Understanding the Transition to Long-Term Care Homes: Perceptions of Family Care Partners of Older Adult Veterans

Georgia Ann Stewart

Thesis submitted to the University of Ottawa in partial fulfillment of the requirement for the Master of Science degree in Interdisciplinary Health Sciences

Interdisciplinary School of Health Sciences

Faculty of Health Sciences

University of Ottawa

Supervisor: Dr. Annie Robitaille

Abstract

Veterans and their family care partners represent a distinct demographic with unique needs that may differ from the general population. The transition to a long-term care home (LTCH) has the potential to profoundly impact older adult Veterans and their family care partners; however, there is a paucity of research on how this move affects them specifically. This qualitative descriptive (QD) study explored the experiences and needs of older adult Veterans and their family care partners transitioning into a LTCH from the perspective of nine care partners. Purposive sampling was used to recruit family care partners of Veterans living in LTCHs across Canada. One-time semi-structured interviews were conducted. Coding and thematic analysis were used to iteratively categorize and synthesize the data. The findings revealed three overarching themes with sub-themes: 1) information gaps and knowledge use, 2) feeling valued, recognized, and supported, and 3) the health and well-being of the Veteran/care partner. These themes were seen throughout all stages of the move to a LTCH, including the pre-transition, during-transition, and post-transition stages, and either served to impede or assist in a positive transition. The results of this study contribute to an increased awareness of the specific challenges and facilitators faced by care partners and Veterans moving into a LTCH. Further research is warranted in order to create tailored programs and policies that better support the needs of this population throughout this transition.

Résumé

Les Vétérans et leurs partenaires de soins familiaux représentent une population distincte, avec des besoins uniques qui peuvent différer de ceux de la population générale. La transition vers un foyer de soins de longue durée (SLD) peut avoir un impact profond sur les Vétérans plus âgés et leurs partenaires de soins; cependant, il existe peu de recherches sur la façon dont cette transition les affecte spécifiquement. Cette étude qualitative descriptive (QD) a exploré les expériences et les besoins des Vétérans âgés et de leurs partenaires de soins familiaux en transition vers un SLD, du point de vue du partenaire de soins. Un échantillonnage raisonné a été utilisé pour recruter des partenaires de soins familiaux d'Vétérans vivant dans des foyers de SLD à travers le Canada. Des entretiens semi-structurés ont été menés en une seule fois. Le codage et l'analyse thématique ont été utilisés pour catégoriser et synthétiser les données de façon itérative. Les résultats ont révélé trois thèmes principaux avec des sous-thèmes: 1) les lacunes en matière d'information et l'utilisation des connaissances, 2) le sentiment d'être valorisé, reconnu et soutenu, et 3) la santé et le bien-être du Vétéran/partenaire de soins. Ces thèmes ont été observés à toutes les étapes de la transition vers un foyer de SLD, y compris avant, pendant et après la transition, et ont soit entravé, soit favorisé une transition positive. Les résultats de cette étude contribuent à une meilleure prise de conscience des défis et des facilitateurs spécifiques auxquels sont confrontés les partenaires de soins et les Vétérans qui s'installent dans un foyer de SLD. , D'autres recherches sont nécessaires pour créer des programmes et des politiques adaptés qui répondent mieux aux besoins de cette population tout au long de la transition.

Acknowledgements

I would like to thank the following individuals, without whom this research would not have been possible. First and foremost, I owe my deepest gratitude to my thesis supervisor, Dr. Annie Robitaille. I am incredibly thankful to have had such a supportive role model who encouraged me to pursue my research interests and provided numerous opportunities for growth and learning. Your oversight, guidance, and expertise made this thesis possible.

I would also like to thank my thesis advisory members and examiners, Dr. Linda Garcia, Dr. Kim Ritchie, and Dr. Raywat Deonandan, for their support and contributions to this project. Additionally, I am sincerely thankful for Dr. Kelly A. Pilato. Your kindness and encouragement throughout the past two years have helped me immensely. I would have been lost in the qualitative research world without you.

I would like to show my gratitude to all the family care partners who participated in this research. Your time and willingness to share your experiences were invaluable to this project. Thank you for allowing me to share your stories.

Additionally, I am grateful to all of the members of the Veterans Advisory Committee. Your expertise and advice were an asset to this study. I would also like to thank all of the research team members involved in the larger project my thesis was a part of—a big thank you to Michaela Adams for your help with participant tracking and scheduling interviews.

Finally, I would like to thank all my family and friends for their constant and unwavering support throughout the past two years. To my friends, thank you for the laughs when I needed them and the reminders to take breaks. To my sister Lily, even though you are younger than me, your wisdom and advice have helped me more than you know in completing this thesis. To my mom and dad, thank you for instilling many of the characteristics I have today that have allowed

me to pursue education at this level. Mom, thank you for your grammatical expertise and for always being there for me. Dad, thank you for being there to listen to me and knowing when I needed a good laugh.

Table of Contents

List of Abbreviations

CAF	Canadian Armed Forces
CCHS	Canadian Community Health Survey
CLSA	Canadian Longitudinal Study on Aging
LASS	Life After Service Survey
LTCH	Long-term care home
QD	Qualitative descriptive
PTSD	Post-traumatic stress disorder
SOC	Sense of Community
VAC	Veterans Affairs Canada
VIP	Veterans Independence Program
WHO	World Health Organization

Chapter 1: Introduction

1.1 Veterans' Health and Well-Being

Veterans make up approximately 1.5% of the Canadian population aged 17 and older (Statistics Canada, 2022), with an average age of 67 years old (Wolfson et al., 2023). By 2026, nearly 33% of the Veteran population will be over 70 years old (VanTil et al., 2018; Veterans Affairs Canada, 2022). It is clear from these statistics that a significant cohort of Veterans are reaching the age at which they may need additional support. Unsurprisingly, researchers have shown how the health and well-being of older Veterans are often related to their history of military service, and it is therefore crucial that their unique needs be identified and addressed (Aldwin et al., 2018; Veterans Ombudsman, 2017).

Although those who enter the military are generally selected to have better mental and physical health than civilians of the same age (Aldwin et al., 2018), these individuals are also more likely to be exposed to combat trauma and other extreme stressors, putting them at increased risk of adverse health outcomes (Spiro III & Settersten Jr., 2012). Over the past twenty years, there has been a significant shift in the landscape of Veteran health and well-being (Brydges et al., 2024). Research indicates that recently released Canadian Veterans are facing more health issues compared to those released in earlier decades (Brydges et al., 2024). Further, Sweet et al. (2020) used data from the Life After Service Studies (LASS) 2013, 2016, 2019 survey and the Canadian Community Health Survey (CCHS), and found that Veterans were twice as likely to report chronic pain as well as higher rates of health issues such as back problems, arthritis, depression, anxiety, and post-traumatic stress disorder (PTSD) compared to Canadians in the general population. Thompson et al. (2016) also used data from the LASS survey and noted that hearing problems were more prevalent among Veterans when compared to

the civilian population. An additional study that compared Veterans to the Canadian population found that Veterans reported a higher prevalence of needing help with one or more activity of daily living, fair or poor physical and mental health, lifetime suicidal ideation, being diagnosed with a mood or anxiety disorder, migraines, chronic pain, gastrointestinal problems, cardiovascular disease, and high blood pressure (Hall et al., 2022). These findings demonstrated how Veterans differ from Canadians in various areas of health and well-being, further highlighting their unique needs (Hall et al., 2022).

Since Veterans are at an increased risk of chronic health conditions compared with other Canadians (Hall et al., 2022; Sweet et al., 2020), they may need more support to remain living in the comfort of their own home (Williams et al., 2016). In a 2017 report by the Veterans Ombudsman on the journey from home to a long-term care home (LTCH), Veterans voiced concerns surrounding a lack of support for service-related physical and mental health conditions that limit their ability to perform activities of daily living within their own home (Veterans Ombudsman, 2017). This report also stated that Veterans felt they were an added burden to their care partners because their activities of daily living often became the responsibility of a spouse or other informal care partner (Veterans Ombudsman, 2017).

1.2 Impact on Family Care Partners

Family care partners of Veterans are defined as family members, friends, or other acquaintances who provide essential care and support to former military service members (Rylee et al., 2019). These individuals represent a unique population, as the Veterans they care for can require specific needs that may differ from the general population (Pedlar & Thompson, 2011; Sweet et al., 2020). Supporting Veterans at home can often be challenging for care partners, resulting in impacts on their own health and well-being (Uphold et al., 2014). Shepherd-Banigan

et al. (2020) outlined some of the hardships that care partners experience supporting Veterans coping with traumatic stress and other ailments from their military service, which included poor physical health outcomes, feelings of isolation, concerns about stigma and high emotional stress (Shepherd-Banigan et al., 2020). Pinciotti et al. (2017) focused on care partners of Veterans living with both PTSD and dementia and found that they were at a greater risk of adverse health outcomes than those caring for Veterans with only dementia. Their study emphasized how comorbidities among Veterans can result in additional challenges for care partners, ultimately putting them at a greater risk for negative caregiving consequences (Pinciotti et al., 2017). To prevent these adverse effects, care partners require support.

1.3 Available Resources

In Canada, many resources are available to Veterans and their care partners through various organizations. The Veterans Transition Network has created a comprehensive list of these services and the organizations that offer them (Veterans Transition Network, n.d.) For example, the Veteran Family Program provided by Veterans Affairs Canada (VAC) gives medically released CAF (Canadian Armed Forces) members and their families continued access to the Military Family Resource Centre (Veterans Affairs Canada, n.d.). These resources include group sessions on topics related to transitioning from military to civilian life and a mental health first aid course (Veterans Affairs Canada, n.d.). The Caregiver Recognition Benefit is another program offered by VAC, which involves a tax-free monthly benefit for the person providing care, allowing Veterans to remain at home for as long as possible (Veterans Affairs Canada, n.d.).

In addition to the resources discussed above for care partners, some organizations offer services for Veterans. The Treatment Benefits Program, created by VAC, includes 14 programs

of choice: dental services, hearing services, hospital services, medical supplies, prescription drugs, psychological counselling, and many others (Veterans Ombudsman, 2017). Another resource of use to Veterans is The Veterans Independence Program, which was developed to help Veterans stay in their own homes for as long as possible while maintaining their dignity and health (Veterans Ombudsman, 2017). This program provides financial contributions for home care services such as grounds maintenance, housekeeping, personal care, access to nutrition, health services, ambulatory care, transportation, and home adaptions (Veterans Ombudsman, 2017). In addition to the programs offered by VAC, several other organizations have resources for Veterans, including The Royal Canadian Legion, Solider On, Veterans Emergency Transition Services (VETS) Canada, and many more. These resources can help alleviate some stress; however, it is often not enough (Veterans Affairs Canada, 2019).

Despite these available services, Veterans and their families still feel there is a lack of adequate support (Veterans Ombudsman, 2017). A report done in Canada looked at the challenges faced by Veterans and their families across the continuum of care (at home, in assisted living, and in a LTCH) regarding access to and use of the current programs and services in place for this population (Veterans Ombudsman, 2017). Some of these challenges included a lack of timely follow-up regarding Veterans' medical care, insufficient support for instrumental activities of daily living, and eligibility criteria for accessing housekeeping and group maintenance services, excluding Veterans' family care partners (Veterans Ombudsman, 2017). If home care services and programs cannot meet the needs of Veterans and their family care partners, this can often lead to the decision to move into a LTCH (Veterans Ombudsman, 2017). While the literature generally supports the idea that ageing in place is the ideal situation and contributes to the quality of life of the Veteran, it is important to recognize that living in a home

or neighbourhood that does not meet one's needs can result in poorer physical, psychological, and social outcomes (Pinazo-Hernandis et al., 2022). Hence, for some family care partners and Veterans, the choice to move into a LTCH can be the preferred option regardless of whether they had more support at home (Kokonya & Fitzsimons, 2018).

1.4 Veterans Living in Long-Term Care Homes in Canada

Once Veterans receive a bed in a LTCH, their unique needs must be addressed, as they differ from the general aging population (Katz, 2012; Pedlar & Thompson, 2011). In a recent study by Gauvin et al. (2022), which used data from the Canadian Longitudinal Study on Aging (CLSA), it was discovered that CAF Veterans were more likely to screen positive for PTSD compared to civilians. A study on World War II Veterans in LTCHs in Canada assessed 67 Veterans for PTSD and reported that 23% met the diagnostic criteria for lifetime PTSD (Herrmann & Eryavec, 1994). Of those Veterans with PTSD, 57% experienced chronic symptoms (Herrmann & Eryavec, 1994). Research has also found that Veterans with PTSD are twice as likely to develop dementia than those without PTSD (Qureshi et al., 2010; Ritchie et al., 2022). These co-occurring conditions require more time and resources to be allocated to Veterans living in LTCHs (Ritchie et al., 2022). Therefore, giving the same support to this population without considering the differences in care complexities may contribute to the difficulty in meeting Veterans' care needs in this setting (Ritchie et al., 2022). Additionally, Veterans have been reported to have higher rates of anxiety disorders, migraines, chronic pain, gastrointestinal problems, cardiovascular disease, and higher blood pressure (Hall et al., 2022). As Veterans transition into a LTCH, these health conditions must be considered.

When living in a LTCH, trauma-related stimuli in the environment can cause symptoms associated with dementia and PTSD to worsen among Veterans (Cook et al., 2003). Carlson et al.

(2008) looked specifically at potential triggers for Veterans with PTSD living in a LTCH. They found these included staff members speaking a different language, seeing other bedridden residents, and staff appearing angry or impatient. These scenarios reminded Veterans of wartime experiences leading to a re-activation of distress associated with their past trauma (Carlson et al., 2008). To better support Veterans in LTCHs, it is essential to consider the unique impact that different stimuli in this environment have on them.

In addition to the impacts of LTCHs' physical settings on Veterans, their social and emotional needs must also be met. Although the literature is limited on the social care needs of Veterans in LTCHs, a recent scoping review was conducted to explore this area of research (Gillin et al., 2024). They found that while Veterans had similar social connections, care preferences, and autonomy needs compared to those of civilians in LTCHs, they differed in their social care needs due to their military backgrounds (Gillin et al., 2024). This can often look like providing activities in LTCHs that acknowledge the life history of Veterans (Veterans Ombudsman, 2014). In a review by Veterans Affairs Canada (2019), they discussed some of the benefits of LTCHs providing activities tailored to Veterans. These events put on by the LTCHs contributed to filling Veterans' social needs and providing them with a sense of community (Veterans Affairs Canada, 2019). This highlighted the potential advantages of Veteran-specific support in LTCHs.

1.5 Family Care Partners of Veterans in Long-Term Care Homes

Research on civilian family care partners of older adults living in LTCHs has found that they experience a wide range of emotions due to their changing roles concerning how they care for and support their family members (Eom et al., 2016). Alonso et al. (2017) reported on the mental health, quality of life and caregiving satisfaction of civilian care partners with a family

member in a LTCH. The results showed that care partners experienced feelings of guilt and loss towards their family members living in LTCHs (Alonso et al., 2017). However, a good relationship and cooperation between the staff of the LTCH and the family improved the care partners' emotional health and quality of life (Alonso et al., 2017). Given that the care partners in this study were not specific to Veterans, it is essential to consider that the experiences of care partners of Veterans may differ.

There is limited research on family care partners of Veterans' experiences with LTCHs. Petrovic-Poljak and Konnert (2013) investigated how facets of Sense of Community (SOC; i.e., feeling of belonging, having influence, having needs met, and having an emotional connection to individuals in a community) were related to outcomes among family members of Veterans in LTCHs. This study used self-report questionnaires to assess caregiving variables and SOC (Petrovic-Poljak A et al., 2013). They discovered that SOC was positively associated with family adjustment and satisfaction with care (Petrovic-Poljak A et al., 2013). This meant that if the care partner felt their needs and those of the Veteran were being met by the LTCH staff, their LTCH experience was viewed more favourably (Petrovic-Poljak A et al., 2013). They also found that care partners' connections to the military community were positively related to SOC in LTCHs (Petrovic-Poljak A et al., 2013). Although this study offered insight into how feelings of belonging and having one's needs met contribute to positive outcomes among care partners of Veterans, further research is required concerning their specific needs and how they can be met. Being aware of the needs of care partners will not only improve their experiences but also those of Veterans living in LTCHs (Eom et al., 2016).

1.6 Transition into Long-Term Care Homes for Veterans and their Care Partners

An important factor that influences Veterans' and their care partners' experiences with LTCHs is the transition to the home (Kokonya & Fitzsimons, 2018). The transition to a LTCH can start months or sometimes even years before the Veteran actually moves into the home and continues until they are adjusted to their new environment (Kokonya & Fitzsimons, 2018). This transition period from the community to a LTCH can be a challenging time for both Veterans and their care partners as it is often met with uncertainty (Veterans Ombudsman, 2014). In Canada, an important factor that specifically impacts the transition for Veterans and their care partners is the type of bed they are eligible to apply for (Veterans Ombudsman, 2014). Community beds are found in provincially licensed homes and are available to all residents of the province, while contract beds are identified and funded for priority access by Veterans under federal-provincial agreements (Veterans Ombudsman, 2014). Many contract beds can be found in former federal Veteran hospitals, and others are available in smaller numbers in 197 provincially licensed LTCHs across Canada (Veterans Ombudsman, 2014). While community beds offer a range of recreational activities for their residents, homes with contract beds may provide programming specifically for Veterans, including music therapy, woodworking, horticultural therapy, memorial walls, and enhanced remembrance ceremonies (Veterans Affairs Canada, 2019). Further research is needed to examine the transition and experiences of Veterans moving into both types of homes.

Regardless of the type of bed in a LTCH that a Veteran is eligible to move into, the demand for both contract and community beds currently outweighs availability (Veterans Affairs Canada, 2019). Therefore, numerous Veterans and their family members face long wait times and uncertainty concerning LTCH access (Veterans Ombudsman, 2014). Although there is

limited research on how these difficulties specifically impact Veterans' and care partners' transition experiences, studies with older adults and care partners reported that these challenges contributed to adverse health and well-being outcomes (Fitzpatrick & Tzouvara, 2019). Additionally, qualitative studies on civilian older adults and care partners transition experiences to LTCHs highlighted the need for adequate information on how healthcare systems function, options of available care, and how to access resources through all stages of the move (Brooks et al., 2022; O'Neill & Ryan, 2023). However, with minimal research on care partners' and Veterans' experiences on the transition into a LTCH, it is unknown if similar factors impact this sub-population. To improve the transition experience of Veterans and their care partners, all stages of this process must be understood, beginning with the decision to move from the community to a LTCH.

Kirchen and Hersch (2015), is one of the few studies to focus specifically on Veterans' experiences when transitioning to a LTCH. Through a qualitative phenomenological approach, they found that the importance of family, home spirituality, leisure time use, making choices, music, and military culture were factors that facilitated adjustment to a LTCH (Kirchen & Hersch, 2015). Although this study identified factors associated with how Veterans adjust to a LTCH once they have moved in, there is still a gap in research regarding their experiences with the actual transition (i.e., before, during, and after they move into the LTCH). In addition, there is no literature, to my knowledge, on how this transition impacts care partners of Veterans. This research is needed because moving into a LTCH is already something that many Veterans and their care partners view negatively (Brooks et al., 2022; Fitzpatrick & Tzouvara, 2019). This transition may be improved by learning about the experiences and needs of these two understudied populations throughout all stages of the move to a LTCH. A better understanding

of these earlier stages might also help to enhance the experiences of Veterans and their families once they have moved to their new homes.

1.7 Theoretical Frameworks

Two models can be used to investigate the transition process for Veterans and their family care partners including the Social Determinants of Health model (WHO, n.d.) and the TRANSCIT model (Groenvynck et al., 2021).

1.7.1 The Social Determinants of Health Model

The World Health Organization (WHO) defines the Social Determinants of Health model as the "conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life. These complex, integrated, and overlapping forces and systems include the social environment, physical environment, health services, and structural and societal factors" (WHO, n.d.). According to the Social Determinants of Health model (WHO, n.d.), the context of people's lives determines their health. Since Veterans possess unique life experiences that continue to impact them as they age, this is a vital aspect to consider when investigating the needs of Veterans and their care partners moving into a LTCH. In a review compiled by the Department of Veterans Affairs in the United States, the Social Determinants of Health model was used to explore the service use of Veterans compared to civilians (Duan-Porter et al., 2017). This review highlighted the importance of factoring in Veteran status, which meant acknowledging how their military experience may impact their use of services (Duan-Porter et al., 2017). They found evidence that trauma exposures may be different between Veterans and civilians, suggesting that understanding the impacts of trauma on healthcare utilization and outcomes could help to inform policies for current and future service needs (Duan-Porter et al., 2017). This supports the use of the Social Determinants of Health

model for contributing to the development of new knowledge that addresses gaps in health programs and services for Veterans and family care partners transitioning into a LTCH. Considering this population's unique needs will lead to improved health outcomes and quality of life for both Veterans and their families.

1.7.2 TRANSCIT Model

Another framework known as the TRANSCIT model can assist in transition research as it outlines the pre-, during-, and post-transition stages of the move to a LTCH (Groenvynck et al., 2021). The model validates the necessity to view the transition from the community to a LTCH as a journey (Groenvynck et al., 2021). This is an important implication for examining transition experiences to LTCHs, as previous research has often only focused on one stage of the process (Buhr et al., 2006; Kirchen & Hersch, 2015). The TRANSCIT model presents a timeline with three stages. The first is referred to as the pre-transition phase which involves the initial discussion of moving into a LTCH, the transition decision being made, and then choosing a LTCH (Groenvynck et al., 2021). The during-transition period is the time on the wait list of the chosen LTCH, which ends as soon as the older adult relocates (Groenvynck et al., 2021). The final stage is the post-transition phase, which focuses on the adjustment and acceptance of the new living environment (Groenvynck et al., 2021). This model's components and stages can help guide transition research by providing a framework that addresses all aspects of this process.

The TRANSCIT model can be used as a guideline to highlight the needs of older adults and their family care partners. It emphasizes the need for partnership, reducing the fragmentation that often occurs with translational care (Groenvynck et al., 2022). This will ultimately improve the move from the community to a LTCH for both older adults and their family members. Multiple studies indicate that negative feelings associated with moving into a LTCH can be

alleviated by a successful care transition (Groenvynck et al., 2022; Sussman & Dupis, 2014). This research mainly focused on civilians. Therefore, there is a need to specifically investigate how all phases of the transition into an LTCH impact veterans and their care partners. A better understanding of the transition from the community to a LTCH will paint a more comprehensive picture of the journey lived by older adult Canadian Veterans and their family care partners. It will also contribute to developing interventions better tailored to the needs of Veterans and their families.

1.8 Research Objective

This thesis aimed to examine the transition period to a LTCH for Veterans and their family care partners. The specific objective was: (1) To explore the experiences and identify the needs of older adult Veterans and their family care partners transitioning from the community to an LTCH from the perspective of the family care partner.

Chapter 2: Methodology

2.1 Qualitative Descriptive Approach

A qualitative descriptive design (QD) was used for this study as it aims to stay close to and describe participants' experiences. This design provides a straightforward description of experiences and perceptions (Sandelowski, 2010), particularly in areas where little is known about the topic under investigation (Doyle et al., 2020). This is especially relevant for this study as there is no research, to my knowledge, on the experience of care partners of Veterans transitioning into a LTCH. This approach also acknowledges the subjective nature of the problem and the different experiences participants have. It allows for the findings to be presented in a way that closely resembles the terminology used in the initial research question (Bradshaw et al., 2017; Sandelowski, 2000).

2.2 Paradigm and Epistemology

The literature shows that the first step in qualitative research begins with the epistemology being stated by the researcher (Burr, 2015; Cresswell & Poth, 2018; Lincoln & Guba, 2005). This position will ultimately orient and inform the methodology and methods chosen for this study (Cresswell & Poth, 2018; Tracy & Hinrichs, 2017). Social constructionism was selected to orient this research because it focuses on how social reality exists as individuals experience it, with multiple perspectives in any given situation (Burr, 2015). This is appropriate for this study since the experiences of care partners of Veterans transitioning into a LTCH are understood to have different meanings for each individual (Burr, 2015; Cresswell & Poth, 2018). Additionally, constructionism posits that the researcher must recognize their background and position themselves in the research to acknowledge how their personal and cultural experiences shape their interpretation (Cresswell & Poth, 2018). This requires the researcher to engage in reflexivity throughout the different stages of the research process.

2.2.1 Reflexivity

It is important that the researcher is reflexive and understands their role in the QD research process. Since data collection and interpretation are impacted by the characteristics and experiences of the researcher, it is vital to engage in reflexivity (Hennink et al., 2011). This process involves a "conscious self-reflection on the part of the researchers to make explicit their potential influence on the research process" (Hennink et al., 2011, p.19). I believe that the researcher cannot separate who they are from the research as my social identity and experiences are a part of who I am and will ultimately impact my research. In the present study, there are various ways my personal characteristics may have influenced the research process and are therefore important to acknowledge. Since I am a young female MSc student, I understand that

this may have impacted my interactions with family care partners during interviews. I recognize that I come from a place of privilege as a white, middle-class student and power as a researcher. I hope my role as a student helped to bridge the power imbalance. Additionally, I do not have any prior experience in the military. Therefore, this may have affected my interactions with the care partners during the interviews and later when analyzing the transcripts. To ensure that my preconceived notions and biases were challenged, I engaged in reflexivity. This was achieved through participating in critical reviews and conversations with my supervisor and members of the Veterans Advisory Committee throughout the entire research process. This began at the very beginning of this study when the interview guide was created. The questions were created in consultation with members of the Veterans Advisory Committee to ensure that they were relevant and applicable to the care partners I would be interviewing. The Social Determinants of Health model (WHO, n.d.) and the TRANSCIT model (Groenvynck et al., 2021) were also used to provide a framework for capturing the transition experiences of this population. As interviews were conducted, I kept a journal where I recorded my decisions and interpretations throughout the research process. This allowed me to continuously reflect on how I was interacting with the participants and the influence this would have on their responses. When data analysis and interpretation began, I engaged in reflexivity by continuing to have conversations with the advisory committee and my supervisor about what I was seeing in the results.

2.3 Methods

2.3.1 Participant Recruitment and Sampling

This study was part of a larger project entitled “Supporting preferences of older Veterans and families in later life to promote health and well-being”. Care partners of older Veterans (55 years or older) living in a LTCH in Canada were recruited. This included English and/or French-

speaking participants who care for a Veteran in a home with contract beds and those without. These care partners were defined as unpaid family members, friends, or neighbours who care for a Veteran. The Veterans they support were defined as "a former officer or non-commissioned member of the Canadian Armed Forces (Regular or Reserve), which includes all individuals with any amount of service after enrollment and at any point in their lifetime but are no longer an active member. This includes all individuals who, at any point in their life, wore a uniform" (VanTil et al., 2016, p.26). This definition was agreed upon through reviewing the literature (VanTil et al., 2016) and consultations with the Veterans Advisory Committee to determine which definition was most inclusive and appropriate for this project. The broad inclusion criteria allowed for a wide range of participants when collecting data. This was in line with the methodology chosen for this master's thesis, as Sandelowski (2010) suggests that maximum variation is especially useful in QD research because it acknowledges the range of experiences in healthcare research.

With regards to the sampling technique, it needed to be reflective of the study design and research question (Bradshaw et al., 2017). Purposive sampling is often used to achieve this within the QD approach. This refers to selecting research participants to address the research objectives and provide knowledge and experience for the studied phenomenon (Doyle et al., 2020; J. Ritchie et al., 2014). Therefore, purposive sampling was used because it aligned with the research approach selected for this study. Various recruitment strategies were used to carry out this type of sampling. A list was created that included all of the LTCHs across Canada and their contact information. These homes were emailed/called and asked if recruitment could occur in their establishments (see Appendix A). Family care partners of Veterans were then informed by email through each LTCH's email list of family members (see Appendix B), and an electronic

recruitment flyer was shared with them (see Appendix C). Additionally, we were able to recruit potential participants by presenting our research at family councils associated with different LTCHs. Recruitment was also conducted by advertising the study on social media. Members of the Veterans Advisory Committee of the larger project also shared recruitment materials with their contacts. This latter approach proved to be instrumental to the recruitment process as this committee included individuals associated with the Royal Canadian Legion, The Council on Aging in Ottawa, Veterans Affairs Canada, Perley Health, Veterans' House Canada, Canadian Coalition for Seniors' Mental Health, Atlas, Commissioners Ottawa, CIMVHR, researchers at the University of Ottawa, McMaster University, and Sunnybrook Research Institute with experience in Veterans' health and aging, as well as individuals with lived and living experiences. All eligible participants were invited for an interview. Participants received compensation for their time in the form of a $30 gift card.

2.3.2 Data Collection

Data was collected through one-time, semi-structured interviews with nine family care partners of Veterans. The interview guide (see Appendix D) was created and informed using the Social Determinants of Health model (WHO, n.d.), the TRANSCIT model (Groenvynck et al., 2021), previous research findings on the topic, and input from the Veterans Advisory Committee of the larger project. Since both French- and English-speaking participants were recruited for this project, the interview guide was also translated into French. Discussion topics included the care partners' needs and experiences and those of Veterans transitioning from the community to a LTCH. A semi-structured interview guide was used as it enabled care partners to elaborate on their experiences. It allowed for a deeper understanding of the transition of the older Veteran in their life from the community to a LTCH, as well as the impact that it had on them. The

interview guide included both open-ended questions as well as probing questions. The open-ended questions allowed the researcher to explore specific topics in greater depth. An example of this included: How did you and your (family member/friend) choose which LTCH they wanted to move to? Probes were used to help maintain participants' focus and clarify unclear exchanges (Rubin & Rubin, 2012). Examples of probes included: What was useful during the move to the LTCH? Were there any resources (programs, people, services, financial support) that would have helped during this time? Was there anything additional that would have helped that you didn't have? Probes were also used to address specific topics such as location (rural or urban), language, and Veteran/care partner-specific preferences. An example of this included: What was important when choosing a LTCH? – home for Veterans? Geographic locations? Language or cultural features of the home?

Research team members pilot-tested the interview guide with Veterans, care partners, and family and friends. This ensured the questions were relevant and the guide was easy to follow. Interviews were 42 to 78 minutes long and conducted from August 2023 until November 2023. I conducted all of the interviews with the care partners of Veterans living in long-term care. Before the interviews began, I received training from a qualitative research expert. This involved learning proper interviewing techniques followed by meetings where I would interview someone from our research team and receive feedback. When interviews with the care partners began, I made sure I was constantly reflecting on ways to improve my skills as an interviewer. Interviews took place at a convenient time for the participants and were completed via telephone or videoconference and audio recorded. Rubin and Rubin (2012) argue that note-taking is helpful to improve accuracy even when interviews are recorded. Thus, I took notes to help document key pieces of information and identify crucial non-verbal communication cues that could not be

audio recorded. Following each interview, I went through the demographic questionnaire with participants (see Appendix E).

2.3.3 Data Analysis

Interview data was transcribed verbatim and then analyzed using reflexive thematic analysis. This type of analysis aligns with the descriptive qualitative methodology chosen for this study. Sandleouski (2000) states that through data analysis, this design should move from un-interpreted participant quotations to interpreted findings, which can remain 'data-near". Reflexive thematic analysis offers an organic approach to coding and theme development and allows for the active role of the researcher in these processes (Clarke & Braun, 2017). Reflexive thematic analysis is defined by Braun & Clarke (2021) as a process that "emphasizes the importance of the researcher's subjectivity as an analytic resource, and their reflexive engagement with theory, data, and interpretation" (p. 330). Therefore, throughout the analytic process, I took the time to immerse myself in the data while continuously and rigorously reflecting on my biases and thinking. Data was reviewed as it was collected to identify common elements, draw initial connections between ideas, and establish thematic saturation. Broadly speaking, thematic saturation is reached when no new ideas that critically change the overall findings emerge in the data (Hennink & Kaiser, 2022; Saunders et al., 2018).

I transcribed the interview data verbatim and, along with two senior researchers, performed the thematic analysis described by Braun and Clarke (Braun & Clarke, 2021). This included familiarizing oneself with the data, generating initial codes, searching for themes, reviewing, defining, and naming themes (Braun & Clarke, 2021). NVivo v.14 (NVivo, n.d.) was used to organize and code interview data. I independently coded all interviews while two senior researchers each coded half of the interviews so that double coding was completed. This phase

involved inductive open coding to generate codes directly from the interview data until an intercoder agreement was reached. Multiple meetings were held to discuss disagreements and create a codebook. Coded data was then themed by iteratively going back and forth between the interviews as part of a reflexive process to allow themes to emerge. Thematic maps were used to help identify the relationships within and between codes and themes (Braun & Clarke, 2021). Subsequent critical discussions among the researchers followed to conceptualize final themes and sub-themes. These themes were then reviewed and discussed with the Veterans Advisory Committee to add to the trustworthiness of the findings.

2.4 Issues of Trustworthiness

Trustworthiness is often used to express attributes related to the qualitative research process (Connelly, 2016). It is essential to ensuring that a study is rigorous enough to produce findings capable of impacting policy or practice (Connelly, 2016). It examines whether the researcher achieved what they set out to examine at the onset of their project and whether the participant can see that through the final product (Connelly, 2016; Lincoln & Guba, 2005). Trustworthiness was achieved in this study by clearly outlining the research procedures used and being reflexive throughout each stage of this project. Reflexivity allowed the researcher to discuss their positionality and biases, ultimately contributing to the trustworthiness of this study. Another way in which this research addressed trustworthiness was through criteria such as credibility and transferability (Cypress, 2017; Graneheim & Lundman, 2004).

2.4.1 Credibility

This term is defined as the ability to accurately report on a phenomenon and address the intended problem to be investigated (Graneheim & Lundman, 2004). Credibility deals with the

focus of the research and refers to the confidence in how well data and analysis processes achieved the study's intended goal (Graneheim & Lundman, 2004). This was accomplished by ensuring that the participants of this study were informed about what they would be discussing in the interview. The researcher verbally outlined the study and confirmed participants read and signed the consent form, guaranteeing anonymity. These factors helped ensure that participants spoke truthfully about their experiences, ultimately contributing to the study's credibility. Another way in which credibility was achieved was through consistent meetings with the Veterans Advisory Committee. The members of this group were able to offer guidance and invaluable insight based on their own expertise and experiences throughout all stages of this research process.

2.4.2 Transferability

This term refers to the relevance and applicability of the findings beyond the immediate participants of the study (Lincoln & Guba, 2005). Researchers can give suggestions about transferability, but it is the reader’s responsibility to determine whether the findings are transferable to another context (Graneheim & Lundman, 2004). To demonstrate transferability, the study must offer a clear and distinct description of culture and context, the selection and characteristics of participants, and the data collection and analysis process (Graneheim & Lundman, 2004). Through detailed, in-depth descriptions, the transferability of data becomes apparent to readers (Cresswell & Poth, 2018). This was demonstrated by clearly outlining the characteristics/inclusion criteria of the study participants and giving a thorough description of the data collection and analysis methods.

2.5 Ethical Considerations

A crucial priority of research is to ensure that no harm comes to participants (Rubin & Rubin, 2012). Since this study involved the experiences of human participants, ethics approval needed to be obtained. The University of Ottawa REB approved the ethical components of the larger study entitled "Supporting preferences of older Veterans and families in later life to promote health and well-being**"** (see Appendix F). A statement in the consent form highlighted that this project may be used for student research purposes. I was, therefore, able to use the interview data to address the research objectives of my thesis. Each participant provided informed consent before their interview (see Appendix G).

Chapter 3: Understanding the Transition to Long-Term Care Homes: Perceptions of Family Care Partners of Older Adult Veterans

We have formatted this article for the peer-reviewed *Journal of Military, Veteran, and Family Health research*. I have included a Word version of the manuscript in this chapter. The manuscript adheres to the journal's formatting requirements. The manuscript has been submitted and is awaiting reviewer selection.

Authors: Georgia Stewart BHSc[1], Kelly A. Pilato PhD[2], Annie Robitaille PhD[1,3*]

1. Faculty of Interdisciplinary Health Sciences, University of Ottawa, Ottawa, ON, Canada
2. Faculty of Health Sciences, Brock University, St. Catharines, ON, Canada
3. Perley Health, Ottawa, ON, Canada

Understanding the Transition to Long-Term Care: Perceptions of Family Care Partners of Older Adult Veterans

ABSTRACT

Introduction: Veterans and their family care partners represent a unique demographic with specific needs that may differ from the general population. The transition to a long-term care home (LTCH) has the potential to impact older adult Veterans and their care partners profoundly, yet there is limited research on how this move affects them. This study explored the experiences and needs of older adult Veterans and their family care partners transitioning into a LTCH from the perspective of the care partner. **Methods:** A qualitative descriptive design was used for this project. One-time semi-structured interviews were conducted with nine family care partners of older adult Veterans living in LTCHs across Canada. Coding and thematic analysis were used to iteratively categorize and synthesize the data. **Results:** The analysis revealed three overarching themes with sub-themes: 1) information gaps and knowledge use, 2) feeling valued, recognized, and supported, and 3) the health and well-being of the Veteran/family care partner. These themes were seen throughout all stages of the move to a LTCH, including the pre-transition, during-transition, and post-transition stages, and either served to impede or assist in a positive transition. **Discussion:** The results of this study will lead to an increased awareness of the specific challenges and facilitators faced by care partners and Veterans transitioning into a LTCH, ultimately leading to recommended changes in how they are supported throughout this move.

Key words: older adult Veterans, family care partners, long-term care, transition, qualitative study, Canada

RÉSUMÉ

Introduction. Les Vétérans et leurs proches aidants représentent un groupe démographique unique avec des besoins spécifiques qui peuvent différer de ceux de la population générale. La transition vers un foyer de soins de longue durée (SLD) peut avoir de profondes répercussions sur les Vétérans plus âgés et leurs partenaires de soins. Cependant, peu d'études ont été menées sur la façon dont cette transition les affecte. Cette étude a exploré les expériences et les besoins des Vétérans âgés et de leurs proches aidants en transition vers un foyer de SLD, du point de vue du partenaire de soins. **Méthodes.** Un modèle descriptif qualitatif a été utilisé pour ce projet. Des entrevues semi-structurées ont été menées auprès de neuf proches aidants de Vétérans plus âgés vivant dans des foyers de SLD à travers le Canada. Le codage et l'analyse thématique ont été utilisés pour catégoriser et synthétiser les données de façon itérative. **Résultats.** L'analyse a révélé trois thèmes principaux avec des sous-thèmes : 1) les lacunes en matière d'information et l'utilisation des connaissances, 2) le sentiment d'être valorisé, reconnu et soutenu, et 3) la santé et le bien-être du Vétéran/ partenaire de soins. Ces thèmes ont été observés à toutes les étapes de la transition vers un foyer de SLD, y compris la pré-transition, la transition et la post-transition, et ont soit entravé, soit aidé à une transition positive. **Discussion.** Les résultats de cette étude permettront de mieux connaître les défis spécifiques et les éléments facilitateurs auxquels sont confrontés les proches aidants et les Vétérans en transition vers un foyer de SLD, ce qui permettra de recommander des changements dans la manière dont ils sont soutenus tout au long de cette transition.

Mots clés: Vétérans âgés, proches aidants, soins de longue durée, transition, étude qualitative, Canada

INTRODUCTION

The health and well-being of Veterans can differ from that of Canadian civilians due to the unique context of military service [1,2]. Scholars have shown that those who served in the military are at an increased risk of physical and mental harm [3], which can lead to poor health outcomes that continue to impact Veterans as they age [4]. Veterans currently comprise approximately 1.5% of the Canadian population aged 17 and older [5], with an average age of 67 [6]. By 2026, roughly 33% of the Veteran population will be over the age of 70 [7]. It is clear that a major cohort of Veterans are reaching the age at which they may need additional support.

Time and again, this support comes in the form of family care partners. The needs and experiences of family care partners may also differ from those of the general population due to the unique health requirements of the Veterans they care for [8,9]. Supporting Veterans can be challenging for family care partners, often resulting in poor physical health outcomes, feelings of isolation, concerns about stigma and high emotional stress [9,10]. Previous research has emphasized how comorbidities among Veterans can result in additional challenges for their care partners, putting them at a greater risk for negative impacts on their health and well-being [11]. To prevent these adverse effects, care partners require support [11].

In Canada, various organizations offer a range of resources to Veterans and their care partners[12,13]. Despite these resources, some Veterans and their families still feel inadequately supported, leading to the decision to move into a long-term care home (LTCH) [13]. For other family care partners and Veterans, the choice to move into a LTCH is the preferred option regardless of whether they had more support at home [14]. Many factors may influence the transition into a LTCH for Veterans and their care partners within Canada. Depending on the Veterans' eligibility status, they can apply for a contract bed or a community bed in a LTCH [15].

Community beds are found in provincially licensed homes available to all residents, while contract beds are identified and funded for priority access by Veterans under federal-provincial agreements [15]. Homes with contract beds may also offer programming specifically for Veterans, including woodworking, horticultural therapy, memorial walls, and enhanced remembrance ceremonies [16].

Regardless of the type of bed in a LTCH that a Veteran is eligible to move into, the demand for contract and community beds outweighs availability [16]. Therefore, Veterans and their family members are faced with long wait times and uncertainty about LTCH access [15]. Although there is limited research on how these difficulties specifically impact the transition experiences of Veterans and family care partners, studies with civilian older adults and care partners reported that these challenges contributed to negative health and well-being[17,18]. Qualitative studies on civilian older adults and care partners also highlight the need for adequate information on how healthcare systems function, options of available care, and how to access resources through all stages of transition into a LTCH [17–21]. However, with minimal research on care partners' and Veterans' experiences on the transition into a LTCH, it is unknown if similar factors impact this sub-population.

To investigate and improve the transition process for Veterans and their care partners, two models can be used to structure research in this area. The first is the social determinants of health model [22]. According to this model, the context of people's lives contributes to their health [22]. Although many determinants of health cannot be controlled, some can be influenced by external factors [22]. Health services are a modifiable determinant of health [22] and an important focus when looking at the needs of family care partners and Veterans moving into a LTCH. Another framework known as the TRANSCIT care model can assist in transition research as it

outlines the pre-, during-, and post-transition stages of the move to a LTCH [20]. The pre-transition phase focuses on the decision process surrounding moving into a LTCH [20]. The during-transition phase captures the experience of the initial move into a LTCH . The post-transition phase looks at the adaption to the LTCH once the family member has moved in [20]. With previous studies only addressing one part of the move to a LTCH [18,19,23], the TRANSCIT care model ensures that the entire transition is explored. Since there is limited research on the transitions to LTCHs for Veterans and their care partners, the structure provided by these models ensures that the needs of this population are highlighted throughout the entire move. Such research could improve existing resources, programs and initiatives, ultimately contributing to Veterans' and their care partners' overall health and well-being. Therefore, this study aimed to explore: what are the experiences and needs of older adult Veterans and their family care partners transitioning from the community to a LTCH from the perspective of the family care partner?

METHODS

Design

This study used a qualitative description approach informed by a constructivist paradigm. Qualitative description was advantageous for this study as it allowed a straightforward depiction of experiences and perceptions [24], particularly in this area of research where little is known about the topic [25].

Participant recruitment and sampling

As part of a larger project entitled “XXXX,” this study used one-time semi-structured interviews with family care partners of older Veterans (55 years or older) living in LTCHs in Canada. This included English and/or French-speaking participants who care for a Veteran in a

home with contract beds and those without. Care partners were defined as unpaid family members, friends, or neighbours who care for a Veteran. The Veterans they care for were defined as "a former officer or non-commissioned member of the Canadian Armed Forces (Regular or Reserve), which includes all individuals with any amount of service after enrollment and at any point in their lifetime but are no longer an active member." [26]. These broad inclusion criteria allowed for a wide range of participants congruent with qualitative description [27].

We used a purposive sampling approach [28]. We contacted LTCHs across Canada and asked if recruitment could occur in their homes. We informed family care partners of Veterans via email through each LTCH's email list of family members, and an electronic recruitment flyer was shared with them. Additionally, we recruited through social media advertising and Advisory Committee members of the larger project shared recruitment materials with their contacts. The committee included Veteran, care partner, and LTCH organizations, persons with lived and living experiences, and researchers from various disciplines. All eligible participants were invited for an interview and received a $30 gift card. We used pseudonyms in illustrative quotes and removed potentially identifying information.

Data collection

Interviews ranged from 42 to 78 minutes in length. They were conducted virtually via telephone or videoconference and audio recorded. The TRANSCIT care model [20], social determinants of health model [22], previous research findings, and input from the Advisory Committee of the larger project informed the interview guide. Discussion topics included the care partners' needs and experiences and those of the Veteran concerning the transition from the community to a LTCH.

Data analysis

Researchers assistants transcribed the interview data verbatim, and two researchers and one Master's student performed the thematic analysis described by Braun and Clarke [29]. This included familiarizing oneself with the data, generating initial codes, searching for themes, reviewing, defining, and naming themes [29]. The Master's student and researchers immersed themselves in the data throughout the analytic process while continuously and rigorously reflecting on their biases. In the first stage, one researcher and a Master's student independently coded each interview (XXXX, XXXX, XXXX) in NVivo v.14 using inductive open coding to generate codes directly from the interview data until intercoder agreement was reached. A second researcher was brought in for disagreements. Coded data was then themed by iteratively going back and forth between the interviews as part of a reflexive process to allow themes to emerge. Thematic maps were used to help identify the relationships within and between codes and themes. Subsequent critical discussions among the researchers followed to conceptualize final themes and sub-themes. These themes were then reviewed and discussed with the Advisory Committee to add to the trustworthiness of the findings.

Ethical considerations

Each participant provided informed written consent before their interview. In cases where the participant could not sign the consent form, verbal consent was obtained. The Y University REB granted this study's ethical approval.

RESULTS

Nine family care partners from three provinces (ON, BC, NS) across Canada participated in phone/video conference interviews between August 2023 and November 2024. The time since the Veteran's transition to a LTCH ranged from 1 year to 12 years, with most participants

reporting 2 years or less. Participants included two males and seven females residing in rural (n=4) and urban (n=5) settings. Three care partners (3 females) reported the Veteran they cared for lived in an LTCH with only community beds, and six (4 females, 2 males) stated the Veteran they cared for lived in a home with contract beds. Additional demographic characteristics of the participants are presented in Table 1.

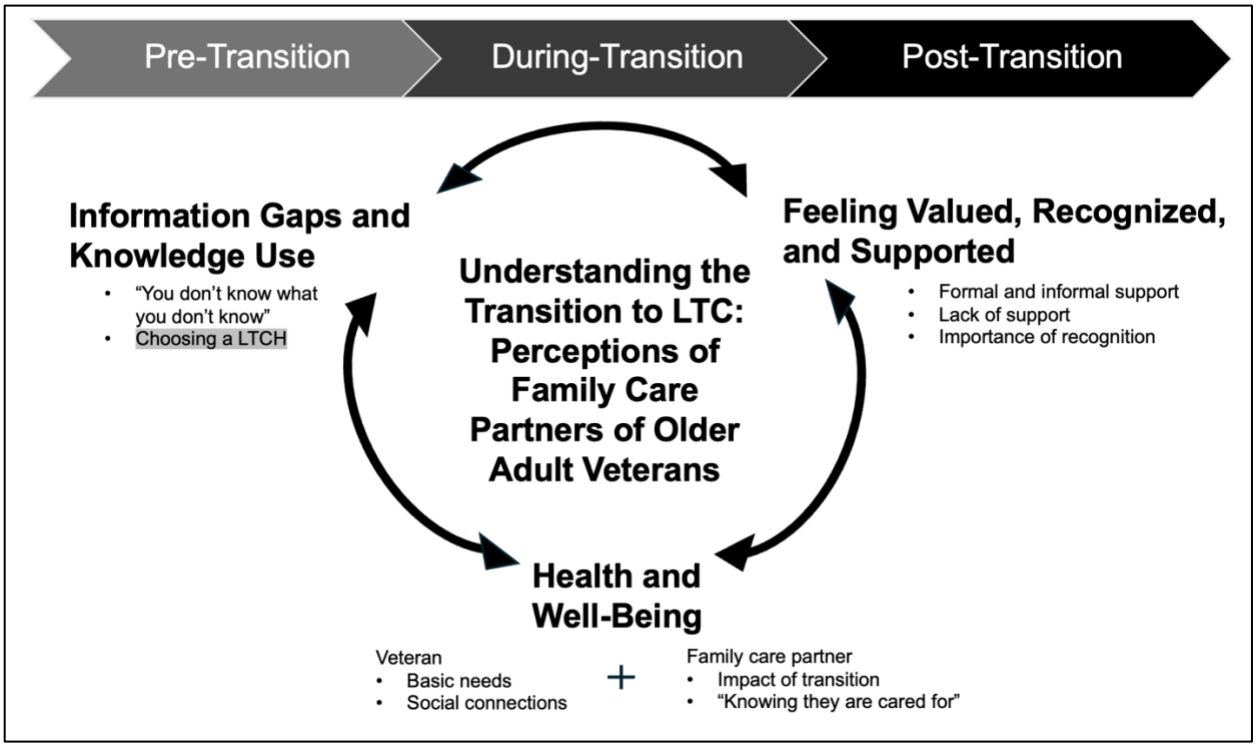
Table 1. Demographic characteristics of participants.

Participant characteristics	n = 9
Age (years)	
Mean (range)	63 (53-77)
Sex	
Male	2 (22%)
Female	7 (78%)
Gender identity	
Man	2 (22%)
Woman	7 (78%)
Relation to Veteran	
Spouse	2 (22%)
Child	7 (78%)
Length of time as a care partner (years)	
Mean (range)	11 (4-20)
Ethnicity	
Caucasian	9 (100%)
Marital status	
Married/common law	6 (67%)
Separated	1 (11%)
Divorced	1 (11%)
Widowed	1 (11%)
Highest level of education	
Highschool	1 (11%)
Non-university certificate	3 (33%)
Bachelor's degree	3 (33%)
University degree above a bachelor's degree	2 (22%)
Province of residence	
Ontario	3 (33%)
British Columbia	3 (33%)
Nova Scotia	3 (33%)
Location of residence	
Rural	4 (44%)

Urban	5 (56%)
Where the Veteran resides	
In the same city	5 (56%)
In a different city	4 (44%)
Veteran disabilities	
Yes	9 (100%)
Blind	1 (11%)
Deaf/hard of hearing	6 (67%)
Physical/orthopedic	5 (56%)
Cognitive difficulties	6 (67%)
Mental health illness	2 (22%)
No	0 (0%)
Care partner disabilities	
Yes	2 (22%)
Physical/orthopedic	2 (22%)
No	7 (78%)
Language	
English	9 (100%)
Annual household income	
$25,000 – $49,000	1 (11%)
$50,000 - $99,000	3 (33%)
$100, 000 - $199, 000	2 (22%)
More than $200, 000	2 (22%)
Prefer not to say	1 (11%)

Through exploring the move to a LTCH from the perspectives of family care partners of Veterans, three themes were identified that appeared across all stages of the transition: 1) information gaps and knowledge use, 2) feeling valued, recognized and supported, and 3) the health and well-being of the Veteran/care partner.

Figure 1. Thematic diagram.



1. Information gaps and knowledge use

Throughout all stages of the transition, information gaps and knowledge use were important to the care partners' experiences and, ultimately, the Veterans. The presence or absence of information surrounding available resources, Veteran-specific services, and selecting a LTCH was discussed.

1.1. "You don't know what you don't know"

When discussing their perceptions of the transition into a LTCH, family care partners highlighted the challenge of not knowing where to turn for information about this process. One care partner emphasized:

> When you're in the community, you don't know what you don't know. Your community centers are really the place where people go for information, and I found no information. We weren't tapping into resources that might have existed because he was a Veteran. It wasn't on anyone's radar. (Brenda, 62, Veteran home)

This was also true for Brenda and other participants during the transition to a LTCH. She stated:

> I don't even think there's anything in long-term care that says, "Are you a Veteran?". Like being a Veteran gives you some very unique life experience that no one else is gonna have. It needs to be talked about moving into long-term care. (Brenda, 62, Veteran home)

1.2. Choosing a LTCH

This was a large part of the pre-transition stage. When choosing which LTCH they would apply to, available information influenced the decision. One care partner stated, "******name of Veteran long-term care home****** was number one on the list, and it was because it was Veterans. That's the only way" (Susan, 77, Veteran home). The LTCHs with beds for Veterans often had resources and other perks that influenced the decision. They believed the waitlist was shorter in homes with contract beds than in homes with community beds. One care partner stated: "You get them in much faster there" (Mary, 72, Veteran home). The location of the LTCH was also used to rank the LTCHs they applied to. One care partner explained, "It was purely proximity. It's [referring to LTCH] really close to my home. That mattered" (Richard, 65, Veteran home).

2. Feeling valued, recognized, and supported

This theme represents the support care partners spoke about receiving, either formally or informally, or lack thereof towards themselves and the Veteran. Recognition for being a Veteran and a care partner of a Veteran was also important.

2.1. Formal and informal support

Formal support included caseworkers, LTCH staff members, and family councils. During the initial move into a LTCH, care partners spoke about how support from the LTCH staff made the Veteran feel a sense of "home." One care partner stated, "From the moment he got there, the staff were just amazing. They made it like he was coming home type of thing" (Sandra, 60, Veteran home). This support from the LTCH staff helped the Veterans adapt to their new environment, and for the care partner, it supported the changes they experienced in their caregiving role. Other care partners discussed how they found support through joining or creating friend and family councils at the LTCH. One care partner shared, "that's why I started the family council was basically to give us more support" (Nancy, 53, Community home). Another aspect of formal support was the use of Veteran specific resources by care partners. During the pre-transition stage, one care partner stated, "So yeah, VAC covers a good part of that room. So, knowing that we could get him a private room and have some of it covered, that went a long way" (Scott, 57, Veteran home).

Informal support involved family members, friends, and neighbours who played a key role in helping care partners identify resources they otherwise wouldn't have been aware of. One participant explained, "I did find out that you can go and get a caseworker. Someone just told me about that because I happened to be living in an apartment building, and there happened to be others who were also aging in that apartment building" (Brenda, 62, Veteran home). Another participant spoke about the support their spouse was offered when navigating the transition to a LTCH for his dad. They stated, "She could help me fill out the forms. And she was always like, my sounding board and advice, right. Guiding me" (Scott, 57, Veteran home).

2.2. Lack of support

Care partners also highlighted the lack of support they felt throughout the entire transition process, stating, “The family needs support. Take care of family caregivers” (Melissa, 65, Community home). Others felt a lack of support when communicating with the LTCH staff, explaining, “I never have that single point of contact when someone else is gone, and someone else is gone. And it's just that's been really challenging. The level of communication” (Richard, 65, Veteran home).

2.3. Importance of recognition

Family care partners were asked if they felt their family member was recognized as a Veteran throughout the transition and if that was important. Some deemed this recognition important, stating, “He wanted to identify and share with everybody his Veteran experience plus his experience serving. He wanted people to know” (Susan, 77, Veteran home). Another care partner spoke about how the LTCH recognized Veterans by offering “special remembrance day ceremonies [and] bringing the Legion members in” (Scott, 57, Veteran home). However, this was only true in LTCHs with contract beds. In contrast, when participants of Veterans in LTCHs with community beds were asked the same question about recognition, they had a different response. One family care partner stated:

> Families are asked to complete this questionnaire. And I thought, “This is cool” cause she served in the Air Force. And never once, even though my sisters and I went over that document, making sure we put everything in that was important to Mom, did anybody ever comment or say anything. (Melissa, 65, Veteran home)

Some participants spoke about the importance of feeling recognized as a family care partner by the LTCH staff, stating, “I certainly feel valued, and I feel respected” (Susan, 77,

Veteran home). Others did not echo this feeling; instead, they explained, “No, I don't feel valued. I don't feel supported there at all. They don't listen to what I have to say” (Mary, 72, Veteran home). Another care partner went on to specifically address the lack of recognition they felt as a care partner of a Veteran throughout the entire transition to a LTCH. “They don't have an appreciation for the fact that the whole family was in the military. We all sacrificed for that life, but we don't matter” (Richard, 65, Veteran home).

3. Health and well-being

Different factors contributed to the health and well-being of the Veteran and the care partner throughout each transition stage, including meeting basic needs and having social connections. Care partners also discussed how the transition impacted them personally and what was most important to their health and well-being.

3.1. Basic needs of the Veteran

In the pre-transition, participants talked about the decline in the Veterans’ health as one of the main reasons for choosing to transition into a LTCH. One care partner stated, “We knew there was nothing we could do. There was no way he could have stayed at home. He just was not, well, mentally” (Scott, 57, Veteran home).

Once the transition had been made into a LTCH, participants reflected on whether the basic needs of the Veteran in their life were being met and the impact this had. For example, one care partner said, “Some days he will admit he's angry because staff are not meeting his needs, his emotional needs” (Melissa, 65, Community home). There was a perception among some care partners that “Basic care, they don't even get basic care” (Mary, 72, Veteran home). Yet, other

care partners were satisfied with the care the Veteran in their life was receiving. “When I leave there, I know that ******name of family member****** is in great hands” (Laura, 58, Veteran home).

3.2. Social connections for the Veteran

An additional component that family care partners talked about in the post-transition stage was the social connections available to their family members and how they perceived this to impact the Veterans’ well-being. Some care partners of Veterans living in LTCHs with contract beds spoke about the benefits of co-locating Veterans. One care partner stated, “There’s something about the camaraderie of Veterans, and honestly, it’s…I don't think they realize the impact day to day on people not having that, that similar background and that similar experience” (Scott, 57, Veteran home).

3.3. Impact of transition on the family care partner

In the pre-transition, when the Veteran was still living in the community, care partners discussed feeling like “I can’t do this anymore”. One care partner explained:

> I was initially very upset to have to put him into long-term care. But my family said you have to let him go to long-term care because there was no way I could look after him and his needs at home. (Sandra, 60, Veteran home)

In the during-transition stage family care partners described feeling relief, sadness, and guilt. One care partner stated, “The only thing that I found hard was leaving him because he was crying. And so was I. I didn't want to leave him, but I had to” (Laura, 58, Veteran home). The post-transition had different impacts on care partners. For some, it gave them more time for themselves. Others felt that once their family member was in a LTCH, they had to continue to advocate for them. One care partner explained, “I've had to advocate for my mother for two and

a half years. You really need to speak up, advocate, to promote change" (Melissa, 65, Community home).

3.4."Knowing that they are cared for"

Ultimately, what mattered most for care partners own well being was that the Veteran in their life was cared for. One care partner responded, "To my own sense of well-being is knowing that my Mom is well cared for, and any concerns raised are addressed" (Susan, 77, Veteran home). Another care partner stated, "I just want to see Dad and know that he is cared for. I don't need anything for myself" (Richard, 65, Veteran home).

DISCUSSION

This research explored the transition to a LTCH from the perspective of family care partners of Veterans, uncovering the intricate nature of their experiences and those of the Veterans they care for. Throughout all stages of transition, family care partners faced significant challenges in accessing necessary information and resources to support both themselves and the Veterans they care for. These findings align with similar research on civilian care partners and older adults entering LTCHs, which identified substantial information gaps throughout the transition process [14,30,31] that unnecessarily forced care partners to make strenuous efforts to get the information they wanted [32]. There is a need for enhanced information and communication to help family members of Veterans through this process, particularly during the pre-transition phase. This begins by ensuring that Veterans are identified as such by healthcare providers in the community and then, as they transition into a LTCH, by the staff at the home. Once identified, it is imperative that Veterans and their care partners are provided with the Veteran-specific information and resources available to them.

This study also highlighted the recognition given to Veterans in LTCHs with contract beds and the impact of co-locating them as a significant factor influencing care partners' perceptions and decisions regarding placement. Some viewed this recognition as a benefit that enhanced the LTCH environment and facilitated discussions around placement. Others were unaware of this option for their family member. Similar findings were mentioned in a report by Veterans Affairs Canada that discussed some of the advantages of contract beds in LTCHs. They reported that co-locating Veterans filled a social need and gave them a sense of community whereby Veteran friendly programming ultimately honoured and recognized their life experiences in the military [16] . In their phenomenological qualitative research, Kirchen and Hersch [23] also concluded that recognition of military service and the ability to incorporate this into activities in the home was a facilitator in the Veterans' adaption to their new environment [23]. Other research supports that acknowledging residents' culture and life history when moving into a LTCH helps them adapt to their new environment [33–35]. Thus, healthcare providers must inquire about a history of military service (i.e., Veteran status)[36]. Using a person-centerd care approach, this information can then be incorporated throughout the transition into a LTCH and onward [37]. This would allow Veterans to communicate what is most important to them and what they would like to be prioritized to meet their wishes [37].

We found that viewing the move to a LTCH as a journey rather than a single event (i.e., initial move) is important. For families, the transition begins months or years before the actual move and can extend well beyond the move into a LTCH. This is consistent with Kokonya, who found that the transition can not be defined as one specific time point but instead needs to be viewed as a process that takes place over a period of time [14]. Poor transitional care can lead to adverse outcomes for both older adults and their family care partners [21]. Although many

experiences discussed in this study are similar to those of civilian care partners [17,38], this research highlighted the unique needs of Veterans and their families. It underscored the complexity of transitioning to a LTCH for Veterans and family care partners by demonstrating the urgent need for enhanced support, information access, and recognition to facilitate a smoother experience. Addressing these gaps can significantly improve the transition for Veterans and their care partners, positively impacting their health and well-being.

LIMITATIONS AND FUTURE DIRECTIONS

While this research has many strengths, some limitations must also be noted. Firstly, family care partners were reflecting on transitions to LTCHs from one to twelve years ago, which may introduce recall bias. However, this extended period of time might also provide a more comprehensive perspective on their needs and experiences, as well as those of the Veterans. Although participants represented various regions across Canada, future research should include family care partners from all provinces and territories for greater transferability, to understand provincial differences, and to ensure a more gender-diverse sample. Despite these limitations, findings provide valuable insight into the perceptions of family care partners of Veterans transitioning into LTCHs, ultimately contributing to a better understanding of this unique population's needs and experiences.

CONCLUSION

This study illuminates the critical experiences and challenges faced by family care partners of older adult Veterans during the transition to a LTCH. It highlights the necessity of providing robust support systems by capturing a comprehensive view of their perceptions and needs. The findings emphasize the importance of enhancing information accessibility and

awareness at every transition stage, underscoring the need for targeted interventions to better support family care partners and Veterans specifically. Our findings can be used to inform future policy and practice improvements to ease the transition process and ensure better health and well-being outcomes for all involved.

REFERENCES

1. Hall AL, Sweet J, Tweel M, MacLean MB. Comparing negative health indicators in male and female veterans with the Canadian general population. BMJ Mil Health. 2022 Feb 1;168(1):82–7.
2. Katz IraR. Geriatric psychiatry in the department of Veterans Affairs: serving the needs of aged and aging Veterans. Am J Geriatr Psychiatry. 2012 Mar 1;20(3):195–8.
3. Wilmoth JM, London AS, Oliver WJ. Military service experiences and older men's trajectories of self-rated health. In: Long-term outcomes of military service: the health and well-being of aging veterans. Washington, DC, US: American Psychological Association; 2018. p. 125–45.
4. Pruchno R. Veterans aging. The Gerontologist. 2016 Feb 1;56(1):1–4.
5. Statistics Canada. On guard for thee: serving in the Canadian Armed Forces. 2022. Report No.: 11-001–X.
6. Wolfson C, Gauvin DE, Schulz J, et al. The Canadian longitudinal study on aging: a vehicle for research on aging in older Veterans. Mil Med. 2023 Jan 31;usad012.
7. VanTil LD, MacLean MB, Sweet J, Mckinnon K. Understanding future needs of Canadian Veterans. Health report. Statistics Canada; 2018 Nov. Report No.:82-003-X.

8. Petrovic-Poljak A, Konnert C. Sense of community in long-term care: the views of family caregivers of elderly military veterans. Int Psychogeriatr. 2013 Mar;25(3):390–402.

9. Shepherd-Banigan M, Sherman SR, Lindquist JH, et al. Family caregivers of Veterans experience high levels of burden, distress, and financial strain. J Am Geriatr Soc. 2020;68(11):2675–83.

10. Uphold CR, Jordan M, Freytes M. Chapter 8 family caregivers of veterans: a critical review of the empirical literature and recommendations for future research. Annu Rev Nurs Res. 2014;32:155–202.

11. Pinciotti CM, Bass DM, McCarthy CA, et al. Negative consequences of family caregiving for Veterans with PTSD and dementia. J Nerv Ment Dis. 2017 Feb;205(2):106.

12. Veterans Transition Network. Resources [Internet]. [cited 2024 Jul 7]. Available from: https://vtncanada.org/resources/?gclid=EAIaIQobChMI5KT6rqvA_AIVl-bjBx2azAJQEAAYBCAAEgLYM_D_BwE

13. Veterans Ombudsman. Continuum of care: a journey from home to long term care [Internet]. 2017 [cited 2024 May 6]. Available from: https://www.ombudsman-veterans.gc.ca/en/publications/systemic-reviews/continuum

14. Kokonya A. Transition to Long-Term Care: Preparing Older Adults and their Families: MEDSURG Nursing. 2018 Jun 5;27(3):143–8.

15. Veterans Ombudsman. Veterans' long-term care needs [Internet]. 2014 Feb [cited 2024 May 6]. Available from: https://ombudsman-veterans.gc.ca/en/publications/systemic-reviews/assisted-living-review

16. Veterans Affairs Canada. Evaluation of the long-term care program and the intermediate care component of the Veterans Independence Program. January 2019 [Internet]. 2019 [cited 2024 May 6]. Available from: https://www.veterans.gc.ca/en/about-vac/publications-reports/departmental-reports/departmental-audit-evaluation/2019-evaluation-long-term-care

17. Brooks D, Beattie E, Fielding E, et al. Long-term care placement: the transitional support needs and preferences of spousal dementia caregivers. Dementia. 2022;21(3):794–809.

18. Fitzpatrick JM, Tzouvara V. Facilitators and inhibitors of transition for older people who have relocated to a long-term care facility: A systematic review. Health Soc Care Community. 2019;27(3):e57–81.

19. Hainstock T, Cloutier D, Penning M. From home to 'home': Mapping the caregiver journey in the transition from home care into residential care. J Aging Stud. 2017 Dec 1;43:32–9.

20. Groenvynck L, Boer B de, Hamers JPH, et al. Toward a partnership in the transition from home to a nursing home: the TRANSCIT model. J Am Med Dir Assoc. 2021 Feb 1;22(2):351–6.

21. Groenvynck L, Fakha A, de Boer B, et al. Interventions to improve the transition from home to a nursing home: a scoping review. The Gerontologist. 2022 Aug 12;62(7):369–83.

22. WHO. Determinants of health [Internet]. [cited 2024 Jun 16]. Available from: https://www.who.int/news-room/questions-and-answers/item/determinants-of-health

23. Kirchen T, Hersch G. Understanding person and environment factors that facilitate Veteran adaptation to long-term care. Phys Occup Ther Geriatr. 2015 Aug 19;33.

24. Sandelowski M. Whatever happened to qualitative description? Res Nurs Health. 2000;23(4):334–40.

25. Doyle L, McCabe C, Keogh B, et al. An overview of the qualitative descriptive design within nursing research. J Res Nurs JRN. 2020 Aug;25(5):443–55.

26. VanTil LD, Thompson JM, MacLean MB, Pedlar DJ. Screening questions to identify Canadian Veterans. J Mil Veteran Fam Health. 2016 Apr;2(1):28–32.

27. Sandelowski M. What's in a name? Qualitative description revisited. Res Nurs Health. 2010;33(1):77–84.

28. Bradshaw C, Atkinson S, Doody O. Employing a qualitative description approach in health care research. 2017;4

29. Braun V, Clarke V. One size fits all? What counts as quality practice in (reflexive) thematic analysis? Qual Res Psychol. 2021 Jul 3;18(3):328–52.

30. Eom K, Penkunas MJ, Chan AWM. Effect of caregiving relationship and formal long-term care service use on caregiver well-being: family caregivers' well-being. Geriatr Gerontol Int. 2017;17:1714-721.

31. Afram B, Verbeek H, Bleijlevens MHC, Hamers JPH. Needs of informal caregivers during transition from home towards institutional care in dementia: a systematic review of qualitative studies. Int Psychogeriatr. 2015 Jun;27(6):891–902.

32. Johansson A, Ruzin HO, Graneheim UH, Lindgren BM. Remaining connected despite separation – former family caregivers' experiences of aspects that facilitate and hinder the process of relinquishing the care of a person with dementia to a nursing home. Aging Ment Health. 2014 Nov 17;18(8):1029–36.

33. Sun C, Ding Y, Cui Y, et al. The adaptation of older adults' transition to residential care facilities and cultural factors: a meta-synthesis. BMC Geriatr. 2021 Jan 18;21(1):64.

34. Cooney A. 'Finding home': a grounded theory on how older people 'find home' in long-term care settings. Int J Older People Nurs. 2012;7(3):188–99.

35. Iwasiw C, Goldenberg D, MacMaster E, McMcutcheon S, Bol N. Residents' perspectives of their first 2 weeks in a long-term care facility. J Clin Nurs. 1996;5(6):339–405.

36. Karel MJ, Wray LO, Adler G, et al. Mental health needs of aging Veterans: recent evidence and clinical recommendations. Clin Gerontol. 2022 Mar 15;45(2):252–71.

37. Li J, Porock D. Resident outcomes of person-centered care in long-term care: a narrative review of interventional research. Int J Nurs Stud. 2014 Oct 1;51(10):1395–415.

38. Buhr GT, Kuchibhatla M, Clipp EC. Caregivers' reasons for nursing home placement: clues for improving discussions with families prior to the transition. Gerontologist. 2006 Feb 1;46(1):52–61.

Chapter 4: Discussion

4.1. Discussion of Key Findings and Recommendations

The objective of this thesis was to explore the transition to a LTCH from the perspective of family care partners of Veterans, revealing their unique experiences and those of the Veterans they care for. The results found in the article presented above have elucidated three important points, and recommendations will be offered: 1) Access and use of relevant information throughout all stages of the move to a LTCH, 2) Importance of identifying Veterans and family care partners of Veterans as such, and 3) Looking at the transition as a journey instead of a singular event.

4.1.1 Access and Use of Relevant Information

The findings showed the importance of information accessibility and awareness for Veterans and care partners at every transition stage. In the pre-transition stage, the family care partners in our study spoke about the information that influenced the decision on which LTCH was chosen. This was similar to previous research that emphasized geographic proximity to the LTCH as a significant aspect of the decision and whether they served Veterans specifically (Miller et al., 2018). The results of our study supported this, as some care partners emphasized they chose a LTCH with beds specifically for Veterans because they knew this would contribute to their family members' well-being.

Additionally, the family care partners in our study spoke about not knowing where to turn for information regarding the move into a LTCH. This aligned with similar research on civilian care partners and older adults entering LTCHs, identifying substantial information gaps throughout the transition process (Afram et al., 2015; Eom et al., 2016; Kokonya & Fitzsimons, 2018). This lack of information unnecessarily forced care partners to make strenuous efforts to

get the information they wanted (Johansson et al., 2014). A systematic review of qualitative studies looked at the needs of civilian older adults and their care partners during the transition from the community to a LTCH (Afram et al., 2015). One prominent theme in the literature was the lack of knowledge and information regarding the entire process (Afram et al., 2015). The review paper gave multiple examples of challenges that care partners and older adults faced, such as not being informed about financial options, lack of knowledge concerning available care options, and not understanding the system and policies associated with LTCHs (Afram et al., 2015). Although these points are similar to those reported in our study, care partners of Veterans faced additional challenges due to not being aware of the Veteran-specific resources and information available to them. This further shows the need to ensure that information and services targeted towards Veterans and their care partners are more accessible.

The results of our study also highlighted the need to better map the aging process to prepare Veterans and their care partners for the potential move to an LTCH. This could look like creating a 'Tool Kit' that family physicians, Veteran-specific organizations, and LTCH organizations can share with Veterans and their care partners. It would lay out the move to a LTCH, starting with the pre-transition, then during-transition and finally post-transition (Groenvynck et al., 2021). This 'Tool Kit' could highlight resources and information specific to Veterans and their care partners, allowing them to feel better supported and equipped throughout the entire process. Having these conversations sooner can make the transition to a LTCH smoother and less stressful. Earlier discussions can help Veterans and their families feel more prepared and confident about the potential move to a LTCH.

4.1.2 Identification of Veterans and Person- and Family-Centred Care

The results of our research also highlighted some key factors that contributed to the health and well-being of the Veteran and their care partner throughout the transition to a LTCH. For the care partners of this study, what contributed most to this was knowing that their family members were being taken care of, which meant the Veterans' basic care and social connection needs were met. This ultimately needs to start by ensuring that Veterans are identified as such so that they can be supported throughout the move into an LTCH in a way that acknowledges the specific needs they may have due to military service. This will allow healthcare providers to equip Veterans and their families with the appropriate resources. This starts in the community when Veterans and their family care partners seek assistance and continues into the LTCH setting.

Additionally, there needs to be a checklist on intake forms for LTCHs that includes the option to indicate that the resident is a Veteran. This information then needs to be utilized and elaborated on through working as a team with the LTCH staff, Veteran, and family care partner. (Karel et al., 2022; Ritchie et al., 2022). Multiple studies support the importance of acknowledging residents' culture and life history when moving into a LTCH, stating that it helps them adapt to the new environment and reassures the care partner that their family member's health and well-being are supported (Cooney, 2012; Iwasiw et al., 1996; Sun et al., 2021). Further, rates of obesity, mental health conditions and chronic pain, owing to higher rates of back problems and arthritis, are higher among Veterans than the general population (VanTil et al., 2018; Wolfson et al., 2023). Clinicians must be aware of these differences and acknowledge them when providing care. For example, the impact of PTSD can extend well into the later years of Veterans' lives. In a study focusing on 120 Canadian Veterans who served during WWII and

the Korean War, aged 68 to 69, it was found that those with PTSD experienced significant functional impairments and reduced health-related quality of life even more than 50 years after service (Richardson et al., 2010). When Veterans transition into a LTCH they may have military-related physical and mental health care needs for which non-military informed care may be ineffective or counterproductive (Gillin et al., 2024). Therefore, it is essential that as Veterans age and some transition into LTCHs, these unique needs are recognized, as this will ultimately contribute to healthcare professionals' ability to provide the best care possible.

Using a person-centred care approach would allow for this information to be incorporated throughout the transition into a LTCH and onward. The person-and family-centred care approach involves healthcare organizations and healthcare professionals actively understanding what patients value (Registered Nurses' Association of Ontario, 2015). Person- and family-centred care focuses on the whole person as a unique individual and does not just define them based upon their illness or disease (Registered Nurses' Association of Ontario, 2015). In viewing the individual through this lens, healthcare providers come to know and understand the person's life story, experience of health, the role of family in the person's life, and their role in supporting the person to achieve optimal health and well-being (Registered Nurses' Association of Ontario, 2015). An example of how this approach can be implemented within the LTCH setting would be to offer customized recreational plans to achieve specific goals and outcomes as determined by the Veteran (Alzheimer Society of Canada, 2014). This would ultimately improve the transition for Veterans, allowing them to adapt more quickly to their new environment. Additionally, family care partners often seek support to stay connected with the older adult in their life and, therefore, often want to be included as part of the care team (Groenvynck et al., 2021). Research shows that person-centred information educating older

adults and family care partners on the transition process positively impacts their experience (Groenvynck et al., 2021).

Trauma-informed care is another essential approach that healthcare professionals should consider when caring for Veterans (O'Malley et al., 2023). The long-lasting psychological impacts of trauma may manifest later in life, exacerbated by the normative effects of aging and significant changes in Veterans' lives, such as the move into a LTCH (O'Malley et al., 2023). The LTCH staff may not have the skills or knowledge needed to address symptoms or reduce traumatization. Incorporating trauma-informed care practices in LTCHs, as well as other clinical settings where Veterans may be seeking care, can mitigate these effects (O'Malley et al., 2023).

4.1.3 Journey to a LTCH

The findings of this research also emphasized the importance of looking at the transition to a LTCH as a journey instead of just the initial move into the new setting. The results of our study supported this, as care partners explained the transition itself is, in reality, an action that begins months or sometimes years earlier and can extend well beyond the actual move into a LTCH. This is consistent with previous findings on civilian care partners and older adults, as one study highlighted how the transition cannot be defined as one specific time point but instead needs to be viewed as a process that takes place over a period of time (Kokonya & Fitzsimons, 2018). Poor transitional care can lead to adverse outcomes for both older adults and their family care partners (Groenvynck et al., 2022). Therefore, our study ensured that the entire transition experience was captured and discussed by first defining each transition stage (pre-, during-, and post-transition) guided by the TRANSCIT care model (Groenvynck et al., 2021).

The transition to a LTCH should be considered a continuum (Johansson et al., 2014). Currently, the situation before and after admission into a LTCH is treated as separate stages

when, instead, it should be viewed as one integrated process (Groenvynck et al., 2021). Although several of the experiences care partners of Veterans discussed are similar to those of civilians (Brooks et al., 2022; Buhr et al., 2006), our study highlighted some of the unique needs of Veterans and their families. These included the urgent need for enhanced support and access to information specifically for Veterans and their families. Additionally, Veterans need to be identified as such to facilitate a smoother and more positive transition experience. Multicomponent programmes should be offered to support Veterans and their care partners during the entire transition journey. By addressing these gaps in the move to a LTCH for Veterans and their care partners, this transition can be significantly improved, ultimately contributing positively to this population's health and well-being.

4.2 Implications and Significance

This study represents the first glimpse into the experiences of Canadian Veterans and their family care partners on the transition into a LTCH. This interdisciplinary project included collaborations with Veteran, care partner, and LTCH organizations, persons with lived and living experiences, and researchers from various disciplines, building capacity in Veteran-related research and highlighting the importance of supporting Veterans and their care partners as they transition into a LTCH. Additionally, the larger project that this study was a part of is currently ongoing; we are working with a CIHR Research Chair in Applied Public Health (2SLGBTQI+ Health and Aging) to continue creating partnerships that reach equity/diversity groups.

It is important that the findings from this research are shared through academic streams as well as with Veterans and their family members. Last fall, I presented preliminary results at the Canadian Institute for Military and Veteran Health Research (CIMVHR; (CIMVHR, 2023)). It is also crucial that these findings are shared in a way that will be socially relevant and can be used

for actionable change. As such, dissemination strategies should not be limited to purely academic streams, as these remain primarily inaccessible to both Veterans and their family care partners. Therefore, the results of this research must be shared with family and friends councils at the LTCHs and members of the advisory committee who have connections with Veterans and care partners within the community.

4.3 Limitations and Future Directions

Although this study had many strengths, some limitations must be acknowledged. Firstly, qualitative methods provide an excellent mechanism to examine previously unexplored phenomena. This thesis aimed not to yield generalizable results but instead offer a first look at the experiences and needs of care partners and Veterans transitioning into a LTCH. Therefore, the use of qualitative methods was appropriate for this study. Although the sample was small, with nine participants, thematic saturation was reached in the general themes raised by family care partners. This data offered a glimpse into the experiences and needs of this population, pointing to the need for targeted interventions specifically designed to support family care partners and Veterans.

Additionally, the family care partners in this sample reflected on transitions to LTCHs that occurred one to twelve years ago. This may have led to recall bias that could have affected their recollections. Still, six participants reflected on transitions less than two years ago. It is also important to note that some family care partners (i.e., those who experienced the transition within the past two years) were reflecting on transitions to LTCHs that took place during COVID-19. This meant that extra restrictions were in place during the initial move and may have impacted their experience differently than those who transitioned before or after the pandemic. Therefore, including those who experienced the transition more than two years ago allowed us to

get information about transitions before COVID-19 and may have allowed care partners ample reflective time to provide a more comprehensive perspective on their own needs and experiences and those of the Veterans in their care.

Another limitation is that while the participants represented various geographic regions across Canada, future research should include family care partners from all provinces and territories to enhance the transferability of findings. An effort was made to recruit participants from minority groups by contacting LTCHs in rural locations and homes with francophone populations. The interview guide included probing questions to address these topics. Four of the care partners in our study were located in a rural setting. Future studies should also investigate the transition to LTCHs by examining provincial differences, urban versus rural settings, those in language minority groups, and ensuring a more gender-diverse sample as their experiences and needs may differ . Our recruitment strategy involved contacting LTCHs and organizations virtually due to time and financial constraints. Future success may be found with in-person recruitment. We were able to present our study at a family and friends council meeting at a LTCH in Ottawa, this could be carried out across Canada at LTCHs to gain a more diverse and larger sample.

Although participants were recruited from homes with contract beds and those with community beds, the sample sizes in each subgroup were insufficient to draw strong comparisons of their experiences. Future research should examine the differences and similarities in participants' experiences based on the type of bed the Veteran receives in a LTCH. It would also be beneficial for future research to gain the perspective of Veterans as this would offer a more complete picture of the journey to a LTCH. Additionally, with the traditional war-service Veteran population declining and the overall CAF Veteran population aging, future research

needs to consider the impact these demographic shifts will have on LTCH requirements (Veterans Ombudsman, 2017). The needs of CAF Veterans may differ from those of the Veteran population that LTCHs are familiar with caring for (Veterans Ombudsman, 2017). Our study sample included two war service Veterans; the rest were CAF Veterans. Although our sample size was not large enough to draw comparisons, within-group differences amongst Veterans have been identified in the literature, showing a growing acceptance amongst researchers and policymakers to acknowledge diversity amongst the Veteran population rather than viewing Veterans in LTCHs, as a homogeneous group (Parry & Pitchford-Hyde, 2023; Perrier, 2021). While some Veterans may enjoy a continued connection to the military and their Veteran identity in the LTCH environment (Reynolds & Paget, 2015), others may feel ambivalent, disinterested, or find reminiscence about their military service distressing (Simons et al., 2021; Wiersma, 2008). Despite the limitations, the findings provide initial data and valuable insights into the perceptions of family care partners of Veterans transitioning into LTCHs, ultimately contributing to a better understanding of the needs and experiences of this unique population.

4.4 Conclusion

In conclusion, this thesis highlighted the significant experiences and challenges encountered by family care partners and older adult Veterans during the transition to a LTCH. It underscored the critical need for robust support systems by providing the first investigation into care partners' perceptions and requirements throughout this move. The findings showed the necessity of improving information accessibility and awareness at every stage of the transition, pointing to the need for targeted interventions specifically designed to support family care partners and Veterans. These insights can guide the development of future policies and practices to streamline the transition process, ultimately fostering better health and well-being outcomes

for all involved. Moreover, this study demonstrates the need for ongoing research and continued improvement in support strategies to adapt to the evolving needs of this population, ensuring a smoother and more positive transition experience.

References

Afram, B., Verbeek, H., Bleijlevens, M. H. C., & Hamers, J. P. H. (2015). Needs of informal caregivers during transition from home towards institutional care in dementia: A systematic review of qualitative studies. *International Psychogeriatrics*, *27*(6), 891–902. https://doi.org/10.1017/S1041610214002154

Aldwin, C. M., Park, C. L., Choun, S., & Lee, H. (2018). The impact of military service on stress, health, and well-being in later life. In *Long-term outcomes of military service: The health and well-being of aging veterans* (pp. 167–186). American Psychological Association. https://doi.org/10.1037/0000061-010

Alonso, M. S.-I., Prieto Ursúa, M., & Caperos, J. M. (2017). The family caregiver after the institutionalization of the dependent elderly relative. *Educational Gerontology*, *43*(12), 650–661. https://doi.org/10.1080/03601277.2017.1386403

Alzheimer Society of Canada. (2014). *PC P.E.A.R.L.S.: 7 key elements of person-centred care of people with dementia in long-term care homes* (p. 24).

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a Qualitative Description Approach in Health Care Research. *Global Qualitative Nursing Research*, *4*, 2333393617742282. https://doi.org/10.1177/2333393617742282

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Brooks, D., Beattie, E., Fielding, E., Wyles, K., & Edwards, H. (2022). Long-term care placement: The transitional support needs and preferences of spousal dementia caregivers. *Dementia*, *21*(3), 794–809.

Brydges, M., Mebrahtu, E., Maclennan, E., Flanagan, A., Pedlar, D., Muscedere, J., & Sinha, S. (2024). *Addressing the coming of age and its related complexities among Canada's Veterans.* National Institute on Aging, Toronto Metropolitan University, the Canadian Institute for Military and Veteran Health Research and the Canadian Frailty Network.

Buhr, G. T., Kuchibhatla, M., & Clipp, E. C. (2006). Caregivers' reasons for nursing home placement: Clues for improving discussions with families prior to the transition. *Gerontologist, 46*(1), 52–61. gnh.

Burr, V. (2015). *Soical constructionism* (3rd ed.). Routledge/Taylor & Francis Group.

Carlson, E. B., Lauderdale, S., Hawkins, J., & Sheikh, J. I. (2008). Posttraumatic Stress and Aggression Among Veterans in Long-term Care. *Journal of Geriatric Psychiatry and Neurology, 21*(1), 61–71. https://doi.org/10.1177/0891988707311557

CIMVHR. (2023, October). *CIMVHR Forum 2023—Ottawa Gatineau* [Online post]. https://cimvhrforum.ca/about/

Clarke, V., & Braun, V. (2017). Thematic analysis. *The Journal of Positive Psychology, 12*(3), 297–298. https://doi.org/10.1080/17439760.2016.1262613

Connelly, L. (2016). Trustworthiness in Qualitative Research. *MEDSURG Nursing, 25*, 435–436.

Cook, J. M., Ruzek, J. I., & Cassidy, E. (2003). Practical Geriatrics: Possible Association of Posttraumatic Stress Disorder With Cognitive Impairment Among Older Adults. *Psychiatric Services, 54*(9), 1223–1225. https://doi.org/10.1176/appi.ps.54.9.1223

Cooney, A. (2012). 'Finding home': A grounded theory on how older people 'find home' in long-term care settings. *International Journal of Older People Nursing, 7*(3), 188–199. https://doi.org/10.1111/j.1748-3743.2011.00278.x

Cresswell, J., & Poth, C. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.

Cypress, B. S. (2017). Rigor or Reliability and Validity in Qualitative Research: Perspectives, Strategies, Reconceptualization, and Recommendations. *Dimensions of Critical Care Nursing: DCCN*, *36*(4), 253–263. https://doi.org/10.1097/DCC.0000000000000253

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing: JRN*, *25*(5), 443–455. https://doi.org/10.1177/1744987119880234

Duan-Porter, W., Martinson, B., Taylor, B., Falde, S., Gnan, K., Greer, N., MacDonald, R., Rosebush, C., & Wilt, T. (2017). *Evidence review: Social determinants of health for Veterans* (VA ESP Project 09–009).

Eom, K., Penkunas, M. J., & Chan, A. W. M. (2016). Effect of caregiving relationship and formal long-term care service use on caregiver well-being: Family caregivers' well-being. *Geriatrics & Gerontology International*. https://doi.org/10.1111/ggi.12958

Fitzpatrick, J. M., & Tzouvara, V. (2019). Facilitators and inhibitors of transition for older people who have relocated to a long-term care facility: A systematic review. *Health & Social Care in the Community*, *27*(3), e57–e81. https://doi.org/10.1111/hsc.12647

Gauvin, D. E., Wolfson, C., Aiken, A. B., Feinstein, A., Raina, P., & VanTil, L. D. (2022). Correlates of posttraumatic stress disorder among Veterans in the Canadian Longitudinal Study on Aging. *Journal of Military, Veteran and Family Health*, *8*(1), 38–55. https://doi.org/10.3138/jmvfh-2021-0030

Gillin, N., Almond, M., & Fossey, M. (2024). *Veterans in Care Homes: An International Scoping Review to Inform UK Policy and Practice*. 346–359.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Groenvynck, L., Boer, B. de, Hamers, J. P. H., Achterberg, T. van, Rossum, E. van, & Verbeek, H. (2021). Toward a Partnership in the Transition from Home to a Nursing Home: The TRANSCIT Model. *Journal of the American Medical Directors Association*, *22*(2), 351–356. https://doi.org/10.1016/j.jamda.2020.09.041

Groenvynck, L., Fakha, A., de Boer, B., Hamers, J. P. H., van Achterberg, T., van Rossum, E., & Verbeek, H. (2022). Interventions to Improve the Transition From Home to a Nursing Home: A Scoping Review. *The Gerontologist*, *62*(7), e369–e383. https://doi.org/10.1093/geront/gnab036

Hall, A. L., Sweet, J., Tweel, M., & MacLean, M. B. (2022). Comparing negative health indicators in male and female veterans with the Canadian general population. *BMJ Mil Health*, *168*(1), 82–87. https://doi.org/10.1136/bmjmilitary-2020-001526

Hennink, M., Hutter, I., & Bailey, A. (2011). *Qualitative research methods*. Sage Publications.

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine*, *292*, 114523. https://doi.org/10.1016/j.socscimed.2021.114523

Herrmann, N., & Eryavec, G. (1994). Posttraumatic Stress Disorder in Institutionalized World War II Veterans. *The American Journal of Geriatric Psychiatry*, *2*(4), 324–331. https://doi.org/10.1097/00019442-199402040-00007

Iwasiw, C., Goldenberg, D., MacMaster, E., McMcutcheon, S., & Bol, N. (1996). Residents' perspectives of their first 2 weeks in a long-term care facility. *Journal of Clinical*

Nursing, *5*(6), 339–405. https://doi-org.proxy.bib.uottawa.ca/10.1111/j.1365-2702.1996.tb00271.x

Johansson, A., Ruzin, H. O., Graneheim, U. H., & Lindgren, B.-M. (2014). Remaining connected despite separation – former family caregivers' experiences of aspects that facilitate and hinder the process of relinquishing the care of a person with dementia to a nursing home. *Aging & Mental Health*, *18*(8), 1029–1036. https://doi.org/10.1080/13607863.2014.908456

Karel, M. J., Wray, L. O., Adler, G., Hannum, A. O. R., Luci, K., Brady, L. A., & McGuire, M. H. (2022). Mental Health Needs of Aging Veterans: Recent Evidence and Clinical Recommendations. *Clinical Gerontologist*, *45*(2), 252–271. https://doi.org/10.1080/07317115.2020.1716910

Katz, Ira. R. (2012). Geriatric Psychiatry in the Department of Veterans Affairs: Serving the Needs of Aged and Aging Veterans. *The American Journal of Geriatric Psychiatry*, *20*(3), 195–198. https://doi.org/10.1097/JGP.0b013e3182435f00

Kirchen, T., & Hersch, G. (2015). Understanding Person and Environment Factors that Facilitate Veteran Adaptation to Long-Term Care. *Physical & Occupational Therapy in Geriatrics*, *33*. https://doi.org/10.3109/02703181.2015.1037979

Kokonya, A., & Fitzsimons, V. (2018). Transition to Long-Term Care: Preparing Older Adults and their Families. *MedSurg Nursing*, *27*(3), 143–149.

Lincoln, Y., & Guba, E. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In *The Sage handbook of qualitative research* (pp. 191–215). Sage Publications.

Miller, E. A., Gidmark, S., Gadbois, E., Rudolph, J. L., & Intrator, O. (2018). Staff Perceptions of Key Factors Guiding Nursing Home Search and Selection Within the Veterans Health Administration. *The Gerontologist*, *58*(4), e226–e238. https://doi.org/10.1093/geront/gnx096

NVivo. (n.d.). Lumivero. Retrieved July 20, 2024, from https://lumivero.com/products/nvivo/

O'Malley, K. A., Sullivan, J. L., Mills, W., Driver, J., & Moye, J. (2023). Trauma-Informed Care in Long-Term Care Settings: From Policy to Practice. *The Gerontologist*, *63*(5), 803–811. https://doi.org/10.1093/geront/gnac072

O'Neill, M., & Ryan, A. (2023). Experiences and Perceptions of Older People Making the Transition to Living in a Care Home: An Integrative Literature Review. *International Journal of Research in Nursing*, *14*(1), 1–18. https://doi.org/10.3844/ijrnsp.2023.1.18

Parry, K., & Pitchford-Hyde, J. (2023). *'We may have bad days. . . That doesn't make us killers': How military veterans perceive contemporary British media representations of military and post-military life*. *16*(3), 440–458.

Pedlar, D. J., & Thompson, J. (2011). Research in the life course of Canadian military Veterans and their families. In *Shaping the future: Military and Veteran health research* (pp. 15–31). Canadian Defence Academy Press.

Perrier, T. (2021). Treating Invisible Wounds: Improving The Cultural Competency Of Non-Va Providers Treating Rural Veterans Through Telepsychiatry. *Yale School of Nursing Digital Theses*. https://elischolar.library.yale.edu/ysndt/1122

Petrovic-Poljak A, Konnert C, Petrovic-Poljak, A., & Konnert, C. (2013). Sense of community in long-term care: The views of family caregivers of elderly military veterans. *International Psychogeriatrics*, *25*(3), 390–402. cin20. https://doi.org/10.1017/S1041610212001524

Pinazo-Hernandis, S., Blanco-Molina, M., & Ortega-Moreno, R. (2022). Aging in Place: Connections, Relationships, Social Participation and Social Support in the Face of Crisis Situations. *International Journal of Environmental Research and Public Health*, *19*(24), 16623. https://doi.org/10.3390/ijerph192416623

Pinciotti, C. M., Bass, D. M., McCarthy, C. A., Judge, K. S., Wilson, N. L., Morgan, R. O., Snow, A. L., & Kunik, M. E. (2017). Negative Consequences of Family Caregiving for Veterans With PTSD and Dementia. *The Journal of Nervous and Mental Disease*, *205*(2), 106. https://doi.org/10.1097/NMD.0000000000000560

Qureshi, S. U., Kimbrell, T., Pyne, J. M., Magruder, K. M., Hudson, T. J., Petersen, N. J., Yu, H.-J., Schulz, P. E., & Kunik, M. E. (2010). Greater prevalence and incidence of dementia in older veterans with posttraumatic stress disorder. *Journal of the American Geriatrics Society*, *58*(9), 1627–1633. https://doi.org/10.1111/j.1532-5415.2010.02977.x

Registered Nurses' Association of Ontario. (2015). *Person-and-family-centred care*.

Richardson, J., Long, M., Pedlar, D., & Elhai, J. (2010). Posttraumatic stress disorder and health realted quality of life in pension-seeking Canadian World War II and Korean War Veterans. *The Journal of Clinical Psychology, 71*(08), 1099-1101.

Ritchie, J., Lewis, J., Elam, G., Tennant, R., & Rahim, N. (2014). Designing and selecting samples. In *Qualitative reserach practice: A guide for social science students and researchers*. Sage Publications.

Ritchie, K., Cramm, H., Aiken, A., Donnelly, C., & Goldie, C. (2022). PTSD Symptoms and Dementia in Older Veterans Who are Living in Long-Term Care. *Qualitative Health Research*, *32*(3), 504–519. cin20. https://doi.org/10.1177/10497323211061345

Rubin, H. J., & Rubin, I. (2012). *Qualitative interviewing; the art of hearing data*. Sage Publications.

Rylee, T. L., Sarkar, S., Reed, S. C., Rafizadeh, E., & Bell, J. F. (2019). Unmet Needs for Information and Support Among Military Caregivers. *Military Medicine*, *184*(11–12), e922–e928. https://doi.org/10.1093/milmed/usz109

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*(4), 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, *33*(1), 77–84. https://doi.org/10.1002/nur.20362

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, *52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

Shepherd-Banigan, M., Smith, V. A., Lindquist, J. H., Cary, M. P., Miller, K. E. M., Chapman, J. G., Van Houtven, C. H., & Cary, M. P. J. (2020). Identifying treatment effects of an informal caregiver education intervention to increase days in the community and decrease caregiver distress: A machine-learning secondary analysis of subgroup effects in the HI-FIVES randomized clinical trial. *Trials*, *21*(1), 1–10. cin20. https://doi.org/10.1186/s13063-020-4113-x

Spiro III, A., & Settersten Jr., R. A. (2012). Long-Term Implications of Military Service for Later-Life Health and Well-Being. *Research in Human Development*, *9*(3), 183–190. https://doi.org/10.1080/15427609.2012.705551

Statistics Canada. (2022). *On guard for thee: Serving in the Canadian Armed Forces* (11-001–X).

Sun, C., Ding, Y., Cui, Y., Zhu, S., Li, X., Chen, S., Zhou, R., & Yu, Y. (2021). The adaptation of older adults' transition to residential care facilities and cultural factors: A meta-synthesis. *BMC Geriatrics*, *21*(1), 64. https://doi.org/10.1186/s12877-020-01987-w

Sweet, J., Poirier, A., Pound, T., & Van Til, L. (2020). *Well-Being of Canadian Regular Force Veterans: Findings from LASS 2019 Survey* [Research Directorate Technical Report]. Veterans Affairs Canada. https://www.veterans.gc.ca/en/about-vac/research/research-papers/well-being-canadian-regular-force-veterans-findings-lass-2019-survey

Thompson, J. M., VanTil, L., Feder, K., Sweet, J., Boswall, M., Courchesne, C., Banta, G. A., Lamontagne, P., Bogaert, L., McKinnon, K., & Poirier, A. (2016). Prevalence of hearing problems among Canadian Armed Forces Veterans: Life After Service Studies. *Journal of Military, Veteran and Family Health*, *2*(2), 62–72. https://doi.org/10.3138/jmvfh.4030

Tracy, S. J., & Hinrichs, M. M. (2017). Big Tent Criteria for Qualitative Quality. In *The International Encyclopedia of Communication Research Methods* (pp. 1–10). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781118901731.iecrm0016

Uphold, C. R., Jordan, M., & Freytes, M. (2014). Chapter 8 family caregivers of veterans: A critical review of the empirical literature and recommendations for future research. *Annual Review of Nursing Research*, *32*, 155–202. https://doi.org/10.1891/0739-6686.32.155

VanTil, L. D., MacLean, M. B., Sweet, J., & Mckinnon, K. (2018). *Understanding future needs of Canadian veterans* (pp. 20–25) [Health report]. https://www150.statcan.gc.ca/n1/pub/82-003-x/2018011/article/00003-eng.htm

VanTil, L. D., Thompson, J. M., MacLean, M. B., & Pedlar, D. J. (2016). Screening questions to identify Canadian Veterans. *Journal of Military, Veteran and Family Health*, *2*(1), 28–32. https://doi.org/10.3138/jmvfh.3587

Veterans Affairs Canada. (n.d.). *Families and caregivers*. Retrieved July 7, 2024, from https://veterans.gc.ca/en/families-and-caregivers

Veterans Affairs Canada. (2019). *Evaluation of the Long-term Care Program and the Intermediate Care Component of the Veterans Independence Program January 2019*. https://www.veterans.gc.ca/en/about-vac/publications-reports/departmental-reports/departmental-audit-evaluation/2019-evaluation-long-term-care

Veterans Affairs Canada. (2022). *Facts and Figures*. https://www.veterans.gc.ca/en/news-and-media/facts-and-figures

Veterans Ombudsman. (2014). *Veterans' Long-Term Care Needs—February, 2014*. https://ombudsman-veterans.gc.ca/en/publications/systemic-reviews/assisted-living-review

Veterans Ombudsman. (2017a). *Continuum of Care: A Journey from Home to Long Term Care - October 17, 2017*. https://www.ombudsman-veterans.gc.ca/en/publications/systemic-reviews/continuum

Veterans Ombudsman. (2017b). *Continuum of Care: A Journey from Home to Long Term Care - October 17, 2017*. https://www.ombudsman-veterans.gc.ca/en/publications/systemic-reviews/continuum

Veterans Transition Network. (n.d.). *Resources*. Retrieved July 7, 2024, from https://vtncanada.org/resources/?gclid=EAIaIQobChMI5KT6rqvA_AIVl-bjBx2azAJQEAAYBCAAEgLYM_D_BwE

WHO. (n.d.). *Determinants of health*. Retrieved June 16, 2024, from https://www.who.int/news-room/questions-and-answers/item/determinants-of-health

Williams, P., Lum, J., Morton-Chang, F., Kulusik, K., Peckham, A., Warrick, N., & Ying, A. (2016). *Integrating long-term care into a community-based continuum: Shifting from "beds" to "places".* (59). Institute for Research on Public Policy. https://irpp.org/research-studies/integrating-long-term-care-into-a-community-based-continuum/

Wolfson, C., Gauvin, D. E., Schulz, J., Magalhaes, S., Tansey, C. M., Feinstein, A., Aiken, A., Scarfo, B., Middleton, J., Raina, P., VanTil, L., & Molnar-Szakacs, I. (2023). The Canadian Longitudinal Study on Aging: A Vehicle for Research on Aging in Older Veterans. *Military Medicine*, usad012. https://doi.org/10.1093/milmed/usad012

Appendices

Appendix A: Recruitment Email Shared to LTCHs/Organizations/Family and Friends Councils

French will follow

To whom it may concern;

Hello,

My name is Georgia Stewart and I'm a master's student under the supervision of Dr. Annie Robitaille. We have recently received a grant through Veterans Affairs and will be conducting a qualitative study examining the needs of Veterans and their families across settings (e.g., community, funded home care, and long-term care) as care needs change. A better understanding of the transitions to long-term care would paint a more comprehensive picture of the journey lived by older Canadian Veterans and would facilitate the development of better-tailored programs and policies to the needs of older Veterans and their families.

We were wondering if you would be interested in being a part of our research project by allowing us to recruit Veterans and family members of Veterans living in long-term care. There are three ways your [home/organization] can participate in this study. You can choose to participate in one or up to all three options.

1. Your [long-term care home/organization name] can participate in this study by allowing us to recruit family members of Veterans to participate in a one-hour virtual interview. This only requires you to send an invitation email (which we will provide) and they can contact us directly if they are interested.
2. Your [long-term care home/organization name] can participate in this study by allowing us to recruit family members/caregivers to participate in a 40-minute online questionnaire. This only requires you to send an invitation email (which we will provide) to family members with a Survey Monkey link that they can complete if they choose to participate.
3. Finally, your [long-term care home/organization name] can participate in this study by allowing us to recruit Veteran residents to participate in a 45-minute interview (in-person) with our research team. This only requires you to circulate an invitation email and post an advertisement poster to your bulletin board (which we will provide). They can contact us directly or you can provide us with the names and contact information of Veterans who are willing to be contacted to participate in the study.

Unless explicitly specified, the involvement of your long-term care facility will not be kept anonymous.

I am available to speak via videoconference or telephone if you have any questions.

Thank you in advance for your consideration.

Sincerely,

Georgia Stewart

Bonjour,

Je m'appelle Georgia Stewart et je suis une étudiante qui fait ça maîtrise sous la supervision de Dre Annie Robitaille. Nous avons récemment reçu une subvention par l'intermédiaire d'Anciens Combattants et mènerons une étude qualitative examinant les besoins des Vétérans et de leurs familles dans diffèrent contextes de vie (p. ex., communauté, soins à domicile financés et soins de longue durée) à mesure que leurs besoins changent. Une meilleure compréhension des transitions vers les soins de longue durée desserrait une image plus complète du parcours vécu par les Vétérans canadiens et faciliterait l'élaboration de programmes et de politiques mieux adaptés aux besoins des Vétérans et de leurs familles.

Nous vous demandions si vous seriez intéressé à faire partie de notre projet de recherche en nous permettant de recruter des Vétérans et/ou des membres de leurs familles vivant dans votre foyer de soins de longue durée. Votre foyer peut participer à cette étude de trois manières. Vous pouvez choisir de participer à une seule ou jusqu'aux trois options.

1. Votre foyer de soins de longue durée peut participer à cette étude en nous permettant de recruter des membres de la famille des Vétérans pour participer à une entrevue virtuelle d'une heure. Cela nécessite seulement que vous envoyiez un courriel d'invitation (que nous fournirons) et ils peuvent nous contacter directement s'ils sont intéressés.
2. Votre foyer de soins de longue durée peut participer à cette étude en nous permettant de recruter des membres de la famille/proches aidants pour participer à un questionnaire en ligne de 40 minutes. Cela nécessite uniquement que vous envoyiez un courriel d'information (que nous fournirons) aux membres de la famille avec un lien Survey Monkey qu'ils pourront compléter s'ils choisissent de participer.
3. Enfin, votre foyer de soins de longue durée peut participer à cette étude en nous permettant de recruter des résidents Vétérans pour participer à une entrevue de 45 minutes (en personne) avec notre équipe de recherche. Cela vous oblige seulement à faire circuler un courriel d'invitation et à publier une affiche publicitaire sur votre babillard (que nous vous fournirons). Ils peuvent nous contacter directement ou vous pouvez nous fournir les noms et les coordonnées des Vétérans qui acceptent d'être contactés pour participer à l'étude.

À moins d'indication explicite, l'implication de votre établissement de soins de longue durée ne restera pas anonyme.

Je suis disponible pour parler par visioconférence ou par téléphone si vous avez des questions.

Merci d'avance pour votre considération.

Sincèrement,

Georgia Stewart

Appendix B: Email Invitation to Care Partners

Subject: Invitation to participate in a national research project "Supporting preferences of older Veterans and families in later life to promote health and well-being"

Hello,

I am writing to you today to invite you to participate in a study entitled "Supporting preferences of older Veterans and families in later life to promote health and well-being".

The objectives of this study are to examine:

1) What are the best practices in community programming to improve health outcomes for older Veterans and their families/caregivers while supporting ageing at home and reduce/delay admission to long-term care?
2) How can these changes be adapted and scaled to different contexts (e.g., Rural, Female, LGBTQ2, Low-Income, and Visible Minority Veterans)?
3) How can transitions (e.g., the transition from community to long-term care) be improved to support older Veterans and their families/caregivers as care needs change?

Please note that the project is being conducted independently from the organizations and agencies from which you may be recruited and that your decision to participate (or not) will not impact your relationship with the organization (or LTC home). You will have the right to end your participation in the study at any time, for any reason.

We are inviting **caregivers/ family members** of older Canadian Veterans to participate in this research study. You can choose to participate in the study in one or both of the following ways:

1) Participate in a 1-hour interview (via telephone or videoconferencing) with our research team
2) Complete a 40-minute online survey

All participants must be:

1) Able to provide informed consent verbally or in writing
2) English or French- speaking
3) A caregiver of a Veteran. Our study defines a Veteran as a former officer or non-commissioned member of the Canadian Armed Forces; Regular or Reserve force. This description includes anyone who has served, regardless of the duration of their service, but who is no longer serving in an active capacity. This includes all individuals who, at any point in their life, wore a uniform.

If you choose to participate in the **interview portion of the research:**

You will be asked a series of open-ended questions about your experiences or recommendations regarding:

1) Your role as a caregiver
2) Navigating transitions that you or your care partner may have experienced
3) Best practices in community programming to improve health outcomes for older Veterans and their families
4) How can transitions (e.g., the transition from community to long-term care) be improved to support older Veterans and their families as care needs change?

As a thank you for your time and participation, you will receive a mailed 30$ Tim Hortons gift card following the virtual/telephone interview. Mailing addresses will only be collected for those who wish to receive a gift card and will be deleted as soon as the gift card is mailed.

If you choose to participate in the **survey portion of the research:**

- You will be asked to complete an online survey. The time required to complete this questionnaire is estimated at 40 minutes. You will be asked questions regarding your carer role and how and if it has an impact on your health.
- Due to the anonymous nature of the survey, we will not be able to provide any compensation if you wish to exclusively participate in this portion.
- If you would like to participate in the survey portion of the research project, please click the following link :

The University of Ottawa Research Ethics Board has approved the ethical components of this project. Should you have any ethical concerns with the study, please contact the University of Ottawa (by phone: 613-562-5387 or by email: ethics@uottawa.ca).

The research study is an opportunity for you to contribute to change in your community or country regarding the health needs of Veterans and their families.

Participation in this study is voluntary. You have the right to leave the study at any time without any repercussions.

If you are interested in participating in the interview portion of the study, I can give you a copy of the Informed Consent for your review and we can start the process of enrolling you in the study. If you would like to participate, please email the research assistant: [redacted]

If you have any other questions, you can contact:

Primary Investigator:

Annie Robitaille [redacted] Assistant Professor, Faculty of Health Sciences, Interdisciplinary School of Health Sciences, University of Ottawa

Appendix C: Recruitment Poster (EN/FR)

Soutenir les préférences des Vétérans plus âgés et des familles pour promouvoir la santé et le bien-être

Recherche menée par Dre Annie Robitaille

Nous avons besoin de votre avis et opinions!

Nous menons une recherche pour découvrir:

1. Quelles sont les meilleures pratiques en programmation commaunautaire pour améliorer la santé des Vétérans ?
2. Comment soutenir le vieillissement à domicile et réduire/ retarder l'admission en soins de longue durée?
3. Comment ces changements peuvent-ils être adaptés selon différentes populations (p. ex. milieu rural, femme, à faible revenu, minorité visible) ?

Qui peut participer?

- Les Vétérans âgés de 55 ans ou plus qui acceptent de participer à une entrevue d'une heure (via téléphone ou videoconférence) avec notre équipe de recherche pour nous faire part de leurs besoins, de leurs expériences et de leurs idées.
- Les proches aidants/ membres de la famille des Vétérans qui sont prêts à participer à l'étude dans une ou deux des façon suivantes: 1) Participer à une entrevue d'une heure (per téléphone ou vidéoconférence) avec notre équipe de recherche, 2) Répondre à un sondage en ligne de 40 minutes sur votre rôle d'aidant.
  - Les Vétérans et les proches aidants qui participent à la partie entrevue de l'étude recevront une carte-cadeau Tim Hortons de 30$

Tous les participants doivent :

- Parlez le français ou l'anglais
- Être des résidents canadiens (nes)

Pour plus d'informations, veuillez contacter: [redacted]

uOttawa

Perley Health
Centre of Excellence in Frailty-Informed Care™

Les aspects éthiques de cette étude ont été approuvés par le comité d'éthique de l'Université d'Ottawa.

Appendix D: Interview Guide of a Care Partner with a Veteran living in LTC

Interview Question	Prompts
1. How would you describe your (family member's/friend's) initial transition to living in a long-term care home? (How was it when they first moved into long-term care? What was the process like?)	How was it before? How was it during? How was it after? Was it more difficult or easier than expected? Do you think transitions are different for Veterans? Why or why not? Do you think certain things could have made the transition easier?
- What was useful with their move into the long-term care home?	Were there any resources (programs, people, services, financial supports) that would have helped during this time? Was there anything additional that would have helped that you didn't have?
- What about before the decision for your family member/friend to move into a long-term care home? Could you and your **(**family member/friend) have used additional resources for your (family member/friend) to remain living at home longer? If so, what are they?	
2. How did you and your (family member/friend) choose which long-term care home they wanted to move to?	Was —— important when choosing a LTC home: • **Home for Veterans** • Type of care provided • Geographic location • Language or cultural features of the home
- Did they end up in the long-term care home of their choice?	

- Approximately how long was your (family member/friend) on a waiting list for a long-term care home? - Thinking about everything we talked about (family members/friends' choice of LTCH, length of time on the waiting list) did any of this have an impact on the transition? Please explain - What about for Veterans? (Do you think the move into long-term care is different or the same for Veterans and their families?)	
3. We've just discussed your (family members/friends) move into long-term care and now I would like to talk about your experience since your (family member/friend) has moved into long-term care. Tell me what that's like? - Any difficulties or challenges? - Do you think these are specific to being a family member/friend of a Veteran? - How have you managed to overcome or resolve these challenges?	How does this impact them and you? (Both perspectives are fine: Care partners experience and/or perceived Veterans experience)
4. How about their care needs? How are those being met?	
5. How about the activities available to your (family member/friend) in their long-term care home? - Are there activities they wish were available but are not? Can you give me some examples.	What are the activities they like the most or help them the most and why? Did your (family member/friend) experience the following obstacles: • There are no activities that correspond to their interests • Activities offered are

- What activities, if any, do you think should be available to Veterans specifically? - Are there any obstacles that prevent them from participating in activities?	not adapted to their language or culture • The activities that are available are too easy or difficult for their current level of functioning
6. How about the opportunities for social connection in your family member/friend's long-term care home? - Are there any obstacles to having more social connections? - Are social connections with other Veterans important to them? Do they have enough opportunities for social connection with Veterans?	How does/doesn't this impact them? How about: • Cultural differences • Language differences • Interests • Specific routines Do you feel that they fit in with others?
7. How about the physical living environment? (Their room, common areas etc.) - Anything that they particularly liked or that was challenging for them	What changes would you make to their physical surroundings if you could?
8. Are there ways that you feel that Veterans and their families could be better recognized/supported by others? - Do you feel understood and valued as a care partner of a Veteran by others?	Family/care partners? Other residents? Healthcare providers?

- Do you feel that your family member/friend is understood and valued (as a Veteran) by others?	
9. Thinking back to everything we have discussed so far, what is most important to your overall sense of well-being and that of your (family member/friend).	
10. Is there anything you would like to add that we haven't discussed but that you feel would be important for us to know?	

Appendix E: Demographic Questionnaire

1. What sex were you assigned at birth, meaning on your original certificate?:
   - ☐ Male
   - ☐ Female
   - ☐ Prefer not to answer

2. Which best describes your current gender identity?:
   - ☐ Man
   - ☐ Woman
   - ☐ Gender-diverse
   - ☐ Nonbinary
   - ☐ Prefer not to answer
   - ☐ Prefer to self-describe: Please specify:

3. What is your age?:

4. What is your relation to the Veteran you are caring for:
   - ☐ Spouse
   - ☐ Child
   - ☐ Sister/brother
   - ☐ Cousin
   - ☐ Friend

   Other:

5. How long have you been a caregiver to the Veteran in your life?:

6. Please specify your ethnicity?:
   - ☐ Caucasian/ White/ European Origin
   - ☐ African- American/ Black / African Origin
   - ☐ Latino-a/ Hispanic

☐ Asian- American / Asian Origin / Pacific Islander

☐ Native American / Aboriginal Canadian

☐ Bi-racial / Multi-racial

Other:

7. What is your Marital Status?:
   ☐ Single

   ☐ Married / Common law

   ☐ Widowed

   ☐ Divorced

   ☐ Separated

8. What is the highest degree or level of education that you have completed?:
   ☐ Some high school

   ☐ High school

   ☐ Non-University certificate (trade certificate diploma from a vocational school or apprenticeship training. Certificate or diploma from a community college, CEGEP, etc.)
   ☐ Bachelor's degree

   ☐ University degree above a bachelor's degree (master's degree, PhD, MD, JD, etc.)

9. Where is your home located?:
   ☐ Urban/ city

   ☐ Rural/ town

      Please specify your distance from the nearest city

10. How far do you reside from the Veteran in your life:
    ☐ In the same city/ town

    ☐ In a different city/ town

       Please specify the distance:

11. Where does the Veteran in your life live:
    ☐ Long term care home/ assisted living facilities

- ☐ Retirement home/ communities
- ☐ With a family member that provides care
- ☐ With me in my home
- ☐ Independent living / homeowner/ home renter

12. Does the Veteran in your life have any disabilities?:
    - ☐ No
    - ☐ Yes, please specify below:
        - ☐ Physical / Orthopedic (e.g., amputation, paralysis, stroke, reduced mobility)
        - ☐ Blind / Visually Impaired
        - ☐ Deaf/ Hard of Hearing
        - ☐ Cognitive difficulties (e.g, mild cognitive impairment, dementia)
        - ☐ Mental Health Illness (e.g., PTSD, depression, substance use)

        Other:

13. Do you have any disabilities?:
    - ☐ No
    - ☐ Yes, please specify below:
        - ☐ Physical / Orthopedic (e.g., amputation, paralysis, stroke, reduced mobility)
        - ☐ Blind / Visually Impaired
        - ☐ Deaf/ Hard of Hearing
        - ☐ Cognitive difficulties (e.g, mild cognitive impairment, dementia)
        - ☐ Mental Health Illness (e.g., PTSD, depression, substance use)

        Other:

14. What language do you primarily speak:
    - ☐ English
    - ☐ French

☐ Both English and French

Other:

15. What is your annual household income?

☐ Less than $25, 000

☐ $25,000 - $50, 000

☐ $50, 000 - $100, 000

☐ $100, 000 - $200, 000

☐ More than $200, 000

☐ Prefer not to say

Appendix F: Ethics Certificate from the University of Ottawa Research Ethics Board

13/11/2023

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE I CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-09-22-8336
Titre du projet / Project Title	Supporting preferences of older Veterans and families in later life to promote health and well-being
Type de projet / Project Type	Recherche de professeur / Professor's research project
Statut du projet / Project Status	Renouvelé / Renewed
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	07/12/2022
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	06/12/2024

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Annie ROBITAILLE	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Chercheur Principal / Principal Investigator
Michaela ADAMS	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Assistant de recherche / Research Assistant
Danielle SINDEN	The Perley and Rideau Veterans' Health Centre	Collaborateur / Collaborator
Benoît ROBERT	Perley Rideau Veterans' Health Centre	Co-chercheur / Co-investigator
Jacinthe SAVARD	École des sciences de la réadaptation / School of Rehabilitation Sciences	Co-chercheur / Co-investigator
Amy HSU	Département de médecine familiale / Department of Family Medicine	Co-chercheur / Co-investigator
Sina POURFARZANEH	Département de sociologie et d'anthropologie / Department of Sociology and Anthropology	Coordonnateur de recherche / Research Coordinator
Valérie RANGER	École de psychologie / School of Psychology	Assistant de recherche / Research Assistant
Georgia STEWART	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Étudiant-chercheur / Student-researcher
Emma STARR	University of Ottawa	Étudiant-chercheur / Student-researcher

Conditions spéciales ou commentaires / Special conditions or comments

550, rue Cumberland, pièce 154
Ottawa (Ontario) K1N 6N5 Canada

550 Cumberland Street, Room 154
Ottawa, Ontario K1N 6N5 Canada

613-562-5387 • 613-562-5338 • ethique@uOttawa.ca / ethics@uOttawa.ca
www.recherche.uottawa.ca/deontologie I www.recherche.uottawa.ca/ethics

Appendix G: Information Letter and Consent Form

uOttawa
Faculté des sciences de la santé
Faculty of Health Sciences

Université d'Ottawa
Faculté des sciences de la santé

École interdisciplinaire des sciences de la santé

University of Ottawa
Faculty of Health Sciences

Interdisciplinary School of Health Sciences

Consent Form- Veterans & Caregivers

Study: Supporting preferences of older Veterans and families in later life to promote health and well-being

Principal Investigator:
Annie Robitaille
Assistant Professor, Faculty of Health Sciences, Interdisciplinary School of Health Sciences
University of Ottawa
[redacted]

Dear Madam, Sir,
This is to inform you of a research project being conducted by researchers from the University of Ottawa and Perley Health.

What is the purpose of this study?
The objectives of this study are to examine: (1) What are the best practices in community programming to improve health outcomes for older Veterans and their families and support ageing at home and reduce/delay admission to long-term care? (2) How can these be adapted and scaled to different contexts (e.g. Rural, Female, LGBTQ2, Low-Income, and Visible Minority Veterans)? (3) How can transitions (e.g., the transition from community to long-term care) be improved to support older Veterans and their families as care needs change? The project is being conducted independently from the organizations and agencies from which participants may be recruited and your decision to participate (or not) will not impact your relationship with these organizations and agencies.

What will my participation involve?
As a participant, you will be asked to share your experience on the practices in community programming that have improved health outcomes for older Veterans and their families, supported ageing at home and reduced/delayed admission to long-term care. We will also seek your insight on how the transition from community to long-term care can be improved to support older Veterans and their families as care needs change. The interview will be conducted virtually, facilitated through Zoom. The interview will be approximately 60 minutes in duration and will be audio-recorded.

☎ 613-562-5800 ext. 2983
613-562-5632

25 Université/University
Ottawa ON K1N 6N5 Canada

www.uOttawa.ca

uOttawa
Faculté des sciences de la santé
Faculty of Health Sciences

Université d'Ottawa
Faculté des sciences de la santé

École interdisciplinaire des sciences de la santé

University of Ottawa
Faculty of Health Sciences

Interdisciplinary School of Health Sciences

613-562-5800 ext. 2983
613-562-5632

25 Université/University
Ottawa ON K1N 6N5 Canada

www.uOttawa.ca

What are the benefits of my participation?
You may benefit from sharing your experiences during the interview with a research assistant. In addition, the data gained from this project will lead to recommendations that can promote health and well-being for Veterans and their families.

What are the potential risks of my participation?
There is a level of risk related to participation in this study. The topics discussed in the interviews may cause some tiredness and emotional discomfort. You are asked to inform members of the research team if that is the case. You can stop the interview at any time and/ or decline to answer any questions.

Neither your participation in this interview nor your responses to the questions will have an impact on your relationship with the organizations and agencies from which you may be recruited.

Is there anything I can do if I found this experiment to be emotionally upsetting?
If you experience psychological or emotional discomfort during or after the interview, please feel free to contact:

- Distress Centre of Ottawa and Region - 613-238-3311, www.dcottawa.on.ca
- Ottawa Mental Health Crisis Line - 613-722-6914, www.crisisline.ca.
- Canada Suicide Prevention Service (Canada Wide; Bilingual) -1-833-456-4566

Funding Source and Research Team: This study is being funded through the Veterans and Family Well-Being grant provide by Veterans Affairs Canada. Data from this project may be used for student project purposes.
The following researchers will be a part of informing and conducting the study:

- Annie Robitaille (University of Ottawa)
- Valerie Ranger (University of Ottawa)
- Benoît Robert (The Perley and Rideau Veterans' Health Centre)
- Jacinthe Savard (University of Ottawa)
- Danielle Sinden (The Perley and Rideau Veterans' Health Centre)
- Amy Hsu (University of Ottawa)
- Sina Pourfazaneh (University of Ottawa)
- Georgia Steward (University of Ottawa
- Emma Starr (University of Ottawa)
- Katelyn Adey (University of Ottawa)

uOttawa
Faculté des sciences de la santé
Faculty of Health Sciences

Université d'Ottawa
Faculté des sciences de la santé

École interdisciplinaire des sciences de la santé

University of Ottawa
Faculty of Health Sciences

Interdisciplinary School of Health Sciences

- Michaela Adams (The Perley and Rideau Veterans' Health Centre)

Confidentiality and Privacy: You have received assurance from the researchers that the information that you will share will remain strictly confidential. You understand that the contents will be used only for the purpose of the research stated above. Names or other identifying information (i.e., names, unique diagnoses, etc.) will be removed from transcripts and data. Names of LTC homes will not be revealed. You will be identified by a code. Only summarized findings will be reported (no individual data) in future publications.

Privacy and confidentiality cannot be guaranteed if you share any information that would indicate harm or risk of harm to myself or others (references to suicide or plans to physically harm another human). Should you make such a disclosure, the research team will consult the appropriate authorities to ensure the participant's health and safety.

Conservation of Data: The data collected including, audio recordings, interview transcripts, researchers' notes, and consent forms will be kept securely on a password-protected OneDrive folder. Only researchers and research assistants working on the study will have access to the research documents. The data collected will be kept for five years following the end of the study. After this period, all electronic data will be securely deleted, and all paper documentation will be shredded.

Compensation: You will receive a 30$ Tim Horton gift card for compensation for your time. If you choose to withdraw from the study, you will still receive this compensation. The gift cards will be mailed to you if you agree to provide your mailing address for this sole purpose.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be removed from the dataset and not used in the study.

If you have any questions about the study, you may contact the Principal Investigator. If you have any questions regarding the ethical conduct of this study, you may contact the Office of Research and Integrity via email (ethics@uottawa.ca) or telephone (613-562-5387).

☎ 613-562-5800 ext. 2983
🖷 613-562-5632

25 Université/University
Ottawa ON K1N 6N5 Canada

www.uOttawa.ca

uOttawa
Faculté des sciences de la santé
Faculty of Health Sciences

Université d'Ottawa
Faculté des sciences
de la santé

École interdisciplinaire
des sciences de la santé

University of Ottawa
Faculty of Health
Sciences

Interdisciplinary School
of Health Sciences

☎ 613-562-5800 ext. 2983
🖷 613-562-5632

25 Université/University
Ottawa ON K1N 6N5 Canada

www.uOttawa.ca

It is recommended that you keep a copy of this consent form for your records.

Acceptance:

By signing your name below, you agree to participate in this research study.

Participant's name: _____ Date: _____

Participant's signature: _____Date: _____

Researcher's signature: _____Date: _____