

# Home First: Exploring the Impact of Community-based Home Care for Older Adults and Their Family Caregivers\*

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## RÉSUMÉ

Avec la croissance rapide de la population plus âgée, il est devenu urgent de trouver des approches en matière de soins de santé qui aident les personnes âgées à vieillir dans le milieu de leur choix, en assurant une réorientation philosophique des services de santé. Nous nous sommes penchés sur le projet Home Care Home First - Quick Response Project, réalisé dans une ville de l'Ouest canadien, afin de comprendre les perceptions de clients âgés de plus de 75 ans et de leurs aidants naturels quant aux services communautaires améliorés offerts par Home First. Le modèle méthodologique utilisé est celui de la description interprétative. Nous avons analysé les expériences de huit personnes âgées et de onze aidants naturels ayant fait appel à Home First. Les personnes âgées s'étaient toutes inscrites à Home First en raison d'un changement majeur dans leur état de santé. Quatre thèmes ont été identifiés : vieillir dans le milieu de son choix avec du soutien, la philosophie de soins, les processus de Home First et l'importance du programme. Dans l'ensemble, les clients et les aidants naturels ont réagi positivement aux services offerts dans le cadre du programme Home First. Les clients ont indiqué qu'ils appréciaient leur indépendance et désiraient vieillir dans les milieux de leur choix, qui reflétaient la communauté dans laquelle ils vivaient depuis de nombreuses années.

## ABSTRACT

Given the rapidly expanding older adult population, finding health care approaches that support older adults to age in their choice of place, with an accompanying philosophical re-orientation of health services, is becoming more urgent. We studied the Home Care Home First – Quick Response Project to understand how clients over age 75 and their family caregivers perceived the enhanced community-based services delivered through Home First. Using interpretive description as the methodological design, we explored the experiences of eight older adults and 11 family caregivers; all older adults were enrolled in Home First due to a significant change in their health status. We identified four themes: growing older in chosen places with support, philosophy of care, processes of Home First, and the significance of Home First for clients. Overall, clients and family caregivers responded positively to the Home First services. Clients valued their independence and growing older in places they had specifically chosen.

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Well it's just the freedom that a person has in their own home. If I don't want to shave for a day or two, I don't shave, you know? [laughter]. We can sleep in, we can stay up. Some nights we read to midnight and you know, it's just ... I guess it's freedom and to go into the kitchen and prepare something if you want something and have a snack and we just feel comfortable here, you know? We've been here now since, say '59, 1959. (Phyllis's husband)

This statement draws attention to the reasons some people give to explain their choice to grow older in places they call home. Over the past several years, the Saskatchewan Ministry of Health has identified and addressed the need for older adults and their family caregivers to safely and independently live in their community with a variety of services and support options (Saskatoon Health Region, 2013). One of the initiatives is called "Home Care Home First – Quick Response Project", which we refer to as "Home First" in this article.

Home First was established in 2013 in Saskatoon, Saskatchewan. The aim of Home First was to improve community supports through access to an interprofessional team, to allow older adults to grow older in their choice of place, even though they may require increasing support related to life changes, including health challenges, social interactions, and relationships (Government of Saskatchewan, 2013). In this study, we explored the experiences of older adults and their family caregivers with Home First. Four key themes emerged: (a) growing older in chosen places with support, (b) philosophy of care, (c) processes of Home First, and (d) the significance of Home First for clients and family caregivers. These themes are discussed in relation to the way care is provided with older adults living in the community. We drew on the work of Bowlby (2012), who has brought our attention to the importance of place and time in the social organization and experience of care.

## Background

With the first baby boomers having reached the age of 65 in 2011, the older adult population is rapidly growing. Over the past 10 years the proportion of people age

65 years and older living in Saskatoon has reached 11.6 per cent (Statistics Canada, 2014a). Despite older adults "accounting for only 14.8% of Saskatchewan's current population, nearly half of our health care spending occurs on their behalf" (Fiessel et al., 2013, p. 1). Stonebridge and Hermus (2017) suggested that as the Canadian population continues to grow older, health care services and supports will be impacted, with an expected 71 per cent increase in both paid and unpaid continuing care supports by 2026 (Hermus, Stonebridge, & Edenhoffer, 2015). In relation to health care services, older adults aged 85–89 years continue to be the largest home care client group within the Saskatoon Health Region. Older adults often live with complex co-morbid health conditions and experience frailty, both of which require frequent and intensive home care support and hospital admissions.

The shifting landscape of care, from formal – such as hospitals and rehabilitation services – to informal settings, including home (Gillsjö, Schwartz-Barcott, & von Post, 2011; Williams, 2002), also influences the understanding of home as a place of care by older adults. Coming to an understanding of growing older at home is important, because the entry of care providers redefines home as a caringscape/carescape (Bowlby, 2012). Bowlby suggested that "a person faces a multidimensional 'landscape', or 'caringscape', of alternative future ways of life involving different patterns of caring" (p. 2110); for her, "the term 'carescape' [...] refer[s] to the resource and service context shaping the 'caringscape terrain'" (p. 2112). As indicated by Ivanova, Wallenburg, and Bal (2016), *place* is not a rigid spot on the map. Place is about specificities, and it is infused by memories, experiences, hopes, meanings, and values. In this article, home is understood as a place of care where older adults want to contribute to the decision-making processes in relation to their care. Home is a complex site for study (Williams, 2002). It is embedded with many meanings associated with personal identity, security, and privacy; *place* changes according to socioeconomic circumstances and demographics.

Finding approaches in health care that support older adults to age in their choice of place, with an accompanying philosophical re-orientation of health services, is

becoming more urgent. One promising approach to support seniors aging in their choice of place is Home First, which since 2013 has provided a care option for older adults living in communities with complex health care needs.

Home First was developed as a distinct program under the umbrella of Home Care in response to an increasing need for better integration of service supports by an interprofessional team to respond to the complex care needs required by adults over 75 years of age and by their family caregivers (Saskatoon Health Region, 2013). In the spring of 2015, approximately 50 clients were registered at Home First. However, as our study progressed, this number increased by threefold over the 3 months of data collection. Home Care and non-Home Care clients were determined eligible for Home First services if they (a) were born before January 1, 1938, (b) had three or more emergency department (ED) visits in the previous 12 months, (c) had been discharged from ED or acute care settings in the previous 60 days, (d) were classified as alternate level of care in an acute care bed, (e) did not qualify for the long-term care (LTC) wait list, and (f) their care needs fell into each of the domains of the contact assessment tool (i.e., medication condition and care needs, client characteristics, and life/social circumstances) (Saskatoon Health Region, 2013). During the study period, the length of service provided by Home First to clients was not time limited.

The program's purpose was to improve outcomes for older adults living with complex care needs within their community by providing care and support beyond regular Home Care services. Unlike regular Home Care, meeting the needs of clients was achieved through an interprofessional team, which included a nurse practitioner, registered nurses, community care aides, pharmacists, a social worker, a mental health worker, an occupational therapist, a physiotherapist, a dietitian, home maintenance worker, and volunteers (Saskatoon Health Region, 2013). Collaboration occurred between the interprofessional team and the family physician, which provided continuity in care. Additional specialty services were also consulted on a case-by-case basis, including speech pathology, palliative care, and respite care.

The interprofessional team attended not only to the complex care needs of the client, but also to the needs of family caregivers, particularly in relation to home maintenance and mental health. This response was essential, since older adults who grow older in their home may experience functional limitations that challenge their ability to continue living in their current residence and thus potentially confine them (Bowlby, 2012). Home Care tends to be client specific, task oriented,

provided by unregulated care staff, and coordinated by registered nurses. In contrast, the Home First program we studied more specifically focused on responding to crisis and intensive short-term service needs; encouraging early discharge from acute care to community options; preventing unnecessary admissions to emergency departments; and engaging additional service providers to support older adults to remain in their homes and reduce caregiver burden (Government of Saskatchewan, 2013; Saskatoon Health Region, 2013). To meet these goals, Home First staff were assigned five to six patients per a 5.5 hours-of-service per day, compared to Home Care's eight to 12 patients. The decreased number of assigned patients enabled Home First staff to spend an average of one hour per client visit, compared to an average visit of 30 minutes for Home Care. Home First staff utilized the additional time to educate patients and caregivers about resources to maintain health and well-being, promote independence and self-management, and perform more intensive monitoring of health conditions (Saskatoon Health Region, 2013).

Home First operated within an implied philosophy that valued the voices of older adults and their family caregivers. Viewing older adults as "embodied and social beings, [who] can reclaim meanings of age through the stories they share" (Yamasaki, 2009, p. 588) is rooted in narrative gerontology. This perspective values the uniqueness, individuality, dignity, and humanity of the lives of older adults (Kenyon, Bohlmeijer, & Randall, 2011). Team members lived the philosophy through client-centred care in which the domains of medical conditions and care needs, client characteristics (i.e., age, cognitive ability, behavior changes, self-management ability, education, language), and life/social circumstances (i.e., living arrangements, income/financial resources, social/caregiver supports) (Saskatoon Health Region, 2013) were integrated into care and relationships were negotiated; a position that supports a shift from seeing the individual as being aged, a disease, or a diagnosis to, instead, regarding the individual as a storied life (Allen, 2004).

Programs such as Home First are urgently needed because remaining in the home is the most preferred residential situation for older adults (Bradley & Longino, 2009; Smith-Carrier et al., 2017). Place and identity are closely linked, whereby place reflects the time and social contexts, and the stories we tell, along with the stories that are told about us (Baldwin, 2008). Older adults opt to grow older in their home for various reasons, including being familiar with their neighbourhood and community; their family living nearby; or having ties to volunteer or recreational activities, amenities, and places of worship. It often reflects a "*simultaneity of stories-so-far*" (Massey, 2005, p. 54,

original emphasis). Currently in Canada, 92 per cent of older adults reside in private homes (Statistics Canada, 2014b).

The desire of older adults to remain in their homes is compromised by their ability to access essential services within their community, such as government offices, physicians, cultural centres, and private or public businesses (Patterson, 2004). As identified by the Saskatoon Health Region (2013), older adults and their family caregivers may experience an inability to access care in their homes because the health region has a “limited capacity to respond to the diversity of care needs” (p. 6). These limitations may contribute to caregiver burnout, increased hospital admissions, poorly coordinated hospital discharges, and institutionalization of older adults into personal care homes or long-term care settings (Saskatoon Health Region, 2013). Health care service providers need to attend to the complex care needs of older adults to support them to safely and independently remain in their homes. Older adults and their family caregivers have an increased need for, or maintenance of, autonomy and control, beliefs, attitudes, physical environments, and social pressures (Löfqvist et al., 2013). Our purpose in this study was to explore the experiences of clients and family caregivers with the services and support provided by Home First, given the complex needs of older adults who want to remain in their home over time.

## Methods and Study Design

On the basis of our interest in clinical practice, we used an interpretive descriptive design. With interpretive description, we investigate a clinical phenomenon with the goal of informing the practice of everyday practitioners (Thorne, Kirkham, & O’Flynn-Magee, 2004). Interpretive description is built on the premise that theorization is shaped by the need to inform practice. The philosophical assumptions of interpretive description are as follows: (a) reality is socially constructed; (b) commonalities and variations exist in human experience; and (c) researchers are inextricably linked to their object of research (Thorne, 2008). Interpretive description builds on small-scale qualitative investigations of a phenomenon utilizing relatively small purposive samples (Thorne et al., 2004). In this study, we utilized thematic analysis for the data analysis. We sought to explore the subjective experiences of clients and family caregivers with the services of Home First.

### Recruitment

Participants in the study were clients of Home First, along with their family caregivers. At the time of recruitment, 50 clients were registered with Home First

for a period of one to 14 months. Our target sample for this study was 20 participants for one-to-one interviews. The Home First manager invited all clients and their family caregivers to participate and requested permission to pass along their contact information to the research team, who were not associated with Home First. Once contact information was shared with the researchers, members of the research team contacted the clients and family caregivers to discuss further details of the study and obtain consent. Twenty people, 13 clients and seven family caregivers, indicated that they could be contacted. The 13 clients represented 26 per cent of Home First clients in 2015.

### Participants

The researchers contacted all 20 people; five of the clients did not participate in the study because they were unavailable or unable to answer the questions due to cognitive impairment. We interviewed a total of 19 participants, including eight clients and 11 family caregivers. The increase in family caregivers from seven to 11 was the result of additional caregivers expressing a desire to participate in the study at the time of the researcher’s visit. Of the eight client participants, five were male and three were female. The average age of the participating clients was 80 years, and they had been registered with Home First for a period of one to 14 months. All clients were living with complex health conditions, including chronic obstructive pulmonary disease, congestive heart failure, cancer, arthritis, stroke, and peripheral vascular disease. Of the 11 family caregivers, eight were spouses (seven females and one male) and three were adult children (daughter, son, and daughter-in-law). Among these, three family caregivers had cared for a spouse or parent who had recently died. Family caregiver ages ranged from 53 to 91 years.

### Data Collection

We used a semi-structured interview guide for data collection. We included the following sample questions in the client interview guide:

1. Based on your records, you are receiving the following services. Is it important to you that you receive extra services to be able to stay in your home?
2. How helpful have these services been in allowing you to stay in your home? Can you tell me more about these services? Why are these important to you?
3. How do you feel about the services you are receiving from Home First?

A sample of the family caregiver questions follows:

1. What have been your challenges in being a caregiver?
2. What kind of supports would be helpful to you?
3. How important is it to grow older in your home with support?



The interview guide was reviewed by older adults outside of Home First for comprehensiveness and readability. Four researchers conducted interviews with participants over a period of three months; each participant was interviewed once. The interviews were conducted with either the client, the client and family caregiver(s), or family caregiver(s), lasting between one to two hours. All interviews were voice recorded and transcribed. Participants were invited to review their transcripts; two participants accepted the invitation and clarified their statements captured during the interview and which we reintegrated into the analysis process (Birt, Scott, Cavers, Campbell, & Walter, 2016). To maintain participant anonymity, we assigned clients a pseudonym and referred to family caregivers through their relationship with the client.

### Data Analysis

Techniques for data analysis in an interpretive descriptive study can vary (Thorne et al., 2004); for this study, we analysed data using a thematic approach. In accordance with Thorne's (2008) emphasis on careful analysis, three researchers independently read the transcripts, developing themes. The researchers then engaged in multiple conversations to identify key themes while attending to (a) what was learned about the phenomenon, and (b) how this knowledge shapes practice. We followed a process outlined by Morse (1994) to (a) generate understanding of the context and experiences under study; (b) look for patterns of commonality and variation; (c) explore theoretical explanations; and (d) inquire into the relevance to practice. Key to our approach was a process that involved ongoing discussions with multiple researchers and clinicians to ensure that themes were clear, well defined, and reliable. Clinicians in particular ensured that we inquired into the relevance to practice. We ensured that themes were directly linked to the data and the interview guide.

### Ethics Approval

Ethics approval was obtained from the University of Saskatchewan, the Saskatchewan Polytechnic, and the University of Alberta Research Ethics Boards. Operational approval was obtained from the Saskatoon Health Region. All participants signed consent forms and were informed of their ability to withdraw from the study at any time without impact on their care.

## Findings

Continuing to grow older at home was important to participants in this study because home provided freedom and supported their rhythms of life. This was reflected in the four themes: (a) growing older in chosen places with support, (b) philosophy of care, (c) processes

of Home First, and (d) the significance of Home First for clients and their family caregivers. Further analysis placed these themes in relation to the caring process and how clients and family caregivers perceived their care. In this article, we refer to clients of Home First through pseudonyms (e.g., Phyllis) and family caregivers are identified through their relationship to the clients (e.g., Phyllis's husband or daughter-in-law).

### *Growing Older in Chosen Places with Support*

For participants in this study, home was everything to them; there were no alternatives to home. Many described their home as "this is the world here" (Ron), and "well, it means everything. I mean who wants to move out into a care facility? Not me" (Phyllis). The intent of Home First was to enable clients to receive care in their homes. This was congruent with the desire of clients and family caregivers to remain in their homes.

Among the participants, there was a shared sense that staying at home for as long as possible was very important, and accessing services and care would enable them to achieve this goal. This was evident by Laurie's response regarding whether she would accept services in the future: "Oh, maybe someday I might. If I do [need them] I would certainly get them, I certainly would, yes, because I would want to stay home as long as I could, you know." However, to remain in their home, clients and family caregivers recognized that "You have to have somebody with you who's capable if you're gonna age in place, because it's a 24-hour job" (Ron). This finding resonates with the demands of being a family caregiver and the need for support for the caregiver and not only the client. Peter's wife expressed the increased caregiver burden by stating "My life isn't my own".

Throughout the interviews, participants described having considered other alternatives to home. For example:

We gave only fleeting thoughts to the possibility of putting her in a long-term care [home], just finger snapping in one ear and out the other ... because our goal is to keep her home because that's where she's happiest, you know. (Phyllis's husband).

Peter suggested he would rather die than consider alternatives to growing older in his home: "So it's just when it becomes too much of a burden for either of us to carry on ... I hope someone will strike me down with some fatal disease and that will solve that problem." For some, considering alternatives to home was not possible because of past experiences and perceptions of care alternatives. For Arthur, the perceptions of his wife about long-term care interrupted her ability to imagine possibilities of alternatives to home because

“like honestly there’s no quality of life, the consistency is not there because people, shifts change; staff change; the food’s lousy; it’s impersonal.” Home is linked to quality of life; moreover, it is a very personal space.

Some participants shared stories of moving. Moving from home was associated with new ways of life and financial implications. For many, the timing to move was an important consideration in order to maximize the positive experiences provided by the move:

To enjoy assisted living ... you should go into those places if you’re willing to relax a bit when you’re about 70 or maybe 68 ... you get used to the routine and you can make another life, and it’s hard to make another life at 90. (Peter’s wife)

There may have been a time when the ability to move was determined by financial possibilities to do so. Peter commented, “I have a friend who’s a lawyer and he says ... very few of my clients have ever thought about how much money they need to retire on.”

In addition, stories of moving were told in relation to family caregivers who moved in with their parents, to maintain their parents’ relationships within their communities. Phyllis’s daughter-in-law noted that she and her husband decided to move in with her parents-in-law: “I think for [our] parents, yes, because they have a really close church community in the city and we were living outside of the city ... ” Strong social and familial ties held by parents informed decisions of family caregivers to relocate if they did not already live with the older adult.

### *Philosophy of Care*

Participants did not describe the Home First philosophy of care explicitly, yet they were clearly aware of the approach. Through articulating their experiences of living with complex health care needs in the community and their engagement with service providers, they indicated that Home First staff planned and provided care holistically, rather than focusing on their disease, diagnosis, or health care needs. George’s wife pointed out that the biggest impact was

probably the fact that we were getting physical and mental [care] altogether ... I was phoning a lot and [Client-Patient Access Services provider] was excellent and for all kinds of support, like she got after me for making sure that I was looking after myself and stuff like that ...

Participants noted that, to achieve holistic client-centred care, Home First staff took the time to build relationships with them.

Andy’s wife found that inclusion was important in the process of building relationships. She observed:

Well, they don’t put me down and they just take me at face value and [the Social Worker], she just said tell it like it is and that’s what we do. We just sit and we talk, and we tell it like it is and she’s honest and I’m honest with her and it’s good communication, yeah, and that’s the best.

Furthermore, care and compassion are key to building relationships, which requires consistency in the staff:

I think it gives us hope to know that we have that consistency. Then we can do things or make choices, otherwise you feel like you’re at the beck and call of somebody knocking on that door, opening the door and saying, Who are you? Are you going to be compassionate? This is our home, this isn’t an institution. I’ll welcome anybody in here who has come with the best intentions for Arthur. (Arthur’s wife)

Consistency of staff is required to ensure that people are included in their care in meaningful ways. Larry’s wife spoke to the importance of staff consistency from the perspective of continuity of care:

It’s so, so important. That was the real value of the Home First program because we knew who it was and we knew what to expect ... and it helped with their assessments because they had been here the day before or the week before; they knew Larry.

Participants described Home First’s emphasis on holistic care based on relationships as differing significantly from their experiences with Home Care. For example, Ron’s wife likened the care to washing the same fabric in two different types of laundry detergent. She said, “Oh my goodness, there’s shades of difference. There’s shades of difference between Home First and Home Care ... and maybe the Home Care program needs to use the same detergent.” Participants described Home First’s approach to care as person-focused, which sought solutions to care that responded to the needs of individuals and couples. Laurie’s wife commented that “there is always a solution given. And we feel like we are very important. That we are cared for – we as a couple.” This focus on including all people who supported the client, as well as the holistic focus, clearly differentiated Home First from regular Home Care.

Participants also described the importance of communication as a means to enhance continuity in their care. They indicated that information shared with a staff member was always communicated back to the team: “A couple of care aides that I’ve mentioned things to, I know that it goes back to their meetings” (Arthur’s wife), and “He [the care provider] never trespassed where he shouldn’t, but he advised the nurses then, ‘cause they’d know, they would come the next day and know that this should be looked at” (Ron’s wife). Information was communicated during interprofessional

morning huddles, said participants, “and it was not necessarily the same nurse every day but they had really good communication in their own ... the little scrums they had in the morning” (Larry’s wife). Through observations of providers’ communication practices, participants indicated the continuity in care they received.

Teamwork was regarded by clients and family caregivers as essential: “You know, the whole team is so important. It’s not just one aspect of your being. Everything works together” (Larry’s wife). Clients and family caregivers indicated that they, in addition to Home First staff, were also members of the team: “Yeah, they’d sit and talk with me and discuss things and, you know, what to expect, and if I needed to ask questions, I would ask questions” (Arthur’s wife). Ron’s wife summarized the teamwork of Home First as being “one piece of fabric ... Home First, palliative care ... stitched together ‘cause they have the same philosophy”.

#### *Processes of Home First*

Within Home First, there were a variety of ways people worked with clients. Two factors central to Home First were service provision – which “was really critical, this ability to activate people in meaningful ways and [to have] people who were willing to stay with the family” (Edward’s daughter) – and the ability to work within a team. The provision of services focused on what was needed and was described as “excellent ... [the nurse practitioner] helped coordinate things with the community so that if we needed more help she was able to access it ...” (Larry’s wife). Another client, Lisa, said “they gave me a service that I didn’t even know existed ... you give her your grocery list and give her some money ... she will pick up all your groceries”, which was made possible through the engagement of volunteers in the program. Ron’s wife gave yet another example of Home First’s provision of care:

The services provided were adapted to the assessed needs of clients. [The nurse practitioner] is allowed to write prescriptions. And is allowed to order, say if he’s got a bladder infection, is allowed to order a test. So instead of him and I having to go hauling him into the car, and hauling him out to the thing, and then hauling him back to the car, and hauling it all back, all of that back breaking and whatever time ... and waiting in the doctor’s office, 2½ hours the last time, sometimes it’s 3 and 4, just to get him to say yes, I think you have a bladder infection, so we’ll order a urine test and send it to the lab.

Although services were adapted to meet the needs of clients, services were not always delivered at a convenient time. However, this was not a primary concern of the participants because they recognized that patient

care was complex and unpredictable, as indicated by George’s wife: “Well, they tried. There were some times that it got too late, but we could understand that. They didn’t have any idea, really, what they were going to encounter with the patient before us.”

The combination of services was also important. By combining services, respite was woven into care.

The sort of physiotherapy he needed was more than just the physiotherapist could provide and I wasn’t able to do the exercises with him, along with everything else I was doing. So what they arranged was the people who came in to do respite and when I’d have respite and leave the home, they would do physiotherapy with him, which really ... that was very good too. ... So twice a week physiotherapy was done by the respite people, the caregivers. (Larry’s wife)

Participants did indicate that the transition from acute care to Home First was not seamless. “I have no idea what would have happened ... never given information about Home First ... never connected to even Home Care ... discharged home with the assumption we would figure it out, and so this period of transition was not the best” (Ivy’s daughter). The complex interplay between services, volunteers, and respite care was significant in the experiences of the study participants.

#### *Significance of Home First for Participants*

Home First services were described as being easily accessible. For example, regarding availability: “Once we figured out what we needed to do and what the services were, they acted very fast and were available anytime we called, gave us advice over the phone, came for home visits” (Phyllis’s daughter-in-law). Availability also included help being timely “‘cause I know somebody will listen, I don’t have to wait for 2 weeks” (Arthur’s wife). Participants also recognized that Home First services were limited, and services needed to be used responsibly:

I know if I really need it I can call and I can get help. I don’t abuse that. Like sometimes they say “maybe you could use more help,” I say “well maybe.” “Maybe you need to rest,” “yeah I do, but I think I can manage it.” I’ll do this, or that, or the other thing, because ... Oh there’s one other thing: I don’t want to jeopardize other people having this kind of help. (Ron’s wife)

Prior to receiving Home First services, however, participants had little awareness the program was available:

It was like a puzzle, everything kind of fit into place, and we were so surprised because we had not heard of this program before and I have aging parents as well. They hadn’t heard of it, none of our friends – no one had heard of it, and yet it had



all of these support services available. (Phyllis's daughter-in-law)

Services were constantly negotiated between service providers, clients, and family caregivers which allowed for services to be responsive to needs both immediate and urgent, as well as long-term. With the start and follow-through of Home First services, participants began to see the potential benefit: "I think we can stay here as long as we can with this help" (Ron's wife). Without somebody coming every day, "Larry would have been in hospital because we could not have managed here" (Larry's wife). Mobile services supported participants to receive care in their homes, as described by Noel:

I was needing catheters changed ... when I was having clots, they came to unplug the clots, otherwise I'd have to go to emerg and I did go to emerg before that, all the time. So that was very important to have them come in ... I have lab services now, which to me is very important because sometimes if I needed lab work done I might not feel well enough. ... how can you go to the lab when you're not feeling well enough to even take a cab there.

For Larry, Home First meant he no longer went to hospital. Prior to Home First, his wife explained that

basically [over] 5 months [Larry] spent 170 days in hospital. Since being on the Home First program ... he has been in hospital a total of 10 days in 7 months, and now he has not been in hospital since last July. This would not have happened without the Home First program.

Unequivocally, Home First "saved my life" (Lisa), a sentiment reiterated by Larry's wife who stated "it was a lifesaver for us. Larry would not be as well as he is now; we would not have been in our own home." In her role as caregiver, the daily navigation of the hospital setting, and advocating for Larry's health and personal needs, was exhausting. By Larry's care being provided in their own home, Larry's wife felt they had the time and support to meet both their health and relationship needs. These statements further iterate the perceptions of participants that Home First is "close to the perfect dream" (Ron's wife).

## Discussion

Evident in the four themes – growing older in chosen places with support, philosophy of care, processes of Home First, and the significance of Home First for clients and family caregivers – is the importance of understanding how older adults define living independently in their own home. The participants specified that independence did not necessarily mean they could do all things without assistance; rather, their understanding of independence had shifted to also include support

from services. In relation to the acceptance of support and services, Bowlby (2012) in her work on caring spaces and carescapes suggested we need to reconsider our understanding of independence – that it is neither natural nor desirable. Rather, human relationships involve interdependency. This means we need to move "away from the idea that being cared for is necessarily a situation of undesirable dependency" (Bowlby, 2012, p. 2102). Participants' evolving understanding of independence aligns with Bowlby's findings (2012), wherein she suggested that sometimes we are the carers, sometimes we are the cared-for, and sometimes we are both simultaneously.

For participants in this study, deciding who will enter their home and developing the caring relationship were very important. The homes of older adults became their "stronghold and freedom" (Gillsjö et al., 2011, p. 8), in which they decided whom they would welcome into the home, open the door to, and remain in contact with (Gillsjö et al., 2011). Participants perceived that Home First staff came with a readiness to begin a relationship with them before they provided care. By building relationships, sufficient trust was established to allow staff to enter the home and build a caringscape. Within the caringscape, clients, family caregivers, and Home First staff negotiated a shift from independence to interdependence, with the recognition that needs, care directions, and people change over time (Bowlby, 2012).

In addition, to meet the needs of clients, care must be conceptualized as collaborative. This reflects the broader understanding of place and social relationship (Bowlby, 2012). In our study, participants indicated that without Home First, their ability to grow older in their home would have been significantly compromised. The findings supported Home First's vision (Saskatoon Health Region, 2013), which emphasized the importance of seniors accessing care that was timely, appropriate, supportive, and allowed older adults to continue to live in their homes safely and independently (Government of Saskatchewan, 2013; Saskatoon Health Region, 2013).

To achieve a shift in the focus of care, communication is essential. It is achieved through relationship-building and person-centred care that attends to relations of power, reciprocity, and the daily rhythms and experiences of the person receiving care. Participants in the study indicated that communication was a key component in enhancing the continuity of care within Home First services. Care providers came with an understanding of co-presence: They came with time to sit and listen to experiences, including physical and mental health concerns, and attend to questions and trepidations. Co-presence also provided the opportunity to



observe non-verbal body language and the experience of home as the place of receiving care (Bowlby, 2012; Urry, 2002). This finding supports work by Sundler, Eide, van Dulmen, and Holmström (2016) suggesting that high-quality care requires the person and communication to be put in the forefront, which involves a commitment from teams, and a shift in culture both at an organizational level and in the individual encounter (McCormack, Dewing, & McCance, 2011; Sundler et al., 2016).

The Canadian Interprofessional Health Collaborative (2010) proposed team processes that encourage communication between team members, thereby demonstrating increasing interprofessional competence and capacity of the team, and effective coordination of team interactions with the client and family caregivers. From the perspective of the participants in our study, Home First achieved this shift through purposeful communication strategies. Similar to the findings of Smith-Carrier et al. (2017), the clients and family caregivers in our study experienced teamwork in their care and felt engaged with the team, which brought a sense of satisfaction.

Caring in partnership with older adults living with complex health care needs in the community requires interdisciplinary and interprofessional teams to positively impact quality of life and satisfaction with care (Calkins, 1999; Gougeon, Johnson, & Morse, 2017; Montagnini et al., 2014; Stall, Nowaczynski, & Sinha, 2014). Abbasi, Khera, Dabravolskaj, and Xia (2017) have suggested that team members need various opportunities to collaborate and to share knowledge and expertise. Home First clients and family caregivers both indicated that hospital visits were avoided through access to the interprofessional Home First team, with care and service provision having a positive effect on the study participants' health status. These outcomes may in no small way be related to how effectively the Home First team collaborated and communicated with each other (Gougeon et al., 2017).

As suggested by Brown, Davies, and Martens (1990) as well as by Bowlby (2012), the trajectory of growing older differs for each person; therefore, the services that participants require is greatly influenced by the complexity of their health care needs. Home First clients and family caregivers indicated that services were tailored to meet their needs and that additional resources and services were added to their care as required. This attention to the daily rhythms and experiences of the client and family caregiver meant that care did not disrupt participants' routines, nor was it wrong or unwelcomed (Bowlby, 2012). The Home First team was positioned to provide services proactively and could respond to individual needs of participants

in a timely way. This approach to care supported the delivery of flexible care, which allowed for the anticipation of changes in care needs and relationships over time (Smith-Carrier et al., 2017). According to Bowlby (2012), this means care can be negotiated and renegotiated without the discontinuation of services.

In our study, some participants indicated that they did not plan their "growing older". Bowlby (2012) suggested that this occurs because people may plan only some parts of their journey, leaving others to chance. For many participants, their need for care was defined by the occurrence of a significant health event, such as stroke, peripheral vascular disease, chronic obstructive pulmonary disease, congestive heart failure, or their inability to complete activities of daily living. In this way, growing older becomes an ad hoc experience, and with each interruption comes surprise and a need for immediate action. During these times, Gillsjö et al. (2011) described the home as becoming a place of unknowns and uncertainty, and possibly a place where participants can no longer live. It is here where the Home First interprofessional team might interrupt the uncertainty through advocacy and proactive interactions, therefore positioning older adults to grow older in their chosen places.

Study participants stated that Home First gave them hope, the ideal service, and that – as one participant said – it was "close to the perfect dream". Such statements indicated that the culture of Home First was having a significant impact at the level of the individual encounter, suggesting that care providers were integrating the processes of being co-present and collaborative in designing services with older adults. To be present means to connect with each other; to touch; to have eye contact; to attend to body language, facial expressions, and silences (Urry, 2002). Previous work by Bowlby (2012) and Urry (2002) suggested that these processes encouraged Home First staff and older adults, as well as family caregivers, to come together for conversations, discussions, problem solving, and commitment within a caringscape to design care reflective of the needs and desired outcomes of the person and not the organization.

## Limitations

Home First and its context and findings are difficult to generalize to other settings. Home First provided care only for older adults living with complex health care needs who met specific inclusion criteria. The focus of the study was on the perspectives of clients and their family caregivers of Home First services, and did not explicitly explore the views of the health care team. Although thematic analysis worked well for the purpose of our study, attention to language, power structures,

and institutional discourses might further enhance our understanding of Home First.

## Recommendations

A relationship between the Home First interprofessional team and patient-engagement is suggested in our data; however, it has not been clearly defined. Understanding this relationship is crucial to negotiate and articulate future continuity of care with older adults with complex health care needs living in the community and maintaining home as a place of care. According to Bodenheimer and Sinsky (2014), collaborative strategies are needed to ensure that sustainable, community-based service models are present. Further exploration of the intersection between leadership, interdisciplinary teams, and patient engagement in Home First is necessary and is currently in progress.

The strong emphasis on co-presence and caringscapes was significant in Home First. We suggest community-based programs be developed that reflect co-presence and are attentive to caringscapes, which develop when the home becomes a place of care. Through this approach, health care professionals can develop caring relationships in partnership with older adults experiencing complex health needs and provide support for their family caregivers in the place of their choice.

## Conclusion

In this study, we explored the perspectives of clients and their family caregivers concerning the Home First program. According to our findings, Home First directly met Saskatoon Health Region's (2013) intentions to provide seniors with a service that is timely, appropriate, supportive, and allows older adults to continue to live in their homes safely and independently. The findings from this study may inform future creative and innovative approaches to enhanced community-based care delivery involving older adults and their family caregivers.

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