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Experiences of Older People Living with Frailty Transitioning from Hospital to Home — A Qualitative Descriptive Study

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Abstract

This qualitative study explores the experiences of older people living with frailty, their informal caregivers, healthcare professionals, and administrators during the transition from hospital to home within the Ontario Health Teams (OHT) model. Using focus group discussions (FG1: older adults and caregivers, FG2: healthcare administrators, and FG3: healthcare professionals), the study identifies six key themes critical to successful care transitions: 1) healthcare as holistic care, 2) the therapeutic value of familiar surroundings, 3) the need for patient and caregiver voice and choice, 4) the challenges of navigating the disconnect between hospital and community care, 5) the importance of supporting informal caregivers, and 6) the impact of income, language, and equity on care access. The findings highlight significant communication, coordination, and resource allocation gaps impeding effective transitions. Such problems are associated with emotional strains of patients, caregivers, and health care providers, and higher chances of caregiver burnout and hospital readmission. The paper highlights the necessity of integrated, patient-centred care models, in which a smooth transition, effective communication, and active participation of patients and caregivers in the care planning are essential. A solution to these issues is the proposed Integrated Transitional Care Model (ITCM), based on the insights of the study, to enhance care coordination, decrease readmissions, and offer equitable care to older adults who may be frail. The study highlights the need to develop a collaborative healthcare system in which all stakeholders, including patients, caregivers, medical practitioners, and administrators, collaborate to facilitate smooth and well-coordinated transitions and better health results. The results present meaningful policy, practice, and research implications to improve care transitions of frail older adults in Ontario and elsewhere.

Keywords: *Older Adults, Frailty, Hospital-To-Home Transition, Ontario Health Teams, Integrated Care, Caregiver Support, Healthcare Professionals, Communication, Equity, Transitional Care Model.*

Introduction

Older people living with frailty (OPLF) often experience reduced health and functionality that is then compounded by other conditions, e.g., loneliness, isolation, polypharmacy, and inactivity (Dent et al., 2019). The current population of Canadians aged 65 and above who experience frailty is more than 1.6 million, which will rise to 2.5 million by 2030 (Canadian Frailty Network, 2023). Frailty is a significant health concern for healthcare systems, increasing the complexity of patient needs and increasing hospital readmissions (Kojima et al., 2019). Frailty also impacts the ability of many older adults to live independently due to their complex medical, psychological, and social needs, resulting in unmet care needs and higher dependency on healthcare systems.

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There is a special challenge in older adults who are long-term patients in hospitals, and who are designated as Alternate Level of Care (ALC) patients, i.e., clinically stable, but cannot be discharged as they have nowhere safe to return to and must still be kept under the care (Chuang et al., 2023). Many ALC patients in Ontario are frail elderly, putting a strain on the hospital system. The extended hospitalisation and the delay in transferring these individuals to the proper care facilities usually lead to a functional loss. This emphasizes that discharge planning and care coordination need to be improved. The Ontario Health Teams (OHTs) were created in 2019 to combine the healthcare services of different sectors to enhance an individual's transition out of the hospital and into the home (Embuldeniya et al., 2021). This complex solution aims to offer easily made transitions, improved patient care, and less fragmented care coordination. Very little is written on how OHTs can effectively address the needs of frail older adults, especially. The present paper will aim to investigate the life of older people living with frailty, their caregivers, healthcare providers (HCPs), and administrators within the framework of the hospital-home transition as one of the components of the OHT model. It will pursue obstacles, facilitators, and opportunities to help in patient-centred care.

Literature Review

The hospital-home transfer of OPLF is enclosed in complex issues around the patients, the essential care partners (ECPs), health care providers (HCPs), and the administrators (Naqvi, 2023). Ontario Health Teams (OHTs) and other integrated care frameworks are tailored to meet these issues through collaboration across hospital, primary care, home care, long-term care, and community support services. The models are also supposed to provide more aligned, patient-centred care, resulting in improved outcomes and reduced gaps in care (Dong et al., 2024). This review summarises the significant research into frailty, transitions between hospitals and homes, and integrated care, pinpointing gaps in what is currently known and providing an insight into the experiences of older adults with frailty and their most important health partners in such transitions. Frail older adults have many obstacles in their hospital-to-home transition. Frailty is linked to physical and functional impairments, so the hospital-to-home transfer is complicated (Grady et al., 2023). According to several studies, frail aged people have an increased complication burden, increased hospitalisation, or readmissions. According to one study by Sawan et al. (2021), good transitional care may enhance the outcomes and decrease healthcare spending. However, when the care is not well coordinated, it creates gaps in care and risks to the patient. There is ongoing emphasis in international research on the importance of enhanced integration of services to improve transitions and outcomes. The OHT model has been implemented in Ontario to help hospitals, community services, and long-term care providers work together to promote collaboration. However, its efficacy in meeting the needs of frail elders is understudied.

Older Adults and Health Partners in Transitions

Many studies have examined the experiences of OPLF, ECPs, and HCPs during hospital-to-home transition. The study by Rustad et al. (2016) was descriptive and conducted on

14 patients above 80 years, exploring the experience of transition between hospital and municipal home care. The results showed two dominant themes: the absence of patient input to discharge planning and ineffective communication within the care settings. Such findings are reinforced by studies that show that patients and caregivers undergo easier transitions in cases where they actively participate in the discharge planning (Forsman & Svensson, 2019). Inclusion of patients and their families in the planning process enhances compliance with treatment, decreases the hospitalisation rate, and provides care that suits the needs of the patient.

Nevertheless, barriers that may affect OPLF are the absence of inclusive discharge meetings, poor communication, and role ambiguity of healthcare providers, which worsen the risks of transitioning home. Equally, a UK study (Hanratty et al., 2012) also noted four key themes during the transition of OPLF to home: (1) the focus on institutional processes at the expense of patient-centred care, (2) the absence of streamlined support in different care settings, (3) the difficulty in being heard by the providers, and (4) the significance of patient dignity in the decision-making process. The paper highlighted how a more personalised and patient-centred perspective of care transitions may enhance satisfaction and decrease care-related problems. The suggestions of this study involve the engagement of OPLF and their ECPs in the discharge planning process to make the care more relevant to patients and their respective situations.

The role of Unpaid Caregivers

Essential caregivers, such as family members or friends, assist the OPLF in transitioning from hospital to home. In research conducted by Semere et al. (2019) on Chinese-speaking and Spanish-speaking caregivers living in the United States, the language barriers and lack of access to professional interpreters posed considerable difficulties with understanding discharge directions and arranging care. Irrespective of these challenges, 90 percent of ECPs said that they managed numerous caregiving functions such as activities of daily living (ADLs) and health care decision-making. The research findings were that effective transitions require customised support of the ECP, such as language support. These ECPs are vital in the process but are not adequately supported, which adds to burnout and a higher level of stress (Gérain & Sech, 2019). Similarly, in a phenomenological study of the home care nursing managers in Norway conducted by Dale and Hvalvik (2013), it was established that the nursing leaders were not consulted during the hospital-to-home transfer, thus resulting in poorly coordinated care and increased stress among the staff. As highlighted in the study, there was a need to plan and better allocate resources and facilitate improved communication among all the health partners. The quality of care provided to frail older adults was reduced due to inconsistent care delivery and insufficient resources amid transitions, which resulted in burnout among the nursing staff. These results are consistent with the ever-increasing literature on including all primary health partners' patients, ECPs, and HCPs in the care process to provide continuity and mitigate the risk of adverse outcomes.

Community Care Problems

The problems of caring for vulnerable OPLF in the community are multiple. In a longitudinal research study carried out by Aronson (2002), it was indicated that OPLF in Ontario complained that they received poor and impersonal care, which led to functional deterioration and hospitalisation. The participants of this study could rarely remain at home following the decrease in the services provided by home care and the lack of available assistance. This is aligned with a study conducted by Turcotte et al. (2015), who discovered that the needs of OPLF are often notoften fulfilled in the community. The lack of access to social services and transportation facilities predisposes older adults to adverse health outcomes (i.e., falls and depression). These issues provide evidence to support the need for stronger and more personalised care plans that not only address the medical needs of older adult populations but also the social and psychological needs.

Algorithms of Integrated Care and Its Impact

Integrated care models have been proposed as one of the solutions to address the mentioned issues and improve transitional care from hospital to home. OPLF, Institute-level care could be postponed and hospitalisations reduced with coordinated team-based care, as shown by the Montreal System of Integrated Care for Older Persons (SIPA) (Béland et al., 2006). Similarly, systematic reviews of nurse-led integrated care teams have reported that these models may increase functional outcomes and reduce hospital readmissions. A systematic review of interprofessional care models by Trivedi et al. (2013) reported that interprofessional collaboration resulted in better health outcomes and patient and caregiver satisfaction. Nevertheless, these models have major implementation issues, such as limited resources, disjointed healthcare processes, and inconsistent care provision. Although integrated care models have promise, there is still little evidence of their effectiveness in the long term. Deschodt et al. (2020) concluded in a meta-analysis that there was no meaningful decrease in nursing home or hospital readmissions for patients receiving integrated care, indicating that although such models have a promise for improved care delivery and experiences, more studies are necessary to see the actual effect and impact on OPLF during transitions. Moreover, there are still knowledge gaps in the experiences of healthcare administrators and policymakers in influencing the care transitions. These stakeholders are pivotal in resource allocation, policy formulation, and coordination of care, but they are not always represented in the available care transition research..

Conceptual Framework

This paper is based on the Quintuple Aim model that builds upon the Triple Aim by incorporating healthcare providers' well-being and equity. The Quintuple Aim focuses on patient satisfaction, population health, lowered healthcare spending, the well-being of healthcare providers, and equitable access to services (Arnets et al., 2020). This set of dimensions provides a balanced

model for investigating experiences related to transitional care in OPLF and the perspectives of the stakeholders involved in patient care, such as caregivers, healthcare professionals, and administrators. The framework proved helpful, particularly in developing the research questions and the objective of the Ontario Health Teams (OHTs) Integrated Care Model, which is the backbone of this study.

In 2019, the Ontario Ministry of Health suggested the OHT model, which proposes an interdisciplinary coordinated healthcare model to introduce service integration between hospitals, primary care, home care, long-term care, and community support (Haverfield et al., 2020). This integrated care model aligns with the goals of the Quintuple Aim because it focuses on seamless logistics and patient-centred and holistic health outcomes. Our research question was to identify the challenges, facilitators, and opportunities of the existing system experienced by OPLF and other key healthcare partners during the hospital-home transitions.

Methodology

Research Design

The research was conducted using a qualitative descriptive methodology, as it was the most suitable methodology to gain insight into what people would typically experience in a real-life scenario without exposing them to rigid theories. The research approach was a straightforward study of the phenomenon under investigation since it examines the participants' lived experiences in a natural setting. Qualitative description is more useful in those studies that want to maintain the holistic perspective. The data were analysed using the Reflexive Thematic Analysis (RTA) approach, as Braun and Clarke (2006) explained. RTA is a discontinuous process, which is why one can immerse himself/herself in the data about explicit and implicit themes that may be present in the interviewees' stories. This methodology was suitable because the common and distinct views of the participants were identified, analysed, and interpreted in the broader context of the transitions between carers.

Sampling and Recruitment

Participants were chosen strategically to ensure we could capture various experiences and views. Participants were recruited at the Toronto Grace Health Centre (TGHC), a Toronto, Ontario facility comprising 270 beds. In total, 60 participants were recruited from complex continuing care, rehabilitation, and transitional care. There were three separate focus groups (FGs) of participants to investigate the experiences of various important stakeholders:

- Focus Group 1 (FG1): Older adults who live with frailty and unpaid caregivers:
- Focus Group 2 (FG2): Healthcare providers with direct patient care experience in hospitals and communities.
- Focus Group 3 (FG3): Administrators and leadership team members who oversee and supervise the transition process between the hospital and home.

Participants were recruited through purposive sampling and based on knowledge and experience relating to the subject. The eligibility criteria in OPLF were 65 years and above, TGHC Alternate Level of Care (ALC), and Clinical Frailty Scale (CFS) scores of 4 and above. Caregivers were considered if they were directly involved in patient care. The healthcare practitioners and administrators were chosen according to their involvement in care coordination, policymaking, or administration regarding transitional care of OPLF. Recruitment was done with the aid of social workers (SWs), who identified the eligible patients and caregivers when they were present in the hospital. Eligible patients and caregivers were then approached by the study team and provided with information and consent forms. Among the healthcare professionals and administrators, recruitment was conducted through internal TGHC communication channels and other healthcare institutions.

Data Collection

Semi-structured focus group interviews were used to collect data; this mode provided sufficient flexibility to capture emerging themes but was rich and in-depth. The main aim of using focus groups in qualitative research is to provide a platform where subjects can interact and gain experience as a group, through which valuable insights are created. The style is also favourable to the sense of comfort, allowing free discussions and ideation. The focus group interviews took place in neutral, non-clinical environments at TGHC, balancing the power dynamic between the researcher and respondents. The sessions were roughly 90 minutes long and moderated by the investigator and the research assistants. Speech-to-text software was used to provide live transcription and capture the data with high accuracy. The focus group discussions and the interview questions followed a semi-structured interview guide. They were open-ended, allowing the participants to share their personal experiences and reflections on the hospital-to-home transition process. The interview guide was designed to cover the following themes within the sequence of the objectives of the OHT model:

- Patient Care Experience: Experiences in the discharge process and the interactions with hospital personnel.
- Patient Partnership and Community Engagement: Involvement of patients and their caregivers in discharge planning, and their interests in transitioning home.
- Care Coordination and In-Scope Practices: Barriers and facilitators to access care services after discharge, hospital and community care provider coordination, and caregiver role.
- Performance and Quality Improvement: Review positive and negative discharge processes with improvement ideas.
- Digital Health: Digital technology and digital tools used to support care transitions.

Data Analysis

Data was analysed through a Reflexive Thematic Analysis (RTA) process, which facilitated the identification of similar themes and patterns in the focus group data. RTA also emphasises the active position of the researcher in interpreting the information, fostering the idea of reflexivity regarding the position of the opinion in the interpretation of the information. This methodology was particularly suitable in this study of the intricate and contextually mediated experiences of OPLF and their health partners, which is of central concern. The procedures involved when analysing the data were:

- Getting used to the Data: The Data were read and reread to get conversant with the information.
- Creating Initial Codes: Patterns, recurrent features, and themes were identified and coded.
- Themes Search Codes: Initial themes were sorted into broader themes related to the research questions.
- Things: Themes were checked and overlaid throughout the data to promote coherence.
- Member Checking: The subjects were also asked to check the initial findings to make them accurate.
- Defining and Naming Themes: The final themes were well correlated until they made sense to the research question and to the participants' experiences.

The cyclical quality of RTA allowed the researchers to narrow in on themes as they continuously worked with the data, which assured the depth and breadth of their understanding of the participants' experiences. Themes were identified in terms of barriers to successful transitions, the role of essential care partners, and the importance of better coordination in the sectors involved in healthcare.

Ethical Considerations

The principles of the Canadian Tri-Council Policy Statement were followed in this study, which the TGHC Joint Research Ethics Board approved. All participants provided informed consent, and confidentiality was maintained during the study. The participants were guaranteed that it was their will to participate, and their withdrawal was of no consequence. No financial compensation was offered, and those taking part were compensated for the travel, meals, and parking costs. All data was stored securely with only authorized access by the research team.

Results

Focus Group 1 (FG1): Older People Living with Frailty and Caregivers

Participant Characteristics

Recruitment for Focus Group 1 (FG1) aimed to include approximately 15 participants from two groups: OPLF and essential care partners. This target was set for recruitment, but the study remained open to including more participants to ensure diversity and data saturation. The older adult participants were at various stages of the care continuum, including those in hospital, transitional care facilities, long-term care homes (LTCH), and home settings (Table 1).

Essential care partners were predominantly female (73%), with the majority being adult children of the older adults (64%) (Table 2). The study found that the diversity of participant backgrounds helped enrich the data and provided a broad perspective on the transitional care process.

Table 1: Participant Characteristics: Older People Living with Frailty

Demographic Information of Older People Living with Frailty (n=18)	**n (%)**
Gender	
Male	13 (72%)
Female	5 (28%)
Current Continuum of Care	
Currently in hospital—Waiting to go home	7 (39%)
Currently in hospital—Waiting to go LTCH/assisted living	3 (17%)
Currently in transitional care facility—Waiting to go LTCH/assisted living	5 (28%)
Currently in LTCH/assisted living	1 (6%)
Currently at home <1 month	1 (6%)
Currently at home >1 month	1 (6%)
Practice Setting	
Hospital	10 (57%)
Community	8 (43%)

Table 2: Participant Characteristics: Essential Care Partners

Demographic Information of Essential Care Partners (n=11)	**n (%)**
Gender	
Male	3 (27%)
Female	8 (73%)
Relationship with Older People Living with Frailty	
Spouse/Partner	2 (18%)
Adult child of older adult	7 (64%)
Extended family member (excludes spouse/partner and adult children)	1 (9%)
Non-family (friend/neighbour)	1 (9%)

Themes Identified

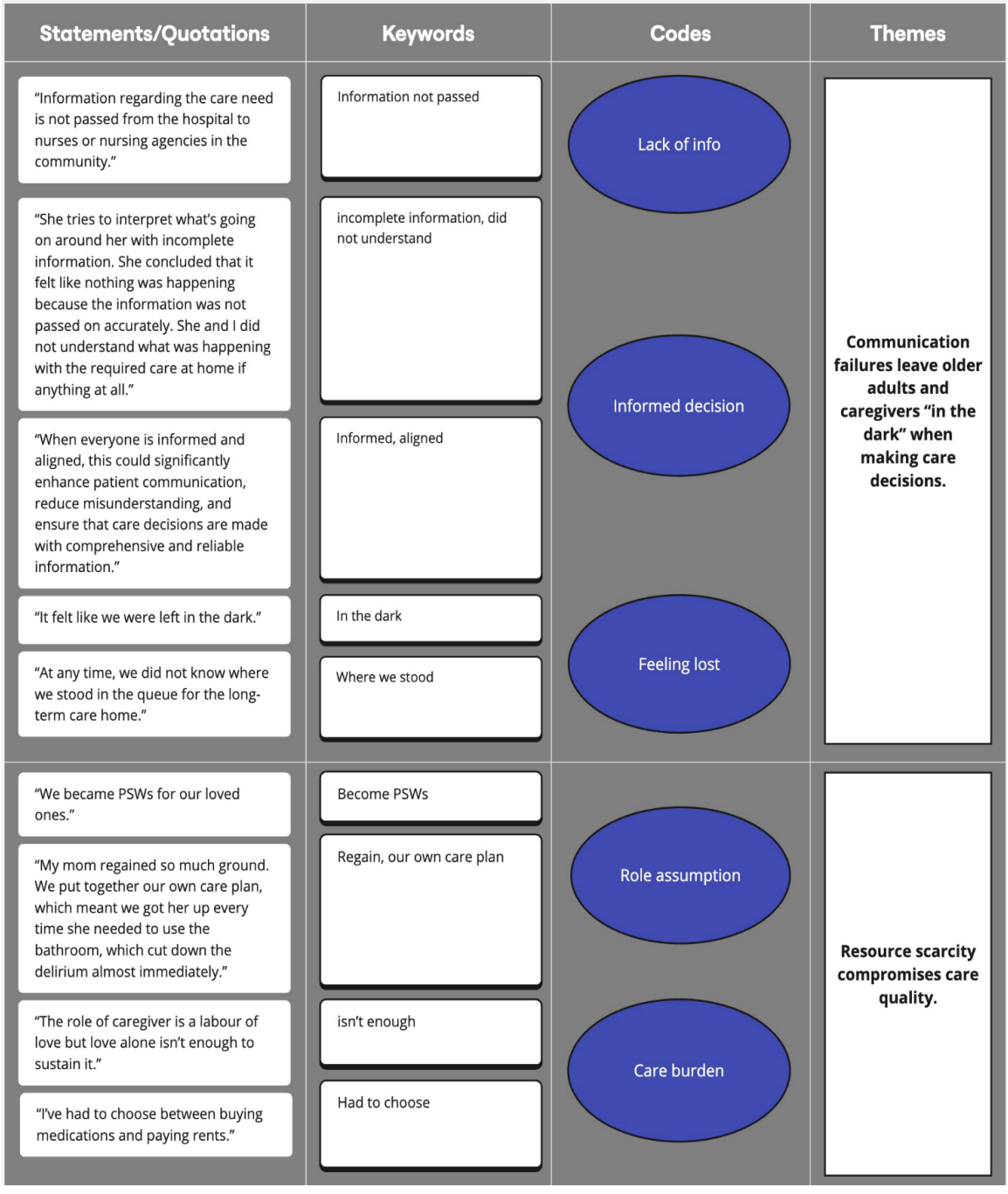
The focus group discussions identified five primary themes that encapsulated the challenges and facilitators faced by older adults with frailty and their caregivers during hospital-to-home transitions:

1. Communication failures leave OPLF and caregivers "in the dark" when making care decisions.
2. Resource scarcity compromises care quality.
3. Lack of training and education impedes access to quality care.
4. Navigational challenges between different healthcare “worlds” compromise personal identity and sense of security.
5. Exclusion from decision-making threatens patient-centred care.

Table 3: Major Themes Identified in FG1 (Older People Living with Frailty and Caregivers)

Theme	**Description**

Theme 1: Communication failures	Participants experienced significant gaps in communication between hospital and home care teams.
Theme 2: Resource scarcity	Limited resources, especially healthcare staff and medical equipment, impacted care quality.
Theme 3: Lack of training and education	A lack of proper training for healthcare providers and caregivers limited access to quality care.
Theme 4: Navigational challenges	The complexity of moving between healthcare systems led to feelings of loss of personal control.
Theme 5: Exclusion from decision-making	The absence of patient and caregiver involvement in care decisions hindered patient-centred care.


Statements/Quotations
Keywords
Codes
Themes
"Information regarding the care need is not passed from the hospital to nurses or nursing agencies in the community."
"She tries to interpret what's going on around her with incomplete information. She concluded that it felt like nothing was happening because the information was not passed on accurately. She and I did not understand what was happening with the required care at home if anything at all."
"When everyone is informed and aligned, this could significantly enhance patient communication, reduce misunderstanding, and ensure that care decisions are made with comprehensive and reliable information."
"It felt like we were left in the dark."
"At any time, we did not know where we stood in the queue for the long-term care home."
Information not passed
incomplete information, did not understand
Informed, aligned
In the dark
Where we stood
Lack of info
Informed decision
Feeling lost
Communication failures leave older adults and caregivers "in the dark" when making care decisions.
"We became PSWs for our loved ones."
"My mom regained so much ground. We put together our own care plan, which meant we got her up every time she needed to use the bathroom, which cut down the delirium almost immediately."
"The role of caregiver is a labour of love but love alone isn't enough to sustain it."
"I've had to choose between buying medications and paying rents."
Become PSWs
Regain, our own care plan
isn't enough
Had to choose
Role assumption
Care burden
Resource scarcity compromises care quality.

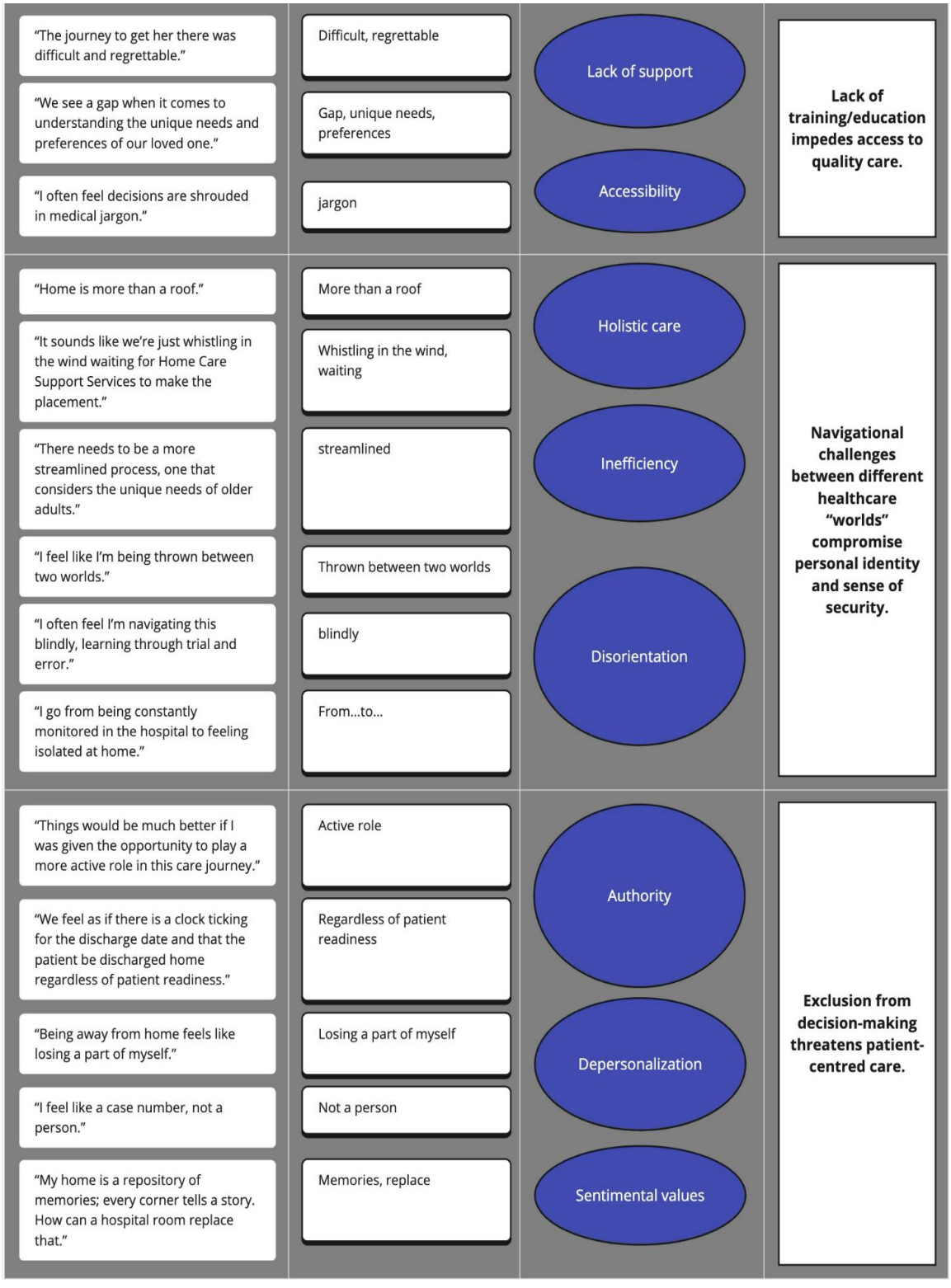

"The journey to get her there was difficult and regrettable."
"We see a gap when it comes to understanding the unique needs and preferences of our loved one."
"I often feel decisions are shrouded in medical jargon."
Difficult, regrettable
Gap, unique needs, preferences
jargon
Lack of support
Accessibility
Lack of training/education impedes access to quality care.
"Home is more than a roof."
"It sounds like we're just whistling in the wind waiting for Home Care Support Services to make the placement."
"There needs to be a more streamlined process, one that considers the unique needs of older adults."
"I feel like I'm being thrown between two worlds."
"I often feel I'm navigating this blindly, learning through trial and error."
"I go from being constantly monitored in the hospital to feeling isolated at home."
More than a roof
Whistling in the wind, waiting
streamlined
Thrown between two worlds
blindly
From...to...
Holistic care
Inefficiency
Disorientation
Navigational challenges between different healthcare "worlds" compromise personal identity and sense of security.
"Things would be much better if I was given the opportunity to play a more active role in this care journey."
"We feel as if there is a clock ticking for the discharge date and that the patient be discharged home regardless of patient readiness."
"Being away from home feels like losing a part of myself."
"I feel like a case number, not a person."
"My home is a repository of memories; every corner tells a story. How can a hospital room replace that."
Active role
Regardless of patient readiness
Losing a part of myself
Not a person
Memories, replace
Authority
Depersonalization
Sentimental values
Exclusion from decision-making threatens patient-centred care.

Figure 1: FG1 Theme Coding

Communication Failures Leave OPLF and Caregivers "In the Dark" When Making Care Decisions

A significant concern raised by participants in FG1 was the communication gap between hospital discharge teams and community-based care providers. Many participants felt that important information about the patient's care plan was not communicated effectively, leaving caregivers and patients without adequate guidance. One participant described the experience as feeling lost and **"**in the dark**"** due to incomplete information:

"She [the patient] tried to interpret what was happening around her with incomplete information... It felt like nothing was happening because information was not passed on accurately." [Appendix 6-CGINT 008]

Participants emphasised the need for a standardised discharge summary to be electronically shared with caregivers and home care providers. A unified approach to communication was recommended, where all healthcare partners would have access to the same information, reducing confusion and improving patient outcomes.

"A unified approach, where all key health partners are informed and aligned, could significantly enhance patient communication." [Appendix 6-CGINT 005]

Resource Scarcity Compromises Care Quality

FG1 participants discussed the strained healthcare resources within the community, particularly the lack of personal support workers (PSWs) and essential medical equipment, such as wheelchairs and walkers. These shortages directly affected the quality of care provided to frail older adults once they transitioned home. One participant expressed frustration:

"The lack of resources in community care means we are forced to play the role of PSWs for our loved ones. However, it is unrealistic to expect informal caregivers to take on such a demanding role." [Appendix 6-CGINT 009]

Participants strongly advocated for caregiver training and the provision of respite care services to alleviate the burden on informal caregivers. They also called for better organization and management of community health resources to ensure the proper care of OPLF.

Lack of Training and Education Impedes Access to Quality Care

A recurring theme in FG1 was inadequate training for healthcare professionals in caring for OPLF. Many participants believed continuous professional development and

specialised training programs were necessary to equip caregivers and healthcare staff with the skills to provide high-quality, person-centred care. One participant noted:

"Healthcare staff do not have adequate skills, especially in addressing the unique needs of frail older adults... They give them substandard care." [Appendix 6-HCP 004]

Participants also suggested implementing case-based training modules and interdisciplinary staff training to improve care coordination and patient outcomes.

Navigational Challenges between Different Healthcare "Worlds" Compromise Personal Identity and Sense of Security

Participants discussed the emotional and psychological toll that navigational challenges placed on older adults and caregivers. The process of transitioning from hospital to home or another care setting was described as a confusing and disempowering experience, often leading to feelings of loss of control over personal identity. One participant highlighted the frustration:

"It feels like we are just whistling in the wind, waiting for Home Care to make the placement... It is overwhelming." [Appendix 6-DYADINT 002]

The team noted that a central care coordinator/case manager would be needed to oversee the transition process and facilitate smooth communication between different healthcare providers.

Exclusion from Decision-Making Threatens Patient-Centred Care

FG1 participants revealed that OPLF and their caregivers were not always included in decision-making processes concerning care plans. This omission was perceived as a threat to patient-centred care that entails participation of patients and caregivers in decisions that affect them. One caregiver shared:

"We were never consulted... It felt like our input did not matter. We just had to accept whatever was decided for us." [Appendix 6-PTINT 001]

The participants emphasised the need to empower patients and caregivers to participate actively in their care journeys. Healthcare providers were recommended to honour the autonomy of patients and involve caregivers in the decisions, thus increasing care satisfaction and improving outcomes.

According to the findings of Focus Group 1, there are several significant barriers in the transitional care process of OPLF. The main points of concern are communication failures, lack of resources, lack of training, and inter-healthcare system navigation obstacles. It was also found that exclusion is a barrier to providing patient-centred care.

These themes highlight the need for integrated communications, sufficient resources, and empowering patient engagement in care-related decisions to maximise the experience of OPLF and their caregivers during the transition process.

Focus Group 2 (FG2): Leadership Team in Multiple Healthcare Settings

Participant Characteristics

Focus Group 2 (FG2) consisted of an eclectic collection of healthcare management and leadership teams representing different parts of the Ontario healthcare system. This group was a mix of hospital, community agency, Ontario Health, and Ontario Health at Home professionals. The leadership and management team members of the following departments were identified as potential participants, quality, finance, risk, nursing, strategy, and policy. FG2 participants consisted of six females and eight males with ages between 40 and 55 years (Table 4).

FG2 was hosted as a roundtable discussion at the Toronto Grace Health Centre (TGHC), where the different viewpoints about the systemic issues and facilitators for the OPLF transitioning between hospital and home were discussed. This group read the hospital-home discharge policies and implementation, assessing the processes of in-home care delivery as well as systemic obstacles to a seamless transition.

Table 4: Participant Characteristics: Leadership and Administration Focus Group

Demographic Information of Leadership Team (n=14)	**n (%)**
Gender	
Male	8 (57%)
Female	6 (43%)
Profession	
Healthcare Finance Executive	2 (14%)
Patient Safety and Healthcare Quality Executive	2 (14%)
Nurse Managers or Nursing Leadership (Chief Nursing Executive)	3 (21%)
Health Human Resource Executive	4 (29%)
Home Care Agency Executives	3 (21%)
Practice Setting	

Hospital	8 (57%)
Community	6 (43%)

Major Themes Identified

FG2 identified five primary themes that shaped the discussions about healthcare delivery and the challenges faced in transitioning frail older adults from hospital to home:

1. Funding shortfalls limit care for patients returning to the community.
2. Health Human Resource (HHR) constraints, rooted in the institutionalised funding model, threaten the continuity and consistency of care.
3. Lack of quality data and data disruption compromise care continuity.
4. Communication lapses and accountability gaps undermine coordination between hospital and community care.
5. Holistic and patient-centred approaches enhance care by adjusting to patients' social and emotional needs.

Table 5: Major Themes Identified in FG2 (Leadership Team)

Theme	**Description**
Theme 1: Funding shortfalls	Insufficient funding for community-based care limits patients' ability to transition safely.
Theme 2: Health Human Resources (HHR) constraints	Institutionalised funding models impact the availability and consistency of healthcare workers.
Theme 3: Lack of quality data and disruption	Inefficient data management systems disrupt the flow of patient information, affecting care continuity.
Theme 4: Communication lapses and accountability gaps	Gaps in communication between hospital discharge teams and community care providers hinder transitions.
Theme 5: Holistic and patient-centred approaches	Emphasis on holistic care that integrates social, emotional, and medical needs of patients.

Statements/Quotations	Keywords	Codes	Themes
"Additional funding for the clients in the community could be used for medical equipment, home care support- such as PSW in the home, and professional care – such as nursing, rehabilitation, and rehabilitation assessments."	Additional funding, in the community	Inflexibility	**Funding shortfalls limiting care for patients returning to the community .**
"Cookie-cutter approach should not be used."	Cookie-cutter		
"Acute care takes up all the funding, and it is hard to change the funding. Funding should follow the patient."	Hard to change, follow the patient.		
"Fewer resources exist once we leave hospitals and get to long-term care, assisted living, or transitional care facilities, leading to caregiver burnout."	Fewer resources	Misallocation	
"To sustain community support, our health system will need to shift funds from hospital to home- and community-based care...to provide individualized community care for out older adults."	Shift funds, individualized care		
"Resources like PSWs are extremely limited and often impossible to acquired, especially in rural areas."	Extremely limited, rural areas	Insufficiency	
"Time allotted for care is simply insufficient."	Time, insufficient		
"PSWs do not have enough time to provide care after discharge; rushed and unfeasible."	Not [] enough time		
"Increasing the number of hospital beds to accommodate the elevate number of ALC patients without addressing the root cause of our health system's ALC problem is not a solution."	Increasing hospital beds, not a solution	Inefficiency	
"There is a risk of readmissions due to lack of PSWs or community supports."	Risk of readmissions		
"We have seen patients discharged from hospitals without the necessary medical equipment, such as wheelchairs and guard rails, leaving them vulnerable and helpless."	Without necessary [] equipment, helpless		
"There is a lack of a reliable and skilled workforce in the community to support older adults living with frailty."	Lack of [] workforce, in the community	Payment model issues	**Health human resources (HHR) constraints, rooted in the institutionalized funding model, threaten the continuity and consistency of care**
"Fee for service model, based on which most of the workforce is employed, causes inconsistencies in care...a patient is taken care by varied staff."	Fee for service, inconsistencies		
"There is a significant lack of human resources as a result of inconsistent hours, poor coordination, mismanagement of staff, and poor continuity of care."	Lack of human resources.	Workforce shortage	
"A shortage of PSWs is a significant issue since most patients need them."	Shortage of PSWs		
"An increase of ALC care to a minimum of four hours would reduce readmission rates."	Reduce readmission	Accountability	
"What organization should be responsible for the clients going home?"	What [] responsible		
"Who is the home care agency accountable to?"	Who [] accountable		
"There is a need to increase the scope of RPNs and PSWs and to expand the scope of care and practice."	Increase the scope	Scope /Capacity expansion	
"The limited time for provision of community programs does not do [patients] justice."	Limited time		
"What do patients do after ninety days when they have chronic diseases that affect them a lifetime?"	90 days, lifetime, what do patients do	Community support	
"The majority of the problems are preventable; increasing the number of advanced practice nurses and professional staff in the community to complete regular patient risk assessments would improve client outcomes."	Increasing the number, regular assessments		

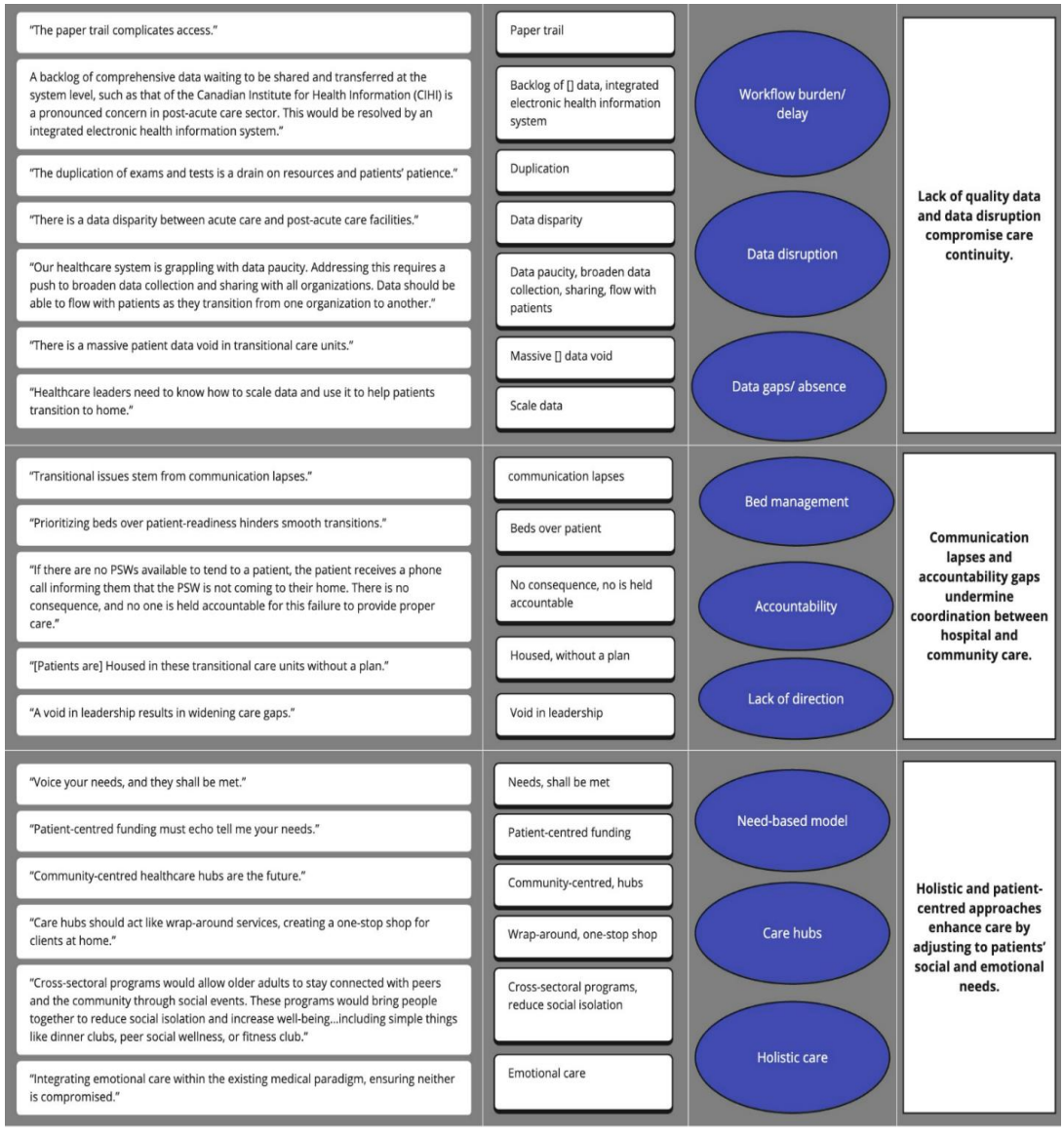


Figure 2: Theme Coding

Funding Shortfalls Limit Care for Patients Returning to the Community

One of the most significant issues raised by the participants in FG2 was the inadequacy of funding for community-based healthcare. The respondents pointed out the lack of funds limited access to essential services, including personal support workers (PSWs), nursing, and rehabilitation services. One participant remarked:

"Additional funding for clients in the community could be used for medical equipment, home care support, such as PSWs, and professional care, like nursing and rehabilitation." [Appendix 6 – ADM 002]

The group observed that acute care funding usually dominated over community care funding. Therefore, there were gaps in care provision to patients who had already been transferred to their homes. Respondents supported a patient-centred funding model which would track the patient and allocate resources that are customised to their medical and social needs:

"Acute care takes up all the funding, and it is hard to change the funding. Funding should follow the patient." [Appendix 6-ADM002]

Participants discussed the importance of **coordinated care** for patients in the community, calling for a dedicated coordinator to track clients' needs and ensure appropriate funding allocation:

"To sustain community support, our health system must shift funds from hospitals to home- and community-based care." [Appendix 6 – ADM 005]

Health Human Resources (HHR) Constraints, Rooted in the Institutionalised Funding Model, Threaten the Continuity and Consistency of Care

FG2 participants pointed to severe health human resources (HHR) limitations due to an unstable funding model. It has been argued by many that the shortage of stable and full-time PSWs in community care facilities has led to poor delivery of care. One participant shared:

"There is a lack of a reliable and skilled workforce in the community to support OPLF." [Appendix 6 – ADM 003]

The **"**fee-for-service" model employed by many healthcare providers has led to unstable hours for PSWs, resulting in frequent staff turnover and poor continuity of care:

"PSWs are not guaranteed hours with one organisation, so they tend to work for different service provider organisations to maximise hours worked." [Appendix 6-ADM011]

The absence of continuity was also made worse during the COVID-19 pandemic, which redirected the focus of PSWs to hospitals, putting further pressure on community care. FG2 participants demanded more PSWs' working hours and a more stable workforce:

"Increasing PSW care to a minimum of four hours per day would reduce readmission rates." [Appendix 6-ADM008]

Lack of Quality Data and Data Disruption Compromises Care Continuity

The participants of FG2 discussed the impact of inconsistent and disconnected data management systems and their influence on the continuity of care when transitioning between hospital and home. The paper-based systems that many transitional care facilities still use have become a barrier to data access.

"The paper trail complicates access [to data]." [Appendix 6-ADM011]

The absence of integration of patient data systems across various healthcare sectors was a major issue, resulting in duplication of tests and examinations and adding to unnecessary healthcare expenses. FG2 members concurred that electronic health records (EHR) systems that are integrated are essential in enhancing data flow:

"Our healthcare system is grappling with data paucity. Addressing this requires broadening data collection and sharing with all organisations." [Appendix 6 – ADM 003]

Participants stressed the importance of real-time data to facilitate personalised care plans and enhance program development:

"Healthcare leaders need to know how to scale data and use it to help patients transition to home." [Appendix 6-ADM002]

Communication Lapses and Accountability Gaps Undermine Coordination between Hospital and Community Care

The lack of communication between hospital discharge and community care providers was highlighted as a significant deficiency impacting successful transitions. FG2 observed that the discharge procedures in hospitals tended to give priority to available bed space rather than patient preparedness, and this resulted in hasty discharge without a well-designed care plan:

"Prioritising beds over patient readiness hinders smooth transitions." [Appendix 6-ADM008]

FG2 also discussed the lack of accountability in the discharge process, where patients were left without clear follow-up care. One participant remarked:

"If are no PSWs available to tend to a patient, the patient receives a phone call informing them that the PSW is not coming... There is no consequence, and no one is held accountable for this failure." [Appendix 6 – ADM 013]

The participants promoted an all-inclusive discharge plan involving effective communication, a revised care plan, and responsibility in care delivery. The participants

underlined that the transition process should be managed by a care coordinator who must provide continuity and avoid unnecessary readmissions.

Holistic and Patient-Centred Approaches Enhance Care by Adjusting to Patients' Social and Emotional Needs

FG2 participants emphasised the need to treat patients in a holistic and patient-centred approach, focusing on medical as well as social and emotional needs. They observed that OPLF had a significant problem with social isolation, especially following discharge. One participant stated:

"Cross-sectoral programs would allow older adults to stay connected with peers and the community through social events." [Appendix 6 – ADM 002]

Participants advocated for community-centred healthcare hubs that integrate medical, social, and emotional care to prevent social isolation and enhance well-being:

"Community-centred healthcare hubs are the future." [Appendix 6-ADM013]

They visualised these hubs providing various services such as healthcare, social, rehabilitation, and chronic disease support to provide better care and life for OPLF.

Focus Group 2 outcomes point to various systemic opportunities and obstacles in OPLF transitioning from hospital to home care. The important topics identified were the necessity of improved funding, human resources, data integration, communication, and accountability in the discharge process. Also, a more holistic, patient-centred approach was suggested to meet the social and emotional needs of OPLF..

Focus Group 3: Healthcare Professionals (HCPs)

Participant Characteristics

Focus Group 3 (FG3) was composed of healthcare professionals (HCPs) working across diverse areas of the Ontario healthcare system: hospitals, community health organisations, Ontario Health, and Ontario Health at Home (Table 14). The respondents represented a broad spectrum of healthcare professionals, including physicians, nurses, physiotherapists, occupational therapists, rehab assistants, respiratory therapists, speech-language pathologists, social workers, and personal support workers (PSWs). This heterogeneous group of 15 healthcare providers represented a range of roles and perspectives in hospital and community settings, which provided a rich learning environment for collaboration in their discussions about frailty and challenges in the transition of older adults to the home setting (Table 6).

Table 6: Participant Characteristics: Healthcare Providers (HCPs)

Demographic Information of Healthcare Providers (n=15)	**n (%)**
Gender	
Male	7 (47%)
Female	8 (53%)
Profession	
Physicians	1 (7%)
Nurses (1 RN, 2 RPNs)	3 (20%)
Occupational Therapists (OT)	1 (7%)
Physiotherapists (PT)	1 (7%)
Rehabilitation Assistants	1 (7%)
Respiratory Therapists (RT)	1 (7%)
Speech-Language Pathologists (SLP)	1 (7%)
Social Workers (SWs)	2 (13%)
Personal Support Workers (PSWs)	4 (27%)
Practice Setting	
Hospital	8 (53%)
Community	7 (47%)

Major Themes Identified

Five primary themes emerged from FG3's discussions, highlighting key challenges and potential facilitators in the transition of older adults with frailty from hospital to home:

1. Unrealistic expectations and failure to align care goals create challenges in patient-provider relationships.

2. Communication barriers and documentation gaps impact quality of care.

3. The limited availability of post-discharge and community support "is a joke."

4. Inadequate planning and coordination lead to delays, inconsistencies, and increased risks in discharge.

5. Fragmentation in policy highlights the need for a collaborative care model redesign.

Table 7: Major Themes Identified in FG3 (HCPs)

Theme	**Description**
Theme 1: Unrealistic expectations and failure to align care goals	Divergence between patient/caregiver expectations and healthcare professionals' goals leads to distress.
Theme 2: Communication barriers and documentation gaps	Poor communication and documentation hinder care coordination and quality.
Theme 3: Limited availability of post-discharge support	Insufficient community support for patients' post-discharge creates strain.
Theme 4: Inadequate planning and coordination	Lack of standardisation in discharge planning leads to delays and risks.
Theme 5: Fragmentation in policy	Need for better integration between hospital and community services.

Statements/Quotations	Keywords	Codes	Themes
"Sometimes patients want to leave even when it's not recommended."	not recommended	Lack of understanding	**Unrealistic expectations and failure to align care goals create challenges in patient-provider relationship.**
"Some people come in not knowing what rehab even is."	Not knowing		
"Patients fear the unknown while in hospital. Patients oftentimes cannot anticipate the recovery process or what their life will be like when discharged from the hospital."	Fear the unknown, cannot anticipate		
"The patient has unrealistic expectations. They expect to return to the exact same condition prior to their accident."	Unrealistic expectations	Unrealistic expectation	
"Sometimes caregivers demand an unreasonable amount of rehabilitation (such as 4 hours of rehab per day)."	Unreasonable amount		
"On one hand, we do not want to discourage patients by setting expectations too low. On the other hand, setting high expectations can lead to disappointment and emotional distress for both healthcare providers and patients and their caregivers if expectation are not met."	Discourage, disappointment, emotional distress	Communicate expectation	
"There is a need for formalized process that ensures the team can set realistic expectations and communicate them clearly to all participants."	Set realistic expectations, communicate clearly		
"I get very frustrated when I get a new patient and they have an incomplete chart."	Incomplete chart	Documentation gaps	**Communication barriers and documentation gaps impact quality of care.**
"It sometimes feels like we're handed a script to follow, without any say in its writing."	Without any say		
"The lack of communication may be perceived as a sign of lack of empathy on the part of the care provider."	Lack of empathy	Perceived low-quality care	
"If a patient feels that their concerns are not being heard or that their care providers are not adequately prepared or are incompetent, they are more likely to be uncooperative and less engaged in their own care."	Not being heard, uncooperative, less engaged		
"Ensuring that the patient's voice is not just heard, but also integrated into the care plan."	Integrated into the care plan	Inclusive care	
"One patient stopped eating for a while, but started eating again once we brought a translator."	translator	Communication barriers	
"Patients can feel helpless when they can't communicate."	helpless		

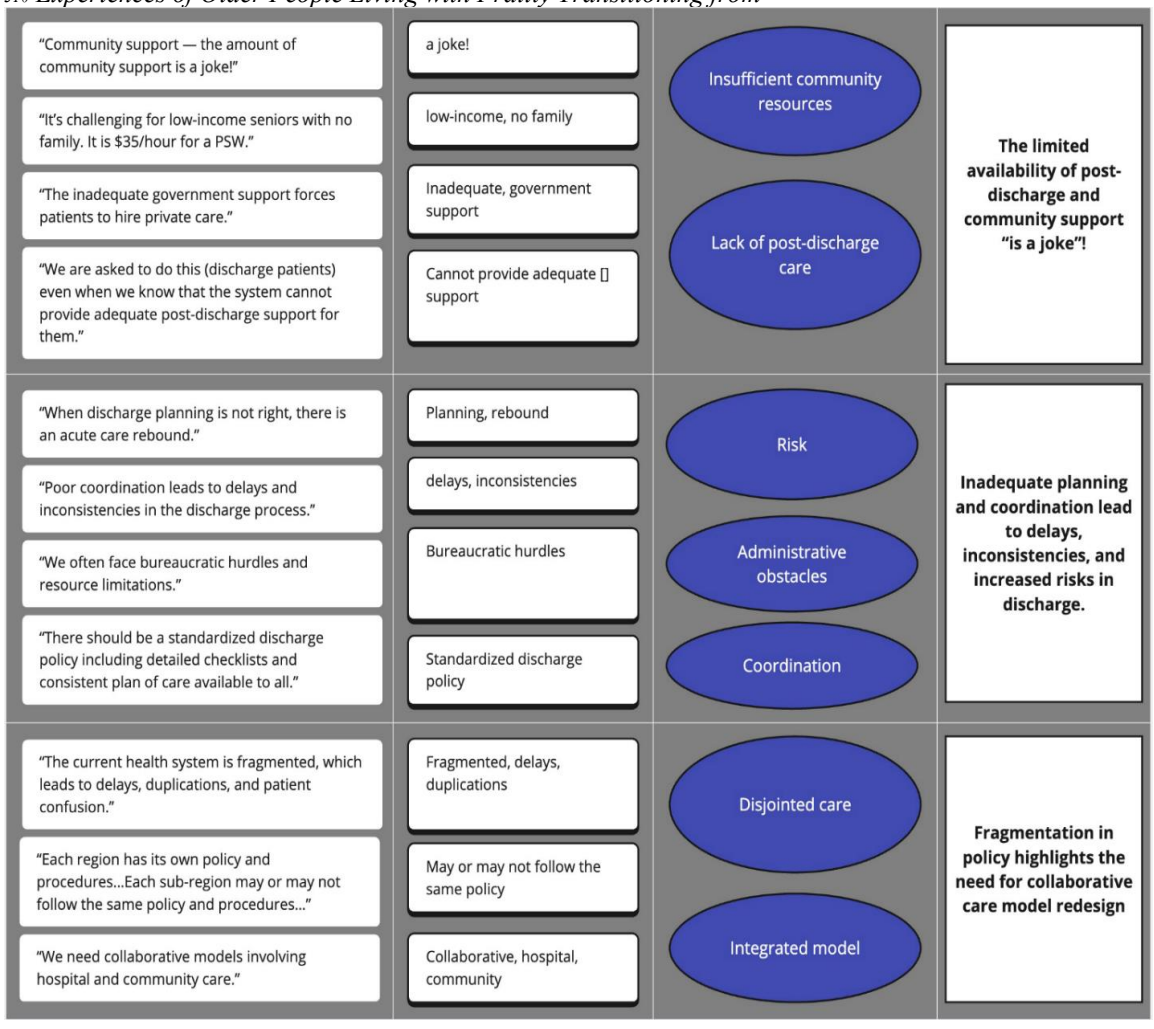


Figure 3: FG3 Theme Coding

Unrealistic Expectations and Failure to Align Care Goals Create Challenges in Patient-Provider Relationship

FG3 participants spoke of the lack of correlation of expectations amongst healthcare professionals, patients, and caregivers on the discharge process. The unrealistic expectations of patients and caregivers towards the care outcome and discharge schedule usually cause psychological trauma and organisational issues among the healthcare providers. Among the main arguments of the discussion were:

Excessive expectations: The patients wanted to return to their state before illness, and this was often not medically possible. Healthcare providers observed that complicated patients needed a longer in-hospital recovery and rehabilitation.

One HCP shared:

"The patient has unrealistic expectations. They expect to return to the exact same condition prior to their accident." [Appendix 6-HCP009]

Non-compliance: Some patients insisted on returning home before they were medically ready, while others ignored rehabilitation advice. This created friction between patients, caregivers, and healthcare professionals. One healthcare professional expressed frustration:

"Sometimes patients want to leave even when it is not recommended." [Appendix 6-HCP008]

Patient emotional distress: The group noted that the uncertainty surrounding recovery led to frustration and disappointment, which ultimately impacted recovery progress:

"Patients fear the unknown while in the hospital. Patients often cannot anticipate the recovery process or their life when discharged from the hospital." [Appendix 6 – HCP 008]

FG3 concluded that misaligned expectations created significant barriers to effective care transitions. A standardised discharge protocol involving patients and caregivers to align expectations was suggested to address this issue.

Communication Barriers and Documentation Gaps Impact Quality of Care

Participants in FG3 identified communication breakdowns and documentation gaps as significant obstacles in ensuring quality care during the transition process. The challenges included:

Incomplete patient information: HCPs discussed the frustration of receiving incomplete charts or outdated patient information, which made it challenging to provide appropriate care. One participant shared:

"I get very frustrated when I get a new patient, and they have an incomplete chart." [Appendix 6-HCP006]

Lack of empathy: Poor communication between providers and patients leads to misunderstandings, which patients sometimes interpret as a lack of empathy. One HCP stated:

"The lack of communication may be perceived as a sign of a lack of empathy on the part of the care providers." [Appendix 6 – HCP 007]

FG3 stressed clear, empathetic communication as a key to developing trust between patients and caregivers and when transitioning between the hospital and home. Cultural sensitivity training and standardised shift reports were possible solutions to enhance communication.

The Limited Availability of Post-Discharge and Community Support

The lack of community support for patients transitioning home from the hospital was a significant concern raised by FG3. Key issues included:

Inadequate support: Many participants expressed frustration with the lack of available PSWs in the community, which left patients without the necessary care post-discharge. One participant remarked:

"The amount of community support is a joke!" [Appendix 6-HCP005]

Cost of care: For patients who could afford private care, the cost of hiring PSWs was prohibitive for many older adults with frailty, exacerbating health inequalities. One PSW participant noted:

"It is challenging for low-income seniors with no family. It is $35/hour for a PSW." [Appendix 6-HCP001]

FG3 suggested that subsidised care programs for low-income patients could help alleviate these challenges and improve the post-discharge transition.

Inadequate Planning and Coordination Lead to Delays, Inconsistencies, and Increased Risks in Discharge

Another significant matter FG3 addressed was the absence of coordination of healthcare teams and organisations in discharge planning. The delays and discontinuity of the discharge procedures were common due to bureaucratic procedures and scarcity of resources:

"Poor coordination leads to delays and inconsistencies in the discharge process." [Appendix 6 – HCP006]

FG3 recommended the implementation of a standardised discharge policy, including a checklist for all HCPs involved in patient care to ensure consistent planning:

"There should be a standardised discharge policy including detailed checklists and a consistent plan of care available to all HCPs involved in a patient's care journey." [Appendix 6 – HCP009]

Lastly, the disintegration of policies between various regions and organisations in Ontario was a serious impediment to adequate care transitions. FG3 underscored the need for a collaborative model of care that would address the gap between hospital and community care:

"The current health system is fragmented, which leads to delays, duplications, and patient confusion." [Appendix 6 – HCP 004]

The group advocated for a collaborative model to integrate services from different providers, ensuring cohesive care for older adults transitioning from hospital to home.

The FG3 discussions highlighted several important obstacles to successful transitions among frail older adults. These included a mismatch in expectations, poor communication, inadequate post-discharge follow-up, failure to plan appropriately, and policy fragmentation. FG3 suggested standardised protocols, such as improved communication mechanisms and collaborative care models, to solve these challenges. The second phase of this study will assess such findings within the context of a systemic healthcare redesign project..

Discussion

The main aim of this paper was to understand the experiences of OPLF and their primary health partners during the transition from hospital to home within the Ontario Health Teams (OHT) model. This paper examined these experiences through a qualitative descriptive method, which included three focus groups (FGs) with OPLF and their essential care partners, healthcare professionals (HCPs), and administrators.

It is widely recognised in the literature that the benefits of integrated care, especially within the frailty context, have been proven to positively impact health-related quality of life and negatively impact hospital readmissions in the case of hospital-community transitions that are well supported (Gérain & Sech, 2019). Empowerment to self-manage conditions at home has been demonstrated in previous studies to enhance patient satisfaction, which is the aim of integrated care models. However, this study found that these outcomes are only achievable when critical systemic issues are addressed. Communication barriers, poor allocation of resources, and separation between hospital and community services were the most significant barriers noted by the participants. These problems jeopardise the future of integrated care and should be dealt with to offer effective care transitions.

The findings of this article can supplement the literature positing that successful transitions are premised on the integration of care between the different sectors of the

healthcare system. The discussions of the three focus groups identified a set of themes, which can be categorised as significant impediments to smooth transitions.

These results may be compared to the literature, which underlines the importance of efficient communication, adequate distribution of resources, and actively engaged patients and caregivers in healthcare choices as the mechanisms of obtaining improved transition results (Trivedi et al., 2013). Moreover, the health equity emphasis, noted in Insight Theme 6, considers that of the Quintuple Aim, which conveys health equity among other goals such as improving patient experience and reducing costs. Contemporary research should have a more direct focus on equity in the delivery of integrated care, particularly, the focus should be placed on work with marginalised populations (rural population or low-income patients, etc.).

The OHT model, which promotes the interaction of healthcare professionals, patients, their families, caregivers, and primary care professionals, has immense potential in changing care transitions. However, to succeed, systemic problems such as ineffective communication, bureaucracy, and unequal distribution of resources must be addressed. Information sharing, care coordination, and proper funding should be the focus of home and community-based care to enable OPLF to transition to the community successfully after a hospital stay.

The research reveals specific noteworthy results regarding the needs of OPLF in hospital-to-home transitions. Those findings demonstrate the significance of further, more integrated, and collaborative care within the OHT system. Despite the promises of integrated care, much remains unmet in the areas of service delivery, particularly in communication, resource allocation, and caregiver support. The gaps identified in this research will necessitate that integrated transitional care models be designed so that patients can obtain efficient and equitable services.

The Integrated Transitional Care Model (ITCM), developed because of this study, is a step in the right direction. This model is founded on the comprehensive needs of older adults living with frailty and is distinguished by the coordination of care, support of caregivers, and equality in access to healthcare resources. The OHT model of introducing the ITCM can help to significantly increase the quality of care among the OPLF and reduce the burden on their caregivers. Future research must address this model's long-term effectiveness and identify how to organize care better, allocate resources, and provide more support services for essential care partners. The introduction of digital tools, such as remote monitoring and data sharing, could assist the ITCM in becoming more effective by offering opportunities to implement the interventions promptly and increasing the continuity of care.

The other aspect that emerges in the study is the involvement of the ECPs in the care planning, particularly the informal caregiver who takes centre stage in the transition

management process. The ITCM should include a mechanism that will ensure the essential care partner receives education, emotional support, and respite care to prevent caregiver burnout and maintain the healthy lives of both the patient and the essential care partner.

This paper has generated practical findings that could be used to inform improved healthcare experiences related to the transfer of OPLF between hospitals and home. Key findings indicate that an elaborate transitional care model should be developed to address the various demands of the patients, essential care partners, and health care providers. The ITCM, as proposed in this study, has been designed to fill the communication gaps and resource limitations and support caregivers with collaborative care and technology-based solutions.

Early ITCM implementation has shown positive results, as it has already been found to deliver improved patient outcomes and caregiver well-being in initial tests. Further development and expansion of this model across Ontario- and potentially within other regions- would lead to more efficient and sustainable healthcare provision that could reduce unnecessary hospital readmissions, increase patient satisfaction, and provide more help to essential care partners. Future funding models should precede community-based care and equitable distribution of resources and enhance cooperation across the sectors.

The ITCM requires a significant policy shift to support patients, especially older adults living with frailty. ITCM would be successful by incorporating changes in policy that encourage integrated care teams, digital health tools, and enhanced integration of financing across health sectors. Policymakers must also address structural imbalances in accessing care, particularly for members of rural or marginalised populations.

The evidence of this study will be disseminated through various platforms to communicate this information to appropriate stakeholders. The results will be discussed in the form of an online seminar to collect feedback on the results from healthcare professionals, caregivers, and policy experts. In addition, group presentations will be made to professional organisations such as the Social Work Association, Registered Nurses Associations, patient-family advisory councils, and Ontario Health Teams to engage interested parties in policy-making. Scientific publications and conference presentations will also be used to disseminate the findings to a broader audience through social media, podcasts, and presentations by the hospital discharge team.

This study has several strengths that render it interesting in the research of OPLF in the hospital-to-home transition. One of the most significant strengths is the multi-stakeholder approach involving the patient, caregivers, healthcare professionals, and administrators. Such a technique provided a holistic account of the barriers and facilitators in the transitioning process. In addition, the study's sample size (58 participants) was robust,

ensuring rich and in-depth data. Finally, the OHT model introduced a timely and topical model for evaluating integrated care. Even though the study is intense, it also has some limitations. Recruitment challenges influenced the richness of the data, as we experienced a high drop-out rate among the OPLF. In addition, healthcare workers were concerned with the repercussions or consequences of sharing their experience when discharging patients from the hospital. This may have led to some form of prejudice in the feedback provided. Lastly, focus group sizes (in FG1 and FG2) may have limited individual contributions. In future research, it is recommended to separate larger focus groups into small groups of respondents in distinct categories so that the researchers can understand their specific opinions more deeply.

Conclusion

This study presents valuable insights into the issues and challenges OPLF and their caregivers, health care professionals, and hospital administrators face during the hospital-to-home transition. Using a qualitative methodology coupled with the Ontario Health Teams (OHT) conceptual framework throws light on the issues of the care transition process and the need to provide comprehensive and patient-centred care. The outcomes emphasise how important good communication, cooperation, and holistic care are in the transition process.

The study came up with six key themes that must be present in improving transitional care of the older adult living with frailty namely necessity of holistic care, therapy of familiar environments, participation of patient and caregivers, the impact of a lack of connectivity in the provision of care between hospital and community care, the role of more support to informal care givers, and the role of inequity in accessing care. It is important to consider and explore such themes to facilitate better care outcomes and reduce hospital readmissions for OPLF and complex medical and social needs.

The introduction of the Integrated Transitional Care Model (ITCM), a continuation of the OHT model, is a potentially effective means of helping OPLF through coordination and the use of technologies in care provision. ITCM is also committed to patient and caregiver empowerment, caregiver support, resource allocation, and care equity to offer an ideal transition between the hospital and home or community. The initial application of the ITCM has been positive, particularly in decreasing hospital readmission rates and improving the living standards of OPLF.

This paper reaffirms the significance of change in the healthcare system, specifically the alignment of care among hospitals, primary care, and community services. The findings show that policy reforms must focus on enhancing communication, providing equal access to resources, and supporting caregivers to create a more unified healthcare system. The OHT model can achieve much by addressing the gaps, and hence, older adults may age in place with dignity and support.

Lastly, the paper spotlights the challenges of OPLF and their essential care partners in care transitions and offers practical solutions to barriers in the OHT model. Through collaboration and active listening skills, the healthcare system will enhance the continuity of care and provide high-quality and more personalised care to OPLF.

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