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Barriers and Facilitators of a Community-Based, Slow-Stream Rehabilitation, Hospital-to-Home Transition Program for Older Adults: Perspectives of a Multidisciplinary Care Team

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Article

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Résumé

L'objectif de cette étude était d'examiner les points de vue du personnel de soutien, des professionnels de la santé et des coordonnateurs de soins qui recommandent des patients ou collaborent à un programme communautaire de transition de l'hôpital au domicile basé sur la réadaptation lente. Cette étude qualitative descriptive se concentrait sur les lacunes de services, ainsi que sur les obstacles et les facteurs de facilitation liés à la mise en œuvre et au fonctionnement du programme. Vingt-trois personnes ont participé à des groupes de discussion ou des entrevues individuelles semi-structurées. Six chercheurs ont analysé les transcriptions de ces entrevues selon une méthode thématique inductive. Les thèmes émergents de cette analyse ont été classés selon l'échelle socio-écologique suivante : 1) niveau macro – lacunes de services pendant l'attente du programme, capacité d'accueil limitée du programme et lacunes de services à la suite du programme; 2) niveau méso – manque de connaissance du programme, absence d'un processus précis de recommandation, absence de critères précis d'admissibilité et nécessité d'une meilleure communication entre les milieux de soins; 3) niveau micro – prestation de services, bienfaits du programme pour les participants, communication centrée sur la personne, limites structurelles du programme, nécessité d'utiliser des paramètres de résultats et manque de suivi. La mise en œuvre d'un processus fluide de communication et de documentation des renseignements sur les patients et l'utilisation de critères précis de recommandation et de paramètres de résultats normalisés pourraient réduire le nombre de recommandations inappropriées et fournir une information utile au personnel qui collabore au programme ou y recommande des patients.

Abstract

The purpose of this study was to examine the perspectives of support staff, health care professionals, and care coordinators working in or referring to a community-based, slow-stream rehabilitation, hospital-to-home transition program regarding gaps in services, and barriers and facilitators related to implementation and functioning of the program. This was a qualitative descriptive study. Recruitment was conducted through purposive sampling, and 23 individuals participated in a focus groups or individual semi-structured interview. Transcripts were analyzed by six researchers using inductive thematic analysis. Themes that emerged were organized based on a socio-ecological framework. Themes were categorized as: (1) macro level, meaning gaps while waiting for program, limited program capacity, and gaps in service post-program completion; (2) meso level, meaning lack of knowledge and awareness of the program, lack of specific referral process and procedures, lack of specific eligibility criteria, and need for enhanced communication among care settings; or (3) micro level, meaning services provided, program participant benefits, person-centred communication, program structure constraints, need for use of outcome measures, and follow-up or lack of follow-up. Implementation of seamless patient information sharing, documentation, use of specific referral criteria, and use of standardized outcome measures may reduce the number of unsuitable referrals and provide useful information for referral and program staff.

Canada's current hospital-focused care system continues to be best suited for acute and short-term use (Allen, Hutchinson, Brown, & Livingston, 2014), despite the exponential increase in the number of older adults and the proportion of older adults living with complex health care needs (Canadian Institute for Health Information, 2002). The mismatch between a growing older adult

population with complex care needs and a system focused on singular, acute conditions results in: (1) challenges with ensuring effective discharge processes and the provision of timely and adequate care post hospital stay (Allen et al., 2014); and (2) older adults typically being discharged prior to full recovery and achievement of rehabilitation potential and without proper supports in the community (Comans, Peel, Gray, & Scuffham, 2013). These challenges are reflective, in part, of patient-level factors and health care system barriers. Patient-level factors such as new limitations in activities of daily living developed during hospitalization, difficulty in managing chronic conditions, and cognitive impairments often require an increased level of and need for ongoing support and services (Allen et al., 2014). Health care system barriers such as breakdown in communication among delivery levels, inadequate provision of patient and caregiver information, poor continuity of care, and limited access to community services (Kiran et al., 2020) lead to negative consequences including medication errors, increased health care costs, hospital readmission rates and institutionalization rates, and decreased quality of care and quality of life for both the older adults and their caregivers (Allen et al., 2014; Mansukhani, Bridgeman, Candelario, & Eckert, 2015; Verhaegh et al., 2014).

Properly planned and conducted transitional care interventions can decrease hospital readmission rates and emergency department visits and improve older adults' quality of life (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011; Verhaegh et al., 2014). A "transitional intervention" has been defined as any intervention that promotes safe and timely transfer of patients among levels of care and across care settings (Allen et al., 2014). Some transition interventions take place when the older adult is in the hospital (pre-discharge strategies), and may include discharge planning and medication reconciliation. Other interventions, such as education about chronic disease management, home visits, and follow-up phone calls, target the post-discharge time frame (Allen et al., 2014) A meta-review assessing discharge interventions in developed countries found that patient and caregiver education were the most beneficial for improving older adults' emotional status and decreasing hospital readmission rates (Mistiaen et al., 2007). Allen et al. (2014) found that interventions led by multidisciplinary teams and involving the patient had the greatest impact on decreasing hospital readmission rates and improving quality of life. Other interventions and elements, including care planning, communication among providers, preparation of the patient and caregiver, reconciliation of medications, community-based follow-up, and patient education about self-management have also been found to be essential to successful transitions (Allen et al., 2014).

Interestingly, research has found that currently available frameworks for care transitions for older adults are lacking specific mention of integrated community programs that include occupational therapy or physiotherapy specifically, or rehabilitation and rehabilitation professionals in general (Kalu, Maximos, Sengiad, & Dal Bello-Haas, 2019). Available programs often lack some of the necessary coordination and provision of post-discharge services that may bridge the transition between hospital discharge and initiation of community services (Falvey et al., 2016; Watkins, Hall, & Kring, 2012). Specifically, nutrition support, transportation, and the provision of support services for instrumental activities of daily living are typically lacking (Watkins et al., 2012). Community-based, slow-stream rehabilitation (SSR) hospital-to-home transition programs may be a model of care that provides the much-needed support for older adults following an acute hospital stay. SSR programs are structured to be multidisciplinary, longer in overall program duration, but with shorter duration and lower intensity sessions, and are therefore ideal for older adults who are frail or who have complex multiple health conditions (Maximos, Seng-iad, Tang, Stratford, & Dal Bello-Haas, 2019). These programs have been shown to improve physical abilities and independence with activities of daily living and instrumental activities of daily living among older adults, as well as decreasing hospital readmissions (Maximos et al., 2019).

As part of a comprehensive evaluation of a community-based, SSR, hospital-to-home transition program for older adults, we were interested in learning more about specific program processes and practices and any real or potential program process and practice-related gaps, stumbling blocks, and enablers. Therefore, the purpose of this qualitative descriptive study was to examine the perspectives of care providers working in or referring to the program to identify factors that may act as barriers to or facilitators of successful implementation and functioning of a community-based, SSR, hospital-to-home transition program.

Methods

Study Design

This was a qualitative description study, with methods conducted as described by Sandelowski (2010), which aimed to describe and identify a phenomenon through naturalistic inquiry from a social constructivist view (Bradshaw, Atkinson, & Doody, 2017; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). Qualitative description is used when the aim of the researcher is to present facts but not to interpret the data in terms of perceptions, emotions, or the philosophical underpinnings of those interviewed (Sandelowski, 2010).

Study Context

The community-based, SSR, hospital-to-home transition program was designed to assist older adults with continued rehabilitation and other health-related needs to enable them to return to independent living in the community (home) after discharge from an acute care hospital stay or from an inpatient rehabilitation or convalescent care program. The program was developed as a day program; for example, participants attend the program during the day and return home daily allowing them to recover in their own homes, while receiving nursing, physiotherapy, recreation, and other health care professional interventions and support such as pharmacy and occupational therapy. The program was considered SSR as it provides lower-intensity rehabilitation for shorter durations of time. At the time of the study, participants attended the program from Monday to Friday for 1 month and completed a variety of activities each day, including individual and group exercises and social and cognitive activities. Participants received group-based and one-on-one education on an array of topics, such as falls prevention, nutrition, and managing polypharmacy. Snacks and a mid-day meal were provided, as was transportation to and from the program. After the 30 days, the older adult was discharged from the program and could be referred to other community-based programs or support services if and as needed.

At the time of the study, the program was located in one of the 14 Local Health Integration Networks responsible for planning, integrating, and funding health care, as well as for delivering and coordinating home and community care, based on local needs. The discharge process from hospital to community in the LHIN that housed the program at the time of the study was facilitated by

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hospital-based case coordinators. These care coordinators and LHIN community-based care coordinators referred older adults to the program.

Participant Criteria and Recruitment

The aim of qualitative description is to generate a rich descriptive database of different perspectives and major themes (Bradshaw et al., 2017). Therefore, a sample of care providers with diverse disciplines working within or referring to the program was recruited. Recruitment was conducted through purposive sampling, which is a technique that involves intentionally sampling a group of people who can best inform the researcher about the phenomenon of interest (Creswell & Poth, 2016). Participants were included if they were directly involved with or had experience with the care of older adults in the program or were directly involved with or had experience with referring older adults to the program. Those identified as potential study participants included individuals working within the LHIN as case coordinators, working within complex continuing care or convalescent care, and directly working within the program. Potential participants were sent a recruitment letter via e-mail or mail and were asked to contact the project coordinator if they were interested in setting up a phone or in-person interview or attending a focus group. In keeping with the methodology for qualitative studies, no sample size was calculated (Creswell & Poth, 2016), and participant recruitment was conducted until a wide array of individuals were interviewed and themes occurred more than five times.

Data Collection

Individuals participated in one of two focus groups (n = 11) or an individual semi-structured interview (n = 12) based on personal preference. Focus groups were conducted in person by two researchers at the program location and were approximately 1 hour in length; individual semi-structured interviews were conducted either in person or via telephone and were approximately 30–60 minutes in length. For both data collection methods, researchers used semi-structured interview guides composed of the same introductory information and the same open-ended and probing questions related to needs and strengths of, concerns about, and challenges with current program services. Interviews and focus groups were audio recorded and transcribed verbatim. Researchers identified themselves as research assistants who were facilitators rather than topic experts, in order to allow for neutrality and objectivity when collecting data (Willis et al., 2016). Also, researchers recorded observation notes, field notes, and reflexive notes about perspectives, reactions, and feelings that arose during focus groups or semi-structured interviews. These notes were also transcribed and were used to further enhance the transparency of the analysis and the validity of results (Creswell & Poth, 2016).

Data Analysis

All interview transcripts were analyzed using data-driven inductive thematic analysis (Braun & Clarke, 2014), a type of analysis that is free from theoretical frameworks and researchers' analytical preconceptions. This analysis aims to identify, analyze, and report patterns within data (Braun & Clarke, 2006). Thematic analysis was completed by six researchers in independent pairs. During the coding process, each researcher kept reflexive journals to document their ideas and thoughts. For each transcript, researchers followed the six steps of thematic analysis guideline described by Braun and Clarke (2006), which involves initially conducting an independent analysis of the transcript consisting of reading the transcript to familiarize themselves with the information, then generating codes through line-by-line reading, and then generating themes from the data. If needed, researchers referred to observation, field and reflexive notes taken during the interviews, or focus group to further contextualize codes and themes. Once the researchers reviewed the transcript and generated themes individually, they then met with their pair-partner to review and resolve any discrepancies collaboratively through discussion. All six researchers met midway through the review process and all transcripts were reviewed to discuss findings and resolve discrepancies in code books. This was done to triangulate all codes and themes to derive a final coding book. Themes were then presented to the broader multidisciplinary research team members who were not involved in the coding process for further analysis and feedback. The code book was then adjusted according to feedback (e.g., fit of themes, potential areas of over-interpretation of data). This triangulation process with the larger research team occurred multiple times until a final agreed-upon code book was developed.

As part of the thematic analysis, an overarching examination of the themes that emerged from the inductive approach used was conducted. Themes that emerged were organized based on an underlying structure that became evident, specifically a socio-ecological framework structure that highlights multiple levels of impact, influence, and interactions: macro-meso-micro levels of health care systems – patient level (micro), health care organization and community level (meso), policy level (macro) (World Health Organization, 2002); and health care priority setting levels – macro-level (national, provincial), meso-level (regional, institutional), and micro-level (clinical program) (Kapiriri, Norheim, & Martin, 2007) (Tables 1–3). Macro-meso-micro level terminology and framework structure have been used in an array of research including policy research (e.g., Kapiriri et al., 2007), scope of practice research (e.g., Smith, McNeil, Mitchell, Boyle, & Ries, 2019), and community intervention research (e.g., Otiso et al., 2017; Valentijn, Schepman, Opheij, & Bruijnzeels, 2013) to describe and understand a phenomenon of interest using a macro-, meso-, micro-level framework to identify potential areas where barriers and facilitators exist.

Ethical Considerations

Participants were informed of the research aims and provided with written informed consent. This study was approved by the Research Ethics Board. Specific names and locations that appeared in participants' transcribed comments were replaced with a pseudonym to ensure anonymity.

Results

Twelve semi-structured interviews and two focus groups (n = 11) were conducted with a total of 23 participants (see Table 4 for participant information). Six participants were employed by the LHIN, 6 were employed by other referral sites, and 11 were employed in the program.

An overarching theme was time, with three distinct time points identified by study participants as important: before program admission; that is, before older adults begin the program; during the program; and following program completion. Some themes

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Table 1. Facilitators of and barriers to enhancing and implementing a community-based, hospital-to-home slow-stream rehabilitation program at the macro level

			Macro-Level Factors
Facilitator/Barrier	Theme	Program Time Point	Quotes
Barrier	Gaps while waiting for the program	Pre- program	"Initially the idea was that while people were waiting the services could be heightened so we could put in physio and OT in the home to bridge and transition." (P8) "Um, recognition that the service is needed right away and it may be short term but they need it when they leave the hospital, not after a period of time." (P11) "During that initial month home from hospital is when the input is needed, not three months or two months or six weeks but its often that initial first month that's critical in determining how people get back into the community and how well they do." (P12) "The challenges would be getting enough home care services in the home in order to transition someone into the program" (P14) "And of course you may have, ummm maybe a little deterioration of their condition you know." (P15) "Maybe if you had more CCAC services that allowed, maybe an assistant a PT assistant or more PT assistant with not only a home program but with equipment." (P15) "I mean in a perfect world I'd like to say there could be like an in between program or a… you know someone who could go in to their home and….like a home care but for that specific…and do exercises with them there." (P16) "I would say the challenges are deterioration, caregiver burden" (P22)
Barrier	Limited program capacity and need for expansion of program service	During program	"Funding and long waitlists, so more patients wanting access to it is obviously going to increase the waitlist" (P4) "So right now our ratio is approximately 5:1, if you reduce that ratio you might have more success." (P2) "…so you've got a lot of competing programs trying to use a fixed number of machines, and that can add challenges for sure." (P2) " So let's say you have 2 people sort of keeping eyes and getting people on and off the NuStep and monitoring there time spent and there ability to manage transfers, it means that those people are going to be taken away from your staff pool. They probably wont be available to do the prep for the meals, or getting somebody upstairs so you know, so it's really about managing your staff compliment." (P3) "Probably the only challenge is trying to get enough people through all, in one day every day, um sometimes we ran into challenges because it's a shared gym, um specifically with the rehab portion of it, and with that shared gym there's only a certain number of machines, so you run into delays. And sometimes the workload can be a larger amount on one person in a short amount of time, so in other words, trying to get numerous amounts of people in, and you've got up to 15 participants in, in like a 3-hour window sort of thing and that can add challenges. And so we try to space it out throughout the day however the bulk of your work is usually happening within those time constraints, because of transportation, lunch, and various other things."(P1) "But I think if we had more room, if we could accommodate more people. You know that would be great.… maybe if we had maybe another pair of hands or maybe two other persons you know we might be able to offer more. So increased staffing and maybe some more space." (P15) "I think I would enhance our gym piece so we had almost our own space and more tools that are rehab focused. I mean, it took us years to get parallel bars. These standard pieces of equipment in the world of rehab and we didn't go into it with a lot of that. So I think that would be a big piece. I think transportation too I would offer some more options. " (P5) "The drawbacks of the program are that we have all kinds of people that need that kind of program. And they can only accommodate so many people at one time" (P22) "The government needs to give us more money so we can open another one. Because we are the only one in [location] with this kind of set up." (TP01) "Something that can be improved. Expansion of the program… to accommodate more people" (CP01) "It would be nice if there were more programs like [community-program], even if the VON could do something like that but it would be great because that program is west [location] and you've got [multiple locations of interest] this whole area, I don't know about [another location] and all those areas but even in our area there's only one location so somebody in [far location], they're not going to want to do that drive and [program] would not be able to do that, get everybody there on time."(P9) "Probably where they're located, that there's enough of them, we could use more, sometimes it's like, geographic boundaries right so if somebody lives there and they're not in the catchment areas." (P12) "I think the research shows that isolation is one of the biggest factors in determining health for seniors so when you look at all the research on mobility and walking and exercise and bone density on all of those, a program like this can address all of those problems as well as socialization. So I think its quite important that seniors have this connection and more of these programs." (P11) "I don't know what to say about that. I mean, it's successful now I'd say a continuation of it would be the most obvious or else I don't know… more sites I mean it would never be the same but that type of program…"(FG2)

(Continued)

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Table 1. *Continued*

			Macro-Level Factors
Facilitator/Barrier	Theme	Program Time Point	Quotes
Barrier	Gaps in service post-program completion	Post-program	"There are some people who do really well at [community program] and then they go home and they don't go to a program or they don't have something and then they… don't um, continue to do well." (P8) "They get exercises, its free of cost, they're picked up, they're given a meal, they're taken home and they're treated very, very well. Then, at the end of 30 days, you pull the rug out. It tells them that there is hope and things can change, but then many of them do not have the resources to make it happen" (P3) "It's just that, at the end of it we have mixed feelings because quite often they want more, because often we have made them realize sometimes what their true potential is. At the end it means it ends, and we have to find somewhere else to send them on to. This quite often costs money and not everybody can afford it so its bittersweet but it is an excellent program. " (P3) "They cannot afford to participate in any kind of exercise because of financial constraints. I see it all the time because at the end of every assessment we make a plan, its always a question "where do you go from here, who's gonna do your meals, who's gonna do your laundry, how are you going to get from point A to point B" and quite often you hear "I don't have the money, I can't afford" (P2) "There's not enough of programs that do more strengthening compared to cognition. That's a very big thing…they are now waiting on another waitlist for example for another program that's available." (P10) "no funding to subsidize their ability to attend these programs so when it comes down to whether they would have a PSW come for free and do some exercises compared to leave the home and attend the program for $15, 16, 19 dollars a day they're just not going to do it" (P9) "Okay so, for most people that are referred to the program, they're referred by a LIHN case coordinator, whether they are coming from homecare or from the hospital, but once they are discharged from the program they do not necessarily have access to those services" (P1) "There aren't many other facilities that even have a fitness centre. So that would be one major asset for any type of facility especially long term care, assisted living places where there's a fitness facility, and staff to help them with" (P2) "Most of them do have a cost so we usually tell people that the free service usually stops here. Over the years we've gotten good at finding things that pop up so falls prevention would be free, that's something we often refer people to, and we offer that here and there are many other sites around the city. So there's things that come up but they always come and go. So those things exist now but might not've two years ago and two years from now these wont probably exist." (P5) "The [another city program] home support exercise program which I refer a lot of my patients to and it's an amazing program, um, and, initially when I started referring a year ago I think it was the waitlist wasn't that "long now it's like up to 6 months and the back up poor thing is on her own and she's trying to do everything." (P9) "Some Support so that they're not just going to be left at home and have nothing in place and unfortunately with our ADP our waitlist a lot of the programs they're stuck to wait [ing]." (P10)

Table 2. Facilitators of and barriers to enhancing and implementing a community-based, hospital-to-home slow-stream rehabilitation program at the meso level

			Meso-Level Factors
Facilitator/ Barrier	Theme	Program Time Point	Quotes
Barrier	Lack of knowledge and awareness of the program	Pre-program	"We have a lot of changes in staff so there's always a possibility that newer staff are not aware of [program]" (FG2) [talking about brochures] "Something so that they know what it is, who the person is, how it works, what it entails and um, and maybe um, and that's something we could use as case managers for those that don't really know about it." (P8) "I know it's integrated with, actually I don't know if I know the right thing, but its integrated with the day program that [person name] organizes and directs the program… you know their assessed and it's specific to them um, that the goals of the program I think are to make them feel well again, to make them feel motivated, like they're okay, um, and get over that hump of being ill." (P9) "But I go back to awareness, not a lot of people are aware of it, because it is such a unique program out there, and so continuing to develop awareness around the program. There are so many people who aren't aware of it so they stay in hospital for an exponential amount of time." (P2) "I think it's whoever knows about it which predominately is the case managers that have been here for a while that know about. We're the ones that are promoting it and letting patients know about it, but I don't know how patients are finding out about it otherwise." (FG2)

(Continued)

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Table 2. *Continued*

Meso-Level Factors			
Facilitator/ Barrier	Theme	Program Time Point	Quotes
			"Right. They might not know the full scope of it so I think that there should be a nice little package, very small it could be two pages, one could be the overview which could be the general information so that especially new case managers can identify oh, this would be great for my patient and then the second page could be the checklist or the forms or the indicators." (P9) "Something to give to the applications would be great" (P10) "I think because of the way things are now and the amount of information case managers need to know I think there should be a package, an information package that could be given to the patient so that they can see the expectations, how it works and they don't need to sign a consent or anything but at least something so that they know what it is…"(P6) "I could use some brochures (Laughter). I steal some from the social worker and physio but typically the physio and the social worker have brochures and give it to them. "(P12) "There are some handouts available now there's nothing really current I think that's something we… it's a little outdated and very often times they're seen by the community care coordinator as well after discharge from the hospital who can reinforce the information."(P11)
	Lack of specific referral process and procedures	Pre-program	"There's not really a system of who gets referred to us" (P4) "…however another negative is that we're not properly instructed there's no referral base in our computer system to indicate that this person has been referred to [program]… " (P10) "…there's no paperwork or anything and because I luckily know about it's just basically I have to send a task and that's it" (P8) "[Name] will leave a voicemail and just kind of outline… but that voicemail then has to be… like when I get her voicemail I enter it into the patient's file just as a client update so it would be quite nice if there was actually something written, and in the end it might be even easier for [Name]…it would be a living, breathing record which would be quite nice as opposed to a verbatim, because if I don't document, not everybody documents verbatim, so you're kind of interpreting what's being said. Like an admission and a discharge, they are very short and sweet." (P9) "There's no docushare or specific way to know unless we call the PCA and see if the person has been added or to call [Name] and see if the person has been added." (FG2)
	Lack of specific eligibility criteria	Pre-program	"The thing that I'm most dissatisfied with is that we don't really know who this program is for" (P5) "so I don't really know if [program] has specific parameters but I will call and say I have a lady with MS and you know they… if transfers are an issue or something I need to clarify if they can handle that." (P12) [Referral staff discussing who he/she believes the program was designed for stating the following] "I think the program is designed for people but a certain level of independence and ability to follow through on commands and able to benefit from the program," (P11) "But also bigger picture, improving the communication within the system of who is eligible… I feel like the eligibility is too wide. Well I just think it goes back to the hospital, but it's not only the hospital referrals because people quite often get referred community-based. So it's almost like an education for the referring coordinators." (P1) "So actually looking at the criteria, because it's so wide, "well, you've had to have a hospitalization within the last 3 months", and almost anyone can say "well I've been in the hospital". So I would like to see that the eligibility criteria is more specific to who's appropriate and who's not appropriate."(P2) "My concern in all of this is the appropriateness of the referrals. I believe if we had some kind of focus group or even just a meeting with the case managers who make referrals to us. It would be good to just remind them of the focus of this program and who it is intended to serve so when they make their referrals they are more appropriate. If we could inform physicians in the community whether it's through written material just informing them of what we offer here so they do not refer people who require focus PT management which belongs in a clinic in the community because the participants will lose time and they have expectations thinking that they can get everything done here." (P3) [Discussion regarding criteria]"No, like when we do a short stay rest or convalescent care form, there's people who work on those goals but there's nothing for G2H. And I think for experienced case managers, they know what the programs about but for brand new case managers its like, what? So…"(FG2) [discussing perceived criteria] " Someone that doesn't have too many comorbidities, who is able to use their gait aids really well, that they're able to cognitively absorb health teaching and need just some improvement. [discussing whether criteria list present]…No" (P8) [program staff discussing issues on admitting program participant and the back and forth unclear communication] "So, "yes this is for you", "no this isn't for you". Because what happens is that I have to call back and plead a case on why this person- like I did that last week for 8 people- trying to please my case on why"(P1)

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Table 2. *Continued*

Meso-Level Factors			
Facilitator/ Barrier	Theme	Program Time Point	Quotes
	Need for enhanced communication among care settings	Pre- and post-program	"Three business days to accept. But sometimes if you have concerns or questions you just kind of like send questions and they have to answer so that when it's not really clear and you've got some concerns that's kind of a delay but then you have to make a decision yes or no" (P7) "A high majority of them, so they'll have a care coordinator in the community and I just tell them that there are adult day programs um, and then the care coordinator in the community will have to apply for them." (P12) "I would say just not knowing the wait times because I would call and say somebody's being discharged do you think they might be coming into the program, I don't know if it's two weeks, three weeks, a month, so I have to tell the family you will expect a call but I can't guarantee when." (P12) [staff discussing how they discuss the program as an option to family post discharge but unsure of staff communication and who is responsible for referral] "I think the LIHN is making that referral maybe a week before or I don't know… what is the time limit?… Um, or they might be already in a community with home support services waiting to get into [program]so depending on the waitlist, that's why I was wondering if there was a more of a priority or a need for convalescent care to go to [program] or… P: They always go on the waitlist, yeah. (FG2)" "It's not up to us it's up to the LIHN because I have this conversation with the care coordinator sometimes they are already on the list sometimes they were sent back from another transitional bed program to the hospital that has requirements for our program so… Or if not, when they are in here they will have a file opened for them and then they go through the same process." (P6) "A lot of hospital case managers or sometimes when I'm seeing someone in the hospital ill either do it there and then because I know how to do it or ill ask the community… I know some of the hospital case managers will ask the community case manager to follow up with [program]referral but they identify from hospital, but they get the community case manager to assess it in the home. "(P9) "Because this is very tough when the resident comes from convalescent care they expect that we're gonna do everything because this is what the hospital says…" (P8) "[Name] will leave a voicemail and just kind of outline… but that voicemail then has to be… like when I get her voicemail I enter it into the patient's file just as a client update so it would be quite nice if there was actually something written, and in the end it might be even easier for [Name] because then she wouldn't have to just leave a voicemail, she could write out like a progress or summary note and send it, almost like at the hospital when they do a discharge note, fax it into us and then it would go directly into the patient's file and it would be a living, breathing record which would be quite nice as opposed to a verbatim, because if I don't document, not everybody documents verbatim, so you're kind of interpreting what's being said. Like an admission and a discharge, they are very short and sweet." (P9) "Sometimes the referrals are presenting that the patient is walking and that but they were not walking and it's really like a hospitalization like it's really the patients are coming very deconditioned." (P7)

Table 3. Facilitators of and barriers to enhancing and implementing a community-based, hospital-to-home slow-stream rehabilitation program at the micro level

Micro-Level Factors			
Facilitator/Barrier	Theme	Program Time Point	Quotes
Facilitator	Services provided	During program	"some avenue of nursing staff um, I believe an RPN and that there's a rec therapist as well as someone that coordinates the program…Proper nutrition even, that's something we talk about as well is proper eating, some people come in with diabetes and we have to monitor that or Parkinson's is another one, or having had a fall and what that deals with" (P2) "I think the transportation is key, I think if we were to eliminate that I think we would see a decline probably in referrals" (P6) "…I think the meal is also a big part. I think a lot of times this is probably the best meal people get in their whole day" (P5) "I know it's free, transportation's provided, meals provided, physio-focused, they have to have goals, and then I think that they offer some additional services like a shower or foot care" (P12) "People aren't paying out of pocket and that transportation is provided. A lot of older people or people in the community with like a walking aid or something its hard for them to find transportation and they don't have to pay for it.- Oh yea. And we have the physiotherapist, the nurse, the gym, we do a lunch, there's coffee and tea in the morning."(P3)

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Table 3. *Continued*

			Micro-Level Factors
Facilitator/Barrier	Theme	Program Time Point	Quotes
			"I would say the best thing, one is that we provide transportation" (FG1) "The fact that they get transportation is stellar, its amazing" (P6) "It's great that they will come to the door and assist you with transportation because that's a huge barrier for some clients in going to any rehab or adult day program" (P8) "No cost, it's covered by the ministry of health. So that's the other thing big bonus." (FG1) "And the good part is it's at no cost to them" (P3) "…how we are set up so that basically you can get OT, PT, Nursing, PSW all under one umbrella." (P1) "I think just having a wide variety of professional, you know like [Name] being an RN, to myself being a PSW, to having a physio therapist, I think that it's great to have all of that in one program." (P4) "The fact that they have a PSW to help with toileting or a med reviewing like a nurse is great" (P9) "[Name] runs it, she's very informative, she's up to date and she actually does a lot of proactive work there too with regards to insuring that the patients are optimized from an equipment perspective and I know that they have OT and physio there and it's an intensive daily rehab program so it gets more benefits than just doing physio and home exercise programs for those certain individuals" (P10)
Facilitator	Program participant benefits	During and post-program	"…back to the full body abilities, so there's the rehabilitation piece which takes into account your mind, body, spiritual, all the various assets to helping that rehabilitation model" (P2) "Every single time, we've seen leaps and bounds from where they started" (P10) "I see that they give to the people new meaning, they give them confidence, they seem to be offering care without boundaries, care without any kind of condition…" (P3) "I think also knowing that they can improve, it just reminds them that hey I can improve later, it's possible that I can keep going so it just gives them more intrinsic motivation to continue on with other programs that [Name] finds for them" (FG1) "…once they're finished their 30 days, they move into other programs, one being the fitness center, some people become community members, and we see them continuing to interact, and actually develop social ties with other members, who are also part of the program, and kind of rekindling those friendships if you will" (P2) "…but I know that people leave here happy most of the time. They feel that they've made improvement, is it enough to sustain them ongoing" (P5) "Social ability within the program-so, participants who come into the program don't know each other at the start of the program, but because they're on the same journey, they gravitate and connect with each other. So, they really form bonds that last beyond the program. And we see that because once they're finished their 30 days, they move into other programs, one being the fitness centre, some people become community members, and we see them continuing to interact, and actually develop social ties with other members" (FG2) "it just gives the patient a little bit more confidence, when they're discharged from hospital they have something else to continue working on some of their goals, it helps the caregiver, sometimes when people have been in hospital for a long time they're nervous and it gives them some sort of knowing that there's some program that they can go to and it's sort of partners with their adjusting to home" (P9) "Like definitely I see the social aspect and not even like…in their room they're chatting they get to play games like they're stimulated… They're playing trivia games, bingo like they get that cognitive stimulation that you don't always get in maybe at home watching TV all day." (P3) "Long term [effects] I suppose better quality of life…. Because they have improved mobility, improved function… increased independence. So just better quality of life in general" (P11) "and then of course there is the physical aspect of things, where they go to the gym and they get stronger and they're encouraged." (P3)
Facilitator	Person-centred communication	Pre-, during, and post-program	"We discuss their goals, what do they want to achieve and we have the background knowledge of the therapist as well to assist but yes we would be discussing goals." (P10) "Once we've assessed somebody and determined that they're not quite at their functional baseline, we give them the option of you know, here are some programs that might assist you in further gaining and what I do at the point of the bedside is provide education around the program and with their consent I would refer them to the program" (P9) "Yes. So we have that family meeting in convalescent care when we discuss the progress and discharge destination…on day 45 you know what, this patient needs to be here for like, up to 90 days because we don't see that going home sooner than 90 days so the family knows, this is the day that is for potential discharge so they are planning everything ahead…"(P7) "And their families are involved a lot in a lot of cases so it's a good relationship that we can build with the family and they feel really comfortable to approach us and talk to us about things…" (P6) "Communication and also the teaching aspect for them and to actually specify the tasks that they need to complete, that's a huge part if they can't work on specific tasks of what they do need when they're at home it's of no use to them later on" (P10)

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Table 3. *Continued*

Micro-Level Factors			
Facilitator/Barrier	Theme	Program Time Point	Quotes
			"… they'll tell you things as a friend…So then I'll go afterwards if it's something medically related and I'll tell the nurse and say oh just so you know she mentioned this or that, you know for anything beneficial medical wise" (P4) "Also, the nutritional aspect of it, the health talks, [Name] the [occupation] does a great job. I know that [he/she] empowered many people with the talks that she gives in telling them how to manage health issues" (P3) "Um, I guess I would go back to really, the staff and the passion that they have. Because those are the feedback that I get from families and clients themselves that they- - love the staff. Yeah. And when they have to go to another program they'll say "but it's just not the same". So to me that seems to be the core." (P1) "So the [occupation of program staff member] who's in there, [Name], really takes a real personal approach with each person, really helps make them feel acknowledged and accommodated as best she can. We try to get all the variable information that's necessary to make their experience as positive as possible"(P2) "We often tell people as a part of our script if you will when they come in that there is very little you will say that will offend us so if you want something or need something please do tell us and most people are sure to tell us what they want and want they don't want… One of our strengths, and I don't know if it's just the team or if it's our organization or what I don't know what it is, but were good at relationships and so people open up pretty quickly here." (P5) "I think that's what it is because you know personally wise a participant will come and their stay depends on how we speak to them how we operate with them in terms of giving care. So, they will, they will stay. They will look forward to coming."(P8) "[Person] sits and hears their whole story start to finish, how did you get here, what does your home look like, how do you get in and out of the shower, things like that. [name] great at figuring out what they need to make things better or she works with [name] to do their walkers" (FG1) "Um, I know people love it so I don't know what happens there that people love it, so it has to be the interpersonal relationships as well as the actual program."(P6) "I think that warm hand off. As opposed to just saying um, would you like to go to an adult day program, here's the information, the staff will actually make that connection so whether that's through the CCAC or the program itself, to actually make the referrals, send the form, perhaps set up a start date, like I think it's taking that extra mile that helps people be successful."(P5) "[Program staff discussing follow-up phone call] Um, so generally from those phone calls we do find that unfortunately there has been some, kind of, cause generally these people are medically frail to begin with, um, so there may have been a hospitalization or a fall. But it's also a good time to follow up to say so "what programs are you in", "are you connected with a community resource". (P8)
Barrier	Program structure constraints	During and post-program	"Timing doesn't work for everyone because it is a morning program. If there was two different streams, a morning and afternoon, it would be beneficial to a lot of the population who's not able to get up so early and have their PSW come and assist them…" (P10) "I don't know if extending the program hours benefits anything or not, because there's a point in the day where our participants just get to a fatigue level where extending the program wouldn't necessarily help them" (P2) "But, it would be cool if you could almost personalize it to keep people… some people have made so much improvement in the first 2 to 3 weeks that they don't even necessarily need the 30 day" (P4) "So sometimes its hard to explain to them like, so we're gonna go over and do a crossword or we're gonna play a word game or whatever they're kind of like, why, I'm here for rehab, I'm here for physio, why can't [Name] take me to the gym all day. So sometimes that's a challenge." (FG1) "I think the ability to go as many times as they need to during the week, and the ability to stay for an extended period of time are good. In terms of discharging maybe a graduated discharge you know so that they're not just finished with the program and that's it so kind of a graduated way of seeing over how they do as the program is decreased. "(P8) "I think it should be tapered maybe, so you get this lovely one month program and then you're done, can you, you know, ween it down to bi-monthly, you know or, like a step-down program so that it sort of prepares them and educates them about other resources in the community um, I don't know if you would want to call it a coach but somebody just to say what's your quality of life? How are things at home? What else would you like to be doing? Sort of the navigator."(P12) "…I just find also to one of the downfalls is that there isn't an ability to re-enter the program subsequently…" (P10) "the biggest complaint is that the program isn't long enough" (FG1) "I think just hearing them want to stay you know there's only so much we can do and it stinks that we're like sorry it's the end of the 30 days, bye. I don't know for me that's a challenge to not be able to give them more than that…Because there are some folks that are here they just need a 2-week, some need a whole month, so it just depends on your needs but you have a maximum" (FG1)

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Table 3. *Continued*

Micro-Level Factors			
Facilitator/Barrier	Theme	Program Time Point	Quotes
			"The four weeks is a good idea and then step down two times a week for another two weeks and then assess for another transition to complete independence at home or maybe a need for a home continuation step down."(P9) "They feel that the program has stopped too early and that they would've like to have had um, a summary week or two and then enter into another rehab program, perhaps not daily but to have something established that they could stream right into that program for one to two days a week" (P10) "Either enhance the program to make it longer or have a follow through like a tail end of a program option um, or have the ability to repeat the program if they still some time or to also in accommodation with that is to maybe make two certain streams that one would be like a 12 to 6 and one would be like a 9 to 3 type of a program." (P10)
Barrier	Need for use of outcome measures	Pre-, during, and post-program	"If they generated a mini assessment, like an ADL or some kind of measure of what their abilities were… and then did an ability summary assessment that would be kind of beneficial" (P10) [Referral staff discussing how they perceive that to enter the program there should be a screening process and the following aspects should be screened] "I think their emotional, psychological one has to be evaluated, life satisfaction type screens and that kind of thing, and caregiver stress" (P12) "I like the standardized test that we have put into place through your research study. I don't know if there's a better way to validate what we're doing. Those are the accepted measures and I think we should stick with that. I think that helps us to decide the who, and the when and the where" (P5) "I think it would be nice to have the admission and discharge documentation for the patient" (P9)
Barrier	Need for continued follow-up by program or referral staff	Post- program	"…sometimes I never see the people again…" (P8) [Suggestion by program staff discussing how the program participant is no longer on their radar]"I believe if there was some kind of outreach to people in the community, where there is some kind of early oversight if things are going in the wrong direction….you know just get eyes on them" (P3) "… I don't know if they have any support that's… I don't really ask and I… I really have no idea what is happening after that one month. Do they have any support? Of course they have like services if they are eligible from LIHN but what about the physio you know? The physio I think is the key". (P7) "so yeah I'd say more often than not I don't see people again after and if they still have things with us then that runs out eventually." (P6) [discussing what happens after program] I'm assuming that they're informed of other programs such as the YMCA one or the regular Goldie's program and they work with their care coordinator in the community to find out if there's senior programs or… [stated the do not follow-up personally]"(P11) [Study Participant working within the program discussing the struggle for older adult program participants post program completion stating the following] "Well, if they're living on their own then they don't have the community or family support, they're the ones that I find fall off the radar because they don't know who to call." (P1)

Table 4. Employment Location and occupations of participants

Employment Location	Participant Occupation	Number of Participants
Community-based, slow-stream rehabilitation hospital-to-home transition program	Healthcare professional (e.g., nursing staff, physiotherapy, case managers)	2
	Administrative staff	2
	Frontline staff (e.g., personal support workers, activity staff)	7
	Number of participants	11
Local Health Integrated Network	Community case coordinator	2
	Hospital case coordinator	2
	Both hospital and home case coordinators	2
	Number of participants	6
Other referral site e.g., convalescent care unit	Administrative staff	3
	Frontline staff (e.g., personal support workers, activity staff)	3
	Number of participants	6
Number of participants		23

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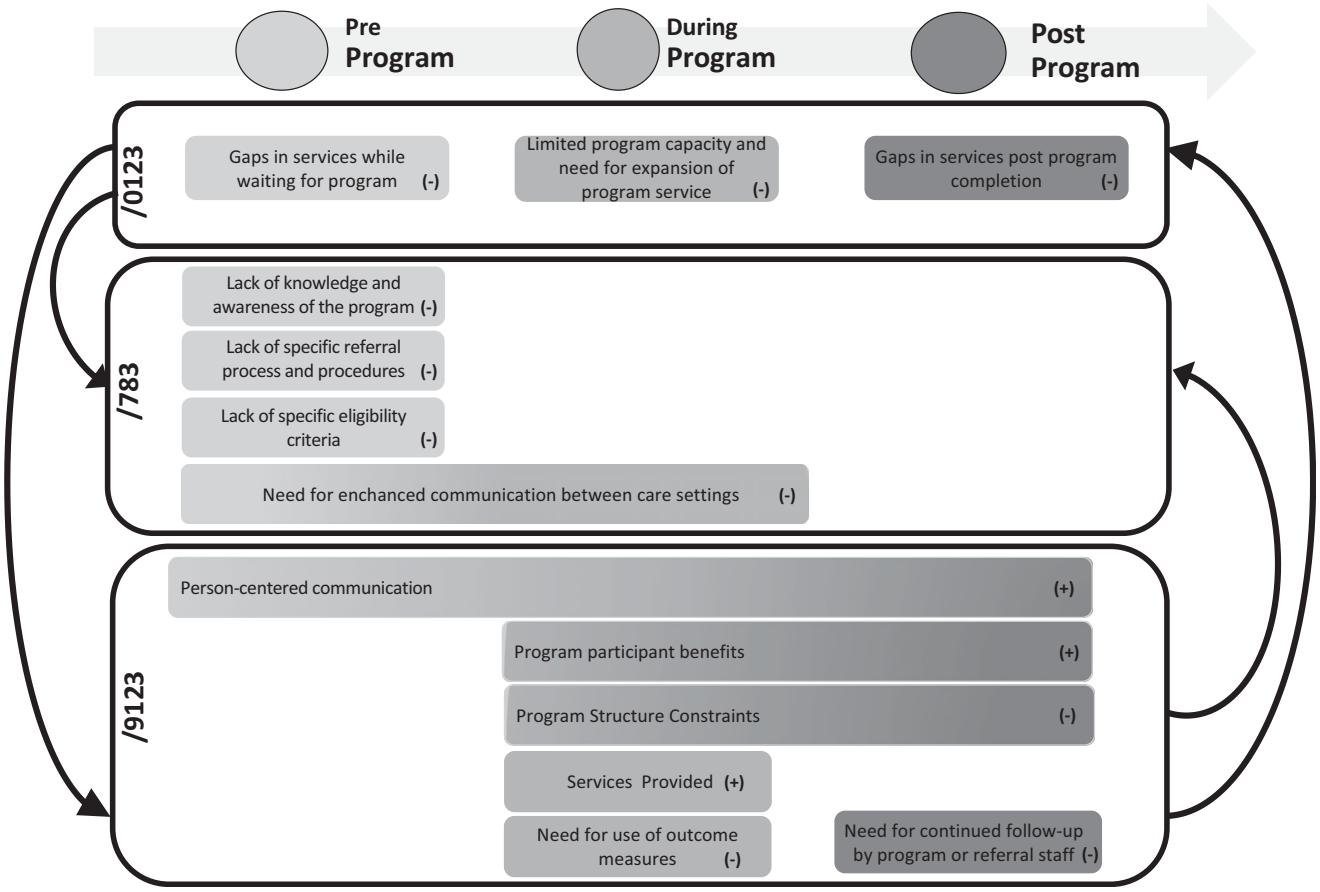

Figure 1. An overview of over-arching themes and sub-themes categorized by socio-ecological framework: macro, meso, and micro levels. All themes have been categorized into macro, meso and micro levels, and the interaction among the levels has been identified through the directions of the arrows. Changes in macro level barriers will directly impact resources available for knowledge dissemination and communication among service delivery levels at a meso level and will impact the program structure constraints and services available at a micro level. In turn, changes at a micro level such as improving use of outcome measures in the program or implementing a Web site for the program will in turn affect all the barriers seen at a meso level, and may improve resource allocation at a macro level. (-) indicates that the theme was considered a barrier to and (+) indicates that the theme was considered a facilitator of enhancing and implementing a community-based, hospital-to-home, SSR program.

extended across all time points, whereas others were bound to a particular time point (Figure 1 provides an overview of themes).

Macro-Level Factors

Macro-level factors have been described as federal or provincial-level factors (Kapiriri et al., 2007), such as policy, resource allocation, funding for supports and services, and initiatives (World Health Organization, 2002) to support older adults post-hospitalization. Participants described the current lack of resource allocation and funding for hospital-to-home transition supports and services as barriers to further program development. This lack of resource allocation and funding extended across all three time points. Although the program provided specific supports and services at a particular point in time post-hospital discharge, what transpired before and after the program were also highlighted as elements important to consider for a comprehensive model of care for hospital-to-home transition for older adults. No macro- level facilitators were identified. Macro-level themes included: gaps while waiting for program, limited program capacity and need for expansion of program services, and gaps in service following program completion.

Gaps while waiting for the program

Program participant (older adult) needs prior to admission into the program encompassed services that would support the older adult post-hospital discharge and were often unmet. Gaps, in other words lack of continuity of care, included lack of availability of home care support and health education, as well as lack of timely and continued rehabilitation including occupational and physiotherapy. These gaps were discussed by both referral and program staff as impeding older adult success in the program. Participants noted that there are currently very few to no resources, supports, and services available post-hospital discharge to prevent loss of any gains made while hospitalized and to prevent loss of independence while the older adult is waiting to be admitted into the community program. “Um, recognition that the service is needed right away and it may be short term but they need it when they leave the hospital, not after a period of time” (P11).

Limited program capacity and need for expansion of program service

A barrier was that the current capacity of the program was limited both in terms of the number of older adults that could be admitted at any one time as a result of lack of funding and the challenges

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related to capacity within the program. This barrier hindered program delivery because limited exercise equipment resulted in wait times for equipment, having to share equipment with participants in other programs offered by the facility, and the ratio of number of staff to number of older adults in program. Growth in the number of programs across regions was identified by study participants as a method of enhancing the model of care by allowing for greater access to hospital-to-home transition programs.

> You've got a lot of competing programs that need to use a fixed number of machines, and that can be a challenge for sure. (P2)

> It would be nice if there were more programs like [program], even if the VON could do something like that but it would be great because that program is west [location] and you've got [multiple locations of interest] in this whole area. I don't know about [another location] and all those areas but even in our area there's only one location so somebody in [far location], they're not going to want to do that drive and [program] would not be able to do that, get everybody there on time. (P9)

Gaps in service following program completion

The lack of available low-cost or no-charge community-based programs and services that would support gains made and assist with continuity of care was considered a health care gap that could lead to potential loss of benefits that were made during the community program. Programs were either not available in general or not available in the older adult's community or were too costly. Participants expressed concern about the lack of these important community resources and what would happen to the older adult's-physical and emotional well-being after discharge from the program.

> [in program] They get exercises, it's free of cost…. Then, at the end of 30 days, you pull the rug out. It tells them that there is hope and things can change, but then many of them do not have the resources to make it happen. (P3)

Meso-Level Factors

Meso-level factors exist at the health care organization and community level (World Health Organization, 2002) or the regional level (Kapiriri et al., 2007). Kapiriri et al. (2007) described meso-level factors as being priorities within the organization and its related community sources. Examples of meso-level factors can include tools within and between care delivery levels, knowledge and expertise of staff, and values and priorities of the larger organization of interest (Kapiriri et al., 2007; World Health Organization, 2002). Meso-level themes identified in this study included: lack of knowledge and awareness of the program, lack of specific referral process and procedures, lack of specific eligibility criteria, and need for enhanced communication among care settings, and all were deemed areas of improvement to be implemented to enhance the model of care. No meso-level themes were identified as facilitators.

Lack of knowledge and awareness of the program

This theme comprised lack of understanding of the services provided by the program and not having information about the program to distribute to other staff members or potential program participants. Lack of knowledge and awareness were perceived as a barrier mainly by referral staff and program leadership. The study participants indicated that they did not have access to information pamphlets and only knew that the program existed through "word of mouth". Because of the high turnover of care coordinators, program knowledge and awareness often disappears when the care coordinator leaves. In addition, those who knew of the program's existence indicated difficulty identifying all the different elements and components or the goals of the program.

> We have a lot of changes in staff so there's always a possibility that newer staff are not aware of [program]. (FG1)

> I could use some brochures (Laughter). I steal some from the social worker and physio but typically the physio and the social worker have brochures and give it to them. (P12)

Lack of specific referral process and procedures

The lack of specific referral processes and procedures was viewed by study participants as an area needing improvement, which led to barriers in regard to who was admitted to the program and how to provide access to the program. Specifically, the lack of a defined set of actions to be undertaken to transfer participant information from one level of care to the program and the lack of a paper trail for referrals resulted in uncertainty about how to refer to the program, when to refer to the program, and whether the referral was actually received by the program. Also, the general referral process used differed based on whether the referral was from a community care coordinator, the hospital care coordinator, or individuals from other sites such as convalescent care. The referral process was often dependent on whether the staff referring the prospective older adult participant knew whom to contact.

> …however, another negative is that we're not properly instructed there's no referral base in our computer system to indicate that this person has been referred to [program]… (P10)

Lack of specific eligibility criteria

The need to have a better understanding of the characteristics of potential older adult participants who would most benefit from the program was identified as important by referral and program staff. Both the program and referral staff discussed the need to use standardized measures and cut-off values as a potential way to ensure appropriateness of referrals. The referral staff noted that they had a general idea of who would most benefit from the program, but did not have a clear understanding of any eligibility criteria. This led to some confusion and inappropriate referrals to the program.

> So actually looking at the criteria, because it's so wide, "well, you've had to have a hospitalization within the last 3 months", and almost anyone can say "well I've been in the hospital". So I would like to see that the eligibility criteria is more specific to who's appropriate and who's not appropriate.(P2)

> I think [The program] is designed for people but a certain level of independence and ability to follow through on commands and able to benefit from the program. (P11)

Need for enhanced communication among care settings

Written or spoken communication should take place any time patient information has to be moved from one level of care to another or from a care setting to the program. For example, communication could take place between community level and the hospital (e.g., community case coordinators and hospital

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discharge staff) or between community settings (e.g… program staff and LHIN staff). Study participants discussed the need to enhance methods of communication among service delivery levels to increase knowledge about patient's medical status, decrease lag time for information sharing, and increase clarity of communication. Communication issues were viewed as barriers that needed to be addressed.

> It's not up to us it's up to the LIHN because I have this conversation with the care coordinator sometimes they are already on the list sometimes they were sent back from another transitional bed program to the hospital that has requirements for our program so… Or if not, when they are in here they will have a file opened for them and then they go through the same process. (FG3)

Micro-Level Factors

Micro-level factors include patient-level factors and day-to-day program components that either support or hamper individual empowerment, such as communication with the patient, patient goals, and program structure (Kapiriri et al., 2007; World Health Organization, 2002). Most of the participants noted micro-level factors as important components to maintain. Themes included services provided, program participant benefits, and person-centred communication. Study participants noted program structure constraints, need for utilization of outcome measures, and lack of follow-up as hindering program participant long-term success.

Services provided

A variety of program activities, education, care, and supports were provided to older adult participants. The following were considered components that should be retained, built upon, and expanded: multidisciplinary care, free transportation to and from the program, provision of meals, health and nutritional education, social activities, and rehabilitation.

> Its free, transportations provided, meals provided, physio-focused, they have to have goals, and then I think that they offer some additional services like a shower or foot care. (P11)

Program participant benefits

Study participants identified that program participant benefits were directly related to program activities, and included increased physical function, improved mobility, and increased endurance, as well as decreased isolation and depression. Some intrinsic benefits included renewed sense of meaning, motivation to continue to be active, and motivation to be engaged in their community.

> I think also knowing that they can improve, it just reminds them that hey I can improve later, it's possible that I can keep going so it just gives them more intrinsic motivation to continue on with other programs. (FG1)

> …back to the full body abilities, so there's the rehabilitation piece which takes into account your mind, body, spiritual, all the various assets to helping that rehabilitation model. (P2)

Person-centred communication

Person-centred communication is a method of gathering or providing a two-way stream of information sharing between staff and participants or their families in a way that is empathetic and AUaccommodating of individual's beliefs, desires, knowledge, and experiences (Williams et al., 2018). Person-centred communication was evident and was engaged in across all time points by referral and program staff. All study participants discussed the importance of continued person-centred communication as a critical component of any model of care.

Prior to the start of the program referral, staff met with family and prospective participants about the program and rehabilitation goals. During the program, program staff provided emotional support and developed relationships with the older adult participants. Program staff described being open and having a willingness to listen to the older adult program participants' opinions and needs. This openness and willingness to listen continued during discussions of linking older adults and their families with community resources.

> Yes. So we have that family meeting in convalescent care when we discuss the progress and discharge destination…on day 45 you know what, this patient needs to be here for like, up to 90 days because we don't see that going home sooner than 90 days so the family knows, this is the day that is for potential discharge so they are planning everything ahead… (P7)

> So the [occupation of program staff member] who's in there, [Name], really takes a real personal approach with each person, really helps make them feel acknowledged and accommodated as best she can. We try to get all the variable information that's necessary to make their experience as positive as possible. (P2)

Program structure constraints

Program structure included elements that comprised the design of the program such as total length of the program, daily schedule, and time spent in the program per day. Program and referral staff discussed that not all older adult program participants progressed at the same rate and that the 30-day program length was a limitation for some older adults. Study participants highlighted the need for more flexibility, such as having a step-down approach where after the 30-day program, participants could continue three times a week and then twice a week and then once a week for a limited time. Because of individualized needs, some older adult participants would have benefited from being able to attend the program for half days rather than full days. Participants also indicated they would have liked the ability to re-enter the program should issues arise, or be able to stay in the program for an extended period of time, beyond the 30 days.

> Timing doesn't work for everyone because it is a morning program. If there were two different streams, a morning and afternoon, it would be beneficial to a lot of the population who's not able to get up so early and have their PSW come and assist them… (P10)

> I think it should be tapered maybe, so you get this lovely one month program and then you're done, can you, you know, ween it down to bi-monthly, you know or, like a step-down program so that it sort of prepares them and educates them about other resources in the community um, I don't know if you would want to call it a coach but somebody just to say what's your quality of life? How are things at home? What else would you like to be doing? Sort of the navigator. (P14)

Need for use of outcome measures

Using standardized tools with cut-off values that could objectively measure older adults' physical ability, psychological well-being, and ability to complete activities of daily living was viewed as important. Study participants stated that the implementation of standardized measures in a model of care would be beneficial for communicating patient progress and needs among different care

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settings, as well as would providing evidence to support the need for the program, to sustain current funding levels, and to advocate for increased expansion and funding in the future.

> If they generated a mini assessment, like an ADL or some kind of measure of what their abilities were… and then did an ability summary assessment that would be kind of beneficial. (P9)

Need for continued follow-up by program or referral staff

Study participants stated that once the program was completed, there was no further follow-up with the older adults to determine if the recommendations were implemented. Both program and referral staff participants stated that having opportunities to maintain communication with older adult participants after program completion would be beneficial, may enhance longer-term benefits, and could potentially identify new challenges that arise for older adults post-program completion sooner rather than later.

> … I don't know if they have any support that's… I don't really ask and I… I really have no idea what is happening after that one month. Do they have any support? Of course, they have like services if they are eligible from LIHN but what about the physio you know? The physio I think is the key. (P7)

Discussion

SSR programs, designed to provide optimal care for older adults with complex health care needs or who are not able to participate in "traditional" rehabilitation programs, are available in institutionalized settings across Canada (Maximos et al., 2019) to address activities of daily living and mobility problems, prevent institutionalization, and decrease hospital readmission. No study to date has evaluated the transition process from hospital or convalescent care to a community-based, SSR, hospital-to-home transition program from the perspective of a multidisciplinary care team, which led to this study.

Perhaps not surprisingly, most of the stated barriers and gaps were at a macro or meso level and were out of the study participants' control, whereas all the facilitators were at a micro level. Study participants emphasized the importance and role that community hospital-to-home transition programs for older adults play in decreasing institutionalization and allowing for return to independent living post-hospitalization. However, macro and meso level factors such as limited government resource allocation, lack of knowledge about the program, need for more well-defined referral processes and communication across service delivery levels were considered barriers that would need to be addressed for further program development, implementation and success. Many of the barriers of care identified in this study are similar to those previously reported by policy researchers, healthcare workers, family caregivers, as well as older adults themselves: break-down between care delivery levels (Mansukhani et al., 2015), lack of community-based follow-up (Russell, Skinner, & Fowler, 2019), limited access to services and resources; and specifically in Ontario, lack of timely services and community supports, limitations of funded services and coordination of care (Kiran et al., 2020).

In 2007, the government of Ontario proposed a provincial 'Aging in Place' initiative that would enable older adults to continue leading healthy, independent lives in their own home. This initiative aimed to provide $1.1 billion over four years with an increase of $143.4 million for community-based programming in the first year alone (Peckham, Rudoler, Li, & D'Souza, 2018). The program goals were to improve coordination of services from hospital to community and support initiatives that would decrease emergency department and alternative level of care usage. This led to multiple LHIN-funded initiatives across different regions of Ontario (Peckham et al., 2018). However these initiatives are at the provincial level and are not part of Canada's Medicare system, and thus lack universal, sustained funding for building capacity in the community (Peckham et al., 2018). Competing political agendas have resulted in fragmentation within the community and social care subsectors (Russell et al., 2019). Community initiatives are often motivated by a single funding injection and thus long-term sustaining of initiatives becomes difficult when funding is withdrawn (Russell et al., 2019). Russell et al. (2019) suggest that a top-down approach rather than bottom-up approach to coordination of funding is needed, which would allow for sustained programming and planning with communication and collaboration directly with policy makers. An analysis conducted by Russell et al. (2019) found that in order to maintain sustainability of community initiatives community champions, multi-disciplinary and cross-sector collaborations, and systemic municipal involvement are required.

In addition to sustainability, communication across system delivery levels requires cross-system talk between different medical record platforms, otherwise sharing of information is difficult to coordinate (Russell et al., 2019). Communication issues across service delivery levels is not unique to Ontario or the Canadian health care system, but has also been highlighted in the United States and in Europe (Mansukhani et al., 2015; Vermeir et al., 2015) and include lack of time for spoken communication or secure systems for indirect communication, such e-mail, referral documents, and availability of assessment information among home care, rehabilitation staff, and acute care providers. In the United States, systems and tools have been developed to share patient information across care delivery levels. The Continuity Assessment Records and Evaluation platform is an example of such a tool, intended to provide up-to-date and accurate information at the time of hospital discharge and during the transition of care period (Mansukhani et al., 2015). Platforms such as these have been shown to decrease hospital readmission rates, improve quality of care and patient involvement, and decrease overall health care costs (Mansukhani et al., 2015; Vermeir et al., 2015).

In contrast to the barriers, all facilitators were either related to day-to-day program activities or to the program structure. Micro-level facilitators identified included the services available to older adult participants, person-centred communication, and extrinsic as well as intrinsic gains directly related to program design. According to the study participants, the program was successful because it combines rehabilitation, nutrition, and education with opportunities for social interactions and the ability to seek guidance from an array of health care professionals. Integrated care at a micro level, where a program or clinic provides a multidisciplinary care team and multifaceted programing to assist older adults with multiple chronic conditions or functional limitations, is an often used as a framework for patient care (Briggs, Valentijn, Thiyagarajan, & de Carvalho, 2018). Many of the facilitators are similar to those documented in the SSR program (Maximos et al., 2019) and community-based program literature (Berger, Escher, Mengle, & Sullivan, 2018; Kjerstad & Tuntland, 2016; Shumba, Haufiku, & Mitonga, 2020). Yet to date, SSR programs have been solely housed in institutionalized settings such as hospitals and long-term care facilities (Maximos et al., 2019). SSR programs provide an array of services for the older adult with complex health care needs, often via a multidisciplinary care team, and have been shown to successfully improve function and decrease

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institutionalization and hospital readmission (Maximos et al., 2019). The multidisciplinary structure and array of services are considered important in both SSR and community-based programs, as is the ability to provide the education and skills to both the older adult and their family caregivers that are needed for independent living (Maximos et al., 2019).

Services that study participants described as being important to the success of older adults transitioning back to independent living post-hospitalization and that should continue in any future program included nutrition, transportation to and from the program, socialization opportunities, and rehabilitation services. Previous literature has shown that provision of services such as nutrition, education about chronic conditions and management, transportation or access to community services (e.g., grocery, gyms, coffee shops), and access to home care supports have been associated with maintained physical function, improved mental health, improved quality of life, and a reduction in emergency department use for older adults living independently in their homes (Falvey et al., 2016; Jeste et al., 2016). Rehabilitation services such as physiotherapy have also been found to decrease hospital readmission and improve physical function for older adults with complex health care needs (Falvey et al., 2016). Interventions aimed at improving functional difficulties and focusing on reducing risk factors related to co-morbidities (eg. education or medication management) have been shown to improve health and decrease hospital expenditure (Smith, Soubhi, Fortin, Hudon, & O'Dowd, 2012). These findings, as well as the findings of previous policy statements, the World Health Organization highlights the need for major reforms to health care systems to support an aging population through the integration of health and social services to address prevention and management of declining functional ability in older adults (Briggs et al., 2018; World Health Organization, 2015, 2016).

The study participants also discussed aspects that were not directly related to program resources but rather were related to communication with older adult clients and their families. Study participants felt that person-centred communication and collaboration with the clients and their families were vital. Person-centred communication that takes into consideration the person and their family's values has been shown to be important to clinicians, clients, and their families and improves quality of care and adherence (Kiran et al., 2020). Research related to hospital-to-home transition interventions has found that good communication and collaboration improve quality of life and decrease readmission rates (Verhaegh et al., 2014). Hence, staff training about the importance of and the implementation of person-centred communication and collaboration with program participants to set goals should continue in any model of care.

Even though there are many policy and structural changes that would need to be implemented at a macro level, such as increased funding to expand the program and improve sustainability, and a health care deliver-wide communication system, there are changes that can be made at a micro level that would lead to program enhancement. Barriers such as lack of program knowledge and awareness, communication, referral processes. and eligibility criteria could be addressed through various initiatives. For example, pamphlets, a dedicated Web site, or orientation videos could be developed for new referring staff. Research has shown that a dedicated platform, such as a Web site with articles, program information, and printable forms and documents can serve as a centralized repository of resources for health care providers, referral staff, older adults, families, and the community and can improve awareness of services (Berger et al., 2018). Incorporating tools such as decision aids would improve experience of those using the service and lead to greater uptake of the service. For the model of care, an eligibility criterion check list, as well as the availability of referral and standardized assessment forms would be important to have for referring staff to improve their experience and improve uptake. Online and other tools would be a mechanism for seamless sharing of information across care delivery levels, would assist in reducing inappropriate referrals to the program, and could serve to highlight the successes of the program. Although these initiatives would not require policy changes, funding would be required for implementation.

The current program structure and constraints were considered barriers. The study participants felt that there should be more flexibility; for example, full days or half days, the ability to participate in the program for more than 30 days, and the ability to gradually taper attendance in the program. Older adults with complex health needs may require longer rehabilitation time to achieve independent living (Falvey, Mangione, & Stevens-Lapsley, 2015). A scoping review conducted by Maximos et al. (2019) that examined components of SSR programs in single-payer or single-payer-like health care systems worldwide found that the average length of SSR programs ranged from 2 to 4 months. Other types of community-based programs for older adults have ranged from 6 weeks to 3 months (Malik et al., 2020). The desire to provide longer rehabilitation time or a step-down model to allow older adults to more gradually adjust to independent community living post-hospitalization is supported by literature and would be a unique feature of this program. However, providing this program flexibility would require increased funding allocation to support staffing and the capacity to accommodate the individualized program structure and the needs of other programs housed at the facility.

Limitations

Despite the richness of information gathered from this qualitative study, limitations exist. This study assessed one specific program in an LHIN in the province of Ontario; therefore, the extent to which findings about facilitators and barriers are generalizable to different settings, provinces, and countries is not known. With qualitative description methods, researchers developed themes without interpretation; therefore, an in-depth analysis of phenomena was not conducted. Qualitative description methodology does not often consider the intricacy and complexity of differing perspectives and multiple truths that often emerges in other qualitative methods such as phenomenology or ethnography studies. To ensure rigor and triangulation, as well as to ensure that themes resonated with multiple health professionals involved in the transition process, reflexive notes and themes were reviewed with a multidisciplinary research team during and post-analysis. However, themes were not revisited by study participants for confirmation, to decrease the demand on participants' time and because of staff turnover. This meant that we did not have an opportunity to check interpretation of what was said during the interview process or to correct any misinterpretation or errors that may have occurred directly with the study participants.

Conclusion

This is one of the first studies to examine perceptions and perspectives of care providers working in or referring to a community-based, SSR, hospital-to-home transition program for older adults. Many positive aspects of the program, such as the services provided, the

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benefits to older adult clients, and person-centred communications would be vital to the program's continued success, implementation, and functioning. Yet, many areas that were identified as barriers need to be addressed. Implementation of seamless patient information sharing through platforms or other tools, and the use of specific referral criteria and standardized outcome measures may reduce unsuitable referrals and inaccurate information, and may provide important information for referral and program staff. Future development and further expansion of existing programs should allow for individualized program design to suit the goals and needs of the older adult, but this would require changes at the macro level.

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