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POSTER ABSTRACT

Improving Home Care Integration in East Toronto through Stakeholder-Informed Communication Strategies

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Background: In 2023, East Toronto Health Partners (ETHP), an Ontario Health Team, launched the Integrated Neighbourhood Home Care Program as part of the province's Leading Projects (LP) initiative to test new models of home care. One of seven LPs across Ontario, the ETHP program embeds home care within local community Health Access centres that bring together primary care, social services, and home care providers at the neighbourhood level.

Methods: The East Toronto LP model was designed to reduce fragmentation in response to patient and family feedback about the difficulties created by health system silos. Implementation planning showed that mechanisms for information-sharing and collaboration were insufficient, posing risks to effective integration. These gaps highlighted the need for focused stakeholder interviews with frontline staff.

The LP team conducted semi-structured interviews with family physicians, nurse practitioners, occupational therapists, home care coordinators, and social workers. Interviews explored routine, urgent, and transitional care scenarios (e.g., chronic disease management, acute respiratory exacerbation, and post-stroke recovery) and elicited pain points, workarounds, and ideal communication pathways. Transcripts were analyzed thematically to identify cross-cutting issues and opportunities.

Results: Stakeholders consistently described:
1. Fragmented tools: Dependence on fax, phone calls, and siloed EMRs created delays and duplication; providers often unaware of services delivered or declined.
2. Closed-loop gaps: No reliable mechanism to confirm receipt of updates or care plan changes; feedback loops often absent.
3. Information asymmetry: Families were frequently the only link relaying concerns between home care and primary care, creating inequities and missed opportunities for early intervention.
4. Variation in readiness for technology: While some providers welcomed secure digital messaging or integrated EMR access, others preferred simple phone/fax systems, highlighting the need for flexible solutions.

Implications: The LP model was initially shaped by feedback from patients and families who experienced the challenges of health system silos. Subsequent engagement with frontline providers helped identify communication barriers and opportunities to strengthen the model's design. Interview findings highlight that successful neighbourhood-based home care integration depends on more than structural reorganization. It requires reliable, bidirectional communication pathways that support coordinated, person-centred care.

Stakeholders consistently advocated for simple but standardized tools, including periodic summary reports, secure direct messaging, and clear escalation channels for urgent issues. Embedding these practices into the LP offers transferable lessons for other Ontario Health Teams. Integration relies not only on co-location and defined roles, but on co-designed communication norms grounded in frontline realities.

This work demonstrates how inclusive engagement across patients, families, and providers can build workforce capability, strengthen collaboration, and foster shared ownership in neighbourhood-based care delivery.