



RESEARCH SUMMARY | STUDY 9

Community Assets Supporting Transitions (CAST) - A pragmatic effectiveness-implementation trial to evaluate a hospital-to-home transitional care intervention compared to usual care for older adults with multiple chronic conditions and depressive symptoms

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STUDY PARTNERS

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What is this research about?

Transitioning home from hospital is challenging for older adults with multiple chronic conditions (MCC) particularly when they are also experiencing symptoms of depression. Researchers are evaluating the Community Assets Supporting Transitions (CAST) program, a new hospital-to-home transitional care program that aims to reduce depressive symptoms, improve patients' quality of life and self-management ability, and support family caregivers. Researchers will determine the effects, implementation, and costs of CAST, a 6-month program that will be delivered by Registered Nurses who will support patients transitioning from hospital to home through in-home visits, telephone follow-up, and care coordination. The researchers are working side-by-side with patients, caregivers and providers from three communities in Ontario to tailor the intervention to each community. The three partner communities include Sudbury, Burlington and Hamilton.

How will the researchers get their findings?

Hospitals in each partnering community will recruit 72 patients, for a total sample size of 216. A pragmatic randomized controlled trial will be used to compare patients receiving the CAST program plus usual care to a usual care-only control group. This trial is based on a CIHR-funded feasibility study that was conducted in collaboration with the Hamilton Niagara Haldimand Brant Community Care Access Centre.

What do the researchers expect to find?

Researchers will examine the effects, implementation, and costs of the 6-month CAST program for older adults with depressive symptoms and MCC. The overall goal is to improve health outcomes in these older adult patients, and reduce the use of expensive health services, e.g., hospitalization.

Why is there a need for this research?

Typically, older adults with MCC require more health services and have a higher risk of hospitalization compared to those with one chronic condition. The transition home from hospital increases the risk for depression, yet depression is often undiagnosed or undertreated in this population. Older adults with MCC as well as their family caregivers often find it challenging to navigate and coordinate the range of essential healthcare services when those services are provided by multiple medical specialists working in different locations.

About the ACHRU

Aging, Community and Health Research Unit (ACHRU) researchers work together with older adults with MCC and their family caregivers to promote optimal aging at home. The ACHRU designs and evaluates new and innovative community-based healthcare interventions to improve access to healthcare and quality of life. Studies focus on the prevention and management of MCC, for seniors who have dementia, depression, diabetes and/or stroke.



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