The Voice Project: Exploring older adults’ experiences of managing multiple chronic conditions during care transitions with participatory visual narrative methods

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- Research program is focused on improving the quality, safety and experience of older adults as they navigate the healthcare system

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- Largest English-French bilingual university in the world
- Over 35,000 undergraduate students per year
- Over 6,000 post-graduate students per year
We know…

• Care transitions lead to fragmentation in care, decreased quality of care, and an increase in adverse events (McMurray et al., 2013, Forster et al. 2003, Kripalani et al. 2007, Laugaland et al., 2012)

• Older adults (>65 years) with multiple chronic conditions comprise of 5% of the population which accounts for approx. 66% of the health care costs (OMHLTC, 2012)

• Engaging patients and families can improve their quality of care (Carmen et al. 2013, Entwistle et al. 1998)
Purpose

• To explore the experiences of older adults with multiple chronic conditions while moving across the health care system, and identify potential areas for future interventions.
Methods

• Qualitative descriptive study
• 60-90 min audio-recorded patient/family co-led photo walkabouts (n=9)
• Capture ‘visual’ experiences instead of only verbal events
• Actively engage patients and families
Inclusion criteria

• Older adults
• Managing at least two chronic conditions
• Receiving primary care services for greater than 90 days
• Experienced at least one transfer across sectors within the past 90 days
• Aged 50 years or older
• Were legally competent
• Family members at least 18 years of age
Results

• **Theme 1:** Active involvement in care transitions: partners in care planning, families as critical advocates, getting organized for self-monitoring, acting upon previous experiences

  - **Medication cabinet**
  - ‘Tracking’ schedule for symptom management, and for follow-up appointments
Results

• **Theme 2:** Positive experiences during care transitions: coordination of care between sectors, nurses involvement in care coordination

• **Theme 3:** Accessing community services and resources: responsive and personalized care, home support, and knowledge of resources
Results

Documents of community resources available

Mobile app to track medications
Results

• **Theme 4:** Challenges with follow-up care: difficulties booking follow-up appointment, challenges getting to follow-up appointments, timely access to primary care, adverse events post-discharge

• **Theme 5:** Lack of meaningful engagement during discharge planning: lack of involvement in discharge planning, not prepared for discharge

• **Theme 6:** Presence of systemic barriers in care transitions: limited access to resources, provider-centered care
Opportunities

• Strengthening support for person- and family-centered integrated care

• Engaging older adults and families in their care management and care transitions in meaningful ways

• Providing adequate support/resources for family members and informal caregivers
Conclusion

- Perspective of older adults and their families
- Lack of meaningful engagement during care transition
- Importance of active involvement in managing their care transitions
- Insights on methods to better engage patients and their families