McMaster University | Health Forum

Rapid evidence profile appendices

Examining approaches to improve care transitions to long-term care facilities

16 August 2024

[MHF product code: REP 77]

Appendices

Appendix 1: Methodological details

We use a standard protocol for preparing rapid evidence profiles (REP) to ensure that our approach to identifying research evidence is as systematic and transparent as possible in the time we were given to prepare the profile.

Engaging subject matter experts

At the beginning of each rapid evidence profile and throughout its development, we engage a subject matter expert, who helps us to scope the question and ensures relevant context is taken into account in the summary of the evidence.

Identifying research evidence

For this REP, we searched Health Systems Evidence and PubMed for:
1) evidence syntheses
2) single studies.

We searched Health Systems Evidence using a sector filter for 'long-term care' combined with a search for (transition). In PubMed, we used an open text search for (long*term care OR "skilled nursing" OR "advanced nursing" OR "care home") AND (transition*), combined with a date limit of the past five years. Links provide access to the full search strategy.

Each source for these documents is assigned to one team member who conducts hand searches (when a source contains a smaller number of documents) or keyword searches to identify potentially relevant documents. A final inclusion assessment is performed both by the person who did the initial screening and the lead author of the rapid evidence profile, with disagreements resolved by consensus or with the input of a third reviewer on the team. The team uses a dedicated virtual channel to discuss and iteratively refine inclusion/exclusion criteria throughout the process, which provides a running list of considerations that all members can consult during the first stages of assessment.

During this process we include published, pre-print, and grey literature. We do not exclude documents based on the language of a document. However, we are not able to extract key findings from documents that are written in languages other than Chinese, English, French, Portuguese, or Spanish. We provide any documents that do not have content available in these languages in an appendix containing documents excluded at the final stages of reviewing. We excluded documents that did not directly address the research questions and the relevant organizing framework.

Assessing relevance and quality of evidence

We assess the relevance of each included evidence document as being of high, moderate or low relevance to the question.

Two reviewers independently appraised the quality of the guidelines we identified as being highly relevant using AGREE II. We used three domains in the tool (stakeholder involvement, rigour of development, and editorial independence) and classified guidelines as high quality if they were scored as 60% or higher across each of these domains.

Two reviewers independently appraise the methodological quality of evidence syntheses that are deemed to be highly relevant using the first version of the AMSTAR tool. Two reviewers independently appraise each synthesis, and disagreements are resolved by consensus with a third reviewer if needed. AMSTAR rates overall methodological quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality. High-quality evidence syntheses are those with scores of eight or higher out of a possible 11, medium-quality evidence syntheses are those with scores between four and seven, and low-quality evidence syntheses are those with scores less than four. It is important to note that the AMSTAR tool was developed to assess evidence syntheses focused on clinical interventions, so not all criteria apply to those pertaining to health-system arrangements or implementation strategies. Furthermore, we apply the AMSTAR criteria to evidence syntheses addressing all types of questions, not just those addressing questions about effectiveness, and some of these evidence syntheses addressing other types of questions are syntheses of qualitative studies. While AMSTAR does not account for some of the key attributes of syntheses of qualitative studies, such as whether and how citizens and subject-matter experts were involved, researchers' competency, and how reflexivity was approached, it remains the best general quality-assessment tool of which we're aware. Where the denominator is not 11, an aspect of the tool was considered not relevant by the raters. In comparing ratings, it is therefore important to keep both parts of the score (i.e., the numerator and denominator) in mind. For example, an evidence synthesis that scores 8/8 is generally of comparable quality to another scoring 11/11; both ratings are considered 'high scores.' A high score signals that readers of the evidence synthesis can have a high level of confidence in its findings. A low score, on the other hand, does not mean that the evidence synthesis should be discarded, merely that less confidence can be placed in its findings and that it needs to be examined closely to identify its limitations. (Lewin S, Oxman AD, Lavis JN, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP): 8. Deciding how much confidence to place in a systematic review. *Health Research Policy and Systems* 2009; 7 (Suppl1):S8.)

Identifying experiences from other countries and from Canadian provinces and territories

For each REP, we work with the requestors and a subject matter expert to collectively decide on what countries (and/or states or provinces) to examine based on the question posed. For other countries, we searched relevant government and stakeholder websites including websites of the offices or departments responsible for Veterans' affairs and the websites of agencies and organizations responsible for delivering Veterans' health services. In Canada, a similar approach was used, searching the website of provincial and territorial ministries of health and their associated agencies and organizations. While we do not exclude content based on language. Where information is not available in English, Chinese, French, Portuguese, or Spanish, we attempt to use site-specific translation functions or Google translate. A full list of websites and organizations searched is available upon request.

Preparing the profile

Each included document is cited in the reference list at the end of the REP. For all included guidelines, evidence syntheses, and single studies (when included), we prepare a small number of bullet points that provide a summary of the key findings, which are used to summarize key messages in the text. Protocols and titles/questions have their titles hyperlinked, given that findings are not yet available.

We then draft a summary that highlights the key findings from all highly relevant documents (alongside their date of last search and methodological quality) as well as key findings from the jurisdictional scan.

Appendix 2: Key findings from highly relevant evidence syntheses and single studies

Dimensions of the organizing framework	Health outcomes	Patient/caregiver experience	Provider experience	Costs
Changes to governance arrangements to improve the transition to long-term care	–	–	–	–
Changes to financial arrangements to improve the transition to long-term care	–	• One recent low-quality evidence synthesis found financial incentives for care coordination during transitions may be one approach to improve patient experience, but some adverse events have been reported and additional studies are needed (1) • One recent medium-quality evidence synthesis found financial incentives focused on primary care coordination with health professionals working in long-term care may be an effective approach to ensure patient follow-up during a transition (2)	–	–
Changes to delivery arrangements to improve the transition to long-term care	• One recent medium-quality evidence synthesis found that the application of person-centred care principles during transitions to long-term care (e.g., through personalization of care and environment, opportunities to choice and feedback) improved patient quality of life (3) • One recent medium-quality evidence synthesis found involving pharmacist to provide medication reconciliation as part of the transition to long-term care reduced medication errors and discrepancies – which can be viewed as a proxy for health outcomes (4) • One recent single study found improved mental health outcomes among individuals who were supported in their transition to long-term care through a patient checklist to identify social, physical, and cultural needs, clear information (including through diagrams and handouts) about what to expect on a typical day, understanding of where there is room for flexibility and patient	• One recent low-quality evidence synthesis found ensuring communication among health professionals involved in a transition, smooth transfer of information and care responsibilities, and education and involvement of the patient and their family were all key to optimizing patient experience during a transition to long-term care (1) • One older medium-quality evidence synthesis identified four principles for care for individuals with dementia during transitions to long-term-care including: ○ respecting the complexity and individual context of the transition ○ seeking input from the person living with dementia about the transition (or supporting shared decision-making) ○ encouraging regular social contact with friends and family ○ providing support to integrate socially within the new long-term are setting (7) • One older medium-quality evidence synthesis found facilitators of positive transitions to long-term care homes include: ○ enhancing resilience through self-efficacy and continuation of one's faith, values, belief, and identity ○ supporting connections and relationships with co-residents and staff, as well as between staff and the individual's family ○ encouraging patients to make the space their own by including personal possessions and maintaining elements of choice (8) • Two older medium-quality evidence syntheses found carers' experience of transitions for family members was supported when caregivers were familiar with residential care staff, had easy access to their family member's information, participated in care decisions, and had begun planning for the transition early on (9; 10)	–	–

Dimensions of the organizing framework	Health outcomes	Patient/caregiver experience	Provider experience	Costs
	decision-making, and personalization of a resident's space (5) • One recent single study found that the Health Optimization Program from Elders (HOPE), which included rehabilitation readiness assessments, patient and caregiver education, direct communication with providers during pre-discharge and post-discharge from hospital, resulted in lower rates of hospital readmission (6)	• Three recent and one older single study found the use of the Residential Care Transition Module (which provides a 12-week intervention of six individually tailored one-hour sessions with a trained transition counsellor using education and therapeutic techniques) reduced stress, guilt and improved ability to support caring among caregivers of individuals with dementia; however, a fifth recent single study found no significant change in caregiver stress (11-15) • One recent single study found having one-on-one relationships with staff and designing programming that reflects personal lifestyles and sustains meaningful relationships improves loneliness and social isolation following transitions (16) • A recent single study found transitions were improved through ongoing communication between caregivers and long-term care providers and navigational supports (17) • A recent single study found communication among providers and use of evidence-based models improved patient experience of transitions to long-term care (18)		

Appendix 3: Details about each identified evidence synthesis

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations

• Sectors involved in the transition
  ○ Long-term care
• Providers involved in supporting the transition
  ○ Caregivers and family members
• Changes to delivery arrangements to improve the transition to long-term care
• Populations
  ○ People with dementia
• Outcomes
  ○ Care experience (including for the caregiver)
	Five preliminary principles for care during transition to long-term care (LTC) for people with dementia include respecting the complexity and individual context of the transition to LTC, seeking input from the person living with dementia about the transition to LTC (or supporting shared decision-making), encouraging regular social contact with friends and family throughout all stages of the transition, and providing support to integrate socially within the new LTC setting (7)
	• Five studies discussed the self-reported experience of persons with dementia informed by interviews with these people, while two other studies discussed experiences of persons with dementia through reports from proxies such as family or formal carer partners
	• In all five self-report studies, the decision to move to LTC was made by someone other than the person with dementia
	• Across the self-report studies persons with dementia experienced both personal (e.g., hearing impairment) and circumstantial (e.g., facility culture, cognitive impairment of co-residents) barriers to social interaction
	• Participants desired connection with family throughout the transition period and to form new relationships with co-residents in LTC
	• Participants reported fear of losing agency in their lives, where this fear would also impair hopes of a positive experience
	• Both proxy-report studies also reported loss of independence and agency of persons with dementia before and after transitioning to LTC
		High	No	6/9	2018	None	• Personal character-istics associated with discrimin-ation (e.g. age, disability)

• Sectors involved in the transition
  ○ Long-term care
• Providers involved in supporting the transition
  ○ Physicians
• Changes to delivery arrangements to improve the transition to long-term care
  ○ Ensuring timely transitions
  ○ Improving transition navigation support
	Organizational and financial domains play a pivotal role in optimizing care transitions to long-term care (1)
	• This review aimed to understand the financial and organizational structures that affect care transition in long-term care
	• 229 studies were included in which 13 (92%) publications discussed organizational aspects and only 16 (8%) publications were related to financial aspects
	• Organizational aspects that affect care transition include:
	  ○ coordination of resources
	  ○ communication among involved professional groups
	  ○ transfer of information and care responsibility of the patient
	  ○ training and education of staff
	  ○ e-health
		High	No	2/9	2020	No	None reported

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations

• Changes to financial arrangements to improve the transition to long-term care
• Outcomes
  ○ Care experience (including for the caregiver)
	○ education and involvement of the patient, family, and social care
	• Financial aspects include:
	  ○ provider payment mechanisms such as financial incentives are important drivers in improving care transition among older adults in long-term care systems						

• Sectors involved in the transition
  ○ Long-term care
• Providers involved in supporting the transition
  ○ Physicians
• Changes to financial arrangements to improve the transition to long-term care
• Outcomes
  ○ Provider experience
	Financial incentives are potentially powerful tools to improve care transition among older adults in long-term care systems (2)
	• This study aims to review all available evidence on financial aspects that may have an impact on care transitions in long-term care among older adults
	• 19 articles on financial aspects were included in this review
	• Financial incentives may play an important role in long-term care systems by either improving or hampering care transitions of older adults
	• Identified three types of financial incentives that may play a significant role in care transition and care coordination as a whole:
	  ○ reimbursement mechanism
	  ○ reward
	  ○ penalty
	• The highest interest in financial incentives was in primary care settings
	• Rewarding primary care doctors for their efforts in coordinating care is an important aspect motivating them to follow up with the patient
		High	No	5/10	2020	No	None reported

• Sectors involved in the transition
  ○ Long-term care
• Changes to delivery arrangements to improve the transition to long-term care
  ○ Ensuring timely transitions
  ○ Providing culturally appropriate and trauma-informed care
  ○ Providing support for family and caregivers
• Outcomes
	To facilitate the transition of older adults into long-term care, interventions should focus on key areas such as enhancing the resilience of the individual, strengthening interpersonal connections and relationships, fostering a sense of home within the care facility, and improving the organizational aspects of the care facility (8)
	• This review aimed to understand facilitates and inhibits the transition process from the perspective of older people, their families, and care facility staff
	• 34 studies including 25 qualitative, seven quantitative and two mixed methods met the inclusion criteria
	• Facilitating and inhibiting factors were personal and community focused and mapped to four themes:
	  ○ The first theme resilience of the older person, person-focused transition facilitators included self-efficacy; self-determined motivation; continuation of one's faith, values, and beliefs;
		High	No	7/9	2017	No	None reported

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
○ Care experience (including for the caregiver)	ethnic identity, a positive personal philosophy; and personal coping strategies ○ The second theme was connections and relationships with co-residents, staff, and families, which had the potential to facilitate and inhibit transition; meaningful relationships with co-residents and staff are important for a good care home life, as are relationships between residents, staff, and families ○ The third theme was this is my new home and transition facilitators included older people being enabled to create their own space, retain cherished personal possessions, express their self-identity, and have choice and privacy ○ The fourth theme was the care facility as an organization; facilitating transition was older adults being satisfied with the care facility and the standard of care • Potential transition inhibitors included moving in processes and practices; care approaches that promoted dependence, were task focused, and did not promote resident-centred care; an overemphasis on risk minimization; and organizational constraints such as inadequate staffing levels						
• Sectors involved in the transition ○ Specialty care ○ Long-term care • Providers involved in supporting the transition ○ Caregivers and family members • Populations ○ People with dementia • Outcomes ○ Care experience (including for the caregiver)	Carers' transition experience of a family member with dementia moving into residential care was facilitated by a connection with different care and supportive stakeholders (9) • Family carers' connection to residential care staff, family, or friends may help to provide them with a feeling of being supported and a normalized, shared experience of transition • Support groups may provide a non-judgmental space for family carers to share their experience with those who might understand • Shared decision-making between carers and their family member with dementia to move into residential care in addition to their continued caregiving role helped to alleviate the feeling of guilt stemming from supposed abandonment or betrayal • Carers' ability to cope was facilitated by the ease of access to information from residential care staff on their family member with dementia • Sharing the care responsibility with residential care staff helped to relieve the burden on family carers while also giving them more time for self-care as a means of coping	High	None	4/9	2018	None	None identified
• Sectors involved in the transition	The medical needs of older adults in long-term care facilities should be better explored due to higher rates of mortality and hospitalizations (19)	Medium	Non-living	3/9	2022	Not available	None reported

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
○ Home and community care ○ Long-term care • Outcomes ○ Health outcomes ○ Hospital admissions	• This review compared the mortality and hospitalizations of older adults living in residential care facilities to those living in nursing homes • The risk of mortality was higher in nursing homes than in residential care; however, the authors note that there is limited information on what factors contribute to effective care						
• Sectors involved in the transition ○ Home and community care ○ Long-term care • Providers involved in supporting the transition ○ Physicians ▪ Generalists ▪ Specialists ○ Nurses ○ Pharmacists ○ Caregivers and family members • Changes to delivery arrangements to improve the transition to long-term care ○ Ensuring timely transitions ○ Providing support for family and caregivers • Populations ○ People with dementia ○ Indigenous peoples • Outcomes ○ Care experience (including for the caregiver)	Carers experience mixed emotions like guilt and relief, face loneliness and stress from sudden separations, and benefit from familiarity with aged care facilities and early planning, which helps ease the transition and support continuity in their relations (10) • The review's focus was identifying and synthesizing evidence on carers' experiences when their care recipient is admitted permanently to a residential aged care facility • The findings highlighted that effective interventions must provide continuous support for carers throughout the entire transition process • Pre-planning and addressing carers' psychosocial needs were identified as being crucial for a positive transition experience	High	No	6/9	2013	No	None reported
• Sectors involved in the transition ○ Long-term care • Providers involved in supporting the transition	Implementing person-centred care in long-term residential care greatly improves residents' quality of life by personalizing routines and environments, enhancing staff-resident interactions, and involving family members, but obstacles like rigid routines, staff shortages, and insufficient resources often hinder its full implementation (3)	High	No	6/9	2021	No	None reported

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
○ Caregivers and family members • Changes to delivery arrangements to improve the transition to long-term care ○ Ensuring timely transitions ○ Providing support for family and caregivers • Populations ○ People with dementia • Outcomes ○ Health outcomes	• The focus of the review was to explore the interrelationships between person-centred care and quality of life in long-term residential care • The review highlights that person-centred care can significantly enhance resident quality of life; however, interpretations of what constitutes person-centred care vary among studies • Key factors to improve quality of life identified include personalizing care and environments, actively incorporating resident feedback and addressing issues related to adaptability within long-term residential care settings (i.e., affecting autonomy and independence) • Some of the barriers identified include organizational routines (e.g., rigidness can obstruct person-centred care), time constraints and limited resources (e.g., can often lead to task-oriented care rather than personalized approaches), and lack of flexibility in routines (e.g., not adapting meal service styles or not allowing individual wake-up times)						
• Sectors involved in the transition ○ Specialty care ○ Long-term care • Providers involved in supporting the transition ○ Pharmacists • Changes to delivery arrangements to improve the transition to long-term care ○ Improving medication reconciliation upon transition • Outcomes ○ Health outcomes	Pharmacists play an important role, particularly in medication reconciliation for older adults who are transitioning to and from long-term care settings (4) • The scoping review focused on pharmacist interventions for older adults transitioning to and from certain settings (e.g., long-term care, acute rehabilitation, residential care facilities, care homes, skilled nursing facilities, or assisted living facilities) • Pharmacist-based interventions appear to be efficacious in medication reconciliation, mitigation of medication errors and discrepancies, and medication prescribing • The authors concluded that pharmacists could be involved in medication reconciliation during admission or discharge, patient counselling, and/or clinical medication reviews	High	No	5/9	14 July 2022	No	None reported

Appendix 4: Details about each identified single study

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations

• Sectors involved in the transition
  ○ Long-term care
• Providers involved in supporting the transition
  ○ Caregivers and family members
• Outcomes
  ○ Care experience (including for the caregiver)
  ○ Provider experience
	The mental health of older adults transitioning into residential aged care may be supported with strategies in the overall transition experience, recognizing and responding to mental health needs, and individually tailored support (5)
	• To help them settle into the home, residents identified a need for real-world information that is consistent with the realities of what they could expect in their daily life and routines
	• Forming new friendships and being treated as an individual were factors that helped with adjusting to living in the home
	• Uncertainties surrounding the transition created stress and confusion for some residents
	• Personalizing an incoming resident's room helped to create a sense of comfort and familiarity upon their arrival
	• Informing staff of incoming residents' health information and history (e.g., mental health conditions, triggers) helped them put in place proper support strategies for residents
	• For new residents, the admission process was improved through a complete review of the resident handbook and more structured tours
	• For prospective residents and their family, a checklist was developed that will help identify individual social, physical, spiritual, and cultural needs
	• A consumer-led process involving residents, their family, and staff informed the development and improvement of resident resources
	  ○ Practical information on living in the home was to be added to the resident handbook (e.g., privacy in the room, flexibility of meal times, and permission to leave)
	  ○ A diagram depicting a typical day in the home with information on meal times, staff shift changes, and other activities was to be provided
	  ○ Opportunities exist for facilitating the introduction of residents into the home, including considering the role of pastoral care practitioners in emotional support and relationship-building and a 'buddy system' among residents
		High	Publication date: February 2022
			
			Jurisdiction studied: Victoria, Australia
			
			Methods used: Qualitative (phenomenological)
				None identified

• Sectors involved in the transition
  ○ Specialty care
• Providers involved in supporting the transition
  ○ Allied health professionals
	A videoconferencing counselling program tailored individually for family caregivers of people with dementia was feasible and acceptable during the transition period to residential care (11)
	• The Residential Care Transition Module, an evidence-based individualized psychosocial intervention originally developed for family
		High	Publication date: 2024
			
			Jurisdiction studied: Australia
				None identified

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations
○ Caregivers and family members • Changes to delivery arrangements to improve the transition to long-term care ○ Improving transition navigation support ○ Providing support for family and caregivers • Populations ○ People with dementia • Outcomes ○ Care experience (including for the caregiver)	caregivers of people with dementia after being placed in residential care, was provided during the transition period itself through videoconferencing to help family members manage stressors ○ The transition period results from an inherent delay between receiving approval following formal assessment of need and subsequent residential care placement, a requirement in Australia for government subsidized facilities • The 12-week intervention involved six individually tailored one-hour sessions with a trained transition counsellor using education, mindfulness practices, cognitive behavioural therapy, and narrative therapy ○ The final session summarized the discussions from all sessions and ad-hoc sessions were possible if needed • The components of the intervention included: ○ education on dementia and residential care admission procedures and setting ○ strategies for coping, managing stress, and self-care ○ reframing guilt and grief related to admission, family separation, and dementia progression ○ skills for communicating with residential care staff ○ reviewing support, communication, and involvement among the family ○ supporting the evolving caregiving roles in the family and discussions on activities and visitations • A standard PDF information sheet was provided but was not found to be useful in both the intervention and control groups, citing it was "nothing new" • The videoconferencing delivery format of the intervention was found to be feasible and acceptable • Preliminary effects suggest that the intervention may help improve stress, guilt, and support for caring (statistically insignificant effect), but did not improve grief • Family caregivers found the counselling program acceptable and helpful for validating their feelings and developing strategies for problem-solving and coping during the transition		Methods used: Randomized controlled trial	
• Sectors involved in the transition ○ Home and community care ○ Long-term care • Changes to delivery arrangements to improve the transition to long-term care ○ Ensuring timely transitions	One-year mortality rates varied significantly by type of aged care service, with permanent residential care having the highest mortality (35%) and home care packages the lowest (15%); younger women (65–69) showed the highest mortality rate ratios compared to the general population, especially in permanent residential care (20)	Medium	Publication date: 2020 Jurisdiction studied: Australia Methods used: Population-based retrospective analysis	None reported

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations
• Populations ○ People with frailty	• The study examined one-year mortality rates among Australians entering aged care services compared to the general population • The findings highlighted that aged care recipients experience significant mortality variations based on service type, age, and sex, with the highest rates in younger women and those receiving permanent residential care			

• Providers involved in supporting the transition
  ○ Caregivers and family members
• Changes to delivery arrangements to improve the transition to long-term care
• Changes to financial arrangements to improve the transition to long-term care
• Changes to governance arrangements to improve the transition to long-term care
  ○ Improving complaints management processes (for when problems do arise)
• Outcomes
  ○ Health outcomes
  ○ Care experience (including for the caregiver)
	Loneliness and social isolation experiences following transitions into residential care can be combated with strategies focused on greater staffing resources and psychoeducation (16)
	• Perception of agency and autonomy is an important factor in wellness in later life, which may be taken from older adults during the transition into residential care
	• The most common contributor to residents' feelings of loneliness was loss (of loved ones, possessions, lifestyle, etc.)
	• Demotivation due to chronic illness was also shared as a contributor
	• Findings presented that lonely and socially isolated residents are less likely to take part in available programming in comparison with more socially active residents
	• Recommendations on ways to address barriers to engagement included developing one-on-one relationships between staff and residents, fostering peer interactions, and designing programming that reflects personal lifestyles and sustains meaningful engagement
		High	Publication date: 2023
			
			Jurisdiction studied: Canada
			
			Methods used: Semi-structured qualitative interviews
				None

• Sectors involved in the transition
  ○ Long-term care
• Providers involved in supporting the transition
  ○ Physicians
  ○ Caregivers and family members
• Changes to delivery arrangements to improve the transition to long-term care
  ○ Ensuring timely transitions
• Populations
  ○ People with dementia
• Outcomes
  ○ Health outcomes
  ▪ Hospital admissions
	The HOPE program appears to be a promising care model for elderly people transitioning from the hospital to a skilled nurse facility, as the rate of hospital readmission was lower compared to those not in the program (6)
	• The Health Optimization Program for Elders (HOPE) is a transitional care model for elderly adults for the transition from the hospital to a skilled nurse facility
	• Strategies within HOPE included rehabilitation readiness assessments, patient and caregiver education, and direct communication with providers and staff during prehospital discharge and post-discharge
	• The program reported to have lower rates of hospital readmission rates compared to those not enrolled in the program
		High	Publication date: 12 December 2018
			
			Jurisdiction studied: United States
			
			Methods used: Evaluation
				None reported

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations

• Sectors involved in the transition
  ○ Home and community care
  ○ Long-term care
• Providers involved in supporting the transition
  ○ Caregivers and family members
• Changes to delivery arrangements to improve the transition to long-term care
  ○ Providing support for family and caregivers
• Outcomes
  ○ Care experience (including for the caregiver)
	Caregivers play an important role in the transition from home care to residential care for their loved ones; ongoing communication with providers, health education for caregivers, and support for health system navigation were highlighted as important strategies (17)
	• Caregivers reported that ongoing communication between them and care providers is important (e.g., how to navigate the health system's rules and regulations, expectations of their family member's health journey), especially at critical junctures of their family member's transition from home care to residential care
	• Caregivers are important at each critical juncture, such as pre-, during, and post-transition, where the authors recommended that they should be part of the care team
	• The increasing demands on caregivers may cause additional stress
		High	Publication date: 2017
			
			Jurisdiction studied: Canada
			
			Methods used: Thematic qualitative analysis
				None reported

• Sectors involved in the transition
  ○ Long-term care
• Providers involved in supporting the transition
  ○ Caregivers and family members
• Changes to delivery arrangements to improve the transition to long-term care
  ○ Providing support for family and caregivers
• Outcomes
  ○ Care experience (including for the caregiver)
	Evidence suggests that the Residential Care Transition Module (RCTM) is significantly associated with a reduction in the psychological and emotional stress of caregivers transitioning their relatives into residential facilities while increasing coping skills (12)
	• Family caregivers who received the four-month RCTM intervention reported lower levels of perceived stress than a control group who did not receive the intervention at both four- and eight-month intervals
	• The RCTM was specifically developed to address the common stressors reported by caregivers during the transition process, the dimensions of support were:
	  ○ psychoeducation (stressors are identified and a curriculum is developed)
	  ○ promotion of communication (strengthen communication skills and relationships, facilitate moderated family sessions)
	  ○ problem solving (individual counselling)
	  ○ patient behaviour management strategies (for unpredictable outbursts during visits)
	  ○ concrete planning (goals for optimal care for relatives, and methods to achieve them with staff)
	  ○ making families aware (of the variety of treatments used in residential long-term care)
	  ○ ad hoc counselling (ongoing and informal correspondence with a transition counsellor)
	• Authors suggest that the provision of psychosocial support may have allowed caregivers to better manage their emotional distress
		High	Publication date: 2015
			
			Jurisdiction studied: United States
			
			Methods used: Multiple method pilo evaluation
				None identified

• Sectors involved in the transition
  ○ Specialty care
  ○ Long-term care
	Factors that can reduce hospital admissions and support transition into long-term care home include communication across providers and the use of evidence-based models to facilitate decision-making (18)	High	Publication date: December 2018
			
			Jurisdiction studied: United States
				None reported

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations

• Changes to delivery arrangements to improve the transition to long-term care
• Outcomes
  ○ Health outcomes
  ▪ Hospital admissions
	• This study looked at supports provided by long-term care facilities to reduce hospital admission and improve healthcare transitions
	• Facilitators for the transition include communication across care coordinators and healthcare providers utilizing evidence-based transition models
	  ○ The Interventions to Reduce Acute Care Transitions (INTERACT) model was used most often
	• Barriers to successful transitions include:
	  ○ time limitations preventing effective discharge planning
	  ○ financial barriers, as there is no reimbursement for residential facilities to assist with transition
			Methods used: Cross-sectional survey	

• Sectors involved in the transition
  ○ Long-term care
• Providers involved in supporting the transition
  ○ Caregivers and family members
• Changes to delivery arrangements to improve the transition to long-term care
  ○ Providing support for family and caregivers
• Populations
  ○ People with dementia
• Outcomes
  ○ Care experience (including for the caregiver)
	No significant differences were observed in the subjective stress and depressive symptoms of caregivers receiving the RCTM over four months of participation, highlighting the need for a broader consideration of contextual factors that may influence the efficacy of nonpharmacological interventions given the heterogenous nature of dementia care (13)
	• Aligning measures with the goals and values of dementia caregivers on a circumstantial basis may better demonstrate the benefits of interventions such as the RCTM
	• Complex empirical results of this study suggest the need to potentially alter the timing and content of the RCTM based on the duration of the recipients' stay in long-term care
	  ○ For example, the specific transitional period before and after entering long-term care may require more intensive psychosocial/educational support
	  ○ The 12-month intervention design may not have accurately captured these challenges
	• This study sample was predominantly a white and well-educated demographic, which does not accurately represent the total U.S. residential care population
	  ○ Volunteers were used for the study sample that do not fully reflect the differing circumstances of dementia caregivers and their experiences
		High	Publication date: 2024
			
			Jurisdiction studied: United States
			
			Methods used: Randomized contro trial
				None identified

• Sectors involved in the transition
  ○ Home and community care
  ○ Long-term care
• Providers involved in supporting the transition
• Changes to delivery arrangements to improve the transition to long-term care
	Equal reliance on home care and facility-based residential care was found among older individuals; however, age, changes in cognitive performance, and changes in activities of daily living were important predictors of transitions to residential care (21)
	• Gaps in services and programs in home care for persons with dementia can lead to premature transition to facility-based care
	• Residential care is indispensable as the condition progresses; accordingly, the right mix of home care services and residential care is
		Medium	Publication date: January 2019 (data from 2011)
			
			Jurisdiction studied: Canada
			
			Methods used: Latent transition analysis
				Socio-economic status

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations
○ Ensuring timely transitions • Populations ○ People with dementia • Outcomes ○ Health outcomes ▪ Hospital admissions ○ Care experience (including for the caregiver) ○ Cost	important to reduce unnecessary transitions and costs of institutionalization or hospitalization ○ Increasing age and lower income levels could be a marker of vulnerability, as those receiving income support could require more consistent care ○ Monitoring cognitive performance and abilities with the Activities of Daily Living (ADL) early on, including the use of assessment tools (RAI-MDS 2.0 and RAI-HC), could reduce unnecessary transitions into hospitals ○ Long-term care could benefit from end-of-life care for persons with dementia ○ Special attention is needed to the quality of long-term care services, especially for clients who have higher levels of dementia and depression as they voice high dissatisfaction of the provided services			
• Sectors involved in the transition ○ Long-term care • Providers involved in supporting the transition ○ Caregivers and family members • Changes to delivery arrangements to improve the transition to long-term care ○ Providing support for family and caregivers • Populations ○ People with dementia • Outcomes ○ Care experience (including for the caregiver)	The RCTM pilot intervention targeting spousal carers of persons with dementia transitioning to residential care showed favourable effects on perceived stress, depression, and nursing home hassles in comparison with the control group (14) • The telehealth intervention consists of six sessions within 12 weeks, slightly tailored to the Australian context, conducted by trained transition counsellors using various counselling techniques • Its components include working on the carers' experience in their partner's transition to residential care, communication skills with the residential care staff, loss and grief with the progression of dementia and transitioning into different caring responsibilities • This type of intervention was deemed feasible, acceptable and useful in that context and the dose was appropriate; nonetheless, participants preferred telephone calls over videoconferencing • Carers with lower levels of stress and depression benefited from printed information with reference to external resources; nonetheless, those who had higher levels of stress and depression benefited from counselling sessions	High	Publication date: December 2021 Jurisdiction studied: Australia Methods used: Randomized control trial pilot	None identified
• Sectors involved in the transition ○ Home and community care ○ Long-term care • Providers involved in supporting the transition ○ Caregivers and family members • Changes to delivery arrangements to improve the transition to long-term care	Families supporting older adult transitions to long-term care homes experience disempowerment on three levels: 1) prior to placement (in relation to the system barriers in home/community care); 2) reaching point in the panelling process (in relation to their lack of involvement in the waitlisting process); and 3) during and after the move (in relation to the rushed transitions, poor information, and admission protocols) (22) • The qualitative analysis featured a total of 55 interviews with 22 family member caregivers	Medium	Publication date: April 2023 Jurisdiction studied: Manitoba, Canada Methods used: Qualitative analysis	None identified

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations
○ Providing support for family and caregivers • Changes to governance arrangements to improve the transition to long-term care ○ Involving consumers in the transition ○ Improving complaints management processes (for when problems do arise) • Outcomes ○ Care experience (including for the caregiver)	• The findings from this study confirm prior research to indicate that family caregivers experience stress, burden, and dissatisfaction from long-term residential care transitions			
• Sectors involved in the transition ○ Long-term care • Providers involved in supporting the transition ○ Caregivers and family members • Changes to delivery arrangements to improve the transition to long-term care ○ Providing support for family and caregivers • Changes to governance arrangements to improve the transition to long-term care ○ Involving consumers in the transition • Populations ○ People with dementia • Outcomes ○ Care experience (including for the caregiver)	The RCTM is a highly valued and acceptable telehealth intervention that can support the care transition by improving mood, caregiving confidence, and communication and interaction with care recipients (15) • Six content-related benefits include: 1) dementia education; 2) communication strategies; 3) personalized resource provision; 4) promotion of engagement with care recipients; 5) management of responsibilities; and 6) relaxation exercises • Three coaching-related benefits include: 1) emotional support and reassurance; 2) knowledgeability; and 3) being a neutral third party	High	Publication date: January 2023 Jurisdiction studied: United States Methods used: Qualitative analysis, interviews	None identified
• Sectors involved in the transition ○ Long-term care • Providers involved in supporting the transition ○ Caregivers and family members • Changes to delivery arrangements to improve the transition to long-term care	Shared power and reciprocity are potential benefits of leveraging information and communication technologies to understand the engagement challenges of caregivers and older adults in residential care (23) • Apprehension regarding the use of information and communication technologies stemmed from being patronizing, the lack of privacy policy, and the use of 'happy moments' as a marking instrument	Medium	Publication date: March 2022 Jurisdiction studied: Netherlands Methods used: Participatory Action Research (PAR) approach	None identified

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations

• Changes to governance arrangements to improve the transition to long-term care
  ○ Involving consumers in the transition
  ○ Improving complaints management processes (for when problems do arise)
• Outcomes
  ○ Care experience (including for the caregiver)				

• Sectors involved in the transition
  ○ Specialty care
  ○ Long-term care
• Providers involved in supporting the transition
  ○ Physicians
  ▪ Generalists
  ○ Nurses
  ○ Allied health professionals
  ▪ Physiotherapists
  ▪ Occupational therapists
  ○ Caregivers and family members
  ○ Consumers
• Changes to delivery arrangements to improve the transition to long-term care
  ○ Ensuring timely transitions
  ○ Providing support for family and caregivers
• Outcomes
  ○ Care experience (including for the caregiver)
	The transition from palliative care to residential care for people with advanced cancer require effective and timely service coordination and collaboration between different providers and the families involved, empowerment for decision-making among caregivers and the patients (e.g., the conduct of family meetings), and transparency (24)
	• The authors interviewed patients, family members, medical consultants, allied health professionals (i.e., occupational therapist, physiotherapist), a pastoral care worker, and a nurse unit manager in a general hospital situated in Melbourne
	• Themes of abandonment, guilt, and uncertainty were highlighted by the participants
	• Participants involved in social work found that they were responsible for translation, clarification of goals of care, and providing support and information
	• Family meetings that were facilitated by social workers and the development of a transition framework were described as important strategies
		Medium	Publication date: 2017
			
			Jurisdiction studied: Australia
			
			Methods used: Thematic qualitative analysis
				None reported

• Sectors involved in the transition
  ○ Home and community care
  ○ Primary care
• Providers involved in supporting the transition
  ○ Physicians
  ○ Nurses
  ○ Caregivers and family members
	Themes generated from the study yielded the transitional care progression model, which serves as the only available framework for implementing transitional care in the region (25)
	• Incorporating early screening for depression can combat “giving up” behaviours among older adults
	• Empowering care recipients and caregivers to engage in consistent monitoring during the post-discharge phase can facilitate early identification and reporting of complications
		Medium	Publication date: 2024
			
			Jurisdiction studied: India
			
			Methods used: Qualitative survey
				None reported

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations

• Changes to delivery arrangements to improve the transition to long-term care
  ○ Ensuring timely transitions
  ○ Providing support for family and caregivers
• Outcomes
  ○ Health outcomes
  ○ Care experience (including for the caregiver)
	• Providing training on medication administration ensures reconciliation with previous and current prescriptions and improves compliance to the treatment regimen			

• Sectors involved in the transition
  ○ Long-term care
• Providers involved in supporting the transition
  ○ Caregivers and family members
• Changes to delivery arrangements to improve the transition to long-term care
• Changes to financial arrangements to improve the transition to long-term care
• Changes to governance arrangements to improve the transition to long-term care
• Populations
  ○ People with dementia
• Outcomes
  ○ Care experience (including for the caregiver)
	Ex-caregivers show improved psychological well-being over time, but ongoing physical decline after transitioning, with greater psychological recovery observed among those bereaved (26)
	• The study examined the psychological and physical wellbeing of ex-caregivers following their transition from caregiving roles (i.e., dementia caregiver role)
	• Transition from caregiving generally leads to psychological recovery but physical decline, with age playing a significant role
	• The specific reason for transition has less impact compared to the transition itself
		Medium	Publication date: 2016
			
			Jurisdiction studied: Australia
			
			Methods used: Longitudinal design
				None reported

• Sectors involved in the transition
  ○ Home and community care
  ○ Long-term care
• Populations
  ○ People with dementia
	Factors associated with transitioning to private living included dementia diagnosis, women gender, and losing a spouse (27)
	• This study looked at factors contributing to transitioning from living at home to a senior's residence using census data
	• Factors associated with transitions into private living included a diagnosis of dementia, women gender, and losing a spouse
	• Protective factors included immigrant status as many lived in multigenerational households
	• No details on the factors supporting the transition process were identified
		Medium	Publication date: 16 May 2018
			
			Jurisdiction studied: Canada
			
			Methods used: Cross-sectional
				• Race/ethnicity/culture/language
				• Gender/sex

• Sectors involved in the transition
  ○ Home and community care
  ○ Long-term care
	Frail older people moved in with family or into residential care homes voluntarily or involuntarily across a wide range of ownership in decision-making (28)	Low	Publication date: 2019
			
			Jurisdiction studied: Cambridge, U.K.
				• Personal characteristics associated

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations

• Providers involved in supporting the transition
  ○ Caregivers and family members
• Populations
  ○ People with frailty
	• Among those who voluntarily moved into residential care, there were examples of shared ownership in decision-making where an older person either agreed to the move or were negotiated into doing so (after initial hesitance) by family
	  ○ An older person's connection to a care home facilitated their agreement to move; this could be from personal experience with the home during prior respite care or having a connection with a staff at the home
			Methods used: Qualitative interviews within an existing longitudinal study	with discriminati on

• Sectors involved in the transition
  ○ Long-term care
• Providers involved in supporting the transition
  ○ Caregivers and family members
• Populations
  ○ People with dementia
• Outcomes
  ○ Provider experience
	Transitioning an older parent to a residential care or nursing home created experiences with decision-making challenges, conflicting emotions, and positive and negative reflections among their children (29)
	• Many stakeholders were involved in a decision process defined by disagreement and conflicts with family members were a common source of stress
	• The decision to transition was often one made out of necessity with many perceiving it to be a last resort and the only available option
	• Conflicting emotions were present; anxiety and guilt overlapped during the transition but progressed to more positive emotions toward the end of the process
	  ○ For many, there was sense of fear around the transition stemming from a lack of preparedness, support, or guidance
	  ○ Children involved in placing parents with dementia or Alzheimer's disease into care facilities appeared to experience the emotions of guilt, shame, and fear of inadequate knowledge of the system more strongly
	• Many felt a sense of relief after the transition of their parent due to less anxiety and the removed burden
	• Some thought that positive outcomes for their parents came about from the transition while others experienced a profound sense of mortality during this process
		Low	Publication date: 2023
			
			Jurisdiction studied: United Kingdom
			
			Methods used: Qualitative (semi-structured interviews, retrospective narrative)
				None identified

Appendix 5: Details from the jurisdictional scan about approaches to improve the transition to long-term care

Jurisdiction	Policy approaches
Canadian provinces and territories	

British Columbia	• Family Caregivers of British Columbia published a Moving from Home to Facility resource to support caregivers with a loved one transitioning to long-term care
	  ○ An eligibility assessment will be conducted on the family member requiring assistance to determine whether they will be deemed eligible for residential care facilities, assisted living, or home care
	  ○ A preference for a specific residential care facilities can be stated, and the Long-Term Care Case Manager will support in the process for choosing a facility at the time of assessment and application
	  ○ It is recommended that in preparation for the transition to long-term care, families should: 1) prepare a list of questions to collect as much information as possible (e.g., staff, meals, hygiene, communication, activities, health care); and 2) contact the facilities and complete a tour with the family member who will be going into care
	  ○ Several resources are available on the Family Caregivers of British Columbia's Learning Centre to support the emotional preparation for transitioning to long-term care (e.g., Facility Placement: Coping with the Move, Caregiving After Facility Placement, Managing the Transition to Facility Placement)
	• Alzheimer's Society of British Columbia has held webinars on transitioning to long-term care while living with dementia to provide strategies that can ease their transition and prepare them for their move to long-term care
	  ○ Caregiver tips to help with adjusting to long-term care include: 1) familiarizing themselves with the facility to understand the staff, management, and residents; 2) be involved with care tasks, such as meals and grooming; 3) reassuring the family member in long-term care how much you care; and 4) attending care plan meetings with the resident's care team
	  ○ A list of resources has been published to support resident's transition to long-term care
	• In British Columbia, eligible veterans for home and community care services will need to have their local health authority contact Veterans Affairs Canada for an eligibility assessment for federal benefits and arrange placement on the Veterans' priority access bed waitlist
	• Island Health and Vancouver Coastal Health have released long-term care access guides to help those residents moving into one of their facilities
	• Fraser Health has released information on the transition from assisted living to long-term care, which occurs when a tenant's care needs increases beyond the capabilities of their provider
	  ○ This transition consists of a Fraser Health assisted living clinician meeting with the tenant (and/or family) to review the long-term care placement process, ensure outcome scores match the level of care of the facility, and complete the referral process; clinicians will ensure that adequate care can be safely provided to the tenant/resident in the interim
	• Vancouver Coastal Health has a Transition Services Team that supports older adults transferring from the hospital to the community; this includes a team of professionals that facilitates the process for clients needing residential care services

Alberta	• Alberta residents seeking to obtain continuing care will be connected with a Case Manager that will help support their transition to long-term care
	  ○ A case manager will meet with the resident, and complete an assessment to determine their health care needs; if transitioning from the hospital setting, the assessment will be completed by a member of the healthcare team, such as Transition Services or the Discharge Coordinator
	  ○ Note that as care needs and transition through levels of care change, there is a possibility that the Case Manager may vary
	• Alberta Health Services published an information and decision-making guide for patients and families moving into a continuing care home, which includes a section on preparing to move into long-term care
	• Transition Services bridges the link between acute care patients and community-based services; can include patient transfer into different settings and the community
	• Social Workers and Continuing Care Counsellors operating in some Alberta communities can offer social program support regarding benefits, navigating the health system, and supporting the care journey of older adults in care settings

Saskatchewan	• In Saskatchewan, the local health authority will assign an Assessor Coordinator/Client Care Coordinator for the family member requiring admission to a care home ○ The coordinator will be responsible for reviewing, determining, and approving the level of care required; will support in routinely assessing needs if placed on the waiting list

Jurisdiction	Policy approaches
	○ The Saskatchewan Health Quality Council released a resource guide on High-Quality Care Transitions: A Guide to Improving Continuity of Care to describe a framework that can be used to help achieve seamless care transitions within the health systems for patients
Manitoba	• Federal and provincial collaboration through: ○ Aging with Dignity Agreement with around $3 billion investment over five years (2023–24 to 2027–28) to support home and community care services and to support long-term care (LTC) workforce and by keeping residents safe with better quality of life ○ Working Together Agreement with around $434 million over three years to improve healthcare and fix the damage of staffing shortages; under this agreement there is a plan to hire around 100 home care workers • Winnipeg Regional Health Authority (WRHA) has The WRHA's Long Term Care Access Centre (LTCAC) that is responsible for determining the eligibility for transitioning from home to LTC, maintaining waiting lists, ensuring the consumers' needs are met, and ensuring appropriate housings and LTC; this includes hosting an online resource page with the required information • Similarly, Manitoba Health has the Aging in Place website
Ontario	• Ontario residents who have applied to the province's Ontario Health atHome program to access long-term care and are waiting for placement are eligible to receive community paramedicine for long-term care services that can help them to stay healthy at home and avoid emergency hospital visits ○ When a placement becomes available, the applicant will have 24 hours to accept or reject the offer that includes a move-in date and up to five days to move into the long-term care facility ○ Ontario Health atHome provides information on their website on what documents and items new residents to long-term care will need for their upcoming move • Ontario Health Quality has developed a number of resources, including a quality standard, to support the transition of patients from hospital to home (including long-term care homes) ○ The quality standard emphasis: ▪ information sharing on admission with primary care and other care providers ▪ comprehensive assessment of current and evolving health and social care needs ▪ patient, family, and caregiver involvement in transition planning through the development of a written transition plan ▪ transition plans to be shared with all relevant care providers ▪ coordinated transitions through a named health care professional who is responsible for timely transition planning, coordination, and communication ▪ medication review and reconciliation before leaving hospital, including a plan for how to access medications in the community ▪ coordinated follow-up with their primary care provider that is booked before leaving the hospital ▪ out-of-pocket costs and limited funded services are clearly explained to patients and caregivers and the healthcare team makes an effort to avoid unaffordable costs in the transition plan • The Alzheimer Society Toronto has developed a long-term care transition guide that provides tips to support the move from home to long-term care at each stage of the process • The Veterans Care program at St. Joseph's Healthcare Foundation's Parkwood Institute provides Veterans approved by Veterans Affair Canada with several resources to help them transition to long-term care, including: ○ a call from their social work team to arrange for a bed in one of their care units and confirm the day and time of their move ○ assigning a primary physician for their medical care ○ advice and tips on what documents and supplies to bring with them • On their first day, Veterans at Parkwood Institute will meet the nurses and physician who will be caring for them and be asked about their health and daily routine; they are also provided with several care items, such as bedding, bedside furniture, and television and telephone service (for a fee) • Sunnybrook's Veterans Program is the largest Veteran's care facility in Canada and supports eligible Veterans moving into long-term care by assigning them a care team who will assess their needs upon arrival to determine their routine and treatment plan and by providing new residents with information and resources (e.g., a Welcome Package) to help prepare for the transition
Quebec	• The Réseau Universitaire Intégré en Santé et Services Sociaux (RUISSS) at Université Laval launched an initiative designed to improve the transition process for seniors moving from home to residential care

Jurisdiction	Policy approaches
	○ The PATIenTS program aims to address common challenges faced during this transition by enhancing communication between healthcare providers and increasing support for families ○ Key aspects of the PATIenTS program include: ▪ personalized care plans: tailoring care plans to meet the specific needs of each senior, ensuring a smoother transition and better alignment with their individual requirements ▪ enhanced communication: improving the flow of information between various healthcare professionals involved in the senior's care to ensure coordinated and effective support ▪ family support: offering additional resources and guidance to families to help them navigate the transition and make informed decisions about their loved one's care ○ Overall, the initiative focuses on optimizing the transition process to improve both the experience and outcomes for seniors entering residential care, reflecting a collaborative approach to enhancing care for aging populations • The Government of Canada will contribute nearly $1.2 billion to support Quebec's five-year action plan, aimed at helping individuals age with dignity while staying close to home and having access to home care or safe long-term care facilities by: ○ enhance access to home and community care: increase support for community groups and social economy organizations that provide home care services, and expand service hours for long-term, short-term, and palliative home care ○ improve safety and quality of life in long-term care facilities: provide housing that meets seniors' needs for a better living environment, and support the development of seniors' homes and alternative housing options
New Brunswick	• New Brunswick's Long Term Care Program coordinates services for those exploring options such as remaining in home, caregiver supports, or attending residential services ○ Individuals 65 years or older who are medically stable and require long term services are eligible for this program ○ Individuals must have an assessment of personal care, completed by a social worker ○ A financial assessment is needed for those who cannot cover services, depending on their household income • Self-managed support provides flexibility for individuals requiring additional support, but do not wish to attend long-term care; it can be inferred that that this can be used to support the transition from home to long-term care ○ Individuals in this program are given a lump sum payment each month to hire their own services according to their unique needs (e.g., allied health professionals) ○ Funds can be carried over within the same calendar year ○ Family members, not residing in the residence, can be hired as caregivers ○ Detailed records of all spending must be maintained ○ A social worker reviews the plans each year to ensure appropriate spending ○ Individuals admitted within the long-term care and disability support programs are eligible to apply ○ Individuals are able to opt out of the program at any time and can still be eligible for long-term care later on • Home first is another program that can support independent living, and possibly be utilized to support transition to long-term care ○ This program includes an educational program on community services and healthy living ○ Trained home first reviewers can assist with creating a personalized action plan ○ Home repairs and adaptations may occur as a part of the program (e.g., bathroom grab bars or improved lighting), individuals may be eligible for a grant up to $1,500 • The government of New Brunswick also offers specialized services like Memory Care Homes and Nursing Homes; however, minimal details on transition supports were identified ○ The website does offer tips on helpful questions to ask (e.g., menu or fee inquiries) and a list of available facilities ○ A social worker from the long-term care program can help individuals identify their goals and figure out the most appropriate choice of care needs ○ For nursing homes, individuals can select their preferred choice; however, due to long waiting lists individuals might have to move into an interim placement ▪ The placement must be 100 km or less from preferred residence

Jurisdiction	Policy approaches
	▪ If individuals decline either preferred or interim placement, they will be moved to the bottom of the waiting lists and may be charged a fee if residing in a hospital • A guide is available to help family members select the most appropriate home for their loved ones ○ The guide includes information on the types of homes, the assessment process, and arranging visits
Nova Scotia	• Nova Scotia has prepared a guide for transitioning into long-term care ○ A care and placement coordinator are allocated to support the transition process ○ A care coordinator can help individuals identify the most appropriate residence, seek other options (e.g., home management) as well as coordinate an assessment of needs ○ A needs assessment includes health needs, physical needs, and safety concerns ○ The care coordinator can provide a list of locations in the preferred community and help identify questions to address concerns ○ Care coordinators can help complete financial applications for those who cannot afford long-term care services ○ Individuals who must stay at a hospital must accept the first bed that is available; however, they can remain on a waitlist if it is not their preferred home ○ The guide provides tips on the transition including preparing a joint bank account to facilitate payments, setting aside money for first accommodation, property management, personal care wishes, label personnel items, writing down key information about self, securing legal documents, and bringing medications/medical equipment ○ Caregivers can support transition by helping move into home, bringing familiar objects, emotional support, staying informed, listening to your opinions, maintaining a sense of humour, and staying connected (e.g., in person or through internet) • Caregivers Nova Scotia provides a transition to care guide ○ The website provides tips on which questions to ask and helpful personal accounts of the transition process ○ The guide advises caregivers to rest, handling difficult conversations with loved ones, and leaning on the supports of others ○ Tips to handle negative comments include never dismissing negative comments, listening to emotion behind words, treating loved ones as equals, and illustrating progress of complaints ○ Caregivers can support individuals by creating an at-home atmosphere using items from the loved one, family photos, holiday decorations, and fresh flowers ○ Caregivers should familiarize themselves with long-term care policies, procedures, and staff ○ Tips for successful visits include having a visiting schedule, including loved one's favourite activities (e.g., outing, stroll, sharing photos)
Prince Edward Island	• A care coordinator is responsible for facilitating the transition to long-term care services ○ Care coordinators can help discuss options, identify suitable residences, and navigate financial applications • The Canada-Prince Edward Island Home and Community Care states that cultural specialization should be include in long-term care facilities to ease the transition ○ Cultural specialization includes recognizing traditional holidays, offering traditional cuisine, and bilingual caregivers
Newfoundland and Labrador	• The regional health authority conducts an assessment to determine if an individual requires long-term personal care • No additional information on the transition process could be identified
Yukon	• The Government of Yukon is enhancing the territory's healthcare system by increasing the number of long-term care rooms at Whistle Bend Place and adding more acute care beds at Whitehorse General Hospital ○ The Government of Yukon and the Yukon Hospital Corporation will reconfigure existing spaces to create 12 new long-term care rooms at Whistle Bend Place, which will free up an additional five acute care beds at the Whitehorse General Hospital's Thomson Centre; this initiative aims to increase the availability of long-term care rooms and acute care beds, thereby expanding both services in the Yukon ○ In 2024–25, the Government of Yukon is investing $6.3 million to cover the cost of increasing bed capacity in the territory • The Aging in Place action plan provides a path forward upon which the entire community will work together to promote, protect, and enhance the well-being of Yukon seniors and Elders ○ Four interconnected pillars form the basis of this plan: ▪ the goal of Pillar 1 is to work together to ensure that seniors maintain cultural, social, and recreational connectedness within their communities and that their contributions are valued ▪ the goal of Pillar 2 is a future where seniors and Elders have access to a full continuum of housing options that are adequate, suitable, and affordable

Jurisdiction	Policy approaches
	▪ the goal of Pillar 3 is a Yukon where seniors and Elders have access to a range of transportation options that meet their needs ▪ the goal of Pillar 4 is to ensure that seniors and Elders have access to a wide range of suitable programs and services that support their health, independence, and active participation in their community • The Government of Yukon has entered into a bilateral agreement with the Government of Canada, known as the Aging with Dignity Agreement ○ Through the Aging with Dignity Agreement, the Government of Canada will provide close to $12 million to support the Yukon's five-year action plan to help people living in the territory age with dignity close to home, with access to home care or care in a safe long-term care facility, including to: ▪ enhance workplace stability to provide clients with culturally safe, quality person-centred care in a psychologically safe environment ▪ enhance supports for the education, health, and wellness of long-term care staff to improve infection prevention and control and adherence to long-term care standards
Northwest Territories	• The Government of the Northwest Territories has entered into a bilateral agreement with the Government of Canada, known as the Aging with Dignity Agreement • The Government of Northwest Territories Department of Health and Social Services will use the Aging with Dignity funding to support two activities regarding long-term care ○ Long-term care staffing standard: ▪ The long-term care standards mandate a minimum of 3.6 hours of direct care per resident per day in long-term care facilities to meet clinical staffing requirements ▪ While some long-term care facilities in the NWT already meet this standard, others do not and will need additional resources to comply with the long-term care standard ▪ Aging with Dignity funding from 2023–24 to 2027–28 will support this transition, including adopting a staffing ratio of 30% nursing to 70% Resident Care Aide and ensuring 24/7 Registered Nurse coverage ○ Territorial housekeeping specialist and furniture and equipment replacement: ▪ Infection prevention and control assessments in Northwest Territories long-term care facilities have revealed deficiencies such as a lack of standardized cleaning practice training and the need to replace worn equipment and furniture ▪ Aging with Dignity funding from 2023–24 to 2024–25 will be allocated to establish a Territorial Housekeeping Specialist ▪ The specialist will address deficiencies by developing and implementing housekeeping policies and standardized training ▪ Additionally, the funding will support the replacement of long-term care equipment and furnishings to ensure infection prevention and control standards are met
Nunavut	• The Government of Nunavut has entered into a bilateral agreement with the Government of Canada, known as the Aging with Dignity Agreement ○ Through the Aging with Dignity Agreement, the Government of Canada will provide over $12 million to support Nunavut's five-year action plan to ensure aging with dignity close to home, with access to home care or care in safe long-term care facilities ○ This funding will: ▪ Enable nurse practitioners to provide virtual care for long-term care facilities ▪ Enhance long-term care standards by helping Nunavut meet new national standards through culturally appropriate care, providing Inuit-specific counselling for residents outside the territory, and addressing organizational challenges within the Home and Continuing Care Division facilities
Veteran-specific approaches in each of the Five Eyes countries	
Australia	• Coordinated Veterans' Care (CVC) Program: ○ Provides proactive care coordination for Veteran Gold Card holders with chronic health conditions and Veteran White Card holders with chronic Department of Veterans' Affairs accepted mental health conditions ○ Aims to improve participant quality of life and decrease the risk of unplanned hospitalization (e.g., through better management of chronic conditions) ○ Involves a team-based approach, including the participant, their general practitioner, and a care coordinator (i.e., within a general practice setting)

Jurisdiction	Policy approaches
	○ Develops a care plan to meet the health needs of the participant and manage ongoing care, which indirectly helps to improve transitions to long-term residential and nursing care when the time comes • The Department of Veterans' Affairs Residential Aged Care program ○ Offers support for moving into residential aged care (e.g., retirement villages, government-funded aged care facilities) ○ Provides guides to help through the process and find information on aged care services and supports (i.e., resources for a smooth transition)
Canada	• Veterans Affairs Canada may provide financial support for those admitted to care in a community or contract bed through its long-term care program ○ Contract beds are only available to WWII and Korean War veterans and are arranged between the federal government and provincial governments, health authorities, or institutions ○ Community beds are available to provincial residents with no Veterans-specific priority access ○ The conditions of qualification for financial assistance include a low income, a service-related disability, or a health-related need for long-term care ○ As long-term care service is a provincial responsibility, Veterans must meet provincial eligibility for admission before being considered for federal funding support • A generic guided support program with a Veterans service agent is available to assist with coordinating services and supports, including the need for assistance complicated by health challenges • A report by Veterans Ombudsman recommended a "Continuum of Care" program for a "single coordinated entry system" spanning home care, assisted living, and long-term care that is meant to help Veterans navigate through the different levels of care over time ○ No findings on whether this has been implemented • As part of a short-term preferred admission beds initiative, Veteran Affairs Canada arranged two-year agreements starting in 2016 with provincial partners to broaden eligibility and expedite access to long-term care beds for Veterans ○ These arrangements were limited to urban centres and only available in some provinces • Uncertainties exist in Veteran Affairs Canada's constitutional authority to administer such a program, and it continues to fulfil its responsibility to the long-term care of veterans mostly in financial terms
New Zealand	• Veterans' Affairs' Social Rehabilitation ○ Social Rehabilitation consists of various services tailored to meet individual needs, with an assessment to determine the best options ○ The assessment also considers the needs of an individual's spouse, partner, child, dependent, or other support persons related to the support they provide ○ Participation in Social Rehabilitation may be required based on the person's situation, but individuals can also apply voluntarily ○ Depending on circumstances, Veterans may be eligible for services such as attendant care (e.g., personal assistance), childcare, home help (e.g., cleaning and cooking), home modification (e.g., wheelchair ramps), aids and appliances (e.g., mobility aids), other services, training for independence, and transport for independence ○ All these supports indirectly help to improve transitions to long-term residential and nursing care when the time comes • Veterans' Independence Programme ○ The Veterans' Independence Programme provides services and support to Veterans with an accepted service-related injury or illness who struggle to perform activities necessary for independent living at home ○ Eligibility includes Veterans with service-related injuries or illnesses who receive impairment compensation or War Disablement Pension ○ Veterans' Affairs considers factors such as the Veteran's level of impairment, employment status, living alone, geographic location, access to services, existing support, and whether requested services overlap with social rehabilitation services ○ Services provided under the Programme support activities necessary for independent living (e.g., shopping, meal preparation, housework) and include short-term attendant care, foot health maintenance, interior house cleaning, house and garden maintenance, home adaptations (e.g., ramps or rails), travel support, allowance for adaptive clothing, and personal medical alarms ▪ All these supports indirectly help to improve transitions to long-term residential and nursing care when the time comes ▪ The program is currently suspended until March 2025 for new clients without a service-related health condition • Residential Care Subsidy provided from Work and Income, an organization within the Ministry of Social Development ○ The Residential Care Subsidy is available for long-term residential care in hospitals or rest homes

Jurisdiction	Policy approaches
	○ The subsidy helps with the cost of care, paid directly to the hospital or rest home by Health New Zealand – Te Whatu Ora ○ Eligibility criteria include: ▪ aged 65 or older, or 50–64 and single with no dependent children ▪ assessed as needing long-term residential care for an indefinite length of time ○ Receiving contracted care services ○ Not eligible if under 50 and single ▪ The financial support helps veterans overcome the financial difficulty of transitioning to long-term residential or nursing care
United Kingdom	• The Forces in Mind Trust Research Centre indicated in their review of older Veterans in the United Kingdom that there is limited information about the needed supports for this population group, particularly around the use of care homes and support systems • The Aged Veterans Fund had funded an initiative in 2016 called the Greater Manchester Armed Forces Families Integrated Health and Wellbeing, where it sought to create an integrated care model that involved improvements in transitions between services and care; however, there are no findings reported • The Age UK's Personalised Integrated Care program brings together voluntary health and social organizations, where an older adult co-creates a care plan with a coordinator, engages with Age UK volunteers to help achieve goals, and meets with multidisciplinary teams in primary care settings.
United States	• Veterans in the U.S. are able to access assisted living, residential care and home health care through Veterans Affairs, which offers a number of resources for Veterans interested in applying for these forms of care

Appendix 6: Documents excluded at the final stages of reviewing

Document type	Hyperlinked title
Evidence synthesis	Changing trends in health orientation among older adults: A scoping review
Commentary	Policies shaping nursing home medication practices: Involving nurses to advance individualized deprescribing
	Seniors in transition: Exploring pathways across the care continuum

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