease morbidity, mortality and hospital

admissions (Caplan, Williams, Daly, & Abraham, 2004; Cohen et al., 2002; Van Craen et al.,

2010). The use of CGA in primary and community care has also been documented (Heckman et

al., 2013; Welsh et al., 2014). Trials of CGA combined with multidimensional interventions with

community-dwelling older adults have shown improvement in clients' self-reported ability to

complete activities of daily living (Boult et al., 2001; Melis et al., 2008). CGA has also been

used by Mobile Geriatric Assessment Teams to coordinate the provision of targeted

multidisciplinary primary care to rural-dwelling, and frail, older adults and has been applied in a

preventive context for at-risk community-dwelling seniors (Beauchet, Launay, Merjagnan,

Kabeshova, & Annweiler, 2014; Rockwood et al., 2003; Suijker et al., 2012).

A key element of CGA is that comprehensive assessment and delivery of care are

intended to be both integrated and carried out by point-of-care providers. The interRAI Home

Care Assessment (RAI-HC) is a standardized patient assessment tool designed to collect

comprehensive patient information for care planning and collaborative decision-making by

multiple providers in home care (interRAI, 2012; Parsons et al., 2013; Stolee, 2010). The way

the RAI-HC effectively combines cross-disciplinary information in a standard format makes it

ideal to guide CGA practice in home care, yet the structure and organization of care in this sector

can impede the opportunity for this tool to be used to its full capacity.

Within the home care sector in Ontario, Canada, numerous layers of service provision

and a lack of role clarity between assessment for service allocation and point-of-care planning

often result in multiple assessments for each client (Health Quality Ontario, 2012). Since 2002,

the RAI-HC has been mandated for use in Ontario to guide service allocation of government-

funded home care services (Guthrie et al., 2014). However, care coordinators have 14 days

following client admission to complete RAI-HC assessments and the data are not routinely shared with or used by direct-service home care agencies in their delivery of services (Doran et al., 2013). Multiple providers from different health care disciplines are often involved in the direct care of older adults, but they work in isolation of each other in individual client homes and therefore individually collect the information they need to provide care (Ontario Health Coalition, 2011; Parsons & Parsons, 2012; Toscan et al., 2012).

Nurses, occupational therapists (OTs) and physiotherapists (PTs) are the most common providers conducting client assessments at the point-of-care in home care (Ontario Home Care Association, 2013). However, to date, their specific assessment and information-sharing practices are largely unknown and undocumented. An understanding of the geriatric care assessment practices of individual providers is required to determine how to optimize individual provider contributions to CGA and care planning in this sector. Consultation research to address this knowledge gap in home care is challenging as the geographic dispersion of providers and variable care schedules of clients make it difficult to coordinate and conduct face-to-face interviews and focus groups (Ellenbecker, Samia, Cushman, & Alster, 2008). As an alternate route, online surveys are an effective method of collecting point-of-care provider perspectives since they allow researchers to sample participants efficiently, by reaching a broader group of people, and allow providers to participate at their convenience (Dillman, 2000).

The purpose of this study was to develop and pilot test an online self-report survey tool to explore the geriatric care assessment practices of Nurses, OTs and PTs in home care.

4.3 Methods

4.3.1 Survey Development

The Geriatric Care Assessment Practices (G-CAP) survey was developed using multiple sources of information and guided by a multi-step approach recommended by Streiner and Norman (2008):

1. Confirm there is no pre-existing survey tool

A scan of published and grey literature was completed to confirm there were no pre-existing tools for collecting data on the geriatric care assessment practices of point-of-care providers in home care.

2. Determine specificity of the tool

Informed by the background and scope of the project, the researchers determined that the G-CAP survey would focus on the geriatric assessment practices of nurses, OTs and PTs in home care. In accordance with Ontario's action plan for seniors, the geriatric population was defined as any individual aged 65 years and older who was currently receiving home care for any health issue (The Ontario Seniors' Secretariat, 2013).

3. Consider homogeneity of the tool

Researchers hypothesized that the G-CAP survey items would be meaningful at the individual level and therefore would not be added together to generate a single composite score. However, the researchers planned to explore internal consistency (α) between subsets of seemingly related items to determine whether sub-scales existed within the tool. If present, this would indicate groups of effect indicators of sub-constructs related to the overall construct of geriatric assessment (Streiner & Norman, 2008).

4. Determine the range of items to be included in the scale

As it is preferable in scale development to derive items from multiple sources, previous literature and expert opinion were used to create the item pool (Streiner & Norman, 2008). A scan of published and grey literature and current practices in CGA was completed to determine relevant geriatric care domains, standardized assessment tools and other items that should be explored in this type of survey. A group of clinical leaders from various disciplines involved in geriatric home care at a Canadian home care agency were also consulted in a meeting format to help formulate additional items for inclusion in the G-CAP survey based on their individual and collective experiences in home care planning.

Once the first draft of candidate domains and items was completed, a convenience sample of management, education and clinical experts in nursing, occupational therapy and physiotherapy ($N = 7$) were recruited to participate in key informant interviews where they were asked to review and confirm the candidate list of domains and items to be included in the survey and comment on face validity and content validity (relevance, representativeness and coverage of items). The key informants were also asked to review survey items for any ambiguous wording and comment on the overall length of the tool from a feasibility perspective (Streiner & Norman, 2008). All key informants provided written consent to participate in the interviews, which were audio-recorded and transcribed verbatim (see Appendix D). Interview transcripts were thematically analyzed by two independent researchers using an inductive coding method and NVivo 10 software (Lofland et al., 2006; Pope, Ziebland, & Mays, 2000; QSR International Pty Ltd, 2012). After completing their individual analyses, the two researchers came together to compare, contrast and finalize the themes.

5. Scaling the responses

Researchers determined that three different types of response options were needed to

match the question types in the initial pool of survey items: 1) perceived frequency; 2) level of agreement; and 3) perceived importance. As these response options are bipolar in nature, they were scaled on a seven point Likert scale (Streiner & Norman, 2008).

4.3.2 Pilot Testing

<u>Reliability and Validity</u>

Test-retest reliability of the G-CAP survey for use with nurses, OTs and PTs in home care was explored. Point-of-care providers were asked to participate in the survey on two separate occasions, time one (T1) and time two (T2), which were separated by a period of two weeks, to determine the stability of their responses about their geriatric care assessment practices over time. Discriminative construct validity was explored by testing the following hypotheses about differences between nurse, OT and PT responses:

a) Rehabilitation therapists will use measures of functional status/ activity and rest more often than nurses;

b) Nurses will use measures of skin integrity more often than rehabilitation therapists;

c) Rehabilitation therapists will assess mobility more often than nurses;

d) Rehabilitation therapists will use measures of mobility more often than nurses; and

e) OTs will use measures of the patient environment more often than PTs.

Convergent and divergent construct validity was explored by testing the following hypotheses about correlations between survey items:

a) Years of experience will be positively correlated with having heard about the RAI-HC;

b) Opinions that client assessment requires observation of a client in their home will be positively correlated with the use of observation and interview skills;

33

c) Believing assessment involves conversations with health care providers will be positively correlated with sharing information; and

d) Believing that standardized assessment tools are part of geriatric assessment will be negatively correlated with years of experience.

4.3.3 Data Collection

To make sure the analysis of test-retest reliability was appropriately powered, the hypothesis testing approach of Kraemer and Thiemann (1987) was used to determine an appropriate sample size for G-CAP survey participants. To determine whether an "excellent" reliability of >0.75 was significantly different from a "poor" reliability of 0.40, a target sample size of 21 participants at T1 and T2 was determined to be appropriate (Fleiss, 1986; Fleiss & Cohen, 1973; Kraemer, 1987). This sample size is also sufficient for detecting large correlations (>0.5) (Cohen, 1988; Kraemer, 1987).

Point-of-care nurses, OTs and PTs in four geographic areas within a single home care provider agency in Ontario made up the participant pool for this study. A convenience sampling strategy was employed until the target sample size was reached. T1 recruitment began with telephone information sessions between a researcher (JG) and clinical leaders within each of the four jurisdictions of the agency. Following these information sessions, mass e-mail messages were sent out by clinical leaders to approximately 290 frontline staff requesting their voluntary participation in the survey.

Participants were asked to provide their e-mail addresses at the end of T1 survey completion. Within one week, a researcher (JG) e-mailed each T1 survey participant directly, inviting them to participate in the survey at T2, and providing them with a one week deadline to do so. This deadline was to ensure that both T1 and T2 survey completion took place within a 14

day period; an optimal time frame for test-retest reliability (Streiner & Norman, 2008). Up to two reminder e-mails were sent to each participant to complete the survey, after which point if they had not participated, it was assumed that they had decided to withdraw from the study.

Participants were not paid for their time to complete the survey at T1 or T2, but in recognition of their efforts, they were given the option to enter their name into a draw for one of four gift cards ($50 CAD each) if they completed the survey at both T1 and T2.

4.3.4 Data Analysis

Participant survey responses at T1 were used to provide demographic information and to complete construct validity analyses; data from T1 and T2 were used to analyze test-retest-reliability. All skipped frequency questions were coded as "never" and all skipped agreement or importance questions were coded as "neutral".

Statistical analyses were completed using IBM SPSS 20.0 software, beginning with descriptive statistics (IBM, 2007). First, internal consistency (α) was explored for groups of related categorical items. Cronbach's alpha values less than 0.5 were considered unacceptable, between 0.51 and 0.60 were considered poor, between 0.61 and 7.0 were considered acceptable, between 0.71 and 0.90 were considered good and greater than 0.90 were considered to be excellent (Kline, 2000). For groups of items with $\alpha > 0.61$, a single Intra-Class Correlation Coefficient (ICC2, A1) was calculated to determine test-retest reliability for these potential sub-scales of related items (Streiner & Norman, 2008). The test-retest reliability of individual categorical items of the G-CAP survey was evaluated using weighted kappa coefficients with quadratic weights. Following the guidelines suggested by Fleiss (1986), reliability values below 0.40 were considered poor, between 0.41 and 0.75 were considered fair to good and >0.75 were considered excellent. Discriminative construct validity was evaluated by comparing mean results

using a two-tailed independent samples t-test statistic with a 5% level of significance ($\alpha = 0.05$) for various hypotheses about differences between disciplines. Convergent and divergent construct validity was tested by calculating Pearson product moment correlations to test various theories about relationships between items in the G-CAP survey. Following the guidelines suggested by Cohen (1988), correlations of 0.1 were considered small, of 0.3 were considered moderate, and of 0.5 were considered large.

4.4 Results

4.4.1 The G-CAP Survey

An initial scan of published and grey literature identified various classifications of care domains relevant to CGA. Table 4.1 illustrates some examples of these different classifications.

Consideration of these various conceptualizations of CGA domains in terms of their frequency of inclusion in the literature, relevance to home care, research and interdisciplinary practice led to defining a list of initial domains and items to consider for inclusion in the G-CAP survey (see Table 4.2). Additional academic and grey literature searching and consultation with the clinical leadership group led to refinement of the domains and item pool for inclusion in the survey, including the addition of items related to opinions, use and knowledge of the RAI-HC and clinician observation and interview skills (see Table 4.2).

Key informant interviews indicated good face validity for the proposed survey domains and items. All key informants indicated that they believed the survey domains and items appeared to be assessing the geriatric care assessment practices of point-of-care home care providers and felt that the data provided would be valuable. For example, one expert indicated: "This is nice…it is nice. I think it is nice. It will be interesting to see what you are going to get…I think it will be really interesting to see what comes out of it".

Table 4.1 Examples of CGA assessment domain classifications reported in the literature

Guthrie et al., 2014 (Guthrie et al., 2014)	Elsawy & Higgins, 2011 (Elsawy & Higgins, 2011)	Cobb, Duthie & Murphy, 2002 (Cobb, 2002)	Stauder et al., 2010 (Stauder, Moser, Holzner, Sperner-Unterweger, & Kemmler, 2010)	Fleming & Scamehorn, 2006 (Fleming, 2006)	Gallo et al., 2006 (Gallo, 2006)	Stolee, 2010 (Stolee, 2010)
Functional ability

Communication

Pain

Cognition

Mood

Service use | Functional ability (ADLs, IADLs)

Physical health (disease screening, nutrition, vision, hearing, continence, balance and fall prevention, osteoporosis, polypharmacy)

Cognition and mental health (depression, dementia)

Socio-environmental circumstances | Physical (functional status, nutrition, vision, hearing)

Cognitive (dementia)

Psychologic (depression, anxiety)

Social (personal support, caregiver burden, advance directives, abuse)

Driving (assess risks) | General functioning in everyday life

Comorbidities

Nutritional status

Cognition

Health-related quality of life

Social support | FEEBLE
Forgetful
Eyes
Ears
Brown bag of medications
Leaking (continence)
Eat

FALLERS
Fall
ADLs
Lonely
Living
Expectations
Rest
Specialists

ARE
Advanced directives
Ride (driving)
ED visits

FRAIIL
Family
Religion
Access
Income
Lifestyle | Functional

ADLs/ IADLs
Cognitive

Depression

Social and economic issues

Substance use

Driving | Physical function

Cognitive function

Self-rated health

Psychosocial function

Health care use

Other |

In terms of content validity, key informants were generally supportive of the items included in the survey; however, they suggested a reclassification of some of the survey domains using language they felt would be better understood by point-of-care providers in home care. Key informants suggested nine additional standardized assessment tools that should be included in the survey (see Table 4.2).

Table 4.2 Development of domains and items to be included in the G-CAP survey

Source of input	Domains	Items
Literature (academic & grey)	• Cognition and mood • Pain • Wounds (Skin) • Function • Mobility • Environment • Quality of life • Social support • Financial situation • Demographics	• 50 standardized assessment tools
Clinical Leadership Group	• RAI-HC	• Observation and interview skills • Opinions • Use • Knowledge/ awareness
Clinical Expert Key Informants	• Cognition and mood • Pain • Skin integrity • Functional status/ activity and rest • Mobility/ balance/ ambulation • Safety (environment, abuse risk and fall risk) • Medication management • Quality of life • Resources (social and financial) • Interdisciplinary collaboration	• 9 additional standardized assessment tools • Attitudes • Experience

Clinical expert key informants also discussed various barriers and facilitators to adopting an interdisciplinary common assessment approach in home care (see Table 4.3). These perceptions of barriers and facilitators informed the inclusion of additional survey items related to attitudes towards assessment, and experiences with interdisciplinary collaboration.

Table 4.3 Expert opinions regarding the barriers and facilitators for moving to a common assessment approach in geriatric home care

Barriers	Facilitators
Competing care priorities across disciplines	Identification and prioritization of client goals
Too many standardized assessment tools available	Knowing what data are needed by all point-of-care providers
Point-of-care providers working in isolation of each other	Interdisciplinary collaboration
No access to data collected by other point-of-care providers	Leveraging technology for information-sharing

Experts indicated that the survey was quite long, although they also agreed that all of the items were necessary for a thorough exploration of geriatric assessment practices. This prompted the decision to include automatic skip patterns in the survey so that participants would not spend time responding to questions in an area that was not applicable to their individual geriatric assessment practices.

The final version of the G-CAP survey included 33 questions related to the following five areas: 1) Assessment methods; 2) Attitudes toward assessment; 3) Perceptions of the RAI-HC; 4) Interdisciplinary collaboration; and 5) Demographic information (see Appendix E).

4.4.2 Participant Characteristics

A total of 27 out of ~290 health care providers (9.3%) who were e-mailed the survey, participated at T1. Of these 27 participants, 20 (74.1%) subsequently participated in the survey at T2. Participation took place between September 1, 2014 and November 30, 2014. Participants

were mostly female (96.3%) and ranged in age from 23 to 75 years (M = 42.6, SD = 13.8), with

an average of 15.6 years of experience in their respective disciplines (SD = 12.7, Range: 1-53).

More than half of the participants (55.6%) had been working in home care for at least five years,

with one-third (33.3%) having worked in the sector longer than ten years. Most participants had

experience working in other health care sectors, with 70.4% having previously worked in a

hospital and 51.9% in long-term care. The majority of participants (88.9%) indicated that more

than half of their home care clients are over the age of 65. The demographics of participants are

displayed in Table 4.4.

Table 4.4 Characteristics of G-CAP survey participants

Characteristic		All providers (*N*= 27)	Nurses (*n*= 12)	OTs (*n*= 8)	PTs (*n*=7)
Age* *Mean* (*SD*) (Range)		*42.6 (13.8)* (23-75)	*41.1 (14.9)* (23-67)	*46.4 (15.2)* (30-75)	*41.0 (11.6)* (29-60)
Gender *n*		Female *26*, Male *1*	Female *12*	Female *8*	Female *6* Male *1*
Years in practice *Mean* (*SD*) (Range)		*15.6 (12.7)* (1-53)	*10.2 (9.3)* (1-28)	*22.6 (15.4)* (6-53)	*16.9 (11.6)* (7-37)
Working in home care *n* (%)	<1 year:	*5* (18.5)	*4* (33.3)	*0* (0)	*1* (14.3)
	1-5 years:	*7* (25.9)	*2* (16.7)	*1* (12.5)	*4* (57.1)
	6-10 years:	*6* (22.2)	*2* (16.7)	*3* (37.5)	*1* (14.3)
	>10 years:	*9* (33.3)	*4* (33.3)	*4* (50.0)	*1* (14.3)
Working in other sectors *n* (%)	Hospital	*19* (70.4)	*9* (75.0)	*6* (75.0)	*4* (57.1)
	LTC	*14* (51.9)	*9* (75.0)	*1* (12.5)	*4* (57.1)
	Rehab**	*6* (22.2)	*1* (8.3)	*3* (37.5)	*2* (28.6)
	Palliative	*5* (18.5)	*2* (16.7)	*2* (25.)	*1* (14.3)
	Private	*11* (40.7)	*2* (16.7)	*3* (37.5)	*6* (85.7)
Clients over 65 years *n* (%)	< 25%	*0* (0)	*0* (0)	*0* (0)	*0* (0)
	26-50%	*3* (11.1)	*2* (16.7)	*1* (12.5)	*0* (0)
	51-75%	*12* (44.4)	*7* (58.3)	*3* (37.5)	*2* (28.6)
	76-100%	*12* (44.4)	*3* (25.0)	*4* (50.0)	*5*(71.4)

*Two participants did not indicate their age.
**Legend: Rehab = Inpatient Rehab

4.4.3 Reliability

ICC2 (*A,1*) coefficients indicate fair to good test-retest reliability, on average, for groups

of related categorical items comprising potential sub-scales of the G-CAP survey within a

population of interdisciplinary home care providers (*M* = 0.58) (see Table 4.5).

Table 4.5 Test-retest reliability for groups of related categorical items (potential-subscales)

G-CAP Survey Section	Potential Sub-Scale Name	Questions (items)	Internal Consistency (*α*)	*ICC 2 (A,1)* (95% Confidence Interval)
Methods of Assessment	Assessment of Geriatric Care Domains	1, 3, 5, 7, 9, 11, 13, 15, 17	*0.91*	*0.57* (0.46-0.66)
	Use of Clinical Observation and Interview Skills	2i, 4i, 6d, 8l, 10l, 12f, 14h, 16c, 18n	*0.89*	*0.41* (0.0-1.0)
Attitudes Toward Client Assessment in Home Care	Holistic Assessment Practices	19 a-l	*0.72*	*0.62* (0.53-0.69)
Perceptions of the RAI-HC Assessment Tool	Use of RAI-HC	21 a-c	*0.74*	*0.78* (0.66-0.86)
Interdisciplinary Collaboration	Collaborative Goal-Setting	23 a-g	*0.82*	*0.52* (0.39-0.62)
	Interdisciplinary Information-sharing	25 a-e	*0.76*	*0.53* (0.37-0.66)

Mean weighted kappa coefficients indicate fair to good test-retest reliability, on average,

for individual categorical items of the G-CAP survey within a population of interdisciplinary

home care providers (*M kappa* = 0.63) (see Table 4.6).

Table 4.6 Test-retest reliability for individual categorical items

G-CAP Survey Section	Questions (items)	*Mean Weighted Kappa Coefficient* (**Range**)
Methods of Assessment	2a, 2b, 4a, 4b, 4c, 4e, 4f, 6a, 8a, 10e, 12b*	*0.64* (0.30-0.98)
Perceptions of the RAI-HC Assessment Tool	20	0.66 (0.37-0.95)
	22 a-f	*0.56* (0.08-0.97)
Interdisciplinary Collaboration	24 a-d	*0.65* (0.46-0.75)
Demographic Information	28, 30, 31, 33**	*0.62* (0.43-0.90)

*Only questions about tools that were rated to be used more than almost never (> 2 on a 7 point scale) were included in the analysis
**Question 32 was excluded due to a glitch in the online question format and given that all providers were from the same home care agency

4.4.4 Validity

Significant two sample t-test statistics ($p < 0.05$, two-tailed) confirmed the hypothesized differences among nurse, OT and PT responses. Table 4.7 depicts the t-test scores that support each hypothesis about differences between these groups (*M* t = 3.0; *M* p = 0.01), which indicate good discriminative construct validity for use of the G-CAP survey with interdisciplinary home health care providers.

Table 4.7 Discriminative construct validity for use of the G-CAP survey with interdisciplinary home health care providers

Hypotheses about differences between groups	G-CAP item	*Mean*	*t test value (p value)*
Rehabilitation therapists will use measures of functional status/ activity and rest more often than nurses	Functional Independence Measure (FIM)	Therapist *M= 3.4* Nurse *M= 1.0*	*4.0 (0.001)*
	Functional Reach Test	Therapist *M= 1.6* Nurse *M= 1.0*	*2.9 (0.012)*
Nurses will use measures of skin integrity more often than rehabilitation therapists	Braden Scale for Pressure Sore Risk	Nurse *M= 5.0* Therapist *M= 2.4*	*3.6 (0.002)*
Rehabilitation therapists will assess mobility more often than nurses	Assessment of mobility/ balance/ ambulation	Therapist *M= 6.5* Nurse *M= 5.1*	*2.3 (0.037)*
Rehabilitation therapists will use measures of mobility	Berg Balance Scale	Therapist *M= 2.5* Nurse *M= 1.1*	*3.5 (0.003)*

more often than nurses	Timed Up and Go Test (TUG)	Therapist *M= 2.7* Nurse *M= 1.0*	*3.2 (0.004)*
Occupational therapists will use measures of the patient environment more often than physiotherapists	SAFER-HOME	Occupational Therapist *M= 2.8* Physiotherapist *M= 1.0*	*1.8 (0.013)*

Pearson's product moment correlation coefficients *(r)* confirmed expected convergent and divergent relationships between survey items and demographic information. Table 4.8 details the correlation coefficients for each hypothesis tested, with moderate correlation values, on average (*M* r = |0.39|), which further indicates good construct validity for use of the G-CAP survey with interdisciplinary home health care providers.

Table 4.8 Convergent and divergent construct validity for use of the G-CAP survey with interdisciplinary home health care providers

Hypotheses	G-CAP Questions (items)	Pearson's correlation *r*
Years of experience in general and in home care will be positively correlated with having heard about the RAI-HC	29 and 20	*0.27*
	30 and 20	*0.25*
Opinions that client assessment requires observation of a client in their home will be positively correlated with the use of individual observation and interview skills in each domain	19f and 2i	*0.33*
	19f and 4i	*0.33*
	19f and 6d	*0.36*
	19f and 8l	*0.73**
	19f and 10l	*0.63**
	19f and 12f	*0.60**
	19f and 14h	*0.39***
	19f and 16b	*0.44***
	19f and 18n	*0.44**
Believing assessment involves conversations with providers within and across disciplines will be positively correlated with sharing and receiving information within and across disciplines	19d and 25a	*0.24*
	19d and 25d	*0.34*
	19e and 25b	*0.27*

	19e and 25e	*0.27*
Believing that standardized assessment tools are part of geriatric assessment will be negatively correlated with the number of years in practice and in home	19a and 29	*-0.43**
	19a and 30	*-0.36*

*p< 0.01 (two-tailed)
**p< 0.05 (two-tailed)

4.4.5 Preliminary Survey Findings

Pilot survey data point to five notable findings regarding the geriatric care assessment practices of nurses, OTs and PTs in home care.

1. Survey participants use their own clinical observation and interview skills far more often than any standardized tools for geriatric assessment.

Participants indicated that they use their own observation and interview skills to assess each of the nine geriatric care domains included in the G-CAP survey ($M = 5.6/7$, $SD = 2.1$, Range: 1-7) significantly more often than any standardized assessment tools ($M = 1.7/7$, $SD = 1.6$, Range: 1-7). The only standardized assessment tools that participants indicated they used more than "almost never" (> 2 on a 7 point scale), on average, were the *Numeric Pain Rating Scale* (NPRS), which is used often ($M = 5.0/7$, $SD = 2.4$, Range: 1-7), the *Verbal Rating Scale* for pain, which is used often ($M = 5.0/7$, $SD = 2.4$, Range: 1-7) and the *Braden Scale for Predicting Pressure Score Risk*, which is rarely used ($M = 3.4/7$, $SD = 2.5$, Range: 1-7).

2. The majority of survey participants had heard of the RAI-HC, but do not actually use it.

59.3% of the survey participants had previously heard about the RAI-HC, yet, on average, never use it to conduct comprehensive assessments of older home care clients ($M =1.66/7$, $SD =1.7$, Range: 1-6).

3. Participants said that client input is the most important source of information for goal-setting.

On average, participants rated input from the client as the most important ($M = 6.7/7$, $SD = 0.45$, Range: 6-7) for setting individual client goals. Participants consistently rated the

44

assessment data that others collect (*M* = 5.9/7, *SD* = 0.78, Range: 4-7) as well as the professional

opinion of other health care providers as less important (*M* = 5.9/7, *SD* = 0.80, Range: 4-7) when

establishing these goals.

4. <u>Participants agreed that they could use client information collected by other health care</u>

<u>professionals but also agreed that they need to conduct client assessments themselves in order to</u>

<u>provide care.</u>

   While participants strongly agreed that they could use client information collected by other

health care professionals (*M* = 6.0/7, *SD* = 0.83, Range: 4-7), they also somewhat agreed that

they must conduct client assessments themselves in order to provide care to clients (*M* = 5.7/7,

SD = 1.3, Range: 1-7 on a 7 point scale).

5. <u>Participants only sometimes share, and rarely receive assessment information from other</u>

<u>health care providers.</u>

   Participants indicated they only sometimes share client information with other health care

providers in their discipline (*M* = 4.2/7, *SD* = 1.6, Range: 2-7) or outside of their discipline (*M* =

4.3/7, *SD* = 1.4, Range: 1-4). While participants sometimes indicated they receive client

information from other health care providers in their discipline (*M* = 4.0/7, *SD* = 1.4, Range: 1-

7), they rarely receive client information from other health care providers outside of their

discipline (*M* = 3.7/7, *SD* = 1.3, Range: 1-7).

4.5 Discussion

4.5.1 Reliability and Validity of the Geriatric Care Assessment Practices (G-CAP) Survey

   The G-CAP survey showed fair to good test-retest reliability according to the Fleiss

criteria (Fleiss, 1986). However, it is important to note that these criteria are not specific to ICC,

kappa and correlation values and are routinely used to interpret many different types of reliability

coefficients in the literature. Therefore, setting reliability cut-off values has been reported to be a fairly arbitrary, although common practice, in the development of novel measurement tools and scales (Streiner & Norman, 2008; Van Ness, Towle, & Juthani-Mehta, 2008). The author Nunnally (1978), however, adds a critical distinction for interpreting psychometric data, based on the purpose of the tool that is being developed. If the tool is being used for research purposes, a reliability coefficient of at least 0.70 is suggested; whereas, tools being used for clinical decision-making should have reliability values of at least 0.90 (Nunnally, 1978).

As the G-CAP survey was developed specifically for research purposes, there is room for some improvement in test-retest reliability. Participant responses were almost exclusively at the high end of the scale ($M = 5.6/7$), for the frequency of assessment on each care domain, while their responses for the frequency of utilizing standardized assessment tools was substantially lower ($M = 1.7/7$). Based on these results, modification of the scales to better distinguish between respective ceiling and floor effects would enhance reliability and the ability to discriminate between more nuanced positive and negative responses (Streiner & Norman, 2008). These changes will be made prior to the broad scale administration of the G-CAP survey. Further, as reliability is context-specific, Streiner and Norman (2008) suggest that it tends to increase when a tool is administered in a more heterogeneous population, which is planned for the next phase of this research when the G-CAP survey is administered to a wider group of home care Nurses, OTs and PTs.

The G-CAP survey showed good construct validity, with all hypotheses being supported by significant two-tailed two sample t-test statistics and moderate correlation values. No additional modifications to the tool will be made from a validity perspective.

4.5.2 Exploring the Geriatric Care Assessment Practices of Nurses, OTs and PTs in Home Care

Survey participants said they use their clinical observation and interview skills far more than any standardized assessment tools when conducting geriatric assessments at the point-of-care in home care. Previous literature supports the use of clinical judgment in geriatric care, especially in predicting falls risk (Milisen et al., 2012; Turkoski et al., 1997). One study found that clinical judgment was more accurate than traditionally used falls-risk assessment tools, although less sensitive (Vassallo, Poynter, Sharma, Kwan, & Allen, 2008). Clinical judgment has also been shown to be more effective than standardized assessment in predicting frailty in geriatric patients with cancer (Smets et al., 2014). However, standardized assessment has been found to be superior to clinical judgment in other areas of geriatric care, including functional assessment of cognition and activities of daily living, particularly in predicting more moderate impairments in function that could be targeted with earlier intervention and identifying frailty (Kirkhus et al., 2017; Pinholt et al., 1987; Worrall, 1996). Further exploration of the individual and combined use of standardized tools and clinical judgement is needed to support a CGA type of assessment approach in home care.

Only 59.3% of surveyed home health care providers had previously heard about the RAI-HC. Of these participants, most also indicated that they never use the RAI-HC themselves to collect data about geriatric clients to plan and provide care. These results further illuminate the previously cited disconnect between LHIN (system level) assessment for the purposes of service allocation and point-of-care assessment for the purposes of real-time care delivery in Ontario home care (Guthrie et al., 2014). Further, participants indicated that they use very few other standardized assessment tools, which is potentially indicative that they do not believe there to be a more appropriate alternative to the RAI-HC as a comprehensive standardized assessment at the

point-of-care in geriatric home care. This suggests that the perceived potential of the RAI-HC is

under-realized and supports the need to further explore the applicability of the RAI-HC in point-

of-care assessment to foster real-time care planning.

Survey participants' opinions regarding the priority of information sources for individual

goal-setting indicate input from the client as most important. While their prioritization of client

input in goal-setting is aligned to current best practices in shared-decision making and person-

and family-centred care for individual interactions between clients and providers, participants'

responses are also reflective of the need to improve interdisciplinary collaboration in geriatric

home care (Butterworth & Campbell, 2014; Kuluski et al., 2017; Lally, 2012; Registered Nurses

Association of Ontario, 2015; Schulman-Green et al., 2006). Participants indicated they only

sometimes share and rarely receive client assessment information from other point-of-care

providers and that professional opinion and assessment data from other point-of-care providers

are the least important sources of information for client goal-setting. Additionally, 96.2% of

participants indicated that they can make use of client data collected by other point-of-care

providers, but 85.1% of participants also said that they must conduct the client assessment

themselves to be able to provide care. These findings are in contrast to defined optimal

collaborative practice, which Curran (2004) says:

> …involves the continuous interaction of two or more professionals or
> disciplines organized into a common effort to solve or explore common
> issues, with the best possible participation of the patient. Collaborative
> practice is designed to promote the active participation of each discipline
> in patient care. It enhances patient- and family-centred goals and values,
> provides mechanisms for continuous communication among caregivers,
> optimizes staff participation in clinical decision-making within and
> across disciplines and fosters respect for disciplinary contributions of all
> professionals. (p.1)

Further exploration is required into mechanisms for consistent and efficient communication and

information-sharing between providers at the point-of-care in home care (Dahlke et al., 2018; Lindberg, Nilsson, Zotterman, Soderberg, & Skar, 2013).

4.5.3 Limitations

This study has several limitations. First, the data represent a pilot implementation of the G-CAP survey and are only reflective of health care provider views in three disciplines in a single direct-service home care agency. However, the representation of nurses ($n = 12$), OTs ($n = 8$) and PTs ($n = 7$) in the study sample is reflective of the representation of these disciplines within home care in Ontario. In 2010, there were 125,844 nurses working in Ontario and the community care sector employed 18.4% of these nurses; in 2011, there were 4,506 occupational therapists working in Ontario, with 31.1% working in the community sector; and in 2009, there were 6,391 physiotherapists working in Ontario, with 14.8% working in the community sector (Canadian Institute for Health Information, 2011a; Health Human Resources, 2009; Ontario Home Care Association, 2011). Further, the study sample represents four different geographic locations across Ontario. Additional research is required to explore the geriatric care assessment/client observation and information-sharing practices of other relevant disciplines within home care, including social workers, speech-language pathologists and personal support workers.

Another limitation in the study methods was the low response rate to the G-CAP survey (9.3%), which might be attributed to the busy schedules of point-of-care providers, the length of the survey, lack of personalization in e-mail administration or lack of direct remuneration; however, these methods were chosen to test an efficient approach for reaching large numbers of point-of-care providers across the province, which is required in the next phase of this work where broad administration of the G-CAP survey will occur.

4.6 Conclusions

The newly developed G-CAP survey tool showed fair to good test-retest reliability and good construct validity for investigating the geriatric care assessment practices of interdisciplinary home health care providers.

Preliminary data indicate that point-of-care geriatric assessment in home care by nurses, OTs and PTs is heavily focused on clinical observation and interview skills, with limited use of the RAI-HC or any standardized assessment tools to collect client information at the point-of-care. Although there is good intention to set and work towards common person- and family-centred goals by individual point-of-care providers, limited information-sharing occurs between providers, both within and across disciplines.

Pilot results point to the potential to integrate RAI-HC data collected for service allocation at the system level with clinical judgment and assessment data collected by point-of-care providers to reflect a more CGA-type approach. Next steps include a broad administration of the G-CAP survey across multiple home care service provider agencies in Ontario. Results will be used to inform the development and testing of a more seamless geriatric care planning approach that is reflective of CGA and that could transcend discipline, agency and system boundaries to achieve more efficient and integrated geriatric home care.

CHAPTER 5: MEASURING ASSESSMENT PRACTICES OF POINT-OF-CARE PROVIDERS IN GERIATRIC HOME CARE USING THE GERIATRIC CARE ASSESSMENT PRACTICES (G-CAP) SURVEY[5]

5.1 Abstract

Background

Comprehensive geriatric assessment (CGA) is a holistic interdisciplinary approach that has been demonstrated to improve care outcomes and experiences in institutional settings. While recommendations have been made to guide the adoption of CGA across settings, uptake of point-of-care provider CGA in home care is largely unmeasured.

Methods

Previously, we developed and pilot-tested the Geriatric Care Assessment Practices (G-CAP) survey to explore the assessment practices of point-of-care home care providers. In the present study, the G-CAP survey was administered to 303 point-of-care providers ($n = 100$ nurses, $n = 101$ OTs and $n = 102$ PTs) in Ontario, Canada.

Results

Participants indicated reliance on their clinical observation and interview skills far more than any standardized assessment tools to assess relevant geriatric care domains. While agreement with holistic assessment and collaborative goal-setting practices was high, participants indicated a lack of confidence to apply existing CGA tools and limited support structures for interdisciplinary collaboration and information-sharing.

Conclusions

Point-of-care CGA in home care requires the adoption of tools and processes that facilitate a team approach to information gathering, sharing and decision-making.

---

[5] Chapter 5 has been drafted in manuscript format for submission to the Journal of Interprofessional Care

5.2 Introduction

There is a current shift in health care literature and policy in terms of how we conceptualize and measure aging and health. The trend is moving away from a biomedical focus on disability and the accumulation of deficits to a biopsychosocial approach that focuses on the capacity and capabilities of people as they age (Huber et al., 2011; Huber et al., 2016). The World Health Organization (WHO) defines the term 'healthy aging' as "the process of developing and maintaining the functional ability that enables well-being in older age" (World Health Organization, 2015, p. 28). This definition is slowly helping to change the discourse around healthy aging from growing old with the absence of disease to a more all-inclusive understanding of individuals, using a life course perspective on health, and taking into account the reality that many older adults have more than one health condition that may or may not be well controlled (Sixsmith et al., 2014; World Health Organization, 2015). In terms of assessing the health of older adults, the WHO definition of 'healthy aging' requires a holistic and integrated approach that investigates not only the presence and absence of individual diseases, but more importantly focuses on the collective impact of these diseases on an older adult's daily functioning (Philip et al., 2017).

Comprehensive geriatric assessment (CGA) is an interdisciplinary and multidimensional care planning and service delivery model for older adults with complex, multi-morbid health issues that emphasizes functional, social and environmental factors of health in addition to medical diagnoses (Heckman et al., 2013; Welsh et al., 2014). CGA has been widely applied by specialist providers (e.g., geriatricians) in institutional care settings across the continuum of care and has been shown to predict adverse events, in addition to improving functional outcomes, decreasing morbidity, mortality and hospital admissions (Avelino-Silva et al., 2014; Baztan et

al., 2009; Caplan et al., 2004; Cohen et al., 2002; Ellis et al., 2011; Van Craen et al., 2010).

While applications of CGA in primary care and community settings have been cited, there is

limited evidence of sustainability beyond trials and pilot studies and a distinct lack of

information about the practical steps and tools that non-specialist providers can use to work

together to achieve the same outcomes cited in institutional care (Beauchet et al., 2014; Boult et

al., 2001; Melis et al., 2008; Philip et al., 2017; Rockwood et al., 2003; Suijker et al., 2012).

Extending the principles of CGA into the home care setting is important for translating thought

leadership in 'healthy aging' into positive action in this sector (Sixsmith et al., 2014).

5.3 Background

Point-of-care providers who conduct geriatric assessment in the home care setting

include, but are not limited to, nurses, occupational therapists (OTs) and physiotherapists (PTs)

(Health Canada, 2016; Kay et al., 2017). The unique training and education these regulated

health professionals receive within their respective disciplines means they approach patient

assessment using different lenses, methods and tools (Giosa et al., 2018). In a recent realist

review on interdisciplinary person- and family-centred geriatric home care, various theories

emerged to explain the mechanisms by which each of these three disciplines approach their roles

in person- and family-centred care from planning through to care delivery (Giosa et al., 2018).

Watson's Theory of Human Caring emerged in the review as an appropriate theory to describe

nurses' relational approach to care (Giosa et al., 2018 ; Watson & Woodward, 2010). Within this

overall approach, nurses are trained to use a 'head-to-toe' method to patient assessment, which

considers the physical, emotional and mental aspects of all parts of the body and relies heavily

on clinical observation skills (Anderson, Nix, Norman, & McPike, 2014). The Canadian Model

of Occupational Performance emerged in the review as a theory that can explicate OTs' approach

to care, which is one that seeks to understand the inter-play between an individual person, their environment and their occupation (Canadian Association of Occupational Therapists, 2015; Giosa et al., 2018). OTs focus on assessment practices that enable them to design and implement solutions to enhance individual independence according to their capabilities, function and lifestyle (Doiezie, Salgado-Sanchez, & Pautas, 2017). The International Classification of Functioning Disability and Health emerged in the review as an appropriate theory to describe PTs' contributions to person- and family-centred geriatric care as it uses a lens of physical and environmental factors to draw connections between anatomy, dysfunction and an individual's ability to participate in daily activities (Finger, Cieza, Stoll, Stucki, & Huber, 2006). PTs approach patient assessment through a model of functional health that is primarily concerned with pain, range of joint motion, and muscle strength in order to develop targeted solutions to help individuals regain function (Thonnard & Penta, 2007).

These findings suggest that the various different point-of-care providers participating in health assessment of older adults in home care may best contribute to interdisciplinary CGA in different ways, given their competing priorities and areas of expertise. Unfortunately, the assessment methods of these point-of-care providers are not transparent nor are they broadly measured or reported in the home care literature.

In Ontario, Canada a *Competency Framework for Interprofessional Comprehensive Geriatric Assessment* was recently developed to describe the competencies and expectations of regulated health professionals participating in CGA, including the overlapping knowledge, skills and attitudes that would help professionals participate as part of an interdisciplinary team (Kay et al., 2017). The framework recommends that successful CGA requires a combination of clinical judgement and the use of standardized, valid and reliable patient assessment tools to collect in-

depth information on an older adult's medical and social history and clinical data in 13 different domains (Kay et al., 2017). Collaborative goal-setting and shared-decision-making between providers, older adults and family/friend caregivers are also cited as important to the assessment process (Kay et al., 2017). Further, interdisciplinary collaboration and communication are outlined as vital to CGA in order to ensure that patient assessment is not conducted by individual providers working in isolation and that the interpretation, analysis and application of assessment data into a care plan involves the unique clinical expertise of all team members involved (Kay et al., 2017).

Current geriatric assessment in Ontario home care is fragmented into two separate activities: service allocation and point-of-care planning. In terms of service allocation, the interRAI Home Care Assessment (RAI-HC) is a standardized comprehensive patient assessment tool that is mandated for use by service coordinators working within 14 Local Health Integration Networks (LHINs; regional health authorities) to designate appropriate services to long-stay clients (Guthrie et al., 2014; interRAI, 2012). Similarly, the interRAI Community Health Assessment (RAI-CHA) is used more broadly in home and community care, particularly by community support service agencies across the province (Community Care Information Management, 2010). The RAI-HC and RAI-CHA are also designed to support point-of-care planning by direct service providers; however, their use, or the use of any other standardized patient assessment tools at the point-of-care in Ontario home care, is largely unknown. There is also limited knowledge of the extent of the use of clinical judgment, collaborative goal-setting and interdisciplinary collaboration for assessment at the point-of-care.

In a previous study, we developed the Geriatric Care Assessment Practices (G-CAP) survey and validated its use with point-of-care nurses, OTs and PTs in Ontario home care. The

purpose of the G-CAP survey is to systematically explore these providers' assessment practices

at the point-of-care (Giosa et al., 2018). Pilot data indicated that point-of-care providers use their

clinical judgment more often than any standardized assessment tools, including the RAI-HC.

Additional themes that emerged in the pilot study include that client input was considered most

important to point-of-care providers for goal-setting and that individual providers tend to always

conduct their own assessments of older adults and rarely share or receive assessment data within

or across their disciplines (Giosa et al., 2018). The objective of this follow up study was to

broadly administer the G-CAP survey to point-of-care nurses, OTs and PTs working in home

care to further test, confirm, refute and/or expand on the themes that emerged from the pilot

research.

5.4 Methods

5.4.1 The G-CAP Survey

The G-CAP survey is an online self-report tool including 34 questions related to the

following areas: 1) Assessment methods; 2) Attitudes toward assessment; 3) Perceptions of the

RAI-HC and RAI-CHA[6]; 4) Interdisciplinary collaboration; and 5) Demographic information

(see Appendix F). Based on the pilot study recommendations, the G-CAP survey items were

scaled on a 5-point Likert scale in order to improve the scale reliability. In moving away from

the original 7-point Likert scale, the neutral point was shifted depending on the question in order

to better discriminate between positive and negative responses (Giosa, Stolee, & Holyoke, 2018).

The G-CAP survey takes approximately 30 minutes to complete online.

5.4.2 Data Collection

When calculating the desired sample size for dissemination, the Dillman (2000) method

---

[6] This version of the survey included one additional question to the version of the survey used in the pilot study on the use of the RAI-CHA in an attempt to be more comprehensive.

was used. This technique considers the proportion of the true population to be measured, the size

of the population being sampled, the likely variation in the population that is being sampled, and

how confident the researcher wants to be in their estimate (Dillman, 2000) (see Figure 5.1).

$$Ns = \frac{(Np)\ (p)\ (1-p)}{(Np-1)\ (B\,/\,C)^2 + (p)\ (1-p)}$$

Np= the size of the population
P= the proportion of the population expected to choose a certain option for a key question
B = acceptable sampling error, (e.g. ± 10%)
C = Z statistic associated with the desired confidence level, typically 1.96 for 95% confidence

Figure 5.1 Formula used for sample size calculations

In 2010, there were 125,844 nurses working in Ontario and the community care sector

employed 18.4% of these nurses (Np_{RN} = ~23,155) (Ontario Home Care Association, 2011). In

2011, there were 4,506 OTs working in Ontario, with 31.1% working in the community sector

(Np_{OT}= ~889) (Canadian Institute for Health Information, 2011a). In 2009, there were 6,391

PTs working in Ontario, with 948 working in the community sector (Np_{PT}= ~948) (Health

Human Resources, 2009). The sample size estimate was based on a sampling error of 10% (*B*)

with a 95% confidence interval (*C*= 1.96); an estimate of 50% was chosen as a conservative

estimate of the proportion of population expected to express positive attitudes toward patient

assessment (*P*). According to this method, a sample of ~96 nurses, ~88 PTs and ~88 OTs were

determined to be needed to complete the survey to adequately explore the geriatric assessment

practices of point-of-care home care providers in Ontario. Accounting for survey attrition, the

researchers aimed for a sample size of ~300 frontline providers (Dillman, 2000).

The primary researcher (JG) e-mailed a letter to leaders at home care service provider

organizations listed on the Home Care Ontario website (http://www.homecareontario.ca/) to

explain the study and determine their interest and willingness to assist with the online

distribution of the survey to their point-of-care staff. The researcher followed up by phone with the organizational leaders, as was necessary, to address any questions or concerns they had. It was the intention of the researcher to recruit three or more organizations to distribute the online survey to ensure adequate variety in the respondents around geriatric assessment. Once an organizational leader agreed to assist with the distribution of the survey, the researcher e-mailed instructions to the designated main contact at the organization, including a template e-mail with a link to the survey that was to be sent out to point-of-care providers in each discipline. Providers were eligible to participate in the voluntary survey if they were a registered nurse or registered practical nurse, OT or PT providing direct home care services to older adults who were 65 years of age or older. FluidSurveys[7] (www.fluidsurveys.com) was used to collect survey responses.

Survey administration took place over a period of two weeks at each home care provider organization. This timeframe was chosen to balance giving potential respondents enough time to participate but not so much time that they prolonged responding and forgot about the survey. The researcher worked with the designated contact at each of the organizations to get the survey sent out via e-mail and provided them with any support they required. In recognition of participants' effort and time to participate in the survey, respondents had an option to receive a $25.00 CAD honorarium once they had completed the survey. The first page of the survey served as an information letter and consent form (See Appendix G). One week after the survey had been distributed at each organization, the researcher provided the designated contact at the organization with a template reminder e-mail that could be sent out to all initial recipients of the survey link. After the second week had passed, the link to the survey was closed to each particular organization.

---

[7] N.B. Fluid-Surveys has since been acquired by SurveyMonkey (www.surveymonkey.com)

5.4.3 Data Analysis

Data from FluidSurveys were downloaded into Microsoft Excel spreadsheets and uploaded into IBM SPSS 20.0 software to complete statistical analyses (IBM Corp, 2013). All skipped frequency questions were coded as "never" and all skipped agreement or importance questions were coded as "neutral". Descriptive statistics were calculated to explore demographic information and to summarize the key findings for: the entire sample of point-of-care providers, and each sub-sample of the three disciplines who participated. In an effort to organize the analysis of the large dataset into manageable sections, internal consistency values (α) were explored and confirmed (>0.70) for the following sub-scales of related items that were uncovered in the pilot study (Giosa et al., 2018):

- Use of clinical observation and interview skills;

- Holistic assessment practices;

- Use of RAI-HC;

- Collaborative goal-setting; and

- Interdisciplinary information-sharing.

Data from the questions within each confirmed sub-scale were aggregated in the analysis. 'Assessment of geriatric care domains' emerged as another sub-scale within the pilot data; however, internal consistency was not confirmed in the present study and therefore the analysis was completed at the individual question level for this category. Analysis at the individual question level was also completed for the remaining items of the G-CAP survey that were not otherwise included in one of the above sub-scales (Giosa et al., 2018).

5.4.4 Ethical Considerations

This study received ethics clearance from the University of Waterloo Office of Research

Ethics (ORE #19586). All survey participants provided informed consent by selecting 'agree' following a review of the information letter and consent form on the first page of the G-CAP survey.

5.5 Results

5.5.1 Participant Characteristics

A total of 303 point-of-care home care providers ($n = 100$ nurses, $n = 101$ OTs and $n = 102$ PTs) representing 12 different service provider agencies across Ontario participated in the G-CAP survey between the period of May and December, 2015. The majority of participants were female (86.1%), ranging in age from 23 to 82 years ($M = 41.4$, $SD = 12.2$) with an average of 15 years of experience working in their respective disciplines ($SD = 13.3$, Range: 0-64). Approximately half of the participants (48.5%) had been working in home care for more than five years, and about one third of participants (32.9%) had more than ten years of home care experience. The majority of participants had previous experience working in a hospital setting (63.4%) and about half of the participants (46.2%) had experience working in the long-term care sector. Almost all participants (90.1%) indicated that more than half of their home care clients were over the age of 65 years. The demographics of participants are displayed in Table 5.1.

Table 5.1 Participant characteristics for broad administration of G-CAP survey

Characteristic		All providers (*N* = 303)	Nurses (*n* = 100)	OTs (*n* = 101)	PTs (*n* =102)
Age *Mean (SD)* (Range)		*41.4 (12.2)* (23-82)	*40.3 (11.2)* (23-64)	*36.7 (10.4)* (26-76)	*47.4 (12.6)* (27-82)
Gender *n*		Female *261* Male *34* Other *2* Not Specified *6*	Female *88* Male *9* Other *1* Not Specified *2*	Female *91* Male *7* Other *1* Not Specified *2*	Female *82* Male *18* Not Specified *2*
Years in practice *Mean (SD)* (Range)		*15.0 (13.3)* (0-64)	*12.6 (11.9)* (0-43)	*11.6 (11.7)* (0-64)	*20.7 (14.4)* (0-50)
Working in home care *n* (%)	<1 year:	*39* (13.0)	*19* (19)	*8* (8.1)	*12* (11.8)
	1-5 years:	*116* (38.5)	*38* (38)	*46* (46.5)	*32* (31.4)
	6-10 years:	*47* (15.6)	*17* (17)	*14* (14.1)	*16* (15.7)
	>10 years:	*99* (32.9)	*26* (26)	*31* (31.3)	*42* (41.2)
Working in other sectors *n* (%)	Hospital	*192* (63.4)	*69* (69)	*56* (55.4)	*67* (65.7)
	LTC	*140* (46.2)	*63* (63)	*30* (29.7)	*47* (46.1)
	Rehab*	*84* (27.7)	*8* (8)	*35* (34.7)	*41* (40.2)
	Palliative	*57* (18.8)	*25* (25)	*18* (17.8)	*14* (13.7)
	Private	*110* (36.3)	*17* (17)	*22* (21.8)	*71* (69.6)
Clients over 65 years *n* (%)	< 25%	*6* (2.0)	*4* (4)	*2* (2.0)	*0* (0)
	26-50%	*22* (7.3)	*15* (15)	*4* (4.0)	*3* (2.9)
	51-75%	*93* (30.7)	*48* (48)	*25* (25.3)	*20* (19.6)
	76-100%	*180* (59.4)	*33* (33)	*68* (68.7)	*79* (77.5)

* Legend: Rehab = Inpatient Rehab

5.5.2 Assessment of Geriatric Care Domains

Overall, participants indicated that they assess each of the nine domains of geriatric care included in the G-CAP survey at least 'often' (*M* = 3 on a 5 point scale where 1 = never-rarely and 5 = always), when visiting older home care clients for the first time. This trend was the same within each individual discipline, except for PTs who indicated they only 'sometimes' (*M* = 2.49) assess the social and financial resources of older adults during their first home care visit with them. Of the nine care domains explored in the survey, functional status/activity and rest, mobility/ balance/ ambulation and safety (environment, abuse risk and falls risk) were the most often assessed areas of care across all participants and for OTs and PTs respectively; however,

nurses indicated the domains of pain (*M* = 4.76), medication managment (*M* = 4.71) and skin

integrity (*M* = 4.65) to be their top priority areas of assessment with older home care clients. PTs

and OTs differed in terms of their fourth priority areas of assessment, with PTs focusing more

often on pain (*M* = 4.68) and OTs focusing more often on medication management (*M* = 4.37)

(see Table 5.2).

Table 5.2 Assessment of geriatric care domains

	Mean (SD)*			
Domain	**All Participants** **(*N* = 303)**	**Nurses** **(*n* = 100)**	**OTs** **(*n* = 101)**	**PTs** **(*n* = 102)**
Cognition	*3.83 (1.20)*	*4.10 (1.08)*	*3.61 (1.20)*	*3.79 (1.28)*
Pain	*4.55 (0.86)*	***4.76 (0.71)* †**	*4.23 (1.00)*	*4.68 (0.75)*
Skin	*4.06 (1.18)*	***4.65 (0.66)* †**	*4.13 (1.02)*	*3.41 (1.40)*
Function	***4.61 (0.82)* †**	*4.33 (0.94)*	***4.75 (0.75)* †**	***4.75 (0.69)* †**
Mobility	***4.62 (0.80)* †**	*4.38 (0.98)*	***4.69 (0.67)* †**	***4.79 (0.64)* †**
Safety	***4.76 (0.70)* †**	*4.62 (0.86)*	***4.91 (0.45)* †**	***4.75 (0.71)* †**
Quality of Life	*3.82 (1.25)*	*4.19 (1.10)*	*3.69 (1.22)*	*3.57 (1.35)*
Medication	*4.14 (1.27)*	***4.71 (0.80)* †**	*4.37 (0.95)*	*3.35 (1.53)*
Resources	*3.22 (1.46)*	*3.28 (1.47)*	*3.91 (1.12)*	*2.49 (1.36)*

*Participant responses ranged from 1-5 on a 5-point Likert scale for all items
†The 3 domains with highest average scores per group

5.5.3 Use of Standardized Assessment Tools

On average, participants in all disciplines indicated that they 'never' (*M* = 1.46-1.81 on a

5 point scale where 1= never and 5= often-always) use any of the 68 standardized patient

assessment tools included in the G-CAP survey to assess the nine domains of geriatric care

during their first home care visits with older adults (see Table 5.3).

Table 5.3 Overall use of standardized assessment tools

	Mean (SD)*		
All Participants **(*N* = 303)**	**Nurses** **(*n* = 100)**	**OTs** **(*n* = 101)**	**PTs** **(*n* = 102)**
1.64 (0.62)	*1.86 (0.82)*	*1.46 (0.68)*	*1.61 (0.84)*

*Participant responses ranged from 1-5 on a 5 point scale for all items

Of the 68 standardized patient assessment tools that were asked about in the G-CAP survey, only two pain scales and one skin integrity scale were rated to be used by all participants more than 'rarely' ($M = 3$ on a 5 point scale where $1 =$ never and $5 =$ often-always); the *Verbal Rating Scale* ($M = 3.82$), the *Numeric Pain Rating Scale* ($M = 3.95$), and the *Braden Scale for Predicting Pressure Sore Risk* ($M = 3.13$). In addition to these scales, nurses use a few other assessment tools more often than 'rarely', including, the *Mini-Mental State Examination* ($M = 3.46$) to assess cognition, the *Falls Risk Assessment Tool* to assess safety, and two additional pain scales; the *Facial Grimace and Behavioural Checklist Flowcharts* ($M = 3.54$) and the *Edmonton Symptom Assessment Scale* ($M = 3.96$). OTs also more than 'rarely' use the *Montreal Cognitive Assessment* ($M = 3.99$) to assess cognition and PTs 'sometimes' use the *Berg Balance Scale* ($M = 4.21$) and the *Timed Up and Go* test ($M = 4.43$) to assess mobility, activity and rest in older adults (see Table 5.4).

5.5.4 Use of Clinical Observation and Interview Skills

On average, participants indicated that they use their clinical observation and interview skills more than 'sometimes' ($M = 4.27$-4.66 on a 5 point scale where $1 =$ never and $5 =$ often-always) to assess the nine areas of geriatric care asked about in the G-CAP survey within this sub-scale, with OTs relying on these skills slightly more often than PTs and nurses, on average (see Table 5.5).

Table 5.4 Use of individual standardized assessment tools

Assessment Tool	All Participants (N = 303)	Nurses (n = 100)	OTs (n = 101)	PTs (n = 102)
	Mean (SD)*			
Cognition				
Montreal Cognitive Assessment (MOCA)			3.99 (1.20)	
Mini Mental State Examination (MMSE)		3.46 (1.41)	3.43 (1.20)	
Pain				
Brief Pain Index (BPI)		3.06 (1.80)		
Visual Analogue Scale for Pain (VAS)				
Verbal Rating Scale (VRS)	3.82 (1.60)	4.38 (1.23)	3.12 (1.63)	3.67 (1.72)
Numeric Pain Rating Scale (NPRS)	3.95 (1.53)	4.44 (1.18)	3.21 (1.66)	4.21 (1.44)
Facial Grimace and Behavioral Checklist Flowcharts (FGBC)		3.37 (1.54)		
Edmonton Symptom Assessment Scale (ESAS)		3.96 (1.41)		
Skin				
Braden Scale for Predicting Pressure Sore Risk (BS)	3.13 (1.73)	4.55 (0.95)	3.49 (1.43)	
Safety				
Falls Risk Assessment Tool (FRAT)		3.59 (1.71)		
Mobility				
Berg Balance Scale (BBS)				4.21 (0.99)
Timed Up and Go (TUG)				4.43 (1.02)

*Participant responses ranged from 1-5 on a 5 point scale for all items

Table 5.5 Use of clinical observation and interview skills

All Participants (N = 303)	Nurses (n = 100)	OTs (n = 101)	PTs (n = 102)
Mean (SD)*			
4.50 (0.17)	4.57 (0.16)	4.66 (0.15)	4.27 (0.33)

*Participant responses ranged from 1-5 on a 5 point scale for all items

5.5.5 Holistic Assessment Practices

On average, participants indicated that they more than 'somewhat agree' (M = 4.29-4.44 on a 5 point scale where 1= strongly disagree and 5 = strongly agree) with holistic assessment practices, including that client assessment involves the use of standardized tools, conversations with older adults, their family/friend caregivers and other point-of-care providers, as well as observation and documentation practices. This sub-scale also asked to what degree participants endorse assessment as an ongoing process throughout the care journey, and whether participants need to collect assessment data themselves or whether they can rely on data collected by other point-of-care providers (see Table 5.6) (see Appendix F, question 19 a-l).

Table 5.6 Endorsement of holistic assessment practices

*Mean (SD)**			
All Participants **(*N* = 303)**	**Nurses** **(*n* = 100)**	**OTs** **(*n* = 101)**	**PTs** **(*n* = 102)**
4.34 (0.54)	*4.30 (0.56)*	*4.66 (0.64)*	*4.44 (0.49)*

*Participant responses ranged from 1-5 on a 5 point scale for all items

5.5.6 Use of RAI-HC and RAI-CHA

More than half of all participants had heard of the RAI-HC (65.3%) and the RAI-CHA (55.4%) tools, with OTs and PTs having slightly higher awareness of the tools than nurse participants (see Table 5.7).

Table 5.7 Awareness of the RAI-HC and RAI-CHA tools

Tool	All Participants (*N* = 303)	Nurses (*n* = 100)	OTs (*n* = 101)	PTs (*n*= 102)
RAI-HC	198 *(65.3%)*	53 *(53%)*	74 *(73.3%)*	71 *(69.6%)*
RAI-CHA	168 *(55.4%)*	48 *(48%)*	59 *(58.4%)*	61 *(59.8%)*

While many participants had heard of these tools, on average, participants indicated they 'never' to 'almost never' use either of the tools, data from the tools, or the clinical assessment protocols derived from the tools to plan and provide care to older home care clients (M = 1.97-2.02 on a 5

point scale where 1 = never and 5 = often-always) (see Table 5.8) (see Appendix F, question

22a-c).

Table 5.8 Use of the RAI-HC and RAI-CHA tools

Mean (SD)*			
All Participants **(N = 303)**	**Nurses** **(n = 100)**	**OTs** **(n = 101)**	**PTs** **(n = 102)**
1.99 (0.53)	*2.02 (0.35)*	*1.97 (0.65)*	*1.98 (0.61)*

*Participant responses ranged from 1-5 on a 5 point scale for all items

Participants were also fairly skeptical and lacked confidence with respect to questions

regarding the utility of and their own ability to use both the RAI-HC and RAI-CHA tools. For

example, participants indicated that they 'somewhat disagree' that the RAI-HC and RAI-CHA

contained all the information they would need to plan and provide care to older adults ($M = 2.21$

on 5 point scale where 1 = strongly disagree and 5 = strongly agree). Additionally, participants

also responded that they 'somewhat disagree' that they feel confident to both collect data using

the RAI-HC or RAI-CHA ($M = 2.33$) or interpret data collected by someone else using the RAI-

HC or RAI-CHA ($M = 2.59$) to plan and provide care to older adults (see Table 5.9).

Table 5.9 Utility and ability to use the RAI-HC and RAI-CHA tools

	Mean (SD)*			
Item	**All Participants (N = 303)**	**Nurses (n = 100)**	**OTs (n = 101)**	**PTs (n = 102)**
The RAI-HC/ RAI-CHA includes all the information I need	*2.21 (1.3)*	*2.25 (1.41)*	*2.27 (1.26)*	*2.12 (1.14)*
I feel confident that I can use the RAI-HC/ RAI-CHA to collect information	*2.33 (1.38)*	*2.46 (1.55)*	*2.23 (1.31)*	*2.29 (1.28)*
I feel confident that I can interpret data from the RAI-HC/ RAI-CHA	*2.59 (1.42)*	*2.53 (1.56)*	*2.71 (1.37)*	*2.54 (1.33)*

*Participant responses ranged from 1-5 on a 5 point scale for all items

5.5.7 Collaborative Goal-Setting

When asked about collaborative goal-setting practices, on average, participants indicated 'important' ($M = 4.54$-4.68 on a 5 point scale where 1 = not at all important and 5 = very important) in relation to the various information sources within this G-CAP survey sub-scale, including assessment data they collect themselves, assessment data collected by others, their professional opinion, the professional opinion of others, information from the client chart, and input from the older adult and their family/friend caregivers (see Table 5.10) (see Appendix F, question 24a-g).

Table 5.10 Collaborative goal-setting practices

Mean (SD) (Range)*			
All Participants **(N = *303*)**	**Nurses** **(*n* = 100)**	**OTs** **(*n* = 101)**	**PTs** **(*n* = 102)**
4.63 (0.61)	*4.66 (0.15)*	*4.54 (0.29)*	*4.68 (0.24)*

*Participant responses ranged from 1-5 on a 5 point scale for all items

5.5.8 Interdisciplinary Collaboration

Participants, on average, were fairly neutral as to their interactions with other point-of care providers, indicating that they 'neither agree nor disagree' ($M = 3.30$-3.80 on a 5 point scale where 1 = strongly disagree and 5 = strongly agree) with statements about always knowing what other providers are working with an older adult, that all point-of-care providers work toward a common goal, that privacy inhibits them from sharing information and that they feel part of an integrated team. Within individual disciplines, only nurses indicated that they 'somewhat agree' ($M = 4.07$) that all providers work towards a common goal (see Table 5.11).

Table 5.11 Endorsement of interdisciplinary collaboration

Item	Mean (SD)*			
	All Participants (*N* = 303)	**Nurses** (*n* = 100)	**OTs** (*n* = 101)	**PTs** (*n* = 102)
I always know what other providers are working	3.47 (1.27)	3.54 (1.20)	3.12 (1.27)	3.75 (1.28)
All providers work towards common goals	3.80 (1.03)	4.07 (0.95)	3.49 (1.08)	3.83 (0.99)
Privacy inhibits information-sharing	3.30 (1.33)	3.66 (1.32)	3.15 (1.20)	3.10 (1.41)
I feel part of an integrated team	3.51 (1.32)	3.94 (1.15)	3.02 (1.36)	3.59 (1.32)

*Participant responses ranged from 1-5 on a 5 point scale for all items

5.5.9 Interdisciplinary Information-Sharing

For the questions comprising the G-CAP sub-scale of interdisciplinary information-sharing, overall participants indicated that they 'rarely' share or receive information within or outside of their respective disciplines (*M* = 3.58 on a 5 point scale where 1 = never and 5 = often-always). Nurses, however, rated interdisciplinary information-sharing slightly higher, indicating that they 'sometimes' share and receive information within and across disciplines (*M* = 4.07) (see Table 5.12) (see Appendix F, question 26a-e).

Table 5.12 Endorsement of interdisciplinary information-sharing

Mean (SD)*			
All Participants (N = *303*)	**Nurses** (*n* = 100)	**OTs** (*n* = 101)	**PTs** (*n* = 102)
3.58 (0.14)	4.15 (0.29)	3.36 (0.28)	3.35 (0.17)

*Participant responses ranged from 1-5 on a 5 point scale for all items

5.6 Discussion

5.6.1 Comprehensive Geriatric Assessment in Home Care

Participants reported that they routinely assess all nine areas of geriatric care included in the G-CAP survey on their first home care visit with older adults and their family/friend caregivers. These nine areas are consistent with the clinical assessment domains recommended in Ontario's *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*, indicating that home care providers are well-positioned to participate in CGA from an information-gathering standpoint (Kay et al., 2017). However, with all providers individually collecting the information they need in each of these areas, concerns about duplication, overlap and redundancy emerge. Previous research in home care has documented that older adults experience high levels of stress when having to repeatedly share the same information with multiple different providers (Woodward, Abelson, & Hutchison, 2001). Developing a process for each discipline to uniquely contribute to a collaborative comprehensive assessment of the various geriatric care domains would be important for minimizing assessment burden in home care.

Ontario's *Competency Framework for Interprofessional Comprehensive Geriatric Assessment* recommends that effective assessment of older adults include a blend of clinical judgement and standardized assessment (Kay et al., 2017). The G-CAP survey uncovered that point-of-care provider participants rely far more on their clinical observation and interview skills than on any standardized assessment tools to assess relevant geriatric care domains. While these findings suggest a relative over-reliance on clinical observation and interview skills, it is important to consider the necessity of these skills in order for point-of-care providers to participate in the skillful process of clinical decision-making, which requires combining scientific knowledge, experiences and clinical judgement within the context of a particular

69

situation (Benner, Tanner, & Chesla, 2009; van Graan, Williams, & Koen, 2016). In nursing, clinical judgement has been associated with problem-solving using Tanner's Clinical Judgement Model, which emphasizes effective noticing through focused observation (Tanner, 2006; van Graan et al., 2016). Clinical observation and judgment are also essential to physiotherapy practice, with movement observation being cited as the primary assessment and diagnostic tool of PTs and effective clinical observation being associated with more experienced clinicians (McGinnis, Hack, Nixon-Cave, & Michlovitz, 2009; Wainwright, Shepard, Harman, & Stephens, 2011). Observation is also critical to the validity of interventions and care plans derived from OT assessments, as their focus is on performance of daily activities within the context of an individuals' environment and daily life (Brentnall & Bundy, 2009). The integration of scientific, narrative, and pragmatic reasoning that focuses on observations of structural context (e.g., resource constraints, equipment availability) have been cited as essential to effective clinical judgement in this discipline (Schell & Cervero, 1993).

In terms of balancing observation and clinical judgment with standardized assessment at the point-of-care, it is necessary to consider the structural factors in place that might be contributing to the usage patterns of standardized assessment tools by point-of-care providers. For example, the G-CAP survey uncovered that nurses were using several more standardized assessment tools than other disciplines, which might align to a greater proportion of home care services being delivered by nurses than by PTs or OTs in Ontario. In 2015-2016, 21.5% of home care services were nursing visits, versus only 2.1% of visits being from PTs and 1.5% of visits being from OTs respectively (Home Care Ontario, 2017). With this variability in time spent delivering point-of-care services, there is even greater justification for integrating clinical observation and interview data collected at the point-of -care with standardized assessment data

already being collected through the RAI-HC and RAI-CHA tools for service allocation. This would maximize efficiency and completeness of information available to each provider in terms of the overall client care situation.

Participants demonstrated strong agreement with holistic assessment practices including that client assessment involves the use of standardized tools, dialogue with older adults, their family/friend caregivers, and other point-of-care providers within and outside of their own discipline, and clinical observation. They also agreed that client assessment should be documented, that it goes beyond an administrative purpose to be impactful to the care they provide, and that they can make use of data collected by other providers even though they also must collect assessment data themselves. Perceptions and beliefs around collaborative goal-setting activities were also very positive among participants who indicated that creating goals requires a combination of assessment data, professional opinions and input from multiple sources including older adults and family/friend caregivers and other providers. These findings build on previous theories and provide evidence that a philosophy of person- and family-centred care resonates with and has been adopted by many point-of-care providers during their one-on-one interactions with older adults and their family/friend caregivers (Giosa et al., 2018).

In contrast to their holistic assessment and client goal-setting practice beliefs, participants indicated a lack of interdisciplinary collaboration and information-sharing both within and across disciplines at the point-of-care, and neutral feelings towards feeling part of an integrated home care team. There is evidence that provider attitudes and beliefs are strong facilitators of person- and family-centred care practices at the point-of-care, therefore the gap between provider attitudes and practice findings in the present study might be explained by systemic and structural barriers that impede a holistic CGA approach at the point-of-care (Moore et al., 2017). Such

71

barriers cited in the literature include the pervasiveness of 'usual' positivist medicine and bio-medical models of care, poor documentation and communication tools and processes and time constraints (Moore et al., 2017). The current study findings that point-of-care providers do not use, and lack the confidence to apply, the RAI-HC and RAI-CHA tools and data confirms the disconnect between service allocation and care planning structures in Ontario home care. As the RAI-HC and RAI-CHA data are routinely collected to make service decisions in this sector, these data could and should be better optimized for use at the point-of-care. The need for enhanced provider education and training on how to apply these data in real-time practice is also supported by these findings. Additionally, future work should explore how point-of-care provider observations, goal-setting and care-planning could inform service allocation decisions throughout the care journey.

5.6.2 Strengths

To our knowledge, this is the first study that has systematically explored and attempted to measure the assessment practices of point-of-care providers working in home care using a validated survey. The study sample was large and diverse, reaching across the province and including almost equal representation from each of the three disciplines of interest. Using an online survey was a substantial facilitator of the strengths of this study.

5.6.3 Limitations

The present study also has several limitations. First, the researchers were unable to estimate a response rate for survey participants as information about the number of providers at each participating organization within each discipline was not collected. The G-CAP survey was administered within only one province in Canada, which may limit the generalizability of the findings to other provinces. Since home care is funded at the provincial level in Canada,

exploration into point-of-care assessment using the G-CAP survey could be repeated in other provinces to explore individual contexts. This study is also limited by the exclusion of a variety of other point-of-care providers who participate in geriatric home care, including but not limited to personal support workers (PSWs), social workers and dietitians. Nurses, OTs and PTs were chosen as the disciplines of focus as they are the most common providers cited to participate in client assessment in current home care practice, and in publicly-funded home care, supervise the work of PSWs (Local Health Integration Networks, 2014b). Nonetheless, the need to understand and include the contributions of PSWs and other providers into comprehensive geriatric assessment in home care is an area for future research. Finally, the G-CAP survey did not explore the assessment of family/friend caregiver needs by point-of-care providers. While the survey did cover the assessment of the social resources of older adults, future research could focus on understanding how the needs of family/friend caregivers are/ could be explicitly integrated into the CGA process.

5.7 Conclusions

The promotion of 'healthy aging' in home care through CGA is supported by point-of-care providers through their positive attitudes and beliefs towards holistic assessment and collaborative goal-setting practices. However, the tendency of these providers to work in isolation of one another with limited communication and information-sharing has resulted in unrealized potential to effectively and efficiently use the skills of different types of providers in a person-and family-centred care-planning process at the point-of-care. Further, there is a need to close the gap between standardized assessment and data used for service allocation and observation and clinical judgement applied at the point-of-care. Future work points to the need for more standardized collaborative care processes, training and communication tools.

CHAPTER 6: IMPROVING PERSON-AND FAMILY-CENTRED GOAL-SETTING IN GERIATRIC HOME CARE: A SOLUTIONS-FOCUSED APPROACH[8]

6.1 Abstract

Background

Goal-setting with older adults at the point-of-care in home care is often inhibited by a lack of structure to support person- and family-centred care planning, paternalistic provider attitudes and task-oriented delivery models. The objective of this research study was to determine how goal-setting practices for older clients could be re-oriented around individuals' self-perceived goals, needs and preferences in home care.

Methods

Solutions-focused semi-structured key informant interviews were conducted with older adult home care clients aged 65 years and older ($n = 13$) and their family/friend caregivers ($n = 12$) to explore their ideas around changes, solutions and strategies for person and family-centred goal-setting. Participants were recruited through community advertisement in a single region of Ontario, Canada between July and October of 2017. Interviews were conducted in-person, either individually or in older adult/caregiver dyads and were audio-recorded and transcribed verbatim. Thematic analysis was guided by a multi-step framework method using NVivo10 and Microsoft Excel software.

Results

Four themes emerged from the data, including: 1) seeing beyond age enables respect and dignity; 2) relational communication involves two-way information sharing; 3) doing 'with' instead of doing 'for' promotes participation; and 4) collaboration is easier when older adults and

---

[8] This chapter has been drafted in manuscript format for submission to Health and Social Care in the Community

family/friend caregivers lead the way. Older adults and family/friend caregivers want to be actively engaged in dialogue during care planning to ensure that their preferences, needs, and personal history are applied in designing a care plan that promotes their participation at a level they choose and in a format that is conducive to their wishes for their personal environment.

Conclusions

Findings from this study add the older adult and family/friend caregiver perspective to existing recommendations in recent literature for combatting ageism, improved relational communication, reablement interventions and better collaboration in geriatric care. Next steps for this work could involve testing the changes, solutions and strategies that emerged to determine their impact on the experience of person-and family-centred home care by older adults and family/friend caregivers.

.

6.2 Background

The demand for health care providers to partner directly with patients and family/friend caregivers in the planning and delivery of care is on the rise as a result of the growing body of literature and evidence supporting person- and family-centred care (PFCC) (Kogan, Wilber, & Mosqueda, 2016). While there is no single unifying definition of PFCC, individual choice and personal autonomy are key distinguishing factors from traditional biomedical models of care delivery (Cott, 2004; DiLollo & Favreau, 2010; Edvardsson & Innes, 2010; Edvardsson, Winblad, & Sandman, 2008; Kogan et al., 2016). Goal-setting has been cited as a key opportunity to operationalize PFCC in care planning activities, particularly in home and community settings where care is delivered in individuals' personal environments (Furze, 2015). Person and family-centred goal-setting requires an understanding of patient and family/friend caregiver values in order to prioritize care activities in terms of what the patient sees as important and aligned to their lifestyle preferences, and to improve communication between patients and their health care providers (Carroll, 2011; Duchan & Black, 2001; Kogan et al., 2016).

Evidence suggests that there is great variation in terms of the extent to which individuals wish to be engaged as active participants in care and decision-making, with older adults being cited as preferring less active roles (Levinson, Kao, Kuby, & Thisted, 2005; Schulman-Green et al., 2006). Rather than providers tailoring older adult participation accordingly, paternalistic and authoritative decision-making often prevails in care planning, based on assumptions that all older adults' goals are the same and/or that they do not have goals at all (Schulman-Green et al., 2006; Sockolow, Radhakrishnan, Chou, & Wojciechowicz, 2017). In fact, just the opposite has been demonstrated, with a study citing a diverse range of goals for community-dwelling older adults pertaining to health problems, living accommodations, social and family relationships and

mobility (Robben, Perry, Olde Rikkert, Heinen, & Melis, 2011).

In home care, systemic barriers such as limited time, task-based delivery models and providers working in isolation of one another further inhibit goal-setting opportunities and practices at the point-of-care (Sockolow et al., 2017). Often no goal information is recorded in these settings, and if there are goals identified, they typically pertain to individual elements of clinical care and are not written in the patient voice or integrated across providers (Robben et al., 2011; Sockolow et al., 2017). Person- and family-centred goal-setting has the potential to integrate the contributions of the various providers involved in geriatric home care so that they are all working towards a common goal (Parsons et al., 2012). Mutual goal-setting with older adults has also been shown to be an important motivational determinant for enhancing participation in self-management of illnesses and disease and has demonstrated improved physical and mental well-being (Cheng, 2018).

In Ontario, Canada there are 14 Local Health Integration Networks (LHINs; regional health authorities), which are responsible for allocating funds and coordinating home and community care (Local Health Integration Networks, 2014a). In terms of point-of-care delivery, direct service provider agencies are contracted by the LHIN to provide these services (Health Council of Canada, 2012; Home Care Ontario, 2014). LHIN care coordinators set service goals based on clinical needs of clients and families for the purposes of allocating appropriate home care services; however, there is currently no structure in place to support person and family-centred goal-setting between point-of-care providers, older adults and their family/friend caregivers (Gill & Connelly, 2013; Parsons & Parsons, 2012). Understanding how goal-setting could be more person-and family-centred for older adults in home care has the potential to improve experiences of integrated care.

The objective of this research study was to determine how geriatric client goal-setting practices in home care could be re-oriented around individuals' self-perceived goals, needs and preferences.

6.3 Methods

6.3.1 Solutions-Focused Key Informant Interviews

Solutions-focused semi-structured key informant interviews were conducted with older adult home care clients and their family/friend caregivers. The solutions-focused approach is rooted in counseling and therapy practices and is future-focused, goal-directed and aimed at searching for solutions rather than focusing on problems (Proudlock & Wellman, 2011; Walsh, Moss, & FitzGerald, 2006). According to the solutions-focused approach, "understanding the cause of the problem is not a necessary step in resolving it" (Lethem, 2002, p. 189). There are three discourses that are important in a solutions-focused approach:

1) The Change Discourse: involves identifying strengths and qualities that will facilitate positive change as well as the goals for the change instead of focusing on the problems;

2) The Solution Discourse: involves identifying what the world would look like if the problem was solved; and

3) The Strategy Discourse: involves developing an action plan with tasks to be performed (Bloor & Pearson, 2004).

Extensive consultation research has revealed poor experiences of older adults and their family/friend caregivers with care planning in the home care system (Giosa et al., 2014; Manderson, McMurray, Piraino, & Stolee, 2012; Toscan et al., 2012; Toscan et al., 2013). Instead of replicating previous findings, a solutions-focused approach allowed the researchers to

leverage the first-hand experiences and expertise of older adults and their family/friend caregivers as users of the system to develop ideas for changing how they are engaged in goal-setting in the planning phase of their care.

6.3.2 Data Collection

This study received ethics clearance from the University of Waterloo Office of Research Ethics (ORE #22251). Key informant interview participants included older adults aged 65 years or older who were currently receiving or had previously received (within five years) publicly-funded home care services in one Local Health Integration Network (LHIN; regional health authority in Ontario, Canada). Self-identified family/friend caregivers of these older adult home care recipients were also eligible to participate. Community advertisement served as the main recruitment strategy, with an aim to recruit up to 25 participants according to qualitative sampling guidelines to reach saturation (Bernard, 2000; Green & Thorogood, 2009, p. 120). Paper recruitment flyers were posted throughout the communities within the LHIN (e.g., supermarkets, churches, community centres, libraries and doctors' offices); electronic copies of the same flyer were distributed via e-mail to various older adult stakeholder groups (see Appendix H). Interested participants contacted the primary researcher (JG), who provided additional information about the study by telephone. Interviews were then scheduled at a convenient time and location/format (e.g., at home, by telephone) for participants, who were provided with a study information letter and asked to provide written consent (see Appendix I).

A semi-structured interview guide was developed according to the three discourses of a solutions-focused approach and probed the following four key concepts of PFCC in relation to goal-setting in geriatric home care; 1) Dignity and Respect; 2) Information Sharing; 3) Participation; and 4) Collaboration (The Institute for Patient and Family Centred Care, 2010)

(Appendix J). Interviews lasted for 30-60 minutes, were conducted either with single older adults or with older adult/caregiver dyads depending on the older adults' preferences, and were audio-recorded. The primary researcher (JG) kept a diary of detailed reflexive notes following each participant interview to document any reflections or initial interpretations of the conversations (Gale et al., 2013) (see Appendix K). Participants received a $25.00 CAD honorarium for their participation in the form of a VISA gift card.

6.3.3 Data Analysis

Thematic data analysis was guided by the multi-step framework method as described by Gale and colleagues (Gale et al., 2013):

Step 1: Transcription

All audio-recorded interviews were transcribed verbatim. These transcripts, along with the reflexive notes taken by the primary researcher (JG), were imported into NVivo 10 software for analysis (QSR International Pty Ltd, 2012).

Step 2: Familiarization with the interviews

The primary researcher (JG) became immersed in each interview by thoroughly reading each transcript and corresponding reflexive notes in detail. Additional memos were created in NVivo 10 (QSR International Pty Ltd, 2012) regarding initial analytical impressions during this step in the analysis. After reviewing all transcripts, the primary researcher (JG) selected three transcripts thought to be representative of the data to commence step three below.

Step 3: Coding

Two researchers (JG, PS) independently coded the three representative transcripts using an inductive open coding approach (Lofland et al., 2006; Pope et al., 2000). Line-by-line reading of each transcript was completed by each researcher to identify important short phrases,

sentences and passages (meaning units) and assign a label to classify them systematically (Gale

et al., 2013) (see Table 6.1). Each researcher also recorded reflexive notes at this stage to

document their impressions of the data and ideas about patterns and trends across the three

transcripts.

Table 6.1 Sample open coding scheme

Excerpt from Transcript	Meaning Unit	Label
…and I keep adding new information. I stick stuff in the back and then they can read- Like, I told them about the wedding and when the grandbaby was born and that kind of stuff. So, they know they can talk to him about that sort of thing and the aphasia book is here all the time, but [name] doesn't need to use it because she's ... Like, she- Like I said, she's like one of our kids now. (laughs) And so, she knows probably more about the family than I do, but ... (laughs)	*I stick stuff in the back and then they can read- Like, I told them about the wedding and when the grandbaby was born and that kind of stuff. So, they know they can talk to him about that sort of thing*	Personal history, family dynamics and background matter
Her skills to determine his mood for the day and his needs for the day, and, and meet that. Um, he talks nonstop about himself while she's there, "And I used to do this, and I did that." And she's, "Oh, is that right?" And she gets him laughing. So she's a mood changer right away. And then she sits down and has a coffee with me for 20 minutes, so it's social. You know, and then she leaves. And um, I've never seen her anything but up and bubbly.	*Her skills to determine his mood for the day and his needs for the day, and, and meet that.*	Good communication and listening skills are essential

Step 4: Developing a working analytical framework

After completing the open coding on each of the three transcripts, the two researchers

(JG, PS) met to compare the labels they had assigned to the data and determine an agreed upon

set of codes. Researchers then inductively categorized these codes and then deductively grouped

these categories according to the four elements of PFCC that were explored in the interviews

(The Institute for Patient and Family Centred Care, 2010). A chart was developed demonstrating

the relationship between codes, categories and elements of PFCC that would form the working

analytical framework for the remainder of the analysis (see Table 6.2).

Table 6.2 Working analytical framework

Element of PFCC	Respect and Dignity	Information-Sharing	Participation	Collaboration
Category	Ageist assumptions are dangerous	Relational communication takes work	Doing 'with' is harder than doing 'for'	Older adults/ caregivers control the home environment
Codes	Older adults are not just a collection of body parts and diseases	Individual preferences and needs are important	Acknowledging family/friend caregiver burnout, sacrifice and contributions	Older adults and family/friend caregivers advocate for themselves
	Older adults have a range of sight, hearing and cognitive capacities	Providers need detailed knowledge of the health issue(s)	Shared decision-making is needed for patient-driven care planning	Scheduling and reliability are important for building trust
	Older adults should have equal access to recovery-focused care	Good communication and listening skills are essential	Older adults and their family/friend caregivers have unique goals	The home is primarily a personal and not a clinical environment
		Consistency among and between providers is key	More help is needed with less clinical tasks	Choice is important to older adults and family/friend caregivers
		Personal history, family dynamics		

82

	and background matter		

Step 5: Applying the analytical framework

The primary researcher (JG) applied the working analytical framework to code the remaining 17 transcripts using NVivo 10 software (QSR International Pty Ltd, 2012). Detailed reflexive notes were taken throughout this stage of the analysis in order to track key impressions about the data as they emerged in relation to the three discourses of a solutions-focused approach.

Step 6: Charting the data into the framework matrix

Once all the data were coded using the analytical framework, the primary researcher (JG) developed a series of four matrices to summarize the data for each category using Microsoft Excel. The rows in each matrix represented each interview (older adult or older adult/caregiver dyad) and the columns in each matrix represented each code within a category. Coded data was abstracted from NVivo 10 (QSR International Pty Ltd, 2012) to populate the cells within the matrix with illustrative points using verbatim words and quotes as much as possible (see Table 6.3).

Table 6.3 Sample matrix for 'respect and dignity: ageist assumptions are dangerous'

	Older adults are not just a collection of body parts and diseases	**Older adults have a range of sight, hearing and cognitive capacities**	**Older adults should have equal access to recovery-focused care**
Janice* (older adult)	Older adults grew up in a different era where you were very conservative about <u>showing your body parts</u> and having a stranger of the opposite sex bathe you requires them to	Retirement home staff <u>forget that we're adults</u> and poor excuses for lack of consistency in providers (e.g., so you don't become too attached should you die) <u>do not sit well</u>	Nurse working on toenails causing chronic pain was going to give up saying: '<u>I don't think we are getting anywhere</u>' and older adult persisted and wanted to know <u>step</u>

	be very professional**	with us	by step what other action could be taken
Doris (older adult)	The home PT wasn't interested in the person; she was interested in physio and didn't explain why she was giving certain exercises for certain parts of the body	Assumptions are made that because you look old you must be stupid, you must be deaf and you must be blind.	A PT assessing pain in the foot offered no proactive help and the conversation was sparse, you have to live with it sort of thing.
Janet (older adult) and Alice (caregiver)	Food modification recommendations were made only considering what parts of the body were not working properly which made her really not want to eat at all	Home care assessment questions seemed to be checking whether I had my marbles and asked if I knew what year I was born	Home care assessment questions seemed like they had already pre-determined that down the road, they wanted to get her into a nursing home
Sue (caregiver)	He has to be seen as the patient forever—all he's got really out of four appendages is his left arm and he's not naturally a left-handed person so this is difficult for him	Just because he has a speech disorder does not mean he does not want to communicate and he tries to say to them "what's new?" and they will not engage and reply "well, not much new"	…for old people, it's, it's like, um ... uh, it's like ... do as little as possible, spend as little as possible. But for newborn babies, "Oh, wow." Yeah. You know, like ... (laughs) It's ... uh, uh, we can't do too, we can't do too much ever, ever, you know?
Julia (Caregiver)	Contrasting the publicly funded palliative home care (it didn't seem to matter whether she could do the care that was required, it was just her body) with the privately funded care where the providers would give massages, use cold compresses, readjust pillows (they were totally aware of the	I wish they knew how extremely intelligent she was - several times the home support worker would talk to her like she was an imbecile.	Older adult told caregiver - I just feel like they just want to stand me up against the wall and hose me down, and, and, uh, use a big hand blower and blow it all off me, and then throw me into bed.

	process of death)		

Step 7: Interpreting the Data

Themes were generated from the matrices by comparing and contrasting data among participants and categories and also across categories. The primary researcher (JG) used the three discourses of a solutions-focused approach to elaborate on fill out each of the themes. Themes were shared and discussed with a second researcher on the team (PS) to ensure they were consistent with the overall coding framework.

6.4 Results

Thirteen older adults and 12 family/friend caregivers were interviewed between July and October of 2017 (see Table 6.4). Five interviews were with older adult/caregiver dyads. Six of the family/friend caregivers interviewed were spouses, and six were adult daughters of older adults. Older adults were receiving home care services for a variety of health issues including stroke, multiple sclerosis, Amyotrophic Lateral Sclerosis, muscular dystrophy, Parkinson's disease, cancer and dementia.

Table 6.4 Key informant interview participant characteristics

Characteristics		Older adults (n=13)	Family/friend caregivers (n= 12)
Area	Rural	1	2
	Urban	12	10
Age Group (years)	55-65		10
	65-75	5	1
	75-85	4	1
	85+	4	0
Gender	Male	4	1
	Female	9	11
Living Arrangements	Alone	8	
	With someone else	5	
Housing	Detached house	6	
	Apartment	4	

	building		
	Retirement home	3	

The following four themes emerged from the data: 1) seeing beyond age enables respect and dignity; 2) relational communication involves two-way information sharing; 3) doing 'with' instead of doing 'for' promotes participation; 5) collaboration is easier when older adults/ family/ friend caregivers lead the way (see Table 6.5).

Table 6.5 Solutions-focused themes for improving person- and family-centred goal-setting in geriatric home care

Theme	Seeing beyond age enables respect and dignity	Relational communication involves two-way information sharing	Doing 'with' instead of doing 'for' promotes participation	Collaboration is easier when older adults/ family/friend caregivers lead the way
Change	Decrease ageism around sight, hearing, cognition and care needs	Increase awareness of personal history, needs and background	Make fewer assumptions that aging in place means being sedentary	Increase opportunities to direct the care environment
Solution	Focus on older adult capacity and reactivation	Uncover a holistic picture of the care situation	Support older adults to be as independent as possible	Actively engage in shared decision-making
Strategy	Talk with and not at older adults/ family/friend caregivers	Build trust and understanding	Trust older adults/ family/friend caregivers to know their limits	Tailor care activities based on preferences that matter

6.4.1 Seeing Beyond Age Enables Respect and Dignity

Older adults and their family/friend caregivers shared that respect and dignity would be better supported in geriatric home care if providers were able to see beyond age when determining older adult goals and needs. Older adults and family/friend caregivers agreed

that point-of-care providers need to make fewer ageist assumptions about the abilities of older

adults in order to promote more active goal-setting. One older adult named Doris shared her

belief that ageist assumptions are easy for point-of-care providers, based on physical appearance

and numerical age: "Yes, it's sort of, a, an assumption, you see? ...It's, I mean, after all, I

suppose that it's justifiable cause you look old (laughter). And you are old. But, um, it's not as

bad as they think." She shared that a more holistic view on aging and goal-setting would reveal

more opportunities in her care situation. Older adults also spoke about their desire to eliminate

the often patronizing tone of conversations, tainted by assumptions about hearing, sight,

cognition or care needs. One participant expressed:

> And not speak to senior citizens like they're idiots, and don't understand what's
> going on. Um, being called "dear". Uh ... I guess we're just coming into this now, there
> have been a few ages of things that I run into before, but somebody called me "dear" the
> other day, and I thought, "Oh, Lord. I have arrived." –Beatrice (older adult)

Older adults and family/friend caregivers alike believed that decreased ageism could be realized

through focused goal-setting to protect older adult capacity and promote reactivation. One

family/friend caregiver shared her experience with a complete lack of goal-setting when the

planning team assumed that her husband would require institutional care and she needed to

advocate a more rehabilitative approach:

> And then they send somebody to check out your home. It- I, I found at the hospital,
> though, their first, their first ... Um, go-to reaction was, "What home are you gonna put
> him in?" And I'm going, "Oh. Well, I didn't think he was that sick." Like ... (laughs) You
> know, like, uh, it's a stroke, yeah, but his whole right side was, um ... what they called
> 'weakened'. –Karen (family/friend caregiver)

Family/friend caregivers felt their inclusion in goal-setting would allow them to more accurately

represent and communicate realistic goals and ideas more aligned with the preferences and

abilities of the care recipient. One family/friend caregiver spoke about her husband's experience

as a result of her advocacy:

He was able to enjoy his kids all summer. We were able to get away. And that's the purpose of it. So he might have another year. He might have another five. But those one year or that five to be as good as could make it without judgment ... so the odd time I do, uh, I do get, uh, a caregiver…it's your age, what the heck? You're going to be gone soon, so I'm not going to help… we'll get that. You know. And then they get mother bear coming out of her cave, you know, sort of thing. –Hazel (family/friend caregiver)

According to this participant, the ideal world would mean that this proactive approach would become usual practice and not require constant advocacy by family/friend caregivers. To decrease ageism and foster more proactive goal-setting, participants felt that point-of-care providers would need to talk 'with' older adults and family/friend caregivers instead of 'at' them. One older adult shared his positive experience of goal-setting when point-of-care providers used conversational versus instructive care planning:

So, that's one of the key things that, honestly, I would give them 100% because in fact they wanted to know what are my choices and why are those choices important and so on. Uh, that's very important for the individual. It's not to say, "This is what we deliver. If you like it, you can take it. If not, tough bananas." Um, it's not ... healthcare is not about that. Healthcare is about the individual. Uh, and you have to come to understand that by taking that history and then sharing it –Joe (older adult)

He and his family/friend caregiver felt very strongly that this interactive dialogue allowed point-of-care providers to see beyond his age, treat him as an individual with capabilities and define corresponding goals.

6.4.2 Relational Communication Involves Two-Way Information Sharing

Older adults and family/friend caregivers stressed the importance and need for more two-way information sharing in order to establish a pattern of communication built on a relationship between the older adult and the point-of-care providers in a way that would support goal-oriented care. One family/friend caregiver named John shared his frustrating experience trying to engage point-of-care providers in this manner: "Um ... they suffer from ... at least one major problem ... And from my perspective, it's highly important. That is, they do not communicate, or if you

attempt to communicate, I get the feeling you're being ignored." Older adults and family/friend caregivers agreed that the most substantial change had to come from point-of-care providers knowing and using personal history, needs and background information in care planning. One older adult talked about some care providers respecting his desire to read information once they knew about his previous profession:

> Uh, sometimes they do. We'll- We'll talk and they'll ask me questions about my previous work. I was a reporter and photographer with, uh, the old [name] newspaper office here. I was there for 12 years, and, I guess, that's where I ... No, I always liked books. And, uh, they sometimes ask me about- about my work at the [newspaper office] –Jack (older adult)

In terms of a solution to realize this change, older adults talked about providers having a more holistic view of the care situation when planning and providing care. One family/friend caregiver had worked as a personal support worker prior to retirement and described how building relational communication through information-sharing was an ideal approach:

> And- and, kind of, a- as time went on if I was with the same person, uh, I would like ... there'd be time to, kind of, form some type of a relationship with them and- and it was more of a one-on-one basis and so ... And they would ... We would talk. They would tell me things, and- and I would, sort of, take that back with me and- and put it up here.— Penny (family/friend caregiver)

Another family/friend caregiver recommended that point-of-care providers use a personal biography sheet to record and share information to support a holistic approach:

> Oh, God. Wouldn't that be wonderful? A little bio sheet, okay. What did this man do for a living? How many children does he have? Does he have grandchildren? Where were you born? Do you speak two languages? What are your skills? You have hobbies? What religion are you? Are you religious?—Hazel (family/friend caregiver)

According to older adults and their family/friend caregivers, a key strategy for realizing the solution of uncovering a holistic picture of care requires building trust and understanding with older adults and family/friend caregivers:

And, uh, uh, it's like, a bit of a bonding like, you know, that, uh, you'll ask them how their children are and, when you've had a blood test or something, they'll say, how did that go or something, you know? –Janice (older adult)

A family/friend caregiver talked about this type of bonding between her husband and his care providers:

Um, so it's, um, I glimpse into what my husband, like, some of the workers are really good, and they'll, they visit with him as they're doing their work. And, uh, and I hear a laughter coming from the bedroom when they're, you know, getting him ready for breakfast and that kind of thing and, or, you know, tell about their family or a holiday or experience, and they really engage with him. –Sue (family/friend caregiver)

This caregiver was very adamant that this type of relational communication puts everyone at ease in the care planning situation, and brings some humanity and reality into the goal-setting process through balancing clinical and non-clinical information sharing.

6.4.3 Doing 'With' Instead of Doing 'For' Promotes Participation

Older adults and family/friend caregivers expressed their ideas about care planning being more participatory if point-of-care providers do care activities 'with' older adults rather than 'for' them. One older adult name Lois expressed her attempts to be more independent in her bath routine: "Like they'll bath me if I want them to bath me, but I, I usually don't, I usually like to do it myself…But I ask them to stay just in case I fall or something. In the bathtub." According to participants, a key change to support more participatory care would be for providers not to assume that aging at home necessarily means growing more inactive. One older adult shared her experience of requesting assistance and being met with a response that assumed she did not want to be involved in the activity herself:

And I said was there ever, was there any way that I could have somebody help me with my grocery shopping? And he said 'Oh, yes, you, they have this, uh, you give them a list and they go out and shop and they bring it back and, uh, you pay for it.' But, that's not helping with my grocery shopping, that is just grocery shopping. –Doris (older adult)

90

Older adults and family/friend caregivers felt that participatory goal-setting in geriatric home care would allow point-of-care providers to support older adults and family/friend caregivers to be as independent as possible. One older adult named Janet discussed her desire for more dialogue in the re-assessment process she undergoes every six months with her home care provider, sharing that there is an assumption made that they will continue to bathe her and make her bed regardless of changes in her needs or preferences: "No, they don't ask how I am, is there anything I would like, but just that they know that I get washed and the bed made. And they emphasize the sponge bath, and I said, "Yes, I know, I do not have a shower."" Participants felt that a strategy for achieving this outcome of more participatory goal-setting would be for providers to trust older adult/ family/friend caregiver opinions, suggestions and understanding of their own limits. For example, one older adult shared:

> Although, in some ways, they limit what I want to do. Like I get into the bath, I say, "Let me sit down and put my legs in myself." That's going to take some training, because they want to do it. That type of thing…'Cause they're afraid I'll fall, whereas I'm the one that knows whether my balance is good or not. –Gail (older adult)

A family/friend caregiver also shared her experience in listening to a point-of-care provider's advice against her own judgment and the poor outcome it led to:

> An occupational therapist came in and said, "You're pretty wobbly on your feet. You really should have a walker." Because he was, a little, you know, he's got a cane. So all right, [name] gets the walker. Well, it's been horrible. Because you start walking bent over, and he's so bent over now he can't stand up straight. And even his neck is down like this, so he has to go like this, all from the walker. –Hazel (family/friend caregiver)

This family/friend caregiver felt that had she been heard, her husband could have continued to use his cane and rebuilt his walking ability with participatory rehabilitation.

6.4.4 Collaboration is Easier When Older Adults/ Family/Friend Caregivers Lead the Way

Older adults and family/friend caregivers discussed the reality that in a home-care setting,

collaboration with point-of-care providers is easier when they are able to lead the way. One

family/friend caregiver expressed her desire for providers to accommodate her priorities as a

result of her more dominant role in care:

> Um, the priorities here are to just get through a day and put a decent meal on the table once a day and meet his needs because, um, I don't know that they ever stop to think that, you know, "She's here, uh, 21 hours a day with no help. We're only here three hours a day," and, um, you know, if he needs help through the night, guess who's it, you know? I am. –Sue (family/ friend caregiver)

According to participants, providers should recognize the right of older adults and family/friend

caregivers to direct and control the care in their own homes. One older adult discussed her

efforts:

> Yeah, I know. The one I have, she's a person that really ... The warmth affects her a lot. She sweats a lot, so she'll come in the house, and I'm the one that needs it warmer, she'll just open all the windows. And I've told her several times, "It's my house. I will tell you." Now I did have that into her head, (laughs) now she's starting to do it again. –Gail (older adult)

Participants shared that more collaboration in geriatric home care planning would involve shared

decision-making. For example, one older adult discussed a decision not to undergo suggested

treatment after discussion with all of his care providers:

> Uh, I'm diabetic. My heart's a lot better than it was when I had the heart attack. And, uh, I'm getting close to, uh, I have kidney disease and the doctor is getting me closer to the time where I might have to go on dialysis. I'm- I'm not gonna go on that because I'm 85, uh, I've done everything I've ever wanted to do in my life, and there's no reason why I would want to sit for so many hours and so many days watching my blood go out into a machine and back in. –Jack (older adult)

This ideally collaborative approach would require provider flexibility to tailor care activities to

unique and desired preferences. For example, one family/friend caregiver discussed the efforts of

a dietitian:

We did get a dietician that was wonderful, that said, "I'm not going to read you the riot act on," said, "What will you eat? Let's work with that." And so we found things that he will eat, and so they're in his diet. You know. What is it? Yeah. How can we work with you instead of getting you to fit into the system? –Hazel (family/friend caregiver)

Another family/friend caregiver described an ideal approach to a smoking cessation plan for her mother who had unique needs due to dementia:

So, I said, "That's not an option, but instead of smoking two cartons in a month, can we cut it down to one? Can we at least try to figure out something. I don't want a miracle. I don't wanna take the last thing ..." That's the last thing she has, and I ... I don't wanna kill her with it, but I've taken everything from my ... in my mom's eyes, I've taken everything. –Margaret (family/friend caregiver)

This family/friend caregiver strongly commended the provider for open-mindedness and flexibility to meet the needs of the unique care situation.

6.5 Discussion

Older adults and their family/friend caregivers shared a range of ideas for improving person- and family-centred goal-setting in geriatric home care based on their lived experiences and expertise. Participants identified that seeing beyond age, relational communication, doing 'with' instead of doing 'for', and collaboration were key enabling factors of respect and dignity, information-sharing, participation and collaboration in the care planning process. Older adults and family/friend caregivers want to be actively engaged in dialogue during care planning to ensure that their preferences, needs, and personal history are applied in designing a care plan that promotes their participation at a level they choose and that is conducive to their personal environment.

Ageist stereotypes and discrimination against older adults have been cited as significant barriers to health equity for this population in terms of both quantity and quality of care and related health outcomes (Wyman, Shiovitz-Ezra, & Bengel, 2018). Ageism can take place at different levels in the health care system, with micro (personal) level ageism involving the

attitudes of individual providers, ageist communication styles and decision-making about care

and macro (system) level ageism involving health care funding structures, policies and training

of professionals (Wyman et al., 2018). At the micro level, a recent study found that ageist

communication can emerge across disciplines due to limited provider self-awareness, with

providers gravitating towards the simplest options and not being able to relate to older adults as

individuals (Ben-Harush et al., 2017). Adopting the solutions-focused approach to ageism that

emerged from the current study would include decreasing provider assumptions about sight,

hearing and cognition and focusing on capacity and reactivation. Participants identified that

talking with older adults and their family/friend caregivers has the potential to address the main

ageist challenges at the micro level of home care in practical ways.

Relational communication builds empathy for older adults' unique care situations and

incorporates this empathy into care planning (Eton et al., 2017; Mercer, Maxwell, Heaney, &

Watt, 2004) The communicative and interpersonal skills of providers have been coined and

measured in the literature as health care provider relational quality (HPRQ) (Eton et al., 2017). In

measuring HPRQ, patients' choices of the following statements were found to be positively

correlated with increased self-management ability: "my healthcare provider spends enough time

with me"; "my healthcare provider listens carefully to me"; and "I have trust in my healthcare

provider" (Eton et al., 2017). Similarly, another validated measure of the quality of one-on-one

interactions between point-of-care providers and patients called the consultation and relational

empathy (CARE) measure includes "letting you tell your story", "being interested in you as a

whole person" and "explaining things clearly" as key indicators of a positive therapeutic

relationship (Mercer et al., 2004). These findings are aligned with the results of the present

study, which suggest that building trust and understanding among providers, older adults and

family/friend caregivers is a key strategy for providers to acquire increased awareness of personal needs, history and background.

Promoting increased independence and restorative care is a trend in current home care provision to help older adults retain, regain or gain the skills they need to function in their everyday lives as independently as possible and to increase quality of life (Aspinal, Glasby, Rostgaard, Tuntland, & Westendorp, 2016; Tessier, Beaulieu, McGinn, & Latulippe, 2016). Unfortunately, the processes of mutual goal-setting for reablement and for designing and delivering these customized care activities is largely undescribed in the literature (Legg, Gladman, Drummond, & Davidson, 2016). The current study suggests that a reablement type of approach could be achieved through goal-setting practices where point-of-care providers make fewer assumptions about the sedentary nature of older adults and promote independence in planning care activities that take into account older adults' and family/friend caregivers' interpretations of their abilities and limits.

Enhanced collaboration between older adults, family/friend caregivers and health care providers has often be recommended in literature exploring their experiences delivering and receiving care (Giosa et al., 2014; Toscan et al., 2012; Toscan et al., 2013), yet few studies have explored the specific activities required by point-of-care providers to support this outcome. A recent qualitative study found that there is great disparity between providers' and older adults'/ family/friend caregivers' impressions of their collaboration in the care planning process, with providers citing a much higher perceived collaboration than the other groups (Ploeg et al., 2017). This study goes on to recommend that providers should apply person- and family-centred approaches that involve "listening to and acting on the voices of older adults and family members" (Ploeg et al., 2017, p. 13). The findings of this study are aligned and suggest that

providers can facilitate enhanced collaboration by encouraging older adults and family/friend caregivers to direct and control the care environment, participate in shared-decision making and then tailor care activities based on preferences that they express to be important.

6.5.1 Strengths

Strengths of this qualitative study include the use of a solutions-focused approach to actively engage older adults and family/friend caregivers in developing ideas for change, extending current knowledge beyond documenting older adults' and family/friend caregivers' experiences. Another key strength of this approach is that ideas for change, solutions and strategies emerged based on lived experiences of individuals who are well-accustomed to existing structural and systemic barriers and therefore applying these ideas in current practice should be feasible.

6.5.2 Limitations

This study may be limited since recruitment of participants took place within only one of the 14 health regions (LHINs) in Ontario. However, saturation was reached with this sample, which included a balance between older adults and family/friend caregivers and represented a broad range of ages, health concerns, urban and rural dwellings and relationships between caregivers and care recipients. The study participants also lacked ethnic diversity, mainly due to requirements for participation in English only. Further, there was no direct member-checking of the emergent themes; however, the findings were validated and applied in a follow up co-design workshop on integrated care with older adults, family/friend caregivers and health care providers (see chapter 7).

6.6 Conclusions

According to participants, person- and family-centred goal-setting would be better

supported by providers who take time to see beyond age, engage in relational communication, facilitate participatory goal-setting and collaborate more effectively. The changes and solutions suggested by older adults and family/friend caregivers in this study are consistent with recommendations for applying person-and family-centred care in recent literature and extend current knowledge by offering tangible strategies that can be tested in geriatric home care goal-setting practice.

CHAPTER 7: AN IMPLEMENTATION FRAMEWORK FOR INTEGRATED GERIATRIC CARE PLANNING AT THE POINT-OF-CARE IN HOME CARE

7.1 Abstract

Background

Within the current context of citizen engagement, person- and family-centred care and people-powered health, the health services research landscape is shifting from one that views academic researchers and health care professionals as "experts" to one that values and prioritizes the lived experiences of system users and acknowledges shared expertise across all perspectives involved in developing solutions for positive system change. Within this changing context, traditional consultative research methods often fall short of truly engaging system users as partners in an action-oriented way. The purpose of this interpretation stage of the overall mixed-methods study on integrated care planning was to apply findings from phases one and two in the development of an implementation framework that represents what an integrated geriatric care planning approach looks like from the perspective of system users in home care.

Methods

A co-design workshop was held with older adults, family/friend caregivers and point-of-care providers using generative research practices from the field of service design. Findings from phase one (G-CAP survey) and phase two (solutions-focused interviews) of this research were applied in the development of four gamestorming activities, in order to creatively engage participants in discussing, designing and testing out novel ideas for improving geriatric home care planning during the workshop. Participants sat in small groups that included a mix of the different types of stakeholders and each group had a facilitator and a facilitator helper to work through the exercises with them. Participants completed a co-design feedback survey at the end

of the workshop to express their views on the experience. Immediately following the workshop, the main researcher (JG) held a debrief session with the facilitators and facilitator helpers and collected the notes, photographs and creative artefacts that emerged from each small group through the activities (e.g., worksheets, empathy/journey maps). Directed content analysis was applied to the data, which were organized according to the following implementation framework categories: 1) influencing factors; 2) strategies; and 3) evaluations. Survey data were uploaded into Microsoft Excel and descriptively analyzed using SPSS 20 software.

Results

Nineteen system users participated in the co-design workshop ($n = 5$ older adults, $n = 9$ family/friend caregivers and $n = 5$ point-of-care providers). An implementation framework emerged that included three key influencing factors for integrated geriatric care planning at the point of care in home care: 1) inclusive assessment practices; 2) dialogue-based goal-setting; and 3) flexible communication strategies. Feedback on the co-design workshop experience indicated that participants felt very confident that their contributions would influence change ($M = 4.07$ on a 5 point scale where 1 = not at all and 5 = extremely) and would be very willing to participate in a future co-design session ($M = 4.80$ on a 5 point scale where 1 = not at all and 5 = extremely).

Discussion

Evidence suggests that inclusive assessment practices could be supported by the use of the Edmonton Frail Scale and RAI-HC data at the point-of-care to improve integration between service allocation and point-of-care planning in home care. There is a need to explore the development of a personal biography assessment tool to support participants' wishes for more fulsome non-clinical background information about older adults to influence care planning. Goal Attainment Scaling, the Canadian Occupational Performance Measure and the concept of 'positive health' could be explored for their potential to support the implementation of dialogue-

based goal-setting at the point-of-care. The Electronic Patient-Reported Outcome (ePRO) mobile application and portal, coupled with paper-based alternatives, could potentially support the implementation of flexible communication strategies.

Conclusions

Meaningful engagement of older adults, family/friend caregivers and point-of-care providers in co-design through gamestorming narrows the 'know-do' gap in knowledge translation. Geriatric care planning at the point-of-care that involves inclusive assessment, dialogue-based goal-setting and flexible communication strategies has the potential to improve the experience of integrated care and the integration between service allocation and care delivery. Next steps for this work include additional co-design workshops to further operationalize the solutions in the implementation framework for a pilot-testing phase.

7.2 Background

7.2.1 Citizen Engagement, Person-and Family-Centred Care and People-Powered Health

The citizen engagement movement is growing at a rapid pace, with the internet and social media equipping individuals with information and enabling them to have an active voice in conversations, debates and problem-solving on important issues relevant to their individual needs, values and priorities (Alloway & Goldhar, 2018; Skoric, Zhu, Goh, & Pang, 2015). In terms of health care, the person- and family-centred care and people-powered health movements have shifted the focal point of 'expertise' in health system design, delivery, research and evaluation from lying mainly with professional health care providers, senior health care leaders and academic researchers towards valuing, prioritizing and authentically including the lived experiences of health care recipients and their family/friend caregivers (Holroyd-Leduc et al., 2016; Horne, Khan, & Corrigan, 2013; Maurits, de Veer, Groenewegen, & Francke, 2018). Citizen engagement in health care embraces the concepts of inclusivity, mutual respect and co-design and within the context of health research and priority setting has demonstrated enhanced research quality, relevance and efficiency (Health Canada, 2015; Holroyd-Leduc et al., 2016).

7.2.2 Engagement of Older Adults and Family/Friend Caregivers in Health Services Research

Unfortunately, the engagement of older adults and their family/friend caregivers in health services research has been limited to date for a variety of reasons including, but not limited to, the challenge of reaching more vulnerable populations, the time it takes, and the requirements for special accommodations to make the engagement feasible for individuals participating (Holroyd-Leduc et al., 2016). A recent realist review conducted in partnership with older adults revealed that their engagement in research and priority setting must be holistic to address individual needs, approachable in terms of the attitudes portrayed by researchers, flexible and adaptable in

method and expected outcomes, and include feedback loops and ways to share and discuss findings and next steps (McNeil et al., 2016). A key principle to successful engagement of older adults and their family/friend caregivers in health care research and planning is relationship-building, where dynamic and responsive partnerships are authentically formed between participants and researchers (McNeil et al., 2016). Early involvement in the research process, communication, and the establishment of clear expectations have been documented as enabling factors for relationship-building between older adults and their family/friend caregivers and researchers (McNeil et al., 2016). It has been suggested that this partnership approach to engagement contributes towards a more integrated health care system, where power and control are shared and individuals are actively involved as co-producers of care instead of treated as passive observers (Ferrer & Goodwin, 2014). These strategies and recommendations are helpful in moving forward our understanding of what is required to meaningfully engage older adults, yet there is a need for greater understanding and further development of the practical methods, tools and techniques that support this type of work.

7.2.3 Participatory Methodology

Traditionally in the research process, the findings, applications and recommendations that emerge from a research study are shared with system users and stakeholders at the end of a project through a process called 'knowledge translation', whereby researchers hand off the knowledge and responsibility for action to those who are most impacted by the findings (e.g., government decision makers, community service providers, patients, and families). While knowledge translation is still very much a part of research studies today, it has recently been criticized in the implementation science literature for reinforcing the 'know-do gap', which is the idea that the people who create the knowledge are separate from the people who use it (Jull,

Giles, & Graham, 2017). The 'know-do' gap is often responsible for poor and inefficient uptake

of research findings and limited understanding of the impact the research has on changes in

practice and policy (Jull et al., 2017). Therefore, simply including methods of 'knowledge

translation' in a health services research study is starting to no longer be accepted as adequate,

and does not align to the philosophies of person-and family-centred care, people-powered health

or citizen engagement. Instead, knowledge co-creation is taking hold in the literature, where

researchers and knowledge users work together in partnership to bring their unique expertise and

context to research problems (Jull et al., 2017). Through engaging in a collaborative approach to

finding and creating solutions, co-creation leads to findings that are more likely to be used in the

health care system and have a better chance of making social impact (Jull et al., 2017).

Within the realm of health services research, two participatory methodologies have been

cited to be consistent with a co-production approach, including integrated knowledge translation

(IKT) and community-based participatory research (CBPR) (Jull et al., 2017). IKT emerged in

the Canadian health research funder context and emphasizes a collaborative approach between

researchers and knowledge users to co-create knowledge across the entire research process

(Canadian Institutes of Health Research, 2015). However, the purpose of IKT is stated as

"raising knowledge users' awareness of research findings and facilitating the use of those

findings" (Canadian Institutes of Health Research, 2015, p. 1). This statement about the purpose

and intention of IKT methods raises questions about its alignment with co-production and

authentic engagement principles. For example, the definition suggests that the purpose of IKT is

to raise awareness and facilitate use of knowledge, not create it in partnership. This suggests that

IKT methods still create an imbalance in power between researchers and knowledge users.

CBPR, also referred commonly to as action-research or participatory action research, is strongly

103

rooted in social justice and has been defined by the Kellogg Foundation (1992) as a:

> collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community, has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities (para 2).

In CBPR, it is essential that community members are involved in every stage of the research process, from problem naming, to developing the research plan, to implementation and then evaluating the outcomes (Jull et al., 2017). Further, there is a focus on addressing and minimizing inequities and power differentials in the CBPR methodology (Jull et al., 2017) . In health services research, a true CBPR approach is difficult to achieve, as research problems are often dictated or pre-described by funding bodies and granting agencies and many projects are intended to be multijurisdictional and not singular in terms of the community of focus.

Within the current context of health services research, the challenge becomes finding ways to engage system users in authentic co-production, drawing from parts of both the IKT and CBPR and other methodologies that are aligned with this philosophy and working within the funding and structural constraints of this research sector outlined above. One emerging methodology that is gaining traction in this regard is experience-based co-design (EBCD). Drawing on traditional design sciences (e.g., engineering, architecture, computer and graphic design) EBCD attempts to shift the focus away from consulting system users on their experiences to collaborating on the design of the ideal user experience (Bate & Robert, 2006). Focusing on experiences means placing less emphasis on the pursuit of objectivity and defined processes and outcomes and more emphasis on subjective stories and organic, iterative pathways to knowledge (Bate & Robert, 2006). Unfortunately, within the methodology of EBCD, health services researchers tend to gravitate to usual and comfortable qualitative methods including, but not limited to, key informant interviews, surveys, and focus groups when attempting to take on

this type of work. This is evidenced by the EBCD toolkit that is widely applied by researchers carrying out this methodology (The Kings Fund, 2018). The step-by-step tool-kit is fairly prescriptive and rigid, involving video-taped interviews, and feedback groups (focus groups) that separate and join together the various stakeholder groups (The Kings Fund, 2018). Another area of the design sciences, not referenced in EBCD, is service design. Service design is grounded in the ideology of collective creativity, which is premised on the fact that when people come together, individual creativity is boosted and the breadth, quality and number of ideas brought forward are exponentially greater than if people are asked to provide input on their own, particularly when the group that is brought together is diverse (Sanders & Stappers, 2012). Generative research methods are applied in service design, which involves thinking beyond what people say (e.g., focus groups), and do (e.g., observation) to honing in on what people make (Sanders & Stappers, 2012). Focusing on what people make is an essential element in the service design process that sets generative research apart from other participatory methods. Having people participate in a creative activity allows them to express themselves and their ideas in a different way (Sanders & Stappers, 2012).

7.2.4 Research Objectives for Interpretation Phase

To meet the objective of developing an implementation framework for a new integrated geriatric care planning approach at the service provider level in Ontario home care, the final question to be addressed was: *What does an integrated geriatric care planning approach look like to system users (older adults, family/friend caregivers, point-of-care providers) in Ontario home care?* In the interpretation phase of sequential transformative mixed methods research, the researcher traditionally brings together the qualitative and quantitative data to draw overall conclusions from the study (Creswell et al., 2003). However, as this research study applied a

pragmatic theoretical perspective through a lens of collective creativity, it would not have been sufficient to complete the interpretation phase without involving older adults, their family/friend caregivers and point-of-care providers. As such, the researcher applied generative research practices from the field of service design to hold a collaborative co-design workshop in order to complete the interpretation phase of this research, which relied on a combination of activities around what people say, what people do, and what people make (Sanders & Stappers, 2012).

7.3 Methods

7.3.1 Gamestorming

'Gamestorming' was used to carry out the co-design workshop and uncover the key components for a new approach to geriatric care planning in home care (Gray, Brown, & Macanufo, 2010). Gamestorming is a holistic collaboration approach, comprised of interactive, hands-on game-style activities that enable anyone to participate in the co-creative process (Gray et al., 2010). By focusing on what people say, what people do and what people make, gamestorming allows participants to temporarily suspend themselves from reality and enter into an alternate safe and creative space where "players can engage in behavior that might be risky, uncomfortable or even rude in their normal lives" (Gray et al., 2010, p. 1). In generative research, the goals of the gamestorming are "fuzzy", meaning that they create a framework for exploration, experimentation, trial and error and cannot be known precisely in advance (Gray et al., 2010; Sanders & Stappers, 2012). This was aligned with the aim of the interpretation stage of the present study, which was for the elements of the implementation framework for integrated geriatric care planning in home care to emerge from stakeholder collaboration as opposed to being pre-prescribed by the literature and the researchers' interpretations.

7.3.2 Workshop Preparation

Findings from the G-CAP survey with point-of-care nurses, OTs and PTs (phase one) and the solutions-focused interviews with older adults and family/friend caregivers (phase two) were applied by the researchers in choosing the gamestorming activities and developing the materials to support these activities in the co-design workshop.

Activity #1- Frame the Problem

The G-CAP survey findings in phase one of this study revealed that point-of-care providers have both common and unique needs for information within and across disciplines during care planning. Point-of-care providers' reliance on observation and interview skills over the use of standardized assessment tools also emerged in phase one data. Finally, the G-CAP survey results indicated that point-of-care providers have a positive perception of holistic assessment practices and their participation in collaborative goal-setting. To build on and expand these quantitative findings, researchers felt it would be important to ask older adult and family/friend caregiver workshop participants to elaborate on the information they would most like providers to know about them. Similarly, it would be important to understand the specific information point-of-care providers would most like to know (e.g., during their observations and interviews) about older adults and their family/friend caregivers.

To facilitate the collection of this information, the first gamestorming activity was designed around a warm-up game called "frame the problem". This game is meant to help everyone come to a common understanding of the problem at hand and sets the stage for the challenge of designing a solution (Gray et al., 2010; p.90). With this purpose in mind, the researchers developed the "My Top 5 Things" gamestorming activity (Appendix L). For this activity, a worksheet was created to allow participants to first choose the perspective they were

bringing to the discussion (older adult patient, family/friend caregiver or point-of-care provider). Next, the worksheet was designed to ask participants to brainstorm and list/draw the five most important pieces of information they would want point-of-care providers to know about their care situation, or the five most important things they as point-of-care providers would want to know about the care situation. In addition, the worksheet included space where participants could elaborate on why this information was important to them for their role in care. The worksheet was intended to support an interactive discussion among participants following the independent brainstorming to share similarities and differences across perspectives.

Activity #2- Empathy and Journey Mapping

The solutions-focused interviews with older adults and family/friend caregivers revealed four key themes for improvement in integrated geriatric care planning in home care: 1) seeing beyond age enables respect and dignity; 2) relational communication involves two-way information sharing; 3) doing 'with' instead of doing 'for' promotes participation; and 4) collaboration is easier when older adults/ family/friend caregivers lead the way. To build on and expand these qualitative findings, researchers felt it would be important to ask workshop participants to engage in interactive discussions around a home care story that elucidates these themes and to discuss the opportunities for solutions within the context of the home care environment.

To facilitate the collection of this information, researchers designed an activity based on the gamestorming activities of "empathy mapping" and "journey mapping". The purpose of empathy mapping in this context was to build a sense of understanding among participants who come to geriatric care planning with different lenses and to think about what might be common experiences for all and what might be unique to each person's role (Gray et al., 2010, p. 65).

108

With these purposes in mind, researchers developed the "Peter's Story" gamestorming activity.

Researchers applied the findings from the solutions-focused interviews to develop a series of

"personas" or case studies to use in the activity (Appendix M). The personas were based around

the fictional home care experience of an older adult named Peter. To provide a holistic view of

Peter's care situation, researchers not only developed Peter's persona, but also additional

personas for his family/friend caregiver (his wife Rebecca), his personal support worker (PSW)

(Simon), his nurse (Margaret), his occupational therapist (OT) (Cynthia) and his physiotherapist

(PT) (Michael). These personas included a picture of the fictional characters as well as details on

their age, home status, occupation, family situation, personal health, personal goals and a short

description of their background and how they came to be involved in Peter's care story. All

persona descriptions ended at a point in Peter's story where he is about to receive his first home

care visit. The researchers' intention was for the personas to be read aloud during the activity and

for each workshop participant to take on a persona different from their own perspective that they

could represent in the journey mapping component of the exercise.

Journey mapping in the present study context was intended to allow participants to apply

empathy in order to visualize and vocalize the holistic process of geriatric care planning from a

service perspective (Stickdorn & Schneider, 2012).To support the journey mapping component

of the exercise, researchers created a series of seven different scenario cards representing

individual days over a two week period of Peter's home care experience. Each card provided

information on both the activities and actions of the players involved in Peter's home care that

day as well as a description of the overall emotions being felt by Peter, his family/friend

caregiver and his point-of-care providers. The scenario cards were created to probe key tensions

around assessment and goal-setting that emerged from the G-CAP findings (phase one) and the

solutions-focused interviews (phase two) including multiple assessments by different providers, limited communication and lack of information-sharing (Appendix N). Researchers also developed a large worksheet called "Planning for care at home" to support this exercise. Using the scenario cards as key touchpoints in the geriatric care planning experience, the activity was designed to allow participants to use descriptions and pictures to walk through the ideal user experience including what is happening, who is involved, what information, tools and resources are required, and what outcomes (e.g., emotions) are desired, and to map these on to the large worksheet (Appendix O). A set of colour-coded "tiles" was also developed as prompts that participants could use to participate in the mapping exercise. These prompts emerged directly from data collected through the G-CAP survey (phase one) and the solutions-focused interviews (phase two) and included examples of the types of information needed about older adults (red tiles) and family/friend caregivers (green tiles) and the tools and processes suggested for improved information-sharing and communication (purple tiles) at the point-of-care (Appendix P).

Activity #3- Prototyping

The findings from the G-CAP survey (phase one) and solutions-focused interviews (phase two) provided insight into both the weaknesses and bright spots of geriatric assessment in home care; the first two activities in the co-design workshop were designed to delve deeper into and expand on these findings with ideas for solutions and improvement. Aligned with the generative research focus on creativity and 'making' things, the researchers designed the third and fourth gamestorming activities for the workshop as prototyping exercises to start to operationalize and test the emergent ideas for improving geriatric care planning in home care.

To support prototyping within the context of the present study, researchers developed a

110

gamestorming activity called "Our best idea to improve geriatric care planning in home care". A worksheet was designed to ask participants to sketch the best idea that they believed to have emerged from "Peter's story" exercise (activity #2). Templates of a variety of different vehicles to support these sketches were produced (e.g., tablet, smart phone, binder, book) to help facilitate the creative process for participants (see Appendix Q). In addition to these sketches, the worksheet also included sections for participants to describe how their solution would be used, by whom, for what, when and how, during the time points of before the home care visit, during the home care visit and following the home care visit (See Appendix Q).

Activity #4- Bodystorming

Findings from the G-CAP survey (phase one) and the solutions-focused interviews (phase two) indicated a disconnect between recommendations and best practices in the literature for geriatric care planning and point-of-care activities, suggesting barriers in terms of feasibility at the point-of-care within the context of current home care policies, funding arrangements, structures and tools. As such, researchers felt it would be important to engage workshop participants in testing out the feasibility of the ideas and prototypes that emerge through activity #3. An activity was developed to align with the gamestorming exercise of "bodystorming", which is brainstorming done with the body and is grounded in the idea that people can figure things out by trying them out and acting them out (Gray et al., 2010, p. 59). Researchers developed a worksheet to support this exercise called "Act it out: how would your best idea play out for Peter's story?" (Appendix R). The worksheet was designed to allow participants to choose one of the seven scenario cards, indicate the 'actors' (personas) involved in the scenario and then to script the scene in terms of what is said between and done by the actors before, during and following the home care visit and most importantly, how their idea was applied and

111

used. The worksheet was designed to facilitate participants "trying out" their ideas in a role play exercise where they would be asked to talk through the experience of applying their new idea and describe what seems to work well, not so well, etc. This exercise was developed with the intention to help the group get closer to understanding how the key elements of geriatric care planning in home care would come together in the real world (Gray et al., 2010, p. 59).

In addition to the specific worksheets and tools developed for each gamestorming activity, a variety of other creative materials was required at the workshop to provide participants with multiple ways for sharing their input throughout the day, including sticky notes, markers, paper, scissors, construction paper, glue and scissors.

7.3.3 Workshop Implementation/ Data Collection

To determine an appropriate sample size for a co-design workshop, several factors were considered, including the number of different types of stakeholders to be involved, the number of facilitators available and the types of activities that were to be carried out (Sanders & Stappers, 2012). For this research study, the important stakeholders to include in the workshop were older adults, their family/friend caregivers, and point-of-care home care providers. A variety of facilitators were available to support the co-design workshop including members of the primary research team (JG and PH) as well as other researchers affiliated with the collaborating research groups involved in this study. The types of activities that were to be completed in the workshop either required participants to work in one large group or in several small groups. Taking all of these factors into consideration, it was deemed reasonable to recruit approximately 10-15 participants for the workshop.

Recruitment of participants took place within one of the 14 Local Health Integration Networks (LHINs) within Ontario, which are regional health authorities organized according to

geography. The recruitment strategy for older adult and family/friend caregiver workshop participants was two-fold. First, older adult and family/friend caregivers who participated in the solutions-focused interviews (phase 2) and had indicated their interest in participating in future phases of the work, were invited to participate. Additionally, the researchers worked with a contact at the community seniors' association to distribute and post recruitment flyers around the community inviting participation in the workshop (Appendix S). To be eligible to participate, older adults had to be at least 65 years of age and either be currently receiving home care services or have had received home care services within the past five years. Family/friend caregivers had to self-identify as being the primary support person to an older adult who was currently receiving or who had received home care services within the past five years. Recruitment of point-of-care provider workshop participants took place through a single home care service provider agency through their service delivery centre within the specified LHIN. The primary researcher (JG) worked directly with the health services supervisor and the rehabilitation services supervisor at the site to invite various point-of-care providers to participate in the workshop. All types of point-of-care providers were invited to participate in the workshop, including but not limited to nurses, OTs, PTs, PSWs, dietitians, speech language pathologists and social workers. Interested participants contacted the primary researcher (JG) who provided additional information about the study and answered any questions they had. All workshop participants were provided with an information letter and were required to provide written consent to participate (see Appendix T). Participants were also invited to sign a photo release consent form (Appendix U) to allow facilitators to document the workshop activities using photography.

As the activities were hands-on and interactive, the workshop took place in a local

community centre program room, which was carefully chosen to ensure that it would accommodate the various needs of participants (e.g., accessibility, adequate parking, central location, temperature control, adequate lighting, comfortable seating, proximity to washrooms). Participants were organized into three small groups; each sitting at their own table and including representation from each of the three different stakeholder groups. Every small group had a main facilitator and an additional facilitator helper to assist participants with the gamestorming activities. The primary researcher (JG) also acted as the overall facilitator during large group discussions and activities.

The one day co-design workshop ran from 10:00 a.m. to 3:00 p.m. with several breaks and lunch included. A 10:00 a.m. start time was important to family/friend caregiver and older adult participants to accommodate morning care routines. The workshop began with a brief introduction and overview of the day provided by the primary researcher (JG) to the large group with a short presentation on phases one and two of the research study and the overall themes and data that had emerged. Next, the primary researcher (JG) outlined the "rules of play" for the day, including that all input and ideas would be valuable and that everyone would have the opportunity to be heard (Sanders & Stappers, 2012, p. 2). Participants then broke into small groups to participate in activities #1 and #2 before lunch and activities #3 and #4 after lunch. For activity #4, participants came back together as a large group to share and role play their developed scenes. At the end of the workshop, participants were asked to participate in a voluntary feedback survey on their co-design experience (Appendix V). Facilitators and facilitator helpers took notes of their observations throughout the day and documented the outcomes of each activity by taking photographs and collecting the artefacts made by participants (e.g., empathy/journey maps) (Sanders & Stappers, 2012).

All staff participants were paid for their time and mileage to participate in the workshops. Older adults and their family caregivers were offered a $100.00 CAD honorarium in the form of a VISA gift card for their participation.

7.3.4 Data Analysis

Immediately following the co-design workshop, the primary researcher (JG) led a debrief session with the facilitators and facilitator helpers to discuss their initial overall impressions of the day, similarities and differences across small groups and standout themes that would contribute to the implementation framework for an integrated geriatric care planning approach in home care. The main facilitator also collected facilitator notes, photographs taken throughout the day, the various creative artefacts that were made by participants during the activities, and the completed co-design feedback surveys. Directed content analysis was completed on the various sources of data by the primary researcher (JG) using the key categories of an implementation framework according to Moullin et al. (2015) to guide the coding process: 1) influencing factors; 2) strategies for implementation; and 3) evaluations of successful implementation (Hsieh & Shannon, 2005; Moullin, Sabater-Hernandez, Fernandez-Llimos, & Benrimoj, 2015). Data from the co-design feedback survey were entered into Microsoft Excel for analysis. Descriptive statistics were calculated using SPSS 20 software (IBM, 2007).

7.3.5 Ethical Considerations

This study received ethics clearance from the University of Waterloo Office of Research Ethics (ORE #19586 & #22251).

7.4 Results

7.4.1 Participants

A total of 19 participants took part in the co-design workshop, including older adults (*n* =

5), family/friend caregivers ($n = 9$) and point of care providers ($n = 5$). All workshop participants were female. Two of the older adults, six of the family/friend caregivers and none of the point-of-care providers had previously participated in the solutions-focused interviews. Four of five of the older adults lived alone. Four of the family/friend caregivers were spouses of older adults, three were adult daughters and two had other family/friend relationships to an older adult receiving home care services. Point-of-care provider participants included a nurse, occupational therapist, physiotherapist, dietitian and a social worker (see Table 7.1).

Table 7.1 Co-design workshop participant characteristics

Participant characteristics	Older Adults (*n=5*)	Family/Friend Caregivers (*n=9*)	Point-of-care providers (*n=5*)
Previously Interviewed *n*	*2*	*6*	N/A
Gender *n*	Female: *5*	Female: *9*	Female: *5*
Other descriptors *n*	Lives alone: *4* Lives with spouse: *1*	Spouses: *4* Adult daughters: *3* Other: *2*	Nurse: *1* OT: *1* PT: *1* Dietitian: *1* Social worker: *1*

7.4.2 Data from the Co-Design Workshop

The co-design workshop produced 40 completed worksheets (artefacts) from the gamestorming activities, and 53 photographs (see Table 7.2). The debriefing session also produced 5 double-spaced pages of typed notes documented by the primary researcher (JG).

Table 7.2 Data from the co-design workshop

	Worksheets Completed (Artefacts)	Photographs
Activity #1	16	13
Activity #2	6 large sheets with 432 sticky notes/ colour-coded tiles	18
Activity #3	9	6
Activity #4	9	16

The artefacts collected from workshop activities included both text and pictorial data (see

Figures 7.1a-d).

Figure 7.1a Sample artefact from activity #1

Figure 7.1b Sample artefact from activity #2

Figure 7.1c Sample artefact from activity #3

Figure 7.1d Sample artefact from activity #4

7.4.3 Implementation Framework

An implementation framework for integrated geriatric care planning in home care emerged from the data that included three major influencing factors: 1) inclusive assessment practices; 2) dialogue-based goal-setting; and 3) flexible communication strategies. These factors were supported by various strategies for implementation discussed in the workshop, including some specific recommendations about tools and technology to be explored. Finally, ideas for evaluation emerged through understanding ideal outcomes from the various participant perspectives (see Table 7.3). The sections to follow provide an explanation of the data that led to the development of the various components of the implementation framework.

Table 7.3 Implementation framework for integrated geriatric care planning in home care

Influencing Factors	Inclusive Assessment Practices	Dialogue-Based Goal-Setting	Flexible Communication Strategies
Strategies	Collaborative assessment by all point-of-care providers using a common assessment tool(s) that integrate with the RAI-HC	Point-of-care providers use observation and interview skills to co-create and document realistic, meaningful and measureable goals with older adults and family/friend caregivers	Everyone involved has equal and consistent access/ ability to update information on goals, progress and setbacks using a format chosen by older adults/ family/friend caregivers
Potential Tools and Technology	• Short common assessment tool • LHIN-owned data • Personal biography Sheet	• Interdisciplinary binder • Whiteboard in the home • Decision-making tree/map	• Online portal • In-home communication book • Common smart device • Application on tablet
Evaluations	The information everyone needs	The experience everyone wants	Feeling part of a virtual team

7.4.4 Inclusive Assessment Practices

Data from all gamestorming activities pointed to the need for assessment practices at the point-of-care to be inclusive of all perspectives including point-of-care providers, older adults and their family/friend caregivers. Activity #1 asked participants to list the five most important pieces of information they would want point-of-care providers to know or would want to know as point-of-care providers. Most of the important items listed by participants pertained to information that would lie with the older adult or family/friend caregiver and would be applicable to all point-of-care providers, irrespective of discipline. For example, almost all participants listed that point-of-care providers need to know about the older adult's social support system, including family composite and dynamics, family/friend caregiver availability, financial situation/source of income and social and community networks. When asked why this type of information was important to them, participants wrote statements like:

"to be able to fill in the gaps/identify how best to support the patient" –point-of-care provider;

"this helps me make appropriate recommendations and involve caregivers" –point-of-care provider;

"you can give more personal care and understand the patient better" –older adult;

"when speaking to the patient you can incorporate some of their likes when caring for the patient" –older adult; and

"it helps to have confirmation of what I am seeing" –family/friend caregiver.

These statements indicate that participants see a benefit and value for the application of inclusive assessment practices in terms of seamless information, appropriate recommendations, personalized care and confidence level in their own abilities.

In terms of strategies to support inclusive assessment practices, gamestorming activity #2 revealed participants' strong belief that point-of-care providers should participate in a collaborative assessment process where each provider would build on the previous providers' findings during their first home care visit with an older adult. One of the scenario cards in this activity details the experience of an older adult and family/friend caregiver being asked about the same information multiple times by different providers. Participants were asked to discuss opportunities around this scenario card in terms of the collection of information. Participant responses across all three small groups (expressed anonymously on sticky notes) were indicative of the need for a simple, user-friendly and collaborative approach that integrates with what is being done for service allocation at the LHIN (e.g., the RAI-HC data). Some sticky notes read:

"one sheet with all professionals involved";

"one point of info that is easy to use and find";

"proper assessment…initial assessment done as team"; and

"LHIN should gather and share [data] through in-person visit".

Participants felt strongly that this team-based approach to assessment would limit the need for

121

the older adult and family/friend caregiver in the scenario to tell their story multiple times.

Activities #3 and #4 allowed participants to push beyond this general strategy of collaborative assessment to create and try out some ideas for tools and technology that could support this strategy. Three major ideas were co-created by older adults, family/friend caregivers and point-of-care providers specific to assessment. The first idea was for a short paper-based common assessment tool that would be kept in the home so that any provider could contribute to it and/or review it during their first home care visit. Important information identified by participants to be assessed by this tool included medication schedule, assistive devices, symptoms and major problems, therapeutic goals and safety concerns (see Figure 7.2a). Another idea that emerged through these activities was to apply "LHIN-owned" (RAI-HC) data more effectively. Participants shared that everyone involved in the circle of care should have access to a client's file, which would prevent unnecessary duplication and redundant assessments. Further, participants felt that information at the point-of-care should be transmitted to the LHIN in order to ensure they continue to have updated and accurate information for service allocation purposes (see Figure 7.2b). The last idea about tools and technology for assessment that emerged through activities #3 and #4 was for the development of a personal biography sheet. Participants felt it would be important for point-of-care providers to work with older adults and family/friend caregivers to fill out a one page sheet with non-clinical background information about the older adult including information on family, occupation, best memories, hobbies and interests and favourite foods, for example. Participants felt the biography sheet should be left in the home and for all point-of-care providers to look at it at the start of their visit to understand a more holistic picture of the person they are working with (see Figure 7.2c).

Figure 7.2a Common paper-based assessment tool

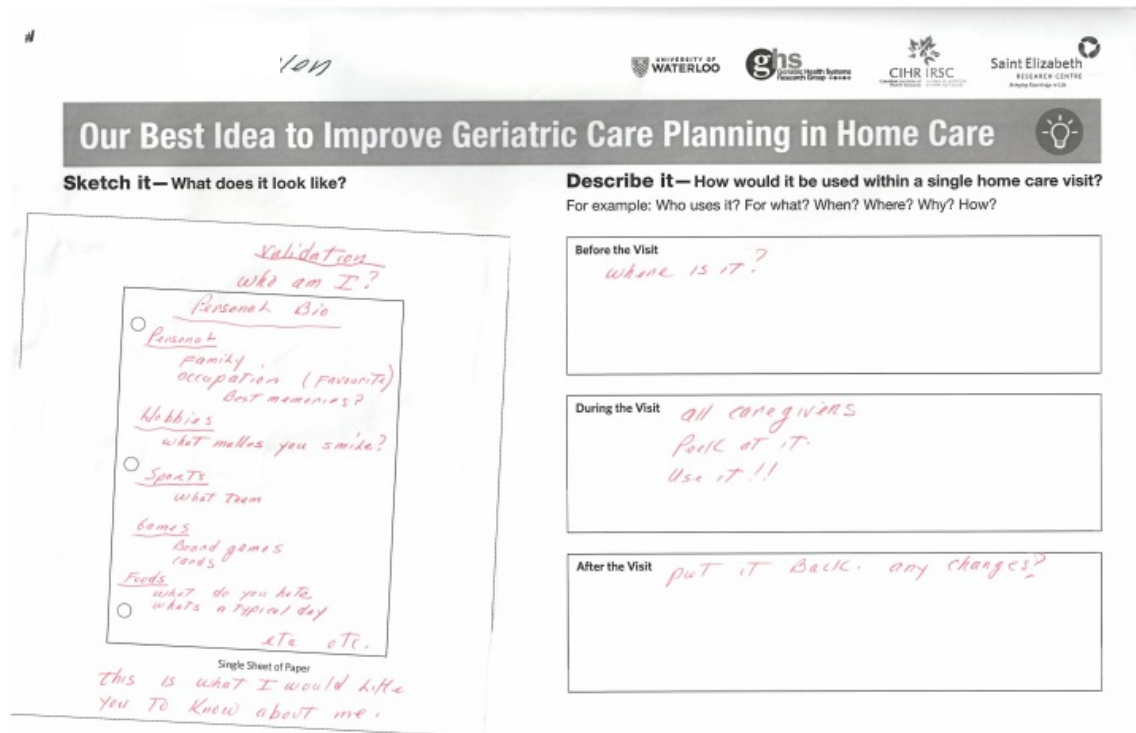**Figure 7.2b Better use of LHIN-owned data**

Figure 7.2c Personal Biography Sheet

Participants discussed various ideal outcomes from an emotional perspective during activity #2 related to assessment practices, including the need to feel knowledgeable, confident, and able to meet the needs of the care situation. Looking across all activities, the following information emerged as necessary to everyone at the point-of-care:

- Familial/social/financial supports

- Safety/risks/medical directives

- Overall cognitive status/ mood

- Health history/primary concern

- Personal history/interests

- Members of the care team

- Nutrition/meals/eating habits

- Hearing and vision

- Medication

According to participant contributions to the co-design activities, evaluating successful implementation of inclusive assessment practices at the point-of-care would require a measure of whether everyone involved felt like they had the information that they needed to confidently participate in the care situation.

7.4.5 Dialogue-Based Goal-Setting

All gamestorming activities revealed data indicating that point-of-care goal-setting must be based on a conversation and ongoing dialogue between older adults, their family/friend caregivers and point-of-care providers. Going beyond just asking family/friend caregivers about information to asking them why the information is important to them in activity #1 prompted participants to explicitly list their goals in their reasoning. Statements from the worksheet included:

"I want a deeper understanding of my condition, of treatment outcomes" –older adult;

"I want to stay in my apartment as long as possible" –older adult;

"It is important to me that he be safe while I was out running errands" –family/friend caregiver; and

"It would give me time for my family" –family/friend caregiver.

These statements indicate that participants were more than able to articulate their goals when information-gathering is approached in a way that encourages their participation and sharing.

In terms of a strategy to support the influencing factor of dialogue-based goal-setting, data from activity #2 revealed participants' views that point-of-care providers should use their observation and interview skills to co-create and document realistic, meaningful and measureable

goals with older adults and their family/friend caregivers. One of the scenario cards in activity #2 detailed the experience of an older adult pondering his goal to attend a classic car show that is unknown to point-of-care providers. Participants were asked to discuss opportunities around this scenario card in terms of goal-setting. Responses across all three small groups were indicative of the need for dialogue in the goal-setting process. For example, some sticky notes read:

"goals in own words";

"patients values and goals";

"having a provider ask and listen to patients' needs which may be non-medical";

"open conversations";

"listening and learning";

"sharing experiences";

"feeling heard and encouraged";

"what do you want to get out of this care?"; and

"relationship/connection with health care provider".

Building relationships and trust through dialogue was expressed as important to participants through ensuring older adults and family/friend caregivers feel invited to share, feel heard and have the opportunity to indicate what success looks like to them in their care.

In terms of tools and technology that would support a dialogue-based goal-setting strategy, participants co-created three different ideas in the workshop through activities #2, #3 and #4. The first idea emerged as an interdisciplinary binder that would remain in the home at all times and have separate tabs for each discipline of provider that is working with the older adult as well as a tab for older adults and family/friend caregivers. Participants felt that everyone involved in the circle of care should have access to client information from each discipline, including family/friend caregiver needs, and that progress notes could be created and left to ensure ongoing dialogue among the team (Figure 7.3a). The second idea that emerged was for a

whiteboard/ communication board in the home. Some participants felt that having a visual representation of the older adult and/or family/friend caregiver goals in the home would be superior to having them written in a book format where they may or may not be seen on a regular basis (Figure 7.3b). Another idea that emerged in terms of tools and technology to support dialogue-based goal-setting was the concept of a decision-tree or map that could support the goal-setting process. Participants felt that key considerations, questions and contacts could be included in this decision-tree to assist point-of-care providers, older adults and family/friend caregivers move from open-ended questions to sharing through discussion and ultimately to defining goals and supports (Figure 7.3c).

Figure 7.3a Interdisciplinary binder

Figure 7.3b Whiteboard communication
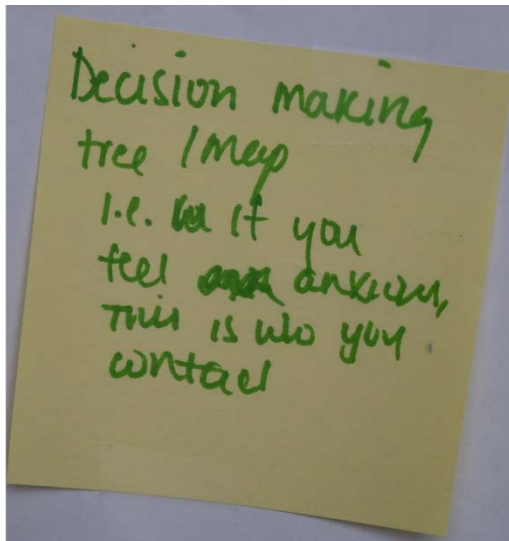
Figure 7.3c Decision-making tree/map

In terms of evaluating the influencing factor of dialogue-based goal-setting, participants expressed through activity #2 some key emotional outcomes that could be achieved through this approach, including feeling empathy, trust, having clear expectations, feeling safe, being optimistic, motivated and feeling supported. According to participant discussions, all of these outcomes are relevant to each of the perspectives involved including older adults, family/friend caregivers and point-of-care providers. Understanding these outcomes from each perspective could be achieved through measuring patient, family/friend caregiver and point-of-care provider

experiences.

7.4.6 Flexible Communication Strategies

The need for flexible communication strategies among all individuals involved at the point-of-care emerged from the gamestorming activities as a key influencing factor for the implementation of integrated geriatric care planning in home care. Participants felt that the process of communication and information-sharing should be consistent, but that the method in terms of how the communication takes place should be adaptable to suit the needs of each unique care situation. Data from activity #1 revealed that all types of participants are not only open to communication with other members of the team, but feel that good communication practices can positively benefit their individual experience in terms of both receiving and providing care. Statements from activity #1 worksheets included:

"[they] can e-mail us, we look up new meds and procedures" –family/friend caregiver;

"reduce my organizational challenges" –family/friend caregiver;

"essential to have access to a thorough medical assessment/history to provide good care and avoid having the client answer the same questions" –point-of-care provider;

"it is important for family to be close because they don't feel they have been forgotten" –point-of-care provider; and

"would like updates etc. health care providers need to share information" –older adult.

Participants' comments on the importance of communication were less focused on the actual vehicle of communication and more focused on the process and the outcomes of communication.

In terms of a strategy to support the implementation of the influencing factor of flexible communication strategies, participants vocalized the need for everyone involved at the point-of-care to have equal and consistent access and ability to update information on goals, progress and

setbacks using a format chosen by the older adult and family/friend caregivers. One of the scenario cards in activity #2 detailed a physiotherapist coming into the home for the first time after the older adult had been on service for over a week and asking him many of the same questions he had already answered about his health status to other providers. When participants were asked to dialogue about opportunities around communication and information-sharing in this scenario, many different ideas for how to make the process more seamless emerged. For example, some sticky notes read:

"multidisciplinary charting that patients and caregivers can access";

"clear writing or online";

"large print chart";

"skype among team";

"paper plan";

"electronic plan"; and

"available electronically and in home".

There was consensus among participants that there is not one format of communication and information sharing that would work universally across all situations and therefore having the older adult and family/friend caregiver dictate the methods they were most comfortable with or most preferred would be most aligned to a person-and family-centred care approach.

Through activities #3 and #4, participants were able to co-create four different ideas for tools and technologies they felt would work best to facilitate communication among all members of the care team at the point-of-care, including older adults and family/friend caregivers. The first idea that emerged was for an online portal to be developed that could be updated with 3-4 lines of information following every provider visit. Participants felt these 3-4 lines of information should be written in lay language so that it was understandable to any member of the

130

point-of-care team, including older adults and family/friend caregivers. Participants indicated that the online portal could also be supplemented by a one-page handout that would detail the members of the point-of-care team and their individual contact information for one-on-one communication (Figure 7.4a). The second idea that emerged from participants was for an in-home communication book to be created where all members of the point-of-care team could record their observations of the care situation and review and act on the observations made by others (Figure 7.4b). The third idea that emerged through activities #3 and #4 was for everyone to be given a common smart device pre-loaded with the same software/programs for communication to ensure compatibility and consistency across members of the point-of-care team. Point-of-care provider participants felt that this would particularly help in situations where information-sharing barriers arise as a result of multiple provider organizations being involved and using different charting systems (Figure 7.4c). Lastly, there was an idea to develop a mobile application (app) that could be downloaded and used on a tablet. Participants described the app having both a charting and documentation function where information could be viewed, entered and updated by any member of the team, including older adults and family/friend caregivers. Participants also explained that the app could function as a conversation tool during a visit, where providers would show and explain the information they are adding to the app to ensure understanding (Figure 7.4d).

Figure 7.4a Online portal

Figure 7.4b In-home communication book

Figure 7.4c Common smart device

Figure 7.4d Mobile application

In terms of evaluation of the influencing factor of flexible communication strategies, participants indicated that communication in home care most often had to be done remotely, whether by paper or electronic means, as there would be a rare occasion where all team members would be in the same place at the same time. Clear expectations around accountability and adequate time to participate in communication and information-sharing emerged as important facilitators. Another key element that emerged in terms of evaluation was the constant need to understand and reinforce that older adults, their family/friend caregivers and providers such as PSWs are recognized as important members of the care team. This need for virtual team communication emerged strongly in activity #2 in response to all scenario cards. Some sticky notes read:

"fam[ily] members recognized as care providers";

"PSWs as coordinators";

"defined roles for different members of the team";

"chain of accountability"; and

"extra half hour per day for providers to read and share".

According to participant input, measuring successful communication at the point-of-care would require understanding whether everyone involved felt like they were part of and contributing to a virtual home care team.

7.4.7 Co-Design Experience Feedback Survey

The co-design experience feedback survey revealed that all participants had an overall positive experience participating in the workshop. Participants mostly felt like they had the right information to participate in the discussions during the co-design activities ($M = 4.17$ on a 5 point scale where $1 =$ not at all and $5 =$ always). They also felt very comfortable to share their experiences, ideas and opinions during the co-design session ($M = 4.33$ on a 5 point scale where

1 = not at all and 5 = extremely). Mostly, participants felt heard and understood (M = 4.61 on a 5 point scale where 1 = not at all and 5 = always) and encouraged by the facilitators of the co-design activities to share their ideas for improvement (M = 4.67 on a 5 point scale where 1 = not at all and 5 = always). Participants were very comfortable being separated into small groups for the workshop (M = 4.50 on a 5 point scale where 1 = not at all and 5 = extremely) and mostly felt that everyone in their small groups had an opportunity to participate in the discussions (M = 4.5 were 1 = not at all and 5 = always). The empathy/journey mapping exercise (activity #3) was thought to be somewhat useful by participants (M = 3.92 on a 5 point scale where 1 = not at all and 5 = extremely). Participants were very confident that their contributions during the workshop would influence change (M = 4.07 on a 5 point scale where 1 = not at all and 5 =e xtremely) and indicated they were very likely to participate in another co-design workshop in the future (M = 4.80 where 1 = not at all and 5 = extremely). Satisfaction with the organizational elements of the workshop was also high (M = 4.80-5.00 on a 5 point scale where 1 = not at all satisfied and 5 = very satisfied). A breakdown of co-design experience feedback survey results by participant group can be found in Table 7.4

Table 7.4 Co-design feedback survey

Survey item	All participants (*N* = 18)*	Older adults (*n* = 4)	Family/Friend Caregivers (*n* = 9)	Point-of-care providers (*n* = 5)
	M (SD) (min-max)	*M (SD)* (min-max)	*M (SD)* (min-max)	*M (SD)* (min-max)
Right information to participate in discussions	*4.17 (0.806)* (2-5)	*4.00 (0.82)* (3-5)	*4.00 (0.87)* (2-5)	*4.60 (0.55)* (4-5)
Comfort to share experiences/ideas/opinions	*4.33 (0.87)* (2-5)	*4.50 (0.58)* (4-5)	*4.11 (0.93)* (2-5)	*4.60 (0.89)* (3-5)
Extent were you heard and understood	*4.61 (0.62)* (3-5)	*5.00 (0)* (5-5)	*4.56 (0.53)* (4-5)	*4.40 (0.89)* (3-5)
Encouraged to share your ideas	*4.67 (0.62)* (3-5)	*4.75 (0.50)* (4-5)	*4.56 (0.73)* (3-5)	*4.80 (0.45)* (4-5)

Comfort with sitting in small groups	*4.50 (0.73)* (3-5)	*4.75 (0.50)* (4-5)	*4.22 (0.83)* (3-5)	*4.80 (0.45)* (4-5)
Extent everyone had an opportunity to participate	*4.50 (0.51)* (3-5)	*5.00 (0.58)* (4-5)	*4.33 (0.71)* (3-5)	*4.80 (0.45)* (4-5)
Usefulness of empathy/journey mapping exercise	*3.92 (0.67)* (3-5)	*3.50 (0.71)* (3-5)	*4.00 (0.82)* (3-5)	*4.00 (0.71)* (3-5)
Confidence that contributions will influence change	*4.07 (0.82)* (3-5)	*3.50 (0.71)* (3-5)	*4.38 (0.74)* (3-5)	*3.80 (0.84)* (3-5)
Satisfied with food/drink	*4.93 (0.28)* (4-5)	*5.00 (0)* (5-5)	*4.88 (0.35)* (4-5)	*5.00 (0)* (5-5)
Satisfied with frequency of breaks	*4.87 (0.38)* (4-5)	*5.00 (0)* (5-5)	*4.75 (0.46)* (4-5)	*5.00 (0)* (5-5)
Satisfied with accessibility of the room	*5.00 (0)* (5-5)	*5.00 (0)* (5-5)	*5.00 (0)* (5-5)	*5.00 (0)* (5-5)
Satisfied with proximity to washrooms	*4.93 (0.28)* (4-5)	*5.00 (0)* (5-5)	*5.00 (0)* (5-5)	*4.80 (0.45)* (4-5)
Satisfied with parking	*4.87 (0.55)* (3-5)	*5.00 (0)* (5-5)	*4.75 (0.71)* (3-5)	*5.00 (0)* (5-5)
Likelihood to participate in another co-design session	*4.80 (0.44)* (4-5)	*4.50 (0.71)* (4-5)	*4.75 (0.46)* (4-5)	*5.00 (0)* (5-5)

*one workshop participant did not fill out a co-design experience feedback survey because they left the workshop a few minutes early

7.5 Discussion

Co-creation with older adults, family/friend caregivers and point-of-care providers led to the development of an implementation framework for more integrated geriatric care planning in home care that detailed the influencing factors, strategies, tools, technology and potential evaluation methods that should be taken into consideration when operationalizing this approach in practice.

7.5.1 Inclusive Assessment Practices

Comprehensive geriatric assessment (CGA) in home care highlights the importance of interdisciplinary team participation in the assessment, with each team member contributing their unique knowledge and skillset to a holistic view of an older adult's needs (Ellis et al., 2011; Kay et al., 2017). Findings from the present study are aligned to this approach, but in the context of

improving integration, participants asserted that interdisciplinary assessment should supplement

and build from an inclusive assessment process at the point-of-care. The term 'inclusive

assessment' is new in the context of health care, but has strong roots in the field of education,

where it is used to ensure the diverse learning needs and abilities of students are accommodated

in the assessment process to maximize personal, social and academic growth (Keating, Zybutz,

& Rouse, 2012). Participation in inclusive practices offers the "opportunity to solve

psychological and social conflicts, experiment with new ideas, new relationships and new roles,

which in turn facilitate active thinking skills, intellectual development and motivation" (Gurin,

Dey, Hurtado, & Gurin, 2002; Kaur, Noman, & Nordin, 2017, p. 757). According to the results

of the present study, inclusive assessment practices to promote integrated geriatric care planning

in home care would require the initial assessment process and tool(s) to accommodate

participation from any and all disciplines of point-of-care providers in addition to older adults

and their family/friend caregivers. From this integrated approach to collecting information that

everyone at the point-of-care needs, individual providers could then proceed with their own

discipline specific assessments that would build on the initial inclusive assessment data.

In terms of what common assessment tool(s) to apply in an inclusive assessment

approach, participants developed ideas for a short paper-based assessment tool, better use of

LHIN-owned data (RAI-HC), and the need to collect more details on personal biography and

history. When looking at the information that participants indicated was needed by everyone at

the point of care, researchers noted a striking similarity to the information included in the

assessment of frailty using the Edmonton Frail Scale (Table 7.5). There is no single accepted

definition of frailty, but it is often conceptualized as a "multidimensional state of vulnerability

arising from a complex interplay of biological, cognitive, and social factors" (Fried et al., 2001;

137

Perna et al., 2017, p. 2). The Edmonton Frail Scale is a short, multidimensional clinical

assessment tool that has been demonstrated to be reliable and valid for use in both inpatient and

outpatient care settings to identify frail older adults most at risk for negative outcomes (Rolfson,

Majumdar, Tsuyuki, Tahir, & Rockwood, 2006). This measure is scored out of 17 and includes

questions on cognition, general health status, functional independence, social support,

medication use, nutrition, mood, continence and functional performance (Perna et al., 2017). In a

study that investigated the performance of three different conceptualizations of frailty in the

Ontario home care setting, the Edmonton Frail Scale was found to be a good predictor of

negative outcomes for older adults (Armstrong, Stolee, Hirdes, & Poss, 2010). Researchers

suggest that there is potential for the Edmonton Frail Scale to be used by non-specialists in home

care as a brief clinical instrument for measuring frailty in older adults and by doing so, proactive

measures and supports can be identified and targeted to these individuals to improve health

outcomes at no additional cost (Armstrong et al., 2010; Markle-Reid et al., 2006). This evidence

suggests that the Edmonton Frail Scale could be considered as a tool to support the

implementation of inclusive assessment practices at the point-of-care for more integrated

geriatric care planning.

Table 7.5 Comparison of study findings to Edmonton Frail Scale

List of information needed by everyone at the point-of-care from study participants	Edmonton Frail Scale
Familial/social/financial supports	Social Support
Safety/risks/medical directives	Functional Independence Functional Performance
Overall cognitive status/ mood	Cognition Mood
Health history/primary concern Hearing and vision	General Health Status

Personal history/interests	
Members of the care team	
Nutrition/meals/eating habits	Nutrition
Medication	Medication use
	Mood
	Continence

In terms of participants' suggestions to better integrate point-of-care assessment with LHIN-owned data from the RAI-HC, it is interesting to note that the study by Armstrong et al. (2010) referenced above used RAI-HC data to operationalize the Edmonton Frail Scale by selecting items in the RAI-HC that were comparable to the items in the Edmonton Frail Scale. This suggests that applying the Edmonton Frail Scale at the point-of-care could be done directly and collaboratively by the point-of-care team, if a RAI-HC has not yet been completed on a client (or will not be completed if a client is planned to be on service for less than 60 days) by the LHIN for service allocation. Alternatively, data from the RAI-HC could be shared with point-of-care providers in the format of an Edmonton Frail Scale score if it had already been collected by the LHIN for service allocation purposes. This type of approach could help to narrow the gap between assessment for service allocation and care planning purposes at the point-of-care in Ontario home care. The use of the Edmonton Frail Scale to support inclusive assessment practices will be an area for exploration in future stages of this research. One of the items that was recognized as important to participants that is not covered by the Edmonton Frail Scale is an assessment of older adults' personal history and interests. The recommendation in the present study for the development of a personal biography sheet for use at the point-of-care as part of an

inclusive assessment process is reasonable, and should be explored in future phases of this work.

In terms of measuring inclusive assessment practices, evidence from the education context reveals that equal opportunity to participate in the assessment process has a positive impact on engagement, relationships, role clarity and problem solving (Kaur et al., 2017; Keating et al., 2012). Therefore, it would be valuable to assess whether everyone involved in the care team, including older adults and family/friend caregivers, felt that they had the information they needed to actively and effectively participate in care. One existing tool that could be explored in the evaluation of the influencing factor of inclusive assessment in older adults is the Patient Activation Measure, which assesses the knowledge, skills, beliefs and behaviours that an individual requires to manage a chronic illness or condition (Hibbard, Stockard, Mahoney, & Tusler, 2004). From a caregiver perspective, the Family Caregiver Preparedness Inventory could be explored as a measure of successful inclusive assessment practices (The Change Foundation, 2016). This eight-item instrument is a self-assessment of family caregiver readiness for providing physical care, providing emotional support, coordinating home care services and managing stress (The Change Foundation, 2016). Lastly, point-of-care provider self-efficacy could be a measure of inclusive assessment practices. For example, a recent study demonstrated the ability to measure nurses' knowledge and skill levels for quality dementia care using the Dementia Self-Efficacy scale (Hopkins, 2017).This scale could be developed to be more broadly applied across patient populations, or a new self-efficacy scale could be explored in future phases of this work.

7.5.2 Dialogue-Based Goal-Setting

Shared decision-making between health care providers and patients has been cited to involve a clinical consultation where there is consideration of the options available and the risks

140

and benefits to the patient in the context of what is important to them in order to reach a mutual

decision that is clinically appropriate and aligned to patient values (Butterworth & Campbell,

2014; Lally, 2012). The findings from the present study are aligned to the process of shared

decision-making, but focus on a more upstream interaction between older adults, family/friend

caregivers and health care providers to link shared-decision-making to the goal-setting process,

before treatment options are considered. This concept emerged in the implementation framework

as the influencing factor of dialogue-based goal-setting, where point-of-care providers would

engage older adults and family/friend caregivers in proactive discussions about their life goals to

inform the care planning process. This is in line with recommendations from a recent study on

home care communication where authors point out the need for providers to spend more time

paying attention to older adults' existential needs, rather than simply on bodily functions

(Kristensen Dorte et al., 2017). In a study conducted by Shulman-Green et al. (2006), the authors

explored the concept of goal-setting as a shared decision-making strategy among clinicians and

older adults. It was revealed, however, that clinicians were not convinced that older adults were

capable of participating in a dialogue about their goals, with one physician stating:

> when you actually do have that conversation on what the patient's goals are, often you
> get a blank stare back. Well, if you're the doctor, you know what is best, so I think in
> many ways having the awareness to bring up the topic is difficult, and then once you
> bring it up it's not necessarily a dialogue (p.149).

Further, clinicians within that study talked about providers lacking training on consideration of

patient-driven goals. Another physician stated:

> it seems to me like when we talk about goals there are many different domains of goals,
> and that medical training ... [focuses] on what the physicians' goals should be. For
> example, with diabetes, we want a hemoglobin and such and such and there hasn't been
> much focus on having that conversation of what the patient's goals are (p.147).

These findings suggest that clinicians may need support, training and resources to participate in

dialogue-based goal-setting at the point of care.

The emergent strategy to support dialogue-based goal-setting in the present study was for point-of-care providers to use their observation and interview skills to work with clients and family/friend caregivers to set meaningful and measurable goals. Participants co-created the idea that a decision-tree or map could aid point-of-care providers in navigating these kinds of conversations and help to facilitate the goal-setting process. One goal-setting method that could potentially be adapted to support dialogue-based goal-setting at the point of care is Goal Attainment Scaling (GAS). GAS is a well-cited individualized outcome measurement technique that has been used with a wide variety of patient populations across the continuum of care for both research/evaluation and clinical/therapeutic purposes (Rockwood, Stolee, & Fox, 1993; Stolee, Zaza, Pedlar, & Myers, 1999). GAS has been used to evaluate patient-centred outcomes with the geriatric population in both institutional and home-based settings and with a wide range of health care providers including nurses, occupational therapists and physiotherapists (Hale, 2010; Lannin, 2003; Rockwood et al., 2003; Rockwood et al., 1993; Stolee et al., 2012; Stolee et al., 1999). GAS allows clinicians to select multiple goals for a patient based on their unique health situation and concerns and then scale these goals on a five point scale to allow measurement of the degree of goal attainment over a specified amount of time. Further, the GAS method allows for the calculation of a standardized goal attainment score, which can be used to compare results across patient groups with different goals (Stolee et al., 1999). There have been reports of improved patient and family involvement in care planning in geriatric care settings as a result of using the GAS method, including using GAS to guide conversations with patients and families and helping patients to understand the progress they have made (Stolee et al., 1999). However, several barriers to using GAS have been cited in terms of understanding exactly what

process should be used to negotiate person-centred goals with patients and families and how to set these goals based on their specific needs and preferences (Hale, 2010). In one recent study on GAS in geriatric primary care, researchers cite the successful partnership between providers and patients in the development of person and family-centred goals, using the Canadian Occupational Performance Measure (COPM) as a way to identify patient needs, preferences and priorities in self-care, productivity and leisure activities (Toto, Skidmore, Terhorst, Rosen, & Weiner, 2015). The COPM is an outcome measure, designed to support occupational therapists in conducting a five-step semi-structured interview in order to assess individual, client-identified problem areas in daily function and produces both scores for satisfaction and performance (Law et al., 1990). The GAS method and the COPM measure could be explored in future phases of this research to operationalize the influencing factor of dialogue-based goal setting with older adults and family/friend caregivers.

The concept of positive health could be also be explored in future research phases to support dialogue-based goal-setting at the point-of-care with older adults and family/friend caregivers. Positive health emerged in 2011 as a new definition of health that recognizes the reality for people to cope with various ailments as they age and therefore acknowledges health as a means to a meaningful life, rather than an ultimate goal in and of itself (Huber et al., 2011). Positive health is defined as: "the ability to adapt and to self-manage, in the face of social, physical and emotional challenges" (Huber et al., 2016, p. 1). Within the concept of positive health there are four key pillars, including: 1) bodily functions; 2) mental well-being; 3) meaningfulness; 4) social-societal participation; and 5) daily functioning (Huber et al., 2016). A spider web assessment tool of the positive health pillars has been developed to support conversations between clinicians and patients in terms of what is most important to them. By asking patients

143

what they would most like to change and getting them to assign a numeric rating to each pillar, a visual representation or map of their goals for positive health can be created (Figure 7.5) (Huber, 2018). Applying this tool at the point-of-care in geriatric home care has the potential to support meaningful dialogue between point-of-care providers, older adults and family/friend caregivers and support the integration of life goals into the plan of care.
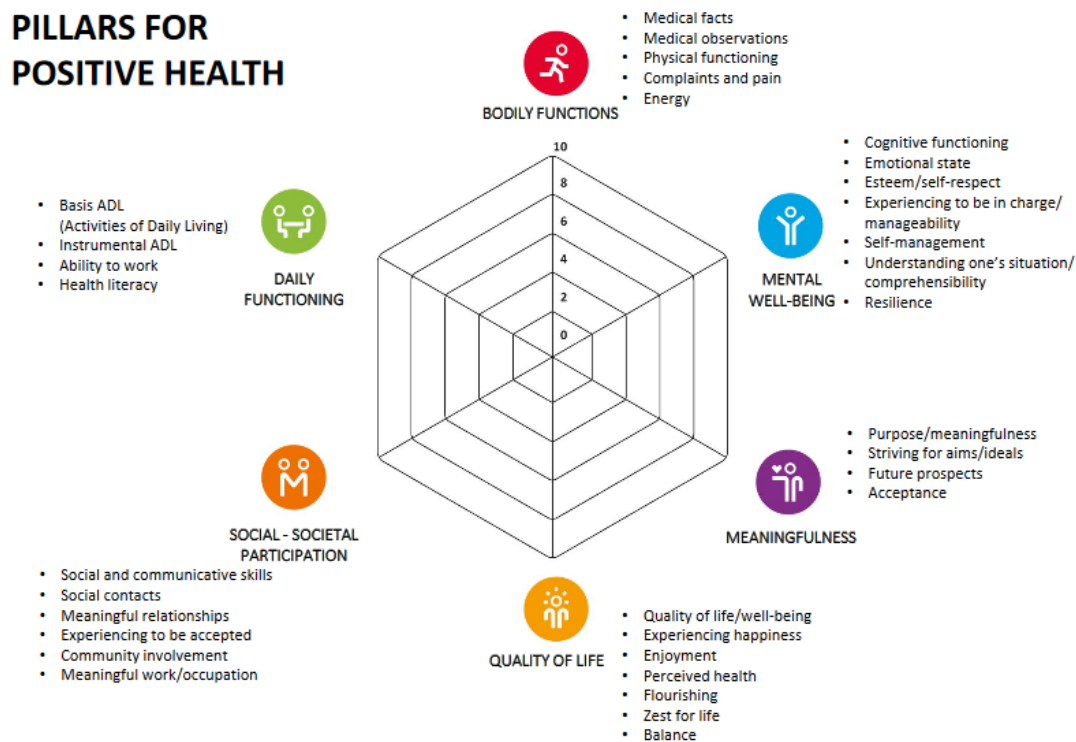
Figure 7.5 Pillars for positive health[9]

In terms of measuring successful dialogue-based goal-setting, co-design workshop participants' input pointed to the need to understand individual experiences from the older adult, family/ friend caregiver and point-of-care provider perspectives. Currently in Ontario, the home care experience is measured through the Client and Caregiver Experience Evaluation (CCEE) survey (Health Quality Ontario, 2018). The CCEE was developed in 2009 and is a self-report

---

[9] This figure was reproduced with permission of the lead author (see Appendix W)

measure of the experience of LHIN-funded home care services used for accountability, service provider performance management, public reporting and quality improvement (Health Quality Ontario, 2018). Currently, Health Quality Ontario, Health Shared Services Ontario and the University of Toronto are collaborating on the development of two new surveys of client and family/friend caregiver experience in home care to match the evolving acuity of services provided in the home care setting (Health Quality Ontario, 2018). There is an opportunity for the results of the present study to influence this work and help to ensure outcomes relevant to meaningful dialogue-based goal-setting are adequately captured in the new tools including empathy, trust, having clear expectations, feeling safe, being optimistic, motivated and feeling supported. In terms of measuring point-of-care provider experiences, a newly developed survey called the *Provider and Staff Perceptions of Integrated Care Survey* (PSPIC) could be explored in future research phases, which is a 21-item tool that covers the following topics related to dialogue-based goal-setting:

- Communication in a way that patients understand;

- Viewing patients as equal partners in care; and

- Routine encouragement of patients to actively participate in setting goals (Derrett et al., 2017).

Modifications to the PSPIC tool to explicitly include the family/friend caregiver would need to be explored to align with the present study findings.

7.5.3 Flexible Communication Strategies

The need for improved communication in the home and community care setting has been a longstanding recommendation in the health services literature, with providers wanting decreased information silos across disciplines and patients and families wanting better access to

their health information (Lyngstad, Hofoss, Grimsmo, & Hellesø, 2015; Pitsilldes et al., 2006; Toscan et al., 2012). The potential for information technology to improve communication in home care has been widely discussed, but under-developed and largely unrealized due to issues of compatibility, dual documentation, lack of buy-in and the need for more training and support (Koru, Alhuwail, Topaz, Norcio, & Mills, 2016; Lyngstad et al., 2015). Further, patients and families are often not explicitly included in the implementation of information technology solutions in health care, which tend to focus on enhanced communication among the clinical team (Koru et al., 2016; Pitsilldes et al., 2006). Findings from the present study are aligned with previous recommendations to optimize information technology to support communication at the point-of-care in home care but within the context of the influencing factor of flexible communication strategies. Co-design workshop participants stressed that the communication process itself should be the priority for standardization, supported by a variety of tools and technology offering the same communication functionality. Further, participants felt strongly that the vehicle of communication should be chosen by the older adult and family/friend caregiver to maximize their engagement and participation in an integrated care planning approach. Co-created ideas for tools and technologies to support flexible communication strategies included an online portal, in-home communication book, common smart device and a mobile app on a tablet.

Recently, researchers at the University of Toronto developed the Electronic Patient-Reported Outcome (ePRO) mobile application and portal and have tested its implementation in primary care (Hans, Gray, Gill, & Tiessen, 2018). The ePRO tool was created to support self-management and guide care planning for complex patient populations with the following functions, which allow patients and providers to:

- Collaborate on goal-setting;

146

- Input data, comments etc.;

- Adjust health goals and monitor progress; and

- Measure and report on standardized outcome measures.

Primary care study patient participants were given common Samsung smartphones to access the

ePRO app for the duration of the study and providers accessed the tool via a desktop portal

(Hans et al., 2018). Findings suggested a heavy resistance by point-of-care providers to adopt the

ePRO tool into their daily workflow practices, despite their acknowledgement that the app could

enhance care planning and self-management for complex patients (Hans et al., 2018). Change

management suggestions include enhanced education and training on the tool, better alignment

and integration of the tool across other systems in place and the need to address privacy and

liability concerns (Hans et al., 2018). A tool like the ePRO app could be explored in future

research phases to support flexible communication strategies in the home as it aligns to

participant suggestions around an electronic portal, common smart device and mobile

application, but more consideration would be required around change management in the pilot-

phase of this work. Further investigation is also required to understand how an in-home

communication book could mimic the functionality of an electronic tool for communication,

should that be the older adult/family/friend caregivers' preferred format.

In terms of measuring the successful implementation of flexible communication

strategies in geriatric home care planning, participants' input included finding a way to measure

whether older adults, family/friend caregivers and point-of-care providers felt that they were part

of a virtual home care team. One tool to explore in future phases of this research could be The

Index of Interdisciplinary Collaboration (IIC). The IIC was developed to measure the self-

reported level of collaboration among professional health care providers and has been applied in

community palliative care settings with a wide range of providers (Bainbridge et al., 2015). The IIC contains questions pertaining to:

- group commitment;
- common goals/shared values;
- perceived interdependence;
- reciprocity;
- respect;
- shared risk/responsibility;
- trust;
- communication;
- information systems and materials; and
- standardized assessment and monitoring of patient need (Bainbridge et al., 2015).

This index could provide guidance in terms of future directions for developing a measure of participation in virtual home care teams, although more work is required to understand variations in measuring this participation from the older adult and family/friend caregiver perspectives as there is no existing tool that could be found that explores their participation in interdisciplinary teams.

7.5.4 Strengths

The interpretation phase of the present study has several strengths. First, positive feedback on the co-design experience from all participants indicates that applying a generative research approach through gamestorming is an effective method for engaging older adults, family/friend caregivers and point-of-care providers in the co-production process. These findings build on recommendations in previous participatory design work with older adults for

researchers to engage care dyads in more design-oriented methods (Hwang et al., 2015). Further, focusing on what people say, what people do and what people make in the co-design workshop, resulted in tangible solutions that will help to close the 'know-do' gap in operationalizing the implementation framework for more integrated geriatric care planning in home care. Another strength of this research phase was the inclusion of multiple different types of providers including nurses, OTs, PTs, dietitians and social workers; whereas, the previous phases focused mainly on nurses, OTs and PTs. While PSWs did not participate explicitly in the workshop, activity #2 included both personas and scenario cards addressing the PSW role in care planning at the point-of-care.

7.5.5 Limitations

Several limitations should be acknowledged for the interpretation phase of this study. First, the co-design sample was representative of only one of the 14 LHINs in Ontario and therefore cannot be considered representative of all older adults, family/friend caregivers and point-of-care providers participating in geriatric home care across the province. Further, as all 19 co-design workshop participants were female, we cannot rule out the potential for a gender bias in the findings. Researchers also acknowledge that the gamestorming activities could not be designed to incorporate the wide range of unique geriatric care situations that exist in real practice, and therefore the activities themselves and/or the facilitation of the activities may have influenced the findings.

7.6 Conclusions

Meaningful engagement of older adults, family/friend caregivers and point-of-care providers in co-design through gamestorming narrows the 'know-do' gap in knowledge translation. The implementation framework for geriatric care planning at the point-of-care in

home care that emerged from this study includes tangible solutions co-created by system users. Geriatric care planning at the point-of-care that involves inclusive assessment, dialogue-based goal-setting and flexible communications strategies has the potential to enhance the experience of integrated care and improve integration between service allocation and care delivery. Next steps for this work include additional co-design workshops to further operationalize the solutions in the implementation framework and develop a pilot-testing phase of these solutions in real home care practice.

CHAPTER 8: SUMMARY AND GENERAL DISCUSSION

8.1 Thesis Summary

Developing an integrated geriatric care planning approach in home care was a sequential transformative mixed methods study that applied a pragmatic research lens and an ideology of collective creativity (Creswell et al., 2003; Feilzer, 2010; Sanders & Stappers, 2008; Sanders & Stappers, 2012).

Phase one of this study involved the development, psychometric testing and broad administration of the Geriatric Care Assessment Practices (G-CAP) survey tool with point-of-care home care providers across Ontario. Findings revealed that clinical observation and interview skills are used far more frequently than standardized assessment tools and data at the point-of-care in geriatric home care. While participants were in agreement with holistic assessment, goal-setting and collaborative team practices, the current home care structure does not include processess and tools to support them in exercising these practices at the point-of-care.

Phase two of this study involved solutions-focused key informant interviews with older adults and their family/friend caregivers to undrstand how care planning in home care could be re-oriented around their individual needs and preferences. Findings revealed that point-of-care providers could improve goal-setting at the point of care by: promoting respect and dignity through seeing beyond an individual's age during the care planning process; facilitating two-way information sharing through relational communication that prioritizes personal history, needs and preferences; encouraging participation in care by taking a reactivation approach to care planning; and fostering collaboration by allowing older adults and family/friend caregivers to make decisions about the care environment in their own home.

151

The interpretation phase of this research study applied generative research methods to conduct a co-design workshop with older adults, their family/friend caregivers and point-of-care providers. Building on the findings from phases one and two of this study, researchers designed interactive, hands-on gamestorming activities to engage stakeholders in the co-production of a new integrated geriatric care planning approach at the point-of-care in home care. An implementation framework emerged that included three key influencing factors for integrated geriatric care planning: 1) inclusive assessment practices; 2) dialogue-based goal-setting; and 3) flexible communication strategies. These influencing factors are supported by co-produced practical ideas for strategies, tools and technologies, as well as potential evaluation methods to determine successful implementation of the new approach.

8.2 What this study adds to current literature

Preceding chapters have discussed contributions to the literature for each stage of this research study, but several additional contributions of the overall research study should also be noted.

Due to the growing acuity of health care services and interventions being delivered in the home, the focus of care planning in recent home care literature has been on improving patient safety following transitions back to community from highly medical, institutional care settings (Kronhaus, Zimmerman, Fuller, & Reed, 2018; Laugaland, Aase, & Barach, 2012; Rostgaard, 2012). For example, a pan-national retrospective Canadian study on patient safety in home care uncovered an adverse event rate of 4.2%, with 56% of these events being preventable and most often related to falls; wound infections; psychosocial, behavioural or mental health issues; and medication errors (Blais et al., 2013). It was also uncovered that patients, caregivers and health care providers were all contributors to these avoidable adverse events (Blais et al., 2013).

Improved communication and information-sharing among clinicians, caregivers and patients has been cited as a key recommendation to enhance patient safety in the home care environment (Rostgaard, 2012). Another recent study applied data from the Resident Assessment Instrument-Home Care (RAI-HC), a standardized comprehensive clinical assessment tool, to demonstrate that patients at higher risk of adverse events such as long-term care placement and death would be more likely to benefit from psychosocial and mental health interventions in addition to medical care (Sinn et al., 2018). Findings from the current study add to existing literature on patient safety by providing practical solutions for improved assessment, goal-setting and communication practices through a lens of integrated care. The implementation framework for an integrated geriatric care planning approach in home care is aligned with the above areas of patient safety concern, hones in on both medical and psychosocial elements of care planning, and has the potential to promote partnerships and shared accountability between older adults, their family/friend caregivers and point-of-care providers in the care-planning process.

Findings from the current study also add to existing implementation science and knowledge translation literature. A recent systematic literature review on the comprehensiveness of implementation frameworks for innovations in health care uncovered that most implementation frameworks in the health care innovation space are descriptive and explanatory, and not prescriptive or predictive (Moullin et al., 2015). Descriptive frameworks include properties, characteristics and qualities of implementation; explanatory frameworks include information about linkages and relationships between concepts in a framework; predictive frameworks anticipate relationships between concepts of implementation; and prescriptive frameworks talk about the implementation process through steps and procedures (Moullin et al., 2015). A lack of predictive or prescriptive detail in an implementation framework limits its

applicability or action-oriented nature (Moullin et al., 2015). Descriptive and explanatory

frameworks may not move beyond the pre-implementation stage of development, which includes

innovation creation, refinement and impact evaluation, to implementation (Greenhalgh, Robert,

Macfarlane, Bate, & Kyriakidou, 2004). The current research study was guided by the

development phase of the Medical Research Council (MRC) framework for developing complex

interventions. At the outset of the study, researchers explicitly acknowledged the linkage and

relationship between the development stage and the testing, evaluation and implementation

stages of developing complex interventions and simultaneously worked within the Co-Creating

Knowledge Translation Framework to ensure that key stakeholders authentically contributed to

the development phase of the implementation framework (Powell et al., 2013). As a lack of

inclusion of patient perspectives in the development of integrated care interventions has been

cited as a pitfall of research in this area (Mittinty et al., 2018), this participatory approach

ensured the framework was both descriptive and explanatory, but also predictive in terms of how

each of the influencing factors, strategies and evaluations would contribute to the

implementation of integrated care planning (Craig et al., 2013). The prescriptive elements of this

implementation framework will be the focus of the next phase of this research in validating,

refining and piloting the framework in real home care practice.

This research also adds to current knowledge in integrated care in terms of understanding

the operationalization of its various dimensions described in the literature (Valentijn et al., 2015;

Valentijn et al., 2013). For example, the implementation framework for integrated care planning

at the point-of-care in home care has implications for clinical, professional, functional and

normative integration as defined by the Rainbow Model of Integrated Care (Valentijn et al.,

2015; Valentijn et al., 2013). In terms of clinical integration, the implementation framework

154

details three influencing factors that together would comprise a seamless holistic care planning process and experience for all stakeholders. In relation to professional integration, the framework proposes flexible communication strategies for enhancing interdisciplinary contributions to care planning at the point-of-care through a virtual team approach that is not dependent on providers being in the same place at the same time. Functional integration is captured in the implementation framework through detailing the tools, technologies and activities that would be required in terms of integrated service delivery of inclusive assessment practices, dialogue-based goal-setting and flexible communication strategies. Finally, in terms of normative integration, the resulting framework hinges on all stakeholders sharing the same goal in terms of working collaboratively to achieve an integrated care planning approach at the point-of-care (Valentijn et al., 2015; Valentijn et al., 2013).

8.3 Implications

8.3.1 Policy

The findings of this study are timely within the current political landscape of Ontario. Major criticisms of the current Ontario health care system include that its administration-heavy, bureaucratic and opaque structure creates too much waste in a system that needs more frontline care across all sectors (Picard, 2018a). For example, Ontario has over 94 arms-length government health care agencies and the number keeps growing (Picard, 2018a). In terms of home and community care, the former Liberal government announced plans late in 2017 that they were going to become involved in direct service provision of point-of-care personal support services through a new government agency called Personal Support Services Ontario (Ontario Society of Occupational Therapists, 2018). The stated purpose of this new agency was to give high-users of the home and community care system (who receive 14 hours of care or more per

155

week) more control and easier access to services through self-directed care within a given budget (Ontario Society of Occupational Therapists, 2018). This announcement was cause for concern for independent for-profit and not-for- profit home and community care organizations across the province who strongly opposed this new agency for fear it would have negative consequences for and cause more confusion to clients, families, and health care workers across the already complex sector (Picard, 2018b).

Recently, a new Conservative government has come into power in Ontario. While there is a lack of clarity on any immediate future directions in the provincial health care system, it is clear that integrated care at the point-of-care in home care will need to be a major focal point to address the above pain points, rather than simply adding additional layers to the existing system or exclusively increasing capacity in other sectors. The election platform of the current Conservative government included plans to introduce 30,000 new institutional care beds over the next 10 years to improve patient access and flow (Ontario PC, 2018). In advance of the election, this strategy was called out by Dr. Samir Sinha, a lead for Ontario's Action Plan for Seniors, who strongly argued that more beds will exacerbate and not solve current issues in the system (Sinha, 2018). Dr. Sinha encouraged all government parties to look to the home and community care system in Denmark, which expanded drastically in the 1980s as a result of realizing the reason people were ending up and staying in hospitals was because there were not enough support services to keep them at home (Sinha, 2018). Findings from a recent study investigating alternative level of care (ALC) (a clinical designation for patients who no longer require the care intensity in their current setting but are awaiting placement elsewhere) in six Canadian hospitals support Dr. Sinha's recommendations, uncovering that insufficient home and community care supports, underestimation of patient potential for independence, deconditioning of patients in

hospital and poor knowledge of home care in the acute setting were the major reasons why patients tend to remain in hospital long after they no longer require acute care (Bender & Holyoke, 2018). Home care in Denmark has been praised for increasing visibility of political, administrative and user level practices; however, is still looking for strategies to balance and integrate standardization and individualization at the point-of-care (Rostgaard, 2012). The implementation framework for a new geriatric care planning approach at the point-of-care could help to inform this balance of standardization and individualization at the point-of-care in home care and improve integration between service allocation and care delivery in the sector. As the new provincial government moves forward in Ontario, plans for restructuring home and community care will likely emerge, which could provide opportunities to embed learnings from the current study on integrated care planning into home care structures across the province.

The need for integrated home care delivery for older adults extends beyond the province of Ontario and findings from the current study could inform future home care policy directions across Canada. While the funding structure and organization of health care differs across provinces, common themes exist in terms of meeting the needs of the growing population of older adults in Canada. For example, British Columbia, Alberta and Nova Scotia have all cited ALC issues as a result of poor access and lack of appropriately integrated home and community care and support services for older adults (Gerein, 2017 ; Longhurst, 2017; "Pictou County a model for Nova Scotia home care," 2016). In Nova Scotia, improved communication and coordination between the government funder, provider agency and patient/family members has been cited to improve wait times and increase access to home care services in a particular region ("Pictou County a model for Nova Scotia home care," 2016). The implementation framework for integrated geriatric care planning in home care could add some rigour and standardization to

157

these communication and coordination practices to help scale them up across the province and beyond. For example, The National Seniors Strategy that has been proposed in Canada calls for federal leadership in developing and sharing best practices, common standards, targets and benchmarks for home and community care provision across the country (Sinha et al., 2016). One of the four pillars of the National Seniors Strategy is "Care Closer to Home", which cites integrated care at home by providers with the appropriate knowledge and skills as a major requirement to achieve this aim (Institute for Research on Public Policy, 2015; Sinha et al., 2016). The implementation framework for integrated geriatric care planning in home care that emerged in the current study has the potential to inform best practices and common standards in terms of the knowledge and skills required by providers to enhance integrated assessment, goal-setting and communication at the point-of-care in the home care sector.

Findings from the present study are also in line with directions for aging policy internationally. For example, the International Federation on Aging (IFA) is a non-governmental organization on aging with a vision to protect and respect the health, rights and choices of older people through being a global liaison between experts working on age-related policy (International Federation on Aging, 2018). In August 2018, the IFA is hosting the 14th Global Congress on Aging in Toronto, Ontario where the main themes include: 1) combating ageism; 2) toward healthy aging; 3) age-friendly communities; and 4) addressing inequalities (International Federation on Aging, 2018). The current study was accepted for presentation under the combating ageism theme, as findings that emerged from the solutions-focused key informant interviews and the co-design workshop demonstrate not only that older adults are capable and wish to be engaged in research that impacts their care, but also that they have practical ideas and solutions for decreasing ageist attitudes and assumptions in the geriatric care planning process.

158

8.3.2 Practice

Within current Ontario home care practice, there is a revived interest in the RAI-HC as a result of the recent roll out of a refreshed suite of interRAI assessment tools for various sectors across the province. Additionally, the Canadian Institute for Health Information is launching the *Integrated interRAI Reporting System* that will bring together data from the updated versions of these tools with the goal to be able to offer closer to 'real-time' reporting (Canadian Institute for Health Information, 2018). LHINs and direct service provider agencies alike are currently participating in conversations and revisiting opportunities to make better use of standardized assessment data for care planning in home care. Findings from this research study are highly relevant and could inform next steps taken by these parties in terms of improved data sharing and integration for service allocation and point-of-care planning, involving a balance between standardized assessment and clinical judgment. Another practice issue in home and community care is the growing health human resources shortage to meet the increasing service demands being placed on the sector. Reports on this shortage have been calling for integrated care reform to improve the efficient use of the limited providers available within the sector for almost a decade (Erie St. Clair LHIN, 2010; Sun, Doran, Bloomberg, & Bloomberg, 2017). Findings from the current study offer tangible strategies and solutions that should be explored within the context of maximizing individual provider contributions and teamwork in care planning at the point-of-care, which could help the sector work towards adopting the National Health Service user-driven definition of integrated care for older adults: "I can plan my care with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes" (National Voices, 2013, p. 5).

8.3.3 Research

In terms of research implications, the current study adds to understanding in terms of how to conduct bottom-up integrated care research in home and community care that authentically engages system users throughout the entire research process (Wodchis et al., 2015). This confirms that the concept of 'nothing about me without me', that is often cited in health care practice to reinforce the need for patient engagement, not only should, but can be adopted more consistently in health services research studies (Delbanco et al., 2001). The positive feedback received through the co-design engagement survey in the interpretation phase of this research is further evidence of the success of this type of research engagement. Future research should explore and test the applicability of co-design through gamestorming activities in other areas of health services research with older adults, their family/friend caregivers and point-of-care providers.

The current study resulted in an implementation framework that details clinical, professional, functional and normative integration in geriatric home care planning according to three influencing factors and supporting strategies, tools, technologies and evaluation methods. This framework adds to knowledge on comprehensive geriatric assessment in home and community settings and at the point of care, whereas previously literature has been mainly focused on institutional settings (Avelino-Silva et al., 2014; Baztan et al., 2009; Caplan et al., 2004; Cohen et al., 2002; Ellis et al., 2011; Van Craen et al., 2010). Next steps in this research will aim to operationalize the elements of the implementation framework through additional engagement of system users in co-design activities in the development of a pilot test of the new approach in real home care practice. Future research studies should consider the use of the Co-Creating Knowledge Translation Framework in the development of health innovations and

interventions as a way to increase the action-oriented nature of the findings and enhance

potential for uptake and use (Powell et al., 2013).

8.4 Strengths and Limitations

This study had several noteworthy strengths. This project helps to address the major

dearth of academic literature on care planning in home care and publishing these findings will

contribute to the evidence-base on this topic from which to draw in future work. Applying a

pragmatic research lens and ideology of collective creativity ensured meaningful engagement of

older adults, their family/friend caregivers and point-of-care providers throughout the various

stages of the mixed methods research study (Creswell et al., 2003; Feilzer, 2010; Sanders &

Stappers, 2008; Sanders & Stappers, 2012). The researchers successfully introduced the

solutions-focused interview approach (Proudlock & Wellman, 2011; Welsh et al., 2014) and

generative research methods through co-design into the research study, which broadens

knowledge in research engagement practices within health services research (Sanders &

Stappers, 2012). Further, the focus on what people make, in addition to what people say and do,

through gamestorming activities promoted the inclusion of tangible strategies and solutions in

the implementation framework, as opposed to simply making recommendations, which will

facilitate an easier transition into the pilot phase of this work (Gray et al., 2010). Another

strength of this dissertation research study was its large sample size. In total, across the various

stages of the project, 396 stakeholders were engaged in the development of an implementation

framework for a new integrated geriatric care planning approach in home care.

This research study also had several limitations. First, the sample of home care

stakeholders was recruited specifically from the province of Ontario, where the structure of the

home care sector is complex and unique to other provinces across the country. This may limit the

generalizability of the findings in terms of implementation across Canada; however, the areas of improvement identified in terms of assessment, goal-setting and communication are consistent with the identified needs for integrated care in Canada (Better Home Care, 2016). Another limitation of the study is that stakeholders from only one of 14 Local Health Integration Networks (LHINs) in Ontario were engaged in the testing of the G-CAP survey, the solutions-focused interviews and the co-design workshop. The development and broad administration of the G-CAP survey, however, included point-of-care providers from various LHINs across the province and future research will focus on ensuring more equal geographic representation. It should also be noted that this research study recruited only English-speaking participants, and did not explicitly consider socioeconomic status or the different integrated care needs of marginalized groups in the development of the implementation framework. Future work could involve validating and adapting the framework to meet the needs of these sub-populations. Another limitation of this research was only conducting a single co-design workshop. If resources and time allowed, the researchers would have liked to host a variety of nested workshops across the province to further iterate and validate the emergent implementation framework. Finally, the G-CAP survey was focused specifically on nursing, occupational therapy and physiotherapy disciplines, which excluded a variety of other health care providers who work at the point-of-care in home care. While efforts were made to include other disciplines' perspectives in the co-design workshop, both in terms of the participants, and the gamestorming activities, future phases of this work will need to test the applicability of the findings across all disciplines.

8.5 Future Research Directions

Immediate next steps in this research study are to host additional nested co-design

162

workshop sessions to engage a wider sample of older adult, family/friend caregiver and point-of-care provider stakeholders in the co-production of the implementation framework. Goals of these sessions will be to confirm and refine the influencing factors of the framework and to further operationalize and prototype the strategies, tools and technologies that emerged in the current study for supporting more integrated geriatric care planning in home care. Once the implementation framework is finalized, researchers will aim to host a co-design session specifically on the design of a pilot trial of the new approach to geriatric care planning, which would involve further collaboration with stakeholders on the various methods for evaluating the successful implementation of each of the influencing factors in the framework. Finally, researchers have established that SE Health, a national health care organization in Canada with significant home and community care operations, will be a partner in running a pilot study of the new approach to integrated geriatric care planning in home care. SE Research Centre, an arm of SE Health, will be a collaborator in this future work.

8.6 Conclusions

According to older adults, their family/friend caregivers and point-of-care providers, geriatric care planning at the point-of-care could be more integrated through inclusive assessment practices, dialogue-based goal-setting and flexible communication strategies. Engaging older adults, their family/friend caregivers and point-of-care providers in participatory research methods enhanced the applicability and action-oriented nature of this mixed methods research study and resulted in an implementation framework that will be operationalized and pilot-tested in future phases of this work.

REFERENCES

Alloway, C. A., & Goldhar, J. (2018). *Transformation through integration: the answer is with patients and their families* Paper presented at the 18th International Conference on Integrated Care, Utrecht, Netherlands.

Anderson, B., Nix, E., Norman, B., & McPike, H. D. (2014). An evidence based approach to undergraduate physical assessment practicum course development. *Nurse Educ Pract, 14*(3), 242-246. doi:10.1016/j.nepr.2013.08.007

Armstrong, J. J., Stolee, P., Hirdes, J. P., & Poss, J. W. (2010). Examining three frailty conceptualizations in their ability to predict negative outcomes for home-care clients. *Age Ageing, 39*(6), 755-758. doi:10.1093/ageing/afq121

Aspinal, F., Glasby, J., Rostgaard, T., Tuntland, H., & Westendorp, R. G. (2016). New horizons: Reablement - supporting older people towards independence. *Age Ageing, 45*(5), 572-576. doi:10.1093/ageing/afw094

Auditor General of Ontario. (2015). *Annual report of the office of the auditor general of Ontario*. Toronto, ON. Retrieved from http://www.auditor.on.ca/en/reports_en/en15/3.01en15.pdf

Avelino-Silva, T. J., Farfel, J. M., Curiati, J. A., Amaral, J. R., Campora, F., & Jacob-Filho, W. (2014). Comprehensive geriatric assessment predicts mortality and adverse outcomes in hospitalized older adults. *BMC Geriatrics, 14*(1), 129. doi:10.1186/1471-2318-14-129

Bainbridge, D., Brazil, K., Krueger, P., Ploeg, J., Taniguchi, A., & Darnay, J. (2015). Measuring horizontal integration among health care providers in the community: an examination of a collaborative process within a palliative care network. *J Interprof Care, 29*(3), 245-252. doi:10.3109/13561820.2014.984019

Baranek, P. (2010). *Integration of care: summary report analysing the responses of all provider groups [Background Report]*. The Change Foundation. Toronto, ON. Retrieved from www.changefoundation.ca/site/wp.../integration_of_care_report1.pdf

Baranek, P. M., Deber, R., & Williams, A. P. (2004). *Epilogue. Almost home: reforming home and community care in Ontario* Toronto, ON: University of Toronto Press.

Bate, P., & Robert, G. (2006). Experience-based design: from redesigning the system around the patient to co-designing services with the patient. *Quality & Safety in Health Care, 15*(5), 307-310. doi:10.1136/qshc.2005.016527

Baztan, J. J., Suarez-Garcia, F. M., Lopez-Arrieta, J., Rodriguez-Manas, L., & Rodriguez-Artalejo, F. (2009). Effectiveness of acute geriatric units on functional decline, living at home, and case fatality among older patients admitted to hospital for acute medical disorders: meta-analysis. *BMJ Open, 338*, b50. doi:10.1136/bmj.b50

Beauchet, O., Launay, C. P., Merjagnan, C., Kabeshova, A., & Annweiler, C. (2014). Quantified self and comprehensive geriatric assessment: older adults are able to evaluate their own health and functional status. *PLoS One, 9*(6), e100636. doi:10.1371/journal.pone.0100636

Ben-Harush, A., Shiovitz-Ezra, S., Doron, I., Alon, S., Leibovitz, A., Golander, H., . . . Ayalon, L. (2017). Ageism among physicians, nurses, and social workers: findings from a qualitative study. *European Journal of Ageing, 14*(1), 39-48. doi:10.1007/s10433-016-0389-9

Bender, D., & Holyoke, P. (2018). Why some patients who do not need hospitalization cannot leave: A case study of reviews in 6 Canadian hospitals. *Healthcare Management Forum, 31*(4), 121-125. doi:10.1177/0840470418755408

Benner, P., Tanner, C., & Chesla, C. (2009). *Expertise in nurisng practice: caring, clinical judgement and ethics* (2nd ed.). New York, NY: Springer.

Bergold, J., & Thomas, S. (2012). Participatory research methods: a methodological approach in motion. *2012, 13*(1). doi:10.17169/fqs-13.1.1801

Bernard, H. R. (2000). *Social research methods*. Thousand Oaks, California: Sage.

Better Home Care. (2016). *Better home care in Canada: a national action plan*. Ottawa, ON. Retrieved from http://www.thehomecareplan.ca/wp-content/uploads/2016/10/Better-Home-Care-Report-Oct-web.pdf

Blais, R., Sears, N. A., Doran, D., Baker, G. R., Macdonald, M., Mitchell, L., & Thalès, S. (2013). Assessing adverse events among home care clients in three Canadian provinces using chart review. *BMJ quality & safety, 22*(12), 989-997. doi:10.1136/bmjqs-2013-002039

Blewett, L. A., Johnson, K., McCarthy, T., Lackner, T., & Brandt, B. (2010). Improving geriatric transitional care through inter-professional care teams. *J Eval Clin Pract, 16*(1), 57-63. doi:10.1111/j.1365-2753.2008.01114.x

Bloor, R., & Pearson, D. (2004). Brief solution-focused organizational redesign: a model for international mental health consultancy. *International Journal of Mental Health, 33*(2), 44-53.

Boult, C., Boult, L. B., Morishita, L., Dowd, B., Kane, R. L., & Urdangarin, C. F. (2001). A randomized clinical trial of outpatient geriatric evaluation and management. *J Am Geriatr Soc, 49*(4), 351-359.

Brentnall, J., & Bundy, A. C. (2009). The concept of reliability in the context of observational assessments. *OTJR: Occupation, Participation and Health, 29*(2), 63-71. doi:10.3928/15394492-20090301-01

Butterworth, J. E., & Campbell, J. L. (2014). Older patients and their GPs: shared decision making in enhancing trust. *Br J Gen Prac, 64*(628), e709-718. doi:10.3399/bjgp14X682297

Campbell, L. J., & Cole, K. D. (1987). Geriatric assessment teams. *Clinics in Geriatric Medicine, 1*, 99-110.

Canadian Association of Occupational Therapists. (2015). *Canadian model of occupational performance*. Ottawa, ON. Retrieved from http://www.caot.ca/default.asp?pageid=3781

Canadian Home Care Association. (2013). *Portraits of home care in Canada*. Mississauga, ON. Retrieved from http://www.cdnhomecare.ca/content.php?doc=293

Canadian Home Care Association, & Accreditation Canada. (2015). *Advancing Quality Improvement and Integrated Care*. Ottawa, ON. Retrieved from http://www.cdnhomecare.ca/media.php?mid=4328

Canadian Institute for Health Information. (2011a). *Occupational therapists in Canada, 2011--national and jurisdictional highlights*. Canadian Institute for Health Information. Ottawa, ON. Retrieved from www.cihi.ca/CIHI-exportal/pdf/internet/OT2011_HIGHLIGHTS_PROFILES_EN

Canadian Institute for Health Information. (2011b). *Seniors and the health care system: What is the impact of multiple chronic conditions?* . Ottawa, ON. Retrieved from http://secure.cihi.ca/cihiweb/products/air-chronic_disease_aib_en.pdf

Canadian Institute for Health Information. (2018). *CIHI interRAI update*. Ottawa, ON. Retrieved

from https://www.cihi.ca/sites/default/files/document/irrs-infosheet-may-2017-en.pdf

Canadian Institutes of Health Research. (2015). *Guide to knowledge translation planning at*

CIHR: integrated and end-of-grant approaches Ottawa, ON. Retrieved from

http://www.cihr-irsc.gc.ca/e/45321.html

Canadian Nurses Association. (2018). *Establish standards for home care*. Ottawa, ON. Retrieved

from https://www.canadian-nurse.com/~/media/cna/page-content/pdf-en/establish-

standards-for-home-care_e.pdf?la=en

Caplan, G. A., Williams, A. J., Daly, B., & Abraham, K. (2004). A randomized, controlled trial

of comprehensive geriatric assessment and multidisciplinary intervention after discharge

of elderly from the emergency department--the DEED II study. *J Am Geriatr Soc, 52*(9),

1417-1423. doi:10.1111/j.1532-5415.2004.52401.x

Care Quality Commission. (2016). *Building bridges breaking barriers: how care is integrated*

across health and social care and the impact on older people who use services, and their

families and carers. Care Quality Commission. Newcastle, UK. Retrieved from

https://www.cqc.org.uk/sites/default/files/20160712b_buildingbridges_report.pdf

Carroll, J. G. (2011). In the "medical home" adult primary care setting, practitioners are seeing

an increasing emphasis on patient involvement in setting the goals of care. *Quality*

management in health care, 20(2), 87-88. doi:10.1097/qmh.0b013e318215d488

Cheng, W. L. S. (2018). The effects of mutual goal-setting practice in older adults with chronic

illness. *Geriatric Nursing, 39*(2), 143-150. doi:10.1016/j.gerinurse.2017.07.007

Cobb, E. L., Duthie, E.H., Murphy, J.B. (2002). *Geriatrics review syllabus: a core curriculum in geriatric medicine* (5th ed.). Malden, MA: Blackwell Publishing for the American Geriatrics Society

Cohen, H. J., Feussner, J. R., Weinberger, M., Carnes, M., Hamdy, R. C., Hsieh, F., . . . Lavori, P. (2002). A controlled trial of inpatient and outpatient geriatric evaluation and management. *N Engl J Med, 346*(12), 905-912. doi:10.1056/NEJMsa010285

Cohen, J. (1988). *Statistical power analysis for the behavioural sciences*. New York: Routledge Academic.

Coleman, E. A. (2003). Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. *J Am Geriatr Soc, 51*(4), 549-555. doi:10.1046/j.1532-5415.2003.51185.x

Coleman, E. A., & Boult, C. (2003). Improving the quality of transitional care for persons with complex care needs. *J Am Geriatr Soc, 51*(4), 556-557. doi:10.1046/j.1532-5415.2003.51186.x

Community Care Information Management. (2010). *Community support services common assessment project*. Paper presented at the Ontario Association of Community Care Access Centres Conference, Toronto, Ontario.

Cott, C. A. (2004). Client-centred rehabilitation: client perspectives. *Disabil Rehabil, 26*(24), 1411-1422. doi:10.1080/09638280400000237

Covinsky, K. E., Palmer, R. M., Fortinsky, R. H., Counsell, S. R., Stewart, A. L., Kresevic, D., . . . Landefeld, C. S. (2003). Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: Increased vulnerability with age. *J Am Geriatr Soc, 51*(4), 451-458. doi:10.1046/j.1532-5415.2003.51152.x

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2013). Developing

    and evaluating complex interventions: The new Medical Research Council guidance.

    International Journal of Nursing Studies, 50(5), 587-592.

    doi:10.1016/j.ijnurstu.2012.09.010

Crawford, C. L., Omery, A., & Seago, J. A. (2012). The challenges of nurse-physician

    communication: a review of the evidence. *J Nurs Adm, 42*(12), 548-550.

    doi:10.1097/NNA.0b013e318274b4c0

Creswell, J. W., Clark, V. L., Gutmann, M. L., & Hanson, W. E. (2003). 'Advanced mixed

    methods research designs' In A. Tashakkori, & Teddlie, C. (Ed.), *Handbook of mixed*

    methods in social and behavioural research (pp. 209-240). London, UK: Sage.

Creswell, J. W., & Plano Clark, V. L. (2007). *Participatory research methods: a methodological*

    approach in motion. Thousand Oaks, CA: SAGE.

Curran, V. (2004). *Interprofessional education for collaborative patient-centred practice:*

    research synthesis paper. Health Canada. Retrieved from

    https://pdfs.semanticscholar.org/3fb5/206cc62ef10868a1fdca047420b122066bc3.pdf

Dahlke, S., Steil, K., Freund-Heritage, R., Colborne, M., Labonte, S., & Wagg, A. (2018). Older

    people and their families' perceptions about their experiences with interprofessional

    teams. *Nurs Open, 5*(2), 158-166. doi:10.1002/nop2.123

Delbanco, T., Berwick Donald, M., Boufford Jo, I., Edgman, L., Ollenschläger, G., Plamping,

    D., & Rockefeller Richard, G. (2001). Healthcare in a land called PeoplePower: nothing

    about me without me. *Health Expectations, 4*(3), 144-150. doi:10.1046/j.1369-

    6513.2001.00145.x

Department of Health. (2014). *Comprehensive health assessment of the older person in the healthcare system* Victoria State Government Melbourne, Australia Retrieved from http://www.anmfvic.asn.au/~/media/files/ANMF/Presentations/ANMC%202017/1d.pdf

Department of Justice. (2011). *Canada Health Act*. Ottawa, ON Retrieved from http://laws-lois.justice.gc.ca/eng/acts/c-6/.

Derrett, S., Gunter, K. E., Samaranayaka, A., Singer, S. J., Nocon, R. S., Quinn, M. T., . . . Chin, M. H. (2017). Development and testing of the provider and staff perceptions of integrated care (PSPIC) survey. *Med Care Res Rev*, 1077558717745936. doi:10.1177/1077558717745936

Dillman, D. (2000). *Mail and internet surveys: the tailored design method* (2nd ed.). New York: John Wiley and Sons

DiLollo, A., & Favreau, C. (2010). Person-centered care and speech and language therapy. *Semin Speech Lang, 31*(2), 90-97. doi:10.1055/s-0030-1252110

Doiezie, E., Salgado-Sanchez, L., & Pautas, E. (2017). Adaptation of the home, the occupational therapist's assessment. *Soins Gerontologie, 22*(124), 30-34. doi:10.1016/j.sger.2017.02.009

Doran, D. M., Hirdes, J. P., Blais, R., Baker, G. R., Poss, J. W., Li, X., . . . Jantzi, M. (2013). Adverse events among Ontario home care clients associated with emergency room visit or hospitalization: a retrospective cohort study. *BMC Health Services Research, 13*(1), 227. doi:10.1186/1472-6963-13-227

Duchan, J., & Black, M. (2001). Progressing toward life goals: a person-centered approach to evaluating therapy. *Topics in Language Disorders, 22*(1), 37-49.

171

Edvardsson, D., & Innes, A. (2010). Measuring person-centered care: a critical comparative review of published tools. *Gerontologist, 50*(6), 834-846. doi:10.1093/geront/gnq047

Edvardsson, D., Winblad, B., & Sandman, P. O. (2008). Person-centred care of people with severe Alzheimer's disease: current status and ways forward. *Lancet Neurol, 7*(4), 362-367. doi:10.1016/s1474-4422(08)70063-2

Elkan, R., Kendrick, D., Dewey, M., Hewitt, M., Robinson, J., Blair, M., . . . Brummell, K. (2001). Effectiveness of home based support for older people: systematic review and meta-analysis. *Bmj, 323*(7315), 719-725.

Ellenbecker, C. H., Samia, L., Cushman, M. J., & Alster, K. (2008). Patient safety and quality in home health care. In R. G. Hughes (Ed.), *Patient safety and quality: an evidence based handbook for nurses*. Rockville MD: Agency for Healthcare Research and Quality (US).

Ellis, G., Whitehead, M. A., O'Neill, D., Langhorne, P., & Robinson, D. (2011). Comprehensive geriatric assessment for older adults admitted to hospital. *Cochrane Database Syst Rev*(7), Cd006211. doi:10.1002/14651858.CD006211.pub2

Elsawy, B., & Higgins, K. E. (2011). The geriatric assessment. *Am Fam Physician, 83*(1), 48-56.

Erie St. Clair LHIN. (2010). *Externally-informed annual health systems trends report – third edition trend backgrounder*. Eerie St Clair LHIN. Chatham, ON. Retrieved from http://www.eriestclairlhin.on.ca/Search.aspx?search=health%20human%20resources

Eton, D. T., Ridgeway, J. L., Linzer, M., Boehm, D. H., Rogers, E. A., Yost, K. J., . . . Anderson, R. T. (2017). Healthcare provider relational quality is associated with better self-management and less treatment burden in people with multiple chronic conditions. *Patient preference and adherence, 11*, 1635-1646. doi:10.2147/PPA.S145942

Feilzer, M. Y. (2010). Doing mixed methods research pragmatically: implications for the

 rediscovery of pragmatism as a research paradigm. *Journal of Mixed Methods Research,*

 4(1), 6-16. doi:10.1177/1558689809349691

Ferrer, L., & Goodwin, N. (2014). What are the principles that underpin integrated care? *Int J*

 Integr Care, 14, e037. doi:http://doi.org/10.5334/ijic.1884

Finger, M. E., Cieza, A., Stoll, J., Stucki, G., & Huber, E. O. (2006). Identification of

 intervention categories for physical therapy, based on the international classification of

 functioning, disability and health: a delphi exercise. *Phys Ther, 86*(9), 1203-1220.

 doi:10.2522/ptj.20050134

Fleiss, J. L. (1986). *Design and analysis of clinical experiments*. New York, NY: Willey

Fleiss, J. L., & Cohen, J. (1973). The equivalence of weighted kappa and the intraclass

 correlation coefficient as measures of reliability. *Educational and Psychological*

 Measurement, 33(3), 613-619. doi:10.1177/001316447303300309

Fleming, J., Scamehorn, K. (2006). *FEEBLE FALLERS ARE FRAIL (Acronym for domains in*

 comprehensive geriatric assessment). POGOe - Portal of Geriatrics Online Education.

 Orlando, FLA. Retrieved from https://pogoe.org/productid/18597

Fried, L. P., Tangen, C. M., Walston, J., Newman, A. B., Hirsch, C., Gottdiener, J., . . .

 McBurnie, M. A. (2001). Frailty in older adults: evidence for a phenotype. *J Gerontol A*

 Biol Sci Med Sci, 56(3), M146-156.

Furze, G. (2015). Goal setting: A key skill for person-centred care. *Practice Nursing, 26*(5), 241-

 244. doi:10.12968/pnur.2015.26.5.241

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework

    method for the analysis of qualitative data in multi-disciplinary health research. *BMC*

    Medical Research Methodology, 13(1), 117. doi:10.1186/1471-2288-13-117

Gallo, J., Paveza, G., Reichel, W., Fulmer, T., Kazer, M.W., Shea, J.M., Guttman, C. (2006).

    Handbook of geriatric assessment (4th ed.). Sudbury, MA: Jones and Bartlett.

Gerein, K. (2017). Alberta health minister hopes to transform system with big investment in

    home care. *Edmonton Journal*. Retrieved from https://edmontonjournal.com/news/local-

    news/alberta-health-minister-hopes-to-transform-system-with-big-investment-in-home-

    care

Gill, C., & Connelly, C. (2013). *Success in home care: balancing the needs of clients, workers,*

    and organizations. Paper presented at the McMaster University Faculty of Health

    Sciences Research Plenary 2013, Hamilton, ON.

Giosa, J. L., Holyoke, P., Bender, D., Tudge, S., & Gifford, W. (2015). Observe, Coach, Assist

    and Report: an emerging framework for integrating unregulated healthcare providers into

    interdisciplinary healthcare teams *Journal of Research in Interprofessional Practice and*

    Education, 5(2). doi:http://dx.doi.org/10.22230/jripe.2015v5n2a200

Giosa, J. L., Holyoke, P., & Stolee, P. (2018). Let's get real about person and family-centred

    geriatric home care: A realist synthesis *Canadian Journal on Aging (submitted).*

Giosa, J. L., Stolee, P., Dupuis, S. L., Mock, S. E., & Santi, S. M. (2014). An Examination of

    Family Caregiver Experiences during Care Transitions of Older Adults. *Canadian*

    Journal on Aging, 96. doi:10.1017/S0714980814000026

Giosa, J. L., Stolee, P., & Holyoke, P. (2018). The geriatric care assessment practices of nurses,

    occupational therapists and physiotherapists in home care: development and pilot-testing

of the Geriatric Care Assessment Practices (G-CAP) survey. *BMC Geriatrics (in preparation)*.

Goodwin, N. (2013). Understanding integrated care: A complex process, a fundamental principle. *Int J Integr Care, 13*(JANUARY - MARCH 2). doi:http://doi.org/10.5334/ijic.1144

Gray, D., Brown, S., & Macanufo, J. (2010). *Gamestorming: a playbook for innovators, rulebreakers and changemakers*. Sebastopol, CA: O'Reilly Media Inc

Gray, L. C., Berg, K., Fries, B. E., Henrard, J.-C., Hirdes, J. P., Steel, K., & Morris, J. N. (2009). Sharing clinical information across care settings: the birth of an integrated assessment system. *BMC Health Services Research, 9*(1), 71. doi:10.1186/1472-6963-9-71

Green, J., & Thorogood, N. (2009). *Qualitative methods for health research* (2nd ed.). Thousand Oaks, California: Sage.

Greene, J. C. (2007). *Mixed methods in social inquiry*. San Francisco, CA: Jossey-Bass.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Q, 82*(4), 581-629. doi:10.1111/j.0887-378X.2004.00325.x

Gurin, P., Dey, E., Hurtado, S., & Gurin, G. (2002). Diversity and higher education: theory and impact on educational outcomes. *Harvard Educational Review, 72*(3), 330-367. doi:10.17763/haer.72.3.01151786u134n051

Guthrie, D. M., Pitman, R., Fletcher, P. C., Hirdes, J. P., Stolee, P., Poss, J. W., . . . Ezekiel, H. J. (2014). Data sharing between home care professionals: a feasibility study using the RAI Home Care instrument. *BMC Geriatrics, 14*(1), 81. doi:10.1186/1471-2318-14-81

Hale, L. A. (2010). Using Goal Attainment Scaling in physiotherapeutic home-based stroke rehabilitation. *Advances in Physiotherapy, 12*(3), 142-149. doi:10.3109/14038196.2010.486040

Hans, P. K., Gray, C. S., Gill, A., & Tiessen, J. (2018). The provider perspective: investigating the effect of the Electronic Patient-Reported Outcome (ePRO) mobile application and portal on primary care provider workflow. *Prim Health Care Res Dev, 19*(2), 151-164. doi:10.1017/s1463423617000573

Harvey, G., Dollard, J., Marshall, A., & Mittinty, M. M. (2018). Achieving integrated care for older people: shuffling the deckchairs or making the system watertight for the future? *International Journal of Health Policy and Management, 7*(4), 290-293. doi:10.15171/ijhpm.2017.144

Health Canada. (2015). *Unleashing innovation: excellent healthcare for Canada*. Ottawa, ON. Retrieved from http://www.healthycanadians.gc.ca/publications/health-system-systeme-sante/report-healthcare-innovation-rapport-soins/alt/report-healthcare-innovation-rapport-soins-eng.pdf

Health Canada. (2016). *Home and Community Health Care*. Ottawa, ON. Retrieved from https://www.canada.ca/en/health-canada/services/home-continuing-care/home-community-care.html?=undefined&wbdisable=true

Health Council of Canada. (2012). *Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?* Toronto, ON. Retrieved from https://healthcouncilcanada.ca/348/

Health Human Resources. (2009). *Physiotherapists in Canada*. Canadian Institute for Health

    Information. Ottawa, ON. Retrieved from

    www.cptbc.org/pdf/CIHReport.PTinCanada.2009.pdf

Health Quality Ontario. (2012). *Quality monitor: 2012 report on Ontario's health care system*.

    Health Quality Ontario. Toronto, ON. Retrieved from

    http://www.hqontario.ca/portals/0/documents/pr/qmonitor-full-report-2012-en.pdf

Health Quality Ontario. (2018). Overview of home and community care experiences survey

    development project: Site visit to SE Health. Toronto, ON: Health Quality Ontario

Heckman, G., Gray, L. C., & Hirdes, J. P. (2013). Addressing health care needs for frail seniors

    in Canada: The role of interRAI instruments. *Canadian Geriatrics Society Journal of*

    CME, 3(1), 7-16.

Hibbard, J. H., Stockard, J., Mahoney, E. R., & Tusler, M. (2004). Development of the Patient

    Activation Measure (PAM): conceptualizing and measuring activation in patients and

    consumers. *Health Services Research, 39*(4 Pt 1), 1005-1026. doi:10.1111/j.1475-

    6773.2004.00269.x

Hollander, M. J., Liu, G., & Chappell, N. L. (2009). Who cares and how much? The imputed

    economic contribution to the Canadian healthcare system of middle-aged and older

    unpaid caregivers providing care to the elderly. *Healthc Q, 12*(2), 42-49.

Holroyd-Leduc, J., Resin, J., Ashley, L., Barwich, D., Elliott, J., Huras, P., . . . Muscedere, J.

    (2016). Giving voice to older adults living with frailty and their family caregivers:

    engagement of older adults living with frailty in research, health care decision making,

    and in health policy. *Research Involvement and Engagement, 2*, 23. doi:10.1186/s40900-

    016-0038-7

Home Care Ontario. (2014). List of members. Retrieved from

    http://www.homecareontario.ca/our-members/list-of-members

Home Care Ontario. (2017). Facts and figures- publicly funded home care. Retrieved from

    http://www.homecareontario.ca/home-care-services/facts-

    figures/publiclyfundedhomecare

Hopkins, W. (2017). *Evaluating nurses' self-efficacy in caring for patients with dementia.*

    (Doctor of Nursing Practice), Walden University, Minneapolis, MN.

Horne, M., Khan, H., & Corrigan, P. (2013). *People powered health: health for people, by*

    people and with people. Nesta. London, UK. Retrieved from

    https://www.innovationunit.org/wp-content/uploads/2017/04/7-PPH-system-change-

    paper.pdf

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis.

    Qualitative Health Research, 15(9), 1277-1288. doi:10.1177/1049732305276687

Huber, M. (2018). *The power of 'positive health': about a new concept of health and its*

    elaboration. Paper presented at the 18th International Conference on Integrated Care,

    Utrecht, Netherlands.

    https://drive.google.com/drive/folders/1G6QO4yTFb5wJEk9xEvRHtcZn4Ly8YYZk

Huber, M., Knottnerus, J. A., Green, L., Horst, H. v. d., Jadad, A. R., Kromhout, D., . . . Smid,

    H. (2011). How should we define health? *Bmj, 343*. doi:10.1136/bmj.d4163

Huber, M., van Vliet, M., Giezenberg, M., Winkens, B., Heerkens, Y., Dagnelie, P. C., &

    Knottnerus, J. A. (2016). Towards a 'patient-centred' operationalisation of the new

    dynamic concept of health: a mixed methods study. *BMJ Open, 6*(1), e010091.

    doi:10.1136/bmjopen-2015-010091

Huss, A., Stuck, A. E., Rubenstein, L. Z., Egger, M., & Clough-Gorr, K. M. (2008). Multidimensional preventive home visit programs for community-dwelling older adults: a systematic review and meta-analysis of randomized controlled trials. *J Gerontol A Biol Sci Med Sci, 63*(3), 298-307.

Hwang, A. S., Truong, K. N., Cameron, J. I., Lindqvist, E., Nygard, L., & Mihailidis, A. (2015). Co-designing Ambient Assisted Living (AAL) environments: unravelling the situated context of informal dementia care. *BioMed Research International, 2015*. doi:10.1155/2015/720483

IBM. (2007). SPSS for windows (Version 16.0). Chicago: SPSS, Inc.

Institute for Research on Public Policy. (2015). *Designing a national seniors strategy on aging*. Montreal, QC. Retrieved from https://www.cma.ca/En/Lists/Medias/task-force-aging-report-e.pdf

International Federation on Aging. (2018). About the International Federation on Aging. Retrieved from https://www.ifa-fiv.org/about/

interRAI. (2012). Home care. Retrieved from http://www.interrai.org/home-care.html

Janse, B., Huijsman, R., Looman, W. M., & Fabbricotti, I. N. (2018). Formal and informal care for community-dwelling frail elderly people over time: A comparison of integrated and usual care in the Netherlands. *Health and Social Care in the Community, 26*(2), e280-e290. doi:10.1111/hsc.12516

Jordan, M. E., Lanham, H. J., Crabtree, B. F., Nutting, P. A., Miller, W. L., Stange, K. C., & McDaniel, R. R. (2009). The role of conversation in health care interventions: enabling sensemaking and learning. *Implementation Science: IS, 4*, 15-15. doi:10.1186/1748-5908-4-15

Jull, J., Giles, A., & Graham, I. D. (2017). Community-based participatory research and

    integrated knowledge translation: advancing the co-creation of knowledge. *Implement*

    Sci, 12(1), 150. doi:10.1186/s13012-017-0696-3

Kaur, A., Noman, M., & Nordin, H. (2017). Inclusive assessment for linguistically diverse

    learners in higher education. *Assessment & Evaluation in Higher Education, 42*(5), 756-

    771. doi:10.1080/02602938.2016.1187250

Kay, K., Hawkins, S. A., Day, A. M. B., Briscoe, M., Daly, D., & Wong, K. (2017). *A*

    competency framework for interprofessional comprehensive geriatric assessment.

    Retrieved from Toronto, ON: http://seniorscarenetwork.ca/wp-

    content/uploads/2017/10/2017-CGA-Competencies-Framework-Report-FINAL.pdf

Keating, N., Zybutz, T., & Rouse, K. (2012). Inclusive assessment at point-of-design.

    Innovations in Education and Teaching International, 49(3), 249-256.

    doi:10.1080/14703297.2012.703022

Kellogg Foundation. (1992). *Community-based public health initiative* Battle Creek, MI.

    Retrieved from https://www.wkkf.org/resource-directory/resource/2001/12/overview-of-

    the-community-based-public-health-initiative

Kirkhus, L., Šaltytė Benth, J., Rostoft, S., Grønberg, B. H., Hjermstad, M. J., Selbæk, G., . . .

    Jordhøy, M. S. (2017). Geriatric assessment is superior to oncologists' clinical judgement

    in identifying frailty. *British Journal of Cancer, 117*(4), 470-477.

    doi:10.1038/bjc.2017.202

Kline, P. (2000). *The handbook of psychological testing* (2nd ed.). New York: Routledge

Kodner, D. L. (2009). All together now: a conceptual exploration of integrated care. *Healthcare*

    quarterly (Toronto, Ont.), 13 Spec No, 6-15.

Kogan, A. C., Wilber, K., & Mosqueda, L. (2016). Person-centered care for older adults with chronic conditions and functional impairment: a systematic literature review. *J Am Geriatr Soc, 64*(1), e1-e7. doi:10.1111/jgs.13873

Koru, G., Alhuwail, D., Topaz, M., Norcio, A. F., & Mills, M. E. (2016). Investigating the challenges and opportunities in home care to facilitate effective information technology adoption. *J Am Med Dir Assoc, 17*(1), 53-58. doi:10.1016/j.jamda.2015.10.008

Kraemer, H. C., Thiemann, S. (1987). *How many subjects? Statistical power analysis in research*. Thousand Oaks, CA: Sage Publications Inc.

Kristensen Dorte, V., Sundler Annelie, J., Eide, H., Hafskjold, L., Ruud, I., & Holmström Inger, K. (2017). Characteristics of communication with older people in home care: a qualitative analysis of audio recordings of home care visits. *Journal of Clinical Nursing, 26*(23-24), 4613-4621. doi:10.1111/jocn.13807

Kronhaus, A., Zimmerman, S., Fuller, S., & Reed, D. (2018). Implementing integrated care into assisted living—the road (finally) taken. *J Am Med Dir Assoc*. doi:https://doi.org/10.1016/j.jamda.2018.05.003

Kuluski, K., Nelson, M., Tracy, C. S., Alloway, C. A., Shorrock, C., Shearkhani, S., & Upshur, R. E. G. (2017). Experience of care as a critical component of health system performance measurement: recommendations for moving forward. *HealthcarePapers, 17*(2), 8-20.

Lally, J., Tullo, E. (2012). Engaging older people in decisions about their healthcare: the case for shared decision making. *Reviews in Clinical Gerontology, 22*(2), 99-107. doi:https://doi.org/10.1017/S0959259811000281

Lanham, H. J., McDaniel, R. R., Jr., Crabtree, B. F., Miller, W. L., Stange, K. C., Tallia, A. F., & Nutting, P. (2009). How improving practice relationships among clinicians and

nonclinicians can improve quality in primary care. *Jt Comm J Qual Patient Saf, 35*(9), 457-466.

Lannin, N. (2003). Goal attainment scaling allows program evaluation of a home-based occupational therapy program. *Occup Ther Health Care, 17*(1), 43-54. doi:10.1080/J003v17n01_04

Laugaland, K., Aase, K., & Barach, P. (2012). Interventions to improve patient safety in transitional care--a review of the evidence. *Work, 41 Suppl 1*, 2915-2924. doi:10.3233/wor-2012-0544-2915

Law, M., Baptiste, S., McColl, M., Opzoomer, A., Polatajko, H., & Pollock, N. (1990). The Canadian occupational performance measure: an outcome measure for occupational therapy. *Canadian Journal of Occupational Therapy, 57*(2), 82-87. doi:10.1177/000841749005700207

Leatt, P., Pink, G. H., & Guerriere, M. (2000). Towards a Canadian model of integrated healthcare. *Healthc Pap, 1*(2), 13-35.

Legare, F., Stacey, D., Briere, N., Fraser, K., Desroches, S., Dumont, S., . . . Aube, D. (2013). Healthcare providers' intentions to engage in an interprofessional approach to shared decision-making in home care programs: a mixed methods study. *J Interprof Care, 27*(3), 214-222. doi:10.3109/13561820.2013.763777

Legg, L., Gladman, J., Drummond, A., & Davidson, A. (2016). A systematic review of the evidence on home care reablement services. *Clinical Rehabilitation, 30*(8), 741-749. doi:10.1177/0269215515603220

Lethem, J. (2002). Brief solution focused therapy. *Child and Adolescent Mental Health, 7*(4), 189-192. doi:doi:10.1111/1475-3588.00033

Levinson, W., Kao, A., Kuby, A., & Thisted, R. A. (2005). Not all patients want to participate in decision making. A national study of public preferences. *J Gen Intern Med, 20*(6), 531-535. doi:10.1111/j.1525-1497.2005.04101.x

Lindberg, B., Nilsson, C., Zotterman, D., Soderberg, S., & Skar, L. (2013). Using information and communication technology in home care for communication between patients, family members, and healthcare professionals: a systematic review. *Int J Telemed Appl, 2013*, 461829. doi:10.1155/2013/461829

Lloyd, J., & Wait, S. (2005). Integrated care: a guide for policymakers. Retrieved from https://www.popline.org/node/175307

Local Health Integration Networks. (2014a). Local Health Integration Networks (LHINs) plan, integrate and fund local health care, improving access and patient experience. Retrieved from http://www.lhins.on.ca/

Local Health Integration Networks. (2014b). *Personal support and homemaking services schedule*. Local Health and Integration Networks. Retrieved from http://healthcareathome.ca/serviceproviders/en/Documents/Schedule_3_-_Personal_Support_and_Homemaking_Services_Schedule_(Consolidated_Services_Version)%20(Blackline).pdf

Lofland, J., Snow, D. A., Anderson, L., & Lofland, L. H. (2006). *Analyzing social settings: a guide to qualitative observation and analysis* (4th ed.). Belmont, CA: Wadsworth Publishing

Longhurst, A. (2017). *Privatization and declining access to BC seniors' care* Canadian Centre for Policy Alternatives. Vancouver, BC Retrieved from

https://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2017/03/access_to_seniors_care_report_170327%20FINAL.pdf

Lyngstad, M., Hofoss, D., Grimsmo, A., & Hellesø, R. (2015). Predictors for assessing electronic messaging between nurses and general practitioners as a useful tool for communication in home health care services: a cross-sectional study. *Journal of Medical Internet Research, 17*(2), e47. doi:10.2196/jmir.4056

MacAdam, M. (2009). *Moving toward health service integration: provincial progress in system change for seniors*. Canadian Policy Research Networks. Ottawa. Retrieved from http://globalag.igc.org/health/world/2009/canada.pdf

Manderson, B., McMurray, J., Piraino, E., & Stolee, P. (2012). Navigation roles support chronically ill older adults through healthcare transitions: a systematic review of the literature. *Health Soc Care Community, 20*(2), 113-127. doi:10.1111/j.1365-2524.2011.01032.x

Manojlovich, M., Squires, J. E., Davies, B., & Graham, I. D. (2015). Hiding in plain sight: communication theory in implementation science. *Implement Sci, 10*, 58. doi:10.1186/s13012-015-0244-y

Markle-Reid, M., Weir, R., Browne, G., Roberts, J., Gafni, A., & Henderson, S. (2006). Health promotion for frail older home care clients. *J Adv Nurs, 54*(3), 381-395. doi:10.1111/j.1365-2648.2006.03817.x

Maurits, E. E. M., de Veer, A. J. E., Groenewegen, P. P., & Francke, A. L. (2018). Attractiveness of people-centred and integrated Dutch home care: A nationwide survey among nurses. *Health and Social Care in the Community*. doi:10.1111/hsc.12564

McGinnis, P. Q., Hack, L. M., Nixon-Cave, K., & Michlovitz, S. L. (2009). Factors that

    influence the clinical decision making of physical therapists in choosing a balance

    assessment approach. *Phys Ther, 89*(3), 233-247. doi:10.2522/ptj.20080131

McNeil, H., Elliott, J., Huson, K., Ashbourne, J., Heckman, G., Walker, J., & Stolee, P. (2016).

    Engaging older adults in healthcare research and planning: a realist synthesis. *Research*

    Involvement and Engagement, 2(1), 10. doi:10.1186/s40900-016-0022-2

Melis, R. J., van Eijken, M. I., Teerenstra, S., van Achterberg, T., Parker, S. G., Borm, G. F., . . .

    Rikkert, M. G. (2008). A randomized study of a multidisciplinary program to intervene

    on geriatric syndromes in vulnerable older people who live at home (Dutch EASYcare

    Study). *J Gerontol A Biol Sci Med Sci, 63*(3), 283-290.

Mercer, S. W., Maxwell, M., Heaney, D., & Watt, G. C. (2004). The consultation and relational

    empathy (CARE) measure: development and preliminary validation and reliability of an

    empathy-based consultation process measure. *Fam Pract, 21*(6), 699-705.

    doi:10.1093/fampra/cmh621

Milisen, K., Coussement, J., Flamaing, J., Vlaeyen, E., Schwendimann, R., Dejaeger, E., . . .

    Boonen, S. (2012). Fall prediction according to nurses' clinical judgment: differences

    between medical, surgical, and geriatric wards. *J Am Geriatr Soc, 60*(6), 1115-1121.

    doi:10.1111/j.1532-5415.2012.03957.x

Ministry of Health and Long-Term Care. (2015a). *Bringing Care Home*. Toronto, ON. Retrieved

    from http://health.gov.on.ca/en/public/programs/lhin/docs/hcc_report.pdf

Ministry of Health and Long-Term Care. (2015b). *Putting patients first: a proposal to strengthen*

    person-centred health care in Ontario. Toronto, ON. Retrieved from

    http://www.health.gov.on.ca/en/news/bulletin/2015/docs/discussion_paper_20151217.pdf

Ministry of Health and Long-Term Care. (2016). Ontario investing an additional $100 million

    this year in home and community care: province increasing access to home care for those

    with high needs [Press release]. Retrieved from

    https://news.ontario.ca/mohltc/en/2016/07/ontario-investing-an-additional-100-million-

    this-year-in-home-and-community-care.html

Ministry of Health and Long-Term Care. (2017). *Complex needs working group report*. Complex

    Needs Working Group. Toronto, ON. Retrieved from

    http://www.health.gov.on.ca/en/common/ministry/publications/reports/complex_needs/do

    cs/complex_needs_report.pdf

Mittinty, M. M., Marshall, A., & Harvey, G. (2018). What integrated care means from an older

    person's perspective? A scoping review protocol. *BMJ Open, 8*(3). doi:10.1136/bmjopen-

    2017-019256

Moore, L., Britten, N., Lydahl, D., Naldemirci, O., Elam, M., & Wolf, A. (2017). Barriers and

    facilitators to the implementation of person-centred care in different healthcare contexts.

    Scandinavian Journal of Caring Sciences, 31(4), 662-673. doi:doi:10.1111/scs.12376

Moullin, J. C., Sabater-Hernandez, D., Fernandez-Llimos, F., & Benrimoj, S. I. (2015). A

    systematic review of implementation frameworks of innovations in healthcare and

    resulting generic implementation framework. *Health Res Policy Syst, 13*, 16.

    doi:10.1186/s12961-015-0005-z

National Voices. (2013). *A narrative for person-centred coordinated care*. London, UK.

    Retrieved from https://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-

    cc.pdf

Nelson, S., Turnbull, J., Bainbridge, L., Caulfield, T., Hudon, G., & Kendell, D. (2014).

    Optimizing Scopes of Practice: New Models of Care for a New Health Care System.

    Retrieved from Ottawa, ON: http://cahs-acss.ca/optimizing-scopes-of-practice-new-

    models-of-care-for-a-new-health-care-system/

NHS Foundation Trust. (2012). *Writing good care plans: a good practice guide*. London, UK.

    Retrieved from http://oxleas.nhs.uk/site-media/cms-

    downloads/Writing_Good_Care_Plans_Oxleas.pdf

Nolte, E., & McKee, M. (2008). *Caring for people with chronic conditions. A health system*

    perspective. (E. Nolte & M. Mckee Eds.). Maidenhead, UK: Open University Press.

Nunnally, J. C. (1978). *Psychometric theory* (2nd ed.). New York: McGraw-Hill

Ontario Health Coalition. (2011). *Still waiting: An assessment of Ontario's home care system*

    after two decades of restructuring. Retrieved from Toronto:

    http://www.ontariohealthcoalition.ca/wp-content/uploads/Full-Report-April-4-2011.pdf

Ontario Health Coalition. (2015). *The Care We Need*. Retrieved from Toronto, ON:

    http://www.ontariohealthcoalition.ca/wp-content/uploads/home-care-the-care-we-need-

    report-final.pdf

Ontario Home Care Association. (2011). *Home Care Nursing in Ontario*. Hamilton, ON.

    Retrieved from http://www.homecareontario.ca/docs/default-source/HHR/hc-nsg-in-

    ontario---mar-2011---final-rev.pdf?sfvrsn=8

Ontario Home Care Association. (2013). Home care in Ontario-facts and figures. Retrieved from

    http://www.homecareontario.ca/home-care-services/facts-

    figures/publiclyfundedhomecare

Ontario Home Care Association. (2018). Ontario's home care system at a tipping point, more

    investment needed: home care Ontario Retrieved from https://www.newswire.ca/news-

    releases/ontarios-home-care-system-at-a-tipping-point-more-investment-needed-home-

    care-ontario-670109103.html

Ontario PC. (2018). Plan for the people. Retrieved from

    https://www.ontariopc.ca/plan_for_the_people

Ontario Society of Occupational Therapists. (2018). Government creates new agency: personal

    support services Ontario. Retrieved from

    https://www.osot.on.ca/TAGGED/News/Government_Creates_new_Agency___Personal

    _Support_Services_Ontario.aspx

Parsons, J., Rouse, P., Robinson, E. M., Sheridan, N., & Connolly, M. J. (2012). Goal setting as a

    feature of homecare services for older people: does it make a difference? *Age Ageing,*

    41(1), 24-29. doi:10.1093/ageing/afr118

Parsons, J. G., & Parsons, M. J. (2012). The effect of a designated tool on person-centred goal

    identification and service planning among older people receiving homecare in New

    Zealand. *Health Soc Care Community, 20*(6), 653-662. doi:10.1111/j.1365-

    2524.2012.01081.x

Parsons, M., Senior, H., Mei-Hu Chen, X., Jacobs, S., Parsons, J., Sheridan, N., & Kenealy, T.

    (2013). Assessment without action; a randomised evaluation of the interRAI home care

    compared to a national assessment tool on identification of needs and service provision

    for older people in New Zealand. *Health Soc Care Community, 21*(5), 536-544.

    doi:10.1111/hsc.12045

Perna, S., Francis, M. D. A., Bologna, C., Moncaglieri, F., Riva, A., Morazzoni, P., . . .

        Rondanelli, M. (2017). Performance of Edmonton Frail Scale on frailty assessment: its

        association with multi-dimensional geriatric conditions assessed with specific screening

        tools. *BMC Geriatrics, 17*, 2. doi:10.1186/s12877-016-0382-3

Philip, I., Tugay, K., Hildon, Z., Aw, S., Jeon, Y.-H., Naegle, M., . . . Hardman, M. (2017).

        Person-centred assessment to integrate care for older people. Stirling, UK.

Picard, A. (2018a). Doug Ford needs to rein in Ontario's bureaucratic health-care mess *The*

        Globe and Mail. Retrieved from https://www.theglobeandmail.com/opinion/article-doug-

        ford-needs-to-rein-in-ontarios-bureaucratic-health-care-mess/

Picard, A. (2018b). Ontario is courting a home care fiasco. *The Globe and Mail*. Retrieved from

        https://www.theglobeandmail.com/opinion/ontario-is-courting-a-home-care-

        fiasco/article38175867/

Pictou County a model for Nova Scotia home care. (2016). *The Chronicle Herald*. Retrieved

        from http://thechronicleherald.ca/novascotia/1355523-pictou-county-a-model-for-nova-

        scotia-home-care

Pinelle, D., & Gutwin, C. (2002). *Supporting collaboration in multidisciplinary home care*

        teams. Paper presented at the AMIA 2002 Annual Symposium, Saskatoon, SK.

Pinholt, E. M., Kroenke, K., Hanley, J. F., Kussman, M. J., Twyman, P. L., & Carpenter, J. L.

        (1987). Functional assessment of the elderly: A comparison of standard instruments with

        clinical judgment. *Archives of Internal Medicine, 147*(3), 484-488.

        doi:10.1001/archinte.1987.00370030088017

Pitsilldes, A., Samaras, G., Pitsilldes, B., Georgiades, D., Andreou, P., & Christodoulou, E. (2006). DITIS: Virtual collaborative teams for home healthcare *Journal of Mobile Multimedia, 2*(1), 23-36.

Ploeg, J., Matthew-Maich, N., Fraser, K., Dufour, S., McAiney, C., Kaasalainen, S., . . . Emili, A. (2017). Managing multiple chronic conditions in the community: a Canadian qualitative study of the experiences of older adults, family caregivers and healthcare providers. *BMC Geriatrics, 17*, 40. doi:10.1186/s12877-017-0431-6

Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care. Analysing qualitative data. *Bmj, 320*(7227), 114-116.

Powell, K., Kitson, A., Hoon, E., Newbury, J., Wilson, A., & Beilby, J. (2013). A study protocol for applying the co-creating knowledge translation framework to a population health study. *Implementation Science, 8*(1). doi:10.1186/1748-5908-8-98

Proudlock, S., & Wellman, N. (2011). Solution focused groups: The results look promising. *Counselling Psychology Review, 26*(23), 45-55.

QSR International Pty Ltd. (2012). Nvivo qualitative data analysis software (Version 10): QSR International.

Registered Nurses Association of Ontario. (2013). *Developing and sustaining interprofessional health care: optimizing patients/clients, organizational, and system outcomes*. Registered Nurses Association of Ontario Toronto, ON. Retrieved from http://rnao.ca/bpg/guidelines/interprofessional-team-work-healthcare

Registered Nurses Association of Ontario. (2015). *Person- and family- centred care clinical best practice guidelines*. Toronto, ON. Retrieved from http://rnao.ca/bpg/guidelines/person-and-family-centred-care

Robben, S. H. M., Perry, M., Olde Rikkert, M. G. M., Heinen, M. M., & Melis, R. J. F. (2011). Care-related goals of community-dwelling frail older adults. *J Am Geriatr Soc, 59*(8), 1552-1554. doi:10.1111/j.1532-5415.2011.03515.x

Rockwood, K., Howlett, S., Stadnyk, K., Carver, D., Powell, C., & Stolee, P. (2003). Responsiveness of goal attainment scaling in a randomized controlled trial of comprehensive geriatric assessment. *J Clin Epidemiol, 56*(8), 736-743.

Rockwood, K., Stolee, P., & Fox, R. A. (1993). Use of goal attainment scaling in measuring clinically important change in the frail elderly. *J Clin Epidemiol, 46*(10), 1113-1118.

Rogerson, S. L., Weiss, L. J., & Phillips, S. L. (2006). What do our seniors need? Outcomes of at-home comprehensive geriatric assessments. *Annals of Long-Term Care, 14*(10), 31-34.

Rolfson, D. B., Majumdar, S. R., Tsuyuki, R. T., Tahir, A., & Rockwood, K. (2006). Validity and reliability of the Edmonton Frail Scale. *Age Ageing, 35*(5), 526-529. doi:10.1093/ageing/afl041

Rostgaard, T. (2012). Quality reforms in Danish home care - balancing between standardisation and individualisation. *Health Soc Care Community, 20*(3), 247-254. doi:10.1111/j.1365-2524.2012.01066.x

Sahlen, K. G., Löfgren, C., Mari Hellner, B., & Lindholm, L. (2008). Preventive home visits to older people are cost-effective. *Scandinavian Journal of Public Health, 36*(3), 265-271. doi:10.1177/1403494807086983

Sanders, E., & Stappers, P. J. (2008). Co-creation and the new landscapes of design *International Journal of CoCreation in Design and the Arts, 4*(1), 5-18.

Sanders, E., & Stappers, P. J. (2012). *Convivial toolbox: generative research for the front end of design*. Amsterdam, NL: BIS Publishers.

Schell, B. A., & Cervero, R. M. (1993). Clinical reasoning in occupational therapy: an

    integrative review. *Am J Occup Ther, 47*(7), 605-610.

Schulman-Green, D. J., Naik, A. D., Bradley, E. H., McCorkle, R., & Bogardus, S. T. (2006).

    Goal setting as a shared decision making strategy among clinicians and their older

    patients. *Patient Education and Counseling, 63*(1-2), 145-151.

    doi:10.1016/j.pec.2005.09.010

Shaw, S., Rosen, R., & Rumbold, B. (2011). *What is integrated care?* Retrieved from London,

    UK: https://www.nuffieldtrust.org.uk/files/2017-01/what-is-integrated-care-report-web-

    final.pdf

Singer, S. J., Burgers, J., Friedberg, M., Rosenthal, M. B., Leape, L., & Schneider, E. (2011).

    Defining and measuring integrated patient care: promoting the next frontier in health care

    delivery. *Medical Care Research and Review, 68*(1), 112-127.

    doi:10.1177/1077558710371485

Sinha, S. (2018). The prescription to fix hallway medicine once and for all. *The Toronto Star*.

    Retrieved from https://www.thestar.com/opinion/contributors/2018/06/04/the-

    prescription-to-fix-hallway-medicine-once-and-for-all.html

Sinha, S. K., Griffin, B., Ringer, T., Reppas-Rindlisbacher, C., Stewart, E., Wong, I., . . .

    Anderson, G. (2016). *An evidence-informed national seniors strategy for Canada.*

    Alliance for a National Seniors Strategy. Toronto, ON. Retrieved from

    http://nationalseniorsstrategy.ca/wp-content/uploads/2016/10/National-Seniors-Strategy-

    Second-Edition.pdf

Sinn, C.-L. J., Betini, R. S. D., Wright, J., Eckler, L., Chang, B. W., Hogeveen, S., . . . Hirdes, J.

    P. (2018). Adverse events in home care: identifying and responding with interRAI scales

and clinical assessment protocols. *Canadian Journal on Aging / La Revue canadienne du vieillissement, 37*(1), 60-69. doi:10.1017/S0714980817000538

Sixsmith, J., Sixsmith, A., Fänge, A. M., Naumann, D., Kucsera, C., Tomsone, S., . . . Woolrych, R. (2014). Healthy ageing and home: The perspectives of very old people in five European countries. *Social Science & Medicine, 106*, 1-9. doi:https://doi.org/10.1016/j.socscimed.2014.01.006

Skoric, M. M., Zhu, Q., Goh, D., & Pang, N. (2015). Social media and citizen engagement: A meta-analytic review. *New Media & Society, 18*(9), 1817-1839. doi:10.1177/1461444815616221

Smets, I. H., Kempen, G. I., Janssen-Heijnen, M. L., Deckx, L., Buntinx, F. J., & van den Akker, M. (2014). Four screening instruments for frailty in older patients with and without cancer: a diagnostic study. *BMC Geriatrics, 14*(1), 26. doi:10.1186/1471-2318-14-26

Sockolow, P., Radhakrishnan, K., Chou, E. Y., & Wojciechowicz, C. (2017). Patient health goals elicited during home care admission: a categorization. *Western Journal of Nursing Research, 39*(11), 1447-1458. doi:10.1177/0193945916676541

Statistics Canada. (2015). Research highlights on health and aging Retrieved from https://www.statcan.gc.ca/pub/11-631-x/11-631-x2016001-eng.htm#a2

Stauder, R., Moser, K., Holzner, B., Sperner-Unterweger, B., & Kemmler, G. (2010). Six independent domains are defined by geriatric assessment in elderly cancer patients. *Crit Rev Oncol Hematol, 74*(2), 97-105. doi:10.1016/j.critrevonc.2009.04.010

Stein, K. V., & Rieder, A. (2009). Integrated care at the crossroads—defining the way forward. *Int J Integr Care, 9*, e10.

Stickdorn, M., & Schneider, J. (2012). *This is service design thinking: basics, tools, cases*.

    Hoboken, NJ: Wiley.

Stolee, P. (2010). Measuring outcomes of multidimensional interventions. In *Brocklehurst's*

    textbook of geriatric medicine and gerontology (7th ed., pp. 1-17). Philadelphia: Elsevier.

Stolee, P., Awad, M., Byrne, K., DeForge, R., Clements, S., & Glenny, C. (2012). A multi-site

    study of the feasibility and clinical utility of Goal Attainment Scaling in geriatric day

    hospitals. *Disabil Rehabil, 34*(20), 1716-1726. doi:10.3109/09638288.2012.660600

Stolee, P., Zaza, C., Pedlar, A., & Myers, A. M. (1999). Clinical experience with Goal

    Attainment Scaling in geriatric care. *J Aging Health, 11*(1), 96-124.

    doi:10.1177/089826439901100106

Streiner, D. L., & Norman, G. R. (2008). *Health measurement scales: a practical guide to their*

    development and use. New York: Oxford University Press.

Suijker, J. J., Buurman, B. M., ter Riet, G., van Rijn, M., de Haan, R. J., de Rooij, S. E., & Moll

    van Charante, E. P. (2012). Comprehensive geriatric assessment, multifactorial

    interventions and nurse-led care coordination to prevent functional decline in community-

    dwelling older persons: protocol of a cluster randomized trial. *BMC Health Services*

    Research, 12(1), 85. doi:10.1186/1472-6963-12-85

Sun, W., Doran, D., Bloomberg, L. S., & Bloomberg, L. S. (2017). Using remote activity

    monitoring and guideline system for home care clients to support geriatric nursing care in

    the community. *GSTF Journal of Nursing and Health Care (JNHC), 1*(2).

Tanner, C. A. (2006). Thinking like a nurse: a research-based model of clinical judgment in

    nursing. *J Nurs Educ, 45*(6), 204-211.

Tessier, A., Beaulieu, M.-D., McGinn, C. A., & Latulippe, R. (2016). Effectiveness of

      reablement: a systematic review. *Healthcare Policy, 11*(4), 49-59.

The Change Foundation. (2008). *Who is the puzzle maker? Patient /caregiver perspectives on*

      navigating health services in Ontario. Retrieved from Toronto, ON:

      www.changefoundation.ca/site/wpcontent/.../ChgFdn_Puzzle_Web.pdf

The Change Foundation. (2011). *Integration of care: the perspectives of home and community*

      providers. Toronto, ON. Retrieved from http://www.changefoundation.ca/integration-of-

      care-perspectives-of-home-and-community-providers/

The Change Foundation. (2016). *Family caregiver assessment in health care settings: summary*

      of The Change Foundation's literature review and environmental scan project. The

      Change Foundation. Toronto, ON. Retrieved from

      www.changefoundation.ca/site/wp.../Caregiver-Assessment-Summary-FINAL.pdf

The Institute for Patient and Family Centred Care. (2010). Frequently asked questions. Retrieved

      from http://www.ipfcc.org/faq.html

The Kings Fund. (2018). Experience based co-design toolkit. Retrieved from

      https://www.pointofcarefoundation.org.uk/resource/experience-based-co-design-ebcd-

      toolkit/

The Ontario Seniors' Secretariat. (2013). *Independence, activity, and good health: Ontario's*

      action plan for seniors. Hamilton, ON. Retrieved from

      http://www.homecareontario.ca/docs/default-source/publications-

      mo/ontarioseniorsactionplan-en.pdf?sfvrsn=10

Thonnard, J. L., & Penta, M. (2007). Functional assessment in physiotherapy. A literature

      review. *Eura Medicophys, 43*(4), 525-541.

Toscan, J., Mairs, K., Hinton, S., & Stolee, P. (2012). Integrated transitional care: Patient, informal caregiver and health care provider perspectives on care transitions for older persons with hip fracture. *Int J Integr Care, 12*(APRIL - JUNE 2012).

Toscan, J., Manderson, B., Santi, S. M., & Stolee, P. (2013). "Just another fish in the pond": the transitional care experience of a hip fracture patient. *Int J Integr Care, 13*, e023.

Toto, P. E., Skidmore, E. R., Terhorst, L., Rosen, J., & Weiner, D. K. (2015). Goal Attainment Scaling (GAS) in geriatric primary care: a feasibility study. *Arch Gerontol Geriatr, 60*(1), 16-21. doi:10.1016/j.archger.2014.10.022

Turkoski, B., Pierce, L. L., Schreck, S., Salter, J., Radziewicz, R., Guhde, J., & Brady, R. (1997). Clinical nursing judgment related to reducing the incidence of falls by elderly patients. *Rehabil Nursing, 22*(3), 124-130.

Valentijn, P. P., Boesveld, I. C., van der Klauw, D. M., Ruwaard, D., Struijs, J. N., Molema, J. J. W., . . . Vrijhoef, H. J. M. (2015). Towards a taxonomy for integrated care: A mixed-methods study. *Int J Integr Care, 15*(Jan-Mar 2015).

Valentijn, P. P., Schepman, S. M., Opheij, W., & Bruijnzeels, M. A. (2013). Understanding integrated care: A comprehensive conceptual framework based on the integrative functions of primary care. *Int J Integr Care, 13*(JANUARY - MARCH 2).

Van Craen, K., Braes, T., Wellens, N., Denhaerynck, K., Flamaing, J., Moons, P., . . . Milisen, K. (2010). The effectiveness of inpatient geriatric evaluation and management units: a systematic review and meta-analysis. *J Am Geriatr Soc, 58*(1), 83-92. doi:10.1111/j.1532-5415.2009.02621.x

van Graan, A. C., Williams, M. J. S., & Koen, M. P. (2016). Professional nurses' understanding

of clinical judgement: A contextual inquiry. *Health SA Gesondheid, 21*, 280-293.

doi:https://doi.org/10.1016/j.hsag.2016.04.001

Van Ness, P. H., Towle, V. R., & Juthani-Mehta, M. (2008). Testing measurement reliability in

older populations: methods for informed discrimination in instrument selection and

application. *J Aging Health, 20*(2), 183-197. doi:10.1177/0898264307310448

Vassallo, M., Poynter, L., Sharma, J. C., Kwan, J., & Allen, S. C. (2008). Fall risk-assessment

tools compared with clinical judgment: an evaluation in a rehabilitation ward. *Age

Ageing, 37*(3), 277-281. doi:10.1093/ageing/afn062

Virani, T. (2012). *Interprofessional collaborative teams*. Retrieved from Ottawa, ON:

http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/Virani-

Interprofessional-EN.pdf?sfvrsn=0

Wainwright, S. F., Shepard, K. F., Harman, L. B., & Stephens, J. (2011). Factors that influence

the clinical decision making of novice and experienced physical therapists. *Phys Ther,

91*(1), 87-101. doi:10.2522/ptj.20100161

Walsh, K., Moss, C., & FitzGerald, M. (2006). Solution-focused approaches and their relevance

to practice development. *Practice Development in Health Care, 5*(3), 145-155.

doi:doi:10.1002/pdh.192

Ward, K. T., & Reuben, D. B. (2018). Comprehensive geriatric assessment Retrieved from

https://www.uptodate.com/contents/comprehensive-geriatric-assessment

Watson, J., & Woodward, T. K. (2010). Jean Watson's theory of human caring. *Nursing

Theories and Nursing Practice, 3*, 351-369.

Welsh, T. J., Gordon, A. L., & Gladman, J. R. (2014). Comprehensive geriatric assessment--a guide for the non-specialist. *Int J Clin Pract, 68*(3), 290-293. doi:10.1111/ijcp.12313

Wodchis, W. P., Dixon, A., Anderson, G. M., & Goodwin, N. (2015). Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *Int J Integr Care, 15*.

Woodward, C. E., Abelson, J., & Hutchison, B. (2001). *My home is not my home anymore: improving continuity of care in homecare*. Ottawa, ON. Retrieved from https://www.cfhi-fcass.ca/SearchResultsNews/01-12-01/b2ca67cb-fea9-4411-b86b-1fc24352fef6.aspx

World Health Organization. (2008). *Integrated health services – World Health Organization technical brief.* Retrieved from www.who.int/healthsystems/service_delivery_techbrief1.pdf

World Health Organization. (2015). *World report on ageing and health*. Retrieved from Luxembourg, Germany: http://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf;jsessionid=C149D28CEF601AD21975ABC47595503C?sequence=1

World Health Organization. (2016). *Integrated care models: an overview*. Copenhagan, Denmark. Retrieved from ww.euro.who.int/__data/assets/pdf_file/.../Integrated-care-models-overview.pdf

Worrall, G., Chaulk, P. C., Briffett, E. (1996). Functional assessment verses clinical judgement in predicting outcomes of community-based continuing care: A prospective study. *Canadian Family Physician, 42*, 2360-2367.

Wyman, M. F., Shiovitz-Ezra, S., & Bengel, J. (2018). Ageism in the health care system:

    providers, patients, and systems. In L. Ayalon & C. Tesch-Römer (Eds.), *Contemporary*

    perspectives on ageism (pp. 193-212). Cham: Springer International Publishing.

APPENDIX A: PERMISSION TO USE THE MRC FRAMEWORK FOR DEVELOPING COMPLEX INTERVENTIONS FIGURE

From: Peter Craig
To: Elizabeth Kalles
Cc: Justine Giosa
Subject: [EXTERNAL] RE: Image Use - for Dissertation
Date: Thursday, June 28, 2018 4:47:05 AM
Attachments: image001.png

Please exercise caution. The message below is from an EXTERNAL source. Please do not open attachments or click links from an unknown or suspicious origin.Thank you.

Dear Elizabeth

Justine is welcome to use the figure so long as the dissertation cites the source, and says 'Reproduced with permission'.
Good luck with completing the thesis. Kind regards
Peter

Peter Craig
Senior Research Fellow Informing Healthy Public Policy

MRC/CSO Social and Public Health Sciences Unit University of Glasgow
200 Renfield Street Glasgow G2 3QB

0141 353 7559 (Direct line)
0141 353 7500 (Reception)
0780 952 6311 (Mobile)

www.sphsu.mrc.ac.uk

APPENDIX B: PERMISSION TO USE THE CO-CREATING KNOWLEDGE TRANSLATION FRAMEWORK FIGURE

From: Kathryn Powell
To: Elizabeth Kalles
Subject: [EXTERNAL] Re: Image Use - for Dissertation
Date: Thursday, June 28, 2018 9:01:51 PM

Dear Elizabeth
I can confirm that you have permission for your student Justine Giosa, Manager of Research Operations in the SE Research Centre and PhD Candidate at the University of Waterloo in Ontario, Canada, has permission to reproduce the image Figure 1, "Information to knowledge in the co-creating KT (co-KT) knowledge translation framework" from the 2013 article, A study protocol for applying the co-creating knowledge translation framework to a population health study, in her thesis/dissertation.
The conditions under which permission is given are: a $0 copyright permission to use the above image
Appropriate and correct acknowledgement and citation is given accompanying the image at any and all places where the image is used in the thesis
This permission is only for thesis.

I wish your student well, and by all means let me know if you wish to use the image in other documents - we thought it was very powerful and has proven most pragmatic

Best wishes, Kathryn

Dr Kathryn Powell
Senior Policy Officer **|** Policy and Advocacy Unit

The Royal Australasian College of Physicians
145 Macquarie Street, Sydney NSW, 2000
Phone: (02) 9256 5497 Fax: (02) 9252 3310
Email: kathryn.powell@racp.edu.au

APPENDIX C: PERMISSION TO USE THE ROLE OF USERS, RESEARCHERS AND DESIGNERS IN CLASSIC VERSUS CO-DESIGN METHODS FIGURE

From: Pieter Jan Stappers - IO

To: Elizabeth Kalles; Justine Giosa

Cc: Liz Sanders

Subject: [EXTERNAL] Re:

Image Use - for
Dissertation

Date:

Thursday, June 28,2018
2:01:53 AM

please feel free to use the figure in the dissertation.

I attach a version cut straight from the digital version of Sanders, E. B. N., & Stappers, P. J. (2012). *Convivial toolbox: Generative research for the front end of design.* Amsterdam: BIS.

I also attach the original black and white version from Sanders, E. B. N., & Stappers, P. J. (2008). Co-creation and the new landscapes of design. *Co-design*, *4*(1), 5-18.

you can use either one. Success!,

//pj
dr. Pieter Jan Stappers, Professor of Design Techniques

http://studiolab.ide.tudelft.nl/stappers/ +31 15 278 5202 (secr. ...3029)

<mailto:P.J.Stappers@tudelft.nl>   **room 32 C-3-130, Landbergstraat 15, NL-2628 CE Delft.**

APPENDIX D: INFORMATION LETTER AND INFORMED CONSENT FOR DEVELOPMENT OF THE G-CAP SURVEY

Date:

Dear [name]

Re: Key Informant Interviews for a research study *"Understanding current assessment and goal-setting practices across disciplines in home care for older adults"*

I am a PhD student at the University of Waterloo in the School of Public Health and Health Systems and a Research Associate of the Saint Elizabeth Research Centre and I am writing to tell you about a research study on the current assessment and goal-setting practices in three major professional health care disciplines involved in the home care provision of older adults: nursing, physiotherapy and occupational therapy. This study is being conducted as part of my PhD coursework, under the supervision of Dr. Paul Stolee. I would like to invite you to participate in the study by taking part in a key informant interview about your knowledge and expertise on patient assessment within your discipline. The interview would last for approximately one hour and take place at a time and location that is convenient for you.

Before you decide whether to be interviewed, I will tell you about the study.

Who is conducting this study?
Justine Giosa is conducting this study as part of her PhD course work, under the supervision of Dr. Paul Stolee in the School of Public Health and Health Systems at the University of Waterloo. The contact information of both the student investigator and faculty supervisor can be found at the end of this letter. This study is being funded by the Saint Elizabeth Research Centre at Saint Elizabeth Health Care.

Why are we doing this study?
The interRAI Home Care Assessment System (RAI-HC) is designed to collect comprehensive, client information for care planning and decision making by multiple providers in home care. While the RAI-HC is mandated for use by the Community Care Access Centres (CCACs), the data are not universally accessible to, shared with or used by service provider agencies. As such, frontline providers have adapted their own tools and strategies to individually collect, use and report the information they need. This is an enormous barrier to collaborative care, which can have very negative outcomes for elderly clients who tend to have multi-morbidities and complex service needs.

The goal of the project is to explore similarities and differences in the geriatric assessment practices of the major professional health care disciplines involved in the home care provision of older adults to uncover and understand the barriers to changing/ adopting a common assessment approach.

What are you being invited to do?
I am inviting you to be interviewed by me for about one hour during a convenient time for you (which can be outside of work hours should this be necessary). This would preferably take place in person but could be by telephone if that is more convenient for you. In the interview, you will be asked about your experience managing and teaching health care providers within your discipline and your understanding, experience and expertise in the assessment of older adults in home care.

There are no risks or discomfort from your participation in the research. We do think that if you agree to be interviewed, you can give input that will help inform a survey of frontline professionals about their understanding of the purpose of assessment, their assessment practices and their information needs.

Voluntary Participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision about whether or not to participate has no effect on your relationship with any of the researchers, or any organization associated with the research or your employer. You can decline to participate in the study without penalty. If you agree to participate, you will be able to talk about whatever you are comfortable with, may choose not to answer any of the questions or stop the interview at any time.

You will not receive any remuneration from researchers for participating in the interview. Should you be interested in participating, please discuss with your employer whether this interview can take place during working hours or whether it should take place outside of working hours.

Withdrawal from the Study: You can stop participating in the study at any time, for any reason. Your decision to stop participating or to refuse to answer particular questions has no effect on your relationship with any of the researchers or any organization associated with the research. If you decide to leave the study, all of the information collected from you will be immediately destroyed wherever possible.

Confidentiality: The interview will be recorded so we won't miss anything you say, but the recording and any notes of the discussion will be kept confidential to the fullest extent possible by law. Audio-recordings will be deleted from the recorder immediately following the study and electronic data will be will be kept secure on encrypted computers and retained indefinitely. Written records (e.g., consent forms will be kept in a locked file cabinet at the University of Waterloo and only research staff will have access to them. All written records will be shredded confidentially after a period of five years. If we use a quote from the discussion in reporting our findings, we will make it anonymous.

Questions about the Research? If you have questions about the research in general or about your role in the study, please feel free to contact the student researcher or faculty supervisor directly:

Justine Giosa, MSc
PhD Student
School of Public Health and Health Systems
University of Waterloo
Research Associate
Saint Elizabeth Research Centre

jgiosa@uwaterloo.ca
905-968-6564

Paul Stolee, PhD
Associate Professor
School of Public Health and Health Systems
University of Waterloo

stolee@uwaterloo.ca
519-888-4567 X35879

I would like to assure you that this study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee. However, the final decision about participation is yours. If you have any comments or concerns resulting from your participation in this study, please feel free to contact Dr. Maureen Nummelin in the Office of Research Ethics at 1-519-888-4567, Ext. 36005 or maureen.nummelin@uwaterloo.ca.

I sincerely hope that you will consider participating in an interview.

Sincerely,

Justine Giosa, MSc
PhD Student
School of Public Health and Health Systems
University of Waterloo

Research Associate
Saint Elizabeth Research Centre
jgiosa@uwaterloo.ca
905-968-6564

CONSENT TO PARTICIPATE IN AN INTERVIEW FOR A RESEARCH STUDY CALLED:
Understanding current assessment and goal-setting practices across disciplines in home care for older adults

By signing this consent form, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities. **Please review the following statements:**

I have read the information presented in the information letter about a study being conducted by Justine Giosa and Dr. Paul Stolee of the Department of School of Public Health and Health Systems at the University of Waterloo.

I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that I have the option of allowing my interview to be audio recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in the study report and/or publications to come from this research, with the understanding that the quotations will be anonymous.

I was informed that I may withdraw my consent at any time without penalty by advising the researcher.

This project has been reviewed by, and received ethics clearance through a University of Waterloo Research Ethics Committee. I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the Director, Office of Research Ethics at 519-888-4567 ext. 36005.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.
☐YES ☐NO
I agree to have my interview audio recorded.
☐YES ☐NO
I agree to the use of anonymous quotations in any thesis or publication that comes of this research.
☐YES ☐NO
My signature below indicates my consent.

Signatures

Printed Name of Participant   Signature   Date

Printed Name of Principal Investigator/   Signature   Date
Designated representative

When this study is completed, we will write up a summary of the results. Would you be interested in receiving a copy?

☐ Yes, please email me a summary of results. My email address is:
☐ Yes, please mail me a summary of results. My mailing address is:
☐ No, I do not wish to receive a summary of results

APPENDIX E: PILOT VERSION OF THE G-CAP SURVEY

Section 1: Methods of Assessment

First, we would like to ask you some questions about your assessment practices with older adults during your first visit in their home.

Cognition and Mood

1. How often do you conduct an assessment (formal or informal) of an older adult's cognition and mood during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 3; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 2]

How often do you use the following assessment tools/approaches to collect information about an older home care client's cognition and/or mood?

2a Montreal Cognitive Assessment (MoCA)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

2b Mini-Mental State Examination (MMSE)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

2c Centre for Epidemiological Studies Depression Scale (CES-D)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

2d Geriatric Depression Scale

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

2e Glasgow Coma Scale

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

2f The Delirium Index

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

2g The Confusion Assessment Method (CAM)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

2h Delirium Rating Scale

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

2i I use my own observation and/or interview skills to assess an older adult home care client's cognition and mood

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

Pain

3 How often do you conduct an assessment (formal or informal) of an older adult's pain during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 5; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 4]

How often do you use the following assessment tools/ approaches to collect information about an older home care client's pain (area and intensity)?

4a Brief Pain Inventory

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

4b Numeric Pain Rating Scale (NPRS)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

4c Verbal Rating Scale (Pain)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

4d Baker-Wong Pain Scale

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

4e Visual Analogue Scale for Pain

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

4f Facial Grimace and Behaviour Checklist Flowcharts (Pain)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

4g McGill Pain Questionnaire

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

4h Northern Pain Scale

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

4i I use my own observation and/or interview skills to assess an older adult home care client's pain

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

Skin Integrity

5 How often do you conduct an assessment (formal or informal) of an older adult's skin integrity during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 7; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 6]

How often do you use the following assessment tools/ approaches to collect information about an older home care patient's skin integrity?

6a Braden Scale for Predicting Pressure Sore Risk

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

6b Bates-Jensen Wound Assessment Tool (BWAT)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

6c Pressure Ulcer Scale for Healing (PUSH)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

6d I use my own observation and/or interview skills to assess an older adult home care client's skin integrity

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

Functional Status/Activity and Rest

7 How often do you conduct an assessment (formal or informal) of an older adult's functional status/ activity and rest during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 9; if they answer

How often do you use the following assessment tools to collect information about an older home care client's functional status/ activity and rest?

8a Functional Independence Measure (FIM)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

8b Katz Index of Independence in Activities of Daily Living

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

8c Barthel Index

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

8d Borg Rating Scale of Perceived Exertion

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

8e (SMAF) Functional Autonomy Measurement System

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

8f Functional Reach Test

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

8g OARS-IADL (Older Americans Resources and Services Scale-Instrumental Activities of Daily Living)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

8h Reintegration to Normal Living Index (RNL)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

8i (TEMPA) Test d'Evaluation des Membres Superieurs des Personnes Agees

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

8j Canadian Occupational Therapy Performance Measure (COPM)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

8k Assessment of Motor and Process Skills (AMPS)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

8l I use my own observation/interview skills to assess an older adult home care client's functional status/ activity and rest

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

Mobility/ Balance/ Ambulation

9 How often do you conduct an assessment (formal or informal) of an older adult's mobility/ balance/ ambulation during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 11; if they answer

How often do you use the following assessment tools to collect information about an older home care client's mobility/ balance/ ambulation?

10a Community Balance and Mobility Scale

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

10b Lower Extremity Functional Scale

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

10c Berg Balance Scale

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

10d Short Form Berg Balance Scale 3 Point

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

10e Timed Get Up and Go Test (TUG)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

10f Timed-Stands Test

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

10g Five Times Sit to Stand Test

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

10h Walk Test—2 minute, 6 minute, 12 minute, self-paced, shuttle

☐ Never ☐ Almost never ☐ Rarely ☐ Sometimes ☐ Often ☐ Almost always ☐ Always

10i Gait Speed

☐ Never ☐ Almost never ☐ Rarely ☐ Sometimes ☐ Often ☐ Almost always ☐ Always

10j Physiotherapy Functional Mobility Profile (PFMP)

☐ Never ☐ Almost never ☐ Rarely ☐ Sometimes ☐ Often ☐ Almost always ☐ Always

10k Activities-Specific Balance Confidence Scale

☐ Never ☐ Almost never ☐ Rarely ☐ Sometimes ☐ Often ☐ Almost always ☐ Always

10l I use my own observation and/or interview skills to assess an older adult home care client's mobility/balance/ambulation

☐ Never ☐ Almost never ☐ Rarely ☐ Sometimes ☐ Often ☐ Almost always ☐ Always

Safety (Environment, Abuse risk and Falls Risk)

11 How often do you conduct an assessment (formal or informal) of an older adult's safety (environment, abuse risk and falls risk) during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐ Never ☐ Almost never ☐ Rarely ☐ Sometimes ☐ Often ☐ Almost always ☐ Always

214

How often do you use the following assessment tools/ approaches to collect information about an older home care client's safety (environment, abuse risk and falls risk)?

12a SAFER-HOME

☐   ☐   ☐   ☐   ☐   ☐   ☐
Never   Almost never   Rarely   Sometimes   Often   Almost always   Always

12b Falls Risk Assessment Tool (FRAT)

☐   ☐   ☐   ☐   ☐   ☐   ☐
Never   Almost never   Rarely   Sometimes   Often   Almost always   Always

12c Falls Risk for Older People in the Community (FROP-Com)

☐   ☐   ☐   ☐   ☐   ☐   ☐
Never   Almost never   Rarely   Sometimes   Often   Almost always   Always

12d Indicators of Abuse (IOA)

☐   ☐   ☐   ☐   ☐   ☐   ☐
Never   Almost never   Rarely   Sometimes   Often   Almost always   Always

12e Caregiver Abuse Screen (CASE)

☐   ☐   ☐   ☐   ☐   ☐   ☐
Never   Almost never   Rarely   Sometimes   Often   Almost always   Always

12f I use my own observation and/or interview skills to assess an older adult home care client's safety (environment, abuse risk and falls risk)

☐   ☐   ☐   ☐   ☐   ☐   ☐
Never   Almost never   Rarely   Sometimes   Often   Almost always   Always

Quality of Life

13 How often do you conduct an assessment (formal or informal) of an older adult's quality of life during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 15; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 14]

How often do you use the following assessment tools to collect information about an older home care client's quality of life?

14a Community Integration Questionnaire II

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

14b Life Satisfaction Questionnaire 9

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

14c (EuroQoL-5D) European Quality of Life Scale

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

14d Health Utilities Index (HUI Mark 2/3)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

14e Nottingham Health Profile

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

14f SF-12 (12-item short-form health survey)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

14g SF-36 (Medical Outcomes Study 36-item short-form health survey)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

14h I use my own observation and/or interview skills to assess an older adult home care client's quality of life

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

Medication Management

15 How often do you conduct an assessment (formal or informal) of an older adult's medication management during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 17; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 16]

How often do you use the following assessment tools to collect information about an older home care client's medication management?

16a Medication Management Ability Assessment

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

16b Other tool (please list): _____

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

16c I use my own observation and/or interview skills to assess an older adult home care client's medication management

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

Resources (Social and Financial)

17 How often do you conduct an assessment (formal or informal) of an older adult's resources (social and financial) during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 19; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 18]

How often do you use the following assessment tools/approaches to collect information about an older home care client's resources (social and financial)?

18a Multidimensional Scale of Perceived Social Support

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18b Social Support Inventory (SSI)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18c General Social Survey (GSS)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18d Index of Social Support

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18e Practitioner Assessment of Network Type (PANT)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18f Personal Resource Questionnaire (PRQ85)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18g The MOS Social Support Survey

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18h The RAND Social Health Battery

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18i Assessment of Perceived Loneliness

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18j Assessment of Social Isolation

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18k Social Support Questionnaire

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18l Interpersonal Support Evaluation List (ISEL)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18m Semi-Structured Clinical Interview for Financial Capacity; SCIFC

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

18n I use my own observation and/or interview skills to assess an older adult home care client's resources (social and financial)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

Section 2: Attitudes towards client assessment in home care

Next, we would like to ask you some questions about your ideas about client assessment in home care

Please indicate the extent to which you agree/ disagree with the following statements about client assessment:

19a Client assessment involves collecting information about individuals using standardized tools

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor	Somewhat agree	Strongly agree	Completely agree

disagree

19b Client assessment requires a conversation with the client

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

19c Client assessment involves a conversation with the patient's family caregiver(s) (assuming they have one)

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

19d Client assessment involves a conversation with other health care providers in my discipline

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

19e Client assessment involves a conversation with other health care providers outside of my discipline

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

19f Client assessment requires observation of the client in their home environment

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

19g Client assessment data should be recorded in a client's chart

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

19h Client assessment is an administrative practice

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor	Somewhat agree	Strongly agree	Completely agree

disagree

19i Client assessment impacts how I deliver care to a client

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

19j Client assessment is an ongoing process throughout a client's care journey

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

19k In order to provide care to a client, I must conduct the client assessment myself

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

19l I can make use of client information collected by other health care professionals to provide care to clients

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

Section 3: Perceptions of the InterRAI-HC Assessment Tool

Next, we would like to ask you some questions about your experience with and perceptions of the inter-RAI home care assessment tool (RAI-HC).

20 I have heard about the RAI-HC assessment tool before

☐	☐
Yes	No

[If they answer yes, fluid surveys will proceed to question 21; if they answer no, fluid surveys will skill to question 23]

Please indicate your level of experience with the RAI-HC

21a I use the RAI-HC to conduct comprehensive assessments of older home care clients

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

21b I use RAI-HC data collected by someone else to plan and deliver care to older home care clients

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

21c I use Clinical Assessment Protocols (CAPs) associated with the RAI-HC to plan and deliver care to older home care clients

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

Please indicate the extent to which you agree/ disagree with the following statements about the RAI-HC :

22a The RAI-HC tool includes all the information I need to plan and deliver care to an older home care client

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

22b The RAI-HC tool is too long to complete in a home care visit with an older home care client

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

22c Collecting data with the RAI-HC is an administrative practice completed by the CCAC

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

22d I feel confident that I can use the RAI-HC to collect information about an older home care client

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

223

22e I feel confident that I can interpret data from the RAI-HC assessment to plan and deliver care to older home care clients

☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐
Completely disagree | Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree | Completely agree

22f RAI-HC data that gets collected by the CCAC is not linked to the care I provide

☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐
Completely disagree | Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree | Completely agree

Section 4: Interdisciplinary Collaboration

Next, we would like to ask you some questions about your experiences sharing and receiving information from other health care providers and working together to set individualized client goals.

Please indicate the relative importance of each of the following sources of input/ information for setting individual client goals in home care for older adults:

23a Assessment data that I collect

☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐
Not at all important | Not very important | Somewhat un-important | Neutral | Important | Very Important | Extremely important

23b Assessment data that others collect

☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐
Not at all important | Not very important | Somewhat un-important | Neutral | Important | Very Important | Extremely important

23c My professional opinion

☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐
Not at all important | Not very important | Somewhat un-important | Neutral | Important | Very Important | Extremely important

23d The professional opinion of other health care providers

☐	☐	☐	☐	☐	☐	☐
Not at all important	Not very important	Somewhat un-important	Neutral	Important	Very Important	Extremely important

23e Information from the client's chart

☐	☐	☐	☐	☐	☐	☐
Not at all important	Not very important	Somewhat un-important	Neutral	Important	Very Important	Extremely important

23f Input from the client

☐	☐	☐	☐	☐	☐	☐
Not at all important	Not very important	Somewhat un-important	Neutral	Important	Very Important	Extremely important

23g Input from the client's family members

☐	☐	☐	☐	☐	☐	☐
Not at all important	Not very important	Somewhat un-important	Neutral	Important	Very Important	Extremely important

Please indicate the extent to which you agree/disagree with the following statements about your collaboration with others in the care of older home care patients

24a I always know what other health care providers are working with an older home care client I care for

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

24b All health care providers involved in the care for an older home care client work towards common goals

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

24c Privacy and confidentiality prevent me from sharing information about a client's situation with other health care providers

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

24d I feel like I am part of an integrated team when I am caring for older home care clients

☐	☐	☐	☐	☐	☐	☐
Completely disagree	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Completely agree

Please indicate how often you collaborate with other health care professionals to care for older home care clients in the following ways:

25a I share client assessment information with other home health care providers in my discipline

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

25b I share client assessment information with home health care providers in other disciplines

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

25c I share client assessment information with personal support workers (PSWs)

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

25d I receive client assessment information from other home health care providers in my discipline

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

25e I receive client assessment information from home health care providers outside of my discipline

☐	☐	☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often	Almost always	Always

Section 5: Demographic Information

We are asking that you provide some demographic information so that we can describe the overall characteristics of the group of survey participants in our reports. This information will be reported as summary statistics only, will not be used at any time to identify you individually and will be kept strictly confidential at all times.

26 What is your gender identity?
☐Male
☐Female

27 What is your year of birth?
[drop down list]

28 What is your professional designation? (Please choose from the list below)

☐Registered Nurse
☐Registered Practical Nurse
☐Occupational Therapist
☐Physiotherapist

29 In what year did you receive this professional designation? [drop down list]

30 How long have you been working in the home care sector? (Please choose from the list below)

☐Less than one year 1
☐1-5 years 2
☐6-10 years 3
☐Greater than 10 years 4

What other health care sectors have you worked in? (choose all that apply)

31a ☐Hospital
31b ☐In-patient rehabilitation
31c ☐Long-term care
31d ☐Palliative care
31e ☐Private sector

32 What home care provider agency(ies) do you currently work for? (choose all that apply)
[list names of participating organizations]

33 Approximately what percentage of the clients you work with in the community are over the age of 65?

☐Less than 25%
☐25-50%
☐51-75%
☐More than 75%

APPENDIX F: FINAL VERSION OF THE G-CAP SURVEY

Section 1: Methods of Assessment

First, we would like to ask you some questions about your assessment practices with older adults during your first visit in their home.

Cognition and Mood

1 How often do you conduct an assessment (formal or informal) of an older adult's cognition and mood during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐
Never- Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 3; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 2]

How often do you use the following assessment tools/approaches to collect information about an older home care client's cognition and/or mood?

2a Montreal Cognitive Assessment (MoCA)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

2b Mini-Mental State Examination (MMSE)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

2c Centre for Epidemiological Studies Depression Scale (CES-D)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

2d Geriatric Depression Scale

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

2e Glasgow Coma Scale

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

2f The Delirium Index

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

2g The Confusion Assessment Method (CAM)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

2h Delirium Rating Scale

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

2i I use my own observation and/or interview skills to assess an older adult home care client's cognition and mood

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

Pain

3 How often do you conduct an assessment (formal or informal) of an older adult's pain during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐
Never- Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 5; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 4]

How often do you use the following assessment tools/ approaches to collect information about an older home care client's pain (area and intensity)?

4a Brief Pain Inventory

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

4b Numeric Pain Rating Scale (NPRS)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

4c Verbal Rating Scale (Pain)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

4d Baker-Wong Pain Scale

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

4e Visual Analogue Scale for Pain

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

4f Facial Grimace and Behaviour Checklist Flowcharts (Pain)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

4g McGill Pain Questionnaire

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

4h Northern Pain Scale

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

4i Edmonton System Assessment System (ESAS)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

4j I use my own observation and/or interview skills to assess an older adult home care client's pain

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

4k Other tools: _____

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

Skin Integrity

5 How often do you conduct an assessment (formal or informal) of an older adult's skin integrity during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐
Never- Rarely	Sometimes	Often	Almost always	Always

 [If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 7; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 6]

How often do you use the following assessment tools/ approaches to collect information about an older home care patient's skin integrity?

6a Brief Scale for Predicting Pressure Sore Risk

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

6b Bates-Jensen Wound Assessment Tool (BWAT)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

6c Pressure Ulcer Scale for Healing (PUSH)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

6d I use my own observation and/or interview skills to assess an older adult home care client's skin integrity

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

6e Other tools: _____

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

Functional Status/Activity and Rest

7 How often do you conduct an assessment (formal or informal) of an older adult's functional status/ activity and rest during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐
Never- Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 9; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 8]

How often do you use the following assessment tools to collect information about an older home care client's functional status/ activity and rest?

8a Functional Independence Measure (FIM)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

8b Katz Index of Independence in Activities of Daily Living

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

231

8c Barthel Index

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

8d Borg Rating Scale of Perceived Exertion

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

8e (SMAF) Functional Autonomy Measurement System

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

8f Functional Reach Test

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

8g OARS-IADL (Older Americans Resources and Services Scale-Instrumental Activities of Daily Living)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

8h Reintegration to Normal Living Index (RNL)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

8i (TEMPA) Test d'Evaluation des Membres Superieurs des Personnes Agees

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

8j Canadian Occupational Therapy Performance Measure (COPM)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

8k Assessment of Motor and Process Skills (AMPS)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

8l I use my own observation/interview skills to assess an older adult home care client's functional status/ activity and rest

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

8m Other tools: _____

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

Mobility/ Balance/ Ambulation

9 How often do you conduct an assessment (formal or informal) of an older adult's mobility/ balance/ ambulation during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐
Never- Rarely	Sometimes	Often	Almost always	Always

 [If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 11; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 10]

How often do you use the following assessment tools to collect information about an older home care client's mobility/ balance/ ambulation?

10a Community Balance and Mobility Scale

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

10b Lower Extremity Functional Scale

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

10c Berg Balance Scale

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

10d Short Form Berg Balance Scale 3 Point

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

10e Timed Get Up and Go Test (TUG)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

10f Timed-Stands Test

□	□	□	□	□
Never	Almost never	Rarely	Sometimes	Often- Always

10g Five Times Sit to Stand Test

□	□	□	□	□
Never	Almost never	Rarely	Sometimes	Often- Always

10h Walk Test—2 minute, 6 minute, 12 minute, self-paced, shuttle

□	□	□	□	□
Never	Almost never	Rarely	Sometimes	Often- Always

10i Gait Speed

□	□	□	□	□
Never	Almost never	Rarely	Sometimes	Often- Always

10j Physiotherapy Functional Mobility Profile (PFMP)

□	□	□	□	□
Never	Almost never	Rarely	Sometimes	Often- Always

10k Activities-Specific Balance Confidence Scale

□	□	□	□	□
Never	Almost never	Rarely	Sometimes	Often- Always

10l Tinetti Balance Test

□	□	□	□	□
Never	Almost never	Rarely	Sometimes	Often- Always

10m I use my own observation and/or interview skills to assess an older adult home care client's mobility/balance/ambulation

□	□	□	□	□
Never	Almost never	Rarely	Sometimes	Often- Always

10n Other Tools_____

□	□	□	□	□
Never	Almost never	Rarely	Sometimes	Often- Always

Safety (Environment, Abuse risk and Falls Risk)

11 How often do you conduct an assessment (formal or informal) of an older adult's safety (environment, abuse risk and falls risk) during your first home care visit with them in order to make decisions about their care needs and/or provide care?

234

☐	☐	☐	☐	☐
Never- Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 13; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 12]

How often do you use the following assessment tools/ approaches to collect information about an older home care client's safety (environment, abuse risk and falls risk)?

12a SAFER-HOME

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

12b Falls Risk Assessment Tool (FRAT)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

12c Falls Risk for Older People in the Community (FROP-Com)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

12d Indicators of Abuse (IOA)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

12e Caregiver Abuse Screen (CASE)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

12f I use my own observation and/or interview skills to assess an older adult home care client's safety (environment, abuse risk and falls risk)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

12g Other tools: _____

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

Quality of Life

13 How often do you conduct an assessment (formal or informal) of an older adult's quality of life during your first home care visit with them in order to make decisions about their care needs and/or provide care?

235

☐	☐	☐	☐	☐
Never- Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 15; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 14]

How often do you use the following assessment tools to collect information about an older home care client's quality of life?

14a Community Integration Questionnaire II

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

14b Life Satisfaction Questionnaire 9

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

14c (EuroQoL-5D) European Quality of Life Scale

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

14d Health Utilities Index (HUI Mark 2/3)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

14e Nottingham Health Profile

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

14f SF-12 (12-item short-form health survey)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

14g SF-36 (Medical Outcomes Study 36-item short-form health survey)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

14h I use my own observation and/or interview skills to assess an older adult home care client's quality of life

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

14i Other tools: _____

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

Medication Management

15 How often do you conduct an assessment (formal or informal) of an older adult's medication management during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐
Never- Rarely	Sometimes	Often	Almost always	Always

[If they answer Never, Almost Never or Rarely, fluid surveys will skip to question 17; if they answer Sometimes, Often, Almost Always or Always, fluid surveys will proceed to question 16]

How often do you use the following assessment tools to collect information about an older home care client's medication management?

16a Medication Management Ability Assessment

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

16b Other tool (please list): _____

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

16c I use my own observation and/or interview skills to assess an older adult home care client's medication management

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

16d Other tools: _____

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

Resources (Social and Financial)

17 How often do you conduct an assessment (formal or informal) of an older adult's resources (social and financial) during your first home care visit with them in order to make decisions about their care needs and/or provide care?

☐	☐	☐	☐	☐
Never- Rarely	Sometimes	Often	Almost always	Always

How often do you use the following assessment tools/approaches to collect information about an older home care client's resources (social and financial)?

18a Multidimensional Scale of Perceived Social Support

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18b Social Support Inventory (SSI)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18c General Social Survey (GSS)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18d Index of Social Support

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18e Practitioner Assessment of Network Type (PANT)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18f Personal Resource Questionnaire (PRQ85)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18g The MOS Social Support Survey

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18h The RAND Social Health Battery

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18i Assessment of Perceived Loneliness

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18j Assessment of Social Isolation

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18k Social Support Questionnaire

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18l Interpersonal Support Evaluation List (ISEL)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18m Semi-Structured Clinical Interview for Financial Capacity; SCIFC

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18n I use my own observation and/or interview skills to assess an older adult home care client's resources (social and financial)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

18o Other tools: _____

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

Section 2: Attitudes towards client assessment in home care

Next, we would like to ask you some questions about your ideas about client assessment in home care

Please indicate the extent to which you agree/ disagree with the following statements about client assessment:

19a Client assessment involves collecting information about individuals using standardized tools

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

19b Client assessment requires a conversation with the client

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

19c Client assessment involves a conversation with the patient's family caregiver(s) (assuming they have one)

☐ Strongly disagree   ☐ Somewhat disagree   ☐ Neither agree nor disagree   ☐ Somewhat agree   ☐ Strongly agree

19d Client assessment involves a conversation with other health care providers in my discipline

☐ Strongly disagree   ☐ Somewhat disagree   ☐ Neither agree nor disagree   ☐ Somewhat agree   ☐ Strongly agree

19e Client assessment involves a conversation with other health care providers outside of my discipline

☐ Strongly disagree   ☐ Somewhat disagree   ☐ Neither agree nor disagree   ☐ Somewhat agree   ☐ Strongly agree

19f Client assessment requires observation of the client in their home environment

☐ Strongly disagree   ☐ Somewhat disagree   ☐ Neither agree nor disagree   ☐ Somewhat agree   ☐ Strongly agree

19g Client assessment data should be recorded in a client's chart

☐ Strongly disagree   ☐ Somewhat disagree   ☐ Neither agree nor disagree   ☐ Somewhat agree   ☐ Strongly agree

19h Client assessment is an administrative practice

☐ Strongly disagree   ☐ Somewhat disagree   ☐ Neither agree nor disagree   ☐ Somewhat agree   ☐ Strongly agree

19i Client assessment impacts how I deliver care to a client

☐ Strongly disagree   ☐ Somewhat disagree   ☐ Neither agree nor disagree   ☐ Somewhat agree   ☐ Strongly agree

19j Client assessment is an ongoing process throughout a client's care journey

☐ Strongly disagree   ☐ Somewhat disagree   ☐ Neither agree nor disagree   ☐ Somewhat agree   ☐ Strongly agree

19k In order to provide care to a client, I must conduct the client assessment myself

☐ Strongly disagree   ☐ Somewhat disagree   ☐ Neither agree nor disagree   ☐ Somewhat agree   ☐ Strongly agree

19l I can make use of client information collected by other health care professionals to provide care to clients

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

Section 3: Perceptions of the InterRAI Assessment Tools

Next, we would like to ask you some questions about your experience with and perceptions of the interRAI assessment tools.

20 I have heard about the interRAI home care (RAI-HC) assessment tool before

☐	☐
Yes	No

21. I have heard about the interRAI community health assessment (RAI-CHA) before

☐	☐
Yes	No

[If they answer yes to question 20 or 21, fluid surveys will proceed to question 22; if they answer no, fluid surveys will skill to question 24]

Please indicate your level of experience with the RAI-HC

22a I use the RAI-HC and/or the RAI-CHA to conduct comprehensive assessments of older home care clients

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

22b I use RAI-HC and/or RAI-CHA data collected by someone else to plan and deliver care to older home care clients

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

22c I use Clinical Assessment Protocols (CAPs) associated with the RAI-HC and/or RAI_CHA to plan and deliver care to older home care clients

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

Please indicate the extent to which you agree/ disagree with the following statements about the RAI-HC:

23a The RAI-HC and/or RAI-CHA tool includes all the information I need to plan and deliver care to an

241

older home care client

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

23b The RAI-HC and/or RAI-CHA tool is too long to complete in a home care visit with an older home care client

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

23c Collecting data with the RAI-HC and/or RAI-CHA is an administrative practice completed by the CCAC

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

23d I feel confident that I can use the RAI-HC and/or RAI-CHA to collect information about an older home care client

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

23e I feel confident that I can interpret data from the RAI-HC and/or RAI-CHA to plan and deliver care to older home care clients

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

23f RAI-HC and/or RAI-CHA data that gets collected by the CCAC is not linked to the care I provide

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

Section 4: Interdisciplinary Collaboration

Next, we would like to ask you some questions about your experiences sharing and receiving information from other health care providers and working together to set individualized client goals.

Please indicate the relative importance of each of the following sources of input/ information for setting individual client goals in home care for older adults:

24a Assessment data that I collect

☐	☐	☐	☐	☐
Not at all important	Somewhat un-important	Neutral	Important	Very important

24b Assessment data that others collect

☐	☐	☐	☐	☐
Not at all important	Somewhat un-important	Neutral	Important	Very important

24c My professional opinion

☐	☐	☐	☐	☐
Not at all important	Somewhat un-important	Neutral	Important	Very important

24d The professional opinion of other health care providers

☐	☐	☐	☐	☐
Not at all important	Somewhat un-important	Neutral	Important	Very important

24e Information from the client's chart

☐	☐	☐	☐	☐
Not at all important	Somewhat un-important	Neutral	Important	Very important

24f Input from the client

☐	☐	☐	☐	☐
Not at all important	Somewhat un-important	Neutral	Important	Very important

24g Input from the client's family members

☐	☐	☐	☐	☐
Not at all important	Somewhat un-important	Neutral	Important	Very important

Please indicate the extent to which you agree/disagree with the following statements about your collaboration with others in the care of older home care patients

25a I always know what other health care providers are working with an older home care client I care for

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

25b All health care providers involved in the care for an older home care client work towards common goals

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

25c Privacy and confidentiality prevent me from sharing information about a client's situation with other health care providers

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

25d I feel like I am part of an integrated team when I am caring for older home care clients

☐	☐	☐	☐	☐
Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

Please indicate how often you collaborate with other health care professionals to care for older home care clients in the following ways:

26a I share client assessment information with other home health care providers in my discipline

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

26b I share client assessment information with home health care providers in other disciplines

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

26c I share client assessment information with personal support workers (PSWs)

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

26d I receive client assessment information from other home health care providers in my discipline

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

26e I receive client assessment information from home health care providers outside of my discipline

☐	☐	☐	☐	☐
Never	Almost never	Rarely	Sometimes	Often- Always

Section 5: Demographic Information

We are asking that you provide some demographic information so that we can describe the overall characteristics of the group of survey participants in our reports. This information will be reported as summary statistics only, will not be used at any time to identify you individually and will be kept strictly confidential at all times.

27 What is your gender identity?

☐Male

☐Female

28 What is your year of birth?

[drop down list]

29 What is your professional designation? (Please choose from the list below)

☐Registered Nurse

☐Registered Practical Nurse

☐Occupational Therapist

☐Physiotherapist

30 In what year did you receive this professional designation?[drop down list]

31 How long have you been working in the home care sector? (Please choose from the list below)

☐Less than one year 1

☐1-5 years 2

☐6-10 years 3

☐Greater than 10 years 4

What other health care sectors have you worked in? (choose all that apply)

32a ☐Hospital

32b ☐In-patient rehabilitation

32c ☐Long-term care

32d☐Palliative care

32e☐Private sector

33 What home care provider agency(ies) do you currently work for? (choose all that apply)

[list names of participating organizations]

34 Approximately what percentage of the clients you work with in the community are over the age of 65?

☐Less than 25%

☐25-50%

☐51-75%

☐More than 75%

APPENDIX G: INFORMATION AND CONSENT PAGE OF THE G-CAP SURVEY

You are invited to participate in this online survey as part of a research study conducted by **researchers at the University of Waterloo and the Saint Elizabeth Research Centre**. The purpose of this survey is to help us find out more about the assessment of geriatric home care patients to determine their care needs. If you decide to participate, the survey will take 30 minutes of your own time to complete and your answers will be kept confidential at all times.

Survey questions focus on your experiences and assessment practices with older home care patients. Participation in this survey is voluntary. You may decline to answer any questions that you do not wish to answer by simply skipping to the next question and you can withdraw your participation at any time by not submitting your responses. There are no known or anticipated risks from participating in this study. Your decision whether or not to participate has no effect on your employment and/or association with the organization that sent you the survey now or in the future.

It is important for you to know that any information that you provide will be confidential. All of the data will be summarized and no individual could be identified from these summarized results. Furthermore, the Fluid Surveys website is programmed to collect responses alone and will not collect any information that could potentially identify you (such as machine identifiers). The servers on which FluidSurveys operate are located in Canada, so personal information will be primarily stored in Canada however personal information may also be processed in and transferred or disclosed to countries in which SurveyMonkey affiliates are located and in which service providers are located or have servers.

The data, with no personal identifiers, collected from this survey will be maintained on a password-protected computer database in a restricted access area of the university. As well, the data will be electronically archived after completion of the study and maintained for two years and then erased.

We are looking for 100 nurses, 100 physiotherapists and 100 occupational therapists to participate in the survey. If you decide to participate and if you are one of these first 100 participants, you will have an option to enter your contact information at the end of the survey in order to receive a $25.00 (CAD) honorarium in the form of a cheque, which will be mailed to you within a month of your participation in the survey. In order to administer this cheque, we will require you to share your full name and mailing address as well as your telephone number and/or email address so we can contact you if necessary.

Your contact information will be stored separately from your survey results and will only be shared with the finance department at Saint Elizabeth Health Care in order to administer the honorarium cheques. The finance department will keep this information confidential at all times and will destroy the information after the cheques have been administered. The amount received is taxable. It is your responsibility to report this amount for income tax purposes. Should you have any questions about the

study, please contact one of the following researchers:

Justine Giosa at 905-968-6564 or jgiosa@uwaterloo.ca
Dr. Paul Stolee at 519-888-4567 X35879 or stolee@uwaterloo.ca or

We would like to assure you that this study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee. However, the final decision about participation is yours. If you have any comments or concerns resulting from your participation in this survey, please feel free to contact Dr. Maureen Nummelin in the Office of Research Ethics at 1-519-888-4567, Ext. 36005 or maureen.nummelin@uwaterloo.ca.

Consent to Participate
With full knowledge of all foregoing, I agree of my own free will, to participate in this study

[insert check box] I agree to participate. (Please click next to continue)

[insert check box] I do not wish to participate (Please close your browser now)

APPENDIX H: RECRUITMENT FLYER FOR KEY INFORMANT INTERVIEWS

APPENDIX I: INFORMATION AND CONSENT FOR KEY INFORMANT INTERVIEWS

[Insert Date]

Hello [name],

This letter is an invitation for you to take part in a key informant interview to provide ideas for how the home care experience of older adults can be improved based your experience with home care services (as a client or family/ friend caregiver). Your participation in this interview is entirely voluntary and your decision to participate or not will have no effect on the care that you or your family member/ friend receives currently or in the future.

Please take time to read the following information carefully.

Who is conducting this research? Justine Giosa is a PhD student in the School of Public Health and Health Systems at the University of Waterloo. This work is being completed as her PhD research project under the supervision of Dr. Paul Stolee. Justine holds a Canadian Institutes of Health Research (CIHR) Sir Frederick Banting and Charles Best Canada Graduate Scholarship and is a Senior Research Associate in the Saint Elizabeth Research Centre of Saint Elizabeth, a collaborating organization for this research study.

What is the purpose of this research study? Older people want to remain in their homes as long as possible. To do so, many people require home care services to meet their multiple complex health needs; however, to get it, individuals and their family members and friends often have to tell their story multiple times to different providers who may not communicate with each other to coordinate care. The purpose of this study is to design a new approach to care planning for older adults receiving home care in Ontario that will enhance the experience of older adults and their family and friend caregivers and improve provider teamwork.

What are you being asked to do? You are being asked to participate in a 30-60 minute interview with Justine Giosa (the PhD student researcher) where you will be asked about your experience working with health care providers in home care to set goals and express and include your unique needs and preferences in your home care or the home care of your family member or friend. We want to know what suggestions you might have for improving the care planning process based on your experience. This information will be used to develop a plan for a more integrated geriatric care planning approach in home care. The interview can take place at a time and location that is convenient for you. We would prefer an in-person interview, but if not possible, we can arrange to complete the interview by telephone. If you agree to participate, we'll need your written consent on the attached form. Even after you provide consent, you can choose to stop participating in the study at any time. You may also decide to skip any questions you do not wish to answer during the interview.

To thank you for your participation in this research you have the option to receive a $25.00 (CAD) honorarium in the form of a Visa gift card, which will be provided to you in person during your interview or mailed to you following your telephone intervi**ew. The amount received is taxable. It is your responsibility to report this amount for income tax purposes.You may only complete one interview.**

Recording and Confidentiality: Justine would like to audio record the interview so she does not miss anything you say, but the recordings and any notes of the discussion will be kept confidential at all times. The recordings and the notes will be anonymized and kept secure on password protected computers and only Justine and her PhD supervisor will have access to them. If we use a quote from the discussion in reporting the findings, we will make it anonymous. We will delete the recordings and shred any paper notes within 7 years.

We might use anonymous quotes from the interview in the following ways:
- in teaching, demonstration and workshop materials,
- in scholarly papers, articles and other publications,
- in presentations at academic, health care conferences

Questions about the Research? If you have questions about the research in general or about your role in the study, please feel free to contact Justine Giosa (the PhD student researcher) or Dr. Paul Stolee (the faculty supervisor) directly.

This project has been reviewed by, and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #22251). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or   ore-ceo@uwaterloo.ca.

We sincerely hope that you will consider participating in an interview.

Sincerely,

Justine Giosa, PhD candidate
School of Public Health and Health Systems, University of Waterloo
Senior Research Associate, Saint Elizabeth Research Centre
jgiosa@uwaterloo.ca
1-800- 463-1763 ext. 146564

Paul Stolee PhD, CE
Professor
School of Public Health and Health Systems, University of Waterloo
stolee@uwaterloo.ca
(519) 888-4567 ext. 35879

CONSENT FORM

By signing this consent form, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

I have read the information presented in the information letter about a study being conducted Justine Giosa and supervised by Dr. Paul Stolee from the School of Public Health and Health Systems at the University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I understand that all of the information collected in this interview will be kept confidential. I am also aware that excerpts from the interview may be included in the publications to come from this research, with the understanding that the quotations will be anonymous.

I was informed that I may withdraw my consent at any time without penalty by advising the researcher.

This project has been reviewed by, and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #22251). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this interview session and to keep in confidence information that could identify specific participants and/or the information they provided.

☐YES ☐NO
I agree to have my interview session audio recorded.
☐YES ☐NO
I agree to the use of anonymous quotations in any thesis or publication that comes of this research.
☐YES ☐NO
I would like to receive the $25.00 (CAD) Visa gift card honorarium for my participation. *I understand the amount received is taxable and that it is my responsibility to report this amount for income tax purposes.*

☐YES ☐NO (IF TELEPHONE INTERVIEW) My Mailing Address is:
_____

Participant Name: _____ (Please print)

Participant Signature: _____

Witness Name: _____ (Please print)

Witness Signature: _____

Date: _____

When this study is completed, we will write a summary of the results. Would you be interested in receiving a copy?

☐YES, please e-mail me a summary of the results. My e-mail address is:
☐YES, please mail me a summary of the results. My mailing address is:
☐NO, I do not wish to receive a summary of results

Would you be interested in being contacted to participate in a future stage of this research?

☐YES, please contact me at: _____
☐NO, I do not wish to be contacted

APPENDIX J: SAMPLE INTERVIEW GUIDE FOR KEY INFORMANT INTERVIEWS

Respect and Dignity

Can you tell me about a time when you felt that health care providers treated you with respect, listened to your input and acknowledged your choices?

[if yes]- what made this experience so great and how could providers consistently make this happen?

[if no]- What could providers do to make you feel like your input and choices are respected, acknowledged and incorporated into the care planning process? How do you think they should do this?

Information Sharing

Can you tell me about a time when health care providers took the time to talk to you about your/ your family/friend's needs and preferences for care?

[if yes]- what made this experience so great and how could providers consistently make this happen?

[if no]- What could providers do to make sure your needs and preferences are acknowledged and incorporated into the care planning process? How do you think they should do this?

Participation

Can you tell me about a time during your home care experience (as a client or caregiver) that you felt encouraged and supported in participating in goal-setting at a level you wanted to be?

[if yes] – what made this experience so great and how could providers consistently make this happen?

[if no]- How could providers encourage and support you and your family to participate in goal-setting at the level you would like?

Collaboration

Do you have any suggestions for how health care providers could better involve you in the care planning process? [e.g. asking questions about your unique needs, goal-setting, documenting your goals etc.]

APPENDIX K: SAMPLE MEMO FOLLOWING PARTICIPANT INTERVIEW

Memo: Interview with Participant #5-DORIS

Doris was very well prepared for her interview. When I arrived, it was clear that nobody was keeping up with the yard work. All of the gardens were completely overgrown and unkempt. Doris answered the door--her house was tidy but full of trinkets and collectables and stuck in the era of the 1960s. Doris was well dressed--a blouse, sweater and a pleated skirt and black sturdy shoes. Her hair was neat--grey and combed back with several bobby pins. She was not wearing any make up.

There seemed to be semi-repair jobs being done in various areas of the very old house. The kitchen did not seem to be set up very functionally for someone with limited mobility and I found myself wondering if anyone actually cooked in that kitchen anymore.

There was a cat roaming about.

The house was somewhat tidy but had not been thoroughly cleaned in a long time and there was a strange odour throughout.

Before we started the interview, I complemented Doris on her lovely backyard that I could see from the place at her table where we were to conduct the interview. Doris proceeded to tell me that her young neighbours drove her crazy because their kids were constantly outside in the summer time on the trampoline until all hours of the night and very early in the morning, which she did not appreciate.

Doris had typed and printed out several documents before I arrived--one was notes she had taken from an event on home care services that she attended at a seniors centre. Another was a detailed recount of her medical history for over 15 years. Another was a list of her biggest concerns, goals and recommendations to improve home care for older adults.

Doris was very outspoken and to the point. She was not afraid to speak her mind and did not hold back on her opinions about the system.

She seemed lonely and a bit frustrated that her physical limitations were preventing her from being as independent as she felt in her mind. She seemed equally frustrated that adequate services and supports weren't in place to help her maintain independence, instead of making her even more dependent.

APPENDIX L: MY 5 TOP THINGS WORKSHEET

My Top Five Things: About Me/The Person Who Supports Me

CHOOSE YOUR PERSPECTIVE:

☐ **Patient**
The Top 5 Things I want my home health care team to know about me.

☐ **Caregiver**
The Top 5 Things I want my spouse/friend/parent's home health care team to know about **ME** as their support person (caregiver).

☐ **Home Healthcare Provider**
The Top 5 Things I want to know about my patient and/or their caregiver or support person.

#1 [ ] → Why is this important to you? → [ ]

#2 [ ] → Why is this important to you? → [ ]

#3 [ ] → Why is this important to you? → [ ]

#4 [ ] → Why is this important to you? → [ ]

#5 [ ] → Why is this important to you? → [ ]

APPENDIX M: SAMPLE PERSONA FROM ACTIVITY #2

Peter

Age: 74 years old

Home Status: Lives in a bungalow in Elora, Ontario with his wife Rebecca; they have been married and living in the same home for 43 years

Occupation: Retired accountant

Family: Peter and Rebecca have two adult children, Jeff who lives in Toronto with his wife and three boys ages 5, 8 and 11; and Melissa who lives in Calgary and is a single parent to a three year old girl.

Health: Parkinson's disease and recently fell, broke his hip and had surgery. Peter also wears hearing aids.

Goals: Peter wants to be at home as long as possible but he does not want to be a burden to his family; his wife has already helped him so much and his children are busy with their own lives so he doesn't want them to worry.

Peter was 28 when he first met Rebecca through a friend and they have been inseparable ever since. They were married in 1974. It was not long before they welcomed their first born, Jeff, followed by their beautiful daughter, Melissa. It seemed like their children grew up so fast and just like that they left home to start their own lives.

Peter was always in good health and prided himself on regular exercise and healthy eating. Around his 65th birthday, Peter started to notice some changes in himself. He felt tired and 'fuzzy', he seemed to be dragging his feet when he walked and had a hard time holding his coffee mug without shaking. At first he tried to hide these things, but eventually he realized that he should seek some medical advice.

After several doctors and specialists visits, Peter was diagnosed with Parkinson's disease. The news was hard to take, but Peter was optimistic that if he followed the doctor's orders, that he would be okay. To focus on his health, Peter decided it was time to retire from his job and Rebecca supported his decision. Peter knew he could keep busy by spending more time on his classic car hobby. He has always loved classic cars. His favourite day of the year is the Fergus Antique and Classic Car Show, held annually in Fergus every September. He loves the chance to see the great collection of classic cars as well as visit with old friends. What makes it even more special for Peter is that it has become a tradition for Jeff and his grandsons to come to the car show with him.

For 9 years, Peter managed okay—his tremors progressed and he started using a cane but he was in good spirits. He even convinced Rebecca to retire two years ago so they could travel—to Calgary to visit Melissa and their granddaughter, a Caribbean cruise and even a dream trip to Europe!

This past summer everything changed. Peter started feeling dizzy and was losing his balance often. He started using a walker instead of a cane, but it was clunky and sometimes he didn't bother with it when he was at home.

One day in July, on his way to the bathroom, he tripped and fell in the hall. Rebecca came running and realized something was terribly wrong— Peter was in so much pain. He was rushed to Grand River Hospital where he was told that he had broken his hip. The next few days and weeks were a blur—surgery, pain, a transfer to Freeport Hospital for rehabilitation, surgical wound complications, daily therapy, so many different nurses, and awful food—Peter was just exhausted and so was Rebecca. He wanted to go home.

Finally, after what felt like forever, Peter got cleared by his care team to go home. He had re-gained enough strength to walk with his walker, although he knew he still had a long road ahead. Someone called a "care coordinator" (from the Waterloo-Wellington Local Health Integration Network) came to speak to him about what support he would need at home. Peter didn't really know how to answer her questions and wished Rebecca had been there for the meeting. He was told that a nurse would be visiting within 24 hours of him going home, that he would get some therapy visits at home, and that he would also get help twice a week with showers.

It was August 15th and Peter was going home. He was so glad but knew Rebecca was worried about how they would manage. Peter doesn't want to be a burden on his wife and children. All he could think about was getting strong enough to get to the classic car show on September 8th.

APPENDIX N: SAMPLE SCENARIO CARDS FROM ACTIVITY #2

Day 2 -1

Actions:

- Nurse arrives on time but with someone named Natalie who is a trainee—Peter and Rebecca did not know Natalie was coming

- Margaret starts asking Peter and Rebecca questions about Peter's medical history— many are the same questions they had answered at the hospital and Rebecca wonders why Margaret doesn't already have this information

EMOTIONS
Confused

Day 2 -2

Actions:

- Margaret changes Peter's surgical wound bandage and asks Rebecca if she could take care of this moving forward, since she overheard her mention that she was a retired nurse

EMOTIONS
Confused

Day 4 -1

Actions:

- PSW Simon arrives to help Peter with his bath

- Rebecca and Peter show Simon around the house, and explain Peter's morning routine including that he is very particular about having lotion on his arms for his dry skin

- Simon gets started on the bath and asks Peter why he doesn't have a bath bench in his tub—Peter doesn't know—Simon completes the bath with Peter sitting in the tub on a folding chair

EMOTIONS
Frustrated

Day 4 -2

Actions:

- Later that day an OT named Cynthia comes to complete a safety assessment. She is 20 minutes late and seems frazzled. Cynthia recommends that Peter have a bath bench and places an order for this new equipment

- Rebecca asks Cynthia why she didn't come before Simon—Cynthia didn't know who Simon was

EMOTIONS
Frustrated

APPENDIX O: LARGE WORKSHEET FROM ACTIVITY #2
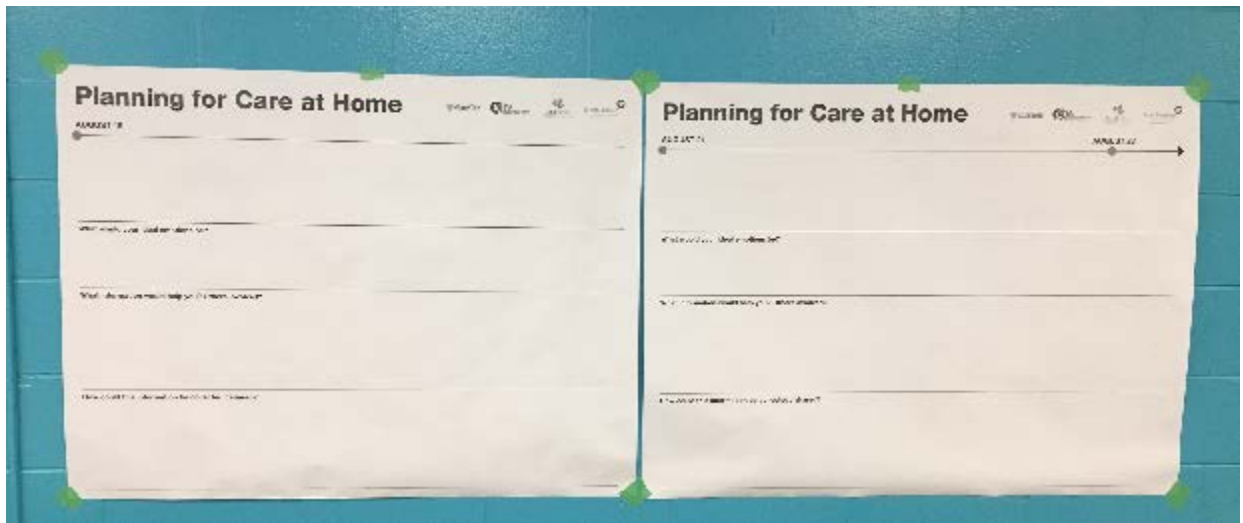
APPENDIX P: SAMPLE COLOUR-CODED TILES FROM ACTIVITY #2

PATIENT INFORMATION	PATIENT INFORMATION	PATIENT INFORMATION	PATIENT INFORMATION
Pain (source, amount, frequency)	Seeing Ability	Safety Concerns (in home, personal)	Major Hobbies and interests
Goals (in their own words)	Preferred way to be addressed (first name, last name)	Living Arrangements	Current/ Previous Occupation
Daily Schedule	Current/Previous Physical Activity Level	Family Dynamics	Preferred sex of provider(s)
Access to Social Supports	Allergies	Current/ Previous Cognitive Status	Available Community Support Services
Medication Management ability	Financial Resources available	Understanding of own health conditions/status	If they have a family doctor

INFORMATION / TOOLS	INFORMATION / TOOLS	INFORMATION / TOOLS	INFORMATION / TOOLS
Paper checklist	Mobile phone/ tablet application	Standardized assessment tool	Instant messaging/ chat group
Paper Journal	Online chart	Verbal dialogue	Online discussion forum
Paper diary	Website	Email	Photograph it
Binder	Magnet on the fridge	Telephone call	Videotape it
Paper folder	One Page fridge summary	Online scheduling system	Write it down

APPENDIX Q: OUR BEST IDEA WORKSHEET AND TEMPLATES FOR ACTIVITY #3

Our Best Idea to Improve Geriatric Care Planning in Home Care

Sketch it — What does it look like?

Paste the type of tool here
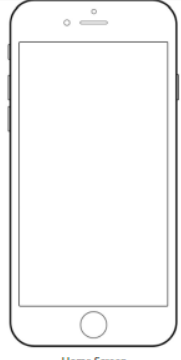
Describe it — How would it be used within a single home care visit?
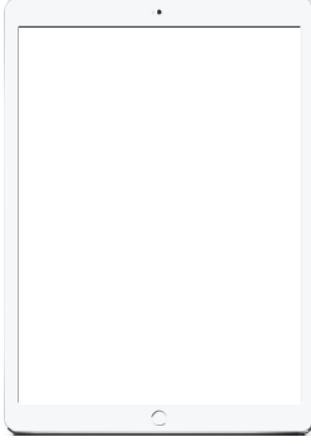For example: Who uses it? For what? When? Where? Why? How?
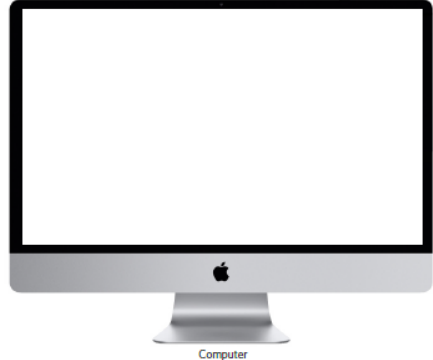
Before the Visit

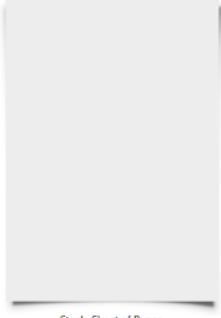**During the Visit**

After the Visit

Home Screen

Tablet

Computer

Single Sheet of Paper

Booklet

APPENDIX R: ACT IT OUT WORKSHEET FOR ACTIVITY #4

Act it Out: How would your best idea play out for Peter's story?

Choose a Scenario: ☐ Day 1 ☐ Day 2 ☐ Day 4 ☐ Day 5 ☐ Day 7 ☐ Day 9 ☐ Day 10 ☐ Day 13

Choose your Actors:

	Which health care roles are involved?	
Peter: _____	OT: _____	Nurse: _____
Rebecca: _____	PT: _____	PSW: _____

Create the Scene: Who interacts with who? What do they say? What do they do?
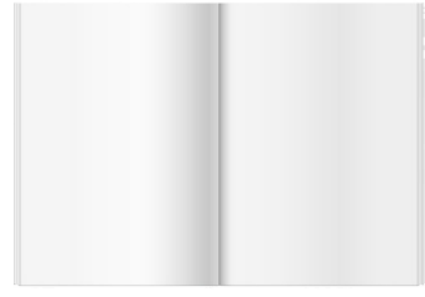
Before the Visit	During the Visit	After the Visit

APPENDIX S: CO-DESIGN WORKSHOP PARTICIPANT RECRUITMENT FLYER

APPENDIX T: INFORMATION AND CONSENT FOR CO-DESIGN WORKSHOP

OLDER ADULT/FAMILY/FRIEND CAREGIVER VERSION

Dear [name],

This letter is an invitation for you to take part in a co-design workshop where you will partner with researchers, health care providers and other individuals who have received or supported those who have received home care services to develop ideas for a more integrated geriatric care planning approach for home care in Ontario. Your participation in this co-design workshop is entirely voluntary and your decision to participate or not will have no effect on the care that you or your family member/ friend receives currently or in the future.

Please take time to read the following information carefully.

Who is conducting this research? Justine Giosa is a PhD student in the School of Public Health and Health Systems at the University of Waterloo. This work is being completed as her PhD research project under the supervision of Dr. Paul Stolee. Justine holds a Canadian Institutes of Health Research (CIHR) Sir Frederick Banting and Charles Best Canada Graduate Scholarship and is a Senior Research Associate in the Saint Elizabeth Research Centre of Saint Elizabeth, a collaborating organization for this research study.

What is the purpose of this research study? Older people want to remain in their homes as long as possible. To do so, many people require home care services to meet their multiple complex health needs; however, to get it, individuals and their family members and friends often have to tell their story multiple times to different providers who may not communicate with each other to coordinate care. The purpose of this study is to design a new approach to care planning for older adults receiving home care in Ontario that will enhance the experience of older adults and their family and friend caregivers and improve provider teamwork.

What are you being asked to do? You are being asked to participate in a co-design workshop with researchers, other individuals who have received home care and their family/ friend caregivers and health care providers. The workshop will be approximately 5 hours in length (with appropriate breaks and a lunch break) and take place on [insert date and time] at [insert location details]. Refreshments and Lunch will be provided. You will be engaged in creative group exercises where you will be asked to design elements of a new and more integrated approach to geriatric care planning in home care (e.g. assessment, goal-setting and communication). These elements will be applied in an implementation framework for a more integrated geriatric care planning approach in home care.

This workshop requires group work and therefore you must attend the workshop in person. If you agree to participate, we'll need your written consent on the attached form. Even after you provide consent, you can choose to stop participating in the study at any time. You may also decide to skip any of the exercises throughout the workshop.

To thank you for your participation in this research you have the option to receive a $100.00 (CAD)

honorarium in the form of a Visa gift card, which will be provided to you in person at the workshop. *The amount received is taxable. It is your responsibility to report this amount for income tax purposes*

Documentation and Confidentiality: Justine Giosa (the PhD student researcher) will be the lead facilitator from the workshop and will have assistance from members of the Saint Elizabeth Research Centre to co-facilitate the exercises throughout the day. These additional facilitators will be required to sign a confidentiality and non-disclosure agreement to protect the information you and others share during the session. To document the day, Justine and the other facilitators will keep notes, take photographs (please see attached photo consent form) and collect the artifacts you create during the creative activities. Your name will not be attached to any of the information/ items collected throughout the day and all information from the workshop will be kept confidential at all times. Hard copies of information will be kept locked in secure filing cabinets at the University of Waterloo and electronic files will be kept secure on password protected computers and only Justine and her PhD supervisor will have access to them. We will delete the recordings and shred any paper notes, photographs and other hard data within 7 years.

We might use anonymous information and consented photographs from the workshop in the following ways:
- in teaching, demonstration and workshop materials,
- in scholarly papers, articles and other publications,
- in presentations at academic, health care conferences

Questions about the Research? If you have questions about the research in general or about your role in the study, please feel free to contact Justine Giosa (the PhD student researcher) or Dr. Paul Stolee (the faculty supervisor) directly.

This project has been reviewed by, and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# 22251). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

We sincerely hope that you will consider participating in the co-design workshop.

Sincerely,

Justine Giosa, PhD candidate
School of Public Health and Health Systems, University of Waterloo
Senior Research Associate, Saint Elizabeth Research Centre
jgiosa@uwaterloo.ca
1-800- 463-1763 ext. 146564

Paul Stolee PhD, CE
Professor
School of Public Health and Health Systems, University of Waterloo
stolee@uwaterloo.ca
(519) 888-4567 ext. 35879

CONSENT FORM

By signing this consent form, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

_____

I have read the information presented in the information letter about a study being conducted Justine Giosa and supervised by Dr. Paul Stolee from the School of Public Health and Health Systems at the University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I understand that all of the information collected in the co-design workshop session will be kept confidential. I understand that any information that I provide will be reported anonymously in the study results.

I am aware that I have the option of allowing myself to be photographed during the co-design workshop.

I was informed that I may withdraw my consent at any time without penalty by advising the researcher.

This project has been reviewed by, and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #22251). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this co-design workshop and to keep in confidence information that could identify specific participants and/or the information they provided.

☐YES ☐NO
I agree to being photographed during the co-design workshop (if yes: please fill out attached photo consent form)
☐YES ☐NO
I agree to the use of anonymous quotations in any thesis or publication that comes of this research.
☐YES ☐NO
I would like to receive the $100.00 (CAD) Visa gift card honorarium for my participation. *I understand the amount received is taxable and it is my responsibility to report this amount for income tax purposes.*
☐YES ☐NO

Participant Name: _____ (Please print)

Participant Signature: _____

Witness Name: _____ (Please print)

Witness Signature: _____

Date: _____

When this study is completed, we will write a summary of the results. Would you be interested in receiving a copy?

☐ YES, please e-mail me a summary of the results. My e-mail address is:

☐ YES, please mail me a summary of the results. My mailing address is:

☐ NO, I do not wish to receive a summary of results

Would you be interested in being contacted to participate in a future stage of this research?

☐ YES, please contact me at:

☐ NO, I do not wish to be contacted

POINT-OF-CARE PROVIDER VERSION

Dear [name],

This letter is an invitation for you to take part in a co-design workshop where you will partner with researchers, other health care providers and individuals who have received or supported those who have received home care services to develop ideas for a more integrated geriatric care planning approach for home care in Ontario. Your participation in this co-design workshop is entirely voluntary and your decision to participate or not will have no effect on your employment with Saint Elizabeth now or in the future.

Please take time to read the following information carefully.

Who is conducting this research? Justine Giosa is a PhD student in the School of Public Health and Health Systems at the University of Waterloo. This work is being completed as her PhD research project under the supervision of Dr. Paul Stolee. Justine holds a Canadian Institutes of Health Research (CIHR) Sir Frederick Banting and Charles Best Canada Graduate Scholarship and is a Senior Research Associate in the Saint Elizabeth Research Centre of Saint Elizabeth, a collaborating organization for this research study.

What is the purpose of this research study? Older people want to remain in their homes as long as possible. To do so, many people require home care services to meet their multiple complex health needs; however, to get it, individuals and their family members and friends often have to tell their story multiple times to different providers who may not communicate with each other to coordinate care. The purpose of this study is to design a new approach to care planning for older adults receiving home care in Ontario that will enhance the experience of older adults and their family and friend caregivers and improve provider teamwork.

What are you being asked to do? You are being asked to participate in a co-design workshop with researchers, individuals who have received home care and their family/ friend caregivers and other health care providers. The workshop will be approximately 5 hours in length (with appropriate breaks and a lunch break) and take place on [insert date and time] at [insert location details]. Refreshments and Lunch will be provided. You will be engaged in creative group exercises where you will be asked to design elements of a new and more integrated approach to geriatric care planning in home care (e.g. assessment, goal-setting and communication). These elements will be applied in an implementation framework for a more integrated geriatric care planning approach in home care.

This workshop requires group work and therefore you must attend the workshop in person. If you agree to participate, we'll need your written consent on the attached form. Even after you provide consent, you can choose to stop participating in the study at any time. You may also decide to skip any of the exercises throughout the workshop.

To thank you for your participation in this research you will have the option to be paid your normal Saint Elizabeth hourly wage to participate in the workshop. The cheque will be prepared in advance of the workshop by the Saint Elizabeth finance department, will not be seen by the researchers and will be kept confidential at all times. The cheque will be given to you in person at the workshop in a sealed envelope.

Documentation and Confidentiality: Justine Giosa (the PhD student researcher) will be the lead facilitator from the workshop and will have assistance from members of the Saint Elizabeth Research Centre to co-facilitate the exercises throughout the day. These additional facilitators will be required to sign a confidentiality and non-disclosure agreement to protect the information you and others share during the session. To document the day, Justine and the other facilitators will keep notes, take photographs (please see attached photo consent form) and collect the artifacts you create during the creative activities. Your name will not be attached to any of the information/ items collected throughout the day and all information from the workshop will be kept confidential at all times. Hard copies of information will be kept locked in secure filing cabinets at the University of Waterloo and electronic files will be kept secure on password protected computers and only Justine and her PhD supervisor will have access to them. We will delete the recordings and shred any paper notes, photographs and other hard data within 7 years.

We might use anonymous information and consented photographs from the workshop in the following ways:
- in teaching, demonstration and workshop materials,
- in scholarly papers, articles and other publications,
- in presentations at academic, health care conferences

Questions about the Research? If you have questions about the research in general or about your role in the study, please feel free to contact Justine Giosa (the PhD student researcher) or Dr. Paul Stolee (the faculty supervisor) directly.

This project has been reviewed by, and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #22251). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

We sincerely hope that you will consider participating in the co-design workshop.

Sincerely,

Justine Giosa, PhD candidate
School of Public Health and Health Systems, University of Waterloo
Senior Research Associate, Saint Elizabeth Research Centre
jgiosa@uwaterloo.ca
1-800- 463-1763 ext. 146564

Paul Stolee PhD, CE
Professor
School of Public Health and Health Systems, University of Waterloo
stolee@uwaterloo.ca
(519) 888-4567 ext. 35879

CONSENT FORM
By signing this consent form, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

_____

I have read the information presented in the information letter about a study being conducted Justine Giosa and supervised by Dr. Paul Stolee from the School of Public Health and Health Systems at the University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I understand that all of the information collected in the co-design session will be kept confidential. I understand that any information that I provide will be reported anonymously in the study results.

I am aware that I have the option of allowing myself to be photographed during the co-design workshop.
I was informed that I may withdraw my consent at any time without penalty by advising the researcher. This project has been reviewed by, and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #22251). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this co-design workshop and to keep in confidence information that could identify specific participants and/or the information they provided.

☐YES ☐NO
I agree to be photographed during the co-design workshop (if yes: please fill out attached photo consent form)
☐YES ☐NO
I agree to the use of anonymous quotations in any thesis or publication that comes of this research.
☐YES ☐NO

I would like to receive payment for the time that I spend participating in the workshop.
☐YES   ☐NO

Participant Name: _____ (Please print)

Participant Signature: _____

Witness Name: _____ (Please print)

Witness Signature: _____

Date: _____

When this study is completed, we will write a summary of the results. Would you be interested in receiving a copy?

☐YES, please e-mail me a summary of the results. My e-mail address is:

☐YES, please mail me a summary of the results. My mailing address is:

☐NO, I do not wish to receive a summary of results

Would you be interested in being contacted to participate in a future stage of this research?

☐YES, please contact me at:

☐NO, I do not wish to be contacted

APPENDIX U: CO-DESIGN WORKSHOP PARTICIPANT PHOTO RELEASE

Personal Release / Consent for Photographs

I, _____

(Full name)

of

_____

(Address)

hereby give consent to Justine Giosa (PhD student researcher) and Dr. Paul Stolee (faculty supervisor) to take and produce photographs of myself. I further agree that Justine Giosa and Dr. Paul Stolee may use these photographs for educational purposes (e.g. as data in the research study, in conference presentations) pertaining to the research study titled: "*Developing and integrated geriatric care planning approach in home care: common assessment, person and family-centred goal setting and interdisciplinary collaboration*".

I understand that Justine Giosa and Dr. Paul Stolee will not under any circumstances use my name in conjunction with the above mentioned terms.

Further specifications are listed below:

_____
_____
_____
_____

_____

Signature

Dated the _____ day of _____ , 20_____ .

APPENDIX V: CO-DESIGN EXPERIENCE FEEDBACK SURVEY

Survey of Participant Co-Design Experience

Thank you for participating in the co-design session(s). We value your contributions to this project. In an effort to learn from and improve our collaborative activities in the future, we invite you to complete the following brief survey to help us better understand how to make these collaborative activities meaningful to future participants.

1. Please indicate what perspective you represented at the co-design session(s):

☐Patient   ☐ Family/Friend Caregiver   ☐Health Care Provider

2. To what extent did you feel that you had the right information to participate in the discussions during the co-design session(s)?

☐NOT AT ALL   ☐A LITTLE   ☐SOMEWHAT   ☐MOSTLY   ☐ALWAYS

3. How comfortable were you to share your experiences/ideas/opinions with the program at the co-design session(s)?

☐NOT AT ALL   ☐A LITTLE   ☐SOMEWHAT   ☐VERY   ☐EXTREMELY

4. To what extent did you feel your experiences/ideas/opinions were heard and understood by the facilitators of the co-design session(s)?

☐NOT AT ALL   ☐A LITTLE   ☐SOMEWHAT   ☐MOSTLY   ☐ALWAYS

5. To what extent did you feel encouraged by the facilitators to share your ideas for improvement to the program during the co-design session(s)?

☐NOT AT ALL   ☐A LITTLE   ☐SOMEWHAT   ☐MOSTLY   ☐ALWAYS

6. How comfortable were you being separated into small groups representing the different patient and family member perspectives during the co-design session(s)?

☐NOT AT ALL   ☐A LITTLE   ☐SOMEWHAT   ☐VERY   ☐EXTREMELY

7. To what extent did you feel that everyone had an opportunity to participate in the discussions at in your small group?

☐NOT AT ALL   ☐A LITTLE   ☐SOMEWHAT   ☐VERY   ☐EXTREMELY

8. How useful was the mapping exercise (using the colour-coded tiles) for helping your small group to identify key opportunities for improvement to the program?

☐NOT AT ALL   ☐A LITTLE   ☐SOMEWHAT   ☐VERY   ☐EXTREMELY

9. How confident are you that your contributions to the co-design session(s) will influence decision-making and improvements to the program?

☐NOT AT ALL   ☐A LITTLE   ☐SOMEWHAT   ☐VERY   ☐EXTREMELY

10. How satisfied were you with the following elements of the co-design session(s)?

a) Food and drinks available

☐VERY DISSATISFIED   ☐DISSATISFIED   ☐NEUTRAL   ☐SATISFIED   ☐VERY SATISSFIED

b) Frequency of breaks

☐VERY DISSATISFIED   ☐DISSATISFIED   ☐NEUTRAL   ☐SATISFIED   ☐VERY SATISSFIED

c) Accessibility of the room

☐VERY DISSATISFIED   ☐DISSATISFIED   ☐NEUTRAL   ☐SATISFIED   ☐VERY SATISSFIED

d) Proximity to washrooms

☐VERY DISSATISFIED   ☐DISSATISFIED   ☐NEUTRAL   ☐SATISFIED   ☐VERY SATISSFIED

e) Parking

☐VERY   ☐DISSATISFIED   ☐NEUTRAL   ☐SATISFIED   ☐VERY
DISSATISFIED   SATISSFIED

11. How likely would you be to participate in another co-design session in the future?

☐NOT AT ALL   ☐A LITTLE   ☐SOMEWHAT   ☐VERY   ☐EXTREMELY

COMMENTS: _____

12. Do you have any other suggestions for improvement to the co-design session(s)?

COMMENTS: _____

APPENDIX W: PERMISSION TO USE POSITIVE HEALTH FIGURE

From: Machteld Huber

To: Justine Giosa; Elizabeth Kalles; Machteld Huber **Subject:** [EXTERNAL] RE: Image Use - for Dissertation
Date: Wednesday, July 04, 2018 12:32:02 AM

Attachments: image001.pg
image004.pg

Dear Justine,

Sorry for the silence – a bit too much work on my desk…..

It is okay to use the image. But please realize – and mention – that we use it in a type of conversation in wich the key-questions are „what is important to you?" and "what would you like to change, if possible?".

The professional should listen and ask open questions and learn not to immediately provide advise, but coach.

We call this ‚the different conversation', where the difference is in the attitude of the professional. People who know 'non-violent conversation' recognize this in our approach.

Well, all the best with your discussion chapter!

And I would appreciate to receive your dissertation if possible!

Best wishes,
Machteld Huber